Basic Billing for Dental Providers

Provider Relations
2021
AGENDA

- Medicaid Services
- Programs & Cards
- Managed Care/MyCare Ohio
- Provider Responsibilities
- Policy
- MITS & Claims
- Websites & Forms
Must enter two of the following: tax ID, NPI, or 7 digit Ohio Medicaid provider number.

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

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

IVR:
1-800-686-1516
Helpful phone numbers

- Adjustments
  614-466-5080

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

- Coordination of Benefits Section
  614-752-5768
  614-728-0757 (fax)
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
Covered Services (not limited to)

- Acupuncture
- Behavioral Health
- Dental
- Dialysis
- Dietitian
- Durable Medical Equipment
- Home Health
- Private Duty Nursing
- Hospice
- Hospital (Inpatient/Outpatient)
- ICF-IID Facility
- Nursing Facility
- Pharmacy
- Physician
- Transportation
- Vision
Programs & Cards
Ohio Medicaid

- This card is the traditional fee-for-service Medicaid card
- No longer issued monthly
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

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 here for you!

Billing
- Provider billing and data exchange related instructions, policies, and resources.

COVID-19
- Ohio Department of Medicaid COVID-19 Resources and Guidelines

MITS
- Medicaid Information Technology Information System (MITS) Resources

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

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

TLF Carrier List
- Click download to obtain the full listing of Third Party Carrier list and numbers

Direct Deposit
- OBM Shared Services is a business processing center that processes common administrative

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
- Remote Access, MITS 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

## Recipient Information

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## Benefit / Assignment Plan

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Inpatient Hospital Services Plan (IHSP)

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**Presumptive Eligibility**

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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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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</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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Managed Care & MyCare Ohio
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

## Benefit / Assignment Plan

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## Case/Cat/Seq Spenddown

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## TPL

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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>
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### Lock-In

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# MITS Eligibility MyCare Opt-Out

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<td>$0.00</td>
<td>$0.00</td>
</tr>
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</table>

## Case/Cat/Seq Spenddown

***No rows found***

## TPL

***No rows found***

## Managed Care

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Plan Description</th>
<th>Effective Date</th>
<th>End Date</th>
<th>Managed Care Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>MOLINA HEALTHCARE OF OHIO INC</td>
<td>HMO, MyCare Ohio</td>
<td>07/01/2018</td>
<td>09/30/2021</td>
<td>Medicaid Only</td>
</tr>
</tbody>
</table>

## Lock-In

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## Medicare

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Effective Date</th>
<th>End Date</th>
<th>Plan Name</th>
<th>Plan ID</th>
<th>Medicare ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>PART A</td>
<td>10/30/2016</td>
<td>10/31/2019</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PART B</td>
<td>10/30/2016</td>
<td>10/31/2019</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PART C</td>
<td>08/01/2017</td>
<td>09/30/2021</td>
<td>AARP MEDICAREX 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

## Resources for Providers

<table>
<thead>
<tr>
<th>Billing</th>
<th>COVID-19</th>
<th>Enrollment &amp; Support</th>
<th>Managed Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider billing and data exchange related instructions, policies, and resources.</td>
<td>Ohio Department of Medicaid COVID-19 Resources and Guides for Providers</td>
<td>Ohio Medicaid is changing the way we do business. We are streamlining provider enrollment and support services to make it easier for you to</td>
<td>The next generation of Ohio Medicaid managed care is designed to improve wellness and health outcomes, support providers in better</td>
</tr>
<tr>
<td>MITs</td>
<td>Policies &amp; Guidelines</td>
<td>Programs &amp; Initiatives</td>
<td></td>
</tr>
<tr>
<td>Medicaid Information Technology Information System (MITS) Resources</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## 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
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
- Abide by the regulations and policies of the state
- Recoup any third party resources available

Provider Agreement: OAC 5160-1-17.2
Provider Responsibilities

- Demographic Maintenance in MITS
Provider Responsibilities

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

Warning:

The Provider Search records in ORP are not intended to be used for verification of a provider’s credentials. They are intended primarily for the providers to use in verifying the accuracy of the information from Medicare and Medicaid. This information should not be used to verify the accuracy of any other information (such as the license status of a provider). This information is not to be used to verify the accuracy of any information (such as the license status of a provider).
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?

- Notified in writing prior to the service that Medicaid will not be billed
- Agrees to be liable for payment and signs statement
- Explain the service could be free by another provider
- 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 conditions 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 services unless the individual qualifies for the hospital care assurance program (HCAP) in accord 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)
Billing Resources

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.

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

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

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 & 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 800-666-1516.
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)?
Co-Payments and Exclusions: OAC 5160-1-09

There is a co-payment requirement for dental services
  • This may apply to individuals enrolled in managed care

Co-Payment exclusions:
  • Under age 21
  • Pregnant or in the post partum period
  • Nursing facility and ICF-IID residents
  • Individuals receiving emergency services
  • Individuals receiving hospice care
  • Individuals received Medicaid under the breast and cervical cancer option
Ohio Medicaid Dental Program - Resources

OAC 5160-5-01 - Dental services
sets forth Medicaid coverage and payment policies for dental services. It includes one appendix that lays out coverage of dental services by category.

http://codes.ohio.gov/oac/5160-5

Appendix DD of 5160-1-60 Medicaid payment
The list of CDT procedure codes, maximum fees and effective dates of coverage is contained here and is posted on the Fees Schedules and Rates page of the Ohio Medicaid web site.

http://medicaid.ohio.gov/providers/FeeScheduleAndRates.aspx
Ohio Medicaid Dental Program - Changes

Changes effective January 1, 2021:

• Two new frenectomy procedure codes, D7961 buccal/labial and D7962 lingual, replaced a single non-specific procedure code (D7960) which was deleted by ADA. The maximum fee for D7961 and D7962 is $119.13.

• A new procedure code for counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use (D1321) is covered. The maximum fee for D1321 is $15.00. The coverage limit is two times per 365 days without prior authorization.
Ohio Medicaid Dental Program – Changes, cont.

• New procedure code for prefabricated porcelain - ceramic crown – permanent tooth (D2928) is covered. This allows coverage of these crowns for both anterior and posterior permanent teeth equivalent to stainless steel crowns and at the same fees. The maximum fee for D2928 “prefab porcelain/ceramic crown - posterior permanent tooth” is $101.92. The maximum fee for D2928 “prefab porcelain/ceramic crown - anterior permanent tooth” is $153.00.

• Coverage of new COVID-19 testing procedure (D0604, D0605) is added. These test fall under the Clinical Laboratory Improvements Act (CLIA) and require a Certificate of Waiver from CMS prior to administering the tests. The maximum fee for D0604 is $35.92. The maximum fee for D0605 is $45.23.
Ohio Medicaid Dental Program – Changes, cont.

- A dated reference has been updated and reference to OAC 5160-1-18 “Telehealth” has been added in the rule body of OAC 5160-5-01 “Dental services.” Dental residents have also been delineated as rendering providers.

- Annual procedure code maintenance - Procedure code terminology is updated based on Code on Dental Procedures and Nomenclature (CDT) changes for 2021. The descriptors for a number of services have been revised in Appendix A of OAC 5160-5-01.

- HB 11 required ODM to cover two dental cleanings per year for pregnant women and several special groups such as foster children and employed individuals with disabilities regardless of their age. Coverage of two exams for these individuals ages 21 and older are covered in conjunction with two cleanings per year.
Ohio Medicaid Dental Program – Changes, cont.

• ChCoverage of **dental sealants** has been updated to 1 per 5 years per first and second molar per provider per patient (D1351).

• Coverage of **cone beam CT with view of both jaws** (D0367) has been added. The maximum fee for D0367 is $106.32.

• Coverage of **interim therapeutic restorations** (ITR) for primary and permanent teeth (D2940, D2941) has been added. D2940 “protective restoration” is covered for primary and permanent teeth with a limit of 1 per 180 days per tooth and a lifetime limit of 5 per tooth. D2941 “interim therapeutic restoration - primary dentition” is covered for primary teeth with a limit of 1 per 180 days per tooth and a lifetime limit of 5 per tooth. The maximum fee for D2940 and D2941 is $18.00.

• Coverage of **alveoloplasty in conjunction with extractions** – one to three teeth (D7311) has been added. The maximum fee for D7311 is $49.53
Ohio Medicaid Dental Program – Changes, cont.

- Coverage of **recementation of crowns** (D2920) has been added. The maximum fee for D2920 is $45.00.

- Coverage of **unspecified orthodontic procedure** (D8999) has been added. The fee for D8999 is determined during prior authorization review.

- Certain dental services will be covered through **teledentistry** coverage of which is specified in OAC 5160-1-18 “Telehealth.” D9995 **teledentistry-synchronous; real-time encounter** is to be reported in addition to other procedures (e.g. diagnostic) delivered to the patient through teledentistry on the date of service. Teledentistry services are to be provided in accordance with Chapter 4715. of the Revised Code and Chapter 4715-23 of the Administrative Code.
Ohio Medicaid Dental Program – Changes, cont.

Dentists are authorized to administer COVID-19 vaccines as of March 16, 2021. The following CDT codes for vaccine administration should be used when billing these services on a dental claim:

- D1701 Pfizer BioNTech Covid-19 Vaccine Administration - first dose ADM SARS-CoV2 30MCG/0.3ML
- D1702 Pfizer BioNTech Covid-19 Vaccine Administration - scnd dose ADM SARS-CoV2 30MG/0.3ML
- D1703 Moderna Covid-19 Vaccine Administration - first dose ADM SARS-CoV2 100MCG/0.5ML
- D1704 Moderna Covid-19 Vaccine Administration - scnd dose ADM SARS-CoV2 100MCG/0.5ML
- D1707 Janssen Covid-19 Vaccine Administration - single dose ADM SARS-CoV2 VAC AD26 .5ML

Maximum vaccine fees are $37.98
MITS & Claims
Medicaid Information Technology System (MITS)

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

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

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

Internet Access (high speed works best)

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

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

Turn **OFF** pop up blocker functionality
MITS

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

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

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

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

MITS access will time-out after 15 minutes of system inactivity
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 to be in the next payment cycle

MITS Portal

Free submission

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

Easier for us to help you with your claim submission issues!
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.
Submission of a Dental Claim

<table>
<thead>
<tr>
<th>Dental Claim:</th>
<th>NPI -</th>
</tr>
</thead>
<tbody>
<tr>
<td>BILLING INFORMATION</td>
<td>SERVICE INFORMATION</td>
</tr>
<tr>
<td>ICN</td>
<td>*Release of Information</td>
</tr>
<tr>
<td>Claim Received Date</td>
<td>NO</td>
</tr>
<tr>
<td>Provider ID</td>
<td>From Date</td>
</tr>
<tr>
<td>Medicaid Billing Number</td>
<td>To Date</td>
</tr>
<tr>
<td>*Date of Birth</td>
<td>Emergency</td>
</tr>
<tr>
<td>Last Name</td>
<td>Accident Related To</td>
</tr>
<tr>
<td>First Name, MI</td>
<td>Accident State</td>
</tr>
<tr>
<td>*Patient Account #</td>
<td>Accident Date</td>
</tr>
<tr>
<td>Referring Provider #</td>
<td>EPSDT</td>
</tr>
<tr>
<td>Rendering ID</td>
<td>Prior Authorization #</td>
</tr>
<tr>
<td>Patient Amount Paid</td>
<td>TOTAL CHARGES</td>
</tr>
<tr>
<td>$0.00</td>
<td></td>
</tr>
</tbody>
</table>

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Charges</td>
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<td></td>
</tr>
<tr>
<td>Medicaid Allowed Amount</td>
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</tr>
<tr>
<td>TPL Paid Amount</td>
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<td></td>
</tr>
<tr>
<td>Total Medicaid Paid Amount</td>
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<td></td>
</tr>
<tr>
<td>Medicaid CoPay Amount</td>
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</tbody>
</table>

**_header - Other Payer**

***No rows found***

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

<table>
<thead>
<tr>
<th>Item</th>
<th>DOS</th>
<th>Procedure Code</th>
<th>Units</th>
<th>Tooth Number</th>
<th>Quadrant</th>
<th>Charges</th>
<th>Status</th>
<th>Medicaid Allowed Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>1</td>
<td></td>
<td>0</td>
<td>$0.00</td>
<td></td>
<td>$0.00</td>
<td></td>
<td>$0.00</td>
</tr>
</tbody>
</table>

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

#### Surfaces (Detail Item 1)

***No rows found***

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

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

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

Portal errors return the claim with a “fix” needed

Claim shows a ‘NOT SUBMITTED YET’ status still

The following messages were generated:

- From DOS is required.
- Procedure is required.
- A valid Place Of Service is required
- A valid Procedure Code is required
- Units must be greater than 0.
- Charges must be greater than $0.00.
- A valid Medicaid Billing Number is required
- A valid Medicaid Billing Number and Date of Birth combination is required.
## Claim Example

![Dental Claim Form](image)

### BILLING INFORMATION
- **ICN**
- **Claim Received Date**
- **Provider ID**
- **NPI**
- **Medicaid Billing Number**
- **Date of Birth**
- **Last Name**
- **First Name, MI**
- **Patient Account #**
- **Referring Provider #**
- **Rendering ID**
- **Patient Amount Paid**: $0.00

### SERVICE INFORMATION
- **Release of Information**
  - From Date: [Dropdown]
  - To Date: [Dropdown]
- **Emergency**
  - [Dropdown]
- **Accident Related To**
  - [Dropdown]
- **Accident State**
  - [Dropdown]
- **Accident Country**
  - [Dropdown]
- **Accident Date**
  - [Dropdown]
- **EPSDT**
  - [Dropdown]
- **Place of Service**
  - [Dropdown]
- **Prior Authorization #**
  - [Dropdown]

### TOTAL CHARGES
- **Total Charges**: $750.00
- **Medicaid Allowed Amount**: $0.00
- **TPL Paid Amount**: $0.00
- **Total Medicaid Paid Amount**: $285.45
- **Medicaid CoPay Amount**: $3.00

### Notes
Claim Example, cont.

### Header - Other Payer

*** No rows found ***

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

### Header - Other Payer Amounts and Adjustment Reason Codes

### Detail

<table>
<thead>
<tr>
<th>Item</th>
<th>DOS</th>
<th>Procedure Code</th>
<th>Units</th>
<th>Tooth Number</th>
<th>Quadrant</th>
<th>Charges</th>
<th>Status</th>
<th>Medicaid Allowed Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>05/11/2021</td>
<td>D7140</td>
<td>1.00</td>
<td>09</td>
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<td>$150.00</td>
<td>PAID</td>
<td>$57.69</td>
</tr>
<tr>
<td>4</td>
<td>05/11/2021</td>
<td>D7140</td>
<td>1.00</td>
<td>08</td>
<td></td>
<td>$150.00</td>
<td>PAID</td>
<td>$57.69</td>
</tr>
<tr>
<td>3</td>
<td>05/11/2021</td>
<td>D7140</td>
<td>1.00</td>
<td>05</td>
<td></td>
<td>$150.00</td>
<td>PAID</td>
<td>$57.69</td>
</tr>
<tr>
<td>2</td>
<td>05/11/2021</td>
<td>D7140</td>
<td>1.00</td>
<td>04</td>
<td></td>
<td>$150.00</td>
<td>PAID</td>
<td>$57.69</td>
</tr>
<tr>
<td>1</td>
<td>05/11/2021</td>
<td>D7140</td>
<td>1.00</td>
<td>03</td>
<td></td>
<td>$150.00</td>
<td>PAID</td>
<td>$57.69</td>
</tr>
</tbody>
</table>

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

### Detail - Other Payer

<table>
<thead>
<tr>
<th>Item</th>
<th>Procedure Code</th>
<th>DOS</th>
<th>Units</th>
<th>Tooth Number</th>
<th>Charges</th>
<th>Medicaid Allowed Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>D7140</td>
<td>05/11/2021</td>
<td>1.00</td>
<td>09</td>
<td>$150.00</td>
<td>$57.69</td>
</tr>
</tbody>
</table>

Rendering Provider: 456123789
Status: PAID
Claim Example, cont.

**Surfaces (Detail Item 5)**

*** No rows found ***

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

[delete]  [add an item]

**Attachments**

*** No rows found ***

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

[delete]  [add an item]

**Supporting Data for Delayed Submission / Resubmission**

DISCLAIMER: Documentation to justify the use of this panel and data entered must be retained for future audit purposes.

Previously Denied ICN or TCN

**Claim Status Information**

Claim Status  PAID
Claim ICN     2221131008506
Paid Date     05/24/2021
Paid Amount   $285.45
### Claim Example, cont.

#### EOB Information

<table>
<thead>
<tr>
<th>Detail Number</th>
<th>Error Disposition</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>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td>9001</td>
<td>REIMBURSEMENT REDUCED BY THE MEMBERS CO-PAYMENT AMOUNT</td>
<td>3</td>
<td>$3.00</td>
<td>Co-payment Amount</td>
<td>M16</td>
<td>Alert: Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision.</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>9918</td>
<td>PRICING ADJUSTMENT - MAX FEE PRICING APPLIED</td>
<td>45</td>
<td>$92.31</td>
<td></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>

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)
All claims are assigned an ICN

<table>
<thead>
<tr>
<th>Region Code</th>
<th>Calendar Year</th>
<th>Julian Day</th>
<th>Claim Type/Batch Number</th>
<th>Claim Number in Batch</th>
</tr>
</thead>
<tbody>
<tr>
<td>22</td>
<td>21</td>
<td>170</td>
<td>357</td>
<td>321</td>
</tr>
</tbody>
</table>
Providers have 365 days to submit FFS claims

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

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

Claims over 2 years old will be denied

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

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

**Supporting Data for Delayed Submission / Resubmission**

*DISCLAIMER: Documentation to justify the use of this panel and data entered must be retained for future audit purposes.*

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

#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.
Uploading an Attachment

This panel allows you to electronically upload an attachment onto your claim in MITS.
Electronic attachments are accepted for Claims, Prior Authorization, and Enrollment Processing.

Acceptable file formats:
- BMP, DOC, DOCX, GIF, JPG, PDF, PPT, PPTX, TIFF, TXT, XLS, and XLSX

Each attachment must be <50 MB in size.
Each file must pass an anti-virus scan in MITS.
A maximum of 10 attachments may be uploaded.
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
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.

<table>
<thead>
<tr>
<th>Item</th>
<th>FDOS</th>
<th>Units</th>
<th>Charges</th>
<th>Medicaid Allowed Amount</th>
<th>Status</th>
<th>Place of Service</th>
<th>Procedure Code</th>
<th>Modifier 1</th>
<th>Modifier 2</th>
<th>Modifier 3</th>
<th>Modifier 4</th>
<th>Final EAPG</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>01/11/2021</td>
<td>1.00</td>
<td>$5.00</td>
<td>$0.00</td>
<td>12</td>
<td>A4452</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

- Place Of Service: 12
- Procedure Code: A4452
- Units: 10
- Charges: $50.00
- Medicaid Allowed Amount: $0.00
- Rendering Provider: 1234567890
- Submitted EAPG:
- Initial EAPG:
- Status:
- Visit Start Time:
- Visit End Time:
- Service Duration less than 90 days

Select appropriate options for "Referred EPSDT Service/Family Planning Diagnosis Code Pointer" and "Modifiers".
## Claim Status Information

<table>
<thead>
<tr>
<th>Claim Status</th>
<th>PAID</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim IGN</td>
<td>2221305000002</td>
</tr>
<tr>
<td>Paid Date</td>
<td></td>
</tr>
<tr>
<td>Paid Amount</td>
<td>$0.32</td>
</tr>
</tbody>
</table>

## EOB Information

<table>
<thead>
<tr>
<th>Detail Number</th>
<th>Error Code</th>
<th>EOB Description</th>
<th>CARC</th>
<th>CARC Amount</th>
<th>CARC Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>9918</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>
</tr>
</tbody>
</table>

### Actions
- [cancel]
- [adjust]
- [void]
- [copy claim]
**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>
</tr>
</tbody>
</table>

**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>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>9918</td>
<td></td>
<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>
<td>M16</td>
<td>Alert: Please see our website, mailings, or bulletins for more details concerning this policy/procedure/decision.</td>
</tr>
</tbody>
</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>EOB Code</th>
<th>EOB Description</th>
<th>CARC</th>
<th>CARC Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>9918</td>
<td>PRICING ADJUSTMENT - MAX FEE PRICING APPLIED</td>
<td>45</td>
<td>CARC</td>
<td>$1.00</td>
<td>Alert: Please see our website, mailings, or bulletins for more details concerning this policy/procedure/decision.</td>
</tr>
</tbody>
</table>

### Adjustment Information
- **ICN**
  - 5821305000001
  - 2221305000002
- **Date Adjusted**
  - 01/11/2021
  - 01/11/2021
**Claim Status Information**

- **Claim Status**: DENIED
- **Claim TCN**: 5821305000002
- **Denied Date**: 
- **Paid Amount**: $0.00

**EOB Information**

<table>
<thead>
<tr>
<th>Detail Number</th>
<th>Error Code</th>
<th>EOB Description</th>
<th>CARC Amount</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 02000 Service Payment Information REF), if present.

**Adjustment Information**

<table>
<thead>
<tr>
<th>Claim TCN</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.

| Item | DOS | Units | Charges | Medicaid Allowed Amount | Status | Place of Service | Procedure Code | Modifier 1 | Modifier 2 | Modifier 3 | Modifier 4 | Final EAPG |
|------|-----|-------|---------|--------------------------|--------|------------------|---------------|-------------|------------|------------|------------|------------|-------------|
| 1    | 01/11/2021 | 10.00 | $5.00   | $0.00                   | DENIED | 12               | 44452         |             |            |            |            |             |

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

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

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

(Additional information and buttons: NDC, ClaimCheck, Additional Provider Information)
Copying a Paid Claim

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

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

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

- Developed by the Centers for Medicare & Medicaid Services
  - To control inappropriate payment of claims from improper reporting of CPT and HCPCS codes
  - NCCI serves as a common model and standard for handling claims for procedures and services that are performed by one provider for one individual on a single date of service
Procedure to procedure (PTP) “Incidental” edit which determines whether a pair of procedure codes should not be reported together because one procedure is incidental to (performed as a natural consequence or adjunct to) the other.

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

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

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

MITS will automatically calculate the allowed amount.
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>$200.00</td>
<td>01/20/2021</td>
<td>01234</td>
<td></td>
</tr>
</tbody>
</table>

Select row above to update - or - click add an item button below.
Claims with Other Payers, cont.

If the Other Payer is a Medicare HMO, select “HMO, Medicare Risk” in the Claim Filing Indicator drop down menu.
Claims with Other Payers, cont.

The X12 website provides adjustment reason codes (ARC)

**COMMON ARCs:**

1. **Deductible**
2. **Coinsurance**
3. **Co-payment**
45. **Contractual Obligation/Write off**
96. **Non-covered services**
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.

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

Select row above to update -or- click add an item button below.
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
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
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
  https://Medicaid.ohio.gov

➢ MALs & MTLs
  https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/policies-guidelines

➢ Ohio Administrative Codes
  http://codes.ohio.gov/oac/5160

➢ MITS home page
  https://portal.ohmits.com/Public/Providers/tabId/43/Default.aspx
Websites

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

➢ Electronic Funds Transfer
http://www.ohiosharedservices.ohio.gov/

➢ Information for Trading Partners (EDI)
https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/billing/trading-partners/trading-partners

➢ X12 Website (ARC Codes)
https://x12.org/codes/claim-adjustment-reason-codes
➢ ODM 06614 – Health Insurance Fact Request

➢ ODM 06653 – Medical Claim Review Request

## 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:** [Input Field]

### Show Entries

- **Show:** [Dropdown] 25 entries