Ohio Administrative Code

Rule 5160-1-27.1 Hold and review process.

Effective: September 3, 2015

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

(1) Hold and review without prior notification.

(a) The Ohio department of medicaid (ODM) may place a medicaid provider's claim(s) payment on hold and review, in whole or in part, without first notifying the provider for the following reasons:

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

(ii) When a provider has been indicted for a criminal offense.

(b) ODM shall notify the provider in writing within ten business days that the provider's claims have been, and will continue to be, subject to hold and review.

(2) Hold and review with prior notification.

(a) ODM may place a medicaid provider's claim(s) payment on hold and review, in whole or in part, with prior notice to the provider under the following circumstances:

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

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

(iii) A medicaid provider's agreement has been proposed for termination for reasons other than those stated in paragraph (A) of this rule; or

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

(b) ODM will notify the provider in writing within ten business days before the effective start date of the hold and review.

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

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

(D) Failure by ODM to notify a provider of a hold and review shall not impede the agency from taking actions under this rule.

(E) The notice from ODM shall:

(1) State the general reasons for the withholding of the medicaid provider's claims payments, but need not disclose any specific information concerning an ongoing investigation involving alleged fraud and/or willful misrepresentation;

(2) State the effective date ODM implements the hold and review process;

(3) State the types of services and claims, in whole or in part, that will be subject to the hold and review process;

(4) Identify the documentation required to be submitted to ODM by the provider:

(5) Inform the provider of the right to submit evidence for consideration to ODM;

(6) State the contact at ODM for questions regarding the hold and review process.

(F) Except for medicaid providers required to submit medical claims to ODM electronically, all claims from providers placed on hold and review must be submitted in non-electronic (paper) format.

(G) Providers who must submit medical claims electronically must 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 ODM.

(H) ODM may, if appropriate, send copies of the notice to 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.

(I) ODM 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:

(1) Forward the claim for adjudication;

(2) Forward the claim for denial; or

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

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