5160-58-03 MyCare Ohio plans: Covered Services

MCTL 41

Effective Date: March 1, 2014

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

(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) 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 paragraph (B) of rule 5160-26-05.1 of the Administrative Code; and

(4) ) If a member is unable to obtain medically-necessary medicaid services from a plan 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 plan may place limits on services;

(1) On the basis of medical necessity;

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

(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 plan must cover annual physical examinations for adults.

(D) At the request of a member, a plan must provide for a second opinion from a qualified health care professional within the panel. If such 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 plan must assure that 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 plan 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 plan cannot limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.

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

(4) The plan 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 PCP or the plan's twenty-four-hour toll-free call-in-system.

(5) The plan 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 plan but provides emergency services to an plan member, regardless of whether or not 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 plan 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.

(8) 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 plan 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 plan must assure that 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 plan 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 that 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 that 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 plan 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 plan does not respond within one hour of a provider's request for preapproval of further services that were 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 plan 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 plan fails to respond within one hour to a provider request for authorization to provide such services.

(ii) The plan cannot be contacted.

(iii) The plan'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 plan's financial responsibility for post stabilization care services it has 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) Exclusions, limitations and clarifications.

(1) The plan 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 plan 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 PCP if that PCP is not a women's health specialist.

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

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

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

(6) The plan must provide all early and periodic screening, diagnosis and treatment (EPSDT) services, also known as healthchek services, in accordance with the periodicity schedule identified in Chapter 5160-14 of the Administrative Code, to healthchek eligible members and assure that services are delivered and monitored as follows:

(a) Healthchek exams must include those components specified in Chapter 5160-14 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) The plan or its contracting provider must notify members of the appropriate healthchek exam intervals as specified in Chapter 5160-14 of the Administrative Code.

(c) Healthchek exams are to be 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.

(l) A plan is not required to cover services provided to members outside the United States.

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