Ohio Administrative Code

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

Effective: July 1, 2017

(A) Purpose

This rule establishes procedures for an intermediate care facility for individuals with intellectual disabilities (ICFIID) to submit claims and be paid for services rendered.

(B) Exchanging information regarding residents of an ICFIID

(1) Notification of change in income

An ICFIID shall notify the department in a format prescribed by the department and notify the county department of job and family services via email of a change in the income of a medicaid-eligible resident within five calendar days following the ICFIID's awareness of the change in income.

(2) Notification of death

An ICFIID shall notify the department in a format prescribed by the department and notify the county department of job and family services via email of the death of a medicaid-eligible resident within five calendar days following the resident's death. Within ten calendar days of receipt of the notification, the county department of job and family services shall terminate medicaid eligibility.

(C) Submission of claims for services included in the ICFIID per diem rate

(1) An ICFIID shall submit claims for payment for services that are included in the ICFIID per diem rate either directly or as a trading partner as defined in rule 5160-1-20 of the Administrative Code or through another trading partner. The ICFIID shall be a medicaid provider in an active enrollment status for all dates within the claim span.

(2) The ICFIID shall electronically submit claims for payment, including adjustments, for services that are included in the ICFIID 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 resident within a single calendar month and shall not cross calendar months. If an ICFIID determines that a claim that has been paid should have included additional per diem service days, the ICFIID shall timely submit an adjustment claim correcting the entire calendar month's claim

information.

(7) When a medicaid-eligible resident of an ICFIID has a patient liability obligation, the entire monthly amount of patient liability, as determined in accordance with rule 5160:1-3-04.3 of the Administrative Code, shall be reported by the ICFIID on the resident's monthly claim. When a resident 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 medicaid-eligible resident determine that the lump sum shall be assigned to the ICFIID as payment for past per diem services received by the resident, the ICFIID 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 ICFIID. When there are lump sum monies remaining after adjusting all prior payments, the ICFIID shall apply the remaining lump sum balance to current and future claims. When the resident is discharged or passes away prior to exhausting the lump sum payment, the ICFIID 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 calendar days of the actual date of service.

(ii) A claim received beyond three hundred sixty-five calendar days of the actual date of service shall be denied except when the provisions of paragraph (C)(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 calendar days from the actual date of service; or

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

(ii) A resubmitted claim received beyond seven hundred thirty calendar 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 ICFIID identifies an underpaid claim, the ICFIID shall submit an adjustment to the Ohio department of medicaid within one hundred eighty calendar days of the date the underpaid claim was paid by the Ohio department of medicaid.

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

(iii) When the Ohio department of medicaid identifies the need for an ICFIID to adjust a claim, it shall notify the ICFIID to make the adjustment. The ICFIID shall make the adjustment within sixty calendar days of notification. If the ICFIID 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 calendar days of the date the Ohio department of medicaid processes an

adjustment, there are no outgoing payments for the ICFIID against which the adjustment can be made, the Ohio department of medicaid shall issue an invoice to the ICFIID for the resulting credit balance. The ICFIID shall seek reconsideration or remit payment to the Ohio department of medicaid within sixty calendar days of the date of the invoice. The ICFIID shall include a copy of the invoice with the payment. If the ICFIID 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 ICFIID within one hundred eighty calendar days from the date medicare or other insurance plan paid the claim to the ICFIID.

(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 calendar days of the date of the administrative hearing decision or eligibility determination. The ICFIID 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 5160:1-2-11 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 calendar 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 calendar days from the date medicare or other insurance plan paid the claim.

(D) Submission of claims for services not included in the ICFIID per diem rate

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