

Ohio Department of Medicaid
ADDENDUM TO ODM PROVIDER AGREEMENT FOR VENTILATOR SERVICES IN NURSING FACILITIES

SECTION I: PROVIDER INFORMATION		
Facility Name <i>(DBA)</i>		
Facility Street Address <i>(Physical location of ventilator program discrete unit)</i>		
City	State	Zip Code
Medicaid Provider Number		Area of Discrete Unit Within Facility
Number of Beds in Discrete Unit		Effective Date <i>(to be completed by Medicaid staff)</i>
SECTION II: ADDITIONAL PROVIDER REQUIREMENTS		
<p>In addition to the requirements specified in the Nursing Facility Provider Agreement, the Nursing Facility (NF) shall comply with all of the requirements included in 5160-3-18 of the Revised Code including but not limited to the following:</p>		
<ul style="list-style-type: none"> A. Be licensed and Medicaid certified and meet the requirements for NFs in accordance with 42 U.S.C. 1396r (2/1/2017). B. Agree to comply with all provisions of OAC rule 5160-3-18 “Nursing facilities (NFs): ventilator program” as if included in this agreement for the provision of services under the Ohio Department of Medicaid (ODM) ventilator program. C. Provide services to individuals who are ventilator dependent and have Medicaid as their primary payer. D. Comply with the provisions in Chapters 5164 and 5165 of the Revised Code regarding provider agreements, and with the provisions in Rules 5160-3-02 through 5160-3-02.2 of the Administrative Code regarding execution and maintenance of provider agreements between ODM and the operator of a NF. E. Cooperate with ODM or its designee during all provider oversight and monitoring activities in accordance with OAC 5160-3-18. F. Designate a discrete unit within the NF for the use of individuals in the ODM NF ventilator program. If there is a change in the size or location of the designated discrete unit or number of beds in the discrete unit, the NF shall notify ODM of the change via email at nfpolicy@medicaid.ohio.gov within five business days of the change. G. Have ventilators connected to emergency outlets, which are connected to an on-site backup generator in an amount sufficient to meet the needs of the ventilator dependent individuals. H. Not have been in the centers for Medicare and Medicaid services (CMS) special focus facility (SFF) program for the previous six months. I. Notify ODM via email at nfpolicy@medicaid.ohio.gov of their SFF status within one business day of receipt of notice of being informed by CMS. A copy of the letter should be included. J. Provide all of the following services: <ul style="list-style-type: none"> 1. For at least five hours per week, the services of a licensed respiratory therapist or the services of a registered nurse who has worked for a minimum of one year with ventilator dependent individuals. The licensed respiratory therapist or the registered nurse as applicable, shall provide direct care to the ventilator dependent individuals. 2. If ordered by a physician, initial assessments for physical therapy, occupational therapy, and speech therapy within forty-eight hours of receiving the order for a ventilator dependent individual. 3. If ordered by a physician, up to two hours of therapies per day, six days per week for each ventilator dependent individual. 4. In emergency situations as determined by a physician, access to laboratory services that are available twenty-four hours per day, seven days per week with a turnaround time of four hours. 		

- 5. For new admissions, administer pain medications to a ventilator dependent individual within two hours from the receipt of the physician order.
- K. Submit a request to participate in the NF ventilator program via email at nfstay@medicaid.ohio.gov with information that the NF is capable of fulfilling all of the requirements specified in this rule and receive an approved ODM 10198, "Addendum To ODM Provider Agreement For Ventilator Services In Nursing Facilities" (2/2017)
- L. Submit quarterly reports, and if required, a plan of action to ODM in accordance with 5160-3-18.
- M. Follow the process identified in 5160-3-18 to withdraw from the ODM NF ventilator program.

SECTION III: PROVIDER SIGNATURE

(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 ventilator services unit in the Medicaid program. I agree to be bound by this agreement and all applicable laws. I certify the information submitted on the request and the information as it appears on this provider agreement is accurate and complete. I agree that our business organization will notify the Ohio Department of Medicaid in writing of any subsequent changes to the information contained in the request or in this agreement.

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

(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 ventilator services unit 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 request 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 the Ohio Department of Medicaid in writing of any subsequent changes to the information contained in the request or in this agreement.

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

SECTION IV: SIGNATURE OF AUTHORIZED DEPARTMENT OF MEDICAID (ODM) REPRESENTATIVE

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