

# General Information for Medicaid Providers Table of Contents

**John R. Kasich, Governor**

**John B. McCarthy, Director**

## Ohio Department of Medicaid

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### eManual Contents

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# Medicaid Handbook Transmittal Letters

# MHTL 3334-15-12 (General Medicaid Home and Community Based Service Rule Rescission)

## Medicaid Handbook Transmittal Letter (MHTL) No. 3334-15-12

April 24, 2015

TO: Eligible Providers of Medicaid Services  
Chief Executive Officers, Managed Care Plans (MCPs)

FROM: John B. McCarthy, Director

SUBJECT: General Medicaid Home and Community Based Service Rule Rescission

**Rule 5160-1-06**, "Home and community-based service waivers: general description," is being rescinded in order to streamline the rules found in Division 5160 of the Administrative Code, and because it is obsolete and no longer serves a functional purpose. Provisions within the rule will be moved to Administrative Code rules 5160-46-02 and 5160-50-02.

### Access to Rules and Related Material

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### Additional Information

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Ohio Department of Medicaid  
Bureau of Provider Services

P.O. Box 1461

Columbus, OH 43216-1461

Telephone (800) 686-1516

# MHTL 3334-15-11 (Limitations on Payments for Elective Obstetric Deliveries)

## Medicaid Handbook Transmittal Letter (MHTL) No. 3334-15-11

April 24, 2015

TO: Eligible Providers of Medicaid Services  
Chief Executive Officers, Managed Care Plans (MCPs)

FROM: John B. McCarthy, Director

SUBJECT: Limitations on payments for elective obstetric deliveries

### Summary

**Rule 5160-1-10**, "Limitations on elective obstetric deliveries," is being established to create coverage limitations for early elective obstetric deliveries.

Changes: This rule creates conditions under which Ohio Medicaid will make payment for early elective obstetric deliveries. The gestational age of the fetus must be at least 39 weeks, or maternal and/or fetal conditions must indicate medical necessity.

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# MHTL 3334-15-10 (Update to OAC 5160-1-60.2)

## Medicaid Handbook Transmittal Letter (MHTL) No. 3334-15-10

Date of Publishing (*TBA after e-Review Approval*)

TO: Eligible Providers of Medicaid Services  
Chief Executive Officers, Managed Care Plans (MCPs)

FROM: John B. McCarthy, Director

SUBJECT: Update to OAC 5160-1-60.2

### Summary

Rule [5160-1-60.2](#), **Direct reimbursement to Medicaid recipients for out-of-pocket payments for Medicaid covered services**, is proposed for rescission and will be replaced by a new rule with the same rule number. This rule describes the current direct reimbursement process. The rule is being rescinded to better organize information and for five year rule review.

Rule [5160-1-60.2](#), **Direct reimbursement for out-of-pocket expense incurred for Medicaid covered services**, is proposed for adoption to replace the current rule. The new rule will make the following changes to the Department's coverage of incurred out-of-pocket expenses:

- Expand the group eligible for direct reimbursement of incurred out-of-pocket expenses to include recipients who have been erroneously charged Medicaid co-pays and persons not obligated to pay for a Medicaid recipient's medical bills (e.g., family members);
- Eliminate the coverage limitation that requires the applicant to submit the request to the Department within 90 days from a eligibility determination error, state hearing decision, or other judicial decision;
- Add a coverage limitation that requires the applicant to submit a request to the Department for direct reimbursement either within 90 days of making a request to the provider for reimbursement or not receiving reimbursement from the provider within 90 days from the date of request;
- Change the definition of Medicaid covered service to eliminate reference to medical necessity and clarify that a service may be covered under this rule when the service is eligible for Medicaid coverage;
- Add documentation that is required by the applicant to be turned over to ODM before being eligible for direct reimbursement coverage;
- Clarify that medical service costs used to spend-down to Medicaid eligibility or a spend-down paid directly to the county are not eligible for reimbursement under this rule; and
- Clarify that when an applicant meets all conditions for direct reimbursement coverage for out-of-pocket expenses, the applicant will receive reimbursement equal to the full documented amount.

**Rule Clarification:** An error exists in the final filed version of the rule. Provision (C)(5) says:

The applicant for reimbursement contacts the provider and requests reimbursement, and the provider either does not agree to reimburse the applicant or does not agree to reimburse the applicant but does not do so in a timely fashion.

Provision (C)(5) should say the following:

The applicant for reimbursement contacts the provider and requests reimbursement, and the provider either does not agree to reimburse the applicant or does agree to reimburse the applicant but does not do so in a timely fashion.

ODM will operationalize the rule in accordance with the latter statement. The current language in the final filed rule will be updated as soon as possible.

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# MHTL 3334-15-09 (Termination of Medicaid Provider Agreements - Rule Update)

## Medicaid Handbook Transmittal Letter (MHTL) No. 3334-15-09

April 3, 2015

TO: Eligible Providers of Medicaid Services  
Chief Executive Officers, Managed Care Plans (MCPs)

FROM: John B. McCarthy, Director

SUBJECT: Termination of Medicaid Provider Agreements - Rule Update

### Summary

**Rule 5160-1-17.6**, "Termination and denial of provider agreement," is being reviewed and updated in accordance with five-year rule review.

This rule sets forth the substantive and procedural policy for termination or denial of a Medicaid provider agreement. The rule helps the Department comply with federal regulations that require the State to terminate or deny a provider agreement when program integrity conditions are not met and State law, which gives the ODM Director "best interest" authority. Best interest authority allows the Director to terminate or deny a provider agreement if entering into a provider agreement, or the continuation of an agreement, is not in the best interest of Medicaid recipients and/or the State of Ohio. The rule also describes what appeal rights a provider has regarding the termination or denial of a provider agreement.

The following are the changes to the current rule: reference changes from re-enrollment to revalidation, in accordance with changes to ORC 5164.32; addition of a provision which states if the provider is convicted of one of the offenses that caused a provider agreement to be suspended in accordance with ORC 5164.36 or 42 CFR 455.23, then the Department will terminate the provider agreement; clarification that providers must give the Department written notice of their voluntary termination, the voluntary termination only applies to situations where providers have chosen to voluntarily terminate their agreement, and the Department has the discretion to deny a provider's voluntary termination if the provider is facing involuntary termination pending ODM action; change the exemption to ICFs/IID to incorporate the new rule governed by the Department of Developmental Disabilities; addition of conditions related to termination that result in a provider being ineligible for payment; and reference changes from ODJFS to ODM and rule citation changes from 5101 to 5160.

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# MHTL 3334-15-08 (Rescission of MetroHealth Care Plus Rule 5160-54-01)

## Medicaid Handbook Transmittal Letter (MHTL) No. 3334-15-08

April 13, 2015

TO: Eligible Providers of Medicaid Services  
Chief Executive Officers, Managed Care Plans (MCPs)

FROM: John B. McCarthy, Director

SUBJECT: Rescission of MetroHealth Care Plus Rule 5160-54-01

### Summary

**Rule 5160-54-01**, "Medicaid expansion demonstration programs: metrohealth care plus," is being rescinded due to the closing of the Medicaid waiver demonstration in Cuyahoga County. The last day of the demonstration waiver was April 13, 2014. All eligible enrollees have been transferred into the Medicaid program.

Changes: Rule 5160-54-01 is being rescinded due to the closing of the Medicaid waiver demonstration in Cuyahoga County. This rule sets forth the policies related to the Medicaid waiver demonstration in Cuyahoga County, including eligibility standards, covered benefits, and the grievance process.

### Access to Rules and Related Material

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# MHTL 3334-15-07 (Suspension of Medicaid Provider Agreements - Rule Update)

## Medicaid Handbook Transmittal Letter (MHTL) No. 3334-15-07

March 31, 2015

TO: Eligible Providers of Medicaid Services  
Chief Executive Officers, Managed Care Plans (MCPs)

FROM: John B. McCarthy, Director

SUBJECT: Suspension of Medicaid Provider Agreements - Rule Update

### Summary

**Rule 5160-1-17.5**, Suspension of Medicaid provider agreements, is being rescinded as part of five-year rule review.

**Rule [5160-1-17.5](#)**, Suspension of Medicaid provider agreements, is being created in accordance with a five-year rule review. This rule sets forth Medicaid policies for suspensions of Medicaid provider agreements.

The current rule requires that ODM suspend a Medicaid provider agreement held by a non-institutional provider upon receiving notice and a copy of an indictment that charges a Medicaid provider, its owner or owners, officer, authorized agent, manager, or employee with committing a felony or misdemeanor that is associated with the provider's involvement with the Medicaid program. The current rule also describes the conditions that apply to suspended provider agreements and a provider's due process rights under a suspension.

Through the new rule, the Department is proposing to use credible allegation of fraud as an additional reason under which to suspend a Medicaid provider agreement. Suspensions specifically for indictments may become less frequent as more suspensions fall under credible allegation of fraud suspensions. All providers can be subject to credible allegations of fraud and, therefore, all providers are eligible to be suspended under this provision. The federal regulation that requires this action, 42 CFR 455.23, also allows good cause exemptions for situations where the Medicaid program suspects fraud but does not want to suspend payments. An amendment is included in the new rule that would allow the Department not to suspend a provider agreement if one or more of the good cause exemptions listed in the federal regulation apply. Suspension for credible allegation of fraud is also a state law requirement and can be found at R.C. 5164.36.

The amendment also includes a rewriting of the regulation to more clearly state conditions that apply to the suspended provider. If a provider is suspended for a credible allegation of fraud, then any other provider agreements that the provider is directly associated with may also be suspended. To comply with 42 CFR 455.23, the Department is also proposing to eliminate the current provision that requires the termination of Medicaid reimbursement to only apply to payments for services rendered after the date of the suspension notice. Federal regulations require that all payments be suspended, not simply payments for services rendered after the date of suspension.

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# MHTL 3334-15-06 (Medical Necessity - Rule Update)

## Medicaid Handbook Transmittal Letter (MHTL) No. 3334-15-06

March 31, 2015

TO: Eligible Providers of Medicaid Services  
Chief Executive Officers, Managed Care Plans (MCPs)

FROM: John B. McCarthy, Director

SUBJECT: Medical Necessity - Rule update

**Rule 5160-1-01**, "Medicaid: medical necessity," is being rescinded as part of five-year rule review.

**Rule [5160-1-01](#)**, "Medicaid medical necessity: definitions and principles," is being created to update Medicaid policy and in accordance with five-year rule review.

Rule 5160-1-01 establishes definitions for medical necessity and establishes under what conditions medical necessity is met. Changes from the rescinded version of 5160-1-01 to the new and updated version of 5160-1-01 include the following: establishing the rule as a definition rule and not a coverage rule; removing coverage policy for preventive services (a new rule will be established that describes ODM's coverage policy for preventive services); creating a new definition of medical necessity for individuals covered by EPSDT; revising the definition of medical necessity to create a scope of applicability termed "adverse health condition;" creating a new condition for medical necessity, describing who must be the primary beneficiary of the service; clarifying that a service delivered by a physician or other practitioner does not, in and of itself, mean that the service is medically necessary and eligible for payment; and clarifying that implementing criterion for medical necessity may be described under other Medicaid coverage rules.

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# MHTL 3334-15-05 (Claim Inquiries - Rule Update)

## Medicaid Handbook Transmittal Letter (MHTL) No. 3334-15-05

March 31, 2015

TO: Eligible Providers of Medicaid Services  
Chief Executive Officers, Managed Care Plans (MCPs)

FROM: John B. McCarthy, Director

SUBJECT: Claim Inquiries - Rule Update

**Rule 5160-1-19.9**, Inquiries regarding the status of claims [except for services provided through a Medicaid managed care program], is being rescinded as part of five-year rule review.

**Rule 5160-1-19.9**, Inquiries regarding the status of claims [except for services provided through a Medicaid managed care program], is being created in accordance with five-year rule review.

Changes: Rule 5160-1-19.9 establishes under what conditions a provider may submit a written inquiry regarding the status of claims. The creation of the Ohio Department of Medicaid requires both the Department references in rule to change from ODJFS to ODM and any rule citations in the Ohio Administrative Code to change from 5101 to 5160. Some amendments to 5160-1-19.9 are related to both the Department and the rule references. The other amendment to the rule removes the conditions under which a provider may submit a claims inquiry and limits the conditions to the submission of written claims inquiries. This amendment removes the reporting of information requirement.

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Bureau of Provider Services

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Columbus, OH 43216-1461

Telephone (800) 686-1516

# MHTL 3334-15-04 (Modifications to Rule 5160-1-60 and Its Appendix)

## Medicaid Handbook Transmittal Letter (MHTL) No. 3334-15-04

March 5, 2015

TO: Eligible Medicaid Providers  
Chief Executive Officers, Managed Care Plans  
Directors, County Departments of Job and Family Services

FROM: John B. McCarthy, Medicaid Director

SUBJECT: Modifications to Rule 5160-1-60 and Its Appendix

Rule [5160-1-60](#) of the Ohio Administrative Code, "Medicaid reimbursement," sets forth payment policies for services furnished by many professional, non-institutional providers. This rule and its appendix (designated DD for historical reasons) are being proposed for rescission and replacement by new rule 5160-1-60, retitled "Medicaid payment," with a new Appendix DD. These changes take effect for dates of service beginning December 31, 2014.

### Summary of Changes

The body of the rule is reorganized, streamlined, and clarified.

- Terminology is brought up to date. In particular, the words *reimburse* and *reimbursement* are replaced by the more accurate terms *pay* and *payment*.
- Redundant, vague, or self-evident statements that have no impact on Medicaid payment policy are struck.
- Language is added to clarify that although the appendix to the rule lists the Medicaid maximum payment amounts for many services and items, specific payment amounts or payment formulas set forth in other rules in agency 5160 of the Ohio Administrative Code take precedence. Explicit references to those portions of the Administrative Code are omitted.
- A new provision is added to establish the initial maximum payment amount for a covered procedure, service, or supply represented by a new HCPCS procedure code that takes effect at the beginning of a calendar year. For convenience, a list of such initial maximum payment amounts will be posted no later than January first on the department's web site.

Note: For many years, the department has implemented the annual HCPCS update through the emergency rule-filing process, the nature of which leaves only one or two opportunities over the course of a year to make other changes unrelated to HCPCS, such as adjustments in maximum payment amounts. These new provisions obviate that problem and allow for much more flexibility in the maintenance of a payment schedule that is used by the majority of non-institutional Medicaid providers.

The appendix to the rule is restructured.

- Pursuant to section 5164.70 of the Ohio Revised Code and paragraph (D) of current rule 5160-1-60, the maximum payment amounts for certain procedures, services, or supplies are reduced so that they do not exceed the corresponding maximum Medicare allowed amounts.
- Medicaid maximum payment amounts for molecular pathology procedures and for the transportation of portable X-ray equipment are increased in response to comments made by stakeholders.
- The professional/technical split indicators for radiology and diagnostic medicine procedures are revised to reflect Medicare payment ratios.
- Initial Medicaid maximum payment amounts are established for adult preventive medicine procedures covered under the Medicaid program.
- Payment information for six groups of procedures, services, or supplies is relocated to separate sections of the appendix:

- Laboratory-related services that are payable under the Medicare physician fee schedule or under the clinical laboratory fee schedule
- Transportation services
- Durable medical equipment, prostheses, orthoses, and supplies (DMEPOS)
- Dentistry services
- Eyeglass frames, ocular lenses, and eye prostheses
- Facility procedures performed by an ambulatory surgery center (ASC)

### **Access to Rules and Related Material**

Information about the services and programs of the Ohio Department of Medicaid (ODM) may be accessed through the main ODM web page, <http://www.medicaid.ohio.gov/>.

Some information about provider payment is listed by provider type on the 'Fee Schedule and Rates' web page, which may be accessed through the main ODM web page (Providers > Fee Schedule and Rates).

The Ohio Department of Job and Family Services (ODJFS) maintains an "electronic manuals" web page of ODJFS and Medicaid rules, manuals, transmittal letters, forms, and handbooks. This "eManuals" web page may be accessed through the main ODM web page (Resources > Publications > eManuals) or directly at <http://emanuals.odjfs.state.oh.us/emanuals/>.

From the "eManuals" page, providers may view documents online by following these steps:

- (1) Select the 'Medicaid - Provider' collection.
- (2) Select the appropriate service provider type or handbook.
- (3) Select the desired document type.
- (4) Select the desired item from the 'Table of Contents' pull-down menu.

Current Medicaid maximum payment amounts for many professional services are listed in rule [5160-1-60](#) or in Appendix DD to that rule. Providers may view this information by following these steps:

- (1) Select the 'Medicaid - Provider' collection.
- (2) Select 'General Information for Medicaid Providers'.
- (3) Select 'General Information for Medicaid Providers (Rules)'.
- (4) Select the rule number and title from the 'Table of Contents' pull-down menu.
- (5) Scroll down and select the link to Appendix DD.

The Legal/Policy Central web site includes a calendar of documents that have recently been published, <http://www.odjfs.state.oh.us/lpc/calendar/>. It also displays a listing of ODJFS and Medicaid manual transmittal letters, <http://www.odjfs.state.oh.us/lpc/mtl/>, categorized by letter number and subject, with links to PDF copies of the documents.

To receive automatic electronic notification when new Medicaid transmittal letters are published, interested parties may sign up at <http://medicaid.ohio.gov/HOME/ODMEmailListSignup.aspx>.

### **Additional Information**

Questions pertaining to this letter should be directed to the Ohio Department of Medicaid:

Bureau of Provider Services  
P.O. Box 1461  
Columbus, OH 43216-1461  
(800) 686-1516

# **MHTL 3334-15-03 (UPDATE - Medicaid Requirements for ORP Will Go Into Effect January 12, 2015)**

## **Medicaid Handbook Transmittal Letter (MHTL) No. 3334-15-03**

January 22, 2015

TO: All Eligible Providers  
FROM: John B. McCarthy  
Director, Department of Medicaid (ODM)  
SUBJECT: UPDATE - Medicaid Requirements for Ordering, Referring, and Prescribing (ORP) will go into effect January 12, 2015

### **Summary**

Ohio Administrative Code rule 5160-1-17.9, "Ordering or referring providers," was created in order to comply with new program integrity regulations contained in Section 6401 of the Patient Protection and Affordable Care Act (ACA). Medicaid is implementing new requirements in accordance with 42 CFR 455.410, "Enrollment and screening of providers," and 42 CFR 455.440, "National Provider Identifier (NPI)."

Ohio Medicaid providers who order, refer, certify, or prescribe (ORP) are required to be enrolled with the Department and the Ohio Department of Medicaid (ODM) is required to screen all ordering, referring, certifying, and prescribing providers. The name and NPI of such providers are required on the claim for services rendered, procedures performed, items supplied, or drugs furnished or dispensed (services) and billed to the Department.

In anticipation of these changes, Ohio Medicaid has worked closely with providers and their respective associations over the last several months. Through such engagement and issues identified by providers regarding potential disruption in payment, we have decided to extend the effective date of these changes.

### **ORP requirements will now go into effect on January 12, 2015.**

The Ohio Department of Medicaid will begin to deny claims that require, but do not include, both the ordering, referring, certifying, or prescribing provider's legal name and NPI, and if the ORP provider is not enrolled in Medicaid. The enforcement will begin for claims submitted with dates of service on or after January 12, 2015.

Providers who are rendering services to Medicaid beneficiaries and bill the Department should ensure that such services are being ordered, referred, certified, or prescribed by an eligible provider who is enrolled in Medicaid. The billing provider should refer to their applicable Medicaid program rules to determine what services require an order, referral, certification, or prescription. The following individual providers are eligible to order, refer, or prescribe within the Medicaid program and within their scope of practice:

- Physicians
- Advanced Practice Registered Nurses
- Psychologists
- Podiatrists
- Optometrists
- Dentists
- Chiropractors
- Physician Assistants

The Department will enforce ORP requirements on claims submitted by the following provider types:

- Hospitals (inpatient and outpatient)
- Outpatient Health Facilities

- Other Accredited Home Health Agencies
- Non-agency Personal Care Aide (ODM administered waivers only)
- Private Duty Nurses
- Hospice
- Waiver Service Organizations (ODM administered waivers only)
- Waiver Service Individuals (ODM administered waivers only)
- Clinics
- Mental Health Clinics
- Medicare Certified Home Health Agencies
- Clinical Nurse Specialists
- Pharmacies
- Nurse Practitioners
- Home and Community-Based Assistive Living
- Durable Medical Equipment Suppliers
- Imaging\Testing Facilities
- Independent Laboratories
- Portable X-Ray Suppliers
- Nursing Facilities

The Department created an abbreviated screening and application process for providers who do not wish to bill the Department but who wish to enroll as ordering, referring, certifying, or prescribing providers-only. An application fee is not required and the application can be filled out online. The Department created a way in which billing providers can search the Medicaid enrollment status of the ordering, referring, certifying, or prescribing services in MITS.

As has been recommended in previous guidance by ODM, Medicaid providers who bill for services that are referred, ordered, certified, or prescribed by non-Medicaid enrolled physicians or other health care professionals should be

prepared to ensure those referring, ordering, and prescribing physicians and other health care professionals have NPIs and are enrolled in the Medicaid program.

**ODM will not implement ORP requirements for automatic Medicare crossovers. Medicare crossovers submitted directly to ODM by the provider will be subject to ORP requirements.**

For further information, all providers are welcome to view ODM's responses to ORP Frequently Asked Questions (FAQ) at

<http://medicaid.ohio.gov/PROVIDERS/EnrollmentandSupport/ProviderEnrollment/ORP.aspx>. Providers may also call the ODM provider hotline at 1-800-686-1516.

More guidance regarding ORP HIPPA claim adjustment reason codes, remark codes, and EOB codes are also available on the provider's landing page in MITS.

Claims submitted to a managed care organization are currently exempt from the new requirements.

### **Access to Rules and Related Material**

The main Ohio Department of Medicaid (ODM) web page includes links to valuable information about its services, programs, and rules; the address is <http://www.medicaid.ohio.gov>. The web page of the Ohio Department of Medicaid (ODM) includes a link to the Medicaid "eManuals." The link will be found by first going to the resources tab at the top of the ODM webpage and then scrolling over the publications tab.

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- (2) Select the appropriate service provider type or handbook.
- (3) Select the desired document type.
- (4) Select the desired item from the 'Table of Contents' pull-down menu.

Most current Medicaid maximum reimbursement amounts are listed in rule 5160-1-60 or in Appendix DD to that rule. Providers may view this information by following these steps:

- (1) Select the 'Ohio Health Plans - Provider' folder.
- (2) Select 'General Information for Medicaid Providers'.
- (3) Select 'General Information for Medicaid Providers (Rules)'.
- (4) Select '5160-1-60 Medicaid Reimbursement' from the 'Table of Contents' pull-down menu and then scroll down to the link to Appendix DD.

The Legal/Policy Central - Calendar site, <http://www.odjfs.state.oh.us/lpc/calendar/>, is a quick reference for finding documents that have recently been published. This site also provides a link to a listing of Medicaid manual transmittal letters, <http://www.odjfs.state.oh.us/lpc/mtl/>. The listing is categorized by letter number and subject, and a link is provided to each easy-print (PDF) document.

To receive automatic electronic notification when new Medicaid transmittal letters are published, sign up for the ODJFS e-mail subscription service at <http://www.odjfs.state.oh.us/subscribe/>.

### **Additional Information**

Questions pertaining to this letter should be addressed to:

Ohio Department of Medicaid Bureau of Provider Services P.O. Box 1461  
Columbus, OH 43216-1461  
Telephone (800) 686-1516

# MHTL 3334-15-01 (Medicaid Coverage of Telemedicine and Related Services)

## Medicaid Handbook Transmittal Letter (MHTL) No. 3334-15-01

January 2, 2015

TO: Eligible Providers of Medicaid Services  
Chief Executive Officers, Managed Care Plans (MCPs)

FROM: John B. McCarthy, Director

SUBJECT: Medicaid Coverage of Telemedicine and Related Services

### **RULE SUMMARY**

**Rule 5160-1-18, Telemedicine**, will be created to establish policy relating to the coverage of Medicaid services delivered through telemedicine.

Changes: Rule 5160-1-18 will be created to establish that, for purposes of Medicaid coverage, telemedicine is the direct delivery of evaluation and management (E&M) or psychiatric services to a Medicaid eligible patient via synchronous, interactive, real-time electronic communication that comprises both audio and video elements. Physicians (MD, DO) and licensed psychologists may be eligible for payment for eligible services rendered through telemedicine, and physician offices, clinics, Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs) and outpatient hospitals may be eligible for a telemedicine originating payment.

### **Billing Instructions**

#### *Originating Site:*

The following provider types will be eligible as an originating site, either using a Q3014 HCPCS code (Q3014) or a GQ modifier: Primary Care Clinic, Outpatient Hospital, Rural Health Clinic (Medical), Federally Qualified Health Clinic (Medical), Physician, Professional Medical Group, Podiatrist, and Optometrist.

When the following codes are billed in lieu of a Q3014, a GQ modifier must be used to signify a telemedicine originating service was also present during the visit:

99201-99215

99241-99245

99251-99255

92002

92004

92012

92014

Providers will not be eligible for payment as an originating site for a Q3014 along with any of the CPT codes listed above for the same patient, same date of the service.

Providers are only eligible to bill the Q3014 on a professional claim.

#### *Distant Site*

Distant site providers will be eligible for payment when the health care service is rendered by one of the following provider types: Physician, Psychologist, and Federally Qualified Health Center (Medical & Mental Health). Only resident modifiers will be accepted.

Providers billing for services rendered as a distant site will be eligible for payment when the GT modifier is used in conjunction with one of the following CPT codes:

99201-99215

99241-99245

99251-99255

90791-90792

90804-90858

90863

Providers are only eligible to bill as a distant site on a professional claim.

#### *Federally Qualified Health Centers (FQHCs)/Rural Health Clinics (RHCs)*

When billing as an originating site, FQHCs/RHCs must use a T1015 HCPCS code with a UA modifier. The Q3014 must be included on the claim. FQHCs/RHCs will not be eligible for both services billed using a U1 and UA modifier.

#### *Limitations*

Providers will not be eligible for payment when a Q3014 and a CPT code with a GQ modifier is submitted for the same patient, same date of service, and same provider.

Providers will not be eligible for payment when a Q3014 or a CPT code with a GQ modifier and a CPT code with a GT modifier is submitted for the same patient, same date of service, and same provider.

Place of service **home** (POS 12) is not an acceptable place of service for either an originating or a distant site. Inpatient hospital, nursing facility, and inpatient psychiatric hospitals are additional place of service restrictions for an originating site payment. All current place of service restrictions for E&M and Psychiatric codes apply.

#### **Access to Rules and Related Material**

The main Ohio Department of Medicaid (ODM) web page includes links to valuable information about its services, programs, and rules; the address is <http://www.medicaid.ohio.gov>. The web page of the Ohio Department of Medicaid (ODM) includes a link to the Medicaid "eManuals." The link will be found by first going to the resources tab at the top of the ODM webpage and then scrolling over the publications tab.

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- (2) Select the appropriate service provider type or handbook.
- (3) Select the desired document type.
- (4) Select the desired item from the 'Table of Contents' pull-down menu.

Most current Medicaid maximum reimbursement amounts are listed in rule 5160-1-60 or in Appendix DD to that rule. Providers may view this information by following these steps:

- (1) Select the 'Medicaid - Provider' folder.
- (2) Select 'General Information for Medicaid Providers'.
- (3) Select 'General Information for Medicaid Providers (Rules)'.
- (4) Select '5160-1-60 Medicaid Reimbursement' from the 'Table of Contents' pull-down menu and then scroll down to the link to Appendix DD.

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**Additional Information**

Questions pertaining to this letter should be addressed to:

Ohio Department of Medicaid

Bureau of Provider Services

P.O. Box 1461

Columbus, OH 43216-1461

Telephone (800) 686-1516

# MHTL 3334-14-08 (Medicaid Consumer Liability)

## Medicaid Handbook Transmittal Letter (MHTL) No. 3334-14-08

November 20, 2014

TO: Eligible Providers of Medicaid Services  
Chief Executive Officers, Managed Care Plans (MCPs)

FROM: John B. McCarthy, Director

SUBJECT: Medicaid Consumer Liability

### Summary

**Rule [5160-1-13.1](#), Medicaid Consumer Liability**, is being reviewed and amended in accordance with five-year rule review.

Changes: Rule 5160-1-13.1 establishes policy for what constitutes payment in full to providers for Medicaid services rendered to a Medicaid member. The rule also stipulates under which conditions a provider may bill the Medicaid member for Medicaid covered and non-covered services. The creation of the Ohio Department of Medicaid requires both the Department references in rule to change from ODJFS to ODM and any rule citations in the Ohio Administrative Code to change from 5101 to 5160. The amendments to 5160-1-13.1 are related to both the Department and the rule references. Another amendment to the rule removes the exemption in the title of the rule for services delivered through the managed care program because the Department does not want conflicting policies for consumer safeguards across the Department. This rule serves as a floor regarding consumer liability for Medicaid covered services across the delivery systems in the Medicaid program.

### Access to Rules and Related Material

The main Ohio Department of Medicaid (ODM) web page includes links to valuable information about its services, programs, and rules; the address is <http://www.medicaid.ohio.gov>. The web page of the Ohio Department of Medicaid (ODM) includes a link to the Medicaid "eManuals." The link will be found by first going to the resources tab at the top of the ODM webpage and then scrolling over the publications tab.

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- (2) Select the appropriate service provider type or handbook.
- (3) Select the desired document type.
- (4) Select the desired item from the 'Table of Contents' pull-down menu.

Most current Medicaid maximum reimbursement amounts are listed in rule 5101:3-1-60 or in Appendix DD to that rule. Providers may view this information by following these steps:

- (1) Select the 'Medicaid - Provider' folder.
- (2) Select 'General Information for Medicaid Providers'.
- (3) Select 'General Information for Medicaid Providers (Rules)'.
- (4) Select '5160-1-60 Medicaid Reimbursement' from the 'Table of Contents' pull-down menu and then scroll down to the link to Appendix DD.

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**Additional Information**

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Ohio Department of Medicaid, P.O. Box 1461

Bureau of Provider Services

Columbus, OH 43216-1461

Telephone (800) 686-1516

# MHTL 3334-14-07 (General Medicaid Rules Update)

## Medicaid Handbook Transmittal Letter (MHTL) No. 3334-14-07

November 4, 2014

TO: Eligible Providers of Medicaid Services  
Chief Executive Officers, Managed Care Plans (MCPs)

FROM: John B. McCarthy, Director

SUBJECT: General Medicaid Rules Update

### Summary

**Rule [5160-1-03](#), Medicaid: relationship to the children with medical handicaps program under Title V of the Social Security Act**, is being reviewed and amended in accordance with a five-year rule review.

Changes: This rule describes the Medicaid program's relationship to the Children with Medical Handicaps (CMH) program under Title V of the Social Security Act. Specifically, this rule describes how medically necessary services shall be billed for children eligible for both Medicaid and CMH services. Claims for services shall first be submitted to the Medicaid program, and, then, if the services are not covered, claims shall be submitted to the CMH program as the secondary payer after Medicaid. The creation of the Ohio Department of Medicaid requires both the Department references in rule to change from ODJFS to ODM and any rule citations in the Ohio Administrative Code to change from 5101 to 5160. The amendments to 5160-1-03 are related to both the Department and the rule references. Other amendments deal with removing unnecessary references to general Medicaid policy and billing instructions.

**Rule [5160-1-11](#), Out-of-state coverage (except for services delivered through contracted managed care plans (MCPs))**, is being reviewed and amended in accordance with a five-year rule review.

Changes: Rule 5160-1-11 defines Department policy regarding the conditions under which out-of-state providers may be reimbursed for rendering services to Medicaid consumers. The rule also defines conditions that out-of-state providers must comply with prior to providing services to Medicaid consumers. The creation of the Ohio Department of Medicaid requires both the Department references in rule to change from ODJFS to ODM and any rule citations in the Ohio Administrative Code to change from 5101 to 5160. The amendments to 5160-1-11 are related to both the Department and the rule references.

### Access to Rules and Related Material

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- (2) Select the appropriate service provider type or handbook.
- (3) Select the desired document type.
- (4) Select the desired item from the 'Table of Contents' pull-down menu.

Most current Medicaid maximum reimbursement amounts are listed in rule 5101:3-1-60 or in Appendix DD to that rule. Providers may view this information by following these steps:

- (1) Select the 'Medicaid - Provider' folder.
- (2) Select 'General Information for Medicaid Providers'.
- (3) Select 'General Information for Medicaid Providers (Rules)'.
- (4) Select '5160-1-60 Medicaid Reimbursement' from the 'Table of Contents' pull-down menu and then scroll down to the link to Appendix DD.

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### **Additional Information**

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P.O. Box 1461  
Columbus, OH 43216-1461  
Telephone (800) 686-1516

# MHTL 3334-14-06 (Medicaid Reimbursement for Medicare Part C Cost Sharing Rule Update)

## Medicaid Handbook Transmittal Letter (MHTL) No. 3334-14-06

November 4, 2014

TO: Eligible Providers of Medicaid Services  
Chief Executive Officers, Managed Care Plans (MCPs)

FROM: John B. McCarthy, Director

SUBJECT: Medicaid Reimbursement for Medicare Part C Cost Sharing Rule Update

### Summary

Rule [5160-1-05.1](#), Payment for "Medicare Part C" costs sharing, is being reviewed and amended in accordance with a five-year rule review.

Changes: Rule 5160-1-05.1 describes ODM reimbursement methodology for qualified Medicare and Medicaid beneficiaries who are receiving medical services through Medicare Part C Medicare Advantage Plans. ODM generally pays the lesser of the sum of the cost sharing provided by the Part C plan, the difference between the plans' payment and the Medicaid allowable amount for the same service, or the Medicaid liability for the cost sharing had the service been rendered under Part A or Part B. There are no proposed changes to the substance of the rule.

### Access to Rules and Related Material

The main Ohio Department of Medicaid (ODM) web page includes links to valuable information about its services, programs, and rules; the address is <http://www.medicaid.ohio.gov>. The web page of the Ohio Department of Medicaid (ODM) includes a link to the Medicaid "eManuals." The link will be found by first going to the resources tab at the top of the ODM webpage and then scrolling over the publications tab.

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Most current Medicaid maximum reimbursement amounts are listed in rule 5101:3-1-60 or in Appendix DD to that rule. Providers may view this information by following these steps:

- (1) Select the 'Medicaid - Provider' folder.
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**Additional Information**

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Bureau of Provider Services

P.O. Box 1461

Columbus, OH 43216-1461

Telephone (800) 686-1516

# MHTL 3334-14-05 (Reduction in Interest Rates for Medicaid Overpayments)

## Medicaid Handbook Transmittal Letter (MHTL) No. 3334-14-05

September 9, 2014

TO: Eligible Providers of Medicaid Services  
FROM: John B. McCarthy, Director  
SUBJECT: Reduction in Interest Rates for Medicaid Overpayments

### Summary

Rule [5160-1-25](#), **Interest on overpayments**, is being amended in order to comply with new interest rate requirements for Medicaid overpayments contained in Section 5164.60 of the biennium budget, House Bill 59.

**Change:** [5160-1-25](#) is being amended to reduce the interest rate from the maximum real estate mortgage rate to the average bank prime rate in effect on the first day of the quarter in which the excess payment is discovered. The Department is also proposing to eliminate the ability of the Department of Medicaid to waive interest owed on overpayments less than \$50, and change name, rule and statute references from ODJFS to the newly created Department of Medicaid.

### Access to Rules and Related Material

The main Ohio Department of Job and Family Services (ODJFS) web page includes links to valuable information about its services and programs; the address is <http://www.jfs.ohio.gov>. The web page of the Ohio Department of Medicaid (ODM) may be accessed through the ODJFS main page or directly at <http://www.medicaid.ohio.gov/>.

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Most current Medicaid maximum reimbursement amounts are listed in rule [5160-1-60](#) or in Appendix DD to that rule. Providers may view this information by following these steps:

- (1) Select the 'Ohio Health Plans - Provider' folder.
- (2) Select 'General Information for Medicaid Providers'.
- (3) Select 'General Information for Medicaid Providers (Rules)'.
- (4) Select '5160-1-60 Medicaid Reimbursement' from the 'Table of Contents' pull-down menu and then scroll down to the link to Appendix DD.

The Legal/Policy Central - Calendar site, <http://www.odjfs.state.oh.us/lpc/calendar/>, is a quick reference for finding documents that have recently been published. This site also provides a link to a listing of Medicaid manual transmittal letters, <http://www.odjfs.state.oh.us/lpc/mtl/>. The listing is categorized by letter number and subject, and a link is provided to each easy-print (PDF) document.

To receive automatic electronic notification when new Medicaid transmittal letters are published, sign up for the ODJFS e-mail subscription service at

<http://www.odjfs.state.oh.us/subscribe/>.

### Additional Information

Questions pertaining to this letter should be addressed to:

Department of Medicaid

Bureau of Provider Services

P.O. Box 1461

Columbus, OH 43216-1461

Telephone (800) 686-1516

# MHTL 3334-14-04 (Modifications to Administrative Rule 5160-4-25)

## Medicaid Handbook Transmittal Letter (MHTL) No. 3334-14-04

August 13, 2014

TO: Eligible Medicaid Providers  
Chief Executive Officers, Managed Care Plans  
Directors, County Departments of Job and Family Services

FROM: John B. McCarthy, Director of Medicaid

SUBJECT: Modifications to Administrative Rule 5160-4-25

Modifications are being made to one administrative rule that affect payments made for services rendered by Medicaid providers.

Rule [5160-4-25](#), titled "Laboratory and radiology services," sets forth provisions for coverage and payment of laboratory and radiology services performed by physicians and other non-institutional providers. This rule is being proposed for amendment.

*Changes:* The amendments to this rule reduce the amount of the reduction in Medicaid reimbursement that will occur when more than one radiology procedure is performed by the same provider or provider group for an individual patient on the same date. Under this amendment, payment will be made for the primary procedure at 100% and for each additional global or technical component of a procedure is reduced to 50% of the Medicaid fee schedule allowed amount. Each additional professional component of the procedure will be reduced to 75% of the Medicaid fee schedule allowed amount. (This provision mirrors Medicare payment policy.)

The effective date for these changes in our claims payment system will be for dates of service July 1, 2014 forward. However the implementation date for these changes will be in December. ODM will discuss with HP the possibility of adjusting any affected claims due to the implementation date.

### Access to Rules and Related Material

Information about the services and programs of the Ohio Department of Medicaid (ODM) may be accessed through the main ODM web page, <http://www.medicaid.ohio.gov/>.

Some information about provider payment is listed by provider type on the 'Fee Schedule and Rates' web page, which may be accessed through the main ODM web page (Providers > Fee Schedule and Rates).

The Ohio Department of Job and Family Services (ODJFS) maintains an "electronic manuals" web page of ODJFS and Medicaid rules, manuals, transmittal letters, forms, and handbooks. This "eManuals" web page may be accessed through the main ODM web page (Resources > Publications > eManuals) or directly at <http://emanuals.odjfs.state.oh.us/emanuals/>.

From the "eManuals" page, providers may view documents online by following these steps:

- (1) Select the 'Medicaid - Provider' collection.
- (2) Select the appropriate service provider type or handbook.
- (3) Select the desired document type.
- (4) Select the desired item from the 'Table of Contents' pull-down menu.

Current Medicaid maximum payment amounts for many professional services are listed in rule 5160-1-60 (formerly 5101:3-1-60) or in Appendix DD to that rule. Providers may view this information by following these steps:

- (1) Select the 'Medicaid - Provider' collection.
- (2) Select 'General Information for Medicaid Providers'.
- (3) Select 'General Information for Medicaid Providers (Rules)'.

- (4) Select the rule number and title from the 'Table of Contents' pull-down menu.
- (5) Scroll down and select the link to Appendix DD.

The Legal/Policy Central web site includes a calendar of documents that have recently been published, <http://www.odjfs.state.oh.us/lpc/calendar/>. It also displays a listing of ODJFS and Medicaid manual transmittal letters, <http://www.odjfs.state.oh.us/lpc/mtl/>, categorized by letter number and subject, with links to PDF copies of the documents.

To receive automatic electronic notification when new Medicaid transmittal letters are published, interested parties may sign up at <http://medicaid.ohio.gov/HOME/ODMEmailListSignup.aspx>.

### **Additional Information**

Questions pertaining to this letter should be addressed to:

Ohio Department of Medicaid  
Bureau of Provider Services  
P.O. Box 1461  
Columbus, OH 43216-1461  
Telephone (800) 686-1516

# MHTL 3334-14-03 (Rule 5160-1-20, "Electronic Data Interchange (EDI) Trading Partner Enrollment and Testing")

## Medicaid Handbook Transmittal Letter (MHTL) No. 3334-14-03

June 26, 2014

TO: Eligible Medicaid Providers  
Chief Executive Officers, Managed Care Plans (MCPs)  
Directors, County Departments of Job and Family Services

FROM: John B. McCarthy, Director

SUBJECT: Rule 5160-1-20, "Electronic data interchange (EDI) trading partner enrollment and testing"

### Summary

This Medicaid Handbook Transmittal Letter (MHTL) is to notify providers of the amendments to rule 5160-1-20, which describes the enrollment criteria and testing requirements for enrollment as a trading partner with the Ohio Department Medicaid (ODM) to submit Electronic Data Interchange (EDI) transactions.

**Rule 5160-1-20**, "Electronic data interchange (EDI) trading partner enrollment and testing " describes and defines general provisions for covered entities (including health plans, health care clearinghouses and health care providers), and EVS vendors to enroll as a trading partner with ODM.

Changes: Amendments to this rule include the following:

- Adds Eligibility Verification Services (EVS) vendors as a trading partner for purposes of the rule;
- Updates the process for completing the required trading partner profile; and
- Specifies for trading partners submitting 270/271 and 276/277 transactions, the requirement to submit to The Ohio Department of Medicaid (ODM) a report of all providers by national provider identifier (NPI) that the trading partner represents on a quarterly basis and that they shall be responsible for any breach of information and be held fully liable for any and all costs relating to such a breach.

ODJFS maintains an "electronic manuals" web page of the department's rules, manuals, transmittal letters, forms, and handbooks. The web address for this "eManuals" web page is <http://emanuals.odjfs.state.oh.us/emanuals/>.

From the "eManuals" page, providers may view documents online by following these steps:

- (1) Select the 'Ohio Health Plans - Provider' collection.
- (2) Select the appropriate service provider type or handbook.
- (3) Select the desired document type.
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The Legal/Policy Central - Calendar site, <http://www.odjfs.state.oh.us/lpc/calendar/>, is a quick reference for finding documents that have recently been published. This site also provides a link to a listing of ODJFS manual transmittal letters, <http://www.odjfs.state.oh.us/lpc/mtl/>. The listing is categorized by letter number and subject, and a link is provided to each easy-print (PDF) document.

To receive automatic electronic notification when new Medicaid transmittal letters are published, sign up for the ODJFS e-mail subscription service at <http://www.odjfs.state.oh.us/subscribe/>.

### Additional Information

Questions pertaining to this letter should be addressed to:

Ohio Department of Medicaid  
Bureau of Provider Services

P.O. Box 1461

Columbus, OH 43216-1461

Telephone (800) 686-1516

# MHTL 3334-14-02 (Additional Guidance Around Changes to the Medicare Part B Cost Sharing Reimbursement Methodology)

## Medicaid Handbook Transmittal Letter (MHTL) No. 3334-14-02

April 30, 2014

TO: Eligible Providers of Medicaid Services  
Chief Executive Officers, Managed Care Plans (MCPs)

FROM: John B. McCarthy, Director

SUBJECT: Additional guidance around changes to the Medicare Part B cost sharing reimbursement methodology

### Summary

As a result of the fiscal year 14/15 state budget (Am. Sub. HB 59, authorized under Section 323.230), the Ohio Department of Medicaid (ODM) recently implemented changes to how it prices Medicare Part B crossover claims. The changes officially went into effect for dates of service on or after January 1, 2014.

Like many other states, Ohio has exercised its authority under federal law (§1902(n)(2) of the Social Security Act) to pay no more than what Medicaid would have paid had it been the primary payer. This alternative payment methodology has been approved by CMS. Effectively, this means ODM reimburses the lesser of the cost sharing that, absent Medicaid eligibility, would have been owed by the beneficiary - that is the difference between what Medicare paid and the Medicaid maximum allowable for the service rendered, procedure performed, or items supplied. All providers, except those providing physician services, are impacted by this change. Hospitals and nursing facilities have been subject to this reimbursement methodology since 2011. ODM also uses a similar reimbursement methodology for Medicare Part A and C crossover claims.

Below are examples that illustrate how the new reimbursement methodology works:

#### ***Example 1:***

Medicare allowable = \$100

Medicare paid = \$80

Coinsurance = \$20

Before the policy change, ODM would have paid the full \$20.

First, assume the Medicaid maximum allowable for that billed procedure or supply is \$75. This fee is less than what Medicare already paid. Under the new policy, this means ODM pays \$0 for the crossover claim.

Next, assume the Medicaid maximum allowable for the billed procedure or supply is \$85. This fee is more than what Medicare already paid. Under our new policy, ODM will pay the lesser of the \$20 coinsurance charge or the difference between the Medicaid paid amount and the Medicaid maximum allowable ( $\$85 - \$80 = \$5$ ). Because \$5 is less than the \$20, ODM will pay \$5.

#### ***Example 2:***

Medicare allowable = \$100

Medicare paid = \$0

Deductible = \$100

Before the policy change, ODM would have paid the full \$100.

Next, assume the Medicaid allowable for that billed procedure or supply is \$75. This fee is more than what Medicare already paid. Under our new policy, ODM will pay the lesser of the \$100 deductible charge or the difference between the Medicaid paid amount and the Medicaid maximum allowable ( $\$75 - 0 = \$75$ ). Because \$75 is less than \$100, ODM will pay \$75.

### Additional Provider Information

The term "physician services" found in both the authorizing State statute and the OAC rule is defined as services provided by (1) a doctor of medicine or osteopathy, (2) a doctor of dental surgery or dental medicine, (3) a doctor of podiatric medicine, (4) a doctor of optometry, and (5) a chiropractor. This definition is consistent with provisions of the Social Security Act found at §1905(a)(5) and §1861(r)(1). ODM has also decided to add certified registered nurse anesthetists (CRNA), certified nurse midwives, clinical nurse specialists, and nurse practitioners. These individual providers are thus excluded from the new reimbursement methodology. All other individual provider types are subject to the new reimbursement methodology found in OAC 5160-1-05.3(B)(3).

**IMPORTANT: *In order to ensure exclusion from the new reimbursement methodology, the individual provider should be enrolled in the Medicaid program and should be, when appropriate, included on each line of the claim as the rendering provider.***

### **Access to Rules and Related Material**

The main Ohio Department of Job and Family Services (ODJFS) web page includes links to valuable information about its services and programs; the address is <http://www.ifs.ohio.gov>. The web page of the Ohio Department of Medicaid (ODM) may be accessed through the ODJFS main page or directly at <http://www.medicaid.ohio.gov>.

ODJFS maintains an "electronic manuals" web page of ODJFS and Medicaid rules, manuals, transmittal letters, forms, and handbooks. The web address for this "eManuals" web page is <http://emanuals.odjfs.state.oh.us/emanuals/>.

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- (1) Select the 'Ohio Health Plans - Provider' collection.
- (2) Select the appropriate service provider type or handbook.
- (3) Select the desired document type.
- (4) Select the desired item from the 'Table of Contents' pull-down menu.

Most current Medicaid maximum reimbursement amounts are listed in rule 5101:3-1-60 or in Appendix DD to that rule. Providers may view this information by following these steps:

- (1) Select the 'Ohio Health Plans - Provider' folder.
- (2) Select 'General Information for Medicaid Providers'.
- (3) Select 'General Information for Medicaid Providers (Rules)'.
- (4) Select '5101:3-1-60 Medicaid Reimbursement' from the 'Table of Contents' pull-down menu and then scroll down to the link to Appendix DD.

The Legal/Policy Central - Calendar site, <http://www.odjfs.state.oh.us/lpc/calendar/>, is a quick reference for finding documents that have recently been published. This site also provides a link to a listing of ODJFS and Medicaid letters, <http://www.odjfs.state.oh.us/lpc/mtl/>. The listing is categorized by letter number and subject, and a link is provided to each easy-print (PDF) document.

To receive automatic electronic notification when new Medicaid transmittal letters are published, sign up for the ODJFS e-mail subscription service at <http://www.odjfs.state.oh.us/subscribe/>.

### **Additional Information**

Questions pertaining to this letter should be addressed to:

Ohio Department of Medicaid  
Bureau of Provider Services  
P.O. Box 1461  
Columbus, OH 43216-1461  
Telephone (800) 686-1516



# **MHTL 3334-14-01 (HCPCS Updates to Administrative Rules 5160-1-60, 5160-2-21, 5160-4-22, 5160-21-02.3, and 5160-35-04)**

**Medicaid Handbook Transmittal Letter (MHTL) No. 3334-14-01**

**Hospital Handbook Transmittal Letter (HHTL) No. 3352-14-04**

**Long Term Care Services and Supports Transmittal Letter (LTCSSSTL) No. 14-04**

March 28, 2014

TO: Eligible Non-Institutional Providers  
Eligible Hospital Providers  
Eligible Medicaid School Program Providers  
Chief Executive Officers, Managed Care Plans  
Directors, County Departments of Job and Family Services  
Other Interested Parties

FROM: John B. McCarthy, Director of Medicaid

SUBJECT: HCPCS Updates to Administrative Rules 5160-1-60, 5160-2-21, 5160-4-22, 5160-21-02.3, and 5160-35-04

The federal Centers for Medicare and Medicaid Services, in conjunction with the American Medical Association and other professional groups, updates the Healthcare Common Procedure Coding System (HCPCS) annually. To the extent that HCPCS codes or descriptions are incorporated into the Ohio Administrative Code (OAC) governing the Medicaid program, changes made to HCPCS necessitate corresponding changes in OAC rules. Codes must be added, deleted, or revised, and maximum payment amounts and coverage policies must be established for new codes.

Changes are being made to the following rules, effective for dates of service January 1, 2014, or thereafter:

Rule [5160-1-60](#), "Medicaid reimbursement," sets forth payment policies for services furnished by professional providers.

*Changes:* In the appendix to this rule, new HCPCS codes are added, obsolete HCPCS codes are marked as discontinued, definitions are revised, and maximum payment amounts are established for new codes. No change is being made to the rule body itself.

Rule [5160-2-21](#), "Policies for outpatient hospital services," sets forth policies and payment rates for outpatient services delivered by hospitals that are subject to prospective payment based on diagnosis related groups (DRG).

*Changes:* In the appendices to this rule, new covered HCPCS codes are added, obsolete HCPCS codes are removed, and the fee schedules associated with the codes are updated. No change is being made to the rule body itself.

Rule [5160-4-22](#), "Surgical services," sets forth coverage and payment policies for surgical services delivered by physician providers.

*Changes:* In the appendix to this rule, new HCPCS codes are added, obsolete HCPCS codes are struck, definitions are revised, and updates are made to the schedule of surgical procedures that are subject to multiple-procedure, bilateral-procedure, or assistant-at-surgery fee adjustments. Within the body of this rule, references to the Ohio Department of Medicaid or to other Medicaid rules are modified to comport with the new agency name and designation in the Ohio Administrative Code.

Rule [5160-21-02.3](#), "Limited family planning benefit," sets forth payment policies for services that are covered under this benefit.

*Changes:* In the appendix to this rule, one new HCPCS code is added. Within the body of this rule, references to other Medicaid rules are modified to comport with the new agency designation in the Ohio Administrative Code.

Rule [5160-35-04](#), "Reimbursement for services provided by medicaid school program (MSP) providers," sets forth payment policies for services that are covered under this program.

*Changes:* In the appendix to this rule, four new HCPCS codes are added to replace one obsolete HCPCS code that is struck, and maximum payment amounts are established for the new codes. Within the body of this rule, references to the Ohio Department of Medicaid or to other Medicaid rules are modified to comport with the new agency name and designation in the Ohio Administrative Code, and citations of federal law are updated.

### **Access to Rules and Related Material**

Information about the services and programs of the Ohio Department of Medicaid (ODM) may be accessed through the main ODM web page, <http://www.medicaid.ohio.gov/>.

Some information about provider payment is listed by provider type on the 'Fee Schedule and Rates' web page, which may be accessed through the main ODM web page (Providers > Fee Schedule and Rates).

The Ohio Department of Job and Family Services (ODJFS) maintains an "electronic manuals" web page of ODJFS and Medicaid rules, manuals, transmittal letters, forms, and handbooks. This "eManuals" web page may be accessed through the main ODM web page (Resources > Publications > eManuals) or directly at <http://emanuals.odjfs.state.oh.us/emanuals/>.

From the "eManuals" page, providers may view documents online by following these steps:

- (1) Select the 'Medicaid - Provider' collection.
- (2) Select the appropriate service provider type or handbook.
- (3) Select the desired document type.
- (4) Select the desired item from the 'Table of Contents' pull-down menu.

Current Medicaid maximum payment amounts for many professional services are listed in rule 5160-1-60 (formerly 5101:3-1-60) or in Appendix DD to that rule. Providers may view this information by following these steps:

- (1) Select the 'Medicaid - Provider' collection.
- (2) Select 'General Information for Medicaid Providers'.
- (3) Select 'General Information for Medicaid Providers (Rules)'.
- (4) Select the rule number and title from the 'Table of Contents' pull-down menu.
- (5) Scroll down and select the link to Appendix DD.

The Legal/Policy Central web site includes a calendar of documents that have recently been published, <http://www.odjfs.state.oh.us/lpc/calendar/>. It also displays a listing of ODJFS and Medicaid manual transmittal letters, <http://www.odjfs.state.oh.us/lpc/mtl/>, categorized by letter number and subject, with links to PDF copies of the documents.

To receive automatic electronic notification when new Medicaid transmittal letters are published, interested parties may sign up at <http://medicaid.ohio.gov/HOME/ODMEmailListSignup.aspx>.

### **Additional Information**

Questions pertaining to this letter should be addressed to the Ohio Department of Medicaid.

Hospital services policy:

Bureau of Health Plan Policy, Hospital Services  
P.O. Box 182709  
Columbus, OH 43218-2709

(800) 686-1516

hospital\_policy@medicaid.ohio.gov

Medicaid School Program policy:

Bureau of Long-Term Care Services and Support

P.O. Box 182709

Columbus, OH 43218-2709

bltcss@medicaid.ohio.gov

Other provider policy:

Bureau of Provider Services

P.O. Box 1461

Columbus, OH 43216-1461

(800) 686-1516

# MHTL 3334-13-13 (Modifications to Administrative Rules 5160-10-03, 5160-10-08, 5160-10-13, 5160-10-13.1, 5160-10-16, and 5160-15-02.8)

## Medicaid Handbook Transmittal Letter (MHTL) No. 3334-13-13

January 9, 2014

TO: Eligible Medicaid Providers of Durable Medical Equipment (DME)  
Chief Executive Officers, Managed Care Plans  
Directors, County Departments of Job and Family Services

FROM: John B. McCarthy, Director of Medicaid

SUBJECT: Modifications to Administrative Rules 5160-10-03, 5160-10-08, 5160-10-13, 5160-10-13.1, 5160-10-16, and 5160-15-02.8

A nursing facility (NF) that participates in Medicaid is paid a daily amount (a "per diem") for providing a defined package—or bundle—of goods and services to its Medicaid-eligible residents. Amended Substitute House Bill 59 (130th General Assembly) has removed three items from this bundle: (1) custom wheelchairs and major wheelchair repairs, (2) oxygen, and (3) transportation by ambulance or wheelchair van. Payment for these items and services is no longer included in the NF per diem. These services may now be furnished by eligible Medicaid providers on a fee-for-service basis.

The following rules are being amended accordingly.

Rule [5160-10-03](#), titled "Medicaid supply list," describes the coverage of medical/surgical supplies, durable medical equipment, and supplier services by the Ohio Medicaid program. The appendix to the rule indicates whether an item is covered for all places of service, is covered only when it is provided in someone's personal residence, or is not covered when it is provided in a NF. This rule is being rescinded and replaced by new rule 5160-10-03.

New rule [5160-10-03](#), titled "Medical supplies and the medicaid supply list," describes the coverage of medical/surgical supplies, durable medical equipment, and supplier services by the Ohio Medicaid program. The appendix to the rule indicates whether an item is covered for all places of service, is covered only when it is provided in someone's personal residence, or is not covered when it is provided in a NF. This rule replaces current rule 5160-10-03.

*Changes:* The body of the rule has been reorganized and streamlined, and unnecessary references have been removed. The nursing facility (NF) limitation on the coverage of oxygen and custom wheelchairs has been removed from appendix A. Form JFS 01913 (a certificate of medical necessity) is still referenced in the body of the rule, but it is no longer incorporated into the rule as appendix B. These changes take effect on December 31, 2013.

Rule [5160-10-08](#), titled "Repair of medical equipment," sets forth coverage and payment provisions for the repair of medical equipment.

*Changes:* The exclusion of fee-for-service coverage of custom wheelchair repair for nursing facility (NF) residents has been removed. The required modifier for certain repairs has been changed from RP to RB, and Healthcare Common Procedure Coding System (HCPCS) procedure code K0739 has been adopted to represent a labor component of durable medical equipment (DME) repairs for which no other specific procedure code exists. Form JFS 01904 (a certificate of medical necessity) is still referenced in the body of the rule, but it is no longer incorporated into the rule as an appendix. These changes take effect on December 31, 2013.

Rule [5160-10-13](#), titled "Oxygen: covered services and limitations in a private residence," sets forth coverage and payment provisions for oxygen provided in a person's home. This rule is being rescinded and replaced by new rule 5160-10-13.

Rule [5160-10-13.1](#), titled "Oxygen: covered services and limitations in an intermediate care facility for the mentally retarded (ICF-MR)," sets forth coverage and payment provisions for oxygen provided to residents of long-term care facilities. This rule is being rescinded and replaced by new rule 5160-10-13.

New rule [5160-10-13](#), titled "Oxygen services," sets forth coverage and payment provisions for oxygen. This rule replaces current rules 5160-10-13 and 5160-10-13.1.

*Changes:* The exclusion of fee-for-service coverage of oxygen for NF residents has been removed. Maximum fee amounts for oxygen services have been revised and are now listed in a new appendix to the rule instead of Appendix DD to rule 5160-1-60 of the Ohio Administrative Code. These changes take effect on December 31, 2013.

Rule [5160-10-16](#), titled "Wheelchairs," sets forth coverage and payment provisions for wheelchairs.

*Changes:* The exclusion of fee-for-service coverage of custom wheelchairs for NF residents has been removed. The required modifier for certain repairs has been changed from RP to RB. References to ODJFS have been updated, and other minor corrections have been made to the text. These changes take effect on December 31, 2013.

Rule [5160-15-02.8](#), titled "Medical transportation services: eligible providers," sets forth the conditions under which businesses may be enrolled as providers of ambulance or wheelchair van (ambulette) services. It also specifies that for transportation services provided to residents of a NF, payment will no longer be made on a fee-for-service basis and that the provisions in Chapter 5160-15 of the Ohio Administrative Code (transportation rules governing ambulance and wheelchair van services) no longer apply.

*Change:* The exclusion of fee-for-service coverage of transportation services for NF residents has been removed. This change takes effect on January 1, 2014.

### **DME Question Line and Voice Mailbox**

Providers who have questions about program coverage of and limitations on DME may call the DME Question Line and Voice Mailbox at 614-466-1503. No response will be given to questions involving individual consumer eligibility, the submission of a new prior authorization request, the status of an existing prior authorization request, or a previous claim for durable medical equipment.

### **Access to Rules and Related Material**

Information about the services and programs of the Ohio Department of Medicaid may be accessed through the main web page of the Ohio Department of Job and Family Services (ODJFS), <http://www.jfs.ohio.gov>. The address of the ODJFS Medicaid page is <http://www.jfs.ohio.gov/ohp/>.

ODJFS maintains an "electronic manuals" web page of the department's rules, manuals, transmittal letters, forms, and handbooks. The web address for this "eManuals" web page is <http://emanuals.odjfs.state.oh.us/emanuals/>.

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- (2) Select the appropriate service provider type or handbook.
- (3) Select the desired document type.
- (4) Select the desired item from the 'Table of Contents' pull-down menu.

Current Medicaid maximum payment amounts for many professional services are listed in rule [5160-1-60](#) or in Appendix DD to that rule. Providers may view this information by following these steps:

- (1) Select the 'Ohio Health Plans - Provider' folder.
- (2) Select 'General Information for Medicaid Providers'.
- (3) Select 'General Information for Medicaid Providers (Rules)'.
- (4) Select the rule number and title from the 'Table of Contents' pull-down menu.
- (5) Scroll down and select the link to Appendix DD.

The Legal/Policy Central - Calendar site, <http://www.odjfs.state.oh.us/lpc/calendar/>, is a quick reference for finding documents that have recently been published. This site also provides a link to a listing of ODJFS manual transmittal letters, <http://www.odjfs.state.oh.us/lpc/mtl/>. The listing is categorized by letter number and subject, and a link is provided to each easy-print (PDF) document.

To receive automatic electronic notification when new Medicaid transmittal letters are published, sign up for the ODJFS e-mail subscription service at <http://www.odjfs.state.oh.us/subscribe/>.

### **Additional Information**

Questions pertaining to this letter should be addressed to:

Ohio Department of Medicaid

Bureau of Provider Services

P.O. Box 1461

Columbus, OH 43216-1461

Telephone (800) 686-1516

# MHTL 3334-13-12 (Modifications to Administrative Rules 5160-1-60, 5160-4-02.2, 5160-4-09, and 5160-4-25)

## Medicaid Handbook Transmittal Letter (MHTL) No. 3334-13-12

January 9, 2014

TO: Eligible Medicaid Providers  
Chief Executive Officers, Managed Care Plans  
Directors, County Departments of Job and Family Services

FROM: John B. McCarthy, Director of Medicaid

SUBJECT: Modifications to Administrative Rules 5160-1-60, 5160-4-02.2, 5160-4-09, and 5160-4-25

Modifications are being made in four administrative rules that affect payments made for services rendered by Medicaid providers.

Rule [5160-1-60](#), titled "Medicaid reimbursement," sets forth payment policies for services furnished by professional providers. This rule is being proposed for amendment, and the changes take effect on December 31, 2013.

*Changes:* Within the body of the rule, one unnecessary sentence is eliminated. In addition to minor nonsubstantive corrections, several significant changes are made to the appendix:

- For each of more than 1,700 procedures, two separate maximum fees are established. One maximum fee applies when the procedure is performed in a non-facility setting such as a physician's office; the other applies when the procedure is performed in an institutional setting such as a hospital or a skilled nursing facility. These fees are shown in two new columns that have been added to the table.
- Maximum fee amounts for more than 100 genetic procedures are updated. Most of these procedures involve molecular pathology; the fees for these "mopath" procedures are based on allowed payment amounts recently established by the Centers for Medicare & Medicaid Services (CMS).
- Maximum fee amounts for oxygen services are removed and listed instead in the new appendix to revised rule 5160-10-13 of the Ohio Administrative Code.
- Pursuant to section 5164.70 of the Ohio Revised Code and paragraph (D) of this rule, the maximum fees for certain procedures, services, or supplies are reduced so that they do not exceed the corresponding maximum Medicare allowed amounts.

Rule [5160-4-02.2](#), titled "Site differential payments and place of service," sets forth provisions under which payment for a procedure or service differs according to the location in which the procedure or service is performed. This rule is being proposed for amendment, and the changes take effect on January 1, 2014.

*Changes:* A provision is added that allows payment of two different fee amounts; one applies when the procedure is performed in a non-facility setting such as a physician's office, and the other applies when the procedure is performed in an institutional setting such as a hospital or a skilled nursing facility. (This provision, which mirrors Medicare payment policy, compensates physicians for the extra overhead expenses they incur when providing services in non-hospital settings.) The appendix to the rule is removed; the fees are shown instead in Appendix DD to rule 5160-1-60. In addition, certain phrases and references in the rule are clarified or corrected.

Rule [5160-4-09](#), titled "Office incentive program," establishes additional payment amounts for certain procedures in order to encourage physicians and clinics to perform those procedures in non-hospital settings and to compensate physicians for the extra overhead cost involved. The establishment in rule 5160-4-02.2 of separate non-facility and facility fees for certain services makes the office incentive program obsolete. So this rule, which includes an appendix, is being proposed for rescission as of January 1, 2014.

Rule [5160-4-25](#), titled "Laboratory and radiology services," sets forth provisions for coverage and payment of laboratory and radiology services performed by physicians and other non-institutional providers. This rule is being proposed for amendment, and the changes take effect on January 1, 2014.

*Changes:* A payment-reduction provision is added that applies when more than one radiology procedure is performed by the same provider or provider group for an individual patient on the same date; under this provision, payment is made for the primary procedure at 100% and for each additional procedure at 50%. (This provision mirrors Medicare payment policy.) In addition, certain phrases and abbreviations in the rule are clarified or corrected.

### **Access to Rules and Related Material**

Information about the services and programs of the Ohio Department of Medicaid may be accessed through the main web page of the Ohio Department of Job and Family Services (ODJFS), <http://www.jfs.ohio.gov>. The address of the ODJFS Medicaid page is <http://www.jfs.ohio.gov/ohp/>.

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- (2) Select the appropriate service provider type or handbook.
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- (4) Select the desired item from the 'Table of Contents' pull-down menu.

Current Medicaid maximum payment amounts for many professional services are listed in rule [5160-1-60](#) or in Appendix DD to that rule. Providers may view this information by following these steps:

- (1) Select the 'Ohio Health Plans - Provider' folder.
- (2) Select 'General Information for Medicaid Providers'.
- (3) Select 'General Information for Medicaid Providers (Rules)'.
- (4) Select the rule number and title from the 'Table of Contents' pull-down menu.
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### **Additional Information**

Questions pertaining to this letter should be addressed to:

Ohio Department of Medicaid  
Bureau of Provider Services  
P.O. Box 1461  
Columbus, OH 43216-1461  
Telephone (800) 686-1516

# MHTL 3334-13-11 (Consolidation of Administrative Rules Governing Skilled Therapy and Revision of Psychology Services Rule 5160-8-05)

Medicaid Handbook Transmittal Letter (MHTL) No. 3334-13-11

January 9, 2014

TO: Eligible Medicaid Providers of Skilled Therapy  
Eligible Medicaid Providers of Psychology Services  
Chief Executive Officers, Managed Care Plans  
Directors, County Departments of Job and Family Services

FROM: John B. McCarthy, Director of Medicaid

SUBJECT: Consolidation of Administrative Rules Governing Skilled Therapy and Revision of Psychology Services Rule 5160-8-05

## Summary

The provision of skilled therapy services (physical therapy, occupational therapy, speech-language pathology services, and audiology services) in non-institutional settings is currently addressed in eight rules found in three separate chapters of the Ohio Administrative Code:

Rule [5160-4-26](#), "Covered physical medicine and rehabilitation services"

Rule [5160-8-01](#), "Eligible providers of limited practitioner services"

Rule [5160-8-02](#), "Covered physical therapy services and limitations"

Rule [5160-8-03](#), "Covered occupational therapy services and limitations"

Rule [5160-34-01](#), "Physical therapy, occupational therapy and speech-language pathology/audiology services: general provisions"

Rule [5160-34-01.1](#), "Physical therapy, occupational therapy and speech-language pathology/audiology services: definitions"

Rule [5160-34-01.2](#), "Physical therapy, occupational therapy and speech-language pathology/audiology services: coverage and limitations"

Rule [5160-34-01.3](#), "Physical therapy, occupational therapy and speech-language pathology/audiology services: reimbursement"

All eight of these rules are being rescinded and replaced by five new rules:

Rule [5160-8-30](#), "Skilled therapy: scope and definitions"

Rule [5160-8-31](#), "Skilled therapy: providers"

Rule [5160-8-32](#), "Skilled therapy: coverage"

Rule [5160-8-33](#), "Skilled therapy: documentation of services"

Rule [5160-8-34](#), "Skilled therapy: payment"

A new rule is being adopted to address physical medicine and rehabilitation services furnished by a physician or by a licensed individual under the supervision of a physician:

Rule [5160-4-26](#), "Physical medicine and rehabilitation services"

The current rule governing psychology services, which includes references to a rescinded rule, is being rescinded:

Rule [5160-8-05](#), "Covered psychology services and limitations"

It is being replaced by a new rule of the same number:

## Rule [5160-8-05](#), "Psychology services provided by licensed psychologists"

All changes take effect for dates of service January 1, 2014, or after.

### Results of the Changes

Several aspects of the consolidation of the skilled therapy rules are particularly noteworthy:

- The content of the rules has been reorganized and streamlined. As a result, there is no longer a need for Chapter 5160-34 of the Ohio Administrative Code.
- Unnecessary definitions have been removed.
- Parts of the current rules that duplicate provisions found elsewhere in the Ohio Administrative Code have been deleted.
- Speech-language pathologists and audiologists are now recognized as eligible providers who can submit claims to Medicaid on their own behalf. If they wish to do so, they may continue to receive payment for services that are reported on claims submitted through other providers, as the current rules require; the revised rules will give them an option they did not have before of becoming independent providers.
- The Medicaid requirement that therapy services be provided only by prescription is being eliminated, and all references to a "Medicaid-authorized prescriber" are being removed. Providers will continue to be bound by any licensing requirements that concern prescribing or prescriptions, but Medicaid will no longer superimpose additional prescription requirements not found in licensure law.
- For ease and consistency of administration, a defined benefit year replaces the rolling calendar year as the period within which service limits apply. The limit of thirty dates of service for any combination of physical therapy and occupational therapy is changed to thirty dates of service for each type of therapy.
- A payment-reduction provision is added that applies when more than one skilled therapy service of the same type is rendered by a non-institutional provider to an individual patient on the same date; under this provision, payment is made for the primary procedure at 100% and for each additional procedure at 50%.

There are several significant revisions in the new psychology services rule, [5160-8-05](#):

- Unnecessary references to past dates of service have been removed.
- The specification of procedure codes and modifiers has been discontinued. Descriptions of service are sufficient to indicate what is covered under Medicaid. (Descriptions are also not likely to change very much, even if code sets are revamped.) Providers are simply directed to report appropriate procedure codes and modifiers on claims, instructions for which are readily available from the department and other sources.
- Under the current rule, a doctoral-level clinical psychology intern may provide a psychology service if the licensed psychologist responsible for an individual's care furnishes direct supervision of the intern and has face-to-face contact with the individual during the visit (a phrase that has been interpreted to mean "each visit"). Psychologists have indicated that these supervision and contact requirements are overly stringent and exceed the relevant provisions set forth in the Ohio Revised Code. The new rule calls for general supervision, and face-to-face contact is required during the initial visit and no less often than once per quarter (or during each visit if visits are scheduled more than three months apart).

New rule [5160-4-26](#) maintains Medicaid coverage and payment policy for physical medicine and rehabilitation services, and it includes a reference to rules governing physical therapy, occupational therapy, speech-language pathology, and audiology.

### Access to Rules and Related Material

Information about the services and programs of the Ohio Department of Medicaid may be accessed through the main web page of the Ohio Department of Job and Family Services (ODJFS), <http://www.ifs.ohio.gov>. The address of the ODJFS Medicaid page is <http://www.ifs.ohio.gov/ohp/>.

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Current Medicaid maximum payment amounts for many professional services are listed in rule [5160-1-60](#) or in Appendix DD to that rule. Providers may view this information by following these steps:

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### **Additional Information**

Questions pertaining to this letter should be addressed to:

Ohio Department of Medicaid  
Bureau of Provider Services  
P.O. Box 1461  
Columbus, OH 43216-1461  
Telephone (800) 686-1516

# MHTL 3334-13-10 (Changes to the Medicare Part B cost sharing reimbursement methodology)

## Medicaid Handbook Transmittal Letter (MHTL) No. 3334-13-10

December 30, 2013

TO: Eligible Providers of Medicaid Services  
Chief Executive Officers, Managed Care Plans (MCPs)

FROM: John B. McCarthy, Director

SUBJECT: Changes to the Medicare Part B cost sharing reimbursement methodology

### Summary

Rule [5160-1-05.3](#), **Medicare Part B cost sharing**, is being amended to comply with the mandatory provisions included in the recently passed biennium state budget bill, specifically Section 323.230.

Changes: Rule 5160-1-05.3 is being amended to allow the Department to reimburse up to the Medicaid maximum amount for services, other than physician services, received by a consumer dually enrolled in both Medicaid and Medicare, if using the Medicaid maximum amount results in a lower payment when compared to the full Medicare cost sharing amount. This rule amendment also includes the renumbering of several Ohio Administrative Code references, reflecting the creation of the new Ohio Department of Medicaid.

### Access to Rules and Related Material

The main ODJFS web page includes links to valuable information about its services and programs; the address is <http://www.jfs.ohio.gov>. The web page of the Ohio Department of Medicaid may be accessed through the ODJFS main page or directly at <http://www.jfs.ohio.gov/ohp/>.

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- (3) Select the desired document type.
- (4) Select the desired item from the 'Table of Contents' pull-down menu.

Most current Medicaid maximum reimbursement amounts are listed in rule 5160-1-60 or in Appendix DD to that rule. Providers may view this information by following these steps:

- (1) Select the 'Ohio Health Plans - Provider' folder.
- (2) Select 'General Information for Medicaid Providers'.
- (3) Select 'General Information for Medicaid Providers (Rules)'.
- (4) Select '5160-1-60 Medicaid Reimbursement' from the 'Table of Contents' pull-down menu and then scroll down to the link to Appendix DD.

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**Additional Information**

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Ohio Department of Medicaid

Bureau of Provider Services

P.O. Box 1461

Columbus, OH 43216-1461

Telephone (800) 686-1516

# MHTL 3334-13-09 (New Medicaid Requirements for Ordering, Referring, and Prescribing Providers)

## Medicaid Handbook Transmittal Letter (MHTL) No. 3334-13-09

October 22, 2013

TO: Eligible Providers of Medicaid Services  
Chief Executive Officers, Managed Care Plans (MCPs)

FROM: John B. McCarthy  
Director, Department of Medicaid (ODM)

SUBJECT: New Medicaid Requirements for Ordering, Referring, and Prescribing Providers

### Summary

**Rule 5101:3-1-17.9, Ordering or referring providers**, is being created in order to comply with new program integrity regulations contained in Section 6401 of the Patient Protection and Affordable Care Act (ACA). Medicaid is implementing new requirements in accordance with 42 CFR 455.410, "Enrollment and screening of providers," and 42 CFR 455.440, "National Provider Identifier (NPI)." Ohio Medicaid will require any ordering, referring, or prescribing providers to be screened and enrolled as participating providers with the Medicaid program.

**Change:** Rule 5101:3-1-17.9 is being proposed to specify that Medicaid cannot pay the eligible rendering provider for any health care service requiring a referral, order, or prescription from a physician or other health care professional unless the ordering, prescribing, or referring provider is enrolled with Ohio Medicaid. Furthermore, if a claim fails to include the NPI or the legal name of the physician or health care professional who ordered or prescribed the service, or referred the client for the service, Medicaid reimbursement will not be allowed. Claims submitted to a managed care organization are specifically exempted from the new requirements.

### Additional Provider Information

Future guidance will be released by the Ohio Department of Medicaid (ODM) as to when the above policy change will be enforced in the claims adjudication system. Until then, claims processing and adjudication will not be impacted by this change. However, as a result of the upcoming policy change, all Medicaid providers who render and submit claims for services referred, ordered, or prescribed by non-Medicaid enrolled physicians or other health care professionals should start to prepare for future enforcement by ensuring those referring, ordering, and prescribing physicians and other health care professionals have NPIs and are enrolled in the Medicaid program. Additional implementation details will be provided for providers at a future date.

### Access to Rules and Related Material

The main ODJFS web page includes links to valuable information about its services and programs; the address is <http://www.ifs.ohio.gov>. The web page of the Ohio Department of Medicaid may be accessed through the ODJFS main page or directly at <http://www.ifs.ohio.gov/ohp/>.

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- (3) Select the desired document type.
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Most current Medicaid maximum reimbursement amounts are listed in rule 5101:3-1-60 or in Appendix DD to that rule. Providers may view this information by following these steps:

- (1) Select the 'Ohio Health Plans - Provider' folder.
- (2) Select 'General Information for Medicaid Providers'.
- (3) Select 'General Information for Medicaid Providers (Rules)'.
- (4) Select '5101:3-1-60 Medicaid Reimbursement' from the 'Table of Contents' pull-down menu and then scroll down to the link to Appendix DD.

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### **Additional Information**

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Bureau of Provider Services  
P.O. Box 1461  
Columbus, OH 43216-1461  
Telephone (800) 686-1516

# MHTL 3334-13-08 (Modifications to Professional Services Rules 5101:3-1-60, 5101:3-4-06, 5101:3-4-12, and 5101:3-4-13 and Their Appendices)

## Medicaid Handbook Transmittal Letter (MHTL) No. 3334-13-08

September 3, 2013

TO: Eligible Medicaid Providers  
Chief Executive Officers, Managed Care Plans  
Directors, County Departments of Job and Family Services

FROM: John B. McCarthy, Director of Medical Assistance

SUBJECT: Modifications to Professional Services Rules 5101:3-1-60, 5101:3-4-06, 5101:3-4-12, and 5101:3-4-13 and Their Appendices

Modifications are being made in four administrative rules that establish coverage and reimbursement policies for professional services, physician visits conducted in a variety of settings, or pharmaceuticals administered by providers. These changes take effect on September 1, 2013.

Rule [5101:3-1-60](#), titled "Medicaid reimbursement," sets forth reimbursement policies for services furnished by professional providers. This rule is being proposed for rescission and replacement by a new rule of the same number and title.

*Changes:* The text of the rule is being reorganized, streamlined, and clarified; a new provision states explicitly that reimbursement limits may be set on the basis of the characteristics of an individual procedure, service, or supply or the relationships between procedures, services, or supplies.

The appendix to the rule is being amended in several ways:

- Typographical errors are corrected, new Healthcare Common Procedure Coding System (HCPCS) codes are added, obsolete HCPCS codes are discontinued, coverage is initiated for some previously noncovered HCPCS codes, adjustments are made to the professional/technical split of certain current HCPCS codes, and code descriptions are revised.
- The 'Visit' column, whose sole function has been to display an indicator for 12 blood-related procedures that may be separately reimbursable on the day of surgery, is being discontinued; this provision will now be addressed in the body of rule 5101:3-4-06.
- Pursuant to section 5111.021 of the Ohio Revised Code and paragraph (D) of this rule, the maximum fees for certain procedures, services, or supplies are reduced so that they do not exceed the corresponding maximum Medicare allowed amounts.
- Long sections of outdated items (such as old models of spectacle frames and lenses) are collapsed into single entries.
- Perhaps most significant, entries for vaccines and other provider-administered pharmaceuticals—represented, for example, by Current Procedural Terminology (CPT) codes in the range from 90476 to 90749, CPT codes in the range from 90281 to 90399, or HCPCS codes beginning with the letter J—are removed from this appendix and replaced with a reference to new rule 5101:3-4-12.

Rule [5101:3-4-06](#), titled "Physician visits," sets forth coverage and reimbursement policies for physician visits conducted in a variety of settings. This rule is being proposed for amendment.

*Changes:* In the section dealing with visits related to surgical procedures, references to the visit indicator in rule 5101:3-1-60 are being removed. Other corrections are being made to improve clarity and to update a reference to the Coordinated Services Program.

Rule [5101:3-4-12](#), titled "Immunizations," sets forth general provisions for coverage and reimbursement of immunizations and vaccines. This rule is being proposed for rescission and replacement by a new rule of the

same number, titled "Immunizations, injections and infusions (including trigger-point injections), and provider-administered pharmaceuticals."

*Changes:* The rule is being reorganized, streamlined, and clarified, and the content of existing rule 5101:3-4-13 is being incorporated. The two existing appendices to the rule are being discontinued; the new rule instead prescribes a methodology for establishing a maximum allowable fee for a covered provider-administered pharmaceutical, and it specifies a web location where a list of covered provider-administered pharmaceuticals will be found. A superfluous reference to national organizations and an unnecessary provision concerning the determination of medical necessity are being removed. A new provision will allow reimbursement for vaccine administration rather than an evaluation and management service (i.e., an office visit) when an immunization procedure is performed by a provider who is eligible for increased reimbursement in accordance with rule 5101:3-1-60.3.

Rule **5101:3-4-13**, titled "Therapeutic injections (including trigger point injections) and prescribed drugs," sets forth general provisions for coverage and reimbursement of injections and pharmaceuticals administered as physician services. This rule is being proposed for rescission.

*Changes:* The content of the rule is being incorporated into new rule 5101:3-4-12, titled "Immunizations, injections and infusions (including trigger-point injections), and provider-administered pharmaceuticals." A new rule 5101:3-4-13, titled "Relocated provisions concerning injections and provider-administered pharmaceuticals," is being proposed for adoption. This placeholder rule simply cites new rule 5101:3-4-12; it serves to ensure that existing references to rule 5101:3-4-13 remain functional until they can be updated.

### **Access to Rules and Related Material**

The main web page of the Ohio Department of Job and Family Services (ODJFS) includes links to valuable information about its services and programs; the address is <http://www.jfs.ohio.gov>. The web page of the Office of Medical Assistance (Medicaid) may be accessed through the ODJFS main page or directly at <http://www.jfs.ohio.gov/ohp/>.

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- (4) Select the desired item from the 'Table of Contents' pull-down menu.

Most current Medicaid maximum reimbursement amounts are listed in rule 5101:3-1-60 or in Appendix DD to that rule. Providers may view this information by following these steps:

- (1) Select the 'Ohio Health Plans - Provider' folder.
- (2) Select 'General Information for Medicaid Providers'.
- (3) Select 'General Information for Medicaid Providers (Rules)'.
- (4) Select '5101:3-1-60 Medicaid Reimbursement' from the 'Table of Contents' pull-down menu and then scroll down to the link to Appendix DD.

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Questions pertaining to this letter should be addressed to:

Office of Medical Assistance

Bureau of Provider Services

P.O. Box 1461

Columbus, OH 43216-1461

Telephone (800) 686-1516

# MHTL 3334-13-07 (National Correct Coding Initiative)

## Medicaid Handbook Transmittal Letter (MHTL) No. 3334-13-07

July 23, 2013

TO: Eligible Providers of Professional Services  
FROM: John B. McCarthy, Medicaid Director  
SUBJECT: National Correct Coding Initiative

The National Correct Coding Initiative (NCCI) was developed by the Centers for Medicare & Medicaid Services (CMS) to control inappropriate payment of claims resulting from the improper reporting of Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes. NCCI serves as a common model and standard for handling claims for procedures and services that are performed by one provider for one individual on a single date of service.

The claim-processing system of the Office of Medical Assistance (OMA), known as the Medicaid Information Technology System (MITS), uses McKesson ClaimCheck® for its clinical editing function. Because OMA has planned to implement NCCI by the end of June 2013, the ClaimCheck module has been upgraded and is now fully compatible with NCCI. When it processes a claim, MITS applies two types of NCCI tests, which are referred to as "edits":

- **A procedure-to-procedure (PTP) "incidental" edit** determines whether a pair of procedure codes should not be reported together because one procedure is incidental to (performed as a natural consequence of or adjunct to) the other.
- **A medically unlikely edit (MUE)** determines whether the units of service (UOS) exceed the maximum that a provider would be likely to report under most circumstances. (MUEs mainly affect claims submitted by providers of durable medical equipment and supplies.)

There are circumstances in which it is appropriate for a provider to be paid separately for two procedures but an NCCI edit denies payment for one of them. In those circumstances, NCCI allows providers to append one of several modifiers to the procedure code:

58 - Staged or related procedure or service by same physician during the postoperative period

59 - Distinct procedural service

78 - Unplanned return to the operating/procedure room by the same physician following initial procedure for a related procedure during the postoperative period

79 - Unrelated procedure by same physician during the postoperative period

Claims submitted by several provider types are already subject to ClaimCheck edits. As of June 26, 2013, ClaimCheck/NCCI editing will be applied to claims submitted by seven additional provider types:

- Alcohol and drug treatment center
- Ambulatory surgery center (ASC)
- Chiropractor
- Community mental health center (CMHC)
- Durable medical equipment (DME) provider, basic
- DME provider, orthotics and prosthetics
- DME provider, special license

Moreover, modifiers 58, 59, 78, and 79 will be accepted on applicable claims submitted by any provider of professional services.

It is important to note that there are some significant differences between *Medicaid* NCCI and *Medicare* NCCI. More information about Medicaid is available from <http://www.medicaid.gov>. Details about Medicaid NCCI

can be found at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html>.

### **Access to Rules and Related Material**

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### **Additional Information**

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Bureau of Provider Services  
P.O. Box 1461  
Columbus, OH 43216-1461  
Telephone (800) 686-1516

# MHTL 3334-13-06 (Rule 5101:3-10-05 Reimbursement for Covered Services)

## Medicaid Handbook Transmittal Letter (MHTL) No. 3334-13-06

June 27, 2013

TO: Durable Medical Equipment (DME) Providers of Medicaid Services  
Directors, County Departments of Job and Family Services  
CEOs, Managed Care Plans

FROM: John B. McCarthy, Director

SUBJECT: Rule 5101:3-10-05 Reimbursement for covered services

### Summary

The following rules was amended and filed to be effective for dates of service on and after July 1, 2013.

Rule [5101:3-10-05](#), titled "Reimbursement for Covered Services," sets forth the reimbursement provisions for the Medicaid durable medical equipment (DME) benefit. The changes to this rule include the following:

- Updated language pertaining to the dispensing of orthotic and prosthetic (O&P) supplies.
- A new provision requiring that prescriptions for certain DME and O&P items designated by the Centers for Medicare & Medicaid Services must have originated as a result of a face-to-face encounter.
- Updated language regarding cost effective reimbursement.
- Updated language regarding reimbursement when the consumer expires prior to the dispensing of custom molded or fitted items.
- Updated language regarding the use of the RT (right side) and LT (left side) modifiers.

### Access to Rules and Related Material

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- (2) Select 'General Information for Medicaid Providers'.
- (3) Select 'General Information for Medicaid Providers (Rules)'.
- (4) Select '[5101:3-1-60](#) Medicaid Reimbursement' from the 'Table of Contents' pull-down menu and then scroll down to the link to Appendix DD.

The Legal/Policy Central - Calendar site, <http://www.odjfs.state.oh.us/lpc/calendar/>, is a quick reference for finding documents that have recently been published. This site also provides a link to a listing of OMA

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### **Additional Information**

Questions pertaining to this letter should be addressed to:

Office of Medical Assistance

Bureau of Provider Services

P.O. Box 1461

Columbus, OH 43216-1461

Telephone (800) 686-1516

# MHTL 3334-13-05 (MPIP Rules)

## Medicaid Handbook Transmittal Letter (MHTL) No. 3334-13-05

September 26, 2013

TO: Eligible Providers  
Chief Executive Officers, Managed Care Plans (MCPs)

FROM: John B. McCarthy, Director

SUBJECT: Medicaid Provider Incentive Program (MPIP) Rules

### Summary

The Centers for Medicare and Medicaid Services (CMS) recently released its Stage 2 final rule for the EHR incentive payment programs. There were specific updates to the Medicaid EHR incentive program that impacts Ohio's Medicaid Provider Incentive Program (MPIP). Rules [5101:3-57-01](#) "Medicaid Provider Incentive Program (MPIP): Program Eligibility Requirements" and [5101:3-57-03](#) "Medicaid Provider Incentive Program (MPIP): Incentive Payments (calculation, duration, amount and limit)" are being revised to include the updates from the federal rule, which in many cases, provides eligible providers more flexibility with qualifying for incentive payments. Rule [5101:3-57-02](#) "Medicaid Provider Incentive Program (MPIP): Certified Electronic Health Record (EHR) Technology Requirements, Adopt, Implement, or Upgrade and Meaningful Use Stage One" is being rescinded, parts of which are now included in rule 5101:3-57-01 "Medicaid Provider Incentive Program (MPIP): Program Eligibility Requirements."

These rules are also being revised to eliminate duplication in rules where there is language in a federal rule covering the area. In places where we are relying on the federal rule, the Ohio Administrative Code (OAC) references the federal rule and its respective effective date.

Rule [5101:3-57-04](#) "Medicaid Provider Incentive Program (MPIP): Program Integrity and Provider Appeals" is being amended for the sole purpose of replacing references to the Ohio Department of Job and Family Services (ODJFS), with the Ohio Department of Medicaid (ODM). No other changes are being made to this rule.

### Access to Rules and Related Material

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### Additional Information

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Ohio Department of Medicaid

Bureau of Provider Services

P.O. Box 1461

Columbus, OH 43216-1461

Telephone (800) 686-1516

# MHTL 3334-13-04 (2013 Healthcare Common Procedure Coding System (HCPCS) Regular File)

## Medicaid Handbook Transmittal Letter (MHTL) No. 3334-13-04

March 27, 2013

TO: All Eligible Providers of Medicaid Services  
Directors, County Departments of Job and Family Services  
CEOs, Managed Care Plans

FROM: John B. McCarthy, Director

SUBJECT: 2013 Healthcare Common Procedure Coding System (HCPCS) Regular File

### Summary

The following rules were amended and emergency filed to implement the new HCPCS codes that are effective for dates of service on and after January 1, 2013. The permanent versions of these rules will be effective on March 28, 2013. They will replace the emergency filed version of these rules that were effective January 1, 2013.

The HCPCS, which includes Current Procedural Terminology (CPT) codes, is a medical procedure coding system that is the national standard for reporting medical services for billing and claims payment purposes. It is also used by Medicare, private health insurance plans, and managed care plans, as well as state workers' compensation programs and state Medicaid programs.

The Centers for Medicare and Medicaid Services (CMS), in conjunction with the American Medical Association and other professional groups, updates the HCPCS on an annual basis. OMA must implement the HCPCS updates for the Medicaid program to comply with the federal Health Insurance Portability and Accountability Act (HIPAA), which requires the use of a nationally standardized coding system (45 CFR 162.1000 and 45 CFR 162.1002). The updates to these codes require OMA to make changes in the Ohio Administrative Code (OAC) because HCPCS codes are included in OAC rules or their appendices that guide the Medicaid program.

The following types of HCPCS code changes will be effective for dates of service on and after January 1, 2013: new codes added, obsolete codes deleted, revised codes implemented, changes in definition, and associated reimbursement changes. New HCPCS codes correspond to services without existing codes or services with existing codes that have been simultaneously rendered obsolete. New HCPCS codes that correspond to services without prior existing codes require coverage and payment decisions that are reflected in the rules and/or their appendices. Revised HCPCS codes correspond to services that have a revised definition.

Rules being amended to comply with HCPCS updates are as follows:

**Rule [5101:3-1-60](#)**, entitled "Medicaid reimbursement," sets forth the Medicaid reimbursement policies for all professional providers. The appendix to this rule is being updated to add new HCPCS codes, delete obsolete HCPCS codes, revise definitions, and update reimbursement amounts associated with the codes. A new payment status indicator has also been developed. This new status indicator (B) will be used to signify bundled procedures. No separate payment will be made for bundled procedures as these services are incidental to the primary procedure. Some of the coding changes require amendments to existing policy on coverage. No changes are being made to the rule body itself.

**Rule [5101:3-4-06](#)**, entitled "Physician visits," sets forth coverage and reimbursement policies for physician visits provided in a variety of settings. Changes include the addition of codes for transitional care management services as distinct, covered services for which eligible providers of physician services may obtain reimbursement. The changes are driven only by HCPCS code updates. Changes also include updates to rule references.

**Rule [5101:3-4-12](#)**, entitled "Immunizations," sets forth coverage and reimbursement policies for immunization services. Changes to Appendix A of the rule, which contains vaccines covered under the federal vaccines for children program, include the addition of a new influenza virus vaccine code and the deletion of codes for tetanus and diphtheria vaccine. Changes to Appendix B of the rule, which sets forth vaccines that are covered for adults, include the addition of a code for Hepatitis B vaccine and the deletion of codes for tetanus and diphtheria vaccine. Medicaid coverage is not changing as a result of these code changes, as tetanus and diphtheria vaccines will continue to be covered for children and adults using different HCPCS codes. No changes are being made to the rule body itself.

**Rule [5101:3-4-19](#)**, entitled "Allergy services," sets forth coverage and reimbursement policies for allergy sensitivity tests performed by eligible providers of physician services, and immunotherapy. Changes include the addition of new HCPCS codes and deletion of obsolete HCPCS codes related to ingestion challenge testing.

**Rule [5101:3-4-22](#)**, entitled "Surgical services," sets forth coverage and billing practices for surgical services delivered by physician providers of Medicaid services. The appendix of the rule is being updated based on current values contained in the Relative Value Unit file that the Centers for Medicare and Medicaid releases annually for surgical procedures subject to multiple, bilateral, or assistant at surgery procedure pricing. No changes are being made to the rule body itself.

**Rule [5101:3-4-29](#)**, entitled "Services provided for the diagnosis & treatment of mental and emotional disorders," sets forth coverage and reimbursement policy for services that are provided by physician providers for the diagnosis and treatment of mental and emotional disorders. The changes to this rule update rule references that have become obsolete because outdated procedure codes in OAC 5101:3-8-05 have been replaced.

**Rule [5101:3-4-33](#)**, entitled "Coverage of fluoride varnish by non-dental providers," sets forth the coverage and limitations of the application of fluoride varnish by non-dental providers. The changes to this rule replace an outdated procedure code and an outdated rule reference.

**Rule [5101:3-5-04](#)**, entitled "Dental program: covered preventive services & limitations," sets forth the coverage and limitations of preventive dental services. The change to this rule replaces outdated procedure code nomenclature for the topical application of fluoride.

**Rule [5101:3-8-05](#)**, entitled "Covered psychology services & limitations," sets forth the coverage and limitations of services provided by independent psychologists. The rule is being changed to replace outdated procedure codes, update procedure code nomenclature, update outdated rule references, and describe coverage for a new code, interactive complexity, which must be billed as an add-on code to several new psychotherapy codes as a result of the HCPCS updates.

**Rule [5101:3-21-02.3](#)**, entitled "Limited family planning benefit," sets forth coverage and reimbursement policies for procedures and services that are covered under this benefit. The appendix to this rule is being updated to add new HCPCS codes, delete obsolete codes, and update the fee schedule. Anesthesia provided during tubal ligations, vasectomies, and hysterectomies have been added to the appendix to this rule. No changes are being made to the rule body itself.

### **Access to Rules and Related Material**

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### **Additional Information**

Questions pertaining to this letter should be addressed to:

Office of Medical Assistance  
Bureau of Provider Services  
P.O. Box 1461  
Columbus, OH 43216-1461  
Telephone (800) 686-1516

# MHTL 3334-13-03 (Medicaid Expansion Demonstration Program: MetroHealth Care Plus)

## Medicaid Handbook Transmittal Letter (MHTL) No. 3334-13-03

February 26, 2013

FROM: John B. McCarthy, Director, Office of Medical Assistance  
TO: Eligible Providers of Medicaid Services  
Chief Executive Officers, Managed Care Plans (MCPs)  
Directors, County Departments of Job and Family Services  
SUBJECT: Medicaid Expansion Demonstration Program: MetroHealth Care Plus

### Summary

**Rule 5101:3-54-01**, Medicaid expansion demonstration program, "MetroHealth Care Plus," is being adopted to implement Ohio's Medicaid 1115 waiver demonstration in Cuyahoga County. The program will build on current Ohio Medicaid eligibility levels and target parents and childless adults with income up to 133 percent of the Federal Poverty Level, who are not currently insured or eligible for Medicaid. Eligibility criteria for "MetroHealth Care Plus," which will be determined by The MetroHealth System, will be based on income, residency, and citizenship, as described in Appendix A to the rule. Covered benefits and providers under "MetroHealth Care Plus" will be limited to those identified by The MetroHealth System, as described in Appendix B. Recipients will have access to the State's fair hearing process after exhausting The MetroHealth System's internal grievance protocols, as described in Appendix C.

### Access to Rules and Related Material

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### Additional Information

Questions pertaining to this letter should be addressed to:

Ohio Department of Job and Family Services  
Office of Ohio Health Plans, Bureau of Policy and Health Plan Services  
Policy Management and Development Section

P.O. Box 182709

Columbus, OH 43216-1461

[Medicaid@jfs.ohio.gov](mailto:Medicaid@jfs.ohio.gov)

Or

John R. Corlett

Vice President, Government Relations and Community Affairs

The MetroHealth System

2500 MetroHealth Drive, M128

Cleveland, Ohio 44109

[jcorlett@metrohealth.org](mailto:jcorlett@metrohealth.org)

# MHTL 3334-13-02 (New Rule 5101:3-1-60.3: Affordable Care Act Primary Care Physician Rate Increase)

## Medicaid Handbook Transmittal Letter (MHTL) No. 3334-13-02

January 2, 2013

TO: Eligible Medicaid Providers  
Chief Executive Officers, Managed Care Plans  
Directors, County Departments of Job and Family Services

FROM: John B. McCarthy, Director of Medical Assistance

SUBJECT: New Rule 5101:3-1-60.3: Affordable Care Act Primary Care Physician Rate Increase

### Summary

Ohio Administrative Code rule [5101:3-1-60.3](#) is being adopted to comply with provisions of the Affordable Care Act which require a qualified physician with a specialty designation of family medicine, internal medicine, pediatric medicine, or a subspecialty recognized by the American Board of Medical Specialties, the American Board of Physician Specialties, or the American Osteopathic Association within one of these three specialty designations, shall receive increased reimbursement for primary care services rendered to Medicaid eligible individuals. A physician within the specialty designations above can qualify by providing proof of board certification or certifying that at least 60 percent of all billed services provided by these physicians are considered primary care services. This new rule will be effective from January 1, 2013 through December 31, 2014.

The primary care services subject to the increased payment are Current Procedural Terminology (CPT) evaluation and management procedure codes 99201 to 99499, and CPT vaccine administration codes 90460, 90461 and 90470 to 90474. The increased reimbursement available for these codes applies in both the fee-for-service and the managed care delivery systems.

The reimbursement to be paid to a qualified provider for rendering the specified primary care services contained in this rule will be either 100% of the 2013 or 2014 Medicare Physician Fee Schedule non facility allowed amount, or the amount calculated by replacing the 2013 or 2014 conversion factor with the 2009 conversion factor, whichever results in a higher fee. However, if a provider's billed charge is less than the amount otherwise available under this rate increase, the provider will be reimbursed the billed charge.

### Access to Rules and Related Material

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**Additional Information**

Questions pertaining to this letter should be addressed to:

Ohio Department of Job and Family Services

Office of Medical Assistance, Bureau of Provider Services

P.O. Box 1461

Columbus, OH 43216-1461

Telephone (800) 686-1516

# MHTL 3334-13-01 (Discontinuation of Paper Claims Submission)

## Medicaid Handbook Transmittal Letter (MHTL) No. 3334-13-01

January 4, 2013

TO: Eligible Medicaid Providers  
Chief Executive Officers, Managed Care Plans (MCPs)  
Directors, County Departments of Job and Family Services

FROM: John B. McCarthy  
Director, Medical Assistance

SUBJECT: Discontinuation of Paper Claims Submission

### Summary

Ohio Administrative Code (OAC) rule [5101:3-1-19](#) is being amended to comply with Section 5111.052 of the Ohio Revised Code which requires that as of January 1, 2013, Medicaid providers use only electronic claims submission processes to submit claims to the Ohio Department of Job & Family Services. Prior to this change, hard copy paper claims were allowed for certain claim submissions. After this change goes into effect, providers will be required to submit all claims through either electronic data interchange (EDI), the Medicaid Information Technology System (MITS) web portal, or the point-of-sale system for pharmacy claims. This rule is also being amended to change Medicaid agency references from the Ohio Department of Job and Family Services (ODJFS) to the Office of Medical Assistance (OMA) in accordance with Section 5111.01 of the Ohio Revised Code, and to remove the effective date reference to 45 C.F.R. 162.1002.

### Rule Changes

Rule [5101:3-1-19](#), "Claim Submission," describes policies for Medicaid provider claims submission. Changes include:

- Paragraph (A)(3) is being inserted to allow for an exception to electronic claims submission when required by OMA to submit in a different format (such as a provider subject to the hold and review process).
- Policies pertaining to hard copy paper claims submission are being removed from the rule.
- References to ODJFS are being replaced with OMA.
- The effective date reference to 45 C.F.R. 162.1002 is being removed in order to reflect the currently effective version of this federal regulation in OAC. This is necessary to ensure Ohio Medicaid policies are consistent with the federally established timeline for compliance with use of the International Classification of Diseases, 10th Edition (ICD-10), which recently was extended from October 1, 2013 to October 1, 2014.

### Access to Rules and Related Material

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#### Additional Information

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Office of Medical Assistance, Bureau of Provider Services  
P.O. Box 1461  
Columbus, OH 43216-1461  
Telephone (800) 686-1516

# **MHTL 3334-12-05 (General Medicaid Provider Information on Ohio Medicaid Health Homes for Individuals with Serious and Persistent Mental Illness)**

## **Medicaid Handbook Transmittal Letter (MHTL) No. 3334-12-05**

October 4, 2012

**TO:** Eligible Medicaid Providers  
Chief Executive Officers, Managed Care Plans  
Directors, County Departments of Job and Family Services

**FROM:** John B. McCarthy, Director  
Office of Medical Assistance

**SUBJECT:** General Medicaid Provider Information on Ohio Medicaid Health Homes for Individuals with Serious and Persistent Mental Illness

### **Summary**

This Medicaid Handbook Transmittal Letter (MHTL) provides information about Ohio Medicaid's new health home benefit for individuals with serious and persistent mental illness (SPMI). This letter contains general information on the background, implementation plan, and other information important to any Medicaid providers that may serve individuals with SPMI. This communication is intended to provide basic information for Medicaid providers other than those that will serve as health homes for SPMI. Health home providers will receive separate communications regarding details such as certification, rate setting, billing, and claims payment.

### **Background**

Leaders of Ohio's health and human services agencies believe that better care coordination can result in improved health outcomes while spending less of the taxpayer's dollars. Health homes aim to integrate physical and behavioral health care by offering and facilitating access to medical, behavioral and social services that are timely, of high quality and coordinated by an individualized care team. Ohio Medicaid teamed up with the Ohio Department of Mental Health to focus on creating health homes for individuals on Medicaid who have serious and persistent mental illness (SPMI).

A health home is not a building; it is a coordinated, person-centered system of care. An individual who is eligible for health home services can obtain comprehensive medical and mental health care, drug and/or alcohol addiction treatment, and social services that are coordinated by a team of health care professionals.

The following health home services will be available for individuals with serious and persistent mental illness:

- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Comprehensive Transitional Care
- Individual and Family Support
- Referral to Community and Social Support Services

Ohio Medicaid health homes for individuals with serious and persistent mental illness are designed to:

- Improve care coordination
- Improve integration of physical and behavioral health care
- Improve health outcomes
- Lower rates of hospital emergency department use

- Reduce hospital admissions and readmissions
- Decrease reliance on long term care facilities
- Improve the experience of care and consumer quality of life
- Reduce healthcare costs

Community behavioral health providers that meet state-defined requirements, including integration of primary and behavioral health care services, can qualify as health homes. Health home services will be provided by a team consisting of the following health care professionals:

- Health Home Team Leader
- Embedded Primary Care Clinician
- Care Manager
- Qualified Health Home Services Specialists

Adults and children who have Medicaid benefits and meet the State of Ohio definition of SPMI (which includes adults with serious mental illness and children with serious emotional disturbance) will be eligible for health home services in community behavioral health centers.

### **Implementation Plan**

Because the health home concept requires participating community behavioral health providers to transform their practices, the Medicaid health homes for individuals with SPMI will be implemented through a phased-in approach based on the county or counties composing the provider's service area. The overall roll-out plan will consist of three different phases. Phase I will include five counties with implementation scheduled for October 1, 2012. Phase II will include thirty counties with implementation tentatively scheduled for April 1, 2013. Phase III will include the remaining fifty-three counties with implementation tentatively scheduled for July 1, 2013.

Below is a list of counties, by phase:

Phase I will be implemented in October 2012 in the following counties: Butler County, Adams County , Scioto County, Lawrence County, and Lucas County.

Phase II is tentatively scheduled for implementation in April 2013 in the following counties: Fulton, Williams, Defiance, Henry, Cuyahoga, Summit, Portage, Huron, Crawford, Richland, Ashland, Marion, Morrow, Delaware, Knox, Franklin, Licking, Preble, Montgomery, Fayette, Pickaway, Hocking Ross, Vinton, Athens, Washington, Pike, Jackson, Gallia, and Meigs.

Phase III is tentatively scheduled for implementation in July 2013 in the remaining Ohio counties.

Regions chosen for Phase I offer diversity geographically and in the models of care that can be offered, resulting in gradual growth that will help in promoting the success of the health homes initiative in Ohio. Please note that the implementation schedule for the second and third phase is considered tentative and is subject to change. ODMH and ODJFS will continue working in partnership with stakeholders on the implementation of health homes. As community behavioral health centers are selected for participation as Medicaid health homes for SPMI, the ODMH health homes website will be updated so that all Medicaid providers have access to health home contact information in the event they would like to refer any potentially eligible consumers for an assessment for health home services.

### **Important Information for ALL Medicaid providers**

Community behavioral health providers that elect to become health homes for individuals with SPMI will be expected to interact with other Medicaid providers through various activities essential to the health home service. Some examples of health home activities that may involve interaction with other Medicaid providers treating SPMI health home enrollees include:

- Tracking test results, referrals, and follow-ups;
- Facilitating and managing care transitions (inpatient to inpatient, residential, community settings) to prevent unnecessary inpatient admissions, inappropriate emergency department use, and other adverse outcomes such as homelessness;

- Developing a comprehensive discharge and/or transition plan with short-term and long-term follow-up;
- Conducting or facilitating clinical hand-offs as face-to-face interactions between providers to exchange information and ask questions; and
- Assisting consumers in making appointments and validating that the consumer attended the appointment and the outcome of the visit and any needed follow-up.

For health home participants enrolled in Medicaid managed care plans (MCPs), the health home will be establishing relationships with MCPs to ensure all needs of health home members are met and establish clear delineation of service delivery responsibilities. All health home services will be provided by the health home provider, who will work with MCPs and collaborate with MCP panel providers and clinicians.

All Medicaid providers should be aware of this new benefit for individuals with SPMI, as health home providers may be reaching out to other Medicaid providers as part of their delivery of the health home service. Medicaid providers may also want to refer potentially eligible individuals to SPMI health homes in their service areas if they believe this service may benefit those consumers.

### **Health Home Resources**

The Ohio Department of Mental Health website contains additional information about health homes. This website will continue to be updated as implementation plans are finalized, and will include a list of SPMI health home providers once they approved for participation.

<http://mentalhealth.ohio.gov/what-we-do/protect-and-monitor/medicaid/hhc-main.shtml>

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### **Additional Information**

Questions pertaining specifically to the SPMI health homes should be addressed to:

[healthhomes@mh.ohio.gov](mailto:healthhomes@mh.ohio.gov)

Other general Medicaid provider questions should be addressed to:

Ohio Department of Job and Family Services

Office of Ohio Health Plans, Bureau of Provider Services

P.O. Box 1461

Columbus, OH 43216-1461

Telephone (800) 686-1516

# MHTL 3334-12-04 (Medicaid Provider Incentive Program (MPIP) Rules)

## Medicaid Handbook Transmittal Letter (MHTL) No. 3334-12-04

September 6, 2012

TO: Eligible Medicaid Providers  
Chief Executive Officers, Managed Care Plans (MCPs)

FROM: Michael B. Colbert, Director

SUBJECT: Medicaid Provider Incentive Program (MPIP) Rules

### Summary

Rules 5101:3-57-03, "Medicaid Provider Incentive Program (MPIP): incentive payments (calculation, duration, amount and limit)" and 5101:3-57-04, "Medicaid Provider Incentive Program (MPIP): program integrity and provider appeals" are being amended.

**Rule [5101:3-57-03](#)**, describes and defines the process for which incentive payments will be calculated and disbursed including any federally mandated maximum amounts, calculation and timeframes to receive payment. This rule sets forth the requirements for an eligible professional to voluntarily reassign his or her incentive payments. This rule also explains that incentive payments are subject to offsets, adjustments, and recoupment.

**Changes:** This rule is being amended to reference federal rule 42 CFR 495.310 for calculating the eligible hospital incentive payment, instead of listing all data elements required to calculate the eligible hospital incentive payment as required by federal rule. This amendment is to ensure consistency with federal rule. It also adds requirements around providers switching from the Medicare electronic health records (EHR) incentive to MPIP.

**Rule [5101:3-57-04](#)**, describes the process for requesting a review in the event of an adverse determination made in regards to an eligible professional's or eligible hospital's MPIP application, or if the eligible professional or eligible hospital does not agree with the incentive payment amount determined by MPIP. This rule also explains that MPIP applications are subject to prepayment review, post payment audit and specific record retention timeframes.

**Changes:** This rule is being amended to clarify for eligible providers what happens in the event of an untimely appeal request.

### Access to Rules and Related Material

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**Additional Information**

Questions pertaining to this letter should be addressed to:

Ohio Department of Job and Family Services

Office of Ohio Health Plans, Bureau of Provider Services

P.O. Box 1461

Columbus, OH 43216-1461

Telephone (800) 686-1516

# MHTL 3334-12-03 (New 2012 HCPCS and CPT Codes)

## Medicaid Handbook Transmittal Letter (MHTL) No. 3334-12-03

April 2, 2012

TO: Eligible Providers of Advanced Practice Nurse, Ambulatory Surgery Center, Chiropractic, Fee-for-Service Clinic, Federally Qualified Health Center, Physical and Occupational Therapy, Physician, Podiatry, Psychology, and Rural Health Clinic Services

Chief Executive Officers, Managed Care Plans (MCPs)

Directors, County Departments of Job and Family Services

FROM: Michael B. Colbert, Director

SUBJECT: New 2012 HCPCS and CPT Codes

### Summary

This letter provides information regarding the amendment of Ohio Administrative Code (OAC) rules [5101:3-1-60](#), [5101:3-4-12](#), and [5101:3-4-22](#). These rules have been amended to implement the new Healthcare Common Procedure Coding System (HCPCS) codes effective for dates of service on and after January 1, 2012. These rules are effective March 30, 2012, and replace emergency versions of the rules that took effect on December 30, 2011.

**Rule [5101:3-1-60](#)**, "Medicaid reimbursement," describes the reimbursement policies for all professional providers.

*Changes:* New HCPCS codes have been added, obsolete HCPCS codes have been deleted, and definitions have been revised. Maximum payment amounts for the new HCPCS codes have been created, and payment amounts for HCPCS codes that are now obsolete have been deleted. Updates have been made to the reimbursement and coverage of nineteen physician-administered drugs; the reimbursement rates for these drugs will be equal to the Medicare Part B Average Sales Price as of January 1, 2012. The maximum fees for certain procedures have been corrected; in particular, the maximum fees for sixteen procedures have been reduced because in the previous version they erroneously included a facility reimbursement component. Coverage and reimbursement information has been added for Oncotype DX, a genetic profile panel test for breast cancer patients.

**Rule [5101:3-4-12](#)**, "Immunizations," describes provisions for coverage and reimbursement of immunizations and immune globulins.

*Change:* Appendix B to this rule is being updated to add coverage and reimbursement for a new influenza vaccine, represented by Current Procedural Terminology (CPT) code 90654. Additionally, coverage of the CPT code for pandemic influenza (90663) is being deleted from Appendix A to the rule because this vaccine is no longer being manufactured. The rule body is being updated to reflect these changes in coverage.

**Rule [5101:3-4-22](#)**, "Surgical services," describes coverage provisions for certain services provided by physician providers of Medicaid services.

*Changes:* The appendix to this rule is being updated to include new HCPCS codes, to delete obsolete codes, and to provide information on appropriate surgery modifiers for the newly covered codes. No changes were made to the rule body itself.

### Access to Rules and Related Material

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Most current Medicaid maximum reimbursement amounts are listed in rule 5101:3-1-60 or in Appendix DD to that rule. Providers may view this information by following these steps:

- (1) Select the 'Ohio Health Plans - Provider' folder.
- (2) Select 'General Information for Medicaid Providers'.
- (3) Select 'General Information for Medicaid Providers (Rules)'.
- (4) Select '5101:3-1-60 Medicaid Reimbursement' from the 'Table of Contents' pull-down menu and then scroll down to the link to Appendix DD.

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#### **Additional Information**

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Office of Ohio Health Plans, Bureau of Provider Services  
P.O. Box 1461  
Columbus, OH 43216-1461  
Telephone (800) 686-1516

# MHTL 3334-12-02 (Recission of MITS Transition Rule)

## Medicaid Handbook Transmittal Letter (MHTL) No. 3334-12-02

February 1, 2012

TO: Eligible Providers  
Chief Executive Officers, Managed Care Plans (MCPs)  
Directors, County Departments of Job and Family Services

FROM: Michael B. Colbert, Director

SUBJECT: Recission of MITS Transition Rule

### Summary

Rule [5101:3-1-19.4](#), "Transitioning from the Medicaid Management Information System (MMIS) to the Medicaid Information Technology System (MITS)" is being rescinded. This rule allowed the department to return to providers certain paper forms used in the old MMIS system in order to transition to MITS. With the transition to MITS completed, the process described in rule 5101:3-1-19.4 is no longer applicable. Providers should refer to rule 5101:3-1-19, "Claim Submission," for information pertaining to claims submission in MITS.

### Access to Rules and Related Material

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P.O. Box 1461  
Columbus, OH 43216-1461  
Telephone (800) 686-1516

# MHTL 3334-12-01 (Provider Screening and Application Fee)

## Medicaid Handbook Transmittal Letter (MHTL) No. 3334-12-01

January 5, 2012

TO: All Eligible Providers  
Chief Executive Officers, Managed Care Plans (MCPs)  
Directors, County Departments of Job and Family Services

FROM: Michael B. Colbert, Director

SUBJECT: Provider Screening and Application Fee

### Summary

Section 6401 of the Patient Protection and Affordable Care Act (ACA) requires providers to meet certain provider screening requirements and pay an associated application fee. Based on federal regulations and federal guidance, providers are assigned to one of three provider screening levels: limited, moderate, or high. Certain providers must also pay an application fee when submitting an enrollment application. The amount of the application fee is determined by the Centers for Medicare and Medicaid Services and is adjusted yearly by the percentage change in the consumer price index for all urban consumers for the twelve-month period starting in June of the previous year. The current application fee is \$523.00. Ohio Administrative Code (OAC) rule [5101:3-1-17](#) is being amended and new rule [5101:3-1-17.8](#) is being adopted to implement this ACA provision. These rules will be effective March 31, 2012.

### Rule Changes

**Rule [5101:3-1-17](#)**, "Eligible Providers," describes the requirements and classifications of an eligible Medicaid provider.

Changes: The rule is being amended to add the provider screening requirements and payment of the application fee as conditions of becoming an eligible Medicaid provider.

**Rule [5101:3-1-17.8](#)**, "Provider Screening and Application Fee," describes the provider screening requirements and the associated application fee. Appendix A of this rule lists provider types and the associated screening levels and application fee status.

### Access to Rules and Related Material

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Office of Ohio Health Plans, Bureau of Provider Services

P.O. Box 1461

Columbus, OH 43216-1461

Telephone (800) 686-1516

# MHTL 3334-11-12 (Medicaid Provider Incentive Program (MPIP) Rules)

## Medicaid Handbook Transmittal Letter (MHTL) No. 3334-11-12

December 30, 2011

TO: Eligible Medicaid Providers  
Chief Executive Officers, Managed Care Plans (MCPs)

FROM: Michael B. Colbert, Director

SUBJECT: Medicaid Provider Incentive Program (MPIP) Rules

### Summary

The rules addressed in this Medicaid Handbook Transmittal Letter (MHTL) are being adopted to implement the provisions of ORC 5111.0215, adopted under Am. Sub. H.B. 153, 129th G.A., and Section 4201 of the American Recovery and Reinvestment Act of 2009 (ARRA), Pub. L. 111-5, and the published regulations at 42 CFR Part 495 that establish a program that permits certain eligible professionals and eligible hospitals participating in Ohio's Medicaid program to receive incentive payments if they are meaningful users of certified electronic health records (EHR) technology.

### Rule Adoption

**New Rule [5101:3-57-01](#)**, "Medicaid provider incentive program (MPIP): eligible providers and patient volume requirements" sets forth eligibility criteria for eligible professionals and eligible hospitals including establishing patient volume and minimum patient volume threshold requirements.

**New Rule [5101:3-57-02](#)**, "Medicaid provider incentive program (MPIP): certified electronic health record (EHR) technology requirements, adopt, implement, or upgrade and meaningful use stage one" sets forth adopt, implement or upgrade, and meaningful use criteria that must be met in order for an eligible professional or eligible hospital to receive an incentive payment. This rule describes and defines the following:

- The requirements for eligible professionals and eligible hospitals to select and implement only certified EHR products in order to meet adopt, implement, or upgrade (AIU); and
- Meaningful use stage one criteria, including reporting periods, meaningful use measures, objectives and any associated exclusions, and demonstration of meaningful use stage one.

**New Rule [5101:3-57-03](#)**, "Medicaid Provider Incentive Program (MPIP): incentive payments (calculation, duration, amount and limit)" describes and defines the process for which incentive payments will be calculated and disbursed including any federally mandated maximum amounts, calculation and timeframes to receive payment. This rule sets forth the requirements for an eligible professional to voluntarily reassign his or her incentive payments. This rule also explains that incentive payments are subject to offsets, adjustments, and recoupment.

**New Rule [5101:3-57-04](#)**, "Medicaid Provider Incentive Program (MPIP): program integrity and provider appeals" describes the process for requesting a review in the event of an adverse determination made in regards to an eligible professional's or eligible hospital's MPIP application, or if the eligible professional or eligible hospital does not agree with the incentive payment amount determined by MPIP. This rule also explains that MPIP applications are subject to prepayment review, post payment audit and specific record retention timeframes.

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Office of Ohio Health Plans, Bureau of Provider Services  
P.O. Box 1461  
Columbus, OH 43216-1461  
Telephone (800) 686-1516

# MHTL 3334-11-11 (Coordinated Services Program)

## Medicaid Handbook Transmittal Letter (MHTL) No. 3334-11-11

December 20, 2011

TO: Eligible Medicaid Providers  
Chief Executive Officers, Managed Care Plans (MCPs)  
Directors, County Departments of Job and Family Services

FROM: Michael B. Colbert, Director

SUBJECT: Coordinated Services Program

### Summary

This Medicaid Handbook Transmittal Letter (MHTL) provides information regarding changes to Ohio Administrative Code rule [5101:3-20-01](#), the Coordinated Services Program (CSP). The CSP will replace two existing programs, the Primary Alternative Care and Treatment program, which applies to consumers that are not enrolled in managed care, and the Controlled Substances and Member Management program, which applies to managed care plans. CSP will target Medicaid consumers whose use of Medicaid services demonstrates a pattern of receiving services at a frequency or in an amount that exceeds medical necessity. CSP will require an enrolled consumer to obtain certain services from a designated pharmacy or a designated primary provider of physician services. This rule will be effective January 1, 2012.

### Rule Changes

**Proposed rule [3-20-01](#)**, "Coordinated Services Program," outlines the CSP and its operation. This rule replaces 5101:3-20-01, "PACT Program: Definitions," 5101:3-20-02, "PACT Program: Operational Components," and 5101:3-20-03, "PACT Program: Provider Participation."

Changes: Rule was redesigned to create and establish the CSP and its new operations as required by 5111.085 of the Ohio Revised Code. Rule was restructured to provide additional clarity to consumers and providers about the program's enrollment process and operations.

### Access to Rules and Related Material

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Office of Ohio Health Plans, Bureau of Provider Services

P.O. Box 1461

Columbus, OH 43216-1461

Telephone (800) 686-1516

# MHTL 3334-11-10 (Sterilization Services and Hysterectomy Covered by Medicaid)

## Medicaid Handbook Transmittal Letter (MHTL) No. 3334-11-10

December 9, 2011

TO: Eligible Providers of Advanced Practice Nurse, Ambulatory Surgery Center, Fee-for-Service Clinic, Federally Qualified Health Clinic, Physician and Rural Health Clinic Services  
Chief Executive Officers, Managed Care Plans (MCPs)  
Directors, County Departments of Job and Family Services

FROM: Michael B. Colbert, Director

SUBJECT: Sterilization Services and Hysterectomy Covered by Medicaid

### Summary

This letter provides information regarding the amendment of Ohio Administrative Code (OAC) rule 5101:3-21-02.2. This rule will be effective October 1, 2011.

**Rule 5101:3-21-02.2**, "Medicaid covered reproductive health services: permanent contraception/sterilization services and hysterectomy," describes the circumstances under which sterilization and hysterectomy are covered by Ohio Medicaid. It also delineates appropriate use of "Acknowledgement of Hysterectomy Information" (JFS 03199) and "Consent for Sterilization" forms. The forms are used for two different purposes: (1) informing women that a hysterectomy may result in sterilization (JFS 03199) and obtaining consent for a procedure for which the primary purpose is sterilization.

#### Changes:

"Acknowledgement of Hysterectomy Information" (JFS 03199) has been revised based on provider recommendations.

ODJFS will begin using the federal version of the "Consent for Sterilization" form, available in English (HHS 687) and Spanish (HHS 687.1). ODJFS production of JFS 03198 has been discontinued although providers may continue to use existing stock through the version specific dates published in this rule.

The body of the rule has also been updated to provide information on the versions of JFS 03199, JFS 03198 and HHS 687 that are available.

### Access to Rules and Related Material

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Most current Medicaid maximum reimbursement amounts are listed in rule 5101:3-1-60 or in Appendix DD to that rule. Providers may view this information by following these steps:

- (1) Select the 'Ohio Health Plans - Provider' folder.
- (2) Select 'General Information for Medicaid Providers'.

- (3) Select 'General Information for Medicaid Providers (Rules)'.
- (4) Select '5101:3-1-60 Medicaid Reimbursement' from the 'Table of Contents' pull-down menu and then scroll down to the link to Appendix DD.

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### **Additional Information**

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Office of Ohio Health Plans, Bureau of Policy and Health Plan Services

P.O. Box 1461

Columbus, OH 43216-1461

Telephone (800) 686-1516

# MHTL 3334-11-09 (Rule 5101:3-1-20, "Electronic data interchange (EDI) trading partner enrollment and testing")

## Medicaid Handbook Transmittal Letter (MHTL) No. 3334-11-09

December 9, 2011

TO: Eligible Medicaid Providers  
Chief Executive Officers, Managed Care Plans (MCPs)  
Directors, County Departments of Job and Family Services

FROM: Michael B. Colbert, Director

SUBJECT: Rule 5101:3-1-20, "Electronic data interchange (EDI) trading partner enrollment and testing"

### Summary

This Medicaid Handbook Transmittal Letter (MHTL) is to notify providers of new rule 5101:3-1-20, which describes the enrollment criteria and testing requirements for enrollment as a trading partner with the Ohio Department of Job and Family Services (ODJFS) to submit Electronic Data Interchange (EDI) transactions. This information was previously described in rules 5101:3-1-20.1 and 5101:3-1-20.2, which were rescinded effective August 2, 2011.

**Rule 5101:3-1-20**, "Electronic data interchange (EDI) trading partner enrollment and testing" describes and defines general provisions for covered entities, including health plans, health care clearinghouses and health care providers, to enroll as a trading partner with ODJFS.

Changes: This rule contains information similar to what was included in rescinded rules 5101:3-1-20.1 "Electronic data interchange (EDI) trading partner definitions and criteria to enroll as an EDI trading partner," and 5101:3-1-20.2, "Responsibilities related to the submission of claims via electronic data interchange (EDI) (except for services provided through a medicaid managed care program)." The new rule adds two additional testing requirements:

- The 270 (eligibility) and 276 (claim status inquiry) transaction types are required to be submitted for testing, and
- Trading partners must test the transaction types that they will be submitting in production.

### Access to Rules and Related Material

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To receive automatic electronic notification when new Medicaid transmittal letters are published, sign up for the ODJFS e-mail subscription service at <http://www.odjfs.state.oh.us/subscribe/>.

**Additional Information**

Questions pertaining to this letter should be addressed to:

Ohio Department of Job and Family Services

Office of Ohio Health Plans, Bureau of Provider Services

P.O. Box 1461

Columbus, OH 43216-1461

Telephone (800) 686-1516

# MHTL 3334-11-08 (Co-Payment Rule Updates)

## Medicaid Handbook Transmittal Letter (MHTL) No. 3334-11-08

October 4, 2011

TO: Eligible Medicaid Providers  
Chief Executive Officers, Managed Care Plans (MCPs)  
Directors, County Departments of Job and Family Services

FROM: Michael B. Colbert, Director

SUBJECT: Co-Payment Rule Updates

### Summary

This Medicaid Handbook Transmittal Letter (MHTL) provides information regarding changes to Ohio Administrative Code rule [5101:3-1-09](#). In February 2010, the pharmacy benefit was "carved out" of the Medicaid managed care capitation rate to allow the Ohio Department of Job and Family Services to collect rebates on pharmaceuticals, which at the time could only be collected by the state in the fee-for-service program. In March 2010, the federal Affordable Care Act created the same access to drug rebates in Medicaid managed care. In support of better care coordination, the pharmacy benefit is being carved back into the managed care program effective October 1, 2011. Rule 5101:3-1-09, which describes Medicaid co-payments, is being amended to support this change and because of the five year rule review.

**Rule [5101:3-1-09](#)**, currently titled "Medicaid Co-Payment Program [Except for Services Provided Through a Medicaid Managed Health Care Program]" is being rescinded and replaced by a rule of the same number, now titled "Co-Payments."

Changes: Language was removed that required consumers enrolled in a Medicaid managed care plan to pay co-payments on prescription drugs received through the Medicaid pharmacy benefit when it was carved out of the managed care program. The rule clarifies that co-payments for services provided through a Medicaid managed care plan, including pharmacy services that are being carved back into managed care, are now subject to the managed care copayment requirements in Chapter 5101:3-26 of Administrative Code. In addition, the rule has been restructured to provide clarity regarding services that require a co-payment, requirements for providers when applying copayments, and exclusions to co-payment requirements.

### Access to Rules and Related Material

The main ODJFS web page includes links to valuable information about its services and programs; the address is <http://www.ifs.ohio.gov>. The web page of the Office of Ohio Health Plans (Medicaid) may be accessed through the ODJFS main page or directly at <http://www.ifs.ohio.gov/ohp/>.

Most current Medicaid maximum reimbursement amounts are listed in rule [5101:3-1-60](#) or in Appendix DD to that rule. Providers may view this information by following these steps:

- (1) Select the 'Ohio Health Plans - Provider' folder.
- (2) Select 'General Information for Medicaid Providers'.
- (3) Select 'General Information for Medicaid Providers (Rules)'.
- (4) Select '[5101:3-1-60](#) Medicaid Reimbursement' from the 'Table of Contents' pull-down menu and then scroll down to the link to Appendix DD.

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Telephone (800) 686-1516

# MHTL 3334-11-07 (Re-issuance of the Electronic Billing Instructions Provider Manual)

## Medicaid Handbook Transmittal Letter (MHTL) No. 3334-11-07

August 3, 2011

TO: Eligible Medicaid Providers  
Chief Executive Officers, Managed Care Plans (MCPs)  
Directors, County Departments of Job and Family Services

FROM: Michael B. Colbert, Director

SUBJECT: Re-issuance of the Electronic Billing Instructions Provider Manual

### Notice

In August 2011, the Ohio Department of Job and Family Services (ODJFS) will replace its nearly 30-year-old Medicaid Management Information System (MMIS) with a new web-based Medicaid Information Technology System (MITS). MITS is designed to have greater flexibility, adaptability, and functionality for providers. Provisions of the Ohio Administrative Code (OAC) will also be more fully integrated into the MITS structure; as a result, when MITS is implemented, claims will be processed and paid more consistently in accordance with Medicaid rules. This MHTL is an advisory notice to let you know about some of the changes that are being made as a result of MITS implementation. No action on your part is required.

Several forms, instruction sheets, and transmittal letters related to the submission of claims have been stored in the 'Billing Instructions' manual within the 'Ohio Health Plans - Provider' collection on the ODJFS electronic manuals ("eManuals") web page. These documents deal mostly with processes used in MMIS. Some of the items are outdated, and implementation of MITS will render others obsolete. Documents that are no longer relevant will be removed on or before the MITS "Go-Live" date of August 2, 2011, and remaining items will be updated as necessary over the coming months.

The following items will be removed from the 'Billing Instructions' manual:

- Paper Claims Grid May 2010
- General Billing Information for ODJFS Paper Claims - Paper Claims Submission Address List
- JFS 03612 Dental Prior Authorization Form
- JFS 03612 Dental Prior Authorization Instructions
- JFS 06780 Medicaid Claim Billing Form
- JFS 06780 Part B and C Crossover Billing Instructions for Paper Claims
- ODJFS Dental Instructions for Paper Claims
- Medical Assistance Letters
  - MAL 522, "Guidance on the Implementation of Employee Education about False Claims Recovery as provided in MAL 516" [[link](#)]
  - MAL 516, "Employee Education About False Claims Recovery" [[link](#)]
  - MAL 466, "Professional Billing Instructions for Medicare HMO Crossover Claims"
  - MAL 455, "JFS 06653 Medical Claim Review Request Form"
  - MAL 396-A, "Revised ADA Claim Form Billing Instructions"
  - MAL 396, "ADA Claim Form Update, Effective August 1, 2001"
  - MAL 378, "Claim Credit Reversal Form ODHS 6768"

The following items will be updated or added:

- The link to the EDI Companion Guides web page will be reestablished, and links to individual Companion Guides will be included.
- Three new Web Portal billing guides for professional, institutional, and dental claims are being developed and will be added. These billing guides will offer practical suggestions and tips to ensure that claims can be submitted and processed successfully in the MITS Web Portal.
- Because submission of hard-copy claims will still be permitted in a very few circumstances, billing instructions for paper claim forms will be maintained:
  - ODJFS Instructions for Completing the CMS-1500 Paper Claim Form (updated)
  - ODJFS Instructions for Completing the UB-04 Paper Claim Form for Hospitals (updated)
  - ODJFS Instructions for Completing the UB-04 Paper Claim Form for Freestanding Dialysis Clinics (updated)
  - ODJFS Instructions for Completing the ADA 2006 Paper Claim Form (updated)

The structure of the 'Billing Instructions' manual will be modified. Other documents may be added in the future as they are needed.

### **Access to Rules and Related Material**

The main ODJFS web page includes links to valuable information about its services and programs; the address is <http://www.ifs.ohio.gov>. The web page of the Office of Ohio Health Plans (Medicaid) may be accessed through the ODJFS main page or directly at <http://www.ifs.ohio.gov/ohp/>.

In addition to the 'Billing Instructions' manual, an abundance of information for Medicaid providers is available on the eManuals web page, <http://emanuals.odjfs.state.oh.us/emanuals/>.

From the eManuals page, providers may view documents online by following these steps:

- (1) Select the 'Ohio Health Plans - Provider' collection.
- (2) Select the appropriate service provider type or manual.
- (3) Select the desired chapter or document type.
- (4) Select the desired item from the 'Table of Contents' pull-down menu.

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### **Additional Information**

Questions pertaining to this letter should be addressed to:

Ohio Department of Job and Family Services  
 Office of Ohio Health Plans, Bureau of Provider Services  
 P.O. Box 1461  
 Columbus, OH 43216-1461  
 Telephone (800) 686-1516

# MHTL 3334-11-06 (MITS-Related Changes to Rules)

## Medicaid Handbook Transmittal Letter (MHTL) No. 3334-11-06

July 26, 2011

TO: All Medicaid Providers  
Medicaid Managed Care Plans  
Directors, County Departments of Job and Family Services

FROM: Michael B. Colbert, Director

SUBJECT: MITS-Related Changes to Rules

### Summary

Rule [5101:3-1-19.3](#), "General Claim Submission [Except for Services Provided to Consumers who are Members of a Medicaid Managed Care Program]," is being rescinded in conjunction with the Medicaid Information Technology System (MITS). This rule provided information on submission of claims to Medicaid's Medicaid Management Information System (MMIS), which is being phased out. MITS is Ohio Medicaid's new electronic claims submission interface and is scheduled to become operational on August 2, 2011. The rule is being replaced with 5101:3-1-19, to be titled "Claim Submission," which is also effective August 2, 2011. Information about 5101:3-1-19 and other changes to claim submission policy can be found in MHTL 3334-11-03, "MITS-Related Changes to Rules in OAC Chapter 5101:3-1."

### Access to Rules and Related Material

The main ODJFS web page includes links to valuable information about its services and programs; the address is <http://www.ifs.ohio.gov>. The web page of the Office of Ohio Health Plans (Medicaid) may be accessed through the ODJFS main page or directly at <http://www.ifs.ohio.gov/ohp/>.

From the "eManuals" page, providers may view documents online by following these steps:

- (1) Select the 'Ohio Health Plans - Provider' folder.
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### Additional Information

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Office of Ohio Health Plans, Bureau of Provider Services  
P.O. Box 1461  
Columbus, OH 43216-1461  
Telephone (800) 686-1516

# MHTL 3334-11-05 (General Medicaid Rule Updates)

## Medicaid Handbook Transmittal Letter (MHTL) No. 3334-11-05

July 26, 2011

TO: All Eligible Providers  
Chief Executive Officers, Managed Care Plans (MCPs)  
Directors, County Departments of Job and Family Services

FROM: Michael B. Colbert, Director

SUBJECT: General Medicaid Rule Updates

### Summary

The purpose of this MHTL is to notify providers of recent changes to rules 5101:3-1-02 and 5101:3-1-15 of the Ohio Administrative Code. Rule 5101:3-1-02, General Medicaid Principles, is being rescinded and replaced to include prohibition on payment for provider-preventable conditions as required by the Patient Protection and Affordable Care Act of 2009 and because of the five year rule review. Rule 5101:3-1-15, Medicaid Card, is being rescinded as part of the five year rule review.

### Rule Changes

Rule [5101:3-1-02](#), "General reimbursement principles," describes principles regarding Medicaid reimbursement.

Changes: The rule has been restructured to provide clarity for providers to determine if a service is reimbursable. Language has been added to prohibit payment for provider-preventable conditions as required by the Patient Protection and Affordable Care Act. Also, language added stating a medical service is reimbursable if a consumer is eligible as defined in Chapter 5101:3-1 of the Administrative Code.

Rule [5101:3-1-15](#), "Medicaid Card," describes the Medicaid Card.

Changes: The rule is being rescinded as part of the five year rule review process.

### Access to Rules and Related Material

The main ODJFS web page includes links to valuable information about its services and programs; the address is <http://www.jfs.ohio.gov>. The web page of the Office of Ohio Health Plans (Medicaid) may be accessed through the ODJFS main page or directly at <http://www.jfs.ohio.gov/ohp/>.

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### Additional Information

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P.O. Box 1461

Columbus, OH 43216-1461

Telephone (800) 686-1516

# MHTL 3334-11-04 (Transitioning from MMIS to MITS)

## Medicaid Handbook Transmittal Letter (MHTL) No. 3334-11-04

June 30, 2011

TO: Eligible Medicaid Providers  
Chief Executive Officers, Medicaid Managed Care Plans  
Directors, County Departments of Job and Family Services

FROM: Michael B. Colbert, Director

SUBJECT: Transitioning from the Medicaid Management Information System to the Medicaid Information Technology System

### Summary

Rule [5101:3-1-19.4](#) of the Ohio Administrative Code (OAC) is being adopted to support a transition from the Medicaid Management Information System (MMIS) to the Medicaid Information Technology System (MITS) being implemented by the Ohio Department of Job and Family Services (ODJFS). With MITS, Ohio Medicaid will retire its nearly 30-year old MMIS and create a more multi-functional, secure, and provider-accessible system. Beginning July 1, 2011, ODJFS will return to providers and trading partners certain types of paper-based transactions because:

1. Several claim formats are being discontinued or replaced. These outdated paper claim forms cannot be processed in MITS.
2. Time must be allowed for current paper transactions to be processed in MMIS and included in the data base before MITS is implemented.

The first reason is critical to the successful implementation of MITS because ODJFS will no longer have the technical ability to process outdated institutional, dental, and professional claim forms. ODJFS will need to return paper claims that have not been processed by MMIS to providers for submission through the MITS web portal or through electronic data interchange (EDI).

The second reason is equally important because ODJFS needs to implement MITS with the most accurate and up-to-date information possible. This requires ODJFS start with a data base that includes processed paper transactions submitted to MMIS by providers and trading partners. Provider enrollment/reenrollment, demographic changes and certain types of paper claims that are not processed by MMIS prior to the MITS "Go Live" date will need to be returned to providers for submission through MITS. Correct and timely MITS editing, payment, and reporting require that ODJFS have in place a complete and current data base prior to Go Live.

### Rule Adoption

New Rule [5101:3-1-19.4](#) enables ODJFS to return unprocessed paper transactions to providers, including:

- UB-92
- ADA Revised 2000 (dental)
- ODJFS 6780 (Medicare crossover billed by providers in lieu of the automatic crossover process)
- The "CMS 1500" professional claim
- Non-Medicare coordination of benefits claims
- Paper adjustment claims
- Medical claim inquiries

The rule also allows the return of unprocessed paper claim inquiries and paper provider enrollment/reenrollment and demographic updates. Paper transactions identified in this rule that have not been

processed by MMIS prior to MITS implementation may be returned to providers and trading partners. Providers may then submit new transactions to MITS for processing.

### **Access to Rules and Related Material**

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### **Additional Information**

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Office of Ohio Health Plans, Bureau of Provider Services  
P.O. Box 1461  
Columbus, OH 43216-1461  
Telephone (800) 686-1516

# MHTL 3334-11-03 (MITS-Related Changes to Rules in OAC Chapter 5101:3-1)

## Medicaid Handbook Transmittal Letter (MHTL) No. 3334-11-03

July 26, 2011

TO: Eligible Medicaid Providers  
Medicaid Managed Care Plans  
Directors, County Departments of Job and Family Services

FROM: Michael B. Colbert, Director

SUBJECT: MITS-Related Changes to Rules in OAC Chapter 5101:3-1

The rules addressed in this transmittal letter are being amended for three reasons: (1) to comply with requirements of the five-year review process, (2) to update existing rule language, and (3) to support implementation of the Medicaid Information Technology System (MITS). MITS is Ohio Medicaid's new electronic claims submission interface and is scheduled to become operational on August 2, 2011, which is the effective date of these rules.

### Amended Rules

**Rule [5101:3-1-05](#)**, "Medicaid coordination of benefits with the Medicare program (Title XVIII)," establishes criteria for the coordination of Medicaid benefits with Medicare.

Changes: New language defines acceptable formats to use in submitting Medicare crossover claims. Existing language is replaced with a reference to the appropriate rule that describes claims submission requirements.

**Rule [5101:3-1-08](#)**, "Coordination of benefits," establishes criteria for coordination of Medicaid benefits with third-party insurance plans other than Medicare.

Changes: Existing language is replaced with a reference to the appropriate rule that describes claims submission requirements. Language pertaining to billing instructions on the electronic manuals website has been removed.

**Rule [5101:3-1-17](#)**, "Eligible providers [except intermediate care facilities for the mentally retarded (ICFs-MR) and Medicaid contracting managed care plans (MCPs)]," establishes eligibility requirements for providers.

Changes: The two types of professional group practices recognized by ODJFS as eligible providers in the Medicaid program are defined. Dated information or language pertaining to billing instructions has been removed.

**Rule [5101:3-1-17.2](#)**, "Provider agreement for providers [except long-term care nursing facilities and Medicaid contracting managed care plans (MCPs)]" establishes requirements for agreements between Ohio Medicaid and providers of services to Medicaid consumers.

Changes: The rule has been made applicable to all Ohio Medicaid providers and specifies that enrollment materials must be submitted through the MITS web portal. Provider agreements submitted in paper form will be returned to the provider unprocessed.

**Rule [5101:3-1-31](#)**, "Prior authorization [except for services provided through Medicaid contracting managed care plans (MCPs)]," establishes reimbursement policies and procedures for items and services requiring prior authorization from ODJFS.

Changes: As of August 2, 2011, prior authorization requests must be submitted through the MITS web portal. Unnecessary or duplicative language has been eliminated or, where applicable, replaced with a reference to an appropriate rule that includes the same information.

### Rescinded Rules

Existing **rules 5101:3-1-19 through 5101:3-1-19.2, 5101:3-1-19.7 through 5101:3-1-19.8, and 5101:3-1-20 through 5101:3-1-20.2** are being rescinded, and the information in them is being consolidated into a single new rule, **5101:3-1-19**.

**Rule 5101:3-1-19**, "General principles regarding claim submission [except for services provided through a Medicaid managed care program]," established general principles for submitting claims to Ohio Medicaid.

**Rule 5101:3-1-19.1**, "Medicaid claim formats for paper claim submission [except for services provided through a Medicaid managed care program]," established criteria for submitting paper claims to Ohio Medicaid.

**Rule 5101:3-1-19.2**, "Medicaid claim formats for the submission of claims via electronic data interchange (EDI) [except for services provided through a Medicaid managed care program]," established criteria for submitting EDI claims to Ohio Medicaid.

**Rule 5101:3-1-19.7**, "Prompt payment and interest provisions [except for services provided through Medicaid contracting managed care plans (MCPs)]," established requirements for prompt payment of claims and provisions for the payment of interest.

**Rule 5101:3-1-19.8**, "Resolution of payment errors and overpayments [except for services provided through a long term care nursing facility or a Medicaid managed care program]," established criteria for resolving claim payment errors and claim overpayments.

**Rule 5101:3-1-20**, "Responsibilities related to the electronic submission of cartridge tapes (C-Tapes) [except for services provided through a Medicaid managed care program]," established Ohio Medicaid's policy on entering into business relationships with electronic billing agents.

**Rule 5101:3-1-20.1**, "Electronic data interchange (EDI) trading partner definitions and criteria to enroll as an EDI trading partner," established criteria for enrollment as an EDI trading partner.

**Rule 5101:3-1-20.2**, "Responsibilities related to the submission of claims via electronic data interchange (EDI) (except for services provided through a Medicaid managed care program)," established criteria to be met by EDI trading partners enrolled with Ohio Medicaid.

### **New Rule**

**Rule 5101:3-1-19**, "Claim Submission [except long-term care nursing facilities and Medicaid contracting managed care plans (MCPs)]," a new rule that establishes criteria for submitting claims and claims adjustments to Ohio Medicaid.

Changes: This newly created rule specifies acceptable media for claim submission and acceptable claim formats, timely filing requirements, the process by which adjustments can be submitted, prompt payment provisions, and guidelines for trading partners submitting electronic data interchange (EDI) transactions. As of August 2, 2011, Medicare crossover claims, claims

indicating third-party insurance plan information, and claims requiring attachments or additional documentation for processing must be submitted either in the EDI format or through the MITS web portal. Additionally, ODJFS will no longer process refund checks for overpayments except in limited circumstances detailed in the rule.

### **Access to Rules and Related Material**

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### **Additional Information**

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P.O. Box 1461  
Columbus, OH 43216-1461  
Telephone (800) 686-1516

# MHTL 3334-11-02 (New 2011 HCPCS and CPT Codes)

## Medicaid Handbook Transmittal Letter (MHTL) No. 3334-11-02

March 28, 2011

TO: Eligible Providers of Advanced Practice Nurse, Ambulatory Surgery Center, Chiropractic, Fee-for-Service Clinic, Federally Qualified Health Clinic, Physical and Occupational Therapy, Physician, Podiatry, Psychology, and Rural Health Clinic Services

Chief Executive Officers, Managed Care Plans (MCPs)

Directors, County Departments of Job and Family Services

FROM: Michael B. Colbert, Director

SUBJECT: New 2011 HCPCS and CPT Codes

### Summary

This letter provides information regarding the amendment of Ohio Administrative Code (OAC) rules 5101:3-1-19.3, 5101:3-1-60, 5101:3-4-09, 5101:3-4-12, and 5101:3-4-22. These rules have been amended to implement the new Healthcare Common Procedure Coding System (HCPCS) codes effective for dates of service on and after January 1, 2011. These rules are effective March 30, 2011 and replace emergency versions of the rules which were effective on December 30, 2010.

**Rule [5101:3-1-19.3](#)**, "General claim submission [except for services provided to consumers who are members of a Medicaid managed care program]," describes the criteria for submitting claims to Ohio Medicaid.

Changes: References to the 2009 and 2010 versions of the Current Procedural Terminology (CPT) codes and the Healthcare Common Procedure Coding System (HCPCS) codes have been replaced with the 2010 and 2011 versions. The 2010 CPT and HCPCS code sets are effective for dates of service January 1, 2010 through December 31, 2010. The 2011 CPT and HCPCS code sets are effective for dates of service January 1, 2011 through December 31, 2011.

**Rule [5101:3-1-60](#)**, "Medicaid reimbursement," describes the reimbursement policies for all professional providers.

Changes: New HCPCS codes have been added, obsolete HCPCS codes have been deleted, and definitions have been revised. Maximum payment amounts for the new HCPCS codes have been created and payment amounts for HCPCS codes that are now obsolete have been deleted. Amendments to existing coverage policy were made as a result of some coding changes.

Changes also include updates to reimbursement and coverage of physician administered drugs.

**Rule [5101:3-4-09](#)**, "Office incentive program," describes additional payment amounts for services and procedures when they are provided in a physician's office, group practice office, or a clinic.

Change: An obsolete HCPCS code has been replaced with a new code.

**Rule [5101:3-4-12](#)**, "Immunizations," describes provisions for coverage and reimbursement of immunizations and immune globulins.

Change: New HCPCS codes have been added and obsolete HCPCS codes have been deleted.

**Rule [5101:3-4-22](#)**, "Surgical services," describes coverage provisions for certain services provided by physician providers of Medicaid services.

Changes: New HCPCS codes have been added, obsolete HCPCS codes have been deleted, definitions have been revised, and the fee schedules have been updated for new 2010 HCPCS codes. Modifier information has been updated.

### Access to Rules and Related Material

The main ODJFS web page includes links to valuable information about its services and programs; the address is <http://www.ifs.ohio.gov>. The web page of the Office of Ohio Health Plans (Medicaid) may be accessed through the ODJFS main page or directly at <http://www.ifs.ohio.gov/ohp/>.

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- (3) Select the desired document type.
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Most current Medicaid maximum reimbursement amounts are listed in rule 5101:3-1-60 or in Appendix DD to that rule. Providers may view this information by following these steps:

- (1) Select the 'Ohio Health Plans - Provider' folder.
- (2) Select 'General Information for Medicaid Providers'.
- (3) Select 'General Information for Medicaid Providers (Rules)'.
- (4) Select '5101:3-1-60 Medicaid Reimbursement' from the 'Table of Contents' pull-down menu and then scroll down to the link to Appendix DD.

The Legal/Policy Central - Calendar site, <http://www.odjfs.state.oh.us/lpc/calendar/>, is a quick reference for finding documents that have recently been published. This site also provides a link to a listing of ODJFS manual transmittal letters, <http://www.odjfs.state.oh.us/lpc/mtl/>. The listing is categorized by letter number and subject, and a link is provided to each easy-print (PDF) document.

To receive automatic electronic notification when new Medicaid transmittal letters are published, sign up for the ODJFS e-mail subscription service at <http://www.odjfs.state.oh.us/subscribe/>.

### **Additional Information**

Questions pertaining to this letter should be addressed to:

Ohio Department of Job and Family Services  
Office of Ohio Health Plans, Bureau of Provider Services  
P.O. Box 1461  
Columbus, OH 43216-1461  
Telephone (800) 686-1516

# **MHTL 3334-11-01 (Rule 5101:3-14-01, "Healthchek: Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Mandatory Services for Medicaid Recipients Under Twenty-One Years of Age.")**

**Medicaid Handbook Transmittal Letter (MHTL) No. 3334-11-01**

February 16, 2011

TO: Eligible Medicaid Providers  
Medicaid Managed Care Plans  
Directors, County Departments of Job and Family Services

FROM: Michael B. Colbert, Director

SUBJECT: Rule 5101:3-14-01, "Healthchek: early and periodic screening, diagnostic and treatment (EPSDT) mandatory services for medicaid recipients under twenty-one years of age."

The rule addressed in this transmittal letter was rescinded and replaced with a new rule for two reasons: (1) to comply with requirements of the five-year review process and (2) to update existing rule language.

## **Rule Changes**

**New rule [5101:3-14-01](#)**, "Healthchek: early and periodic screening, diagnostic and treatment (EPSDT) mandatory services for medicaid recipients under twenty-one years of age," provides definitions of terms used in Chapter 5101:3-14 of the Administrative Code and outlines Healthchek coverage requirements.

Changes: This new rule replaces a rescinded rule of the same number. Definitions for terms used throughout Chapter 5101:3-14 were added. Language was updated to clarify Healthchek coverage requirements.

## **Access to Rules and Related Material**

The main ODJFS web page includes links to valuable information about its services and programs; the address is <http://www.ifs.ohio.gov>. The web page of the Office of Ohio Health Plans (Medicaid) may be accessed through the ODJFS main page or directly at <http://www.ifs.ohio.gov/ohp/>.

ODJFS maintains an "electronic manuals" web page of the department's rules, manuals, transmittal letters, forms, and handbooks. The web address for this "eManuals" web page is <http://emanuals.odjfs.state.oh.us/emanuals/>.

From the "eManuals" page, providers may view documents online by following these steps:

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## **Additional Information**

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Office of Ohio Health Plans, Bureau of Provider Services

P.O. Box 1461

Columbus, OH 43216-1461

Telephone (800) 686-1516

# MHTL 3334-10-03 (Length of Ohio Medicaid Time-Limited Provider Agreement)

## Medicaid Handbook Transmittal Letter (MHTL) No. 3334-10-03

April 29, 2010

TO: All Eligible Medicaid Providers  
Directors, County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: Length of Ohio Medicaid Time-Limited Provider Agreement

Rule [5101:3-1-17.4](#), entitled Length and type of provider agreements, is being amended in accordance with section 5111.028 of the Amended Substitute House Bill 1 of the 128th General Assembly to support the extension of Medicaid provider agreements to seven years, and for five year rule review. This rule describes what types of provider agreements are available under the Ohio Medicaid program, how long the provider agreement lasts before the provider must re-enroll with the Medicaid program and what Medicaid providers must do in order to re-enroll with the Ohio Medicaid program. Changes to this rule include a new rule title, adding managed care plans and hospitals to the list of Ohio Medicaid provider types that do not receive time-limited provider agreements (therefore exempting hospitals from re-enrollment) and lengthening the time period of time-limited Medicaid provider agreements from three years to seven years. Additionally, the rule explains that any existing open-ended provider agreement, not exempt from time-limited provider agreement provisions in this rule, will be converted to a time-limited provider agreement on or before January 1, 2015.

### Web Page:

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### Questions:

Questions pertaining to this letter should be addressed to:

Ohio Department of Job and Family Services  
Office of Ohio Health Plans, Bureau of Provider Services  
P.O. Box 1461  
Columbus, OH 43216-1461  
Telephone 800-686-1516

# MHTL 3334-10-02 (New 2010 HCPCS and CPT Codes and Policy Updates)

## Medicaid Handbook Transmittal Letter (MHTL) No. 3334-10-02

April 2, 2010

To: All Advanced Practice Nurses, Ambulatory Surgery Centers, Chiropractors, Fee-for-Service Clinics, Durable Medical Equipment Suppliers, Federally Qualified Health Clinics, Managed Care Plans, Physical and Occupational Therapists, Physicians, Podiatrists, Psychologists, Rural Health Clinics, Directors, County Departments of Job and Family Services

From: Douglas E. Lumpkin, Director

Subject: New 2010 HCPCS and CPT Codes and Policy Updates

This letter provides information regarding the amendment of Ohio Administrative Code (OAC) rules 5101:3-1-19.3, 5101:3-1-60, 5101:3-4-22, and 5101:3-10-03. Rules 5101:3-1-19.3, 5101:3-1-60, and 5101:3-4-22 are being amended to implement the new Healthcare Common Procedure Coding System (HCPCS) codes that are effective for dates of service on and after January 1, 2010, and to implement additional policy updates. Additionally, OAC rules 5101:3-1-60 and 5101:3-10-03 are being amended to fully implement the Medicaid managed care pharmacy carve out. These rules replace emergency rules which were effective on January 1, 2010.

Rule [5101:3-1-19.3](#), entitled "General claim submission [except for services provided to consumers who are members of a Medicaid managed care program]," sets forth criteria for submitting claims to Ohio Medicaid. Changes include updating the references to HCPCS texts published by the American Medical Association. References to "Health Care Common Procedure Coding System HCPCS 2008" (1/08 edition) and the "Health Care Common Procedure Coding System HCPCS 2009" (1/09 edition) are replaced with references to "Health Care Common Procedure Coding System HCPCS 2009" (1/09 edition) and "Health Care Common Procedure Coding System HCPCS 2010" (1/10 edition), respectively. The codes found in the replacement references are effective for dates of service January 1, 2009 through December 31, 2009, and for dates of services January 1, 2010 through December 31, 2010, respectively. This rule is also being proposed for five year rule review.

Rule [5101:3-1-60](#), entitled "Medicaid reimbursement," sets forth the reimbursement policies for all professional providers. Changes include the addition of new HCPCS codes, deletion of obsolete HCPCS codes, and revision of definitions. Changes also include the creation of maximum payment amounts for the HCPCS codes and discontinuing the amounts for HCPCS codes obsoleted. Some of the coding changes require amendments to existing policy on coverage.

In addition to being amended to accommodate the HCPCS update, rule 5101:3-1-60 must be amended to fully implement a pharmacy carve out for the Medicaid Managed Health Care Program. Under the proposed carve out, Medicaid managed care plans (MCPs) will no longer be responsible for providing pharmacy services and certain medical supplies (including diabetic testing supplies, supplies for self-injection of medication, inhaler spacers, and peak flow meters) to their members and will no longer receive capitation payments that include prescribed drugs and certain medical supplies provided through pharmacies. Instead, pharmacy providers under contract with the Department will be reimbursed directly for dispensing prescribed drugs and certain supplies to MCP enrollees. The changes to the rule include ending coverage for the codes that correspond to medical supplies removed from the durable medical equipment (DME) benefit by rule 5101:3-10-03, for dates of services beginning February 1, 2010, since they will instead be covered under the pharmacy benefit and no longer provided by DME providers. As a result of these changes, only pharmacies under contract with the Department will be able to provide the impacted supplies to Medicaid consumers. This rule is also being proposed for five year rule review.

Rule [5101:3-4-22](#), entitled "Surgical services," sets forth coverage provisions for these services provided by physician providers of Medicaid services. Changes include the addition of new HCPCS codes, deletion of obsolete HCPCS codes, revision of definitions, and updates to the fee schedules for new 2010 HCPCS codes. This rule is also being proposed for amendment to update modifier information and for five year rule review.

Rule [5101:3-10-03](#), entitled "Medicaid Supply List," sets forth the list of durable medical equipment and supplies covered by the Medicaid program. This rule must be amended to fully implement the pharmacy carve out. Changes to the rule include removing from the supply list certain supplies that will no longer be considered part of the DME benefit, but will instead be considered part of the pharmacy benefit and no longer provided by DME providers, for dates of service beginning February 1, 2010. As a result of these changes, only pharmacies under contract with the Department will be able to provide the impacted supplies to Medicaid consumers. This rule is also being proposed for five year rule review.

### **Web Page:**

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page of the department's rules, manuals, letters, forms, and handbooks. The URL for this "eManuals" page is <http://emanuals.odjfs.state.oh.us/emanuals/>.

Providers may view documents online by:

- (1) Selecting the "Ohio Health Plans - Provider" folder;
- (2) Selecting the appropriate service provider type or handbook;
- (3) Selecting the "Table of Contents";
- (4) Selecting the desired document type;
- (5) Selecting the desired item from the "Table of Contents" pull-down menu.

Most current Medicaid maximum reimbursement rates are listed in rule 5101:3-1-60 or in Appendix DD to that rule. Providers may view these rates by:

- (1) Selecting the "Ohio Health Plans - Provider" folder;
- (2) Selecting "General Information for Medicaid Providers";
- (3) Selecting "General Information for Medicaid Providers (Rules)";
- (4) Selecting "5101:3-1-60 Medicaid Reimbursement" from the "Table of Contents" pull-down menu.

The Legal/Policy Central - Calendar site (<http://www.odjfs.state.oh.us/lpc/calendar/>) is a quick reference for finding documents that have recently been published. This site also provides a link to a listing of ODJFS manual transmittal letters (<http://www.odjfs.state.oh.us/lpc/mtl/>). The listing is categorized by letter number and subject, and a link is provided to each easy-print (PDF) document.

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### **Questions:**

Questions pertaining to this letter should be addressed to:

Ohio Department of Job and Family Services  
Office of Ohio Health Plans, Bureau of Provider Services  
P.O. Box 1461  
Columbus, OH 43216-1461  
Telephone 800-686-1516

# MHTL 3334-10-01 (Update to General Medicaid Rules to Carve Out Prescription Drug Services from the Medicaid Managed Health Care Program)

## Medicaid Handbook Transmittal Letter (MHTL) No. 3334-10-01

February 26, 2010

TO: All Eligible Medicaid Providers  
Directors, County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: Update to General Medicaid Rules to Carve Out Prescription Drug Services from the Medicaid Managed Health Care Program

The purpose of this Medicaid Handbook Transmittal Letter (MHTL) is to announce amendments to Ohio Administrative Code rules. These amendments are being made to support carving the pharmacy benefit out of the Medicaid managed care program. Carving pharmacy out of the managed care benefit was assumed in Am. Sub. HB 1 of the 128th General Assembly, because the funds appropriated to JFS in the 600525 account, found in section 309.10 of Am. Sub. HB 1, assume the fiscal impact associated with these changes.

Rule [5101:3-1-09](#), entitled Medicaid co-payment program [except for Medicaid consumers enrolled in a Medicaid managed health care program], is being amended for five-year rule review and to clarify that all Medicaid consumers may have a co-payment for pharmacy services, whether enrolled in the Medicaid fee-for-service program or a Medicaid managed care plan. This rule sets forth policy on co-payments for the Ohio Medicaid program. This rule is being amended to change the title of the rule and the opening paragraph that will require consumers enrolled in a Medicaid managed care plan to pay co-payments on prescription drugs received through the Medicaid pharmacy benefit. Other amendments include deleting references to the Disability Medical Assistance program and to billing instructions located on the ODJFS website.

Rule [5101:3-1-13.1](#), entitled Medicaid consumer liability [except for Medicaid consumers enrolled in a Medicaid managed health care program], is being amended to clarify that all Medicaid consumers may have a co-payment for pharmacy services, whether enrolled in the Medicaid fee-for-service program or a Medicaid managed care plan. This rule sets forth policy on Medicaid consumer liability under the Medicaid program. The only amendment to this rule is in the title of the rule to be consistent with other Ohio Administrative Code Chapter 5101:3-1 rule titles. The title change will clarify that all Medicaid consumers are liable for the payment of co-payments for pharmaceutical drugs under the fee-for-service pharmacy benefit. There are no changes to the rule body.

Rule [5101:3-1-19](#), entitled General principles regarding claim submission [except for services provided through a Medicaid managed care program], is being amended for five-year rule review and to clarify that all Medicaid consumers may have a co-payment for pharmacy services, whether enrolled in the Medicaid fee-for-service program or a Medicaid managed care plan. This rule sets for policy for Medicaid providers on how to properly send medical claims for payment of Medicaid services. This rule is being amended to more clearly state that prescription drug claims are exempt from this rule and are defined in Chapter [5101:3-9](#) of the Administrative Code. Additional amendments include more accurately stating what types of claims submissions the Department accepts for payment of Medicaid services, more clearly explaining policy on claims resubmitted for payment when original requests were denied payment, clarifying policy on obtaining claims status information and reorganization of paragraphs throughout the rule.

### Web Page:

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**Questions:**

Questions pertaining to this letter should be addressed to:

Ohio Department of Job and Family Services  
Office of Ohio Health Plans, Bureau of Provider Services  
P.O. Box 1461  
Columbus, OH 43216-1461  
Telephone 800-686-1516

# **MHTL 3334-09-05 (New Rule 5101:3-1-17.7 Regarding Medicaid Providers Resuming Participation in the Ohio Medicaid Program)**

## **Medicaid Handbook Transmittal Letter (MHTL) No. 3334-09-05**

December 17, 2009

**TO:** All Eligible Medicaid Providers  
Directors, County Departments of Job and Family Services

**FROM:** Douglas E. Lumpkin, Director

**SUBJECT:** New Rule 5101:3-1-17.7 Regarding Medicaid Providers Resuming Participation in the Ohio Medicaid Program

This new rule is being proposed to explain what former participating Medicaid providers must do to be reinstated as Medicaid providers for participation in the Medicaid program. Additional information includes the necessity of completing a new application for enrollment by former providers who had their previous Medicaid agreement terminated, factors the Ohio Department of Job and Family Services (ODJFS) will consider when making the reinstatement determination and communication of the reinstatement decision by ODJFS.

### **Web Page:**

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### **Questions:**

Questions pertaining to this MHTL should be addressed to:

Office of Ohio Health Plans  
Provider Services Section  
P.O. Box 1461  
Columbus OH 43216-1461  
800-686-1516

# MHTL 3334-09-04 (Medicaid Payment for Medicare Part B Cost Sharing)

## Medicaid Handbook Transmittal Letter (MHTL) No. 3334-09-04

October 28, 2009

TO: All Eligible Medicaid Providers  
Directors, County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: Medicaid Payment for Medicare Part B Cost Sharing

As a result of Amended Sub. House Bill 1 of the 128th General Assembly and these rule changes, ODJFS will no longer be making direct payment for cost-sharing for certain services that will now be included in the NF per diem. Medicaid providers of oxygen, wheelchairs, skilled therapies (PT, OT, speech-language/audiology), or medical transportation services will no longer receive cost-sharing payments directly from Medicaid when these services are delivered to Medicaid consumers who reside in NFs. The fiscal impact will be provider specific.

Rule [5101:3-1-05](#) entitled, Medicaid coordination of benefits with the medicare program (Title XVIII), defines Medicaid's coordination of benefits with the Medicare program. It also describes the Medicare crossover claim process, reimbursement of cost sharing and what a provider must do to receive payment for a covered Medicaid service when Medicare denied payment as the primary insurance. Changes to the rule can be found in paragraphs (E)(2) and (E)(3). The changes direct providers to Chapter 5101:3-3 of the Administrative Code to find Medicaid cost sharing obligations for nursing facility services included in the nursing facility per diem. The changes also clarify cost sharing for Medicare Part B services not covered under rule 5101:3-2-25 or Chapter 5101:3-3 of the Administrative Code are covered under rule 5101:3-1-05.3 of the Administrative Code. These changes are the same for both the Executive Order emergency filing and this regular filing.

Rule [5101:3-1-05.3](#) entitled, Payment for "Medicare Part B" cost sharing, defines Medicaid's payment methodologies for Medicare Part B crossover claims not covered under Chapters 5101:3-2 and 5101:3-3 of the Administrative Code. Changes include directing providers to Chapter 5101:3-3 of the Administrative Code to find Medicaid cost sharing obligations for nursing facility services included in the nursing facility per diem. Other changes to the rule are not substantive and should better clarify to providers our payment policies for cost sharing on Part B crossover claims.

### Web Page:

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### Questions:

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Ohio Department of Job and Family Services

Office of Ohio Health Plans, Bureau of Provider Services

P.O. Box 1461

Columbus, OH 43216-1461

Telephone 800-686-1516

# MHTL 3334-09-03 (Updates to Rule 5101:3-1-29 Medicaid Fraud, Waste and Abuse)

## Medicaid Handbook Transmittal Letter (MHTL) No. 3334-09-03

October 5, 2009

TO: All Eligible Medicaid Providers  
Directors, County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: Updates to Rule 5101:3-1-29 Medicaid Fraud, Waste and Abuse

This rule is being proposed for amendment in accordance with five year rule review. This rule explains what steps the Ohio Department of Job and Family Services (ODJFS) will take if fraud, waste or abuse to the Medicaid program are committed by Medicaid providers or consumers. Changes to this rule are not substantive. Changes include rewording paragraphs as needed, adding or deleting information as needed and updating office department names where necessary.

### Web Page:

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### Questions:

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Office of Ohio Health Plans, Bureau of Provider Services  
P.O. Box 1461  
Columbus, OH 43216-1461  
Telephone 800-686-1516

# **MHTL 3334-09-02 (Discontinuing the Disability Medical Assistance (DMA) Program and the Rescission of Ohio Administrative Code (OAC) Rule 5101:3-23-01)**

**Medicaid Handbook Transmittal Letter (MHTL) No. 3334-09-02**

September 30, 2009

TO: All Eligible Medicaid Providers  
Directors, County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: Discontinuing the Disability Medical Assistance (DMA) Program and the Rescission of Ohio Administrative Code (OAC) Rule 5101:3-23-01

This rule is being proposed for rescission as a result of Amended Substitute House Bill 1 of the 128th General Assembly, which repeals the Disability Medical Assistance (DMA) program. This rule sets forth the medical benefits covered by, and the Medicaid providers that may participate in, the DMA program.

The Ohio Department of Job and Family Services (ODJFS) is working with county departments of job and family services to inform consumers that their health care coverage under the DMA program will end on October 31, 2009. ODJFS is encouraging providers to work with the department to advance the goal of educating consumers of the DMA program about this change in benefits.

To this end, providers may inform consumers that, in the absence of the DMA program, benefits may be available through the following resources: federally qualified health centers, free clinics, veterans' services organizations, local alcohol and drug addiction and mental health boards, and pharmaceutical companies' prescription assistance programs. ODJFS is working to inform these providers that they may experience a slight influx in caseload as a result of the elimination of the DMA program.

Additionally, the Partnership for Prescription Assistance helps qualifying patients without prescription drug coverage get the medicines they need for free or for a very nominal cost. Consumers can contact the Partnership for Prescription Assistance by calling 1-888-4PPA-NOW (1-888-477-2669) or accessing the Web site at <https://www.pparx.org>. Consumers can also access the consumer hotline to receive a listing of prescription assistance programs by calling 1-800-324-8680 or TDD 1-800-292-3572. Lastly, consumers can call 211 - if available in their counties - for assistance in completing prescription assistance program applications.

The Legal/Policy Central - Calendar site (<http://www.odjfs.state.oh.us/lpc/calendar>) can be used to quickly locate recently published documents. This site also provides a link to a listing of ODJFS manual transmittal letters (<http://www.odjfs.state.oh.us/lpc/mtl>). The listing is categorized by letter number and subject, with links to PDF versions of each document.

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Questions pertaining to this MHTL should be addressed to:

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Provider Services Section  
P.O. Box 1461  
Columbus OH 43216-1461  
800-686-1516

# MHTL 3334-09-01 (ODJFS Paper Reduction Strategy Implementation)

## Medicaid Handbook Transmittal Letter (MHTL) No. 3334-09-01

June 30, 2009

TO: All Eligible Medicaid Providers  
Directors, County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: ODJFS Paper Reduction Strategy Implementation

The purpose of this Medicaid Handbook Transmittal Letter (MHTL) is to announce the promulgation of a new rule, 5101:3-1-17.1 of the Ohio Administrative Code (OAC), entitled Notification of rule and program changes. This rule explains that, before the effective date of the final adoption, amendment, or rescission of a rule, the Ohio Department of Job and Family Services (ODJFS) shall make a reasonable effort to notify persons affected. "Reasonable effort" means posting the new or amended rule on the ODJFS website. Also under this rule, persons affected by a proposed rule change can register to receive electronic communication of such changes by submitting their names and e-mail addresses to ODJFS at:

<http://www.odjfs.state.oh.us/subscribe/>. Please note that this MHTL will most likely be the last paper transmittal letter ODJFS sends to providers.

Employing electronic means of communication will allow ODJFS to increase efficient and cost-effective communication with providers and the public. In the future, ODJFS will undertake additional paper reduction strategies. These will include - with certain exceptions - discontinuing acceptance of paper claim forms (e.g., HCFA/CMS 1500, UB-92 or UB-04, American Dental Association and the ODJFS 06780 Medicare Crossover forms). Most providers will be required to submit claims via electronic data interchange (EDI). Providers not currently using EDI and still submitting paper claims to ODJFS may use the ODJFS Ohio Medicaid Provider Portal. Rule changes will accompany this policy modification, thereby affording providers and members of the public an opportunity for public comment.

Additionally, ODJFS would like to encourage providers to receive Medicaid payments via electronic funds transfer (EFT) instead of by paper warrant. Approximately 45% of all Medicaid providers still receive payment by paper warrant. In order to make the payment system faster and more efficient, and to reduce costs, ODJFS is asking providers to verify the method by which they currently receive payment. If you still receive payments in paper form and would like to switch to direct deposit (EFT), visit the ODJFS website at <http://jfs.ohio.gov/OHP/provider.stm>. Clicking on the link entitled Direct Deposit (located directly under the heading entitled "Billing") will bring up a printable document that may be filled out and sent to the Office of Budget & Management.

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page of the department's rules, manuals, letters, forms, and handbooks. The URL for this "eManuals" page is <http://emanuals.odjfs.state.oh.us/emanuals/>.

Providers may view documents online by:

- (1) Selecting the "Ohio Health Plans - Provider" folder;
- (2) Selecting the appropriate topic from the document list; and
- (3) Selecting the desired item from the "Table of Contents" pull-down menu.

The Legal/Policy Central - Calendar site (<http://www.odjfs.state.oh.us/lpc/calendar/>) is a quick reference for finding documents that have recently been published. This site also provides a link to a listing of ODJFS manual transmittal letters (<http://www.odjfs.state.oh.us/lpc/mtl/>). The listing is categorized by letter number and subject, and a link is provided to each easy-print (PDF) document.

Questions pertaining to this letter should be addressed to:

Office of Ohio Health Plans  
Bureau of Provider Services

P.O. Box 1461

Columbus, OH 43216-1461

Telephone 800-686-1516

# **MHTL 3334-08-01 (Accepting Only the New CMS 1500 Paper Claim Form (Revised 2005))**

## **Medicaid Handbook Transmittal Letter (MHTL) No. 3334-08-01**

December 12, 2008

**TO:** All Eligible Medicaid Providers  
Directors, County Departments of Job and Family Services  
Medical Assistance Coordinators

**FROM:** Helen E. Jones-Kelley, Director

**SUBJECT:** Accepting Only the New CMS 1500 Paper Claim Form (Revised 2005)

The purpose of this Medicaid Handbook Transmittal Letter (MHTL) is to announce that beginning on and after February 16, 2009, ODJFS will no longer accept the 1990 Health Care Financing Administration (HCFA) 1500 paper claim form. Any 1990 version HCFA 1500 claim form received by ODJFS on and after February 16, 2009, will be returned to the provider unprocessed.

Beginning on and after February 16, 2009, ODJFS will only accept the new Centers for Medicare and Medicaid Services (CMS) 1500 paper claim form revised August 2005 and approved by the National Uniform Claim Committee. This change is being made to accommodate the National Provider Identifier (NPI) on the new CMS 1500 paper claim form.

All typical providers will be required to send the NPI on the new CMS 1500 claim form. On and after February 16, 2009, any CMS 1500 paper claim(s) received by ODJFS from a typical provider without an NPI will be processed and denied payment.

All atypical providers that have been issued an NPI will be required to provide the NPI on the new CMS 1500 claim form. On and after February 16, 2009, any CMS paper claim(s) received by ODJFS from an atypical provider that has been issued an NPI, but does not supply the NPI on the claim, will have the claim processed and denied payment.

All atypical providers that have not been issued an NPI will not be required to provide the NPI on the new CMS 1500 claim form and will continue to use the Medicaid legacy number for processing claims for payment.

### **ODJFS Billing Instructions for the CMS 1500 Paper Claim Form**

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page of the department's rules, manuals, letters, forms, and handbooks. The URL for this "eManuals" page is <http://emanuals.odjfs.state.oh.us/emanuals/>.

Providers may view billing instructions online by:

- (1) Selecting the "Ohio Health Plans - Provider" folder;
- (2) Selecting the "Billing Instructions" folder; and
- (3) Selecting "BIN.1001. CMS 1500 Revised Versions for 1990 and 2005"

The Legal/Policy Central - Calendar site (<http://www.odjfs.state.oh.us/lpc/calendar/>) is a quick reference for finding documents that have recently been published. This site also provides a link to a listing of ODJFS manual transmittal letters (<http://www.odjfs.state.oh.us/lpc/mtl/>). The listing is categorized by letter number and subject, and a link is provided to each easy-print (PDF) document.

Questions pertaining to this letter should be addressed to:

Office of Ohio Health Plans  
Provider Services Section  
P.O. Box 1461  
Columbus, OH 43216-1461

800-686-1516

# MHTL 3334-07-05 (Ohio Administrative Code (OAC) rules)

## Medicaid Handbook Transmittal Letter (MHTL) No. 3334-07-05

January 3, 2008

TO: All Eligible Medicaid Providers  
Directors, County Departments of Job and Family Services  
Medical Assistance Coordinators

FROM: Helen E. Jones-Kelley, Director

SUBJECT: Ohio Administrative Code (OAC) rules 5101:3-1-17.4 Length and type of provider agreements, 5101:3-1-17.5 Suspension of Medicaid provider agreements, 5101:3-1-17.6 Termination and denial of provider agreement, and 5101.3-1-57 Process for provider appeals from proposed departmental actions.

The purpose of this Medicaid Handbook Transmittal Letter (MHTL) is to announce new policies affecting Medicaid provider agreements pursuant to Amended Substitute House Bill No. 119. and Section 5111. of the Revised Code.

The full text for each of these rule changes can be found on the Department's website at <http://emanuals.odjfs.state.oh.us/emanuals> in the Ohio Department of Job and Family Services (ODJFS) Ohio Administrative Code link under Legal Services.

**OAC Rule 5101:3-1-17.4**, entitled Length and type of provider agreements [Except Long-Term Care Nursing Facilities (NFs), Intermediate Care Facilities for the Mentally Retarded (ICFs-MR) and Medicaid Contracting Managed Care Plans (MCPs)], has been rescinded and replaced with a new rule 5101:3-1-17.4 of the Administrative Code to implement provisions of Revised Code 5111.028 adopted under Amended Substitute House Bill 119. This rule codifies the effective date of a Medicaid provider agreement, the types of Medicaid provider agreements, and the length of time a Medicaid provider agreement is effective.

**OAC Rule 5101:3-1-17.4**, entitled Length and type of provider agreements, has replaced the existing rule 5101:3-1-17.4 of the Administrative Code to implement provisions of Revised Code 5111.028 adopted under Amended Substitute House Bill 119. This rule describes the effective date of a Medicaid provider agreement, the types of Medicaid provider agreements (open-ended and time-limited), and the length of time a Medicaid provider agreement is effective. Additions to this new rule include definitions of the types of provider agreements (open-ended and time-limited), new language regarding the conversion from provider agreements without a time limit to provider agreements with a time limit, and the types of providers (nursing facilities and intermediate care facilities for the mentally retarded) that are not subject to the conversion to a time-limited provider agreement. This new rule also includes the process by which ODJFS will convert open-ended provider agreements to time-limited provider agreements and that there will be a required re-enrollment process for when a time-limited agreement expires and the provider wants to extend their agreement with ODJFS and the consequences of failure to re-enroll in the time and manner required by ODJFS.

**OAC Rule 5101:3-1-17.5**, entitled Suspension of Medicaid provider agreements, implements the provisions of Revised Code 5111.031 adopted under Amended Substitute House Bill 119. This new rule defines a non-agency provider, a non-institutional provider, and an owner and describes when ODJFS shall suspend a Medicaid provider agreement upon notification of indictment for any of the qualifying offenses specified in this rule. The suspension of the provider agreement includes the suspension of Medicaid reimbursement and this rule describes the process for a provider or owner to request reconsideration of the suspension of the provider agreement.

**OAC Rule 5101:3-1-17.6**, entitled 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)], has been amended to implement provisions of Revised Code 5111.028 adopted under Amended Substitute House Bill 119. This rule describes when ODJFS may or shall propose to terminate or deny a Medicaid provider agreement.

New language includes that ODJFS may terminate or deny a Medicaid provider agreement when ODJFS determines it is not in the best interest of the Medicaid consumers or the state of Ohio to do business with the provider. "Not in the best interest" now includes, but is not limited to, a provider that has not billed or otherwise submitted a Medicaid claim to ODJFS for two years or longer, and when a provider fails to meet applicable provider requirements or for any reason permitted or required by federal law.

Additions to the rule include that ODJFS shall terminate or deny a Medicaid provider agreement when: The provider has not obtained the license, permit, certificate, or maintained the certification required by the Medicaid provider agreement; an official, board, commission, department, division, bureau, or other agency of this state, other than ODJFS, has denied, terminated, or not renewed a license, permit, certificate or certification that is required for participation; a provider has been convicted of or pled guilty to a one of the offenses that caused the provider agreement to be suspended; the provider has failed to apply for re-enrollment within the time and manner required; a provider fails to timely submit a required background check.

Language was also added to clarify that a Medicaid provider may voluntarily terminate their provider agreement and how the provider should notify ODJFS if they choose to voluntarily terminate the agreement.

**OAC Rule 5101:3-1-57**, entitled Process for provider appeals from proposed departmental actions, has been amended to implement provisions of Revised Code 5111.028, 5111.031, and 5111.06, adopted under Amended Substitute House Bill 119.

This rule describes the process for provider appeals from proposed departmental action. The appeals process is designed to provide a hearing under Chapter 119. of the Revised Code whereby a provider may appeal the proposed decision by ODJFS to deny, terminate, or not renew a provider agreement or to implement a final fiscal audit.

Changes to the rules include additional circumstances when the appeals process under Chapter 119. of the Revised Code does not apply. These include, but are not limited to, the following departmental actions: when a license, certificate, and/or permit is required but the provider fails to obtain or maintain the license, certificate, or permit; when the provider agreement is suspended pending indictment of the provider; when the provider agreement is denied, terminated, or not renewed because the provider has been convicted of one of the offenses that caused a suspension; when the provider agreement is converted from an open-ended agreement to a time-limited agreement; when the provider agreement has expired and has been terminated because the provider failed to re-enroll in the time and manner required by ODJFS; and when the provider agreement is terminated or not renewed because the provider has not billed or otherwise submitted a Medicaid claims to ODJFS for two years or longer and ODJFS has determined that the provider has moved from the address on record without leaving a forwarding address with ODJFS.

#### **Additional Information:**

For more information on the Sections of the Revised Code referred to in this MHTL, please visit our website at <http://jfs.ohio.gov/OHP/provider.stm>

#### **Requesting Paper Updates:**

Providers will receive one printed copy of this letter and an accompanying JFS 03400, "ODJFS, Service Provider Update Request Form." Providers may request a second printed copy of this letter with all attachments by completing the JFS 03400 and returning it to ODJFS in accordance with the instructions at the top of the form.

Questions pertaining to this MHTL should be addressed to:

Bureau of Plan Operations

The Provider Services Section

P.O. Box 1461

Columbus, Ohio 43216-1461

Toll free telephone number 1-800-686-1516

# MHTL 3334-07-04 (Updates to General Medicaid Policy on Medicaid's Relationship to the Title V Program)

## Medicaid Handbook Transmittal Letter (MHTL) No. 3334-07-04

August 21, 2007

TO: All Eligible Medicaid Providers  
Directors, County Departments of Job and Family Services  
Medical Assistance Coordinators

FROM: Helen E. Jones-Kelley, Director

SUBJECT: Updates to General Medicaid Policy on Medicaid's Relationship to the Title V Program, Assignment of Provider Claims, Interest Applied on Overpayments to Medicaid Providers and Medicaid's Hold and Review Process

### EFFECTIVE SEPTEMBER 1, 2007

The purpose of this Medicaid Handbook Transmittal Letter (MHTL) is to announce updates to general Medicaid Ohio Administrative Code (OAC) rules. The full text of these rule changes can be found on the Department's website at <http://emanuals.odjfs.state.oh.us/emanuals>.

Rule **5101:3-1-03**, entitled Medicaid: relationship to Title V programs, is rescinded in accordance with the five year rule review and is replaced by a new rule 5101:3-1-03 with new language regarding the Medicaid program's relationship to the Children with Medical Handicaps program under Title V of the Social Security Act. This rule describes the Medicaid program's relationship to the Children with Medical Handicaps (CMH) program under Title V of the Social Security Act. Specifically, this rule describes how medically necessary services shall be billed for children eligible for both Medicaid and CMH services. Claims for services shall first be submitted to the Medicaid program, then if the services are not covered, claims shall then be submitted to the CMH program as the secondary payer after Medicaid.

Rule **5101:3-1-03**, entitled Medicaid: relationship to the children with medical handicaps program under Title V of the Social Security Act, replaces the existing rule 5101:3-1-03 with new language regarding the Medicaid program's relationship to the Children with Medical Handicaps program under Title V of the Social Security Act. Specifically, this rule describes how medically necessary services shall be billed for children eligible for both Medicaid and CMH services. Claims for services shall first be submitted to the Medicaid program, then if the services are not covered, claims shall then be submitted to the CMH program as the secondary payer after Medicaid.

Rule **5101:3-1-23**, entitled Assignment of provider claims, is being rescinded in accordance with the five year rule review and is replaced by a new rule 5101:3-1-23 with new language regarding the assignment of Medicaid provider claims payment.

Rule **5101:3-1-23**, entitled Assignment of provider claims, replaces the existing rule 5101:3-1-23 to align the rule with federal regulations per 42 C.F.R 447.10. This rule describes that payment for services rendered to Medicaid consumers may only be made to the Medicaid provider, except as prescribed in this rule. The exceptions include: (1) A billing agency or accounting firm when the conditions of this rule are met. (2) An employer, facility, or organization that has contractual agreements with individual practitioners in order to submit claims and receive payment on their behalf. (3) Payment may be reassigned from the provider to a government agency or by a court order. This rule also describes that payment may not be made through a "factor," as defined in this rule.

Rule **5101:3-1-25**, entitled Interest on overpayments made to Medicaid providers, is being amended to align with Section 1343.01 of the Revised Code and for the five year rule review. This rule explains how interest is calculated on overpayments made to specified Medicaid providers. Changes include deleting the exception of Medicaid managed care plans from the title and placing the exception in paragraph (A) and adding nursing facility and ICF-MR rate calculations as exceptions to this rule, deleting obsolete or incorrect references and language throughout the rule, and adding new language to clarify repayment provisions, and moving

necessary information in paragraph (E) to paragraph (A). The rule clarifies the definition of "maximum real estate mortgage rate" as a flat eight percent rate authorized in Section 1343.01(A) of the Revised Code instead of the fluctuating interest rate previously referenced in Section 1343(B)(4) of the Revised Code.

Rule **5101:3-1-27**, entitled Review of provider records, is being amended to include a new definition of the hold and review process administered by the ODJFS.

Rule **5101:3-1-27.1**, entitled Hold and review process, is a new rule that describes the ODJFS hold and review process. This includes review of Medicaid provider's claims, including records and supporting documentation, for determination of claims payment or reimbursement.

Rule **5101:3-1-27.2**, entitled Medicaid hold and review process for Medicaid claims paid through state agencies other than Ohio Department of Job and Family Services, is a new rule that describes the hold and review process for Medicaid claims paid through state agencies other than ODJFS. The other state agency administers a component of the Medicaid program under the terms of a contract with ODJFS under section 5111.91 of the Ohio Revised Code and pays claims for Medicaid services or reimburses local entities for claims paid for Medicaid services.

### **Web Page and Paper Distribution:**

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals, and handbooks. The URL is as follows:

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

This transmittal letter, and any attachments, may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider."
- (2) Select "General Information For Medicaid Providers."
- (3) From the "Table of Contents" dropdown, select the transmittal letter number.

Providers will receive one hard copy of this transmittal letter and, if there are attachments, one hard copy of the JFS 03400 "Ohio Department of Job and Family Services, Service Provider Update Request Form." If a provider does not have access to the Internet and wishes to request a paper copy of this transmittal letter with all attachments, the provider should complete the attached JFS 03400 and return it to the Ohio Department of Job and Family according to the instructions at the top of the form.

### **Questions pertaining to this MHTL should be addressed to:**

Office of Ohio Health Plans

Provider Services Section

P.O. Box 1461

Columbus, Ohio 43216-1461

Toll free telephone number 1-800-686-1516

# **MHTL 3334-07-03 (Important Information For Medicaid Providers Pertaining to Discontinuance of Mailing Paper Remittance Advice Notices to Medicaid Providers)**

## **Medicaid Handbook Transmittal Letter (MHTL) No. 3334-07-03**

June 19, 2007

**TO:** All Eligible Medicaid Providers  
Directors, County Departments of Job and Family Services  
Medical Assistance Coordinators

**FROM:** Helen E. Jones-Kelley, Director

**SUBJECT:** Important Information For Medicaid Providers Pertaining to Discontinuance of Mailing Paper Remittance Advice Notices to Medicaid Providers

Beginning July 1, 2007 your Medicaid remittance advice (RA) will be accessible only via the Internet. The Ohio Department of Job and Family Services (ODJFS) will no longer mail paper RAs with your check or electronic funds transfer (EFT) statement. This does not change the claims submission process.

To access your remittance advice go to the ODJFS web site at: <http://jfs.ohio.gov/OHP/provider.stm> and click on the link to "Remittance Advice". On your first visit you will need to establish a password. To do this click on "Sign In". Enter your Medicaid Provider number in the "User ID" field and the last four digits of your Federal Tax ID Number (either your Employer Identification Number or Social Security Number) in the "Password" field. You will be prompted to enter your name and e-mail address. You must have an e-mail address to establish your account. Once you have done this you will be prompted to change your password.

There will be on-line assistance available in the form of a help function. This website will be available beginning in late June 2007. RAs will continue to be mailed, along with being posted to the internet, through June 2007. Beginning July 1, 2007, RAs will be accessible only via the Internet.

### **Other important information:**

- If you receive your Medicaid payment by EFT, effective July 5, 2007 your funds will be deposited on Thursdays, not Wednesday as is the current process.
- If you receive payment by warrant (check) you will notice minor differences in the layout of the warrant.
- Your Electronic Data Interchange (EDI) 835 Remittance Advice will be issued on Thursdays. Please inform your trading partners.

Questions pertaining to this MHTL should be addressed to:

Office of Ohio Health Plans  
Provider Services Section  
P.O. Box 1461  
Columbus, Ohio 43216-1461  
Toll free telephone number: 1-800-686-1516

## **MHTL 3334-07-02 (Claim submission)**

### **Medicaid Handbook Transmittal Letter (MHTL) No. 3334-07-02**

May 9, 2007

TO: All Eligible Atypical Medicaid Providers Not Required to Obtain an NPI  
Directors, County Departments of Job and Family Services  
Medical Assistance Coordinators

FROM: Helen E. Jones-Kelley, Director

SUBJECT: Claim submission OAC 5101:3-1-19, 5101:3-1-19.1, 5101:3-1-19.2, 5101:3-1-19.7, 5101:3-1-19.8, 5101:3-1-20, 5101:3-1-20.1, and 5101:3-1-20.2 and Ohio Medicaid provider eligibility OAC 5101:3-1-17 and 5101:3-1-17.3 regarding the transition to the national provider identifier (NPI).

The purpose of this Medicaid Handbook Transmittal Letter (MHTL) is to announce updates to general Medicaid OAC rules to be effective May 23, 2007.

The full text for each of these rule changes can be found on the Department's website at <http://emanuals.odjfs.state.oh.us/emanuals> in the ODJFS Ohio Administrative Code link under Legal Services.

**OAC Rule 5101:3-1-17**, entitled Eligible providers, has been amended to include new language concerning the national provider identifier (NPI) requirements. (See NPI update below)

**OAC Rule 5101:3-1-17.3**, entitled Provider disclosure requirements, has been amended to include national provider identifier (NPI) provider disclosure requirements.

**OAC Rule 5101:3-1-19**, entitled General principles regarding claim submission, is a new rule that combines general information from various rules, relevant to all claims submission, into this new general rule. This rule is not replacing any existing rules at this time but mainly complements rule 5101:3-1-19.3. New language is introduced concerning claims submission when attachments are required as well as new language concerning the resubmission of denied claims.

**OAC Rule 5101:3-1-19.1**, entitled Medicaid claim formats for paper claim submission, has been amended to transition to the new paper claim form versions to accommodate the national provider identifier (NPI). Language specific to paper claim submissions that has been removed from 5101:3-1-19.3 has been added to this rule. OAC Rule 5101:3-1-19.2, entitled Medicaid claim formats for the submission of claims via electronic data interchange (EDI), has been amended to update provider type billing formats and to delete language housed in rule 5101:3-1-19.3.

**OAC Rule 5101:3-1-19.7**, entitled Prompt payment and interest provisions, has been amended to update language and rule references. New language has been added to support the transition to Ohio Administrative Knowledge System (OAKS).

**OAC Rule 5101:3-1-19.8**, entitled Resolution of payment errors and overpayments, has been amended to add new language concerning claim payment adjustment processes and methods for completing claim payment adjustments, including electronic adjustments and clarification concerning crediting adjustment amounts against future payments. In addition, revision dates for adjustment request forms have been updated. Language that is outdated or that is referenced in other rules has been deleted.

**OAC Rule 5101:3-1-20**, entitled Responsibilities related to the electronic submission of cartridge tapes (C-tapes), has been amended to codify that ODJFS will no longer accept cartridge tape as a method of provider claim submission. Cartridge tape will only be accepted from sister agencies or the ODJFS contracted data entry vendor. Provider claims must be submitted by either electronic data interchange or on a paper claim form. Old and outdated language is being deleted concerning cartridge tape.

**OAC Rule 5101:3-1-20.1**, entitled Electronic data interchange (EDI) trading partner definitions and criteria to enroll as an EDI trading partner, has been amended only to add a revision date to a code of federal regulation (C.F.R.) reference.

**OAC Rule 5101:3-1-20.2**, entitled Responsibilities related to the submission of claims via electronic data interchange (EDI), has been amended to delete old language and to add new language concerning EDI claim submission policies and procedures.

### **New Paper Form Announcement**

ODJFS is pleased to announce that providers may begin submitting the new CMS 1500 (08/05) claim form on May 23, 2007. Providers may continue to submit the old CMS 1500 (12-90) claim form until ODJFS announces that it will no longer accept the old CMS 1500 (12-90) forms. Providers must follow the appropriate (old form/new form) billing instructions dated 5/2007 posted to the <http://emanuals.odjfs.state.oh.us/emanuals> website under the Ohio Health Plans-Providers, Billing Instructions link.

Note: Both NPI and the Medicaid legacy identifiers are required on the new forms (if NPI is applicable). Only the Medicaid legacy identifier may be submitted on the old forms.

### **National Provider Identifier (NPI) Update**

If you have received this letter, ODJFS considers you an atypical provider. Atypical providers are not required to obtain an NPI. Atypical providers are expected to submit only a Medicaid legacy identifier on all claim formats. Atypical providers are not expected to submit an NPI on claims.\* (See note on exception below)

\* If an atypical provider obtains an NPI, the atypical provider must submit both their Medicaid legacy identifier and their NPI unless the provider is still submitting the old paper CMS 1500 (12-90) claim form. Only Medicaid legacy identifiers may be submitted on the old paper CMS 1500 claim form.

Note: If an atypical provider obtains an NPI, ODJFS must assume that the provider determined that some of the services it provides makes it a covered entity under the NPI provisions.

### **The Ohio Administrative Knowledge System (OAKS) & Remittance Advice (RA) Announcement**

The State of Ohio has announced its release of certain phases of the OAKS project. Medicaid providers still receiving payment by state warrant (checks) will notice a newly designed check for all payments beginning July 1<sup>st</sup>. If you receive payment via electronic funds transfer (EFT), you will not be impacted by the check redesign.

Also beginning July 1<sup>st</sup>, Medicaid providers will be able to view their remittance advice via the internet. ODJFS is establishing a secure website for Medicaid providers to log on to view and download their RA. Paper remittance advices will no longer be mailed to providers. This change is part of the larger plan to make state operations more efficient through the implementation of OAKS. Please visit the Office of Budget and Management website at [www.obm.ohio.gov](http://www.obm.ohio.gov) to learn more about OAKS. Please look for future communications on how to access the website.

Questions pertaining to this MHTL should be addressed to:

Office of Ohio Health Plans

Provider Services Section

P.O. Box 1461

Columbus, Ohio 43216-1461

Toll free telephone number 1-800-686-1516

## MHTL 3334-07-01 (Claim submission)

### Medicaid Handbook Transmittal Letter (MHTL) No. 3334-07-01

May 9, 2007

TO: All Eligible Typical Medicaid Providers Required by ODJFS to Obtain an NPI  
Directors, County Departments of Job and Family Services  
Medical Assistance Coordinators

FROM: Helen E. Jones-Kelley, Director

SUBJECT: Claim submission OAC 5101:3-1-19, 5101:3-1-19.1, 5101:3-1-19.2, 5101:3-1-19.7, 5101:3-1-19.8, 5101:3-1-20, 5101:3-1-20.1, and 5101:3-1-20.2 and Ohio Medicaid provider eligibility OAC 5101:3-1-17 and 5101:3-1-17.3 regarding the transition to the national provider identifier (NPI).

The purpose of this Medicaid Handbook Transmittal Letter (MHTL) is to announce updates to general Medicaid OAC rules to be effective May 23, 2007.

The full text for each of these rule changes can be found on the Department's website at <http://emanuals.odjfs.state.oh.us/emanuals> in the ODJFS Ohio Administrative Code link under Legal Services.

**OAC Rule 5101:3-1-17**, entitled Eligible providers, has been amended to include new language concerning the national provider identifier (NPI) requirements. (See NPI update below)

**OAC Rule 5101:3-1-17.3**, entitled Provider disclosure requirements, has been amended to include national provider identifier (NPI) provider disclosure requirements.

**OAC Rule 5101:3-1-19**, entitled General principles regarding claim submission, is a new rule that combines general information from various rules, relevant to all claims submission, into this new general rule. This rule is not replacing any existing rules at this time but mainly complements rule 5101:3-1-19.3. New language is introduced concerning claims submission when attachments are required as well as new language concerning the resubmission of denied claims.

**OAC Rule 5101:3-1-19.1**, entitled Medicaid claim formats for paper claim submission, has been amended to transition to the new paper claim form versions to accommodate the national provider identifier (NPI). Language specific to paper claim submissions that has been removed from 5101:3-1-19.3 has been added to this rule. **OAC Rule 5101:3-1-19.2**, entitled Medicaid claim formats for the submission of claims via electronic data interchange (EDI), has been amended to update provider type billing formats and to delete language housed in rule 5101:3-1-19.3.

**OAC Rule 5101:3-1-19.7**, entitled Prompt payment and interest provisions, has been amended to update language and rule references. New language has been added to support the transition to Ohio Administrative Knowledge System (OAKS).

**OAC Rule 5101:3-1-19.8**, entitled Resolution of payment errors and overpayments, has been amended to add new language concerning claim payment adjustment processes and methods for completing claim payment adjustments, including electronic adjustments and clarification concerning crediting adjustment amounts against future payments. In addition, revision dates for adjustment request forms have been updated. Language that is outdated or that is referenced in other rules has been deleted.

**OAC Rule 5101:3-1-20**, entitled Responsibilities related to the electronic submission of cartridge tapes (C-tapes), has been amended to codify that ODJFS will no longer accept cartridge tape as a method of provider claim submission. Cartridge tape will only be accepted from sister agencies or the ODJFS contracted data entry vendor. Provider claims must be submitted by either electronic data interchange or on a paper claim form. Old and outdated language is being deleted concerning cartridge tape.

**OAC Rule 5101:3-1-20.1**, entitled Electronic data interchange (EDI) trading partner definitions and criteria to enroll as an EDI trading partner, has been amended only to add a revision date to a code of federal regulation (C.F.R.) reference.

**OAC Rule 5101:3-1-20.2**, entitled Responsibilities related to the submission of claims via electronic data interchange (EDI), has been amended to delete old language and to add new language concerning EDI claim submission policies and procedures.

### **New Paper Form Announcement**

ODJFS is pleased to announce that we will begin accepting the new CMS 1500 (08/05) claim form on May 23, 2007. Providers may continue to submit the old CMS 1500 (12-90) claim form until ODJFS announces that it will no longer accept the old form. Providers must follow the appropriate (old form/new form) billing instructions dated 5/2007 posted to the <http://emanuals.odjfs.state.oh.us/emanuals> website under the Ohio Health Plans-Providers, Billing Instructions link.

Note: Both NPI and the Medicaid legacy identifiers are required on the new forms. Only the Medicaid legacy identifier may be submitted on the old forms.

### **National Provider Identifier (NPI) Announcement**

ODJFS is extending their National Provider Identifier (NPI) dual identifier period until December 31, 2007. During this extended period ODJFS requires both the Medicaid legacy provider identifier and the NPI on claims (\* see note below). Failure to continue to send the Medicaid legacy provider identifier during the extended dual identifier period will result in non-payment or rejection of claims. Providers and Trading partners will be notified in the event ODJFS believes the dual identifier period can end sooner than December 31, 2007, or needs to be extended to the CMS approved date of May 23, 2008. The dates in this MHTL regarding NPI supersedes all dates announced in previous MHTLs or Medical Assistance Letters (MALs).

\* Pharmacies billing for pharmacy services on the NCPDP 5.1 format must submit only the NPI for claims submitted on and after May 23, 2007.

\* Providers submitting the old paper claim forms accepted by ODJFS (i.e., CMS 1500 (revised 12-90), ADA 2000 (revised 1999) and the old UB-92), must submit only the Medicaid legacy identifier.

### **The Ohio Administrative Knowledge System (OAKS) & Remittance Advice (RA) Announcement**

The State of Ohio has announced its release of certain phases of the OAKS project. Medicaid providers still receiving payment by state warrant (checks) will notice a newly designed check for all payments beginning July 1st. If you receive payment via electronic funds transfer (EFT), you will not be impacted by the check redesign.

Also beginning July 1st, Medicaid providers will be able to view their remittance advice via the internet. ODJFS is establishing a secure website for Medicaid providers to log on to view and download their RA. Paper remittance advices will no longer be mailed to providers. This change is part of the larger plan to make state operations more efficient through the implementation of OAKS. Please visit the Office of Budget and Management website at [www.obm.ohio.gov](http://www.obm.ohio.gov) to learn more about OAKS. Please look for future communications on how to access the website.

Questions pertaining to this MHTL should be addressed to:

Office of Ohio Health Plans

Provider Services Section

P.O. Box 1461

Columbus, Ohio 43216-1461

Toll free telephone number 1-800-686-1516

# MHTL 3334-06-01 (Ohio Administrative Code (OAC) rules)

## Medicaid Handbook Transmittal Letter (MHTL) No. 3334-06-01

December 22, 2006

TO: All Eligible Medicaid Providers  
Directors, County Department of Job and Family Services  
Medical Assistance Coordinators

FROM: Barbara E. Riley, Director

SUBJECT: Ohio Administrative Code (OAC) rules 5101:3-1-05 Medicaid Coordination of Benefits with the Medicare Program (Title XVIII), 5101:3-1-05.3 Payment for Medicare Part-B Cost Sharing, 5101:3-1-08 Coordination of Benefits, and 5101:3-1-15 Medicaid Card.

The purpose of this Medicaid Handbook Transmittal Letter (MHTL) is to announce rule revisions effective December 18, 2006 to general Medicaid OAC rules pertaining to the coordination of benefits between the Medicaid and Medicare programs, how Medicaid pays for Medicare Part-B cost sharing, coordination of benefits (COB) with insurers other than Medicare and updates to the Medicaid Card rule.

This MHTL also provides information pertaining to electronic data interchange (EDI) transactions being sent to Group Healthcare Incorporated (GHI) for Medicare/Medicaid dual eligibles and updates providers about the new national paper claims formats for the professional 1500 claim form, the American Dental Association (ADA) dental claim form and the new UB-04 institutional claim form.

### Revised Rules

These rule revisions, specifically for the rules pertaining to the coordination of benefits between Medicaid and Medicare and/or other third party insurances, clarify our expectations that providers and/or trading partners are expected to conduct business in a manner that assures Medicaid is the payer of last resort and to maintain documentation sufficient to support that the information submitted to ODJFS on a COB or Medicare crossover claim is accurate and valid (for example providers are expected to maintain documentation which supports that the submission of a TPL over-ride code or in-bound claim adjustment reason (CAS) code was valid, maintain documentation which supports the payment made by the third party was accurately reported on the claim, or maintain documentation which supports that the amounts determined by Medicare as co-insurance and deductible amounts were accurately reported on the claim, etc.).

The full text for each of these rule changes can be found on the Department's website at <http://emanuals.odjfs.state.oh.us/emanuals> in the ODJFS Ohio Administrative Code link under Legal Services.

**OAC Rule 5101:3-1-05**, entitled Medicaid: relationship to medicare (Title XVIII), has been rescinded and replaced with a new rule 5101:3-1-05 entitled Medicaid coordination of benefits with the medicare program (Title XVIII) with new language regarding the Medicaid program's relationship with the Medicare program. This rule describes different types of Medicare programs and beneficiaries, what the Medicaid program pays for and how the Medicaid program pays when a consumer also has Medicare.

**OAC Rule 5101:3-1-05.3**, entitled Payment for "Medicare Part B" cost sharing, has been adopted to incorporate language regarding Medicaid's payment for Medicare Part B cost sharing. This rule sets forth the reimbursement limitations for Medicaid's cost sharing amounts of Medicare Part B services and explains how the Medicaid program will reimburse for those services.

**OAC Rule 5101:3-1-08**, entitled Third-party liability, has been rescinded and replaced with a new rule 5101:3-1-08 entitled Coordination of benefits with new language regarding the Medicaid program's coordination of benefits with third party insurances. Content includes information on how providers should bill the Medicaid program when other medical insurance benefits exist. Changes include a definitions section with many coordination of benefits terms, what steps a provider must take to obtain other insurance payments prior to billing the Medicaid program, what valid reasons may exist for non-payment from a third party insurance, and documentation requirements.

**OAC Rule 5101:3-1-15**, entitled Medicaid card, was amended due to the five year rule review. This rule describes the different types of Medicaid cards available under the Medicaid program. Changes are nominal and include updating the ODJFS acronym and amending old program language to reflect current program language.

### **EDI transactions sent to GHI for Medicare/Medicaid Dual Eligibles**

Ohio Health Plans (OHP) is requesting that Ohio Medicaid Providers include their Ohio Medicaid Legacy Identifiers concurrently with their Medicare Identifiers on all EDI transactions they are sending to Medicare for Medicare/Medicaid dual eligibles. This will assist OHP as the implementation deadline for the National Provider Identifier (NPI) approaches.

Ohio Medicare Providers can include their Ohio Medicaid Legacy Identifiers by submitting an additional REF segment with a 1D qualifier and their corresponding Ohio Medicaid Legacy Identifier in any loop they are currently sending a REF segment with a 1C or 1G qualifier and their Medicare Identifier. It is important for you to share this request with the trading partner you use to send EDI transactions.

### **New National Paper Claim Forms**

ODJFS recognizes that the health care industry has released new paper claim forms:

- The professional 1500 health insurance claim form for use by October 1, 2006.
- The ADA dental claim form for use by January 1, 2007
- The UB-04 institutional claim form for use by March 1, 2007.

ODJFS is not accepting the new paper 1500 claim form at this time and does not plan to accept the ADA Dental claim form or the UB-04 institutional claim form for reimbursement of Medicaid services by the national release dates. Medicaid providers that have begun using the new paper claim forms, or that are planning to use the new forms, will need to maintain a billing system that will continue to accommodate the use of the forms ODJFS currently recognizes for purposes of reimbursement. If providers are making modifications to billing software to accommodate new information contained in the new claim forms, it will be important that providers maintain software specifications for the current forms in order to bill the Medicaid program for reimbursement of services.

ODJFS is committed to the transition to new paper forms as soon as possible. Information as to when the Medicaid program will begin accepting the new paper forms will be forthcoming in future communications, but providers will be given a minimum of sixty days notice. Copies of the paper claim forms and the billing instructions recognized by ODJFS are located on the internet at <http://emanuals.odjfs.state.oh.us/emanuals> under the folder titled Billing Instructions. ODJFS will post on this website, at the beginning of each month beginning December 1, 2006, a document entitled "The Paper Form and Other Claim Format Grid." The document will list the paper forms that will be accepted by ODJFS for each of three months, the posting month and each of the two subsequent months, providing advance notice of two months of any change in acceptable paper forms. As example, the first posting will itemize the paper forms acceptable for submission in each of the months of December 2006, January 2007, and February 2007. When a change is announced it will first appear in the itemization of the third month listed on the website. ODJFS will also post the new paper claim forms and billing instructions on the website for each of the new forms when the effective date for implementation is announced.

### ***Special Notations about the New Paper Forms:***

*As long as ODJFS is only accepting the old paper claim formats the provider billing numbers submitted on the claim must be the Ohio Medicaid legacy number assigned to*

*the provider and may not be the NPI number. ODJFS will not be accepting the NPI number on paper claim forms until we adopt the new paper forms.*

*Each Medicaid Managed Care Plan (MCP) will determine the billing forms and formats they accept for the submission and payment of claims covered by the MCP. Each MCP will determine if and when they will begin accepting the new paper forms. For your patients enrolled in Medicaid Managed Care Plan, please check with the respective MCP.*

**Questions pertaining to this MHTL should be addressed to:**

Bureau of Plan Operation

Provider Network Management Section

P.O. Box 1461

Columbus, Ohio 43216-1461

Toll free telephone number 1-800-686-1516

If you do not have internet access, you may request a paper copy of this MHTL by completing and returning the attached form JFS 03400.

# MHTL 3334-02-01 (Chapter 3334, General Information Handbook)

Medical Handbook Transmittal Letter No. 3334-02-01

February 3, 2003

TO: All Providers of Medical Services  
Directors, County Departments of Job and Family Services  
Medical Assistance Coordinators

FROM: Thomas J. Hayes, Director

SUBJECT: Chapter 3334, General Information Handbook

## Notice

**Chapter 3334, General Information Handbook is available on the web in an Easy Print format**

The 2002 edition of Chapter 3334, General Information Handbook is now available on the web in an **Easy Print (PDF)** format at the web address below:

<http://www.state.oh.us/odjfs/ohp/bhpp/handbook/index.stm>

This Medicaid Handbook Transmittal Letter (MHTL) is to inform you that the department has released a 2002 edition of Chapter 3334. Chapter 3334, the General Information Handbook for Medicaid providers incorporates policy updates that went into effect in May and July, 2002. **The handbook contains rules and information relevant to all Medicaid providers. This MHTL is intended only to summarize changes in rules included in this handbook and is not inclusive of all changes that were made.** Providers are encouraged to read the handbook and rules in their entirety for updates which may be important to them. This handbook replaces all previously issued Chapter 3334 Handbook materials. The rules contained in this handbook are also available on the department's website at: <http://dynaweb.odjfs.state.oh.us:6336/dynaweb/>.

### Handbook and Policy Update:

The following is a summary of updated policy information found in each section of the handbook:

#### Section I.

##### The Medicaid Handbook

- This section describes the purpose of this handbook, handbook updating, and includes updated instructions regarding accessing provider information (rules, handbooks, MALs, MHTLs) online at the department's web site.

#### Section II.

##### Navigating the Medicaid Program

- Changes include updates in department phone numbers and addresses.
- The department's "Most Commonly Asked Questions" have been updated.

#### Section III.

##### The Medicaid Program

- Rule 5101:3-1-01 entitled "Medicaid: medical necessity" defines medical necessity in regards to the provision of medicaid covered services. The former rule, 5101:3-1-01, which covered both medical necessity and general principles for reimbursement was divided into two separate rules. Rule 5101:3-1-01 now addresses medical necessity and a new rule, 5101:3-1-02, was developed to address general principles for reimbursement. Medical necessity was further defined to include a requirement that the service be the lowest cost alternative that effectively addresses and treats the medical problem.

- Rule 5101:3-1-02 entitled "General principles regarding reimbursement for medicaid covered services [except as provided through medicaid contracting managed care plans(MCPs)]" defines the general principles regarding reimbursement for medicaid covered services. The information in this rule was formerly in rule 5101:3-1-01. The new rule 5101:3-1-02 was developed to cover general principles for reimbursement. No policy changes were added.
- Rule 5101:3-1-13.1 entitled "Medicaid consumer liability [except for consumers enrolled in medicaid contracting managed care plans (MCPs)]" defines conditions under which medicaid consumers may and may not be billed for medical services. The rule was reorganized to clarify a consumer's liability for the provision of Medicaid covered services:
  - ***Providers, with the exception of long-term care facilities as provided in chapter 5101:3-3 of the Administrative Code, 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 and signs a written statement to that effect prior to the service being rendered.***
  - ***Services which are not covered by the medicaid program, including services requiring prior authorization which have been denied by the department, may be billed to the consumer when the provisions in paragraphs (1) and (2) above are met.***

## Section IV.

### Ohio Medicaid Program Medical Cards

- This section has been updated to include descriptions and examples of the Medicaid program's new medical cards.

## Section V.

### Medicaid Providers

- Rule 5101:3-1-11 entitled "Out-of-state coverage [except as provided through medicaid contracting managed care plans (MCPs)]" defines department policy regarding the conditions under which out-of-state providers may be reimbursed for rendering services to medicaid consumers. The rule has been restructured and now includes new conditions that out-of-state providers must comply with prior to providing services to Medicaid consumers:
  - ***Out-of-state providers must be licensed, accredited, or certified by their respective states to be considered eligible to provide services to Ohio medicaid consumers. Any standards applicable to the provision of the service in the state in which the service is being furnished must be met, as well as those standards set forth in the Ohio medicaid program and in the Ohio Administrative Code.***
- Rule 5101:3-1-17 entitled "Eligible providers [except nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR)] and medicaid contracting managed care plans (MCPs)]" defines the department's policy regarding eligible providers approved for participation in the medicaid program. The rule was amended to accommodate changes in program terminology.
- Rule 5101:3-1-17.2 entitled "Provider agreement for providers [except long term care facilities and medicaid contracting managed care plans (MCPs)]" defines the medicaid program's provider agreement including terms under which providers must adhere in order to provide services to medicaid consumers. The following new provisions were added to the rule:
  - ***That neither the individual practitioner, nor the company, nor any owner, director, officer, or employee of the company, nor any independent contractor retained by the company, is currently subject to sanction under medicare, medicaid, disability assistance medical,***

**or Title XX; or, is otherwise prohibited from providing services to medicare, medicaid, disability assistance medical, or Title XX beneficiaries.**

- **To follow the regulations and policies set forth in the appropriate edition of the medicaid handbook.**
  - **To provide to ODJFS, through the court of jurisdiction, notice of any bankruptcy action brought by the provider. Notice shall be mailed to: office of legal services, Ohio department of job and family services.**
  - **To comply with the appropriate advance directives requirements for hospitals, providers of home health care, personal care services, and hospices, as specified in Chapter 3701-83 of the Administrative Code.**
  - **To comply with confidentiality safeguards and the use and release of information regarding public assistance recipients as described in section 5101.27 of the Revised Code.**
- Rule 5101:3-1-17.3 entitled "Provider disclosure requirements" defines disclosure requirements related to provider business practices. Minor sentence structure changes were made to the rule.
  - Rule 5101:3-1-17.4 entitled "Length and type of "Provider agreements" [except nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR), and medicaid contracting managed care plans (MCPs)]" defines departmental policy regarding the length and type of provider agreements. New provisions regarding closed-end agreements and certain out-of-state providers are:
    - **Closed-end agreements are for a specific period of time not to exceed twelve months. Closed-end agreements automatically expire on the designated date unless renewed by the provider and approved by the department. Providers must notify the department of their intent to renew their provider agreement prior to the termination of their current closed-end provider agreement. Providers failing to notify the department of their intent to renew their provider agreement will be notified of the termination of their provider agreement and their right to appeal the termination under Chapter 119. of the Ohio Revised Code.**
    - **Out-of-state providers, as defined in rule 5101:3-1-17 of the Administrative Code, who practice in non-contiguous states, with the exception of pharmacy, durable medical supply, long term care nursing facility, laboratory, and transportation providers, will be enrolled using a closed-end provider agreement for a period not to exceed twelve months unless renewed annually prior to the agreements' termination date by both parties.**
  - Rule 5101:3-1-17.6 entitled "Termination and denial of provider agreement [except nursing facilities (NFS), and intermediate care facilities for the mentally retarded (ICFS-MR)]" describes department guidelines regarding the termination and denial of provider agreements. The rule was amended to update the policies regarding the termination and denial of provider agreements and to correct minor syntax problems. New provisions for termination and/or denial of a provider agreement include:
    - **The provider has not submitted claims or transacted any business with the department for a period of twenty four months. The department will notify the provider of the proposed termination. The provider will have forty five days from the date of the notification to contact the department regarding the proposed termination and request to continue their provider agreement. If the provider fails to contact the department within forty five days to request continuation of their provider agreement the provider agreement will be terminated, and the department will notify them of their right to appeal the termination under Chapter 119. of the Revised Code.**
    - **The provider fails to notify the department within thirty days of any changes in licensure, certification, accreditation, or registration status, ownership, closure, specialty, additions, deletions, or replacements in group memberships, and address, as referenced in paragraph (F) of rule 5101: 3-1-17.2 of the Administrative Code.**

- ***The provider fails to repay an overpayment or recovery amount assessed as a result of a final adjudication order.***
- ***The provider has a previous or current exclusion, suspension, termination or involuntary withdrawal from participation in any medicaid program, or any other public or private health insurance program.***
- ***The provider has been convicted under federal or state law of a criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct.***
- ***The provider has not responded to two certified mail correspondences and the provider's business cannot otherwise be located.***
- ***The provider signed a closed-end provider agreement and failed to notify the department of the intent to renew the provider agreement as defined in paragraph (B) (2) of rule 5101:3-1-17.4 of the Administrative Code.***
- The department also added a provision regarding denial of claims to providers whose agreement is reinstated after termination for cause:

***The department reserves the right to deny twelve months retroactivity for the submission of claims to providers whose agreement is reinstated after termination for cause as described in paragraph (C) of this rule, and as defined in paragraph (A) (3) of rule 5101:3-1-17.4 of the Administrative Code.***

- Rule 5101:3-1-27 entitled "Review of provider records" describes the policy for review of provider records. The rule contains changes in language regarding the request of provider records for audit and review purposes.
- Rule 5101:3-1-29 entitled "Medicaid fraud, waste and abuse" defines circumstances regarding fraud and abuse by medicaid providers and consumers. The definition of fraud and abuse was changed to include waste (fraud, waste and abuse). Additional provisions were added which fall under fraud, waste and abuse:
  - ***Billing for services that are outside the current license limitations or specific practice parameters of the person supplying the service.***
  - ***Misrepresenting by commission or omission any information on the provider enrollment form or included in the provider packet.***
  - ***Ordering excessive quantities of medical supplies, drugs and biologicals, or other services.***

Examples of cases of fraud, waste, and abuse by a consumer were updated to include:

- ***Alteration, sale, or lending of the medicaid card to others for securing medical services, or other related criminal activities.***
- ***Receiving excessive medical visits and services.***
- ***Obtaining services outside of those personally needed and used by the consumer.***

## Section VII.

### Appeals Process

- There were no substantive changes in the provider appeal process.

### Appendix A.

#### Department Directory

- Addresses and phone numbers of departmental/section areas were updated.
- County department phone numbers were updated

- Regional offices location, and phone numbers were updated.

Below is a form you may use to obtain a paper copy of this handbook:

Questions pertaining to this MHTL should be addressed to:

The Bureau of Plan Operations

Provider Network Management Section

P.O. Box 1461

Columbus, Ohio 43216-1461

In-State: 1-800-686-6108 (toll-free) or (614) 728-3288

# Medical Assistance Letters

# **MAL 594 (Update - Medicaid Requirements for Ordering, Referring, and Prescribing Providers for the Following Billing Providers: Outpatient Health Facilities and Clinics)**

**Medical Assistance Letter (MAL) 594**

**Medicaid Handbook Transmittal Letter (MHTL) No. 3347-14-01**

May 16, 2014

TO: Eligible Providers of Outpatient Health Facilities and Clinics

FROM: John B. McCarthy

Director, Department of Medicaid (ODM)

SUBJECT: UPDATE - Medicaid Requirements for Ordering, Referring, and Prescribing Providers for the following billing providers: Outpatient Health Facilities and Clinics.

## **Summary**

Rule [5160-1-17.9](#), "Ordering or referring providers," has been created in order to comply with new program integrity regulations contained in Section 6401 of the Patient Protection and Affordable Care Act (ACA). Medicaid is implementing new requirements in accordance with 42 CFR 455.410, "Enrollment and screening of providers," and 42 CFR 455.440, "National Provider Identifier (NPI)." Ohio Medicaid is thus required to enroll and screen all ordering, referring, certifying, and prescribing providers. The name and NPI of such providers are required on the claim for services rendered, procedures performed, items supplied, or drugs furnished or dispensed (services) and billed to the Department.

To implement the federal regulations described above, Rule 5160-1-17.9 specifies that Medicaid cannot pay the eligible rendering provider for any health care service requiring a referral, order, certification, or prescription from a physician or other health care professional unless the ordering, referring, certifying, or prescribing (ORP) provider is enrolled with Ohio Medicaid. Furthermore, if a claim fails to include the NPI or the legal name of the physician or health care professional who ordered, referred, certified, or prescribed the service, Medicaid reimbursement will not be allowed. Claims submitted to a managed care organization are specifically exempted from the new requirements.

## **ORP phase-in (or pay and post) period**

The Ohio Department of Medicaid (ODM) will begin ORP implementation by posting edits for claims that require, but do not include, both the ordering, referring, certifying, or prescribing (ORP) provider's legal name and NPI and if the ORP provider is not enrolled in Medicaid. The edit will not deny the claim; rather the billing provider will receive information from ODM that states the claim does not have the required ordering, referring, certifying, or prescribing provider information. This phase-in period is expected to run from July 1, 2014 through at least December 31, 2014. Again, billing providers will not receive a denial for payment because of ORP implementation but will receive information that may require action on the part of both the billing and ORP provider.

Providers who are rendering services to Medicaid beneficiaries and bill the Department should ensure that such services are being ordered, referred, certified, or prescribed by a provider who is enrolled in Medicaid. The billing provider should double-check their applicable Medicaid program rules to determine what services requires an order, referral, certification, or prescription. The Department will soon be releasing a list of provider types and specialties to which the requirements of ORP will apply. The Department has created an abbreviated screening and application process for providers who do not wish to bill the Department but who wish to enroll as ordering, referring, certifying, or prescribing providers-only. An application fee is not required and the application can be filled out online. The Department is also working diligently to create a way in which billing providers can search the Medicaid enrollment status of the ordering, referring, certifying, or prescribing services in MITS.

As has been recommended in previous guidance by ODM, Medicaid providers who bill for services that are referred, ordered, certified, or prescribed by non-Medicaid enrolled physicians or other health care

professionals should be preparing for future enforcement by ensuring those referring, ordering, and prescribing physicians and other health care professionals have NPIs and are enrolled in the Medicaid program. **ODM plans on issuing a series of implementation guidance in the coming weeks that will, among other things, clarify who is potentially impacted by the change in policy. This letter serves as the first of such implementation guidance.**

- Providers who are enrolled as Provider Types (PT) 04, "Outpatient Health Facilities," and that specialize in physical therapy, speech therapy, lab, or x-ray and submit bills to the Department for services rendered will always be required to submit the name and NPI of the ordering provider and the provider will be required to be enrolled with the Ohio Medicaid program. Please consult the applicable Medicaid coverage rules to ensure the provider is authorized to order the covered service.
- Providers who are enrolled as PT 50, "Clinic," and that specialize in rehabilitation (including physical therapy), hearing and speech, diagnostic imaging, pharmacy, durable medical equipment, or orthotics and prosthetics and submit bills to the Department for services rendered will always be required to submit the name and NPI of the ordering provider and the provider will be required to be enrolled with the Ohio Medicaid program. Please consult the applicable Medicaid coverage rules to ensure the provider is authorized to order the covered service.
- Providers who are enrolled as PT 51, "Mental Health Clinic," and that operate as pharmacy and submit bills to the Department for drugs will always be required to submit the name and NPI of the prescribing provider and the provider will be required to be enrolled with the Ohio Medicaid program. Please consult the applicable Medicaid coverage rules to ensure the provider is authorized to prescribe the covered drug.
- **ODM has decided not to implement ORP requirements for automatic crossovers.** Crossovers submitted directly to ODM by the provider may be subject to ORP requirements.

For further information, all providers are welcome to view ODM's responses to ORP Frequently Asked Questions (FAQ) at <http://medicaid.ohio.gov/PROVIDERS/EnrollmentandSupport/ProviderEnrollment/ORP.aspx> Providers may also call the ODM provider hotline at 1-800-686-1516.

More guidance on the implementation of Rule 5160-1-17.9 will be introduced in the coming weeks.

### **Access to Rules and Related Material**

The main ODJFS web page includes links to valuable information about its services and programs; the address is <http://www.jfs.ohio.gov>. The web page of the Ohio Department of Medicaid may be accessed through the ODJFS main page or directly at <http://www.medicaid.ohio.gov>.

ODJFS maintains an "electronic manuals" web page of the department's rules, manuals, transmittal letters, forms, and handbooks. The web address for this "eManuals" web page is <http://emanuals.odjfs.state.oh.us/emanuals/>.

From the "eManuals" page, providers may view documents online by following these steps:

- (1) Select the 'Ohio Health Plans - Provider' collection.
- (2) Select the appropriate service provider type or handbook.
- (3) Select the desired document type.
- (4) Select the desired item from the 'Table of Contents' pull-down menu.

Most current Medicaid maximum reimbursement amounts are listed in rule 5101:3-1-60 or in Appendix DD to that rule. Providers may view this information by following these steps:

- (1) Select the 'Ohio Health Plans - Provider' folder.
- (2) Select 'General Information for Medicaid Providers'.
- (3) Select 'General Information for Medicaid Providers (Rules)'.
- (4) Select '5101:3-1-60 Medicaid Reimbursement' from the 'Table of Contents' pull-down menu and then scroll down to the link to Appendix DD.

The Legal/Policy Central - Calendar site, <http://www.odjfs.state.oh.us/lpc/calendar/>, is a quick reference for finding documents that have recently been published. This site also provides a link to a listing of Medicaid manual transmittal letters, <http://www.odjfs.state.oh.us/lpc/mtl/>. The listing is categorized by letter number and subject, and a link is provided to each easy-print (PDF) document.

To receive automatic electronic notification when new Medicaid transmittal letters are published, sign up for the ODJFS e-mail subscription service at <http://www.odjfs.state.oh.us/subscribe/>.

### **Additional Information**

Questions pertaining to this letter should be addressed to:

Ohio Department of Medicaid

Bureau of Provider Services

P.O. Box 1461

Columbus, OH 43216-1461

Telephone (800) 686-1516

# MAL 590 (New Prior Authorization Process Affecting Home Health Services for Individuals Age 21 and Over)

## Medical Assistance Letter (MAL) 590

[Long Term Care Services and Supports Transmittal Letter \(LTCSSSTL\) No. 14-01](#)

January 15, 2014

TO: Interested Home Health Stakeholders  
FROM: John B. McCarthy, Director  
SUBJECT: New Prior Authorization Process Affecting Home Health Services for Individuals Age 21 and Over

*The following applies only to Medicaid fee-for-service enrollees. It does not apply to individuals enrolled on Medicaid managed care plans.*

Due to recent guidance from the Centers for Medicare and Medicaid Services (CMS), the Ohio Department of Medicaid (ODM) will now provide for a prior authorization review of home health services for individuals age 21 and over whose physician has determined that **medical necessity exists for more home health services than what is currently available.**

The new prior authorization process is effective immediately.

If you are a Medicare-certified home health care agency seeking prior authorization for more home health services than what is currently available, see the chart below for the entity responsible for the medical-necessity review:

Enrollment Type		Entity Responsible for Medical Necessity Review for Prior Authorization	Special Billing Instructions
Fee-For-Service		Permedion *	Bill with the appropriate prior authorization number
Sister-Agency Administered Waivers	Assisted Living, Choices, PASSPORT, Individual Options, Level One, Self-Empowered Life Funding (SELF) and Transitions Developmental Disabilities (TDD) waivers	Permedion *	Bill with the appropriate prior authorization number
ODM-Administered Waivers	Ohio Home Care and Transitions Carve-Out waivers	Appropriate ODM waiver case management agency	Bill with the new U7 modifier

\* A request form with instructions for completion can be found on Permedion's website at [www.hmspermedion.com/oh-medicaid](http://www.hmspermedion.com/oh-medicaid). Please fax the completed form to the fax number on the form.

## **MAL 561 (Announcement of Changes to Coverage of Prescription Drugs and Certain Medical Supplies)**

**Medical Assistance Letter No [561](#)** (Announcement of Changes to Coverage of Prescription Drugs and Certain Medical Supplies), is maintained in the Pharmacy Services e-book.

# MAL 556 (Changes to Vision Care Services)

## Medical Assistance Letter (MAL) No. 556

September 14, 2009

TO: All Providers of Vision Services  
Directors, County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: Changes to Vision Care Services

### UPDATE OF MEDICAID APPROVED FRAME LIST

Effective on July 15, 2009, ODJFS will replace eight current frames with eight new frames. Frames being removed and added are listed below and will be available through our contracting laboratories Classic Optical and Korrekt Optical. The laboratories will be sending notices outlining what frames are being replaced, the new frames that will be available and any current frames that will remain available for Medicaid consumers.

Frames Being Removed		Frames Being Added	
Men	Boys	Men	Boys
Boulevard 1201	Andy	Ralph	PT 56
Walt	Taylor	Tornado	J5602
Blazer		U 36	
Women	Girls	Women	Girls
Looking Glass 7146	Laurel	Finale	The Gift
Angel		U 33	
Spectra		U 14	

Questions pertaining to this letter should be addressed to:

Office of Ohio Health Plans  
Bureau of Provider Services  
P.O. Box 1461  
Columbus, OH 43216-1461  
Telephone 800-686-1516

# MAL 551 (Update to Vision Volume Purchasing Contract and Changes to Vision Services)

## Medical Assistance Letter (MAL) No. 551

April 2, 2009

TO: All Medicaid Providers of Vision Services  
Directors, County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: Update to Vision Volume Purchasing Contract and Changes to Vision Services

### UPDATE OF NEW VISION VOLUME PURCHASING CONTRACT OPTICAL LABORATORIES & CHANGES TO VISION CARE SERVICES FOR 2009

The purpose of this Medical Assistance Letter (MAL) is to clarify updates for the new vision volume purchasing contract and changes for all providers of vision care services.

A new contract has been awarded to Classic Optical Laboratories, Inc., a current vendor of eyewear, and Korrekt Optical, a new vendor. As of April 1, 2009, vision care service providers previously using Select Optical laboratory for the fabrication of glasses will no longer be able to submit orders to Select Optical. Select Optical will, however, fill orders for any eyeglasses requested prior to April 1, 2009, that it can ship to providers by April 12, 2009. Any orders not able to be shipped by Select Optical laboratory by April 12, 2009 will be returned to the vision care service provider and must be resubmitted to a currently participating vendor.

On and after April 1, 2009, all new orders should be submitted to either Classic Optical Laboratories, Inc. or Korrekt Optical. The address for Classic Optical Laboratories, Inc. is P.O. Box 1341, Youngstown, Ohio 44501-1341. Orders may also be submitted online at [www.classicoptical.com](http://www.classicoptical.com). Classic's toll-free phone number is (888) 522-2020. The address for Korrekt Optical is 4036 Dutchmans Lane, Louisville, KY 40207. Korrekt's toll-free phone number is (800) 624-4225.

Please note that there will also be changes to the new contract, including the following:

- Glass lenses and/or U-V lens will only be covered if found to be medically necessary by the Medicaid provider and prior authorized by ODJFS.
- Photochromatic lenses will be offered for both plastic and polycarbonate lenses if found to be medically necessary by the Medicaid provider and prior authorized by ODJFS.
- Antireflective coatings will no longer be a covered service under the Ohio Medicaid program.

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page of the department's rules, manuals, letters, forms, and handbooks. The URL for this "eManuals" page is <http://emanuals.odjfs.state.oh.us/emanuals/>.

Providers may view documents online by:

- (1) Selecting the "Ohio Health Plans - Provider" folder;
- (2) Selecting the appropriate topic from the document list; and
- (3) Selecting the desired item from the "Table of Contents" pull-down menu.

The Legal/Policy Central - Calendar site (<http://www.odjfs.state.oh.us/lpc/calendar/>) is a quick reference for finding documents that have recently been published. This site also provides a link to a listing of ODJFS manual transmittal letters (<http://www.odjfs.state.oh.us/lpc/mtl/>). The listing is categorized by letter number and subject, and a link is provided to each easy-print (PDF) document.

Questions pertaining to this letter should be addressed to:

Office of Ohio Health Plans  
Bureau of Provider Services

P.O. Box 1461

Columbus, OH 43216-1461

Telephone 800-686-1516

# **MAL 536 (Suspension of Medicaid Provider Agreements and Changes in Chapter 119 Hearing Rights for Certain Proposed Departmental Actions)**

## **Medical Assistance Letter (MAL) No. 536**

September 20, 2007

TO: All Eligible Medicaid Providers (Except Non-Agency Providers)  
Directors, County Departments of Job and Family Services  
Medical Assistance Coordinators

FROM: Helen E. Jones-Kelley, Director

SUBJECT: Suspension of Medicaid Provider Agreements and Changes in Chapter 119 Hearing Rights for Certain Proposed Departmental Actions

### **EFFECTIVE OCTOBER 1, 2007**

The purpose of this Medical Assistance Letter (MAL) is to announce that ODJFS shall implement new policies allowing suspension of Ohio Medicaid Provider Agreements and changes in hearing rights provided under Chapter 119. of the Revised Code for certain departmental actions.

#### **Suspension of Ohio Medicaid Provider Agreements**

**Long-term care nursing facilities, intermediate care facilities for the mentally retarded and Medicaid contracting managed care plans are exempt from suspension of provider agreements.**

ODJFS will suspend a Medicaid Provider Agreement upon receiving notice and a copy of an indictment that charges an Ohio Medicaid provider, any owner, officer, authorized agent, associate, manager, or employee with committing an offense that would be a felony or misdemeanor under the laws of this state and the act relates to or results from either of the following:

- Prescribing, furnishing or billing for medical care, services, or supplies under the Medicaid program; or
- Participating in the performance of management or administrative services relating to prescribing, billing, or furnishing medical care, services or supplies under the Medicaid program.

During a suspension, a Medicaid provider, any owner, officer, authorized agent, associate, manager, or employee:

- Shall not own or provide services to any other Medicaid provider or risk contractor or arrange for, render, or order services for Medicaid consumers during the period of suspension; and
- Shall not receive reimbursement in the form of direct payments from ODJFS or indirect payments of Medicaid funds in the form of salary, shared fees, contracts, kickbacks, or rebates from or through any participating provider or risk contractor.

ODJFS is not required to provide Chapter 119 hearing rights when a Medicaid provider agreement is subject to suspension. A reconsideration process will be available, however.

#### **Proposed ODJFS Actions on Medicaid Provider Agreements Without Appeal Rights**

Section 5111.06 of the Revised Code increases the number of circumstances in which ODJFS may deny, terminate, or not renew a Medicaid provider agreement without granting the provider Chapter 119 hearing rights. These circumstances are as follows:

- When a managed care plan or fee-for-service provider fails to hold and/or maintain proper licensures, permits, certificates or certifications as required by the terms of the provider agreement to do business with the Ohio Medicaid program.
- When a provider agreement for a fee-for-service provider has been suspended in accordance with this MAL.

- When a provider agreement for a fee-for-service provider is converted from an open-ended provider agreement to a time-limited provider agreement.
- When a fee-for-service provider fails to properly re-enroll with the Ohio Medicaid program.
- When a fee-for-service provider has not billed or otherwise submitted a Medicaid claims to ODJFS for two years or longer, and the provider has not left a forwarding address with ODJFS.

### **Additional Information**

For more information regarding suspension of Medicaid provider agreements or regarding ODJFS actions to deny, terminate or not renew a Medicaid provider agreement, please visit our website at

[http://jfs.ohio.gov/OHP/Latest\\_News.stm](http://jfs.ohio.gov/OHP/Latest_News.stm).

Effective October 1, 2007, ODJFS has statutory authority to suspend a Medicaid provider agreement or deny, terminate or not renew a Medicaid provider agreement without a Chapter 119 hearing under the circumstances above. Ohio Administrative Code rules will be promulgated in the future to reflect the new statute. The new or amended rules will go through the Clearance and Public Hearing process where testimony regarding the rules may be given.

The suspension provisions are somewhat different for non-agency providers that are providing home and community-based services to consumers with disabilities. For more information regarding the effect of these provisions on non-agency providers, please refer to [MAL 537](#).

Questions pertaining to this MAL should be addressed to:

Office of Ohio Health Plans

Provider Services Section

P.O. Box 1461

Columbus, Ohio 43216-1461

Toll free telephone number: 1-800-686-1516

# **MAL 522 (Guidance on the Implementation of Employee Education about False Claims Recovery as provided in MAL 516)**

## **Medical Assistance Letter (MAL) No. 522**

August 14, 2007

TO: All Medicaid Providers  
Directors, County Departments of Job and Family Services  
Medical Assistance Coordinators

FROM: Helen E. Jones-Kelley, Director

SUBJECT: Guidance on the Implementation of Employee Education about False Claims Recovery as provided in MAL 516

This medical assistance letter is being sent to provide updated information related to MAL 516 that was mailed November 9, 2006, regarding the requirements of The Deficit Reduction Act (DRA) of 2005, Section 6032 (see also Section 5111.101 of the Revised Code) and guidance as provided by Centers for Medicare and Medicaid Services (CMS) in State Medicaid Director Letters (SMDL) #06-024 and #07-003, which are available for download, along with their attachments, from the CMS website at <http://www.cms.hhs.gov/SMDL>.

SMDL #06-024 offers definitions of several terms found in Section 6032 of the DRA.

An "employee" includes any officer as well as any employee of the entity.

A "contractor" or "agent" has been limited to one who, on behalf of the entity, furnishes, or otherwise authorizes the furnishing of Medicaid health care items or services, performs billing or coding functions, or is involved in monitoring of health care provided by the entity.

An "entity" has been defined to include a governmental agency, an organization, a unit, a corporation, a partnership, or other business arrangement (including any Medicaid managed care organization, irrespective of the form of business structure or arrangement by which it exists), whether for-profit or not-for-profit, which receives or makes payments, under a State plan approved under title XIX or under any waiver of such plan, totaling at least \$5,000,000 annually.

A government agency that merely administers the Medicaid program, in whole or part, is not an entity for purposes of Section 6032 of the DRA. However, if a governmental component provides Medicaid health care items or services for which Medicaid payments are made it would qualify as an entity.

For purposes of calculating the \$5,000,000 threshold, an entity may be one who submits claims for payments using one or more provider identification or tax identification numbers and may provide items or services at more than a single location or under more than one contractual or other payment arrangement.

The determination of whether the threshold amount has been met is effective January 1 of each calendar year and is based upon the amount of Ohio Medicaid funds received or payments made in the prior federal fiscal year, October 1 through September 30. Thus, for the calendar year of 2007, and effective January 1, 2007, the entity should determine the total amount received or payments made between October 1, 2005, and September 30, 2006.

Entities that meet the threshold amount must establish and disseminate written policies regarding fraud, waste and abuse that must also be adopted by contractors and agents of the entity. The written policies may be either on paper or in electronic format, but must be readily available to all employees, contractors, or agents. If an entity does not currently have an employee handbook, it is not required that one be established for compliance with the requirements of this regulation.

Providers are advised to consult with their own legal counsel to determine what actions are needed based upon DRA Section 6032, the aforementioned SMDLs and RC 5111.101.

In an effort to ensure compliance, new Ohio Medicaid providers will be given information regarding false claims education responsibilities. The Managed Care Organization (MCO) provider agreements were revised effective January 1, 2007, to incorporate the provisions of Section 6032 of the DRA.

Utilizing our Decision Support System, ODJFS will annually identify those providers who meet the threshold amount. ODJFS will select from a variety of methods to ensure compliance. These methods may include, but are not limited to: incorporation of the five million dollar threshold into ODJFS' existing risk assessment used to determine providers for audit and/or verification during compliance audits, record reviews and policy reviews that identified entities are meeting this DRA requirement. Compliance of MCOs will be monitored annually through a variety of methods which could include an attestation of compliance, annual reporting, policy review, document review, and on-site audits.

Ohio Medicaid's Office of Research, Assessment and Accountability will begin reviews to ensure compliance with Section 6032 of the DRA on July 1, 2007. This compliance monitoring will be ongoing, based upon the Medicaid providers selected for an on-site audit and will examine policies in effect as of January 1, 2007.

Questions pertaining to this MAL should be addressed to:

Bureau of Health Plan Policy  
Strategic Development Section  
P.O. Box 182709  
Columbus, OH 43218-2709  
614-466-6420

# **MAL 516 (Employee Education about False Claims Recovery)**

## **Medical Assistance Letter (MAL) No. 516**

November 9, 2006

TO: All Medicaid Providers  
Directors, County Departments of Job and Family Services  
Medical Assistance Coordinators

FROM: Barbara E. Riley, Director

SUBJECT: Employee Education about False Claims Recovery

This medical assistance letter (MAL) is being sent in fulfillment of the requirements of Section 6032 "Employee Education about False Claims Recovery" of The Deficit Reduction Act of 2005 (also see Section 5111.101 of the Revised Code).

Effective January 1, 2007, Section 6032 of The Deficit Reduction Act of 2005 requires that entities who receive or make annual payments of at least five million dollars under the Medicaid state plan, as a condition of receiving such payments, establish written policies for all employees and contractors that provide detailed information about the federal False Claims Act and other state and federal laws.

These policies must include providing information about administrative remedies for false claims and statements established under various sections of the United States Code and state laws relating to civil or criminal penalties for false claims, and whistleblower or other protections available and the role of such provisions in prevention or detection of fraud, waste and abuse in federal health care programs. In addition, such entities are required to make materials available to their employees and contractors that set forth the entity's policies and procedures for detecting and preventing fraud, waste and abuse.

In that the Ohio Department of Job and Family Services (ODJFS) is such an entity, and Medicaid providers and CDJFSs may be viewed as contractors in the application of this law, ODJFS is making its policies and information available to you in compliance with this regulation. The written policies and information may be viewed on the Ohio Health Plans web site at: <http://jfs.ohio.gov/ohp/> under the "Reports, Information & Publications" heading.

*Please be advised that if you are also an entity that receives or makes annual payments within the Medicaid program of five million dollars or more, you are required, as a condition of receiving such payments, to establish your own written materials and policies for your employees and contractors and to make such materials available to your employees and contractors, including placement in your employee handbook.*

### **Medicaid Providers:**

For those of you still receiving payments in the form of paper warrant, ODJFS highly suggests exploring electronic funds transfer (EFT) for payment instead of paper warrants.

Benefits of EFT include:

- Receipt of payment quicker. The funds will be transferred directly to your account on the day paper warrants are normally mailed.
- No more worry about lost or stolen checks or postal holidays delaying receipt of your warrant.
- If you change residences or work-place, your payment will still be deposited into your banking account.

For additional information and to begin receiving funds electronically, you will find the EFT form at the ODJFS provider web site: <http://jfs.ohio.gov/OHP/bpo/pnms/providerDocuments/jfs00000.pdf>.

Questions pertaining to this MAL should be addressed to:

Bureau of Plan Operations  
The Provider Network Management Section

P.O. Box 1461

Columbus, OH 43216-1461

In-state toll free telephone number 1-800-686-1516

Out-of-state telephone number 1-614-728-3288

# **MAL 449 (Recent Rule Revisions Concerning Third Party Liability And Protected Health Care Information)**

## **Medical Assistance Letter (MAL) No. 449**

June 18, 2003

**TO:** All Medicaid Providers  
Directors, County Departments of Job and Family Services  
Medical Assistance Coordinators

**FROM:** Thomas Hayes, Director

**SUBJECT:** Recent Rule Revisions Concerning Third Party Liability And Protected Health Care Information As Part of Privacy Provisions Implemented Under The Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The purpose of this Medical Assistance Letter (MAL) is to notify Medicaid providers of recent changes in the department's procedures regarding third party liability brought about by the privacy provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). These changes have been recorded in rule 5101:3-1-08, effective 5/01/03. This rule describes the department's subrogation rights pursuant to section 5101.58 of the Revised Code against the liability of a third party for the cost of medical services paid by the department. New procedures outlined in this rule require the medicaid consumer to provide notice to the department prior to initiating any action against a liable third party. The department will take steps to protect its subrogation rights if that notice is not provided. If any person, whether the consumer or an individual acting on the behalf of a consumer, requests a financial statement (a claim) from a medicaid provider for services paid by the department or to be billed to the department on behalf of the medicaid consumer, the provider shall:

- Require that the consumer or their representative make their request for access to financial statements in writing,
- Notify the department immediately upon receipt of the consumer's written request and forward a copy of the request to the Ohio department of job and family services, bureau of plan operations, benefit and recovery section,
- Release the financial statement to the consumer or their representative no later than thirty days after the date the request is received, and finally
- Stamp or type on each page of the financial statement in bold font "SUBJECT TO SUBROGATION PURSUANT TO SECTION 5101.58 OF THE OHIO REVISED CODE. FAILURE TO COMPLY MAY RESULT IN PERSONAL LIABILITY.

This rule applies to financial statements whether or not the provider has received reimbursement from the department. This rule is not intended to prevent or restrict the provider from furnishing records of medical treatment and condition to the consumer.

Rule 5101:3-1-08 of the Administrative Code, effective 5/01/03, is located on the department's website at: <http://dynaweb.odjfs.state.oh.us:6336/dynaweb>

# MAL 448 (Distribution of Ohio Health Plan Program Information)

## Medical Assistance Letter 448

May 5, 2003

TO: All Ohio Health Plan Providers (except Long Term Care)  
All Health Plan Provider Associations

FROM: Thomas J. Hayes, Director

SUBJECT: Distribution of Ohio Health Plan Program Information

This letter explains our paper transmittal reduction (PTR) plan that will not eliminate, but reduce the number of paper transmittals and their attachments that are distributed. The PTR was developed as a result of feedback received during the last quarter of 2002 when some of you participated in a survey regarding our efforts to more effectively provide Ohio Health Plan (OHP) program information.

The PTR plan will go into effect on July 1, 2003; we will transition into the new plan between now and June 30, 2003. During this period of transition, providers will be asked to complete the attached form by **May 16, 2003** to select the format that they wish to use to receive future program updates. Format options are explained below.

**Option 1, Standard Distribution.** This option is for providers who have Internet access and is the most efficient method of distribution. Providers will receive e-mail notification of program updates during the week that they are published. The e-mail will include links to the electronic manuals and to the Legal/Policy Central Calendar. The Legal/Policy Central Calendar provides a daily list of handbook and/or transmittal letter issuances with links to the electronic manuals site and to printer-friendly (Acrobat) versions of the documents. Visit the electronic manuals site at: <http://dynaweb.odjfs.state.oh.us:6336/dynaweb/medicaid/>. Visit the Legal/Policy Central Calendar at: <http://www.state.oh.us/odjfs/lpc/calendar>.

**Option 2, Paper Distribution.** This is the current system used for paper distributions and is for providers who do not have Internet access. Providers will receive paper notices, i.e., MALs, HHTLs, MHTLs, CSTLs, of program updates limited to a summary of the changes to rules, handbooks and/or policies without attachments. Paper notices will normally be received within 10 - 15 business days of the director's signature. Providers wanting the complete program update (paper notice with attachments) will have to request that information using the JFS 03400, which will be included in the transmittal letter notice.

In addition to the above listed options, providers may elect to receive a courtesy copy of the ODJFS Electronic Manuals CD-ROM. This supplement is distributed quarterly and contains complete, consolidated handbooks and forms for all OHP programs. A CD-ROM drive is required for its use.

To select the format in which you wish to receive program updates including the supplemental CD-ROM, complete and submit the attached form.

Questions regarding the electronic handbook procedures may be e-mailed to [handbook\\_update\\_inssuance@odjfs.state.oh.us](mailto:handbook_update_inssuance@odjfs.state.oh.us).

# **MAL 444 (Changes to Ohio Medicaid Provider Rules, OAC Chapter 5101:3-1 (General Information))**

## **Medical Assistance Letter (MAL) No. 444**

### **Ohio Medicaid Provider Rules**

February 24, 2003

TO: All Providers of Medical Services  
Directors, County Departments of Job and Family Services  
Medical Assistance Coordinators

FROM: Thomas Hayes, Director

SUBJECT: Changes to Ohio Medicaid Provider Rules, OAC Chapter 5101:3-1 (General Information)

### **Ohio Medicaid Provider Rules, OAC Chapter 5101:3-1 (General Information)**

The purpose of this MAL is to inform all providers of medical services of changes to Ohio Administrative Code rules contained in Chapter 5101:3-1. These rules were reviewed, and changes made, as part of the mandated 5-year rule review process. The effective date for rules 5101:3-1-05, 5101:3-1-15, 5101:3-1-23, 5101:3-1-25, 5101:3-1-31, and 5101:3-1-57, is May 30, 2002. The effective date for rules 5101:3-1-03, 5101:3-1-08, 5101:3-1-19.1, 5101:3-1-19.3, 5101:3-1-19.7, 5101:3-1-19.8, 5101:3-1-19.9, and 5101:3-1-20.0 is July 1, 2002. Rule 5101:3-1-39 was rescinded effective May 30, 2002. Rule 5101:3-1-19.5 was rescinded effective July 1, 2002. The rules are available to view or print on the department's website at:

**<http://dynaweb.odjfs.state.oh.us:6336/dynaweb/medicaid>**

The following is a summary of the changes.

Rule 5101:3-1-03 entitled "Medicaid: relationship to Title V programs" explains the relationship of Medicaid to Title V programs in regard to submission of claims for reimbursement of services. The rule was rescinded and refiled. The refiled rule was changed to include all Title V programs rather than the prior focus which was the Children with Medical Handicaps program.

Rule 5101:3-1-05 entitled "Medicaid: relationship to Medicare (Title XVIII)" This rule explains the relationship between the medicaid program and the medicare program. The rule was amended to accommodate changes in department business practices (language and terminology).

Rule 5101:3-1-08 entitled "Third-party liability" explains the process for provider reimbursement in instances which the medicaid consumer has health insurance through a third party resource. This rule was updated for clarity and compliance to HIPAA guidelines.

Rule 5101:3-1-15 entitled "Medicaid card" describes provisions concerning the health care identification card issued to medicaid consumers. This rule was rescinded and refiled. The refiled rule contains updated information concerning the types of medicaid cards issued to medicaid consumers, and updated departmental terminology.

Rule 5101:3-1-19.1 entitled "Medicaid claim forms and coding requirements [except for services provided through medicaid contracting managed care plans (MCPs)]" describes the guidelines for using medicaid claim forms and incorporates the coding requirements for medicaid covered services previously described in 5101:3-1-195 which was rescinded.

Rule 5101:3-1-19.3 entitled "Claim submission [except for services provided through medicaid contracting managed care plans (MCPs)]" describes the guidelines for claim submission. This rule was updated and re-organized to improve clarity.

Rule 5101:3-1-19.7 entitled "Prompt payment and interest provisions [except for services provided through medicaid contracting managed care plans (MCPs)]" describes the guidelines for prompt payment and interest provisions. This rule was re-organized and updated to accommodate changes in department business practices.

Rule 5101:3-1-19.8 entitled "Payment errors and overpayments [except for services provided through medicaid contracting managed care plans (MCPs)]" describes the process for the adjustment of payment errors and overpayments. This rule was updated for clarity and to accommodate changes in department business practices.

Rule 5101:3-1-19.9 entitled "Inquiries regarding the status of claims [except for services provided through medicaid contracting managed care plans (MCPs)]" describes the process for provider inquiries regarding the status of claims. This rule was re-organized and updated for clarity.

Rule 5101:3-1-20.0 entitled "Responsibilities related to electronic submissions [except for services provided through medicaid contracting managed care plans (MCPs)]" is a new rule which outlines the guidelines for provider claim submissions. These guidelines were previously described in OAC rules 5101:3-18-03, 5101:3-18-04, 5101:3-18-05, 5101:3-18-06, and 5101:3-18-07 which were rescinded.

Rule 5101:3-1-23 entitled "Prohibition against factoring" defined entities which may not submit claims for medicaid reimbursement. This rule was rescinded and refiled. The refiled rule was renamed "Assignment of provider claims" and defines those organizations which payment for Medicaid covered services furnished to Medicaid consumers may be made and, requires that:

***Payment for any covered service furnished to a Medicaid consumer may not be made to or through a factor. A "factor" is defined as an individual or an organization such as a collection agency or service bureau that advances money to a provider for accounts receivable which have been assigned, sold, or otherwise transferred to such an organization or an individual for an added fee or a deduction of a portion of such accounts receivable.***

Rule 5101:3-1-25 entitled "Interest on overpayments" described department policy regarding the interest applied to overpayments made to medicaid providers. Rule language was updated to incorporate necessary changes in department business practices, including the exemption of medicaid managed care plans. The amended rule is now entitled "Interest on overpayments [except for medicaid contracting managed care plans (MCPs)]."

Rule 5101:3-1-31 entitled "Prior authorization [except for medicaid contracting managed care plans (MCPs)]" describes the process for the reimbursement of medical services requiring prior authorization. The rule was rescinded and refiled. The refiled rule contains changes in the organization of the prior authorization process as previously defined in rule.

Rule 5101:3-1-39 entitled "Abbreviations" contains abbreviations used in rules found in 5101:3 of the Administrative Code. The rule was rescinded because the abbreviations are out of date.

Rule 5101:3-1-57 entitled "Process for provider appeals from proposed departmental actions." describes department guidelines regarding the processes for provider appeals from departmental actions. Language in the rule was amended to accommodate necessary changes in department business practices.

# **General Information for Medicaid Providers (Rules)**

**5160-1 (Formerly 5101:3-1)**

[MHTL 3334-15-06](#)

**Effective Date: March 22, 2015**

**Most Current Prior Effective Date: [July 1, 2006](#)**

Medical necessity is a fundamental concept underlying the medicaid program.

- (A) Medical necessity for individuals covered by early and periodic screening, diagnosis and treatment (EPSDT) is defined as procedures, items, or services that prevent, diagnose, evaluate, correct, ameliorate, or treat an adverse health condition such as an illness, injury, disease or its symptoms, emotional or behavioral dysfunction, intellectual deficit, cognitive impairment, or developmental disability.
- (B) Medical necessity for individuals not covered by EPSDT is defined as procedures, items, or services that prevent, diagnose, evaluate, or treat an adverse health condition such as an illness, injury, disease or its symptoms, emotional or behavioral dysfunction, intellectual deficit, cognitive impairment, or developmental disability and without which the person 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.
- (C) Conditions of medical necessity are met if all the following apply:
- (1) Meets generally accepted standards of medical practice;
  - (2) Clinically appropriate in its type, frequency, extent, duration, and delivery setting;
  - (3) Appropriate to the adverse health condition for which it is provided and is expected to produce the desired outcome;
  - (4) Is the lowest cost alternative that effectively addresses and treats the medical problem;
  - (5) Provides unique, essential, and appropriate information if it is used for diagnostic purposes; and
  - (6) Not provided primarily for the economic benefit of the provider nor for the convenience of the provider or anyone else other than the recipient.
- (D) The fact that a physician, dentist or other licensed practitioner renders, prescribes, orders, certifies, recommends, approves, or submits a claim for a procedure, item, or service does not, in and of itself make the procedure, item, or service medically necessary and does not guarantee payment for it.
- (E) The definition and conditions of medical necessity articulated in this rule apply throughout the entire medicaid program. More specific criteria regarding the conditions of medical necessity for particular categories of service may be set forth within ODM coverage policies or rules.

Replaces: 5160-1-01

Effective: 03/22/2015

Five Year Review (FYR) Dates: 03/22/2020

Certification: CERTIFIED ELECTRONICALLY

Date: 03/12/2015

Promulgated Under: 119.03

Statutory Authority: 5164.02

Rule Amplifies: 5164.02

Prior Effective Dates: 4/7/77, 9/19/77, 12/21/77, 12/30/77, 7/1/80, 2/19/82, 10/1/84, 10/1/87, 6/1/91, 5/30/02, 07/01/2006

**Effective Date: August 2, 2011**

**Most Current Prior Effective Date: [July 1, 2006](#)**

This rule describes general principles regarding reimbursement of services by medicaid. Reimbursement may be subject to additional administrative criteria as described in division 5101:3 of the Administrative Code.

(A) A medical service is reimbursable if:

- (1) The service is determined medically necessary as defined in rule 5101:3-1-01 of the Administrative Code.
- (2) The request for the service is originated by the consumer or the consumer's authorized representative.
- (3) The service is rendered to an eligible medicaid consumer as defined in division 5101:1 of the Administrative Code.
- (4) The service is provided within the limits of the consumer's medicaid or medicaid managed care plan benefit package.
- (5) The service is provided within the scope of practice of the rendering provider as defined by applicable federal, state, and local laws and regulations.
- (6) The service is rendered by a provider assigned to or selected by the consumer or consumer's authorized representative, with the exception of consumers enrolled in the coordinated services program as defined in Chapter 5101:3-20 of the Administrative Code.
- (7) The service is rendered by an eligible provider or panel provider for managed care plan participating provider.

(B) A medical service is not reimbursable if:

- (1) The service is charged to medicaid at a rate greater than the provider's usual and customary charge to other patients.
  - (a) Inpatient hospital services billed by hospitals reimbursed on a prospective payment basis, as defined in Chapter 5101:3-2 of the Administrative Code, will not pay, in the aggregate, more than the provider's customary and prevailing charges for comparable services.
  - (b) Chapter 5101:3-3 of the Administrative Code defines these provisions as they apply to providers of long-term care services.
- (2) The service is free to the public, except when medicaid reimbursement for such services is prescribed by federal law.
- (3) The service is a provider-preventable condition as defined in 42 CFR 447.26. The prohibition on provider-preventable conditions shall not result in a loss of access to care or services for medicaid consumers.

(C) As required by the centers for medicare and medicaid services (CMS), habilitation services (as defined in 42. U.S.C. 1396n (c) (5)) are covered under medicaid only when:

- (1) They are a part of services provided in an intermediate care facility for persons with mental retardation (ICF/MR), or
- (2) They are included under a federally approved home and community-based services (HCBS) waiver, and are medically necessary services identified in an enrollee's particular HCBS waiver. Special education and related services that otherwise are available to the individual through a local educational agency and vocational rehabilitation services that otherwise are available to

the individual through a program funded under 29 U.S.C. 730 are not reimbursable through federally approved waivers.

(D) Additional reimbursement principles applicable to services delivered through medicaid managed care plans are described in Chapter 5101:3-26 of the Administrative Code.

Replaces: 5101:3-1-02

Effective:

R.C. 119.032 review dates:

Certification

Date

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02

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**5160-1-03 Medicaid: Relationship to the Children with Medical Handicaps Program under Title V of the Social Security Act**

**\*Formerly\* 5101:3-1-03 Medicaid: Relationship to the Children with Medical Handicaps Program under Title V of the Social Security Act**

**MHTL 3334-14-07**

**Effective Date: November 2, 2014**

**Most Current Prior Effective Date: September 1, 2007**

- (A) For persons eligible under both medicaid, administered by the Ohio department of ~~job and family services (ODJFS)~~ medicaid (ODM), and the children with medical handicaps (CMH) program, administered by the Ohio department of health (ODH), medicaid is the first payer of health care claims (unless a consumer has third party insurance and/or is a medicare beneficiary, then rules ~~5101:3-1-05~~5160-1-05 and ~~5101:3-1-08~~5160-1-08 of the Administrative Code regarding coordination of benefits with a primary payer apply) and its payment constitutes payment in full.
- (B) As long as eligibility has been established under the CMH program and services were authorized by the ~~bureau for children with medical handicaps CMH (BCMh)~~, medicaid providers shall submit all claims for services to persons eligible under both medicaid and the CMH program first to ~~ODJFS~~ODM for adjudication under the medicaid program (unless there is a primary payer as described in paragraph (A) of this rule). ~~The medicaid program covers services that are medically necessary in accordance with rule 5101:3-1-01 of the Administrative Code. If the service or services are not covered under medicaid, the claim shall be denied. The reason for the denial will be stated on the ODJFS remittance advice. When the service or services are denied by medicaid, a claim may be submitted for payment to BCMH along with documentation of the denial from ODJFS.~~

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**Effective Date: August 2, 2011**

**Most Current Prior Effective Date: [October 29, 2009](#)**

Paragraphs (A)(7) to (F)(4) of this rule do not apply to pharmacy services covered under the medicare part D program. Pharmacy services covered under the medicare part D program should be billed in accordance with rule 5101:3-9-06 of the Administrative Code.

(A) Definitions.

- (1) "Medicare" is a federally financed program of hospital insurance (part A) and supplemental medical insurance (also called SMI and/or part B) for aged and disabled persons.
- (2) "Medicare Benefits" means the health care services available to the consumer through the medicare program where payment for the services are either completely the obligation of the medicare program or in part the obligation of the medicare program with the remaining payment (cost sharing) obligations belonging to the consumer, some other third party payer and/or medicaid.
- (3) "Original Medicare (also known as traditional medicare)" is a health plan that pays for medicare benefits provided to beneficiaries on a fee-for-service basis.
- (4) "Medicare Advantage Plan (also known as medicare part C plan)" is a managed care delivery system that includes coverage for both hospital insurance and SMI, but the delivery of health care services are contracted to and provided by an approved medicare managed care plan, preferred provider organization, private fee-for-service plans or medicare specialty plans.
- (5) "Medicare Cost Sharing" means the portion of a medicare crossover claim paid by medicaid.
- (6) "Dual Eligibles or Dually Eligible Consumers" are individuals who are entitled to medicare hospital insurance and/or SMI and are eligible for medicaid to pay some form of medicare cost sharing. The following is a list of dual eligibles that qualify to have medicaid pay all or part of the cost sharing portion of a paid medicare claim:
  - (a) "Qualified Medicare Beneficiaries without Other Medicaid (QMB Only)" are individuals entitled to medicare hospital insurance, have income of one hundred per cent of the federal poverty level (FPL) or less and resources that do not exceed twice the limit for supplemental security income (SSI) eligibility, and are not otherwise eligible for full medicaid benefits.
  - (b) "QMBs with Full Medicaid (QMB Plus)" are individuals entitled to medicare hospital insurance, have incomes of one hundred per cent FPL or less and resources that do not exceed twice the limit for SSI eligibility, and are eligible for full medicaid benefits.
  - (c) "Specified Low-Income Medicare Beneficiaries with Full Medicaid (SLMB Plus)" are individuals entitled to medicare hospital insurance, have income of greater than one hundred per cent FPL, but less than one hundred twenty per cent FPL and resources that do not in exceed twice the limit for SSI eligibility, and are eligible for full medicaid benefits.
  - (d) "Medicaid Only Dual Eligibles (for example Non QMB)" are individuals entitled to medicare hospital insurance and/or SMI and are eligible for full medicaid benefits. They are not eligible for medicaid in any of the other dual eligible categories (for example QMB). Typically, these individuals need to spend down to qualify for medicaid or fall into a medicaid eligibility poverty group that exceeds the limits of other dual eligible categories.

(7) "Medicare Crossover Claim" means any claim that has been submitted to the Ohio department of job and family services (ODJFS) for medicare cost sharing payments after the claim has been adjudicated and paid by the medicare central processor, medicare carrier/intermediary or the medicare managed care plan and the medicare central processor or medicare carrier/intermediary has determined the deductible, coinsurance and/or co-payment amounts. Claims denied by the medicare carrier/intermediary or the medicare managed care plan are not considered medicare crossover claims. See paragraphs (E) and (F) of this rule for policy on services denied or not covered by medicare.

(a) "Automatic Crossover Claim" is a medicare claim submitted to ODJFS via the automatic medicare crossover process described in paragraph (B)~~(1)~~(2)(a) of this rule.

(b) "Provider-Submitted Crossover Claim" means a medicare crossover claim submitted to ODJFS as described in paragraph (B)~~(1)~~(2)(b) of this rule.

(B) Medicare crossover process.

(1) ODJFS will no longer accept the JFS 06780 "Medicaid Claim Billing" form (rev. 10/2001) for processing and payment of medicare crossover claims. Medicare crossover claims must meet the claim submission guidelines in accordance with rule 5101:3-1-19 of the Administrative Code.

~~(1)~~(2) The medicare program determines the portion of medicare cost sharing, if any, due to the provider based on medicare's business rules and submits the claim for payment to ODJFS using the automatic medicare crossover process.

(a) The "Automatic Medicare Crossover Process" is the coordination of benefit (COB) process whereby the provider bills medicare for services provided to the patient who meets the criteria described in paragraphs (A)(6)(a) to (A)(6)(d) of this rule or is a dual eligible described in paragraph (A)(6) of this rule. Medicare adjudicates the claim, pays the provider and electronically submits the claim to ODJFS for the medicare cost sharing amounts. Then, the provider is paid by medicaid within ninety days from the date of payment by medicare.

(b) When the automatic medicare crossover process does not work (i.e., the provider has received payment by medicare, has not received a payment from medicaid for the medicare cost sharing portion and at least ninety days has elapsed from the date of the receipt of the medicare payment), the provider may submit a medicare crossover claim directly to ODJFS. This is considered the "Provider-Submitted Crossover Claim Process."

~~(2)~~(3) For a provider to receive reimbursement through the automatic medicare crossover process, all of the following criteria must be met:

(a) The provider must be recognized as both a medicare and medicaid provider;

(b) The provider must accept medicare assignment; and

(c) The consumer must be receiving health care benefits under the original medicare part A and part B program (i.e., the consumer is not enrolled in a medicare managed care plan). At this time ODJFS does not have payer-to-payer COB arrangements with medicare managed care plans.

~~(3)~~(4) For medicare crossover claims, the total sum of the payments made by ODJFS, medicare and/or all other third party payers is considered payment in full and no additional payment may be requested from the consumer with the exception of medicare co-payments as specified in paragraph (E)(5) of this rule. This is true whether or not the provider normally accepts assignment under medicare.

(a) When the provider's total reimbursement from medicare and all other third party payers equals or exceeds the medicare approved (allowed/covered) amount, no additional payment will be made by ODJFS.

(b) If payment (other than the cost sharing amounts) is inadvertently received from both medicare and medicaid for the same service, the ODJFS claims adjustment unit must be

notified in accordance with the provisions set forth in rule ~~5101:3-1-19.8~~ 5101:3-1-19 of the Administrative Code.

~~(4)(5) For a provider to receive reimbursement through the provider-submitted crossover claim process, crossover claims must be submitted to ODJFS either within three hundred sixty-five days from the date of service or within one hundred eighty days from the medicare payment date. When other third party payers are involved in the payment of the claim after the claim has been paid by medicare, the claim must be submitted within one hundred eighty days from the date of payment by the payer responsible immediately prior to the submission to ODJFS. Provider submitted crossover claims must be submitted timely in accordance with rule 5101:3-1-19 of the Administrative Code.~~ ~~(5)(6)~~ Crossover claims are not subject to medicaid co-payments in accordance with rule 5101:3-1-09 of the Administrative Code.

(C) When the medicaid consumer is covered by other third party payers, in addition to medicare, medicaid is the payer of last resort. Whether or not medicare is the primary payer, providers must bill all other third party payers prior to submitting a crossover claim to ODJFS in accordance with rule 5101:3-1-08 of the Administrative Code.

(D) ODJFS will not pay for services denied by medicare for lack of medical necessity, but may pay claims denied for reasons other than medical necessity in accordance with paragraph (F) of this rule as long as the services are covered under the medicaid program. ODJFS will not pay for any service payable by, but not billed to, medicare.

(E) Reimbursement for medicare cost sharing on medicare crossover claims.

Reimbursement for medicare crossover claims is limited to the dual eligibles listed in paragraph (A)(6) of this rule.

(1) The medicaid maximum reimbursement for the medicare cost sharing of hospital inpatient, outpatient or emergency room services is set forth in rule 5101:3-2-25 of the Administrative Code for consumers that elected to receive medicare benefits under original medicare.

(2) The medicaid maximum reimbursement for the medicare cost sharing of nursing facility services included in the nursing facility per diem is set forth in Chapter 5101:3-3 of the Administrative Code for consumers that elected to receive medicare benefits under original medicare.

(3) The medicaid maximum reimbursement for the medicare cost sharing of all other part B services not included in paragraph (E)(1) or (E)(2) of this rule is set forth in rule 5101:3-1-05.3 of the Administrative Code for consumers that elected to receive medicare benefits under original medicare.

(4) The medicaid maximum reimbursement for the medicare cost sharing of all advantage plan (part C) services is set forth in rule 5101:3-1-05.1 of the Administrative Code for consumers that elected to receive medicare benefits under a medicare advantage plan.

(5) Cost sharing for medicare part D services is not reimbursable by ODJFS in accordance with rule 5101:3-9-06 of the Administrative Code. Dually eligible consumers may be required to pay medicare co-payments for prescription drugs that are covered by medicare part D.

(F) Services that are not covered by medicare must be submitted to ODJFS as a regular medicaid claim and should never be submitted as a medicare crossover claim.

With the exception of long term care nursing facilities, ~~When~~ when the service is denied by medicare, and is also denied by medicaid with an error message indicating that the service is covered under medicare and the provider has documentation to support the service is not covered under medicare, the provider must do all of the following when requesting payment consideration from ODJFS:

(1) ~~Complete an appropriate "CMS 1500 Form (rev. 12/1990)" or a "CMS UB-92 Form (rev. 01/1992)"~~ Submit the appropriate claim in accordance with rule 5101:3-1-19 of the Administrative Code;

- (2) Attach the summary notice of medicare benefits that shows the denied medicare services, and the denial reason code with the denial reason code explanation from the medicare summary of benefits, the provider is requesting ODJFS to consider for payment;
- (3) Attach a completed "JFS 06653 Medical Claim Review Request Form (rev. 05/2010~~07/2003~~)"; and
- (4) Submit all forms together to the address indicated on the JFS 06653 form.

(G) Long term care nursing facility providers must submit the appropriate claim in accordance with Chapter 5101:3-3 of the Administrative Code.

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R.C. 119.032 review dates: 10/01/2014

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**5160-1-05.1 Payment for "Medicare Part C" Cost Sharing**

**\*Formerly\* 5101:3-1-05.1 Payment for "Medicare Part C" Cost Sharing**

**MHTL 3334-14-06**

***Effective Date: November 9, 2014***

***Most Current Prior Effective Date: July 30, 2004***

- (A) For qualified medicare beneficiaries and medicaid consumers enrolled in medicare part C managed health care plans (medicare advantage plans) the department will pay as cost sharing the lesser of:
- (1) The ~~providers~~provider's billed charges for the service (except for hospital and nursing facility services); or
  - (2) The deductible, coinsurance and co-payment amount as provided by the medicare part C plan; or
  - (3) The difference between the medicare part C plan's payment to a provider for a service or services identified and the medicaid maximum allowable reimbursement rate for the same identified service or services; or
  - (4) The medicaid liability for the cost sharing if the service had been rendered under medicare part A or part B.
- (B) This payment arrangement applies to qualified medicare beneficiaries and medicaid consumers enrolled in a medicare part C plan.
- (C) The medicaid provider is ultimately responsible for accurate and valid reporting of medicaid claims submitted for payment.
- (1) Providers submitting medicare part C crossover claims to the medicaid program must be able to provide upon request documentation that supports that the information provided on the claim matches the information on the part C plan's remittance advice.
  - (2) Providers submitting medicare part C crossover claims to the medicaid program who are paid under a capitation arrangement with the medicare part C plan, and do not submit claims to the plan for services rendered, must be able to provide upon request documentation of the capitation arrangement including specific details about the plan's cost sharing requirements.

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Rule Amplifies: 5164.02

Prior Effective Dates: 5-14-04 (Emer.), 7-30-04

5160-1-05.3 Payment for "Medicare Part B" Cost Sharing

~~\*Formerly\*~~ 5101:3-1-05.3 Payment for "Medicare Part B" Cost Sharing

[MHTL 3334-13-10](#)

**Effective Date: January 1, 2014**

**Most Current Prior Effective Date: [October 29, 2009](#)**

- (A) The reimbursement methodology set forth in paragraph (B) of this rule is limited to medicare part B services that meet all of the following criteria:
- (1) Are not hospital services defined in accordance with Chapter ~~5101:3-2~~5160-2 of the Administrative Code;
  - (2) Are not nursing facility services included in the nursing facility per diem as defined in accordance with Chapter ~~5101:3-3~~5160-3 of the Administrative Code;
  - (3) Are covered as supplemental medical insurance benefits under the medicare program; and
  - (4) Are provided to dual eligibles, defined in accordance with paragraph (A)(6) of rule ~~5101:3-4-05~~5160-1-05 of the Administrative Code, who elect to receive their medicare part B benefits through the original medicare program.
- (B) The Ohio department ~~of job and family services (ODJFS)~~ of medicaid (ODM) will pay the lesser of the following calculations for part B cost sharing described in this rule:
- (1) The sum of the deductible and coinsurance medicare specifies ~~ODJFS~~ ODM is obligated to pay for crossover claims; or
  - (2) The difference between the medicare approved amount and the sum of the amount medicare paid and all other third party (insurance other than medicare or medicaid) payments; or
  - (3) Except for physician services, the difference between the sum of the amount medicare paid and any third party payments, and the medicaid maximum allowable reimbursement rate for the same identified service or services.
- (C) When payment for part B cost sharing is made using the method described in paragraph (B)(2) or (B)(3) of this rule and the sum of the amounts paid by medicare and all other third party insurers exceeds the medicare or medicaid approved amount, ~~ODJFS~~ ODM will not make any additional payment to the provider, or will make a payment of zero dollars, and the service(s) are considered to be paid in full to the provider.

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Rule Amplifies: Section 323.230 of Am. Sub. HB 59

Prior Effective Dates: 12/18/06, 7/31/09 (Emer), 10/29/2009

MHTL 3334-11-03

**Effective Date: August 2, 2011**

**Most Current Prior Effective Date: December 18, 2006**

~~Paragraph (A) of this rule contains common definitions regarding coordination of benefits used in this and other rules of the Administrative Code. Paragraphs (B) to (M) of this rule explain the Ohio department of job and family services's (ODJFS) expectations of providers in regard to the collection of all third party resources for a rendered service to a medicaid consumer prior to the provider requesting reimbursement from ODJFS.~~

(A) Definitions.

- (1) "Coordination of benefits (COB)" means the process of determining which health plan or insurance policy will pay first and/or determining the payment obligations of each health plan, medical insurance policy, or third party resource when two or more health plans, insurance policies or third party resources cover the same benefits for a medicaid consumer.
- (2) "Explanation of benefits (EOB)" or "remittance advice" means the information sent to providers and/or plan beneficiaries (consumers) by any other third party payer, medicare and/or medicaid to explain the adjudication of the claim.
- (3) "COB claim" means any claim that meets either the definition of third party claim as described in paragraph (A)(9) of this rule or the definition of medicare crossover claim as described in rule 5101:3-1-05 of the Administrative Code.
- (4) "Medicare benefits" is as defined in rule 5101:3-1-05 of the Administrative Code.
- (5) "Third party (TP)" is as defined in section 5101.571 of the Revised Code.
- (6) "Third party payer (TPP)" means an entity, other than the medicaid or medicare programs, responsible for adjudicating and paying claims for third party benefits rendered to an eligible medicaid consumer.
- (7) "Third party benefit" means any health care service(s) available to consumers through any medical insurance policy or through some other resource that covers medical benefits and the payment for those services is either completely the obligation of the TPP or in part the obligation of the consumer, the TPP and/or medicaid. (Examples of a third party benefit include private health or accidental insurance, medicare, CHAMPUS or worker's compensation.)
- (8) "Third party liability (TPL)" means the payment obligations of the TPP for health care services rendered to eligible medicaid consumers when the consumer also has third party benefits as described in paragraph (A)(7) of this rule.
- (9) "Third party claim" means any claim(s) submitted to ODJFS for reimbursement after all TPPs have met their payment obligations. In addition, the following will be considered third party claims by ODJFS:
  - (a) Any claim received by ODJFS that shows no prior payment by a TPP, but, ODJFS's records indicate the consumer has third party benefits.
  - (b) Any claim received by ODJFS that shows no prior payment by a TPP, but, the provider's records indicate the medicaid consumer has third party benefits.

- (B) If the existence of a third party benefit is known to ODJFS, a code number that represents the name of the third party payer covering the consumer will be indicated on the consumer's medicaid card. ~~Providers may use this code to obtain third party benefit information found in the ODJFS provider billing instructions (rev. 7/1/2006 and located on the internet at <http://emanuals.odjfs.state.oh.us/emanuals>). The "Third Party Carrier Table" in the provider billing instructions contains the names, code numbers, and addresses of third party payers who can be~~

~~matched to the code number on the medicaid card. Providers can use the appropriate TPP name and address found in the billing instructions to bill the third party insurer prior to billing medicaid. If the TPP is not provided on the list, the~~ The provider ~~may~~ shall obtain from the consumer the name and address of the insurance company, and any other necessary information, and bill the insurance company prior to billing ODJFS.

- (C) The provider must always review the consumer's Ohio medicaid card for evidence of third party benefits. Whether there is or is not an indication of a TPP on the medicaid card, the provider must always request from the consumer or his or her representative information about any third party benefit(s). If the consumer specifies no TP coverage and the medicaid card does not indicate TP coverage, the provider may submit a claim to medicaid (and the claim for the service is not considered a TP claim). If, as a result of this process, the provider determines that TP liability exists, the provider may only submit a claim for reimbursement if it first takes reasonable measures to obtain TP payments as set forth in paragraph (D) of this rule.
- (D) The medicaid program must be the last payer to receive and adjudicate the claim, except as determined by rule 5101:3-1-03 of the Administrative Code, and the state sponsored program awarding reparations to victims of crime under sections 2743.51 to 2743.72 of the Revised Code. ODJFS reimburses for covered services only after the provider takes reasonable measures to obtain all third party payments and file claims with all TPPs prior to billing ODJFS. Providers who have gone through reasonable measures to obtain all third party payments, but who have not received payment from a TPP, or have gone through reasonable measures and received partial payment, may use an appropriate code on the claim to obtain payment and submit a claim to ODJFS requesting reimbursement for the rendered service(s).
- (1) Providers are considered by ODJFS to have taken reasonable measures to obtain all third party payments if they comply with one of the following requirements:
- (a) The provider submits a claim first to the TPP and receives a remittance advice indicating that a valid reason for non-payment applies for the service as described in paragraph (D)(2) of this rule.
  - (b) The provider submits a claim first to the TPP for the rendered service(s) no less than three times within a ninety-day period and does not receive a remittance advice or other communication from the TPP within ninety days of the last submission to the TPP. Providers must be able to document each claim submission and the date of the submission.
  - (c) The provider followed the process described in paragraph (C) of this rule for the billed service and meets the following requirements:
    - (i) The provider did not find a change in third party coverage;
    - (ii) The billed service was previously rendered to the medicaid consumer by the provider within the last three hundred sixty-five days; and
    - (iii) The claim for the previously rendered service met the requirements of paragraph (D)(1)(a) or (D)(1)(d) of this rule.
  - (d) The provider did not send a claim to the TPP, but has received and retained at least one of the following types of documentation that indicates a valid reason for non-payment for the service(s) as set forth in paragraph (D)(2) of this rule:
    - (i) Written documentation from the TPP;
    - (ii) Written documentation from the TPPs automated eligibility and claim verification system;
    - (iii) Written documentation from the TPPs member benefits reference guide/manual; or
    - (iv) Any other reliable method for obtaining information and/or documentation from the TPP that there is no third party benefit coverage for the rendered service(s).

(e) The provider submits a claim first to the TPP and receives a partial payment along with a remittance advice documenting the allocation of the billed charges.

(2) Valid reasons for non-payment from a third party payer to the provider for a third party benefit claim include, but are not limited to, the following:

- (a) The service(s) is not covered under the medicaid consumer's third party benefits.
- (b) The medical expenses for the medicaid consumer were incurred prior to the third party benefits coverage dates.
- (c) The medical expenses for the medicaid consumer were incurred after the third party benefits coverage was terminated.
- (d) The medicaid consumer does not have third party benefits through the TPP for the date of service.
- (e) All of the provider's billed charges or the TPPs approved rate was applied to the consumer's third party benefit deductible amount.
- (f) All of the provider's billed charges or the TPPs approved rate was applied in total across the consumer's deductible, coinsurance and/or co-payment for the third party benefit.
- (g) The medicaid consumer has not met eligibility, out-of-pocket expenses, required waiting periods or residency requirements for his/her third party benefits.
- (h) The medicaid consumer is a dependent of the individual with third party benefits, but the benefits do not cover the individual's dependents.
- (i) The medicaid consumer has reached the lifetime benefit maximum for the medical service being billed to the third party payer.
- (j) The medicaid consumer has reached the benefit maximum of his/her third party benefits.
- (k) The TPP is disputing or contesting its liability to pay the claim or cover the service.

(E) Providers who have gone through reasonable measures as described in paragraph (D) of this rule to obtain all third party payments, but who have not received payment from a TPP, or received a partial payment, may submit a claim to ODJFS requesting reimbursement for the rendered service(s). If payment from the TPP is received after ODJFS has made payment, the provider is required to repay ODJFS any overpaid amount. The provider must not reimburse any overpaid amounts to the consumer.

(F) ~~Information on how to submit a claim that will have a zero paid amount in the third party field on the claim can be found in the billing instructions on the electronic manuals website.~~ Third party claims must meet the claim submission guidelines in accordance with rule 5101:3-1-19 of the Administrative Code.

(G) Medicaid reimbursement for third party claims will not exceed the medicaid maximum payment for the service, determined in accordance with applicable rules for the service, less all third party payments for the service. If the result is less than or equal to zero dollars, there will be no further medicaid payment for the service.

(H) ODJFS will reject a TP claim when a third party claim indicates coverage by a TPP, or when the existence of third party benefits is known to ODJFS, and the submitted claim does not indicate collection of the third party payment or does not indicate compliance with paragraph (D) of this rule. Providers should complete their investigation of available third party benefits before submitting a TP claim to ODJFS for payment.

(1) Providers and/or trading partners must maintain documentation to support all required information submitted on a third party claim (for example, if the submitted information indicates one hundred per cent of approved charges were allocated to the plan deductible, then the provider must have documentation to support the TPP allocated the approved charges to the plan deductible).

- (2) Providers and/or trading partners must not omit from a TP claim any required TP claim information issued to them by the TPP, by the consumer or any other source (for example, the omission of the payment denial reasons that were issued by the TPP).
- (I) ODJFS will make audit exceptions if a post-payment review reveals that the provider and/or trading partner did not maintain documentation to support the information submitted on a TP claim or reveals that the omission of required TP claim information resulted in an overpayment or an inappropriate payment of the claim.
- (J) The provider is prohibited from billing the consumer any charges in accordance with paragraph (A) of rule 5101:3-1-60 of the Administrative Code.
- (K) If the consumer states his/her private health insurance has changed or been terminated, the provider should advise the consumer to contact his/her county caseworker to correct the case record. Once the case record has been corrected, the provider may bill ODJFS directly.
- (L) ODJFS has right of recovery pursuant to section 5101.58 of the Revised Code (medicaid, or any federal or state funded public health program) against the liability of a third party for the cost of medical services paid by ODJFS, or billable to ODJFS for payment at a later date. Section 5101.58 of the Revised Code requires that a medicaid consumer provide notice to ODJFS prior to initiating any action against a liable third party. ODJFS will take steps to protect its rights of recovery if that notice is not provided. If any person, whether the consumer or an individual acting on the behalf of a consumer, requests a financial statement (a claim) from a medicaid provider for services paid by ODJFS or to be billed to ODJFS on behalf of the medicaid consumer, the provider shall meet all of the following four requirements:
- (1) Require that the consumer or the consumer's representative make his/her request for access to financial statements in writing.
  - (2) Notify ODJFS immediately upon receipt of the consumer's written request and forward a copy of the request to ODJFS, bureau of consumer and operational support, coordination of benefits section. ~~plan operations, benefit and recovery section.~~
  - (3) Release the financial statement to the consumer or the consumer's representative no later than thirty days after the date the request is received.
  - (4) Stamp or type on each page of the financial statement in bold font "SUBJECT TO RIGHT OF RECOVERY PURSUANT TO SECTION 5101.58 OF THE OHIO REVISED CODE. FAILURE TO COMPLY MAY RESULT IN PERSONAL LIABILITY."
- This rule applies to financial statements whether or not the provider has received reimbursement from ODJFS. This rule is not intended to prevent or restrict the provider from furnishing records of medical treatment and condition to the consumer.
- (M) When the medicaid consumer is covered by medicare, in addition to other third party payers, medicaid is the payer of last resort. Whether or not a TPP is the primary payer, providers must bill all other third party payers and medicare prior to submitting a claim to ODJFS in accordance with rule 5101:3-1-05 of the Administrative Code.
- (N) Medicaid managed care plans (MCPs) are exempt from this rule. MCPs are responsible for coordination of benefits pursuant to Chapter 5101:3-26 of the Administrative Code.

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Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02

Prior Effective Dates: 4/7/77, 12/21/77, 12/30/77, 4/1/79, 10/1/84, 10/1/87, 7/7/02, 5/1/03, 1/1/04, 12/18/06

**MHTL 3334-11-08**

**Effective Date: October 1, 2011**

**Most Current Prior Effective Date: February 1, 2010**

This rule sets forth requirements regarding co-payments by consumers for medicaid-covered services.

(A) Certain medicaid services are subject to consumer co-payments. Information regarding these services and co-payment amounts can be found in the following Administrative Code rules:

- (1) Co-payments for dental services are described in rule **5101:3-5-01** of the Administrative Code.
- (2) Co-payments for vision services are described in rule **5101:3-6-01** of the Administrative code.
- (3) Co-payments for non-emergency emergency department services are described in rule **5101:3-2-21.1** of the Administrative Code.
- (4) Co-payments for pharmacy services are described in rule **5101:3-9-09** of the Administrative Code.
- (5) Co-payment requirements for services provided through a medicaid managed care plan are described in Chapter **5101:3-26** of the Administrative Code.

(B) With regard to the application of consumer payments, the following apply:

- (1) No provider may deny services to a consumer who is eligible for the services on account of the consumer's inability to pay the medicaid co-payment. Consumers who are able to pay their medicaid co-payment may declare their inability to pay for services or medication and receive their services or medication without paying their medicaid co-payment amount. With regard to a consumer who is unable to pay a required medicaid co-payment in accordance with this paragraph, this does not:
  - (a) Relieve the medicaid consumer from the obligation to pay a medicaid co-payment; or
  - (b) Prohibit the provider from attempting to collect an unpaid medicaid co-payment.
- (2) No provider shall waive a medicaid consumer's obligation to pay a provider a medicaid co-payment except when paragraph (A)(5) of this rule applies.
- (3) No provider or drug manufacturer, including the manufacturer's representative, employee, independent contractor, or agent, shall pay any co-payment on behalf of a medicaid consumer.
- (4) If it is the routine business practice of the provider to refuse service to any individual who owes an outstanding debt to the provider, the provider may consider an unpaid medicaid co-payment as an outstanding debt and refuse service to a medicaid consumer who owes the provider an outstanding debt. If the provider intends to refuse service to a medicaid consumer who owes the provider an outstanding debt, the provider shall notify the individual of the provider's intent to refuse services. In determining outstanding debt of a medicaid consumer, the following apply:
  - (a) A provider's decision to continue rendering services to a medicaid consumer who has an unpaid co-payment shall not be considered an outstanding debt of a medicaid consumer.
  - (b) Charges which are prohibited in accordance with paragraph (A) of rule **5101:3-1-60** of the Administrative code may not be considered an outstanding debt of a medicaid consumer.

(C) The following consumers are excluded from the co-payment requirement for dental, vision, non-emergency emergency department services and pharmacy services:

- (1) Children and youth under the age of twenty-one.
  - (a) The provider may use the consumer's date of birth to identify if this exclusion applies; or

- (b) The provider may submit the claim to the department. During adjudication of the claim, if the department identifies the consumer as a child or youth under the age of twenty-one, the department will not reduce the medicaid payment by the co-payment amount.
- (2) Pregnant women during pregnancy and women with post-partum coverage as defined in Chapter 5101:1-40 of the Administrative Code. The following also apply:
- (a) Routine eye examinations and the dispensation of eyeglasses during a consumer's pregnancy are subject to co-payment.
- (b) For all other claims, the provider may accept the consumer's self-declaration of her pregnancy if the pregnancy/ post-partum co-payment exclusion applies. If the provider reports this exclusion applies, the medicaid payment will not be reduced by the co-payment amount.
- (3) Residents of a nursing facility (NF) or intermediate care facility for the mentally retarded (ICF/MR).
- (a) The provider may use the consumer's address to validate whether the consumer resides in a NF or ICF/MR; or
- (b) The consumer may submit the claim to the department. During the adjudication of the claim, if the department identifies the consumer as a resident of a NF or ICF/MR, the department will not reduce the medicaid payment by the co-payment amount.
- (4) Consumers receiving emergency services are excluded from co-payment when they are provided in a hospital, clinic, office, or other facility that is equipped to furnish the required care, after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy;
- (5) Consumers receiving family planning services defined as pregnancy/contraception management services in rule [5101:3-21-02](#) of the Administrative Code are excluded from co-payment when these services are provided to an individual of child-bearing age. The provider may determine on the basis of his or her professional judgment that the consumer is receiving pregnancy prevention/ contraceptive services and the co-payment exclusion applies.
- (6) Consumers receiving hospice services are excluded from co-payment obligations. The provider may accept the consumer's self-declaration that he or she is enrolled in hospice. If the provider reports that the consumer is enrolled in hospice, the medicaid payment will not be reduced by the co-payment amount.
- (D) Medicare cross-over claims as defined in rule [5101:3-1-05](#) of the Administrative Code are not subject to medicaid co-payments.

Replaces: 5101:3-1-09

Effective: 10/01/2011

R.C. 119.032 review dates: 10/01/2016

Certification: CERTIFIED ELECTRONICALLY

Date: 09/21/2011

Promulgated Under: 119.03

Statutory Authority: 5111.02, 5111.0112

Rule Amplifies: 5111.01, 5111.02, 5111.0112, 5111.172, section 309.37.50 of Am. Sub. H.B. 153, 129th G.A.

Prior Effective Dates: 1/1/06, 7/1/09, 2/1/10

[MHTL 3334-15-11](#)

**Effective Date: May 1, 2015**

- (A) Payment for any cesarean section, labor induction, or any delivery following labor induction is subject to the following criteria:
- (1) Gestational age of the fetus must be determined to be at least thirty-nine weeks; or
  - (2) If a delivery occurs prior to thirty-nine weeks gestation, maternal and/or fetal conditions must indicate medical necessity for the delivery.
- (B) Cesarean sections, labor inductions, or any deliveries following labor induction that occur prior to thirty-nine weeks gestation that are not considered medically necessary are not eligible for payment.

Effective: 05/01/2015

Five Year Review (FYR) Dates: 05/01/2020

Certification: CERTIFIED ELECTRONICALLY

Date: 04/20/2015

Promulgated Under: 119.03

Statutory Authority: 5164.02

Rule Amplifies: 5164.02

**5160-1-11 Out-of-State Coverage [Except as Provided through Medicaid Contracting Managed Care Plans (MCPs)]**

**\*Formerly\* 5101:3-1-11 Out-of-State Coverage [Except as Provided through Medicaid Contracting Managed Care Plans (MCPs)]**

**MHTL 3334-14-07**

**Effective Date: November 2, 2014**

**Most Current Prior Effective Date: July 1, 2005**

- (A) Out-of-state providers must be licensed, accredited, or certified by their respective states to be considered eligible to provide services to Ohio medicaid consumers. Any standards applicable to the provision of the service in the state in which the service is being furnished must be met, as well as those standards set forth in the Ohio medicaid program and in the Ohio Administrative Code. Out-of-state providers must enroll as Ohio medicaid providers in order to obtain reimbursement and must follow appropriate billing procedures in accordance with ~~Chapter 5101:3-4~~Chapter 5160-1 of the Administrative Code and ~~Chapter 5101:3-3~~Chapter 5160-3 of the Administrative Code for long term care nursing facility services.
- (B) Ohio medicaid covered services will be reimbursed when rendered by out-of-state providers only under the following circumstances:
- (1) The medically necessary services are not available within the state of Ohio, and the use of out-of-state providers to perform the services is prior-authorized by the department or its designee in accordance with rule ~~5101:3-1-31~~5160-1-31 of the Administrative Code; or
  - (2) The medical need arose as a result of an emergency, an accident, and/or an illness which occurred during the period the consumer was temporarily absent from Ohio, and the consumers' health would have been endangered if care was postponed until the consumer returned to Ohio or attempted to return to Ohio; or
  - (3) The provider location for the medically necessary service is in a bordering state, and it is the usual practice of residents in that community to utilize out-of-state providers, so long as the cost of the service does not exceed the cost of the service provided by in-state providers; or
  - (4) The state determines on the basis of medical advice, that the needed medical services or necessary supplementary resources are more readily available in another state.

Effective: 11/02/2014

Five Year Review (FYR) Dates: 08/05/2014 and 11/02/2019

Certification: CERTIFIED ELECTRONICALLY

Date: 10/23/2014

Promulgated Under: 119.03

Statutory Authority: 5164.02

Rule Amplifies: 5164.02

Prior Effective Dates: 4/7/77, 12/21/77, 12/30/77, 7/1/80, 10/1/87, 5/30/02, 07/01/2005

5160-1-13.1 Medicaid Consumer Liability

**\*Formerly\*** 5101:3-1-13.1 Medicaid Consumer Liability [Except for Services Provided Through a Medicaid Managed Health Care Program]

[MHTL 3334-14-08](#)

**Effective Date: November 28, 2014**

**Most Current Prior Effective Date: [February 1, 2010](#)**

- (A) The medicaid payment for a covered service constitutes payment-in-full and may not be construed as a partial payment even when the reimbursement amount is less than the provider's charge. The provider may not collect and/or bill the consumer for any difference between the medicaid payment and the provider's charge or request the consumer to share in the cost through a deductible, coinsurance, co-payment or other similar charge, other than medicaid co-payments as defined in rule ~~5101:3-1-09~~5160-1-09 of the Administrative Code. The provider may not charge the consumer a down payment, refundable or otherwise.
- (B) A medicaid consumer cannot be billed when a medicaid claim has been denied due to:
- (1) Unacceptable or untimely submissions of claims;
  - (2) Failure to request a prior authorization; or
  - (3) A peer review organization (PRO) retroactively denying services for lack of medical necessity.
- (C) Providers are not required to bill the Ohio department of ~~job and family services (ODJFS)~~medicaid (ODM) for medicaid-covered services rendered to eligible consumers. However, providers may not bill consumers in lieu of ~~ODJFS~~ODM unless:
- (1) The consumer is notified in writing prior to the service being rendered that the provider will not bill ~~ODJFS~~ODM 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.
- (D) Services that are not covered by the medicaid program, including services requiring prior authorization that have been denied by ~~ODJFS~~ODM, may be billed to the consumer when the provisions in paragraphs (C)(1) and (C)(2) of this rule are met.

Effective: 11/28/2014

Five Year Review (FYR) Dates: 09/08/2014 and 11/28/2019

Certification: CERTIFIED ELECTRONICALLY

Date: 11/18/2014

Promulgated Under: 119.03

Statutory Authority: 5164.02

Rule Amplifies: 5164.02

Prior Effective Dates: 6/3/83, 2/11/84, 10/1/84, 7/1/85 (Emer), 9/30/85, 10/1/87, 5/30/02, 1/1/04, 7/1/05, 1/6/06, 02/01/2010

[MHTL 3334-12-01](#)

**To Be Effective: March 31, 2012**

**Most Current Prior Effective Date: [August 2, 2011](#)**

This rule sets forth the eligibility requirements for medicaid providers. Provider eligibility requirements for medicaid managed care plans can be found in Chapter 5101:3-26 of the Administrative Code.

- (A) "Eligible provider" means any individual, group practice, ~~other~~ corporation, organization, or health care institution that:
- (1) Meets the applicable provider requirements and standards in division 5101:3 of the Administrative Code that address the applicable provider types and service categories covered under the Ohio medicaid program;
  - (2) Meets the additional requirements and standards set forth in this rule; ~~and~~
  - (3) Has met the provider screening requirements and paid the associated application fee in accordance with rule 5101:3-1-17.8 of the Administrative Code; and
  - ~~(3)~~(4) Is approved for participation in the medicaid program by the Ohio department of job and family services (ODJFS) as evidenced by the issuance of both a signed "Provider Agreement" and an Ohio medicaid ~~legacy~~ provider number.
- (B) Eligible providers enrolled in the Ohio medicaid program will each be classified as a "Typical" provider or an "Atypical" provider and will also be classified as an "Entity Type 1" provider or an "Entity Type 2" provider.
- (1) "Typical Provider" means any provider assigned a provider type that ODJFS has determined is eligible to provide covered services that meet the definition of health care services in accordance with 45 C.F.R. 160.103 (2/2006).
  - (2) "Atypical Provider" means any provider assigned a covered provider type that ODJFS has determined is eligible to provide covered services that are non-health care services (i.e., those services that do not meet the definition of health care services in accordance with 45 C.F.R. 160.103 (2/2006)).
  - (3) "Entity Type 1" means a provider assigned a covered provider type that is for an individual health care provider. An individual health care provider cannot be a subpart and cannot designate a subpart. A sole proprietorship is a form of business that, in terms of a national provider identifier (NPI) assignment, is an entity type 1 that is eligible for a single NPI. As an individual, a sole proprietor/sole proprietorship cannot have subparts and cannot designate subparts.
  - (4) "Entity Type 2" means:
    - (a) Any provider enrolled that is assigned a covered professional group provider type as specified in paragraph (C) of this rule; or
    - (b) Any provider enrolled that is assigned any provider type that is neither an individual provider type nor a professional group provider type.
- (C) A provider can be assigned a professional group provider type only if it is organized for the sole purpose of providing professional services authorized under Chapters 4715., 4725., 4731., 4732., 4734., 4755.04 to 4755.56, or 4723.41 to 4723.485 of the Revised Code, meets the requirements in either paragraph (C)(1) or (C)(2) of this rule, and meets the other requirements set forth in paragraphs (C)(3) and (C)(4) of this rule.
- (1) A professional practice that is owned by an individual may be enrolled as a professional group practice if the practice is formed as an organizational structure listed in paragraphs (C)(3)(a) to

(C)(3)(d) of this rule and the owner (member) of the practice possesses a valid license, certificate or other legal authorization issued under Chapters 4715., 4725., 4731., 4732., 4734., 4755.04 to 4755.56, or 4723.41 to 4723.485 of the Revised Code and also meets the respective requirements in paragraph (A)(1) of this rule.

An individual provider enrolling with the medicaid program that does not meet the provisions listed in paragraph (C) of this rule may only be enrolled as an individual provider.

- (2) Any group of two or more individuals may be enrolled as a professional group practice if the practice is formed as an organizational structure listed in paragraph (C)(3) of this rule. ODJFS recognizes two kinds of professional group practices, a professional medical group and a professional dental group.
    - (a) A professional medical group is a group that consists of individual practitioners recognized by ODJFS as eligible members. The types of individual practitioners recognized by ODJFS as eligible members include: advanced practice nurses, optometrists, opticians, chiropractors, occupational therapists, physical therapists, physicians, osteopaths, anesthesia assistants, podiatrists, and psychologists. The practice must consist of two or more members, of like or different licensure, or only an incorporated individual organized in accordance with paragraph (C)(3)(b) of this rule. Dentists may not enroll as a member of a professional medical group.
    - (b) A professional dental group is a group that consists only of dentists. The practice must consist of two or more dentists, or only an incorporated individual dentist organized in accordance with paragraph (C)(3)(b) of this rule.
  - (3) For purposes of the Ohio medicaid program, a professional group may be organized in accordance with one of the following organizational structures:
    - (a) A corporation formed under Chapter 1701. of the Revised Code;
    - (b) A limited liability corporation formed under Chapter 1705. of the Revised Code;
    - (c) A non-profit corporation formed under Chapter 1702. of the Revised Code;
    - (d) A professional association formed under Chapter 1785. of the Revised Code; or
    - (e) A partnership formed under Ohio law.
  - (4) Each member or each employee of the professional group practice (including an individual that is incorporated) that possesses a license, certificate or other legal authorization issued under Chapters 4715., 4725., 4731., 4732., 4734., 4755.04 to 4755.56, or 4723.41 to 4723.485 of the Revised Code and also meets the respective requirements in paragraph (A)(1) of this rule must have an individual provider agreement with ODJFS.
- (D) Requirements for an NPI and the consequences of not having an NPI when an NPI is required.
- (1) A typical provider must obtain an NPI.
    - (a) With the exception of NPI requirements for long term care facilities described in ~~paragraph~~ paragraphs (D)(1)(b) and (D)(1)(c) of this rule, a typical provider enrolling with ODJFS is required to obtain a unique NPI in order to be approved as an eligible provider under the Medicaid program.
    - (b) A provider of nursing facility services is required to obtain an NPI.
    - (c) A provider of intermediate care facility for the mentally retarded (ICF-MR) services is not required to obtain an NPI.
  - (2) An atypical provider is not required to obtain an NPI unless the provider determines it provides health care services in accordance with 45 C.F.R. 160.103 (2/2006).
    - (a) Each atypical provider must self-assess the services it provides and determine if it provides health care services.

- (b) An atypical provider that determines it does not provide health care services and does not obtain a NPI will be issued a Ohio medicaid legacy number to be submitted on claims for payment.
  - (c) An atypical provider that determines it provides any health care services is required to obtain an NPI, regardless of the type of services the provider performs under the medicaid program.
- (3) Typical providers and atypical providers that have been issued an NPI must disclose each NPI they have been issued to ODJFS in accordance with rule 5101:3-1-17.3 of the Administrative Code.
- (4) Typical providers and atypical providers that are required to obtain an NPI will have claims denied for payment if any of the following apply:
- (a) Providers submit a claim without an NPI present on the claim when an NPI is required on the claim.
  - (b) Providers submit a claim with an NPI that is not recognized by ODJFS as a valid NPI based on the information disclosed in accordance with rule 5101:3-1-17.3 of the Administrative Code.
  - (c) Providers do not submit claims to ODJFS within the timely filing limitations in accordance with rule 5101:3-1-19 of the Administrative Code. ODJFS will not make exceptions for providers that do not submit claims within the timely filing limitations because the provider failed to get an NPI or failed to disclose an NPI to ODJFS per rule 5101:3-1-17.3 of the Administrative Code.
- (5) Covered organization health care providers are responsible for determining if they have components or subparts and the covered organization health care provider must ensure that their subparts obtain their own unique NPI, or they must obtain one for them. A subpart is not itself a separate legal entity, but is part of a covered organization health care provider that is a legal entity. A subpart must furnish health care as defined in 45 C.F.R. 160.103 (2/2006).
- (E) If an "Entity Type 2" health care provider consists of subparts that are issued a unique NPI but the subpart does not meet the requirements to be an eligible provider as set forth in this rule, all transactions must be submitted under the NPI of the "Entity Type 2" medicaid provider under which it is a subpart. ODJFS will make exceptions for automatic crossover claims received from the medicare coordination of benefits administrator for those NPIs issued to a subpart of an "Entity Type 2" provider if the subpart is enrolled as an eligible provider under medicare.
- "Entity Type 1" (individual) providers can never be a subpart of an "Entity Type 2" provider.
- (F) Not all health care providers providing health care services in accordance with 45 C.F.R. 160.103 (2/2006) are eligible to enroll as providers under the Ohio medicaid program. The receipt of an NPI does not guarantee enrollment as an Ohio medicaid provider.
- (G) ODJFS does not enroll providers outside of the United States and its territories.

Effective: 03/31/2012

R.C. 119.032 review dates: 08/01/2016

Certification: CERTIFIED ELECTRONICALLY

Date: 01/03/2012

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02, 5111.029, 5111.063

Prior Effective Dates: 4/7/77, 10/1/87, 1/1/95, 12/31/96 (Emer), 3/22/97, 5/30/02, 8/11/05, 5/23/07, 1/1/08, 8/2/11

5160-1-17.1 Notification of Rule and Program Changes

**\*Formerly\*** 5101:3-1-17.1 Notification of Rule and Program Changes

**Effective Date: August 1, 2009**

- (A) Before the effective date of the final adoption, amendment or rescission of a rule in division 5101:3 of the Administrative Code, the Ohio department of job and family services (ODJFS) shall make a reasonable effort to notify persons affected by the rule adoption, amendment or rescission. "Reasonable effort to notify persons" means posting the full text of a new or amended rule on the ODJFS website.
- (B) ODJFS may use electronic mail (e-mail) to communicate notice of final rule action. Persons may voluntarily submit an e-mail address on an ODJFS-maintained website in order to receive an electronic communication of any final rule adoption, amendment or rescission. ODJFS shall maintain the electronic distribution list, but is not responsible for the validity of any e-mail address on the list. The sole responsibility for the validity of any e-mail address maintained on the distribution list is that of the person who submitted the address.

Effective:

R.C. 119.032 review dates:

Certification

Date

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 119.03(e)

[MHTL 3334-11-03](#)

**Effective Date: August 2, 2011**

**Most Current Prior Effective Date: [December 30, 2005 \(Emergency\)](#)**

~~For purposes of this rule, for the medicaid and the disability medical assistance programs, services and benefits are covered in accordance with the provisions set forth in division-level 5101:3 of the Administrative Code.~~

Provisions of provider agreements for long term care nursing facilities are defined in Chapter 5101:3-3 of the Administrative Code. Provisions for provider agreements for medicaid contracting managed care plans are defined in Chapter 5101:3-26 of the Administrative Code.A valid provider agreement with medicaid will act as a provider agreement for participation in the medicaid program~~and/or the disability medical assistance programs~~. All medicaid provider applications must be submitted through the medicaid information technology system (MITS) web portal. Provider applications submitted in paper format will be returned to the provider unprocessed.

If a provider application requires additional supporting documentation by the department for the application process to be completed, the supporting documentation may be sent through the MITS web portal or sent to the department through regular mail service.A provider agreement is a contract between the Ohio department of job and family services (ODJFS) and a provider of medicaid covered services. By signing this agreement the provider agrees to comply with the terms of the provider agreement, Revised Code, Administrative Code, and federal statutes and rules; and the provider certifies and agrees:

- (A) To render medical services as medically necessary for the patient and only in the amount required by the patient without regard to race, creed, color, age, sex, national origin, source(s) of payment, or handicap; submit claims only for services actually performed; and, bill ODJFS for no more than the usual and customary fee charged other patients for the same service.
- (B) To ascertain and recoup any third-party resource(s) available to the consumer prior to billing ODJFS. ODJFS will then pay any unpaid balance up to the lesser of the provider's billed charge or the maximum allowable reimbursement as set forth in division-level 5101:3 of the Administrative Code.
- (C) To accept the allowable reimbursement for all covered services as payment-in-full, except as required in paragraph (B) of this rule. The provider will not seek reimbursement for that service, except as defined in rule 5101:3-1-09 of the Administrative Code, from the patient, any member of the family, or any other person.
- (D) To maintain all records necessary and in such form so as to fully disclose the extent of services provided and significant business transactions. The provider will maintain such records for a period of six years from the date of receipt of payment based upon those records or until any audit initiated within the six year period is completed.
- (E) To furnish to ODJFS, the secretary of the department of health and human services, or the Ohio medicaid fraud control unit or their designees any information maintained under paragraph (D) of this rule for audit and review purposes. Audits may use statistical sampling. Failure to supply requested records within thirty days shall result in withholding of medicaid ~~or disability medical assistance~~ payments and may result in termination from the medicaid ~~and disability medical assistance programs~~ program.
- (F) To inform ODJFS within thirty days of any changes in licensure, certification, or registration status; ownership; specialty; additions, deletions, or replacements in group membership and hospital-based physician affiliations; and address.
- (G) To disclose ownership and control information, and to disclose the identity of any person who has been convicted of a criminal offense related to medicare, medicaid, ~~disability medical assistance~~, or services

provided under Title XX of the Social Security Act (as in effect 12/07/2010) (Title XX) services, as specified in rule 5101:3-1-17.3 of the Administrative Code.

- (H) That neither the individual practitioner, nor the company, nor any owner, director, officer, or employee of the company, nor any independent contractor retained by the company, is currently subject to sanction under medicare, medicaid, ~~disability medical assistance~~, or Title XX; or, is otherwise prohibited from providing services to medicare, medicaid, ~~disability medical assistance~~, or Title XX beneficiaries.
- (I) To provide to ODJFS, through the court of jurisdiction, notice of any bankruptcy action brought by the provider. Notice shall be mailed to: office of legal services, Ohio department of job and family services.
- (J) To comply with the appropriate advance directives requirements for hospitals, providers of home health care, personal care services, and hospices as specified in Chapter 3701-83 of the Administrative Code.
- (K) To comply with the confidentiality safeguards and the use and release of information regarding public assistance recipients as described in section 5101.27 of the Revised Code.
- (L) To comply with section 121.36 of the Revised Code and rule 5101:3-1-39 of the Administrative Code when providing home care services.

Effective: 08/02/2011

R.C. 119.032 review dates: 09/20/2010 and 08/01/2016

Certification: CERTIFIED ELECTRONICALLY

Date: 06/20/2011

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02

Prior Effective Dates: 4/7/77, 12/30/77, 1/1/79, 3/23/79, 8/31/79, 11/1/79, 7/1/80, 7/7/80, 10/1/87, 1/1/93, 5/30/02, 1/1/04, 9/26/04, 8/11/05, 12/30/05 (Emer), 3/27/06

5160-1-17.3 Provider Disclosure Requirements

**\*Formerly\*** 5101:3-1-17.3 Provider Disclosure Requirements

**Effective Date: May 23, 2007**

**Most Current Prior Effective Date: [August 11, 2005](#)**

- (A) Providers, ~~other than individual practitioners or groups of practitioners,~~ shall disclose to the Ohio department of job and ~~family~~ family services (ODJFS) or its designee full and complete information concerning the name and address of each person:
- (1) Who, with respect to the provider:
    - (a) Is an officer or director;
    - (b) Is a partner;
    - (c) Has a direct or indirect ownership interest totaling five per cent or more; or
    - (d) Has an interest of five per cent or more in any mortgage, deed of trust, note, or other obligation secured by the provider if that interest equals at least five per cent of the value of the property or assets of the provider.
  - (2) Who, with respect to any subcontractor in which the provider has a direct or indirect ownership or control interest of five per cent or more:
    - (a) Is an officer or director;
    - (b) Is a partner;
    - (c) Has a direct or indirect ownership interest totaling five per cent or more; or
    - (d) Has an interest of five per cent or more in any mortgage, deed of trust, note, or other obligation secured by the provider if that interest equals at ~~leave~~ least five per cent of the value of the property or assets of the provider.
  - (3) Who has been convicted or indicted of a criminal offense related to ~~his~~ involvement in any program operated under Title XVIII, XIX, or XX of the Social Security Act and who has an ownership or control interest in the provider, or is an agent or managing employee (i.e., an individual, including a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control or who directly or indirectly conducts the day-to-day operations).
- (B) Providers, ~~other than individual practitioners or groups of practitioners,~~ shall supply ODJFS, or its designee, within thirty-five days of the date of a specific request, full and complete information concerning:
- (1) The ownership of any subcontractor with which the provider has had, during the twelve months prior to the date of the request, business transactions in an aggregate amount of twenty-five thousand dollars; and
  - (2) Any significant business transactions occurring during the five-year period ending on the date of such request, between the facility and any wholly owned supplier or any subcontractor.
- (C) Disclose whether any of the persons named, in compliance with paragraphs (A)(2) and (A)(3) of this rule, are related to another as spouse, parent, child, or sibling.
- (D) Disclose the name of any other disclosing entity in which a person with an ownership or control interest in the provider also has an ownership or control interest.
- (1) This requirement applies to the extent that the provider can obtain this information by requesting it in writing from the person.
  - (2) The provider must:
    - (a) Keep copies of all these requests and the responses to them;

- (b) Make them available to the secretary of health and human services or ODJFS upon request; and
- (c) Advise the secretary of health and human services or ODJFS when there is no response to a request.

(E) Providers shall disclose their national provider identifier (NPI) by supplying ODJFS a copy of the national plan and provider enumeration system (NPPES) NPI notification received. Upon receipt of written notification from NPPES, a provider shall report any additions, change in ownership, or change in the assignment of the provider's NPI to ODJFS.

Effective: 05/23/2007

R.C. 119.032 review dates: 03/06/2007 and 05/01/2012

Certification: CERTIFIED ELECTRONICALLY

Date: 05/11/2007

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Rule Amplifies: 5111.01, 5111.02

Prior Effective Dates: 4/7/77, 12/30/77, 1/1/79, 3/23/79, 8/31/79, 11/1/79, 7/1/80, 7/7/80, 10/1/87, 5/30/02, 8/11/05

[MHTL 3334-10-03](#)

**Effective Date: May 1, 2010**

**Most Current Prior Effective Date: [January 1, 2008](#)**

- (A) ~~Provider agreements are one of three types~~ Definitions:
- (1) Open-ended provider ~~agreements~~ agreement. This type of provider agreement has ~~have~~ no specific termination date and ~~continue~~ continues to be in effect as long as agreeable by both parties.
  - (2) Time-limited provider ~~agreements~~ agreement. This type of provider agreement is ~~are~~ for a specific period of time and will expire on a designated date unless renewed in accordance with the Ohio department of job and family services (ODJFS) re-enrollment process. ~~The~~ A time-limited provider ~~agreements~~ agreement will be limited to no longer than ~~three~~ seven years from the effective date.
  - ~~(3) Provider agreements with managed care plans (MCPs) are administered in accordance with Chapter 5101:3-26 of the Administrative Code, and are not subject to the provisions of this rule.~~
- (B) ~~The following providers shall have open-ended agreements~~ The use of time-limited provider agreements pursuant to this rule does not apply to provider agreements issued to the following, including any provider agreements issued to the following that are otherwise time-limited under the medicaid program:
- (1) Nursing facilities, as defined in section 5111.20 of the Revised Code;~~;~~
  - (2) Intermediate care facilities for the mentally retarded, as defined in section 5111.20 of the Revised Code;~~;~~
  - (3) Managed care organizations under contract with the department pursuant to section 5111.17 of the Revised Code; and ~~Providers that were enrolled prior to January 1, 2008 and have not been converted to a time-limited agreement in accordance with paragraph (C) of this rule.~~
  - (4) Hospitals.
- (C) The following agreements shall be time-limited agreements or will be converted to time-limited agreements pursuant to section 5111.028 of the Revised Code, unless the provider is one of the provider types listed in paragraphs (B)(1) to (B)(4) of this rule:
- (1) Any new provider agreement shall be time-limited in accordance with this rule ~~with the exceptions listed in paragraphs (B)(1) and (B)(2t) of this rule.~~
  - (2) Any existing open-ended provider agreement held by a provider that was enrolled before January 1, 2008, shall be converted to a time-limited agreement on or before January 1, 2015, ~~over a period of three years~~ in accordance with this rule ~~with the exceptions listed in paragraphs (B)(1) and (B)(2) of this rule.~~
    - (a) ODJFS shall select the provider agreements to be converted and automatically phase in time-limited agreements in a manner and for a time determined by ODJFS.
    - (b) ODJFS shall notify the provider by sending a conversion notice by regular mail to the address on file that the provider has been automatically converted to a time-limited-agreement in accordance with this rule. Providers are not required to respond to the ODJFS conversion notice.
    - (c) Providers that have been selected and converted to time-limited agreements may not request that the proposed expiration be altered, either to an earlier or later date.

- (3) ODJFS may convert any existing open-ended provider agreement to a time-limited provider agreement whenever the conversion is in the best interest of the medicaid consumers or the state of Ohio.
  - (4) The conversion from an open-ended to a time-limited provider agreement does not affect the amount or scope of medicaid reimbursement.
  - (5) The length of time-limited agreements is decided by ODJFS and is determined by provider type. The length of time-limited agreements may vary by provider type but will be consistent for all providers within like provider types. ODJFS may change the length of time-limited agreements by provider type and the length of these agreements may change or vary upon the discretion of ODJFS.
  - (6) ODJFS will notify the provider when its time-limited provider agreement is close to expiration and when the re-enrollment process is required, as described in paragraph (D) of this rule.
- (D) Re-enrollment is the process ~~in which~~ that a provider with a time-limited agreement is required to follow to renew its provider agreement. The re-enrollment process does not apply to MCPs or open-ended agreements. The re-enrollment process is as follows:

- (1) ODJFS shall send a re-enrollment notice by regular mail ninety days prior to the expiration date of the provider's time-limited agreement to the provider's address on file notifying the provider that it is required to renew its agreement.
- (2) The re-enrollment notice shall instruct the provider what is required to complete the re-enrollment process. Providers are expected to meet all conditions for participation as an eligible provider that are in effect in division 5101:3 of the Administrative Code at the time of re-enrollment.
- (3) The provider shall submit all required information before the re-enrollment deadline date specified in the re-enrollment notice.
- (4) A provider shall not initiate re-enrollment prior to the receipt of the re-enrollment notification sent by ODJFS as specified in paragraph (D) of this rule. This rule does not negate the requirement that a provider must disclose any changes to its provider agreement in accordance with rule 5101:3-1-17.3 of the Administrative Code. The reporting of changes in accordance with rule 5101:3-1-17.3 of the Administrative Code does not constitute the initiation of re-enrollment and remains the provider's responsibility.
- (5) When a provider fails to re-enroll in the time and the manner required by ODJFS, as specified in this rule and in accordance with the re-enrollment notice referred to in paragraph (D)(2) of this rule, ODJFS may deny an application for re-enrollment or terminate a time-limited provider agreement. The denial or termination will take effect thirty days after ODJFS mails a written notice to the provider by regular mail to the address on file notifying the provider of the decision. ODJFS shall specify in the notice the date on which the provider is required to cease operating under a terminated provider agreement.

In lieu of denying an application for re-enrollment or terminating a time-limited agreement when a provider fails to re-enroll in the time and manner required and the agreement expires, ODJFS may deny claims submitted by the provider until the provider completes the re-enrollment process and the re-enrollment application is approved by ODJFS. Once the re-enrollment application is approved by ODJFS, ODJFS may allow the provider to re-submit any claims that were denied while its re-enrollment application pended ODJFS approval. ODJFS will not deny claims pursuant to this paragraph when a provider has re-enrolled in the time and the manner required by ODJFS.

- (6) If a provider files an application for re-enrollment within the time and in the manner required, as specified in this rule, but the provider agreement expires before ODJFS acts on the application or before the effective date of the ODJFS decision on the application, the provider may continue operating under the terms of the expired agreement until the effective date of the ODJFS decision.

- (7) If a provider files an application for re-enrollment in the time and manner required, as specified in this rule, but has not been able to obtain a renewal of its licensure, certification, accreditation, or registration due to a delay in processing by an official, board, commission, department, division, bureau or other agency of state or federal government:
- (a) ODJFS shall not deny the application for re-enrollment or deny payment of services if the provider has included documentation with the re-enrollment application that the licensure, certification, accreditation, or registration has been delayed for processing by an official, board, commission, department, division, bureau or other agency of state or federal government; and
  - (b) When the decision is made by an official, board, commission, department, division, bureau or other agency of state or federal government to approve or reject an application for renewal of required licensure, certification, accreditation, or registration, the provider is obligated to notify ODJFS within thirty days of the date of approval or rejection in accordance with rule 5101:3-1-17.2 of the Administrative Code.

~~(8) ODJFS may deny retroactive eligibility to a provider for failure to meet re-enrollment requirements as specified in this rule.~~

- (E) The effective date of a new provider agreement is the date on which the provider signs the application and meets all of the federal and state requirements for participation in the medicaid program. The effective date of a new provider agreement may be made retroactive for up to twelve months prior to the date of application. A retroactive period will be counted when assigning a time-limit to a new provider agreement to encompass dates on which the provider furnished covered services to a medicaid consumer for which the provider has not been reimbursed. Upon ODJFS approval of the application and the effective date of the agreement, ODJFS will accept claims submitted timely for the retroactive period. Exceptions to the twelve month retroactive period include:
- (1) When required licensure, certification, accreditation, or registration is obtained by the provider within the twelve months prior to the application date, the effective date will be that date on which the required license, certification, accreditation, or registration was obtained.
  - (2) Claims submitted within the twelve month retroactive period will be denied for any service provided if the provider did not meet all ODJFS program requirements for participation on the date the service was provided.
  - (3) ODJFS may deny retroactive eligibility to a provider for failure to meet re-enrollment requirements as specified in this rule.
- (F) Pursuant to section 5111.06 of the Revised Code, ODJFS is not required to issue a notice of hearing rights, in accordance with Chapter 119. of the Revised Code, when converting a provider agreement to a time-limited agreement or when terminating a time-limited provider agreement due to the provider's failure to file an application for re-enrollment.
- (G) ~~To ensure program integrity~~In processing an application for re-enrollment, ODJFS ~~may reserves the right to~~ conduct ~~pre-enrollment~~an on-site ~~reviews~~review at the provider's facility, place of business, or both, as ODJFS deems necessary to ensure program integrity.

Effective: 05/01/2010

R.C. 119.032 review dates: 02/09/2010 and 05/01/2015

Certification: CERTIFIED ELECTRONICALLY

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MHTL 3334-15-07

**Effective Date: March 22, 2015**

**Most Current Prior Effective Date: January 1, 2008**

(A) Definitions:

- (1) "Credible allegation of fraud" means an accusation of fraud as defined in 5164.36 of the Revised Code.
- (2) "Non-institutional provider" means any person or entity with a medicaid provider agreement other than a hospital, long-term care nursing facility, intermediate care facility for individuals with intellectual disabilities or medicaid contracting managed care plans.

(B) The Ohio Department of Medicaid (ODM) shall suspend a medicaid provider agreement when at least one of the following conditions apply:

- (1) Upon determining there is a credible allegation of fraud for which an investigation is pending against a provider under the medicaid program, unless good cause to not suspend is found pursuant to 42 CFR 455.23(e) or (f), effective Feb. 2, 2011; or
- (2) Upon receiving notice and copy of an indictment that charges a non-institutional provider, its owner or owners, officer, authorized agent, associate, manager, or employee with committing an offense as specified in division (E) of section 5164.37 of the Revised Code.

(C) Upon suspension of the provider agreement, the following conditions apply:

- (1) If a provider is suspended pursuant to this rule, then any other provider agreements where the provider is an owner, officer, authorized agent, manager, or employee may also be suspended.
- (2) A provider, its owner or owners, officer, authorized agent, associate, manager, or employee shall not own or provide services to any other medical provider or risk contractor or arrange for, render, or order services for medicaid recipients during the period of suspension.
- (3) During the period of suspension, the provider owner or owners, officer, authorized agent, associate, manager, or employee shall not receive reimbursement in the form of direct payments from ODM or indirect payments of medicaid funds.
- (4) The suspension shall continue until either of the following:
  - (a) The department or a prosecuting authority determines that there is insufficient evidence of fraud by the provider;
  - (b) The proceedings in any related criminal case are completed through dismissal of the indictment or through conviction, entry of a guilty plea, or finding of not guilty.
- (5) If ODM commences a process to terminate the suspended provider agreement, the suspension shall continue in effect until the termination process is concluded.

(D) Reconsideration of suspension:

- (1) A provider, owner, or owners subject to a suspension may request a reconsideration in accordance with 5164.36 or 5164.37 of the Revised Code . A request for reconsideration is not subject to Chapter 119 of the Revised Code.
- (2) The reconsideration shall be conducted by the ODM director or the director's designee in the office where the contestation arose provided that the designee was not involved in the original decision. Decisions made by the director or the director's designee are not appealable or subject to further reconsideration.

Replaces: 5160-1-17.5

Effective: 03/22/2015

Five Year Review (FYR) Dates: 03/22/2020

Certification: CERTIFIED ELECTRONICALLY

Date: 03/12/2015

Promulgated Under: 119.03

Statutory Authority: 5164.01, 5164.36

Rule Amplifies: 5164.36, 5164.37

Prior Effective Dates: 01/01/2008

MHTL 3334-15-09

**Effective Date: April 9, 2015**

**Most Current Prior Effective Date: January 1, 2008**

- (A) For purposes of this rule, the following definitions apply:
- (1) "Ownership or control interest" means ~~any person who has~~ having at least five per cent ownership, or interest, either directly, indirectly, or in any combination, ~~as a medicaid provider or person who must be disclosed in accordance with rule 5101:3-1-17.3 of the Administrative Code.~~
  - (2) "Provider" ~~means any individual, group practice, other corporation, or health care institution~~ has the same meaning as "eligible provider," as defined in rule 5101:3-1-17.25160-1-17 of the Administrative Code, or any rule contained in division 5101:3 of the Administrative Code.
  - (3) "Provider Agreement" means an agreement as defined in rule ~~5101:3-1-17.25160-1-17.2~~ 5160-1-17.2 of the Administrative Code or any rule contained in ~~division~~ agency 5101:35160 of the Administrative Code.
- (B) Termination for long term care nursing facilities and intermediate care facilities for individuals with intellectual disabilities is located in Chapter 5160-3 and 5123:2-7 of the Administrative Code.
- (C) Termination for providers enrolled in a medicaid managed care plan is located in Chapter 5160-26 of the Administrative Code.
- ~~(B)~~(D) A provider may voluntarily terminate a provider agreement upon written notice thirty days before the provider's chosen termination date. The Ohio Department of Medicaid (ODM) has the discretion to accept or deny a voluntary termination for a provider who is facing involuntary termination due to an ODM action. ~~The Ohio department of job and family services (ODJFS)~~ ODM may waive the thirty day requirement if appropriate.
- ~~(C)~~ ~~ODJFS may terminate a provider agreement upon thirty days written notice prior to the termination date. When the termination of a provider agreement is based upon a denial, suspension, revocation, limitation, or failure to renew any license, permit, certificate or certification, the provider is ineligible for reimbursement for services provided after the effective date of the denial, suspension, revocation, failure to renew or imposition of limitation imposed by an official, board, commission, department, division, bureau, or other agency of state or federal government.~~
- (E) A provider is ineligible for payment for dates of service on or after the effective date of a denial, suspension, revocation, limitation, or failure to renew a license, permit, certificate, or certification issued by an official, board, commission, department, bureau, or other agency of the state or federal government.
- (F) A provider that was terminated because of a conviction that was a result of a suspension due to credible allegation of fraud is ineligible for all payments, regardless of the dates of service.
- ~~(D)~~(G) ~~ODJFS~~ ODM may propose termination or denial of a provider agreement at any time it is determined that continuation or assumption of provider status is not in the best interest of ~~consumers~~ recipients or the state of Ohio. The phrase "not in the best interest" shall include, but not be limited to, the following circumstances or occurrences:
- (1) The provider has not billed or otherwise submitted a medicaid claim to ~~ODJFS~~ ODM for two years or longer.
  - (2) The provider, or any person having an ownership or controlling interest in the provider, or who is an agent or employee of the provider, has been indicted or granted immunity from prosecution for, or has pled guilty to, or has been convicted of, any criminal offense against the state of Ohio or any other state or territory, whether the offense occurred prior to or during the period of ownership, employment, or agency.

- (3) The provider has made false representations, by omission or commission, on the provider enrollment application or does not fully and accurately disclose to ~~ODJFS~~ODM information as required by the provider agreement, ~~or any rule contained in division 5101:3~~agency 5160 of the Administrative Code, ~~or any provisions contained in 42 C.F.R., Part 455, Subpart B (October 1, 2014).~~
- (4) The provider has been determined liable for negligent performance of professional services to its clientele or patients.
- (5) As determined by ~~ODJFS~~ODM, the provider has departed from or failed to conform to accepted standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established.
- (6) The provider has been formally reprimanded or censured, placed on probation, suspended or placed on practice limitations for unethical conduct or improper practices by a state licensure board or by an association of its peers.
- (7) The provider fails to file cost reports as required.
- (8) The provider makes false statements, provides false information, or alters records, documents, charts, or prescriptions, or fails to cooperate or provide records or documentation upon request during an audit or review of provider activity by staff or contracting entity of ~~ODJFS~~ODM, any county department of job and family services, the attorney general's office, the auditor of state, the department of health and human services, or any other state or federal agency which, by law, has authorized access to records or documents. An alteration of provider records does not include records for which there is a properly documented correction.
- (9) The provider has not corrected ~~deficiencies~~deficiency(ies) after receiving a written notice of operational ~~deficiencies~~deficiency from ~~ODJFS~~ODM.
- (10) The provider fails to abide by, meet the requirements of, or have the capacity to comply with the terms and conditions of the provider agreement, and/or rules and regulations promulgated by ~~ODJFS~~ODM.
- (11) The provider has been suspended or terminated from participation in another government medical program other than a program that requires automatic termination.
- (12) The provider is found in violation of section 504 of the Rehabilitation Act of 1973, as amended (January 1, 2015), or the Civil Rights Act of 1964, as amended (January 1, 2015), in relation to the employment of individuals, the provision of services or in the purchase of goods and services.
- (13) The provider, by any act or omission, has negatively affected the health, safety, or welfare of the medicaid ~~consumers~~recipient or the fiscal or programmatic integrity of the medicaid program.
- (14) The office of the attorney general, auditor of state, or any board, bureau, commission, or department has recommended that ~~ODJFS~~ODM terminate the provider agreement where the reason for the request bears a reasonable relationship to the administration of the medicaid program; or the integrity of state and/or federal funds.
- (15) As determined by ~~ODJFS~~ODM, the provider fails to use reasonable care or discretion in the storage, administration, dispensing, or prescribing of drugs, or fails to employ acceptable scientific methods in the selection of drugs or other modalities of treatment of disease.
- (16) As determined by ~~ODJFS~~ODM, the provider sells, gives away, personally furnishes, prescribes, or administers drugs for other than legal and legitimate therapeutic purposes.
- (17) The United States drug enforcement agency has suspended or revoked the provider's registration for any act or acts which would constitute a violation of paragraph ~~(D)~~(E)(5), ~~(D)~~(E)(15), or ~~(D)~~(E)(16) of this rule.
- (18) ~~After ODJFS has provided written billing instructions, the~~The provider or the provider's staff misrepresents the type and/or units of service, inflates billing codes to increase payments, or

bills for, or receives payments for services not rendered, or any other practice that is a violation of any rule contained in ~~the division~~ agency 5160 5101:3 of the Administrative Code.

- (19) As determined by ODJFSODM, the provider, or the provider's staff prescribes, authorizes, bills for, or receives payments for, services that are not medically necessary as defined in rule ~~5101:3-1-01~~5160-1-01 of the Administrative Code.
- (20) The provider or the provider's staff lack the ability or legal authority to provide services for which the provider has billed, because of lack of equipment or material, or a failure to comply with minimal requirements under state and federal law.
- (21) The provider consistently violates the prohibition against billing medicaid ~~consumers~~recipients or assigning provider claims to a factor, as found in rule ~~5101:3-1-13.1~~5160-1-13.1 ~~or 5101:3-1-23~~ of the Administrative Code or 42 CFR 447.10 (October 1, 2014).
- (22) The provider fails to notify ODJFSODM within thirty days of any changes in licensure, certification, accreditation, or registration status, ownership, closure, specialty, additions, deletions, or replacements in group memberships, and address, ~~as referenced in paragraph (F) of rule 5101:3-1-17.2 of the Administrative Code.~~
- (23) The provider fails to repay an overpayment or recovery amount assessed as a result of a final adjudication order.
- (24) The provider has a previous or current exclusion, suspension, termination or involuntary withdrawal from participation in any medicaid program, or any other public or private health insurance program.
- (25) The provider has been convicted under federal or state law of a criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct.
- (26) The provider has not responded to two certified mail correspondences from ODM and the provider's business cannot otherwise be located.
- (27) The provider signed a ~~time-limited~~ provider agreement and failed to ~~notify ODJFS of the intent to renew~~revalidate the provider agreement in accordance with rule ~~5101:3-1-17.4~~5160-1-17.4 of the Administrative Code.

~~(28) The provider fails to meet all applicable provider requirements set forth in division 5101:3 of the Administrative Code.~~

~~(29)~~(28) Any reason permitted or required by federal law.

~~(E)~~(H) For any reason permitted or required by federal law, ~~ODJFS~~ODM may deny or exclude from participation in the medicaid program any individual, provider of services or goods, or other entity that does not possess a medicaid provider agreement.

~~(F)~~(I) ODJFSODM shall terminate or deny a provider agreement when any of the following apply:

- (1) Any license, permit, or certification that is required in the provider agreement or department rule has been denied, suspended, revoked, not renewed or is otherwise limited and the provider has been afforded the opportunity for a hearing in accordance with the hearing process established by the official, board, commission, department, division, bureau, or other agency of state or federal government.
- (2) The terms of a provider agreement require the provider to hold a license, permit, or certificate, or maintain certification, issued by an official, board, commission, department, division, bureau, or other agency of state or federal government, other than ODJFSODM, and the provider has not obtained the license, permit, certificate, or maintained the certification.
- (3) An official, board, commission, department, division, bureau, or other agency of this state, other than ODJFSODM, has denied, terminated, or not renewed a license, permit, certificate or certification that is required for participation, notwithstanding the fact that the provider may hold a license, permit, certificate or certification from an official, board, commission, department, division, bureau, or other agency of another state.

- (4) A judgment has been entered in either a criminal or civil action against a medicaid provider or its owner, officer, authorized agent, associate, manager, or employee in an action brought pursuant to section 109.85 of the Revised Code, except if the provider or owner can demonstrate to ODJFSODM that the provider or owner did not directly or indirectly sanction the action of its authorized agent, associate, manager, or employee which resulted in the conviction or entry of judgment.
- (5) The provider is terminated, suspended, or excluded by the medicare program and/or by the federal department of health and human services and that action is binding on the provider's participation in the medicaid program or renders federal financial participation unavailable for that provider's participation in the medicaid program.
- (6) The provider has been convicted of, or pled guilty to, any criminal activity materially related to either the medicare or medicaid program or has been convicted of one of the offenses that caused the provider agreement to be suspended in accordance with rule 5160-1-17.5 of the Administrative Code.
- ~~(7) The provider has been convicted of one of the offenses that caused the provider agreement to be suspended in accordance with rule 5101:3-1-17.5 of the Administrative Code.~~
- ~~(8)~~(7) The provider has failed to apply for ~~re-enrollment~~revalidation within the time and in the manner specified for ~~re-enrollment~~revalidation pursuant to ~~section 5111.028~~5164.32 of the Revised Code.
- ~~(9)~~(8) The provider fails to timely submit a required background check or when the background check reveals that the provider has been convicted of, or pled guilty to a disqualifying offense unless the provider meets specific circumstances provided in ~~division 5101:3~~agency 5160 of the Administrative Code.
- ~~(10)~~(9) ODJFSODM has determined that the provider facility has closed or is not providing medicaid covered services.
- ~~(G)~~(J) Appeal rights for the termination or denial of a provider agreement provided in this rule are found in rule ~~5101:3-1-57~~5160-1-57 of the Administrative Code.
- ~~(H)~~(K) In determining the length of termination, ODJFSODM shall consider the following:
- (1) The number and nature of program violations and other related offenses and the degree to which the provider participated in the offense;
  - (2) The nature and extent of any adverse impact the violations have had on ~~consumers~~recipients, including but not limited to the health and safety of those ~~consumers~~recipients who are aged and/or at greater physical, mental and emotional risk;
  - (3) The amount of any damages incurred by the medicaid program;
  - (4) Whether there are any mitigating circumstances;
  - (5) Any other facts bearing on the nature and seriousness of the violations or related offenses;
  - (6) The current, pending and previous sanction record of the provider under the medicare, medicaid, or other health-related programs; and
  - (7) Whether the provider is pending any future state or federal litigation relating to the current or any similar offense.
- ~~(I)~~(L) ODJFSODM reserves the right to deny twelve months retroactivity for the submission of claims to providers whose agreement is reinstated after termination for cause in accordance with this rule.

Effective: 04/09/2015

Five Year Review (FYR) Dates: 01/13/2015 and 04/09/2020

Certification: CERTIFIED ELECTRONICALLY

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**5160-1-17.7 Application by a Former Participating Medicaid Provider to Resume Participation in the Ohio Medicaid Program [Except for Medicaid Contracting Managed Care Plans (MCPs)]**

**\*Formerly\* 5101:3-1-17.7 Application by a Former Participating Medicaid Provider to Resume Participation in the Ohio Medicaid Program [Except for Medicaid Contracting Managed Care Plans (MCPs)]**

**MHTL 3334-09-05**

***Effective Date: December 19, 2009***

- (A) An individual or entity that at one time was a participating provider in the Ohio medicaid program and whose provider agreement was terminated either voluntarily or involuntarily in accordance with rule 5101:3-1-17.6 of the Administrative Code must complete a new application for enrollment if that individual or entity wants to resume participation in the Ohio medicaid program.
- (B) In considering an application for participation in the Ohio medicaid program by a former medicaid provider described in paragraph (A) of this rule, and except as provided by paragraphs (C) and (D) of this rule, the Ohio department of job and family services (ODJFS) may grant the application only if it is reasonably certain that the types of actions that formed the basis for termination or exclusion have not recurred and will not recur. In making this determination, ODJFS will consider, in addition to any factors set forth in state law:
- (1) The conduct of the former medicaid provider from the date the provider's previous provider agreement was terminated;
  - (2) Whether all fines, and all debts due and owing, including overpayments, to any federal, state or local government that relate to any of the state health care programs, have been paid, or satisfactory arrangements have been made, that fulfill these obligations; and
  - (3) Whether all requirements for participation are met at the time of the application filed pursuant to paragraph (A) of this rule, as evidenced by all appropriate and required documentation submitted with the application by the former medicaid provider.
- (C) Notwithstanding paragraph (B) of this rule, ODFJS shall deny the application of a former medicaid provider whose provider agreement was terminated under paragraph (F)(4) or (F)(6) of rule 5101:3-1-17.6 of the Administrative Code.
- (D) In the case of a former medicaid provider that allowed its provider agreement to lapse by failing to timely renew its provider agreement, and whose provider agreement has been inactive for at least sixty days, ODJFS may, without regard to the criteria set forth in paragraph (B) of this rule and at its discretion, grant an application that demonstrates through all appropriate and required documentation that the requirements to participate as a medicaid provider are met at the time the application is filed.
- (E) If ODJFS approves an application filed under paragraph (A) of this rule, it must give written notice to the applicant specifying the date on which participation in the Ohio medicaid program may resume. The notice shall specify whether the applicant is assigned its former provider number or a new provider number, the determination of which shall be in the sole discretion of ODJFS.
- (F) If ODJFS does not approve an application filed under paragraph (A) of this rule, it must give the applicant written notice of that decision. The notice will provide review rights in accordance with rule 5101:3-1-57 of the Administrative Code.

Effective: 12/19/2009

R.C. 119.032 review dates: 12/01/2014

Certification: CERTIFIED ELECTRONICALLY

Date: 12/09/2009

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02

[MHTL 3334-12-01](#)

**To Be Effective: March 31, 2012**

5101:3-1-17.8 [Appendix A](#)

(A) To become an eligible provider as described in rule 5101:3-1-17 of the Administrative Code, a provider must meet the screening requirements described in this rule and pay an applicable application fee if required in the appendix to this rule. Provider screening and application fees are required at the time of enrollment and re-enrollment as defined in rule 5101:3-17.4 of the Administrative Code.

(1) Exemptions from this rule.

- (a) If a provider is required to participate in the medicare program as a condition of enrollment in medicaid or elects to participate in the medicare program and has met the provider screening requirements and paid an applicable application fee to the centers for medicare and medicaid services (CMS) or its designee, the provider is exempt from this rule.
- (b) If a provider has met the provider screening requirements and paid an applicable application fee to another state medicaid agency or its designee, the provider is exempt from this rule.
- (c) A provider must provide documentation to support it meets the criteria for an exemption described in paragraphs (A)(1)(a) and (A)(1)(b) of this rule.

(2) The appendix to this rule sets forth:

- (a) The screening risk level assigned to each provider type in accordance with paragraph (B) of this rule; and
- (b) The provider types that must pay an application fee in accordance with paragraph (C) of this rule.

(B) Screening requirements differ by risk level. If more than one risk level could apply to a provider, the highest level of screening is required.

(1) Limited.

- (a) Providers are subject to verification that they meet any applicable medicaid requirements as stated in division 5101:3 of the Administrative Code for their provider type; and
- (b) Providers are subject to license verifications, including state licensure verification in states other than Ohio; and
- (c) Providers are subject to database checks on a pre- and post-enrollment basis to ensure that providers continue to meet the enrollment criteria for their provider type.
  - (i) Database checks must confirm the identity and exclusion status of providers and any person with a five per cent or greater ownership or control interest; or any person who is an agent or an individual (including a general manager, business manager, administrator, director, or consultant) who directly or indirectly manages, advises, or supervises any element of the practices, finances, or operations of the provider entity.
  - (ii) Databases to be checked include, but are not limited to, the social security administration's death master file, the national plan and provider enumeration systems (NPPEs), the list of excluded individuals/entities (LEIE), and the excluded parties list system (EPLS).

(2) Moderate.

- (a) Providers are subject to the requirements in paragraph (B)(1) of this rule; and
- (b) Providers are subject to on-site visits.
  - (i) Pre- and post-enrollment site visits by the Ohio department of job and family services (ODJFS) or its designee will verify that information provided to ODJFS or its designee is accurate and to determine compliance with medicaid enrollment requirements.
  - (ii) Once enrolled, providers must allow CMS or its agents or contractors, or ODJFS or its agents or contractors to conduct unannounced on-site inspections of any and all provider locations.

(3) High.

- (a) Providers are subject to the requirements in paragraphs (B)(1) and (B)(2)(b) of this rule; and
- (b) Each person with a five per cent or greater ownership or control interest with the provider is subject to a criminal background check and is required to submit his or her fingerprints within thirty days of submission of the application in a form and manner determined by ODJFS, or its designee.

(C) Application fee.

- (1) Provider types identified as subject to an application fee in the appendix to this rule must submit the fee in a form and manner determined by ODJFS at the time of application for enrollment or re-enrollment as a medicaid provider. If proof of fee payment is not submitted with the provider's application, the application will be denied.
- (2) Individual physicians and non-physician practitioners are exempt from paying an application fee in accordance with 42 C.F.R. 455.460, effective February 2, 2011.
- (3) ODJFS may waive an application fee if:
  - (a) ODJFS determines that imposing the fee would have an adverse impact on beneficiary access to services; and
  - (b) ODJFS has requested and CMS has approved a waiver of the fee.
- (4) If ODJFS receives approval from CMS to waive a medicaid application fee, providers are still subject to the screening requirements set forth in this rule.
- (5) The application fee is equal to the amount established by CMS and includes an annual adjustment for inflation in accordance with paragraph (a)(2)(C)(i) of 42 U.S.C. 1395cc(j).
- (6) The application fee will not be refunded if:
  - (a) Enrollment is denied as a result of failure to meet the provider screening requirements described in this rule; or
  - (b) If enrollment is denied based on the results of the provider screening.

(D) If enrollment is denied as a result of failure to meet the provider screening requirements or failure to pay any associated application fee, the provider may request a hearing pursuant to Chapter 119. of the Revised Code.

Effective: 03/31/2012

R.C. 119.032 review dates: 08/01/2016

Certification: CERTIFIED ELECTRONICALLY

Date: 01/03/2012

Promulgated Under: 119.03

Statutory Authority: 5111.02, 5111.063

Rule Amplifies: 5111.02, 5111.063

**Effective Date: January 1, 2014**

(A) Definitions for purposes of this rule only:

- (1) A "participating provider" is an active provider who bills the medicaid program for rendered services, or who is an active provider who orders, prescribes, refers, or certifies but does not bill the medicaid program.
- (2) An "ordering or referring only provider" is a provider who orders, prescribes, refers, or certifies an item or service reported on a claim, and is not a billing provider in the medicaid program. For example: a provider orders items or services for the medicaid consumer, such as prescription drugs, durable medical equipment, prosthetics, orthotics, and supplies, clinical laboratory services, or imaging services, and may certify home health services for a medicaid consumer.
- (3) "Physician" or "supervising physician" means an individual authorized to practice medicine in Ohio or another state.
- (4) "Other professional" means those providers, other than physicians, who order, prescribe, refer, or certify an item or service reported on a claim. Examples include but are not limited to: physician assistant, clinical nurse specialist, nurse practitioner, clinical psychologist, certified nurse midwife, clinical social worker, and interns, residents, and fellows.

(B) A physician or other professional who is an ordering or referring only provider of medicaid services must be enrolled as a participating provider with the medicaid program.

(C) An ordering or referring only provider shall be considered limited risk for purposes of screening, as defined in rule 5101:3-1-17.8 of the Administrative Code.

(D) Ordering and referring only providers who are enrolled with the office shall revalidate in accordance with rule 5101:3-1-17.4 of the Administrative Code.

(E) Claims for services that require an order, prescription, referral, or certification will be denied if they do not include the following:

- (1) A valid national provider identifier (NPI) and the legal name of the ordering, prescribing, referring, or certifying provider; or,
- (2) If the ordering, prescribing, referring, or certifying provider is not a provider type eligible to participate in Ohio medicaid, a valid NPI and the legal name of the physician or other professional supervising the ordering or referring provider.

(F) This rule does not apply to services delivered through medicaid managed care plans.

Effective: 01/01/2014

R.C. 119.032 review dates: 07/01/2018

Certification: CERTIFIED ELECTRONICALLY

Date: 10/07/2013

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02

MHTL 3334-15-01

**Effective Date: January 2, 2015**

Unless stated otherwise in rule 4731-11-09 or elsewhere in the Administrative Code, the following rule applies to health care services covered by the medicaid program and delivered using telemedicine.

(A) For purposes of this rule, the following definitions apply:

- (1) "Telemedicine" is the direct delivery of services to a patient via synchronous, interactive, real-time electronic communication that comprises both audio and video elements. The following activities are not telemedicine:
  - (a) The delivery of service by electronic mail, telephone, or facsimile transmission;
  - (b) Conversations between practitioners regarding the patient without the patient present either physically or via synchronous, interactive, real-time electronic communication; and
  - (c) Audio-video communication related to the delivery of service in an intensive care unit.
- (2) "Distant site" is the physical location of the treating practitioner at the time a health care service is provided through the use of telemedicine.
- (3) "Originating site" is the physical location of the patient at the time a health care service is provided through the use of telemedicine. The originating site may be one of five places:
  - (a) The office of a medical doctor, doctor of osteopathic medicine, optometrist, or podiatrist;
  - (b) A federally qualified health center, as defined in chapter 5160-28 of the Administrative Code, rural health center, or primary care clinic;
  - (c) An outpatient hospital;
  - (d) An inpatient hospital; or
  - (e) A nursing facility.

(B) Requirements and responsibilities.

- (1) The originating site is responsible for documenting the medical necessity of the health care service provided through the use of telemedicine, for securing the informed consent of the patient, and for developing and maintaining progress notes.
- (2) The rendering practitioner at the distant site must be a medical doctor, doctor of osteopathic medicine or licensed psychologist or a federally qualified health center, as defined in chapter 5160-28. When the rendering provider is a federally qualified health center the rendering practitioner must be a medical doctor, doctor of osteopathic medicine or licensed psychologist.
- (3) The distant site is responsible for maintaining documentation of the health care service delivered through the use of telemedicine and for sending progress notes to the originating site for incorporation into the patient's records.

(C) Coverage.

- (1) Payment may be made for the following health care services delivered at the distant site:
  - (a) Evaluation and management services characterized as "office or other outpatient services";
  - (b) Evaluation and management services characterized as either "office or other outpatient consultations" or "inpatient consultations"; or
  - (c) Psychiatry services characterized as "psychiatric diagnostic procedures", "psychotherapy," "pharmacologic management," or "interactive complexity."

(2) When the originating site is located within a five mile radius from the distant site, providers at the distant or originating site are not eligible for payments related to telemedicine under this rule.

(D) Claim payment.

- (1) The distant site provider may submit a professional claim for the health care service delivered through the use of telemedicine. No institutional (facility) claim may be submitted by the distant site provider for the health care service delivered through the use of telemedicine. All appropriate codes and modifiers must be reported.
- (2) An originating site provider that is neither an inpatient hospital nor a nursing facility may submit a claim for a telemedicine originating fee. If such an originating site provider renders a separately identifiable evaluation and management service to the patient on the same date as the health care service delivered through the use of telemedicine, the provider may submit either a claim for the evaluation and management service or the telemedicine originating fee with the appropriate modifier. No originating site provider may receive both a telemedicine originating fee and payment for an evaluation and management service provided to a patient on the same day.
- (3) The payment amount for a health care service delivered through the use of telemedicine, a telemedicine originating fee, or an evaluation and management service is the lesser of the submitted charge or the maximum amount shown in Appendix DD to rule 5160-1-60 of the Administrative Code for the date of service.

Effective: 01/02/2015

Five Year Review (FYR) Dates: 01/02/2020

Certification: CERTIFIED ELECTRONICALLY

Date: 12/23/2014

Promulgated Under: 119.03

Statutory Authority: 5164.02, 5164.95

Rule Amplifies: 5164.02, 5164.95

MHTL 3334-13-01

**Effective Date: January 1, 2013**

**Most Current Prior Effective Date: August 2, 2011**

- (A) The following claims for services rendered to medicaid consumers are exempt from this rule:
- (1) Claims for services provided through medicaid managed care plans must be submitted in accordance with Chapter 5101:3-26 of the Administrative Code; and
  - (2) Claims submitted by nursing facility providers must be submitted in accordance with rules 5101:3-1-05, 5101:3-1-08, and 5101:3-3-39.1 of the Administrative Code.
  - (3) Claims submitted by a provider or type of provider required by the office of medical assistance to submit claims in a format other than the electronic claims submission formats provided in paragraph (B) of this rule.
- (B) All other claims, except for a state agency that has an interagency agreement with ~~ODJFS~~ the office of medical assistance (OMA) to submit claims in a different format, must be submitted to the ~~ODJFS~~ OMA through one of the following formats:
- (1) Electronic data interchange (EDI) in accordance with standards established under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. EDI formats for claims submission include:
    - (a) The "837 Health Care Claim Professional" (837P) electronic format;
    - (b) The "837 Health Care Claim Institutional" (837I) electronic format; or
    - (c) The "837 Health Care Claim Dental" (837D) electronic format.
  - (2) The medicaid information technology system (MITS) web portal; or
  - (3) Pharmacy point-of-sale; ~~or~~ ;
  - ~~(4) Hard copy paper claim, with the exception of paragraphs (C)(1) and (C)(2) of this rule, in accordance with standards developed by the national uniform billing committee, the national uniform claim committee or the American dental association. Paper claim formats include:~~
    - ~~(a) The "CMS 1500" professional claim format (rev. 8/2005);~~
    - ~~(b) The "UB-04" institutional claim format (rev. 5/2007); or~~
    - ~~(c) The "American Dental Association" claim format (rev. 2006).~~
- ~~(C) The following claims must be submitted for payment in either the EDI format or through the MITS web portal:~~
- ~~(1) Medicare crossover claims in accordance with rule 5101:3-1-05 of the Administrative Code; or~~
  - ~~(2) Claims that indicate other third party insurance plan information in accordance with rule 5101:3-1-08 of the Administrative Code.~~
- ~~(D)~~ (C) Claims must be submitted pursuant to the national correct coding initiative and coding standards set forth in the following guides and described in 45 CFR 162.1000 and 45 CFR 162.1002 ~~(as in effect 12/07/2010)~~:
- (1) The healthcare common procedure coding system;
  - (2) The current procedure terminology codebook;
  - (3) The current dental terminology codebook; or
  - (4) The international classification of diseases codebook.

~~(E)~~(D) Timely filing limitations.

- (1) Original claim submissions.
  - (a) Claims other than inpatient hospital claims must be received by ~~ODJFS~~OMA within three hundred sixty-five days of the actual date the service was provided.
  - (b) Inpatient hospital claims must be received within three hundred sixty-five days from the date of discharge.
  - (c) Claims received beyond three hundred sixty-five days from the actual date of service or hospital discharge will be denied except when the provisions of paragraph ~~(F)~~(E) of this rule apply.
  - (d) For purposes of this rule, the date of receipt is the date ~~ODJFS~~OMA assigns an internal control number.
- (2) Re-submission of denied claims.
  - (a) Claims denied by the ~~department~~OMA may be re-submitted for payment and must be received by the later of the following dates:
    - (i) Three hundred sixty-five days from the actual date of service; or
    - (ii) One hundred eighty days from the date the claim denied, even if this date is beyond three hundred sixty five days from the original date of service.
  - (b) Resubmitted claims received beyond seven hundred thirty days from the actual date of service or hospital discharge will be denied.
- (3) Claims with prior payment by medicare or another insurance plan must be received within one hundred eighty days from the date medicare or the insurance plan paid the claim.

~~(F)~~(E) Exceptions to timely filing requirements.

- (1) When submission of a claim is delayed due to the pendency of an administrative hearing decision by ~~ODJFS~~ the Ohio department of job and family services (ODJFS) or an eligibility determination by a county department of job and family services (CDJFS), the claim must be received within one hundred eighty days from the date of the administrative hearing decision by ODJFS or the eligibility determination by the CDJFS. Documentation showing the date of service and the administrative hearing decision or eligibility determination must be submitted with the claim. In no case shall a delay in processing eligibility information at the CDJFS (as required in rule 5101:1-38-01.2 of the Administrative Code) be a basis for denial of payment under this provision.
- (2) When a claim can not be submitted to ~~ODJFS~~OMA within three hundred sixty five days of the actual date of service due to coordination of benefits delays with medicare and/or other third party payers, the claim must be received by ~~ODJFS~~OMA within one hundred eighty days from the date medicare or the other insurance plan paid the claim.
- (3) When a claim has been submitted and denied and is later found to meet the provisions in paragraph ~~(F)(1)~~(E)(1) or ~~(F)(2)~~(E)(2) of this rule, the claim may be resubmitted with documentation attached to support the delay in submission.

~~(G)~~(F) Adjustments to claims.

- (1) Adjustments to underpaid claims must be submitted within one hundred eighty days from the date medicaid paid the claim.
- (2) Adjustments to overpaid claims must be submitted, and overpayments refunded, to ~~ODJFS~~OMA, within sixty days of discovery.
  - (a) Overpayments are recoverable by ~~ODJFS~~OMA at the time of discovery. Appeal rights under Chapter 119. of the Revised Code may be exercised to the extent provided in accordance with rule 5101:3-1-57 of the Administrative Code. All recoverable amounts

are subject to the application of interest in accordance with rule 5101:3-1-25 of the Administrative Code.

(b) ODJFS OMA will pursue collections by invoice for overpayments that result in a credit balance due to the department OMA and remain outstanding for more than sixty days.

- (3) Adjustments may be submitted through the EDI format or through the MITS web portal.
- (4) ODJFS OMA will no longer accept paper adjustment forms, except in cases where ODJFS OMA determines a paper adjustment must be used for a claim to be adjusted.
- (5) ODJFS OMA will no longer process refund checks from providers for claim overpayments, except when an invoice or letter for collection of an outstanding overpayment has been sent to the provider for an ODJFS OMA audit or review.

~~(H)~~(G) Claims that require a specific ODJFS OMA form to accompany the claim (for example, a claim for a hysterectomy service must have a hysterectomy consent form accompany the claim) may be submitted through the web portal, regular mail, or EDI format.

- (1) Claims submitted via EDI shall be consistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA)-compliant format.
- (2) All supporting documentation shall be submitted with the designated electronic data management system (EDMS) cover sheet.

~~(H)~~(H) Trading partners submitting EDI transactions.

- (1) Trading partners must enroll and receive an ODJFS OMA defined trading partner number in order to submit EDI transactions.
- (2) To become an active trading partner with ODJFS OMA, all trading partners must abide by all ODJFS OMA testing requirements, including the completing of a ninety per cent pass rate for each transaction type tested.
- (3) Only authorized trading partners that are actively submitting and receiving 837 health care claim transaction sets may submit and receive the 270/271 and the 276/277 transaction sets.

Effective:

R.C. 119.032 review dates: 08/01/2016

Certification

Date

Promulgated Under: 119.03

Statutory Authority: 5111.02, 5111.052

Rule Amplifies: 5111.01, 5111.02, 5111.021, 5111.052

Prior Effective Dates: 6/1/78, 6/3/83, 8/1/83 (Emer), 10/1/83, 2/1/84, 10/1/84, 7/1/85 (Emer), 7/11/85 (Emer), 9/30/85, 8/1/86, 10/1/87, 2/1/88, 5/1/89, 7/1/90, 7/1/02, 7/1/03, 10/16/03 (Emer), 1/1/04, 11/15/04, 12/30/04 (Emer), 4/1/05, 3/28/05, 7/1/05, 12/30/05 (Emer), 3/27/06, 12/29/06 (Emer), 3/29/07, 5/23/07, 12/31/07 (Emer), 3/30/08, 12/31/08 (Emer), 3/31/09, 12/31/09 (Emer), 2/1/10, 3/31/10, 8/1/11

**5160-1-19.9 Inquiries Regarding the Status of Claims [Except for Services Provided through a Medicaid Managed Care Program]**

**MHTL 3334-15-05**

**Effective Date: March 22, 2015**

**Most Current Prior Effective Date: January 1, 2004 (No Change)**

- (A) The following options may be used to inquire about the status of claims:**
- (1) The Ohio department of medicaid provider call center;**
  - (2) Interactive voice response (IVR) system;**
  - (3) Electronic data interchange (EDI) submitted as a 276/277 health care claim status request and response transaction format; or**
  - (4) The Ohio medicaid information technology system (MITS) web portal.**
- (B) All of the following conditions must be met prior to submitting written inquiries regarding the status of claims to the department:**
- (1) The provider's accounts receivable have been properly reconciled using the department's medicaid remittance advice statement;**
  - (2) The claim meets claim submission requirements;**
  - (3) The services provided were medicaid covered services; and**
  - (4) Medicaid eligibility of the recipient is verified. Eligibility may be verified by using the Ohio MITS web portal or the 270/271 health care eligibility benefit inquiry and response transaction formats.**

Replaces: 5160-1-19.9

Effective: 03/22/2015

Five Year Review (FYR) Dates: 03/22/2020

Certification: CERTIFIED ELECTRONICALLY

Date: 03/12/2015

Promulgated Under: 119.03

Statutory Authority: 5164.02

Rule Amplifies: 5164.02

Prior Effective Dates: 10/1/87, 5/1/89, 7/1/02, 10/16/03 (Emer.), 1/1/04

**Effective Date: July 3, 2014**

**Most Current Prior Effective Date: [January 1, 2012](#)**

(A) For purposes of this rule, the following definitions apply:

- (1) "Covered entity," as defined by 45 C.F.R. 160.103 (rev. ~~2/2006~~/2014), is a health plan, a health care clearinghouse, or a health care provider that transmits health care information in an electronic format in connection with a transaction covered by this rule. The following definitions apply:
  - (a) "Health plan" is an individual or group health plan that provides, or pays the cost of medical care.
  - (b) "Health care clearinghouse" is a public or private entity, including a billing service, repricing company, community health management information system or community health information system, and value-added networks and switches, that does either of the following functions:
    - (i) Processes or facilitates the processing of health information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction; or
    - (ii) Receives a standard transaction from another entity and processes or facilitates the processing of health information into a nonstandard format or nonstandard data content for the receiving entity.
  - (c) "Health care provider" is a provider of medical or health services, and any person or organization who furnishes, bills for, or is paid for health care services in the normal course of business.
- (2) "Electronic data interchange (EDI) transactions" are transactions developed by standards development organizations recognized by the federal centers for medicare and medicaid services (CMS) and adopted by the Ohio department of ~~job and family services (ODJFS)~~ medicaid (ODM). The different EDI transactions are defined as follows:
  - (a) "ANSI X12 820 premium payment" is a transaction used to make a payment and/or send a remittance advice.
  - (b) "ANSI X12 834 monthly member roster or enrollment/disenrollment in a health plan" is a transaction used to establish communication between the sponsor of the insurance product and the payer.
  - (c) "ANSI X12 835 health care claims payment/remittance advice" is a transaction used to make a payment and/or send an explanation of benefits remittance advice.
  - (d) "ANSI X12 837 health care claim" is a transaction used to submit health care claim billing/encounter information, or both, from providers (institutional, professional, or dental) of health care services to payers, either directly or via clearinghouses.
  - (e) "ANSI X12 270 eligibility, coverage, or benefit inquiry" is a transaction used to inquire about the eligibility, benefits or coverage under a subscriber's health care policy.
  - (f) "ANSI X12 271 eligibility, coverage, or benefit information response" is a transaction used to communicate information about, or changes to, eligibility, benefits, and/or coverage.
  - (g) "ANSI X12 276 health care claim status request" is a transaction used to request the status of a health care claim.

- (h) "ANSI X12 277 health care claim status notification" is a transaction used to respond to a request regarding the status of a health care claim.
- (i) "ANSI X12 278 health care services review information request and response" is a transaction used to transmit health care service information for the purpose of referral, certification/authorization, notification, or reporting the outcome of a health care services review.

(3) "Eligibility verification services (EVS) vendor" means an entity with which a state contracts for the purpose of providing Medicaid recipient eligibility verification data to state-approved Medicaid Providers that provide medical services to persons who are eligible for Medicaid assistance.

~~(3)~~(4) "Trading partner" is a covered entity or EVS vendor that submits, receives, routes, and/or translates EDI transactions directly related to the administration or provision of medical assistance provided under a public assistance program.

(B) Trading partners submitting EDI transactions.

(1) Trading partners must meet the definition of a covered entity as defined in paragraph (A)(1) of this rule ~~and be a health plan, a healthcare clearinghouse or a health care provider~~ or be an EVS vendor.

(2) To enroll as a medicaid EDI trading partner with ~~ODJFS~~ODM under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, and be issued a trading partner number, a covered entity must complete the following:

(a) Complete and submit the Medicaid ~~The JFS 01957~~ "Trading Partner Profile" by completing the trading partner enrollment process ~~form (rev. 5/2006).~~

(b) The JFS 06306 "Designation of an 835 or 834-820 Trading Partner" form (rev. 12/2006). This form is required only if the trading partner will be receiving the 835 remittance advice on behalf of its clients.

(c) A trading partner agreement. Two original trading partner agreements must be signed by an authorized representative of the trading partner and submitted to ~~ODJFS~~ODM. A countersigned original will be returned to the trading partner and must be kept on file.

(3) Once the medicaid trading partner number is assigned, the trading partner is eligible to submit claims, claim status inquiries, or eligibility inquiries for the testing process in accordance with paragraph (C) of this rule.

(C) Testing requirements.

(1) To become an active trading partner with ~~ODJFS~~ODM, all trading partners must abide by all ~~ODJFS~~ODM testing requirements as outlined in this paragraph and in the "Electronic Data Interchange Trading Partner Information Guide." The "Electronic Data Interchange Trading Partner Information Guide" is available at <http://jfs.ohio.gov/OHP/tradingpartners/pdfs/EDITradingPartnerInformationGuide.pdf> ~~(rev. 1/2011)~~ [medicaid.ohio.gov](http://medicaid.ohio.gov).

(a) Trading partners are required to submit three files per the following transaction types that must pass testing: 837 (professional, institutional and dental), 270 (eligibility) and 276 (claim status inquiry).

(b) Trading partners ~~must~~ are only required to test the transaction types that they will be submitting in production.

(c) Each file must contain a minimum of fifty claims, claim status inquiries, or eligibility inquiries.

(d) All EDI files must completely pass X12 integrity testing, HIPAA syntax, and HIPAA situation testing. Trading partners are required to modify their EDI files in accordance with any new federally mandated HIPAA standards.

- (e) During testing, trading partners may submit one claim file per day, per 837 transaction (one professional, one institutional, and one dental) and/or one eligibility inquiry and/or one claim status inquiry per day.
- (f) Test files are considered passing when ninety per cent of the claims submitted pass the test adjudication process. A ninety per cent pass rate must be reached for each transaction type tested.

(D) Trading partners that are not actively submitting and receiving 837 health care claim transaction sets ~~may not submit and receive 270/271 and 276/277 transaction sets~~, but who are actively submitting and receiving 270/271 and 276/277 transaction sets are subject to the following requirements:

- (1) Trading partners must provide, in a manner specified by ODM, a report of all providers by national provider identifier (NPI) that the trading partner represents. The first report is due at the time of initiating a trading partner agreement with ODM. Subsequent reports are due quarterly based on the calendar year, no later than January 1, April 1, July 1 and October 1.
- (2) Trading partners shall be responsible for any breach of information and be held fully liable for any and all costs relating to such a breach.

Effective: 07/03/2014

R.C. 119.032 review dates: 11/01/2016

Certification: CERTIFIED ELECTRONICALLY

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Promulgated Under: 119.03

Statutory Authority: 5164.02

Rule Amplifies: 5162.03, 5164.02

Prior Effective Dates: 10/16/03 (Emer.), 1/1/04, 11/15/04, 5/23/07, 12/11/11

**Effective Date:** *September 1, 2007*

**Most Current Prior Effective Date:** [May 30, 2002](#)

Payment for medicaid covered services rendered to medicaid consumers may be made only to a medicaid provider except as provided in this rule.

- (A) Payment for medicaid covered services may be made in accordance with paragraphs (A)(1) to (A)(3) of this rule:
- (1) Payment may be made to or through a billing agency or accounting firm that prepares invoices or receives payments in the name of the medicaid provider if the compensation meets the following requirements:
    - (a) It is related to the cost of processing the billing;
    - (b) It is not related on a percentage or other basis to the amount that is billed or collected;  
and
    - (c) It is not dependent upon the collection of the payment.
  - (2) For individual practitioners, payment may be made as follows:
    - (a) To the employer of the practitioner, if the practitioner requires as a condition of employment to turn over his or her fees to the employer;
    - (b) To the facility in which the service is provided, if the practitioner has a contract under which the facility submits the claim; or
    - (c) To a foundation, plan, or similar organization operating an organized health care delivery system, such as a managed care organization, if the practitioner has a contract under which the organization submits the claim.
  - (3) Payment may be made by reassignment from the medicaid provider to a government agency or reassignment by a court order.
- (B) Medicaid providers are responsible for any payment received under their provider agreement in accordance with rule 5101:3-1-17.2 of the Administrative Code. The assignment of provider claims must be in accordance with services rendered by valid providers under Chapter 5101:3-1 of the Administrative Code. Medicaid providers that receive payment for any assignment of provider claims that is false or misleading may be prosecuted under federal and state law.
- (C) Payment for any covered service rendered to a medicaid consumer may not be made to or through a factor. A "factor" is defined as an individual or an organization such as a collection agency or service bureau that advances money to a provider for accounts receivable that have been assigned, sold, or otherwise transferred to such an organization or an individual for an added fee or a deduction of a portion of such accounts receivable.

Replaces: 5101:3-1-23

Effective: 09/01/2007

R.C. 119.032 review dates: 09/01/2012

Certification: CERTIFIED ELECTRONICALLY

Date: 08/09/2007

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02

Prior Effective Dates: 6/3/83, 2/1/84, 10/1/84, 7/1/85 (Emer), 9/30/85, 10/1/87, 5/30/02

~~\*Formerly\*~~ 5101:3-1-25 Interest on Overpayments Made to Medicaid Providers[Except for Medicaid Contracting Managed Care Plans (MCPs)]

[MHTL 3334-14-05](#)

**Effective Date: September 4, 2014**

**Most Current Prior Effective Date: [September 1, 2007](#)**

- (A) Except for medicaid contracting managed care plans (MCPs), and nursing facilities and intermediate care facilities for individuals with intellectual disabilities (ICF/IID) ~~the mentally retarded (ICF-MR)~~ rate recalculations performed in accordance with sections 5165.41 and 5124.41 of the Revised Code~~rule 5101:3-3-22 of the Administrative Code~~, any provider of services or goods contracting with the Ohio department of medicaid (ODM)~~job and family services (ODJFS)~~ pursuant to Title XIX of the Social Security Act who, without intent, obtains payment from the medicaid program~~under Chapter 5111. of the Revised Code~~ in excess of the amount to which the provider is entitled becomes liable for payment of interest charged in accordance with this rule on the amount of the overpayment. The interest rate charged is the average bank prime rate in effect on the first day of the calendar quarter during which the provider receives notice of the excess payment, ~~maximum real estate mortgage rate applicable on the date the payment was made to a provider~~ as determined in accordance with section 5164.60~~division (A) of section 1343.01~~ of the Revised Code, ~~as amended~~. Interest payments shall be calculated on the basis of simple interest.
- (B) Interest payments shall be charged on a daily basis for the period from the date the payment was made to the date upon which repayment is received by the state.
- (C) The "date payment was made" shall mean the following:
- (1) For any reasonable cost basis, prospective payment basis, or other cost-related rate final settlement issued by ~~ODJFS~~ODM, the "date payment was made" shall be ten days from the date the final settlement is received by the provider as shown by the U.S. postal service return receipt slip, with a notice of rights to appeal pursuant to Chapter 119. of the Revised Code.
  - (2) For audits conducted in accordance with rule ~~5101:3-1-27~~5160-1-27 of the Administrative Code, the "date payment was made" shall be the latest date a warrant or electronic funds transfer (EFT) was issued to pay an item included in the random sample.
  - (3) For post-payment reviews conducted in accordance with rule ~~5101:3-1-27~~5160-1-27 of the Administrative Code, the "date payment was made" shall be the latest date a warrant or EFT was issued in payment of a claim that is included in the review.
- (D) The "date upon which repayment is received by the state" shall mean the following:
- (1) In the case of repayment by check or EFT, the "date upon which repayment is received by the state" shall be the date the repayment is date-stamped by ~~ODJFS~~ODM, the date the repayment is deposited as certified mail with the U.S. postal service, or the date the EFT is deposited in the state's account.
  - (2) In the case of repayment by one or more offsets implemented by the ~~ODJFS~~ODM claims adjustment unit against future claims payments owed to the provider, the "date upon which repayment is received by the state" shall be the date on which the total amount of the overpayment is fully recovered.
- ~~(E)~~
- ~~(F)~~(E) ~~ODJFS may waive interest when repayment is made in full and the amount of interest owed by any single provider is less than fifty dollars.~~ ODJFSODM may waive interest when voluntary repayment of individual claims is made by a provider before any notification by ODJFSODM that an overpayment has occurred.

R.C. 119.032 review dates: 06/13/2014 and 09/04/2019

Certification: CERTIFIED ELECTRONICALLY

Date: 08/25/2014

Promulgated Under: 119.03

Statutory Authority: 5164.02

Rule Amplifies: 5164.60

Prior Effective Dates: 8/1/82 (Temp), 11/1/82, 2/1/84, 10/1/87, 5/30/02, 09/01/2007

[MHTL 3334-07-04](#)

**Effective Date:** *September 1, 2007*

**Most Current Prior Effective Date:** [May 30, 2002](#)

- (A) As specified in division ~~level-designation~~ 5101:3 of the Administrative Code, all medicaid providers are required to keep such records as are necessary to establish medical necessity, and to fully disclose the basis for the type, extent, and level of the services provided to medicaid consumers, and to document significant business transactions. Medicaid providers are required to provide such records and documentation to the Ohio department of job and family services (ODJFS), the secretary of the federal department of health and human services, or the state medicaid fraud control unit upon request.
- (B) For purposes of this rule, the following definitions apply:
- (1) "Audit" means a formal postpayment examination, made in accordance with generally accepted auditing standards, of a medicaid provider's records and documentation to determine program compliance, the extent and validity of services paid for under the medicaid program and to identify any inappropriate payments. The department shall have the authority to use statistical methods to conduct audits and to determine the amount of overpayment. An audit may result in a final adjudication order by the department.
  - (2) "Hold and Review" means a process of prepayment review of a medicaid provider's claims, including client records, medical records, or other supporting documentation, for determination of appropriate claims payment or reimbursement.
    - (a) Hold and review administered by ODJFS will be done in accordance with rule 5101:3-1-27.1 of the Administrative Code.
    - (b) Hold and review administered by state agencies other than ODJFS will be done in accordance with rule 5101:3-1-27.2 of the Administrative Code.
  - ~~(2)~~(3) "Review" means ~~an informal, prepayment or postpayment,~~ a postpayment limited scope investigation, special project and/or special analysis, examination or monitoring of a medicaid provider's records, claims and/or supporting documentation to determine quality of care, compliance with accepted standards of care, program compliance and/or validity of services rendered, billed, or paid for under the medicaid program. A review may result in an educational letter, the denial of invalid services or claims, a corrective action plan subject to department approval, and/or the collection of overpayments under rule 5101:3-1-19.8 of the Administrative Code.
  - ~~(3)~~(4) "Notice of operational deficiency" means a ~~formal~~ written notice issued by the department, ~~pursuant to an audit and review,~~ that identifies provider conduct, treatment or practices that are determined by the department not to be in the best interests of the consumer or the medicaid program and/or are noncompliant with the regulations governing the medicaid program and that must be corrected. The notice states the nature of the deficiency, the time period that the provider has to correct the deficiency and the person within the department the provider is to contact to verify that the deficiency has been corrected.
- (C) Records, documentation and information must be available regarding any services for which payment has been or will be claimed to determine that payment has been or will be made in accordance with applicable federal and state requirements. For the purposes of this rule, an invoice constitutes a business transaction but does not constitute a record which is documentation of a medical service.
- (D) Various methods of audit and review will be utilized in all cases of suspected waste and abuse, in accordance with rule 5101:3-1-29 of the Administrative Code. If waste and abuse are apparent, the department will take action to gain compliance and recoup inappropriate payments.

- (E) The provider must maintain all records as stipulated in this rule and rule 5101:3-1-17.2 or Chapter 5101:3-3 of the Administrative Code, as applicable.
- (F) All records, documentation and/or information requested in accordance with paragraph (B) of this rule shall be submitted to the department or its' designee, in an appropriate manner as determined by the department. Records subject to audit and review must be produced at no cost to the department.
  - (1) Records subject to audit and review must be made available for examination in the time period described in rule 5101:3-1-17.2 of the Administrative Code, or as determined by the department or its' designee. Failure to supply requested records, documentation and/or information as indicated in this rule will result in no payment for outstanding services.
  - (2) In all situations the department has the authority to conduct an on-site visit with the provider at the provider's location for the examination or collection of records, and/or for compliance verification. Upon such occasions, as deemed necessary by the department or its' designee, a member of the provider's staff is to be assigned to assist in collecting the information. Upon request from the department, the provider will photocopy or make the applicable records available for photocopying.
  - (3) Services billed to and reimbursed by the department, which are not validated in the consumers record, are subject to recoupment through the audit and review process described in this rule.

Effective: 09/01/2007

R.C. 119.032 review dates: 02/12/2007 and 09/01/2012

Certification: CERTIFIED ELECTRONICALLY

Date: 08/09/2007

Promulgated Under: 119.03

Statutory Authority: 5111.02, 5111.10, 5111.85

Rule Amplifies: 5111.10, 5111.02, 5111.85

Prior Effective Dates: 4/7/77, 7/1/80, 10/1/84, 10/1/87, 7/1/90, 8/1/96, 5/30/02

**MHTL 3334-07-04**

***Effective Date: September 1, 2007***

- (A) "Hold and Review" is defined in accordance with rule 5101:3-1-27 of the Administrative Code.
- (1) Hold and review without prior notification.
- (a) The Ohio department of job and family services (ODJFS) may place a medicaid provider's claim(s) payment on hold and review, in whole or in part, without first notifying the provider for the following reasons:
- (i) In response to allegations of fraud or other willful misrepresentation of claims submission; or
- (ii) When a provider has been indicted for a criminal offense.
- (b) ODJFS shall notify the provider in writing within ten business days that the provider's claims have been, and will continue to be, subject to hold and review. The notice shall describe the documentation needed to review the claims placed on hold and review along with the items stated in paragraph (E)(1) to (E)(6) of this rule.
- (2) Hold and review with prior notification.
- (a) ODJFS may place a medicaid provider's claim(s) payment on hold and review, in whole or in part, with prior notice to the provider under the following circumstances:
- (i) When the information is used to complement or follow up a provider certification or other quality review process;
- (ii) Upon request from the office of the attorney general, the office of inspector general or the auditor of state;
- (iii) A medicaid provider's agreement has been proposed for termination for reasons other than those stated in paragraph (A) of this rule; or
- (iv) For reasons otherwise necessary to assure the basic integrity of claims submission and payment.
- (b) ODJFS will notify the provider in writing within ten business days before the effective start date of the hold and review.
- (B) Review of the medicaid provider's claims and documentation for the hold and review process is subject to the provisions of rule 5101:3-1-27 of the Administrative Code.
- (C) The hold and review may be applied without regard to date of service. Claims subject to the hold and review process include any claims for payment received by ODJFS after the effective date of the hold and review even if such claims are for dates of service that occurred prior to the effective date of the hold and review.
- (D) Failure by ODJFS to notify a provider of a hold and review shall not impede the agency from taking actions under this rule.
- (E) The notice from ODJFS shall:
- (1) State the general reasons for the withholding of the medicaid provider's claims payments, but need not disclose any specific information concerning an ongoing investigation involving alleged fraud and/or willful misrepresentation;
- (2) State the effective date ODJFS implements the hold and review process;
- (3) State the types of services and claims, in whole or in part, that will be subject to the hold and review process. Any claims received by ODJFS on or after the date of written notification may

be subject to hold and review even if such claims are for dates of service that occurred prior to the effective date of the hold and review;

- (4) State the documentation required to be submitted to ODJFS by the provider:
- (a) Except for medicaid providers required to submit medical claims to ODJFS electronically, all claims from providers placed on hold and review must be submitted in non-electronic (paper) format.
  - (b) Providers who must submit medical claims electronically must submit paper documentation supporting each claim submitted electronically. These claims will not be processed until both the claim and the supporting documentation are reviewed by ODJFS.
- (5) Inform the provider of the right to submit evidence for consideration to ODJFS;
- (6) State the contact at ODJFS for questions regarding the hold and review process.
- (F) ODJFS may, if appropriate, send copies of the notice to local, state and federal entities that are involved in the review or that need to be aware of the review in order to assure the integrity of claims submission and payment.
- (G) No later than one hundred twenty days from the date ODJFS holds a claim for review, ODJFS shall forward the claim for adjudication if it is determined that the documentation supports the validity of the claim, or for denial processing if the documentation submitted does not support that paying the claim would be in compliance with law or if the provider fails to submit the requested supporting documentation to ODJFS. If the review results in ODJFS concluding that the provider has a pattern of submitting claims that are not in compliance with law, ODJFS may issue a "Notice of Operation Deficiency" to the provider and continue to hold and review the provider's claims until the operational deficiency is eliminated.
- (H) Medicaid providers are not entitled to a hearing under Chapter 119. or section 5111.06 of the Revised Code for any action taken by ODJFS under this rule.

Effective: 09/01/2007

R.C. 119.032 review dates: 09/01/2012

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Date: 08/09/2007

Promulgated Under: 119.03

Statutory Authority: 5111.02, 5111.10, 5111.85

Rule Amplifies: 5111.10, 5111.02, 5111.85

5160-1-27.2 Medicaid Hold and Review Process for Medicaid Claims Paid Through State Agencies Other Than the Ohio Department of Job and Family Services

**\*Formerly\*** 5101:3-1-27.2 Medicaid Hold and Review Process for Medicaid Claims Paid Through State Agencies Other Than the Ohio Department of Job and Family Services

**MHTL 3334-07-04**

***Effective Date: September 1, 2007***

- (A) "Medicaid administrative agency" means a state agency other than the Ohio department of job and family services (ODJFS) that:
- (1) Administers a component of the medicaid program under the terms of a contract with ODJFS under section 5111.91 of the Revised Code; and
  - (2) Pays claims for medicaid services or reimburses local entities for claims paid for medicaid services.
- (B) "Hold and Review" is defined in accordance with rule 5101:3-1-27 of the Administrative Code.
- (C) Hold and review may be initiated by ODJFS or a medicaid administrative agency for the following reasons:
- (1) When the information is used to complement or follow-up a provider or certification or other quality review process;
  - (2) In response to allegations of fraud or willful misrepresentation of claims submission;
  - (3) Upon the request of the office of the attorney general, the office of inspector general, or the auditor of state;
  - (4) When a provider's medicaid provider agreement is subject to termination;
  - (5) When a provider has been indicted for a criminal offense; or
  - (6) For reasons otherwise necessary to assure the basic integrity of claims submission and payment.
- (D) The hold and review may be applied without regard to date of service. Claims subject to the hold and review process, may include any claims for payment received by ODJFS, the medicaid administrative agency, or a local entity that pays medicaid providers directly, after the effective date of the hold and review even if such claims are for dates of service that occurred prior to the effective date of the hold and review.
- (E) Hold and review initiated by medicaid administrative agencies.
- (1) The medicaid administrative agency shall have formal written approval from ODJFS to initiate a hold and review process.
  - (2) The medicaid administrative agency may recruit the assistance of local governmental entities to review records subject to hold and review.
  - (3) The medicaid administrative agency may initiate hold and review without prior notification to the provider when the medicaid administrative agency receives a request to initiate hold and review from the office of the attorney general, the office of inspector general, the auditor of state, or ODJFS.
  - (4) When the medicaid administrative agency initiates hold and review without prior notification to the provider, the medicaid administrative agency shall provide written notice to the provider, including a copy of ODJFS written approval within ten business days of initiating a hold and review.
  - (5) The medicaid administrative agency may initiate hold and review with prior notification to the provider for any purpose contained in paragraph (C) of this rule. The medicaid administrative

agency shall notify the provider at least ten business days prior to subjecting the provider's claims to hold and review.

- (6) For claims payment that the medicaid administrative agency pays directly to the medicaid provider, the medicaid administrative agency may subject the medicaid provider's claim(s) payment, in part or in whole, to hold and review.
- (7) For reimbursements the medicaid administrative agency makes to local entities for claims that the local entity pays to the medicaid provider directly, the medicaid administrative agency:
  - (a) May require the local entity to hold the medicaid provider's claim(s) payment for claims subject to hold and review;
  - (b) May deny reimbursement to the local entity for the claims on which the hold and review was requested after allowing the local entity a reasonable time to comply; and
  - (c) Shall not deny reimbursement to the local entity for claims that the local entity paid prior to the request.
- (8) A failure by the medicaid administrative agency to notify a provider of a hold and review process shall not impede the agency from taking actions under this rule.
- (9) Review of the medicaid provider's claims and documentation for hold and review is subject to the provisions of rule 5101:3-1-27 of the Administrative Code.
- (10) The notice from the medicaid administrative agency shall:
  - (a) State the general reasons for subjecting the medicaid provider's claims to hold and review, but need not disclose any specific information concerning an ongoing investigation involving alleged fraud and/or willful misrepresentation;
  - (b) State the date the medicaid administrative agency implements the hold and review;
  - (c) State the types of services and claims that are subject to hold and review;
  - (d) State the documentation required to submit to the medicaid administrative agency;
  - (e) Inform the provider of the right to submit evidence for consideration to the medicaid administrative agency; and
  - (f) State the contact at the medicaid administrative agency for questions regarding the hold and review and where to send the requested documentation.
- (11) The medicaid administrative agency shall send copies of the notice to all local, state, and federal entities that are involved in the review or that need to be aware of the review in order to assure the integrity of claims submission and payment.
- (12) Providers who submit medical claims electronically may be required under this rule to submit paper documentation supporting each claim submitted electronically. These claims will not be processed until both the claim and the supporting documentation are reviewed by the medicaid administrative agency.
- (13) No later than one hundred twenty days from the date the medicaid administrative agency holds a claim for review, the medicaid administrative agency shall forward the claim for adjudication if it is determined that the documentation submitted supports the validity of the claim, or for denial if the documentation submitted does not support that the claim would be in compliance with the law or if a provider fails to submit the requested supporting documentation. If a review results in the medicaid administrative agency concluding that the provider has a pattern of submitting claims that are not in compliance with the law, the medicaid administrative agency may request ODJFS to issue a 'notice of operational deficiency' to the provider and may continue to hold and review the providers claims until the ODJFS determines that the operational deficiency is eliminated.

(F) Hold and review process initiated by ODJFS.

- (1) ODJFS may require a medicaid administrative agency to initiate a hold and review described in this rule or to cooperate in a hold and review initiated by ODJFS under rule 5101:3-1-27.1 of the Administrative Code.
- (2) In cooperating with a request from ODJFS to initiate a hold and review, medicaid administrative agencies shall:
  - (a) Comply with the provider notification requirements of this rule; and
  - (b) Suspend payment or reimbursement of the claims that are subject to hold and review; and
  - (c) Require local entities to suspend payment for the claims subject to hold and review; and
  - (d) Obtain provider records, including client records, medical records, and other supporting documentation that ODJFS requests as part of the review from local entities and providers; and
  - (e) Participate in the review of records and other supporting documentation when requested by ODJFS; and
  - (f) Provide any other information requested by ODJFS in order to assure accurate tracking and timely resolution of the claims subject to hold and review.
- (3) For claims associated with alcohol and drug addiction services, ODJFS shall rely on the Ohio department of alcohol and drug addiction services to obtain and review provider records, including client records and medical records, as necessary to assure the special confidentiality of these records required by 42 C.F.R., part 2 as amended through October 1, 2006.
- (4) After requesting a hold and review and allowing the medicaid administrative agency a reasonable time to comply, ODJFS may stop drawing from the centers for medicare and medicaid services, and passing to the other agency, the federal match associated with the claims that are subject to the review. ODJFS will not withhold federal match for claims that other agencies or local entities paid prior to the ODJFS request.
- (G) For purposes of determining whether time limits for the submission of claims have been met for claims subjected to hold and review, the date of claims submission shall be the date that the medicaid administrative agency received the original claim from the provider.
- (H) A provider is not entitled to a hearing under Chapter 119. or section 5111.06 of the Revised Code for any action taken by ODJFS or a medicaid administrative agency under this rule.

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R.C. 119.032 review dates: 09/01/2012

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Rule Amplifies: 5111.02, 5111.10, 5111.85

MHTL 3334-09-03

**Effective Date: October 8, 2009**

**Most Current Prior Effective Date: December 30, 2005**

~~(A) The Ohio department of job and family services is required to have in effect a program to prevent and detect fraud, waste, and abuse in the medicaid program. Where cases of suspected fraud or misrepresentation to obtain payment from the medicaid program are detected, providers will be subject to a review or an audit by the department. In all instances of fraud, waste, and abuse, any amount in excess of that legitimately due to the provider will be recouped by the department through its surveillance and utilization review section, the state auditor, or the office of the attorney general. Overutilization of services by a provider, while possibly not considered fraudulent acts, may constitute abuse to the medicaid program. Consequently, in all instances of fraud, waste, and abuse, any amount in excess of that legitimately due to the provider will be recouped by the department through its surveillance and utilization review section, the state auditor, or the office of the attorney general. Waste and abuse results either directly or indirectly in financial losses to the medicaid program, its consumers, or their families. Various methods of audit and review will be utilized to determine waste and abuse. If waste and abuse is suspected or apparent, the department will take action to gain compliance and recoup inappropriate payments through audit and review as stipulated in rule 5101:3-1-27 of the Administrative Code. For purposes of this rule, the following definitions apply:~~

~~(1) "Fraud" is defined as an intentional deception, false statement, or misrepresentation made by a person with the knowledge that the deception, false statement, or misrepresentation could result in some unauthorized benefit to oneself or another person. It includes any act that constitutes fraud under applicable federal or state law. If fraud is suspected or apparent, referral of the case to the attorney general's medicaid fraud control unit and/or the appropriate enforcement officials will be made by the Ohio department of job and family services (ODJFS).~~

~~(2) "Waste and abuse" are defined as practices that are inconsistent with professional standards of care; medical necessity; or sound fiscal, business, or medical practices; and that constitute an overutilization of medicaid covered services and result in an unnecessary cost to the medicaid program.~~

(B) ODJFS shall have in effect a program to prevent and detect fraud, waste, and abuse in the medicaid program. Where cases of suspected fraud to obtain payment from the medicaid program are detected, providers will be subject to a review or an audit by ODJFS. If waste and abuse are suspected or apparent, ODJFS will take action to gain compliance and recoup inappropriate payments through audit and review in accordance with rule 5101:3-1-27 or 5101:3-26-06 of the Administrative Code. ~~For purposes of this rule, the following definitions apply:~~In all instances of fraud, waste, and abuse, any payment amount in excess of that legitimately due to the provider will be recouped by ODJFS through the office of fiscal and monitoring services, the state auditor, or the office of the attorney general.

~~(1) "Fraud" is defined as an intentional deception, false statement or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to oneself or another person. It includes any act that constitutes fraud under applicable federal or state law. If fraud is suspected or apparent, referral of the case to the attorney general's medicaid fraud control unit and/or the appropriate enforcement officials will be made.~~

~~(2) "Waste and abuse" are defined as practices that are inconsistent with professional standards of care; medical necessity; or sound fiscal, business, or medical practices; and that constitute an overutilization of medicaid covered services and result in an unnecessary cost to the medicaid program.~~

(C) Cases of provider fraud, waste, and abuse may include, but are not limited to, the following:

- (1) A pattern of duplicate billing by a provider to obtain reimbursement to which the provider is not entitled.
  - (2) Misrepresentation as to services provided, quantity provided, date of service, or to whom provided.
  - (3) Billing for services not provided.
  - (4) A pattern of billing, certifying, prescribing, or ordering services that are not medically necessary or reimbursable in accordance with rule 5101:3-1-01 of the Administrative Code, not clinically proven and effective, and not consistent with medicaid program rules and regulations ~~and billing instructions~~.
  - (5) Differing charges for the same services to medicaid and non-medicaid consumers. For inpatient hospital services billed by hospitals reimbursed on a prospective payment basis, ~~the department~~ ODJFS will not pay, in the aggregate, more than the provider's customary and prevailing charges for comparable services.
  - (6) Violation of a provider agreement by requesting or obtaining additional payment for covered medicaid services from either the consumer or consumer's family, other than medicaid co-payments as designated in rule 5101:3-1-09 of the Administrative Code.
  - (7) Collusive activities, involving the medicaid program, between a medicaid provider and any person or business entity ~~which would involve the medicaid program~~.
  - (8) Misrepresentation of cost report data so as to maximize reimbursement and/or misrepresent gains or losses.
  - (9) Billing for services that are outside the current license limitations or specific practice parameters of the person supplying the service.
  - (10) Misrepresenting by commission or omission any information on the provider enrollment form or included in the provider enrollment packet.
  - (11) Ordering excessive quantities of medical supplies, drugs and biologicals, or other services.
- (D) ~~The department will not pay for services subsequent to the date of termination which have been prescribed, ordered, or rendered by a provider who has been terminated under the medicaid program as defined in rule 5101:3-1-17.6 of the Administrative Code.~~ ODJFS will not pay for services prescribed, ordered, or rendered by a provider, when those services were prescribed, ordered, or rendered by that provider after the date the provider was terminated under the medicaid program in accordance with rule 5101:3-1-17.6 of the Administrative Code.
- (E) ~~There are~~ In instances when ~~the~~ a provider suspects that there may be ~~consumer fraud, misrepresentation, or overutilization of services.~~ When fraud, waste, or ~~and~~ abuse by a consumer, is suspected, the provider should contact the local county department of job and family services. Cases of consumer fraud, waste, and abuse may include, but are not limited to:
- (1) Alteration, sale, or lending of the medicaid card to others for securing medical services, or other related criminal activities.
  - (2) Receiving excessive medical visits and services.
  - (3) Obtaining services outside of those personally needed and used by the consumer.
- (F) ~~Responsibility for the business practices of employees must be assumed by providers. It is presumed~~ Providers must assume responsibility for the business practices of employees. ODJFS presumes that providers will take the necessary time to thoroughly acquaint themselves and their employees with all rules relative to their participation in the medicaid program. Ignorance of medicaid program rules will not be an acceptable justification for violation of department rules.

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MHTL 3334-11-03

**Effective Date: August 2, 2011**

**Most Current Prior Effective Date: August 11, 2005**

- (A) Reimbursement for some items and/or services covered under the medicaid program is available only upon obtaining prior authorization from the Ohio department of job and family services (ODJFS). Prior authorization must be obtained from ODJFS or its designee by the provider before the services are rendered or the items delivered, unless the services meet the provisions in paragraph (F) of this rule. ~~Items and/or services which require prior authorization are identified in Chapters 5101:3-2 to 5101:3-56 of the Administrative Code. Citations for some of these services are listed in paragraphs (A)(1) to (A)(5) of this rule.~~
- ~~(1) Prior authorization for transplantation services must be obtained by the hospital before the service is rendered in accordance with rule 5101:3-2-07.1 of the Administrative Code.~~
  - ~~(2) In addition to services requiring prior authorization, some hospital inpatient and outpatient services may require pre-certification in accordance with rules 5101:3-2-40 and 5101:3-2-42 of the Administrative Code.~~
  - ~~(3) Prior authorization for out-of state coverage will be made in accordance with rule 5101:3-1-11 of the Administrative Code.~~
  - ~~(4) Prior authorization for long-term care outlier services will be made in accordance with rules 5101:3-3-54.1, 5101:3-3-54.5, and 5101:3-3-87.1 of the Administrative Code.~~
  - ~~(5) Prior authorization for pharmacy services will be made in accordance with Chapter 5101:3-9 of the Administrative Code.~~
- (B) Services, supplies or prescription drugs that require prior authorization by the department are identified in Chapters 5101:3-2 to 5101:3-56 of the Administrative Code.
- (C) All prior authorization requests must be submitted through the medicaid information technology system (MITS) web portal. Paper prior authorization requests will be returned to the provider unprocessed.
- ~~(B) Completed prior authorization forms and any necessary supporting documentation should be mailed or faxed to the location listed at the bottom of the request form. A duplicate copy of each request must be retained in the providers records. Telephone requests for prior authorization will only be accepted for pharmacy services.~~
- ~~(1) The following forms must be used when requesting prior authorization:
    - ~~(a) Requests for authorization of medical services, supplies, equipment or transportation services must be submitted on the JFS 03142 "Prior Authorization" form (rev. 2/2003).~~
    - ~~(b) Requests for the authorization of dental services must be submitted on the JFS 03612 "Prior Authorization for Dental Services" form (rev. 3/2003).~~
    - ~~(c) Requests for the authorization of medically necessary transport must be submitted on the JFS 03452 "Practitioner Certification of Medical Necessity for Ambulette Transportation" form (rev. 07/2003) and must accompany form JFS-03142.~~~~
  - ~~(2) Requests for prior authorization submitted to ODJFS or its designee must include correct HCPCS or CPT code(s) for that date of service in accordance with rule 5101:3-1-19.3 of the Administrative Code.~~

- (3) ~~When a request for prior authorization does not include documentation required for review of medical necessity, the request will be denied. The provider may submit a new request with the required documentation.~~
- (D) When the prior authorization request has been processed by ODJFS or its designee, the provider will receive notification indicating the decision for each ~~item and/or service requested~~ service, supply or prescription drug. ~~Reimbursement by ODJFS is limited to those items as specified in the physicians orders and indicated in the approval notification~~ Only those services, supplies or prescription drugs approved in the prior authorization notice will be reimbursed.
- (E) When a request for prior authorization has been approved, the notification will include a prior authorization (PA) number. In order for the provider to be reimbursed, the provider must use the assigned PA number when submitting ~~on~~ the medicaid claim for payment.
- (F) In situations where the provider considers a delay in providing ~~items and/or~~ services, supplies or prescription drugs requiring prior authorization to be detrimental to the health of the consumer, the services, supplies or prescription drugs may be rendered or ~~item~~-delivered and approval for reimbursement sought after the fact.
- (G) When a request for prior authorization is denied, ODJFS or its designee will issue a notice of medical determination and a right to a state hearing to the consumer. A copy of this denial notice will be sent to the county department of job and family services to be filed in the consumer's case record. Providers will also be notified of the denial.
- (G) ~~Reimbursement for a prior authorized service or item is contingent upon:~~
- (1) ~~The consumer being eligible for medicaid at the time the service is rendered.~~
  - (2) ~~The provider renders services in accordance with the rules contained in Chapters 5101:3-2 to 5101:3-56 of the Administrative Code.~~
  - (3) ~~The reduction of benefits by third-party payers, including medicare, have been properly applied to the request for payment from ODJFS.~~
  - (4) ~~ODJFS's timely filing limitations for claims have not been violated in accordance with rule 5101:3-1-19.3 of the Administrative Code.~~
  - (5) ~~The determination of medical necessity by ODJFS or its designee has been met in accordance with rule 5101:3-1-01 of the Administrative Code.~~

Effective: 08/02/2011

R.C. 119.032 review dates: 09/20/2010 and 08/01/2016

Certification: CERTIFIED ELECTRONICALLY

Date: 06/20/2011

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02

Prior Effective Dates: 4/7/77, 12/21/77, 12/30/77, 7/1/80, 10/1/87, 7/1/91 (Emer), 9/30/91, 5/30/02, 8/11/05

[MHTL 3334-15-04](#)

**Effective Date: December 31, 2014**

**Most Current Prior Effective Date: [March 27, 2014](#)**

5160-1-60 [Appendix DD](#)

- (A) The medicaid payment for a covered procedure, service, or supply constitutes payment in full and may not be construed as a partial payment when the payment amount is less than the provider's submitted charge. A provider may not collect from a medicaid recipient nor bill a medicaid recipient for any difference between the medicaid payment and the provider's submitted charge, nor may a provider ask a medicaid recipient to share in the cost through a deductible, coinsurance, copayment, or other similar charge other than medicaid copayments as defined in rule 5160-1-09 of the Administrative Code. Nothing in agency 5160 of the Administrative Code, however, precludes a provider from requesting payment, collecting, or waiving the collection of medicare copayments from a medicaid recipient for medicare part D services. Medicaid recipient liability provisions set forth in rule 5160-1-13.1 of the Administrative Code do not apply to medicare part D services.
- (B) Providers are expected to submit their usual and customary charge (the amount charged to the general public) on all claims. The medicaid payment amount for a covered service, procedure, or supply is the lesser of the submitted charge or the established medicaid maximum. Medicaid maximum payment amounts for many existing services, procedures, and supplies, particularly services rendered by practitioners of the healing arts, are set forth in the appendix to this rule. The initial maximum payment amount for a covered procedure, service, or supply represented by a new procedure code that takes effect at the beginning of a calendar year is established in accordance with paragraph (J) of this rule. Specific payment amounts or payment formulas set forth in other rules in agency 5160 of the Administrative Code supersede corresponding entries in the appendix to this rule.
- (C) Pursuant to rule 5160-1-08 of the Administrative Code, providers are expected to take reasonable measures to determine any third-party resource available to a medicaid recipient and to file a claim with that third party when required to do so under rule 5160-1-08 of the Administrative Code. When there is a third-party payer, medicaid payment for a covered procedure, service, or supply is the lesser of two amounts:
- (1) The provider's submitted charge; or
  - (2) The medicaid maximum payment amount less the sum of all third-party payments and any applicable medicaid copayment (unless the difference is zero or less, in which case medicaid will make no further payment).
- (D) For services that are subject to a copayment pursuant to rule 5160-1-09 of the Administrative Code, the total medicaid maximum payment amount is reduced by the total medicaid copayment. The provider may collect from the medicaid recipient or bill the medicaid recipient for the total medicaid copayment, which is determined in accordance with the relevant rule of the Administrative Code.
- (E) For a facility service provided by an ambulatory surgery center (ASC), the medicaid maximum payment amount is the surgical group rate indicated by numeric code in the 'current ASC group' column in the section of the appendix to this rule that pertains to ASC services. For dates of service beginning January 1, 2010, nine surgical group rates have been established:
- (1) Group 1: Two hundred forty-six dollars and seventy-eight cents;
  - (2) Group 2: Three hundred thirty-one dollars and seventy cents;
  - (3) Group 3: Three hundred eighty dollars and sixty-six cents;
  - (4) Group 4: Four hundred sixty-eight dollars and fifty-eight cents;
  - (5) Group 5: Five hundred thirty-four dollars and fifty-two cents;
  - (6) Group 6: Seven hundred four dollars and thirty-seven cents;

- (7) Group 7: Seven hundred forty-two dollars and thirty-three cents;
- (8) Group 8: Eight hundred thirteen dollars and twenty-seven cents; and
- (9) Group 9: One thousand thirty-two dollars and seven cents.
- (F) Except as otherwise permitted by federal statute or regulation, the medicaid maximum payment amounts described in this rule must not exceed the established maximum medicare allowed amounts for the same procedures, services, or supplies.
- (G) Medicaid payment is not allowed for non-covered procedures, services, and supplies nor for covered procedures, services, or supplies that are denied by the department as a result of a prepayment review, utilization review, or prior authorization process. (Chapter 5160-2 of the Administrative Code describes how these provisions are applied to inpatient and outpatient hospital services.)
- (H) Additional information about the coverage of and payment for certain procedures is shown in the 'prof/tech split' and 'PC/TC indicator' columns of the appendix to this rule.
- (1) A 'prof/tech split' entry indicates that the procedure is made up of both a professional and a technical component for the time period shown. The indicator denotes the relative proportions of the medicaid maximum payment amount allocated to the professional and technical components. For example, the indicator C means that the medicaid maximum payment amounts for the professional component and for the technical component are, respectively, forty per cent and sixty per cent of the medicaid maximum payment amount for the total procedure. There are thirteen such indicators:
- (a) C: Forty per cent / sixty per cent;
- (b) D: Eighty per cent / twenty per cent;
- (c) F: Ten per cent / ninety per cent;
- (d) G: Twenty per cent / eighty per cent;
- (e) H: Twenty-five per cent / seventy-five per cent;
- (f) I: Thirty per cent / seventy per cent;
- (g) J: Thirty-five per cent / sixty-five per cent;
- (h) K: Fifty per cent / fifty per cent;
- (i) L: Sixty per cent / forty per cent;
- (j) M: Seventy per cent / thirty per cent;
- (k) O: One hundred per cent / zero per cent;
- (l) P: Seventy-five per cent / twenty-five per cent; and
- (m) Q: Ninety per cent / ten per cent.
- (2) A numeric 'PC/TC indicator' entry shows the degree to which a procedure is professional or technical in nature or has a professional or technical component; these numeric values are defined by the centers for medicare and medicaid services (CMS), <http://www.cms.gov>. A lowercase alphabetic 'PC/TC indicator' entry indicates a medicaid payment restriction based on the location in which the procedure is performed (a place-of-service restriction). Meanings of these numeric and alphabetic indicators are summarized in the appendix to this rule.
- (I) The department may set payment limits based on the characteristics of an individual procedure, service, or supply or the relationships between procedures, services, or supplies. For example, payment may be disallowed for a procedure if it is incompatible with another procedure or another procedure makes it redundant. In configuring its claim-processing system, the department may define its own limits, adopt limits established by an authoritative source, or modify limits established by an authoritative source.

(J) The "Healthcare Common Procedure Coding System (HCPCS)" is a numeric and alphanumeric code set maintained and distributed by CMS for the uniform designation of certain medical procedures and related services. Level one of HCPCS consists of "Current Procedural Terminology (CPT)," a comprehensive listing of medical terms and codes published by the American medical association (AMA), <http://www.ama-assn.org>, for the uniform designation of diagnostic and therapeutic procedures in surgery, medicine, and the medical specialties. At the beginning of each calendar year, CMS and the AMA may add procedure codes, discontinue (delete) procedure codes, and revise the descriptions of procedure codes. For a covered procedure, service, or supply represented by a new HCPCS procedure code that takes effect at the beginning of a calendar year, the initial maximum payment amount is set at eighty per cent of the medicare allowed amount. For convenience, a list of such initial maximum payment amounts is posted no later than January first on the department's web site, <http://medicaid.ohio.gov>.

Replaces: 5160-1-60

Effective: 12/31/2014

Five Year Review (FYR) Dates: 12/31/2019

Certification: CERTIFIED ELECTRONICALLY

Date: 12/15/2014

Promulgated Under: 119.03

Statutory Authority: 5164.02

Rule Amplifies: 5162.03, 5162.20, 5164.02, 5164.70 Prior Effective Dates: 07/10/1983, 10/01/1983 (Emer), 12/29/1983, 10/01/1984 (Emer), 12/30/1984, 02/15/1985 (Emer), 05/01/1985, 08/01/1985, 11/27/1985 (Emer), 01/16/1986, 05/09/1986 (Emer), 07/30/1986 (Emer), 10/25/1986, 05/01/1987, 10/01/1987, 01/04/1988, 06/23/1988, 10/01/1988, 01/13/1989 (Emer), 04/13/1989, 09/01/1989 (Emer), 12/01/1989, 05/01/1990, 06/20/1990 (Emer), 09/05/1990, 11/23/1990, 02/17/1991, 05/25/1991, 12/30/1991, 04/01/1992 (Emer), 07/01/1992, 07/31/1992 (Emer), 10/30/1992, 12/31/1992 (Emer), 04/01/1993, 07/01/1993, 11/15/1993, 12/30/1993 (Emer), 03/31/1994, 05/02/1994 (Emer), 07/01/1994, 09/30/1994 (Emer), 12/30/1994 (Emer), 03/30/1995, 08/01/1995, 12/29/1995 (Emer), 02/01/1996 (Emer), 04/04/1996, 12/31/1996 (Emer), 03/31/1997, 08/01/1997, 10/02/1997, 12/31/1997 (Emer), 03/19/1998, 07/01/1998, 12/31/1998 (Emer), 03/31/1999, 12/31/1999 (Emer), 03/20/2000, 12/31/2000 (Emer), 03/30/2001, 12/31/2001 (Emer), 03/29/2002, 07/01/2002, 11/14/2002, 03/24/2003, 07/01/2003, 09/25/2003, 12/08/2003, 01/02/2004 (Emer), 04/01/2004, 10/01/2004, 11/01/2004 (Emer), 01/16/2005, 09/01/2005, 11/17/2005, 12/30/2005 (Emer), 03/27/2006, 07/15/2006, 10/15/2006, 12/29/2006 (Emer), 03/29/2007, 07/26/2007, 12/31/2007 (Emer), 03/30/2008, 07/01/2008 (Emer), 08/21/2008, 11/13/2008, 12/31/2008 (Emer), 03/31/2009, 07/01/2009, 12/24/2009, 12/31/2009 (Emer), 02/01/2010 (Emer), 03/31/2010, 12/06/2010, 12/30/2010 (Emer), 03/30/2011, 09/01/2011, 12/22/2011, 12/30/2011 (Emer), 03/29/2012, 12/31/2012 (Emer), 03/28/2013, 09/01/2013, 12/18/2013 (Emer), 12/31/2013, 03/27/2014 [follow-up to the 12/18/2013 emergency version]

5160-1-60.1 Special Provisions for Reimbursement for Physician Groups Acting as Outpatient Hospital Clinics

**\*Formerly\*** 5101:3-1-60.1 Special Provisions for Reimbursement for Physician Groups Acting as Outpatient Hospital Clinics

**Effective Date: February 1, 2007**

**Most Current Prior Effective Date: [July 24, 1994](#)**

- (A) for physician services rendered on and after the effective date of this rule by physician group practices ~~which~~ that meet the criteria described in paragraphs (B) and (C) of this rule, the reimbursement amounts in appendix DD ~~of~~ to rule 5101:3-1-60 of the Administrative Code, except for CPT codes 80002 to 89399, will be multiplied by 1.4. Pregnancy\_ related services will be reimbursed according to appendix A ~~of~~ to rule 5101:3-4-081 of the Administrative Code from March 3, 1992 through March 31, 1992. Pregnancy services will be reimbursed in accordance with appendix DD ~~of~~ to rule 5101:3-1-60 of the Administrative Code from April 1, 1992. for dates of service May 1, 1994 and thereafter, the following evaluation and management codes will be reimbursed in accordance with appendix DD ~~of~~ to rule 5101:3-1-60 of the Administrative Code: 99211, 99212, 99213, 99214, and 99215. "CPT" as used in this rule is defined in rule 5101:3-1-19.3 of the Administrative Code.
- (B) The physician group practice is physically attached to a hospital ~~which~~ that does not provide physician clinic outpatient services and the hospital and physician group practice have signed a letter of agreement indicating that the physician group practice provides the outpatient hospital clinic service for that hospital.
- (C) The Ohio department of ~~human~~ job and family services provider utilization summary for calendar year 1990 establishes that the physician group practice provides at least forty per cent of the total number of Medicaid physician visits provided in the county in which the physician group practice is located and an aggregate total of at least ten per cent of the physician visits provided in the contiguous counties.

Effective: February 1, 2007

R.C. 119.032 review dates: 10/03/2006

Certification

Date

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02, 5111.021

Prior Effective Dates: 3/3/92 (Emer), 6/1/92, 5/2/94 (Emer), 7/24/94

[MHTL 3334-15-10](#)

**Effective Date: July 1, 2015**

**Most Current Prior Effective Date: [April 22, 1999](#) (No Change)**

(A) For purposes of this rule only:

- (1) "Medicaid covered service" is defined as a service that is eligible for coverage by the Ohio medicaid program and is delivered by a medical provider that qualifies for a medicaid provider agreement.
- (2) "Applicant for reimbursement" is defined as:
  - (a) An individual who has been erroneously determined ineligible for the medicaid program or whose determination was incorrectly delayed, and who is seeking reimbursement for medical expenses incurred during the time period when the individual should have been covered by medicaid but was not due to an error or incorrect delay and for which the applicant paid; or
  - (b) An individual who has been erroneously charged a medicaid co-pay for a service eligible for a co-pay in accordance with 5160-1-09 of the Administrative Code, and who is seeking reimbursement of the co-pay amount incurred during the time period when the individual should not have been subject to a co-pay and for which the applicant paid; or.
  - (c) A person not legally obligated to pay for an individual's medical bills but who does, in fact, contribute payment toward the individual's medical bills incurred during the time period when the individual should have been covered by medicaid but was not due to an error or incorrect delay as specified in paragraph (B)(3) of this rule and for which an applicant paid.

(B) In the case of an erroneous determination of ineligibility or an incorrect delay in determining eligibility, the Ohio department of medicaid (ODM) will directly reimburse an applicant for medical expenses only if all of the following requirements are met:

- (1) The individual was erroneously determined ineligible for medicaid, or the individual was found to be eligible for medicaid but the determination of eligibility was incorrectly delayed, and the date on which the individual received the medicaid-covered service was within the period of coverage for which the individual should have been eligible for medicaid.
- (2) The service was a medicaid-covered service as defined in paragraph (A)(1) of this rule, and the service was not a nursing facility service included in the nursing facility's per diem rate;
- (3) For an erroneous determination of eligibility or an incorrect delay in determining eligibility, the individual requests and receives a documented county department of job and family services (CDJFS) determination of a CDJFS error, or a state hearing, or administrative review, or judicial action to dispute the CDJFS' erroneous finding of ineligibility or incorrect delay in determining eligibility;
- (4) The applicant for reimbursement contacts the provider and requests reimbursement, and the provider either does not agree to reimburse the applicant or does agree to reimburse the applicant but does not do so in a timely fashion;
- (5) Within ninety days from the date the provider does not agree to reimburse the applicant, the applicant requests direct reimbursement from ODM. The applicant can also request direct reimbursement from ODM if the provider does agree to reimburse the applicant but does not do so within ninety days of the date of the applicant's request;
- (6) Within ninety days from the date the applicant asks ODM for direct reimbursement as described in paragraph (B)(5) of this rule, the applicant provides the following documentation to ODM:

- (a) Written verification of a bill from the provider which specifies the medicaid-covered services provided;
- (b) Written verification that the applicant paid the provider;
- (c) Any other documentation that may be requested by ODM, including proof that the provider did not agree to reimburse the applicant, or did agree to reimburse the applicant but did not do so within ninety days of the request, as specified in paragraph (B)(5) of this rule; and
- (d) The name, address, and phone number of the provider who rendered the medicaid-covered services to the applicant and the name of the billing provider.

(C) In the case of an erroneous co-pay, ODM will directly reimburse an applicant for co-pay charges only if all of the following requirements are met:

- (1) The date of service for the co-pay charge was a date in which the applicant for reimbursement was eligible for coverage by ODM.
- (2) The co-pay was applied to a service eligible for a co-pay under provision 5160-1-09 of the Administrative Code.
- (3) The date of service for the co-pay charge was within a date in which the applicant for reimbursement was exempt from co-pay requirements by either 5160-1-09 of the Administrative Code or 42 CFR 447.56 (January 1, 2015).
- (4) The applicant erroneously paid the co-pay.
- (5) The applicant for reimbursement contacts the provider and requests reimbursement, and the provider either does not agree to reimburse the applicant or does not agree to reimburse the applicant but does not do so in a timely fashion.
- (6) Within ninety days from the date the provider does not agree to reimburse the applicant, the applicant requests direct reimbursement from ODM. The applicant can also request direct reimbursement from ODM if the provider does agree to reimburse the applicant but does not do so within ninety days of the date of the applicant's request.
- (7) Within ninety days from the date the applicant asks ODM for direct reimbursement as described in paragraph (B)(5) of this rule, the applicant provides the following documentation to ODM:
  - (a) Written verification of a bill from the provider which specifies the medicaid-covered services provided;
  - (b) Written verification that the applicant paid the provider;
  - (c) Any other documentation that may be requested by ODM, including proof that the provider did not agree to reimburse the applicant, or did agree to reimburse the applicant but did not do so within ninety days of the request, as specified in paragraph (B)(5) of this rule; and
  - (d) The name, address, and phone number of the provider who rendered the medicaid-covered services to the applicant.

(D) Within 90 days of meeting the conditions specified in paragraph (B) or (C), ODM will process the request for reimbursement. Applicants for reimbursement who receive an approval for reimbursement will be reimbursed either the full documented amount of their out-of-pocket medical expenses or the co-pay charges incurred while the individual received medical care.

(E) The bills identified as satisfying a person's spenddown obligation or paid to the county to meet medicaid eligibility are not reimbursable by the medicaid program.

(F) All the provisions set forth in agency 5160 of the Administrative Code remain in effect, except that direct reimbursement by ODM to applicants for reimbursement is permitted under the circumstances set forth in this rule. All notice and hearing provisions set forth in division 5101:6 of the Administrative

Code apply to determinations made under this rule, and hearing officers have authority to direct ODM to make a determination for reimbursement in accordance with this rule.

Replaces: 5160-1-60.2

Effective: 07/01/2015

Five Year Review (FYR) Dates: 07/01/2020

Certification: CERTIFIED ELECTRONICALLY

Date: 04/29/2015

Promulgated Under: 119.03

Statutory Authority: 5164.02

Rule Amplifies: 5164.01, 5164.02

Prior Effective Dates: 4/22/99

5160-1-60.3 Primary care physician rate increase

**\*Formerly\*** 5101:3-1-60.3 Primary care physician rate increase

[MHTL 3334-13-02](#)

**Effective Date: January 1, 2013**

- (A) For dates of service on or after January 1, 2013 through December 31, 2014, medicaid providers with the following specialty designations may receive increased reimbursement for rendering certain primary care services to medicaid-eligible individuals in both the fee for service and managed care populations:
- (1) Family practice,
  - (2) General internal medicine,
  - (3) Pediatric medicine, or
  - (4) A subspecialty recognized by the American board of medical specialties, within family practice, general internal medicine, or pediatric medicine.
- (B) The primary care services subject to the increased payment are represented by current procedural terminology (CPT) evaluation and management procedure codes 99201 to 99499; CPT vaccine administration codes 90460, 90461, and 90471 to 90474; and their successor codes.
- (C) Except for circumstances described in paragraph (D) of this rule, the reimbursement to be paid to a qualified provider specified in paragraph (A) of this rule for rendering a service specified in paragraph (B) of this rule shall be the greater of two amounts:
- (1) The allowed amount applicable to the site of service that is derived from the "Medicare Part B Physician Fee Schedule" for the calendar year in which the service was rendered ([www.cms.gov](http://www.cms.gov)) ; or
  - (2) The same allowed amount calculated with the conversion factor (CF) for calendar year 2009 in place of the CF for the calendar year in which the service was rendered.
- (D) If the provider's billed charge is less than the amount described in paragraph (C) of this rule, the reimbursement to be paid to a qualified provider shall be the billed charge.

Effective: 01/01/2013

R.C. 119.032 review dates: 01/01/2018

Certification: CERTIFIED ELECTRONICALLY

Date: 12/21/2012

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02, 5111.021

**5160-57 (Formerly 5101:3-57)**

MHTL 3334-13-05

**Effective Date: October 1, 2013**

**Most Current Prior Effective Date: January 1, 2012**

- (A) The medicaid provider incentive program (MPIP) is Ohio's program for implementing section 4201 of the American Recovery and Reinvestment Act of 2009 (ARRA), Pub. L. No. 111-5, and the published regulations at 42 C.F.R. Part 495 (as in effect on ~~July 28, 2010~~ January 1, 2013) that establish a program that permits certain eligible professionals and eligible hospitals participating in medicaid programs to receive incentive payments if they are meaningful users of certified electronic health ~~records~~ record (EHR) technology. The incentive payments are not a reimbursement, but are intended to encourage eligible professionals and eligible hospitals to adopt, implement, or upgrade to certified EHR technology and use it in a meaningful manner. MPIP incentive payments will only be made as long as federal funds are available.
- (B) The following medicaid providers are eligible to participate in MPIP:
- (1) Medicaid eligible professionals; and
  - (2) Medicaid eligible hospitals.
- (C) Medicaid eligible professionals:
- (1) Eligible professionals participating in Ohio's MPIP program are subject to the program eligibility rules and regulations published at 42 C.F.R. Part 495 (as in effect on January 1, 2013).
  - ~~(1)~~(2) An eligible professional is limited to the following types of providers, consistent with the scope of practice as it is recognized under Ohio law as applicable for each type of professional:
    - (a) Physicians, including optometrists, in accordance with rule 5101:3-4-01 of the Administrative Code.
    - (b) ~~Dentist.~~ Dentists.
    - (c) Advanced practice nurses as defined in section 4723.43 of the Revised Code.
    - ~~(c)~~ ~~Certified nurse-midwives.~~
    - ~~(d)~~ ~~Nurse practitioners.~~
    - ~~(e)~~(d) Physician assistants (PA) practicing in a federally qualified health center (FQHC) or a rural health clinic ~~center~~ (RHC) that is so led by a PA. "So led" means the PA is the primary provider in a clinic (for example, when there is a part-time physician and the PA is full-time, the PA will be considered as the primary provider); the PA is a clinical or medical ~~medicaid~~ director at a clinical site or practice; or the PA is an owner of an RHC.
  - ~~(2)~~(3) An eligible professional must, for each year of participation in MPIP:
    - (a) Be an enrolled Ohio medicaid provider with an active Ohio medicaid provider agreement.
    - ~~(b)~~ ~~Not be hospital-based.~~
      - ~~(i)~~ ~~An eligible professional is considered hospital-based if ninety per cent or more of the eligible professional's medicaid encounters are furnished in an inpatient hospital (place of service code (POS) 21) or an emergency room (POS 23) setting in the calendar year (CY) prior to the payment year.~~
      - ~~(ii)~~ ~~The hospital-based exclusion does not apply to a medicaid eligible professional qualifying as practicing predominantly through a FQHC or RHC as defined in paragraph (C)(4)(c) of this rule.~~
    - ~~(c)~~(b) Not have received an EHR incentive payment within the current payment year from:

- (i) Another state;
- (ii) MPIP; or
- (iii) The medicare EHR incentive payment program.

~~(3)~~(c) ~~An eligible professional must not~~ Not have a current sanction or exclusion identified at:

- ~~(a)~~(i) The United States department of health and human services, office of inspector general, list of excluded individuals and entities: or
- ~~(b)~~(ii) The Ohio list of excluded providers.

(4) ~~An eligible professional must meet one of the following patient volume criteria:~~

- ~~(a) Have a minimum patient volume of thirty per cent attributable to individuals whose medical services delivered were eligible for and reimbursed by medicaid.~~
- ~~(b) Have a minimum patient volume of twenty per cent attributable to individuals whose medical services delivered were eligible for and reimbursed by medicaid if the provider is a pediatrician.~~
  - ~~(i) For purposes of MPIP only, a pediatrician means a medical doctor, who diagnoses, treats, examines, and prevents diseases and injuries in children. A pediatrician must hold a doctor of medicine (MD) or doctor of osteopathy (DO) degree and hold a current, in good standing board certification in pediatrics through the American board of pediatrics, the American board of surgery, the American board of radiology, the American board of urology or the American osteopathic board of pediatrics.~~
- ~~(c) Practice predominantly through a FQHC or RHC and have a minimum thirty per cent patient volume attributable to needy individual encounters (as defined in paragraph (F)(3) of this rule). An eligible professional practices predominantly through an FQHC or RHC if the clinical location for over fifty per cent of his or her total patient encounters over a period of six months in the most recent CY occurs through an FQHC or an RHC.~~

(D) Medicaid eligible hospitals.

(1) Eligible hospitals participating in Ohio's MPIP program are subject to the program eligibility rules and regulations published at 42 C.F.R. Part 495 (as in effect on January 1, 2013).

~~(1)~~(2) An eligible hospital must be one of the following:

- (a) An acute care hospital where the average length of stay is twenty-five days or fewer (acute care hospital's average length of stay will be calculated based on the hospital's fiscal year); and has a federal centers for medicare and medicaid services (CMS) certification number that has the last four digits in the series 0001-0879 or 1300-1399.
- (b) Cancer hospitals and critical access hospitals are included in the definition of an acute care hospital and will be eligible for MPIP if they meet the requirements ~~under of~~ an acute care hospital ~~as described~~ defined in this rule.
- (c) A children's hospital that is separately certified and is either freestanding or a hospital-within-a hospital that has a CMS certification number with the last four digits in the series 3300-3399 and predominantly treats individuals under the age of twenty-one.

~~(2)~~(3) An eligible hospital must, for each year of participation in MPIP: An eligible hospital must be an enrolled Ohio medicaid provider with an active Ohio medicaid provider agreement.

- (a) Be an enrolled Ohio medicaid provider with an active Ohio medicaid provider agreement.
- (b) Not have received an EHR incentive payment, within the current payment year, from:
  - (i) Another state; or
  - (ii) MPIP.

(c) Not have a current sanction or exclusion identified at:

(i) The United States department of health and human services, office of inspector general, list of excluded individuals and entities; or

(ii) The Ohio list of excluded providers.

~~(3) An eligible hospital may be dually eligible for both the medicare EHR incentive payment program and MPIP if it meets all of the following criteria:~~

~~(a) Is a sub-section(d) hospital in the fifty United States or the District of Columbia, as defined in section 1886(d)(1)(B) of the Social Security Act (2010), 42 U.S.C. 1395ww; and~~

~~(b) Has a CMS certification number ending in 0001-0879;~~

~~(4) An eligible hospital must not have received a medicaid EHR incentive payment, within the current payment year, from:~~

~~(a) Another state; or~~

~~(b) MPIP.~~

~~(5) An eligible hospital must not have a current sanction or exclusion identified at:~~

~~(a) The United States department of health and human services, office of inspector general, list of excluded individuals and entities; or~~

~~(b) The Ohio list of excluded providers.~~

~~(6) An eligible hospital must meet a minimum patient volume of ten per cent attributable to those individuals whose medical services delivered were eligible for and reimbursed by medicaid. A children's hospital is exempt from meeting a patient volume threshold.~~

(E) Establishing patient volume.

(1) Eligible professionals and eligible hospitals must annually meet patient volume requirements in accordance with 42 C.F.R. 495.304 paragraphs (c) through (f) (as in effect on January 1, 2013). Childrens hospitals as defined in paragraph (D)(2)(c) of this rule are exempt from meeting medicaid patient volume requirements.

~~(1)(2) Patient volume is calculated in accordance with the patient encounter methodology defined in 42 C.F.R. 495.306(c) (as in effect on ~~July 28, 2010~~ January 1, 2013).~~

(3) For purposes of MPIP only, a pediatrician means a medical doctor, who diagnoses, treats, examines, and prevents diseases and injuries in children. A pediatrician must hold a doctor of medicine (MD) or doctor of osteopathy (DO) degree and hold a current, in good-standing board certification in pediatrics through the American board of pediatrics, the American board of surgery, the American board of radiology, the American board of urology or the American osteopathic board of pediatrics or a current, in good standing, pediatric subspecialty certificate recognized by the American board of medical specialties.

~~(2) To calculate patient volume, an eligible professional must divide:~~

~~(a) The total medicaid patient encounters (fee-for-service and managed care) in any continuous ninety-day period, beginning on the first day of a month, in the preceding CY; by~~

~~(b) The total patient encounters in the same ninety-day period.~~

~~(3) To calculate needy individual patient volume, an eligible professional must divide:~~

~~(a) The total needy individual patient encounters in any continuous ninety-day period, beginning on the first day of a month, in the preceding CY; by~~

~~(b) The total patient encounters in the same ninety-day period.~~

~~(4) To calculate patient volume, an eligible hospital must divide:~~

- (a) ~~The total medicaid-patient encounters (fee-for-service and managed care) in any continuous ninety-day period, beginning on the first day of a month, in the preceding federal fiscal year (FFY); by~~
- (b) ~~The total encounters in the same ninety-day period.~~

(F) Encounters.

- (1) Encounters are defined in accordance with 42 C.F.R. 495.306(e) (as in effect on ~~July 28, 2010~~January 1, 2013).
- (2) ~~For purposes of calculating eligible professional patient volume, a medicaid encounter means services rendered to an individual on any one day where medicaid (fee-for-service and managed care):~~
  - (a) ~~Paid for part or all of the service; or~~
  - (b) ~~Paid for part or all of the individual's premiums, co-payments, and cost sharing.~~
- (3) ~~For purposes of calculating needy individual patient volume, a needy patient encounter means services rendered to an individual on any one day where:~~
  - (a) ~~Medicaid (including the state children's health insurance program (SCHIP)) paid for part or all of the service; or~~
  - (b) ~~Medicaid (including SCHIP) paid for part or all of the individual's premiums, co-payments, and cost sharing; or~~
  - (c) ~~Services were furnished at no cost; and calculated as being uncompensated or charity care. If an eligible professional's data are not available on charity care, then the eligible professional may use data on uncompensated care and must include a downward adjustment to eliminate bad debt (as defined in 42 C.F.R. 413.89, as in effect on October 1, 2004); or~~
  - (d) ~~The services were paid for at a reduced cost based on a sliding scale and determined by the individual's ability to pay.~~
- (4) ~~For purposes of calculating eligible hospital patient volume, a medicaid encounter means both of the following:~~
  - (a) ~~Services rendered to an individual per inpatient discharge where medicaid (fee-for-service and managed care):~~
    - (i) ~~Paid for part or all of the service; or~~
    - (ii) ~~Paid for part or all of the individual's premiums, co-payments, and cost sharing.~~
  - (b) ~~Services rendered in an emergency department on any one day where medicaid (fee-for-service and managed care):~~
    - (i) ~~Paid for part or all of the service; or~~
    - (ii) ~~Paid for part or all of the individual's premiums, co-payments, and cost sharing.~~

~~(5)~~(2) Out-of-state encounters.

- (a) An eligible professional and eligible hospital may use out-of-state medicaid encounters for calculating patient volume.
- (b) "Out-of-state encounters" are services rendered by an eligible professional or eligible hospital to a non-Ohio resident that meets the definitions of an encounter as defined in paragraph (F) of this rule.
- (c) If out-of-state medicaid encounters are included in the numerator then all out-of-state encounters, for the same representative time period, should be included in the denominator.

- (d) Eligible professionals and eligible hospitals are required to provide documentation to support the use of out-of-state encounters and must report each state's out-of-state encounters separately through the MPIP system, in a manner specified by the Ohio department of medicaid (ODM) of job and family services (ODJFS).

(G) Group practice or clinic patient volume proxy.

- (1) A group practice or clinic will be permitted to calculate patient volume at the group practice or clinic level, but only in accordance with all of the following limitations defined in 42 C.F.R. 495.306(h) (as in effect on ~~July 28, 2010~~ January 1, 2013):
  - (a) The group practice or clinic's patient volume is appropriate as a patient volume methodology calculation for the eligible professional.
  - (b) There is an auditable data source to support the group practice's or clinic's patient volume determination.
  - (c) All eligible professionals in the group practice or clinic must use the same methodology for the payment year.
  - (d) The group practice or clinic must use the entire practice's or clinic's patient volume and not limit patient volume in any way.
  - (e) If an eligible professional works inside and outside of the group practice or clinic, the patient volume calculation includes only those encounters associated with the group practice or clinic, and not the eligible professional's outside encounters.
- (2) To calculate patient volume at the group practice or clinic level, all medicaid eligible professionals, (as defined in paragraph (C) of this rule), of the group practice or clinic must be an enrolled Ohio medicaid provider with an active Ohio medicaid provider agreement.:
  - ~~(a) Have a valid, current Ohio medicaid provider agreement; and~~
  - ~~(b) Have rendered and billed medicaid for at least one medicaid covered service with a date of service in the ninety-day period associated with the calculation of patient volume, and has been reimbursed for that service.~~
- (3) Each group practice or clinic must confirm in writing, in a manner specified by ~~the ODM, ODJFS,~~ from each eligible professional in the group practice or clinic, that the eligible professional is consenting to one of the following:
  - (a) Attesting as a member of the group practice or clinic and permitting the group practice or clinic to use his or her encounters in the group practice or clinic patient volume proxy calculation; or
  - (b) Not attesting as a member of the group practice or clinic but will permit the group practice or clinic to use his or her encounters in the group practice or clinic patient volume proxy calculation.
- (4) Evidence of an eligible professional's consent must be provided for processing through the MPIP system and must include the following information:
  - (a) The group practice or clinic name and medicaid ID number;
  - (b) The name and medicaid ID number of each eligible professional in the group; and
  - (c) Must specify if each eligible professional is consenting to the use of his or her encounters as defined in paragraphs (G)(3)(a) and (G)(3)(b) of this rule.
- (5) If an eligible professional is not attesting as a member of a group practice or clinic but will permit a group practice or clinic to use his or her encounters in the patient volume proxy calculation for the group practice or clinic, the non-participating eligible professional cannot use those encounters toward his or her individual patient volume calculation.
- (6) If any eligible professional within the group practice or clinic does not provide written consent for the group practice or clinic to use his or her encounters in the patient volume proxy calculation

for the group practice of clinic, the group practice or clinic is precluded from using a group practice or clinic patient volume proxy.

- (7) Supporting documentation must be provided for processing through the MPIP system of the attested patient volume proxy and include the medicaid encounters, total encounters, name and medicaid ID of all medicaid practitioners used in the group practice or clinic patient volume proxy calculation. This information shall be provided in a manner specified by ODM. ~~ODJFS~~.
- (8) Eligible professionals must be employed by the group practice or clinic at the time of attestation in order to use the group practice's or clinic's patient volume proxy.

~~(H) SCHIP adjustment.~~

- ~~(1) Eligible professionals (except for eligible professionals practicing predominantly through a FQHC/RHC) and eligible hospitals (except for children's hospitals) in counties with children covered by virtue of Title XXI of the Social Security Act, will be subject to a federally required SCHIP adjustment to patient volume. This adjustment is a reduction equal to the value of the lesser of the average statewide per cent of children covered by virtue of Title XXI or by the per cent of children covered by virtue of Title XXI in the county that serves as the primary location for the eligible professional or eligible hospital.~~
- ~~(2) The SCHIP adjustment will be made by the MPIP system at the time of registration when the eligible professional or eligible hospital selects the county that serves as the primary location for the eligible professional or eligible hospital.~~

(H) Meaningful use (MU)

- (1) Eligible professionals and eligible hospitals must:
  - (a) Meet all activities required to receive an incentive payment in accordance with 42 C.F.R. 495.314 (as in effect on January 1, 2013), in addition to all program eligibility requirements.
  - (b) Report which certified EHR technology they have adopted, implemented or upgraded to by providing supporting documentation through the MPIP system at the time of registration and attestation, in a manner specified by ODM.
  - (c) Select an EHR reporting period and meet the definition of meaningful EHR user as defined in 42 C.F.R. 495.4 (as in effect on January 1, 2013).
  - (d) Meet the MU criteria established in 42 C.F.R. 495.6 (as in effect on January 1, 2013).
  - (e) Demonstrate that meaningful use objectives and measures are met, in accordance with 42 C.F.R. 495.8 (as in effect on January 1, 2013).
- (2) Demonstration of MU is subject to review by both ODM and CMS.
- (3) Dual eligible hospitals meeting MU criteria for the medicare EHR incentive program will be deemed meaningful users for MPIP, but will be required to meet additional MPIP program eligibility requirements.

Replaces: Part of 5101:3-57-02

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(A) Medicaid provider incentive program (MPIP) incentive payments.

- (1) All MPIP incentive payments will be calculated in accordance with 42 C.F.R. 495.310 (as in effect on January 1, 2013 ~~July 28, 2010~~).
- (2) An eligible professional or eligible hospital will be eligible to receive the federally specified incentive payment amount, regardless of the purchase or implementation costs of their electronic health record (EHR) system as long as the eligible professional or eligible hospital meets all MPIP program eligibility requirements as specified in Chapter 5101:3-57 of the Administrative Code.
- (3) In no case may any medicaid eligible professional or eligible hospital receive an incentive payment after payment year 2021.
- (4) ~~"Payment year" means:~~
  - ~~(a) For an eligible professional, a calendar year (CY) beginning with CY 2011; and~~
  - ~~(b) For an eligible hospital, a federal fiscal year (FFY) beginning with FFY 2011.~~

(B) Eligible professional incentive payments.

- ~~(1) First payment year requirements.~~
  - ~~(a) The first payment year for an eligible professional is the first CY for which the eligible professional receives an incentive payment.~~
  - ~~(b) In the first payment year, to receive an incentive payment, the medicaid eligible professional must demonstrate the following:~~
    - ~~(i) That during the payment year he or she met all eligible professional eligibility requirements defined in rule 5101:3-57-01 of the Administrative Code; and~~
    - ~~(ii) That he or she adopted, implemented or upgraded to certified EHR technology pursuant to paragraph (B) of rule 5101:3-57-02 of the Administrative Code.~~
  - ~~(c) Payment may not exceed twenty-one thousand two hundred fifty dollars.~~
  - ~~(d) Eligible professionals may not begin receiving payments any later than CY 2016.~~
- ~~(2) Requirements in subsequent payment years.~~
  - ~~(a) The second, third, fourth, fifth, or sixth payment year for an eligible professional is the second, third, fourth, fifth, or sixth CY for which the eligible professional receives an incentive payment regardless of whether the year immediately follows the prior payment year.~~
  - ~~(b) In the second, third, fourth, fifth and sixth payment years, to receive incentive payment, the medicaid eligible professional must demonstrate the following:~~
    - ~~(i) That he or she has met all eligible professional eligibility requirements defined in rule 5101:3-57-01 of the Administrative Code; and~~
    - ~~(ii) That during the EHR reporting period for the applicable payment year, he or she is a meaningful EHR user of certified EHR technology as defined in rule 5101:3-57-02 of the Administrative Code.~~

~~(c) Payment may not exceed eight thousand five hundred dollars.~~

~~(d) Eligible professionals may receive payments in non-consecutive years.~~

~~(3) An eligible professional shall not participate for more than a total of six payment years, and in no case will the maximum incentive payments over a six-year period exceed sixty-three thousand seven hundred fifty dollars.~~

~~(4) The following limitations apply:~~

~~(a) An eligible professional who is a pediatrician, as defined in paragraph (C)(4)(b) of rule 5101:3-57-01 of the Administrative Code, with a patient volume of less than thirty per cent, but who meets the patient volume requirement of at least twenty per cent, is limited to the following:~~

~~(i) The maximum payment in the first payment year is fourteen thousand one hundred sixty-seven dollars.~~

~~(ii) The maximum payment in subsequent years is five thousand six hundred sixty-seven dollars.~~

~~(iii) The maximum amount for a pediatrician under this limitation shall not exceed forty-two thousand five hundred dollars.~~

~~(iv) Pediatricians meeting the thirty per cent patient volume threshold in a payment year may be eligible to receive the maximum incentive payment amount, for that payment year as defined in paragraphs (B)(1) to (B)(3) of this rule.~~

~~(5) An eligible professional who switches to MPIP from the medicare EHR incentive payment program is placed in the payment year that the eligible professional would have been in had the eligible professional begun in, and remained in, the medicare EHR incentive payment program in accordance with 42 C.F.R. 495.10 (as in effect on July 28, 2010).~~

~~(6)~~(1) Reassignment of payment.

(a) Assignment of the incentive payment must be consistent with federal and state medicaid laws, rules, and regulations, (including without limitation, fraud, waste, and abuse laws rules and regulations).

(b) Eligible professionals may reassign incentive payments to an employer or entity with which the eligible professional has a valid contractual arrangement allowing the employer or entity to bill for and receive payment for the eligible professional's covered professional services. The employer or entity for which payment is reassigned must be an Ohio medicaid provider with an active Ohio medicaid provider agreement.

(c) An eligible professional may not reassign an incentive payment to more than one employer or entity. In cases where eligible professionals are associated with more than one practice, the eligible professional must select one tax identification number to receive any applicable EHR incentive payment.

(C) Eligible hospital incentive payments.

~~(1) First payment year requirements.~~

~~(a) The first payment year for an eligible hospital is the first FFY for which the eligible hospital receives an incentive payment.~~

~~(b) In the first payment year, to receive an incentive payment, the medicaid eligible hospital must demonstrate the following:~~

~~(i) That during the payment year it met all eligible hospital eligibility requirements defined in rule 5101:3-57-01 of the Administrative Code; and~~

~~(ii) That it has adopted, implemented or upgraded to certified EHR technology pursuant to paragraph (B) of rule 5101:3-57-02 of the Administrative Code.~~

- (2) ~~Subsequent payment year's requirements.~~
- (a) ~~The second, third, fourth, fifth, or sixth payment year for an eligible hospital is the second, third, fourth, fifth, or sixth FFY for which the hospital receives an incentive payment.~~
  - (b) ~~In the second, third, fourth, fifth and sixth payment years, to receive incentive payment, the medicaid-eligible hospital must demonstrate the following:~~
    - (i) ~~That it has met all eligible hospital eligibility requirements defined in rule 5101:3-57-01 of the Administrative Code; and~~
    - (ii) ~~That during the EHR reporting period for the applicable payment year, it is a meaningful EHR user of certified EHR technology as defined in rule 5101:3-57-02 of the Administrative Code.~~

- (3) ~~An incentive payment to an eligible hospital is subject to the following conditions:~~
- (a) ~~No eligible hospital may begin receiving incentive payments for any year after FFY 2016.~~
  - (b) ~~Prior to FFY 2016, payments may be made to an eligible hospital on a non-consecutive, annual basis for a FFY.~~
  - (c) ~~After FFY 2016, a hospital may not receive an incentive payment unless it received an incentive payment in the prior FFY.~~
  - (d) ~~A multi-site hospital with one federal centers for medicare and medicaid services (GMS) certification number is considered one hospital for purposes of calculating payment.~~
- (4) ~~Eligible hospital incentive payments will be calculated in accordance with 42 C.F.R. 495.310 (as in effect on July 28, 2010).~~

- ~~(5)~~(1) All data used to calculate the hospital EHR incentive payment amount must be provided through the MPIP system at the time of the eligible hospital's application and attestation, in a manner specified by the Ohio department of medicaid (ODM). ~~job and family services (ODJFS).~~
- ~~(6)~~(2) All eligible hospital calculations of the aggregate EHR hospital incentive payment made at the time of MPIP application are subject to review and may be adjusted based on review findings.
- ~~(7)~~(3) An eligible hospital may be paid up to one hundred per cent of the calculated aggregate EHR incentive amount over a four-year period, if it meets all MPIP program eligibility requirements: forty per cent in year one; thirty per cent in year two; twenty per cent in year three; and ten per cent in year four.
- ~~(8)~~(4) An eligible hospital may not alter or modify data elements used to calculate the hospital EHR incentive payment after MPIP has processed an eligible hospitals application for payment and payment has been disbursed for the payment year.

(D) Issuance of payments.

- (1) MPIP incentive payment will be issued and disbursed in compliance with 42 C.F.R. 495.312 (as in effect on ~~July 28, 2010~~ January 1, 2013).
- (2) Payments will be made to the taxpayer identification number selected at the time of registration.

(E) Offsets, adjustments and recoupment of payment.

- (1) MPIP payments are subject to offsets, adjustments and recoupments. These and/or other collection methods will be applied to the medicaid EHR incentive payments to reimburse or pay for medicaid overpayments, fines, penalties, or other debts owed by the provider or its assignee(s) to the medicaid state agency, Ohio county or local governments, the department of health and human services, or any other federal agency.
- (2) ~~ODJFS~~ODM will identify and recoup overpayments made under the incentive program that result from incorrect or fraudulent attestations, quality measures, cost data, patient data, or any other submission required to establish eligibility or qualify for a payment.

- (3) Eligible professionals and eligible hospitals must report any suspected overpayments of an incentive payment to ~~ODJFS~~ ODM within sixty days of its discovery.

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(A) Program integrity.

(1) MPIP legal notice.

(a) All eligible professionals and eligible hospitals submitting an application to receive an MPIP payment are required to sign the MPIP legal notice before confirming and submitting their application.

(b) All program applicants are bound by the requirements of the MPIP legal notice.

(2) Eligible professional and eligible hospital MPIP applications and attestations are subject to verification by the Ohio department of medicaid (ODM) ~~job and family services (ODJFS)~~.

(3) For any given payment year an eligible professional and eligible hospital must register for MPIP by the end of the calendar year (CY) for an eligible professional and federal fiscal year (FFY) for an eligible hospital.

(4) An eligible professional and eligible hospital will have sixty days after the end of the CY for an eligible professional and FFY for and eligible hospital to complete attestation via the MPIP system for a given payment year.

(5) Post payment audits and record retention.

(a) An eligible professional's and eligible hospital's MPIP application and attestation are subject to a post payment audit.

(b) ~~ODJFS~~ODM or its designee, the state auditor's office, the state attorney general's office and the federal centers for medicare and medicaid services (CMS) may conduct reviews and audits of MPIP applications for the purpose of determining compliance with the requirements of this chapter as well as with applicable state and federal requirements.

(c) Audits and reviews may be conducted on-site as determined necessary based on periodic analysis of medical, financial, and other information.

(d) Records stored electronically must be produced at the eligible professional's or eligible hospital's expense, upon request, in the format specified by ODM~~ODJFS~~.

(e) All records must be maintained for a minimum of seven years following the last day of the CY for eligible professionals or FFY for eligible hospitals in which payment related to the attestation has been received, or in the event that the eligible professional or eligible hospital has been notified that state or federal authorities have commenced an audit or investigation of their MPIP application, until such time as the matter under audit, appeal or investigation has been resolved.

(f) An eligible professional and eligible hospital must comply with all audit recoveries.

(6) Fraud, waste, and abuse.

(a) Suspicion or detection of fraud and abuse by ~~ODJFS~~ODM will be referred to the medicaid fraud control unit (MFCU) in the office of the attorney general (AG). Referrals to the MFCU will be investigated for prosecutorial merit.

(b) Substantiated cases of fraud and abuse will be prosecuted according to federal and state regulations.

(B) Provider appeals.

- (1) An eligible professional or eligible hospital may appeal the following issues related to MPIP, by first requesting an informal review:
  - (a) Incentive payment amounts.
  - (b) Provider eligibility determinations (i.e. patient volume, hospital-based).
  - (c) Demonstration of adoption, implementation, or upgrade, and meaningful use eligibility.
- (2) Appeals filed after the deadlines specified in paragraphs (B)(3)(a) and (B)(4)(a) of this rule, will be dismissed without the ability to refile. If the deadline falls on a saturday, sunday, state or federal holiday, the period for requesting an appeal will be extended to the next business day.
- (3) Informal review.
  - (a) If the MPIP system has made a preliminary determination that may be adverse regarding the incentive payment application of an eligible professional or eligible hospital, the eligible professional or eligible hospital may request an informal review of the preliminary determination via the MPIP system, within fifteen calendar days of notification of an adverse preliminary determination.
  - (b) A request for informal review shall be made via the MPIP system and may include supporting documentation to support the request.
  - (c) An eligible professional or eligible hospital will be notified of the informal review decision via email and will be advised to log into the MPIP system to see the details of the review decision.
  - (d) An eligible professional or eligible hospital may withdraw the request for an informal review via the MPIP system, without reason, at any time, after the initial filing and before an informal review decision is issued.
- (4) Request for reconsideration.
  - (a) If the informal review upholds the preliminary adverse determination and the eligible professional or eligible hospital does not agree with the informal review decision, the eligible professional or eligible hospital may submit a written request for reconsideration no later than fifteen calendar days after the date of notification of determination via the MPIP system.
  - (b) The request for reconsideration shall be initiated via the MPIP system and must include a written and signed letter from the eligible professional or eligible hospital containing the following information:
    - (i) Clear identification of the affected eligible professional or eligible hospital;
    - (ii) The proposed action being contested;
    - (iii) The basis for requesting reconsideration; and
    - (iv) Supporting documentation being submitted.
  - (c) The written request for reconsideration must be signed, dated, include any supporting documentation and must be uploaded via the MPIP system.
  - (d) An eligible professional or eligible hospital will be notified in writing, by certified mail, of the reconsideration decision.
- (5) In accordance with Chapter 2505. of the Revised Code, an eligible professional or eligible hospital may appeal the reconsideration decision by filing a notice of appeal with the court of common pleas of Franklin county. The notice shall identify the decision being appealed and the specific grounds for the appeal. The notice of appeal shall be filed not later than fifteen days after the department mails its notice of the reconsideration decision. A copy of the notice of appeal shall be filed with the department not later than three days after the notice is filed with the court.

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(A) The following definitions apply to Chapter 5160-70 of the Administrative Code:

- (1) "Appellant" means the party who requested an adjudication hearing pursuant to Chapter 119. of the Revised Code and is appealing the adjudication order to the Franklin County Court of Common Pleas.
- (2) "Certified mail" means the United States Postal Service mail service in which the delivery person obtains the signature of the recipient of the mail on a form as proof of delivery to the specified addressee. Pursuant to section 1.02 of the Revised Code, certified mail includes registered mail.
- (3) "Department" means the Ohio department of medicaid ("ODM").
- (4) "Depository agent" means the ODM office of legal services at its official mailing address for the purpose of receiving correspondence or filings for any hearing held under authority of Chapter 5160-70 of the Administrative Code.
- (5) "Director" means the director of ODM.
- (6) "Adjudication order" means the order made by the director after notice and an opportunity for a hearing is afforded pursuant to Chapter 119. of the Revised Code.
- (7) "Final fiscal audit" means a medicaid final rate settlement or a medicaid hospital final settlement, including a final settlement in which Title V monies are offset against medicaid monies proposed for adjudication by ODM.
- (8) "Hearing" means a hearing held by ODM in compliance with sections 119.06 to 119.13 of the Revised Code.
- (9) "Last known address" means the most recent mailing address reported to ODM in compliance with reporting requirements.
- (10) "Notice of intended action" means the written notice to the party of the department's intended action and notice of the right to a hearing pursuant to Chapter 119. of the Revised Code.
- (11) "ODM" means the Ohio department of medicaid.
- (12) "Participants in the hearing" means the party and the party's counsel in the hearing and ODM and ODM's counsel in the hearing.
- (13) "Party" means a person whose interests are the subject of a notice of intended action by ODM.
- (14) "Person" means an individual, corporation, whether nonprofit or for profit, a partnership, a limited liability company, and unincorporated society or association.
- (15) "Medicaid provider" or "provider" means a person or governmental entity with a valid provider agreement to provide medical services or supplies to medicaid recipients. To the extent appropriate in the context, "medicaid provider" or "provider" includes a person or governmental entity applying for a provider agreement, a former medicaid provider, or both.
- (16) "Notice by ordinary mail" means the service obtained by the agency after the party fails to claim the certified mail notice and the agency sends the notice by ordinary mail using a certificate of mailing to the party's last known address and the ordinary mail notice is not returned showing failure of delivery.
- (17) "Provider agreement" means a contract between ODM and a person or governmental entity that allows the person or governmental entity to provide medical services and supplies for the Ohio medicaid program.
- (18) "Take any action based on a final fiscal audit" means ODM issuing a notice of intended action seeking recovery of medicaid overpayments that were identified in the final fiscal audit.

(B) Computation of time deadlines

Section 1.14 of the Revised Code controls the computing of time deadlines imposed by Chapter 119. of the Revised Code and Chapter 5160-70 of the Administrative Code. The time within which an act is required by law to be completed is computed by excluding the first day and including the last day. When the last day falls on a Saturday, Sunday, or legal holiday, the act may be completed on the next succeeding day that is not a Saturday, Sunday, or legal holiday. When the last day to perform an act that is required by law to be performed in a public office occurs when that public office is closed to the public for the entire day, the act may be performed on the next succeeding day that is not a Saturday, Sunday, or legal holiday and on which the public office is open.

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- (A) Chapter 5160-70 of the Administrative Code prescribes the procedures to be followed when medicaid providers seek review of actions or proposed actions of the department, except for any action taken or decision made by the department with respect to entering into or refusing to enter into a contract with a managed care organization pursuant to section 5167.10 of the Revised Code and any action taken under section 5165.60 to 5165.89 of the Revised Code. The rules in Chapter 5160-70 prevail over the provisions set forth in Chapter 5101:6-50.
- (B) Except as provided in paragraph (C) of this rule and section 5164.58 of the Revised Code, the department shall do the following by issuing an order pursuant to an adjudication conducted in accordance with Chapter 119. of the Revised Code:
- (1) Pursuant to section 5164.38 of the Revised Code, refuse to enter into a provider agreement with a provider;
  - (2) Pursuant to section 5164.38 of the Revised Code, refuse to revalidate a medicaid provider's provider agreement;
  - (3) Pursuant to section 5164.38 of the Revised Code, suspend or terminate an existing medicaid provider's provider agreement;
  - (4) Pursuant to section 5164.38 of the Revised Code, take any action based upon a final fiscal audit;
  - (5) Pursuant to section 5165.46 of the Revised Code:
    - (a) take any audit disallowance that the department makes as the result of a nursing facility cost report audit under section 5165.109 of the Revised Code;
    - (b) make any adverse finding that results from an exception review of resident assessment data conducted for a nursing facility under section 5165.193 of the Revised Code after the effective date of the nursing facility's medicaid payment rate for direct care costs that is based on the resident assessment data;
    - (c) recover any medicaid payment deemed an overpayment based upon the final cost report filed by an exiting nursing facility operator under section 5165.523 of the Revised Code;
    - (d) impose any penalty under section 5165.42 of the Revised Code or section 5165.523 of the Revised Code.
  - (6) Pursuant to section 5165.525 of the Revised Code, issue a final debt summary report;
  - (7) Pursuant to section 5165.77(A) of the Revised Code, terminate a nursing facility's participation in the medical assistance program, appoint a temporary manager of a nursing facility, or deny payment to a nursing facility for all medicaid eligible residents admitted after the effective date of the order.
- (C) The Chapter 119. administrative procedures, including hearing rights, are not applicable to department actions that include, but are not limited to, the following:
- (1) Pursuant to section 5164.38 of the Revised Code, the termination of the provider agreement because the terms of the provider agreement require the medicaid provider to hold a license, permit, or certificate or maintain a certification issued by an official, board, commission, department, division, bureau, or other agency of state or federal government other than the department of medicaid, and the license, permit, certificate, or certification has been denied, revoked, not renewed, suspended, or otherwise limited;
  - (2) Pursuant to section 5164.38 of the Revised Code, the termination of the provider agreement because the terms of the provider agreement require the medicaid provider to hold a license, permit, or certificate or maintain certification issued by an official, board, commission, department, division, bureau, or other agency of state or federal government other than the

department of medicaid, and the provider has not obtained the license, permit, certificate, or certification;

- (3) Pursuant to section 5164.38 of the Revised Code, the denial of the medicaid provider's application for a provider agreement or the provider's provider agreement is terminated or not revalidated, because of or pursuant to any of the following:

  - (a) The termination, refusal to renew, or denial of a license, permit, certificate, or certification by an official, board, commission, department, division, bureau, or other agency of this state other than the department of medicaid, notwithstanding the fact that the provider may hold a license, permit, certificate, or certification from an official, board, commission, department, division, bureau, or other agency of another state;
  - (b) Division (E)(3)(b) of section 5164.38 of the Revised Code and division (D) of 5164.35 of the Revised Code, when a judgment has been entered in either a criminal or civil action against a medicaid provider or its owner, officer, authorized agent, associate, manager, or employee in an action brought pursuant to section 109.85 of the Revised Code, except if the provider or owner can demonstrate to the department that the provider or owner did not directly or indirectly sanction the action of its authorized agent, associate, manager, or employee which resulted in the entry of judgment;
  - (c) Division (E)(3)(b) of section 5164.38 of the Revised Code and division (E) of section 5164.35 of the Revised Code, when the attorney general on behalf of the state has commenced proceedings in any court of competent jurisdiction and settled or compromised any such case brought under section 5164.35 of the Revised Code;
  - (d) The provider's termination, suspension, or exclusion from the medicare program or from another state's medicaid program and, in either case, the termination, suspension, or exclusion is binding on the provider's participation in the Ohio medicaid program;
  - (e) The provider has pleaded guilty to or been convicted of a criminal activity materially related to the medicare or medicaid programs;
  - (f) The conviction of the provider or its owner, officer, authorized agent, associate, manager, or employee of one of the offenses that caused the provider's provider agreement to be suspended pursuant to section 5164.36 of the Revised Code; and
  - (g) The failure of the provider to provide the department the national provider identifier assigned to the provider by the national provider system pursuant to 45 C.F.R 162.408 (October 1, 2014). In this case, the department may take its action by sending a notice explaining the action to the provider. The notice shall be sent to the provider's last known address on record with the department. The notice may be sent by ordinary mail.
- (4) Pursuant to section 5164.38 of the Revised Code, the denial of the provider's application for a provider agreement, or the provider's provider agreement is terminated or suspended, as a result of action by the United States department of health and human services and that action is binding on the provider's medicaid participation;
- (5) Pursuant to section 5164.38 of the Revised Code, referencing sections 5164.36 and 5164.37 of the Revised Code, the suspension of the provider's provider agreement and payments pending indictment of the provider;
- (6) Pursuant to section 5164.38 of the Revised Code, the denial of the application for a provider agreement because the application was not complete. In this case, the department may take its action by sending a notice explaining the action to the applicant. The notice shall be sent to the applicant's last known address on record with the department. The notice may be sent by ordinary mail;
- (7) Pursuant to section 5164.38 of the Revised Code, the conversion of the provider's provider agreement under section 5164.32 of the Revised Code from a provider agreement that is not time-limited to a provider agreement that is time-limited. In this case, the department may take its action by sending a notice explaining the action to the provider. The notice shall be sent to

the provider's last known address on record with the department. The notice may be sent by ordinary mail;

- (8) Unless the provider is a nursing facility or ICF/IID, the non-revalidation of the provider's provider agreement pursuant to division (B)(1) of section 5164.32 of the Revised Code;
- (9) The suspension, termination, or non-revalidation of the provider's provider agreement because of either of the following:
  - (a) Any reason authorized or required by one or more of the following: 42 C.F.R. 455.106, 455.23, 455.416, 455.434, or 455.450 (October 1, 2014);
  - (b) The provider has not billed or otherwise submitted a medicaid claim for two years or longer. In this case, the department may take its action by sending a notice explaining the action to the provider. The notice shall be sent to the provider's address on record with the department. The notice may be sent by ordinary mail.
- (10) Acts of the director, agency employees or contractors of ODM that are ministerial in nature;
- (11) Actions of ODM that are subject to public hearings under an administrative review procedure other than the review provided by Chapter 119. of the Revised Code;
- (12) Rate calculations and interim settlements;
- (13) Claims payment denial determinations and claims adjustments for reasons including, but not limited to, duplicate payments and payment for services not rendered;
- (14) Notices of operational deficiency, and reviews and audits that are not subject to the Chapter 119. administrative procedure;
- (15) Proceedings, authorized by section 5101.31 of the Revised Code and rules in Chapters 5101:6-1 to 5101:6-9 of the Administrative Code, provided to applicants for, or recipients of, benefits administered by the department, its designees, or contractors;
- (16) Personnel action appeals of employees of ODM or of a county department of job and family services;
- (17) Disputes involving the issuance, denial, or termination of a contract, a grant, or an interagency agreement issued by ODM or a protest filed with regard to a request for proposals or a request for application issued by ODM;
- (18) Administrative actions taken by ODM that involve program administration and funding affecting county departments of job and family services.

(D) Except as otherwise set forth in the Ohio Administrative Code, actions taken that meet the exceptions of paragraph (C) of this rule and other administrative actions regarding medicaid providers that are not subject to hearings under Chapter 119. of the Revised Code and those individuals or providers who do not have medicaid provider agreements and are proposed for exclusion from participation may be reconsidered by the director, assistant director, or the deputy director over the area where the contestation arose. The director, assistant director, or the deputy director may designate who conducts the reconsideration, provided that the designee was not involved in the original decision or contestation. If the department takes an action that is subject to reconsideration, the department may set deadlines by which the person affected by the action shall submit his or her written request for reconsideration and the documentation supporting the request. The deadline shall be no fewer than thirty days from the date appearing on the letter sent to the person. When the department sets a deadline for requesting reconsideration, reconsideration requests and supporting documentation received after the deadline may be considered at the department's discretion. ODM shall not reconsider its reconsideration decisions.

- (1) See Chapter 5160-2 of the Administrative Code for additional provisions specific to hospital services.
- (2) See Chapter 5160-3 of the Administrative Code for additional provisions specific to nursing facilities.

- (3) See Chapter 5160-26 of the Administrative Code for additional provisions specific to managed care plans (MCPs).
- (E) When the department takes an action under paragraph (B)(2) or (B)(3) of this rule and the provider requests an adjudication hearing pursuant to Chapter 119. of the Revised Code, the department may withhold payments to the provider if each of the following conditions is met:
- (1) The department complies with the provisions of section 119.07 of the Revised Code;
  - (2) The department does not request a hearing continuance; and
  - (3) The department issues an adjudication order within thirty days after the hearing is completed.
- (F) When the department takes an action under paragraph (B)(4) of this rule and the provider requests an adjudication hearing pursuant to Chapter 119. of the Revised Code, the department may withhold payment to the provider if each of the following conditions is met:
- (1) The department complies with the provisions of section 119.07 of the Revised Code;
  - (2) The department does not request a hearing continuance;
  - (3) The department issues an adjudication order within thirty days after the hearing is completed; and
  - (4) The department withholds only an amount that does not exceed the amounts determined in the final fiscal audit.
- (G) The provisions of paragraphs (E) and (F) of this rule do not apply to long-term care facilities (LTCFs). Nursing facility and ICF/IID providers whose provider agreements are terminated pursuant to paragraph (B)(5)(b) of this section may continue to receive medicaid payments for up to thirty days after the effective date of the termination if the provider makes reasonable efforts to transfer medicaid recipients to another facility or to alternate care and if federal financial participation is provided for the payments. See Chapter 5160-3 of the Administrative Code for additional provisions specific to LTCFs.

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(A) Notice of intended action

- (1) Whenever ODM proposes to take an action that the Ohio general assembly has expressly made subject to the administrative adjudication procedure outlined in Chapter 119. of the Revised Code, ODM shall give notice of the intended action to the party informing the party of the party's right to a hearing. Notice shall be given by certified mail, return receipt requested, and shall, at a minimum, include all of the following:
  - (a) The specific action or actions ODM intends to take;
  - (b) The charges or other reasons for the proposed action or actions;
  - (c) The statutes or rules directly involved;
  - (d) A statement informing the party that the party is entitled to a hearing if the party requests it within thirty calendar days of the time of mailing the notice;
  - (e) A statement informing the party that at the hearing the party may appear in person or through an attorney;
  - (f) A statement informing the party that the party or the party's attorney may present the party's position, arguments or contentions entirely in writing, and that at the hearing the party or the party's attorney may present evidence and examine witnesses appearing for and against the party; and
  - (g) A statement informing the party that rules governing hearings in accordance with Chapter 119. of the Revised Code are found in Chapter 5160-70 of the Administrative Code.
- (2) ODM shall also mail a copy of the notice to the party's attorney or other representative of record. To qualify as an attorney or representative of record, the party or the attorney or representative shall notify ODM, in writing, that the attorney or representative is to be designated the attorney or representative of record. The notification shall include the address where ODM should mail the notice to the attorney or representative of record. The mailing of notice to the party's attorney or representative is not deemed to perfect service of the notice. Failure to mail a copy of the notice to the attorney or representative of record shall not result in failure of otherwise perfected service upon the party. In those instances where a party is a corporation doing business in Ohio or is incorporated in Ohio, the mailing of notice to the corporation's statutory agent pursuant to sections 1701.07 and 1703.19 of the Revised Code shall perfect service, provided that all the requirements of paragraph (A) of this rule are met.
- (3) When any notice sent by certified mail pursuant to this rule is returned because the party fails to claim the notice, ODM shall send the notice by ordinary mail to the party at the party's last known address and shall obtain a certificate of mailing. Service by ordinary mail is complete when the certificate of mailing is obtained unless the notice is returned showing failure of delivery.
- (4) If any notice sent by certified or ordinary mail is returned for failure of delivery, ODM either shall make personal delivery of the notice by an employee or agent of ODM or shall cause a summary of the substantive provisions of the notice to be published once a week for three consecutive weeks in a newspaper of general circulation in the county where the last known address of the party is located. When notice is given by publication, a proof-of-publication affidavit, with the first publication of the notice set forth in the affidavit, shall be mailed by ordinary mail to the party at the party's last known address and the notice shall be deemed received as of the date of the last publication. An employee or agent of ODM may make personal delivery of the notice upon a party at any time.

(5) Refusal of delivery by personal service or by mail is not failure of delivery, and service is deemed to be complete at the time of personal refusal or at the time of receipt by ODM of the refused mail as demonstrated by the ODM time and date stamp. Failure of delivery occurs only when a mailed notice is returned by the postal authority marked undeliverable, address or addressee unknown, or forwarding address unknown or expired.

(B) Making a request for a hearing

(1) Any request for a hearing made as the result of notice issued pursuant to paragraph (A) of this rule must be made in writing and mailed or delivered to the depository agent within thirty calendar days of the following, as applicable:

- (a) The time of mailing the notice if notice is given pursuant to paragraph (A)(1) of this rule;
- (b) The date that service is complete if notice is given pursuant to paragraph (A)(3) or (A)(5) of this rule;
- (c) The date of the last publication if notice is given by publication pursuant to paragraph (A)(4) of this rule; or
- (d) The date of personal service.

(2) If a request for a hearing is mailed to the depository agent, the request is deemed to have been made as follows:

- (a) If the request is mailed by certified mail, as of the date stamped by the U.S. postal service on its receipt form (PS form 3800 or any future equivalent postal service form);
- (b) If the request is mailed by ordinary U.S. mail, as of the date of the postmark appearing upon the envelope containing the request;
- (c) If the request is mailed by ordinary U.S. mail and the postmark is illegible or fails to appear on the envelope, as of the date of its receipt by the depository agent as evidenced by the agent's time stamp.

(3) If a request for a hearing is made by facsimile transmission or by electronic mail to the depository agent, the request is deemed to have been made as of the date of its receipt as evidenced by the receipt date generated by the facsimile transmission or the date of receipt shown in the source code of the electronic mail received by the depository agent.

(4) If a request for a hearing is mailed, personally delivered, made by facsimile transmission, or made by electronic mail to a person or address other than the depository agent, the request is deemed to have been made as of the date of its receipt by the depository agent as evidenced by the depository agent's time stamp.

(5) If a request for a hearing is personally delivered to the depository agent, the request is deemed to have been made as of the date of its receipt as evidenced by the depository agent's time stamp.

(6) All requests for hearings must include a copy of the notice of intended action that is being contested and clearly identify the party who is making the request by providing the party's name, address, and phone number.

(C) Failure to request a hearing

When a party fails to request a hearing or the request is not submitted timely, ODM shall issue an adjudication order adopting and implementing the notice of intended action.

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(A) Initial scheduling of the hearing

- (1) When a party timely requests a hearing, ODM shall set the date, time, and place for the hearing and notify the party of the scheduling. ODM shall initially schedule the hearing not earlier than seven calendar days but not later than fifteen calendar days after the hearing was requested. The first notification concerning a scheduled hearing shall be sent by certified mail, return receipt requested. All subsequent letters and notices shall be sent by ordinary United States mail.
- (2) Nothing in this rule shall be construed as preventing ODM from postponing and rescheduling any hearing upon its own motion or upon the motion of a party who can show good cause for such a request.
- (3) Nothing in this rule shall be construed as preventing ODM and the party from entering into a written agreement establishing the time, date, and place of the hearing.

(B) Joinder of individual cases

On its own motion or on motion of a party, ODM or the hearing examiner may join any individual cases where there exist incidents of common ownership or interest and where joinder would be appropriate for efficiency and economic fairness to the participants in the hearing.

(C) Attorney representation in hearings conducted under this chapter

- (1) The attorney general, or assistants or special counsel designated by the attorney general, shall represent ODM.
- (2) Any individual not appearing pro se and any corporation, partnership, association, or other entity must be represented by an attorney admitted to the practice of law in this state. Individuals authorized to practice law in any other jurisdiction may be permitted to represent a party before ODM upon compliance with the Ohio Supreme Court Rules for the Government of the Bar of Ohio. When a party is represented by more than one attorney, one attorney must be designated by the party as "trial counsel," and that attorney is deemed the party's attorney of record and is primarily responsible for the party's case at the hearing. No attorney representing a party is permitted to withdraw from any hearing proceeding before ODM without prior notice being served upon ODM and prior approval by the hearing examiner.

(D) Authority of hearing examiners appointed by ODM

The director may assign a hearing examiner to conduct any hearing held subject to Chapter 5160-70 of the Administrative Code. Any person assigned to be a hearing examiner must be admitted to the practice of law in the state of Ohio and have such other qualifications as the director deems necessary. The hearing examiner may be an employee of ODM or under contract with ODM. The hearing examiner has the same powers as granted to ODM in conducting the hearing; however, nothing in this rule or in any other ODM rule is to be construed as granting a hearing examiner the authority to dismiss any hearing. These powers include, but are not limited to, the following:

- (1) The general authority to regulate the course of the hearing and to issue orders governing the conduct of the hearing;
- (2) The authority to administer oaths or affirmations, order the production of documents and the attendance of witnesses, call and examine witnesses in a reasonable and impartial manner, and determine the order in which the participants in the hearing present testimony and are examined in a manner consistent with essential fairness and justice;
- (3) The authority to rule on the admissibility of evidence, objections, procedural motions, and other procedural matters provided, however, that the hearing examiner shall not consider or admit into evidence documentation or information that the provider failed, upon request, to furnish to ODM

or its contractor during the final fiscal audit process unless ODM agrees to the admissibility of such post final fiscal audit production of documentation or information;

- (4) The authority to hold pre-hearing conferences for the purpose of resolving issues that can be resolved by the participants in the hearing, including facilitation of a settlement, identifying the witnesses to be presented and the subjects of their testimony, discussing possible admissions or stipulations regarding the authenticity of records, identifying and marking exhibits, ruling on any procedural motions of the participants in the hearing, resolving outstanding discovery claims, clarifying the issues to be addressed at the hearing, and discussing any other matters deemed appropriate by the hearing examiner for the thorough and expeditious preparation and disposition of the case;
- (5) The authority to take such other actions as might be necessary to avoid unnecessary delay, prevent presentation of irrelevant or cumulative evidence, prevent argumentative, repetitious, or irrelevant examination or cross-examination, and to assure that the hearing proceeds in an orderly and expeditious manner;
- (6) Nothing in this rule or in any other ODM rule is to be construed as granting a hearing examiner the authority to dismiss any hearing. Nothing in this rule or in any other ODM rule limits the director's authority to withdraw a notice of intended action or limits the authority of the director to define the scope of any hearing;
- (7) The authority to require the submission of briefs and memoranda at any time during the proceeding. The hearing examiner may limit these filings to one or more specific issues and may prescribe procedures and time schedules for their submission;
- (8) The authority to require that a copy of any unreported court decision cited in any brief or memorandum be attached to the brief or memorandum containing the citation.

(E) Pre-hearing conferences

Reasonable notice of all pre-hearing conferences shall be provided to participants in the hearing in advance of each conference. The pre-hearing conference may be conducted by phone if agreed to by the parties and the hearing examiner. Unless otherwise ordered for good cause shown, failure to attend a pre-hearing conference precludes objections to rulings made at such conference.

- (1) The first pre-hearing conference is set by ODM. The participants in the hearing shall each file a pre-hearing questionnaire if directed to do so by ODM in the letter scheduling the conference. The hearing examiner may also require the submission of a pre-hearing questionnaire before the scheduled date of any pre-hearing conference or before any scheduled hearing.
- (2) Following the conclusion of any pre-hearing conference, the hearing examiner conducting the conference shall issue an appropriate pre-hearing report and order reciting or summarizing any agreements reached or rulings made. Unless otherwise ordered for good cause shown, any order issued is binding upon all participants in the hearing, and such orders control the subsequent course of the proceeding. Hearing examiner orders shall be in writing, furnished to the participants in the hearing, and be part of the record of the case. However, the hearing examiner may modify such orders if, at or before the hearing, modification assists to preserve the essential fairness and progress of the hearing.
- (3) Each party and ODM must file a final pre-hearing questionnaire at least ten business days before the hearing or at an earlier date established by the hearing examiner. The questionnaire shall include, at a minimum, a statement of each specific question of law or fact to be decided at the hearing, a list of expert and non-expert witnesses, a list of all exhibits expected to be introduced at the hearing, stipulations, and the estimated number of days required for hearing. Only the relevant issues of law or fact set forth on the final questionnaires shall be considered or rebutted at the hearing. The party waives its right to contest any other issues of law and fact. The questionnaire shall inform the hearing examiner if discovery is complete and, if discovery is incomplete, provide a statement of an agreed upon discovery cut-off date. The questionnaire shall inform the hearing examiner whether or not any motions are yet to be filed. The

questionnaire must be signed by trial counsel. After the filing of the final pre-hearing questionnaire, no further additions to the proposed list of witnesses and exhibits shall be permitted without good cause shown and the approval of the hearing examiner.

(4) ODM, upon its own motion or that of the hearing examiner, may waive any pre-hearing conference or questionnaire and may issue a written notice to the participants in the hearing scheduling the hearing and setting forth the conditions applicable to the conduct of the hearing.

(F) Filing with depository agent

(1) All briefs, memoranda, motions, or other filings shall be filed with the depository agent within three days after service on the other participants in the hearing. A certificate of service shall be attached attesting to the service of a copy of the filing on the other participants in the hearing and the hearing examiner. Service is governed by rule 5 of the Ohio Rules of Civil Procedure ([www.supremecourt.ohio.gov/LegalResources/Rules/civil/CivilProcedure.pdf](http://www.supremecourt.ohio.gov/LegalResources/Rules/civil/CivilProcedure.pdf), July 1, 2014) except that any reference to "court" in rule 5 will be interpreted to refer to the "depository agent."

(2) A copy of all written requests or filings that are made to the depository agent, the director, or the hearing examiner shall be served upon the other participants in the hearing and the hearing examiner. A certificate of service shall be attached attesting to the service of a copy on the other participants and the hearing examiner.

(3) Only those pleadings, orders, and other documents filed with the depository agent shall be a part of the official record.

(4) All briefs, memoranda, motions, or other pleadings and documents shall be on eight-and-one-half-inch by eleven-inch paper and double-spaced.

(5) All orders, reports, recommendations, and rulings issued by the hearing examiner shall be signed, dated, and filed with the depository agent.

(6) All exhibits, or other evidence admitted into the record or proffered, shall be filed by the hearing examiner with the depository agent at the conclusion of the hearing.

(G) Withdrawal of notice of intended action

ODM, upon its own motion, at any time before the issuance of an adjudication order, may withdraw its notice of intended action without prejudice to the rights of the parties. A party may withdraw a request for a hearing only with the prior approval of the hearing examiner.

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(A) Pre-hearing discovery

- (1) Unless otherwise ordered by the hearing examiner, pre-hearing discovery is allowed. Unless otherwise ordered by the hearing examiner or as set forth in this rule, pre-hearing discovery shall be conducted and used at the hearing in accordance with the Ohio Rules of Civil Procedure ([www.supremecourt.ohio.gov/LegalResources/Rules/civil/CivilProcedure.pdf](http://www.supremecourt.ohio.gov/LegalResources/Rules/civil/CivilProcedure.pdf), July 1, 2014) except that any reference to "court" shall be interpreted to refer to the "hearing examiner".
- (2) Depositions of ODM employees shall be conducted in the Columbus offices of ODM during normal business hours unless other arrangements are approved by ODM.
- (3) In accordance with Civ. R. 45, depositions of persons who are not participants in the hearing shall be taken in the county where the deponent resides or is employed or transacts business in person, or at such other convenient place as agreed to by the participants in the hearing or as fixed by an order of the hearing examiner.
- (4) Pre-hearing discovery may begin immediately after a hearing request is timely made and must be completed before the commencement of the hearing, unless the hearing examiner issues an order establishing a different begin date and/or end date for discovery.
- (5) At a time required by the hearing examiner, a party shall provide a report prepared by every witness identified as an expert by the party. The report shall be signed by the witness and shall contain a complete statement of all opinions to be expressed and the basis and reasons therefor; the data or other information considered by the witness in forming the opinions; any exhibits to be used as a summary of or support for the opinions; the qualifications of the witness, including a list of all publications authored by the witness within the preceding ten years; the compensation to be paid for the study and testimony; and a listing of any other cases in which the witness has testified as an expert at trial or by deposition within the preceding four years or at any time if the witness testified in any matter in which ODM or its predecessor agencies were a party or participants in a hearing. An expert witness who is an employee of ODM shall not be required to prepare an expert witness report. The participants in a hearing shall bear their own expert witness costs. Any participant in the hearing seeking discovery of an expert shall not be required to pay any portion of the fees and expenses incurred by the other participants in obtaining facts and opinions from an expert or for costs of the expert witness in responding to discovery.

(B) Subpoena issuance and enforcement

- (1) ODM shall issue blank subpoena forms to a participant in the hearing requesting a subpoena. The requestor is responsible for completing the subpoena form, including the address where the person is to be served, and returning the completed subpoena form to the depository agent along with a written request for service. The written request for service and the completed subpoena must be received by the depository agent no later than twenty-one business days before the commencement of the hearing or deposition, unless otherwise ordered by the hearing examiner for good cause shown. At its discretion, ODM may make available an electronic version of the subpoena and may authorize electronic submission of a completed subpoena.
- (2) For hearings, upon its own initiation or that of any participant in the hearing, ODM shall issue a subpoena to any person within the state requiring the person's attendance as a witness and/or the production of books, records or papers at the hearing. For any person subpoenaed for attendance at a hearing, at the time of service of such a subpoena upon a person outside of Franklin County, the fees for one day's attendance and mileage shall be tendered, without demand by the person being subpoenaed. At the time of service of such a subpoena upon a person inside of Franklin County, the fees for one day's attendance and mileage shall be

tendered upon demand by the person being subpoenaed. ODM shall pay the fees and mileage as set forth in section 119.094 of the Revised Code.

- (3) For depositions, upon its own initiation or that of any participant in the hearing, ODM shall issue a subpoena to any person within the state who is not a participant in the hearing, requiring his or her attendance and/or the production of books, records or papers.
- (a) Participants in the hearing shall participate in depositions upon notice of opposing counsel. A subpoena may not be used to obtain the attendance of a participant or the production of documents by a participant in discovery. Rather, a participant's attendance at a deposition shall be obtained only by notice under Civ.R. 30, and the production of books, records, and papers shall be obtained from a participant in discovery only pursuant to Civ. R. 34.
- (b) For any person who is not a participant in the hearing and who is subpoenaed for attendance at a deposition and/or for the production of books, records or papers, at the time of service of a subpoena upon a person outside of Franklin County, the fees for one day's attendance and mileage shall be tendered, without demand by the person being subpoenaed. At the time of service of a subpoena upon a person inside of Franklin County, the fees for one day's attendance and mileage shall be tendered, upon demand by the person being subpoenaed. The amount of the fees and mileage shall be the same as those set forth in section 2335.06 of the Revised Code. Sections 119.09 and 119.094 of the Revised Code require ODM to pay fees and mileage only of persons subpoenaed as witnesses in a hearing. ODM is not required to pay the fees and mileage for a person subpoenaed for a deposition. The participant in the hearing requesting ODM to issue a subpoena for a deposition shall include with the request a check for the fees and mileage made payable to the person subpoenaed.
- (4) All subpoenas issued under this rule shall be directed to the sheriff of the county where the person to be served resides or is found, and the sheriff shall serve and return the subpoena in the same manner as a subpoena in a criminal case. The sheriff shall be paid by ODM the same fees for services as are allowed in the court of common pleas in criminal cases as established in section 311.17 of the Revised Code.
- (5) In any case of disobedience or neglect of any subpoena served upon any person, or the refusal of any witness to testify to any matter in which there may be lawful interrogation, ODM shall apply to the court of common pleas where such disobedience, neglect, or refusal occurs for an order to compel obedience by attachment proceedings for contempt, as in the case of disobedience of the requirements of a subpoena issued from such court or a refusal to testify therein.

Effective: 01/01/2015

Five Year Review (FYR) Dates: 01/01/2020

Certification: CERTIFIED ELECTRONICALLY

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**Effective Date: January 1, 2015**

(A) Conducting the hearing

- (1) The date, time, and place of any hearing before ODM is set by ODM or the hearing examiner. The hearing examiner shall provide written or electronic notice before the date of the hearing to all participants in the hearing and file a copy of the written notice with the depository agent. Hearings shall be scheduled in accordance with the following requirements.
  - (a) All hearings shall be conducted in Columbus during normal business hours unless other times are authorized by the director or the hearing examiner.
  - (b) Upon the written request of a party, the director may designate the site of the hearing to be the county seat of the county wherein a party resides or, alternately, a place within fifty miles of a party's residence. The approval of an alternative location is at the discretion of the director. Requests for an alternative hearing site must be filed with the depository agent at least forty five days before the scheduled date of the hearing and served as provided in rule 5160-70-04 of the Administrative Code.
  - (c) Once begun, the hearing shall continue day to day until completed, unless continued by the hearing examiner for good cause shown.
- (2) Subject to the prior approval of the hearing examiner, the party may choose to present its case entirely in writing provided that a written request is made by the party no later than fourteen business days before the date scheduled for the hearing. Any request by a party to present its case entirely in writing must be filed with the depository agent and served as provided in rule 5160-70-04 of the Administrative Code. Any party who elects to present the case entirely in writing must do so in accordance with procedures ordered by the hearing examiner. The hearing examiner's order shall be in writing and filed with the depository agent. In the event that the party elects to present its case in writing, ODM may elect to present its case entirely in writing. Nothing in this rule is to be construed as preventing ODM from compelling the attendance of the party or other witnesses at the hearing and questioning the party or other witnesses as if on cross-examination. Nothing in this rule is to be construed as preventing the party from examining any witnesses or evidence presented by ODM at the hearing.
- (3) During the course of any hearing, the participants in the hearing may enter into oral stipulations of fact, procedure, or the authenticity of documents, which shall be incorporated into the record and shall bind the conduct of the participants. The hearing examiner may require oral stipulations to be reduced to writing and submitted to the hearing examiner. The hearing examiner has the power to rule on the admissibility of evidence or testimony, but a participant may make objections to the rulings. If the hearing examiner refuses to admit evidence or testimony, the participant seeking admission of same must make a proffer thereof and such proffer shall be made a part of the record of the hearing. The hearing examiner may refer to the Ohio Rules of Evidence ([www.supremecourt.ohio.gov/LegalResources/Rules/evidence/evidence.pdf](http://www.supremecourt.ohio.gov/LegalResources/Rules/evidence/evidence.pdf), July 1, 2012) as guidance in making decisions on admissibility.
- (4) Any notice of intended action or any document that supports the issuance of the notice of intended action issued by ODM, if offered into evidence, constitutes, regardless of consent of any party, prima facie evidence sufficient to establish the facts contained therein and that, if not rebutted by the party, is sufficient to sustain a determination that ODM has met its burden of proof. The party carries the burden of production to rebut the prima facie evidence. Nothing in this rule prevents ODM from presenting additional evidence in reply to the rebuttal evidence presented by the party.

(B) Report and recommendation and filing objections

- (1) After the conclusion of the hearing, the hearing examiner shall submit to ODM a written report setting forth the hearing examiner's findings of fact and conclusions of law and a recommendation of the action to be taken by ODM. The report shall be filed with the depository agent. Within five days of the report's filing with the depository agent, as evidenced by the time stamp of the agent, ODM shall send by certified mail, return receipt requested, to the party, the party's attorney, or other authorized representative of record a copy of the hearing examiner's report. The report shall be considered to have been mailed as of the mailing date appearing on United States postal service form 3800 or any future equivalent postal service form. If delivery is not successful by certified mail, the provisions regarding the steps subsequent to the mailing of certified mail in section 119.07 of the Revised Code shall be followed for service of the report.
- (2) Any participant in the hearing may file written objections to the hearing examiner's report. Any such objections must be received no later than ten days after the participant in the hearing receives the report. The director may grant an extension of time to file objections if the participant's written request for an extension is received by ODM no later than ten days after the participant's receipt of the report. The date the participant in a hearing receives the hearing examiner's report is the receipt date indicated on the United States postal service form 3800, or any future equivalent postal services form. The director shall consider timely written objections before approving, modifying, or disapproving the recommendation of the hearing examiner.
- (3) The director may order additional testimony to be taken by the hearing examiner and permit the introduction of further documentary evidence to the hearing examiner. The hearing examiner shall issue a revised written report and recommendation after consideration of any additional testimony and evidence. If the hearing examiner issues a revised report and recommendation, the provisions of paragraphs (B)(1) and (2) of this rule shall be applied to the revised report and recommendation in the same manner as they were applied to the original report and recommendation.

(C) Adjudication order

- (1) The recommendation of the hearing examiner may be approved, modified, or disapproved by the director. In those instances where the director modifies or disapproves the recommendation of the hearing examiner, the director shall include the reasons therefor and incorporate said reasons into the adjudication order.
- (2) After the director enters an order approving, modifying, or disapproving the hearing examiner's recommendation on the ODM journal of proceedings, the director shall mail to any party by certified mail, return receipt requested, a copy of the order and a statement of the time and method by which an appeal may be perfected. A copy of such order shall be mailed to the attorney or other authorized representative of record.

(D) Appeal of an adjudication order

- (1) Any party adversely affected by an adjudication order, pursuant to this rule, may appeal from that order to the Franklin County Court of Common Pleas.
- (2) Any party desiring to appeal pursuant to this rule must file a notice of appeal with the depository agent setting forth the order appealed from and stating that the agency's order is not supported by reliable, probative, and substantial evidence and is not in accordance with law. The notice may, but need not, set forth the specific grounds of the party's appeal beyond the statement that the agency's order is not supported by reliable, probative, and substantial evidence and is not in accordance with law. In order to be determined filed with ODM, the notice of appeal must be received by the depository agent, as evidenced by an ODM date and time stamp, no later than fifteen days after the mailing to the party, as evidenced by the mailing date on the United States postal service form 3800 or any future equivalent postal service form, of the adjudication order to be appealed from. The appellant shall also file the notice of appeal with the Franklin county court of common pleas no later than fifteen days after the mailing to the party, as evidenced by United States postal service form 3800 or any future equivalent postal service form, of the

adjudication order to be appealed from. In filing a notice of appeal with the agency or the court, the notice that is filed may be the original notice or a copy of the original notice.

(E) Any stenographic record, including depositions, related to a hearing or an appeal pursuant to section 119.12 of the Revised Code shall not be considered a public record for purposes of section 149.43 of the Revised Code.

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