Ohio Administrative Code

Rule 4123-6-03.2 MCO participation in the HPP -- MCO application for certification or recertification.

Effective: November 13, 2015

(A) Upon request by a managed care organization, the bureau shall send the managed care organization an MCO application for certification for the managed care organization to complete and submit to the bureau.

(B) The MCO application submitted to the bureau by the managed care organization shall include a list of bureau certified providers in its provider panel and/or bureau certified providers with which the managed care organization has arrangements.

(C) The MCO application submitted to the bureau by the managed care organization shall include the following, whether the managed care organization elects to retain a provider panel or enters into provider arrangements:

(1) A description of the managed care organization's health care provider panel or provider arrangements, which shall include a substantial number of the medical, health care professional and pharmacy providers currently being utilized by injured workers. The provider panel or provider arrangements shall cover the geographic area in which the managed care organization determines it shall compete, and may include out-of-state providers.

(2) A description of how the managed care organization's provider panel or provider arrangements shall provide timely, geographically convenient access to a full range of medical services and supplies for injured workers, including access to specialized services.

(3) A description of the managed care organization's process and methodology for credentialing providers in the managed care organization's provider panel, if applicable, and the managed care organization's process and methodology for assisting non-bureau certified providers in the managed care organization's provider panel or with which the managed care organization has provider arrangements in applying for bureau provider credentialing and certification.

(4) A description of the managed care organization's process and methodology for payment of providers in the managed care organization's provider panel or under a provider arrangement.

(5) A description of the managed care organization's policies and procedures for sanctioning and terminating providers in the managed care organization's panel, if applicable, and a description of the managed care organization's methodology to notify the bureau, employers and employees of any changes in the managed care organization's provider panel or provider arrangements.

(6) A description of the managed care organization's methodology for distributing provider panel and provider arrangement directories and directory updates to employers and employees.

(D) The MCO application for certification submitted to the bureau by the managed care organization shall include, at a minimum, the following information and provisions, as more fully detailed within the MCO application for certification itself:

(1) A statement that the application is without misrepresentation, misstatement, or omission of a relevant fact or other representations involving dishonesty, fraud, or deceit.

(2) A description of the geographic area of the state of Ohio for which the managed care organization wishes to be certified by the bureau. The minimum geographic area shall be a county. The bureau shall certify MCO participation on a county basis. The managed care organization may apply for coverage in more than one county or statewide.

(3) A description of the managed care organization that includes, but is not limited to, a profile that includes a disclosure statement regarding the managed care organization's organizational structure, including subsidiary, parent and affiliate relationships, together with historical and current data. The managed care organization must identify its principals; provide the managed care organization's date of incorporation or formation of partnership, or limited liability company, or business trust; provide any trade names or fictitious names the managed care organization is, or has been, doing business under; provide the number of years the managed care organization has operated in Ohio; identify other states in which the managed care organization is doing business or has done business; provide a table of organization with the number of employees; and identify any banking relationships, including all account information with any financial institutions.

(4) A description of the managed care organization's business continuation plan.

(5) A description of the bureau approved treatment guidelines used by the managed care organization, including a description of how the managed care organization shall implement the treatment guidelines.

(6) A description of the managed care organization's utilization review process.

(7) A description of the managed care organization's quality assurance/improvement standards program and process, including the use of satisfaction surveys.

(8) A description of the managed care organization's medical dispute resolution process that meets the requirements of rule 4123-6-16 of the Administrative Code.

(9) A description of the managed care organization's administrative and bill payment grievance processes.

(10) A description of the managed care organization's information system platforms, capabilities and capacities; a description of the managed care organization's system for reporting necessary data elements, including but not limited to those required for performance measurements; and the managed care organization's measures in place to ensure data security, including back-up systems.

(11) A description of the managed care organization's medical case management policies and procedures.

(12) A description of the managed care organization's policies and procedures regarding the protection of confidential and sensitive records.

(13) A description of the managed care organization's policies and procedures regarding retention of information.

(14) A description of the managed care organization's provider relations and education program.

(15) A description of the managed care organization's employer and employee relations and education program, including but not limited to a description of methodologies to be used to explain options available to injured workers, including treatment by non-network providers and the dispute resolution process.

(16) A description of the managed care organization's provider bill payment processes including, but not limited to, clinical editing software (including review criteria, process and methodology).

(17) Attestation of intent to obtain and maintain insurance coverage as required by the MCO contract, with proof of such coverage to be submitted to the bureau prior to execution of the contract, and current workers' compensation coverage.

(18) Attestation of intent to obtain and maintain professional accreditations as required by the MCO contract, with proof of such accreditations to be submitted to the bureau prior to execution of the contract.

(19) A description of any and all individuals and entities the managed care organization is affiliated with (including, but not limited to, a subcontractor or subcontractee, vendor or vendee, joint venture or other arrangement), and a copy of the MCO's contract or agreement with each individual or entity. For purposes of this rule, "affiliated with the MCO" shall have the same meaning as defined in paragraph (B) of rule 4123-6-03.9 of the Administrative Code.

(20) Other descriptions and requirements as contained in divisions (F)(1) to (F)(10) of section 4121.44 of the Revised Code.

(E) For MCO recertification, prior to the expiration of an MCO's certification, the bureau shall send the certified MCO an application for recertification, which must be completed and returned to the bureau. The MCO must be able to provide proof of delivery of the completed application to the bureau upon request. The MCO application for recertification may be amended from time to time at the bureaus discretion.

(F) The bureau shall review the application for certification or recertification submitted by the

managed care organization. The bureau reserves the right to cross-check data with other governmental agencies or licensing or accrediting bodies.

(G) During the bureau's review of the application for certification or recertification, the managed care organization shall provide to the bureau any additional documentation requested and shall permit the bureau, upon request and with reasonable notice given, to conduct an onsite review of the managed care organization.

(H) A managed care organization may cure any defects in its application for certification or recertification within thirty days of notice by the bureau of such defect in its application.

(I) The bureau may require that the application be accompanied by an application fee, which shall not exceed the amount sufficient to cover the cost of processing the application.

(J) The bureau shall hold as confidential and proprietary information contained in a managed care organization's application for certification or recertification, and other information furnished to the bureau by a managed care organization for purposes of obtaining certification or to comply with performance and auditing requirements established by the administrator, in accordance with divisions (H)(1) and (H)(2) of section 4121.44 of the Revised Code.

(K) The bureau shall not accept or approve any MCO application for certification or recertification in which the managed care organization proposes to subcontract or outsource medical case management services. However, an MCO may subcontract onsite or out-of-state medical case management services with the prior approval of the bureau, provided such services are conducted under the supervision of the MCO.