Ohio | Department of Medicaid

Mike DeWine, Governor
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TO: Contracted Medicaid Managed Care Plans
Contracted MyCare Ohio Plans

FROM: Roxanne Richardson, Deputy Director
Office of Managed Care

DATE: June 30, 2020

SUBJECT: Medical Necessity Reviews for Non-Covered Services and Prior Authorization Limitations

Many of the services listed as "non-covered services" in Appendix G.2 of the Medicaid managed care and MyCare Ohio provider agreements are covered when determined to be medically necessary. Prior to making a determination regarding coverage of a service, plans should review applicable OAC rules (e.g. 5160-1-61 as referenced below) and conduct a medical necessity review if appropriate. As a reminder, under Ohio's Early and Periodic Screening, Diagnostic and Treatment program (EPSDT), plans must review all requests for medical necessity for individuals under the age of 21.

OAC rule 5160-1-61 allows for payment of "non-covered services" when:

- The service is medically necessary;
- The service is not experimental;
- The service is provided to an individual who has received another service that is experimental in nature or that is performed for purposes of research or clinical trial; and
- The need for the non-experimental service did not arise solely because the individual received an experimental service or participated in research or a clinical trial.

The list of non-covered services in Appendix G is not considered all inclusive.

A non-covered code is a specific procedure code for a covered service that is not listed on one of the Ohio Department of Medicaid (ODM) fee schedules. The fact that a code is not on an ODM fee schedule does not mean that a specific service is non-covered. Plans must cover all codes listed on any fee-for-service (FFS) fee schedule and must consider covering codes beyond those listed on the FFS fee schedule. A non-covered code for a covered service may be covered by ODM FFS by using a miscellaneous code.

Per OAC rules 5160-26-03 and 5160-58-03, prior authorization is available for services on which a plan has placed a preidentified limitation to ensure the limitation may be exceeded when medically necessary, unless the plan's limitation is also a limitation for FFS Medicaid coverage. If a prior authorization request is received that exceed the plan's frequency limitation, the plan must determine if the request is medically necessary before issuing a denial. Subsequently, per ORC 5160.34 and appendix C of the provider agreement, the provider must also receive their own appeal rights separate from the member.