Ohio | Department of Medicaid

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

Basic Billing for Home Health Agency Providers

External Business Relations

2018

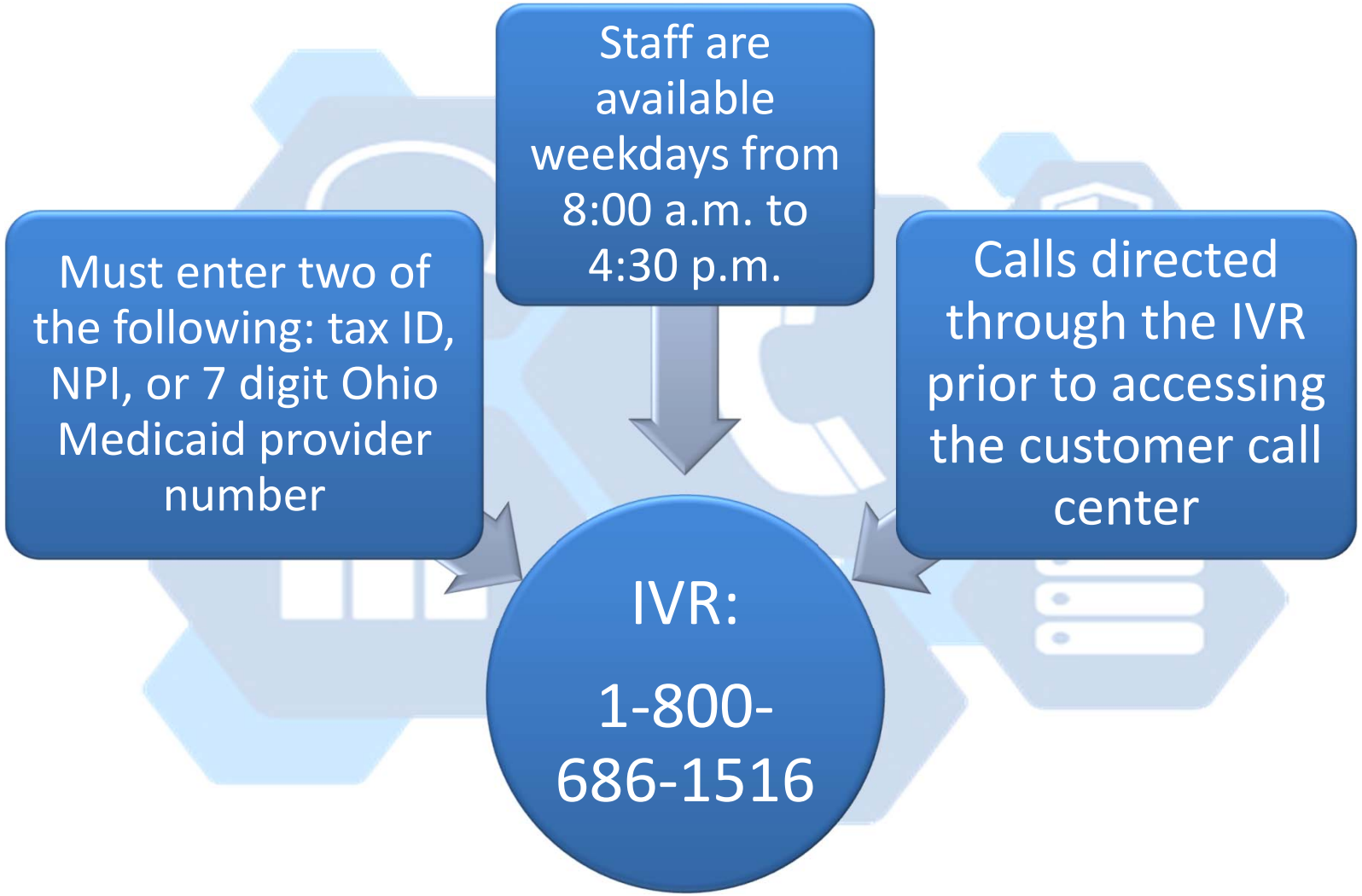
AGENDA

- Medicaid Services
- Programs & Cards
- Managed Care/MyCare Ohio
- Provider Responsibilities
- Policy
- Electronic Visit Verification
- MITS & Claims
- Websites & Forms

External Business Relations Team

Sarah Bivens
Ava Cottrell
Ed Ortopan

Manager - Meagan Grove


Staff are available weekdays from 8:00 a.m. to 4:30 p.m.
Must enter two of the following: tax ID, NPI, or 7 digit Ohio Medicaid provider number
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**

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
ALLEN

Ohio Medicaid

Case Number
5082482

Eligibility Begin Date
01/01/2018

Void After Date
01/31/2018

Ohio Department of Medicaid
medicaid.ohio.gov

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

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

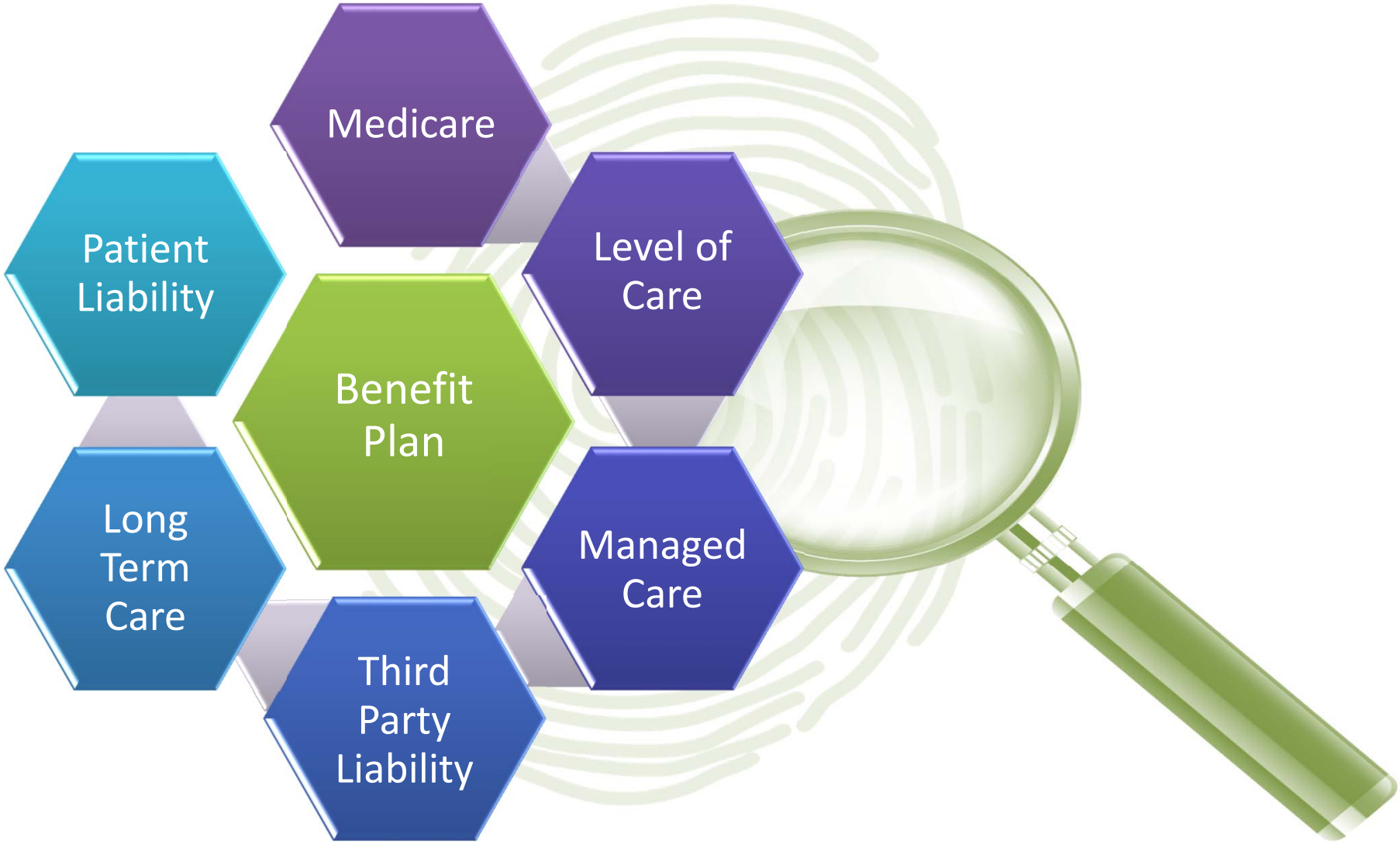
- Individuals must cooperate with requests from third-party insurance companies needing to authorize coverage
- Individuals must cooperate with request from a Medicaid provider for information which is needed in order to bill third party insurances
- Providers may contact the local CDJFS office to report 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


Medicare
Patient Liability
Level of Care
Benefit Plan
Long Term Care
Managed Care
Third Party Liability

Eligibility Verification Request

- You can search up to 3 years at a time!!

Ohio Department of Medicaid

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		Birth Date	
SSN		DOS Date Format	MM/DD/YYYY
Procedure Code		From DOS	01/12/2015
		To DOS	01/11/2018

search

clear

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

Eligibility Verification Request

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			

Associated Child(ren) Search

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 ***

Eligibility Verification Request

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	
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★ 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

Associated Child(ren)

Medicaid Billing Number	First Name	MI	Last Name	Gender	Date of Birth
123456789012	AUDREY		DOE	FEMALE	11/20/2004
987654321012	ALEX		DOE	MALE	09/14/2006

Eligibility Verification Request

TPL

Carrier Name	Carrier Number	NAIC	Policy Number	Policy Holder	Coverage Type	Coverage	Effective Date	End Date	Group Number
AARP HEALTH CARE	00570		082029958-1		IND	INPATIENT COVERAGE	01/30/2018	01/31/2018	PLAN-NV
AARP HEALTH CARE	00570		082029958-1		IND	PHYSICIAN/OUTPATIENT COVERAGE	01/30/2018	01/31/2018	PLAN-NV
AETNA US HEALTH	00250		W116635166		IND	INPATIENT COVERAGE	01/30/2018	01/31/2018	724775
AETNA US HEALTH	00250		W116635166		IND	PHYSICIAN/OUTPATIENT COVERAGE	01/30/2018	01/31/2018	724775

Managed Care

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

Lock-In

*** No rows found ***

Medicare

Coverage	Effective Date	End Date	Plan Name	Plan ID	Medicare ID
PART A	12/01/2017	12/08/2017			272012289D6
PART B	12/01/2017	12/08/2017			272012289D6

Service Limitation

*** No rows found ***

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

Eligibility Verification Request

Level of Care Determinations

LOC Requested	Status	Determination Date	LOC Determination	Description	LOC Begin Date	LOC End Date
		09/01/2017	NF; NF WAIVER; RSS	INTERMEDIATE (ILOC)	12/01/2017	12/08/2017
		08/23/2017	NF; NF WAIVER; RSS	INTERMEDIATE (ILOC)	12/01/2017	12/08/2017
				UNKNOWN LEVEL OF CARE	12/01/2017	12/07/2017

Patient Liability

Financial Payer	Monthly Amount	Type	Effective Date	End Date
DEFAULT	$491.00	Pro-rated Nursing Home	12/01/2017	12/08/2017

Long Term Care Facility Placements

Facility Type	Date of Admission	Effective Begin Date of Medicaid Coverage	End Date of Medicaid Coverage	Date of Discharge
NURSING FACILITY	07/25/2017	12/01/2017	12/08/2017	

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

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

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:

Name (First, M.I., Last Name)	Date of Birth	PE Type	Date Coverage Begins	Medicaid ID
John Doe	11/19/1959	PE Adult	06/25/2018	910194194194

Presumptive Eligibility

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

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

Reimbursement policy is set under 5160-1 and can result in a payment of zero dollars

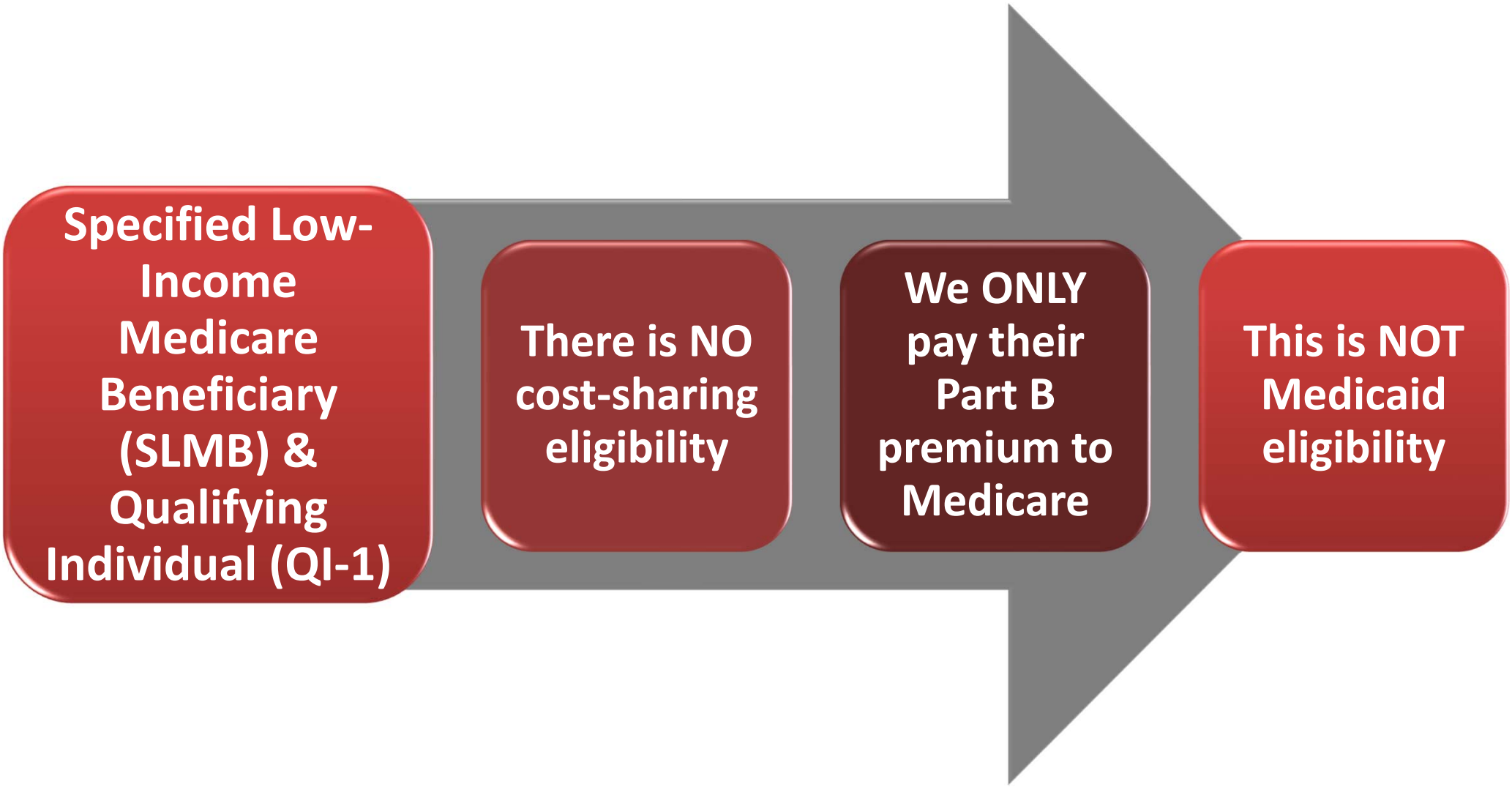
Medicaid only covers their monthly Medicare premium, co-insurance and/or deductible after Medicare has paid

Can I Bill Them?

MLN Matters® Number: SE1128 Revised Release Date of Revised Article: December 4, 2017

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

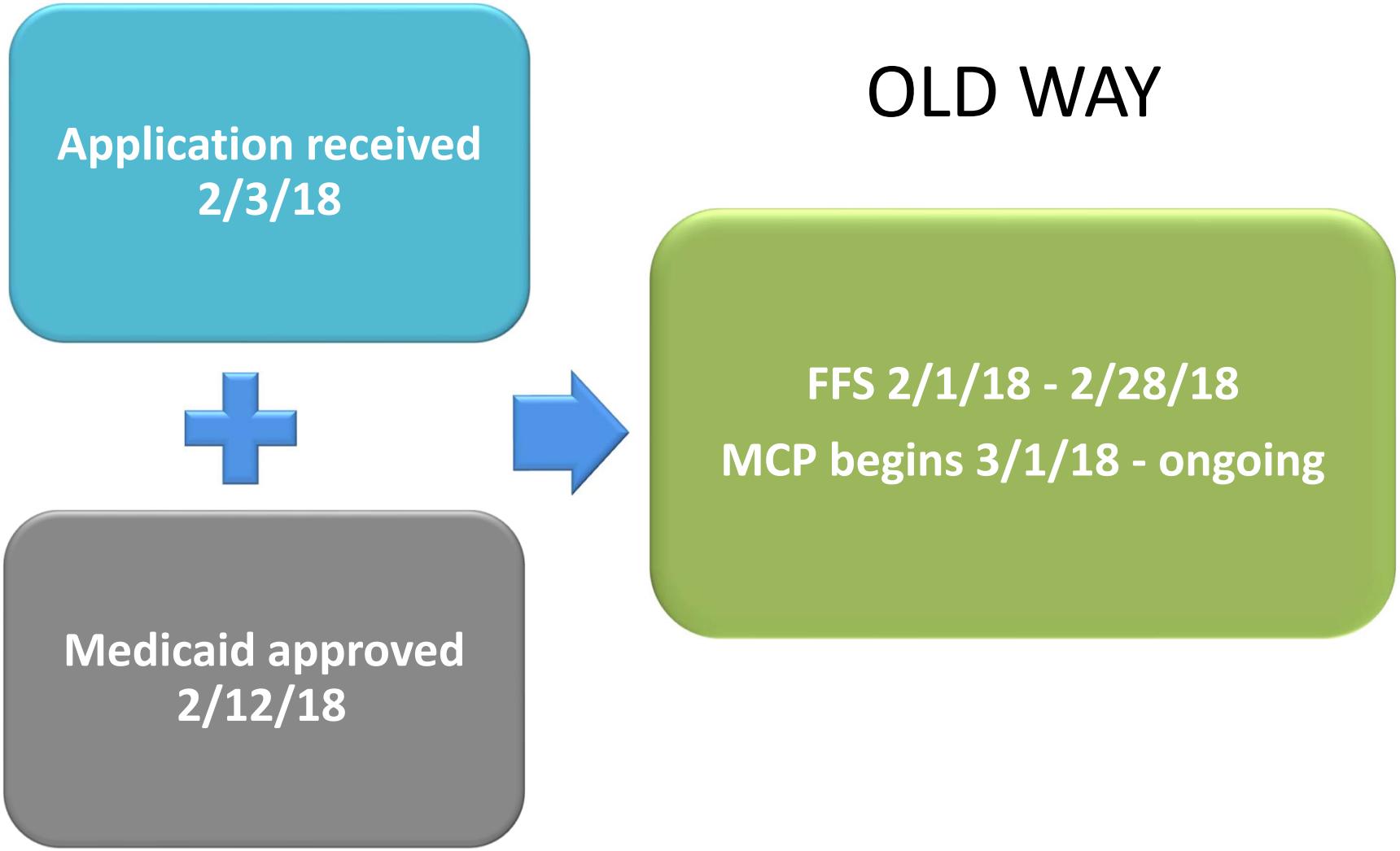
Managed Care Day One - Effective January 1, 2018

- 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

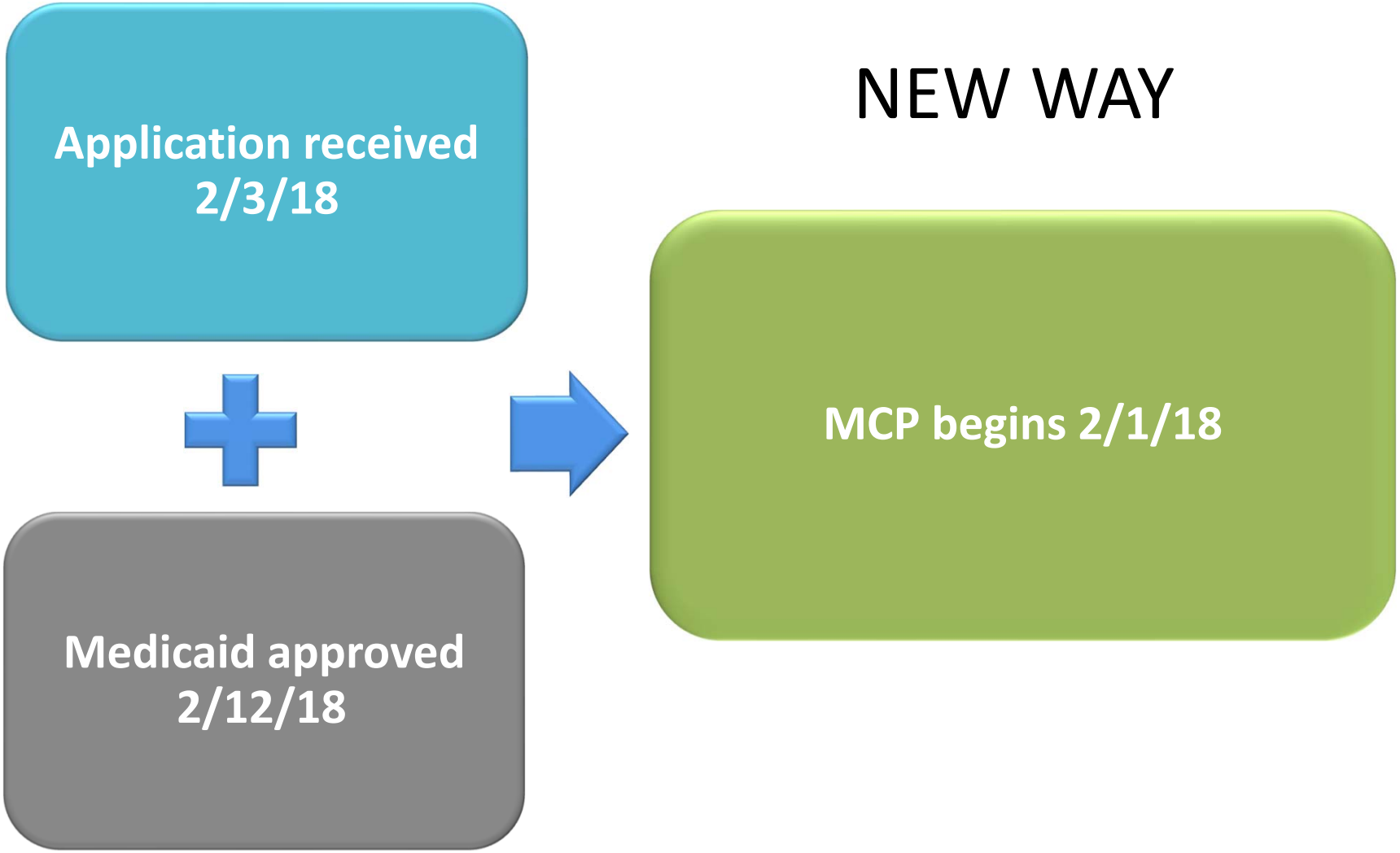
How Does it Work Now?

	'The old way'	Day One
Individual completes Application	4/3/2018	4/3/2018
Determined eligible for Medicaid	5/17/2017	5/17/2017
Fee-For-Service	4/1/2018 → 5/31/2018	4/1/2018 → 4/30/2018
Managed Care Plan	6/1/2018 → 12/31/2299	5/1/2018 → 12/31/2299

OLD WAY


Application received
2/3/18
Medicaid approved
2/12/18
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

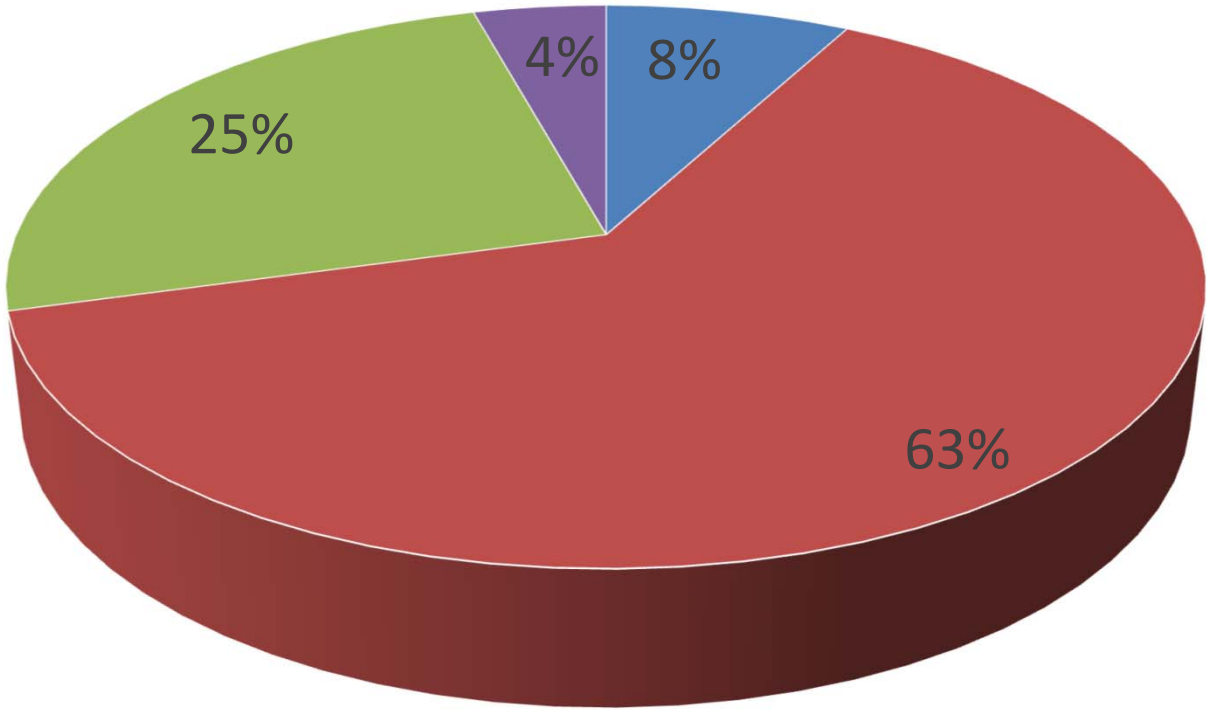
MITS looks for previous MCP in last 90 days

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

Then individual is assigned by an assignment algorithm

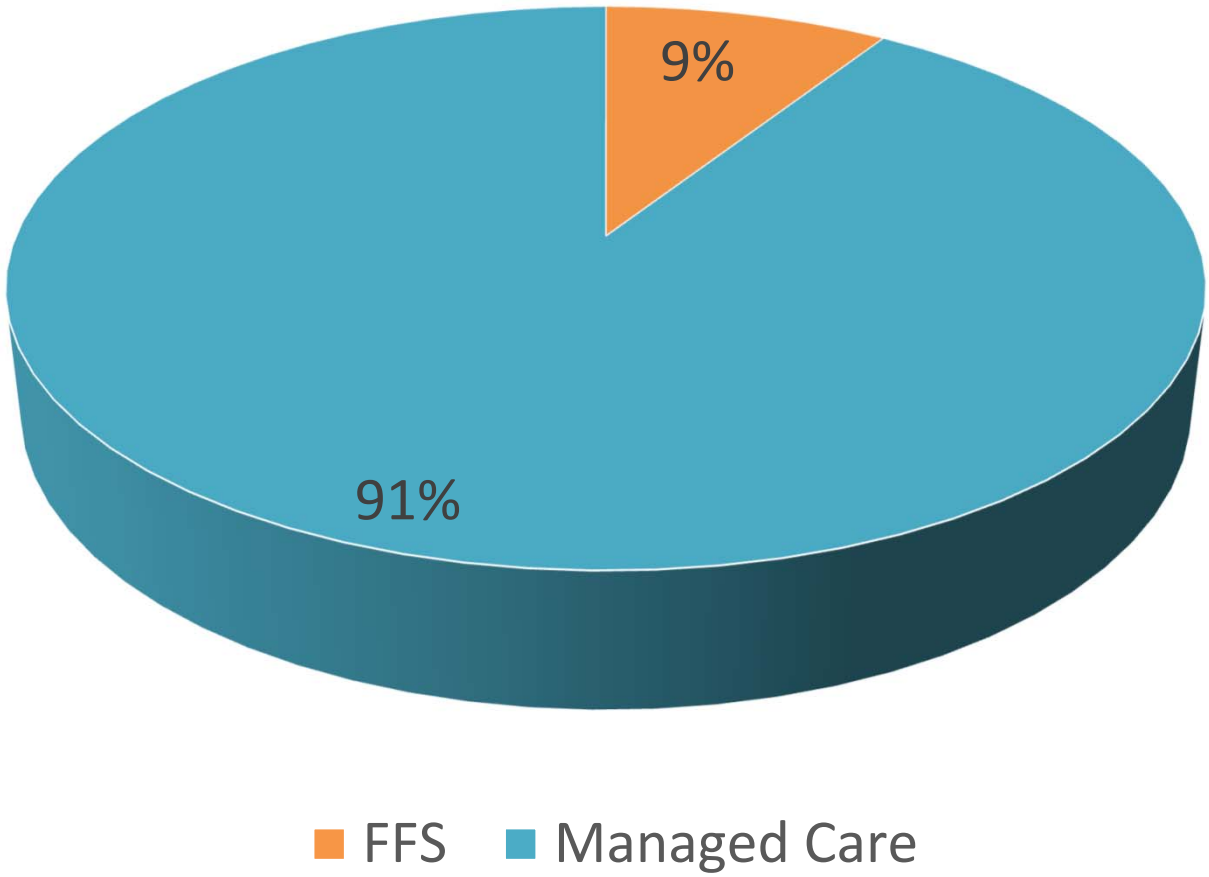
The assigned plan can be changed as desired during first 3 months

Managed Care Enrollment Groups - 2018



ABD CFC Group 8 MyCare

FFS vs. Managed Care Enrollment - 2018



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

Adult Extension and HCBS Waiver

- ✓ Adults eligible via the extension will be able to access a home and community based waiver (HCBS) if a level of care requirement is met ***(MCPs are responsible for state plan health care services)***
- ✓ HCBS waivers include: Passport, Ohio Home Care, and Assisted Living ***(Fee-For-Service Medicaid is still responsible for waiver services)***
- ✓ Current HCBS waiver case management agencies will continue to coordinate waiver services

Managed Care Benefit Package

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

MITS Managed Care Eligibility

Benefit / Assignment Plan

Benefit / Assignment Plan	Effective Date	End Date	Provider Name	Dental Co-Pay Amount	Vision Co-Pay Amount
Medicaid Schools	12/01/2017	02/28/2018		$0.00	$0.00
MRDD Targeted Case Mgmt	12/01/2017	02/28/2018		$0.00	$0.00
Alcohol and Drug Addiction Services	12/01/2017	02/28/2018		$0.00	$0.00
Ohio Mental health	12/01/2017	02/28/2018		$0.00	$0.00
Medicaid	12/01/2017	02/28/2018		$0.00	$0.00

Case/Cat/Seq Spenddown

*** No rows found ***

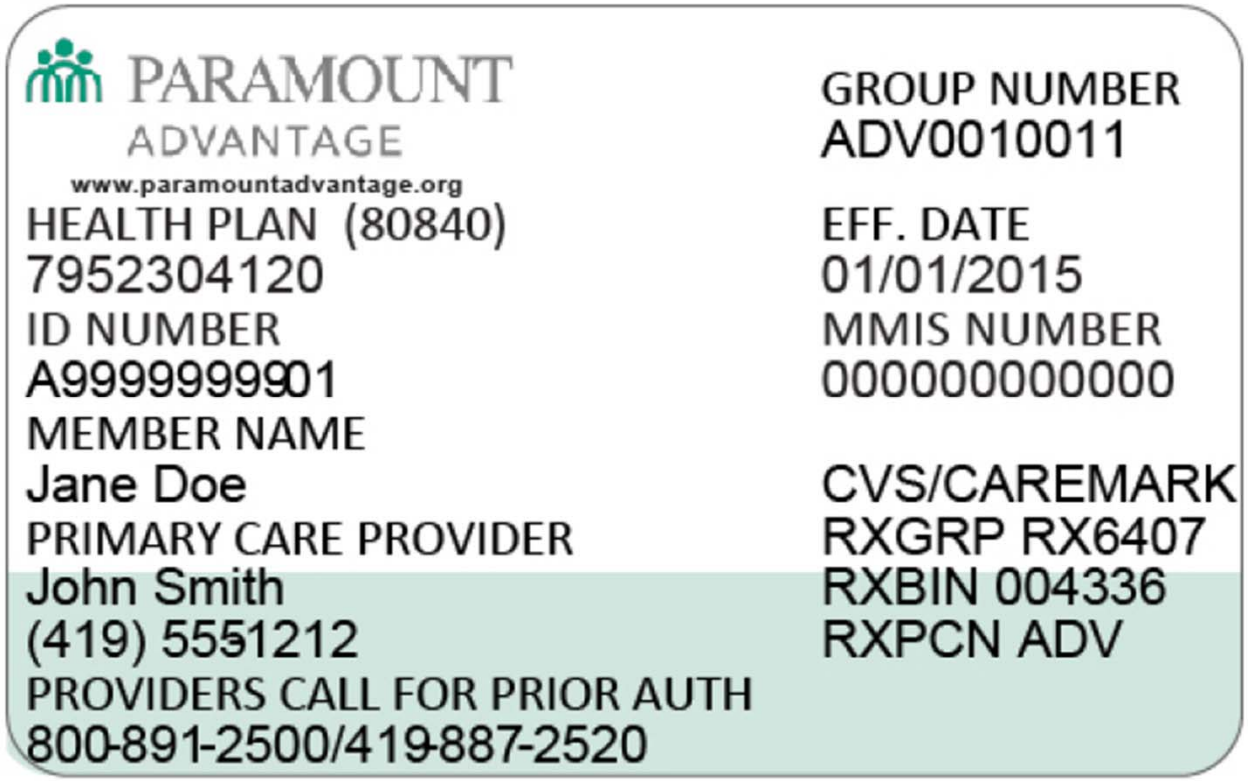
TPL

*** No rows found ***

Managed Care

Plan Name	Plan Description	Effective Date	End Date	Managed Care Benefits
PARAMOUNT ADVANTAGE	HMO, CFC	12/01/2017	02/28/2018	

Managed Care Sample Card



Managed Care Ohio Contracting

Providers who are interested in delivering services to a Managed Care individuals 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

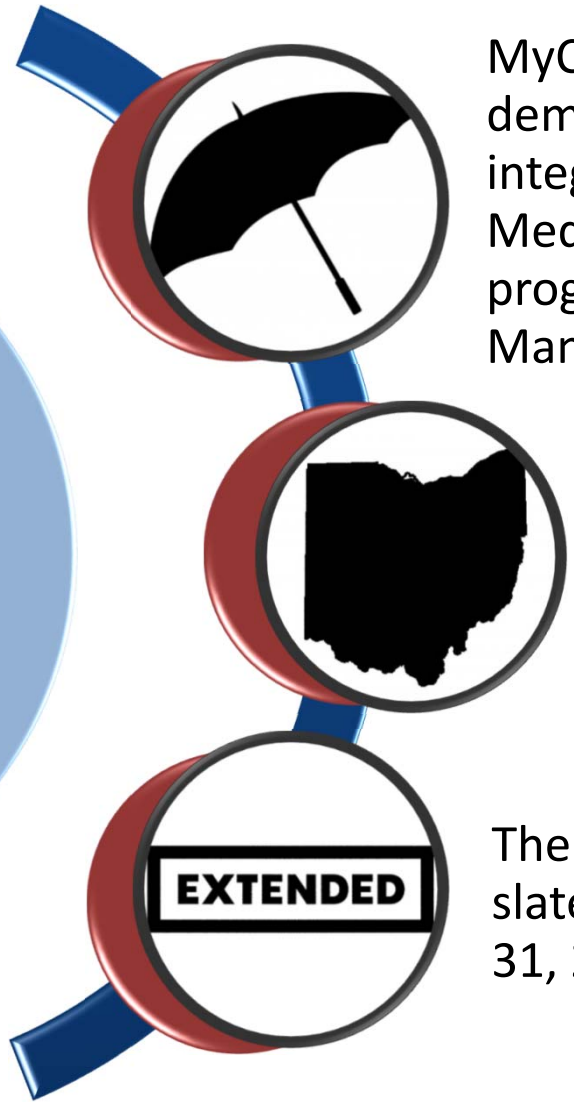
800-488-0134 https://www.CareSource.com/

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

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

800-600-9007 https://www.uhccommunityplan.com

MyCare Ohio



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

HOW DO YOU KNOW IF SOMEONE IS ENROLLED IN MYCARE?

- Providers need to check the MITS provider portal each time before providing services to a Medicaid individual
- 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 an individual is enrolled in a Managed Care Plan based on the eligibility dates of service you enter

MyCare Ohio Opt-In Sample Card

MyCareOhio
Connecting Medicare + Medicaid

CareSource

Member Name: <Cardholder Name>
Member ID #: <Cardholder ID#>
Health Plan (80840)

MMIS Number: <Medicaid Recipient ID#>

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

H8452 - 001

MedicareRx
Prescription Drug Coverage

RxBin: 004336
RxPCN: MEDDADV
RxGRP: RX5045

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)	**Eligibility Verification:**	1-800-488-0134
Behavioral Health Crisis:	1-866-206-7361	**Pharmacy Help Desk:**	1-800-488-0134
		Claims Inquiry:	1-800-488-0134
Care Management:	1-855-475-3163	**Provider Questions:**	1-800-488-0134
24-Hour Nurse Advice:	1-866-206-7361 (TTY: 1-800-750-0750 or 711		
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-In

Benefit / Assignment Plan

Benefit / Assignment Plan	Effective Date	End Date	Provider Name	Dental Co-Pay Amount	Vision Co-Pay Amount
MRDD Targeted Case Mgmt	12/01/2017	01/31/2018		$0.00	$0.00
Alcohol and Drug Addiction Services	12/01/2017	01/31/2018		$0.00	$0.00
Ohio Mental health	12/01/2017	01/31/2018		$0.00	$0.00
Medicaid	12/01/2017	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, MyCare Ohio	12/01/2017	01/31/2018	Dual Benefits

Lock-In

*** No rows found ***

Medicare

Coverage	Effective Date	End Date	Plan Name	Plan ID	Medicare ID
PART A	12/01/2017	01/31/2018			018562948A
PART B	12/01/2017	01/31/2018			018562948A
PART C	12/01/2017	01/31/2018	CARESOURCE MYCARE OHIO	H8452	018562948A
PART D	01/01/2018	01/31/2018	*H8452/001	001	018562948A
PART D	12/01/2017	12/31/2017	*H8452/001	001	018562948A

MyCare Ohio Opt-Out Sample Card

MyCareOhio
Connecting Medicare + Medicaid

CareSource

Member Name: <Cardholder Name>
Member ID #: <Cardholder ID#>

MMIS Number: <Medicaid Recipient ID#>

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

RxBin: 004336
RxPCN: ADV
RxGRP: RX3292

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

Benefit / Assignment Plan	Effective Date	End Date	Provider Name	Dental Co-Pay Amount	Vision Co-Pay Amount
MRDD Targeted Case Mgmt	10/01/2017	01/31/2018		$0.00	$0.00
Alcohol and Drug Addiction Services	10/01/2017	01/31/2018		$0.00	$0.00
Ohio Mental health	10/01/2017	01/31/2018		$0.00	$0.00
Medicaid	10/01/2017	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
BUCKEYE COMMUNITY HEALTH PLAN	HMO, MyCare Ohio	10/01/2017	01/31/2018	Medicaid Only

Lock-In

*** No rows found ***

Medicare

Coverage	Effective Date	End Date	Plan Name	Plan ID	Medicare ID
PART A	10/01/2017	01/31/2018			300685983A
PART B	10/01/2017	01/31/2018			300685983A
PART C	11/01/2017	01/31/2018	ANTHEM SENIOR ADVANTAGE PLUS	H3655	300685983A

MyCare Ohio Region Breakdown

Northwest	Southwest	West Central	Central	East Central	Northeast Central	Northeast
Aetna Buckeye	Aetna Molina	Buckeye Molina	Aetna Molina	Caresource United	Caresource United	Caresource Buckeye United
Fulton Lucas Ottawa Wood	Butler Warren Clinton Hamilton Clermont	Clark Green Montgomery	Union Delaware Franklin Pickaway Madison	Summit Portage Stark Wayne	Trumbull Mahoning Columbiana	Lorain Cuyahoga Lake Geauga Medina

MyCare Ohio Managed Care Contracting

Providers who are interested in delivering services to MyCare Ohio individuals 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

MyCare Ohio Managed Care Plans

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

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

855-364-0974 https://www.aetnabetterhealth.com/ohio

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

800-600-9007 https://www.uhccommunityplan.com/

PROVIDER COMPLAINTS

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

Certification issues

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

Provider credentialing concerns

Please send to Ohio Department of Insurance (ODI)

Ohio | Department of Medicaid

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 1-800-686-1516.

Complaint Details

MCP Name: *

Complaint Reason: *

* Are you contracted with this Health Plan? ○ Yes ○ No

* Is this complaint related to the MyCare Program? ○ Yes ○ No

* Have you already contacted the MCP about this issue? ○ Yes ○ No

* Is this complaint related to any previously submitted complaints? ○ Yes ○ No

* Is this complaint related to children with special health care needs? ○ Yes ○ No

* Is the patient receiving or seeking mental health or substance abuse services? ○ Yes ○ No

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

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:

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

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)

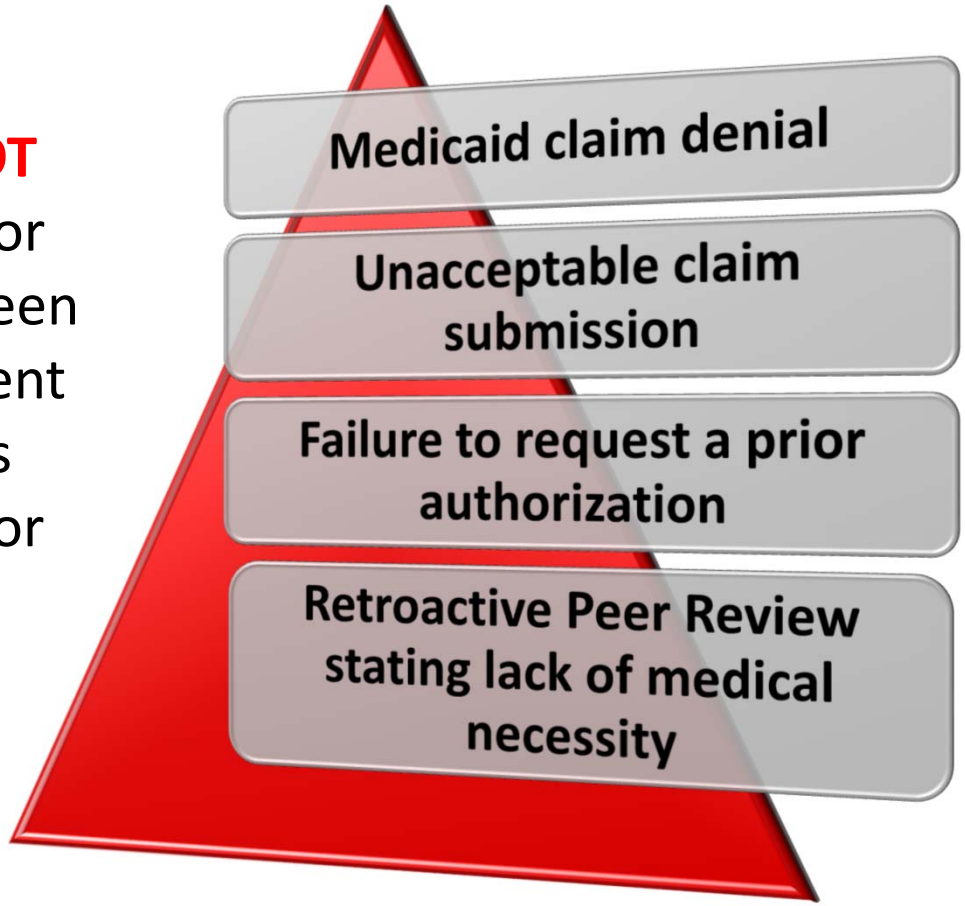
The department will reimburse the provider the lesser of the Medicaid maximum allowable rate (established fee schedule) or the UCC

Coordination of Benefits: OAC 5160-1-08

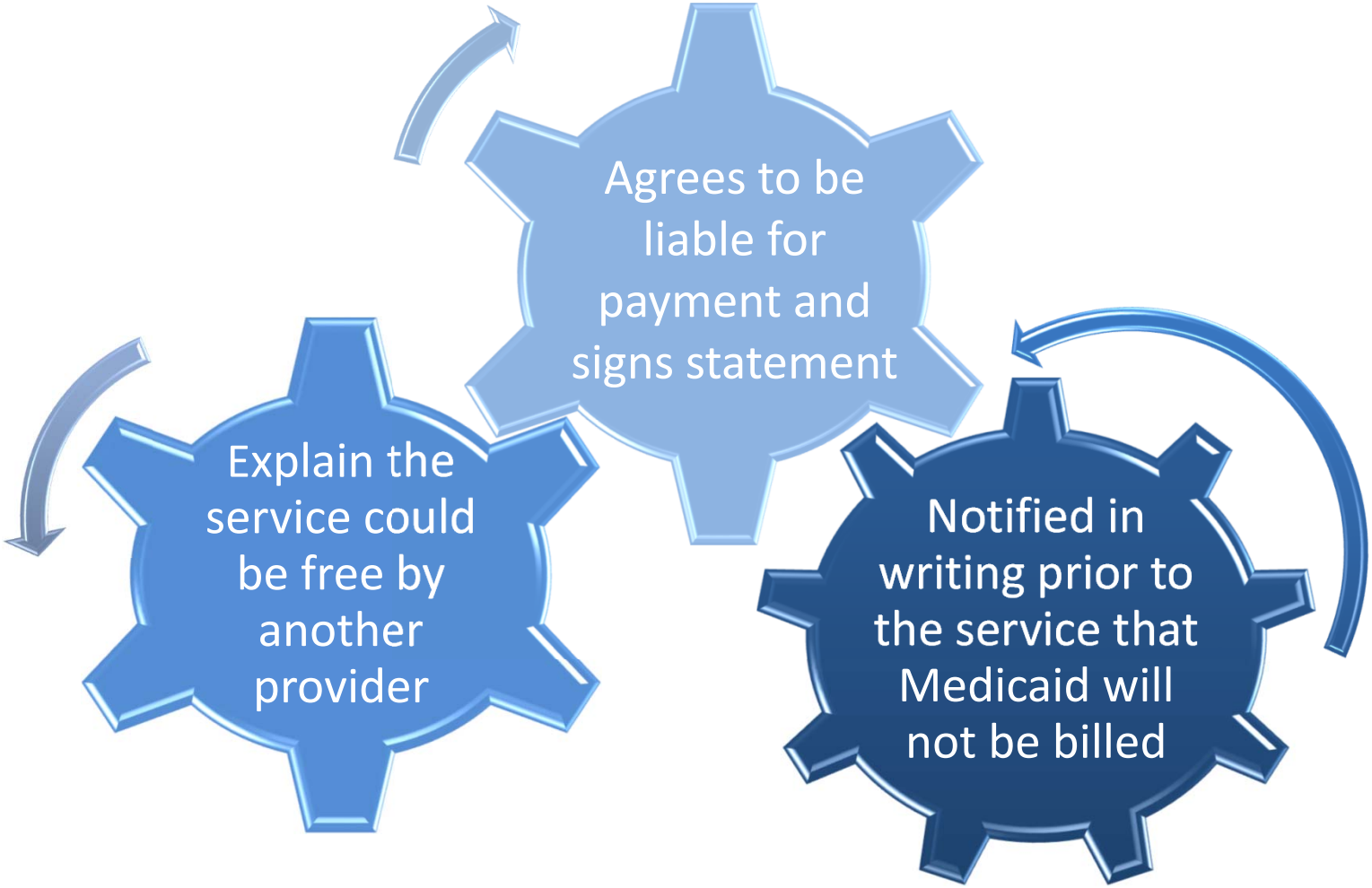
- The Ohio Administrative Code requires that a Medicaid consumer provide notice to the department prior to initiating any action against a liable third party
- The department will take steps to protect its subrogation rights if that notice is not provided
- For questions, contact the Coordination of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

Medicaid Consumer Liability 5160-1-13.1

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:



When Can you Bill an Individual?



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 ODJFS unless:

_____ (1) The consumer is notified in writing prior to the service being rendered that the provider will not bill ODJFS 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 ODJFS, may be billed to the consumer when the provisions in paragraphs (C)(1) and (C)(2) of this rule are met.

EXAMPLE

The Ohio Department of Medicaid Website

Provider News

Ohio | Department of Medicaid

Text Size: +A -A

Select Language

Powered by Google Translate

Translation Disclaimer

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

PROVIDERS

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 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)

Related Content

- Benefit Coordination & Recovery
- Fee Schedules/Rates
- Medicaid Forms
- ODJFS Forms
- MITS EDMS Cover Page
  - Instructions
- Healthchek Screening Forms
- e-Manuals
- Helpful Links
- Get a National Provider Identifier (NPI)
- Transmittal Letter Notification
- Medicaid Provider Incentive Program (MPIP)
- ICD-10

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)

Billing Resources

Ohio | Department of Medicaid

Search... GO

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

PROVIDERS

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Independent Provider Overtime Rates - Effective January 1, 2016 (Rev. 4/1/16)

- Enrollment and Support
- Fee Schedule and Rates
- Billing
- Training
- Managed Care
- Provider Types
- MITS
- Payment Innovation
- DRA Attestation

- Direct Deposit
- Billing Instructions
- HIPAA and EDI Information
- Trading Partners
- How to Refund Overpayments
- Remittance Advice
- Answers for MITS Problems
- HIPAA 5010 Implementation
- Behavioral Health Integration Project
- ICD-10

Need technical assistance?
Provider Hotline: (800) 686-1516

Access the **MITS Portal**

Related Content

- Benefit Coordination & Recovery
- Fee Schedules/Rates
- Medicaid Forms
- ODJFS Forms
- MITS EDMS Cover Page

How to Find Modifiers Recognized by Ohio Medicaid

- Scroll to the bottom of the page

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

- EDI Companion Guide for Professional Claims

INSTITUTIONAL OR FACILITY-BASED CLAIMS:

- Web Portal Billing Guide for Institutional Claims
- EDI Companion Guide for Institutional Claims
- ODM Hospital Billing Guidelines
  - For Dates of Discharge and Dates of Service On or Before 7/31/2017
  - For Dates of Discharge and Dates of Service On or After 8/1/2017

DENTAL CLAIMS:

- Web Portal Billing Guide for Dental Claims
- EDI Companion Guide for Dental Claims

MODIFIERS:

- Modifiers recognized by ODM

State Plan Services

OAC 5160-12

Services that all Medicaid individuals may receive if medically necessary

ODM submits a State Plan to the federal government that describes how Medicaid will administer the program

What are Private Duty Nursing Services?

- Medicaid State Plan Nursing Services provide home health services when a medical need for part-time intermittent skilled nursing or aide care and therapies is needed for an individual
- Private Duty Nursing Services (PDN) provides those continuous and complex nursing services in a home setting
  - PDN is performed by a RN or LPN
- Continuous care is defined as more than four hours but less than 12 hours-per visit
- These services must be prior authorized
  - ODM determines eligibility for PDN along with the amount, scope, and duration of services

Who Can/Cannot Receive PDN Services?

CAN

An individual who is:

*Medicaid eligible
*Requires continuous skilled nursing services
*Has a comparable institutional level of care
*Is not receiving hospice services

CANNOT

Someone who has elected hospice care must access their nursing services through the hospice benefit

*Except for children under age 21 who are receiving concurrent curative treatment with hospice

State Plan PDN Services Reimbursement: OAC 5160-12-06

T1000 Private Duty Nursing

Base Rate – for initial 35 to 60 minutes of delivered service

Unit Rate – 15 minute units of delivered service when initial visit is:

Greater than 60 minutes or less than or equal to 34 minutes in length

Appropriate modifiers may be required by policy and needed for proper reimbursement

State Plan Home Health Procedure Codes

- ☑ **G0151** - Physical therapy
- ☑ **G0152** - Occupational therapy
- ☑ **G0153** - Speech-language pathology
- ☑ **G0156** - Home health aide
- ☑ **G0299** - Home health nursing - RN
- ☑ **G0300** - Home health nursing - LPN

Rates found in OAC 5160-12-05

Ohio Home Care Program: OAC 5160-12-02

Post Hospital PDN Services

Up to 56 hours a week
More than 4 but max of 12 hours/visit/nurse per day/24 hour period
Up to 60 consecutive days post hospital discharge

Not provided for: habilitative care, RN assessment services, and RN consultation services

What Are Waiver Services?

- Waiver refers to an exception to federal law that waives certain Ohio Medicaid eligibility requirements and allows eligible Medicaid individuals to live in the community instead of in a nursing facility or other institution
- An individual must be determined eligible for waiver services
- ODM administers one waiver known as Ohio Home Care Wavier (OHC)
- The Department of Developmental Disabilities (DODD) and The Ohio Department of Aging (ODA) administer additional waiver programs

ODM-administered waiver programs: OAC 5160-45-10

- Ensure individuals are protected from abuse, neglect, exploitation, and other threats to their health, safety and well-being
- Work with the individual and care manager to coordinate care
  - Agree to provide services in the person-centered services plan
  - Participate in developing a back-up plan of care
- Maintain and retain all required documentation
- Verify service delivery using an ODM-approved EVV system

Ohio home care waiver (OHC): OAC 5160-46-04(A)

Waiver Nursing Services

Nursing tasks and activities requiring skills of a registered nurse (RN) or licensed practical nurse (LPN) if directed by an RN

Examples include: Intravenous (IV) insertion, IV medication administration, central line dressings, blood product administration, and medical pump programming

Ohio home care waiver (OHC): OAC 5160-46-04(B)

Personal Care Aide Services

Assists individuals with activities of daily living and instrumental activities of daily living

Examples include: bathing, dressing, range of motion exercises, general homemaking activities, household chores, paying bills, accompanying or transporting the individual, and meal preparation

Waiver Services Reimbursement

Use the appropriate procedure code for the service

Base Rate – for initial 35 to 60 minutes of delivered service

Unit Rate – 15 minute units of delivered service when initial visit is:

Greater than 60 minutes or less than or equal to 34 minutes in length

Appropriate modifiers may be required by policy and needed for proper reimbursement

Common Waiver Services Procedure Codes

- ☑ **T1002** - Waiver nursing by RN
- ☑ **T1003** - Waiver nursing by LPN
- ☑ **T1019** - Personal care aide services
- ☑ **S5125** - Home care attendant (HCAS)

Rates found in OAC 5160-46-06 and 5160-46-06.1

Possible Modifiers

Modifiers	Description
U1	Infusion therapy (RNs only)
U2	Second visit on same day
U3	Three or more visits on the same day
U4	12 hours to 16 hours per visit
U5	Healthtrack (EPSDT)
U7	Over 14 hours
U8	HCAS in lieu of intermittent nursing services 4 hours or less

Additional Modifiers

Modifiers	Descriptions
U9	RN consultation with T1001
HQ	Group visit
TD	RN visit
TE	LPN visit

What is the Person - Centered Services Plan?

A document the case manager (CM) and others develop with the individual

It specifies all the services which are currently necessary for an individual to remain at home

It lists the goals, needed services, cost of services, who is liable for payment, service providers, home care team members, and any decision regarding individual options

The individual and all providers need to receive a copy and understand it

The plan authorizes the service units (hours) providers can be reimbursed and may specify the schedule of visits

Person - Centered Services Plan

Ohio Department of Medicaid-Administered Waiver
ALL SERVICES PLAN

Consumer's name	*Consumer's billing number*	0	4	32
CONSUMER NAME (last, first mi)	MMIS NUMBER	PROGRAM CODE	CM REGION	COUNTY CODE

GOAL #
1-PCA

GOALS / OBJECTIVES / METHODS

GOAL:
PERSONAL CARE AIDE

OBJECTIVE:
Consumer name will be safe, clean, healthy, and comfortable in the home environment. He will live in his home setting as independently and safely as possible. The home will be clean and free of clutter. All personal care needs will be met, and Consumer will be clean and wear clean clothing appropriate for the weather. He will remain hydrated and well-nourished.

METHOD:
CURRENT AUTHORIZATION: Effective 1/17/2017 Aide to visit 1 time per day, 5 days per week, 3 hrs each visit Mon-Fri. *Provider name*, IP, to work Monday-Friday 3 hours each visit. Billing: Pt liability and Waiver ********** PREVIOUS AUTHORIZATION: Effective 12/26/2016 Aide to visit 1 time per day, 5 days per week, 3 hrs each visit Mon-Fri. *Provider* to work Mon, Wed, and Fri Preservation of funding for Tues and Thurs hours. Billing: Pt liability and Waiver ********** PREVIOUS AUTHORIZATION: 5 shifts per week, 1 shift per day (Monday through Friday)for 2 hours each shift. BILLING: 1 shift to State Plan/G0156, remaining shifts to Waiver/T1019 ********** Aides to assist with transfers and locomotion as needed, including monitoring for falls and fall risks. Personal care to include bathing, dressing, hair care, oral care, and skin care as needed and requested. Homemaking to include dusting, sweeping, mopping, cleaning of kitchen and bathroom, dishes, bed making, linen changes, laundry, meal prep, and trash removal as needed and requested. Access to the community as needed and allowed by agency policy. Aides are to only tend to Consumer's personal items and areas.

GOAL #
14-
HDM

GOALS / OBJECTIVES / METHODS

GOAL:
HOME DELIVERED MEALS

OBJECTIVE:
Consumer will be well nourished and hydrated with access to nutritious food when alone at meal times which will enable him to remain healthy and maintain nutritional levels as recommended by his physician.

Person - Centered Services Plan

ALL SERVICES PLAN
Units
Display Past 2 Months

Consumer's billing number	*Consumer's name and address*		1/13/2017 4:40:28 PM	3/14/2016 - 3/13/2017
MMIS NUMBER	CONSUMERNAME (last,first)	COST LEVEL CODE	DATE THIS PLAN ACTIVATED	EFFECTIVE DATE m/d/yyyy

GOAL #	SERVICE	UNITS/ MONTH	START DATE	END DATE	PROVIDER/CONTACT	NT	PHONE # & FAX # & EMAIL	PAYMENT SOURCE	ESTIMATED COST/MO (COMPLETE FOR OHC costs only)
3-BUP, 11-IS	Other:		3/14/2016		*Spouse's name* Wife *Address*	☐	P xxx-xxx-xxxx	Gratis/ Volunteer -no pymt	
7-MD	Medical Care		3/14/2016		*Physician's name* MD General Practice *Address*	☐	Pxxx-xxx-xxxx F xxx-xxx-xxxx	Medicaid	
1-PCA	Wvr PCA/Agency T1019	B=18 S=72	4/6/2016	12/25/2016	0000000 To be determined All, Ohio 00000	☐	P xxx-xxx-xxxx	Medicaid	$672.66
1-PCA	HHAide/StPl G0156	B=5 S=20	4/6/2016	12/25/2016	Provider Pending 0000000 To be determined All, Ohio 00000	☐	P xxx-xxx-xxxx	State Plan	$186.85
17 LIA	Wvr PCA/NAP T1019	B=4 S=32	12/26/2016		*Provider's name* OETP *Provider number* *Address*	☐	P xxx-xxx-xxxx E email@gmail.com	Patient Liability Provider may NOT bill Medicaid for this amount. Consumer is to be billed this amount prior to billing	$151.00

Person - Centered Services Plan

ALL SERVICES PLAN
TeamTeam Members Initial Participating in Plan Development

Name/Relationship	Consumer / Guardian / Representative	Participation Date	Participation Method
Consumer	Consumer	3/4/2016	In person
Other provider	*Guardian's name*	3/4/2016	Assigned
Other provider #2	Case Manager	4/6/2016	In person

Name	Signature; If Present	Participation Date	Participation Method
Provider's name		1/13/2017	Email
Therapy provider's name		12/23/2016	
Physician's name		3/14/2016	Fax

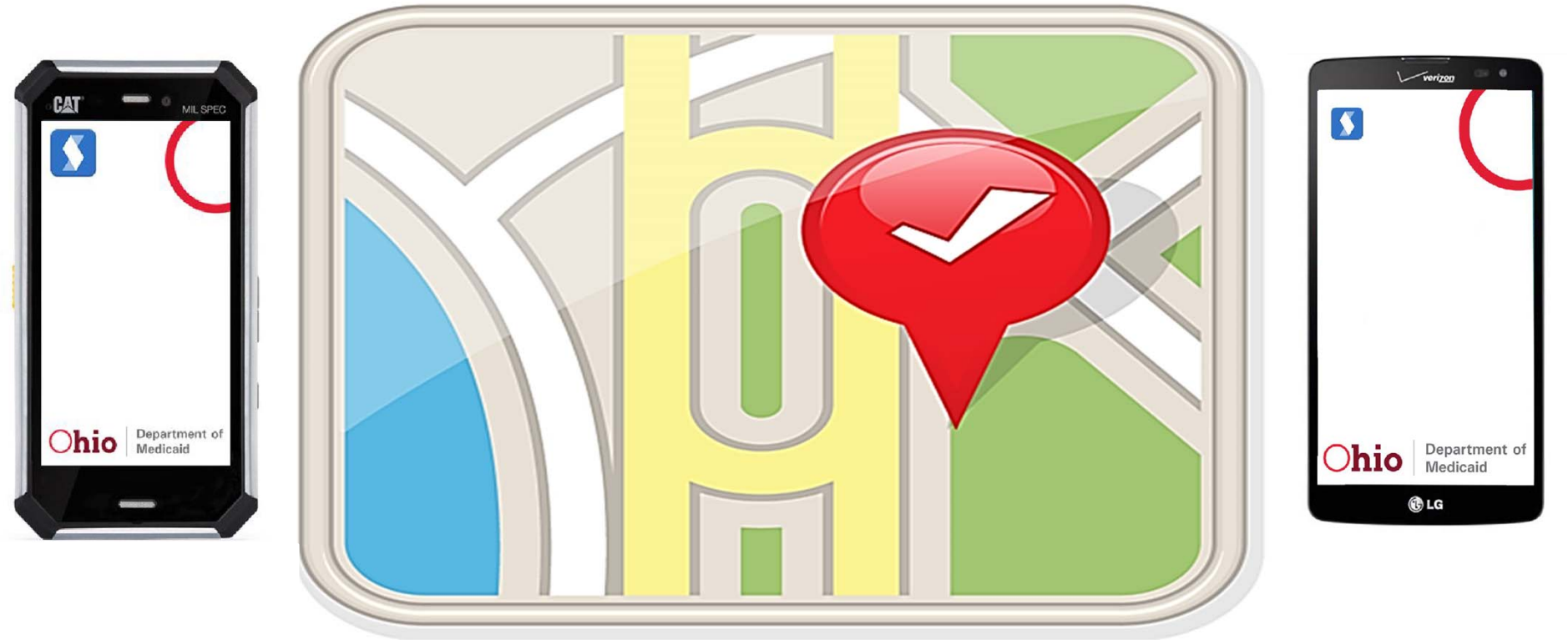
This plan will be reviewed according to the following schedule:
6 Months 1-3 Monthly Visits 4-6 Monthly Visits 2 Calls Mo, 1, 1 call 2-6 Mos.

CM Monitoring will occur according to the following schedule:
6 Months 1-3 Monthly Visits 4-6 Monthly Visits 2 Calls Mo, 1, 1 call 2-6 Mos.

I understand that I ☑ have ☐ do not have monthly patient liability of $151 per month I understand that this means that I must pay $151 each month to:

Provider's name

Electronic Visit Verification



Providers Affected Right Now

16 – Other Accredited Home Health Agency / 160 – Other Accredited Home Health Agency

16 – Other Accredited Home Health Agency / 161 – ODM Otherwise Accredited Home Health Agency

60 – Medicare Certified Home Health Agency / 600 – Medicare Certified Home Health Agency

60 – Medicare Certified Home Health Agency / 601 – ODM Medicare Certified Home Health Agency

Current Included Services

State Plan Home Health Aide

State Plan Home Health Nursing

Private Duty Nursing (PDN)

Ohio Home Care Waiver Nursing

Ohio Home Care Waiver Personal Care Aide

Home Care Attendant

RN Assessment

Which Procedure Codes Require EVV?

G0156 - Home Health Care Providers - Aide - each 15 min
G0299 - Home Health - RN - each 15 min
G0300 - Home Health - LPN - each 15 min
T1000 - Private Duty/Independent Nursing
T1001 - Nursing Assessment/Evaluation
T1002 - RN Services up to 15 min
T1003 - LPN/LVN Services up to 15 min
T1019 - Personal Care Services - 15 min
S5125 - Attendant Care Service - 15 min

What should I be doing today?

- Logging all visits with the EVV or an alternate EVV vendor
  - Clearing any and all visit exceptions
- Visit the ODM webpage often for updates
- Read all correspondence received by ODM
- Keep your email updated in MITS

http://medicaid.ohio.gov/INITIATIVES/ElectronicVisitVerification.aspx

What is Your Email?

- If no email is listed in MITS, then **no** Sandata account
  - Whatever is in the service location in MITS is what is used for your Sandata account
- To update or add your email, log into the MITS Provider Portal
  - Click on the "demographic maintenance" tab
  - Select "Location Name Address" option
    - ✓ Four address types will show: Home Office, Mail To, Pay To, and Service Location
    - ✓ Email must be updated for all four types, saving each type before changing the next one

How to Update an Email in MITS

Ohio Department of Medicaid

Search

Welcome, EVANSD2 Thursday 05/17/2018 11:59:58 AM

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

demographic maintenance 1099 information provider faq mits days report correspondence self attestation

ordering/referring/prescribing search group affiliation group members cpc group cpc group members cpc accreditations cpc attestations

Service Location > Location Name Address > Service Language > 1099 Mailing Address

Provider Information

Medicaid Provider ID	[redacted]	Address Type	[redacted]
National Provider ID		Address	
Practice Type			
Provider Type		City	
Ownership		County	
Medicaid Effective Date		State/Zip	
Medicaid End Date		Phone	

How to Update an Email in MITS

All four types

Service Location > Location Name Address > Service Language > 1099 Mailing Address

The following messages were generated:

Save was Successful

Provider Information

Medicaid Provider ID	[redacted]	Address Type	[redacted]
National Provider ID		Address	
Practice Type			
Provider Type		City	
Ownership		County	
Medicaid Effective Date		State/Zip	
Medicaid End Date		Phone	

Location Name Address

Address Type	Name	Address 1	City	State	Zip	Zip + 4	Phone 1
HOME OFFICE	[redacted]						
MAIL TO							
PAY TO							
SERVICE LOC	[redacted]						

Type changes below.

Name Type	Business Name / Personal Name		
Name	CARETENDERS VS OF OHIO LLC		
Title			
Address Type	SERVICE LOC		
Usage Type			
Country	[redacted]		
Contact Name	[redacted]		
*Phone 1	[redacted]	Fax 1	(000)000-0000
Phone 2	[redacted]	Fax 2	(000)000-0000
*Address 1	[redacted]		
Address 2			
*City	[redacted]		
*State	OH		
*Zip	[redacted]		
*E-Mail	[redacted]	*Confirm E-Mail	[redacted]

del alternate service location | add alternate service location | save | cancel

SAVE!!!

*You **MUST** use the number provided to you in your welcome kits

If the incorrect number is used your visit could be logged under the wrong provider, which is a **HIPAA** violation

*You can search for individuals Santrax ID or Medicaid ID via the mobile app

Things to Know

- There is no cost to providers who use Sandata's system
- EVV will capture and log visit data electronically
- Claim submission process will not change but additional claim edits have been enabled
- ODM is open to agency providers using an approved alternate system, non-agencies must use Sandata

EVV Changes

Time is not being used to match visits, exact units are being used

Providers now have the option to download the Sandata app onto their phone/personal device to use in place of the EVV device

- Not for an individual's device -

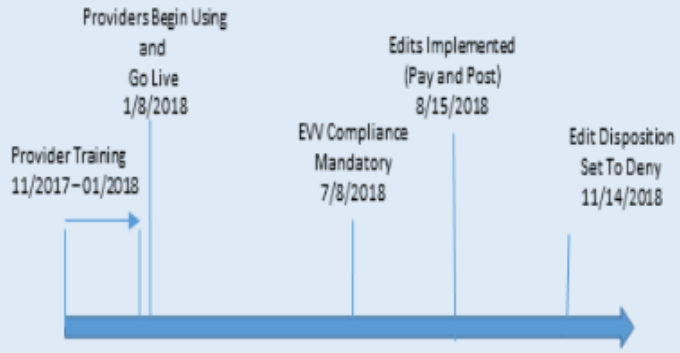
ODM removed the 90 day exception, which means EVV would need to be used beginning on the first date of service

UNIT CALCULATION Phase 1 Services

Table 1: Units to Time	MINUTES AND SECONDS
1	00:01 - 15:59
2	16:00 - 34:59
3	35:00 - 45:59
4	46:00 - 60:59
5	61:00 - 75:59
6	76:00 - 90:59
7	91:00 - 105:59
8	106:00 - 120:59
9+	Every 15 minute increment will be an additional unit

Ohio | Department of Medicaid

Phase 1



Phase 1 will apply to selected services billed directly to Medicaid (known as fee-for-service):
State Plan Home Health Services
Ohio Home Care Waiver Services

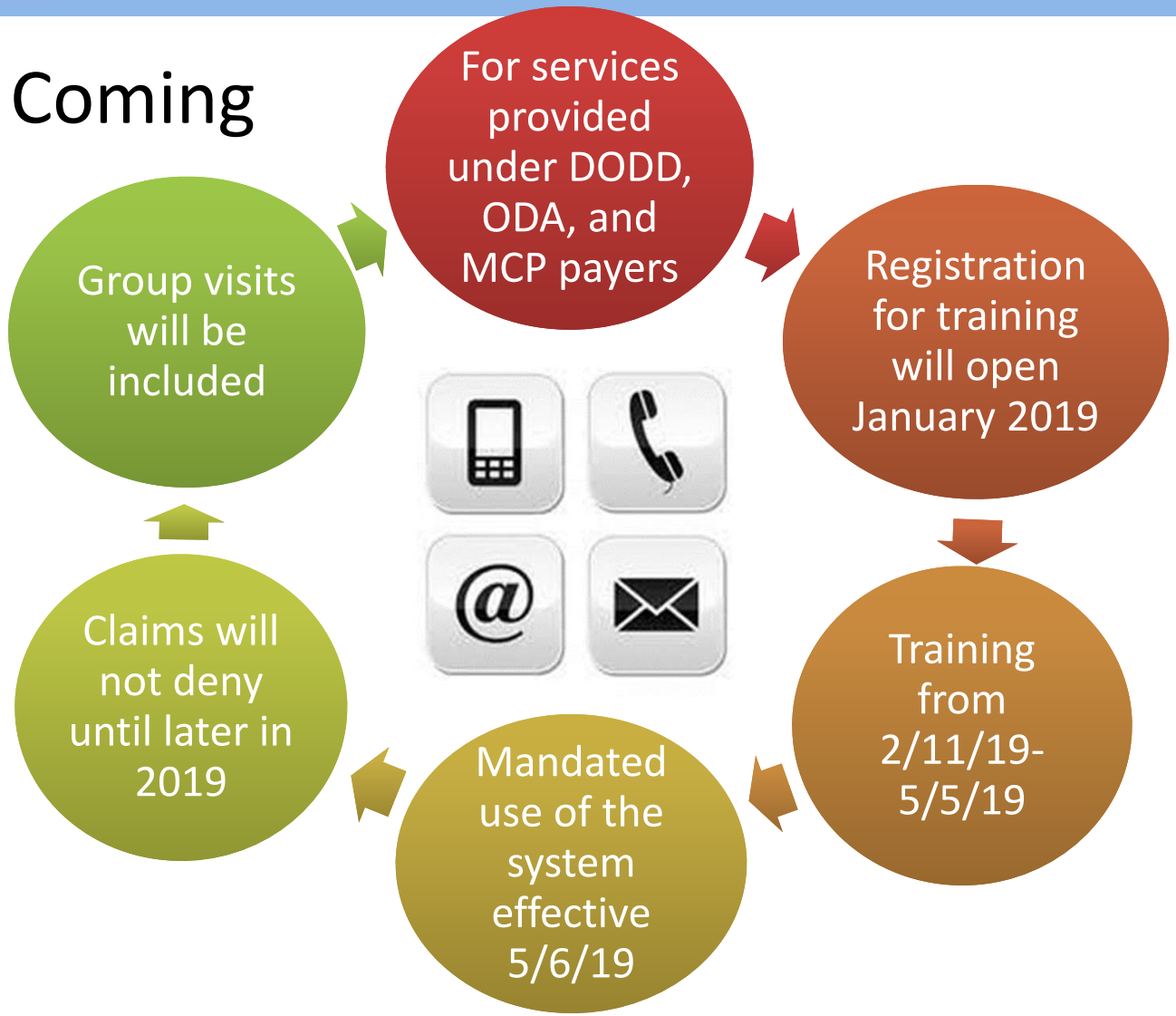
Phase 2

Phase 2 will include the Managed Care Organizations, Department of Development Disabilities, the Ohio Department of Aging and Group Visits from Phase 1.

Phase 3

Phase 3 will include Self-Direction, Home-Based Therapy Services and any remaining CURES Act requirements.

Phase 2 is Coming

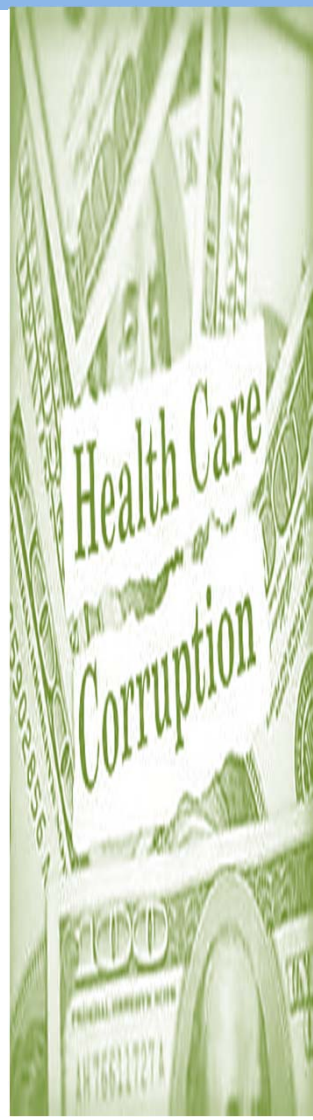


Structural Reviews of Providers and Investigation of Provider Occurrences: OAC 5160-45-06

Providers are subject to structural reviews during each of the first three years of furnishing billable services

- Thereafter structural reviews may be conducted biennially if all of the following apply to the provider:
  - There were no findings during the most recent review
  - Was not substantiated to be the violator in an incident
  - Was not the subject of more than one provider occurrence during the previous 12 months
  - Does not live with an individual receiving ODM-administered waiver services

Surveillance and Utilization Review Section (SURS)



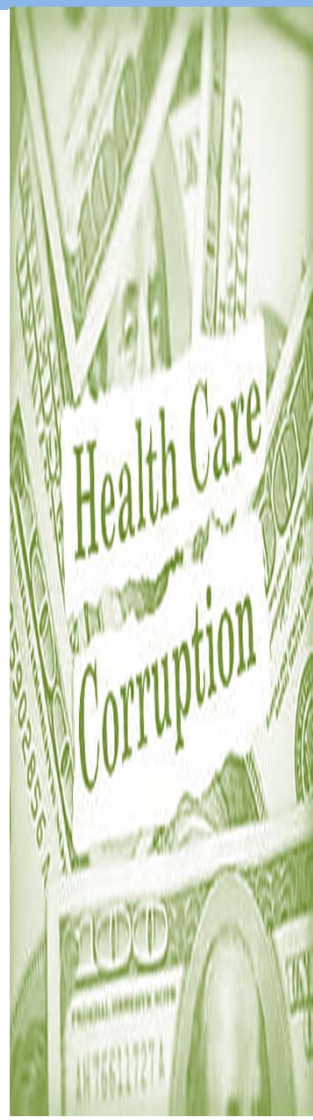
- Review records and/or claims for compliance with ODM rules, which include:
  - Unauthorized services
  - Up-coding
  - Unbundling
  - Documentation issues

Surveillance and Utilization Review Section (SURS)

Top five provider types reviewed:

1. **Home Health Services**
2. Durable Medical Equipment
3. Skilled Nursing Facilities
4. Physician Services
5. **Private Duty Nursing**

Surveillance and Utilization Review Section (SURS)



- Review details:
  - Up to 6 years of records be reviewed by SURS
- Potential outcomes of limited scope reviews:
  - No identified overpayment
  - Overpayment identification or a referral to Ohio Attorney General (Medicaid Fraud Control Unit)

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

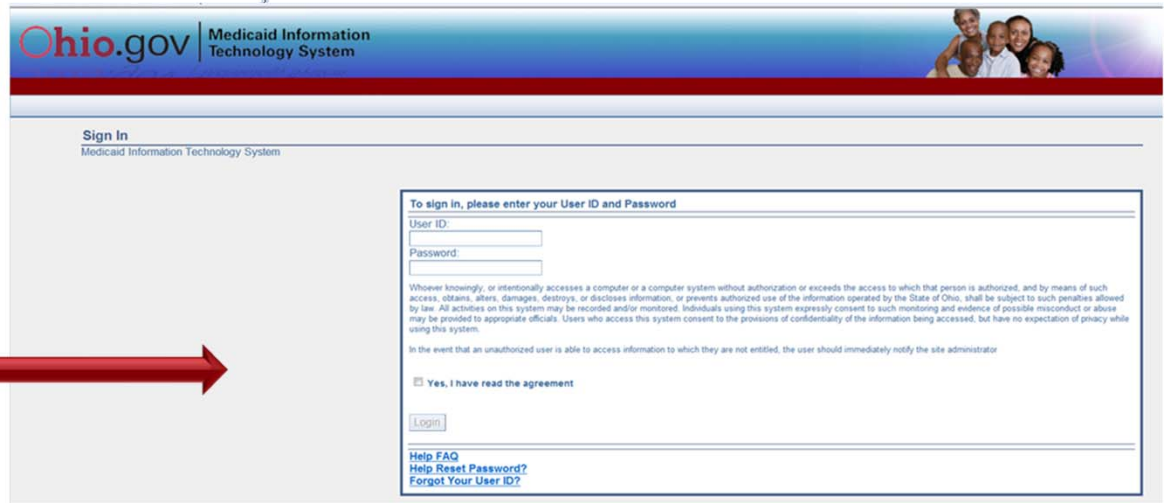
Mac users use current version of Safari, Firefox, or Chrome

Turn **OFF** pop up blocker functionality

- Go to http://Medicaid.ohio.gov
- 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

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

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

Submission of a Professional Claim

Ohio.gov | Medicaid Information Technology System

Search

Welcome,

Super User Providers Account Trading Partners Claims Eligibility Prior Authorization Reports Portal Admin Security Admin

search search detail dental institutional

Claims

- Search
- Search Detail
- Dental
- Institutional (for Inpatient, Outpatient, L
- Professional

Search
Search Detail
Dental
Institutional
Professional

Home | OHP Home | Site Settings | Site Map | Privacy Statement | Contact Us

AMA & ADA Copyright

Copyright 2011 HP Enterprise Services. All rights reserved.

Submission of a Professional Claim

Professional Claim: NPI -

BILLING INFORMATION

ICN	
Claim Received Date	
Claim Type	M - PROFESSIONAL
Provider ID	NPI
*Medicaid Billing Number	
*Date of Birth	
Last Name	
First Name, MI	
*Patient Account #	0
Medical Record #	
Referring Provider #	
Rendering ID	
*Medicare Assignment	NOT ASSIGNED
Patient Amount Paid	$0.00
*ICD Version	10

SERVICE INFORMATION

*Release of Information	NOT ALLOWED TO RELEASE DATA
From Date	
To Date	
Signature Source	
Accident Related To	
Accident State	
Accident Country	[Search]
Accident Date	
EPSDT Referral	
Prior Authorization #	
Hospital Discharge Date	
Last Menstrual Period	

TOTAL CHARGES

Total Charges	$0.00
Medicaid Allowed Amount	$0.00
TPL Paid Amount	$0.00
Total Medicaid Paid Amount	$0.00
Medicaid CoPay Amount	$0.00
Note Reference Code	
Notes	

Diagnosis

*** No rows found ***

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

delete | add an item

Header - Other Payer

*** No rows found ***

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

delete | add an item

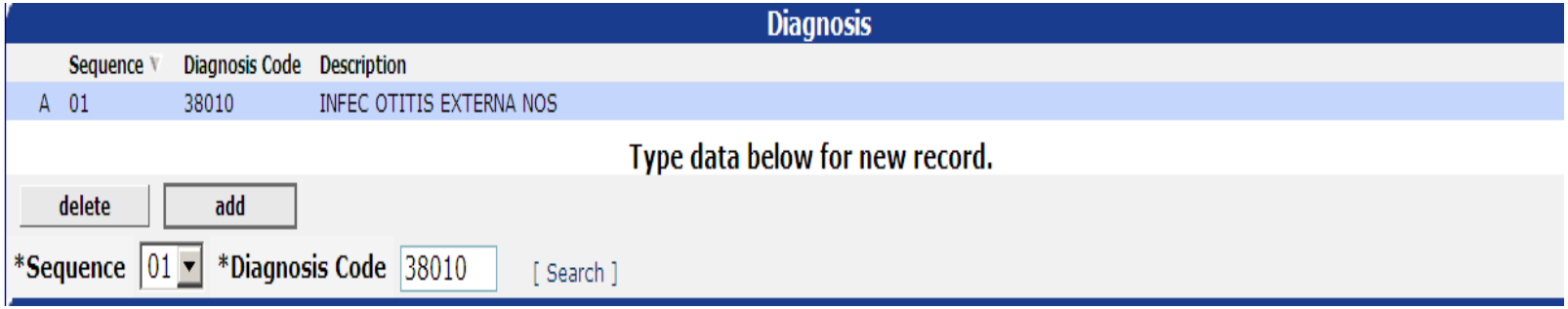
Diagnosis Codes: required on most claims

- Must include all characters specified by ICD
- Do **NOT** enter the decimal points
- There are system edits and audits against the codes

A Diagnosis Code is Optional with the following Procedure Codes

G0151, G0152, G0153, G0154, G0156, H0045, S0215, S5101, S5102, S5125, S5160, S5161, S5165, S5170, T1000, T1002, T1003, T1019, and T2029

If one or more diagnoses are specified, then each claim line in the 'Detail' panel must point to (be associated with) at least one diagnosis



Diagnosis Code Pointer

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.

delete | add an item | copy

Item	1	*Place Of Service	[Search]
*From DOS		*Procedure Code	[Search]
To DOS		Emergency	
*Units	0		
*Charges	$0.00	Referred EPSDT Service/ Family Planning	
Medicaid Allowed Amount	$0.00	*Diagnosis Code Pointer	
Rendering Provider		Modifiers	[Search] [Search] [Search] [Search]
Submitted EAPG		Final EAPG	
Initial EAPG		Pay Action	
Status			

NDC | Detail - Other Payer | ClaimCheck | Additional Provider Information

This must point to the proper diagnosis associated with the rendered service

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	5	10/05/2017	32.00	$159.86	$0.00		12	T1019	U2				
A	4	10/05/2017	16.00	$53.29	$0.00		12	T1019					
A	3	10/04/2017	48.00	$159.86	$0.00		12	T1019					
A	2	10/03/2017	48.00	$159.86	$0.00		12	T1019					
A	1	10/02/2017	48.00	$159.86	$0.00		12	T1019					

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

delete | add an item | copy

Item	5	*Place Of Service	12 [Search]
*From DOS	10/05/2017	*Procedure Code	T1019 [Search]
To DOS	10/05/2017	Emergency	
*Units	32.00		
*Charges	$159.86	Referred EPSDT Service/ Family Planning	
Medicaid Allowed Amount	$0.00	Diagnosis Code Pointer	
Rendering Provider		Modifiers	U2 [Search] [Search] [Search] [Search]
Submitted EAPG		Final EAPG	
Initial EAPG		Pay Action	
Status			

NDC | Detail - Other Payer | ClaimCheck | Additional Provider Information

Entering Ordering Provider Information

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	5	10/05/2017	32.00	$159.86	$0.00		12	T1019	U2				
A	4	10/05/2017	16.00	$53.29	$0.00		12	T1019					
A	3	10/04/2017	48.00	$159.86	$0.00		12	T1019					
A	2	10/03/2017	48.00	$159.86	$0.00		12	T1019					
A	1	10/02/2017	48.00	$159.86	$0.00		12	T1019					

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

delete | add an item | copy

Item	5	*Place Of Service	12 [Search]
*From DOS	10/05/2017	*Procedure Code	T1019 [Search]
To DOS	10/05/2017	Emergency	
*Units	32.00		
*Charges	$159.86	Referred EPSDT Service/ Family Planning	
Medicaid Allowed Amount	$0.00	Diagnosis Code Pointer	
Rendering Provider		Modifiers	U2 [Search] [Search] [Search] [Search]
Submitted EAPG		Final EAPG	
Initial EAPG		Pay Action	
Status			

NDC | Detail - Other Payer | ClaimCheck | Additional Provider Information

Entering Ordering Provider Information, cont.

Medicaid Allowed Amount	$0.00	Diagnosis Code Pointer	
Rendering Provider		Modifiers	U2 [Search] [Search] [Search] [Search]
Submitted EAPG		Final EAPG	
Initial EAPG		Pay Action	
Status			

NDC | Detail - Other Payer | ClaimCheck | Additional Provider Information

Additional Provider Information

*** No rows found ***

Select row above to update -or- click Add button below.

delete | add an item

Attachments

*** No rows found ***

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

delete | add an item

Entering Ordering Provider Information, cont.

Medicaid Allowed Amount	$0.00	Diagnosis Code Pointer	
Rendering Provider		Modifiers	U2 [Search] [Search]
			[Search] [Search]
Submitted EAPG		Final EAPG	
Initial EAPG		Pay Action	
Status			

NDC | Detail - Other Payer | ClaimCheck | Additional Provider Information

Additional Provider Information

	Detail Item	Type of Provider	Provider #	Last Name	First Name, MI
A	0				

Type data below for new record.

delete | add an item

*Detail Item 1

*Type of Provider

*Provider #

*Last Name

*First Name, MI

Ordering Provider
Referring Provider
Supervising Provider

Entering Ordering Provider Information, cont.

Medicaid Allowed Amount	$0.00	Diagnosis Code Pointer	
Rendering Provider		Modifiers	U2 [Search] [Search] [Search] [Search]
Submitted EAPG		Final EAPG	
Initial EAPG		Pay Action	
Status			

NDC | Detail - Other Payer | ClaimCheck | Additional Provider Information

Additional Provider Information

	Detail Item	Type of Provider	Provider #	Last Name	First Name, MI
A	0				

Type data below for new record.

delete | add an item

*Detail Item: 1

*Type of Provider: Ordering Provider

*Provider #: 1234567890

*Last Name: SMITH

*First Name, MI: JOHN A

- 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.

All claims are assigned an ICN

2218170357321

Region Code	Calendar Year	Julian Day	Claim Type/ Batch Number	Claim Number in Batch
22	18	170	357	321

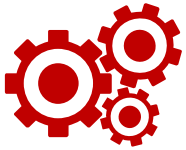
Providers have 365 days to submit FFS claims

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

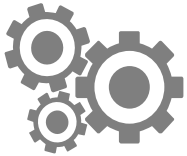
- Use this panel on the claim for billing claims over 365 days, when timely filing criteria has been met
- Enter the previously denied ICN and select “DELAYED SUBMISSION/RESUBMISSION” in the Reason drop down menu
- When done correctly, MITS will bypass timely filing edits

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.

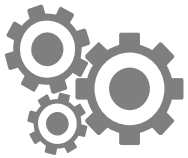
Previously Denied ICN or TCN | **Reason**

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

Must use the spacing shown

Notes	**DECISION 20171225**

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 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

Attachments

Type of Document	Transmission Type
A	

Type data below for new record.

delete | add

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

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:

Voided

Adjusted

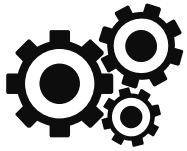
Copied

Adjusting a Paid Claim

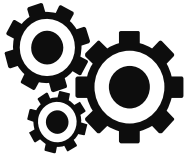
- Open the claim requiring an adjustment
- Change and save the necessary information
- Click the “adjust” button

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

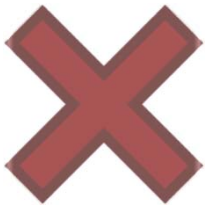
5018173127250 Now paid $45.00

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 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

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

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

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

Header - Other Payer

	Last Name	First Name	MI	Date of Birth	Relationship	Gender	Policy ID	Paid Amount	Paid Date	Electronic Payer ID
A	SMITH	JOHN	A	01/01/1950	FATHER	MALE	987654	$200.00	01/05/2018	01234

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

delete | add an item

*Claim Filing Indicator	COMMERCIAL INSURANCE	*Insurance Carrier Name	BLUE CROSS BLUE SHIELD
*Policy Holder Relationship to Insured	FATHER	*Electronic Payer ID	01234
*Policy Holder Last Name	SMITH	Insured's Policy ID	987654
*Policy Holder First Name, MI	JOHN A	*Payer Sequence	PRIMARY
Policy Holder Date of Birth	01/01/1950	Medicare ICN	
Gender	MALE		
*Paid Amount	$200.00		
*Paid Date	01/05/2018		
Allowed Amount	$0.00		

Header - Other Payer Amounts and Adjustment Reason Codes

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 - Other Payer

	Last Name	First Name	MI	Date of Birth	Relationship	Gender	Policy ID	Paid Amount	Paid Date	Electronic Payer ID
A	SMITH	JOHN	A	01/01/1950	SELF	MALE	987654	$200.00	01/05/2018	43210

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

delete | add an item

*Claim Filing Indicator	HMO, MEDICARE RISK	*Insurance Carrier Name	HUMANA MEDICARE
*Policy Holder Relationship to Insured	SELF	*Electronic Payer ID	43210
*Policy Holder Last Name	SMITH	Insured's Policy ID	456789
*Policy Holder First Name, MI	JOHN A	*Payer Sequence	PRIMARY
Policy Holder Date of Birth	01/01/1950	Medicare ICN	
Gender	MALE		
*Paid Amount	$200.00		
*Paid Date	01/05/2018		
Allowed Amount	$0.00		

Header - Other Payer Amounts and Adjustment Reason Codes

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

Header - Other Payer Amounts and Adjustment Reason Codes

	Electronic Payer ID	CAS Group Code	ARC	Amount
A	01234	PR-Patient Responsibility	1	$50.00
A	01234	CO-Contractual Obligations	45	$150.00

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

delete | add an item

Payer Header Level Adjustment Reason Codes (ARC) and Amounts

*Electronic Payer ID: 01234

*CAS Group Code: PR-Patient Responsibility

*ARC: 1

*Amount: $50.00

Third Party Liability (TPL) Claims

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

Detail - Other Payer Amounts and Adjustment Reason Codes

Detail - Other Payer Amounts and Adjustment Reason Codes

	Detail Item/Electronic Payer ID	CAS Group Code	ARC	Amount
A	1/43210	PR-Patient Responsibility	1	$50.00
A	1/43210	CO-Contractual Obligations	45	$150.00

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

delete | add an item

Payer Line Level Adjustment Reason Codes(ARC) and Amounts

*Detail Item/Electronic Payer ID: 1/43210

*CAS Group Code: CO-Contractual Obligations

*ARC: 45

*Amount: $150.00

ARC Codes

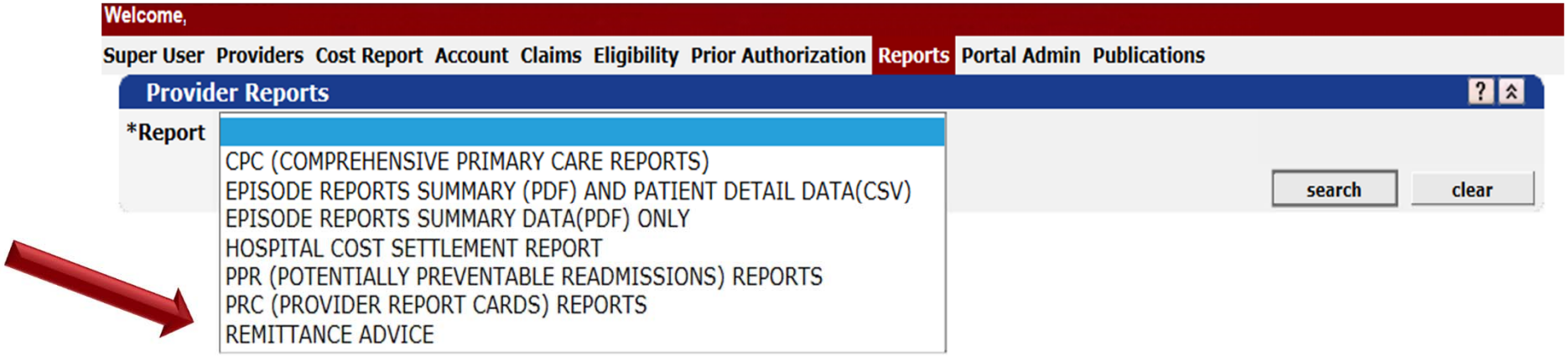
The X12 website provides adjustment reason codes (ARCs)

COMMON ARCs:

- 1 • Deductible
- 2 • Coinsurance
- 3 • Co-payment
- 45 • Contractual Obligation/Write off
- 96 • 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 twice

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

Provider Reports

*Report: REMITTANCE ADVICE

Payment Date:

RA Number:

Check/EFT Number:

search clear

Please select the row to show the report

RA Number	Part Number	RA Date
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 >

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

Prior Authorization (PA)

- 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

Websites

- Ohio Department of Medicaid home page

http://Medicaid.ohio.gov

- Ohio Department of Medicaid provider page

http://Medicaid.Ohio.Gov/Providers.aspx

- MALs & MTLs

http://medicaid.ohio.gov/RESOURCES/Publications/ODM-Guidance#161542-medicaid-policy

- LAWriter

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

Websites

- Provider Enrollment

http://www.medicaid.ohio.gov/PROVIDERS/EnrollmentandSupport/ProviderEnrollment.aspx

- MITS home page

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

- Electronic Funds Transfer

http://www.ohiosharedservices.ohio.gov/

Websites

- Companion Guides (EDI)

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

- Electronic Visit Verification (EVV)

http://medicaid.ohio.gov/INITIATIVES/ElectronicVisitVerification.aspx

- Healthchek

http://medicaid.ohio.gov/FOROHIOANS/Programs/Lead.aspx

- X12 Website (ARC 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/MedicaidForms.aspx

ANY
QUESTIONS
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