

5101:3-26-03.1 **Managed health care programs: Care coordination.**

(A) MCP care coordination responsibilities.

- (1) MCPs must ensure that each member has a PCP who will serve as an ongoing source of primary care and assist with care coordination appropriate to the member's needs.
- (2) MCPs must ensure that PCPs are in compliance with the following triage requirements:
 - (a) Members with emergency care needs must be triaged and treated immediately on presentation at the PCP site;
 - (b) Members with persistent symptoms must be treated no later than the end of the following working day after their initial contact with the PCP site; and
 - (c) Members with requests for routine care must be seen within six weeks.
- (3) At the request of the member, MCPs must provide for a second opinion from a qualified health care professional within the MCP's panel. If such a qualified health care professional is not available within the MCP's panel, the MCP must arrange for the member to obtain a second opinion outside the panel, at no cost to the member.
- (4) Care coordination with non-contracting providers.
 - (a) MCPs are required to share specific information with ODJFS-designated non-contracting providers such as ODMH Community Mental Health Centers, ODADAS-certified medicaid providers, FOHCs/RHCs, and QFPPs. Such information includes, but is not limited to, the MCP's contact information and a list of panel laboratories and pharmacies.
 - (b) Upon request, MCPs must provide information to ODJFS to document the non-contracting providers identified by the MCP under paragraph (A)(4)(a) of this rule and the information the MCP provided to each provider.
- (5) MCPs that require referrals to specialists must ensure that information on referral approvals and denials is made available to ODJFS upon request.
- (6) MCPs must provide a centralized twenty-four-hour toll-free call-in system which is available nationwide.
 - (a) The call-in system must be staffed by trained medical professionals who will provide members with medical advice and direct members to the appropriate care setting. Such system must also provide information to

members and/or providers as necessary to assure access, including, but not limited to, membership status. MCPs may not require members to contact their PCP or any other entity prior to contacting the twenty-four-hour toll-free call-in system for advice or direction concerning emergency and/or after-hours services.

(b) A log for the twenty-four-hour toll-free call-in system must be maintained, and accessible, by the MCP and must include at a minimum:

(i) Identification of the member;

(ii) Date and time of call;

(iii) Member's question, concern or presenting problem;

(iv) Disposition of call;

(v) PCP or other provider if contacted by MCP; and

(vi) Name and title of person taking the call.

(c) The twenty-four-hour toll-free call-in system must have services available to assist:

(i) Hearing impaired members; and

(ii) LEP members in the primary language of the member.

(7) The MCP must have a utilization management (UM) program with clearly defined structures and processes designed to maximize the effectiveness of the care provided to the member.

(a) The UM program must be based on written policies and procedures that include, at a minimum, the following:

(i) The specification of the information sources used to make determinations of medical necessity;

(ii) The criteria, based on sound clinical evidence, to make UM decisions and the specific procedures for appropriately applying the criteria;

(iii) A description of how providers will obtain utilization management criteria;

(iv) A description of how UM criteria will be made available to

non-contracting providers upon request; and

(v) A description of how the MCP will monitor the impact of the UM program to detect and correct potential under- and over-utilization.

(b) The MCP's UM program must also assure and document the following:

(i) An annual review and update of the UM program;

(ii) The involvement of a designated senior physician in the UM program;

(iii) The use of appropriate qualified licensed health professionals to assess the clinical information used to support UM decisions;

(iv) The use of board-certified consultants to assist in making medical necessity determinations, as necessary;

(v) That UM decisions are consistent with clinical practice guidelines as specified in paragraph (B) of rule 5101:3-26-05.1 of the Administrative Code.

(vi) The reason for each denial of a service, based on sound clinical evidence; and

(vii) That compensation by the MCP to individuals or entities that conduct UM activities does not offer incentives to deny, limit, or discontinue medically-necessary services to any member.

(c) MCPs, at a minimum, must have and follow written policies and procedures for processing requests for initial and continuing authorizations of services from their providers and members. The MCPs must assure and document the following:

(i) Consistent application of review criteria for authorization decisions;

(ii) Consultation with the requesting provider, when necessary;

(iii) That any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease;

(iv) That a written notice will be sent to the member and the requesting provider of any decision to reduce, suspend, terminate or deny a

service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the member must meet the requirements of rules 5101:6-2-35, 5101:3-26-08.4 and 5101:3-26-08.5 of the Administrative Code;

- (v) For standard authorization decisions, the MCP must provide notice to the provider and member as expeditiously as the member's health condition requires but no later than five working days following receipt of the request for service, except as specified in paragraph (A)(7)(d) of this rule. If requested by the member, provider or MCP, standard authorization decisions may be extended up to fourteen additional calendar days. If requested by the MCP, the MCP must submit to ODJFS for prior-approval, documentation as to how the extension is in the member's interest. If ODJFS approves the MCP's extension request, the MCP must give the member written notice of the reason for the decision to extend the time frame and inform the member of the right to file a grievance if he or she disagrees with that decision. The MCP must carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires;
- (vi) If a provider indicates or the MCP determines that following the standard authorization time frame could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the MCP must make an expedited authorization decision and provide notice of the authorization decision as expeditiously as the member's health condition requires but no later than three working days after receipt of the request for service. If requested by the member or MCP, expedited authorization decisions may be extended up to fourteen additional calendar days. If requested by the MCP, the MCP must submit to ODJFS for prior-approval, documentation as to how the extension is in the member's interest. If ODJFS approves the MCP's extension request, the MCP must give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision. The MCP must carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires;
- (vii) Service authorization decisions not reached within the time frames specified in paragraphs (A)(7)(c)(v) and (A)(7)(c)(vi) and (A)(7)(d) of this rule constitute a denial, and the MCPs must give notice to the member as specified in paragraph (B)(2)(d) of rule 5101:3-26-08.4 of the Administrative Code.

(3) Recommending referrals to specialists, as required;

(4) Triaging members as described in paragraph (A)(2) of this rule;

(5) Participating in the development of case management treatment plans; and

(6) Notifying the MCP of members who may benefit from case management.

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Certification

Date

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