Ohio Administrative Code

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

Effective: June 12, 2022

(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 explain 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 rule 5160-2-13 and 5160-1-17.2 of the Administrative Code.