Ohio Administrative Code

Rule 5160-43-07 Specialized recovery services program compliance: provider monitoring, oversight, structural reviews and investigations.

Effective: August 1, 2016

(A) The Ohio department of medicaid (ODM) is responsible for the ongoing monitoring and oversight of all providers of specialized recovery services (hereafter referred to as providers) and contractors to ensure compliance with program requirements.

(B) Monitoring and oversight of specialized recovery services program providers and recovery management contractors:

(1) ODM and/or its designee (hereafter referred to as ODM) shall conduct ongoing monitoring and oversight of providers and contractors, to verify each provider is:

(a) Complying with the terms and conditions of its medicaid provider agreement or contract, the program and all applicable federal, state and local regulations;

(b) Ensuring the health and welfare of individuals to whom they provide services; and

(c) Ensuring the provision of quality services as part of the program.

(2) Monitoring and oversight may include, but is not limited to:

(a) Interviews with individuals enrolled in the program and/or their authorized representative or legal guardian, providers and contractor staff;

(b) Visits to the provider's place of business or another agreed upon location for the purpose of examining or collecting records, reviewing documentation, and conducting structural reviews; and

(c) Reviews of electronic and/or hard copy records and billing documentation.

(3) Providers and contractors shall fully cooperate with all requests made by ODM, as part of the

monitoring and oversight process. This includes, but is not limited to:

(a) Upon request, arranging for or furnishing an adequate workspace for ODM to conduct visits. This workspace must be in a secure location which protects sensitive information from being disclosed contrary to relevant confidentiality and information disclosure laws;

(b) Making all requested information available at the time of review, and in accordance with the terms of compliance with contracts, as applicable; and

(c) Ensuring the availability of supervisors and/or other staff who may possess relevant information to answer questions.

(4) At the conclusion of a provider monitoring and oversight review:

(a) ODM shall notify the provider or contractor in writing of its findings.

(b) ODM may:

(i) Request the provider or contractor submit to ODM a plan of correction within the prescribed time frame. The plan of correction shall set forth the action(s) that must be taken by the provider or contractor to correct each finding, and establish a target date by which the corrective action must be completed. If ODM does not approve the submitted plan of correction, ODM may request a new plan of correction or take other appropriate action;

(ii) Provide technical assistance to the provider or contractor;

(iii) Refer the provider or contractor to other regulatory and oversight entities for further investigation;

(iv) Issue the provider or contractor a notice of operational deficiency based upon the review and findings;

(v) Propose suspension or termination of the provider's medicaid provider agreement pursuant to

section 5164.38 of the Revised Code and rules 5160-1-17.5 and 5160-1-17.6 of the Administrative Code, as applicable; or

(vi) Terminate the contractor's contract pursuant to its terms.

(C) Structural reviews.

(1) All service providers shall be subject to structural reviews by ODM during each of the first three years after a provider begins furnishing billable services. Thereafter, structural reviews shall be conducted annually unless, at the discretion of ODM, biennial structural reviews may be conducted with a provider when all of the following apply;

(a) There were no findings against the provider during the provider's most recent structural review;

(b) The provider was not substantiated to be the violator in an incident described in rule 5160-43-06 of the Administrative Code; and

(c) The provider was not the subject of more than one provider occurrence during the previous twelve months.

(2) All program service providers may be subject to an announced or unannounced structural review at any time as determined by ODM.

(3) Structural reviews must be conducted in person between the provider and ODM, unless prior-approved by ODM, and in a manner consistent with paragraph (B)(3) of this rule.

(4) All structural reviews must use an ODM-approved structural review tool.

(5) Structural reviews shall not occur while the provider is furnishing services to an individual.

(6) The structural review process consists of the following activities:

(a) Except for unannounced structural reviews, the provider shall be notified in advance of the review

to arrange a mutually acceptable time, date and location for the review. Advance notification shall also include identification of the time period for which the review is being conducted and a list of the types of documents required for the review.

(b) The provider shall ensure the availability of required documents and maintain the confidentiality of information about the individual enrolled in the program.

(c) ODM shall examine any incident reports or provider occurrences related to the provider. Documented findings of non-compliance shall be addressed during the review.

(d) An evaluation of compliance with the rules within this chapter of the Administrative Code shall be conducted by ODM.

(e) A unit of service verification shall be conducted by ODM to assure that all program services are authorized, delivered and reimbursed in accordance with the individual's approved person-centered care plan.

(f) An evaluation to determine whether the provider has implemented all plans of correction that were approved since the last review.

(g) At the conclusion of the review, ODM shall conduct an exit conference with the provider to discuss preliminary findings, any remediation and other required follow-up.

(7) ODM shall issue a written findings report to the provider. The report shall summarize the overall outcome of the structural review, specify the Administrative Code rules that are the basis for which non-compliance has been determined, and outline the specific findings of non-compliance that the provider must address in a plan of correction, including any remediation.

(8) Plans of correction for structural reviews must be submitted to ODM for all identified findings of noncompliance, including any remediation, within forty-five calendar days after the date on the written report.

(9) If ODM finds the provider's plan of correction acceptable, it shall acknowledge, in writing, to the

provider that the plan addresses the findings outlined in the written report. If ODM determines that it cannot approve the provider's plan of correction, ODM shall inform the provider of this determination in writing, require the provider to submit a new plan of correction and specify the required actions that must be included in the plan of correction. The provider must submit the new plan of correction within ten calendar days.

(10) If ODM determines through the structural review process that an overpayment of a provider claim has occurred, the provider shall make all payment adjustments in accordance with rule 5160-1-19 of the Administrative Code and the provider's approved plan of correction.

(11) ODM may take action against the provider as specified in paragraph (B)(4)(b) of this rule for failure to comply with the structural review requirements set forth in this rule.

(D) Investigation of provider occurrences.

(1) Upon discovery, ODM or its designee shall investigate provider occurrences including requesting any documentation required for the investigation.

(2) If ODM substantiates the provider occurrence, it shall notify the provider in a manner that confirms provider receipt. The notification shall specify:

(a) The provider's action or inaction that constituted the provider occurrence;

(b) The Administrative Code rule(s) that support the finding(s) of non-compliance; and

(c) Actions the provider must take to correct the finding(s) of non-compliance, including any remediation or required payment adjustments.

(3) Plans of correction for provider occurrences must be submitted to ODM for all identified findings of non-compliance, including any remediation, within forty-five calendar days after the date on the written report.

(4) If ODM finds the provider's plan of correction acceptable, it shall acknowledge, in writing, to the

provider that the plan addresses the findings outlined in the written report. If ODM determines that it cannot approve the provider's plan of correction, it shall inform the provider of this determination in writing, require the provider to submit a new plan of correction and specify the required actions that must be included in the plan of correction. The provider must submit the new plan of correction within ten calendar days.

(5) If ODM determines through the investigation of a provider occurrence that an overpayment of a provider claim has occurred, the provider shall make all payment adjustments in accordance with rule 5160-1-19 of the Administrative Code and the provider's approved plan of correction.

(6) ODM may take action against the provider as specified in paragraph (B)(4)(b) of this rule for failure to comply with the investigation of provider occurrences requirements set forth in this rule.