

As Introduced

135th General Assembly

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H. B. No. 130

Representative Miller, K.

**Cosponsors: Representatives Rogers, Manning, Johnson, Cutrona, Hillyer, Troy,
Galonski, Somani, Denson, Manchester, Dell'Aquila, Dean, Cross**

A BILL

To amend section 5160.34 and to enact sections 1
1751.721, 1751.722, 1751.723, 3923.042, 2
3923.043, 3923.044, 5160.341, and 5160.342 of 3
the Revised Code to establish an exemption to 4
prior authorization requirements. 5

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

Section 1. That section 5160.34 be amended and sections 6
1751.721, 1751.722, 1751.723, 3923.042, 3923.043, 3923.044, 7
5160.341, and 5160.342 of the Revised Code be enacted to read as 8
follows: 9

Sec. 1751.721. (A) A health insuring corporation that 10
applies a prior authorization requirement shall make prior 11
authorization data available on its public web site in a readily 12
accessible format. 13

(B) The data shall include all of the following 14
information: 15

(1) The specialty of the health care provider requesting 16
the prior authorization; 17

(2) Whether the prior authorization is for a health care service, a medical device, or a drug; 18
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(3) The indication for use of the service, device, or drug under the prior authorization; 20
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(4) If the prior authorization request was denied, the reason for the denial; 22
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(5) If the approval or denial of a prior authorization request was appealed and the result of the appeal; 24
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(6) The amount of time between the submission of a prior authorization request and the response from the corporation. 26
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Sec. 1751.722. (A) (1) If a health insuring corporation has a prior authorization requirement for a health care service, medical device, or drug and, during the previous twelve-month period, the corporation approved at least eighty per cent of the prior authorization requests submitted by a health care provider for that service, device, or drug, the insurer or its designee shall not require the health care provider to comply with the requirement for that service, device, or drug. 28
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(2) Such an exemption shall be provided for not less than twelve months. 36
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(3) Nothing in this section shall be construed as prohibiting a corporation from establishing an exemption period of more than twelve months. 38
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(B) (1) A health care provider that does not receive an exemption under division (A) of this section may request that the corporation provide evidence to the provider supporting its decision to not grant an exemption. 41
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(2) The health care provider may make such a request at 45

any time, but it may make not more than one such request for the 46
same service, device, or drug in a calendar year. 47

(3) A health insuring corporation shall comply with such a 48
request. 49

(C) A health care provider may appeal a health insuring 50
corporation's decision to deny an exemption. 51

(D) A health insuring corporation shall not require a 52
health care provider to request an exemption provided under 53
division (A) of this section. 54

(E) When an exemption is granted under division (A) of 55
this section for a health care service, medical device, or drug, 56
the corporation shall notify the health care provider in 57
question. The notice shall be in writing and include all of the 58
following information: 59

(1) A statement that the health care provider qualifies 60
for an exemption to a prior authorization requirement; 61

(2) The health care service, medical device, or drug to 62
which the exemption applies; 63

(3) The dates the exemption will begin and end. 64

(F) (1) At the end of the twelve-month exemption period, a 65
health insuring corporation may evaluate an exemption it has 66
granted under division (A) of this section. 67

(2) (a) A corporation conducting such an evaluation shall 68
review ten claims submitted to the corporation, selected at 69
random, for the health care service, medical device, or drug in 70
question. 71

(b) The reviewed claims shall be from the immediately 72

preceding three months. If there are not ten relevant claims in 73
the preceding three months, the corporation may review earlier 74
claims. 75

(3)(a) If less than eighty per cent of the claims reviewed 76
would have been approved based on medical necessity, then the 77
corporation may revoke the exemption provided under division (A) 78
of this section. 79

(b) A corporation that is revoking an exemption shall 80
provide the health care provider with both of the following: 81

(i) The information it relied upon in making its 82
determination; 83

(ii) A plain language explanation of how to appeal the 84
decision. 85

(4) A corporation shall not evaluate a health care 86
provider's exemption relating to a particular service, device, 87
or drug more than once every twelve months. 88

(5) Nothing in this section shall be construed as 89
requiring a corporation to evaluate an existing exemption. 90

(G) If an exemption is revoked and not appealed, the 91
exemption shall remain in effect until thirty days after the 92
date the corporation notifies the health care provider of the 93
corporation's decision to revoke the exemption. 94

(H) A health care provider may appeal the revocation of an 95
exemption within thirty days of receiving notice of the 96
revocation. If the health care provider appeals the revocation 97
and the revocation is upheld, the exemption remains in effect 98
until five days after the date the revocation is upheld. 99

(I) A decision to revoke or deny an exemption shall only 100

be made by a health care provider licensed in this state who 101
practices the same or a similar specialty as the health care 102
provider being considered for an exemption and who has 103
experience in providing the service, device, or drug to which 104
the exemption or potential exemption applies. 105

(J) Nothing in this section shall be construed as 106
prohibiting a health insuring corporation from making an 107
administrative denial of a claim. 108

Sec. 1751.723. (A) A series of violations of section 109
1751.721 or 1751.722 of the Revised Code that, taken together, 110
constitute a practice or pattern shall be considered an unfair 111
and deceptive practice under sections 3901.19 to 3901.26 of the 112
Revised Code. 113

(B) Notwithstanding division (F) of section 121.95 of the 114
Revised Code, the superintendent of insurance may adopt rules as 115
necessary to carry out the requirements of sections 1751.721 to 116
1751.723 of the Revised Code. 117

Sec. 3923.042. (A) A sickness and accident insurer that 118
applies a prior authorization requirement shall make prior 119
authorization data available on its public web site in a readily 120
accessible format. 121

(B) The data shall include all of the following 122
information: 123

(1) The specialty of the health care provider requesting 124
the prior authorization; 125

(2) Whether the prior authorization is for a medical 126
service, a medical device, or a drug; 127

(3) The indication for use of the service, device, or drug 128

<u>under the prior authorization;</u>	129
<u>(4) If the prior authorization request was denied, the</u>	130
<u>reason for the denial;</u>	131
<u>(5) If the approval or denial of a prior authorization</u>	132
<u>request was appealed and the result of the appeal;</u>	133
<u>(6) The amount of time between the submission of a prior</u>	134
<u>authorization request and the response from the insurer.</u>	135
<u>Sec. 3923.043. (A) (1) If a sickness and accident insurer</u>	136
<u>has a prior authorization requirement for a health care service,</u>	137
<u>medical device, or drug and, during the previous twelve-month</u>	138
<u>period, the insurer approved at least eighty per cent of the</u>	139
<u>prior authorization requests submitted by a health care provider</u>	140
<u>for that service, device, or drug, the insurer or its designee</u>	141
<u>shall not require the health care provider to comply with the</u>	142
<u>requirement for that service, device, or drug.</u>	143
<u>(2) Such an exemption shall be provided for not less than</u>	144
<u>twelve months.</u>	145
<u>(3) Nothing in this section shall be construed as</u>	146
<u>prohibiting an insurer from establishing an exemption period of</u>	147
<u>more than twelve months.</u>	148
<u>(B) (1) A health care provider that does not receive an</u>	149
<u>exemption under division (A) of this section may request that</u>	150
<u>the sickness and accident insurer provide evidence to the</u>	151
<u>provider supporting its decision to not grant an exemption.</u>	152
<u>(2) The insurer may make the request at any time, but it</u>	153
<u>may make not more than one such request for the same service,</u>	154
<u>device, or drug in a calendar year.</u>	155
<u>(3) A sickness and accident insurer shall comply with such</u>	156

<u>a request.</u>	157
<u>(C) A health care provider may appeal a sickness and accident insurer's decision to deny an exemption.</u>	158 159
<u>(D) A sickness and accident insurer shall not require a health care provider to request an exemption provided under division (A) of this section.</u>	160 161 162
<u>(E) When an exemption is granted under division (A) of this section for a health care service, medical device, or drug, the sickness and accident insurer shall notify the health care provider in question. The notice shall be in writing and include all of the following information:</u>	163 164 165 166 167
<u>(1) A statement that the health care provider qualifies for an exemption to a prior authorization requirement;</u>	168 169
<u>(2) The health care service, medical device, or drug to which the exemption applies;</u>	170 171
<u>(3) The dates the exemption will begin and end.</u>	172
<u>(F) (1) At the end of the twelve-month exemption period, a sickness and accident insurer may evaluate an exemption it has granted under division (A) of this section.</u>	173 174 175
<u>(2) (a) An insurer conducting such an evaluation shall review ten claims submitted to the insurer, selected at random, for the health care service, medical device, or drug in question.</u>	176 177 178 179
<u>(b) The reviewed claims shall be from the immediately preceding three months. If there are not ten relevant claims in the preceding three months, the insurer may review earlier claims.</u>	180 181 182 183

(3) (a) If less than eighty per cent of the claims reviewed 184
would have been approved based on medical necessity, then the 185
insurer may revoke the exemption provided under division (A) of 186
this section. 187

(b) An insurer that is revoking an exemption shall provide 188
the health care provider with both of the following: 189

(i) The information it relied upon in making its 190
determination; 191

(ii) A plain language explanation of how to appeal the 192
decision. 193

(4) An insurer shall not evaluate a health care provider's 194
exemption relating to a particular service, device, or drug more 195
than once every twelve months. 196

(5) Nothing in this section shall be construed as 197
requiring an insurer to evaluate an existing exemption. 198

(G) If an exemption is revoked and not appealed, the 199
exemption shall remain in effect until thirty days after the 200
date the sickness and accident insurer notifies the health care 201
provider of the insurer's decision to revoke the exemption. 202

(H) A health care provider may appeal the revocation of an 203
exemption within thirty days after receiving notification of the 204
revocation. If a health care provider appeals a revocation and 205
the revocation is upheld, the exemption remains in effect until 206
five days after the date the revocation is upheld. 207

(I) A decision to revoke or deny an exemption shall only 208
be made by a health care provider licensed in this state who 209
practices the same or a similar specialty as the health care 210
provider being considered for an exemption and who has 211

experience in providing the service, device, or drug to which 212
the exemption or potential exemption applies. 213

(J) Nothing in this section shall be construed as 214
prohibiting a sickness and accident insurer from making an 215
administrative denial of a claim. 216

Sec. 3923.044. (A) A series of violations of section 217
3923.042 or 3923.043 of the Revised Code that, taken together, 218
constitute a practice or pattern shall be considered an unfair 219
and deceptive practice under sections 3901.19 to 3901.26 of the 220
Revised Code. 221

(B) Notwithstanding division (F) of section 121.95 of the 222
Revised Code, the superintendent of insurance may adopt rules as 223
necessary to carry out the requirements of sections 3923.042 to 224
3923.044 of the Revised Code. 225

Sec. 5160.34. (A) As used in ~~this section~~ sections 5160.34 226
to 5160.342 of the Revised Code: 227

(1) "Chronic condition" means a medical condition that has 228
persisted after reasonable efforts have been made to relieve or 229
cure its cause and has continued, either continuously or 230
episodically, for longer than six continuous months. 231

(2) "Clinical peer" means a health care provider in the 232
same, or in a similar, specialty that typically manages the 233
medical condition, procedure, or treatment under review. 234

(3) "Emergency services" has the same meaning as in 235
section 1753.28 of the Revised Code. 236

(4) "Prior authorization requirement" means any practice 237
implemented by a medical assistance program in which coverage of 238
a health care service, device, or drug is dependent upon a 239

medical assistance recipient or a health care provider, 240
receiving approval from the department of medicaid or its 241
designee, including a medicaid managed care organization, prior 242
to the service, device, or drug being performed, received, or 243
prescribed, as applicable. "Prior authorization" includes 244
prospective or utilization review procedures conducted prior to 245
providing a health care service, medical device, or drug. 246

(5) "Urgent care services" means a medical care or other 247
service for a condition where application of the timeframe for 248
making routine or non-life threatening care determinations is 249
either of the following: 250

(a) Could seriously jeopardize the life, health, or safety 251
of the recipient or others due to the recipient's psychological 252
state; 253

(b) In the opinion of a practitioner with knowledge of the 254
recipient's medical or behavioral condition, would subject the 255
recipient to adverse health consequences without the care or 256
treatment that is the subject of the request. 257

(6) "Utilization review" ~~and "utilization review-~~ 258
~~organization" have~~ has the same ~~meanings~~ meaning as in section 259
1751.77 of the Revised Code. 260

(B) If a medical assistance program has a prior 261
authorization requirement, the department of medicaid or its 262
designee, including a medicaid managed care organization, shall 263
do all of the following: 264

(1) On or before January 1, 2018, permit a health care 265
provider to access the prior authorization form through the 266
applicable electronic software system. 267

(2) (a) On or before January 1, 2018, permit the department 268

or its designee to accept and respond to prior prescription 269
benefit authorization requests through a secure electronic 270
transmission. 271

(b) On or before January 1, 2018, the department or its 272
designee shall accept and respond to prior prescription benefit 273
authorization requests through a secure electronic transmission 274
using NCPDP SCRIPT standard ePA transactions, and for prior 275
medical benefit authorization requests through a secure 276
electronic transmission using standards established by the 277
council for affordable quality health care on operating rules 278
for information exchange or its successor. 279

(c) For purposes of division (B) (2) of this section, 280
neither of the following shall be considered a secure electronic 281
transmission: 282

(i) A facsimile; 283

(ii) A proprietary payer portal for prescription drug 284
requests that does not use NCPDP SCRIPT standard. 285

(3) On or before January 1, 2018, a health care provider 286
and the department of medicaid or its designee may enter into a 287
contractual arrangement under which the department or its 288
designee agrees to process prior authorization requests that are 289
not submitted electronically because of the financial hardship 290
that electronic submission of prior authorization requests would 291
create for the provider or if internet connectivity is limited 292
or unavailable where the provider is located. 293

(4) (a) On or before January 1, 2018, if the health care 294
provider submits the request for prior authorization 295
electronically as described in divisions (B) (1) and (2) of this 296
section, the department or its designee shall respond to all 297

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 327
eligibility for the medical assistance program. 328

(b) The duration of all other prior authorization 329
approvals shall be dictated by the medical assistance program. 330

(c) The department or its designee, in relation to prior 331
approval under division (B) (6) (a) of this section, may require a 332
health care provider to submit information to the department or 333
its designee indicating that the patient's chronic condition has 334
not changed. 335

(i) The request for information by the department or its 336
designee and the response by the health care provider shall be 337
in an electronic format, which may be by electronic mail or 338
other electronic communication. 339

(ii) The frequency of the submission of requested 340
information shall be consistent with medical or scientific 341
evidence as defined in section 3922.01 of the Revised Code, but 342
shall not be required more frequently than quarterly. 343

(iii) If the health care provider does not respond within 344
five calendar days from the date the request was received, the 345
insurer or plan may terminate the twelve-month approval. 346

(d) A twelve-month approval provided under division (B) (6) 347
(a) of this section is no longer valid and automatically 348
terminates if there are changes to federal or state laws or 349
federal regulatory guidance or compliance information 350
prescribing that the drug in question is no longer approved or 351
safe for the intended purpose. 352

(e) A twelve-month approval provided under division (B) (6) 353
(a) of this section does not apply to and is not required for 354
any of the following: 355

(i) Medications that are prescribed for a non-maintenance condition;	356 357
(ii) Medications that have a typical treatment of less than one year;	358 359
(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;	360 361 362
(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;	363 364 365
(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;	366 367 368
(vi) Medications that are not prescribed by an in-network provider as part of a care management program.	369 370
(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:	371 372 373 374
(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.	375 376 377
(b) Medications that are controlled substances not included in division (B)(6)(e)(v) of this section.	378 379
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.	380 381 382 383

(8) Nothing in division (B) (6) or (7) of this section 384
prohibits the substitution, in accordance with section 4729.38 385
of the Revised Code, of any drug that has received a twelve- 386
month approval under division (B) (6) (a) of this section when 387
there is a release of either of the following: 388

(a) A United States food and drug administration approved 389
comparable brand product or a generic counterpart of a brand 390
product that is listed as therapeutically equivalent in the 391
United States food and drug administration's publication titled 392
approved drug products with therapeutic equivalence evaluations; 393

(b) An interchangeable biological product, as defined in 394
section 3715.01 of the Revised Code. 395

(9) (a) On or after January 1, 2017, upon written request, 396
the department or its designee shall permit a retrospective 397
review for a claim that is submitted for a service where prior 398
authorization was required, but not obtained if the service in 399
question meets all of the following: 400

(i) The service is directly related to another service for 401
which prior approval has already been obtained and that has 402
already been performed. 403

(ii) The new service was not known to be needed at the 404
time the original prior authorized service was performed. 405

(iii) The need for the new service was revealed at the 406
time the original authorized service was performed. 407

(b) Once the written request and all necessary information 408
is received, the department or its designee shall review the 409
claim for coverage and medical necessity. The department or its 410
designee shall not deny a claim for such a new service based 411
solely on the fact that a prior authorization approval was not 412

received for the new service in question. 413

(10) (a) On or before January 1, 2017, disclose to all 414
participating health care providers any new prior authorization 415
requirement at least thirty days prior to the effective date of 416
the new requirement. 417

(b) The notice may be sent via electronic mail or standard 418
mail and shall be conspicuously entitled "Notice of Changes to 419
Prior Authorization Requirements." The notice is not required to 420
contain a complete listing of all changes made to the prior 421
authorization requirements, but shall include specific 422
information on where the health care provider may locate the 423
information on the department's or its designee's web site or, 424
if applicable, the department's or its designee's portal. 425

(c) All participating health care providers shall promptly 426
notify the department or its designee of any changes to the 427
health care provider's electronic mail or standard mail address. 428

(11) (a) On or before January 1, 2017, make available to 429
all participating health care providers on its web site or 430
provider portal a listing of its prior authorization 431
requirements, including specific information or documentation 432
that a provider must submit in order for the prior authorization 433
request to be considered complete. 434

(b) Make available on its web site information about the 435
medical assistance programs offered in this state that clearly 436
identifies specific services, drugs, or devices to which a prior 437
authorization requirement exists. 438

(12) On or before January 1, 2018, establish a streamlined 439
appeal process relating to adverse prior authorization 440
determinations that shall include all of the following: 441

(a) For urgent care services, the appeal shall be 442
considered within forty-eight hours after the department or its 443
designee receives the appeal. 444

(b) For all other matters, the appeal shall be considered 445
within ten calendar days after the department or its designee 446
receives the appeal. 447

(c) The appeal shall be between the health care provider 448
requesting the service in question and a clinical peer appointed 449
by or contracted by the department or the department's designee. 450

(d) If the appeal does not resolve the disagreement, the 451
appeal procedures shall permit the recipient to further appeal 452
in accordance with section 5160.31 of the Revised Code. 453

(C) Beginning January 1, 2017, except in cases of 454
fraudulent or materially incorrect information, the department 455
or its designee shall not retroactively deny a prior 456
authorization for a health care service, drug, or device when 457
all of the following are met: 458

(1) The health care provider submits a prior authorization 459
request to the department or its designee for a health care 460
service, drug, or device. 461

(2) The department or its designee approves the prior 462
authorization request after determining that all of the 463
following are true: 464

(a) The recipient is eligible for the health care service, 465
drug, or device under the medical assistance program. 466

(b) The health care service, drug, or device is covered by 467
the medical assistance program. 468

(c) The health care service, drug, or device meets the 469

department's standards for medical necessity and prior 470
authorization. 471

(3) The health care provider renders the health care 472
service, drug, or device pursuant to the approved prior 473
authorization request and all of the terms and conditions of the 474
health care provider's contract with the department or the 475
department's designee. 476

(4) On the date the health care provider renders the prior 477
approved health care service, drug, or device, all of the 478
following are true: 479

(a) The recipient is eligible for the medical assistance 480
program. 481

(b) The recipient's condition or circumstances related to 482
the recipient's care has not changed. 483

(c) The health care provider submits an accurate claim 484
that matches the information submitted by the health care 485
provider in the approved prior authorization request. 486

(5) If the health care provider submits a claim that 487
includes an unintentional error and the error results in a claim 488
that does not match the information originally submitted by the 489
health care provider in the approved prior authorization 490
request, upon receiving a denial of services from the department 491
or its designee, the health care provider may resubmit the claim 492
pursuant to division (C) of this section with the information 493
that matches the information included in the approved prior 494
authorization. 495

(D) Any provision of a contractual arrangement entered 496
into between the department or its designee and a health care 497
provider or recipient that is contrary to divisions (A) to (C) 498

of this section is unenforceable. 499

(E) The director of medicaid may adopt rules in accordance 500
with Chapter 119. of the Revised Code as necessary to implement 501
the provisions of this section and section 5160.342 of the 502
Revised Code. 503

Sec. 5160.341. (A) If the department or its designee 504
applies a prior authorization requirement, it shall make prior 505
authorization data available on its public web site in a readily 506
accessible format. 507

(B) The data shall include all of the following 508
information: 509

(1) The specialty of the health care provider requesting 510
the prior authorization; 511

(2) Whether the prior authorization is for a health care 512
service, a medical device, or a drug; 513

(3) The indication for use of the service, device, or drug 514
under the prior authorization; 515

(4) If the prior authorization request was denied, the 516
reason for the denial; 517

(5) If the approval or denial of a prior authorization 518
request was appealed and the result of the appeal; 519

(6) The amount of time between the submission of a prior 520
authorization request and the response from the department or 521
its designee. 522

Sec. 5160.342. (A) (1) If a medical assistance program has 523
a prior authorization requirement for a health care service, 524
medical device, or drug and, during the previous twelve-month 525

period, the department of medicaid or its designee approved at 526
least eighty per cent of the prior authorization requests 527
submitted by a health care provider for that service, device, or 528
drug, the department or its designee shall not require the 529
health care provider to comply with the requirement for that 530
service, device, or drug. 531

(2) Such an exemption shall be provided for not less than 532
twelve months. 533

(3) Nothing in this section shall be construed as 534
prohibiting the department or its designee from establishing an 535
exemption period of more than twelve months. 536

(B) (1) A health care provider that does not receive an 537
exemption under division (A) of this section may request that 538
the department or the department's designee provide evidence to 539
the provider supporting its decision to not grant an exemption. 540

(2) The health care provider may make such a request at 541
any time, but it may make not more than one such request for the 542
same service, device, or drug in a calendar year. 543

(3) The department or its designee shall comply with such 544
a request. 545

(C) A health care provider may appeal the department or 546
its designee's decision to deny an exemption. 547

(D) The department or its designee shall not require a 548
health care provider to request an exemption provided under 549
division (A) of this section. 550

(E) When an exemption is granted under division (A) of 551
this section for a health care service, medical device, or drug, 552
the department or its designee shall notify the health care 553

provider in question. The notice shall include all of the 554
following information: 555

(1) A statement that the health care provider qualifies 556
for an exemption to a prior authorization requirement; 557

(2) The health care service, medical device, or drug to 558
which the exemption applies; 559

(3) The dates the exemption will begin and end. 560

(F) (1) At the end of the twelve-month exemption period, 561
the department or its designee may evaluate an exemption it has 562
granted under division (A) of this section. 563

(2) (a) When conducting such an evaluation, the department 564
or its designee shall review ten claims submitted to the 565
department or its designee, selected at random, for the health 566
care service, medical device, or drug in question. 567

(b) The reviewed claims shall be from the immediately 568
preceding three months. If there are not ten relevant claims in 569
the preceding three months, the department or its designee may 570
review earlier claims. 571

(3) (a) If less than eighty per cent of the claims reviewed 572
would have been approved based on medical necessity, then the 573
department or its designee may revoke the exemption provided 574
under division (A) of this section. 575

(b) If the department or its designee revokes an 576
exemption, it shall provide the health care provider with both 577
of the following: 578

(i) The information it relied upon in making its 579
determination; 580

(ii) A plain language explanation of how to appeal the 581
decision. 582

(4) The department or its designee shall not evaluate a 583
health care provider's exemption relating to a particular 584
service, device, or drug more than once every twelve months. 585

(5) Nothing in this section shall be construed as 586
requiring the department or its designee to evaluate an existing 587
exemption. 588

(G) If an exemption is revoked and not appealed, the 589
exemption shall remain in effect until thirty days after the 590
date the department or its designee notifies the health care 591
provider of the department or its designee's decision to revoke 592
the exemption. 593

(H) A health care provider may appeal the revocation of an 594
exemption within thirty days of receiving notice of the 595
revocation. If the health care provider appeals the revocation 596
and the revocation is upheld, the exemption remains in effect 597
until five days after the date the revocation is upheld. 598

(I) A decision to revoke or deny an exemption shall only 599
be made by a health care provider licensed in this state who 600
practices the same or a similar specialty as the health care 601
provider being considered for an exemption and who has 602
experience in providing the service, device, or drug to which 603
the exemption or potential exemption applies. 604

(J) Nothing in this section shall be construed as 605
prohibiting the department or its designee from making an 606
administrative denial of a claim. 607

Section 2. That existing section 5160.34 of the Revised 608
Code is hereby repealed. 609