

ACTION: Final

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Appeals and reconsideration of departmental determinations regarding hospital inpatient and outpatient services.

(A) General.

Pursuant to rules 5101:3-1-57 and 5101:6-50-01 of the Administrative Code, hospitals may appeal under Chapter 119. of the Revised Code final settlements that are based upon final audits by the department. Rule 5101:3-2-24 of the Administrative Code describes ~~the nature of final fiscal audits and final settlements performed by the department's bureau of financial audits department.~~ Rules 5101:3-1-29 and 5101:3-1-27 of the Administrative Code describe the audits performed by the department's ~~bureau of surveillance and utilization review section, the implementation of which~~ are also appealable under Chapter 119. of the Revised Code. Since the scope and substance of these two types of audits differ, in no instance will the conduct and implementation of one type of audit preclude the conduct and implementation of the other.

(B) Utilization review reconsideration.

Pursuant to rule 5101:3-2-07.13 of the Administrative Code, the department or a medical review entity under contract to the department may make determinations regarding utilization review in accordance with the standards set forth in rules 5101:3-2-02, 5101:3-2-07.9, 5101:3-2-07.13, and 5101:3-2-40, ~~and 5101:3-2-42~~ of the Administrative Code. These determinations are subject to the reconsideration process described in rule 5101:3-1-57 of the Administrative Code as follows:

- (1) A written request for a reconsideration must be submitted to the department or the medical review entity, whichever made the initial determination, within sixty days of the date of the determination. The department or the medical review entity shall have thirty working days from receipt of the request for reconsideration to issue a written decision accepting, modifying, or rejecting its previous determination. The request for reconsideration must include:
- (a) A copy of the written determination;
 - (b) A copy of the patient's medical record; and
 - (c) Copies of any and all additional information that may support the provider's position.
 - ~~(d) The department or the medical review entity shall have thirty working days from receipt of the request for reconsideration to issue a written decision accepting, modifying, or rejecting its previous determination.~~

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(2) The department will conduct an administrative review of the reconsideration decision if the provider submits its request within thirty days of that decision. The department shall have thirty working days from receipt of the request for review to issue a final and binding decision. A request for an administrative review must include:

- (a) A letter requesting a review of the reconsideration;
- (b) A statement as to why the provider believes that the reconsideration decision was in error; and
- (c) Any further documentation supporting the provider's position.

~~(d) The department shall have thirty working days from receipt of the request for review to issue a final and binding decision.~~

(3) The department may extend time frames described in paragraphs (B)(1); ~~(B)(1)(d); and (B)(2) and (B)(2)(d)~~ of this rule, where adherence to time frames causes exceptional hardships to a large number of hospitals or where adherence to time frames as described in paragraphs (B)(1); ~~(B)(1)(d); and (B)(2) and (B)(2)(d)~~ of this rule causes exceptional hardship to a hospital because potential determinations constitute a large portion of that hospital's total medicaid business.

(C) Reconsideration of inpatient hospital payments.

(1) Except when the department's determination is based on a finding made by medicare, the proper application of rules 5101:3-2-07.1 and 5101:3-2-07.2 of the Administrative Code and the proper calculation of amounts (including source data used to calculate the amounts) determined in accordance with rules 5101:3-2-07.4, 5101:3-2-07.6, and 5101:3-2-07.7 of the Administrative Code are subject to the reconsideration process described in rule 5101:3-1-57 of the Administrative Code as follows:

- (a) Requests for reconsideration authorized by paragraph (C)(1) of this rule must be submitted to the department in writing. If the request for reconsideration involves a rate component or determination made at the beginning of the rate year, the request must be submitted within ninety days of the beginning of the rate year. If the request involves an adjustment or a determination made by the department after the beginning of the rate year, the request must be submitted within thirty days of the date the adjustment or determination was implemented. The

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request must include a statement as to why the provider believes that the rate component or determination was incorrect as well as all documentation supporting the provider's position.

(b) The department shall have thirty days from receipt of the request for reconsideration to issue a final and binding decision.

(2) When a medicare audit finding was used by the department in establishing a rate component and the finding is subsequently overturned on appeal, the provider may request reconsideration of the affected rate component. Such requests must be submitted to the department in writing prior to final settlement as described rule 5101:3-2-24 of the Administrative Code and within thirty days of the date the hospital receives notification from medicare of the appeal decision. The request for reconsideration of a medicare audit finding that has been overturned on appeal must include all documentation that explains the appeal decision. The department shall have thirty days in which to notify the provider of its final and binding decision regarding the medicare audit finding.

(3) Reconsideration may also be requested if a hospital believes that a claim or claims were paid in error because of an incorrect DRG (diagnosis related groups) assignment or incorrect payment calculation. In such an instance, the hospital must resubmit the claim(s) for an adjustment as described in rule 5101:3-1-19.8 of the Administrative Code. Following the adjustment process, if the hospital continues to believe that the department's DRG assignment or payment calculation was in error, the provider may submit a written request for reconsideration that includes all documentation supporting the providers position. In this instance, the department shall have sixty days in which to notify the provider of its final and binding decision.

(D) State hearings for medicaid recipients whose claim for inpatient hospital services is denied.

Any recipient whose claim for inpatient hospital services is denied may request a state hearing in accordance with ~~division-level designation~~ division 5101:6 of the Administrative Code. The determination of whether outlier payments will be made or the amounts of outlier payments as described in rule 5101:3-2-07.9 of the Administrative Code is not a denial of a claim for inpatient hospital services. Similarly, the determination of amounts payable for inpatient hospital services involving readmissions or transfers is not a denial of a claim for inpatient hospital services.

(E) The following items are not subject to the department's reconsideration process:

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- (1) The use of the DRG classification system and the method of classification of discharges within DRGs.
- (2) The assignment of relative weights to DRGs based on the methodology set forth in rule 5101:3-2-07.3 of the Administrative Code.
- (3) The establishment of peer groups as set forth in rule 5101:3-2-07.2 of the Administrative Code.
- (4) The methodology used to determine prospective payment rates as described in rules 5101:3-2-07.4 and 5101:3-2-07.6 to 5101:3-2-07.8 of the Administrative Code.
- (5) The methodology used to identify cost and day thresholds for services ~~which~~ that may qualify for outlier payments as described in rule 5101:3-2-07.9 of the Administrative Code.
- (6) The formulas used to determine rates of payment for outliers, certain transfers and readmissions, and services subject to preadmission certification, as described, respectively, in rules 5101:3-2-07.9, 5101:3-2-07.11, and 5101:3-2-40, ~~and 5101:3-2-42~~ of the Administrative Code.
- (7) The peer group average cost per discharge for all hospitals except when the conditions detailed in rule 5101:3-2-07.8 of the Administrative Code are met.
- (8) Statewide calculations of the direct and indirect medical education threshold for allowable costs per intern and ~~residents~~ resident as described in rule 5101:3-2-07.7 of the Administrative Code and of the threshold for establishing which hospitals will be recognized as providing a disproportionate share of indigent care as described in rule 5101:3-2-07.5 of the Administrative Code.

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Certification

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