Ohio | Department of Medicaid

Mike DeWine, Governor
Jon Husted, Lt. Governor

Maureen M. Corcoran, Director

Medicaid Clearance Letter

TO: **Eligible Providers of Medicaid Services**

FROM: **Maureen Corcoran**
Director, Ohio Department of Medicaid (ODM)

SUBJECT: **Ohio Administrative Code 5160-1-31 Prior Authorization**

Summary

Current Ohio Administrative Code Rule 5160-1-31, entitled "Prior authorization [except for services provided through medicaid contracting managed care plans (MCPs)]," has been reviewed as part of the five-year rule review process and will be proposed for rescission. It will be replaced with a new rule with the same number as greater than fifty per cent of the rule is being amended to update policy and outdated information, and to remove unnecessary language. This rule describes how Medicaid reimbursement for some items and services requires prior authorization through the Ohio Department of Job and Family Services (ODJFS). The rule outlines the process for submitting a prior authorization along with an exception to this requirement when the delay to obtain said authorization would prove to be detrimental to the health of the Medicaid covered individual. The rule explains that providers are entitled to hearing rights when a prior authorization request is denied as well as explaining proper notice requirements associated with these rights.

New Ohio Administrative Code Rule 5160-1-31, entitled "Prior authorization," will be proposed for adoption to update policy and outdated information regarding prior authorization (PA), and to remove unnecessary language. The new rule will replace the existing rule which will be proposed for rescission. This rule will govern managed care entity (MCE) PA requirements, and corresponding language was added throughout. This rule will update references to the Ohio Administrative Code and changes references from Ohio Department of Job and Family Services (ODJFS) to Ohio Department of Medicaid (ODM), reflecting the change in oversight of the Medicaid program. The rule will clarify that PA request submission and the exceptions to PA requirements are governed for pharmacy services by Ohio Administrative Code rule 5160-9-03. The rule will also incorporate the provisions from Ohio Revised Code 5160.34. Sections of the rule concerning PA procedures such as the use of the assigned PA number for submitting claims and language to provide a written denial and hearing rights will be removed. This rule will include language directing providers to the ODM main website to locate PA submission guidance. The rule will also include a new ODM process by which providers who have received a denied prior authorization request may have that denial reviewed by ODM or its designee. Information that must be submitted in the reconsideration will be stated as well as relevant time frames. For

denials made by a MCE or transplant consortium, the rule will explain the organization's process for reconsideration must be followed by the provider. The rule will also exclude certain inpatient and outpatient hospital services and instead refer to a separate OAC rule to govern the specific PA requirements for these services.

Access to Rules and Related Material

The main Ohio Department of Medicaid (ODM) web page includes links to valuable information about its services, programs, and rules; the address is http://www.medicaid.ohio.gov

Additional Information

Questions pertaining to this letter should be addressed to:

Ohio Department of Medicaid
Bureau of Provider Services
P.O. Box 1461
Columbus, OH 43216-1461
Telephone (800) 686-1516

5160-1-31 **Prior authorization.**

(A) Reimbursement for certain items or services covered under the medicaid program is dependent on obtaining prior authorization from the Ohio department of medicaid (ODM), its designee, or a medicaid managed care entity (MCE). Prior authorization requests have to be approved by ODM, its designee, or MCE before the services are rendered or the items are delivered unless the services or items meet the provisions stated in section 5160.34 of the Revised Code or paragraph (D) of this rule.

(B) Except as authorized under section 5160.34 of the Revised Code, prior authorization requests submitted via paper cannot be processed. All other prior authorization requests should be submitted pursuant to the instructions located at www.medicaid.ohio.gov.

(C) For services or items requiring prior authorization, only those approved in the prior authorization determination will be eligible for reimbursement.

(D) In situations where the provider considers a delay in providing services or an item requiring prior authorization to be detrimental to the health of the medicaid recipient, the services or item may be rendered or delivered and approval for reimbursement sought after the fact. In cases of emergency situations for prescribed drugs requiring prior authorization, the prescribed drug may be rendered without prior authorization in accordance with rule 5160-9-03 of the Administrative Code.

(E) A medicaid provider may request a reconsideration of an adverse prior authorization determination in accordance with section 5160.34 of the Revised Code. A reconsideration of an adverse prior authorization determination rendered by an MCE or transplant consortium should be submitted and addressed in accordance with their respective processes for reconsideration. A reconsideration of an adverse prior authorization determination rendered by ODM or its designee should be submitted and addressed in the following manner:

(1) The request for reconsideration has to be received by ODM or its designee within sixty calendar days of the notification to the provider of an adverse determination. A valid request for reconsideration should be submitted pursuant to the instructions located at www.medicaid.ohio.gov and include the following:

(a) Medicaid recipient's name and medicaid number;

(b) Name of requested service or item and billing code;

(c) Date of service or item request;

(d) Clinical documentation supporting medical necessity for the service or item;

(e) A reference to any relevant federal or state law or regulation, if applicable;

(f) An explanation outlining the reason for reconsideration, including supportive information not previously submitted as necessary; and

(g) If applicable, an indication of whether the service or item qualifies as "urgent care services" as defined in section 5160.34 of the Revised Code.

(2) ODM or its designee will make a standard reconsideration determination within ten calendar days of receipt. If an expedited review is requested because the service or item qualifies as urgent care services, the reconsideration determination will be made no later than forty-eight hours after receipt.

(3) The review of the reconsideration will be conducted by a clinical peer appointed or contracted by ODM or its designee.

(4) The provider reconsideration process afforded under this rule does not interfere with the medicaid recipient's right to appeal in accordance with division 5101:6 of the Administrative Code.

(F) The provisions stated in this rule do not apply to prior authorization requests for inpatient or outpatient hospital services, which are subject to the prior authorization provisions in rule 5160-2-40 of the Administrative Code.