

5101:3-12-30 Monitoring Under ODJFS-Administered Home And Community-Based Service Waivers.

Effective Date: July 1, 2004

- (A) Every ODJFS-administered waiver provider will submit to regularly scheduled monitoring. The monitoring will include:
- (1) Structural review of compliance with rules 5101:3-12-05, 5101:3-12-06, 5101:3-12-07, 5101:3-1-172, 5101:3-1-173, and 5101:3-12-25 or 5101:3-12-26 of the Administrative Code, as determined by the appropriate provider type; and
 - (2) Continuous monitoring of provider compliance and performance through the provider occurrence process enumerated in paragraph (D) of this rule.
- (B) ODJFS may contract with other agencies or entities to perform one or more functions enumerated in this rule.
- (C) Structural reviews
- (1) ODJFS will conduct an annual face-to-face structural review of all ODJFS-administered waiver providers using the ODJFS structural compliance review tool, beginning from the first date of service delivery, with the exception of the following:
 - (a) For medicare certified home health agencies and JCAHO or CHAP accredited agencies, the results of the respective certifying or accrediting body will serve as the required structural review.
 - (b) For home modifications, vehicle modifications, equipment and supplies and emergency response system providers, the structural review will occur annually through the second year of service delivery, and biennially thereafter.
 - (2) ODJFS may conduct a structural review as a result of reported provider occurrences as defined in paragraph (D) of this rule.
 - (3) The structural review will include no less than the following:
 - (a) A telephone call or a written announcement establishing the date, time and location of the review.
 - (b) An evaluation of compliance in accordance with paragraph (A) of this rule.
 - (c) A unit of service verification audit assuring that services authorized and delivered are billed for correctly.
 - (d) An evaluation of the ODJFS-administered waiver provider's implementation of any/all plans of correction.
 - (e) An exit conference with agency/provider staff or with the independent provider.
 - (4) For the structural review, ODJFS will gather unit of service verification samples. These will consist of:
 - (a) Ten per cent of the agency-based provider's current ODJFS-administered waiver service delivery records for each service, with a minimum of three and a maximum of thirty records per service/per provider.
 - (b) Three months of clinical records and supporting documentation per consumer for all independent providers. In cases where the independent provider services more than one ODJFS-administered waiver consumer, the structural review will examine three months of clinical records and supporting documentation up to a maximum of six consumers. The findings of this limited review may result in an expanded review of records.

- (5) The unit of service verification audit described in paragraph (C) (3) (c) of this rule will include a comparison of services authorized, delivered and billed as it relates to the consumer's all services plan. ODJFS will report any/all provider overpayments to the department's surveillance and utilization review section. Providers will return any overpayment of funds to ODJFS.
- (6) ODJFS will conduct a combined structural review for all agency-based ODFJS-administered waiver providers that provide both daily living and nursing services. The total sample will equal the required sample as set forth in paragraphs (C) (4) (a) and (C) (4) (b) of this rule.
- (7) ODJFS reserves the right to conduct unannounced structural reviews at any time to evaluate alleged health and/or safety issues, provider occurrences and/or performance concerns. The provider will cooperate by accommodating ODJFS, meeting, making available appropriate meeting space, records and/or other documents requested as part of the review.
- (8) ODJFS will complete one structural review tool per service for each consumer record contained in the review sample, as described in paragraphs (C) (4) (a) and (C) (4) (b) of his rule.
- (9) After the structural review has been conducted, ODJFS will issue a written report to the provider. The report will summarize the overall outcome of the compliance review, list specific rule citations where noncompliance has been determined, and outline specific requirements or actions that must be addressed in a plan of correction. ODJFS may issue an abbreviated written report when identifying consumer health and/or safety issues.
- (10) No later than forty-five calendar days after ODJFS mails the written report described in paragraph (C) (9) of this rule, the provider must submit to ODJFS a plan of correction for all identified noncompliance findings. If ODJFS issues an abbreviated written report identifying consumer health and/or safety issues, the provider's plan of correction must be submitted to ODJFS within five working days after it was mailed.
- (11) If ODJFS finds the provider's plan of correction acceptable, it shall approve the plan and confirm to the provider that the plan addresses the issues of noncompliance outlined in ODJFS' written report. If ODJFS determines that it cannot approve the provider's plan of correction, it will 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 new plan of correction. The provider must submit the new plan of correction by the date specified by ODJFS.
- (12) ODJFS may impose sanctions upon the provider in accordance with rule 5101:3-12-08 of the Administrative Code in the event the provider:
 - (a) Has not followed the plan of correction and/or successfully achieved the plan's desired results.
 - (b) Has not complied with the timeframes enumerated in this rule.
 - (c) Has created a serious and immediate threat to the health and/or safety of any ODJFS-administered waiver consumer.
 - (d) Did not cooperate in meeting face-to-face for the structural review.
 - (e) Did not make service delivery and/or clinical records available.
 - (f) Did not submit a satisfactory plan of correction, or upon request, resubmit a satisfactory plan of correction.

(D) Provider occurrence process

- (1) Provider occurrence means:
 - (a) Consumer care violations;
 - (b) Provider billing violations;
 - (c) Medicaid fraud; and/or

- (d) Substandard provider performance.
- (2) ODJFS will investigate provider occurrences and gather supporting documentation upon discovery of any such occurrence.
- (3) ODJFS may gather any of the following information as part of the investigation:
 - (a) Clinical and/or progress notes from the provider;
 - (b) Case management documentation from the consumer's file;
 - (c) Assessment information;
 - (d) The all services plan;
 - (e) MMIS billing information;
 - (f) Doctor's orders;
 - (g) Prior occurrence reports;
 - (h) Consumer/family documentation;
 - (i) Any other relevant supporting documentation.
- (4) If ODJFS decides to substantiate the occurrence, it will notify the provider via certified mail with a cease and desist letter. The letter will:
 - (a) Outline the alleged behavior or practice which must be stopped by the provider;
 - (b) Specify the Administrative Code rule cites that support the noncompliance finding;
 - (c) Specify what the provider must do to correct the finding; and
 - (d) Specify the date on which the provider must submit a plan of correction to ODJFS, not to exceed thirty calendar days after the date the letter was mailed.
- (5) If ODJFS finds the provider's plan of correction acceptable, it shall approve the plan and confirm to the provider that the plan addresses the issues of noncompliance outlined in the cease and desist order. If ODJFS determines that it cannot approve the provider's plan of correction, it will 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 new plan of correction. The provider must submit the new plan of correction by the date specified by ODJFS..
- (6) The provider may request technical assistance from ODJFS to correct deficiencies or findings of noncompliance at any time.
- (7) ODJFS may conduct a structural review as outlined in paragraph (C) of this rule to evaluate the provider's implementation of the plan of correction.
- (8) ODJFS reserves the right to conduct unannounced provider structural reviews at any time to evaluate provider occurrences. The provider will cooperate by accommodating ODJFS, meeting, making available appropriate meeting space, records, and/or other documents that may be requested as a part of the review.
- (9) ODJFS may impose sanctions upon the provider in accordance with rule 5101:3-12-08 of the Administrative Code in the event the provider:
 - (a) Has not followed the plan of correction and/or successfully achieved the plan's desired results;
 - (b) Has not complied with the time frames outlined in paragraph (D) of this rule;
 - (c) Has repeated substantiated occurrences;
 - (d) Has created a serious and immediate threat to the health and/or safety of the consumer.

- (10) All allegations of medicaid fraud will be processed by ODJFS using supporting documentation enumerated in subparagraph (D) (3) of this rule, and shall be immediately referred to the medicaid fraud control unit (MFCU) of the Ohio attorney general's office.
- (11) All allegations of provider overpayment will be processed by ODJFS. The occurrence reporting form, along with the supporting documentation as enumerated in subparagraph (D) (3) of this rule will be forwarded to the surveillance and utilization review section. Overpayments will be returned to ODJFS.
- (12) ODJFS will review a provider's occurrence reports prior to conducting a structural compliance review. Documented noncompliance will be addressed during the review.

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R.C. 119.032 review dates:

Certification

Date

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