Ohio | Common Sense Initiative

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Business Impact Analysis

Agency, Board, or Commission Name: Ohio Department of Medicaid

Rule Contact Name and Contact Information:

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Regulation/Package Title (a general description of the rules' substantive content):

Appeals, Utilization, and Psychiatric Pre-Certification

Rule Number(s): 5160-2-07.12, 5160-2-12, 5160-2-07.13, 5160-2-13, 5160-2-40 (Rescind), and 5160-2-40 (New)

Date of Submission for CSI Review: 11/9/2021

Public Comment Period End Date: 11/16/2021

Rule Type/Number of Rules:

New/3 rules — **No Change/____ rules (FYR? ____)**

Amended/____ rules (FYR? ___) — **Rescinded/3 rules (FYR? 3)**

The Common Sense Initiative is established in R.C. 107.61 to eliminate excessive and duplicative rules and regulations that stand in the way of job creation. Under the Common Sense Initiative, agencies must balance the critical objectives of regulations that have an adverse impact on business with the costs of compliance by the regulated parties. Agencies should promote transparency, responsiveness, predictability, and flexibility while developing regulations that are fair and easy to follow. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.

Reason for Submission

1. **R.C. 106.03 and 106.031 require agencies, when reviewing a rule, to determine whether the rule has an adverse impact on businesses as defined by R.C. 107.52. If the agency determines that it does, it must complete a business impact analysis and submit the rule for CSI review.**

   Which adverse impact(s) to businesses has the agency determined the rule(s) create?

   The rule(s):

   a. ☒ **Requires a license, permit, or any other prior authorization to engage in or operate a line of business.**

   b. ☒ **Imposes a criminal penalty, a civil penalty, or another sanction, or creates a cause of action for failure to comply with its terms.**

   c. ☒ **Requires specific expenditures or the report of information as a condition of compliance.**

   d. ☒ **Is likely to directly reduce the revenue or increase the expenses of the lines of business to which it will apply or applies.**

Regulatory Intent

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

   OAC rule 5160-2-07.12, entitled **Appeals and reconsideration of departmental determinations regarding hospital inpatient, and outpatient services**, is being proposed for rescission. This rule sets forth the process for appealing the results of a final fiscal audit and requesting reconsideration after a utilization review of inpatient or outpatient hospital services. The provisions of this rule are being incorporated in Ohio Administrative Code (OAC) rule 5160-2-12.

   OAC rule 5160-2-12, entitled **Appeals and reconsideration of departmental determinations regarding hospital inpatient, and outpatient services**, is being proposed for adoption. This rule sets forth the process for appealing the results of a final fiscal audit and requesting reconsideration of hospital payments or after a utilization review of inpatient or outpatient hospital services by the Department or its contracted medical review entity. The rule is being proposed as part of the five-year rule review process and will replace OAC rule 5160-2-07.12. The rule is being renumbered to align with the OAC Chapter 2 rule numbering. The changes to the rule include the addition of section (E)(11) – (17) addressing

outpatient hospital items not subject to the department's reconsideration process, updated references to the Ohio Administrative Code and Code of Federal Regulations, and compliance with regulatory restriction language requirements in Ohio Revised Code (ORC) 121.95.

OAC rule 5160-2-07.13, entitled **Utilization control**, is being proposed for rescission. This rule sets forth the nature and timelines of utilization reviews conducted on inpatient and outpatient hospital services. The provisions of this rule are being incorporated in OAC rule 5160-2-13.

OAC rule 5160-2-13, entitled **Utilization review**, is being proposed for adoption. This rule 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. The rule is being proposed as part of the five-year rule review process and will replace OAC rule 5160-2-07.13. The rule is being renumbered to align with the OAC Chapter 2 rule numbering. The proposed changes to the rule include removal of the paragraph regarding delegating psychiatric pre-certification to MHAS, adding the updated policy language regarding the reimbursement for elective care subject to pre-certification review from rescinded rule 5160-2-40 [5160-2-40 (G)(5) to rule 5160-2-13 (B)(4)], removing unnecessary language, adding clarifying language, and updating references to the Ohio Administrative Code and Code of Federal Regulations.

OAC rule 5160-2-40, entitled **Pre-certification review**, is being proposed for rescission. This rule sets forth the pre-certification review program for inpatient services. It addresses guidelines for pre-certification, pre-certification of medical and surgical services provided in an inpatient or outpatient setting, pre-certification for psychiatric admissions, appeal and reconsideration of pre-certification decisions, and reimbursement for elective care subject to pre-certification. The provisions of this rule describing psychiatric pre-certification review are being incorporated in new OAC rule 5160-2-40.

OAC rule 5160-2-40, entitled **Psychiatric pre-certification review**, sets forth the pre-certification review program for inpatient psychiatric admissions. The rule establishes guidelines and exclusions for pre-certification, pre-certification of psychiatric admissions, retrospective pre-certification, appeal of pre-certification decisions, and reimbursements subject to pre-certification review. This rule is being proposed as a result of the five-year rule review process and will replace OAC rule 5160-2-40. Changes to the rule include the removal of guidelines for pre-certification of elective medical and surgical services provided in an inpatient or outpatient setting, and updated rule definitions, guidelines, and added paragraph (C)(2) to exclude pre-certification of

psychiatric admissions for those individuals enrolled in OhioRISE. The rule also contains amended regulatory language and updated paragraph references within the rule and references to other rules in the Ohio Administrative Code (OAC).

3. **Please list the Ohio statute(s) that authorize the agency, board or commission to adopt the rule(s) and the statute(s) that amplify that authority.**

   Revised Code Section 5164.02 authorizes ODM to adopt the rule, and 5162.03 and 5164.02 amplify that authority.

4. **Does the regulation implement a federal requirement? 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?**
   If yes, please briefly explain the source and substance of the federal requirement.

   Yes, OAC rule 5160-2-13 (new) and rule 5160-2-07.13 (rescinded) implement a federal requirement. 42 C.F.R. 456.3 requires the state to implement a utilization review program that implements 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 Subpart B; and provides for the control of the utilization of inpatient services in accordance with Subparts C through I.

   The new rules, OAC 5160-2-12 and OAC 5160-2-40, and the rescinded rules, OAC 5160-2-07.12 and OAC 5160-2-40, do not implement a federal requirement.

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

   The federal regulation requires the Ohio Department of Medicaid (the Department) to implement a utilization review program, however, it does not specifically delineate how utilization review is to operate. The rules in this packet merely put a process around implementing the generally stated federal requirements.

6. **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 hospitals and managed care plans will be informed of Medicaid policy regarding utilization review.

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

   The Department should see an improved dataset of claims to be used in analysis and rate setting. Hospital providers will be able to improve future claim activities, resulting in fewer errors.

8. **Are any of the proposed rules contained in this rule package being submitted pursuant to R.C. 101.352, 101.353, 106.032, 121.93, or 121.931?**
   If yes, please specify the rule number(s), the specific R.C. section requiring this submission, and a detailed explanation.

   No, the proposed rule package is not being submitted pursuant to the aforementioned laws.

Development of the Regulation

9. **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.

   On 11/5/2020, the Department initiated conversation with the Ohio Hospital Association (OHA) to seek comments regarding the proposed changes to the rules. On 11/13/2020, OHA responded with their comments and the Department incorporated the recommendations in the rules.

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

    OHA expressed concern that the regulatory language in OAC 5160-2-13(C)(3) is too narrow and does not include other practitioners. OHA recommended that the Department amend the "physician services" to "practitioner of physician services" since the term "physician" in OAC rule 5160-2-02 was expanded in ORC 3727.06 to include other practitioners permitted to order an inpatient hospital admission per their scope of practice and their hospital credentials. The Department adopted the recommended regulatory language.

11. **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?**

    No scientific data was used to develop the rules or the measurable outcomes of the rules.

12. 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?

The Department did not consider alternative regulations, the Administrative Code rules were determined to be the best method to address these issues.

13. 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 Department did not specifically consider a performance-based regulation, as these processes are not conducive to a performance-based process.

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

The Department reviewed the regulations cited within the rules to ensure these regulations do not duplicate existing Ohio regulations. ODM Legal Services also reviewed these rules to ensure that duplication does not exist.

15. 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.

A Hospital Handbook Transmittal Letter (HHTL) will be posted on ODM's website that will describe the changes for hospitals. Hospitals can also obtain necessary assistance by emailing hospital_policy@medicaid.ohio.gov.

Adverse Impact to Business

16. 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; and

These regulations impact all hospitals enrolled as Ohio Medicaid providers.

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

The nature of the adverse impact for all rules is employer time to submit requests and records. In addition, OAC rule 5160-2-13 (new) and 5160-2-07.13 (rescinded) provide for denying or recouping payments that do not meet the conditions described in the rule.

c. 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.

OAC rule 5160-2-12 (new) and rule 5160-2-07.12 (rescinded) allow a provider to submit requests for reconsideration. There may be an adverse impact in terms of the cost associated with submitting the reconsideration requests and patient's medical records and other information supportive of the provider's position. It is difficult to estimate a dollar amount due to the inability to predict the volume of requests for reconsideration and due to provider differences in business practices. The adverse impact may be calculated by multiplying the employee's rate by the time taken to produce the records.

OAC rule 5160-2-13 (new) and rule 5160-2-07.13 (rescinded) state that if a hospital's claims are selected for utilization review as part of the retrospective review, the Department or its contracted reviewing agency may request information or medical records from the hospital, and may conduct on-site medical record reviews; this request for information or medical records may result in an adverse impact.

An ad hoc survey conducted by OHA of its members determined that the average cost of producing medical records when requested by the Department's contracted review entity is $83.81 per medical record. Every month, approximately 1,500 medical records are reviewed, which results in an estimated annual cost of compliance of $1.5 million to the industry. Though providers incur an estimated annual cost of $1.5 million, providers received $541.3 million in inpatient fee-for-service hospital payments and $135.4 million in outpatient fee-for-service hospital payments in state fiscal year 2019. Due to the random sampling process used to select claims for review, it is not possible to determine how many claims from hospitals will ultimately be selected. In addition, in cases where a hospital's medical review does not meet the conditions set forth in section (B)(1) of this rule, the Department may deny or recoup payment. Therefore, the rule may reduce revenues or increase expenses of the lines of business to which it may apply.

OAC rule 5160-2-40 (new) and 5160-2-40 (rescinded) require providers requesting psychiatric pre-certification to electronically submit the request and electronic medical records to show that the covered psychiatric services are being provided in the most appropriate cost-effective setting based on medical necessity. This cost cannot be estimated in dollars due to the different clinical practices and populations seen by

providers and the unpredictability of the individual circumstances that may influence a provider to recommend that the patient be seen in a more costly setting than would normally be recommended. However, the time it takes an employee to prepare and electronically submit electronic medical records to the Department and the employee's hourly rate may be used to calculate an estimated cost.

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

The Department determined the regulatory intent justifies the adverse impact to participating hospitals because the rules ensure appropriate medically necessary services are being performed.

Regulatory Flexibility

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

No. This regulation applies equally to all hospital providers to ensure appropriate and necessary services.

19. 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 for paperwork violations associated with the implementation of these rules.

20. What resources are available to assist small businesses with compliance of the regulation?

The Department's medical review entity, Permedion, may assist with compliance. 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 or submit a constituent inquiry at http://medicaid.ohio.gov/CONTACT.aspx.

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

(A) General.

Pursuant to Chapter 5160-70 of the Administrative Code, final settlements that are based upon final audits by the department may be appealed by hospitals under Chapter 119. of the Revised Code. Rule 5160-2-24 of the Administrative Code describes final fiscal audits and final settlements performed by the department. Rules 5160-1-29 and 5160-1-27 of the Administrative Code describe the audits performed by the department which 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 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 5160-1-01, 5160-2-02, 5160-2-07.13, 5160-2-21, 5160-2-40, and 5160-2-65 of the Administrative Code. These determinations are subject to the reconsideration process described in rule 5160-70-02 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 business days from receipt of the request for reconsideration to issue a 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) If the submitted request for a reconsideration is incomplete, the department or the medical review entity will notify the provider of missing documentation. The notice will give the provider two business days to submit the missing documentation.

(3) 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 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.

(4) The department may extend time frames described in paragraphs (B)(1) and (B)(3) 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)(3) 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 rule 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 5160-2-07.6, and 5160-2-07.7 of the Administrative Code are subject to the reconsideration process described in rule 5160-70-02 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 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.

(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 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).

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

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

(5) The methodology used to determine prospective payment rates as described in rule 5160-2-65 of the Administrative Code.

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

(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 5160-2-65 and 5160-2-40 of the Administrative Code.

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

(9) Statewide calculations of the direct and indirect medical education threshold for allowable costs per intern and resident as described in rule 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 5160-2-09 of the Administrative Code.

5160-2-12 Appeals and reconsideration of departmental determinations regarding hospital inpatient and outpatient services.

(A) Appeals.

Pursuant to Chapter 5160-70 of the Administrative Code, final settlements that are based upon final audits by the department may be appealed by hospitals under Chapter 119. of the Revised Code. Rule 5160-2-24 of the Administrative Code describes final fiscal audits and final settlements performed by the department. Rules 5160-1-27 and 5160-1-29 of the Administrative Code describe the audits performed by the department which 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 5160-2-13 of the Administrative Code, the department or a medical review entity under contract with the department may make determinations regarding utilization review. These determinations are subject to the reconsideration process described in rule 5160-70-02 of the Administrative Code as follows:

(1) A written request for a reconsideration should 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 has thirty business days from receipt of the request for reconsideration to issue a 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) If the submitted request for a reconsideration is incomplete, the department or the medical review entity will notify the provider of missing documentation. The notice will give the provider two business days to submit the missing documentation.

(3) 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 has thirty 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.

(4) The department may extend time frames described in paragraphs (B)(1) and (B)(3) 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)(3) 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 hospital payments.

(1) Except when the department's determination is based on a finding made by medicare, the proper application of rules 5160-2-65, 5160-2-75, and 5160-2-76 of the Administrative Code and the proper calculation of amounts (including source data used to calculate the amounts) determined in accordance with rules 5160-2-66 and 5160-2-67 of the Administrative Code are subject to the reconsideration process described in rule 5160-70-02 of the Administrative Code as follows:

(a) Requests for reconsideration authorized by paragraph (C)(1) of this rule should 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 should 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 should be submitted within thirty calendar days of the date the adjustment or determination was implemented. The request should 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 has 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 should be submitted to the department in writing prior to final

settlement as described in rule 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 should include all documentation that explains the appeal decision. The department has thirty business days in which to notify the provider of its final and binding decision regarding the medicare audit finding.

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

Any recipient whose claim for 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 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).

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

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

(5) The methodology used to determine prospective payment rates as described in rule 5160-2-65 of the Administrative Code.

(6) The methodology used to identify cost thresholds for services that may qualify for outlier payments as described in rule 5160-2-65 of the Administrative Code.

(7) The formulas used to determine rates of payment for outliers, certain transfers and readmissions, and services subject to pre-certification, as described, respectively, in rules 5160-2-65 and 5160-2-40 of the Administrative Code.

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

(9) Statewide calculations of the direct and indirect medical education threshold for allowable costs per intern and resident as described in rule 5160-2-67 of the

Administrative Code.

(10) The threshold for establishing which hospitals will be recognized as providing a disproportionate share of indigent care as described in rule 5160-2-09 of the Administrative Code.

(11) The use of the Enhanced Ambulatory Patient Groups (EAPG) classification system and the method of classification of claim details within EAPGs.

(12) The assignment of EAPGs.

(13) The assignment of relative weights to EAPGs based on the methodology set forth in rule 5160-2-75 of the Administrative Code.

(14) The establishment of peer groups as set forth in rule 5160-2-75 of the Administrative Code.

(15) The methodology used to determine prospective payment rates as described in rule 5160-2-75 of the Administrative Code.

(16) The peer group average cost per detail for all hospitals except when the conditions detailed in rule 5160-2-75 of the Administrative Code are met.

(17) Technical denials, which are the result of failure to submit medical records within thirty calendar days of the original request in accordance with rules 5160-2-13 and 5160-1-17.2 of the Administrative Code.

5160-2-07.13 **Utilization control.**

(A) The Ohio department of 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. For the purposes of this rule, "ODM" means ODM or its contracted medical review entity. During the course of its analyses, ODM may request information or records from the hospital and may conduct on-site medical record reviews. Utilization reviews shall be conducted in accordance with section 5164.57 of the Revised Code.

(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) ODM shall review a statistical sample of all admissions retrospectively.

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

(1) ODM may review transfers as defined in rule 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. 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 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) ODM may review readmissions to determine if the readmission as defined in rule 5160-2-02 of the Administrative Code is appropriate.

(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) 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 5160-1-01 and 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) 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 5160-2-21 of the Administrative Code.

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

(D) 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.

(E) Pre-certification review as detailed in rule 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 ODM to determine whether the care or services were medically necessary as defined in rule 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 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 ODM for review must be supplied within thirty calendar days of the request as described in rule 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 ODM as described in this rule are appealable to ODM and are subject to the reconsideration process described in rule 5160-2-07.12 of the Administrative Code.

(J) 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.

(K) Recovery of payments for professional services.

Effective for services rendered on or after January 1, 2016, payments made in accordance with appendix DD to rule 5160-1-60 of the Administrative Code for professional services that are associated with a recouped hospital payment that is not eligible for resubmission due to the results of a utilization review, shall be recovered by ODM.

5160-2-13 **Utilization review.**

(A) The Ohio department of medicaid (ODM) will perform or contract with a medical review entity to perform utilization review for medicaid inpatient services regardless of the payment methodology used for reimbursement of those services. For the purposes of this rule, "ODM" means ODM or its contracted medical review entity. During the course of its analyses, ODM may request information or records from the hospital and may conduct on-site medical record reviews.

(B) ODM will review a statistical sample of all admissions retrospectively.

(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 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 mandated in 42 C.F.R. 456.3(b), in effect as of October 1, 2021; and to assess compliance with agency 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 ODM may deny payment or recoup payment beginning with the first inappropriate admission or discharge. Any negative determinations should be made by a physician.

(3) If the diagnostic or procedural information on the claim 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.

(4) ODM may determine upon retrospective review, in accordance with this rule, that the location of services was not medically necessary, but that the services rendered were medically necessary. In such instances:

(a) 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 5160-2-75 of the Administrative Code.

(b) Only laboratory and diagnostic radiology services rendered during the

remainder of the medically unnecessary admission may be billed in accordance with rule 5160-2-75 of the Administrative Code.

(c) The outpatient bill will be submitted with a copy of the reconsideration affirming the original decision or the administrative decision issued in accordance with rule 5160-2-12 of the Administrative Code.

(d) The outpatient bill with attachments will 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.

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

(1) ODM may review transfers as defined in rule 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. ODM considers a transfer appropriate if the transfer is necessary because the individual needs some treatment or care that is unavailable at the transferring hospital or if there are other exceptional circumstances that justify transfer.

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) ODM may review readmissions to determine if the readmission as defined in rule 5160-2-02 of the Administrative Code is appropriate.

(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 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 the result of circumstances as described in paragraph (C)(2)(a) or (C)(2)(b) of this rule, 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) 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 a practitioner of physician services 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 5160-1-01 and 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) 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 5160-2-75 of the Administrative Code.

(5) ODM may review cases in which a denial letter has been issued by the hospital. In addition, ODM will review all cases in which the attending practitioner of physician services or recipient (or family member) disagrees with the hospital's decision and requests a review of the case. The hospital will send a copy of each denial letter to ODM's medical review entity.

(D) 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, 2021.

(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 will submit a corrected claim reflecting this information.

(E) Psychiatric pre-certification review as detailed in rule 5160-2-40 of the Administrative Code will be conducted in addition to the utilization review activities described in this rule.

(F) Outpatient hospital services may also be reviewed by ODM to determine whether the care or services were medically necessary as defined in rule 5160-1-01 of the Administrative Code, to determine whether the services were appropriately billed, and to assess the quality of care rendered as mandated in 42 C.F.R. 456.3(b), in effect as of October 1, 2021.

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

(H) Medical records will be maintained in accordance with 42 C.F.R. 482.24, in effect as of October 1, 2021. Records requested by ODM for review will be supplied within thirty calendar days of the request as described in rule 5160-1-17.2 of the Administrative Code. Failure to produce records within thirty days will result in withholding or recoupment of medicaid payments.

(I) With the exception of paragraph (H) of this rule, decisions made by ODM as described in this rule are appealable to ODM and are subject to the reconsideration process described in rule 5160-2-12 of the Administrative Code.

(J) Over or under payments resulting from a utilization review will be settled in accordance with section 5164.57 of the Revised Code.

(K) Recovery of payments for professional services.

Payments made in accordance with appendix DD to rule 5160-1-60 of the Administrative Code for professional services that are associated with a recouped hospital payment that is not eligible for resubmission due to the results of a utilization review, will be recovered by ODM.

5160-2-40 **Pre-certification review.**

This rule describes the pre-certification review program for inpatient services. Paragraph (C) of this rule is specific to the medical/surgical pre-certification program. Paragraph (D) of this rule is specific to the psychiatric pre-certification program.

(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) "Medical necessity" is defined in rule 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. 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 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 ODM (or its 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.

(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 (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 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 submitting an electronic request to the department. The reviewing agency is

to make a decision on a pre-certification request within three 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 ODM or its contractual designee. The reviewing agency shall notify the recipient, the requesting physician, the hospital, and 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 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 (ODM or its contractual designee) prior to an admission to a hospital or within two business days of the admission.

(3) The provider must request pre-certification for a psychiatric admission by submitting an electronic request to the department. The reviewing agency is to make a decision on a pre-certification request within three 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 ODM or its contractual designee. The reviewing agency shall notify the recipient, the requesting physician, the hospital, and ODM of all decisions in writing by the close of the fourth 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 5160-2-07.12 of the Administrative Code.

(F) Recipients have a right to a hearing in accordance with division 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 5160-2-22 of the Administrative Code for hospital admissions reimbursed on a cost basis and rule 5160-2-65 of the Administrative Code for hospital admissions reimbursed on a prospective basis. Outpatient hospital services are reimbursed according to rule 5160-2-21 of the Administrative Code for hospitals subject to prospective reimbursement, and according to rule 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 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 may be liable for payment of these services in accordance with rule 5160-1-13.1 of the Administrative Code.

(5) The medical review entity may determine upon retrospective review, in accordance with rule 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 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 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 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.

5160-2-40 **Psychiatric pre-certification review.**

(A) Definitions.

For purposes of this rule, the following definitions apply:

(1) A "hospital" is a provider eligible under rule 5160-2-01 of the Administrative Code.

(2) "Medical necessity" is as defined in rule 5160-1-01 of the Administrative Code.

(3) "Pre-certification" is a process whereby the Ohio department of medicaid (ODM) or its contracted medical review entity assures that covered psychiatric services are medically necessary and are provided in the most appropriate and cost-effective setting.

(4) 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 unit and an admission to a distinct part psychiatric unit within the same facility is considered a psychiatric admission and is subject to pre-certification.

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

(B) Guidelines for pre-certification.

(1) The decision that the provision of 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 should be present to justify proposed care.

(2) The individual circumstances of each patient are considered 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 should be fully documented in the medical record in order to be considered as part of the review.

(3) If an inpatient stay is not deemed medically necessary, the location of service delivery may be altered as a result of pre-certification.

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

(1) Recipients enrolled in managed care organizations as defined in ~~OAC~~ Chapter 5160-26 of the Administrative Code and under contract with ODM for provision of health services to recipients;

(2) Recipients enrolled in Ohio resilience through integrated systems and excellence (OhioRISE) as defined in Chapter 5160-59 of the Administrative Code and under contract with ODM for provision of health services to recipients;

(3) Patients who are jointly eligible for medicare and medicaid and who are being admitted under the medicare "part A" benefit; or

(4) Medical or surgical admissions.

(D) Pre-certification of psychiatric admissions.

(1) All pre-certification requests for psychiatric admissions for individuals who are medicaid eligible at the time of the admission will be submitted to ODM or its reviewing agency prior to an admission to a hospital or within two business days of the admission.

(2) The provider will request pre-certification for a psychiatric admission by submitting an electronic request to ODM. The reviewing agency is to make a decision on a pre-certification request within three business days of receipt of a properly submitted request, which is to include the information addressed in the standards of medical practice. A request is properly submitted if 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 will be reviewed by a physician representing ODM or its reviewing agency. The reviewing agency will notify the recipient, the requesting provider, the hospital, and ODM of all decisions in writing by the close of the fourth business day after the request is received.

(3) Pre-certification may be requested on a retrospective basis when:

(a) a patient is not identified as a medicaid recipient; or

(b) eligibility is pending at the time of admission; or

(c) application for medicaid is made subsequent to admission.

(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 5160-2-12 of the Administrative Code.

(F) Recipients have a right to a hearing in accordance with division 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 subject to pre-certification review.

(1) The payment for treatment is contingent upon the acceptance of the reviewing agency's recommendation on the appropriate service location and the medical necessity of the admission.

(2) A certification that an inpatient stay is medically necessary does not guarantee payment for that service. The individual has to be a medicaid recipient at the time the service is rendered, and the service has to be a covered service.

(3) A psychiatric admission, as defined in paragraph (A)(4) of this rule, is reimbursed according to the rates for inpatient hospital services pursuant to rule 5160-2-65 of the Administrative Code for hospital admissions reimbursed on a prospective basis. Qualified provider services are reimbursed according to medicaid maximums for physician services pursuant to appendix DD to rule 5160-1-60 of the Administrative Code.

(4) In any instance when an admission that needs pre-certification occurs and the admission has not been approved, hospital payments will not be made. If separate professional provider payments have been made for services associated with the medically unnecessary admission, such payments will be recovered by ODM. Recipients should not be billed for charges associated with the admission except under circumstances described in paragraph (G)(5) of this rule.

(5) If the pre-certification process is initiated prospectively by the provider and hospital inpatient services are denied, or if an admission requiring pre-certification is not found to be medically necessary and the recipient chooses hospitalization, this admission and all associated services may be considered noncovered services and the recipient may be liable for payment of these services in accordance with rule 5160-1-13.1 of the Administrative Code.