All audits performed and cost reports shall be retained for at least three years. Failure to retain or provide the required financial and statistical records renders the provider liable for monetary damages equal to the difference between (a) established unit rates paid to the provider for the prospective year in question and (b) the lowest unit rates for like services paid in the state to a community mental health facility similar in structure.

CONTRACTED SERVICES: It is recognized that community mental health facilities may wish to augment staff delivered services through contractual arrangements. Such arrangements are recognized to the extent that the conditions set forth in this paragraph are met. Under the community mental health facility program, services provided by contract may either be included as a cost item in determining the prospective rates or may be billed independently by the contract provider. If the contract provider bills independently, any such services will not be subject to prospective cost-related reimbursement, but will instead be reimbursed in accordance with methods established for that particular service program involved (e.g., physician (psychiatric) services will be reimbursed under provisions set forth in Chapter 5101:3-4 of the Administrative Code). In order for contractual arrangements to be recognized, community mental health facilities must provide the following information to the Ohio Department of Mental Health at the point of entry into the program and any subsequent point when new contracts are negotiated or when existing contracts are revised:

(i) identification by name and, where applicable, Medicaid provider number of each individual practitioner providing services under contractual arrangements. Where the contract is let with a legal entity other than the individual practitioner, both the name of the legal entity and the name(s) of any individual practitioner(s) involved must be furnished.

(ii) a written statement indicating, for each legal entity or individual practitioner, whether the contracted services are:

(a) to be included as a cost item and reimbursed under the applicable prospective rate for the type of service provided; or

(b) to be billed independently by the legal entity or individual practitioner under contract.

14b. Services for Individuals Age 65 or Older in Institutions for Mental Diseases

1. Inpatient Hospital Services

Reimbursement is on the basis of reasonable cost for services rendered, not exceeding the Medicare reimbursement rate.

2. Skilled Nursing Facility Services

None designated to date.

3. Intermediate Care Facility Services

None designated to date.

15. Intermediate Care Facility Services - General (Other than Institutions for Tuberculosis or Mental Diseases)

See Attachment 4.19-D

a. Intermediate Care Facility Service - Public Institutions for Mentally Retarded or Developmentally Disabled

See Attachment 4.19-D

16. Inpatient Psychiatric Hospital Services for Individuals Under 22

Reimbursement is the same as outlined in Inpatient Hospital Services under Number 1.

17. Any Other Type of Remedial Care, etc.

a. Transportation

Payment is made on the basis of the customary and reasonable charge up to the department's maximum reimbursement schedule for such services.

c. Care and Services in Christian Science Sanitoria

Payment is the same as it is in any ICF admitting the general geriatric or disabled patient. Both Christian Science facilities are certified as ICFs.

d. Skilled Nursing Services for Patients Under 21

Payment is the same for patients under 21 years of age as it is for an individual over 21 requiring skilled nursing care.

e. Emergency Hospital Services

Payment is made on the basis of itemized charges for services rendered.

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8. Private Duty Nursing Services

Payment is based on the customary and reasonable charge. Payment may not exceed the reimbursement made for the same services under Medicare.

9. Clinic Services

Payment is based on the basis of customary and reasonable charges up to the 75th percentile established for the particular service rendered. In no instance may the payment exceed Medicare reimbursement for the same services.

10. Dental Services

Payment is on the basis of customary and usual fee up to the Department's maximum schedule for dental services.

11. Physical Therapy and Related Services

a. Physical Therapy

The basis of payment is the customary and reasonable charge up to the 75th percentile not to exceed Medicare reimbursement for the same type of service.

b. Occupational Therapy

Based on customary and reasonable charges up to the 75th percentile not to exceed Medicare reimbursement for the same type of service.

c. Speech, Hearing and Language Disorders

Services provided by or under the supervision of a speech pathologist or audiologist.

Based on customary and reasonable charges up to the 75th percentile not to exceed Medicare reimbursement for the same service.

12. Prescribed Drugs, Dentures and Prosthetic Devices and Eyeglasses

a. Prescribed Drugs

(1) CERTAIN MULTI-SOURCE LEGEND DRUGS: For certain multi-source drugs (certain drugs that are marketed or sold by two or more formulators or labelers,

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or drugs that are marketed or sold by the same formulator or labeler under two or more different proprietary names, or both under a proprietary name and without such a name), the upper limit for reimbursement is the maximum allowable cost designated by the Department, plus a dispensing fee.

The billed charge must be the lower of (1) the acquisition cost of the drug plus a dispensing fee or (2) the maximum allowable cost designated by the Department plus a dispensing fee. In each case, the billed charge must not exceed the usual and customary charge of the pharmacy for the drug, which is inclusive of overheads such as billing charges, prescription charges, delivery charges, etc.

(2) OTHER LEGEND DRUGS: The reimbursement for all legend drugs other than those governed by maximum allowable cost provisions will not exceed (1) the closest estimate of the price generally and currently paid by providers for a specific drug plus a dispensing fee or (2) the usual and customary charge of the provider. Estimates of the price generally and currently paid shall be based on the package size of the drugs most frequently purchased by providers. In determining the estimated acquisition cost, the Department will take into consideration any price information supplied by HEW when establishing drug estimated acquisition costs. Reimbursement to dispensing physicians will not exceed acquisition cost.

Reimbursement to outpatient hospital pharmacies or other public/private health care agencies, including clinics, must not exceed the actual invoice cost plus a dispensing fee.

The billed charge must be the lower of (1) the acquisition cost plus a dispensing fee or (2) the usual and customary charge. In each case, the dispensing fee is inclusive of overheads such as billing charges, prescription charges, delivery charges, etc., and must not exceed the charge made to the general public for the same service.

(3) DIETARY SUPPLEMENTS: The upper limit for reimbursement is the Department's fee schedule based on the cost of the dietary supplements plus a markup of 20 percent. Payment for dietary supplements is on the basis of the

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cost of the supplement not to exceed 20 percent or the pharmacist's usual and customary charge, whichever is less.

(4) INSULIN: The upper limit for insulin is the estimated acquisition cost as determined by the Department plus a dispensing fee. Payment for insulin is on the basis of the estimated acquisition cost of the drug plus a 50 percent markup, or the estimated acquisition cost plus a dispensing fee, whichever is the lesser amount.

(5) DISPENSING FEE: Dispensing fee is defined as the lesser of the provider's usual dispensing fee (or markup) or the maximum dispensing fee established by the Department as a result of periodic surveys.

b. Dentures

Billing is according to the practitioner's usual and customary fee. Actual reimbursement is based on a fee schedule developed by the Ohio Department of Public Welfare.

c. Prosthetic Devices

Payment is made on the basis of the customary and reasonable fee for such items, not to exceed the Department's maximum payment schedule for such items.

d. Eyeglasses

Billing for services according to the provider's reasonable and customary charges. Reimbursement is on the basis of the Department's maximum payment schedule.

14b. Services for Individuals Age 65 or Older in Institutions for Mental Diseases

1. Inpatient Hospital Services

Reimbursement is on the basis of reasonable cost for services rendered, not exceeding the Medicare reimbursement rate.

2. Skilled Nursing Facility Services

None designated to date.

5101:3-3-21 Reasonable cost-related administrative and general services costs.

(A) The ceiling for administrative and general services costs set forth in paragraph (B) of this rule have been determined to be adequate to reimburse the actual allowable costs of an economically and efficiently operated nursing home. The ceiling includes all allowable and reasonable costs listed in the uniform chart of accounts (see Rule 5101:3-3-261 of the Administrative Code and the cost report instructions as published annually by the department). Examples of cost classifications are:

(1) Administrator, other administrative;

(2) Office and administrative supplies, printing, postage, copier, instruments and minor equipment, other supplies and materials, repairs;

(3) Communications, travel - including leased motor vehicle, travel - other, promotional - help wanted, promotional - yellow pages;

(4) Cafeteria, cleaning services, housekeeping, laundry and linen;

(5) Legal fees, consulting fees, accounting fees, license fees, and dues and subscriptions, interest other than property and equipment, data services, insurance, donated services;

(6) Plant operations and maintenance including, but not limited to, purchased services and maintenance and repairs, and other supplies and materials;

(7) For those employees whose salaries are reimbursed under the allowance for administrative and general services, the costs of employee benefits including, but not limited to, payroll taxes (FICA), state and federal unemployment insurance and workers' compensation, and for such employees' wearing apparel;

(8) Other allowable fringe benefits for those employees whose salaries are reimbursed under the allowance for administrative and general services costs including group health insurance, pension and retirement, and group life insurance;

(9) Other allowable in-house administrative expenses, not listed above but listed on the chart of accounts including, but not limited to, department heads, temporary employees, and nonworked compensation;

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(10) Other allowable administrative and general services costs not listed above but listed on the chart of accounts under the heading of administrative and general services costs, including allowable purchased administrative expenses ~~including~~ WHICH INCLUDE, but ARE not limited to, allowable expenses for outside training, seminars, meetings and conventions;

(11) Other allowable administrative and general services costs listed on the uniform chart of accounts under other services including, but not limited to, grounds;

(12) Home office costs, management fees, stock maintenance costs, and other costs which the department has included in the allowance for administrative and general services.

(B) The ceiling for all routine administrative and general services costs for all SNF or ICF facilities participating in the Medicaid program ~~(except public facilities)~~ is the rate at the eighty-third percentile of audited costs for the prior cost report as experienced by a scientifically selected sample of such nursing homes participating in the Medicaid program plus an inflation factor. The ceiling for all routine administrative and general services costs for all ICF-MR facilities participating in the Medicaid program (except ~~public facilities~~ STATE OPERATED INSTITUTIONS) is the rate at the seventy-sixth percentile of audited costs for the prior cost report period as experienced by a scientifically selected sample of such nursing homes participating in the Medicaid program plus an inflation factor.

(1) The sample of nursing homes LTCFs used to determine the ceilings shall not include hospital-based LTCFs or ~~public~~ STATE OPERATED institutions.

(2) The inflation factor used shall be the "~~All Items~~ SERVICES Less ~~Mortgage Interest Costs~~" RENT OF SHELTER" index from the table, "All Urban Consumers, Seasonally Adjusted" found in the "Consumer Price Index" published by the United States Department of Labor, and shall update costs from the midpoint of the cost reporting period to the midpoint of the rate year.

(3) The findings of the audited sample are considered final for the purposes of calculating the ceiling rate for administrative and general services costs.

(4) The ceiling for administrative and general services costs may be reduced if necessary in order to comply with paragraphs (B) and (C) of rule 5101:3-3-18 of the Administrative Code.

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(C) The interim allowance for routine and nonroutine administrative and general services costs shall be calculated up to the ceilings specified in paragraphs (B) and (D) of this rule for each home based upon the historical costs reported for the prior cost reporting period updated by the inflation factor identified in paragraph (B)(2) of this rule, plus the two dollars per day maximum efficiency incentive adjusted beginning with the rates paid in July, 1981, and annually thereafter by the "~~All Items~~ SERVICES Less ~~Mortgage Interest Costs~~ RENT OF SHELTER" index from the table, "All Urban Consumers, Seasonally Adjusted" found in the "Consumer Price Index" published by the United States Department of Labor.

(D) ~~The ceiling for administrative and general services costs for public facilities is the ceiling for nonpublic facilities as delineated in paragraph (B) of this rule.~~

(1) ~~The final allowance for administrative and general services costs is the facility's audited actual, allowable, and reasonable costs up to the ceiling specified.~~

(2) ~~Recovery of an overpayment shall occur if the interim allowance exceeds the final allowance.~~

Effective Date: _____

Certification: _____

_____
Date

Promulgated under: RC Chapter 119.

Rule amplifies: RC Section 5111.24, 5111.27(D)(2), 5111.02(D), 5111.20(A)

Prior Effective Dates: 6/3/83, 7/1/83, 9/29/83, 3/1/84, 3/29/85

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TIMELY CLAIMS PAYMENT

A. Claim is defined as follows:

1. All services listed on an invoice except for drugs and supplies are considered to be one claim.

2. Each drug or supply line is one claim.