

October 1, 1984 will be cost-settled on a prorated basis. Under this provision, the hospital submits a full fiscal year cost report in accordance with rule 5101:3-2-23 of the Administrative Code. Allowable costs for the portion of the reporting period prior to October 1, 1984 are determined as follows.

- (a) The department determines total allowable costs for the hospital's fiscal year in accordance with paragraphs (A) to (B)(3) of this rule.
  - (b) Based on the best available information submitted by the hospital and approved by the department, the department determines the per cent of total covered medicaid days for the reporting period which represent covered medicaid days applicable to dates of service prior to October 1, 1984.
  - (c) Allowable costs (as determined under paragraph (C)(1)(a) of this rule) are multiplied by the per cent of covered medicaid days determined under paragraph (C)(1)(b) of this rule. The resulting amount represents allowable medicaid costs for the portion of the hospital's fiscal year preceding October 1, 1984.
- (2) As identified in rule 5101:3-2-21 of the Administrative Code, certain outpatient services are no longer subject to reasonable cost reimbursement for services provided on and after July 1, 1988. Allowable costs for the portion of the hospital's reporting period prior to July 1, 1988 are determined in accordance with paragraph (B) of this rule and the provisions of rule 5101:3-2-20 of the Administrative Code.
- (D) Scope of audits for hospital services reimbursed on a prospective payment basis other than reasonable cost reimbursement.
- (1) For hospitals services subject to prospective payment, audit activities are undertaken for several purposes. For each cost-reporting period, cost reports are audited, following the criteria outlined in paragraphs (D)(1)(a) to (D)(1)(e) of this rule for the purpose of reaching interim and final settlement with a hospital. For determination of amounts related to indigent care adjustment provisions described in rule 5101:3-2-0715

TN No. 92-15 APPROVAL DATE 5-5-93

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TN No. 91-13 EFFECTIVE DATE 7-1-92

of the Administrative Code, audit steps will be performed following the criteria outlined in paragraph (D)(1)(h) of this rule. During years in which prospective payments are being rebased, additional activities such as those described in paragraphs (D)(1)(f) and (D)(1)(g) of this rule are undertaken to establish program costs used for the calculations described in rule 5101:3-2-074 of the Administrative Code. For hospital services identified in rule 5101:3-2-071 of the Administrative Code as being subject to prospective payment, desk or field audits of interim cost reports are performed to determine whether:

- (a) Services billed were provided;
- (b) Services billed were provided to persons eligible as medicaid recipients on the date(s) services were rendered;
- (c) Services billed are covered under the medicaid program in accordance with Chapter 5101:3-2 of the Administrative Code;
- (d) Payments made under medicaid are, in the aggregate on a statewide basis, equal to or less than amounts which would have been recognized under Title XVIII (medicare) for comparable services and on a hospital-specific basis equal to or less than the provider's customary and prevailing charges for comparable services in accordance with 42 CFR 447.253;
- (e) Amounts of third-party payments reported to the department as described in rules 5101:3-1-08 and 5101:3-2-25 of the Administrative Code reflect the actual amounts received;
- (f) Costs reported to the department represent actual incurred, reasonable, and allowable costs in accordance with rule 5101:3-2-22 of the Administrative Code; and
- (g) Medicaid discharges and associated charges and days as reported on the cost report are consistent with those reflected for the same period in the ODHS paid claims history. In cases where data submitted by the hospital on the cost report are inconsistent

TN No. 92-15 APPROVAL DATE 5-5-93

SUPERSEDES

TN No. 91-13 EFFECTIVE DATE 7-6-92

with data in the ODHS paid claims data file, the cost report is subject to adjustment as described in paragraph (D)(2) of this rule. Inconsistencies subject to adjustment include, but are not limited to:

- (i) Submitted discharges lower than those in the ODHS paid claims data file.
  - (ii) Submitted charge-to-day ratio lower than that in the ODHS paid claims data file.
  - (iii) Submitted charges lower than those in the ODHS paid claims data file.
  - (iv) Other inconsistencies that require analysis and auditor judgment to determine the appropriate type of adjustment.
- (h) Amounts related to indigent care adjustments described in rule 5101:3-2-0715 of the Administrative Code were based upon data described in rule 5101:3-2-0715 of the Administrative Code.
- (2) For hospitals subject to prospective payment for inpatient services, the audits may result in the following adjustments:
- (a) If the review identified in paragraphs (D)(1)(g)(i) to (D)(1)(g)(iv) of this rule indicates that the cost report reflects fewer medicaid discharges and/or a discrepancy exists between reported medicaid charges and those reflected in the ODHS paid claims data file, the interim cost report may be adjusted to reflect inpatient days, charges, and discharge counts from the ODHS paid claims data file.
  - (b) If the reviews identified in paragraphs (D)(1)(a) to (D)(1)(c) and (D)(1)(e) of this rule indicate that inappropriate charges were attributed to medicaid program charges in the cost report, the interim cost report will be adjusted to remove such charges.

TN No. 92-15 APPROVAL DATE 5-5-93  
SUPERSEDES  
TN No. 91-13 EFFECTIVE DATE 7-1-92

(c) If the review described in paragraph (D)(1)(f) of this rule identifies that nonallowable disallowed costs were included in the cost report, the interim cost report will be adjusted to remove such costs.

(3) Other adjustments provided by the medicare fiscal intermediary, either tentative or final, and supplied to the department as of September 1, 1987, will be incorporated into the interim cost report described in paragraph (D) of rule 5101:3-2-074 of the Administrative Code. Federal audit findings submitted to the department after that time will be implemented as described in rule 5101:3-2-078 of the Administrative Code if the affected rate has been in effect for less than two prospective rate periods following implementation of rebased rate components and if the department notifies the affected hospital of the audit finding within thirty days of receipt of the finding. Hospitals may request reconsideration of the adjustment within thirty days of notification following the procedures outlined in rule 5101:3-2-0712 of the Administrative Code.

(4) Overpayments determined as a result of findings made under the provisions of paragraphs (D)(1)(a) to (D)(1)(e) of this rule will be collected by the department.

(E) Interim and final settlement

(1) Any adjustments described in paragraphs (D)(2) and (D)(3) of this rule will be reflected in the interim or final settlement cost report. Overpayments or underpayments, as described in paragraphs (D)(1)(a) to (D)(1)(d) of this rule, will be collected by the department at settlements based upon findings associated with the cost-reporting period being settled. Retrospective adjustments to payment rates as described in rule 5101:3-2-078 of the Administrative Code that are identified prior to interim settlement will be incorporated into interim settlement in instances when such adjustments to payment rates affect payments for discharges occurring during the cost-reporting period being settled.

TN No. 92-15 APPROVAL DATE 5-5-93

SUPERSEDES

TN No. 91-13 EFFECTIVE DATE 7-1-92

- (2) Final settlement constitutes the implementation of the final fiscal audit for a cost-reporting period.
- (a) Any adjustments not incorporated into interim settlement and all applicable retrospective adjustments to payment rates in effect for discharges occurring during the cost-reporting period will be incorporated into final settlement for that cost-reporting period.
- (b) ANY PENDING REQUEST FOR RECONSIDERATION FILED PURSUANT TO PARAGRAPHS (B) AND (C) OF RULE 5101:3-2-0712 OF THE ADMINISTRATIVE CODE WILL BE INCORPORATED INTO FINAL SETTLEMENT.
- ~~Any pending request for reconsideration filed pursuant to paragraph (C) of rule 5101:3-2-0712 of the Administrative Code or any final administrative decision to which an objection has been filed pursuant to paragraph (C)(8) of rule 5101:3-2-0712 of the Administrative Code will be incorporated into final settlement.~~
- (c) If a hospital has an outstanding medicare appeal that has not been resolved and that could affect settlement of hospital-specific rate components, the hospital may accept, with reservations, final settlement incorporating adjustments not based on unresolved medicare audit exceptions and hold open that portion of the settlement, with all rights to appeal under Chapter 119. of the Revised Code, based on unresolved medicare audit exceptions.
- (d) In no instance will adjustments to rates that were in effect during the period covered by final settlement be made following final settlement, and only components of rates that are based solely on hospital-specific data are subject to recalculation and adjustment after such rates have been in effect for two prospective payment periods following the implementation of rebased rate components.

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Date

Promulgated Under RC Chapter 119.

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Rule Amplifies RC Sections 5111.01 and 5111.02

Prior Effective Dates: 4/7/77, 10/1/84, 7/3/86, 10/19/87,  
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5101:3-2-25 THIRD-PARTY LIABILITY.

RULE 5101:3-1-08 OF THE ADMINISTRATIVE CODE SETS FORTH GENERAL PROVISIONS REGARDING REQUIREMENTS THAT THE DEPARTMENT MAKE PAYMENT FOR COVERED SERVICES ONLY AFTER ANY AVAILABLE THIRD-PARTY BENEFITS ARE EXHAUSTED. IN ADDITION TO THOSE GENERAL PROVISIONS, THIS RULE IDENTIFIES OTHER REQUIREMENTS APPLICABLE TO SERVICES PROVIDED BY HOSPITALS.

- (A) ALL HOSPITALS ARE TO UTILIZE THIRD-PARTY RESOURCES FOR ALL SERVICES A RECIPIENT RECEIVES WHILE IN THE HOSPITAL. IF A HOSPITAL RECEIVES REIMBURSEMENT FROM A THIRD-PARTY SUBSEQUENT TO SUBMITTING A CLAIM OR SUBSEQUENT TO RECEIVING PAYMENT FROM THE DEPARTMENT, THE HOSPITAL IS TO REPAY THE DEPARTMENT BY SUBMITTING A CLAIM ADJUSTMENT. PATIENT LIABILITIES ASSOCIATED WITH PERSONS ELIGIBLE FOR MEDICAID UNDER SPEND-DOWN PROVISIONS (SEE CHAPTER 5101:1-39 OF THE ADMINISTRATIVE CODE) ARE CONSIDERED A THIRD-PARTY RESOURCE. BENEFITS AVAILABLE UNDER THE TITLE XVIII MEDICARE PROGRAM, PART A AND PART B, ARE CONSIDERED A THIRD-PARTY RESOURCE, INCLUDING MEDICARE PART A LIFETIME RESERVE DAYS.
- (B) THE FOLLOWING PAYMENT PROVISIONS APPLY WHEN BILLING FOR SERVICES PROVIDED TO MEDICAID ELIGIBLES HAVING AVAILABLE RESOURCES.
- (1) IF A RECIPIENT IS ENTITLED TO MEDICARE BENEFITS, THE DEPARTMENT PAYS THE AMOUNT OF THE MEDICARE DEDUCTIBLE AND COINSURANCE MINUS ANY OTHER RESOURCES AVAILABLE TO THE RECIPIENT FOR HOSPITAL SERVICES. IF A PATIENT WHO IS JOINTLY ELIGIBLE FOR MEDICARE AND MEDICAID EXHAUSTS MEDICARE BENEFITS WHILE HOSPITALIZED, AND THE PATIENT'S HOSPITALIZATION EXCEEDS THE APPLICABLE MEDICARE THRESHOLD CRITERIA IN ACCORDANCE WITH 42 CFR 405.475(b), THE DEPARTMENT WILL PAY THE DIFFERENCE BETWEEN THAT AMOUNT PAYABLE BY MEDICARE AND THE AMOUNT THAT WOULD BE PAYABLE BY MEDICAID IF THE HOSPITALIZATION WERE BILLED, IN ITS ENTIRETY, TO THE DEPARTMENT AS A MEDICAID-ONLY CLAIM. THE AMOUNT THAT WOULD BE PAYABLE BY MEDICAID IS EITHER THE APPLICABLE DRG PROSPECTIVE PAYMENT OR THE PAYMENT APPLICABLE FOR SERVICES REIMBURSED ON A REASONABLE COST BASIS AS DESCRIBED IN PARAGRAPH (B)(2) OF THIS RULE.
- (2) IF A RECIPIENT IS ENTITLED TO HOSPITAL INSURANCE BENEFITS OTHER THAN MEDICARE, THE DEPARTMENT PAYS EITHER THE APPLICABLE DRG PROSPECTIVE PAYMENT (SEE RULES 5101:3-2-07 TO 5101:3-2-074 AND 5101:3-2-076 TO 5101:3-2-0713 OF THE ADMINISTRATIVE CODE) OR THE PAYMENT APPLICABLE FOR SERVICES REIMBURSED ON A REASONABLE COST BASIS (SEE RULE 5101:3-2-22 OF THE ADMINISTRATIVE CODE), MINUS ANY RESOURCES AVAILABLE TO THE PATIENT FOR HOSPITAL SERVICES. SUCH RESOURCES INCLUDE MEDICARE PART B PAYMENTS AND PATIENT LIABILITIES ASSOCIATED WITH PERSONS ELIGIBLE ON A SPEND-DOWN BASIS AS DESCRIBED IN PARAGRAPH (A) OF THIS RULE. IF THE RESOURCES AVAILABLE TO A RECIPIENT EQUAL OR EXCEED AMOUNTS PAYABLE IN ACCORDANCE WITH THIS PARAGRAPH, THE DEPARTMENT MAKES NO PAYMENT FOR THE HOSPITAL SERVICES.

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Supersedes \_\_\_\_\_ Date Appr. 7/26/85  
State Rep. In. \_\_\_\_\_ Date Eff. 10/1/84

EFFECTIVE DATE: \_\_\_\_\_

CERTIFICATION: \_\_\_\_\_

\_\_\_\_\_  
DATE

PROMULGATED UNDER REVISED CODE CHAPTER 119.  
STATUTORY AUTHORITY REVISED CODE SECTION 5111.02

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5101:3-2-30 Multi-tiered charge level for certain outpatient hospital services.

- (A) Notwithstanding provisions of rule 5101:3-2-22 of the Administrative Code, for emergency room and other outpatient services which include a facility fee, hospitals must establish a minimum of two charge levels for the facility charge component. The differential between the highest and lowest charge level must be at least fifty per cent.
- (B) This rule is not applicable to out-of-state hospitals or to hospitals whose gross billings for outpatient services provided to medicaid patients do not exceed one per cent of total gross billings for outpatient services in the most recent cost reporting period.
- (C) Hospitals may apply for a waiver of this provision in instances when, because of subsidies or other unusual circumstances, the level of a single charge for such services is sufficiently low to negate the cost-containment effect inherent in applying multiple charge levels. Requests for any such waivers must contain documentation adequate to demonstrate that the granting of a waiver will not adversely affect medicaid program expenditures.

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Certification: \_\_\_\_\_

\_\_\_\_\_  
Date

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5101:3-2-40 PRE-CERTIFICATION REVIEW.

THIS RULE DESCRIBES THE PRE-CERTIFICATION REVIEW PROGRAM FOR INPATIENT AND OUTPATIENT SERVICES. FOR THE MEDICAL/SURGICAL PRE-CERTIFICATION PROGRAM, PARAGRAPHS (A) TO (C) AND (E) TO (G) OF THIS RULE ARE TO BE USED. FOR THE PSYCHIATRIC PRE-CERTIFICATION PROGRAM, PARAGRAPHS (A)(12), (B) AND (D) TO (G) OF THIS RULE ARE TO BE USED.

(A) DEFINITIONS.

- (1) AN "EMERGENCY ADMISSION" IS AN ADMISSION TO TREAT A CONDITION REQUIRING MEDICAL AND/OR SURGICAL TREATMENT WITHIN THE NEXT FORTY-EIGHT HOURS WHEN, IN THE ABSENCE OF SUCH TREATMENT, IT CAN REASONABLY BE EXPECTED THAT THE PATIENT MAY SUFFER UNBEARABLE PAIN, PHYSICAL IMPAIRMENT, SERIOUS BODILY INJURY OR DEATH.
- (2) "DIAGNOSTIC SERVICES" IS DEFINED IN PARAGRAPH (B) OF RULE 5101:3-2-02 OF THE ADMINISTRATIVE CODE.
- (3) "MEDICALLY NECESSARY SERVICES" IS DEFINED IN PARAGRAPH (B) OF RULE 5101:3-2-02 OF THE ADMINISTRATIVE CODE.
- (4) "STANDARDS OF MEDICAL PRACTICE" ARE NATIONALLY RECOGNIZED PROTOCOLS FOR DIAGNOSTIC AND THERAPEUTIC CARE. THESE PROTOCOLS ARE APPROVED BY THE MEDICAID PROGRAM AND ARE UPDATED ANNUALLY. THE STANDARDS OF MEDICAL PRACTICE WILL BE MAILED TO ALL PROVIDERS THIRTY DAYS IN ADVANCE OF REQUIRING PRE-CERTIFICATION.
- (5) AN "ELECTIVE ADMISSION" IS ANY ADMISSION THAT DOES NOT MEET THE EMERGENCY ADMISSION DEFINITION IN PARAGRAPH (A)(1) OF THIS RULE.
- (6) "ELECTIVE CARE" IS MEDICAL OR SURGICAL TREATMENT THAT MAY BE POSTPONED FOR AT LEAST FORTY-EIGHT HOURS WITHOUT CAUSING THE PATIENT UNBEARABLE PAIN, PHYSICAL IMPAIRMENT, SERIOUS BODILY INJURY OR DEATH.
- (7) FOR PURPOSES OF THIS RULE, A "HOSPITAL" IS A PROVIDER ELIGIBLE UNDER RULE 5101:3-2-01 OF THE ADMINISTRATIVE CODE.
- (8) "PRE-ADMISSION TESTING" IS TESTING THAT CAN BE COMPLETED PRIOR TO AN ADMISSION.

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