

**As Concurred by the Senate**

**131st General Assembly**

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**Sub. S. B. No. 129**

**Senators Gardner, Cafaro**

**Cosponsors: Senators Yuko, Skindell, Manning, Brown, Seitz, Williams, Hite, Oelslager, Lehner, Tavares, Eklund, Hughes, Jones, Obhof, Patton, Sawyer, Schiavoni, Thomas, Uecker, Faber, Hackett, Hottinger, Jordan**

**Representatives Bishoff, DeVitis, Henne, Amstutz, Anielski, Antani, Boyd, Brown, Burkley, Conditt, Craig, Cupp, Green, Hambley, Huffman, Lepore-Hagan, McClain, Patterson, Rogers, Schaffer, Sears, Smith, R., Sprague**

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**A BILL**

To amend sections 340.034, 1739.05, and 5119.25, to 1  
enact sections 1751.72, 3923.041, and 5160.34 of 2  
the Revised Code, and to amend Sections 110.12 3  
and 812.40 of Am. Sub. H.B. 64 of the 131st 4  
General Assembly, to amend Section 812.40 of Am. 5  
Sub. H.B. 483 of the 130th General Assembly to 6  
amend the law related to the prior authorization 7  
requirements of insurers and to delay the 8  
effective date of certain laws regarding 9  
community mental health and addiction services. 10

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

**Section 1.** That sections 340.034, 1739.05, and 5119.25 be 11  
amended and sections 1751.72, 3923.041, and 5160.34 of the 12  
Revised Code be enacted to read as follows: 13

**Sec. 340.034.** All of the following apply to the recovery 14

housing required by section 340.033 of the Revised Code to be 15  
included in the array of treatment services and recovery support 16  
for all levels of opioid and co-occurring drug addiction that 17  
are part of the continuum of care established by each board of 18  
alcohol, drug addiction, and mental health services pursuant to 19  
division (A)(11) of section 340.03 of the Revised Code: 20

(A) The recovery housing shall not be subject to 21  
residential facility licensure by the department of mental 22  
health and addiction services under section 5119.34 of the 23  
Revised Code. In addition, the recovery housing shall not be 24  
owned and operated by a board of alcohol, drug addiction, and 25  
mental health services unless any of the following applies: 26

(1) The board owns and operates the recovery housing on 27  
~~September 15, 2016~~July 1, 2017. 28

(2) The board utilizes local funds in the development, 29  
purchase, or operation of the recovery housing. 30

(3) The board determines that there is a need for the 31  
board to assume the ownership and operation of the recovery 32  
housing such as when an existing owner and operator of the 33  
recovery housing goes out of business, and the board considers 34  
the assumption of ownership and operation of the recovery 35  
housing to be in the best interest of the community. 36

(B) The recovery housing shall have protocols for all of 37  
the following: 38

(1) Administrative oversight; 39

(2) Quality standards; 40

(3) Policies and procedures, including house rules, for 41  
its residents to which the residents must agree to adhere. 42

(C) Family members of the recovery housing's residents may 43  
reside in the recovery housing to the extent the recovery 44  
housing's protocols permit. 45

(D) The recovery housing shall not limit a resident's 46  
duration of stay to an arbitrary or fixed amount of time. 47  
Instead, each resident's duration of stay shall be determined by 48  
the resident's needs, progress, and willingness to abide by the 49  
recovery housing's protocols, in collaboration with the recovery 50  
housing's owner and operator, and, if appropriate, in 51  
consultation and integration with a community addiction services 52  
provider. 53

(E) The recovery housing may permit its residents to 54  
receive medication-assisted treatment. 55

(F) A recovery housing resident may receive addiction 56  
services that are certified by the department of mental health 57  
and addiction services under section 5119.36 of the Revised 58  
Code. 59

**Sec. 1739.05.** (A) A multiple employer welfare arrangement 60  
that is created pursuant to sections 1739.01 to 1739.22 of the 61  
Revised Code and that operates a group self-insurance program 62  
may be established only if any of the following applies: 63

(1) The arrangement has and maintains a minimum enrollment 64  
of three hundred employees of two or more employers. 65

(2) The arrangement has and maintains a minimum enrollment 66  
of three hundred self-employed individuals. 67

(3) The arrangement has and maintains a minimum enrollment 68  
of three hundred employees or self-employed individuals in any 69  
combination of divisions (A) (1) and (2) of this section. 70

(B) A multiple employer welfare arrangement that is 71  
created pursuant to sections 1739.01 to 1739.22 of the Revised 72  
Code and that operates a group self-insurance program shall 73  
comply with all laws applicable to self-funded programs in this 74  
state, including sections 3901.04, 3901.041, 3901.19 to 3901.26, 75  
3901.38, 3901.381 to 3901.3814, 3901.40, 3901.45, 3901.46, 76  
3901.491, 3902.01 to 3902.14, 3923.041, 3923.24, 3923.282, 77  
3923.30, 3923.301, 3923.38, 3923.581, 3923.63, 3923.80, 3923.85, 78  
3924.031, 3924.032, and 3924.27 of the Revised Code. 79

(C) A multiple employer welfare arrangement created 80  
pursuant to sections 1739.01 to 1739.22 of the Revised Code 81  
shall solicit enrollments only through agents or solicitors 82  
licensed pursuant to Chapter 3905. of the Revised Code to sell 83  
or solicit sickness and accident insurance. 84

(D) A multiple employer welfare arrangement created 85  
pursuant to sections 1739.01 to 1739.22 of the Revised Code 86  
shall provide benefits only to individuals who are members, 87  
employees of members, or the dependents of members or employees, 88  
or are eligible for continuation of coverage under section 89  
1751.53 or 3923.38 of the Revised Code or under Title X of the 90  
"Consolidated Omnibus Budget Reconciliation Act of 1985," 100  
Stat. 227, 29 U.S.C.A. 1161, as amended. 92

(E) A multiple employer welfare arrangement created 93  
pursuant to sections 1739.01 to 1739.22 of the Revised Code is 94  
subject to, and shall comply with, sections 3903.81 to 3903.93 95  
of the Revised Code in the same manner as other life or health 96  
insurers, as defined in section 3903.81 of the Revised Code. 97

**Sec. 1751.72.** (A) As used in this section: 98

(1) "Chronic condition" means a medical condition that has 99

persisted after reasonable efforts have been made to relieve or 100  
cure its cause and has continued, either continuously or 101  
episodically, for longer than six continuous months. 102

(2) "Clinical peer" means a health care practitioner in 103  
the same, or in a similar, specialty that typically manages the 104  
medical condition, procedure, or treatment under review. 105

(3) "Covered person" means a person receiving coverage for 106  
health services under a policy, contract, or agreement issued by 107  
a health insuring corporation. 108

(4) "Emergency services" has the same meaning as in 109  
section 1753.28 of the Revised Code. 110

(5) "Fraudulent or materially incorrect information" means 111  
any type of intentional deception or misrepresentation made by a 112  
person with the knowledge that the deception could result in 113  
some unauthorized benefit to the covered person in question. 114

(6) "Health care practitioner" has the same meaning as in 115  
section 3701.74 of the Revised Code. 116

(7) "NCPDP SCRIPT standard" means the national council for 117  
prescription drug programs SCRIPT standard version 201310 or the 118  
most recent standard adopted by the the United States department 119  
of health and human services. 120

(8) "Prior authorization requirement" means any practice 121  
implemented by a health insuring corporation in which coverage 122  
of a health care service, device, or drug is dependent upon a 123  
covered person or a health care practitioner obtaining approval 124  
from the health insuring corporation prior to the service, 125  
device, or drug being performed, received, or prescribed, as 126  
applicable. "Prior authorization" includes prospective or 127  
utilization review procedures conducted prior to providing a 128

health care service, device, or drug. 129

(9) "Urgent care services" means a medical care or other 130  
service for a condition where application of the timeframe for 131  
making routine or non-life threatening care determinations is 132  
either of the following: 133

(a) Could seriously jeopardize the life, health, or safety 134  
of the patient or others due to the patient's psychological 135  
state; 136

(b) In the opinion of a practitioner with knowledge of the 137  
patient's medical or behavioral condition, would subject the 138  
patient to adverse health consequences without the care or 139  
treatment that is the subject of the request. 140

(10) "Utilization review" and "utilization review 141  
organization" have the same meanings as in section 1751.77 of 142  
the Revised Code. 143

(B) If a policy, contract, or agreement issued by a health 144  
insuring corporation contains a prior authorization requirement, 145  
then all of the following apply: 146

(1) On or before January 1, 2018, the health insuring 147  
corporation shall permit health care practitioners to access the 148  
prior authorization form through the applicable electronic 149  
software system. 150

(2) (a) For policies issued on or after January 1, 2018, 151  
the health insuring corporation or other payer acting on behalf 152  
of the health insuring corporation, shall accept prior 153  
authorization requests through a secure electronic transmission. 154

(b) For policies issued on or after January 1, 2018, the 155  
health insuring corporation, a pharmacy benefit manager 156

responsible for handling prior authorization requests, or other 157  
payer acting on behalf of the health insuring corporation shall 158  
accept and respond to prior prescription benefit authorization 159  
requests through a secure electronic transmission using NCPDP 160  
SCRIPT standard ePA transactions, and for prior medical benefit 161  
authorization requests through a secure electronic transmission 162  
using standards established by the council for affordable 163  
quality health care on operating rules for information exchange 164  
or its successor. 165

(c) For purposes of division (B) (2) of this section, 166  
neither of the following shall be considered a secure electronic 167  
transmission: 168

(i) A facsimile; 169

(ii) A proprietary payer portal for prescription drug 170  
requests that does not use NCPDP SCRIPT standard. 171

(3) For policies issued on or after January 1, 2018, a 172  
health care practitioner and health insuring corporation may 173  
enter into a contractual arrangement under which the health 174  
insuring corporation agrees to process prior authorization 175  
requests that are not submitted electronically because of the 176  
financial hardship that electronic submission of prior 177  
authorization requests would create for the health care 178  
practitioner or if internet connectivity is limited or 179  
unavailable where the health care practitioner is located. 180

(4) (a) For policies issued on or after January 1, 2018, if 181  
the health care practitioner submits the request for prior 182  
authorization as described in divisions (B) (1) and (2) of this 183  
section, the health insuring corporation shall respond to all 184  
prior authorization requests within forty-eight hours for urgent 185

care services, or ten calendar days for any prior approval 186  
request that is not for an urgent care service, of the time the 187  
request is received by the health insuring corporation with all 188  
information necessary to support the prior authorization 189  
request. Division (B) (4) of this section does not apply to 190  
emergency services. 191

(b) (i) The response required under division (B) (4) (a) of 192  
this section shall indicate whether the request is approved, 193  
denied, or incomplete. If the prior authorization is denied, the 194  
health insuring corporation shall provide the specific reason 195  
for the denial. If the prior authorization request is 196  
incomplete, the health insuring corporation shall indicate the 197  
specific additional information that is required to process the 198  
request. 199

(ii) For a response that is considered incomplete, the 200  
health care practitioner shall provide the additional 201  
information requested under division (B) (4) (b) (i) of this 202  
section within seventy-two hours of the time the request is 203  
received by the practitioner. 204

(5) (a) For policies issued on or after January 1, 2018, if 205  
a health care practitioner submits a prior authorization request 206  
as described in divisions (B) (1) and (2) of this section, the 207  
health insuring corporation shall provide an electronic receipt 208  
to the health care practitioner acknowledging that the prior 209  
authorization request was received. 210

(b) For policies issued on or after January 1, 2018, if a 211  
health insuring corporation requests additional information that 212  
is required to process a prior authorization request as 213  
described in division (B) (4) (b) (i) of this section, the health 214  
care practitioner shall provide an electronic receipt to the 215



health insuring corporation acknowledging that the request for 216  
additional information was received. 217

(6) (a) For policies issued on or after January 1, 2017, 218  
for a prior approval related to a chronic condition, the health 219  
insuring corporation shall honor a prior authorization approval 220  
for an approved drug for the lesser of the following from the 221  
date of the approval: 222

(i) Twelve months; 223

(ii) The last day of the covered person's eligibility 224  
under the policy, contract, or agreement. 225

(b) The duration of all other prior authorization 226  
approvals shall be dictated by the policy, contract, or 227  
agreement issued by the health insuring corporation. 228

(c) A health insuring corporation may, in relation to a 229  
prior approval under division (B) (6) (a) of this section, require 230  
a health care practitioner to submit information to the health 231  
insuring corporation indicating that the patient's chronic 232  
condition has not changed. 233

(i) The request for information by the health insuring 234  
corporation and the response by the health care practitioner 235  
shall be in an electronic format, which may be by electronic 236  
mail or other electronic communication. 237

(ii) The frequency of the submission of requested 238  
information shall be consistent with medical or scientific 239  
evidence as defined in section 3922.01 of the Revised Code, but 240  
shall not be required more frequently than quarterly. 241

(iii) If the health care practitioner does not respond 242  
within five calendar days from the date the request was 243

received, the health insuring corporation may terminate the 244  
twelve-month approval. 245

(d) A year long approval provided under division (B) (6) (a) 246  
of this section is no longer valid and automatically terminates 247  
if there are changes to federal or state laws or federal 248  
regulatory guidance or compliance information prescribing that 249  
the drug in question is no longer approved or safe for the 250  
intended purpose. 251

(e) A twelve-month approval provided under division (B) (6) 252  
(a) of this section does not apply to and is not required for 253  
any of the following: 254

(i) Medications that are prescribed for a non-maintenance 255  
condition; 256

(ii) Medications that have a typical treatment of less 257  
than one year; 258

(iii) Medications that require an initial trial period to 259  
determine effectiveness and tolerability, beyond which a one- 260  
year, or greater, prior authorization period will be given; 261

(iv) Medications where there is medical or scientific 262  
evidence as defined in section 3922.01 of the Revised Code that 263  
do not support a twelve-month prior approval; 264

(v) Medications that are a schedule I or II controlled 265  
substance or any opioid analgesic or benzodiazepine, as defined 266  
in section 3719.01 of the Revised Code; 267

(vi) Medications that are not prescribed by an in-network 268  
provider as part of a care management program. 269

(7) For policies issued on or after January 1, 2017, a 270  
health insuring corporation may, but is not required to, provide 271

the twelve-month approval prescribed in division (B) (6) (a) of 272  
this section for a prescription drug that meets either of the 273  
following: 274

(a) The drug is prescribed or administered to treat a rare 275  
medical condition and pursuant to medical or scientific evidence 276  
as defined in section 3922.01 of the Revised Code. 277

(b) Medications that are controlled substances not 278  
included in division (B) (6) (e) (v) of this section. 279

For purposes of division (B) (7) of this section, "rare 280  
medical condition" means any disease or condition that affects 281  
fewer than two hundred thousand individuals in the United 282  
States. 283

(8) Nothing in division (B) (6) or (7) of this section 284  
prohibits the substitution of any drug that has received a 285  
twelve-month approval under division (B) (6) (a) of this section 286  
when there is a release of a United States food and drug 287  
administration approved comparable brand product or a generic 288  
counterpart of a brand product that is listed as therapeutically 289  
equivalent in the United States food and drug administration's 290  
publication titled approved drug products with therapeutic 291  
equivalence evaluations. 292

(9) (a) For policies issued on or after January 1, 2017, 293  
upon written request, a health insuring corporation shall permit 294  
a retrospective review for a claim that is submitted for a 295  
service where prior authorization was required but not obtained 296  
if the service in question meets all of the following: 297

(i) The service is directly related to another service for 298  
which prior approval has already been obtained and that has 299  
already been performed. 300

(ii) The new service was not known to be needed at the 301  
time the original prior authorized service was performed. 302

(iii) The need for the new service was revealed at the 303  
time the original authorized service was performed. 304

(b) Once the written request and all necessary information 305  
is received, the health insuring corporation shall review the 306  
claim for coverage and medical necessity. The health insuring 307  
corporation shall not deny a claim for such a new service based 308  
solely on the fact that a prior authorization approval was not 309  
received for the new service in question. 310

(10) (a) For policies issued on or after January 1, 2017, 311  
the health insuring corporation shall disclose to all 312  
participating health care practitioners any new prior 313  
authorization requirement at least thirty days prior to the 314  
effective date of the new requirement. 315

(b) The notice may be sent via electronic mail or standard 316  
mail and shall be conspicuously entitled "Notice of Changes to 317  
Prior Authorization Requirements." The notice is not required to 318  
contain a complete listing of all changes made to the prior 319  
authorization requirements, but shall include specific 320  
information on where the health care practitioner may locate the 321  
information on the health insuring corporation's web site or, if 322  
applicable, the health insuring corporation's portal. 323

(c) All participating health care practitioners shall 324  
promptly notify the health insuring corporation of any changes 325  
to the health care practitioner's electronic mail or standard 326  
mail address. 327

(11) (a) For policies issued on or after January 1, 2017, 328  
the health insuring corporation shall make available to all 329

participating health care practitioners on its web site or 330  
provider portal a listing of its prior authorization 331  
requirements, including specific information or documentation 332  
that a provider must submit in order for the prior authorization 333  
request to be considered complete. 334

(b) The health insuring corporation shall make available 335  
on its web site information about the policies, contracts, or 336  
agreements offered by the health insuring corporation that 337  
clearly identifies specific services, drugs, or devices to which 338  
a prior authorization requirement exists. 339

(12) For policies issued on or after January 1, 2018, the 340  
health insuring corporation shall establish a streamlined appeal 341  
process relating to adverse prior authorization decision 342  
determinations that shall include all of the following: 343

(a) For urgent care services, the appeal shall be 344  
considered within forty-eight hours after the health insuring 345  
corporation receives the appeal. 346

(b) For all other matters, the appeal shall be considered 347  
within ten calendar days after the health insuring corporation 348  
receives the appeal. 349

(c) The appeal shall be between the health care 350  
practitioner requesting the service in question and a clinical 351  
peer. 352

(d) If the appeal does not resolve the disagreement, 353  
either the covered person or an authorized representative as 354  
defined in section 3922.01 of the Revised Code may request an 355  
external review under Chapter 3922. of the Revised Code to the 356  
extent Chapter 3922. of the Revised Code is applicable. 357

(C) For policies issued on or after January 1, 2017, 358

except in cases of fraudulent or materially incorrect 359  
information, a health insuring corporation shall not 360  
retroactively deny a prior authorization for a health care 361  
service, drug, or device when all of the following are met: 362

(1) The health care practitioner submits a prior 363  
authorization request to the health insuring corporation for a 364  
health care service, drug, or device. 365

(2) The health insuring corporation approves the prior 366  
authorization request after determining that all of the 367  
following are true: 368

(a) The patient is eligible under the health benefit plan. 369

(b) The health care service, drug, or device is covered 370  
under the patient's health benefit plan. 371

(c) The health care service, drug, or device meets the 372  
health insuring corporation's standards for medical necessity 373  
and prior authorization. 374

(3) The health care practitioner renders the health care 375  
service, drug, or device pursuant to the approved prior 376  
authorization request and all of the terms and conditions of the 377  
health care practitioner's contract with the health insuring 378  
corporation. 379

(4) On the date the health care practitioner renders the 380  
prior approved health care service, drug, or device, all of the 381  
following are true: 382

(a) The patient is eligible under the health benefit plan. 383

(b) The patient's condition or circumstances related to 384  
the patient's care has not changed. 385

(c) The health care practitioner submits an accurate claim 386  
that matches the information submitted by the health care 387  
practitioner in the approved prior authorization request. 388

(5) If the health care practitioner submits a claim that 389  
includes an unintentional error and the error results in a claim 390  
that does not match the information originally submitted by the 391  
health care practitioner in the approved prior authorization 392  
request, upon receiving a denial of services from the health 393  
insuring corporation, the health care practitioner may resubmit 394  
the claim pursuant to division (C) of this section with the 395  
information that matches the information included in the 396  
approved prior authorization. 397

(D) Any provision of a contractual arrangement entered 398  
into between a health insuring corporation and a health care 399  
practitioner or beneficiary that is contrary to divisions (A) to 400  
(C) of this section is unenforceable. 401

(E) For policies issued on or after January 1, 2017, 402  
committing a series of violations of this section that, taken 403  
together, constitute a practice or pattern shall be considered 404  
an unfair and deceptive practice under sections 3901.19 to 405  
3901.26 of the Revised Code. 406

(F) The superintendent of insurance may adopt rules in 407  
accordance with Chapter 119. of the Revised Code as necessary to 408  
implement the provisions of this section. 409

(G) This section does not apply to any of the following 410  
types of coverage: a policy, contract, certificate, or agreement 411  
that covers only a specified accident, accident only, credit, 412  
dental, disability income, long-term care, hospital indemnity, 413  
supplemental coverage as described in section 3923.37 of the 414

Revised Code, specified disease, or vision care; coverage issued 415  
as a supplement to liability insurance; insurance arising out of 416  
workers' compensation or similar law; automobile medical payment 417  
insurance; insurance under which benefits are payable with or 418  
without regard to fault and which is statutorily required to be 419  
contained in any liability insurance policy or equivalent self- 420  
insurance; a medicare supplement policy of insurance as defined 421  
by the superintendent of insurance by rule; coverage under a 422  
plan through medicare or the federal employees benefit program; 423  
or any coverage issued under Chapter 55 of Title 10 of the 424  
United States Code and any coverage issued as a supplement to 425  
that coverage. 426

**Sec. 3923.041.** (A) As used in this section: 427

(1) "Chronic condition" means a medical condition that has 428  
persisted after reasonable efforts have been made to relieve or 429  
cure its cause and has continued, either continuously or 430  
episodically, for longer than six continuous months. 431

(2) "Clinical peer" means a health care practitioner in 432  
the same or in a similar, specialty that typically manages the 433  
medical condition, procedure, or treatment under review. 434

(3) "Covered person" means a person receiving coverage for 435  
health services under a policy of sickness and accident 436  
insurance or a public employee benefit plan. 437

(4) "Emergency service" has the same meaning as in section 438  
1753.28 of the Revised Code. 439

(5) "Fraudulent or materially incorrect information" means 440  
any type of intentional deception or misrepresentation made by a 441  
person with the knowledge that the deception could result in 442  
some unauthorized benefit to the covered person in question. 443



(6) "Health care practitioner" has the same meaning as in 444  
section 3701.74 of the Revised Code. 445

(7) "NCPDP SCRIPT standard" means the national council for 446  
prescription drug programs SCRIPT standard version 201310 or the 447  
most recent standard adopted by the United States department of 448  
health and human services. 449

(8) "Prior authorization requirement" means any practice 450  
implemented by either a sickness and accident insurer or a 451  
public employee benefit plan in which coverage of a health care 452  
service, device, or drug is dependent upon a covered person or a 453  
health care practitioner obtaining approval from the insurer or 454  
plan prior to the service, device, or drug being performed, 455  
received, or prescribed, as applicable. "Prior authorization" 456  
includes prospective or utilization review procedures conducted 457  
prior to providing a health care service, device, or drug. 458

(9) "Urgent care services" means a medical care or other 459  
service for a condition where application of the timeframe for 460  
making routine or non-life threatening care determinations is 461  
either of the following: 462

(a) Could seriously jeopardize the life, health, or safety 463  
of the patient or others due to the patient's psychological 464  
state; 465

(b) In the opinion of a practitioner with knowledge of the 466  
patient's medical or behavioral condition, would subject the 467  
patient to adverse health consequences without the care or 468  
treatment that is the subject of the request. 469

(10) "Utilization review" and "utilization review 470  
organization" have the same meanings as in section 1751.77 of 471  
the Revised Code. 472

(B) If a policy issued by a sickness and accident insurer or a public employee benefit plan contains a prior authorization requirement, then all of the following apply: 473  
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(1) For policies issued on or after January 1, 2018, the insurer or plan shall permit health care practitioners to access the prior authorization form through the applicable electronic software system. 476  
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(2) (a) For policies issued on or after January 1, 2018, the insurer or plan, or other payer acting on behalf of the insurer or plan, to accept prior authorization requests through a secure electronic transmission. 480  
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(b) For policies issued on or after January 1, 2018, the insurer or plan, a pharmacy benefit manager responsible for handling prior authorization requests, or other payer acting on behalf of the insurer or plan shall accept and respond to prior prescription benefit authorization requests through a secure electronic transmission using NCPDP SCRIPT standard ePA transactions, and for prior medical benefit authorization requests through a secure electronic transmission using standards established by the council for affordable quality health care on operating rules for information exchange or its successor. 484  
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(c) For purposes of division (B) (2) of this section, neither of the following shall be considered a secure electronic transmission: 495  
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(i) A facsimile; 498

(ii) A proprietary payer portal for prescription drug requests that does not use NCPDP SCRIPT standard. 499  
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(3) For policies issued on or after January 1, 2018, a 501

health care practitioner and an insurer or plan may enter into a 502  
contractual arrangement under which the insurer or plan agrees 503  
to process prior authorization requests that are not submitted 504  
electronically because of the financial hardship that electronic 505  
submission of prior authorization requests would create for the 506  
health care practitioner or if internet connectivity is limited 507  
or unavailable where the health care practitioner is located. 508

(4) (a) For policies issued on or after January 1, 2018, if 509  
the health care practitioner submits the request for prior 510  
authorization electronically as described in divisions (B) (1) 511  
and (2) of this section, the insurer or plan shall respond to 512  
all prior authorization requests within forty-eight hours for 513  
urgent care services, or ten calendar days for any prior 514  
approval request that is not for an urgent care service, of the 515  
time the request is received by the insurer or plan with all 516  
information necessary to support the prior authorization 517  
request. Division (B) (4) of this section does not apply to 518  
emergency services. 519

(b) (i) The response required under division (B) (4) (a) of 520  
this section shall indicate whether the request is approved, 521  
denied, or incomplete. If the prior authorization is denied, the 522  
insurer or plan shall provide the specific reason for the 523  
denial. If the prior authorization request is incomplete, the 524  
insurer or plan shall indicate the specific additional 525  
information that is required to process the request. 526

(ii) For a response that is considered incomplete, the 527  
health care practitioner shall provide the additional 528  
information requested under division (B) (4) (b) (i) of this 529  
section within seventy-two hours of the time the request is 530  
received by the practitioner. 531

(5) (a) For policies issued on or after January 1, 2018, if 532  
a health care practitioner submits a prior authorization request 533  
as described in divisions (B) (1) and (2) of this section, the 534  
insurer or plan shall provide an electronic receipt to the 535  
health care practitioner acknowledging that the prior 536  
authorization request was received. 537

(b) For policies issued on or after January 1, 2018, if an 538  
issuer or plan requests additional information that is required 539  
to process a prior authorization request as described in 540  
division (B) (4) (b) (i) of this section, the health care 541  
practitioner shall provide an electronic receipt to the issuer 542  
or plan acknowledging that the request for additional 543  
information was received. 544

(6) (a) For policies issued on or after January 1, 2017, 545  
for a prior approval related to a chronic condition, the insurer 546  
or plan shall honor a prior authorization approval for an 547  
approved drug for the lesser of the following from the date of 548  
the approval: 549

(i) Twelve months; 550

(ii) The last day of the covered person's eligibility 551  
under the policy or plan. 552

(b) The duration of all other prior authorization 553  
approvals shall be dictated by the policy or plan. 554

(c) An insurer or plan, in relation to prior approval 555  
under division (B) (6) (a) of this section, may require a health 556  
care practitioner to submit information to the insurer or plan 557  
indicating that the patient's chronic condition has not changed. 558

(i) The request for information by the insurer or plan and 559  
the response by the health care practitioner shall be in an 560

electronic format, which may be by traditional electronic mail 561  
or other electronic communication. 562

(ii) The frequency of the submission of requested 563  
information shall be consistent with medical or scientific 564  
evidence as defined in section 3922.01 of the Revised Code, but 565  
shall not be required more frequently than quarterly. 566

(iii) If the health care practitioner does not respond 567  
within five calendar days from the date the request was 568  
received, the insurer or plan may terminate the twelve-month 569  
approval. 570

(d) A year long approval provided under division (B) (6) (a) 571  
of this section is no longer valid and automatically terminates 572  
if there are changes to federal or state laws or federal 573  
regulatory guidance or compliance information prescribing that 574  
the drug in question is no longer approved or safe for the 575  
intended purpose. 576

(e) A twelve-month approval provided under division (B) (6) 577  
(a) of this section does not apply to and is not required for 578  
any of the following: 579

(i) Medications that are prescribed for a non-maintenance 580  
condition; 581

(ii) Medications that have a typical treatment of less 582  
than one year; 583

(iii) Medications that require an initial trial period to 584  
determine effectiveness and tolerability, beyond which a one- 585  
year, or greater, prior authorization period will be given; 586

(iv) Medications where there is medical or scientific 587  
evidence as defined in section 3922.01 of the Revised Code that 588

do not support a twelve-month prior approval; 589

(v) Medications that are a schedule I or II controlled 590  
substance or any opioid analgesic or benzodiazepine, as defined 591  
in section 3719.01 of the Revised Code; 592

(vi) Medications that are not prescribed by an in-network 593  
provider as part of the care management program. 594

(7) For policies issued on or after January 1, 2017, an 595  
insurer or plan may, but is not required to, provide the twelve- 596  
month approval prescribed in division (B) (6) (a) of this section 597  
for a prescription drug that meets either of the following: 598

(a) The drug is prescribed or administered to treat a rare 599  
medical condition and pursuant to medical or scientific evidence 600  
as defined in section 3922.01 of the Revised Code. 601

(b) Medications that are controlled substances not 602  
included in division (B) (6) (e) (v) of this section. 603

For purposes of division (B) (7) of this section, "rare 604  
medical condition" means any disease or condition that affects 605  
fewer than two hundred thousand individuals in the United 606  
States. 607

(8) Nothing in division (B) (6) or (7) of this section 608  
prohibits the substitution of any drug that has received a 609  
twelve-month approval under division (B) (6) (a) of this section 610  
when there is a release of a United States food and drug 611  
administration approved comparable brand product or a generic 612  
counterpart of a brand product that is listed as therapeutically 613  
equivalent in the United States food and drug administration's 614  
publication titled approved drug products with therapeutic 615  
equivalence evaluations. 616

(9) (a) For policies issued on or after January 1, 2017, 617  
upon written request, an insurer or plan shall permit a 618  
retrospective review for a claim that is submitted for a service 619  
where prior authorization was required but not obtained if the 620  
service in question meets all of the following: 621

(i) The service is directly related to another service for 622  
which prior approval has already been obtained and that has 623  
already been performed. 624

(ii) The new service was not known to be needed at the 625  
time the original prior authorized service was performed. 626

(iii) The need for the new service was revealed at the 627  
time the original authorized service was performed. 628

(b) Once the written request and all necessary information 629  
is received, the insurer or plan shall review the claim for 630  
coverage and medical necessity. The insurer or plan shall not 631  
deny a claim for such a new service based solely on the fact 632  
that a prior authorization approval was not received for the new 633  
service in question. 634

(10) (a) For policies issued on or after January 1, 2017, 635  
the insurer or plan shall disclose to all participating health 636  
care practitioners any new prior authorization requirement at 637  
least thirty days prior to the effective date of the new 638  
requirement. 639

(b) The notice may be sent via electronic mail or standard 640  
mail and shall be conspicuously entitled "Notice of Changes to 641  
Prior Authorization Requirements." The notice is not required to 642  
contain a complete listing of all changes made to the prior 643  
authorization requirements, but shall include specific 644  
information on where the health care practitioner may locate the 645

information on the insurer or plan's web site or, if applicable, 646  
the insurer's or plan's portal. 647

(c) All participating health care practitioners shall 648  
promptly notify the insurer or plan of any changes to the health 649  
care practitioner's electronic mail or standard mail address. 650

(11) (a) For policies issued on or after January 1, 2017, 651  
the insurer or plan shall make available to all participating 652  
health care practitioners on its web site or provider portal a 653  
listing of its prior authorization requirements, including 654  
specific information or documentation that a provider must 655  
submit in order for the prior authorization request to be 656  
considered complete. 657

(b) The insurer or plan shall make available on its web 658  
site information about the policies, contracts, or agreements 659  
offered by the insurer or plan that clearly identifies specific 660  
services, drugs, or devices to which a prior authorization 661  
requirement exists. 662

(12) For policies issued on or after January 1, 2018, the 663  
insurer or plan shall establish a streamlined appeal process 664  
relating to adverse prior authorization determinations that 665  
shall include all of the following: 666

(a) For urgent care services, the appeal shall be 667  
considered within forty-eight hours after the insurer or plan 668  
receives the appeal. 669

(b) For all other matters, the appeal shall be considered 670  
within ten calendar days after the insurer or plan receives the 671  
appeal. 672

(c) The appeal shall be between the health care 673  
practitioner requesting the service in question and a clinical 674



peer. 675

(d) If the appeal does not resolve the disagreement, 676  
either the covered person or an authorized representative as 677  
defined in section 3922.01 of the Revised Code may request an 678  
external review under Chapter 3922. of the Revised Code to the 679  
extent Chapter 3922. of the Revised Code is applicable. 680

(C) For policies issued on or after January 1, 2017, 681  
except in cases of fraudulent or materially incorrect 682  
information, an insurer or plan shall not retroactively deny a 683  
prior authorization for a health care service, drug, or device 684  
when all of the following are met: 685

(1) The health care practitioner submits a prior 686  
authorization request to the insurer or plan for a health care 687  
service, drug, or device; 688

(2) The insurer or plan approves the prior authorization 689  
request after determining that all of the following are true: 690

(a) The patient is eligible under the health benefit plan. 691

(b) The health care service, drug, or device is covered 692  
under the patient's health benefit plan. 693

(c) The health care service, drug, or device meets the 694  
insurer's or plan's standards for medical necessity and prior 695  
authorization. 696

(3) The health care practitioner renders the health care 697  
service, drug, or device pursuant to the approved prior 698  
authorization request and all of the terms and conditions of the 699  
health care practitioner's contract with the insurer or plan; 700

(4) On the date the health care practitioner renders the 701  
prior approved health care service, drug, or device, all of the 702

following are true: 703

(a) The patient is eligible under the health benefit plan. 704

(b) The patient's condition or circumstances related to 705  
the patient's care has not changed. 706

(c) The health care practitioner submits an accurate claim 707  
that matches the information submitted by the health care 708  
practitioner in the approved prior authorization request. 709

(5) If the health care practitioner submits a claim that 710  
includes an unintentional error and the error results in a claim 711  
that does not match the information originally submitted by the 712  
health care practitioner in the approved prior authorization 713  
request, upon receiving a denial of services from the insurer or 714  
plan, the health care practitioner may resubmit the claim 715  
pursuant to division (C) of this section with the information 716  
that matches the information included in the approved prior 717  
authorization. 718

(D) Any provision of a contractual arrangement entered 719  
into between an insurer or plan and a health care practitioner 720  
or beneficiary that is contrary to divisions (A) to (C) of this 721  
section is unenforceable. 722

(E) For policies issued on or after January 1, 2017, 723  
committing a series of violations of this section that, taken 724  
together, constitute a practice or pattern shall be considered 725  
an unfair and deceptive practice under sections 3901.19 to 726  
3901.26 of the Revised Code. 727

(F) The superintendent of insurance may adopt rules in 728  
accordance with Chapter 119. of the Revised Code as necessary to 729  
implement the provisions of this section. 730

(G) This section does not apply to any of the following 731  
types of coverage: a policy, contract, certificate, or agreement 732  
that covers only a specified accident, accident only, credit, 733  
dental, disability income, long-term care, hospital indemnity, 734  
supplemental coverage as described in section 3923.37 of the 735  
Revised Code, specified disease, or vision care; coverage issued 736  
as a supplement to liability insurance; insurance arising out of 737  
workers' compensation or similar law; automobile medical payment 738  
insurance; insurance under which benefits are payable with or 739  
without regard to fault and which is statutorily required to be 740  
contained in any liability insurance policy or equivalent self- 741  
insurance; a medicare supplement policy of insurance as defined 742  
by the superintendent of insurance by rule; coverage under a 743  
plan through medicare or the federal employees benefit program; 744  
or any coverage issued under Chapter 55 of Title 10 of the 745  
United States Code and any coverage issued as a supplement to 746  
that coverage. 747

**Sec. 5119.25.** (A) The director of mental health and 748  
addiction services, in whole or in part, may withhold funds 749  
otherwise to be allocated to a board of alcohol, drug addiction, 750  
and mental health services under section 5119.23 of the Revised 751  
Code if the board fails to comply with Chapter 340. or 5119. of 752  
the Revised Code or rules of the department of mental health and 753  
addiction services. However, beginning ~~September 15, 2016~~July 1, 754  
2017, the director shall withhold all such funds from the board 755  
when required to do so under division (A) (4) of section 340.08 756  
of the Revised Code or division (G) (1) of section 5119.22 of the 757  
Revised Code. 758

(B) The director of mental health and addiction services 759  
may withhold funds otherwise to be allocated to a board of 760  
alcohol, drug addiction, and mental health services under 761

section 5119.23 of the Revised Code if the board denies 762  
available service on the basis of race, color, religion, creed, 763  
sex, age, national origin, disability as defined in section 764  
4112.01 of the Revised Code, or developmental disability. 765

(C) The director shall issue a notice identifying the 766  
areas of noncompliance and the action necessary to achieve 767  
compliance. The director may offer technical assistance to the 768  
board to achieve compliance. The board shall have thirty days 769  
from receipt of the notice of noncompliance to present its 770  
position that it is in compliance or to submit to the director 771  
evidence of corrective action the board took to achieve 772  
compliance. Before withholding funds, the director or the 773  
director's designee shall hold a hearing within thirty days of 774  
receipt of the board's position or evidence to determine if 775  
there are continuing violations and that either assistance is 776  
rejected or the board is unable, or has failed, to achieve 777  
compliance. The director may appoint a representative from 778  
another board of alcohol, drug addiction, and mental health 779  
services to serve as a mentor for the board in developing and 780  
executing a plan of corrective action to achieve compliance. Any 781  
such representative shall be from a board that is in compliance 782  
with Chapter 340. of the Revised Code, this chapter, and the 783  
department's rules. Subsequent to the hearing process, if it is 784  
determined that compliance has not been achieved, the director 785  
may allocate all or part of the withheld funds to one or more 786  
community mental health services providers or community 787  
addiction services providers to provide the mental health 788  
service or addiction service for which the board is not in 789  
compliance until the time that there is compliance. The director 790  
shall adopt rules in accordance with Chapter 119. of the Revised 791  
Code to implement this section. 792

<u>Sec. 5160.34. (A) As used in this section:</u>	793
<u>(1) "Chronic condition" means a medical condition that has</u>	794
<u>persisted after reasonable efforts have been made to relieve or</u>	795
<u>cure its cause and has continued, either continuously or</u>	796
<u>episodically, for longer than six continuous months.</u>	797
<u>(2) "Clinical peer" means a medical provider in the same,</u>	798
<u>or in a similar, specialty that typically manages the medical</u>	799
<u>condition, procedure, or treatment under review.</u>	800
<u>(3) "Emergency services" has the same meaning as in</u>	801
<u>section 1753.28 of the Revised Code.</u>	802
<u>(4) "Prior authorization requirement" means any practice</u>	803
<u>implemented by a medical assistance program in which coverage of</u>	804
<u>a health care service, device, or drug is dependent upon a</u>	805
<u>medical assistance recipient or a health care provider,</u>	806
<u>receiving approval from the department of medicaid or its</u>	807
<u>designee, including a medicaid managed care organization, prior</u>	808
<u>to the service, device, or drug being performed, received, or</u>	809
<u>prescribed, as applicable. "Prior authorization" includes</u>	810
<u>prospective or utilization review procedures conducted prior to</u>	811
<u>providing a health care service, device, or drug.</u>	812
<u>(5) "Urgent care services" means a medical care or other</u>	813
<u>service for a condition where application of the timeframe for</u>	814
<u>making routine or non-life threatening care determinations is</u>	815
<u>either of the following:</u>	816
<u>(a) Could seriously jeopardize the life, health, or safety</u>	817
<u>of the recipient or others due to the recipient's psychological</u>	818
<u>state;</u>	819
<u>(b) In the opinion of a practitioner with knowledge of the</u>	820
<u>recipient's medical or behavioral condition, would subject the</u>	821

recipient to adverse health consequences without the care or 822  
treatment that is the subject of the request. 823

(6) "Utilization review" and "utilization review 824  
organization" have the same meanings as in section 1751.77 of 825  
the Revised Code. 826

(B) If a medical assistance program has a prior 827  
authorization requirement, the department of medicaid or its 828  
designee, including a medicaid managed care organization, shall 829  
do all of the following: 830

(1) On or before January 1, 2018, permit a health care 831  
provider to access the prior authorization form through the 832  
applicable electronic software system. 833

(2) (a) On or before January 1, 2018, permit the department 834  
or its designee to accept and respond to prior prescription 835  
benefit authorization requests through a secure electronic 836  
transmission. 837

(b) On or before January 1, 2018, the department or its 838  
designee shall accept and respond to prior prescription benefit 839  
authorization requests through a secure electronic transmission 840  
using NCPDP SCRIPT standard ePA transactions, and for prior 841  
medical benefit authorization requests through a secure 842  
electronic transmission using standards established by the 843  
council for affordable quality health care on operating rules 844  
for information exchange or its successor. 845

(c) For purposes of division (B) (2) of this section, 846  
neither of the following shall be considered a secure electronic 847  
transmission: 848

(i) A facsimile; 849

(ii) A proprietary payer portal for prescription drug requests that does not use NCPDP SCRIPT standard. 850  
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(3) On or before January 1, 2018, a health care provider and the department of medicaid or its designee may enter into a contractual arrangement under which the department or its designee agrees to process prior authorization requests that are not submitted electronically because of the financial hardship that electronic submission of prior authorization requests would create for the provider or if internet connectivity is limited or unavailable where the provider is located. 852  
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(4) (a) On or before January 1, 2018, if the health care provider submits the request for prior authorization electronically as described in divisions (B) (1) and (2) of this section, respond to all prior authorization requests within forty-eight hours for urgent care services, or ten calendar days for any prior approval request that is not for an urgent care service, of the time the request is received by the department or its designee with all information necessary to support the prior authorization request. Division (B) (5) of this section does not apply to emergency services. 860  
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(b) (i) The response required under division (B) (4) (a) of this section shall indicate whether the request is approved, denied, or incomplete. If the prior authorization is denied, the department or its designee shall provide the specific reason for the denial. 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. 870  
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(ii) For a response that is considered incomplete, the health care provider shall provide the additional information requested under division (B) (4) (b) (i) of this section within 877  
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seventy-two hours of the time the request is received by the 880  
provider. 881

(5) (a) On or before January 1, 2018, if a health care 882  
provider submits a prior authorization request as described in 883  
divisions (B) (1) and (2) of this section, the department or its 884  
designee shall provide an electronic receipt to the health care 885  
provider acknowledging that the prior authorization request was 886  
received. 887

(b) On or before January 1, 2018, if the department or its 888  
designee requests additional information that is required to 889  
process a prior authorization request as described in division 890  
(B) (4) (b) (i) of this section, the health care provider shall 891  
provide an electronic receipt to the department or its designee 892  
acknowledging that the request for additional information was 893  
received. 894

(6) (a) On or before January 1, 2017, honor a prior 895  
authorization approval for an approved drug for the lesser of 896  
the following from the date of approval: 897

(i) Twelve months; 898

(ii) The last day of the medical assistance recipient's 899  
eligibility for the medical assistance program. 900

(b) The duration of all other prior authorization 901  
approvals shall be dictated by the medical assistance program. 902

(c) The department or its designee, in relation to prior 903  
approval under division (B) (6) (a) of this section, may require a 904  
health care provider to submit information to the department or 905  
its designee indicating that the patient's chronic condition has 906  
not changed. 907



(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 traditional electronic mail or other electronic communication. 908  
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(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. 912  
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(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. 916  
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(d) A year long 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. 919  
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(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: 925  
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(i) Medications that are prescribed for a non-maintenance condition; 928  
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(ii) Medications that have a typical treatment of less than one year; 930  
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(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; 932  
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(iv) Medications where there is medical or scientific 935

evidence as defined in section 3922.01 of the Revised Code that 936  
do not support a twelve-month prior approval; 937

(v) Medications that are a schedule I or II controlled 938  
substance or any opioid analgesic or benzodiazepine, as defined 939  
in section 3719.01 of the Revised Code; 940

(vi) Medications that are not prescribed by an in-network 941  
provider as part of a care management program. 942

(7) On or before January 1, 2017, the department or its 943  
designee may, but is not required to, provide the twelve-month 944  
approval prescribed in division (B)(6)(a) of this section for a 945  
prescription drug that meets either of the following: 946

(a) The drug is prescribed or administered to treat a rare 947  
medical condition and pursuant to medical or scientific evidence 948  
as defined in section 3922.01 of the Revised Code. 949

(b) Medications that are controlled substances not 950  
included in division (B)(6)(e)(v) of this section. 951

For purposes of division (B)(7) of this section, "rare 952  
medical condition" means any disease or condition that affects 953  
fewer than two-hundred thousand individuals in the United 954  
States. 955

(8) Nothing in division (B)(6) or (7) of this section 956  
prohibits the substitution of any drug that has received a 957  
twelve-month approval under division (B)(6)(a) of this section 958  
when there is a release of a United States food and drug 959  
administration approved comparable brand product or a generic 960  
counterpart of a brand product that is listed as therapeutically 961  
equivalent in the United States food and drug administration's 962  
publication titled approved drug products with therapeutic 963  
equivalence evaluations. 964

(9) (a) On or after January 1, 2017, upon written request, 965  
the department or its designee shall permit a retrospective 966  
review for a claim that is submitted for a service where prior 967  
authorization was required, but not obtained if the service in 968  
question meets all of the following: 969

(i) The service is directly related to another service for 970  
which prior approval has already been obtained and that has 971  
already been performed. 972

(ii) The new service was not known to be needed at the 973  
time the original prior authorized service was performed. 974

(iii) The need for the new service was revealed at the 975  
time the original authorized service was performed. 976

(b) Once the written request and all necessary information 977  
is received, the department or its designee shall review the 978  
claim for coverage and medical necessity. The department or its 979  
designee shall not deny a claim for such a new service based 980  
solely on the fact that a prior authorization approval was not 981  
received for the new service in question. 982

(10) (a) On or before January 1, 2017, disclose to all 983  
participating health care providers any new prior authorization 984  
requirement at least thirty days prior to the effective date of 985  
the new requirement. 986

(b) The notice may be sent via electronic mail or standard 987  
mail and shall be conspicuously entitled "Notice of Changes to 988  
Prior Authorization Requirements." The notice is not required to 989  
contain a complete listing of all changes made to the prior 990  
authorization requirements, but shall include specific 991  
information on where the health care practitioner may locate the 992  
information on the department's or its designee's web site or, 993

if applicable, the department's or its designee's portal. 994

(c) All participating health care providers shall promptly 995  
notify the department or its designee of any changes to the 996  
health care provider's electronic mail or standard mail address. 997

(11) (a) On or before January 1, 2017, make available to 998  
all participating health care providers on its web site or 999  
provider portal a listing of its prior authorization 1000  
requirements, including specific information or documentation 1001  
that a provider must submit in order for the prior authorization 1002  
request to be considered complete. 1003

(b) Make available on its web site information about the 1004  
medical assistance programs offered in this state that clearly 1005  
identifies specific services, drugs, or devices to which a prior 1006  
authorization requirement exists. 1007

(12) On or before January 1, 2018, establish a streamlined 1008  
appeal process relating to adverse prior authorization 1009  
determinations that shall include all of the following: 1010

(a) For urgent care services, the appeal shall be 1011  
considered within forty-eight hours after the department or its 1012  
designee receives the appeal. 1013

(b) For all other matters, the appeal shall be considered 1014  
within ten calendar days after the department or its designee 1015  
receives the appeal. 1016

(c) The appeal shall be between the health care provider 1017  
requesting the service in question and a clinical peer appointed 1018  
by or contracted by the department or the department's designee. 1019

(d) If the appeal does not resolve the disagreement, the 1020  
appeal procedures shall permit the recipient to further appeal 1021

in accordance with section 5160.31 of the Revised Code. 1022

(C) Beginning January 1, 2017, except in cases of 1023  
fraudulent or materially incorrect information, the department 1024  
or its designee shall not retroactively deny a prior 1025  
authorization for a health care service, drug, or device when 1026  
all of the following are met: 1027

(1) The health care provider submits a prior authorization 1028  
request to the department or its designee for a health care 1029  
service, drug, or device. 1030

(2) The department or its designee approves the prior 1031  
authorization request after determining that all of the 1032  
following are true: 1033

(a) The recipient is eligible for the health care service, 1034  
drug, or device under the medical assistance program. 1035

(b) The health care service, drug, or device is covered by 1036  
the medical assistance program. 1037

(c) The health care service, drug, or device meets the 1038  
department's standards for medical necessity and prior 1039  
authorization. 1040

(3) The health care provider renders the health care 1041  
service, drug, or device pursuant to the approved prior 1042  
authorization request and all of the terms and conditions of the 1043  
health care provider's contract with the department or the 1044  
department's designee. 1045

(4) On the date the health care provider renders the prior 1046  
approved health care service, drug, or device, all of the 1047  
following are true: 1048

(a) The recipient is eligible for the medical assistance 1049

program. 1050

(b) The recipient's condition or circumstances related to 1051  
the recipient's care has not changed. 1052

(c) The health care provider submits an accurate claim 1053  
that matches the information submitted by the health care 1054  
provider in the approved prior authorization request. 1055

(5) If the health care provider submits a claim that 1056  
includes an unintentional error and the error results in a claim 1057  
that does not match the information originally submitted by the 1058  
health care provider in the approved prior authorization 1059  
request, upon receiving a denial of services from the department 1060  
or its designee, the health care practitioner may resubmit the 1061  
claim pursuant to division (C) of this section with the 1062  
information that matches the information included in the 1063  
approved prior authorization. 1064

(D) Any provision of a contractual arrangement entered 1065  
into between the department or its designee and a health care 1066  
provider or recipient that is contrary to divisions (A) to (C) 1067  
of this section is unenforceable. 1068

(E) The director of medicaid may adopt rules in accordance 1069  
with Chapter 119. of the Revised Code as necessary to implement 1070  
the provisions of this section. 1071

**Section 2.** That existing sections 340.034, 1739.05, and 1072  
5119.25 of the Revised Code are hereby repealed. 1073

**Section 3.** That sections 110.12 and 812.40 of Am. Sub. 1074  
H.B. 64 of the 131st General Assembly be amended to read as 1075  
follows: 1076

**Sec. 110.12.** Sections 110.10 and 110.11 of ~~this act~~ Am. 1077

Sub. H.B. 64 of the 131st General Assembly shall take effect 1078  
~~September 15, 2016~~July 1, 2017. 1079

It is the intent of this amendment to delay the taking 1080  
effect of the amendments to sections 340.01, 340.03, 340.15, and 1081  
5119.21 of the Revised Code, as contemplated by the amendment, 1082  
until July 1, 2017. 1083

**Sec. 812.40.** Section 340.034 of the Revised Code takes 1084  
effect ~~September 15, 2016~~July 1, 2017. 1085

**Section 4.** That existing Sections 110.12 and 812.40 of Am. 1086  
Sub. H.B. 64 of the 131st General Assembly are hereby repealed. 1087

**Section 5.** That Section 812.40 of Am. Sub. H.B. 483 of the 1088  
130th General Assembly be amended to read as follows: 1089

**Sec. 812.40.** (A) The following take effect ~~two years after~~ 1090  
~~the effective date of this act~~July 1, 2017: 1091

(1) The amendments by ~~this act~~Am. Sub. H.B. 483 of the 1092  
130th General Assembly to sections 340.01, 340.03, 340.08, 1093  
340.09, 340.15, 5119.21, and 5119.22 of the Revised Code; 1094

(2) The enactment by ~~this act~~Am. Sub. H.B. 483 of the 1095  
130th General Assembly of sections 340.033, 340.034, 340.20, 1096  
5119.362, 5119.363, and 5119.364 of the Revised Code. 1097

(B) The amendments by ~~this act~~Am. Sub. H.B. 483 of the 1098  
130th General Assembly to division (A) of section 5119.25 of the 1099  
Revised Code take effect ~~two years after the effective date of~~ 1100  
~~this section~~July 1, 2017. The amendments by ~~this act~~Am. Sub. 1101  
H.B. 483 of the 130th General Assembly to division (C) of that 1102  
section take effect at the earliest time permitted by law. 1103

**Section 6.** That existing Section 812.40 of Am. Sub. H.B. 1104  
483 of the 130th General Assembly is hereby repealed. 1105

**Section 7.** Sections 340.034 and 5119.25 of the Revised Code, as amended by this act, take effect on September 15, 2016.

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