5160-59-03 **OhioRISE: covered services.**

(A) The Ohio resilience through integrated systems and excellence (OhioRISE) plan has to ensure:

(1) Services are sufficient in amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are provided;

(2) The amount, duration, and scope of a medically necessary service is not arbitrarily denied or reduced solely because of the diagnosis, type of illness, or condition;

(3) Prior authorization is available for services on which the OhioRISE plan has placed a preidentified limitation to ensure the limitation may be exceeded when medically necessary;

(4) Coverage decisions are based on the coverage and medical necessity criteria published in agency 5160 of the Administrative Code and practice guidelines specified in rule 5160-26-05.1 of the Administrative Code; and

(5) If a member is unable to obtain medically necessary services described in this rule through an OhioRISE plan network provider, the OhioRISE plan has to adequately and timely cover the services out of network, until the OhioRISE plan is able to provide the services from a network provider.

(6) Providers delivering services in the OhioRISE program will adhere to the incident management criteria set forth in rule 5160-44-05 of the Administrative Code.

(B) The OhioRISE plan has to ensure members have access to the following services when medically necessary:

(1) Care coordination as described in rule 5160-59-03.2 of the Administrative Code.

(2) Intensive home-based treatment (IHBT) as described in rule 5160-59-03.3 of the Administrative Code.

(3) Respite services for members twenty years of age or younger with behavioral health needs in accordance with rule 5160-59-03.4 of the Administrative Code.

(4) Inpatient hospital services provided in accordance with Chapter 5160-2 of the Administrative Code in a free-standing psychiatric hospital or a general acute care hospital that are:

(a) Inpatient psychiatric services; or

(b) Inpatient substance use disorder (SUD) services (including withdrawal management) provided in accordance with American society of addiction medicine (ASAM) level of care four.

(5) Psychiatric residential treatment facility (PRTF) services as described in 42 C.F.R. 441.150 (October 1, 2021) through 42 C.F.R 441.184 (October 1, 2021).

(6) Opioid treatment program (OTP) services delivered by community SUD programs licensed by Ohio department of mental health and addiction services and/or certified by the substance abuse and mental health services administration (SAMHSA) as an OTP.

(7) Behavioral health services provided in accordance with Chapter 5160-27 of the Administrative Code.

(8) Behavioral health services provided in accordance with rule 5160-8-05 of the Administrative Code.

(9) Behavioral health services rendered by psychiatrists and physician assistants under the supervision of psychiatrists in accordance with Chapter 5160-4 of the Administrative Code and psychiatric advanced practice registered nurses in accordance with rule 5160-4-04 of the Administrative Code.

(10) Behavioral health services rendered by outpatient hospital providers in accordance with Chapter 5160-2 of the Administrative Code except for emergency department services.

(11) Behavioral health services rendered in federally qualified health centers (FQHCs) and rural health clinics (RHCs) in accordance with Chapter 5160-28 of the Administrative Code.

(12) Physician administered drugs in accordance with rule 5160-4-12 of the Administrative Code for the treatment of mental health and SUD conditions.

(13) Primary flex funds as described in rule 5160-59-03.5 of the Administrative Code.

(14) Services and supports included in the OhioRISE 1915(c) home and community-based services waiver in accordance with rule 5160-59-05 of the Administrative Code.

(C) The OhioRISE plan may place appropriate limits on a service:

(1) On the basis of medical necessity for the member's condition or diagnosis; or

(2) For the purposes of utilization control, provided the services can be reasonably expected to achieve their purpose as specified in paragraph (A)(1) of this rule.

(D) The OhioRISE plan has to ensure that the services described in paragraph (B) of this rule that are emergency services, as described 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, covered services described in paragraph (B) of this rule that are emergency services have to be provided and reimbursed in accordance with the following:

(1) The OhioRISE plan will not deny reimbursement for treatment obtained when a member had an emergency medical condition.

(2) The OhioRISE plan cannot limit what constitutes an emergency medical condition on the basis of diagnoses or symptoms.

(3) The OhioRISE plan has to cover emergency services without requiring prior authorization.

(4) The OhioRISE plan has to cover services as described in paragraph (B) in this rule related to the member's emergency medical condition when the member is instructed to go to an emergency facility by a representative of the OhioRISE plan, the member's managed care organization (MCO), or the member's primary care provider (PCP).

(5) The OhioRISE plan cannot deny reimbursement of emergency services based on the treating provider, hospital, or fiscal representative not notifying the member's PCP of the visit.

(6) The OhioRISE plan has to cover the services described in paragraph (B) of this rule that are emergency services when the services are delivered by a non-contracting provider of emergency services. Such services will be reimbursed by the OhioRISE plan at the lesser of billed charges or one hundred per cent of the Ohio medicaid program fee-for-service reimbursement rate (less any reimbursements 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 OhioRISE plan has to reimburse at this rate only until the member can be transferred to a provider designated by the OhioRISE plan.

(7) The OhioRISE plan has to cover the services as described in paragraph (B) of this rule that are emergency services until the member is stabilized and can be safely discharged or transferred.

(8) The OhioRISE plan has to adhere to the judgment of the attending provider when the attending provider requests a member's transfer to another facility or discharge. The OhioRISE plan may establish arrangements with hospitals whereby the OhioRISE plan may designate one of its contracting providers to assume the attending provider's responsibilities to stabilize, treat and transfer the member.

(9) A member who has had an emergency medical condition will not be held liable for reimbursement of any subsequent screening and treatment needed to diagnose the specific condition or stabilize the member.

(E) The OhioRISE plan has to 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. Such information will be made available upon request to non-contracting providers, including non-contracting providers of emergency services. The OhioRISE plan will 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.

(F) The OhioRISE plan has to ensure any services described in paragraph (B) of this rule that are post-stabilization care services, as described in rule 5160-26-01 of the Administrative Code, are provided and covered twenty-four hours a day, seven days a week.

(1) The OhioRISE plan has to designate a telephone line that is available twenty-four hours a day to receive provider requests for coverage of post-stabilization care services. The OhioRISE plan has to document that the telephone number and process for obtaining authorization has been provided to each emergency facility in the service area. The OhioRISE plan has to 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 the OhioRISE plan communicated the decision in writing to the provider.

(2) At a minimum, the services described in paragraph (B) of this rule that are post-stabilization care services have to be provided and reimbursed in accordance with the following:

(a) The OhioRISE plan has to cover services obtained within or outside the OhioRISE plan's network that are pre-approved in writing to the requesting provider by a plan provider or other OhioRISE plan representative.

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

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

(i) The OhioRISE plan fails to respond within one hour to a provider request for authorization to provide such services;

(ii) The provider has documented an attempt to contact the OhioRISE plan to request authorization, but the OhioRISE plan cannot be contacted; or

(iii) The OhioRISE 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 OhioRISE plan will give the treating provider the opportunity to consult with an OhioRISE plan provider and the treating provider may continue with care until a plan provider is reached or one of the criteria specified in paragraph (F)(3) of this rule is met.

(3) The OhioRISE plan's financial responsibility for services described in paragraph (B) of this rule that are post-stabilization care services not pre-approved ends when:

(a) An OhioRISE plan provider with privileges at the treating hospital assumes responsibility for the member's care;

(b) An OhioRISE plan provider assumes responsibility for the member's care through transfer;

(c) An OhioRISE plan representative and the treating provider reach an agreement concerning the member's care; or

(d) The member is discharged.

(G) OhioRISE plan responsibilities for reimbursement of other services.

(1) ODM may approve referral of the OhioRISE plan's members to certain OhioRISE plan non-contracting hospitals, as specified in rule 5160-26-11 of the Administrative Code, for non-emergency hospital services that are OhioRISE covered services as described in paragraph (B) of this rule. When ODM permits such authorization, ODM will notify the OhioRISE plan and the OhioRISE plan's non-contracting hospital of the terms and conditions of the approval, including the duration, and the OhioRISE plan will reimburse the OhioRISE plan's non-contracting hospital at one hundred per cent of the current Ohio medicaid program fee-for-service reimbursement rate in effect for the date of service for all medicaid-covered non-emergency hospital services delivered by the OhioRISE plan's non-contracting hospital. ODM will base its determination of when an OhioRISE plan's members can be referred to an OhioRISE plan non-contracting hospital pursuant to the following:

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

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

(2) Paragraph (G)(1) of this rule is not applicable when the OhioRISE plan and an OhioRISE plan non-contracting hospital have mutually agreed that the non-contracting hospital will provide non-emergency OhioRISE covered hospital services to the OhioRISE plan's members. The OhioRISE plan will ensure that such arrangements comply with rule 5160-26-05 of the Administrative Code.

(3) The OhioRISE plan is not responsible for reimbursement of services provided through the medicaid school program (MSP) pursuant to Chapter 5160-35 of the Administrative Code. The OhioRISE plan will ensure access to services described in paragraph (B) of this rule for members who are unable to timely access services or are unwilling to access services through MSP providers.

(4) The OhioRISE plan is not required to cover services provided to members outside the United States.

(5) The OhioRISE plan will ensure that eligible members receive all behavioral health early and periodic screening, diagnosis and treatment (EPSDT) services in accordance with rule 5160-1-14 of the Administrative Code.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

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