

**As Introduced**

**136th General Assembly**

**Regular Session**

**2025-2026**

**H. B. No. 220**

**Representative Workman**

---

To amend sections 1751.72, 3923.041, and 5160.34 of 1  
the Revised Code regarding health insurance and 2  
Medicaid program prior authorization 3  
requirements. 4

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

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

**Sec. 1751.72.** (A) As used in this section: 7

(1) "Chronic condition" means a medical condition that has 8  
persisted after reasonable efforts have been made to relieve or 9  
cure its cause and has continued, either continuously or 10  
episodically, for longer than six continuous months. 11

(2) "Clinical peer" means a health care practitioner in 12  
the same, or in a similar, specialty that typically manages the 13  
medical condition, procedure, or treatment under review. 14

(3) "Covered person" means a person receiving coverage for 15  
health services under a policy, contract, or agreement issued by 16  
a health insuring corporation. 17

(4) "Emergency services" has the same meaning as in 18  
section 1753.28 of the Revised Code. 19

(5) "Fraudulent or materially incorrect information" means 20  
any type of intentional deception or misrepresentation made by a 21  
person with the knowledge that the deception could result in 22  
some unauthorized benefit to the covered person in question. 23

(6) "Health care practitioner" has the same meaning as in 24  
section 3701.74 of the Revised Code. 25

(7) "NCPDP SCRIPT standard" means the national council for 26  
prescription drug programs SCRIPT standard version 201310 or the 27  
most recent standard adopted by the the United States department 28  
of health and human services. 29

(8) "Prior authorization requirement" means any practice 30  
implemented by a health insuring corporation in which coverage 31  
of a health care service, device, or drug is dependent upon a 32  
covered person or a health care practitioner obtaining approval 33  
from the health insuring corporation prior to the service, 34  
device, or drug being performed, received, or prescribed, as 35  
applicable. "Prior authorization" includes prospective or 36  
utilization review procedures conducted prior to providing a 37  
health care service, device, or drug. 38

(9) "Urgent care services" means a medical care or other 39  
service for a condition where application of the timeframe for 40  
making routine or non-life threatening care determinations is 41  
either of the following: 42

(a) Could seriously jeopardize the life, health, or safety 43  
of the patient or others due to the patient's psychological 44  
state; 45

(b) In the opinion of a practitioner with knowledge of the 46  
patient's medical or behavioral condition, would subject the 47  
patient to adverse health consequences without the care or 48

treatment that is the subject of the request. 49

(10) "Utilization review" and "utilization review 50  
organization" have the same meanings as in section 1751.77 of 51  
the Revised Code. 52

(B) If a policy, contract, or agreement issued by a health 53  
insuring corporation contains a prior authorization requirement, 54  
then all of the following apply: 55

(1) On or before January 1, 2018, the health insuring 56  
corporation shall permit health care practitioners to access the 57  
prior authorization form through the applicable electronic 58  
software system. 59

(2) (a) For policies issued on or after January 1, 2018, 60  
the health insuring corporation or other payer acting on behalf 61  
of the health insuring corporation, shall accept prior 62  
authorization requests through a secure electronic transmission. 63

(b) For policies issued on or after January 1, 2018, the 64  
health insuring corporation, a pharmacy benefit manager 65  
responsible for handling prior authorization requests, or other 66  
payer acting on behalf of the health insuring corporation shall 67  
accept and respond to prior prescription benefit authorization 68  
requests through a secure electronic transmission using NCPDP 69  
SCRIPT standard ePA transactions, and for prior medical benefit 70  
authorization requests through a secure electronic transmission 71  
using standards established by the council for affordable 72  
quality health care on operating rules for information exchange 73  
or its successor. 74

(c) For purposes of division (B) (2) of this section, 75  
neither of the following shall be considered a secure electronic 76  
transmission: 77

(i) A facsimile;	78
(ii) A proprietary payer portal for prescription drug requests that does not use NCPDP SCRIPT standard.	79 80
(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.	81 82 83 84 85 86 87 88 89
(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.	90 91 92 93 94 95 96 97 98
(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.	99 100 101 102 103
(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.	104 105 106

(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 164  
evidence as defined in section 3922.01 of the Revised Code that 165  
do not support a twelve-month prior approval; 166

(v) Medications that are a schedule I or II controlled 167  
substance or any opioid analgesic or benzodiazepine, as defined 168  
in section 3719.01 of the Revised Code; 169

(vi) Medications that are not prescribed by an in-network 170  
provider as part of a care management program. 171

(f) For policies issued on or after the first day of 172  
January following the effective date of this amendment, 173  
following a prior authorization approval under division (B) (6) 174  
(a) of this section, if a provider prescribes a change in dosage 175  
of the approved drug, the health insuring corporation shall 176  
honor the prior authorization approval as applied to the change 177  
in dosage for the period required by that division. 178

(7) For policies issued on or after January 1, 2017, a 179  
health insuring corporation may, but is not required to, provide 180  
the twelve-month approval prescribed in division (B) (6) (a) of 181  
this section for a prescription drug that meets either of the 182  
following: 183

(a) The drug is prescribed or administered to treat a rare 184  
medical condition and pursuant to medical or scientific evidence 185  
as defined in section 3922.01 of the Revised Code. 186

(b) Medications that are controlled substances not 187  
included in division (B) (6) (e) (v) of this section. 188

For purposes of division (B) (7) of this section, "rare 189  
medical condition" means any disease or condition that affects 190  
fewer than two hundred thousand individuals in the United 191  
States. 192

(8) Nothing in division (B) (6) or (7) of this section 193  
prohibits the substitution, in accordance with section 4729.38 194  
of the Revised Code, of any drug that has received a twelve- 195  
month approval under division (B) (6) (a) of this section when 196  
there is a release of either of the following: 197

(a) A United States food and drug administration approved 198  
comparable brand product or a generic counterpart of a brand 199  
product that is listed as therapeutically equivalent in the 200  
United States food and drug administration's publication titled 201  
approved drug products with therapeutic equivalence evaluations; 202

(b) An interchangeable biological product, as defined in 203  
section 3715.01 of the Revised Code. 204

(9) (a) For policies issued on or after January 1, 2017, 205  
upon written request, a health insuring corporation shall permit 206  
a retrospective review for a claim that is submitted for a 207  
service where prior authorization was required but not obtained 208  
if the service in question meets all of the following: 209

(i) The service is directly related to another service for 210  
which prior approval has already been obtained and that has 211  
already been performed. 212

(ii) The new service was not known to be needed at the 213  
time the original prior authorized service was performed. 214

(iii) The need for the new service was revealed at the 215  
time the original authorized service was performed. 216

(b) Once the written request and all necessary information 217  
is received, the health insuring corporation shall review the 218  
claim for coverage and medical necessity. The health insuring 219  
corporation shall not deny a claim for such a new service based 220  
solely on the fact that a prior authorization approval was not 221



received for the new service in question. 222

(10) (a) For policies issued on or after January 1, 2017, 223  
the health insuring corporation shall disclose to all 224  
participating health care practitioners any new prior 225  
authorization requirement at least thirty days prior to the 226  
effective date of the new requirement. 227

(b) The notice may be sent via electronic mail or standard 228  
mail and shall be conspicuously entitled "Notice of Changes to 229  
Prior Authorization Requirements." The notice is not required to 230  
contain a complete listing of all changes made to the prior 231  
authorization requirements, but shall include specific 232  
information on where the health care practitioner may locate the 233  
information on the health insuring corporation's web site or, if 234  
applicable, the health insuring corporation's portal. 235

(c) All participating health care practitioners shall 236  
promptly notify the health insuring corporation of any changes 237  
to the health care practitioner's electronic mail or standard 238  
mail address. 239

(11) (a) For policies issued on or after January 1, 2017, 240  
the health insuring corporation shall make available to all 241  
participating health care practitioners on its web site or 242  
provider portal a listing of its prior authorization 243  
requirements, including specific information or documentation 244  
that a practitioner must submit in order for the prior 245  
authorization request to be considered complete. 246

(b) The health insuring corporation shall make available 247  
on its web site information about the policies, contracts, or 248  
agreements offered by the health insuring corporation that 249  
clearly identifies specific services, drugs, or devices to which 250

a prior authorization requirement exists. 251

(12) For policies issued on or after January 1, 2018, the 252  
health insuring corporation shall establish a streamlined appeal 253  
process relating to adverse prior authorization determinations 254  
that shall include all of the following: 255

(a) For urgent care services, the appeal shall be 256  
considered within forty-eight hours after the health insuring 257  
corporation receives the appeal. 258

(b) For all other matters, the appeal shall be considered 259  
within ten calendar days after the health insuring corporation 260  
receives the appeal. 261

(c) The appeal shall be between the health care 262  
practitioner requesting the service in question and a clinical 263  
peer and, for policies issued on or after the first day of 264  
January following the effective date of this amendment, the 265  
health insuring corporation shall identify the name, specialty, 266  
and relevant qualifications of the clinical peer who evaluates 267  
the appeal. 268

(d) If the appeal does not resolve the disagreement, 269  
either the covered person or an authorized representative as 270  
defined in section 3922.01 of the Revised Code may request an 271  
external review under Chapter 3922. of the Revised Code to the 272  
extent Chapter 3922. of the Revised Code is applicable. 273

(e) For policies issued on or after the first day of 274  
January following the effective date of this amendment, the 275  
health insuring corporation shall not charge a fee for appealing 276  
an adverse prior authorization determination. 277

(C) For policies issued on or after January 1, 2017, 278  
except in cases of fraudulent or materially incorrect 279

information, a health insuring corporation shall not 280  
retroactively deny a prior authorization for a health care 281  
service, drug, or device including, for policies issued on or 282  
after the first day of January following the effective date of 283  
this section, a prior authorization for mental health or 284  
substance use disorder treatment, when all of the following are 285  
met: 286

(1) The health care practitioner submits a prior 287  
authorization request to the health insuring corporation for a 288  
health care service, drug, or device. 289

(2) The health insuring corporation approves the prior 290  
authorization request after determining that all of the 291  
following that apply to the policy are true: 292

(a) The patient is eligible under the health benefit plan. 293

(b) The health care service, drug, or device is covered 294  
under the patient's health benefit plan. 295

(c) ~~The~~ For policies issued before the first day of 296  
January following the effective date of this amendment, the 297  
health care service, drug, or device meets the health insuring 298  
corporation's standards for medical necessity and prior 299  
authorization. 300

(3) The health care practitioner renders the health care 301  
service, drug, or device pursuant to the approved prior 302  
authorization request and all of the terms and conditions of the 303  
health care practitioner's contract with the health insuring 304  
corporation. 305

(4) On the date the health care practitioner renders the 306  
prior approved health care service, drug, or device, all of the 307  
following are true: 308

(a) The patient is eligible under the health benefit plan. 309

(b) The patient's condition or circumstances related to 310  
the patient's care has not changed. 311

(c) The health care practitioner submits an accurate claim 312  
that matches the information submitted by the health care 313  
practitioner in the approved prior authorization request. 314

(5) If the health care practitioner submits a claim that 315  
includes an unintentional error and the error results in a claim 316  
that does not match the information originally submitted by the 317  
health care practitioner in the approved prior authorization 318  
request, upon receiving a denial of services from the health 319  
insuring corporation, the health care practitioner may resubmit 320  
the claim pursuant to division (C) of this section with the 321  
information that matches the information included in the 322  
approved prior authorization. 323

(D) Any provision of a contractual arrangement entered 324  
into between a health insuring corporation and a health care 325  
practitioner or beneficiary that is contrary to divisions (A) to 326  
(C) of this section is unenforceable. 327

(E) For policies issued on or after January 1, 2017, 328  
committing a series of violations of this section that, taken 329  
together, constitute a practice or pattern shall be considered 330  
an unfair and deceptive practice under sections 3901.19 to 331  
3901.26 of the Revised Code. 332

(F) The superintendent of insurance may adopt rules in 333  
accordance with Chapter 119. of the Revised Code as necessary to 334  
implement the provisions of this section. 335

(G) This section does not apply to any of the following 336  
types of coverage: a policy, contract, certificate, or agreement 337

that covers only a specified accident, accident only, credit, 338  
dental, disability income, long-term care, hospital indemnity, 339  
supplemental coverage as described in section 3923.37 of the 340  
Revised Code, specified disease, or vision care; a dental 341  
benefit that is offered as a part of a policy, contract, 342  
certificate, or agreement offered by a health insuring 343  
corporation; coverage issued as a supplement to liability 344  
insurance; insurance arising out of workers' compensation or 345  
similar law; automobile medical payment insurance; insurance 346  
under which benefits are payable with or without regard to fault 347  
and which is statutorily required to be contained in any 348  
liability insurance policy or equivalent self-insurance; a 349  
medicare supplement policy of insurance as defined by the 350  
superintendent of insurance by rule; coverage under a plan 351  
through medicare or the federal employees benefit program; or 352  
any coverage issued under Chapter 55 of Title 10 of the United 353  
States Code and any coverage issued as a supplement to that 354  
coverage. 355

**Sec. 3923.041.** (A) As used in this section: 356

(1) "Chronic condition" means a medical condition that has 357  
persisted after reasonable efforts have been made to relieve or 358  
cure its cause and has continued, either continuously or 359  
episodically, for longer than six continuous months. 360

(2) "Clinical peer" means a health care practitioner in 361  
the same or in a similar, specialty that typically manages the 362  
medical condition, procedure, or treatment under review. 363

(3) "Covered person" means a person receiving coverage for 364  
health services under a policy of sickness and accident 365  
insurance or a public employee benefit plan. 366

(4) "Emergency service" has the same meaning as in section 367  
1753.28 of the Revised Code. 368

(5) "Fraudulent or materially incorrect information" means 369  
any type of intentional deception or misrepresentation made by a 370  
person with the knowledge that the deception could result in 371  
some unauthorized benefit to the covered person in question. 372

(6) "Health care practitioner" has the same meaning as in 373  
section 3701.74 of the Revised Code. 374

(7) "NCPDP SCRIPT standard" means the national council for 375  
prescription drug programs SCRIPT standard version 201310 or the 376  
most recent standard adopted by the United States department of 377  
health and human services. 378

(8) "Prior authorization requirement" means any practice 379  
implemented by either a sickness and accident insurer or a 380  
public employee benefit plan in which coverage of a health care 381  
service, device, or drug is dependent upon a covered person or a 382  
health care practitioner obtaining approval from the insurer or 383  
plan prior to the service, device, or drug being performed, 384  
received, or prescribed, as applicable. "Prior authorization" 385  
includes prospective or utilization review procedures conducted 386  
prior to providing a healthcare service, device, or drug. 387

(9) "Urgent care services" means a medical care or other 388  
service for a condition where application of the timeframe for 389  
making routine or non-life threatening care determinations is 390  
either of the following: 391

(a) Could seriously jeopardize the life, health, or safety 392  
of the patient or others due to the patient's psychological 393  
state; 394

(b) In the opinion of a practitioner with knowledge of the 395

patient's medical or behavioral condition, would subject the 396  
patient to adverse health consequences without the care or 397  
treatment that is the subject of the request. 398

(10) "Utilization review" and "utilization review 399  
organization" have the same meanings as in section 1751.77 of 400  
the Revised Code. 401

(B) If a policy issued by a sickness and accident insurer 402  
or a public employee benefit plan contains a prior authorization 403  
requirement, then all of the following apply: 404

(1) For policies issued on or after January 1, 2018, the 405  
insurer or plan shall permit health care practitioners to access 406  
the prior authorization form through the applicable electronic 407  
software system. 408

(2) (a) For policies issued on or after January 1, 2018, 409  
the insurer or plan, or other payer acting on behalf of the 410  
insurer or plan, to accept prior authorization requests through 411  
a secure electronic transmission. 412

(b) For policies issued on or after January 1, 2018, the 413  
insurer or plan, a pharmacy benefit manager responsible for 414  
handling prior authorization requests, or other payer acting on 415  
behalf of the insurer or plan shall accept and respond to prior 416  
prescription benefit authorization requests through a secure 417  
electronic transmission using NCPDP SCRIPT standard ePA 418  
transactions, and for prior medical benefit authorization 419  
requests through a secure electronic transmission using 420  
standards established by the council for affordable quality 421  
health care on operating rules for information exchange or its 422  
successor. 423

(c) For purposes of division (B) (2) of this section, 424

neither of the following shall be considered a secure electronic 425  
transmission: 426

(i) A facsimile; 427

(ii) A proprietary payer portal for prescription drug 428  
requests that does not use NCPDP SCRIPT standard. 429

(3) For policies issued on or after January 1, 2018, a 430  
health care practitioner and an insurer or plan may enter into a 431  
contractual arrangement under which the insurer or plan agrees 432  
to process prior authorization requests that are not submitted 433  
electronically because of the financial hardship that electronic 434  
submission of prior authorization requests would create for the 435  
health care practitioner or if internet connectivity is limited 436  
or unavailable where the health care practitioner is located. 437

(4) (a) For policies issued on or after January 1, 2018, if 438  
the health care practitioner submits the request for prior 439  
authorization electronically as described in divisions (B) (1) 440  
and (2) of this section, the insurer or plan shall respond to 441  
all prior authorization requests within forty-eight hours for 442  
urgent care services, or ten calendar days for any prior 443  
authorization request that is not for an urgent care service, of 444  
the time the request is received by the insurer or plan. 445  
Division (B) (4) of this section does not apply to emergency 446  
services. 447

(b) The response required under division (B) (4) (a) of this 448  
section shall indicate whether the request is approved or 449  
denied. If the prior authorization is denied, the insurer or 450  
plan shall provide the specific reason for the denial. 451

(c) If the prior authorization request is incomplete, the 452  
insurer or plan shall indicate the specific additional 453



information that is required to process the request. 454

(5) (a) For policies issued on or after January 1, 2018, if 455  
a health care practitioner submits a prior authorization request 456  
as described in divisions (B) (1) and (2) of this section, the 457  
insurer or plan shall provide an electronic receipt to the 458  
health care practitioner acknowledging that the prior 459  
authorization request was received. 460

(b) For policies issued on or after January 1, 2018, if an 461  
issuer or plan requests additional information that is required 462  
to process a prior authorization request as described in 463  
division (B) (4) (c) of this section, the health care practitioner 464  
shall provide an electronic receipt to the issuer or plan 465  
acknowledging that the request for additional information was 466  
received. 467

(6) (a) For policies issued on or after January 1, 2017, 468  
for a prior approval related to a chronic condition, the insurer 469  
or plan shall honor a prior authorization approval for an 470  
approved drug for the lesser of the following from the date of 471  
the approval: 472

(i) Twelve months; 473  
(ii) The last day of the covered person's eligibility 474  
under the policy or plan. 475

(b) The duration of all other prior authorization 476  
approvals shall be dictated by the policy or plan. 477

(c) An insurer or plan, in relation to prior approval 478  
under division (B) (6) (a) of this section, may require a health 479  
care practitioner to submit information to the insurer or plan 480  
indicating that the patient's chronic condition has not changed. 481

(i) The request for information by the insurer or plan and 482  
the response by the health care practitioner shall be in an 483  
electronic format, which may be by electronic mail or other 484  
electronic communication. 485

(ii) The frequency of the submission of requested 486  
information shall be consistent with medical or scientific 487  
evidence, as defined in section 3922.01 of the Revised Code, but 488  
shall not be required more frequently than quarterly. 489

(iii) If the health care practitioner does not respond 490  
within five calendar days from the date the request was 491  
received, the insurer or plan may terminate the twelve-month 492  
approval. 493

(d) A twelve-month approval provided under division (B) (6) 494  
(a) of this section is no longer valid and automatically 495  
terminates if there are changes to federal or state laws or 496  
federal regulatory guidance or compliance information 497  
prescribing that the drug in question is no longer approved or 498  
safe for the intended purpose. 499

(e) A twelve-month approval provided under division (B) (6) 500  
(a) of this section does not apply to and is not required for 501  
any of the following: 502

(i) Medications that are prescribed for a non-maintenance 503  
condition; 504

(ii) Medications that have a typical treatment of less 505  
than one year; 506

(iii) Medications that require an initial trial period to 507  
determine effectiveness and tolerability, beyond which a one- 508  
year, or greater, prior authorization period will be given; 509

(iv) Medications where there is medical or scientific 510  
evidence as defined in section 3922.01 of the Revised Code that 511  
do not support a twelve-month prior approval; 512

(v) Medications that are a schedule I or II controlled 513  
substance or any opioid analgesic or benzodiazepine, as defined 514  
in section 3719.01 of the Revised Code; 515

(vi) Medications that are not prescribed by an in-network 516  
provider as part of the care management program. 517

(f) For policies issued on or after the first day of 518  
January following the effective date of this amendment, 519  
following a prior authorization approval under division (B) (6) 520  
(a) of this section, if a provider prescribes a change in dosage 521  
of the approved drug, the insurer or plan shall honor the prior 522  
authorization approval as applied to the change in dosage for 523  
the period required by that division. 524

(7) For policies issued on or after January 1, 2017, an 525  
insurer or plan may, but is not required to, provide the twelve- 526  
month approval prescribed in division (B) (6) (a) of this section 527  
for a prescription drug that meets either of the following: 528

(a) The drug is prescribed or administered to treat a rare 529  
medical condition and pursuant to medical or scientific evidence 530  
as defined in section 3922.01 of the Revised Code. 531

(b) Medications that are controlled substances not 532  
included in division (B) (6) (e) (v) of this section. 533

For purposes of division (B) (7) of this section, "rare 534  
medical condition" means any disease or condition that affects 535  
fewer than two hundred thousand individuals in the United 536  
States. 537

(8) Nothing in division (B) (6) or (7) of this section 538  
prohibits the substitution, in accordance with section 4729.38 539  
of the Revised Code, of any drug that has received a twelve- 540  
month approval under division (B) (6) (a) of this section when 541  
there is a release of either of the following: 542

(a) A United States food and drug administration approved 543  
comparable brand product or a generic counterpart of a brand 544  
product that is listed as therapeutically equivalent in the 545  
United States food and drug administration's publication titled 546  
approved drug products with therapeutic equivalence evaluations; 547

(b) An interchangeable biological product, as defined in 548  
section 3715.01 of the Revised Code. 549

(9) (a) For policies issued on or after January 1, 2017, 550  
upon written request, an insurer or plan shall permit a 551  
retrospective review for a claim that is submitted for a service 552  
where prior authorization was required but not obtained if the 553  
service in question meets all of the following: 554

(i) The service is directly related to another service for 555  
which prior approval has already been obtained and that has 556  
already been performed. 557

(ii) The new service was not known to be needed at the 558  
time the original prior authorized service was performed. 559

(iii) The need for the new service was revealed at the 560  
time the original authorized service was performed. 561

(b) Once the written request and all necessary information 562  
is received, the insurer or plan shall review the claim for 563  
coverage and medical necessity. The insurer or plan shall not 564  
deny a claim for such a new service based solely on the fact 565  
that a prior authorization approval was not received for the new 566

service in question. 567

(10) (a) For policies issued on or after January 1, 2017, 568  
the insurer or plan shall disclose to all participating health 569  
care practitioners any new prior authorization requirement at 570  
least thirty days prior to the effective date of the new 571  
requirement. 572

(b) The notice may be sent via electronic mail or standard 573  
mail and shall be conspicuously entitled "Notice of Changes to 574  
Prior Authorization Requirements." The notice is not required to 575  
contain a complete listing of all changes made to the prior 576  
authorization requirements, but shall include specific 577  
information on where the health care practitioner may locate the 578  
information on the insurer or plan's web site or, if applicable, 579  
the insurer's or plan's portal. 580

(c) All participating health care practitioners shall 581  
promptly notify the insurer or plan of any changes to the health 582  
care practitioner's electronic mail or standard mail address. 583

(11) (a) For policies issued on or after January 1, 2017, 584  
the insurer or plan shall make available to all participating 585  
health care practitioners on its web site or provider portal a 586  
listing of its prior authorization requirements, including 587  
specific information or documentation that a practitioner must 588  
submit in order for the prior authorization request to be 589  
considered complete. 590

(b) The insurer or plan shall make available on its web 591  
site information about the policies, contracts, or agreements 592  
offered by the insurer or plan that clearly identifies specific 593  
services, drugs, or devices to which a prior authorization 594  
requirement exists. 595

(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 and, for policies issued on or after the first day of January following the effective date of this section, the insurer or plan shall identify the name, specialty, and relevant qualifications of the clinical peer who evaluates the appeal.

(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.

(e) For policies issued on or after the first day of January following the effective date of this amendment, the insurer or plan shall not charge a fee for appealing an adverse prior authorization determination.

(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\_

including, for policies issued on or after the first day of 625  
January following the effective date of this amendment, an 626  
authorization for mental health or substance use disorder 627  
treatment, when all of the following are met: 628

(1) The health care practitioner submits a prior 629  
authorization request to the insurer or plan for a health care 630  
service, drug, or device; 631

(2) The insurer or plan approves the prior authorization 632  
request after determining that all of the following that apply 633  
to the policy are true: 634

(a) The patient is eligible under the health benefit plan. 635

(b) The health care service, drug, or device is covered 636  
under the patient's health benefit plan. 637

(c) ~~The~~ For policies issued before the first day of 638  
January following the effective date of this amendment, the 639  
health care service, drug, or device meets the insurer's or 640  
plan's standards for medical necessity and prior authorization. 641

(3) The health care practitioner renders the health care 642  
service, drug, or device pursuant to the approved prior 643  
authorization request and all of the terms and conditions of the 644  
health care practitioner's contract with the insurer or plan; 645

(4) On the date the health care practitioner renders the 646  
prior approved health care service, drug, or device, all of the 647  
following are true: 648

(a) The patient is eligible under the health benefit plan. 649

(b) The patient's condition or circumstances related to 650  
the patient's care has not changed. 651

(c) The health care practitioner submits an accurate claim 652  
that matches the information submitted by the health care 653  
practitioner in the approved prior authorization request. 654

(5) If the health care practitioner submits a claim that 655  
includes an unintentional error and the error results in a claim 656  
that does not match the information originally submitted by the 657  
health care practitioner in the approved prior authorization 658  
request, upon receiving a denial of services from the insurer or 659  
plan, the health care practitioner may resubmit the claim 660  
pursuant to division (C) of this section with the information 661  
that matches the information included in the approved prior 662  
authorization. 663

(D) Any provision of a contractual arrangement entered 664  
into between an insurer or plan and a health care practitioner 665  
or beneficiary that is contrary to divisions (A) to (C) of this 666  
section is unenforceable. 667

(E) For policies issued on or after January 1, 2017, 668  
committing a series of violations of this section that, taken 669  
together, constitute a practice or pattern shall be considered 670  
an unfair and deceptive practice under sections 3901.19 to 671  
3901.26 of the Revised Code. 672

(F) The superintendent of insurance may adopt rules in 673  
accordance with Chapter 119. of the Revised Code as necessary to 674  
implement the provisions of this section. 675

(G) This section does not apply to any of the following 676  
types of coverage: a policy, contract, certificate, or agreement 677  
that covers only a specified accident, accident only, credit, 678  
dental, disability income, long-term care, hospital indemnity, 679  
supplemental coverage as described in section 3923.37 of the 680



Revised Code, specified disease, or vision care; a dental 681  
benefit that is offered as a part of a policy of sickness and 682  
accident insurance or a public employee benefit plan; coverage 683  
issued as a supplement to liability insurance; insurance arising 684  
out of workers' compensation or similar law; automobile medical 685  
payment insurance; insurance under which benefits are payable 686  
with or without regard to fault and which is statutorily 687  
required to be contained in any liability insurance policy or 688  
equivalent self-insurance; a medicare supplement policy of 689  
insurance as defined by the superintendent of insurance by rule; 690  
coverage under a plan through medicare or the federal employees 691  
benefit program; or any coverage issued under Chapter 55 of 692  
Title 10 of the United States Code and any coverage issued as a 693  
supplement to that coverage. 694

**Sec. 5160.34.** (A) As used in this section: 695

(1) "Chronic condition" means a medical condition that has 696  
persisted after reasonable efforts have been made to relieve or 697  
cure its cause and has continued, either continuously or 698  
episodically, for longer than six continuous months. 699

(2) "Clinical peer" means a health care provider in the 700  
same, or in a similar, specialty that typically manages the 701  
medical condition, procedure, or treatment under review. 702

(3) "Emergency services" has the same meaning as in 703  
section 1753.28 of the Revised Code. 704

(4) "Prior authorization requirement" means any practice 705  
implemented by a medical assistance program in which coverage of 706  
a health care service, device, or drug is dependent upon a 707  
medical assistance recipient or a health care provider, 708  
receiving approval from the department of medicaid or its 709

designee, including a medicaid managed care organization, prior 710  
to the service, device, or drug being performed, received, or 711  
prescribed, as applicable. "Prior authorization" includes 712  
prospective or utilization review procedures conducted prior to 713  
providing a health care service, device, or drug. 714

(5) "Urgent care services" means a medical care or other 715  
service for a condition where application of the timeframe for 716  
making routine or non-life threatening care determinations is 717  
either of the following: 718

(a) Could seriously jeopardize the life, health, or safety 719  
of the recipient or others due to the recipient's psychological 720  
state; 721

(b) In the opinion of a practitioner with knowledge of the 722  
recipient's medical or behavioral condition, would subject the 723  
recipient to adverse health consequences without the care or 724  
treatment that is the subject of the request. 725

(6) "Utilization review" and "utilization review 726  
organization" have the same meanings as in section 1751.77 of 727  
the Revised Code. 728

(B) If a medical assistance program has a prior 729  
authorization requirement, the department of medicaid or its 730  
designee, including a medicaid managed care organization, shall 731  
do all of the following: 732

(1) On or before January 1, 2018, permit a health care 733  
provider to access the prior authorization form through the 734  
applicable electronic software system. 735

(2) (a) On or before January 1, 2018, permit the department 736  
or its designee to accept and respond to prior prescription 737  
benefit authorization requests through a secure electronic 738

transmission. 739

(b) On or before January 1, 2018, the department or its 740  
designee shall accept and respond to prior prescription benefit 741  
authorization requests through a secure electronic transmission 742  
using NCPDP SCRIPT standard ePA transactions, and for prior 743  
medical benefit authorization requests through a secure 744  
electronic transmission using standards established by the 745  
council for affordable quality health care on operating rules 746  
for information exchange or its successor. 747

(c) For purposes of division (B)(2) of this section, 748  
neither of the following shall be considered a secure electronic 749  
transmission: 750

(i) A facsimile; 751

(ii) A proprietary payer portal for prescription drug 752  
requests that does not use NCPDP SCRIPT standard. 753

(3) On or before January 1, 2018, a health care provider 754  
and the department of medicaid or its designee may enter into a 755  
contractual arrangement under which the department or its 756  
designee agrees to process prior authorization requests that are 757  
not submitted electronically because of the financial hardship 758  
that electronic submission of prior authorization requests would 759  
create for the provider or if internet connectivity is limited 760  
or unavailable where the provider is located. 761

(4) (a) On or before January 1, 2018, if the health care 762  
provider submits the request for prior authorization 763  
electronically as described in divisions (B)(1) and (2) of this 764  
section, respond to all prior authorization requests within 765  
forty-eight hours for urgent care services, or ten calendar days 766  
for any prior authorization request that is not for an urgent 767

care service, of the time the request is received by the 768  
department or its designee. Division (B)(4) of this section does 769  
not apply to emergency services. 770

(b) The response required under division (B)(4)(a) of this 771  
section shall indicate whether the request is approved or 772  
denied. If the prior authorization is denied, the department or 773  
its designee shall provide the specific reason for the denial. 774

(c) If the prior authorization request is incomplete, the 775  
department or its designee shall indicate the specific 776  
additional information that is required to process the request. 777

(5)(a) On or before January 1, 2018, if a health care 778  
provider submits a prior authorization request as described in 779  
divisions (B)(1) and (2) of this section, the department or its 780  
designee shall provide an electronic receipt to the health care 781  
provider acknowledging that the prior authorization request was 782  
received. 783

(b) On or before January 1, 2018, if the department or its 784  
designee requests additional information that is required to 785  
process a prior authorization request as described in division 786  
(B)(4)(c) of this section, the health care provider shall 787  
provide an electronic receipt to the department or its designee 788  
acknowledging that the request for additional information was 789  
received. 790

(6)(a) On or before January 1, 2017, honor a prior 791  
authorization approval for an approved drug for the lesser of 792  
the following from the date of approval: 793

(i) Twelve months; 794

(ii) The last day of the medical assistance recipient's 795  
eligibility for the medical assistance program. 796

(b) The duration of all other prior authorization 797  
approvals shall be dictated by the medical assistance program. 798

(c) The department or its designee, in relation to prior 799  
approval under division (B) (6) (a) of this section, may require a 800  
health care provider to submit information to the department or 801  
its designee indicating that the patient's chronic condition has 802  
not changed. 803

(i) The request for information by the department or its 804  
designee and the response by the health care provider shall be 805  
in an electronic format, which may be by electronic mail or 806  
other electronic communication. 807

(ii) The frequency of the submission of requested 808  
information shall be consistent with medical or scientific 809  
evidence as defined in section 3922.01 of the Revised Code, but 810  
shall not be required more frequently than quarterly. 811

(iii) If the health care provider does not respond within 812  
five calendar days from the date the request was received, the 813  
insurer or plan may terminate the twelve-month approval. 814

(d) A twelve-month approval provided under division (B) (6) 815  
(a) of this section is no longer valid and automatically 816  
terminates if there are changes to federal or state laws or 817  
federal regulatory guidance or compliance information 818  
prescribing that the drug in question is no longer approved or 819  
safe for the intended purpose. 820

(e) A twelve-month approval provided under division (B) (6) 821  
(a) of this section does not apply to and is not required for 822  
any of the following: 823

(i) Medications that are prescribed for a non-maintenance 824  
condition; 825

(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.

(f) If, following a prior authorization approval under division (B) (6) (a) of this section, a provider prescribes a change in dosage of the approved drug, the department or its designee shall honor the prior authorization approval as applied to the change in dosage for the period required by that division.

(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 882  
is received, the department or its designee shall review the 883  
claim for coverage and medical necessity. The department or its 884  
designee shall not deny a claim for such a new service based 885  
solely on the fact that a prior authorization approval was not 886  
received for the new service in question. 887

(10)(a) On or before January 1, 2017, disclose to all 888  
participating health care providers any new prior authorization 889  
requirement at least thirty days prior to the effective date of 890  
the new requirement. 891

(b) The notice may be sent via electronic mail or standard 892  
mail and shall be conspicuously entitled "Notice of Changes to 893  
Prior Authorization Requirements." The notice is not required to 894  
contain a complete listing of all changes made to the prior 895  
authorization requirements, but shall include specific 896  
information on where the health care provider may locate the 897  
information on the department's or its designee's web site or, 898  
if applicable, the department's or its designee's portal. 899

(c) All participating health care providers shall promptly 900  
notify the department or its designee of any changes to the 901  
health care provider's electronic mail or standard mail address. 902

(11)(a) On or before January 1, 2017, make available to 903  
all participating health care providers on its web site or 904  
provider portal a listing of its prior authorization 905  
requirements, including specific information or documentation 906  
that a provider must submit in order for the prior authorization 907  
request to be considered complete. 908

(b) Make available on its web site information about the 909  
medical assistance programs offered in this state that clearly 910



identifies specific services, drugs, or devices to which a prior 911  
authorization requirement exists. 912

(12) On or before January 1, 2018, establish a streamlined 913  
appeal process relating to adverse prior authorization 914  
determinations that shall include all of the following: 915

(a) For urgent care services, the appeal shall be 916  
considered within forty-eight hours after the department or its 917  
designee receives the appeal. 918

(b) For all other matters, the appeal shall be considered 919  
within ten calendar days after the department or its designee 920  
receives the appeal. 921

(c) The appeal shall be between the health care provider 922  
requesting the service in question and a clinical peer appointed 923  
by or contracted by the department or the department's designee. 924  
In the appeal determination provided to the health care 925  
practitioner, the department or its designee shall identify the 926  
name, specialty, and relevant qualifications of the clinical 927  
peer who evaluated the appeal. 928

(d) If the appeal does not resolve the disagreement, the 929  
appeal procedures shall permit the recipient to further appeal 930  
in accordance with section 5160.31 of the Revised Code. 931

(e) The department or its designee shall not charge a fee 932  
for appealing an adverse prior authorization determination. 933

(C) Beginning January 1, 2017, except in cases of 934  
fraudulent or materially incorrect information, the department 935  
or its designee shall not retroactively deny a prior 936  
authorization for a health care service, drug, or device, 937  
including an authorization for mental health or substance use 938  
disorder treatment, when all of the following are met: 939

(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 both 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 968  
includes an unintentional error and the error results in a claim 969  
that does not match the information originally submitted by the 970  
health care provider in the approved prior authorization 971  
request, upon receiving a denial of services from the department 972  
or its designee, the health care provider may resubmit the claim 973  
pursuant to division (C) of this section with the information 974  
that matches the information included in the approved prior 975  
authorization. 976

(D) Any provision of a contractual arrangement entered 977  
into between the department or its designee and a health care 978  
provider or recipient that is contrary to divisions (A) to (C) 979  
of this section is unenforceable. 980

(E) The director of medicaid may adopt rules in accordance 981  
with Chapter 119. of the Revised Code as necessary to implement 982  
the provisions of this section. 983

**Section 2.** That existing sections 1751.72, 3923.041, and 984  
5160.34 of the Revised Code are hereby repealed. 985