Ohio | Department of Medicaid

Mike DeWine, Governor
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OHIO DEPARTMENT OF MEDICAID

To: **ALL CLEARANCE REVIEWERS**

From: **Shirley Williams**

Date: **January 18, 2022**

Subject: **ODM10283 Draft Form**

Attached for your review and comment is the following Ohio Department of Medicaid (ODM) form: **ODM 10283 "Ohio Medicaid Provider Enrollment Agreement"**. This form has been created for providers that do not complete the enrollment process electronically through the MITS system. Ohio Administrative Code (OAC) 5160-1-17.2 requires all providers to have a valid Provider Agreement with ODM and this forms allows this requirement to be met when done outside of the MITS system. The proposed effective date will align with the ODM 10282.

ODM 10283 "Ohio Medicaid Provider Enrollment Agreement".

- The ODM 10283 will be used in conjunction with the ODM 10282 "Managed Care Entity Out-of-Network Provider Application".
- This form is a part of the enrollment process for providers with no provider type in MITS; and
- Streamline the payment process.

Thank you in advance for your comments.

Attachments

Ohio Department of Medicaid

OHIO MEDICAID PROVIDER ENROLLMENT AGREEMENT

This provider agreement is a contract between the Ohio Department of Medicaid (*the Department*) and the undersigned provider of medical assistance services in which the Provider agrees to comply with the terms of this provider agreement, Ohio statutes, Ohio Administrative Code rules, and Federal statutes and rules, and agrees and certifies to:

1. Render medical assistance services as medically necessary for the patient and only in the amount requiredby the patient without regard to race, color, age, gender, sexual orientation, marital status, national origin,ancestry, religion, disability or source(s) of payment; submit claims only for services actually performed, and bill the Managed Care Entities for no more than the usual and customary fee charged other patients for the sameservice.

2. Ascertain and recoup any third-party resource(s) available to the recipient prior to billing the Managed Care Entity. The Department will then pay any unpaid balance up to the lesser of the provider's billed charge or the maximum allowable reimbursement.

3. Accept the allowable reimbursement for all covered services as payment-in-full and, except as required in paragraph 2 above, will not seek reimbursement for that service from the patient, any member of the family, or any other person.

4. Maintain all records necessary and in such form so as to fully disclose the extent of services provided and significant business transactions. The provider will maintain such records for a period of six years from the date of receipt of payment based upon those records or until any initiated audit is completed, whichever is longer.

5. Furnish to the Department, the secretary of the Department of Health and Human Services, or the Ohio Medicaid Fraud Control unit, or any of their designees, any information maintained under paragraph 4 above for audit or review purposes. Audits may use statistical sampling. Failure to supply requested records within thirty days shall result in withholding of Medicaid payments and may result in termination from the Medicaid program.

6. Inform the Department within thirty days of any changes in licensure, certification, or registration status; ownership; specialty; additions, deletions, or replacements in group membership and hospital-based physicians; and address.

7. Disclose ownership and control information, and disclose the identity of any person (*as specified in 42 CFR,Part 455, Subpart B and 1002, Subpart A, as amended, and as specified in rule 5160-1-17.3 of the Administrative Code*) who has been convicted of a criminal offense related to Medicare, Medicaid, or services provided under Title XX of the Social Security Act.

8. Attest that neither the individual practitioner, nor the company, nor any owner, director, officer, employee of the company, nor any independent contractor retained by the company is currently subject to sanction under Medicare, Medicaid or Title XX or otherwise is prohibited from providing services to Medicare, Medicaid or Title XX beneficiaries.

9. To follow the regulations and policies set forth in the most current edition of the Medicaid Handbook.

10. Comply with Ohio Revised Code 5164.46 (B) (2) Electronic claims submission process; electronic funds transfers; arrange to receive Medicaid payment from the Department by means of electronic funds transfer.

11. Provide to the Department, through the court of jurisdiction, notice of any action brought by the provider inaccordance with the Title 11 of the United States Code (*Bankruptcy*). Notice shall be mailed to: "Office of Legal Counsel, Ohio Department of Medicaid, P.O. Box 182709, Columbus, Ohio, 43218-2709".

12. Comply with the advance directives requirements for hospitals, nursing facilities, providers of home healthcare and personal care services, hospices, and HMOs specified in 42 CFR 489, Subpart I and 42 CFR 417.436(d).

13. Comply with Section 6032 of the Deficit Reduction Act. This requirement applies to health care entities who receive Medicaid reimbursements of $5,000,000 per year or more, to establish written policies for alltheir own employees and contractors to provide information about the False Claims Act, provide remedies for false claims, a description of false claims laws, whistleblower protections and detailed provisions for detecting and preventing fraud, waste and abuse.

14. Fully cooperate with the Department, its agents, and other state or federal agencies engaged in ensuring the integrity of the Ohio Medicaid program. Full cooperation includes, but is not limited to, making yourself and your records available upon request.

15. This provider agreement may be canceled by either party upon 30 days written notice prior to termination date.

16. I further certify that I am the individual practitioner who is applying for the provider number, or in the case of a business organization, I am the officer, chief executive officer, or general partner of the business organization that is applying for the provider number. I further agree to be bound by this agreement, and certify that the information I have given on this application is factual. As such, I have disclosed my name, social security number and date of birth on the application for enrollment, in accordance with 42 CFR, Part 455, Subpart B and 1002, Subpart A, as amended, and as specified in rule 5160-1-17.3 of the Administrative Code.

☐ I accept the terms and conditions contained in paragraphs 1 through 17 above.

Signature *(Authorized Representative)* Date