Basic Billing for Physicians

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 1-800-888-1151.

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)

Patient Liability

Long Term Care
<table>
<thead>
<tr>
<th>Eligibility Verification Request</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Billing Number</td>
</tr>
<tr>
<td>SSN</td>
</tr>
<tr>
<td>Procedure Code</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

*This information is only valid for 'from date' to end of the month searched.*
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>County of Residence</th>
<th>County of Eligibility</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>CUYAHOGA</td>
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</tr>
</tbody>
</table>

- SSN: [County Office](http://jfs.ohio.gov/County/County_Directory.pdf)
- Number Bed Hold Days Used Paid CY

### Benefit / Assignment Plan

<table>
<thead>
<tr>
<th>Benefit / Assignment Plan</th>
<th>Effective Date</th>
<th>End Date</th>
<th>Provider Name</th>
<th>Dental Co-Pay Amount</th>
<th>Vision Co-Pay Amount</th>
</tr>
</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>
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<tr>
<td>Alcohol and Drug Addiction Services</td>
<td>01/01/2018</td>
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<td></td>
<td>$0.00</td>
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<td>01/01/2018</td>
<td>01/31/2018</td>
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</tr>
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<td>Medicaid</td>
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### Case/Cat/Seq Spenddown

No rows found
## Eligibility Verification Request

**Recipient Information**

<table>
<thead>
<tr>
<th>Field</th>
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<tbody>
<tr>
<td>Medicaid Billing Number</td>
<td></td>
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<tr>
<td>Last Name</td>
<td></td>
</tr>
<tr>
<td>First Name</td>
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<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Date of Birth</td>
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</tr>
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<td>Date of Death</td>
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<tr>
<td>County of Residence</td>
<td>CUYAHOGA</td>
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<tr>
<td>County of Eligibility</td>
<td></td>
</tr>
<tr>
<td>SSN</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>
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<th>Vision Co-Pay Amount</th>
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<tbody>
<tr>
<td>Medicaid</td>
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<td>01/31/2018</td>
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<td>Medicaid</td>
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<td>01/31/2018</td>
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<td>$0.00</td>
<td>$0.00</td>
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</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>
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<tbody>
<tr>
<td>123456789012</td>
<td>AUDREY</td>
<td></td>
<td>DOE</td>
<td>FEMALE</td>
<td>11/20/2004</td>
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<td>987654321012</td>
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<td>DOE</td>
<td>MALE</td>
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### Eligibility Verification Request

#### TPL

<table>
<thead>
<tr>
<th>Carrier Name</th>
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<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></td>
<td>082029958-1</td>
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<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>
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<td></td>
<td>082029958-1</td>
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<td>IND</td>
<td>PHYSICIAN/OUTPATIENT COVERAGE</td>
<td>01/30/2018</td>
<td>01/31/2018</td>
<td>PLAN-NV</td>
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<tr>
<td>AETNA US HEALTH</td>
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<td></td>
<td>W116635166</td>
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<td>INPATIENT COVERAGE</td>
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<td>724775</td>
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<tr>
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<td>01/31/2018</td>
<td>724775</td>
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#### 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>
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</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></td>
<td>272012289D6</td>
</tr>
<tr>
<td>PART B</td>
<td>12/01/2017</td>
<td>12/08/2017</td>
<td></td>
<td></td>
<td>272012289D6</td>
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</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>
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<td></td>
<td>UNKNOWN LEVEL OF CARE</td>
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<td>12/07/2017</td>
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### Patient Liability

<table>
<thead>
<tr>
<th>Financial Payer</th>
<th>Monthly Amount</th>
<th>Type</th>
<th>Effective Date</th>
<th>End Date</th>
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</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>
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</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

Members 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>County of Residence</td>
<td>County of Eligibility</td>
</tr>
<tr>
<td>County Office</td>
<td>City of Residence Directory.pdf</td>
</tr>
<tr>
<td>Number Bed Hold Days Used Paid CY</td>
<td>20170101: 10</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>
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<td>$0.00</td>
</tr>
<tr>
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<td>01/01/2017</td>
<td>06/30/2017</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
</tbody>
</table>
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
Issued to qualified consumers who receive Medicare

Qualified Medicare Beneficiary (QMB)

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

Reimbursement policy is set under 5160-1 and can result in a payment of zero dollars
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
Healthchek: OAC 5160-14-03

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>New Patient Initial Visit</th>
<th>Established Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infant</td>
<td>1 – 4</td>
</tr>
<tr>
<td>99381</td>
<td>99391</td>
</tr>
<tr>
<td>99382</td>
<td>99392</td>
</tr>
<tr>
<td>99383</td>
<td>99393</td>
</tr>
<tr>
<td>99384</td>
<td>99394</td>
</tr>
<tr>
<td>99385</td>
<td>99395</td>
</tr>
</tbody>
</table>

*Infant*: 1 – 4 months

*1 – 4*: 5 – 11 months

*5 – 11*: 12 – 17 months

*12 – 17*: 18 – 20 months
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.
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 recipients will be assigned to a Managed Care Plan the first day of the current month when a recipient 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>5/3/2017</td>
<td>5/3/2017</td>
</tr>
<tr>
<td>Determined eligibility for Medicaid</td>
<td>5/17/2017</td>
<td>5/17/2017</td>
</tr>
<tr>
<td>Fee-For-Service</td>
<td>5/1/2017 → 5/31/2017</td>
<td>X</td>
</tr>
<tr>
<td>Managed Care Plan</td>
<td>6/1/2017 → 12/31/2299</td>
<td>5/1/2017 → 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)
Adults eligible via the extension will be able to access a home and community based waiver (HCBS) if a level of care requirement is met. (MCPs are responsible for state plan health care services)

HCBS waivers include: Passport, Ohio Home Care, and Assisted Living. (Fee-for-Service Medicaid is still responsible for waiver services)

Current HCBS waiver case management agencies will continue to coordinate waiver services.
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 recipient.

The MITS provider portal will show if a recipient is enrolled in a Managed Care plan based on the eligibility dates of service you enter.
## 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>Medicaid Schools</td>
<td>12/01/2017</td>
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<tr>
<td>Alcohol and Drug Addiction Services</td>
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<td>$0.00</td>
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### Case/Cat/Seq Spenddown

*** 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

- CareSource: 800-488-0134, https://www.CareSource.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 recipient.

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

The MITS provider portal will show if a recipient is enrolled in a Managed Care Plan based on the eligibility dates of service you enter.
### 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>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
## 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>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>
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<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>
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<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>300685983A</td>
</tr>
<tr>
<td>PART B</td>
<td>10/01/2017</td>
<td>01/31/2018</td>
<td></td>
<td></td>
<td>300685983A</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

Member Name: [Cardholder Name]
Member ID #: [Cardholder ID#]
MMIS Number: [Medicaid Recipient ID#]
PCP Name: [PCP Name]
PCP Phone: [PCP Phone]

RxBin: 004336
RxPCN: ADV
RxGRP: RX3292

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

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

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

Mail pharmacy claims to:
CVS Caremark
P.O. Box 52066
Phoenix, AZ 85072-2066
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 Fulton, Lucas, Ottawa, Wood</td>
<td>- Aetna - Buckeye</td>
</tr>
<tr>
<td>Southwest: 19,456 Butler, Clermont, Clinton, Hamilton, Warren</td>
<td>- Aetna - Molina</td>
</tr>
<tr>
<td>West Central: 12,381 Clark, Greene, Montgomery</td>
<td>- Buckeye - Molina</td>
</tr>
<tr>
<td>Central: 16,029 Delaware, Franklin, Madison, Pickaway, Union</td>
<td>- Aetna - Molina</td>
</tr>
<tr>
<td>East Central: 16,225 Portage, Stark, Summit, Wayne</td>
<td>- CareSource - United</td>
</tr>
<tr>
<td>Northeast Central: 9,284 Columbiana, Mahoning, Trumbull</td>
<td>- CareSource - United</td>
</tr>
<tr>
<td>Northeast: 31,712 Cuyahoga, Geauga, Lake, Lorain, Medina</td>
<td>- Buckeye - CareSource - United</td>
</tr>
</tbody>
</table>
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

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

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

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

800-600-9007 https://www.Uhccommunityplan.com
PROVIDER COMPLAINTS

Work directly with the Plan first

If not resolved, submit a complaint to Ohio Department of Medicaid (ODM) at http://www.ohiomh.com/ProviderComplaintForm.aspx

Certification issues

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

Provider credentialing concerns

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 1-800-886-1516.

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.
There is a federally required, non-refundable application fee when a provider submits a new or revalidation application. The 2018 fee is $569.00 per application. This fee applies to organizational providers only (not individual providers, practitioners, or practitioner groups).
Provider Agreement: OAC 5160-1-17.2

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

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

Medicaid Payment:
OAC 5160-1-60

The department’s payment constitutes payment-in-full for any of our covered services.

Providers are expected to bill the department their Usual and Customary Charges (UCC).

The department will reimburse the provider the lesser of the Medicaid maximum allowable rate (established fee schedule) or the UCC.
The Ohio Administrative Code requires that a Medicaid consumer provide notice to the department prior to initiating any action against a liable third party.

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

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

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

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

5160-1-13.1 Medicaid Consumer Liability

Date of service: _________________

Type of Service: ______________________

Name/account number: ____________________________________________

Billing number: ______________________

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

☐ (D) 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 Filling 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 two types of letters:

- Medicaid Transmittal Letters (MTL)
- Medical Assistance Letter (MAL)
How to Find Modifiers Recognized by Ohio Medicaid
How to Find Modifiers Recognized by Ohio Medicaid

- Scroll to the bottom of the page
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%
Gynecological Service change

NEW CODES

G0101  Q0091

REPLACING

S0612  S0610

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
- S9436 – Childbirth Preparation/Lamaze
- H1002 – Care Coordination
- H1003 – At Risk Education
- 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 \textbf{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
Covered Podiatric Services & Associated Limitations: OAC 5160-7-03

Payment for additional evaluation & management services when provided by a podiatrist

New procedure codes which require decision making of moderate complexity

- 99349
- 99344
- 99343
- 99214
- 99204
Providers eligible to receive payment for acupuncture:

- An acupuncturist
- A recognized acupuncture provider
- Ambulatory health care clinic as defined in OAC 5160-13
- Cost-Based Clinics (FQHC, RHC)
- Professional medical group
Acupuncture Services

- Payment may be made for service that meets the following:
  - Is medically necessary per OAC 5160-1-01
  - Is performed at the written order of a practitioner, during the one year supervisory period, per section 4762.10 or 4762.11 of the Ohio Revised Code
  - Is rendered by a practitioner who is enrolled in the Medicaid program
  - Is rendered for treatment of:
      - Low back pain
      - Migraine
- Payment for more than 30 visits per benefit year requires prior authorization
Acupuncture Services

- No separate payment will be made for both an evaluation & management service and acupuncture service rendered by the same provider to the same individual on the same day.
- No separate payment is made for services that are an incidental part of a visit (e.g., providing instruction on breathing techniques, diet, or exercise).
- No separate payment will be made for additional treatment in either of the following circumstances:
  - Symptoms show no evidence of clinical improvement after an initial treatment period.
  - Symptoms worsen over a course of treatment.
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>97810</td>
<td>Acupuncture, one or more needles, without electrical stimulation, initial 15 minutes of one-on-one contact with the patient.</td>
<td>$25 per 15 minute increment</td>
</tr>
<tr>
<td>97811</td>
<td>Acupuncture, one or more needles, without electrical stimulation, each additional 15 minute increment of personal one-on-one contact with the patient, with reinsertion. (Listed separately in addition to primary code.)</td>
<td>$17.50 per each additional 15 minute increment</td>
</tr>
<tr>
<td>97813</td>
<td>Acupuncture, one or more needles, with electrical stimulation, initial 15 minutes of one-on-one contact with the patient.</td>
<td>$31.15 per 15 minute increment</td>
</tr>
<tr>
<td>97814</td>
<td>Acupuncture, one or more needles, with electrical stimulation, each additional 15 minute increment of personal one-on-one contact with the patient, with reinsertion. (Listed separately in addition to primary code.)</td>
<td>$23.65 per each additional 15 minute increment</td>
</tr>
</tbody>
</table>
MITS and Claims
Medicaid Information Technology System (MITS)

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

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

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

Internet Access (high speed works best)

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

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

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

Select the “Provider Tab” at the top

Click on the “Access the MITS Portal” image on the right of the page
Once directed to this page, click the link to “Login”

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

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

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

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

MITS access will time-out after 15 minutes of system inactivity
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!
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 a Professional Claim
# Submission of a Professional Claim

**Professional Claim:**

**NPI:**

**BILLING INFORMATION**

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

**SERVICE INFORMATION**

- **Release of Information**
- **From Date**
- **To Date**
- **Signature Source**
- **Accident Related To**
- **Accident State**
- **Accident Country**
- **Accident Date**
- **EPSDT Referral**
- **Prior Authorization #**
- **Hospital Discharge Date**
- **Last Menstrual Period**

**TOTAL CHARGES**

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

---

**Diagnosis**

*** No rows found ***

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

**Header - Other Payer**

*** No rows found ***

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

### Table: Diagnosis Codes

<table>
<thead>
<tr>
<th>Sequence</th>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>1519</td>
<td>HEART DISEASE, UNSPECIFIED</td>
</tr>
</tbody>
</table>

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

### Details

<table>
<thead>
<tr>
<th>Item</th>
<th>FDOS</th>
<th>Units</th>
<th>Charges</th>
<th>Medicaid Allowed Amount</th>
<th>Status</th>
<th>Place Of Service</th>
<th>Procedure Code</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>1</td>
<td>0</td>
<td>$0.00</td>
<td>$0.00</td>
<td></td>
<td></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.

### Other Payer

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

### Other Payer Amounts and Adjustment Reason Codes

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

---

*From DOS To DOS:

*Units: 0

*Charges: $0.00

Medicaid Allowed Amount: $0.00

---

*Place Of Service: 

*Procedure Code: 

Emergency: 

Referred EPSDT Service/Family Planning:

*Diagnosis Code: 

Printer: 

---
### Detail Panel

**Table:**

<table>
<thead>
<tr>
<th>Item</th>
<th>FDOS</th>
<th>Units</th>
<th>Charges</th>
<th>Medicaid Allowed Amount</th>
<th>Status</th>
<th>Place of Service</th>
<th>Procedure Code</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>1</td>
<td>0</td>
<td>$0.00</td>
<td>$0.00</td>
<td></td>
<td></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.

- **Item**: 1
- **From DOS**: 
- **To DOS**: 
- **Units**: 0
- **Charges**: $0.00

**Medicaid Allowed Amount**: $0.00

**Rendering Provider**: 

**Submitted EAPG**: 

**Initial EAPG**: 

**Status**: 

**Place Of Service**: 

**Procedure Code**: 

**Emergency**: 

**Referred EPSDT Service/Family Planning**: 

**Diagnosis Code**: 

**Modifiers**: [Search] [Search] [Search] [Search] [Search]

**Final EAPG**: 

**Pay Action**: 

---

**Buttons:**
- **Delete**
- **Add An Item**
- **Copy**

---

**Links:**
- NDC
- Detail - Other Payer
- ClaimCheck
- Additional Provider Information
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
### Detail Panel

| Item | FDOS       | Units | Charges | Medicaid Allowed Amount | Status | Place of Service | Procedure Code | Modifier 1 | Modifier 2 | Modifier 3 | Modifier 4 | Final EAPG |
|------|------------|-------|---------|-------------------------|--------|------------------|----------------|-------------|------------|------------|------------|------------|------------|
| A    | 01/20/2018 | 1.00  | $350.00 | $0.00                   | 11     | $2287            | 78             |             |            |            |            |            |

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

- **Item**: 1
- **From DOS**: 01/20/2018
- **To DOS**: 01/20/2018
- **Units**: 1.00
- **Charges**: $350.00

**Medicaid Allowed Amount**: $0.00

**Rendering Provider**: 

**Submitted EAPG**: 

**Initial EAPG**: 

**Status**: 
- Visit Start Time: 
- Visit End Time: 
- Service Duration less than 90 days: 

**Place Of Service**: 11
**Procedure Code**: 52287
**Emergency**: 

**Referred EPSDT Service/Family Planning Diagnosis Code Pointer**: 

**Modifiers**: 78

**Final EAPG**: 

**Pay Action**: 

- [Search]
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.
National Drug Code (NDC)

- 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>NDC</th>
<th>NDC Sequence Number</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</td>
<td>1</td>
<td>54406080701</td>
<td>ELOCTATE</td>
<td>UN-Unit</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

<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

<table>
<thead>
<tr>
<th>Supporting Data for Delayed Submission / Resubmission</th>
</tr>
</thead>
<tbody>
<tr>
<td>DISCLAIRMER: Documentation to justify the use of this panel and data entered must be retained for future audit purposes.</td>
</tr>
<tr>
<td>Previously Denied ICN or TCN</td>
</tr>
</tbody>
</table>
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
If Medicare issues a denial and indicates that the patient is responsible for the payment, submit the claim to ODM by following these steps:

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

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

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

<table>
<thead>
<tr>
<th>Header - Other Payer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name</td>
</tr>
<tr>
<td>-----------</td>
</tr>
<tr>
<td>A SMITH</td>
</tr>
</tbody>
</table>

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

- **Claim Filing Indicator**: HMO, MEDICARE RISK
- **Insurance Carrier Name**: HUMANA MEDICARE
- **Electronic Payer ID**: 43210
- **Paid Amount**: $200.00
- **Paid Date**: 01/05/2018
- **Allowed Amount**: $0.00
Header vs Detail

Header level

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

Detail level

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

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

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

The X12 website provides adjustment reason codes (ARCs)

COMMON ARCs:

- **1** • Deductible
- **2** • Coinsurance
- **3** • Co-payment
- **45** • Contractual Obligation/Write off
- **96** • Non-covered services
Remittance Advice (RA)

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

- Select “Remittance Advice” and click “Search”
- To see all remits to date, do not enter any data, and click search twice
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

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

- PRAF 2.0 login
  http://www.nurtureohio.com/login
FORMS

- 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?