



Department of
Medicaid

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

Basic Billing for Independent Home Health 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

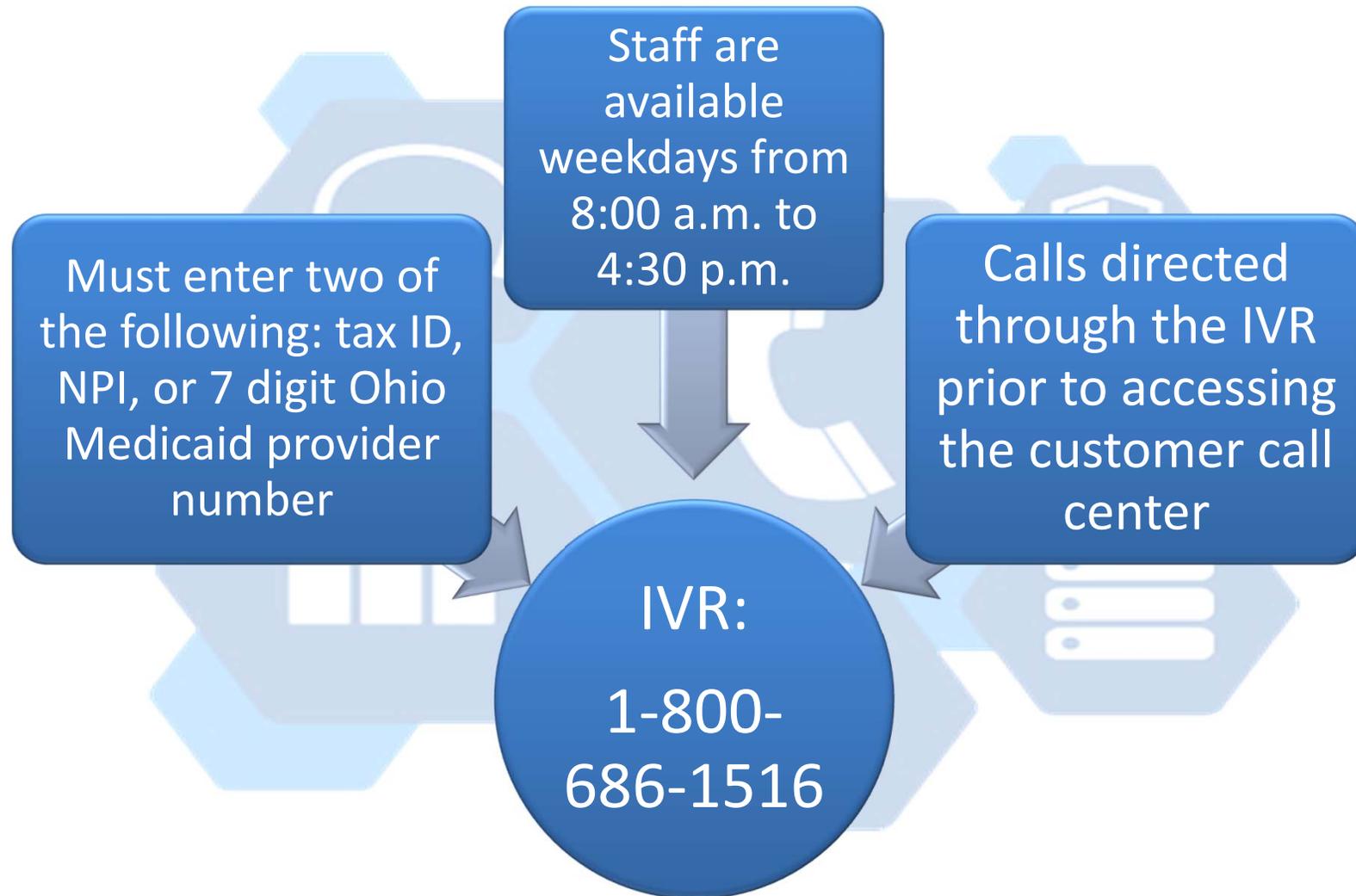
Sarah Bivens

Ava Cottrell

Ed Ortopan



Manager - Meagan Grove



☐ 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**

<p>Notice to Consumer: Please carry this card with you at all times and present this card whenever you request Medicaid services. If this card is lost or stolen, contact the county department of job and family services at once.</p> <p>Notice to Providers of Medical Services: If there is evidence of tampering or if this card is mutilated, contact the local county department of job and family services or check the Provider MITS Portal for eligibility. Questions regarding claims for service or eligibility should be directed to Provider Services at 1-800-686-1516.</p> <p>Note: Use the Medicaid ID for all claim submissions.</p> <p><u>medicaid.ohio.gov</u></p> <p>Consumer's Signature: _____</p>	<p style="writing-mode: vertical-rl; transform: rotate(180deg);">Fold</p>	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;">County</td> <td style="width: 30%;"></td> </tr> <tr> <td>ALLEN</td> <td style="text-align: right;">Ohio Medicaid</td> </tr> <tr> <td>Case Number</td> <td></td> </tr> <tr> <td>5082482</td> <td></td> </tr> <tr> <td>Eligibility Begin Date</td> <td></td> </tr> <tr> <td>01/01/2018</td> <td></td> </tr> <tr> <td>Void After Date</td> <td></td> </tr> <tr> <td>01/31/2018</td> <td></td> </tr> <tr> <td colspan="2" style="text-align: center;">Ohio Department of Medicaid</td> </tr> <tr> <td colspan="2" style="text-align: center;">medicaid.ohio.gov</td> </tr> <tr> <td colspan="2" style="text-align: center;">Consumer Hotline: 1-800-324-8680</td> </tr> <tr> <td colspan="2" style="text-align: center;">[or TTY 1-800-292-3572]</td> </tr> </table>	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]	
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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 Addition 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





Eligibility Verification Request

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

Welcome

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

eligibility search hospice enrollment

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

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



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	

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
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★ 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

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		W1166 35166		IND	INPATIENT COVERAGE	01/30/2018	01/31/2018	724775	
AETNA US HEALTH	00250		W1166 35166		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 Eligibility 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

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**

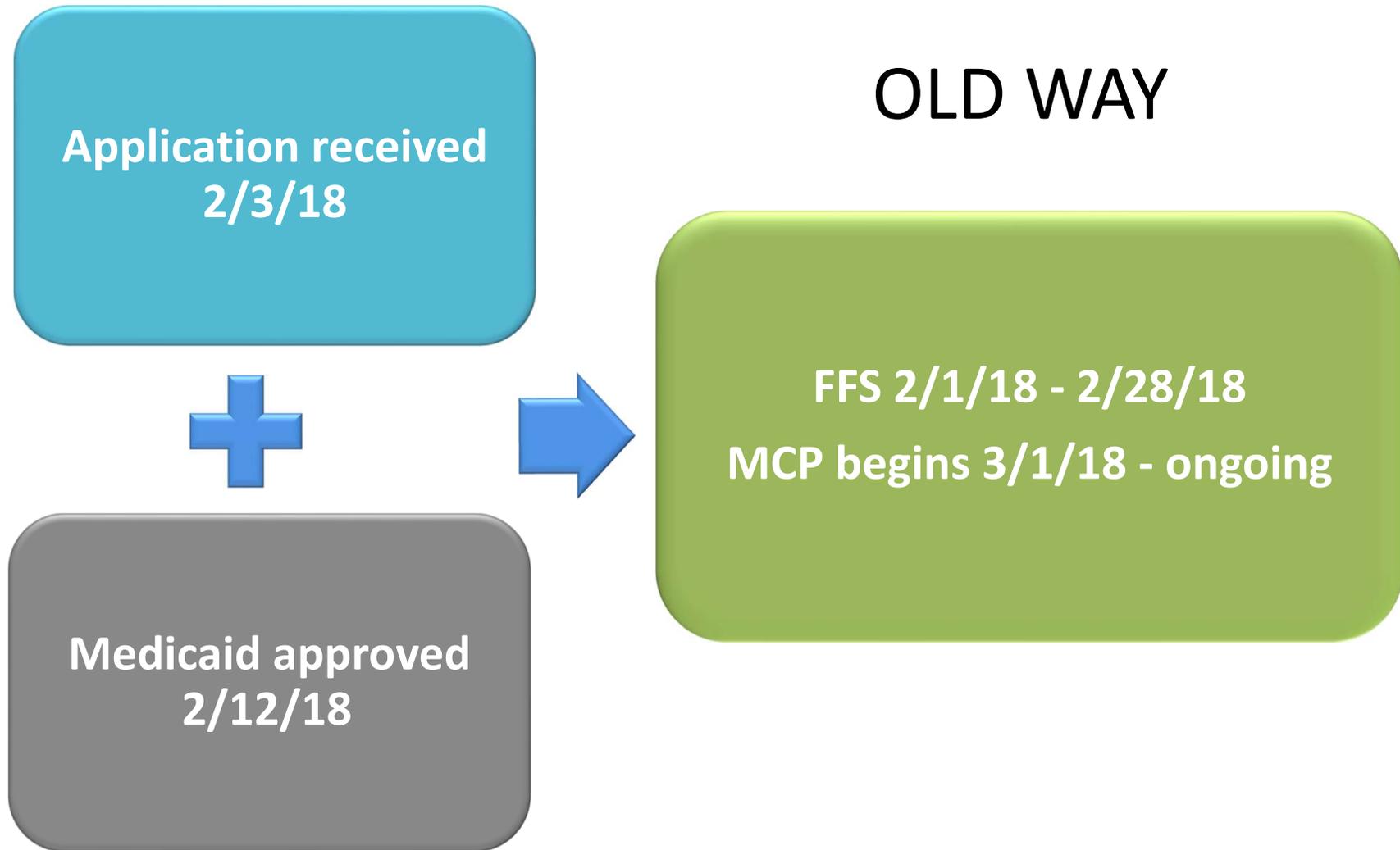
MANAGED CARE/MYCARE OHIO

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	5/17/2018	5/17/2018
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



Application received
2/3/18



Medicaid approved
2/12/18



NEW WAY

MCP begins 2/1/18

Day One MCP Assignments



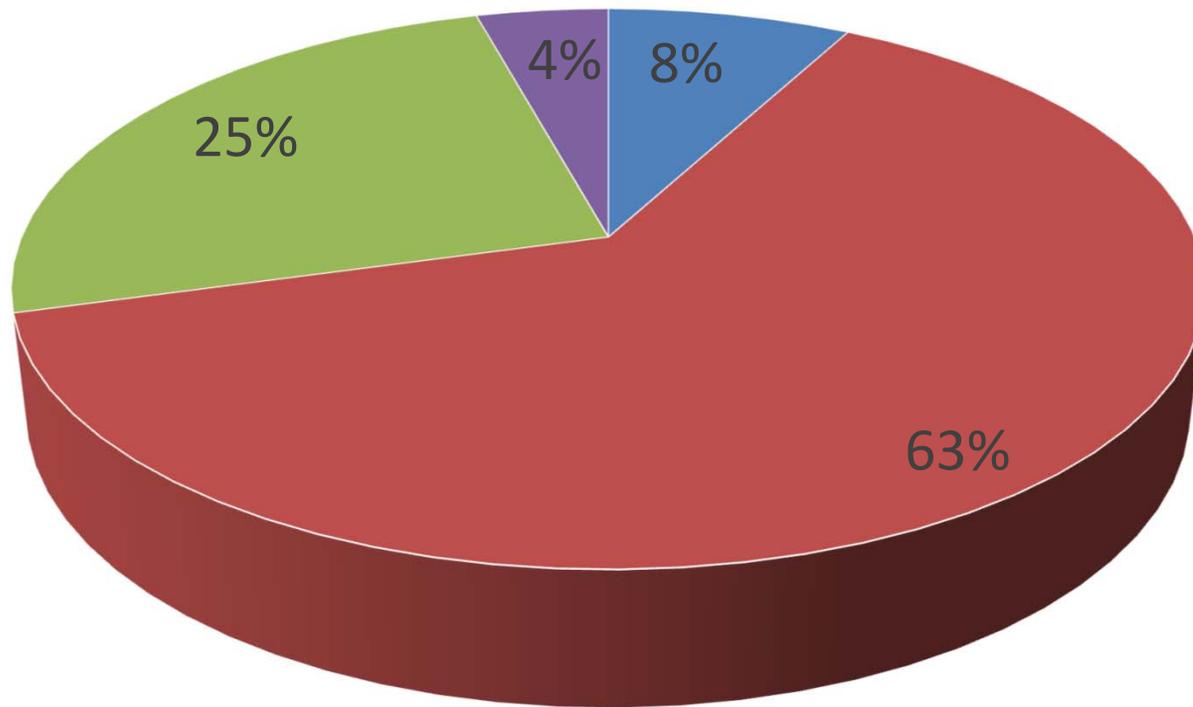
MITS looks for previous MCP in last 90 days

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

Then individual is assigned by an assignment algorithm

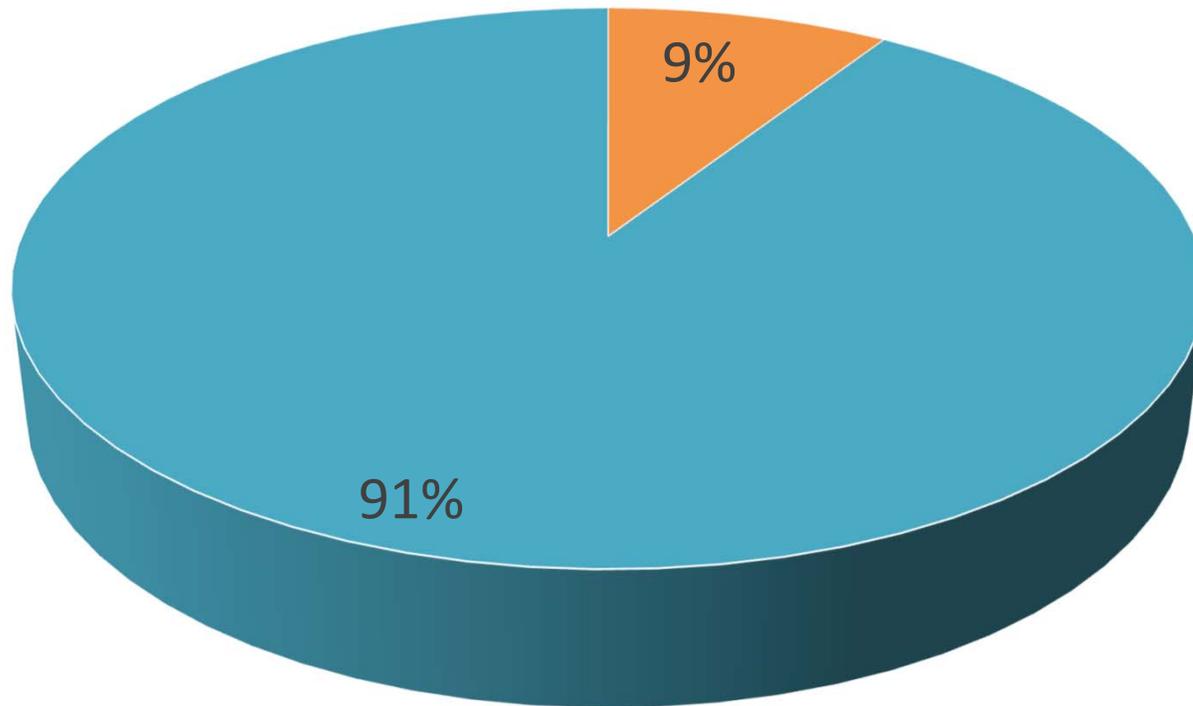
The assigned plan can be changed as desired during first 3 months

Managed Care Enrollment Groups - 2018



■ ABD ■ CFC ■ Group 8 ■ MyCare

FFS vs. Managed Care Enrollment - 2018



■ FFS ■ Managed Care

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
Medicaid 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 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



PARAMOUNT
ADVANTAGE

www.paramountadvantage.org

HEALTH PLAN (80840)
7952304120

ID NUMBER
A9999999901

MEMBER NAME
Jane Doe

PRIMARY CARE PROVIDER
John Smith
(419) 5551212

PROVIDERS CALL FOR PRIOR AUTH
800-891-2500/419-887-2520

GROUP NUMBER
ADV0010011

EFF. DATE
01/01/2015

MMIS NUMBER
000000000000

CVS/CAREMARK
RXGRP RX6407
RXBIN 004336
RXPCN ADV



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

aetna®

AETNA BETTER HEALTH® OF OHIO

buckeye
health plan.CareSource®PARAMOUNT
HEALTH
CAREMOLINA®
HEALTHCAREUnitedHealthcare®

Oversight of Managed Care Plans

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



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

A magnifying glass with a blue handle and a red frame. The lens shows the word "EXTENDED" in bold, black, uppercase letters on a white background.

EXTENDED

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



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)

**Behavioral Health
Crisis:** 1-866-206-7361

Care Management: 1-855-475-3163

**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

Eligibility Verification: 1-800-488-0134

Pharmacy Help Desk: 1-800-488-0134

Claims Inquiry: 1-800-488-0134

Provider Questions: 1-800-488-0134

**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](https://www.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



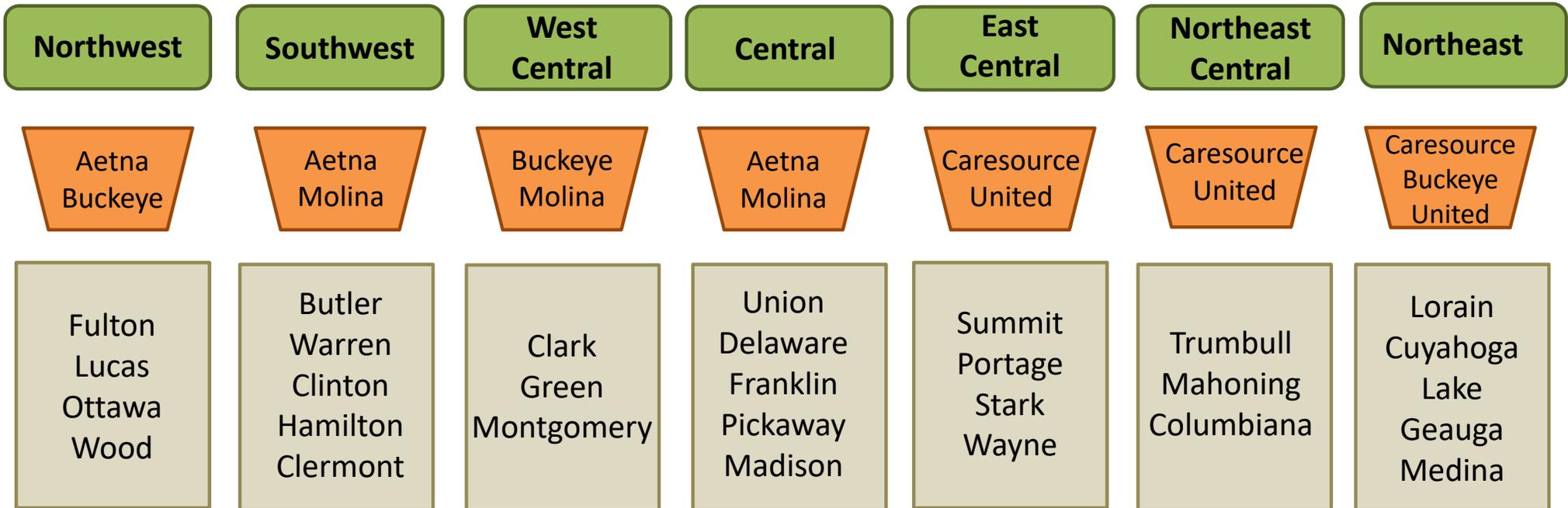
Lock-In

*** 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





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>



AETNA BETTER HEALTH® OF OHIO

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)

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

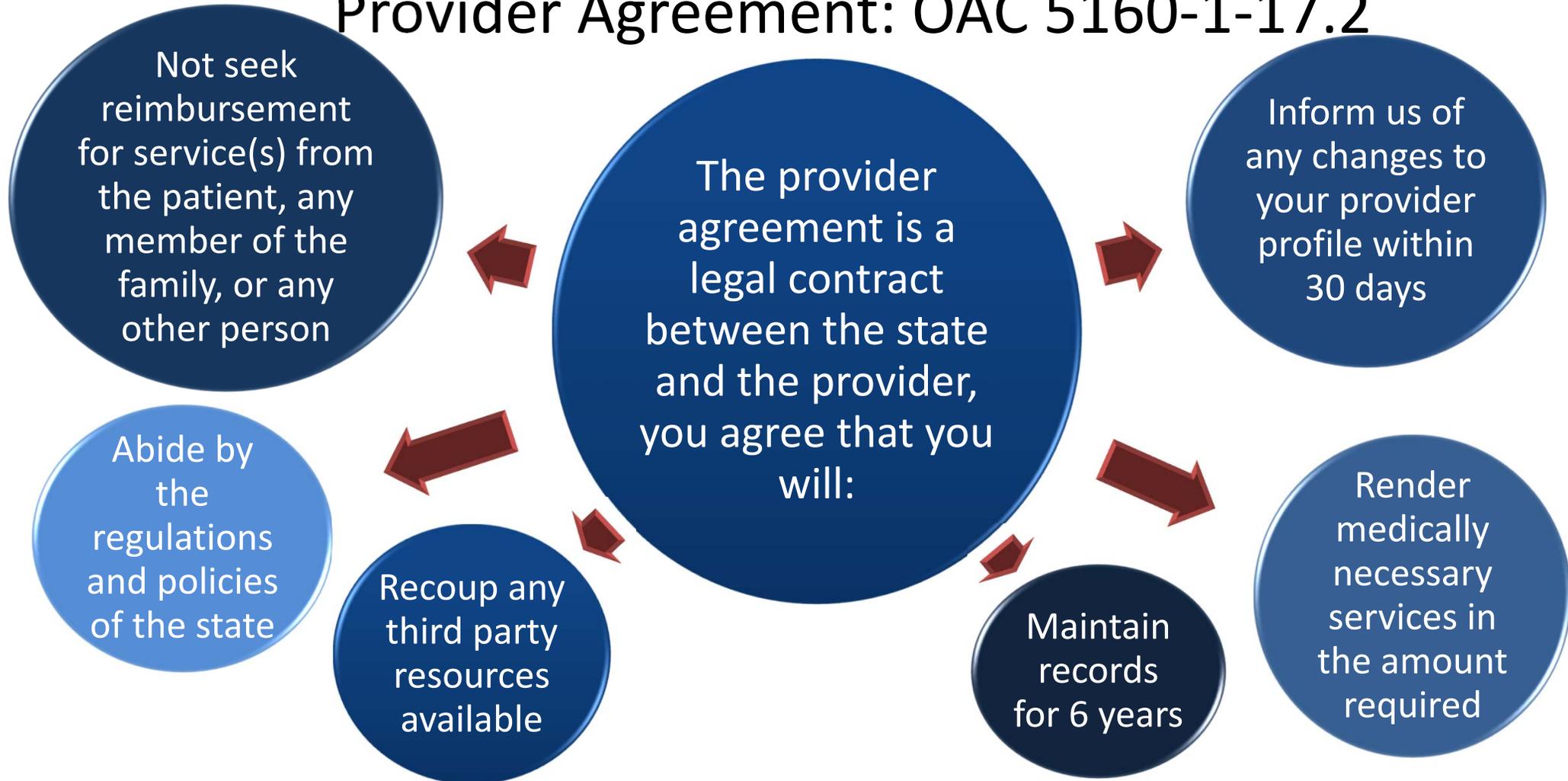


The 2018 fee is \$569.00 per application



This fee applies to organizational providers only (not individual providers, practitioners, or practitioner groups)

Provider Agreement: OAC 5160-1-17.2



**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**

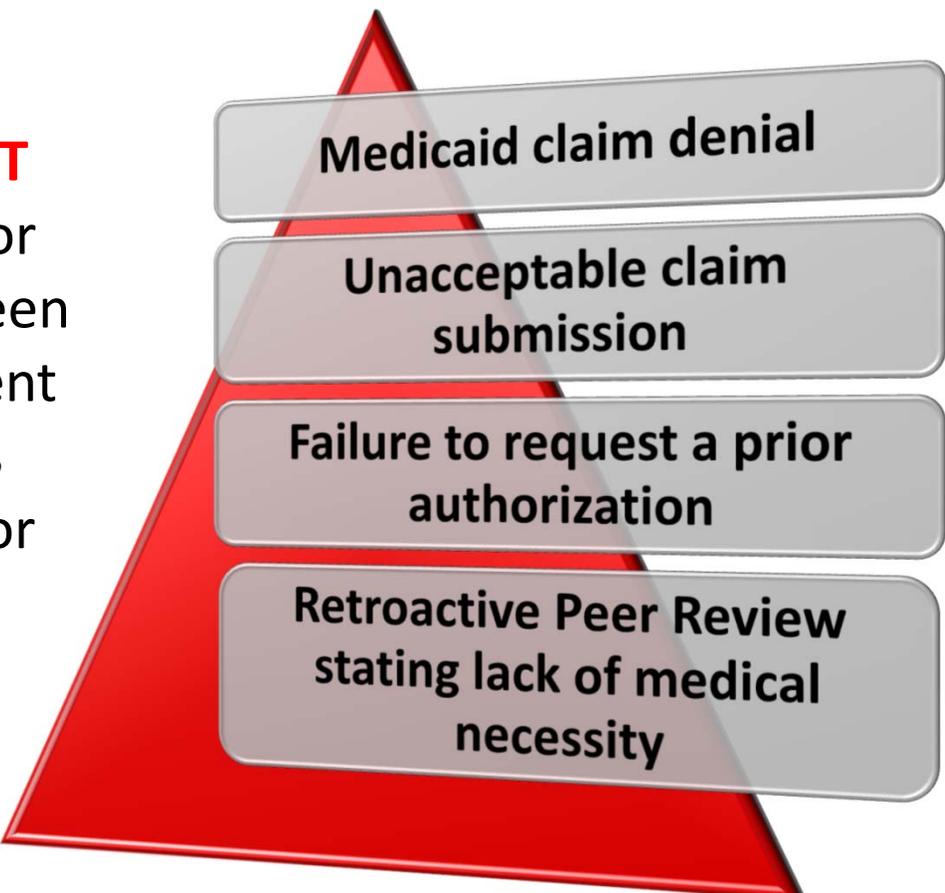
Coordination of Benefits: OAC 5160-1-08

- 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:



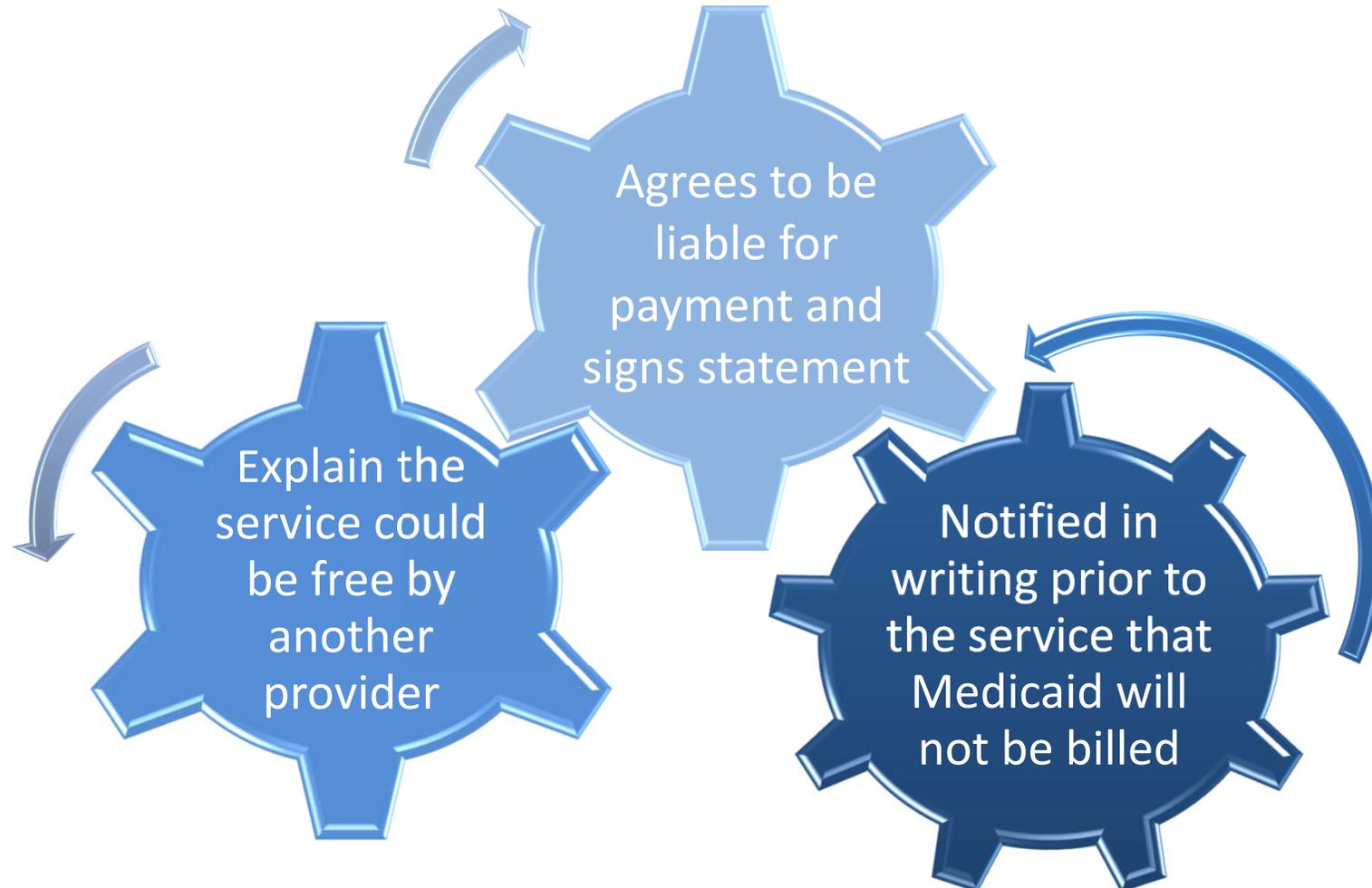
Medicaid claim denial

Unacceptable claim submission

Failure to request a prior authorization

Retroactive Peer Review stating lack of medical necessity

When Can you Bill an Individual?



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.

The Ohio Department of Medicaid Website

The screenshot shows the Ohio Department of Medicaid website homepage. At the top left is the Ohio Department of Medicaid logo. To the right are utility links for 'Text Size: +A -A', a 'Select Language' dropdown menu, and a 'Powered by Google Translate' notice with a 'Translation Disclaimer' link. Below this is a dark blue navigation bar with white text links: HOME, MEDICAID 101, FOR OHIOANS, PROVIDERS, INITIATIVES, NEWS, RESOURCES, CAREERS, and CONTACT. The main content area features a large blue banner with the Ohio Department of Medicaid logo and the text 'Learn more about the state's first executive-level Medicaid agency.' To the right of the banner is a 'Director's Welcome' section with a video player showing Director Barbara Sears. Below the banner are two promotional boxes: 'Are you uninsured? Ohio Benefits' and 'Are you unemployed? Ohio MEANS Jobs.' At the bottom are three blue buttons with icons: 'Managed Care Plans 2016 Report Card', 'Information for Independent Providers', and 'Payment Innovation Ohio's SIM Grant'. On the right side, there is a 'Tweets by @OH_Medicaid' section showing a tweet from John Kasich about disposing of unused prescriptions, and a 'Testimony & Presentations' section with a video player.

Provider News



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

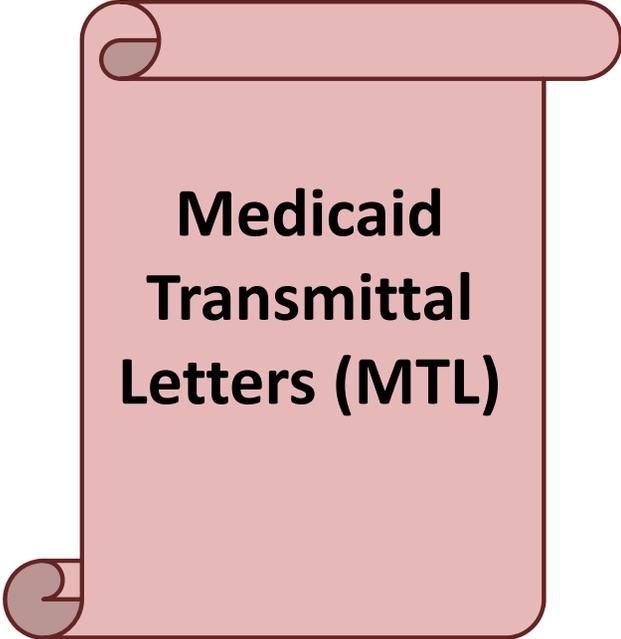
- [Benefit Coordination & Recovery](#)
- [Fee Schedules/Rates](#)
- [Medicaid Forms](#)
- [ODJFS Forms](#)
- [MITS EDMS Cover Page](#)
 - [Instructions](#)
- [Healthchek Screening Forms](#)
- [e-Manuals](#)
- [Helpful Links](#)
- [Get a National Provider Identifier \(NPI\)](#)
- [Transmittal Letter Notification](#)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



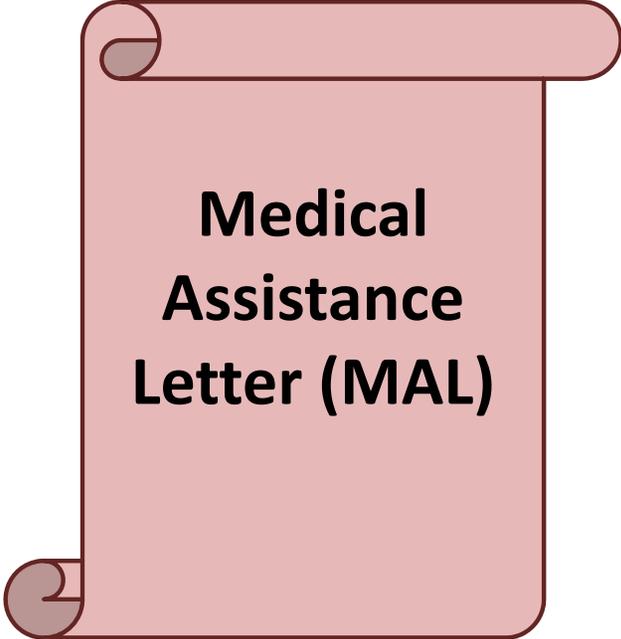
Access the
MITS Portal

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

- HOME
- MEDICAID 101
- FOR OHIOANS
- PROVIDERS**
- INITIATIVES
- NEWS
- RESOURCES
- CAREERS
- CONTACT

PROVIDERS

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Ohio is home to more than 83,000 active Medicaid providers. Our network is critical in ensuring reliable and timely care for Ohioans. We will become a go-to resource for learning more about training, billing, rate-setting and other issues that affect the provider community.

Provider News

- Please listen carefully when calling the IVR as the**
- Notice Regarding Pregnancy Risk Assessment and Notification System (1/18/2017)
- 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)

- 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

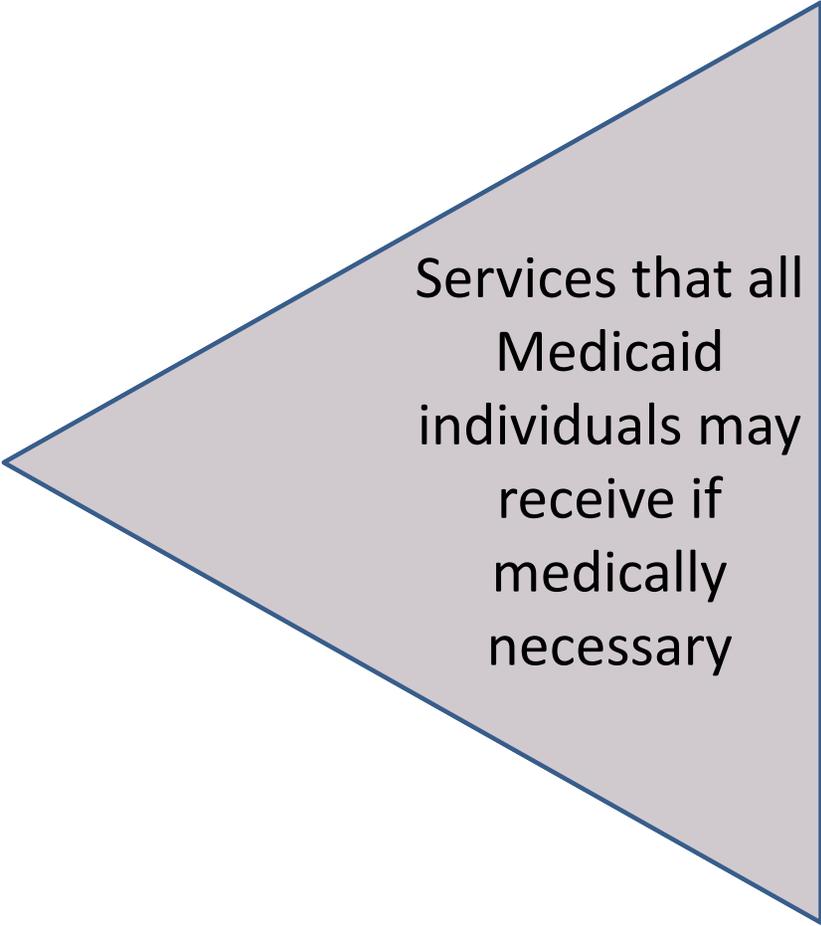
MODIFIERS:

- Modifiers recognized by ODM

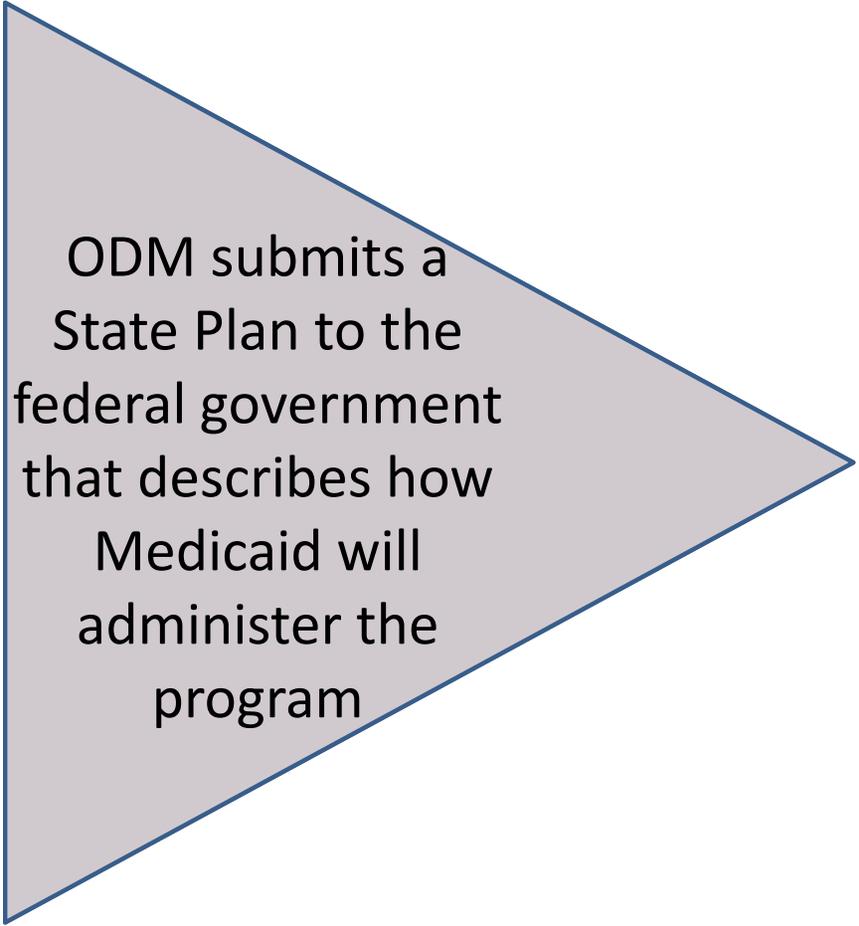
State Plan

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 – each 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

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 – each 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
U3	Three or more visits
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
UA	Non-agency RN or LPN visit if portion of visit is overtime
TU	Non-agency RN or LPN visit if entire visit is overtime

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**

<i>Consumer's name</i>	<i>Consumer's billing number</i>	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

<i>Consumer's billing number</i>	<i>Consumer's name and address</i>		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		<i>Spouse's name</i> Wife <i>Address</i>	<input type="checkbox"/>	P xxx-xxx-xxxx	Gratis/ Volunteer -no pymt	
7-MD	Medical Care		3/14/2016		<i>Physician's name MD</i> General Practice <i>Address</i>	<input type="checkbox"/>	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	<input type="checkbox"/>	P xxx-xxx-xxxx	Medicaid	\$672.66
1-PCA	HHAide/StPI G0156	B=5 S=20	4/6/2016	12/25/2016	Provider Pending 0000000 To be determined All, Ohio 00000	<input type="checkbox"/>	P xxx-xxx-xxxx	State Plan	\$186.85
17 LIA	Wvr PCA/NAP T1019	B=4 S=32	12/26/2016		<i>Provider's name</i> OETP <i>Provider number</i> <i>Address</i>	<input type="checkbox"/>	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

Team Team Members Initial Participating in Plan Development

<i>Consumer</i>	Consumer	3/4/2016	In person
Name/Relationship	Consumer / Guardian / Representative	Participation Date	Participation Method
<i>Other provider</i>	<i>Guardian's name</i>	3/4/2016	Assigned
Name/Relationship	Case Manager	Participation Date	Participation Method
<i>Other provider #2</i>		4/6/2016	In person
Name	Signature; If Present	Participation Date	Participation Method
<i>Provider's name</i>		1/13/2017	Email
Name	Signature; If Present	Participation Date	Participation Method
<i>Therapy provider's name</i>		12/23/2016	
Name	Signature; If Present	Participation Date	Participation Method
<i>Physician's name</i>		3/14/2016	Fax
Name	Signature; If Present	Participation Date	Participation Method

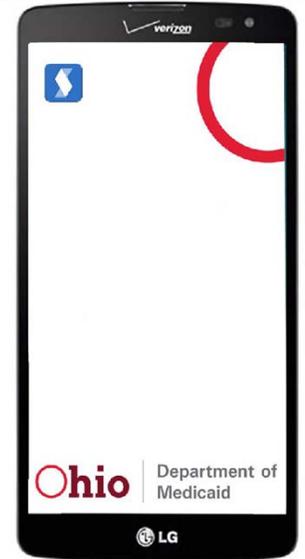
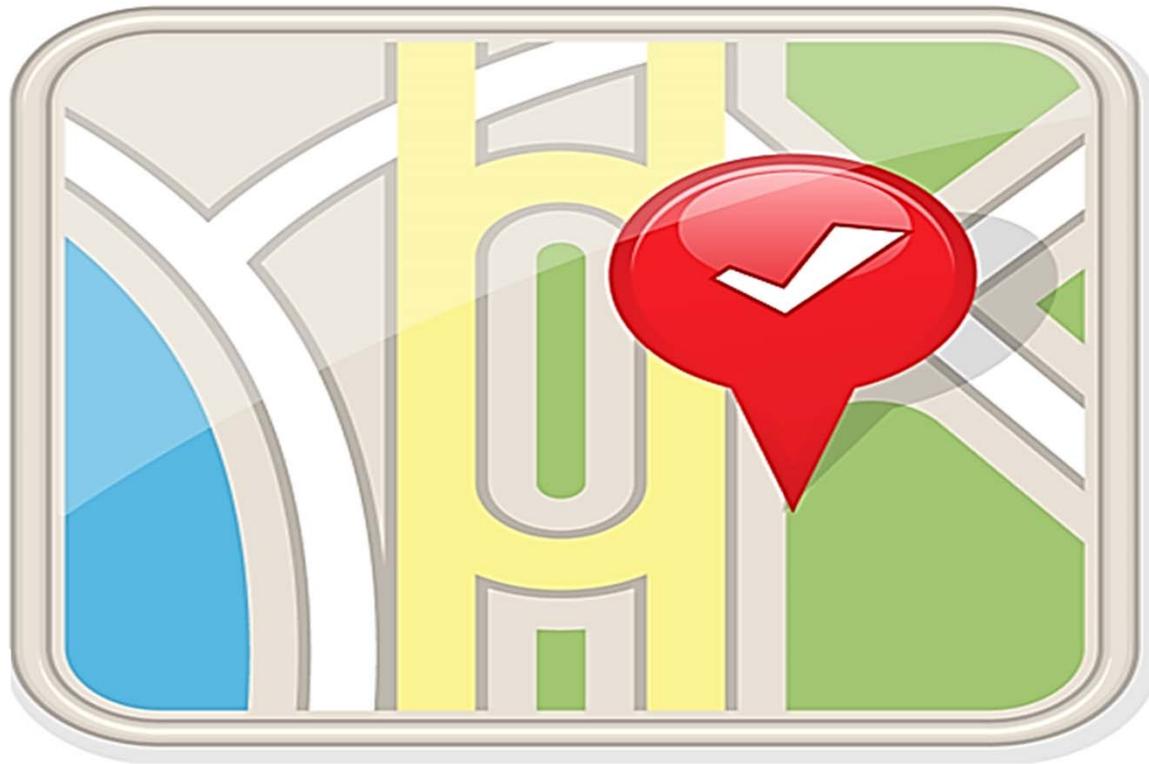
This plan will be reviewed according to the following schedule:
6 Months 1-3 Monthly Visits 4-6 Monthly Visits 2 Calls
Mo, 1, 1 call 2-6 Mos.

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

25 – Non-Agency Personal Care Aide / 000 – All Specialties

26 – Non-Agency Home Care Attendant / 260 – ODM Waiver Non – Agency home Care Attendant

38 – Non-Agency Nurse – RN or LPN / 380 – RN – Private Duty Nursing

38 – Non-Agency Nurse – RN or LPN / 381 – PDN/ODM Waiver Registered Nurse

38 – Non-Agency Nurse – RN or LPN / 382 – LPN – Private Duty Nursing

38 – Non-Agency Nurse – RN or LPN / 383 – PDN/ODM Waiver Registered Nurse

Services to be Included



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?

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

Welcome, EVANS2 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		Address Type	
National Provider ID		Address	
Practice Type		City	
Provider Type		County	
Ownership		State/Zip	
Medicaid Effective Date		Phone	
Medicaid End Date			

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

Location Name Address

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

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

*E-Mail
*Confirm E-Mail

del alternate service location add alternate service location **save** cancel

SAVE!!!

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 -

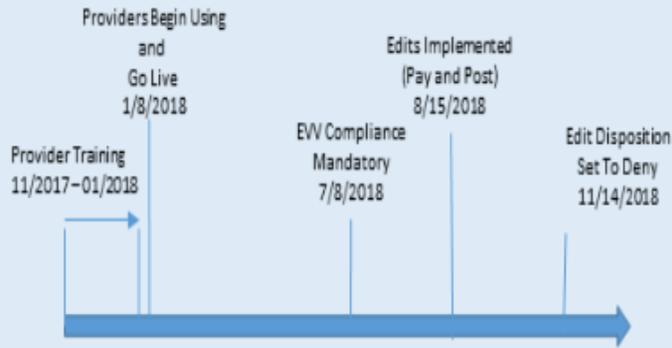
WHAT'S NEW

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

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



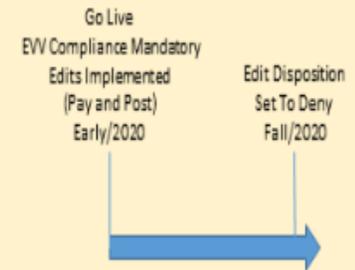
Phase 2

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



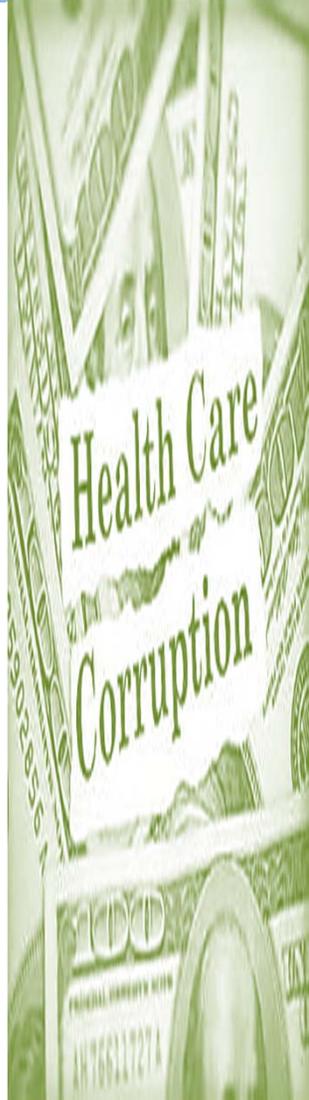
Structural Reviews of Providers and Investigation of Provider Occurrences: OAC 5160-45-06

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**



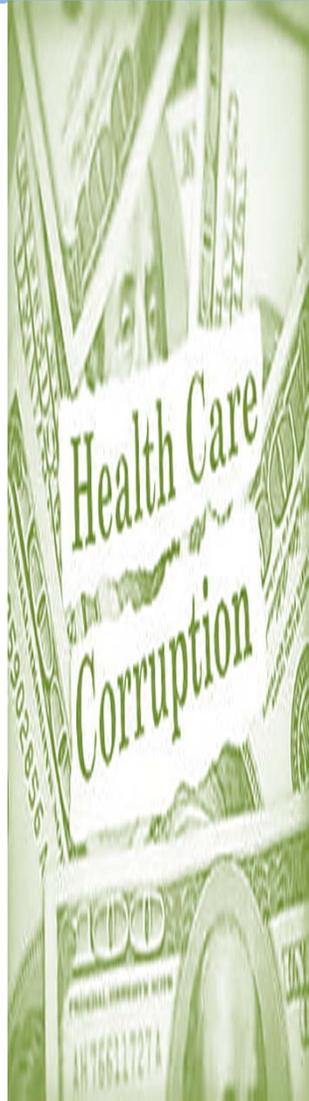
Surveillance and Utilization Review Section (SURS)

➤ 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)



MITTS 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



The screenshot shows the Ohio Department of Medicaid website. At the top left is the 'Ohio Department of Medicaid' logo. To the right are navigation links: 'About ODM | Our Services | Resources | News & Events'. Below this is a search bar. A secondary navigation bar includes 'Home Consumers Providers Trading Partners Public Information Publications'. Under 'Providers', there are sub-links: 'enrollment', 'enrollment tracking search', 'long-term care', and 'account setup'. The date and time 'Tuesday 06/16/2015 11:34:38 AM' are displayed. A 'Provider Home' section contains text about the enrollment wizard. A red box highlights a 'Login to secure site' link with a sub-link 'Click Here to Login'.

Once directed to this page, click the link to “Login”



You will then be directed to another page where you will need to enter your “User ID” and “Password”



The screenshot shows the 'Sign In' page for the Medicaid Information Technology System. It features the 'Ohio.gov Medicaid Information Technology System' header with a family photo. The page title is 'Sign In Medicaid Information Technology System'. The main content area is titled 'To sign in, please enter your User ID and Password' and contains input fields for 'User ID' and 'Password'. Below these fields is a legal disclaimer and a checkbox for 'Yes, I have read the agreement'. A 'Login' button is at the bottom. Links for 'Help FAQ', 'Help Reset Password?', and 'Forgot Your User ID?' are provided at the bottom.

MITTS Navigation

“COPY”, “PASTE”, and “PRINT” features all work in the MITTS 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**

MITTS 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



MITTS 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

The screenshot shows the Ohio.gov Medicaid Information Technology System interface. At the top left is the Ohio.gov logo and the text "Medicaid Information Technology System". To the right is a search bar with a "Search" button. Below the header is a navigation menu with the following items: Super User, Providers, Account, Trading Partners, Claims, Eligibility, Prior Authorization, Reports, Portal Admin, Security, Admin. The "Claims" menu is expanded, showing a sub-menu with the following items: Search, Search Detail, Dental, Institutional, and Professional. The "Professional" item is highlighted. Below the navigation menu is a "Claims" section with a list of links: Search, Search Detail, Dental, Institutional (for Inpatient, Outpatient, L), and Professional.



Submission of a Professional Claim

Professional Claim: NPI -	
BILLING INFORMATION	
ICN	
Claim Received Date	
Claim Type	M - PROFESSIONAL
Provider ID	NPI
*Medicaid Billing Number	<input type="text"/>
*Date of Birth	<input type="text"/>
Last Name	
First Name, MI	
*Patient Account #	0
Medical Record #	<input type="text"/>
Referring Provider #	<input type="text"/>
Rendering ID	<input type="text"/>
*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	<input type="text"/>
Accident Related To	<input type="text"/>
Accident State	<input type="text"/>
Accident Country	<input type="text"/> [Search]
Accident Date	<input type="text"/>
EPSDT Referral	<input type="text"/>
Prior Authorization #	<input type="text"/>
Hospital Discharge Date	<input type="text"/>
Last Menstrual Period	<input type="text"/>
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	<input type="text"/>
Notes	
Diagnosis	
*** No rows found ***	
Select row above to update -or- click add an item button below.	
<input type="button" value="delete"/>	<input type="button" value="add an item"/>
Header - Other Payer	
*** No rows found ***	
Select row above to update -or- click add an item button below.	
<input type="button" value="delete"/>	<input type="button" value="add an item"/>



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		
Sequence ▾	Diagnosis Code	Description
A 01	38010	INFECTION OF THE EAR, NOS

Type data below for new record.

*Sequence *Diagnosis Code [Search]



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

*From DOS

To DOS

*Units

*Charges

Medicaid Allowed Amount

Rendering Provider

Submitted EAPG

Initial EAPG

Status

*Place Of Service [Search]

*Procedure Code [Search]

Emergency

Referred EPSDT Service/
Family Planning

*Diagnosis Code Pointer

Modifiers [Search] [Search]

[Search] [Search]

Final EAPG

Pay Action

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

NDC
Detail - Other Payer
ClaimCheck
Additional Provider Information



Multiple Visits



- If providing multiple visits on the same day, all of the visits must be entered on the same claim
 - U2 and U3 indicate additional visits
- If overtime occurs during a day with multiple visits, the overtime must be billed on the same claim as the other visits
 - Overtime can be achieved during the middle of a visit

OVERTIME: How do you know if you are eligible for overtime?

Your work week begins Sunday at 12:00 am and ends Saturday at 11:59 pm

You are billing for **more than** 40 hours or 160 fifteen-minute units within that one work week time period

You provided services that are billed by the effected codes: T1019, S5125, T1002, T1003, or T1000

Can be
Included

- Delivered services under waiver programs administered by:
 - The Ohio Department of Medicaid (ODM)
 - The Ohio Department of Developmental Disabilities (DODD)
 - The Ohio Department of Aging (ODA)
- Time spent delivering Private Duty Nursing (PDN) services

Cannot
be
Included

- Services that are not being billed for Medicaid reimbursement
- Claims submitted to a managed care plan



Partial Overtime

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	03/08/2018	24.00	\$93.26		12	T1019	UA				
A	4	03/08/2018	24.00	\$93.26		12	T1019					
A	3	03/07/2018	48.00	\$159.86		12	T1019					
A	2	03/06/2018	48.00	\$159.86		12	T1019					
A	1	03/05/2018	48.00	\$159.86		12	T1019					



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

delete
add an item
copy

Item 5

***From DOS** 03/08/2018

To DOS 03/08/2018

***Units** 24.00

***Charges** \$93.26

Medicaid Allowed Amount \$0.00

Rendering Provider

Submitted EAPG

Initial EAPG

Status

Visit Start Time [dropdown] [dropdown] [dropdown]

Visit End Time [dropdown] [dropdown] [dropdown]

Service Duration less than 90 days

***Place Of Service** 12 [Search]

***Procedure Code** T1019 [Search]

Emergency [dropdown]

Referred EPSDT Service/ Family Planning [dropdown]

Diagnosis Code Pointer [dropdown] [dropdown] [dropdown] [dropdown]

Modifiers UA [Search] [Search] [Search] [Search]

Final EAPG

Pay Action



Second Visit all Overtime

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



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

delete | **add an item** | copy

Item 5

***From DOS** 10/05/2017

To DOS 10/05/2017

***Units** 32.00

***Charges** \$159.86

Medicaid Allowed Amount \$0.00

Rendering Provider

Submitted EAPG

Initial EAPG

Status

***Place Of Service** 12 [Search]

***Procedure Code** T1019 [Search]

Emergency

Referred EPSDT Service/ Family Planning

Diagnosis Code

Pointer

Modifiers U2 [Search] TU [Search]

[Search] [Search]

Final EAPG

Pay Action



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

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

delete
add an item
copy

Item 5

***From DOS** 10/05/2017

To DOS 10/05/2017

***Units** 32.00

***Charges** \$159.86

Medicaid Allowed Amount \$0.00

Rendering Provider

Submitted EAPG

Initial EAPG

Status

***Place Of Service** 12 [Search]

***Procedure Code** T1019 [Search]

Emergency

Referred EPSDT Service/ Family Planning

Diagnosis Code Pointer

Modifiers U2 [Search] TU [Search]

[Search] [Search]

Final EAPG

Pay Action

NDC
Detail - Other Payer
ClaimCheck
Additional Provider Information



Entering Ordering Provider Information, cont.

Medicaid Allowed Amount	\$0.00	Diagnosis Code	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Rendering Provider	<input type="text"/>	Pointer	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Submitted EAPG	<input type="text"/>	Modifiers	<input type="text" value="U2"/>	[Search]	<input type="text" value="TU"/>	[Search]
Initial EAPG	<input type="text"/>		<input type="text"/>	[Search]	<input type="text"/>	[Search]
Status		Final EAPG				
		Pay Action				
NDC	Detail - Other Payer	ClaimCheck	Additional Provider Information			
Additional Provider Information						
*** No rows found ***						
Select row above to update -or- click Add button below.						
<input type="button" value="delete"/>	<input type="button" value="add an item"/>					
Attachments						
*** No rows found ***						
Select row above to update -or- click add an item button below.						
<input type="button" value="delete"/>	<input type="button" value="add an item"/>					



Entering Ordering Provider Information, cont.

Medicaid Allowed Amount \$0.00	Diagnosis Code Pointer <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Rendering Provider <input type="text"/>	Modifiers <input type="text" value="U2"/> [Search] <input type="text" value="TU"/> [Search]
Submitted EAPG <input type="text"/>	<input type="text"/> [Search] <input type="text"/> [Search]
Initial EAPG	Final EAPG
Status	Pay Action

- 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.

<input type="button" value="delete"/>	<input type="button" value="add an item"/>
*Detail Item 1 <input type="text"/>	
*Type of Provider	<input type="text" value="Ordering Provider"/>
*Provider #	<input type="text" value="Referring Provider"/>
*Last Name	<input type="text" value="Supervising Provider"/>
*First Name, MI	<input type="text"/>



Entering Ordering Provider Information, cont.

Medicaid Allowed Amount	\$0.00	Diagnosis Code	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Rendering Provider	<input type="text"/>	Pointer	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Submitted EAPG	<input type="text"/>	Modifiers	<input type="text" value="U2"/>	[Search]	<input type="text" value="TU"/>	[Search]
Initial EAPG	<input type="text"/>		<input type="text"/>	[Search]	<input type="text"/>	[Search]
Status		Final EAPG				
		Pay Action				

- 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.

<input type="button" value="delete"/>	<input type="button" value="add an item"/>
*Detail Item	1 <input type="text"/>
*Type of Provider	Ordering Provider <input type="text"/>
*Provider #	1234567890
*Last Name	SMITH
*First Name, MI	JOHN <input type="text" value="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 Status Information

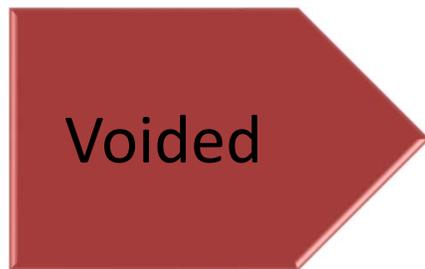
Claim Status Not Submitted yet

submit

cancel



Paid claims can be:



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

Claim Portal Errors



MITTS 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.							

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



Timely Filing



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”

Medicaid CoPay Amount

\$0.00

Note Reference Code



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.	
<input type="button" value="delete"/> <input type="button" value="add"/>	
<p>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.</p> <p>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.</p>	
*Type of Document	<input type="text"/>
*Transmission Type	<input type="text"/>



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



Adjusting a Paid Claim



cancel

adjust

void

copy claim

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



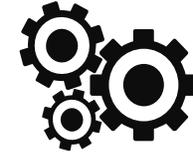
Adjusting a Paid Claim



- 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
5818185127250

Originally paid \$45.00
Now paid \$50.00

Additional payment of \$5.00



2018172234001
5018173127250

Originally paid \$50.00
Now paid \$45.00

Account receivable (\$5.00)



Voiding a Paid Claim



cancel

adjust

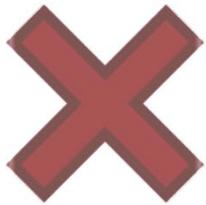
void

copy 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



cancel

adjust

void

copy claim



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.

*Claim Filing Indicator	COMMERCIAL INSURANCE	<input type="button" value="v"/>	*Insurance Carrier Name	BLUE CROSS BLUE SHIELD
*Policy Holder Relationship to Insured	FATHER	<input type="button" value="v"/>	*Electronic Payer ID	01234
*Policy Holder Last Name	SMITH		Insured's Policy ID	987654
*Policy Holder First Name, MI	JOHN	A	*Payer Sequence	PRIMARY <input type="button" value="v"/>
Policy Holder Date of Birth	01/01/1950		Medicare ICN	
Gender	MALE	<input type="button" value="v"/>		
*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.

<input type="button" value="delete"/>	<input type="button" value="add an item"/>
---------------------------------------	--

*Claim Filing Indicator	HMO, MEDICARE RISK	<input type="button" value="v"/>
*Policy Holder Relationship to Insured	SELF	<input type="button" value="v"/>
*Policy Holder Last Name	SMITH	
*Policy Holder First Name, MI	JOHN	A
Policy Holder Date of Birth	01/01/1950	
Gender	MALE	<input type="button" value="v"/>
*Paid Amount	\$200.00	
*Paid Date	01/05/2018	
Allowed Amount	\$0.00	

*Insurance Carrier Name	HUMANA MEDICARE	
*Electronic Payer ID	43210	
Insured's Policy ID	456789	
*Payer Sequence	PRIMARY	<input type="button" value="v"/>
Medicare ICN		

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.

Payer Header Level Adjustment Reason Codes (ARC) and Amounts

*Electronic Payer ID

*CAS Group Code

*ARC

*Amount



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.

Payer Line Level Adjustment Reason Codes(ARC) and Amounts

*Detail Item/Electronic Payer ID
 *CAS Group Code
 *ARC
 *Amount

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

Welcome,

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

Provider Reports ? ^

*Report

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

search clear



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

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>

