Ohio Administrative Code

Rule 5160-1-17.6 Termination and denial of provider agreement.

Effective: April 9, 2015

(A) For purposes of this rule, the following definitions apply:

(1) "Ownership or control interest" means having at least five per cent ownership, or interest, either directly, indirectly, or in any combination.

(2) "Provider" has the same meaning as "eligible provider," as defined in rule 5160-1-17 of the Administrative Code.

(3) "Provider Agreement" means an agreement as defined in rule 5160-1-17.2 of the Administrative Code or any rule contained in agency 5160 of the Administrative Code.

(B) Termination for long term care nursing facilities and intermediate care facilities for individuals with intellectual disabilities is located in Chapters 5160-3 and 5123:2-7 of the Administrative Code.

(C) Termination for providers enrolled in a medicaid managed care plan is located in Chapter 5160-26 of the Administrative Code.

(D) A provider may voluntarily terminate a provider agreement upon written notice thirty days before the provider's chosen termination date. The Ohio department of medicaid (ODM) has the discretion to accept or deny a voluntary termination for a provider who is facing involuntary termination due to an ODM action. ODM may waive the thirty day requirement if appropriate.

(E) A provider is ineligible for payment for dates of service on or after the effective date of a denial, suspension, revocation, limitation, or failure to renew a license, permit, certifcate, or certification issued by an official, board, commission, department, bureau, or other agency of the state or federal government.

(F) A provider that was terminated because of a conviction that was a result of a suspension due to

credible allegation of fraud is ineligible for all payments, regardless of the dates of service.

(G) ODM may propose termination or denial of a provider agreement at any time it is determined that continuation or assumption of provider status is not in the best interest of recipients or the state of Ohio. The phrase "not in the best interest" shall include, but not be limited to, the following circumstances or occurrences:

(1) The provider has not billed or otherwise submitted a medicaid claim to ODM for two years or longer.

(2) The provider, or any person having an ownership or controlling interest in the provider, or who is an agent or employee of the provider, has been indicted or granted immunity from prosecution for, or has pled guilty to, or has been convicted of, any criminal offense against the state of Ohio or any other state or territory, whether the offense occured prior to or during the period of ownership, employment, or agency.

(3) The provider has made false representations, by omission or commission, on the provider enrollment application or does not fully and accurately disclose to ODM information as required by the provider agreement, any rule contained in agency 5160 of the Administrative Code, or any provisions contained in 42 C.F.R., Part 455, Subpart B (October 1, 2014)..

(4) The provider has been determined liable for negligent performance of professional services to its clientele or patients.

(5) As determined by ODM, the provider has departed from or failed to conform to accepted standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established.

(6) The provider has been formally reprimanded or censured, placed on probation, suspended or placed on practice limitations for unethical conduct or improper practices by a state licensure board or by an association of its peers.

(7) The provider fails to file cost reports as required.

(8) The provider makes false statements, provides false information, or alters records, documents, charts, or prescriptions, or fails to cooperate or provide records or documentation upon request during an audit or review of provider activity by staff or contracting entity of ODM, any county department of job and family services, the attorney general's office, the auditor of state, the department of health and human services, or any other state or federal agency which, by law, has authorized access to records or documents. An alteration of provider records does not include records for which there is a properly documented correction.

(9) The provider has not corrected deficiency(ies) after receiving a written notice of operational deficiency from ODM.

(10) The provider fails to abide by, meet the requirements of, or have the capacity to comply with the terms and conditions of the provider agreement, and/or rules and regulations promulgated by ODM.

(11) The provider has been suspended or terminated from participation in another government medical program other than a program that requires automatic termination.

(12) The provider is found in violation of section 504 of the Rehabilitation Act of 1973, as amended (January 1, 2015), or the Civil Rights Act of 1964, as amended (January 1, 2015), in relation to the employment of individuals, the provision of services or in the purchase of goods and services.

(13) The provider, by any act or omission, has negatively affected the health, safety, or welfare of the medicaid recipient or the fiscal or programmatic integrity of the medicaid program.

(14) The office of the attorney general, auditor of state, or any board, bureau, commission, or department has recommended that ODM terminate the provider agreement where the reason for the request bears a reasonable relationship to the administration of the medicaid program or the integrity of state and/or federal funds.

(15) As determined by ODM, the provider fails to use reasonable care or discretion in the storage, administration, dispensing, or prescribing of drugs, or fails to employ acceptable scientific methods in the selection of drugs or other modalities of treatment of disease.

(16) As determined by ODM, the provider sells, gives away, personally furnishes, prescribes, or administers drugs for other than legal and legitimate therapeutic purposes.

(17) The United States drug enforcement agency has suspended or revoked the provider's registration for any act or acts which would constitute a violation of paragraph (E)(5), (E)(15), or (E)(16) of this rule.

(18) The provider or the provider's staff misrepresents the type and/or units of service, inflates billing codes to increase payments, or bills for, or receives payments for services not rendered, or any other practice that is a violation of any rule contained in agency 5160 of the Administrative Code.

(19) As determined by ODM, the provider, or the provider's staff prescribes, authorizes, bills for, or receives payments for, services that are not medically necessary as defined in rule 5160-1-01 of the Administrative Code.

(20) The provider or the provider's staff lack the ability or legal authority to provide services for which the provider has billed, because of lack of equipment or material, or a failure to comply with minimal requirements under state and federal law.

(21) The provider consistently violates the prohibition against billing medicaid recipients or assigning provider claims to a factor, as found in rule 5160-1-13.1 of the Administrative Code or 42 CFR 447.10 (October 1, 2014).

(22) The provider fails to notify ODM within thirty days of any changes in licensure, certification, accreditation, or registration status, ownership, closure, specialty, additions, deletions, or replacements in group memberships, and address.

(23) The provider fails to repay an overpayment or recovery amount assessed as a result of a final adjudication order.

(24) The provider has a previous or current exclusion, suspension, termination or involuntary

withdrawal from participation in any medicaid program, or any other public or private health insurance program.

(25) The provider has been convicted under federal or state law of a criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct.

(26) The provider has not responded to two certified mail correspondences from ODM and the provider's business cannot otherwise be located.

(27) The provider signed a provider agreement and failed to revalidate the provider agreement in accordance with rule 5160-1-17.4 of the Administrative Code.

(28) Any reason permitted or required by federal law.

(H) For any reason permitted or required by federal law, ODM may deny or exclude from participation in the medicaid program any individual, provider of services or goods, or other entity that does not possess a medicaid provider agreement.

(I) ODM shall terminate or deny a provider agreement when any of the following apply:

(1) Any license, permit, or certification that is required in the provider agreement or department rule has been denied, suspended, revoked, not renewed or is otherwise limited and the provider has been afforded the opportunity for a hearing in accordance with the hearing process established by the official, board, commission, department, division, bureau, or other agency of state or federal government.

(2) The terms of a provider agreement require the provider to hold a license, permit, or certificate, or maintain certification, issued by an official, board, commission, department, division, bureau, or other agency of state or federal government, other than ODM, and the provider has not obtained the license, permit, certificate, or maintained the certification.

(3) An official, board, commission, department, division, bureau, or other agency of this state, other than ODM, has denied, terminated, or not renewed a license, permit, certificate or certification that is

required for participation, notwithstanding the fact that the provider may hold a license, permit, certificate or certification from an official, board, commission, department, division, bureau, or other agency of another state.

(4) A judgment has been entered in either a criminal or civil action against a medicaid provider or its owner, officer, authorized agent, associate, manager, or employee in an action brought pursuant to section 109.85 of the Revised Code, except if the provider or owner can demonstrate to ODM that the provider or owner did not directly or indirectly sanction the action of its authorized agent, associate, manager, or employee which resulted in the conviction or entry of judgment.

(5) The provider is terminated, suspended, or excluded by the medicare program and/or by the federal department of health and human services and that action is binding on the provider's participation in the medicaid program or renders federal financial participation unavailable for that provider's participation in the medicaid program.

(6) The provider has been convicted of, or pled guilty to, any criminal activity materially related to either the medicare or medicaid program or has been convicted of one of the offenses that caused the provider agreement to be suspended in accordance with rule 5160-1-17.5 of the Administrative Code..

(7) The provider has failed to apply for revalidation within the time and in the manner specified for revalidation pursuant to section 5164.32 of the Revised Code.

(8) The provider fails to timely submit a required background check or when the background check reveals that the provider has been convicted of, or pled guilty to a disqualifying offense unless the provider meets specific circumstances provided in agency 5160 of the Administrative Code.

(9) ODM has determined that the provider facility has closed or is not providing medicaid covered services.

(J) Appeal rights for the termination or denial of a provider agreement provided in this rule are found in rule 5160-1-57 of the Administrative Code.

(K) In determining the length of termination, ODM shall consider the following:

(1) The number and nature of program violations and other related offenses and the degree to which the provider participated in the offense;

(2) The nature and extent of any adverse impact the violations have had on recipients, including but not limited to the health and safety of those recipients who are aged and/or at greater physical, mental and emotional risk;

(3) The amount of any damages incurred by the medicaid program;

(4) Whether there are any mitigating circumstances;

(5) Any other facts bearing on the nature and seriousness of the violations or related offenses;

(6) The current, pending and previous sanction record of the provider under the medicare, medicaid, or other health-related programs; and

(7) Whether the provider is pending any future state or federal litigation relating to the current or any similar offense.

(L) ODM reserves the right to deny twelve months retroactivity for the submission of claims to providers whose agreement is reinstated after termination for cause in accordance with this rule.