TO BE RESCINDED

5101:3-26-03 **Managed health care programs: Covered services.**

(A) Except as provided in this rule, MCPs must cover, at a minimum, all services under the Ohio medicaid program when provided, prescribed, or arranged by a provider authorized by the MCP, including any medically- necessary service covered by medicaid and provided to enrolled medicaid children who are categorically eligible for Title V (children with medical handicaps).

(B) MCPs must cover annual examinations for adults.

(C) MCPs must assure that emergency and post-stabilization care services as defined in rule 5101:3-26-01 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) MCPs must cover all emergency services without requiring prior authorization.

(2) MCPs must cover medicaid-covered services related to the enrollee's emergency medical condition when the enrollee is instructed to go to an emergency facility by the enrollee's PCP or the MCP's twenty-four-hour toll-free call-in system.

(3) An MCP must cover emergency services as defined in rule 5101:3-26-01 of the Administrative Code when the services are delivered by a provider not contracting with the MCP. Such services must be reimbursed by the MCP at the lesser of one hundred per cent of the current medicaid provider reimbursement rate or billed charges. If an inpatient admission results, the MCP is required to reimburse at this rate only until the enrollee can be transferred to a provider designated by the MCP.

(4) MCPs must adhere to the judgement of the attending physician when requesting enrollee transfer to another facility or discharge. MCPs may establish arrangements with hospitals whereby the MCP may designate one of its contracting physicians to assume the attending physician's responsibilities to stabilize, treat and transfer the enrollee.

(5) Post-stabilization care services must be covered by the MCP when the MCP fails to respond within one hour to a provider request for authorization to provide such services. The MCP must designate a telephone line to receive such provider requests in accordance with ODJFS specifications. The line must be available twenty-four hours a day. MCPs must document that the telephone number and process for obtaining authorization has been provided

to each emergency facility in the service area. The MCP must maintain a record of provider requests and MCP responses to document authorization or non-authorization of services within the specified time frames.

(D) MCPs must cover urgent care services as defined in rule 5101:3-26-01 of the Administrative Code, including any diagnostic services necessary to assess the enrollee's need for urgent care, when an enrollee is injured or becomes ill while temporarily outside the enrollee's county of residence. MCP responsibility is limited to the coverage for those services which are required before the enrollee can, without medically harmful consequences, return to the enrollee's county of residence and/or to the care and direction of the MCP.

(1) MCPs must cover urgent care services related to the condition for which an enrollee is instructed to go to an urgent care facility by the enrollee's PCP or the MCP's twenty-four hour toll-free call-in system.

(E) MCPs must establish, in writing, the criteria for compensation of emergency and urgent care services to noncontracting providers and the procedures for notification and claim filing. Such information must be made available to providers on request.

(F) MCPs must make a decision on requests for the authorization of any medicaid-covered service and notify the requesting provider or enrollee of such decision within five working days of receipt of the request. MCPs must maintain a record of such requests, including enrollee identifying information, service requested, date received, decision, date of decision, and basis for denial, if applicable. If the request is denied in whole or in part, the MCP must also simultaneously notify the enrollee in writing of their right to request a state hearing in accordance with rule 5101:6-2-35 of the Administrative Code.

(G) The MCP must notify affected enrollees of any reduction or termination of medicaid-covered services in writing no later than fifteen calendar days prior to the proposed reduction or termination. If an enrollee requests a state hearing within the timely notice period of fifteen calendar days, the MCP must continue the service in accordance with rule 5101:6-4-01 of the Administrative Code.

(H) The MCP must notify an enrollee of the right to request a state hearing if the MCP learns that the enrollee has been billed by a provider due to the MCP's denial of payment and that notice has not been issued. Such notification must be in accordance with rule 5101:6-2-35 of the Administrative Code.

(I) Exclusions, limitations and clarifications.

(1) When an MCP enrollee has been found by ODJFS to meet the criteria for either a skilled, intermediate, or ICF-MR level of care and is then placed in a NF, or ICF-MR, ODJFS will disenroll the enrollee from the MCP. Enrollees will not be eligible for such disenrollment if they are placed in a NF for a short-term rehabilitative stay as determined by ODJFS.

(2) When an MCP enrollee has been found by ODJFS to meet the criteria for placement in a home and community-based waiver program administered by ODJFS, ODA, or ODMR-DD, ODJFS will disenroll the enrollee from the MCP.

(3) MCPs must advise enrollees via the member handbook of where and how to access behavioral health services.

(4) MCPs must advise enrollees via the member handbook of the ability to self refer to family planning services provided by qualified family planning providers. The MCP is responsible for payment of claims for family planning services delivered by QFPPs not contracting with the MCP at the lesser of one hundred per cent of the current medicaid provider reimbursement rate or billed charges.

(5) MCPs must advise enrollees via the member handbook of the ability to self refer to any obstetrician or gynecologist within the MCP's panel for covered obstetric and gynecological services. MCPs must also advise enrollees via the member handbook of the ability following confirmation of pregnancy by the provider's office to self refer to a certified nurse midwife, if one is available in the service area and as specified by the MCP, for prenatal care, delivery, and postpartum care.

(6) MCPs must advise enrollees via the member handbook of the ability to access covered services provided by an FQHC or RHC. MCPs must ensure access to FQHC and RHC services.

(7) MCPs must advise enrollees via the member handbook of the ability to access covered services provided by a certified nurse practitioner, if one is available in the service area, as specified by the MCP. MCPs must ensure access to a certified nurse practitioner, if one is available in the service area.

(8) MCPs are not responsible for the payment of services provided through community alternative funding services (CAFS) providers.

(9) MCPs 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 5101:3-14 of the Administrative Code, to eligible enrollees and assure that services are delivered and monitored as follows:

(a) Healthchek exams must include those components specified in Chapter 5101:3-14 of the Administrative Code. All components of exams must be documented and included in the medical record of each healthchek eligible enrollee and made available for the ODJFS annual external quality review.

(b) The MCP/provider site must notify enrollees of the appropriate healthchek exam intervals as specified in Chapter 5101:3-14 of the Administrative Code.

(c) Healthchek exams are to be completed within ninety days of the initial effective date of enrollment for those children found to have possible ongoing conditions likely to require case management services.

Effective:

R.C. 119.032 review dates: 04/15/2003

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Certification

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Date

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