5160-45-10 **ODM-administered waiver programs: Provider conditions of participation.**

(A) ODM-administered waiver service providers shall maintain a professional relationship with the individuals to whom they provide services. Providers shall furnish services in a person-centered manner that is in accordance with the individual's approved all services plan, is attentive to the individual's needs, and maximizes the individual's independence. Providers shall refrain from any behavior that may detract from the goals, objectives and services outlined in the individual's approved all services plan and/or that may jeopardize the individual's health and welfare.

(B) ODM-administered waiver service providers shall:

(1) Maintain an active, valid medicaid provider agreement as set forth in rule 5160-1-17.2 of the Administrative Code.

(2) Comply with all provider requirements as set forth in chapter 5101:3-45 of the Administrative Code, and chapter 5160-3-46, 5160-50 or 5160-3-58 of the Administrative Code, depending upon the waiver(s) for which the provider is furnishing services. Provider requirements include, but are not limited to:

(a) Provider enrollment as set forth in rule 5160-45-04 of the Administrative Code;

(b) Provider service specifications as set forth in rule 5160-46-04, 5160-46-04.1, 5160-50-04, 5160-50-04.1 or 5160-58-04 of the Administrative Code, as applicable;

(c) Criminal record checks as set forth in rule 5160-45-07 or 5160-45-08, as applicable, and rule 5160-45-11 of the Administrative Code;

(d) Incident reporting as set forth in rule 5160-45-05 of the Administrative Code; and

(e) Provider monitoring, reviews and oversight as set forth in rules 5160-45-06 and 5160-45-09 of the Administrative Code.

(3) Deliver services professionally, respectfully and legally.

(4) Ensure that individuals to whom the provider is furnishing ODM-administered waiver services are protected from abuse, neglect, exploitation and other threats to their health, safety and well-being. Upon entering into a medicaid provider agreement, and annually thereafter, all providers including all employees who have direct contact with individuals enrolled on an ODM-administered waiver, must acknowledge in writing they have reviewed rule 5160-45-05 of the Administrative Code regarding incident management and related procedures.

(5) Work with the individual and case manager to coordinate service delivery, including, but not limited to:

(a) Agreeing to provide and providing services in the amount, scope, location and duration they have capacity to provide, and as specified on the individual's approved all services plan.

(b) Participating in the development of a back-up plan in the event that providers are unable to furnish services on the appointed date and time.

(c) Contacting the individual and the case manager in the event the provider is unable to render services on the appointed date and time.

(i) In the case of an emergency or unplanned absence, the provider shall immediately activate the back-up plan as set forth in the individual's approved all services plan, and contact the individual and case manager and verify their receipt of information about the absence.

(ii) In the event of a planned absence, the provider shall contact the individual and case manager no later than seventy-two hours prior to the absence and verify their receipt of information about the absence.

(6) Upon request and within the timeframe prescribed in the request, provide information and documentation to ODM, its designee and the centers for medicare and medicaid services (CMS).

(7) Participate in all appropriate provider trainings mandated or sponsored by ODM or its designees, including but not limited to those set forth in chapters 5160-45, 5160-46, 5160-50 and 5160-58 of the Administrative Code.

(8) Be knowledgeable about and comply with all applicable federal and state laws, including the "Health Insurance Portability and Accountability Act of 1996" (HIPAA) regulations set forth in 45 C.F.R. parts 160 and 164 (January 25, 2013), and the medicaid safeguarding information requirements set forth in 42 C.F.R. 431.300 to 431.306 (November 1, 2013), along with sections 5160.45 to 5160.481 of the Revised Code.

(9) Ensure that the provider's contact information, including but not limited to address, telephone number, fax number and email address, is current. In the event of a change in contact information, the provider shall notify ODM via the medicaid information technology system (MITS) and its designee, no later than seven calendar days after such changes have occurred.

(10) Maintain and retain all required documentation related to the services

delivered during the visit, including but not limited to: an individual-specific description and details of the tasks performed or not performed in accordance with the approved all services plan and when required, the individual's plan of care.

(a) Validation of service delivery shall include, but not be limited to the date and location of service delivery, arrival and departure times, the dated signature of the provider and the dated signature of the individual or authorized representative. All signatures shall be obtained at the end of every visit or upon completion of the scheduled service. When services are rendered in multiple visits per day, signatures must be obtained upon completion of each visit.

(b) Acceptable signatures include, but are not limited to a handwritten signature, initials, a stamp or mark, or an electronic signature. Any accommodations to the individual's or authorized representative's signature shall be documented on the all services plan.

(c) Collection and maintenance of documentation, including through technology-based systems, must be in compliance with the requirements set forth in paragraph (B)(10) of this rule.

(11) Retain all records of service delivery and billing for a period of six years after the date of receipt of the payment based upon those records, or until any initiated audit is completed, whichever is longer.

(12) Cooperate with ODM and its designee during all provider monitoring and oversight activities by being available to answer questions during reviews, and by assuring the availability and confidentiality of individual information and other documents that may be requested as part of provider monitoring activities.

(13) To the extent not otherwise required by rule 5160-45-05 of the Administrative Code, notify ODM or its designee within twenty-four hours when the provider is aware of issues that may affect the individual and/or provider's ability to render services as directed in the individual's all services plan. Issues may include, but are not limited to the following:

(a) The individual consistently declines services

(b) The individual plans to or has moved to another residential address.

(c) There are changes in the physical, mental and/or emotional status of the individual.

(d) There are changes in the individual's environmental conditions.

(e) The individual's caregiver status has changed.

(f) The individual no longer requires medically necessary services as defined in rule 5160-1-01 of the Administrative Code.

(g) The individual's actions toward the provider are threatening or the provider feels unsafe or threatened in the individual's environment.

(h) The individual is consistently noncompliant with physician orders, or is noncompliant with physician orders in a manner that may jeopardize his or her health and welfare.

(i) The individual's requests conflict with his or her all services plan and/or may jeopordize his or her health and welfare.

(j) Any other situation that affects the individual's health and welfare.

(14) Make arrangements to accept all correspondence sent by ODM or its designee, including but not limited to, certified mail.

(15) Provide and maintain a current e-mail address to ODM and/or its designee in order to receive electronic notification of any rule adoption, amendment or rescission, and any other communications from ODM or its designee

(16) Submit written notification to the individual and ODM or its designee at least thirty calendar days before the anticipated last date of service if the provider is terminating the provision of ODM-administered waiver services to the individual. Exceptions to the thirty-day advance notification requirement are set forth in paragraphs (B)(16)(a) and (B)(16)(b) of this rule.

(a) The provider must submit verbal and written notification to the individual and ODM or its designee at least ten days before the anticipated last date of service if the individual:

(i) Has been admitted to a hospital;

(ii) Has been placed in an institutional setting; or

(iii) Has been incarcerated.

(b) ODM may waive advance notification for a provider upon request and on a case-by-case basis.

(C) At no time, shall the ODM-administered waiver service providers:

(1) Engage in any behavior that causes or may cause physical, verbal, mental or

emotional abuse or distress to the individual.

(2) Engage in any other behavior that may compromise the health and welfare of the individual.

(3) Engage in any activity or behavior that may take advantage of or manipulate the individual or his or her authorized representative, family or household members or may result in a conflict of interest, exploitation, or any other advantage for personal gain. This includes, but is not limited to:

(a) Misrepresentation.

(b) Accepting, obtaining, attempting to obtain, borrowing, or receiving money or anything of value including, but not limited to gifts, tips, credit cards or other items.

(c) Being designated on any financial account including, but not limited to bank accounts and credit cards.

(d) Using real or personal property of another.

(e) Using information of another.

(f) Lending or giving money or anything of value.

(g) Engaging in the sale or purchase of products, services or personal items.

(h) Engaging in any activity that takes advantage of or manipulates ODM-administered waiver program rules.

(4) Falsify the individual's signature, including using copies of the signature.

(5) Make fraudulent, deceptive or misleading statements in the advertising, solicitation, administration or billing of services.

(6) Submit a claim for waiver services rendered while the individual is hospitalized, institutionalized or incarcerated. The only exception is when the individual is receiving out-of-home respite as set forth on his or her all services plan.

(D) While rendering services, ODM-administered waiver service providers shall not:

(1) Take the individual to the provider's place of residence.

(2) Bring children, animals, friends, relatives, other individuals or anyone else to the individual's place of residence.

(3) Provide care to persons other than the individual.

(4) Smoke without the consent of the individual.

(5) Sleep.

(6) Engage in any activity that is not related to the provision of services to the extent the activity distracts from, or interfers with, service delivery. Such activities include, but are not limited to the following:

(a) Using electronic devices for personal or entertainment purposes including, but not limited to watching television, using the computer or playing games.

(b) Making or receiving personal communications.

(c) Engaging in socialization with persons other than the individual.

(7) Deliver services when the provider is medically, physically or emotionally unfit.

(8) Use or be under the influence of the following while providing services:

(a) Alcohol.

(b) Illegal drugs.

(c) Chemical substances.

(d) Controlled substances that may adversely affect the provider's ability to furnish services.

(9) Engage in any activity or conduct that may reasonably be interpreted as sexual in nature, regardless of whether or not it is consensual.

(10) Engage in any behavior that may reasonably be interpreted as inappropriate involvement in the individual's personal beliefs or relationships including, but not limited to discussing religion, politics or personal issues.

(11) Consume the individual's food and/or drink without his or her offer and consent.

(E) ODM-administered waiver service providers shall not be designated to serve or make decisions for the individual in any capacity involving a declaration for mental health treatment, general power of attorney, health care power of attorney, financial power of attorney, guardianship pursuant to court order, as an authorized representative, or as a representative payee as that term is described in paragraph (E)(3) of this rule, except as provided in paragraphs (E)(1) to (E)(4) of this rule.

(1) A provider may be appointed by the court to serve as legal guardian for the individual pursuant to Chapter 2111. of the Revised Code if the provider is a family member.

(2) A provider may serve as an authorized representative or pursuant to a declaration for mental health treatment, general power of attorney, health care power of attorney, financial power of attorney or guardianship if the provider is the individual's parent or spouse.

(3) A provider may serve as the individual's representative payee if the provider is the individual's parent or spouse. For purposes of this rule, "representative payee" means a parent or spouse the individual designates to receive and manage payments that would otherwise be made directly to the individual.

(4) A provider may be designated as an authorized representative or pursuant to a declaration for mental health treatment, general power of attorney, health care power of attorney, financial power of attorney or guardianship for the individual if:

(a) The provider was serving in that capacity prior to September 1, 2005; and

(b) The provider was the individual's paid medical provider prior to September 1, 2005; and

(c) The designation is not otherwise prohibited by law.

(F) Agency providers shall pay applicable federal, state and local income and employment taxes in compliance with federal, state and local requirements. Federal employment taxes include medicare and social security.

(G) Non-agency providers shall pay applicable federal, state and local income and employment taxes in compliance with federal, state and local requirements. Federal employment taxes include medicare and social security. On an annual basis, non-agency providers must submit an ODM-approved affidavit stating that they paid their applicable federal, state and local income and employment taxes.

(H) Failure to meet the requirements set forth in this rule may result in any of the actions set forth in rules 5160-45-05 and 5160-45-09 of the Administrative Code including, but not limited to, termination of the medicaid provider agreement in accordance with rule 5160-1-17.6 of the Administrative Code. In the event ODM proposes termination of the medicaid provider agreement, the provider shall be entitled to a hearing under Chapter 119. of the Revised Code in accordance with division 5101:6 of the Administrative Code.

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