Basic Billing for Ambulance & Wheelchair Van Transportation Providers

Provider Relations
2021
Programs & Cards
Managed Care/MyCare Ohio
Provider Responsibilities
Policy
Provider Network Management
MITS & Claim Submission
Websites
Forms
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

Eligibility Verification Request

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 get started.

Managed Care

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

MITS

Medicaid Information Technology Information System (MITS) Resources

Policies & Guidelines

Ohio Medicaid Policy is developed at the federal and state level. It guides how we operate our programs and how we regulate our

Programs & Initiatives

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

Direct Deposit

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

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.

Eligibility Search

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

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

- Presumptive Eligibility (PE) Portal Walk Through for Qualified Entities
- Remote Access - MITS Agent Account and Access Report
- Eligibility Search
Eligibility Verification Request

You can search up to 4 years back

TIP: Always check eligibility prior to billing
Eligibility Verification Request

**Recipient Information**

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<tr>
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<th>SSN</th>
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**Benefit / Assignment Plan**

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Inpatient Hospital Services Plan (IHSP)

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Presumptive Eligibility

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### Benefit / Assignment Plan

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QMB

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<tr>
<td>Qualified Medicare Beneficiaries</td>
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Can I bill them?

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

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

Federal law bars Medicare providers and suppliers from billing an individual enrolled in the QMB program for Medicare Part A and Part B cost sharing for covered items and services (see Sections 1902(n)(3)(B), 1902(n)(3)(C), 1905(p)(3), 1866(a)(1)(A), and 1848(g)(3)(A) of the Social Security Act [the Act]). The QMB system updates are part of CMS’ ongoing efforts to help providers comply with QMB billing prohibitions.
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| County Office [http://jfs.ohio.gov/county/cntydir.htm](http://jfs.ohio.gov/county/cntydir.htm) |
| Number Bed Hold Days Used | Paid CY |

### Benefit / Assignment Plan

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Programs & Cards

- Presumptive Eligibility

  - This is a limited benefit to allow time for full determination of eligibility for medical assistance
  - It has been expanded to provide coverage for parent and caretaker relatives and extension adults
  - Covers children up to age 19 and pregnant women
Presumptive Eligibility

Members will receive a Presumptive Eligibility letter if a state qualified entity determines presumptive eligibility.

Presumptive Eligibility

MISSISSIPPI RIVERS
21 S FRONT ST
COLUMBUS, OH 43215

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

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

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

APPROVED:

<table>
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<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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<thead>
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<th>Name (First, M.I., Last Name)</th>
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Managed Care & MyCare
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

<table>
<thead>
<tr>
<th>Benefit / Assignment Plan</th>
<th>Effective Date</th>
<th>End Date</th>
<th>Provider Name</th>
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## Case/Cat/Seq Spenddown

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## TPL

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## Managed Care

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MyCare Ohio is a demonstration project that integrates Medicare and Medicaid services into one program, operated by a Managed Care Plan.

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

The project is currently slated to end on December 31, 2022.
### MITS Eligibility MyCare Opt-In

#### Benefit / Assignment Plan

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## MITS Eligibility MyCare Opt-Out

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### Case/Cat/Seq Spenddown

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### TPL

*** No rows found ***

### Managed Care

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<td>HMO, MyCare Ohio</td>
<td>07/01/2018</td>
<td>09/30/2021</td>
<td>Medicaid Only</td>
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### Lock-In

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### Medicare

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<td>PART D</td>
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</table>
Submitting a Managed Care Complaint

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
- 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

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

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

<table>
<thead>
<tr>
<th>Ordering Provider NPI</th>
<th>Ordering Provider Name</th>
</tr>
</thead>
<tbody>
<tr>
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<td>SMITH, JOHN D</td>
</tr>
<tr>
<td>1034134734</td>
<td>SMITH, JOHN A</td>
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<tr>
<td>14227221122</td>
<td>SMITH, JOHN M</td>
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<tr>
<td>1206206106</td>
<td>SMITH, JOHN R</td>
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<td>1237137537</td>
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<tr>
<td>1019019719</td>
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</tr>
<tr>
<td>1245745245</td>
<td>SMITH, JOHN P</td>
</tr>
</tbody>
</table>

1 2 3 4 5 6 7 8 9 10 ... Next >
ORP Search
A provider may **NOT**
collect and/or bill for
any difference between
the Medicaid payment
and the provider’s
charge, or for the
following:

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

- Notified in writing prior to the service that Medicaid will not be billed
- Agrees to be liable for payment and signs statement
- Explain the service could be free by another provider
- Notified in writing prior to the service that Medicaid will not be billed
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 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 ____________
Provider Responsibilities

• Wheelchair Van Services: OAC 5160-15-22
  » Payment may be made for the following services:
    ▪ Transport by wheelchair van
    ▪ Mileage, wheelchair van
    ▪ Attendant services
Provider Responsibilities

- Ground Ambulance Services: OAC 5160-15-23
  
  » Payment may be made for the following services:
    
    - Basic life support, provided in both a non-emergency and emergency
    - Advanced life support, level 1, both emergency and non-emergency
    - Advanced life support, level 2
    - Specialty care transport
    - Mileage, ground ambulance
    - Attendant service, ground ambulance
Provider Responsibilities

• Air Ambulance Services: OAC 5160-15-24

  » Payment may be made for the following services:
    ▪ Ambulance transport, fixed-wing
    ▪ Ambulance transport, rotary-wing
    ▪ Mileage, fixed-wing ambulance
    ▪ Mileage, rotary-wing ambulance
Provider Responsibilities

• Surveillance and Utilization Review Section (SURS)

» Top ten provider types reviewed by SURS:

1. Home Health Services
2. Durable Medical Equipment
3. Skilled Nursing Facilities
4. Physician Services
5. Private Duty Nursing
6. Wheelchair Van Services
7. Hospice Services
8. Ambulance Services
9. Prescribed Drugs
10. Labs
Provider Responsibilities

• SURS, cont.

» Review records and/or claims for compliance with ODM rules which include:
  ▪ Unauthorized services
  ▪ Up-coding
  ▪ Unbundling
  ▪ Documentation issues
Provider Responsibilities

• SURS, cont.

  » Limited Scope Reviews can be accomplished by:

  Data Mining
  Record Requests
  Desk Reviews
  Onsite Reviews
Provider Responsibilities

• SURS, cont.

  » Review details:
    ▪ Up to 6 years can be reviewed by SURS

  » Potential outcomes of Limited Scope Reviews:
    ▪ No identified overpayment
    ▪ Overpayment identification or referral to the Ohio Attorney General (Medicaid Fraud Control Unit)
Provider Responsibilities

• SURS, cont.

As of 4/1/20 the interest rate was set at 3.25%
Policy
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...
Policy

https://codes.ohio.gov
How to Find Modifiers Recognized by Ohio Medicaid

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...
Policy

• Transportation service from an eligible provider: 5160-15-21

  » The following practitioners may certify the necessity of either a wheelchair van service or an ambulance service:

    ▪ Advanced Practice Registered Nurse (APRN)
    ▪ Doctor of medicine, osteopathy or podiatric medicine
    ▪ Physician Assistant
    ▪ Any other professional recognized by ODM as having prescriptive authority
Policy

• Transportation service from an eligible provider: 5160-15-21

  » The following practitioners may certify the necessity of a wheelchair van service:
    ▪ Chiropractor
    ▪ Licensed Practical Nurse (LPN) or Registered Nurse (RN)
    ▪ Occupational Therapist or Physical Therapist
    ▪ Psychologist
    ▪ Certified rehabilitation counselor
    ▪ Any other professional recognized by ODM as having the qualifications necessary to determine whether an individual needs a mobility device
Policy

• Wheelchair Van Services: OAC 5160-15-22
  » Payment may be made for the following services:
    ▪ Transport by wheelchair van
    ▪ Mileage, wheelchair van
    ▪ Attendant services
Policy

- Ground Ambulance Services: OAC 5160-15-23

  » Payment may be made for the following services:
    - Basic life support, provided in both a non-emergency and emergency
    - Advanced life support, level 1, both emergency and non-emergency
    - Advanced life support, level 2
    - Specialty care transport
    - Mileage, ground ambulance
    - Attendant service, ground ambulance
Policy

• Air Ambulance Services: OAC 5160-15-24
  » Payment may be made for the following services:
    ▪ Ambulance transport, fixed-wing
    ▪ Ambulance transport, rotary-wing
    ▪ Mileage, fixed-wing ambulance
    ▪ Mileage, rotary-wing ambulance
MITS & Claims
MITS and Claims

Medicaid Information Technology System (MITS)

- MITS is a web-based application that is accessible via any modern browser
- MITS design is based upon the Medicaid Information Technology Architecture (MITA)
- MITS is able to process transactions in “real time”
MITS and Claims

- Methods of Claim Submission

- Electronic Data Interchange (EDI): Fees for claims submitted received by Wednesday at Noon for weekend adjudication.

- MITS Portal: Free submission received by Friday at 5:00 P.M. for weekend adjudication.
MITS and Claims

• 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
MITS and Claims

- Submission of a Professional Claim
MITS and Claims

• Submission of a Professional Claim, cont.
MITS

• Submission of a Professional Claim, cont.
MITS and Claims

• Procedure Codes
  » Wheelchair Van
    ▪ A0130 – Base Rate
    ▪ S0209 – Mileage
    ▪ T2001 - Attendant
MITS and Claims

• Procedure Codes

  » Ground Ambulance
    ▪ A0424 – Ambulance Attendant
    ▪ A0425 – Mileage
    ▪ A0426 – Advanced Life Support, Level 1, Non-emergency
    ▪ A0427 – Advanced Life Support, Level 1, Emergency
    ▪ A0428 – Basic Life Support, Non-emergency
    ▪ A0429 – Basic Life Support, Emergency
    ▪ A0433 – Advanced Life Support, Level 2
    ▪ A0434 – Specialty Care Transport
MITS and Claims

• Procedure Codes

  » Air Ambulance
    - A0430 – Transportation by Fixed-wing Ambulance
    - A0431 – Transportation by Rotary-wing Ambulance
    - A0435 – Mileage, Fixed-wing ambulance 1st passenger only
    - A0436 – Mileage, Rotary-wing ambulance 1st passenger only
MITS and Claims

• Modifiers

  » **U3** indicates a wheelchair van service provided in an ambulance
    ▪ Used only with A0130, S0209 and T2001
  » **U6** indicates a service that is unavailable when the vehicle arrives at destination
  » **UA** indicates a *second* trip taken by same person on same day in same type of vehicle to or from the same type of location
  » **UB** indicates a *third* trip taken by the same individual on the same day in the same type of vehicle to or from the same type of location
MITS and Claims

- **Detail panel – Round Trip**

<table>
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<tr>
<th>Item</th>
<th>FDOS</th>
<th>Units</th>
<th>Charges</th>
<th>Medicaid Allowed Amount</th>
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<th>Modifier 2</th>
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Select row above to update or click add an item button below.

- *Place Of Service*: 41
- *Procedure Code*: S0209

Referred EPSDT Service/Family Planning Diagnosis Code Pointer
- Modifiers: HN

Pay Action
MITS and Claims

• Detail Panel – Multiple Trips

» If a provider is providing multiple trips on the same day, all of the visits must be noted on a single claim

- Ensure proper modifier is used for each trip
MITS and Claims

• Detail panel – Multiple Trips
MITS and Claims

• Detail Panel – Additional Trip

  » If provider provides an additional trip taken for the same person on the same day in the same type of vehicle to or from the same type of location

  » All of visits must be noted on a single claim

  ▪ Ensure proper modifier is used for each trip
## MITS and Claims

- **Detail panel – Additional Trips**

![Image of MITS and Claims interface](image)

### Table: Additional Trips

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<thead>
<tr>
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<th>Units</th>
<th>Charges</th>
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Select row above to update - or - click add an item button below.
Claim Submission

- Detail panel

<table>
<thead>
<tr>
<th>Item</th>
<th>FDOS</th>
<th>Units</th>
<th>Charges</th>
<th>Medicaid Allowed Amount</th>
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</tr>
</tbody>
</table>

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

*Place Of Service: 11
*Procedure Code: 97814
*Diagnosis Code Pointer: 01

Referred EPSDT Service/Family Planning

Modifiers [Search] [Search] [Search]

Final EAPG [Search] [Search] [Search]

Pay Action

- Medicaid Allowed Amount: $0.00
- Rendering Provider: 
- Submitted EAPG: 
- Initial EAPG: 
- Status: 
  - Visit Start Time: 
  - Visit End Time: 
  - Service Duration less than 90 days: 

NDC Detail - Other Payor ClaimCheck Additional Provider Information
MITS and Claims

• Entering the Ordering Provider’s information
MITS and Claims

• Entering the Ordering Provider’s information
MITS and Claims

• Entering the Ordering Provider’s information, cont.
MITS and Claims

• Entering the Ordering Provider’s information, cont.
MITS and Claims

• Entering the Ordering Provider’s information, cont.
MITS and Claims

• Once all fields have been completed
  » Click the “submit” button at the bottom right
  » You may “cancel” the claim at anytime, but the information will not be saved in MITS
MITS and Claims

• Adjudication will happen in “real time”, the claim status will show:
  » Paid
  » Denied
  » Suspended
MITS and Claims

- Internal Control Number (ICN)
  - The ICN replaced the Transaction Control Number (TCN)
  - Each claim will be assigned a separate ICN
  
  2021170357321

<table>
<thead>
<tr>
<th>Region Code</th>
<th>Calendar Year</th>
<th>Julian Date</th>
<th>Claim Type/Batch Number</th>
<th>Number of Claim in Batch</th>
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</thead>
<tbody>
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<td>170</td>
<td>357</td>
<td>321</td>
</tr>
</tbody>
</table>
MITS and Claims

• Internal Control Number (ICN), cont.

  » Primary region codes on a new claim submission

  20 Electronic (EDI) 837 without attachment
  21 Electronic (EDI) 837 with an attachment
  22 Web Portal without attachment
  23 Web Portal with an attachment

* Region codes in 50’s indicate an adjustment to your claim
MITS and Claims

- Adjudication happens in “real time”
  - If there are no errors, the claim status will show:
    - Paid
    - Denied
    - Suspended
## Claim Portal Errors

Select row above to update - or - click add

### Supporting Data for Delayed Submission / Resubmission

**DISCLAIMER:** Documentation to justify the use of this panel and data entry.

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

### Claim Status Information

**Claim Status:** Not Submitted yet
Claim Portal Errors, cont.

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

Scroll to the top of the claim

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.
### Claim Portal Errors, cont.

<table>
<thead>
<tr>
<th>Item</th>
<th>From DOS</th>
<th>To DOS</th>
<th>Units</th>
<th>Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>01/11/2021</td>
<td>01/11/2021</td>
<td>0</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

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

- **Place Of Service**
- **Procedure Code**
- **Referral EPSDT Service**
- **Family Planning**
- **Diagnosis Code**
- **Modifiers**
- **Final EAPG**

**Medicaid Allowed Amount**: $0.00

**Rendering Provider**: 

**Submitted EAPG**: 

**Initial EAPG**: 

**Status**: 

- **Visit Start Time**
- **Visit End Time**

**Service Duration less than 90 days**: ☐
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
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, cont.

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

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

**Must use the spacing shown**

**Notes**

DECISION 20210825
MITS and Claims

• Medicare Denials

  » If Medicare issues a denial and indicates that the patient is responsible for the payment, submit the claim to ODM by following these steps:

    • Enter the claim in MITS
    • Do not enter any Medicare information on the claim
    • Complete and upload a ODM 6653 form and a copy of the Medicare EOB
MITS and Claims

• Attachment Panel

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

![Attentions Panel](image-url)
MITS and Claims

• Attachment Panel, cont.

» Electronic attachments are accepted for Claims, Prior Authorization, Enrollment, and Re-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
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.

#### Detail

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

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

- **Place Of Service**: 12
- **Procedure Code**: A4452
- **EAPG**

**Referred EPSDT Service/Family Planning**

**Diagnosis Code**

**Modifiers**

**Final EAPG**

**Pay Action**

---

**NDC**

**Detail - Other Payer**

**Claim Item**

**Additional Provider Information**
Example, cont.
### Claim Status Information

- **Claim Status**: PAID
- **Claim ID**: 22213050000002
- **Paid Date**: 
- **Paid Amount**: $0.32

### EOB Information

<table>
<thead>
<tr>
<th>Detail</th>
<th>Error Code</th>
<th>Error 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 web site, mailings, or bulletins for more details concerning this policy/procedure/decision.</td>
</tr>
</tbody>
</table>

(cancel | adjust | void | copy claim)
### Claim Status Information

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

### EOB Information

<table>
<thead>
<tr>
<th>Detail Number</th>
<th>Error Code</th>
<th>EOB Description</th>
<th>CARC</th>
<th>CARC Amount</th>
<th>CARC Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>9918</td>
<td>PRICING ADJUSTMENT - MAX FEE PRICING APPLIED</td>
<td>45</td>
<td>$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>5821305000001</td>
<td>01/11/2021</td>
</tr>
<tr>
<td>2221305000002</td>
<td>01/11/2021</td>
</tr>
</tbody>
</table>
Voiding a Paid Claim

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

- **Claim Status**: PAID
- **Claim ICN**: 5821305000001
- **Paid Date**:  
- **Paid Amount**: $3.20

### EOB Information

<table>
<thead>
<tr>
<th>Detail Number</th>
<th>Error Code</th>
<th>EOB Description</th>
<th>CARC</th>
<th>CARC Amount</th>
<th>CARC Description</th>
<th>RARC</th>
<th>RARC Description</th>
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<tbody>
<tr>
<td>1</td>
<td>9918</td>
<td>PRICING ADJUSTMENT - MAX FEE PRICING APPLIED</td>
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<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>
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<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>5821305000001</td>
<td>01/11/2021</td>
</tr>
<tr>
<td>2221305000002</td>
<td>01/11/2021</td>
</tr>
</tbody>
</table>

[Arrow pointing up]
### Claim Status Information

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

### EOB Information

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

The related or qualifying claim/service was not identified on this claim. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 5010 Service Payment Information REF), if present.

### Adjustment Information

<table>
<thead>
<tr>
<th>ICN</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
MITS and Claims

• Remittance Advice (RA)
  » All claims processed are available on the MITS Portal
  » Weekly reports become available on Wednesdays
MITS and Claims

- Remittance Advice (RA), cont.
  - Select “Remittance Advice” and click search twice
  - To see all remits to date, don’t enter any specific data
Websites
Websites

• Ohio Department of Medicaid home page
  http://Medicaid.ohio.gov

• Ohio Department of Medicaid provider page
  https://medicaid.ohio.gov/wps/portal/gov/medicaid/

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

Ohio Laws & Administrative Rules
  http://codes.ohio.gov
Websites

• Electronic Data Interchange (EDI)
  » Information for Trading Partners
    https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/billing/trading-partners/trading-partners
  » Companion Guides
    https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/billing/trading-partners/companion-guides/companion-guides
  » Technical Questions/EDI Support Unit
    ▪ Transitioned partners contact DXC EDI Support
      ❖ 844-324-7089
      ❖ OhioMCD-EDI-Support@dxc.com