Ohio Administrative Code

Rule 5160-26-01 Managed health care programs: definitions.

Effective: July 19, 2020

As used in Chapter 5160-26 of the AdministrativeCode:

(A) "Abuse" means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the medicaid program.

(B) "Advance directive" means written instructions such as a living will or durable power of attorney for health care relating to the provision of health care when an adult is incapacitated.

(C) "Authorized representative" has the same meaning as in rule 5160:1-1-01 of the Administrative Code.

(D) "Consumer contact record (CCR)" means the record containing demographic health-related information provided by an eligible individual, managed care member, or the Ohio department of medicaid (ODM) that is used by the Ohio medicaid consumer hotline to process membership transactions.

(E) "Coordination of benefits (COB)" means a procedure establishing the order in which health care entities pay their claims as described in rule 5160-26-09.1 of the Administrative Code.

(F) "Covered services" means those medical services set forth in rule 5160-26-03 of the Administrative Code or a subset of those medical services.

(G) "Eligible individual" means any medicaid recipient who is a legal resident of the managed care service area and is in one of the categories specified in the MCO's provider agreement with ODM.

(H) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

(I) "Emergency services" means covered inpatient services, outpatient services, or medical transportation services that are provided by a qualified provider and are needed to evaluate, treat, or stabilize an emergency medical condition. As used in this chapter, providers of emergency services also include physicians or other health care professionals or health care facilities not under employment or under contractual arrangement with an MCO.

(J) "Explanation of benefits (EOB)," otherwise known as "explanation of payment (EOP)," or "remittance advice (RA)," means the information sent to providers and/or members by any other third party payer, or MCO, to explain the adjudication of a claim.

(K) "Federally qualified health center (FQHC)" has the same meaning as in rule 5160-28-01 of the Administrative Code.

(L) "Fraud" means any intentional deception or misrepresentation made by an individual or entity with the knowledge that the deception could result in some unauthorized benefit to the individual, the entity, or some other person. This includes any act that constitutes fraud under applicable federal or state law. Member fraud means the altering of information or documents in order to fraudulently receive unauthorized benefits or to knowingly permit others to use the member's identification card to obtain services or supplies.

(M) "Healthchek" services, otherwise known as early and periodic screening, diagnostic, and treatment (EPSDT) services, are comprehensive preventive health services available to individuals under twenty-one years of age who are enrolled in medicaid as those services are described in rule 5160-1-14 of the Administrative Code.

(N) "Hospital" means an institution located at a single site that is engaged primarily in providing to inpatients, by or under the supervision of an organized medical staff of physicians licensed under Chapter 4731. of the Revised Code, diagnostic services and therapeutic services for medical diagnosis and treatment or rehabilitation of injured, disabled, or sick persons. "Hospital" does not mean an institution that is operated by the United States government.

(O) "Hospital services" means those inpatient and outpatient services that are generally and customarily provided by hospitals.

(P) "Inpatient facility" means an acute or general hospital.

(Q) "Intermediate care facility for individuals with intellectual disabilities (ICF/IID)" has the same meaning as in section 5124.01 of the Revised Code.

(R) "Managed care" means a health care delivery system operated by the state in accordance with 42 C.F.R. part 438 (October 1, 2019).

(S) "Managed care organization (MCO)" or "managed care plan (MCP)" means a health insuring corporation (HIC) licensed in the state of Ohio that enters into a managed care provider agreement with ODM.

(T) "Medicaid" means medical assistance as defined in section 5162.01 of the Revised Code.

(U) "Medicaid fraud control unit (MCFU)" means an identifiable entity of state or federal government charged with the investigation and prosecution of fraud and related offenses within medicaid.

(V) "Medically necessary," or "medical necessity," has the same meaning as in rule 5160-1-01 of the Administrative Code.

(W) "Medicare" means the federally financed medical assistance program defined in 42 U.S.C. 1395 (as in effect July 1, 2020).

(X) "Member" or "enrollee" means a medicaid recipient who has selected MCO membership or has been assigned to an MCO for the purpose of receiving health care services.

(Y) "Nursing facility" has the same meaning as in section 5165.01 of the Revised Code.

(Z) "Ohio medicaid consumer hotline" means the managed care enrollment broker and customer service agent for individuals receiving Ohio medicaid services.

(AA) "Oral interpretation services" means services provided to a limited-reading proficient eligible individual or member to ensure that he or she receives MCO information in a format and manner that is easily understood by the eligible individual or member.

(BB) "Oral translation services" means services provided to a limited-English proficient eligible individual or member to ensure that he or she receives MCO information translated into the primary language of the eligible individual or member.

(CC) "Pending member," or "pending enrollee," means an eligible individual who has selected or been assigned to an MCO but whose MCO membership is not yet effective.

(DD) "Post-stabilization care services" means covered services related to an emergency medical condition that a treating provider views as medically necessary after an emergency medical condition has been stabilized in order to maintain the stabilized condition, or under the circumstances described in 42 C.F.R. 422.113 (October 1, 2019) to improve or resolve the member's condition.

(EE) "Premium" means the monthly payment amount per member to which the MCO is entitled as compensation for performing its obligations in accordance with Chapter 5160-26 of the Administrative Code and/or the provider agreement with ODM.

(FF) "Primary care provider (PCP)" means an individual physician (M.D. or D.O.), a physician group practice, an advanced practice registered nurse as defined in section 4723.01 of the Revised Code, an advanced practice nurse group practice within an acceptable specialty, or a physician assistant who meets the requirements of rule 5160-4-03 of the Administrative Code contracting with

an MCO to provide services as specified in rule 5160-26-03.1 of the Administrative Code. Acceptable PCP specialty types include family/general practice, internal medicine, pediatrics, and obstetrics/gynecology (OB/GYNs).

(GG) "Protected health information (PHI)" means information received from or on behalf of ODM that meets the definition of PHI as defined by 45 C.F.R. 160.103 (October 1, 2019).

(HH) "Provider" means a hospital, health care facility, physician, dentist, pharmacy, or otherwise licensed or certified appropriate individual or entity that is authorized to or may be entitled to reimbursement for health care-related services rendered to an MCO's member.

(II) "Provider agreement" means a formal agreement between ODM and an MCO for the provision of medically necessary services to medicaid recipients who are enrolled in the MCO.

(JJ) "Provider panel," otherwise known as "panel" or "network," means the MCO's contracted providers available to the MCO's general membership.

(KK) "Qualified family planning provider (QFPP)" means any public or nonprofit health care provider that complies with guidelines/standards set forth in 42 U.S.C. 300 (as in effect July 1, 2020), and receives either Title X funding or family planning funding from the Ohio department of health.

(LL) "Risk" or "underwriting risk" means the possibility that an MCO may incur a loss because the cost of providing services may exceed the payments made by ODM to the contractor for services covered under the provider agreement.

(MM) "Rural health clinic (RHC)" has the same meaning as in rule 5160-28-01 of the Administrative Code.

(NN) "Self-referral" means the process by which an MCO member may access certain services without prior approval from the PCP or the MCO.

(OO) "Service area" means the geographic area specified in the MCO's provider agreement where

the MCO agrees to provide Medicaid services to members residing in those areas.

(PP) "State cut-off" means the eighth state working day prior to the end of a calendar month.

(QQ) "Subcontract" means a written contract between an MCO and a third party, including the MCO's parent company or any subsidiary corporation owned by the MCO's parent company, or between the third party and a fourth party, or between any subsequent parties, to perform a specific part of the obligations specified under the MCO's provider agreement with ODM.

(RR) "Subcontractor" means any party that has entered into a subcontract to perform a specific part of the obligations specified under the MCO's provider agreement with ODM.

(SS) "Third party" means the same as in section 5160.35 of the Revised Code.

(TT) "Third party administrator" means any entity used in accordance with the provisions of this chapter to manage or administer a portion of services in fulfillment of the provider agreement with ODM.

(UU) "Third party benefit" means any health care service(s) available to members through any medical insurance policy or through some other resource that covers medical benefits and the payment for those services is either completely the obligation of the third party payer (TPP) or in part the obligation of the member, the TPP, and/or the MCO.

(VV) "Third party claim" or "COB claim" means any claim submitted to the MCO for reimbursement after all TPPs have met their payment obligations. In addition, the following will be considered third party claims by the MCO:

(1) Any claim received by the MCO that shows no prior payment by a TPP, but the MCO's records indicate that the member has third party benefits.

(2) Any claim received by the MCO that shows no prior payment by a TPP, but the provider's records indicate that the member has third party benefits.

(WW) "Third party liability (TPL)" means the payment obligations of the TPP for health care services rendered to a member when the member also has third party benefits as described in paragraph (UU) of this rule.

(XX) "Third party payer (TPP)" means an individual, an entity, or a program responsible for adjudicating and paying claims for third party benefits rendered to an eligible member.

(YY) "Title X services" means services and supplies allowed under 42 U.S.C. 300 (as in effect July 1, 2020), and provided by a qualified family planning provider.

(ZZ) "Tort action," or "subrogation," means the right of ODM to recover payment received from a third party payer who may be liable for the cost of medical services and care arising out of an injury, disease, or disability to the member.

(AAA) "Waste" means payment for or the attempt to obtain payment for items or services when there may be no intent to deceive or misrepresent, but poor or inefficient billing or treatment methods result in unnecessary costs.