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COMMISSION
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Ohio Administrative Code

Rule 5160-70-02 Procedures for Providers Seeking Review of Department Actions or Proposed Department Actions.

Effective: January 1, 2015

(A) Chapter 5160-70 of the Administrative Code prescribes the procedures to be followed when medicaid providers seek review of actions or proposed actions of the department, except for any action taken or decision made by the department with respect to entering into or refusing to enter into a contract with a managed care organization pursuant to section 5167.10 of the Revised Code and any action taken under section 5165.60 to 5165.89 of the Revised Code. The rules in Chapter 5160-70 of the Administrative Code prevail over the provisions set forth in Chapter 5101:6-50 of the Administrative Code.

(B) Except as provided in paragraph (C) of this rule and section 5164.58 of the Revised Code, the department shall do the following by issuing an order pursuant to an adjudication conducted in accordance with Chapter 119. of the Revised Code:

(1) Pursuant to section 5164.38 of the Revised Code, refuse to enter into a provider agreement with a provider;

(2) Pursuant to section 5164.38 of the Revised Code, refuse to revalidate a medicaid providers provider agreement;

(3) Pursuant to section 5164.38 of the Revised Code, suspend or terminate an existing medicaid providers provider agreement;

(4) Pursuant to section 5164.38 of the Revised Code, take any action based upon a final fiscal audit;

(5) Pursuant to section 5165.46 of the Revised Code:

(a) Take any audit disallowance that the department makes as the result of a nursing facility cost report audit under section 5165.109 of the Revised Code;

(b) Make any adverse finding that results from an exception review of resident assessment data conducted for a nursing facility under section 5165.193 of the Revised Code after the effective date of the nursing facilitys medicaid payment rate for direct care costs that is based on the resident assessment data;

(c) Recover any medicaid payment deemed an overpayment based upon the final cost report filed by an exiting nursing facility operator under section 5165.523 of the Revised Code;

(d) Impose any penalty under section 5165.42 of the Revised Code or section 5165.523 of the Revised Code.

(6) Pursuant to section 5165.525 of the Revised Code, issue a final debt summary report;

(7) Pursuant to division (A) of section 5165.77 of the Revised Code, terminate a nursing facility's participation in the medical assistance program, appoint a temporary manager of a nursing facility, or deny payment to a nursing facility for all medicaid eligible residents admitted after the effective date of the order.

(C) The Chapter 119. administrative procedures, including hearing rights, are not applicable to department actions that include, but are not limited to, the following:

(1) Pursuant to section 5164.38 of the Revised Code, the termination of the provider agreement because the terms of the provider agreement require the medicaid provider to hold a license, permit, or certificate or maintain a certification issued by an official, board, commission, department, division, bureau, or other agency of state or federal government other than the department of medicaid, and the license, permit, certificate, or certification has been denied, revoked, not renewed, suspended, or otherwise limited;

(2) Pursuant to section 5164.38 of the Revised Code, the termination of the provider agreement because the terms of the provider agreement require the medicaid provider to hold a license, permit, or certificate or maintain certification issued by an official, board, commission, department, division, bureau, or other agency of state or federal government other than the department of medicaid, and the provider has not obtained the license, permit, certificate, or certification;

(3) Pursuant to section 5164.38 of the Revised Code, the denial of the medicaid providers application for a provider agreement or the providers provider agreement is terminated or not revalidated, because of or pursuant to any of the following:

(a) The termination, refusal to renew, or denial of a license, permit, certificate, or certification by an official, board, commission, department, division, bureau, or other agency of this state other than the department of medicaid, notwithstanding the fact that the provider may hold a license, permit, certificate, or certification from an official, board, commission, department, division, bureau, or other agency of another state;

(b) Division (E)(3)(b) of section 5164.38 of the Revised Code and division (D) of section 5164.35 of the Revised Code, when a judgment has been entered in either a criminal or civil action against a medicaid provider or its owner, officer, authorized agent, associate, manager, or employee in an action brought pursuant to section 109.85 of the Revised Code, except if the provider or owner can demonstrate to the department that the provider or owner did not directly or indirectly sanction the action of its authorized agent, associate, manager, or employee which resulted in the entry of judgment;

(c) Division (E)(3)(b) of section 5164.38 of the Revised Code and division (E) of section 5164.35 of the Revised Code, when the attorney general on behalf of the state has commenced proceedings in any court of competent jurisdiction and settled or compromised any such case brought under section 5164.35 of the Revised Code;

(d) The providers termination, suspension, or exclusion from the medicare program or from another states medicaid program and, in either case, the termination, suspension, or exclusion is binding on the providers participation in the Ohio medicaid program;

(e) The provider has pleaded guilty to or been convicted of a criminal activity materially related to the medicare or medicaid programs;

(f) The conviction of the provider or its owner, officer, authorized agent, associate, manager, or employee of one of the offenses that caused the providers provider agreement to be suspended

pursuant to section 5164.36 of the Revised Code; and

(g) The failure of the provider to provide the department the national provider identifier assigned to the provider by the national provider system pursuant to 45 C.F.R 162.408 (October 1, 2014). In this case, the department may take its action by sending a notice explaining the action to the provider. The notice shall be sent to the providers last known address on record with the department. The notice may be sent by ordinary mail.

(4) Pursuant to section 5164.38 of the Revised Code, the denial of the providers application for a provider agreement, or the providers provider agreement is terminated or suspended, as a result of action by the United States department of health and human services and that action is binding on the providers medicaid participation;

(5) Pursuant to section 5164.38 of the Revised Code, referencing sections 5164.36 and 5164.37 of the Revised Code, the suspension of the providers provider agreement and payments pending indictment of the provider;

(6) Pursuant to section 5164.38 of the Revised Code, the denial of the application for a provider agreement because the application was not complete. In this case, the department may take its action by sending a notice explaining the action to the applicant. The notice shall be sent to the applicants last known address on record with the department. The notice may be sent by ordinary mail;

(7) Pursuant to section 5164.38 of the Revised Code, the conversion of the providers provider agreement under section 5164.32 of the Revised Code from a provider agreement that is not time-limited to a provider agreement that is time-limited. In this case, the department may take its action by sending a notice explaining the action to the provider. The notice shall be sent to the providers last known address on record with the department. The notice may be sent by ordinary mail;

(8) Unless the provider is a nursing facility or ICF/IID, the non-revalidation of the providers provider agreement pursuant to division (B)(1) of section 5164.32 of the Revised Code;

(9) The suspension, termination, or non-revalidation of the providers provider agreement because of either of the following:

(a) Any reason authorized or required by one or more of the following: 42 C.F.R. 455.106, 455.23, 455.416, 455.434, or 455.450 (October 1, 2014);

(b) The provider has not billed or otherwise submitted a medicaid claim for two years or longer. In this case, the department may take its action by sending a notice explaining the action to the provider. The notice shall be sent to the providers address on record with the department. The notice may be sent by ordinary mail.

(10) Acts of the director, agency employees or contractors of ODM that are ministerial in nature;

(11) Actions of ODM that are subject to public hearings under an administrative review procedure other than the review provided by Chapter 119. of the Revised Code;

(12) Rate calculations and interim settlements;

(13) Claims payment denial determinations and claims adjustments for reasons including, but not limited to, duplicate payments and payment for services not rendered;

(14) Notices of operational deficiency, and reviews and audits that are not subject to the Chapter 119. administrative procedure;

(15) Proceedings, authorized by section 5101.31 of the Revised Code and rules in Chapters 5101:6-1 to 5101:6-9 of the Administrative Code, provided to applicants for, or recipients of, benefits administered by the department, its designees, or contractors;

(16) Personnel action appeals of employees of ODM or of a county department of job and family services;

(17) Disputes involving the issuance, denial, or termination of a contract, a grant, or an interagency agreement issued by ODM or a protest filed with regard to a request for proposals or a request for application issued by ODM;

(18) Administrative actions taken by ODM that involve program administration and funding affecting county departments of job and family services.

(D) Except as otherwise set forth in the Ohio Administrative Code, actions taken that meet the exceptions of paragraph (C) of this rule and other administrative actions regarding medicaid providers that are not subject to hearings under Chapter 119. of the Revised Code and those individuals or providers who do not have medicaid provider agreements and are proposed for exclusion from participation may be reconsidered by the director, assistant director, or the deputy director over the area where the contestation arose. The director, assistant director, or the deputy director may designate who conducts the reconsideration, provided that the designee was not involved in the original decision or contestation. If the department takes an action that is subject to reconsideration, the department may set deadlines by which the person affected by the action shall submit his or her written request for reconsideration and the documentation supporting the request. The deadline shall be no fewer than thirty days from the date appearing on the letter sent to the person. When the department sets a deadline for requesting reconsideration, reconsideration requests and supporting documentation received after the deadline may be considered at the departments discretion. ODM shall not reconsider its reconsideration decisions.

(1) See Chapter 5160-2 of the Administrative Code for additional provisions specific to hospital services.

(2) See Chapter 5160-3 of the Administrative Code for additional provisions specific to nursing facilities.

(3) See Chapter 5160-26 of the Administrative Code for additional provisions specific to managed care plans (MCPs).

(E) When the department takes an action under paragraph (B)(2) or (B)(3) of this rule and the provider requests an adjudication hearing pursuant to Chapter 119. of the Revised Code, the department may withhold payments to the provider if each of the following conditions is met:

(1) The department complies with the provisions of section 119.07 of the Revised Code;

(2) The department does not request a hearing continuance; and

(3) The department issues an adjudication order within thirty days after the hearing is completed.

(F) When the department takes an action under paragraph (B)(4) of this rule and the provider requests an adjudication hearing pursuant to Chapter 119. of the Revised Code, the department may withhold payment to the provider if each of the following conditions is met:

(1) The department complies with the provisions of section 119.07 of the Revised Code;

(2) The department does not request a hearing continuance;

(3) The department issues an adjudication order within thirty days after the hearing is completed; and

(4) The department withholds only an amount that does not exceed the amounts determined in the final fiscal audit.

(G) The provisions of paragraphs (E) and (F) of this rule do not apply to long-term care facilities (LTCFs). Nursing facility and ICF/IID providers whose provider agreements are terminated pursuant to paragraph (B)(5)(b) of this rule may continue to receive medicaid payments for up to thirty days after the effective date of the termination if the provider makes reasonable efforts to transfer medicaid recipients to another facility or to alternate care and if federal financial participation is provided for the payments. See Chapter 5160-3 of the Administrative Code for additional provisions specific to LTCFs.