Section 1: Rules governing waiver services

Ohio Administrative Code Chapter 5123:2-9 Home and Community-Based Services (HCBS) Waivers - General Requirements

OAC Chapter 5123:2-9-06 Home and community-based service waivers-payment for waiver services
The purpose of this rule is to establish the standards governing payment for home and community-based services (HCBS) under components of the Medicaid program that the Ohio Department of Developmental Disabilities administers pursuant to section 5111.871 of the Revised Code.

OAC Chapter 5123:2-9-08 Compliance reviews of certified HCBS waiver providers
This rule governs compliance reviews conducted by the department and the county board to assure compliance by certified providers with certification standards. This rule applies to all certified providers, including certified providers licensed in accordance with section 5123.19 of the Revised Code.

OAC Chapter 5123:2-9-11 Free choice of provider
The purpose of this rule is to establish procedures for individuals to choose qualified and willing providers of home and community-based services in accordance with provisions set forth in sections 5126.046 and 5123.044 of the Revised Code. This rule clarifies the department's role in assuring the free choice of provider processes are adhered to and is intended to emphasize the right of individuals to choose any qualified provider of home and community-based services. Nothing in this rule shall have the effect or shall be interpreted as limiting that choice.

The full texts of these rules are available on our website: Rules in Effect. This list is illustrative of the rules covering waiver services, and is not meant to be exhaustive. You are advised to go to our website to become familiar with the rules.

General information

- You can only be paid for services if:

    1. The services are identified on an approved Individual Service Plan [ISP]
    2. The service is recommended for payment through the Payment Authorization of Waiver Services [PAWS] process.
    3. You or your agency supplied the service.[1]
    4. You submit claims within three hundred fifty days after the service is provided.[2]

- You will need to identify if your client(s) have third-party health care coverage [insurance] and file a claim accordingly. This should be done annually and any correspondence with the insurance company retained with your billing records. [1]

- You cannot bill any individual except for cases where the individual has a **Patient Liability** [PL] for their cost of care. It is your responsibility to determine if the individual receiving services has PL and the monthly amount of that liability. Contact your local CBDD for assistance.

- Federal law requires an IRS form **1099-MISC** to be issued to non-corporate providers who make more than $600 per calendar year, regardless of whether payments are considered excludable from their gross income.[3] 1099's are issued by Ohio Shared Services [OSS], a division of the Office of Budget and Management, and not by DODD. If you do not receive your IRS form 1099, need to request a duplicate, or have a question about what is on your 1099, please contact the Office of Shared services directly. They can be reached by phone at (614) 338-4781 or 1877OHIOSS1 (18776446771), or by email at vendor@ohio.gov. DODD cannot give any advice regarding taxes, and you are strongly encouraged to consult an accountant or the IRS as factors of self-employment apply.

- You will need to maintain service documentation for a period of six years from the date of receipt of payment, or until an initiated audit is resolved, whichever is longer. This must be available for review by authorized agencies. [4]

- You will be paid at the statewide rate for each waiver service that is delivered, or at your usual and customary rate [UCR], whichever is lesser. The billing units, service codes, and payment rates are included in service-specific rules available on our website.[5]

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[1] OAC 5123-2-9-06
[2] OAC 5123_2-9-19
[3] 26 United States Code Section 6041A
[4] OAC 5123_2-9-05
[5] http://dodd.ohio.gov/rules/

- All claims must be submitted through the Medicaid Billing System [eMBS]. You may choose to contract with a billing agent rather than do your own billing. Billing agents are not employed or certified by the department, and DODD does not monitor or guarantee the performance of any billing agent and does not recommend or endorse any of the billing agents. DODD shall not be responsible or liable directly or indirectly for any loss or dispute related to the use of a billing agent.

  You remain responsible for the accuracy and completeness of all claims, including those submitted by billing agents. You are also responsible for meeting all HIPAA requirements, including a signed Business Associate Agreement with the billing agent. This Agreement is required by federal law, and it explains the billing agent's obligations for confidentiality.

http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/contractprov.html

- **Claims must be received by 11:45 am every Wednesday to be included in that particular week's submissions.** Notification will be provided via the eMBS application if submission dates are to change. There is no guarantee that claims submitted after this time will be processed on that billing cycle.

- Claims submitted that are error-free are then forwarded to the Ohio Department of Medicaid [ODM] for review and approval for payment.

  If DODD identifies claims containing errors, an Error Report is generated and can be accessed through eMBS. Claims that error are not forwarded to ODM for payment approval. You or your billing agent must make the necessary corrections and resubmit the claims.

  If ODM denies a claim for any reason, a denial report will be generated and can be accessed through eMBS. Claims that are denied are not paid and need to be corrected and resubmitted before payment can be issued.

  Processing time for a claim is 16 to 21 days, beginning with the day the claim is picked up for processing.