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

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

- Coordination of Benefits Section
  614-752-5768
  614-728-0757 (fax)
IVR: 1-800-686-1516

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

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

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

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

1. Alcohol and Drug 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
Eligibility Verification Request

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

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

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

You can search up to 4 years back

TIP: Always check eligibility prior to billing
Eligibility Verification Request

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

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

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

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

## Patient Liability

<table>
<thead>
<tr>
<th>Financial Payer</th>
<th>Monthly Amount</th>
<th>Type</th>
<th>Effective Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>DEFAULT</td>
<td>$1,949.00</td>
<td>Nursing Home</td>
<td>08/01/2021</td>
<td>09/30/2021</td>
</tr>
<tr>
<td>DEFAULT</td>
<td>$1,949.00</td>
<td>Nursing Home</td>
<td>07/01/2021</td>
<td>07/31/2021</td>
</tr>
<tr>
<td>DEFAULT</td>
<td>$1,949.00</td>
<td>Nursing Home</td>
<td>06/01/2021</td>
<td>06/30/2021</td>
</tr>
<tr>
<td>DEFAULT</td>
<td>$1,949.00</td>
<td>Nursing Home</td>
<td>05/01/2021</td>
<td>05/31/2021</td>
</tr>
<tr>
<td>DEFAULT</td>
<td>$5,319.00</td>
<td>Nursing Home</td>
<td>04/01/2021</td>
<td>04/30/2021</td>
</tr>
<tr>
<td>DEFAULT</td>
<td>$5,319.00</td>
<td>Nursing Home</td>
<td>03/01/2021</td>
<td>03/31/2021</td>
</tr>
</tbody>
</table>

## Long Term Care Facility Placements

<table>
<thead>
<tr>
<th>Facility Type</th>
<th>Date of Admission</th>
<th>Effective Begin Date of Medicaid Coverage</th>
<th>End Date of Medicaid Coverage</th>
<th>Date of Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>NURSING FACILITY</td>
<td>09/29/2020</td>
<td>01/01/2021</td>
<td>09/30/2021</td>
<td></td>
</tr>
</tbody>
</table>

## Recipient Restricted Coverage

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

## Special Program

*** No rows found ***
Presumptive Eligibility

Covers children up to age 19 and pregnant women

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

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

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

Presumptive Eligibility

MISSISSIPPI RIVERS
21 S FRONT ST
COLUMBUS, OH 43215

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

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

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

APPROVED:

<table>
<thead>
<tr>
<th>Name (First, M.I., Last Name)</th>
<th>Date of Birth</th>
<th>PE Type</th>
<th>Date Coverage Begins</th>
<th>Medicaid ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>MISSISSIPPI RIVERS</td>
<td>01/01/1987</td>
<td>PE PREGNANT</td>
<td>05/09/2021</td>
<td>910001331813</td>
</tr>
</tbody>
</table>
Presumptive Eligibility

NOTE TO MEDICAID PROVIDERS:

Non-pharmacy Medicaid Providers- You must verify eligibility in the MITS system.

Pharmacy Medicaid Providers- This letter is proof of Medicaid eligibility on the date this form is issued. After date of issuance, you must verify eligibility in the Pharmacy system.

Call this number if you are having difficulty processing a pharmacy claim: 1-877-518-1545 (24 hours a day, 7 days a week). Pharmacy staff should use the following billing information: BIN: 015863 PCN: OHPOP Group: not needed.

Qualified Entity Name: REGENCY HOSP OF COLUMBUS LLC
PE Determination Site: PO BOX 644219 PITTSBURGH, PA 15264
Qualified Entity Staff Name: DYAGENT DYAGENT
Contact Number: (222)333-1234

Signature of Qualified Entity Designee: __________________________ Date: __________
Presumptive Eligibility

Other members will receive this Presumptive Eligibility letter:

CDJFS Presumptive Eligibility

John Doe  
123 Main St.  
Anytown, OH 43210

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

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

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

APPROVED:

<table>
<thead>
<tr>
<th>Name (First, M.I., Last Name)</th>
<th>Date of Birth</th>
<th>PE Type</th>
<th>Date Coverage Begins</th>
<th>Medicaid ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>John Doe</td>
<td>11/19/1959</td>
<td>PE Adult</td>
<td>06/25/2021</td>
<td>910194194194</td>
</tr>
</tbody>
</table>
Presumptive Eligibility

The benefit/assignment plan will look like this:

<table>
<thead>
<tr>
<th>Recipient Information</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Billing Number</td>
<td></td>
</tr>
<tr>
<td>Last Name</td>
<td></td>
</tr>
<tr>
<td>First Name</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Date of Birth</td>
<td></td>
</tr>
<tr>
<td>Date of Death</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SSN</th>
<th>County of Residence</th>
<th>County of Eligibility</th>
<th>County Office</th>
<th><a href="http://jfs.ohio.gov/county/cntydir.stm">http://jfs.ohio.gov/county/cntydir.stm</a></th>
<th>Number Bed Hold Days Used Paid CY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Benefit / Assignment Plan</th>
<th>Effective Date</th>
<th>End Date</th>
<th>Provider Name</th>
<th>Dental Co-Pay Amount</th>
<th>Vision Co-Pay Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRESumptive:MRDD Targeted Case Mgmt</td>
<td>02/14/2019</td>
<td>09/30/2021</td>
<td>Provider Name</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>PRESumptive:Alcohol and Drug Addiction Services</td>
<td>02/14/2019</td>
<td>09/30/2021</td>
<td>Provider Name</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>PRESumptive:Medicaid</td>
<td>02/14/2019</td>
<td>09/30/2021</td>
<td>Provider Name</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>PRESumptive:Ohio Mental health</td>
<td>02/14/2019</td>
<td>09/30/2021</td>
<td>Provider Name</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
</tbody>
</table>
Qualified Medicare Beneficiary (QMB)

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

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

Billing individuals enrolled in the QMB program is prohibited by federal law

Federal law bars Medicare providers and suppliers from billing an individual enrolled in the QMB program for Medicare Part A and Part B cost sharing for covered items and services (see Sections 1902(n)(3)(B), 1902(n)(3)(C), 1905(p)(3), 1866(a)(1)(A), and 1848(g)(3)(A) of the Social Security Act [the Act]). The QMB system updates are part of CMS’ ongoing efforts to help providers comply with QMB billing prohibitions.
Qualified Medicare Beneficiary (QMB)

Qualified Medicare Beneficiary will show up in the benefit/assignment plan panel

<table>
<thead>
<tr>
<th>Recipient Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Billing Number</td>
</tr>
<tr>
<td>Last Name</td>
</tr>
<tr>
<td>First Name</td>
</tr>
<tr>
<td>Gender</td>
</tr>
<tr>
<td>Date of Birth</td>
</tr>
<tr>
<td>Date of Death</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Benefit / Assignment Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit / Assignment Plan</td>
</tr>
<tr>
<td>Qualified Medicare Beneficiaries</td>
</tr>
</tbody>
</table>
Specified Low-Income Medicare Beneficiary (SLMB) & Qualifying Individual (QI-1)

There is NO cost-sharing eligibility

We ONLY pay their Part B premium to Medicare

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

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

<table>
<thead>
<tr>
<th>Benefit / Assignment Plan</th>
<th>Effective Date</th>
<th>End Date</th>
<th>Provider Name</th>
<th>Dental Co-Pay Amount</th>
<th>Vision Co-Pay Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>SLMB</td>
<td>05/01/2017</td>
<td>07/31/2021</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Benefit / Assignment Plan</th>
<th>Effective Date</th>
<th>End Date</th>
<th>Provider Name</th>
<th>Dental Co-Pay Amount</th>
<th>Vision Co-Pay Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>QI 1/QI 2</td>
<td>04/26/2017</td>
<td>07/31/2021</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
</tbody>
</table>
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: OAC 5160-1-14

- Hearing Screening
- Immunization Screening
- Lead Toxicity Screening
- Lab Tests
- Dental Screening
When completing a HealthChek exam please complete all components of the exam and bill the correct *Preventive Medicine* code for the appropriate age group.
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.

<table>
<thead>
<tr>
<th>Time (min)</th>
<th>Code</th>
<th>Time (min)</th>
<th>Code</th>
<th>Time (min)</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td>99202</td>
<td>30</td>
<td>99203</td>
<td>45</td>
<td>99204</td>
</tr>
<tr>
<td>15</td>
<td>99213</td>
<td>25</td>
<td>99214</td>
<td>40</td>
<td>99215</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>99205</td>
</tr>
</tbody>
</table>

New Patient Initial Visit
Established Patient

Use These Codes
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
Adult Extension and HCBS Waiver

- Adults eligible via the extension will be able to access a home and community-based waiver (HCBS) if a level of care requirement is met. *(MCEs are responsible for state plan health care services)*
- HCBS waivers include Passport, Ohio Home Care, and Assisted Living. *(Fee-for-Service Medicaid is still responsible for waiver services)*
- Current HCBS waiver case management agencies will continue to coordinate waiver services.
Managed Care Benefits Package

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

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

### Benefit / Assignment Plan

<table>
<thead>
<tr>
<th>Benefit / Assignment Plan</th>
<th>Effective Date</th>
<th>End Date</th>
<th>Provider Name</th>
<th>Dental Co-Pay Amount</th>
<th>Vision Co-Pay Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRDD Targeted Case Mgmt</td>
<td>01/01/2019</td>
<td>10/31/2021</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Alcohol and Drug Addiction Services</td>
<td>01/01/2019</td>
<td>10/31/2021</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Ohio Mental Health</td>
<td>01/01/2019</td>
<td>10/31/2021</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Medicaid</td>
<td>01/01/2019</td>
<td>10/31/2021</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>MRDD Targeted Case Mgmt</td>
<td>10/24/2018</td>
<td>12/31/2018</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Alcohol and Drug Addiction Services</td>
<td>10/24/2018</td>
<td>12/31/2018</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Ohio Mental health</td>
<td>10/24/2018</td>
<td>12/31/2018</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Medicaid</td>
<td>10/24/2018</td>
<td>12/31/2018</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

### Case/Cat/Seq Spenddown

*** No rows found ***

### TPL

*** No rows found ***

### 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>
<tbody>
<tr>
<td>CARESOURCE</td>
<td>HMO, CFC</td>
<td>10/24/2018</td>
<td>10/31/2021</td>
<td></td>
</tr>
</tbody>
</table>
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

- Buckeye Health Plan
  - Phone: 866-296-8731
  - Website: https://www.buckeyehealthplan.com

- CareSource
  - Phone: 800-488-0134
  - Website: https://www.CareSource.com

- Paramount Health Care
  - Phone: 855-522-9076
  - Website: https://www.paramounthealthcare.com

- Molina Healthcare
  - Phone: 855-322-4079
  - Website: https://www.molinahealthcare.com

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

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

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

- 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
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
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: 1-855-475-3163 (TTY: 1-800-750-0750 or 711)
Behavioral Health Crisis: 1-866-206-7961
Care Management: 1-855-475-3163
24-Hour Nurse Advice: 1-866-206-7961 (TTY: 1-800-750-0750 or 711)
Website: CARESource.com/MyCare
Mail medical claims to: CARESource

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 pharmacy claims to: CVS Caremark
P.O. Box 52066
Phoenix, AZ 85072-2066

H8452 - 001
MITS Eligibility MyCare Opt-In

If an individual’s Medicaid **and** Medicare benefits are covered by the Managed Care Plan, you will see **dual benefits**.

<table>
<thead>
<tr>
<th>Managed Care</th>
<th>Plan Name</th>
<th>Plan Description</th>
<th>Effective Date</th>
<th>End Date</th>
<th>Managed Care Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>BUCKEYE COMMUNITY HEALTH PLAN</td>
<td>HMO, MyCare Ohio</td>
<td>10/24/2018</td>
<td>09/30/2021</td>
<td>Dual Benefits</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicare</th>
<th>Effective Date</th>
<th>End Date</th>
<th>Plan Name</th>
<th>Plan ID</th>
<th>Medicare ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>PART A</td>
<td>10/24/2018</td>
<td>10/31/2019</td>
<td></td>
<td></td>
<td>2YU3Q9WU99</td>
</tr>
<tr>
<td>PART B</td>
<td>10/24/2018</td>
<td>10/31/2019</td>
<td></td>
<td></td>
<td>2YU3Q9WU99</td>
</tr>
<tr>
<td>PART C</td>
<td>10/24/2018</td>
<td>09/30/2021</td>
<td>BUCKEYE HEALTH PLAN - MYCARE OHIO</td>
<td>H0022</td>
<td>2YU3Q9WU99</td>
</tr>
<tr>
<td>PART D</td>
<td>10/24/2018</td>
<td>10/31/2019</td>
<td>&quot;H0022/001&quot;</td>
<td>001</td>
<td>2YU3Q9WU99</td>
</tr>
</tbody>
</table>
MyCare Ohio Opt-Out Sample Card

Member Name: <Cardholder Name>
Member ID #: <Cardholder ID#>
MMIS Number: <Medicaid Recipient ID#>
PCP Name: <PCP Name>
PCP Phone: <PCP Phone>

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

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

Things to know:

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

MyCare Ohio Managed Care Contracting
MyCare Ohio Managed Care Plans

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

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

855-364-0974 [https://www.aetnabetterhealth.com/ohio](https://www.aetnabetterhealth.com/ohio)

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

WORK DIRECTLY WITH THE PLAN FIRST

IF NOT RESOLVED, SUBMIT A COMPLAINT TO OHIO DEPARTMENT OF MEDICAID (ODM)

MEDICAID.OHIO.GOV > RESOURCES FOR PROVIDERS > MANAGED CARE
Submitting a Managed Care Complaint

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

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

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

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

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

Provider Complaint Form Guidance

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

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

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

**Submission Tips:**

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

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

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

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

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

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

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

Provider Agreement: OAC 5160-1-17.2
Per OAC 5160-1-17.2(F), providers must inform ODM of any changes within 30 days
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.
Missed appointment fee
Unacceptable or untimely claim submission
Failure to request a prior authorization
Retroactive Peer Review stating lack of medical necessity

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

Medicaid Recipient Liability: OAC 5160-1-13.1
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
When Can you Bill an Individual?

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

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

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

Resources for Providers

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

https://codes.ohio.gov

Ohio's Official Online Publication of State Laws and Regulations

Ohio law consists of the Ohio Constitution, the Ohio Revised Code and the Ohio Administrative Code. The Constitution is the state's highest law superseding all others. The Revised Code is the codified law of the state while the Administrative Code is a compilation of administrative rules adopted by state agencies. Use the tools on this site to search or browse them all.

Ohio Constitution | Browse

Ohio Revised Code | Browse

Ohio Administrative Code | Browse
How to Find Modifiers Recognized by ODM

MODIFIERS:
- Modifiers recognized by ODM

DURABLE MEDICAL EQUIPMENT CLAIMS:
- Codes/Rates/Fee Schedules FAQs
- How to read the RA (RemittanceAdvice)
Pregnancy Related Services: MAL No. 605

Three “pregnancy-related services” rules were rescinded and consolidated into this rule, effective 1/1/17 and revised 7/1/21

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

The maximum payment amount for the first delivery is 100%

Payment for the second delivery of a multiple birth is 50%

Payment for the 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
Gynecological Service change

NEW CODES

G0101  Q0091

REPLACING

S0610  S0612

MTL No. 3334-16-18 notified providers of a coding change for gynecological services
Guidelines have been developed for completing forms associated with the following rules:

- **OAC 5160-21-02.2**
  - ODM 03199 Acknowledgement of Hysterectomy Information (formerly ODJFS 03199)
  - HHS-687 (OMB 0937 0166) Consent for Sterilization

- **OAC 5160-17-01**
  - ODM 03197 Abortion Certification Form (formerly ODJFS 03197)

Note: Forms ODM 03197 and 03199 were revised 6/1/221. Instruction forms ODM 03197-I and 03199-I are now obsolete.
Form ODM 03197 must be completed before payment can be made for the following CPT codes:

59840  59850  59852  59856  59866
59841  59851  59855  59857

Form ODM 03197 must be completed before payment can be made for the following ICD-10 codes:

10A00ZZ  10A04ZZ  10A07ZX  10A07ZZ
10A03ZZ  10A07Z6  10A07ZW  10A08ZZ
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
Healthchek: Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Covered Services: OAC 5160-1-14

- Previous rules 5160-14-01, 02, 03, 04, 05, and 09 consolidated into this new rule as of 11/1/17
- Changes include:
  - Definitions – “Bright Future Guidelines” added
  - Providers – Requirements in a single paragraph
  - Screening Visits – Language of rule derived from Social Security Act
  - Claim Submission Instructions – Removed from the rule, to be posted on ODM’s website with other claim submission instructions
  - Coverage – Unnecessary restriction on the coverage of habilitation service removed from the rule
Substitute Practitioners (Locum Tenens): OAC 5160-1-80

- Effective 10/1/2018, revised 1/1/2020
- The substitute practitioner receives payment from the regular practitioner on a fee-for-time basis
- Appropriate procedure code(s) must be accompanied by the Q6 modifier
- The NPI of the regular practitioner is reported in the rendering provider field of each detail, and the NPI of the substitute practitioner is reported in the rendering provider field of the claim header (or in the notes field for a dental claim)
Services Provided by a Physician Assistant: OAC 5160-4-03

**Revision effective 1/1/22**

- Payment may be made for a covered service performed by a physician assistant only if the physician assistant practices under either of the following arrangements:
  - The physician assistant provides services under a supervision agreement in accordance with ORC 4730.19; or
  - The physician assistant practices in a health care facility and provides services authorized by the facility.
- For assistant-at-surgery services, payment is 25% of the Medicaid maximum for the covered primary surgical procedure. (Modifier AS is reported on the claim, not UD.)
- For a covered immunization, injection of medication, or provider-administered pharmaceutical, payment is 100% of the schedule amount listed.
- For all other covered services, payment is the lesser of the submitted charge or 85% of the Medicaid maximum.
- Payment for services provided by a hospital-employed physician assistant will be made to the hospital.
The form APN in the rule was changed to APRN on 1/1/17

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

For assistant-at-surgery services, payment is 25% of the Medicaid maximum for the covered primary surgical procedure (Modifier AS is reported on the claim, not SA, SB, or UC.)
These provisions apply to procedures and procedure components performed by the same provider or provider group for the same patient in the same session.

When more than one imaging procedure is performed, the payment amounts remain the same for the following services:

- Covered primary procedure
- Additional covered total procedure
- Technical component alone of an additional covered procedure

The maximum payment amount for the professional component alone was increased from 75% to 95%.
Podiatry Services: OAC 5160-7-01
Effective 1/1/18 coverage was added for the following procedures:

- 99172
- 99173
- 99174
- 99177

ODM covers all procedures specified on the US Preventive Service Task Force (USPSTF) A and B recommendation list.
Acupuncture Services: OAC 5160-8-51

- Rendering provider
  - An acupuncturist recognized under ORC 4762.02
  - An individual practitioner, other than an acupuncturist (e.g., a physician or a chiropractor), holding a credential specified by law

- Billing ("pay-to") provider
  - An acupuncturist recognized under ORC 4762.02
  - An individual practitioner other than an acupuncturist (e.g., a physician or a chiropractor) holding a credential specified by law
  - An ambulatory health care clinic (OAC Chapter 5160-13)
  - A federally qualified health center (FQHC)
  - A rural health clinic (RHC)
  - An individual practitioner who supervises an acupuncturist or other credentialed acupuncture provider [as of 4/1/21]
  - A professional medical group
  - A hospital [as of 4/1/21]
Acupuncture Services: OAC 5160-8-51

- Payment may be made for a service, performed at the written order of a practitioner, that is rendered for treatment of one of the following conditions:
  - Low back pain
  - Migraine
  - Cervical (neck) pain [as of 4/1/21]
  - Osteoarthritis of the hip [as of 4/1/21]
  - Osteoarthritis of the knee [as of 4/1/21]
  - Nausea or vomiting related to pregnancy or chemotherapy [as of 4/1/21]
  - Acute post-operative pain [as of 4/1/21]
- Payment for more than 30 visits per benefit year requires prior authorization
No separate payment will be made for the following services:

- Both an evaluation and management (E&M) service and an acupuncture service rendered by the same provider to the same individual on the same day
- Services that are an incidental part of a visit (e.g., providing instruction on breathing techniques, diet, or exercise)
  - An acupuncture service performed by a non-physician in a hospital setting (for which the practitioner must make payment arrangements with the hospital) [as of 4/1/21]
- Additional treatment in either of the following circumstances:
  - Symptoms show no evidence of clinical improvement after an initial treatment period
  - Symptoms worsen over a course of treatment
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>97810</td>
<td>Acupuncture, one or more needles, without electrical stimulation, initial 15 minutes of one-on-one contact with the patient.</td>
<td>$25 per 15 minute increment</td>
</tr>
<tr>
<td>97811</td>
<td>Acupuncture, one or more needles, without electrical stimulation, each additional 15 minute increment of personal one-on-one contact with the patient, with reinsertion. (Listed separately in addition to primary code.)</td>
<td>$17.50 per each additional 15 minute increment</td>
</tr>
<tr>
<td>97813</td>
<td>Acupuncture, one or more needles, with electrical stimulation, initial 15 minutes of one-on-one contact with the patient.</td>
<td>$31.15 per 15 minute increment</td>
</tr>
<tr>
<td>97814</td>
<td>Acupuncture, one or more needles, with electrical stimulation, each additional 15 minute increment of personal one-on-one contact with the patient, with reinsertion. (Listed separately in addition to primary code.)</td>
<td>$23.65 per each additional 15 minute increment</td>
</tr>
</tbody>
</table>
MITS & Claims
Medicaid Information Technology System (MITS)

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

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

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

Internet Access (high speed works best)

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

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

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

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

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

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

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

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

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

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

Benefits of direct deposit include:

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

Fees for claims submitted

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

MITS Portal

Free submission

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

We can help with your claim issues

Free submission

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

Trading partners contact DXC for EDI Support

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

Claim entry format is divided into sections or panels

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

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

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

### Professional Claim:

**BILLING INFORMATION**

- **ICN**
- **Claim Received Date**
- **Claim Type** M - PROFESSIONAL
- **Provider ID**

- **Medicaid Billing Number**
- **Date of Birth**
- **Last Name**
- **First Name, MI**
- **Patient Account #**
- **Medical Record #**
- **Referring Provider #**
- **Rendering ID**

- **Medicare Assignment** NOT ASSIGNED
- **Patient Amount Paid** $0.00
- **ICD Version** 10

### SERVICE INFORMATION

- **Release of Information** NOT ALLOWED TO RELEASE DATA
- **Signature Source**
- **Accident Related To**
- **Accident State**
- **Accident Country**
- **Accident Date**

### TOTAL CHARGES

- **Total Charges** $0.00
- **Medicaid Allowed Amount** $0.00
- **TPL Paid Amount** $0.00
- **Total Medicaid Paid Amount** $0.00
- **Medicaid CoPay Amount** $0.00
- **Note Reference Code**

### Notes

---

### Diagnosis

*** No rows found ***

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

### Header - Other Payer

*** No rows found ***

Select row above to update or click add an item button below.
Effective 1/1/2020

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

Required on professional claims only

Diagnosis Codes: Medicaid Advisory Letter (MAL) No. 626-A

<table>
<thead>
<tr>
<th>Sequence</th>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 02</td>
<td>E559</td>
<td>VITAMIN D DEFICIENCY, UNSPECIFIED</td>
</tr>
<tr>
<td>A 01</td>
<td>R5081</td>
<td>FEVER PRESENTING WITH CONDITIONS CLASSIFIED ELSEWHERE</td>
</tr>
</tbody>
</table>
## Detail Panel

<table>
<thead>
<tr>
<th>Item</th>
<th>Itemld</th>
<th>FDOS</th>
<th>Units</th>
<th>Charges</th>
<th>Medicaid Allowed Amount</th>
<th>Status</th>
<th>Place of Service</th>
<th>Procedure Code</th>
<th>Modifier 1</th>
<th>Modifier 2</th>
<th>Modifier 3</th>
<th>Modifier 4</th>
<th>Final EAPG</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>1</td>
<td>10/20/2021</td>
<td>1.00</td>
<td>$375.00</td>
<td>$0.00</td>
<td>11</td>
<td></td>
<td>52287</td>
<td>78</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

- **Item**: 1
- **From DOS**: 10/20/2021
- **To DOS**: 10/20/2021
- **Units**: 1.00
- **Charges**: $375.00
- **Medicaid Allowed Amount**: $0.00
- **Rendering Provider**: 
- **Submitted EAPG**: 
- **Initial EAPG**: 
- **Status**: 
- **Visit Start Time**: 
- **Visit End Time**: 
- **Service Duration less than 90 days**: 
- **Place Of Service**: 11
- **Procedure Code**: 52287
- **Referred EPSDT Service/Family Planning**: 
- **Diagnosis Code Pointer**
- **Modifiers**: 78
- **Final EAPG**: 
- **Pay Action**: 
- **NDC**
- **Detail - Other Payor**
- **Chains/Plan**
- **Additional Provider Information**
Procedure Codes

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.
National Drug Code (NDC)

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.
National Drug Code (NDC)

<table>
<thead>
<tr>
<th>Detail Item</th>
<th>NDC Sequence Number</th>
<th>NDC</th>
<th>Drug Name</th>
<th>Unit of Measure</th>
<th>Prescription Number</th>
<th>Drug Unit Price</th>
<th>Unit Quantity Submitted</th>
</tr>
</thead>
</table>
| A           | 1                   | 64406080701 | ELOCTATE   | UN-Unit         |                     | $1.71           | 1000.000               

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

*Detail Item: 1
*NDC: 64406080701
*Drug Name: ELOCTATE
*Unit of Measure: UN-Unit

*Drug Unit Price: $1.71
*Unit Quantity Submitted: 1000.000
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 claim submissions are assigned an ICN

2221170357321

<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

Portal errors will show up at the top of the page

The following messages were generated:

- From DOS is required.
- Procedure is required.
- A valid Place Of Service is required
- A valid Procedure Code is required.
- Units must be greater than 0.
- Charges must be greater than $0.00.
- A valid Medicaid Billing Number is required
- A valid Medicaid Billing Number and Date of Birth combination is required.
Providers have 365 days to submit Fee For Service claims

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

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

Claims over 2 years old will be denied.

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

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

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.*

<table>
<thead>
<tr>
<th>Previously Denied ICN or TCN</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></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 – Additional Information.”
Special Billing Instructions – Eligibility Delay

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

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

Must use the spacing shown
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.
Uploading an Attachment

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

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

- 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.
Adjusting a Paid Claim – Example

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

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

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

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

* Make sure to wait until after the 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
ClaimChek Edits

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

- 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.
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.

A COB claim is considered to be adjudicated at the line/detail level if figures are reported for individual line items.
Other payer information is entered in the Header – Other Payer panel

### Third Party Liability (TPL) Claims

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
<th>Date of Birth</th>
<th>Relationship</th>
<th>Gender</th>
<th>Policy ID</th>
<th>Paid Amount</th>
<th>Paid Date</th>
<th>Electronic Payer ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>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>

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

- **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
- **Allowed Amount**: 0.00

- **Insurance Carrier Name**: BLUE CROSS BLUE SHIELD
- **Electronic Payer ID**: 01234
- **Insured’s Policy ID**: 987654
- **Payer Sequence**: PRIMARY
- **Medicare ICN**

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*Header - Other Payer Amounts and Adjustment Reason Codes*
If the TPL is a Medicare HMO, select “HMO, Medicare Risk” in the Claim Filing Indicator drop down menu.
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.

<table>
<thead>
<tr>
<th>Detail Item/Electronic Payer ID</th>
<th>CAS Group Code</th>
<th>ARC</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 1/43210</td>
<td>PR-Patient Responsibility</td>
<td>1</td>
<td>$50.00</td>
</tr>
<tr>
<td>A 1/43210</td>
<td>CO-Contractual Obligations</td>
<td>45</td>
<td>$150.00</td>
</tr>
</tbody>
</table>

Select row above to update – or – click add an item button below.
Adjustment Reason Codes (ARCs)

The X12 website provides adjustment reason codes (ARCs)

COMMON ARCs:

1. Deductible
2. Coinsurance
3. Co-payment
45. Contractual Obligation/Write off
96. Non-covered services
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\%252f52fPortal\%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)**

- **National Drug Code (NDC) Search**

- **Healthchek**

- **X12 Website (ARC 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
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

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

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

Reports & Research
Ohio Medicaid values transparency and accountability in all we do. We are committed to providing our stakeholders and partners with...

Helpful Links
Not seeing what you are looking for? We want to help you find the information you need. Check out these links to federal and state...

Initiatives
The Ohio Department of Medicaid is dedicated to being a national leader in health care coverage innovation. In collaboration with our... Legal and Contracts
We want to make it easier for you to do business with us. This page includes important information and links for vendors and others...

Medicaid Forms
Ohio Department of Medicaid Forms Library

For Medicaid Vendors
Provides information on invoices and computer use.

Request for Proposals
The Ohio Department of Medicaid is committed to using competitive procurement.

Single Pharmacy Benefit Manager (SPBM) Request For Proposal
This page contains public responses to the Single Pharmacy Benefit Manager (SPBM)
### 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><a href="#">ORDER FORM</a></td>
<td>Application for Health Coverage &amp; Help Paying Costs</td>
</tr>
<tr>
<td>ODM 03528</td>
<td><a href="#">ORDER FORM</a></td>
<td>Healthchk &amp; Pregnancy Related Services Information Sheet</td>
</tr>
<tr>
<td>ODM 10129</td>
<td><a href="#">ORDER FORM</a></td>
<td>Long-Term Services and Supports Questionnaire (LTSSQ) - Email Request</td>
</tr>
<tr>
<td>ODM 02399</td>
<td><a href="#">ORDER FORM</a></td>
<td>Request for Medicaid Home and Community Based Services (HCBS)</td>
</tr>
</tbody>
</table>

**Search:**

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