



Ohio | Department of Medicaid
John R. Kasich, Governor
 John B. McCarthy, Director

Provider Oversight

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- Public Consulting Group, PCG, awarded contract that started July 1, 2013 for
 - Provider enrollment
 - Onsite Reviews
 - Incident Investigations
 - Structural Reviews

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Provider Enrollment

Enrollment and Revalidation of waiver providers contracts with the Ohio Department of Medicaid

- Assure all documents received for application (BCI, social security card; Government Issued ID, notice of the National Provider Identifier Enumerator (NPI, for RN, LPN and Home Health Agencies), W-9 form, signed Medicaid Agreement and Confirmation from an individual on the waiver program (personal care aide))
- Verify licensure status of licensed individuals (nurses, STNA)
- Complete database verifications
 - Excluded Parties, Excluded Individual and Entities List Systems
 - Ohio Department of Developmental Disabilities Registry of Employees Guilty of Abuse, Neglect or Misappropriation
 - Ohio Attorney General's Sex Offender and Child-victim data base
 - Ohio Department of Rehabilitation and Corrections' Inmates database and
 - Ohio Department of Health's Nurse Aide Registry

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Onsite Reviews

- Reviews that are required to be conducted on high risk providers (home health, non-emergency transportation, DME).
- Reviews can be conducted prior to being enrolled or after being enrolled
- Usually unannounced

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Incident Management and Investigation (OAC 5160-45-05)
(Protection from Harm)

- Initiate incident or occurrence reports when discovered during an oversight process or upon complaint or report from any party
- Incidents include, but are not limited to, all of the following:
 1. Abuse: the injury, confinement, control, intimidation or punishment of an individual by another person that has resulted, or could reasonably be expected to result, in physical harm, pain, fear or mental anguish. Abuse includes, but is not limited to physical, emotional, verbal and/or sexual abuse, and use of restraint, seclusion or restrictive intervention that results in, or could reasonably be expected to result in, physical harm, pain, fear or mental anguish to the individual.
 2. Neglect: when there is a duty to do so, the failure to provide goods, services and/or treatment necessary to assure the health and welfare of an individual.
 3. Exploitation: the unlawful or improper act of using an individual or an individual's resources for monetary or personal benefit, profit or gain.
 4. Misappropriation: depriving, defrauding or otherwise obtaining the money, or real or personal property (including medication) of an individual by any means prohibited by law.
 5. Death

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6. Hospitalization or emergency department visit (including observation) as a result of Accident, injury or fall; injury or illness of an unknown cause or origin and Reoccurrence of an illness or medical condition within seven calendar days of the individual's discharge from a hospital
7. Unauthorized use of restraint, seclusion and/or restrictive intervention that does not result in, or cannot reasonably be expected to result in, injury to the individual.
8. An unexpected crisis in the individual's family or environment that results in an inability to assure the individual's health and welfare in his or her primary place of residence.
9. Inappropriate service delivery including, but not limited to, A provider's violation of the conditions of participation set forth in rule 5160-45-10 of the Administrative Code; Services provided to the individual that are beyond the provider's scope of practice; Services delivered to the individual without, or not in accordance with, physician's orders; and Medication administration errors involving the individual
10. Actions on the part of the individual that place the health and welfare of the individual or others at risk including, but not limited to: The individual cannot be located; Activities that involve law enforcement; Misuse of medications; and Use of illegal substances.

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Incident Management and Investigation (OAC 5160-45-05)
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- Investigation usually concluded within 45 days
- Case management agencies will develop a prevention plan that will be placed in the All Service Plan

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Structural Reviews (OAC 5160-45-06)

- ◆ All non-agency waiver providers shall be subject to a structural review.
- ◆ Structural reviews must be conducted face-to-face between the provider and ODM or its designee. All structural reviews must use an ODM-approved structural review tool. The structural review process includes the following:
 - ◆ 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.
 - ◆ 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.
- ◆ 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.
- ◆ A unit of service verification shall be conducted 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.
- ◆ An evaluation shall be conducted to determine whether the provider has implemented all plans of correction that may exist.
- ◆ 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.

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Structural Reviews (OAC 5160-45-06)

- Written findings report shall be issued to the provider
- Within forty-five calendar days after the date on the written report, the provider must submit to ODM or its designee a plan of correction for all identified issues or findings of noncompliance.
- PCG will either accept or reject the provider's plan of correction and the provider will be notified
- The provider shall return the overpayment to ODM in accordance with departmental policy and procedures.
- ODM may impose sanctions upon a provider in accordance with rule 5160-45-09, includes but is not limited to
 - (1) Refuses to accept the certified letter when it is delivered;
 - (2) Fails to respond to ODMs' 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 ODM-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.

There is a discrepancy in the E-manual Version and the Law Writer version of the rule. Once clarified we will share the information

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Structural Reviews (OAC 5160-45-06)

- If providers have issues or questions about their structural reviews they should call the reviewer that is listed on the structural review report
- If the reviewer is unresponsive the provider can ALWAYS ask to talk to the supervisor
- If the supervisor still cannot answer the questions or resolve the problems they can then call me
- When providers sign their provider agreement they agree to follow the rules. Structural reviews are the way ODM determines whether or not the providers are providing service in accordance with the rules and the documentation requirements
- PROVIDERS ARE SHOULD READ and KNOW THE RULES
- Providers can call PCG (877-908-1746) and inquire about education and training opportunities

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Questions previously provided:

- Ordinary Mail
- Notification of Reviews
- Documentation requirements
- Case Manager Contacts
- Social Visits during care hours
- Consumers requiring providers work outside the authorization on the all service plan
- If individual requires accommodations for signature THIS MUST BE SPECIFIED IN THE ASP

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QUESTIONS

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