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OHIO LEGISLATIVE SERVICE
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Ohio Administrative Code

Rule 5160-58-03 MyCare Ohio plans: covered services.

Effective: January 1, 2018

(A) A MyCare Ohio plan (MCOP) must ensure members have access to all medically-necessary medical, drug, behavioral health, nursing facility and home and community-based services (HCBS) covered by Ohio medicaid. After consideration of verified third party liability including medicare coverage pursuant to rule 5160-26-09.1 of the Administrative Code, the MCOP must ensure:

(1) Services are sufficient in amount, duration or scope to reasonably be expected to achieve the purpose for which the services are furnished;

(2) The amount, duration, or scope of a required service is not arbitrarily denied or reduced solely because of the diagnosis, type of illness, or condition;

(3) Prior authorization is available for services on which an MCOP has placed a pre-identified limitation to ensure the limitation may be exceeded when medically necessary, unless the MCOP's limitation is also a limitation for fee-for-service medicaid coverage;

(4) Medicaid coverage decisions are based on the coverage and medical necessity criteria published in agency 5160 of the Administrative Code; and practice guidelines specified in rule 5160-26-05.1 of the Administrative Code; and

(5)) If a member is unable to obtain medically-necessary medicaid services from an MCOP panel provider, the plan must adequately and timely cover the services out of panel until the plan is able to provide the services from a panel provider.

(B) The MCOP may place appropriate limits on a service;

(1) On the basis of medical necessity for the member's condition or diagnosis; or;

(2) Except as otherwise specified in this rule, to available panel providers; or

(3) For the purposes of utilization control, provided the services furnished can be reasonably expected to achieve their purpose as specified in paragraph (A)(1) of this rule.

(C) The MCOP must cover annual physical examinations for adults.

(D) At the request of a member, an MCOP must provide for a second opinion from a qualified health care professional within the panel. If a qualified health care professional is not available within the plan's panel, the plan must arrange for the member to obtain a second opinion outside the panel, at no cost to the member.

(E) The MCOP must ensure emergency services as defined in rule 5160-26-01 of the Administrative Code are provided and covered twenty-four hours a day, seven days a week. At a minimum, such services must be provided and reimbursed in accordance with the following:

(1) The MCOP may not deny payment for treatment obtained when a member had an emergency medical condition as defined in rule 5160-26-01 of the Administrative Code.

(2) The MCOP cannot limit what constitutes an emergency medical condition on the basis of diagnoses or symptoms.

(3) The MCOP must cover all emergency services without requiring prior authorization.

(4) The MCOP must cover medicaid-covered services related to the member's emergency medical condition when the member is instructed to go to an emergency facility by a representative of the plan including but not limited to the member's primary care provider (PCP) or the plan's twenty-four-hour toll-free call-in-system.

(5) The MCOP cannot deny payment of emergency services based on the treating provider, hospital, or fiscal representative not notifying the member's PCP of the visit.

(6) For the purposes of this rule, "non-contracting provider of emergency services" means any person, institution, or entity who does not contract with the MCOP but provides emergency services

to a plan member, regardless of whether that provider has a medicaid provider agreement with ODM. The plan must cover emergency services as defined in rule 5160-26-01 of the Administrative Code when the services are delivered by a non-contracting provider of emergency services. Claims for these services cannot be denied regardless of whether the services meet an emergency medical condition as defined in rule 5160-26-01 of the Administrative Code. Such services must be reimbursed by the plan at the lesser of billed charges or one hundred per cent of the Ohio medicaid program fee-for-service reimbursement rate (less any payments for indirect costs of medical education and direct costs of graduate medical education that is included in the Ohio medicaid program fee-for-service reimbursement rate) in effect for the date of service. If an inpatient admission results, the plan is required to reimburse at this rate only until the member can be transferred to a provider designated by the plan.

(7) The MCOP must cover emergency services until the member is stabilized and can be safely discharged or transferred.

(8) The MCOP must adhere to the judgment of the attending provider when the attending provider requests a member's transfer to another facility or discharge. The plan may establish arrangements with hospitals whereby the plan may designate one of its contracting providers to assume the attending provider's responsibilities to stabilize, treat and transfer the member.

(9) A member who has had an emergency medical condition may not be held liable for payment of any subsequent screening and treatment needed to diagnose the specific condition or stabilize the member.

(F) The MCOP must establish, in writing, the process and procedures for the submission of claims for services delivered by non-contracting providers, including non-contracting providers of emergency services as described in paragraph (E)(6) of this rule. These written policies and procedures must be made available to non-contracting providers, including non-contracting providers of emergency services, on request. The plan may not establish claims filing and processing procedures for non-contracting providers, including non-contracting providers of emergency services, that are more stringent than those established for their contracting providers.

(G) The MCOP must ensure post-stabilization care services as defined in rule 5160-26-01 of the

Administrative Code are provided and covered twenty-four hours a day, seven days a week.

(1) The MCOP must designate a telephone line to receive provider requests for coverage of post-stabilization care services. The line must be available twenty-four hours a day, seven days a week. The plan must document the telephone number and process for obtaining authorization has been provided to each emergency facility in the service area. The plan must maintain a record of any request for coverage of post-stabilization care services that is denied including, at a minimum, the time of the provider's request and the time the plan communicated the decision in writing to the provider.

(2) At a minimum, post-stabilization care services must be provided and reimbursed in accordance with the following:

(a) The MCOP must cover services obtained within or outside the plan's panel that have not been pre-approved in writing by a plan provider or other plan representative.

(b) If the MCOP does not respond within one hour of a provider's request for preapproval of further services administered to maintain the member's stabilized condition, the plan must cover the services, whether or not they were provided within the plan's panel.

(c) The MCOP must cover services obtained within or outside the plan's panel that are not pre-approved by a plan provider or other plan representative but are administered to maintain, improve or resolve the member's stabilized condition if:

(i) The MCOP fails to respond within one hour to a provider request for authorization to provide such services.

(ii) The MCOP cannot be contacted.

(iii) The MCOP's representative and treating provider cannot reach an agreement concerning the member's care and a plan provider is not available for consultation. In this situation, the plan must give the treating provider the opportunity to consult with a plan provider and the treating provider may continue with care until a plan provider is reached or one of the criteria specified in paragraph

(G)(3) of this rule is met.

(3) The MCOP's financial responsibility for post stabilization care services not pre-approved ends when:

(a) A plan provider with privileges at the treating hospital assumes responsibility for the member's care;

(b) A plan provider assumes responsibility for the member's care after the member is transferred to another facility;

(c) A plan representative and the treating provider reach an agreement concerning the member's care; or

(d) The member is discharged.

(H) MCOP responsibilities for payment of other services.

(1) The MCOP must permit members to self-refer to Title X services provided by any qualified family planning provider (QFPP). The plan is responsible for payment of claims for Title X services delivered by QFPPs not contracting with the plan at the lesser of one hundred per cent of the Ohio medicaid program fee-for-service reimbursement rate or billed charges, in effect for the date of service.

(2) The MCOP must permit members to self-refer to any women's health specialist within the plan's panel for covered care necessary to provide women's routine and preventative health care services. This is in addition to the member's designated primary care provider (PCP) if that PCP is not a women's health specialist.

(3) The MCOP must ensure access to covered services provided by all federally qualified health centers (FQHCs) and rural health clinics (RHCs).

(4) Where available, the MCOP must ensure access to covered services provided by a certified nurse

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practitioner.

(5) The MCOP is not responsible for payment of services provided through the medicaid schools program pursuant to Chapter 5160-35 of the Administrative Code.

(6) The MCOP must provide all early and periodic screening, diagnosis and treatment (EPSDT) services, also known as healthchek services, in accordance with rule 5160-1-14 of the Administrative Code, to healthchek eligible members and ensure healthchek exams:

(a) Include the components specified in rule 5160-1-14 of the Administrative Code. All components of exams must be documented and included in the medical record of each healthchek eligible member and made available for the ODM annual external quality review.

(b) Are completed within ninety days of the initial effective date of membership for those children found to have a possible ongoing condition likely to require care management services.

(7) An MCOP is not required to cover services provided to members outside the United States.

(8) When a member is determined to be no longer eligible for enrollment in an MCOP during a stay in an institution for mental disease (IMD), the MCOP is not responsible for payment of that IMD stay after the date of disenrollment from the plan.