Basic Billing for Ambulance & Wheelchair Van Transportation Providers

External Business Relations
2018
Agenda:
External Business Relations Team

Sarah Bivens
Ava Cottrell
Laura Gipson
Ed Ortopan
Janene Rowe
Chezré Willoughby

Manager - Meagan Grove
Medicaid Services

• 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
Medical Necessity: OAC 5160-1-01

Is the fundamental concept underlying the Medicaid Program

All services must meet accepted standards of medical practice
Medicaid Services

• IVR 1-800-686-1516

» Calls directed through the IVR prior to accessing the customer call center staff

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

» 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
Medicaid Services

• 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)
Programs & Cards
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 1-800-888-1518.

Note: Use the Medicaid ID for all claim submissions.

medicaid.ohio.gov
Consumer’s Signature:

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]
Programs & Cards

**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
Programs & Cards

• 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
Programs & Cards

- 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
Programs & Cards

• Eligibility Search
  »Full Medicaid eligibility on the MITS portal will show four (or more) benefit spans:
    ▪ Medicaid
    ▪ MRDD Targeted Case Management
    ▪ Alcohol and Drug Addiction Services
    ▪ Ohio Mental Health

  »Additional spans when applicable:
    ▪ Alternative Benefit Plan, for Extension adults
    ▪ Medicaid School Program span, if applicable by age
Programs & Cards

• Eligibility Search, cont.

» Verification of the following:

- Medicare
- Managed Care
- Long Term Care
- Patient Liability
- Benefit Plan
- Third Party
Programs & Cards

• Eligibility Search

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

- Eligibility Verification Request
  
  »You can search up to 3 years at a time!!

![Image of Eligibility Verification Request form]

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

- Eligibility Verification Request - results, cont.

<table>
<thead>
<tr>
<th>Recipient Information</th>
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<tbody>
<tr>
<td>Medicaid Billing Number</td>
<td></td>
</tr>
<tr>
<td>Last Name</td>
<td></td>
</tr>
<tr>
<td>First Name</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
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</tr>
<tr>
<td>Date of Birth</td>
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</tr>
<tr>
<td>Date of Death</td>
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<td>SSN</td>
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<td>County of Residence</td>
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<tr>
<td>County Office</td>
<td><a href="http://jfs.ohio.gov/County/County_Directory.pdf">http://jfs.ohio.gov/County/County_Directory.pdf</a></td>
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<td>Number Bed Hold Days Used Paid CY</td>
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<table>
<thead>
<tr>
<th>Benefit / Assignment Plan</th>
<th>Effective Date</th>
<th>End Date</th>
<th>Provider Name</th>
<th>Dental Co-Pay Amount</th>
<th>Vision Co-Pay Amount</th>
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<tbody>
<tr>
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<td>Alcohol and Drug Addiction Services</td>
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Case/Cat/Sen Spenddown

*** No rows found ***
Programs & Cards

• Eligibility Verification Request - results, cont.
Programs & Cards

• Eligibility Verification Request - results, cont.
Programs & Cards

• Presumptive Eligibility

- 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
- Covers children up to age 19 and pregnant women
Programs & Cards

- Some members will receive a Presumptive Eligibility letter

![Presumptive Eligibility Letter](image-url)
Programs & Cards

- Other members will receive a Presumptive Eligibility Card
Qualified Medicare Beneficiary (QMB)

Issued to qualified consumers who receive Medicare

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

Reimbursement policy is set under 5160-1 and can result in a payment of zero dollars
Specified Low-Income Medicare Beneficiary (SLMB) & Qualifying Individual (QI-1)

Medicaid **ONLY** pays the Part B premium to Medicare
This is **NOT** Medicaid eligibility
There is **NO** cost-sharing eligibility
Managed Care/MyCare
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>
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<tbody>
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<td>Recipient completes</td>
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<td>5/3/2017</td>
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<td>5/17/2017</td>
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<td>Fee-For-Service</td>
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<td>Managed Care Plan</td>
<td>6/1/2017 → 12/31/2299</td>
<td>5/1/2017 → 12/31/2299</td>
</tr>
</tbody>
</table>
Managed Care/MyCare

3 Population Groups Eligible for Managed Care

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

- For the Adult Expansion Population
Managed Care/MyCare

• Managed Care Benefit Package
  » Managed Care Plans must cover all medically necessary Medicaid covered services
  » Some value-added services:
    ▪ Care management to help members coordinate care and ensure they are getting the care that they need
    ▪ Access to toll-free 24/7 hotline for medical advice, staffed by nurses
    ▪ On-line searchable provider directory
    ▪ Preventative care reminders
    ▪ Expanded benefits including additional transportation options, and other incentives (varies among the MCPs)
Managed Care/MyCare

• Individuals with **optional enrollment** in Medicaid Managed Care Plan

  » Native Americans that are members of a federally recognized tribe

  » Home and Community Based waivers thru DODD effective 1/1/17
Managed Care/MyCare

- 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.
  - For recipients enrolled in a MyCare Ohio Managed Care plan it will show if they are enrolled for Dual Benefits or Medicaid Only.
### Benefit / Assignment Plan

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

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### TPL

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### Managed Care

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Plan Description</th>
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<td>CARESOURCE</td>
<td>HMO, ABD</td>
<td>01/01/2018</td>
<td>01/31/2018</td>
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</tbody>
</table>
Managed Care/MyCare

Managed Care Sample Card

CareSource
Health Care with Heart

Member Name: Mary Doe
Date of Birth: 04-12-73

CareSource Member ID #: 12345678900
MMIS #: 987654321000
Primary Care Provider/Clinic Name:
Good, Iam A.
Provider/Clinic Phone: (937) 123-4567
Member Services: 1-800-488-0134 (TTY: 1-800-750-0750 or 711)
24-hour Nurse Line: 1-866-206-0554 (TTY: 1-800-750-0750 or 711)
Managed Care/MyCare

• “Traditional” Managed Care Plans
  » Buckeye (Centene)
    ▪ 866-296-8731 http://www.buckeyehealthplan.com
  » Caresource
    ▪ 800-488-0134 http://www.CareSource.com/
  » Molina
    ▪ 855-322-4079 http://www.molinahealthcare.com
  » United HealthCare
    ▪ 800-600-9007 http://www.uhccommunityplan.com
  » Paramount
    ▪ 419-887-2564 mailto:advantagecompliance@promedica.org
Managed Care/MyCare

Integrated Care Delivery System (ICDS) “MyCare Ohio”

- MyCare Ohio is a demonstration project that integrates Medicare and Medicaid services into one program
- MyCare Ohio operates in seven geographic regions covering 29 counties
- Project was extended for 2 additional years (ending 12/31/2019)
Managed Care/MyCare

- MyCare Ohio Benefits

  » Package includes all benefits available through the traditional Medicare and Medicaid programs
    ▪ Including Long Term Social Services (LTSS) and Behavioral Health, which is new to Managed Care

  » Plans may elect to include additional value-added benefits in their health care packages
Managed Care/MyCare

• 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
    ▪ Reside in one of the demonstration project regions
Managed Care/MyCare

- Individuals that are exempt from MyCare Ohio
  - Individuals with an ICF-IID level-of-care served in a ICF-IID waiver
  - Individuals who have third-party insurance, including retirement benefits
  - Individuals enrolled in PACE program
## Managed Care/MyCare

### Benefit / Assignment Plan

<table>
<thead>
<tr>
<th>Benefit / Assignment Plan</th>
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### Case/Cat/Seq Spenddown

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### TPL

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### Managed Care

**Plan Name**: CARESOURCE  
**Plan Description**: HMO, MyCare Ohio  
**Effective Date**: 12/01/2017  
**End Date**: 01/31/2018  
**Managed Care Benefits**: Dual Benefits

### Lock-In

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### Medicare

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<tr>
<th>Coverage</th>
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</table>
Managed Care/MyCare

MyCare Ohio Opt-In Sample Card

[Image of a sample MyCare Ohio card with highlighted information: RxBin: 004336, RxPCN: MEDDADV, RxGRP: RX5045]
### Benefit / Assignment Plan

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<td>Alcohol and Drug Addiction Services</td>
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<td>Ohio Mental health</td>
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<td>$0.00</td>
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### Case/Cat/Seq Spenddown

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### TPL

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### Managed Care

- **Plan Name**: BUCKEYE COMMUNITY HEALTH PLAN
- **Plan Description**: HMO, MyCare Ohio
- **Effective Date**: 10/01/2017
- **End Date**: 01/31/2018
- **Managed Care Benefits**: Medicaid Only

### Lock-In

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### 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>
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<td>ANTHEM SENIOR ADVANTAGE PLUS</td>
<td>H3655</td>
<td>300685983A</td>
</tr>
</tbody>
</table>
MyCare Ohio Opt-Out Sample Card

* Buckeye Medicaid Member Only *

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: <866-549-8289>  
TTY: <800-750-0750>  

Behavioral Health Crisis: <866-549-8289>  

Care Management: <866-548-0236>  

24-Hour Nurse Advice: <866-246-4358>  
TTY: <800-750-0750>  

Website: http://mmp.bchpohio.com  

Send Medicaid claims to: Buckeye Community Health Plan  
PO Box 6200  
Farmington, MO 63640

*Note: Member is eligible for Medicare through original Medicare or another health plan. You must submit Medicare claims to the member’s primary care insurance.
## Managed Care/MyCare

<table>
<thead>
<tr>
<th>MCPs providing “Traditional” Medicaid Managed Care</th>
<th>MCPs participating in MyCare Ohio (ICDs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Buckeye (Centene)</td>
<td>• Buckeye (Centene)</td>
</tr>
<tr>
<td>• Caresource</td>
<td>• Caresource</td>
</tr>
<tr>
<td>• Molina</td>
<td>• Molina</td>
</tr>
<tr>
<td>• United Healthcare</td>
<td>• United Healthcare</td>
</tr>
<tr>
<td>• Paramount</td>
<td>• Aetna</td>
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</tbody>
</table>
Managed Care/MyCare

Northwest: Aetna, Buckeye
Southwest: Aetna, Molina
West Central: Buckeye, Molina
Central: Aetna, Molina
East Central: Caresource, United
Northeast Central: Caresource, United
Northeast: Caresource Buckeye, United

Fulton, Lucas, Warren, Clinton, Hamilton, Clermont
Clark, Green, Montgomery
Union, Delaware, Franklin, Pickaway, Madison
Summit, Portage, Stark, Wayne
Trumbull, Mahoning, Columbiana
Lorain, Cuyahoga, Lake, Geauga, Medina
Managed Care/MyCare

• MyCare Ohio Managed Care Plans
  » Aetna
    ▪ 855-364-0974 http://www.aetnabetterhealth.com/ohio
  » Buckeye (Centene)
    ▪ 866-296-8731 http://www.bchpohio.com
  » Caresource
    ▪ 800-488-0134 http://www.CareSource.com/MyCare
  » Molina
    ▪ 855-322-4079 http://www.molinahealthcare.com/duals
  » United HealthCare
    ▪ 800-600-9007 http://www.Uhcconnected.com/ohio
Managed Care/MyCare

• Contracting with a MCP
  » If a provider is interested in delivering services to a Managed Care member, a contract or agreement with the plan is necessary
  » 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 contracts are separate from ABD/CFC Managed Care plan contracts
Managed Care/MyCare

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

- Work directly with the Plan first
- If not resolved after working with the plan, submit a complaint to the Ohio Department of Medicaid (ODM)
- Certification issues, work with the Area Agency on Aging (AAA) or ODM for MyCare Ohio waiver providers
- Provider credentialing concerns can be sent to Ohio Department of Insurance (ODI)

[http://www.ohiomh.com/ProviderComplaintForm.aspx](http://www.ohiomh.com/ProviderComplaintForm.aspx)
Provider Responsibilities
Provider Responsibilities

• Provider Enrollment
  
  » There is a non-refundable application fee when an application is submitted to become a Medicaid provider
    ▪ This is a federal requirement
    ▪ The 2018 fee is $569.00 per application
    ▪ The fee applies to organizational providers only (not individual providers, practitioners, or practitioner groups)
Provider Responsibilities

• Provider Revalidation

» The 5 year revalidation is a federal requirement
» Make sure your mailing address is up to date in the Demographics panel in MITS
» Providers that do not revalidate will have their Medicaid agreement terminated
» The non-refundable application fee also applies to the revalidation of your provider agreement
Provider Responsibilities

• Provider Agreement: OAC 5160-1-17.2

The provider agreement is a legal contract between the state and the provider

Accept the allowable reimbursements as payment-in-full

Maintain records for 6 years

Not seek reimbursement for service(s) from the patient, any member of the family, or any other person
Provider Responsibilities

• General Reimbursement Principles: OAC 5160-1-02 and 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
Provider Responsibilities

- Medicaid Consumer Liability: OAC 5160-1-13.1
  
  A provider may **NOT** collect and/or bill for any difference between the Medicaid payment and the provider’s charge, as well as the following:
Provider Responsibilities

- When can you bill an Individual?

  - 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
Provider Responsibilities

• Coordination of Benefits: OAC 5160-1-08

» The Ohio Revised 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
Provider Responsibilities

• 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

http://www.supplier.obm.ohio.gov/Update/Medicaid.aspx
Provider Responsibilities

• Wheelchair Van Services: OAC 5160-15-22

» Payment may be made for the following services:

- Transport by wheelchair van
- Mileage, wheelchair van
- Attendant services
Provider Responsibilities

• Ground Ambulance Services: OAC 5160-15-23

  » Payment may be made for the following services:
    ▪ Basic life support, provided in both a non-emergency and emergency
    ▪ Advanced life support, level 1, both emergency and non-emergency
    ▪ Advanced life support, level 2
    ▪ Specialty care transport
    ▪ Mileage, ground ambulance
    ▪ Attendant service, ground ambulance
Provider Responsibilities

• Air Ambulance Services: OAC 5160-15-24

» Payment may be made for the following services:

- Ambulance transport, fixed-wing
- Ambulance transport, rotary-wing
- Mileage, fixed-wing ambulance
- Mileage, rotary-wing ambulance
Provider Responsibilities

• Surveillance and Utilization Review Section (SURS)

» Top ten provider types reviewed by SURS:

  1. Home Health Services
  2. Durable Medical Equipment
  3. Skilled Nursing Facilities
  4. Physician Services
  5. Private Duty Nursing
  6. Wheelchair Van Services
  7. Hospice Services
  8. Ambulance Services
  9. Prescribed Drugs
  10. Labs
Provider Responsibilities

• SURS, cont.

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

• SURS, cont.

»Limited Scope Reviews can be accomplished by:
Provider Responsibilities

• SURS, cont.

» Review details:
  ▪ Up to 6 years can be reviewed by SURS

» Potential outcomes of Limited Scope Reviews:
  ▪ No identified overpayment
  ▪ Overpayment identification or referral to the Ohio Attorney General (Medicaid Fraud Control Unit)
Provider Responsibilities

- SURS, cont.

### SURS Interest Calculation Spreadsheet

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Provider #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enter Findings Amount:</th>
<th>$4,068.31</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interest Rate:</td>
<td>3.50%</td>
</tr>
<tr>
<td>Enter last date of payment:</td>
<td>12/7/2011</td>
</tr>
<tr>
<td>Enter Date of Letter/Memo:</td>
<td>10/12/2016</td>
</tr>
<tr>
<td>Number of days:</td>
<td>1,771</td>
</tr>
<tr>
<td>Interest to be paid:</td>
<td>$690.89</td>
</tr>
</tbody>
</table>

As of 1/1/18 the interest rate has been increased to 4.50%!
Policy
Policy

• Policy Updates

»Policy updates from Ohio Medicaid announce the changes to the Ohio Administrative Code that may affect providers. There are two types of letters:
  • Medical Assistance Letter (MAL)
  • Medicaid Transmittal Letters (MTL)

http://medicaid.ohio.gov/RESOURCES/Publications/ODMGuidance.aspx#161542-medicaid-policy
Policy

• Modifiers

» Providers - > Billing - > Billing Instructions

- For Dates of Discharge and Dates of Service On or After 8/1/2017

DENTAL CLAIMS:
- Web Portal Billing Guide for Dental Claims
- EDI Companion Guide for Dental Claims

MODIFIERS:
- Modifiers recognized by ODM

DURABLE MEDICAL EQUIPMENT CLAIMS:
Policy
• Ordering, Referring and Prescribing Providers (ORP) 5160-1-17.9

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.

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.
Policy

- Transportation service from an eligible provider: 5160-15-21

  » The following practitioners may certify the necessity of **either** a wheelchair van service **or** an ambulance service:

    ▪ Advanced Practice Registered Nurse (APRN)
    ▪ Doctor of medicine, osteopathy or podiatric medicine
    ▪ Physician Assistant
Policy

• Transportation service from an eligible provider: 5160-15-21

  » The following practitioners may certify the necessity of a wheelchair van service:
    ▪ Chiropractor
    ▪ Licensed Practical Nurse (LPN) or Registered Nurse (RN)
    ▪ Occupational or Physical Therapist
    ▪ Psychologist
    ▪ Certified rehabilitation counselor
    ▪ Any other professional recognized by ODM as having the qualifications necessary to determine the need for a mobility device.
MITS and Claims
MITS and Claims

Medicaid Information Technology System (MITS)

- MITS is a web-based application that is accessible via any modern browser
- MITS design is based upon the Medicaid Information Technology Architecture (MITA)
- MITS is able to process transactions in “real time”
MITS and Claims

• How do I access the MITS Portal?

  » Go to http://Medicaid.ohio.gov
  » Select the “Provider Tab” at the top
  » Click on the “MITS Portal” on the right
MITS and Claims

• MITS Web Portal Navigation
  » The “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 the mouse to move between fields)
  » MITS Web Portal access will time-out after 15 minutes of inactivity in the system
MITS and Claims

• ORP search in MITS
MITS and Claims

• ORP search in MITS, cont.
MITS and Claims

• ORP search in MITS, cont.

[Image of MITS interface with the following details:
- Ordering Provider NPI: 1268168168
- Ordering Provider Last Name
- First, M1
- Date of Service: 01/11/2018]

[Search Results table:
- Ordering Provider NPI: 1268168168
- Ordering Provider Name: SMITH, JOHN D]
MITS and Claims

- Methods of Claim Submission

- **Electronic Data Interchange (EDI)**: Received by Wednesday at Noon for weekend adjudication. Fees for claims submitted.

- **MITS Portal**: Received by Friday at 5:00 P.M. for weekend adjudication. Free submission.
MITS and Claims

• Claim Submission

» Claim entry format is divided into sections or panels

» Each panel will have an asterisk (*) denoting that the fields are required

  ▪ Some fields are situational for claims adjudication and do not have an asterisk
MITS and Claims

• Submission of a Professional Claim
MITS and Claims

• Submission of a Professional Claim, cont.
MITS

- Submission of a Professional Claim, cont.
MITS and Claims

• Procedure Codes
  » Wheelchair Van
    ▪ A0130 – Base Rate
    ▪ S0209 – Mileage
    ▪ T2001 - Attendant
MITS and Claims

• Procedure Codes

  » Ground Ambulance
    • A0424 – Ambulance Attendant
    • A0425 – Mileage
    • A0426 – Advanced Life Support, Level 1, Non-emergency
    • A0427 – Advanced Life Support, Level 1, Emergency
    • A0428 – Basic Life Support, Non-emergency
    • A0429 – Basic Life Support, Emergency
    • A0433 – Advanced Life Support, Level 2
    • A0434 – Specialty Care Transport
MITS and Claims

- Procedure Codes
  - Air Ambulance
    - A0430 – Transportation by Fixed-wing Ambulance
    - A0431 – Transportation by Rotary-wing Ambulance
    - A0435 – Mileage, Fixed-wing ambulance 1<sup>st</sup> passenger only
    - A0436 – Mileage, Rotary-wing ambulance 1<sup>st</sup> passenger only
MITS and Claims

• Modifiers

  » **U3** indicates a wheelchair van service provided in an ambulance
    ▪ Used only with A0130, S0209 and T2001
  » **U6** indicates a service that is unavailable when the vehicle arrives at destination
  » **UA** indicates a *second* trip taken by same person on same day in same type of vehicle to or from the same type of location
  » **UB** indicates a *third* trip taken by the same individual on the same day in the same type of vehicle to or from the same type of location
MITS and Claims

- Detail panel – Round Trip
MITS and Claims

• Detail Panel – Multiple Trips

» If a provider is providing multiple trips on the same day, all of the visits must be noted on a single claim

  ▪ Ensure proper modifier is used for each trip
**MITS and Claims**

- Detail panel – Multiple Trips

![MITS and Claims Image](image-url)
MITS and Claims

• Detail Panel – Additional Trip

  » If provider provides an additional trip taken for the same person on the same day in the same type of vehicle to or from the same type of location

  » All of visits must be noted on a single claim

    ▪ Ensure proper modifier is used for each trip
MITS and Claims

- Detail panel – Additional Trips
MITS and Claims

• Entering the Ordering Provider’s information
MITS and Claims

• Entering the Ordering Provider’s information
### MITS and Claims

- Entering the Ordering Provider’s information, cont.

<table>
<thead>
<tr>
<th>Rendering Provider</th>
<th>Modifiers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HN [Search] [Search]</td>
</tr>
<tr>
<td>Submitted EAPG</td>
<td>Final EAPG</td>
</tr>
<tr>
<td>Initial EAPG</td>
<td>Pay Action</td>
</tr>
</tbody>
</table>

Status
- Visit Start Time
- Visit End Time
- Service Duration (less than 90 days)

**Additional Provider Information**

<table>
<thead>
<tr>
<th>Detail Item</th>
<th>Type of Provider</th>
<th>Provider #</th>
<th>Last Name</th>
<th>First Name, MI</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Type data below for new record.

- [delete] [add an item]

- *Detail Item
- *Type of Provider: 1 2 3
- *Provider #: 4
- *Last Name
- *First Name, MI

**Attachments**

***No rows found***

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

- Entering the Ordering Provider’s information, cont.
MITS and Claims

• Entering the Ordering Provider’s information, cont.
MITS and Claims

• Once all fields have been completed

  » Click the “submit” button at the bottom right
  » You may “cancel” the claim at anytime, but the information will not be saved in MITS
MITS and Claims

- Adjudication will happen in “real time”, the claim status will show:
  
  » Paid
  » Denied
  » Suspended
MITS and Claims

• Internal Control Number (ICN)

  » The ICN replaced the Transaction Control Number (TCN)
  » Each claim will be assigned a separate ICN

  2018170357321

<table>
<thead>
<tr>
<th>Region Code</th>
<th>Calendar Year</th>
<th>Julian Date</th>
<th>Claim Type/Batch Number</th>
<th>Number of Claim in Batch</th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td>18</td>
<td>170</td>
<td>357</td>
<td>321</td>
</tr>
</tbody>
</table>
MITS and Claims

- Internal Control Number (ICN), cont.
  
  » Primary region codes on a new claim submission

  20 Electronic (EDI) 837 without attachment
  21 Electronic (EDI) 837 with an attachment
  22 Web Portal without attachment
  23 Web Portal with an attachment

*Region codes in 50’s indicate an adjustment to your claim
MITS and Claims

• Portal Errors

» If there are portal errors the claim status returned will be “NOT YET SUBMITTED” and the errors will be listed at the top of the claim submission screen

» MITS will not accept a claim without all required fields completed

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.
MITS and Claims

• Special Billing Instructions, cont.

» This panel is used for claims over 365 days that meet timely filing requirements

» Enter the previously denied ICN and select “DELAYED SUBMISSION/RESUBMISSION” in the Reason dropdown menu

» MITS will bypass timely filing edits when appropriate
MITS and Claims

• 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, you can submit the claim via the MITS Portal

• The claim must be submitted within 180 days of the hearing decision or eligibility determination date
MITS and Claims

• Special Billing Instructions – Eligibility Delay, cont.

  » In the Note Reference Code dropdown menu select “ADD”
  » In the Notes box you will need to enter the hearing decision or eligibility determination information
MITS and Claims

• Special Billing Instructions – Eligibility Delay, cont.

  » 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

  Notes: DECISION^20171225
MITS and Claims

• Medicare Denials

  »If Medicare issues a denial and indicates that the patient is responsible for the payment, submit the claim to ODM by following these steps:

  • Enter the claim in MITS
  • Do not enter any Medicare information on the claim
  • Complete and upload a ODM 6653 form and a copy of the Medicare EOB
MITS and Claims

• Attachment Panel

»This panel allows you to electronically upload an attachment onto your claim in MITS
MITS and Claims

• Attachment Panel, cont.

» Electronic attachments are accepted for Claims, Prior Authorization, Enrollment, and Re-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
MITS and Claims

- Claim Adjustment

> Claims with a status of *Paid* can be:

- Adjusted
- Voided
- Copied
MITS and Claims

• Claim Adjustment, cont.

»To **ADJUST** a *Paid* claim:

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

• Claim Adjustment, cont.

> 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
## MITS and Claims

- **Claim Adjustment, Cont.**

<table>
<thead>
<tr>
<th>Adjusting up</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2218180234001</td>
<td>Originally paid</td>
<td>$45.00</td>
</tr>
<tr>
<td>5818185127250</td>
<td>Now paid</td>
<td>$50.00</td>
</tr>
<tr>
<td>Additional payment</td>
<td>$5.00</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Adjusting down</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2218172234001</td>
<td>Originally paid</td>
<td>$30.00</td>
</tr>
<tr>
<td>5818173127250</td>
<td>Now paid</td>
<td>$20.00</td>
</tr>
<tr>
<td>Account Receivable</td>
<td>($10.00)</td>
<td></td>
</tr>
</tbody>
</table>
MITS and Claims

• Claim Adjustment, cont.
  » To **VOID** 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”
Claim Submission

• Claim Adjustment, cont.

Voided Claim

2218180234001 Originally paid $45.00
5818185127250 Account receivable ($45.00)

* Make sure to wait until after the weekend’s adjudication cycle to submit a new, corrected, claim if one is needed
MITS and Claims

• Claim Adjustment, cont.

» How to **COPY** a *Paid* claim:
  ▪ Open the claim you wish to copy
  ▪ Click the “copy claim” button at the bottom of the claim
  ▪ A new 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
MITS and Claims

• Claimcheck Edits
  » Clinically oriented software tool that automatically identifies inappropriate code combinations and discrepancies in claims
  » Will look at the coding accuracy of procedures, not medical necessity, and will prevent inappropriate payment for certain services which include:
    ▪ Duplicate services (same person, same provider, same date)
    ▪ Individual services that should be grouped or bundled
    ▪ Mutually exclusive services
    ▪ Services rendered incidental to other services
    ▪ Services covered by a pre or post-operative period
    ▪ Visits in conjunction with other services
MITS and Claims

• 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
MITS and Claims

• Coordination of Benefit Claims (COB)

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.
MITS and Claims

• Coordination of Benefit Claims (COB), cont.

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
MITS and Claims

• X12 Website
  » The X12 website provides adjustment reason codes (ARCs) that must be entered on claims that involve other payers

Some of the most common ARCs are:

- 1 (Deductible)
- 2 (Coinsurance)
- 3 (Co-payment)
- 45 (Contractual Obligation/Write-Off)
- 96 (Non-covered services)
MITS and Claims

• Remittance Advice (RA)

» All claims processed are available on the MITS Portal

» Weekly reports become available on Wednesdays
MITS and Claims

- Remittance Advice (RA), cont.
  - Select “Remittance Advice” and click search twice
  - To see all remits to date, don’t enter any specific data
Websites
Websites

• Ohio Department of Medicaid home page
  http://Medicaid.ohio.gov
• Ohio Department of Medicaid provider page
  http://Medicaid.ohio.gov/providers.aspx
• MITS home page
  https://portal.ohmits.com/Public/Providers/tabId/43/Default.aspx
• LAWriter
  http://codes.ohio.gov/oac/5160
Websites

• Electronic Data Interchange (EDI)
  » Information for Trading Partners
  http://medicaid.ohio.gov/PROVIDERS/Billing/HIPAAandEDIInformation.aspx

  » Companion Guides
  http://medicaid.ohio.gov/PROVIDERS/MITS/HIPAA5010Implementation.aspx

  » Technical Questions/EDI Support Unit
    ▪ Transitioned partners contact DXC EDI Support
      ❖ 844-324-7089
      ❖ OhioMCD-EDI-Support@dxc.com
Forms
Forms

- ODM 06614 – Health Insurance Fact Request
- ODM 06653 – Medical Claim Review Request
- ODM 10199 – Request for Approval of Claim Specialty Care Transport and Related Mileage
Questions