Ohio Revised Code

Section 5164.38 Adjudication orders of department.

Effective: October 17, 2019
Legislation: House Bill 166 - 133rd General Assembly

(A) As used in this section:

(1) "Party" has the same meaning as in division (G) of section 119.01 of the Revised Code.

(2) "Revalidate" means to approve a medicaid provider's continued enrollment as a medicaid provider in accordance with the revalidation process established in rules authorized by section 5164.32 of the Revised Code.

(B) This section does not apply to either of the following:

(1) Any action taken or decision made by the department of medicaid 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;

(2) Any action taken by the department under division (D)(2) of section 5124.60, division (D)(1) or (2) of section 5124.61, or sections 5165.60 to 5165.89 of the Revised Code.

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

(1) Refuse to enter into a provider agreement with a medicaid provider;

(2) Refuse to revalidate a medicaid provider's provider agreement;

(3) Suspend or terminate a medicaid provider's provider agreement;

(4) Take any action based upon a final fiscal audit of a medicaid provider.

(D) Any party who is adversely affected by the issuance of an adjudication order under division (C) of this section may appeal to the court of common pleas of Franklin county in accordance with section 119.12 of the Revised Code.

(E) The department is not required to comply with division (C)(1), (2), or (3) of this section whenever any of the following occur:

(1) The terms of a 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) The terms of a 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) The medicaid provider's application for a provider agreement is denied, or the provider's 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 (D) or (E) of section 5164.35 of the Revised Code;

(c) The provider's termination, suspension, or exclusion from the medicare program or from another state's medicaid program and, in either case, the termination, suspension, or exclusion is binding on the provider's participation in the medicaid program in this state;

(d) The provider's pleading guilty to or being convicted of a criminal activity materially related to either the medicare or medicaid program;

(e) The provider or its owner, officer, authorized agent, associate, manager, or employee having been convicted of one of the offenses that caused the provider's provider agreement to be suspended pursuant to section 5164.36 of the Revised Code;

(f) The provider's failure to provide the department the national provider identifier assigned the provider by the national provider system pursuant to 45 C.F.R. 162.408.

(4) The medicaid provider's application for a provider agreement is denied, or the provider's 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 provider's medicaid participation.

(5) The medicaid provider's provider agreement and medicaid payments to the provider are suspended under section 5164.36 or 5164.37 of the Revised Code.

(6) The medicaid provider's application for a provider agreement is denied because the provider's application was not complete;

(7) The medicaid provider's provider agreement is converted 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.

(8) Unless the medicaid provider is a nursing facility or ICF/IID, the provider's provider agreement is not revalidated pursuant to division (B)(1) of section 5164.32 of the Revised Code.

(9) The medicaid provider's provider agreement is suspended, terminated, or not revalidated 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;

(b) The provider has not billed or otherwise submitted a medicaid claim for two years or longer.

(F) In the case of a medicaid provider described in division (E)(3)(f), (6), (7), or (9)(b) of this section, the department may take its action by sending a notice explaining the action to the provider. The notice shall be sent to the medicaid provider's address on record with the department. The notice may be sent by regular mail.

(G) The department may withhold payments for medicaid services rendered by a medicaid provider during the pendency of proceedings initiated under division (C)(1), (2), or (3) of this section. If the proceedings are initiated under division (C)(4) of this section, the department may withhold payments only to the extent that they equal amounts determined in a final fiscal audit as being due the state. This division does not apply if the department fails to comply with section 119.07 of the Revised Code, requests a continuance of the hearing, or does not issue a decision within thirty days after the hearing is completed. This division does not apply to nursing facilities and ICFs/IID.