Ohio Administrative Code

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

Effective: June 12, 2022

(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 under contract with ODM for provision of health services to recipients;

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

(3) 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 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.