5160-45-06 **Ohio department of medicaid (ODM) -administered waiver program: structural reviews of providers and investigation of provider occurrences.**

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

(1) A structural review of compliance with all ODM-administered waiver provider requirements in accordance with paragraph (B) of this rule.

(2) Investigation of provider occurrences in accordance with paragraph (C) of this rule.

(B) Structural reviews.

(1) Medicare-certified and/or otherwise accredited agencies as defined in rule 5160-45-01 of the Administrative Code are subject to reviews in accordance with their certification and accreditation bodies, and therefore shall be exempt from a regularly scheduled structural review. Such agencies shall submit a copy of their updated certification and/or accreditation, and upon request of ODM or its designee, shall make available to ODM or its designee within ten business days, all review reports and accepted plans of correction from the certification and/or accreditation bodies.

(2) All other ODM-administered waiver providers shall be subject to structural reviews by ODM or its designee 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 or its designee, 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 5160-45-05 of the Administrative Code;

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

(d) The provider does not live with an individual receiving ODM-administered waiver services.

(3) All ODM-administered waiver providers may be subject to an announced or unannounced structural review at any time as determined by ODM or its designee.

(4) Structural reviews must be conducted in person between the provider and ODM or its designee, unless prior-approved by ODM and in a manner consistent with paragraph (B)(3) of rule 5160-45-09 of the Administrative Code.

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

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

(7) 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 type 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 on the ODM-administered waiver.

(c) ODM or its designee shall examine any incident reports or provider occurrences related to the provider. Documented findings of noncompliance shall be addressed during the review.

(d) The structural review shall include an evaluation of compliance with Chapter 5160-45 of the Administrative Code and Chapter 5160-46, 5160-50 and/or 5160-58 of the Administrative Code, depending upon the waiver(s) under which the provider is furnishing services.

(e) A unit of service verification shall be conducted by ODM or its designee to assure that all waiver services are authorized, delivered and reimbursed in accordance with the approved all services plan for the individual receiving waiver services.

(f) An evaluation shall be conducted 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 or its designee shall conduct an exit conference with the non-agency provider, or in the case of an agency provider, the agency administrator or his or her designee, about its preliminary findings, any individual remediation and other required follow-up.

(8) ODM 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 findings of noncompliance the provider must address in a plan of correction, including any individual remediation.

(C) Provider occurrences.

(1) "Provider occurrence" means any alleged, suspected or actual performance or operational issue by a provider furnishing ODM-administered waiver services that does not meet the definition of an incident as set forth in rule 5160-45-05 of the Administrative Code. Provider occurrences include, but are not limited to alleged violations of provider eligibility and/or service specification requirements, billing issues including overpayments, and medicaid fraud.

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

(3) If ODM or its designee 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 noncompliance;

(c) What the provider must do to correct the finding(s) of noncompliance, including any individual remediation or required payment adjustments;

(D) Plans of correction for structural reviews and provider occurrences.

(1) The provider must submit to ODM or its designee a plan of correction for all identified findings of noncompliance, including any individual remediation, within forty-five calendar days after the date on the written report.

(2) If ODM or its designee 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 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 plan of correction. The provider must submit the new plan of correction within ten calendar days.

(E) If ODM or its designee determines through the structural review process or 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.

(F) ODM may take action against the provider in accordance with rule 5160-45-09 of the Administrative Code for failure to comply with any of the requirements set forth in this rule.

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Certification

01/22/2015

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