Basic Billing for Home Health Agency Providers

Provider Relations
2022
IVR: 1-800-686-1516

Must enter two of the following: tax ID, NPI, or 7 digit Ohio Medicaid provider number

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

Calls directed through the IVR prior to accessing the customer call center
Helpful Phone Numbers

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

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

Is the fundamental concept underlying the Medicaid Program

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

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

- This is the traditional fee-for-service Medicaid card
- Issued annually as of October 1, 2018
• Automatically eligible for Medicaid as long as eligible for SSI

• Children, parents, caretakers, and expansion

• 65+, or blind/disabled with no SSI
Conditions of Eligibility and Verifications: OAC 5160:1-2-10

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

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

Additional spans when applicable:

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

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 burdens to allow more time for you to spend with patients. After all, Ohio Medicaid is less about rules and more about people.

### Resources for Providers

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

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

- **Enrollment & Support**
- **Managed Care**
- **Programs & Initiatives**

The next generation of Ohio Medicaid managed care is designed to improve wellness and health outcomes, support providers in better ways, and give ohioans the tools they need to be healthy. The Ohio Department of Medicaid has many programs and initiatives to enhance the quality of care for patients and support our providers in these efforts.

### 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 (PEL) Portal Walk Through for Qualified Entities
- Provider Direct Access (PDA) Agent Account and Access Reports
- **Eligibility Search**

### Fee Schedule & Rates

Disclaimer about fee schedule and rates available for providers.
Eligibility Verification Request

You can search up to 4 years back

TIP: Always check eligibility prior to billing
Eligibility Verification Request

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

<table>
<thead>
<tr>
<th>Recipient Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Billing Number</td>
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<table>
<thead>
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<td>Dental Co-Pay Amount</td>
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<tr>
<td>Vision Co-Pay Amount</td>
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Eligibility Verification Request

If an individual has a third-party payer, you can find that information under the TPL panel
Presumptive Eligibility

Covers children up to age 19 and pregnant women

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

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

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

**Presumptive Eligibility**

MISSISSIPPI RIVERS
21 S FRONT ST
COLUMBUS, OH 43215

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

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

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

**APPROVED:**

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

Other members will receive this Presumptive Eligibility letter:

CDJFS Presumptive Eligibility

John Doe
123 Main St.
Anytown, OH 43210

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

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

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

APPROVED:

<table>
<thead>
<tr>
<th>Name (First, M.I., Last Name)</th>
<th>Date of Birth</th>
<th>PE Type</th>
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Presumptive Eligibility

The benefit/assignment plan will look like this:
Medicaid Pre-Release Enrollment Program

- Institutionalized individuals close to release are enrolled into a Medicaid Managed Care plan prior to release
- Individual must agree and be eligible for the program
- MCP Care Manager will develop a transition plan
- More than 20,000 individuals have benefited from this program
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

<table>
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<tr>
<th>Recipient Information</th>
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<tbody>
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</tr>
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</tr>
<tr>
<td>Dental Co-Pay Amount</td>
</tr>
<tr>
<td>Vision Co-Pay Amount</td>
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</table>

Qualified Medicare Beneficiaries 10/24/2016 06/30/2021
Specified Low-Income Medicare Beneficiary (SLMB) & Qualifying Individual (QI-1)

There is NO cost-sharing eligibility

We ONLY pay their Part B premium to Medicare

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

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

<table>
<thead>
<tr>
<th>Benefit / Assignment Plan</th>
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<th>End Date</th>
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This is what will appear if the individual has QI 1/QI 2:

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Managed Care & MyCare Ohio
3 Population Groups Eligible for Traditional Managed Care

- **Supplemental Security Income (SSI)**
- **Modified Adjusted Gross Income (MAGI)**
- **Aged, Blind, Disabled (ABD)**

  - Adoption children, Breast and Cervical Cancer Patients (BCCP), Foster children, and Bureau of Children with Medical Handicaps (BCMH)
Adult Extension and HCBS Waiver

- Adults eligible via the extension will be able to access a home and community based waiver (HCBS) if a level of care requirement is met. *(MCPs are responsible for state plan health care services)*

- HCBS waivers include Passport, Ohio Home Care, and Assisted Living. *(Fee-For-Service Medicaid is still responsible for waiver services)*

- Current HCBS waiver case management agencies will continue to coordinate waiver services
Managed Care Benefit Package

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

Some value-added services:
- Online searchable provider directory
- Toll-free 24/7 hotline for medical advice
- Expanded benefits including additional transportation options plus other incentives
- Care management to help members coordinate care
If an individual is enrolled in a Managed Care Plan, the plan information will be shown in the Managed Care panel along with the effective and end dates.

### Benefit / Assignment Plan

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

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### TPL

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### Managed Care

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Traditional Managed Care Contracting

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

Things to know:

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

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

- Buckeye Health Plan
  866-296-8731 [https://www.buckeyehealthplan.com](https://www.buckeyehealthplan.com)

- CareSource
  800-488-0134 [https://www.CareSource.com/](https://www.CareSource.com/)

- Paramount Health Care
  855-522-9076 [https://www.paramounthealthcare.com/](https://www.paramounthealthcare.com/)

- Molina Healthcare
  855-322-4079 [https://www.molinahealthcare.com](https://www.molinahealthcare.com)

- UnitedHealthcare
  800-600-9007 [https://www.uhccommunityplan.com](https://www.uhccommunityplan.com)
MyCare Ohio is a demonstration project that integrates Medicare and Medicaid services into one program, operated by a Managed Care Plan.

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

The project is currently slated to end on December 31, 2022.
MyCare Ohio Eligibility

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

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

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

If an individual’s Medicaid and Medicare benefits are covered by the Managed Care Plan, you will see dual benefits.
MITS Eligibility MyCare Opt-Out

If the Managed Care Plan covers **only** the individual’s Medicaid benefits, you will see **Medicaid Only**
MyCare Managed Care Contracting

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

Things to know:

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

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

800-488-0134  https://www.CareSource.com/MyCare

855-364-0974  https://www.aetnabetterhealth.com/ohio

855-322-4079  https://www.molinahealthcare.com/duals

800-600-9007  https://www.uhccommunityplan.com/
PROVIDER COMPLAINTS

Provider licensure issues
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

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...

- Billing: Provider billing and data exchange related instructions, policies, and resources.
- COVID-19: Ohio Department of Medicaid COVID-19 Resources and Guides for Providers
- MITS: Medicaid Information Technology Information System (MITS) Resources
- Managed Care: The next generation of Ohio Medicaid managed care is designed to improve wellness and health outcomes, support providers in better...

Provider Inquiries

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

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

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

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

Provider Complaint Form Guidance

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

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

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

Submission Tips:

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

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

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

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

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

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

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

There is also a federally required 5 year revalidation.

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

Online applications can be found on our website.
Provider Agreement: OAC 5160-1-17.2

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

- Abide by the regulations and policies of the state
- Recoup any third party resources available
- Maintain records for 6 years
- Render medically necessary services in the amount required
- Inform ODM of any changes to your provider profile within 30 days
- Not seek reimbursement for service(s) from the patient, any member of the family, or any other person
General Reimbursement Principles:
OAC 5160-1-02

The department’s payment constitutes payment-in-full for any of our covered services.

Providers are expected to bill the department their Usual and Customary Charges (UCC).

The department will reimburse the provider the lesser of the Medicaid maximum allowable rate (established fee schedule) or the UCC.

Medicaid Payment:
OAC 5160-1-60
# Updating Demographic Information in MITS

Per OAC 5160-1-17.2(F), providers must inform ODM of any changes within 30 days

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**Provider Information**

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<th>National Provider ID</th>
<th>Practice Type</th>
<th>Provider Type</th>
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<td>FRANKLIN</td>
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<td>614-505-5055</td>
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</table>
The Ohio Administrative Code requires that a Medicaid consumer provide notice to the department prior to initiating any action against a liable third party.

The department will take steps to protect its subrogation rights if that notice is not provided.

For questions, contact the Coordination of Benefits Section at 614-752-5768.
Medicaid Recipient Liability: OAC 5160-1-13.1

A provider may **NOT** collect and/or bill for any difference between the Medicaid payment and the provider’s charge, as well as for the following:

- Missed appointment fee
- Unacceptable or untimely claim submission
- Failure to request a prior authorization
- Retroactive Peer Review stating lack of medical necessity
When Can You Bill an Individual?

1. Notified in writing prior to the service that Medicaid will not be billed.
2. Explains the service could be free by another provider.
3. Agrees to be liable for payment and signs statement.
4. Notified in writing prior to the service that Medicaid will not be billed.
5. Explains the service could be free by another provider.
6. Agrees to be liable for payment and signs statement.
When Can You Bill an Individual?

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

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

- 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 ➤ COVID-19 ➤ Enrollment & Support ➤ Managed Care
Provider billing and data exchange related instructions, policies, and resources.
Ohio Department of Medicaid COVID-19 Resources and Guides for Providers
Ohio Medicaid is changing the way we do business. We are streamlining provider enrollment and support services to make it easier for you to manage your care.
The next generation of Ohio Medicaid managed care is designed to improve wellness and health outcomes, support providers in better ways, and enhance the quality of care for patients.

MITS ➤
Medicaid Information Technology Information System (MITS) Resources
Ohio Medicaid policy is developed at the federal and state level. It guides how we operate our programs and how we regulate our providers.
The Ohio Department of Medicaid has many programs and initiatives to enhance the quality of care for patients and support our providers in the...
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.

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

- O.R.C. - Ohio Revised Code
- C.F.R. - Code of Federal Regulations
- Title 19 - Compilation Of The Social Security Laws
- O.A.C. - 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
# How to Find Modifiers Recognized by ODM

<table>
<thead>
<tr>
<th>Resources for Providers</th>
<th>COVID-19</th>
<th>Enrollment &amp; Support</th>
<th>Managed Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Billing</td>
<td></td>
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<tr>
<td>MITS</td>
<td>Policies &amp; Guidelines</td>
<td>Programs &amp; Initiatives</td>
<td></td>
</tr>
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<td>Medicaid Information Technology Information System (MITS) Resources</td>
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<td></td>
</tr>
</tbody>
</table>

**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)?
State Plan Services: OAC 5160-12

Services that all Medicaid individuals may receive if medically necessary

ODM submits a State Plan to the federal government that describes how Medicaid will administer the program
What are Private Duty Nursing (PDN) Services?

- Medicaid State Plan Nursing Services provide home health services when a medical need for part-time intermittent skilled nursing or aide care and therapies is needed for an individual.
- Private Duty Nursing (PDN) Services provides those continuous and complex nursing services in a home setting.
  - PDN is performed by a RN or LPN.
- Continuous care is defined as more than four hours but less than 12 hours per visit.
- These services must be prior authorized.
  - ODM determines eligibility for PDN along with the amount, scope, and duration of services.
Who Can / Cannot Receive PDN Services?

An individual who is:

- Medicaid eligible
- Requires continuous skilled nursing services
- Has a comparable institutional level of care
- Is not receiving hospice services

Someone who has elected hospice care must access their nursing services through the hospice benefit

- Except for children under age 21 who are receiving concurrent curative treatment with hospice
State Plan PDN Services Reimbursement: OAC 5160-12-06

T1000 Private Duty Nursing

Base Rate – for initial 35 to 60 minutes of delivered service

Unit Rate – 15 minute units of delivered service when initial visit is:
  Greater than 60 minutes or less than or equal to 34 minutes in length

Appropriate modifiers may be required by policy and needed for proper reimbursement
State Plan Home Health Procedure Codes

- **G0151** - Physical therapy
- **G0152** - Occupational therapy
- **G0153** - Speech-language pathology
- **G0156** - Home health aide
- **G0299** - Home health nursing - RN
- **G0300** - Home health nursing - LPN

Rates found in OAC 5160-12-05
Ohio Home Care Program: OAC 5160-12-02

Post Hospital PDN Services

- Up to 56 hours a week
- More than 4 but max of 12 hours/visit/nurse per day/24 hour period
- Up to 60 consecutive days post hospital discharge

- Not provided for habilitative care, RN assessment services, and RN consultation services
What are Waiver Services?

- Waiver refers to an exception to federal law that waives certain Ohio Medicaid eligibility requirements and allows eligible Medicaid individuals to live in the community instead of in a nursing facility or other institution.

- An individual must be determined eligible for waiver services.

- ODM administers one waiver known as Ohio Home Care Waiver (OHC).

- The Department of Developmental Disabilities (DODD) and The Ohio Department of Aging (ODA) administer additional waiver programs.
Ensure individuals are protected from abuse, neglect, exploitation, and other threats to their health, safety and well-being

Work with the individual and care manager to coordinate care
  • Agree to provide services in the person-centered services plan
  • Participate in developing a back-up plan of care

Maintain and retain all required documentation

Verify service delivery using an ODM-approved EVV system
Ohio Home Care Waiver (OHC): OAC 5160-46-04

Waiver Nursing Services

Nursing tasks and activities requiring skills of a registered nurse (RN) or licensed practical nurse (LPN) if directed by an RN

Examples include intravenous (IV) insertion, IV medication administration, central line dressings, blood product administration, and medical pump programming
Ohio Home Care Waiver (OHC): OAC 5160-46-04

Personal Care Aide Services

Assists individuals with activities of daily living and instrumental activities of daily living

Examples include bathing, dressing, range of motion exercises, general homemaking activities, household chores, paying bills, accompanying or transporting the individual, and meal preparation
Waiver Services Reimbursement

Use the appropriate procedure code for the service

Base Rate – for initial 35 to 60 minutes of delivered service

Unit Rate – 15 minute units of delivered service when initial visit is:
  Greater than 60 minutes or less than or equal to 34 minutes in length

Appropriate modifiers may be required by policy and needed for proper reimbursement
Common Waiver Services Procedure Codes

- **T1002** - Waiver nursing by RN
- **T1003** - Waiver nursing by LPN
- **T1019** - Personal care aide services
- **S5125** - Home care attendant (HCAS)

Rates found in OAC 5160-46-06 and 5160-46-06.1
# Possible Modifiers

<table>
<thead>
<tr>
<th>Modifiers</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>U1</td>
<td>Infusion therapy (RNs only)</td>
</tr>
<tr>
<td>U2</td>
<td>Second visit on same day</td>
</tr>
<tr>
<td>U3</td>
<td>Three or more visits on the same day</td>
</tr>
<tr>
<td>U4</td>
<td>12 hours to 16 hours per visit</td>
</tr>
<tr>
<td>U5</td>
<td>Healthchek (EPSDT)</td>
</tr>
<tr>
<td>U7</td>
<td>Over 14 hours</td>
</tr>
<tr>
<td>U8</td>
<td>HCAS in lieu of intermittent nursing services 4 hours or less</td>
</tr>
</tbody>
</table>
### Possible Modifiers

<table>
<thead>
<tr>
<th>Modifiers</th>
<th>Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>U9</td>
<td>RN consultation with T1001</td>
</tr>
<tr>
<td>HQ</td>
<td>Group visit</td>
</tr>
<tr>
<td>TD</td>
<td>RN visit</td>
</tr>
<tr>
<td>TE</td>
<td>LPN visit</td>
</tr>
</tbody>
</table>
What is the Person-Centered Services Plan?

- A document the case manager (CM) and others develop with the individual
- It specifies all the services which are currently necessary for an individual to remain at home
- It lists the goals, needed services, cost of services, who is liable for payment, service providers, home care team members, and any decision regarding individual options
- The individual and all providers need to receive a copy and understand it
- The plan authorizes the service units (hours) providers can be reimbursed and may specify the schedule of visits
Structural Reviews of Providers and Investigation of Provider Occurrences: OAC 5160-45-06

Providers are subject to structural reviews during each of the first three years of furnishing billable services

➢ Thereafter structural reviews may be conducted biennially if all the following apply to the provider:
  • There were no findings during the most recent review
  • Was not substantiated to be the violator in an incident
  • Was not the subject of more than one provider occurrence during the previous 12 months
  • Does not live with an individual receiving ODM-administered waiver services
Surveillance and Utilization Review Section (SURS)

- Review records and/or claims for compliance with ODM rules, which include:
  - Unauthorized services
  - Up-coding
  - Unbundling
  - Documentation issues
Surveillance and Utilization Review Section (SURS)

➤ Review details:
  • Up to 6 years of records be reviewed by SURS

➤ Potential outcomes of limited scope reviews:
  • No identified overpayment
  • Overpayment identification or a referral to Ohio Attorney General (Medicaid Fraud Control Unit)
MITS & Claims
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 for you!

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
Medicaid Information Technology System (MITS)

- MITS is a web-based application that is accessible via any modern browser.
- MITS is available to all Ohio Medicaid providers who have been registered and have created an account.
- MITS is able to process transactions in “real time.”
Technical Requirements

Internet Access (high speed works best)

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

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

Turn OFF pop up blocker functionality
How to Access the MITS Portal

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

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

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

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

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

MITS access will time-out after 15 minutes of system inactivity
Electronic Funds Transfer

ODM will start requiring Electronic Funds Transfer (EFT) for payment instead of paper warrants

Benefits of direct deposit include:

- **Quicker funds** - transferred directly to your account on the day paper warrants are normally mailed
- **No worry** - no lost or stolen checks or postal holidays delaying receipt of your warrant
- **Address change** - your payment will still be deposited into your banking account
Electronic Data Interchange (EDI)

Fees for claims submitted

Claims must be received by Wednesday at Noon for the next payment cycle

MITS Portal

Free submission

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

We can help with your claim issues
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

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

### Professional Claim Form

<table>
<thead>
<tr>
<th>BILLING INFORMATION</th>
<th>SERVICE INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICN</td>
<td>*Release of Information</td>
</tr>
<tr>
<td>Claim Received Date</td>
<td>From Date</td>
</tr>
<tr>
<td>Claim Type</td>
<td>To Date</td>
</tr>
<tr>
<td>Provider ID</td>
<td>Signature Source</td>
</tr>
<tr>
<td>Medicaid Billing Number</td>
<td>Accident Related To</td>
</tr>
<tr>
<td>Date of Birth</td>
<td>Accident State</td>
</tr>
<tr>
<td>Last Name</td>
<td>Accident Country</td>
</tr>
<tr>
<td>First Name, MI</td>
<td>Accident Date</td>
</tr>
<tr>
<td>*Patient Account #</td>
<td>EPSDT Referral</td>
</tr>
<tr>
<td>Medical Record #</td>
<td>Prior Authorization #</td>
</tr>
<tr>
<td>Referring Provider #</td>
<td>Hospital Discharge Date</td>
</tr>
<tr>
<td>Rendering ID</td>
<td>Last Menstrual Period</td>
</tr>
</tbody>
</table>

### Diagnosis

#### No rows found

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

#### Header - Other Payer

#### No rows found

**Select row above to update -or- click add an item button below.**
Diagnosis Codes: Required on Most Claims

Must include all characters specified by ICD

Do **NOT** enter the decimal points

There are system edits and audits against the codes
Diagnosis Codes

A diagnosis code is optional with the following procedure codes:

G0151, G0152, G0153, G0154, G0156, H0045, S0215, S5101, S5102, S5125, S5160, S5161, S5165, S5170, T1000, T1002, T1003, T1019, and T2029

If one or more diagnoses are specified, then each claim line in the 'Detail' panel must point to (be associated with) at least one diagnosis
Diagnosis code Pointer

This must point to the proper diagnosis associated with the rendered service.
### Detail Panel

| Item | FDOS      | Unit | Charges | Medicaid Allowed Amount | Status | Place of Service | Procedure Code | Modifier 1 | Modifier 2 | Modifier 3 | Modifier 4 | Final EAPC |
|------|-----------|------|---------|-------------------------|--------|------------------|----------------|-------------|------------|------------|------------|------------|------------|
| A    | 5         | 12/09/2021 | 32.00  | $159.86                 | $0.00  | 12               | T1019         | U2          | TU         |            |            |            |
| A    | 4         | 12/09/2021 | 16.00  | $51.29                  | $0.00  | 12               | T1019         |             |            |            |            |            |
| A    | 3         | 12/09/2021 | 48.00  | $159.86                 | $0.00  | 12               | T1019         |             |            |            |            |            |
| A    | 2         | 12/09/2021 | 48.00  | $159.86                 | $0.00  | 12               | T1019         |             |            |            |            |            |
| A    | 1         | 12/09/2021 | 48.00  | $159.86                 | $0.00  | 12               | T1019         |             |            |            |            |            |

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

**Item 5**

*From DOS: 12/09/2021*

*To DOS: 12/09/2021*

*Units: 32.00*

*Charges: $159.86*

**Medicaid Allowed Amount:** $0.00

**Rendering Provider:**

**Submitted EAPG:**

**Initial EAPG:**

**Status:**

**Visit Start Time:**

**Visit End Time:**

**Service Duration:**

less than 90 days

**Final EAPG:**

**Pay Action:**

**Place Of Service:** 12 [Search]

**Procedure Code:** T1019 [Search]

**Emergency:**

**Referred EPSDT Service/Family Planning:**

**Diagnosis Code Pointer:** 01 [Search]

**Modifiers:** U2 [Search] TU [Search]

**Additional Provider Information**
## Entering Ordering Provider Information

### Additional Provider Information

<table>
<thead>
<tr>
<th>Detail Item</th>
<th>Type of Provider</th>
<th>Provider #</th>
<th>Last Name</th>
<th>First Name, MI</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Ordering Provider</td>
<td>1234567890</td>
<td>SMITH</td>
<td>JOHN</td>
</tr>
</tbody>
</table>
➢ Click the “submit” button at the bottom right

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

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

Portal errors return the claim with a “fix” needed

Portal errors will show up at the top of the page

Claim shows a ‘NOT SUBMITTED YET’ status still
Claim Submission

All claim submissions are assigned an ICN

<table>
<thead>
<tr>
<th>Region Code</th>
<th>Calendar Year</th>
<th>Julian Day</th>
<th>Claim Type/Batch Number</th>
<th>Claim Number in Batch</th>
</tr>
</thead>
<tbody>
<tr>
<td>22</td>
<td>21</td>
<td>170</td>
<td>357</td>
<td>321</td>
</tr>
</tbody>
</table>

2221170357321
Providers have 365 days to submit 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.

Timely Filing
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.*

| Previously Denied ICN or TCN | Reason |  |
Timely Filing Exceptions: OAC 5160-3-39.1

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

- The claim must be submitted within 180 days of the hearing decision or eligibility determination date
How to Bill After a Delay

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

- In the Note Reference Code dropdown menu select “ADD”
How to Bill After a Delay

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

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

Must use the spacing shown
Medicare Denials

- If Medicare issues a denial and indicates that the patient is responsible for the payment, submit the claim to ODM by following these steps:
  - Enter a claim in MITS
  - Do not enter any Medicare information on the claim
  - Complete and upload a ODM 06653 and a copy of the Medicare EOB
Uploading an Attachment

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

- Electronic attachments are accepted for Claims, Prior Authorization, and Enrollment Processing
- Acceptable file formats:
  - BMP, DOC, DOCX, GIF, JPG, PDF, PPT, PPTX, TIFF, TXT, XLS, and XLSX
- Each attachment must be less than 50 MB in size
- Each file must pass an anti-virus scan in MITS
- A maximum of 10 attachments may be uploaded
Paid Claims Can Be:

- Voided
- Adjusted
- Copied
Adjusting a Paid Claim

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

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

2021172234001
Originally paid $50.00
5021173127250
Now paid $45.00
Account receivable ($5.00)
Voiding a Paid Claim

- Open the claim you wish to void
- Click the “void” button at the bottom of the claim
- The status is flagged as “non-adjustable” in MITS
- An adjustment is automatically created and given a status of “denied”
Voiding a Paid Claim: Example

2221180234001
5821185127250

Originally paid $45.00
Account receivable ($45.00)

* Make sure to wait until after the adjudication cycle to submit a new, corrected claim if one is needed
Copying a Paid Claim

- Open the claim you wish to copy
- Click the “copy claim” button at the bottom of the claim
- A new duplicate claim will be created, make and save all necessary changes
- The “submit” and “cancel” buttons will display at the bottom
- Click the “submit” button
- The claim will be assigned a new ICN
ClaimChek Edits

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

Developed by the Centers for Medicare & Medicaid Services

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

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

- Medically unlikely edit (MUE) determines whether the units of service exceed maximum units that a provider would be likely to report under most circumstances.
Other payer information can be reported at the claim level (header) or at the line level (detail), depending on the other payer’s claim adjudication.

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

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

Other payer information is entered in the Header – Other Payer panel.
Third Party Liability (TPL) Claims

If the TPL is a Medicare HMO, select “HMO, Medicare Risk” in the Claim Filing Indicator drop down menu.

<table>
<thead>
<tr>
<th>Header - Other Payer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name</td>
</tr>
<tr>
<td>A SMITH</td>
</tr>
</tbody>
</table>

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

- *Claim Filing Indicator: HMO, MEDICARE RISK
- *Policy Holder Relationship to Insured: FATHER
- *Policy Holder Last Name: SMITH
- *Policy Holder First Name, MI: JOHN, A
- *Policy Holder Date of Birth: 01/01/1950
- *Gender: MALE
- *Paid Amount: $200.00
- *Paid Date: 08/07/2021
- *Insurance Carrier Name: HUMANA MEDICARE
- *Electronic Payer ID: 01234
- Insured’s Policy ID: 987654
- *Payer Sequence Medicare ICN: PRIMARY
Header vs. Detail

Header level

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

Detail level

- A COB claim is considered to be adjudicated at the line/detail level if figures are reported for individual line items.
Adjustment Reason Codes (ARCs)

The X12 website provides adjustment reason codes (ARCs)

COMMON ARCs:

1. Deductible
2. Coinsurance
3. Co-payment
45. Contractual Obligation/Write off
96. Non-covered services
**Third Party Liability (TPL) Claims**

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

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

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

Payer Line Level Adjustment Reason Codes (ARC) and Amounts

*Detail Item/Electronic Payer ID: 1/43210
*CAS Group Code: CO-Contractual Obligations
*ARC: 45
*Amount: $150.00
Remittance Advice (RA)

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

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

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

- Information pages
  - Banner messages to the provider community

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

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

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

- Within the Prior Authorization subsystem providers can:
  - Submit a new Prior Authorization
  - Search for previously submitted Prior Authorizations

- Within the Prior Authorization panel providers can:
  - Attach documentation
  - Add comments to a Prior Authorization that is in a pending status
  - View reviewer comments
  - View Prior Authorization usage, including units and dollars used
Prior Authorization (PA)

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

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

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

- If a PA is marked approved with an authorized dollar amount of $0.00, it will still pay at the Medicaid maximum allowable reimbursement rate
Websites & Forms
Websites

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

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

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

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

- **Companion Guides (EDI)**

- **Electronic Visit Verification (EVV)**

- **Healthchek**

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

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

## Medicaid Forms

**Ohio Department of Medicaid Forms Library**

### Order Forms/Email Requests

<table>
<thead>
<tr>
<th>Form Number</th>
<th>Order Form</th>
<th>Form Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>ODM 07216</td>
<td>ORDER FORM</td>
<td>Application for Health Coverage &amp; Help Paying Costs</td>
</tr>
<tr>
<td>ODM 03528</td>
<td>ORDER FORM</td>
<td>Healthcheck &amp; Pregnancy Related Services Information Sheet</td>
</tr>
<tr>
<td>ODM 10129</td>
<td>ORDER FORM</td>
<td>Long-Term Services and Supports Questionnaire (LTSSQ) - Email Request</td>
</tr>
<tr>
<td>ODM 02339</td>
<td>ORDER FORM</td>
<td>Request for Medicaid Home and Community-Based Services (HCBS)</td>
</tr>
</tbody>
</table>

### Search:

- **Search**: 663
- **Show**: 25 entries

<table>
<thead>
<tr>
<th>File Name</th>
<th>Language</th>
<th>Form Name</th>
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</thead>
<tbody>
<tr>
<td>ODM 06653</td>
<td>English</td>
<td>Medical Claim Review Request</td>
</tr>
<tr>
<td>ODM 06653</td>
<td>English</td>
<td>Medical Claim Review Request - Instructions</td>
</tr>
</tbody>
</table>

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