Basic Billing for Hospitals

External Business Relations
2018
AGENDA

➢ Medicaid Services
➢ Programs & Cards
➢ Managed Care/MyCare Ohio
➢ Provider Responsibilities
➢ Policy
➢ MITS & Claims
➢ Websites & Forms
External Business Relations Team

Sarah Bivens
Ava Cottrell
Ed Ortopan
Janene Rowe
Chezré Willoughby

Manager - Meagan Grove
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
Medicaid Medical Necessity: OAC 5160-1-01

Is the fundamental concept underlying the Medicaid Program

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

- Acupuncture
- Behavioral Health
- Dental
- Dialysis
- Dietitian
- Durable Medical Equipment
- Home Health
- Hospice
- Hospital (Inpatient/Outpatient)
- ICF-IID Facility
- Nursing Facility
- Pharmacy
- Physician
- Transportation
- Vision
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)
Providers will be required to enter two out of the following three pieces of data: tax ID, NPI, or 7 digit Ohio Medicaid provider number.

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

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

IVR: 1-800-686-1516
Programs & Cards
Ohio Medicaid

- This card is the traditional fee-for-service Medicaid card
- 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 1-800-888-1516.

Note: Use the Medicaid ID for all claim submissions.

medicaid.ohio.gov

Consumer’s Signature:

Ohio Medicaid

County
ALLEN

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

- Consumers must cooperate with requests from third-party insurance companies to provide additional information needed in order to authorize coverage.

- Consumers must cooperate with requests from a Medicaid provider; managed care plan; or a managed care plan’s contracted provider for additional information which is needed in order to bill third party insurances appropriately.
Conditions of Eligibility and Verifications

- Providers may contact local CDJFS offices to report non-cooperative consumers

- CDJFS may terminate eligibility if an individual fails or refuses, without good cause, to cooperate by providing necessary verifications or by providing consent for the administrative agency to obtain verification.
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
Verifiable information

Medicare

Benefit Plan

Managed Care / MyCare

Third Party Liability (TPL)

Long Term Care

Patient Liability
### Eligibility Verification Request

<table>
<thead>
<tr>
<th>Medicaid Billing Number</th>
<th>SSN</th>
<th>Procedure Code</th>
<th>Birth Date</th>
<th>DOS Date Format</th>
<th>From DOS</th>
<th>To DOS</th>
</tr>
</thead>
</table>

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

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

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

### Recipient Information

<table>
<thead>
<tr>
<th>Medicaid Billing Number</th>
<th>Last Name</th>
<th>First Name</th>
<th>Gender</th>
<th>Date of Birth</th>
<th>Date of Death</th>
<th>SSN</th>
<th>County of Residence</th>
<th>County of Eligibility</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**County Office** [http://jfs.ohio.gov/County/County_Directory.pdf](http://jfs.ohio.gov/County/County_Directory.pdf)

**Number Bed Hold Days Used Paid CY**

### Benefit / Assignment Plan

<table>
<thead>
<tr>
<th>Benefit / Assignment Plan</th>
<th>Effective Date</th>
<th>End Date</th>
<th>Provider Name</th>
<th>Dental Co-Pay Amount</th>
<th>Vision Co-Pay Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Schools</td>
<td>01/01/2018</td>
<td>01/31/2018</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>MRDD Targeted Case Mgmt</td>
<td>01/01/2018</td>
<td>01/31/2018</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Alcohol and Drug Addiction Services</td>
<td>01/01/2018</td>
<td>01/31/2018</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Ohio Mental health</td>
<td>01/01/2018</td>
<td>01/31/2018</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Medicaid</td>
<td>01/01/2018</td>
<td>01/31/2018</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

### Case/Cat/Seq Spenddown

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

## Recipient Information

<table>
<thead>
<tr>
<th>Medicaid Billing Number</th>
<th>Last Name</th>
<th>First Name</th>
<th>Gender</th>
<th>County of Residence</th>
<th>County of Eligibility</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>CUYAHOGA</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of Birth</th>
<th>Date of Death</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SSN</th>
<th>County Office <a href="http://jfs.ohio.gov/County/County_Directory.pdf">http://jfs.ohio.gov/County/County_Directory.pdf</a></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number Bed Hold Days Used Paid CY</td>
</tr>
</tbody>
</table>

## Benefit / Assignment Plan

<table>
<thead>
<tr>
<th>Benefit / Assignment Plan</th>
<th>Effective Date</th>
<th>End Date</th>
<th>Provider Name</th>
<th>Dental Co-Pay Amount</th>
<th>Vision Co-Pay Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Schools</td>
<td>01/01/2018</td>
<td>01/31/2018</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>★ MRDD Targeted Case Mgmt</td>
<td>01/01/2018</td>
<td>01/31/2018</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>★ Alcohol and Drug Addiction Services</td>
<td>01/01/2018</td>
<td>01/31/2018</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>★ Ohio Mental health</td>
<td>01/01/2018</td>
<td>01/31/2018</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>★ Medicaid</td>
<td>01/01/2018</td>
<td>01/31/2018</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

## Associated Child(ren)

<table>
<thead>
<tr>
<th>Medicaid Billing Number</th>
<th>First Name</th>
<th>MI</th>
<th>Last Name</th>
<th>Gender</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>123456789012</td>
<td>AUDREY</td>
<td></td>
<td>DOE</td>
<td>FEMALE</td>
<td>11/20/2004</td>
</tr>
<tr>
<td>987654321012</td>
<td>ALEX</td>
<td></td>
<td>DOE</td>
<td>MALE</td>
<td>09/14/2006</td>
</tr>
</tbody>
</table>
## Eligibility Verification Request

### TPL

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

### Managed Care

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Plan Description</th>
<th>Effective Date</th>
<th>End Date</th>
<th>Managed Care Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>CARESOURCE</td>
<td>HMO, CFC</td>
<td>01/01/2018</td>
<td>01/31/2018</td>
<td></td>
</tr>
</tbody>
</table>

### Lock-In

*** No rows found ***

### Medicare

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Effective Date</th>
<th>End Date</th>
<th>Plan Name</th>
<th>Plan ID</th>
<th>Medicare ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>PART A</td>
<td>12/01/2017</td>
<td>12/08/2017</td>
<td></td>
<td>272012289D6</td>
<td></td>
</tr>
<tr>
<td>PART B</td>
<td>12/01/2017</td>
<td>12/08/2017</td>
<td></td>
<td>272012289D6</td>
<td></td>
</tr>
</tbody>
</table>

### Service Limitation

*** No rows found ***

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

## Level of Care Determinations

<table>
<thead>
<tr>
<th>LOC Requested</th>
<th>Status</th>
<th>Determination Date</th>
<th>LOC Determination</th>
<th>Description</th>
<th>LOC Begin Date</th>
<th>LOC End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>09/01/2017</td>
<td>NF; NF WAIVER; RSS</td>
<td>INTERMEDIATE (ILOC)</td>
<td>12/01/2017</td>
<td>12/08/2017</td>
</tr>
<tr>
<td></td>
<td></td>
<td>08/23/2017</td>
<td>NF; NF WAIVER; RSS</td>
<td>INTERMEDIATE (ILOC)</td>
<td>12/01/2017</td>
<td>12/08/2017</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>UNKNOW LEVEL OF CARE</td>
<td></td>
<td>12/01/2017</td>
<td>12/07/2017</td>
</tr>
</tbody>
</table>

## Patient Liability

<table>
<thead>
<tr>
<th>Financial Payer</th>
<th>Monthly Amount</th>
<th>Type</th>
<th>Effective Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>DEFAULT</td>
<td>$491.00</td>
<td>Pro-rated Nursing Home</td>
<td>12/01/2017</td>
<td>12/08/2017</td>
</tr>
</tbody>
</table>

## Long Term Care Facility Placements

<table>
<thead>
<tr>
<th>Facility Type</th>
<th>Date of Admission</th>
<th>Effective Begin Date of Medicaid Coverage</th>
<th>End Date of Medicaid Coverage</th>
<th>Date of Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>NURSING FACILITY</td>
<td>07/25/2017</td>
<td>12/01/2017</td>
<td>12/08/2017</td>
<td></td>
</tr>
</tbody>
</table>

## Recipient Restricted Coverage

*** No rows found ***

## Special Program

*** No rows found ***
Presumptive Eligibility

Covers children up to age 19 and pregnant women

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

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

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

Other members will receive a Presumptive Eligibility Card
Presumptive Eligibility

### Recipient Information

<table>
<thead>
<tr>
<th>Medicaid Billing Number</th>
<th>SSN</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Last Name</th>
<th>County of Residence</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>First Name</th>
<th>County of Eligibility</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender</th>
<th>County Office <a href="http://jfs.ohio.gov/County/County_Directory.pdf">Link</a></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of Birth</th>
<th>Date of Death</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Benefit / Assignment Plan

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

### Case/Cat/Seq Spenddown

Number Bed Hold Days Used Paid CY 20170101: 10
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 receive 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

**Billing 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
Healthcheck: OAC 5160-1-14

Early & Periodic Screening Diagnosis & Treatment (EPSDT) for children from birth through age 20

Minimum services include:

- Comprehensive Health and Developmental History
- Developmental Screening (including mental and physical)
- Nutritional Screening
- Vision Screening
Healthchek

- Hearing Screening
- Immunization Screening
- Lead Toxicity Screening
- Lab Tests
- Dental Screening
HealthChek Procedure Codes

When completing a HealthChek exam please complete all components of the exam and bill the correct *Preventive Medicine* code for the appropriate age group.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infant</td>
<td>99381, 99391</td>
</tr>
<tr>
<td>1 – 4</td>
<td>99382, 99392</td>
</tr>
<tr>
<td>5 – 11</td>
<td>99383, 99393</td>
</tr>
<tr>
<td>12 – 17</td>
<td>99384, 99394</td>
</tr>
<tr>
<td>18 – 20</td>
<td>99385, 99395</td>
</tr>
</tbody>
</table>

New Patient Initial Visit

Established Patient

Use These Codes
HealthChek Procedure Codes

When completing a HealthChek exam please complete all components of the exam and bill the correct *Evaluation and Management* code for the appropriate time spent.

<table>
<thead>
<tr>
<th>New Patient Initial Visit</th>
<th>Established Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>20 min. 99202</td>
<td>15 min. 99213</td>
</tr>
<tr>
<td>30 min. 99203</td>
<td>25 min. 99214</td>
</tr>
<tr>
<td>45 min. 99204</td>
<td>40 min. 99215</td>
</tr>
<tr>
<td>60 min. 99205</td>
<td></td>
</tr>
</tbody>
</table>

Use These Codes

Use These Codes
Managed Care/MyCare Ohio
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
Managed Care Day One

- New individuals will be assigned to a Managed Care Plan the first day of the current month when an individual is found eligible for Medicaid

<table>
<thead>
<tr>
<th></th>
<th>‘The old way’</th>
<th>Day One</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recipient completes Application</td>
<td>4/3/2018</td>
<td>4/3/2018</td>
</tr>
<tr>
<td>Determined eligible for Medicaid</td>
<td>5/17/2018</td>
<td>5/17/2018</td>
</tr>
<tr>
<td>Fee-For-Service</td>
<td>4/1/2018 → 5/31/2018</td>
<td>4/1/2018 → 4/30/2018</td>
</tr>
<tr>
<td>Managed Care Plan</td>
<td>6/1/2018 → 12/31/2299</td>
<td>5/1/2018 → 12/31/2299</td>
</tr>
</tbody>
</table>
3 Population Groups Eligible for Traditional Managed Care

- Medicaid Managed Care MAGI (CFC)
- Medicaid Managed Care Non-MAGI (ABD)
- Medicaid Managed Care Adult MAGI (expansion population)

Population added for mandatory enrollment in 2017:

- Adoption children, Breast and Cervical Cancer Patients (BCCP), Foster children, and Bureau of Children with Medical Handicaps (BCMH)
Individuals with optional enrollment in Traditional Managed Care Plans

Native Americans that are members of a federally recognized tribe

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

Some value-added services:

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

## Benefit / Assignment Plan

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

## Case/Cat/Seq Spenddown

*** No rows found ***

## TPL

*** No rows found ***

## Managed Care

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Plan Description</th>
<th>Effective Date</th>
<th>End Date</th>
<th>Managed Care Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>PARAMOUNT ADVANTAGE</td>
<td>HMO, CFC</td>
<td>12/01/2017</td>
<td>02/28/2018</td>
<td></td>
</tr>
</tbody>
</table>
Traditional Managed Care Sample Card
Providers who are interested in delivering services to a Managed Care member must be fully enrolled with Medicaid and 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; therefore, contact the plan for the specific requirements.
- ABD/CFC Managed Care plan contracts may be separate from MyCare Ohio plan contracts.
Traditional Managed Care Plans

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

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

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

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

800-600-9007 https://www.uhccommunityplan.com
MyCare Ohio is a demonstration project that integrates Medicare and Medicaid services into one program, operated by a Managed Care Plan.

MyCare Ohio operates in seven geographic regions covering 29 counties and includes more than 100,000 beneficiaries.

The project is currently slated to end on December 31, 2019.
➢ Package includes *all* benefits available through the traditional Medicare and Medicaid programs

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

The MITS provider portal will show if a individual is enrolled in a Managed Care Plan based on the eligibility dates of service you enter.
# MITS Eligibility screen

<table>
<thead>
<tr>
<th>Benefit / Assignment Plan</th>
<th>Effective Date</th>
<th>End Date</th>
<th>Provider Name</th>
<th>Dental Co-Pay Amount</th>
<th>Vision Co-Pay Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRDD Targeted Case Mgmt</td>
<td>12/01/2017</td>
<td>01/31/2018</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Alcohol and Drug Addiction Services</td>
<td>12/01/2017</td>
<td>01/31/2018</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Ohio Mental Health</td>
<td>12/01/2017</td>
<td>01/31/2018</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Medicaid</td>
<td>12/01/2017</td>
<td>01/31/2018</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

**Case/Cat/Seq Spenddown**

*** No rows found ***

**TPL**

*** No rows found ***

**Managed Care**

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

**Lock-In**

*** No rows found ***

**Medicare**

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

<table>
<thead>
<tr>
<th>Benefit / Assignment Plan</th>
<th>Effective Date</th>
<th>End Date</th>
<th>Provider Name</th>
<th>Dental Co-Pay Amount</th>
<th>Vision Co-Pay Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRDD Targeted Case Mgmt</td>
<td>10/01/2017</td>
<td>01/31/2018</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Alcohol and Drug Addiction Services</td>
<td>10/01/2017</td>
<td>01/31/2018</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Ohio Mental health</td>
<td>10/01/2017</td>
<td>01/31/2018</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Medicaid</td>
<td>10/01/2017</td>
<td>01/31/2018</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

### Case/Cat/Seq Spenddown

*** No rows found ***

### TPL

*** No rows found ***

### Managed Care

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Plan Description</th>
<th>Effective Date</th>
<th>End Date</th>
<th>Managed Care Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>CARESOURCE</td>
<td>HMO, MyCare Ohio</td>
<td>10/01/2017</td>
<td>01/31/2018</td>
<td>Medicaid Only</td>
</tr>
</tbody>
</table>

### Lock-In

*** No rows found ***

### Medicare

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Effective Date</th>
<th>End Date</th>
<th>Plan Name</th>
<th>Plan ID</th>
<th>Medicare ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>PART A</td>
<td>10/01/2017</td>
<td>01/31/2018</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PART B</td>
<td>10/01/2017</td>
<td>01/31/2018</td>
<td></td>
<td>300685983A</td>
<td></td>
</tr>
<tr>
<td>PART C</td>
<td>11/01/2017</td>
<td>01/31/2018</td>
<td>ANTHEM SENIOR ADVANTAGE PLUS</td>
<td>H3655</td>
<td>300685983A</td>
</tr>
</tbody>
</table>
MyCare Ohio Opt-Out Sample Card

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
MyCare Ohio Region Breakdown

- Individuals will have the ability to enroll by phone, online, or by mail.

<table>
<thead>
<tr>
<th>DEMONSTRATION REGION &amp; POPULATION</th>
<th>MANAGED CARE PLANS AVAILABLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northwest: 9,884</td>
<td>- Aetna</td>
</tr>
<tr>
<td>Fulton, Lucas, Ottawa, Wood</td>
<td>- Buckeye</td>
</tr>
<tr>
<td>Southwest: 19,456</td>
<td>- Aetna</td>
</tr>
<tr>
<td>Butler, Clermont, Clinton, Hamilton, Warren</td>
<td>- Molina</td>
</tr>
<tr>
<td>West Central: 12,381</td>
<td>- Buckeye</td>
</tr>
<tr>
<td>Clark, Greene, Montgomery</td>
<td>- Molina</td>
</tr>
<tr>
<td>Central: 16,029</td>
<td>- Aetna</td>
</tr>
<tr>
<td>Delaware, Franklin, Madison, Pickaway, Union</td>
<td>- Molina</td>
</tr>
<tr>
<td>East Central: 16,225</td>
<td>- CareSource</td>
</tr>
<tr>
<td>Portage, Stark, Summit, Wayne</td>
<td>- United</td>
</tr>
<tr>
<td>Northeast Central: 9,284</td>
<td>- CareSource</td>
</tr>
<tr>
<td>Columbiana, Mahoning, Trumbull</td>
<td>- United</td>
</tr>
<tr>
<td>Northeast: 31,712</td>
<td>- Buckeye</td>
</tr>
<tr>
<td>Cuyahoga, Geauga, Lake, Lorain, Medina</td>
<td>- CareSource</td>
</tr>
<tr>
<td></td>
<td>- United</td>
</tr>
</tbody>
</table>
MyCare Managed Care Contracting

Providers who are interested in delivering services to a MyCare Ohio member must be fully enrolled with Medicaid and 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; therefore, contact the plan for the specific requirements.
- MyCare Ohio Managed Care plan contracts may be separate from ABD/CFC plan contracts.
MyCare Ohio Managed Care Plans

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

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

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

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

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

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

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

Instructions
This form is for Managed Care providers only. Providers must appeal denied claims to the MCP before the Ohio Department of Medicaid will process a complaint. If your complaint involves multiple Managed Care Plans (MCPs), please complete one form per MCP. The resolution timeframes for Managed Care complaints are 2 business days for complaints involving access to care, and 15 business days for all other issues. If you have a complaint regarding Medicaid Fee For Service please call 1-800-686-1516.

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

- Maintain records for 6 years
- Inform us of any changes to your provider profile within 30 days
- Render medically necessary services in the amount required
- Recoup any third party resources available
- Abide by the regulations and policies of the state
- Not seek reimbursement for service(s) from the patient, any member of the family, or any other person
- 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.
The Ohio Administrative Code requires that a Medicaid consumer provide notice to the department prior to initiating any action against a liable third party.

The department will take steps to protect its subrogation rights if that notice is not provided.

For questions, contact the Coordination of Benefits Section at 614-752-5768.
A provider may **NOT** collect and/or bill for any difference between the Medicaid payment and the provider’s charge, as well as for the following:

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

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

5160-1-13.1 Medicaid Consumer Liability

Date of service: ________________

Type of Service: ________________

Name/account number: ____________________________________________

Billing number: ______________________

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

☐ (1) The consumer is notified in writing prior to the service being rendered that the provider will not bill ODIFS 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: ____________________________________________

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

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 Billing Reminder for ICF-IID Providers (6/29/2016)

Notice Regarding Provision of Progesterone (6/13/16)

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

- Medicaid Transmittal Letters (MTL)
- Hospital Handbook Transmittal Letter (HHTL)
- Medical Assistance Letter (MAL)
Effective 4/1/2018 the following modifiers will be used for APRNs:

- **SA** indicates a service performed by a CNP
- **SB** indicates a service performed by a CNM
- **UC** indicates a service performed by a CNS
- **QX** indicates an anesthesia service performed by a CRNA (or anesthesiologist assistant) with the medical direction of an anesthesiologist
- **QZ** indicates an anesthesia service performed by a CRNA without the medical direction of an anesthesiologist
- **AS** indicates a service performed by an assistant-at-surgery

❖ No additional modifier (SA, SB, or UC) is used to indicate an APRN (the practitioner is identified by NPI as the rendering provider)
Guidelines on how to complete these forms are found in the rules listed below:

- **ODM 03199** Acknowledgement of Hysterectomy Information (formerly ODJFS 03199)
- **HHS-687** (OMB 0937 0166) Consent for Sterilization
- **ODM 03197** Abortion Certification Form (formerly ODJFS 03197)
Medicaid Advisory Letter (MAL) No. 612

ODM will cover sterilization services if all the following requirements of the OAC and CFR are met:

- The individual is at least twenty-one years old at the time consent is obtained
- The individual is not mentally incompetent
- The individual is not institutionalized
- The individual has voluntarily given informed consent
Medicaid Advisory Letter (MAL) No. 612

Form **ODM 03197** must be completed before payment can be made for the following codes:

**CPT**
- 59840
- 59841
- 59850
- 59851
- 59852
- 59855
- 59856
- 59857
- 59866

**ICD-10**
- 10A00ZZ
- 10A03ZZ
- 10A04ZZ
- 10A07ZX
- 10A07Z6
- 10A07ZW
- 10A07ZZ
- 10A08ZZ
New Explanation of Benefits Codes for Hospitals HHTL 3352-16-02

• Effective January 2016
• No longer using the 6653 process
• Must use “utilization/tpl vendor approved resubmission” as the reason
• Must use the 56 ICN for the takeback

<table>
<thead>
<tr>
<th>Supporting Data for Delayed Submission / Resubmission</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DISCLAIMER:</strong> Documentation to justify the use of this panel and data entered must be retained for future audit purposes.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Previously Denied ICN or TCN</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>DELAYED SUBMISSION/RESUBMISSION</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Claim Status Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Claim Status</strong></td>
</tr>
<tr>
<td><strong>Utilization/Tpl Vendor Approved Resubmission</strong></td>
</tr>
</tbody>
</table>
How to Find Modifiers Recognized by Ohio Medicaid
How to Find Modifiers Recognized by Ohio Medicaid

➢ Scroll to the bottom of the page
New Utilization Review Vendor

• KEPRO (Keystone Peer Review Organization) will be handling all utilization reviews

• Effective 7/1/17

• KEPRO will be doing all Prior Authorizations and Hospital reviews

• Your process will not be changing
Rates for ASCs will no longer be maintained in this rule

- 8/1/2017 ASC rates were moved to OAC 5160-22-01
- ASC claims will process through 3M’s Enhanced Ambulatory Patient Group (EAPG) software
- EAPGs use procedure codes, not diagnosis codes, as initial classification

Payment for neonatal and newborn care services will be increased to seventy-five percent of the Ohio Medicare allowed amount
Medicaid Payment: OAC 5160-1-60

➢ ASC EAPG Payment
  • DME and Pharmaceuticals will pay outside EAPG
  • Use same EAPG relative weights as out patient
  • All ASC have same base rate
  • Lab and radiology services are paid the lesser of the EAPG payment or billed charges

➢ ASC Base Rate = $74.83 and ASC Cost-to-Charge Ratio = .18
  • ASC base rate and CCR is equal to 80% of statewide average Outpatient Hospital base rate and CCR
Prior Authorization (PA) will need to be requested for select codes

- The covered code list has a PA indicator on the codes that now require a PA

- Use the MITS provider portal to request a PA

- ASCs are PA assignment type 57
Medicaid Payment: OAC 5160-1-60

➢ The expanded code list can be found at:
   http://medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates/SchedulesandRates.aspx

➢ Two webinars available for ASC’s
   • PA training webinar
     https://attendee.gotowebinar.com/recording/1363716958699805953
   • EAPG training webinar
     https://attendee.gotowebinar.com/recording/5547934847121846795
DRC Inpatient Hospitalization

1. ODRC sends applications to ODM Direct Enrollment Unit for offenders who are admitted to a hospital for a period of at least 24 hours

2. ODM Direct Enrollment Unit processes the application and maintains the case in their ODM caseload

3. Eligibility for a full year is approved, then Pre-Termination Review (PTR) to determine if there is a need to keep them on Medicaid
There is *no length of time* limit for services as long as the individual continues to be eligible for Medicaid and is receiving services as an inpatient in the medical facility.

72 hour roll-in for outpatient services does not apply for IHSP individuals.

Outpatient services prior to the date of admission must be submitted to DRC or the correctional facility for payment.
The ordering National Provider Identifier (NPI) must be for an individual physician/non-physician practitioner (not the NPI of an organizational provider).

The ordering physician/non-physician practitioner must be actively enrolled and must be of a specialty type that is eligible to order in the Ohio Medicaid program.
Providers should ensure that services are being ordered, referred, or prescribed by an eligible provider who is enrolled in Medicaid.

| Providers may enroll as an ORP-only provider or as a Medicaid billing provider | ORP-only providers have an expedited screening process | Online applications can be found on our website |
Eligible Providers: OAC 5160-2-01

Changes to be effective for discharges on or after 7/1/17

– Added Paragraph “C”

▪ Allows MCP to now cover inpatient psychiatric services

▪ Only for individuals aged 21 - 64

▪ This change does not apply to traditional FFS Medicaid
Three Calendar Day Roll-In

- Effective 1/1/16
- Outpatient (OP) services provided within three calendar days prior to the date of admission will be covered as inpatient (IP) services
  - Including emergency room and observation services
  - “From Date” should start with the first date of OP and the “Through Date” should be the date of discharge
  - “Admit Date” field is the day the patient was admitted as IP
Classification of Hospitals: OAC 5160-2-05

➢ As of 1/1/18 nineteen hospitals were reclassified from the Rural to Urban peer groups and were set to receive the new peer group base rate
• The rule will be updated with the following effective 8/1/18:
  ❖ Beginning on or after 1/1/19 any hospital geographically located in an Ohio county that has been newly included or newly excluded from a Core Based Statistical Area (CBSA) will be placed into either the rural peer group or, based on geographical location of the hospital, the urban peer group. The hospital’s new base rate will be the average cost per discharge of the new peer group without stop loss/gain provisions included.
Potentially Preventable Readmissions (PPR) Program: OAC 5160-2-14

➢ Reduces payment for clinically-related and clinically-preventable readmissions

• Encourages underperforming hospitals to improve the level of care provided during a patient’s inpatient admission
• A hospital with excess readmissions* will be subject to a reduction of their hospital-specific base rate by one percent

* Defined as an actual-to-expected readmission ratio of greater than one
Coordination of Benefits: Hospital Services: OAC 5160-2-25

HHTL 3352-17-04

Private Insurance

Medicare

Medicaid

Payment to be made only after any available third-party benefits are exhausted
Inpatient Hospital Services: OAC 5160-2-65

Updated fixed cost outlier thresholds for dates of discharge on or after 7/4/17

- Neonate and tracheostomy DRGs = $25,000
- Major Teaching or Children’s Peer Group Hospitals = $60,000
- All other DRGs/Peer Groups = $75,000
Inpatient Hospital Services: OAC 5160-2-65

Interim bill is for advanced billing of an extended inpatient hospital stay

All Interim Bills (Bill Type 112 & 113) must be for periods of 30 days or more

DRG-Exempt provider may submit a Final Interim (Bill type 114) to close out the stay

DRG Hospital must void all Interim Bills and submit a final admit through discharge bill (Bill Type 111) for the entire stay

DRG Hospitals will pay their hospital-specific inpatient cost-to-charge ratio for Bill Types 112 and 113
Transfer Billing: Located in the hospital billing guidelines

Section 2.1.1
• Transfer between Acute Care and Medicare Distinct Part Psychiatric Units

Section 2.1.2
• Multiple Transfers between Acute Care and Medicare Distinct Part Psychiatric Units

Section 2.1.3
• Transfers between Acute and Distinct Part Rehabilitation Units
Reimbursement for Outpatient Hospital Services: OAC 5160-2-75

- Changes effective for dates of services on or after 8/1/17
- Establishes the Enhanced Ambulatory Patient Groups (EAPG) as the reimbursement logic for outpatient services
- Due to the initial EAPG implementation, hospitals cannot submit a claim that spans from 7/31/17 through 8/1/17
- CPT codes are updated annually on January 1st, so hospitals cannot submit a claim that spans 12/31 and 1/1 of any year
Reimbursement for Outpatient Hospital Services:
OAC 5160-2-75

➢ EAPG Packaging

- Uniform list of EAPGs that always package with significant procedures or medical visit EAPGs
  - Example: Incidental medical supplies (i.e. gauze, dressings, sutures, etc.) on a surgery claim
  - Example: Lab test on same day as a surgery

- If ancillary service is on the claim on its own, packaging may or may not apply
Significant Procedure Consolidation

- When a patient has multiple significant procedures, some of the significant procedures may require minimal additional time or resources.

- Significant procedure consolidation collapses multiple related significant procedure EAPGs into a single EAPG for payment.

  - Example: EAPG 063 Level II Endoscopy would pay 100%, but if EAPG for Level I Endoscopy was on the same claim, it would consolidate with EAPG 063 (no separate payment).
Reimbursement for Outpatient Hospital Services: OAC 5160-2-75

- Discounting pricing logic is used when:
  - Multiple unconsolidated significant procedures are on the claim; highest weighted EAPG is paid 100%, secondary 50%
  - Multiple unpackaged ancillaries are on the claim; highest weighted EAPG is paid 100%, secondary 50%
  - Modifiers (e.g. 50, bilateral procedure) are present; code with modifier 50 is paid at 150% of standard rate
Reimbursement for Outpatient Hospital Services: OAC 5160-2-75

➢ Payment Formula:

▪ Detail Payment = Base Rate * EAPG relative weight * Discount percentage (if applicable)

▪ Total claim payment = sum of all detail payments

▪ Lab and radiology services are paid the lesser of the EAPG payment or billed charges

▪ Items consolidated or packaged are paid $0.00
Reimbursement for Outpatient Hospital Services: 
OAC 5160-2-75

Example payment calculation for 2 gastrointestinal EAPGs, 134-Diagnostic Upper GI Endoscopy or Intubation, and 149-Screening Colorectal Services and EGD:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Current Payment</th>
<th>EAPG</th>
<th>Relative Weight</th>
<th>Cleveland Clinic Base Rate</th>
<th>RW * Base Rate</th>
<th>Discounting</th>
<th>Final Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>43239</td>
<td>EGD BIOPSY SINGLE/MULTIPLE</td>
<td>$692.00</td>
<td>134</td>
<td>4.6595</td>
<td>$101.12</td>
<td>471.17</td>
<td>100%</td>
<td>$471.17</td>
</tr>
<tr>
<td>45380</td>
<td>COLONOSCOPY AND BIOPSY</td>
<td>$346.00</td>
<td>149</td>
<td>3.8031</td>
<td>$101.12</td>
<td>384.57</td>
<td>50%</td>
<td>$192.29</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$1,038.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$663.46</td>
</tr>
</tbody>
</table>
Reimbursement for Outpatient Hospital Services: OAC 5160-2-75

➢ Pricing Outside of EAPG

– Certain services may be paid outside of EAPG
Medicaid now accepts select CDT D codes in outpatient hospital setting

Hospitals should bill the same CDT D codes that the dentist uses on corresponding professional claim

The outpatient hospital setting is **NOT** the designated place for dental procedures

- Should only be utilized when medically necessary
Pricing Outside of EAPG: Observation

– We now accept observation code **G0378** which is an hourly code this is the preferred code
  ▪ Limited to 48 hours
  ▪ May span across 3 days

– Observation services reported with CPT codes **99218 - 99220, 99224 - 99226, 99234 - 99236** will continue to be **limited** to one unit per day, for a maximum of two consecutive days
Pricing Outside of EAPG: Durable Medical Equipment (DME)

- DME that is not packaged or consolidated will reimburse the lesser of charges or the payment amount listed on the Durable Medical Equipment Fee Schedule.

- EAPGs 1001 – 1020 are DME EAPGs.

- If a DME item is not priced on the fee schedule, it will pay $0.
Pharmaceuticals that are not packaged or consolidated will reimburse the lesser of charges or the payment amount listed on the Provider Administered Pharmaceutical Fee Schedule.

If a pharmaceutical is not on the fee schedule or is listed as ‘By Report’ the detail will reimburse at 60% of the hospital cost (60%*CCR*billed charges).
Vaccines for Children (VFC) may be reimbursed for individuals 18 years of age or younger

- $10 reimbursement for administration
- No payment for the vaccine itself
Option to have only high cost items reimbursed and forego payment for any other procedure and ancillary services performed on the same date

- Bill the UB modifier on the surgery code or main procedure code provided on the date of service
- Submit all procedures, drugs, and medical supplies on the claim
Pharmaceutical pricing is based on provider administered fee schedule when a rate exists.

- Otherwise, the payment is calculated as drug charges multiplied by the hospital’s cost to charge ratio, multiplied by 60%.

Independently billed medical supplies are calculated as billed charges multiplied by the hospital’s cost to charge ratio, multiplied by 60%.
EAPG Grouper returns Pay Action Flags which tell us whether a procedure is applicable for full payment, discounting, etc.

<table>
<thead>
<tr>
<th>Pay Action</th>
<th>Description</th>
<th>Affect on Payment</th>
<th>EOB</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td>Not processed</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>01</td>
<td>Full Payment</td>
<td>100%</td>
<td>9222</td>
</tr>
<tr>
<td>02</td>
<td>Consolidated</td>
<td>0%</td>
<td>9221</td>
</tr>
<tr>
<td>03</td>
<td>Discounted</td>
<td>50%</td>
<td>9220</td>
</tr>
<tr>
<td>04</td>
<td>Packaged</td>
<td>0%</td>
<td>9221</td>
</tr>
<tr>
<td>05</td>
<td>No Payment</td>
<td>0%</td>
<td>9221</td>
</tr>
<tr>
<td>06</td>
<td>Bilateral</td>
<td>150%</td>
<td>9958</td>
</tr>
<tr>
<td>07</td>
<td>Discounted Bilateral</td>
<td>75%</td>
<td>9959</td>
</tr>
<tr>
<td>13</td>
<td>Alternate Payment</td>
<td>Flat Payment</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Lesser of Charges or EAPG Payment</td>
<td>100%</td>
<td>9225</td>
</tr>
<tr>
<td>85</td>
<td>No Payment, No Charges</td>
<td>0%</td>
<td></td>
</tr>
</tbody>
</table>
Carve-in for hospitals and MyCare Ohio was **8/1/2017**, full managed care carve-in will be effective **7/1/2018**

The following DRGs became effective **7/1/2017** for detox services provided in Psychiatric hospitals:
- 770 – Drug & Alcohol Abuse or Dependence
- 773 – Opioid Abuse and Dependence
- 774 – Cocaine Abuse and Dependence
- 775 – Alcohol Abuse and Dependence
- 776 – Other Drug Abuse and Dependence

* Psych hospitals should submit only one claim for all inpatient services *
All hospitals that meet the Medicare conditions of participation may provide Outpatient BH and Substance Use Disorder (SUD) services

Payment will match Community Mental Health Center (CMHC)/SUD agency reimbursement

- Rates based upon the level of the professional providing the services
Behavioral Health Redesign OAC 5160-2-75 (G)(2)

- Payment will match CMHC/SUD agency reimbursement
  - Rates based upon the level of the professional providing the services

- Mental Health and SUD services are *excluded* from the 72-hour inpatient roll-in
  - Medical service provided in the 72 hours before an IP stay must be submitted with the IP claim
Each claim for MH or SUD must contain the following:

- Modifier **HE** at the detail level for each MH or SUD CPT/HCPCS code
- Revenue center code **0671, 0900, 0904, 0906, 0907, 0911, 0912, 0913, 0914, 0915, 0916, 0918, 0919** or **1002** for each MH or SUD detail line
- A MH or SUD diagnosis code
- Modifier signifying the highest level of practitioner who performed the service
## Behavioral Health Redesign OAC 5160-2-75 (G)(2)

<table>
<thead>
<tr>
<th>RCC</th>
<th>Description</th>
<th>Covered under EAPG</th>
<th>Covered in Outpatient Hospital for BH redesign services (with HE modifier) effective 8/1/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>0900</td>
<td>BH Treatment/Services</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>0904</td>
<td>Activity Therapy</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>0906</td>
<td>IOP - Chemical Dependency</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>0907</td>
<td>Day Treatment</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>0911</td>
<td>Rehabilitation</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>0912</td>
<td>Partial Hospitalization - Less Intensive (Half Day)</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>0913</td>
<td>Partial Hospitalization - Intensive (Full Day)</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>0914</td>
<td>Individual Therapy</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>0915</td>
<td>Group Therapy</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>0916</td>
<td>Family Therapy</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>0918</td>
<td>Testing</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>0919</td>
<td>Other Psych Services</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>1002</td>
<td>Residential Treatment – Chemical Dependency</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>0671</td>
<td>Outpatient Special Residence Charges - All Home or Community Based Services</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>
# Behavioral Health Redesign OAC 5160-2-75 (G)(2)

<table>
<thead>
<tr>
<th>Service Date On or After</th>
<th>Type of Medicaid Enrollment</th>
<th>Claims for Appendix F Services</th>
<th>Claims for BH Services with modifier ‘HE’</th>
<th>Claims for Medical Services</th>
<th>Inpatient Services</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Patient Age Under 21 or Over 65</td>
<td>Patient Age 21-64</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>General Hospital</td>
<td>Freestanding Psychiatric Hospitals</td>
</tr>
<tr>
<td>7/1/2017</td>
<td>FFS</td>
<td>FFS</td>
<td>Not Available</td>
<td>FFS</td>
<td>FFS</td>
<td>FFS</td>
</tr>
<tr>
<td></td>
<td>MCP</td>
<td>MCP</td>
<td>Not Available</td>
<td>MCP</td>
<td>MCP</td>
<td>FFS</td>
</tr>
<tr>
<td></td>
<td>MyCare</td>
<td>MyCare</td>
<td>Not Available</td>
<td>MyCare</td>
<td>MyCare</td>
<td>MyCare</td>
</tr>
<tr>
<td>8/1/2017</td>
<td>FFS</td>
<td>FFS</td>
<td>FFS</td>
<td>FFS</td>
<td>FFS</td>
<td>FFS</td>
</tr>
<tr>
<td></td>
<td>MCP</td>
<td>MCP</td>
<td>FFS</td>
<td>MCP</td>
<td>MCP</td>
<td>FFS</td>
</tr>
<tr>
<td></td>
<td>MyCare</td>
<td>MyCare</td>
<td>MyCare</td>
<td>MyCare</td>
<td>MyCare</td>
<td>MyCare</td>
</tr>
<tr>
<td>1/1/2018**</td>
<td>FFS</td>
<td>FFS</td>
<td>FFS</td>
<td>FFS</td>
<td>FFS</td>
<td>FFS</td>
</tr>
<tr>
<td></td>
<td>MCP</td>
<td>MCP</td>
<td>MCP</td>
<td>MCP</td>
<td>MCP</td>
<td>MCP</td>
</tr>
<tr>
<td></td>
<td>MyCare</td>
<td>MyCare</td>
<td>MyCare</td>
<td>MyCare</td>
<td>MyCare</td>
<td>MyCare</td>
</tr>
</tbody>
</table>

*Appendix F services relate to services described in Appendix F of Ohio Administrative Code rule 5160-2-21, which include some behavioral health services, will continue to be available via EAPG beginning 8/1/17

**Managed Care carve-in date subject to the legislative process

FFS = Fee-for-Service Medicaid
MCP = Medicaid Managed Care
MyCare = MyCare Ohio (dual-eligible) Plan
Reimbursement for LARC devices: OAC 5160-2-79

- Effective 7/6/17
- Result of Sub. S.B. 332 of the Ohio 131st General Assembly
- Implements recommendations made by the Commission on Infant Mortality
- Includes intrauterine devices (IUD) and subdermal contraceptive implants
Payment for long-acting reversible contraceptives when provided postpartum
- Provided in an inpatient setting prior to patient’s discharge
- Billed outpatient, after a separate claim related to labor and delivery has been paid
- Payment rates per the Provider-Administered Pharmaceuticals fee schedule
- Not eligible for 340B
Reimbursement for LARC devices: OAC 5160-2-79

- LARC device or implant must be billed using Type of Bill 131
  Only 1 detail line on claim and **NO** other procedure codes listed

- Paid in-patient claim must include a secondary ICD-10 CM diagnosis code for the Z37- Outcome of Delivery Range Codes
LARC device or implant must be reported using:
- Revenue Center Code 0278
- Medical/Surgical Supplies and Devices

MITS configured to pay for separate inpatient postpartum LARC claims effective 7/12/17

MITS configured to pay retroactive for dates of service on or after 7/6/17

Reimbursement for LARC devices: OAC 5160-2-79
Inpatient Facility Stay During A Change

Managed Health Care Program: Eligibility and Enrollment OAC 5160-26-02

Who do I BILL?

<table>
<thead>
<tr>
<th>Admit Plan</th>
<th>Enrollment Change</th>
<th>Responsible Plan*</th>
</tr>
</thead>
<tbody>
<tr>
<td>FFS</td>
<td>FFS -&gt; MCP</td>
<td>FFS</td>
</tr>
<tr>
<td>MCP</td>
<td>MCP -&gt; FFS</td>
<td>MCP</td>
</tr>
<tr>
<td>MCP₁</td>
<td>MCP₁ -&gt; MCP₂</td>
<td>MCP₁</td>
</tr>
</tbody>
</table>
340B Drugs

- Hospitals recognized as a 340B entity are required to notify ODM when 340B purchased drugs are provided to a Medicaid individual
  - 340B reporting is for outpatient claims only
  - RCC 25X or 636 should be billed with a pharmaceutical J or Q code, an NDC, and modifier SE
  - SE modifier **must** be used for dates of service 1/1/2018 and later
    - If a non-340B entity submits the SE modifier edit 3203 – modifier restriction will post and pay on their claims for dates of service on or after 4/1/18 through 9/30/18
    - Starting 10/1/18 non-340B entities using the SE modifier will have their claims denied with edit 3203
RCC 25X and/or 636 with HCPCS J-Code or Q-Code

- Effective DOS **1/1/16** covered vaccine/toxoid CPT codes are reimbursable with RCC 25X or 636

- Effective DOS **10/1/16** covered immune globulins, serum, recombinant products CPT codes are reimbursable when submitted with RCC 25X or 636

- Refer to Hospital Billing Guidelines, section 2.16.2
Effective for dates of service on or after **July 1, 2017**
- Informational only edit, will not affect reimbursement

If a claim (one date of service) contains **two** detail lines with the same RCC, same pharmaceutical HCPCS code, and same NDC but **one** detail line contains modifier **JW**, the second detail line will not deny as a duplicate

EOB 9950 will post on the detail containing modifier **JW** which will result in payment of $0 for that line
Physician assistants are allowed to practice within their scope of practice as authorized by state law.

Physician assistants are allowed to practice within the scope of practice of the physician assistant’s supervising physician.

Physician assistants may receive payment for serving as assistant-at-surgery with an AS modifier alone, when listed as the rendering provider.
APN is now Advanced Practice Registered Nurse (APRN)

Unless a specific exception is noted, all other Medicaid rules that pertain to services by a physician apply to APRNs

APRNs may receive payment for serving as assistant-at-surgery with an AS modifier alone, when listed as the rendering provider
When more than one imaging procedure is performed, the payment amounts remain the same for the following:

- Covered primary procedure, additional covered total procedure, and technical component alone of an additional covered procedure
- Must be performed by the same provider or provider group for the same patient in the same session

The maximum payment amount for the professional component alone was increased from 75% to 95%
MTL No. 3334-16-18 notified providers of a coding change for gynecological services.
Pregnancy Related Services: OAC 5160-21-04

Optional preventive health services available to Medicaid eligible women and are intended to promote positive birth outcomes by supplementing regular obstetrical care.

In addition to delivery services, reimbursement is available for each of the following services:

- H1000 – At Risk Assessment
- H1001 – Antepartum Management
- H1002 – Care Coordination
- H1003 – At Risk Education
- S9436 – Childbirth Preparation/Lamaze
- S9452 – Nutrition Class for pregnant women
Pregnancy Related Services:(MAL No. 605)

Three “pregnancy-related services” rules were rescinded and consolidated into this rule, effective 1/1/17

Provision that allows separate Medicaid payment for delivery services rendered because of multiple births

The maximum payment amount for the first delivery is 100%

The second delivery of a multiple birth is 50%

Third delivery is 25%

ODM form 03535 “Prenatal Risk Assessment” has been replaced by ODM form 10207 and the online NurtureOhio PRAF 2.0 system
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”
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 for weekend adjudication

MITS Portal

Free submission

Claims must be received by Friday at 5:00 P.M. for weekend adjudication

We can help with your claim submission issues!

Free submission

We can help 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
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 an Institutional Claim
### Submission of an Institutional Claim

#### Institutional Claim:

**BILLING INFORMATION**

- **ICN**
- **Claim Received Date**
- **Provider ID**
- **Type Of Bill** [Search]
- **Claim Type**
- **Medicaid Billing Number**
- **Date of Birth**
- **Last Name**
- **First Name, MI**
- **Patient Account #**
- **Medical Record #**
- **Attending Physician #**
- **Last Name**
- **First Name, MI**
- **Operating Physician #**
- **Other Physician #**
- **ICD Version** 10
- **Patient Amount Paid** $0.00

**SERVICE INFORMATION**

- **Release of Information**
  - *From Date*
  - *To Date*
  - Admission Date
  - Admission Hour
  - *Admission Type*
  - Admit Source [Search]
  - Discharge Hour
  - *Patient Status*
  - *Covered Days* 0
  - Non Covered Days 0
  - Coinsurance Days 0
  - Lifetime Reserve Days
  - Prior Authorization #/
    Precertification #

**TOTAL CHARGES**

- Total Charges $0.00
- Total Non Covered Charges $0.00
- Total Covered Charges $0.00
- Medicaid CoPay Amount $0.00

**Note Reference Code**

**Notes**
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 those codes
### Diagnosis Codes

#### Diagnoses

<table>
<thead>
<tr>
<th>Sequence</th>
<th>Diagnosis Code</th>
<th>Description</th>
<th>Present on Admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>J440</td>
<td>CHRONIC OBSTRUCTIVE PULMON DISEASE W ACUTE LOWER RESP INFCT</td>
<td>YES</td>
</tr>
</tbody>
</table>

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

#### Other Payer

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

- *Claim Filing Indicator*
- *Policy Holder Relationship to Insured*
- *Policy Holder Last Name*
- *Policy Holder First Name, MI*
- *Policy Holder Date of Birth*
- *Gender*
- *Paid Amount*
- *Paid Date*
- *Electronic Payer ID*
- *Insured's Policy ID*
- *Payer Sequence*
- *Medicare ICN*
<table>
<thead>
<tr>
<th>Item</th>
<th>Date of Service</th>
<th>Revenue Code</th>
<th>HCPCS/HIPPS Rate Codes</th>
<th>Units</th>
<th>Total Charges</th>
<th>NonCovered Charges</th>
<th>Medicaid Allowed Amount</th>
<th>Status</th>
<th>Modifier 1</th>
<th>Modifier 2</th>
<th>Modifier 3</th>
<th>Modifier 4</th>
<th>Final EAPG</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td></td>
<td></td>
<td></td>
<td>0</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Select row above to update or click add an item button below.
Multiple surgery codes have a payment limit of one unit per line

- If billed with multiple units the claim will deny

Procedure codes that are not identified as multiple surgery codes may be billed with multiple units

When applicable modifiers may be needed in order to bill certain surgical procedures
Drug products are identified and reported using a unique, three-segment number which serves as a universal product identifier for drugs.

Providers billing HCPCS codes in the J series and Q or S series, that represent drugs and CPT codes 90281 – 90399 series (immune globulins) must include the 11 digit NDC number.
If the NDC number printed on a drug package consists of only 10 digits, add a leading zero to the appropriate segment.

If the NDC number is missing or invalid, the claim line will deny.

The FDA publishes the listed numbers.
National Drug Code (NDC)

<table>
<thead>
<tr>
<th>Detail Item</th>
<th>NDC Sequence Number</th>
<th>NDC</th>
<th>Drug Name</th>
<th>Unit of Measure</th>
<th>Prescription Number</th>
<th>Drug Unit Price</th>
<th>Unit Quantity Submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 1</td>
<td>1</td>
<td>54406080701</td>
<td>ELOCTATE</td>
<td>UN-Unit</td>
<td></td>
<td>$1.71</td>
<td>1000.000</td>
</tr>
</tbody>
</table>

Select row above to update -or- click add an item button below.
➢ Click the “submit” button at the bottom right

➢ You may “cancel” the claim at anytime, but the information will not be saved in MITS
Paid claims can be:

- Voided
- Adjusted
- Copied
All claims are assigned an ICN

2218170357321

<table>
<thead>
<tr>
<th>Region Code</th>
<th>Calendar Year</th>
<th>Julian Day</th>
<th>Claim Type/Batch Number</th>
<th>Claim Number in Batch</th>
</tr>
</thead>
<tbody>
<tr>
<td>22</td>
<td>18</td>
<td>170</td>
<td>357</td>
<td>321</td>
</tr>
</tbody>
</table>
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.
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: [Field]
Reason: [Field]
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]
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
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
This panel allows you to electronically upload an attachment onto your claim in MITS.
Uploading an Attachment

➢ Electronic attachments are accepted for Claims, Prior Authorization, and Enrollment Processing
➢ Acceptable file formats: BMP, DOC, DOCX, GIF, JPG, PDF, PPT, PPTX, TIFF, TXT, XLS, and XLSX
➢ Each attachment must be <50 MB in size
➢ Each file must pass an anti-virus scan in MITS
➢ A maximum of 10 attachments may be uploaded
Adjusting a Paid Claim

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

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

2218180234001          Originally paid $45.00
5818185127250          Now paid $50.00
                         Additional payment of $5.00

2018172234001          Originally paid $50.00
5018173127250          Now paid $45.00
                         Account receivable ($5.00)
Voiding a Paid Claim

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

2218180234001
5818185127250

Originally paid $45.00
Account receivable ($45.00)

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

- Open the claim you wish to copy
- Click the “copy claim” button at the bottom of the claim
- A new duplicate claim will be created, make and save all necessary changes
- The “submit” and “cancel” buttons will display at the bottom
- Click the “submit” button
- The claim will be assigned a new ICN
Clinically oriented software tool that automatically identifies inappropriate code combinations and discrepancies in claims

Will look at the coding accuracy of procedures, not medical necessity, and will prevent inappropriate payment for certain services which include:

• Duplicate services (same person, same provider, same date)
• Individual services that should be grouped or bundled
• Mutually exclusive services
• Services rendered incidental to other services
• Services covered by a pre or post-operative period
• Visits in conjunction with other services
The National Correct Coding Initiative (NCCI)

Developed by the Centers for Medicare & Medicaid Services

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

➢ Procedure to procedure (PTP) “Incidental” edit which determines whether a pair of procedure codes should not be reported together because one procedure is incidental to (performed as a natural consequence or adjunct to) the other.

➢ Medically unlikely edit (MUE) determines whether the units of service exceed maximum units that a provider would be likely to report under most circumstances.
**Third Party Liability (TPL) Claims**

- Other payer information can be reported at the claim level (header) or at the line level (detail), depending on the other payer’s claim adjudication.
- HIPAA compliant adjustment reason codes and amounts are required to be on the claim.
- MITS will automatically calculate the allowed amount.
Third Party Liability (TPL) Claims

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

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

---

**Header - Other Payer**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
<th>Date of Birth</th>
<th>Relationship</th>
<th>Gender</th>
<th>Policy ID</th>
<th>Paid Amount</th>
<th>Paid Date</th>
<th>Electronic Payer ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>SMITH</td>
<td>JOHN</td>
<td>A</td>
<td>01/01/1950</td>
<td>SELF</td>
<td>MALE</td>
<td>987654</td>
<td>$200.00</td>
<td>01/05/2018</td>
<td>43210</td>
</tr>
</tbody>
</table>

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

- **Claim Filing Indicator**: HMO, MEDICARE RISK
- **Policy Holder Relationship to Insured**: SELF
- **Policy Holder Last Name**: SMITH
- **Policy Holder First Name, MI**: JOHN, A
- **Policy Holder Date of Birth**: 01/01/1950
- **Gender**: MALE
- **Paid Amount**: $200.00
- **Paid Date**: 01/05/2018
- **Electronic Payer ID**: 43210

**Insurance Carrier Name**: HUMANA MEDICARE

- **Insured’s Policy ID**: 456789
- **Payer Sequence Medicare ICN**: PRIMARY

---

**Header - Other Payer Amounts and Adjustment Reason Codes**
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.

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.

<table>
<thead>
<tr>
<th>Electronic Payer ID</th>
<th>CAS Group Code</th>
<th>ARC</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 01234</td>
<td>PR-Patient Respons</td>
<td>1</td>
<td>$50.00</td>
</tr>
<tr>
<td>A 01234</td>
<td>CO-Contractual Obl</td>
<td>45</td>
<td>$150.00</td>
</tr>
</tbody>
</table>

Select row above to update -or- click add an item button below.
Third Party Liability (TPL) Claims

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

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

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

**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)

- Deductible
- Coinsurance
- Co-payment
- Contractual Obligation/Write off
- Non-covered services

COMMON ARCs:
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
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
   WWW.Medicaid.Ohio.Gov/Providers.aspx

➢ MALs & MTLs
   http://medicaid.ohio.gov/RESOURCES/Publications/ODMGuidance.aspx#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.supplier.obm.ohio.gov/Update/Medicaid.aspx

➢ Information for Trading Partners (EDI)
http://medicaid.ohio.gov/PROVIDERS/Billing/HIPAAandEDIInformation.aspx
Websites

➢ Companion Guides (EDI)
http://medicaid.ohio.gov/PROVIDERS/MITS/HIPAA5010Implementation.aspx

➢ National Drug Code (NDC) Search
http://www.accessdata.fda.gov/scripts/cder/ndc/default.cfm

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

➢ X12 Website (ARC Codes)
http://www.x12.org/codes/claim-adjustment-reason-codes/
Websites

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

➢ PRAF 2.0 Information on the ODM site
http://medicaid.ohio.gov/PROVIDERS/PRAF.aspx

➢ PRAF 2.0 login
http://www.nurtureohio.com/login

➢ Hospital Billing Guide
➢ ODM 06614 – Health Insurance Fact Request
➢ ODM 06653 – Medical Claim Review Request
➢ ODM 03197 – Prior Authorization: Abortion Certification
➢ ODM 03199 – Acknowledgement of Hysterectomy Information
➢ ODM 10207 – Pregnancy Risk Assessment Communication (PRAF)

http://medicaid.ohio.gov/RESOURCES/Publications/MedicaidForms.aspx

➢ HHS-687 – Consent for Sterilization
ANY QUESTIONS?