

As Reported by the House Insurance Committee

136th General Assembly

Regular Session

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Sub. 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 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) For policies delivered, issued for delivery, or renewed on or after the effective date of this amendment, following a prior authorization approval under division (B) (6) (a) of this section, if a provider prescribes a change in dosage of the approved drug, the health insuring corporation shall honor the prior authorization approval as applied to the change in dosage for the period required by that division.

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

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

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

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

(8) Nothing in division (B) (6) or (7) of this section 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 delivered, issued for delivery, or 264
renewed on or after the effective date of this amendment, the 265
health insuring corporation shall identify the specialty and 266
relevant qualifications of the clinical peer who evaluates the 267
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 delivered, issued for delivery, or 274
renewed on or after 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 delivered, 282
issued for delivery, or renewed on or after the effective date 283
of this amendment, 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 delivered, issued for delivery, or 296
renewed before the effective date of this amendment, the health 297
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 the response by the health care practitioner shall be in an electronic format, which may be by electronic mail or other electronic communication.

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

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

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

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

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

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

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

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

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

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

(f) For policies delivered, issued for delivery, or renewed on or after the effective date of this amendment, following a prior authorization approval under division (B) (6) (a) of this section, if a provider prescribes a change in dosage of the approved drug, the insurer or plan shall honor the prior authorization approval as applied to the change in dosage for the period required by that division.

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

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

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

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

(8) Nothing in division (B) (6) or (7) of this section 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 delivered, issued for delivery, or renewed on or after the effective date of this amendment, the insurer or plan shall identify the 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 delivered, issued for delivery, or renewed on or after 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 delivered, issued for delivery, or 625
renewed on or after 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 delivered, issued for delivery, or 638
renewed before the effective date of this amendment, the health 639
care service, drug, or device meets the insurer's or plan's 640
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; 826
827

(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; 828
829
830

(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; 831
832
833

(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; 834
835
836

(vi) Medications that are not prescribed by an in-network provider as part of a care management program. 837
838

(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. 839
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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: 845
846
847
848

(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. 849
850
851

(b) Medications that are controlled substances not included in division (B) (6) (e) (v) of this section. 852
853

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
specialty and relevant qualifications of the clinical peer who 927
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

Section 3. Sections 1 and 2 of this act take effect 986
January 1, 2028. 987