5101:3-45-06 **ODJFS-administered waiver program: structural reviews of providers and investigation of alleged provider occurrences and overpayments.**

(A) The Ohio department of job and family services (ODJFS) or its designee shall continuously monitor every ODJFS-administered waiver provider. Monitoring activities shall include, but not be limited to:

(1) A structural review of compliance in accordance with paragraphs (B), (D) and (E) of this rule.

(2) Investigation of alleged provider occurrences and overpayments in accordance with paragraphs (C), (D) and (E) of this rule.

(B) Structural reviews.

(1) All non-agency waiver providers shall be subject to a structural review. The process shall consist of the following:

(a) New non-agency providers who enter into their first time-limited provider agreement in accordance with rule 5101:3-1-17.4 of the Administrative Code shall have an annual face-to-face structural review for each of the first three years after the date on which the non-agency provider begins furnishing billable waiver services. Upon renewal of the time-limited provider agreement, and if the non-agency provider does not meet any of the conditions set forth in paragraph (B)(1)(b) of this rule, the non-agency provider shall be subject to a biennial face-to-face structural review. Non-agency providers shall continue to meet all waiver provider eligibility requirements at all times.

(b) Non-agency providers shall be subject to an annual face-to-face structural review when any of the following conditions exist:

(i) The provider has been substantiated to be the violator in a reportable incident as described in rule 5101:3-45-05 of the Administrative Code;

(ii) Two or more provider occurrences as described in paragraph (C) of this rule have been substantiated in a twelve-month period;

(iii) The provider has allegedly received cumulative overpayments of two-hundred fifty dollars or more over a twelve-month period; or

(iv) The provider lives with the consumer.

(c) Non-agency providers who do not meet the conditions set forth in paragraph (B)(1)(a) or (B)(1)(b) of this rule shall be subject to a biennial face-to-face structural review. Non-agency providers shall

continue to meet all waiver provider eligibility requirements at all time.

(2) Medicare-certified, and otherwise-accredited agencies are subject to reviews in accordance with their certification and accreditation bodies, and therefore shall be exempt from a regularly scheduled structural review.

(3) All other ODJFS-administered waiver providers shall be subject to a biennial structural review. The first structural review must occur no later than two years after the date on which the provider begins furnishing billable waiver services.

(4) All ODJFS-administered waiver providers may be subject to an announced or unannounced structural review when any of the following have been reported to ODJFS or its designee:

(a) A provider occurrence;

(b) Health and welfare issues involving the provider and an ODJFS-administered waiver consumer; or

(c) Any other provider performance issues.

(5) Structural reviews must be conducted face-to-face between the provider and ODJFS or its designee. All structural reviews must use an ODJFS-approved structural review tool. The structural review process includes the following:

(a) Except for unannounced structural reviews, the provider shall be notified in advance of the review. Advance notification shall include a list of the documents required for the review. Advance notification shall also include a mutually acceptable date, time and location when the review is conducted face-to-face.

(b) The provider shall assure the availability and confidentiality of consumer information and other documents that may be requested as part of the structural review. The review shall not occur while the provider is furnishing services to a consumer.

(c) In preparation for the review, the reviewer shall examine the provider's occurrence and incident reports. Documented findings of noncompliance shall be addressed during the review.

(d) The structural review shall include an evaluation of compliance with chapter 5101:3-45 of the Administrative Code, and Chapter(s) 5101:3-46, 5101:3-47 and/or 5101:3-50 of the Administrative Code, depending upon the waiver(s) for which the provider is furnishing services.

(e) A unit of service verification shall be conducted by ODJFS or its designee to assure that all waiver services are authorized, delivered and reimbursed in accordance with the consumer's approved all services plan. Alleged overpayments resulting from the unit of service verification shall be handled in accordance with paragraph (D) of this rule.

(i) The reviewer shall examine, at a minimum, three months of clinical records and supporting documentation per consumer for all non-agency providers for up to six consumers.

(ii) For all other providers subject to a structural review, the reviewer shall examine, at a minimum, ten per cent of the provider's service delivery records and supporting documentation. The review shall include no fewer than three, and no more than thirty, records per service/per provider.

(iii) The findings of the unit of service verification may result in an expanded review of records.

(f) An evaluation shall be conducted to determine whether the provider has implemented all plans of correction that may exist.

(g) The reviewer shall conduct an exit conference with the non-agency provider, or in the case of an agency provider, the agency administrator, to discuss its preliminary findings from the structural review and any required follow-up.

(6) After the exit conference has occurred, ODJFS or its designee 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 noncompliance has been determined, and outline the specific issues or findings of noncompliance the provider must address in a plan of correction.

(7) No later than forty-five calendar days after the date on the written report described in paragraph (B)(6) of this rule, the provider must submit to ODJFS or its designee a plan of correction for all identified issues or findings of noncompliance.

(8) If ODJFS or its designee finds the provider's plan of correction acceptable, it shall acknowledge, in writing, to the provider that the plan addresses the issues outlined in the written report. If ODJFS or its designee determines that it cannot approve the provider's plan of correction, it shall inform the provider of this determination, in writing, require that the provider submit a new plan of correction and specify the required actions that must be included in the

new plan of correction. The provider must submit the new plan of correction within the specified timeframe.

(C) Investigation of alleged provider occurrences.

(1) Provider occurrences include, but are not limited to, allegations of provider billing violations, medicaid fraud and substandard provider performance.

(2) ODJFS or its designee shall investigate alleged provider occurrences and gather supporting documentation upon discovery. Depending upon the specific provider occurrence, and as part of its investigation, ODJFS or its designee may gather any of the following:

(a) Clinical progress notes from the provider;

(b) Case management documentation from the consumer's file or electronic record;

(c) The consumer's assessment and reassessments;

(d) The consumer's all service plans;

(e) Provider billing information;

(f) Physicians' orders;

(g) Prior occurrence reports; or

(h) Any other relevant information.

(3) If ODJFS or its designee substantiates the alleged provider occurrence, it shall notify the provider via certified mail. The letter shall specify:

(a) The alleged behavior(s) that must be stopped by the provider;

(b) The Administrative Code rules that support the finding(s) of noncompliance;

(c) What the provider must do to correct the finding(s) of noncompliance; and

(d) The timeframe within which a plan of correction must be submitted to ODJFS or its designee, not to exceed thirty calendar days after the date the certified letter was mailed.

(4) If ODJFS or its designee finds the provider's plan of correction acceptable, it shall acknowledge, in writing, to the provider that the plan addresses the issues outlined in the certified letter.

(a) If ODJFS or its designee determines that it cannot approve the provider's plan of correction, it shall inform the provider of this determination in writing, require that the provider submit a new plan of correction and specify the required actions that must be included in the new plan of correction. The provider must submit the new plan of correction within the specified timeframe.

(b) The provider may request technical assistance from ODJFS or its designee at any time.

(D) ODJFS shall investigate all allegations of provider overpayments resulting from structural reviews or provider occurrence reporting. When an overpayment is affirmed by ODJFS, the provider shall return the overpayment to ODJFS in accordance with departmental policy and procedures.

(E) ODJFS may impose sanctions upon a provider in accordance with rule 5101:3-45-09 of the Administrative Code in the event a provider does any of the following:

(1) Refuses to accept the certified letter when it is delivered;

(2) Fails to respond to ODJFS's or its designee's request for a plan of correction;

(3) Has not followed the plan of correction and/or successfully achieved the plan's desired results;

(4) Has not complied with the timeframes set forth in this rule;

(5) Has failed to protect consumers from repeated and substantiated reportable incidents;

(6) Has multiple substantiated provider occurrences;

(7) Has created a serious and immediate threat to the health and welfare of any ODJFS-administered waiver consumer;

(8) Did not attend or cooperate during the face-to-face structural review;

(9) Did not make available requested documents; or

(10) Did not submit a satisfactory plan of correction, or upon request, resubmit a satisfactory plan of correction.

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