6 Prepayment Review Steps For Ohio Medicaid Providers

By **Cole DuBose and John Carney** (November 19, 2026)



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A new Ohio law governing Medicaid managed care prepayment review took effect on Oct. 6. The statute, Ohio Revised Code Section 5167.23, gives providers placed on prepayment review under its provisions a way to challenge the review: written notice, a statutorily required managed care organization grievance process, and a right to appeal to the Ohio Department of Medicaid if the grievance process is unsuccessful.

Previously, Ohio MCOs generally paid claims upfront and sought to recoup noncompliant claims later. More recently, in response to concerns about fraud, waste and abuse, MCOs have placed behavioral health providers on prepayment review, requiring supporting documentation to be reviewed before claims are paid. Providers report that the documentation and submission requirements have become particularly burdensome, resulting in claim denials and delayed payments.

The new law provides a framework for challenging prepayment review, but the processes and remedies available to a provider depend on whether the provider was placed on review before or after the law's effective date. This article addresses practical steps providers can take in response to prepayment review and how the statutory change may alleviate some of the problems providers have experienced.

Regardless of whether the new statute's protections apply, providers should preserve their claim-level appeal rights, review their provider agreements for any additional contractual remedies, monitor the MCO's compliance with applicable claims-processing and payment requirements, and consider legal action for violations of Ohio's Prompt Payment Law.

Each issue may have a different deadline and process. Accordingly, the most effective response is to preserve the notice, create a claim log, use the applicable grievance process, and build a record supporting the applicable administrative or contractual remedies.

1. Obtain notice and identify MCO concerns.

Under the new statute, an MCO must obtain ODM approval before placing a provider on prepayment review. For approval, the MCO must present credible indicators of fraud, waste or abuse by the provider. If placed on prepayment review, providers should preserve the MCO's written notice and determine what the MCO is actually requiring.

The notice should be reviewed for several basic points:

- When did the review begin?
- Which location, services and claims are covered?
- What records must be submitted, and by when?
- What concern does the MCO identify?
- What grievance process and deadlines does the MCO identify?

Providers should request clarification when the notice does not identify the affected claims, services, time period, or documentation requirements with enough detail to permit a meaningful response. A provider also should ask for the MCO's grievance policy and any instructions, forms or deadlines that apply.

This early review helps the provider respond accurately to the MCO's concerns and identify potential grounds to challenge the review, including an unclear written basis, an inadequate grievance process, or a review that extends beyond the concerns identified in the notice.

2. Act expeditiously and build a record.

To challenge placement on prepayment review, providers should first identify the applicable MCO grievance or review process, which will depend on whether the provider was placed on review before or after the statute's effective date. Regardless of the applicable process, providers should clearly document the basis for their challenge and build a record to support any subsequent available appeal.

Before filing, providers should calendar every deadline and confirm the MCO's submission requirements, including deadlines for the grievance and record requests, required forms and the expected date of the MCO's decision. Providers should submit materials in a way that creates a clear record of what was sent and when.

The grievance should directly address the MCO's stated reason for review and explain how the supporting documents answer the specific concern and identify any misunderstanding of the services, billing practice or patient population at issue.

Providers should also request practical relief. The appropriate request will depend on the facts, but may include:

- Limiting review to the services, codes, locations or time periods at issue;
- Establishing a defined schedule for the MCO to decide submitted claims;
- Paying claims that are fully supported and not affected by the identified concern;
- Identifying a single point of contact for records and claim-status questions; and
- Providing clear, objective conditions for release from prepayment review.

3. Avoid missing claims deadlines.

A provider's challenge to prepayment review is not the same as a challenge to an individual claim denial. A grievance about the overall review may not preserve the provider's rights to dispute each claim.

Accordingly, providers should maintain a separate claim log for each MCO and continue to use the MCO's ordinary claim dispute and appeal procedures for individual denials. At a minimum, the log should show the service date, claim number, submission date, records requested, records provided, proof of delivery, MCO decision, denial reason, amount at issue, and applicable dispute or appeal deadlines. Providers should also identify claims that remain pending without a decision.

4. Monitor claims payments and preserve prompt pay arguments.

Prepayment review does not give an MCO unlimited time to hold a claim. Providers should review the applicable Ohio prompt-pay requirements under the Prompt Payment Law, the provider agreement and the MCO's policies to determine whether claims are being decided and paid within the required timeframes.

The key question is often whether a claim is clean or whether the MCO has a permitted basis to request additional information or deny payment. A provider should therefore separate claims that are genuinely under review from claims that are complete, supported,

and not tied to the stated concern.

If claims remain unpaid, providers should ask the MCO to identify the status of each claim and the specific reason payment has not been made. Providers should raise payment-timing concerns in the grievance process when they relate to the review and through the claim dispute process when they relate to particular claims.

Although prompt-pay rules do not necessarily require payment of a claim that the MCO may lawfully review, they may support a challenge to continued delay or the withholding of claims outside the stated scope of the prepayment review. Counsel should evaluate the governing statute, regulations, agreement and facts before asserting a prompt-pay violation.

5. Review the provider agreement for additional rights.

Providers should review their MCO agreement for provisions addressing payment, documentation, record production, audit or review rights, claim disputes, arbitration, notice, and remedies.

The agreement may provide protections beyond those established by the new law, including deadlines for MCO decisions or a separate process for claim disputes. It may also require arbitration or another dispute-resolution step before a provider can file suit.

Providers should identify those provisions early, because contractual deadlines can run concurrently with statutory grievance and claim-level appeal deadlines.

6. Consider ODM escalation and legal remedies.

If the MCO grievance process is unsuccessful, a provider eligible for the new statutory appeal should seek review by ODM. The appeal should clearly explain the action being challenged, the provider's response to the MCO's stated concerns, the relief requested and the documents supporting that request.

Depending on the facts, providers may also consider other ODM complaint channels for claim-processing problems or MCO conduct that falls outside, or alongside, the statutory appeal. A general ODM provider complaint, however, has different requirements and serves a different purpose than the specific appeal route created by the new law.

Legal action may also be appropriate in some cases. Counsel should assess whether the provider agreement supports a payment claim, whether the agreement requires arbitration, and whether declaratory or injunctive relief is available.

If the provider faces an immediate risk of closure or serious disruption to patient care, counsel may consider emergency relief. Missing payments alone may not establish irreparable harm, so providers should document cash reserves, payroll obligations, threats to continued operations, effects on patients and why ordinary monetary relief would not adequately address the harm.

The immediate priority is to gather and organize the MCO notice, grievance procedures, provider agreement, claim records and correspondence. Providers who act early will be better positioned to challenge an improper or overly broad review, preserve payment rights on individual claims, and present a complete record to ODM if an appeal is necessary.

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