CSI - Ohio

The Common Sense Initiative

Business Impact Analysis

Agency Name: Ohio Department of Medicaid

Regulation/Package Title: BHPP Hospital Utilization Review

Rule Number(s): 5160-2-07.12, 5160-2-07.13, 5160-2-40

Date:

Rule Type:

- ☐ **New**
- ☐ **Amended**
- X **5-Year Review**
- ☐ **Rescinded**

The Common Sense Initiative was established by Executive Order 2011-01K and placed within the Office of the Lieutenant Governor. Under the CSI Initiative, agencies should balance the critical objectives of all regulations with the costs of compliance by the regulated parties. Agencies should promote transparency, consistency, predictability, and flexibility in regulatory activities. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.

Regulatory Intent

1. **Please briefly describe the draft regulation in plain language.**
   Please include the key provisions of the regulation as well as any proposed amendments.

   Rule 5160-2-07.12 sets forth the process for requesting reconsideration after a utilization review of inpatient or outpatient hospital services by the Department or its medical review entity. The rule is being proposed for five-year rule review. The proposed changes are updates of references to Ohio Administrative Code (OAC), the addition of clarifying language, and the removal of the allowance of reconsideration based upon disagreement with assignment of a diagnostic related group.

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Rule 5160-2-07.13 sets forth the nature and timelines of utilization reviews conducted on inpatient and outpatient hospital services by the Department or its contracted medical review entity as required by 42 C.F.R. 456.3, effective as of October 1, 2013. The rule is being proposed for five-year rule review. The proposed changes are the addition of language formerly located in OAC 5160-2-04 around utilization review expectations regarding the justification of amounts billed by hospitals for take-home drugs, updates to OAC rule and agency references, adding date references to Code of Federal Regulations references, and updating the rule structure to improve readability.

Rule 5160-2-40 describes the pre-certification review program for inpatient services. The rule is being proposed for five-year rule review. The proposed changes are updates to OAC rule and agency references, the addition of clarifying language and updating the rule structure to improve readability. Additionally, the psychiatric precertification request period is being increased to two business days from the date of admission.

2. **Please list the Ohio statute authorizing the Agency to adopt this regulation.**

   5164.02

3. **Does the regulation implement a federal requirement?** Yes. **Is the proposed regulation being adopted or amended to enable the state to obtain or maintain approval to administer and enforce a federal law or to participate in a federal program?** Yes.
   If yes, please briefly explain the source and substance of the federal requirement.

   As the state Medicaid agency, the Department is required by 42 C.F.R 456.3 to implement a utilization control program that does the following: safeguards against unnecessary or inappropriate use of Medicaid services and against excess payments; assesses the quality of services provided; provides for the control of the utilization of all services provided under the plan in accordance with 42 C.F.R. 456.3 subpart B, and provides for the control of the utilization of inpatient services in accordance with subparts C through I.

4. **If the regulation includes provisions not specifically required by the federal government, please explain the rationale for exceeding the federal requirement.**

   The federal regulation does not specifically delineate how utilization control is to operate. The rules in this packet merely put a process around implementing the generally stated federal requirement.

5. **What is the public purpose for this regulation (i.e., why does the Agency feel that there needs to be any regulation in this area at all)?**

   The public purpose for these rules is to safeguard Medicaid resources against unnecessary or inappropriate use of Medicaid services and excess payments, assure beneficiary access to

quality hospital services and to ensure that that hospitals and Managed Care plans will be informed of Medicaid policy regarding utilization control.

6. **How will the Agency measure the success of this regulation in terms of outputs and/or outcomes?**

   The federally mandated Utilization Review program is not new, and the measureable outcome in financial terms is the recovery of state payments for unsupported hospital services of approximately $30 million annually.

Development of the Regulation

7. **Please list the stakeholders included by the Agency in the development or initial review of the draft regulation.**
   If applicable, please include the date and medium by which the stakeholders were initially contacted.

   All stakeholders will initially be notified through the clearance review process. Monthly meetings between the Ohio Hospital Association (OHA), Ohio Children's Hospital Association (OCHA), and the Ohio Department of Medicaid will also be used to review the draft rules. Comments received during these processes will be used to refine the draft rules. This section will be updated based on comments received during these processes.

8. **What input was provided by the stakeholders, and how did that input affect the draft regulation being proposed by the Agency?**

   No comments were received during the clearance review process.

9. **What scientific data was used to develop the rule or the measurable outcomes of the rule? How does this data support the regulation being proposed?**

   Not applicable.

10. **What alternative regulations (or specific provisions within the regulation) did the Agency consider, and why did it determine that these alternatives were not appropriate? If none, why didn't the Agency consider regulatory alternatives?**

    None. The rules are a result of a federal mandate.

11. **Did the Agency specifically consider a performance-based regulation? Please explain.**
    Performance-based regulations define the required outcome, but don't dictate the process the regulated stakeholders must use to achieve compliance.

    No. The utilization control process is quite complicated and descriptive rules are required to implement the process.

12. **What measures did the Agency take to ensure that this regulation does not duplicate an existing Ohio regulation?**

The agency reviewed the regulations cited within the rules and reduced duplication when possible by referring readers to other existing rules. Ohio Administrative Code (OAC) rule 5160-2-07.13 is the only regulation that implements a utilization review program on hospitals. OAC rule 5160-2-07.12 is the only rule that gives hospitals appeal rights for determinations made as a result of utilization review. OAC 5160-2-40 is the only rule that addresses precertification for the delivery of services in a less cost effective setting due to individual circumstances such as severity of illness and medical necessity.

13. **Please describe the Agency's plan for implementation of the regulation, including any measures to ensure that the regulation is applied consistently and predictably for the regulated community.**

The hospital utilization review program is not a new program. The Ohio Department of Medicaid contracts with an independent medical review entity to perform utilization review of Medicaid inpatient services regardless of the payment methodology used for reimbursement of those services.

OAC 5160-2-07.13 clearly indicates for the reviewing entity the areas to be reviewed, the sources of review materials and the time period for review. This regulation requires all reviews to be completed within 12 months of the payment date, or, in the case of interim payments, within 12 months after the last payment has been made. To minimize the burden on a specific set of providers or line of business and protect the interests of Ohio tax payers, Ohio Medicaid's independent review entity selects a stratified, random sample of admissions for review from several different categories, including: transfers, readmissions, claims for which outlier payments were made, admissions with short lengths of stay, and DRG assignment.

For all admissions selected, medical records and physician attestation are reviewed along with the diagnostic and procedural information on the claim to determine appropriateness of coding, medical necessity, medical appropriateness of discharge, and quality of care rendered. Outpatient hospitals are also reviewed to determine whether the care or services were medically necessary.

In cases where the care is found to be medically necessary and appropriate, but the coding is incorrect, providers are allowed to resubmit their claims with correct coding. Additionally, providers may contest determinations made during utilization review. The process for doing so is also outlined in Ohio Administrative Code to ensure consistency across providers.

OAC 5160-2-07.12 outlines the process for Departmental reconsideration regarding decisions made during utilization review.

OAC 5160-2-40 describes the Department's policy regarding requests to perform procedures traditionally provided in an outpatient setting in the more expensive inpatient setting. All providers who think that an inpatient rather than outpatient setting is more clinically

appropriate, must electronically submit a precertification request along with documentation demonstrating the medical necessity of performing the procedure in the more costly setting.

The procedures requiring precertification are published by the Department or its designee and nationally recognized protocols for diagnostic and therapeutic care based on severity of illness and intensity of services are used as standards of medical practice by the Department in determining appropriateness of service setting. The Department notifies all hospital providers of these standards and any changes to them.

Adverse Impact to Business

14. Provide a summary of the estimated cost of compliance with the rule. Specifically, please do the following:

a. Identify the scope of the impacted business community;

This regulation impacts all hospitals enrolled as Ohio Medicaid providers.

Identify the nature of the adverse impact (e.g., license fees, fines, employer time for compliance); and

The utilization review program is not a new program. We have indicated an adverse impact on hospitals since hospitals must submit additional information to support the payments they have received from the Medicaid program. Documentation related to precertification, utilization review, and appeals includes medical records and other supporting documentation. These may increase staff time.

b. Quantify the expected adverse impact from the regulation.
The adverse impact can be quantified in terms of dollars, hours to comply, or other factors; and may be estimated for the entire regulated population or for a "representative business." Please include the source for your information/estimated impact.

If there is an adverse impact, it is expected to be negligible due to the fact that any increased provision of documentation will be offset by good clinical practice associated with a complete clinical record. This review should also result in improved health outcomes for Medicaid beneficiaries.

15. Why did the Agency determine that the regulatory intent justifies the adverse impact to the regulated business community?

Medical providers keep medical records as part of good medical practice. The regulatory intent and fiscal responsibility of ensuring medical necessity and appropriateness of the provision of services and hospital admissions offsets any cost associated with the provision of medical records to the Department or its medical review entity.

Regulatory Flexibility

16. Does the regulation provide any exemptions or alternative means of compliance for small businesses? Please explain.

No. This regulation is a federal mandate. Documentation of medical necessity and clinical appropriateness can be obtained from existing medical records.

17. How will the agency apply Ohio Revised Code section 119.14 (waiver of fines and penalties for paperwork violations and first-time offenders) into implementation of the regulation?

There are no fines or penalties associated with the implementation of these rules.

18. What resources are available to assist small businesses with compliance of the regulation? Smaller hospitals may be part of the random sample selected for review. The Department's medical review entity, Permedion, may assist the hospital by conducting an on-site medical record review. The Permedion website can be accessed by providers at www.hmspermedion.com. Providers may also email questions or concerns to Ohio Department of Medicaid at Hospital_Policy@medicaid.ohio.gov.

DRAFT - NOT FOR FILING

5160-2-07.12 Appeals and reconsideration of departmental determinations regarding hospital inpatient and outpatient services.

(A) General.

Pursuant to rules ~~5101:3-1-57~~5160-1-57 and 5101:6-50-01 of the Administrative Code, final settlements that are based upon final audits by the department may be appealed by hospitals ~~may appeal~~ under Chapter 119. of the Revised Code ~~final settlements that are based upon final audits by the department~~. Rule ~~5101:3-2-24~~5160-2-24 of the Administrative Code describes final fiscal audits and final settlements performed by the department. Rules ~~5101:3-1-29~~5160-1-29 and ~~5101:3-1-27~~5160-1-27 of the Administrative Code describe the audits performed by the department~~'s surveillance and utilization review section,~~ which ~~are also~~may be appealable under Chapter 119. of the Revised Code. Since the scope and substance of these two types of audits differ, in no instance will the conduct and implementation of one type of audit preclude the conduct and implementation of the other.

(B) Utilization review reconsideration.

Pursuant to rule ~~5101:3-2-07.13~~5160-2-07.13 of the Administrative Code, the department or a medical review entity under contract to the department may make determinations regarding utilization review in accordance with the standards set forth in rules ~~5101:3-2-02~~5160-1-01, 5160-2-02, ~~5101:3-2-07.9~~5160-2-65, ~~5101:3-2-07.13~~5160-2-07.13, and ~~5101:3-2-40~~5160-2-40 of the Administrative Code. These determinations are subject to the reconsideration process described in rule ~~5101:3-1-57~~5160-1-57 of the Administrative Code as follows:

(1) A written request for a reconsideration must be submitted to the department or the medical review entity, whichever made the initial determination as indicated by the denial letter, within sixty calendar days of the date of the determination. The department or the medical review entity shall have thirty ~~working~~business days from receipt of the request for reconsideration to issue a ~~written~~ final and binding decision accepting, modifying, or rejecting its previous determination. The request for reconsideration must include:

(a) A copy of the written determination;

(b) A copy of the patient's medical record (if not already submitted to the review entity); and

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

(2) The department will conduct an administrative review of the reconsideration decision if the provider submits its request within thirty calendar days of that decision. The department shall have thirty ~~working~~business days from receipt of the request for review to issue a final and binding 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; and

(c) Any further documentation supporting the provider's position.

(3) The department may extend time frames described in paragraphs (B)(1) and (B)(2) of this rule, where adherence to time frames causes exceptional hardships to a large number of hospitals or where adherence to time frames as described in paragraphs (B)(1) and (B)(2) of this rule causes exceptional hardship to a hospital because potential determinations constitute a large portion of that hospital's total medicaid business.

(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~~rule ~~5101:3-2-07.1 and 5101:3-2-07.2~~5160-2-65 of the Administrative Code and the proper calculation of amounts (including source data used to calculate the amounts) determined in accordance with rules ~~5101:3-2-07.4,~~ ~~5101:3-2-07.6~~5160-2-07.6, and ~~5101:3-2-07.7~~5160-2-07.7 of the Administrative Code are subject to the reconsideration process described in rule ~~5101:3-1-57~~5160-1-57 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 calendar 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 calendar 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 business 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 rule ~~5101:3-2-24~~5160-2-24 of the Administrative Code and within thirty calendar 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 business 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 (diagnosis related groups) assignment or incorrect payment calculation. In such an instance, the hospital must resubmit the claim(s) for an adjustment as described in rule 5101:3-1-19.8 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.~~

(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 division 5101:6 of the Administrative Code. The determination of whether outlier payments will be made or the amounts of outlier payments as described in rule ~~5101:3-2-07.9~~5160-2-65 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 Diagnosis related groups (DRG) classification system and the method of classification of discharges within DRGs.

(2) The assignment of DRGs and Severity of Illness (SOI).

~~(2)~~ (3) The assignment of relative weights to DRGs based on the methodology set forth in rule ~~5101:3-2-07.3~~5160-2-65 of the Administrative Code.

~~(3)~~ (4) The establishment of peer groups as set forth in rule ~~5101:3-2-07.2~~5160-2-65 of the Administrative Code.

~~(4)~~ (5) The methodology used to determine prospective payment rates as described in rules ~~5101:3-2-07.4~~5160-2-65 ~~and 5101:3-2-07.6 to 5101:3-2-07.8~~ of the Administrative Code.

~~(5)~~ (6) The methodology used to identify cost and day thresholds for services that may qualify for outlier payments as described in rule ~~5101:3-2-07.9~~ 5160-2-65 of the Administrative Code.

~~(6)~~ (7) 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 ~~5101:3-2-07.9~~5160-2-65~~,~~ ~~5101:3-2-07.11,~~ and ~~5101:3-2-40~~ 5160-2-40 of the Administrative Code.

~~(7)~~ (8) The peer group average cost per discharge for all hospitals except when the conditions detailed in rule ~~5101:3-2-07.8~~ 5160-2-65 of the Administrative Code are met.

~~(8)~~ (9) Statewide calculations of the direct and indirect medical education threshold for allowable costs per intern and resident as described in rule ~~5101:3-2-07.7~~5160-2-07.7 of the Administrative Code and of the threshold for establishing which hospitals will be recognized as providing a disproportionate share of indigent care as described in rule ~~5101:3-2-07.5~~5160-2-07.5 of the Administrative Code.

DRAFT - NOT FOR FILING

5160-2-07.13 Utilization control.

(A) The Ohio department of ~~job and family services~~ medicaid (ODM) 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, ~~"ODJFS" means ODJFS or its contractual designee~~. ~~ODJFS~~"ODM" means ODM or its contracted medical review entity.~~,~~ ~~during~~During the course of its analyses, ODM 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 5101:3-2-07.11 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 ODJFS.~~

Reviews shall be completed within twelve months of the payment date and in the case of interim payments described in rule 5160-2-65 of the Administrative Code within twelve months after the last payment has been made.

(1) The nature of the utilization review program for medicaid inpatient services is described in paragraphs (A) to (E) of this rule. Paragraphs (C) to (D)(3) of this rule provide examples of reviews to be completed by ODM.

(2) Utilization review of outpatient hospital services is described in paragraph (F) of this rule.

(B) ~~ODJFS~~ODM 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; to determine if the care was medically necessary as defined in rule ~~5101:3-2-02~~5160-1-01 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 C.F.R. 456.3(b), in effect as of October 1, 2013, and to assess compliance with agency ~~division 5101:3-~~ 5160 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 ~~ODJFS~~ODM may deny payment or recoup payment beginning with the first inappropriate admission and/or discharge. Any negative determinations must be made by a physician.

(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) ~~ODJFS~~ ODM may include in its retrospective review sample the categories of admissions described in paragraphs (C)(1) to (D)(3) of this rule.

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(1) ~~ODJFS~~ODM may review transfers as defined in rule ~~5101:3-2-02~~5160-2-02 of the Administrative Code. The purpose of the transfer review will be to examine the documented reasons for and appropriateness of the transfer. ~~ODJFS~~ODM considers a transfer as appropriate if the transfer is required because the individual requires some treatment or care that 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 ODJFS based on the merits of each case. If any of the hospital's transfer cases reviewed are found to be inappropriate transfers, then ODJFS may intensify the review, including the addition of prepayment review and pretransfer certification. ODJFS may deny payment to or recoup payment from a provider who has transferred patients inappropriately.~~

Because this provision addresses exceptional cases, it is impossible to delineate exact criteria to cover all possible circumstances. Cases will be individually considered by ODM based on the merits of each case. If any of the hospital's transfer cases reviewed are found to be inappropriate transfers, then ODM may intensify the review, including the addition of prepayment review and pretransfer certification. ODM may deny payment to or recoup payment from a provider who has transferred patients inappropriately.

(2) ~~ODJFS~~ ODM may review readmissions to determine if the ~~as readmissions are~~ readmission as defined in rule ~~5101:3-2-02~~5160-2-02 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, ODJFS will determine if the readmission resulted from complications or other circumstances that arose because of an early discharge and/or other treatment errors. If the readmission is unrelated, ODJFS 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.~~

(a) If the readmission is related to the first hospitalization, ODM will determine if the readmission resulted from complications or other circumstances that arose because of an early discharge and/or other treatment errors.

(b) If the readmission is unrelated, ODM will determine if the treatment or care provided during the readmission should have been provided during the first hospitalization.

(c) 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.

(3) ~~ODJFS~~ODM 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 based on services 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~~ 5160-1-01 and ~~5101:3-2-03~~5160-2-03 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 that would be paid if the nonallowable or noncovered days or services were excluded from the claim.

(4) ~~ODJFS~~ ODM may review admissions with short lengths of stay. Reviews in this category will be concentrated on any admission with a length of stay greater than two standard deviations below the mean length of stay for the DRG (diagnosis related groups) of that admission. This is based on the distribution, by DRG, of lengths of stay of admissions in Ohio medicaid inpatient claims. 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~~5160-2-21 of the Administrative Code.

(5) ~~ODJFS~~ ODM shall review cases in which a denial letter has been issued by the hospital. In addition, ~~ODJFS~~ ODM 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 ~~ODJFS's~~ODM's medical review entity.

(D) ~~ODJFS~~ODM 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 C.F.R. 412.46, in effect as of October 1, 2012.

(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, the provider must submit a corrected claim reflecting this information.~~ODJFS 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) Pre-certification review as detailed in rule ~~5101:3-2-40~~5160-2-40 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 ~~ODJFS~~ ODM to determine whether the care or services were medically necessary as defined in rule ~~5101:3-2-02~~5160-1-01 of the Administrative Code, to determine whether the services were appropriately billed, and to assess the quality of care rendered as described in 42 C.F.R. 456.3(b), in effect as of October 1, 2013.

(G) Intensified reviews may result whenever ~~ODJFS~~ ODM identifies inappropriate admission or billing practices during reviews conducted in accordance with this rule. These reviews may periodically result in the requirement that hospitals produce evidence of invoice costs supporting amounts billed for take-home drugs.

(H) Medical records must be maintained in accordance with 42 C.F.R. 482.24., in effect as of October 1, 2013,

Records requested by ~~ODJFS~~ODM for review must be supplied within thirty calendar days of the request as described in rule ~~5101:3-1-17.2~~5160-1-17.2 of the Administrative Code. Failure to produce records within thirty days shall result in withholding or recoupment of medicaid payments.

(I) Decisions made by ~~the medical review entity~~ ODM as described in this rule are appealable to ~~the medical review entity~~ ODM and are subject to the reconsideration process described in rule ~~5101:3-2-07.12~~5160-2-07.12 of the Administrative Code.

(J) ~~ODJFS~~ ODM has delegated to the Ohio department of mental health and addiction services (ODMHAS) the authority to make determinations regarding utilization review for inpatient psychiatric services in accordance with paragraphs (B), (C), (D), and (E) of this rule.

DRAFT - NOT FOR FILING

5160-2-40 Pre-certification review.

This rule describes the pre-certification review program for inpatient ~~and outpatient~~ services. Paragraph (C) of this rule is specific to ~~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), (B) and~~ Paragraph (D) is specific to the psychiatric pre-certification program.~~to (G) of this rule are to be used as applicable.~~

(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) "~~Medically~~Medical ~~necessary services~~necessity" ~~are~~ is defined in ~~paragraph (B) of~~ rule ~~5101:3-2-02~~5160-1-01 of the Administrative Code.

(3) "Standards of medical practice" are nationally recognized protocols for diagnostic and therapeutic care. These protocols are approved by the medicaid program. ~~ODJFS~~The Ohio department of medicaid (ODM) will notify providers of the standards of medical practice to be used by the department. If the department should change the protocols, providers will be notified sixty business days in advance.

(4) An "elective admission" is any admission that does not meet the emergency admission definition in paragraph (A)(1) of this rule.

(5) "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.

(6) For purposes of this rule, a "hospital" is a provider eligible under rule ~~5101:3-2-01~~5160-2-01 of the Administrative Code.

(7) A "surgical admission" is an admission to a hospital in which surgery is performed as part of the treatment plan.

(8) A "medical admission" is a nonsurgical, nonpsychiatric, and nonmaternity admission.

(9) "Pre-certification" is a process whereby ~~ODJFS~~ODM (or its ~~contractual designee~~contracted medical review entity) assures that covered medical and psychiatric services, and covered surgical procedures are medically necessary and are provided in the most appropriate and cost effective setting. ~~Since it may be determined that an inpatient stay is not required for the provision of that covered medical or covered surgical care, the location of service delivery may be altered as a result of pre-certification. The payment of that treatment or procedure is contingent upon the acceptance of the review agency's recommendation on the appropriate location of service, and medical necessity of the admission and/or procedure. The department will mail the precertification list and standards of medical practice to all providers thirty days in advance of requiring pre-certification.~~

(B) Guidelines for pre-certification

(1) The decision that the provision of elective diagnostic and/or therapeutic care is medically necessary will be based upon nationally recognized standards of medical practice, derived from indicators of severity of illness and intensity of services. Both severity of illness and intensity of service must be present to justify proposed care. When indicated, determinations will also include a consideration of relevant and appropriate psycho-social factors.

(2) The individual circumstances of each patient is taken into account when making a decision about the appropriateness of a hospital admission. Issues that will be considered in making the decision about whether or not an admission is medically necessary include psycho-social factors and factors related to the home environment including proximity to the hospital and the accessibility of alternative sites of care; these issues must be fully documented in the medical record in order to be considered as part of the review.

(3) If an inpatient stay is not required for the provision of covered medical or surgical care, the location of service delivery may be altered as a result of pre-certification.

(4) The payment of that treatment or procedure is contingent upon the acceptance of the review entity's recommendation on the appropriate service location and the medical necessity of the admission and/or procedure.

(5) The department will post the precertification list and standards of medical practice thirty business days prior to requiring pre-certification.

(C) Pre-certification of medical and surgical services provided in an inpatient or outpatient setting.

(1) Admission for individuals who are medicaid eligible at the time of the admission and who do not meet any of the exemptions in paragraph (C)(2) of this rule must be certified by the reviewing agency (~~ODJFS~~ODM or its contractual designee) prior to an admission to a hospital as defined in paragraph (A)(6) of this rule.

(2) Excluded from the pre-certification process are:

(a) Emergency admissions, with the exception of emergency psychiatric admissions.

(b) Substance abuse admissions.

(c) Maternity admissions.

(d) Recipients enrolled in health insuring corporations under contract with the department for provision of health services to recipients.

(e) Services provided in hospitals which are located in noncontiguous states.

(f) Elective care that is performed in a hospital inpatient setting on a patient who is already hospitalized for a medically necessary condition unrelated to the elective care or when an unrelated procedure which does not require pre-certification is being performed simultaneously.

(g) Persons whose eligibility is pending at the time of admission or who make application for medicaid subsequent to admission.

(h) Patients who are jointly eligible for medicare and medicaid and who are being admitted under the medicare "part A" benefit.

(i) Patients who are eligible for benefits through a third party insurance as the primary payer for the services subject to pre-certification.

(j) Transfers from one hospital to another hospital with the exception of those hospitals identified for intensified review in accordance with paragraph (C)(1) of rule ~~5101:3-2-07.13~~5160-2-07.13 of the Administrative Code.

(k) Admissions for those elective surgical procedures or diagnoses which are not included in the department's pre-certification list.

(l) If the patient is not identified as a medicaid recipient at the time of an elective admission or procedure. However, every effort should be made by both the attending and/or admitting physicians and hospital providers to identify medicaid recipients before an admission or procedure that requires precertification.

(3) The provider must request pre-certification for an admission and/or procedure that does not meet the exemption criteria listed in paragraphs (C)(2)(a) to (C)(2)(l) of this rule and is on the department's pre-certification list by ~~contacting the reviewing agency~~submitting a request to the department. The reviewing agency is to make a decision on a pre-certification request within three ~~working~~ business days of receipt of a properly submitted request, which is to include the information addressed in the standards of medical practice. "Receipt of a properly submitted request" means that all information needed by the reviewing agency to make a decision based upon the guidelines in paragraph (B) of this rule has been provided to the reviewing agency. All negative decisions shall be reviewed by a physician representing ~~ODJFS~~ODM or its contractual designee. The reviewing agency shall notify ~~in writing~~ the recipient, the requesting physician, the hospital, and ~~ODJFS~~ODM in writing of all decisions. The reviewing agency must provide that written notice is sent to the requesting physician, recipient, and hospital by the close of the fourth ~~working~~business day after the request is received.

(D) Pre-certification psychiatric.

(1) General information.

The following definitions pertain to psychiatric admissions:

(a) A "psychiatric admission" is an admission of an individual to a hospital with a primary diagnosis of mental illness and not a medical or surgical admission. A discharge from a medical/surgical unit and an admission to a distinct part psychiatric unit within the same facility is considered to be a psychiatric admission and is subject to pre-certification.

(b) An "emergency psychiatric admission" is an admission where the attending psychiatrist believes that there is likelihood of serious harm to the patient or others and that the patient requires both intervention and a protective environment immediately.

(2) All psychiatric admissions for individuals who are medicaid eligible at the time of the admission must be certified by the reviewing agency (~~ODJFS~~ODM or its contractual designee) prior to an admission to a

hospital or ~~by the next working~~within two business days ~~after the~~of the admission ~~has occurred~~.

(3) The provider must request pre-certification for a psychiatric admission by ~~contacting the reviewing agency~~submitting an electronic request to the department. The reviewing agency is to make a decision on a pre-certification request within three ~~working~~ business days of receipt of a properly submitted request, which is to include the information addressed in the standards of medical practice. "Receipt of a properly submitted request" means that all information needed by the reviewing agency to make a decision based upon the guidelines set forth in paragraph (B) of this rule has been provided to the reviewing agency. All negative decisions shall be reviewed by a physician representing ~~ODJFS~~ ODM or its contractual designee. The reviewing agency shall notify the recipient, the requesting physician, the hospital, and ~~ODJFS~~ ODM of all decisions in writing by the close of the fourth ~~working~~business day after the request is received.

(E) Decisions made by the medical review entity as described in this rule are appealable to the medical review entity and are subject to the reconsideration process described in rule ~~5101:3-2-07.12~~ 5160-2-07.12 of the Administrative Code.

(F) Recipients have a right to a hearing in accordance with division ~~level~~ 5101:6 of the Administrative Code. This hearing is separate and distinct from the provider's appeal, as described in paragraph (E) of this rule.

(G) Reimbursement for elective care subject to pre-certification review.

(1) A certification that an inpatient stay is necessary for the provision of care and/or a procedure is medically necessary does not guarantee payment for that service. The individual must be a medicaid recipient at the time the service is rendered and the service must be a covered service.

(2) An elective admission, as defined in paragraph (A)(4) of this rule, is reimbursed according to the rates for inpatient hospital services pursuant to rule ~~5101:3-2-22~~5160-2-22 of the Administrative Code for hospital admissions reimbursed on a cost basis and rule ~~5101:3-2-07.11~~5160-2-65 of the Administrative Code for hospital admissions reimbursed on a prospective basis. Outpatient hospital services are reimbursed according to rule ~~5101:3-2-21~~5160-2-21 of the Administrative Code for hospitals subject to prospective reimbursement, and according to rule ~~5101:3-2-22~~5160-2-22 of the Administrative Code for those hospitals reimbursed on a cost basis. Associated physician services are reimbursed according to medicaid maximums for physician services pursuant to appendix DD to rule ~~5101:3-1-60~~5160-1-60 of the Administrative Code.

(3) In any instance when an admission or a procedure that requires pre-certification is performed and the admission and/or procedure has not been approved, hospital payments will not be made. If physician payments have been made for services associated with the medically unnecessary procedure, such payments will be recovered by the department. Recipients may not be billed for charges associated with the admission and/or procedure except under circumstances described in paragraph (G)(4) of this rule.

(4) If the pre-certification process is initiated prospectively by the provider and hospital inpatient services are denied, or if an admission and/or procedure requiring pre-certification is not found to be medically necessary and the recipient chooses hospitalization or to have the medically unnecessary service, these

admissions and/or procedures and all associated services would be considered noncovered services and the recipient ~~will~~may be liable for payment of these services in accordance with rule ~~5101:3-1-13.1~~5160-1-13.1 of the Administrative Code.

(5) The medical review entity may determine upon retrospective review, in accordance with rule ~~5101:3-2-07.13~~5160-2-07.13 of the Administrative Code, that the location of service was not medically necessary, but that services rendered were medically necessary. In this instance, the hospital may bill the department on an outpatient basis for those medically necessary services that were rendered on the date of admission in accordance with rule ~~5101:3-2-21~~5160-2-21 of the Administrative Code. Only laboratory and diagnostic radiology services rendered during the remainder of the medically unnecessary admission may be billed in accordance with rule ~~5101:3-2-02~~5160-2-02 of the Administrative Code on the outpatient claim. The outpatient bill must be submitted with a copy of the reconsideration affirming the original decision and/or the administrative decision issued in accordance with rule ~~5101:3-2-07.12~~5160-2-07.12 of the Administrative Code. The outpatient bill with attachments must be submitted to the department within sixty calendar days from the date on the remittance advice recouping the DRG payment for the medically unnecessary admission.