Reset Form

Ohio Department of Medicaid

Addendum to ODM 03623 for Nursing Facilities (NFs); Ohio Medicaid Provider Agreement for Pediatric Outlier Services

(For Ohio and Out-of-State Providers)

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

Facility Name *(DBA)*		
Facility Address *(Physical location of free standing NF-PED or NF-PED 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 RESPONSIBLITIES SPECIFIC TO NF-PEDIATRIC 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 agree to comply with all provisions of OAC rule 5101:3-3-54.5 "Pediatric Outlier Care in Nursing Facilities (NF-PED Services)" as if included in this agreement for the provision of NF-PED 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 NF-PED 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.

C. The Provider must provide prior authorized NF-PED services in either a discrete, distinctly identified unit of the NF dedicated to the provision of outlier services for persons requiring NF-PED services, or in a free standing NF-PED.

D. The Provider must agree to provide or arrange for the provision of 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 the Medicaid prior authorization committee, or Medicaid designee, for the receipt of NF-PED 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. Diagnostic radiology services, laboratory services, and dental services.

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SECTION 2 – ADDITIONAL LTCF PROVIDER RESPONSIBLITIES SPECIFIC TO NF-PED OUTLIER SERVICES, CONTINUED

6. Ventilator care requiring the professional assessment of a registered nurse (RN) and/or a respiratory therapist, supplies and equipment including, but not limited to, the provision of oxygen, regular monitoring of blood gases, and frequent suctioning.

7. Therapeutic and training services consistent with the individual program plan that ordinarily would occupy most of the day.

E. 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.

F. 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.

G. 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 shall be reviewed by the appropriate program staff at least monthly and/or within fourteen (14) days of each readmission, 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.

H. 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 discharge planning evaluation shall include recommendations for any counseling and training of the individual and family members or other 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.

I. 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.

J. 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.

K. The Provider must agree to cooperate with the Medicaid oversight function for provision of NF-PED 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.

SECTION 2 – ADDITIONAL LTCF PROVIDER RESPONSIBLITIES SPECIFIC TO NF-PED OUTLIER SERVICES, CONTINUED

L. The Provider must agree to accept the Medicaid per diem rate established for prior authorized NF-PED outlier services, or an adjusted "step down" rate for the provision of services for any individual who has been determined by Medicaid to no longer require NF-PED outlier services but for whom no appropriate alternative placement is available, as payment in full. The Provider must agree to make no additional charge to the individual, any member of the individual's family, or to any other source for 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).

M. The Provider must agree to maintain such records necessary to fully distinguish the costs of operating the NF-PED unit or free standing NF-PED, to disclose the extent of services provided by the NF-PED unit or free standing NF-PED, and to maintain all information regarding payments claimed by the Provider for furnishing NF-PED 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-PEDIATRIC 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 NF-PED unit or free standing NF-PED 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 (*print or type*)	Title (*print or type*)
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 (*print or type*)	Title (*print or type*)

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-PED unit or free standing NF-PED 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 (*print or type*)	Title (*print or type*)
Authorized Agent of Provider Signature	Date of Signature

SECTION 4 - SIGNATURE OF AUTHORIZED MEDICAID REPRESENTATIVE

Authorized Medicaid Representative Name (*print or type*)	Title (*print or type*)
Authorized Medicaid Representative Signature	Date of Signature