Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID) Basic Billing Training 2015

External Business Relations

Ohio Medicaid Services

Alison Barr
Ava Cottrell
Kathy Frye
Laura Gipson
Jamie Watkins

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

Ohio Medicaid Services

- Agenda
  - Ohio Medicaid Services
  - Programs & Cards
  - Provider Responsibilities
  - Ohio Policy
  - ICD-10
  - MITS
  - Claim Submission
  - Forms

Ohio Medicaid Services

- Ohio Medicaid Covers:
  - 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

- Covered Services (not limited to)
  - Behavioral Health
  - Dental
  - Dialysis
  - Durable Medical Equipment
  - Home Health
  - Hospice
  - Hospital (Inpatient/Outpatient)
  - ICF-IID Facility
  - Nursing Facility
  - Pharmacy
  - Physician
  - Transportation
  - Vision

Ohio Medicaid Services

Medical Necessity

Is the fundamental concept underlying the Medicaid Program

All services must meet accepted standards of medical practice

Ohio Medicaid Services

- Provider Assistance
  - ICF.IID@Medicaid.ohio.gov
    - Emails will be monitored during normal business hours
    - Email your provider number, current contact information, all ICNs for the claims in question, and all other pertinent information
  - Questions on why an ICF-IID claim denied
  - Questions regarding the payments on ICF-IID claims
  - Questions specific to ICF-IID claims

Ohio Medicaid Services

- Provider Assistance cont'd
  - **IVR 1-800-686-1516**
    - Provider Assistance staff are available weekdays from 8:00 a.m. to 4:30 p.m.
    - HIPAA laws require you to authenticate with your Provider Identification Number (PIN) to access Protected Health Information (PHI)
  - Assistance in submitting a claim
  - Questions specific to the MITS billing system
  - Assistance with MITS portal accounts

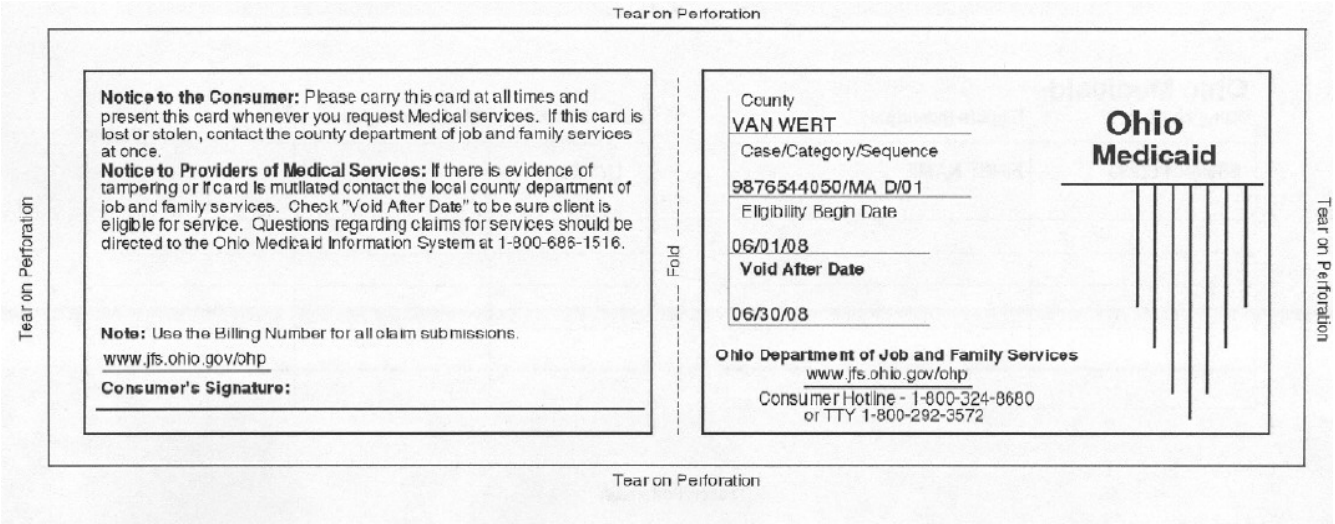
Ohio Medicaid Services

- Other Phone Numbers
  - Enrollment
    - 1-800-922-3042
  - OSHIP (Ohio Senior Health Insurance Information Program)
    - 1-800-686-1578
  - Coordination of Benefits Section
    - 614-752-5768
  - Long Term Care Payment Unit
    - 614-466-7575
    - 614-995-5959 (fax)

Programs & Cards

Programs & Cards

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


Tear on Perforation

Notice to the Consumer: Please carry this card at all times and present this card whenever you request Medical services. If this card is lost or stolen, contact the county department of job and family services at once.
Notice to Providers of Medical Services: If there is evidence of tampering or if card is mutilated contact the local county department of job and family services. Check "Void After Date" to be sure client is eligible for service. Questions regarding claims for services should be directed to the Ohio Medicaid Information System at 1-800-686-1516.

Note: Use the Billing Number for all claim submissions.
www.jfs.ohio.gov/ohp
Consumer's Signature:

Fold

County
VAN WERT
Case/Category/Sequence
9876544050/MA D/01
Eligibility Begin Date
06/01/08
Void After Date
06/30/08

Ohio Medicaid

Ohio Department of Job and Family Services
www.jfs.ohio.gov/ohp
Consumer Hotline - 1-800-324-8680
or TTY 1-800-292-3572

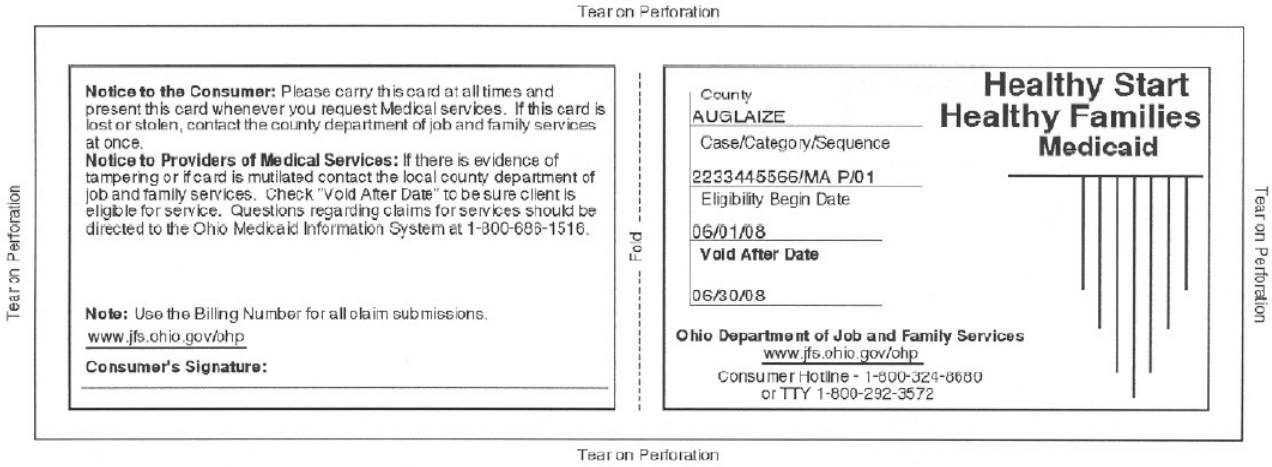
Tear on Perforation

Tear on Perforation

Tear on Perforation

Programs & Cards

- Healthy Families/Healthy Start Medicaid
  - Healthy Families is for children and parents who have household income below 90% of the FPL
  - Healthy Start is for children through age 18 years old and pregnant women with household income below 200% of the Federal Poverty Level (FPL)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Note: Use the Billing Number for all claim submissions.
www.jfs.ohio.gov/ohp
Consumer's Signature:

Fold

County
AUGLAIZE
Case/Category/Sequence
2233445566/MA P/01
Eligibility Begin Date
06/01/08
Void After Date
06/30/08

Healthy Start
Healthy Families
Medicaid

Ohio Department of Job and Family Services
www.jfs.ohio.gov/ohp
Consumer Hotline - 1-800-324-8680
or TTY 1-800-292-3572

Tear on Perforation

Tear on Perforation

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

Programs & Cards

- Presumptive Eligibility cont'd
  - If the CDJFS determines presumptive eligibility the consumer will receive this card
  - If a qualified entity determines presumptive eligibility the consumer will receive a letter

Notice to Consumer: Please carry this card with you at all times and present this card whenever you request Medicaid services. If this card is lost or stolen, contact the county department of job and family services at once.

Notice to Providers of Medical Services: If there is evidence of tampering or if this card is mutilated, contact the local county department of job and family services or check the Provider MITS Portal for eligibility. Questions regarding claims for service or eligibility should be directed to Provider Services at 1-800-686-1516.

Inpatient hospital services are not covered.

Note: Use the Medicaid ID for all claim submissions.

medicaid.ohio.gov

Consumer's Signature:

Fold

County
BUTLER

Case Number
012345678910

Eligibility Begin Date
07/01/2013

Void After Date
08/30/2013

Presumptive Medicaid

Ohio Department of Medicaid
medicaid.ohio.gov
Consumer Hotline: 1-800-324-8680
[or TTY 1-800-292-3572]

Programs & Cards

- Family Planning Services
  - This program is available to families with a net income below 200% of the FPL, who have no other medical coverage
  - This program has limited services. Examples:
    - Pregnancy preventions
    - Diagnosis and treatment of STI's, other than HIV or Hepatitis B
    - Mammography when indicated by a breast examination
    - Vaccinations against Human Papillomavirus (HPV) or Hepatitis B

Programs & Cards

- Family Planning Services cont'd

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Note: Use the Billing Number for all claim submissions.

www.jfs.ohio.gov/ohp

Consumer's Signature:

Fold

County

LORAIN

Case/Category/Sequence

7727727722/MA Z/01

Eligibility Begin Date

10/01/11

Void After Date

10/31/11

Ohio Department of Job and Family Services

www.jfs.ohio.gov/ohp

Consumer Hotline - 1-800-324-8680

or TTY 1-800-292-3572

Family Planning Services

Programs & Cards

- Reinstatement of Medicaid for Public Institution Recipients (RoMPIR)
  - For those who were receiving Medicaid prior to being placed in a public institution and are released from the institution within 12 months of the previous eligibility
  - One Medicaid card good for 60 days

Tear on Perforation

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Note: Use the Billing Number for all claim submissions.

www.jfs.ohio.gov/ohp

Consumer's Signature:

Fold

County
FRANKLIN

Reinstated Medicaid Temporary Coverage Period

Case/Category/Sequence
4433221100/MA Z/01

Eligibility Begin Date
12/02/08

Void After Date

01/30/09

Ohio Department of Job and Family Services
www.jfs.ohio.gov/ohp
Consumer Hotline - 1-800-324-8680
or TTY 1-800-292-3572

Tear on Perforation

Tear on Perforation

Tear on Perforation

Programs & Cards

- Qualified Medicare Beneficiary (QMB)
  - Issued to qualified consumers who receive Medicare
  - Medicaid only covers their monthly Medicare Part B premiums, co-insurance and/or deductible after Medicare has paid

Tear on Perforation

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Notice to Providers of Medical Services: If there is evidence of tampering or if card is mutilated contact the local county department of job and family services. Check "Void After Date" to be sure client is eligible for service. Questions regarding claims for services should be directed to the Ohio Medicaid Information System at 1-800-686-1516.

NOTE: Medicare coinsurance and deductible coverage only.

www.jfs.ohio.gov/ohp

Consumer's Signature:

Fold

County
CLARK

Case/Category/Sequence
5678911223/MA L/01

Eligibility Begin Date
06/01/08

Void After Date
06/30/08

Ohio Qualified Medicare Beneficiary

Ohio Department of Job and Family Services
www.jfs.ohio.gov/ohp
Consumer Hotline - 1-800-324-8680
or TTY 1-800-292-3572

Tear on Perforation

Tear on Perforation

Tear on Perforation

Programs & Cards

- Specified Low-Income Medicare Beneficiary (SLMB) & Qualifying Individual (QI1, QI2)
  - We ONLY pay their Part B premium to Medicare
  - This is NOT Medicaid eligibility
  - There is no cost-sharing eligibility

Programs & Cards

- Medicaid Spenddown: 5160:1-3-04.1
  - When a Medicaid consumer's monthly income exceeds the need standard there is a spenddown
  - Three ways spenddown can be met:
    - **Ongoing**: Routinely occurring medical expenses, of the same type and amount each month, not covered by Medicaid
    - **Pay-In**: The spenddown amount is paid to the CDJFS
    - **Delayed**: Medical expenses vary from month to month, must verify the incurred amount with the CDJFS

Programs & Cards

- Conditions of Eligibility for Each Application or Recipient: 5160:1-1-58
  - 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 for Each Application or Recipient: 5160:1-1-58 cont'd
  - 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 verifications

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 2015 fee is $553.00 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
  - Notification letters will be sent 90 days before your revalidation deadline
  - Make sure your mailing address is up to date in the Demographics panel in MITS

Provider Responsibilities

- Provider Revalidation cont'd
  - Do not attempt to revalidate until you receive the notification letter
  - 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 Agreement: 5160-1-17.2
  - The provider agreement is a legal contract between the state and the provider
  - In the contract, you agreed to:
    - Accept the allowable reimbursements as payment-in-full
    - Agreed to not seek reimbursement for that service from the patient, any member of the family, or any other person
    - Maintain records for 6 years

Provider Responsibilities

- Provider Agreement: 5160-1-17.2 cont'd
  - You also agreed 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: 5160-1-02 and 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 reimburses the provider at the Medicaid rate (established fee schedule)or the UCC, whichever is the lesser of the two

Provider Responsibilities

- Recipient Liability: 5160-1-13.1
  - 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

- Recipient Liability cont'd
  - 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 other Medicaid providers may render the service at no cost to the consumer

Provider Responsibilities

- Subrogation Rights: 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://media.obm.ohio.gov/oss/documents/EFT+FORM+-+REVISED+01+14+2014.pdf

Provider Responsibilities

❖ Ohio Medicaid Website: www.Medicaid.ohio.gov

Provider Responsibilities

Ohio.gov | State Agencies | Online Services

Ohio
Department of Medicaid
John R. Kasich, Governor
John B. McCarthy, Director

Search... GO

HOME | MEDICAID 101 | FOR OHIOANS | PROVIDERS | INITIATIVES | NEWS | RESOURCES | CONTACT

PROVIDERS

Welcome Providers

Ohio is home to more than 75,000 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

UPDATED 8.15.2013: Primary Care Rate Increase: Approved Providers

2013 Primary Care Physician Rate Increase FAQ

Self Attestation Grace Period Extended

Accessing the Self Attestation Panel

Provider Enrollment Application Fee

Behavioral Health Provider Integration Project

Ohio Medicaid Vendor Letter

MITS Provider Training

Provider Hotline

Need Technical Assistance?
The Provider Hotline can help.
(800) 686.1516

MITS

MITS PORTAL

Related Content

- Benefit Coordination & Recovery
- Fee Schedules/Rates
- Forms
  - MITS EDMS Cover Page
  - Instructions
- Healthchek Screening Forms
- e-Manuals
- Helpful Links
- Get a National Provider Identifier (NPI)

Ohio Policy

Ohio 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 Handbook Transmittal Letters (MHTL)

Ohio Policy

❖ ODM Transmittal Notification Screen

HOME | MEDICAID 101 | FOR OHIOANS | PROVIDERS | INITIATIVES | NEWS | RESOURCES | CAREERS | CONTACT

HOME > ODM Email List Signup

Stay Informed

The Ohio Department of Medicaid wants to keep you up-to-speed with all the important news and announcements concerning our agency. This email subscription service allows us to communicate on an efficient, timely basis with Ohio Medicaid's diverse group of stakeholders.

If you are interested in receiving regular updates, please subscribe below with your name, email address, and selection of which communications will be of help to you. If you are a Medicaid provider, please include your Medicaid provider number when prompted (company name is optional).

Other resources: MITS, eManuals, Update Calendar, MTL Listing (Note: The MTL Listing provides PDF documents of most information posted on the eManuals site.)

Email List Sign-up

Email address:	
Last Name:	
First Name:	
Company Name:	
ProviderId:	
	☐ Rule and policy updates published in the Ohio Medicaid Eligibility Manual. ☐ Medicaid Information Technology System Updates. ☐ Rule and policy updates published for all Ohio Medicaid Provider types.
	Subscribe

Ohio Policy

- DODD Rule Notification Screen
  - www.dodd.ohio.gov/RulesLaws/Pages/default.aspx
    - Notice of public hearings on proposed rules actions
    - Transmittal memos with adopted (final-filed) rules

HOME | INDIVIDUALS & FAMILIES | PROVIDERS | COUNTY BOARDS | MY DODD

Home → Rules & Laws

Rules & Laws

Governing State Agencies

State agencies like DODD are governed by state rules and laws, as well as federal regulations and codes. Stakeholders are encouraged to participate in the process of adopting, amending, or rescinding rules and laws.

Subscribe to Rules Notice To keep system stakeholders apprised of rule actions, the Ohio Department of Developmental Disabilities offers a subscription service. Subscribing to this e-mail service ensures that the subscriber receives notification of public hearings regarding proposed rule actions and transmittal memoranda regarding final rule actions.

To subscribe to the Rules Notice service, send e-mail to join-rules-notice@list.dodd.ohio.gov.
To unsubscribe to the Rules Notice service, send e-mail to unsubscribe-rules-notice@list.dodd.ohio.gov.

For more information about administrative rules, contact Becky Phillips, Administrative Rules Coordinator, via e-mail at becky.phillips@dodd.ohio.gov or by phone at (614) 644-7393.

Ohio Policy

- ODM Policy
  - Ordering, Referring and Prescribing Providers: 5160-1-17.9
    - MHTL 3334-15-03 (Update to MHTL 3334-13-09)
  - Patient Liability: 5160:1-3-24
  - Lump Sums Payments: 5160:3-05.8

http://emanuals.odjfs.state.oh.us/emanuals/

Ohio Policy

- Ordering, Referring and Prescribing Providers (ORP): Rule 5160-1-17.9
  - This federal regulation is being implemented under Section 6401 of the Patient Protection and Affordable Care Act of 2010 (ACA) requiring
    - 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.

Ohio Policy

- ORP cont'd
  - Providers who are rendering services to Medicaid beneficiaries should ensure that such 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 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

Ohio Policy

- Patient Liability: Rule 5160:1-3-24
  - The monthly cost of care for Medicaid consumers receiving long term care services
  - Amount is determined by the CDJFS
  - The CDJFS must prorate the patient liability if the consumer is institutionalized for less than a month
    - Due to death or discharge from the facility
  - The CDJFS must recalculate when notified of changes

Ohio Policy

- Patient Liability cont'd
  - The CDJFS must notify the facility of changes to the patient liability and retroactive adjustments
  - The consumer must pay the patient liability monthly
  - The facility must accept the patient liability amount
  - The facility must refund overpayment of patient liability to the individual
  - The facility must report the entire patient liability on the claim which will be deducted from the payment amount

Ohio Policy

- Lump Sums: 5160:3-05.8
  - Income accrued over two or more months or money payment not related to any time period
  - Examples:
    - Gifts, prizes, awards
    - Retirement or pension funds
    - Out-of-court settlements
    - Proceeds received from a life insurance policy
    - Income and property tax refunds
    - Proceeds from the sale of real property

Ohio Policy

- DODD Policy
  - Intermediate care facilities- claim submission, payment, and adjustment process: 5123:2-7-15 *(revised effective 7/1/15)*
  - Coverage of bed-hold days for medical necessity and other limited absences: 5123:2-7-08
  - Intermediate care facilities- Developmental disabilities level of care: 5123:2-8-01 *(new rule effective 7/1/15)*

www.dodd.ohio.gov/RulesLaws/Pages/RulesInEffect.aspx

Ohio Policy

- Claim Submission: Rule 5123:2-7-15(D)
  - Claims must be submitted pursuant to the national correct coding initiative and coding standards
  - All claims must be submitted through:
    - Electronic Data Interchange (EDI)
    - The Medicaid Information Technology System (MITS) web portal
  - All claims must follow timely filing requirements

Ohio Policy

- Claim Submission cont'd
  - Include days of service provided, including qualifying leave days
  - A single claim cannot cross calendar months
    - Paid claim may be adjusted if additional per diem service days need included
  - The entire patient liability amount has to be entered on the claim
    - Including month of admit, discharge, transfer, and if recipient switches from Medicare to Medicaid mid-month

Ohio Policy

- Claim Submission cont'd
  - Treatment of lump sum money payments
    - CDJFS will notify the facility of need for action on the 9401 form
    - CDJFS and recipient may agree to go off Medicaid until eligible again or lump sum monies shall be assigned to the facility as payment for past per diem services
    - Value code 31 and total amount of lump sum must be entered on past paid claims in order to fully offset the amount
    - If money remains after all past claims are adjusted then current and future claims shall report remaining amount

Ohio Policy

- Timely Filing Requirements: Rule 5123:2-7-15(D)(9)
  - Original claim submissions
    - Must be received within 365 days of the date of service
    - Claims received beyond 365 days of the date of service will deny
    - Date of receipt is the date the MITS billing system receives the claim

Ohio Policy

- Timely Filing Requirements cont'd
  - Resubmission of denied claims
    - May be submitted during the 365 days of the date of service
    - When beyond the 365 time frame, must be submitted within 180 days of the denied claim
    - Claims received beyond 2 years from the original date of service will be denied

Ohio Policy

- Timely Filing Requirements cont'd
  - Adjustments to claims
    - Must be submitted within 180 days from the date Medicaid paid the claim, when underpaid
    - Must be submitted within 60 days of discovery, when overpaid
    - May be submitted through EDI or directly on the MITS portal

Ohio Policy

- Coverage of Bed-Hold Days: 5123: 2-7-08
  - ICF occupied day
    - Day of admission
    - Day of stay that is 8 hours or more
  - ICF readmission
    - A resident who is readmitted to the same facility following a hospital stay
    - The status of a resident who returns after a therapeutic program or a visit with family and friends
    - A resident may be readmitted if not officially discharged

Ohio Policy

- Coverage of Bed-Hold Days cont'd
  - ICF bed-hold day
    - A day for which a bed is reserved for a resident through Medicaid payment while the resident is temporarily absent from the facility
  - Acceptable absences:
    - Hospitalization
    - Therapeutic leave days
    - Visitation with friends or relatives

Ohio Policy

- Coverage of Bed-Hold Days cont'd
  - The number and frequency of bed-hold days used shall be considered in evaluating the continuing need for intermediate care facility care
  - Requests beyond 30 days in a calendar year require prior authorization
    - The facility must submit the 09402 to the CDJFS before the first 30 days exhaust
    - Shall be consistent with the goals of the resident's habilitation plan and medical records
    - Leave requested for hospitalization, therapeutic leave days, or visits with family and friends

Ohio Policy

- Coverage of Bed-Hold Days cont'd
  - **Exclusions** of bed-hold covered days
    - Hospice
      - Must contract with and pay ICF provider
    - Institution for mental disease
      - Patient over 21 and under 65 is Medicaid ineligible
    - Home and community-based services waiver
      - Short term respite care as a waiver service
    - Restricted Medicaid coverage
      - Time period that a consumer is ineligible for LTC services
    - Facility closure and resident relocation

ICD-9 vs. ICD-10

DIAGNOSIS

NON-INSTITUTIONAL // INPATIENT // OUTPATIENT

ICD-9 CM		ICD-10 CM
3-5	# OF ALPHANUMERIC CHARACTERS	3-7
14,000	# OF CODES	69,000

PROCEDURE

// INPATIENT ONLY //

ICD-9 PCS		ICD-10 PCS
3-4	# OF NUMERIC CHARACTERS / # OF ALPHANUMERIC CHARACTERS	7
4,000	# OF CODES	72,000

ICD-10

- International Classification of Disease (ICD)
  - Codes used in virtually every healthcare setting, including inpatient and outpatient hospital settings and physician offices, as well as in professional medical services
    - The 10th edition, ICD-10, will replace the current ICD-9 code set
    - The effective date is 10/1/15
      - For professional and outpatient services provided on or after 10/1/15

ICD-10

- ICD-10 cont'd
  - ODM has completed their implementation of ICD-10 and is ready for the 10/1/15 compliance date
  - ODM will continue to actively engage with sister state agencies, managed care plans, trading partners, and many provider associations to ensure all of Ohio Medicaid will be ready for the transition
  - System testing with clearinghouses, trading partners, and external vendors will continue through the summer of 2015
    - For managed care plans, contact their specific plan for ICD-10 testing
  - Ohio Administrative Code rules and policies will be updated to the appropriate ICD-10 terminology and/or codes

ICD-10

- How to prepare: assess, remediate, and test
  - Conduct ICD-10 needs assessment- where is ICD-9 used
    - Billing software
    - Clearinghouses and trading partners
    - Electronic health records
    - Reports and medical records
  - Update your policies, procedures, reports, and systems
    - Review your medical records and documentation– may need to expand for ICD-10
      - Code a current medical record in ICD-10
    - Review your 'superbill'– may need to update for ICD-10

ICD-10

- How to prepare: assess, remediate, and test, cont'd
  - **Test, Test, Test!**
    - Test internally
    - Test with your vendors (EHRs, etc.), Medicaid managed care plans, clearinghouses, and trading partners
    - Verify that your vendors, clearinghouses, and trading partners are testing with Ohio Medicaid
      - If you submit claims through the MITS web portal, consider testing with a clearinghouse or trading partner

ICD-10

- Educate your staff and yourself about ICD-10
  - Determine staff training needs
  - Practice coding in ICD-10
    - Code a claim using a current medical record
    - CollabT - ICD10questions@medicaid.ohio.gov
  - Pay attention to communications from CMS, ODM, Medicaid managed care plans, provider associations, and trading partners
  - Take advantage of free training resources such as those offered by CMS

ICD-10

- Collaborative Testing Tool (CollabT)
  - CMS's contractor Noblis, subcontracted with Edifecs to develop a testing tool for State Medicaid Agencies and their providers
  - The web-based tool provides the opportunity to practice ICD-10 coding with real medical records and provides instantaneous feedback so coders can learn from their mistakes
  - There is no cost for providers to practice the ICD-10 coding in CollabT tool

ICD-10

- Stay up-to-date on ODM's ICD-10 communications
  - ODM ICD-10 webpage: www.medicaid.ohio.gov/PROVIDERS/Billing/ICD10.aspx
    - Includes the ICD-10 Transition Information for Providers and Staff (TIPS) billing guidelines
    - Includes frequently asked questions
  - ODM MITS web portal and fee-for-service remittance advice banner messages
  - E-mail ICD-10 questions to: ICD10questions@medicaid.ohio.gov
  - Work with each Medicaid managed care plan (MCP); each MCP has their own ICD-10 webpage

ICD-10

- Stay up-to-date on ODM ICD-10 communications cont'd
  - Other resources
    - CMS has developed several implementation handbooks. To view the guides, please visit: www.cms.gov/Medicare/Coding/ICD10/ProviderResources.html
    - WEDI (Workgroup for Electronic Data Interchange) has taken a lead in assisting in ICD-10 implementation. Their ICD-10 Roadmap Tool Kit is here: http://www.wedi.org/
    - Provider associations

ICD-10

- Important changes
  - Claims that do not use the ICD-10 diagnosis and procedure codes for dates of service on or after 10/1/15 cannot be processed
  - Claims for services provided before 10/1/15 must use the ICD-9 codes
  - When adjusting a paid claim, use the code set that was effective on the date of the service

MITS

MITS

- Medicaid Information Technology System (MITS)
  - MITS is a web-based system
  - MITS design is based upon the Medicaid Information Technology Architecture (MITA)
  - MITS is a .NET environment able to process transactions in "real time"

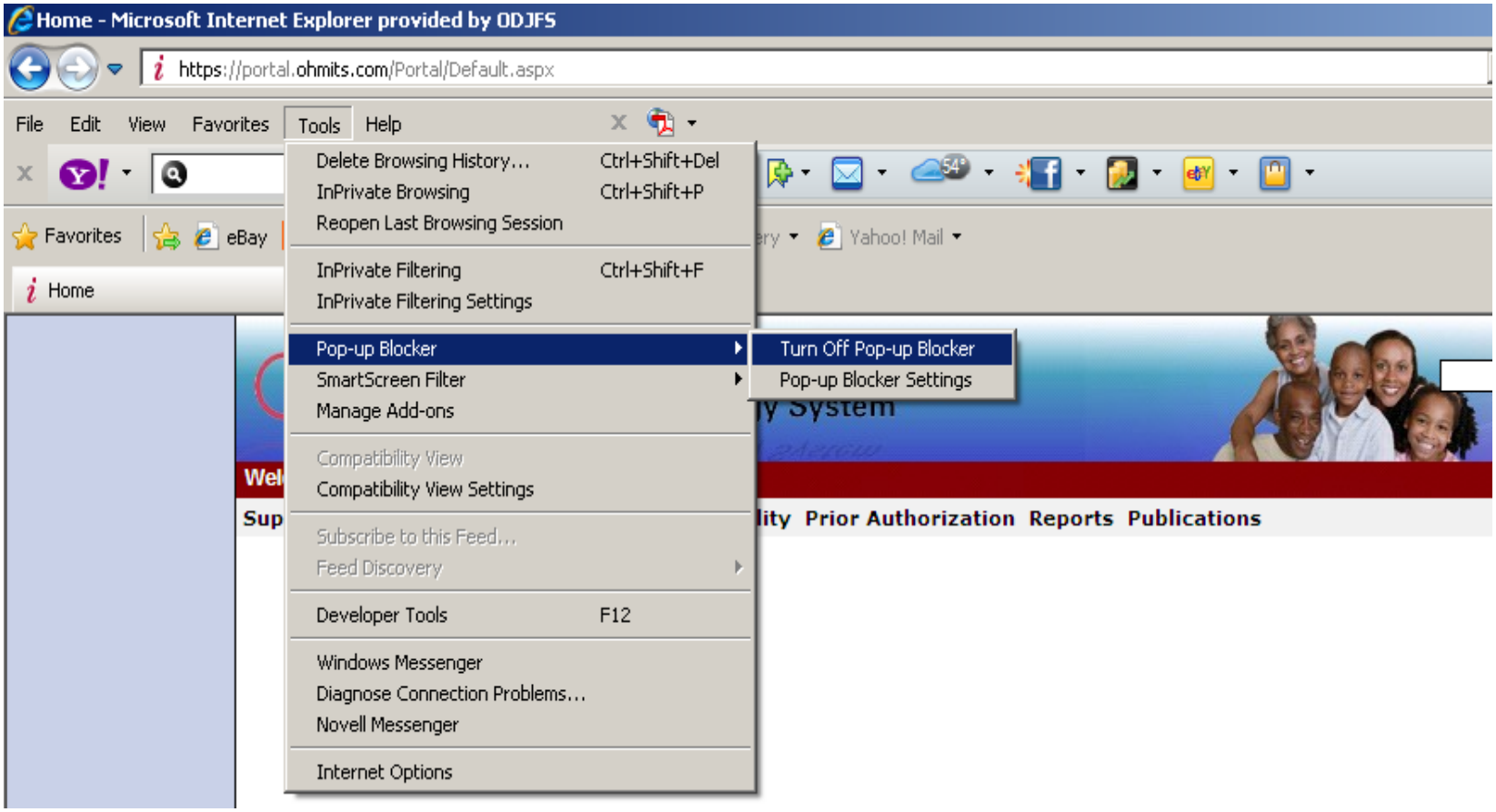
MITS

- Technical Requirements
  - Internet Access (high speed works best)
  - Internet Explorer version 8.0 and above or Firefox 1.5-3.5
  - MAC Users-download Internet Explorer for MAC
  - Turn **OFF** pop up blocker functionality

MITS

- Technical Requirements cont'd:
  - 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 on 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


Home - Microsoft Internet Explorer provided by ODJFS
https://portal.ohmits.com/Portal/Default.aspx
File Edit View Favorites Tools Help
Delete Browsing History... Ctrl+Shift+Del
InPrivate Browsing Ctrl+Shift+P
Reopen Last Browsing Session
InPrivate Filtering Ctrl+Shift+F
InPrivate Filtering Settings
Pop-up Blocker
SmartScreen Filter
Manage Add-ons
Compatibility View
Compatibility View Settings
Subscribe to this Feed...
Feed Discovery
Developer Tools F12
Windows Messenger
Diagnose Connection Problems...
Novell Messenger
Internet Options
Turn Off Pop-up Blocker
Pop-up Blocker Settings
Favorites
eBay
Yahoo! Mail
Home
Prior Authorization
Reports
Publications

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

MITS

Ohio Department of Medicaid

Search

About ODM | Our Services | Resources | News & Events

Tuesday 06/16/2015 11:34:38 AM

Home Consumers Providers Trading Partners Public Information Publications

enrollment enrollment tracking search long-term care account setup

Ohio Department of Medicaid

Provider Home

Using the Provider Enrollment wizard, applicants are guided through the necessary steps to complete and submit an enrollment application to become a Medicaid provider. After logging in to the Secured Site, providers can use self-service tools to manage their account, access their mailbox, update demographic information, exchange data files, request eligibility verification, and process claims, prior authorizations, and referrals.

Login to secure site

- Click Here to Login

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”

Ohio.gov | Medicaid Information Technology System

Sign In

Medicaid Information Technology System

To sign in, please enter your User ID and Password

User ID:

Password:

Whoever knowingly, or intentionally accesses a computer or a computer system without authorization or exceeds the access to which that person is authorized, and by means of such access, obtains, alters, damages, destroys, or discloses information, or prevents authorized use of the information operated by the State of Ohio, shall be subject to such penalties allowed by law. All activities on this system may be recorded and/or monitored. Individuals using this system expressly consent to such monitoring and evidence of possible misconduct or abuse may be provided to appropriate officials. Users who access this system consent to the provisions of confidentiality of the information being accessed, but have no expectation of privacy while using this system.

In the event that an unauthorized user is able to access information to which they are not entitled, the user should immediately notify the site administrator

Yes, I have read the agreement

Login

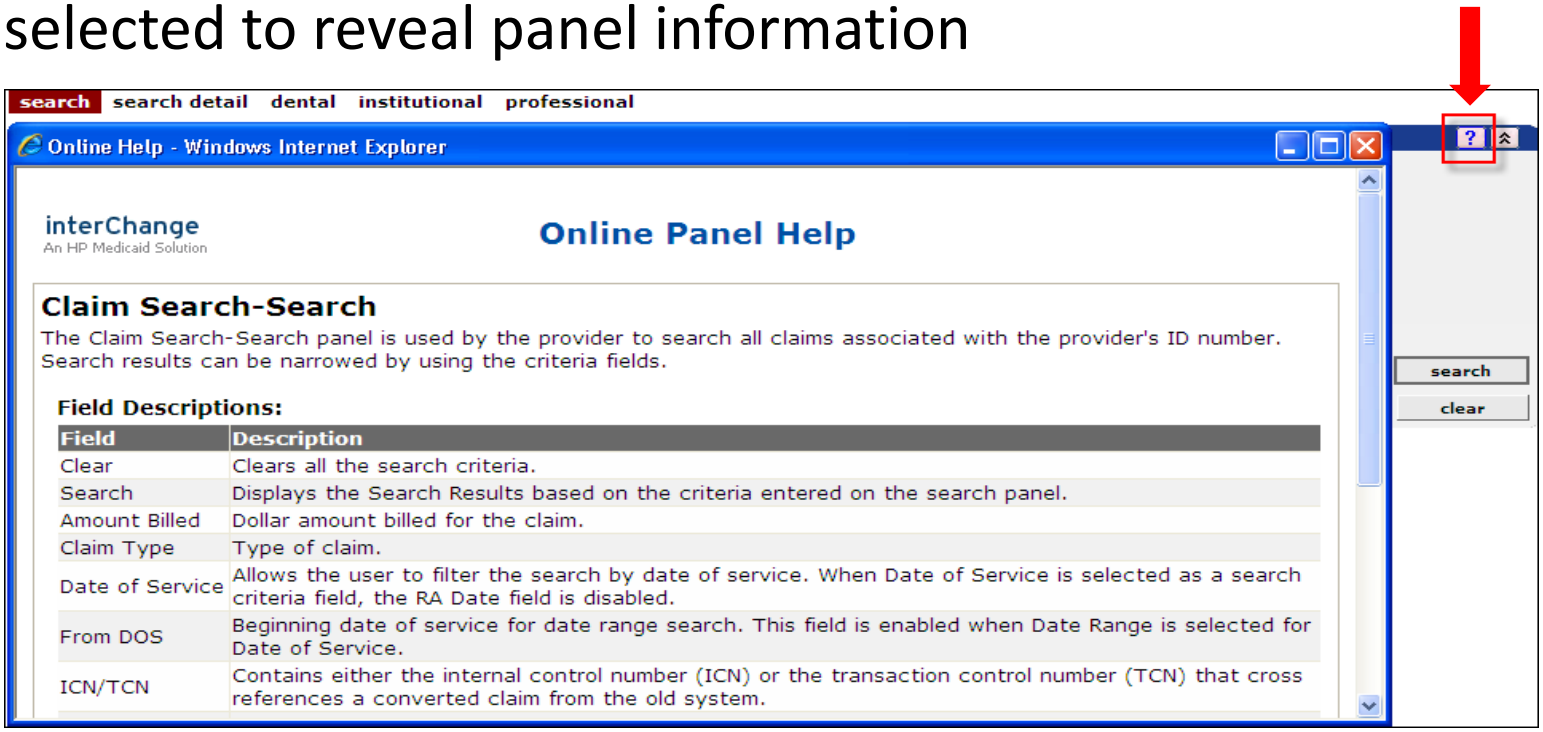
Help FAQ
Help Reset Password?
Forgot Your User ID?

MITS

- MITS Web Portal Navigation
  - "Copy", "Paste", and "Print" features will work in the MITS Portal
  - "Back" feature will **NOT** work in the MITS Portal
  - MITS Web Portal access will time-out after 15 minutes of inactivity to the system

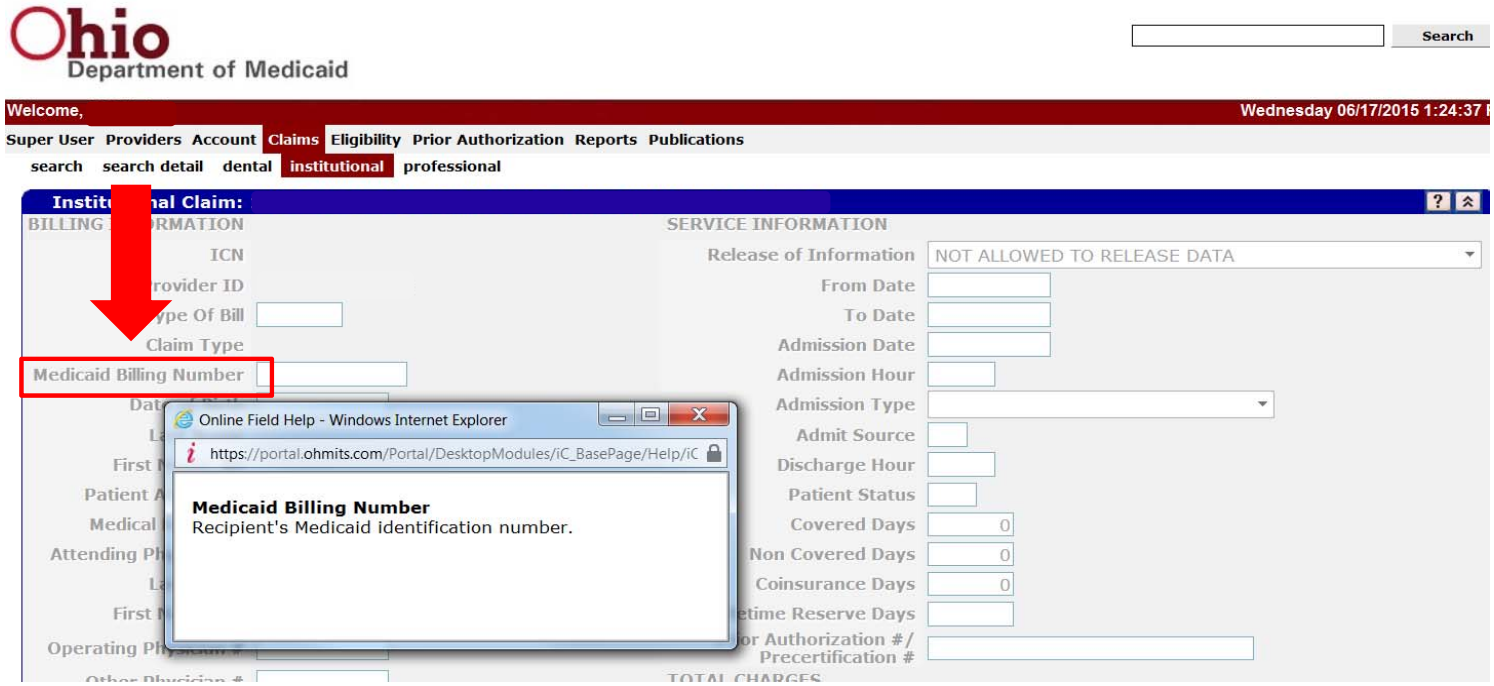
MITS

- Panel Help
  - The "?" button in the upper right corner of a panel may be selected to reveal panel information



MITS

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



MITS

- Administrator Account Setup
  - One account per billing NPI/Ohio Medicaid provider ID
    - Only one person may set this up
  - Access to all secure information
  - Responsible for assigning roles to agents (unlimited)
  - Responsible for maintaining the provider MITS portal account, including updating demographic information

MITS

Go to: https://portal.ohmits.com/public/Providers/tabid/43/Default.aspx

Provider Home

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Search Provider Directory

Allow a user to perform searches for providers and community resources by different search criteria such as county, city, state, or zip code.

Fee Schedules

View schedules based on provider types in PDF/HTML/CSV

Search Publications

Allow a user to perform a search for a publication and view the document.

Managed Care

Ohio Medicaid contracts with Managed Care Plans (MCPs) to provide quality health care to many Ohio Medicaid consumers.

Login to secure site

- Click Here to Login

Provider Enrollment

To enroll as a new Medicaid Provider:

- Provider Enrollment Application
- Check Enrollment Application
- Enrollment FAQ's

Provider Setup/Registration

If you have a 7 digit Ohio Medicaid Provider Number: Click here to register for MITS access.

- Click here to setup your account

START HERE

Agent Setup

If you are a provider employee or doing work on behalf of a provider

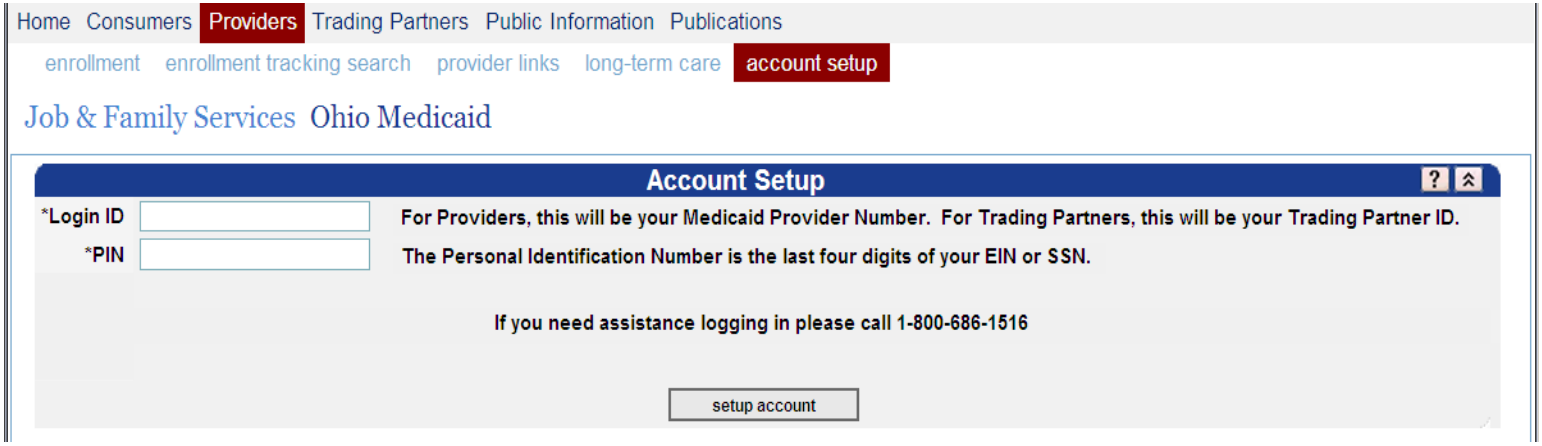
- Click here to setup your agent account

Note: Provider must approve.

Quick Links

- Enroll as a HOME Choice provider
- OHP Provider Page

MITS



- To create the account your **Login ID** is your 7 digit Medicaid Provider Number
- The **PIN** is the last four digits of your Employee Identification Number (EIN) or Social Security Number (SSN) that is on your provider file
- Click the **Setup Account** button

MITS

- After you click the “Setup Account” button, the system prompts you to “Agree” by selecting the checkmark “Yes” and “I agree to the Terms of Service”

- After accepting the terms, the registration page will display

- On the “Register as a Provider” page, type in the required registration information, including your first and last name, emailed address, create your own user ID and password, then click the “Register” button
  - The user ID can never be changed!!

- Follow **ALL** steps or your registration will not work

MITS

- Agent Account Setup
  - Someone working on the Administrator's behalf
    - Additional office staff or a billing agency
  - There may be numerous agents per provider number
  - Each Agent needs only one account
  - Administrators set up Agents roles
  - Agents set up own accounts
  - Accounts setup by Pay-To NPI
  - Agent User ID remains the same

MITS

Search Provider Directory

Allow a user to perform searches for providers and community resources by different search criteria such as county, city, state, or zip code.

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Ohio Medicaid contracts with Managed Care Plans (MCPs) to provide quality health care [illegible] insurers.

START HERE

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- Click here to setup your agent account

Note: Provider must approve.

Quick Links

- Enroll as a HOME Choice provider
- OHP Provider Page

MITS

Terms of Service

In order to complete the registration process, please read the Provider Web Portal User Agreement below, check the agreement box indicating that you have read the Terms of Service agreement and then click on the "I Agree" button if applicable. It may be necessary to scroll down on the outside of the gray window on the right (not within the white agreement box) to see the "I Agree" button.

OHIO MEDICAID INFORMATION TECHNOLOGY SYSTEM: PROVIDER WEB PORTAL USER AGREEMENT

This User Account Agreement is made by and between the State of Ohio Department of Job and Family Services, ("ODJFS"), and a licensed health care provider, or an entity who acts on behalf of a licensed health care provider, who has signed up for an account on this website ("User").

This Agreement becomes effective today, and shall remain in effect until 01/01/2099, or until terminated with or without cause by either party.

Pursuant to the terms of this Agreement, User is authorized to access confidential Medicaid data through the use of computer-related media (system inquiry, on-line update, printed reports, ad hoc reporting, CD reports, etc.), commonly known as the Ohio Medicaid Information Technology System ("OH MITS").

User is responsible for complying with all applicable federal and state laws, rules, and regulations when creating, receiving, maintaining, or transmitting information within the OH MITS.

User agrees to use appropriate administrative, technical, and physical safeguards to prevent any use or disclosure of information retrieved from MMIS that is not permitted or provided for by this Agreement.

User shall only use and/or disclose information retrieved from the OH MITS to perform obligations and responsibilities as authorized by ODJFS and this Agreement.

User understands that, in accordance with state and federal law, information retrieved from the OH MITS may be used solely for the

☐ **Yes, I have read the Terms of Service agreement**

I Agree | Disagree

Clicking "I Agree" constitutes a signature of this Agreement. By signing this Agreement, I acknowledge that I have read and understand this

MITS

Register as an Agent

Enter your personal information and press **Register** when finished.

*First Name:

Middle Initial:

*Last Name:

*Email Address:

Telephone Number:

***User ID:**

***Password:**

***Confirm Password:**

Register | Cancel

* required

Privacy | Disclaimer

Your User ID must meet the following criteria:

- Minimum of 6 characters in length
- Maximum of 8 characters in length
- Mandatory 1 number (no more than or no less than, just 1 number)

Your Password must meet the following criteria:

- Minimum of 8 characters in length
- Maximum of 15 characters in length
- Minimum of 1 alphabetic character
- Minimum of 1 numeric character
- Maximum number of sequential characters is 6
- Cannot be the same as your User ID
- Passwords are case sensitive

MITS

- Agent Account Setup cont'd
  - Each agent is assigned one or more of the following roles:
    - Eligibility search
    - Claim search
    - Claim submission
    - Prior authorization search
    - Prior authorization submission
    - 1099 information (including remittance advices)

MITS

❖ Agent Maintenance Panel

Agent Maintenance

User Name | Contact First Name | Contact Last Name

A

remove agent | add agent

*User Name: Illuminating [Search]

Contact First Name: Thomas A

Contact Last Name: Edison

Agent Roles

Assigned Roles		Available Roles
Claim Submission	<	Prior Auth Submit
Prior Auth Search	<<	Eligibility
	>	Claim Search
	>>	1099 Information

MITS

- Agent Account Setup
  - Agents can have the option to switch providers

MITS

- Agent Account Setup cont'd
  - Select the default provider

Switch Provider

National Provider ID	Medicaid Provider ID	Address	City	State	Zip	Zip + 4	Tax	Provider Type	Default Provider ID
	000123456	777 ANY ST N	ANYCITY	ST	55555-	5555		DAYTON PHYSICIAN	
	000123456	999 ANY ST LN	ANYCITY	ST	55555	5555		COLUMBUS PHYSICIAN	X

Select row above to update

Current Provider 999999999

National Provider ID

Address 999 ANY ST LN

City ANY CITY

State ST

Zip 55555-5555

Medicaid Provider ID 999999999

Taxonomy

Provider Type COLUMBUS PHYSICIAN

Default Provider ID X

switch to

set as default

MITS

- Eligibility Search
  - Full Medicaid eligibility on the MITS portal will show four 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'd
  - Verification of the following:
    - Medicare
    - Managed Care
    - Benefit Plan
    - Third Party
    - Case Spenddown
    - Patient Liability
    - Third Party
    - Long Term Care

MITS

- Eligibility Search

MITS

❖ Eligibility Verification Request

Ohio Department of Medicaid

Search

Welcome, Wednesday 06/17/2015 1:51:03 PM

Super User Providers Account Claims Eligibility Prior Authorization Reports Publications

eligibility search hospice enrollment

Eligibility Verification Request

Medicaid Billing Number	123456789000	Birth Date	02/08/1977
SSN		DOS Date Format	MM/DD/YYYY
Procedure Code		From DOS	05/01/2015
		To DOS	06/17/2015

search

clear

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AMA & ADA Copyright

Eligibility Search

❖ Eligibility Verification Request-results

Recipient Information

Medicaid Billing Number		**SSN**	
Last Name		**County of Residence**	GALLIA
First Name		**County of Eligibility**	
Gender		**County Office http://jfs.ohio.gov/County/County_Directory.pdf**	
Date of Birth		**Number Bed Hold Days Used Paid CY**	
Date of Death			

Benefit / Assignment Plan

Benefit / Assignment Plan	Effective Date	End Date	Provider Name	Dental Co-Pay Amount	Vision Co-Pay Amount
Medicaid	05/01/2015	06/17/2015		$0.00	$0.00
MRDD Targeted Case Mgmt	05/01/2015	06/17/2015		$0.00	$0.00
Alcohol and Drug Addiction Services	05/01/2015	06/17/2015		$0.00	$0.00
Ohio Mental health	05/01/2015	06/17/2015		$0.00	$0.00

Eligibility Search

❖ Eligibility Verification Request-results cont'd

Case/Cat/Seq Spenddown

Monthly Amount	Effective Date	End Date	Type
$0.00	05/01/2015	06/17/2015	RECURRING

TPL

*** No rows found ***

Managed Care

*** No rows found ***

Lock-In

*** No rows found ***

Medicare

Coverage	Effective Date	End Date	Plan Name	Plan ID	HIC
PART A	05/01/2015	06/17/2015			282367464C1
PART B	05/01/2015	06/17/2015			282367464C1
PART D	05/01/2015	05/31/2015	COMMUNITY CCRX BASIC (PDP)	083	282367464C1
PART D	05/01/2015	05/31/2015	CVS CAREMARK VALUE (PDP)	028	282367464C1
PART D	05/01/2015	05/31/2015	LIMITED INCOME NET PROGRAM	001	282367464C1

Service Limitation

*** No rows found ***

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

Level of Care Determinations

LOC Requested	Status	Determination Date	LOC Determination	Description	LOC Begin Date	LOC End Date
				UNKNOWN LEVEL OF CARE	05/01/2015	05/31/2015

Patient Liability

Financial Payer	Monthly Amount	Type	Effective Date	End Date
DEFAULT	$644.00	Nursing Home	05/01/2015	06/30/2015

Long Term Care Facility Placements

Facility Type	Date of Admission	Effective Begin Date of Medicaid Coverage	End Date of Medicaid Coverage	Date of Discharge
STATE OPERATED ICF-MR	05/27/2003	05/27/2003	12/31/2299	12/31/2299

Special Program

*** No rows found ***

Claim Submission

- Process for DOS up to 6/30/15
  - Provider sends paper payment request form 9400 to ODM
  - Claims are manually created; adjusted; voided; resubmitted by ODM
    - Provider submits form 9400 for adjustments
  - MITS billing system adjudicates claims

Claim Submission

- Process for DOS 7/1/15 and after
  - Provider submits claims directly on MITS portal and/or through electronic data entry (EDI)
  - Claims are adjusted, voided, and resubmitted by the provider through the portal and/or EDI
  - MITS billing system adjudicates claims

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
    - Will need a trading partner-fees for submitting claims
    - 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

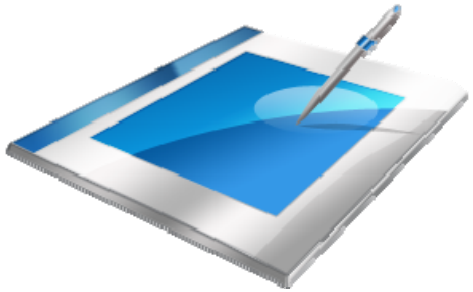
http://medicaid.ohio.gov/PROVIDERS/MITS/HIPAA5010Implementation.aspx

- Technical Questions/EDI Support Unit

614-387-1212

New email address

DAS-EDI-Support@das.ohio.gov

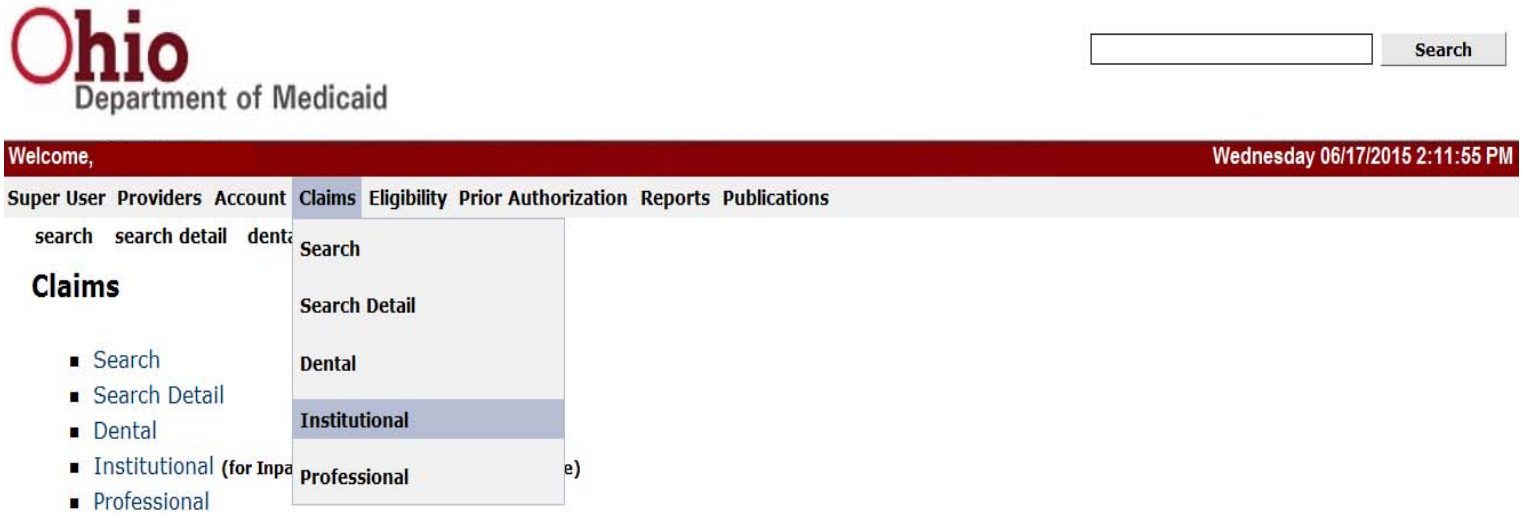


Claim Submission

- Claim Submission
  - Claims entry format is divided into sections called panels
  - Each panel will have an * asterisk denoting a required field
    - There are some fields that are situational for claims adjudication that do not have an asterisk, but are required for adjudication

Claim Submission

- Submission of an Institutional Claim



Claim Submission

❖ Submission of an Institutional Claim cont'd

Institutional Claim

BILLING INFORMATION

ICN
Provider ID
Type Of Bill
Claim Type
Medicaid Billing Number
Date of Birth
Last Name
First Name, MI
Patient Account #
Medical Record #
Attending Physician #
Last Name
First Name, MI
Operating Physician #
Other Physician #
ICD Version 10
Patient Amount Paid $0.00

SERVICE INFORMATION

Release of Information NOT ALLOWED TO RELEASE DATA
From Date
To Date
Admission Date
Admission Hour
Admission Type
Admit Source
Discharge Hour
Patient Status
Covered Days 0
Non Covered Days 0
Coinsurance Days 0
Lifetime Reserve Days
Prior Authorization #/ Precertification #

TOTAL CHARGES

Total Charges $0.00
Total Non Covered Charges $0.00
Total Covered Charges $0.00
Medicaid CoPay Amount $0.00
Note Reference Code
Notes

Condition | Inpatient Procedure | Occurrence/Span | Value

Claim Submission

- Submission of an Institutional Claim cont'd

Diagnosis

	Sequence	Diagnosis Code	Description	Present on Admission
A				

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

delete | add an item

Sequence | Diagnosis Code

Present on Admission

Header - Other Payer

*** No rows found ***

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

delete | add an item

Header - Other Payer Amounts and Adjustment Reason Codes

Detail

	Item	Date of Service	Revenue Code	HCPCS/HIPPS Rate Codes	Units	Total Charges	Non Covered Charges	Medicaid Allowed Amount	Status	Modifier 1	Modifier 2	Modifier 3	Modifier 4
A	1				0	$0.00	$0.00	$0.00					

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

delete | add an item | copy

Item 1

Date of Service

To DOS

Revenue Code

HCPCS/HIPPS Rate Codes

Modifiers

Units 0

Units Of Measurement

Per Diem Rate $0.00

Total Charges $0.00

Non Covered Charges $0.00

Medicaid Allowed Amount $0.00

Status

NDC | Detail - Other Payer

Attachments

*** No rows found ***

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

delete | add an item

Supporting Data for Delayed Submission / Resubmission

DISCLAIMER: Documentation to justify the use of this panel and data entered must be retained for future audit purposes.

Previously Denied ICN or TCN

Claim Status Information

Claim Status Not Submitted yet

Claim Submission

- Types of Bill
  - 651: Intermediate Care-Level 1, admit through discharge
  - 652: Intermediate Care-Level 1, interim-first claim
  - 653: Intermediate Care-Level 1, interim-continuing claim
  - 654: Intermediate Care-Level 1, interim-last claim
  - 657: Intermediate Care-Level 1, replacement of prior claim
  - 658: Intermediate Care-Level 1, void/cancel of prior claim

Claim Submission

❖ Patient Status Codes

Search Results

Patient Status	Description	Effective Date	End Date
01	DISCHARGED TO HOME OR SELF CARE (ROUTINE DISCHARGE)	01/01/1900	12/31/2299
02	DISCHARGED/TRANSFERRED TO A SHORT-TERM GENERAL HOSPI	01/01/1900	12/31/2299
03	DISCHARGED/TRANSFERRED TO SKILLED NURSING FACILITY (	01/01/1900	12/31/2299
04	DISCHARGED/TRANSFERRED TO A FACILITY THAT PROVIDES C	01/01/1900	12/31/2299
05	DISCHARGED/TRANSFERRED TO A DESIGNATED CANCER CENTER	01/01/1900	12/31/2299
06	DISCHARGED/TRANSFERRED TO HOME UNDER CARE OF AN ORGA	01/01/1900	12/31/2299
07	LEFT AGAINST MEDICAL ADVICE OR DISCONTINUED CARE	01/01/1900	12/31/2299
09	ADMITTED AS AN INPATIENT TO THIS HOSPITAL	01/01/1900	12/31/2299
20	EXPIRED	01/01/1900	12/31/2299
21	DISCHARGED/TRANSFERRED TO COURT/LAW ENFORCEMENT	01/01/1900	12/31/2299

1 2 3 4 Next >

Search Results

Patient Status	Description	Effective Date	End Date
30	STILL PATIENT	01/01/1900	12/31/2299
40	EXPIRED AT HOME	01/01/1900	12/31/2299
41	EXPIRED IN A MEDICAL FACILITY (E.G. HOSPITAL, SNF, I	01/01/1900	12/31/2299
42	EXPIRED - PLACE UNKNOWN	01/01/1900	12/31/2299
43	DISCHARGED/TRANSFERRED TO A FEDERAL HEALTH CARE FACI	01/01/1900	12/31/2299
50	HOSPICE - HOME	01/01/1900	12/31/2299
51	HOSPICE - MEDICAL FACILITY (CERTIFIED) PROVIDING HOS	01/01/1900	12/31/2299
61	DISCHARGED/TRANSFERRED TO A HOSPITAL-BASED MEDICARE	01/01/1900	12/31/2299
62	DISCHARGED/TRANSFERRED TO AN INPATIENT REHABILITATIO	01/01/1900	12/31/2299
63	DISCHARGED/TRANSFERRED TO A MEDICARE CERTIFIED LONG	01/01/1900	12/31/2299

< Previous 1 2 3 4 Next >

Claim Submission

❖ Patient Status Codes cont'd

Search Results

Patient Status	Description	Effective Date	End Date
64	DISCHARGED/TRANSFERRED TO A NURSING FACILITY CERTIFI	01/01/1900	12/31/2299
65	DISCHARGED/TRANSFERRED TO A PSYCHIATRIC HOSPITAL OR	01/01/1900	12/31/2299
66	DISCHARGED/TRANSFERRED TO A CRITICAL ACCESS HOSPITAL	01/01/1900	12/31/2299
69	DISCHARGED/TRANSFERRED TO A DESIGNATED DISASTER ALTE	10/01/2013	12/31/2299
70	DISCHARGED/TRANSFERRED TO ANOTHER TYPE OF HEALTH CAR	01/01/1900	12/31/2299
81	DISCHARGED TO HOME OR SELF CARE WITH A PLANNED ACUTE	10/01/2013	12/31/2299
82	DISCHARGED/TRANSFERRED TO A SHORT TERM GENERAL HOSPI	10/01/2013	12/31/2299
83	DISCHARGED/TRANSFERRED TO A SKILLED NURSING FACILITY	10/01/2013	12/31/2299
84	DISCHARGED/TRANSFERRED TO A FACILITY THAT PROVIDES C	10/01/2013	12/31/2299
85	DISCHARGED/TRANSFERRED TO A DESIGNATED CANCER CENTER	10/01/2013	12/31/2299

< Previous 1 2 3 4 Next >

Search Results

Patient Status	Description	Effective Date	End Date
86	DISCHARGED/TRANSFERRED TO HOME UNDER CARE OF ORGANIZ	10/01/2013	12/31/2299
87	DISCHARGED/TRANSFERRED TO COURT/LAW ENFORCEMENT WITH	10/01/2013	12/31/2299
88	DISCHARGED/TRANSFERRED TO A FEDERAL HEALTH CARE FACI	10/01/2013	12/31/2299
89	DISCHARGED/TRANS FERTED TO A HOSPITAL BASED MEDICARE	10/01/2013	12/31/2299
90	DISCHARGED/TRANSF TO INPATIENT REHAB FACILITY (IRF)	10/01/2013	12/31/2299
91	DISCHARGED/TRANSFERRED TO A MEDICARE CERTIFIED LONG	10/01/2013	12/31/2299
92	DISCHARGED/TRANSFERRED TO NURSING FACILITY CERTIFIED	10/01/2013	12/31/2299
93	DISCHARGED/TRANSFERRED TO A PSYCHIATRIC HOSPITAL OR	10/01/2013	12/31/2299
94	DISCHARGED/TRANSFERRED TO A CRITICAL ACCESS HOSPITAL	10/01/2013	12/31/2299
95	DISCHARGED/TRANSFERRED TO ANOTHER TYPE OF HEALTH CAR	10/01/2013	12/31/2299

< Previous 1 2 3 4

Claim Submission

❖ Admit Type Codes

Search Results

Admit Type	Description	Effective Date	End Date
1	EMERGENCY	01/01/1900	12/31/2299
2	URGENT	01/01/1900	12/31/2299
3	ELECTIVE	01/01/1900	12/31/2299
4	NEWBORN	01/01/1900	12/31/2299
5	TRAUMA	01/01/1900	12/31/2299
9	INFORMATION NOT AVAILABLE	01/01/1900	12/31/2299

Claim Submission

- Diagnosis Codes
  - Are required on ICF-IID Institutional claims
    - Must include the number of digits specified by ICD
    - MITS does not accept the decimals, enter ONLY numbers
    - System edits and audits will be applied to those codes

Claim Submission

- Acuity Level Flat Fee Pricing
  - Enter on the claim as value code 24
  - Must enter the appropriate level in the ‘amount’ field
  - Payment will be lesser of the two: per diem rate or acuity level flat fee rate
    - Calculated in MITS automatically
  - Current levels:
    - A05 Typical adaptive needs and chronic behaviors
    - A06 Typical adaptive needs and non-significant behaviors

Claim Submission

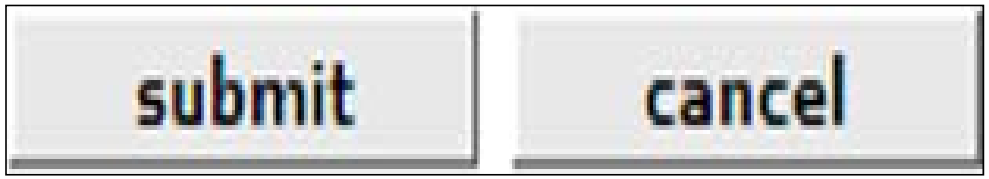
- Revenue Center Codes
  - 101 Room and board covered days
  - 182 Visits with Friends and Family leave day
  - 183 Therapeutic leave day
  - 185 Hospital leave day
  - 410 Pediatric ventilator

Claim Submission

- Pediatric Ventilator Add-on
  - Non-state operated facility with 893 type specialty
  - Children who are vent dependent, up to 22 years old
  - $300 per resident, per day
    - Added on to the per diem
  - Bill a separate detail line with revenue code 410
  - Add occurrence code 73 with appropriate date range for the dates the child had the vent
    - Date range must match the units billed at the detail line

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

- Adjudication will happen in “real time”. If no errors the claim will show:
  - Paid
  - Denied
  - Suspended

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

❖ Example #1 Standard Claim

Welcome, OH SUPER USER

Super User | Providers | Account | Claims | Eligibility | Prior Authorization | Reports | Publications

search | search detail | dental | institutional | professional

Institutional Claim:

BILLING INFORMATION

ICN	2215180000008
Provider ID	NPI
Type Of Bill	0653
Claim Type	L - LONG TERM CARE
Medicaid Billing Number	
Date of Birth	
Last Name	
First Name, MI	
Patient Account #	
Medical Record #	
Attending Physician #	
Last Name	
First Name, MI	
Operating Physician #	
Other Physician #	
ICD Version	10
Patient Amount Paid	$0.00

SERVICE INFORMATION

Release of Information	NOT ALLOWED TO RELEASE DATA
From Date	01/01/2016
To Date	01/31/2016
Admission Date	01/01/2016
Admission Hour	0900
Admission Type	9 - INFORMATION NOT AVAILABLE
Admit Source	
Discharge Hour	
Patient Status	30
Covered Days	31
Non Covered Days	0
Coinsurance Days	0
Lifetime Reserve Days	0
Prior Authorization #/ Precertification #	

TOTAL CHARGES

Total Charges	$50,000.00
Total Non Covered Charges	$0.00
Total Covered Charges	$50,000.00
Medicaid CoPay Amount	$0.00
Note Reference Code	
Notes	

Condition | Inpatient Procedure | Occurrence/Span | Value

Monthly patient liability amount goes here

Claim Submission

❖ Example #1 Standard Claim cont'd

Diagnosis

Sequence	Diagnosis Code	Description	Present on Admission
Principal	E0800	DIAB D/T UNDRL COND W HYPROSM W/O NONKET	

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

delete | add an item

Sequence | Diagnosis Code

Present on Admission

Header - Other Payer

*** No rows found ***

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

delete | add an item

Header - Other Payer Amounts and Adjustment Reason Codes

Detail

Item	Date of Service	Revenue Code	HCPCS/HIPPS Rate Codes	Units	Total Charges	Non Covered Charges	Medicaid Allowed Amount	Status	Modifier 1	Modifier 2	Modifier 3	Modifier 4
4	01/24/2016	185		8.00	$12,000.00	$0.00	$4,937.12	PAID				
3	01/16/2016	182		8.00	$12,000.00	$0.00	$4,937.12	PAID				
2	01/08/2016	183		8.00	$12,000.00	$0.00	$4,937.12	PAID				
1	01/01/2016	101		7.00	$14,000.00	$0.00	$4,319.98	PAID				

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

delete | add an item | copy

Item	1	Units	7.00
*Date of Service	01/01/2016	Units Of Measurement	Days
To DOS	01/07/2016	*Per Diem Rate	$2,000.00
Revenue Code	101	Total Charges	$14,000.00
HCPCS/HIPPS Rate Codes		Non Covered Charges	$0.00
Modifiers		Medicaid Allowed Amount	$4,319.98
		Status	PAID

NDC | Detail - Other Payer

Claim Submission

❖ Example #1 Standard Claim cont'd

Attachments

*** No rows found ***

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

delete | add an item

Supporting Data for Delayed Submission / Resubmission

DISCLAIMER: Documentation to justify the use of this panel and data entered must be retained for future audit purposes.

Previously Denied ICN or TCN

Claim Status Information

Claim Status	PAID
Claim ICN	2215180000008
Paid Date	
Paid Amount	$19,131.34

EOB Information

Detail Number	Error Disposition	EOB Code	EOB Description	CARC	CARC Amount	CARC Description	RARC	RARC Description

Claim Submission

❖ Example #2 Acuity Level Claim

Condition | Inpatient Procedure | Occurrence/Span | Value

Value

Sequence	Value	Description	Amount
1	24	MEDICAID RATE CODE	5.00

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

delete | add an item

Sequence 1

Value 24 Amount 5.00

Diagnosis

Sequence	Diagnosis Code	Description	Present on Admission
Principal	25000	DMII WO CMP NT ST UNCNTR	

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

delete | add an item

Sequence Diagnosis Code

Present on Admission

Header - Other Payer

*** No rows found ***

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

delete | add an item

Header - Other Payer Amounts and Adjustment Reason Codes

Detail

Item	Date of Service	Revenue Code	HCPCS/HIPPS Rate Codes	Units	Total Charges	Non Covered Charges	Medicaid Allowed Amount	Status	Modifier 1	Modifier 2	Modifier 3	Modifier 4
2	07/16/2015	183		16.00	$4,424.04	$0.00	$0.00	PAID				
1	07/01/2015	101		15.00	$4,144.35	$0.00	$0.00	PAID				

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

delete | add an item | copy

Item 1

*Date of Service 07/01/2015

To DOS 07/15/2015

Revenue Code 101

HCPCS/HIPPS Rate Codes

Modifiers

Units 15.00

Units Of Measurement Days

*Per Diem Rate $276.29

Total Charges $4,144.35

Non Covered Charges $0.00

Medicaid Allowed Amount $0.00

Status PAID

NDC | Detail - Other Payer

Claim Submission

❖ Example #3 Pediatric Ventilator Claim

Condition | Inpatient Procedure | Occurrence/Span | Value

Occurrence/Span

Sequence	Occurrence Code	Description	From Date	To Date
1	73	BENEFIT ELIGIBILITY PERIOD	10/06/2014	10/10/2014

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

delete | add an item

Sequence 1 From Date 10/06/2014

Occurrence Code 73 To Date 10/10/2014

Diagnosis

Sequence	Diagnosis Code	Description	Present on Admission
Principal	E119	TYPE 2 DIABETES MELLITUS WITHOUT COMPLIC	

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

delete | add an item

Sequence | Diagnosis Code

Present on Admission

Header - Other Payer

*** No rows found ***

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

delete | add an item

Header - Other Payer Amounts and Adjustment Reason Codes

Detail

Item	Date of Service	Revenue Code	HCPCS/HIPPS Rate Codes	Units	Total Charges	Non Covered Charges	Medicaid Allowed Amount	Status	Modifier 1	Modifier 2	Modifier 3	Modifier 4
2	10/06/2015	410		5.00	$1,000.00	$0.00	$1,500.00	PAID				
1	10/01/2015	101		31.00	$11,909.58	$0.00	$0.00	PAID				

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

delete | add an item | copy

Item 2

*Date of Service 10/06/2015

To DOS 10/10/2015

Revenue Code 410

HCPCS/HIPPS Rate Codes

Modifiers

Units 5.00

Units Of Measurement Days

Per Diem Rate $300.00

Total Charges $1,500.00

Non Covered Charges $0.00

Medicaid Allowed Amount $1,500.00

Status PAID

NDC | Detail - Other Payer

Claim Submission

❖ Example #4 Discharge/Death Claim

Institutional Claim:

BILLING INFORMATION

ICN	2215210000013
Provider ID	
*Type Of Bill	0651 [Search]
Claim Type	L - LONG TERM CARE
Medicaid Billing Number	
*Date of Birth	
Last Name	
First Name, MI	
*Patient Account #	CCC
Medical Record #	
*Attending Physician #	
*Last Name	
*First Name, MI	
Operating Physician #	
Other Physician #	
*ICD Version	09
*Patient Amount Paid	$0.00

SERVICE INFORMATION

*Release of Information	NOT ALLOWED TO RELEASE DATA
*From Date	08/01/2015
*To Date	08/10/2015
Admission Date	08/01/2015
Admission Hour	1900
*Admission Type	3 - ELECTIVE
Admit Source	[Search]
Discharge Hour	
*Patient Status	01
*Covered Days	9
Non Covered Days	1
Coinsurance Days	0
Lifetime Reserve Days	0
Prior Authorization #/ Precertification #	

TOTAL CHARGES

Total Charges	$2,000.00
Total Non Covered Charges	$200.00
Total Covered Charges	$1,800.00
Medicaid CoPay Amount	$0.00
Note Reference Code	
Notes	

Condition | Inpatient Procedure | Occurrence/Span | Value

Claim Submission

- Example #4 Discharge/Death Claim cont'd
  - First detail line: covered days

Detail

Item	Date of Service	Revenue Code	HCPCS/HIPPS Rate Codes	Units	Total Charges	Non Covered Charges	Medicaid Allowed Amount	Status	Modifier 1	Modifier 2	Modifier 3	Modifier 4
2	08/10/2015	101		1.00	$0.00	$200.00	$0.00	PAID				
1	08/01/2015	101		9.00	$1,800.00	$0.00	$2,372.58	PAID				

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

delete | add an item | copy

Item	1	*Units	9.00
*Date of Service	08/01/2015	*Units Of Measurement	Days
To DOS	08/09/2015	*Per Diem Rate	$200.00
*Revenue Code	101 [Search]	*Total Charges	$1,800.00
HCPCS/HIPPS Rate Codes	[Search]	Non Covered Charges	$0.00
Modifiers	[Search] [Search]	Medicaid Allowed Amount	$2,372.58
	[Search] [Search]	Status	PAID

NDC | Detail - Other Payer

Claim Submission

- Example #4 Discharge/Death claim cont'd
  - Second detail line: non-covered day

Detail

Item	Date of Service	Revenue Code	HCPCS/HIPPS Rate Codes	Units	Total Charges	Non Covered Charges	Medicaid Allowed Amount	Status	Modifier 1	Modifier 2	Modifier 3	Modifier 4
2	08/10/2015	101		1.00	$0.00	$200.00	$0.00	PAID				
1	08/01/2015	101		9.00	$1,800.00	$0.00	$2,372.58	PAID				

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

delete | add an item | copy

Item 2

*Date of Service 08/10/2015

To DOS 08/10/2015

*Revenue Code 101 [Search]

HCPCS/HIPPS Rate Codes [Search]

Modifiers [Search] [Search] [Search] [Search]

*Units 1.00

*Units Of Measurement Days

*Per Diem Rate $200.00

*Total Charges $0.00

Non Covered Charges $200.00

Medicaid Allowed Amount $0.00

Status PAID

NDC | Detail - Other Payer

Claim Submission

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

2015170357321

20	15	170	357	321
Region Code	Calendar Year	Julian Day	Claim Type/Batch Number	Number of Claim in Batch

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)
  - Primary Region Codes, continued
    - 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

- Special Billing Instructions-Eligibility Delay
  - If you are submitting a claim that is more than 365 days after the date of service due to a hearing decision or delay in eligibility determination you can submit the claim via the MITS
    - The claim must be submitted within 180 days of the hearing decision or eligibility determination

Claim Submission

- Eligibility Delay cont'd
  - In the Note Reference Code box select 'ADD'
  - In the Notes box enter the Hearing Decision or Eligibility Determination

Medicaid CoPay Amount	$0.00
Note Reference Code	**ADD**

Claim Submission

- Eligibility Delay cont'd
  - Hearing Decision: APPEALS XXXXXXX CCYYMMDD
    - XXXXXXX 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

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

Supporting Data for Delayed Submission / Resubmission

DISCLAIMER: Documentation to justify the use of this panel and data entered must be retained for future audit purposes.

Previously Denied ICN or TCN

Claim Submission

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

Claim Submission

- Claim Adjustment cont'd
  - 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'd
  - 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'd
  - Adjustment example:

2215180234001	Originally paid	$45.00
5815185127250	Now paid	$50.00
	Additional payment	$5.00

2015172234001	Originally paid	$50.00
5015173127250	Now paid	$45.00
	Account Receivable	($5.00)

Claim Submission

- Claim Adjustment cont'd
  - 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'd
  - Void example:

2215103234001	Originally paid $45.00
5815115127250	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'd
  - 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

MITS

- Remittance Advices
  - All claims processed are available on the MITS portal
  - Weekly reports become available on Wednesdays

MITS

- Remittance Advices cont'd
  - Select Remittance Advice and click Search
  - To see all Remits don't enter specific data

Super User Providers Account Claims Eligibility Prior Authorization Reports Publications

Provider Reports

*Report: REMITTANCE ADVICE

Payment Date:

RA Number:

Check/EFT Number:

search clear

Please select the row to show the report

RA Number	Part Number	RA Date
14656175	1	04/01/2015
14638898	1	03/25/2015
14621963	1	03/18/2015
14604512	1	03/11/2015
14587213	1	03/04/2015
14569996	1	02/25/2015
14553184	1	02/18/2015
14535844	1	02/11/2015
14518374	1	02/04/2015
14500932	1	01/28/2015

MITS

- Remittance Advices cont'd
  - 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

MITS

- Remittance Advices cont'd
  - 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

MITS

- Remittance Advices cont'd
  - 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 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

Forms

Forms

- ODM 09400- ICF-IID Payment Requests
  - Formerly called Nursing Facility Payment and Adjustment Authorization
  - Being accepted through 6/30/17 for resolution of DOS prior to 7/1/15
- ODM 09401- Facility CDJFS Transmittal
- ODM 09402- Extended Bed Hold Day(s) Prior Authorization
- ODM 09405- Personal Needs Allowance Remittance Notice
- ODM 03622- Preadmission Screening/Resident Review (PAS/RR) Identification Screen
- ODM 06614- Health Insurance Fact Request

http://www.Medicaid.Ohio.gov/Resources/Publications/MedicaidForms

Questions