

Ohio Department of Medicaid
Addendum to ODM 03623 for Nursing Facilities (NFs);
Ohio Medicaid Provider Agreement for Traumatic Brain Injury Outlier Services
 (For Ohio and Out-of-State Providers)

SECTION 1 - NF-TBI OUTLIER FACILITY/UNIT ADDRESS, IDENTIFIERS, AND BED INFORMATION

Facility Name (DBA)		
Facility Address (Physical location of free standing NF-TBI or NF-TBI unit)		
City, State, Zip Code		
National Provider Identifier (NPI)		Medicaid Legacy Number (formerly Medicaid provider number)
Number of Beds	Facility Type and Sub-type	Effective Date

SECTION 2 – ADDITIONAL LTCF PROVIDER RESPONSIBILITIES SPECIFIC TO NF-TBI OUTLIER SERVICES

In addition to the conditions in ODM 03623, the following requirements must be met:

- A. The Provider must be an Ohio Medicaid certified Nursing Facility (NF), and must follow appropriate billing procedures in accordance with Ohio Administrative Code (OAC) Chapters 5101:3-1 and 5101:3-3. Out-of-state Providers must also be a Medicaid certified NF in their state to be considered eligible to provide services to Ohio Medicaid consumers.
- B. The Provider must provide prior authorized intensive rehabilitation services to individuals with severe maladaptive behaviors due to traumatic brain injury (NF-TBI services) in either a discrete, distinctly identified unit of the NF dedicated to the provision of outlier services for persons with severe maladaptive behaviors due to traumatic brain injury, or in a free standing NF-TBI.
- C. The Provider must agree to comply with all provisions of OAC rule 5101:3-3-54.1 "Outlier Long-Term Care Services for Individuals with Severe Maladaptive Behaviors due to Traumatic Brain Injury (NF-TBI services)" as if included in this agreement for the provision of NF-TBI services. Out-of-state Providers must agree to comply with all provisions of OAC rule 5101:3-3-17.3 "Out-of-State Placement for Individuals with Traumatic Brain Injury (TBI)" and OAC rule 5101:3-1-11 regarding out-of-state Medicaid coverage as if included in this agreement for the provision of NF-TBI services. Ohio service provision standards are in addition to any standards applicable to the provision of the service in the state in which the service is being furnished.
- D. The Provider must obtain and/or retain accreditation as a brain injury comprehensive integrated inpatient program from the Commission on Accreditation of Rehabilitation Facilities (CARF) for the distinct part NF-TBI unit or free standing NF-TBI. The Provider shall submit to the Ohio Department of Medicaid (ODM), copies of any communication regarding accreditation from, and to, the commission immediately following receipt or submittal of the communication. If the Provider does not have current accreditation from CARF on the effective date of the NF-TBI services provider agreement, the Provider must be eligible for accreditation pending a site survey and expect accreditation no later than six months following the effective date of the NF-TBI services provider agreement.

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SECTION 2 – ADDITIONAL LTCF PROVIDER RESPONSIBILITIES SPECIFIC TO NF-TBI OUTLIER SERVICES, CONTINUED

- E. The Provider must agree to provide the following, with the exception of any specific items that are direct billed in accordance with Rule 5101:3-3-19 of the Administrative Code, as needed, to individuals who receive prior authorization from ODM, or ODM designee, for the receipt of NF-TBI services:
1. Twenty-four (24) hour skilled nursing care and such personal care as may be required for the health, safety, and well-being of the individual.
 2. Dietary supplements used for oral feeding, even if written as a prescription item by a physician.
 3. Serial casting and splinting delivered by licensed personnel.
 4. Orthotic services delivered by licensed personnel.
 5. Obtain and immediately submit copies to the ODM designated outlier coordinator, or ODM designee, upon receipt of, the reports regarding initial inpatient consultation services by professionals of the following specialties, if ordered by a physician: Audiology, neuropsychology, optometry, dermatology, gastroenterology, general surgery, gynecology, internal medicine, neurology, neuropsychiatry, neurosurgery, ophthalmology, orthopedics, otorhinolaryngology, pediatrics, physical medicine and rehabilitation, plastic surgery, podiatry, and urology.
 6. Therapeutic and training services consistent with the individual program plan that ordinarily would occupy most of the day, with at least three (3) hours per day during a five (5) day week from occupational therapy, physical therapy, psychology/neuropsychology, and/or speech-language pathology, as well as interventions for the twenty four (24) hour a day, seven (7) day a week reinforcement of the cognitive retraining and/or neurobehavioral rehabilitation programs developed for the individual to effect a change in behavior, in addition to the other services delivered by physicians and nurses.
 7. Physical therapy, occupational therapy, speech therapy, audiology, respiratory therapy, and psychosocial services or social work services must be provided directly, or supervised by professionals who are licensed or certified as appropriate, and the Provider must provide supplies for the provision of these services.
 8. As indicated by the individual program plan, cognitive retraining as defined in OAC 5101:3-3-54.1(B)(2). The individual program plan must indicate which professionals have responsibility for documentation and evaluation of the cognitive retraining program and their corresponding reinforcement interventions.
 9. As indicated by the individual program plan, neurobehavioral rehabilitation services as defined in OAC 5101:3-3-54.1(B)(6). The individual program plan must indicate which professionals have responsibility for documentation and evaluation of the neurobehavioral rehabilitation services and their corresponding reinforcement interventions.
- F. Prior to an individual's admission, the Provider must develop accurate assessments, or reassessments, by an interdisciplinary team which addresses the individual's health, social, psychological, educational, vocational, and chemical dependency needs and submit a copy of this preliminary evaluation to the ODM designated outlier coordinator, or ODM designee.

SECTION 2 – ADDITIONAL LTCF PROVIDER RESPONSIBILITIES SPECIFIC TO NF-TBI OUTLIER SERVICES, CONTINUED

- G. Within fourteen (14) days after admission, the Provider must develop and submit to the ODM designated outlier coordinator, or ODM designee, accurate assessments, or reassessments, by an interdisciplinary team which address the individual's health, social, psychological, educational, vocational, and chemical dependency needs, to supplement the preliminary evaluation conducted prior to admission.
- H. Within fourteen (14) days after admission, the Provider must develop and submit to the ODM designated outlier coordinator, or ODM designee, a comprehensive, individualized program plan for coordinated, integrated services developed by the interdisciplinary team, including the ODM case manager, in conjunction with the individual and others concerned with the individual's welfare. The plan must state the specific objectives necessary to address the individual's needs as identified by the comprehensive assessment, specific treatment modalities, anticipated time frames for the accomplishment of objectives, measures to be used to assess the effects of services, and person(s) responsible for plan implementation. The plan must include intervention strategies for the twenty four (24) hour a day, seven (7) day a week reinforcement of the cognitive retraining and/or neurobehavioral rehabilitation programs developed for the individual in order to effect a change in behavior. The plan shall be reviewed by the appropriate program staff at least monthly, revised as necessary, and when revisions are made, submitted to the ODM designated outlier coordinator, or ODM designee, within three (3) working days following the revision.
- I. Within fourteen (14) days after admission, the Provider must develop and submit to the ODM designated outlier coordinator, or ODM designee, a written discharge planning evaluation developed by the interdisciplinary team, including the ODM case manager, in conjunction with the individual and others concerned with the individual's welfare. The evaluation shall include recommendations for any counseling and training of the individual and family members or interested persons to prepare them for post-discharge care, an evaluation of the likely need for appropriate post-discharge services, the availability of those services, the providers of those services, the payment source for each service, and dates on which notification of the individual's needs and anticipated time frames was or would be made to the providers of those services.
- J. When periodic reassessments of the discharge plan indicate that the individual's discharge needs have changed, the Provider must submit the results of the reassessments and the revised discharge plan to the ODM designated outlier coordinator, or ODM designee, within three (3) working days following the revision.
- K. The Provider must prepare and provide to the ODM designated outlier coordinator, or ODM designee, a monthly report in a format approved by ODM that summarizes the individual's program plan, progress, changes in treatment, and discharge plan, including referrals made and anticipated time frames.
- L. The Provider must agree to cooperate with the ODM oversight function for provision of NF-TBI services. The Provider must notify the ODM designated outlier coordinator, or ODM designee, at least one (1) week in advance of each team meeting, and provide the ODM designated coordinator, or ODM designee, with minutes of those meetings upon request.
- M. The Provider must agree to accept the Medicaid per diem rate established for prior authorized NF-TBI outlier services in accordance with OAC rule 5101:3-3-54.1, or OAC rule 5101:3-3-17.3 for out-of-state Providers, as payment in full and make no additional charge to the individual, any member of the individual's family, or to any other source for NF-TBI covered services. Excepted are charges for third-party resources pursuant to OAC rule 5101:3-1-08, or made in accordance with conditions specified in OAC rule 5101:3-3-16.5 regarding personal needs allowances (PNAs). Out-of-state Providers shall, additionally, assure ODM that consultants, ancillary, and acute services not covered in the contract rate can be made available to an individual on the Ohio Medicaid program.

SECTION 2 – ADDITIONAL LTCF PROVIDER RESPONSIBILITIES SPECIFIC TO NF-TBI OUTLIER SERVICES, CONTINUED

- N. If prior authorization is denied during an assessment that was requested for an individual who is already residing in the NF-TBI unit or free standing NF-TBI, the Provider must agree to move the individual to the first available NF bed that is not in the TBI unit or free standing NF-TBI for as long as NF services are needed, or until such time as a more appropriate placement can be made. The Provider must also agree to accept payment for the provision of services at a non-outlier NF level as payment in full for that individual.
- O. The Provider must agree to maintain such records necessary to fully distinguish the costs of operating the NF-TBI unit or free standing NF-TBI, to disclose the extent of services provided by the NF-TBI unit or free standing NF-TBI, and to maintain all information regarding payments claimed by the Provider for furnishing NF-TBI services for a period of six (6) years; or if an audit is initiated within the six (6) year period, until the audit is completed and every exception is resolved.

SECTION 3 - PROVIDER SIGNATURE FOR NF-TBI OUTLIER UNIT OR FACILITY
 (Please select either option (A) Provider Representative or (B) Authorized Agent of Provider)

OPTION (A) By my signature below, I certify that I am the owner, officer, chief executive officer, general partner, or board member of the business organization entering into this provider agreement to operate this NF-TBI unit or free standing NF-TBI in the Medicaid program. I agree to be bound by this agreement and all applicable laws. I certify the information submitted on the application and the information as it appears in this provider agreement is accurate and complete. I agree that our business organization will notify ODM, in writing, of any subsequent changes to the information contained in the application or this agreement.

Provider Representative Name <i>(print or type)</i>	Title <i>(print or type)</i>
Provider Representative Signature	Date of Signature

OPTION (B) By my signature below, I certify that I am signing with agent authority from and on behalf of

Name <i>(print or type)</i>	Title <i>(print or type)</i>
who is the owner, officer, chief executive officer, general partner, or board member of the business organization entering into this provider agreement to operate this NF-TBI unit or free standing NF-TBI in the Medicaid program, and that I have been given the authority to bind the business organization to this agreement and all applicable laws. I certify, on the organization's behalf, that the information submitted on the application and the information as it appears in this provider agreement is accurate and complete. Further, by my signature, I am binding the business organization to notify ODM, in writing, of any subsequent changes to the information contained in the application or this agreement.	
Name of Authorized Agent of Provider <i>(print or type)</i>	Title <i>(print or type)</i>
Authorized Agent of Provider Signature	Date of Signature

SECTION 4 - SIGNATURE OF AUTHORIZED ODJFS REPRESENTATIVE

Authorized ODM Representative Name <i>(print or type)</i>	Title <i>(print or type)</i>
Authorized ODM Representative Signature	Date of Signature