Basic Billing for Federally Qualified Health Centers (FQHCs) & Rural Health Clinics (RHCs)

Provider Relations
December 2021
Programs & Cards
Managed Care & MyCare Ohio
Provider Responsibilities
Policy
MITS & Claim Submissions
Websites & Forms
Helpful phone numbers

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

Coordination of Benefits Section
614-752-5768
614-728-0757 (fax)
Providers will be required to enter two out of the following three pieces of data: tax ID (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.
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**
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
- NEMSIS Training: 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

Take note of the effective and end dates of coverage, the results will depend on the dates used in your search.

### Recipient Information

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<tr>
<th>Medicaid Billing Number</th>
<th>Last Name</th>
<th>First Name</th>
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### Benefit / Assignment Plan

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<th>Provider Name</th>
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### Associated Child(ren)

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Eligibility Verification Request

You can check to see if the individual has Managed Care and/or Medicare coverage

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**Managed Care**

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**Medicare**

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**Service Limitation**  
*** No rows found ***
Eligibility Verification Request

By clicking on the managed care plan description, a pop-up box will display their provider ID.
Inpatient Hospital Services Plan (IHSP)

If you see the IHSP benefit plan only services from an inpatient hospital stay will be covered
Presumptive Eligibility

Covers children up to age 19 and pregnant women

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

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

Ohio's statewide Presumptive Eligibility (PE) initiative provides uninsured residents with the opportunity to receive immediate health care services through Medicaid if they are presumed to be eligible.

Hospitals and FQHCs are eligible to participate in Ohio’s presumptive eligibility initiative.

To become a Qualified Entity complete the steps described here:

https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/billing/presumptive-eligibility-training/presumptive-eligibility-training

*See later slides in the policy section for additional QE information
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:

<table>
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<tr>
<th>Name (First, M.I., Last Name)</th>
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Presumptive Eligibility

Members should share this letter with their pharmacy if filling a prescription on the day it is issued.

NOTE TO MEDICAID PROVIDERS:

Non-pharmacy Medicaid Providers- You must verify eligibility in the MITS system.

Pharmacy Medicaid Providers- This letter is proof of Medicaid eligibility on the date this form is issued. After date of issuance, you must verify eligibility in the Pharmacy system.

Call this number if you are having difficulty processing a pharmacy claim: 1-877-518-1545 (24 hours a day, 7 days a week). Pharmacy staff should use the following billing information: BIN: 015863 PCN: OHPGP Group: not needed.

Qualified Entity Name: REGENCY HOSP OF COLUMBUS LLC
PE Determination Site: PO BOX 644219 PITTSBURGH, PA 15264
Qualified Entity Staff Name: DYAGENT DYAGENT
Contact Number: (222)333-1234

Signature of Qualified Entity Designee : _____________________________ Date: ___________
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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Presumptive Eligibility

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<td>First Name</td>
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<td>Gender</td>
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<td>Date of Birth</td>
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<td>Date of Death</td>
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<th>Effective Date</th>
<th>End Date</th>
<th>Provider Name</th>
<th>Dental Co-Pay Amount</th>
<th>Vision Co-Pay Amount</th>
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<td>and Drug Addiction</td>
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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.
Qualified Medicare Beneficiary (QMB)

Issued to qualified consumers who receive Medicare

Reimbursement policy is set under 5160-1 and can result in a payment of zero dollars

Medicaid only covers their monthly Medicare premium, co-insurance and/or deductible after Medicare has paid
Can I Bill Them?

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

**Billing individuals enrolled in the QMB program is Prohibited by Federal Law**

Federal law bars Medicare providers and suppliers from billing an individual enrolled in the QMB program for Medicare Part A and Part B cost sharing for covered items and services (see Sections 1902(n)(3)(B), 1902(n)(3)(C), 1905(p)(3), 1866(a)(1)(A), and 1848(g)(3)(A) of the Social Security Act [the Act]). The QMB system updates are part of CMS’ ongoing efforts to help providers comply with QMB billing prohibitions.
Qualified Medicare Beneficiary will show up in the benefit/assignment plan panel.
Specified Low-Income Medicare Beneficiary (SLMB) & Qualifying Individual (QI-1)

There is NO cost-sharing eligibility

We ONLY pay their Part B premium to Medicare

This is NOT Medicaid eligibility
SLMB and QI 1/QI 2

This is what will appear in the benefit/assignment plan panel if the individual has SLMB or QI 1/QI/2

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<th>Benefit / Assignment Plan</th>
<th>Effective Date</th>
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Oversight of Managed Care Organizations (MCOs)

- Managed Care Plans sign a Provider Agreement
- OAC 5160-26: Managed Care Plan
- OAC 5160-58: MyCare Ohio
- Each MCO has a Contract Administrator at the Ohio Department of Medicaid
Traditional Managed Care Organizations

- Buckeye Health Plan: 866-296-8731 [https://www.buckeyehealthplan.com](https://www.buckeyehealthplan.com)
- CareSource: 800-488-0134 [https://www.CareSource.com](https://www.CareSource.com)
- Paramount Health Care: 800-891-2542 [https://www.paramounthealthcare.com](https://www.paramounthealthcare.com)
- UnitedHealthcare: 800-600-9007 [https://www.uhccommunityplan.com](https://www.uhccommunityplan.com)
MITS Managed Care Eligibility

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

<table>
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<th>Effective Date</th>
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**Case/Cat/Seq Spenddown**

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**TPL**

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**Managed Care**

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<th>Plan Description</th>
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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.
MyCare Ohio Eligibility

In order to be eligible for MyCare Ohio an individual must be:

- Eligible for all parts of Medicare (Parts A, B, and D) and be fully eligible for Medicaid
- Over the age of 18
- Residing in one of the demonstration project regions
Groups that are *NOT* eligible for enrollment in MyCare Ohio:

- Individuals with an ICF-IID level-of-care served in an ICF-IID waiver
- Individuals enrolled in the PACE program
- Individuals who have third-party insurance, including retirement benefits
MITS Managed Care Eligibility

If an individual’s Medicaid and Medicare benefits are covered by the MCO, you will see **dual benefits**

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

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**TPL**

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**Managed Care**

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**Lock-In**

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**Medicare**

<table>
<thead>
<tr>
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<th>Plan Name</th>
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<tr>
<td>PART A</td>
<td>10/24/2018</td>
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<td>PART B</td>
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MITS Managed Care Eligibility

If the MCO covers **only** the individual’s Medicaid benefits, you will see Medicaid Only

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<th>Benefit / Assignment Plan</th>
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<tr>
<td>Plan Name</td>
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<tr>
<td>--------------</td>
</tr>
<tr>
<td>MOLINA HEALTHCARE OF OHIO INC</td>
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<td>Plan Name</td>
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<tr>
<td>-------------</td>
</tr>
<tr>
<td>PART A</td>
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<tr>
<td>PART B</td>
</tr>
<tr>
<td>PART C</td>
</tr>
<tr>
<td>PART D</td>
</tr>
</tbody>
</table>
MyCare Ohio Managed Care Organizations

- Buckeye Health Plan: 866-296-8731 [https://www.buckeyehealthplan.com](https://www.buckeyehealthplan.com)
- CareSource: 800-488-0134 [https://www.CareSource.com/MyCare](https://www.CareSource.com/MyCare)
Third-Party Duties; Medicaid Managed Care Organizations

Ohio Revised Code 5160.40:

- The department, or Medicaid managed care organization, has right of recovery under section 5160.37
- The claim must be submitted not later than six years after the date of service
- The third party must respond to the department’s request for payment not later than 90 business days after the receipt of written proof of claim
Recoupment of Overpayment

Ohio Revised Code 5160.77:

- Effective **10/17/2019**
- When a managed care organization seeks to recoup an overpayment made to a provider, it shall provide all of the details of the recoupment including the following:
  - Name, address, and Medicaid identification number of the individual
  - Date(s) that the services were provided
  - Reason for the recoupment
  - Method by which the provider may contest the proposed recoupment
Managed Care vs Fee-for-Service (FFS)

Some ways the MCOs are allowed to differ from FFS:

- Whether an item or service requires Prior Authorization
- What modifiers should be used with a specific code
- What fee will be paid to providers **
- How long a provider has to submit their claims timely **

** Check your agreement with each MCO for specifics
Managed Care vs FFS

Some ways the MCOs are *not* allowed to differ from FFS:

- The MCOs should not request the use of improper place of service codes
- The MCOs cannot refuse to cover an item/service that FFS covers (a different code may be used, but the service itself cannot be denied if ODM covers it)
PROVIDER COMPLAINTS

Provider licensure issues
Please send to Ohio Department of Insurance (ODI)

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

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

## Instructions
This form is for Managed Care providers only. Providers must challenge the decision of all denied claims and prior authorizations with the Managed Care Organization (MCO) using the appropriate processes (appeal, dispute, etc.) before the Ohio Department of Medicaid will process a complaint. If your complaint involves multiple MCOs, please complete one form per MCO. The resolution time frame for Managed Care complaints is 15 business days. If you have a complaint regarding Medicaid Fee For Service please call 1-800-686-1516.

## Complaint Details

<table>
<thead>
<tr>
<th>Field</th>
<th>Validation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCO Name:</td>
<td>*</td>
<td>Enter the name of the Managed Care Organization (MCO)</td>
</tr>
<tr>
<td>Complaint Reason:</td>
<td>*</td>
<td>Enter the reason for the complaint</td>
</tr>
</tbody>
</table>

* Is this complaint related to the MyCare Program?  
- Yes  
- No

* Is this complaint related to any previously submitted complaints?  
- Yes  
- No

* Is this complaint related to children with special health care needs?  
- Yes  
- No

Please summarize your complaint in the text box below: **required**
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:

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

Select the Providers tab and Demographic Maintenance to ensure your information is up to date
Demographic Maintenance in MITS

Based on your provider agreement you have a requirement to update your demographics within 30 days of changes.
Demographic Maintenance in MITS

Under the Providers tab you will find an option to add group members.
**Demographic Maintenance in MITS**

Be sure to add all of your group members to ensure claims that list them as the rendering process correctly.

<table>
<thead>
<tr>
<th>Group Member ID</th>
<th>Group Member NPI</th>
<th>Group Member Name</th>
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<th>Revalidation Date</th>
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<td>0395560</td>
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</tbody>
</table>

Select row above to update or click Add button below.
An ORP search can be performed in the MITS secure portal to ensure you have the correct information for the ORP provider to include on your claim.
ORP Search in MITS

Searching just using a name may pull up several results

Welcome,

Trade Files Admin
demographic maintenance 1099 information provider faq mits days report correspondence self attestation hospital cost report
ordering/referring/prescribing search group affiliation group members cpc group cpc group members cpc accreditations cpc attestations

Ordering/Referring/Prescribing Search
Ordering Provider NPI
Ordering Provider Last Name SMITH
First, MI JOHN
*Date of Service 10/01/2019

Search Results

Ordering Provider NPI Ordering Provider Name
1268168168 SMITH, JOHN Q
1034134734 SMITH, JOHN A
1422722122 SMITH, JOHN M
1206260106 SMITH, JOHN R
1237137537 SMITH, JOHN S
1446646046 SMITH, JOHN B
1019019719 SMITH, JOHN F
1245745245 SMITH, JOHN P

1 2 3 4 5 6 7 8 9 10 ... Next >
ORP Search in MITS

We recommend using the NPI to get the most accurate results for your search.
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
- Explain the service could be free by another provider
- Agrees to be liable for payment and signs statement
- Notified in writing prior to the service that Medicaid will not be billed
The statement must be signed before the service is rendered. If the service requires multiple visits, this must be done prior to each visit.

This cannot be done if the service is a prescription for a controlled substance.
Welcome to the Ohio Department of Medicaid. Our mission is providing quality, accessible, person-centric health care programs and services to Ohio families and individuals. Today more than three million Ohioans rely on Medicaid for their health care benefits. Our provider network supports nearly 200,000 professionals – each committed to helping our communities stay healthy. With that kind of responsibility, we know it’s important to make information easy to find and easy to understand. So, come on in and take a look around.
Provider News

Resources for Providers

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...

Welcome Providers

Access the MITS Portal

Enrollment & Support

Maximus Cybersecurity Incident

The American Rescue Plan Act (ARPA) gives states new funding to invest in home- and community-based services. And, we want your ideas!

Do Not Send Paper Claims
Do not send hard copy/paper claims.
Policy
Ohio Medicaid announces changes to the Ohio Administrative Code and guidance/clarification that may affect providers via letters. There are two types of letters:

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

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

Prior Authorization Requirements
Medicaid Eligibility Procedure Letters (MEPLs)
Medicaid Eligibility Manual Transmittal Letters (MEMTLs)
Medicaid Transmittal Letters (MTLs), Medicaid Handbook
Medicaid Advisory Letters (MALs)
Hospital Handbook Transmittal Letters (HHTLs)
eManuals (Pre-July 2015)
Managed Care Policy Guidance Letters

Clarifications of non-institutional services policy not related directly to OAC rule changes
Announcements of non-OAC policy changes that affect Medicaid eligibility
Summaries of OAC rule changes concerning Medicaid eligibility
Summaries of OAC rule changes concerning non-institutional services
Summaries of OAC rule changes concerning hospital services
Archive of policy documents dating from a time when Medicaid was part of the Ohio
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

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

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

- OBC - Ohio Revised Code
- CFR - 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

Ohio's Official Online Publication of State Laws and Regulations

Ohio law consists of the Ohio Constitution, the Ohio Revised Code and the Ohio Administrative Code. The Constitution is the state's highest law superseding all others. The Revised Code is the codified law of the state while the Administrative Code is a compilation of administrative rules adopted by state agencies. Use the tools on this site to search or browse them all.

Ohio Constitution | Browse

Ohio Revised Code | Browse

Ohio Administrative Code | Browse
How to Find Modifiers Recognized by Ohio Medicaid

MODIFIERS:
- Modifiers recognized by ODM

DURABLE MEDICAL EQUIPMENT CLAIMS:
- Codes/Rates/Fee Schedules FAQ's
- 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)?
Modifiers Recognized by Ohio Medicaid

Modifers Recognized by Ohio Medicaid

Modifiers are two-character codes used along with a service or supply procedure code to provide additional information about the service or supply rendered. Care must be taken when reporting modifiers with procedure codes because using a modifier inappropriately can result in the denial of payment or an incorrect payment for a service or supply. The Ohio Department of Medicaid (ODM) accepts many, but not all, modifiers recognized by the American Medical Association (AMA), the Centers for Medicare and Medicaid Services (CMS), and the American Society of Anesthesiologists (ASA).

ODM also recognizes Medicaid state-specific HCPCS modifiers beginning with the letter U. These state-specific "U-modifiers" can be tailored to an individual state's Medicaid policy when no other modifier adequately represents the policy purpose. The state determines how each U modifier is to be used and the same U-modifier can take on different meanings when it is used with different service or supply
Prospective Payment System (PPS)

ODM complies with provisions set forth in Section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA)

Requires states to establish a PPS for FQHCs and RHCs

A separate all-inclusive per-visit payment amount (PVPA) is established for each FQHC or RHC service provided at a FQHC or RHC service site

PVPAs are specific to an FQHC or RHC service site

No FQHC or RHC service site may submit claims based on the PVPAs of another service site
MAL No. 621 Prohibition of Commingling in FQHCs and RHCs

- This applies to RHC and FQHC practitioners who are dually enrolled as another provider type (PT) – PT 50 or PT 84/95

- ODM follows Medicare’s policy on the prohibition of commingling by FQHC and RHC providers as set forth in Chapter 13 of the “Medicare Benefit Policy Manual”

- Commingling refers to the sharing of FQHC or RHC space, staff (employed or contracted), supplies, equipment, and/or other resources with another onsite provider operated by the same FQHC or RHC
Commingling is prohibited in order to prevent:

1. duplicate Medicaid payment; or
2. selectively choosing a higher or lower payment amount for services

FQHC and RHC providers may only submit claims for non-FQHC and RHC services if the service cannot be claimed as an FQHC or RHC service.

FQHC and RHC practitioners may not render or separately submit claims for FQHC or RHC-covered services as another type of provider in the FQHC or RHC, or in an area outside of the certified FQHC or RHC space such as a treatment room adjacent to the FQHC or RHC, during FQHC or RHC hours of operations.
MAL No. 621 Prohibition of Commingling in FQHCs and RHCs

- FQHCs and RHCs that share resources (waiting rooms, telephones, receptionists) with another entity must maintain accurate records to assure that all costs claimed for Medicaid payment are only for the FQHC or RHC staff, space, or other resources.
  
  - Any shared staff, space, or other resources must be allocated appropriately between FQHC or RHC and non-RHC or non-FQHC usage to avoid duplicate payment.
MAL No. 622 Requirements to Report Individual Practitioners’ NPIs in the Rendering Fields on Claims

- FQHCs and RHCs must report on their claim individual practitioners’ National Provider Identifiers (NPIs) in the rendering provider field.

- For Electronic Data Interchange (EDI) submissions, the individual rendering providers’ NPIs will be reported in the 2310B Rendering Provider loop.

- Claims will be rejected if they do not include the individual practitioner’s NPI.
MAL No. 622-A Requirement to Report Individual Practitioners’ NPIs in the Rendering Fields on Claims

**Update** to MAL No. 622:

- Services rendered by mid-level health care workers (e.g., registered nurses) and unlicensed dependent practitioners (i.e., behavioral health trainees) should continue to be reported under the overseeing practitioner’s NPI

- Transportation, DME, laboratory, and radiology should continue to be reported under the organizational NPI
Group therapy services do not meet the criteria for a face-to-face encounter in a FQHC or RHC

FQHCs and RHCs may submit claims for group therapy using their ambulatory health care clinic (AHCC – provider type 50) number
MAL No. 627 Transportation Services

- FQHCs are allowed up to 4 transports on the same date of service for the same individual
  
  **Example:**
  1. Trip to one FQHC for medical service
  2. Trip to another FQHC for mental health service
  3. Trip back to first FQHC for pick-up of medications
  4. Trip home

- T1015 U9 with up to 4 units and T2003 with up to 4 units

- Tentatively effective **4/1/2021** RHCs will also be paid for transportation services under the PPS
MAL No. 628 Payment for Long-Acting Reversible Contraception (LARC)

- In addition to submitting a claim for a medical visit for a LARC insertion procedure, separate payment may be made for a LARC device or implant
  - Claim may be submitted using the AHCC (PT 50) number
MAL No. 632 Payment for Hepatitis A Vaccine Provided Through Non-Participating VFC Providers

- ODM developed an avenue to provide a Hepatitis A vaccination to high risk or exposed individuals as quickly as possible
- Enables providers to be reimbursed for both the administration and the vaccine toxoid component
- Effective 5/1/2019, non-participating VFC providers can also be reimbursed for administration code (CPT 90471) and the Hepatitis A vaccines (CPT codes 90633 and 90634)
- The SK modifier must be reported with the appropriate vaccine code
Separate payment will be made for Medication-Assisted Treatment (MAT) and take-home medications furnished at a FQHC or RHC.

In order to be paid for office-based opioid treatment, practitioners must:

- Submit the Drug Addiction Treatment Act of 2000 (DATA 2000) waiver documentation through the MITS provider portal, and
- Obtain a MITS provider specialty 704
MAL No. 634 Payment for MAT and Take-Home Medications

- FQHC or RHC may be paid for evaluation & management (E&M) service associated with the MAT and the administered pharmaceutical(s)
  - J0571 – J0575, J8499

- In addition, a separate claim for the dispensing of the medication may be submitted under the AHCC (PT 50) number
  - T1502 – Dispensing of the medication
  - S5000, S5000 HD, S5001 – Take home medication
MAL No. 635 Payment for FQHC and RHC Services Rendered Through Telehealth

- FQHCs and RHCs must follow the claims submission guidance in “Telehealth Billing Guidance for Dates of Service On or After 11/15/2020”

- Covered telehealth services and provider requirements can be found in OAC 5160-1-18 Telehealth, Appendix A

- Payment (including wraparound payment) for covered FQHC and RHC services listed in OAC rules 5160-28-03.1 and 5160-28-3.3 is made under the prospective payment system (PPS)
Telehealth: OAC 5160-1-18

- Patient location is flexible and is reported through a modifier for certain settings
- No Distance Requirement between patient and practitioner site
- Practitioner location is flexible and is reported through a modifier for certain settings
- No originating site or patient site fee can be billed
Telehealth: OAC 5160-1-18

Expanded Practitioner type to include:

- Physician Assistant
- Clinical Nurse Specialist
- Certified Nurse Midwife
- Certified Nurse Practitioner
- Podiatrist
- Licensed Independent Behavioral Health Providers (LISW, LICDC, LIMFT, LPCC) and supervised practitioners
- Skilled therapists: OT, PT, SLP, Aud
- Dentist
- Optometrist
- Dietitian
- Pharmacists
Telehealth: OAC 5160-1-18

Practitioner Locations include:

- No restriction on practitioners
- If patient is not *active* or practice is not a CPC practice, practitioner location must be office

If receiving telehealth services for 12 consecutive months, at least one in person exam or assessment of the patient is required

- This could be provided by the telehealth provider, the patient’s usual source of care, or the telehealth provider could refer the patient to another practitioner
Telehealth Billing Guidelines

- As set forth in rule 5160-1-18, for a covered telehealth service that is also an FQHC or RHC service, the face-to-face requirement is waived and payment is made in accordance with Chapter 5160-28 of the Administrative Code.

- Medical nutrition therapy and lactation services rendered by eligible FQHC and RHC practitioners will be paid under the PPS.
  - When these services are rendered by a practitioner not listed in Chapter 5160-28 of the Administrative Code, these services shall be paid through FFS under the clinic provider type 50.
Telehealth Billing Guidelines

- Remote patient monitoring will be paid through FFS as a covered non-FQHC/RHC service under the clinic provider type 50.

- Group therapy will continue to be paid through FFS as a covered non-FQHC/RHC service under the clinic provider type 50.

- Services under the Specialized Recovery Services (SRS) program are not currently covered FQHC or RHC services.
Telehealth Billing Guidelines

When the FQHC or RHC is billing as the practitioner site:

- The T1015 encounter code must be reported in the first detail line of the claim with the appropriate U modifier indicating the type of visit.
- The next detail line reported on the claim must be the service (procedure code) provided via telehealth.
- Modifier GT must be reported with the procedure code in addition to any other required modifiers.
  - If there is more than one modifier, the GT modifier should be reported first.
- The place of service code reported on the claim must reflect the physical location of the practitioner.
MAL No. 645 Payment for Laboratory Services

Seven laboratory tests and services for which payment is made under the PPS:

<table>
<thead>
<tr>
<th>Service</th>
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</thead>
<tbody>
<tr>
<td>Venipuncture</td>
</tr>
<tr>
<td>Chemical examination of urine by stick or tablet method or both</td>
</tr>
<tr>
<td>Hematocrit or hemoglobin analysis</td>
</tr>
<tr>
<td>Blood sugar analysis</td>
</tr>
<tr>
<td>Examination of stool specimens for occult blood</td>
</tr>
<tr>
<td>Pregnancy test</td>
</tr>
<tr>
<td>Primary culturing for transmittal to a certified laboratory</td>
</tr>
</tbody>
</table>

Payment for all other laboratory services must be made outside of the PPS and paid off the fee schedule

- Reported as laboratory services performed by an independent laboratory (PT 80), or
- Reported under the FQHC/RHC clinic (PT 50)
MAL No. 651 Payment for the Application of Topical Fluoride Varnish

Payment for topical fluoride varnish is made separately outside of the PPS when a non-dental practitioner applies topical fluoride varnish at a FQHC or RHC

• Reported under the FQHC/RHC clinic provider number (PT 50)
• Reported on a claim using CPT code 99188

Payment for topical fluoride varnish furnished by dental practitioners will continue to be made under the PPS:

• Reported on claims using ADA dental code D1206
Effective 1/17/2021 ODM began covering pharmacists’ services in accordance with rule 5160-8-52

Covered pharmacists’ services provided by a FQHC or RHC will be treated as medical services under the PPS
MAL No. 655 Payment for Vaccines

- Payment for a vaccine furnished by a FQHC or RHC is paid under the PPS unless it is part of a mass immunization.
- On a claim the office visit code 99211 or the appropriate vaccine administration code, plus the vaccine itself may be reported.
- The practitioner administering the vaccine should be reported as the rendering provider.
  - The exception is if a RN furnished the vaccine, the supervising/overseeing medical practitioner should be reported as the rendering on the claim.
- Payment for a vaccine done as part of a mass immunization is made outside of the PPS.
  - Reported under the FQHC or RHC clinic provider number (PT 50)
Coverage policy for ROP and PRAF is set forth in 5160-21-04

- Payment may be made for one ROP that is diagnosed in conjunction with an E&M service not associated with a normal obstetrics/gynecology visit
  - Can be submitted on form ODM 10257, ROP, or its web-based equivalent located here: https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/special-programs-and-initiatives/praf/praf

- PRAF may be used to screen an individual for medical and social factors that may place the individual at risk for preterm birth or other poor pregnancy outcomes
  - Payment may be made for one assessment and can be submitted on form ODM 1027 PRAF or its web-based equivalent found here: https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/special-programs-and-initiatives/praf/praf

Payment for the ROP and PRAF is made outside of the PPS and should be reported under the FQHC or RHC clinic number (PT 50)
MAL No. 660 Payment for FFS Claims for Electronic PRAF (e-PRAF)

- Changes made to Medicaid payment rule 5160-1-60 effective 7/1/2021
- Increased the rate for electronic submission from $12.10 to $90.00
- Instead of using modifier TH, providers should now use modifier 33 for e-PRAFs
- Corrected coding guidance = H1000 + 33 modifier
- Be sure to adjust any FFS claims for e-PRAFS with dates of service 7/1/2021 or later with the correct modifier to be sure to receive the correct reimbursement rate
Qualified Entity Requirements and Responsibilities for Determining Presumptive Eligibility

OAC 5160-1-17.12 effective **11/9/2019**

To become a Qualifying Entity (QE) a facility must:

- Have an active provider agreement
- Read the presumptive eligibility training guide found on ODM’s website
- Attest that it will meet the terms and conditions as a QE by reading, signing, and sending form ODM 10252
Qualified Entity Requirements and Responsibilities for Determining Presumptive Eligibility

Once designated as a QE, a facility must:

- Remain in good standing as an ODM provider
- Follow OAC 5160:1-2-13 & all applicable federal & state laws when determining Medicaid PE
- Verify the individual is not already enrolled
- Without compensation, agree to perform all of the administrative functions associated with PE
Qualified Entity Requirements and Responsibilities for Determining Presumptive Eligibility

Guidelines to remain a QE:

- If the QE is a FQHC and is able to do so, provide thirty-six hours’ worth of medically necessary medications to any person enrolled presumptively by the QE at the time of determination if such needs are determined during a medical visit.

- At least eighty-five percent of all persons enrolled presumptively by the QE have completed application for full Medicaid.

- At least eighty-five of individuals completing application for full Medicaid result in an awarding of Medicaid eligibility.
FQHCs/RHCs may use a second Medicaid provider number to submit claims for non-FQHC/RHC services and will be paid based on the fee schedule.

Examples of AHCC services:

- Inpatient hospital surgery, visits, or consultations
- Medicare crossover claims
- Durable Medical Equipment
- Group Therapy Services
- Chronic Care Management
- Take home drugs billed through pharmacy program per OAC 5160-9
- Medical nutrition therapy services when rendered by a registered dietitian
- Acupuncture when rendered by an acupuncturist

**PT 50 is only used for an FQHC or RHC to submit claims for covered non-PPS services furnished to individuals not enrolled in a MCO**
Cost-based Clinic: Definitions and Explanations

OAC 5160-28-01

(P)(2) Multiple encounters with one or multiple health professionals constitute a **single visit** if all of the following conditions are satisfied:

(a) All encounters take place on the same day
(b) All contact involves a single cost-based clinic service; and
(c) The service rendered is for a single purpose, illness, injury, condition, or complaint

(3) Multiple encounters constitute **separate visits** if one of the following conditions is satisfied:

(a) The encounters involve different cost-based clinic services; or
(b) the services rendered are for different purposes, illnesses, conditions, or complaints or for additional diagnosis and treatment
Cost-based Clinic: Submission and Payment of FQHC Claims

OAC 5160-28-08.1

(A) Claims for services provided to managed care plan (MCP) enrollees, including requests for prior authorization by an MCP of a FQHC service, must be submitted in accordance with Chapter 5160-26 of the Administrative Code.

(B) In claims submitted to the department for all other services, an FQHC must include the following data:

(1) procedure code for an encounter;
(2) appropriate modifier to specify the FQHC service; and
(3) additional codes representing all procedures performed during the encounter, along with any required modifiers.
In claims submitted to the department for supplemental (wraparound) payment for services provided to an MCP enrollee, an FQHC must also include the following data:

1. The name of the MCP that paid for the FQHC service;
2. The identification code of the MCP, assigned by the department;
3. The MCP payment plus amounts received from any other third-party payers; and
4. Any other information, such as an adjustment reason code, that is necessary for the coordination of benefits.
Dental Services: OAC 5160-5-01

Some dental services require tooth or quadrant number distinction (extractions, crowns, scaling & planning etc.)

There is no way to notate this information on the professional claim form

FQHCs and RHCs cannot use the tooth or quadrant number fields on the prior authorization (PA)

- This information should be entered in the ‘Provider Notes’ section
- You should also enter a comment stating you are a FQHC or RHC
Providers eligible to receive payment for acupuncture:

- An acupuncturist
- A recognized acupuncture provider
- Ambulatory health care clinic as defined in OAC 5160-13
- FQHCs and RHCs
- Professional medical group

- FQHCs and RHCs will receive their PVPA for services rendered by a physician or chiropractor

- Acupuncture services furnished by an acupuncturist are paid as a covered non-PPS services under a FQHC or RHC’s PT 50
Acupuncture Services: OAC 5160-8-51

Payment may be made for service that meets the following:

- Is medically necessary per OAC 5160-1-01
- Is performed at the written order of a practitioner, during the one-year supervisory period, per section 4762.10 or 4762.11 of the Ohio Revised Code (ORC)
- Is rendered by a practitioner who is enrolled in the Medicaid program
- Is rendered for treatment of:
  - Low back pain
  - Migraine

Payment for more than 30 visits per benefit year requires PA
Acupuncture Services: OAC 5160-8-51

No separate payment will be made for both an E&M service and acupuncture service rendered by the same provider to the same individual on the same day.

No separate payment is made for:

- Services that are an incidental part of a visit (e.g., providing instruction on breathing techniques, diet, or exercise)
- Additional treatment in either of the following circumstances:
  - Symptoms show no evidence of clinical improvement after an initial treatment period
  - Symptoms worsen over a course of treatment
MITS & Claim Submissions
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”
MITS Provider Portals

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 be directed to another page where you will need to enter your user ID and password.
MITS Navigation

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

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

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

MITS access will time-out after 15 minutes of system inactivity
Electronic Data Interchange (EDI)

**Fees for claims submitted**

Claims must be received by Wednesday at Noon for that week’s adjudication

---

MITS Portal

**Free submission**

Claims must be received by Friday at 5:00 P.M. for that week’s adjudication

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

Trading partners contact DXC for EDI Support

844-324-7089 or OhioMCD-EDI-Support@dxc.com
Claim entry format is divided into sections or panels

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

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

Once logged into the MITS Secure Provider Portal, click on the Claims tab, then click Professional
Submission of a Professional Claim

Complete the appropriate billing and service information
MAL No. 626-A Diagnosis Code Reporting Required on Claims

Effective 1/1/2020

To comply with current HIPAA standards, diagnosis codes must be reported for all Medicaid covered services

Professional claim form only
Entering a Diagnosis Code

Enter all diagnosis codes in the diagnosis panel.
Entering a Diagnosis Code

Select sequence ‘01’ then enter in the diagnosis code with no decimal
Entering a Diagnosis Code

Once the information is entered, click the blue line to save the information, then click ‘add an item’ to enter the next diagnosis.
Completing the Detail Panel

Enter the first detail line information, click the blue line to save, then select ‘add an item’ to enter the second detail line, continuing as needed.
Completing the Detail Panel

Encounter code T1015 and modifiers

- **U1** – Medical
- **U2** – Dental
- **U3** – Mental Health
- **U4** – PT or OT Services
- **U5** – Speech Pathology
- **U6** – Podiatry
- **U7** – Vision
- **U8** – Chiropractic
- **U9** – Transportation

RHCs can only use modifier U1. They should use it for both medical and mental health services.

Use T1015 with the U1 modifier and procedure code 99406 or 99407 for smoking cessation.
## Detail Panel – Transportation Claim Example

<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>Modifiers</th>
<th>Final EAPG</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>03/01/2021</td>
<td>4.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>11</td>
<td>T2003</td>
<td></td>
<td></td>
<td>09</td>
</tr>
<tr>
<td>A</td>
<td>03/01/2021</td>
<td>4.00</td>
<td>$500.00</td>
<td>$0.00</td>
<td>11</td>
<td>T1015</td>
<td></td>
<td></td>
<td>09</td>
</tr>
</tbody>
</table>

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

**Item**
- 2
- From DOS: 03/01/2021
- To DOS: 03/01/2021
- Units: 4.00
- Charges: $0.00

**Medicaid Allowed Amount**: $0.00

**Rendering Provider**

**Submitted EAPG**

**Initial EAPG**

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

**Place Of Service**: 11

**Procedure Code**: T2003

**Referred EPSDT Service/Family Planning**: [Search]

**Diagnosis Code Pointer**: [Search]

**Modifiers**: [Search]

**Pay Action**: [Search]
Behavioral Health Service Claims

Mental health services rendered by a psychiatrist

- T1015 with U1 modifier

Other licensed practitioners rendering the service

- T1015 with U3 modifier

Trainees and non-licensed practitioners rendering service at a FQHC/RHC must be reported under the overseeing practitioner’s NPI
Entering the ORP’s Information

At the bottom of the detail panel, click the ‘Additional Provider Information’ button, to open the additional provider information panel.
Entering the ORP’s Information

Select the appropriate detail item number – the number you select points to that specific detail line above
Entering the ORP’s Information

Click on the drop down and select the appropriate type of ORP
Entering the ORP’s Information

Enter the ORP’s information – be sure to complete an ORP search first as you must enter his/her information exactly how it is found in MITS.
Dental Services Delivered at FQHCs

Services requiring prior authorization

- **Do not** enter tooth number or quadrant number in the Line Item Panel on the PA
  - Enter one line with the total number of units for the same procedure code, not multiple lines

- Utilize the Provider Notes panel on the PA
  - Keep your comments short & to the point
  - First sentence should be “We are a FQHC.”
  - Next list the service with identifiers, e.g., “Crowns on #23 & 25”
Dental Services Delivered at FQHCs

Here is an example of how you should enter notes on a PA for dental services

<table>
<thead>
<tr>
<th>Date Entered</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>11/17/2021</td>
<td>WE ARE A FQHC. SCALING AND PLANING ON QUADRANT 10.</td>
</tr>
</tbody>
</table>

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

An amount equal to the MCO payment gap that is paid by the department to augment the MCO payment

May only submit a wraparound claim for services that would have been paid to the FQHC or RHC under the PPS payment method

Covered non-PPS services are paid FFS and not eligible for wraparound payments
# Wraparound Payment Claim Example

## Header - Other Payer

<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>SMITH</td>
<td>JOHN</td>
<td>A</td>
<td>01/01/1950</td>
<td>SELF</td>
<td>MALE</td>
<td>$200.00</td>
<td>10/01/2021</td>
<td>87726</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>*Claim Filing Indicator</th>
<th>HMO</th>
<th>*Policy Holder Relationship to Insured</th>
<th>SELF</th>
</tr>
</thead>
<tbody>
<tr>
<td>*Policy Holder Last Name</td>
<td>SMITH</td>
<td>*Policy Holder First Name, MI</td>
<td>JOHN A</td>
</tr>
<tr>
<td>Policy Holder Date of Birth</td>
<td>01/01/1950</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>MALE</td>
<td>*Paid Amount</td>
<td>$200.00</td>
</tr>
<tr>
<td>*Paid Date</td>
<td>10/01/2021</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allowed Amount</td>
<td>$0.00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Header - Other Payer Amounts and Adjustment Reason Codes

<table>
<thead>
<tr>
<th>Electronic Payer ID</th>
<th>CAS Group Code</th>
<th>ARC</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>87726</td>
<td>CO-Contractual Obligations</td>
<td>45</td>
<td>$50.00</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>*Electronic Payer ID</th>
<th>87726</th>
</tr>
</thead>
<tbody>
<tr>
<td>*CAS Group Code</td>
<td>CO-Contractual Obligations</td>
</tr>
<tr>
<td>*ARC</td>
<td>45</td>
</tr>
<tr>
<td>*Amount</td>
<td>$50.00</td>
</tr>
</tbody>
</table>
### Wraparound Payment Claim Example

#### 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>
</thead>
<tbody>
<tr>
<td>A</td>
<td>09/25/2021</td>
<td>0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>11</td>
<td>99214</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>09/25/2021</td>
<td>1.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>11</td>
<td>T1015</td>
<td>U1</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**: 11
- **Procedure Code**: T1015
- **Emergency**: Yes
- **Submitted EPSDT Service/Family Planning**: Yes
- **Diagnosis Code Pointer**: 01
- **Modifiers**: U1
- **Final EAPG**: [Search]
- **Initial EAPG**: [Search]
- **Pay Action**: [Search]

- **Rendering Provider**: 1234567890
- **Medicaid Allowed Amount**: $0.00
- **Status**:
  - Visit Start Time: Yes
  - Visit End Time: Yes
  - Service Duration less than 90 days: No
Medicare Wraparound Claim

When Medicare is the primary payer:

- FQHCs should seek the wraparound payment from Medicare, not Medicaid
  - This includes when an individual has a MyCare Ohio plan
  - FQHCs can claim Medicare wraparound payments from the appropriate Medicare Administrative Contractor in the same manner they would for individuals enrolled in Medicare Advantage
Medicare Wraparound Claim/Medicaid Cost Sharing

When applicable ODM or the MCO will pay cost-sharing after Medicare pays

- ODM Cost-sharing is covered in OAC 5160-1 (Coordination of Benefits)
- For MCOs consult your contract with each one for the specific details
Claims with Other Payers

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.
Coordination of Benefits for PPS Services

Medicaid fee-for-service (FFS), no Medicare coverage

For each NMMTP (Non-Medicare/-Medicaid third party) payer, the NMMTP payment is applied and the NMMTP policyholder liability amount is calculated.

ODM pays the lesser of two figures:

- The Medicaid PVPA (per-visit payment amount) less the sum of all NMMTP payments; or
- The sum of all NMMTP policyholder liability amounts.
Coordination of Benefits for PPS Services

Medicaid fee-for-service (FFS), traditional Medicare

For each NMMTP payer, the NMMTP payment is applied and the NMMTP policyholder liability amount is calculated

Medicare pays the lesser of two figures:

- The Medicare PPS/AIR (all-inclusive rate) covered amount less the sum of all NMMTP payments; or

- The sum of all NMMTP policyholder liability amounts

ODM pays any applicable Medicare cost-sharing
Coordination of Benefits for PPS Services

Medicaid fee-for-service (FFS), Medicare Advantage Plan (MAP)

For each NMMTP payer, the NMMTP payment is applied and the NMMTP policyholder liability amount is calculated.

The MAP pays the lesser of two figures:

- The MAP allowed amount less the sum of all NMMTP payments; or
- The sum of all NMMTP policyholder liability amounts
Coordination of Benefits for PPS Services

Medicaid fee-for-service (FFS), Medicare Advantage Plan (MAP)

The FQHC or RHC receives additional payment

- For an FQHC claim, the Medicare Administrative Contractor pays the Medicare wraparound payment amount
- For an RHC claim, any amount by which the sum of payments made by the NMMTP payers and by the MAP falls short of the Medicare AIR allowed amount is accounted for in the annual AIR cost reconciliation

ODM pays an applicable Medicare cost-sharing
Coordination of Benefits for PPS Services

Medicaid MCO, no Medicare coverage

For each NMMTP payer, the NMMTP payment is applied and the NMMTP policyholder liability amount is calculated

The MCO makes payment based on its contract with the provider. Generally, the MCO, pays the lesser of the following two amounts:

- The MCO contracted amount less the sum of all NMMTP payments; or
- The sum of all NMMTP policyholder liability amounts

ODM pays the Medicaid wraparound payment amount
Coordination of Benefits for PPS Services

MCOP opt-out membership *(coordination of Medicaid benefits only)*, MCOP region

- There are no NMMTP payments (individuals with NMMTP coverage cannot currently enroll in MyCare Ohio)
- Medicare pays the Medicare PPS/AIR covered amount
- The MCOP pays the applicable Medicare cost-sharing amount
Coordination of Benefits for PPS Services

MCOP opt-in membership *(coordination of both Medicare and Medicaid benefits)*, MCOP region

- There are no NMMTP payments (individuals with NMMTP coverage cannot currently enroll in MyCare Ohio)

- The MCOP pays the MCOP contracted amount
Coordination of Benefits for PPS Services

MCOP opt-in membership (*coordination of both Medicare and Medicaid benefits*), MCOP region

The FHQC or RHC receives additional payment determined by the Medicare PPS/AIR allowed amount

- For an FQHC claim, Medicare is responsible for the Medicare wraparound payment amount through the Medicare Administrative Contractor

- For an RHC claim, any difference obtained by subtracting the payment made the MCOP from Medicare AIR allowed amount is accounted for in the annual Medicare AIR cost reconciliation

The MCOP pays any applicable Medicare cost-sharing
Coordination of Benefits for PPS Services

Services, such as dental treatment or vision care, that are not covered by Medicare and services rendered by a healthcare practitioner who is not eligible to participate in Medicare are handled by Medicaid as if the individual had no Medicare eligibility

- For such claims, an MCOP functions as a Medicaid MCO, and ODM may make a Medicaid wraparound payment
# Claims with Other Payers

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>SMITH</td>
<td>JOHN</td>
<td>A</td>
<td>01/01/1950</td>
<td>SELF</td>
<td>MALE</td>
<td></td>
<td>$200.00</td>
<td>10/01/2021</td>
<td>987654</td>
</tr>
</tbody>
</table>

*Claim Filing Indicator: COMMERCIAL INSURANCE
*Policy Holder Relationship to Insured: SELF
*Policy Holder Last Name: SMITH
*Policy Holder First Name, MI: JOHN
Policy Holder Date of Birth: 01/01/1950
*Gender: MALE
*Paid Amount: $200.00
*Paid Date: 10/01/2021

*Insurance Carrier Name: BLUE CROSS BLUE SHIELD
*Electronic Payer ID: 987654
*Insured's Policy ID
*Payer Sequence: PRIMARY

Header - Other Payer Amounts and Adjustment Reason Codes
Claims with Other Payers

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

The X12 website provides adjustment reason codes (ARCs)

COMMON ARCs:

1. Deductible
2. Coinsurance
3. Co-payment
45. Contractual Obligation/Write off
96. Non-covered services
Claims with Other Payers

Header vs Detail

Header level

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

Detail level

- A COB claim is considered to be adjudicated at the line/detail level if figures are reported for individual line items.
Claims with Other Payers

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

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

ARCs for a detail pay Other Payer are entered in the Detail – Other Payer Amounts and Adjustment Reason Codes Panel.
Claim Submission

Once all fields have been completed

- Click the “Submit” button to submit the claim
- You may “Cancel” the claim at anytime but the information will not be saved
Claim Submission

All claim submissions are assigned an ICN

2221170357321

<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>
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</thead>
<tbody>
<tr>
<td>22</td>
<td>21</td>
<td>170</td>
<td>357</td>
<td>321</td>
</tr>
</tbody>
</table>
Claim Submission

Adjudication happens in “real time”

- If there are no errors, the claim status will show:
  - Paid
  - Denied
  - Suspended
Claim Portal Errors

Select row above to update - or - click add

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

MITS will not accept a claim without all required fields being populated. Scroll to the top of the claim to see the errors.

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.
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
Providers Have 365 Days to Submit FFS Claims

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

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.
Providers Have 365 Days to Submit FFS Claims

- Claims over 2 years old will be denied

- There are exceptions to the 365 day rule

- FQHCs & RHCs have 180 days from the MCO paid date to submit a wraparound claim
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
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 – Additional Information”
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

Notes

DECISION 20171225
Uploading an Attachment

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

Electronic attachments are accepted for Claims, Prior Authorization, and Enrollment Processing

Acceptable file formats:

- BMP, DOC, DOCX, GIF, JPG, PDF, PPT, PPTX, TIFF, TXT, XLS, and XLSX

Each attachment must be <50 MB in size

Each file must pass an anti-virus scan in MITS

A maximum of 10 attachments may be uploaded
Adjusting a Paid Claim

1. Open the claim requiring an adjustment
2. Change and save the necessary information
3. 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.
Claim Adjustment Example

2221305000002  Originally paid $45.00
5821305000001  Now paid $50.00

Additional payment of $5.00

2021172234001  Originally paid $50.00
5021173127250  Now paid $45.00

Account receivable ($5.00)
Claim Adjustment Example

Original paid claim, prior to making appropriate changes and clicking adjust

<table>
<thead>
<tr>
<th>Claim Status Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim Status</td>
</tr>
<tr>
<td>Claim ICN</td>
</tr>
<tr>
<td>Paid Date</td>
</tr>
<tr>
<td>Paid Amount</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EOB Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Detail</td>
</tr>
<tr>
<td>-----------------</td>
</tr>
<tr>
<td>1</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.)

Alert: Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision.

(cancel) adjust (void) (copy claim)
Claim Adjustment Example

The adjusted claim now has a new ICN, new status, and new paid amount.
Voiding a Paid Claim

1. Open the claim you wish to void

2. Click the “void” button at the bottom of the claim

The status is flagged as “non-adjustable” in MITS

An adjustment ICN is automatically created and given a status of “denied”
Voided Claim Example

2221305000001
5821305000001

Originally paid $45.00
Account receivable ($45.00)

* Make sure to wait until after the weekend’s adjudication cycle to submit a new, corrected claim if one is needed
Voided Claim Example

An adjusted paid claim, prior to clicking void
Voided Claim Example

The voided claim is now in a denied status, with a new ICN, and with the appropriate EOB
Copying a Claim

1. Open the claim you wish to copy
2. Click the “copy claim” button at the bottom of the claim
3. A new duplicate claim will be created, make and save all necessary changes
4. The “submit” and “cancel” buttons will display at the bottom
5. Click the “submit” button

The claim will be assigned a new ICN
ClaimsXten

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
Remittance Advice (RA)

All claims processed are available on the MITS Portal

Weekly reports become available on Wednesdays
Remittance Advice (RA)

Select “Remittance Advice” and click “Search”

To see all remits to date, do not enter any data, and click search twice
Remittance Advice (RA)

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

**Information pages**
- Banner messages to the provider community

**EOB code explanations**
- Provides a comparison of codes to the description

**TPL claim denial information**
- Provides other insurance information for any TPL claim denials
Websites & Forms
Websites

Ohio Department of Medicaid home page

https://Medicaid.ohio.gov

MALs & MTLs

https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/policies-guidelines

Ohio Administrative Codes

https://codes.ohio.gov/ohio-administrative-code/5160
Websites

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

National Drug Code (NDC) Search
http://www.accessdata.fda.gov/scripts/cder/ndc/default.cfm

X12 Website (ARC Codes)
http://www.x12.org/codes/claim-adjustment-reason-codes/
ODM 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>
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<tbody>
<tr>
<td>ODM 07216</td>
<td>(ORDER FORM)</td>
<td>Application for Health Coverage &amp; Help Paying Costs</td>
</tr>
<tr>
<td>ODM 03520</td>
<td>(ORDER FORM)</td>
<td>Healthchek &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>
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Search: 663
Show: 25 entries

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<td>Medical Claim Review Request</td>
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<tr>
<td>ODM 066531</td>
<td>English</td>
<td>Medical Claim Review Request - Instructions</td>
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</table>

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

ODM 06614 – Health Insurance Fact Request
ODM 06653 – Medical Claim Review Request

ODM 03197 – Prior Authorization: Abortion Certification
ODM 03199 – Acknowledgement of Hysterectomy Information
HHS-687 – Consent for Sterilization

ODM 03421 FQHC/Outpatient Health Facility Cost Report
ODM 10252 Acknowledgement of Terms and Conditions Governing the Presumptive Eligibility Determinations