Hospice Basic Billing Training

External Business Relations

August 2017

Ohio Medicaid Services

- Agenda
  - Ohio Medicaid Services
  - Programs & Cards
  - Managed Care/MyCare Ohio
  - Provider Responsibilities
  - Policy
  - MITS
  - Hospice Enrollment
  - Claim Submission
  - Websites
  - Forms

Ohio Medicaid Services

- Ombudsmen

  Sarah Bivens
  Ava Cottrell
  Laura Gipson
  Ed Ortopan
  Janene Rowe
  Chezré Willoughby

Manager-Meagan Grove

Ohio Medicaid Services

- Ombudsman:
  - Investigate and resolve billing issues
  - Identify system and policy issues
  - Speak at seminars for provider associations
  - Conduct individual consultations with providers
  - Conduct basic billing trainings

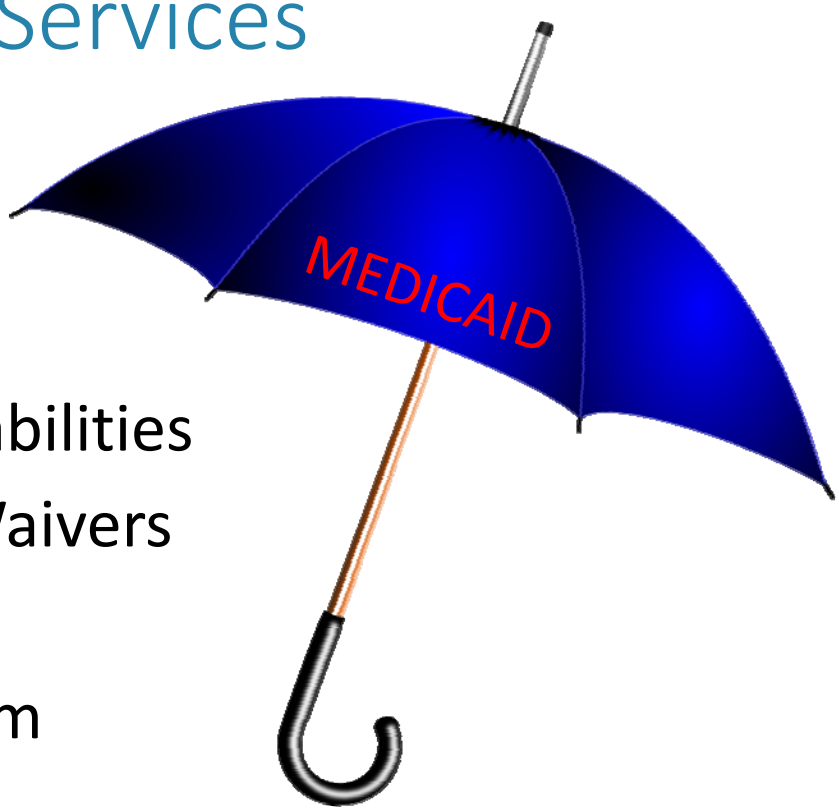
om·buds·man \ˈäm-ˌbu̇dz-mən, ˈȯm-, -bədz-, -ˌman

- *a person who investigates complaints and tries to deal with problems fairly*
- *one that investigates, reports on, and helps settle complaints*

Ohio Department of Medicaid
John R. Kasich, Governor
Barbara R. Sears, Director

Ohio Medicaid Services

- 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



Ohio Medicaid Services

- Covered Services (not limited to)
  - Behavioral Health
  - Dental
  - Dialysis
  - Dietitian
  - Durable Medical Equipment
  - Home Health
  - Hospice
  - Hospital (Inpatient/Outpatient)
  - ICF-IID Facility
  - Nursing Facility
  - Pharmacy
  - Physician
  - Transportation
  - Vision

Ohio Medicaid Services

Medical Necessity: OAC 5160-1-01

Is the fundamental concept underlying the Medicaid Program

All services must meet accepted standards of medical practice

Ohio Medicaid Services

- IVR 1-800-686-1516
  - Calls directed through the IVR prior to accessing the customer call center staff
  - Staff are available weekdays from 8:00 a.m. to 4:30 p.m.
  - Providers will be required to enter two out the following three pieces of data: tax ID, NPI, and 7 digit Ohio Medicaid provider number

Ohio Medicaid Services

- Helpful phone numbers
  - Adjustments
    - 614-466-5080
  - OSHIP (Ohio Senior Health Insurance Information Program)
    - 1-800-686-1578
  - Coordination of Benefits Section
    - 614-752-5768
    - 614-728-0757 (fax)

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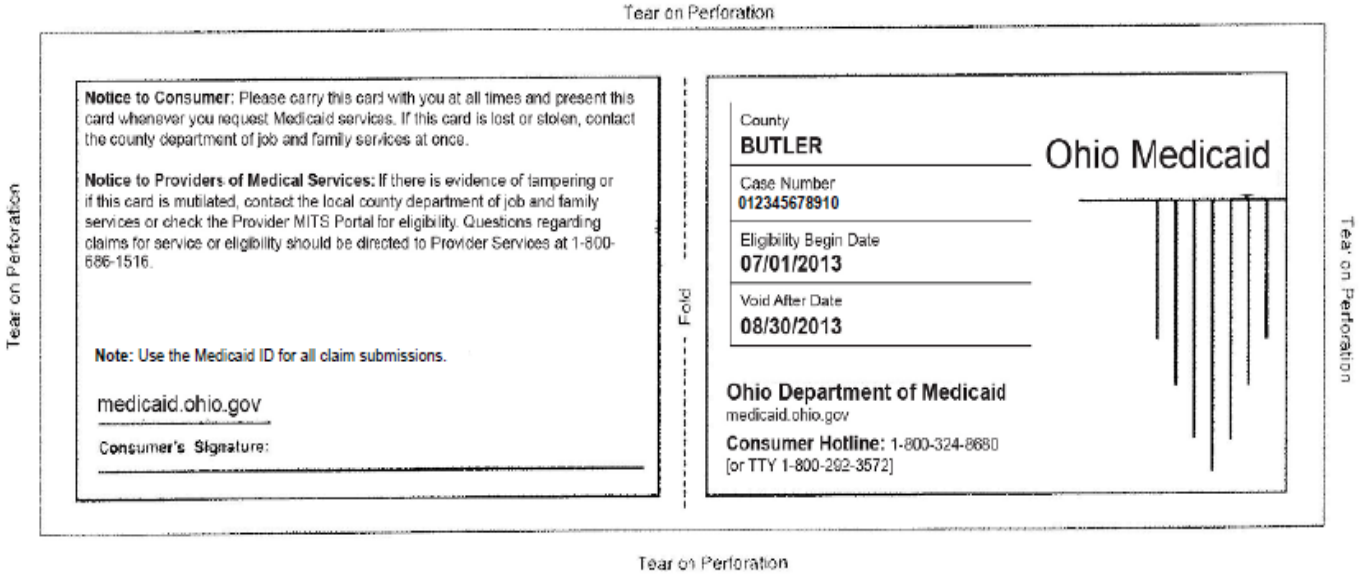
Programs & Cards

Programs & Cards

- Ohio Medicaid
  - This card is the traditional fee-for-service Medicaid card
  - Issued monthly


Tear on Perforation

Notice to Consumer: Please carry this card with you at all times and present this card whenever you request Medicaid services. If this card is lost or stolen, contact the county department of job and family services at once.

Notice to Providers of Medical Services: If there is evidence of tampering or if this card is mutilated, contact the local county department of job and family services or check the Provider MITS Portal for eligibility. Questions regarding claims for service or eligibility should be directed to Provider Services at 1-800-686-1516.

Note: Use the Medicaid ID for all claim submissions.

medicaid.ohio.gov

Consumer's Signature:

Fold

County
BUTLER

Case Number
012345678910

Eligibility Begin Date
07/01/2013

Void After Date
08/30/2013

Ohio Medicaid

Ohio Department of Medicaid
medicaid.ohio.gov
Consumer Hotline: 1-800-324-8680
[or TTY 1-800-292-3572]

Tear on Perforation

Tear on Perforation

Tear on Perforation

Ohio
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Programs & Cards

- Ohio Medicaid Categories
  - Some categories include:
    - 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, and/or Disabled (**ABD**) → **65+, or blind/disabled with no SSI**

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Programs & Cards

- Presumptive Eligibility
  - Covers children up to age 19 and pregnant women
    - It has now 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
  - Once approved by a CDJFS or a qualified entity an approval letter will be received

Programs & Cards

❖ Presumptive Eligibility, cont.

Recipient Information

Medicaid Billing Number		**SSN**	
Last Name		**County of Residence**	
First Name		**County of Eligibility**	
Gender		**County Office http://jfs.ohio.gov/County/County_Directory.pdf**	
Date of Birth		**Number Bed Hold Days Used Paid CY**	20170101: 10
Date of Death			

Benefit / Assignment Plan

Benefit / Assignment Plan	Effective Date	End Date	Provider Name	Dental Co-Pay Amount	Vision Co-Pay Amount
PRESUMPTIVE:Alternative Benefit Plan Medicaid Expansion	01/01/2017	06/30/2017		$0.00	$0.00
PRESUMPTIVE:MRDD Targeted Case Mgmt	01/01/2017	06/30/2017		$0.00	$0.00
PRESUMPTIVE:Alcohol and Drug Addiction Services	01/01/2017	06/30/2017		$0.00	$0.00
PRESUMPTIVE:Ohio Mental health	01/01/2017	06/30/2017		$0.00	$0.00
PRESUMPTIVE:Medicaid	01/01/2017	06/30/2017		$0.00	$0.00

Case/Cat/Seq Spenddown

Ohio Department of Medicaid
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Programs & Cards

- 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
  - Combined effort with ODRC, Ohio MHAS, ODH, and MCPs
  - All DRC facilities activated by January 2017
  - More than 11,000 individuals have benefited from this program

Program & Cards

DRC Inpatient Hospitalization

Process *Overview*

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 on Medicaid

Program & Cards

- Eligibility Verification Request- DRC Inpatient
  - Individuals who have Medicaid through the DRC Inpatient program will have the 'Inpatient Hospital Services Plan' in MITS

Recipient Information

Medicaid Billing Number		SSN	
Last Name		County of Residence	FRANKLIN
First Name		County of Eligibility	
Gender	MALE	County Office http://jfs.ohio.gov/County/County_Directory.pdf	
Date of Birth		Number Bed Hold Days Used Paid CY	
Date of Death			

Benefit / Assignment Plan

Benefit / Assignment Plan	Effective Date	End Date	Provider Name	Dental Co-Pay Amount	Vision Co-Pay Amount
Inpatient Hospital Services Plan	05/01/2017	05/31/2017		$0.00	$0.00

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Programs & Cards

- 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
    - Note: Co-insurance and/or deductible payments are based on the reimbursement policies currently set in place under 5160-1 General Provisions and could result in a payment of zero dollars

Programs & Cards

- Specified Low-Income Medicare Beneficiary (SLMB) & Qualifying Individual (QI-1)
  - We *ONLY* pay their Part B premium to Medicare
  - This is *NOT* Medicaid eligibility
  - There is *NO* cost-sharing eligibility

Programs & Cards

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

Programs & Cards

- Conditions of Eligibility and Verifications, cont.
  - 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

Managed Care/MyCare Ohio

Managed Care/MyCare Ohio

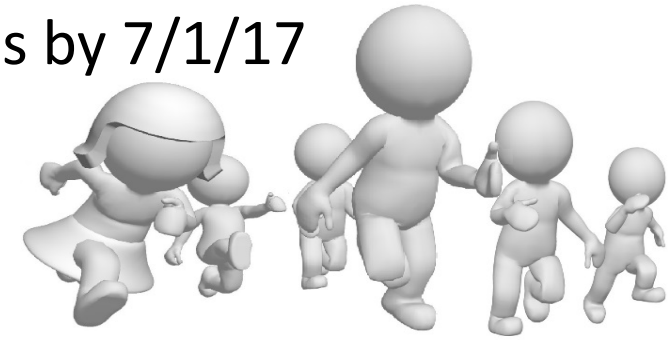
- Three different groups of Managed Care eligible:
  - Medicaid Managed Care MAGI (CFC)
  - Medicaid Managed Care Non-MAGI (ABD)
  - Medicaid Managed Care Adult MAGI
    - For the adult extension population

Managed Care/MyCare Ohio

- Managed Care Benefit Package
  - Managed Care Plans must cover all medically necessary Medicaid covered services
  - Some value-Added Services:
    - Care management to help members coordinate care and ensure they are getting the care that they need
    - Access to toll-free 24/7 hotline for medical advice, staffed by nurses
    - On-line searchable provider directory
    - Preventative care reminders
    - Expanded benefits including additional transportation options, and other incentives (varies among the MCPs)

Managed Care/MyCare Ohio

- *New populations* moving into Managed Care
  - The Managed Care population will continue to grow so always check eligibility prior to providing services
    - Adoption children 1/1/17
    - Breast and Cervical Cancer Patients (BCCP)- 1/1/17
    - Bureau of Children with Medical Handicaps (BCMH) - 1/1/17
    - Foster children – transitioning in phases by 7/1/17



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Managed Care/MyCare Ohio

- Individuals with *optional enrollment* in Medicaid Managed Care Plan
  - Native Americans that are members of federally recognized tribes
  - Home and Community Based waivers thru DODD 1/1/17

Managed Care/MyCare Ohio

- Adult Extension and HCBS Waiver
  - Adults eligible via the extension will be able to access a home-and community-base waiver (HCBS) if a level of care requirement is met
  - HCBS waivers include: Passport, Ohio Home Care, and Assisted Living
  - MCPs will be responsible for health care services however waiver services will be paid by traditional Medicaid
  - Current HCBS waiver case management agencies will continue to coordinate wavier services

Managed Care/MyCare Ohio

- 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 recipient
  - The MITS provider portal will show if a recipient is enrolled in a Managed Care Plan based on the eligibility dates of service you enter
  - For recipients enrolled in a MyCare Ohio Managed Care plan it will show if they are enrolled for *Dual Benefits* or *Medicaid Only*

Managed Care/MyCare Ohio

Benefit / Assignment Plan

Benefit / Assignment Plan	Effective Date	End Date	Provider Name	Dental Co-Pay Amount	Vision Co-Pay Amount
MAGI-GROUP VIII:Alternative Benefit Plan Medicaid Expansion	01/01/2017	02/28/2017		$0.00	$0.00
MAGI-GROUP VIII:MRDD Targeted Case Mgmt	01/01/2017	02/28/2017		$0.00	$0.00
MAGI-GROUP VIII:Alcohol and Drug Addiction Services	01/01/2017	02/28/2017		$0.00	$0.00
MAGI-GROUP VIII:Ohio Mental health	01/01/2017	02/28/2017		$0.00	$0.00
MAGI-GROUP VIII:Medicaid	01/01/2017	02/28/2017		$0.00	$0.00

Case/Cat/Seq Spenddown

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Managed Care

Plan Name	Plan Description	Effective Date	End Date	Managed Care Benefits
CARESOURCE	HMO, CFC	01/01/2017	02/28/2017	

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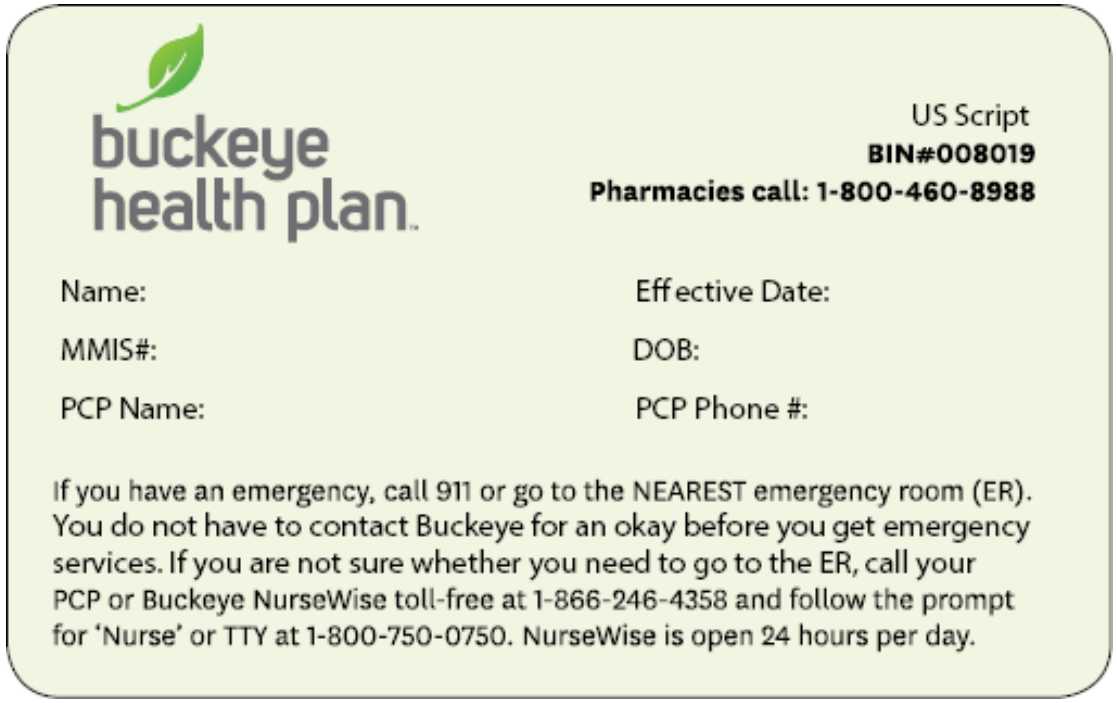
Managed Care/MyCare Ohio

Managed Care Sample Card



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Managed Care/MyCare Ohio

- Integrated Care Delivery System (ICDS) "MyCare Ohio"
  - 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 was extended for 2 additional years

Managed Care/MyCare Ohio

- MyCare Ohio Benefits
  - Package includes all benefits available through the traditional Medicare and Medicaid programs
    - Including Long Term Social Services (LTSS) and Behavioral Health, which is new to Managed Care
  - Plans may elect to include additional value-added benefits in their health care packages

Managed Care/MyCare Ohio

- 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
    - Reside in one of the demonstration project regions

*Individuals residing in NF's and those enrolled in a NF-level of care 1915c waiver are included in the demonstration project-- except for ICF-IID individuals and/or those receiving behavioral health services

Managed Care/MyCare Ohio

Benefit / Assignment Plan

Benefit / Assignment Plan	Effective Date	End Date	Provider Name	Dental Co-Pay Amount	Vision Co-Pay Amount
MRDD Targeted Case Mgmt	01/01/2017	02/28/2017		$0.00	$0.00
Alcohol and Drug Addiction Services	01/01/2017	02/28/2017		$0.00	$0.00
Ohio Mental health	01/01/2017	02/28/2017		$0.00	$0.00
Medicaid	01/01/2017	02/28/2017		$0.00	$0.00

Case/Cat/Seq Spenddown

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TPL

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Managed Care

Plan Name	Plan Description	Effective Date	End Date	Managed Care Benefits
CARESOURCE	HMO, MyCare Ohio	01/01/2017	02/28/2017	Dual Benefits

Lock-In

*** No rows found ***

Medicare

Coverage	Effective Date	End Date	Plan Name	Plan ID	HIC
PART A	01/01/2017	02/28/2017			
PART B	01/01/2017	02/28/2017			
PART C	01/01/2017	02/28/2017	CARESOURCE MYCARE OHIO	H8452	
PART D	01/01/2017	01/31/2017	*H8452/001	001	

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Managed Care/MyCare Ohio

MyCare Ohio Opt-In Sample Card

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:	866-549-8289 (TDD/TTY 800-750-0750)
Behavioral Health Crisis:	866-549-8289
Care Management:	866-549-8289
24-Hour Nurse Advice:	866-246-4358 Option 7)
Website:	www.bchpohio.com
Send claims to:	Buckeye Community Health Plan P.O. Box 3060 Farmington, MO 63640-3822

Managed Care/MyCare Ohio

MyCare Ohio Opt-Out Sample Card

Buckeye Community Health Plan

MyCareOhio
Connecting Medicare + Medicaid

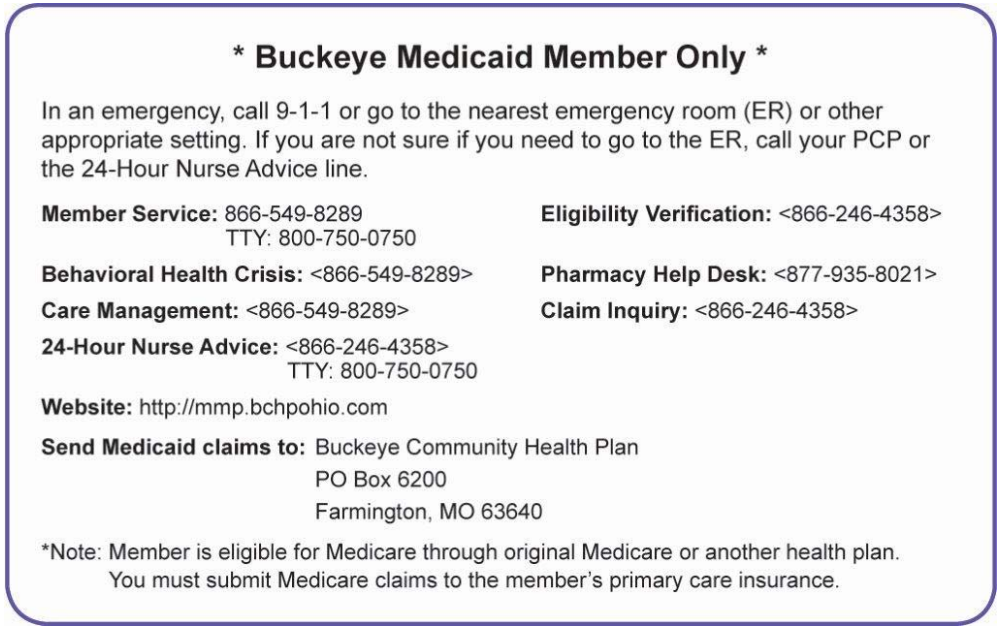
Buckeye Community Health Plan - MyCare Ohio

Member Name: <Cardholder Name>
<Health Plan: <Card Issuer Identifier>>

MMIS Number: <Medicaid Recipient ID#2>

PCP Name: <PCP Name>
PCP Phone: <PCP Phone>

RxBin: 600428
RxPCN: 0624000
RxID: <RxID#3>


*** Buckeye Medicaid Member Only ***

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: 866-549-8289
TTY: 800-750-0750

Eligibility Verification: <866-246-4358>

Behavioral Health Crisis: <866-549-8289>

Pharmacy Help Desk: <877-935-8021>

Care Management: <866-549-8289>

Claim Inquiry: <866-246-4358>

24-Hour Nurse Advice: <866-246-4358>
TTY: 800-750-0750

Website: http://mmp.bchpohio.com

Send Medicaid claims to: Buckeye Community Health Plan
PO Box 6200
Farmington, MO 63640

*Note: Member is eligible for Medicare through original Medicare or another health plan. You must submit Medicare claims to the member's primary care insurance.

Managed Care/MyCare Ohio

- Individuals *Exempt* from MyCare Ohio Groups
  - The following groups are not eligible for enrollment in MyCare Ohio:
    - Individuals with an ICF-IID level-of-care served in an ICF-IID waiver
    - Individuals who have third-party insurance, including retirement benefits
    - Individuals enrolled in PACE program

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Managed Care/MyCare Ohio

MCPs providing "Traditional" Medicaid Managed Care	MCPs participating in MyCare Ohio (ICDS)
• Buckeye (Centene) • Caresource • Molina • United HealthCare • Paramount	• Buckeye (Centene) • Caresource • Molina • United HealthCare • Aetna

Managed Care/MyCare Ohio

- MyCare Ohio Region Breakdown

Northwest	Southwest	West Central	Central	East Central	Northeast Central	Northeast
Aetna Buckeye	Aetna Molina	Buckeye Molina	Aetna Molina	Caresource United	Caresource United	Caresource Buckeye United
Fulton Lucas Ottawa Wood	Butler Warren Clinton Hamilton Clermont	Clark Green Montgomery	Union Delaware Franklin Pickaway Madison	Summit Portage Stark Wayne	Trumbull Mahoning Columbiana	Lorain Cuyahoga Lake Geauga Medina

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Managed Care/MyCare Ohio

- Managed Care Contracting
  - If a provider is interested in delivering services to a Managed Care member, a contract or agreement with the plan is necessary
    - 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 contracts are *separate* from ABD/CFC Managed Care plan contracts

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Managed Care/MyCare Ohio

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

Managed Care/MyCare Ohio

- Provider Complaints
  - Work directly with the Plan first
  - If not resolved, submit a complaint to Ohio Department of Medicaid (ODM)
    - http://www.ohiomh.com/ProviderComplaintForm.aspx
  - Certification issues, work with the Area Agency on Aging (AAA) or ODM for MyCare Ohio waiver providers
  - Provider credentialing concerns can be sent to Ohio Department of Insurance (ODI)

Provider Responsibilities

Provider Responsibilities

- Provider Enrollment
  - There is a non-refundable application fee when an application is submitted to become a Medicaid provider
    - This is a federal requirement
    - The 2017 fee is $560.00 per application
    - The fee applies to organizational providers only (not individual providers, practitioners, or practitioner groups)

Provider Responsibilities

- Provider Revalidation
  - The 5 year revalidation is a federal requirement
  - Make sure your mailing address is up to date in the Demographics panel in MITS
  - Providers that do not revalidate will have their Medicaid agreement terminated
  - The non-refundable application fee also applies to the revalidation of your provider agreement

Provider Responsibilities

Ohio | Department of Medicaid

Text Size: +A -A

Select Language
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Translation Disclaimer

HOME | MEDICAID 101 | FOR OHIOANS | PROVIDERS | INITIATIVES | RESOURCES | CAREERS | CONTACT

- Enrollment and Support
  - Provider Enrollment
  - Provider Assistance
  - Provider Exclusion and Suspension List
  - Federal Requirement for Revalidation ReEnrollment
  - Automated Registry Check
- Fee Schedule and Rates
- Billing
- Training
- Managed Care
- Provider Types
- MITS
- Payment Innovation
- DRA Attestation
- Prior Authorization Requirements

Learn more about the state's first executiv

ector's Welcome

Director
Barbara Sears
Ohio Department of Medicaid

Tweets by @OH_Medicaid

Ohio Medicaid Retweeted
HealthTransformation
@OHTohio
Governor Kasich protects health coverage, signs budget conta.cc/2twaJbT
01 Jul

Are you uninsured?
Ohio | Benefits

Are you unemployed?
Ohio MEANS Jobs.

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Provider Responsibilities

- Provider Revalidation, cont.
  - Check online for past, current, and future revalidations

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ODM mails a reminder notice to providers 90 days prior to the expiration of their Ohio Medicaid provider agreement to the mailing address of record in the Medicaid Information System (MITS). Therefore, it is vital that providers maintain a current address in MITS. The notice will provide revalidation instructions and direct the provider to the ODM Internet-based provider application portal.

Certain organizational providers are required to pay an application fee. MITS will inform providers if they are required to pay the application fee.

This page lists revalidation dates so providers can learn their revalidation deadline.

Providers may call Provider Enrollment at 1-800-686-1516 with any questions.

Questions and Answers

Revalidation Instructions

Upcoming Revalidations

- 2019, 2020, 2021
- 2018
- 2017
- 2016

Important Notice for Providers that Have Received Revalidation Letters

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Provider Responsibilities

- Provider Agreement: OAC 5160-1-17.2
  - The provider agreement is a legal contract between the state and the provider
  - In the contract, you agree you will:
    - Accept the allowable reimbursements as payment-in-full
    - Not seek reimbursement for service(s) from the patient, any member of the family, or any other person
    - Maintain records for 6 years

Provider Responsibilities

- Provider Agreement, cont.
  - You also agree to:
    - Render medically necessary services in the amount required
    - Recoup any third party resources available
    - Inform us of any changes to your provider profile within 30 days
    - Abide by the regulations and policies of the state

Provider Responsibilities

- Provider Reimbursement: OAC 5160-1-02 and 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

Provider Responsibilities

- Medicaid Consumer Liability: OAC 5160-1-13.1
  - A provider ***MAY NOT*** collect and/or bill for any difference between the Medicaid payment and the provider's charge
  - A Medicaid consumer ***CANNOT*** be billed:
    - When a Medicaid claim has been denied
    - Unacceptable claim submission
    - Failure to request a prior authorization
    - Retroactive Peer Review determination of lack of medical necessity

Provider Responsibilities

- Consumer Liability, cont.
  - 3 steps ***must be*** followed in order to bill a consumer
    1. The consumer is notified in writing prior to the service being rendered that the provider will not bill the department for the covered service; ***and***
    2. The consumer agrees to be liable for payment of the service and signs a written statement to that effect prior to the service being rendered; ***and***
    3. The provider explains to the consumer that the service is a covered Medicaid service and that other Medicaid providers may render the service at no cost to the consumer

Provider Responsibilities

- Coordination of Benefits: OAC 5160-1-08
  - The Ohio Revised 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

Provider Responsibilities

- 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

http://www.supplier.obm.ohio.gov/Update/Medicaid.aspx

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Provider Responsibilities

- Ohio Medicaid Website: www.Medicaid.ohio.gov

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Provider Responsibilities

Ohio.gov | State Agencies | Online Services

Ohio | Department of Medicaid

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PROVIDERS

Welcome Providers

Ohio is home to more than 83,000 active Medicaid providers. The partnership between Ohio Medicaid and its provider network is critical in ensuring reliable and timely care for beneficiaries across the state. In the months ahead, this page will become a go-to resource for learning more about training, billing, rate-setting and additional areas interest concerning the provider community.

Provider News

Please listen carefully when calling the IVR as the options have changed as of 6/17/2016.

Timely Filing Reminder for ICF-IID Providers (6/29/2016)

Notice Regarding Provision of Progesterone (6/13/16)

Independent Provider Overtime Rates - Effective January 1, 2016 (Rev. 4/1/16)

Post-Implementation ORP FAQs

Medicaid Requirements for Ordering, Referring, and Prescribing (ORP) - Effective January 12, 2015

Pay and Post Period for Ordering, Referring and Prescribing Provider Requirements

Provider Enrollment Application Fee

Behavioral Health Provider Integration Project

Nurse and Aide Service Rate Modernization

Need technical assistance?
Provider Hotline: (800) 686-1516

Access the **MITS Portal**

Related Content

- Benefit Coordination & Recovery
- Fee Schedules/Rates
- Medicaid Forms
- ODJFS Forms
- MITS EDMS Cover Page
  - Instructions
- Healthchek Screening Forms
- e-Manuals
- Helpful Links
- Get a National Provider Identifier (NPI)
- Transmittal Letter Notification
- Medicaid Provider Incentive

Policy

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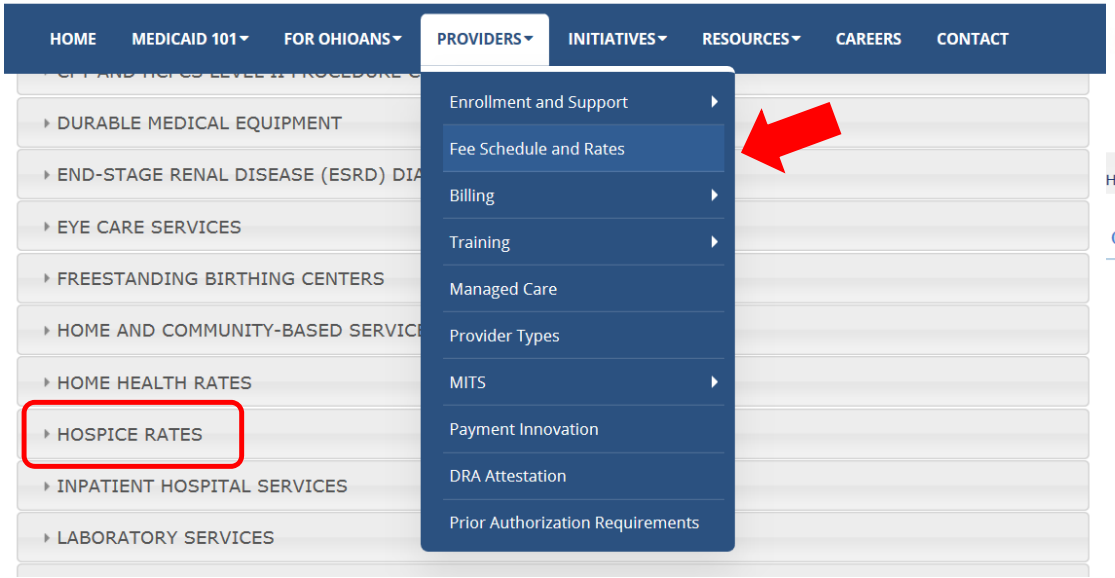
Policy

- Policy Updates
  - Policy updates from Ohio Medicaid announce the changes to Ohio Administrative Code that may affect providers. There are two types of letters:
    - Medical Assistance Letters (MAL)
    - Medicaid Transmittal Letters (MTL)

http://medicaid.ohio.gov/RESOURCES/Publications/ODMGuidance.aspx#1535541-medicaid-policy

Policy

❖ Medicaid Fee Schedules and Rates



Policy

Scroll down for Hospice Chapter 56

❖ LAWriter - Ohio Medicaid Laws

5160 Medicaid

Chapter 5160-1 General Provisions.

Chapter 5160-2 Hospital Services.

Chapter 5160-3 Long-Term Care Facilities; Nursing Facilities; Intermediate Care Facilities for the Mentally Retarded.

Chapter 5160-4 Physician Services.

Chapter 5160-5 Dental Program.

Chapter 5160-6 Vision Care Services.

Chapter 5160-7 Podiatric Services.

Chapter 5160-8 Limited Practitioner Services.

Chapter 5160-9 Pharmacy Services.

Chapter 5160-10 Medical Supplies, Durable Medical Equipment, Orthoses, and Prosthesis Providers.

Chapter 5160-11 Independent Laboratory and X-Ray Services.

Chapter 5160-12 Ohio Home Care Program.

Chapter 5160-13 Ambulatory Health Care Clinic Services.

Chapter 5160-14 Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) Services.

Chapter 5160-15 Medical Transportation Services.

Chapter 5160-16 Rural Health Services.

Chapter 5160-17 Abortions.

Chapter 5160-18 Freestanding Birth Center.

Chapter 5160-20 Primary Alternative Care and Treatment Program.

Go

Prev | Next

Chapter 5160-1 General Provisions.

Chapter 5160-2 Hospital Services.

Chapter 5160-3 Long-Term Care Facilities; Nursing Facilities; Intermediate Care Facilities for the Mentally Retarded.

Chapter 5160-4 Physician Services.

Chapter 5160-5 Dental Program.

Chapter 5160-6 Vision Care Services.

Chapter 5160-7 Podiatric Services.

Chapter 5160-8 Limited Practitioner Services.

Chapter 5160-9 Pharmacy Services.

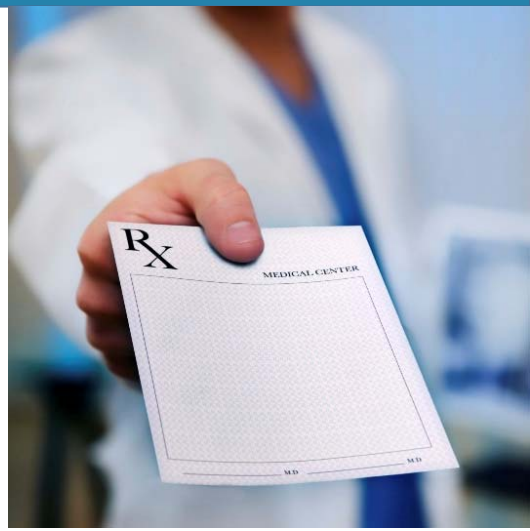
Chapter 5160-10 Medical Supplies, Durable Medical Equipment, Orthoses, and Prosthesis Providers.

Chapter 5160-11 Independent Laboratory and X-Ray Services.

Chapter 5160-12 Ohio Home Care Program.

Chapter 5160-13 Ambulatory Health Care Clinic Services.

Policy



- Ordering, Referring and Prescribing Providers (ORP): OAC 5160-1-17.9
  - Went into effect 1/12/2015
  - Federal regulation was implemented under Section 6401 of the Patient Protection and Affordable Care Act of 2010 (ACA)

Policy

- ORP, cont.
  - 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

Ohio Department of Medicaid
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Policy

- ORP, cont.
  - 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: http://www.medicaid.ohio.gov/PROVIDERS/EnrollmentandSupport/ProviderEnrollment/ORP.aspx

Policy

- ORP, cont.
  - Search for ORP information on the MITS portal

Ohio Departme edicaid

Search

Welcome,

Super User | Providers | Cost Report | Account | Claims | Eligibility | Prior Authorization | Reports | Portal Admin | Publications

demographic maintenance | 1099 information | provider faq | mits days report | correspondence | self attestation

ordering/referring/ prescribing search | group affiliation | group members

Ordering/Referring/Prescribing Search

Ordering Provider NPI

Ordering Provider Last Name: SMITH

First, MI

*Date of Service: 08/04/2017

search

clear

**If you receive no results, the information is either incorrect or the provider is not enrolled with Ohio Medicaid

Search Results

Ordering Provider NPI	Ordering Provider Name
1417128380	SMITH, ALEXIS M
1609219773	SMITH, AMY J
1801980636	SMITH, ANDRE L
1972967214	SMITH, APRIL
1083926083	SMITH, ASHLEY
1689670846	SMITH, BRADLEY J
1639387863	SMITH, BRADLEY M
1588111678	SMITH, BRIANNA S
1972521797	SMITH, CHARLES K
1902001282	SMITH, CHRISTINE N

1 2 3 4 5 6 7 8 9 10 ... Next >

Policy

- Hospice Services Reporting Requirements: OAC 5160-56-03.3
  - Hospice Enrollments—**NEW PROCESS!!**
    - Must be completed and processed on the MITS Provider Portal
    - Only for Individuals in fee-for-service Medicaid, not those enrolled into a managed care plan
    - All Individuals in which hospice is seeking reimbursement after all other payers
    - Must provide all required information in order for the hospice enrollment to process or billed claims will not pay

Policy

- Hospice Services Reporting Requirements: OAC 5160-56-03.3(A)(2)
  - Hospice Enrollments, cont.
    - All individuals with routine home care, T2042, for DOS on or after 1/1/16
    - Any individual, for any hospice service, where an original claim needs to be submitted
    - Any individual, for any hospice service, where a claim needs to be adjusted

Policy

- Hospice Services Reporting Requirements: OAC 5160-56-03.3, cont.
  - Hospice Enrollments, cont.

    - Mass adjustment will take place in 2018 to correct previous payments
    - Claims with no enrollments will deny and retract any previous payments received
      - For all professional claims, for procedure codes T2042, G0299, and G0155

Policy

- Hospice Services Reimbursement: OAC 5160-56-06
  - Service Intensity Add-On (SIA) Codes
    - New codes that have been backdated to be *effective 1/1/16*
    - Payment for routine home care by an RN or licensed social worker **within the last 7** days of life, when the discharge from hospice is due to death
    - Billed using code **G0299**, for direct care by in-person visit from an RN
    - Billed using code **G0155**, for direct care by in-person visit from a social worker
      - Should not be billed until after the individual has passed away
      - May be billed individually as long as T2042 was already billed and paid
      - Can be billed on the same claim as T2042 for those days

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Policy

- Hospice Services Reimbursement: OAC 5160-56-06, cont.
  - Hospice procedure codes based on level of care:
    - Code **T2042** used for one unit per day to bill routine home care
      - Individual who is receiving services at home, who is not receiving continuous home care
      - Reimbursement is paid using a two-tiered system based on the Episode of Care:
        1. First episode - per diem is paid at the higher rate for first 60 days; lower rate for the remainder of the episode beyond 60 days
        2. Gap of 60 days or more - will break the current episode
        3. Second episode - begins on the 61st day following a break in service

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Policy

- Hospice Services Reimbursement: OAC 5160-56-06, cont.
  - Hospice procedure codes based on level of care:
    - Code **T2043** used for one unit per hour
      - With a minimum of 8 hours per day, for continuous home care
    - Code **T2044** used for one unit per day for inpatient respite care
    - Code **T2045** used for one unit per day for general inpatient care

Policy

- Hospice Services Reimbursement: OAC 5160-56-06, cont.
  - Hospice may receive R&B payments for individuals who are residents, overnight, of nursing facilities or ICF-IID facilities
    - Bill for R&B using procedure code **T2046**
    - Reimbursed at 95% of the rate established for the Long Term Care Facility (LTCF)
      - Must be manually calculating the 95% and entering it as the billed charge on each claim, until the grace period is over
    - Only for days the individual receives routine home care or continuous care
    - Bill even if the days are compensated via patient liability

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MITS

MITS

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

MITS

- Technical Requirements
  - Internet Access (high speed works best)
  - Internet Explorer version 10 or higher and current versions of Firefox or Chrome
  - Mac users can use current versions of Safari, Firefox or Chrome
  - Turn ***OFF*** pop up blocker functionality

MITS

- Technical Requirements, cont.
  - If you are using IE10 and having difficulty signing into the MITS portal do the following:
    - On the top line of your Internet Explore page, click on Tools> then click on Compatibility View Settings>
    - Type in OHMITS.com (beside the “add” button) and then click the “add” button
    - Finally click the “close” button at the bottom of the page. Then log in to the portal normally

MITS

Home - Microsoft Internet Explorer provided by ODJFS

https://portal.ohmits.com/Portal/Default.aspx

File Edit View Favorites Tools Help

Delete Browsing History... Ctrl+Shift+Del
InPrivate Browsing Ctrl+Shift+P
Reopen Last Browsing Session

InPrivate Filtering Ctrl+Shift+F
InPrivate Filtering Settings

Pop-up Blocker
SmartScreen Filter
Manage Add-ons

Compatibility View
Compatibility View Settings

Subscribe to this Feed...
Feed Discovery

Developer Tools F12

Windows Messenger
Diagnose Connection Problems...
Novell Messenger

Internet Options

Turn Off Pop-up Blocker
Pop-up Blocker Settings

Favorites eBay Yahoo! Mail

Home

Prior Authorization Reports Publications

MITS

- How do I access the MITS Portal?
  - Go to http://Medicaid.ohio.gov
  - Select the "Provider Tab" at the top
  - Click on the "MITS Portal" on the right

MITS

Ohio Department of Medicaid

Search

About ODM | Our Services | Resources | News & Events

Tuesday 06/16/2015 11:34:38 AM

Home Consumers Providers Trading Partners Public Information Publications

enrollment enrollment tracking search long-term care account setup

Ohio Department of Medicaid

Provider Home

Using the Provider Enrollment wizard, applicants are guided through the necessary steps to complete and submit an enrollment application to become a Medicaid provider. After logging in to the Secured Site, providers can use self-service tools to manage their account, access their mailbox, update demographic information, exchange data files, request eligibility verification, and process claims, prior authorizations, and referrals.

Login to secure site

- Click Here to Login

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"

Ohio.gov | Medicaid Information Technology System

Sign In

Medicaid Information Technology System

To sign in, please enter your User ID and Password

User ID:

Password:

Whoever knowingly, or intentionally accesses a computer or a computer system without authorization or exceeds the access to which that person is authorized, and by means of such access, obtains, alters, damages, destroys, or discloses information, or prevents authorized use of the information operated by the State of Ohio, shall be subject to such penalties allowed by law. All activities on this system may be recorded and/or monitored. Individuals using this system expressly consent to such monitoring and evidence of possible misconduct or abuse may be provided to appropriate officials. Users who access this system consent to the provisions of confidentiality of the information being accessed, but have no expectation of privacy while using this system.

In the event that an unauthorized user is able to access information to which they are not entitled, the user should immediately notify the site administrator.

Yes, I have read the agreement

Login

Help FAQ
Help Reset Password?
Forgot Your User ID?

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MITS

- MITS Web Portal Navigation
  - The "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 the mouse to move between fields)
  - MITS Web Portal access will time-out after 15 minutes of inactivity in the system

MITS

- Panel Help
  - The "?" button in the upper right corner of a panel may be selected to reveal panel information

search search detail dental institutional professional

Online Help - Windows Internet Explorer

interChange
An HP Medicaid Solution

Online Panel Help

Claim Search-Search

The Claim Search-Search panel is used by the provider to search all claims associated with the provider's ID number. Search results can be narrowed by using the criteria fields.

Field Descriptions:

Field	Description
Clear	Clears all the search criteria.
Search	Displays the Search Results based on the criteria entered on the search panel.
Amount Billed	Dollar amount billed for the claim.
Claim Type	Type of claim.
Date of Service	Allows the user to filter the search by date of service. When Date of Service is selected as a search criteria field, the RA Date field is disabled.
From DOS	Beginning date of service for date range search. This field is enabled when Date Range is selected for Date of Service.
ICN/TCN	Contains either the internal control number (ICN) or the transaction control number (TCN) that cross references a converted claim from the old system.

search
clear

MITS

- Field Help
  - Clicking a field title will open a box containing field information

Welcome,

Super User Providers Account Claims Eligibility Prior Authorization Reports Publications

search search detail dental institutional professional

Institutional Claim: NPI -

BILLING INFORMATION

ICN

Provider ID NPI

Type Of Bill

Claim Type

Medicaid Billing Number

SERVICE INFORMATION

Release of Information NOT ALLOWED TO RELEASE DATA

From Date

To Date

Admission Date

Admission Hour

Admission Type

Admit Source

Discharge Hour

Patient Status

Covered Days 0

Non Covered Days 0

Coinsurance Days 0

Lifetime Reserve Days

Prior Authorization #/ Precertification #

Online Field Help - Windows Internet Explorer

https://portal.ohmits.com/Portal/DesktopModules/iC_BasePage/Help/iC

Medicaid Billing Number
Recipient's Medicaid identification number.

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MITS

- Eligibility Search
  - Full Medicaid eligibility on the MITS portal will show four (or more) benefit spans:
    - Medicaid
    - MRDD Targeted Case Management
    - Alcohol and Drug Addiction Services
    - Ohio Mental Health
  - Additional spans when applicable:
    - Alternative Benefit Plan, for Extension adults
    - Medicaid School Program span, if applicable by age

MITS

- Eligibility Search, cont.
  - Verification of the following:
    - Medicare
    - Managed Care
    - Benefit Plan
    - Third Party
    - Patient Liability
    - Long Term Care

MITS

❖ Eligibility Search

Super User Providers Cost Report Account Claims **Eligibility** Prior Authorization Reports Portal Admin Publications

eligibility search hospice enrollment

Eligibility Verification Request

Medicaid Billing Number		Birth Date	
SSN		DOS Date Format	MM/DD/YYYY
Procedure Code		From DOS	02/17/2017
		To DOS	02/17/2017

search

clear

*This information is only valid for 'from date' to end of the month searched.

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MITS

- Eligibility Verification Request
  - You can search up to 3 years at a time!!

Super User Providers Cost Report Account Claims Eligibility Prior Authorization Reports Portal Admin Publications

eligibility search hospice enrollment

Eligibility Verification Request

Medicaid Billing Number		Birth Date	
SSN		DOS Date Format	MM/DD/YYYY
Procedure Code		From DOS	03/01/2014
		To DOS	02/17/2017

search

clear

*This information is only valid for 'from date' to end of the month searched.

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MITS

❖ Eligibility Verification Request-result

Recipient Information

Medicaid Billing Number		SSN	
Last Name		County of Residence	CRAWFORD
First Name		County of Eligibility	
Gender		County Office http://jfs.ohio.gov/County/County_Directory.pdf	
Date of Birth		Number Bed Hold Days Used Paid CY	20160101: 4
Date of Death			

Associated Child(ren) Search

Benefit / Assignment Plan

Benefit / Assignment Plan	Effective Date	End Date	Provider Name	Dental Co-Pay Amount	Vision Co-Pay Amount
MRDD Targeted Case Mgmt	09/01/2015	02/28/2017		$0.00	$0.00
Alcohol and Drug Addiction Services	09/01/2015	02/28/2017		$0.00	$0.00
Ohio Mental health	09/01/2015	02/28/2017		$0.00	$0.00
Medicaid	09/01/2015	02/28/2017		$0.00	$0.00
MRDD Targeted Case Mgmt	05/01/2014	08/31/2015		$0.00	$0.00
Alcohol and Drug Addiction Services	05/01/2014	08/31/2015		$0.00	$0.00
Ohio Mental health	05/01/2014	08/31/2015		$0.00	$0.00
Medicaid	05/01/2014	08/31/2015		$0.00	$0.00
MAGI-GROUP VIII:Alternative Benefit Plan Medicaid Expansion	03/01/2014	04/30/2014		$0.00	$0.00
MAGI-GROUP VIII:MRDD Targeted Case Mgmt	03/01/2014	04/30/2014		$0.00	$0.00

1 2 Next >

Case/Cat/Seq Spenddown

*** No rows found ***

TPL

Carrier Name	Carrier Number	NAIC	Policy Number	Policy Holder	Coverage Type	Coverage	Effective Date	End Date	Group Number
					IND	PHYSICIAN/OUTPATIENT COVERAGE	02/01/2015	02/28/2017	
					IND	INPATIENT COVERAGE	02/01/2015	02/28/2017	

Managed Care

Plan Name	Plan Description	Effective Date	End Date	Managed Care Benefits
CARESOURCE	HMO, CFC	06/01/2014	02/28/2017	

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MITS

❖ Eligibility Verification Request-results, cont.

Lock-In
*** No rows found ***

Medicare
*** No rows found ***

Service Limitation
*** No rows found ***

Enter a Procedure Code on the Eligibility Verification Request panel to search for Service Limitations.

Level of Care Determinations
*** No rows found ***

Patient Liability
*** No rows found ***

Long Term Care Facility Placements
*** No rows found ***

Recipient Restricted Coverage
*** No rows found ***

Special Program
*** No rows found ***

MITS

- Eligibility Verification Request-results, cont.
  - Search for children who are on the same case as their mom

Recipient Information

Medicaid Billing Number		SSN	
Last Name		County of Residence	CRAWFORD
First Name		County of Eligibility	
Gender		County Office http://jfs.ohio.gov/County/County_Directory.pdf	
Date of Birth		Number Bed Hold Days Used Paid CY	20160101: 4
Date of Death			

Associated Child(ren) Search

Associated Child(ren)

Medicaid Billing Number	First Name	MI	Last Name	Gender	Date of Birth
123456789012	AUDREY		DOE	FEMALE	11/20/2004
987654321012	ALEX		DOE	MALE	09/14/2006

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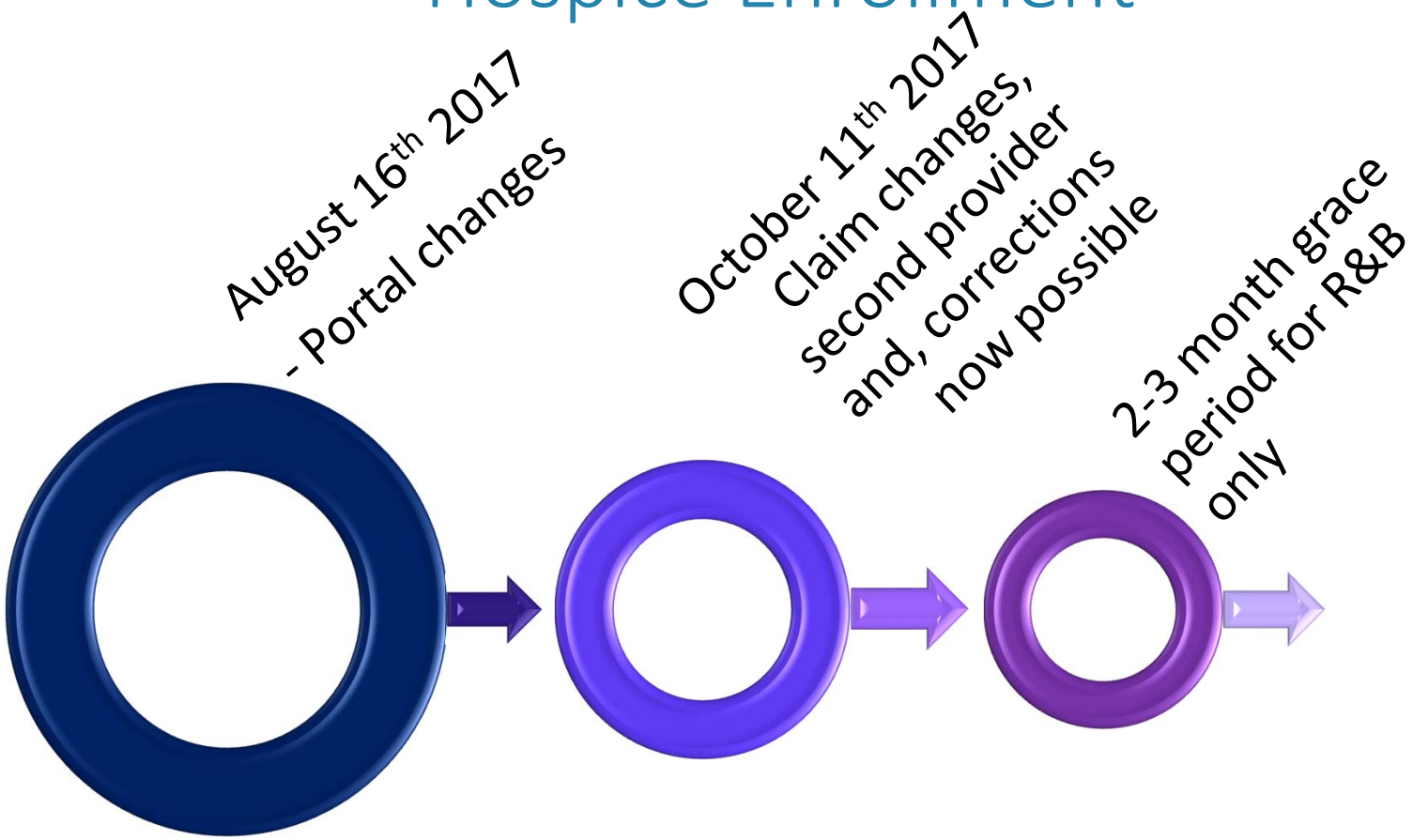
Hospice Enrollment

Hospice Enrollment



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Hospice Enrollment

❖ Steps on completing a Hospice Enrollment

Ohio Department of Medicaid

Search

Welcome,

Super User | Providers | Cost Report | Account | Trading Partners | Claims | Episode Claims | Eligibility | Prior Authorization | Reports | Portal Admin | Security

Trade Files | Admin

demographic maintenance | 1099 information | provider faq | mits days report | cor | on | hospital cost report

ordering/referring/ prescribing search | group affiliation | group members

Eligibility Search
Health Homes
Deemed Eligible Newborn
Presumptively Eligible
Child
Presumptively Eligible
Pregnant Woman
Psychiatric Admission
Hospice Enrollment

Name
Provider ID 05/05/2011-12/31/2299 NPI
Medicare
Zip Code 45040

You can view your Remittance Advices, your 835 transactio ing Reports on the menu bar.

Hospice Enrollment

Hospice Enrollment

❖ Steps on completing a Hospice Enrollment, cont.

Ohio Department of Medicaid

Search

Welcome,

Super User Providers Cost Report Account Trading Partners Claims Episode Claims Eligibility Prior Authorization Reports Portal Admin Security Trade Files Admin

eligibility search health homes deemed eligible newborn presumptively eligible child presumptively eligible pregnant woman psychiatric admission hospice enrollment

Hospice Enrollment Search: NPI -

Hospice Tracking Number

Medicaid Billing Number

search

clear

add

Hospice Enrollment

❖ Steps on completing a Hospice Enrollment, cont.

Ohio Department of Medicaid

Search

Welcome,

Super User Providers Cost Report Account Trading Partners Claims Episode Claims Eligibility Prior Authorization Reports Portal Admin Security Trade Files Admin

eligibility search health homes deemed eligible newborn presumptively eligible child presumptively eligible pregnant woman psychiatric admission hospice enrollment

Hospice - Application: NPI -

*Type of Action
Change of Hospice Provider
New Enrollment
Hospice Provider Name
Hospice Provider ID
Medicaid Billing Number
Consumer Date of Birth
Consumer Name
County of Record
Submission Date 08/07/2017

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Hospice Enrollment

❖ Steps on completing a Hospice Enrollment, cont.

Hospice - Application: NPI -

*Type of Action

(Changing this selection will remove any unsaved changes.)

Hospice Provider Name

Hospice Provider ID

Medicaid Billing Number

Consumer Date of Birth

Consumer Name

County of Record FRANKLIN

Submission Date 07/19/2017

Consumer name will populate once you enter a correct billing number and DOB

County and State of Recipient's Hospice Service Location

County of Service	State of Service	Effective Date	End Date
FRANKLIN	OH	07/18/2017	10/15/2017

Select row above to update -or- click Add button below.

delete add

State of Service AA

County of Service

Effective Date

End Date

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Hospice Enrollment

❖ Steps on completing a Hospice Enrollment, cont.

County and State of Recipient's Hospice Service Location

*** No rows found ***

Select row above to update -or- click Add button below.

delete add

Enrollment - Disenrollment

*Election Date

Date of Disenrollment

Hospice Benefit Period

*** No rows found ***

Select row above to update -or- click Add button below.

delete add

Hospice Episode of Care

*** No rows found ***

Hospice Other Payer Spans

*** No rows found ***

Select row above to update -or- click Add button below.

delete add

Hospice Terminal Illness Diagnosis

*** No rows found ***

Select row above to update -or- click Add button below.

delete add

Provider Service Span

*** No rows found ***

Select row above to update -or- click Add button below.

delete add

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Hospice Enrollment

- Steps on completing a Hospice Enrollment, cont.
  - Must enter benefit periods in chronological order, start at the beginning with the 1st 90 day period

Hospice Benefit Period

Benefit Period Segment Indicator	Benefit Period Effective Date	Benefit Period End Date	Status	Reason for Updating Benefit Period
FIRST 90 DAY PERIOD	07/18/2017	10/15/2017	PROCESSED	

Type changes below.

delete add

Benefit Period Segment Indicator: FIRST 90 DAY PERIOD

Benefit Period Effective Date: 07/18/2017

Benefit Period End Date: 10/15/2017

CERTIFYING PHYSICIAN INFORMATION

Hospice IDG Physician		Attending Physician	
NPI		NPI	
Oral Certification Date	07/01/2017	Oral Certification Date	07/01/2017
Written Certification Date	07/10/2017	Written Certification Date	07/10/2017

Update Benefit Period

Reason For Updating Benefit Period

Benefit Plans [Search]

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Hospice Enrollment

- Steps on completing a Hospice Enrollment, cont.
  - Provider has the ability to search eligibility while completing the hospice enrollment

Hospice Benefit Period

Benefit Period Segment Indicator	Benefit Period Effective Date	Benefit Period End Date	Status	Reason for Updating Benefit Period
FIRST 90 DAY PERIOD	01/01/2016	03/30/2016	PROCESSED	
SECOND 90 DAY PERIOD	03/31/2016	06/15/2016	INCOMPLETE	

Type changes below.

delete add

Benefit Period Segment Indicator: SECOND 90 DAY PERIOD
Benefit Period Effective Date: 03/31/2016
Benefit Period End Date: 06/15/2016
CERTIFYING PHYSICIAN INFORMATION
Hospice IDG Physician
NPI: 1386628931
Oral Certification Date:
Written Certification Date: 03/30/2016
Update Benefit Period: ☐
Reason For Updating Benefit Period:
Benefit Plans: [Search]

Enter the dates in question

Benefit Plans [Close]

Search

Effective Date: 03/31/2016
End Date: 06/15/2016
search clear

Search Results

Health program	Effective Date	End Date
MCAID	20140101	22991231

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Hospice Enrollment

❖ Steps on completing a Hospice Enrollment, cont.

Hospice Episode of Care

Episode of Care	First Date	Last Date	Number of Calendar Days in Episode	Number of Benefit Days in Episode	Date of 61st Day
Episode 1	07/18/2017	10/15/2017	90	90	09/16/2017

Hospice Terminal Illness Diagnosis

Benefit Period	Primary Hospice Terminal Diagnosis	Terminal Diagnosis 2	Terminal Diagnosis 3	ICD Version	Diagnosis Effective Date	Diagnosis End Date
07/18/2017 - 10/15/2017	A010			10	07/18/2017	10/15/2017

Type changes below.

delete add

Benefit Period	07/18/2017 - 10/15/2017			
*ICD Version	10			
Code			Diagnosis Description	
*Primary Hospice Terminal Diagnosis	A010	[Search]		TYPHOID FEVER
Terminal Diagnosis 2		[Search]		
Terminal Diagnosis 3		[Search]		
*Diagnosis Effective Date	07/18/2017			
*Diagnosis End Date	10/15/2017			

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Hospice Enrollment

❖ Steps on completing a Hospice Enrollment, cont.

Provider Service Span

Hospice Provider	Effective Date	End Date
	07/18/2017	10/15/2017

Select row above to update -or- click Add button below.

delete add

Effective Date

End Date

HLTCF Provider Service Span

*** No rows found ***

Select row above to update -or- click Add button below.

delete add

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Hospice Enrollment

- Steps on completing a Hospice Enrollment, cont.
  - After completing all fields, click 'submit' at the bottom
  - Once processed, additional benefit periods may be

Confirmation

Your Hospice application has been updated on 07/18/2017

Your Hospice Tracking Number is

***IMPORTANT - This Hospice Tracking Number (HTN) is necessary for accessing the status of submitted enrollments. Please write this number down or print this page and keep it for your records PRIOR TO EXITING. Applications submitted after 4 PM will not be processed until the next business day.**

Please remember to submit the following required documents:

WHAT'S NEXT?

- *To upload required document (or to obtain a cover page), select: Upload required documents*

Hospice Enrollment

- HLTCF Provider Service Span panel
  - Hospice provider must enter the LTC provider and dates in the hospice enrollment so claims pay correctly
  - The claim will deny if this field is left blank

HLTCF Provider Service Span

HLTCF Provider Medicaid ID	HLTCF Provider NPI ID	Provider Name	Effective Date	End Date
A				

Type data below for new record.

delete | add

*HLTCF Provider Medicaid ID [Search] Provider Name

HLTCF Provider NPI ID

*Effective Date

*End Date

Hospice Enrollment

- Steps on adding an additional benefit period
  - Enter the tracking number and/or Medicaid billing number, click search

Ohio Department of Medicaid

Search

Welcome,

Super User Providers Cost Report Account Trading Partners Claims Episode Claims Eligibility Prior Authorization Reports Portal Admin Security Trade Files Admin

eligibility search health homes deemed eligible newborn presumptively eligible child presumptively eligible pregnant woman psychiatric admission hospice enrollment

Hospice Enrollment Search

Hospice Tracking Number

Medicaid Billing Number

search

clear

add

Search Results

Hospice Tracking Number	Medicaid Billing Number	Name	Date Received	Status	Denial Reason
			07/19/2017	PROCESSED	

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Hospice Enrollment

- Steps on adding an additional benefit period, cont.
  - Chose 'Maintain Hospice Record'

Hospice - Application:

*Type of Action	Benefit Termination Close Current Service Span for a change of provider Death Maintain Hospice Record Revocation
Hospice Provider Name	
Hospice Provider ID	
Medicaid Billing Number	
Consumer Date of Birth	
Consumer Name	
County of Record	CUYAHOGA
Submission Date	07/07/2017

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Hospice Enrollment

- Steps on adding an additional benefit period, cont.
  - Proceed to add a matching span in each appropriate panel

County and State of Recipient's Hospice Service Location

County of Service	State of Service	Effective Date	End Date
ALLEN	OH	07/21/2017	10/18/2017
ALLEN	OH	01/17/2018	03/17/2018
ALLEN	OH	10/19/2017	01/16/2018

Type changes below.

delete add

State of Service OH

County of Service ALLEN

Effective Date 10/19/2017

*End Date 01/16/2018

Hospice Enrollment

- Steps on adding an additional benefit period, cont.
  - Previous benefit period must have a 'PROCESSED' status first

Hospice Benefit Period

Benefit Period Segment Indicator	Benefit Period Effective Date	Benefit Period End Date	Status	Reason for Updating Benefit Period
FIRST 90 DAY PERIOD	07/21/2017	10/18/2017	PROCESSED	
SUBSEQUENT 60 DAY PERIOD	01/17/2018	03/17/2018	PROCESSED	
SECOND 90 DAY PERIOD	10/19/2017	01/16/2018	PROCESSED	

Type changes below.

delete add

Benefit Period Segment Indicator SUBSEQUENT 60 DAY PERIOD

Benefit Period Effective Date 01/17/2018

Benefit Period End Date 03/17/2018

CERTIFYING PHYSICIAN INFORMATION

Hospice IDG Physician		Attending Physician	
NPI		NPI	
Oral Certification Date		Oral Certification Date	
Written Certification Date	01/17/2018	Written Certification Date	01/17/2018

Update Benefit Period ☐

Reason For Updating Benefit Period

Benefit Plans [Search]

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Hospice Enrollment

- Steps on adding an additional benefit period, cont.
  - Episode of Care will calculate and populate automatically
  - Enter any other applicable third party liability (TPL) insurers

Hospice Episode of Care

Episode of Care	First Date	Last Date	Number of Calendar Days in Episode	Number of Benefit Days in Episode	Date of 61st Day
Episode 1	07/21/2017	03/17/2018	240	240	09/19/2017

Hospice Other Payer Spans

Payer Type	Payer Name	Effective Date	End Date
Medicare	MEDICARE PART B	02/01/2017	12/31/2299

Select row above to update -or- click Add button below.

delete add

Payer Type Effective Date

Payer Name End Date

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Hospice Enrollment

- Steps on adding an additional benefit period, cont.
  - Both dates must match the dates entered in the benefit period panel

Provider Service Span

Hospice Provider	Effective Date	End Date
	01/17/2018	03/17/2018
	10/19/2017	01/16/2018
	07/21/2017	10/18/2017

Select row above to update -or- click Add button below.

delete add

Effective Date

End Date

Hospice Enrollment

❖ Steps on adding an additional benefit period, cont.

Hospice Terminal Illness Diagnosis

Benefit Period	Primary Hospice Terminal Diagnosis	Terminal Diagnosis 2	Terminal Diagnosis 3	ICD Version	Diagnosis Effective Date	Diagnosis End Date
07/21/2017 - 10/18/2017	E11			10	07/21/2017	10/18/2017
01/17/2018 - 03/17/2018	E11			10	01/17/2018	03/17/2018
10/19/2017 - 01/16/2018	E11			10	10/19/2017	01/16/2018

Type changes below.

delete add

Benefit Period 01/17/2018 - 03/17/2018

*ICD Version 10

Code			Diagnosis Description
*Primary Hospice Terminal Diagnosis	E11	[Search]	TYPE 2 DIABETES MELLITUS
Terminal Diagnosis 2		[Search]	
Terminal Diagnosis 3		[Search]	

*Diagnosis Effective Date 01/17/2018

*Diagnosis End Date 03/17/2018

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Hospice Enrollment

- Example of numerous episodes of care
  - Two gaps of >60 days between benefit periods

Hospice Benefit Period

Benefit Period Segment Indicator	Benefit Period Effective Date	Benefit Period End Date	Status	Reason for Updating Benefit Period
SUBSEQUENT 60 DAY PERIOD	06/15/2017	08/13/2017	PROCESSED	
SECOND 90 DAY PERIOD	01/01/2017	03/31/2017	PROCESSED	
FIRST 90 DAY PERIOD	07/21/2016	10/18/2016	PROCESSED	

Type changes below.

delete add

Benefit Period Segment Indicator: SUBSEQUENT 60 DAY PERIOD
Benefit Period Effective Date: 06/15/2017
Benefit Period End Date: 08/13/2017

CERTIFYING PHYSICIAN INFORMATION

Hospice IDG Physician		Attending Physician	
NPI		NPI	
Oral Certification Date		Oral Certification Date	
Written Certification Date	06/15/2017	Written Certification Date	06/15/2017

Update Benefit Period ☐
Reason For Updating Benefit Period
Benefit Plans [Search]

Hospice Episode of Care

Episode of Care	First Date	Last Date	Number of Calendar Days in Episode	Number of Benefit Days in Episode	Date of 61st Day
Episode 1	07/21/2016	10/18/2016	90	90	09/19/2016
Episode 2	01/01/2017	03/31/2017	90	90	03/02/2017
Episode 3	06/15/2017	08/13/2017	60	60	<61

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Hospice Enrollment

- Example of numerous episodes of care, cont.
  - Gap of < or equal to 60 days and >60 days between benefit periods

Hospice Benefit Period

Benefit Period Segment Indicator	Benefit Period Effective Date	Benefit Period End Date	Status	Reason for Updating Benefit Period
FIRST 90 DAY PERIOD	04/01/2016	06/29/2016	PROCESSED	
SECOND 90 DAY PERIOD	06/30/2016	09/27/2016	PROCESSED	
SUBSEQUENT 60 DAY PERIOD	09/30/2016	11/28/2016	PROCESSED	
SUBSEQUENT 60 DAY PERIOD	11/29/2016	01/27/2017	PROCESSED	
SUBSEQUENT 60 DAY PERIOD	01/28/2017	03/28/2017	PROCESSED	
SUBSEQUENT 60 DAY PERIOD	06/02/2017	07/31/2017	PROCESSED	
SUBSEQUENT 60 DAY PERIOD	08/01/2017	09/29/2017	PROCESSED	

Type changes below.

delete add

Benefit Period Segment Indicator: FIRST 90 DAY PERIOD
Benefit Period Effective Date: 04/01/2016
Benefit Period End Date: 06/29/2016

CERTIFYING PHYSICIAN INFORMATION

Hospice IDG Physician		Attending Physician	
NPI	1972622348	NPI	1972622348
Oral Certification Date	04/04/2016	Oral Certification Date	04/04/2016
Written Certification Date	04/05/2016	Written Certification Date	04/05/2016

Update Benefit Period ☐
Reason For Updating Benefit Period
Benefit Plans [Search]

Hospice Episode of Care

Episode of Care	First Date	Last Date	Number of Calendar Days in Episode	Number of Benefit Days in Episode	Date of 61st Day
Episode 1	04/01/2016	03/28/2017	362	360	06/02/2016
Episode 2	06/02/2017	09/29/2017	120	120	08/01/2017

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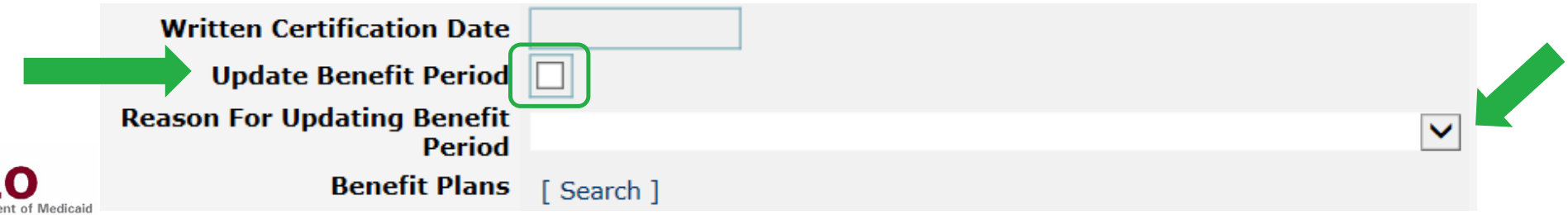
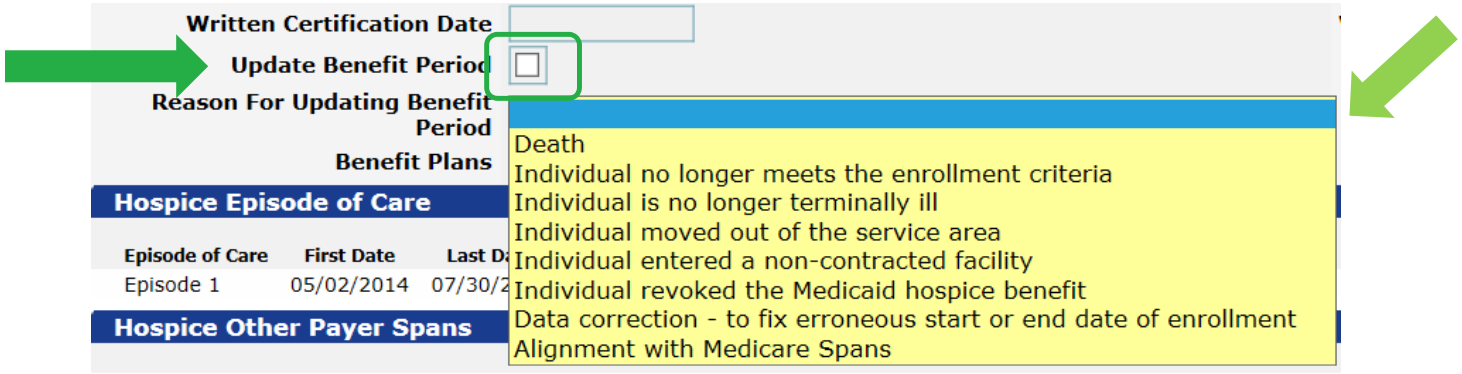
Hospice Enrollment

- Updating a Hospice Enrollment
  - Use the 'Update Benefit Period' box when adding a new benefit period under the action of "New Enrollment" or "Maintain Hospice Record"
    - When it is known that the benefit period end date is less than what the system assigned
  - Open the enrollment record and check the 'Update Benefit Period' box



Hospice Enrollment

- Updating a Hospice Enrollment, cont.
  - Must provide a reason for why benefit period dates are being changed:
    - First 5 options would be used if criteria was met for termination
    - Data correction - should not be used at this time, for future use
    - Medicare alignment - May be used to have the Medicaid benefit period dates fit Medicare's



Hospice Enrollment

- Ending a Hospice Enrollment
  - Chose the appropriate 'Type of Action'
  - Use when someone dies, revokes hospice, or a provider terminates hospice during a benefit period in 'processed' status

Hospice - Application:

*Type of Action	Benefit Termination Close Current Service Span for a change of provider Death Maintain Hospice Record Revocation
Hospice Provider Name	
Hospice Provider ID	
Medicaid Billing Number	
Consumer Date of Birth	
Consumer Name	
County of Record	CUYAHOGA
Submission Date	07/07/2017

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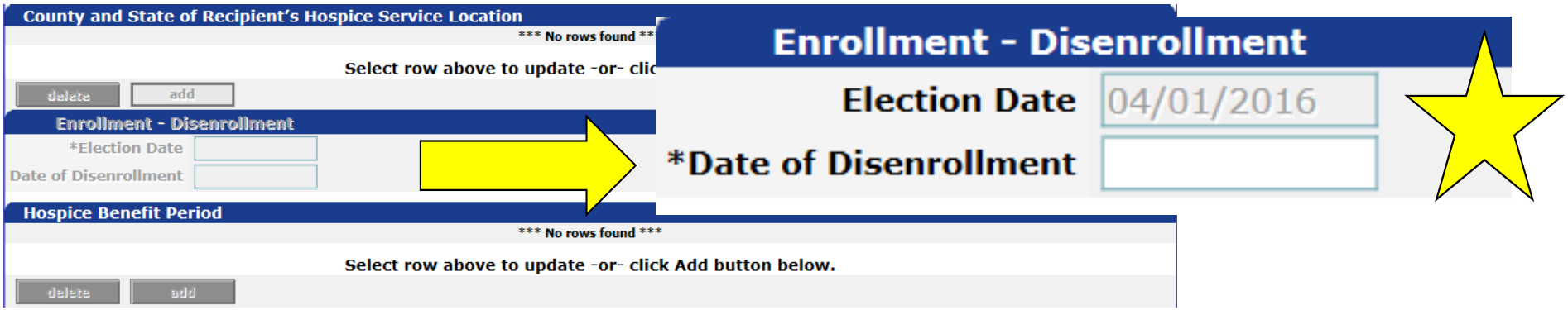
Hospice Enrollment

- Ending a Hospice Enrollment, cont.
  - You are now able to complete the 'Enrollment-Disenrollment' date of disenrollment and click 'submit'



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Hospice Enrollment

- Hospice Enrollment Denial Letters
  - You may leave all the search fields blank and then click 'search' to populate all denial letters

Welcome,

Super User | Providers | Cost Report | Account | Trading Partners | Claims | Episode Claims | Eligibility | Prior Authorization | Reports | Portal Admin | Security | Trade Files | Admin

demographic maintenance | 1099 information | provider f… | …t | correspondence | self attestation | hospital cost report | ordering/referring/ prescribing search | group affiliation | group m… | …ers

Letter Search

Letter Name: Hospice Application Denial Errors Letter

Date Type

Date From

Date To

Period Type

Records: 20

search

clear

Search Results

Document Number	Letter Name	Period Type	Date Sent
6517217200002	Hospice Application Denial Errors Letter		08/04/2017
6517207200008	Hospice Application Denial Errors Letter		07/25/2017
6517207200009	Hospice Application Denial Errors Letter		07/25/2017

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Hospice Enrollment

❖ Hospice Enrollment Denial Letters Codes

Error Code	Error Description
2049	GeoStan Validate Address Error - contact SysArchitect
2067	LTC Vendor Pay end date must be on or before the Elig end date
2069	Invalid Lockin end date
2121	Source Code is not on file
2167	Invalid Other Recipient ID
2355	Begin Date must be a valid date
2356	End Date must be a valid date
2453	Recipient not a part of a valid Case/Cat/Seq
2999	System error encountered during PS/2 process, contact EDS

Hospice Enrollment

❖ Hospice Enrollment Denial Letters Codes, cont.

Error Code	Error Description
4068	Effective Date Received Begins Before The Plan is Active
4390	Medicaid Coverage Missing
4400	No medicaid coverage found
4901	Hospice not allowed with PACE
4902	Hospice Coverage already exists
4903	Hospice Not allowed with RSS AID Category
4904	Recipient enrolled in Managed Care
5015	Invalid HOSPC EligCase data
5016	Invalid HOSPC Lockin data

Hospice Enrollment

- Hospice Enrollment Denial Letters Example

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July 26, 2017

[redacted]
CINCINNATI, OH 45246-4113

Subject: Notification of the Medicaid Hospice benefit enrollment errors

The following lists the application processing errors.

Recipient ID	Hospice Tracking Number	Submission Date	Recipient Name	Error Code	Error Description
[redacted]	5807	07/25/2017	[redacted]	2069	Invalid Lockin end date

Please make the corrections needed to correct the application.

Error Code	Error Description
2069	Invalid Lockin end date

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Claim Submission

Claim Submission

- Methods of Claim Submission
  - Electronic Data Interchange
    - Claims received electronically by Wednesday at 12:00 P.M. will be processed for adjudication over the weekend
    - Fees for claims submitted
    - No limit to the number of claims submitted daily
  - MITS Web Portal
    - Claims received by Friday at 5:00 P.M. will be processed for adjudication over the weekend
    - Free submission

Claim Submission

- Electronic Data Interchange (EDI)
  - Information for Trading Partners

    http://medicaid.ohio.gov/PROVIDERS/Billing/HIPAAandEDIInformation.aspx
  - Companion Guides

    http://medicaid.ohio.gov/PROVIDERS/MITS/HIPAA5010Implementation.aspx
  - Technical Questions/EDI Support Unit
    - 844-324-7089 or OhioMCD-EDI-Support@dxc.com

Claim Submission

- Claim Submission
  - Claims entry format is divided into sections called 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

Claim Submission

- Submission of a Professional Claim

Ohio.gov | Medicaid Information Technology System

Search

Welcome,

Super User Providers Account Trading Partners Claims Eligibility Prior Authorization Reports Portal Admin Security Admin

search search detail dental institutional

Claims

- Search
- Search Detail
- Dental
- Institutional (for Inpatient, Outpatient, L
- Professional

Search
Search Detail
Dental
Institutional
Professional

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Claim Submission

❖ Submission of a Professional Claim, cont.

Professional Claim: NPI -

BILLING INFORMATION

ICN	
Claim Received Date	
Claim Type	M - PROFESSIONAL
Provider ID	NPI
*Medicaid Billing Number	
*Date of Birth	
Last Name	
First Name, MI	
*Patient Account #	0
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
From Date	
To Date	
Signature Source	
Accident Related To	
Accident State	
Accident Country	[Search]
Accident Date	
EPSDT Referral	
Prior Authorization #	
Hospital Discharge Date	
Last Menstrual Period	

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.

delete | add an item

Header - Other Payer

*** No rows found ***

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

delete | add an item

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Claim Submission

- Submission of a Professional Claim, cont.
  - 'Patient Amount Paid' field is used to report a consumer's monthly patient liability amount

Professional Claim: NPI -

BILLING INFORMATION		SERVICE INFORMATION	
ICN		*Release of Information	NOT ALLOWED TO RELEASE DATA
Claim Received Date		From Date	
Claim Type	M - PROFESSIONAL	To Date	
Provider ID	NPI	Signature Source	
*Medicaid Billing Number		Accident Related To	
*Date of Birth		Accident State	
Last Name		Accident Country	[Search]
First Name, MI		Accident Date	
*Patient Account #	0	EPSDT Referral	
Medical Record #		Prior Authorization #	
Referring Provider #		Hospital Discharge Date	
Rendering ID		Last Menstrual Period	
*Medicare Assignment	NOT ASSIGNED	TOTAL CHARGES	
Patient Amount Paid	$0.00	Total Charges	$0.00
*ICD Version	10	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	

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Claim Submission

❖ Submission of a Professional Claim, cont.

Diagnosis

Sequence	Diagnosis Code	Description
A		

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

delete | add an item

*Sequence *Diagnosis Code [Search]

Header - Other Payer

*** No rows found ***

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

delete | add an item

Header - Other Payer Amounts and Adjustment Reason Codes

Detail

Item	FDOS	Units	Charges	Medicaid Allowed Amount	Status	Place of Service	Procedure Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4
A 1		0	$0.00	$0.00							

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

delete | add an item | copy

Item 1

*From DOS

To DOS

*Units 0

*Charges $0.00

Medicaid Allowed Amount $0.00

Rendering Provider

Ordering Provider #

Last Name

First Name, MI

Status

*Place Of Service [Search]

*Procedure Code [Search]

Emergency

Referred EPSDT Service/ Family Planning

*Diagnosis Code Pointer

Modifiers [Search] [Search] [Search] [Search]

NDC | Detail - Other Payer | ClaimCheck

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Claim Submission

- International Classification of Disease (ICD) codes are used in virtually every healthcare setting
  - Went into effect on 10/1/2015
  - Dates of service prior to 10/1/15 require the use of ICD-9 codes
  - Dates of service on or after 10/1/15 require the use of ICD-10 codes
  - When entering an enrollment for a hospice benefit period span that crosses both codes sets, you will need to break the span into two lines to report both proper diagnosis codes

Claim Submission

- Diagnosis Codes
  - Are required on hospice claims
    - Must include the number of characters specified by ICD
    - MITS does not accept decimal points, only enter numbers & letters
    - System edits and audits will be applied to those codes

NEW

Claim Submission

- Additional Provider Information Panel
  - A new "button" in the detail panel
  - Panel is used to report:
    - Ordering Provider
    - Referring Provider
    - Supervising Provider
  - Enter the NPI, last name, first name, and middle initial (if applicable)

Claim Submission

Detail

	Item	FDOS	Units	Charges	Medicaid Allowed Amount	Status	Place of Service	Procedure Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Final EAPG
A	1		0	$0.00	$0.00								

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

delete | add an item | copy

Item 1
*From DOS
To DOS
*Units 0
*Charges $0.00
Medicaid Allowed Amount $0.00
Rendering Provider
Submitted EAPG
Initial EAPG
Status

*Place Of Service [Search]
*Procedure Code [Search]
Emergency
Referred EPSDT Service/ Family Planning
Diagnosis Code Pointer
Modifiers [Search] [Search] [Search] [Search]
Final EAPG
Pay Action

NDC | Detail - Other Payer | ClaimCheck | Additional Provider Information

Additional Provider Information

	Detail Item	Type of Provider	Provider #	Last Name	First Name, MI
A	0				

Type data below for new record.

delete | add an item

*Detail Item
*Type of Provider
*Provider #
*Last Name
*First Name, MI

Ordering Provider
Referring Provider
Supervising Provider

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Claim Submission

- Once all fields have been completed
  - Click on the "Submit" button to submit the claim
  - You may "Cancel" the claim at anytime but the information will not be retained

Claim Submission

- Portal Errors
  - If there are portal errors, the claim status returned will be 'NOT SUBMITTED YET' and the errors will be listed at the top of the screen
  - MITS will not accept a claim without all required fields being populated

The following messages were generated:

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

Claim Submission

- Adjudication will happen in "real time". If there are no errors, the claim status will show:
  - Paid
  - Denied
  - Suspended

Claim Submission

- Claim Suspense
  - Non room and board services (T2042-T2045) are paid the hospice rate that is applicable for the county that is listed on the enrollment panel effective 01/01/2016
  - If the needed state/county code is not loaded into MITS claims will suspend for no rate
  - Providers will need to contact ODM to have this information updated

Claim Submission

- Internal Control Number (ICN)
  - The ICN replaced the Transaction Control Number (TCN)
  - All claims will be assigned an ICN

2017170357321

Region Code	Calendar Year	Julian Day	Claim Type/ Batch Number	Claim Number in Batch
20	17	170	357	321

Claim Submission

- Internal Control Number (ICN)
  - Primary region codes new claim submission
    - **20** Electronic (EDI) 837 without attachment
    - **21** Electronic (EDI) 837 with attachment
    - **22** Web Portal without attachment
    - **23** Web Portal with attachment

Claim Submission

- Internal Control Number (ICN), cont.
  - Additional primary region codes
    - **50** Adjustment-Non-check related
    - **51** Adjustment-Check related
    - **52** Mass Adjustment-Non-check related
    - **53** Mass Adjustment-Check related
    - **54** Mass Adjustment-Void transaction
    - **55** Mass Adjustment-Provider retro rates
    - **56** Adjustment-Void non-check related
    - **57** Adjustment-Void check related
    - **58** Adjustment-Internet claims

Claim Submission

- Timely Filing
  - 12 monthly timely filing edits will be temporarily suppressed
  - Claims will pay for hospice providers and all rendering specialties for DOS 01/01/2016 - on

END DATE =

Claim Submission

- Special Billing Instructions
  - This panel is used for claims over 365 days that meet timely filing requirements
  - Enter the previously denied ICN for the audit trail and tracking purposes
  - MITS will bypass timely filing edits when appropriate

Supporting Data for Delayed Submission / Resubmission

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

Previously Denied ICN or TCN **Reason**

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Claim Submission

- Special Billing Instructions - Eligibility Delay
  - If you are submitting a claim that is more than 365 days after the date of the service due to a hearing decision or delay in eligibility determination you can submit the claim via the MITS portal
    - The claim must be submitted within 180 days of the hearing decision or eligibility determination date

Claim Submission

- Special Billing Instructions - Eligibility Delay, cont.
  - In the Note Reference Code box select "ADD"
  - In the Notes box you will need to enter the hearing decision or eligibility determination information

Medicaid CoPay Amount	$0.00
Note Reference Code	ADD

Claim Submission

- Special Billing Instructions - Eligibility Delay, cont.
  - Hearing Decision: APPEALS ####### CCYYMMDD
    - ####### is the hearing number and the CCYYMMDD is the date on the hearing decision
  - Eligibility Determination: DECISION CCYYMMDD
    - CCYYMMDD is the date on the eligibility determination notice from the CDJFS

Must use the spacing shown

Notes **DECISION 20171225**

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Claim Submission

- Medicare Denials
  - If Medicare issues a denial and indicates that the patient is responsible for the payment, then submit the claim to ODM as a Medicaid claim 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

Claim Submission

- Attachments Panel
  - Upload electronically within the claim or mail with the EDMS cover sheet

Attachments

Type of Document	Transmission Type
A	

Type data below for new record.

delete add

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

For documents transmitted via Upload, an upload button will appear after the claim has been submitted. Only file types of gif, tiff, bmp, jpg, ppt, doc, xls, pdf, txt, and mdi can be uploaded.

*Type of Document

*Transmission Type

Claim Submission

- Electronic Attachments
  - Accepted for Claims, Prior Authorizations, Enrollment and Re-enrollment processing
  - Acceptable file formats:
    - BMP, DOC, DOCX, GIF, JPG, MDI, PDF, PPT, PPTX, TIFF, TXT, XLS, and XLSX
  - Size: each attachment must be <50 MB
  - Each file must pass the MITS anti-virus scan
  - Number: a maximum of 10 attachments per submission

Claim Submission

- Claim Adjustment
  - ***Paid*** claims can be:
    - Adjusted
    - Voided
    - Copied

Claim Submission

- Claim Adjustment, cont.
  - To ***adjust*** a *paid* claim:
    - Select the claim to adjust
    - Change and save the necessary informatic
    - Click the adjust button

Claim Submission

- Claim Adjustment, cont.
  - Once you click the adjust button
    - A new claim is created and assigned an adjusted ICN
    - Refer to the information in the "Claim Status Information" and "EOB Information" areas at the bottom of the page to see how your new claim processed

Claim Submission

- Claim Adjustment, cont.
  - Example:

2217180234001	Originally paid	$45.00
5817185127250	Now paid	$50.00
	Additional payment	$5.00

2017172234001	Originally paid	$50.00
5017173127250	Now paid	$45.00
	Account Receivable	($5.00)

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Claim Submission

- Claim Adjustment, cont.
  - Voiding paid claims
    - Select the claim you wish to void
    - Click the void button at the bottom of the page
    - The status of the original claim does not change however, the claim is flagged as "non-adjustable" in MITS
    - An adjustment is automatically created and given a status of "denied"

Claim Submission

- Claim Adjustment, cont.
  - Example:

2217103234001	Originally paid	$45.00
5817115127250	Reversal "Void" Account Receivable	($45.00)

**Make sure to wait until after weekend adjudication if another claim needs to be submitted

Claim Submission

- Claim Adjustment, cont.
  - Copying paid claims
    - Search and open the claim you want to copy
    - At the bottom of the claim, select "Copy Claim"
    - Make and save all necessary changes
    - The "submit" and "cancel" buttons display at the bottom of the new page
    - Select "submit" when changes are made
    - Claim is assigned a new ICN

Claim Submission

- ClaimCheck 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 including:
    - Duplicate services (same person, same provider, same date)
    - Individual services that should be grouped (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

Claim Submission

- The National Correct Coding Initiative (NCCI)
  - Developed by 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

Claim Submission

- NCCI, cont.
  - 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

Claim Submission

- Coordination of Benefit Claims (COB)
  - 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

Claim Submission

- COB, cont.
  - 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

Claim Submission

- Washington Publishing Website
  - The Washington Publishing website provides adjustment reason codes (ARCs) that must be noted on claims that involve "other payers"
    - http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/
    - The common ARCs are noted below:
      - 1 (Deductible)
      - 2 (Coinsurance)
      - 3 (Co-payment)
      - 45 (Contractual Obligation/Write-Off)
      - 96 (Non-covered services)

WPC Washington Publishing Company

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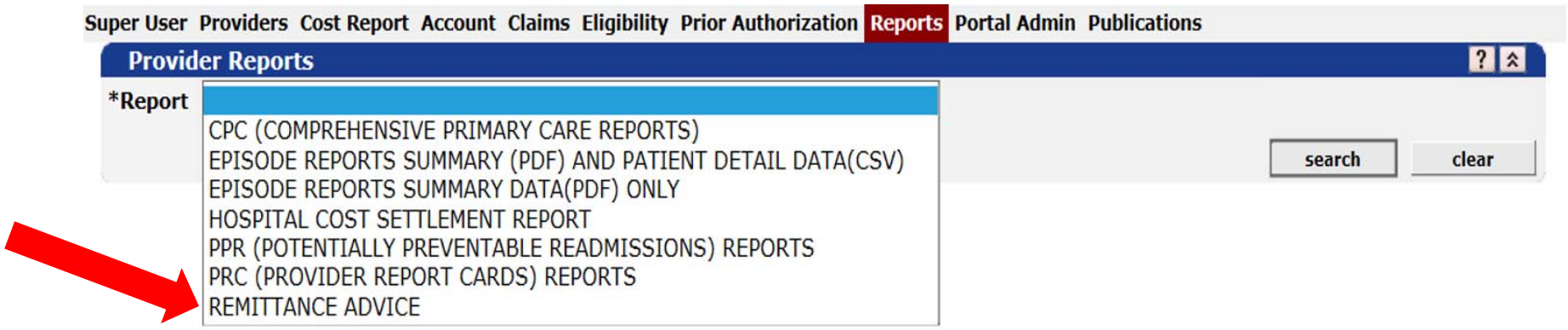
Claim Submission

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



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Claim Submission

- RA, cont.
  - Select “remittance advice” and click search
  - To see all remits to date, don’t enter any specific data, and click search twice

Super User Providers Cost Report Account Claims Eligibility Prior Authorization Reports Portal Admin Publications

Provider Reports

*Report: REMITTANCE ADVICE
Payment Date:
RA Number:
Check/EFT Number:

search clear

Please select the row to show the report

RA Number	Part Number	RA Date
16161973	1	01/06/2017
16146862	1	12/30/2016
16145695	1	12/23/2016
16131620	1	12/22/2016
16116473	1	12/15/2016
16101611	1	12/08/2016
16086726	1	12/01/2016
16071717	1	11/25/2016
16056394	1	11/17/2016
16041108	1	11/10/2016

1 2 3 4 5 6 7 8 9 10 ... Next >

Claim Submission

- RA, cont.
  - Pages are titled by claim type and outcome
    - CMS 1500, Inpatient, Outpatient, Long Term Care and Dental
    - Medicare Crossovers A, B, and C
    - Paid, Denied and Adjustments
  - Adjustment page
    - Identifies the original claim header information and the new adjusted claim

Claim Submission

- RA, cont.
  - Financial transactions
    - Expenditures- Non-claim payments made to the provider on this RA
    - Accounts receivable- Balance of claim and non claim amounts due to Medicaid that resulted from this RA and prior RA's for which a balance is outstanding
  - Summary
    - Provides current payment information
    - Per month information
    - Year to date information

Claim Submission

- RA, cont.
  - Informational pages
    - Banner messages- provides messages to the provider community
  - EOB code descriptions
    - Provides a comparison of the codes to the description that appeared on the claims
  - TPL information
    - If a claim was not paid due to the recipient having another payer source (third party liability) this section provides other insurance information

Websites

Websites

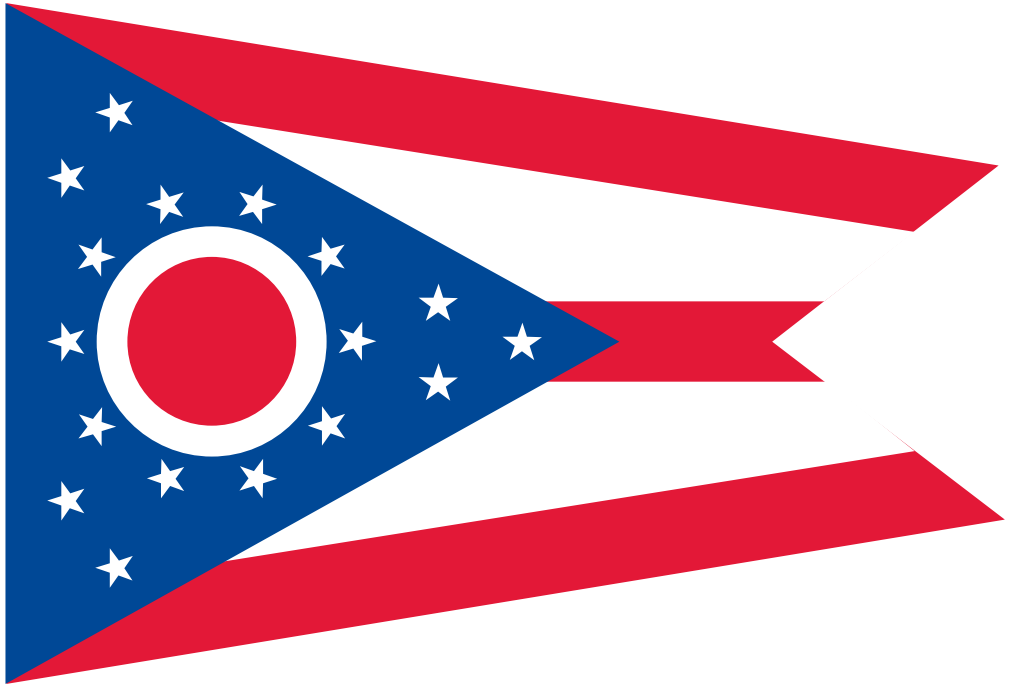
- Ohio Department of Medicaid home page
  http://medicaid.ohio.gov
- Ohio Department of Medicaid provider page
  http://medicaid.ohio.gov/providers.aspx
- MITS page
  https://portal.ohmits.com/Public/Providers/tabId/43/Default.aspx
- LAWriter
  http://codes.ohio.gov/oac/5160

Forms

Forms

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

http://www.Medicaid.Ohio.gov/Resources/Publications/MedicaidForms

Questions

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