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5101:3-2-07.13 **Utilization control.**

(A) The Ohio department of job and family services shall perform or shall require a medical review entity to perform utilization review for medicaid inpatient services regardless of the payment methodology used for reimbursement of those services. The nature of this program is described in paragraphs (A) to (E) of this rule. Utilization review of outpatient hospital services is described in paragraph (F) of this rule. For the purposes of this rule, "ODJFS" means ODJFS or its contractual designee. ODJFS, during the course of its analyses, may request information or records from the hospital and may conduct on-site medical record reviews. Reviews shall be completed within twelve months of the payment date and in the case of interim payments described in rule 5101:3-2-07.11 of the Administrative Code within twelve months after the last payment has been made. Paragraphs (C) to (D)(3) of this rule provide examples of reviews to be completed by ODJFS.

(B) ODJFS shall review a minimum of two per cent of all admissions retrospectively. Admissions selected for review will be drawn from several categories including but not limited to those identified in paragraphs (C)(1) to (D)(3) of this rule.

(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 ~~as described in rule 5101:3-2-40 of the Administrative Code~~; to determine if the care was medically necessary as defined in rule 5101:3-2-02 of the Administrative Code; to determine whether the discharge occurred at a medically appropriate time, to assess the quality of care rendered as described in 42 ~~CFR~~ C.F.R. 456.3(b), and to assess compliance with division 5101:3 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 ~~the department~~ ODJFS may deny payment or recoup payment beginning with the first inappropriate admission and/or discharge. ~~In all instances, physicians will make any negative determination.~~ Any negative determinations must be made by a physician.

(3) If the diagnostic and/or procedural information on the claim form 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.

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

(1) ODJFS may review transfers as defined in rule 5101:3-2-02 of the

Administrative Code. The purpose of the transfer review will be to examine the documented reasons for and appropriateness of the transfer. ODJFS considers a transfer as appropriate if the transfer is required because the individual requires some treatment or care ~~which~~ that is unavailable at the transferring hospital or if there are other exceptional circumstances that justify transfer. Because this provision addresses exceptional cases, it is impossible to delineate exact criteria to cover all possible circumstances. Cases will be individually considered by ODJFS based on the merits of each case. If any of the hospital's transfer cases reviewed are found to be inappropriate transfers, then ~~the department~~ ODJFS may intensify the review, including the addition of prepayment review and pretransfer certification. ODJFS may deny payment to or recoup payment from a provider who has transferred patients inappropriately.

(2) ODJFS may review readmissions as readmissions are defined in rule 5101:3-2-02 of the Administrative Code. The purpose of readmission review is to determine if the readmission is appropriate. If the readmission is related to the first hospitalization, ODJFS will determine if the readmission resulted from complications or other circumstances ~~which~~ that arose because of an early discharge and/or other treatment errors. If the readmission is unrelated, ODJFS will determine if the treatment or care provided during the readmission should have been provided during the first hospitalization. If it is determined the readmission was inappropriate, 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) ODJFS 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 ~~in terms of having actually been~~ based on services rendered, ordered by the physician, 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 5101:3-2-02 and 5101:3-2-03 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 ~~which~~ that would be paid if the nonallowable or noncovered days or services were excluded from the claim.

(4) ODJFS 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 5101:3-2-21 of the Administrative Code.

(5) ODJFS shall review cases in which a denial letter has been issued by the hospital. In addition, ODJFS shall review all cases in which the attending physician and/or recipient (or family member) disagrees with the hospital's decision and requests a review of the case. The hospital must send a copy of each denial letter to ~~the department's~~ ODJFS's medical review entity.

(D) ODJFS 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 ~~CFR~~ C.F.R. 412.46.

(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, ODJFS may correct the claim information and recalculate payment based on the appropriate DRG assignment. If the recalculation shows an overpayment was made to the hospital, the overpayment will be reconciled as an adjustment to the claim. In all instances, the information found in the medical record when used in conjunction with the physician attestation is controlling.

(E) Pre-certification review as detailed in ~~rules~~ rule 5101:3-2-40 ~~and 5101:3-2-42~~ of the Administrative Code shall be conducted in addition to the utilization review activities described in this rule.

(F) Outpatient hospital services may also be reviewed by ODJFS ~~or its contractual designee~~ to determine whether the care or services were medically necessary as defined in rule 5101:3-2-02 of the Administrative Code, to determine whether the services were appropriately billed, and to assess the quality of care rendered as described in 42 ~~CFR~~ C.F.R. 456.3(b).

(G) Intensified reviews may result whenever ODJFS identifies inappropriate admission or billing practices during reviews conducted in accordance with this rule.

(H) Medical records must be maintained in accordance with 42 ~~CFR~~ C.F.R. 482.24. Records requested by ODJFS for review must be supplied within thirty days of the request as described in rule 5101:3-1-17.2 of the Administrative Code. Failure to produce records within thirty days shall result in withholding or recoupment of medicaid payments.

(I) Decisions made by the medical review entity as described in this rule are appealable to the medical review entity and are subject to the reconsideration process described in rule 5101:3-2-07.12 of the Administrative Code.

(J) ODJFS has delegated to the Ohio department of mental health ~~(ODHM)~~ (ODMH) the authority to make determinations regarding utilization review for inpatient psychiatric services in accordance with paragraphs (B), (C), (D), and (E) of this rule.

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