

Ohio Medicaid School Program: The Basics 2009



Ombudsman Unit
External Business Relations
Office of Ohio Health Plans
Ohio Department of Job and Family Services

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Ohio Medicaid School Program: The Basics 2009

Ohio Department of
Job and Family Services

Ombudsman

Audrea Caesar
Kathy Frye
Laura Gipson
Dwayne Knowles
Jamie Speakes
Lakeisha Yawn




Office of Ohio Health Plans
External Business Relations
614-752-9551

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External Business Relations

- Investigate and resolve billing issues
- Identify system and policy issues
- Speak at seminars for provider associations
- Conduct individual consultations with providers
- Conduct weekly basic billing trainings



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Agenda

- General Information
- Programs & Cards
- Provider Responsibilities
- Websites, MITS, EDI
- Policy
- Billing
- Forms



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General Information



Ohio

Department of
Job and Family Services

Ohio Department of Job & Family Services (ODJFS)

- Child Support
- Children & Families
- Unemployment Compensation
- Family Stability
- **Ohio Health Plans**
- Workforce Development
- Faith Based Initiatives

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Ohio Health Plans

- Covered Families and Children (Healthy Start and Healthy Families)
- Aged, Blind or People with Disabilities
- Home and Community Based Waivers
- Medicare Premium Assistance
- Hospital Care Assurance Program
- Disability Medical Assistance (DMA)
- Medicaid Managed Care

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Medicaid in Ohio

2.2 million Ohioans served
Coverage for 1 in 6 Ohioans

- 1 in 3 children
- 175,000 seniors age 85+
- 361,000 non-elderly adults and children w/ disabilities
- Pays for 40% of all Ohio births
- Pays for 65% of nursing home care



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Medicaid in Ohio

- Publicly funded health care for Ohioans with limited income or chronic disabilities
- Funded with State (40%) and Federal (60%) dollars
- \$11.18 billion expenditures in 2008
- \$11.95 billion expenditures in 2009 (EST)
- 25 percent of Ohio's statespending



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Ohio Medicaid Benefits

- Transportation services
- Physician Services
- Inpatient/ Outpatient Services
- Nursing Facility Dental services
- Durable medical equipment
- Home Health Services
- Hospice Services
- Behavioral Health
- Pharmacy Services
- Vision

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Medical Necessity

The fundamental concept underlying the Medicaid Program.



All services must meet accepted standards of medical practice

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Interactive Voice Response System (IVR) 1-800-686-1516



- All calls are directed through the IVR prior to accessing the customer call center staff
- Providers are responsible for granting and maintaining IVR access for their billing entities or trading partners
- Provider Assistance staff are available weekdays from 8:00 am to 4:30 pm

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Interactive Voice Response System (IVR) 1-800-686-1516

- Because of HIPAA laws you must authenticate with your Provider Identification Number (PIN) to access Protected Health Information (PHI)
- Be aware that the IVR prompts may change as we enhance our IVR System
- A reference guide is available on our website to assist with detailed instructions:

<http://jfs.ohio.gov/ohp/providers/ivr.stm>

Programs

- Fee For Service
 - Medicaid, Healthy Start/Healthy Families, Expedited Medicaid
- Managed Care
 - Amerigroup, Buckeye Community Health Plan, Caresource, Molina, Paramount Advantage, Unison Health Care, Wellcare Of Ohio

Provider Responsibilities



Ohio Department of Job and Family Services



Provider Agreement 5101:3-1-17.2

The provider agreement is a legal contract between the state and the provider. In that contract, you agreed to:

- Accept the allowable reimbursements as payment-in-full and will not seek reimbursement for that service from the patient, any member of the family, or any other person
- Maintain records for 6 years

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Provider Agreement (Continued)

You also agreed to:

- Render medically necessary services in the amount required
- Recoup any third party resources available
- Inform us of any changes to your provider profile within 30 days
- Abide by the regulations and policies of the state

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Time Limited Provider Agreements

House Bill 119 requires ODJFS to convert its Medicaid provider agreements from open ended to time limited agreements good for up to three years.

- MSP active on 10-1-07 will be active until 10-1-10

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Provider Reimbursement

5101:3-1-02, 5101:3-35-04,
5101:3-1-60

- The department's payment constitutes payment-in-full for any of our covered services
- The MSP provider is Reimbursed the Federal Financial Participation (FFP) portion ONLY using the Medicaid rates established in the fee schedule per the Appendix of Ohio Administrative Code
- The MSP provider is reimbursed through a Certified Public Expenditure (CPE) arrangement which requires reconciliation to assure the amount reimbursed does not exceed cost

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Provider Profile Changes



- An email address is available to update your provider profile
- Use to update your phone number or address information only
- Do not use when documentation is required for the change

MEDICAID_PROVIDER_UPDATE@odjfs.state.oh.us

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Timely Claim Submission

5101:3-1-19.3

- Claims must be received by the department within 365 days from the date of service
- When the claim is nearing or over 365 days and the claim has denied (for other than timely filing), you have 180 days from the date on the remittance advice to re-file the claim to Medicaid



Timely Claim Submission Continued

If the claim is not submitted timely due to:

- Delayed eligibility determination
- State hearing decision

You have an additional 180 days from the decision, or hearing to submit the claim

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Back Dated Claims

- MSP must be enrolled as a provider no later than February 28, 2009 to receive reimbursement for services provided July 1, 2005 – September 30, 2009
- Claims for July 1, 2005 - September 30, 2008 must be received by 9/30/09. Claims for July 1, 2005 - September 30, 2007 will deny to be paid later through the CMS approved back claim methodology
- All claims shall be submitted using EDI

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Recipient Liability 5101:3-1-13.1

A Medicaid consumer cannot be billed:

- When a Medicaid claim has been denied
- Unacceptable claim submission
- Failure to request a prior authorization
- Retroactive Peer Review determination of lack of medical necessity

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Websites, MITS, & Electronic Data Interchange (EDI)



Ohio Department of Job and Family Services

Websites

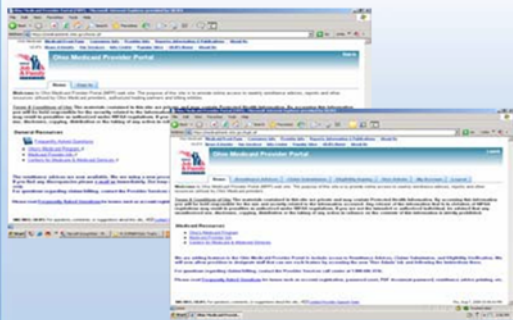
- From ifs.ohio.gov click on "Medicaid"
- Click on "Providers"
- Make your selection from the List –



Billing	Enrollment & Support
Direct Deposit Billing Instructions EDI, HIPAA & Code Sets NPI QDJFS Trading Partners Remittance Advice	Fee Schedules/Rates How to Enroll Provider Assistance, Ombudsman & MACs Sanctioned/Terminated Providers HB 119 Provider Agreement Provisions
Provider Types	Other Resources
Clinic (FOHC, RHC, OHF) Dental HME/DME Managed Care Physician	Handbook Updates Forms E-Manuals General Information Chapter 3334 Helpful Links Cost Avoidance/TPL

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Ohio Medicaid Provider Portal



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Portal Eligibility Inquiry



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Medicaid Information Technology System (MITS)

- MITS will replace the 20-year-old Medicaid Management Information System (MMIS)
- MITS will improve efficiency by automating many processes that are currently performed manually
- It will also allow providers and consumers to conveniently access our system via a dedicated Web portal
- For more info visit <http://jfs.ohio.gov/mits/info.stm>

Electronic Data Interchange

MSP MUST submit claims via EDI submission.
5101:3-35-04

Information for Trading Partners:

jfs.ohio.gov/OHP/tradingpartners/info.stm

- Companion Guides
837 Health Care Claim Professional
- Claim Submission Calendar
- EDI Information Guide
- Technical Questions /EDI Support Unit
614-387-1212
MMIS-EDI-Support@odjfs.state.oh.us

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EDI Adjustments

- Adjustments can be made electronically through the EDI process
- The EDI process is more efficient than paper
- **Inquire about EDI Adjustment** with your Trading Partner/Billing Company

Two Types of Adjustments

- ./ Replacement – Bill Type XX7
- ./ Reversal - Bill Type XX8



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Ohio Medicaid Policy

Ohio

Department of
Job and Family Services

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MSP Administrative Rules

- 5101:3-35-01 Definitions
- 5101:3-35-02 Qualifications
- 5101:3-35-04 Reimbursement
- 5101:3-35-05 Services (including exclusions)
- 5101:3-35-06 Other MSP Services

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5101:3-35-04

Reimbursement for Services Provided by MSP

- Assessment/Evaluation services CANNOT be billed more than once per continuous 12 month period
- Re-assessment/Re-evaluation services CANNOT be billed more than once per continuous 6 month period
- Skilled services CANNOT be billed for dates of service beyond 12 months of the initial assessment/evaluation or re-assessment/re-evaluation

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5101:3-35-04

Reimbursement for Services Provided by MSP

Medically necessary services for individuals under 21 that go beyond the coverage and limitations must go through Prior Authorization



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Appendix

(partial list example)

CODE	SERVICE	DESCRIPTION	PRICE
92555	Aud	Speech audiometry threshold; each	\$13.23
97032	OT,PT	Electrical stimulation (manual) application of a modality to one or more areas; direct (one-on-one) contact; 15 minutes	\$18.63
97112	PT	Neuromuscular re-education of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities; direct (one-on-one) contact; 15 minutes	\$18.50
H0004	MH	Behavioral health counseling and therapy; 15 minutes	\$11.25
T1003	Nursing	LPN/LVN services; 15 minutes	\$9.56

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Appendix

For billing unit reported in minutes:

- Number of units equals number of minutes for each service per school/calendar day divided by the billing unit for the service
- May round up if 8 or more minutes for service code of 15 minutes



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Example

Child A

receives electrical stimulation from the OT for 30 minutes

(code 97032 - 15 minute billing unit)

$$\begin{aligned} \# \text{ of units} &= 30 \text{ minutes} / 15 \text{ minutes} \\ &= \underline{2 \text{ units}} \end{aligned}$$



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Example

Child B

receives electrical stimulation from the OT for 38 minutes

(code 97032 - 15 minute billing unit)

$$\begin{aligned} \# \text{ of units} &= 38 \text{ minutes} / 15 \text{ minute} \\ \# \text{ of units} &= 2 \text{ units with 8 minutes} \\ &\text{remaining} \\ &= \underline{3 \text{ units}} \end{aligned}$$



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Example

Child C

receives electrical stimulation from the OT for 22 minutes

(code 97032 – 15 minute billing unit)



of units = 22 minutes/15 minutes
of units = 1 unit with 7 minutes remaining
= 1 unit

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5101:3-35-05

Services Authorized for Medicaid Coverage that can be Provided by Medicaid School Providers

1. Occupational therapy
2. Physical therapy
3. Speech-language pathology services
4. Audiology services
5. Nursing services
6. Mental health services
7. Assessments/Evaluations

All services for which reimbursement sought must be listed on the Individualized Education Program (IEP)

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Occupational Therapy Allowable Services

- Evaluation and re-evaluation to determine the current sensory and motor functional level and identify appropriate therapeutic interventions
- Therapy to improve and teach skills and behaviors
- Application and instruction of the use of orthotic and prosthetic devices

Physical Therapy Allowable Services

- Evaluation and re-evaluation to determine the current level of physical function and identify appropriate therapeutic interventions
- Therapy with or without assistive devices, for preventing, correcting, or alleviating impairment
- Application and instruction in the use of orthotic and prosthetic devices

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Speech-Language Pathology Allowable Services

- Evaluation and re-evaluation to determine the current level of speech-language and treatment
- Therapy with or without devices for preventing, correcting, or alleviating impairment
- Application and instruction in the use of assistive devices



Audiology Allowable Services

Evaluation and re-evaluation to determine the current level of hearing and to identify appropriate treatment



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Nursing Allowable Services

- Assessment/Evaluation to determine the current health status to facilitate treatment
- Administering medications prescribed by a Medicaid authorized prescriber
- Implementation of nursing procedures which may include tube feeds, bowel and bladder care, colostomy care, catheterizations, respiratory treatment and other services prescribed

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Mental Health Allowable Services

- Diagnosis and rehabilitative treatment
- Assessment and diagnostic services
- Psychological and neuropsychological testing
- Rehabilitative treatment for purpose of treating, correcting, or alleviating mental /emotional impairment

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5101:3-35-06 Other Services

- Specialized medical transport
- Targeted case management
- Medical supplies and equipment
 - (unallowable-supplies and equipment for use outside of school)



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Transportation

- Must be in a specially adapted vehicle
- Must be for a child with a disability
- Must be for Medicaid eligible child to and from school to receive medically necessary services
- Must be indicated in the IEP

Targeted Case Management (TCM)

- Includes assessment, care planning, referral & linkage, monitoring & follow-up activities
- Must be provided to assist a Medicaid eligible child to access medical, social, educational & other needed services (not just education)
- Must be indicated in the IEP in amount, frequency, and duration along with the name of the case manager

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Medical Supplies and Equipment

- Must be medically necessary
- Must be indicated in the IEP
- Must only be used in school
- Reimbursement is ONLY through the cost report

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Transaction Control Number (TCN)

7 09045 02 700 0033 00

↓ ↓ ↓ ↓ ↓ ↓
 Claim Input Batch Date/ Destination/ Batch Document Claim
 Medium Julian Date Location Code Number Number Number

- 0 – Exam Entry (Keyed in House)
- 1 – Key Entry Contractors
- 2 – 6780s & Medicare/Medicaid Crossovers
- 4 – Computer Generated Credit or Adjustment
- 5 – Exam Entry (Keyed in-house) for the CMS 1500, ADA, and UB92 forms
- 6 – Key Entry (Contractors) for the CMS 1500, ADA, and UB 92 forms
- 7 – Electronic Data Interchange or EDI (Tape CMS 1500, ADA, and UB92)
- 8 – Encounter Data (Managed Care Only)

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Remittance Advice Notices (RA)

- Use your RA information to post your accounts
- EOB/CAS/Remark Codes explain the disposition of the claim or line of the claim
- Use the following types of codes to determine why the claim has denied in order to re-submit.
 - ./ Explanation of Benefit Codes
 - ./ Claim Adjustment Segment Reason Codes
 - ./ Remittance Advice Remark Codes



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Hints for Using the Remittance Advice Notice (RA)

- Each RA is organized by type of claim and status of claim such as **PAID** or **DENIED**
- Each claim is tracked by the **TCN**
- An Allowed Charge Source Code is shown by each amount to show what has been done to that line
- Text for the EOB Codes are at the end of each RA
- Code text may also be found at:

www.wpc-edi.com

Hints for Using the Remittance Advice Notice (RA)

- The end of the remittance advice shows duplicate claims
- Zeros in the date field indicate that the claim appears twice on that remittance

---- LISTED BELOW ARE PAID CLAIMS THAT CAUSED THE REFERENCED LINE (PD REF) ABOVE TO BE DENIED AS DUPLICATES ----

REF	LINE ITEM	TCN	CLAIM TYPE	PROCEDURE CODE	MOD	FROM DATE	TO DATE	UNITS	ALLOWED CHARGE	DATE PAID
001	001	7-0023-02-100-0001-36	L	99214		01/16/08	01/16/08		52.57	02/06/08
002	001	7-0084-02-100-0001-02	L	99213		02/01/08	02/01/08		34.35	06/06/08

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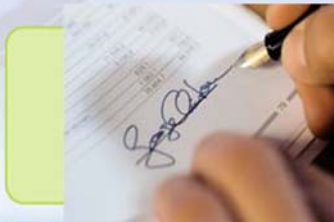
Ohio Medicaid Allowed Charge Source Codes

Code	Definition	Code	Definition
A	Manually Priced	T	No Pay
B	By Report	Z	Prior Authorization
C	Maximum Fee	1	In-Office Surgery
G	Billed Charge	2	Outpatient Surgery
H	Outpatient % of Charges	3	Ambulatory Surgery Center
I	Medicare Coinsurance/Deductible	4	Reduced Not to Exceed Limit
K	Denied	5	Limit by Units of Service
M	Outpatient Lab Maximum Fee	8	Outpatient Procedure % of Payment

This is a partial list created as an example

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Forms



Ohio Department of Job and Family Services

ODJFS FORMS

<http://www.odjfs.state.oh.us/forms/inter.asp>

- JFS 03612 Prior Authorization Form
- JFS 06653 Medical Claim Review Request

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JFS 03142 Prior Authorization

- The form incorrectly requests the Case Number, we actually need the 12-digit Billing Number from the inside of the Medicaid card
- Please give us either the age of the individual or the month, day, and year of birth or both
- Only request PA for provision of services (CPT codes) beyond those approved in the MSP rules

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JFS 03142 Prior Authorization

- If more than one assessment/evaluation is needed for a child within a continuous 12 month period
- If more than one re-assessment/re-evaluation is needed for an eligible child within a continuous 6 month period
- If an eligible child requires a medically necessary service that is not on the list of approved services for the MSP

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JFS 06653

Medical Claim Review Request Form

To be used when:

- submitting a claim with service dates over a year old due to:
 1. A state hearing decision by ODJFS
 2. An eligibility determination by a county JFS
 3. Coordination of benefits with Medicare and/or a third party payer
 4. Within 180 days of a previously denied claim.
- Attach the necessary documentation to prove that the claim was timely
- Attach the claim

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Questions



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Department of Medicaid

John R. Kasich, Governor

John B. McCarthy, Director

Provider IVR User Guide

1-800-686-1516

www.medicaid.ohio.gov

MAKING
OHIO
BETTER

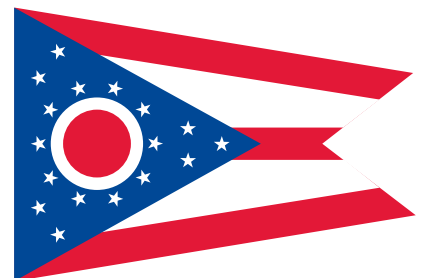


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IVR Overview

The Ohio Medicaid Provider Services Interactive Voice Response System (IVR) provides 24-hour, 7-day a week access to information regarding provider application status, client eligibility, provider-group affiliation, claim status, payment status and provider information.

New providers, who have recently submitted their enrollment application, may use their Application Tracking Number (ATN) to retrieve application status information.

Existing Ohio Medicaid Providers will need 2 of the following 3 pieces of information to authenticate to this system: their NPI, their provider number and their Tax ID number.

NOTE: PINs are no longer required or used within this IVR system.

To obtain eligibility information, authenticated providers may enter the 12-digit consumer billing number, OR the consumer's Social Security Number and Date of Birth. In addition, the date of service must be entered. Consumer eligibility information is available for the past 36 months. To obtain claims information, authenticated providers may inquire by Internal Control Number (ICN) or by the 12-digit Consumer Billing Number and the earliest Date of Service as well as claim type and prescription number if known. Claims information is available for the past 36 months.

When you call the IVR, general information is provided. If you are familiar with the menu options, you may enter your selection at any time. The majority of menus allow you to press star (*) to repeat the menu or to press the pound (#) key to return to the main menu or previous menu.

The following matrices will provide the IVR menus and the options for navigating from the main menu to the subsequent ones.

Main Menu

MENU	OPTIONS
If you are a Medicaid provider and exclusively need a current MITS web portal password reset	1
If you wish to become an Ohio Medicaid provider or have submitted an initial enrollment application,	2
If you are a current provider and have been issued a Medicaid Provider Number	3
If you have EDI submission questions	4
To repeat these options	Star (*)

New Provider Menu

MENU	OPTIONS
For Ohio Home Care Waiver questions	1
To find out the status of your application or for Provider status	2
For all other questions	3
To repeat these options	Star (*)
To return to the main menu	Pound (#)

New Provider Status Menu

MENU	OPTIONS
For provider status (enter 7-digit provider ID number)	1
For application status (enter 6-digit ATN)	2
To speak to a representative	0
To repeat menu	Star (*)
To return to the previous menu	Pound (#)

Current Provider Menu

Existing Ohio Medicaid Providers may check the status of their revalidation application, as well as check on provider-group affiliations, without authentication. To retrieve eligibility, claims and payment information, they will need to enter authenticate by entering 2 of the following 3 pieces of information: their NPI, their provider number and their Tax ID number.

NOTE: PINs are no longer required or used within this IVR system.

MENU	OPTIONS
For Revalidation questions (enter ATN for status of revalidation application)	1
To verify Provider-Group Affiliations (enter provider ID and group number)	2
To verify receipt of your BCI Background check,	3
To find out the status of a provider using the associated Provider ID	4
To access eligibility, claims and payment information using your NPI, as well as your provider number or tax ID number	5
To repeat this menu	Star (*)
To return to the main menu	Pound (#)

Authenticated Provider Inquiries Menu

MENU	OPTIONS
For questions about consumer eligibility	1
For questions about claims	2
For questions about payment status	3
To repeat this menu	Star (*)
To return to the main menu	Pound (#)

By entering the consumer's 12 digit billing number, or the consumer's Social Security Number and date of birth, along with the date of service, the caller can verify if the consumer is eligible for Ohio Medicaid on the specified date. If the consumer is eligible for Ohio Medicaid, the caller will also be provided with the following plan and waiver information about the consumer, where applicable:

- Expedited Medicaid
- Long Term Care Facility
- Managed Care (HMO)
- Transitions Carve Out Waiver
- Passport Waiver
- Federal Qualified Medicare Beneficiary program (QMB)
- Individual Option Waiver
- Ohio Home Care Waiver
- Assisted Living Waiver
- Transitions DD Waiver
- PACE
- Dept of Developmental Disabilities Level 1 Waiver
- ODA Choices Waiver
- Medicare Part A
- Medicare Part B
- Third party coverage
- Case Number
- Provider Information
- County of residency or jurisdiction

Eligibility Menu

To obtain eligibility information, you may enter the 12-digit consumer billing number, OR the consumer's Social Security Number and Date of Birth. You will also be required to enter the date of service. Consumer eligibility information is available for the past 36 months.

MENU	OPTIONS
To inquire by Consumer Billing number	1
To inquire by Social Security Number and Date of Birth	2
If you do not have this information	3
To repeat this menu	Star (*)
To return to the previous menu	Pound (#)

Claim Status Menu

- Claims status may be retrieved by entering the Internal Control Number (ICN) or by the 12-digit or Consumer Billing Number and the earliest date of service, along with the Claim type and prescription number if known. Claims information is available for the past 36 months.

MENU	OPTIONS
To inquire using the ICN (enter ICN)	1
To inquire using the consumer billing number (enter CBN and DOS) *	2
To repeat these options	Star (*)
To return to the Provider Support (Authenticated Provider Inquiries) menu	Pound (#)

*You may retrieve information for a pharmacy claim or all other claim types.

- For pharmacy claims, you will be prompted to enter a prescription number
- For all other claims, you may choose the specific claim type to retrieve the associated data. The claim type selection should be based on the type of service provided. As an example, a physician inquiring about a Medicare/Medicaid Crossover Claim Status, should choose the option for Professional Crossover Claim. Ohio Home Care providers should choose the Professional claim option.

MENU	OPTIONS
For all claim types	1
For a Professional Claim	2
For an Outpatient Claim	3
For an Inpatient Claim	4
For a Professional Crossover Claim	5
For an Inpatient Crossover Claim	6
For an Outpatient Crossover Claim	7
For a Dental Claim	8
For a Long-Term Care claim	9

Payment Status Menu

The system will speak the three most recent payments made to the authenticated provider. These payments might include a pending future payment. The information provided is restricted to:

- Check issue date
- Payment amount
- Check or EFT Number

Information messages are then provided about check reissues due to a change of address. Providers are required to update their address on the MITS Portal under Demographic Maintenance before requesting the check or payment be reissued. Once this is completed, a provider may call 614-466-6068 if related to a paper check or 877-644-6771 for an EFT payment.

Fact Sheet

Conversion to Time-Limited Provider Agreements

Ohio Revised Code (R.C.) 5111.028 requires the Ohio Department of Job and Family Services (ODJFS) to convert its Medicaid provider agreements from open-ended agreements (no expiration date) to time-limited agreements that must be renewed every three years.

R.C. 5111.028 exempts the following providers from the time-limited provision:

- Managed Care Plans
- Skilled Nursing Facilities
- Intermediate Care Facilities for the Mentally Retarded

All providers who submitted an application prior to January 1, 2008, except those exempted as described above, will receive a written conversion notice between January 1, 2009 and December 31, 2010. This notice that will notify them of the conversion of their open-ended provider agreement, and will specify the renewal date of their new time-limited provider agreement.

The change from an open-ended agreement to a time-limited agreement does not affect a provider's current enrollment status or any activity. It is not an adjudication order, and is not subject to appeal or reconsideration.

Time-limited provider agreements are valid for not longer than three years. Upon the renewal date of a time-limited agreement, providers will be required to re-enroll to continue with the Ohio Medicaid program. ODJFS will mail a re-enrollment notice 120 days before the renewal date of your time-limited agreement.

Due to the number of providers who participate in the Medicaid program and the volume of re-enrollment materials to be processed, providers may not submit their re-enrollment package until they receive the re-enrollment notice from ODJFS.

All providers will keep their same Medicaid provider number upon conversion to a time-limited agreement and at the time of re-enrollment.

ODJFS rules applicable to the conversion to time-limited agreements may be viewed under the link "ODJFS Ohio Administrative Code" under the link "Legal Services" at the ODJFS electronic manuals site:

<http://emanuals.odjfs.state.oh.us/emanuals>

- 5101:3-1-17.4 Length and Type of Provider Agreements
- 5101:3-1-17.6 Termination and Denial of Provider Agreement (Except Long-Term Care Nursing Facilities (NFs), Intermediate Care Facilities for the Mentally Retarded (ICFs-MR) and Medicaid Contracting Managed Care Plans (MCPs))

Reimbursement

5101:3-1-02

5101:3-1-60

jfs.ohio.gov

- The department's payment constitutes payment-in-full for any of our covered services.
- Providers are expected to bill the department their usual and customary charges (UCC).
- The department reimburses the provider at the Medicaid rate (established fee schedule) or the UCC whichever is the lesser of the two.

Timely Submission of Claims 5101:3-1-19.3

Claims must be received by The Department of Job and Family Services (ODJFS) within 365 days of the service date or hospital discharge date. The “date of receipt” is defined as the date the department receives a claim and assigns a transaction control number.

If a service date on a claim is more than 365 days old but less than 730 days old, the claim will be considered for payment only if:

- It is being resubmitted less than 180 days after an ODJFS denial.
- A third party or Medicare payment or denial was made less than 180 days prior to submission.
- A county eligibility determination or court decision was made less than 180 days prior to submission.

Recipient Liability

5101:3-1-13.1

The Medicaid payment for a covered service constitutes payment-in-full and may not be construed as a partial payment when the reimbursement amount is less than the provider's charge.

- The provider may not collect or bill the difference in charges to the consumer.
- The provider may not request the consumer to share in the cost through a deductible, coinsurance, co-payment or other similar charge, **other than Medicaid co-payment as defined in OAC 5101:3-1-09.**
- The provider may not charge the consumer a down payment (even if refundable).

If you receive a denial for a Medicaid claim for one of the reasons shown below, this does not constitute that the services were non-covered. The consumer may still not be billed.

- Unacceptable claim submission
- Untimely claim submission
- Failure to request prior authorization
- Retroactive Peer Review determination of lack of medical necessity

Providers are not required to bill the department for Medicaid-covered services rendered to eligible consumers. However, providers may not bill consumers in lieu of the department unless:

- 1) The consumer is notified in writing prior to the service being rendered that the provider will not bill the department for the covered service; and**
- 2) The consumer agrees to be liable for payment of the service and signs a written statement to that effect prior to the service being rendered; and**
- 3) The provider explains to the consumer that the service is a covered Medicaid service and other Medicaid providers may render the service at no cost to the consumer.**

Services that are not covered by the Medicaid program, including services requiring prior authorization that have been denied by the department, may be billed to the consumer when the provisions shown above in **1 and 2 are met.**

Accessing Ohio Medicaid Websites

ODJFS Website:

<http://jfs.ohio.gov>

Ohio Medicaid Website:

<http://jfs.ohio.gov/OHP/index.stm>

Ohio Medicaid Provider Page

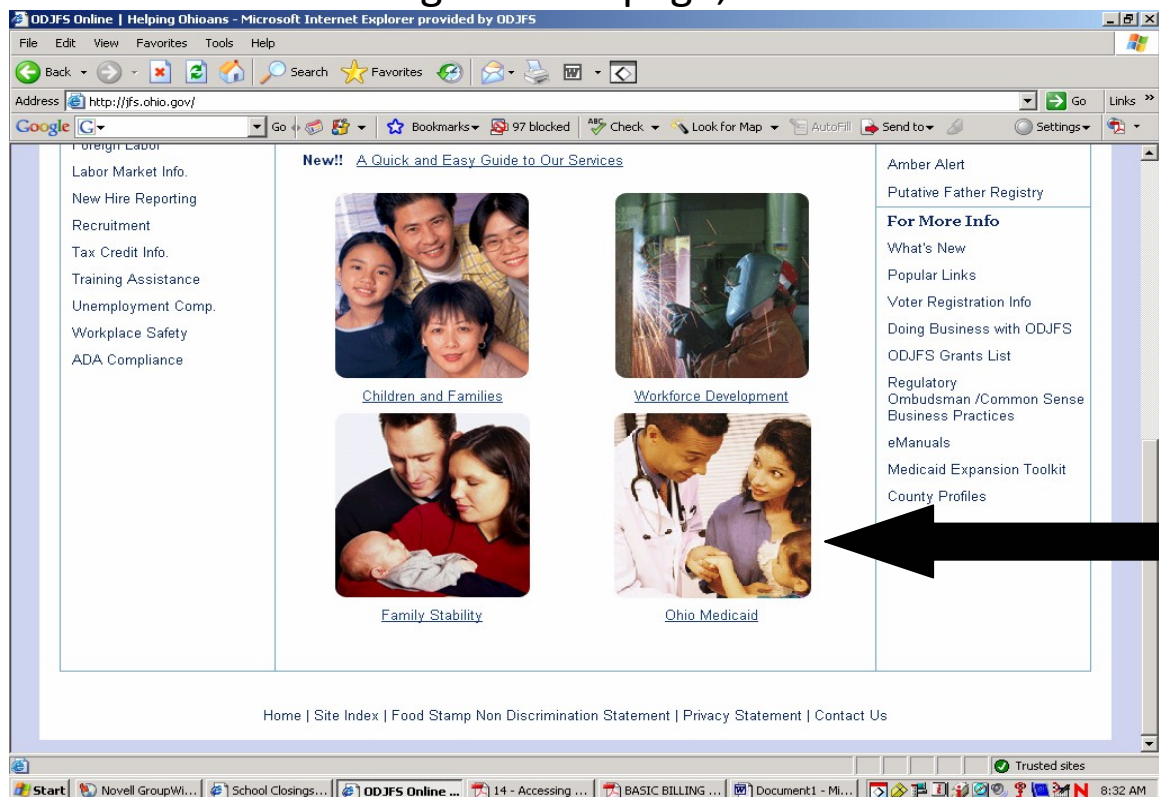
<http://jfs.ohio.gov/OHP/provider.stm>

Emanuals

<http://emanuals.odjfs.state.oh.us>

Navigating The ODJFS Website

- Go to jfs.ohio.gov
- At the bottom right of the page, click on “Medicaid”



- You Should Now See the Medicaid Home Page...



- Next, click on Providers...



- From the Provider page you may access the **Fee Schedule**, **Emanuals**, **The Medicaid Provider Portal**, and a wealth of other Medicaid Resources for Providers.



Department of Job and Family Services

Ohio Medicaid Provider Portal Desk Reference Consumer Eligibility

Ohio Medicaid: [Medicaid Front Page](#) | [Consumer Info](#) | [Provider Info](#) | [Reports, Information & Publications](#) | [About Us](#)
ODJFS: [News & Events](#) | [Our Services](#) | [Info Center](#) | [Popular Sites](#) | [ODJFS Home](#) | [About Us](#)

Ohio Medicaid Provider Portal [Logout](#)

[Home](#) | [Remittance Advices](#) | [Claim Submission](#) | **[Eligibility Inquiry](#)** | [User Admin](#) | [My Account](#) | [Logout](#)

Eligibility Portal [Print](#) | [Eligibility Portal FAQ](#) | [Page Help](#)

Query Information

Primary Identifier:
 Medicaid Billing Number SSN

Secondary Verification Fields (*enter at least one field*):
Last Name: Date of Birth:

Service Date Range:
From: To:

MIS-MSS, ODJFS. For questions, comments, or suggestions about this site, [Contact Provider Support Team](#). Fri, Aug 8, 2008 03:58:50 AM

Eligibility Portal Frequently Asked Questions

Q: My session is locked out. Why is this?

A: Lockout occurs in three instances:

- 1.) After 20 minutes of inactivity a lockout prevents a session being abandoned and an unauthorized person viewing protected health information.

- 2.) At logon, after three (3) consecutive unsuccessful logon attempts, the logon is locked to prevent an unauthorized person obtaining entry through trial and error.

- 3.) The last lockout situation occurs after a high number of invalid searches. This is intended to prevent searches for a valid recipient through trial and error indicating insufficient information to validate why the information is needed.

Q: Why can only one search be done at a time?

A: This service is designed to allow providers to verify eligibility at the point of registration, confirm eligibility of Medicaid enrollees scheduled for the day, or problem solve billing issues. It is not intended to replace the batches of HIPAA 270 EDI transactions that you can enter via your trading partner.

Q: Why do we need date of birth or last name with the recipient ID?

A: The date of birth or last name are needed to ensure there was no accidental miss-keying of the Recipient ID or Social Security Number. This helps to ensure HIPAA privacy protection.

Q: What is the oldest date of service you can enter?

A: The search will allow you to enter dates as old as 3 years from current date. Although new claims cannot be entered that are this old, this information is intended to assist providers with corrections to outstanding claims.

Q: What is the latest date you can enter?

A: Eligibility can only be verified up to current date.

Q: What does the message 'no eligibility in requested spans' mean?

A: This message indicates that there is no eligibility for the date range entered. Another date range may, however, return eligibility.

Q: How accurate is the Medicare information?

A: Information from Medicare (part A, B, C, and D information) is currently only received once per month. The information shown is accurate at the time this information was received. We recommend referring to the Medicare site for the most current information.

Q: Why are there dates missing from some monthly eligibility spans at the beginning of every month?

A: In some cases, individuals can 'spend down' their income to become Medicaid eligible. Part of the month they will not be eligible. Refer to the eligibility span under **Medicaid Recipient Eligibility Benefit Plan** to ensure coverage.

Q: Where does the information under 'Other Liability' come from?

A: This information comes from a variety of sources including the county caseworker and information from certain insurance carriers. Although every effort is made to ensure accuracy the definitive source of coverage is the insurance carrier.

Q: How do I print the information returned by the eligibility request?

A: Information can be printed using the 'Print' button displayed on the results.

Q: What does the end date of '2399' mean?

A: If there is currently no end date on file for the recipient we will show the end date of '2399'. Note that eligibility is always month to month determination.

Q: How often must I change my password?

A: You must change your password every 60 days to insure security.

Q: How do I reset my password?

A: You first click-on the 'My Account' tab. Then you click on the 'Change Password' link. Then you enter the old password, then enter your new password, and then confirm the new password. Then you click-on the 'Change Password' button. Your password change verification will then be sent to your email account.

Q: How current is the Medicare Information?

A: The Eligibility verification uses a copy of the files used for adjudication. Since the copy process is done daily there can be a day delay in information. The 'Other Liability' information is updated two times per month.

Medicaid Information Technology System (MITS)

Ohio's MMIS Replacement Project: MITS

MITS is first and foremost a strategic project to enable Ohio Medicaid to respond to current and emerging business demands in the health care marketplace. MITS will replace the 20-year-old legacy Medicaid Management Information System (MMIS). MITS will improve efficiency by automating many processes that are currently performed manually. It will also allow providers and consumers to conveniently access our system via a dedicated Web portal.

The key business driver for MITS is the need for an information technology system capable of rapidly implementing state and federal Medicaid program changes and meeting today's business needs for Ohio Medicaid. Ohio's MMIS is a mainframe-based system which processed about 64 million health care claims in calendar year 2007 for more than 2 million Ohioans covered by Ohio Medicaid. Unfortunately, MMIS does not provide the functionality needed to support the increasing demands placed on Ohio's Medicaid program. It must be replaced with web-based technology that can easily adapt to program fluctuations and needs.

The development and implementation of MITS provides the opportunity to improve operations and to streamline functionality for managed care plans, fee-for-service providers, and Medicaid consumers. MITS will provide a secure Web site that will offer more support through an array of automated business solutions to increase self-service capabilities.

Contact us: MITS@jfs.ohio.gov

<http://jfs.ohio.gov/mits/info.stm>

Ohio Department of Education

5101:3-35-01 Definitions

[CATL-EDU 09-01](#)

Effective Date: March 2, 2009

- (A) For the purposes of Chapter 5101:3-35 of the Administrative Code, the following terms are defined as:
- (1) At the direction of: communication of a plan of care to a licensed practical nurse by a licensed physician or registered nurse who is acting within the scope of his or her practice under Ohio law for the provision of nursing services by the licensed practical nurse.
 - (2) Clinical setting: for the purpose of counseling and social work roles, a location in the school, or a location for which the medicaid school program provider has contracted for the delivery of services, where the child's confidentiality can be maintained when a service is being rendered.
 - (3) Community School: a public school, independent of any school district, established in accordance with Chapter 3314. of the Revised Code that is part of the state's program of education.
 - (4) Direct supervision: the licensed practitioner of the healing arts shall conduct face-to-face client evaluations initially and periodically thereafter, and be present with the licensed aide in the same space designated for service delivery throughout the time the licensed aide is providing service and immediately available to provide assistance and direction throughout the time the aide is performing services. Direct supervision does not mean the licensed practitioner of the healing arts must be in the same room while the aide is providing services, except when the room is the only service delivery space. The availability of the licensed practitioner of the healing arts by telephone or the presence of the licensed practitioner of the healing arts somewhere else in the building does not constitute direct supervision.
 - (5) Eligible child: a student for whom medicaid reimbursement may be sought through the medicaid school program who is enrolled in an entity defined in paragraph (B)(1) of rule 5101:3-35-02 of the Administrative Code, who is between the age of three to twenty-one, and has an individualized education program in which is indicated services that are allowable under medicaid.
 - (6) General supervision: the licensed practitioner of the healing arts is available, but not necessarily present in the same space designated for service delivery or on-site, to monitor the provision of service. However, if the licensed practitioner of the healing arts is not physically present in the same space designated for service delivery, he or she shall be immediately available to the assistant for consultation purposes at all times. The supervision requires an interactive process and shall include, but is not limited to, an initial face-to-face client evaluation and periodically thereafter, routine consult with the assistant before the assistant's initiation of any client treatment plan and/or modification of the treatment plan, and review of the following: client assessment, reassessment, treatment plan, intervention and the discontinuation of intervention, and/or treatment plan. Co-signing client documentation alone does not meet the general supervision requirements.
 - (7) Habilitation: the process by which the staff of a facility or agency assists an individual with mental retardation or other developmental disabilities in acquiring and maintaining those life skills that enable the individual to cope more effectively with the demands of the individual's own person and environment, and in raising the level of the individual's personal, physical, mental, social, and vocational efficiency.

- (8) IEP: the individualized education program as described in section 3323.011 of the Revised Code.
- (9) Local education agency: city school district, local school district, exempted village school district, as defined in sections 3311.01 to 3311.04 of the Revised Code.
- (10) Maintenance: services provided to individuals for the purpose of maintaining a level of functionality, not improvement of functionality.
- (11) Medicaid authorized prescriber: a physician (M.D. or D.O.), podiatrist, dentist, or advanced practice nurse working within his or her scope of practice as defined by state law.
- (12) Medical home: a physician, physician group practice, or an advanced practice nurse with a current medicaid provider agreement, or a provider with a contract with an Ohio medicaid managed care plan. This provider serves as an ongoing source of primary and preventive care and provides assistance with care coordination for the patient.
- (13) Medically necessary: skilled services recommended by a qualified licensed practitioner in accordance with rules 5101:3-35-05 and 5101:3-35-06 of the Administrative Code who is acting within the scope of his or her licensure and based on his or her professional judgment regarding medical services that are necessary for the eligible child for the diagnosis or treatment of disease, illness, or injury and without which the eligible child can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. A medically necessary service shall: meet generally accepted standards of medical practice; be appropriate to the illness or injury for which it is performed as to type of service and expected outcome; be appropriate to the intensity of service and level of setting; provide unique, essential, and appropriate information when used for diagnostic purposes; be the lowest cost alternative that effectively addresses and treats the medical problem; and meet general principles regarding reimbursement for medicaid covered services found in rule 5101:3-1-02 of the Administrative Code.
- (14) MSP: the medicaid school program as set forth in Chapter 5101:3-35 of the Administrative Code.
- (15) MSP provider: entity that meets the qualifications delineated in rule 5101:3-35-02 of the Administrative Code.
- (16) Skilled services: services of such complexity and sophistication that the service can be safely and effectively performed only by or under the supervision of a licensed practitioner of the healing arts practicing within the scope of their licensure. Skilled services do not include services provided by persons not licensed in accordance with the Ohio Revised Code.
- (17) State school: school under the control and supervision of the state board of education established for students who are deaf or blind as defined by section 3325.01 of the Revised Code.

Replaces: 5101:3-35-01 Effective: R.C. 119.032 review dates: Certification Date Promulgated Under: 119.03 Statutory Authority: 5111.02 Rule Amplifies: 5111.02 Prior Effective Dates: 11/26/2008 (Emer.)

5101:3-35-02 Qualifications to be a Medicaid School Program (MSP) Provider

[CATL-EDU 09-01](#)

Effective Date: March 2, 2009

- (A) The purpose of this rule is to set forth the qualifications to become and the requirements for a medicaid school program (MSP) provider.
- (B) An MSP provider shall:
- (1) Be one of the following:
 - (a) Local education agency (LEA) city school district, local school district, exempted village school district as defined in sections 3311.01 to 3311.04 of the Revised Code;
 - (b) State school for the deaf as defined by section 3325.01 of the Revised Code;
 - (c) State school for the blind as defined by section 3325.01 of the Revised Code;
 - (d) Community school as defined by Chapter 3314. of the Revised Code; or
 - (e) For the period July 1, 2005 through September 30, 2008 only, an educational service center (ESC) as defined in section 3311.05 of the Revised Code.
 - (i) The ESC shall comply with the requirements of this chapter except as waived by the centers for medicare and medicaid services (CMS).
 - (ii) The ESC shall have the ability to be a MSP provider and submit claims with a date of service between July 1, 2005 through September 30, 2008 only.
 - (iii) After September 30, 2008, the ESC will no longer be a MSP provider and cannot submit claims with a date of service on or after October 1, 2008.
 - (2) Obtain and maintain a current valid medicaid provider agreement in accordance with rule 5101:3-1-17.2 of the Administrative Code. The medicaid provider agreement shall indicate the services to be provided as well as an attestation of compliance with paragraph (B)(3) of this rule.
 - (3) Employ or contract for at least one of the following:
 - (a) Occupational therapist who holds a current, valid license to practice occupational therapy issued under Chapter 4755. of the Revised Code.
 - (b) Physical therapist who holds a current, valid license to practice physical therapy issued under Chapter 4755. of the Revised Code.
 - (c) Speech-language pathologist who holds a current, valid license to practice speech-language pathology issued under Chapter 4753. of the Revised Code.
 - (d) Audiologist who holds a current, valid license to practice audiology issued under Chapter 4753. of the Revised Code.

- (e) Licensed clinical counselor or licensed counselor who holds a current, valid license to practice professional counseling issued under Chapter 4757 of the Revised Code.
- (f) Licensed psychologist or licensed school psychologist who holds a current, valid license to practice psychology or school psychology issued under Chapter 4732. of the Revised Code or under rule 3301-24-05 of the Administrative Code.
- (g) Licensed independent social worker or social worker who holds a current, valid license to practice social work issued under Chapter 4757. of the Revised Code.
- (h) Licensed registered nurse who holds a current, valid license to practice nursing issued under Chapter 4723. of the Revised Code.

(C) An MSP provider shall ensure all employees and contractors who have in-person contact with consumers for the provision of services undergo and successfully complete criminal records checks pursuant to rules adopted under section 5111.032 of the Revised Code.

(D) An MSP provider shall provide services in accordance with rules 5101:3-35-05 and 5101:3-35-06 of the Administrative Code.

(E) An MSP provider shall submit claims in accordance with rule 5101:3-35-04 of the Administrative Code to receive reimbursement for the provision of services.

(F) An MSP provider shall comply with the following for cost reporting and cost reconciliation purposes:

(1) Participate in the random moment time study (RMTS), designed to document the level of effort of MSP providers on a state-wide basis, in compliance with the applicable RMTS guide provided by the Ohio department of education (ODE).

(2) Submit a December count of special education students.

(3) Prepare a cost report in accordance with paragraph (K)(2) of rule 5101:3-35-04 of the Administrative Code.

(4) Contract with an authorized entity to perform an agreed upon procedures review of the cost report and to document adjustments to the cost report, in accordance with paragraph (K)(2) of rule 5101:3-35-04 of the Administrative Code.

(5) Adhere to all applicable rules, including, but not limited to 45 C.F.R. 92, dated October 1, 2007, Revised Code, Administrative Code, CMS Publication 15-1, and provisions outlined in the cost report instructions.

Replaces: 5101:3-35-02 Effective: R.C. 119.032 review dates: Certification Date Promulgated Under: 119.03 Statutory Authority: 5111.02 Rule Amplifies: 5111.02 Prior Effective Dates: 11/26/2008 (Emer.)

5101:3-35-04 Reimbursement for Services Provided by Medicaid School Program (MSP) Providers

[CATL-EDU 09-01](#)

Effective Date: March 2, 2009

(A) The purpose of this rule is to set forth the provisions for claiming to receive medicaid reimbursement for the provision of services by medicaid school program (MSP) providers as defined in Chapter 5101:3-35 of the Administrative Code.

(B) Covered services provided through MSP providers that are allowable for medicaid reimbursement are listed in the appendix to this rule and are provided in accordance with Chapter 5101:3-35 of the Administrative Code. The following limits apply:

- (1) Assessment/evaluation services cannot be billed more than once per continuous twelve month period.
- (2) Re-assessment/re-evaluation services cannot be billed more than once per continuous six-month period.
- (3) Skilled services cannot be billed for dates of service beyond twelve months of the initial assessment/evaluation or re-assessment/re-evaluation.

(C) Medically necessary services for individuals under age twenty-one that go beyond the coverage and limitations established in this rule shall be:

- (1) Prior authorized by the department in accordance with rule 5101:3-1-31 of the Administrative Code; and
- (2) Services defined as medical assistance in accordance with section 1905(a) of the Social Security Act, 42 U.S.C 1396d.

(D) The following conditions shall be met in order to receive medicaid reimbursement for services provided through the medicaid school program:

- (1) The school district shall be a qualified MSP provider in accordance with rule 5101:3-35-02 of the Administrative Code.
- (2) The MSP provider shall submit claims for reimbursement for only those services for which it has statutory responsibility to provide to either an eligible child or for assessment/evaluation for a medicaid eligible child for whom they are trying to determine the appropriateness of developing an individualized education program (IEP).
- (3) The executive officer of the MSP provider or his/her designee shall attest to the validity of the non-federal share of expenditures in accordance with paragraph (G) of this rule.
- (4) The service provided through the MSP provider shall be provided by or under the direction of a licensed practitioner of the healing arts and provided in accordance with rules 5101:3-35-05 and 5101:3-35-06 of the Administrative Code.
- (5) The service for which reimbursement is sought shall be one clearly identified in the IEP of an eligible child, with the exception of the initial assessment/evaluation as described in paragraph (B)(7) of rule 5101:3-35-05 of the Administrative Code.

- (6) The MSP provider must be enrolled as a MSP provider no later than February 28, 2009 in order to receive reimbursement for services provided during the back claiming period (July 1, 2005 through September 30, 2009), and must adhere to the methodology for claiming and cost reconciliation developed by ODJFS in cooperation with ODE and approved by the centers for medicare and medicaid services (CMS).
- (E) The MSP provider is required to enroll and submit claims as an ODJFS electronic data interchange (EDI) trading partner or contract with an ODJFS EDI trading partner for the submission of claims to ODJFS.
- (F) Claims shall be submitted in accordance with rule 5101:3-1-02 of the Administrative Code.
- (G) When a medicaid claim is submitted through an EDI trading partner, the claim shall include a ten character code that is the first item listed in the NTE02 field, and that is an attestation of whether or not the claim is certified by the executive officer of the MSP provider or his/her designee as follows:
- (1) Attest yes: used if the claim is certified by the executive officer of the MSP provider or his/her designee to only include expenditures under the medicaid program under Title XIX of the Social Security Act (the Act), and as applicable, under the state children's health insurance program (SCHIP), under Title XXI of the Act, that are allowable in accordance with applicable implementing federal, state, and local statutes, regulations, and policies, and the state plan approved by the secretary of health and human services and in effect at the time of the submission of this claim; and the expenditures included in the claim are based on the MSP provider's accounting of actual recorded expenditures; and the required amount of local public funds were available and used to match the MSP provider's (local public school district's) allowable expenditures included in this claim, and such local public funds were in accordance with all applicable federal requirements for the non-federal share match of expenditures; and federal matching funds are not being claimed in this claim submission to match any expenditure under any medicaid and/or SCHIP state plan amendment that has not been approved by the secretary of health and human services effective for the period of this claim.
- (2) Attest nay: used if the claim is not certified by the executive officer of the MSP provider or his/her designee to only include expenditures under the medicaid program under Title XIX of the Social Security Act (the Act), and as applicable, under the state children's health insurance program (SCHIP), under Title XXI of the Act, that are allowable in accordance with applicable implementing federal, state, and local statutes, regulations, and policies, and the state plan approved by the secretary of health and human services and in effect at the time of the submission of this claim; and the expenditures included in the claim are based on the MSP provider's accounting of actual recorded expenditures; and the required amount of local public funds were available and used to match the MSP provider's (local public school district's) allowable expenditures included in this claim, and such local public funds were in accordance with all applicable federal requirements for the non-federal share match of expenditures; and federal matching funds are not being claimed in this claim submission to match any expenditure under any medicaid and/or SCHIP state plan amendment that has not been approved by the secretary of health and human services effective for the period of this claim. If attest nay is used, the claim will be denied for payment.
- (H) With the exception of claims for services provided with a date-of-service between July 1, 2005 through September 30, 2008, claim submissions must be received by ODJFS within three-hundred sixty-five days of the actual date the service was provided. Claim submission for services provided with a date-of-service between July 1, 2005 through September 30, 2008 must be received by ODJFS no later than September 30, 2009. All claims shall be submitted using only the EDI billing method as defined by rule 5101:3-1-19.3 of the Administrative Code.

(I) References to cartridge tape, paper claim and pharmacy-point-of-sale in rule 5101:3-1-19.3 of the Administrative Code are not applicable to the claim and shall not be allowed.

(J) A billing unit for a service code reported in minutes is as indicated in the appendix to this rule, and claims shall be for minutes of actual service delivery time. The number of units is equivalent to the total number of minutes of each type of service, as distinguished by service codes, provided during the school or calendar day to the eligible child, divided by the number of minutes identified for the service code. One additional unit of service may be added to this quotient if the remainder equals eight or more minutes for service codes with a fifteen minute billing unit.

(K) The following applies to medicaid reimbursement:

(1) Interim payments. ODJFS shall reimburse the MSP provider interim payments. The interim payments shall be the federal financial participation (FFP) portion of the lesser of the billed charge (not to exceed the usual and customary charge) or the medicaid maximum according to the department's procedure code reference files for the particular services performed.

(2) Cost reports. Each MSP provider shall complete the Ohio department of education (ODE) developed medicaid school based cost report. The cost report is to be completed by the MSP provider in compliance with the cost report instructions also developed by ODE. The MSP provider shall contract with an independent certified public accountant (CPA) firm, the state auditor, or other entity authorized to conduct audits in the state of Ohio to perform an agreed upon procedures review of the cost report and document adjustments to the cost report. Once completed, the cost report shall be submitted to ODE no later than six months after the end of the fiscal year. The submitted cost report will be used by ODE and ODJFS in the cost reconciliation and final settlement process. ODJFS or ODE may conduct a desk or field audit up to three years after the fiscal year end based on risk assessment criteria developed by ODJFS. All cost reports for each fiscal year prior to the effective date of this rule but not starting earlier than July 1, 2005 shall be submitted in accordance with the schedule developed by ODJFS in cooperation with ODE and approved by CMS.

(3) Final cost settlement and reconciliation. The ODJFS shall reconcile the federal financial participation (FFP) identified in the cost report against the interim payments made by ODJFS to the MSP provider and issue a notice of reconciliation that denotes the amount due to or from the MSP provider. ODJFS shall review this notice of reconciliation and certify for payment. An overpayment determined as a result of this annual reconciliation to actual cost shall be collected from the MSP provider by ODJFS. An underpayment determined as a result of this annual reconciliation to actual cost shall be paid to the MSP provider by ODJFS.

(4) The provider shall accept reimbursement for all covered services as payment in full with limitations as set forth in accordance with rule 5101:3-1-60 of the Administrative Code.

(5) The MSP providers shall comply with all applicable federal and state rules, including but not limited to 45 C.F.R. 92 dated October 1, 2007, 45 C.F.R. 74 dated October 1, 2007, Chapters 5101:3-1 and 5101:3-35 of the Administrative Code, CMS Publication 15-1, and the terms and conditions set forth within the provider agreement.

(L) Records shall be maintained by providers in accordance with rule 5101:3-1-27 of the Administrative Code. Records necessary to fully disclose the extent of services provided and costs associated with these services shall be maintained for a period of six years from the date of receipt of payment based upon those records or until any initiated audit, review, investigation or other activities are completed and appropriately resolved, whichever is longer. Records shall be made available upon request to ODJFS, ODE or the U.S.

department of health and human services. Failure to supply requested records, documentation and/or information as indicated in this rule may result in no payment for outstanding services or other legal recourse.

(M) State monitoring: ODJFS or its designee may conduct audits, reviews, investigations, or any other activities necessary to assure a medicaid school program provider, its subgrantee(s) or subcontractor(s) are compliant with federal and state requirements. Based on the results of an audit, review, investigation or other activities, ODJFS may seek legal recourse, including but not limited to, recoupment of funding related to overpayments, misuse, fraud waste or abuse or noncompliance with federal or state requirements from the medicaid school provider.

Appendix A - Ohio Medicaid School Program CPT Code Assignments

[Click here to view Appendix A, Ohio Medicaid School Program CPT Code Assignments](#)

Replaces: 5101:3-35-04 Effective: R.C. 119.032 review dates: Certification Date Promulgated Under: 119.03 Statutory Authority: 5111.02 Rule Amplifies: 5111.02 Prior Effective Dates: 11/26/2008 (Emer.)

**APPENDIX
OHIO MEDICAID SCHOOL PROGRAM
CPT CODE ASSIGNMENTS**

Code	Service	Description	
90804	MH	Individual psychotherapy; insight oriented, behaviour modifying and/or supportive; office; face-to-face; 20-30 minutes	\$36.69
90806	MH	Individual psychotherapy; insight oriented, behaviour modifying and/or supportive; office; face-to-face; 45-50 minutes	\$57.10
90810	MH	Individual Interactive psychotherapy, office; face-to-face; 20-30 min	\$45.28
90812	MH	Individual Interactive psychotherapy, office, face-to-face; 45-50 minutes	\$61.71
90846	MH	Family psychotherapy (without the patient present); each	\$55.86
90847	MH	Family psychotherapy (with the patient present); each	\$63.39
90853	MH	Group psychotherapy (other than of a multiple-family group); each	\$27.88
92506	SLP, Aud	Evaluation of speech, language, voice, communication, and/or auditory processing; each	\$81.68
92507	SLP, Aud	Treatment of speech, language, voice, communication, and/or auditory processing disorder, individual; each	\$57.23
92508	SLP, Aud	Treatment of speech, language, voice, communication, and/or auditory processing disorder, Group Therapy of 2 or more; each	\$30.43
92630	SLP, Aud	auditory rehabilitation, prelingual hearing loss; each	\$20.61
92633	SLP, Aud	auditory rehabilitation, postlingual hearing loss; each	\$20.61
92551	SLP, Aud, Nurse	Screening test, pure tone; air only (hearing screen); each	\$10.26
92552	Aud	Pure tone audiometry (threshold); air only; each	\$19.56
92555	Aud	Speech audiometry threshold; each	\$13.23
92557	Aud	Comprehensive audiometry threshold evaluation and speech recognition; each	\$47.82
92567	Aud, Nurse	Tympanometry (impedance testing); each	\$28.26
96101	MH	Psychological testing; with face-to-face, interpretation and report; per hour	\$64.21
96110	MH	Developmental testing, limited, with face-to-face, interpretation and report; each	\$50.00
96111	MH	Developmental testing, extended, with face-to-face, interpretation and report; each	\$50.00
96116	MH	Neurobehavioral status exam; with face-to-face, interpretation and report; per hour	\$54.32
96118	MH	Neuropsychological testing; with face-to-face, interpretation and report; per hour	\$78.31
96150	MH	Health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires); face-to-face with the patient; initial assessment; 15 minutes	\$23.08
96151	MH	Health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires); face-to-face with the patient; reassessment; 15 minutes	\$22.32
96152	MH	Health and behavior intervention; face-to-face; individual; 15 minutes	\$21.21
96153	MH	Health and behavior intervention; face-to-face; group (2 or more patients); 15 minutes	\$5.19

97001	PT	Physical Therapy evaluation, each	\$45.65
97002	PT	Physical Therapy re-evaluation, each	\$28.26
97003	OT	Occupational Therapy evaluation, each	\$54.76
97004	OT	Occupational Therapy re-evaluation, each	\$35.20
97012	OT, PT	Traction, mechanical; each	\$17.14
97016	OT, PT	Vasopneumatic devices; each	\$15.89
97032	OT, PT	Electrical stimulation (manual) application of a modality to one or more areas; direct (one-on-one) contact; 15 minutes	\$18.63
97110	OT, PT	Therapeutic procedure, one or more areas; therapeutic exercises to develop strength and endurance, range of motion and flexibility; direct (one-on-one) contact; 15 minutes	\$16.95
97112	OT, PT	Neuromuscular re-education of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities; direct (one-on-one) contact; 15 minutes	\$18.50
97113	OT, PT	Aquatic therapy with therapeutic exercises; direct (one-on-one) contact; 15 minutes	\$18.11
97116	OT, PT	Gait training, includes stair climbing; direct (one-on-one) contact; 15 minutes	\$16.43
97124	OT, PT	Massage therapy; direct (one-on-one) contact; 15 minutes	\$15.02
97140	OT, PT	Manual therapy techniques, one or more regions; direct (one-on-one) contact; 15 minutes	\$14.13
97760	OT, PT	Orthotic management and training, upper and/or lower extremity(s), and or trunk; 15 minutes	\$38.36
97761	OT, PT	Prosthetic training, upper and/or lower extremity(s); 15 minutes	\$38.36
97530	OT, PT	Therapeutic activities, direct (one-on-one) contact (use of dynamic activities to improve functional performance); 15 minutes	\$17.75
97532	OT, PT	Cognitive skills development or improve attention, memory, problem solving; direct (one-on-one) contact; 15 minutes	\$20.20
97533	OT, PT	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands; direct (one-on-one) contact; 15 minutes.	\$22.04
97150	OT, PT	Therapeutic procedures; group of 2 or more, with constant attendance; to be reported for each member of group; 15 minutes	\$19.21
T2003	Transport	Non-emergency transportation: encounter/trip	\$5.20
H0004	MH	Behavioral health counseling and therapy; 15 minutes	\$11.25
H0031	MH	Mental health assessment, by Non-physician; each	\$48.50
T1001	Nursing	Nursing assessment/evaluation , each	\$11.25
T1002	Nursing	RN services; 15 minutes	\$11.25
T1003	Nursing	LPN/LVN services; 15 minutes	\$9.56
T1017	TCM	Targeted Case Management; 15 minutes	\$10.56

5101:3-35-05 Services Authorized for Medicaid Coverage that can be Provided by Medicaid School Program (MSP) Providers

[CATL-EDU 09-01](#)

Effective Date: March 2, 2009

(A) The purpose of this rule is to set forth the services authorized for medicaid coverage that a MSP provider can provide, and to set forth the conditions for providing the services.

(B) A MSP provider may provide skilled services. Following are the skilled services an MSP provider may provide:

(1) Occupational therapy services:

(a) Description: services that evaluate and treat, as well as services to analyze, select, and adapt activities for an eligible child whose functioning is impaired by developmental deficiencies, physical injury or illness. The occupational therapy service shall be recommended by a licensed occupational therapist acting within the scope of his or her practice under Ohio law who holds a current, valid license to practice occupational therapy issued under Chapter 4755. of the Revised Code. Services provided by an individual holding a limited permit, as described in section 4755.08 of the Revised Code, are not allowable.

(b) Qualified practitioners who can deliver the services:

(i) Licensed occupational therapist who holds a current, valid license to practice occupational therapy issued under Chapter 4755. of the Revised Code, who is employed or contracted with the MSP provider, and who is acting within the scope of his or her practice under Ohio law.

(ii) Licensed occupational therapy assistant who holds a current, valid license issued under Chapter 4755. of the Revised Code, who is employed or contracted with the MSP provider, and who is acting within the scope of his or her practice under Ohio law. Further, the licensed occupational therapy assistant shall be practicing under the general supervision of a licensed occupational therapist who is employed or contracted by the MSP provider.

(c) Allowable activities include:

(i) Evaluation and re-evaluation to determine the current sensory and motor functional level of the eligible child and identifying appropriate therapeutic interventions to address the findings of the evaluation/re-evaluation.

(ii) Therapy to improve the sensory and motor functioning of the eligible child, to teach skills and behaviors crucial to the eligible child's independent and productive level of functioning.

(iii) Application and instruction in the use of orthotic and prosthetic devices, and other equipment to accomplish the goal of therapy in accordance with paragraph (B)(1)(c)(ii) of this rule.

(2) Physical therapy services

(a) Description: services that evaluate and treat an eligible child by physical measures and the use of therapeutic exercises and procedures, with or without assistive devices, for the purpose of correcting, or alleviating a disability. The physical therapy service shall be recommended by a licensed physical therapist acting within the scope of his or her practice under Ohio law who holds a current, valid license to practice physical therapy issued under Chapter 4755. of the Revised Code.

(b) Qualified practitioners who can deliver the services:

(i) Licensed physical therapist who holds a current, valid license to practice physical therapy issued under Chapter 4755. of the Revised Code, who is employed or contracted with the MSP provider, and who is acting within the scope of his or her practice under Ohio law.

(ii) Licensed physical therapist assistant who holds a current, valid license issued under Chapter 4755. of the Revised Code, who is employed or contracted with the MSP provider, who is acting within the scope of his or her practice under Ohio law, and who is practicing under the general supervision of a licensed physical therapist employed or contracted by the MSP provider.

(c) Allowable activities include:

(i) Evaluation and re-evaluation to determine the current level of physical functioning of the eligible child and to identify appropriate therapeutic interventions to address the findings of the evaluation/re-evaluation.

(ii) Therapy, with or without assistive devices, for the purpose of preventing, correcting or alleviating the impairment of the eligible child.

(iii) Application and instruction in the use of orthotic and prosthetic devices, and other equipment to accomplish the goal of therapy in accordance with paragraph (B)(2)(c)(ii) of this rule.

(3) Speech-language pathology services

(a) Description: services that are planned, directed, supervised and conducted for individuals or groups of individuals who have or are suspected of having disorders of communication. The application of principles, methods, or procedures related to the development and disorders of human communication can include identification, evaluation, and treatment. The speech-language pathology service shall be recommended by a licensed speech-language pathologist acting within the scope of his or her practice under Ohio law who holds a current, valid license to practice speech-language pathology issued under Chapter 4753. of the Revised Code.

(b) Qualified practitioners who can deliver the services:

(i) Licensed speech-language pathologist who holds a current, valid license to practice speech-language pathology issued under Chapter 4753. of the Revised Code, who is employed or contracted with the MSP provider, and who is acting within the scope of his or her practice under Ohio law.

- (ii) Licensed speech-language pathology aide who holds a current, valid license issued under Chapter 4753. of the Revised Code, who is employed or contracted with the MSP provider, who is acting within the scope of his or her practice under Ohio law, and who is practicing under the direct supervision of the licensed speech-language pathologist who completed, signed and submitted to the Ohio board of speech-language pathology and audiology the speech-language pathology aide plan. The supervising speech-language pathologist shall be employed or contracted by the MSP provider.
- (c) Allowable activities include:
 - (i) Evaluation and re-evaluation to determine the current level of speech-language of the eligible child and to identify the appropriate speech-language treatment to address the findings of the evaluation/re-evaluation.
 - (ii) Therapy, with or without assistive devices, for the purpose of preventing, correcting or alleviating the impairment of the eligible child.
 - (iii) Application and instruction in the use of assistive devices.
- (4) Audiology services
 - (a) Description: hearing exams and diagnostic tests requiring the application of principles, methods, or procedures related to hearing and the disorders of hearing. Services provided for the purpose of maintenance or habilitation are not allowable. The audiology service shall be recommended by a licensed audiologist acting within the scope of his or her practice under Ohio law who holds a current, valid license to practice audiology issued under Chapter 4753. of the Revised Code.
 - (b) Qualified practitioners who can deliver the services:
 - (i) Licensed audiologist who holds a current, valid license to practice audiology issued under Chapter 4753. of the Revised Code, who is employed or contracted with the MSP provider, and who is acting within the scope of his or her practice under Ohio law.
 - (ii) Licensed audiology aide holds a current, valid license issued under Chapter 4753. of the Revised Code, who is employed or contracted with the MSP provider, who is acting within the scope of his or her practice under Ohio law, and who is practicing under the direct supervision of the licensed audiologist who completed, signed and submitted to the Ohio board of speech-language pathology and audiology the audiology aide plan. The supervising audiologist shall be employed or contracted by the MSP provider.
 - (c) Allowable activities include:
 - (i) Evaluation and re-evaluation to determine the current level of hearing of the eligible child and to identify the appropriate audiology treatment to address the findings of the evaluation/re-evaluation.
- (5) Nursing services

(a) Description: services from a registered nurse that provides to individuals and groups nursing care as defined in Chapter 4723. of the Revised Code. And, services from a licensed practical nurse that provides to individuals and groups nursing care as defined in Chapter 4723. Revised Code. The nursing service, with the exception of evaluations and assessments, shall be prescribed by a medicaid authorized prescriber acting within the scope of his or her practice under Ohio law who holds a current, valid license.

(b) Qualified practitioners who may deliver the services:

(i) Licensed registered nurse who holds a current, valid license issued under Chapter 4723. of the Revised Code, who is employed or contracted with the MSP provider, and who is acting within the scope of his or her practice under Ohio law.

(ii) Licensed practical nurse who holds a current, valid license issued under Chapter 4723. of the Revised Code, who is employed or contracted with the MSP provider, who is practicing at the direction of a medicaid authorized prescriber, and who is acting within the scope of his or her practice under Ohio law.

(c) Allowable activities include:

(i) Assessment/evaluation to determine the current health status of the eligible child in order to identify and facilitate provision of appropriate nursing treatment to address the findings of the assessment/evaluation.

(ii) Administering medications prescribed by a medicaid authorized prescriber.

(iii) The implementation of medical/nursing procedures/treatments prescribed by a medicaid authorized prescriber for the medicaid eligible child, which may include tube feeds, bowel and bladder care, colostomy care, catheterizations, respiratory treatment, and any other services that are prescribed by a medicaid authorized prescriber.

(6) Mental health services

(a) Description:

(i) Counseling services rendered to an individual or group and involves the application of clinical counseling principles, methods, or procedures to assist individuals in achieving more effective personal or social development and adjustment, including the diagnosis and treatment of mental and emotional disorders;

(ii) Social work services that involve the application of specialized knowledge of human development and behavior and social, economic, and cultural systems in directly assisting individuals, families, and groups in a clinical setting to improve or restore their capacity for social functioning, including counseling, the use of psychosocial interventions, and the use of social psychotherapy, which includes the diagnosis and treatment of mental and emotional disorders; and

(iii) Psychology services that are the application of psychological procedures to assess, diagnose, prevent, treat, or ameliorate psychological problems or emotional or mental disorders of individuals or groups; or to assess or improve psychological

adjustment or functioning of individuals or groups, whether or not there is a diagnosable pre-existing psychological problem.

(b) Qualified practitioners who can deliver the services:

(i) Licensed clinical counselor, licensed counselor who holds a current, valid license to practice professional counseling issued under Chapter 4757. of the Revised Code, who is employed by or contracted with the MSP provider, and who is acting within the scope of his or her practice under Ohio law;

(ii) Licensed independent social worker, or licensed social worker who holds a current, valid license to practice social work issued under Chapter 4757. of the Revised Code, who is employed by or contracted with the MSP provider, and who is acting within the scope of his or her practice under Ohio law;

(iii) Licensed psychologist or a licensed school psychologist who holds a current, valid license to practice psychology issued under Chapter 4732. of the Revised Code, or to practice school psychology issued under Chapter 4732. of the Revised Code or under rule 3301-24-05 of the Administrative Code who is employed or contracted with the MSP provider, and who is acting within the scope of his or her practice under Ohio law.

(c) Allowable activities include:

(i) Diagnosis and rehabilitative treatment of mental and emotional disorders performed by a licensed independent social worker, licensed social worker, professional counselor, or professional clinical counselor acting within his or her scope of practice under Ohio law.

(ii) Assessment and diagnostic services performed by a licensed psychologist or a licensed school psychologist acting within his or her scope of practice under Ohio law to determine the current psychological condition of the eligible child and to identify appropriate psychological treatment and/or therapy for the eligible child to address the findings of the assessment/diagnosis.

(iii) Psychological and neuropsychological testing when performed to assist in determining the possible presence of a psychological or neuropsychological disorder.

(iv) Rehabilitative treatment using psychological procedures for the purpose of treating, correcting or alleviating the mental and emotional impairment of the eligible child.

(d) Unallowable activities include sensitivity training, sexual competency training, educational activities (including testing and diagnosis - this does not include initial assessments nor re-assessment as indicated in paragraph (B)(7) of this rule), monitoring activities of daily living, recreational therapies, teaching grooming skills, sensory stimulation, teaching social interaction/diversion skills, crisis intervention not included in an eligible child's individualized educational program (IEP), and family therapy that is not as a direct benefit to the eligible child.

(7) Assessments/Evaluations

(a) Description: the initial assessment/evaluation that is part of the multi-factored evaluation or MFE (reimbursement is limited to one per continuous twelve month period per child unless prior authorization is obtained) conducted for an eligible child without an IEP or conducted for a two year old child with a disability to determine whether or not an IEP is appropriate. The assessment/evaluation shall include recommendation for service (amount, frequency, and duration), and shall be signed by the qualified practitioner who conducted the assessment/evaluation. Reimbursement is not available for the development of the IEP.

(b) Description: the re-assessment/re-evaluation conducted thereafter and identified in the eligible child's IEP (reimbursement is limited to one per continuous six month period per child unless prior authorization is obtained). The re-assessment/re-evaluation shall include recommendation for service (amount, frequency, and duration) and be signed by the qualified practitioner who conducted the re-assessment/re-evaluation. Reimbursement is not available for the development of the IEP.

(c) Qualified practitioners who may deliver the initial assessment/evaluation, or re-assessment/re-evaluation services: one of the qualified practitioners identified in paragraphs (B)(1) to (B)(6) of this rule who holds a current, valid license, who is employed or contracted with the MSP provider, and who is acting within the scope of his or her practice under Ohio law.

(C) Although the following list is not all-inclusive, the following are not allowable:

- (1) Development of the IEP.
- (2) Services provided for the purpose of maintenance or habilitation.
- (3) Services and activities that go beyond the recommendation of the qualified practitioner conducting the assessment/evaluation, re-assessment/re-evaluation and therefore are provided solely for the purpose of education, special education or special instruction.
- (4) Health/medical screens, including mass screens provided to an eligible child with an IEP.
- (5) Counseling parents and teachers regarding hearing loss.
- (6) In-services.
- (7) Fittings for amplification devices, and equipment troubleshooting and/or repair.
- (8) Nursing services provided as a part of immunizations process.
- (9) Instruction on self-care that does not require the expertise of the licensed practitioner.
- (10) Services provided to a child who does not have an IEP with the exception of the initial assessment/evaluation as described in paragraph (B)(7) of this rule.
- (11) Services not indicated in an eligible child's IEP prior to the provision of the service with the exception of the initial assessment/evaluation as described in paragraph (B)(7) of this rule.

(12) Services provided to a child who does not have a disability and a need for special education and related services with the exception of the initial assessment/evaluation as described in paragraph (B)(7) of this rule.

(13) Services provided on days or at times when the eligible child is not in attendance in the IEP designated school setting.

(14) Services that are not provided under the appropriate supervision and/or at the appropriate direction of a licensed practitioner of the healing arts.

(15) Services provided by a non-licensed person.

(16) Services for which an eligible child fails to show progress toward IEP identified goals over two consecutive three-month periods and there is no documentation that the methods and/or techniques applied have been modified to improve progress.

(17) Services provided as a part of the eligible child's waiver services, or as a part of services through an intermediate care facility for the mentally retarded or of a nursing facility.

(18) Services and activities that are not a direct benefit to the eligible child.

(D) In accordance with rule 5101:3-1-01 of the Administrative Code, the services provided shall be medically necessary and the type, frequency, scope and duration of the services shall fall within the normal range of services considered under acceptable standards of medical and healing arts professional practice, as appropriate.

(E) The services provided are of such level of complexity and sophistication, or the condition of the patient is such that the service can be safely and effectively performed only by or under the supervision of a licensed practitioner as indicated in this rule.

(F) The services provided shall be listed in a plan of care that is included in the eligible child's IEP. The plan of care shall:

(1) Be based on the initial assessment/evaluation conducted during the multi-factored evaluation or the subsequent assessments/evaluations and re-assessments/re-evaluations.

(2) Be signed by the qualified practitioner who recommends the service as a result of the assessment/evaluation, re-assessment/re-evaluation.

(3) Include specific services to be used, and the amount, duration and frequency of each service.

(4) Include specific goals to be achieved as a result of service provided, including the level or degree of improvement expected.

(5) For nursing services, reference and identify the location of the prescription of a physician, and for medications, reference and identify the location of the prescription of a physician or an advanced practice nurse with certification to prescribe in accordance with Ohio law.

(6) Specify timelines for re-assessment/re-evaluation, which should be no more than twelve-months from the date of the initial assessment/evaluation, of the eligible child and updates to the plan of care/IEP.

(G) The documentation for the provision of each service shall be maintained for purposes of supporting the delivery of the service and to provide an audit trail. Documentation shall include:

- (1) The date (i.e., day, month, and year) that the activity was provided.
- (2) The full legal name of the child for whom the activity was provided.
- (3) A description of the service, procedure, and method provided, as well as the location where the service is delivered (may be in case notes or a coded system with a corresponding key).
- (4) Group size if the service was provided to more than one individual during the service delivery time.
- (5) The duration in minutes or time in/time out of the activity provided. Duration in minutes is acceptable if the schedule of the person delivering the service is maintained on file.
- (6) A description of the actual progress demonstrated by the eligible child toward the stated goals outlined in the plan of care for each continuous three-month reporting period.
- (7) The signature or initials of the person delivering the service on each entry of service delivery. Each documentation recording sheet shall contain a legend that indicates the name (typed or printed), title, signature, and initials of the person delivering the service to correspond with each entry's identifying signature or initials.
- (8) Evidence in either the child's case file or a separate supervision log that the appropriate supervision was provided.
- (9) A description of efforts made to coordinate services with the eligible child's medical home in accordance with the medicaid provider agreement.

(H) The claims for reimbursement for services shall be submitted in accordance with rule 5101:3-35-04 of the Administrative Code.

Replaces: 5101:3-35-05 Effective: R.C. 119.032 review dates: Certification Date Promulgated Under: 119.03 Statutory Authority: 5111.02 Rule Amplifies: 5111.02 Prior Effective Dates: 11/26/2008 (Emer.)

5101:3-35-06 Other Services, Medical Supplies and Equipment Authorized for Medicaid Coverage that can be Provided by Medicaid School Program (MSP) Providers

[CATL-EDU 09-01](#)

Effective Date: March 2, 2009

(A) The purpose of this rule is to set forth the services authorized for medicaid coverage, beyond those indicated in rule 5101:3-35-05 of the Administrative Code, that a MSP provider can provide, and to set forth the conditions for providing the services.

(B) In addition to the services indicated in rule 5101:3-35-05 of the Administrative Code, a MSP provider may provide the following:

(1) Specialized medical transportation services:

(a) Description: the transportation service, not reimbursed through other medicaid programs, and that is provided in accordance with the requirements for ambulette services in rule 5101:3-15-02 of the Administrative Code. The transportation service shall be provided through use of a specially adapted vehicle to transport a medicaid eligible child to and from the medicaid school provider to receive medically necessary medicaid services allowable under section 1905(a) of the Social Security Act.

(b) Qualified practitioners who can deliver the services: MSP providers using a vehicle adapted to serve the needs of the disabled, including a specially adapted school bus.

(c) The service unit will be per trip.

(d) Unallowable: transportation that is provided in a vehicle that has not been specially adapted to transport an eligible child with a disability, transportation that is not indicated in an eligible child's individualized education program (IEP), and transportation provided from home to school and from school to home is unallowable.

(2) Targeted case management services (TCM):

(a) Description: assessment, care planning, referral and linkage, monitoring and follow-up activities specified in an eligible child's IEP that will assist the eligible child in gaining access to medical, social, educational and other needed services. The amount, frequency, and duration of the case management services, as well as the case manager responsible for providing the case management service, shall be indicated in the eligible child's IEP.

(b) Qualified practitioners who may deliver the services:

(i) A licensed registered nurse who holds a current, valid license issued under section 4723.09 of the Revised Code, and who is employed or contracted with the MSP provider.

(ii) An individual with a baccalaureate degree with a major in education or social work, and who is employed or contracted with the MSP provider.

(iii) An individual who has earned credit in course work equivalent to that required for a major in a specific special education area, and who is employed or contracted with the MSP provider.

- (iv) A person who is employed or contracted with the MSP provider, and who has a minimum of three years personal experience in the direct care of an individual with special needs.
- (c) The service unit will be fifteen minutes.
- (d) Targeted case management shall be billed on a separate claim from all other services. If it is billed on a claim with other services, the targeted case management claim will be denied. This is strictly a billing issue and does not effect the provision of services.
- (e) Activities under targeted case management are:
 - (i) Assessment: for an eligible child with an IEP, ensuring the prescription, by a medicaid authorized prescriber for services for which medicaid reimbursement shall be sought, is in the eligible child's case file; gathering of comprehensive information concerning the eligible child's preferences, personal goals, needs, abilities, health status and other available supports; determining the eligible child's need for case management; obtaining agreement from the eligible child and/or parent/legal guardian, whichever is appropriate, to allow the provision of case management; making arrangements to obtain from therapists and appropriately qualified persons the initial and on-going evaluation of the eligible child's need for any medical, educational, social, and other services.
 - (ii) Care planning: for an eligible child with an IEP, ensuring the active participation of the eligible child and the eligible child's parent/legal guardian and family; working with the eligible child's IEP team to develop the IEP goals and course of action to respond to the assessed needs of the eligible child; coordinating with the eligible child's medical home.
 - (iii) Referral and linkage: connecting an eligible child with an IEP to individuals capable of providing needed medical, social, educational and other needed services.
 - (iv) Monitoring and follow-up: ensuring that the IEP is effectively implemented and adequately addresses the needs of the eligible child; conducting quality assurance reviews on behalf of the eligible child and incorporating the results of quality assurance reviews into amendments of the IEP; reviewing the progress toward goals in the IEP and making recommendation for assessment as appropriate based upon progress reviews; ensuring that services are provided in accordance with the IEP and that IEP services are effectively coordinated through communication with service providers, including the medical home.
- (f) Although the following list is not all-inclusive, the following activities are not allowable as targeted case management through an MSP provider:
 - (i) Providing medical, educational, vocational, transportation, or social services to which the eligible individual has been referred.
 - (ii) Providing the direct delivery of foster care services.
 - (iii) Providing services to an eligible child who has been determined to not have a developmental disability according to section 5123.01 of the Revised Code.

- (iv) Providing services to an eligible child who is on a waiver program receiving targeted case management from county boards of mental retardation and development disabilities (CBMRDD).
- (v) Conducting quality assurance systems reviews.
- (vi) Conducting activities related to the development, monitoring or implementation of an individual service plan (ISP) for an eligible child on a waiver.
- (vii) Performing activities for or providing services to groups of individuals.
- (viii) Activities performed and services provided by someone who is not an employee of or contracted with an MSP provider to provide targeted case management.
- (ix) Activities performed and services provided by someone who is not the case manager specified in the eligible child's IEP.
- (x) Providing services for which claims are submitted through or should have been submitted through another program.

(3) Medical supplies and equipment:

- (a) Supplies and equipment that are medically necessary as described in rule 5101:3-1-01 of the Administrative Code for the care and treatment of a medicaid eligible child with an IEP while attending school and that are necessary for the qualified practitioner, as described in rule 5101:3-35-05 of the Administrative Code, to perform his or her function for an eligible child.
- (b) Claim for the cost of medical supplies and equipment are reimbursed through the cost reporting process in accordance with paragraph (J)(2) of rule 5101:3-35-04 of the Administrative Code.
- (c) Unallowable: supplies and equipment furnished to a medicaid eligible child for use outside the school. In order to be reimbursed for supplies and equipment furnished to an eligible child for use outside the school, the school shall be approved under the medicaid program as a medical supplies provider. See Chapter 5101:3-10 of the Administrative Code for coverage, limitation, billing, and reimbursement provisions relative to medical supplies providers.
- (d) Claims cannot be submitted for medical supplies and equipment for which a claim was submitted or should have been submitted through another program.

(C) The service provided shall be necessary to enable the recipient to access medically necessary services of the type, frequency, scope and duration that fall within the normal range of services considered under acceptable standards of medical and healing arts professional practice, as appropriate, in accordance with rule 5101:3-1-01 of the Administrative Code.

(D) The services provided shall be listed in a plan of care that is part of the eligible child's IEP. The plan of care shall:

- (1) Be based on the initial assessment/evaluation conducted during the multi-factored evaluation or the subsequent assessments/evaluations and re-assessments/re-evaluations.

- (2) Be signed by the qualified practitioner who recommends the service as a result of the assessment/evaluation, re-assessment/re-evaluation.
- (3) Include specific services to be provided, and the amount, duration and frequency of each service.
- (4) Include specific goals to be achieved for each service.
- (5) Include the prescription for services by the medicaid authorized prescriber, as applicable.
- (6) Specify timelines for re-assessment/re-evaluation of the eligible child and updates to the plan of care.

(E) The documentation for the provision of each service shall be maintained for purposes of an audit trail. Documentation shall include:

- (1) The date (i.e., day, month, and year) that the services, medical supplies and/or equipment were provided.
- (2) The full legal name of the child for whom the services, medical supplies and/or equipment was provided.
- (3) A description of the services, medical supplies and/or equipment provided and location where the services, medical supplies and/or equipment are delivered (may be in case notes or a coded system with a corresponding key).
- (4) The duration in minutes or time in/time out of the transportation and/or targeted case management service provided. Duration in minutes is acceptable if the schedule of the person delivering the service is maintained on file.
- (5) A description of actual progress the eligible child is making/has made toward the stated goals in the plan of care for each continuous three-month reporting period.
- (6) The signature or initials of the person delivering the services, medical supplies and/or equipment on each entry of services, medical supplies and/or equipment delivery. Each documentation recording sheet shall contain a legend that indicates the name (typed or printed), title, signature, and initials of the person delivering the services, medical supplies and/or equipment to correspond with each entry's identifying signature or initials.
- (7) A description of efforts made to coordinate services with the eligible child's medical home in accordance with the medicaid provider agreement.

(F) The claims for reimbursement for services shall be submitted in accordance with rule 5101:3-35-04 of the Administrative Code.

Replaces: 5101:3-35-06 Effective: R.C. 119.032 review dates: Certification Date Promulgated Under: 119.03 Statutory Authority: 5111.02 Rule Amplifies: 5111.02 Prior Effective Dates: 11/26/2008 (Emer.)

Remittance Advice Information

Claims are adjudicated weekly by the department. Depending on your submission activity you will receive remittance advice information as often as weekly. If you submit claims less often, you will receive remittance advice information only as the claims are adjudicated. Please use your remittance advice information to post your claim payment information to your patients' accounts.

The remittance advice often includes notifications concerning policies or procedure changes at the beginning of the remittance advice. The claim information is organized by paid claims, denied claims, Medicare/Medicaid Crossover claims, etc. Make sure when you review the remittance advice that you take note of the section that you are reviewing.

When a claim is denied, review the CAS and Remark Codes shown at the end of the remittance advice to determine what is in error on your claim. When this information can be corrected, resubmit the corrected claim. The department keeps records of denied claims but denied claim information will not affect any future submission of claims. You may resubmit your corrected claim at any time. No time has to lapse after a claim is denied before you are able to resubmit.

When claims are denied because there is an exact duplicate or a possible duplicate, we will give you reference information near the end of the remittance advice. The claim that is being denied will show a 3 digit reference number at the end of the line on the right side. This reference number will be shown at the beginning of the reference information. Please see an example of this portion of the remittance advice Information shown below.

LISTED BELOW ARE PAID CLAIMS THAT CAUSED THE REFERENCED LINES (PD REF) ABOVE TO BE DENIED AS DUPLICATES							
REF	TCN	CLAIM TYPE	TYPE OF BILL	COVERED-DATES	CHARGE	ALLOWED CHARGE	DATE PAID
001	7-05258-00-029-0000-30	P	L	07/01/XX 07/25/XX	8,425.33	5634.15	10/26/XX
002	7-05258-00-029-0001-31	P	L	07/11/XX 07/13/XX	2,522.15	1299.03	00/00/00

The reference information will show the original transaction control number of the paid claim, the claim type, the type of bill, the covered dates, the full charge, the amount the department allowed, and the date of the payment/remittance advice. When the Date Paid shows zeros, two claims entered the system for adjudication during the same week. Both claims will appear on your remittance, both may be denied or one may pay and the other deny. When both claims deny, resubmit the claim making sure that it is submitted only once during that adjudication period (week, running from Wednesday through Tuesday).

Transaction Control Number (TCN)

Claim
Input
Medium

7

Batch
Date
Julian Date

09045

Destination/
Location
Code

02

Batch
Number

700

Document
Number

0033

Claim
Number

00

- 0 - Exam Entry (Keyed in-house)
- 1 - Key Entry (Contractors)
- 2 - Tape for the 6780, along with Medicare/Medicaid Crossovers
- 4 - Computer Generated Credit or Adjustment
- 5 - Exam Entry (Keyed in-house) for the CMS 1500, ADA, and UB92 forms
- 6 - Key Entry (Contractors) for the CMS 1500, ADA, and UB 92 forms
- 7 - Electronic Data Interchange (EDI) or Tape (sister agencies only) for the CMS 1500, ADA, and UB92
- 8 - Encounter Data (Managed Health Care only)
- 9 - Computer Generated Credit or Adjustment

Ohio Medicaid Allowed Charge Source Codes

These codes indicate how each allowed charge was determined.
Codes can be found on the remittance advice by the amounts.

Code	Definition	Code	Definition
A	Manually Priced	R	Mental Health Per Diem Rate
B	By Report	S	DRG Per Diem Rate
C	Maximum Fee	T	No Pay
D	Inpatient % of Charges	U	DRG Normal
E	Home Health Revenue Code	V	DRG High Day
F	Diagnosis Related Group	W	DRG High Cost
G	Billed Charge	X	DRG Transfer
H	Outpatient % of Charges	Y	DRG Check Not Approved
I	Medicare Coinsurance/ Deductible	Z	Prior Authorization
J	Encounter Code	1	In-Office Surgery
K	Denied	2	Outpatient Surgery
L	Capitation Rate	3	Ambulatory Surgery Center
M	Outpatient Lab Maximum Fee	4	Reduced Not to Exceed Limit
N	Negotiated Rate	5	Limit by Units of Service
O	DRG File	6	Outpatient Drug Exception
P	Drug File	7	Outpatient Roll In
Q	Nursing Home Per Diem Rate	8	Outpatient Procedure % of Payment

**OHIO DEPARTMENT OF JOB AND FAMILY SERVICES
PRIOR AUTHORIZATION
Type or Print Legibly**

State Use Only
Prior Authorization Control Number

Check type of Medical Card: **D** Medicaid **D** Disability Assistance (DA) **D** OMB **D** Other _____

The Provider is responsible for verifying client eligibility at the date of service by viewing the client's Medical Card

Provider Information

Provider Number 	Date Form Completed
Provider Name	
Street Address	
City, State and Zip Code	
Provider Telephone Number and Ext. () ()	Provider Fax Number () ()
Contact Person	

Client Information

Billing Number 		
Client's Last Name	First Name	
Street Address/Facility Name and Address		
City and Zip Code	County	
Client Resides: DLTC Facility	D MRDD Facility	Date of Birth
D Personal Residence	D Other, specify _____	/ /

Attach Prescription/Certification signed by the appropriate physician or practitioner including the complete diagnosis medical history, degree of impairment, and medical necessity. Give complete description of service or item (including make, model, serial number, freight charges and NOC code.) Attach any additional supportive information.

REQUESTED SERVICES

Quantity	Procedure Code	Usual and Customary Charge
----------	----------------	----------------------------

- 2
- 3
- 4
- 5
- 6

- 1. _____ 4. _____
- 2. _____ 5. _____
- 3. _____ 6. _____

SERVICE/RENTAL DATES
D No Previous Service
Previous Service/Rental Dates (inclusive) FROM: TO
This Request-Service/Rental Dates FROM: TO:
Dispense Date

Notes:

STATE USE ONLY - DO NOT COMPLETE SECTIONS BELOW

Quantity	Code	Approved Dollar Amount	Reason Code	Override Code
1				
2				
3				
4				
5				
6				

Line No.

Comments

_____	Reviewer
_____	Date

Submit to Ohio Department of Job and Family Service, Medical Operations Section P.O. Box 1002, Columbus, Ohio 43216-0002. Do not send claim with this form. Approved prior authorization is **contingent upon eligibility** of client at the time of service and the department's claim and prior authorization filing limitations. Completion of this form is required by rule 5101 :3-1-31 of the Ohio Administrative Code for provider to be eligible for reimbursement of Medicaid Services requiring prior authorization.

**OHIO DEPARTMENT OF JOB AND FAMILY SERVICES
 PROVIDER NETWORK MANAGEMENT SECTION
 MEDICAL CLAIM REVIEW REQUEST FORM**

INSTRUCTIONS TO COMPLETE THIS FORM ARE ON THE REVERSE SIDE.

1. PROVIDER INFORMATION
Provider Name _____ Address _____ City _____ State _____ Zip _____ Contact Person _____

2. SUBMISSION DATE OF THIS FORM ____/____/____
Individual Provider# _____
Group Provider# _____ (When appropriate)
Telephone # (____) - _____

3. CLAIM INQUIRY INFORMATION
Recipient Name _____ Billing #(12digits) _____ Service Date _____ or Discharge Date _____

4. CLAIM HISTORY INFORMATION
Transaction Control Numbers
TCN _____
TCN _____
TCN _____
<i>Please note: All transaction control #s are 17 digits</i>

5. Please enter all applicable Medicaid E.O.B. denial codes, which apply to the attached claim. EOB _____ EOB _____ EOB _____ EOB _____

(Please include all necessary documentation, e.g. remittance advices, Medicare and/or Insurance EOBs).

6. Explanation of request: _____

<i>Internal Use Only</i>
Date of Receipt Stamp

ODJFS USE ONLY	9 Claim not approved for processing, please see the attached letter. _____ _____ _____
Reviewer ID _____	

**Each claim requires a separate JFS 06653 Medical Claim Review Request Form
 Please call our Interactive Voice Response Unit (IVR) at 1-800-686-1516 for claim status verification.**

Instructions for completing this form: This form is not to be used for routine claim submission and/or to request an adjustment to a paid claim. Complete the JFS 06653 Medical Claim Review Request Form (Sections 1, 2, 3, 4, 5, AND 6) when submitting an unpaid claim with a service date of more than one year due to one of the following reasons:

- A delay due to an administrative hearing decision by the Department of Job and Family Services
- A delay in eligibility determination by a county department of job and family services
- Coordination of benefits with Medicare and/or a third party payer

A claim form must be attached to the JFS 06653 Medical Claim Review Request Form, for review and processing purposes. Please include information to document your previous claim submission or the event which delayed your claim submission such as a county letter demonstrating a delay in eligibility and/or a third party payer or Medicare explanation of benefits.

A written response to the JFS 06653 Medical Claim Review Request Form will not be provided when the claim is approved and forwarded for processing. A written response to the JFS 06653 Medical Review Request Form will be provided for those claims which are returned to the provider as not approved for processing.

Please mail the completed JFS 06653 Medical Claim Review Request Form to: ODJFS Provider Network Management Section, P.O. Box 1461, Columbus, Ohio, 43216-1461. For your convenience the JFS 06653 Medical Claim Review Request Form can be downloaded from our web site at www.state.oh.us/scripts/odjfs/forms or ordered from the Document Development Section, Warehouse Services Unit at 2098 Integrity Drive North, Columbus, Ohio 43209.

- 1. Provider Information:** Enter the provider's name, street address, city, state, and zip code and contact person.
- 2. Submission date to ODJFS:** Enter the date, the 06653 Medical Claim Review Request Form is being submitted to the department. Enter the numerical seven digit Ohio Medicaid individual provider number, and the numerical seven digit Ohio Medicaid group provider number, when appropriate, and phone number including the area code.
- 3. Claim Inquiry Information:** Enter the recipient name, the 12 digit billing number, and the service or discharge date.
- 4. Claims History Information:** Enter **each** of the 17 digit transaction control number(s) (TCN) along with the remittance advice for the claim review requested. Timely filing and timely resubmission of your claim will assist the department with the review of your claim.
- 5. EOB Code Information:** Enter the Explanation of Benefits (EOB) codes from the department's remittance advice that pertain to the claim.
- 6. Explanation of Request:** Enter an explanation why you are requesting a review of this claim.

IMPORTANT INFORMATION!

Briefly this rule states: *Your initial claim submission must comply with Ohio Administrative Code, Rule 5101:3-1-19.3. Initial claims must be received by the department within three-hundred-sixty-five days of the date the service was provided, or from the date of discharge. The date of receipt for purposes of this rule is the date the department receives a claim and assigns a transaction control number. Initial claims received beyond the three-hundred-sixty-five day time limit should not be processed for payment by the department unless the claim submittal is delayed due to the pendency of either an administrative hearing decision by the department or an eligibility determination by a county department of job and family services, or coordination of benefits with a third party payer or Medicare explanation of benefits. Consideration of payment will be made if the claim is received within one-hundred-eighty days of the date of the administrative decision by the department, eligibility determination by the county department of job and family services, or coordination of benefits with a third party payer or Medicare explanation of benefits.*