Basic Billing for Hospitals

Provider Relations

2021
AGENDA

- Medicaid Services
- Programs & Cards
- Managed Care/MyCare Ohio
- Provider Responsibilities
- Policy
- MITS & Claims
- Websites & Forms
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
Medicaid Medical Necessity: OAC 5160-1-01

Is the fundamental concept underlying the Medicaid Program

All Services must meet accepted standards of medical practice
Covered Services (not limited to)

- Acupuncture
- Behavioral Health
- Dental
- Dialysis
- Dietitian
- Durable Medical Equipment
- Home Health
- Hospice
- Hospital (Inpatient/Outpatient)
- ICF-IID Facility
- Nursing Facility
- Pharmacy
- Physician
- Transportation
- Vision
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)
Providers will be required to enter two out of the following three pieces of data: tax ID, NPI, or 7 digit Ohio Medicaid provider number.

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

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

IVR: 1-800-686-1516
Programs & Cards
Ohio Medicaid

- This is the traditional fee-for-service Medicaid card
- Issued annually as of October 1, 2018
Supplemental Security Income (SSI)

- Automatically Eligible for Medicaid as long as eligible for SSI

Modified Adjusted Gross Income (MAGI)

- Children, parents, caretakers, and expansion

Aged, Blind, Disabled (ABD)

- 65+, or blind/disabled with no SSI
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.
Conditions of Eligibility and Verifications

- Providers may contact local CDJFS offices to report non-cooperative consumers

- CDJFS may terminate eligibility if an individual fails or refuses, without good cause, to cooperate by providing necessary verifications or by providing consent for the administrative agency to obtain verification
Full Medicaid eligibility on the MITS Portal will show **four** (or more) benefit spans:

1. Alcohol and Drug Addition 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
Medicare Benefit Plan
Managed Care / MyCare
Third Party Liability (TPL)
Verifiable information
Patient Liability
Long Term Care
Eligibility Verification Request

You can search up to 4 years back

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

### Recipient Information
- **Medicaid Billing Number**
- **Last Name**
- **First Name**
- **Gender**
- **Date of Birth**
- **SSN**
- **County of Residence**
- **County of Eligibility**
- **County Office** [http://jfs.ohio.gov/County/County_Directory.pdf](http://jfs.ohio.gov/County/County_Directory.pdf)
- **Number Bed Hold Days Used Paid CY**

### Benefit / Assignment Plan

<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>
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<td>910700745973</td>
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Eligibility Verification Request

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### Managed Care

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<td>MOLINA HEALTHCARE OF OHIO INC</td>
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### Lock-In

### Medicare

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### Service Limitation

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Presumptive Eligibility

Covers children up to age 19 and pregnant women

It has been expanded to provide coverage for parent and caretaker relatives and extension adults

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

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

To become a Qualified Entity complete the steps described here:
http://www.medicaid.ohio.gov/Provider/Training/PresumptiveEligibility
Presumptive Eligibility

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

Other members will receive a Presumptive Eligibility Card
## Presumptive Eligibility

### Recipient Information

<table>
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<tr>
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Medicaid Pre-Release Enrollment Program

- Institutionalized individuals close to release are enrolled into a Medicaid Managed Care plan, prior to release
- Individual must agree and be eligible for the program
- MCP Care Manager will develop a transition plan
Qualified Medicare Beneficiary (QMB)

- Issued to qualified Individuals who receive Medicare
- Reimbursement policy is set under 5160-1 and can result in a payment of zero dollars
- Medicaid only covers their monthly Medicare premium, co-insurance and/or deductible after Medicare has paid
Can I bill them?

MLN Matters® Number: SE1128 Revised Release Date of Revised Article: December 4, 2017

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 under any circumstances (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 program is a State Medicaid benefit that assists low-income Medicare beneficiaries with Medicare Part A and Part B premiums and cost-sharing, including deductibles, coinsurance, and copays.
QMB

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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
<table>
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Healthcheck: OAC 5160-1-14

Early & Periodic Screening Diagnosis & Treatment (EPSDT) for children from birth through age 20

Minimum services include:

- Comprehensive Health and Developmental History
- Developmental Screening (including mental and physical)
- Nutritional Screening
- Vision Screening
Healthchek

- Hearing Screening
- Immunization Screening
- Lead Toxicity Screening
- Lab Tests
- Dental Screening
HealthChek Procedure Codes

When completing a HealthChek exam please complete all components of the exam and bill the correct *Preventive Medicine* code for the appropriate age group.

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<td>12 – 17</td>
<td>99384, 99394</td>
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<td>18 – 20</td>
<td>99385, 99395</td>
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</table>
HealthChek Procedure Codes

When completing a HealthChek exam please complete all components of the exam and bill the correct *Evaluation and Management* code for the appropriate time spent.

- **New Patient Initial Visit**
  - 20 min. Use These Codes: 99202
  - 15 min. Use These Codes: 99213

- **Established Patient**
  - 30 min. Use These Codes: 99203
  - 25 min. Use These Codes: 99214
  - 45 min. Use These Codes: 99204
  - 40 min. Use These Codes: 99215
  - 60 min. Use These Codes: 99205
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
3 Population Groups Eligible for Traditional Managed Care

- Medicaid Managed Care MAGI (CFC)
- Medicaid Managed Care Non-MAGI (ABD)
- Medicaid Managed Care Adult MAGI (expansion population)

Population added for mandatory enrollment in 2017

- Adoption children, Breast and Cervical Cancer Patients (BCCP), Foster children, and Bureau of Children with Medical Handicaps (BCMH)
Individuals with optional enrollment in Traditional Managed Care Plans

Native Americans that are members of a federally recognized tribe

Home and Community Based waivers thru DODD effective 1/1/17
Managed Care Plans must cover all medically necessary Medicaid covered services

Some value-added services:

- On-line searchable provider directory
- Access to toll-free 24/7 hotline for medical advice, staffed by nurses
- Expanded benefits including additional transportation options, and other incentives (varies among the MCPs)
- Care management to help members coordinate care and ensure they are getting the care that they need
HOW DO YOU KNOW IF SOMEONE IS ENROLLED IN MANAGED CARE?

Providers need to check the MITS provider portal each time before providing services to a Medicaid individual.

The MITS provider portal will show if an individual is enrolled in a Managed Care plan based on the eligibility dates of service you enter.
# MITS Managed Care Eligibility

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<th>Benefit / Assignment Plan</th>
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## TPL

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## Managed Care

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<th>Plan Description</th>
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Traditional Managed Care Sample Card

PARAMOUNT ADVANTAGE
www.paramountadvantage.org
HEALTH PLAN (80840) 7952304120
ID NUMBER A9999999901
MEMBER NAME Jane Doe
PRIMARY CARE PROVIDER John Smith
(419) 5551212

GROUP NUMBER ADV0010011
EFF. DATE 01/01/2015
MMIS NUMBER 000000000000

CVS/CAREMARK
RXGRP RX6407
RXBIN 004336
RXPCN ADV

PROVIDERS CALL FOR PRIOR AUTH
800-891-2500/419-887-2520
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

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

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

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

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

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

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

The project is currently slated to end on December 31, 2022.
Package includes *all* benefits available through the traditional Medicare and Medicaid programs.

- This includes Long Term Services and Supports (LTSS) and Behavioral Health.

- Plans may elect to include additional *value-added benefits* in their health care packages.
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
**HOW DO YOU KNOW IF SOMEONE IS ENROLLED IN MYCARE?**

- Providers need to check the MITS provider portal each time before providing services to a Medicaid individual.

- For individuals enrolled in a MyCare Ohio Managed Care plan it will show if they are enrolled for **Dual Benefits OR Medicaid Only**.

- The MITS provider portal will show if a individual is enrolled in a Managed Care Plan based on the eligibility dates of service you enter.
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<tr>
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### Case/ Cat/Seq Spenddown

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### TPL

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### Managed Care

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Plan Description</th>
<th>Effective Date</th>
<th>End Date</th>
<th>Managed Care Benefits</th>
</tr>
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<tbody>
<tr>
<td>BUCKEYE COMMUNITY HEALTH PLAN</td>
<td>HMO, MyCare Ohio</td>
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### Lock-In

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### Medicare

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<th>Plan Name</th>
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<th>Medicare ID</th>
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<tr>
<td>PART A</td>
<td>10/24/2018</td>
<td>10/31/2019</td>
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<tr>
<td>PART B</td>
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<td>10/31/2019</td>
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<tr>
<td>PART C</td>
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<td>BUCKEYE HEALTH PLAN - MYCARE OHIO</td>
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<td>PART D</td>
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<td>001</td>
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</table>
MyCare Ohio Opt-In Sample Card

Member Name: <Cardholder Name>
Member ID #: <Cardholder ID#>
Health Plan (80840)
MMIS Number: <Medicaid Recipient ID#>
PCP Name: <PCP Name>
PCP Phone: <PCP Phone>
RxBin: 004336
RxPCN: MEDDADV
RxGRP: RX5045

In an emergency, call 9-1-1 or go to the nearest emergency room (ER) or other appropriate setting. If you are not sure if you need to go to the ER, call your PCP or the 24-Hour Nurse Advice line.

Member Service: 1-855-475-3183
(TTY: 1-800-750-0750 or 711)
Behavioral Health Crisis: 1-866-206-7361
Care Management: 1-855-475-3183
24-Hour Nurse Advice: 1-866-206-7361
(TTY: 1-800-750-0750 or 711)
Website: CareSource.com/MyCare

Eligibility Verification: 1-800-488-0134
Pharmacy Help Desk: 1-800-488-0134
Claims Inquiry: 1-800-488-0134
Provider Questions: 1-800-488-0134

Mail medical claims to:
CareSource
Attn: Claims Department
P.O. Box 8730
Dayton, OH 45401-8738
Mail pharmacy claims to:
CVS Caremark
P.O. Box 52066
Phoenix, AZ 85072-2066
## MITS Eligibility MyCare Opt-Out

<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>
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<tr>
<td>MRDD Targeted Case Mgmt</td>
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<td>Ohio Mental Health</td>
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<td>09/30/2021</td>
<td></td>
<td>$0.00</td>
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<td>Medicaid</td>
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### Case/Cat/Seq Spenddown

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### TPL

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### Managed Care

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Plan Description</th>
<th>Effective Date</th>
<th>End Date</th>
<th>Managed Care Benefits</th>
</tr>
</thead>
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<tr>
<td>MOLINA HEALTHCARE OF OHIO INC</td>
<td>HMO, MyCare Ohio</td>
<td>07/01/2018</td>
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### Lock-In

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### Medicare

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<th>Coverage</th>
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<th>Plan Name</th>
<th>Plan ID</th>
<th>Medicare ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>PART A</td>
<td>10/30/2016</td>
<td>10/31/2019</td>
<td></td>
<td>9RG7AP3AF00</td>
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<td>PART B</td>
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<td>10/31/2019</td>
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<td>PART C</td>
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<td>AARP MEDICAREX PREFERRED (PDP)</td>
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<td>PART D</td>
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<td>CVS CAREMARK VALUE (PDP)</td>
<td>028</td>
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</table>
MyCare Ohio Opt-Out Sample Card

RxBin: 004336
RxPCN: ADV
RxGRP: RX3292

In an emergency, call 9-1-1 or go to the nearest emergency room (ER) or other appropriate setting. If you are not sure if you need to go to the ER, call your PCP or the 24-Hour Nurse Advice line.

Member Service: 1-855-475-3163 (TTY: 1-800-750-0750 or 711)
Behavioral Health Crisis: 1-866-206-7861 (TTY: 1-800-750-0750 or 711)
Care Management: 1-855-475-3163 (TTY: 1-800-750-0750 or 711)
24-Hour Nurse Advice: 1-866-206-7861 (TTY: 1-800-750-0750 or 711)
Provider/Pharmacy Questions: 1-800-488-0134
Website: CareSource.com/MyCare

Mail medical claims to:
CareSource
Attn: Claims Department
P.O. Box 8730
Dayton, OH 45401-8738

Mail pharmacy claims to:
CVS Caremark
P.O. Box 52066
Phoenix, AZ 85072-2066
MyCare Ohio Region Breakdown

- Individuals will have the ability to enroll by phone, online, or by mail.

<table>
<thead>
<tr>
<th>DEMONSTRATION REGION &amp; POPULATION</th>
<th>MANAGED CARE PLANS AVAILABLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northwest: 9,884 Fulton, Lucas, Ottawa, Wood</td>
<td>- Aetna - Buckeye</td>
</tr>
<tr>
<td>Southwest: 19,456 Butler, Clermont, Clinton, Hamilton, Warren</td>
<td>- Aetna - Molina</td>
</tr>
<tr>
<td>West Central: 12,381 Clark, Greene, Montgomery</td>
<td>- Buckeye - Molina</td>
</tr>
<tr>
<td>Central: 16,029 Delaware, Franklin, Madison, Pickaway, Union</td>
<td>- Aetna - Molina</td>
</tr>
<tr>
<td>East Central: 16,225 Portage, Stark, Summit, Wayne</td>
<td>- CareSource - United</td>
</tr>
<tr>
<td>Northeast Central: 9,284 Columbiana, Mahoning, Trumbull</td>
<td>- CareSource - United</td>
</tr>
<tr>
<td>Northeast: 31,712 Cuyahoga, Geauga, Lake, Lorain, Medina</td>
<td>- Buckeye - Caresource - United</td>
</tr>
</tbody>
</table>
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

Provider credentialing concerns

Please send to Ohio Department of Insurance (ODI)

Certification issues

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

Provider credentialing concerns

Please send to Ohio Department of Medicaid (ODM) at
http://www.ohiomh.com/ProviderComplaintForm.aspx
Submitting a Managed Care Complaint

Provider Inquiries

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

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

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

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

Provider Complaint Form Guidance

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

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

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

Submission Tips:

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

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

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

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

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

Instructions

This form is for Managed Care providers only. Providers must appeal denied claims to the MCP before the Ohio Department of Medicaid will process a complaint. If your complaint involves multiple Managed Care Plans (MCPs), please complete one form per MCP. The resolution timeframes for Managed Care complaints are 2 business days for complaints involving access to care, and 15 business days for all other issues. If you have a complaint regarding Medicaid Fee For Service please call 1-800-666-1516.

Complaint Details

MCP Name:  

Complaint Reason:  

* Are you contracted with this Health Plan?  ○ Yes  ○ No

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

* Have you already contacted the MCP about this issue?  ○ Yes  ○ No

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

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

* Is the patient receiving or seeking mental health or substance abuse services?  ○ Yes  ○ No
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 Enrollment and Revalidation

There is a federally required, non-refundable application fee when a provider submits a new or revalidation application.

The 2018 fee is $569.00 per application.

This fee applies to organizational providers only (not individual providers, practitioners, or practitioner groups).
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:

- Inform us of any changes to your provider profile within 30 days
- Render medically necessary services in the amount required
- Maintain records for 6 years
- 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
General Reimbursement Principles:
OAC 5160-1-02

Medicaid Payment:
OAC 5160-1-60

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

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

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

- Medicaid claim denial
- Unacceptable claim submission
- Failure to request a prior authorization
- Retroactive Peer Review stating lack of medical necessity
When Can you Bill an Individual?

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

This cannot be done if the service is a prescription for a controlled substance.
Policy
Policy updates from Ohio Medicaid announce the changes to the Ohio Administrative Code that may affect providers. There are three types of letters:

- Medicaid Transmittal Letters (MTL)
- Hospital Handbook Transmittal Letter (HHTL)
- Medical Assistance Letter (MAL)
Effective 4/1/2018 the following modifiers will be used for APRNs:

- **SA** indicates a service performed by a **CNP**
- **SB** indicates a service performed by a **CNM**
- **UC** indicates a service performed by a **CNS**
- **QX** indicates an anesthesia service performed by a **CRNA** (or anesthesiologist assistant) with the medical direction of an anesthesiologist
- **QZ** indicates an anesthesia service performed by a **CRNA** without the medical direction of an anesthesiologist
- **AS** indicates a service performed by an assistant-at-surgery

- No additional modifier (SA, SB, or UC) is used to indicate an APRN (the practitioner is identified by NPI as the rendering provider)
Medicaid Advisory Letter (MAL) No. 612

Guidelines on how to complete these forms are found in the rules listed below:

- **ODM 03199** Acknowledgement of Hysterectomy Information (formerly ODJFS 03199)
- **HHS-687** (OMB 0937 0166) Consent for Sterilization

- **ODM 03197** Abortion Certification Form (formerly ODJFS 03197)
Medicaid Advisory Letter (MAL) No. 612

ODM will cover sterilization services if all the following requirements of the OAC and CFR are met:

- The individual is at least twenty-one years old at the time consent is obtained
- The individual is not mentally incompetent
- The individual is not institutionalized
- The individual has voluntarily given informed consent
Medicaid Advisory Letter (MAL) No. 612

Form **ODM 03197** must be completed before payment can be made for the following codes:

**CPT**
- 59840
- 59841
- 59850
- 59851
- 59852
- 59855
- 59856
- 59857
- 59866

**ICD-10**
- 10A00ZZ
- 10A03ZZ
- 10A04ZZ
- 10A07ZX
- 10A07Z6
- 10A07ZW
- 10A07ZZ
- 10A08ZZ
New Explanation of Benefits Codes for Hospitals HHTL 3352-16-02

- Must use “utilization/tpl vendor approved resubmission” as the reason
- Must use the 56 ICN for the takeback
How to Find Modifiers Recognized by Ohio Medicaid

MODIFIERS:
- Modifiers recognized by ODM

DURABLE MEDICAL EQUIPMENT CLAIMS:
- Codes/Rates/Fee Schedules FAQs
- How to read the RA (Remittance Advice)

Common Questions
- How long do I have to submit a claim?
- As a Provider, am I allowed to bill the patient for missed appointments?
- When is the Recipient liable?
- What is National Provider Identifier (NPI)?
ASC claims process through 3M’s Enhanced Ambulatory Patient Group (EAPG) software

EAPGs use procedure codes, not diagnosis codes, as initial classification

ASC EAPG Payment
- DME and Pharmaceuticals pay outside EAPG
- Use same EAPG relative weights as outpatient
- All ASC have same base rate
- Lab and radiology services are paid the lesser of the EAPG payment or billed charges

ASC Base Rate = $83.34 and ASC Cost-to-Charge Ratio = 20%
- ASC base rate and CCR is equal to 80% of statewide average Outpatient Hospital base rate CCR
Prior Authorizations (PA) need to be requested for select codes

- The covered code list has a PA indicator on the codes that now require a PA

Use the MITS provider portal to request a PA

ASCs are PA assignment type 57
ASCs Payment: OAC 5160-22-01

- The expanded code list can be found at: 

- Two webinars available for ASC’s
  - PA training webinar
    https://attendee.gotowebinar.com/recording/1363716958699805953
  
  - EAPG training webinar
    https://attendee.gotowebinar.com/recording/5547934847121846795
DRC Inpatient Hospitalization

1. ODRC sends applications to ODM Direct Enrollment Unit for offenders who are admitted to a hospital for a period of at least 24 hours

2. ODM Direct Enrollment Unit processes the application and maintains the case in their ODM caseload

3. Eligibility for a full year is approved, then Pre-Termination Review (PTR) to determine if there is a need to keep them on Medicaid
Inpatient Hospital Services Plan (IHSP)

There is no length of time limit for services as long as the individual continues to be eligible for Medicaid and is receiving services as an inpatient in the medical facility.

72 hour roll-in for outpatient services does not apply for IHSP individuals.

Outpatient services prior to the date of admission must be submitted to DRC or the correctional facility for payment.
The ordering National Provider Identifier (NPI) must be for an individual physician/non-physician practitioner (not the NPI of an organizational provider).

The ordering physician/non-physician practitioner must be actively enrolled and must be of a specialty type that is eligible to order in the Ohio Medicaid program.
Providers should ensure that services are being ordered, referred, or prescribed by an eligible provider who is enrolled in Medicaid.

| Providers may enroll as an ORP-only provider or as a Medicaid billing provider | ORP-only providers have an expedited screening process | Online applications can be found on our website |
Eligible Providers: OAC 5160-2-01

- Allows MCP to cover inpatient psychiatric services
- Only for individuals aged 21 - 64
- This policy does not apply to traditional FFS Medicaid
Three Calendar Day Roll-In

- Outpatient (OP) services provided within three calendar days prior to the date of admission will be covered as inpatient (IP) services
- Including emergency room and observation services
- “From Date” should start with the first date of OP and the “Through Date” should be the date of discharge
- “Admit Date” field is the day the patient was admitted as IP
Potentially Preventable Readmissions (PPR) Program:  
OAC 5160-2-14

- Reduces payment for clinically-related and clinically-preventable readmissions
  - Encourages underperforming hospitals to improve the level of care provided during a patient’s inpatient admission
  - A hospital with excess readmissions* will be subject to a reduction of their hospital-specific base rate by one percent

* Defined as an actual-to-expected readmission ratio of greater than one
Payment to be made only after any available third-party benefits are exhausted
Inpatient Hospital Services: OAC 5160-2-65

Fixed cost outlier thresholds for dates of discharge on or after 7/4/17

- Neonate and tracheostomy DRGs = $25,000
- Major Teaching or Children’s Peer Group Hospitals = $60,000
- All other DRGs/Peer Groups = $75,000
Inpatient Hospital Services: OAC 5160-2-65

Interim bill is for advanced billing of an extended inpatient hospital stay

- All Interim Bills (Bill Type 112 & 113) must be for periods of 30 days or more
- DRG-Exempt providers may submit a Final Interim (Bill type 114) to close out the stay
- DRG Hospitals must void all Interim Bills and submit a final admit through discharge bill (Bill Type 111) for the entire stay
- DRG Hospitals will be paid their hospital-specific inpatient cost-to-charge ratio for Bill Types 112 and 113
Transfer Billing: Located in the hospital billing guidelines

- Section 2.1.1: Transfer between Acute Care and Medicare Distinct Part Psychiatric Units
- Section 2.1.2: Multiple Transfers between Acute Care and Medicare Distinct Part Psychiatric Units
- Section 2.1.3: Transfers between Acute and Distinct Part Rehabilitation Units
Reimbursement for Outpatient Hospital Services: OAC 5160-2-75

- Establishes the Enhanced Ambulatory Patient Groups (EAPG) as the reimbursement logic for outpatient services

- CPT codes are updated annually on January 1\textsuperscript{st}, so hospitals cannot submit a claim that spans 12/31 and 1/1 of any year
EAPG Packaging

Uniform list of EAPGs that always package with significant procedures or medical visit EAPGs

- Example: Incidental medical supplies (i.e. gauze, dressings, sutures, etc.) on a surgery claim
- Example: Lab test on same day as a surgery

If ancillary service is on the claim on its own, packaging may or may not apply
Significant Procedure Consolidation

When a patient has multiple significant procedures, some of the significant procedures may require minimal additional time or resources.

Significant procedure consolidation collapses multiple related significant procedure EAPGs into a single EAPG for payment.

*Example:* EAPG 063 Level II Endoscopy would pay 100%, but if EAPG for Level I Endoscopy was on the same claim, it would consolidate with EAPG 063 (no separate payment).
Discounting pricing logic is used when:

- Multiple unconsolidated significant procedures are on the claim; highest weighted EAPG is paid 100%, secondary 50%
- Multiple unpackaged ancillaries are on the claim; highest weighted EAPG is paid 100%, secondary 50%
- Modifiers (e.g. 50, bilateral procedure) are present; code with modifier 50 is paid at 150% of standard rate
Reimbursement for Outpatient Hospital Services: OAC 5160-2-75

- Payment Formula:
  - Detail Payment = Base Rate * EAPG relative weight * Discount percentage (if applicable)
  - Total claim payment = sum of all detail payments
  - Lab and radiology services are paid the lesser of the EAPG payment or billed charges
  - Items consolidated or packaged are paid $0.00
Reimbursement for Outpatient Hospital Services: OAC 5160-2-75

Example payment calculation for 2 gastrointestinal EAPGs, 134-Diagnostic Upper GI Endoscopy or Intubation, and 149-Screening Colorectal Services and EGD:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>EAPG</th>
<th>Relative Weight</th>
<th>Cleveland Clinic Base Rate</th>
<th>RW * Base Rate</th>
<th>Discounting</th>
<th>Final Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>43239</td>
<td>EGD BIOPSY SINGLE/MULTIPLE</td>
<td>134</td>
<td>4.5552</td>
<td>$146.53</td>
<td>$667.47</td>
<td>100%</td>
<td>$667.47</td>
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<tr>
<td>45380</td>
<td>COLONOSCOPY AND BIOPSY</td>
<td>149</td>
<td>4.3758</td>
<td>$146.53</td>
<td>$641.19</td>
<td>50%</td>
<td>$320.59</td>
</tr>
</tbody>
</table>

$988.06
Reimbursement for Outpatient Hospital Services: OAC 5160-2-75

- Pricing Outside of EAPG
  - Certain services may be paid outside of EAPG
Medicaid now accepts select CDT D codes in outpatient hospital setting.

Hospitals should bill the same CDT D codes that the dentist uses on corresponding professional claim.

The outpatient hospital setting is **NOT** the designated place for dental procedures.

- Should only be utilized when medically necessary.
Pricing Outside of EAPG: Observation

- **G0378** is the preferred code to report observation services for EAPG
  - Hourly code, so it cannot exceed 24 units per day
  - Limited to 48 hours
  - May span across 3 days

- Observation services reported with CPT codes **99217 - 99220, 99224 - 99226, 99234 - 99236** will continue to be *limited* to one unit per day, for a maximum of two consecutive days
Pricing Outside of EAPG: Durable Medical Equipment (DME)

- DME that is not packaged or consolidated will reimburse the lesser of charges or the payment amount listed on the Durable Medical Equipment Fee Schedule.
- EAPGs 1001 – 1020 are DME EAPGs.
- If a DME item is not priced on the fee schedule, it will pay $0.
Pharmaceuticals that are not packaged or consolidated will reimburse the lesser of charges or the payment amount listed on the Provider Administered Pharmaceutical Fee Schedule.

If a pharmaceutical is not on the fee schedule or is listed as ‘By Report’ the detail will reimburse at 60% of the hospital cost (60%*CCR*billed charges).
Vaccines for Children (VFC) may be reimbursed for individuals 18 years of age or younger

- $10 reimbursement for administration
- No payment for the vaccine itself
Option to have only high cost items reimbursed and forego payment for any other procedure and ancillary services performed on the same date

- Bill the UB modifier on the surgery code or main procedure code provided on the date of service
- Submit all procedures, drugs, and medical supplies on the claim
Pharmaceutical pricing is based on provider administered fee schedule when a rate exists

- Otherwise, the payment is calculated as drug charges multiplied by the hospital’s cost to charge ratio, multiplied by 60%

- Independently billed medical supplies are calculated as billed charges multiplied by the hospital’s cost to charge ratio, multiplied by 60%
Pricing Outside of EAPG

EAPG Grouper returns Pay Action Flags which tell us whether a procedure is applicable for full payment, discounting, etc.

<table>
<thead>
<tr>
<th>Pay Action</th>
<th>Description</th>
<th>Affect on Payment</th>
<th>EOB</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td>Not processed</td>
<td>0%</td>
<td>9222</td>
</tr>
<tr>
<td>01</td>
<td>Full Payment</td>
<td>100%</td>
<td>9221</td>
</tr>
<tr>
<td>02</td>
<td>Consolidated</td>
<td>0%</td>
<td>9220</td>
</tr>
<tr>
<td>03</td>
<td>Discounted</td>
<td>50%</td>
<td>9221</td>
</tr>
<tr>
<td>04</td>
<td>Packaged</td>
<td>0%</td>
<td>9221</td>
</tr>
<tr>
<td>05</td>
<td>No Payment</td>
<td>0%</td>
<td>9221</td>
</tr>
<tr>
<td>06</td>
<td>Bilateral</td>
<td>150%</td>
<td>9958</td>
</tr>
<tr>
<td>07</td>
<td>Discounted Bilateral</td>
<td>75%</td>
<td>9959</td>
</tr>
<tr>
<td>13</td>
<td>Alternate Payment</td>
<td>Flat Payment</td>
<td>9225</td>
</tr>
<tr>
<td>18</td>
<td>Lesser of Charges or EAPG Payment</td>
<td>100%</td>
<td>9225</td>
</tr>
<tr>
<td>85</td>
<td>No Payment, No Charges</td>
<td>0%</td>
<td>9225</td>
</tr>
</tbody>
</table>
Behavioral Health

- Full-managed care carve-in has been in effect since 7/1/2018

- The following DRGs became effective 7/1/2017 for detox services provided in Psychiatric hospitals:
  - 770 – Drug & Alcohol Abuse or Dependence
  - 773 – Opioid Abuse and Dependence
  - 774 – Cocaine Abuse and Dependence
  - 775 – Alcohol Abuse and Dependence
  - 776 – Other Drug Abuse and Dependence

* Psych hospitals should submit only one claim for all inpatient services *
All hospitals that meet the Medicare conditions of participation may provide Outpatient BH and Substance Use Disorder (SUD) services.

Payment will match Community Mental Health Center (CMHC)/SUD agency reimbursement.
- Rates based upon the level of the professional providing the services.
Payment will match CMHC/SUD agency reimbursement

- Rates based upon the level of the professional providing the services

Mental Health and SUD services are excluded from the 72-hour inpatient roll-in

- Medical service provided in the 72 hours before an IP stay must be submitted with the IP claim
Each claim for MH or SUD must contain the following:

- Modifier **HE** at the detail level for each MH or SUD CPT/HCPCS code
- Revenue center code 025X, 0636, 0671, 771, 0900, 901, 0904, 0906, 0907, 0911, 0912, 0913, 0914, 0915, 0916, 0918, 0919 or 1002 for each MH or SUD detail line
- A MH or SUD diagnosis code
- Modifier signifying the highest level of practitioner who performed the service
Behavioral Health Redesign OAC 5160-2-75 (G)(2)

<table>
<thead>
<tr>
<th>RCC</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>25X</td>
<td>Pharmacy</td>
</tr>
<tr>
<td>636</td>
<td>Pharmacy - Drugs Requiring Detailed Coding</td>
</tr>
<tr>
<td>671</td>
<td>Outpatient Special Residence Charges - All Home or Community Based Services</td>
</tr>
<tr>
<td>771</td>
<td>Preventative Care Services - Vaccine Administration</td>
</tr>
<tr>
<td>780</td>
<td>Telemedicine</td>
</tr>
<tr>
<td>900</td>
<td>BH Treatment/Services</td>
</tr>
<tr>
<td>901</td>
<td>Electroshock Treatment</td>
</tr>
<tr>
<td>904</td>
<td>Activity Therapy</td>
</tr>
<tr>
<td>906</td>
<td>IOP - Chemical Dependency</td>
</tr>
<tr>
<td>907</td>
<td>Day Treatment</td>
</tr>
<tr>
<td>911</td>
<td>Rehabilitation</td>
</tr>
<tr>
<td>912</td>
<td>Partial Hospitalization - Less Intensive (Half Day)</td>
</tr>
<tr>
<td>913</td>
<td>Partial Hospitalization - Intensive (Full Day)</td>
</tr>
<tr>
<td>914</td>
<td>Individual Therapy</td>
</tr>
<tr>
<td>915</td>
<td>Group Therapy</td>
</tr>
<tr>
<td>916</td>
<td>Family Therapy</td>
</tr>
<tr>
<td>918</td>
<td>Testing</td>
</tr>
<tr>
<td>919</td>
<td>Other Psych Services</td>
</tr>
<tr>
<td>1002</td>
<td>Residential Treatment - Chemical Dependency</td>
</tr>
</tbody>
</table>

Detail lines containing these RCCs must include an 'HE' modifier.
Payment for long-acting reversible contraceptives when provided postpartum

- Provided in an inpatient setting prior to patient’s discharge
- Billed outpatient, after a separate claim related to labor and delivery has been paid
- Payment rates per the Provider-Administered Pharmaceuticals fee schedule
- Not eligible for 340B

Reimbursement for LARC devices: OAC 5160-2-79
Reimbursement for LARC devices: OAC 5160-2-79

- LARC device or implant must be billed using Type of Bill 131
  Only 1 detail line on claim and **NO** other procedure codes listed

- Paid in-patient claim must include a secondary ICD-10 CM diagnosis code for the Z37- Outcome of Delivery Range Codes
LARC device or implant must be reported using:

- Revenue Center Code 0278
- Medical/Surgical Supplies and Devices

MITS configured to pay for separate inpatient postpartum LARC claims effective 7/12/17

Reimbursement for LARC devices: OAC 5160-2-79
Inpatient Facility Stay During A Change

Managed Health Care Program: Eligibility and Enrollment OAC 5160-26-02

Who do I BILL?

<table>
<thead>
<tr>
<th>Admit Plan</th>
<th>Enrollment Change</th>
<th>Responsible Plan*</th>
</tr>
</thead>
<tbody>
<tr>
<td>FFS</td>
<td>FFS -&gt; MCP</td>
<td>FFS</td>
</tr>
<tr>
<td>MCP</td>
<td>MCP -&gt; FFS</td>
<td>MCP</td>
</tr>
<tr>
<td>MCP₁</td>
<td>MCP₁ -&gt; MCP₂</td>
<td>MCP₁</td>
</tr>
</tbody>
</table>
Hospitals recognized as a 340B entity are required to notify ODM when 340B purchased drugs are provided to a Medicaid individual

- 340B reporting is for outpatient claims only
- RCC 25X or 636 should be billed with a pharmaceutical J or Q code, an NDC, and modifier SE
- Non-340B entities using the SE modifier will have their claims denied with edit 3203
Provider-administered pharmaceutical HCPCS J-codes and Q-codes submitted with RCC 25X or 636 will be paid in accordance with the rate listed on the Provider Administered Pharmaceuticals Fee Schedule for that date of service.

Provider-administered pharmaceuticals are identified on the EAPG Covered Codes List.

If a non-provider-administered pharmaceutical is billed with RCC 25X or 636, that detail will be assigned an EAPG and will be paid in accordance with the standard EAPG reimbursement methodology.

Reimbursement for these items are subject to the discounting factors as determined by the EAPG grouper.

Refer to Hospital Billing Guidelines, section 3.3.1
Modifier JW – Drug amount discarded/not administered to patient

- Effective for dates of service on or after July 1, 2017
  - Informational only edit, will not affect reimbursement

- If a claim (one date of service) contains two detail lines with the same RCC, same pharmaceutical HCPCS code, and same NDC but one detail line contains modifier JW, the second detail line will not deny as a duplicate

- EOB 9950 will post on the detail containing modifier JW which will result in payment of $0 for that line
Physician assistants are allowed to practice within their scope of practice as authorized by state law.

Physician assistants are allowed to practice within the scope of practice of the physician assistant’s supervising physician.

Physician assistants may receive payment for serving as assistant-at-surgery with an AS modifier alone, when listed as the rendering provider.
APN is now Advanced Practice Registered Nurse (APRN)

Unless a specific exception is noted, all other Medicaid rules that pertain to services by a physician apply to APRNs

APRNs may receive payment for serving as assistant-at-surgery with an AS modifier alone, when listed as the rendering provider
When more than one imaging procedure is performed, the payment amounts remain the same for the following:

- Covered primary procedure, additional covered total procedure, and technical component alone of an additional covered procedure
- Must be performed by the same provider or provider group for the same patient in the same session

The maximum payment amount for the professional component alone was increased from 75% to 95%
Gynecological Service change

**NEW CODES**

- G0101
- Q0091

**REPLACING**

- S0612
- S0610

MTL No. 3334-16-18 notified providers of a coding change for gynecological services.
Pregnancy Related Services: OAC 5160-21-04

Optional preventive health services available to Medicaid eligible women and are intended to promote positive birth outcomes by supplementing regular obstetrical care.

In addition to delivery services, reimbursement is available for each of the following services:

- H1000 – At Risk Assessment
- H1001 – Antepartum Management
- S9436 – Childbirth Preparation/Lamaze
- H1002 – Care Coordination
- H1003 – At Risk Education
- S9452 – Nutrition Class for pregnant women
Three “pregnancy-related services” rules were rescinded and consolidated into this rule, effective 1/1/17.

Provision that allows separate Medicaid payment for delivery services rendered because of multiple births.

The maximum payment amount for the first delivery is 100%

The second delivery of a multiple birth is 50%

Third delivery is 25%

ODM form 03535 “Prenatal Risk Assessment” has been replaced by ODM form 10207 and the online NurtureOhio PRAF 2.0 system.
MITS & Claims
Medicaid Information Technology System (MITS)

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

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

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

Internet Access (high speed works best)

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

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

Turn OFF pop up blocker functionality
MITS

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

You will then be directed to another page where you will need to enter your “User ID” and “Password”
MITS Navigation

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

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

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

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

**Fees for claims submitted**

Claims must be received by Wednesday at Noon for weekend adjudication

---

**MITS Portal**

**Free submission**

Claims must be received by Friday at 5:00 P.M. for weekend adjudication

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

Trading partners contact DXC for EDI Support

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

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

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

<table>
<thead>
<tr>
<th>Institutional Claim:</th>
<th>Service Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Billing Information</strong></td>
<td><strong>Release of Information</strong></td>
</tr>
<tr>
<td>ICN</td>
<td>NOT ALLOWED TO RELEASE DATA</td>
</tr>
<tr>
<td>Claim Received Date</td>
<td>*From Date</td>
</tr>
<tr>
<td>Provider ID</td>
<td>*To Date</td>
</tr>
<tr>
<td>*Type Of Bill</td>
<td>Admission Date</td>
</tr>
<tr>
<td>[ Search ]</td>
<td>Admission Hour</td>
</tr>
<tr>
<td>Claim Type</td>
<td>*Admission Type</td>
</tr>
<tr>
<td>*Medicaid Billing Number</td>
<td>Admit Source</td>
</tr>
<tr>
<td>*Date of Birth</td>
<td>[ Search ]</td>
</tr>
<tr>
<td>Last Name</td>
<td>*Patient Status</td>
</tr>
<tr>
<td>First Name, MI</td>
<td></td>
</tr>
<tr>
<td>*Patient Account #</td>
<td>Non Covered Days</td>
</tr>
<tr>
<td>Medical Record #</td>
<td>Covered Days</td>
</tr>
<tr>
<td>*Attending Physician #</td>
<td>0</td>
</tr>
<tr>
<td>*Last Name</td>
<td>Non Covered Days</td>
</tr>
<tr>
<td>*First Name, MI</td>
<td>0</td>
</tr>
<tr>
<td>Operating Physician #</td>
<td>Coinsurance Days</td>
</tr>
<tr>
<td>Other Physician #</td>
<td>0</td>
</tr>
<tr>
<td>*ICD Version</td>
<td>Lifetime Reserve Days</td>
</tr>
<tr>
<td>10</td>
<td>Prior Authorization #/</td>
</tr>
<tr>
<td>*Patient Amount Paid</td>
<td>PreCertification #</td>
</tr>
<tr>
<td>$0.00</td>
<td>TOTAL CHARGES</td>
</tr>
<tr>
<td></td>
<td>Total Charges</td>
</tr>
<tr>
<td></td>
<td>$0.00</td>
</tr>
<tr>
<td></td>
<td>Total Non Covered Charges</td>
</tr>
<tr>
<td></td>
<td>$0.00</td>
</tr>
<tr>
<td></td>
<td>Total Covered Charges</td>
</tr>
<tr>
<td></td>
<td>$0.00</td>
</tr>
<tr>
<td></td>
<td>Medicaid CoPay Amount</td>
</tr>
<tr>
<td></td>
<td>$0.00</td>
</tr>
<tr>
<td></td>
<td>Note Reference Code</td>
</tr>
<tr>
<td></td>
<td>[ Search ]</td>
</tr>
<tr>
<td></td>
<td>Notes</td>
</tr>
</tbody>
</table>
Diagnosis Codes:
required on most claims

Must include all characters specified by ICD

Do **NOT** enter the decimal points

There are system edits and audits against those codes
# Diagnosis Codes

<table>
<thead>
<tr>
<th>Sequence</th>
<th>Diagnosis Code</th>
<th>Description</th>
<th>Present on Admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>440</td>
<td>CHRONIC OBSTRUCTIVE PULMON DISEASE W ACUTE LOWER RESP INFECT</td>
<td>YES</td>
</tr>
</tbody>
</table>

*Sequence, Diagnosis Code - Required

**Header - Other Payer**

*Claim Filing Indicator - Required
*Policy Holder Relationship to Insured
*Policy Holder Last Name
*Policy Holder First Name, MI
Policy Holder Date of Birth
Gender
*Paid Amount
*Paid Date
Allowed Amount

*Insurance Carrier Name
*Electronic Payer ID
Insured's Policy ID
*Payer Sequence
Medicare ICN

[Search]
## Detail Panel

### Table Data

<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></td>
<td></td>
<td></td>
<td>0</td>
<td>$0.00</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**: 0
- **Units Of Measurement**: 
- **Per Diem Rate**: $0.00
- **Total Charges**: $0.00
- **Non Covered Charges**: $0.00
- **Medicaid Allowed Amount**: $0.00
- **Status**: 
- **Final EAPG**: 
- **Pay Action**: 

### Additional Fields

- **Date of Service**: 
- **To DOS**: 
- **Revenue Code**: [Search] 
- **HCPCS/HIPPS Rate Codes**: [Search] 
- **Modifiers**: [Search] [Search] [Search] 
- **Submitted EAPG**: [Search] 
- **Initial EAPG**: [Search] 

### Buttons

- **delete**
- **add an item**
- **copy**
Multiple surgery codes have a payment limit of one unit per line

- If billed with multiple units the claim will deny

Procedure codes that are not identified as multiple surgery codes may be billed with multiple units

When applicable modifiers may be needed in order to bill certain surgical procedures
Drug products are identified and reported using a unique, three-segment number which serves as a universal product identifier for drugs.

Providers billing HCPCS codes in the J series and Q or S series, that represent drugs and CPT codes 90281 – 90399 series (immune globulins) must include the 11 digit NDC number.
If the NDC number printed on a drug package consists of only 10 digits, add a leading zero to the appropriate segment.

If the NDC number is missing or invalid, the claim line will deny.

The FDA publishes the listed numbers.
Click the “submit” button at the bottom right

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

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

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

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

Portal errors return the claim with a “fix” needed

Claim shows a ‘NOT SUBMITTED YET’ status still

<table>
<thead>
<tr>
<th>The following messages were generated:</th>
</tr>
</thead>
<tbody>
<tr>
<td>From DOS is required.</td>
</tr>
<tr>
<td>Procedure is required.</td>
</tr>
<tr>
<td>A valid Place Of Service is required</td>
</tr>
<tr>
<td>A valid Procedure Code is required</td>
</tr>
<tr>
<td>Units must be greater than 0.</td>
</tr>
<tr>
<td>Charges must be greater than $0.00.</td>
</tr>
<tr>
<td>A valid Medicaid Billing Number is required</td>
</tr>
<tr>
<td>A valid Medicaid Billing Number and Date of Birth combination is required.</td>
</tr>
</tbody>
</table>
Providers have 365 days to submit FFS claims

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

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

Claims over 2 years old will be denied

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

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

<table>
<thead>
<tr>
<th>Supporting Data for Delayed Submission / Resubmission</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DISCLAIMER:</strong> Documentation to justify the use of this panel and data entered must be retained for future audit purposes.</td>
</tr>
<tr>
<td>Previously Denied ICN or TCN</td>
</tr>
</tbody>
</table>
Special Billing Instructions – Eligibility Delay

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

- The claim must be submitted within 180 days of the hearing decision or eligibility determination date
Special Billing Instructions – Eligibility Delay

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

- In the Note Reference Code dropdown menu select “ADD”.

![Image of Medicaid CoPay Amount and Note Reference Code fields]
Special Billing Instructions – Eligibility Delay

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

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

Must use the spacing shown

Notes

DECISION 20211225
If Medicare issues a denial and indicates that the patient is responsible for the payment, submit the claim to ODM by following these steps:

- Enter a claim in MITS
- Do not enter any Medicare information on the claim
- Complete and upload a ODM 06653 and a copy of the Medicare EOB
Uploading an Attachment

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

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 midi can be uploaded.
Electronic attachments are accepted for Claims, Prior Authorization, and Enrollment Processing

Acceptable file formats:
BMP, DOC, DOCX, GIF, JPG, PDF, PPT, PPTX, TIFF, TXT, XLS, and XLSX

Each attachment must be <50 MB in size
Each file must pass an anti-virus scan in MITS
A maximum of 10 attachments may be uploaded
Adjusting a Paid Claim

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

- 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

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

2021172234001 Originally paid $50.00
5821173127250 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”
Example

2221180234001 Originally paid $45.00
5821185127250 Account receivable ($45.00)

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

- Open the claim you wish to copy
- Click the “copy claim” button at the bottom of the claim
- A new duplicate claim will be created, make and save all necessary changes
- The “submit” and “cancel” buttons will display at the bottom
- Click the “submit” button
- The claim will be assigned a new ICN
Clinically oriented software tool that automatically identifies inappropriate code combinations and discrepancies in claims.

Will look at the coding accuracy of procedures, not medical necessity, and will prevent inappropriate payment for certain services which include:

- Duplicate services (same person, same provider, same date)
- Individual services that should be grouped or bundled
- Mutually exclusive services
- Services rendered incidental to other services
- Services covered by a pre or post-operative period
- Visits in conjunction with other services
The National Correct Coding Initiative (NCCI)

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

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

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

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

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

Other payer information is entered in the Header – Other Payer panel.

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
<th>Date of Birth</th>
<th>Relationship</th>
<th>Gender</th>
<th>Policy ID</th>
<th>Paid Amount</th>
<th>Paid Date</th>
<th>Electronic Payer ID</th>
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</thead>
<tbody>
<tr>
<td>SMITH</td>
<td>JOHN</td>
<td>A</td>
<td>01/01/1950</td>
<td>FATHER</td>
<td>MALE</td>
<td>987654</td>
<td>$200.00</td>
<td>08/07/2021</td>
<td>01234</td>
</tr>
</tbody>
</table>

**Header – Other Payer**

- **Claim Filing Indicator**: COMMERCIAL INSURANCE
- **Policy Holder Relationship to Insured**: FATHER
- **Policy Holder Last Name**: SMITH
- **Policy Holder First Name, MI**: JOHN, A
- **Policy Holder Date of Birth**: 01/01/1950
- **Gender**: MALE
- **Paid Amount**: $200.00
- **Paid Date**: 08/07/2021
- **Electronic Payer ID**: 01234

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

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

Header - Other Payer Amounts and Adjustment Reason Codes
Third Party Liability (TPL) Claims

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

<table>
<thead>
<tr>
<th>Header - Other Payer</th>
<th></th>
<th></th>
<th></th>
<th></th>
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<td>Policy ID</td>
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<td>Paid Amount</td>
<td>$200.00</td>
<td>Paid Date</td>
<td>08/07/2021</td>
<td>01234</td>
<td></td>
</tr>
</tbody>
</table>

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

- **Claim Filing Indicator**: HMO, MEDICARE RISK
- **Policy Holder Relationship to Insured**: FATHER
- **Policy Holder Last Name**: SMITH
- **Policy Holder First Name, MI**: JOHN, A
- **Policy Holder Date of Birth**: 01/01/1950
- **Gender**: MALE
- **Paid Amount**: $200.00
- **Paid Date**: 08/07/2021

**Header - Other Payer Amounts and Adjustment Reason Codes**

- **Insurance Carrier Name**: HUMANA MEDICARE
- **Electronic Payer ID**: 01234
- **Insured’s Policy ID**: 987654
- **Payer Sequence**: PRIMARY
- **Medicare ICN**: 0000000000

- **Allowed Amount**: $0.00
Header vs Detail

Header level

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

Detail level

- A COB claim is considered to be adjudicated at the line/detail level if figures are reported for individual line items.
Third Party Liability (TPL) Claims

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

ARCs for a detail pay TPL are entered in the Detail – Other Payer Amounts and Adjustment Reason Codes panel.
ARC Codes

The X12 website provides adjustment reason codes (ARCs)

- Deductible
- Coinsurance
- Co-payment
- Contractual Obligation/Write off
- Non-covered services

COMMON ARCs:
Remittance Advice (RA)

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

- Select “Remittance Advice” and click “Search”

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

- **Paid, denied, and adjusted claims**

- **Financial transactions**
  - Expenditures - Non-claim payments
  - Accounts receivable - Balance of claim and non-claim amounts due to Medicaid

- **Summary**
  - Current, month, and year to date information
Remittance Advice (RA)

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

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

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

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

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

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

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

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

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

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

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

- Ohio Department of Medicaid provider page
  https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers

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

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

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

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

Information for Trading Partners (EDI)
https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/billing/trading-partners/trading-partners
Websites

- Companion Guides (EDI)
  https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/billing/trading-partners/companion-guides/companion-guides

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

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

- X12 Website (ARC Codes)
  http://www.x12.org/codes/claim-adjustment-reason-codes/
Websites

- PRAF 2.0 Information on the ODM site
  https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/special-programs-and-initiatives/praf/praf

- PRAF 2.0 login
  http://www.nurtureohio.com/login

- Hospital Billing Guide
FORMS

- ODM 06614 – Health Insurance Fact Request
- ODM 06653 – Medical Claim Review Request
- ODM 03197 – Prior Authorization: Abortion Certification
- ODM 03199 – Acknowledgement of Hysterectomy Information
- ODM 10207 – Pregnancy Risk Assessment Communication (PRAF)


- HHS-687 – Consent for Sterilization
# Forms

**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 03529</td>
<td>[ORDER FORM]</td>
<td>Healthchek &amp; Pregnancy Related Services Information Sheet</td>
</tr>
<tr>
<td>ODM 10129</td>
<td>[ORDER FORM]</td>
<td>Long-Term Services and Supports Questionnaire (LTSSQ) - Email Request</td>
</tr>
<tr>
<td>ODM 02399</td>
<td>[ORDER FORM]</td>
<td>Request for Medicaid Home and Community Based Services (HCBS)</td>
</tr>
</tbody>
</table>

## Search

- **Search:** 663

## File List

<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)