Ohio Administrative Code

Rule 5160-1-27.2 Medicaid hold and review process for medicaid claims paid through state agencies other than the Ohio department of medicaid.

Effective: September 3, 2015

(A) "Medicaid administrative agency" means a state agency other than the Ohio department of medicaid that:

(1) Administers a component of the medicaid program under the terms of a contract with ODM under section 5162.35 of the Revised Code; and

(2) Pays claims for medicaid services or reimburses local entities for claims paid for medicaid services.

(B) "Hold and Review" is defined in accordance with rule 5160-1-27 of the Administrative Code.

(C) Hold and review may be initiated by ODM or a medicaid administrative agency for the following reasons:

(1) When the information is used to complement or follow-up a provider or certification or other quality review process;

(2) In response to allegations of fraud or willful misrepresentation of claims submission;

(3) Upon the request of the office of the attorney general, the office of inspector general, or the auditor of state;

(4) When a provider's medicaid provider agreement is subject to termination;

(5) When a provider has been indicted for a criminal offense; or

(6) For reasons otherwise necessary to assure the basic integrity of claims submission and payment.

(D) The hold and review may be applied without regard to date of service.

(E) Hold and review initiated by medicaid administrative agencies.

(1) The medicaid administrative agency shall have formal written approval from ODM to initiate a hold and review process.

(2) The medicaid administrative agency may recruit the assistance of local governmental entities to review records subject to hold and review.

(3) The medicaid administrative agency may initiate hold and review without prior notification to the provider when the medicaid administrative agency receives a request to initiate hold and review from the office of the attorney general, the office of inspector general, the auditor of state, or ODM.

(4) When the medicaid administrative agency initiates hold and review without prior notification to the provider, the medicaid administrative agency shall provide written notice to the provider, including a copy of ODM written approval within ten business days of initiating a hold and review.

(5) The medicaid administrative agency may initiate hold and review with prior notification to the provider for any purpose contained in paragraph (C) of this rule. The medicaid administrative agency shall notify the provider at least ten business days prior to subjecting the provider's claims to hold and review.

(6) For claims payment that the medicaid administrative agency pays directly to the medicaid provider, the medicaid administrative agency may subject the medicaid provider's claim(s) payment, in part or in whole, to hold and review.

(7) For reimbursements the medicaid administrative agency makes to local entities for claims that the local entity pays to the medicaid provider directly, the medicaid administrative agency:

(a) May require the local entity to hold the medicaid provider's claim(s) payment for claims subject to hold and review;

(b) May deny reimbursement to the local entity for the claims on which the hold and review was requested after allowing the local entity a reasonable time to comply; and

(c) Shall not deny reimbursement to the local entity for claims that the local entity paid prior to the request.

(8) A failure by the medicaid administrative agency to notify a provider of a hold and review process shall not impede the agency from taking actions under this rule.

(9) Review of the medicaid provider's claims and documentation for hold and review is subject to the provisions of rule 5160-1-27 of the Administrative Code.

(10) The notice from the medicaid administrative agency shall:

(a) State the general reasons for subjecting the medicaid provider's claims to hold and review, but need not disclose any specific information concerning an ongoing investigation involving alleged fraud and/or willful misrepresentation;

(b) State the date the medicaid administrative agency implements the hold and review;

(c) State the types of services and claims that are subject to hold and review;

(d) Identify the documentation required to submit to the medicaid administrative agency;

(e) Inform the provider of the right to submit evidence for consideration to the medicaid administrative agency; and

(f) State the contact at the medicaid administrative agency for questions regarding the hold and review and where to send the requested documentation.

(11) The medicaid administrative agency shall send copies of the notice to all local, state, and federal entities that are involved in the review or that need to be aware of the review in order to assure the integrity of claims submission and payment.

(12) Providers who submit medical claims electronically may be required under this rule to submit paper documentation supporting each claim submitted electronically. These claims will not be processed until both the claim and the supporting documentation are reviewed by the medicaid administrative agency.

(13) The medicaid administrative agency has one hundred twenty days from the date each claim for payment is received to review the claim and make a determination whether or not to do one of the following:

(a) Forward the claim for adjudication;

(b) Forward the claim for denial; or

(c) Issue a "Notice of Operation Deficiency."

(F) Hold and review process initiated by ODM.

(1) ODM may require a medicaid administrative agency to initiate a hold and review described in this rule or to cooperate in a hold and review initiated by ODM under rule 5160-1-27.1 of the Administrative Code.

(2) In cooperating with a request from ODM to initiate a hold and review, medicaid administrative agencies shall:

(a) Comply with the provider notification requirements of this rule; and

(b) Suspend payment or reimbursement of the claims that are subject to hold and review; and

(c) Require local entities to suspend payment for the claims subject to hold and review; and

(d) Obtain provider records, including client records, medical records, and other supporting documentation that ODM requests as part of the review from local entities and providers; and

(e) Participate in the review of records and other supporting documentation when requested by ODM; and

(f) Provide any other information requested by ODM in order to assure accurate tracking and timely resolution of the claims subject to hold and review.

(3) For claims associated with alcohol and drug addiction services, ODM shall rely on the Ohio department mental health and addiction services to obtain and review provider records, including client records and medical records, as necessary to assure the special confidentiality of these records required by 42 C.F.R., part 2 as amended through October 1, 2006.

(4) After requesting a hold and review and allowing the medicaid administrative agency a reasonable time to comply, ODM may stop drawing from the centers for medicare and medicaid services, and passing to the other agency, the federal match associated with the claims that are subject to the review. ODM will not withhold federal match for claims that other agencies or local entities paid prior to the ODM request.

(G) For purposes of determining whether time limits for the submission of claims have been met for claims subjected to hold and review, the date of claims submission shall be the date that the medicaid administrative agency received the original claim from the provider.

(H) The hold and review process is not subject to Chapter 119. of the Revised Code or any other appeal.