Ohio Administrative Code

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

Effective: January 1, 2026

(A) A MyCare Ohio plan (MCOP) ensures members have access to all medically-necessary medical, medicaid-covered over the counter drugs, behavioral health, nursing facility and home and community-based services (HCBS) covered by Ohio medicaid. Prescription drug coverage for members is provided under the medicare part d program. After consideration of verified third party liability including medicare coverage pursuant to rule 5160-26-09.1 of the Administrative Code, the MCOP ensures:

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

(2) The amount, duration, and 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 the MCOP places 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 rules 5160-58-03.1 and 5160-26-05.1 of the Administrative Code; and

(5) If a member is unable to obtain medically-necessary medicaid services from an MCOP network provider, the MCOP adequately and timely covers the services out of network until the MCOP is able to provide the services from a network 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;

(2) Except as otherwise specified in this rule, to available network 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) Services covered by an MCOP.

(1) The MCOP covers annual physical examinations for adults.

(2) At the request of a member, the MCOP provides for a second opinion from a qualified health care professional within the MCOP's network. If a qualified health care professional is not available within the MCOP's network, the MCOP arranges for the member to obtain a second opinion outside the MCOP's network, at no cost to the member.

(3) The MCOP ensures 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 are provided and reimbursed in accordance with the following:

(a) 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.

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

(c) The MCOP covers all emergency services without requiring prior authorization.

(d) The MCOP covers 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 MCOP including but not limited to the member's primary care provider (PCP) or the MCOP's twenty-four-hour toll-free call-in-system.

(e) 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.

(f) The MCOP covers 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 are reimbursed by the MCOP 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 MCOP reimburses at this rate only until the member can be transferred to a provider designated by the MCOP. Pursuant to section 5167.10 of the Revised Code, the MCOP may not compensate a hospital for inpatient capital costs in an amount that exceeds the maximum rate established by the Ohio department of medicaid (ODM).

(g) The MCOP covers emergency services until the member is stabilized and can be safely discharged or transferred.

(h) 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 MCOP may establish arrangements with hospitals whereby the MCOP may designate one of its contracting providers to assume the attending provider's responsibilities to stabilize, treat and transfer the member.

(i) 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.

(4) The MCOP establishes, 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. These written policies and procedures are made available to non-contracting providers, including non-contracting providers of emergency services, on request. The MCOP 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.

(5) The MCOP ensures 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.

(a) The MCOP must designate a telephone line to receive provider requests for coverage of post-stabilization care services. The line is available twenty-four hours a day, seven days a week. The MCOP documents the telephone number and process for obtaining authorization was provided to each emergency facility in the service area. The MCOP maintains 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 MCOP communicated the decision in writing to the provider.

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

(i) The MCOP covers services obtained within or outside the MCOP's network that are not pre-approved in writing by an MCOP provider or other MCOP representative.

(ii) 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 MCOP covers the services, whether or not they were provided within the MCOP's network.

(iii) The MCOP covers services obtained within or outside the MCOP's network that are not pre-approved by an MCOP provider or other MCOP representative but are administered to maintain, improve or resolve the member's stabilized condition if:

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

(b) The provider documented an attempt to contact the MCOP to request authorization, but the MCOP cannot be contacted.

(c) The MCOP's representative and treating provider cannot reach an agreement concerning the

member's care and a network provider is not available for consultation. In this situation, the MCOP gives the treating provider the opportunity to consult with a network provider and the treating provider may continue with care until a network provider is reached or one of the criteria specified in paragraph (C)(5)(c) of this rule is met.

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

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

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

(iii) An MCOP representative and the treating provider reach an agreement concerning the member's care; or

(iv) The member is discharged.

(6) The MCOP permits members to self-refer to Title X services provided by any qualified family planning provider (QFPP). The MCOP is responsible for payment of claims for Title X services delivered by QFPPs not contracting with the MCOP 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.

(7) The MCOP permits members to self-refer to any women's health specialist within the MCOP's network 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.

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

(9) Where available, the MCOP ensures access to covered services provided by a certified nurse practitioner.

(10) Pharmacy services are covered in accordance with rule 5160-9-03 of the Administrative Code and are limited to items in paragraph (A)(2) of this rule. All other prescription drugs are covered by medicare part D.

(D) MCOP service exclusions.

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

(2) 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 MCOP.