Ohio Administrative Code

Rule 5160-2-40 Pre-certification review.

Effective: April 30, 2015

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.