Ohio Administrative Code

Rule 5160-2-13 Utilization review.

Effective: June 12, 2022

(A) The Ohio department of medicaid (ODM) will perform or contract with a medical review entity to perform utilization review for medicaid inpatient services regardless of the payment methodology used for reimbursement of those services. For the purposes of this rule, "ODM" means ODM or its contracted medical review entity. During the course of its analyses, ODM may request information or records from the hospital and may conduct on-site medical record reviews.

(B) ODM will review a statistical sample of all admissions retrospectively.

(1) While the nature of the review will vary depending on the category of admission, all admissions selected will be reviewed to determine whether care was medically necessary on an inpatient hospital basis; to determine if the care was medically necessary as defined in rule 5160-1-01 of the Administrative Code; to determine whether the discharge occurred at a medically appropriate time; to assess the quality of care rendered as mandated in 42 C.F.R. 456.3(b), in effect as of October 1, 2021; and to assess compliance with agency 5160 of the Administrative Code.

(2) If any of the cases reviewed for a hospital do not meet the conditions described in paragraph (B)(1) of this rule, then ODM may deny payment or recoup payment beginning with the first inappropriate admission or discharge. Any negative determinations should be made by a physician.

(3) If the diagnostic or procedural information on the claim is found to be inconsistent with that found in the medical records in conjunction with the physician attestation, then changes may be made in the coding and payment may be adjusted as described in paragraph (D)(3) of this rule.

(4) ODM may determine upon retrospective review, in accordance with this rule, that the location of services was not medically necessary, but that the services rendered were medically necessary. In such instances:

(a) 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 5160-2-75 of the Administrative Code.

(b) Only laboratory and diagnostic radiology services rendered during the remainder of the medically unnecessary admission may be billed in accordance with rule 5160-2-75 of the Administrative Code.

(c) The outpatient bill will be submitted with a copy of the reconsideration affirming the original decision or the administrative decision issued in accordance with rule 5160-2-12 of the Administrative Code.

(d) The outpatient bill with attachments will 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.

(C) ODM may include in its retrospective review sample the categories of admissions described in paragraphs (C)(1) to (D)(3) of this rule.

(1) ODM may review transfers as defined in rule 5160-2-02 of the Administrative Code. The purpose of the transfer review will be to examine the documented reasons for and appropriateness of the transfer. ODM considers a transfer appropriate if the transfer is necessary because the individual needs some treatment or care that is unavailable at the transferring hospital or if there are other exceptional circumstances that justify transfer.

Cases will be individually considered by ODM based on the merits of each case. If any of the hospital's transfer cases reviewed are found to be inappropriate transfers, then ODM may intensify the review, including the addition of prepayment review and pretransfer certification. ODM may deny payment to or recoup payment from a provider who has transferred patients inappropriately.

(2) ODM may review readmissions to determine if the readmission as defined in rule 5160-2-02 of the Administrative Code is appropriate.

(a) If the readmission is related to the first hospitalization, ODM will determine if the readmission resulted from complications or other circumstances that arose because of an early discharge or other

treatment errors.

(b) If the readmission is unrelated, ODM will determine if the treatment or care provided during the readmission should have been provided during the first hospitalization.

(c) If it is determined the readmission was the result of circumstances as described in paragraph (2)(a) or (2)(b) of this rule, then any payment made for the separate admissions will be recouped. A new payment amount will be determined by collapsing any affected admissions into one payment.

(3) ODM may review claims for which outlier payments are made to determine if days or services were covered and were medically necessary. For outliers, review will be made to determine that all services were medically necessary, appropriately billed based on services rendered, ordered by a practitioner of physician services and not duplicatively billed. If it is determined that services were inappropriately billed or if days or services are determined to be noncovered or not medically necessary as described in rules 5160-1-01 and 5160-2-03 of the Administrative Code, recoupment of any overpayments will occur. Overpayments will be determined by calculating the difference between the amount paid and the amount that would be paid if the nonallowable or noncovered days or services were excluded from the claim.

(4) ODM may review admissions with short lengths of stay. Reviews in this category will be concentrated on any admission with a length of stay greater than two standard deviations below the mean length of stay for the DRG (diagnosis related groups) of that admission. This is based on the distribution, by DRG, of lengths of stay of admissions in Ohio medicaid inpatient claims. Reviews will be conducted to determine if the inpatient stay was medically necessary to provide services or if the services rendered could have been provided in an outpatient setting using observation codes as described in rule 5160-2-75 of the Administrative Code.

(5) ODM may review cases in which a denial letter has been issued by the hospital. In addition, ODM will review all cases in which the the attending practitioner of physician services or recipient (or family member) disagrees with the hospital's decision and requests a review of the case. The hospital will send a copy of each denial letter to ODM's medical review entity.

(D) ODM may review medical records to validate DRG assignment for any admission.

(1) The physician attestation process is to be completed for the medicaid program by following the medicare procedure for attestation as delineated in 42 C.F.R. 412.46, in effect as of October 1, 2021.

(2) DRG validation will be done on the basis of a review of medical records by verifying that the diagnostic and procedural coding used by the hospital is substantiated in these records.

(3) If the diagnostic and procedural information on the claim form is found to be inconsistent with that found in the medical records in conjunction with the physician attestation, the provider will submit a corrected claim reflecting this information.

(E) Pre-certification review as detailed in rule 5160-2-40 of the Administrative Code will be conducted in addition to the utilization review activities described in this rule.

(F) Outpatient hospital services may also be reviewed by ODM to determine whether the care or services were medically necessary as defined in rule 5160-1-01 of the Administrative Code, to determine whether the services were appropriately billed, and to assess the quality of care rendered as mandated in 42 C.F.R. 456.3(b), in effect as of October 1, 2021.

(G) Intensified reviews may result whenever ODM identifies inappropriate admission or billing practices during reviews conducted in accordance with this rule. These reviews may periodically necessitate that hospitals produce evidence of invoice costs supporting amounts billed for take-home drugs.

(H) Medical records will be maintained in accordance with 42 C.F.R. 482.24, in effect as of October 1, 2021. Records requested by ODM for review will be supplied within thirty calendar days of the request as described in rule 5160-1-17.2 of the Administrative Code. Failure to produce records within thirty days will result in withholding or recoupment of medicaid payments.

(I) With the exception of paragraph (H) of this rule, decisions made by ODM as described in this rule are appealable to ODM and are subject to the reconsideration process described in rule 5160-2-12 of the Administrative Code.

(J) Over or under payments resulting from a utilization review will be settled in accordance with section 5164.57 of the Revised Code.

(K) Recovery of payments for professional services.

Payments made in accordance with appendix DD to rule 5160-1-60 of the Administrative Code for professional services that are associated with a recouped hospital payment that is not eligible for resubmission due to the results of a utilization review, will be recovered by ODM.