

B. ODMRDD RESPONSIBILITIES

1. Fiscal Related

- a. Shall invoice ODHS at least quarterly, in a format approved by ODHS, through an ISTV the actual Medicaid reimbursable costs for screening required by OBRA'87 for persons with mental retardation or related condition.
- b. Shall insure that the county boards of MR/DD submit cost reports in a format and on a schedule approved by ODHS for all costs associated with providing PASARR screens.
- c. Shall submit claims for PASARR screens within 365 days of the date the service was provided.
- d. ODMR/DD is responsible for insuring that all necessary financial, statistical and medical records are maintained to disclose fully the extent of PASARR services provided for a period of six years from the date of last reimbursement pursuant to this Agreement, or if an audit is initiated within the six year period, until the audit is completed and every exception resolved. ODMR/DD shall provide these records upon request to ODHS, HCFA, or any other state or federal agency with authority to audit these records.
- e. ODMR/DD shall provide the required state matching share. By entering into this Agreement, ODMR/DD hereby certifies the availability of the required state share for PASAAR services.

Effective 4/1/89

A-179 # 89-16 Date Rec'd 10/15/90  
Date Rec'd NEW Date Ag. 10-18-90  
100 April 1, 1989

PREADMISSION SCREENING AND ANNUAL RESIDENT REVIEW (PASARR)

## A. ODHS RESPONSIBILITIES

## 1. Fiscal Related

- a. Shall process Interagency Fund Transfers (ISTVs) to the account specified by ODMR/DD, transferring the federal share of Medicaid funds. Fund transfers will be contingent upon the availability of federal funds. The federal share transferred to ODMR/DD will be at the rate applicable to Medicaid PASARR activity, which at the time this agreement was entered into is 75% federal and 25% state share.
- b. Shall review county board of MR/DD cost reports, perform annual fiscal audits to verify allowable Medicaid reimbursable costs for PASARR activities, and determine a final settlement of actual allowable costs. If an overpayment occurs, ODMR/DD shall remit to ODHS through ISTV the amount of overpayment within 30 days of notice. If an underpayment occurs, ODHS shall remit to ODMR/DD through an ISTV the amount of the underpayment within 30 days.
- c. Shall decline to make payment for outstanding services if ODMR/DD or any county board of MR/DD fails to provide information or access for fiscal audits or cost settlements as specified in federal regulations, Ohio Administrative Code, or the terms and conditions of this Agreement.
- d. Shall complete and submit FFP claims for OBRA'87 PASARR related Medicaid reimbursable activities. Reimbursement shall be made in accordance with federal and state guidelines unless otherwise specified in writing.

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- e. ODMR/DD shall provide the required state matching share. By entering into this Agreement, ODMR/DD hereby certifies the availability of the required state share for PASAAR services.

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5101:3-37-10 MEDICAID-COVERED HABILITATION CENTER PROGRAM: REIMBURSEMENT.

- (A) THE PURPOSE OF THIS RULE IS TO SET FORTH THE PROVISIONS OF MEDICAID REIMBURSEMENT FOR THE DELIVERY OF MEDICAID-COVERED HABILITATION CENTER PROGRAM SERVICES (AS DEFINED IN CHAPTER 5101:3-37 OF THE ADMINISTRATIVE CODE).
- (B) DEFINITIONS:
- (1) A "UNIT OF ACTIVE TREATMENT SERVICES" IS DEFINED, FOR PURPOSES OF THIS RULE, AS ALL OF THOSE SERVICES RECEIVED BY AN ELIGIBLE RECIPIENT ON ANY GIVEN DAY WHICH WERE DELIVERED IN ACCORDANCE WITH PARAGRAPH (B) OF RULE 5101:3-37-01, RULE 5101:3-37-04, PARAGRAPH (D)(1) OF RULE 5101:3-37-07, AND RULE 5101:3-37-13 OF THE ADMINISTRATIVE CODE).
  - (2) A "UNIT OF PROFESSIONAL SERVICES", OTHER THAN PHYSICIAN SERVICES, IS DEFINED, FOR PURPOSES OF THIS RULE, AS FIFTEEN MINUTES OF TIME SPENT BY THE APPROPRIATE LICENSED PROFESSIONAL HABILITATION CENTER PERSONNEL ON THE DIRECT, FACE-TO-FACE DELIVERY OF A COVERED PROFESSIONAL SERVICE TO AN ELIGIBLE RECIPIENT OR PERSONAL CAREGIVER (AS SPECIFIED IN PARAGRAPH (D)(2) OF RULE 5101:3-37-07 AND RULE 5101:3-37-16 OF THE ADMINISTRATIVE CODE).
  - (3) A "UNIT OF PROFESSIONAL PHYSICIAN SERVICES" IS DEFINED, FOR THE PURPOSES OF THIS RULE, AS ONE FACE-TO-FACE DELIVERY ENCOUNTER BETWEEN THE HABILITATION CENTER PHYSICIAN AND AN ELIGIBLE RECIPIENT (AS SPECIFIED IN PARAGRAPH (D)(2) OF RULE 5101:3-37-07 AND RULE 5101:3-37-16 OF THE ADMINISTRATIVE CODE).
  - (4) A "UNIT OF DELEGATED NURSING SERVICES" IS DEFINED, FOR PURPOSES OF THIS RULE, AS FIFTEEN MINUTES OF TIME SPENT BY THE APPROPRIATE HABILITATION CENTER PERSONNEL, AS DESIGNATED BY THE DELEGATING REGISTERED NURSE, ON THE DIRECT, FACE-TO-FACE DELIVERY OF SERVICES DELEGATED BY, AND UNDER THE DIRECTION AND SUPERVISION OF THE RESPONSIBLE REGISTERED NURSE, TO AN ELIGIBLE RECIPIENT (AS SPECIFIED IN PARAGRAPH (D)(2) OF RULE 5101:3-37-07 AND RULE 5101:3-37-16 OF THE ADMINISTRATIVE CODE).
  - (5) A "UNIT OF TRANSPORTATION SERVICE" IS DEFINED, FOR THE PURPOSES OF THIS RULE, AS A ONE-WAY TRIP BETWEEN THE HABILITATION PROVIDER'S SERVICE SITE AND THE MEDICAID RECIPIENT'S RESIDENCE. TRANSPORTATION BENEFITS ARE AVAILABLE ONLY FOR DAYS WHEN THE RECIPIENT RECEIVES A MEDICAID-COVERED SERVICE AT THE HABILITATION CENTER.
  - (6) "RECIPIENT DAYS" IS DEFINED, FOR THE PURPOSES OF THIS RULE, AS THE TOTAL NUMBER OF DAYS DURING WHICH ALL RECIPIENTS (REGARDLESS OF MEDICAID ELIGIBILITY) ATTENDED THE HABILITATION CENTER.

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- (7) "PROGRAM DAYS" IS DEFINED, FOR THE PURPOSES OF THIS RULE, AS THE TOTAL NUMBER OF MEDICAID REIMBURSABLE UNITS OF ACTIVE TREATMENT SERVICES (AS DEFINED IN PARAGRAPH (B)(1) OF THIS RULE AND PARAGRAPH (B)(3) OF RULE 5101:3-37-13 OF THE ADMINISTRATIVE CODE) WHICH WERE DELIVERED BY A CERTIFIED HABILITATION CENTER DURING A GIVEN TWELVE-MONTH PERIOD.
- (8) "RATE YEAR" IS DEFINED, FOR PURPOSES OF THIS RULE, AS THE STATE FISCAL YEAR DURING WHICH ANY GIVEN SET OF MEDICAID-COVERED HABILITATION CENTER PROGRAM RATES HAS BEEN DETERMINED BY THE ODHS TO BE IN EFFECT.
- (9) "MEDICAID ALLOWABLE REIMBURSEMENT" AND/OR "THE MEDICAID PAYMENT" IS DEFINED, FOR PURPOSES OF THIS RULE, AS THE SUM OF THE FEDERAL MEDICAID DOLLARS THAT ARE PAID DIRECTLY TO A CERTIFIED HABILITATION CENTER BY ODHS AND THOSE STATE/LOCAL DOLLARS THAT HAVE BEEN ALLOCATED AS MATCHING FUNDS FOR THE MEDICAID-COVERED HABILITATION CENTER PROGRAM SERVICES DELIVERED BY THAT HABILITATION CENTER. SUCH PAYMENTS ARE SUBJECT TO FISCAL AUDIT AND COST SETTLEMENT TO ENSURE THAT PAYMENTS ARE EQUAL TO OR LESS THAN ACTUAL, REASONABLE AND ALLOWABLE MEDICAID COST AND ARE OTHERWISE IN ACCORDANCE WITH CHAPTER 5101:3-37 OF THE ADMINISTRATIVE CODE.
- (C) MEDICAID REIMBURSEMENT IN THE MEDICAID-COVERED HABILITATION CENTER PROGRAM IS ONLY AVAILABLE FOR SERVICES WHICH ARE DELIVERED AND DOCUMENTED BY THE CERTIFIED HABILITATION CENTER IN ACCORDANCE WITH THE RULES CONTAINED IN CHAPTER 5101:3-37 OF THE ADMINISTRATIVE CODE.
- (1) THE DOCUMENTATION WHICH MUST BE MAINTAINED IN THE HABILITATION CENTER SHALL INCLUDE:
- (a) A COPY OF THE NOTICE OF CERTIFICATION FROM THE OHIO DEPARTMENT OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES (ODMR/DO) STATING THAT THE PROVIDER IS A CERTIFIED HABILITATION CENTER (SEE RULE 5123:2-15-01 OF THE ADMINISTRATIVE CODE.)
- (b) A COPY OF THE VERIFICATION OF ALLOCATED STATE/LOCAL MATCHING FUNDS AVAILABLE AND COMMITTED TO THE CERTIFIED HABILITATION CENTER FOR THE PURPOSE OF MATCHING FEDERAL MEDICAID DOLLARS IN THE MEDICAID-COVERED HABILITATION CENTER PROGRAM (AS REQUIRED BY RULE 5101:3-37-01 OF THE ADMINISTRATIVE CODE PURSUANT TO DIVISION (B) OF SECTION 5111.041 OF THE REVISED CODE.)

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- (c) A COPY OF THE "MEDICAID-COVERED HABILITATION CENTER PROGRAM-PROVIDER AGREEMENT", "SIGNED AND DATED" BY APPROPRIATE REPRESENTATIVES OF THE CERTIFIED HABILITATION CENTER AND THE STATE OF OHIO (SEE RULE 5101:3-37-01 OF THE ADMINISTRATIVE CODE).
- (d) A CURRENT COPY OF EACH RECIPIENT'S COMPREHENSIVE ASSESSMENT REPORT AND THE INDIVIDUAL HABILITATION PLAN (IHP), OR THE INDIVIDUAL PROGRAM PLAN (IPP) AS DESCRIBED IN PARAGRAPH (B)(2) OF RULE 5101:3-37-13 OF THE ADMINISTRATIVE CODE.
- (e) DOCUMENTATION OF SERVICE DELIVERY FOR ALL MEDICAID-COVERED HABILITATION CENTER PROFESSIONAL SERVICES SHALL BE MAINTAINED IN A RECIPIENT SPECIFIC CHART/FILE, AND SHALL INCLUDE:
- (1) THE RECIPIENT'S NAME AND MEDICAID IDENTIFICATION/RECIPIENT NUMBER;
  - (2) THE DATE ON WHICH THE SERVICE WAS DELIVERED;
  - (3) A DESCRIPTION OF THE SPECIFIC SERVICE WHICH WAS DELIVERED, AND COMMENTS OR CODING REGARDING THE RECIPIENT'S RESPONSE/PROGRESS WHERE APPLICABLE;
  - (4) THE NAME AND POSITION/TITLE OF THE INDIVIDUAL WHO DELIVERED THE SERVICE;
  - (5) THE TOTAL TIME (ROUNDED TO THE NEAREST MINUTE) SPENT IN DELIVERING THE SERVICE;
  - (6) WHEN SERVICES ARE DELIVERED AT A LOCATION OTHER THAN THE CERTIFIED HABILITATION CENTER PREMISES, THE LOCATION AT WHICH THE SERVICE WAS DELIVERED; AND
  - (7) WHEN SERVICES ARE DELIVERED ON BEHALF OF THE RECIPIENT, BUT INCLUDE CONTACT WITH A PERSON OR AGENCY OTHER THAN THE RECIPIENT, THE NAME, AFFILIATION, TITLE/POSITION, RELATIONSHIP TO THE RECIPIENT MUST BE SPECIFIED.
- (f) DOCUMENTATION OF TRANSPORTATION SERVICES MUST BE KEPT IN ACCORDANCE WITH PARAGRAPH (B)(3) OF RULE 5101:3-37-22 OF THE ADMINISTRATIVE CODE.

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- (g) DOCUMENTATION OF ACTIVE TREATMENT SERVICES MUST INCLUDE:
- (1) DATES OF SERVICE TO EACH CLIENT;
  - (2) INDIVIDUAL CLIENT PRODUCTIVITY REPORTS; AND
  - (3) PERIODIC PROGRESS REPORTS TO BE COMPLETED NO LESS FREQUENTLY THAN ON A QUARTERLY BASIS.
- (2) MEDICAID REIMBURSEMENT IN THE MEDICAID-COVERED HABILITATION CENTER PROGRAM IS MADE ONLY FOR THOSE MEDICAID-COVERED HABILITATION CENTER PROGRAM SERVICES ACTUALLY NEEDED AND RECEIVED BY MEDICAID RECIPIENTS WHO MEET THE ELIGIBILITY REQUIREMENTS DEFINED IN RULE 5101:3-37-07 OF THE ADMINISTRATIVE CODE.
- (a) RECIPIENT NEEDS SHALL BE DETERMINED BY THE RECIPIENT'S INTERDISCIPLINARY TEAM AND RECOMMENDATIONS FOR SERVICES TO MEET THOSE NEEDS SHALL BE DOCUMENTED IN THE ANNUAL-COMPREHENSIVE ASSESSMENT REPORT, THE RECIPIENT'S IHP OR IPP, THE REPORTS WRITTEN FOR THE QUARTERLY REVIEW AND ANY SPECIAL REVIEWS NECESSITATED BY A CHANGE IN RECIPIENT NEEDS.
  - (b) THE RECEIPT OF SERVICES SHALL BE DOCUMENTED AS SPECIFIED IN PARAGRAPH (C)(1) OF THIS RULE AND IN PARAGRAPH (B)(4) OF RULE 5101:3-37-22 OF THE ADMINISTRATIVE CODE.
  - (c) SERVICES THAT MAY OTHERWISE BE COVERED IN THE MEDICAID-COVERED HABILITATION CENTER PROGRAM THAT ARE DELIVERED TO A MEDICAID RECIPIENT, BUT WHICH ARE NOT SPECIFIED IN THE RECIPIENT'S IHP OR IPP AND/OR CONTRACTUAL AGREEMENT WITH THE CERTIFIED HABILITATION CENTER (WHERE REQUIRED), ARE DELIVERED IN A MANNER THAT IS INCONSISTENT WITH THE RECIPIENT'S IHP OR IPP, OR WHICH ARE DELIVERED TO AN INDIVIDUAL WHO FAILS TO MEET THE PROGRAM ELIGIBILITY REQUIREMENTS FOR THOSE SERVICES, ARE NOT REIMBURSABLE AS MEDICAID-COVERED HABILITATION CENTER PROGRAM SERVICES.
- (3) THE MEDICAID PAYMENT FOR A COVERED SERVICE, SUBJECT ONLY TO FISCAL AUDIT AND FINAL SETTLEMENT, SHALL CONSTITUTE PAYMENT-IN-FULL AND SHALL NOT BE CONSTRUED TO BE A PARTIAL PAYMENT WHEN THE REIMBURSEMENT AMOUNT IS LESS THAN THE PROVIDER'S CHARGE. THE PROVIDER MAY NOT BILL THE RECIPIENT, ANY MEMBER OF THE RECIPIENT'S FAMILY, NOR ANY OTHER INDIVIDUAL FOR THE DIFFERENCE BETWEEN THE MEDICAID PAYMENT AND THE PROVIDER'S CHARGE, NOR SHALL THE PROVIDER REQUEST THAT THE RECIPIENT SHARE IN THE COST THROUGH A COPAYMENT OR OTHER SIMILAR CHARGE.

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- (4) ODHS SHALL REIMBURSE THE FEDERAL SHARE OF THE MEDICAID PAYMENT FOR ALL MEDICAID ALLOWABLE SERVICES AS DEFINED IN CHAPTER 5101:3-37 OF THE ADMINISTRATIVE CODE WHEN:
- (a) THERE IS A CONTRACT IN PLACE BETWEEN THE ICF-MR AND THE CERTIFIED HABILITATION CENTER IN ACCORDANCE WITH RULE 5101:3-37-04 OF THE ADMINISTRATIVE CODE. THIS CONTRACT SHALL REASSIGN PAYMENT FROM THE ICF-MR TO THE CERTIFIED HABILITATION CENTER.
- (b) THE CERTIFIED HABILITATION CENTER HAS A "MEDICAID COVERED HABILITATION CENTER PROGRAM-PROVIDER AGREEMENT" IN ACCORDANCE WITH PARAGRAPH (C)(2) OF RULE 5101:3-37-01 OF THE ADMINISTRATIVE CODE.
- (5) THE PAYMENT OF THE FEDERAL SHARE OF THE MEDICAID PAYMENT SHALL BE ACCOMPANIED BY REMITTANCE ADVICES WHICH DELINEATE THE TOTAL ALLOWABLE MEDICAID REIMBURSEMENT. THE PROVIDER MUST DRAW DOWN AND ACCOUNT FOR THE USE OF THE STATE/LOCAL MATCHING FUNDS ATTRIBUTABLE TO THE MEDICAID PAYMENT AND KEEP ACCOUNTING RECORDS SUFFICIENT TO ENABLE ODHS TO VERIFY THE USE OF MATCHING FUNDS.
- (6) IN THE EVENT THAT AN AUDIT OF THE CERTIFIED HABILITATION CENTER REVEALS THAT AN OVERPAYMENT HAS BEEN MADE, AND/OR IN THE EVENT THAT THERE IS A FEDERAL DISALLOWANCE OF FEDERAL FINANCIAL PARTICIPATION (FFP) FOR ANY GIVEN MEDICAID-COVERED HABILITATION CENTER PROGRAM CLAIM, ODHS SHALL RECOVER ANY OVERPAYMENTS WHICH HAVE ALREADY BEEN MADE, AND/OR PASS THROUGH SUCH DISALLOWANCE, TO THE CERTIFIED HABILITATION CENTER.
- (D) ALLOWABLE AND REASONABLE COSTS:
- (1) PAYMENT WILL BE MADE FOR THOSE COSTS RECOGNIZED AS REASONABLE AND ALLOWABLE UNDER TITLE XVIII STANDARDS AND PRINCIPLES AS DESCRIBED IN 42 CFR 413, HCPA PUBLICATION 15-1 AND UNDER ADDITIONAL TESTS OF REASONABLENESS AND COST LIMITATIONS AS ESTABLISHED BY THE DEPARTMENT TO ASSURE THE EFFICIENT DELIVERY OF HEALTH SERVICES.
- NON-ALLOWABLE COSTS SHALL INCLUDE:
- (a) THE COST OF GOODS OR SERVICES FURNISHED FREE OR AT LESS THAN MARKET VALUE.
- (b) COST OF SERVICES NOT REIMBURSABLE DUE TO NOT HAVING BEEN BILLED TIMELY AS DEFINED IN RULE 5101:3-1-08 OF THE ADMINISTRATIVE CODE.

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- (c) INTEREST EXPENSE FOR MONEY BORROWED TO ALLEVIATE CASH FLOW PROBLEMS RESULTING FROM RATE REDUCTIONS OR CLAIMS SUSPENSIONS IMPOSED FOR DELINQUENT FILING OF COST REPORTS AS DESCRIBED IN PARAGRAPH (E)(5) OF THIS RULE.
  - (d) THE AMOUNT OF ANY INTEREST ON OVERPAYMENTS AND ANY INTEREST EXPENSE FOR MONEY BORROWED TO ALLEVIATE CASH FLOW PROBLEMS RESULTING FROM A FINAL SETTLEMENT OVERPAYMENT.
  - (e) COSTS RELATED TO PATIENT CARE AND SERVICES THAT ARE NOT COVERED UNDER THE HABILITATION PROGRAM AS DESCRIBED IN RULES 5101:3-37-01 TO 5101:3-37-22 OF THE ADMINISTRATIVE CODE.
- (2) FOR PURPOSES OF DETERMINING ALLOWABLE AND REASONABLE COST IN THE PURCHASE OF GOODS AND SERVICES FROM A RELATED PARTY, THE FOLLOWING DEFINITION OF RELATED SHALL BE USED: "RELATED" IS ONE WHO ENJOYS, OR HAS ENJOYED WITHIN THE PREVIOUS FIVE YEARS, ANY DEGREE OF ANOTHER BUSINESS RELATIONSHIP WITH THE OWNER OR OPERATOR OF THE FACILITY, DIRECTLY OR INDIRECTLY, OR ONE WHO IS RELATED BY MARRIAGE OR BIRTH TO THE OWNER OR OPERATOR OF THE FACILITY. THE DEPARTMENT RESERVES THE RIGHT TO ESTABLISH UPPER LIMITS OR TESTS OF REASONABLENESS FOR COSTS ASSOCIATED WITH RELATED PARTY TRANSACTIONS AS NECESSARY TO ASSURE EFFECTIVE AND EFFICIENT DELIVERY OF HABILITATION SERVICES.
- (3) REIMBURSEMENT FOR ELIGIBLE HABILITATION CENTER COVERED SERVICES MAY NOT EXCEED THE LESSOR OF REASONABLE COST OR BILLED CHARGES. BILLINGS FOR SUCH SERVICES MUST REFLECT THE PROVIDER'S CUSTOMARY CHARGE FOR THE SERVICE RENDERED.
- (E) COST REPORTING:
- (1) CERTIFIED HABILITATION CENTERS WHICH PARTICIPATE AS PROVIDERS IN THE MEDICAID-COVERED HABILITATION CENTER PROGRAM ARE REQUIRED TO SUBMIT ANNUAL REPORTS WHICH COVER A CONSECUTIVE TWELVE-MONTH PERIOD OF THEIR OPERATION. COST REPORTS MUST BE FILED WITHIN FORTY-FIVE DAYS OF THE END OF THE PROVIDER'S COST REPORTING YEAR.
  - (2) COST REPORTS MUST BE SUBMITTED TO ODHS DIVISION OF MEDICAL ASSISTANCE, BUREAU OF HOSPITAL RATES AND AUDITS, USING A FORM APPROVED BY THE DEPARTMENT.
  - (3) ALL COST REPORTS MUST BE PREPARED IN ACCORDANCE WITH TITLE XVIII PRINCIPLES GOVERNING REASONABLE COST REIMBURSEMENT AS SET FORTH

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IN SUBPART B OF 42 CFR 413, HCFA PUBLICATION 15-1, AND CHAPTER 5101:3-37 OF THE ADMINISTRATIVE CODE AND:

- (a) INCLUDE ALL WORKSHEETS AND SCHEDULES AS REQUIRED AND APPROVED BY ODHS.
- (b) INCLUDE ALL INFORMATION NECESSARY FOR THE PROPER DETERMINATION OF COSTS PAYABLE UNDER MEDICAID, INCLUDING FINANCIAL RECORDS AND STATISTICAL DATA.
- (4) UPON APPROVAL OF THE PROVIDER'S WRITTEN REQUEST TO ODHS DIVISION OF MEDICAL ASSISTANCE, BUREAU OF HOSPITAL RATES AND AUDITS, AN AMENDED COST REPORT MAY BE SUBMITTED WITHIN NINETY DAYS OF THE DEADLINE FOR COST REPORT FILING. THE PROVIDER'S WRITTEN REQUEST MUST INCLUDE SUFFICIENT DOCUMENTATION TO JUSTIFY THE APPROVAL OF AN AMENDED REPORT.
- (5) FAILURE TO SUBMIT A TIMELY OR COMPLETE COST REPORT WILL RENDER THE PROVIDER SUBJECT TO:
  - (a) A SUSPENSION OF CLAIMS PAYMENTS. SUSPENSION OF PAYMENTS SHALL BE EFFECTIVE THIRTY DAYS FOLLOWING THE DATE ON WHICH THE COST REPORT WAS DUE. SUSPENSION SHALL BE TERMINATED ON OR BEFORE THE TENTH WORKING DAY FOLLOWING THE RECEIPT OF A COMPLETE COST REPORT.
  - (c) A TERMINATION OF PROVIDER AGREEMENT. TERMINATION OF PROVIDER AGREEMENT SHALL BE PROPOSED NINETY DAYS FOLLOWING THE DATE ON WHICH THE COST REPORT WAS DUE.
- (6) CLAIMS AFFECTED BY WITHHOLDING OR SUSPENSION OF PAYMENTS ARE NOT CONSIDERED TO BE "CLEAN CLAIMS," AS DEFINED IN RULE 5101:3-1-193 OF THE ADMINISTRATIVE CODE.
- (7) THE DEPARTMENT MAY AUTHORIZE EXTENSIONS OF COST REPORT FILING DATES FOR JUST CAUSE. EXTENSION REQUESTS MUST BE MADE IN WRITING TO ODHS DIVISION OF MEDICAL ASSISTANCE, BUREAU OF HOSPITAL RATES AND AUDITS, PRIOR TO THE DUE DATE AND INCLUDE DOCUMENTATION JUSTIFYING THE NEED FOR AN EXTENSION.
- (8) A DESK AUDIT WILL BE PERFORMED BY THE BUREAU OF HOSPITAL RATES AND AUDITS ON ALL COST REPORTS. FOR THE PROGRAM YEAR BEGINNING JULY 1, 1991 AND FOR SUBSEQUENT YEARS, DESK-REVIEWED COST REPORT DATA WILL GENERALLY BE USED TO CALCULATE INTERIM PAYMENT RATES FOR ELIGIBLE HABILITATION CENTER COVERED SERVICES.

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