As Introduced

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H. B. No. 214

Representative Miller, K.

To amend sections 1751.72, 3923.041, and 5160.34 and to enact section 5160.341 of the Revised Code to require the Medicaid program and certain health insurers to report data about prior authorization requirements and to require an exemption to such requirements for certain providers.

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

Section 1. That sections 1751.72, 3923.041, and 5160.34 be amended and section 5160.341 of the Revised Code be enacted to read as follows:

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 services" has the same meaning as in section 1753.28 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) "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 either of the following:

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

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

(10) "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) For policies issued on or after 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) For policies issued on or after 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 for prescription drug requests that does not use NCPDP SCRIPT standard.

(3) For policies issued on or after 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) For policies issued on or after January 1, 2018, if the health care practitioner submits the request for prior authorization as described in divisions (B)(1) and (2) of this section, the health insuring corporation shall respond to all prior authorization requests within forty-eight hours for urgent care services, or ten calendar days for any prior authorization request that is not for an urgent care service, of the time the request is received by the health insuring corporation. Division (B)(4) of this section does not apply to emergency services.

(b) The response required under division (B)(4)(a) of this section shall indicate whether the request is approved or denied. If the prior authorization is denied, the health insuring corporation shall provide the specific reason for the denial.

(c) If the prior authorization request is incomplete, the health insuring corporation shall indicate the specific additional information that is required to process the request.

(5)(a) For policies issued on or after January 1, 2018, if a health care practitioner submits a prior authorization request as described in divisions (B)(1) and (2) of this section, the health insuring corporation shall provide an electronic receipt to the health care practitioner acknowledging that the prior authorization request was received.

(b) For policies issued on or after January 1, 2018, if a health insuring corporation requests additional information that is required to process a prior authorization request as described in division (B)(4)(c) of this section, the health care practitioner shall provide an electronic receipt to the health insuring corporation acknowledging that the request for additional information was received.

(6)(a) For policies issued on or after 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.

(i) The request for information by the health insuring corporation and the response by the health care practitioner 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 practitioner does not respond within five calendar days from the date the request was received, the health insuring corporation 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 do not support a twelve-month prior approval;

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

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

(7) For policies issued on or after 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 either of the following:

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

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

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

(8) Nothing in division (B)(6) or (7) of this section prohibits the substitution, in accordance with section 4729.38 of the Revised Code, of any drug that has received a twelve-

month approval under division (B)(6)(a) of this section when there is a release of either of the following:

(a) A United States food and drug administration approved comparable brand product or a generic counterpart of a brand product that is listed as therapeutically equivalent in the United States food and drug administration's publication titled approved drug products with therapeutic equivalence evaluations;

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

(9)(a) For policies issued 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) For policies issued on or after 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.

(c) All participating health care practitioners shall promptly notify the health insuring corporation of any changes to the health care practitioner's electronic mail or standard mail address.

(11)(a) For policies issued on or after 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 practitioner 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) For policies issued on or after January 1, 2018, the

health insuring corporation shall establish a streamlined appeal process relating to adverse prior authorization determinations that shall include all of the following:

(a) For urgent care services, the appeal shall be considered within forty-eight hours after the health insuring corporation receives the appeal.

(b) For all other matters, the appeal shall be considered within ten calendar days after the health insuring corporation receives the appeal.

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

(d) If the appeal does not resolve the disagreement, either the covered person or an authorized representative as defined in section 3922.01 of the Revised Code may request an external review under Chapter 3922. of the Revised Code to the extent Chapter 3922. of the Revised Code is applicable.

(13)(a) For policies issued on or after January 1, 2027, the health insuring corporation shall make prior authorization data from the previous calendar year available to all participating health care practitioners in aggregate form for all services, drugs, or devices for which prior authorization is required, including all of the following:

(i) The percentage of standard and expedited prior authorization requests that were approved, denied, and approved after appeal;

(ii) The percentage of prior authorization requests for which the timeframe for review was extended;

(iii) The average and median time that elapsed between the submission of a prior authorization request and issuance of a decision by the health insuring corporation for standard and expedited requests.

(b) The health insuring corporation shall ensure that no later than the last day of March each year, beginning in 2027, the data described in division (B)(13)(a) of this section is both:

(i) Made available on the health insuring corporation's web site or provider portal;

(ii) Compiled into a report and submitted to the department of insurance.

(c) The department shall publish each report received under division (B)(13)(b)(ii) of this section on department's web site and submit it to the general assembly in accordance with section 101.68 of the Revised Code.

(14)(a) For policies issued on or after January 1, 2027, the health insuring corporation shall not require a health care provider or health care provider group to comply with a prior authorization requirement for a health care service, medical device, or drug if both of the following apply:

(i) The health insuring corporation approved, or would have approved, at least ninety per cent of the prior authorization requests submitted by the health care provider or health care provider group for that service, device, or drug during the preceding twelve months;

(ii) The health care provider or health care provider group submitted at least twenty prior authorization requests for the service, device, or drug to the health insuring corporation

during the preceding twelve months.

(b) The health insuring corporation shall provide the exemption required by division (B)(14) of this section for a period not less than twelve months. Nothing in division (B)(14) of this section shall be construed as prohibiting a health insuring corporation from providing such an exemption for a period exceeding twelve months.

(c) A health care provider or health care provider group that does not receive an exemption under division (B)(14) of this section may request that the health insuring corporation provide evidence to the provider or provider group supporting the health insuring corporation's decision to not grant an exemption. The health care provider or health care provider group shall not make more than one request under division (B)(14)(c) of this section for the same service, device, or drug in the same calendar year. The health insuring corporation comply with such a request.

(d) A health care provider or health care provider group may appeal the health insuring corporation's decision to deny an exemption under division (B)(14) of this section.

(e) The health insuring corporation shall not require a health care provider or health care provider group to request an exemption under division (B)(14) of this section.

(f) The health insuring corporation shall not deny or reduce payment for a service, device, or drug that is provided without prior authorization pursuant to an exemption granted under division (B)(14) of this section on the sole basis that the service, device, or drug 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. Division (B)(14)(f) of this section does not apply if the providing or supervising provider or provider group does either of the following:

(i) Knowingly and materially misrepresents the service, device, or drug provided in the request for payment with the intent to obtain an unlawful payment amount from the health insuring corporation;

(ii) Fails to substantially perform the service or to provide the device or drug.

(g) The health insuring corporation shall notify the health care provider or health care provider group in writing when the health insuring corporation grants an exemption under division (B)(14) of this section for a service, device, or drug. The notice must include all of the following information:

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

(ii) The service, device, or drug to which the exemption applies;

(iii) The dates the exemption begins and ends.

(h)(i) At the end of the exemption period, the health insuring corporation may evaluate the exemption granted under division (B)(14) of this section.

(ii) In conducting such an evaluation, the health insuring corporation shall review twenty claims submitted to the health insuring corporation in the preceding three months, selected at random, for the service, device, or drug in question. If there

are not twenty relevant claims in the preceding three months, the health insuring corporation may review claims submitted earlier.

(iii) If less than ninety per cent of the reviewed claims would have been approved based on medical necessity, then the health insuring corporation may revoke the exemption. A health insuring corporation that revokes an exemption shall provide the health care provider or health care provider group with the information the health insuring corporation relied upon in revoking the exemption and a plain language explanation of how to appeal the revocation.

(iv) A health insuring corporation shall not evaluate a health care provider's or health care provider group's exemption relating to a particular service, device, or drug more than once every twelve months.

(v) Nothing in division (B)(14) of this section shall be construed as requiring health insuring corporation to evaluate an existing prior authorization exemption.

(i) If an exemption under division (B)(14) of this section is revoked by the health insuring corporation and that revocation is not appealed, the exemption remains in effect for thirty days following the date the health insuring corporation notifies the health care provider or health care provider group of the revocation.

(j) A health care provider or health care provider group may appeal the revocation of an exemption under division (B)(14) of this section within thirty days after receiving notification of the revocation. If the provider or provider group appeals a revocation and the revocation is upheld, the exemption remains

in effect for five days after the date the revocation is upheld.

(k) The health insuring corporation shall not revoke or deny an exemption under division (B)(14) of this section unless a health care provider licensed in this state who practices the same or a similar specialty as the health care provider or health care provider group at issue, and who has experience in providing the service, device, or drug at issue, determines that the denial or revocation is warranted in accordance with division (B)(14) of this section.

(l) Nothing in division (B)(14) of this section shall be construed to prohibit a health insuring corporation from making an administrative denial of a claim.

(C) For policies issued on or after January 1, 2017, except in cases of fraudulent or materially incorrect information, a health insuring corporation shall not retroactively deny a prior authorization for a health care service, drug, or device when all of the following are met:

(1) The health care practitioner submits a prior authorization request to the health insuring corporation for a health care service, drug, or device.

(2) The health insuring corporation approves the prior authorization request after determining that all of the following are true:

(a) The patient is eligible under the health benefit plan.

(b) The health care service, drug, or device is covered under the patient's health benefit plan.

(c) The health care service, drug, or device meets the health insuring corporation's standards for medical necessity

and prior authorization.

(3) The health care practitioner renders the health care service, drug, or device pursuant to the approved prior authorization request and all of the terms and conditions of the health care practitioner's contract with the health insuring corporation.

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

(a) The patient is eligible under the health benefit plan.

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

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

(5) If the health care practitioner 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 practitioner in the approved prior authorization request, upon receiving a denial of services from the health insuring corporation, the health care practitioner 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 a health insuring corporation and a health care practitioner or beneficiary that is contrary to divisions (A) to (C) of this section is unenforceable.

(E) For policies issued on or after 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.

(F) The superintendent of insurance may adopt rules in accordance with Chapter 119. of the Revised Code as necessary to implement the provisions of this section.

(G) This section does not apply to any of the following types of coverage: a policy, contract, certificate, or agreement that covers only a specified accident, accident only, credit, dental, disability income, long-term care, hospital indemnity, supplemental coverage as described in section 3923.37 of the Revised Code, specified disease, or vision care; a dental benefit that is offered as a part of a policy, contract, certificate, or agreement offered by a health insuring corporation; coverage issued as a supplement to liability insurance; insurance arising out of workers' compensation or similar law; automobile medical payment insurance; insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance; a medicare supplement policy of insurance as defined by the superintendent of insurance by rule; coverage under a plan through medicare or the federal employees benefit program; or any coverage issued under Chapter 55 of Title 10 of the United States Code and any coverage issued as a supplement to that coverage.

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 service" has the same meaning as in section 1753.28 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 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" 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 either of the following:

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

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

(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) For policies issued on or after 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) For policies issued on or after 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) For policies issued on or after 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 for prescription drug requests that does not use NCPDP SCRIPT standard.

(3) For policies issued on or after 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) For policies issued on or after January 1, 2018, if the health care practitioner submits the request for prior authorization electronically as described in divisions (B)(1) and (2) of this section, the insurer or plan shall respond to all prior authorization requests within forty-eight hours for urgent care services, or ten calendar days for any prior

authorization request that is not for an urgent care service, of the time the request is received by the insurer or plan. Division (B)(4) of this section does not apply to emergency services.

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

(c) If the prior authorization request is incomplete, the insurer or plan shall indicate the specific additional information that is required to process the request.

(5)(a) For policies issued on or after January 1, 2018, if a health care practitioner submits a prior authorization request as described in divisions (B)(1) and (2) of this section, the insurer or plan shall provide an electronic receipt to the health care practitioner acknowledging that the prior authorization request was received.

(b) For policies issued on or after January 1, 2018, if an issuer or plan requests additional information that is required to process a prior authorization request as described in division (B)(4)(c) of this section, the health care practitioner shall provide an electronic receipt to the issuer or plan acknowledging that the request for additional information was received.

(6)(a) For policies issued on or after 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.

(i) The request for information by the insurer or plan and the response by the health care practitioner 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 practitioner 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 do not support a twelve-month prior approval;

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

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

(7) For policies issued on or after 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 either of the following:

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

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

For purposes of division (B)(7) of this section, "rare

medical condition" means any disease or condition that affects fewer than two hundred thousand individuals in the United States.

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

(a) A United States food and drug administration approved comparable brand product or a generic counterpart of a brand product that is listed as therapeutically equivalent in the United States food and drug administration's publication titled approved drug products with therapeutic equivalence evaluations;

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

(9)(a) For policies issued 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) For policies issued on or after 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.

(c) All participating health care practitioners shall promptly notify the insurer or plan of any changes to the health care practitioner's electronic mail or standard mail address.

(11)(a) For policies issued on or after 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 practitioner 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) For policies issued on or after January 1, 2018, the insurer or plan shall establish a streamlined appeal process relating to adverse prior authorization determinations that shall include all of the following:

(a) For urgent care services, the appeal shall be considered within forty-eight hours after the insurer or plan receives the appeal.

(b) For all other matters, the appeal shall be considered within ten calendar days after the insurer or plan receives the appeal.

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

(d) If the appeal does not resolve the disagreement, either the covered person or an authorized representative as defined in section 3922.01 of the Revised Code may request an external review under Chapter 3922. of the Revised Code to the extent Chapter 3922. of the Revised Code is applicable.

(13)(a) For policies issued on or after January 1, 2027, the insurer or plan shall make prior authorization data from the previous calendar year available to all participating health care practitioners in aggregate form for all services, drugs, or devices for which prior authorization is required, including all of the following:

(i) The percentage of standard and expedited prior

authorization requests that were approved, denied, and approved after appeal;

(ii) The percentage of prior authorization requests for which the timeframe for review was extended;

(iii) The average and median time that elapsed between the submission of a prior authorization request and issuance of a decision by the insurer or plan for standard and expedited requests.

(b) The insurer or plan shall ensure that no later than the last day of March each year, beginning in 2027, the data described in division (B)(13)(a) of this section is both:

(i) Made available on the insurer's or plan's web site or provider portal;

(ii) Compiled into a report and submitted to the department of insurance.

(c) The department shall publish each report received under division (B)(13)(b)(ii) of this section on department's web site and submit it to the general assembly in accordance with section 101.68 of the Revised Code.

(14)(a) For policies issued on or after January 1, 2027, the insurer or plan shall not require a health care provider or health care provider group to comply with a prior authorization requirement for a health care service, medical device, or drug if both of the following apply:

(i) The insurer or plan approved, or would have approved, at least ninety per cent of the prior authorization requests submitted by the health care provider or health care provider group for that service, device, or drug during the preceding

twelve months;

(ii) The health care provider or health care provider group submitted at least twenty prior authorization requests for the service, device, or drug to the insurer or plan during the preceding twelve months.

(b) The insurer or plan shall provide the exemption required by division (B)(14) of this section for a period not less than twelve months. Nothing in division (B)(14) of this section shall be construed as prohibiting an insurer or plan from providing such an exemption for a period exceeding twelve months.

(c) A health care provider or health care provider group that does not receive an exemption under division (B)(14) of this section may request that the insurer or plan provide evidence to the provider or provider group supporting the insurer's or plan's decision to not grant an exemption. The health care provider or health care provider group shall not make more than one request under division (B)(14)(c) of this section for the same service, device, or drug in the same calendar year. The insurer or plan shall comply with such a request.

(d) A health care provider or health care provider group may appeal the insurer's or plan's decision to deny an exemption under division (B)(14) of this section.

(e) The insurer or plan shall not require a health care provider or health care provider group to request an exemption under division (B)(14) of this section.

(f) The insurer or plan shall not deny or reduce payment for a service, device, or drug that is provided without prior

authorization pursuant to an exemption granted under division (B)(14) of this section on the sole basis that the service, device, or drug 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. Division (B)(14)(f) of this section does not apply if the providing or supervising provider or provider group does either of the following:

(i) Knowingly and materially misrepresents the service, device, or drug provided in the request for payment with the intent to obtain an unlawful payment amount from the insurer or plan;

(ii) Fails to substantially perform the service or to provide the device or drug.

(g) The insurer or plan shall notify the health care provider or health care provider group in writing when the insurer or plan grants an exemption under division (B)(14) of this section for a service, device, or drug. The notice must include all of the following information:

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

(ii) The service, device, or drug to which the exemption applies;

(iii) The dates the exemption begins and ends.

(h)(i) At the end of the exemption period, the insurer or plan may evaluate the exemption granted under division (B)(14) of this section.

(ii) In conducting such an evaluation, the insurer or plan shall review twenty claims submitted to the insurer or plan in the preceding three months, selected at random, for the service, device, or drug in question. If there are not twenty relevant claims in the preceding three months, the insurer or plan may review claims submitted earlier.

(iii) If less than ninety per cent of the reviewed claims would have been approved based on medical necessity, then the insurer or plan may revoke the exemption. An insurer or plan that revokes an exemption shall provide the health care provider or health care provider group with the information the insurer or plan relied upon in revoking the exemption and a plain language explanation of how to appeal the revocation.

(iv) An insurer or plan shall not evaluate a health care provider's or health care provider group's exemption relating to a particular service, device, or drug more than once every twelve months.

(v) Nothing in division (B)(14) of this section shall be construed as requiring an insurer or plan to evaluate an existing prior authorization exemption.

(i) If an exemption under division (B)(14) of this section is revoked by the insurer or plan and that revocation is not appealed, the exemption remains in effect for thirty days following the date the insurer or plan notifies the health care provider or health care provider group of the revocation.

(j) A health care provider or health care provider group may appeal the revocation of an exemption under division (B)(14) of this section within thirty days after receiving notification of the revocation. If the provider or provider group appeals a

revocation and the revocation is upheld, the exemption remains in effect for five days after the date the revocation is upheld.

(k) The insurer or plan shall not revoke or deny an exemption under division (B)(14) of this section unless a health care provider licensed in this state who practices the same or a similar specialty as the health care provider or health care provider group at issue, and who has experience in providing the service, device, or drug at issue, determines that the denial or revocation is warranted in accordance with division (B)(14) of this section.

(l) Nothing in division (B)(14) of this section shall be construed to prohibit an insurer or plan from making an administrative denial of a claim.

(C) For policies issued on or after January 1, 2017, except in cases of fraudulent or materially incorrect information, an insurer or plan shall not retroactively deny a prior authorization for a health care service, drug, or device when all of the following are met:

(1) The health care practitioner submits a prior authorization request to the insurer or plan for a health care service, drug, or device;

(2) The insurer or plan approves the prior authorization request after determining that all of the following are true:

(a) The patient is eligible under the health benefit plan.

(b) The health care service, drug, or device is covered under the patient's health benefit plan.

(c) The health care service, drug, or device meets the insurer's or plan's standards for medical necessity and prior

authorization.

(3) The health care practitioner renders the health care service, drug, or device pursuant to the approved prior authorization request and all of the terms and conditions of the health care practitioner's contract with the insurer or plan;

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

(a) The patient is eligible under the health benefit plan.

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

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

(5) If the health care practitioner 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 practitioner in the approved prior authorization request, upon receiving a denial of services from the insurer or plan, the health care practitioner 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 an insurer or plan and a health care practitioner or beneficiary that is contrary to divisions (A) to (C) of this section is unenforceable.

(E) For policies issued on or after 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.

(F) The superintendent of insurance may adopt rules in accordance with Chapter 119. of the Revised Code as necessary to implement the provisions of this section. Notwithstanding any contrary provision of section 121.95 of the Revised Code, a regulatory restriction contained in a rule adopted by the superintendent to implement divisions (B)(13) and (14) of this section is not subject to sections 121.95 to 121.953 of the Revised Code.

(G) This section does not apply to any of the following types of coverage: a policy, contract, certificate, or agreement that covers only a specified accident, accident only, credit, dental, disability income, long-term care, hospital indemnity, supplemental coverage as described in section 3923.37 of the Revised Code, specified disease, or vision care; a dental benefit that is offered as a part of a policy of sickness and accident insurance or a public employee benefit plan; coverage issued as a supplement to liability insurance; insurance arising out of workers' compensation or similar law; automobile medical payment insurance; insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance; a medicare supplement policy of insurance as defined by the superintendent of insurance by rule; coverage under a plan through medicare or the federal employees benefit program; or any coverage issued under Chapter 55 of Title 10 of the United States Code and any coverage issued as a supplement to that coverage.

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 health care provider in the same, or in a similar, specialty that typically manages the medical condition, procedure, or treatment under review.

(3) "Emergency services" has the same meaning as in section 1753.28 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, medical device, or drug.

(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 either of the following:

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

(b) In the opinion of a practitioner with knowledge of the recipient's medical or behavioral condition, would subject the

recipient to adverse health consequences without the care or treatment that is the subject of the request.

(6) "Utilization review" ~~and "utilization review organization" have~~ has the same ~~meanings~~ meaning 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 for prescription drug requests 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 divisions (B)(1) and (2) of this section, the department or its designee shall respond to all prior authorization requests within forty-eight hours for urgent care services, or ten calendar days for any prior authorization request that is not for an urgent care service, of the time the request is received by the department or its designee. Division (B)(4) of this section does not apply to emergency services.

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

(c) 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.

(5)(a) On or before January 1, 2018, if a health care provider submits a prior authorization request as described in divisions (B)(1) and (2) of this section, the department or its

designee shall provide an electronic receipt to the health care provider acknowledging that the prior authorization request was received.

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

(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 do not support a twelve-month prior approval;

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

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

(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 either of the following:

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

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

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

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

(a) A United States food and drug administration approved comparable brand product or a generic counterpart of a brand product that is listed as therapeutically equivalent in the United States food and drug administration's publication titled approved drug products with therapeutic equivalence evaluations;

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

(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 provider 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.

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

(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 appeal process relating to adverse prior authorization determinations that shall include all of the following:

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

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

(c) The appeal shall be between the health care provider requesting the service in question and a clinical peer appointed by or contracted by the department or the department's designee.

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

(13)(a) The department or the department's designee shall not require a health care provider or health care provider group to comply with a prior authorization requirement for a health care service, medical device, or drug if both of the following criteria are met:

(i) The department or its designee approved, or would have approved, at least ninety per cent of the prior authorization requests submitted by the health care provider or health care provider group for that service, device, or drug during the preceding twelve months.

(ii) The health care provider or health care provider group submitted at least twenty prior authorization requests for that service, device, or drug to the department or the department's designee during the preceding twelve months.

(b) The department or its designee shall provide the exemption required by division (B)(13) of this section for a period not less than twelve months. Nothing in division (B)(13) of this section shall be construed as prohibiting the department or its designee from providing such an exemption for a period exceeding twelve months.

(c) A health care provider or health care provider group that does not receive an exemption under division (B)(13) of this section may request that the department or the department's designee provide evidence to the provider or provider group supporting its decision to not grant an exemption. The health care provider or health care provider group shall not make more than one request under division (B)(13)(c) of this section for the same service, device, or drug in a calendar year. The department or department's designee shall comply with such a request.

(d) A health care provider or health care provider group may appeal the department or designee's decision to deny an exemption.

(e) The department or its designee shall not require a health care provider or health care provider group to request an exemption provided under division (B)(13) of this section;

(f) The department or its designee shall not deny or reduce payment for a service, device, or drug that is provided without prior authorization pursuant to an exemption granted under division (B)(13) of this section on the sole basis that the service, device, or drug 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:

(i) Knowingly and materially misrepresents the health care service, device, or drug 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 department's designee;

(ii) Fails to substantially perform the health care service or to provide the medical device or drug.

(g) The department or its designee shall notify the health care provider or health care provider group in writing when the insurer or plan grants an exemption under division (B)(13) of this section for a service, device, or drug. The notice shall include all of the following information:

(i) A statement that the health care provider or health

care provider group qualifies for an exemption to a prior authorization requirement;

(ii) The service, device, or drug to which the exemption applies;

(iii) The dates the exemption will begin and end.

(h)(i) At the end of the exemption period, the department or its designee may evaluate an exemption it has granted under division (B)(13) of this section.

(ii) In conducting such an evaluation, the department or its designee shall review twenty claims submitted to the department or its designee in the preceding three months, selected at random, for the service, device, or drug in question. If there are not twenty relevant claims in the preceding three months, the department or its designee may review claims submitted earlier.

(iii) If less than ninety per cent of the reviewed claims would have been approved based on medical necessity, then the department or its designee may revoke the exemption. If the department or its designee revokes an exemption, it shall provide the health care provider or health care provider group with the information it relied upon in making its determination and a plain language explanation of how to appeal the revocation.

(iv) 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, device, or drug more than once every twelve months.

(v) Nothing in division (B)(13) of this section shall be construed as requiring the department or its designee to

evaluate an existing exemption.

(i) If an exemption under division (B)(13) of this section is revoked by the department or its designee and that revocation is not appealed, the exemption remains in effect for thirty days following the date the department or its designee notifies the health care provider or health care provider group of the revocation.

(j) A health care provider or health care provider group may appeal the revocation of an exemption under division (B)(13) of this section within thirty days after receiving notice of the revocation. If the provider or provider group appeals the revocation and the revocation is upheld, the exemption remains in effect for five days after the date the revocation is upheld.

(k) The department or its designee shall not revoke or deny an exemption under division (B)(13) of this section unless a health care provider licensed in this state who practices the same or a similar specialty as the health care provider or health care provider group at issue, and who has experience in providing the service, device, or drug at issue, determines that the denial or revocation is warranted in accordance with division (B)(13) of this section.

(l) Nothing in division (B)(13) of this section shall be construed as prohibiting the department or its designee from making an administrative denial of a claim.

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

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

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

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

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

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

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

(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. Notwithstanding any contrary provision of section 121.95 of the Revised Code, a regulatory restriction contained in a rule adopted by the director to implement division (B)(13) of this section is not subject to sections 121.95 to 121.953 of the Revised Code.

Sec. 5160.341. (A)(1) If a medical assistance program has a prior authorization requirement for a health care service, medical device, or drug, the department or its designee shall not require a health care provider or health care provider group to comply with the requirement for that health care service, device, or drug if both of the following criteria are met:

(a) The department of medicaid or its designee approved or would have approved at least ninety per cent of the prior authorization requests submitted by the health care provider or health care provider group for that service, device, or drug

during the previous twelve-month period.

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

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

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

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

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

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

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

(D) The department or its designee shall not do either of the following:

(1) Require a health care provider or health care provider group to request an exemption provided under division (A) of

this section;

(2) Deny or reduce payment for a health care service, medical device, or drug that was provided without prior authorization pursuant to an exemption granted under division (A) of this section on the sole basis that the service, device, or drug 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:

(a) Knowingly and materially misrepresents the health care service, medical device, or drug 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;

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

(E) When an exemption is granted under division (A) of this section for a health care service, medical device, or drug, 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:

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

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

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

(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.

(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.

(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.

(3)(a) If less than ninety 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.

(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:

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

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

(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, device, or drug more than once every twelve months.

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

exemption.

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

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

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

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

Section 2. That existing sections 1751.72, 3923.041, and 5160.34 of the Revised Code are hereby repealed.