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

(A) Except as provided in this rule, managed care plans (MCPs) must ensure that members have access to all medically-necessary services covered by medicaid. The MCP 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) Coverage decisions are based on the practice guidelines specified in paragraph (B) of rule 5101:3-26-05.1 of the Administrative Code; and

(4) If a member is unable to obtain medically-necessary services offered by medicaid from a MCP panel provider, the MCP must adequately and timely cover the services out of panel, until the MCP is able to provide the services from a panel provider.

(B) MCPs may place appropriate limits on a service;

(1) On the basis of medical necessity; or

(2) 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) MCPs must cover annual physical examinations for adults.

(D) At the request of the member, MCPs 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 MCP's panel, the MCP must arrange for the member to obtain a second opinion outside the panel, at no cost to the member.

(E) MCPs must assure that emergency 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 may not deny payment for treatment obtained when a member had an emergency medical condition, including cases in which the absence of

immediate medical attention would not have resulted in the outcomes specified in paragraph ~~(U)~~ (T) of rule 5101:3-26-01 of the Administrative Code.

(2) MCPs cannot limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.

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

(4) MCPs 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 MCP including but not limited to the member's PCP or the MCP's twenty-four-hour toll-free call-in-system.

(5) MCPs 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) An MCP must cover emergency services as defined in paragraph ~~(V)~~ (U) of rule 5101:3-26-01 of the Administrative Code when the services are delivered by a provider not contracting with the MCP and claims for these services cannot be denied regardless of whether the services meet an emergency medical condition as defined in paragraph ~~(U)~~ (T) of rule 5101:3-26-01 of the Administrative Code. Such services must be reimbursed by the MCP at the lesser of one hundred per cent of the medicaid provider reimbursement rate or billed charges, in effect for the date of service. If an inpatient admission results, the MCP is required to reimburse at this rate only until the member can be transferred to a provider designated by the MCP.

(7) MCPs must adhere to the judgment of the attending physician when requesting a member's 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 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) MCPs must establish, in writing, the process and procedures for the submission of claims for ~~emergency~~ services delivered by non-contracting providers. Such information must be made available to non-contracting providers on request. MCPs

may not establish claims filing and processing procedures for non-contracting providers that are more stringent ~~that~~ than those established for their contracting providers except that regardless of the claims filing timeframe for contracting providers, MCPs must accept claims for processing from non-contracting providers when submitted within one hundred eighty days from the date of service.

(G) MCPs must assure that 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.

(1) The MCP 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. 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 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 MCP 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) MCPs must cover services obtained within or outside the MCP's panel that are pre-approved in writing to the requesting provider by a plan provider or other MCP representative.

(b) MCPs must cover services obtained within or outside the MCP's panel that are not pre-approved by a plan provider or other MCP representative but are administered to maintain the member's stabilized condition within one hour of a request to the MCP for preapproval of further post-stabilization care services.

(c) MCPs must cover services obtained within or outside the MCP's panel that are not pre-approved by a plan provider or other MCP representative but are administered to maintain, improve or resolve the member's stabilized condition if:

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

(ii) The MCP cannot be contacted.

(iii) The MCP's representative and treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation. In this situation, the MCP must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care until a plan physician is reached or one of the criteria specified in paragraph (G)(3) of this rule is met.

(3) The MCP's financial responsibility for post stabilization care services it has not pre-approved ends when:

(a) A plan physician with privileges at the treating hospital assumes responsibility for the member's care;

(b) A plan physician assumes responsibility for the member's care through transfer;

(c) A MCP representative and the treating physician reach an agreement concerning the member's care; or

(d) The member is discharged.

(H) Exclusions, limitations and clarifications.

(1) ~~MCPs are not responsible for payment of services provided to a member that has been found by the Ohio department of job and family services (ODJFS) to meet the criteria for either a skilled, intermediate, or intermediate care facility for the mentally retarded (ICF-MR) level of care and is then placed in a nursing facility (NF) or ICF-MR, unless the member is placed in a NF for a short-term rehabilitative stay as determined by ODJFS.~~ When an MCP member in the covered families and children (CFC) category of assistance as described in paragraph (B)(1)(a) of rule 5101:3-26-02 of the Administrative Code is placed in a nursing facility (NF) for a short-term rehabilitative stay as determined by ODJFS, MCPs are responsible for the payment of services provided to the member. MCPs are not responsible for the payment of services provided to an MCP member in the CFC category of assistance as described in paragraph (B)(1)(a) of rule 5101:3-26-02 of the Administrative Code when the member is found by ODJFS to meet the criteria for either a NF or intermediate care facility for the mentally retarded (ICF-MR) level of care and is then placed in a NF or ICF-MR.

(2) When an MCP member in the aged, blind, and disabled (ABD) category of

assistance as described in paragraph (B)(1)(b) of rule 5101:3-26-02 of the Administrative Code is placed in a NF or ICF-MR, MCPs are responsible for NF payment and payment for all covered services until the last day of the second calendar month following NF admission.

~~(2)~~(3) MCPs are not responsible for payment of services provided to a member that has been ~~found by ODJFS to meet the criteria for placement~~ enrolled in a home and community-based waiver program administered by ODJFS, the Ohio department of aging (ODA), or the Ohio department of mental retardation and developmental disabilities (ODMR/DD).

(4) MCPs are not responsible for payment of habilitation services as described in 42 U.S.C. 1396n(c)(5) (2002).

~~(3)~~(5) MCP members are permitted to self-refer to all community mental health centers and the Ohio department of alcohol and drug addiction services (ODADAS)-certified medicaid providers. MCPs must ensure access to behavioral health services for members who are unable to timely access services or unwilling to access services through community providers.

~~(4)~~(6) MCP members are permitted to self-refer to family planning services provided by any qualified family planning provider (QFPP). 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 medicaid provider reimbursement rate or billed charges, in effect for the date of service.

~~(5)~~(7) MCPs must permit members to self-refer to any women's health specialist within the MCP'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.

~~(6)~~(8) MCPs must ensure access to covered services provided by all federally qualified health centers (FQHCs) and rural health clinics (RHCs).

~~(7)~~(9) Where available, MCPs must ensure access to covered services provided by a certified nurse practitioner.

~~(8)~~(10) ODJFS may approve an MCP's members to be referred to certain MCP non-contracting hospitals, as specified in rule 5101:3-26-11 of the Administrative Code, for medicaid-covered non-emergency hospital services. When ODJFS permits such authorization, ODJFS will notify the MCP and the MCP non-contracting hospital of the terms and conditions, including the

duration, of the approval and the MCP must reimburse the MCP non-contracting hospital at one hundred per cent of the current medicaid provider reimbursement rate in effect for the date of service for all medicaid-covered non-emergency hospital services delivered by the MCP non-contracting hospital. ODJFS will base its determination of when an MCP's members can be referred to MCP non-contracting hospitals pursuant to the following:

(a) The MCP's submission of a written request to ODJFS for the approval to refer members to a hospital that has declined to contract with the MCP. The request must document the MCP's contracting efforts and why the MCP believes it will be necessary for members to be referred to this particular hospital; and

(b) ODJFS consultation with the MCP non-contracting hospital to determine the basis for the hospital's decision to decline to contract with the MCP, including but not limited to whether the MCP's contracting efforts were unreasonable and/or that contracting with the MCP would have adversely impacted the hospital's business.

~~(9)~~(11) Paragraph ~~(H)(8)~~ (H)(10) of this rule is not applicable when an MCP and an MCP non-contracting hospital have mutually agreed to that hospital providing non-emergency hospital services to an MCP's members. MCPs must ensure that such arrangements comply with paragraph (A)(9) of rule 5101:3-26-05 of the Administrative Code.

~~(10)~~(12) 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 individuals 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 member and made available for the ODJFS annual external quality review.

(b) The MCP~~/~~ or its contracting provider ~~site~~ must notify members 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 membership for those children found to have a possible ongoing condition likely to require case management services.

(I) Out-of-country coverage

MCPs are not required to cover services provided to members outside the United States.

Effective:

R.C. 119.032 review dates: 07/01/2008

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Certification

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Date

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| Promulgated Under: | 119.03 |
| Statutory Authority: | 5111.02, 5111.16, 5111.162, 5111.17 |
| Rule Amplifies: | 5111.01, 5111.02, 5111.021, 5111.16, 5111.162, 5111.17 |
| Prior Effective Dates: | 4/1/85, 5/2/85, 10/1/87, 2/15/89 (Emer), 5/8/89, 11/1/89 (Emer), 5/1/92, 5/1/93, 11/1/94, 7/1/96, 7/1/97 (Emer), 9/27/97, 5/14/99, 2/10/99, 7/1/00, 7/1/01, 7/1/02, 7/1/03, 1/1/06 |