Basic Billing for Hospice

Provider Relations

2022
Must enter two of the following: 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
Helpful Phone Numbers

 OSHIIP (Ohio Senior Health Insurance Information Program)
  1-800-686-1578

 Coordination of Benefits Section
  614-752-5768
  614-728-0757 (fax)
Medicaid Medical Necessity: OAC 5160-1-01

Is the fundamental concept underlying the Medicaid Program

All services must meet accepted standards of medical practice
Ohio Medicaid Covers:

- Covered Families and Children
- Expansion Population
- Aged, Blind, or People with Disabilities
- Home and Community Based Waivers
- Medicare Premium Assistance
- Hospital Care Assurance Program
- Medicaid Managed Care
Programs & Cards
Programs & Cards

• Ohio Medicaid
  » This card is the traditional fee-for-service Medicaid card
  » Issued annually as of October 1, 2018
Conditions of Eligibility and Verifications: OAC 5160:1-2-10

- Individuals must cooperate with requests from third-party insurance companies needing to authorize coverage
- Individuals must cooperate with requests from a Medicaid provider for information which is needed in order to bill third-party insurances
- Providers may contact the local CDJFS office to report non-cooperative individuals
- CDJFS may terminate eligibility
Full Medicaid eligibility on the MITS Portal will show **four** benefit spans:

1. Alcohol and Drug Addiction Services
2. MRDD Targeted Case Management
3. Ohio Mental Health
4. Medicaid

**Additional spans when applicable:**

- Alternative Benefit Plan - for extension adults
- Medicaid School Program - if applicable by age
Eligibility Verification Request

Training Videos
Ohio Medicaid has created a compilation of training videos that cover a variety of topics for providers. If questions remain after reviewing these videos, contact Ohio Medicaid Provider Assistance at 1-800-686-1516.

Check back frequently as training videos will be added as needed. If there are issues viewing these videos, make sure your pop-up blocker is turned off.

- Presumptive Eligibility (PE) Portal Walk Through for Qualified Entities
- Enhanced Eligibility Agent Account and Access Reports
- Eligibility Search
Eligibility Verification Request

You can search up to 4 years back

TIP: Always check eligibility prior to billing
Eligibility Verification Request

- The effective and end dates of will be based off the dates used in the search.
- The associated child(ren) search will bring up any child associated with the member’s ID.

### Recipient Information

<table>
<thead>
<tr>
<th>Medicaid Billing Number</th>
<th>Last Name</th>
<th>First Name</th>
<th>Gender</th>
<th>Date of Birth</th>
<th>Date of Death</th>
<th>SSN</th>
</tr>
</thead>
</table>

### Benefit / Assignment Plan

<table>
<thead>
<tr>
<th>Benefit / Assignment Plan</th>
<th>Effective Date</th>
<th>End Date</th>
<th>Provider Name</th>
<th>Dental Co-Pay Amount</th>
<th>Vision Co-Pay Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Schools</td>
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<td>$0.00</td>
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<td>07/31/2021</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
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<td>07/01/2017</td>
<td>07/31/2021</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Ohio Mental Health</td>
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<td>$0.00</td>
<td>$0.00</td>
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<td>Medicaid</td>
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<td>$0.00</td>
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### Associated Child(ren)

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<th>MI</th>
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<th>Gender</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>910700745972</td>
<td>IMPERIAL</td>
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<td>SMITH</td>
<td>MALE</td>
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<tr>
<td>910700745973</td>
<td>CARTIER</td>
<td></td>
<td>JONES</td>
<td>MALE</td>
<td>01/15/2008</td>
</tr>
</tbody>
</table>
Eligibility Verification Request

If an individual has a third-party payer, you can find that information under the TPL panel.
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
- Combined effort with ODRC, Ohio MHAS, ODH, and MCPs
- All DRC facilities activated by January 2017
- More than 20,000 individuals have benefited from this program
DRC Inpatient Hospitalization

**Process Overview**

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

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

3. Eligibility for a full year is approved, then Pre-Termination Review (PTR) to determine if there is a need to keep on Medicaid
Inpatient Hospital Services Plan (IHSP)

If an individual has an IHSP benefit, the benefit / assignment plan panel will show this:

Inpatient Hospital Services Plan

07/01/2021 07/31/2021

Dental Co-Pay Amount: $0.00
Vision Co-Pay Amount: $0.00

County Office http://jfs.ohio.gov/county/cntydir.stm
Number Bed Hold Days Used Paid CY

SSN
County of Residence
County of Eligibility

Recipient Information
Medicaid Billing Number
Last Name
First Name
Gender
Date of Birth
Date of Death
Presumptive Eligibility

Covers children up to age 19 and pregnant women

Was expanded to provide coverage for parent and caretaker relatives and extension adults

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

- Hospitals and Federally Qualified Health Centers (FQHCs) are eligible to participate in Ohio’s presumptive eligibility initiative.

- To become a Qualified Entity complete the steps described here:
  - [https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/billing/presumptive-eligibility-training/presumptive-eligibility-training](https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/billing/presumptive-eligibility-training/presumptive-eligibility-training)
Presumptive Eligibility

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

**Presumptive Eligibility**

MISSISSIPPI RIVERS
21 S FRONT ST
COLUMBUS, OH 43215

The following individuals have temporary Medicaid coverage under Presumptive Eligibility (PE). The Qualified Entity (QE) has enrolled these persons based on the unverified self-declaration of the patient’s household income, U.S. citizenship or qualified alien status, Ohio residency, and pregnancy (if applicable).

Coverage will stop unless the individuals’ Medicaid applications are processed.

Any individuals not given temporary coverage may still file applications for full Medicaid coverage.

**APPROVED:**

<table>
<thead>
<tr>
<th>Name (First, M.I., Last Name)</th>
<th>Date of Birth</th>
<th>PE Type</th>
<th>Date Coverage Begins</th>
<th>Medicaid ID</th>
</tr>
</thead>
<tbody>
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<td>05/09/2021</td>
<td>910001331813</td>
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</tbody>
</table>
Presumptive Eligibility

Other members will receive this Presumptive Eligibility letter:

CDJFS Presumptive Eligibility

John Doe
123 Main St.
Anytown, OH 43210

The following individuals have temporary Medicaid coverage under Presumptive Eligibility (PE). The County Department of Job and Family Services (CDJFS) enrolled these persons based on the unverified self-declaration of the patient's household income, U.S. citizenship or qualified alien status, Ohio residency, and pregnancy (if applicable).

Presumptive eligibility will stop when a decision is made on your full Medicaid application.

Any individuals not given temporary coverage may still file applications for full Medicaid coverage.

APPROVED:

<table>
<thead>
<tr>
<th>Name (First, M.I., Last Name)</th>
<th>Date of Birth</th>
<th>PE Type</th>
<th>Date Coverage Begins</th>
<th>Medicaid ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>John Doe</td>
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<td>06/25/2021</td>
<td>910194194194</td>
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</table>
Presumptive Eligibility

The benefit/assignment plan will look like this:

<table>
<thead>
<tr>
<th>Recipient Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Billing Number</td>
</tr>
<tr>
<td>Last Name</td>
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<tr>
<td>First Name</td>
</tr>
<tr>
<td>Gender</td>
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<tr>
<td>Date of Birth</td>
</tr>
<tr>
<td>Date of Death</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Recipient Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>County Office <a href="http://jfs">http://jfs</a> ohio gov/county/cntydir.stm</td>
</tr>
<tr>
<td>Number Bed Hold Days Used Paid CY</td>
</tr>
</tbody>
</table>

<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:MRDD Targeted Case Mgmt</td>
<td>02/14/2019</td>
<td>09/30/2021</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>PRESUMPTIVE:Alcohol and Drug Addiction Services</td>
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<td>09/30/2021</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
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<tr>
<td>PRESUMPTIVE:Medicaid</td>
<td>02/14/2019</td>
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<td>$0.00</td>
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<tr>
<td>PRESUMPTIVE:Ohio Mental health</td>
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<td>09/30/2021</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
</tbody>
</table>
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
Can I Bill Them?

MLN Matters® Number: MM11230 Revised Release Date of Revised Article: July 3, 2019

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 for covered items and services (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 system updates are part of CMS’ ongoing efforts to help providers comply with QMB billing prohibitions.
Qualified Medicare Beneficiary will show up in the benefit/assignment plan panel

<table>
<thead>
<tr>
<th>Recipient Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Billing Number</td>
</tr>
<tr>
<td>Last Name</td>
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<tr>
<td>First Name</td>
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<td>Gender</td>
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<tr>
<td>Date of Death</td>
</tr>
<tr>
<td>SSN</td>
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<td>County of Residence</td>
</tr>
<tr>
<td>County of Eligibility</td>
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<tr>
<td>County Office</td>
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<tr>
<td>Number Bed Hold Days</td>
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<td>Used Paid CY</td>
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</table>

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<tr>
<th>Benefit / Assignment Plan</th>
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</thead>
<tbody>
<tr>
<td>Benefit / Assignment Plan</td>
</tr>
<tr>
<td>Effective Date</td>
</tr>
<tr>
<td>Qualified Medicare Beneficiaries</td>
</tr>
</tbody>
</table>
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
SLMB and QI 1 / QI 2

This is what will appear in the benefit/assignment plan panel if the individual has SLMB:

<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>SLMB</td>
<td>05/01/2017</td>
<td>07/31/2021</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
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</tbody>
</table>

This is what will appear if the individual has QI 1/QI 2:

<table>
<thead>
<tr>
<th>Benefit / Assignment Plan</th>
<th>Effective Date</th>
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<th>Provider Name</th>
<th>Dental Co-Pay Amount</th>
<th>Vision Co-Pay Amount</th>
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</thead>
<tbody>
<tr>
<td>QI 1/QI 2</td>
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<td>07/31/2021</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
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</table>
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
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)
Managed Care Benefit Package

Managed Care Plans (MCPs) must cover all medically necessary Medicaid covered services

Some value-added services:

- Online searchable provider directory
- Toll-free 24/7 hotline for medical advice
- Expanded benefits including additional transportation options plus other incentives
- Care management to help members coordinate care
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
MITS Managed Care Eligibility

If an individual is enrolled in a Managed Care Plan, the plan information will be shown in the Managed Care panel along with the effective and end dates.

<table>
<thead>
<tr>
<th>Benefit / Assignment Plan</th>
<th>Effective Date</th>
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<th>Provider Name</th>
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<tbody>
<tr>
<td>MRDD Targeted Case Mgmt</td>
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<td>10/31/2021</td>
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<td>Ohio Mental health</td>
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<tr>
<td>Medicaid</td>
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<td>12/31/2018</td>
<td></td>
<td>$0.00</td>
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</tr>
</tbody>
</table>

*** No rows found ***
Traditional Managed Care Contracting

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

- Buckeye Health Plan: 866-296-8731, [https://www.buckeyehealthplan.com](https://www.buckeyehealthplan.com)
- CareSource: 800-488-0134, [https://www.CareSource.com/](https://www.CareSource.com/)
- Paramount Health Care: 855-522-9076, [https://www.paramounthealthcare.com/](https://www.paramounthealthcare.com/)
- UnitedHealthcare: 800-600-9007, [https://www.uhccommunityplan.com](https://www.uhccommunityplan.com)
MyCare Ohio is a demonstration project that integrates Medicare and Medicaid services into one program, operated by a Managed Care Plan.

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

The project is currently slated to end on December 31, 2022.
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
If an individual’s Medicaid **and** Medicare benefits are covered by the Managed Care Plan, you will see **dual benefits**.
If the Managed Care Plan covers only the individual’s Medicaid benefits, you will see Medicaid Only.
MyCare Managed Care Contracting

Providers who are interested in delivering services to a MyCare Ohio member must be fully enrolled with Medicaid and have a contract or agreement with the plan.

Things to know:

- Each plan has a list of services that require prior authorization.
- Each plan will have their own billing requirements; therefore, contact the plan for the specific requirements.
- MyCare Ohio Managed Care plan contracts may be separate from ABD/CFC plan contracts.
MyCare Ohio Managed Care Plans

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

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/
Work directly with the Plan first
If not resolved, submit a complaint to Ohio Department of Medicaid (ODM)
Medicaid.ohio.gov > Resources for Providers > Managed Care

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

Send to Ohio Department of Insurance (ODI)

Provider licensure issues
Submitting a Managed Care Complaint

Provider Inquiries

Providers should contact the associated managed care organization (MCO) for assistance before submitting a complaint (see hyperlink below) to the Ohio Department of Medicaid (ODM).

Providers should contact the MCO's provider services line and/or their regional provider relations representative. Providers are encouraged to use the appeals, grievance, or arbitration processes as outlined in their individual contract with that MCO. If the MCO or MCO's representative do not return a provider's call within five business days, the provider may complete the provider complaint form below.

All complaints submitted are sent immediately to the corresponding MCO for response. Please note the MCOs will have up to 15 business days to respond.

The provider inquiry guidance document and inquiry form are located HERE. Ensure your pop-up blocker is turned off.
Submitting a Managed Care Complaint

Provider Complaint Form Guidance

The Ohio Department of Medicaid (ODM) maintains a managed care organization (MCO) complaint form. This can be used by any provider who has first attempted to work directly with the plan but has been unsuccessful in getting an appropriate response. Before submitting a complaint, providers should check the plan’s Claims Payment Systemic Errors (CPSE) report for the issue in question.

MCO’s receive these complaints directly, in real time, and have 15 business days to respond to the provider with a resolution. Providers are encouraged to utilize the appeals, grievance, or arbitration processes as outlined in their individual contract with the plan. ODM staff review complaints to verify whether the plan has contacted the provider and given an answer to their question(s). ODM staff cannot arbitrate between the plan and providers.

Please note: ODM does not follow-up with all providers on complaints submitted. ODM reviews all complaints and tracks trends.
Submitting a Managed Care Complaint

**Submission Tips:**

Providers may add supporting documentation directly onto the provider complaint form.

If multiple individuals are affected by a single issue with a plan, the provider is to submit only one complaint for all individuals, however, up to 5 attachments may be uploaded on a single complaint.

*NEW* If the provider submits multiple complaints for the same issue (different individuals, dates of service, practitioners, or files affected), ODM will cancel all duplicate complaints, contact the provider, and request that a single new complaint be submitted for all files affected.

*NEW* If a group provider is submitting a complaint, the “Filing Party Name” on the complaint should list the group’s name and not the individual practitioner.

*NEW* Proper contact information for the person listed in the “Follow-up Name” field must be entered. The plans may attempt to contact the provider via telephone conversation, voicemail left, or email sent. If the plan is continuously unable to reach the listed contact, ODM may close the complaint without direct provider contact.
Submitting a Managed Care Complaint

Fill out the complaint form completely. You will receive a confirmation email once submitted with a confirmation number (C############).
Provider Responsibilities
Provider Enrollment and Revalidation

Providers are required to submit an application to become a Medicaid provider.

There is also a federally required 5 year revalidation.

Providers may enroll as an ORP-only provider or as a Medicaid billing provider.

Online applications can be found on our website.
Provider 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 ODM 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
- Not seek reimbursement for service(s) from the patient, any member of the family, or any other person.
Updating Demographic Information in MITS

Per OAC 5160-1-17.2(F), providers must inform ODM of any changes within 30 days.
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.
Medicaid Recipient 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 for the following:

- Missed appointment fee
- Unacceptable or untimely 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
When Can You Bill an Individual?

- The statement must be signed before the service is rendered. If the service requires multiple visits, this must be done prior to each visit.

- This cannot be done if the service is a prescription for a controlled substance.
Policy
Policy updates from Ohio Medicaid announce the changes to the Ohio Administrative Code that may affect providers.
Policy

https://codes.ohio.gov
Hospice Services Reporting Requirements: 5160-56-03.3

Hospice Enrollment

• Must be completed and processed on the MITS Provider Portal
• Only for Individuals in fee-for-service Medicaid, not those enrolled into a managed care plan
• All Individuals in which hospice is seeking reimbursement after all other payers
• Must provide all required information in order for the hospice enrollment to process or billed claims will not pay
Hospice Services Reporting Requirements: 5160-56-03.3

Hospice Enrollment

• All individuals with routine home care, T2042, for DOS on or after 1/1/16
• Any individual, for any hospice service, where an original claim needs to be submitted
• Any individual, for any hospice service, where a claim needs to be adjusted
Hospice Services Reimbursement: OAC 5160-56-06

Service Intensity Add-On (SIA) Codes

- Payment for routine home care by an RN or licensed social worker within the last 7 days of life, when the discharge from hospice is due to death
- Billed using code G0299, for direct care by in-person visit from an RN
- Billed using code G0155, for direct care by in-person visit from a social worker
  - Should not be billed until after the individual has passed away
  - May be billed individually as long as T2042 was already billed and paid
  - Can be billed on the same claim as T2042 for those days
Hospice Services Reimbursement: OAC 5160-56-06

- Hospice procedure codes based on level of care:
  - Code **T2042** used for one unit per day to bill routine home care for an individual not receiving continuous home care
    - Reimbursement is paid using a two-tiered system based on the Episode of Care:
      1. During the first episode, the per diem is paid at a higher rate; the lower rate is paid for days 61 and after
      2. A gap in hospice services of more than 60 days is required to reset the counter that determines which per diem to apply
      3. A subsequent episode begins after a break in services of 60 days or more; the higher rate will again be paid for the first 60 days of the new episode
Hospice Services Reimbursement: OAC 5160-56-06

- Hospice procedure codes based on level of care:
  - Code **T2043** used for one unit per hour, with a minimum of eight hours per day, for continuous home care
  - Code **T2044** used for one unit per day for inpatient respite care
  - Code **T2045** used for one unit per day for general inpatient care
  - **GT** modifier used when any component of service is delivered via telehealth, in addition to the appropriate procedure code
  - T2044 and T2045 are not eligible to be provided via telehealth
Hospice Services Reimbursement: OAC 5160-56-06

- Hospice may receive R&B payments for individuals who are residents, overnight, of nursing facilities or ICF-IID facilities
  - Bill for R&B using procedure code T2046
  - Reimbursed at 95% of the rate established for the Long-Term Care Facility (LTCF)
- Only for days the individual receives routine home care or continuous care
- Bill even if the days are compensated via patient liability
Hospice Services Reimbursement

- When a hospice member is residing in a nursing facility (NF) and discharges from hospice, the date of discharge is billable by the hospice provider.

- If a hospice member is residing in a NF and passes away, room and board on the date of death is not billable by the hospice provider.
  - Routine home care services are billable for the date of death.
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
How to Access the MITS Portal

- Go to https://Medicaid.ohio.gov
- Select the “Resources for Providers” tab at the top
- Click on “MITS”
- Scroll down and click “Access the MITS Portal” on the right
Once directed to this page, click the link to "Login"

You will 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 the next payment cycle

**MITS Portal**

**Free submission**

Claims must be received by Friday at 5:00 P.M. for the next payment cycle

We can help with your claim issues

We can help with your claim issues
Technical Questions / EDI Support Unit

Trading partners contact DXC for EDI Support

844-324-7089 or OhioMCD-EDI-Support@dxc.com
MITS Web Portal Claim Submission

Claim entry format is divided into sections or panels

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

Some fields are situational for claims adjudication and do not have an asterisk
Hospice Enrollment
Hospice Enrollment

You can view your Remittance Advices, your 835 transactions, by selecting Reports on the menu bar.

Welcome,

Provider ID: 05/05/2011-12/31/2299  NPI
Medicare
Zip Code: 45040

Hospice Enrollment
Hospice Enrollment

[Image of a webpage from the Ohio Department of Medicaid showing a search form for Hospice Enrollment with options for Hospice Tracking Number and Medicaid Billing Number, and an 'add' button.]
Hospice Enrollment

Welcome,


- eligibility search
- health homes
- deemed eligible newborn
- presumptively eligible child
- presumptively eligible pregnant woman
- psychiatric admission
- hospice enrollment

**Hospice - Application:**

*Type of Action:*
- Change of Hospice Provider
- New Enrollment

Hospice Provider Name
Hospice Provider ID
Medicaid Billing Number
Consumer Date of Birth
Consumer Name
County of Record
Submission Date 08/07/2017
Consumer name will populate once you enter a correct billing number and DOB.
Hospice Enrollment

<table>
<thead>
<tr>
<th>County and State of Recipient's Hospice Service Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Select row above to update -or- click Add button below.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enrollment - Disenrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Election Date</td>
</tr>
<tr>
<td>Date of Disenrollment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hospice Benefit Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>*** No rows found ***</td>
</tr>
<tr>
<td>Select row above to update -or- click Add button below.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hospice Episode of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>*** No rows found ***</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hospice Other Payer Spans</th>
</tr>
</thead>
<tbody>
<tr>
<td>*** No rows found ***</td>
</tr>
<tr>
<td>Select row above to update -or- click Add button below.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hospice Terminal Illness Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>*** No rows found ***</td>
</tr>
<tr>
<td>Select row above to update -or- click Add button below.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provider Service Span</th>
</tr>
</thead>
<tbody>
<tr>
<td>*** No rows found ***</td>
</tr>
<tr>
<td>Select row above to update -or- click Add button below.</td>
</tr>
</tbody>
</table>


Hospice Enrollment

- Must enter benefit periods in chronological order, start at the beginning with the 1st 90 day period

![Hospice Enrollment Form](image)
Hospice Enrollment

- Provider has the ability to search eligibility while completing the hospice enrollment

```
<table>
<thead>
<tr>
<th>Benefit Period Segment Indicator</th>
<th>Benefit Period Effective Date</th>
<th>Benefit Period End Date</th>
<th>Status</th>
<th>Reason for Updating Benefit Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>FIRST 90 DAY PERIOD</td>
<td>01/01/2016</td>
<td>03/30/2016</td>
<td>PROCESSED</td>
<td></td>
</tr>
<tr>
<td>SECOND 90 DAY PERIOD</td>
<td>03/31/2016</td>
<td>06/15/2016</td>
<td>INCOMPLETE</td>
<td></td>
</tr>
</tbody>
</table>
```

Enter the dates in question

<table>
<thead>
<tr>
<th>Benefit Period Segment Indicator</th>
<th>SECOND 90 DAY PERIOD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit Period Effective Date</td>
<td>03/31/2016</td>
</tr>
<tr>
<td>Benefit Period End Date</td>
<td>06/15/2016</td>
</tr>
</tbody>
</table>

CERTIFYING PHYSICIAN INFORMATION

- Hospice IDG Physician
- NPI: 1386628931
- Oral Certification Date: 03/30/2016
- Written Certification Date: 03/30/2016

Update Benefit Period

Reason For Updating Benefit Period

Benefit Plans

Search

<table>
<thead>
<tr>
<th>Effective Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>03/31/2016</td>
<td>06/15/2016</td>
</tr>
</tbody>
</table>

Search Results

- MCAID: 2014010122991231

[ Search ]
Hospice Enrollment

### Hospice Episode of Care

<table>
<thead>
<tr>
<th>Episode of Care</th>
<th>First Date</th>
<th>Last Date</th>
<th>Number of Calendar Days in Episode</th>
<th>Number of Benefit Days in Episode</th>
<th>Date of 61st Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Episode 1</td>
<td>07/18/2017</td>
<td>10/15/2017</td>
<td>90</td>
<td>90</td>
<td>09/16/2017</td>
</tr>
</tbody>
</table>

### Hospice Terminal Illness Diagnosis

<table>
<thead>
<tr>
<th>Benefit Period</th>
<th>Primary Hospice Terminal Diagnosis</th>
<th>Terminal Diagnosis 2</th>
<th>Terminal Diagnosis 3</th>
<th>ICD Version</th>
<th>Diagnosis Effective Date</th>
<th>Diagnosis End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>07/18/2017 - 10/15/2017</td>
<td>A010</td>
<td></td>
<td></td>
<td>10</td>
<td>07/18/2017</td>
<td>10/15/2017</td>
</tr>
</tbody>
</table>

**Type changes below.**

- Benefit Period: 07/18/2017 - 10/15/2017
- ICD Version: 10

**Primary Hospice Terminal Diagnosis**: A010

**Terminal Diagnosis 2**: [Search]

**Terminal Diagnosis 3**: [Search]

**Diagnosis Effective Date**: 07/18/2017

**Diagnosis End Date**: 10/15/2017

**Diagnosis Description**: TYPHOID FEVER
### Hospice Enrollment

#### Provider Service Span

<table>
<thead>
<tr>
<th>Hospice Provider</th>
<th>Effective Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>07/18/2017</td>
<td>10/15/2017</td>
</tr>
</tbody>
</table>

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

#### HLTCF Provider Service Span

*** No rows found ***

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

- After completing all fields, click ‘submit’ at the bottom
- Once processed, additional benefit periods may be entered

**Confirmation**

Your Hospice application has been updated on 07/16/2017

Your Hospice Tracking Number is ________

*IMPORTANT - This Hospice Tracking Number (HTN) is necessary for accessing the status of submitted enrollments. Please write this number down or print this page and keep it for your records PRIOR TO EXITING. Applications submitted after 4 PM will not be processed until the next business day.*

Please remember to submit the following required documents:

**WHAT'S NEXT?**

- To upload required document (or to obtain a cover page), select: Upload required documents
Hospice Enrollment

- HLTCF Provider Search Span panel
  - Hospice provider must enter the LTC provider and dates in the hospice enrollment so claims pay correctly
  - The claim will deny if this field is left blank
Hospice Enrollment

- Steps on adding an additional benefit period
  - Enter the tracking number and/or Medicaid billing number, click search
Hospice Enrollment

- Chose ‘Maintain Hospice Record’
Hospice Enrollment

Proceed to add a matching span in each appropriate panel

<table>
<thead>
<tr>
<th>County of Service</th>
<th>State of Service</th>
<th>Effective Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALLEN</td>
<td>OH</td>
<td>07/21/2017</td>
<td>10/18/2017</td>
</tr>
<tr>
<td>ALLEN</td>
<td>OH</td>
<td>01/17/2018</td>
<td>03/17/2018</td>
</tr>
<tr>
<td>ALLEN</td>
<td>OH</td>
<td>10/19/2017</td>
<td>01/16/2018</td>
</tr>
</tbody>
</table>

Type changes below.

![Dialog box for adding or deleting entries]

- [ ] delete
- [ ] add

- State of Service: [OH]
- County of Service: [ALLEN]
- Effective Date: [10/19/2017]
- *End Date: [01/16/2018]
Hospice Enrollment

- Previous benefit period must have a ‘PROCESSED’ status first
Hospice Enrollment

- Episode of Care will calculate and populate automatically

<table>
<thead>
<tr>
<th>Hospice Episode of Care</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Episode of Care</strong></td>
<td><strong>First Date</strong></td>
</tr>
<tr>
<td>Episode 1</td>
<td>07/21/2017</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hospice Other Payer Spans</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Payer Type</strong></td>
<td><strong>Payer Name</strong></td>
</tr>
<tr>
<td>Medicare</td>
<td>MEDICARE PART B</td>
</tr>
</tbody>
</table>

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

- Both dates must match the dates entered in the benefit period panel.

<table>
<thead>
<tr>
<th>Hospice Provider</th>
<th>Effective Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>01/17/2018</td>
<td>03/17/2018</td>
</tr>
<tr>
<td></td>
<td>10/19/2017</td>
<td>01/16/2018</td>
</tr>
<tr>
<td></td>
<td>07/21/2017</td>
<td>10/18/2017</td>
</tr>
</tbody>
</table>

Select row above to update -or- click Add button below.
Hospice Terminal Illness Diagnosis

<table>
<thead>
<tr>
<th>Benefit Period</th>
<th>Primary Hospice Terminal Diagnosis</th>
<th>Terminal Diagnosis 2</th>
<th>Terminal Diagnosis 3</th>
<th>ICD Version</th>
<th>Diagnosis Effective Date</th>
<th>Diagnosis End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>07/21/2017 - 10/18/2017</td>
<td>E11</td>
<td></td>
<td></td>
<td>10</td>
<td>07/21/2017</td>
<td>10/18/2017</td>
</tr>
<tr>
<td>01/17/2018 - 03/17/2018</td>
<td>E11</td>
<td></td>
<td></td>
<td>10</td>
<td>01/17/2018</td>
<td>03/17/2018</td>
</tr>
<tr>
<td>10/19/2017 - 01/16/2018</td>
<td>E11</td>
<td></td>
<td></td>
<td>10</td>
<td>10/19/2017</td>
<td>01/16/2018</td>
</tr>
</tbody>
</table>

Type changes below.

- Benefit Period: 01/17/2018 - 03/17/2018
- ICD Version: 10
- Primary Hospice Terminal Diagnosis: E11
- Diagnosis Description: TYPE 2 DIABETES MELLITUS
- Diagnosis Effective Date: 01/17/2018
- Diagnosis End Date: 03/17/2018
Hospice Enrollment

- Example of numerous episodes of care
  - Two gaps of more than 60 days between benefit periods
Hospice Enrollment

- Gap of 60 days or less and more than 60 days between benefit periods
Hospice Enrollment

- Updating a Hospice Enrollment
  - Use the ‘Update Benefit Period’ box when adding a new benefit period under the action of “New Enrollment” or “Maintain Hospice Record”
    - When it is known that the benefit period end date is less than what the system assigned
  - Open the enrollment record and check the ‘Update Benefit Period’ box
Hospice Enrollment

- Updating a Hospice Enrollment
  - Must provide a reason for why benefit period dates are being changed:
    - First 5 options would be used if criteria was met for termination
    - Data correction - should not be used at this time, for future use
    - Medicare alignment - May be used to have the Medicaid benefit period dates fit Medicare’s
Hospice Enrollment

- Ending a Hospice Enrollment
  - Choose the appropriate ‘Type of Action’
- Use when someone dies, revokes hospice, or a provider terminates hospice during a benefit period in ‘processed’ status
Hospice Enrollment

- Ending a Hospice Enrollment
  - You are now able to complete the ‘Enrollment - Disenrollment’ date of disenrollment and click ‘submit’
Hospice Enrollment Denial Letters

- You may leave all the search fields blank and then click ‘search’ to populate all denial letters
## Hospice Enrollment

### Hospice Enrollment Denial Letter Codes

<table>
<thead>
<tr>
<th>Error Code</th>
<th>Error Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2049</td>
<td>GeoStan Validate Address Error - contact SysArchitect</td>
</tr>
<tr>
<td>2067</td>
<td>LTC Vendor Pay end date must be on or before the Elig end date</td>
</tr>
<tr>
<td>2069</td>
<td>Invalid Lockin end date</td>
</tr>
<tr>
<td>2121</td>
<td>Source Code is not on file</td>
</tr>
<tr>
<td>2167</td>
<td>Invalid Other Recipient ID</td>
</tr>
<tr>
<td>2355</td>
<td>Begin Date must be a valid date</td>
</tr>
<tr>
<td>2356</td>
<td>End Date must be a valid date</td>
</tr>
<tr>
<td>2453</td>
<td>Recipient not a part of a valid Case/Cat/Seq</td>
</tr>
<tr>
<td>2999</td>
<td>System error encountered during PS/2 process, contact EDS</td>
</tr>
</tbody>
</table>
Hospice Enrollment

Hospice Enrollment Denial Letter Codes

<table>
<thead>
<tr>
<th>Error Code</th>
<th>Error Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>4068</td>
<td>Effective Date Received Begins Before The Plan is Active</td>
</tr>
<tr>
<td>4390</td>
<td>Medicaid Coverage Missing</td>
</tr>
<tr>
<td>4400</td>
<td>No medicaid coverage found</td>
</tr>
<tr>
<td>4901</td>
<td>Hospice not allowed with PACE</td>
</tr>
<tr>
<td>4902</td>
<td>Hospice Coverage already exists</td>
</tr>
<tr>
<td>4903</td>
<td>Hospice Not allowed with RSS AID Category</td>
</tr>
<tr>
<td>4904</td>
<td>Recipient enrolled in Managed Care</td>
</tr>
<tr>
<td>5015</td>
<td>Invalid HOSPC EligCase data</td>
</tr>
<tr>
<td>5016</td>
<td>Invalid HOSPC Lockin data</td>
</tr>
</tbody>
</table>
Hospice Enrollment

Hospice Enrollment Denial Letter Example

Subject: Notification of the Medicaid Hospice benefit enrollment errors

The following lists the application processing errors.

<table>
<thead>
<tr>
<th>Recipient ID</th>
<th>Horse tracking number</th>
<th>Submission Date</th>
<th>Recipient Name</th>
<th>Error Code</th>
<th>Error Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5807</td>
<td>07/25/2017</td>
<td></td>
<td>2069</td>
<td>Invalid Lockin end date</td>
</tr>
</tbody>
</table>

Please make the corrections needed to correct the application.
Claim Submission
Claim entry format is divided into sections or panels

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

Some fields are situational for claims adjudication and do not have an asterisk
Submission of a Professional Claim
Submission of a Professional Claim

You can view your Remittance Advices by clicking Reports on the menu bar.
Claim Submission

The ‘Patient Amount Paid’ field is used to report a consumer’s monthly patient liability amount.
Diagnosis Codes

- Are required on hospice claims
  - Must include the number of characters specified by ICD
  - MITS does not accept decimal points, only enter numbers & letters
  - System edits and audits will be applied to those codes
Entering Ordering Provider Information

<table>
<thead>
<tr>
<th>Medicaid Allowed Amount</th>
<th>$0.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rendering Provider</td>
<td></td>
</tr>
<tr>
<td>Submitted EAPG</td>
<td></td>
</tr>
<tr>
<td>Initial EAPG Status</td>
<td></td>
</tr>
<tr>
<td>Diagnosis Code Pointer</td>
<td></td>
</tr>
<tr>
<td>Modifiers</td>
<td>U2</td>
</tr>
<tr>
<td>Final EAPG</td>
<td></td>
</tr>
<tr>
<td>Pay Action</td>
<td></td>
</tr>
</tbody>
</table>

### 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</td>
<td>Ordering Provider</td>
<td>1234567890</td>
<td>SMITH</td>
<td>JOHN</td>
</tr>
</tbody>
</table>

Type data below for new record.
Click the “submit” button at the bottom right

You may “cancel” the claim at anytime, but the information will not be saved in MITS
Claim Portal Errors

MITS will not accept a claim without all required fields being populated

Portal errors return the claim with a “fix” needed

Portal errors will show up at the top of the page

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.
Claim Suspense

- Non room and board services (T2042-T2045) are paid the hospice rate that is applicable for the county that is listed on the enrollment panel effective 01/01/2016
- If the needed state/county code is not loaded into MITS claims will suspend for no rate
- Providers will need to contact ODM to have this information updated
Claim Submission

All claim submissions 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>21</td>
<td>170</td>
<td>357</td>
<td>321</td>
</tr>
</tbody>
</table>

2221170357321
Providers have 365 days to submit Fee For Service claims

During that 365 days they can attempt to submit the claim for payment (if receiving a denial) or adjust it as many times as they need to

An additional 180 days from the resubmit date is given for attempts to correctly submit a denied claim prior to the end of the 365 days

Claims over 2 years old will be denied

There are exceptions to the 365 day rule
Submitting a Claim Over 365 Days Old

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

Supporting Data for Delayed Submission / Resubmission

<table>
<thead>
<tr>
<th>Previously Denied ICN or TCN</th>
<th>Reason</th>
</tr>
</thead>
</table>

Disclaimer: Documentation to justify the use of this panel and data entered must be retained for future audit purposes.
Timely Filing Exceptions: OAC 5160-3-39.1

- 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
How to Bill After a 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”.
How to Bill After a 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

Note Reference Code
ADD - Additional Information
DECISION 20171225
Notes

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 to 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 less than 50 MB in size
- Each file must pass an anti-virus scan in MITS
- A maximum of 10 attachments may be uploaded
Paid Claims Can Be:

- Voided
- Adjusted
- Copied
Adjusting a Paid Claim

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

2221180234001 Originally paid $45.00
5821185127250 Now paid $50.00
Additional payment of $5.00

2021172234001 Originally paid $50.00
5021173127250 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”
Voiding a Paid Claim: Example

2221180234001
5821185127250

Originally paid $45.00
Account receivable ($45.00)

* Make sure to wait until after the 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
ClaimChek Edits

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

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

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

- Medically unlikely edit (MUE) determines whether the units of service exceed maximum units that a provider would be likely to report under most circumstances.
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>SMITH</td>
</tr>
</tbody>
</table>

*Claim Filing Indicator: HMO, MEDICARE RISK

*Policy Holder Relationship to Insured: FATHER

*Policy Holder Last Name: SMITH

*Policy Holder First Name, MI: JOHN

Policy Holder Date of Birth: 01/01/1950

Gender: MALE

*Paid Amount: $200.00

*Paid Date: 08/07/2021

Allowed Amount: $0.00

*Insurance Carrier Name: HUMANA MEDICARE

*Electronic Payer ID: 01234

*Insured’s Policy ID: 987654

*Payer Sequence Medicare ICN: PRIMARY

Select row above to update - or - click add an item button below.
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.
Adjustment Reason Codes (ARCs)

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
Third Party Liability (TPL) Claims

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

<table>
<thead>
<tr>
<th>Electronic Payer ID</th>
<th>CAS Group Code</th>
<th>ARC</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 01234</td>
<td>PR-Patient Responsibility</td>
<td>1</td>
<td>$50.00</td>
</tr>
<tr>
<td>A 01234</td>
<td>CO-Contractual Obligations</td>
<td>45</td>
<td>$150.00</td>
</tr>
</tbody>
</table>
Third Party Liability (TPL) Claims

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

- Ohio Department of Medicaid home page
  http://Medicaid.ohio.gov
- Ohio Department of Medicaid provider page
  https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers
- MALs & MTLs
  https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/policies-guidelines
- Ohio Administrative Codes
  http://codes.ohio.gov/oac/5160
Websites

- Provider Enrollment
  https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/enrollment-and-support/enrollment-and-support

- MITS home page
  https://www.ohmits.com/prosecure/authtam/handler?TAM_OP=login&URL=%2FPortal%2FDesktopModules%2FiC_Authenticate%2FSignIn.aspx%3FReturnUrl%3D%252fPortal%252f

- Electronic Funds Transfer
  https://obm.ohio.gov/wps/portal/gov/obm/areas-of-interest/ohio-suppliers/supplier-forms/
Websites

- Companion Guides (EDI)
  https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/billing/trading-partners/companion-guides/companion-guides

- Electronic Visit Verification (EVV)
  https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/special-programs-and-initiatives/electronic-visit-verification/electronic-visit-verification

- Healthchek
  https://medicaid.ohio.gov/wps/portal/gov/medicaid/families-and-individuals/srvcs/healthchek

- X12 Website (ARC Codes)
  https://x12.org/codes/claim-adjustment-reason-codes
Forms

ODM 06614 – Health Insurance Fact Request

ODM 06653 – Medical Claim Review Request
Forms

Stakeholders & Partners
Ohio Medicaid achieves its health care mission with the strong support and collaboration of our stakeholder partners - state health and human services agencies, associations, advocacy groups, and individuals who help us administer the program today and modernize it for the next generation of...

CMP Reinvestment Program
Civil money penalties (CMPs) are fines imposed on nursing facilities that do not meet federal health and safety standards.

Helpful Links
Not seeing what you are looking for? We want to help you find the information you need. Check out these links to federal and state.

Initiatives
The Ohio Department of Medicaid is dedicated to being a national leader in health care coverage innovation. In collaboration with our

Legal and Contracts
We want to make it easier for you to do business with us. This page includes important information and links for vendors and others

Medicaid Forms
Ohio Department of Medicaid Forms Library

For Medicaid Vendors
Provides information on invoices and computer use.

Request for Proposals
The Ohio Department of Medicaid is committed to using competitive procurement

Single Pharmacy Benefit Manager (SPBM) Request For Proposal
This page contains public responses to the Single Pharmacy Benefit Manager (SPBM)
Form Number | Order Form | Form Name
-------------|-----------|------------------
ODM 07716   | ORDER FORM| Application for Health Coverage & Help Paying Costs
ODM 03528   | ORDER FORM| Healthcheck & Pregnancy Related Services Information Sheet
ODM 10129   | ORDER FORM| Long-Term Services and Supports Questionnaire (LTSSQ) - Email Request
ODM 02399   | ORDER FORM| Request for Medicaid Home and Community Based Services (HCBS)

Search: [ ]

Entries per page: 25

Showing 1 to 2 of 2 entries (filtered from 199 total entries)