836-053-1200
Prior Authorization Requirements for Health Benefit Plans

(1) The provisions of this rule implement the requirements of ORS 743B.420 ~~and the amendments to~~ ORS 743B.422 and ORS 743B.423, as well amendments to ORS 743B.420 and ORS 743B.423 by Oregon Laws 2021~~1921~~, chapter 154 ~~284 154~~ relating to prior authorization determinations. "Prior authorization" means a form of utilization review that requires a provider or an enrollee to request a determination by an insurer**,** prior to provision of health care that is subject to utilization review, that the insurer will provide reimbursement for the health care requested. "Prior authorization" does not include referral approval for evaluation and management services between providers. For the purposes of this rule, "health care" includes all items and services covered by a health benefit plan, including but not limited to medical, behavioral health, dental and vision care items and services.

(2) This rule applies to prior authorization determinations that:

(a) Are issued orally or in writing by an insurer to a provider or enrollee regarding the benefit coverage or medical necessity of a health care item or service to be provided to an enrollee; and

(b) Are required under and obtained in accordance with the terms of a health benefit plan.

(3) A prior authorization may be limited to the services of a specific provider or to services of a designated group of providers who contract with or are employed by the insurer.

(4) Nothing in this rule shall require a health benefit plan to contain a prior authorization requirement.

(5) Except in the case of misrepresentation relevant to a request for prior authorization, a prior authorization determination shall be binding on the insurer for the period of time specified in section (6) of this rule.

(6) A prior authorization determination shall be binding on the insurer for:

(a) The lesser of the following periods:

(A) Five business days following the date of issuance of the authorization; or

(B) The period during which the enrollee's coverage remains in effect, provided that when the insurer issues the prior authorization, the insurer has specific knowledge that the enrollee's coverage will terminate sooner than five business days following the day the authorization is issued and the insurer specifies the termination date in the authorization; and

(b) ~~T~~For an item or service other than a prescription drug, the period during which the enrollee's coverage remains in effect beyond the time period established pursuant to subsection (a) of this section, up to a maximum of ~~3~~60 calendar days or the reasonable duration of the treatment based on clinical standards, whichever is longer.

(c) For a prescription drug, the period during which the enrollee's coverage remains in effect beyond the time period established pursuant to subsection (a) of this section, up to a maximum of one calendar year from the date that the treatment begins following approval of the request if the drug:

(i) Is prescribed as a maintenance therapy that is expected to last at least 12 months based on medical or scientific evidence;

(ii) Continues to be prescribed throughout the 12-month period; and

(iii) Is prescribed for a condition that is within the scope of use for the drug as approved by the United States Food and Drug Administration; or has been proven to be a safe and effective form of treatment for the enrollee's medical condition based on clinical practice guidelines developed from peer-reviewed medical literature.

(d) Paragraph (c) of this subsection does not apply if:

(i) A therapeutic equivalent of the prescription drug or a generic alternative to the prescription drug is or becomes available as a substitute for the drug for which prior authorization is requested or was approved; or

(ii) A biologic product is or becomes available that is determined by the United States Food and Drug Administration to be interchangeable with the drug for which prior authorization is requested or approved.

(7) For purposes of counting days under section (6) of this rule, day one is the first business or calendar day, as applicable, following the day on which the insurer issues a prior authorization determination.

(8) An insurer may not impose a restriction or condition on its prior authorization determinations that limits, restricts or effectively eliminates the binding force established for such determinations in ORS 743B.420 and this rule.

(9) A prior authorization determination is issued when an insurer communicates orally, or in writing, a notice that meets the requirements of section (11) of this rule to the provider or enrollee who submitted the prior authorization request.

(10) Except as provided in section (13), a determination by an insurer on a provider's or an enrollee's request for prior authorization must be issued within a reasonable period of time appropriate to the medical circumstances but no later than two business days after receipt of the request. If the determination is issued orally, the insurer must mail, or send electronically, a written notice of the determination to the provider or enrollee who submitted the prior authorization request no later than two business days after the determination is issued. For the purposes of counting days under this subsection, day one is the first business day following the day on which the insurer receives the request for prior authorization or issues the determination, as applicable.

(11) When an insurer issues a determination in response to a request from a provider or an enrollee for prior authorization of nonemergency health care items or services, the determination must be one of the following:

(a) The requested item or service is authorized;

(b) The requested item or service is not authorized; or

(c) The entire requested item or service is not authorized, but a specified portion of the requested item or service or a specified alternative item or service is authorized.

(12) If an insurer makes a determination meeting the conditions specified in subsections (b) or (c) of section (11), the notice of that determination must be mailed, or sent electronically, to the enrollee who is the subject of the prior authorization request, regardless of whether the enrollee submitted the prior authorization request to the insurer. The notice must specify that the determination constitutes an adverse benefit determination, and that the enrollee has the right to appeal the determination, and to external review of the determination if applicable.

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(13) If additional information from an enrollee or a provider requesting prior authorization is necessary to make a determination on a request for prior authorization, no later than two business days after receipt of the request, the enrollee and the requesting provider, if any, shall be notified in writing of the specific additional information needed to make the determination. The required notice is provided when it is mailed, or delivered electronically, by the insurer. For the purposes of counting days under this subsection, day one is the first business day following the day on which the insurer receives the request for prior authorization. Nothing in this subsection shall be construed to prohibit an insurer from seeking additional information related to a prior authorization request orally or by other means, provided that a written notice is supplied in the event that a determination cannot be made within two business days due to the need for additional information.

(14) Following a request for additional information submitted in compliance with section (13), the insurer must issue a determination by the later of:

(a) Two business days after receipt of a response to the request for additional information. For the purposes of counting days under this subsection, day one is the first business day following the day on which the insurer receives a response; or,

(b) Fifteen days after the date of the request for additional information, unless otherwise provided in federal law. For the purposes of counting days under this subsection, day one is the first calendar day following the day on which the insurer mails, or sends electronically, the request for additional information.

(15) When an insurer requests additional information that is necessary to make a determination on a request for prior authorization, the insurer must specify all of the information reasonably necessary to make a determination. The insurer may not request information that is substantially identical to information previously supplied by the enrollee or provider.

(16) Compliance with this rule by an insurer offering a health benefit plan will be sufficient to demonstrate compliance with the requirement for insurers to act promptly in making determinations in response to requests for prior authorization established by ~~Oregon Laws 201921, chapter 284154, section 2~~ ORS 746.233 (2)(e). Nothing in this rule shall be construed to limit the department's authority under this section to require a health insurer to act equitably and in good faith with respect to approving requests for prior authorization.

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836-053-1203

Prior Authorization Trade Practices for Health Insurance other than Health Benefit plans

(1) The purpose of this rule is to establish standards for determining whether an insurer offering a policy or certificate of health insurance, other than a health benefit plan, acts promptly in response to a request for prior authorization within the meaning of ORS 746.233 (2)(e)~~Oregon Laws 201921, chapter 284154, section 2(2)(e)~~. Nothing in this rule shall be construed to limit the department's authority under this section to require a health insurer to act equitably and in good faith with respect to approving requests for prior authorization.

(2) "Prior authorization" means a form of utilization review that requires a provider or an enrollee to request a determination by an insurer, prior to provision of health care that is subject to utilization review, that the insurer will provide reimbursement for the health care requested.

"Prior authorization" does not include referral approval for evaluation and management services between providers. For the purposes of this rule, “health care” includes all items and services covered by a policy or certificate of health insurance, including but not limited to medical, behavioral health, dental and vision care items and services.

(3) This rule applies to prior authorization determinations that:

(a) Are issued orally or in writing to a provider or enrollee by an insurer offering a policy or certificate of health insurance, other than a health benefit plan, regarding the benefit coverage or medical necessity of a health care item or service to be provided to an enrollee; and

(b) Are required under and obtained in accordance with the terms of a health insurance plan.

(4) A prior authorization may be limited to the services of a specific provider or to services of a designated group of providers who contract with or are employed by the insurer.

(5) Nothing in this rule shall require a policy of health insurance to contain a prior authorization requirement.

(6) Except in the case of misrepresentation relevant to a request for prior authorization, a prior authorization determination shall be binding on the insurer for the period of time specified in section (7) of this rule.

(7) A prior authorization determination shall be binding on the insurer for:

(a) The lesser of the following periods:

(A) Five-business days following the date of issuance of the authorization; or

(B) The period during which the enrollee's coverage remains in effect, provided that when the insurer issues the prior authorization, the insurer has specific knowledge that the enrollee's coverage will terminate sooner than five-business days following the day the authorization is issued and the insurer specifies the termination date in the authorization; and

(b) For an item or service other than a prescription drug, t~~T~~he period during which the enrollee's coverage remains in effect beyond the time period established pursuant to subsection (a) of this section, up to a maximum of 60 ~~30~~ calendar days or the reasonable duration of the treatment based on clinical standards, whichever is longer.

(c) For a prescription drug, the period during which the enrollee's coverage remains in effect beyond the time period established pursuant to subsection (a) of this section, up to a maximum of one calendar year from the date that the treatment begins following approval of the request if the drug:

(i) Is prescribed as a maintenance therapy that is expected to last at least 12 months based on medical or scientific evidence;

(ii) Continues to be prescribed throughout the 12-month period; and

(iii) Is prescribed for a condition that is within the scope of use for the drug as approved by the United States Food and Drug Administration; or has been proven to be a safe and effective form of treatment for the enrollee’s medical condition based on clinical practice guidelines developed from peer-reviewed medical literature.

(d) Paragraph (c) of this subsection does not apply if:

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(i) A therapeutic equivalent of the prescription drug or a generic alternative to the prescription drug is or becomes available as a substitute for the drug for which prior authorization is requested or was approved; or

(ii) A biologic product is or becomes available that is determined by the United States Food and Drug Administration to be interchangeable with the drug for which prior authorization is requested or approved.

(8) For purposes of counting days under section (7) of this rule, day one is the first business or calendar day, as applicable, following the day on which the insurer issues a prior authorization determination.

(9) An insurer may not impose a restriction or condition on its prior authorization determinations that limits, restricts or effectively eliminates the binding force established for such determinations in ORS 743B.420 and this rule.

(10) A prior authorization determination is issued when an insurer communicates orally, or in writing, a notice that meets the requirements of subsection (12) of this rule to the provider or enrollee who submitted the prior authorization request.

(11) Except as provided in section (13), a determination by an insurer on a provider's or an enrollee's request for prior authorization must be issued within a reasonable period of time appropriate to the medical circumstances but no later than two business days after receipt of the request. If the determination is issued orally, the insurer must mail, or send electronically, a written notice of the determination to the provider or enrollee who submitted the prior authorization request no later than two business days after the determination is issued. For the purposes of counting days under this subsection, day one is the first business day following the day on which the insurer receives the request for prior authorization or issues the determination, as applicable.

(12) When an insurer issues a determination in response to a request from a provider or an enrollee for prior authorization of nonemergency health care items or services, the determination must be one of the following:

(a) The requested item or service is authorized;

(b) The requested item or service is not authorized; or

(c) The entire requested item or service is not authorized, but a specified portion of the requested item or service or a specified alternative item or service is authorized.

(13) If additional information from an enrollee or a provider requesting prior authorization is necessary to make a determination on a request for prior authorization, no later than two business days after receipt of the request, the enrollee and the requesting provider, if any, shall be notified in writing of the specific additional information needed to make the determination. The required notice is provided when it is mailed, or delivered electronically, by the insurer. For the purposes of counting days under this subsection, day one is the first business day following the day on which the insurer receives the request for prior authorization. Nothing in this subsection shall be construed to prohibit an insurer from seeking additional information related to a prior authorization request orally or by other means, provided that a written notice is supplied in the event that a determination cannot be issued within two business days due to the need for additional information.

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(14) Following a request for additional information submitted in compliance with section (13), the insurer must issue a determination by the later of:

(a) Two business days after receipt of a response to the request for additional information. For the purposes of counting days under this subsection, day one is the first business day following the day on which the insurer receives a response; or,

(b) Fifteen days after the date of the request for additional information, unless otherwise provided in federal law. For the purposes of counting days under this subsection, day one is the first calendar day following the day on which the insurer mails, or delivers electronically, the request for additional information.

(15) When an insurer requests additional information that is necessary to make a determination on a request for prior authorization, the insurer must specify all of the information reasonably necessary to make a determination. The insurer may not request information that is substantially identical to information previously supplied by the enrollee or provider.

836-053-1070

Reporting of Grievances and Prior Authorization; Format and Contents

(1) To comply with the requirements in ORS 743B.250~~804~~, on or before June 30 of each calendar year, an insurer must submit information pertaining to grievances and prior authorizations ~~closed~~ in the previous calendar year ending December 31. The data must be reported in the format prescribed by the Director of the Department of Consumer and Business Services as set forth on the website of the ~~Insurance~~ Division of Financial Regulation of the Department of Consumer and Business Services at http://www.~~insurance~~dfr.oregon.gov. Filing and reporting requirements in this rule apply to:

(a) A domestic insurer; and

(b) A foreign insurer transacting $2 million or more in health benefit plan premium in Oregon during the calendar year immediately preceding the due date of a required report.

(2) For purposes of this rule, a grievance is “closed” if:

(a) The grievance has been appealed through all available grievance appeal levels; or

(b) The insurer determines that the complainant is no longer pursuing the grievance.

(3) The grievance data to be included in the annual summary required by section (1) of this rule are as follows:

(a) The total number of grievances closed in the reporting year;

(b) The number of grievances closed in each of the categories listed in section (4) of this rule;

(c) The number and percentage of grievances in each of the categories listed in section (4) of this rule in which the insurer’s initial decision is upheld and the number and percentage in which the initial decision is reversed at closure of the grievance;

(d) The number and percentage of all grievances that are closed at the conclusion of the first level of appeal;

(e) The number and percentage of all grievances that are closed at the conclusion of the second level of appeal;

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(f) The number and percentage of all grievances that result in applications for external review; and

(g) For each level of appeal listed in subsections (d) and (e) of this section, the average length of time between the date an enrollee files the appeal and the date an insurer sends written notice of the insurer's determination for that appeal to the enrollee, or person filing the appeal on behalf of the enrollee.

(4) An insurer must report each grievance according to the nature of the grievance. The nature of the grievance shall be determined according to the categories listed in this section. The insurer must report each grievance in one category only and must have a system that allows the insurer to report accurately in the specified categories. If a grievance could fit in more than one category, an insurer shall report the grievance in the category established in this section that the insurer determines to be most appropriate for the grievance. The categories of grievances are as follows:

(a) Adverse benefit determinations based on medical necessity under ORS 743.857;

(b) Adverse benefit determinations based on an insurer's determination that a plan or course of treatment is experimental or investigational under ORS 743.857;

(c) Continuity of care as defined in ORS 743.854;

(d) Access and referral problems including timelines and availability of a provider and quality of clinical care;

(e) Whether a course or plan of treatment is delivered in an appropriate health care setting and with the appropriate level of care;

(f) Adverse benefit determinations of otherwise covered benefits due to imposition of a source-of-injury exclusion, out-of-network or out-of-plan exclusion, annual benefit limits or other limitations of otherwise covered benefits, or imposition of a preexisting condition exclusion in a grandfathered health plan;

(g) Adverse benefit determinations based on general exclusions, not a covered benefit or other coverage issues not listed in this section;

(h) Eligibility for, or termination of enrollment, rescission or cancelation of a policy or certificate;

(i) Quality of plan services, not including the quality of clinical care as provided in subsection (d) of this section;

(j) Emergency services; and

(k) Administrative issues and issues other than those otherwise listed in this section.

(5) Nothing in this rule prohibits an insurer from creating or using its own system to categorize the nature of grievances in order to collect data if the system allows the insurer to report grievances accurately according to the categories in section (4) of this rule and if the system enables the director to track the grievances accurately.

(6) The prior authorization data to be included in the annual summary required by section (1) of this rule are as follows:

(A) The number of prior authorization requests received;

(B) The number of requests that were initially denied and the reasons for the denials, including, but not limited to, lack of medical necessity or failure to provide additional clinical information requested by the insurer;

(C) The number of requests that were initially approved; and

(D) The number of denials that were reversed by internal appeals or external reviews.

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Tracking Grievances and Prior Authorization Requests

An insurer must record data relating to all grievances, significant actions taken from each initial grievance filing through the appeals process, ~~and~~ applications for external review as required by ORS 743B.250,~~804~~ and prior authorization requests in a manner sufficient for the insurer to report specified data on grievances and prior authorization accurately as required by ORS 743B.250~~804~~ and OAR 836-053-1070, and for the insurer to track individual files in response to a market conduct examination or other inquiry by the Director of the Department of Consumer and Business Services under ORS 731.296~~733.170~~ or OAR 836-080-0215.

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