

**Rule No. 560-X-54.07 Payment Methodology for Covered Services.**

(1) Payments made by Medicaid to providers will be on a fee-for-service basis. Each covered service is identified on a claim by a procedure code.

(2) For each recipient, the claim will allow span billing for a period up to one (1) month. There may be multiple claims in a month; however no single claim can cover services performed in different months. For example, claims with dates of service of 2/22/03 to 3/22/03 would not be allowed. If the submitted claim covers dates of service where part, or all of which were covered in a previously paid claim, the claim will be rejected.

(3) Payment will be based on the number of units of service reported on the claim for each procedure code.

(4) Accounting for actual cost and units of services provided during a waiver year must be captured on ~~CMS 372 Report. Centers for Medicare and Medicaid Services (CMS) Form 372.~~ The following accounting definitions will be used to capture reporting data, and the audited figures used in establishing new interim fees:

(a) A waiver year consists of 12 consecutive months starting with the approval date specified in the approved waiver document.

(b) An expenditure occurs when cash or its equivalent is paid in a quarter by a state agency for waiver benefits. For a public/governmental provider, the expenditure is made whenever it is paid or recorded, whichever is earlier. Non-cash payments, such as depreciation, occur when transactions are recorded by the state agency or the provider.

(c) The services provided by an operating agency are reported and paid by dates of service. Thus, all services provided during the 12 months of the waiver year will be attributed to that year.

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**Statutory Authority:** 42 CFR Section 441, Subpart G and the Home and Community-Based Technology Assisted Waiver for Adults.

**History:** Emergency Rule filed and effective March 13, 2003. **Amended:** Filed March 20, 2003; effective June 16, 2003. **Amended:** Filed June 20, 2008; effective September 15, 2008.

**Amended:** Filed April 21, 2014