Ohio Administrative Code

Rule 5160-2-24 Audits.

Effective: February 19, 2023

(A) General provisions.

(1) Audits will be conducted by the Ohio department of medicaid for services rendered by the hospital under the medicaid program. The examination of hospital costs and charges will be made in consideration with generally accepted auditing standards necessary to fulfill the scope of the audit. To facilitate this examination, providers will make available all records and source documents necessary to fully disclose the extent of services provided to program recipients, the corresponding costs and charges made and payments received for such services, for the period corresponding to the cost-reporting period. The principle objective of the audit is to enable the department to determine that payment has been, or will be made, in accordance with federal, state, and department standards. Based on the audit, adjustments in payments to the provider will be made as necessary by provisions of this rule. Records necessary to fully disclose the extent of services provided will be maintained for a period of six years or, if an audit has been initiated, until the audit is completed and every exception is resolved. Said records will be made available, upon request, to the department for audit purposes. No payment for outstanding medical services can be made if a request for audit is refused.

(2) Additionally, audits will be performed to verify hospital costs and charges utilized in the determination of the hospital's contribution to and reimbursement from the hospital care assurance fund and disproportionate share fund as described in rules 5160-2-08, 5160-2-08.1, 5160-2-09 and 5160-2-10 of the Administrative Code.

(3) All audit activities described in this rule may be undertaken during any rate year for the purpose of assuring accuracy of data maintained by the department.

(B) Scope of audits for hospital services reimbursed on a non-diagnostic related groups (DRG) prospective payment basis.

(1) For hospital services reimbursed on a non-DRG prospective payment basis as identified in rule

5160-2-22 of the Administrative Code, audits are performed to determine whether:

(a) Services billed were provided;

(b) Services were provided to persons eligible as medicaid recipients on the date(s) services were rendered;

(c) Services billed are covered under the medicaid program in accordance with Chapter 5160-2 of the Administrative Code;

(d) Costs reported to the department represent actual incurred, reasonable, and allowable costs in accordance with the provisions of rule 5160-2-22 of the Administrative Code;

(e) Payments made to the hospital for services rendered during the cost period being audited were sufficient or insufficient in relation to audit findings;

(f) Payments made under medicaid are, in the aggregate on a statewide basis, equal to or less than amounts that would have been recognized under Title XVIII (medicare) of the Social Security Act in accordance with 42 C.F.R. 447.272 effective as of October 1, 2022 for comparable services and on a hospital-specific basis equal to or less than the provider's customary and prevailing charges for comparable services in accordance with 42 C.F.R. 447.253 effective as of October 1, 2022;

(g) Amounts of third-party payments reported to the department as described in rules 5160-1-08 and 5160-2-25 of the Administrative Code reflect the actual amounts received;

(h) For the purpose of updating interim payment rates that are subject to cost settlement, desk audit procedures will take into consideration the relationship between the prior year's reported costs and audited costs; and

(i) Amounts paid by the hospital and payments made by the department related to the indigent care adjustments described in rules 5160-2-09 and 5160-2-10 of the Administrative Code were based upon data described in rules 5160-2-09 and 5160-2-10 of the Administrative Code.

(2) Underpayments or overpayments determined as a result of findings made under the provisions of paragraphs (B)(1)(a) to (B)(1)(h) of this rule will be reconciled at the time of final settlement as described in paragraph (D)(2) of this rule taking into account any adjustments made during interim settlements as provided in rule 5160-2-23 of the Administrative Code.

(C) Scope of audits for hospital services reimbursed on a prospective payment basis.

(1) For hospitals services subject to prospective payment, audit activities are undertaken for several purposes. For each cost-reporting period, cost reports are audited, following the criteria outlined in paragraphs (C)(1)(a) to (C)(1)(e) of this rule for the purpose of reaching interim and final settlement with a hospital. For determination of amounts related to indigent care adjustment provisions described in rules 5160-2-09 and 5160-2-10 of the Administrative Code, audit steps will be performed following the criteria outlined in paragraph (C)(1)(h) of this rule. During years in which prospective payments are being rebased, additional activities such as those described in paragraphs (C)(1)(f) and (C)(1)(g) of this rule are undertaken to establish program costs used for the calculations described in rules 5160-2-65 and 5160-2-75 of the Administrative Code. For hospital services subject to prospective payment, desk or field audits of interim cost reports are performed to determine whether:

(a) Services billed were provided.

(b) Services billed were provided to persons eligible as medicaid recipients on the date(s) services were rendered.

(c) Services billed are covered under the medicaid program in accordance with Chapter 5160-2 of the Administrative Code.

(d) Payments made under medicaid are, in the aggregate on a statewide basis, equal to or less than amounts that would have been recognized under Title XVIII (medicare) of the Social Security Act in accordance with 42 C.F.R. 447.272 effective as of October 1, 2022 for comparable services and on a hospital-specific basis equal to or less than the provider's customary and prevailing charges for comparable services in accordance with 42 C.F.R. 447.253 effective as of October 1, 2022.

(e) Amounts of third-party payments reported to the department as described in rules 5160-1-08 and 5160-2-25 of the Administrative Code reflect the actual amounts received.

(f) Costs reported to the department represent actual incurred, reasonable, and allowable costs in accordance with rule 5160-2-22 of the Administrative Code.

(g) Medicaid discharges, visits, and associated charges and days as reported on the cost report are consistent with those reflected for the same period in the department's paid claims history. In cases where data submitted by the hospital on the cost report are inconsistent with data in the department's paid claims data file, the cost report is subject to adjustment as described in paragraph (D)(2) of this rule. Inconsistencies subject to adjustment include, but are not limited to:

(i) Submitted discharges and visits lower than those in the department's paid claims data file;

(ii) Submitted charge-to-day ratio lower than that in the department's paid claims data file;

(iii) Submitted charges lower than those in the department's paid claims data file; and

(iv) Other inconsistencies that necessitate analysis and auditor judgment to determine the appropriate type of adjustment.

(h) Amounts related to indigent care adjustments described in rules 5160-2-09 and 5160-2-10 of the Administrative Code were based upon data described in rules 5160-2-09 and 5160-2-10 of the Administrative Code.

(2) For hospitals subject to prospective payment for inpatient and outpatient services, the audits may result in the following adjustments:

(a) If the review identified in paragraphs (C)(1)(g)(i) to (C)(1)(g)(iv) of this rule indicates that the cost report reflects fewer medicaid discharges or visits, or a discrepancy exists between reported medicaid charges and those reflected in the department's paid claims data file, the interim cost report may be adjusted to reflect inpatient days, outpatient visits, charges, and discharge counts from the department's paid claims data file.

(b) If the reviews identified in paragraphs (C)(1)(a) to (C)(1)(c) and (C)(1)(e) of this rule indicate that inappropriate charges were attributed to medicaid program charges in the cost report, the interim cost report will be adjusted to remove such charges.

(c) If the review described in paragraph (C)(1)(f) of this rule identifies that nonallowable disallowed costs were included in the cost report, the interim cost report will be adjusted to remove such costs.

(3) Overpayments determined as a result of findings made under the provisions of paragraphs (C)(1)(a) to (C)(1)(e) of this rule will be collected by the department.

(D) Interim and final settlement.

(1) Any adjustments described in paragraph (C)(2) of this rule will be reflected in the interim or final settlement cost report. Overpayments or underpayments, as described in paragraphs (C)(1)(a) to (C)(1)(d) of this rule, will be collected by the department as settlements based upon findings associated with the cost-reporting period being settled.

(2) Final settlement constitutes the implementation of the final fiscal audit for a cost-reporting period.

(a) Any adjustments not incorporated into interim settlement will be incorporated into final settlement for that cost-reporting period.

(b) Any pending request for reconsideration filed pursuant to paragraphs (B) and (C) of rule 5160-2-12 of the Administrative Code will be incorporated into final settlement.

(c) If a hospital has an outstanding medicare appeal that has not been resolved and that could affect settlement of hospital-specific rate components, the hospital may accept, with reservations, final settlement incorporating adjustments not based on unresolved medicare audit exceptions and hold open that portion of the settlement, with all rights to appeal under Chapter 119. of the Revised Code, based on unresolved medicare audit exceptions.

(d) In no instance will adjustments to rates that were in effect during the period covered by final settlement be made following final settlement. Components of rates that are based solely on hospital-specific data are subject to recalculation and adjustment after such rates have been in effect for two prospective payment periods following the implementation of rebased rate components.