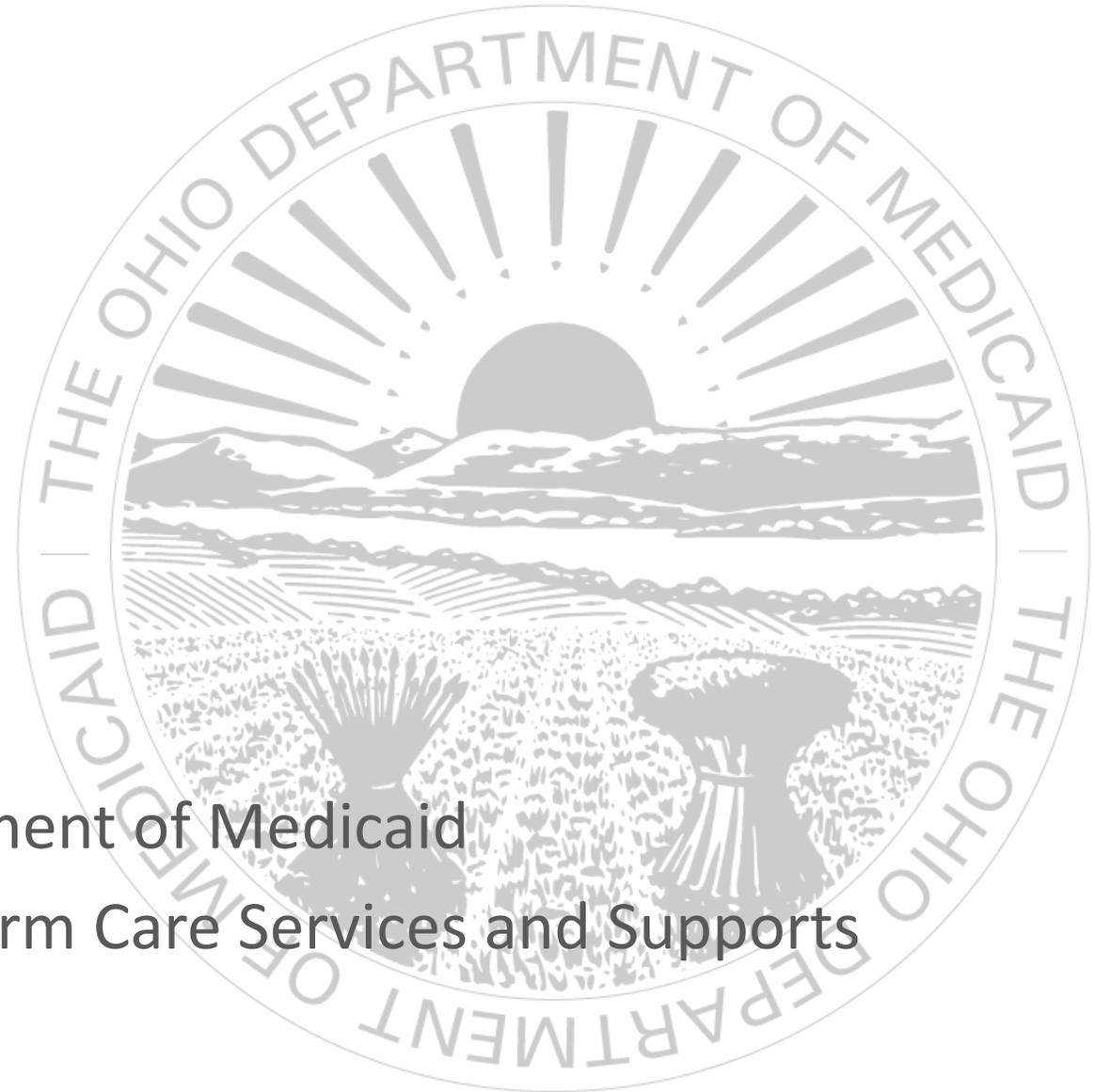


# Facility Communication (ODM 9401)

A presentation given by: Ohio Department of Medicaid  
Front Door Section, Bureau of Long-Term Care Services and Supports  
July 2016



*Making Ohio Better*

# ODM 9401 Changes for 8/1/2016

- Depending on the type of request and/or update, nursing facilities (NF) will submit the ODM 9401 to either:
  - » The PASSPORT Administrative Agency (PAA),
  - » The Ohio Department of Medicaid (ODM); or
  - » The County Department of Job and Family Services (CDJFS)
- Based on the request type, the NF will have to submit the form to more than one entity
- Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID) and Developmental Centers (DC) will submit the ODM 9401 to the CDJFS when completing Section IV (Resident Income Information)

# Current Form

# New Form

**Ohio Department of Medicaid  
FACILITY CDJFS TRANSMITTAL**

**Reset Form**

**Patient Information**

Patient Name (Last, First, MI) \_\_\_\_\_ CRISE Case No. \_\_\_\_\_  
 Medicaid Billing Number (12 digits) \_\_\_\_\_ Medicare Number \_\_\_\_\_  
 Authorized Representative or Contact Person \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Telephone \_\_\_\_\_

**Medical Benefits (Please attach a copy of both sides of benefits card [e.g., insurance, Worker's Compensation, Military, etc.]**

Name \_\_\_\_\_ Address \_\_\_\_\_  
 Policy Number \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Telephone \_\_\_\_\_

**Admission Information**      **Discharge Information**

Admission Date \_\_\_\_\_ Discharge Date \_\_\_\_\_  
 Admitted From  Home  NF  Hosp  RSS  Other  
 Managed Care      Begin Date \_\_\_\_\_ End Date \_\_\_\_\_      Type of Discharge  
 Medicaid      \_\_\_\_\_      \_\_\_\_\_       Transfer to NF  
 Medicare      \_\_\_\_\_      \_\_\_\_\_       Home       Death Date \_\_\_\_\_  
 Private Pay      \_\_\_\_\_      \_\_\_\_\_       Hospice       Assisted Living  
 Commercial Insurance      \_\_\_\_\_      \_\_\_\_\_       Hospital (Leave Days Exhausted)       Other \_\_\_\_\_  
 Short Term Stay      \_\_\_\_\_      \_\_\_\_\_

Name of Facility Patient Admitted to \_\_\_\_\_ Name of Facility Patient Discharged to \_\_\_\_\_  
 Address \_\_\_\_\_ Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_      City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Medicaid Provider Number (7-9 Digits) \_\_\_\_\_ Area Code and Telephone Number \_\_\_\_\_      Medicaid Provider Number (7-9 Digits) \_\_\_\_\_ Area Code and Telephone Number \_\_\_\_\_  
 NPI Number (10 digit) \_\_\_\_\_  
 Amount \$ \_\_\_\_\_ Effective Date of Change \_\_\_\_\_

**Patient Income Information:**  
 Change of Income (Attach Verification)      Check One  Increase  Decrease  
 Type of Lump Sum (e.g. Social Security, Railroad Retirement, Sale of Property, Insurance Payment) \_\_\_\_\_ Date Received \_\_\_\_\_  
 Patient's Personal Needs Account (PNA) \$ \_\_\_\_\_ as of Effective Date \_\_\_\_\_ (to be completed when appropriate-see instructions)  
 Facility Authorized Signature \_\_\_\_\_ Date \_\_\_\_\_

**County Information**

County Name \_\_\_\_\_ County Number \_\_\_\_\_  
 Medicaid (check all that apply)  Approved  Change  Denied  Closed      Begin Date \_\_\_\_\_ End Date \_\_\_\_\_  
 Medicaid  Room and Board Payment  Restricted Coverage  Managed Care      Begin Date \_\_\_\_\_ End Date \_\_\_\_\_

Patient Liability \$ \_\_\_\_\_ Begin Date \_\_\_\_\_ End Date \_\_\_\_\_  
 Patient Liability \$ \_\_\_\_\_ Begin Date \_\_\_\_\_ End Date \_\_\_\_\_  
 Patient Liability \$ \_\_\_\_\_ Begin Date \_\_\_\_\_ End Date \_\_\_\_\_      Level of Care has been completed  
 Yes  No

Type of Lump Sum: \_\_\_\_\_ Lump Sum \$ \_\_\_\_\_ Patient Liability \$ \_\_\_\_\_ Service Date Span \_\_\_\_\_ to \_\_\_\_\_  
 Qualified Medicare Beneficiary (QMB) Eligible?  No  Yes      Effective Date \_\_\_\_\_  
 State Hearing      Date of State of Hearing \_\_\_\_\_      Appeal Number \_\_\_\_\_

Comments \_\_\_\_\_

IM Worker Signature \_\_\_\_\_ Telephone Number \_\_\_\_\_ Date \_\_\_\_\_

Distribution: - Original to: Return to facility upon completion. Copy to: County Department of Job and Family Services, Nursing Home Section. Copy Retained by Facility.

**Ohio Department of Medicaid  
FACILITY COMMUNICATION**

**I. RESIDENT INFORMATION**

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Middle Initial \_\_\_\_\_  
 Medicaid Number (12 digits) \_\_\_\_\_ Social Security Number \_\_\_\_\_  
 If individual does not have a Medicaid Number, has a Medicaid application been submitted?  Yes (provide application date below)  No  Unknown      Application Date (mm/dd/yyyy) \_\_\_\_\_  
 Authorized Representative or Contact Person \_\_\_\_\_ Relationship to Resident \_\_\_\_\_  
 Address \_\_\_\_\_ Apartment/Unit Number \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Telephone Number \_\_\_\_\_

**II. FACILITY INFORMATION - ADMISSION**

Admission Date (mm/dd/yyyy) \_\_\_\_\_ Level of Care Validation Request?  Yes (if yes, select the type)  No      Type of Validation Request  
 Waiver  
 Readmission (same NF) after hospitalization  
 Facility Name \_\_\_\_\_ Medicaid Provider Number \_\_\_\_\_  
 Street Address \_\_\_\_\_ Building Number \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Facility Telephone Number \_\_\_\_\_

**III. FACILITY INFORMATION - UPDATE**

Date of Discharge (mm/dd/yyyy) \_\_\_\_\_ Has the individual changed facilities?  Yes (provide information on new facility below)  No  
 New Facility Name \_\_\_\_\_ New Facility Medicaid Provider Number \_\_\_\_\_  
 New Facility Telephone Number \_\_\_\_\_ New Facility PAA Region \_\_\_\_\_

**IV. RESIDENT INFORMATION - UPDATE**

Date of Death (mm/dd/yyyy) \_\_\_\_\_ Change of Income (attach verification)  Increase  Decrease      Amount \$ \_\_\_\_\_ Effective Date of Change (mm/dd/yyyy) \_\_\_\_\_  
 Type of Lump Sum (i.e. Social Security, Railroad Retirement, Sale of Property, Insurance Payment) \_\_\_\_\_ Date Lump Sum Received (mm/dd/yyyy) \_\_\_\_\_  
 Resident's Personal Needs Account (PNA) \$ \_\_\_\_\_ Effective date of PNA (mm/dd/yyyy) \_\_\_\_\_

**V. SUBMITTER INFORMATION**

Name (First and Last) \_\_\_\_\_ Date (mm/dd/yyyy) \_\_\_\_\_  
 Email Address \_\_\_\_\_ Telephone Number \_\_\_\_\_

**SUBMITTING THE FORM TO THE PAA AND ODM:**

- For any Fee-Far-Service NF stay of greater than 90 days or for a new Medicaid applicant, the NF shall submit the ODM 9401 to the PAA within their region.
- For any Fee-Far-Service Discharge, the NF shall submit the ODM 9401 to ODM via secure email to (NFStay@medicaid.ohio.gov) or FAX (614-466-6742). For faster processing, and if submitting via fax, NFs should ensure that the cover sheet indicates submission of an ODM 9401.

**SUBMITTING THE FORM TO THE CDJFS:**

- For any change in Resident Information (Section IV), the facility shall submit the ODM 9401 to the CDJFS (Nursing Home Section).

# Updated ODM 9401

- **Nursing facilities (NF) will submit the ODM 9401 when:**
  - » The NF stay is fee-for-service and greater than 90 days (or permanent)
  - » The NF resident (or authorized representative, family, guardian, etc.) is applying for Medicaid
  - » There has been a change in an individual's income or assets
- **Nursing facilities will NOT submit the ODM 9401 when:**
  - » The NF resident is on Medicaid Managed Care
  - » The NF stay is less than 90 days and the individual is already receiving Medicaid

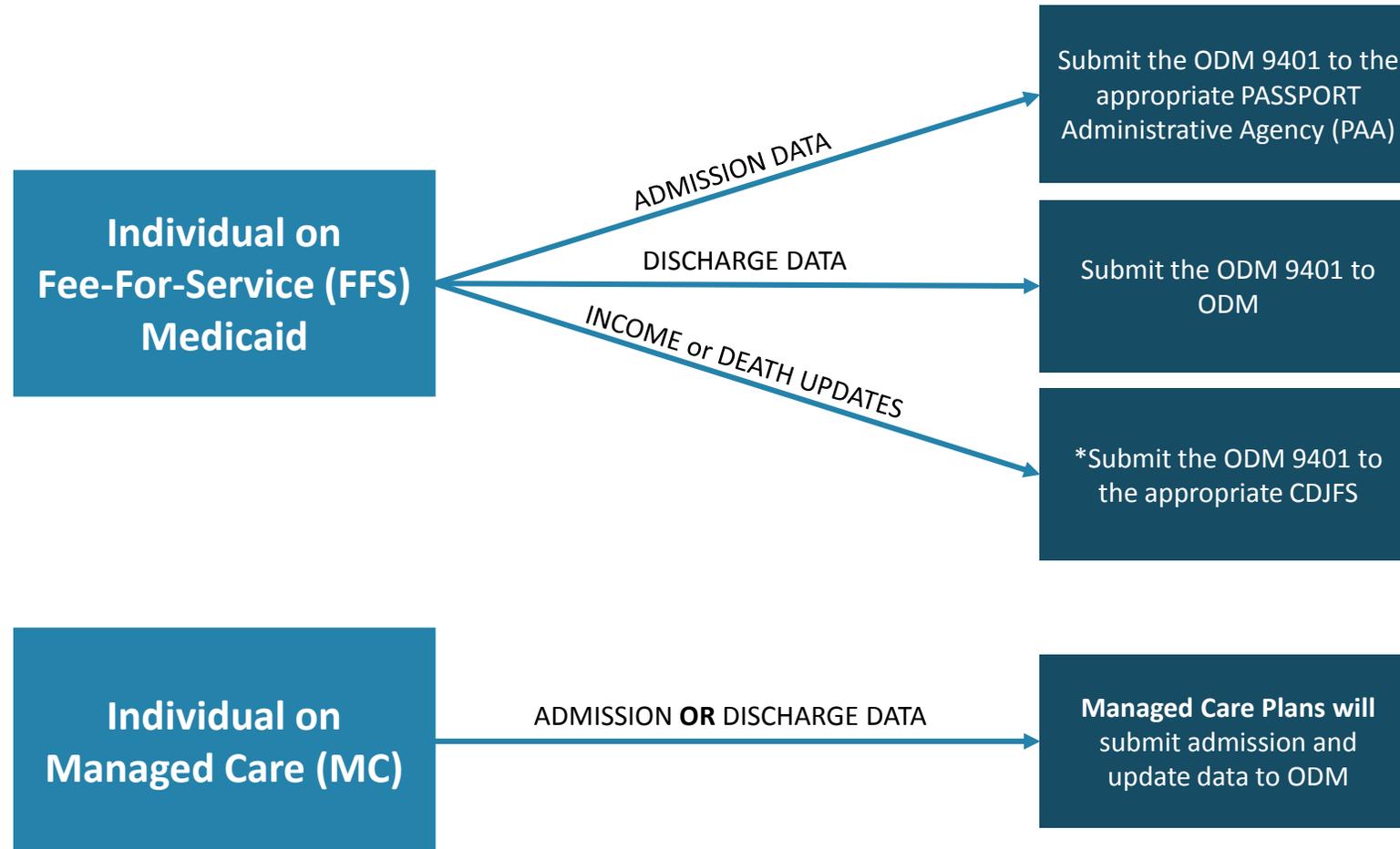
# Updated ODM 9401

- The updated form has six sections:
  - » I. Resident Information
  - » II. Facility Information – Admission
  - » III. Facility Information – Update
  - » IV. Resident Information – Update
  - » V. Submitter Information
  - » VI. County Information *(only to be completed by a CDJFS worker)*

# Updated ODM 9401

- The NF is required to submit the form to
  - » **The appropriate PAA** when the NF is completing the Admission section
  - » **To ODM** when the NF is completing the Update section (discharge or change of facility)
  - » **To the CDJFS** when the NF is completing the Resident Information section (including date of death)
- The NF does not submit the ODM 9401 for individuals enrolled in Managed Care
  - » The Managed Care Plans are required to communicate with ODM for individuals enrolled in a Managed Care Plan

# Basic NF Process Flow



\*Applies to ICFs-IID and Developmental Centers

# Resident Information

- Communicate basic information about the individual residing in the nursing facility and their authorized representative
- This section must always be completed

I. RESIDENT INFORMATION				
First Name		Last Name		Middle Initial
Medicaid Number (12 digits)			Social Security Number	
If individual does not have a Medicaid Number, has a Medicaid application been submitted? <input type="checkbox"/> Yes (provide application date below) <input type="checkbox"/> No <input type="checkbox"/> Unknown			Application Date (mm/dd/yyyy)	
Authorized Representative or Contact Person			Relationship to Resident	
Address			Apartment/Unit Number	
City	State		Zip Code	Telephone Number

# Facility Information - Admission

- Communicate NF admission data to the appropriate PAA when:
  - » An individual's NF stay has exceeded 90 days, or
  - » The individual is applying for Medicaid in order for Medicaid to pay for the NF stay (regardless of intended length of stay)
- NFs are able to indicate to the PAA on the ODM 9401 when the NF is requesting a LOC validation

II. FACILITY INFORMATION - ADMISSION			
Admission Date (mm/dd/yyyy)	Level of Care Validation Request? <input type="checkbox"/> Yes (if yes, select the type) <input type="checkbox"/> No	Type of Validation Request <input type="checkbox"/> Waiver <input type="checkbox"/> Readmission (same NF) after hospitalization	
Facility Name			Medicaid Provider Number
Street Address			Building Number
City	State	Zip Code	Facility Telephone Number

# Facility Information - Update

- Communicate information about the individual's NF stay to the Ohio Department of Medicaid including date of discharge and change of facility information

III. FACILITY INFORMATION - UPDATE	
Date of Discharge (mm/dd/yyyy)	Has the individual changed facilities? <input type="checkbox"/> Yes (provide information on new facility below) <input type="checkbox"/> No
New Facility Name	New Facility Medicaid Provider Number
New Facility Telephone Number	New Facility PAA Region

# Resident Information - Update

- Communicate date of death or change of income/asset information that may impact Medicaid eligibility or patient liability to the CDJFS
- Use this to request that the CDJFS re-run eligibility or patient liability calculation

IV. RESIDENT INFORMATION - UPDATE			
Date of Death (mm/dd/yyyy)	Change of Income (attach verification) <input type="checkbox"/> Increase <input type="checkbox"/> Decrease	Amount \$	Effective Date of Change (mm/dd/yyyy)
Type of Lump Sum (i.e. Social Security, Railroad Retirement, Sale of Property, Insurance Payment)			Date Lump Sum Received (mm/dd/yyyy)
Resident's Personal Needs Account (PNA) \$		Effective date of PNA (mm/dd/yyyy)	

# Submitter Information

- Communicate information about the individual submitting the form
- This section must always be completed

SUBMITTER INFORMATION	
<b>Name</b> <i>(First and Last)</i>	<b>Date</b> <i>(mm/dd/yyyy)</i>
<b>Email Address</b>	<b>Telephone Number</b>

# County Information

- This section will be completed by the CDJFS
- The CDJFS will return the form to the submitter with information regarding Medicaid status, type, patient liability and other information based on the income information submitted

The following information should be completed by the county department of job and family services and returned to the submitter.

VI. COUNTY INFORMATION		
<b>County Name</b>		<b>County Email Address</b>
<b>Medicaid Status</b> <input type="checkbox"/> Approved <input type="checkbox"/> Changed <input type="checkbox"/> Denied <input type="checkbox"/> Discontinued		<b>Status Begin Date (mm/dd/yyyy)</b>
		<b>Status End Date (mm/dd/yyyy)</b>
<b>Medicaid Type</b> <input type="checkbox"/> Medicaid <input type="checkbox"/> Restricted Medicaid Coverage Period <input type="checkbox"/> Managed Care		<b>Type Begin Date (mm/dd/yyyy)</b>
		<b>Type End Date (mm/dd/yyyy)</b>
<b>Patient Liability Amount</b> \$		<b>Begin Date (mm/dd/yyyy)</b> <b>End Date (mm/dd/yyyy)</b>
<b>Lump Sum Amount</b> \$	<b>Qualified Medicare Beneficiary (QMB) Eligible?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>QMB Effective Date (mm/dd/yyyy)</b>
<b>State Hearing?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Date of State Hearing (mm/dd/yyyy)</b>	<b>Appeal Number</b>
<b>Comments</b>		
<b>CDJFS Worker Signature</b>		<b>Telephone Number</b> <b>Date (mm/dd/yyyy)</b>

# Submitting the ODM 9401

- **SUBMITTING THE FORM TO THE PAA AND ODM:**

- » *For any Fee-For-Service NF stay of greater than 90 days or for a new Medicaid applicant, the NF shall submit the ODM 9401 to the PAA within their region.*
- » *For any Fee-For-Service Discharge, the NF shall submit the ODM 9401 to ODM via secure email to ([NFStay@medicaid.ohio.gov](mailto:NFStay@medicaid.ohio.gov)) or FAX (614-466-6945). For faster processing, and if submitting via fax, NFs should ensure that the cover sheet indicates submission of an ODM 9401.*

- **SUBMITTING THE FORM TO THE CDJFS:**

- » *For any change in Resident Information (Section IV), the facility shall submit the ODM 9401 to the CDJFS (Nursing Home Section).*

# Form Revision Process

- The updated form is currently in the ODM clearance process
  - » Public is able to make comments
  - » Form is posted on the ODM website with information about how to comment
- Once the form has gone through the clearance process, any updates will be made based on stakeholder feedback and public comment
- Finalized version of the form will be posted on ODM's website and will be effective on **August 1, 2016** when Ohio Benefits goes live

# What isn't changing?

- Preadmission Screening and Resident Review (PASRR) requirements are not changing with this updated form
  - » NF is still required to submit PAS and receive an approval prior to facility admission
- The process for a NF to submit a LOC request (ODM 3697 or alternative form) is not changing
  - » ODM 9401 can be used to request a LOC validation
- PAAs will continue to communicate Preadmission Review (PAR) results to the NFs as they do today
  - » NF should retain a copy of PAR results letter

**MAKING  
OHIO  
BETTER**

