

- (c) Copies of any and all additional information that may support the provider's position.

The department or the medical review entity shall have thirty WORKING days from receipt of the request for reconsideration to issue a written decision accepting, modifying, or rejecting its previous determination.

- (2) The department will conduct an administrative review of the reconsideration decision if the provider submits its request within thirty days of that decision. A request for an administrative review must include:
- (a) A letter requesting a review of the reconsideration.
- (b) A statement as to why the provider believes that the reconsideration decision was in error.
- (c) Any further documentation supporting the provider's position.

The department shall have thirty WORKING days from receipt of the request for review to issue a final and binding decision.

(C) Reconsideration of inpatient hospital payments.

- (1) Except when the department's determination is based on a finding made by medicare, the proper application of rules 5101:3-2-071 and 5101:3-2-072 of the Administrative Code and the proper calculation of amounts (including source data used to calculate the amounts) determined in accordance with rules 5101:3-2-074 to 5101:3-2-077 are subject to the reconsideration process described in paragraph (B) of rule 5101:3-1-57 of the Administrative Code as follows:
- (a) Requests for reconsideration authorized by paragraph (C)(1) of this rule must be submitted to the department in writing. If the request for reconsideration involves a rate component or determination made at the beginning of the rate year, the request must be submitted within ninety

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days of the beginning of the rate year. If the request involves an adjustment or a determination made by the department after the beginning of the rate year, the request must be submitted within thirty days of the date the adjustment or determination was implemented. The request must include a statement as to why the provider believes that the rate component or determination was incorrect as well as all documentation supporting the provider's position.

- (b) The department shall have thirty days from receipt of the request for reconsideration to issue a final and binding decision.
- (2) When a medicare audit finding was used by the department in establishing a rate component and the finding is subsequently overturned on appeal, the provider may request reconsideration of the affected rate component. Such requests must be submitted to the department in writing prior to final settlement as described in paragraph (E) of rule 5101:3-2-24 of the Administrative Code and within thirty days of the date the hospital receives notification from medicare of the appeal decision. The request for reconsideration of a medicare audit finding that has been overturned on appeal must include all documentation that explains the appeal decision. The department shall have thirty days in which to notify the provider of its final and binding decision regarding the medicare audit finding.
- (3) Reconsideration may also be requested if a hospital believes that a claim or claims were paid in-error because of an incorrect DRG assignment or incorrect payment calculation. In such an instance, the hospital must resubmit the claim(s) for an adjustment as described in rule 5101:3-1-198 of the Administrative Code. Following the adjustment process, if the hospital continues to believe that the department's DRG assignment or payment calculation was in error, the provider may submit a written request for reconsideration that includes all documentation supporting the providers position. In this instance, the department shall have sixty days in which to notify the provider of its final and binding decision.

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- (D) State hearings for medicaid recipients whose claim for inpatient hospital services is denied.

Any recipient whose claim for inpatient hospital services is denied may request a state hearing in accordance with Chapter 5101:1-35 of the Administrative Code. The determination of whether outlier payments will be made or the amounts of outlier payments as described in rule 5101:3-2-079 of the Administrative Code is not a denial of a claim for inpatient hospital services. Similarly, the determination of amounts payable for inpatient hospital services involving readmissions or transfers is not a denial of a claim for inpatient hospital services.

- (E) The following items are not subject to the department's reconsideration process:

- (1) The use of the DRG classification system and the method of classification of discharges within DRGs.
- (2) The assignment of relative weights to DRGs based on the methodology set forth in rule 5101:3-2-073 of the Administrative Code.
- (3) The establishment of peer groups as set forth in rule 5101:3-2-072 of the Administrative Code.
- (4) The methodology used to determine prospective payment rates as described in rules 5101:3-2-074 to 5101:3-2-078 of the Administrative Code.
- (5) The methodology used to identify cost and day thresholds for services which may qualify for outlier payments as described in rule 5101:3-2-079 of the Administrative Code.
- (6) The formulas used to determine rates of payment for outliers, certain transfers and readmissions, and services subject to preadmission certification, as described, respectively, in rules 5101:3-2-079, 5101:3-2-0711 and 5101:3-2-40 to 5101:3-2-42 of the Administrative Code.
- (7) The peer group average cost per discharge for all hospitals except when the conditions detailed in paragraphs (C) to (C)(2)(b) of rule 5101:3-2-078 of the Administrative Code are met.

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- (8) Statewide calculations of the direct and indirect medical education threshold for allowable costs per intern and residents as described in rule 5101:3-2-077 of the Administrative Code and of the threshold for establishing which hospitals will be recognized as providing a disproportionate share of medicaid, general assistance, DISABILITY ASSISTANCE ~~medical (GAM)~~, and crippled children's services as described in rule 5101:3-2-075 of the Administrative Code.

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Certification: *James A. Walker*  
JUN 19 1992  
Date

Promulgated Under RC Chapter 119.

Statutory Authority RC Section 5111.02

Rule Amplifies RC Sections 5111.01 And 5111.02

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5101:3-2-0713            Utilization control.

- (A) The Ohio department of human services shall perform or shall require a medical review entity to perform utilization review for medicaid inpatient services regardless of the payment methodology used for reimbursement of those services. The nature of this program is described in paragraphs (A) to (E) of this rule. Utilization review of outpatient hospital services is described in paragraph (F) of this rule. For the purposes of this rule, "ODHS" means ODHS or its contractual designee. ODHS, during the course of its analyses, may request information or records from the hospital and may conduct on-site medical record reviews. Reviews shall be completed within twelve months of the payment date and in the case of interim payments described in rule 5101:3-2-0711 of the Administrative Code within twelve months after the last payment has been made. Paragraphs (C) to (D)(3) of this rule provide examples of reviews to be completed by ODHS.
- (B) ODHS shall review a minimum of two per cent of all admissions retrospectively. Admissions selected for review will be drawn from several categories including but not limited to those identified in paragraphs (C)(1) to (D)(3) of this rule.
- (1) While the nature of the review will vary depending on the category of admission, all admissions selected will be reviewed to determine whether care was medically necessary on an inpatient hospital basis as described in rule 5101:3-2-41 of the Administrative Code; to determine if the care was medically necessary as defined in rule 5101:3-2-02 of the Administrative Code; to determine whether the discharge occurred at a medically appropriate time, to assess the quality of care rendered as described in 42 CFR 456.3(b), and to assess compliance with 5101:3 of the Administrative Code.
- (2) If any of the cases reviewed for a hospital do not meet the conditions described in paragraph (B)(1) of this rule, then the department may deny payment or recoup payment beginning with the first inappropriate admission and/or discharge. In all instances, physicians will make any negative determination.

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- (3) If the diagnostic and/or procedural information on the claim form is found to be inconsistent with that found in the medical records in conjunction with the physician attestation, then changes may be made in the coding and payment may be adjusted as described in paragraph (D) (3) of this rule.
- (C) ODHS may include in its retrospective review sample the categories of admissions described in paragraphs (C) (1) to (D) (3) of this rule.
- (1) ODHS may review transfers as defined in rule 5101:3-2-02 of the Administrative Code. The purpose of the transfer review will be to examine the documented reasons for and appropriateness of the transfer. ODHS considers a transfer as appropriate if the transfer is required because the individual requires some treatment or care which is unavailable at the transferring hospital or if there are other exceptional circumstances that justify transfer. Because this provision addresses exceptional cases, it is impossible to delineate exact criteria to cover all possible circumstances. Cases will be individually considered by ODHS based on the merits of each case. If any of the hospital's transfer cases reviewed are found to be inappropriate transfers, then the department may intensify the review, including the addition of prepayment review and pretransfer certification. ODHS may deny payment to or recoup payment from a provider who has transferred patients inappropriately.
- (2) ODHS may review readmissions as readmissions are defined in rule 5101:3-2-02 of the Administrative Code. The purpose of readmission review is to determine if the readmission is appropriate. If the readmission is related to the first hospitalization, ODHS will determine if the readmission resulted from complications or other circumstances which arose because of an early discharge and/or other treatment errors. If the readmission is unrelated, ODHS will determine if the treatment or care provided during the readmission should have been provided during the first hospitalization. If it is determined the readmission was inappropriate, then any payment made for the separate admissions will be recouped. A new payment amount will be determined by collapsing any affected admissions into one payment.

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- (3) If the diagnostic and/or procedural information on the claim form is found to be inconsistent with that found in the medical records in conjunction with the physician attestation, then changes may be made in the coding and payment may be adjusted as described in paragraph (D)(3) of this rule.
- (C) ODHS may include in its retrospective review sample the categories of admissions described in paragraphs (C)(1) to (D)(3) of this rule.
- (1) ODHS may review transfers as defined in rule 5101:3-2-02 of the Administrative Code. The purpose of the transfer review will be to examine the documented reasons for and appropriateness of the transfer. ODHS considers a transfer as appropriate if the transfer is required because the individual requires some treatment or care which is unavailable at the transferring hospital or if there are other exceptional circumstances that justify transfer. Because this provision addresses exceptional cases, it is impossible to delineate exact criteria to cover all possible circumstances. Cases will be individually considered by ODHS based on the merits of each case. If any of the hospital's transfer cases reviewed are found to be inappropriate transfers, then the department may intensify the review, including the addition of prepayment review and pretransfer certification. ODHS may deny payment to or recoup payment from a provider who has transferred patients inappropriately.
- (2) ODHS may review readmissions as readmissions are defined in rule 5101:3-2-02 of the Administrative Code. The purpose of readmission review is to determine if the readmission is appropriate. If the readmission is related to the first hospitalization, ODHS will determine if the readmission resulted from complications or other circumstances which arose because of an early discharge and/or other treatment errors. If the readmission is unrelated, ODHS will determine if the treatment or care provided during the readmission should have been provided during the first hospitalization. If it is determined the readmission was inappropriate, then any payment made for the separate admissions will be recouped. A new payment amount will be determined by collapsing any affected admissions into one payment.

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- (3) ODHS may review claims for which outlier payments are made to determine if days or services were covered and were medically necessary. For outliers, review will be made to determine that all services were medically necessary, appropriately billed in terms of having actually been rendered, ordered by the physician, and not duplicatively billed. If it is determined that services were inappropriately billed or if days or services are determined to be noncovered or not medically necessary as described in rules 5101:3-2-02 and 5101:3-2-03 of the Administrative Code, recoupment of any overpayments will occur. Overpayments will be determined by calculating the difference between the amount paid and the amount which would be paid if the nonallowable or noncovered days or services were excluded from the claim.
- (4) ODHS may review admissions with short lengths of stay. Reviews in this category will be concentrated on those admissions with lengths of stay less than two days. Reviews will be conducted to determine if the inpatient stay was medically necessary to provide services or if the services rendered could have been provided in an outpatient setting using observation codes as described in rule 5101:3-2-21 of the Administrative Code.
- (5) ODHS shall review cases in which a denial letter has been issued by the hospital. In addition, ODHS shall review all cases in which the attending physician and/or recipient (or family member) disagrees with the hospital's decision and requests a review of the case. The hospital must send a copy of each denial letter to the department's medical review entity.
- (D) ODHS may review medical records to validate DRG assignment for any admission.
- (1) THE PHYSICIAN ATTESTATION PROCESS IS TO BE COMPLETED FOR THE MEDICAID PROGRAM BY FOLLOWING THE MEDICARE PROCEDURE FOR ATTESTATION AS DELINEATED IN 42 CFR 412.46.

~~The attending physician must shortly before, at the time of, or shortly after discharge, but before a claim is submitted, attest in writing to the principal diagnosis, secondary diagnosis, and names of procedures performed. This process is to be completed for the medicaid program by following the medicare procedure for attestation as delineated in 42 CFR 412.46 (a) and (b).~~

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- (2) DRG validation will be done on the basis of a review of medical records by verifying that the diagnostic and procedural coding used by the hospital is substantiated in these records.
- (3) If the diagnostic and procedural information on the claim form is found to be inconsistent with that found in the medical records in conjunction with the physician attestation, ODHS may correct the claim information and recalculate payment based on the appropriate DRG assignment. If the recalculation shows an overpayment was made to the hospital, the overpayment will be reconciled as an adjustment to the claim. In all instances, the information found in the medical record when used in conjunction with the physician attestation is controlling.
- (E) The preadmission certification program and medical necessity review as detailed in rules 5101:3-2-40 to 5101:3-2-42 of the Administrative Code shall be conducted in addition to the utilization review activities described in this rule.
- (F) Outpatient hospital services may also be reviewed by ODHS or its contractual designee to determine whether the care or services were medically necessary as defined in rule 5101:3-2-02 of the Administrative Code, to determine whether the services were appropriately billed, and to assess the quality of care rendered as described in 42 CFR 456.3(b).
- (G) Intensified reviews may result whenever ODHS identifies inappropriate admission or billing practices during reviews conducted in accordance with this rule.
- (H) Medical records must be maintained in accordance with 42 CFR 482.24. Records requested by ODHS for review must be supplied within thirty days of the request as described in rule 5101:3-1-172 of the Administrative Code. Failure to produce records within thirty days shall result in withholding or recoupment of medicaid payments.

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