## CHAPTER 2. GRIEVANCE PROCEDURES AND PROCESS

**317:2-1-7. Surveillance, Utilization and Review System (SURS) and Program Integrity Audits/Reviews appeals**

SURS and Program Integrity Audits/Reviews appeals are made to the State Medicaid Director.

(1) If a provider disagrees with a decision of the ~~Surveillance, Utilization and Review System Unit (SURS)~~ SURS or Program Integrity Audit/Review which has determined that the provider has received an overpayment, the provider may appeal, within 20 days of the date of that decision to the State Medicaid Director.

(2) The appeal from the SURS or Program Integrity Audit/Review decision ~~will be~~ is commenced by the receipt of a letter from the appellant provider. The letter must set out with specificity, the overpayment decision to which the provider objects along with the grounds for appeal. The letter should explain in detail, the factual and/or legal basis for disagreement with the allegedly erroneous decision. The letter ~~will~~ should also include all relevant exhibits the provider believes necessary to decide the appeal.

(3) Upon ~~the~~ receipt of the appeal by the docket clerk, the matter ~~will be~~ is docketed for the next meeting of the ~~MAC~~ Medical Advisory Committee (MAC). Any appeal received less than four weeks before a scheduled MAC meeting will be set for the following MAC meeting.

(4) The appeal ~~will be~~ is forwarded to the ~~SURS unit or Program Integrity Audit/Review unit~~ OHCA Legal Services Division by the docket clerk for distribution to the members of the subcommittee and for preparation of the OHCA's case. A subcommittee of the MAC ~~will be~~ is formed and ~~render~~ renders a recommendation to the State Medicaid Director.

(5) At the discretion of the MAC, witnesses may be called and information may be solicited from any party by letter, telephonic communication, fax, or other means. The subcommittee may request that members of the Authority be present during their consideration of the appeal. Members of the Authority's Legal Division may be asked to answer legal questions regarding the appeal.

(6) The subcommittee ~~will issue~~ issues a recommendation regarding the appeal, in writing,

within 30 days of the hearing. An exception to the 30 day rule ~~will apply~~ applies in cases where the subcommittee sets the case over until its next scheduled meeting in order to gather additional evidence. The written recommendation ~~will list~~ lists the members of the subcommittee who participated in the decision. In cases where an appeal must be continued, the subcommittee ~~will issue~~ issues a letter within 30 days of the initial hearing to inform the appellant of the continuance.

(7) The recommendation, after being formalized, ~~will be~~ is sent to the docket clerk for review by the State Medicaid Director. The State Medicaid Director ~~will issue~~ issues a decision regarding the appeal within 60 days of the docket clerk's receipt of the recommendation from the MAC. The decision ~~will be~~ is issued to the appellant or his/her authorized agent.

(8) If the provider is dissatisfied with the Medicaid Director's decision, it may be appealed to the CEO under OAC 317:2-1-13.