Ohio Administrative Code

Rule 5160-3-39.1 Claim submission for nursing facilities (NFs).

Effective: March 22, 2015

(A) Requirements for submitting claims for services not included in the NF per diem rate.

Notwithstanding the requirements set forth in paragraph (A)(2) of rule 5160-1-19 of the Administrative Code, NF providers shall submit medicare crossover claims and claims for medicaid reimbursement for allowable services that are not included in the NF per diem rate in accordance with the requirements set forth in rule 5160-1-19 of the Administrative Code.

(B) Requirements for submitting NF per diem claims.

(1) A NF provider submitting a claim for payment, either directly as a trading partner as defined in rule 5160-1-20 of the Administrative Code or through another trading partner, shall be a medicaid provider in an active enrollment status for all dates within the claim span and shall be eligible to provide nursing facility services for those dates.

(2) NF providers shall electronically submit claims for medicaid reimbursement, including adjustments, for services that are included in the NF per diem rate in one of the following formats:

(a) Electronic data interchange (EDI), in accordance with standards established under the health insurance portability and accountability act (HIPAA) (modified August 14, 2002), using the 837 health care claim institutional (837I) electronic format (2015), which is available on the National Uniform Billing Committee website at http://nubc.org/ subscriber/index.dhtml; or

(b) The medicaid information technology system (MITS) web portal.

(3) Claim submissions shall use the UB04 national uniform billing data specifications and shall 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 CFR 162.1000 and 45 CFR 162.1002 (October 1, 2014):

(a) Healthcare common procedure coding system;

(b) Current procedure terminology codebook; and

(c) International classification of diseases codebook.

(4) Trading partners who submit EDI claim transactions also 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 (ODM) 837I companion guide (May 12, 2014), which is available on the ODM website at 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 a provider determines that a claim that has been paid should have included additional per diem service days, the provider shall submit a timely adjustment claim correcting the entire calendar month's claim information.

(7) If a medicaid recipient in the NF 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 NF on the recipients monthly claim. If a recipient is admitted, discharged, transferred to another facility, or switched from medicare to medicaid mid-month, the entire monthly amount of patient liability shall still 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. If 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 5160:1-3-27.5 of the Administrative Code; however, if the county department of job and family services (CDJFS) and the recipient determine that the lump sum shall be assigned to

the NF as payment for past per diem services received by the recipient, the NF provider shall do the following:

(a) Submit adjustment claims for as many prior months as are necessary to fully offset the amount of the lump sum payment that was assigned to the NF.

(b) If there are lump sum monies remaining after adjusting all prior payments, the NF provider shall apply the remaining lump sum balance to current and future claims. If the individual is discharged or passes away prior to exhausting the lump sum payment, the nursing 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 ODM within three hundred sixty-five days of the actual date the service was provided.

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

(iii) For purposes of this rule, the date of receipt will be determined by the date the claim is received in the web portal or the date the claim is recieved via EDI.

(b) Re-submission of a denied claim.

(i) A claim denied by ODM may be re-submitted for payment but the resubmission must be received by ODM 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 original date of service.

(ii) A re-submitted 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 a provider identifies an underpaid claim, the provider shall submit an adjustment within one hundred eighty days of the date the underpaid claim was paid by ODM.

(ii) When a provider discovers it was overpaid on a claim, the provider shall submit an adjustment to ODM within sixty days of discovering the overpayment. ODM shall not accept a check from a provider in lieu of a claim adjustment in this situation.

(iii) If ODM identifies the need for a provider to adjust a claim, ODM shall notify the provider to make the adjustment. The provider shall make the adjustment within sixty days of notification. If the provider fails to make the adjustment, ODM shall either make the adjustment or void the claim as is appropriate for the fact pattern.

(iv) If within sixty days of the date ODM processes an adjustment, there are no outgoing payments for the provider against which the adjustment can be made, ODM shall issue an invoice to the provider for the resulting credit balance. The provider shall seek reconsideration or remit payment to ODM within sixty days of the date of the invoice. The provider shall include a copy of the invoice with the payment. If the provider 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 NF within one hundred eighty days from the date medicare or the insurance plan paid the claim to the NF.

(10) Exceptions to timely filing requirements.

(a) When submission of a claim is delayed due to the pendency of either an administrative hearing decision by ODJFS or an eligibility determination by a CDJFS, the claim must be received within

one hundred eighty days from the date of the administrative hearing decision by the Ohio department of job and family services (ODJFS) or the eligibility determination by the CDJFS. The provider 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 5160:1-2-02 of the Administrative Code be a basis for denial of payment under this provision.

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