Hospice Basic Billing Training

External Business Relations
August 2017
Ohio Medicaid Services

- Ohio Medicaid Services
- Programs & Cards
- Managed Care/MyCare Ohio
- Provider Responsibilities
- Policy
- MITS
- Hospice Enrollment
- Claim Submission
- Websites
- Forms
Ohio Medicaid Services

- Ombudsmen
  - Sarah Bivens
  - Ava Cottrell
  - Laura Gipson
  - Ed Ortopan
  - Janene Rowe
  - Chezré Willoughby

Manager-Meagan Grove
Ohio Medicaid Services

❖ Ombudsman:
  – Investigate and resolve billing issues
  – Identify system and policy issues
  – Speak at seminars for provider associations
  – Conduct individual consultations with providers
  – Conduct basic billing trainings

ombudsman ˈäm-,būdz-mən, ˈöm-, -bədz-, -man
❖ a person who investigates complaints and tries to deal with problems fairly
❖ one that investigates, reports on, and helps settle complaints
Ohio Medicaid Services

- Covered Families and Children
- Expansion Population
- Aged, Blind, or People with Disabilities
- Home and Community Based Waivers
- Medicare Premium Assistance
- Hospital Care Assurance Program
- Medicaid Managed Care
Ohio Medicaid Services

- Behavioral Health
- Dental
- Dialysis
- Dietitian
- Durable Medical Equipment
- Home Health
- Hospice
- Hospital (Inpatient/Outpatient)
- ICF-IID Facility
- Nursing Facility
- Pharmacy
- Physician
- Transportation
- Vision

Covered Services (not limited to)
Ohio Medicaid Services

Medical Necessity: OAC 5160-1-01

Is the fundamental concept underlying the Medicaid Program

All services must meet accepted standards of medical practice
Ohio Medicaid Services

- IVR 1-800-686-1516

- Calls directed through the IVR prior to accessing the customer call center staff

- Staff are available weekdays from 8:00 a.m. to 4:30 p.m.

- Providers will be required to enter two out the following three pieces of data: tax ID, NPI, and 7 digit Ohio Medicaid provider number
Ohio Medicaid Services

- Helpful phone numbers
  - Adjustments
    - 614-466-5080
  - OSHIP (Ohio Senior Health Insurance Information Program)
    - 1-800-686-1578
  - Coordination of Benefits Section
    - 614-752-5768
    - 614-728-0757 (fax)
Programs & Cards
Programs & Cards

- Ohio Medicaid
  - This card is the traditional fee-for-service Medicaid card
  - Issued monthly
Programs & Cards

Ohio Medicaid Categories

- Some categories include:
  - Supplemental Security Income (SSI)
  - Modified Adjusted Gross Income (MAGI)
  - Aged, Blind, and/or Disabled (ABD)

- Automatically eligible for Medicaid as long as eligible for SSI
- Children, parents, caretakers, and expansion
- 65+, or blind/disabled with no SSI
Programs & Cards

- Presumptive Eligibility
  - Covers children up to age 19 and pregnant women
    - It has now expanded to provide coverage for parent and caretaker relatives and extension adults
  - This is a *limited* benefit to allow time for full determination of eligibility for medical assistance
  - Once approved by a CDJFS or a qualified entity an approval letter will be received
Programs & Cards

- Presumptive Eligibility, cont.

### Recipient Information

<table>
<thead>
<tr>
<th>Medicaid Billing Number</th>
<th>SSN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name</td>
<td></td>
</tr>
<tr>
<td>First Name</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>County of Residence</td>
<td></td>
</tr>
<tr>
<td>County of Eligibility</td>
<td></td>
</tr>
<tr>
<td>County Office</td>
<td></td>
</tr>
<tr>
<td>Number Bed Hold Days</td>
<td>20170101: 10</td>
</tr>
<tr>
<td>Used Paid CY</td>
<td></td>
</tr>
</tbody>
</table>

### Benefit / Assignment Plan

<table>
<thead>
<tr>
<th>Benefit / Assignment Plan</th>
<th>Effective Date</th>
<th>End Date</th>
<th>Provider Name</th>
<th>Dental Co-Pay Amount</th>
<th>Vision Co-Pay Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRESUMPTIVE: Alternative Benefit Plan</td>
<td>01/01/2017</td>
<td>06/30/2017</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Medicaid Expansion</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PRESUMPTIVE: MRDD Targeted Case Mgmt</td>
<td>01/01/2017</td>
<td>06/30/2017</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>PRESUMPTIVE: Alcohol and Drug Addiction</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PRESUMPTIVE: Ohio Mental health</td>
<td>01/01/2017</td>
<td>06/30/2017</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>PRESUMPTIVE: Medicaid</td>
<td>01/01/2017</td>
<td>06/30/2017</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

### Case/Cat/Seq Spenddown

- Ohio Department of Medicaid
- John R. Meyer, Director
- Deborah J. Daiber, Director
Programs & Cards

- Medicaid Pre-Release Enrollment Program
  - Institutionalized individuals close to release are enrolled into a Medicaid Managed Care plan, prior to release
    - Individual must agree and be eligible for the program
    - MCP Care Manager will develop a transition plan
  - Combined effort with ODRC, Ohio MHAS, ODH, and MCPs
  - All DRC facilities activated by January 2017
  - More than 11,000 individuals have benefited from this program
Program & Cards

DRC Inpatient Hospitalization

1. ODRC sends applications to ODM Direct Enrollment Unit for offenders who are admitted to a hospital for a period of at least 24 hours

2. ODM Direct Enrollment Unit processes the application and maintains the case in their ODM caseload

3. Eligibility for a full year is approved, then Pre-Termination Review (PTR) to determine if there is a need to keep on Medicaid
Program & Cards

- Eligibility Verification Request - DRC Inpatient
  - Individuals who have Medicaid through the DRC Inpatient program will have the ‘Inpatient Hospital Services Plan’ in MITS

<table>
<thead>
<tr>
<th>Recipient Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Billing Number</td>
</tr>
<tr>
<td>Last Name</td>
</tr>
<tr>
<td>First Name</td>
</tr>
<tr>
<td>Gender</td>
</tr>
<tr>
<td>Date of Birth</td>
</tr>
<tr>
<td>Date of Death</td>
</tr>
<tr>
<td>SSN</td>
</tr>
<tr>
<td>County of Residence</td>
</tr>
<tr>
<td>County of Eligibility</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Benefit / Assignment Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospital Services Plan</td>
</tr>
<tr>
<td>Effective Date</td>
</tr>
<tr>
<td>End Date</td>
</tr>
<tr>
<td>Provider Name</td>
</tr>
<tr>
<td>Dental Co-Pay Amount</td>
</tr>
<tr>
<td>Vision Co-Pay Amount</td>
</tr>
</tbody>
</table>
Programs & Cards

**Qualified Medicare Beneficiary (QMB)**

- Issued to qualified consumers who receive Medicare
- Medicaid only covers their monthly Medicare premium, co-insurance and/or deductible after Medicare has paid
  
  - Note: Co-insurance and/or deductible payments are based on the reimbursement policies currently set in place under 5160-1 General Provisions and could result in a payment of zero dollars
Programs & Cards

- Specified Low-Income Medicare Beneficiary (SLMB) & Qualifying Individual (QI-1)
  - We **ONLY** pay their Part B premium to Medicare
  - This is **NOT** Medicaid eligibility
  - There is **NO** cost-sharing eligibility
Programs & Cards

- Conditions of Eligibility and Verifications: OAC 5160-1-2-10
  - Consumers must cooperate with requests from third-party insurance companies to provide additional information needed in order to authorize coverage
  - Consumers must cooperate with requests from a Medicaid provider; managed care plan; or a managed care plan’s contracted provider for additional information which is needed in order to bill third party insurances appropriately
Programs & Cards

- Conditions of Eligibility and Verifications, cont.
  
  - Providers may contact local CDJFS offices to report non-cooperative consumers
  
  - CDJFS may terminate eligibility if an individual fails or refuses, without good cause, to cooperate by providing necessary verifications or by providing consent for the administrative agency to obtain verification
Managed Care/MyCare Ohio
Managed Care/MyCare Ohio

Three different groups of Managed Care eligible:

- Medicaid Managed Care MAGI (CFC)
- Medicaid Managed Care Non-MAGI (ABD)
- Medicaid Managed Care Adult MAGI
  - For the adult extension population
Managed Care/MyCare Ohio

- Managed Care Benefit Package
  - Managed Care Plans must cover all medically necessary Medicaid covered services
  - Some value-Added Services:
    - Care management to help members coordinate care and ensure they are getting the care that they need
    - Access to toll-free 24/7 hotline for medical advice, staffed by nurses
    - On-line searchable provider directory
    - Preventative care reminders
    - Expanded benefits including additional transportation options, and other incentives (varies among the MCPs)
Managed Care/MyCare Ohio

- **New populations** moving into Managed Care
  - The Managed Care population will continue to grow so always check eligibility prior to providing services
  - Adoption children 1/1/17
  - Breast and Cervical Cancer Patients (BCCP) - 1/1/17
  - Bureau of Children with Medical Handicaps (BCMH) - 1/1/17
  - Foster children – transitioning in phases by 7/1/17
Managed Care/MyCare Ohio

- Individuals with *optional enrollment* in Medicaid Managed Care Plan
  - Native Americans that are members of federally recognized tribes
  - Home and Community Based waivers thru DODD 1/1/17
Managed Care/MyCare Ohio

- Adult Extension and HCBS Waiver
  - Adults eligible via the extension will be able to access a home-and community-base waiver (HCBS) if a level of care requirement is met
  - HCBS waivers include: Passport, Ohio Home Care, and Assisted Living
  - MCPs will be responsible for health care services however waiver services will be paid by traditional Medicaid
  - Current HCBS waiver case management agencies will continue to coordinate waiver services
Managed Care/MyCare Ohio

How do you know if someone is enrolled in Managed Care?

- Providers need to check the MITS provider portal each time *before* providing services to a Medicaid recipient.

- The MITS provider portal will show if a recipient is enrolled in a Managed Care Plan based on the eligibility dates of service you enter.

- For recipients enrolled in a MyCare Ohio Managed Care plan it will show if they are enrolled for *Dual Benefits* or *Medicaid Only*.
### Managed Care/MyCare Ohio

<table>
<thead>
<tr>
<th>Benefit / Assignment Plan</th>
<th>Effective Date</th>
<th>End Date</th>
<th>Provider Name</th>
<th>Dental Co-Pay Amount</th>
<th>Vision Co-Pay Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>MAGI-GROUP VIII:Alternative Benefit Plan Medicaid Expansion</td>
<td>01/01/2017</td>
<td>02/28/2017</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>MAGI-GROUP VIII:MRDD Targeted Case Mgmt</td>
<td>01/01/2017</td>
<td>02/28/2017</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>MAGI-GROUP VIII:Alcohol and Drug Addiction Services</td>
<td>01/01/2017</td>
<td>02/28/2017</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>MAGI-GROUP VIII:Ohio Mental Health</td>
<td>01/01/2017</td>
<td>02/28/2017</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>MAGI-GROUP VIII:Medicaid</td>
<td>01/01/2017</td>
<td>02/28/2017</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

**Case/Cat/Seq Spenddown**

***No rows found***

**IPL**

***No rows found***

**Managed Care**

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Plan Description</th>
<th>Effective Date</th>
<th>End Date</th>
<th>Managed Care Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>CARESOURCE</td>
<td>HMO, CFC</td>
<td>01/01/2017</td>
<td>02/28/2017</td>
<td></td>
</tr>
</tbody>
</table>
Managed Care/MyCare Ohio

Managed Care Sample Card

If you have an emergency, call 911 or go to the NEAREST emergency room (ER). You do not have to contact Buckeye for an okay before you get emergency services. If you are not sure whether you need to go to the ER, call your PCP or Buckeye NurseWise toll-free at 1-866-246-4358 and follow the prompt for ‘Nurse’ or TTY at 1-800-750-0750. NurseWise is open 24 hours per day.
Managed Care/MyCare Ohio

- Integrated Care Delivery System (ICDS) “MyCare Ohio”
  - MyCare Ohio is a demonstration project that integrates Medicare and Medicaid services into one program, operated by a Managed Care Plan
  - MyCare Ohio operates in seven geographic regions covering 29 counties and includes more than 100,000 beneficiaries
  - The project was extended for 2 additional years
Managed Care/MyCare Ohio

- MyCare Ohio Benefits
  - Package includes all benefits available through the traditional Medicare and Medicaid programs
    - Including Long Term Social Services (LTSS) and Behavioral Health, which is new to Managed Care
  - Plans may elect to include additional value-added benefits in their health care packages
Managed Care/MyCare Ohio

- MyCare Ohio Eligibility

- In order to be eligible for MyCare Ohio an individual must be:
  - Eligible for all parts of Medicare (Parts A, B, and D) and be fully eligible for Medicaid
  - Over the age of 18
  - Reside in one of the demonstration project regions

*Individuals residing in NF’s and those enrolled in a NF-level of care 1915c waiver are included in the demonstration project-- except for ICF-IID individuals and/or those receiving behavioral health services
Managed Care/MyCare Ohio

<table>
<thead>
<tr>
<th>Benefit / Assignment Plan</th>
<th>Effective Date</th>
<th>End Date</th>
<th>Provider Name</th>
<th>Dental Co-Pay Amount</th>
<th>Vision Co-Pay Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRDD Targeted Case Mgmt</td>
<td>01/01/2017</td>
<td>02/28/2017</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Alcohol and Drug Addiction Services</td>
<td>01/01/2017</td>
<td>02/28/2017</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Ohio Mental health</td>
<td>01/01/2017</td>
<td>02/28/2017</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Medicaid</td>
<td>01/01/2017</td>
<td>02/28/2017</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

| Case/Cat/Seq Spenddown    | *** No rows found *** |
| TPL                       | *** No rows found *** |

**Managed Care**

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Plan Description</th>
<th>Effective Date</th>
<th>End Date</th>
<th>Managed Care Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>CARESOURCE</td>
<td>HMO, MyCare Ohio</td>
<td>01/01/2017</td>
<td>02/28/2017</td>
<td>Dual Benefits</td>
</tr>
</tbody>
</table>

| Lock-In     | *** No rows found *** |

**Medicare**

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Effective Date</th>
<th>End Date</th>
<th>Plan Name</th>
<th>Plan ID</th>
<th>HIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>PART A</td>
<td>01/01/2017</td>
<td>02/28/2017</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PART B</td>
<td>01/01/2017</td>
<td>02/28/2017</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PART C</td>
<td>01/01/2017</td>
<td>02/28/2017</td>
<td>CARESOURCE MYCARE OHIO</td>
<td>H8452</td>
<td></td>
</tr>
<tr>
<td>PART D</td>
<td>01/01/2017</td>
<td>01/31/2017</td>
<td>*H8452/001</td>
<td>001</td>
<td></td>
</tr>
</tbody>
</table>
Managed Care/MyCare Ohio

MyCare Ohio Opt-In Sample Card

Member Name: Jason Doe
Member ID: (Amisys MC Member #)
Health Plan: Buckeye Community
Health Plan – MyCare Ohio
MMIS Number: <Medicaid Recipient ID#>
PCP Name: <PCP Name>
PCP Phone: <PCP Phone>
Plan Contract: H0022 001

In an emergency, call 9-1-1 or go to the nearest emergency room (ER) or other appropriate setting. If you are not sure if you need to go to the ER, call your PCP or the 24-Hour Nurse Advice line.

Member Service: 866-549-8289 (TDD/TTY 800-750-0750)
Behavioral Health Crisis: 866-549-8289
Care Management: 866-549-8289
24-Hour Nurse Advice: 866-246-4358 Option 7
Website: www.bchphio.com
Send claims to: Buckeye Community Health Plan
P.O. Box 3060
Farmington, MO 63640-3822
Managed Care/MyCare Ohio

MyCare Ohio Opt-Out Sample Card

* Buckeye Medicaid Member Only *

In an emergency, call 9-1-1 or go to the nearest emergency room (ER) or other appropriate setting. If you are not sure if you need to go to the ER, call your PCP or the 24-Hour Nurse Advice line.

- **Member Service**: 866-549-8289
  - TTY: 800-750-0750
- **Behavioral Health Crisis**: 866-549-8289
- **Care Management**: 866-549-8289
- **24-Hour Nurse Advice**: 866-246-4358
  - TTY: 800-750-0750

**Eligibility Verification**: 866-246-4358

**Pharmacy Help Desk**: 877-935-8021

**Claim Inquiry**: 866-246-4358

Website: http://mmp.bchpohio.com

**Send Medicaid claims to**: Buckeye Community Health Plan
PO Box 6200
Farmington, MO 63640

*Note: Member is eligible for Medicare through original Medicare or another health plan. You must submit Medicare claims to the member’s primary care insurance.*
Managed Care/MyCare Ohio

- Individuals *Exempt* from MyCare Ohio Groups
  - The following groups are not eligible for enrollment in MyCare Ohio:
    - Individuals with an ICF-IID level-of-care served in an ICF-IID waiver
    - Individuals who have third-party insurance, including retirement benefits
    - Individuals enrolled in PACE program
Managed Care/MyCare Ohio

MCPs providing “Traditional” Medicaid Managed Care
- Buckeye (Centene)
- Caresource
- Molina
- United HealthCare
- Paramount

MCPs participating in MyCare Ohio (ICDS)
- Buckeye (Centene)
- Caresource
- Molina
- United HealthCare
- Aetna
Managed Care/MyCare Ohio

❖ MyCare Ohio Region Breakdown

Northwest
- Aetna
- Buckeye

Southwest
- Aetna
- Molina

West Central
- Buckeye
- Molina

Central
- Aetna
- Molina

East Central
- Caresource
- United

Northeast Central
- Caresource
- United

Northeast
- Caresource
- Buckeye
- United

Fulton
- Lucas
- Ottawa
- Wood

Butler
- Warren
- Clinton
- Hamilton
- Clermont

Clark
- Green
- Montgomery

Union
- Delaware
- Franklin
- Pickaway
- Madison

Summit
- Portage
- Stark
- Wayne

Trumbull
- Mahoning
- Columbiana

Lorain
- Cuyahoga
- Lake
- Geauga
- Medina
Managed Care/MyCare Ohio

- Managed Care Contracting
  - If a provider is interested in delivering services to a Managed Care member, a contract or agreement with the plan is necessary
    - Each plan has a list of services that require prior authorization
    - Each plan will have their own billing requirements; therefore, contact the plan for the specific requirements
    - MyCare Ohio contracts are separate from ABD/CFC Managed Care plan contracts
Managed Care/MyCare Ohio

- Oversight of Managed Care Plans
  - Managed Care Plans sign a Provider Agreement
  - OAC 5160-26: Traditional Medicaid
  - OAC 5160-58: MyCare Ohio
  - Each MCP has a Contract Administrator with the Department of Medicaid
Managed Care/MyCare Ohio

- Provider Complaints
  - Work directly with the Plan first
  - If not resolved, submit a complaint to Ohio Department of Medicaid (ODM)
    - [http://www.ohiomh.com/ProviderComplaintForm.aspx](http://www.ohiomh.com/ProviderComplaintForm.aspx)
  - Certification issues, work with the Area Agency on Aging (AAA) or ODM for MyCare Ohio waiver providers
  - Provider credentialing concerns can be sent to Ohio Department of Insurance (ODI)
Provider Responsibilities
Provider Responsibilities

- Provider Enrollment
  - There is a non-refundable application fee when an application is submitted to become a Medicaid provider
    - This is a federal requirement
    - The 2017 fee is $560.00 per application
    - The fee applies to organizational providers only (not individual providers, practitioners, or practitioner groups)
Provider Responsibilities

- Provider Revalidation
  - The 5 year revalidation is a federal requirement
  - Make sure your mailing address is up to date in the Demographics panel in MITS
  - Providers that do not revalidate will have their Medicaid agreement terminated
  - The non-refundable application fee also applies to the revalidation of your provider agreement
Provider Responsibilities
Provider Responsibilities

❖ Provider Revalidation, cont.
   – Check online for past, current, and future revalidations

Upcoming Revalidations
- 2019
- 2020
- 2021
- 2018
- 2017
- 2016

Important Notice for Providers that Have Received Revalidation Letter
Provider Responsibilities

- Provider Agreement: OAC 5160-1-17.2
  - The provider agreement is a legal contract between the state and the provider
  - In the contract, you agree you will:
    - Accept the allowable reimbursements as payment-in-full
    - Not seek reimbursement for service(s) from the patient, any member of the family, or any other person
    - Maintain records for 6 years
Provider Responsibilities

Provider Agreement, cont.

- You also agree to:
  - Render medically necessary services in the amount required
  - Recoup any third party resources available
  - Inform us of any changes to your provider profile within 30 days
  - Abide by the regulations and policies of the state
Provider Responsibilities

- Provider Reimbursement: OAC 5160-1-02 and OAC 5160-1-60
  - The department’s payment constitutes payment-in-full for any of our covered services
  - Providers are expected to bill the department their Usual and Customary Charges (UCC)
  - The department will reimburse the provider the lesser of the Medicaid maximum allowable rate (established fee schedule) or the UCC
Provider Responsibilities

- Medicaid Consumer Liability: OAC 5160-1-13.1
  - A provider **MAY NOT** collect and/or bill for any difference between the Medicaid payment and the provider’s charge
  - A Medicaid consumer **CANNOT** be billed:
    - When a Medicaid claim has been denied
    - Unacceptable claim submission
    - Failure to request a prior authorization
    - Retroactive Peer Review determination of lack of medical necessity
Provider Responsibilities

- Consumer Liability, cont.
  - 3 steps must be followed in order to bill a consumer
    1. The consumer is notified in writing prior to the service being rendered that the provider will not bill the department for the covered service; and
    2. The consumer agrees to be liable for payment of the service and signs a written statement to that effect prior to the service being rendered; and
    3. The provider explains to the consumer that the service is a covered Medicaid service and that other Medicaid providers may render the service at no cost to the consumer
Provider Responsibilities

- Coordination of Benefits: OAC 5160-1-08
  - The Ohio Revised Code requires that a Medicaid consumer provide notice to the department prior to initiating any action against a liable third party
  - The department will take steps to protect its subrogation rights if that notice is not provided
  - For questions, contact the Coordination of Benefits Section at 614-752-5768
Provider Responsibilities

- Electronic Funds Transfer
  - ODM will start requiring Electronic Funds Transfer (EFT) for payment instead of paper warrants
  - Benefits of direct deposit include:
    - Quicker funds-transferred directly to your account on the day paper warrants are normally mailed
    - No worry-no lost or stolen checks or postal holidays delaying receipt of your warrant
    - Address change-your payment will still be deposited into your banking account

http://www.supplier.obm.ohio.gov/Update/Medicaid.aspx
Provider Responsibilities

- Ohio Medicaid Website: www.Medicaid.ohio.gov
Provider Responsibilities

Welcome Providers
Ohio is home to more than 83,000 active Medicaid providers. The partnership between Ohio Medicaid and its provider network is critical in ensuring reliable and timely care for beneficiaries across the state. In the months ahead, this page will become a go-to resource for learning more about training, billing, rate-setting and additional areas interest concerning the provider community.

Provider News
Please listen carefully when calling the IVR as the options have changed as of 6/17/2016.
Timely Filing Reminder for ICF-IID Providers (6/29/2016)
Notice Regarding Provision of Progesterone (6/13/16)
Independent Provider Overtime Rates - Effective January 1, 2016 (Rev. 4/1/16)
Post-Implementation ORP FAQs
Medicaid Requirements for Ordering, Referring, and Prescribing (ORP) - Effective January 12, 2015
Pay and Post Period for Ordering, Referring and Prescribing Provider Requirements
Provider Enrollment Application Fee
Behavioral Health Provider Integration Project
Nurse and Aide Service Rate Modernization

Related Content
- Benefit Coordination & Recovery
- Fee Schedules/Rates
- Medicaid Forms
- CDJFS Forms
- MITS EDMS Cover Page
  - Instructions
  - Healthcheck Screening Forms
  - e-Manuals
- Helpful Links
- Get a National Provider Identifier (NPI)
- Transmittal Letter Notification
- Medicaid Provider Inpatient
Policy
Policy

❖ Policy Updates

– Policy updates from Ohio Medicaid announce the changes to Ohio Administrative Code that may affect providers. There are two types of letters:

▪ Medical Assistance Letters (MAL)
▪ Medicaid Transmittal Letters (MTL)

http://medicaid.ohio.gov/RESOURCES/Publications/ODMGuidance.aspx#1535541-medicaid-policy
Policy

- Medicaid Fee Schedules and Rates
## Policy

### LAWriter - Ohio Medicaid Laws

<table>
<thead>
<tr>
<th>Chapter 5160 Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Chapter 5160-1 General Provisions.</strong></td>
</tr>
<tr>
<td><strong>Chapter 5160-2 Hospital Services.</strong></td>
</tr>
<tr>
<td><strong>Chapter 5160-3 Long-Term Care Facilities; Nursing Facilities; Intermediate Care Facilities for the Mentally Retarded.</strong></td>
</tr>
<tr>
<td><strong>Chapter 5160-4 Physician Services.</strong></td>
</tr>
<tr>
<td><strong>Chapter 5160-5 Dental Program.</strong></td>
</tr>
<tr>
<td><strong>Chapter 5160-6 Vision Care Services.</strong></td>
</tr>
<tr>
<td><strong>Chapter 5160-7 Podiatric Services.</strong></td>
</tr>
<tr>
<td><strong>Chapter 5160-8 Limited Practitioner Services.</strong></td>
</tr>
<tr>
<td><strong>Chapter 5160-9 Pharmacy Services.</strong></td>
</tr>
<tr>
<td><strong>Chapter 5160-10 Medical Supplies, Durable Medical Equipment, Orthoses, and Prosthesis Providers.</strong></td>
</tr>
<tr>
<td><strong>Chapter 5160-11 Independent Laboratory and X-Ray Services.</strong></td>
</tr>
<tr>
<td><strong>Chapter 5160-12 Ohio Home Care Program.</strong></td>
</tr>
<tr>
<td><strong>Chapter 5160-13 Ambulatory Health Care Clinic Services.</strong></td>
</tr>
<tr>
<td><strong>Chapter 5160-14 Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) Services.</strong></td>
</tr>
<tr>
<td><strong>Chapter 5160-15 Medical Transportation Services.</strong></td>
</tr>
<tr>
<td><strong>Chapter 5160-16 Rural Health Services.</strong></td>
</tr>
<tr>
<td><strong>Chapter 5160-17 Abortions.</strong></td>
</tr>
<tr>
<td><strong>Chapter 5160-18 Freestanding Birth Center.</strong></td>
</tr>
<tr>
<td><strong>Chapter 5160-20 Primary Alternative Care and Treatment Program.</strong></td>
</tr>
</tbody>
</table>
Policy

- Ordering, Referring and Prescribing Providers (ORP): OAC 5160-1-17.9
  - Went into effect 1/12/2015
  - Federal regulation was implemented under Section 6401 of the Patient Protection and Affordable Care Act of 2010 (ACA)
Policy

- The ordering National Provider Identifier (NPI) must be for an individual physician/non-physician practitioner (not the NPI of an organizational provider)

- The ordering physician/non-physician practitioner must be actively enrolled and must be of a specialty type that is eligible to order in the Ohio Medicaid program
Policy

- Providers should ensure that services are being ordered, referred, or prescribed by an eligible provider who is enrolled in Medicaid

  - Providers may enroll as an ORP-only provider or as a Medicaid billing provider
  - ORP-only providers have an expedited screening process
  - Online applications can be found on our website: http://www.medicaid.ohio.gov/PROVIDERS/EnrollmentandSupport/ProviderEnrollment/ORP.aspx
Policy

❖ ORP, cont.

– Search for ORP information on the MITS portal

**If you receive no results, the information is either incorrect or the provider is not enrolled with Ohio Medicaid**
Policy

❖ Hospice Services Reporting Requirements: OAC 5160-56-03.3
– Hospice Enrollments—NEW PROCESS!!
  ▪ Must be completed and processed on the MITS Provider Portal
  ▪ Only for Individuals in fee-for-service Medicaid, not those enrolled into a managed care plan
  ▪ All Individuals in which hospice is seeking reimbursement after all other payers
  ▪ Must provide all required information in order for the hospice enrollment to process or billed claims will not pay
Policy

- Hospice Services Reporting Requirements: OAC 5160-56-03.3(A)(2)
  - Hospice Enrollments, cont.
    - All individuals with routine home care, T2042, for DOS on or after 1/1/16
    - Any individual, for any hospice service, where an original claim needs to be submitted
    - Any individual, for any hospice service, where a claim needs to be adjusted
Policy

- Hospice Services Reporting Requirements: OAC 5160-56-03.3, cont.
  - Hospice Enrollments, cont.
    - Mass adjustment will take place in 2018 to correct previous payments
    - Claims with no enrollments will deny and retract any previous payments received
      - For all professional claims, for procedure codes T2042, G0299, and G0155
Policy

❖ Hospice Services Reimbursement: OAC 5160-56-06
  – Service Intensity Add-On (SIA) Codes
   New codes that have been backdated to be effective 1/1/16
   Payment for routine home care by an RN or licensed social worker within the last 7 days of life, when the discharge from hospice is due to death
   Billed using code **G0299**, for direct care by in-person visit from an RN
   Billed using code **G0155**, for direct care by in-person visit from a social worker
    ➢ Should not be billed until after the individual has passed away
    ➢ May be billed individually as long as T2042 was already billed and paid
    ➢ Can be billed on the same claim as T2042 for those days
Policy

- Hospice Services Reimbursement: OAC 5160-56-06, cont.
  - Hospice procedure codes based on level of care:
    - Code **T2042** used for one unit per day to bill routine home care
      - Individual who is receiving services at home, who is not receiving continuous home care
      - Reimbursement is paid using a two-tiered system based on the Episode of Care:
        1. First episode - per diem is paid at the higher rate for first 60 days; lower rate for the remainder of the episode beyond 60 days
        2. Gap of 60 days or more - will break the current episode
        3. Second episode - begins on the 61st day following a break in service
Policy

- Hospice Services Reimbursement: OAC 5160-56-06, cont.
  - Hospice procedure codes based on level of care:
    - Code **T2043** used for one unit per hour
      - With a minimum of 8 hours per day, for continuous home care
    - Code **T2044** used for one unit per day for inpatient respite care
    - Code **T2045** used for one unit per day for general inpatient care
Policy

❖ Hospice Services Reimbursement: OAC 5160-56-06, cont.

– Hospice may receive R&B payments for individuals who are residents, overnight, of nursing facilities or ICF-IID facilities
  ▪ Bill for R&B using procedure code T2046
  ▪ Reimbursed at 95% of the rate established for the Long Term Care Facility (LTCF)
    ➢ Must be manually calculating the 95% and entering it as the billed charge on each claim, until the grace period is over
  ▪ Only for days the individual receives routine home care or continuous care
  ▪ Bill even if the days are compensated via patient liability
MITS
MITS

- Medicaid Information Technology System (MITS)
  - MITS is a web-based application that is accessible via any modern browser
  - MITS design is based upon the Medicaid information Technology Architecture (MITA)
  - MITS is able to process transactions in “real time”
MITS

- Technical Requirements
  - Internet Access (high speed works best)
  - Internet Explorer version 10 or higher and current versions of Firefox or Chrome
  - Mac users can use current versions of Safari, Firefox or Chrome
  - Turn OFF pop up blocker functionality
MITS

- If you are using IE10 and having difficulty signing into the MITS portal do the following:
  - On the top line of your Internet Explore page, click on Tools> then click on Compatibility View Settings>
  - Type in OHMITS.com (beside the “add” button) and then click the “add” button
  - Finally click the “close” button at the bottom of the page. Then log in to the portal normally
MITS

❖ How do I access the MITS Portal?

– Go to http://Medicaid.ohio.gov
– Select the “Provider Tab” at the top
– Click on the “MITS Portal” on the right
Once directed to this page, click the link to “Login”.

You will then be directed to another page where you will need to enter your “User ID” and “Password.”
MITS

- The “Copy”, “Paste”, and “Print” features all work in the MITS Portal
- Do **NOT** use the previous page function (back arrow) in your browser
- Do **NOT** use the enter key on the keyboard (use the Tab key or the mouse to move between fields)
- MITS Web Portal access will time-out after 15 minutes of inactivity in the system
Panel Help
- The “?” button in the upper right corner of a panel may be selected to reveal panel information.

![Diagram of Online Panel Help](image)
MITS

- Field Help
  - Clicking a field title will open a box containing field information
MITS

- Eligibility Search
  - Full Medicaid eligibility on the MITS portal will show four (or more) benefit spans:
    - Medicaid
    - MRDD Targeted Case Management
    - Alcohol and Drug Addiction Services
    - Ohio Mental Health
  - Additional spans when applicable:
    - Alternative Benefit Plan, for Extension adults
    - Medicaid School Program span, if applicable by age
MITS

- Eligibility Search, cont.
  - Verification of the following:
    - Medicare
    - Managed Care
    - Benefit Plan
    - Third Party
    - Patient Liability
    - Long Term Care
MITS

- Eligibility Search

Eligibility Verification Request

<table>
<thead>
<tr>
<th>Medicaid Billing Number</th>
<th>Birth Date</th>
<th>SSN</th>
<th>DOS Date Format</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>MM/DD/YYYY</td>
</tr>
<tr>
<td>Procedure Code</td>
<td>From DOS</td>
<td></td>
<td>02/17/2017</td>
</tr>
<tr>
<td></td>
<td>To DOS</td>
<td></td>
<td>02/17/2017</td>
</tr>
</tbody>
</table>

*This information is only valid for 'from date' to end of the month searched.*
MITS

- Eligibility Verification Request
  - You can search up to 3 years at a time!!

*This information is only valid for 'from date' to end of the month searched.
### Eligibility Verification Request-result

<table>
<thead>
<tr>
<th>Recipient Information</th>
<th>Medicaid Billing Number</th>
<th>Last Name</th>
<th>First Name</th>
<th>Gender</th>
<th>Date of Birth</th>
<th>Date of Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>County of Residence</td>
<td>CRAWFORD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>County of Eligibility</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>County Office</td>
<td><a href="http://jfs.ohio.gov/County/County_Directory.pdf">http://jfs.ohio.gov/County/County_Directory.pdf</a></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number Bed Hold Days</td>
<td>20160101: 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Benefit / Assignment Plan

<table>
<thead>
<tr>
<th>Benefit / Assignment Plan</th>
<th>Effective Date</th>
<th>End Date</th>
<th>Provider Name</th>
<th>Dental Co-Pay Amount</th>
<th>Vision Co-Pay Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRDD: Targeted Case Mgmt</td>
<td>09/01/2015</td>
<td>02/28/2017</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Alcohol and Drug Addiction Services</td>
<td>09/01/2015</td>
<td>02/28/2017</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Ohio Mental health</td>
<td>09/01/2015</td>
<td>02/28/2017</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Medicaid</td>
<td>09/01/2015</td>
<td>02/28/2017</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>MRDD: Targeted Case Mgmt</td>
<td>05/01/2014</td>
<td>08/31/2015</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Alcohol and Drug Addiction Services</td>
<td>05/01/2014</td>
<td>08/31/2015</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Ohio Mental health</td>
<td>05/01/2014</td>
<td>08/31/2015</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Medicaid</td>
<td>05/01/2014</td>
<td>08/31/2015</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>MAGI-GROUP VIII: Alternative Benefit Plan Medicaid Extension</td>
<td>03/01/2014</td>
<td>04/30/2014</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>MAGI-GROUP VIII: MRDD Targeted Case Mgmt</td>
<td>03/01/2014</td>
<td>04/30/2014</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

#### Case/Cat/Seg Spenddown

**No rows found***

#### TPI

<table>
<thead>
<tr>
<th>Carrier Name</th>
<th>Carrier Number</th>
<th>NAIC</th>
<th>Policy Number</th>
<th>Policy Holder</th>
<th>Coverage Type</th>
<th>Coverage</th>
<th>Effective Date</th>
<th>End Date</th>
<th>Group Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>PHYSICIAN/OUTPATIENT</td>
<td></td>
<td>02/01/2015</td>
<td>02/28/2017</td>
<td></td>
</tr>
<tr>
<td>IND</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>INPATIENT COVERAGE</td>
<td></td>
<td>02/01/2015</td>
<td>02/28/2017</td>
<td></td>
</tr>
</tbody>
</table>

#### Managed Care

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Plan Description</th>
<th>Effective Date</th>
<th>End Date</th>
<th>Managed Care Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>CARESOURCE</td>
<td>HMO, CFC</td>
<td>08/01/2014</td>
<td>02/28/2017</td>
<td></td>
</tr>
</tbody>
</table>
## MITS

- Eligibility Verification Request-results, cont.

<table>
<thead>
<tr>
<th>Category</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lock-In</td>
<td>No rows found</td>
</tr>
<tr>
<td>Medicare</td>
<td>No rows found</td>
</tr>
<tr>
<td>Service Limitation</td>
<td>No rows found</td>
</tr>
</tbody>
</table>

Enter a Procedure Code on the Eligibility Verification Request panel to search for Service Limitations.

<table>
<thead>
<tr>
<th>Category</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of Care Determinations</td>
<td>No rows found</td>
</tr>
<tr>
<td>Patient Liability</td>
<td>No rows found</td>
</tr>
<tr>
<td>Long Term Care Facility Placements</td>
<td>No rows found</td>
</tr>
<tr>
<td>Recipient Restricted Coverage</td>
<td>No rows found</td>
</tr>
<tr>
<td>Special Program</td>
<td>No rows found</td>
</tr>
</tbody>
</table>
**MITS**

- Eligibility Verification Request-results, cont.
  - Search for children who are on the same case as their mom

### Recipient Information

<table>
<thead>
<tr>
<th>Medicaid Billing Number</th>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
<th>Last Name</th>
<th>Gender</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>11/20/2004</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>MALE</td>
<td>09/14/2006</td>
</tr>
</tbody>
</table>

### Associated Child(ren)

<table>
<thead>
<tr>
<th>Medicaid Billing Number</th>
<th>First Name</th>
<th>MI</th>
<th>Last Name</th>
<th>Gender</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>123456789012</td>
<td>AUDREY</td>
<td></td>
<td>DOE</td>
<td>FEMALE</td>
<td>11/20/2004</td>
</tr>
<tr>
<td>987654321012</td>
<td>ALEX</td>
<td></td>
<td>DOE</td>
<td>MALE</td>
<td>09/14/2006</td>
</tr>
</tbody>
</table>
Hospice Enrollment
Hospice Enrollment

August 16th 2017
- Portal changes

October 11th 2017
Claim changes, second provider and corrections now possible

2-3 month grace period for R&B only
Hospice Enrollment

❖ Steps on completing a Hospice Enrollment
Hospice Enrollment

- Steps on completing a Hospice Enrollment, cont.
Hospice Enrollment

- Steps on completing a Hospice Enrollment, cont.
Hospice Enrollment

- Steps on completing a Hospice Enrollment, cont.

Consumer name will populate once you enter a correct billing number and DOB
Hospice Enrollment

❖ Steps on completing a Hospice Enrollment, cont.

<table>
<thead>
<tr>
<th>County and State of Recipient’s Hospice Service Location</th>
<th>*** No rows found ***</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Select row above to update or click Add button below.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enrollment - Disenrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Election Date</td>
</tr>
<tr>
<td>Date of Disenrollment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hospice Benefit Period</th>
<th>*** No rows found ***</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Select row above to update or click Add button below.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hospice Episode of Care</th>
<th>*** No rows found ***</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Hospice Other Payer Spans</th>
<th>*** No rows found ***</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Select row above to update or click Add button below.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hospice Terminal Illness Diagnosis</th>
<th>*** No rows found ***</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Select row above to update or click Add button below.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provider Service Span</th>
<th>*** No rows found ***</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Select row above to update or click Add button below.</td>
</tr>
</tbody>
</table>
Hospice Enrollment

- Steps on completing a Hospice Enrollment, cont.
  - Must enter benefit periods in chronological order, start at the beginning with the 1st 90 day period
Hospice Enrollment

- Steps on completing a Hospice Enrollment, cont.
  - Provider has the ability to search eligibility while completing the hospice enrollment
Hospice Enrollment

❖ Steps on completing a Hospice Enrollment, cont.

<table>
<thead>
<tr>
<th>Hospice Episode of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Episode of Care</td>
</tr>
<tr>
<td>Episode 1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hospice Terminal Illness Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit Period</td>
</tr>
<tr>
<td>07/18/2017 - 10/15/2017</td>
</tr>
</tbody>
</table>

Type changes below.

- Benefit Period: 07/18/2017 - 10/15/2017
- ICD Version: 10
- Primary Hospice Terminal Diagnosis: A010
- Terminal Diagnosis 2: [Search]
- Terminal Diagnosis 3: [Search]
- Diagnosis Effective Date: 07/18/2017
- Diagnosis End Date: 10/15/2017
- Diagnosis Description: TYPHOID FEVER.
Hospice Enrollment

- Steps on completing a Hospice Enrollment, cont.

<table>
<thead>
<tr>
<th>Hospice Provider</th>
<th>Effective Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>07/18/2017</td>
<td>10/15/2017</td>
</tr>
</tbody>
</table>

Select row above to update or click Add button below.

<table>
<thead>
<tr>
<th>Effective Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Select row above to update or click Add button below.

<table>
<thead>
<tr>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>
Hospice Enrollment

- Steps on completing a Hospice Enrollment, cont.
  - After completing all fields, click ‘submit’ at the bottom
  - Once processed, additional benefit periods may be

**Confirmation**

Your Hospice application has been updated on 07/18/2017

Your Hospice Tracking Number is

*IMPORTANT - This Hospice Tracking Number (HTN) is necessary for accessing the status of submitted enrollments. Please write this number down or print this page and keep it for your records PRIOR TO EXITING. Applications submitted after 4 PM will not be processed until the next business day.

Please remember to submit the following required documents:

**WHAT'S NEXT?**

- To upload required document (or to obtain a cover page), select: Upload required documents
Hospice Enrollment

- HLTCF Provider Service Span panel
  - Hospice provider must enter the LTC provider and dates in the hospice enrollment so claims pay correctly
  - The claim will deny if this field is left blank
Hospice Enrollment

- Steps on adding an additional benefit period
  - Enter the tracking number and/or Medicaid billing number, click search
Hospice Enrollment

- Steps on adding an additional benefit period, cont.
  - Chose ‘Maintain Hospice Record’
Hospice Enrollment

- Steps on adding an additional benefit period, cont.
- Proceed to add a matching span in each appropriate panel
Hospice Enrollment

- Steps on adding an additional benefit period, cont.
  - Previous benefit period must have a ‘PROCESSED’ status first
Hospice Enrollment

- Steps on adding an additional benefit period, cont.
  - Episode of Care will calculate and populate automatically
  - Enter any other applicable third party liability (TPL) insurers

<table>
<thead>
<tr>
<th>Hospice Episode of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Number of Calendar</strong></td>
</tr>
<tr>
<td><strong>Number of Benefit</strong></td>
</tr>
<tr>
<td><strong>Episode of Care</strong></td>
</tr>
<tr>
<td><strong>First Date</strong></td>
</tr>
<tr>
<td><strong>Last Date</strong></td>
</tr>
<tr>
<td><strong>Days in Episode</strong></td>
</tr>
<tr>
<td><strong>Days in Episode</strong></td>
</tr>
<tr>
<td><strong>Date of 61st Day</strong></td>
</tr>
<tr>
<td><strong>Episode 1</strong></td>
</tr>
<tr>
<td>07/21/2017</td>
</tr>
<tr>
<td>03/17/2018</td>
</tr>
<tr>
<td>240</td>
</tr>
<tr>
<td>240</td>
</tr>
<tr>
<td>09/19/2017</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hospice Other Payer Spans</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Payer Type</strong></td>
</tr>
<tr>
<td><strong>Payer Name</strong></td>
</tr>
<tr>
<td><strong>Effective Date</strong></td>
</tr>
<tr>
<td><strong>End Date</strong></td>
</tr>
<tr>
<td><strong>Medicare</strong></td>
</tr>
<tr>
<td><strong>MEDICARE PART B</strong></td>
</tr>
<tr>
<td>02/01/2017</td>
</tr>
<tr>
<td>12/31/2299</td>
</tr>
</tbody>
</table>

Select row above to update -or- click Add button below.
Hospice Enrollment

- Steps on adding an additional benefit period, cont.
  - Both dates must match the dates entered in the benefit period panel
Hospice Enrollment

- Steps on adding an additional benefit period, cont.
Hospice Enrollment

- Example of numerous episodes of care
  - Two gaps of >60 days between benefit periods
Hospice Enrollment

- Example of numerous episodes of care, cont.
  - Gap of < or equal to 60 days and >60 days between benefit periods
Hospice Enrollment

- Updating a Hospice Enrollment
  - Use the ‘Update Benefit Period’ box when adding a new benefit period under the action of “New Enrollment” or “Maintain Hospice Record”
    - When it is known that the benefit period end date is less than what the system assigned
  - Open the enrollment record and check the ‘Update Benefit Period’ box
Hospice Enrollment

- Updating a Hospice Enrollment, cont.
  - Must provide a reason for why benefit period dates are being changed:
    - First 5 options would be used if criteria was met for termination
    - Data correction - should not be used at this time, for future use
    - Medicare alignment - May be used to have the Medicaid benefit period dates fit Medicare’s
Hospice Enrollment

- Ending a Hospice Enrollment
  - Chose the appropriate ‘Type of Action’
  - Use when someone dies, revokes hospice, or a provider terminates hospice during a benefit period in ‘processed’ status
Hospice Enrollment

- Ending a Hospice Enrollment, cont.
  - You are now able to complete the ‘Enrollment-Disenrollment’ date of disenrollment and click ‘submit’
Hospice Enrollment

- Hospice Enrollment Denial Letters
  - You may leave all the search fields blank and then click ‘search’ to populate all denial letters
# Hospice Enrollment

## Hospice Enrollment Denial Letters Codes

<table>
<thead>
<tr>
<th>Error Code</th>
<th>Error Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2049</td>
<td>GeoStan Validate Address Error - contact SysArchitect</td>
</tr>
<tr>
<td>2067</td>
<td>LTC Vendor Pay end date must be on or before the Elig end date</td>
</tr>
<tr>
<td>2069</td>
<td>Invalid Lockin end date</td>
</tr>
<tr>
<td>2121</td>
<td>Source Code is not on file</td>
</tr>
<tr>
<td>2167</td>
<td>Invalid Other Recipient ID</td>
</tr>
<tr>
<td>2355</td>
<td>Begin Date must be a valid date</td>
</tr>
<tr>
<td>2356</td>
<td>End Date must be a valid date</td>
</tr>
<tr>
<td>2453</td>
<td>Recipient not a part of a valid Case/Cat/Seq</td>
</tr>
<tr>
<td>2999</td>
<td>System error encountered during PS/2 process, contact EDS</td>
</tr>
</tbody>
</table>
Hospice Enrollment

- Hospice Enrollment Denial Letters Codes, cont.

<table>
<thead>
<tr>
<th>Error Code</th>
<th>Error Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>4068</td>
<td>Effective Date Received Begins Before The Plan is Active</td>
</tr>
<tr>
<td>4390</td>
<td>Medicaid Coverage Missing</td>
</tr>
<tr>
<td>4400</td>
<td>No medicaid coverage found</td>
</tr>
<tr>
<td>4901</td>
<td>Hospice not allowed with PACE</td>
</tr>
<tr>
<td>4902</td>
<td>Hospice Coverage already exists</td>
</tr>
<tr>
<td>4903</td>
<td>Hospice Not allowed with RSS AID Category</td>
</tr>
<tr>
<td>4904</td>
<td>Recipient enrolled in Managed Care</td>
</tr>
<tr>
<td>5015</td>
<td>Invalid HOSPC EligCase data</td>
</tr>
<tr>
<td>5016</td>
<td>Invalid HOSPC Lockin data</td>
</tr>
</tbody>
</table>
Hospice Enrollment

- Hospice Enrollment Denial Letters Example

```
Subject: Notification of the Medicaid Hospice benefit enrollment errors

The following lists the application processing errors.

<table>
<thead>
<tr>
<th>Recipient ID</th>
<th>Hospice Tracking Number</th>
<th>Submission Date</th>
<th>Recipient Name</th>
<th>Error Code</th>
<th>Error Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>07/25/2027</td>
<td></td>
<td>2069</td>
<td>Invalid Lockin end date</td>
</tr>
</tbody>
</table>

Please make the corrections needed to correct the application.
```
Claim Submission
Claim Submission

Methods of Claim Submission

- Electronic Data Interchange
  - Claims received electronically by Wednesday at 12:00 P.M. will be processed for adjudication over the weekend
  - Fees for claims submitted
  - No limit to the number of claims submitted daily

- MITS Web Portal
  - Claims received by Friday at 5:00 P.M. will be processed for adjudication over the weekend
  - Free submission
Claim Submission

- Electronic Data Interchange (EDI)
  - Information for Trading Partners
    http://medicaid.ohio.gov/PROVIDERS/Billing/HIPAAandEDIInformation.aspx
  - Companion Guides
    http://medicaid.ohio.gov/PROVIDERS/MITS/HIPAA5010Implementation.aspx
  - Technical Questions/EDI Support Unit
    - 844-324-7089 or OhioMCD-EDI-Support@dxc.com
Claim Submission

- Claims entry format is divided into sections called panels

- Each panel will have an asterisk (*) denoting that the fields are required
  - Some fields are situational for claims adjudication and do not have an asterisk
Claim Submission

- Submission of a Professional Claim
Claim Submission

- Submission of a Professional Claim, cont.

### Claim Submission Form

<table>
<thead>
<tr>
<th>Professional Claim</th>
<th>NPI</th>
</tr>
</thead>
<tbody>
<tr>
<td>BILLING INFORMATION</td>
<td></td>
</tr>
<tr>
<td>ICN</td>
<td>Claim Received Date</td>
</tr>
<tr>
<td>*Medicaid Billing Number</td>
<td>*Date of Birth</td>
</tr>
<tr>
<td>First Name, MI</td>
<td>*Patient Account #</td>
</tr>
<tr>
<td>Rendering ID</td>
<td>*Medicare Assignment</td>
</tr>
<tr>
<td>INN</td>
<td>Total Charges</td>
</tr>
<tr>
<td>Medicaid Paid Amount</td>
<td>Medicaid CoPay Amount</td>
</tr>
</tbody>
</table>

### Diagnosis

***No rows found***

Select row above to update or click add an item button below.

### Header - Other Payer

***No rows found***

Select row above to update or click add an item button below.
Claim Submission

- Submission of a Professional Claim, cont.
  - ‘Patient Amount Paid’ field is used to report a consumer’s monthly patient liability amount
Claim Submission

- Submission of a Professional Claim, cont.
Claim Submission

- International Classification of Disease (ICD) codes are used in virtually every healthcare setting
  - Went into effect on 10/1/2015
  - Dates of service prior to 10/1/15 require the use of ICD-9 codes
  - Dates of service on or after 10/1/15 require the use of ICD-10 codes
  - When entering an enrollment for a hospice benefit period span that crosses both codes sets, you will need to break the span into two lines to report both proper diagnosis codes
Claim Submission

- Diagnosis Codes
  - Are required on hospice claims
    - Must include the number of characters specified by ICD
    - MITS does not accept decimal points, only enter numbers & letters
    - System edits and audits will be applied to those codes
Claim Submission

- Additional Provider Information Panel
  - A new “button” in the detail panel
  - Panel is used to report:
    - Ordering Provider
    - Referring Provider
    - Supervising Provider
  - Enter the NPI, last name, first name, and middle initial (if applicable)
Claim Submission

<table>
<thead>
<tr>
<th><strong>Item</strong></th>
<th><strong>FDOS</strong></th>
<th><strong>Units</strong></th>
<th><strong>Charges</strong></th>
<th><strong>Medicaid Allowed Amount</strong></th>
<th><strong>Status</strong></th>
<th><strong>Place of Service</strong></th>
<th><strong>Procedure Code</strong></th>
<th><strong>Modifier 1</strong></th>
<th><strong>Modifier 2</strong></th>
<th><strong>Modifier 3</strong></th>
<th><strong>Modifier 4</strong></th>
<th><strong>Final EAPG</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A</td>
<td>1</td>
<td>0</td>
<td>$0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$0.00</td>
</tr>
</tbody>
</table>

Select row above to update -or- click add an item button below.

* **Place Of Service** [Search]
* **Procedure Code** [Search]
* **Emergency**

Referred EPSDT Service/Family Planning Diagnosis Code Pointer
Modifiers
[Search] [Search] [Search] [Search]

Final EAPG
Pay Action

**Additional Provider Information**

<table>
<thead>
<tr>
<th>Detail Item</th>
<th>Type of Provider</th>
<th>Provider #</th>
<th>Last Name</th>
<th>First Name, MI</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Type data below for new record.

* **Detail Item**

* **Type of Provider**
  - Ordering Provider
  - Referring Provider
  - Supervising Provider

* **Provider #**

* **Last Name**

* **First Name, MI**
Claim Submission

- Once all fields have been completed
  - Click on the “Submit” button to submit the claim
  - You may “Cancel” the claim at anytime but the information will not be retained
Claim Submission

- **Portal Errors**
  - If there are portal errors, the claim status returned will be ‘NOT SUBMITTED YET’ and the errors will be listed at the top of the screen
  - MITS will not accept a claim without all required fields being populated

```
The following messages were generated:
- From DOS is required.
- Procedure is required.
- A valid Place Of Service is required
- A valid Procedure Code is required.
- Units must be greater than 0.
- Charges must be greater than $0.00.
- A valid Medicaid Billing Number is required.
A valid Medicaid Billing Number and Date of Birth combination is required.
```
Claim Submission

- Adjudication will happen in “real time”. If there are no errors, the claim status will show:
  - Paid
  - Denied
  - Suspended
Claim Submission

- Claim Suspense
  - Non room and board services (T2042-T2045) are paid the hospice rate that is applicable for the county that is listed on the enrollment panel effective 01/01/2016
  - If the needed state/county code is not loaded into MITS claims will suspend for no rate
  - Providers will need to contact ODM to have this information updated
Making Ohio Better

OHIO DEPARTMENT OF MEDICAID

Claim Submission

- Internal Control Number (ICN)
  - The ICN replaced the Transaction Control Number (TCN)
  - All claims will be assigned an ICN

2017170357321

<table>
<thead>
<tr>
<th>Region Code</th>
<th>Calendar Year</th>
<th>Julian Day</th>
<th>Claim Type/Batch Number</th>
<th>Claim Number in Batch</th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td>17</td>
<td>170</td>
<td>357</td>
<td>321</td>
</tr>
</tbody>
</table>
Claim Submission

- Internal Control Number (ICN)
  - Primary region codes new claim submission
    - 20 Electronic (EDI) 837 without attachment
    - 21 Electronic (EDI) 837 with attachment
    - 22 Web Portal without attachment
    - 23 Web Portal with attachment
Claim Submission

- Internal Control Number (ICN), cont.
  - Additional primary region codes
    - 50 Adjustment-Non-check related
    - 51 Adjustment-Check related
    - 52 Mass Adjustment-Non-check related
    - 53 Mass Adjustment-Check related
    - 54 Mass Adjustment-Void transaction
    - 55 Mass Adjustment-Provider retro rates
    - 56 Adjustment-Void non-check related
    - 57 Adjustment-Void check related
    - 58 Adjustment-Internet claims
Claim Submission

★ Timely Filing

- 12 monthly timely filing edits will be temporarily suppressed
- Claims will pay for hospice providers and all rendering specialties for DOS 01/01/2016 - on

END DATE =
Claim Submission

- Special Billing Instructions
  - This panel is used for claims over 365 days that meet timely filing requirements
  - Enter the previously denied ICN for the audit trail and tracking purposes
  - MITS will bypass timely filing edits when appropriate
Claim Submission

- Special Billing Instructions - Eligibility Delay

  - If you are submitting a claim that is more than 365 days after the date of the service due to a hearing decision or delay in eligibility determination you can submit the claim via the MITS portal

    - The claim must be submitted within 180 days of the hearing decision or eligibility determination date
Claim Submission

- Special Billing Instructions - Eligibility Delay, cont.
  - In the Note Reference Code box select “ADD”
  - In the Notes box you will need to enter the hearing decision or eligibility determination information
Claim Submission

- Special Billing Instructions - Eligibility Delay, cont.
  - Hearing Decision: APPEALS### CCYYMMDD
    - ### is the hearing number and the CCYYMMDD is the date on the hearing decision
  - Eligibility Determination: DECISION CCYYMMDD
    - CCYYMMDD is the date on the eligibility determination notice from the CDJFS

Must use the spacing shown
Claim Submission

- Medicare Denials

  - If Medicare issues a denial and indicates that the patient is responsible for the payment, then submit the claim to ODM as a Medicaid claim by following these steps:
    - Enter a claim in MITS
    - Do not enter any Medicare information on the claim
    - Complete and upload a ODM 06653 and a copy of the Medicare EOB
Claim Submission

- Attachments Panel
  - Upload electronically within the claim or mail with the EDMS cover sheet
Claim Submission

- Electronic Attachments
  - Accepted for Claims, Prior Authorizations, Enrollment and Re-enrollment processing
  - Acceptable file formats:
    - BMP, DOC, DOCX, GIF, JPG, MDI, PDF, PPT, PPTX, TIFF, TXT, XLS, and XLSX
  - Size: each attachment must be <50 MB
  - Each file must pass the MITS anti-virus scan
  - Number: a maximum of 10 attachments per submission
Claim Submission

- Claim Adjustment
  - *Paid* claims can be:
    - Adjusted
    - Voided
    - Copied
Claim Submission

- Claim Adjustment, cont.

  - To *adjust* a *paid* claim:
    - Select the claim to adjust
    - Change and save the necessary information
    - Click the adjust button
Claim Submission

- Claim Adjustment, cont.
  - Once you click the adjust button
    - A new claim is created and assigned an adjusted ICN
    - Refer to the information in the “Claim Status Information” and “EOB Information” areas at the bottom of the page to see how your new claim processed
Claim Submission

Claim Adjustment, cont.

– Example:

2217180234001 Originally paid $45.00
5817185127250 Now paid $50.00
Additional payment $5.00

2017172234001 Originally paid $50.00
5017173127250 Now paid $45.00
Account Receivable ($5.00)
Claim Submission

- Claim Adjustment, cont.
  - Voiding paid claims
    - Select the claim you wish to void
    - Click the void button at the bottom of the page
    - The status of the original claim does not change however, the claim is flagged as “non-adjustable” in MITS
    - An adjustment is automatically created and given a status of “denied”
Claim Submission

- Claim Adjustment, cont.

- Example:

  2217103234001  Originally paid  $45.00

  5817115127250  Reversal “Void” Account Receivable  ($45.00)

**Make sure to wait until after weekend adjudication if another claim needs to be submitted**
Claim Submission

- Claim Adjustment, cont.
  - Copying paid claims
    - Search and open the claim you want to copy
    - At the bottom of the claim, select “Copy Claim”
    - Make and save all necessary changes
    - The “submit” and “cancel” buttons display at the bottom of the new page
    - Select “submit” when changes are made
    - Claim is assigned a new ICN
Claim Submission

- **ClaimCheck Edits**
  - Clinically oriented software tool that automatically identifies inappropriate code combinations and discrepancies in claims
  - Will look at the coding accuracy of procedures, not medical necessity, and will prevent inappropriate payment for certain services including:
    - Duplicate services (same person, same provider, same date)
    - Individual services that should be grouped (bundled)
    - Mutually exclusive services
    - Services rendered incidental to other services
    - Services covered by a pre or post-operative period
    - Visits in conjunction with other services
Claim Submission

- The National Correct Coding Initiative (NCCI)
  - Developed by Centers for Medicare & Medicaid Services
    - To control inappropriate payment of claims from improper reporting of CPT and HCPCS codes
    - NCCI serves as a common model and standard for handling claims for procedures and services that are performed by one provider for one individual on a single date of service
Claim Submission

- NCCI, cont.

- Procedure to procedure (PTP) “Incidental” edit which determines whether a pair of procedure codes should not be reported together because one procedure is incidental to (performed as a natural consequence or adjunct to) the other.

- Medically unlikely edit (MUE) determines whether the units of service exceed maximum units that a provider would be likely to report under most circumstances.
Claim Submission

- Coordination of Benefit Claims (COB)
  - Other payer information
    - Can be reported at the claim level (header) or at the line level (detail), depending on the other payer’s claim adjudication
    - HIPAA compliant adjustment reason codes and amounts are required to be on the claim
    - MITS will automatically calculate the allowed amount
Claim Submission

❖ COB, cont.

– Header level
  - A COB claim is considered to be adjudicated at the header/claim level if only one set of figures is reported for the entire claim

– Detail level
  - A COB claim is considered to be adjudicated at the line/detail level if figures are reported for individual line items
Claim Submission

- Washington Publishing Website
  - The Washington Publishing website provides adjustment reason codes (ARCs) that must be noted on claims that involve “other payers”
  - The common ARCs are noted below:
    - 1 (Deductible)
    - 2 (Coinsurance)
    - 3 (Co-payment)
    - 45 (Contractual Obligation/Write-Off)
    - 96 (Non-covered services)
Claim Submission

- Remittance Advice (RA)
  - All claims processed are available on the MITS portal
  - Weekly reports become available on Wednesdays
Claim Submission

- RA, cont.
  - Select “remittance advice” and click search
  - To see all remits to date, don’t enter any specific data, and click search twice
Claim Submission

- RA, cont.
  - Pages are titled by claim type and outcome
    - CMS 1500, Inpatient, Outpatient, Long Term Care and Dental
    - Medicare Crossovers A, B, and C
    - Paid, Denied and Adjustments
  - Adjustment page
    - Identifies the original claim header information and the new adjusted claim
Claim Submission

- RA, cont.
  - Financial transactions
    - Expenditures- Non-claim payments made to the provider on this RA
    - Accounts receivable- Balance of claim and non claim amounts due to Medicaid that resulted from this RA and prior RA’s for which a balance is outstanding
  - Summary
    - Provides current payment information
    - Per month information
    - Year to date information
Claim Submission

- RA, cont.
  - Informational pages
    - Banner messages- provides messages to the provider community
  - EOB code descriptions
    - Provides a comparison of the codes to the description that appeared on the claims
  - TPL information
    - If a claim was not paid due to the recipient having another payer source (third party liability) this section provides other insurance information
Websites
Websites

- Ohio Department of Medicaid home page
  [http://medicaid.ohio.gov](http://medicaid.ohio.gov)

- Ohio Department of Medicaid provider page
  [http://medicaid.ohio.gov/providers.aspx](http://medicaid.ohio.gov/providers.aspx)

- MITS page
  [https://portal.ohmits.com/Public/Providers/tabId/43/Default.aspx](https://portal.ohmits.com/Public/Providers/tabId/43/Default.aspx)

- LAWriter
  [http://codes.ohio.gov/oac/5160](http://codes.ohio.gov/oac/5160)
Forms
Forms

- ODM 06614 - Health Insurance Fact Request
- ODM 06653 - Medical Claim Review Request

Questions
MAKING
OHIO
BETTER