Basic Billing for Independent Home Health Providers

Provider Relations

2021
Programs & Cards
Managed Care/MyCare Ohio
Provider Responsibilities
Policy
MITS & Claim Submission
Websites & Forms
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)
Providers will be required to enter two out of the following three pieces of data: tax ID (or SS#), NPI, or 7 digit Ohio Medicaid provider number.

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

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

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

• Helpful phone numbers
  » Adjustments
    ▪ LTCPaymentSection@medicaid.ohio.gov
  » OSHIP (Ohio Senior Health Insurance Information Program)
    ▪ 1-800-686-1578
  » Coordination of Benefits Section
    ▪ 614-752-5768
    ▪ 614-728-0757 (fax)
Programs & Cards
Medicaid Medical Necessity: OAC 5160-1-01

Is the fundamental concept underlying the Medicaid Program

All services must meet accepted standards of medical practice
Ohio Medicaid

- This is the traditional fee-for-service Medicaid card
- Issued annually as of October 1, 2018
Programs & Cards

• Conditions of Eligibility and Verifications: OAC 5160:1-2-10
  » Consumers must cooperate with requests from third-party insurance companies to provide additional information needed in order to authorize coverage
  » Consumers must cooperate with requests from a Medicaid provider; managed care plan; or a managed care plan’s contracted provider for additional information which is needed in order to bill third party insurances appropriately
Eligibility Verification Request

Resources for Providers

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

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 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 participate.

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

Fee Schedule & Rates
Disclaimer about fee schedule and rates available for providers.

Training
Training presentations, videos, and handouts.

TPL Carrier List
Click download to obtain the full listing of Third Party Carrier list and numbers.

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

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

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

- Presumptive Eligibility (PE) Portal Walk Through for Qualified Entities
- Remote Taps - MITS - Agent Account and Access Reports
- Eligibility Search
You can search up to 4 years back

TIP: Always check eligibility prior to billing
# Eligibility Verification Request

## Recipient Information

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

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**Presumptive Eligibility**

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Count Office [http://jfs.ohio.gov/county/cntydir.stm](http://jfs.ohio.gov/county/cntydir.stm)

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**QMB**
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.
<table>
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Programs & Cards

• Presumptive Eligibility

- It has been expanded to provide coverage for parent and caretaker relatives and extension adults.
- Covers children up to age 19 and pregnant women.
- This is a limited benefit to allow time for full determination of eligibility for medical assistance.
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>
<thead>
<tr>
<th>Name (First, M.I., Last Name)</th>
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Presumptive Eligibility

Other members will receive this Presumptive Eligibility letter

CDJFS Presumptive Eligibility

John Doe
123 Main St.
Anytown, OH 43210

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

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

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

APPROVED:

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<th>Name</th>
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Managed Care & MyCare Ohio
Oversight of Managed Care Plans

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

## Benefit / Assignment Plan

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<td>Ohio Mental health</td>
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## Case/Cat/Seq Spenddown

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## TPL

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## Managed Care

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*Ohio Department of Medicaid*
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.
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<table>
<thead>
<tr>
<th>Benefit / Assignment Plan</th>
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## MITS Eligibility MyCare Opt-Out

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<th>Plan Name</th>
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<td>CVS CAREMARK VALUE (PDP)</td>
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</table>
Submitting a Managed Care Complaint

Provider Inquiries

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

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

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

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

Provider Complaint Form Guidance

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

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

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

Submission Tips:

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

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

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

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

*NEW* Proper contact information for the person listed in the “Follow-up Name” field must be entered. The plans may attempt to contact the provider via telephone conversation, voicemail left, or email sent. If the plan is continuously unable to reach the listed contact, ODM may close the complaint without direct provider contact.
Provider Responsibilities
Provider Agreement: OAC 5160-1-17.2

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

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

- Demographic Maintenance in MITS
Provider Responsibilities

- Demographic Maintenance in MITS, cont.
ORP Search

Welcome
Portal Admin Security 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: DWIGHT
*Date of Service: 01/11/2021

Search Results
*** No rows found ***
ORP Search

Ordering/Referring/Prescribing Search

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

Search Results

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<td>1268168168</td>
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<td>1034134734</td>
<td>SMITH, JOHN A</td>
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<tr>
<td>14227221122</td>
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<td>1206206106</td>
<td>SMITH, JOHN R</td>
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<td>1019019719</td>
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ORP Search

Ordering/Referring/Prescribing Search

Ordering Provider NPI: 1268168168
Ordering Provider Last Name: 
First, MI: 
*Date of Service: 01/11/2021

Search Results

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

- Fee for missed appointments
- Unacceptable or untimely claim submission
- Failure to request a prior authorization
- Retroactive Peer Review stating lack of medical necessity
When Can you Bill an Individual?

1. Notified in writing prior to the service that Medicaid will not be billed.
2. Explain the service could be free by another provider.
3. Agrees to be liable for payment and signs statement.
4. Notified in writing prior to the service that Medicaid will not be billed.
S160-1-13.1 Medicaid recipient liability

Date of service: _____________
Type of service: _______________
Name & account number: ___________________________
Billing number: ___________________________

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

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

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

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

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

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

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

Signature ___________________________ Date _______________
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
Provider Responsibilities

- Person - Centered Services Plan (formally known as the All Services Plan)
## Provider Responsibilities

### Person - Centered Services Plan, cont’d

<table>
<thead>
<tr>
<th>Consumer’s billing number</th>
<th>Consumer’s name and address</th>
<th>Cost Level Code</th>
<th>Date This Plan Activated</th>
<th>Effective Date mdyyyy</th>
<th>Estimated Cost/MO (Complete for OHC costs only)</th>
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<tr>
<td></td>
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<td></td>
<td>1/13/2017 4:40:28 PM</td>
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#### Goal 3 - BUP, 11-15
Other: 3/14/2016

- **Spouse’s name:** Wife Address
- **Physician’s name MD General Practice:** Address

<table>
<thead>
<tr>
<th>Goal #</th>
<th>Service</th>
<th>Units/Month</th>
<th>Start Date</th>
<th>End Date</th>
<th>Provider/Contact</th>
<th>Phone # &amp; Fax # &amp; Email</th>
<th>Payment Source</th>
<th>Payment Source Details</th>
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<tr>
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<td>Medical Care</td>
<td>3/14/2016</td>
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<td>17 LIA</td>
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<td>B=4 S=32</td>
<td>12/26/2016</td>
<td></td>
<td>Provider’s name OETP</td>
<td><a href="mailto:email@gmail.com">email@gmail.com</a></td>
<td>Patient Liability</td>
<td>Provider may NOT bill Medicaid for this amount. Consumer is to be billed this amount prior to billing</td>
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</table>

- Provider may NOT bill Medicaid for this amount. Consumer is to be billed this amount prior to billing.
Provider Responsibilities

- Person - Centered Services Plan, cont’d

<table>
<thead>
<tr>
<th>Provider</th>
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<th>Method</th>
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<tbody>
<tr>
<td>Consumer</td>
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<td>Guardian</td>
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<td>Case Manager</td>
<td>Participation Date</td>
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<tr>
<td>4/6/2016</td>
<td>In person</td>
<td></td>
</tr>
<tr>
<td>Signature</td>
<td>1/13/2017</td>
<td>Email</td>
</tr>
<tr>
<td>Signature</td>
<td>12/23/2016</td>
<td>Participation Method</td>
</tr>
<tr>
<td>Signature</td>
<td>3/14/2016</td>
<td>Fax</td>
</tr>
</tbody>
</table>

This plan will be reviewed according to the following schedule:
6 Months 1-3 Monthly Visits 4-6 Monthly Visits 2 Calls Mo, 1, 1 call 2-6 Mos.
CM Monitoring will occur according to the following schedule:
6 Months 1-3 Monthly Visits 4-6 Monthly Visits 2 Calls Mo, 1, 1 call 2-6 Mos.

I understand that I have do not have monthly patient liability of $151 per month I understand that this means that I must pay $151 each month to:

Provider’s name
Provider Responsibilities

❖ Work week
  – The work week begins Sunday at 12:00 AM and ends Saturday at 11:59 PM

❖ Overtime
  – Independent providers delivering services in excess of 40 hours (160 units) are eligible for overtime compensation
    ▪ Only time spent delivering services under an ODM waiver program, Ohio Department of Aging, Ohio Department of Developmental Disabilities, as well as Private Duty Nursing (PDN) as an independent provider are eligible
Provider Responsibilities

❖ Overtime, cont’d

– Personal Care Aide, Home Care Attendant, waiver nursing under the Ohio Home Care Waiver, and PDN services must add a TU or UA modifier when billing overtime

▪ TU indicates entire visit is overtime
▪ UA indicates some units of a visit were overtime

➢ Effected codes are T1019, S5125, T1002, T1003, and T1000
Electronic Visit Verification (EVV)
Included services:

- State Plan Home Health Aide
- State Plan Home Health Nursing
- Private Duty Nursing (PDN)
- Ohio Home Care Waiver Nursing
- Ohio Home are Waiver Personal Care Aide
- Home Care Attendant
- RN Assessment
What to do as a provider:

- Sign up for a training class
  - Registration opens in October for November and December classes
  - Classroom setting, webinar or self paced classes
- Visit the ODM webpage often for updates
- Keep your email updated in MITS
What does EVV mean for agency and non-agency providers?

- There is no cost to providers who use Sandata’s system.
- EVV will capture and log visit data electronically.
- Claim submission process will not change but more information may be required on the claim.
- ODM encourages all providers to use Sandata’s EVV system but it is open to providers using their own EVV systems.
- ODM will post all information pertaining to the phase-in of the EVV system on the webpage. Please visit it often.
TIME LINE:

Design Sessions Began 9/2016

Training Began 11/1/17

EVV Program Launched 1/8/18
Provider Responsibilities

- 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
Provider Responsibilities

❖ SURS, cont’d

– Top five provider types reviewed:

1. Home Health Services
2. Durable Medical Equipment
3. Skilled Nursing Facilities
4. Physician Services
5. Private Duty Nursing
Provider Responsibilities

- **SURS, cont’d**

  - Limited Scope Reviews can be accomplished by:
    - Data mining algorithms
    - Record requests
    - Desk reviews
    - Onsite reviews
Provider Responsibilities

❖ SURS, cont’d

– Review Details:
  ▪ Up to 6 years can 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)
Provider Responsibilities

❖ SURS, cont’d

Dear Provider:

The Surveillance and Utilization Review Section of the Ohio Department of Medicaid (ODM) has conducted a limited review of your Medicaid billings of T1000 – Private Duty Nursing Services. This review was based on information provided by the Bureau of Long Term Care Services & Support and the Ohio Home Care program (formerly CareStar).

We found that you were overpaid by Medicaid because you billed for visits without a signed physician’s order. This violated Ohio Administrative Code Section 5101:3-45-01(RR). Please see the included claims detail report for further information.

The overpayment identified is $4,068.31, plus interest of $690.89, to the date of this letter. Additional interest is accruing at $0.39 per day. Interest is calculated pursuant to Ohio Administrative Code (OAC) Section 5160-1-25.

This review is limited to your paid claims for the review period noted above and is not a full review of your practice. Additionally, this current review does not bar ODM from conducting a new review, a final fiscal audit, or initiating collections for other incorrect or improper payments for the review period of this identified overpayment.
Provider Responsibilities

• SURS, cont.

<table>
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<th>Provider Responsibilities</th>
<th>SURS Interest Calculation Spreadsheet</th>
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<td>PROVIDER #:</td>
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<td>Enter Findings Amount:</td>
<td>$4,068.31</td>
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<tr>
<td>Interest Rate:</td>
<td>3.50%</td>
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<td>Enter last date of payment:</td>
<td>12/7/2011</td>
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<td>Enter Date of Letter/Memo:</td>
<td>10/12/2016</td>
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<tr>
<td>Number of days:</td>
<td>1,771</td>
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<td>$690.89</td>
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<tr>
<td>Per Diem Rate:</td>
<td>$0.3901</td>
</tr>
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</table>

As of 4/1/20 the interest rate was set at 3.25%
Policy updates from Ohio Medicaid announce the changes to the Ohio Administrative Code that may affect providers

- Medicaid Transmittal Letter (MTL)
- Medical Assistance Letter (MAL)
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...

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.

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

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

Rule Renumbering

- Rule 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 Ohio Medicaid

MODIFIERS:
- Modifiers recognized by ODM

DURABLE MEDICAL EQUIPMENT CLAIMS:
- Codes/Rates/Fee Schedules FAQs
- How to read the RA (Remittance Advice)
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 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 Services (PDN) 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
T1000 Private Duty Nursing

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

Unit Rate – each 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
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 (OHC) Waiver: OAC 5160-46-04(A)

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 (OHC) Waiver: OAC 5160-46-04(B)

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 – each 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>
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<tbody>
<tr>
<td>U1</td>
<td>Infusion therapy (RNs only)</td>
</tr>
<tr>
<td>U2</td>
<td>Second visit</td>
</tr>
<tr>
<td>U3</td>
<td>Three or more visits</td>
</tr>
<tr>
<td>U4</td>
<td>12 hours to 16 hours per visit</td>
</tr>
<tr>
<td>U5</td>
<td>Healthtrack (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>
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</table>
## Additional Modifiers

<table>
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<tr>
<th>Modifiers</th>
<th>Descriptions</th>
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<tr>
<td>U9</td>
<td>RN consultation with T1001</td>
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<td>HQ</td>
<td>Group visit</td>
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<tr>
<td>TD</td>
<td>RN visit</td>
</tr>
<tr>
<td>TE</td>
<td>LPN visit</td>
</tr>
<tr>
<td>UA</td>
<td>Non-agency RN or LPN visit if portion of visit is overtime</td>
</tr>
<tr>
<td>TU</td>
<td>Non-agency RN or LPN visit if entire visit is overtime</td>
</tr>
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</table>
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 of 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
MITS & Claims
Medicaid Information Technology System (MITS)

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

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

MITS is able to process transactions in “real time”
Technical Requirements

Internet Access (high speed works best)

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

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

Turn OFF pop up blocker functionality
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

Free submission

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

Trading partners contact DXC for EDI Support

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

Claim entry format is divided into sections or panels

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

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

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

*** No rows found ***

Claim Activity Summary
Number of Claims Paid in Current Month
Submission of a Professional Claim
Diagnosis Codes:
Medicaid Advisory Letter (MAL) No. 626-A

- Effective 1/1/2020

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

- Required on professional claims only
This must point to the proper diagnosis associated with the rendered service.
Multiple Visits

- If providing multiple visits on the same day, all of the visits must be entered on the same claim
  - U2 and U3 indicate additional visits
- If overtime occurs during a day with multiple visits, the overtime must be billed on the same claim as the other visits
  - Overtime can be achieved during the middle of a visit
Appropriate Modifiers

- TU indicates the entire visit is overtime
- UA indicates some units of a visit were overtime
- HQ indicates services were delivered in a group setting
- U2 indicates a second visit on Ohio Home Care Waiver for the same day
- U3 indicates three or more visits on Ohio Home Care Waiver for the same day
- U4 indicates a single visit for more than 12 hours but less than 16 hours
### Detail Panel

<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>1</td>
<td>0</td>
<td>0.00</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

- **Item**: 1
- **Charges**: $0.00
- **Medicaid Allowed Amount**: $0.00
- **Place Of Service**: [Search]
- **Procedure Code**: [Search]
- **Emergency**: [ ]
- **Refunded EPSDT Service/Family Planning**: [ ]
- **Diagnosis Code**: [ ]
- **Modifiers**: [ ]
- **Final EAPG**: [ ]
- **Status**: [ ]

**Rendering Provider**: [ ]

**Submitted EAPG**: [ ]

**Initial EAPG**: [ ]

**Pay Action**: [ ]

**Additional Provider Information**
Claim Submission

❖ Appropriate Modifiers

- TU indicates entire visit is overtime
- UA indicates some units of a visit were overtime
- HQ indicates services were delivered in group setting
- U2 indicates a second visit on Ohio Home Care Wavier for same day
- U3 indicates three or more visits on Ohio Home Care Wavier for same day
- U4 indicates single visit for more than 12 hours but less then 16 hours
Claim Submission

- Multiple Visits on the same date of service
  - If a provider is providing multiple visits on the same day, all of the visits must be noted on a single claim
    - Ensure proper modifier used for each visit
Claim Submission

- Multiple Visits on the same date of service, cont’d
Claim Submission

- **Overtime during the work week**
  - If a provider exceeds 40 hours working within a work week they must submit the hours over 40 for the week as overtime
    - Providers use the UA modifier to indicate overtime
Claim Submission

- Overtime during the work week, cont’d (some units)
Claim Submission

- Overtime during the work week, cont’d (entire visit)
Claim Submission

- Entering the Ordering Provider’s information
Claim Submission

- Entering the Ordering Provider’s information, cont.
Claim Submission

- Entering the Ordering Provider’s information, cont.
Claim Submission

❖ Entering the Ordering Provider’s information, cont.
Click the “submit” button at the bottom right.

You may “cancel” the claim at anytime, but the information will not be saved in MITS.
Paid claims can be:

- Voided
- Adjusted
- Copied
All claims are assigned an ICN

<table>
<thead>
<tr>
<th>Region Code</th>
<th>Calendar Year</th>
<th>Julian Day</th>
<th>Claim Type/Batch Number</th>
<th>Claim Number in Batch</th>
</tr>
</thead>
<tbody>
<tr>
<td>22</td>
<td>21</td>
<td>170</td>
<td>357</td>
<td>321</td>
</tr>
</tbody>
</table>
MITS will not accept a claim without all required fields being populated.

Scroll to the top of the claim.

<table>
<thead>
<tr>
<th>The following messages were generated:</th>
</tr>
</thead>
<tbody>
<tr>
<td>From <code>DOS</code> is required.</td>
</tr>
<tr>
<td>Procedure is required.</td>
</tr>
<tr>
<td>A valid Place Of Service is required.</td>
</tr>
<tr>
<td>A valid Procedure Code is required.</td>
</tr>
<tr>
<td>Units must be greater than 0.</td>
</tr>
<tr>
<td>Charges must be greater than $0.00.</td>
</tr>
</tbody>
</table>
Claim Portal Errors, cont.
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 they can attempt to submit the claim for payment (if receiving a denial) or adjust it as many times as they need to.

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

Claims over 2 years old will be denied.

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

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

Supporting Data for Delayed Submission / Resubmission

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

| Previously Denied ICN or TCN | Reason |
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
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

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

- Once you click the “adjust” button a new claim is created and assigned a new ICN
- Refer to the information in the “Claim Status Information” and “EOB Information” area at the bottom of the page to see how your new claim has processed
Example, cont.

<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>1</td>
<td>1.00</td>
<td>$5.00</td>
<td>$0.00</td>
<td>12</td>
<td>A4452</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

- **Place Of Service**: 12 [Search]
- **Procedure Code**: A4452 [Search]
- **Emergency**

Referred EPSDT Service/Family Planning
- **Diagnosis Code Pointer**: 01 [Search]
- **Modifiers**
  - [Search]
  - [Search]
  - [Search]
- **Final EAPG**
- **Pay Action**
Example, cont.
### Claim Status Information

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

### EOB Information

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

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

### EOB Information

<table>
<thead>
<tr>
<th>Detail Number</th>
<th>Error Code</th>
<th>EOB Description</th>
<th>CARC Amount</th>
<th>CARC Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>9918</td>
<td>PRICING ADJUSTMENT - MAX FEE PRICING APPLIED</td>
<td>45 $1.00</td>
<td>Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability)</td>
</tr>
</tbody>
</table>

### Adjustment Information

<table>
<thead>
<tr>
<th>ICN</th>
<th>Date Adjusted</th>
</tr>
</thead>
<tbody>
<tr>
<td>58213050000001</td>
<td>01/11/2021</td>
</tr>
<tr>
<td>22213050000002</td>
<td>01/11/2021</td>
</tr>
</tbody>
</table>
Voiding a Paid Claim

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

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

### EOB Information

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

### Adjustment Information

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

<table>
<thead>
<tr>
<th>Claim Status</th>
<th>DENIED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim TCN</td>
<td>5821305000002</td>
</tr>
<tr>
<td>Denied Date</td>
<td></td>
</tr>
<tr>
<td>Paid Amount</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

### EOB Information

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

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

### Adjustment Information

<table>
<thead>
<tr>
<th>ICH</th>
<th>Date Adjusted</th>
</tr>
</thead>
<tbody>
<tr>
<td>5821305000002</td>
<td>01/11/2021</td>
</tr>
<tr>
<td>5821305000001</td>
<td>01/11/2021</td>
</tr>
<tr>
<td>2221305000002</td>
<td>01/11/2021</td>
</tr>
</tbody>
</table>
Example, cont.
Copying a Paid Claim

- Open the claim you wish to copy
- Click the “copy claim” button at the bottom of the claim
- A new duplicate claim will be created, make and save all necessary changes
- The “submit” and “cancel” buttons will display at the bottom
- Click the “submit” button
- The claim will be assigned a new ICN
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.
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.
Other payer information is entered in the Header – Other Payer panel.

**Table:**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
<th>Date of Birth</th>
<th>Relationship</th>
<th>Gender</th>
<th>Policy ID</th>
<th>Paid Amount</th>
<th>Paid Date</th>
<th>Electronic Payer ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>JONES</td>
<td>DAVID</td>
<td>A</td>
<td>01/01/1950</td>
<td>FATHER</td>
<td>MALE</td>
<td></td>
<td>200.00</td>
<td>10/01/2019</td>
<td>01234</td>
</tr>
</tbody>
</table>

**Fields:**
- **Claim Filing Indicator:** COMMERCIAL INSURANCE
- **Policy Holder Relationship to Insured:** FATHER
- **Policy Holder Last Name:** JONES
- **Policy Holder First Name, MI:** DAVID, A
- **Policy Holder Date of Birth:** 01/01/1950
- **Gender:** MALE
- **Paid Amount:** $200.00
- **Paid Date:** 10/01/2021
- **Electronic Payer ID:** 01234

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

**Allowed Amount:** $0.00
If the Other Payer is a Medicare HMO, select “HMO, Medicare Risk” in the Claim Filing Indicator drop down menu.
The X12 website provides adjustment reason codes (ARCs)

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

**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) for a header pay Other Payer are entered in the Header – Other Payer Amounts and Adjustment Reason Codes panel.
Claims with Other Payers, cont.

ARCs for a detail pay Other Payer are entered in the Detail – Other Payer Amounts and Adjustment Reason Codes panel.
Claims with Other Payers, cont.
### Claims with Other Payers, cont.

#### Header - Other Payer

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim Filing Indicator</td>
<td>COMMERCIAL INSURANCE</td>
</tr>
<tr>
<td>Policy Holder Relationship to Insured</td>
<td>FATHER</td>
</tr>
<tr>
<td>Policy Holder Last Name</td>
<td>SMITH</td>
</tr>
<tr>
<td>Policy Holder First Name, MI</td>
<td>JOHN</td>
</tr>
<tr>
<td>Policy Holder Date of Birth</td>
<td>01/01/1950</td>
</tr>
<tr>
<td>Gender</td>
<td>MALE</td>
</tr>
<tr>
<td>Paid Amount</td>
<td>$200.00</td>
</tr>
<tr>
<td>Paid Date</td>
<td>03/01/2018</td>
</tr>
<tr>
<td>Electronic Payer ID</td>
<td>0077193</td>
</tr>
<tr>
<td>Insurance Carrier Name</td>
<td>BLUE CROSS BLUE SHIELD</td>
</tr>
<tr>
<td>Electronic Payer ID</td>
<td>0077193</td>
</tr>
<tr>
<td>Insured's Policy ID</td>
<td></td>
</tr>
<tr>
<td>Payer Sequence</td>
<td></td>
</tr>
<tr>
<td>Medicare ICN</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>A</td>
<td>PR-Patient Responsibility</td>
<td>1</td>
<td>$50.00</td>
</tr>
</tbody>
</table>

#### Payer Header Level Adjustment Reason Codes (ARC) and Amounts

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Electronic Payer ID</td>
<td>0077193</td>
</tr>
<tr>
<td>CAS Group Code</td>
<td>PR-Patient Responsibility</td>
</tr>
<tr>
<td>ARC</td>
<td>1</td>
</tr>
<tr>
<td>Amount</td>
<td>$50.00</td>
</tr>
</tbody>
</table>
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
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
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
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/
 Companion Guides (EDI)
https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/billing/trading-partners/companion-guides/companion-guides

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

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

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

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