Memorandum

To: Coordinated Care Organizations (CCOs)

From: Veronica Guerra, CCO Operations Deputy Director, Leslie Ayhens, CCO Quality of Care & Compliance Manager

Date: April 1, 2025

Subject: Handling of requests for prior authorization (PA), including during appeals and hearings

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In preparation for the 2025 Compliance Monitoring Review (CMR) process as well as the move towards a seven (7) day prior authorization processing timeframe, as defined in 42 CFR 438.210(d), effective January 1, 2026, Oregon Health Authority (OHA) would like to clarify requirements related to the handling of requests for prior authorization.

If a CCO needs additional information to process a request for prior authorization, CCOs must make at least three outreach attempts to the requesting provider to gather that information. Those attempts must be made using at least two different methods (e.g. phone or fax) and at three different times. CCOs should spread the outreach attempts out over the available processing timeframe rather than make all outreach attempts on the same day. OHA expects CCOs to make use of the available fourteen (14) day extension prior to issuing a denial based on lack of information. This extension will still be available to CCOs after the prior authorization processing timeframe is reduced to seven (7) days beginning January 1, 2026. OHA anticipates that appropriate handling of initial requests for prior authorization will result in a reduction of duplicate requests for prior authorization submitted after an adverse benefit determination has been made.

CCOs may not restrict or decline provider requests for prior authorization. CCOs must accept and process requests for prior authorization regardless of the timing of

submission in relation to other similar and/or duplicative requests for prior authorization that may be subject to active appeals or hearings processes. However, any provider-initiated requests for reconsideration of a denial, which could include submission of a new PA request, should be handled in a manner consistent with the appeal process requirements described in OARs 410-141-3875, 410-141-3885, 410-141-3890 and 410-141-3895 and 42 CFR 438.400 – 438.424. It is not OHA's expectation that CCOs evaluate each PA request received to determine whether it was submitted in response to a denial and within 60 days of the date of the NOABD. However, when CCOs are aware that this is the case, they should take the following steps concurrent with the PA processing timeframes:

1. Outreach to the provider to determine whether the provider has written permission from the member to request an appeal on the member's behalf. If not, inform the provider of the requirement to have written consent from the member to request an appeal.
2. Outreach to the member/authorized representative to see if the member would like to orally request an appeal of the adverse benefit determination. If so, proceed with the appeal process.
3. If the member declined filing an appeal during the CCO's outreach, contact the provider to make them aware of the declination. Encourage the provider to discuss the declination with the member and remind the provider of their ability to request the appeal on the member's behalf with written consent from the member to do so.
4. Clearly document each step and contact made with the member and the provider to demonstrate that the CCO is taking the necessary steps to protect the member's right to appeal.

CCOs must never encourage providers to submit duplicate requests for prior authorization after an adverse benefit determination has been made as a means of circumventing the appeals process. CCOs may not make use of a "reconsideration" process after an adverse benefit determination has been made in lieu of an appeals process that meets the criteria defined in the OARs and CFRs listed above.

CCOs must inform providers of the requirements described above related to the submission and handling of requests for prior authorization, including that providers

should make use of the appeal process instead of submitting duplicate PA requests in response to a denial.

This guidance will also be posted to the CCO Contracts Forms webpage in the form of a guidance document that OHA will maintain over time.

Questions?

If you have any questions about this announcement, please email the CCO Quality Assurance Team at HSD.QualityAssurance@odhsoha.oregon.gov.

Thank you for your continued support of the Oregon Health Plan and the services you provide to our members.