Ohio Administrative Code

Rule 5160-26-05.1 Managed care: provider services.

Effective: July 18, 2022

(A) A managed care entity (MCE) must provide the following written information to their contracting providers:

(1) The MCE's grievance, appeal and state fair hearing procedures and time frames, including:

(a) The member's right to file grievances and appeals and the requirements and time frames for filing;

(b) The MCE's toll-free telephone number to file oral grievances and appeals;

(c) The member's right to a state fair hearing, the requirements and time frames for requesting a hearing, and representation rules at a hearing;

(d) The availability of assistance from the MCE in filing any of these actions;

(e) The member's right to request continuation of benefits during an appeal or a state hearing and specification that at the discretion of ODM the member may be liable for the cost of any such continued benefits; and

(f) The provider's rights to participate in these processes on behalf of the provider's patients and to challenge the failure of the MCE to cover a specific service.

(2) The MCE's requirements regarding the submission and processing of prior authorization requests including:

(a) A list of the benefits, if any, that require prior authorization approval from the MCE;

(b) The process and format to be used in submitting such requests;

(c) The time frames in which the MCE must respond to such requests;

(d) Pursuant to the provisions of paragraph (A)(1) of this rule, how the provider will be notified of the MCE's decision regarding such requests; and

(e) Pursuant to the provisions of paragraph (A)(1) of this rule, the procedures to be followed in appealing the MCE's denial of a prior authorization request.

(3) The MCE's documentation, legibility, confidentiality, maintenance, and access standards for member medical records; including a member's right to amend or correct his or her medical record as specified in 45 C.F.R. 164.526 (October 1, 2021).

(4) The MCE's process and requirements for the submission of claims and the appeal of denied claims.

(5) The MCE's policies and procedures regarding what action the MCE may take in response to occurrences of undelivered, inappropriate, or substandard health care services, including the reporting of serious deficiencies to the appropriate authorities.

(6) The mutually agreed upon policies and procedures between the MCE and the provider that explains the provider's obligation to provide oral translation, oral interpretation, and sign language services to the MCE's members including:

(a) The provider's responsibility to identify those members who may require such assistance;

(b) The process the provider is to follow in arranging for such services to be provided;

(c) Information that members will not be liable for the costs of such services; and

(d) Specification of whether the MCE or the provider will be financially responsible for the costs of providing these services.

(7) The procedures that providers are to follow in notifying the MCE of changes in their practice,

including at a minimum:

(a) Address and phone numbers;

(b) Providers included in the practice;

(c) Acceptance of new patients; and

(d) Standard office hours.

(8) Specification of what service utilization and provider performance data the MCE will make available to providers.

(9) Specification of the healthchek components to be provided to eligible members as specified in Chapter 5160-14 of the Administrative Code.

(B) In addition to the information in paragraph (A) of this rule, a managed care organization (MCO) has to provide the following written information to providers:

(1) The MCO's expectations for primary care providers (PCPs), including triage obligations.

(2) A description of the MCO's care coordination and care management programs, and the role of the provider in those programs, including:

(a) The MCO's criteria for determining which members might benefit from care management;

(b) The provider's responsibility in identifying members who may meet the MCO's care management criteria; and

(c) The process for the provider to follow in notifying the MCO when such members are identified.

(3) The MCO's expectations regarding the submission and processing of requests for specialist referrals including:

(a) A list of the provider types, if any, that need prior authorization approval from the MCO;

(b) The process and format to be used in submitting prior authorization requests;

(c) How the provider will be notified of the MCO's decision regarding prior authorization requests; and

(d) The procedures to be followed in appealing the MCO's denial of prior authorization requests.

(C) An MCO must adopt practice guidelines and disseminate the guidelines to all affected providers, and upon request to members and pending members. These guidelines must:

(1) Be based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;

(2) Consider the needs of the MCO's members;

(3) Be adopted in consultation with contracting health care professionals; and

(4) Be reviewed and updated periodically, as appropriate.

(D) The MCE must have staff specifically responsible for resolving individual provider issues, including, but not limited to, problems with claims payment, prior authorizations and referrals. The MCE must provide written information to their contracting providers detailing how to contact these designated staff.