Attention: Third-Party Administrators

Re: Prior Authorization – Requests Protected under Ohio State Law

<u>According to Ohio Revised Code, Prior Authorization requests made by Providers on behalf of Patients should be adhered to in the following manner:</u>

Title [39] INSURANCE, Chapter 3923: SICKNESS AND ACCIDENT INSURANCE
3923.041 Policies with prior authorization requirement provisions

(B)(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 <u>all prior authorization requests within forty-eight hours for urgent care services</u>, or <u>ten calendar days</u> 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.