



**Department of
Medicaid**

John R. Kasich, Governor
Barbara R. Sears, Director

Basic Billing for Acupuncturists

External Business Relations

Ombudsman Unit

February 8, 2018

Ohio Medicaid Services

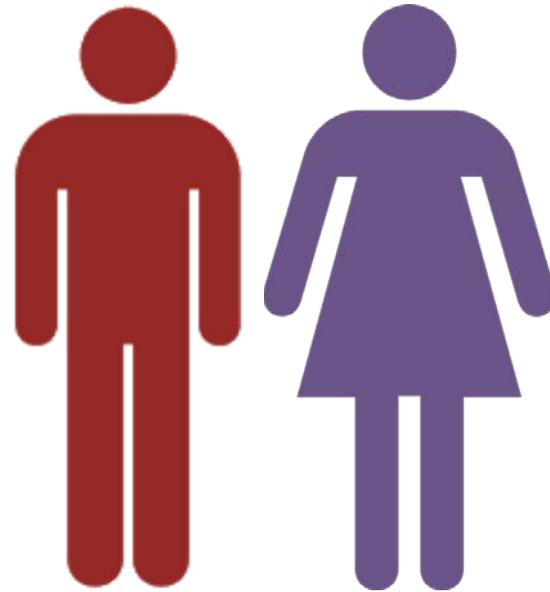
- Agenda

- » Ohio Medicaid Services
- » Programs & Cards
- » Managed Care/MyCare Ohio
- » Provider Responsibilities
- » Policy

- » MITS
- » Claim Submission
- » Prior Authorization
- » Websites
- » Forms

Ohio Medicaid Services

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



Manager - Meagan Grove

Ohio Medicaid Services

- Ombudsmen:
 - » 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

- IVR 1-800-686-1516
 - »Calls directed through the IVR prior to accessing the customer call center staff
 - »Staff are available weekdays from 8:00 a.m. to 4:30 p.m.
 - »Providers will be required to enter two out of the following three pieces of data: tax ID, NPI, or 7 digit Ohio Medicaid provider number



Ohio Medicaid Services

- Helpful phone numbers

- » Adjustments

- 614-466-5080

- » OSHIP (Ohio Senior Health Insurance Information Program)

- 1-800-686-1578

- » Coordination of Benefits Section

- 614-752-5768

- 614-728-0757 (fax)



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



Ohio Medicaid Services

Medical Necessity: OAC 5160-1-01

Is the fundamental concept underlying the Medicaid Program



All services must meet accepted standards of medical practice

Programs & Cards

Programs & Cards

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

Tear on Perforation

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.

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

Ohio Medicaid

Ohio Department of Medicaid
medicaid.ohio.gov

Consumer Hotline: 1-800-324-8680
[or TTY 1-800-292-3572]

Tear on Perforation

Tear on Perforation

Programs & Cards

Supplemental Security Income (SSI)

- Automatically Eligible for Medicaid as long as eligible for SSI

Modified Adjusted Gross Income (MAGI)

- Children, parents, caretakers, and expansion

Aged, Blind, Disabled (ABD)

- 65+, or blind/disabled with no SSI

Programs & Cards

- Presumptive Eligibility

- » Covers children up to age 19 and pregnant women

- It has been 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

- Some members will receive a Presumptive Eligibility letter

Ohio | Benefits

Presumptive Eligibility

NAME
ADDRESS
CITY/STATE/ZIP CODE

The following individuals have temporary Medicaid coverage under Presumptive Eligibility (PE). The Qualified Entity (QE) has enrolled these persons based on the unverified self-declaration of the patient's pregnancy, and/or household income, U.S. citizenship or qualified alien status, and Ohio residency.

Coverage will stop unless the individuals' Medicaid applications are processed.

Any individuals not given temporary coverage may still file applications for full Medicaid coverage.

APPROVED:

Name (First, M.I., Last Name)	Date of Birth	PE Type	Date Coverage Begins	Medicaid ID
NAME	03/17/1981	PE PREGNANT	02/15/2015	111111111111

Programs & Cards

- Other members will receive a Presumptive Eligibility Card

<p>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.</p> <p>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 1-800-688-1516.</p> <p>Inpatient hospital services are not covered.</p> <p>Note: Use the Medicaid ID for all claim submissions.</p> <p>medicaid.ohio.gov</p> <p>Consumer's Signature: _____</p>	<p style="text-align: right;">Presumptive Medicaid</p> <hr/> <p>County BUTLER</p> <hr/> <p>Case Number 012345678910</p> <hr/> <p>Eligibility Begin Date 07/01/2013</p> <hr/> <p>Void After Date 08/30/2013</p> <hr/> <p>Ohio Department of Medicaid medicaid.ohio.gov</p> <p>Consumer Hotline: 1-800-324-8680 [or TTY 1-800-292-3572]</p> 
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Programs & Cards

Recipient Information



Medicaid Billing Number

SSN

Last Name

County of Residence

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 20170101: 10

Date of Death

Benefit / Assignment Plan

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

Case/Cat/Seq Spenddown

Programs & Cards



- Medicaid Pre-Release Enrollment Program
 - » Institutionalized individuals close to release are enrolled into a Medicaid Managed Care plan, prior to release
 - » Individual must agree and be eligible for the program
 - » MCP Care Manager will develop a transition plan
 - » Combined effort with ODRC, Ohio MHAS, ODH, and MCPs
 - » All DRC facilities activated by January 2017
 - » More than **20,000** individuals have benefited from this program

Programs & Cards

- Qualified Medicare Beneficiary (QMB)

- » Issued to qualified consumers who receive Medicare

- » Medicaid only covers their monthly Medicare premium, co-insurance and/or deductible after Medicare has paid

- Note: Co-insurance and/or deductible payments are based on the reimbursement policies currently set in place under 5160-1 General Provisions and could result in a payment of zero dollars



Programs & Cards

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

Programs & Cards

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



Programs & Cards

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

Managed Care/MyCare Ohio

Managed Care/MyCare Ohio

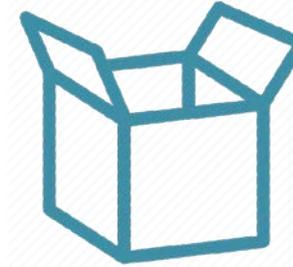
3 Population Groups Eligible for Managed Care

Medicaid Managed Care MAGI (CFC)

Medicaid Managed Care Non-MAGI (ABD)

Medicaid Managed Care Adult MAGI

- For the Adult Expansion Population



Managed Care

- Managed Care Benefit Package

- » Managed Care Plans must cover all medically necessary Medicaid covered services

- » Some value-added services:

- Care management to help members coordinate care and ensure they are getting the care that they need
- Access to toll-free 24/7 hotline for medical advice, staffed by nurses
- On-line searchable provider directory
- Preventative care reminders
- Expanded benefits including additional transportation options, and other incentives (varies among the MCPs)

Managed Care/MyCare Ohio

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

Managed Care/MyCare Ohio

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

Managed Care/MyCare Ohio

- How do you know if someone is enrolled in Managed Care?
 - » Providers need to check the MITS provider portal each time before providing services to a Medicaid recipient
 - » The MITS provider portal will show if a recipient is enrolled in a Managed Care Plan based on the eligibility dates of service you enter
 - » For recipients enrolled in a MyCare Ohio Managed Care plan it will show if they are enrolled for **Dual Benefits** or **Medicaid Only**

Managed Care

Benefit / Assignment Plan					
Benefit / Assignment Plan	Effective Date	End Date	Provider Name	Dental Co-Pay Amount	Vision Co-Pay Amount
MAGI-GROUP VIII:Alternative Benefit Plan Medicaid Expansion	01/01/2017	02/28/2017		\$0.00	\$0.00
MAGI-GROUP VIII:MRDD Targeted Case Mgmt	01/01/2017	02/28/2017		\$0.00	\$0.00
MAGI-GROUP VIII:Alcohol and Drug Addiction Services	01/01/2017	02/28/2017		\$0.00	\$0.00
MAGI-GROUP VIII:Ohio Mental health	01/01/2017	02/28/2017		\$0.00	\$0.00
MAGI-GROUP VIII:Medicaid	01/01/2017	02/28/2017		\$0.00	\$0.00
Case/Cat/Seq Spenddown					
*** No rows found ***					
TPL					
*** No rows found ***					
Managed Care					
Plan Name	Plan Description	Effective Date	End Date	Managed Care Benefits	
CARESOURCE	HMO, CFC	01/01/2017	02/28/2017		



Managed Care

Managed Care Sample Card



US Script
BIN#008019
Pharmacies call: 1-800-460-8988

Name:	Effective Date:
MMIS#:	DOB:
PCP Name:	PCP Phone #:

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

Managed Care

- Medicaid Managed Care Plan Contact Information
 - » Buckeye (Centene)
 - 866-296-8731 <http://www.buckeyehealthplan.com>
 - » Caresource
 - 800-488-0134 <http://www.CareSource.com/>
 - » Molina
 - 855-322-4079 <http://www.molinahealthcare.com>
 - » United HealthCare
 - 800-600-9007 <http://www.uhccommunityplan.com>
 - » Paramount
 - 419-887-2564 <mailto:advantagecompliance@promedica.org>

MyCare Ohio

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

MyCare Ohio

- MyCare Ohio Benefits



- » Package includes all benefits available through the traditional Medicare and Medicaid programs
 - Including Long Term Social Services (LTSS) and Behavioral Health, which is new to Managed Care

- » Plans may elect to include additional value-added benefits in their health care packages

MyCare Ohio

- MyCare Ohio Eligibility

- » In order to be eligible for MyCare Ohio an individual must be:

- Eligible for all parts of Medicare (Parts A, B, and D) and be fully eligible for Medicaid
- Over the age of 18
- Reside in one of the demonstration project regions

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

MyCare Ohio

Benefit / Assignment Plan					
Benefit / Assignment Plan	Effective Date	End Date	Provider Name	Dental Co-Pay Amount	Vision Co-Pay Amount
MRDD Targeted Case Mgmt	01/01/2017	02/28/2017		\$0.00	\$0.00
Alcohol and Drug Addiction Services	01/01/2017	02/28/2017		\$0.00	\$0.00
Ohio Mental health	01/01/2017	02/28/2017		\$0.00	\$0.00
Medicaid	01/01/2017	02/28/2017		\$0.00	\$0.00

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

TPL					
*** No rows found ***					

Managed Care					
Plan Name	Plan Description	Effective Date	End Date	Managed Care Benefits	
CARESOURCE	HMO, MyCare Ohio	01/01/2017	02/28/2017	Dual Benefits	

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

Medicare					
Coverage	Effective Date	End Date	Plan Name	Plan ID	HIC
PART A	01/01/2017	02/28/2017			
PART B	01/01/2017	02/28/2017			
PART C	01/01/2017	02/28/2017	CARESOURCE MYCARE OHIO	H8452	
PART D	01/01/2017	01/31/2017	*H8452/001	001	



MyCare Ohio

MyCare Ohio Opt-In Sample Card



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

MyCareOhio
Connecting Medicare + Medicaid

MedicareRx
Prescription Drug Coverage

RxBin: <RxBin #>
RxPCN: <RxPCN#>
RxBin: 012353
RxPCN: 06241400
RxID: <MC Amisys#-01>

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

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

MyCare Ohio

MyCare Ohio Opt-Out Sample Card



MyCareOhio
Connecting Medicare + Medicaid

Buckeye Community Health Plan - MyCare Ohio

Member Name: <Cardholder Name>
<Health Plan: <Card Issuer Identifier>>

MMIS Number: <Medicaid Recipient ID#2>

PCP Name: <PCP Name>
PCP Phone: <PCP Phone>

RxBin: 600428
RxPCN: 0624000
RxID: <RxID#3>

* Buckeye Medicaid Member Only *

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

Member Service: 866-549-8289
TTY: 800-750-0750

Eligibility Verification: <866-246-4358>

Behavioral Health Crisis: <866-549-8289>

Pharmacy Help Desk: <877-935-8021>

Care Management: <866-549-8289>

Claim Inquiry: <866-246-4358>

24-Hour Nurse Advice: <866-246-4358>
TTY: 800-750-0750

Website: <http://mmp.bchpohio.com>

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

*Note: Member is eligible for Medicare through original Medicare or another health plan. You must submit Medicare claims to the member's primary care insurance.

MyCare Ohio

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

Managed Care/MyCare Ohio

MCPs providing “Traditional” Medicaid Managed Care

- Buckeye (Centene)
- Caresource
- Molina
- United Healthcare
- Paramount

MCPs participating in MyCare Ohio (ICDs)

- Buckeye (Centene)
- Caresource
- Molina
- United Healthcare
- Aetna

MyCare Ohio

Northwest

Aetna
Buckeye

Fulton
Lucas
Ottawa
Wood

Southwest

Aetna
Molina

Butler
Warren
Clinton
Hamilton
Clermont

**West
Central**

Buckeye
Molina

Clark
Green
Montgomery

Central

Aetna
Molina

Union
Delaware
Franklin
Pickaway
Madison

**East
Central**

Caresource
United

Summit
Portage
Stark
Wayne

**Northeast
Central**

Caresource
United

Trumbull
Mahoning
Columbiana

Northeast

Caresource
Buckeye
United

Lorain
Cuyahoga
Lake
Geauga
Medina

Managed Care

- MyCare Contact Information

- » Buckeye (Centene)

- 866-296-8731 <http://www.bchpohio.com>

- » Caresource

- 800-488-0134 <http://www.CareSource.com/MyCare>

- » Molina

- 855-322-4079 <http://www.molinahealthcare.com/duals>

- » United HealthCare

- 800-600-9007 <http://www.Uhconnected.com/ohio>

- » Aetna

- 855-364-0974 <http://www.aetnabetterhealth.com/ohio>

Managed Care/MyCare Ohio

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

Managed Care/MyCare Ohio

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

Managed Care/MyCare Ohio

- Provider Complaints

- » Work directly with the Plan first

- » If not resolved, submit a complaint to Ohio Department of Medicaid (ODM)

- <http://www.ohiomh.com/ProviderComplaintForm.aspx>

- » Certification issues, work with the Area Agency on Aging (AAA) or ODM for MyCare Ohio waiver providers

- » Provider credentialing concerns can be sent to Ohio Department of Insurance (ODI)

Provider Responsibilities

Provider Responsibilities

- Provider Enrollment

- » There is a non-refundable application fee when an application is submitted to become a Medicaid provider
 - This is a federal requirement
 - The 2018 fee is \$569.00 per application
 - The fee applies to organizational providers only (not individual providers, practitioners, or practitioner groups)

Provider Responsibilities

- Provider Revalidation

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

Provider Responsibilities

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

Provider Responsibilities

- Provider Agreement: OAC 5160-1-17.2, cont.
 - » You also agree to:
 - Render medically necessary services in the amount required
 - Recoup any third party resources available
 - Inform us of any changes to your provider profile within 30 days
 - Abide by the regulations and policies of the state

Provider Responsibilities

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

Provider Responsibilities

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

Provider Responsibilities

- Medicaid Consumer Liability: OAC 5160-1-13.1, cont.
 - » 3 steps must be followed in order to bill a consumer
 - 1.** The consumer is notified in writing prior to the service being rendered that the provider will not bill the department for the covered service; and
 - 2.** The consumer agrees to be liable for payment of the service and signs a written statement to that effect prior to the service being rendered; and
 - 3.** The provider explains to the consumer that the service is a covered Medicaid service and that other Medicaid providers may render the service at no cost to the consumer

Provider Responsibilities

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

Provider Responsibilities

- Electronic Funds Transfer

- »ODM will start requiring Electronic Funds Transfer (EFT) for payment instead of paper warrants

- »Benefits of direct deposit include:

- Quicker funds-transferred directly to your account on the day paper warrants are normally mailed
- No worry-no lost or stolen checks or postal holidays delaying receipt of your warrant
- Address change-your payment will still be deposited into your banking account

<http://www.supplier.obm.ohio.gov/Update/Medicaid.aspx>

Provider Responsibilities

The screenshot shows the Ohio Department of Medicaid website. At the top left is the Ohio Department of Medicaid logo. To the right are utility links for text size and language selection. A dark blue navigation bar contains menu items: HOME, MEDICAID 101, FOR OHIOANS, PROVIDERS, INITIATIVES, NEWS, RESOURCES, CAREERS, and CONTACT. The main content area features a large blue banner with the Ohio Department of Medicaid logo and the text "Learn more about the state's first executive-level Medicaid agency." To the right is a "Director's Welcome" section with a video thumbnail of Barbara Sears, Director. Below this is a "Tweets" section showing a tweet from John Kasich about disposing of unused prescriptions. At the bottom are three blue boxes: "Managed Care Plans 2018 Report Card" (with a star icon), "Information for Independent Providers" (with a magnifying glass icon), and "Payment Innovation Ohio's SIM Grant" (with a lightbulb icon).

www.Medicaid.Ohio.Gov

Provider Responsibilities

The screenshot shows the Ohio Department of Medicaid website. At the top left is the Ohio Department of Medicaid logo. To the right, there are utility links for 'Text Size: +A -A', a 'Select Language' dropdown menu, and a 'Powered by Google Translate' notice with a 'Translation Disclaimer' link. Below this is a dark blue navigation bar with white text for 'HOME', 'MEDICAID 101', 'FOR OHIOANS', 'PROVIDERS' (which is highlighted), 'INITIATIVES', 'NEWS', 'RESOURCES', 'CAREERS', and 'CONTACT'. The main content area has a 'PROVIDERS' sub-header and a 'Welcome Providers' section. A paragraph explains that Ohio has over 83,000 active Medicaid providers and that the page will become a go-to resource for training, billing, and rate-setting. Below this is a 'Provider News' section with a bolded notice: 'Please listen carefully when calling the IVR as the options have changed as of 6/17/2016.' This is followed by a list of news items: 'ICF-IID 9400 Provider Notice', 'Managed Long-Term Services and Supports Stakeholder Meeting', 'Managed Long-Term Services and Supports Stakeholder Meeting Invitation (3/31/2017)', 'Notice Regarding Pregnancy Risk Assessment and Notification System (4/14/2017)', 'Timely Filing Reminder for ICF-IID Providers (6/29/2016)', 'Notice Regarding Provision of Progesterone (6/13/16)', and 'Independent Provider Overtime Rates - Effective January 1, 2016 (Rev. 4/1/16)'. On the right side, there is a 'Related Content' section with a list of links: 'Benefit Coordination & Recovery', 'Fee Schedules/Rates', 'Medicaid Forms', 'ODJFS Forms', 'MITS EDMS Cover Page' (with a sub-link for 'Instructions'), 'Healthchek Screening Forms', 'e-Manuals', 'Helpful Links', 'Get a National Provider Identifier (NPI)', 'Transmittal Letter Notification', 'Medicaid Provider Incentive Program (MPIP)', and 'ICD-10'. At the bottom right, there is a blue button with a gear icon and the text 'Access the MITS Portal'.

WWW.Medicaid.Ohio.Gov/Providers.aspx

Policy

Policy

- Policy Updates

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

- Medical Assistance Letter (MAL)
- Medicaid Transmittal Letters (MTL)

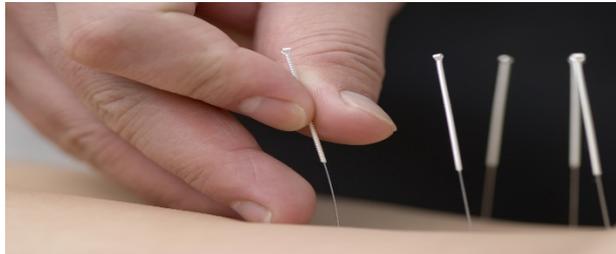
<http://medicaid.ohio.gov/RESOURCES/Publications/ODMGuidance.aspx#161542-medicaid-policy>

Policy

- Acupuncture Services: OAC 5160-8-51
 - » Providers that are eligible to receive payment for covered acupuncture service:
 - An acupuncturist
 - A recognized acupuncture provider
 - Ambulatory health care clinic as defined in OAC 5160-13
 - A federally qualified health center (FQHC)
 - Rural health clinic (RHC)
 - Professional medical group

Policy

- Acupuncture Services: OAC 5160-8-51, cont.
 - » Payment may be made for service that meets the following:
 - Is medically necessary per OAC 5160-1-01
 - Is performed at the written order of a practitioner, during the one year supervisory period, per section 4762.10 or 4762.11 of the Ohio Revised Code



Policy

- Acupuncture Services: OAC 5160-8-51, cont.
 - Is rendered by a practitioner who is enrolled in the Medicaid program
 - Is rendered for treatment of:
 - Low back pain
 - Migraine
- Payment for more than 30 visits per benefit year requires prior authorization

Policy

- Acupuncture Services: OAC 5160-8-51, cont.
 - » No separate payment will be made for both an evaluation & management service and acupuncture service rendered by the same provider to the same individual on the same day
 - » No separate payment is made for services that are an incidental part of a visit (e.g., providing instruction on breathing techniques, diet, or exercise)

Policy

- Acupuncture Services: OAC 5160-8-51, cont.
 - » No separate payment will be made for additional treatment in either of the following circumstances:
 - Symptoms show no evidence of clinical improvement after an initial treatment period
 - Symptoms worsen over a course of treatment

Procedure Codes

Code	Description	Payment
97810	Acupuncture, one or more needles, without electrical stimulation, initial 15 minutes of one-on-one contact with the patient.	\$25 per 15 minute increment
97811	Acupuncture, one or more needles, without electrical stimulation, each additional 15 minute increment of personal one-on-one contact with the patient, with reinsertion. (Listed separately in addition to primary code.)	\$17.50 per each additional 15 minute increment
97813	Acupuncture, one or more needles, with electrical stimulation, initial 15 minutes of one-on-one contact with the patient.	\$31.15 per 15 minute increment
97814	Acupuncture, one or more needles, with electrical stimulation, each additional 15 minute increment of personal one-on-one contact with the patient, with reinsertion. (Listed separately in addition to primary code.)	\$23.65 per each additional 15 minute increment

MIT

MIT S

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

MITS

- Technical Requirements

- » Internet Access (high speed works best)

- » Internet Explorer version 10 or higher and current versions of Firefox or Chrome

- » Mac users can use current versions of Safari, Firefox or Chrome

- » Turn OFF pop up blocker functionality

MITTS

- How do I access the MITTS Portal?
 - » Go to <http://Medicaid.ohio.gov>
 - » Select the “Provider Tab” at the top
 - » Click on the “MITTS Portal” on the right



Access the
MITTS Portal

MITS

Ohio
Department of Medicaid

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?](#)

MIT S

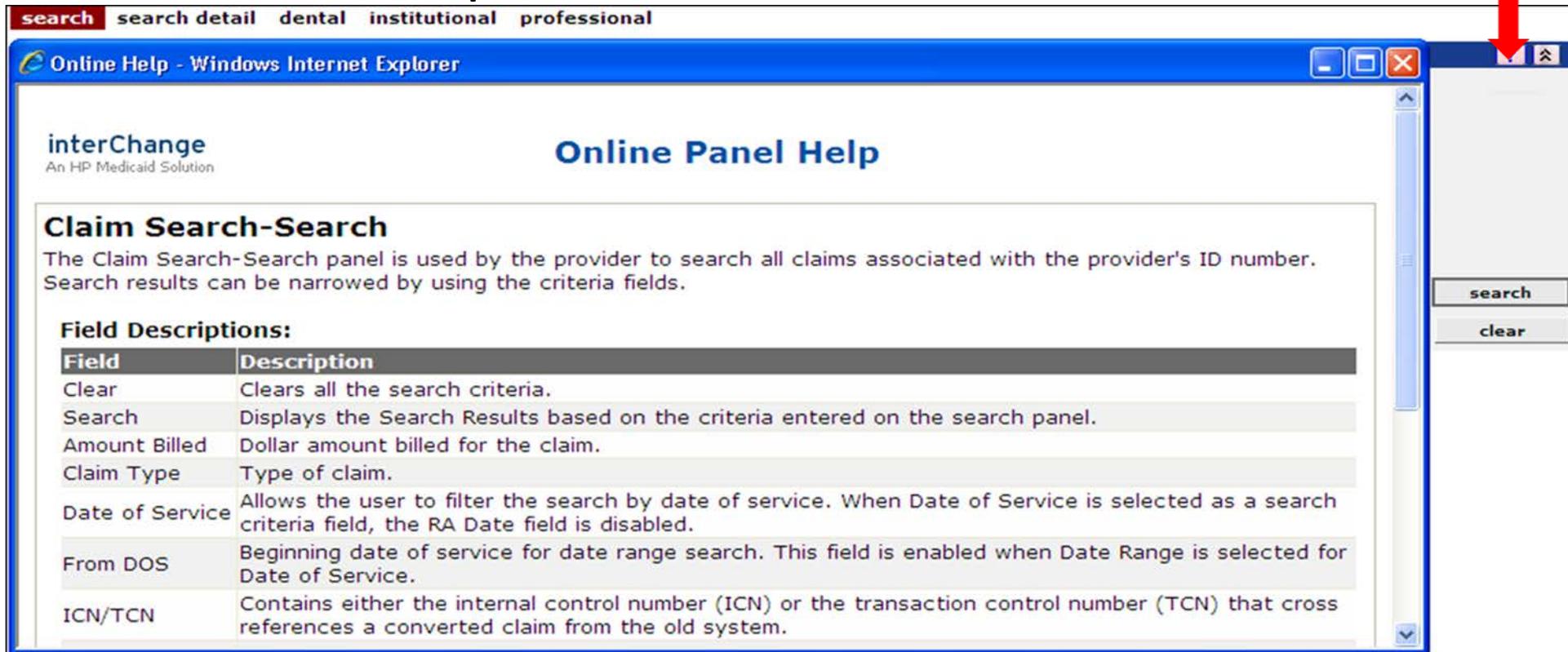
- MIT S Web Portal Navigation

- » The “Copy”, “Paste”, and “Print” features all work in the MIT S Portal
- » Do **NOT** use the previous page function (back arrow) in your browser
- » Do **NOT** use the enter key on the keyboard (use the Tab key or the mouse to move between fields)
- » MIT S Web Portal access will time-out after 15 minutes of inactivity in the system

MITs

- Panel Help

»The “?” button in the upper right corner of a panel may be selected to reveal panel information



The screenshot shows a web browser window titled "Online Help - Windows Internet Explorer". The page content includes the "interChange An HP Medicaid Solution" logo and the heading "Online Panel Help". Below this is a section titled "Claim Search-Search" with a descriptive paragraph: "The Claim Search-Search panel is used by the provider to search all claims associated with the provider's ID number. Search results can be narrowed by using the criteria fields." This is followed by a "Field Descriptions:" section containing a table with two columns: "Field" and "Description".

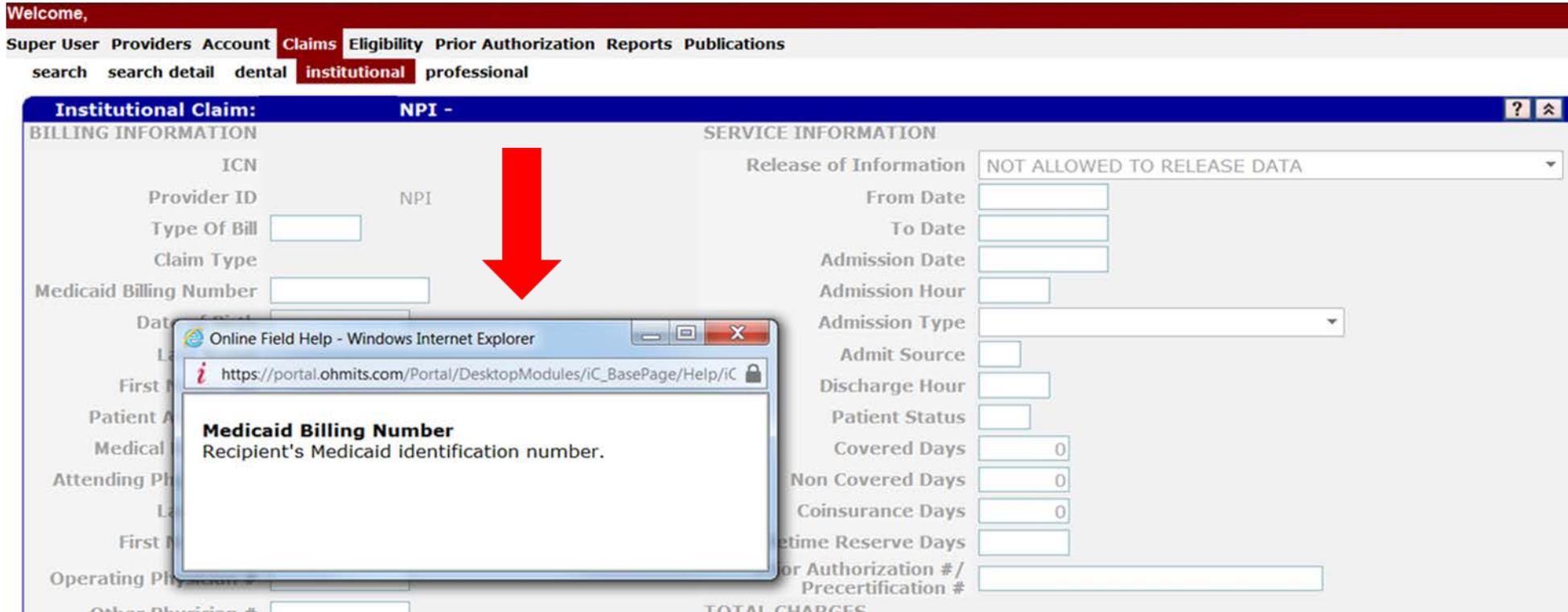
Field	Description
Clear	Clears all the search criteria.
Search	Displays the Search Results based on the criteria entered on the search panel.
Amount Billed	Dollar amount billed for the claim.
Claim Type	Type of claim.
Date of Service	Allows the user to filter the search by date of service. When Date of Service is selected as a search criteria field, the RA Date field is disabled.
From DOS	Beginning date of service for date range search. This field is enabled when Date Range is selected for Date of Service.
ICN/TCN	Contains either the internal control number (ICN) or the transaction control number (TCN) that cross references a converted claim from the old system.

On the right side of the browser window, there is a vertical sidebar with a "search" button and a "clear" button. A red arrow points to a question mark icon in the top right corner of the panel area.

MITs

- Field Help

»Clicking a field title will open a box containing field information



MITs

- Eligibility Search

- » Full Medicaid eligibility on the MITs portal will show four (or more) benefit spans:

- Medicaid
- MRDD Targeted Case Management
- Alcohol and Drug Addiction Services
- Ohio Mental Health

- » Additional spans when applicable:

- Alternative Benefit Plan, for Extension adults
- Medicaid School Program span, if applicable by age

MITS

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

MITs

- Eligibility Search



Welcome

[Super User](#) [Providers](#) [Cost Report](#) [Account](#) [Claims](#) [Episode Claims](#) **Eligibility** [Prior Authorization](#) [Reports](#) [Portal Admin](#) [Publications](#)

eligibility search [hospice enrollment](#)

Eligibility Verification Request



Medicaid Billing Number	<input type="text"/>	Birth Date	<input type="text"/>
SSN	<input type="text"/>	DOS Date Format	MM/DD/YYYY <input type="button" value="v"/>
Procedure Code	<input type="text"/>	From DOS	<input type="text" value="01/11/2018"/>
		To DOS	<input type="text" value="01/11/2018"/>

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

MITS

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



Welcome

[Super User](#) [Providers](#) [Cost Report](#) [Account](#) [Claims](#) [Episode Claims](#) **Eligibility** [Prior Authorization](#) [Reports](#) [Portal Admin](#) [Publications](#)

eligibility search hospice enrollment

Eligibility Verification Request			
Medicaid Billing Number	<input type="text"/>	Birth Date	<input type="text"/>
SSN	<input type="text"/>	DOS Date Format	MM/DD/YYYY <input type="button" value="v"/>
Procedure Code	<input type="text"/>	From DOS	01/12/2015 
		To DOS	01/11/2018
		<input type="button" value="search"/>	
		<input type="button" value="clear"/>	

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

MITs

- Eligibility Verification Request - results

Recipient Information	
Medicaid Billing Number	SSN
Last Name	County of Residence CUYAHOGA
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 Schools	01/01/2018	01/31/2018		\$0.00	\$0.00	
MRDD Targeted Case Mgmt	01/01/2018	01/31/2018		\$0.00	\$0.00	
Alcohol and Drug Addiction Services	01/01/2018	01/31/2018		\$0.00	\$0.00	
Ohio Mental health	01/01/2018	01/31/2018		\$0.00	\$0.00	
Medicaid	01/01/2018	01/31/2018		\$0.00	\$0.00	

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

TPL
*** No rows found ***

Managed Care					
Plan Name	Plan Description	Effective Date	End Date	Managed Care Benefits	
CARESOURCE	HMO, CFC	01/01/2018	01/31/2018		

MITTS

- Eligibility Verification Request - results, cont.

Lock-In

*** No rows found ***

Medicare

*** No rows found ***

Service Limitation

*** No rows found ***

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

Level of Care Determinations

*** No rows found ***

Patient Liability

*** No rows found ***

Long Term Care Facility Placements

*** No rows found ***

Recipient Restricted Coverage

*** No rows found ***

Special Program

*** No rows found ***

Claim Submission

Claim Submission

- Methods of Claim Submission

- » Electronic Data Interchange

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

- » MITS Web Portal

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

Claim Submission

- Electronic Data Interchange (EDI)

- » Information for Trading Partners

- <http://medicaid.ohio.gov/PROVIDERS/Billing/HIPAAandEDIInformation.aspx>

- » Companion Guides

- <http://medicaid.ohio.gov/PROVIDERS/MITS/HIPAA5010Implementation.aspx>

- » Technical Questions/EDI Support Unit

- Transitioned partners contact DXC EDI Support

- ❖ 844-324-7089

- ❖ OhioMCD-EDI-Support@dxc.com

Claim Submission

- Claim Submission
 - » Claim entry format is divided into sections or panels
 - » Each panel will have an asterisk (*) denoting that the fields are required
 - Some fields are situational for claims adjudication and do not have an asterisk

Claim Submission

- Submission of a Professional Claim



The screenshot shows the Ohio Medicaid Information Technology System website. The header includes the Ohio.gov logo and the text "Medicaid Information Technology System". A search bar is visible on the right. The main navigation menu includes "Super User", "Providers", "Account Trading Partners", "Claims", "Eligibility", "Prior Authorization", "Reports", "Portal Admin", "Security", and "Admin". The "Claims" menu is expanded, showing options for "Search", "Search Detail", "Dental", "Institutional", and "Professional". The "Professional" option is highlighted. Below the navigation menu, there is a "Claims" section with a list of links: "Search", "Search Detail", "Dental", "Institutional (for Inpatient, Outpatient, L", and "Professional".

Claim Submission

- Submission of a Professional Claim, cont.

Professional Claim: NPI -
? ↕

BILLING INFORMATION	SERVICE INFORMATION
<p>ICN</p> <p>Claim Received Date</p> <p>Claim Type M - PROFESSIONAL</p> <p>Provider ID NPI</p> <p>*Medicaid Billing Number <input type="text"/></p> <p>*Date of Birth <input type="text"/></p> <p>Last Name</p> <p>First Name, MI</p> <p>*Patient Account # <input type="text" value="0"/></p> <p>Medical Record # <input type="text"/></p> <p>Referring Provider # <input type="text"/></p> <p>Rendering ID <input type="text"/></p> <p>*Medicare Assignment NOT ASSIGNED <input type="checkbox"/></p> <p>Patient Amount Paid <input type="text" value="\$0.00"/></p> <p>*ICD Version 10 <input type="text"/></p>	<p>*Release of Information NOT ALLOWED TO RELEASE DATA <input type="checkbox"/></p> <p>From Date</p> <p>To Date</p> <p>Signature Source <input type="text"/></p> <p>Accident Related To <input type="text"/></p> <p>Accident State <input type="text"/></p> <p>Accident Country <input type="text"/> [Search]</p> <p>Accident Date <input type="text"/></p> <p>EPSDT Referral <input type="text"/></p> <p>Prior Authorization # <input type="text"/></p> <p>Hospital Discharge Date <input type="text"/></p> <p>Last Menstrual Period <input type="text"/></p> <p>TOTAL CHARGES</p> <p>Total Charges \$0.00</p> <p>Medicaid Allowed Amount \$0.00</p> <p>TPL Paid Amount \$0.00</p> <p>Total Medicaid Paid Amount \$0.00</p> <p>Medicaid CoPay Amount \$0.00</p> <p>Note Reference Code <input type="text"/></p> <p>Notes <input type="text"/></p>
Diagnosis	
*** No rows found ***	
Select row above to update -or- click add an item button below.	
<input type="button" value="delete"/> <input type="button" value="add an item"/>	
Header - Other Payer	
*** No rows found ***	
Select row above to update -or- click add an item button below.	
<input type="button" value="delete"/> <input type="button" value="add an item"/>	

Claim Submission

- Submission of a Professional Claim, cont.

Diagnosis

Sequence	Diagnosis Code	Description
A		

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

*Sequence *Diagnosis Code [Search]

Header - Other Payer

*** No rows found ***

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

Detail

Item	FDOS	Units	Charges	Medicaid Allowed Amount	Status	Place of Service	Procedure Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Final EAPG
A	1	0	\$0.00	\$0.00								

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

Item 1

*From DOS

To DOS

*Units

*Charges

Medicaid Allowed Amount \$0.00

Rendering Provider

Submitted EAPG

Initial EAPG

Status

*Place Of Service [Search]

*Procedure Code [Search]

Emergency

Referred EPSDT Service/
Family Planning

*Diagnosis Code
Pointer

Modifiers [Search] [Search]

[Search] [Search]

Final EAPG

Pay Action

NDC
Detail - Other Payer
ClaimCheck
Additional Provider Information

Claim Submission

- Diagnosis Codes

- »Are required on most claims

- ❖Must include the number of characters specified by ICD
 - ❖MITS does not accept decimal points, only enter numbers and letters
 - ❖System edits and audits will be applied to those codes

Claim Submission

- Detail panel

Detail													
Item	FDOS	Units	Charges	Medicaid Allowed Amount	Status	Place of Service	Procedure Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Final EAPG	
A	2	01/11/2018	3.00	\$90.00		11	97814						
A	1	01/11/2018	1.00	\$75.00		11	97813						

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

Item 2

***From DOS** 01/11/2018

To DOS 01/11/2018

***Units** 3.00

***Charges** \$90.00

Medicaid Allowed Amount \$0.00

Rendering Provider

Submitted EAPG

Initial EAPG

Status

Visit Start Time

Visit End Time

Service Duration less than 90 days

***Place Of Service** 11 [Search]

***Procedure Code** 97814 [Search]

Emergency

Referred EPSDT Service/ Family Planning

***Diagnosis Code Pointer** 01

Modifiers [Search] [Search]

[Search] [Search]

Final EAPG

Pay Action

Claim Submission

- Once all fields have been completed
 - » Click the “submit” button at the bottom right
 - » You may “cancel” the claim at anytime, but the information will not be saved in MITS



Claim Submission

- Adjudication will happen in “real time”, the claim status will show:
 - »Paid
 - »Denied
 - »Suspended

Claim Submission

- Internal Control Number (ICN)
 - »The ICN replaced the Transaction Control Number (TCN)
 - »Each claim will be assigned a separate ICN

2018170357321

20	18	170	357	321
Region Code	Calendar Year	Julian Date	Claim Type/Batch Number	Number of Claim in Batch

Claim Submission

- Internal Control Number (ICN), cont.
 - » Primary region codes on a new claim submission
 - 20** Electronic (EDI) 837 without attachment
 - 21** Electronic (EDI) 837 with an attachment
 - 22** Web Portal without attachment
 - 23** Web Portal with an attachment

Claim Submission

- Internal Control Number (ICN), cont.
 - » Additional primary region codes on a new claim submission
 - 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

- Portal Errors

- » If there are portal errors the claim status returned will be “NOT YET SUBMITTED” and the errors will be listed at the top of the claim submission screen
- » MITS will not accept a claim without all required fields completed

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

- Special Billing Instructions

- » This panel is used for claims over 365 days that meet timely filing requirements
- » Enter the previously denied ICN and select “DELAYED SUBMISSION/RESUBMISSION” in the Reason dropdown menu
- » 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 Reason

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 the individual's eligibility determination, you can submit the claim via the MITS Portal
 - The claim must be submitted within 180 days of the hearing decision or eligibility determination date

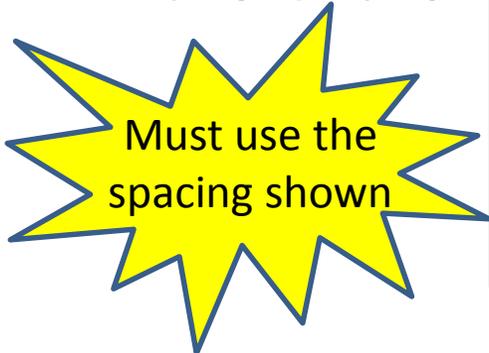
Claim Submission

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

Medicaid CoPay Amount	\$0.00
Note Reference Code	<input type="text"/>

Claim Submission

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



Claim Submission

- Medicare Denials

- » If Medicare issues a denial and indicates that the patient is responsible for the payment, submit the claim to ODM by following these steps:

- Enter the claim in MITS
- Do not enter any Medicare information on the claim
- Complete and upload a ODM 6653 form and a copy of the Medicare EOB

Claim Submission

- Attachment Panel

» This panel allows you to electronically upload an attachment onto your claim in MITS

Attachments

Type of Document	Transmission Type
A	

Type data below for new record.

For attachments submitted via mail, not electronically attached, please send to the appropriate address. A button for printing a cover page and a button to view mailing addresses will appear after the claim has been submitted.

For documents transmitted via Upload, an upload button will appear after the claim has been submitted. Only file types of gif, tiff, bmp, jpg, ppt, doc, xls, pdf, txt, and mdi can be uploaded.

*Type of Document

*Transmission Type

Claim Submission

- Attachment Panel, cont.
 - » Electronic attachments are accepted for Claims, Prior Authorization, Enrollment, and Re-enrollment processing
 - » Acceptable file formats:
 - BMP, DOC, DOCX, GIF, JPG, PDF, PPT, PPTX, TIFF, TXT, XLS, and XLSX
 - » Each attachment must be <50 MB in size
 - » Each file must pass an anti-virus scan in MITS
 - » A maximum of 10 attachments may be uploaded

Claim Submission

- Claim Adjustment

» Claims with a status of *Paid* can be:

- Adjusted
- Voided
- Copied

cancel

adjust

void

copy claim

Claim Submission

- Claim Adjustment, cont.

»To *adjust* a *Paid* claim:

- Open the claim requiring an adjustment
- Change and save the necessary information
- Click the “adjust” button



Claim Submission

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

Claim Submission

- Claim Adjustment, cont.

»Example:

2218180234001

Originally paid \$45.00

5818185127250

Now paid \$50.00

Additional payment of \$5.00

2018172234001

Originally paid \$50.00

5018173127250

Now paid \$45.00

Account receivable (\$5.00)

Claim Submission

- Claim Adjustment, cont.

»To **Void** a **Paid** claim:

- Open the claim you wish to void
- Click the “void” button at the bottom of the claim
- The status is flagged as “non-adjustable” in MITS
- An adjustment is automatically created and given a status of “denied”



Claim Submission

- Claim Adjustment, cont.

»Example:

2218180234001

Originally paid \$45.00

5818185127250

Account receivable (\$45.00)

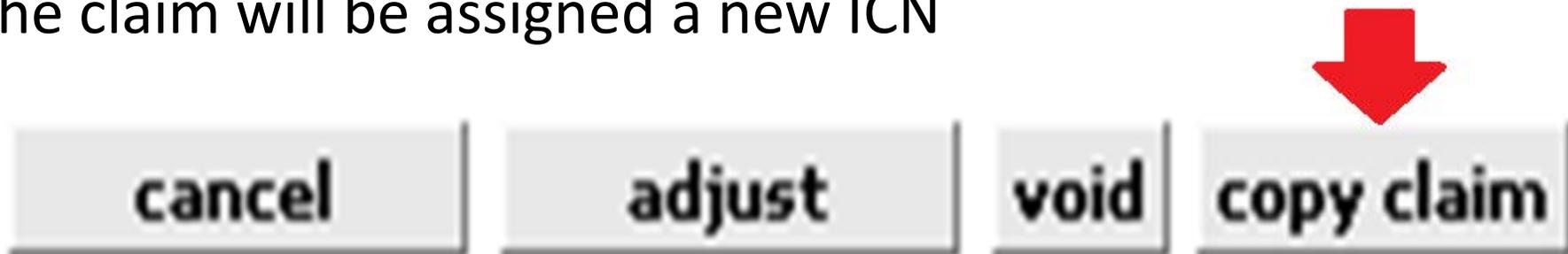
* Make sure to wait until ***after*** the weekend's adjudication cycle to submit a new, corrected, claim if one is needed

Claim Submission

- Claim Adjustment, cont.

»How to **Copy** a **Paid** claim:

- Open the claim you wish to copy
- Click the “copy claim” button at the bottom of the claim
- A new will be created, make and save all necessary changes
- The “submit” and “cancel” buttons will display at the bottom
- Click the “submit” button
- The claim will be assigned a new ICN



Claim Submission

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

Claim Submission

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



Claim Submission

- The National Correct Coding Initiative (NCCI), cont.
 - » Procedure to procedure (PTP) “Incidental” edit which determines whether a pair of procedure codes should not be reported together because one procedure is incidental to (performed as a natural consequence or adjunct to) the other
 - » Medically unlikely edit (MUE) determines whether the units of service exceed maximum units that a provider would be likely to report under most circumstances

Claim Submission

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

Claim Submission

- Coordination of Benefit Claims (COB), cont.
 - » Header level
 - A COB claim is considered to be adjudicated at the header/claim level if only one set of figures is reported for the entire claim
 - » Detail level
 - A COB claim is considered to be adjudicated at the line/detail level if figures are reported for each individual line item

Claim Submission

- X12 Website

- »The X12 website provides adjustment reason codes (ARCs) that must be entered on claims that involve other payers

- <http://www.x12.org/codes/claim-adjustment-reason-codes/>

- Some of the most common ARCs are:

- 1 (Deductible)

- 2 (Coinsurance)

- 3 (Co-payment)

- 45 (Contractual Obligation/Write-Off)

- 96 (Non-covered services)

Claim Submission

- Remittance Advice (RA)
 - »All claims processed are available on the MITS Portal
 - »Weekly reports become available on Wednesdays

The screenshot shows the MITS Portal interface. At the top, a red banner says "Welcome,". Below it is a navigation bar with links: Super User, Providers, Cost Report, Account, Claims, Eligibility, Prior Authorization, Reports (highlighted in red), Portal Admin, and Publications. The "Provider Reports" dropdown menu is open, showing a list of report types. A red arrow points to "REMITTANCE ADVICE" at the bottom of the list. To the right of the dropdown are "search" and "clear" buttons.

Provider Reports

*Report

- CPC (COMPREHENSIVE PRIMARY CARE REPORTS)
- EPISODE REPORTS SUMMARY (PDF) AND PATIENT DETAIL DATA(CSV)
- EPISODE REPORTS SUMMARY DATA(PDF) ONLY
- HOSPITAL COST SETTLEMENT REPORT
- PPR (POTENTIALLY PREVENTABLE READMISSIONS) REPORTS
- PRC (PROVIDER REPORT CARDS) REPORTS
- REMITTANCE ADVICE

search clear

Claim Submission

- Remittance Advice (RA), cont.
 - » Select “Remittance Advice” and click search twice
 - » To see all remits to date, don’t enter any specific data

Super User Providers Cost Report Account Claims Eligibility Prior Authorization **Reports** Portal Admin Publications

Provider Reports ? ^

*Report ▼

Payment Date

RA Number

Check/EFT Number

Please select the row to show the report

RA Number	Part Number	RA Date ▼
16161973	1	01/06/2018
16146862	1	12/30/2017
16145695	1	12/23/2017
16131620	1	12/22/2016
16116473	1	12/15/2016
16101611	1	12/08/2016
16086726	1	12/01/2016
16071717	1	11/25/2016
16056394	1	11/17/2016
16041108	1	11/10/2016

1 2 3 4 5 6 7 8 9 10 ... Next >

Claim Submission

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

Claim Submission

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

Claim Submission

- Remittance Advice (RA), cont.
 - » Informational pages
 - Banner messages provide updates to the provider community
 - » EOB code descriptions
 - Provides a comparison of the code descriptions that appeared on the claims
 - » TPL information
 - If a claim was not paid due to the individual having another payer source or third party liability (TPL), this section provides those insurer's information

Prior Authorization

Prior Authorization

- Prior Authorization (PA)
 - » All prior authorizations must be submitted via the MITS Portal
 - » PAs will not enter the queue for review until at least one attachment has been received
 - Medical notes should be uploaded
 - » Each panel will have an asterisk (*) denoting fields that are required
 - Some fields are situational and do not have an asterisk
 - » The “real time” status of a PA can be obtained in MITS

Prior Authorization

- Prior Authorization (PA), cont.
 - » Within the Prior Authorization subsystem providers can:
 - Submit a new Prior Authorization
 - Search for previously submitted Prior Authorizations
 - » Within the Prior Authorization panel providers can:
 - Attach documentation
 - Add comments to a Prior Authorization that is in a pending status
 - View reviewer comments
 - View Prior Authorization usage, including units and dollars used

Prior Authorization

- Prior Authorization (PA), cont.
 - » A PA will auto deny if supporting documentation is not received within 30 days (including EDMS coversheet and paper attachments)
 - » When reviewers request additional documentation to support the requested PA, the 30 day clock is reset

Prior Authorization

- Prior Authorization (PA), cont.
 - » External Notes Panel
 - Used by the PA reviewer to communicate to the provider
 - Multiple notes may reside on this panel
 - Panel is read-only for providers
 - » If a PA is marked approved with an authorized dollar amount of \$0.00, it will still pay at the Medicaid maximum allowable reimbursement rate

Websites

Websites

- Ohio Department of Medicaid home page

<http://Medicaid.ohio.gov>

- Ohio Department of Medicaid provider page

<http://Medicaid.ohio.gov/providers.aspx>

- MITS home page

<https://portal.ohmits.com/Public/Providers/tabId/43/Default.aspx>

- LAWriter

<http://codes.ohio.gov/oac/5160>

Forms

Forms

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

Questions

