

# Ohio Department of Medicaid

## Provider Frequently Asked Questions

### GENERAL INFORMATION

#### 1. How can I get directly to an Operator for assistance?

Please call the IVR at 1-800-686-1516 and follow the prompts

#### 2. Does the IVR give Managed Care Organization (MCO) information?

The IVR will give you the name of the MCO the consumer is enrolled in.

#### 3. What information should I have on hand when wanting to speak to a representative?

Please have the following on hand:

7 digit Ohio Medicaid Provider number, NPI, EIN and/or SSN

The internal control number (ICN) found on your remittance advice and other pertinent information related to your call

#### 4. Do Providers need to notify Ohio Medicaid of address changes?

Yes, per the Medicaid Provider agreement, a Provider must inform Provider Enrollment at 1-800-686-1516 within thirty days of any

changes in:

- licensure
  - certification or registration status
  - ownership
  - specialty
  - additions, deletions or replacements in group membership \_
- hospital-based physicians
- address changes (MITS portal only)

#### 5. How does a hospice provider enroll a recipient on the MITS Provider Portal?

There are instructions and screenshots on the Medicaid website. They are located at the following link:

<https://medicaid.ohio.gov/Portals/0/Providers/ProviderTypes/Hospice/Hospice-Enrollment-Guide.pdf?ver=2017-10-05-113146-660>

#### 6. Who should I contact when I have questions about revalidation?

Provider Enrollment at 1-800-686-1516. Select option 2 option 2 option 0.

### CLAIMS INFORMATION

#### 1. As a Provider, am I allowed to bill the patient for missed appointments?

Per Centers for Medicare & Medicaid Services (CMS), providers are **NOT** permitted to bill patients for missed appointments. CMS Chicago Regional State Letter # 36-95

#### 2. What is National Provider Identifier (NPI)?

NPI is the National Provider Identifier, a HIPAA requirement. The NPI will be used by healthcare providers in filing and processing claims and other related transactions.

#### 3. What is the Ohio Medicaid Payer ID for Electronic Data Interchange (EDI)?

The Ohio Medicaid Payer ID (receiver Id) is MMISODJFS

#### 4. How long do I have to submit a claim?

Original claims must be received by Ohio Department of Medicaid (ODM) within 365 days of the actual date the service was provided.

Inpatient hospital claims must be received within 365 days from the date of discharge. The "date of receipt" is the date ODM assigns an internal control number (ICN). Claims received beyond three hundred sixty-five days from the actual date of service or hospital discharge will be denied except:

When submission of a claim is delayed due to the pendency of an administrative hearing decision by ODM or an eligibility determination by a county department of job and family services (CDJFS), the claim must be received within 180 days from the date of the administrative hearing decision by ODM or the eligibility determination by the CDJFS, or

When a claim cannot be submitted to ODM within 365 days of the actual date of service due to coordination of benefits delays with Medicare and/or other third party payers, the claim must be received by ODM within 180 days from the date Medicare or the other insurance plan paid the claim. (OAC Rule 5160-1-19)

#### 5. When is the Recipient liable?

Medicaid payment is payment-in-full. The Provider may not collect and/or bill the consumer for any difference between the Medicaid payment and the provider's charge or request the consumer to share in the cost through a deductible, coinsurance, copayment or other similar charge, other than Medicaid co-payments. The provider may not charge the consumer a down payment, refundable or otherwise. Providers may not bill the consumers in lieu of ODM unless:

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 the consumer agrees to be liable and signs a written statement to that effect, prior to the service being rendered, and 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. (OAC Rule 5160-1-13.1)

**6. Does Ohio Medicaid cover for an oral interpreter or sign language interpreter?**

Ohio Medicaid does not pay for an oral interpreter or sign language interpreter.

**7. What is the difference between “Prior Authorization (PA) and Pre-Certification”?**

Reimbursement for some items and/or services covered under the Medicaid program is available only upon obtaining prior authorization. (OAC Rule 5160-1-31) Or, for procedures that are normally considered non-covered and must be reviewed for medical necessity.

Pre-Certification is determined by a contractor to assure that covered medical and psychiatric services, and covered surgical procedures are medically necessary and are provided in the most appropriate and cost effective setting.

(OAC Rule 5160-2- 40)

**8. If my Medicaid provider number is inactive/terminated, will I be able to access information on the IVR or the MITS portal?**

After a provider number is inactive/terminated, the MITS administrator can access information for one year on the MITS portal or by calling the IVR, but agents will not be able to access any information on an inactive/terminated provider number.

**9. Who do I contact when the recipient is enrolled in MyCare?**

**MyCare Plan Toll-Free Number Website**

AETNA 855-364-0974 [www.aetnabetterhealth.com/ohio](http://www.aetnabetterhealth.com/ohio)

BUCKEYE 866-296-8731 [www.buckeyehealthplan.com](http://www.buckeyehealthplan.com)

CARESOURCE 855-475-3163 [www.CareSource.com/MyCare](http://www.CareSource.com/MyCare)

MOLINA 855 322-4079 [www.molinahealthcare.com/duals](http://www.molinahealthcare.com/duals)

UNITEDHEALTHCARE 800-600-9007 [www.uhcprovider.com/Ohio](http://www.uhcprovider.com/Ohio)

**10. What is ORP?**

Ohio Medicaid will now require that all claims list the name as the provider is enrolled in MITS and the National Provider Identifier (NPI) of the health care professional that **ordered, referred or prescribed** (ORP) the items or services. This information is required due to changes in federal and state law. If ORP information is not listed on a claim, the billing Medicaid provider will not receive reimbursement for their services. This means that some health care professionals that are not currently enrolled with Ohio Medicaid will need to submit an application. (OAC Rule 5160-1-17.9)

**MEDICAID PROGRAM INFORMATION**

**3. What does Qualified Medicare Beneficiary (QMB) on the medical card mean?**

This card is issued to qualified consumers who receive Medicare. Medicaid covers only monthly Medicare Part B premiums, coinsurance

and/or deductible after Medicare has paid. (OAC Rule 5160:1-3-01.1)

**4. What do Benefit Plans Specified Low-income Medicare Beneficiary (SLMB) and Qualified Individuals QI1 and QI2) cover?**

These plans cover Part B premium ONLY. They are not Medicaid Eligible. There is no claim coverage.

**5. What is Presumptive Eligibility for Pregnant Women?**

Section 5111.0124 of Amended Substitute House Bill 153 of the 129th General Assembly establishes a program of presumptive Medicaid eligibility for pregnant women. Eligibility under this category is time-limited, and is limited in scope to outpatient prenatal care; this category does not cover labor and delivery or any other inpatient hospitalization. (OAC Rule 5160:1-2-50)

**6. What is the Program of All-Inclusive Care for the Elderly (PACE)?**

PACE is a managed care model that provides participants with all of their needed health care, medical care and ancillary services in acute, sub-acute, institutional and community settings. Services include primary and specialty care, adult day health services, personal care services, inpatient hospital, prescription drug, occupational and physical therapies and nursing home care. To be eligible for PACE, participants must be age 55 or older, live in the Cleveland area and, if seeking Medicaid assistance, qualify for coverage under the institutional financial eligibility standards (participants can be private-pay). Participants also must need an intermediate or skilled level of care and be willing to receive all of their care from PACE program providers. In addition, participants must be able to remain safely in a community setting at the time of initial enrollment. (OAC Rule 5160-36)