

# Medicaid Waiver Billing Instructions

Prepared by the

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## SECTION 1: MEDICAID WAIVER PROVIDER STANDARDS

- **Providers are independent business owners, and as such are responsible for billing the State for services rendered, following their claims as they are processed through the system, and maintaining documentation of services. Below is some information to help providers understand their responsibilities.**
- A Provider must **maintain all necessary records for a period of seven (7) years** in the event of an audit. **Documents retained must contain at a minimum:** the individual's authorized Individual Service Plan (**ISP**), Payment Authorization for Waiver Services (**PAWS**), documentation of services and dates services were delivered, and online reports from the Medicaid Billing System (**MBS**).
- **A Provider can only bill for actual units of services delivered.**
- A Provider should **bill all other third parties before submitting** bills to the Ohio Department of Developmental Disabilities (**DODD**). This should be done **annually** and the denial letters received from the insurance company must be retained with all billing records.
- Claims should be submitted within sixty (60) days from the day the service was delivered.
- A Provider can **only submit I/O and Level 1 waiver claims for services delivered** within the limits **specified on** the individual's authorized Individual Service Plan (**ISP**) and **approved** Payment Authorization for Waiver Services (**PAWS**) form. If the Provider does not have a copy of the ISP, copies must be obtained from the individual receiving the services or the Waiver Contact at the County Board of Developmental Disabilities.
- A Provider cannot bill services delivered in excess of the units authorized on the ISP and the approved PAWS.
- **A Provider cannot bill any individual; except for cases where the individual has a Patient Liability** for their cost of care. It is the Provider's responsibility to determine if the individual receiving services has Patient Liability and the monthly amount of that liability.

## **RULES**

- Chapter 5123:1-2-08 of the Ohio Administrative Code outlines the payment standards for Individual Options (I/O) Waiver services.
- Chapter 5123:2-8-16 of the Ohio Administrative Code outlines the payment standards for Level 1 (LV1) Waiver services.
- Chapter 5123:2-9-06 of the Ohio Administrative Code outlines the statewide payment rates under the I/O and LV1 waivers for individuals enrolled on July 1, 2005.
- Chapter 5123:2-9-12 of the Ohio Administrative Code outlines the payment standards for day habilitation services.
- Chapter 5123:2-9-19 of the Ohio Administrative Code outlines the payment standards for adult day support, vocational habilitation, supported employment-enclave, supported employment-community, and non-medical transportation services

The above-referenced rules can be accessed by going to the following website:

<http://dodd.ohio.gov/rules/rules.htm>

## SECTION 2: GENERAL INFORMATION

This Section will outline the instructions around the submission and reimbursement processes for Medicaid claims for services rendered through the Individual Options (IO) and Level 1 (LV1) Waivers.

- **All direct care service claims must be submitted through the Medicaid Billing System (MBS).** Providers may use their own Personal Computer (PC) to submit direct service claims using the single line entry method through the Medicaid Billing System (MBS), or a commercially produced billing software, or self-produced software (which generates claims in an ASCII text format or 837 format). For more information, contact EDI (electronic data interchange) at [edi.support@dodd.ohio.gov](mailto:edi.support@dodd.ohio.gov). All claim submission methods must meet DODD's data configuration requirements. Providers may hire a billing agent to do their billing for them. A list of agents who meet the technical specifications to direct-entry bill on behalf of DODD certified providers is available upon request. Inclusion on this list does **not** constitute endorsement by the Ohio Department of Developmental Disabilities.
- Claims for Environmental Modifications and/or Adaptive & Assistive Equipment must be submitted in paper format to DODD, Medicaid Development and Administration, Claims Services Unit. Additional information concerning this type of billing procedure can be found in Section 5.
- Claims submitted, which are error-free and match a valid DODD provider contract number are then forwarded to the Ohio Department of Job and Family Services (ODJFS) for processing review and approval for payment.
  - If DODD identifies claims containing errors, an Error Report is generated and accessed through MBS. **Claims that error** are not forwarded to ODJFS for payment approval. The provider or billing agent must make the **necessary corrections** and resubmit the claims.
  - If ODJFS identifies claims containing mistakes, known as “denials”, a denial report will be generated and accessed through MBS. **Claims that are denied** are not paid and **need to be corrected before payment can be issued**. These questions need to be directed to ODJFS.
- **Claims may be submitted** to DODD weekly, biweekly, or monthly.
- **Claims must be received by 11:45 am every Wednesday** to be included in that particular week's submissions. Notification will be provided in advance if submission dates are to change.
- **ODMRDD requires a minimum of twenty-one (21) days to process claims.**

- Reimbursement via EFT, commonly known as “direct deposit”, expedites payments. It helps eliminate the possibility of funds being misdirected, misplaced or stolen via the U.S. Mail. A Vendor’s Authorization Agreement for Automatic Deposit of State Warrants is available on the Ohio Shared Service’s website:

<http://ohiosharedservices.ohio.gov/document.aspx?id=b833fab4-666d-4daf-844f-af62452c34d8>

Please complete and return this form, along with a VOIDED check or deposit slip to:

Ohio Shared Services  
4310 E. Fifth Ave.  
Columbus, OH 43219

**Please note that the Ohio Department of Developmental Disabilities does not process requests for direct deposit. Requests for direct deposit are processed by Ohio Shared Services, a Division of the Ohio Office of Budget and Management. Questions regarding direct deposits, including closing an account or changing banking information, should be directed to Shared Services.**

**Ohio Shared Services**

**Fax:** 614.485.1039

**Telephone:** 614-338-4781 or 1.877.OHIOS1 (1.877.644.6771)

**E-mail:** [vendor@ohio.gov](mailto:vendor@ohio.gov)

- Providers receiving payments (in excess of \$600) from the State of Ohio will receive a 1099 Federal Disclosure of Income each year, issued by the Office of Budget and Management. Tax advice is strongly suggested as factors of self-employment apply.
- If you need to meet with a provider support representative for any reason, Federal HIPAA guidelines require Providers to be seen **by appointment only**.
- When contacting the Claims Services Unit by telephone, it is necessary for you to leave a voice message that includes the following information; Your Name, Company Name (if applicable), DODD Contract Number, Return Telephone Number(s) where you may be reached, and a Brief Description your problem (including the billing cycle number).
- Provider Support Services may also be contacted by e-mail at [provider.support@dodd.ohio.gov](mailto:provider.support@dodd.ohio.gov). In the e-mail message it is necessary for you to include Your Name, Company Name (if applicable), DODD Contract Number, a Brief Description of your problem (including the billing cycle number), and Telephone Number(s) if you would like Provider Support to respond by telephone.

Typical turn around time could be up to 48 hours to respond to phone and/or e-mails inquiries.

## SECTION 3: CLAIMS FILE SUBMISSION

### Internet Procedures

#### Requirement

To have the ability to submit claims to DODD and view reports generated by DODD, you must **obtain a copy** of the **DODD Security Affidavit**. The security affidavit can be located: [https://dodd.ohio.gov/apps/SEC\\_Logon\\_AffidavitRequest.aspx](https://dodd.ohio.gov/apps/SEC_Logon_AffidavitRequest.aspx)

The **affidavit must be completed** according to these instructions:

- A) Request Type  
Check appropriate box: New User, Adding a system or Renewal  
(Renewal notices are sent via e-mail 14 days prior to expiration)
- B) User information  
Check Provider
- C) User Name  
Insert the name of the person who will be accessing the system (Example Rob Wood)
- D) Contract Number or Billing Submitter Number  
Insert the contract number provided to you by DODD. Billing agents will need to submit their own information and include additional information that includes the Provider's Name, Contract Number, and Provider's authorization forms.
- E) Address  
Include your current Address, City, State and Zip Code
- F) E-Mail Address
- G) Telephone Number with Area Code and Fax Number with Area Code.
- H) User Signature and Date

Sign your Name and Insert the Date

**Before mailing or faxing**, please **verify** that the **Submitter ID has been completed** with your Contract number. Billing agents will be assigned contract numbers. Anyone submitting claims in the 837 Format should contact [edi.support@dodd.ohio.gov](mailto:edi.support@dodd.ohio.gov) for further instructions.

**Please Note:** The **County Board Superintendent signature** is **no longer required**.

Once the affidavit has been completed and reviewed, please forward the completed form via fax to the DODD Security Coordinator at **(614) 752-4673** or **mail the** originals to:

Department of Developmental Disabilities  
30 East Broad Street, 12<sup>th</sup> Floor  
Columbus, Ohio 43215-3434  
ATTN: Security Coordinator

**Once the completed form has been received and reviewed for accuracy, the DODD Security Coordinator will assign a User ID and Password. This information will be e-mailed to the e-mail address noted on the form.** The logon will be valid for a period of one (1) year on the production system and 30 days on the test system (837 format).

Once your User ID and Password have been received, you may access the system through the website: <http://dodd.ohio.gov/>

After logging on, a menu of applications is displayed. At the bottom of this page, please change your password. (The passwords assigned are temporary and case sensitive.) Then select “MBS”. This will display the MBS Claims Processing page. From this page, the following actions may be preformed:

- a. Upload Flat MBS Claims File (Waiver file upload) or 837 files.
- b. Single Record Entry Flat MBS Claim (Enter waiver claims – single line entry)
- c. Output Files

Claims may be entered into the system by clicking on the “Single Line Entry”. This screen will change, allowing for entry of a claim. Entry of multiple claims will be batched together for a given day and processed as one (1) file during the MBS production cycle. You can review and/or delete your file by looking under the upload flat file section. **Note: If using the single line entry screen, you are not required to upload file, as describe below.**

Uploading and viewing files: Choose “Upload Flat File”. This will open an “MBS claim file submittal” screen. This screen will allow the local PC to be browsed for the file to upload. Select the file and click on the “upload” button. Please note the size limitations and naming conventions on this screen. Files should follow the file name requirements.

Claims must be in a file named “Mxxxxxxx.nnn”, where xxxxxxx is the seven-digit Provider number assigned by ODMRDD, and nnn is the three numeric characters, which the provider uses to distinguish one file from another. Example: Provider’s ODMRDD assigned contract number is 3121969, and then each file submitted would be named M3121969.001, M3121969.002, etc., (The three (3) numeric characters following the dot (.) can be any numeric pattern the Provider chooses.) All files uploaded during the same production week, Wednesday @ 11:45 am to the following Wednesday @ 11:45 am, must have its own unique file name. The MBS claims submitted screen lists all files uploaded during the production week. Once production has begun, these files cannot be viewed.

**Any Security affidavit issues or Logon/Password related problems** should be reported to the DODD Security Coordinator at: [security.support@dodd.ohio.gov](mailto:security.support@dodd.ohio.gov)  
**Application related problems/Web-page errors or Server Issues** should be sent to: [edi.support@dodd.ohio.gov](mailto:edi.support@dodd.ohio.gov)

All types of Billing, Errors, Denials & other related billing questions should be sent to the Claims Services Unit via e-mail at: [provider.support@dodd.ohio.gov](mailto:provider.support@dodd.ohio.gov) or by telephone at 1-800-617-6733

PAWS issues should be directed to the County Board.

Entities who wish to explore automation of the 837 file submission process should send an e-mail to: [edi.support@dodd.ohio.gov](mailto:edi.support@dodd.ohio.gov) The e-mail should include a brief description of the request, DODD log-on, e-mail address, and anticipated claims volume.

# DATA ELEMENTS

05050524052123456789012HOSHOS123456721AHP0032S00000000225000000000000000space(40)0505240001

A B C D E F G H I J K L M N O P Q R S

A	Billing Period	4 bytes
B	Invoice Date	6 bytes
C	Form Number “2”	1 byte
D	Medicaid Recipient Billing Number	12 bytes
E	Recipient Last Name	5 bytes
F	Recipient First Initial	1 byte
G	Contract Number	7 bytes
H	Day of Service *(Requires a leading “0”)	2 bytes
I	Service Code	3 bytes
J	Units of Service	4 bytes
K	Other Source	1 byte
L	Other Source Amount	7 bytes
M	Group Size	2 bytes
N	Service County ID	2 bytes
O	Usual Customary Rate	7 bytes
P	Contractor Reference Number*(Assigned by Contractor)	9 bytes
Q	Staff Size	2 bytes
R	Filler (space)	40 bytes
S	File Reference Number	10 bytes

**SAMPLE CLAIMS DATA** Total 125 bytes

05050524052123456789012HOSHOS123456721AHP0032S00000000225000000000000000space(42)0505240001  
 05050524052123456789012HOSHOS123456722AHP0032S00000000225000000000000000space(42)0505250001  
 05050524052123456789012HOSHOS123456723AHP0032S00000000225000000000000000space(42)0505260001  
 05050524052123456789012HOSHOS123456724AHP0032S00000000225000000000000000space(42)0505270001  
 05050524052123456789012HOSHOS123456725AHP0032S00000000225000000000000000space(42)0505280001  
 05050524052123456789012HOSHOS123456726AHP0032S00000000225000000000000000space(42)0505290001  
 05050524052123456789012HOSHOS123456727AHP0032S00000000225000000000000000space(42)0505300001

The following are detailed descriptions of each of the data elements identified in the data configuration requirements:

**A. Billing Period:** The month and year in which services being billed were actually delivered, in the form MM (month) YY (year). **Single-digit numbers must include a leading zero.**

**EXAMPLE** - July 2008 would be entered "0708"

**\*\* The Month Billed is not necessarily the month and year in which the claim is submitted. Services delivered in July might not be billed until August.**

**B. INVOICE DATE:** The date on which the claim is submitted, in the form MM (month) DD (day) YY (year). **Single-digit numbers must include a leading zero.** (Single line entry automatically inserts the current date)

**EXAMPLE** – August 1, 2007 would be entered "080107"

**C. MEDICAID RECIPIENT BILLING NUMBER:** The 12 digit Identification Number, which is assigned by ODJFS, is found in the first column on the individual's Ohio Medicaid Card, which is issued monthly.

**D. RECIPIENT LAST NAME:** The **first five (5) letters of the Medicaid eligible individual's last name**. If the last name contains non-alpha characters (such as apostrophes, hyphens, spaces, etc.), enter **only** the first five (5) letters (skip all non-letters). If the last name has less than five (5) letters, place the first letter at the left and leave any blanks at the right (not required for single line entry). Indicators of sequence, such as "Jr." or "II" are considered part of the eligible individual's last name. If the last name is less than five characters and contains an indicator of sequence, the first five letters must be entered into the Last Name field.

This entry must reflect the Medicaid eligible individual's name as it is currently stated on their Ohio Medicaid Card. **EXAMPLES:**

<b><u>Last Name</u></b>	<b><u>Enter As</u></b>
Hoshor	HOSHO
O'Brien	OBRIE
Watt, II	WATTI
Van Meter	VANME
Lock, Jr.	LOCKJ

**F. RECIPIENT FIRST INITIAL:** The initial of the legal first name **of the individual receiving Medicaid services. This initial must correspond with the data found on the individual's Ohio Medicaid Card.**

**EXAMPLE** - William would be entered as **W**  
(Although the individual is called **Bill**, his legal name is **William**)

**G. CONTRACT NUMBER:** The 7-digit number assigned to the Provider by DODD. This number identifies the service provider and is used to match the claim with the Provider's service contract.

**For claims submissions to DODD do NOT use the Medicaid Provider Number assigned by ODJFS.**

**H. DAY OF SERVICE:** The 2-digit number of the day of the month on which the service being billed was actually delivered to the eligible individual. This number, when combined with the Month Billed, will constitute the date of service. **Single-digit numbers must include a leading zero.**

**EXAMPLE** – November 6, 2007 the day of service would be entered as “06”

**I. SERVICE CODE:** The appropriate 3-digit **ALPHA** Service Code.  
<http://dodd.ohio.gov/providers/billingdocs/HIPAABillingCodes.pdf>

**Claims submitted must be for services delivered as specified on the eligible individual's ISP and approved PAWS forms.** If the Provider does not have a copy of the ISP and the PAWS form, copies must be obtained from the individual receiving services or their Waiver Contact at the appropriate County Board of Developmental Disabilities.

**A provider may only claim each specific Service Code and Group Size once for each individual on the same day.** If the same Provider delivers the same service and group size more than once on the same day, the total units of service delivered on that day must be billed as one entry.

**J. UNITS OF SERVICE:** The number of Units delivered to the individual on the Day of Service. (Whether it is 15-minute units, daily units, or mileage.) The Waiver Services & Service Codes Table in Section 6 lists the appropriate Unit of Service measure for each Service Code. **All Units of Service must be expressed as whole numbers.**

**K. OTHER SOURCE:** The one-digit code indicates the third party payment status of the individual's claim. (See page 13)

**\*\* Medicaid is the "payer of last resort".** Prior to submitting a claim for payment, the Provider should determine the availability of other health insurance coverage for the eligible individuals by examining their Ohio Medicaid Card. If third party coverage is

indicated on the individual's Ohio Medicaid Card, the Provider must determine whether the Medicaid covered services being provided are covered by the carrier indicated on the card.

**If no payment from another source has been received and there is no indication of health insurance coverage for the individual, leave this field blank.**

**L. OTHER SOURCE AMOUNT:** The amount of payment received from Other Sources, in dollars and cents (do not use \$, decimal point or comma, i.e., \$5,086.12 is entered 508612). The monetary amount entered on a claim line must be only the portion of the payment that applies to the Day of Service and Service Code. **If the Other Source field is blank or contains an alpha Other Source code (reason code), this field should remain blank.**

**M. GROUP SIZE:** The number of individuals receiving services by the same provider at the same time for the same service code.

**N. SERVICE COUNTY ID:** County of service delivery as defined on the PAWS.

**O. USUAL AND CUSTOMARY RATE (UCR):** The Provider's specified costs for providing various services. (Do not use \$, decimal point or comma, i.e., \$5,086.12 is entered 508612)

**P. CONTRACTOR REFERENCE NUMBER:** A unique nine-digit number assigned by the Provider to identify a claim. (Not a required field)

**Q. STAFF SIZE:** The number of staff providing services to the same individual at the same time for the same service code.

**R. FILLER:** Forty character spaces required if creating your own file.

**S. FILE REFERENCE NUMBER:** A ten-digit number assigned by DODD to track a specific file. It is a required number to delete a file.

**PATIENT LIABILITY CASES**

If the eligible individual receiving services has a monthly Patient Liability for their cost of care, the Patient Liability amount must be billed to the individual and identified on the claims submitted for services delivered to the individual. Since the individual is responsible for the Patient Liability amount, the Provider must enter "1" in the Other Source field. Enter the value of each claim line in the Other Source Amount field until the amount of the Patient Liability is satisfied.

**EXAMPLE** - The individual's obligation is \$96.00 per month in Patient Liability. The service rate is \$2.25 per unit of Homemaker/Personal Care. The individual received 32 units of Homemaker/Personal Care each day. The claims are submitted as follows:

Day of Service Code	Service Service	Units of Service	Other Source	Other Source Amount
01	APC	32	1	7200
02	APC	32	1	2400
03	APC	32		
04	APC	32		

In this example, the \$96.00 Patient Liability has been satisfied for the month.

**ALPHA OTHER SOURCE CODES**

(USED ONLY WHEN PAYMENT **HAS NOT BEEN RECEIVED** FROM A THIRD PARTY)

- R** - No Response from Carrier. The insurance carrier has not responded within 90 days.
- P** - No Coverage for this Medicaid Number. The Provider has confirmed that there is health insurance for some members of the Medicaid case, but this particular individual receiving services is not covered.
- F** - No Coverage for all Medicaid Numbers. The Provider has confirmed that there is no health insurance for any member of the Medicaid case.
- L** - Disputed or Contested Liability. The Provider has confirmed that there is health insurance, but the coverage for the billed service is contested by the carrier.

**S - Non-Covered Services.** The Provider has confirmed that there is health insurance, but the policy does not cover the service being billed.

- X** - Non-cooperative Recipient - The Provider has confirmed that there is health insurance, but the individual/guardian refuses to cooperate in the collection effort.
- E** - Insurance Benefits Exhausted. The Provider has confirmed that there is health insurance, but the policy benefits for the billed service have been exhausted.

**NUMERIC OTHER SOURCE CODES**

(USED ONLY WHEN PAYMENT **HAS BEEN RECEIVED** FROM A THIRD PARTY AND IN PATIENT LIABILITY CASES.)

**1 - Payment received from individual receiving services (Self Pay/Family Pay).** This code is used to **represent Patient Liability.**

- 2** - Payment received from Blue Cross/Blue Shield.
- 3** - Payment received from private insurance carrier.
- 4** - Payment received from employer or union.
- 5** - Payment received from Public Agency.

## **SECTION 5: ENVIRONMENTAL MODIFICATION AND ADAPTIVE & ASSISTIVE EQUIPMENT CLAIMS**

All Environmental Modification Claims and Adaptive & Assistive equipment claims must be approved through the PAWS process. The PAWS establishes each service that is authorized, the Provider who is approved to provide the service, the maximum rate of reimbursement for each service, and the date span during which the service may be provided. Reimbursement shall not exceed the maximum rate established by the PAWS. **Providers will not be reimbursed for sales tax.**

The Service Codes for Environmental Modifications and Adaptive & Assistive Equipment claims are found in Section 6, and should correspond to the Service Codes identified on the individual's PAWS form.

- Adaptive & Assistive Equipment Claims must include the following:
  1. Completed Form 2. A master Form 2 (DMR 1148) is available on the ODMRDD website. This form may be reproduced as needed.
  2. Provider's Invoice
- Environmental Modification Claims must include the following:
  1. Completed Form 2. A master Form 2 is available on the ODMRDD website. This form may be reproduced as needed.
  2. Provider's Invoice
  3. Completed Verification of Environmental Modification Form. A master Verification of Environmental Modification Form is available on the DODD website. This form may be reproduced as needed and must be signed by an authorized County Board representative.

Environmental Modifications and Adaptive & Assistive Equipment claims **must** be submitted in paper format to DODD, Medicaid Development and Administration, Claims Services Unit via fax at 614-466-7359 or mail to ensure prompt processing (See page 1 for address).

**NOTE:** These claims **cannot** be submitted electronically.

Environmental Modifications and Adaptive & Assistive Equipment claims require an additional level of processing. This additional processing causes these claims to extend beyond the 21-day processing timeline for personal service claims. These claims require a minimum of thirty (30) days to be processed for payment.

## SECTION 6: CLAIMS REJECTED AS ERRORS

The Error Report (Weekly Service Delivery input errors for billing cycle JAN08A) is a computer-generated report of all errors detected by DODD's claims processing system for the billing cycle indicated. This report may be viewed in MBS.

**\*\* The claims identified on an Error Report must be resubmitted to DODD with corrections before the claims can be submitted to ODJFS for payment approval.**

Below each Submitted Data Line is one or more **Error Codes** with **error messages** that **describe the reason the claim was rejected**. If errors indicated are in the LAST NAME or INITIAL fields, the last and first names from the current ODJFS Recipient File are printed as an aid in correction.

Contact Provider Support Services if further assistance is needed.

**ERROR CODES AND DESCRIPTIONS:** The following outlines Error Codes and Descriptions for each error code identified. Refer to the corresponding Error Code Description in this section for assistance in understanding and correcting each error.

**(1) DATE OF SERVICE IS MISSING OR INVALID.** The Billing Period and the Day of Service are combined to produce the Date of Service. If this Error Code is indicated, it means an invalid date was entered, or some or all of the date was omitted. An invalid date could be a month or day out of range (such as month "13" or day "30" in February), or a single-digit entry without a leading zero. To correct, enter the Billing Period and/or Day of Service in the correct format with corrected date.

**(2) DATE OF SERVICE EXCEEDS PROCESSING DATE.** The Date of Service was later than the date the computer processed the claim, which means the claim was for a future date. To correct, enter the Billing Period and/or Day of Service in the correct format with corrected date.

**(3) DATE OF SERVICE PROCEEDS START-UP DATE.** The Date of Service was entered wrong. To correct, enter the Billing Period and/or Day of Service in the correct format with corrected date.

**(4) SERVICE CLAIM IS ONE YEAR OLD.** The service date, prior to the processing date, is at least 365 days old. Claims over 365 days old are invalid. To correct, confirm that the Billing Period and/or Day of Service were entered correctly. If incorrect information was entered, re-enter the corrected information.

**(5) SERVICE AVAILABILITY HAS EXPIRED.** Occasionally, services may only be available through a specific date span. This Error Code indicates that the Date of Service was after the date the Service Code billed and the service was no longer allowable. To address this you should confirm that the Billing Period and/or Day of Service has been entered correctly. If incorrect information was entered, re-enter the corrected data.

**(6) INVOICE DATE IS MISSING OR INVALID.** The Invoice Date contained wrong date information or was omitted. To correct, enter the corrected format with the correct date.

**(7) INVOICE DATE EXCEEDS PROCESSING DATE.** The Invoice Date is later than the date the claim was processed. To correct, enter the correct date.

**(9) CLAIM DOES NOT MATCH USEABLE PAWS RECORD.** The eligible individual being served may not have an active PAWS record. The Provider should have an ODMRDD approved PAWS confirmation before submitting claims. You may receive this error if any of the following information has been entered incorrectly into the system: the billing period, the individual's Medicaid recipient number, their first initial, contract number, day of service, service code, group size, county of service or UCR. Review the ODMRDD approved PAWS confirmation for accurate information. If the Provider has an authorized PAWS confirmation, contact the County Board of the service county for assistance.

If the Provider does not have an approved DODD PAWS confirmation, contact the individual's Case Manager at the local County Board of Developmental Disabilities or Council of Government (COG) then resubmit the claim once the DODD confirmation has been received.

**(10) RECIPIENT NUMBER IS MISSING OR INVALID.** The individual's Medicaid Recipient Billing Number contained non-numeric data or was omitted. To correct, review the submitted information and re-enter the correct data.

**(11) RECIPIENT NUMBER CHECK DIGIT IS INVALID.** The individual's Medicaid Recipient Billing Number could not be located by ODJFS. Review the number found on the Ohio Medicaid card. A common cause of this error is a transposition of numbers when entering the number into the system. If this is not the problem, the number could be invalid and Provider Support Services should be contacted.

**(12) PAWS DAILY UNIT LIMIT IS EXCEEDED.** If Waiver services have been authorized through the PAWS process at a Daily Frequency Period, claims must be submitted for a number of units less than or equal to the maximum number of units of service approved for each day.

**(15) RECIPIENT LAST NAME IS MISSING.** The individual receiving services last name is missing. To correct insert the last name in the field (First 5 alpha letters of the last name, See Section 4-E).

**(16) RECIPIENT LAST NAME IS INVALID.** The individual's Last Name contained non-alpha data (such as dashes or apostrophes). The Last Name field is incorrect; the current ODJFS Recipient File is printed below the error to help you correct this error.

**(17) RECIPIENT INITIAL IS MISSING OR INVALID.** The individual's Initial contained non-alpha data or was not included. The Legal First Name field is incorrect; the current ODJFS Recipient File is printed below the error to help you correct this error.

**(18) HOMEMAKER/PERSONAL CARE EXCEEDS 24 HOURS IN A DAY.** HPC service authorized for the eligible individual shall not exceed twenty-four (24) hourly billing units, ninety-six (96) fifteen minute billing units, one (1) daily billing unit, or a combination of **all** units billed by **all** service providers that would total more than twenty-four (24) hours of service on the same day.

**(19) CONTRACT NUMBER IS MISSING OR INVALID.** The Provider's Contract Number contained non-numeric data or was not included. To correct, enter the correct number (See Section 4-E)

**(20) DIFFERENT HOMEMAKER/PERSONAL CARE SERVICES ON SAME DAY.** HPC service shall not be based on a day billing unit when the eligible individual receives this service's from more than one waiver service provider on the same day.

**(21) CONTRACT NUMBER CHECK DIGIT IS INVALID.** The check digit could not be computed by DODD. The most likely cause of this error is the rearrangement of numbers entered on the claim.

**(22) PAWS TOTAL UNIT LIMIT IS EXCEEDED.** The PAWS process sets the maximum units of service that are approved. This error indicates that all approved units have been depleted. Refer to the DODD approved PAWS confirmation for total authorization of units for the fiscal year.

**(23) SERVICE CODE IS MISSING OR INVALID.** The Service Code was not entered correctly or left blank. Refer to Section 6 of these instructions for a listing of valid Service Codes or approved PAWS confirmation.

**(24) UNITS DELIVERED ARE MISSING OR INVALID.** The Units of Service Delivered were not entered or the information entered could not be processed. Check this field; make the necessary corrections and resubmit.

**(25) PAWS TOTAL COST LIMIT IS EXCEEDED.** The PAWS process establishes the maximum dollar amount approved for each individual receiving services. This error indicates that all approved funds have been spent. Refer to the DODD approved PAWS confirmation for total dollar amount authorized.

**(26) UNITS DELIVERED ARE EXCESSIVE.** Claims for any Service Code with quarter-hour (15 minutes) units are restricted to 96 units per day. Claims for any Service Code with hourly units are restricted to 24 units per day. Daily rate codes are restricted to one (1) unit per day. Refer to the DODD approved PAWS confirmation for total units authorized.

**(27) OTHER SOURCE OF PAYMENT IS INVALID.** Values for this field must be one of the following: 1 or 2 or 3 or 4 or 5 or R or P or F or L or S or X or E or blank. The field is left blank only if the individual receiving services does not have patient liability or third party insurance.

**(28) SERVICE DUPLICATED FOR RECIPIENT AND DATE.** If one Provider for the individual receiving services inputs two or more claims during the same billing cycle, duplicating the Service Codes and Dates of Service, this error occurs. The first claim will not error, but all duplicate claims will error.

To correct verify that the entries causing this error are correct and resubmit the corrected claims.

**(29) OTHER SOURCE CODE AND PAYMENT AMOUNT DISAGREE.** If the Other Source field is blank or contains a letter character (R or P or F or L or S or X or E), the Other Source Amount field must be blank. If the situation is reversed and the Other Source field contains a number, (1, 2, 3, 4 or 5) which indicates payment has been received, the Other Source Amount field must contain a dollar amount. These fields **must be** corrected or these claims **will not** be processed (See Section 4-K & L).

**(30) PAWS MONTH UNIT LIMIT IS EXCEEDED.** The PAWS process could establish the maximum Monthly Frequency Period approved for eligible individual receiving services. This error indicates that all approved monthly units have been exceeded. To correct this error, the claims must be for a number of units less than or equal to the maximum number of allowable units on the PAWS approved for each month. Refer to the DODD approved PAWS confirmation for the total number of authorized units per month.

**(31) ATTEMPT TO ADJUST ANOTHER PROVIDER'S CLAIMS.** If Provider "A" enters a claim into the system then zeros out that claim, and Provider "B" re-enters the same claim into the system, and Provider "A" attempts to adjust this claim, Provider "A" would receive this error. According to DODD's system that claim now belongs to Provider "B".

**(32) SERVICE IS IDENTICAL TO PRIOR BILLING.** If a claim is submitted for an eligible individual, Service Code, Date of Service, and Number of Units of Service as a prior paid claim, this error will result.

If the Units of Service differed between the two (2) claims, the new claim is considered an adjustment, and if no errors are discovered, the claim will be stored for later use in the adjustment process. Refer to section (9) for the adjustment process.

**(33) SERVICE IS INAPPROPRIATELY DELIVERED.** Certain combinations of services are inappropriate. For example, HPC service shall not be based on a day billing unit when the eligible individual receives HPC service from more than one waiver service provider on the same date of service.

**(34) PAWS WEEK UNIT LIMIT IS EXCEEDED.** If Waiver services have been authorized through the PAWS process at a Weekly Frequency Period, claims must be for a number of units less than or equal to the maximum number of units of service approved for each week.

**(35) LAST NAME DIFFERS FROM ODJFS RECIPIENT FILE.** The first five letters of the last name entered on the claim must be an exact match to the ODJFS Recipient File. If this error occurs, the Last Name as it appears in the ODJFS Recipient File will be printed on the Error Report as an aid for correction.

**(36) INITIAL DIFFERS FROM ODJFS RECIPIENT FILE.** The First Initial of the Legal First Name entered on the claim must be an exact match to the ODJFS Recipient File. If this error occurs, the First Initial as it appears in the ODJFS Recipient File will be printed on the Error Report as an aid for correction. Please use the First Initial exactly as it appears on the individual's Ohio Medicaid Card.

**(37) RECIPIENT NOT FOUND ON ODJFS RECIPIENT FILE.** A claim for a recipient who does not have a Recipient check digit error and is not found on the ODJFS Recipient File will receive this error. It is necessary to confirm that the twelve-digit Medicaid Recipient Billing Number on the claim is correct and entered on the ODJFS Recipient File

**(39) LEVEL ONE SERVICE EXCEEDS PLAN SPAN LIMIT.** HPC, Respite & Transportation, where the amount billed within the Paws plan exceeds \$5,000.00

**(40) LEVEL ONE SERVICE EXCEEDS WAIVER SPAN LIMIT.** LV1 errors when specialized medical equip-emergency response system costs exceed \$2,000.00 in the waiver span or when environmental adapt (FAA, FVN) is greater than \$2,000.00 and associated services are greater and \$6,000.00 during the waiver span or emergency services exceeds \$8,000.00 during waiver span.

**(41) GROUP SIZE IS MISSING OR INVALID.** This error occurs when the group size is missing or zero has been placed into this field.

**(42) ICD-9 CODE IS MISSING (837 FORMAT).** Contact EDI Support for assistance at: [edi.support@dodd.ohio.gov](mailto:edi.support@dodd.ohio.gov)

**(43) SERVICE DATE NOT FOUND IN ELIGIBILITY SPAN.** The date of service for CAFS claims does not fall within the ODJFS eligibility span.

**(44) SERVICE COUNTY IS MISSING OR INVALID.** This is the specific numeric code used to identify a county in which the eligible individual received service(s). If the service date is after July 1, 2005 and the “new” transition codes are being used on the PAWS, the Provider must include the Service County code in the claims submission(s). County of Service is identified as 01 to 88. These county codes are in the drop down box by field on the single line entry screen.

**(45) STAFF SIZE IS MISSING OR INVALID.** This error occurs when the staff size is missing or zero has been placed into this field.

**(46) STAFF SIZE AND SERVICE CODE DISAGREE.** This error occurs when the staff size and the coordinating services code that goes with a certain staff size doesn't match (see section 6).

**(47) STAFF SIZE EXCEEDS MAXIMUM ALLOWED.** This error occurs when the provider bills for more than 5 staff members for one claims line.

**(48) INPUT RATE IS MISSING OR INVALID.** This error occurs when the rate of claim(s) (the UCR) is missing or non-numeric data was entered into this field.

**(49) SERVICE DATE EXCEEDS ALLOWED ADJUSTMENT SPAN.** Any claim preceding the adjustment cut off date (currently 3/1/06) will receive this error designation. Claims being adjusted may not precede this date of service.

**(50) INDIVIDUAL AGE INAPPROPRIATE FOR FOSTER CARE.** An Individual receiving adult foster care services (AFA or AFO) must be 18 years of age or older.

**(51) SERVICE CODE AND PROVIDER TYPE DISAGREE.** Contact Provider Support [Provider.Support@dodd.ohio.gov](mailto:Provider.Support@dodd.ohio.gov) to have our IT department correct your provider type in the PAWS record.

**(52) HOMEMAKER/PERSONAL CARE AND FOSTER CARE CONFLICT.** An individual may not receive homemaker/personal care services on the same day as adult foster care services. In the event of simultaneous submissions, adult foster care services will receive precedent.

**(53) HIPAA BILLING CODE RECEIVED IS INVALID.** Resubmit using the appropriate billing code.

**(54) NET CLAIM AMOUNT IS LESS THAN ZERO.** Other source amount entered exceeds the amount billed for the individual claim. Resubmit, making certain the amount entered into the other source amount is *equal to or less than* the total claim. If necessary, report the remainder of the patient liability on the following day(s) claim.

**(55) DBU CLAIM OVER CEILING REJECTED BY DODD.** This error occurs when a daily billing unit claim submitted at a rate exceeding the established ceiling is rejected by DODD before submission to ODJFS.

**(56) CLAIM NOT MATCHED WITH ACUITY TABLE.** The claim did not match against the current acuity table, and the billing rate could not be calculated without an acuity value. The claim will be automatically re-submitted until a successful match is made with the acuity table.

**(57) INDIV SUSPENDED FROM PAWS ON THIS DATE.** The service was delivered on a date when the individual was temporarily suspended from PAWS, and thus ineligible for billing.

**CONTACT CLAIMS SERVICES UNIT IF FURTHER ASSISTANCE IS NEEDED.** The toll free telephone number is: (800) 617-6733 or email address is [provider.support@dodd.ohio.gov](mailto:provider.support@dodd.ohio.gov)

## SECTION 7: DENIED CLAIMS

All I/O and LV1 waiver claims are submitted to ODJFS for final adjudication (approval or denial). All claims, which are approved by ODJFS, are processed by DODD for payment. Any claim denied by ODJFS will not be paid by DODD.

If claims are denied by ODJFS, DODD then generates a DENIED Report, which lists all claims that have been denied, along with a three-digit denial code for each denied claim.

The following are the **most common Denial Codes** from ODJFS:

- **218 - TPL CASE MASTER RECORD INDICATES 3RD PARTY COVERAGE**

TPL stands for Third Party Liability. This denial indicates that ODJFS records show that **the recipient has health insurance**. As Medicaid is always the payer of last resort, this “other source” of coverage must be addressed in order for the claim to be approved for payment.

**Refer to Section 4 of this booklet for the proper Other Source Codes.**

Once the appropriate “Other Source Code” has been determined and entered in to the Other Source field on the claim, the **claim must be resubmitted** to DODD for reprocessing.

**Note:** Providers should submit claims to Insurance source reported to ODJFS at least once each year.

- **271 - SERVICE DATES FALL OUTSIDE OF ELIGIBILITY SPAN**

Waiver eligibility is contingent upon **Medicaid eligibility**. If a Medicaid eligible individual has a break in Medicaid eligibility due to a change in resources or circumstances, their eligibility for Waiver services may be suspended. Waiver claims cannot be reimbursed for any Date(s) of Service on which the individual was not Medicaid eligible.

It is important to check the individual’s Medicaid card monthly to confirm that Medicaid eligibility has not been interrupted.

- **289 - TAPE SUBMITTER NOT AUTHORIZED TO SUBMIT CLAIMS FOR THIS PROVIDER**

This denial **usually** only **affects new Providers or Providers that have not billed during the past year**. As DODD acts as the “middle man” between I/O and LV1 waiver providers and ODJFS, DODD must submit an ODHS Form 6301 to ODJFS for each Provider who provides waiver services. This form is signed by the Provider and authorizes DODD to act as an intermediary.

If the Provider has not signed a 6301 form (Electronic Media Notification), claims will be denied. Once the 6301 form is signed and filed with ODJFS, claims must then be resubmitted to DODD for processing. This form is part of the Certification packet. To obtain this form, contact DODD Provider Certification at 1-877-289-3636.

- **914 – PROVIDER STATUS**

This denial means your Medicaid Provider number (ODJFS) has been placed in VOLUNTARY TERMINATION STATUS. The Provider needs to fill out a “Re-Instatement Packet”. Contact Provider Certification for further instructions. 1-800-289-3636 or e-mail them at [certification.support@dodd.ohio.gov](mailto:certification.support@dodd.ohio.gov).

**Contact the Claims Services Unit by phone 1-800-617-6733 or email at [provider.support@dodd.ohio.gov](mailto:provider.support@dodd.ohio.gov) for further assistance with claims that have been denied by ODJFS.**

## SECTION 8: ADJUSTMENTS

Due to the number of variables involved with adjustments, it is always advisable to contact the Claims Services Unit [provider.support@dodd.ohio.gov or (800)617-6733] *before* entering an adjustment. These are just a few examples of common adjustments. Please note that “zero” adjustments are taken out of the next adjustment cycle. There is no longer a “hold-it” on zero adjustments.

In the context of Medicaid waiver claims processing, **adjustments are corrections to paid claims**. Due to additional processing requirements, **adjustments are not processed within the standard 21-day claims processing timeline**. Due to the number of variables present in processing adjustment claims, DODD will not be able to tell providers when the adjustments will take effect. Providers must keep track of their adjustment reports.

Adjustments may be required for a variety reasons, such as:

- a. Claim, in its entirety, was submitted and paid in error.
- b. Number of units of service submitted and paid was incorrect.
- c. Service code submitted and paid was incorrect.
- d. Claim was paid at an incorrect service rate.
- e. Patient liability was not correctly reported after 18 months.
- f. An individual receiving services entered a nursing home or passed away.

**a. CLAIMS SUBMITTED AND PAID IN ERROR:** If claims were paid for services that were not actually delivered, sufficiently documented, or were inappropriate for reimbursement, the Provider **must** submit an adjustment to correct the error. The Provider **must** submit a claim for the same day of service, service code (as the original paid claim), and enter a zero (0) in the units of service column. This entry indicates that there were no units of service delivered on the indicated day of service. **The adjustment for the incorrectly paid claim will be deducted from future claims payment(s).**

**b. INCORRECT UNITS OF SERVICE:** If claims are paid for an incorrect number of units of service, an adjustment **must** be submitted to correct the number of units of service paid.

**NOTE:** The key to submitting proper unit difference adjustments is to **resubmit the claim for the correct number of units** of service delivered, and **NOT** the difference between the correct number of units of service delivered and the actual number of units of service paid.

**EXAMPLE:** If 20 units of service for a specific Service Code was paid for a specific date of service and the provider determines that the correct number of units of service was actually 25, the provider should resubmit a claim for the original month billed and day of service, the original service code, and the **correct** total units of service (which in this example is 25).

The claims processing system will reference the paid claims history to determine that 20 units of service were previously paid and the provider is due an adjustment of 5 units of service. The additional units of service will be processed for payment. On the contrary, if 20 units of service for a specific service code were paid for a specific date of service, and the provider determines that the correct number of units of service was actually 15, the provider should resubmit a claim for the original month billed and day of service, the original service code and the correct total units of service (which in this example is 15). The claims processing system will reference the paid claims history to determine that 20 units of service were previously paid and the provider owes an adjustment of 5 units of service. **The overpayment will be deducted from payment of future claims.**

**c. INCORRECT SERVICE CODE:** If services were paid with an incorrect service code; the provider **must** submit an adjustment to correct the error. The **adjustment would consist of two steps.**

**Step 1:** Enter the original day of service, the original service code that was paid and zero (0) units of service. This entry indicates that there were no units of service delivered on that day.

**Step 2:** This step cannot be taken for two (2) billing cycles after **Step 1** was processed. Enter the same day of service, with the correct service code and the actual number of service units delivered. The net effect of the two entries would be the payment of the correct claim and an adjustment to the incorrectly paid claim. **The adjustment for the incorrectly paid claims will be deducted from future claims payment(s).**

**d. INCORRECT SERVICE RATE:** If claims were submitted and paid with an incorrect service rate, the Provider should submit an adjustment to correct the error. Re-submit the claim, using exactly the same information but with the correct rate. For instance:

If a provider bills for Homemaker/personal care 1:1 [APC], and enters 41 instead of 411 in the Usual Customary Rate field, they would resubmit the claim with the same information, but would put 411 in the UCR field. The system will reference the billing history and cause an adjustment to pay out for the difference.

**e. PATIENT LIABILITY ADJUSTMENTS:** If patient liability was never submitted on the claim the provider must go back to first day or days of the month it was not entered and resubmit the information. If the wrong amount of patient liability was entered, go back to the date of the error and enter in the correct amount. Patient liability submitted in error, can be corrected by re-submitting the claim with the same information, but entering zeros (0) in the other source amount column.

**f. AN INDIVIDUAL RECEIVING SERVICES ENTERED A NURSING HOME OR PASSED AWAY:** The county board notifies the PAWS unit of this occurrence.

**ADJUSTMENT PRINTOUTS:** It is to your benefit to print copies of any/all adjustment report information . Keep the information so that when adjustments are seen at the top of the voucher report you have the ability to reference this information and reconcile.

*Please Note: Adjustments take additional time to process through the MBS system.*

## SECTION 9: WEBLINKS AND FORMS

- **FOR PAWS INFORMATION** <http://dodd.ohio.gov/common/paws.htm>
- **W-9** <http://www.irs.gov/pub/irs-pdf/fw9.pdf>
- **OBM VENDOR INFORMATION FORM (to be filled out along with W-9)**  
<http://ohiosharedservices.ohio.gov/document.aspx?id=098c86b4-3755-4a72-8415-77964ad22128>
- **VENDOR'S AUTHORIZATION AGREEMENT FOR AUTOMATIC DEPOSIT OF STATE WARRANTS & Instructions for Completion (EFT form)**  
<http://ohiosharedservices.ohio.gov/document.aspx?id=b833fab4-666d-4daf-844f-af62452c34d8>
- **SECURITY AFFIDAVIT FORM**  
<http://dodd.ohio.gov/forms/general/security-waiver.pdf>
- **FORM 2 - MONTHLY ROSTER OF SERVICES DELIVERED**  
**For Adaptive & Assistive Equipment-Environmental Modification Claims only.**  
<http://dodd.ohio.gov/forms/Form%202.pdf>
- **VERIFICATION OF ENVIRONMENTAL MODIFICATION FORM**  
<http://dodd.ohio.gov/forms/Environment%20Mods%20Form.pdf>
- **CHANGE OF ADDRESS FORM**  
<http://ohiosharedservices.ohio.gov/document.aspx?id=b833fab4-666d-4daf-844f-af62452c34d8>
- **LIST OF COUNT BOARDS**  
<http://dodd.ohio.gov/contacts/countyboards1.htm>