



Ohio Administrative Code

Rule 5160-43-07 Specialized recovery services program compliance: provider monitoring, oversight, structural reviews and investigations.

Effective: October 15, 2021

(A) The Ohio department of medicaid (ODM) is responsible for the ongoing monitoring and oversight of all providers of specialized recovery services (hereafter referred to as providers) and contractors to ensure compliance with program requirements.

(B) Monitoring and oversight of specialized recovery services program providers and recovery management contractors:

(1) ODM and/or its designee (hereafter referred to as ODM) shall conduct ongoing monitoring and oversight of providers and contractors, to verify each provider is:

(a) Complying with the terms and conditions of its medicaid provider agreement or contract, the program and all applicable federal, state and local regulations;

(b) Ensuring the health and welfare of individuals to whom they provide services; and

(c) Ensuring the provision of quality services as part of the program.

(2) Monitoring and oversight may include, but is not limited to:

(a) Interviews with individuals enrolled in the program and/or their authorized representative or legal guardian, providers and contractor staff;

(b) Visits to the provider's place of business or another agreed upon location for the purpose of examining or collecting records, reviewing documentation, and conducting structural reviews; and

(c) Reviews of electronic and/or hard copy records and billing documentation.

(3) Providers and contractors shall fully cooperate with all requests made by ODM, as part of the



monitoring and oversight process. This includes, but is not limited to:

(a) Upon request, arranging for or furnishing an adequate workspace for ODM to conduct visits. This workspace must be in a secure location which protects sensitive information from being disclosed contrary to relevant confidentiality and information disclosure laws;

(b) Making all requested information available at the time of review, and in accordance with the terms of compliance with contracts, as applicable;

(c) Providing reports as requested by ODM to monitor performance; and

(d) Ensuring the availability of supervisors and/or other staff who may possess relevant information to answer questions.

(4) At the conclusion of a provider monitoring and oversight review:

(a) ODM shall notify the provider or contractor in writing of its findings.

(b) ODM may:

(i) Request the provider or contractor submit to ODM a plan of correction within the prescribed time frame. The plan of correction shall set forth the action(s) that must be taken by the provider or contractor to correct each finding, and establish a target date by which the corrective action must be completed. If ODM does not approve the submitted plan of correction, ODM may request a new plan of correction or take other appropriate action;

(ii) Provide technical assistance to the provider or contractor;

(iii) Refer the provider or contractor to other regulatory and oversight entities for further investigation;

(iv) Issue the provider or contractor a notice of operational deficiency based upon the review and findings;



(v) Propose suspension or termination of the provider's medicaid provider agreement pursuant to section 5164.38 of the Revised Code and rules 5160-1-17.5 and 5160-1-17.6 of the Administrative Code, as applicable; or

(vi) Terminate the contractor's contract pursuant to its terms.

(C) Investigation of provider occurrences.

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

(2) If ODM 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 non-compliance; and

(c) Actions the provider must take to correct the finding(s) of non-compliance, including any remediation or required payment adjustments.

(3) Plans of correction for provider occurrences must be submitted to ODM for all identified findings of non-compliance, including any remediation, within forty-five calendar days after the date on the written report.

(4) If ODM 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 determines that it cannot approve the provider's plan of correction, it shall 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 plan of correction. The provider must submit the new plan of correction within ten calendar days.



(5) If ODM determines through 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.

(6) ODM may take action against the provider as specified in paragraph (B)(4)(b) of this rule for failure to comply with the investigation of provider occurrences requirements set forth in this rule.