

**Addendum to ODM 03623 for Intermediate Care Facilities for the Mentally Retarded (ICFs-MR);  
Ohio Medicaid Provider Agreement for Behavioral Redirection and Medical Monitoring Outlier Services**  
(For Ohio and Out-of-State Providers)

**SECTION 1 - ICF-MR-BRMM OUTLIER FACILITY/UNIT ADDRESS, IDENTIFIERS, AND BED INFORMATION**

Facility Name (DBA)		
Facility Address (Physical location of free-standing ICF-MR-BRMM or ICF-MR-BRMM 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 ICF-MR-BRMM 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 intermediate care facility for the mentally retarded (ICF-MR), and must follow appropriate billing procedures in accordance with Ohio Administrative Code (OAC) Chapter 5101:3-3. Out-of-state Providers must also be a Medicaid certified ICF-MR in their state to be considered eligible to provide services to Ohio Medicaid consumers.
- B. The Provider must agree to cooperate with the MEDICAID oversight function for provision of ICF-MR behavioral redirection and medical monitoring (BRMM) services.
- C. The Provider must agree to comply with all provisions of OAC rule 5101:3-3-17.4 "Outlier Services for Behavioral Redirection and Medical Monitoring (BRMM) for Intermediate Care Facilities for the Mentally Retarded/Developmentally Disabled (ICFs-MR/DD)" as if included in this agreement for the provision of ICF-MR-BRMM services. Additionally, out-of-state Providers must agree to comply with all provisions of OAC rule 5101:3-1-11 regarding out-of-state Medicaid coverage as if included in this agreement for the provision of ICF-MR-BRMM 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 provide prior authorized services to individuals requiring behavioral redirection and medical monitoring (BRMM) services in either a discrete, distinctly identified unit of the ICF-MR dedicated to the provision of outlier services for persons requiring ICF-MR-BRMM services, or in a freestanding ICF-MR-BRMM.
- E. The Provider must provide each resident with their own private bedroom. The Provider must demonstrate the ability to rapidly respond to presented needs for structural changes related to the residents' behavior, and make significant environmental alterations that are expected to reduce, or eliminate, the destructive outcome to people, the environment, or to reduce the need for continual replacement of damaged property.

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**SECTION 2 – ADDL LTCF PROVIDER RESPONSIBILITIES SPECIFIC TO ICF-MR-BRMM OUTLIER SERVICES, CONTINUED**

- F. The Provider must schedule direct care staff to assure that adequately trained staff are present, and on duty, seven (7) days a week, twenty-four (24) hours a day and every day of the year, sufficient to assure that urgent, emergent and routine resident needs are timely and appropriately identified, and met, through the implementation of intervention strategies reflected in the resident's individual plan. Absences of staff for breaks and meals must not compromise this requirement.
- G. The Provider must ensure that staff employed to manage ICF-MR-BRMM services have evidence of two years of occupational experience working with individuals with severe behavioral issues; this includes services delivered by a QMRP.
- H. The Provider must provide staff training programs that address the specific behavioral and medical domains a staff member must master for the thorough understanding and demonstration of competency needed to meet the intensive needs of residents requiring ICF-MR-BRMM services. Initial and continuing direct care staff training must include:
  - 1. Orientation to the free standing ICF-MR-BRMM or distinct part unit's status as a provider of ICF-MR-BRMM services, including the individual eligibility, provider eligibility and prior authorization requirements for ICF-MR BRMM services outlined in OAC rule 5101:3-3-17.4.
  - 2. Information about the disorders/syndromes, behavioral phenotypes, and stages of disease progression affecting the current residents of the ICF-MR-BRMM unit or free-standing ICF-MR-BRMM.
  - 3. Accepted best practices, and innovative approaches, to meet these resident needs in both behavioral and medical domains.
- I. Prior to an individual's admission, the Provider must arrange for a suitable school, or day program, for the individual, and must also develop accurate assessments, or reassessments, by an interdisciplinary team that addresses the individual's health, social, psychological, educational, vocational and chemical dependency needs. The Provider must submit a copy of the preliminary assessment, or reassessment, and a copy of the school or day program plan to the Medicaid designated outlier coordinator, or Medicaid designee.
- J. The Provider must perform sufficient planning prior to an individual's admission, and develop a transitional plan to assure that the facility is ready and able to meet the individual's health, safety, and behavioral needs from the day of admission. This transitional plan shall address any major concerns, and must be submitted for review to the Medicaid designated outlier coordinator, or Medicaid designee, prior to the individual's admission.
- K. Within thirty days after admission, the Provider must develop and submit to the Medicaid designated outlier coordinator, or Medicaid designee, accurate assessments, or reassessments, by an interdisciplinary team that address the individual's health, social, psychological, educational, vocational, and chemical dependency needs to supplement the preliminary evaluation conducted prior to admission.
- L. Within thirty days of the individual's admission, the Provider must develop and submit to the Medicaid designated outlier coordinator, or Medicaid designee, a comprehensive, individualized plan. The plan shall be reviewed by the appropriate program staff at least quarterly and revised as necessary. A copy of any revisions shall be made available to the Medicaid outlier coordinator, or Medicaid designee, upon request.

**SECTION 2 – ADDL LTCF PROVIDER RESPONSIBILITIES SPECIFIC TO ICF-MR-BRMM OUTLIER SERVICES, CONTINUED**

- M. Within thirty days after admission, the Provider must develop and submit for approval to the Medicaid designated outlier coordinator, or Medicaid designee, a written discharge planning evaluation developed by the interdisciplinary team in conjunction with the individual and others concerned with the individual's welfare. The discharge plan must include a description of targeted behavioral and medical/health status indicators that would signify the resident could be safely discharged, recommendations for any counseling and/or 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.
- N. 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 Medicaid designated outlier coordinator, or Medicaid designee, within five (5) working days following the revision.
- O. The Provider must prepare and provide to the Medicaid designated outlier coordinator, or Medicaid designee, a quarterly report in a format approved by Medicaid that summarizes the resident's individual plan, progress, changes in treatment, current status relative to discharge goals, and any updates to the discharge plan, including referrals made and anticipated time frames. The Provider shall notify the Medicaid designated outlier coordinator, or Medicaid designee, at least one (1) week in advance of each full-team meeting. The minutes of the quarterly meetings, as well as a current copy of the resident's individual plan, must be available to the Medicaid designated outlier coordinator, or Medicaid designee, upon request.
- P. The Provider must agree to accept the prior authorized Medicaid per diem rate established for ICF-MR-BRMM services as payment in full, and to make no additional charge to the individual, any member of the individual's family, or to any other source for covered ICF-MR-BRMM services. Excepted are any specific items that are direct billed in accordance with Rule 5101:3-3-19 of the Administrative Code, as needed, for individuals who receive prior authorization from Medicaid for the receipt of ICF-MR-BRMM services, and charges for third-party resources pursuant to OAC rule 5101:3-1-08, or made in accordance with conditions specified in OAC rule 5101:3-3-16.9, regarding personal needs allowances (PNAs).
- Q. If prior authorization is denied during an assessment that was requested for an individual who is already residing in the ICF-MR-BRMM unit or free standing ICF-MR-BRMM, the Provider must agree to move the individual to the first available ICF-MR bed that is not in the ICF-MR-BRMM unit or free standing ICF-MR-BRMM for as long as ICF-MR 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 ICF-MR level as payment in full for that individual.
- R. The Provider must agree to maintain such records necessary to fully distinguish the costs of operating the ICF-MR-BRMM unit or free standing ICF-MR-BRMM, agree to disclose the extent of services provided by the ICF-MR-BRMM unit or free standing ICF-MR-BRMM, and agree to maintain all information regarding payments claimed by the provider for furnishing ICF-MR-BRMM 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 ICF-MR-BRMM OUTLIER SERVICES**  
(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 ICF-MR BRMM unit or free standing ICF-MR-BRMM 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 Medicaid, 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> )
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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 ICF-MR BRMM unit or free standing ICF-MR-BRMM 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 Medicaid, 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 MEDICAID REPRESENTATIVE**

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