Basic Billing for Durable Medical Equipment Providers

Provider Relations

2021
AGENDA

- Medicaid Services
- Programs & Cards
- Managed Care/MyCare Ohio
- Provider Responsibilities
- Policy
- MITS & Claims
- Websites & Forms
Providers will be required to enter two out of the following three pieces of data: tax ID (or SS#), 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.

1-800-686-1516
If you call provider assistance you will be given your number in line upon entering the queue
Medicaid Services

• Helpful phone numbers
  
  » Adjustments
    ▪ LTCPaymentSection@medicaid.ohio.gov
  
  » OSHIP (Ohio Senior Health Insurance Information Program)
    ▪ 1-800-686-1578
  
  » Coordination of Benefits Section
    ▪ 614-752-5768
    ▪ 614-728-0757 (fax)
Programs & Cards
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

- This 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 request from a Medicaid provider for information which is needed in order to bill third party insurances
- Providers may contact the local CDJFS office to report non-cooperative individuals
- CDJFS may terminate eligibility
Ohio Medicaid

- This is the traditional fee-for-service Medicaid card
- Issued annually as of October 1, 2018
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
Eligibility Verification Request

You can search up to 4 years back

TIP: Always check eligibility prior to billing
Eligibility Verification Request

**Recipient Information**

<table>
<thead>
<tr>
<th>Medicaid Billing Number</th>
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<th>Gender</th>
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**Benefit / Assignment Plan**

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<th>End Date</th>
<th>Provider Name</th>
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<th>Vision Co-Pay Amount</th>
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Inpatient Hospital Services Plan (IHSP)

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<tr>
<td>SSN</td>
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<td>County of Residence</td>
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<td>County of Eligibility</td>
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<tr>
<td>County Office</td>
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<td>Number Bed Hold Days</td>
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Presumptive Eligibility

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- **Name**: [Last Name, First Name, Gender, Date of Birth, Date of Death]
- **Website**: [http://jfs.ohio.gov/county/cntydir.stm](http://jfs.ohio.gov/county/cntydir.stm)
- **Number of Bed Hold Days Used Paid CY**: [CNTRD]

### Benefit / Assignment Plan

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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.
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<td>Q1 1/Q1 2</td>
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Programs & Cards

• Presumptive Eligibility

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

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

  Covers children up to age 19 and pregnant women.
Presumptive Eligibility

Members will receive a Presumptive Eligibility letter if a state qualified entity determines presumptive 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:

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<tr>
<th>Name (First, M.I., Last Name)</th>
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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:

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<tr>
<th>Name</th>
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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
### MITS Managed Care Eligibility

<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>
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### Managed Care

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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.
### Benefit / Assignment Plan

<table>
<thead>
<tr>
<th>Benefit / Assignment Plan</th>
<th>Effective Date</th>
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### Lock-In

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# MITS Eligibility MyCare Opt-Out

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</tbody>
</table>

## Lock-In

*** No rows found ***

## Medicare

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Effective Date</th>
<th>End Date</th>
<th>Plan Name</th>
<th>Plan ID</th>
<th>Medicare ID</th>
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</thead>
<tbody>
<tr>
<td>PART A</td>
<td>10/30/2016</td>
<td>10/31/2019</td>
<td></td>
<td>9RG7AP3AF00</td>
<td></td>
</tr>
<tr>
<td>PART B</td>
<td>10/30/2016</td>
<td>10/31/2019</td>
<td></td>
<td>9RG7AP3AF00</td>
<td></td>
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<tr>
<td>PART C</td>
<td>08/01/2017</td>
<td>09/30/2021</td>
<td>AARP MEDICARERX PREFERRED (PDP)</td>
<td>013</td>
<td>9RG7AP3AF00</td>
</tr>
<tr>
<td>PART D</td>
<td>06/01/2018</td>
<td>09/30/2021</td>
<td>CVS CAREMARK VALUE (PDP)</td>
<td>028</td>
<td>9RG7AP3AF00</td>
</tr>
</tbody>
</table>
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.
Provider Responsibilities
Provider Agreement: OAC 5160-1-17.2

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

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

• Demographic Maintenance in MITS
Provider Responsibilities

• Demographic Maintenance in MITS, cont.
ORP Search
ORP Search

Ordering/Referring/Prescribing Search

Ordering Provider NPI: 1268168168
Ordering Provider Last Name: SMITH, JOHN D
*Date of Service: 01/11/2021

Search Results

Ordering Provider NPI: 1268168168
Ordering Provider Name: SMITH, JOHN D
A provider may NOT collect and/or bill for any difference between the Medicaid payment and the provider’s charge, or for the following:

- Fee for missed appointments
- 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?

1. Notified in writing prior to the service that Medicaid will not be billed.
2. Explain the service could be free by another provider.
3. Agrees to be liable for payment and signs statement.
4. Notified in writing prior to the service that Medicaid will not be billed.
5160-1-13.1 Medicaid recipient liability

Date of service: __________________
Type of service: __________________
Name & account number: __________________
Billing number: __________________

☐ (C) A provider may bill a Medicaid recipient for a Medicaid covered service in lieu of submitting a claim to the Ohio department of Medicaid (ODM) only if all of the following conditions are met:

1. The provider explains to the Medicaid recipient that the service is a covered Medicaid service and other Medicaid providers may render the service at no cost to the individual.

2. Prior to each date of service for the specific service rendered, the provider notifies the Medicaid recipient in writing that the provider will not submit a claim to ODM for the service.

3. The Medicaid recipient agrees to be liable for payment of the service and signs a written statement to that effect before service is rendered; and

4. The Medicaid covered service is not a prescription for a controlled substance as defined in section 3719.01 of the Revised Code.

☐ (D) Services that are not covered by the Medicaid program, including services requiring prior authorization that have been denied by ODM, may be billed to a Medicaid recipient when the condition in paragraphs (C)(2) through (C)(4) of this rule are met.

☐ (E) Any individual not covered by Medicaid on the date of service is financially responsible for those services unless the individual qualifies for the hospital care assurance program (HCAP) in accordance with section 5168.14 of the Ohio Revised Code.

Signature __________________________ Date ______________
Policy
Policy updates from Ohio Medicaid announce the changes to the Ohio Administrative Code that may affect providers.

- Medicaid Transmittal Letters (MTL)
- Medical Assistance Letter (MAL)
Policy

Resources for Providers

The relationship between Ohio Medicaid and its provider network is critical to ensuring the individuals we serve receive quality care when they need it. We are listening to your feedback and easing administrative burden to allow more time for you to spend with patients. After all, Ohio Medicaid is i...

- **Billing**
  - Provider billing and data exchange related instructions, policies, and resources.
- **MITS**
  - Medicaid Information Technology Information System (MITS) Resources
- **COVID-19**
  - Ohio Department of Medicaid COVID-19 Resources and Guides for Providers
- **Policies & Guidelines**
  - Ohio Medicaid policy is developed at the federal and state level. It guides how we operate our programs and how we regulate our programs.
- **Enrollment & Support**
  - Ohio Medicaid is changing the way we do business. We are streamlining provider enrollment and support services to make it easier for you to...
- **Managed Care**
  - The next generation of Ohio Medicaid managed care is designed to improve wellness and health outcomes, support providers in better...
- **Prior Authorization Requirements**
  - Prior Authorization Requirements
- **Medicaid Eligibility Procedure Letters (MEPLs)**
  - Announcements of non-OAC policy changes that affect Medicaid eligibility
- **Medicaid Eligibility Manual Transmittal Letters (MEMTLS)**
  - Summaries of OAC rule changes concerning Medicaid eligibility
- **Medicaid Transmittal Letters (MTLs), Medicaid Handbook**
  - Summaries of OAC rule changes concerning non-institutional services
- **Medicaid Advisory Letters (MALs)**
  - Clarifications of non-institutional services policy not related directly to OAC rule changes
- **Hospital Handbook Transmittal Letters (HHTLS)**
  - Summaries of OAC rule changes concerning hospital services
- **eManuals (Pre-July 2015)**
  - Archive of policy documents dating from a time when Medicaid was part of the Ohio
- **Managed Care Policy Guidance Letters**
  - Clarifications of policy pertaining to Medicaid managed care
Policy

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.

Initiatives

The Ohio Department of Medicaid is dedicated to being a national leader in health care coverage innovation. In collaboration with our partners, we want to make it easier for you to do business with us. This page includes important information and links for vendors and others.

Legal and Contracts

Ohio Revised Code

If you would like more information on the Ohio Department of Medicaid rule-making process, please contact Rules@medicaid.ohio.gov.

Rules in Effect

These are the rules that the Ohio Department of Medicaid has adopted and added to the Ohio Administrative Code.

- Medicaid Program Rules, Section 5166
- Medicaid Program Rules, Section 5166:1

In addition, you can view these rules from our on-line program manuals.

Draft Rules

These are rules that Ohio Medicaid staff are drafting and editing, but have not yet been formally proposed for adoption. As part of the public participation process, the Ohio Department of Medicaid solicits and encourages input from affected organizations and individuals.

Rules Statutes

- OAC - Ohio Administrative Code
- ORC - Ohio Revised Code
- CCR - Code of Federal Regulations
- Title 19 - Compilation Of The Social Security Laws
- OAC - Ohio Administrative Code

Rule Renumbering

- Rules Renumbering

Medicaid Regulatory Restriction Inventory

- Medicaid Regulatory Restriction Inventory

Rule Related Sites

- Common Sense Initiative Office
Policy

https://codes.ohio.gov
Policy

The DME rules are in Chapter 5160-10 of the OAC

Chapter 5160-10 | Medical Supplies, Durable Medical Equipment, Orthoses, and Prosthesis Providers
Ohio Administrative Code / 5160

Rule

Rule 5160-10-01 | Durable medical equipment, prostheses, orthoses, and supplies (DMEPOS): general provisions.

Rule 5160-10-02 | DMEPOS: repair.

Rule 5160-10-06 | DMEPOS: wearable cardioverter-defibrillators.

Rule 5160-10-07 | DMEPOS: bathing seats.

Rule 5160-10-08 | DMEPOS: high-frequency chest wall oscillation (HFCWO) devices.

Rule 5160-10-09 | DMEPOS: apnea monitors.

Rule 5160-10-11 | DMEPOS: hearing aids.
Billing Resources

Resources for Providers
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Provider billing and data exchange related instructions, policies, and resources.

COVID-19
Ohio Department of Medicaid COVID-19 Resources and Guides for Providers

Enrollment & Support
Ohio Medicaid is changing the way we do business. We are streamlining provider enrollment and support services to make it easier for you to

Policies & Guidelines
Ohio Medicaid policy is developed at the federal and state level. It guides how we operate our programs and how we regulate our

Managed Care
The next generation of Ohio Medicaid managed care is designed to improve wellness and health outcomes, support providers in better

MITS
Medicaid Information Technology Information System (MITS) Resources

Programs & Initiatives
The Ohio Department of Medicaid has many programs and initiatives to enhance the quality of care for patients and support our providers in the

PHARMACY CLAIMS:
- ODM Pharmacy Benefits

Need Technical Assistance?
Give us a call on our Provider Hotline 800-686-1516.
How to Find Modifiers Recognized by Ohio Medicaid

MODIFIERS:
- Modifiers recognized by ODM

DURABLE MEDICAL EQUIPMENT CLAIMS:
- Codes/Rates/Fee Schedules FAQs
  - How to read the RA (Remittance Advice)

Common Questions
- How long do I have to submit a claim?
- As a Provider, am I allowed to bill the patient for missed appointments?
- When is the Recipient liable?
- What is National Provider Identifier (NPI)?
MITS & Claims
MITS Provider Portal

Resources for Providers

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Common Questions
- I forgot my password or how do I reset my password?
- What is my PIN?
- How do I register for a MITS web portal account?

- What do I do if my password has expired?
- How do I change the email address on my account?

Access the MITS Portal
Medicaid Information Technology System

MITS Online Tutorials for Providers MITS Support Non Provider Communications MITS AidCode
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

• 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.
Detail Panel

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

- **Item**: 1
- ***From DOS**
- **To DOS**
- ***Units**: 0
- ***Charges**: $0.00
- **Medicaid Allowed Amount**: $0.00
- **Rendering Provider**
- **Submitted EAPG**
- **Initial EAPG**
- **Final EAPG**
- **Pay Action**
- **Place Of Service**
- **Procedure Code**
- **Modifiers**
- **Referred EPSDT Service/Family Planning**
- **Diagnosis Code**
- **Modifiers**
- **Emergency**
Entering Ordering Provider Information

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

- **Place Of Service**: [Search]
- **Procedure Code**: [Search]
- **Emergency**: ✓
- **Referred EPSDT Service/Family Planning**: [Search]
- **Diagnosis Code/Pointers**: ✓ ✓ ✓ ✓ ✓
- **Modifiers**: [Search] [Search] [Search] [Search]
- **Final EAPG**: [Search]
- **Pay Action**: [Search] [Search] [Search] [Search]

**Detail**

<table>
<thead>
<tr>
<th>Item</th>
<th>FDOS</th>
<th>Units</th>
<th>Charges</th>
<th>Medicaid Allowed Amount</th>
<th>Status</th>
<th>Place of Service</th>
<th>Procedure Code</th>
<th>Modifier 1</th>
<th>Modifier 2</th>
<th>Modifier 3</th>
<th>Modifier 4</th>
<th>Final EAPG</th>
</tr>
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<td></td>
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</tr>
</tbody>
</table>

**Additional Provider Information**

- **NDC**
- **Detail - Other Payer**
- **ClaimCheck**
Entering Ordering Provider Information, cont.

<table>
<thead>
<tr>
<th>Medicaid Allowed Amount</th>
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</thead>
<tbody>
<tr>
<td>Rendering Provider</td>
<td></td>
</tr>
<tr>
<td>Submitted EAPG</td>
<td></td>
</tr>
<tr>
<td>Initial EAPG</td>
<td></td>
</tr>
<tr>
<td>Status</td>
<td></td>
</tr>
<tr>
<td>Visit Start Time</td>
<td></td>
</tr>
<tr>
<td>Visit End Time</td>
<td></td>
</tr>
<tr>
<td>Service Duration</td>
<td></td>
</tr>
<tr>
<td>less than 90 days</td>
<td></td>
</tr>
<tr>
<td>Diagnosis Code Pointer</td>
<td></td>
</tr>
<tr>
<td>Modifiers</td>
<td></td>
</tr>
<tr>
<td>Final EAPG</td>
<td></td>
</tr>
<tr>
<td>Pay Action</td>
<td></td>
</tr>
</tbody>
</table>

Additional Provider Information

*** No rows found ***

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

[Image of a user interface form with various input fields and buttons for entering provider information]
Entering Ordering Provider Information, cont.

Medicaid Allowed Amount: $0.00
Rendering Provider:
Submitted EAPG:
Initial EAPG:
Status:
Visit Start Time:
Visit End Time:
Service Duration less than 90 days:

Diagnosis Code Pointer:
Modifiers:
[Search]
[Search]
Final EAPG:
Pay Action:

Additional Provider Information:
Detail Item | Type of Provider | Provider # | Last Name | First Name, MI
--- | --- | --- | --- | ---
A | 0 |  |  |  

Type data below for new record.

*Detail Item
*Type of Provider
*Provider #
*Last Name
*First Name, MI

[delete] [add an item]
Entering Ordering Provider Information, cont.

Submitted EAPG
Initial EAPG
Status
Visit Start Time
Visit End Time
Service Duration
less than 90 days

Final EAPG
Pay Action

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>0</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Type data below for new record.

*Detail Item 1
*Type of Provider Ordering Provider
*Provider # 1234567890
*Last Name SMITH
*First Name, MI JOHN
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
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

2021170357321

<table>
<thead>
<tr>
<th>20</th>
<th>21</th>
<th>170</th>
<th>357</th>
<th>321</th>
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<tr>
<td>Region Code</td>
<td>Calendar Year</td>
<td>Julian Date</td>
<td>Claim Type/Batch Number</td>
<td>Number of Claim in Batch</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

- Adjudication happens in “real time”
  - If there are no errors, the claim status will show:
    - Paid
    - Denied
    - Suspended
Claim Portal Errors

Supporting Data for Delayed Submission / Resubmission

DISCLAIMER: Documentation to justify the use of this panel and data entry.

Previously Denied ICN or TCN: [ ] Reason: [ ]

Claim Status Information

Claim Status: Not Submitted yet
Claim Portal Errors, cont.

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

Scroll to the top of the claim

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.
Claim Portal Errors, cont.

<table>
<thead>
<tr>
<th>Item</th>
<th>From DOS</th>
<th>To DOS</th>
<th>Units</th>
<th>Charges</th>
<th>Medicaid Allowed Amount</th>
<th>Rendering Provider</th>
<th>Submitted EAPG</th>
<th>Initial EAPG</th>
<th>Status</th>
<th>Visit Start Time</th>
<th>Service Duration less than 90 days</th>
<th>Pay Action</th>
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<tbody>
<tr>
<td>2</td>
<td>01/11/2021</td>
<td>01/11/2021</td>
<td>0</td>
<td>$0.00</td>
<td>$0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Adjusting a Paid Claim

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

#### Claim Status Information
- **Claim Status**: PAID
- **Claim IDN**: 2221305000002
- **Paid Date**: [Date]
- **Paid Amount**: $0.32

#### EOB Information
<table>
<thead>
<tr>
<th>Detail Number</th>
<th>Error Code</th>
<th>EOB Code</th>
<th>EOB Description</th>
<th>CARC</th>
<th>CARC Amount</th>
<th>CARC Description</th>
<th>RARC</th>
<th>RARC Description</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>9910</td>
<td>9910</td>
<td>PRICING ADJUSTMENT - MAX FEE PRICING APPLIED</td>
<td>45</td>
<td>$4.68</td>
<td>Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability)</td>
<td>M16</td>
<td>Alert: Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision.</td>
</tr>
</tbody>
</table>
### Claim Status Information

<table>
<thead>
<tr>
<th>Claim Status</th>
<th>PAID</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim ICN</td>
<td>5821305000001</td>
</tr>
<tr>
<td>Paid Date</td>
<td></td>
</tr>
<tr>
<td>Paid Amount</td>
<td>$3.20</td>
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### EOB Information

<table>
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<tr>
<th>Detail Number</th>
<th>Error Code</th>
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<th>CARC</th>
<th>CARC Amount</th>
<th>CARC Description</th>
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<td>PRICING ADJUSTMENT - MAX FEE PRICING APPLIED</td>
<td>45</td>
<td>$1.00</td>
<td>Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability)</td>
</tr>
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</table>

### Adjustment Information

<table>
<thead>
<tr>
<th>ICN</th>
<th>Date Adjusted</th>
</tr>
</thead>
<tbody>
<tr>
<td>58213050000001</td>
<td>01/11/2021</td>
</tr>
<tr>
<td>22213050000002</td>
<td>01/11/2021</td>
</tr>
</tbody>
</table>
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”
### Claim Status Information

**Claim Status:** PAID  
**Claim ICN:** 5821305000001  
**Paid Date:**  
**Paid Amount:** $3.20

### EOB Information

<table>
<thead>
<tr>
<th>Detail Number</th>
<th>Error Code</th>
<th>Error Description</th>
<th>CARC</th>
<th>CARC Description</th>
<th>RARC</th>
<th>RARC Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>9918</td>
<td>PRICING ADJUSTMENT - MAX FEE PRICING APPLIED</td>
<td>45</td>
<td>$1.00</td>
<td>M16</td>
<td>Alert: Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision. Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount, and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability)</td>
</tr>
</tbody>
</table>

### Adjustment Information

<table>
<thead>
<tr>
<th>ICN</th>
<th>Date Adjusted</th>
</tr>
</thead>
<tbody>
<tr>
<td>5821305000001</td>
<td>01/11/2021</td>
</tr>
<tr>
<td>2221305000002</td>
<td>01/11/2021</td>
</tr>
</tbody>
</table>
Example, cont.

### Claim Status Information
- **Claim Status**: DENIED
- **Claim ICN**: 582130500002
- **Denied Date**:  
- **Paid Amount**: $0.00

### EOB Information

<table>
<thead>
<tr>
<th>Detail</th>
<th>Error Code</th>
<th>EOB Description</th>
<th>CARC</th>
<th>CARC Description</th>
<th>RARC</th>
<th>RARC Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0566</td>
<td>ELECTRONIC ADJUSTMENT/VOID SET TO DENY</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The related or qualifying claim/service was not identified on this claim. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2000 Service Payment Information REF), if present.

### Adjustment Information

<table>
<thead>
<tr>
<th>ICN</th>
<th>Date Adjusted</th>
</tr>
</thead>
<tbody>
<tr>
<td>582130500002</td>
<td>01/11/2021</td>
</tr>
<tr>
<td>582130500001</td>
<td>01/11/2021</td>
</tr>
<tr>
<td>222130500002</td>
<td>01/11/2021</td>
</tr>
</tbody>
</table>
Example, cont.
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
Providers have 365 days to submit FFS claims

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

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

Claims over 2 years old will be denied.

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

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

<table>
<thead>
<tr>
<th>Supporting Data for Delayed Submission / Resubmission</th>
</tr>
</thead>
<tbody>
<tr>
<td>DISCLAIRMER: Documentation to justify the use of this panel and data entered must be retained for future audit purposes.</td>
</tr>
<tr>
<td>Previously Denied ICN or TCN</td>
</tr>
</tbody>
</table>
Special Billing Instructions – Eligibility Delay

- If you are submitting a claim that is more than 365 days after the date of service due to a hearing decision or delay in the individual’s eligibility determination

- The claim must be submitted within 180 days of the hearing decision or eligibility determination date
Special Billing Instructions – Eligibility Delay

- In the Notes box you will need to enter the hearing decision or eligibility determination information.

- In the Note Reference Code dropdown menu select “ADD”.
Special Billing Instructions – Eligibility Delay

➤ Hearing Decision: APPEALS ####### CCYYMMDD
    ####### is the hearing number and CCYYMMDD is the date on the hearing decision

➤ Eligibility Determination: DECISION CCYYMMDD
    CCYYMMDD is the date on the eligibility determination notice from the CDJFS

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

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

The National Correct Coding Initiative (NCCI)
Third Party Liability (TPL) Claims

Other payer information can be reported at the claim level (header) or at the line level (detail), depending on the other payer’s claim adjudication.

HIPAA compliant adjustment reason codes and amounts are required to be on the claim.

MITS will automatically calculate the allowed amount.
Third Party Liability (TPL) Claims

Other payer information is entered in the Header – Other Payer panel

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
<th>Date of Birth</th>
<th>Relationship</th>
<th>Gender</th>
<th>Policy ID</th>
<th>Paid Amount</th>
<th>Paid Date</th>
<th>Electronic Payer ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>JONES</td>
<td>DAVID</td>
<td>A</td>
<td>01/01/1950</td>
<td>FATHER</td>
<td>MALE</td>
<td></td>
<td>$200.00</td>
<td>01/20/2021</td>
<td>01234</td>
</tr>
</tbody>
</table>

*Claim Filing Indicator*  
*Policy Holder Relationship to Insured*  
*Policy Holder Last Name*  
*Policy Holder First Name, MI*  
*Policy Holder Date of Birth*  
*Gender*  
*Paid Amount*  
*Paid Date*  
*Electronic Payer ID*  
*Insurance Carrier Name*  
*Insured's Policy ID*  
*Payer Sequence*  
*Medicare ICN*
If the TPL is a Medicare HMO, select “HMO, Medicare Risk” in the Claim Filing Indicator drop down menu.
A COB claim is considered to be adjudicated at the header/claim level if only one set of figures is reported for the entire claim.

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

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

ARCs for a detail pay TPL are entered in the Detail – Other Payer Amounts and Adjustment Reason Codes panel.
The X12 website provides adjustment reason codes (ARCs)

- Deductible
- Coinsurance
- Co-payment
- Contractual Obligation/Write off
- Non-covered services
Remittance Advice (RA)

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

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

- **Paid, denied, and adjusted claims**
- **Financial transactions**
  - Expenditures - Non-claim payments
  - Accounts receivable - Balance of claim and non-claim amounts due to Medicaid
- **Summary**
  - Current, month, and year to date information
Remittance Advice (RA)

Information pages
Banner messages to the provider community

EOB code explanations
Provides a comparison of codes to the description

TPL claim denial information
Provides other insurance information for any TPL claim denials
Prior Authorization (PA)

- All prior authorizations must be submitted via the MITS Portal
- PAs will not enter the queue for review until at least one attachment has been received
  - Medical notes should be uploaded
- Each panel will have an asterisk (*) denoting fields that are required
  - Some fields are situational and do not have an asterisk
- The “real time” status of a PA can be obtained in MITS
Prior Authorization (PA)

Within the Prior Authorization subsystem providers can:

• Submit a new Prior Authorization
• Search for previously submitted Prior Authorizations

Within the Prior Authorization panel providers can:

• Attach documentation
• Add comments to a Prior Authorization that is in a pending status
• View reviewer comments
• View Prior Authorization usage, including units and dollars used
Prior Authorization (PA)

- A PA will auto deny if supporting documentation is not received within 30 days (including EDMS coversheet and paper attachments)

- When reviewers request additional documentation to support the requested PA, the 30 day clock is reset
Prior Authorization (PA)

- **External Notes Panel**
  - Used by the PA reviewer to communicate to the provider
  - Multiple notes may reside on this panel
  - Panel is read-only for providers

- If a PA is marked approved with an authorized dollar amount of $0.00, it will still pay at the Medicaid maximum allowable reimbursement rate
Websites & 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/
• MITS home page
  https://www.ohmits.com/prosecure/authtam/handler?TAM_OP=login&URL=%2FPortal%2FDesktopModules%2FiC_Authenticate%2FSignIn.aspx%3FReturnUrl%3D%252fPortal%252f
• Ohio Laws & Administrative Rules
  http://codes.ohio.gov
Websites

• Electronic Data Interchange (EDI)
  » Information for Trading Partners
  https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/billing/trading-partners/trading-partners
  
  » Companion Guides
  https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/billing/trading-partners/companion-guides/companion-guides
  
  » Technical Questions/EDI Support Unit
    ▪ Transitioned partners contact DXC EDI Support
      ❖ 844-324-7089
      ❖ OhioMCD-EDI-Support@dxc.com
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)
### Medicaid Forms

**Ohio Department of Medicaid Forms Library**

#### Order Forms/Email Requests

<table>
<thead>
<tr>
<th>Form Number</th>
<th>Order Form</th>
<th>Form Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>ODM 07216</td>
<td>[ORDER FORM]</td>
<td>Application for Health Coverage &amp; Help Paying Costs</td>
</tr>
<tr>
<td>ODM 03528</td>
<td>[ORDER FORM]</td>
<td>Healthcheck &amp; Pregnancy Related Services Information Sheet</td>
</tr>
<tr>
<td>ODM 10129</td>
<td>[ORDER FORM]</td>
<td>Long-Term Services and Supports Questionnaire (LTSSQ) - Email Request</td>
</tr>
<tr>
<td>ODM 02399</td>
<td>[ORDER FORM]</td>
<td>Request for Medicaid Home and Community Based Services (HCBS)</td>
</tr>
</tbody>
</table>

**Search:**

- **Search:** ODM
- **Show:** 25 entries

**File Name**

- ODM 06653: English - Medical Claim Review Request
- ODM 06653: English - Medical Claim Review Request - Instructions

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