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State/Territory Name: Ohio

State Plan Amendment (SPA) #: 25-0010

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-14-28
Baltimore, Maryland 21244-1850

Financial Management Group

July 7, 2025

Maureen Corcoran, Director
Ohio Department of Medicaid
50 West Town Street, Suite 400
Columbus, Ohio 43215

RE: TN 25-0010

Dear Director Corcoran

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed Ohio state plan amendment (SPA) to Attachment 4.19-A OH 25-0010, which was submitted to CMS on June 3, 2025. This plan amendment removes obsolete pages from the state plan.

We reviewed your SPA submission for compliance with statutory requirements, including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903 as it relates to the identification of an adequate source for the non-federal share of expenditures under the plan, as required by 1902(a)(2), of the Social Security Act and the applicable implementing Federal regulations.

Based upon the information provided by the state, we have approved the amendment with an effective date of June 1, 2025. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Sudev Varma at 301-448-3916 or via email at sudev.varma@cms.hhs.gov

Sincerely,

[redacted]

Rory Howe
Director
Financial Management Group

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 25-0010

2. STATE: OH

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
June 1, 2025

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR 430.10

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2025 $ 0
b. FFY 2026 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
N/A

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
See attached addendum

9. SUBJECT OF AMENDMENT
Removal of obsolete pages from the state plan

10. GOVERNOR'S REVIEW *(Check One)*
( ) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
(●) OTHER, AS SPECIFIED:
The State Medicaid Director is the Governor's designee

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
MAUREEN M. CORCORAN

13. TITLE
STATE MEDICAID DIRECTOR

14. DATE SUBMITTED
June 3, 2025

15. RETURN TO
Greg Niehoff
Ohio Department of Medicaid
P.O. BOX 182709
Columbus, Ohio 43218

FOR CMS USE ONLY

16. DATE RECEIVED
June 3, 2025

17. DATE APPROVED
July 7, 2025

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Rory Howe

21. TITLE OF APPROVING OFFICIAL
Director of Financial Management Group

22. REMARKS
This SPA is for administrative clean-up purposes only. No policies are changed or affected.

Instructions on Back

CMS-179 Addendum for TN 25-0010
"Removal of obsolete pages from the state plan"

Block 8

Attachment 4.19-A:

Un-numbered Table of Contents page (no TN listed)
5101:3-1-07 (TN 84-28)
5101:3-1-08 (TN 84-28)
5101:3-1-51 (TN 84-28)
5101:3-1-57 (TN 84-28)
5101:3-1-58 (TN 84-28)

Ohio Hospital State Plan
Table of Contents

5101: 3-1-07 General Fiscal Policies
3-1-08 General Fiscal Policy: Third Party Liability
3-1-51 Medicaid General Provisions
3-1-57 Appeals Process for providers from proposed Departmental Actions
3-1-58 Policy Monitoring

5101: 3-2-01 - 3-2-079 See Detail on following page.

5101:3-1-07 General fiscal policies.

(A) Submission of invoices--The original copy of the particular provider's invoice should be submitted to the department as soon as possible after the service is provided, but at least monthly. In no case will payment be made for services rendered one year or more prior to receipt of the invoice. The carbon copy of the invoice should be retained by the provider as a record of the claim submitted. The "date of receipt" is the date the department receives the claim, as indicated by the Julian date within the transaction control number assigned by the department.

(B) The department sends a "Remittance Statement" upon payment of the provider's invoice which identifies what service is being paid for, and for which recipient. The information printed on the statement is self-explanatory except for the transaction control number. The "transaction control number" is a number assigned by the department to each claim received that uniquely identifies that claim. When making inquiry of the department concerning a claim payment, the transaction control number for that claim is to be furnished.

(C) Typing of invoices is required on some of the department's invoices - particularly those called optical character reader (OCR). "OCR" is a system whereby the billing information is transmitted directly to the computer resulting in faster payment to the provider.

(D) The "Current Procedural Terminology" (CPT) is used to codify medical procedures and services rendered to a patient by a physician or therapist. (Note: Other ~~providers~~ PRACTITIONERS, such as dentists, are supplied with specific codes.) Each procedure or service is identified with a five-digit code. The modifiers listed in the CPT code book do not apply under Ohio's medicaid program. The department has instituted numerous additions and deletions to the CPT codes which are contained in ~~"Appendix B,"~~ RULE 5101:3-1-60 OF THE ADMINISTRATIVE CODE.

(E) The "International Classification of Diseases" (ICD) is for use in coding the diagnosis or nature of the injury of the patient AND PROCEDURES ASSOCIATED WITH SERVICES. HOSPITALS ARE TO REPORT BOTH DIAGNOSES AND PROCEDURES ACCORDING TO ICD WHEN BILLING FOR INPATIENT AND OUTPATIENT SERVICES.

(F) Method of payment--All payment is by warrant, based on information supplied by the ~~Ohio department of public welfare~~ PROVIDER and paid directly to the provider of the medical services. Federal regulations prohibit the payment for medical services to the recipient of that service. The provider, therefore, must submit invoices on prescribed forms for medical services to the Ohio department of ~~public welfare~~ HUMAN SERVICES for payment.

HCFA-179 # 84-28 Date Rec'd 12/85
Supercedes _____ Date Appr. 7/26/85
State Rep. In. _____ Date Eff. 10/1/84

(G) Mailing of payment warrant--Payment of invoices correctly submitted will be mailed to the name and address associated with each respective provider number as maintained in the department's provider master file. Any changes in a provider's status, address, licensing, certification, board specialties, corporate name, or ownership must be reported immediately to the provider enrollment unit.

The mailing of payment warrants and remittance statements (the explanation of the payment) is a routine process. The department cannot honor requests for pulling a particular warrant for purposes of early mailing or personal pickup. Remittance statements are frequently mailed separately from the payment warrants.

(H) Procedure for adjusting an improper payment.

(1) If an error has been made in the payment either by the provider or the department, it must be corrected by advising the Ohio department of ~~public welfare~~ HUMAN SERVICES of the nature of the error in the following manner:

(a) Circle the line in error on a copy of the remittance statement.

(b) Do not file a corrected billing. Explain the error on the bottom of a copy of the remittance statement. For example:

(i) Duplicate payment

(ii) Overpayment

(iii) Underpayment

(iv) Third-party payment (indicate type of policy, policy number, amount paid, and the company name and address)

(v) Miscellaneous (explain)

(2) Adjustments for an overpayment, a duplicate payment, or payments for services not rendered may be made through a credit against future payment or by remitting a check, payable to the Ohio department of ~~public welfare~~ HUMAN SERVICES, for the payment amount with the above described documentation attached.

(3) If the total payment is in error, ~~please~~ return the warrant and the remittance statement TO THE DEPARTMENT. If only individual line items are in error, ~~please~~ follow the ~~above~~ instructions IN PARAGRAPHS (H)(1) TO (H)(4) OF THIS RULE and return only a copy of the remittance statement to the ~~address below~~ DEPARTMENT. Wherever practical, adjustments for improper payments for individual line items will be made on subsequent payments.

HCFA-179 # 84-28 Date Rec'd 1/2/85
Supercedes _____ Date Appr. 7/26/85
State Rep. In. _____ Date Eff. 10/1/84

(4) All inquiries concerning an adjustment should be directed in writing to: THE DEPARTMENT.

~~"Ohio Department of Public Welfare~~
~~Adjustment Unit~~
~~30 East Broad Street, 37th Floor~~
~~Columbus, Ohio 43215"~~

(I) Inquiries regarding status of bills--Inquiries regarding status of claims must be subsequent to the original billing date or the date on which the claim was resubmitted to the department by at least ninety days. Such inquiries must include a legible photocopy of the original invoice and be directed to: THE DEPARTMENT.

~~"Provider Assistance~~
~~Ohio Department of Public Welfare~~
~~P.O. Box 1461~~
~~Columbus, Ohio 43216"~~

(1) Prior to the submission of the inquiry, be sure:

(a) That the accounts receivable have been properly reconciled using the Ohio department of ~~public welfare~~ HUMAN SERVICES remittance statements. Such records must be adjusted to reflect the amount billed which exceeded the department's maximum reimbursement limit(s).

(b) That the original invoice was submitted within one year of the date of service. FOR HOSPITALS PAID ON A PROSPECTIVE BASIS AS IDENTIFIED IN RULE 5101:3-2-071 OF THE ADMINISTRATIVE CODE, "ONE YEAR FROM THE DATE OF SERVICE" IS ONE YEAR FROM THE DATE OF DISCHARGE.

(c) That the charges were not previously rejected by the department as not payable (i.e., noncovered services, not medically necessary, etc.).

(d) That eligibility of the recipient is verified with the county ~~welfare~~ department OF HUMAN SERVICES if the claim was previously rejected as "recipient ineligible."

(2) All inquiries must include a cover letter which specifies:

(a) Reason for inquiry.

(b) Name, address, provider number, and telephone number of the inquirer.

(J) Prohibition against factoring--No payment for care or services will be made to any organization or individual who is a factor.

HCFA-179 # 84-28 Date Rec'd 1/2/85
Supercedes _____ Date Appr. 7/26/85
State Rep In _____ Date Eff. 10/1/84

"Factor" is defined as an organization (collection agency, service bureau, etc.) or an individual (including those who have power of attorney) who advances money to a provider for his accounts receivable which have been assigned, sold, or otherwise transferred to such an organization or individual for an added fee or a deduction of a portion of such accounts receivable.

A factor is not a billing agent or accounting firm which prepares invoices or receives payments on behalf of the provider provided that the compensation received by the billing agent or accounting firm is on a fee-for-services basis and not on the basis of a percentage of dollar amounts billed or collected. A factor is also not the employer of a physician, dentist, or other practitioner if the practitioner is required to turn over his fees as a condition of employment, or an inpatient services facility (a hospital or nursing home) where there is a contractual agreement between the provider and facility whereby the facility submits the reimbursement claims, or an organized health care delivery system (foundation, plan, or HMO) which bills or receives payments for services performed by individuals under contractual arrangements.

(K) Recovery/audits

(1) The department's payment is payment-in-full for all services covered by the medicaid program made to eligible providers in accordance with applicable policies and procedures. Overpayments, duplicate payments, or payments for services not rendered are recoverable by the department at the time of discovery except in the case of long-term care facilities as provided for in Chapter 5101:3-3 of the Administrative Code. The department may recoup such payments by an automatic adjustment on future payments.

(2) Overpayments, duplicate payments, or payments for services not rendered which are discovered during the course of a fiscal or program audit are immediately collectible except in the case of long-term care facilities as provided for in Chapter 5101:3-3 of the Administrative Code. The provider may submit a certified check in the amount of the agreed upon finding to the "Ohio Department of ~~Public Welfare~~ HUMAN SERVICES, Division of Fiscal Affiars, 30 East Broad Street, 33rd Floor, Columbus, Ohio 43215" or the department will recoup such payments by automatic adjustment of future payments.

(3) Records necessary to fully disclose the extent of services provided must be maintained for a period of three years (or if an audit has been initiated, until the audit is completed and every exception resolved) and said records must be made available, upon request, to the department for audit purposes.

(4) No payment for outstanding medical services can be made if a request for audit is refused (see paragraph (C) of rule 5101:3-1-55 of the Administrative Code for fuller discussion).

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Providers of institutional services, limited to inpatient hospitals, INSTITUTIONAL PSYCHIATRIC FACILITIES, and nursing homes, ~~are reimbursed on a reasonable cost basis, and~~ are subject to various ADDITIONAL requirements. ~~involving cost reports, filing deadlines, settlements and audits.~~ SEE CHAPTER 5101:3-2 OF THE ADMINISTRATIVE CODE FOR REQUIREMENTS REGARDING HOSPITAL AND INSTITUTIONAL PSYCHIATRIC FACILITY SERVICES AND CHAPTER 5101:3-3 OF THE ADMINISTRATIVE CODE FOR REQUIREMENTS RELATIVE TO NURSING HOMES.

~~(L) Delinquent filing of medicaid cost reports~~

~~Hospitals have one hundred eighty days from the close of their fiscal year to file a cost report with the department (see rule 5101:3-2-23 of the Administrative Code).~~

~~(1) At the beginning of the first month overdue, the department will reduce the established percentage by twenty per cent and mail a delinquency letter to inform the provider of late filing penalty procedures.~~

~~(2) At the beginning of the second, third, and fourth months respectively, the department will reduce the percentage by additional ten per cent increments for a cumulative reduction of fifty per cent.~~

~~(3) At the beginning of the fifth month overdue, termination of the provider from the programs (Title XIX, Title V, general relief) will be recommended.~~

~~(M)~~ (L) The department's payment constitutes "payment-in-full" for any covered service. The provider may not bill the recipient for any difference between that payment and the provider's charge. The provider may not charge the recipient any co-payment, cost sharing or similar charge. The provider may not charge the recipient a down payment, refundable or otherwise.

The provider may bill the recipient for any services not covered by the medicaid program, or any service requiring prior authorization which has been denied by the department, if the recipient still chooses to have those services rendered.

The fact that a claim has been returned as nonpayable due to late submission does not mean that services rendered were noncovered and therefore billable to the recipient. The recipient may not be billed for such services.

Providers, with the exception of long-term care facilities as provided for in Chapter 5101:3-3 of the Administrative Code, are not required to bill the department for medicaid covered services rendered to eligible recipients. However, providers may not bill the recipient in lieu of the department unless they so notify the recipient in advance of services being rendered and the recipient agrees to be liable for the charges.

HCFA-179 # 84-28 Date Rec'd 1/2/85
Supercedes _____ Date Appr. 2/26/85
State Rep. In _____ Date Eff. 10/1/84

Effective Date: _____

Certification _____

_____
Date

Promulgated Under Revised Code Chapter 119.

Statutory Authority Revised Code Section 5111.02

Prior Effective Date: 6/3/83, 2/1/84

HCFA-179 # 84-28 Date Rec'd 1/2/85
Supercedes _____ Date Appr. 7/26/85
State Rep. In. _____ Date Eff. 10/1/84

5101:3-1-08 GENERAL FISCAL POLICY: THIRD-PARTY LIABILITY.

(A) THE OHIO MEDICAID PROGRAM CAN MAKE PAYMENT FOR COVERED SERVICES ONLY AFTER ANY AVAILABLE THIRD-PARTY BENEFITS ARE EXHAUSTED. BENEFITS AVAILABLE UNDER THE MEDICAID PROGRAM MUST BE REDUCED TO THE EXTENT THAT THEY ARE PAYABLE BY AN INSURANCE POLICY, VETERANS' COVERAGE, OR OTHER THIRD-PARTY RESOURCE. THIS PROVISION DOES NOT APPLY TO GOVERNMENTAL SUBSIDY FUNDS PAID FOR GENERAL PURPOSES, BUT DOES APPLY IF PAID FOR A SPECIFIC INDIVIDUAL.

(B) PROVIDERS ARE EXPECTED TO TAKE REASONABLE MEASURES TO ASCERTAIN ANY THIRD-PARTY RESOURCE AVAILABLE TO THE RECIPIENT AND TO FILE A CLAIM WITH THAT THIRD PARTY. IN SUCH INSTANCES, THE DEPARTMENT WILL NOT REIMBURSE FOR THE COST OF SERVICES WHICH ARE OR WOULD BE COVERED BY A THIRD-PARTY PAYOR IF BILLED TO THAT THIRD-PARTY PAYOR. FAILURE TO EXPLORE SUCH THIRD-PARTY RESOURCES WHEN KNOWN RENDERS THAT SERVICE NONREIMBURSABLE BY MEDICAID. IF THE PROVIDER RECEIVES A THIRD-PARTY PAYMENT AFTER HAVING RECEIVED A MEDICAID PROGRAM PAYMENT FOR THE SAME ITEMS AND SERVICES, THE DEPARTMENT MUST BE REIMBURSED THE OVERPAYMENT. UNDER NO CIRCUMSTANCES MAY THE PROVIDER REFUND ANY MONEY RECEIVED FROM A THIRD PARTY TO A RECIPIENT.

(1) IF THE EXISTENCE OF ANY THIRD-PARTY RESOURCE IS KNOWN TO THE DEPARTMENT, A NOTATION "PRIVATE HEALTH INSURANCE" OR "MEDICARE AND PRIVATE INSURANCE" WILL APPEAR ON THE "MEDICAL ASSISTANCE IDENTIFICATION" CARD UNDER THE RECIPIENT'S CASE NUMBER. PROVIDERS WILL THEN NEED TO OBTAIN FROM THE RECIPIENT THE NAME OF THE INSURANCE COMPANY, TYPE OF COVERAGE, AND ANY OTHER NECESSARY INFORMATION, AND BILL THE PROPER AGENCY OR INSURANCE COMPANY PRIOR TO BILLING THE DEPARTMENT. AFTER RECEIPT OF THE THIRD-PARTY RESOURCE, THE DEPARTMENT MAY BE BILLED FOR THE BALANCE. WHEN THE EXISTENCE OF THIRD-PARTY RESOURCES IS KNOWN TO THE DEPARTMENT AND A CLAIM IS SUBMITTED THAT DOES NOT INDICATE COLLECTION OF THE THIRD-PARTY PAYMENT, THE CLAIM WILL BE REJECTED PENDING DETERMINATION OF THIRD-PARTY COVERAGE. PROVIDERS ARE TO COMPLETE INVESTIGATION OF AVAILABLE RESOURCES BEFORE SUBMITTING THE CLAIM TO THE DEPARTMENT FOR PAYMENT.

(2) IF THE RECIPIENT STATES HIS PRIVATE HEALTH INSURANCE HAS BEEN CANCELLED, HE SHOULD BE ADVISED TO CONTACT HIS COUNTY DEPARTMENT OF HUMAN SERVICES CASEWORKER TO CORRECT HIS CASE RECORD. IN SUCH CASES, THE PROVIDER MAY BILL MEDICAID DIRECTLY.

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(C) IT IS NOT THE INTENT OF THE DEPARTMENT TO DELAY PAYMENT TO AN ELIGIBLE PROVIDER FOR THE COVERED SERVICES BECAUSE OF AN OUTSTANDING THIRD-PARTY LIABILITY WHICH CANNOT BE CURRENTLY ESTABLISHED OR IS NOT CURRENTLY AVAILABLE TO APPLY AGAINST THE RECIPIENT CHARGES. IF A PAYMENT (OR DENIAL) IS NOT FORTHCOMING FROM THE THIRD PARTY WITHIN THREE MONTHS, THE PROVIDER SHOULD PROCEED WITH SUBMISSION OF A BILL TO THE DEPARTMENT, INDICATING THE NAME AND ADDRESS OF THE POSSIBLE THIRD-PARTY PAYMENT SOURCE. THE DEPARTMENT HAS BEEN GRANTED SUBROGATION RIGHTS FOR DIRECT REIMBURSEMENT FROM AN INSURANCE COMPANY FOR PAID MEDICAL SERVICES. THIS CAPACITY IS PARTICULARLY USEFUL IN SITUATIONS IN WHICH ENTITLEMENT IS DETERMINED AFTER A LENGTHY REVIEW RESULTING FROM AUTOMOBILE ACCIDENTS OR PERSONAL INJURY CASES. THE DEPARTMENT WOULD APPRECIATE NOTIFICATION OF POTENTIAL SITUATIONS WHERE SUCH RECOVERY MAY BE FORTHCOMING. FOR EXAMPLE, WHEN A RECIPIENT REQUESTS A STATEMENT OF SERVICES OR PRESENTS A CLAIM FORM AFTER THE SERVICE HAS BEEN PROVIDED, THE CLAIM FORM IS NOT TO BE COMPLETED BY THE PROVIDER BUT SENT TO THE DEPARTMENT'S THIRD-PARTY RESOURCES SECTION. EXCEPT FOR PROVIDERS OF LONG TERM CARE SERVICES AS DEFINED IN CHAPTER 5101:3-3 OF THE ADMINISTRATIVE CODE, IF AN ATTORNEY OR RECIPIENT REQUESTS MEDICAL INFORMATION ON ANY CASE WHERE MEDICAID HAS PAID THE BILL, THE REQUEST IS TO BE DIRECTED TO THE DEPARTMENT'S THIRD-PARTY RESOURCES SECTION AND NOT TO BE FURNISHED BY THE PROVIDER UNTIL ADVISED TO DO SO BY THE OHIO DEPARTMENT OF HUMAN SERVICES. NOTIFICATION WILL NOT AFFECT THE DEPARTMENT'S PAYMENT TO PROVIDER.

(D) RELATIONSHIP TO MEDICARE--"MEDICARE" (TITLE XVIII) IS A TOTALLY FEDERALLY FINANCED PROGRAM OF HOSPITAL INSURANCE (PART A) AND SUPPLEMENTAL MEDICAL INSURANCE BENEFITS (PART B) COVERING, GENERALLY, INDIVIDUALS AGE SIXTY-FIVE AND OVER, AND CERTAIN DISABLED INDIVIDUALS UNDER THE AGE SIXTY-FIVE. THESE TWO PARTS OF MEDICARE PAY FOR A BASIC PROGRAM OF MEDICAL COVERAGE UNDER WHICH THE PATIENT HAS A CERTAIN LIABILITY. MEDICAID ASSUMES THE LIABILITY FOR THE DEDUCTIBLE AND COINSURANCE ON INDIVIDUALS IT COVERS. THE DEPARTMENT PAYS THE MEDICARE PREMIUM OF ALL JOINTLY ELIGIBLE MEDICARE/MEDICAID RECIPIENTS, AND DOES NOT REIMBURSE PROVIDERS FOR ANY SERVICES PAYABLE BY MEDICARE EXCEPT FOR PAYMENT OF DEDUCTIBLES AND COINSURANCE.

MEDICARE ALSO PAYS FOR SKILLED NURSING FACILITY SERVICES, POST-HOSPITAL HOME HEALTH CARE SERVICES, AND WHOLE BLOOD. THE DEPARTMENT REDUCES ITS PAYMENT TO A MEDICAID SKILLED FACILITY TO THE AMOUNTS PAYABLE UNDER COINSURANCE.

(1) THE DEPARTMENT WILL PAY THE DEDUCTIBLE AND COINSURANCE AMOUNTS FOR THE RECIPIENT. IT WILL NOT, HOWEVER, PAY FOR ANY SERVICE NOT RECOGNIZED BY MEDICARE AS BEING MEDICALLY NECESSARY, NOR WILL IT PAY FOR ANY SERVICE PAYABLE BY (BUT NOT BILLED TO) MEDICARE. CERTAIN PROCEDURES ARE KNOWN TO BE PAYABLE BY MEDICARE. ANY MEDICARE COVERED PROCEDURE PROVIDED TO A MEDICARE/MEDICAID RECIPIENT WHICH IS INADVERTENTLY PAID FOR BY MEDICAID WILL BE SUBTRACTED FROM FUTURE PAYMENTS TO THE PROVIDER OR, FOR LONG-TERM CARE FACILITIES, AS PART OF A SETTLEMENT PROCESS DESCRIBED IN CHAPTER 5101:3-3 OF THE ADMINISTRATIVE CODE.

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Supercedes _____ Date Appr. 2/26/85
State Reg In _____ Date Eff 10/1/84

(2) PROCEDURE FOR SUBMITTING--IN ORDER TO OBTAIN REIMBURSEMENT FROM MEDICAID (TITLE XIX) FOR SERVICES POTENTIALLY COVERED BY MEDICARE (TITLE XVIII), THE PROVIDER MUST BE A PROVIDER RECOGNIZED AS SUCH UNDER THE MEDICARE PROGRAM, AND MUST FIRST SUBMIT A CLAIM TO THE MEDICARE CARRIER FOR PART A SERVICES OR THE MEDICARE INTERMEDIARY FOR PART B SERVICES.

(3) THE DEPARTMENT'S PAYMENT FOR SERVICES REIMBURSABLE UNDER MEDICARE IS LIMITED TO THE COINSURANCE AND DEDUCTIBLE.

(a) NO PAYMENT WILL BE MADE FOR SERVICES DENIED BY MEDICARE FOR LACK OF MEDICAL NECESSITY. PAYMENT WILL BE MADE FOR DENIAL DUE TO REASONS OTHER THAN MEDICAL NECESSITY AS LONG AS THE SERVICES ARE COVERED UNDER THE MEDICAID PROGRAM. IN ORDER FOR SUCH CLAIMS TO BE CONSIDERED, A COPY OF MEDICARE'S REJECTION NOTICE MUST BE ATTACHED TO THE APPROPRIATE MEDICAID INVOICE COMPLETED IN ACCORDANCE WITH THE INSTRUCTIONS IN THE BILLING INVOICE.

(b) NO PAYMENT WILL BE MADE FOR SERVICES PAYABLE BY (BUT NOT BILLED TO) MEDICARE. FOR SOME SERVICES, THIS ADJUSTMENT WILL BE MADE AUTOMATICALLY BY THE DEPARTMENT. IF PROVIDERS RECEIVE PAYMENT FROM MEDICAID FOR MEDICARE-COVERED SERVICES, PROVIDERS ARE TO NOTIFY THE DEPARTMENT.

(c) NORMALLY, PAYMENT WILL NOT BE MADE FOR SERVICES RENDERED TO A MEDICARE ELIGIBLE INDIVIDUAL BY A PROVIDER WHO REFUSES MEDICARE ASSIGNMENT. IT IS RECOGNIZED, HOWEVER, THAT A PROVIDER MAY NOT ALWAYS BE AWARE THAT AN INDIVIDUAL IS ELIGIBLE FOR MEDICAID AS WELL AS MEDICARE. IN THESE INSTANCES PAYMENT OF PATIENT LIABILITY CAN BE MADE IF THE PROVIDER AGREES TO ACCEPT THE TOTAL OF THE MEDICARE AND MEDICAID PAYMENT AS PAYMENT IN FULL FOR THE SERVICE PROVIDED. PROVISIONS OF 42 CFR 477.271 PROHIBIT PAYMENT BY THE DEPARTMENT WHICH, WHEN ADDED TO OTHER PAYMENTS, EXCEEDS THE CHARGE RECOGNIZED BY MEDICARE.

(E) THE DEPARTMENT'S PAYMENT AND MEDICARE PAYMENTS CONSTITUTE "PAYMENT IN FULL" AND NO ADDITIONAL PAYMENT MAY BE SOUGHT FROM THE RECIPIENT. IF PAYMENT (OTHER THAN COINSURANCE AND DEDUCTIBLE) IS INADVERTENTLY RECEIVED FROM BOTH MEDICARE AND MEDICAID FOR THE SAME SERVICE, THE CLAIMS ADJUSTMENT UNIT OF THE DEPARTMENT MUST BE NOTIFIED IN ACCORDANCE WITH THE PROVISION IN RULE 5101:3-1-07 OF THE ADMINISTRATIVE CODE. FAILURE TO NOTIFY THE DEPARTMENT OF SUCH DUPLICATE PAYMENTS WILL RESULT IN LOSS OF MEDICAID PROVIDER STATUS AND POSSIBLE LEGAL REFERRAL.

(F) SEE RULE 5101:3-2-25 OF THE ADMINISTRATIVE CODE FOR THIRD-PARTY LIABILITY PROVISIONS SPECIFIC TO INPATIENT HOSPITAL SERVICES.

(G) SEE CHAPTER 5101:3-3 OF THE ADMINISTRATIVE CODE FOR THIRD-PARTY LIABILITY PROVISIONS SPECIFIC TO LONG-TERM CARE SERVICES.

HCFA-179 # 84-28 Date Rec'd 1/2/85
Supercedes _____ Date Appr. 7/26/85
State Rep. In. _____ Date Eff. 10/1/84

EFFECTIVE DATE:_____

REPLACES RULE 5101:3-1-08

CERTIFICATION:_____

_____
DATE

PROMULGATED UNDER REVISED CODE CHAPTER 119.
STATUTORY AUTHORITY REVISED CODE SECTIONS 5111.02
PRIOR EFFECTIVE DATES: 4/7/77, 12/21/77, 12/30/77, 4/1/79

HCFA-179 # 84-28 Date Rec'd 1/2/85
Supercedes _____ Date Appr. 2/26/85
State Rep. In. _____ Date Eff. 10/1/84

5101:3-1-51 MEDICAID GENERAL PROVISIONS.

(A) "MEDICAID" IS A FEDERAL/STATE FINANCED PROGRAM WHEREBY MEDICAL, REHABILITATIVE, AND OTHER HEALTH-RELATED SERVICES ARE FURNISHED, THROUGH PUBLIC AND PRIVATE SOURCES, TO ELIGIBLE FAMILIES WITH DEPENDENT CHILDREN AND TO ELIGIBLE AGED, BLIND, OR DISABLED INDIVIDUALS WHOSE INCOME AND RESOURCES ARE INSUFFICIENT TO MEET THE COST OF NECESSARY MEDICAL CARE. THE OHIO MEDICAID PROGRAM COVERS THOSE MEDICAL SERVICES NECESSARY FOR THE DIAGNOSIS AND/OR TREATMENT OF A SPECIFIC PROBLEM. PREVENTIVE MEDICINE IS NOT A RECOGNIZED SERVICE ITEM UNDER THE MEDICAID PROGRAM EXCEPT FOR A SPECIALIZED HEALTH SCREENING PROGRAM FOR INDIVIDUALS TWENTY-ONE YEARS OF AGE AND UNDER KNOWN AS EPSDT. INFORMATION REGARDING THE EPSDT PROGRAM IS CONTAINED IN CHAPTER 5101:3-14 OF THE ADMINISTRATIVE CODE.

(B) MEDICAL NECESSITY IS THE FUNDAMENTAL CONCEPT UNDERLYING THE MEDICAID PROGRAM. PHYSICIANS, HOSPITALS, DENTISTS, AND OTHER MEDICAL PROVIDERS RENDER OR AUTHORIZE MEDICAL SERVICES BASED ON THEIR PROFESSIONAL JUDGMENT THAT THE SERVICES ARE NEEDED BY THE INDIVIDUAL TO CORRECT OR AMELIORATE NONDEFERRABLE MEDICAL NEEDS. ODHS REIMBURSES MEDICAL PROVIDERS FOR THOSE SERVICES COVERED WITHIN THE SCOPE OF ITS MEDICAL ASSISTANCE PROGRAM. MOST MEDICAL PROCEDURES ARE COVERED WITHIN CERTAIN ADMINISTRATIVE PARAMETERS. SOME PROCEDURES ARE COVERED IF APPROVED IN ADVANCE BY ODHS. A FEW PROCEDURES ARE NOT ORDINARILY REIMBURSABLE. THE LIMITATIONS IMPOSED SHOULD NOT BE INTERPRETED AS INDICATING THE QUANTITY OR TYPE OF MEDICAL CARE TO BE DELIVERED, AS THIS IS BASED ON THE PROFESSIONAL JUDGMENT OF THE MEDICAL PROVIDER. THE LIMITATIONS ONLY REFLECT THE NECESSITY FOR ODHS TO CONTROL ITS FISCAL OBLIGATIONS. A PROVIDER OF MEDICAL SERVICES MAY REQUEST PAYMENT FOR A MEDICAL SERVICE WHICH HE BELIEVES IS ESSENTIAL FOR A PERSON'S WELL-BEING EVEN IF THAT MEDICAL SERVICE IS NOT ORDINARILY A REIMBURSABLE ITEM.

(C) THE FOLLOWING GENERAL PRINCIPLES GOVERN THE ADMINISTRATION OF MEDICAID AND DETERMINE WHETHER A PARTICULAR MEDICAL SERVICE IS REIMBURSABLE.

(1) THE INDIVIDUAL ORIGINATES ALL REQUESTS FOR MEDICAL SERVICES.

(2) THE INDIVIDUAL IS FREE TO EXERCISE HIS RIGHT TO CHOOSE THE PROVIDER OF HIS CHOICE UNLESS THE INDIVIDUAL RECEIVES SERVICES THROUGH A MANAGED CARE PROGRAM APPROVED UNDER THE STATE PLAN FOR MEDICAL ASSISTANCE, E.G., HEALTH MAINTENANCE ORGANIZATION.

(3) THE INDIVIDUAL RECEIVES THOSE MEDICAL SERVICES NECESSARY TO CORRECT OR AMELIORATE THE SPECIFIC MEDICAL COMPLAINT. PREVENTIVE MEDICINE IS NOT A COVERED SERVICE ITEM EXCEPT UNDER THE EPSDT PROGRAM.

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(4) THE INDIVIDUAL MAKES NO PAYMENT (EXCEPT FOR LIABILITY IN A NURSING HOME) FOR MEDICAL SERVICES COVERED BY THE MEDICAID PROGRAM. THIS MEANS THAT A PROVIDER MUST ACCEPT THE MEDICAID PAYMENT AS PAYMENT IN FULL AND MAY NOT SEEK ADDITIONAL PAYMENT FOR ANY UNPAID PORTION OF THE BILL FROM THE PATIENT.

(5) THE INDIVIDUAL RECEIVES MEDICAL SERVICES AT THE SAME COST AS OR LESS THAN NONMEDICAID PATIENTS. THIS MEANS THAT ODHS WILL NOT PAY FOR SERVICES THAT ARE FREE TO THE GENERAL PUBLIC, OR IN AN AMOUNT GREATER THAN THE PROVIDER'S CUSTOMARY AND PREVAILING CHARGE TO OTHER PATIENTS. FOR INPATIENT HOSPITAL SERVICES BILLED BY HOSPITALS REIMBURSED ON A PROSPECTIVE PAYMENT BASIS AS DEFINED IN CHAPTER 5101:3-2 OF THE ADMINISTRATIVE CODE, THE ODHS WILL NOT PAY, IN THE AGGREGATE, MORE THAN THE PROVIDER'S CUSTOMARY AND PREVAILING CHARGES FOR COMPARABLE SERVICES. SEE CHAPTER 5101:3-3 OF THE ADMINISTRATIVE CODE REGARDING THE PROVISIONS OF THIS PARAGRAPH AS THEY APPLY TO PROVIDERS OF LONG TERM CARE SERVICES.

(6) AN INDIVIDUAL MUST BE PROVIDED NEEDED SERVICES WITHOUT REGARD TO RACE, COLOR, SEX, AGE, NATIONAL ORIGIN, ECONOMIC STATUS, OR HANDICAP.

(7) THE INDIVIDUAL HAS THE RIGHT TO A STATE HEARING IN ACCORDANCE WITH CHAPTER 5101:1-35 OF THE ADMINISTRATIVE CODE.

EFFECTIVE DATE:_____

REPLACES RULE 5101:3-1-51

CERTIFICATION:_____

_____
DATE

PROMULGATED UNDER REVISED CODE CHAPTER 119.
STATUTORY AUTHORITY REVISED CODE SECTION 5111.02
PRIOR EFFECTIVE DATES: 4/7/77, 12/21/77, 12/30/77, 7/1/80, 2/19/82

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5101:3-1-57 APPEALS PROCESS FOR PROVIDERS FROM PROPOSED DEPARTMENTAL ACTIONS.

(A) THE APPEALS PROCESS IS DESIGNED TO PROVIDE A HEARING UNDER CHAPTER 119. OF THE REVISED CODE (ADMINISTRATIVE PROCEDURES ACT) WHEREBY A PROVIDER MAY APPEAL THE PROPOSED DECISION OF THE DEPARTMENT TO SUSPEND, DENY, TERMINATE, OR NOT RENEW A PROVIDER AGREEMENT, OR TO IMPLEMENT A FINAL FISCAL AUDIT.

(1) THE APPEALS PROCESS DOES NOT APPLY IN THE FOLLOWING CIRCUMSTANCES:

(a) WHENEVER THE TERMS OF A PROVIDER AGREEMENT REQUIRE THE PROVIDER TO HAVE A LICENSE, PERMIT, OR CERTIFICATE ISSUED BY AN OFFICIAL, BOARD, COMMISSION, DEPARTMENT, DIVISION OR BUREAU, OR OTHER AGENCY OF STATE GOVERNMENT OTHER THAN ODHS, AND THE LICENSE, PERMIT, OR CERTIFICATE HAS BEEN DENIED OR REVOKED.

(b) WHENEVER PROVIDERS PARTICIPATE IN THE MEDICARE PROGRAM WHERE THE NEGATIVE ACTION TAKEN BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES IS BINDING ON THE PROVIDER'S MEDICAID PARTICIPATION AND WHERE THE FEDERAL AGENCY PROVIDES AN OPPORTUNITY FOR A HEARING.

(2) IF A PROVIDER OBJECTS TO A PROPOSED ADJUDICATION ORDER OF THE DEPARTMENT WHICH WOULD RESULT IN THE DENIAL, TERMINATION, SUSPENSION, OR NONRENEWAL OF A PROVIDER AGREEMENT OR IF HE WISHES TO CONTEST A FINAL FISCAL AUDIT, THE PROVIDER MAY REQUEST A FORMAL HEARING WHICH SHALL BE GOVERNED BY CHAPTER 119. OF THE REVISED CODE. SUCH REQUESTS MUST BE SUBMITTED IN WRITING TO THE DIRECTOR, ODHS. IN ANY MEDICAID HOSPITAL FINAL SETTLEMENT IN WHICH GENERAL RELIEF PROGRAM MONIES OR CRIPPLED CHILDREN'S PROGRAM MONIES ARE OFFSET AGAINST MEDICAID MONIES, THE DEPARTMENT WILL OFFER A RIGHT OF APPEAL PURSUANT TO CHAPTER 119. OF THE REVISED CODE FOR ALL THREE PROGRAM AREAS.

(3) CONTINUATION OF PAYMENT DURING THE APPEAL OF THE PROPOSED TERMINATION OR NONRENEWAL OF A PROVIDER AGREEMENT WILL OCCUR AS FOLLOWS:

(a) PAYMENT UNDER REGULATIONS FOR COVERED SERVICES PROVIDED TO ELIGIBLE RECIPIENTS WILL CONTINUE DURING THE ADMINISTRATIVE APPEALS PROCESS.

(b) IN THE CASE OF SKILLED NURSING AND INTERMEDIATE CARE FACILITIES, PAYMENT WILL CONTINUE DURING THE ADMINISTRATIVE APPEALS PROCESS FOR THOSE RECIPIENTS ADMITTED TO THE FACILITY PRIOR TO THE DETERMINATION OF NONCERTIFICATION OR PROVIDER AGREEMENT TERMINATION. NO NEW ADMISSIONS WILL BE AUTHORIZED SUBSEQUENT TO THE EFFECTIVE DATE OF THE DEPARTMENT'S TERMINATION ACTION OR THE EFFECTIVE DATE OF NONCERTIFICATION BY THE OHIO DEPARTMENT OF HEALTH.

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(B) OTHER ADMINISTRATIVE ACTIONS AFFECTING THE PROVIDER'S MEDICAID PROGRAM STATUS (SUCH AS RATE CALCULATIONS FOR LONG-TERM CARE FACILITIES) WHICH ARE NOT SUBJECT TO HEARINGS UNDER CHAPTER 119. OF THE REVISED CODE MAY BE RECONSIDERED BY THE APPROPRIATE DIVISION CHIEF UPON WRITTEN REQUEST BY THE AFFECTED PROVIDER TO THE DIRECTOR, ODHS. .

(C) SEE RULE 5101:3-2-0712 OF THE ADMINISTRATIVE CODE FOR ADDITIONAL INFORMATION CONCERNING THE APPLICABILITY OF THE APPEALS PROCESS TO INPATIENT SERVICES PROVIDED BY HOSPITALS SUBJECT TO PROSPECTIVE PAYMENT.

(D) SEE CHAPTER 5101:3-3 OF THE ADMINISTRATIVE CODE FOR ADDITIONAL PROVISIONS SPECIFIC TO LTCFS.

EFFECTIVE DATE:_____

REPLACES RULE 5101:3-1-57

CERTIFICATION:_____

_____
DATE

PROMULGATED UNDER REVISED CODE CHAPTER 119.
STATUTORY AUTHORITY REVISED CODE CHAPTER 119. AND SECTIONS 5111.02, 5111.06
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Effective Date 10/1/84

5101:3-1-58 POLICY MONITORING.

UTILIZATION OF SERVICES COVERED UNDER THE MEDICAID PROGRAM IS MONITORED ON AN ONGOING BASIS, AS REQUIRED OF EACH STATE BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES. WHERE CASES OF SUSPECTED FRAUD OR MISREPRESENTATION TO ILLEGALLY OBTAIN PAYMENT FROM THE MEDICAID PROGRAM ARE DETECTED, PROVIDERS ARE SUBJECT TO AN AUDIT BY THE DEPARTMENT. IF FRAUD IS APPARENT, REFERRAL OF THE CASE TO LAW ENFORCEMENT OFFICIALS WILL BE MADE. OVERUTILIZATION OF SERVICES BY CERTAIN PROVIDERS, WHILE POSSIBLY NOT CONSIDERED FRAUDULENT ACTS, MAY CONSTITUTE ABUSE TO THE MEDICAID PROGRAM. THIS ABUSE RESULTS EITHER DIRECTLY OR INDIRECTLY IN FINANCIAL LOSSES TO THE MEDICAID PROGRAM, ITS RECIPIENTS, OR THEIR FAMILIES. VARIOUS METHODS, SUCH AS THOROUGH INVESTIGATION, AUDIT, AND/OR PEER REVIEW, WILL BE UTILIZED TO DETERMINE ABUSE. IN ALL INSTANCES OF FRAUD OR ABUSE, ANY AMOUNT IN EXCESS OF THAT LEGITIMATELY DUE TO THE PROVIDER WILL BE RECOUPED BY THE DEPARTMENT THROUGH ITS BUREAU OF SURVEILLANCE AND UTILIZATION REVIEW, THE STATE AUDITOR, OR THE OFFICE OF THE ATTORNEY GENERAL.

(A) CASES OF PROVIDER FRAUD OR ABUSE MAY INCLUDE, BUT ARE NOT LIMITED TO, THE FOLLOWING:

(1) DUPLICATE BILLING BY A PROVIDER WHICH APPEARS TO BE DONE WITH THE INTENTION OF DEFRAUDING THE STATE AGENCY.

(2) MISREPRESENTATION AS TO SERVICES PROVIDED, DATE OF SERVICE, OR TO WHOM PROVIDED.

(3) BILLING FOR SERVICES NOT PROVIDED.

(4) DIFFERING CHARGES FOR THE SAME ITEMS FOR MEDICAID AND NONMEDICAID RECIPIENTS. FOR INPATIENT HOSPITAL SERVICES BILLED BY HOSPITALS REIMBURSED ON A PROSPECTIVE PAYMENT BASIS AS DEFINED IN CHAPTER 5101:3-2 OF THE ADMINISTRATIVE CODE, ODHS WILL NOT PAY, IN THE AGGREGATE, MORE THAN THE PROVIDER'S CUSTOMARY AND PREVAILING CHARGES FOR COMPARABLE SERVICES.

(5) VIOLATION OF PROVIDER AGREEMENT BY REQUESTING OR OBTAINING ADDITIONAL PAYMENT FOR THE SERVICES RENDERED FROM EITHER THE RECIPIENT OR RECIPIENT'S FAMILY.

(6) COLLUSIONARY ACTIVITIES BETWEEN A MEDICAL PROVIDER AND OTHER PROVIDERS.

(B) THE REVIEW OF A PROVIDER'S RECORDS WILL BE MADE IN ACCORDANCE WITH GENERALLY ACCEPTED AUDITING STANDARDS NECESSARY TO FULFILL THE SCOPE OF THE AUDITS. THE REVIEW SHALL BE OF THOSE RECORDS NECESSARY TO FULLY DISCLOSE THE EXTENT OF SERVICES PROVIDED TO INDIVIDUALS RECEIVING ASSISTANCE UNDER THE MEDICAID PROGRAM. 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 IN ACCORDANCE WITH APPLICABLE FEDERAL AND STATE REQUIREMENTS.

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(1) UPON REQUEST, A MEMBER OF THE PROVIDER'S STAFF IS TO BE ASSIGNED TO ASSIST THE DEPARTMENT IN COLLECTING INFORMATION IDENTIFIED IN PARAGRAPH (B) OF THIS RULE. UPON REQUEST, THE PROVIDER WILL MAKE THE APPLICABLE RECORDS AVAILABLE TO STATE STAFF FOR PHOTOCOPYING.

(2) FOR THE PURPOSES OF THIS RULE, THE DEPARTMENT SHALL HAVE THE AUTHORITY TO USE STATISTICAL METHODS TO AUDIT PROVIDERS AND TO DETERMINE ANY AMOUNT OF OVERPAYMENT.

(C) THERE ARE INSTANCES WHEN THE PROVIDER SUSPECTS THAT THERE MAY BE RECIPIENT FRAUD, MISREPRESENTATION, OR OVERUTILIZATION OF SERVICES. CASES OF RECIPIENT FRAUD OR ABUSE MAY INCLUDE, BUT ARE NOT LIMITED TO:

(1) USE OF ANOTHER PERSON'S MEDICAID CARD.

(2) OBTAINING WHAT WOULD APPEAR TO BE EXCESSIVE QUANTITIES OF MEDICAL SUPPLIES OR OTHER SERVICES.

(3) POSSIBILITY OF EXCESSIVE PHYSICIAN VISITS BY VIRTUE OF THE NUMBER OF PRESCRIPTIONS GENERATED.

(D) WHEN FRAUD OR ABUSE BY A RECIPIENT IS SUSPECTED, CONTACT SHOULD BE MADE WITH THE BUREAU OF SUR.

(E) RESPONSIBILITY FOR THE BUSINESS PRACTICES OF EMPLOYEES MUST BE ASSUMED BY PROVIDERS. IT IS PRESUMED 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 THE CONTENTS OF RULES WILL NOT BE ACCEPTABLE TO THE DEPARTMENT WHEN VIOLATION OF DEPARTMENTAL RULES HAS BEEN DETERMINED.

EFFECTIVE DATE: _____

REPLACES RULE 5101:3-1-58

CERTIFICATION: _____

_____
DATE

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