Basic Billing for Dental Providers

External Business Relations
2018
AGENDA

- Medicaid Services
- Programs & Cards
- Managed Care/MyCare Ohio
- Provider Responsibilities
- Policy
- MITS & Claims
- Websites & Forms
External Business Relations Team
Sarah Bivens
Ava Cottrell
Ed Ortopan
Manager - Meagan Grove
Must enter two of the following: tax ID, NPI, or 7 digit Ohio Medicaid provider number.

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

Calls directed through the IVR prior to accessing the customer call center.

IVR:
1-800-686-1516
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)
Medicaid Medical Necessity: OAC 5160-1-01

Is the fundamental concept underlying the Medicaid Program

All Services must meet accepted standards of medical practice
Ohio Medicaid 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
Covered Services (not limited to)

- Acupuncture
- Behavioral Health
- Dental
- Dialysis
- Dietitian
- Durable Medical Equipment
- Home Health
- Private Duty Nursing
- Hospice
- Hospital (Inpatient/Outpatient)
- ICF-IID Facility
- Nursing Facility
- Pharmacy
- Physician
- Transportation
- Vision
PROGRAMS & CARDS
Ohio Medicaid

- This card is the traditional fee-for-service Medicaid card
- No longer issued monthly
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
Conditions of Eligibility and Verifications: OAC 5160-1-2-10

- Individuals must cooperate with requests from third-party insurance companies needing to authorize coverage.
- Individuals must cooperate with request from a Medicaid provider for information which is needed in order to bill third party insurances.
- Providers may contact the local CDJFS office to report non-cooperative individuals.
- CDJFS may terminate eligibility.
Full Medicaid eligibility on the MITS Portal will show **four** (or more) benefit spans:

1. Alcohol and Drug Addiction Services
2. MRDD Targeted Case Management
3. Ohio Mental Health
4. Medicaid

**Additional spans when applicable:**

- Alternative Benefit Plan - for extension adults
- Medicaid School Program - if applicable by age
Benefit Plan

- Medicare
- Level of Care
- Managed Care
- Long Term Care
- Third Party Liability
- Patient Liability
You can search up to 3 years at a time!!

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

### Recipient Information
- **Medicaid Billing Number**
- **Last Name**
- **First Name**
- **Gender**
- **Date of Birth**
- **Date of Death**
- **SSN**
- **County of Residence**: CUYAHOGA
- **County of Eligibility**: [County Office](http://jfs.ohio.gov/County/County_Directory.pdf)
- **Number Bed Hold Days Used Paid CY**

### 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>
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<tbody>
<tr>
<td>Medicaid Schools</td>
<td>01/01/2018</td>
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<tr>
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<td>Ohio Mental health</td>
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</tbody>
</table>

### Case/Cat/Seq Spenddown

***No rows found***
# Eligibility Verification Request

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</thead>
<tbody>
<tr>
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</tbody>
</table>

**County of Residence**: CUYAHOGA  

**County Office**: http://jfs.ohio.gov/County/County_Directory.pdf  

**Number Bed Hold Days Used Paid CY**: 

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**MRDD Targeted Case Mgmt**:  

**Alcohol and Drug Addiction Services**:  

**Ohio Mental health**:  

**Medicaid**:  

## Associated Child(ren)

<table>
<thead>
<tr>
<th>Medicaid Billing Number</th>
<th>First Name</th>
<th>MI</th>
<th>Last Name</th>
<th>Gender</th>
<th>Date of Birth</th>
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<tbody>
<tr>
<td>123456789012</td>
<td>AUDREY</td>
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<td>DOE</td>
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<td>9087654321012</td>
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## Eligibility Verification Request

### TPL

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<tr>
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<th>NAIC</th>
<th>Policy Number</th>
<th>Policy Holder</th>
<th>Coverage Type</th>
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<th>Group Number</th>
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<tbody>
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### Managed Care

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<tr>
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<th>Plan Description</th>
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<th>End Date</th>
<th>Managed Care Benefits</th>
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<tr>
<td>CARESOURCE</td>
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### Lock-In

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### Medicare

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<tr>
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<th>Effective Date</th>
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<th>Plan Name</th>
<th>Plan ID</th>
<th>Medicare ID</th>
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<td>12/01/2017</td>
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<td>PART B</td>
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<td>272012289D6</td>
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### Service Limitation

*** No rows found ***

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

#### Level of Care Determinations

<table>
<thead>
<tr>
<th>LOC Requested</th>
<th>Status</th>
<th>Determination Date</th>
<th>LOC Determination</th>
<th>Description</th>
<th>LOC Begin Date</th>
<th>LOC End Date</th>
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<tbody>
<tr>
<td>09/01/2017</td>
<td>NF; NF WAIVER; RSS</td>
<td>09/01/2017</td>
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<td>12/08/2017</td>
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<td>08/23/2017</td>
<td>NF; NF WAIVER; RSS</td>
<td>08/23/2017</td>
<td>INTERMEDIATE (ILOC)</td>
<td>UNKNOWN LEVEL OF CARE</td>
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#### Patient Liability

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<tr>
<th>Financial Payer</th>
<th>Monthly Amount</th>
<th>Type</th>
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<tr>
<td>DEFAULT</td>
<td>$491.00</td>
<td>Pro-rated Nursing Home</td>
<td>12/01/2017</td>
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#### Long Term Care Facility Placements

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<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>
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<tr>
<td>NURSING FACILITY</td>
<td>07/25/2017</td>
<td>12/01/2017</td>
<td>12/08/2017</td>
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</table>

#### Recipient Restricted Coverage

*** No rows found ***

#### Special Program

*** No rows found ***
Presumptive Eligibility

Covers children up to age 19 and pregnant women

It was expanded to provide coverage for parent and caretaker relatives and extension adults

This is a limited time benefit to allow for full determination of eligibility for medical assistance
Presumptive Eligibility

Individuals will receive a Presumptive Eligibility letter if a state qualified entity determines presumptive eligibility.
Presumptive Eligibility

Individuals will receive a similar Presumptive Eligibility letter if a CDJFS worker determines the eligibility

CDJFS Presumptive Eligibility

John Doe
123 Main St.
Anytown, OH 43210

The following individuals have temporary Medicaid coverage under Presumptive Eligibility (PE). The County Department of Job and Family Services (CDJFS) enrolled these persons based on the unverified self-declaration of the patient’s household income, U.S. citizenship or qualified alien status, Ohio residency, and pregnancy (if applicable).

Presumptive eligibility will stop when a decision is made on your full Medicaid application.

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

APPROVED:

<table>
<thead>
<tr>
<th>Name (First, M.I., Last Name)</th>
<th>Date of Birth</th>
<th>PE Type</th>
<th>Date Coverage Begins</th>
<th>Medicaid ID</th>
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<tbody>
<tr>
<td>John Doe</td>
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<td>PE Adult</td>
<td>06/25/2018</td>
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</table>
### Recipient Information

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<tr>
<td>County of Residence</td>
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<tr>
<td>County of Eligibility</td>
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</tr>
<tr>
<td>County Office</td>
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<td>Number Bed Hold Days</td>
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### 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>
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<tbody>
<tr>
<td>PRESUMPTIVE: Alternative Benefit Plan</td>
<td>01/01/2017</td>
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<td>Medicaid Expansion</td>
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<td>$0.00</td>
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<tr>
<td>PRESUMPTIVE: MRDD Targeted Case Mgmt</td>
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<td>06/30/2017</td>
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<td>$0.00</td>
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<td>PRESUMPTIVE: Alcohol and Drug Addiction Services</td>
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<td>06/30/2017</td>
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<td>$0.00</td>
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<tr>
<td>PRESUMPTIVE: Ohio Mental health</td>
<td>01/01/2017</td>
<td>06/30/2017</td>
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<td>$0.00</td>
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<tr>
<td>PRESUMPTIVE: Medicaid</td>
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<td>06/30/2017</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

### Case/Cat/Seq Spenddown
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
- More than 20,000 individuals have benefited from this program
Qualified Medicare Beneficiary (QMB)

Issued to qualified individuals who have Medicare

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

Reimbursement policy is set under 5160-1 and can result in a payment of zero dollars
The billing of individuals enrolled in the QMB program is prohibited by federal law

Federal law bars Medicare providers and suppliers from billing an individual enrolled in the QMB program for Medicare Part A and Part B cost-sharing under any circumstances (see Sections 1902(n)(3)(B), 1902(n)(3)(C), 1905(p)(3), 1866(a)(1)(A), and 1848(g)(3)(A) of the Social Security Act [the Act]). The QMB program is a State Medicaid benefit that assists low-income Medicare beneficiaries with Medicare Part A and Part B premiums and cost-sharing, including deductibles, coinsurance, and copays.
Specified Low-Income Medicare Beneficiary (SLMB) & Qualifying Individual (QI-1)

There is NO cost-sharing eligibility

We ONLY pay their Part B premium to Medicare

This is NOT Medicaid eligibility
MANAGED CARE/MYCARE OHIO
Managed Care Day One - Effective January 1, 2018

- New individuals will be assigned a managed care plan the first day of the current month that MITS receives active Medicaid eligibility.
- MITS must receive Medicaid eligibility before Managed Care Assignments can take place.
- Medicaid eligibility established prior to the current month will be Fee-for-Service (FFS) for months prior to the current month.
- Day one lowers the months of FFS and increases the MCP months.
- MyCare Ohio enrollment process stays as-is.
## Managed Care Day One

<table>
<thead>
<tr>
<th></th>
<th>‘The old way’</th>
<th>Day One</th>
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<tbody>
<tr>
<td>Individual completes Application</td>
<td>4/3/2018</td>
<td>4/3/2018</td>
</tr>
<tr>
<td>Determined eligible for Medicaid</td>
<td>5/17/2018</td>
<td>5/17/2018</td>
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<tr>
<td>Fee-For-Service</td>
<td>4/1/2018 (\rightarrow) 5/31/2018</td>
<td>4/1/2018 (\rightarrow) 4/30/2018</td>
</tr>
<tr>
<td>Managed Care Plan</td>
<td>6/1/2017 (\rightarrow) 12/31/2299</td>
<td>5/1/2017 (\rightarrow) 12/31/2299</td>
</tr>
</tbody>
</table>
Application received 2/3/18

Medicaid approved 2/12/18

OLD WAY

FFS 2/1/18 - 2/28/18
MCP begins 3/1/18 - ongoing
NEW WAY

Application received 2/3/18

Medicaid approved 2/12/18

MCP begins 2/1/18
Day One MCP Assignments

MITS looks for previous MCP in last 90 days

Then MITS looks for anyone on a case with family members assigned to a MCP

Then individual is assigned by an assignment algorithm

The assigned plan can be changed as desired during first 3 months
Managed Care Enrollment Groups - 2018
FFS vs. Managed Care Enrollment - 2018

- FFS: 91%
- Managed Care: 9%
3 Population Groups Eligible for Managed Care

- Supplemental Security Income (SSI)
- Modified Adjusted Gross Income (MAGI)
- Aged, Blind, Disabled (ABD)
  - Adoption children, Breast and Cervical Cancer Patients (BCCP), Foster children, and Bureau of Children with Medical Handicaps (BCMH)
Individuals with optional enrollment in Traditional Managed Care Plans

Native Americans that are members of a federally recognized tribe

Home and Community Based waivers thru DODD effective 1/1/17
Managed Care Plans (MCPs) must cover all medically necessary Medicaid covered services.

Some value-added services:

- On-line searchable provider directory
- Toll-free 24/7 hotline for medical advice
- Expanded benefits including additional transportation options plus other incentives
- Care management to help members coordinate care
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 individual.

The MITS provider portal will show if an individual is enrolled in a Managed Care plan based on the eligibility dates of service you enter.
### Benefit / Assignment Plan

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<tr>
<td>Medicaid Schools</td>
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### Case/Cat/Seq Spenddown

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### TPL

*** No rows found ***

### Managed Care

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<tr>
<th>Plan Name</th>
<th>Plan Description</th>
<th>Effective Date</th>
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<tr>
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</table>
Managed Care Sample Card

PARAMOUNT ADVANTAGE
www.paramountadvantage.org

HEALTH PLAN (80840)
7952304120
ID NUMBER
A9999999901
MEMBER NAME
Jane Doe
PRIMARY CARE PROVIDER
John Smith
(419) 5551212

GROUP NUMBER
ADV0010011

EFF. DATE
01/01/2015
MMIS NUMBER
000000000000

CVS/CAREMARK
RXGRP RX6407
RXBIN 004336
RXPCN ADV

PROVIDERS CALL FOR PRIOR AUTH
800-891-2500/419-887-2520
Providers who are interested in delivering services to a Managed Care individual must have a contract or agreement with the plan.

Things to know:

- Each plan has a list of services that require prior authorization.
- Each plan will have their own billing requirements.
- MyCare Ohio contracts may be separate or an addendum to the ABD/CFC Managed Care contract.
Oversight of Managed Care Plans

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

866-296-8731  https://www.buckeyehealthplan.com

800-488-0134  https://www.CareSource.com/

855-522-9076  https://www.paramounthealthcare.com/

855-322-4079  https://www.molinahealthcare.com

800-600-9007  https://www.uhccommunityplan.com
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 is currently slated to end on December 31, 2019.
Package includes *all* benefits available through the traditional *Medicare* and *Medicaid* programs for opt-in and opt-out.

- This includes Long Term Services and Supports (LTSS) and Behavioral Health.

- Plans may elect to include additional *value-added benefits* in their health care packages.
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
- Residing in one of the demonstration project regions
Groups that are *NOT* eligible for enrollment in MyCare Ohio:

- Individuals with an ICF-IID level-of-care served in an ICF-IID waiver
- Individuals enrolled in the PACE program
- Individuals who have third-party insurance, including retirement benefits
Providers need to check the MITS provider portal each time before providing services to a Medicaid recipient.

For recipients enrolled in a MyCare Ohio Managed Care plan it will show if they are enrolled for Dual Benefits OR Medicaid Only.

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.
MyCare Ohio Opt-In Sample Card
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<td>12/01/2017</td>
<td>01/31/2018</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Alcohol and Drug Addiction</td>
<td>12/01/2017</td>
<td>01/31/2018</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ohio Mental health</td>
<td>12/01/2017</td>
<td>01/31/2018</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Medicaid</td>
<td>12/01/2017</td>
<td>01/31/2018</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

### Case/Cat/Seq Spenddown

*** No rows found ***

### TPL

*** No rows found ***

### Managed Care

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Plan Description</th>
<th>Effective Date</th>
<th>End Date</th>
<th>Managed Care Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>CARESOURCE</td>
<td>HMO, MyCare Ohio</td>
<td>12/01/2017</td>
<td>01/31/2018</td>
<td>Dual Benefits</td>
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### Lock-In

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### Medicare

<table>
<thead>
<tr>
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<th>Effective Date</th>
<th>End Date</th>
<th>Plan Name</th>
<th>Plan ID</th>
<th>Medicare ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>PART A</td>
<td>12/01/2017</td>
<td>01/31/2018</td>
<td></td>
<td></td>
<td>018562948A</td>
</tr>
<tr>
<td>PART B</td>
<td>12/01/2017</td>
<td>01/31/2018</td>
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<tr>
<td>PART C</td>
<td>12/01/2017</td>
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<td>018562948A</td>
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<td>PART D</td>
<td>01/01/2018</td>
<td>01/31/2018</td>
<td>*H8452/001</td>
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<tr>
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<td>12/31/2017</td>
<td>*H8452/001</td>
<td>001</td>
<td>018562948A</td>
</tr>
</tbody>
</table>
MyCare Ohio Opt-Out Sample Card

MyCareOhio
Connecting Medicare + Medicaid

RxBin: 004336
RxPCN: ADV
RxGRP: RX3292

CareSource

Member Name: <Cardholder Name>
Member ID #: <Cardholder ID#>
MMIS Number: <Medicaid Recipient ID#>
PCP Name: <PCP Name>
PCP Phone: <PCP Phone>

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: 1-855-475-3163 (TTY: 1-800-750-0750 or 711)
Behavioral Health Crisis: 1-866-206-7861 (TTY: 1-800-750-0750 or 711)
Care Management: 1-855-475-3163 (TTY: 1-800-750-0750 or 711)
24-Hour Nurse Advice: 1-866-206-7861 (TTY: 1-800-750-0750 or 711)
Provider/Pharmacy Questions: 1-800-488-0134
Website: CareSource.com/MyCare

Mail medical claims to:
CareSource
Attn: Claims Department
P.O. Box 8730
Dayton, OH 45401-8738

Mail pharmacy claims to:
CVS Caremark
P.O. Box 52066
Phoenix, AZ 85072-2066
# MITS Eligibility MyCare Opt-Out

## 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>
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</thead>
<tbody>
<tr>
<td>MRDD Targeted Case Mgmt</td>
<td>10/01/2017</td>
<td>01/31/2018</td>
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<tr>
<td>Alcohol and Drug Addiction Services</td>
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<td>$0.00</td>
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## Case/Cat/Seq Spenddown

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## TPL

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<table>
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<tr>
<th>Plan Name</th>
<th>Plan Description</th>
<th>Effective Date</th>
<th>End Date</th>
<th>Managed Care Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>BUCKEYE COMMUNITY HEALTH PLAN</td>
<td>HMO, MyCare Ohio</td>
<td>10/01/2017</td>
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<td>Medicaid Only</td>
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## Lock-In

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## Medicare

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<th>Plan Name</th>
<th>Plan ID</th>
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<td>PART A</td>
<td>10/01/2017</td>
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<td>11/01/2017</td>
<td>01/31/2018</td>
<td>ANTHEM SENIOR ADVANTAGE PLUS</td>
<td>H3655</td>
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MyCare Ohio Region Breakdown

Northwest
- Aetna
- Buckeye
- Fulton
- Lucas
- Warren
- Clinton
- Hamilton
- Clermont

Southwest
- Aetna
- Molina
- Butler
- Green
- Clark
- Clinton
- Montgomery

West Central
- Buckeye
- Molina
- Delaware
- Franklin
- Green
- Montgomery

Central
- Aetna
- Molina
- Union
- Pickaway
- Franklin
- 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
Providers who are interested in delivering services to MyCare Ohio individuals must have a contract or agreement with the plan.

- Each plan has a list of services that require prior authorization.
- Each plan will have their own billing requirements.
- MyCare Ohio contracts may be separate or an addendum to the ABD/CFC Managed Care contract.

Things to know:
MyCare Ohio Managed Care Plans

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

800-488-0134 [https://www.CareSource.com/MyCare](https://www.CareSource.com/MyCare)

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

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

800-600-9007 [https://www.uhccommunityplan.com/](https://www.uhccommunityplan.com/)
Provider credentialing concerns
Please send to Ohio Department of Insurance (ODI)

Certification issues
Work with the Area Agency on Aging (AAA) or ODM for MyCare Ohio waiver providers

Work directly with the Plan first
If not resolved, submit a complaint to Ohio Department of Medicaid (ODM) at https://www.ohiomh.com/ProviderComplaintForm.aspx
# OH Medicaid Managed Care Provider Complaint Form

## Instructions
This form is for Managed Care providers only. Providers must appeal denied claims to the MCP before the Ohio Department of Medicaid will process a complaint. If your complaint involves multiple Managed Care Plans (MCPs), please complete one form per MCP. The resolution timeframes for Managed Care complaints are 2 business days for complaints involving access to care, and 15 business days for all other issues. If you have a complaint regarding Medicaid Fee For Service please call 1-800-686-1016.

## Complaint Details

<table>
<thead>
<tr>
<th>Field</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCP Name:</td>
<td>[Dropdown]</td>
</tr>
<tr>
<td>Complaint Reason:</td>
<td>[Dropdown]</td>
</tr>
<tr>
<td>Are you contracted with this Health Plan?</td>
<td>Yes</td>
</tr>
<tr>
<td>Is this complaint related to the MyCare Program?</td>
<td>Yes</td>
</tr>
<tr>
<td>Have you already contacted the MCP about this issue?</td>
<td>Yes</td>
</tr>
<tr>
<td>Is this complaint related to any previously submitted complaints?</td>
<td>Yes</td>
</tr>
<tr>
<td>Is this complaint related to children with special health care needs?</td>
<td>Yes</td>
</tr>
<tr>
<td>Is the patient receiving or seeking mental health or substance abuse services?</td>
<td>Yes</td>
</tr>
</tbody>
</table>
PROVIDER RESPONSIBILITIES
Provider Enrollment and Revalidation

Providers are required to submit an application to become a Medicaid provider.

There is also a federally required 5 year revalidation.

Providers may enroll as an ORP-only provider or as a Medicaid billing provider.

Online applications can be found on our website.
Provider Enrollment and Revalidation, cont.

There is a federally required, non-refundable application fee when a provider submits a new or revalidation application.

The 2018 fee is $569.00 per application.

This fee applies to organizational providers only (not individual providers, practitioners, or practitioner groups).
Provider Agreement: OAC 5160-1-17.2

The provider agreement is a legal contract between the state and the provider, you agree that you will:

- Maintain records for 6 years
- Inform us of any changes to your provider profile within 30 days
- Render medically necessary services in the amount required
- Recoup any third party resources available
- Abide by the regulations and policies of the state
- Not seek reimbursement for service(s) from the patient, any member of the family, or any other person
- Recoup any third party resources available
- Maintain records for 6 years
- Render medically necessary services in the amount required
- Abide by the regulations and policies of the state
- Not seek reimbursement for service(s) from the patient, any member of the family, or any other person
- Recoup any third party resources available
General Reimbursement Principles:
OAC 5160-1-02

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.
The Ohio Administrative 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.
A provider may NOT collect and/or bill for any difference between the Medicaid payment and the provider’s charge, as well as for the following:

- Medicaid claim denial
- Unacceptable claim submission
- Failure to request a prior authorization
- Retroactive Peer Review stating lack of medical necessity
When Can you Bill an Individual?

- Notified in writing prior to the service that Medicaid will not be billed
- Explain the service could be free by another provider
- Agrees to be liable for payment and signs statement
- Notified in writing prior to the service that Medicaid will not be billed
If not an ABN, then What?

5160-1-13.1 Medicaid Consumer Liability

Date of service: ____________________
Type of Service: ____________________
Name/account number: ______________________________
Billing number: _______________________

☐ (C) Providers may not bill consumers in lieu of ODISFS unless:

(1) The consumer is notified in writing prior to the service being rendered that the provider will not bill ODISFS 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.

Signature: ____________________________________________

☐ (D) Services that are not covered by the Medicaid program, including services requiring prior authorization that have been denied by ODISFS, may be billed to the consumer when the provisions in paragraphs (C)(1) and (C)(2) of this rule are met.
The Ohio Department of Medicaid Website
Provider News

Welcome Providers

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

Provider News

Please listen carefully when calling the IVR as the options have changed as of 6/17/2016.

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)

Independent Provider Overtime Rates - Effective January 1, 2016 (Rev. 4/1/16)
POLICY
Policy updates from Ohio Medicaid announce the changes to the Ohio Administrative Code that may affect providers.

Medicaid Transmittal Letters (MTL)

Medical Assistance Letter (MAL)
How to Find Modifiers Recognized by Ohio Medicaid

Scroll to the bottom of the page
Co-Payments and Exclusions: OAC 5160-1-09

There is a co-payment requirement for dental services:
- This may apply to individuals enrolled in managed care.

Co-Payment exclusions:
- Under age 21
- Pregnant or in the post partum period
- Nursing facility and ICF-IID residents
- Individuals receiving emergency services
- Individuals receiving hospice care
- Individuals received Medicaid under the breast and cervical cancer option
Policy Updates: OAC 5160-5-01

Restoration Audits

- Payment for multiple restorations on the same tooth, on the same date of service, can be made as though done separately
  - Up to a maximum of three restorations

- A tooth surface can only be named once - whether alone or in combination with restorations on other surfaces
  - On maxillary first and second molars, the occlusal surface can be named twice - whether performed alone or in combination with restorations of another surface
Policy Updates: OAC 5160-5-01

- Restoration Audits, cont.
  - On anterior teeth, the facial and lingual surfaces can be named twice
    - Whether performed alone or in combination with restorations of another surface
  - If the incisal angle on an anterior tooth is involved, then only one four surface restoration can be billed for the tooth
    - No additional surfaces or restorations will be allowed
Allowing Payment

- **D0140** “Limited problem focused exam”
  - Allow payment on the same date as other dental treatment services with the exception of other oral exams/evaluations
    - No Payment is made for a limited oral evaluation performed in conjunction with either a comprehensive oral evaluation, periodic oral evaluation or periodontal evaluation
Limitations

D2950 “Core build-up including pins”

Coverage shall be for all permanent teeth except supernumerary (1-32)

Max fee of $76.54

Lifetime limit of 1 per tooth
Limitations

**D1354 “Silver Diamine Fluoride”**

- Limit of 1 unit per date of service paid regardless of number of tooth numbers submitted
- No age restriction
- Lifetime limit of 6 applications
  - Cannot be paid in conjunction with a restoration or crown on the same tooth
Limitations

**D7283** “Placement of device to facilitate eruption of impacted tooth”

Coverage shall be for all teeth excluding supernumerary

Max fee of $75.00

Prior authorization (PA) required
Limitations

- **D7210 “Extraction”**
  - Coverage shall be for all teeth including supernumerary
    - 1-32, A-T, 51-82, AS-TS
  - Max fee of $57.69
  - Lifetime limit of 1 per tooth
Limitations

D9612 Therapeutic parenteral drug administration

Two or more administrations, different medications

Establish max fee of $50.36
Establish audit to only allow one unit of D9610 or D9612
Payment Updates

- **D7670** Alveolus-closed reduction
  Establish max fee of $243.15

- **D9610** Therapeutic parenteral drug, single administration
  Establish max fee of $25.18

- **D7671** Alveolus-open reduction
  Establish max fee of $318.75
Reimbursement Updates

- Deep sedation/general anesthesia/intravenous conscious sedation/analgesia services
  - Assure reimbursement of deep sedation/general anesthesia services at a fixed amount
    - Flat rate of one unit, per patient, per DOS
  - Assure reimbursement of intravenous conscious sedation/analgesia services at a fixed amount
    - Flat rate of one unit, per patient, per DOS
MITS AND CLAIMS
Medicaid Information Technology System (MITS)

MITS is a web-based application that is accessible via any modern browser

MITS is available to all Ohio Medicaid providers who have been registered and have created an account

MITS is able to process transactions in “real time”
Technical Requirements

Internet Access (high speed works best)

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

Mac users use current version of Safari, Firefox, or Chrome

Turn OFF pop up blocker functionality
Go to [http://Medicaid.ohio.gov](http://Medicaid.ohio.gov)

Select the “Provider Tab” at the top

Click on the “Access the MITS Portal” image on the right of the page
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 Navigation

“COPY”, “PASTE”, and “PRINT” features all work in the MITS Portal

Do NOT use the previous page function (back arrow) in your browser

Do NOT use the “enter” key on the keyboard, use the “tab” key or mouse to move between fields

MITS access will time-out after 15 minutes of system inactivity
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.
Electronic Data Interchange (EDI)

**Fees for claims submitted**

Claims must be received by Wednesday at Noon to be in the next payment cycle

MITS Portal

**Free submission**

Claims must be received by Friday at 5:00 P.M. to be in the next payment cycle

Easier for us to help you with your claim submission issues!
Technical Questions/EDI Support Unit

Trading partners contact DXC for EDI Support

844-324-7089 or OhioMCD-EDI-Support@dxc.com
MITS Web Portal 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
Detail Panel

<table>
<thead>
<tr>
<th>Item</th>
<th>DOS</th>
<th>Procedure Code</th>
<th>Units</th>
<th>Tooth Number</th>
<th>Quadrant</th>
<th>Charges</th>
<th>Status</th>
<th>Medicaid Allowed Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
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<tr>
<th>Item</th>
<th>*DOS</th>
<th>*Units</th>
<th>*Charges</th>
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<tbody>
<tr>
<td>1</td>
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</tr>
</tbody>
</table>

Surfaces (Detail Item 1)

***No rows found***

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

MITS will not accept a claim without all required fields being populated.

Portal errors return the claim with a “fix” needed.

Claim shows a ‘NOT SUBMITTED YET’ status still.

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 Example

**Dental Claim: 123456789 NPI - DENTAL INC**

**BILLING INFORMATION**
- **ICN:** 221811111111
- **Claim Received Date:** 05/11/2018
- **Provider ID:** 123456789 NPI
- **Medicaid Billing Number:** 98765432111
- **Date of Birth:** 02/15/1953
- **Last Name:** SMITH
- **First Name, MI:** JOHN
- **Patient Account #:**
- **Referring Provider #:**
- **Rendering ID:** 456123789
- **Patient Amount Paid:** $0.00

**SERVICE INFORMATION**
- **Release of Information:** NO
  - **From Date:** 05/11/2018
  - **To Date:** 05/11/2018
- **Emergency:**
- **Accident Related To:**
- **Accident State:**
- **Accident Country:**
- **Accident Date:**
- **EPSDT:**
- **Place of Service:** 11
- **Prior Authorization #:**

**TOTAL CHARGES**
- **Total Charges:** $750.00
- **Medicaid Allowed Amount:** $0.00
- **TPL Paid Amount:** $0.00
- **Total Medicaid Paid Amount:** $285.45
- **Medicaid CoPay Amount:** $3.00
- **Note Reference Code:**

**Notes**
### Claim Example, cont.

#### Header - Other Payer

*** No rows found ***

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

#### Header - Other Payer Amounts and Adjustment Reason Codes

#### Detail

<table>
<thead>
<tr>
<th>Item</th>
<th>DOS</th>
<th>Procedure Code</th>
<th>Units</th>
<th>Tooth Number</th>
<th>Quadrant</th>
<th>Charges</th>
<th>Status</th>
<th>Medicaid Allowed Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>05/11/2018 D7140</td>
<td>1.00 09</td>
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<tr>
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</tr>
<tr>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
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<td>05/11/2018 D7140</td>
<td>1.00 03</td>
<td>$150.00</td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Detail - Other Payer

<table>
<thead>
<tr>
<th>Item</th>
<th>Procedure Code</th>
<th>Tooth Number</th>
<th>Quadrant</th>
<th>Rendering Provider</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>07140</td>
<td>09</td>
<td>04</td>
<td>456123789</td>
<td>PAID</td>
</tr>
</tbody>
</table>
Claim Example, cont.

### Surfaces (Detail Item 5)

*** No rows found ***

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

### 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

<table>
<thead>
<tr>
<th>Claim Status</th>
<th>PAID</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim ICN</td>
<td>2218131008506</td>
</tr>
<tr>
<td>Paid Date</td>
<td>05/24/2018</td>
</tr>
<tr>
<td>Paid Amount</td>
<td>$285.45</td>
</tr>
</tbody>
</table>
### EOB Information

<table>
<thead>
<tr>
<th><strong>Detail Number</strong></th>
<th><strong>Error Disposition</strong></th>
<th><strong>EOB Code</strong></th>
<th><strong>EOB Description</strong></th>
<th><strong>CARC</strong></th>
<th><strong>CARC Amount</strong></th>
<th><strong>CARC Description</strong></th>
<th><strong>RARC</strong></th>
<th><strong>RARC Description</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td>9001</td>
<td>REIMBURSEMENT REDUCED BY THE MEMBERS CO-PAYMENT AMOUNT</td>
<td>3</td>
<td>$3.00</td>
<td>Co-payment Amount</td>
<td>M16</td>
<td>Alert: Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision.</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>9918</td>
<td>PRICING ADJUSTMENT - MAX FEE PRICING APPLIED</td>
<td>45</td>
<td>$92.31</td>
<td></td>
<td>M16</td>
<td>Alert: Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision.</td>
</tr>
</tbody>
</table>

Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability)
All claims are assigned an ICN

2218170357321

<table>
<thead>
<tr>
<th>Region Code</th>
<th>Calendar Year</th>
<th>Julian Day</th>
<th>Claim Type/Batch Number</th>
<th>Claim Number in Batch</th>
</tr>
</thead>
<tbody>
<tr>
<td>22</td>
<td>18</td>
<td>170</td>
<td>357</td>
<td>321</td>
</tr>
</tbody>
</table>
Providers have 365 days to submit FFS claims

During that 365 days they can attempt to submit the claim for payment (if receiving a denial) or adjust it as many times as they need to

An additional 180 days from the resubmit date is given for attempts to correctly submit a denied claim prior to the end of the 365 days

Claims over 2 years old will be denied

There are exceptions to the 365 day rule
Submitting a Claim Over 365 Days Old

- Use this panel on the claim for billing claims over 365 days, when timely filing criteria has been met
- Enter the previously denied ICN and select “DELAYED SUBMISSION/RESUBMISSION” in the Reason drop down menu
- When done correctly, MITS will bypass timely filing edits

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
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.

- The claim must be submitted within 180 days of the hearing decision or eligibility determination date.
Special Billing Instructions – Eligibility Delay

- In the Notes box you will need to enter the hearing decision or eligibility determination information.

- In the Note Reference Code dropdown menu select “ADD”
Special Billing Instructions – Eligibility Delay

- Hearing Decision: APPEALS#### CCYYMMDD
  #### is the hearing number and CCYYMMDD is the date on the hearing decision

- Eligibility Determination: DECISION CCYYMMDD
  CCYYMMDD is the date on the eligibility determination notice from the CDJFS

Note Reference Code

ADD - Additional Information

DECISION 20171225

Notes

Must use the spacing shown
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 a claim in MITS
- Do not enter any Medicare information on the claim
- Complete and upload a ODM 06653 and a copy of the Medicare EOB
Uploading an Attachment

This panel allows you to electronically upload an attachment onto your claim in MITS.
Uploading an Attachment

- Electronic attachments are accepted for Claims, Prior Authorization, and 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
Paid claims can be:
Adjusting a Paid Claim

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

- 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
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)
Voiding 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”
Example

2218180234001
5818185127250

Originally paid $45.00
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
Copying a Paid Claim

- Open the claim you wish to copy
- Click the “copy claim” button at the bottom of the claim
- A new duplicate claim 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
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
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
The National Correct Coding Initiative (NCCI)

- 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.
Third Party Liability (TPL) Claims

Other payer information can be reported at the claim level (header) or at the line level (detail), depending on the other payer’s claim adjudication.

HIPAA compliant adjustment reason codes and amounts are required to be on the claim.

MITS will automatically calculate the allowed amount.
Third Party Liability (TPL) Claims

Other payer information is entered in the Header – Other Payer panel
Third Party Liability (TPL) Claims

If the TPL is a Medicare HMO, select “HMO, Medicare Risk” in the Claim Filing Indicator drop down menu.
Header vs Detail

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

Detail level
• A COB claim is considered to be adjudicated at the line/detail level if figures are reported for individual line items.
Third Party Liability (TPL) Claims

Adjustment reason codes (ARCs) for a header pay TPL are entered in the Header – Other Payer Amounts and Adjustment Reason Codes panel.
Third Party Liability (TPL) Claims

ARCs for a detail pay TPL are entered in the Detail – Other Payer Amounts and Adjustment Reason Codes panel

<table>
<thead>
<tr>
<th>Detail Item/Electronic Payer ID</th>
<th>CAS Group Code</th>
<th>ARC</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 1/43210</td>
<td>PR-Patient Responsibility</td>
<td>1</td>
<td>$50.00</td>
</tr>
<tr>
<td>A 1/43210</td>
<td>CO-Contractual Obligations</td>
<td>45</td>
<td>$150.00</td>
</tr>
</tbody>
</table>

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

The X12 website provides adjustment reason codes (ARCs)

- Deductible
- Coinsurance
- Co-payment
- Contractual Obligation/Write off
- Non-covered services
Remittance Advice (RA)

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

- Select “Remittance Advice” and click “Search”

- To see all remits to date, do not enter any data, and click search again
Remittance Advice (RA)

- Paid, denied, and adjusted claims
- Financial transactions
  - Expenditures - Non-claim payments
  - Accounts receivable - Balance of claim and non-claim amounts due to Medicaid
- Summary
  - Current, month, and year to date information
Remittance Advice (RA)

Information pages
Banner messages to the provider community

EOB code explanations
Provides a comparison of codes to the description

TPL claim denial information
Provides other insurance information for any TPL claim denials
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
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 (PA)

- 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 (PA)

- 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 and Forms
 Suites Websites

- Ohio Department of Medicaid home page
  https://Medicaid.ohio.gov
- MALs & MTLs
  http://medicaid.ohio.gov/RESOURCES/Publications/ODM-Guidance#161542-medicaid-policy
- LAWriter
  http://codes.ohio.gov/oac/5160
- MITS home page
  https://portal.ohmits.com/Public/Providers/tabId/43/Default.aspx
Websites

- Provider Enrollment
  [http://medicaid.ohio.gov/Provider/EnrollmentandSupport/ProviderEnrollment](http://medicaid.ohio.gov/Provider/EnrollmentandSupport/ProviderEnrollment)

- Electronic Funds Transfer

- Information for Trading Partners (EDI)
  [http://medicaid.ohio.gov/Provider/Billing/TradingPartners](http://medicaid.ohio.gov/Provider/Billing/TradingPartners)

- X12 Website (ARC Codes)
  [www.x12.org/codes/claim-adjustment-reason-codes/](http://www.x12.org/codes/claim-adjustment-reason-codes/)
FORMS

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

http://medicaid.ohio.gov/RESOURCES/Publications/Medicaid-Forms
Any questions?