

5101:3-1-58 Policy monitoring.

Utilization of services covered under the medicaid program is monitored on an ongoing basis, as required of each state by the DHEW. Where cases of suspected fraud or misrepresentation to illegally obtain payment from the medicaid program are detected, providers will be subject to an audit by the department. If fraud is apparent, referral of the case to law enforcement officials will be made. Overutilization of services by certain providers, while possibly not considered fraudulent acts, may constitute abuse to the medicaid program. This abuse results either directly or indirectly in financial losses to the medicaid program, its recipients or their families. Various methods, such as thorough investigation, audit and/or peer review, will be utilized to determine abuse. In all instances of fraud or abuse, any amount in excess of that legitimately due to the provider will be recouped by the department through its bureau of surveillance and utilization review and the state auditor.

(A) Cases of provider fraud or abuse may include, but are not limited to, the following:

- (1) Duplicate billing by a provider which appears to be done with the intention of defrauding the state agency.
- (2) Misrepresentation as to services provided, date of service or to whom provided.
- (3) Billing for services not provided.
- (4) Differing charges for the same items for medicaid and nonmedicaid recipients.
- (5) Violation of provider agreement by requesting or obtaining additional payment for the services rendered from either the recipient or recipient's family.
- (6) Collusionary activities between a medical provider and other providers.

(B) There are instances when the provider suspects that there may be recipient fraud, misrepresentation or overutilization of services. Cases of recipient fraud or abuse may include, but are not limited to:

- (1) Use of another person's medicaid card.
- (2) Obtaining what would appear to be excessive quantities of medical supplies or other services.
- (3) Possibility of excessive physician visits by virtue of the number of prescriptions generated.

(C) When fraud or abuse by a recipient is suspected, contact should be made with the bureau of S/UR.

(D) Responsibility for the business practices of employees must be assumed by providers. It is presumed that providers will take the necessary time to thoroughly acquaint themselves and their employees with all policies relative to their participation in the medicaid program. Ignorance of the contents of rules or associates' business practices will not be acceptable to the department when violation of departmental policies has been determined.

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5101:3-1-59 INTEREST ON OVERPAYMENTS.

- (A) ANY PROVIDER OF SERVICES OR GOODS CONTRACTING WITH THE OHIO DEPARTMENT OF PUBLIC WELFARE PURSUANT TO TITLE XIX OF THE SOCIAL SECURITY ACT, WHO, WITHOUT INTENT, OBTAINS PAYMENT UNDER CHAPTER 5111. OF THE REVISED CODE IN EXCESS OF THE AMOUNT TO WHICH THE PROVIDER IS ENTITLED, THEREBY, BECOMES LIABLE FOR PAYMENT OF INTEREST ON THE AMOUNT OF THE EXCESS PAYMENTS AT THE MAXIMUM REAL ESTATE MORTGAGE RATE ON THE DATE THE PAYMENT WAS MADE TO THAT PERSON FOR THE PERIOD FROM THE DATE UPON WHICH PAYMENT WAS MADE TO THE DATE UPON WHICH REPAYMENT IS MADE TO THE STATE.
- (B) INTEREST PAYMENTS SHALL BE CHARGED ON A DAILY BASIS FROM THE DATE THE PAYMENT WAS MADE TO THE DATE UPON WHICH REPAYMENT IS RECEIVED BY THE STATE.
- (C) THE "DATE PAYMENT WAS MADE" SHALL MEAN AS FOLLOWS:
 - (1) IN ANY REASONABLE COST RATE FINAL SETTLEMENT ISSUED BY THE BUREAU OF NURSING HOME AUDITS OR THE BUREAU OF FISCAL REVIEW, THE "DATE PAYMENT WAS MADE" SHALL BE TEN DAYS FROM THE DATE THE FINAL SETTLEMENT IS RECEIVED BY THE PROVIDER AS SHOWN BY THE U.S. POSTAL SERVICE RETURN RECEIPT SLIP, WITH A NOTICE OF RIGHTS OF APPEAL PURSUANT TO CHAPTER 119. OF THE REVISED CODE.
 - (2) IN ANY FINAL REPORT OF EXAMINATION OR OTHER REPORT OR FINDING ISSUED BY THE BUREAU OF SURVEILLANCE AND UTILIZATION REVIEW WHICH IS BASED ON SCIENTIFIC STATISTICAL SAMPLING, THE "DATE PAYMENT WAS MADE" SHALL BE THE LATEST DATE OF THE WARRANT ISSUED IN PAYMENT FOR ANY ITEM IN THE RANDOM SAMPLES USED FOR ANALYSIS.
 - (3) IN ANY REPORT OF EXAMINATION OR OTHER REPORT OR FINDING ISSUED BY THE BUREAU OF SURVEILLANCE AND UTILIZATION REVIEW WHICH INVOLVES MANUAL REVIEW OF CLAIMS AND DOES NOT INVOLVE STATISTICAL PROJECTION, THE "DATE PAYMENT WAS MADE" SHALL BE THE LATEST DATE OF THE WARRANT ISSUED IN PAYMENT FOR ANY ITEM IN THE PAID CLAIMS USED FOR ANALYSIS.
 - (4) IN ANY CLAIMS ADJUSTMENT ISSUED BY THE DIVISION OF CLAIMS PROCESSING, THE "DATE PAYMENT WAS MADE" SHALL BE THE LATEST DATE OF THE WARRANT ISSUED IN PAYMENT FOR ANY SERVICE OR PRODUCT INVOLVED IN THE OVERPAYMENT, EXCEPT ROUTINE MONTHLY LTCF ADJUSTMENTS.

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- (D) THE "DATE UPON WHICH REPAYMENT IS RECEIVED BY THE STATE" SHALL BE THE DATE THE REPAYMENT IS RECEIVED AND STAMPED IN THE DEPARTMENT OR THE DATE THE REPAYMENT IS DEPOSITED AS CERTIFIED MAIL WITH THE U.S. POSTAL SERVICE.
- (E) THE "MAXIMUM REAL ESTATE MORTGAGE RATE" SHALL BE CALCULATED PURSUANT TO SECTION 1343.01(D)(4) OF THE REVISED CODE, AS AMENDED. NAMELY, THE RATE SHALL BE THREE PER CENT IN EXCESS OF THE DISCOUNT RATE ON NINETY-DAY COMMERCIAL PAPER IN EFFECT AT THE FEDERAL RESERVE BANK IN THE FOURTH FEDERAL RESERVE DISTRICT ON THE DAY THE PAYMENT WAS MADE. (THE APPROPRIATE DISCOUNT RATE ON NINETY-DAY COMMERCIAL PAPER IN EFFECT AT THE FEDERAL RESERVE BANK IN THE FOURTH DISTRICT IS THE ONE THAT THE FEDERAL RESERVE BANK IN THE FOURTH DISTRICT USES AS THE INTEREST RATE IT CHARGES TO MEMBER BANKS.)
- (F) INTEREST PAYMENTS SHALL BE CALCULATED ON THE BASIS OF SIMPLE INTEREST.
- (G) INTEREST SHALL BE CHARGED ON MEDICAID OVERPAYMENTS WHICH HAVE OCCURRED AFTER APRIL 24, 1978, AND WHICH ARE IDENTIFIED FOR REPAYMENT AFTER THE EFFECTIVE DATE OF THIS RULE.
- (H) THE DEPARTMENT MAY WAIVE THE INTEREST PENALTY WHEN REPAYMENT IS MADE IN FULL AND THE AMOUNT OF INTEREST OWED BY ANY SINGLE PROVIDER IS LESS THAN FIFTY DOLLARS.

EFFECTIVE DATE: August 1, 1982

EXPIRATION DATE: October 31, 1982

CERTIFICATION: *Ferris B. Casey*

7/22/82
DATE

Promulgated Under RC § 111.15

Rule amplifies: R.C. § 5111.03

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The State has in place a public process which complies with the requirements of Section 1902 (a)(13)(A) of the Social Security Act.

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OBRA RULES INDEX
STATE OF OHIO

INDEX FOR
RULES UNDER ATTACHMENT 4.19D WHICH ARE MOST
AFFECTED BY THE PROVISIONS OF OBRA

(OCTOBER 1, 1998 THROUGH SEPTEMBER 30, 1999)

<u>Rule Number</u>	<u>Rule Title</u>
Rule 5101:3-3-01	"Definitions"
Rule 5101:3-3-18	"Aggregate Medicaid Rates and Aggregate Medicare Rates Comparison for NFs and ICFs-MR"
Rule 5101:3-3-20	"Medicaid Cost Report Filing, Record Retention, and Disclosure Requirements for NFs and ICFs-MR"
Rule 5101:3-3-201	"Chart of Accounts for NFs and ICFs-MR"
Rule 5101:3-3-21	"Audits of NFs and ICFs-MR"
Rule 5101:3-3-24	"Prospective Rate Reconsideration for NFs and ICFs-MR"
Rule 5101:3-3-241	"Rate Adjustments for NFs; Government Mandates"
Rule 5101:3-3-44	"Method for Establishing the Direct Care Costs Component of the Prospective Rate for NFs"
Rule 5101:3-3-49	"Method for Establishing the Other Protected Costs Component of the Prospective Rate for NFs"
Rule 5101:3-3-50	"Method for Establishing the Indirect Care Costs Component of the Prospective Rate for NFs"
Rule 5101:3-3-51	"Method for Establishing Capital Reimbursement for NFs"

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5101:3-3-01 Definitions.

Except as otherwise provided in Chapter 5101:3-3 of the Administrative Code:

(A) "Allowable costs" are those costs incurred for certified beds in a facility as determined by the department of human services (ODHS) to be reasonable, as set forth under paragraph (AA) of this rule, and do not include fines paid under sections 5111.35 to 5111.62 and 5111.99 of the Revised Code. Unless otherwise enumerated in Chapter 5101:3-3 of the Administrative Code, allowable costs ~~and~~ are also determined in accordance with the following reference material, as currently issued and updated, in the following priority:

- (1) Title 42 Code of Federal Regulations (C.F.R.) ~~chapter iv~~ CHAPTER IV;
- (2) The provider reimbursement manual ("health care financing administration HCFA Publication 15-1,"); or
- (3) Generally accepted accounting principles.

(B) "Annual facility average case-mix score" is the score used to calculate the facility's cost per case-mix unit, and is calculated using the methodology described in rules 5101:3-3-42 and 5101:3-3-77 of the Administrative Code.

(C) "Capital costs" means costs of ownership and nonextensive renovation.

(1) "Cost of ownership" as set forth under rules 5101:3-3-512 and 5101:3-3-842 of the Administrative Code means the actual expense incurred for all of the following:

- (a) Depreciation and interest on any items capitalized under rules 5101:3-3-511 and 5101:3-3-841 of the Administrative Code, including the following:
 - (i) Buildings;
 - (ii) Building improvements;
 - (iii) Equipment;
 - (iv) Extensive renovation;
 - (v) Transportation equipment;

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- (vi) Replacement beds;
 - (b) Amortization and interest on land improvements and leasehold improvements;
 - (c) Amortization of financing costs;
 - (d) Except as provided under paragraph (L) of this rule, lease and rent of land, building, and equipment.
- (2) "Costs of nonextensive renovation" as set forth under rules 5101:3-3-513 and 5101:3-3-843 of the Administrative Code means the actual expense incurred for depreciation or amortization and interest on renovations that are not extensive renovations.
- (D) "Capital lease" and "operating lease" shall be construed in accordance with generally accepted accounting principles.
- (E) "Case-mix score" means the measure determined under rules 5101:3-3-41, 5101:3-3-42, 5101:3-3-76, and 5101:3-3-77 of the Administrative Code of the relative direct-care resources needed to provide care and rehabilitation to a resident of a nursing facility (NFs) or intermediate care facility for the mentally retarded (ICFs-MR).
- (F) "Cost of construction" as set forth in rules 5101:3-3-512 and 5101:3-3-842 of the Administrative Code means the costs incurred for the construction of beds originally contained in the NF or ICF-MR and the costs incurred for the construction of beds added to the NF or ICF-MR after the construction of the original beds. In the case of NFs or ICFs-MR which extensively renovate, "cost of construction" includes the costs incurred for the extensive renovation.
- (G) "Cost per case-mix unit" is calculated by dividing the facility's desk-reviewed, actual, allowable, per diem direct care costs for the calendar year preceding the fiscal year in which the rate will be paid by the annual case-mix score for the calendar year preceding the fiscal year in which the rate will be paid. The lesser of the facility's cost per case-mix unit or the maximum allowable cost per case-mix unit for the fiscal year shall be used to determine the facility's rate for direct care costs, under rules 5101:3-3-44 and 5101:3-3-79 of the Administrative Code.

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- (H) "Date of licensure," for a facility ORIGINALLY licensed as a nursing home under Chapter 3721. of the Revised Code, means the date specific beds ~~are initially~~ WERE ORIGINALLY licensed as nursing home beds under that chapter, REGARDLESS OF WHETHER THEY WERE SUBSEQUENTLY LICENSED AS RESIDENTIAL FACILITY BEDS UNDER SECTION 5123.19 OF THE REVISED CODE. For a facility ~~initially~~ ORIGINALLY licensed as a residential facility under section 5123.19 of the Revised Code, "date of licensure" means the date specific beds ~~are initially~~ WERE ORIGINALLY licensed as residential facility beds under that section.
- (1) If nursing home beds LICENSED UNDER CHAPTER 3721. OF THE REVISED CODE OR RESIDENTIAL FACILITY BEDS LICENSED UNDER SECTION 5123.19 OF THE REVISED CODE were not required by law to be licensed when they were originally used to provide nursing home OR RESIDENTIAL FACILITY services, "date of licensure" means the date the beds first were used to provide nursing home OR RESIDENTIAL FACILITY services, regardless of the date the present ~~owner or operator~~ PROVIDER obtained licensure.
- (2) If a facility adds nursing home or residential facility beds or in the case of an ICF-MR with more than eight beds or a NF, it extensively renovates the facility after its original date of licensure, it will have a different date of licensure for the additional beds or for the extensively renovated facility, unless, in the case of the addition of beds, the beds are added in a space that was constructed at the same time as the previously licensed beds but was not licensed under Chapter 3721. or section 5123.19 of the Revised Code at that time. The licensure date for additional beds or facilities which extensively renovate shall be the date the beds are placed into service.
- (I) "Desk reviewed" means that costs as reported on a cost report submitted under rule 5101:3-3-20 of the Administrative Code and have been subjected to a desk review under rule 5101:3-3-20 of the Administrative Code and preliminarily determined to be allowable costs.
- (J) "Direct care costs" means costs as defined under table 6 of rule 5101:3-3-201 of the Administrative Code.
- (K) "Fiscal year" means the fiscal year of this state, as specified in section 9.34 of the Revised Code.
- (L) "Indirect care costs" means costs as defined under table 7 of rule 5101:3-3-201 of the Administrative Code.

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- (M) "Inpatient days" means all days during which a resident, regardless of payment source, occupies a bed in a NF or ICF-MR that is included in the facility's certified capacity under Title XIX of the "Social Security Act," 49 stat. 620 (1935), 42 U.S.C.A. 301, As amended. Therapeutic or hospital leave days for which payment is made under section 5111.33 of the Revised Code are considered inpatient days proportionate to the percentage of the facility's per resident per day rate paid for those days.
- (N) "Intermediate care facility for the mentally retarded" (ICF-MR) means an intermediate care facility for the mentally retarded certified as in compliance with applicable standards for the medical assistance program by the director of health in accordance with Title XIX of the "Social Security Act."
- (O) "Maintenance and repair expenses means expenditures, except as provided in paragraph (EE) of this rule, that are necessary and proper to maintain an asset in a normally efficient working condition and that do not extend the useful life of the asset two years or more. Maintenance and repairs expense may include, but are not limited to, the cost of ordinary repairs such as painting and wallpapering.
- (P) "Minimum data set plus" (MDS+) is the resident assessment instrument selected by Ohio and approved by the United States health care financing administration (HCFA). The MDS+ provides the resident assessment data which is used to classify the resident into a resource utilization group in the RUG-III case-mix classification system.
- (Q) "Nursing facility" (NF) means a facility, or a distinct part of a facility, that is certified as a nursing facility by the director of health in accordance with Title XIX of the "Social Security Act," and is not an intermediate care facility for the mentally retarded (ICF-MR). "Nursing facility" includes a facility, or a distinct part of a facility, that is certified as a nursing facility by the director of health in accordance with Title XIX of the "Social Security Act," and is certified as a skilled nursing facility by the director in accordance with Title XIX of the "Social Security Act."
- (R) "Other protected costs" means costs as defined under table 5 of rule 5101:3-3-201 of the Administrative Code.
- (S) "Outlier" means residents who have special care needs as defined under rule 5101:3-3-25 of the Administrative Code.
- (T) "Owner" means any person or government entity that has at least five per cent ownership or interest, either directly, indirectly, or in any combination, in a NF or ICF-MR.

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- (U) "Patient" includes "resident."
- (V) Except as provided in paragraphs (V)(1) and (V)(2) of this rule, "per diem" means a NF's or ICF-MR's actual, allowable, costs in a given cost center in a cost reporting period, divided by the facility's inpatient days for that reporting period.
- (1) When calculating indirect care costs for the purpose of establishing rates under rules 5101:3-3-50 and 5101:3-3-83 of the Administrative Code, "per diem" means a facility's actual, allowable indirect care costs in a cost reporting period divided by the greater of the facility's inpatient days for that period or the number of inpatient days the facility would have had during that period if its occupancy rate had been eighty-five per cent.
- (2) When calculating capital costs for the purpose of establishing rates under rules 5101:3-3-51 and 5101:3-3-84 of the Administrative Code, "per diem" means a facility's actual, allowable capital costs in a cost reporting period divided by the greater of the facility's inpatient days for that period or the number of inpatient days the facility would have during that period if its occupancy rate had been ninety-five per cent.
- (W) "Provider" means a person or government entity that operates a NF or ICF-MR under a provider agreement.
- (X) "Provider agreement" means a contract between ODHS and a NF or ICF-MR for the provision of NF or ICF-MR services under the medical assistance program.
- (Y) "Purchased nursing services" means services that are provided by registered nurses, licensed practical nurses, or nurse aides who are temporary personnel furnished by a nursing pool on behalf of the facility. These personnel are not considered to be employees of the facility.
- (Z) "Quarterly facility average case-mix score" is the facility average case-mix score based on data submitted for one reporting quarter and is calculated using the methodology described in rules 5101:3-3-42 and 5101:3-3-77 of the Administrative Code.
- (AA) "Reasonable" means that a cost is an actual cost that is appropriate and helpful to develop and maintain the operation of patient care facilities and activities, including normal standby costs, and that does not exceed what a prudent buyer pays for a given item or services. Reasonable costs may vary from provider to provider and from time to time for the same provider.

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