5123:2-7-15 **Intermediate care facilities for individuals with intellectual disabilities - claim submission, payment, and adjustment process.**

(A) Purpose

This rule establishes procedures for intermediate care facilities for individuals with intellectual disabilities ("intermediate care facilities") to be paid for services rendered and describes the process for intermediate care facilities to electronically submit claims for dates of service on or after July 1, 2015.

(B) Payment for dates of service prior to July 1, 2015

(1) Intermediate care facilities shall submit Ohio department of medicaid form 09400, "Nursing Facility Payment and Adjustment Authorization" (October 2012), directly to the Ohio department of medicaid for payment for dates of service prior to July 1, 2015. The Ohio department of medicaid shall accept form 09400 through June 30, 2017 for the resolution of payment for dates of service prior to July 1, 2015. For dates of service on or after July 1, 2015, intermediate care facilities shall follow the submission of claims processes described in paragraphs (D) and (E) of this rule.

(2) The county department of job and family services and intermediate care facilities shall use Ohio department of medicaid form 09401, "Facility CDJFS Transmittal" (July 2014), to exchange information necessary to complete the billing process for payment.

(C) Exchanging information regarding residents of intermediate care facilities

(1) Notification of admission

Intermediate care facilities shall notify the county department of job and family services of the admission of a new resident who is medicaid eligible or who has an application for medicaid pending by completing and forwarding Ohio department of medicaid form 09401 within five business days following the resident's admission.

(2) Notification of death

Intermediate care facilities shall notify the county department of job and family services of the death of a medicaid eligible resident by completing and forwarding Ohio department of medicaid form 09401 within five business days following the resident's death. The county department of job and family services shall terminate medicaid eligibility and stop vendor payment within ten days of receipt of the form 09401. The county department of job and family services shall complete and return the form 09401 to the intermediate care facility within ten days of receipt for any required payment adjustment. For dates of service prior to July 1, 2015, the intermediate care facility shall

complete and submit Ohio department of medicaid form 09400 to the Ohio department of medicaid when appropriate (e.g., final payment adjustment) within thirty days of receipt of the form 09401. For dates of service on or after July 1, 2015, intermediate care facilities shall follow the submission of claims processes described in paragraphs (D) and (E) of this rule.

(3) Notification of discharge

Intermediate care facilities shall notify the county department of job and family services of the discharge of a medicaid eligible resident by completing and forwarding Ohio department of medicaid form 09401 within five business days following the resident's discharge. The county department of job and family services shall adjust medicaid eligibility within ten days of receipt of the form 09401. The county department of job and family services shall stop vendor payment within ten days of receipt of form 09401. The county department of job and family services shall complete and return the form 09401 to the intermediate care facility within ten days of receipt of the form for any required payment adjustment. For dates of service prior to July 1, 2015, the intermediate care facility shall complete and submit Ohio department of medicaid form 09400 to the Ohio department of medicaid when appropriate (e.g., final payment adjustment) within thirty days of receipt of the form 09401. For dates of service on or after July 1, 2015, intermediate care facilities shall follow the submission of claims processes described in paragraphs (D) and (E) of this rule.

(D) Submission of claims for services included in the intermediate care facility per diem rate for dates of service on or after July 1, 2015

(1) For dates of service on or after July 1, 2015, an intermediate care facility shall submit claims for payment either directly or as a trading partner as defined in rule 5160-1-20 of the Administrative Code or through another trading partner. The intermediate care facility shall be a medicaid provider in an active enrollment status for all dates within the claim span and shall be eligible to provide intermediate care facility services for those dates.

(2) The intermediate care facility shall electronically submit claims for payment, including adjustments, for services that are included in the intermediate care facility per diem rate in one of the following formats:

(a) Electronic data interchange, in accordance with standards established under 45 C.F.R. 160, 45 C.F.R. 162, and 45 C.F.R. 164 as in effect on the effective date of this rule, using the 837 health care claim institutional (837I) electronic format (2015), which is available at the national uniform billing committee website (http://nubc.org/subscriber/index.dhtml); or

(b) The medicaid information technology system web portal.

(3) Claim submissions shall comply with the UB-04 national uniform billing data specifications and be submitted in accordance with the correct national coding initiative and coding standards as set forth in the following guides and as described in 45 C.F.R. 162.1000 and 45 C.F.R. 162.1002 as in effect on the effective date of this rule:

(a) Healthcare common procedure coding system;

(b) Current procedure terminology codebook; and

(c) International classification of diseases codebook.

(4) Trading partners who submit electronic data interchange claim transactions shall follow the requirements set forth in paragraph (H) of rule 5160-1-19 of the Administrative Code.

(5) Claim submissions shall comply with the current version of the claim transaction requirements in this rule and as specified in the Ohio department of medicaid 837I companion guide (May 12, 2014), which is available at the Ohio department of medicaid website (http://medicaid.ohio.gov/providers/mits/hipaa5010implementation. aspx).

(6) A single claim shall include days of service provided, including qualifying leave days, for a single individual within a single calendar month and shall not cross calendar months. If an intermediate care facility determines that a claim that has been paid should have included additional per diem service days, the intermediate care facility shall timely submit an adjustment claim correcting the entire calendar month's claim information.

(7) When a medicaid recipient in the intermediate care facility has a patient liability obligation, the entire monthly amount of patient liability, as determined in accordance with Chapter 5160:1-3 of the Administrative Code, shall be reported by the intermediate care facility on the recipient's monthly claim. When a recipient is admitted, discharged, transfers to another facility, or switches from medicare to medicaid mid-month, the entire monthly amount of patient liability shall be reported on the claim for that month. The patient liability shall be applied as an offset against the amount medicaid would otherwise reimburse for the claim. When the patient liability exceeds the amount medicaid would reimburse, the claim shall be processed with a payment of zero dollars.

(8) The treatment of lump sum payments and their disposition regarding medicaid eligibility are addressed in rule 5160:1-3-05.8 of the Administrative Code; if however, the county department of job and family services and the recipient

determine that the lump sum shall be assigned to the intermediate care facility as payment for past per diem services received by the recipient, the intermediate care facility shall submit adjustment claims for as many prior months as necessary to fully offset the amount of the lump sum payment that was assigned to the intermediate care facility. When there are lump sum monies remaining after adjusting all prior payments, the intermediate care facility shall apply the remaining lump sum balance to current and future claims. When the individual is discharged or passes away prior to exhausting the lump sum payment, the intermediate care facility shall return the balance to the individual or the individual's estate.

(9) Timely filing requirements

(a) Original claim submission

(i) A claim must be received by the Ohio department of medicaid within three hundred sixty-five days of the actual date of service.

(ii) A claim received beyond three hundred sixty-five days of the actual date of service shall be denied except when the provisions of paragraph (D)(10) of this rule apply.

(iii) For purposes of this rule, the date of receipt shall be determined by the date the claim is received in the medicaid information technology system web portal or the date the claim is received via electronic data interchange.

(b) Resubmission of a denied claim

(i) A claim denied by the Ohio department of medicaid may be resubmitted for payment but the resubmission must be received by the Ohio department of medicaid no later than the later of the following dates:

(a) Three hundred sixty-five days from the actual date of service; or

(b) One hundred eighty days from the date the claim was denied, even if this date is beyond three hundred sixty-five days from the actual date of service.

(ii) A resubmitted claim received beyond seven hundred thirty days from the actual date of service shall be denied.

(c) Adjustment to a previously paid claim, including a claim paid at zero dollars

(i) When an intermediate care facility identifies an underpaid claim, the intermediate care facility shall submit an adjustment to the Ohio department of medicaid within one hundred eighty days of the date the underpaid claim was paid by the Ohio department of medicaid.

(ii) When an intermediate care facility identifies an overpaid claim, the intermediate care facility shall submit an adjustment to the Ohio department of medicaid within sixty days of identifying the overpayment. The Ohio department of medicaid shall not accept a check from an intermediate care facility in lieu of a claim adjustment in this situation.

(iii) When the Ohio department of medicaid identifies the need for an intermediate care facility to adjust a claim, it shall notify the intermediate care facility to make the adjustment. The intermediate care facility shall make the adjustment within sixty days of notification. If the intermediate care facility fails to make the adjustment, the Ohio department of medicaid shall either make the adjustment or void the claim as is appropriate for the fact pattern.

(iv) If within sixty days of the date the Ohio department of medicaid processes an adjustment, there are no outgoing payments for the intermediate care facility against which the adjustment can be made, the Ohio department of medicaid shall issue an invoice to the intermediate care facility for the resulting credit balance. The intermediate care facility shall seek reconsideration or remit payment to the Ohio department of medicaid within sixty days of the date of the invoice. The intermediate care facility shall include a copy of the invoice with the payment. If the intermediate care facility fails to include a copy of the invoice or remit full payment, the unpaid balance shall be certified to the Ohio attorney general for collection.

(d) A claim with prior payment by medicare or another insurance plan shall be submitted by the intermediate care facility within one hundred eighty days from the date medicare or other insurance plan paid the claim to the intermediate care facility.

(10) Exceptions to filing timelines

(a) When submission of a claim is delayed due to the pendency of either an administrative hearing decision by the Ohio department of job and family services or an eligibility determination by a county department

of job and family services, the claim must be received within one hundred eighty days of the date of the administrative hearing decision or eligibility determination. The intermediate care facility shall maintain all documentation supporting the information on the claim and shall produce the documentation upon request. In no case shall a delay in processing eligibility information under rule 5160:1-1-58.2 of the Administrative Code be a basis for denial of payment under this provision.

(b) When a claim cannot be submitted to the Ohio department of medicaid within three hundred sixty-five days of the actual date of service due to coordination of benefits delays with medicare and/or other insurance plans, the claim must be received by the Ohio department of medicaid within one hundred eighty days from the date medicare or other insurance plan paid the claim.

(E) Submission of claims for services not included in the intermediate care facility per diem rate for dates of service on or after July 1, 2015

An intermediate care facility shall submit medicare crossover claims and claims for medicaid reimbursement for allowable services that are not included in the intermediate care facility per diem rate in accordance with the requirements set forth in rule 5160-1-19 of the Administrative Code.

Replaces: 5123:2-7-15

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

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