Ohio Administrative Code

Rule 5160-1-11 Out-of-state coverage.

Effective: April 4, 2021

(A) Out-of-state providers:

(1) Should be licensed, accredited, or certified by their respective states to be considered eligible to receive reimbursement for services provided to Ohio medicaid covered individuals.

(2) Should meet any standards applicable to the provision of the service in the state in which the service is being furnished, as well as those standards set forth in the Ohio medicaid program and in the Administrative Code.

(3) Except as provided in paragraph (A)(4) of this rule, need to enroll as Ohio medicaid providers in order to obtain payment and follow appropriate billing procedures in accordance with Chapter 5160-1 of the Administrative Code and Chapter 5160-3 of the Administrative Code for long term care nursing facility services.

(4) Who are rendering services to medicaid covered individuals enrolled in a managed care plan (MCP) are not required to enroll with the Ohio department of medicaid (ODM) when:

(a) The out-of-state provider is not in the MCPs network and is providing services under a single case agreement; or

(b) The out-of-state provider is a pharmacy that is in-network with the MCP under a national contract.

(5) May have their out-of-state provider's enrollment application denied by ODM based on the denial, censure or revocation of their professional license by the applicable licensing board of any other state, or if the applicable licensing board in Ohio denies, censures or revokes a professional license even if another state's licensing board approves the respective provider.

(B) Ohio medicaid covered services will be reimbursed when rendered by out-of-state providers only under the following circumstances:

(1) The medically necessary services are not available within the state of Ohio, and the use of out-of-state providers to perform the services is authorized by the department or its designee, or authorized in accordance with rule 5160-1-31 of the Administrative Code; or

(2) The medical need arose as a result of an emergency, an accident, or an illness which occurred during a period of time the medicaid covered individual was temporarily absent from Ohio; or

(3) The individual's health would have been endangered if care was postponed until the individual returned to Ohio or attempted to return to Ohio; or

(4) The provider location for the medically necessary service is in a bordering state of Ohio, and it is the usual practice of residents in that community to utilize out-of-state providers, so long as the cost of the service does not exceed the cost of the service if provided by in-state providers; or

(5) The state determines on the basis of medical advice, that the needed medical services or necessary supplementary resources are more readily available in another state.