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) The following exceptions to prior authorization apply:

(1) 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.

(2) In cases of emergency, 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.

(3) In the discretion of and as instructed by ODM, a retroactive prior authorization may be sought.

(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.

Replaces: 5160-1-31

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

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