Basic Billing for Nursing Facilities

Provider Relations
2022
Must enter two of the following: tax ID, NPI, or 7 digit Ohio Medicaid provider number.

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

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

IVR: 1-800-686-1516
Helpful Phone Numbers

- 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

Supplemental Security Income (SSI)

• Children, parents, caretakers, and expansion

Modified Adjusted Gross Income (MAGI)

• 65+, or blind/disabled with no SSI

Aged, Blind, Disabled (ABD)
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** 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

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.

- 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.

- 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 managing care, and improve the Medicaid Member experience.

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

Fee Schedule & Rates

Disclaimer about fee schedule and rates available for providers.

Training

- Training presentations, videos, and handouts.

TPA Carrier List

Click download to obtain the full listing of Third Party Administrator (TPA) carrier list and numbers.

Direct Deposit

GBM Shared Services is a business processing center that processes claim 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 1-800-666-1516.

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
- Secure Ohio Medicaid, Agent Account and Access Reports
- Eligibility Search
Eligibility Verification Request

You can search up to 4 years back

TIP: Always check eligibility prior to billing
Eligibility Verification Request

- 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>
</tr>
<tr>
<td>Last Name</td>
</tr>
<tr>
<td>First Name</td>
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<tr>
<td>Gender</td>
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<tr>
<td>Date of Birth</td>
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<tr>
<td>Date of Death</td>
</tr>
<tr>
<td>SSN</td>
</tr>
<tr>
<td>County of Residence</td>
</tr>
<tr>
<td>County of Eligibility</td>
</tr>
<tr>
<td>County Office</td>
</tr>
<tr>
<td>Number Bed</td>
</tr>
<tr>
<td>Hold Days Used</td>
</tr>
<tr>
<td>Paid CY</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Benefit / Assignment Plan</th>
<th>Effective Date</th>
<th>End Date</th>
<th>Provider Name</th>
<th>Dental Co-Pay Amount</th>
<th>Vision Co-Pay Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Schools</td>
<td>07/01/2017</td>
<td>07/31/2021</td>
<td></td>
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<td>$0.00</td>
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<tr>
<td>MRDD Targeted Case Mgmt</td>
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<td></td>
<td>$0.00</td>
<td>$0.00</td>
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<tr>
<td>Alcohol and Drug Addiction Services</td>
<td>07/01/2017</td>
<td>07/31/2021</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
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<tr>
<td>Ohio Mental Health</td>
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<td>$0.00</td>
<td>$0.00</td>
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<tr>
<td>Medicaid</td>
<td>07/01/2017</td>
<td>07/31/2021</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
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</tbody>
</table>

| Associated Child(ren) Search |

<table>
<thead>
<tr>
<th>Medicaid Billing Number</th>
<th>First Name</th>
<th>MI</th>
<th>Last Name</th>
<th>Gender</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>910700745972</td>
<td>IMPERIAL</td>
<td></td>
<td>SMITH</td>
<td>MALE</td>
<td>09/07/2012</td>
</tr>
<tr>
<td>910700745973</td>
<td>CARTIER</td>
<td></td>
<td>JONES</td>
<td>MALE</td>
<td>01/15/2012</td>
</tr>
</tbody>
</table>
Eligibility Verification Request

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

You can review the level of care and determination date, patient liability amounts, long term care placement, and restrictive coverage in these panels.

<table>
<thead>
<tr>
<th>LOC Requested</th>
<th>Status</th>
<th>Determination Date</th>
<th>LOC Determination</th>
<th>Description</th>
<th>LOC Begin Date</th>
<th>LOC End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>09/29/2021</td>
<td>NF; NF WAIVER; RSS</td>
<td>INTERMEDIATE (ILOC)</td>
<td>01/01/2021</td>
<td>06/30/2021</td>
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</table>

<table>
<thead>
<tr>
<th>Financial Payer</th>
<th>Monthly Amount</th>
<th>Type</th>
<th>Effective Date</th>
<th>End Date</th>
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<tr>
<td>DEFAULT</td>
<td>$1,949.00</td>
<td>Nursing Home</td>
<td>08/01/2021</td>
<td>09/30/2021</td>
</tr>
<tr>
<td>DEFAULT</td>
<td>$1,949.00</td>
<td>Nursing Home</td>
<td>07/01/2021</td>
<td>07/31/2021</td>
</tr>
<tr>
<td>DEFAULT</td>
<td>$1,949.00</td>
<td>Nursing Home</td>
<td>06/01/2021</td>
<td>06/30/2021</td>
</tr>
<tr>
<td>DEFAULT</td>
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<td>Nursing Home</td>
<td>05/01/2021</td>
<td>05/31/2021</td>
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<tr>
<td>DEFAULT</td>
<td>$5,319.00</td>
<td>Nursing Home</td>
<td>04/01/2021</td>
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<tr>
<td>DEFAULT</td>
<td>$5,319.00</td>
<td>Nursing Home</td>
<td>03/01/2021</td>
<td>03/31/2021</td>
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<table>
<thead>
<tr>
<th>Facility Type</th>
<th>Date of Admission</th>
<th>Effective Begin Date of Medicaid Coverage</th>
<th>End Date of Medicaid Coverage</th>
<th>Date of Discharge</th>
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<tbody>
<tr>
<td>NURSING FACILITY</td>
<td>09/29/2020</td>
<td>01/01/2021</td>
<td>09/30/2021</td>
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</table>

<table>
<thead>
<tr>
<th>Effective Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/01/2020</td>
<td>02/28/2020</td>
</tr>
</tbody>
</table>

**Special Program**

*** No rows found ***
Patient Liability Discrepancy

Always contact the CDJFS to verify the patient liability amount and dates

If you have made documented multiple attempts to contact the county and there is still a discrepancy, you may reach out to ODM through the “Contact Us” page
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</th>
<th>Date of Birth</th>
<th>PE Type</th>
<th>Date Coverage Begins</th>
<th>Medicaid ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>MISSISSIPPI RIVERS</td>
<td>01/01/1987</td>
<td>PE PREGNANT</td>
<td>05/09/2021</td>
<td>910001331813</td>
</tr>
</tbody>
</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>
<th>Date Coverage Begins</th>
<th>Medicaid ID</th>
</tr>
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<tbody>
<tr>
<td>John Doe</td>
<td>11/19/1959</td>
<td>PE Adult</td>
<td>06/25/2021</td>
<td>910194194194</td>
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</tbody>
</table>
Presumptive Eligibility

The benefit/assignment plan will look like this:

<table>
<thead>
<tr>
<th>Recipient Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Billing Number</td>
</tr>
<tr>
<td>Last Name</td>
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<tr>
<td>First Name</td>
</tr>
<tr>
<td>Gender</td>
</tr>
<tr>
<td>Date of Birth</td>
</tr>
<tr>
<td>Date of Death</td>
</tr>
<tr>
<td>County of Residence</td>
</tr>
<tr>
<td>County of Eligibility</td>
</tr>
<tr>
<td>County Office</td>
</tr>
<tr>
<td><a href="http://jfs.ohio.gov/county/cntydir.stm">http://jfs.ohio.gov/county/cntydir.stm</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Benefit / Assignment Plan</th>
<th>Effective Date</th>
<th>End Date</th>
<th>Provider Name</th>
<th>Dental Co-Pay Amount</th>
<th>Vision Co-Pay Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRESUMPTIVE:MRDD Targeted Case Mgmt</td>
<td>02/14/2019</td>
<td>09/30/2021</td>
<td>$0.00</td>
<td>$0.00</td>
<td></td>
</tr>
<tr>
<td>PRESUMPTIVE:Alcohol and Drug Addiction Services</td>
<td>02/14/2019</td>
<td>09/30/2021</td>
<td>$0.00</td>
<td>$0.00</td>
<td></td>
</tr>
<tr>
<td>PRESUMPTIVE:Medicaid</td>
<td>02/14/2019</td>
<td>09/30/2021</td>
<td>$0.00</td>
<td>$0.00</td>
<td></td>
</tr>
<tr>
<td>PRESUMPTIVE:Ohio Mental health</td>
<td>02/14/2019</td>
<td>09/30/2021</td>
<td>$0.00</td>
<td>$0.00</td>
<td></td>
</tr>
</tbody>
</table>
Issued to qualified consumers who receive Medicare. Medicaid only covers their monthly Medicare premium, co-insurance and/or deductible after Medicare has paid. Reimbursement policy is set under 5160-1 and can result in a payment of zero dollars.
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>
<thead>
<tr>
<th>Recipient Information</th>
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<tbody>
<tr>
<td>Medicaid Billing Number</td>
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<td>Last Name</td>
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<tr>
<td>First Name</td>
</tr>
<tr>
<td>Gender</td>
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<tr>
<td>Date of Birth</td>
</tr>
<tr>
<td>Date of Death</td>
</tr>
<tr>
<td>SSN</td>
</tr>
<tr>
<td>County of Residence</td>
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<tr>
<td>County of Eligibility</td>
</tr>
<tr>
<td>County Office</td>
</tr>
<tr>
<td>Number/Bed Hold Days</td>
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<td>Used/Paid CY</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Benefit / Assignment Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit / Assignment Plan</td>
</tr>
<tr>
<td>Qualified Medicare Beneficiaries</td>
</tr>
<tr>
<td>Effective Date</td>
</tr>
<tr>
<td>10/24/2016</td>
</tr>
<tr>
<td>End Date</td>
</tr>
<tr>
<td>05/30/2021</td>
</tr>
<tr>
<td>Provider Name</td>
</tr>
<tr>
<td>Dental Co-Pay Amount</td>
</tr>
<tr>
<td>$0.00</td>
</tr>
<tr>
<td>Vision Co-Pay Amount</td>
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<td>$0.00</td>
</tr>
</tbody>
</table>

Associated Child(ren) Search
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>
<th>Effective Date</th>
<th>End Date</th>
<th>Provider Name</th>
<th>Dental Co-Pay Amount</th>
<th>Vision Co-Pay Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>SLMB</td>
<td>05/01/2017</td>
<td>07/31/2021</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

This is what will appear if the individual has QI 1/QI 2:

<table>
<thead>
<tr>
<th>Benefit / Assignment Plan</th>
<th>Effective Date</th>
<th>End Date</th>
<th>Provider Name</th>
<th>Dental Co-Pay Amount</th>
<th>Vision Co-Pay Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>QI 1/QI 2</td>
<td>04/26/2017</td>
<td>07/31/2021</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
</tbody>
</table>
Managed Care & MyCare Ohio
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
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
MITS Managed Care Eligibility

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.
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.
Traditional Managed Care Plans

- CareSource: 800-488-0134, https://www.CareSource.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

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 í...

Resources for Providers >

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

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

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

MITS
Medicaid Information Technology Information System (MITS) Resources

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

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

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:

- Maintain records for 6 years
- Inform ODM of any changes to your provider profile within 30 days
- Render medically necessary services in the amount required
- Recoup any third party resources available
- Maintain records for 6 years
- 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
Updating Demographic Information in MITS

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

Provider Information

- Medicaid Provider ID: 0404040 MCD
- National Provider ID: 1578515763 NPI
- Practice Type: OTHER
- Provider Type: 86 - NURSING FACILITY
- Ownership: NO
- Medicaid Effective Date: 08/03/1979
- Medicaid End Date: 05/19/2021

Address Type: PRACTICE LOCATION
- Address: 1111 COLONY RD
- City: WESTERVILLE
- County: FRANKLIN
- State/Zip: OH 43081-3624
- Phone: 614-505-5055
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.
Missed appointment fee
Unacceptable or untimely claim submission
Failure to request a prior authorization
Retroactive Peer Review stating lack of medical necessity

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:
When Can You Bill an Individual?

- Notified in writing prior to the service that Medicaid will not be billed.
- Explains the service could be free by another provider.
- Agrees to be liable for payment and signs a 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.

- Nursing Facility Provider Associations and ODM website
- Medicaid Advisory Letter (MAL)
- Medical Transmittal Letter (MTL)
Policy

Resources for Providers

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

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

MITS
Medicaid Information Technology Information System (MITS) Resources

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.

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

Prior Authorization Requirements
Prior Authorization Requirements

Medicaid Eligibility Procedure Letters (MEPLs)
Announcements of non-OAC policy changes that affect Medicaid eligibility

Medicaid Eligibility Manual Transmittal Letters (MEMTTLs)
Summaries of OAC rule changes concerning Medicaid eligibility

Medicaid Transmittal Letters (MTLs), Medicaid Handbook
Summaries of OAC rule changes concerning non-institutional services

Medicaid Advisory Letters (MALs)
Clarifications of non-institutional services policy not related directly to OAC rule changes

Hospital Handbook Transmittal Letters (HHTLs)
Summaries of OAC rule changes concerning hospital services

eManuals (Pre-July 2015)
Archive of policy documents dating from a time when Medicaid was part of the Ohio

Managed Care Policy Guidance Letters
Clarifications of policy pertaining to Medicaid managed care
Policy

Stakeholders & Partners
Ohio Medicaid achieves its health care mission with the strong support and collaboration of our stakeholder partners - state health and human services agencies, associations, advocacy groups, and individuals who help us administer the program today and modernize it for the next generation of...

CMP Reinvestment Program
Civil money penalties (CMPs) are fines imposed on nursing facilities that do not meet federal health and safety standards.

Helpful Links
Not seeing what you are looking for? We want to help you find the information you need. Check out these links to federal and state... Iniatives
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
• ORC - Ohio Revised Code
• CFR - Code of Federal Regulations
• Title 19 - Compilation Of The Social Security Laws
• OAC - Ohio Administrative Code

Rule Renumbering
• Rules Renumbering

Medicaid Regulatory Restriction Inventory
• Medicaid Regulatory Restriction Inventory

Rule Related Sites
• Common Sense Initiative Office
Policy

https://codes.ohio.gov
Nursing Facility Information

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Provider Hotline
Have questions or need assistance? Call our Provider Hotline at 800-486-1516.

Provider Enrollment
Resources for enrolling as an Ohio Medicaid provider.

Long Term Care
Resources for Long Term Care providers.

Provider Types
Supplementary Information by Provider Service Type.

• Medicaid Eligibility Manual
• Medicaid School Program
• Nursing Facilities (More Information)
• Ohio Home Care Waiver (More Information)
• Outpatient Health Facility Services (More Information)
Nursing Facility Documents

- Nursing Facility Rates and High Occupancy Rates – Updated July 2022
- LTC Claim Revenue Center Codes for NFs – Revised October 2021
- Most Common Scenarios Chart: PASRR and Level of Care (LOC) – Revised May 2016
- Cost Reporting FAQs – Published March 2021
- Nursing Facility Cost Reporting FAQ – Updated March 2021
- Case Mix Questions and Answers – Published April 2018
A LOC determination may occur face-to-face, by a desk review, or by telephone in order to:

- Authorize Medicaid payment to a NF
- Approve Medicaid payment of a NF-based home and community-based services (HCBS) waiver or other NF-based level of care program

A telephone, video conference, or desk review may be conducted in lieu of face-to-face unless the needs require a face-to-face visit.
- All adverse LOC determinations require a face-to-face visit
Provider Agreement: OAC 5160-1-17.2

- Maintaining records
  - Providers must maintain all records necessary to fully disclose the extent of services provided
  - These records must be maintained for a period of six years from the date of receipt of payment or until any audit initiated within the required six year record maintenance period is completed
  - Failure to supply requested records within 30 days shall result in withholding of Medicaid payments and may result in termination from the Medicaid program
Covered Days and Bed-hold Days: OAC 5160-3-16.4

- **Occupied Day**
  - A day of admission or readmission
  - A day during which a Medicaid eligible resident’s stay in a NF is eight hours or more, and for which the NF receives the full per resident per day payment
  - When NF admission and discharge occur on the same day, even if it is less than eight hours

- A day begins at twelve a.m. and ends at eleven fifty-nine p.m.
- The day of NF discharge is not counted as either a bed-hold or an occupied day
Covered Days and Bed-hold Days: OAC 5160-3-16.4

- Limits and payment for NF bed-hold days
  - Covered days
    - A day in which the individual is temporarily absent from the NF for hospitalization, therapeutic leave days, or visits with friends or relatives
    - Resident must intend to return to the facility
    - Limited to 30 calendar days per resident, per year
    - Payment is considered payment in full, and the NF provider shall not seek supplemental payment from the resident
Covered Days and Bed-hold Days: OAC 5160-3-16.4

- Bed-hold days exclusions
  - Hospice
  - Institutions for mental diseases (IMDs)
  - HCBS waiver individual using NF for short-term respite care
  - Restricted Medicaid Coverage
  - Facility closure and resident relocation
Bed-hold days are not available to individuals who are discharged, including:

- Those residents who are temporarily or permanently admitted to another NF
- Exhaustion of NF bed-hold days
- Decision to reside in a community-based setting
- Death
Residents eligible for payment of NF bed-hold days must:

- Be Medicaid eligible and meet patient liability and financial eligibility
- Meet a NF LOC or be using Medicare part A SNF benefit
- Not participating in any excluded categories as indicated in (K) of this rule

Dual-eligible for both Medicare and Medicaid

- If a resident is both Medicare part A and Medicaid eligible, Medicaid payment shall be made for NF bed-hold days up to 30 calendar days per year
- A Level of Care evaluation is not necessary if:
  - A resident receives Medicare part A skilled nursing facility (SNF) benefits in the NF
  - A part A SNF resident in a NF is transferred to the hospital, and the NF bills the hospital bed-hold days to Medicaid
Waiver Individuals

CDJFS caseworkers do not suspend an individual’s waiver span during a short-term NF stay – 90 days

Waiver individuals who become permanent NF residents will have their waiver enrollment ended
Waiver Individuals

- NF therapeutic leave days and visits with friends and family are not payable for NF residents who are on a HCBS waiver and temporarily leave the NF and do not count towards the annual leave day limit, per OAC 5160-3-16.4(D)(4)(b)(iii)

- When admitting someone who is on a waiver it is best to notify the waiver case management agency

- Need to bill using revenue center code 160 for days during the waiver enrollment
The entire monthly amount of patient liability shall be reported by the NF on the individual’s monthly claim:

- In the month of admission, discharge, or death, the entire monthly amount shall still be reported on the claim for that month.
- If the individual is switched from Medicare to Medicaid mid-month, the entire amount shall still be reported on the claim for that month.
- If the patient liability exceeds the amount Medicaid would cover, the claim shall be processed with a payment of zero dollars.
- If the patient liability is adjusted after the initial claim payment, the NF should submit a claim adjustment upon receipt of this change.
Individuals are required to report a change of income, one-time gifts or payments, changes in health insurance coverage, etc.

- Found in OAC 5160:1-2-08 (B)(1)(d)

This form can be used to report any of those changes to the CDJFS

- A Medicaid individual or a designated authorized representative may complete this form
ODM Form 10203

Ohio Department of Medicaid

REPORT A CHANGE FOR MEDICAL ASSISTANCE

Use this form to report any changes for individuals receiving medical assistance and/or their household members. Check the box for each type of change, provide the requested information for that section, and provide the effective date of the change. The Individual Information and Submitter Information sections on the form must be completed. Required fields are marked with an asterisk (*).

You should submit current supporting documents along with this report a change form.

<table>
<thead>
<tr>
<th>INDIVIDUAL INFORMATION</th>
<th>Complete this section for the individual receiving medical assistance. *Indicates required field</th>
</tr>
</thead>
<tbody>
<tr>
<td>*First Name</td>
<td>*Last Name</td>
</tr>
<tr>
<td>Date of Birth (mm/dd/yyyy)</td>
<td>Medicaid Case Number</td>
</tr>
<tr>
<td>*Social Security Number</td>
<td></td>
</tr>
</tbody>
</table>

Has this person been in an accident in the past 12 months?  
☐ Yes  ☐ No  
(If Yes, explain details in the comment section on page two of this form and provide supporting documentation or verification.)

CHANGE NOTIFICATIONS  Check the box if there has been a change in information and enter the effective date.  
Only complete the sections below where information has changed.

☐ Phone Number Change  
Effective Date of Change

☐ Address Change (attach verification of change such as a rent/mortgage receipt, lease, or utility receipts)  
Effective Date of Change (mm/dd/yyyy)

New Street Address  
Apartment/Unit Number

City  
State  
Zip Code  
Phone  
County
Lump Sums: OAC 5160-3-39.1

- If a resident receives a lump sum, report it to the CDJFS
- The CDJFS will work with the resident to determine how the lump sum will be handled and will notify the NF of any amount to be reported on the NF claims
  - Submit adjustments to as many prior months as necessary to offset the amount assigned to the facility
  - Apply any remaining money to current and future claims if needed
  - Report on the claim using **value code 31**
    - Although this value code description indicates “patient liability amount,” it is specifically referring to the lump sum amount and not the individual’s monthly patient liability amount

<table>
<thead>
<tr>
<th>Sequence</th>
<th>Value</th>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>31</td>
<td>PATIENT LIABILITY AMOUNT</td>
<td>4621.00</td>
</tr>
</tbody>
</table>

Select row above to update - or - click add an item button below.
Lump Sums: OAC 5160-3-39.1

Example:

• A resident receives a $12,000 lump sum in July 2021
• Their normal PL amount is $1,000 per month
• Assume the billed amount each month is $6,000

July Claim: enter the PL of $1,000 & value code 31 with amount of $12,000
• Claim will pay $0 and remaining lump sum will be $7,000

Aug. Claim: enter the PL of $1,000 & value code 31 with amount of $7,000
• Claim will pay $0 and the remaining lump sum will be $2,000

Sept. Claim: enter the PL of $1,000 & value code 31 with amount of $2,000
• Claim will pay $3,000
Timely filing limitations

- Claims must be received within 365 days of the actual date the service was provided.
- Denied claims may be re-submitted for payment and must be received within 365 days from the actual date of service or 180 days from the date the claim denied, even if this date is beyond 365 days from the date of service.
- Claims with prior payment by Medicare or another insurance plan must be received within 180 days from the date Medicare or the insurance plan paid the claim.
Adjustments to a Paid Claim: OAC 5160-3-39.1

- **Underpaid claims**
  - Must submit an adjustment within 180 days of the date the underpaid claim was paid by ODM

- **Overpaid claims**
  - Must submit an adjustment within 60 days of discovering the overpayment

- **ODM may notify a provider an adjustment is needed**
  - Providers shall make the adjustment within 60 days of notification
  - If a provider fails to make the adjustment, ODM shall either make the adjustment or void the claim
The NF per diem rate includes the Medicaid payments for Medicare or other
third-party insurance cost-sharing, including coinsurance or deductible
payments, associated with services that are included in the NF per diem rate

Neither the resident nor ODM is responsible for any Medicare or other third-
party insurance cost-sharing, including coinsurance or deductibles, associated
with services that are included in the NF per diem rate

The claim should auto-cross from Medicare to Medicaid on an institutional
part A claim form

• If the payment is not received in an appropriate timeframe, submit the claim directly to
Medicaid
Resident Relocation: 5160-3-02.7

- A NF may temporarily relocate residents for emergencies of 30 days or less for reasons such as:
  - Tornado, severe storms, floods, or other natural disasters
  - Fire
  - Explosion
  - Loss of electrical power
  - Release of hazardous chemicals or materials
  - Outbreak of contagious disease
  - Civil disturbance such as a riot
  - Labor strike that results in a decrease of staff members below that necessary for resident care
Resident Relocation: 5160-3-02.7

- The residents will remain as active residents for the originating NF who will bill Medicaid
- The originating NF will receive payment and make arrangements to pay the receiving NF for the DOS the displaced resident is in their facility
- The originating NF must follow the guidance provided in the Nursing Facility Temporary Relocation Fact Sheet:
  - [https://medicaid.ohio.gov/static/Providers/ProviderTypes/LongTermCare/FactSheets/TempRelocation.pdf](https://medicaid.ohio.gov/static/Providers/ProviderTypes/LongTermCare/FactSheets/TempRelocation.pdf)
Most Common Revenue Center Codes

0101 - Full covered day

0160 – Full day: short-term stay for Waiver consumers

0183 - Leave day: therapeutic

0185 - Leave day: hospital
PA1 / PA2 Revenue Center Codes

0220 – Flat fee full covered day

0169 – Flat fee full day: short-term stay for Waiver consumer

0189 – Flat fee leave day
Vent Weaning Revenue Center Codes

0419 – Vent-dependent services

0410 – Vent weaning services

These days will only pay if the NF is approved for the NF ventilator program
MITS & Claims
Billing Resources

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Programs & Initiatives
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Need Technical Assistance?
Give us a call on our Provider Hotline 800-686-1516.
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](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 an Institutional Claim
Submission of an Institutional Claim

<table>
<thead>
<tr>
<th>Institutional Claim:</th>
<th>SERVICE INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>BILLING INFORMATION</td>
<td>NOT ALLOWED TO RELEASE DATA</td>
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<tr>
<td>ICN</td>
<td></td>
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<tr>
<td>Claim Received Date</td>
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<td>Provider ID</td>
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<td>*Type Of Bill</td>
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<td>Claim Type</td>
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<td>*Medicaid Billing Number</td>
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<tr>
<td>*Date of Birth</td>
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<tr>
<td>Last Name</td>
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<tr>
<td>First Name, MI</td>
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<tr>
<td>*Patient Account #</td>
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</tr>
<tr>
<td>Medical Record #</td>
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<tr>
<td>*Attending Physician #</td>
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<tr>
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</tr>
<tr>
<td>*First Name, MI</td>
<td></td>
</tr>
<tr>
<td>Operating Physician #</td>
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<tr>
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</table>

<table>
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<tr>
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<th>Inpatient Procedure</th>
<th>Occurrence/Span</th>
<th>Value</th>
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<table>
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<tr>
<td>Total Non Covered Charges</td>
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</tr>
<tr>
<td>Total Covered Charges</td>
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</tr>
<tr>
<td>Medicaid Copay Amount</td>
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<tr>
<td>Note Reference Code</td>
<td></td>
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<tr>
<td>Notes</td>
<td></td>
</tr>
</tbody>
</table>
Diagnosis Code: Required on Most Claims

Must include all characters specified by ICD
Do NOT enter the decimal points
There are system edits and audits against those codes

<table>
<thead>
<tr>
<th>Sequence</th>
<th>Diagnosis Code</th>
<th>Description</th>
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<tbody>
<tr>
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<tr>
<td>Other</td>
<td>E039</td>
<td>HYPOTHYROIDISM, UNSPECIFIED</td>
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<tr>
<td>Other</td>
<td>E559</td>
<td>VITAMIN D DEFICIENCY, UNSPECIFIED</td>
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<tr>
<td>Other</td>
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<tr>
<td>Other</td>
<td>I159</td>
<td>SECONDARY HYPERTENSION, UNSPECIFIED</td>
<td></td>
</tr>
</tbody>
</table>

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

Per OAC 5160-3-39.1(6), a claim is to include all the days of the given month.
Submission of an Institutional Claim

Claim with no discharge or leave days

<table>
<thead>
<tr>
<th>Item</th>
<th>Date of Service</th>
<th>Revenue Code</th>
<th>HCPCS/HCPCS Rate Codes</th>
<th>Units</th>
<th>Total Charges</th>
<th>NonCovered Charges</th>
<th>Medicaid Allowed Amount</th>
<th>Status</th>
<th>Modifier 1</th>
<th>Modifier 2</th>
<th>Modifier 3</th>
<th>Modifier 4</th>
<th>Final EAPG</th>
</tr>
</thead>
<tbody>
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<td></td>
<td>31.00</td>
<td>$7,300.00</td>
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<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.
# Submission of an Institutional Claim

## Claim with leave days

<table>
<thead>
<tr>
<th>Item</th>
<th>Date of Service</th>
<th>Revenue Code</th>
<th>Rate Codes</th>
<th>Units</th>
<th>Total Charges</th>
<th>NonCovered Charges</th>
<th>Medicaid Allowed Amount</th>
<th>Status</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>
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<td></td>
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<td>$5,875.00</td>
<td>$0.00</td>
<td>$0.00</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.
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.

The following messages were generated:

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

ICN: 2221170357321
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
5821185127250
Originally paid $45.00
Now paid $50.00
Additional payment of $5.00

2021172234001
5021173127250
Originally paid $50.00
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 Originally paid $45.00
5821185127250 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
Nursing Facility Claim Examples
Short-Term Waiver Stay – Entire Month Waiver

This individual is on a Waiver benefit and was in the NF for the entire month of their short-term stay.

<table>
<thead>
<tr>
<th>Item</th>
<th>Date of Service</th>
<th>Revenue Code</th>
<th>HCPCS/HIPPS Rate Codes</th>
<th>Units</th>
<th>Total Charges</th>
<th>NonCovered Charges</th>
<th>Medicaid Allowed Amount</th>
<th>Status</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>07/01/2021</td>
<td>160</td>
<td></td>
<td>31.00</td>
<td>$7,600.00</td>
<td>$0.00</td>
<td>$0.00</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.

*Units Of Measurement: Days
*Per Diem Rate: $0.00
*Total Charges: $7,600.00
Non Covered Charges: $0.00
Medicaid Allowed Amount: $0.00
Status: Final EAPG
Pay Action:
Short-Term Waiver Stay – Partial Month Waiver

This individual is on a Waiver benefit that closed effective 8/20/2021 when they became a permanent NF resident.

<table>
<thead>
<tr>
<th>Item</th>
<th>Date of Service</th>
<th>Revenue Code</th>
<th>Rate Codes</th>
<th>Units</th>
<th>Total Charges</th>
<th>NonCovered Charges</th>
<th>Medicaid Allowed Amount</th>
<th>Status</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>08/21/2021</td>
<td>101</td>
<td></td>
<td>11.00</td>
<td>$2,695.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>08/01/2021</td>
<td>160</td>
<td></td>
<td>20.00</td>
<td>$4,900.00</td>
<td>$0.00</td>
<td>$0.00</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.
Two Day Hospital Leave Stay

This individual was admitted to the hospital on 6/26/2021 at 6:00am and was discharged back to the NF on 6/28/2021 at noon.

<table>
<thead>
<tr>
<th>Item</th>
<th>Date of Service</th>
<th>Revenue Code</th>
<th>Revenue HIPPS Rate Codes</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>06/28/2021</td>
<td>101</td>
<td></td>
<td>3.00</td>
</tr>
<tr>
<td>A</td>
<td>06/26/2021</td>
<td>185</td>
<td></td>
<td>2.00</td>
</tr>
<tr>
<td>A</td>
<td>06/01/2021</td>
<td>101</td>
<td></td>
<td>25.00</td>
</tr>
</tbody>
</table>

Select row above to update—or—click add an item button below.
Overnight Hospital Stay After 8 Hours in NF

This individual was admitted to the hospital on 10/17/2021 at 3:00pm and discharged back to the NF on 10/18/2021.
Overnight Hospital Stay Under 8 Hours in NF

This individual was admitted to the hospital on 6/17/2021 at 3:00am and discharged back to the NF on 6/18/2021

<table>
<thead>
<tr>
<th>Item</th>
<th>Date of Service</th>
<th>Revenue Code</th>
<th>HCPCS/HIPPS Rate Codes</th>
<th>Units</th>
<th>Total Charges</th>
<th>NonCovered Charges</th>
<th>Medicaid Allowed Amount</th>
<th>Status</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>06/18/2021</td>
<td>101</td>
<td></td>
<td>13.00</td>
<td>$3,185.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>06/17/2021</td>
<td>185</td>
<td></td>
<td>1.00</td>
<td>$245.00</td>
<td>$0.00</td>
<td>$0.00</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>06/01/2021</td>
<td>101</td>
<td></td>
<td>16.00</td>
<td>$3,920.00</td>
<td>$0.00</td>
<td>$0.00</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.
Low Acuity PA1 / PA2 Individual

This individual has a lower acuity and discharged on 4/6/2021 at 7:00am and returned on 4/11/2021

*Note the different revenue codes used for low acuity*

<table>
<thead>
<tr>
<th>Item</th>
<th>Date of Service</th>
<th>Revenue Code</th>
<th>Rate Codes</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>04/11/2021</td>
<td>220</td>
<td></td>
<td>20.00</td>
</tr>
<tr>
<td>A</td>
<td>04/06/2021</td>
<td>189</td>
<td></td>
<td>5.00</td>
</tr>
<tr>
<td>A</td>
<td>04/01/2021</td>
<td>220</td>
<td></td>
<td>5.00</td>
</tr>
</tbody>
</table>

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

*Units* 5.00

*Units Of Measurement*

- Per Diem Rate $0.0000
- Total Charges $750.00
- Non Covered Charges $0.00

Medicaid Allowed Amount $0.00

Status

Final EAPG

Pay Action
Providers have 365 days to submit Fee For Service 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
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”.

![Billing Information](image-url)
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
Uploading an Attachment

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

<table>
<thead>
<tr>
<th>Type of Document</th>
<th>Transmission Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>*Type of Document</td>
<td>*Transmission Type</td>
</tr>
</tbody>
</table>

For attachments submitted via mail, not electronically attached, please send to the appropriate address. A button for printing a cover page and a button to view mailing addresses will appear after the claim has been submitted.

For documents transmitted via Upload, an upload button will appear after the claim has been submitted. Only file types of gif, tiff, bmp, jpg, ppt, doc, xls, pdf, txt, and mdi can be uploaded.
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
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
You may use a RA to see how much patient liability was deducted from a claim.
Resources, Websites, & Forms
Mailboxes

- **NFPolicy@medicaid.ohio.gov** – For questions regarding nursing facility rules and policy requirements
- **NFStay@medicaid.ohio.gov** – For questions regarding nursing facility admissions and/or discharges
- **MDSCaseMix@medicaid.ohio.gov** – For questions regarding Case Mix
- **HCBSPolicy@medicaid.ohio.gov** – For questions regarding HCBS Waivers and other long-term services and support
- **OhioMCD-EDI-Support@dxc.com** or 844-324-7089 – For questions regarding EDI related issues
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)
- Long-Term Care provider page
- Managed Care page
  [https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/managed-care/managed-care](https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/managed-care/managed-care)
Websites

- Ohio Administrative Codes
  http://codes.ohio.gov/oac/5160
- MITS home page
  https://www.ohmits.com/prosecure/authtam/handler?TAM_OP=login&URL=%2FPortal%2FDesktopModules%2FiC_Authenticate%2FSignIn.aspx%3FReturnUrl%3D%252fPortal%252f
- Information for Trading Partners (EDI)
  https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/billing/trading-partners/trading-partners
- Companion Guides (EDI)
  https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/billing/trading-partners/companion-guides/companion-guides
Other Resources

- For Medicaid eligibility and patient liability issues – contact the local County Department of Job and Family Services (CDJFS) that is handling the Medicaid case

- For Managed Care issues – Contact the Managed Care Plan directly. Provider complaints can be filed through the Managed Care link listed in previous slides

- For Fee For Service issues, contact the IVR at 800-686-1516
## Medicaid Forms

**Ohio Department of Medicaid Forms Library**

### Order Forms/Email Requests

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

**Search:**

<table>
<thead>
<tr>
<th>File Name</th>
<th>Language</th>
<th>Form Name</th>
</tr>
</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)
Forms

- ODM 03623 – Provider Agreement for LTC Facilities
- ODM 10203 – Report a Change for Medical Assistance
- ODM 06614 – Health Insurance Fact Request
- ODM 06653 – Medical Claim Review Request