



Ohio Department of Job and Family Services Direct Bill for Nursing Facilities Frequently Asked Questions

1. What is Direct Bill?

Direct Bill for nursing facilities replaces the 9400 process for the nursing facility per diem. It doesn't automate the 9400 process, but requires that nursing facility providers submit room and board claims in accordance with the HIPAA 837 Implementation Guide based on the Federal requirements.

2. What is the timeline for Direct Bill implementation?

The projected date for implementation is for dates of services starting July 1, 2005, to be billed starting August 1, 2005.

3. What is an ODJFS trading partner?

An ODJFS trading partner is a clearinghouse that transmits health care information in an electronic format using a transaction that is tested and approved by ODJFS. A Trading Partner needs to be authorized by ODJFS before they can begin transmitting claims for payment. All of the information necessary to become an ODJFS Trading Partner is located at <http://hipaa.ohio.gov/ODJFS/index.htm>. Select the EDI Trading Partner Information Guide for additional details.

4. Can a nursing facility become a Trading Partner and submit direct bill claims?

Yes. All of the information necessary to become an ODJFS Trading Partner is located at <http://hipaa.ohio.gov/ODJFS/index.htm>. The nursing facility will need to review the Companion Guide for specific criteria that will be required to process nursing facility direct bill claims and then determine how this information can be extracted from their accounting system in a format that can be transmitted to ODJFS in compliance with the Trading Partner specifications. Keep in mind that the authorization process is quite rigorous. Providers who are not ready to begin the process immediately might want to consider temporarily working with an already authorized trading partner.

5. I have purchased a software package that will allow me to submit claims. Can I use it to submit claims to ODJFS?

There are rigid testing criteria that must be met prior to submitting claims in the production environment. Refer to the Information Guide on the ODJFS Trading Partner website <http://hipaa.ohio.gov/odjfs>, "Becoming a Trading Partner."



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6. Do other institutional providers typically become their own trading partners?

Even large hospitals often have relationships with independent trading partners in order to submit their claims; non-institutional providers rarely become self-authorized.

7. Is the trading partner number different than the provider number?

Yes. Refer to the Information Guide on the ODFJS Trading Partner website <http://hipaa.ohio.gov/odjfs>, 'Becoming a Trading Partner' for more information about the trading partner number.

8. If a nursing facility chooses not to become a Trading Partner, how else can direct bill claims be transmitted to ODJFS?

The nursing facility will need to make arrangements with a Trading Partner that is authorized by ODJFS to transmit 837I claims on their behalf. ODJFS has a list of all authorized Trading Partners at <http://hipaa.ohio.gov/ODJFS/authorized.htm>. Also, provider associations might have a list of billing agents that already have established relationships with ODJFS authorized trading partners.

9. How often can claims be transmitted to ODJFS?

Nursing facility services provided within a calendar month by a single provider to a single recipient shall be billed on one claim. Discharge status, expired status, or correction of a previously paid claim can be submitted any time.

10. Can a provider have more than one active trading partner at a time to submit claims on their behalf?

Yes, a provider can contract with more than one trading partner to submit claims on their behalf.

11. What is the payment cycle once a claim is received and deemed ready for payment?

If the claim is received by ODJFS (from the Trading Partner) and accepted into the system by 9am Wednesday, it will be scheduled to pay on the following Wednesday. The submission of room and board claims for payment will begin in August. The anticipated payment cycle for that month is as follows:

- Claims received by ODJFS 08/01 thru 08/03 will be paid on 08/10.
- Claims received by ODJFS 08/04 thru 08/10 will be paid on 08/17.



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- Claims received by ODJFS 08/11 thru 08/17 will be paid on 08/24.
- Claims received by ODJFS 08/18 thru 08/24 will be paid on 08/31.
- Claims received by ODJFS 08/25 thru 08/31 will be paid on 09/07

12. When can I check the status of a claim?

A provider can check the status of a claim by using the Interactive Voice Response (IVR) system. The IVR system can be accessed 24/7 to check the status of a claim. Check with your trading partner for the claim submission date/time and allow 48-72 hours before calling the IVR. The phone number for the IVR is 1.800.686.15.16. Please call for a PIN.

A trading partner will be notified electronically with the 997 Functional Acknowledgement and the Unsolicited 277 for Claim Status within 24 hours of submitting an EDI file.

13. What will be the process for payments and adjustments for service dates prior to 07/01/05?

The nursing facility will continue to use the 9400 process for both payments and adjustments for all claims with dates of service prior to 07/01/05.

14. What if I submit a direct bill claim for dates of service after 07/01/05 and later discover that I made a mistake on the claim?

All adjustments must be submitted using the 837 Institutional transaction for dates of service on or after 07/01/05.

15. Where are the billing instructions for submitting nursing facility room and board claims?

The information for submitting claims can be found on the ODJFS Trading Partner website in the 837 Institutional Companion Guide version 6 at <http://hipaa.ohio.gov/odjfs/>. Also, on the front page of this site under Trading Partner Notes, a change journal is posted. The change journal gives the ODJFS 837I Companion Guide page numbers for specific direct bill data elements

16. Which version of the companion guide should I use?

You must use the 837 Institutional Companion Guide defined by ODJFS. Currently, this is version 6 available on the ODJFS website at <http://hipaa.ohio.gov/ODJFS/index.htm>.



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17. What data elements are required for a Direct Bill claim?

Data elements that are required for Direct Bill room and board claims submission are identified in the ODJFS 837 Institutional Companion Guide. Please refer to the Change Journal in the guide for segments that have ODJFS User Notes for Direct Bill. (Not all required segments have user notes specific to direct bill.) This guide can be found at <http://hipaa.ohio.gov/odjfs/>

18. What are a loops, segments, and elements?

Loops, segments, and elements make up an ANSI X12 transaction.

Loop - set of records in the form of segments with related information

Segment - a record consisting of related data in the form of elements

Element – a field that contains specific claim data

19. Can the Ohio Medicaid generic number for providers be used in an EDI transaction?

Yes, but it must not be used to identify the Submitter or the Billing/Pay-to provider.

20. Is there training offered for Trading Partners?

There is no training specifically for trading partners scheduled at this time.

21. What other transactions are required in the EDI process for ODJFS?

For complete information on the ODJFS requirements for claims processing and claims status, rejected and accepted files, and rejected and accepted claims prior to adjudication, please refer to the EDI Information Guide found on the ODJFS Trading Partner website: <http://hipaa.ohio.gov/odjfs/>.

22. Will the Unsolicited 277 for accepted claims have a TCN assigned?

Yes.

23. Will the Unsolicited 277 for rejected claims have a TCN assigned?

No.



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24. What information should the Trading Partner have when calling to inquire about a claim?

A trading partner should call EDI Support (614-387-1212) and have the following information available when calling

- Trading Partner number
- Date file was sent
- ISA Control number
- ST control number
- TCN (if known)

25. How will I know if a claim was paid or denied?

A trading partner can receive an 835 electronic remittance advice on behalf of a provider. A provider must designate the trading partner who will receive the 835 electronic remittance advice on their behalf. The provider will continue to receive the paper remit.

26. Can a provider have more than one active trading partner at a time to receive the 835 electronic remittance advice?

No. See the ODJFS website <http://hipaa.ohio.gov.odjfs> Required Forms, 835 Designation of a Trading Partner, JFS 06306 form.

27. Can I designate a different trading partner to receive the 835 on my behalf?

See the ODJFS website <http://hipaa.ohio.gov.odjfs> Required Forms, 835 Designation of a Trading Partner, JFS 06306 form. There is a section on the JFS 06306 form specifically designed for this purpose.

28. Where do I find current Claim Adjustment Reason codes?

For more information on these kinds of codes, refer to the Washington Publishing website: <http://www.wpc-edi.com>. Select HIPAA, Code Sets.

29. Can I begin testing immediately?

Yes, you can begin testing as soon as you receive a trading partner number and have been issued an ID and password to your mailbox folder. **We strongly encourage you to begin the process now.** We will accept nursing facility room and board claims for testing on June 16, 2005. However, you can begin testing the 837I with other services, such as therapy claims, that are also billed using the 837I.



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30. What admission date is used for residents with the initial claims 7/1/05? The Medicaid eligibility date or the date and time they resident was initially admitted to the facility? Example - Mary Brown was admitted to the facility 4/3/03 as a private pay. She became Medicaid eligible on 7/1/04. What date should be used for the admission date for our first claim dated 7/1/05?

The admission date should be the original admission date to the facility. Mary Brown's admission date is 4/3/03.

31. A resident is in the hospital on the last day of the month and has zero leave days available. Should this resident status be "02 discharged to hospital" or "30 still patient"? If the answer is "30 still patient" then when should the "02 discharge to hospital" code be used?

If the resident is expected to return to the facility, then 30 should be used. If the resident has been discharged from the facility to the hospital without an expectation of returning, then the 02 status code should be used.

32. A resident is in and out of the hospital three times during the month. What admission date should be used on the claim?

The admission date should be the original admission date to the facility.

33. Please give me an example of when the following codes would be used:

- 22 Date a covered level of care ended**
- 24 The date denial of coverage was received from any insurer**
- 25 The date on which coverage was terminated by a primary payer**
- A3 The date benefits from a primary payer are exhausted**

These occurrence codes are used to report the date the third party payer acted upon the claim if the claim is not submitted to Medicaid for adjudication within 365 days from of date of service. The date reported by these occurrence codes will be used to determine whether the claim was received within 180 days of the third-party payers' adjudication. For example:

- 22 Date a covered level of care ended: report the date a recipient's skilled level of care ended in a Medicare Part A stay.
- 24 The date denial of coverage was received from any insurer: report the date Medicare or a 3rd party payer denied a claim for payment.
- 25 The date on which coverage was terminated by a primary payer: Medicare terminates a recipient's Medicare Part A for a variety of reasons. For example, the person stops paying their premium.
- A3 The date benefits from a primary payer are exhausted:



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A person uses the 100 days skilled care that Medicare Part A pays for, or a person uses all their private insurer benefits.

34. If we receive a lump sum payment that causes the resident to become ineligible for Medicaid for 6 months, do we need to bill ODJFS for those months and show the lump sum amount with value code #31 or just not bill until we expect payment again in the 7th month?

If it is determined by the CDJFS that the lump sum is to be paid to Medicaid, then the NF is required to submit adjustment claims to fully offset the amount of the lump sum payment against prior payments. If the lump sum payment exceeds the amount of prior payments, the NF is required to report payments sufficient to offset the current cost of care until the lump sum is exhausted. In the case when it is determined by the CDJFS that the lump sum results in Medicaid ineligibility, then the NF will not be required to bill.

35. Please give me an example of when the "prior payment" amount would be used on a claim. What would the prior payment amount represent?

The prior payment is the amount that Medicare or another third party payer paid for services within a service time period, or the amount Medicare paid as required on a crossover claim. For example the recipient was in the facility on a Medicare Part A stay for three days, you would report the amount that Medicare paid when submitting a co-insurance claim. Medicare prior payment is reported in Loop 2320, AMT01=N1, and other payer's paid amount is reported in Loop 2320, AMT01=C4.

36. Will all the July claims be a 212 and the rest of the months 213 ?

No. The bill type is contingent on the patient status. Examples include:

If the person is admitted and discharged in July, the patient status could be one of the following: 01 (Discharged to home or self care (routine discharge)) , 02 (Discharged to Hospital), 03 (Discharged to SNF), 04 (Discharged to ICF), 06 (Discharged/transferred to home under care of a home health service organization), 41 (Expired in a Medical Facility), 50 (Hospice – Home), or 51 (Hospice – Medical facility), and the bill type would be 211,(Admit Through Discharge).

If the person is admitted to the facility in July, the patient status would be 30 (still patient) the bill type would be 212 (Interim-First Claim).

If the person has been in the facility prior to July , and continues to be a patient through July, the patient status would be 30 (still patient) and the bill type would be 213 (Interim-Continuing Claim).



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If the person has been in the facility prior to July but is discharged in July, the patient status could be one of the following: 01 (Discharged to home or self care (routine discharge)) , 02 (Discharged to Hospital), 03 (Discharged to SNF), 04 (Discharged to ICF), 06 (Discharged/transferred to home under care of a home health service organization), 41 (Expired in a Medical Facility), 50 (Hospice – Home), or 51 (Hospice – Medical facility), and the bill type would be 214, (Interim Last Claim).

If the claim were a replacement of prior claim, bill type 217, or a 8 Void/Cancel of Prior Claim, bill type 218, use the patient status at the time of the original claim submission.

37. Is it possible for homes not ready for electronic billing to have no negative adjustments for 9400 processing since they will be receiving a reduced vendor already?

Direct bill does not impact the 9400 process for dates of services prior to July 1, 2005. Therefore, the department does not have the authority to change the 9400 adjustment process. The vendor payment represents a contingency plan that will protect providers' cash flow through the gross adjustment process while giving them several more months to become compliant. When these providers submit the 837I for services provided effective July 1, 2005, as required in the rule, they will receive reimbursement based on 100 percent of the provider's rate for nursing facility services.

38. Slide 51 for the state says R & B shall be billed on one claim except when a person shifts from Medicare to Medicaid during the same calendar month then what ? Can we bill two months on one bill ?

No, direct bill requires that only one claim for a single recipient for one month of service be submitted. An exception allows the provider to submit one bill for a Medicare cross-over payment and a second bill for the room and board payment even though both bills are for the same service month.

39. Should date of discharge be included in DTP03 segment of loop 2300?

Yes, the date of discharge should be included on bill types "211, admit through discharge" or "214, interim last claim".



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40. When submitting a claim, should the line level detail be in date order sequence or in revenue code sequence?

Date order is preferred, but not required.

41. Should the diagnosis code reported on the claim be the same as what is reported on the MDS?

Yes

42. Upon readmission to Medicaid – would this start with a new admission date and start the interim billing all over?

The admission date would be the original admission date to the facility and the bill type depends on the patient status not the Medicaid eligibility status.



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**MEDICAID DIRECT BILLING
BILLING EXAMPLES RECEIVED FROM A PROVIDER**

EXAMPLE 1

A Medicaid resident is in-house 4/1-4/9/05, discharges to the hospital (with leave days available) on 4/10/05, returns to the facility on 4/15/05 as a Medicaid resident.

The billing is as follows:

Bill type : 213 (assumes 4/1/05 is not the admission date)
Patient status : 30
Statement Covered Period: 4/1-4/30/05

Service Dates: 4/1-4/9/05 Revenue Code 0101 Covered days
 4/10-4/14/05 Revenue Code 0185 Covered days
 4/15-4/30/05 Revenue Code 0101 Covered days

Admission Date : Original date admitted to the nursing facility

EXAMPLE 2

A Medicaid resident is in-house 4/1-4/9/05, discharges to hospital (with no leave days available) on 4/10, returns to the facility on 4/15 as a Medicaid resident.

The billing is as follows:

Bill type : 213 (assumes 4/1/05 is not the admission date)
Patient status : 30
Statement covered Period: 4/1-4/30/05

Service Dates: 4/1-4/9/05 Revenue Code 0101 Covered days
 4/10-4/14/05 Revenue Code 0185 Noncov days
 4/15-4/30/05 Revenue Code 0101 Covered days

Admission Date : Original date admitted to the nursing facility

Note: charges for noncovered days should be reported as noncovered charges in SV207.



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EXAMPLE 3

A Medicaid resident is in-house 4/1-4/9/05, discharges to the hospital (with leave days available) on 4/10/05, returns to the facility on 4/15/05 as a skilled Medicare resident.

The billing is as follows:

Bill type : 213 (assumes 4/1/05 is not the admission date)
Patient status : 30
Statement covered period: 04/01-04/30/05

Service dates: 4/1-4/9/05 Revenue code 0101 Covered days
4/10-4/14/05 Revenue code 0185 Covered days
04/15-04/30/05 Revenue code 0101 Nocovd Days

Admission Date : Original date admitted to the nursing facility

Note: charges for noncovered days should be reported as noncovered charges in SV207.

EXAMPLE 4

A Medicaid resident is in-house 4/1-4/9/05, discharges to the hospital (without leave days available) on 4/10/05, returns to the facility on 4/15/05 as a skilled Medicare resident.

The billing is as follows:

Bill type : 213 (assumes 4/1/05 is not the admission date)
Patient status : 30
Statement covered period: 4/1-4/30/05

Service dates: 4/1-4/9/05 Revenue Code 0101 Covered days
4/10-4/15/05 Revenue Code 0185 Novcovd days
04/15-4/30/05 Revenue Code 0101 Noncovd days

Admission Date : Original date admitted to the nursing facility

Note: charges for noncovered days should be reported as noncovered charges in SV207.



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EXAMPLE 5

A Medicaid resident is in-house 4/1-4/20/05, discharges to the hospital on 4/21/05 (with leave days available), returns to the facility on 5/5/05 as a skilled Medicare resident and remains skilled until 7/5/05. On 7/6/05 the resident returns to Medicaid coverage.

The April billing is as follows:

Bill type : 213 (assumes 4/1/05 is not the admission date)
Patient status : 30

Statement covered period: 04/01-04/30/05

Service dates: 04/01-04/20/05 Revenue code 0101 Covered days
04/21-04/30/05 Revenue code 0185 Covered days

Admission date : Original admission date to the facility

The May billing is as follows:

Bill type : 213
Patient status : 30

Statement covered period: 05/01-05/04/05 Revenue code 0185 Covered days
05/05-05/31/05 Revenue code 0101 Noncvd days

Note: some of the non-covered days can be billed to Medicare Part A.

The June billing is as follows:

There would be no billing for 6/05 due to the resident using their Medicare benefits for the entire month. However, there would be Medicare Part A billing.

The July billing is as follows:

Bill type : 213
Patient status : 30



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Statement covered period: 07/01-07/31/05

Service dates: 07/01-07/05/05 Revenue code 0101 Noncovd days
07/06-07/31/05 Revenue code 0185 Covered days

Admission date : Original admission date to the facility

Note: There would be Medicare crossover billing for noncovered days resulting in two bills submitted for the month.

EXAMPLE 6

A Medicaid resident is in-house 4/1-4/30/05. The resident receives the proceeds from the sale of property and Medicaid terminates eligibility until the proceeds have been spent.

Assume the recipient is ineligible for only the month of April and is eligible for the month of May.

There would be no April billing.

The May billing would be as follows:

Bill type : 213
Patient status 30

Statement covered period: 04/01-04/30/05

Service Dates: 04/01-04/30/05 Revenue code 0101 Covered days

Admission Date : Original admission date to facility