Ohio Administrative Code

Rule 5160-58-08.4 Grievances, appeals, and state fair hearings for MyCare Ohio.

Effective: January 1, 2026

(A) Grievances and appeals vary depending on the MyCare Ohio enrollment of the member.

(1) If the member is enrolled as a dual-benefits member, as defined in rule 5160-58-01 of the Administrative Code, then all grievances and appeals are conducted by the MyCare Ohio plan (MCOP).

(2) If the member is enrolled as a medicaid-only member, as defined in rule 5160-58-01 of the Administrative Code, then the grievances and appeals for medicare benefits are conducted by the organization(s) that provide(s) the member's medicare services in accordance with 42 CFR 422 Subpart M (October 1, 2025):

(3) If the member is enrolled as a medicaid-only member, then appeals for hybrid services, as defined in rule 5160-58-01 of the Administrative Code, the services are first appealed to medicare and then to the MyCare Ohio plan. Grievances may be made to both medicare and medicaid.

(4) If the member is enrolled as a medicaid-only member, then grievances and appeals for all services which are not covered by medicare, but which are covered by medicaid, are handled by the MCOP.

(B) Grievances are defined in rule 5160-26-01 of the Administrative Code. Members may contact their MCOP to submit a grievance.

(1) A member may file a grievance with an MCOP orally or in writing at any time. An authorized representative needs the member's written consent to file a grievance on the member's behalf.

(2) An MCOP acknowledges the receipt of each grievance to the member filing the grievance. Oral acknowledgment by an MCOP is acceptable. If the grievance is filed in writing, written acknowledgment is made within three business days of receipt of the grievance.

(3) An MCOP reviews and resolves all grievances as expeditiously as the member's health condition requires. Grievance resolutions, including member notification, meet the following time frames:

(a) Within two business days of receipt if the grievance is regarding access to services.

(b) Within thirty calendar days of receipt for all other grievances that are not regarding access to services.

(4) At a minimum, an MCOP provides oral notification to the member of a grievance resolution. If an MCOP is unable to speak directly with the member, or the resolution includes information that needs confirmed in writing, the resolution is provided in writing simultaneously with the MCOP's resolution.

(5) If an MCOP's resolution to a grievance is to affirm the denial, reduction, suspension, or termination of a service, or billing of a member due to the MCOP's denial of payment for that service, the MCOP notifies the member of his or her right to request a state hearing, if the member was not previously notified.

(C) A notice of action (NOA) is sent by an MCOP to a member when an MCOP adverse benefit determination occurs or has occurred.

(1) The NOA explains:

(a) The adverse benefit determination the MCOP has taken or intends to take;

(b) The reasons for the adverse benefit determination, including the right of the member to be provided, upon request and free of charge, reasonable access to copies of all documents, records and other relevant determination information;

(c) The member's right to file an appeal to the MCOP;

(d) Information related to exhausting the MCOP appeal;

(e) The member's right to request a state hearing through the state's hearing system upon exhausting the MCOP appeal process;

(f) Procedures for exercising the member's rights to appeal the adverse benefit determination;

(g) Circumstances under which expedited resolution is available and how to request it;

(h) If applicable, the member's right to have benefits continue, pending the resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay for the cost of those services; and

(i) The date the notice is issued.

(2) The following language and format requirements apply to a NOA issued by an MCOP.

(a) It is provided in a manner and format that may be easily understood by the member;

(b) It explains that oral interpretation is available for any language, written translation is available in prevalent non-English languages, as applicable, and written alternative formats may be available, as needed;

(c) It explains how to access the MCOP's interpretation and translation services, as well as, alternative formats that can be provided by the MCOP;

(d) As directed by ODM, it is printed in the prevalent non-English languages of members in the MCOP's service area; and

(e) It is available in alternative formats, and in an appropriate manner, taking into consideration the special needs of members, including, but not limited to, members who are limited visually or members who have limited reading proficiency.

(3) An MCOP issues a NOA within the following time frames:

(a) For a decision to deny or limit authorization of a requested service, the MCOP issues a NOA simultaneously with the MCOP's decision.

(b) For reduction, suspension, or termination of services prior to the member receiving the services previously authorized by the MCOP, the MCOP gives notice at least fifteen calendar days before the effective date of the adverse benefit determination except:

(i) If probable recipient fraud, as defined in rule 5160-26-01 of the Administrative Code, is verified, the MCOP gives notice five calendar days before the effective date of the adverse benefit determination.

(ii) Under the circumstances set forth in 42 CFR 431.213 (October 1, 2025), the MCOP gives notice on or before the effective date of the adverse benefit determination.

(c) For denial of payment for a non-covered service, the MCOP gives notice simultaneously with the MCOP's action to deny the claim, in whole or part, for a service that is not covered by medicaid, including a service determined through the MCOP's prior authorization process as not medically necessary.

(d) For untimely prior authorization, appeal, or grievance resolution, the MCOP gives notice simultaneously with the MCOP becoming aware of untimely resolution. Service authorization decisions not received within the time frames specified in rules 5160-58-01.1 and 5160-58-03.1 of the Administrative Code constitute a denial and is thus considered to be an adverse benefit determination. Notice is given on the date the authorization decision time frame expires.

(e) There are two NOA documents in MyCare Ohio:

(i) The CMS-10003 "Notice of Denial of Medical Coverage/Payment" (NDMCP) is used for services that are covered by medicare and hybrid services.

(ii) The ODM 04043 "Notice of Denial of Medical Services by Your Managed Care Entity" is used for services covered only by medicaid.

(D) Standard medicaid appeals to an MCOP may be made by a member, a member's authorized representative, or a provider. An appeal may be made orally or in writing within sixty calendar days from the date that the NOA was issued.

(1) An oral appeal filing must be followed by a written appeal. An MCOP will:

(a) Immediately convert an oral appeal filing to a written appeal on behalf of the member; and

(b) Consider the date of the oral appeal filing as the filing date.

(2) Any provider acting on the member's behalf will provide the member's written consent to file an appeal. MCOPs will begin processing the appeal upon receipt of the written consent.

(3) An MCOP acknowledges receipt of each appeal to the member filing the appeal. At a minimum, acknowledgment is made in the same manner the appeal was filed. If an appeal is filed in writing, written acknowledgment is made by an MCOP within three business days of receipt of the appeal.

(4) An MCOP provides members a reasonable opportunity to present evidence and allegations of fact or law, in person as well as in writing, and inform the member of this opportunity sufficiently in advance of the resolution time frame. Upon request, the member or member's authorized representative is provided, free of charge and sufficiently in advance of the resolution time frame, the case file, including medical records, and any other documents and records, and any new or additional evidence considered, relied upon or generated by an MCOP, or at the direction of an MCOP, in connection with the appeal of the adverse benefit determination.

(5) An MCOP considers the member, the member's authorized representative, and an estate representative of a deceased member as parties to the appeal.

(6) An MCOP reviews and resolves each appeal as expeditiously as the member's health condition requires, but the resolution time frame may not exceed fifteen calendar days from the receipt of the appeal unless the resolution time frame is extended.

(7) An MCOP provides written notice of the appeal's resolution to the member, and to the member's authorized representative, if applicable. At a minimum, the written notice includes the resolution decision and date of the resolution.

(8) For medicaid appeal resolutions not resolved wholly in the member's favor, the written notice to the member also includes the following information:

(a) The right to request a state hearing through the state's hearing system;

(b) How to request a state hearing; and if applicable:

(i) The right to continue to receive benefits pending a state hearing; and

(ii) How to request the continuation of benefits.

(c) Oral interpretation is available for any language;

(d) Written translation is available in prevalent non-English languages as applicable;

(e) Written alternative formats may be available as needed; and

(f) How to access the MCOP's interpretation and translation services as well as alternative formats that can be provided by the MCOP.

(9) For medicare or hybrid services, the MCOP provides information explaining the steps involved for a second level appeal in accordance with 42 CFR 422.633, as applicable.

(10) For appeal resolutions decided in favor of the member, an MCOP:

(a) Authorizes or provides the disputed services promptly and as expeditiously as the member's health condition requires, but no later than seventy-two hours from the appeal resolution date, if the services were not furnished while the appeal was pending.

(b) Pays for the disputed services if the member received the services while the appeal was pending.

(11) Standard appeals for integrated services are determined in accordance with 42 CFR 422.633, as applicable.

(E) Expedited appeals to an MCOP.

(1) An MCOP establishes and maintains an expedited review process to resolve appeals when the member requests and the MCOP determines, or the provider indicates in making the request on the member's behalf or supporting the member's request, that taking the time for a standard resolution could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

(2) In utilizing an expedited appeal process, an MCOP complies with the standard appeal process specified in paragraph (F) of this rule, except that the MCOP:

(a) Determines within one business day of the appeal request whether to expedite the appeal resolution;

(b) Makes reasonable efforts to provide prompt oral notification to the member of the decision to expedite or not expedite the appeal resolution;

(c) Informs the member of the limited time available for the member to present evidence and allegations of fact or law in person or in writing;

(d) Resolves the appeal as expeditiously as the member's health condition requires, but the resolution time frame cannot exceed seventy-two hours from the date the MCOP received the appeal unless the resolution time frame is extended as outlined in paragraph (F) of this rule;

(e) Makes reasonable efforts to provide oral notice of the appeal resolution in addition to the required written notification; and

(f) Ensures punitive action is not taken against a provider who requests an expedited resolution or

supports a member's appeal.

(3) If an MCOP denies the request for expedited resolution of an appeal, the MCOP:

(a) Transfers the appeal to the standard resolution time frame of fifteen calendar days from the date the appeal was received unless the resolution time frame is extended as outlined in paragraph (F) of this rule; and

(b) Makes reasonable efforts to provide the member prompt oral notification of the decision not to expedite, and within two calendar days of the receipt of the appeal, provide the member written notice of the reason for the denial, including information that the member can grieve the decision.

(4) Expedited appeals for integrated services are processed in accordance with 42 CFR 422.633, as applicable.

(F) Grievance and appeal resolution extensions.

(1) A member may request the time frame for an MCOP to resolve a grievance or standard or expedited appeal be extended up to fourteen calendar days.

(2) An MCOP may request that the time frame to resolve a grievance, standard appeal, or expedited appeal be extended up to fourteen calendar days. The following requirements apply:

(a) The MCOP seeks such an extension from ODM prior to the expiration of the standard or expedited appeal or grievance resolution time frame;

(b) The MCOP request is supported by documentation of the need for additional information and that the extension is in the member's best interest; and

(c) If ODM approves the extension, the MCOP immediately gives the member written notice of the extension, and includes the following components in the notice:

(i) The MCOP's reason for needing the extension;

(ii) The date a decision will be made; and

(iii) Informs the member of their right to file a grievance if the member disagrees with the extension.

(3) The MCOP maintains documentation of any extension request.

(4) The MCOP processes extensions for Part B drugs in accordance with 42 CFR 422.590, as applicable.

(G) Access to state's hearing system.

(1) In accordance with 42 CFR 438.402 (October 1, 2025), members may request a state hearing only after exhausting the MCOP's appeal process for hybrid services or medicaid-only services. If an MCOP fails to adhere to the notice and timing requirements for appeals set forth in this rule, the member is deemed to have exhausted the MCOP appeal process and may request a state hearing.

(2) When required by paragraph (C)(3) of this rule, and in accordance with division 5101:6 of the Administrative Code, an MCOP notifies members, and any authorized representatives on file with the MCOP, of the right to a state hearing subject to the following requirements:

(a) If an MCOP appeal resolution upholds the denial of a request for the authorization of a service, in whole or in part, the MCOP simultaneously issues the "Notice of Denial of Medical Services By Your Managed Care Entity" (ODM 04043).

(b) If an MCOP appeal resolution upholds the decision to reduce, suspend, or terminate services prior to the member receiving the services as authorized by the MCOP, the MCOP issues the "Notice of Reduction, Suspension or Termination of Medical Services By Your Managed Care Entity" (ODM 04066).

(c) If an MCOP learns a member was billed for services received by the member due to the MCOP's denial of payment, and the MCOP upholds the denial of payment, the MCOP immediately issues the "Notice of Denial of Payment for Medical Services By Your Managed Care Entity" (ODM 04046).

(3) The member or the member's authorized representative may request a state hearing within ninety calendar days from the date of an adverse appeal resolution by contacting the ODJFS bureau of state hearings or local county department of job and family services (CDJFS).

(4) There are no state hearing rights for a member disenrolled from an MCOP pursuant to an MCOP-initiated membership disenrollment in accordance with rule 5160-58-02.1 of the Administrative Code.

(5) Following the bureau of state hearing's notification to an MCOP that a member requested a state hearing, the MCOP:

(a) Completes the "Appeal Summary for Managed Care Entities" (ODM 01959) with appropriate supporting attachments, and files it with the bureau of state hearings, at least three business days prior to the scheduled hearing date. The appeal summary includes all facts and documents relevant to the issue and is sufficient to demonstrate the basis for the MCOP's adverse benefit determination;

(b) Sends a copy of the completed ODM 01959 to the member and the member's authorized representative, if applicable, the CDJFS, and the designated ODM contact; and

(c) If benefits were continued through the appeal process then the MCOP continues or reinstates the benefit(s) if the MCOP is notified the member's state hearing request was received within fifteen calendar days from the date of the appeal resolution.

(6) An MCOP participates in the state hearing, in person or by telephone, on the date indicated on the "Notice to Appear for a Scheduled Hearing" (JFS 04002) sent to the MCOP by the bureau of state hearings.

(7) An MCOP complies with the state hearing decision provided to the MCOP via the "State Hearing Decision" (JFS 04005). If the state hearing decision sustains the member's appeal, the MCOP submits the information required by the "Order of Compliance" (JFS 04068) to the bureau of state hearings. The information, including applicable supporting documentation, is due to the bureau of state hearings, and the designated ODM contact by no later than the compliance date specified in the

hearing decision. If applicable, the MCOP:

(a) Authorizes or provides the disputed services promptly and as expeditiously as the member's health condition requires, but no later than seventy-two hours from the date it receives notice reversing the adverse benefit determination if services were not furnished while the appeal was pending.

(b) Pays for the disputed services if the member received the services while the appeal was pending.

(H) Continuation of benefits while the appeal to an MCOP or state hearing is pending.

(1) Unless a member requests that previously authorized benefits not be continued, an MCOP continues a member's benefits when all the following conditions are met:

(a) The member requests an appeal within fifteen calendar days of the MCOP issuing the NOA;

(b) The appeal involves the termination, suspension, or reduction of services prior to the member receiving the previously authorized services;

(c) The services were ordered by an authorized provider; and

(d) The authorization period has not expired.

(2) If an MCOP continues or reinstates the member's benefits while the appeal or state hearing are pending, the benefits are continued until one of the following occurs:

(a) The member withdraws the appeal or the state hearing request;

(b) The member fails to request a state hearing within fifteen calendar days after the MCOP issues an adverse appeal resolution; or

(c) The bureau of state hearings issues a state hearing decision upholding the reduction, suspension or termination of services.

(3) If the final resolution of the appeal or state hearing upholds an MCOP's original adverse benefit determination the MCOP may recover the cost of the services furnished to the member while the appeal and/or state hearing was pending.

(I) Other duties of an MCOP regarding appeals and grievances.

(1) An MCOP gives members all reasonable assistance filing a grievance, an appeal, or a state hearing request including but not limited to:

(a) Explaining the MCOP's process to be followed in resolving the member's appeal or grievance;

(b) Completing forms and taking other procedural steps as outlined in this rule; and

(c) Providing oral interpretation and oral translation services, sign language assistance, and access to the grievance system through a toll-free number with text telephone yoke (TTY) and interpreter capability.

(2) An MCOP ensures the individuals who make decisions on appeals and grievances are individuals who:

(a) Were neither involved in any previous level of review or decision-making nor a subordinate of any such individual; and

(b) Are health care professionals who have the appropriate clinical expertise in treating the member's condition or disease, if deciding any of the following:

(i) An appeal of a denial based on lack of medical necessity;

(ii) A grievance regarding the denial of an expedited resolution of an appeal; or

(iii) An appeal or grievance involving clinical issues.

(3) In reaching an appeal resolution, the MCOP takes into account all comments, documents, records, and other information submitted by the member and their authorized representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.