



Ohio Revised Code

Section 3923.041 Policies with prior authorization requirement provisions.

Effective: March 21, 2017

Legislation: House Bill 505 - 131st General Assembly

(A) As used in this section:

(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 practitioner in the same or in a similar, specialty that typically manages the medical condition, procedure, or treatment under review.

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

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

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

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

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

(8) "Prior authorization requirement" means any practice implemented by either a sickness and accident insurer or a public employee benefit plan in which coverage of a health care service, device, or drug is dependent upon a covered person or a health care practitioner obtaining approval from the insurer or plan 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, device, or drug.

(9) "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 patient or others due to the patient's psychological state;

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

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

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

(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.

(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.

(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.

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

(4)(a) For policies issued on or after January 1, 2018, if the health care practitioner submits the request for prior authorization electronically as described in divisions (B)(1) and (2) of this section, the insurer or plan 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 insurer or plan. 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 insurer or plan shall provide the specific reason for the denial.

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

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



authorization request was received.

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

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

(i) Twelve months;

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

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

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

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

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

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

(d) A twelve-month approval provided under division (B)(6)(a) of this section is no longer valid and automatically terminates if there are changes to federal or state laws or federal regulatory guidance



or compliance information prescribing that the drug in question is no longer approved or safe for the intended purpose.

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

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

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

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

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

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

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

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

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

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

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



(8) Nothing in division (B)(6) or (7) of this section 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) For policies issued on or after January 1, 2017, upon written request, an insurer or plan 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 insurer or plan shall review the claim for coverage and medical necessity. The insurer or plan 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) For policies issued on or after January 1, 2017, the insurer or plan shall disclose to all participating health care practitioners 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 practitioner may locate the information on the insurer or plan's web site or, if applicable, the insurer's or plan's portal.

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

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

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

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

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

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

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

(d) If the appeal does not resolve the disagreement, either the covered person or an authorized



representative as defined in section 3922.01 of the Revised Code may request an external review under Chapter 3922. of the Revised Code to the extent Chapter 3922. of the Revised Code is applicable.

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

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

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

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

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

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

(3) The health care practitioner 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 practitioner's contract with the insurer or plan;

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

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

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

(c) The health care practitioner submits an accurate claim that matches the information submitted by



the health care practitioner in the approved prior authorization request.

(5) If the health care practitioner 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 practitioner in the approved prior authorization request, upon receiving a denial of services from the insurer or plan, the health care practitioner 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 an insurer or plan and a health care practitioner or beneficiary that is contrary to divisions (A) to (C) of this section is unenforceable.

(E) For policies issued on or after January 1, 2017, committing a series of violations of this section 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.

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

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