Ohio Revised Code

Section 5164.13

Effective: October 06, 2026
Legislation: Senate Bill 315 - 136th General Assembly

(A) As used in this section:

(1) "Independent provider" has the same meaning as in section 5164.341 of the Revised Code.

(2) "Personal care services" means any service reimbursed under the medicaid program that assists a recipient who is not an inpatient in a hospital or a resident of a nursing facility or ICF/IID with activities of daily living, instrumental activities of daily living, supervision, homemaker tasks, attendant care, personal support services, or substantially similar in-home support services that are not medical services.

(3) "Prior authorization" means advance written approval issued by the department of medicaid, a medicaid managed care organization, or other entity contracted to perform utilization review functions before medicaid payment may be made.

(4) "Waiver agency" has the same meaning as in section 5164.342 of the Revised Code.

(B) Subject to division (I) of this section, the department of medicaid shall require prior authorization for personal care services provided under the medicaid program when the personal care services that are requested exceed the amount or scope of services described in a written plan of care or individual service plan for an individual.

(C)(1) To initiate a request for prior authorization under this section, an independent provider shall submit a signed and dated request to the department. An employee of a waiver agency shall submit a signed and dated request to the waiver agency, and the waiver agency shall submit the request to the department.

(2) Included in a request, the independent provider or waiver agency employee shall submit supporting documentation that provides evidence that the requested services are medically necessary in accordance with the standards established under division (E) of this section.

(3) An independent provider or waiver agency employee shall include in a request submitted under division (C)(1) of this section if the services for which prior authorization is requested are urgent care services for which a forty-eight hour determination is necessary under division (D)(3) of this section.

(D)(1) Within ten business days of receiving a request under division (C) of this section, the department shall notify the independent provider or waiver agency if additional information is needed to make a determination. The independent provider or waiver agency shall submit the additional information to the department within five business days of receiving notification from the department.

(2) The department shall review the request and make a determination within ten business days of receiving all necessary information.

(3) If an independent provider or waiver agency employee submits a request for urgent care services under division (C)(3) of this section, the department shall review the request and make a determination within forty-eight hours of receiving all necessary information.

(E) When reviewing a request submitted under division (C) of this section, the department shall determine whether the services for which prior authorization is requested are medically necessary. The department shall determine services to be medically necessary if the services satisfy the following:

(1) The services are appropriate for the individual's health and welfare needs, living arrangement, circumstances, and expected outcomes.

(2) The services are of an appropriate type, amount, duration, scope, and intensity.

(3) The services are the most efficient, effective, and lowest cost alternative that, when combined with other services, ensure the health and welfare of the individual receiving the services.

(4) The services protect the individual from substantial harm expected to occur if the requested services are not authorized.

(F) After conducting a review of a request received under this section, the department shall do one of the following:

(1) Approve the request if the department finds that the services for which prior authorization is requested meet the criteria established under division (E) of this section;

(2) Deny the request;

(3) Approve the request in part if some of the criteria set forth in division (E) of this section are satisfied.

(G) When the department makes a determination regarding a request for prior authorization, the department shall provide written notification to the independent provider or waiver agency either setting forth the reason for denial or indicating that prior authorization has been

approved. The department shall update the prior authorization status to reflect its determination.

(H) If a request for prior authorization is denied, an individual, independent provider, or waiver agency may appeal the denial in accordance with procedures established by the medicaid director under rules adopted under division (J) of this section.

(I) This section does not apply to personal care services provided under a medicaid waiver component administered by the department of developmental disabilities.

(J) The medicaid director shall adopt rules in accordance with Chapter 119. of the Revised Code as necessary to implement this section.