

*Provider Billing Training  
Independent Providers*

Kevin Bracken, Account Examiner

Claims Services Unit

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Email: [provider.support@dodd.ohio.gov](mailto:provider.support@dodd.ohio.gov)

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## Purpose of training

1. Introduction to the DODD website
2. Agencies involved with Medicaid waivers
3. Medicaid and Waivers
4. Payment Authorization for Waiver Services [PAWS]
5. Production cycle and general information
6. Medicaid Billing System [eMBS]
7. Reports
8. Adjustments
9. Service Documentation

# Introduction to the DODD website



# Welcome to the Ohio Department of Developmental Disabilities



**Ohio** | Department of Developmental Disabilities

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[Abuser Registry](#)

[Report Fraud](#)

[Report Abuse](#)



*Welcome*  
*The Ohio Department of Developmental Disabilities (DODD) is responsible for overseeing a statewide system of supports and services for people with developmental disabilities and their families.*



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Welcome to our Website!

Initiatives &



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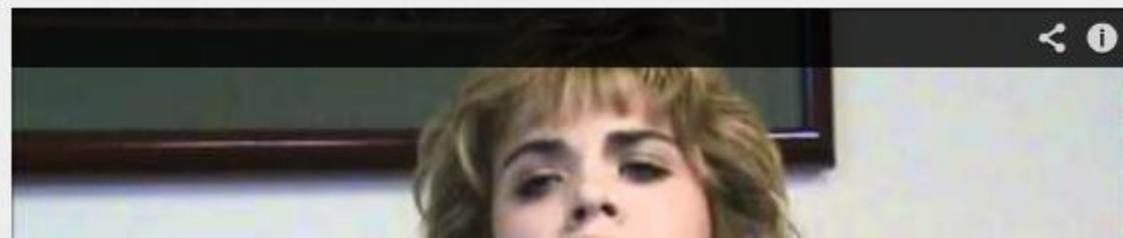
[Home](#) > [Video](#)



[Video Tutorials](#)



Stephanie Barber-Maynard Speaks on SELF waiver





Initiatives & Partnerships

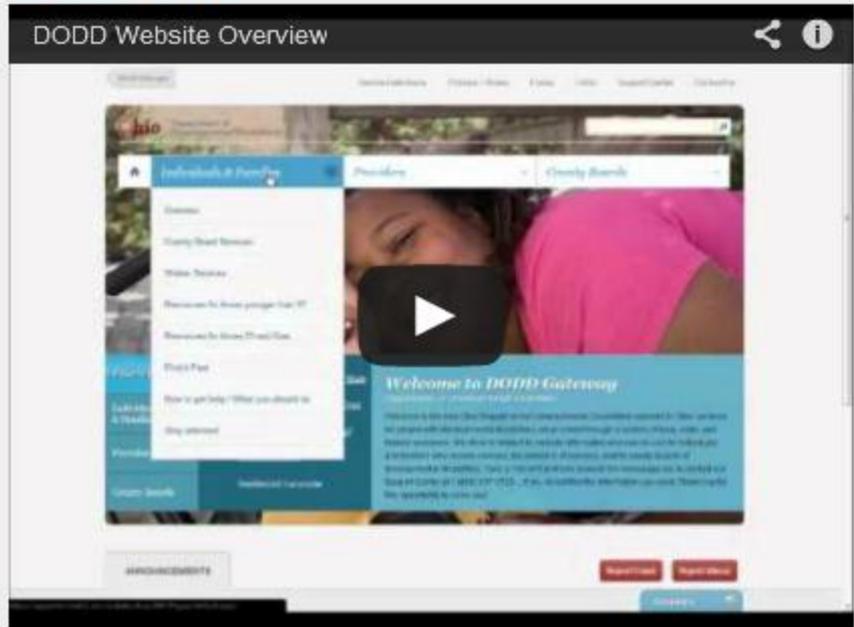


### Site Links

- Home
- Calendar
- Training

## Website Tutorials

### Website Overview



### How to Create Account



## Provider Certification

### Provider Certification

I am applying for certification to provide transportation services and/or other services to individuals who are unable to provide the services.

Independent - (I operate my business under my Social Security Number)

Sole Proprietor - (I operate my business under a Tax ID Number)

Agency: I am applying for Agency Provider certification (i.e., I am the Chief Executive Officer (CEO) of an entity that employs persons for the purpose of providing services).

Small Agency - (i.e., one that serves or plans to serve 50 or fewer individuals)

Large Agency - (i.e., one that serves or plans to serve 51 or more individuals)

SCFAB - Intermediate Care Facility

**Application Type**  
Please select one

I am applying for initial certification

I am applying for renewal certification

I am applying to add additional services to my existing certification

I am applying to update my tax information

**Service Type**  
Please select one

I am applying for certification to provide HCS Waiver Services AND Non-Waiver Services.

I am applying for certification to provide non-waiver services only.

I am currently certified through the Ohio Department of Aging and/or Ohio Department of Job and Family Services and am applying to be a DSSO Provider.

[Apply and Continue](#)

**Ohio** Department of Developmental Disabilities

[Privacy](#)

## Provider Search Overview

### Provider Search

[Save Search](#) [Stop a Saved Search](#)

**Narrow Your Results**

By Searching Within These States

By Mileage

Show Results within 0 miles

0 mi

10 mi

By Service Location

By Group

Click on a group to narrow your results. To view the complete search criteria, click on the question mark icon next to the term.

Show All Results (0)

View Saved Searches (0)

Other Groupings: [View](#) [Update](#)

Learn more about the filters and how they work.

**Use The Results**

- Referrals to Service Providers

**Search Results**

Results for "Non Medical Transportation - Mileage"

1 of 1 Results

Search groups: [View](#) [Update](#)

[View Details of Results](#)

**ADAMS**

Non-Medical Transportation - Mileage

Location for program

Name: Jonathan Adams

Address: 2615 WALNUT STREET, BELL CENTER OHIO 43003

Phone: (614) 244-1111

**ADAMS COMMUNITY LIVING**

Non-Medical Transportation - Mileage

Location for program

Name: Jonathan Adams

Address: 4201 SHILOH ROAD, STE 102, COLUMBUS OH 43228

Phone: (614) 469-4100

**DAISY CHOICE SERVICES LLC**



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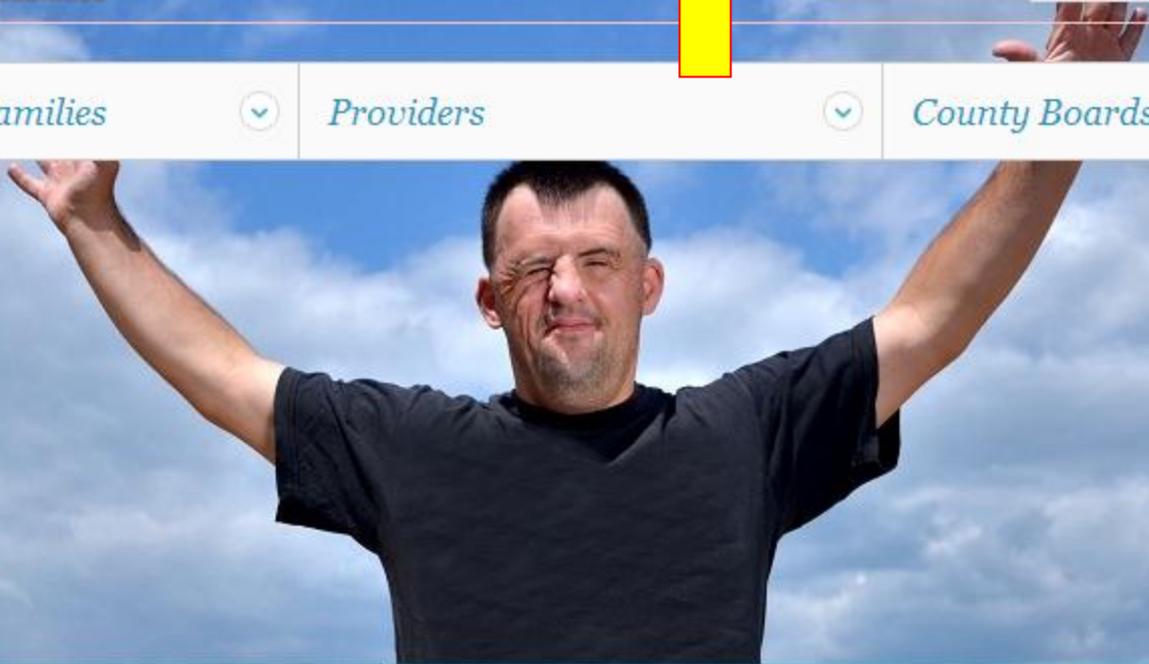
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[Providers](#)



[County Boards](#)



*Find it Fast*

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[Providers](#)

[Resources for those younger than 22](#)

[Resources for those 22 and Over](#)

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Welcome to the new Ohio Department of Developmental Disabilities website! In Ohio, services for people with developmental disabilities are provided through a system of local, state, and federal resources. We strive to make this website informative and easy to use for individuals and families who receive services, for providers of services, and for county boards of developmental disabilities. Take a moment and look around! We encourage you to contact our Support Center at 1 (800) 617-6733 ... if you do not find the information you need. Thank you for

Rules & Laws

Quick Links

- Legislation
- How a Bill Becomes Law
- Rules in Effect**
- Rules Under Development
- Guide to Public Participation
- Subscribe to Rules Notice
- JCARR
- Ohio Administrative Code
- Ohio Revised Code

## Overview of Rules and Laws

Information contained in this section addresses state legislation and administrative rules promulgated by the Ohio Department of Developmental Disabilities (DODD). For federal legislation, click on the link to the [Code of Federal Regulations](#). For rules promulgated by other State of Ohio agencies (e.g., Ohio Department of Job and Family Services, Ohio Department of Education, and Ohio Department of Health), visit the [Register of Ohio](#) website.

### Legislation

The Legislative Liaison acts as a vital link between DODD and the Ohio General Assembly, offering support to members of the legislature, as well as all areas of the department. As such, the Liaison's primary responsibility is to work on issues that impact the developmental disabilities community through the law-making processes and answer constituent inquires. Enacted laws are codified in the Ohio Revised Code (ORC). The legislative function includes the following activities:

- Crafting laws to address system needs;
- Monitoring progress of bills through the legislature;
- Briefing the DODD management team on legislation, including analyses of bills and their potential impact;
- Developing DODD's position on legislation;



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Rules & Laws > Rules in Effect

Rules & Laws

Legislation

How a Bill Becomes Law

Rules in Effect

Rules Under Development

Guide to Public Participation

Subscribe to Rules Notice

Chapter 5123:2-9 Home and Community-Based Services Waivers

5123:2-9-01 HCBS waivers - enrollment and disenrollment

5123:2-9-04 Medicaid local administrative authority  
[Appendix A - Contract Between Department and a County Board](#)

5123:2-9-06 Home and community-based services waivers - documentation and payment for services under the individual options and level one waivers  
[Appendix A - Ohio Developmental Disabilities Profile Funding Ranges by Cost-of-Doing Business Categories](#)  
[Appendix B - Cost-of-Doing-Business Categories](#)

5123:2-9-08 HCBS waivers - Compliance reviews of certified HCBS waiver providers

5123:2-9-11 HCBS waivers - free choice of provider  
[Appendix A - Elements of a Checklist for Provider Choice Process](#)

5123:2-9-14 Home and community-based services waivers - vocational habilitation under the individual options, level one, and self-empowered life funding waivers  
[Appendix A - Self-empowered Life Funding Waiver Process](#)



Individuals & Families



Providers



County Boards



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Certification

Compliance

Billing



Maintain Profile

Resources + Tools

Find it Fast

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Gateway

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## Providers

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Billing 

 Billing Services 

Change of Information

Direct Deposit

Accessing the Medicaid Billing System [MBS]

Becoming or using a billing agent

Billing for adaptive-assistive equipment or environmental modifications

Usual Customary Rate

Maintain Profile

## Provider Billing Services

Providers are independent business owners, and are not employed by the State of Ohio or the Department of Developmental Disabilities.  Providers are responsible for submitting your claims via the Medicaid Billing System, following your claims as they are processed through the system, and documenting services.

### Where to go for help

If you have questions regarding billing or reimbursement, e-mail: [dodd.support@dodd.ohio.gov](mailto:dodd.support@dodd.ohio.gov)

**Phone number: (800) 617-6733**

**Fax number: (614) 466-7359**

When contacting the Claims Services Unit, please provide your full name (and agency name, if applicable), your DODD contract number, phone number (including area code) where you can be reached between 8:00

## Quick Links

[Know Your Date](#)

[List of Federal Holidays DOD will be closed](#)

[Waiver Billing Instructions](#)

[Entering Claims in the enhanced Medicaid Billing System](#)

[How to view weekly reports](#)

[Current HIPAA billing codes](#)

[Error codes](#)

[Denial codes](#)

[Payment limitations for HCBS waiver services](#)

[How to upload a flat file to eMBS](#)

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## Welcome

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## Login for County Boards, Providers, and DODD Central Office

**Please do not bookmark this page or add this page to your favorites. This page will not work as a bookmark or a favorite.**

Type your user name and password.

User name:

Password:

[Back to Portal](#)

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Change Password

Quick Links

Welcome to the DODD Support Center. We are focused on providing support and assistance to you. By calling our toll-free number, you will be able to speak to one of our customer service representatives. Please call 1-800-617-6733 Monday - Friday between the hours of 8:00 a.m. - 4:00 p.m.



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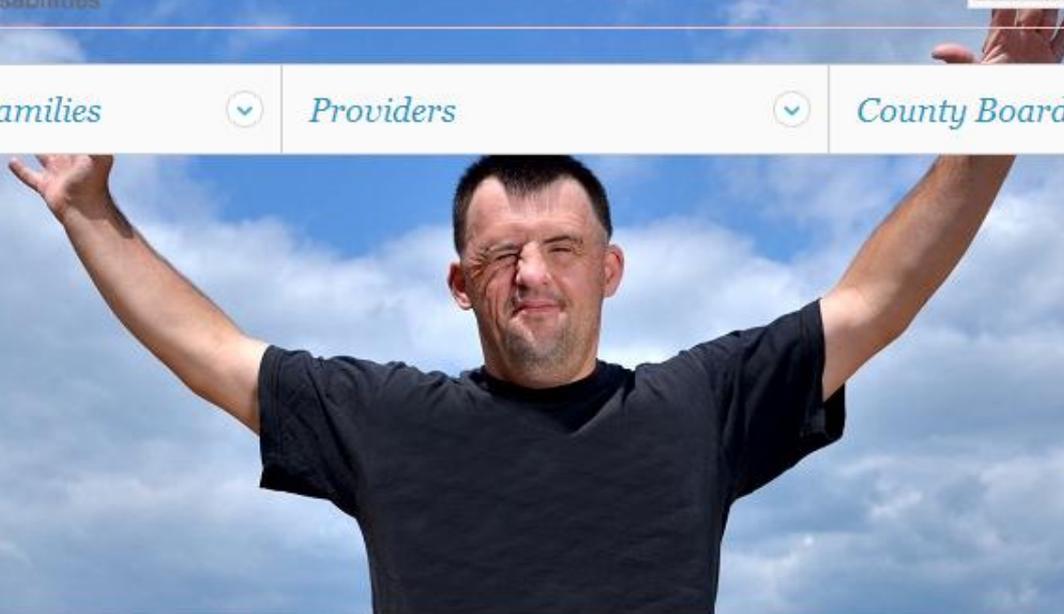
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Glossary

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## Agencies involved with Medicaid waivers

1. **County Department of Job and Family Services**
2. **County Boards of Developmental Disabilities**
3. **Regional Councils of Government [COG's]**
4. **Ohio Department of Developmental Disabilities**
5. **Ohio Department of Job and Family Services**
6. **Office of Budget and Management**
7. **Department of Administrative Services**
8. **Office of the Attorney General**
9. **Centers for Medicare & Medicaid Services**



# County Boards of Developmental Disabilities

- Assist individuals in waiver enrollment and free choice of provider
- Performs assessments and evaluations of individuals receiving waiver services, to include administering the Acuity Assessment Instrument [AAI] and the Developmental Disability Profile [DDP] to determine an individual's funding range
- Develop Individual Service Plans [ISP's] to ensure waiver recipient's safety and well-being
- Enter site costs into the Medicaid Services System [MSS]
- Develop and enter Payment Authorization for Waiver Services [PAWS]
- Funds part of the costs of waiver services
- Provides service and support administration to each individual receiving home and community-based services

**Some of these functions may be performed by a COG**

# Regional Councils of Government [COG's]



- There are 8 COGS in Ohio representing 75 of the 88 counties.
- County Boards of Developmental Disabilities can contract with COG's to provide different services
- COG's often provide training opportunities for both agency and independent providers



# Ohio Department of Developmental Disabilities

## DODD:

- Administers the Individual Options [I/O], Level 1 [LV1], and Self-Empowered Life Funding [SELF] waivers on behalf of the Ohio Department of Job and Family Services [ODJFS]
- Certifies providers of waiver services, including county boards
- Processes reimbursement claims for waiver services
- Oversees and funds 10 developmental centers
- Licenses and oversees Intermediate Care Facilities for Individuals with Developmental Disabilities [ICF/IDD]
- Makes state capital assistance funds available to county boards for purchasing housing for individuals with developmental disabilities

# Units within DODD

## Fiscal Administration

Budget/Audits

## Legal & Oversight

Provider Standards & Review

Major Unusual Incident Investigation

## Information Technology Services

Security

## Medicaid Development and Administration

Waiver Eligibility

Claims Services

Provider Certification

[Note: these are not all units within DODD, but are the units providers are most likely to interact with]

# Ohio Department of Job and Family Services

## ODJFS:

- Is the single state agency for Medicaid in Ohio, operating under the federal Centers for Medicare and Medicaid Services [CMS]
- Assigns Medicaid Provider Numbers, as indicated on your final approval letter
- Processes and approves claims through the Medicaid Information Technology System [MITS]
- Establishes payment rates for waiver services
- Receives funds from the Centers for Medicare and Medicaid Services [CMS] to reimburse providers for waiver services

# Office of Budget and Management

## **OBM, via the division of Ohio Shared Services:**

Processes direct deposit requests and changes to bank account information

Issues IRS forms 1099 Report of Miscellaneous Income

Processes claims through the Ohio Administrative Knowledge System [OAKS]

## **TO CONTACT OSS:**

Ohio Shared Services

4310 E. Fifth Ave.

Columbus, OH 43219

614.338.4781 -or- 877.644.6771

[vendor@ohio.gov](mailto:vendor@ohio.gov)



# Office of the Attorney General



## The OAG:

- Investigates allegations of Medicaid fraud
- Recovers funds paid out that were not in compliance with service-specific rules in Chapters 5123:2-9 of the Ohio Administrative Code



# Centers for Medicare and Medicaid Services

## CMS:

- Is a federal agency within the United States Department of Health and Human Services [DHHS] that administers the Medicare program and works in partnership with state governments to administer Medicaid, the State Children's Health Insurance Program [SCHIP] and the Health Insurance Portability and Accountability Act [HIPAA]
- Reimburses DODD, through ODJFS, for part of the costs of waiver services

# Medicaid & Waivers

# What is Medicaid?

- Medicaid is a state and federally funded health program that was passed as part of the Social Security Act of 1965
- Medicaid began in Ohio in 1968
- Each state operates its own program within guidelines established by the federal government



# The Office of Ohio Health Plans

## New Ohio Medicaid Card Design Effective Spring 2002

(Back of Card)

**Notice to the Consumer:** Please carry this card at all times and present this card whenever you request Medical services. If this card is lost or stolen, contact the county department of job and family services at once.

**Notice to Providers of Medical Services:** If there is evidence of tampering or if card is mutilated contact the local county department of job and family services. Check "Void After Date" to be sure client is eligible for service. Questions regarding claims for services should be directed to the Ohio Department of Job and Family Services, Voice Response Unit (VRU) at 1-800-686-1516, or the Provider Network Management Section at 1-800-686-6108, Option 1.

**Note:** Use the Billing Number for all claim submissions.

**Consumer's Signature:**

Signature of Medicaid consumer or parent/legal guardian of Medicaid eligible child.

Billing numbers for each Medicaid consumer listed. Use this number when submitting claims.

Names of Medicaid consumers listed here.

Ohio Medicaid	
Billing Number	Eligible Individual
999999999999	Jean D Doe
222222222222	Test Name-2
333333333333	Test Name-3
444444444444	Test Name-4
555555555555	Test Name-5
666666666666	Test Name-6
777777777777	Test Name-7

Date of birth for each Medicaid Consumer listed here.

(Front of Card)

County  
LICKING

Case/Category/Sequence  
9999999999/MA A/01

Eligibility Begin Date  
01/01/00

Void After Date  
01/30/00

**Ohio Medicaid**

Ohio Department of Job and Family Services  
Consumer Hotline - 1-800-324-8680  
or TDD 1-800-292-3572

County of Residence

Medicaid Case Number

Name of Medicaid Program

Medicaid eligibility begins on the date listed here.

Medicaid eligibility expires after the date listed here.

Third Party Liability (TPL) information, such as private insurance listed here when applicable.

(Inside of Card)

Date of Birth	Medicare Number	TPL Other Insurance Codes
09/09/99	999999999D	99991 99992 99993
09/24/65	99999999991	99991 99992 99993
09/09/49	99999999993	99991 99992 99993
04/04/94	99999999994	99991 99992 99993
05/05/95	99999999995	99991 99992 99993
06/06/96	99999999996	99991 99992 99993
07/07/97	99999999997	99991 99992 99993

If applicable, Medicare number listed here.

Depending on the type of Medicaid card, clients will need to reapply either every 6 months or every 12 months to keep Medicaid.

Medicaid Cards are mailed out the first of every month

Cards show the legal name and current Medicaid # of clients

Bottom right shows third party liability [insurance]

# What is a Medicaid Waiver?

- A waiver is a way that Medicaid can pay for services to keep individuals in the community so they do not have to move to a long-term care facility or nursing home.
- An individual must have a ICF level of care determination to be on a waiver.
- **Loss of Medicaid = loss of waiver**

- Waivers are good for one calendar year
- County boards can re-enroll waivers electronically
- Failure to re-enroll a waiver in a timely manner can affect enrollment in PAWS

# Types of waivers

## Administered by the Department of Developmental Disabilities

### I/O

- Homemaker/Personal Care
- Home Modifications and Adaptations
- Transportation
- Respite Care
- Social Work
- Home-delivered meals
- Nutrition
- Interpreter Services
- Specialized Adaptive or Assistive
- Medical Equipment and Supplies
- Adult Day Services
- Supported Employment

### LV1

- Homemaker/Personal Care
- Institutional Respite
- Informal Respite
- Transportation
- Personal Emergency Response Systems
- Specialized Medical Equipment and Supplies
- Environmental Accessibility Adaptations
- Emergency Assistance
- Supported Employment
- Day Habilitation

# Types of waivers

## Administered by the Department of Developmental Disabilities

### SELF

- Support Brokerage
- Community Inclusion  
(Personal Assistance, Transportation)
- Integrated Employment
- Functional Behavioral Assessment
- Clinical/Therapeutic Intervention
- Participant-Directed Goods and Services
- Participant/Family Stability Assistance
- Remote Monitoring
- Remote Monitoring Equipment
- Residential Respite
- Community Respite
- Adult Day Supports
- Vocational Habilitation
- Supported Employment – Enclave
- Non-Medical Transportation

### Transitions

[effective January 1, 2013]

- DODD assumes all operating functions for the waiver.
- TDD is completely closed to all new enrollment.
- Case management functions transfer from CareStar to county boards.
- CareStar will continue to perform level of care redeterminations from January 1, 2013 through December 31, 2013.
- Providers are subject to DODD's provider compliance review process.
- The waiver incorporates DODD's procedures for major unusual incidents (OAC 5123:2-17-02) and behavior support (OAC 5123:2-1-12(J)).
- ODJFS maintains responsibility for provider enrollment and claims processing.
- Services and rates remain the same.

Questions may be directed to

[TDDinbox@dodd.ohio.gov](mailto:TDDinbox@dodd.ohio.gov).

# Other types of waivers

**Administered by the Ohio Department of Job and Family Services**

**Ohio Home Care**

**Administered by the Ohio Department on Aging**

**Assisted Living**

**Choices**

**PASSPORT**

**Providers interested in finding out more about different waivers should contact their county board of developmental disabilities, or the agency that administers the waiver directly.**

# Payment Authorization for Waiver Services

- The Payment Authorization for Waiver Services system (PAWS) is the system by which County Boards authorize DODD to reimburse providers for services rendered to individuals on a waiver.
- Any claim submitted by a provider must be matched to an approved PAWS record in order for the claim to be paid.  
**You can only submit claims for services you have performed.**
- Providers have 'read access' to the PAWS system, to verify what is authorized on the PAWS and the enrollment status of the PAWS for an individual on the waiver.
- Providers with questions should contact the County Board Service and Support Administrator (SSA) for the individual.

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Type your user name and password.

User name:

Password:

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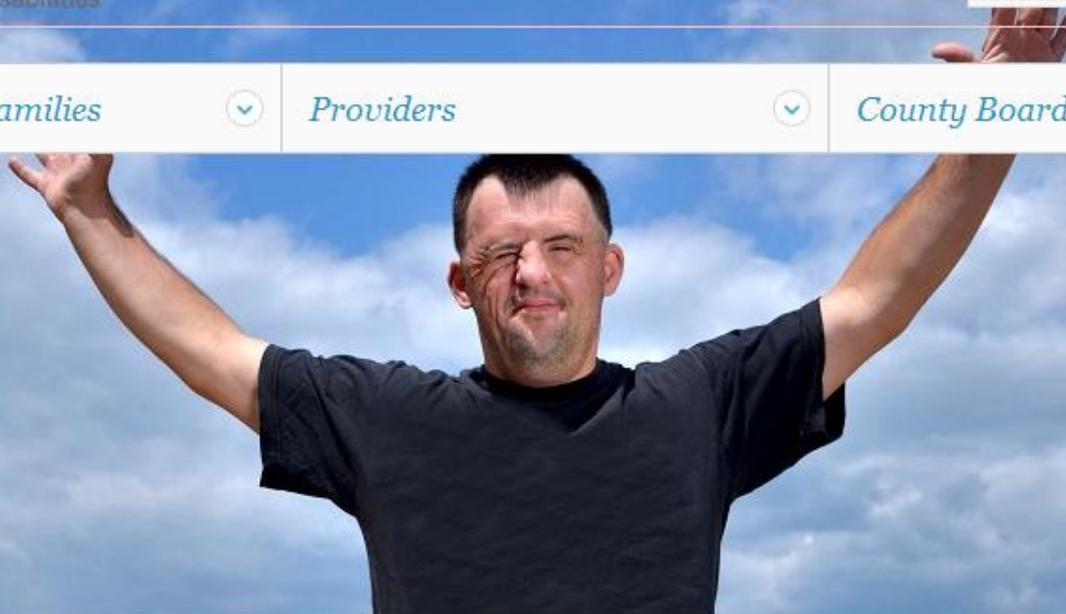
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Select Application

- CRN
- DRA
- eMBS
- IDS
- MAC
- MSS
- PAWS2
- PCS\_Web**
- PCW
- REG
- UDS
- WMS2

Load Application





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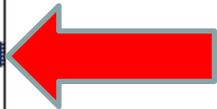
View All

Select Application

- CRN
- DRA
- eMBS
- ITS\_Revise
- MSS
- PAWS2**
- PCU
- REG

Load Applica

**Select 'PAWS2' from the list of applications. This will open in a new browser window, so you may need to disable any pop-up blockers in your browser in order to proceed.**



Individual Name:

**You can search for a specific individuals PAWS, or you can view all the 'Enrolled' or 'Pending' PAWS plans you are associated with.**

Welcome To PAWS!

1. [Search](#)

All Counties

Enrolled

Pending

3. [Contacts](#)

Search Field	Search Text		
Individual No. ▾	Equals ▾	<input type="text"/>	AND ▾
Last Name	Equals ▾	<input type="text"/>	AND ▾
First Name	Equals ▾	<input type="text"/>	AND ▾
SSN	Equals ▾	<input type="text"/>	
Medicaid No.	Equals ▾	<input type="text"/>	Individual Search
CrisE No.			
Individual No.			
DB ID			

**You can search for a PAWS using multiple criteria. Select how you want to search in the 'Search Field' box, and enter the appropriate information in the 'Search Text' box. Even if a PAWS is in pending status, you should be able to view it if your contract number is associated with it.**

Text Search

DOI

Ohio Department of Developmental Disa

Individual Name:

[New Search](#)

1 through 1 of 1

Individual No.	Last Name	First Name	Middle Name	SSN	DOB	Medicaid No.	Creation Date
<a href="#">294592</a>	<a href="#">[REDACTED]</a>	<a href="#">[REDACTED]</a>	<a href="#">[REDACTED]</a>	<a href="#">XXX-XX-XXXX</a>	<a href="#">12/31/1992</a>	<a href="#">[REDACTED]</a>	<a href="#">6/22/2012 8:36:00 AM</a>

**This screen will show you the individual's DODD number, name, Date of Birth, Medicaid number, and creation date of the PAWS. The Social Security Number will be redacted for privacy. Click on any of the blue lines to continue.**

Individual Name	<input type="text"/>
Individual No.	SSN <input type="text" value="xxx-xx-xxxx"/>
DHS Medicaid #	<input type="text"/>

**PAWS Comment**

**This page will show you what PAWS plans have been entered, the approval status of the PAWS plan, if the plan has been or is currently suspended, and general waiver information.**

**PAWS Plan Information**

Waiver Type	County	Match Source	Plan Begin Date	Plan End Date	Approval	Approval Date	Version	Comment
<a href="#">LV1</a>	<a href="#">Cuyahoga County</a>	<a href="#">LONE</a>	<a href="#">04/20/2012</a>	<a href="#">04/19/2013</a>	<a href="#">Enrolled</a>	<a href="#">06/22/2012</a>	<a href="#">2</a>	<a href="#">Comment</a>
LV1	Cuyahoga County	LONE	04/20/2011	04/19/2012	Enrolled	08/26/2011	2	

**Suspension and Disenrollment Information**

Last Date of Service	Service Restart Date	Reason	Notes
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**Waiver Tracking Information**

LOC	LOC Eff. Date	Enroll Begin Date	Enroll End Date	Status	Waiver Type	Comment	#Elig Determined
MR	4/20/2012	04/20/2012	04/19/2013	ENRL - Enrolled	LV1	<a href="#">WTS comment</a>	2
MR	4/20/2011	04/20/2011	04/19/2012	ENRI - Enrolled	LV1	<a href="#">WTS comment</a>	1

PAWS Plan

First Prev Next Last Compare

PAWS Plan Type	Revision	Plan Revision Number	0
Match Source	LONE	This Plan Version No.	2 of 2
Paws Status	Enrolled	PAWS Plan Begin Date	04/20/2012
Reason For Revision	M - PAWS Plan Revised	PAWS Plan End Date	04/19/2013
PAWS Approval Sign On	Jaimey R Karhoff	PAWS Enrolled Date	06/22/2012

This area tells you when the PAWS plan begins and ends, the version, and when it was enrolled. Be certain you are viewing the most recent version.

SUPPORT BROKER INFORMATION

Contract# Name Start End Status

This area only applies to individuals on the SELF waiver

Fiscal Planning

2012 Waiver Costs	1,247.00	2012 Match Funds Needed	447.05
2013 Waiver Costs	2,494.00	2013 Match Funds Needed	894.10
Total Plan Costs	3,741.00	Total Plan Costs - DayHab/Sup Emp.	3,741.00
Total DDP Associated Costs	0.00	Total DayHab/SupEmp Costs	0.00
2012 Match Needed Costs	1,247.00	Total No Match Needed Costs	-10,080.00
2013 Match Needed Costs	2,494.00	Total Adult Day Costs	0.00
Adult Foster Care Agency	0.00	Non-Medical Transport Costs	0.00
Adult Foster Care Individual	0.00		

The county board uses this area for planning the individual's budget.

County Review Comments

[View Comments](#)

Contract#	Name	Start	End	Status
-----------	------	-------	-----	--------

### Fiscal Planning

2012 Waiver Costs	1,247.00	2012 Match Funds Needed	447.05
2013 Waiver Costs	2,494.00	2013 Match Funds Needed	894.10
Total Plan Costs	3,741.00	Total Plan Costs - DayHab/Sup Emp.	3,741.00
Total DDP Associated Costs	0.00	Total DayHab/SupEmp Costs	0.00
2012 Match Needed Costs	1,247.00	Total No Match Needed Costs	-10,080.00
2013 Match Needed Costs	2,494.00	Total Adult Day Costs	0.00
Adult Foster Care Agency	0.00	Non-Medical Transport Costs	0.00
Adult Foster Care Individual	0.00		

### County Review Comments

[View Comments](#)

### Service Items

Details	Code	Begin Date	End Date	Units	FP	Rate	Adds	Contract #	Contractor	Service Title	2012 Total Units	2012 Total Cost	2013 Total Units
<a href="#">Details</a>	F22	04/20/2012	06/30/2012	200	S	0.00				+ HOMEMAKER/PERSC LV1	200	822.00	
<a href="#">Details</a>	F22	07/01/2012	04/19/2013	400	S	0.00				+ HOMEMAKER/PERSC LV1	0	0.00	400
<a href="#">Details</a>	F44	04/20/2012	06/30/2012	100	S	0.00				HOMEMAKER/PERSC ONSITE LV1	100	225.00	
<a href="#">Details</a>	F44	07/01/2012	04/19/2013	200	S	0.00				HOMEMAKER/PERSC ONSITE LV1	0	0.00	200
<a href="#">Details</a>	FTN	04/20/2012	06/30/2012	500	S	0.00				TRANSPORTATION	500	200.00	
<a href="#">Details</a>	FTN	07/01/2012	04/19/2013	1000	D	0.00				TRANSPORTATION	0	0.00	293,000

Code	Begin Date	End Date	Units	FP	Rate	Adds	Contract #	Contractor	Service Title	2012 Total Units	2012Total Costs	2013 Total Units	2013 Total Costs
A22	01/01/12	06/30/12	1400	S	0.00				HOMEMAKER/PERSC I/O	1400	5,754.00		
A22	07/01/12	12/31/12	1600	S	0.00				HOMEMAKER/PERSC I/O	0	0.00	1600	6,576.00
ATN	01/01/12	06/30/12	400	M	0.00				TRANSPORTATION	2400	960.00		
ATN	07/01/12	12/31/12	400	M	0.00				TRANSPORTATION	0	0.00	2400	960.00

**Code:** Authorizes the type of service.

This is an authorization code and is not necessarily what you will submit for billing

**Begin & End date:** The date span services are authorized

**Units:** Indicates the number of units authorized for the date span

Units can be 15 minute or daily units for Homemaker/Personal Care services, or it can indicate mileage or number of trips for transportation

**FP:** The frequency period. This can be 'S' for span, 'M' for monthly, 'W' for weekly, or 'D' for daily.

**Rate:** This is no longer used

**Adds:** Indicates whether the county board has authorized a behavioral or medical add-on

**Contract #, Contractor:** Individual or agency authorized to provide service

**Service Title:** Title of service being authorized

**Total Units:** Total number of units authorized for the span

**Total Cost:** Total dollars authorized for the span

Payment Authorization For Services (PA5)

Original Faxed: XML 9/3/10

Changes Only

001

County	Resident Number	Name (Last, First, Middle)	Medicaid Recipient Billing Number (if applicable)	Expiration Date 09/03/2010								
Funding Source 1/0	Plan Type <input type="checkbox"/> Initial <input type="checkbox"/> Redetermination <input checked="" type="checkbox"/> Revision (#2 )	Social Security Number	Plan Year Period 5/1/2010 to 4/30/2011									
A #	Service Title	Service Beh Code	Med Mod	Begin	End	Max Units	Freq	Rate	Vendor #	Vendor Name	FY 1 Amount	FY 2 Amount
X 1	Homemaker/Personal Ca	ADL		07/01/10	04/30/11	177	S		9801110	AWNS	\$0.00	\$0.00
A 2	Specialized Medical Equip	AAE		07/01/10	04/30/11	1	S	\$1,650.00	0900261	Part. Housing	\$0.00	\$1,650.00
A 3	Homemaker/Personal Ca	ADL		07/01/10	04/30/11		D		9801110	AWNS	\$0.00	\$89,515.84

Some county boards give providers a copy of a Payment Authorization for Services (PAS), which is form that is generated by their own internal software systems. This is not the same thing as a Payment Authorization for Waiver Services (PAWS), and does not mean that the service authorization is in place and billing can begin. Providers should check the actual PAWS system that can be accessed through DODD's application portal to view their waiver recipient's PAWS plans and ensure that services have been properly authorized before submitting claims for services delivered.

\$0.00	\$91,165.84	\$91,980.18	City	State	Zip Code	Telephone Number
<b>Vendor Designated for Patient Liability</b>						
Patient Liability? <input type="checkbox"/> Yes <input type="checkbox"/> No	Vendor Number	Vendor Name	Fax Number	Contact Signature	Date 9/3/2010	
* By Signing, I am verifying that there is an ISP in place to support the services authorized on this PAS form.			Email Address mocharterlin@outland.org	COMR/DO Use Only		
COMR			Medicaid Source COMR/DO Authorized Signatory	Date		

P. 003/003

FAX No. 513-867-5972

SEP/20/2010 08:23 AM

**Claims processing cycle**

**&**

**general information**

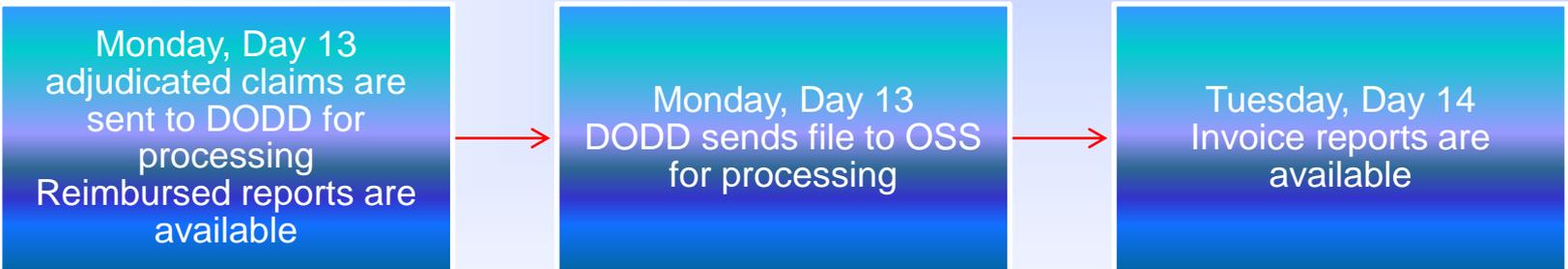
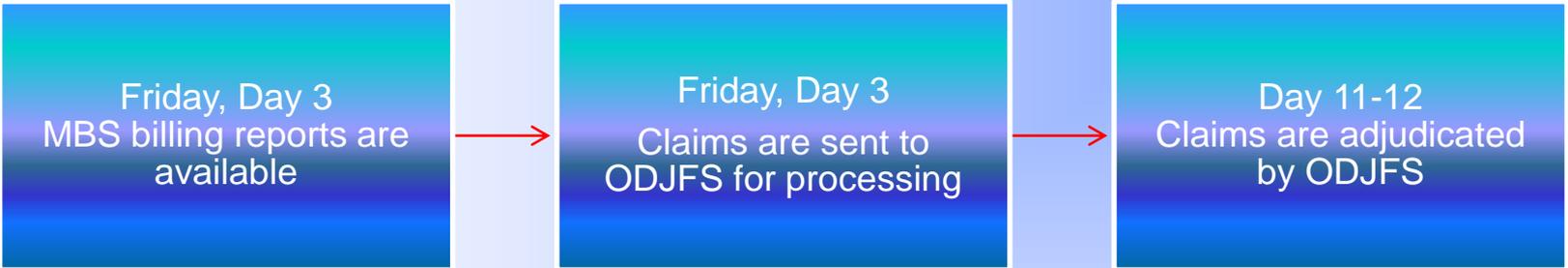
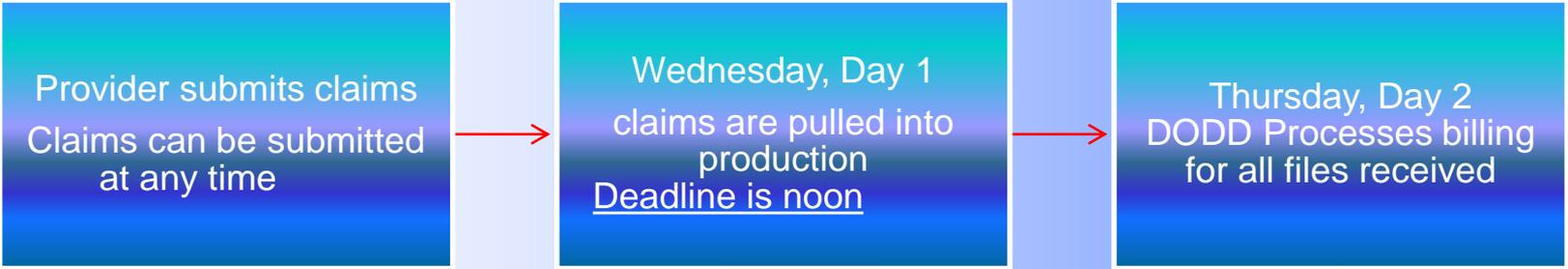
## Billing agents

- As an independent business owner, you can choose to contract with a billing agent rather than do your own billing.
- Neither the State of Ohio nor the Department of DD accepts any liability should you, as an independent business owner, choose to contract with a billing agent.  
The State will not be party to any disputes between providers and billing agents.
- You remain complete responsibility for the accuracy and completeness of all claims, including those submitted by billing agents.

## Payment limitations for waiver services

You can only be paid for services if:

- The services are identified on an approved Individual Service Plan [ISP]
- The service is recommended for payment through the Payment Authorization of Waiver Services [PAWS] process.
- You or your agency supplied the service.
- You submit claims within 330 days of service.
- You maintain service documentation for a period of six years from date of payment.
- Overpayments, duplicate payments, payments for services not rendered, payments for which there is no documentation of services delivered or for which the documentation does not include all of the items required in service-specific rules are recoverable.



**21 day claims processing cycle**

# The Medicaid Billing System

🏠 Logout >

**N** Hello Kevin M Bracken. You have 0 new notifications and 0 new announcements.

View All

Select Application

- CRN
- DRA
- eMBS**
- IDS
- MAC
- MSS
- PAWS2
- PCS\_Web
- PCW
- REG
- SCSNew
- UDS
- WMS2

Load Application



HOME

Home

USER GUIDES

- Billing Instructions
- Uploading Flat Files
- Error Codes
- Payment Limitations for Waiver Services
- DODD Agency Provider Billing Training
- DODD Independent Provider Billing Training
- File Layout Examples

BILLING SUBMISSIONS

- Single Claim Entry
- Upload Flat File
- File Status

County Board Use Only

REPORTS

- Provider Weekly Reports
- Third Party Reports

County Board Use Only

Continue To MBS

CLICK CONTINUE TO MEDICAID BILLING SYSTEM (MBS)

**USER GUIDES: Helpful information at your fingertips**

**BILLING SUBMISSIONS: Where you will go to submit claims, either by uploading a flat file, or using single claim entry. File status will show you the status of files received by DODD.**

**REPORTS: Where you will go to view your weekly reports, which will indicate what claims were/were not successfully processed by DODD and ODJFS.**



HOME

Home

USER GUIDES

Billing Instructions

Uploading Flat Files

Error Codes

Payment Limitations for Waiver Services

File Layout Examples

**BILLING SUBMISSIONS**

Single Claim Entry

Upload Flat File

File Status

County Board Use Only

REPORTS

Provider Weekly Reports

Third Party Reports

County Board Use Only

Continue To MBS

## CLICK CONTINUE TO MEDICAID BILLING SYSTEM (MBS)

### ATTENTION PROVIDERS:

#### \*\*\*\*\*ANNOUNCEMENT ABOUT INTERNET EXPLORER 8.0\*\*\*\*\*

Symptom: The default install of Internet Explorer 8.0 will cause your machine to not allow uploads to Internet sites (Sites accessible on the world wide web, such as DODD Web Portal <https://odmrdd.state.oh.us/apps>). After Browsing for the local file by clicking on BROWSE and then choosing upload a message of "You cannot upload a file starting with the character []. File Not Uploaded!"

Resolution: In your Internet Browser, under TOOLS ---> INTERNET OPTIONS ---> and then the SECURITY TAB (2nd tab over)

1. With INTERNET selected (AT THE TOP under "select a zone to view, or change settings")
2. Navigate to the bottom of this tab and under "Security Level for this Zone" you should notice a slider that is defaulted to Medium-High, Drag this slider down to MEDIUM

This will enable the BROWSE button under the UPLOAD links (Upload Flat File, Upload 837 (Prod), etc.) to allow your Internet Browser to physically transmit the file stored locally on your machine through your Internet Browser to DODD through the MBS Application.

In your Internet Browser (Internet Explorer), in the menu options at the top... Click TOOLS and then, "Internet Options", then under Browsing history: click Settings button On "Temporary Internet Files and History Settings" screen, Check for Newer Versions of Stored Pages should be set to "Every Time I Visit the webpage"

- HOME
- USER GUIDES
- BILLING SUBMISSIONS
  - Single Claim Entry
  - Upload Flat File
  - File Status
- County Board Use Only
- REPORTS

Print Screen

### SINGLE CLAIM ENTRY :

\* indicates required field

Today's Date :  Help

Contract Number (7 Numbers) :  Help \*

Medicaid Recipient Number :  Help \*

Recipient First Initial :  Help \*

Recipient Last Name (First 5 Letters) :  Help \*

Date Of Service (mm/dd/yyyy) :  \* /  \* /  \* Help

Service Code :  Help \*

Units Of Service Delivered :  Help \*

Group Size :  Help

Staff Size :  Help

Service County :  Help \*

Usual Customary Rate \$ :  .  Help \* \*

Other Source Code :  Help

Other Source Amount \$ :  .  Help

Contractor Reference Number (Optional) :  Help

**Contract number: Your 7 digit contract number**

Clear Form

Submit Claim

- HOME
- USER GUIDES
- BILLING SUBMISSIONS
  - Single Claim Entry**
  - Upload Flat File
  - File Status
- County Board Use Only
- REPORTS

**SINGLE CLAIM ENTRY :**

\* indicates required field

Today's Date :  [Help](#)

Contract Number (7 Numbers) :  [Help \\*](#)

Medicaid Recipient Number :

Recipient First Initial :  [Help \\*](#)

Recipient Last Name (First 5 Letters) :  [Hel](#)

Date Of Service (mm/dd/yyyy) :  [Help](#)

Service Code :  [Help](#)

Units Of Service Delivered :  [Help \\*](#)

Group Size :  [Help](#)

Staff Size :  [Help](#)

Service County :  [Help \\*](#)

Usual Customary Rate \$ :  .  [Help \\* \\*](#)

Other Source Code :  [Help](#)

Other Source Amount \$ :  .  [Help](#)

Contractor Reference Number (Optional) :  [Help](#)

**Medicaid Recipient Number;**  
**Recipient First Initial;**  
**Recipient Last Name:**  
 are all based on the individual you provided service

HOME

USER GUIDES

BILLING SUBMISSIONS

Single Claim Entry

Upload Flat File

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### SINGLE CLAIM ENTRY :

\* indicates required field

Today's Date : 8/15/2012 Help

Contract Number (7 Numbers) : Help \*

Medicaid Recipient Number : Help \*

Recipient First Initial : Help \*

Recipient Last Name (First 5 Letters) : Help \*

Date Of Service (mm/dd/yyyy) : Month \* / Day \* / Year \* Help

Service Code :

Units Of Service Delivered : He

Group Size : Help

Staff Size : Help

Service County : Select Help \*

Usual Customary Rate \$ : Help \* \*

Other Source Code : Help

Other Source Amount \$ : Help

Contractor Reference Number (Optional) : Help

Clear Form

Submit Claim

**Date of Service is the Month, Day, and Year that the service you're billing was provided**

- 
- 
- - 
  - 
  -
- 

Print Screen

### SINGLE CLAIM ENTRY :

\* indicates required field

Today's Date :  Help

Contract Number (7 Numbers) :  Help \*

Medicaid Recipient Number :  Help \*

Recipient First Initial :  Help \*

Recipient Last Name (First 5 Letters) :  Help \*

Date Of Service (mm/dd/yyyy) :  \* /  \* /  \* Help

Service Code :

Units Of Service Delivered :  He

Group Size :  Help

Staff Size :  Help

Service County :

Usual Customary Rate \$ :  .  Help \*\*

Other Source Code :  Help

Other Source Amount \$ :  .  Help

Contractor Reference Number (Optional) :  Help

**Service Codes are found in  
service- specific rules available  
on our website**



- 
- 
- - 
  -
- 
- 

### SINGLE CLAIM ENTRY :

*\* indicates required field*

Today's Date :  [Help](#)

Contract Number (7 Numbers) :  [Help \\*](#)

Medicaid Recipient Number :  [Help \\*](#)

Recipient First Initial :  [Help \\*](#)

Recipient Last Name (First 5 Letters) :  [Help \\*](#)

Date Of Service (mm/dd/yyyy) :  \* /  \* /  \* [Help](#)

Service Code :  [Help \\*](#)

Units Of Service Delivered :  **Units of Service Delivered may refer to 15- minute units, daily units, or miles**

Group Size :  [Hi](#)

Staff Size :  [Hi](#)

Service County :  [Help](#)

Usual Customary Rate \$ :  .  [Help \\* \\*](#)

Other Source Code :  [Help](#)

Other Source Amount \$ :  .  [Help](#)

Contractor Reference Number (Optional) :  [Help](#)

HOME

USER GUIDES

BILLING SUBMISSIONS

Single Claim Entry

Upload Flat File

File Status

County Board Use Only

REPORTS

Print Screen

### SINGLE CLAIM ENTRY :

\* indicates required field

Today's Date : 8/15/2012 Help

Contract Number (7 Numbers) : Help \*

Medicaid Recipient Number : Help \*

Recipient First Initial : Help \*

Recipient Last Name (First 5 Letters) : Help \*

Date Of Service (mm/dd/yyyy) : Month \* / Day \* / Year \* Help

Service Code : Help \*

Units Of Service Delivered : Help \*

Group Size : Hi

Staff Size : Hi

Service County : Select

Usual Customary Rate \$ :

Other Source Code : Hi

Other Source Amount \$ : Help

Contractor Reference Number (Optional) : Help

Clear Form

Submit Claim

**Group size is the number of individuals you are providing services to at the same time. An individual does not need to be on a waiver to count in the group size.**

- 
- 
- - 
  -
- 
- 

### SINGLE CLAIM ENTRY :

*\* indicates required field*

Today's Date :  [Help](#)

Contract Number (7 Numbers) :  [Help \\*](#)

Medicaid Recipient Number :  [Help \\*](#)

Recipient First Initial :  [Help \\*](#)

Recipient Last Name (First 5 Letters) :  [Help \\*](#)

Date Of Service (mm/dd/yyyy) :  \* /  \* /  \* [Help](#)

Service Code :  [Help \\*](#)

Units Of Service Delivered :  [Help \\*](#)

Group Size :  [Help](#)

Staff Size :  [Help](#)

Service County :  [Help](#)

Usual Customary Rate \$ :  [Help](#)

Other Source Code :  [Help](#)

Other Source Amount \$ :  .  [Help](#)

Contractor Reference Number (Optional) :  [Help](#)

**Staff size for an independent provider is always '1'.**



Logout >



Hello Kevin Bracken. You have 0 new notifications and 0 new announcements.

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eMBS

Select Application

eMBS

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Submit Recipient File

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### SINGLE CLAIM ENTRY :

\* indicates required field

Today's Date : 6/22/2012 Help

Contract Number (7 Numbers) :  Help \*

Medicaid Recipient Number :  Help \*

Recipient First Initial :  Help \*

Recipient Last Name (First 5 Letters) :  Help \*

Date Of Service (mm/dd/yyyy) :  \* /  \* /  \* Help

Service Code :  Help \*

Units Of Service Delivered :  Help \*

Group Size :  Help

Staff Size :  Help

Service County :

Usual Customary Rate \$ :

Other Source Code :

Other Source Amount \$ :

**Service county is the county the service was performed in, and might be different from the county of residence.**

Contractor Reference Number (Optional) :  Help

Clear Form

Submit Claim

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File Status

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### SINGLE CLAIM ENTRY :

\* indicates required field

Today's Date :  Help

Contract Number (7 Numbers) :  Help \*

Medicaid Recipient Number :  Help \*

Recipient First Initial :  Help \*

Recipient Last Name (First 5 Letters) :  Help \*

Date Of Service (mm/dd/yyyy) :  \* /  \* /  \* Help

Service Code :  Help \*

Units Of Service Delivered :  Help \*

Group Size :  Help

Staff Size :  Help

Service County :  Help \*

Usual Customary Rate \$ :   Help \*\*

Other Source Code :

Other Source Amount \$ :  .  Help

Contractor Reference Number (Optional) :  Help

Clear Form

Submit Claim

**Usual Customary Rate is the rate that you charge for a service**

# Usual Customary Rate

- DODD is required by law to have a mechanism through which providers report their usual and customary rate. This is the purpose of the UCR field in eMBS.
- Your usual customary rate is the rate that you would charge a private-pay individual for the same service you are providing to a Medicaid waiver recipient. You will need to decide what you will charge.
- You will be paid either the maximum rate allowed by Medicaid, or your usual customary rate, depending on which is lower. If you enter a UCR that is lower than the maximum rate, that is what you will be paid.
- The Medicaid maximum rates can be found in service-specific rules available on our website, and may vary according to service county, staff size, and group size.

## Medicaid Maximum Rates

- The maximum rates paid for waiver services are set by Federal guidelines, and can be found in rule 5123:2-9-06 of the Ohio Administrative Code or in other service-specific rules, which are available at the *DODD Rules in Effect* webpage.
- The State of Ohio is divided into 8 Cost of Doing Business categories. The maximum rate is based on the county of service. You will need to find the CoDB category for each county in which you are providing services.
- Having found your CoDB category for your county, you will next check to see the rate of the service(s) you are providing. This is the maximum rate you will be paid. You will decide what your usual customary rate is; however, Medicaid recipients cannot be charged more for their services than non-Medicaid service recipients.
- If you enter a UCR into the Medicaid Billing System that is *lower* than the maximum rate, the lower rate is what you will be paid.

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### SINGLE CLAIM ENTRY :

\* indicates required field

Today's Date :  Help

Contract Number (7 Numbers) :  Help \*

Medicaid Recipient Number :  Help \*

Recipient First Initial :  Help \*

Recipient Last Name (First 5 Letters) :  Help \*

Date Of Service (mm/dd/yyyy) :  \* /  \* /  \* Help

Service Code :  Help \*

Units Of Service Delivered :  Help \*

Group Size :  Help

Staff Size :  Help

Service County :  Help \*

Usual Customary Rate \$ :   Help \*\*

Other Source Code :

Other Source Amount \$ :

Contractor Reference Number (Optional) :

**Other Source Code and Other Source Amount will not be used unless you are reporting patient liability or third party liability**

Clear Form

Submit Claim

## Third party Liability

- “Third party liability (TPL)” means the payment obligations of the Third Party Payer (TPP) for health care services rendered to eligible Medicaid consumers when the consumer also has third party benefits
- “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.
- 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).
- Once per calendar year, prepare an invoice to be submitted to the TPP, and keep a copy of your letter, as well as any reply, in case of an audit.
- Submit claims as you normally would; however, put an ‘S’ in the other source code. This indicates to MITS that you are aware of the TPL, but are not going to be paid through it.

# Patient Liability

- [Ohio Administrative Code 5101:1-39-24](#) defines Patient Liability as “the individuals financial obligation toward the Medicaid cost of care”.
- Patient Liability is determined by the county department of job and family services for the county in which the individual resides.
- The county board shall assign the HCBS waiver service(s) to which each individual’s patient liability shall be applied and assign the corresponding monthly patient liability amount to the HCBS waiver service provider that provides the preponderance of HCBS waiver services. The county board shall notify each individual and HCBS waiver service provider, in writing, of this assignment.
- Upon submission of a claim for payment, the designated HCBS waiver service provider shall report the HCBS waiver service to which the patient liability was assigned and the applicable patient liability amount on the claim for payment using the format prescribed by the department.

The county board will advise you as to how to collect the PL.

EXAMPLE - The client has a \$200.00 per month PL. You start providing services on the 11th. You would normally bill for 32 units of Homemaker/Personal Care-1 staff (APC) at \$4.11 per unit for every day you worked. You would submit your billing as follows:

Day of Service	Service Code	Units of Service	UCR	Other source Code	Other source Amount
11	APC	32	4.11	1	131.52
12	APC	32	4.11	1	68.48
13	APC	32	4.11		

The MBS system will automatically pay you the difference. In this case, on the second day [the 12th] you will be paid \$63.04, which is what you billed for minus the \$68.48 that you entered as PL. The \$200.00 PL has been satisfied for the month.

**Claim Successfully Submitted. Please note the File Reference Number : 1208150001.**

[Print Screen](#)

### SINGLE CLAIM ENTRY :

\* indicates required field

Today's Date :	<input type="text" value="8/15/2012"/>	<a href="#">Help</a>
Contract Number (7 Numbers) :	<input type="text" value="9999999"/>	<a href="#">Help</a>
Medicaid Recipient Number :	<input type="text" value="9999999999999"/>	<a href="#">Help</a>
Recipient First Initial :	<input type="text" value="j"/>	<a href="#">Help</a>
Recipient Last Name (First 5 Letters) :	<input type="text" value="case"/>	<a href="#">Help</a>
Date Of Service (mm/dd/yyyy) :	<input type="text" value="January"/> / <input type="text" value="Day"/> * / <input type="text" value="2012"/>	<a href="#">Help</a>
Service Code :	<input type="text" value="apc"/>	<a href="#">Help</a>
Units Of Service Delivered :	<input type="text"/>	<a href="#">Help</a> *
Group Size :	<input type="text"/>	<a href="#">Help</a>
Staff Size :	<input type="text"/>	<a href="#">Help</a>
Service County :	<input type="text" value="DARKE 19"/>	<a href="#">Help</a>
Usual Customary Rate \$ :	<input type="text"/> . <input type="text"/>	<a href="#">Help</a> * *
Other Source Code :	<input type="text"/>	<a href="#">Help</a>
Other Source Amount \$ :	<input type="text"/> . <input type="text"/>	<a href="#">Help</a>
Contractor Reference Number (Optional) :	<input type="text"/>	<a href="#">Help</a>

After you hit 'submit claim', much of the information you entered remains.

[Glossary](#)



Logout >



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Select Application

PAWS2

Load Application

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  - [Single Claim Entry](#)
  - [Upload Flat File](#)
  - [File Status](#)
- [County Board Use Only](#)
- [REPORTS](#)

### MBS CLAIM FILE SUBMITTAL

Maximum size of each file: 30,000 KB or 30 MB

Files must begin with the letter... M

File types which cannot be uploaded = .xls .doc .pdf .zip .rtf .done .attest .cfo .binary .dat

Select the File to Upload:

File Name :

#### LIST OF THE FILES ON THE WEB

File Name	Delete	View	Download
M9999999_7_20127_55_12.txt	<a href="#">Delete</a>	<a href="#">View</a>	<a href="#">Download</a>



Logout >



Hello Kevin Bracken. You have 0 new notifications and 0 new announcements.

View All

Select Application

PAWS2

Load Application

HOME

USER GUIDES

BILLING SUBMISSIONS

Single Claim Entry

Upload Flat File

File Status

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REPORTS

### MBS CLAIM FILE SUBMITTAL

Maximum size of each file: 30,000 KB or 30 MB

Files must begin with the letter... M

File types which cannot be uploaded = .xls .doc .pdf .zip .rtf .done .attest .cfo .binary .dat

Select the File to Upload:

File Name :

#### LIST OF THE FILES ON THE WEB

File Name	Delete	View	Download
M9999999_7_20127_55_12.tx	Delete	View	Download

File Content : M9999999\_7\_20127\_55\_12.tx

Line#	File Ref #	Invoice Date	Form	Medicaid #	Last Name	First Ini	Contract #	Service Date	Service Code	Units	Other Code	Other Amt.	Group	County	Usual Rate
1	1209070001	090712	2	66666666666666	case	j		010112	apc	96	S	00	01	19	411
2	1209070001	090712	2	66666666666666	case	j		010212	apc	96	S	00	01	19	411
3	1209070001	090712	2	66666666666666	case	j		010312	apc	01	S	00	01	19	411
4	1209070001	090712	2	66666666666666	case	j		010412	apc	96	S	00	01	19	411



Select Application

PAWS2

Load Application

HOME

USER GUIDES

BILLING SUBMISSIONS

Single Claim Entry

Upload Flat File

File Status

County Board Use Only

REPORTS

### MBS CLAIM FILE SUBMITTAL

Maximum size of each file: 30,000 KB or 30 MB

Files must begin with the letter... M

File types which cannot be uploaded = .xls .doc .pdf .zip .rtf .done .attest .cfo .binary .dat

Select the File to Upload:

File Name :

#### LIST OF THE FILES ON THE WEB

File Name	Delete	View	Download
m43011249_7_20127_55_12.txt	Delete	View	Download

**Provider File Reference Number**

Are you sure you wish to delete the selected file : **M9999999\_7\_20127\_55\_12.txt**

If Yes then please enter the File Reference Number and click on Yes else click on No.

Enter File Reference Number:

ther mt.	Group	County	Usual Rate
00	01	19	411
00	01	19	411
00	01	19	411
00	01	19	411

# Provider Weekly Reports



Logout >



Hello Kevin M Bracken. You have 0 new notifications and 0 new announcements.

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- [BILLING SUBMISSIONS](#)
- [REPORTS](#)
  - Provider Weekly Reports**
  - Third Party Reports
  - County Board Use Only

### Provider Weekly Reports

Display Files	Folder Name
<a href="#">View</a>	JAN11D_01-19-11
<a href="#">View</a>	JAN11C_01-12-11
<a href="#">View</a>	JAN11B_01-05-11
<a href="#">View</a>	JAN11A_12-29-10
<a href="#">View</a>	FEB11A_01-26-11
<a href="#">View</a>	DEC10E_12-22-10
<a href="#">View</a>	DEC10D_12-15-10
<a href="#">View</a>	DEC10C_12-08-10
<a href="#">View</a>	DEC10B_12-01-10
<a href="#">View</a>	DEC10A_11-24-10

Download	File Name	Date Modified
<a href="#">Download</a>	BILLED_CLAIM_JAN11C_	1/14/2011 8:07:26 AM
<a href="#">Download</a>	ERROR_DETAIL_JAN11C_	1/14/2011 8:05:09 AM
<a href="#">Download</a>	ERROR_SUMMED_DETAIL_JAN11C_	1/14/2011 8:09:25 AM
<a href="#">Download</a>	ERROR_SUMMED_JAN11C_	1/14/2011 8:04:23 AM
<a href="#">Download</a>	INVCFLAT_JAN11C_	1/24/2011 1:42:30 PM
<a href="#">Download</a>	INVOICE_JAN11C_	1/24/2011 1:45:05 PM
<a href="#">Download</a>	REIMB_APPROVED_JAN11C_	1/24/2011 8:21:04 AM
<a href="#">Download</a>	REIMB_APPROVED_SUM_JAN11C_	1/24/2011 8:22:55 AM
<a href="#">Download</a>	REIMB_FLATAPPV_JAN11C_	1/24/2011 8:24:28 AM

DEPARTMENT OF DEVELOPMENTAL DISABILITIES  
 DIVISION OF INFORMATION SYSTEMS

MEDICAID BILLING SYSTEM  
 TOTAL NET AMOUNT BILLED TO THE DEPARTMENT OF JOB AND FAMILY SERVICES  
 DURING THE CURRENT BILLING CYCLE OF DEC12A  
 BY CONTRACTOR, PROGRAM, AND MONTH/YEAR BILLED

CONTRACT NUMBER=0909090 NAME=PROVIDER AGENCY PROGRAM=INDIV OPTION WAIVER MONTH/YEAR BILLED=2012/08 -----

RECIPIENT BILLING NUMBER	SERV CODE	UNITS OF SERV	GROUP SIZE	STAFF SIZE	CNTY OF SERVICE DELIVERY	DATE OF SERVICE	AMOUNT BILLED	OTHER SOURCE AMOUNT	INPUT RATE	BILLED RATE	NET AMOUNT BILLED	CLM TYP
090909090909	APC	24	1	1	HAMILTON	13AUG2012	\$116.40		\$4.85	\$4.85	\$116.40	C
090909090909	APC	24	1	1	HAMILTON	14AUG2012	\$116.40		\$4.85	\$4.85	\$116.40	C
090909090909	APC	24	1	1	HAMILTON	15AUG2012	\$116.40		\$4.85	\$4.85	\$116.40	C
090909090909	APC	24	1	1	HAMILTON	16AUG2012	\$116.40		\$4.85	\$4.85	\$116.40	C
090909090909	APC	24	1	1	HAMILTON	17AUG2012	\$116.40		\$4.85	\$4.85	\$116.40	C

N = 5

CONTRACT NUMBER=0909090 NAME=PROVIDER AGENCY PROGRAM=INDIV OPTION WAIVER MONTH/YEAR BILLED=2012/09 -----

RECIPIENT BILLING NUMBER	SERV CODE	UNITS OF SERV	GROUP SIZE	STAFF SIZE	CNTY OF SERVICE DELIVERY	DATE OF SERVICE	AMOUNT BILLED	OTHER SOURCE AMOUNT	INPUT RATE	BILLED RATE	NET AMOUNT BILLED	CLM TYP
080808080808	APC	-16	1	1	BUTLER	21SEP2012	\$-76.80		\$4.80	\$4.80	\$-76.80	R
080808080808	APC	24	1	1	BUTLER	21SEP2012	\$115.20		\$4.80	\$4.80	\$115.20	A
070707070707	APC	12	1	1	MONTGOMERY	12SEP2012	\$56.52		\$4.71	\$4.71	\$56.52	C
070707070707	APC	13	1	1	MONTGOMERY	13SEP2012	\$61.23		\$4.71	\$4.71	\$61.23	C
060606060606	APC	-16	1	1	WARREN	28SEP2012	\$-75.36		\$4.71	\$4.71	\$-75.36	R
060606060606	APC	24	1	1	WARREN	28SEP2012	\$113.04		\$4.71	\$4.71	\$113.04	A
060606060606	APC	-24	1	1	WARREN	30SEP2012	\$-113.04		\$4.71	\$4.71	\$-113.04	R
060606060606	APC	16	1	1	WARREN	30SEP2012	\$75.36		\$4.71	\$4.71	\$75.36	A

N = 8

OHIO DEPARTMENT OF DEVELOPMENTAL DISABILITIES

November 30, 20

(MBSERROR)

TOTAL UNITS: 547

MEDICAID BILLING SYSTEM  
SUMMED ERRORS DETAIL REPORT FOR BILLING CYCLE DEC12A

PAGE:

CONTRACT NUMBER: 0909090

CONTRACTOR NAME: PROVIDER AGENCY

MONTH BILLED	INVOICE DATE	FORM	RECIPIENT BILLING NUMBER	LAST NAME	INITIAL	CONTRACT NUMBER	INPUT UNIT RATE	DAY OF SVC	GROUP/STAFF SIZE	CNTY OF SVC	SERVICE CODE	# OF UNITS DELIVERED	OTH SRC	OTHER AMOUNT
--------------	--------------	------	--------------------------	-----------	---------	-----------------	-----------------	------------	------------------	-------------	--------------	----------------------	---------	--------------

1111	112812	2	010101010101	BULL	P	0909090	4.15	11	1/ 1	18	FPC	52		
------	--------	---	--------------	------	---	---------	------	----	------	----	-----	----	--	--

(4 ) CLAIM SUBMITTED PAST THE ALLOWED SUBMISSION DATE

1112	112712	2	090909090909	BRITT	E	0909090	4.71	08	1/ 1	57	APC	24		
------	--------	---	--------------	-------	---	---------	------	----	------	----	-----	----	--	--

(28) SERVICE DUPLICATED FOR RECIP AND DATE

0912	112712	2	080808080808	SHEPH	J	0909090	4.71	24	1/ 1	83	APC	16		
------	--------	---	--------------	-------	---	---------	------	----	------	----	-----	----	--	--

(32) SERVICE IS IDENTICAL TO PRIOR BILLING

ERROR 4 Any claim that is 355 days old or older will receive an error 4, as it cannot be adjudicated by ODJFS within the 365 day limit specified by rule.

ERROR 28 The claim is a duplicate of another claim entered on the same billing cycle.

ERROR 32 The claim is a duplicate of another claim that was paid on an earlier billing cycle.

OHIO DEPARTMENT OF DEVELOPMENTAL DISABILITIES

November 30, 20

(MBSERROR)

TOTAL UNITS: 322  
 MEDICAID BILLING SYSTEM  
 WEEKLY SERVICE DELIVERY INPUT ERRORS FOR BILLING CYCLE DEC12A

PAGE:

CONTRACT NUMBER: 0909090 CONTRACTOR NAME: PROVIDER AGENCY

MONTH BILLED	RECIPIENT BILLING NUMBER	LAST NAME	INITIAL	CONTRACT NUMBER	INPUT UNIT RATE	DAY OF SVC	GROUP/STAFF SIZE	CNTY OF SVC	SERVICE CODE	# OF UNITS DELIVERED	OTHER SOURCE	OTHER SOURCE AMOUNT
1112	090909090909	BENCH	M	0909090	4.71	20	1/ 2	57	APC	48		
(46) STAFF SIZE AND SERVICE CODE DISAGREE												
1112	080808080808	ROWLE	D	0909090	4.80	22	1/ 1	09	APC	24		
(9 ) CLAIM DOES NOT MATCH USEABLE PAWS RECORD												
1112	070707070707	LEE	D	0909090	0.40	23	1/ 1	09	ATN	5		
(36) INITIAL DIFFERS FROM RECIPIENT FILE												
CASE LAST NAME: LEE						CASE FIRST NAME: STAN						
1112	060606060606	WARR	E	0909090	4.85	21	1/ 1	31	APC	24		
(35) LAST NAME DIFFERS FROM RECIPIENT FILE												
CASE LAST NAME: WARD III						CASE FIRST NAME: ED						

DEPARTMENT OF DEVELOPMENTAL DISABILITIES  
DIVISION OF INFORMATION SYSTEMS

15:21 Monday, December

(MBSREIMB)

MEDICAID BILLING SYSTEM  
REMITTANCE ADVICE - PAID CLAIMS  
FROM THE PAY/REJECT TAPE FOR ORIGINAL CLAIMS FROM BILLING CYCLE DEC12A

----- ADJUD DATE=121212 CONTRACT NO=0909090 NAME=PROVIDER AGENCY PROGRAM=INDIV OPTION WAIVER MONTH BILLED=2012

RECIPIENT NAME	RECIPIENT BILLING NUMBER	SERVICE CODE	UNITS OF SERVICE	GROUP SIZE	STAFF SIZE	CNTY OF SERVICE DELIVERY	DATE OF SERVICE	NET AMOUNT CLAIMED	NET AMOUNT ALLOWED	CLA REFER NUM
CASE, JUSTIN	090909090909	APC	20	1	1	AUGLAIZE	24NOV2012	\$79.80	\$79.80	

N = 1

DEPARTMENT OF DEVELOPMENTAL DISABILITIES  
DIVISION OF INFORMATION SYSTEMS

15:21 Monday, December

(MBSREIMB)

MEDICAID BILLING SYSTEM  
REMITTANCE ADVICE - PAID CLAIMS  
FROM THE PAY/REJECT TAPE FOR ORIGINAL CLAIMS FROM BILLING CYCLE DEC12A

----- ADJUD DATE=121212 CONTRACT NO=0909090 NAME=PROVIDER AGENCY PROGRAM=LEVEL 1 WAIVER MONTH BILLED=2012/1

RECIPIENT NAME	RECIPIENT BILLING NUMBER	SERVICE CODE	UNITS OF SERVICE	GROUP SIZE	STAFF SIZE	CNTY OF SERVICE DELIVERY	DATE OF SERVICE	NET AMOUNT CLAIMED	NET AMOUNT ALLOWED	CLA REFER NUM
POTTER, CLAY	080808080808	FIN	28	1	1	AUGLAIZE	22NOV2012	\$77.00	\$77.00	
-----			48					\$156.80	\$156.80	
CNTRNAME			48					\$156.80	\$156.80	
CNTRNUM			48					\$156.80	\$156.80	
ADJUDDT			48					\$156.80	\$156.80	
			=====					=====	=====	
			48					\$156.80	\$156.80	

N = 1

Total N = 2

DEPARTMENT OF DEVELOPMENTAL DISABILITIES  
DIVISION OF INFORMATION SYSTEMS

11:39 Monday, December 1

(MBSREIMB)

MEDICAID BILLING SYSTEM  
REMITTANCE ADVICE - DENIED CLAIMS  
FROM THE PAY/REJECT TAPE FOR ORIGINAL CLAIMS FROM BILLING CYCLE DEC12B

----- ADJUD DATE=121219 CONTRACT NO=0909090 NAME=PROVIDER AGENCY PROGRAM=INDIV OPTION WAIVER MONTH BILLED=2012

RECIPIENT BILLING NUMBER	SERVICE CODE	UNITS OF SERVICE	GROUP SIZE	STAFF SIZE	CNTY OF SERVICE DELIVERY	DATE OF SERVICE	AMOUNT CLAIMED	AMOUNT ALLOWED	DENIAL CODE	DENIAL CODE	CL REFE NUM
CASE, JUSTIN 44444444444444	APC	16	1	1	MONTGOMERY	28NOV2012	\$75.36	\$0.00	102	000	
CASE, JUSTIN 44444444444444	APC	16	1	1	MONTGOMERY	29NOV2012	\$75.36	\$0.00	102	000	
-----		-----				-----		-----			
PROGRAM		32				\$150.72		\$0.00			

N = 2

## \*\*\*\* DENIAL CODE VALUES \*\*\*\*

102 - DUPLICATE CLAIM DENIAL	169 - STAFF AND/OR GROUP SIZE INVALID
218 - 3rd PARTY LIABILITY DENIAL	244 - RECIPIENT WAS NOT ELIGIBLE ON DOS
278 - RECIPIENT ELIGIBILITY DENIAL	301 - PROVIDER LISTED AS INACTIVE IN MITS
308 - RECIPIENT SERVICES COVERED BY HMO PLAN	473 - RECIPIENT ELIGIBILITY DENIAL
686 - PROVIDER LISTED AS INACTIVE IN MITS	689 - HPC AND MUTUALLY EXCLUSIVE SERVICE BILLED C
763 - SERVICE LIMITED TO NO MORE THAN 1 UNIT/DAY	999 - MISCELLANEOUS JFS DENIAL (CONTACT DODD)

FOR ASSISTANCE CONTACT DODD SUPPORT CENTER AT 1-800-617-6733

(MBSINVC)

DEPARTMENT OF DEVELOPMENTAL DISABILITIES  
 DIVISION OF INFORMATION SYSTEMS  
 MEDICAID BILLING SYSTEM  
 DETAILED INVOICE FOR VOUCHERS PAID FOR SERVICES  
 CLAIMED DURING VOUCHER CYCLE DEC12A

----- INVOICE NUM=01068168    PROG=LV1 WAIVER    SCHIP ?=NO    CONTRACT NUM=0909090    NAME=PROVIDER AGENCY.    P

RECIPIENT NAME	RECIPIENT BILLING NUMBER	BILLING DATE	DATE OF SERVICE	SERVICE CODE BILLED	GROUP SIZE	STAFF SIZE	CNTY OF SVC	SERVICE CODE RATE	UNITS DELIV-ERED	CL TY
CASE, JUSTIN	090909090909	07NOV2012	22DEC2011	FIN	1	1	06	2.75	-5	
CASE, JUSTIN	090909090909	07NOV2012	22DEC2011	FIN	1	1	06	2.75	3	

-----  
 BILLPERD  
 VFY

----- INVOICE NUM=01068168    PROG=LV1 WAIVER    SCHIP ?=NO    CONTRACT NUM=0909090    NAME=PROVIDER AGENCY.    P

RECIPIENT NAME	RECIPIENT BILLING NUMBER	BILLING DATE	DATE OF SERVICE	SERVICE CODE BILLED	GROUP SIZE	STAFF SIZE	CNTY OF SVC	SERVICE CODE RATE	UNITS DELIV-ERED	CL TY
POTTER, CLAY	080808080808	29NOV2012	22NOV2012	FIN	1	1	06	2.75	28	C

-----  
 CNTRNAME  
 CNTRNUM  
 MEDIND  
 PROGRAM  
 INVCNUM

# Adjustments

- Due to the number of variables involved with adjustments, it is always advisable to contact provider support ***before*** entering an **adjustment**.
- **Adjustments to previously paid claims must be submitted within 330 days of the date of service, *and/or* within 165 days of the original adjudication date.**
- It is **not** always necessary to back out claims before making an adjustment. **Always** contact provider support *before* backing out claims.
- You must wait for the original claim to be on a reimbursed report before entering an adjustment.

**If you have made an error in billing, you will need to resubmit the claim with the correct information.** For example:

You provide 2 1/2 hours [10 units] of Homemaker/personal care 5 days/week for a total of 50 units per week. You bill:

Day of Service	Service Code	Units of Service
11	APC	10
12	APC	10
13	APC	10
14	APC	10
<b>15</b>	<b>APC</b>	<b>01</b>

You would resubmit the claim for the 15th for **10 units of service**. MBS will automatically deduct the 1 unit you have already been paid. **DO NOT** rebill for 9 units.

If you have any questions, contact **Provider.support@dodd.ohio.gov** or 1 (800)617-6733 to have them talk you through it **before** you attempt to enter an adjustment for the first time!

# Documentation

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# Service Documentation

**Providers of services shall maintain service documentation in accordance with OAC Chapter 5123:2-9-06 and service-specific rules in Chapter 5123:2-9 of the Administrative Code.**

**Service documentation must contain *at a minimum*:**

- (a) Type of service.
- (b) Date of service.
- (c) Name of individual receiving service.
- (d) Medicaid identification number of individual receiving service.
- (e) Name of provider.
- (f) Provider identifier/contract number.
- (g) Written or electronic signature of the person delivering the service, or initials of the person delivering the service if a signature and corresponding initials are on file with the provider.
- (h) Description and details of the services delivered that directly relate to the services specified in the approved individual service plan as the services to be provided.

## **OAC 5123:2-9-30 (E) Documentation of services Homemaker/personal care**

Service documentation for homemaker/personal care shall include each of the following to validate payment for Medicaid services:

- (1)** Type of service.
- (2)** Date of service.
- (3)** Place of service.
- (4)** Name of individual receiving service.
- (5)** Medicaid identification number of individual receiving service.
- (6)** Name of provider.
- (7)** Provider identifier/contract number.
- (8)** Written or electronic signature of the person delivering the service or initials of the person delivering the service if a signature and corresponding initials are on file with the provider.
- (9)** Group size in which the service was provided.
- (10)** Description and details of the services delivered that directly relate to the services specified in the approved individual service plan as the services to be provided.
- (11)** Number of units of the delivered service or continuous amount of uninterrupted time during which the service was provided.
- (12)** Begin and end times of the delivered service.

<sup>1</sup> **Type of service:** Homemaker/Personal Care  
<sup>2</sup> **Date(s) of service:** Dec 31, 2012-Jan 06, 2013  
<sup>3</sup> **Place of service:** 30 E. Broad St., Columbus Ohio 43215-3434  
<sup>4</sup> **Name of individual receiving service:** Justin Case  
<sup>5</sup> **Medicaid number of individual:** 999999999999  
<sup>6</sup> **Name of provider:** Brenda Case  
<sup>7</sup> **Contract number:** 2500000  
<sup>8</sup> **Signature:** *Brenda Case BC*

<sup>10</sup> <b>Type of service as specified on the ISP</b>	<b>Mon</b>	<b>Tue</b>	<b>Wed</b>	<b>Thu</b>	<b>Fri</b>	<b>Sat</b>	<b>Sun</b>
Bathing (0-5 x per week) 5-30 minutes	BC		BC		BC		
Oral Hygiene (0-5 x per week) 5-10 minutes	BC	BC	BC	BC	BC		
Shaving (0-5 x per week) 5-10 minutes	BC	BC	BC	BC	BC		
Nail Care (0-5 x per week) 5-15 minutes		BC		BC			
Toileting (0-30 x per week) 5-15 minutes	BC-4	BC-3	BC-2	BC-3	BC-2		
Supervision (0-7 x per week) up to 24 hours	BC	BC	BC	BC	BC		
Home Activities (0-5 x per week) 5-30 minutes	BC	BC		BC	BC		
Emergency Care (0-7 x per month) 5-30 minutes							
Household Chores (0-7 x per week) 5-45 minutes	BC	BC	BC	BC	BC		
Clothing Care (0-7 x per week) 5-45 minutes	BC		BC		BC		
<sup>9</sup> <b>Group size:</b>	1	1	1	1	1		
<sup>11</sup> <b>Number of units of service:</b>	32	34	32	34	32		
<sup>12</sup> <b>Time in/out:</b>	8am-4pm	8am-4:30pm	8am-4pm	8am-4:30pm	8am-4pm		

Notes: \_\_\_\_\_

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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## **OAC 5123:2-9-24 (E) Documentation of services HPC transportation**

**(2)** Service documentation for transportation shall include each of the following to validate payment for Medicaid services:

- (a)** Type of service.
- (b)** Date of service. **(c)** Name of individual receiving service.
- (d)** Medicaid identification number of individual receiving service.
- (e)** Name of provider.
- (f)** Provider identifier/contract number.
- (g)** Origination and destination points of transportation provided.
- (h)** Total number of miles of transportation provided.
- (i)** Group size in which transportation is provided.
- (j)** Written or electronic signature of the person delivering the service, or initials of the person delivering the service if a signature and corresponding initials are on file with the provider.
- (k)** Description and details of the services delivered that directly relate to the services specified in the approved individual service plan as the services to be provided.

<sup>a</sup>**Type of service:** HPC Transportation  
<sup>b</sup>**Date(s) of service:** Dec 31, 2012-Jan 06, 2013  
<sup>c</sup>**Name of individual receiving service:** Justin Case  
<sup>d</sup>**Medicaid number of individual:** 999999999999  
<sup>e</sup>**Name of provider:** Brenda Case  
<sup>f</sup>**Contract number:** 2500000  
<sup>j</sup>**Signature:** *Brenda Case BC*

<sup>b</sup> Date	<sup>g</sup> Origin	<sup>g</sup> Destination	<sup>h</sup> # of miles	<sup>i</sup> Group size	<sup>k</sup> Details of service
01/02/13	30 E Broad St, Columbus OH 43215	535 Office Center Pl Gahanna OH 43230	22	1	Appt. w/Dr. Pierce
01/03/13	30 E Broad St, Columbus OH 43215	2879 Johnstown Rd Gahanna OH 43219	16	1	ISP meeting w/SSA
01/04/13	30 E Broad St, Columbus OH 43215	215 W Johnstown Rd Gahanna OH 43230	16	1	Bowling outing

Notes: \_all round trips

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## **OAC 5123:2-9-18 (H) Documentation of services non-medical transportation**

**(1)** Service documentation for non-medical transportation at the per-trip rate and non-medical transportation at the per-mile rate shall include each of the following to validate payment for Medicaid services:

- (a)** Type of non-medical transportation service (i.e., per-trip or per-mile) provided.
- (b)** Date of service.
- (c)** License plate number of vehicle used to provide service.
- (d)** Name of individual receiving service.
- (e)** Medicaid identification number of individual receiving service.
- (f)** Name of provider.
- (g)** Provider identifier/contract number.
- (h)** Signature of driver of the vehicle or initials of the driver of the vehicle if the signature and corresponding initials are on file with the provider.
- (i)** Number of miles in each distinct trip and/or commute, as indicated by recording beginning and ending odometer readings.
- (j)** Names of all other passengers/riders, including paid staff and volunteers, who were in the vehicle during any portion of the trip and/or commute.
- (k)** Begin and end times of the trip and/or commute.

OAC 5123:2-9-18 H (1)

**a**Type of service: Non-Medical Transportation per-mile  
**b**Date(s) of service: Dec 31, 2012-Jan 06, 2013  
**c**License plate of vehicle: ABC1234  
**d**Name of individual(s) receiving service: Justin Case  
 Penny Lane  
**e**Medicaid number of individual: 999999999999 (Justin)  
 777777777777 (Penny)  
**f**Name of provider: Case Home Care  
**g**Contract number: 2500000  
**h**Signature of driver: *Brenda Case BC*

<b>b</b> Date	<b>i</b> Odometer beginning	<b>i</b> Odometer ending	<b>i</b> # of miles	<b>i</b> Group size	<b>k</b> Start time	<b>k</b> End time	<b>j</b> Names of passengers
01/02/13	44000	44011	11	1	8:00am	8:30am	Justin
01/02/13	44030	44041	11	1	4:00pm	4:30pm	Justin
01/03/13	44050	44061	11	2	8:00am	8:30am	Justin, Penny Sara Lee (volunteer)
01/03/13	44070	44081	11	2	4:00pm	4:30pm	Justin, Penny Sara Lee (volunteer)
01/04/13	44090	44111	11	1	8:00am	8:30am	Justin
01/04/13	44120	44131	11	1	4:00pm	4:30pm	Justin

OAC 5123:2-9-18 D (3)(4)

<b>Inspect daily:</b>	<b>Mon</b>	<b>Tue</b>	<b>Wed</b>	<b>Thu</b>	<b>Fri</b>
Secure Storage			<i>BC</i>	<i>BC</i>	<i>BC</i>
Two way communication			<i>BC</i>	<i>BC</i>	<i>BC</i>
Fire extinguisher			<i>BC</i>	<i>BC</i>	<i>BC</i>
First aid kit			<i>BC</i>	<i>BC</i>	<i>BC</i>
Lights			<i>BC</i>	<i>BC</i>	<i>BC</i>
Washers/wipers			<i>BC</i>	<i>BC</i>	<i>BC</i>
Emergency equipment			<i>BC</i>	<i>BC</i>	<i>BC</i>
Mirrors			<i>BC</i>	<i>BC</i>	<i>BC</i>
Horn			<i>BC</i>	<i>BC</i>	<i>BC</i>
Tires			<i>BC</i>	<i>BC</i>	<i>BC</i>
Brakes			<i>BC</i>	<i>BC</i>	<i>BC</i>

## Common issues found in documentation

- No documentation
- Insufficient documentation/documentation not supporting **current** ISP
- Billing errors
- Billing a daily rate for HPC & not utilizing the DRA
- Non-medical transportation billed on a day the individual did not receive day services
- Not reporting patient liability

## Top citations from provider compliance reviews

- **No annual MUI training**
- **No annual training on 'The rights of Individuals with Developmental Disabilities'**
- **No current CPR certification**
- **Waiver service delivery documentation does not include all required elements**

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**Claims Services Unit**  
**Ohio Department of Developmental Disabilities**  
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