

As Introduced

136th General Assembly

Regular Session

2025-2026

H. B. No. 214

Representative Miller, K.

To amend sections 1751.72, 3923.041, and 5160.34	1
and to enact section 5160.341 of the Revised	2
Code to require the Medicaid program and certain	3
health insurers to report data about prior	4
authorization requirements and to require an	5
exemption to such requirements for certain	6
providers.	7

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

Section 1. That sections 1751.72, 3923.041, and 5160.34 be	8
amended and section 5160.341 of the Revised Code be enacted to	9
read as follows:	10

Sec. 1751.72. (A) As used in this section:	11
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(1) "Chronic condition" means a medical condition that has	12
persisted after reasonable efforts have been made to relieve or	13
cure its cause and has continued, either continuously or	14
episodically, for longer than six continuous months.	15

(2) "Clinical peer" means a health care practitioner in	16
the same, or in a similar, specialty that typically manages the	17
medical condition, procedure, or treatment under review.	18

(3) "Covered person" means a person receiving coverage for	19
health services under a policy, contract, or agreement issued by	20

a health insuring corporation. 21

(4) "Emergency services" has the same meaning as in 22
section 1753.28 of the Revised Code. 23

(5) "Fraudulent or materially incorrect information" means 24
any type of intentional deception or misrepresentation made by a 25
person with the knowledge that the deception could result in 26
some unauthorized benefit to the covered person in question. 27

(6) "Health care practitioner" has the same meaning as in 28
section 3701.74 of the Revised Code. 29

(7) "NCPDP SCRIPT standard" means the national council for 30
prescription drug programs SCRIPT standard version 201310 or the 31
most recent standard adopted by the the United States department 32
of health and human services. 33

(8) "Prior authorization requirement" means any practice 34
implemented by a health insuring corporation in which coverage 35
of a health care service, device, or drug is dependent upon a 36
covered person or a health care practitioner obtaining approval 37
from the health insuring corporation prior to the service, 38
device, or drug being performed, received, or prescribed, as 39
applicable. "Prior authorization" includes prospective or 40
utilization review procedures conducted prior to providing a 41
health care service, device, or drug. 42

(9) "Urgent care services" means a medical care or other 43
service for a condition where application of the timeframe for 44
making routine or non-life threatening care determinations is 45
either of the following: 46

(a) Could seriously jeopardize the life, health, or safety 47
of the patient or others due to the patient's psychological 48
state; 49

(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, 79
neither of the following shall be considered a secure electronic 80
transmission: 81

(i) A facsimile; 82

(ii) A proprietary payer portal for prescription drug 83
requests that does not use NCPDP SCRIPT standard. 84

(3) For policies issued on or after January 1, 2018, a 85
health care practitioner and health insuring corporation may 86
enter into a contractual arrangement under which the health 87
insuring corporation agrees to process prior authorization 88
requests that are not submitted electronically because of the 89
financial hardship that electronic submission of prior 90
authorization requests would create for the health care 91
practitioner or if internet connectivity is limited or 92
unavailable where the health care practitioner is located. 93

(4)(a) For policies issued on or after January 1, 2018, if 94
the health care practitioner submits the request for prior 95
authorization as described in divisions (B)(1) and (2) of this 96
section, the health insuring corporation shall respond to all 97
prior authorization requests within forty-eight hours for urgent 98
care services, or ten calendar days for any prior authorization 99
request that is not for an urgent care service, of the time the 100
request is received by the health insuring corporation. Division 101
(B)(4) of this section does not apply to emergency services. 102

(b) The response required under division (B)(4)(a) of this 103
section shall indicate whether the request is approved or 104
denied. If the prior authorization is denied, the health 105
insuring corporation shall provide the specific reason for the 106
denial. 107

(c) If the prior authorization request is incomplete, the 108
health insuring corporation shall indicate the specific 109
additional information that is required to process the request. 110

(5) (a) For policies issued on or after January 1, 2018, if 111
a health care practitioner submits a prior authorization request 112
as described in divisions (B) (1) and (2) of this section, the 113
health insuring corporation shall provide an electronic receipt 114
to the health care practitioner acknowledging that the prior 115
authorization request was received. 116

(b) For policies issued on or after January 1, 2018, if a 117
health insuring corporation requests additional information that 118
is required to process a prior authorization request as 119
described in division (B) (4) (c) of this section, the health care 120
practitioner shall provide an electronic receipt to the health 121
insuring corporation acknowledging that the request for 122
additional information was received. 123

(6) (a) For policies issued on or after January 1, 2017, 124
for a prior approval related to a chronic condition, the health 125
insuring corporation shall honor a prior authorization approval 126
for an approved drug for the lesser of the following from the 127
date of the approval: 128

(i) Twelve months; 129

(ii) The last day of the covered person's eligibility 130
under the policy, contract, or agreement. 131

(b) The duration of all other prior authorization 132
approvals shall be dictated by the policy, contract, or 133
agreement issued by the health insuring corporation. 134

(c) A health insuring corporation may, in relation to a 135
prior approval under division (B) (6) (a) of this section, require 136

a health care practitioner to submit information to the health 137
insuring corporation indicating that the patient's chronic 138
condition has not changed. 139

(i) The request for information by the health insuring 140
corporation and the response by the health care practitioner 141
shall be in an electronic format, which may be by electronic 142
mail or other electronic communication. 143

(ii) The frequency of the submission of requested 144
information shall be consistent with medical or scientific 145
evidence as defined in section 3922.01 of the Revised Code, but 146
shall not be required more frequently than quarterly. 147

(iii) If the health care practitioner does not respond 148
within five calendar days from the date the request was 149
received, the health insuring corporation may terminate the 150
twelve-month approval. 151

(d) A twelve-month approval provided under division (B) (6) 152
(a) of this section is no longer valid and automatically 153
terminates if there are changes to federal or state laws or 154
federal regulatory guidance or compliance information 155
prescribing that the drug in question is no longer approved or 156
safe for the intended purpose. 157

(e) A twelve-month approval provided under division (B) (6) 158
(a) of this section does not apply to and is not required for 159
any of the following: 160

(i) Medications that are prescribed for a non-maintenance 161
condition; 162

(ii) Medications that have a typical treatment of less 163
than one year; 164

(iii) Medications that require an initial trial period to 165
determine effectiveness and tolerability, beyond which a one- 166
year, or greater, prior authorization period will be given; 167

(iv) Medications where there is medical or scientific 168
evidence as defined in section 3922.01 of the Revised Code that 169
do not support a twelve-month prior approval; 170

(v) Medications that are a schedule I or II controlled 171
substance or any opioid analgesic or benzodiazepine, as defined 172
in section 3719.01 of the Revised Code; 173

(vi) Medications that are not prescribed by an in-network 174
provider as part of a care management program. 175

(7) For policies issued on or after January 1, 2017, a 176
health insuring corporation may, but is not required to, provide 177
the twelve-month approval prescribed in division (B) (6) (a) of 178
this section for a prescription drug that meets either of the 179
following: 180

(a) The drug is prescribed or administered to treat a rare 181
medical condition and pursuant to medical or scientific evidence 182
as defined in section 3922.01 of the Revised Code. 183

(b) Medications that are controlled substances not 184
included in division (B) (6) (e) (v) of this section. 185

For purposes of division (B) (7) of this section, "rare 186
medical condition" means any disease or condition that affects 187
fewer than two hundred thousand individuals in the United 188
States. 189

(8) Nothing in division (B) (6) or (7) of this section 190
prohibits the substitution, in accordance with section 4729.38 191
of the Revised Code, of any drug that has received a twelve- 192

month approval under division (B) (6) (a) of this section when 193
there is a release of either of the following: 194

(a) A United States food and drug administration approved 195
comparable brand product or a generic counterpart of a brand 196
product that is listed as therapeutically equivalent in the 197
United States food and drug administration's publication titled 198
approved drug products with therapeutic equivalence evaluations; 199

(b) An interchangeable biological product, as defined in 200
section 3715.01 of the Revised Code. 201

(9) (a) For policies issued on or after January 1, 2017, 202
upon written request, a health insuring corporation shall permit 203
a retrospective review for a claim that is submitted for a 204
service where prior authorization was required but not obtained 205
if the service in question meets all of the following: 206

(i) The service is directly related to another service for 207
which prior approval has already been obtained and that has 208
already been performed. 209

(ii) The new service was not known to be needed at the 210
time the original prior authorized service was performed. 211

(iii) The need for the new service was revealed at the 212
time the original authorized service was performed. 213

(b) Once the written request and all necessary information 214
is received, the health insuring corporation shall review the 215
claim for coverage and medical necessity. The health insuring 216
corporation shall not deny a claim for such a new service based 217
solely on the fact that a prior authorization approval was not 218
received for the new service in question. 219

(10) (a) For policies issued on or after January 1, 2017, 220

the health insuring corporation shall disclose to all 221
participating health care practitioners any new prior 222
authorization requirement at least thirty days prior to the 223
effective date of the new requirement. 224

(b) The notice may be sent via electronic mail or standard 225
mail and shall be conspicuously entitled "Notice of Changes to 226
Prior Authorization Requirements." The notice is not required to 227
contain a complete listing of all changes made to the prior 228
authorization requirements, but shall include specific 229
information on where the health care practitioner may locate the 230
information on the health insuring corporation's web site or, if 231
applicable, the health insuring corporation's portal. 232

(c) All participating health care practitioners shall 233
promptly notify the health insuring corporation of any changes 234
to the health care practitioner's electronic mail or standard 235
mail address. 236

(11) (a) For policies issued on or after January 1, 2017, 237
the health insuring corporation shall make available to all 238
participating health care practitioners on its web site or 239
provider portal a listing of its prior authorization 240
requirements, including specific information or documentation 241
that a practitioner must submit in order for the prior 242
authorization request to be considered complete. 243

(b) The health insuring corporation shall make available 244
on its web site information about the policies, contracts, or 245
agreements offered by the health insuring corporation that 246
clearly identifies specific services, drugs, or devices to which 247
a prior authorization requirement exists. 248

(12) For policies issued on or after January 1, 2018, the 249

health insuring corporation shall establish a streamlined appeal 250
process relating to adverse prior authorization determinations 251
that shall include all of the following: 252

(a) For urgent care services, the appeal shall be 253
considered within forty-eight hours after the health insuring 254
corporation receives the appeal. 255

(b) For all other matters, the appeal shall be considered 256
within ten calendar days after the health insuring corporation 257
receives the appeal. 258

(c) The appeal shall be between the health care 259
practitioner requesting the service in question and a clinical 260
peer. 261

(d) If the appeal does not resolve the disagreement, 262
either the covered person or an authorized representative as 263
defined in section 3922.01 of the Revised Code may request an 264
external review under Chapter 3922. of the Revised Code to the 265
extent Chapter 3922. of the Revised Code is applicable. 266

(13) (a) For policies issued on or after January 1, 2027, 267
the health insuring corporation shall make prior authorization 268
data from the previous calendar year available to all 269
participating health care practitioners in aggregate form for 270
all services, drugs, or devices for which prior authorization is 271
required, including all of the following: 272

(i) The percentage of standard and expedited prior 273
authorization requests that were approved, denied, and approved 274
after appeal; 275

(ii) The percentage of prior authorization requests for 276
which the timeframe for review was extended; 277

(iii) The average and median time that elapsed between the 278
submission of a prior authorization request and issuance of a 279
decision by the health insuring corporation for standard and 280
expedited requests. 281

(b) The health insuring corporation shall ensure that no 282
later than the last day of March each year, beginning in 2027, 283
the data described in division (B) (13) (a) of this section is 284
both: 285

(i) Made available on the health insuring corporation's 286
web site or provider portal; 287

(ii) Compiled into a report and submitted to the 288
department of insurance. 289

(c) The department shall publish each report received 290
under division (B) (13) (b) (ii) of this section on department's 291
web site and submit it to the general assembly in accordance 292
with section 101.68 of the Revised Code. 293

(14) (a) For policies issued on or after January 1, 2027, 294
the health insuring corporation shall not require a health care 295
provider or health care provider group to comply with a prior 296
authorization requirement for a health care service, medical 297
device, or drug if both of the following apply: 298

(i) The health insuring corporation approved, or would 299
have approved, at least ninety per cent of the prior 300
authorization requests submitted by the health care provider or 301
health care provider group for that service, device, or drug 302
during the preceding twelve months; 303

(ii) The health care provider or health care provider 304
group submitted at least twenty prior authorization requests for 305
the service, device, or drug to the health insuring corporation 306

during the preceding twelve months.

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(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.

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(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.

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(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.

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(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.

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(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

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different than the provider or provider group that requested the 336
exemption. Division (B) (14) (f) of this section does not apply if 337
the providing or supervising provider or provider group does 338
either of the following: 339

(i) Knowingly and materially misrepresents the service, 340
device, or drug provided in the request for payment with the 341
intent to obtain an unlawful payment amount from the health 342
insuring corporation; 343

(ii) Fails to substantially perform the service or to 344
provide the device or drug. 345

(g) The health insuring corporation shall notify the 346
health care provider or health care provider group in writing 347
when the health insuring corporation grants an exemption under 348
division (B) (14) of this section for a service, device, or drug. 349
The notice must include all of the following information: 350

(i) A statement that the health care provider or health 351
care provider group qualifies for an exemption to a prior 352
authorization requirement; 353

(ii) The service, device, or drug to which the exemption 354
applies; 355

(iii) The dates the exemption begins and ends. 356

(h) (i) At the end of the exemption period, the health 357
insuring corporation may evaluate the exemption granted under 358
division (B) (14) of this section. 359

(ii) In conducting such an evaluation, the health insuring 360
corporation shall review twenty claims submitted to the health 361
insuring corporation in the preceding three months, selected at 362
random, for the service, device, or drug in question. If there 363

are not twenty relevant claims in the preceding three months, 364
the health insuring corporation may review claims submitted 365
earlier. 366

(iii) If less than ninety per cent of the reviewed claims 367
would have been approved based on medical necessity, then the 368
health insuring corporation may revoke the exemption. A health 369
insuring corporation that revokes an exemption shall provide the 370
health care provider or health care provider group with the 371
information the health insuring corporation relied upon in 372
revoking the exemption and a plain language explanation of how 373
to appeal the revocation. 374

(iv) A health insuring corporation shall not evaluate a 375
health care provider's or health care provider group's exemption 376
relating to a particular service, device, or drug more than once 377
every twelve months. 378

(v) Nothing in division (B) (14) of this section shall be 379
construed as requiring health insuring corporation to evaluate 380
an existing prior authorization exemption. 381

(i) If an exemption under division (B) (14) of this section 382
is revoked by the health insuring corporation and that 383
revocation is not appealed, the exemption remains in effect for 384
thirty days following the date the health insuring corporation 385
notifies the health care provider or health care provider group 386
of the revocation. 387

(j) A health care provider or health care provider group 388
may appeal the revocation of an exemption under division (B) (14) 389
of this section within thirty days after receiving notification 390
of the revocation. If the provider or provider group appeals a 391
revocation and the revocation is upheld, the exemption remains 392

in effect for five days after the date the revocation is upheld. 393

(k) The health insuring corporation shall not revoke or 394
deny an exemption under division (B) (14) of this section unless 395
a health care provider licensed in this state who practices the 396
same or a similar specialty as the health care provider or 397
health care provider group at issue, and who has experience in 398
providing the service, device, or drug at issue, determines that 399
the denial or revocation is warranted in accordance with 400
division (B) (14) of this section. 401

(l) Nothing in division (B) (14) of this section shall be 402
construed to prohibit a health insuring corporation from making 403
an administrative denial of a claim. 404

(C) For policies issued on or after January 1, 2017, 405
except in cases of fraudulent or materially incorrect 406
information, a health insuring corporation shall not 407
retroactively deny a prior authorization for a health care 408
service, drug, or device when all of the following are met: 409

(1) The health care practitioner submits a prior 410
authorization request to the health insuring corporation for a 411
health care service, drug, or device. 412

(2) The health insuring corporation approves the prior 413
authorization request after determining that all of the 414
following are true: 415

(a) The patient is eligible under the health benefit plan. 416

(b) The health care service, drug, or device is covered 417
under the patient's health benefit plan. 418

(c) The health care service, drug, or device meets the 419
health insuring corporation's standards for medical necessity 420

and prior authorization. 421

(3) The health care practitioner renders the health care 422
service, drug, or device pursuant to the approved prior 423
authorization request and all of the terms and conditions of the 424
health care practitioner's contract with the health insuring 425
corporation. 426

(4) On the date the health care practitioner renders the 427
prior approved health care service, drug, or device, all of the 428
following are true: 429

(a) The patient is eligible under the health benefit plan. 430

(b) The patient's condition or circumstances related to 431
the patient's care has not changed. 432

(c) The health care practitioner submits an accurate claim 433
that matches the information submitted by the health care 434
practitioner in the approved prior authorization request. 435

(5) If the health care practitioner submits a claim that 436
includes an unintentional error and the error results in a claim 437
that does not match the information originally submitted by the 438
health care practitioner in the approved prior authorization 439
request, upon receiving a denial of services from the health 440
insuring corporation, the health care practitioner may resubmit 441
the claim pursuant to division (C) of this section with the 442
information that matches the information included in the 443
approved prior authorization. 444

(D) Any provision of a contractual arrangement entered 445
into between a health insuring corporation and a health care 446
practitioner or beneficiary that is contrary to divisions (A) to 447
(C) of this section is unenforceable. 448

(E) For policies issued on or after January 1, 2017, 449
committing a series of violations of this section that, taken 450
together, constitute a practice or pattern shall be considered 451
an unfair and deceptive practice under sections 3901.19 to 452
3901.26 of the Revised Code. 453

(F) The superintendent of insurance may adopt rules in 454
accordance with Chapter 119. of the Revised Code as necessary to 455
implement the provisions of this section. 456

(G) This section does not apply to any of the following 457
types of coverage: a policy, contract, certificate, or agreement 458
that covers only a specified accident, accident only, credit, 459
dental, disability income, long-term care, hospital indemnity, 460
supplemental coverage as described in section 3923.37 of the 461
Revised Code, specified disease, or vision care; a dental 462
benefit that is offered as a part of a policy, contract, 463
certificate, or agreement offered by a health insuring 464
corporation; coverage issued as a supplement to liability 465
insurance; insurance arising out of workers' compensation or 466
similar law; automobile medical payment insurance; insurance 467
under which benefits are payable with or without regard to fault 468
and which is statutorily required to be contained in any 469
liability insurance policy or equivalent self-insurance; a 470
medicare supplement policy of insurance as defined by the 471
superintendent of insurance by rule; coverage under a plan 472
through medicare or the federal employees benefit program; or 473
any coverage issued under Chapter 55 of Title 10 of the United 474
States Code and any coverage issued as a supplement to that 475
coverage. 476

Sec. 3923.041. (A) As used in this section: 477

(1) "Chronic condition" means a medical condition that has 478

persisted after reasonable efforts have been made to relieve or 479
cure its cause and has continued, either continuously or 480
episodically, for longer than six continuous months. 481

(2) "Clinical peer" means a health care practitioner in 482
the same or in a similar, specialty that typically manages the 483
medical condition, procedure, or treatment under review. 484

(3) "Covered person" means a person receiving coverage for 485
health services under a policy of sickness and accident 486
insurance or a public employee benefit plan. 487

(4) "Emergency service" has the same meaning as in section 488
1753.28 of the Revised Code. 489

(5) "Fraudulent or materially incorrect information" means 490
any type of intentional deception or misrepresentation made by a 491
person with the knowledge that the deception could result in 492
some unauthorized benefit to the covered person in question. 493

(6) "Health care practitioner" has the same meaning as in 494
section 3701.74 of the Revised Code. 495

(7) "NCPDP SCRIPT standard" means the national council for 496
prescription drug programs SCRIPT standard version 201310 or the 497
most recent standard adopted by the United States department of 498
health and human services. 499

(8) "Prior authorization requirement" means any practice 500
implemented by either a sickness and accident insurer or a 501
public employee benefit plan in which coverage of a health care 502
service, device, or drug is dependent upon a covered person or a 503
health care practitioner obtaining approval from the insurer or 504
plan prior to the service, device, or drug being performed, 505
received, or prescribed, as applicable. "Prior authorization" 506
includes prospective or utilization review procedures conducted 507

prior to providing a health care service, device, or drug. 508

(9) "Urgent care services" means a medical care or other 509
service for a condition where application of the timeframe for 510
making routine or non-life threatening care determinations is 511
either of the following: 512

(a) Could seriously jeopardize the life, health, or safety 513
of the patient or others due to the patient's psychological 514
state; 515

(b) In the opinion of a practitioner with knowledge of the 516
patient's medical or behavioral condition, would subject the 517
patient to adverse health consequences without the care or 518
treatment that is the subject of the request. 519

(10) "Utilization review" and "utilization review 520
organization" have the same meanings as in section 1751.77 of 521
the Revised Code. 522

(B) If a policy issued by a sickness and accident insurer 523
or a public employee benefit plan contains a prior authorization 524
requirement, then all of the following apply: 525

(1) For policies issued on or after January 1, 2018, the 526
insurer or plan shall permit health care practitioners to access 527
the prior authorization form through the applicable electronic 528
software system. 529

(2) (a) For policies issued on or after January 1, 2018, 530
the insurer or plan, or other payer acting on behalf of the 531
insurer or plan, to accept prior authorization requests through 532
a secure electronic transmission. 533

(b) For policies issued on or after January 1, 2018, the 534
insurer or plan, a pharmacy benefit manager responsible for 535

handling prior authorization requests, or other payer acting on 536
behalf of the insurer or plan shall accept and respond to prior 537
prescription benefit authorization requests through a secure 538
electronic transmission using NCPDP SCRIPT standard ePA 539
transactions, and for prior medical benefit authorization 540
requests through a secure electronic transmission using 541
standards established by the council for affordable quality 542
health care on operating rules for information exchange or its 543
successor. 544

(c) For purposes of division (B) (2) of this section, 545
neither of the following shall be considered a secure electronic 546
transmission: 547

(i) A facsimile; 548

(ii) A proprietary payer portal for prescription drug 549
requests that does not use NCPDP SCRIPT standard. 550

(3) For policies issued on or after January 1, 2018, a 551
health care practitioner and an insurer or plan may enter into a 552
contractual arrangement under which the insurer or plan agrees 553
to process prior authorization requests that are not submitted 554
electronically because of the financial hardship that electronic 555
submission of prior authorization requests would create for the 556
health care practitioner or if internet connectivity is limited 557
or unavailable where the health care practitioner is located. 558

(4) (a) For policies issued on or after January 1, 2018, if 559
the health care practitioner submits the request for prior 560
authorization electronically as described in divisions (B) (1) 561
and (2) of this section, the insurer or plan shall respond to 562
all prior authorization requests within forty-eight hours for 563
urgent care services, or ten calendar days for any prior 564

authorization request that is not for an urgent care service, of 565
the time the request is received by the insurer or plan. 566
Division (B) (4) of this section does not apply to emergency 567
services. 568

(b) The response required under division (B) (4) (a) of this 569
section shall indicate whether the request is approved or 570
denied. If the prior authorization is denied, the insurer or 571
plan shall provide the specific reason for the denial. 572

(c) If the prior authorization request is incomplete, the 573
insurer or plan shall indicate the specific additional 574
information that is required to process the request. 575

(5) (a) For policies issued on or after January 1, 2018, if 576
a health care practitioner submits a prior authorization request 577
as described in divisions (B) (1) and (2) of this section, the 578
insurer or plan shall provide an electronic receipt to the 579
health care practitioner acknowledging that the prior 580
authorization request was received. 581

(b) For policies issued on or after January 1, 2018, if an 582
issuer or plan requests additional information that is required 583
to process a prior authorization request as described in 584
division (B) (4) (c) of this section, the health care practitioner 585
shall provide an electronic receipt to the issuer or plan 586
acknowledging that the request for additional information was 587
received. 588

(6) (a) For policies issued on or after January 1, 2017, 589
for a prior approval related to a chronic condition, the insurer 590
or plan shall honor a prior authorization approval for an 591
approved drug for the lesser of the following from the date of 592
the approval: 593

(i) Twelve months; 594

(ii) The last day of the covered person's eligibility 595
under the policy or plan. 596

(b) The duration of all other prior authorization 597
approvals shall be dictated by the policy or plan. 598

(c) An insurer or plan, in relation to prior approval 599
under division (B) (6) (a) of this section, may require a health 600
care practitioner to submit information to the insurer or plan 601
indicating that the patient's chronic condition has not changed. 602

(i) The request for information by the insurer or plan and 603
the response by the health care practitioner shall be in an 604
electronic format, which may be by electronic mail or other 605
electronic communication. 606

(ii) The frequency of the submission of requested 607
information shall be consistent with medical or scientific 608
evidence, as defined in section 3922.01 of the Revised Code, but 609
shall not be required more frequently than quarterly. 610

(iii) If the health care practitioner does not respond 611
within five calendar days from the date the request was 612
received, the insurer or plan may terminate the twelve-month 613
approval. 614

(d) A twelve-month approval provided under division (B) (6) 615
(a) of this section is no longer valid and automatically 616
terminates if there are changes to federal or state laws or 617
federal regulatory guidance or compliance information 618
prescribing that the drug in question is no longer approved or 619
safe for the intended purpose. 620

(e) A twelve-month approval provided under division (B) (6) 621

(a) of this section does not apply to and is not required for 622
any of the following: 623

(i) Medications that are prescribed for a non-maintenance 624
condition; 625

(ii) Medications that have a typical treatment of less 626
than one year; 627

(iii) Medications that require an initial trial period to 628
determine effectiveness and tolerability, beyond which a one- 629
year, or greater, prior authorization period will be given; 630

(iv) Medications where there is medical or scientific 631
evidence as defined in section 3922.01 of the Revised Code that 632
do not support a twelve-month prior approval; 633

(v) Medications that are a schedule I or II controlled 634
substance or any opioid analgesic or benzodiazepine, as defined 635
in section 3719.01 of the Revised Code; 636

(vi) Medications that are not prescribed by an in-network 637
provider as part of the care management program. 638

(7) For policies issued on or after January 1, 2017, an 639
insurer or plan may, but is not required to, provide the twelve- 640
month approval prescribed in division (B) (6) (a) of this section 641
for a prescription drug that meets either of the following: 642

(a) The drug is prescribed or administered to treat a rare 643
medical condition and pursuant to medical or scientific evidence 644
as defined in section 3922.01 of the Revised Code. 645

(b) Medications that are controlled substances not 646
included in division (B) (6) (e) (v) of this section. 647

For purposes of division (B) (7) of this section, "rare 648

medical condition" means any disease or condition that affects 649
fewer than two hundred thousand individuals in the United 650
States. 651

(8) Nothing in division (B) (6) or (7) of this section 652
prohibits the substitution, in accordance with section 4729.38 653
of the Revised Code, of any drug that has received a twelve- 654
month approval under division (B) (6) (a) of this section when 655
there is a release of either of the following: 656

(a) A United States food and drug administration approved 657
comparable brand product or a generic counterpart of a brand 658
product that is listed as therapeutically equivalent in the 659
United States food and drug administration's publication titled 660
approved drug products with therapeutic equivalence evaluations; 661

(b) An interchangeable biological product, as defined in 662
section 3715.01 of the Revised Code. 663

(9) (a) For policies issued on or after January 1, 2017, 664
upon written request, an insurer or plan shall permit a 665
retrospective review for a claim that is submitted for a service 666
where prior authorization was required but not obtained if the 667
service in question meets all of the following: 668

(i) The service is directly related to another service for 669
which prior approval has already been obtained and that has 670
already been performed. 671

(ii) The new service was not known to be needed at the 672
time the original prior authorized service was performed. 673

(iii) The need for the new service was revealed at the 674
time the original authorized service was performed. 675

(b) Once the written request and all necessary information 676

is received, the insurer or plan shall review the claim for 677
coverage and medical necessity. The insurer or plan shall not 678
deny a claim for such a new service based solely on the fact 679
that a prior authorization approval was not received for the new 680
service in question. 681

(10) (a) For policies issued on or after January 1, 2017, 682
the insurer or plan shall disclose to all participating health 683
care practitioners any new prior authorization requirement at 684
least thirty days prior to the effective date of the new 685
requirement. 686

(b) The notice may be sent via electronic mail or standard 687
mail and shall be conspicuously entitled "Notice of Changes to 688
Prior Authorization Requirements." The notice is not required to 689
contain a complete listing of all changes made to the prior 690
authorization requirements, but shall include specific 691
information on where the health care practitioner may locate the 692
information on the insurer or plan's web site or, if applicable, 693
the insurer's or plan's portal. 694

(c) All participating health care practitioners shall 695
promptly notify the insurer or plan of any changes to the health 696
care practitioner's electronic mail or standard mail address. 697

(11) (a) For policies issued on or after January 1, 2017, 698
the insurer or plan shall make available to all participating 699
health care practitioners on its web site or provider portal a 700
listing of its prior authorization requirements, including 701
specific information or documentation that a practitioner must 702
submit in order for the prior authorization request to be 703
considered complete. 704

(b) The insurer or plan shall make available on its web 705

site information about the policies, contracts, or agreements 706
offered by the insurer or plan that clearly identifies specific 707
services, drugs, or devices to which a prior authorization 708
requirement exists. 709

(12) For policies issued on or after January 1, 2018, the 710
insurer or plan shall establish a streamlined appeal process 711
relating to adverse prior authorization determinations that 712
shall include all of the following: 713

(a) For urgent care services, the appeal shall be 714
considered within forty-eight hours after the insurer or plan 715
receives the appeal. 716

(b) For all other matters, the appeal shall be considered 717
within ten calendar days after the insurer or plan receives the 718
appeal. 719

(c) The appeal shall be between the health care 720
practitioner requesting the service in question and a clinical 721
peer. 722

(d) If the appeal does not resolve the disagreement, 723
either the covered person or an authorized representative as 724
defined in section 3922.01 of the Revised Code may request an 725
external review under Chapter 3922. of the Revised Code to the 726
extent Chapter 3922. of the Revised Code is applicable. 727

(13) (a) For policies issued on or after January 1, 2027, 728
the insurer or plan shall make prior authorization data from the 729
previous calendar year available to all participating health 730
care practitioners in aggregate form for all services, drugs, or 731
devices for which prior authorization is required, including all 732
of the following: 733

(i) The percentage of standard and expedited prior 734

authorization requests that were approved, denied, and approved 735
after appeal; 736

(ii) The percentage of prior authorization requests for 737
which the timeframe for review was extended; 738

(iii) The average and median time that elapsed between the 739
submission of a prior authorization request and issuance of a 740
decision by the insurer or plan for standard and expedited 741
requests. 742

(b) The insurer or plan shall ensure that no later than 743
the last day of March each year, beginning in 2027, the data 744
described in division (B) (13) (a) of this section is both: 745

(i) Made available on the insurer's or plan's web site or 746
provider portal; 747

(ii) Compiled into a report and submitted to the 748
department of insurance. 749

(c) The department shall publish each report received 750
under division (B) (13) (b) (ii) of this section on department's 751
web site and submit it to the general assembly in accordance 752
with section 101.68 of the Revised Code. 753

(14) (a) For policies issued on or after January 1, 2027, 754
the insurer or plan shall not require a health care provider or 755
health care provider group to comply with a prior authorization 756
requirement for a health care service, medical device, or drug 757
if both of the following apply: 758

(i) The insurer or plan approved, or would have approved, 759
at least ninety per cent of the prior authorization requests 760
submitted by the health care provider or health care provider 761
group for that service, device, or drug during the preceding 762

twelve months; 763

(ii) The health care provider or health care provider 764
group submitted at least twenty prior authorization requests for 765
the service, device, or drug to the insurer or plan during the 766
preceding twelve months. 767

(b) The insurer or plan shall provide the exemption 768
required by division (B) (14) of this section for a period not 769
less than twelve months. Nothing in division (B) (14) of this 770
section shall be construed as prohibiting an insurer or plan 771
from providing such an exemption for a period exceeding twelve 772
months. 773

(c) A health care provider or health care provider group 774
that does not receive an exemption under division (B) (14) of 775
this section may request that the insurer or plan provide 776
evidence to the provider or provider group supporting the 777
insurer's or plan's decision to not grant an exemption. The 778
health care provider or health care provider group shall not 779
make more than one request under division (B) (14) (c) of this 780
section for the same service, device, or drug in the same 781
calendar year. The insurer or plan shall comply with such a 782
request. 783

(d) A health care provider or health care provider group 784
may appeal the insurer's or plan's decision to deny an exemption 785
under division (B) (14) of this section. 786

(e) The insurer or plan shall not require a health care 787
provider or health care provider group to request an exemption 788
under division (B) (14) of this section. 789

(f) The insurer or plan shall not deny or reduce payment 790
for a service, device, or drug that is provided without prior 791

authorization pursuant to an exemption granted under division 792
(B) (14) of this section on the sole basis that the service, 793
device, or drug was provided by or supervised by a health care 794
provider or health care provider group that is different than 795
the provider or provider group that requested the exemption. 796
Division (B) (14) (f) of this section does not apply if the 797
providing or supervising provider or provider group does either 798
of the following: 799

(i) Knowingly and materially misrepresents the service, 800
device, or drug provided in the request for payment with the 801
intent to obtain an unlawful payment amount from the insurer or 802
plan; 803

(ii) Fails to substantially perform the service or to 804
provide the device or drug. 805

(g) The insurer or plan shall notify the health care 806
provider or health care provider group in writing when the 807
insurer or plan grants an exemption under division (B) (14) of 808
this section for a service, device, or drug. The notice must 809
include all of the following information: 810

(i) A statement that the health care provider or health 811
care provider group qualifies for an exemption to a prior 812
authorization requirement; 813

(ii) The service, device, or drug to which the exemption 814
applies; 815

(iii) The dates the exemption begins and ends. 816

(h) (i) At the end of the exemption period, the insurer or 817
plan may evaluate the exemption granted under division (B) (14) 818
of this section. 819

(ii) In conducting such an evaluation, the insurer or plan 820
shall review twenty claims submitted to the insurer or plan in 821
the preceding three months, selected at random, for the service, 822
device, or drug in question. If there are not twenty relevant 823
claims in the preceding three months, the insurer or plan may 824
review claims submitted earlier. 825

(iii) If less than ninety per cent of the reviewed claims 826
would have been approved based on medical necessity, then the 827
insurer or plan may revoke the exemption. An insurer or plan 828
that revokes an exemption shall provide the health care provider 829
or health care provider group with the information the insurer 830
or plan relied upon in revoking the exemption and a plain 831
language explanation of how to appeal the revocation. 832

(iv) An insurer or plan shall not evaluate a health care 833
provider's or health care provider group's exemption relating to 834
a particular service, device, or drug more than once every 835
twelve months. 836

(v) Nothing in division (B) (14) of this section shall be 837
construed as requiring an insurer or plan to evaluate an 838
existing prior authorization exemption. 839

(i) If an exemption under division (B) (14) of this section 840
is revoked by the insurer or plan and that revocation is not 841
appealed, the exemption remains in effect for thirty days 842
following the date the insurer or plan notifies the health care 843
provider or health care provider group of the revocation. 844

(j) A health care provider or health care provider group 845
may appeal the revocation of an exemption under division (B) (14) 846
of this section within thirty days after receiving notification 847
of the revocation. If the provider or provider group appeals a 848

revocation and the revocation is upheld, the exemption remains 849
in effect for five days after the date the revocation is upheld. 850

(k) The insurer or plan shall not revoke or deny an 851
exemption under division (B) (14) of this section unless a health 852
care provider licensed in this state who practices the same or a 853
similar specialty as the health care provider or health care 854
provider group at issue, and who has experience in providing the 855
service, device, or drug at issue, determines that the denial or 856
revocation is warranted in accordance with division (B) (14) of 857
this section. 858

(l) Nothing in division (B) (14) of this section shall be 859
construed to prohibit an insurer or plan from making an 860
administrative denial of a claim. 861

(C) For policies issued on or after January 1, 2017, 862
except in cases of fraudulent or materially incorrect 863
information, an insurer or plan shall not retroactively deny a 864
prior authorization for a health care service, drug, or device 865
when all of the following are met: 866

(1) The health care practitioner submits a prior 867
authorization request to the insurer or plan for a health care 868
service, drug, or device; 869

(2) The insurer or plan approves the prior authorization 870
request after determining that all of the following are true: 871

(a) The patient is eligible under the health benefit plan. 872

(b) The health care service, drug, or device is covered 873
under the patient's health benefit plan. 874

(c) The health care service, drug, or device meets the 875
insurer's or plan's standards for medical necessity and prior 876

authorization. 877

(3) The health care practitioner renders the health care 878
service, drug, or device pursuant to the approved prior 879
authorization request and all of the terms and conditions of the 880
health care practitioner's contract with the insurer or plan; 881

(4) On the date the health care practitioner renders the 882
prior approved health care service, drug, or device, all of the 883
following are true: 884

(a) The patient is eligible under the health benefit plan. 885

(b) The patient's condition or circumstances related to 886
the patient's care has not changed. 887

(c) The health care practitioner submits an accurate claim 888
that matches the information submitted by the health care 889
practitioner in the approved prior authorization request. 890

(5) If the health care practitioner submits a claim that 891
includes an unintentional error and the error results in a claim 892
that does not match the information originally submitted by the 893
health care practitioner in the approved prior authorization 894
request, upon receiving a denial of services from the insurer or 895
plan, the health care practitioner may resubmit the claim 896
pursuant to division (C) of this section with the information 897
that matches the information included in the approved prior 898
authorization. 899

(D) Any provision of a contractual arrangement entered 900
into between an insurer or plan and a health care practitioner 901
or beneficiary that is contrary to divisions (A) to (C) of this 902
section is unenforceable. 903

(E) For policies issued on or after January 1, 2017, 904

committing a series of violations of this section that, taken 905
together, constitute a practice or pattern shall be considered 906
an unfair and deceptive practice under sections 3901.19 to 907
3901.26 of the Revised Code. 908

(F) The superintendent of insurance may adopt rules in 909
accordance with Chapter 119. of the Revised Code as necessary to 910
implement the provisions of this section. Notwithstanding any 911
contrary provision of section 121.95 of the Revised Code, a 912
regulatory restriction contained in a rule adopted by the 913
superintendent to implement divisions (B)(13) and (14) of this 914
section is not subject to sections 121.95 to 121.953 of the 915
Revised Code. 916

(G) This section does not apply to any of the following 917
types of coverage: a policy, contract, certificate, or agreement 918
that covers only a specified accident, accident only, credit, 919
dental, disability income, long-term care, hospital indemnity, 920
supplemental coverage as described in section 3923.37 of the 921
Revised Code, specified disease, or vision care; a dental 922
benefit that is offered as a part of a policy of sickness and 923
accident insurance or a public employee benefit plan; coverage 924
issued as a supplement to liability insurance; insurance arising 925
out of workers' compensation or similar law; automobile medical 926
payment insurance; insurance under which benefits are payable 927
with or without regard to fault and which is statutorily 928
required to be contained in any liability insurance policy or 929
equivalent self-insurance; a medicare supplement policy of 930
insurance as defined by the superintendent of insurance by rule; 931
coverage under a plan through medicare or the federal employees 932
benefit program; or any coverage issued under Chapter 55 of 933
Title 10 of the United States Code and any coverage issued as a 934
supplement to that coverage. 935

Sec. 5160.34. (A) As used in this section: 936

(1) "Chronic condition" means a medical condition that has 937
persisted after reasonable efforts have been made to relieve or 938
cure its cause and has continued, either continuously or 939
episodically, for longer than six continuous months. 940

(2) "Clinical peer" means a health care provider in the 941
same, or in a similar, specialty that typically manages the 942
medical condition, procedure, or treatment under review. 943

(3) "Emergency services" has the same meaning as in 944
section 1753.28 of the Revised Code. 945

(4) "Prior authorization requirement" means any practice 946
implemented by a medical assistance program in which coverage of 947
a health care service, device, or drug is dependent upon a 948
medical assistance recipient or a health care provider, 949
receiving approval from the department of medicaid or its 950
designee, including a medicaid managed care organization, prior 951
to the service, device, or drug being performed, received, or 952
prescribed, as applicable. "Prior authorization" includes 953
prospective or utilization review procedures conducted prior to 954
providing a health care service, medical device, or drug. 955

(5) "Urgent care services" means a medical care or other 956
service for a condition where application of the timeframe for 957
making routine or non-life threatening care determinations is 958
either of the following: 959

(a) Could seriously jeopardize the life, health, or safety 960
of the recipient or others due to the recipient's psychological 961
state; 962

(b) In the opinion of a practitioner with knowledge of the 963
recipient's medical or behavioral condition, would subject the 964

recipient to adverse health consequences without the care or 965
treatment that is the subject of the request. 966

(6) "Utilization review" ~~and "utilization review~~ 967
~~organization"~~ have has the same ~~meanings~~ meaning as in section 968
1751.77 of the Revised Code. 969

(B) If a medical assistance program has a prior 970
authorization requirement, the department of medicaid or its 971
designee, including a medicaid managed care organization, shall 972
do all of the following: 973

(1) On or before January 1, 2018, permit a health care 974
provider to access the prior authorization form through the 975
applicable electronic software system. 976

(2) (a) On or before January 1, 2018, permit the department 977
or its designee to accept and respond to prior prescription 978
benefit authorization requests through a secure electronic 979
transmission. 980

(b) On or before January 1, 2018, the department or its 981
designee shall accept and respond to prior prescription benefit 982
authorization requests through a secure electronic transmission 983
using NCPDP SCRIPT standard ePA transactions, and for prior 984
medical benefit authorization requests through a secure 985
electronic transmission using standards established by the 986
council for affordable quality health care on operating rules 987
for information exchange or its successor. 988

(c) For purposes of division (B) (2) of this section, 989
neither of the following shall be considered a secure electronic 990
transmission: 991

(i) A facsimile; 992

(ii) A proprietary payer portal for prescription drug requests that does not use NCPDP SCRIPT standard. 993
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(3) On or before January 1, 2018, a health care provider and the department of medicaid or its designee may enter into a contractual arrangement under which the department or its designee agrees to process prior authorization requests that are not submitted electronically because of the financial hardship that electronic submission of prior authorization requests would create for the provider or if internet connectivity is limited or unavailable where the provider is located. 995
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(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. 1003
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(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. 1012
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(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. 1016
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(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 1019
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designee shall provide an electronic receipt to the health care 1022
provider acknowledging that the prior authorization request was 1023
received. 1024

(b) On or before January 1, 2018, if the department or its 1025
designee requests additional information that is required to 1026
process a prior authorization request as described in division 1027
(B) (4) (c) of this section, the health care provider shall 1028
provide an electronic receipt to the department or its designee 1029
acknowledging that the request for additional information was 1030
received. 1031

(6) (a) On or before January 1, 2017, honor a prior 1032
authorization approval for an approved drug for the lesser of 1033
the following from the date of approval: 1034

(i) Twelve months; 1035

(ii) The last day of the medical assistance recipient's 1036
eligibility for the medical assistance program. 1037

(b) The duration of all other prior authorization 1038
approvals shall be dictated by the medical assistance program. 1039

(c) The department or its designee, in relation to prior 1040
approval under division (B) (6) (a) of this section, may require a 1041
health care provider to submit information to the department or 1042
its designee indicating that the patient's chronic condition has 1043
not changed. 1044

(i) The request for information by the department or its 1045
designee and the response by the health care provider shall be 1046
in an electronic format, which may be by electronic mail or 1047
other electronic communication. 1048

(ii) The frequency of the submission of requested 1049

information shall be consistent with medical or scientific 1050
evidence as defined in section 3922.01 of the Revised Code, but 1051
shall not be required more frequently than quarterly. 1052

(iii) If the health care provider does not respond within 1053
five calendar days from the date the request was received, the 1054
insurer or plan may terminate the twelve-month approval. 1055

(d) A twelve-month approval provided under division (B) (6) 1056
(a) of this section is no longer valid and automatically 1057
terminates if there are changes to federal or state laws or 1058
federal regulatory guidance or compliance information 1059
prescribing that the drug in question is no longer approved or 1060
safe for the intended purpose. 1061

(e) A twelve-month approval provided under division (B) (6) 1062
(a) of this section does not apply to and is not required for 1063
any of the following: 1064

(i) Medications that are prescribed for a non-maintenance 1065
condition; 1066

(ii) Medications that have a typical treatment of less 1067
than one year; 1068

(iii) Medications that require an initial trial period to 1069
determine effectiveness and tolerability, beyond which a one- 1070
year, or greater, prior authorization period will be given; 1071

(iv) Medications where there is medical or scientific 1072
evidence as defined in section 3922.01 of the Revised Code that 1073
do not support a twelve-month prior approval; 1074

(v) Medications that are a schedule I or II controlled 1075
substance or any opioid analgesic or benzodiazepine, as defined 1076
in section 3719.01 of the Revised Code; 1077

(vi) Medications that are not prescribed by an in-network provider as part of a care management program. 1078
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(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: 1080
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(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. 1084
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(b) Medications that are controlled substances not included in division (B)(6)(e)(v) of this section. 1087
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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. 1089
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(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: 1093
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(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; 1098
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(b) An interchangeable biological product, as defined in section 3715.01 of the Revised Code. 1103
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(9)(a) On or after January 1, 2017, upon written request, 1105

the department or its designee shall permit a retrospective 1106
review for a claim that is submitted for a service where prior 1107
authorization was required, but not obtained if the service in 1108
question meets all of the following: 1109

(i) The service is directly related to another service for 1110
which prior approval has already been obtained and that has 1111
already been performed. 1112

(ii) The new service was not known to be needed at the 1113
time the original prior authorized service was performed. 1114

(iii) The need for the new service was revealed at the 1115
time the original authorized service was performed. 1116

(b) Once the written request and all necessary information 1117
is received, the department or its designee shall review the 1118
claim for coverage and medical necessity. The department or its 1119
designee shall not deny a claim for such a new service based 1120
solely on the fact that a prior authorization approval was not 1121
received for the new service in question. 1122

(10) (a) On or before January 1, 2017, disclose to all 1123
participating health care providers any new prior authorization 1124
requirement at least thirty days prior to the effective date of 1125
the new requirement. 1126

(b) The notice may be sent via electronic mail or standard 1127
mail and shall be conspicuously entitled "Notice of Changes to 1128
Prior Authorization Requirements." The notice is not required to 1129
contain a complete listing of all changes made to the prior 1130
authorization requirements, but shall include specific 1131
information on where the health care provider may locate the 1132
information on the department's or its designee's web site or, 1133
if applicable, the department's or its designee's portal. 1134

(c) All participating health care providers shall promptly 1135
notify the department or its designee of any changes to the 1136
health care provider's electronic mail or standard mail address. 1137

(11)(a) On or before January 1, 2017, make available to 1138
all participating health care providers on its web site or 1139
provider portal a listing of its prior authorization 1140
requirements, including specific information or documentation 1141
that a provider must submit in order for the prior authorization 1142
request to be considered complete. 1143

(b) Make available on its web site information about the 1144
medical assistance programs offered in this state that clearly 1145
identifies specific services, drugs, or devices to which a prior 1146
authorization requirement exists. 1147

(12) On or before January 1, 2018, establish a streamlined 1148
appeal process relating to adverse prior authorization 1149
determinations that shall include all of the following: 1150

(a) For urgent care services, the appeal shall be 1151
considered within forty-eight hours after the department or its 1152
designee receives the appeal. 1153

(b) For all other matters, the appeal shall be considered 1154
within ten calendar days after the department or its designee 1155
receives the appeal. 1156

(c) The appeal shall be between the health care provider 1157
requesting the service in question and a clinical peer appointed 1158
by or contracted by the department or the department's designee. 1159

(d) If the appeal does not resolve the disagreement, the 1160
appeal procedures shall permit the recipient to further appeal 1161
in accordance with section 5160.31 of the Revised Code. 1162

(13) (a) The department or the department's designee shall 1163
not require a health care provider or health care provider group 1164
to comply with a prior authorization requirement for a health 1165
care service, medical device, or drug if both of the following 1166
criteria are met: 1167

(i) The department or its designee approved, or would have 1168
approved, at least ninety per cent of the prior authorization 1169
requests submitted by the health care provider or health care 1170
provider group for that service, device, or drug during the 1171
preceding twelve months. 1172

(ii) The health care provider or health care provider 1173
group submitted at least twenty prior authorization requests for 1174
that service, device, or drug to the department or the 1175
department's designee during the preceding twelve months. 1176

(b) The department or its designee shall provide the 1177
exemption required by division (B) (13) of this section for a 1178
period not less than twelve months. Nothing in division (B) (13) 1179
of this section shall be construed as prohibiting the department 1180
or its designee from providing such an exemption for a period 1181
exceeding twelve months. 1182

(c) A health care provider or health care provider group 1183
that does not receive an exemption under division (B) (13) of 1184
this section may request that the department or the department's 1185
designee provide evidence to the provider or provider group 1186
supporting its decision to not grant an exemption. The health 1187
care provider or health care provider group shall not make more 1188
than one request under division (B) (13) (c) of this section for 1189
the same service, device, or drug in a calendar year. The 1190
department or department's designee shall comply with such a 1191
request. 1192

(d) A health care provider or health care provider group 1193
may appeal the department or designee's decision to deny an 1194
exemption. 1195

(e) The department or its designee shall not require a 1196
health care provider or health care provider group to request an 1197
exemption provided under division (B) (13) of this section; 1198

(f) The department or its designee shall not deny or 1199
reduce payment for a service, device, or drug that is provided 1200
without prior authorization pursuant to an exemption granted 1201
under division (B) (13) of this section on the sole basis that 1202
the service, device, or drug was provided by or supervised by a 1203
health care provider or health care provider group that is 1204
different than the provider or provider group that requested the 1205
exemption. This division does not apply if the providing or 1206
supervising provider or provider group does either of the 1207
following: 1208

(i) Knowingly and materially misrepresents the health care 1209
service, device, or drug provided in its request for payment 1210
from the department or the department's designee with the intent 1211
to obtain an unlawful payment amount from the department or 1212
department's designee; 1213

(ii) Fails to substantially perform the health care 1214
service or to provide the medical device or drug. 1215

(g) The department or its designee shall notify the health 1216
care provider or health care provider group in writing when the 1217
insurer or plan grants an exemption under division (B) (13) of 1218
this section for a service, device, or drug. The notice shall 1219
include all of the following information: 1220

(i) A statement that the health care provider or health 1221

care provider group qualifies for an exemption to a prior 1222
authorization requirement; 1223

(ii) The service, device, or drug to which the exemption 1224
applies; 1225

(iii) The dates the exemption will begin and end. 1226

(h) (i) At the end of the exemption period, the department 1227
or its designee may evaluate an exemption it has granted under 1228
division (B) (13) of this section. 1229

(ii) In conducting such an evaluation, the department or 1230
its designee shall review twenty claims submitted to the 1231
department or its designee in the preceding three months, 1232
selected at random, for the service, device, or drug in 1233
question. If there are not twenty relevant claims in the 1234
preceding three months, the department or its designee may 1235
review claims submitted earlier. 1236

(iii) If less than ninety per cent of the reviewed claims 1237
would have been approved based on medical necessity, then the 1238
department or its designee may revoke the exemption. If the 1239
department or its designee revokes an exemption, it shall 1240
provide the health care provider or health care provider group 1241
with the information it relied upon in making its determination 1242
and a plain language explanation of how to appeal the 1243
revocation. 1244

(iv) The department or its designee shall not evaluate a 1245
health care provider's or health care provider group's exemption 1246
relating to a particular service, device, or drug more than once 1247
every twelve months. 1248

(v) Nothing in division (B) (13) of this section shall be 1249
construed as requiring the department or its designee to 1250

evaluate an existing exemption. 1251

(i) If an exemption under division (B) (13) of this section 1252
is revoked by the department or its designee and that revocation 1253
is not appealed, the exemption remains in effect for thirty days 1254
following the date the department or its designee notifies the 1255
health care provider or health care provider group of the 1256
revocation. 1257

(j) A health care provider or health care provider group 1258
may appeal the revocation of an exemption under division (B) (13) 1259
of this section within thirty days after receiving notice of the 1260
revocation. If the provider or provider group appeals the 1261
revocation and the revocation is upheld, the exemption remains 1262
in effect for five days after the date the revocation is upheld. 1263

(k) The department or its designee shall not revoke or 1264
deny an exemption under division (B) (13) of this section unless 1265
a health care provider licensed in this state who practices the 1266
same or a similar specialty as the health care provider or 1267
health care provider group at issue, and who has experience in 1268
providing the service, device, or drug at issue, determines that 1269
the denial or revocation is warranted in accordance with 1270
division (B) (13) of this section. 1271

(l) Nothing in division (B) (13) of this section shall be 1272
construed as prohibiting the department or its designee from 1273
making an administrative denial of a claim. 1274

(C) Beginning January 1, 2017, except in cases of 1275
fraudulent or materially incorrect information, the department 1276
or its designee shall not retroactively deny a prior 1277
authorization for a health care service, drug, or device when 1278
all of the following are met: 1279

(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 1308
includes an unintentional error and the error results in a claim 1309
that does not match the information originally submitted by the 1310
health care provider in the approved prior authorization 1311
request, upon receiving a denial of services from the department 1312
or its designee, the health care provider may resubmit the claim 1313
pursuant to division (C) of this section with the information 1314
that matches the information included in the approved prior 1315
authorization. 1316

(D) Any provision of a contractual arrangement entered 1317
into between the department or its designee and a health care 1318
provider or recipient that is contrary to divisions (A) to (C) 1319
of this section is unenforceable. 1320

(E) The director of medicaid may adopt rules in accordance 1321
with Chapter 119. of the Revised Code as necessary to implement 1322
the provisions of this section. Notwithstanding any contrary 1323
provision of section 121.95 of the Revised Code, a regulatory 1324
restriction contained in a rule adopted by the director to 1325
implement division (B)(13) of this section is not subject to 1326
sections 121.95 to 121.953 of the Revised Code. 1327

Sec. 5160.341. (A) (1) If a medical assistance program has 1328
a prior authorization requirement for a health care service, 1329
medical device, or drug, the department or its designee shall 1330
not require a health care provider or health care provider group 1331
to comply with the requirement for that health care service, 1332
device, or drug if both of the following criteria are met: 1333

(a) The department of medicaid or its designee approved or 1334
would have approved at least ninety per cent of the prior 1335
authorization requests submitted by the health care provider or 1336
health care provider group for that service, device, or drug 1337

during the previous twelve-month period. 1338

(b) The health care provider or health care provider group 1339
submitted at least twenty prior authorization requests for that 1340
service, device, or drug to the department or its designee 1341
during that twelve-month period. 1342

(2) Such an exemption shall be provided for not less than 1343
twelve months. 1344

(3) Nothing in this section shall be construed as 1345
prohibiting the department or its designee from establishing an 1346
exemption period of more than twelve months. 1347

(B) (1) A health care provider or health care provider 1348
group that does not receive an exemption under division (A) of 1349
this section may request that the department or the department's 1350
designee provide evidence to the provider or provider group 1351
supporting its decision to not grant an exemption. 1352

(2) The health care provider or health care provider group 1353
may make such a request at any time, but it may make not more 1354
than one such request for the same service, device, or drug in a 1355
calendar year. 1356

(3) The department or its designee shall comply with such 1357
a request. 1358

(C) A health care provider or health care provider group 1359
may appeal the department or its designee's decision to deny an 1360
exemption. 1361

(D) The department or its designee shall not do either of 1362
the following: 1363

(1) Require a health care provider or health care provider 1364
group to request an exemption provided under division (A) of 1365

this section; 1366

(2) Deny or reduce payment for a health care service, 1367
medical device, or drug that was provided without prior 1368
authorization pursuant to an exemption granted under division 1369
(A) of this section on the sole basis that the service, device, 1370
or drug was provided by or supervised by a health care provider 1371
or health care provider group that is different than the 1372
provider or provider group that requested the exemption. This 1373
division does not apply if the providing or supervising provider 1374
or provider group does either of the following: 1375

(a) Knowingly and materially misrepresents the health care 1376
service, medical device, or drug provided in its request for 1377
payment from the department or the department's designee with 1378
the intent to obtain an unlawful payment amount from the 1379
department or its designee; 1380

(b) Fails to substantially perform the health care service 1381
or to provide the medical device or drug. 1382

(E) When an exemption is granted under division (A) of 1383
this section for a health care service, medical device, or drug, 1384
the department or its designee shall notify the health care 1385
provider or health care provider group in question. The notice 1386
shall include all of the following information: 1387

(1) A statement that the health care provider or health 1388
care provider group qualifies for an exemption to a prior 1389
authorization requirement; 1390

(2) The health care service, medical device, or drug to 1391
which the exemption applies; 1392

(3) The dates the exemption will begin and end. 1393

(F) (1) At the end of the exemption period, the department 1394
or its designee may evaluate an exemption it has granted under 1395
division (A) of this section. 1396

(2) (a) When conducting such an evaluation, the department 1397
or its designee shall review twenty claims submitted to the 1398
department or its designee, selected at random, for the health 1399
care service or medical device in question. 1400

(b) The reviewed claims shall be from the immediately 1401
preceding three months. If there are not twenty relevant claims 1402
in the preceding three months, the department or its designee 1403
may review earlier claims. 1404

(3) (a) If less than ninety per cent of the reviewed claims 1405
would have been approved based on medical necessity, then the 1406
department or its designee may revoke the exemption provided 1407
under division (A) of this section. 1408

(b) If the department or its designee revokes an 1409
exemption, it shall provide the health care provider or health 1410
care provider group with both of the following: 1411

(i) The information it relied upon in making its 1412
determination; 1413

(ii) A plain language explanation of how to appeal the 1414
decision. 1415

(4) The department or its designee shall not evaluate a 1416
health care provider's or health care provider group's exemption 1417
relating to a particular service, device, or drug more than once 1418
every twelve months. 1419

(5) Nothing in this section shall be construed as 1420
requiring the department or its designee to evaluate an existing 1421

exemption. 1422

(G) If an exemption is revoked and not appealed, the 1423
exemption shall remain in effect until thirty days after the 1424
date the department or its designee notifies the health care 1425
provider or health care provider group of the department or its 1426
designee's decision to revoke the exemption. 1427

(H) A health care provider or health care provider group 1428
may appeal the revocation of an exemption within thirty days of 1429
receiving notice of the revocation. If the provider or provider 1430
group appeals the revocation and the revocation is upheld, the 1431
exemption remains in effect until five days after the date the 1432
revocation is upheld. 1433

(I) A decision to revoke or deny an exemption shall only 1434
be made by a health care provider licensed in this state who 1435
practices the same or a similar specialty as the health care 1436
provider or health care provider group being considered for an 1437
exemption and who has experience in providing the service, 1438
device, or drug to which the exemption or potential exemption 1439
applies. 1440

(J) Nothing in this section shall be construed as 1441
prohibiting the department or its designee from making an 1442
administrative denial of a claim. 1443

Section 2. That existing sections 1751.72, 3923.041, and 1444
5160.34 of the Revised Code are hereby repealed. 1445