Ohio Administrative Code

Rule 5160-21-02 Reproductive health services: pregnancy prevention/contraceptive management services.

Effective: July 1, 2016

(A) Principles.

(1) A medicaid recipient must have access to pregnancy prevention services without regard to religion, race, color, national origin, disability, age, sex, military status, health status, number of pregnancies, or marital status.

(2) A medicaid recipient must be able to obtain pregnancy prevention services voluntarily, free from coercion or pressure and free to choose the type or method of service to be used.

(3) A medicaid provider must not make the receipt of pregnancy prevention services a prerequisite to eligibility for, receipt of, or participation in any other services offered by the provider.

(4) A medicaid recipient must not be denied other medicaid-covered medically necessary services on the basis of fertility or infertility.

(B) Coverage. Payment may be made for the following pregnancy prevention services:

(1) Temporary pregnancy prevention, including the following services:

(a) Evaluation and management (office) visits and consultations for either or both of two purposes:

(i) Contraceptive management; or

(ii) Pregnancy examination and testing, with either a negative or an inconclusive result, that includes provision of information about pregnancy prevention; and

(b) Individual preventive medicine counseling and health education on topics including but not limited to fertility awareness, natural family planning (the use of fertility awareness to track

ovulation), and risk factor reduction.

(2) Permanent pregnancy prevention, including the following services:

(a) Sterilization performed in accordance with rule 5160-21-02.2 of the Administrative Code; and

(b) Hysterectomy performed in accordance with rule 5160-21-02.2 of the Administrative Code;

(3) Associated medical or surgical services;

(4) Associated laboratory tests or procedures performed in accordance with Chapter 5160-11 of the Administrative Code, including but not limited to the following services:

(a) Screening, diagnostic, and counseling services for the detection of genetic anomalies or hereditary metabolic disorders including but not limited to the following conditions:

(i) Chromosomal anomalies (in non-pregnant patients) that have neonatal implications;

(ii) Sickle cell and other abnormal hemoglobin syndromes;

(iii) Metabolic disorders such as phenylketonuria (PKU), galactosemia, or homocystinuria; and

(iv) Cystic fibrosis (carrier status); and

(b) Screening, diagnosis, and treatment services for sexually transmitted diseases and infections;

(5) Associated drugs prescribed in accordance with Chapter 5160-9 of the Administrative Code or administered in accordance with Chapter 5160-4 of the Administrative Code; and

(6) Associated medical supplies provided in accordance with Chapter 5160-10 of the Administrative Code.

(C) Non-coverage. No payment is made for the following services:

(1) Infertility treatment, including but not limited to the following modalities:

(a) Assisted reproductive technologies (ART);

(b) In vitro fertilization;

(c) Intrauterine insemination (artificial insemination);

(d) Surgery to promote or restore fertility, including procedures for the reversal of voluntary sterilization; and

(e) Drugs for the treatment of infertility, even if they are prescribed in accordance with Chapter 5160-9 of the Administrative Code or administered in accordance with Chapter 5160-4 of the Administrative Code; or

(2) Hysterectomy that would not have been performed except for the purpose of rendering the individual permanently incapable of reproduction.