5160-35-04 **Reimbursement for services provided by medicaid school program (MSP) providers.**

(A) The purpose of this rule is to set forth the provisions for claiming to receive medicaid reimbursement for the provision of services by medicaid school program (MSP) providers as defined in Chapter 5160-35 of the Administrative Code.

(B) The CPT (common procedural terminology) and HCPCS (healthcare common procedure coding system) covered services provided through MSP providers that are allowable for medicaid reimbursement are listed in the appendix to this rule and are provided in accordance with Chapter 5160-35 of the Administrative Code. The following limits apply:

(1) Assessment/evaluation services cannot be billed more than once per continuous twelve month period.

(2) Re-assessment/re-evaluation services cannot be billed more than once per continuous six-month period.

(3) Skilled services cannot be billed for dates of service beyond twelve months of the initial assessment/evaluation or re-assessment/re-evaluation.

(C) Medically necessary services for individuals under age twenty-one that go beyond the coverage and limitations established in this rule shall be:

(1) Prior authorized by the Ohio department of medicaid (ODM) in accordance with rule 5160-1-31 of the Administrative Code; and

(2) Services defined as medical assistance in accordance with section 1905(a) of the Social Security Act, 42 U.S.C. 1396d (January 1, 2013).

(D) The following conditions shall be met in order to receive medicaid reimbursement for services provided through the medicaid school program:

(1) The school district shall be a qualified MSP provider in accordance with rule 5160-35-02 of the Administrative Code.

(2) The MSP provider shall submit claims for reimbursement for all direct service costs provided in accordance with rule 5160-35-05 of the Administrative Code and paragraph (B)(3) of rule 5160-35-06 of the Administrative Code for which the MSP provider will submit a cost report seeking cost reconciliation. Costs for direct services for which a provider has not submitted an interim claim will not be paid to the provider in any final cost report settlement.

(3) The MSP provider shall submit claims for only those services for which it has statutory responsibility to provide to either an eligible child with an IEP or for assessment/evaluation for a medicaid eligible child for whom they are trying to determine the appropriateness of developing an individualized education program (IEP).

(4) The executive officer of the MSP provider or his/her designee shall attest to the validity of the non-federal share of expenditures in accordance with paragraph (G) of this rule.

(5) The service provided through the MSP provider shall be in accordance with rules 5160-35-05 and 5160-35-06 of the Administrative Code.

(6) The service for which reimbursement is sought shall be one clearly identified in the IEP of an eligible child, with the exception of the initial assessment/evaluation as described in paragraph (B)(7) of rule 5160-35-05 of the Administrative Code.

(E) The MSP provider is required to enroll and submit claims as an ODM electronic data interchange (EDI) trading partner or contract with an ODM EDI trading partner for the submission of claims to ODM.

(F) Claims shall be submitted in accordance with rule 5160-1-02 of the Administrative Code.

(G) When a medicaid claim is submitted through an EDI trading partner, the claim shall include a ten character code that is the first item listed in the NTE02 field, and that is an attestation of whether or not the claim is certified by the executive officer of the MSP provider or his/her designee as follows:

(1) Attest yes: used if the claim is certified by the executive officer of the MSP provider or his/her designee to only include expenditures under the medicaid program under Title XIX of the Social Security Act (the Act), and as applicable, under the state children's health insurance program (SCHIP), under Title XXI of the Act, that are allowable in accordance with applicable implementing federal, state, and local statutes, regulations, and policies, and the state plan approved by the secretary of health and human services and in effect at the time of the submission of this claim; and the expenditures included in the claim are based on the MSP provider's accounting of actual recorded expenditures; and the required amount of local public funds were available and used to match the MSP provider's (local public school district's) allowable expenditures included in this claim, and such local public funds

were in accordance with all applicable federal requirements for the non-federal share match of expenditures; and federal matching funds are not being claimed in this claim submission to match any expenditure under any medicaid and/or SCHIP state plan amendment that has not been approved by the secretary of health and human services effective for the period of this claim.

(2) Attest nay: used if the claim is not certified by the executive officer of the MSP provider or his/her designee to only include expenditures under the medicaid program under Title XIX of the Social Security Act (the Act), and as applicable, under the state children's health insurance program (SCHIP), under Title XXI of the Act, that are allowable in accordance with applicable implementing federal, state, and local statutes, regulations, and policies, and the state plan approved by the secretary of health and human services and in effect at the time of the submission of this claim; and the expenditures included in the claim are based on the MSP provider's accounting of actual recorded expenditures; and the required amount of local public funds were available and used to match the MSP provider's (local public school district's) allowable expenditures included in this claim, and such local public funds were in accordance with all applicable federal requirements for the non-federal share match of expenditures; and federal matching funds are not being claimed in this claim submission to match any expenditure under any medicaid and/or SCHIP state plan amendment that has not been approved by the secretary of health and human services effective for the period of this claim. If attest nay is used, the claim will be denied for payment.

(H) Claim submissions must be received by ODM within three-hundred sixty-five days of the actual date the service was provided.

(I) References to cartridge tape, paper claim and pharmacy-point-of-sale in rule 5160-1-20 of the Administrative Code are not applicable to the claim and shall not be allowed.

(J) A billing unit for a service code reported in minutes is as indicated in the appendix to this rule, and claims shall be for minutes of actual service delivery time as follows:

(1) If service is provided in a group of two or more, the total number of minutes of each type of service, as distinguished by service codes, provided during the school or calendar day to the group of children is divided by the number of children in the group. This resulting number is then divided by the number of minutes identified for the service code to determine the number of units of service to an eligible child.

(2) The number of units is equivalent to the total number of minutes of each type of service, as distinguished by service codes, provided during the school or calendar day to the eligible child, divided by the number of minutes (a per hour unit is sixty minutes), or minimum minutes of the range identified for the service code.

(3) For service codes with a fifteen minute billing unit, one additional unit of service may be added to this quotient if the remainder equals eight or more minutes.

(4) For service codes with a per hour billing unit, one additional unit of service may be added to this quotient if the remainder equals fifty-two or more minutes.

(5) For service codes with a billing unit range, one additional unit of service may be added to this quotient if the remainder equals at least the minimum minutes of the range.

(K) The following applies to medicaid reimbursement:

(1) Interim payments. ODM shall reimburse the MSP provider interim payments. The interim payments shall be the federal financial participation (FFP) portion of the lesser of the billed charge (not to exceed the usual and customary charge) or the medicaid maximum according to the department's procedure code reference files for the particular services performed.

(2) Cost reports. Each MSP provider shall complete the Ohio department of education (ODE) developed medicaid school based cost report. The cost report is to be completed by the MSP provider in compliance with all state and federal provisions the cost report instructions also developed by ODE. The MSP provider shall contract with an independent certified public accountant (CPA) firm, the state auditor, or other entity authorized to conduct audits in the state of Ohio to perform an agreed upon procedures review of the cost report and document adjustments to the cost report. Once the agreed upon procedures review is completed, the reviewed cost report shall be submitted to ODE no later than eighteen months after the end of the cost reporting period as identified in the cost report instructions. The submitted cost report will be used by ODE and ODM in the cost reconciliation and final settlement process. ODM or ODE may conduct a desk or field audit up to three years after the fiscal year end based on risk assessment criteria developed by ODM. All cost reports for each fiscal year prior to the effective date of this rule but not starting earlier than July 1, 2005 shall be submitted in accordance with the schedule developed by ODM in cooperation with ODE

and approved by CMS.

(3) Cost report extension. For good cause and upon written request from the MSP provider, ODE may grant an extension of the cost report filing deadline. The written request must be submitted to the grants management unit at ODE thirty calendar days before the cost report submission deadline specified in paragraph (K)(2) of this rule. The request must include information explaining the facts and circumstances giving rise to the need for a cost report extension, projected time line for filing the cost report, and any other information which the MSP provider would like to have considered. Upon reviewing the written request, ODE may, at its sole discretion, request additional information, approve or deny the extension.

(4) Final cost settlement and reconciliation. The ODM and /or its designee shall review the cost reports identify adjustments needed, compare the federal financial participation (FFP) identified in the cost report against the interim payments made by ODM to the MSP provider, identify the number of students for which claims for services were received and paid and determine the proportionate costs for those students using the costs from the cost report for the total population of medicaid eligible IEP students, and issue a notice of intended action pursuant to rule 5160-70-03 of the Administrative Code that denotes the amount due to or from the MSP provider as a result of the reconciliation. The MSP provider will have thirty-days from the date of the notice during which it may request a hearing. If no hearing request is received, ODM will process the reconciled amount. An overpayment determined as a result of this annual reconciliation to actual cost shall be collected from the MSP provider by ODM. An underpayment determined as a result of this annual reconciliation to actual cost shall be paid to the MSP provider by ODM. Failure by a MSP provider to submit an acceptable cost report in accordance with paragraphs (K)(2) and (K)(3) of this rule, will result in full repayment by the MSP provider of the total interim payment received by the MSP provider for the cost reporting period. In addition, failure to submit an acceptable cost report will result in possible revocation of the MSP provider agreement and number.

(5) The provider shall accept reimbursement for all covered services as payment in full with limitations as set forth in accordance with rule 5160-1-60 of the Administrative Code.

(6) The MSP providers shall comply with all applicable federal and state rules, including but not limited to 45 C.F.R. Part 92 (December 24, 2013), 45 C.F.R. Part 74 (December 24, 2013), Chapters 5160-1 and 5160-35 of the Administrative Code, CMS Publication 15-1 (found at www.cms.gov/manuals), and the terms and conditions set forth within the

provider agreement.

(L) Records shall be maintained and disclosed by providers in accordance with rule 5160-1-27 of the Administrative Code. Records necessary to fully disclose the extent of services provided and costs associated with these services shall be maintained for a period of six years from the end of the cost reporting period based upon those records or until any initiated audit, review, investigation or other activities are completed and appropriately resolved, whichever is longer. Records shall be made available upon request to ODM, ODE or the U.S. department of health and human services. Failure to supply requested records, documentation or information as required in this rule may result in no payment for outstanding services, recoupment of any reimbursements provided for services that cannot be validated, termination from the medicaid program and/or any sanctions available pursuant to section 5162.10 of the Revised Code.

(M) State monitoring: ODM or its designee may conduct audits, reviews, investigations, or any other activities necessary to assure a medicaid school program provider, its subgrantee(s) or subcontractor(s) are compliant with federal and state requirements. Based on the results of an audit, review, investigation or other activities, ODM may seek recoupment of funding related to overpayments, misuse, fraud waste or abuse or noncompliance with federal or state requirements from the MSP provider.

Effective:

Five Year Review (FYR) Dates: 04/01/2020

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Certification

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Date

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