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135th General Assembly
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Sub. H. B. No. 130

A BILL

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

period.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

exemption.

(D) A sickness and accident insurer shall not do either of the following:

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

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

(a) Knowingly and materially misrepresents the health care service or medical device provided in its request for payment from the sickness and accident insurer with the intent to obtain an unlawful payment amount from the sickness and accident insurer;

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

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

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

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

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

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

(F)(1) At the end of the exemption period, a sickness and accident insurer may evaluate an exemption it has granted under division (A) of this section.

(2)(a) An insurer conducting such an evaluation shall review twenty claims submitted to the insurer, selected at random, for the health care service or medical device in question.

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

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

(b) An insurer that is revoking an exemption shall provide the health care provider or health care provider group with both of the following:

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

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

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

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

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

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

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

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

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

Revised Code.

(B) Notwithstanding division (F) of section 121.95 of the Revised Code, the superintendent of insurance may adopt rules as necessary to carry out the requirements of sections 3923.042 to 3923.044 of the Revised Code.

Sec. 5160.34. (A) As used in ~~this section~~sections 5160.34 to 5160.342 of the Revised Code:

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

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

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

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

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

either of the following:

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

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

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

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

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

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

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

for information exchange or its successor.

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

(i) A facsimile;

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

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

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

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

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

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

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

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

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

(i) Twelve months;

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

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

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

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

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

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

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

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

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

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

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

(iv) Medications where there is medical or scientific

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

previous twelve-month period.

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

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

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

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

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

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

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

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

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

the following:

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

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

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

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

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

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

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

exemption applies;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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