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

External Business Relations
Ohio Medicaid Services

Alison Barr
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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

- 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](mailto: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
Ohio Medicaid

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

Provider Responsibilities

- Ohio Medicaid Website: [www.Medicaid.ohio.gov](http://www.Medicaid.ohio.gov)
Provider Responsibilities

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 of 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

Related Content

- Benefit Coordination & Recovery
- Fee Schedules/Rates
- Forms
- MITS ECRMS Cover Page
- Instructions
- Healthplan 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

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

Email List Sign-up

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- 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
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](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
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
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

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**PROCEDURE**

// INPATIENT ONLY //

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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:
  ▪ 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

- 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

.datasource

- 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

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

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

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 services to Medicaid consumers.

Provider Setup/Registration
If you have a 7 digit Ohio Medicaid Provider Number, click here to register for MITS access.

Agent Setup
If you are a provider employee or doing work on behalf of a provider, click here to set up your agent account.

Quick Links
- Enroll as a HOME Choice provider
- OHP Provider Page

START HERE
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 01/01/2009, 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
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:

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

Register  Cancel

* required
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 Panel](image)
MITS

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

- Agent Account Setup cont’d
  - Select the default provider
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
Eligibility Verification Request
## Eligibility Search

- Eligibility Verification Request-results

### Recipient Information
- Medicaid Billing Number
- Last Name
- First Name
- Gender
- Date of Birth
- Date of Death

### County Office
- SSN: GALLIA
- County of Residence: GALLIA
- County of Eligibility: GALLIA

### 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>Medicaid</td>
<td>05/01/2015</td>
<td>06/17/2015</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>MRDD Targeted Case Mgmt</td>
<td>05/01/2015</td>
<td>06/17/2015</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Alcohol and Drug Addiction Services</td>
<td>05/01/2015</td>
<td>06/17/2015</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Ohio Mental Health</td>
<td>05/01/2015</td>
<td>06/17/2015</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
</tbody>
</table>
Eligibility Search

- Eligibility Verification Request-results cont’d

### Case/Cat/Seq Spenddown

<table>
<thead>
<tr>
<th>Monthly Amount</th>
<th>Effective Date</th>
<th>End Date</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0.00</td>
<td>05/01/2015</td>
<td>06/17/2015</td>
<td>RECURRING</td>
</tr>
</tbody>
</table>

**TPL**

***No rows found***

**Managed Care**

***No rows found***

**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>NRC</th>
</tr>
</thead>
<tbody>
<tr>
<td>PART A</td>
<td>05/01/2015</td>
<td>06/17/2015</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PART B</td>
<td>05/01/2015</td>
<td>06/17/2015</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PART D</td>
<td>05/01/2015</td>
<td>05/31/2015</td>
<td>COMMUNITY CCRX BASIC (POP)</td>
<td>083</td>
<td>28236746C1</td>
</tr>
<tr>
<td>PART D</td>
<td>05/01/2015</td>
<td>05/31/2015</td>
<td>CVS CAREMARK VALUE (POP)</td>
<td>028</td>
<td>28236746C1</td>
</tr>
<tr>
<td>PART D</td>
<td>05/01/2015</td>
<td>05/31/2015</td>
<td>LIMITED INCOME NET PROGRAM</td>
<td>001</td>
<td>28236746C1</td>
</tr>
</tbody>
</table>

### Service Limitation

***No rows found***

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

### Level of Care Determinations

<table>
<thead>
<tr>
<th>LOC Requested</th>
<th>Status</th>
<th>Determination Date</th>
<th>LOC Determination</th>
<th>LOC Begin Date</th>
<th>LOC End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>UNKNOWN LEVEL OF CARE</td>
<td>05/01/2015</td>
<td>05/31/2015</td>
</tr>
</tbody>
</table>

### Patient Liability

<table>
<thead>
<tr>
<th>Financial Payor</th>
<th>Monthly Amount</th>
<th>Type</th>
<th>Effective Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>DEFAULT</td>
<td>$644.00</td>
<td>Nursing Home</td>
<td>05/01/2015</td>
<td>06/30/2015</td>
</tr>
</tbody>
</table>

### Long Term Care Facility Placements

<table>
<thead>
<tr>
<th>Facility Type</th>
<th>Date of Admission</th>
<th>Effective Begin Date of Medicaid Coverage</th>
<th>End Date of Medicaid Coverage</th>
<th>Date of Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>STATE OPERATED ICF-MR</td>
<td>05/27/2003</td>
<td>05/27/2003</td>
<td>12/31/2099</td>
<td>12/31/2099</td>
</tr>
</tbody>
</table>

### 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](http://medicaid.ohio.gov/PROVIDERS/Billing/HIPAAandEDIInformation.aspx)

- Companion Guides

- 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
Claim Submission

Submission of an Institutional Claim cont’d

<table>
<thead>
<tr>
<th>Sequence</th>
<th>Diagnosis Code</th>
<th>Description</th>
<th>Present on Admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

Header - Other Payer

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

**No rows found**

Detail

<table>
<thead>
<tr>
<th>HCPCS/HCPCS</th>
<th>Rate Code</th>
<th>Units</th>
<th>Total Charges</th>
<th>Non Covered Charges</th>
<th>Medicaid Allowed Amount</th>
<th>Status</th>
<th>Modifier 1</th>
<th>Modifier 2</th>
<th>Modifier 3</th>
<th>Modifier 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item 1</td>
<td></td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

Attachments

**No rows found**

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 ICH or TCR

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

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

<table>
<thead>
<tr>
<th>Search Results</th>
<th>Effective Date</th>
<th>End Date</th>
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</thead>
<tbody>
<tr>
<td>30</td>
<td>STILL PATIENT</td>
<td>01/01/1900</td>
</tr>
<tr>
<td>40</td>
<td>EXPIRED AT HOME</td>
<td>01/01/1900</td>
</tr>
<tr>
<td>41</td>
<td>EXPIRED IN A MEDICAL FACILITY (E.G. HOSPITAL, SNF, I)</td>
<td>01/01/1900</td>
</tr>
<tr>
<td>42</td>
<td>EXPIRED - PLACE UNKNOWN</td>
<td>01/01/1900</td>
</tr>
<tr>
<td>43</td>
<td>DISCHARGED/TRANSFERRED TO A FEDERAL HEALTH CARE FACILITY</td>
<td>01/01/1900</td>
</tr>
<tr>
<td>50</td>
<td>HOSPICE - HOME</td>
<td>01/01/1900</td>
</tr>
<tr>
<td>51</td>
<td>HOSPICE - MEDICAL FACILITY (CERTIFIED) PROVIDING HOS</td>
<td>01/01/1900</td>
</tr>
<tr>
<td>61</td>
<td>DISCHARGED/TRANSFERRED TO A HOSPITAL-BASED MEDICARE</td>
<td>01/01/1900</td>
</tr>
<tr>
<td>62</td>
<td>DISCHARGED/TRANSFERRED TO AN INPATIENT REHABILITATION</td>
<td>01/01/1900</td>
</tr>
<tr>
<td>63</td>
<td>DISCHARGED/TRANSFERRED TO A MEDICARE CERTIFIED LONG</td>
<td>01/01/1900</td>
</tr>
</tbody>
</table>

< Previous 1 2 3 4 Next >
Claim Submission

- Patient Status Codes cont’d

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

<table>
<thead>
<tr>
<th>Patient Status</th>
<th>Description</th>
<th>Effective Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>85</td>
<td>DISCHARGED/TRANSFERRED TO HOME UNDER CARE OF ORGANIZ</td>
<td>10/01/2013</td>
<td>12/31/2299</td>
</tr>
<tr>
<td>87</td>
<td>DISCHARGED/TRANSFERRED TO COURT/LAW ENFORCEMENT WITH</td>
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<td>12/31/2299</td>
</tr>
<tr>
<td>88</td>
<td>DISCHARGED/TRANSFERRED TO A FEDERAL HEALTH CARE FACI</td>
<td>10/01/2013</td>
<td>12/31/2299</td>
</tr>
<tr>
<td>89</td>
<td>DISCHARGED/TRANSFERTED TO A HOSPITAL BASED MEDICARE</td>
<td>10/01/2013</td>
<td>12/31/2299</td>
</tr>
<tr>
<td>90</td>
<td>DISCHARGED/TRANSF TO INPATIENT REHAB FACILITY (RF)</td>
<td>10/01/2013</td>
<td>12/31/2299</td>
</tr>
<tr>
<td>91</td>
<td>DISCHARGED/TRANSFERRED TO A MEDICARE CERTIFIED LON</td>
<td>10/01/2013</td>
<td>12/31/2299</td>
</tr>
<tr>
<td>92</td>
<td>DISCHARGED/TRANSFERRED TO NURSING FACILITY CERTIFIED</td>
<td>10/01/2013</td>
<td>12/31/2299</td>
</tr>
<tr>
<td>93</td>
<td>DISCHARGED/TRANSFERRED TO A PSYCHIATRIC HOSPITAL OR</td>
<td>10/01/2013</td>
<td>12/31/2299</td>
</tr>
<tr>
<td>94</td>
<td>DISCHARGED/TRANSFERRED TO A CRITICAL ACCESS HOSPITAL</td>
<td>10/01/2013</td>
<td>12/31/2299</td>
</tr>
<tr>
<td>95</td>
<td>DISCHARGED/TRANSFERRED TO ANOTHER TYPE OF HEALTH CAR</td>
<td>10/01/2013</td>
<td>12/31/2299</td>
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</tbody>
</table>
Claim Submission

- Admit Type Codes

<table>
<thead>
<tr>
<th>Admit Type</th>
<th>Description</th>
<th>Effective Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>EMERGENCY</td>
<td>01/01/1900</td>
<td>12/31/2299</td>
</tr>
<tr>
<td>2</td>
<td>URGENT</td>
<td>01/01/1900</td>
<td>12/31/2299</td>
</tr>
<tr>
<td>3</td>
<td>ELECTIVE</td>
<td>01/01/1900</td>
<td>12/31/2299</td>
</tr>
<tr>
<td>4</td>
<td>NEWBORN</td>
<td>01/01/1900</td>
<td>12/31/2299</td>
</tr>
<tr>
<td>5</td>
<td>TRAUMA</td>
<td>01/01/1900</td>
<td>12/31/2299</td>
</tr>
<tr>
<td>9</td>
<td>INFORMATION NOT AVAILABLE</td>
<td>01/01/1900</td>
<td>12/31/2299</td>
</tr>
</tbody>
</table>
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

Monthly patient liability amount goes here
Claim Submission

Example #1 Standard Claim cont’d
Claim Submission

Example #1 Standard Claim cont’d

**Attachments**

***No rows found***

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

**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**

<table>
<thead>
<tr>
<th>Detail</th>
<th>Error</th>
<th>EOB Code</th>
<th>EOB Description</th>
<th>CARC</th>
<th>Amount</th>
<th>CARC Description</th>
<th>RARC</th>
<th>RARC Description</th>
</tr>
</thead>
</table>
## Claim Submission

### Example #2 Acuity Level Claim

<table>
<thead>
<tr>
<th>Sequence</th>
<th>Value</th>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>24</td>
<td>MEDICARE RATE CODE</td>
<td>5.00</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Sequence</th>
<th>Diagnosis Code</th>
<th>Description</th>
<th>Present on Admission</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>25000</td>
<td>DME WO CMP NT ST UNCTR</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Item</th>
<th>Date of Service</th>
<th>Revenue Code</th>
<th>HCPCS/HCPCS Rate Codes</th>
<th>Units</th>
<th>Total Charges</th>
<th>Non Covered Charges</th>
<th>Medicaid Allowed Amount</th>
<th>Status</th>
<th>Modifier</th>
<th>Modifier</th>
<th>Modifier</th>
<th>Modifier</th>
<th>Modifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>07/16/2015</td>
<td>183</td>
<td></td>
<td>16.00</td>
<td>$4,424.04</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>PAID</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>07/01/2015</td>
<td>101</td>
<td></td>
<td>15.00</td>
<td>$4,144.35</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>PAID</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

## Diagram

De Morgan's Law

\[
\overline{A \cap B} = \overline{A} \cup \overline{B}
\]

[Diagram of De Morgan's Law]

---

**Ohio Department of Medicaid**
Claim Submission

Example #3 Pediatric Ventilator Claim

<table>
<thead>
<tr>
<th>Occurrence/Span</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>From Date</td>
<td>10/06/2014</td>
</tr>
<tr>
<td>To Date</td>
<td>10/10/2014</td>
</tr>
</tbody>
</table>

**Diagnosis**

- **Principal Diagnosis Code:** E119
- **Type:** DIABETES MELLITUS WITHOUT COMPLICATIONS

**Details**

<table>
<thead>
<tr>
<th>Item</th>
<th>Date of Service</th>
<th>Revenue Code</th>
<th>HCPCS/HCPS</th>
<th>Rate Code</th>
<th>Units</th>
<th>Total Charges</th>
<th>Non Covered Charges</th>
<th>Medicaid Allowed Amount</th>
<th>Status</th>
<th>Modifier 1</th>
<th>Modifier 2</th>
<th>Modifier 3</th>
<th>Modifier 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>10/06/2015</td>
<td>410</td>
<td></td>
<td></td>
<td>5.00</td>
<td>$1,000.00</td>
<td>$0.00</td>
<td>$1,500.00</td>
<td>PAID</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>10/06/2015</td>
<td>410</td>
<td></td>
<td></td>
<td>5.00</td>
<td>$1,000.00</td>
<td>$0.00</td>
<td>$1,500.00</td>
<td>PAID</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Units of Measurement**

- **Units:** 5.00
- **Per Diem Rate:** $300.00
- **Total Charges:** $1,500.00
- **Non Covered Charges:** $0.00
- **Medicaid Allowed Amount:** $1,500.00
- **Status:** PAID
Claim Submission

- Example #4 Discharge/Death Claim
Claim Submission

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

<table>
<thead>
<tr>
<th>Item</th>
<th>Date of Service</th>
<th>Revenue Code</th>
<th>Units</th>
<th>Total Charges</th>
<th>Non Covered Charges</th>
<th>Medicaid Allowed Amount</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>08/01/2015</td>
<td>101</td>
<td>9.00</td>
<td>$1,800.00</td>
<td>$0.00</td>
<td>$2,372.58</td>
<td>PAID</td>
</tr>
<tr>
<td>2</td>
<td>08/10/2015</td>
<td>101</td>
<td>1.00</td>
<td>$0.00</td>
<td>$200.00</td>
<td>$0.00</td>
<td>PAID</td>
</tr>
</tbody>
</table>

*Units: 9.00
*Units Of Measurement: Days
*Per Diem Rate: $200.00
*Total Charges: $1,800.00
Non Covered Charges: $0.00
Medicaid Allowed Amount: $2,372.58
Status: PAID
Claim Submission

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

- Internal Control Number (ICN)
  - The ICN replaced the Transaction Control Number (TCN)
  - All claims will be assigned an ICN
    2015170357321

<table>
<thead>
<tr>
<th>Region Code</th>
<th>Calendar Year</th>
<th>Julian Day</th>
<th>Claim Type/Batch Number</th>
<th>Number of Claim in Batch</th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td>15</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)
  - 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](image)

$0.00

Note Reference Code: ADD
Claim Submission

- Eligibility Delay cont’d
  - Hearing Decision: **APPEALS XXXXXXXX CCYYMMDD**
    - XXXXXXXX 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 TCN 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
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

Questions