

Basic Billing for Nursing Facility Providers

External Business Relations
2018

AGENDA

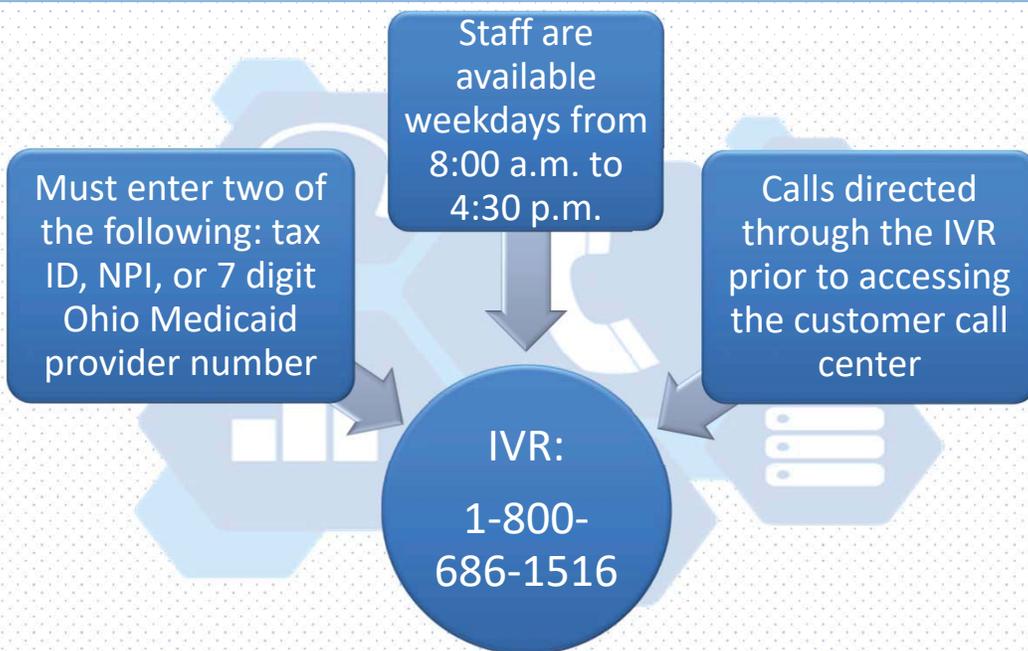
- Medicaid Services
 - Programs & Cards
 - Managed Care/MyCare Ohio
 - Provider Responsibilities
 - Policy
 - Nursing Facility Claim Examples
 - MITS & Claims
 - Web & Forms



External Business Relations Team

Sarah Bivens
Ava Cottrell
Ed Ortopan

Manager - Meagan Grove



☐ 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)



Medicaid Medical Necessity: OAC 5160-1-01

Is the fundamental concept underlying the
Medicaid Program



All Services must meet accepted standards of
medical practice

Ohio Medicaid covers:



- Covered Families and Children
- Expansion Population
- Aged, Blind, or People with Disabilities
- Home and Community Based Waivers
- Medicare Premium Assistance
- Hospital Care Assurance Program
- Medicaid Managed Care

Covered Services (not limited to)

- Acupuncture
- Behavioral Health
- Dental
- Dialysis
- Dietitian
- Durable Medical Equipment
- Home Health
- Private Duty Nursing
- Hospice
- Hospital (Inpatient/Outpatient)
- ICF-IID Facility
- Nursing Facility
- Pharmacy
- Physician
- Transportation
- Vision



Programs & Cards

❑ Ohio Medicaid

- This card is the traditional fee-for-service Medicaid card
- **No longer issued monthly**

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: _____

County

ALLEN

Ohio Medicaid

Case Number

5082482

Eligibility Begin Date

01/01/2018

Void After Date

01/31/2018

Ohio Department of Medicaid

medicaid.ohio.gov

Consumer Hotline: 1-800-324-8680
[or TTY 1-800-292-3572]

FOR

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

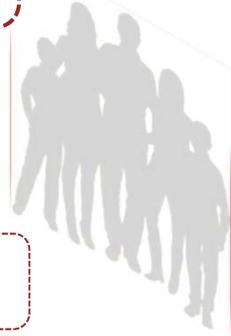
Conditions of Eligibility and Verifications: OAC 5160-1-2-10

- Individuals must cooperate with requests from third-party insurance companies needing to authorize coverage
- Individuals must cooperate with request 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



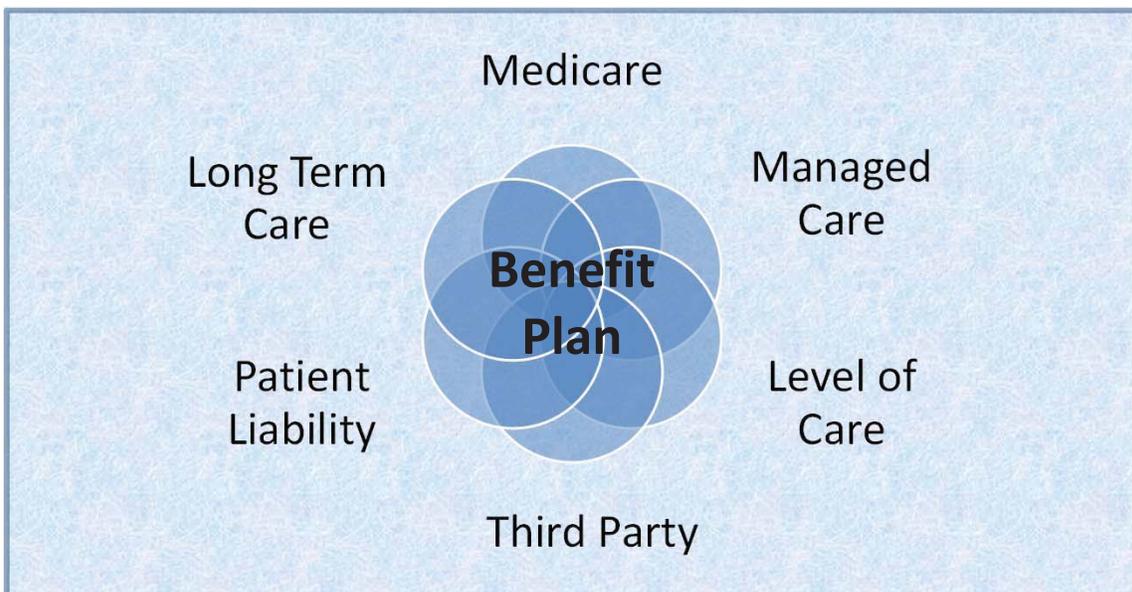
Full Medicaid eligibility on the MITS Portal will show **four** (or more) benefit spans:

1. Alcohol and Drug Addiction Services
2. MRDD Targeted Case Management
3. Ohio Mental Health
4. Medicaid



Additional spans when applicable:

- Alternative Benefit Plan - for extension adults
- Medicaid School Program - if applicable by age





Eligibility Verification Request

➤ You can search up to 3 years at a time!!



Department of Medicaid

 Search

Welcome

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

eligibility search hospice enrollment

Eligibility Verification Request

Medicaid Billing Number	<input type="text"/>	Birth Date	<input type="text"/>
SSN	<input type="text"/>	DOS Date Format	MM/DD/YYYY
Procedure Code	<input type="text"/>	From DOS	01/12/2015
		To DOS	01/11/2018

search clear

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



Eligibility Verification Request

Recipient Information

Medicaid Billing Number	SSN
Last Name	County of Residence CUYAHOGA
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
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
Medicaid Schools	01/01/2018	01/31/2018		\$0.00	\$0.00
★ MRDD Targeted Case Mgmt	01/01/2018	01/31/2018		\$0.00	\$0.00
★ Alcohol and Drug Addiction Services	01/01/2018	01/31/2018		\$0.00	\$0.00
★ Ohio Mental health	01/01/2018	01/31/2018		\$0.00	\$0.00
★ Medicaid	01/01/2018	01/31/2018		\$0.00	\$0.00

Case/Cat/Seq Spenddown

*** No rows found ***



Eligibility Verification Request

Recipient Information

Medicaid Billing Number	SSN
Last Name	County of Residence CUYAHOGA
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
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
Medicaid Schools	01/01/2018	01/31/2018		\$0.00	\$0.00
MRDD Targeted Case Mgmt	01/01/2018	01/31/2018		\$0.00	\$0.00
Alcohol and Drug Addiction Services	01/01/2018	01/31/2018		\$0.00	\$0.00
Ohio Mental health	01/01/2018	01/31/2018		\$0.00	\$0.00
Medicaid	01/01/2018	01/31/2018		\$0.00	\$0.00

Associated Child(ren)

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



Eligibility Verification Request

TPL									
Carrier Name	Carrier Number	NAIC	Policy Number	Policy Holder	Coverage Type	Coverage	Effective Date	End Date	Group Number
AARP HEALTH CARE	00570		082029958-1		IND	INPATIENT COVERAGE	01/30/2018	01/31/2018	PLAN-NV
AARP HEALTH CARE	00570		082029958-1		IND	PHYSICIAN/OUTPATIENT COVERAGE	01/30/2018	01/31/2018	PLAN-NV
AETNA US HEALTH	00250		W116635166		IND	INPATIENT COVERAGE	01/30/2018	01/31/2018	724775
AETNA US HEALTH	00250		W116635166		IND	PHYSICIAN/OUTPATIENT COVERAGE	01/30/2018	01/31/2018	724775

Managed Care

Plan Name	Plan Description	Effective Date	End Date	Managed Care Benefits
CARESOURCE	HMO, CFC	01/01/2018	01/31/2018	

Lock-In

*** No rows found ***

Medicare

Coverage	Effective Date	End Date	Plan Name	Plan ID	Medicare ID
PART A	12/01/2017	12/08/2017			272012289D6
PART B	12/01/2017	12/08/2017			272012289D6

Service Limitation

*** No rows found ***

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



Eligibility Verification Request

Level of Care Determinations						
LOC Requested	Status	Determination Date	LOC Determination	Description	LOC Begin Date	LOC End Date
		09/29/2017	NF; NF WAIVER; RSS	INTERMEDIATE (ILOC)	01/01/2018	09/30/2018

Patient Liability				
Financial Payer	Monthly Amount	Type	Effective Date	End Date
DEFAULT	\$1,949.00	Nursing Home	08/01/2018	09/30/2018
DEFAULT	\$1,949.00	Nursing Home	07/01/2018	07/31/2018
DEFAULT	\$1,949.00	Nursing Home	06/01/2018	06/30/2018
DEFAULT	\$1,949.00	Nursing Home	05/01/2018	05/31/2018
DEFAULT	\$5,319.00	Nursing Home	04/01/2018	04/30/2018
DEFAULT	\$5,319.00	Nursing Home	03/01/2018	03/31/2018

Long Term Care Facility Placements				
Facility Type	Date of Admission	Effective Begin Date of Medicaid Coverage	End Date of Medicaid Coverage	Date of Discharge
NURSING FACILITY	09/29/2017	01/01/2018	09/30/2018	

Recipient Restricted Coverage	
Effective Date	End Date
01/01/2018	02/28/2018

Special Program
*** No rows found ***

Presumptive Eligibility

Covers children up to age 19 and pregnant women

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

This is a limited time 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

Ohio | Benefits

Presumptive Eligibility

NAME
ADDRESS
CITY/STATE/ZIP CODE

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 pregnancy, and/or household income, U.S. citizenship or qualified alien status, and Ohio residency.

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:

Name (First, M.I., Last Name)	Date of Birth	PE Type	Date Coverage Begins	Medicaid ID
NAME	03/17/1981	PE PREGNANT	02/15/2015	111111111111

Presumptive Eligibility

Individuals will receive a similar Presumptive Eligibility letter if a CDJFS worker determines the eligibility

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:

Name (First, M.I., Last Name)	Date of Birth	PE Type	Date Coverage Begins	Medicaid ID
John Doe	11/19/1959	PE Adult	06/25/2018	910194194194

Presumptive Eligibility

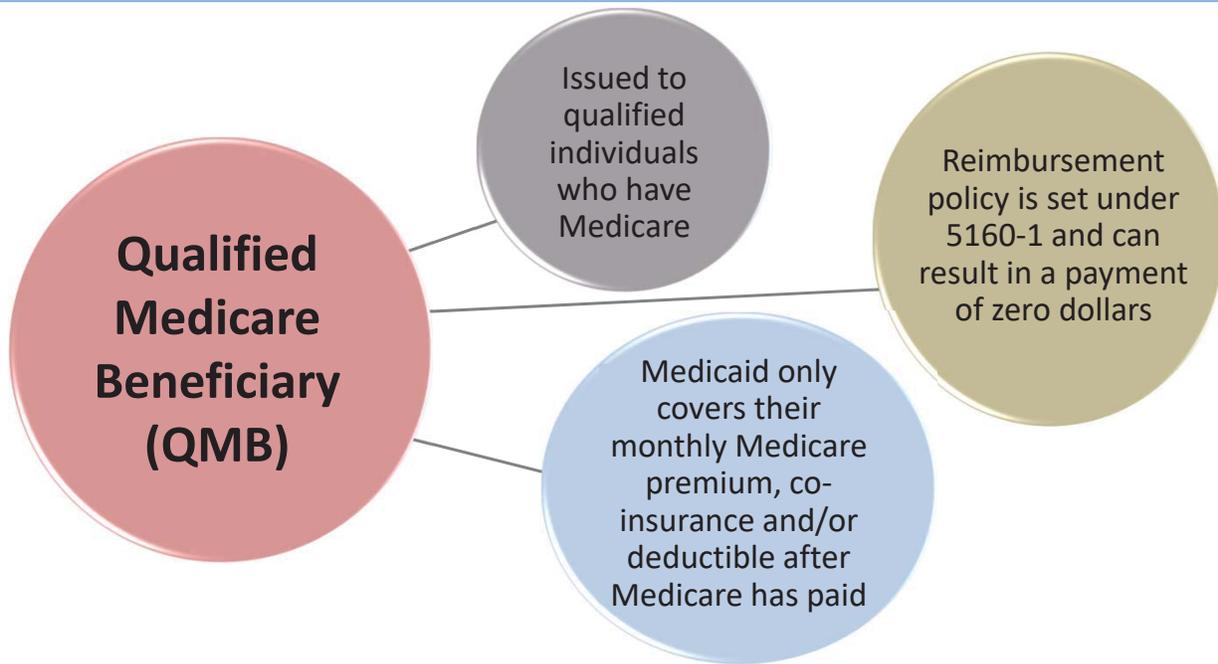
Recipient Information ? ↕

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



Can I Bill Them?

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

The billing of individuals enrolled in the QMB program is prohibited by federal law

Federal law bars Medicare providers and suppliers from billing an individual enrolled in the QMB program for Medicare Part A and Part B cost-sharing under any circumstances (see Sections 1902(n)(3)(B), 1902(n)(3)(C), 1905(p)(3), 1866(a)(1)(A), and 1848(g)(3)(A) of the Social Security Act [the Act]). The QMB program is a State Medicaid benefit that assists low-income Medicare beneficiaries with Medicare Part A and Part B premiums and cost-sharing, including deductibles, coinsurance, and copays.



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

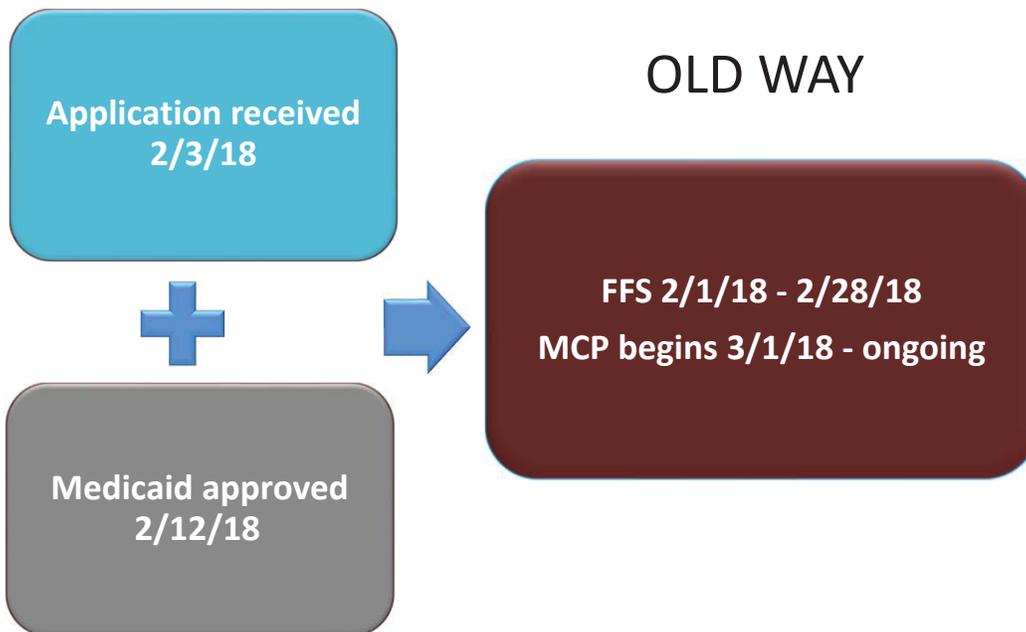
Managed Care/MyCare Ohio

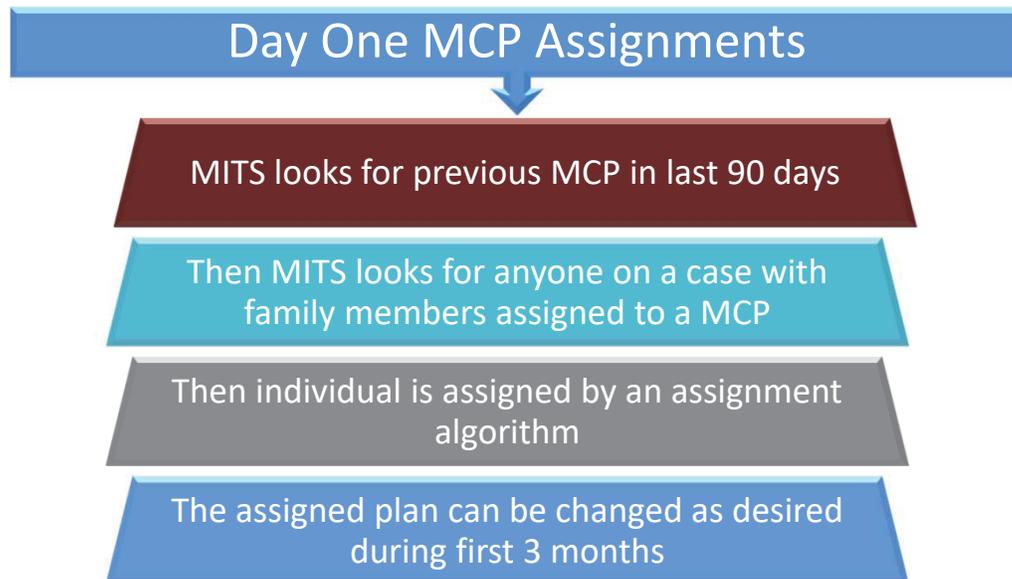
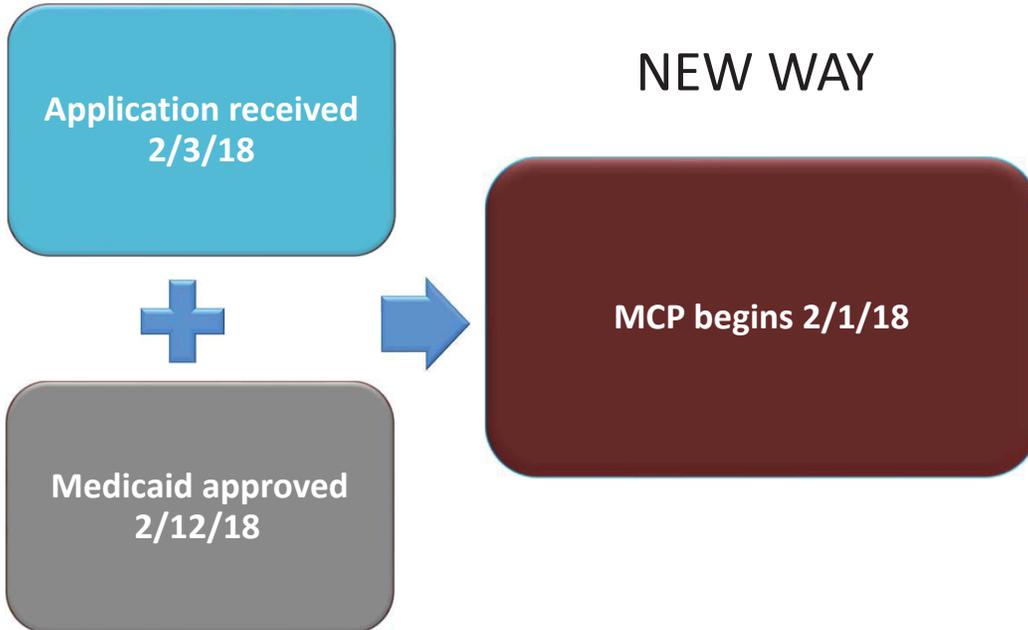
Managed Care Day One - Effective January 1, 2018

- New individuals will be assigned a managed care plan the first day of the current month that MITS receives active Medicaid eligibility
- MITS must receive Medicaid eligibility before Managed Care Assignments can take place
- Medicaid eligibility established prior to the current month will be Fee-for-Service (FFS) for months prior to the current month
- Day one lowers the months of FFS and increases the MCP months
- MyCare Ohio enrollment process stays as-is

How Does it Work Now?

	'The old way'	Day One
Individual completes Application	4/3/2018	4/3/2018
Determined eligible for Medicaid	5/17/2017	5/17/2017
Fee-For-Service	4/1/2018 → 5/31/2018	4/1/2018 → 4/30/2018
Managed Care Plan	6/1/2018 → 12/31/2299	5/1/2018 → 12/31/2299





3 Population Groups Eligible for Traditional Managed Care

Medicaid Managed Care MAGI (CFC)

Medicaid Managed Care Non-MAGI (ABD)

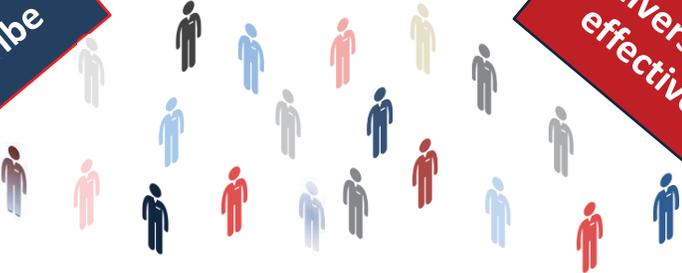
Medicaid Managed Care Adult MAGI (expansion population)

- Population added for mandatory enrollment in 2017
- Adoption children, Breast and Cervical Cancer Patients (BCCP), Foster children, and Bureau of Children with Medical Handicaps (BCMh)

Individuals with optional enrollment in Traditional Managed Care Plans

Native Americans that are members of a federally recognized tribe

Home and Community Based waivers thru DODD effective 1/1/17



Managed Care Benefit Package

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

Some value-added services:

-  On-line 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



HOW DO YOU KNOW IF SOMEONE IS ENROLLED IN MANAGED CARE?

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

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



MITS Managed Care Eligibility

Benefit / Assignment Plan					
Benefit / Assignment Plan	Effective Date	End Date	Provider Name	Dental Co-Pay Amount	Vision Co-Pay Amount
Medicaid Schools	12/01/2017	02/28/2018		\$0.00	\$0.00
MRDD Targeted Case Mgmt	12/01/2017	02/28/2018		\$0.00	\$0.00
Alcohol and Drug Addiction Services	12/01/2017	02/28/2018		\$0.00	\$0.00
Ohio Mental health	12/01/2017	02/28/2018		\$0.00	\$0.00
Medicaid	12/01/2017	02/28/2018		\$0.00	\$0.00

Case/Cat/Seq Spenddown	
*** No rows found ***	

TPL	
*** No rows found ***	

Managed Care				
Plan Name	Plan Description	Effective Date	End Date	Managed Care Benefits
PARAMOUNT ADVANTAGE	HMO, CFC	12/01/2017	02/28/2018	

Managed Care Sample Card



PARAMOUNT
ADVANTAGE

www.paramountadvantage.org

HEALTH PLAN (80840)
7952304120

ID NUMBER
A9999999901

MEMBER NAME
Jane Doe

PRIMARY CARE PROVIDER
John Smith
(419) 5551212

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

GROUP NUMBER
ADV0010011

EFF. DATE
01/01/2015

MMIS NUMBER
000000000000

CVS/CAREMARK
RXGRP RX6407
RXBIN 004336
RXPCN ADV

Managed Care Ohio Contracting

Providers who are interested in delivering services to a Managed Care individuals must 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



MyCare Ohio contracts may be separate or an addendum to the ABD/CFC Managed Care contract

aetna

AETNA BETTER HEALTH[®] OF OHIO

 buckeye
health plan.

 CareSource[®]

 PARAMOUNT
HEALTH
CARE

 MOLINA[®]
HEALTHCARE

 UnitedHealthcare[®]

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



Traditional Managed Care Plans



866-296-8731 <https://www.buckeyehealthplan.com>



800-488-0134 <https://www.CareSource.com/>



855-522-9076 <https://www.paramounthealthcare.com/>



855-322-4079 <https://www.molinahealthcare.com>



800-600-9007 <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

EXTENDED

The project is currently slated to end on December 31, 2019

- Package includes *all* benefits available through the traditional **Medicare** and **Medicaid** programs for opt-in and opt-out
- This includes Long Term Services and Supports (LTSS) and Behavioral Health
- Plans may elect to include additional **value-added benefits** in their health care packages

MyCare Ohio Eligibility

In order to be eligible for MyCare Ohio an individual must be:

**Eligible for all parts of Medicare (Parts A, B, and D)
and be fully eligible for Medicaid**

Over the age of 18

**Residing in one of the demonstration project
regions**

Groups that are *NOT* eligible for enrollment in MyCare Ohio:

Individuals with an ICF-IID level-of-care served in an ICF-IID waiver

Individuals enrolled in the PACE program

Individuals who have third-party insurance, including retirement benefits

HOW DO YOU KNOW IF SOMEONE IS ENROLLED IN MYCARE?

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

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

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

MyCare Ohio Opt-In Sample Card

MyCareOhio
Connecting Medicare + Medicaid

CareSource

Member Name: <Cardholder Name>
Member ID #: <Cardholder ID#>
Health Plan (80840)
MMIS Number: <Medicaid Recipient ID#>
PCP Name: <PCP Name>
PCP Phone: <PCP Phone>
 H8452 - 001

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)	Eligibility Verification: 1-800-488-0134
Behavioral Health Crisis: 1-866-206-7361	Pharmacy Help Desk: 1-800-488-0134
Care Management: 1-855-475-3163	Claims Inquiry: 1-800-488-0134
24-Hour Nurse Advice: 1-866-206-7361 (TTY: 1-800-750-0750 or 711)	Provider 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



RxBin: 004336
RxPCN: MEDDADV
RxGRP: RX5045



MITS Eligibility MyCare Opt-In

Benefit / Assignment Plan						
Benefit / Assignment Plan	Effective Date	End Date	Provider Name	Dental Co-Pay Amount	Vision Co-Pay Amount	
MRDD Targeted Case Mgmt	12/01/2017	01/31/2018		\$0.00	\$0.00	
Alcohol and Drug Addiction Services	12/01/2017	01/31/2018		\$0.00	\$0.00	
Ohio Mental health	12/01/2017	01/31/2018		\$0.00	\$0.00	
Medicaid	12/01/2017	01/31/2018		\$0.00	\$0.00	
Case/Cat/Seq Spenddown						
*** No rows found ***						
TPL						
*** No rows found ***						
Managed Care						
Plan Name	Plan Description	Effective Date	End Date	Managed Care Benefits		
CARESOURCE	HMO, MyCare Ohio	12/01/2017	01/31/2018	Dual Benefits		
Lock-In						
*** No rows found ***						
Medicare						
Coverage	Effective Date	End Date	Plan Name	Plan ID	Medicare ID	
PART A	12/01/2017	01/31/2018			018562948A	
PART B	12/01/2017	01/31/2018			018562948A	
PART C	12/01/2017	01/31/2018	CARESOURCE MYCARE OHIO	H8452	018562948A	
PART D	01/01/2018	01/31/2018	*H8452/001	001	018562948A	
PART D	12/01/2017	12/31/2017	*H8452/001	001	018562948A	

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

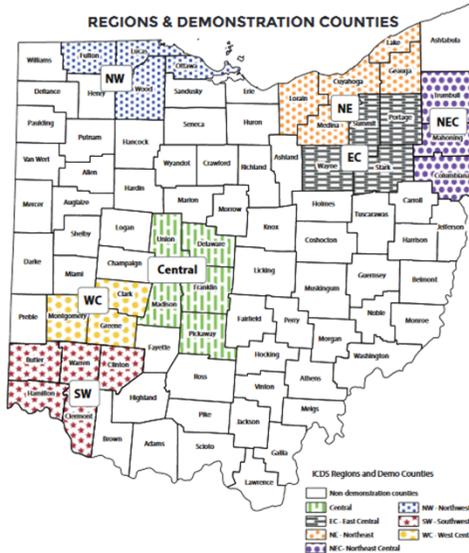
Mail pharmacy claims to: CVS Caremark
 P.O. Box 52066
 Phoenix, AZ 85072-2066



MITS Eligibility MyCare Opt-Out

Benefit / Assignment Plan						
Benefit / Assignment Plan	Effective Date	End Date	Provider Name	Dental Co-Pay Amount	Vision Co-Pay Amount	
MRDD Targeted Case Mgmt	10/01/2017	01/31/2018		\$0.00	\$0.00	\$0.00
Alcohol and Drug Addiction Services	10/01/2017	01/31/2018		\$0.00	\$0.00	\$0.00
Ohio Mental health	10/01/2017	01/31/2018		\$0.00	\$0.00	\$0.00
Medicaid	10/01/2017	01/31/2018		\$0.00	\$0.00	\$0.00
Case/Cat/Seq Spenddown						
*** No rows found ***						
TPL						
*** No rows found ***						
Managed Care						
Plan Name	Plan Description	Effective Date	End Date	Managed Care Benefits		
BUCKEYE COMMUNITY HEALTH PLAN	HMO, MyCare Ohio	10/01/2017	01/31/2018	Medicaid Only		
Lock-In						
*** No rows found ***						
Medicare						
Coverage	Effective Date	End Date	Plan Name	Plan ID	Medicare ID	
PART A	10/01/2017	01/31/2018			300685983A	
PART B	10/01/2017	01/31/2018			300685983A	
PART C	11/01/2017	01/31/2018	ANTHEM SENIOR ADVANTAGE PLUS	H3655	300685983A	

MyCare Ohio Region Breakdown



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

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

MyCare Ohio Managed Care Contracting

Providers who are interested in delivering services to MyCare Ohio individuals must 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



MyCare Ohio contracts may be separate or an addendum to the ABD/CFC Managed Care contract

MyCare Ohio Managed Care Plans



866-296-8731 <https://www.buckeyehealthplan.com/>



800-488-0134 <https://www.CareSource.com/MyCare>



855-364-0974 <https://www.aetnabetterhealth.com/ohio>



855-322-4079 <https://www.molinahealthcare.com/duals>



800-600-9007 <https://www.uhcommunityplan.com/>

PROVIDER COMPLAINTS

Work directly with the Plan first

If not resolved, submit a complaint to Ohio Department of Medicaid (ODM) at <https://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

Please send to Ohio Department of Insurance (ODI)

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 1-800-686-1516.

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

Please summarize your complaint in the text box below. **required**

If related to denied claims, Providers must appeal denied claims to MCP before ODM will process a complaint.

Date Appeal was denied:

Does complaint involve specific patients/consumers? If yes, click here, then 'save' after each patient entered.

Provider/Follow-up Details

Provider Name: <input type="text"/> *	Follow-up Name: <input type="text"/> *
Follow-up Type: <input checked="" type="radio"/> Phone/Email <input type="radio"/> Mail	
Phone: <input type="text"/> * Ext: <input type="text"/>	Email: <input type="text"/> *
Fax: <input type="text"/>	
Medicaid Provider Grp #: <input type="text"/>	MCP Provider #: <input type="text"/>
Indiv Medicaid Provider (MPN) #: <input type="text"/>	Tax ID #: <input type="text"/> *
County: <input type="text"/> *	Provider Category: <input type="text"/> *

Enter the number shown in the image above: * Indicates a required field

Click button once to submit complaint. Do not submit multiple copies of same complaint. We will send a confirmation message with tracking# to your email (if supplied on this form).

Provider Responsibilities

Provider Enrollment and Revalidation



Providers are required to submit an application to become a Medicaid provider



There is also a federally required 5 year revalidation



Providers may enroll as an ORP-only provider or as a Medicaid billing provider



Online applications can be found on our website

Provider Enrollment and Revalidation



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



The 2018 fee is \$569.00 per application



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

Provider Agreement: OAC 5160-1-17.2



Coordination of Benefits: OAC 5160-1-08

- 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



Medicaid Consumer Liability 5160-1-13.1

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

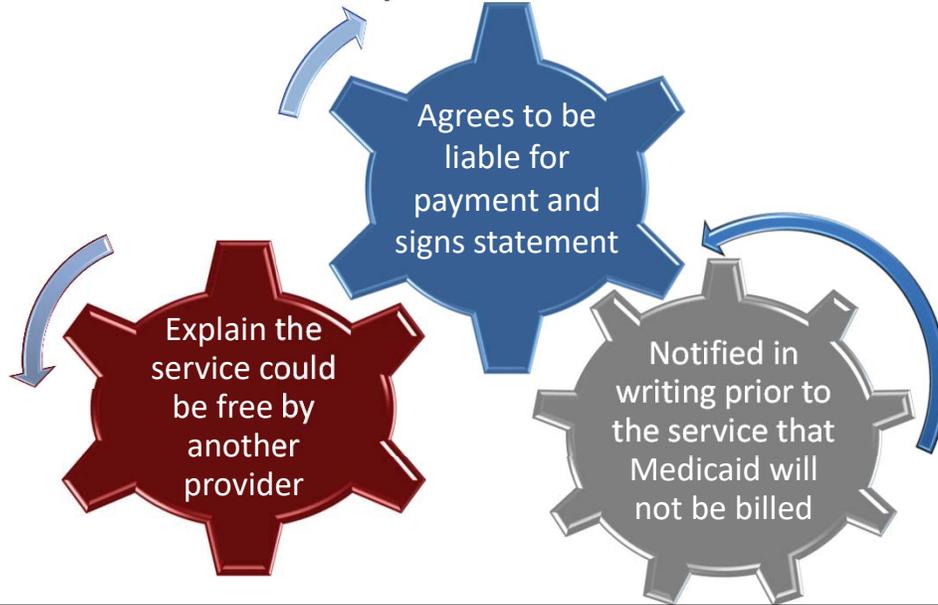
Medicaid claim denial

Unacceptable claim submission

Failure to request a prior authorization

Retroactive Peer Review stating lack of medical necessity

When Can you Bill an Individual?



If not an ABN, then What?

5160-1-13.1 Medicaid Consumer Liability

Date of service: _____
 Type of Service: _____
 Name/account number: _____
 Billing number: _____

- (C) Providers may not bill consumers in lieu of ODJFS unless:
- _____ (1) The consumer is notified in writing prior to the service being rendered that the provider will not bill ODJFS 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 other medicaid providers may render the service at no cost to the consumer.

Signature: _____

- (D) Services that are not covered by the medicaid program, including services requiring prior authorization that have been denied by ODJFS, may be billed to the consumer when the provisions in paragraphs (C)(1) and (C)(2) of this rule are met.

The Ohio Department of Medicaid (ODM) Website

The screenshot shows the homepage of the Ohio Department of Medicaid. At the top left is the Ohio Department of Medicaid logo. To the right are links for Text Size (+A -A) and Select Language, with a note 'Powered by Google Translate' and a 'Translation Disclaimer' link. Below the logo is a navigation menu with links: HOME, MEDICAID 101, FOR OHIOANS, PROVIDERS, INITIATIVES, NEWS, RESOURCES, CAREERS, CONTACT. The main content area features a large banner with the Ohio Department of Medicaid logo and the text 'Learn more about the state's first executive-level Medicaid agency.' To the right of the banner is a 'Director's Welcome' section with a video thumbnail for Director Barbara Sears. Below the banner are two promotional boxes: 'Are you uninsured? Ohio Benefits' and 'Are you unemployed? Ohio MEANS Jobs'. At the bottom of the banner area are three icons: 'Managed Care Plans 2016 Report Card', 'Information for Independent Providers', and 'Payment Innovation Ohio's SIM Grant'. On the right side, there is a 'Tweets by @OH_Medicaid' section showing a tweet from John Kasich about disposing of unused prescriptions. Below the tweets is a 'Testimony & Presentations' section with a video thumbnail.

Provider News

The screenshot shows the 'Provider News' page on the Ohio Department of Medicaid website. The header is identical to the homepage. The navigation menu has 'PROVIDERS' selected. The main content area is titled 'PROVIDERS' and 'Welcome Providers'. It contains a paragraph: '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.' Below this is a section titled 'Provider News' with a sub-header: 'Please listen carefully when calling the IVR as the options have changed as of 6/17/2016.' This section lists several notices: 'ICF-IID 9400 Provider Notice', 'Managed Long-Term Services and Supports Stakeholder Meeting', 'Managed Long-Term Services and Supports Stakeholder Meeting Invitation (3/31/2017)', 'Notice Regarding Pregnancy Risk Assessment and Notification System (4/14/2017)', 'Timely Filing Reminder for ICF-IID Providers (6/29/2016)', 'Notice Regarding Provision of Progesterone (6/13/16)', and 'Independent Provider Overtime Rates - Effective January 1, 2016 (Rev. 4/1/16)'. On the right side, there is a 'Related Content' section with a list of links: 'Benefit Coordination & Recovery', 'Fee Schedules/Rates', 'Medicaid Forms', 'ODJFS Forms', 'MITS EDMS Cover Page', 'Instructions', 'HealthCheck Screening Forms', 'e-Manuals', 'Helpful Links', 'Get a National Provider Identifier (NPI)', 'Transmittal Letter Notification', 'Medicaid Provider Incentive Program (MPIP)', and 'ICD-10'. At the bottom right is a button that says 'Access the MITS Portal' with a gear icon.

Policy

Policy updates from Ohio Medicaid announce the changes to the Ohio Administrative Code that may affect providers.

**Nursing Facility
Provider
Associations and
ODM website**

**Medicaid
Advisory
Letter (MAL)**

**Medical
Transmittal
Letter (MTL)**

Ohio Department of Medicaid

Billing Resources

Ohio Department of Medicaid

Search... GO

HOME MEDICAID 101 FOR OHIOANS PROVIDERS INITIATIVES NEWS RESOURCES CAREERS CONTACT

PROVIDERS

Welcome Providers

Ohio is home to more than 83,000 active Medicaid providers. A strong provider network is critical in ensuring reliable and timely care for all Ohioans. We will become a go-to resource for learning more about trends and issues in the provider community.

Provider News

Please listen carefully when calling the IVR as the system will be updated with new information as of 4/17/2016.

Notice Regarding Pregnancy Risk Assessment and Notification (PRAN) (4/17/2016)

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)

- Enrollment and Support >
- Fee Schedule and Rates
- Billing >**
 - Direct Deposit
 - Billing Instructions**
 - HIPAA and EDI Information
 - Trading Partners
 - How to Refund Overpayments
 - Remittance Advice
 - Answers for MITS Problems
 - HIPAA 5010 Implementation
 - Behavioral Health Integration Project
 - ICD-10
- Training >
- Managed Care
- Provider Types
- MITS >
- Payment Innovation
- DRA Attestation

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

Ohio Department of Medicaid

Long-Term Care Facilities Information

HOME MEDICAID 101 FOR OHIOANS PROVIDERS INITIATIVES RESOURCES CAREERS CONTACT

RESOURCES > Publications > ODM Guidance

ODM Guidance

- eManuals (Pre-July 2015)
- Provider Billing Instructions
- Medicaid Policy
- MITS Resources

- Advances
- Ambulatory
- Billing Instructions
- Buy-in
- Chiropractic
- Clinic
- Community
- Dental Services
- Durable Medical Equipment
- Federally Qualified Health Centers
- Free Standing Ambulatory Care Centers
- General Inpatient
- Home Health
- Hospice (More Information)
- Hospital Handbook (More Information)
- Laboratory Services
- Long Term Care (More Information)
- Managed Health Care (More Information)

Nursing Facility Documents

- Nursing Facility Provider Payment Changes FAQ – Published October 2017
- Nursing Facility Cost Reporting FAQ – Published March 2018
- MDS 3.0 Case Mix Report – Published April 2018
- Case Mix Questions and Answers – Published April 2018
- Nursing Facility Rates and High Occupancy Rates – Effective July 2018



Emergency and Disaster Planning 5160-3-02.7

“Emergencies and disasters” are unexpected situations or sudden occurrences of a serious or urgent nature that create a substantial likelihood that one or more resident may be harmed and/or need to be relocated

Each facility shall have a detailed written plan of procedures to be followed in the event of an emergency or disaster

How to reduce the risk of Disaster?

Preparedness - to reduce the loss & damage to human lives, property

Prevention -completely avoid potential adverse impacts through action taken in advance

Mitigation - limitation of the adverse impacts of hazards and related disasters

Response: provision of emergency services and public assistance during or immediately after a disaster

Recovery-to return life to normal levels after a disaster



NF Level of Care (LOC) 5160-3-14

- ❑ LOC may occur face-to-face or by a desk review in order to:
 - Authorize Medicaid payment to a NF
 - Approve Medicaid payment of a NF-based home and community-based services (HCBS) waiver or other NF-based level of care program



Desk Review LOC Determination 5160-3-14(E)

- Is required within **one business day**:
 - An individual is seeking admission or re-admission to a NF from an acute care hospital or hospital emergency room
 - ODJFS requests a LOC determination for an individual receiving adult protective services and CDJFS **submits** a form at time of LOC request
- Is required within **five calendar days**:
 - A current NF individual is seeking Medicaid payment for continued stay
 - An individual is changing payment from Medicaid managed care to Medicaid fee-for-service for a continued NF stay
 - An individual is transferring from one NF to another NF

Face-to-Face LOC Determinations 5160-3-14(F)

- Is required within **ten calendar days**:
 - An individual or auth rep requests one
 - A ODJFS makes an adverse LOC decision during a desk review
 - A ODJFS decides the information needed through the desk review is inconsistent
 - An individual resides in the community and ODJFS verifies there is no current NF-based LOC
 - ODJFS determines an individual has a pending disenrollment from a NF-based HCBS waiver due to no longer having a NF-based LOC
- Is required within **two business days**:
 - An individual receiving adult protective services when CDJFS does **not** submit the form at the time of LOC request

Covered Days and Bed-hold Days 5160-3-16.4(C)

❑ Occupied Day

- A day of admission or readmission
- Medicaid individual stay in NF is eight hours or more, including individuals on bed-hold status
- NF admission and discharge occur on the same day even if less than eight hours



Covered Days and Bed-hold Days 5160-3-16.4

❑ Eight-hour Rule

- A day begins at twelve a.m. and ends at eleven fifty-nine p.m.
- A day during which an individual's stay in a NF is eight hours or more, the facility receives the full day payment
- The day the individual leaves on bed-hold status if the individual is in the NF for eight hours or more
- Does not apply to the date of discharge

Limits and payment for NF Bed-Hold Days 5160-3-16.4(D)

□ Bed Hold Days

➤ Covered Days

- A day in which the individual is temporarily absent from the NF for hospitalization, therapeutic leave days or visitation with family or friends
- Limited to 30 calendar days per resident, per year
- Payment is considered payment in full



Covered Days and Bed-hold Days 5160-3-16.4 (K)

□ Bed Hold Days

➤ Exclusions

- Hospice
- Institutions for mental diseases (IMDs)
- HCBS waiver individual using NF for short-term respite care
- Restricted Medicaid Coverage
- Facility closure and resident relocation

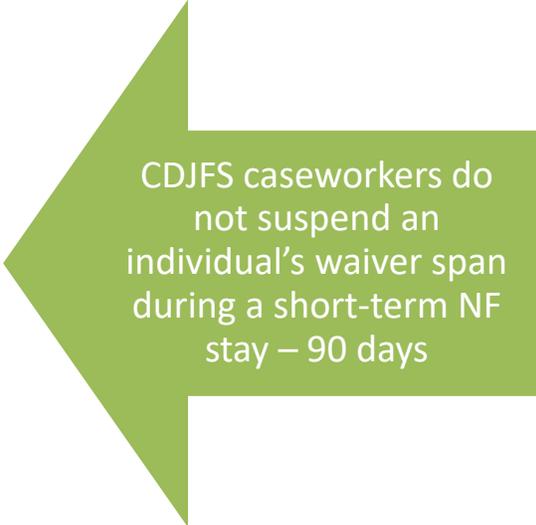


Covered Days and Bed-hold Days 5160-3-16.4(J)(2)

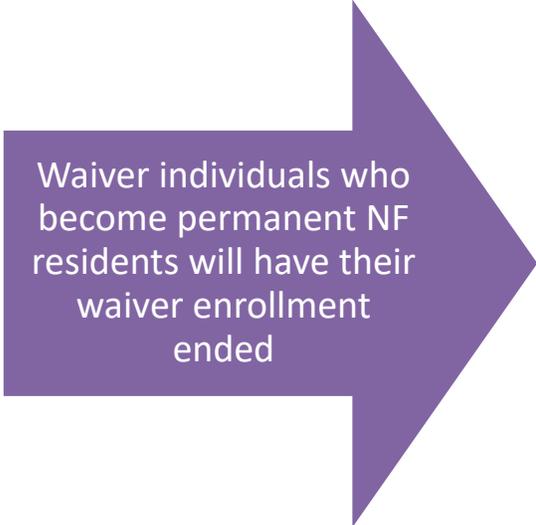
□ Dual-eligible

- If Medicare part A and Medicaid eligible- qualify for NF bed-hold days up to 30
- Level of Care evaluation not necessary if:
 - Receives Medicare part A skilled nursing facility (SNF) benefits in the NF
 - A Part A SNF resident in a NF is transferred to the hospital, and the NF bills the hospital bed-hold days to Medicaid

Waiver Individuals



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



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



Waiver Individuals

- ✓ NF therapeutic leave days are not payable for NF residents who are on a HCBS waiver and do not count towards the annual leave day limit, per OAC 5160-3-16.4(D)(4)(b)(iii)
- ✓ When admitting someone who is on a waiver it is best to notify the waiver case manager
- ✓ Need to bill using revenue center code 160 for days during the waiver enrollment

Patient Liability OAC 5160-3-39.1(B)(7)

The monthly amount of patient liability shall be reported by the NF on the individuals monthly claim

- If the individual is admitted, discharged or transferred the entire monthly amount shall still be reported on the claim for that month
- If the individual is switched from Medicare to Medicaid mid-month the entire amount shall still be reported on the claim for that month
- If the patient liability exceeds the amount Medicaid would cover, the claim shall be processed with a payment of zero

Patient Liability Discrepancy

ALWAYS

First step (should be the only step) – contact the CDJFS to verify the patient liability amount and dates

MAYBE

If you have made documented multiple attempts to contact the county and there is still a discrepancy you may contact provider assistance through the IVR

ODM Form 10203

- Individuals are required to report a change of income, one time gifts or payments, changes in health insurance coverage, etc.
 - Found in OAC 5160:1-2-08 (B)(1)(d)
- This form can be used to report any of those changes to the CDJFS
 - A Medicaid individual or an designated authorized representative may complete this form



Form 10203

Clear Form

Ohio Department of Medicaid
REPORT A CHANGE FOR MEDICAL ASSISTANCE

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

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

INDIVIDUAL INFORMATION Complete this section for the individual receiving medical assistance. *Indicates required field				
*First Name	*Last Name			MI
*Date of Birth (mm/dd/yyyy)	Medicaid Case Number		*Social Security Number	
Has this person been in an accident in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If Yes, explain details in the comment section on page two of this form and provide supporting documentation or verification.)</i>				
CHANGE NOTIFICATIONS Check the box if there has been a change in information and enter the effective date. <i>Only complete the sections below where information has changed.</i>				
<input type="checkbox"/> Phone Number Change		Effective Date of Change		
<input type="checkbox"/> Address Change <i>(attach verification of change such as a rent/mortgage receipt, lease, or utility receipts)</i>		Effective Date of Change (mm/dd/yyyy)		
New Street Address				Apartment/Unit Number
City	State	Zip Code	Phone	County

Lump Sums OAC 5160-3-39.1(B)(8)

- If a resident receives a lump sum, report it to the CDJFS and then report it on all appropriate claims
 - Submit adjustments to as many prior months as necessary to offset the amount assigned to the facility
 - Apply any remaining money to current and future claims if needed
 - Reported on the claim using **value code 31**

Condition	Inpatient Procedure	Occurrence/Span	Value
Value			
Sequence	Value	Description	Amount
A	1 31	PATIENT LIABILITY AMOUNT	4621.00
Select row above to update -or- click add an item button below.			
delete	add an item		
*Sequence	1		
*Value	31	[Search]	*Amount 4621.00

Adjustments to a Paid Claim 5160-3-39.1(B)(9)(c)

-  Underpaid claim – must submit an adjustment within **180** days of the date the underpaid claim was paid by ODM
-  Overpaid Claim – must submit an adjustment within **60** days of discovering the overpayment
 - ODM may notify a provider an adjustment is needed
 - Failure to make the adjustment may result in ODM making the adjustment or voiding the claim



Part A NF Crossover Claims

- OAC 5160-3-64 Nursing Facilities (NFs): payment for cost-sharing other than Medicare part A
 - Medicaid pays the cost-sharing portion
- Claim should auto-cross from Medicare to Medicaid on an institutional part A claim form
 - If payment is not received from Medicaid in an appropriate timeframe, submit the claim on your own to Medicaid
- Provider has 180 days from Medicare's paid date to submit to ODM

ODM 9401 Process

Nursing facilities shall submit data related to **admissions**, **discharges**, and **deaths** via the ODM 9401 for individuals:

- ✓ Applying for Medicaid
- ✓ Who have a pending Medicaid application
- ✓ Who are receiving Medicaid, including:
 - Dually Eligible
 - Individuals on Medicaid fee-for-service (FFS)
 - Individuals on Medicaid managed care plans



Where Does the 9401 Go?

- Provider will submit to the **Passport Administrative Agency (PAA)** when:
 - An individual applying for Medicaid is being **admitted** to or already residing in their facility
 - An individual on FFS Medicaid has been **admitted** to their facility
- Provider will submit to **ODM** when:
 - A managed care individual has been **admitted** to their facility
 - A managed care or FFS individual has been **discharged** from their facility

The ODM 9401 should be submitted within 10 business days to the entities listed above

Most Common Revenue Center Codes

0101 - Full covered day

0183 - Therapeutic leave day

0185 - Hospital leave day

0160 - Full day for short-term stay for waiver individual

PA1/PA2 Revenue Center Codes

0220 – Flat fee full covered day

0189 – Flat fee leave day

0169 – Flat fee full day for short-term waiver individual

PA1/PA2 Revenue Center Codes, cont.

0229 – Flat fee full covered day (reduced rate)

0180 – Flat fee leave day (reduced rate)

0769 – Flat fee full day for short-term waiver individual
(reduced rate)

MITs and 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

Go to <http://Medicaid.ohio.gov>

Select the “Provider Tab” at the top

Click on the “Access the MITS Portal” image on the right of the page



Once directed to this page, click the link to “Login”

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

MITS Navigation

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

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

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

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



Electronic 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 you claim issues

Technical Questions/EDI Support Unit

Trading partners contact DXC for EDI Support



844-324-7089
or
OhioMCD-EDI-Support@dxc.com

MITS Web Portal Claim Submission

Claim entry format is divided into sections or panels

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

➤ Some fields are situational for claims adjudication and do not have an asterisk



Submission of an Institutional Claim

Ohio Department of Medicaid

Search

Welcome,

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

Admin

search search detail dental institutional

Claims

- Search
- Search Detail
- Dental
- Institutional**
- Professional

▪ Search

▪ Search Detail

▪ Dental

▪ Institutional (for Inpatient, Outpatient, Long Term Care)

▪ Professional



Submission of an Institutional Claim

Institutional Claim:	
BILLING INFORMATION	SERVICE INFORMATION
ICN	*Release of Information NOT ALLOWED TO RELEASE DATA
Claim Received Date	*From Date
Provider ID	*To Date
*Type Of Bill [Search]	Admission Date
Claim Type	Admission Hour
*Medicaid Billing Number	*Admission Type
*Date of Birth	Admit Source [Search]
Last Name	Discharge Hour
First Name, MI	*Patient Status [Search]
*Patient Account #	*Covered Days 0
Medical Record #	Non Covered Days 0
*Attending Physician #	Coinsurance Days 0
*Last Name	Lifetime Reserve Days
*First Name, MI	Prior Authorization #/ Precertification #
Operating Physician #	TOTAL CHARGES
Other Physician #	Total Charges \$0.00
*ICD Version 10	Total Non Covered Charges \$0.00
*Patient Amount Paid \$0.00	Total Covered Charges \$0.00
	Medicaid CoPay Amount \$0.00
	Note Reference Code
	Notes

Condition Inpatient Procedure Occurrence/Span Value

Diagnosis Codes: required on most claims



Must include all characters specified by ICD

Do **NOT** enter the decimal points

There are system edits and audits against those codes



Diagnosis Codes

Sequence	Diagnosis Code	Description	Diagnosis
Other	D509	IRON DEFICIENCY ANEMIA, UNSPECIFIED	Present on Admission
Other	E039	HYPOTHYROIDISM, UNSPECIFIED	
Other	E559	VITAMIN D DEFICIENCY, UNSPECIFIED	
Other	E785	HYPERLIPIDEMIA, UNSPECIFIED	
Principal	F0390	UNSPECIFIED DEMENTIA WITHOUT BEHAVIORAL DISTURBANCE	
Admitting	F0390	UNSPECIFIED DEMENTIA WITHOUT BEHAVIORAL DISTURBANCE	
Other	F419	ANXIETY DISORDER, UNSPECIFIED	
Other	H269	UNSPECIFIED CATARACT	
Other	H40039	ANATOMICAL NARROW ANGLE, UNSPECIFIED EYE	
Other	I159	SECONDARY HYPERTENSION, UNSPECIFIED	

1 2 Next >

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

Sequence
 Present on Admission

Diagnosis Code



Detail Panel

Item	Date of Service	Revenue Code	HCPCS/HIPPS Rate Codes	Units	Total Charges	NonCovered Charges	Medicaid Allowed Amount	Status	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Final EAPG
A	1			0	\$0.00	\$0.00	\$0.00						

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

Item *Units
 Date of Service *Units Of Measurement
 To DOS Per Diem Rate
 *Revenue Code [Search] *Total Charges
 HCPCS/HIPPS Rate Codes [Search] Non Covered Charges
 Modifiers [Search] [Search] Medicaid Allowed Amount
 Submitted EAPG Status
 Initial EAPG Final EAPG
 Pay Action

Per OAC 5160-3-39.1(6) a claim is to include all the days of the given month



Submission of an Institutional Claim

➤ Claim with no discharges or leave days

Detail													
Item	Date of Service	Revenue Code	HCPCS/HIPPS Rate Codes	Units	Total Charges	NonCovered Charges	Medicaid Allowed Amount	Status	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Final EAPG
1	04/01/2018	101		30.00	\$6,150.00	\$0.00	\$5,658.00	PAID					

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

delete
add an item
copy

Item <input type="text" value="1"/> *Date of Service <input type="text" value="04/01/2018"/> To DOS <input type="text" value="04/30/2018"/> Revenue Code <input type="text" value="101"/> HCPCS/HIPPS Rate Codes <input type="text" value=""/> Modifiers <input type="text" value=""/> Submitted EAPG <input type="text" value=""/> Initial EAPG <input type="text" value=""/>	Units <input type="text" value="30.00"/> Units Of Measurement <input type="text" value="Days"/> *Per Diem Rate <input type="text" value="\$0.00"/> Total Charges <input type="text" value="\$6,150.00"/> Non Covered Charges <input type="text" value="\$0.00"/> Medicaid Allowed Amount <input type="text" value="\$5,658.00"/> Status <input type="text" value="PAID"/> Final EAPG <input type="text" value=""/> Pay Action <input type="text" value=""/>
---	---



Submission of an Institutional Claim

➤ Claim with a leave day

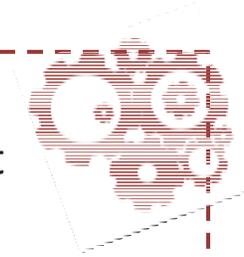
Detail													
Item	Date of Service	Revenue Code	HCPCS/HIPPS Rate Codes	Units	Total Charges	NonCovered Charges	Medicaid Allowed Amount	Status	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Final EAPG
2	07/31/2018	185		1.00	\$185.00	\$0.00	\$31.33	PAID					
1	07/01/2018	101		30.00	\$5,550.00	\$0.00	\$5,221.20	PAID					

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

delete
add an item
copy

Item <input type="text" value="2"/> *Date of Service <input type="text" value="07/31/2018"/> To DOS <input type="text" value="07/31/2018"/> Revenue Code <input type="text" value="185"/> HCPCS/HIPPS Rate Codes <input type="text" value=""/> Modifiers <input type="text" value=""/> Submitted EAPG <input type="text" value=""/> Initial EAPG <input type="text" value=""/>	Units <input type="text" value="1.00"/> Units Of Measurement <input type="text" value="Days"/> Per Diem Rate <input type="text" value="\$0.00"/> Total Charges <input type="text" value="\$185.00"/> Non Covered Charges <input type="text" value="\$0.00"/> Medicaid Allowed Amount <input type="text" value="\$31.33"/> Status <input type="text" value="PAID"/> Final EAPG <input type="text" value=""/> Pay Action <input type="text" value=""/>
---	--

NDC
Detail - Other Payer



- Click the “submit” button at the bottom right
- You may “cancel” the claim at anytime, but the information will not be saved in MITS



Claim Portal Errors



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

Portal errors return the claim with a “fix” needed

Claim shows a ‘NOT SUBMITTED YET’ status still

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

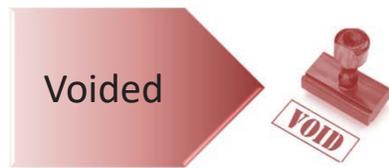
All submitted claims are assigned an ICN



2218170357321

Region Code	Calendar Year	Julian Day	Claim Type/ Batch Number	Claim Number in Batch
22	18	170	357	321

Paid claims can be:





Adjusting a Paid Claim



cancel

adjust

void

copy claim

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

Example



2218180234001
5818185127250

Originally paid \$45.00
Now paid \$50.00

Additional payment of \$5.00



2018172234001
5018173127250

Originally paid \$50.00
Now paid \$45.00

Account receivable (\$5.00)

Voiding a Paid Claim



cancel

adjust

void

copy claim

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

Example



2218180234001
5818185127250

Originally paid \$45.00
Account receivable (\$45.00)

* Make sure to wait until *after* the adjudication cycle to submit a new, corrected claim if one is needed

Copying a Paid Claim



- Open the claim you wish to copy
- Click the “copy claim” button at the bottom of the claim
- A new duplicate claim will be created, make and save all necessary changes
- The “submit” and “cancel” buttons will display at the bottom
- Click the “submit” button
- The claim will be assigned a new ICN



cancel

adjust

void

copy claim

Nursing Facility Claim Examples

Short-term Waiver Stay - Entire Month Waiver

Detail													
Item	Date of Service	Revenue Code	HCPCS/HIPPS Rate Codes	Units	Total Charges	NonCovered Charges	Medicaid Allowed Amount	Status	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Final EAPG
1	01/01/2018	160		31.00	\$8,060.00	\$0.00	\$6,249.91	PAID					

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

delete add an item copy

Item 1

*Date of Service

To DOS

Revenue Code

HCPCS/HIPPS Rate Codes

Modifiers

Submitted EAPG

Initial EAPG

NDC Detail - Other Payer

Units

Units Of Measurement

*Per Diem Rate

Total Charges

Non Covered Charges

Medicaid Allowed Amount

Status

Final EAPG

Pay Action

Short-term Waiver Stay - Partial Month Waiver

Detail													
Item	Date of Service	Revenue Code	HCPCS/HIPPS Rate Codes	Units	Total Charges	NonCovered Charges	Medicaid Allowed Amount	Status	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Final EAPG
1	08/01/2018	160		20.00	\$5,127.46	\$0.00	\$3,394.80	PAID					
2	08/21/2018	101		11.00	\$1,972.10	\$0.00	\$1,867.14	PAID					

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

delete add an item copy

Item 1

*Date of Service

To DOS

*Revenue Code [Search]

HCPCS/HIPPS Rate Codes [Search]

Modifiers [Search] [Search]

Submitted EAPG

Initial EAPG

NDC Detail - Other Payer

*Units

*Units Of Measurement

*Per Diem Rate

*Total Charges

Non Covered Charges

Medicaid Allowed Amount

Status

Final EAPG

Pay Action

Short-term Waiver Stay - Partial Month, cont.

MITS TRICK: Click the black headers and you re-organize your detail lines, such as date of service order!!

Detail													
Item	Date of Service	Revenue Code	HCPSCS/HIPPS Rate Codes	Units	Total Charges	NonCovered Charges	Medicaid Allowed Amount	Status	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Final EAPG
1	08/01/2018	160		20.00	\$5,127.46	\$0.00	\$3,394.80	PAID					
2	08/21/2018	101		11.00	\$1,972.10	\$0.00	\$1,867.14	PAID					

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

delete
add an item
copy

Item: 2

*Date of Service: 08/21/2018

To DOS: 08/31/2018

*Revenue Code: 101 [Search]

HCPSCS/HIPPS Rate Codes: [Search]

Modifiers: [Search] [Search] [Search]

Submitted EAPG: []

Initial EAPG: []

*Units: 11.00

*Units Of Measurement: Days

*Per Diem Rate: \$197.21

*Total Charges: \$1,972.10

Non Covered Charges: \$0.00

Medicaid Allowed Amount: \$1,867.14

Status: PAID

Final EAPG: []

Pay Action: []

NDC
Detail - Other Payer

Two Day Hospital Leave Stay

Detail													
Item	Date of Service	Revenue Code	HCPSCS/HIPPS Rate Codes	Units	Total Charges	NonCovered Charges	Medicaid Allowed Amount	Status	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Final EAPG
3	06/28/2018	101		3.00	\$555.00	\$0.00	\$509.22	PAID					
2	06/26/2018	185		2.00	\$370.00	\$0.00	\$61.11	PAID					
1	06/01/2018	101		25.00	\$4,625.00	\$0.00	\$4,243.50	PAID					

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

delete
add an item
copy

Item: 1

*Date of Service: 06/01/2018

To DOS: 06/25/2018

Revenue Code: 101

HCPSCS/HIPPS Rate Codes: [Search]

Modifiers: [Search] [Search]

Submitted EAPG: []

Initial EAPG: []

Units: 25.00

Units Of Measurement: Days

*Per Diem Rate: \$0.00

Total Charges: \$4,625.00

Non Covered Charges: \$0.00

Medicaid Allowed Amount: \$4,243.50

Status: PAID

Final EAPG: []

Pay Action: []

NDC
Detail - Other Payer

Two Day Hospital Leave Stay, cont.

Detail													
Item	Date of Service	Revenue Code	HCPCS/HIPPS Rate Codes	Units	Total Charges	NonCovered Charges	Medicaid Allowed Amount	Status	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Final EAPG
3	06/28/2018	101		3.00	\$555.00	\$0.00	\$509.22	PAID					
2	06/26/2018	185		2.00	\$370.00	\$0.00	\$61.11	PAID					
1	06/01/2018	101		25.00	\$4,625.00	\$0.00	\$4,243.50	PAID					

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

delete
add an item
copy

Item **2**

*Date of Service

To DOS

Revenue Code

HCPCS/HIPPS Rate Codes

Modifiers

Submitted EAPG

Initial EAPG

Units

Units Of Measurement

Per Diem Rate

Total Charges

Non Covered Charges

Medicaid Allowed Amount

Status

Final EAPG

Pay Action

NDC
Detail - Other Payer

Two Day Hospital Leave Stay, cont.

Detail													
Item	Date of Service	Revenue Code	HCPCS/HIPPS Rate Codes	Units	Total Charges	NonCovered Charges	Medicaid Allowed Amount	Status	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Final EAPG
3	06/28/2018	101		3.00	\$555.00	\$0.00	\$509.22	PAID					
2	06/26/2018	185		2.00	\$370.00	\$0.00	\$61.11	PAID					
1	06/01/2018	101		25.00	\$4,625.00	\$0.00	\$4,243.50	PAID					

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

delete
add an item
copy

Item **3**

*Date of Service

To DOS

Revenue Code

HCPCS/HIPPS Rate Codes

Modifiers

Submitted EAPG

Initial EAPG

Units

Units Of Measurement

*Per Diem Rate

Total Charges

Non Covered Charges

Medicaid Allowed Amount

Status

Final EAPG

Pay Action

NDC
Detail - Other Payer

Overnight Hospital Stay After 8 hours in NF

Detail													
Item	Date of Service	Revenue Code	HCPCS/HIPPS Rate Codes	Units	Total Charges	NonCovered Charges	Medicaid Allowed Amount	Status	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Final EAPG
2	02/18/2018	101		11.00	\$3,013.56	\$0.00	\$2,784.21	PAID					
1	02/01/2018	101		17.00	\$4,657.32	\$0.00	\$4,302.87	PAID					

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

delete
add an item
copy

Item

*Date of Service

To DOS

Revenue Code

HCPCS/HIPPS Rate Codes

Modifiers

Submitted EAPG

Initial EAPG

Units

Units Of Measurement

*Per Diem Rate

Total Charges

Non Covered Charges

Medicaid Allowed Amount

Status

Final EAPG

Pay Action

NDC
Detail - Other Payer

Overnight Hospital Stay After 8 hours in NF, cont.

Detail													
Item	Date of Service	Revenue Code	HCPCS/HIPPS Rate Codes	Units	Total Charges	NonCovered Charges	Medicaid Allowed Amount	Status	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Final EAPG
2	02/18/2018	101		11.00	\$3,013.56	\$0.00	\$2,784.21	PAID					
1	02/01/2018	101		17.00	\$4,657.32	\$0.00	\$4,302.87	PAID					

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

delete
add an item
copy

Item

*Date of Service

To DOS

Revenue Code

HCPCS/HIPPS Rate Codes

Modifiers

Submitted EAPG

Initial EAPG

Units

Units Of Measurement

*Per Diem Rate

Total Charges

Non Covered Charges

Medicaid Allowed Amount

Status

Final EAPG

Pay Action

NDC
Detail - Other Payer

Overnight Hospital Stay Under 8 hours in NF

Item	Date of Service	Revenue Code	HCPCS/HIPPS Rate Codes	Units	Total Charges	NonCovered Charges	Medicaid Allowed Amount	Status	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Final EAPG
3	06/18/2018	101		13.00	\$3,561.48	\$0.00	\$2,206.62	PAID					
2	06/17/2018	185		1.00	\$273.96	\$0.00	\$30.55	PAID					
1	06/01/2018	101		16.00	\$4,383.36	\$0.00	\$2,715.84	PAID					

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

Item 1

*Date of Service: 06/01/2018
 To DOS: 06/16/2018
 *Revenue Code: 101 [Search]

HCPCS/HIPPS Rate Codes: [Search]
 Modifiers: [Search] [Search] [Search]

Submitted EAPG: []
 Initial EAPG: []

NDC:

*Units: 16.00
 *Units Of Measurement: Days
 *Per Diem Rate: \$273.96
 *Total Charges: \$4,383.36
 Non Covered Charges: \$0.00
 Medicaid Allowed Amount: \$2,715.84
 Status: PAID
 Final EAPG: []
 Pay Action: []

Overnight Hospital Stay Under 8 hours in NF, cont.

Item	Date of Service	Revenue Code	HCPCS/HIPPS Rate Codes	Units	Total Charges	NonCovered Charges	Medicaid Allowed Amount	Status	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Final EAPG
3	06/18/2018	101		13.00	\$3,561.48	\$0.00	\$2,206.62	PAID					
2	06/17/2018	185		1.00	\$273.96	\$0.00	\$30.55	PAID					
1	06/01/2018	101		16.00	\$4,383.36	\$0.00	\$2,715.84	PAID					

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

Item 2

*Date of Service: 06/17/2018
 To DOS: 06/17/2018
 *Revenue Code: 185 [Search]

HCPCS/HIPPS Rate Codes: [Search]
 Modifiers: [Search] [Search] [Search]

Submitted EAPG: []
 Initial EAPG: []

NDC:

*Units: 1.00
 *Units Of Measurement: Days
 Per Diem Rate: \$273.96
 *Total Charges: \$273.96
 Non Covered Charges: \$0.00
 Medicaid Allowed Amount: \$30.55
 Status: PAID
 Final EAPG: []
 Pay Action: []

Overnight Hospital Stay Under 8 hours in NF, cont.

Item	Date of Service	Revenue Code	HCPSCS/HIPPS Rate Codes	Units	Total Charges	NonCovered Charges	Medicaid Allowed Amount	Status	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Final EAPG
3	06/18/2018	101		13.00	\$3,561.48	\$0.00	\$2,206.62	PAID					
2	06/17/2018	185		1.00	\$273.96	\$0.00	\$30.55	PAID					
1	06/01/2018	101		16.00	\$4,383.36	\$0.00	\$2,715.84	PAID					

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

Item 3

*Date of Service 06/18/2018

To DOS 06/30/2018

*Revenue Code 101 [Search]

HCPSCS/HIPPS Rate Codes [Search]

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

Submitted EAPG

Initial EAPG

NDC

*Units 13.00

*Units Of Measurement Days

*Per Diem Rate \$273.96

*Total Charges \$3,561.48

Non Covered Charges \$0.00

Medicaid Allowed Amount \$2,206.62

Status PAID

Final EAPG

Pay Action

Low Acuity PA1/PA2 Individual

Item	Date of Service	Revenue Code	HCPSCS/HIPPS Rate Codes	Units	Total Charges	NonCovered Charges	Medicaid Allowed Amount	Status	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Final EAPG
3	04/11/2018	220		20.00	\$130.00	\$0.00	\$130.00	PAID					
2	04/06/2018	189		5.00	\$130.00	\$0.00	\$103.50	PAID					
1	04/01/2018	220		5.00	\$130.00	\$0.00	\$130.00	PAID					

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

Item 1

*Date of Service 04/01/2018

To DOS 04/05/2018

*Revenue Code 220 [Search]

HCPSCS/HIPPS Rate Codes [Search]

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

Submitted EAPG

Initial EAPG

NDC

*Units 5.00

*Units Of Measurement Days

Per Diem Rate \$130.00

*Total Charges \$130.00

Non Covered Charges \$0.00

Medicaid Allowed Amount \$130.00

Status PAID

Final EAPG

Pay Action

Low Acuity PA1/PA2 Individual, cont.

Item	Date of Service	Revenue Code	HCPCS/HIPPS Rate Codes	Units	Total Charges	NonCovered Charges	Medicaid Allowed Amount	Status	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Final EAPG
3	04/11/2018	220		20.00	\$130.00	\$0.00	\$130.00	PAID					
2	04/06/2018	189		5.00	\$130.00	\$0.00	\$103.50	PAID					
1	04/01/2018	220		5.00	\$130.00	\$0.00	\$130.00	PAID					

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

delete
add an item
copy

Item **2** *Units

*Date of Service *Units Of Measurement Days

To DOS Per Diem Rate

*Revenue Code [Search] *Total Charges

HCPCS/HIPPS Rate Codes [Search] Non Covered Charges

Modifiers [Search] [Search] Medicaid Allowed Amount \$103.50

Submitted EAPG Status PAID

Initial EAPG Final EAPG

Pay Action

NDC
Detail - Other Payer

Low Acuity PA1/PA2 Individual, cont.

Item	Date of Service	Revenue Code	HCPCS/HIPPS Rate Codes	Units	Total Charges	NonCovered Charges	Medicaid Allowed Amount	Status	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Final EAPG
3	04/11/2018	220		20.00	\$130.00	\$0.00	\$130.00	PAID					
2	04/06/2018	189		5.00	\$130.00	\$0.00	\$103.50	PAID					
1	04/01/2018	220		5.00	\$130.00	\$0.00	\$130.00	PAID					

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

delete
add an item
copy

Item **3** *Units

*Date of Service *Units Of Measurement Days

To DOS Per Diem Rate

*Revenue Code [Search] *Total Charges

HCPCS/HIPPS Rate Codes [Search] Non Covered Charges

Modifiers [Search] [Search] Medicaid Allowed Amount \$130.00

Submitted EAPG Status PAID

Initial EAPG Final EAPG

Pay Action

NDC
Detail - Other Payer

Providers have 365 days to submit FFS claims

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

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

Claims over 2 years old will be denied

There are exceptions to the 365 day rule

Timely Filing

Submitting a Claim Over 365 Days Old

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

Supporting Data for Delayed Submission / Resubmission

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

Previously Denied ICN or TCN

Reason



Timely Filing Exceptions OAC 5160-3-39.1(B)(10)

- If you are submitting a claim that is more than 365 days after the date of service due to a hearing decision or delay in the individual's eligibility determination
- The claim must be submitted within 180 days of the hearing decision or eligibility determination date



How to Bill After a Delay

- In the Notes box you will need to enter the hearing decision or eligibility determination information
- In the Note Reference Code dropdown menu select "ADD"

Total Medicaid Paid Amount	\$0.00
Medicaid CoPay Amount	\$0.00
Note Reference Code	ADD - Additional Information <input type="checkbox"/>
Notes	<input type="text"/>

How to Bill After a Delay, cont.

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



Note Reference Code	ADD - Additional Information <input type="checkbox"/>
Notes	DECISION 20171225



Uploading an Attachment



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

Attachments	
Type of Document	Transmission Type
A	
Type data below for new record.	
<input type="button" value="delete"/>	<input type="button" value="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	<input type="text"/>
*Transmission Type	<input type="text"/>



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



Remittance Advice (RA)



- All claims processed are available on the MITS Portal
- Weekly reports become available on Wednesdays

Welcome.

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

Provider Reports ? ↕

*Report

- CPC (COMPREHENSIVE PRIMARY CARE REPORTS)
- EPISODE REPORTS SUMMARY (PDF) AND PATIENT DETAIL DATA(CSV)
- EPISODE REPORTS SUMMARY DATA(PDF) ONLY
- HOSPITAL COST SETTLEMENT REPORT
- PPR (POTENTIALLY PREVENTABLE READMISSIONS) REPORTS
- PRC (PROVIDER REPORT CARDS) REPORTS
- REMITTANCE ADVICE

search clear



Remittance Advice (RA)



- Select “Remittance Advice” and click “Search”
- To see all remits to date, do not enter any 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:

Please select the row to show the report

RA Number	Part Number	RA Date
16161973	1	01/06/2018
16146862	1	12/30/2017
16145695	1	12/23/2017
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 >



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



Remittance Advice (RA)



You may use a RA to see how much patient liability was deducted from a claim

ICN	SERVICE DATES		COVERED	NON-COVERED	BILLED	ALLOWED	TPL	PATIENT	LUMP	PAID
PATIENT NUMBER	FROM	THRU	DAYS	DAYS	AMOUNT	AMOUNT	AMOUNT	RESPONSIBILITY	SUM	AMOUNT
RECIPIENT ID:			RECIPIENT NAME:			COUNTY: 38 HOLMES		MED REC NUM:		
CHARGE SOURCE: LTCLOC										
2018213060229	070118	073118	31	0	5,735.00	5,395.24	0.00	1,949.00	0.00	3,446.24
REV	CODE	FROM	THRU	COV	NON-COVERED	DAILY	BILLED	ALLOWED	TPL	PAID
				DAYS	DAYS	RATE	AMOUNT	AMOUNT	AMOUNT	AMOUNT
0101	070118	073118	31		0	174.04	5,735.00	5,395.24	0.00	3,446.24
DETAIL ROBS 9919 9922										

Resources, Websites, and Forms

Mailboxes

NFStay mailbox - NFStay@Medicaid.ohio.gov

- The purpose of this mailbox is to process ODM 09401s and to answer questions related to nursing facility admissions and discharges
- **Inquiries not directly related to ODM 09401s or nursing facility admissions or discharges will not be answered**



✉ Mailboxes ✉

➤ Please follow the guidance below regarding inquiries not directly related to the 9401 process:

- » For managed care information, see the ODM website at:
<http://www.medicaid.ohio.gov/PROVIDERS/ManagedCare.aspx>
- » For managed care issues, contact the managed care plan. If not resolved, provider complaints can be filed through the managed care link listed above.
- » For questions about HCBS waivers and other long-term services and supports:
BHCP@medicaid.ohio.gov
- » Billing and claims - Provider Assistance at 1-800-686-1516
- » Nursing facility rules and policy questions: NFPolicy@medicaid.ohio.gov
- » For other Medicaid information, contact ODM's website at
<http://www.medicaid.ohio.gov/HOME.aspx>

✉ Mailboxes ✉

NF Policy mailbox - NFPolicy@medicaid.ohio.gov

- The purpose of this mailbox is to respond to inquiries regarding Nursing Facility (NF) Policy Rules and requirements
- Only these types of inquiries will be addressed through this mailbox
- **Your inquiry will not be addressed if it does not directly relate to Nursing Facility Policy Rules**

✉ Mailboxes ✉

➤ Please follow the guidance below regarding inquiries that are not directly addressed by the NF Policy Mailbox:

- » **Submit ODM 9401s for Managed Care admissions and all NF discharges to ODM via NFStay@medicaid.ohio.gov**
- » For NF billing and claims issues: call Provider Assistance at 1-800-686-1516
- » For EDI issues: contact EDI Support via Email: OhioMCD-EDI-Support@dxc.com or phone: 844-324-7089.
- » For Medicaid eligibility and patient liability issues: contact the local county department of job and family services (CDJFS) that is handling the Medicaid case
- » For managed care information, see the ODM website at: <http://www.medicicaid.ohio.gov/PROVIDERS/ManagedCare.aspx>
- » For managed care issues, contact the managed care plan. Provider complaints can be filed through the managed care link listed above.
- » For questions about HCBS waivers and other long-term services and supports: email BHCP@medicaid.ohio.gov
- » For other Medicaid information, contact ODM's website at <http://www.medicicaid.ohio.gov/HOME.aspx>

🖥 Websites 🖥

Ohio Department of Medicaid home page

<http://Medicaid.ohio.gov>

Ohio Department of Medicaid provider page

<http://Medicaid.Ohio.Gov/Providers.aspx>

Long Term Care provider page

<http://medicaid.ohio.gov/Provider/ProviderTypes/LongTermCareFacilities>

LAWriter

<http://codes.ohio.gov/oac/5160>

Websites

MITS home page

<https://portal.ohmits.com/Public/Providers/tabId/43/Default.aspx>

Electronic Funds Transfer (click on Medicaid providers)

<http://www.ohiosharedservices.ohio.gov/>

Information for Trading Partners (EDI)

<http://medicaid.ohio.gov/Provider/Billing/TradingPartners>

Companion Guides (EDI)

<http://medicaid.ohio.gov/PROVIDERS/MITS/HIPAA5010Implementation.aspx>

Forms

- ODM 03623 – Provider Agreement for LTC Facilities
- ODM 10203 – Report a Change for Medical Assistance
 - ODM 09401 – Facility Communication
 - ODM 06614 – Health Insurance Fact Request
 - ODM 06653 – Medical Claim Review Request





ANY
QUESTIONS
?

Managed Care Day One

Summary

Effective January 1, 2018, individuals who become eligible for Medicaid and are in mandatory enrollment categories for Medicaid Managed Care will be enrolled in a managed care plan on the first day of the month that MITS receives the Medicaid eligibility information.

Individuals will continue to have ninety (90) days to choose a new managed care plan if they are not satisfied with the plan to which they were assigned.

Examples

- MITS receives information on 1/5/2018 from Ohio Benefits that an individual is determined to be Medicaid eligible with an effective date of 1/1/2018. The individual will be assigned to a managed care plan effective 1/1/2018.
- MITS receives information on 2/2/2018 from Ohio Benefits that an individual is determined to be Medicaid eligible with an effective date of 1/1/2018. The individual will be assigned to a managed care plan effective 2/1/2018. The individual will have fee-for-service coverage for the month of January 2018.

Additional Information

- Enrollment into MyCare Ohio is not changing.
- Enrollment for individuals participating in the Pre-Release Program is not changing.
- Foster care children are not assigned to a managed care plan by the system. Plan selection continues to be the responsibility of the PCSA. Enrollment with the selected plan will be the first day of the month that the eligibility determination and plan selection are received.
- Deemed newborns will continue to be enrolled in the same plan as the mother, effective on the date of birth of the child.

Provider FAQ

- 1. I am being reimbursed at a lower rate than what I was reimbursed by Medicaid fee-for-service (FFS). Doesn't an MCP have to reimburse me the same amount as FFS?**

With the exception of non-contracting providers of emergency services and qualified family planning providers (QFPPs), the reimbursement amount is negotiated between the provider and the managed care plan (i.e., the reimbursement amount may or may not be the same as fee-for-service Medicaid). Providers who are not contracted with the MCP, but are authorized by the MCP to provide services, should ensure they have a mutually agreed upon compensation amount in writing. The reimbursement amount for contracted providers must be specified in the contract between the MCP and the provider. Non-contracting providers of emergency services and QFPP providers must be reimbursed as specified in Ohio Administrative Code (OAC) 5160-26-03.

- 2. I am a non-contracting provider and I continued to see my Medicaid patients, assuming they were still on Medicaid FFS. However, when I submitted their claims, the claims were denied because the patient was on a MCP. When I billed the MCP, the claims were denied because I am a non-contracting provider. Isn't the MCP obligated to pay these claims since the patient is on Medicaid?**

In most circumstances the answer is no, however, there are a few notable exceptions (see below for exceptions). Providers are responsible for checking the patient's eligibility on the first visit of each month, even if the patient states he/she still receiving medical assistance through FFS. Patients who are to be mandatorily enrolled, are assigned to an MCP even if they do not self select one themselves.

- 3. I work with a FQHC. How can I locate the MCP provider number to bill for the wrap-around payment?**

When submitting claims for wrap-around payment, FQHC providers should use the provider number designated for the appropriate MCP population being served – Covered Families and Children (CFC) or Aged, Blind or Disabled (ABD). This information is available through the ODM IVR System by calling (800) 686-1516 or by accessing the ODM online eligibility web portal at: <https://portal.ohmits.com/public/Providers/tabid/43/Default.aspx>.

- 4. The MCP is requiring me to obtain prior authorization (PA) for certain services for which Medicaid FFS never required me to obtain PA. Is this acceptable?**

Yes, although MCPs must provide access to all medically necessary Medicaid covered services, their utilization management requirements can be different from FFS. Therefore, MCPs are allowed to require prior authorization for non-emergency services that FFS does not require PA for, as long as they are not specifically excluded from requiring PA by ODM.

MCPs are required to provide a decision to a standard PA request within 14 calendar days, or as expeditiously as the member's healthcare needs require. PA decisions regarding outpatient covered drugs must be made within 24 hours. Excluding outpatient drugs, for all other PAs, a provider can request an expedited decision to be made as expeditiously as possible, but within 3 working days if the provider believes that the standard decision timeframe could seriously jeopardize the member's life, health or ability to attain, maintain or regain maximum function. Providers must ensure that they submit all of the necessary documentation to the MCP detailing the medical necessity as well as any documentation to expedite the decision.

5. I have been trying to contact a MCP and no one is returning my calls. How am I supposed to get the information that I need?

It is imperative that providers document dates, times and names of each individual with whom they speak at the MCP. If you have submitted paperwork via fax or mail, please keep copies of cover pages, the items sent and certified mail receipts if applicable. If you have contacted both the MCP's customer service line and your regional provider relations representative and neither have returned your calls within a reasonable timeframe, please fill out the provider complaint form on this website. The BMC will contact you and may ask you to fax supporting documentation.

Managed Care Prompt Payment Standards

Managed Care Plans (MCPs) have contractual requirements with ODM for prompt pay. MCPs must pay 90% of all submitted clean claims within 30 days of the date of receipt and 99% of such claims within 90 days of the date of receipt, unless the MCP and its contracted provider(s) have established an alternative payment schedule that is mutually agreed upon and described in their contract.

A “claim” can include any of the following: (1) a bill for services; (2) a line item of services; or (3) all services for one recipient within a bill. A “clean claim” is a claim that can be processed without obtaining additional information from the provider of a service or from a third party. Clean claims do not include payments made to a provider of service or a third party where the timing of the payment is not directly related to submission of a completed claim by the provider of service or third party (e.g., capitation). A clean claim also does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

This prompt pay requirement is an aggregate number claims from ALL providers, and is not on an individual provider basis. If your claims were submitted cleanly (submitted without need for corrections or additional information), and you have not received claims status information or payment from your MCP, you should wait until 90 days have passed before contacting ODM.

Nursing Home Facilities and Home and Community Based Services (HCBS) Provider

ODM encourages providers to verify Medicaid eligibility through the MITS provider portal. The provider portal contains information about member eligibility spans, managed care enrollment, patient liability, and Restricted Medicaid Coverage Period (RMCP). Providers must be contracted with managed care plans, or have a single-care agreement with a plan, to receive payment for eligible services. Members must meet intermediate or skilled level of care to receive long term care services in a nursing home facility or through an HCBS waiver program.

MyCare Ohio members and Medicaid managed care members covered under the Adult Extension eligibility categories are qualified for long term care services in a nursing facility or receiving services through a home and community based services (HCBS) waiver.

Therefore, members of these groups will not be subject to nursing facility, or HCBS waiver, disenrollment. Contact the MCP involved to report admission of a patient; to confirm the category of Ohio Medicaid provided; and to request authorization and payment for MyCare Ohio or Adult Extension Medicaid managed care members.

Only MCPs can request patient disenrollment for non-Adult Extension members in nursing facilities.

Communicating with MCPs

Medicaid MCP Provider Resources:

Visit MCP provider portals; peruse prior authorization policies, reimbursement policies, newsletters, and other materials.

Buckeye: <https://www.buckeyehealthplan.com/providers/resources.html>

CareSource: <https://www.caresource.com/providers/ohio/ohio-providers/>

Molina: <http://www.molinahealthcare.com/providers/oh/medicaid/Pages/home.aspx>

Paramount: <http://www.paramounthealthcare.com/Providers>

United: <http://www.uhccommunityplan.com/health-professionals/oh.html>

Provider Contracting and Credentialing

In order to comply with new federal rules (42 CFR 438.602), providers must submit an application to the Ohio Department of Medicaid, in order to continue providing services through one of the Ohio Medicaid managed care plans.

The enrollment process is electronic and completion takes only a few minutes complete. Begin the process by selecting “Enrollment and Support” from the “Provider” heading or visit: <http://medicaid.ohio.gov/providers/EnrollmentandSupport/ProviderEnrollment.aspx>. The requirement to submit an application to Ohio Medicaid will not cause you to also submit a new application to your current managed care companies. Ohio Medicaid works directly with the managed care plans during transition.

Providers whose current number expired and did not obtain a new Medicaid ID, will not be able to be reimbursed for any services.

How to Submit a Provider Application

1. Go to the MITS Portal
at: <http://medicaid.ohio.gov/providers/EnrollmentandSupport/ProviderEnrollment.aspx>
2. Select the “I need to enroll as a provider to bill Ohio Medicaid” option.
3. Follow the system prompts and provide the requested information.
4. When you have completed all steps, please submit your application.

View the status of your application online using your Application Tracking Number (ATN). Thank you for participating in the Ohio Medicaid program, and we look forward to your timely response. If you need any assistance, please contact our Provider Hotline (800) 686-1516.

For information about contracting with our MCPs, please contact the plans directly. If a MCP requested a new provider to submit a credentialing form, the credentialing process must be completed no later than 90 days after the provider submits **both** the credentialing form and the provider's national provider identification number issued by the Centers for Medicare and Medicaid Services (CMS) to the MCP. The 90 day timeframe is inapplicable to providers that are hospitals, all providers not solicited to be credentialed, and any individual or entity not listed in the definition of 'provider' in Ohio Revised Code 3963.01 (P). Additional information concerning the credentialing process, including a Credentialing and Contracting Provider Complaint Form and key definitions, is available on the ODI website at: <http://www.insurance.ohio.gov/Consumer/Pages/InsPrmpt5.aspx>

It is up to the provider to establish a noncontracted reimbursement agreement (single case agreement) with the MCP in order to continue seeing an MCP's members, if a provider has not yet completed contracting and credentialing. If the MCP is not willing to establish an agreement with a provider, then members must seek services from a contracted provider until you are credentialed with the plan. In most situations, providers are not allowed to direct bill the member, even if the MCP refuses to reimburse the provider, and the provider chooses to continue seeing the member.

Verifying Eligibility and Enrollment

Patients must be eligible for Medicaid and enrolled in a managed care plan (MCP) in order for claims to be potentially covered by a managed care plan. Providers are responsible for confirming the Medicaid eligibility and the MCP insurance coverage—or plan enrollment—of a patient.

The Ohio Department of Medicaid (ODM) has two sources for eligibility and enrollment information. They are:

- Information online through the Medicaid Information Technology System (MITS): <https://portal.ohmits.com/public/Providers/tabid/43/Default.aspx>
- Information through Interactive Voice Response lines at **(800) 686-1516**.
 - The first response will state patient eligibility;
 - The second prompt will give the patient's managed care plan enrollment, if any.

If a MCP portal is not showing member enrollment, but MITS information shows eligibility and enrollment with the MCP, please use the online [provider complaint form](#) and select "eligibility issue" to report the issue, so that the MCP can correct their system.

MCP Provider Agreements and Provider Manuals

MCPs must provide access to all medically-necessary Medicaid covered services, but are not required to use the same coding systems as Medicaid Fee-For-Service (FFS), though all plans must be HIPAA compliant. Please refer to your organization's provider agreement, the MCPs' provider manuals, and the MCPs' provider portals for clinical coverage policies, reimbursement policies, and other tools. Those tools will assist you with resolution of issues regarding contracted fees, grievance and appeal procedures, and contractual disputes. All providers must follow the grievance and appeal procedures outlined in their contracts with the Medicaid Managed Care Plan (MCP) or MyCare Ohio Plans (MCOP).

Because ODM does not monitor contracts among providers and MCPs, ODM cannot intervene in contractual disputes, and individual claims payment issues, between a provider and a MCP or MyCare Ohio Plan. Provider and MCP/MCOP are beyond the authority of the ODM. ODM asks providers to work with their provider services staff person, and the MCP for those issues. If MCPs and MCP provider services staff are not responsive to provider requests for assistance, ODM can escalate for research and pursue further action.

Reimbursement Information

MCPs and MCOPs are not required to reimburse providers who are not contracted with that plan or who do not have a provider reimbursement agreement in place of a contract. These are not matters that involve ODM.

There are important, limited exceptions to this rule:

- Transitional benefits are paid for services provided to newly enrolled members of a MCP;
- Transitional benefits are paid for services provided to newly enrolled members of a MCOP; and,
- Providers must verify with the MCP or MCOP any such transitional benefits before rendering services.

Providers who are not contracted with a Medicaid MCP or MyCare Ohio Plan (MCOP) but who are authorized under agreement with the MCP or MCOP to provide service to its members must ensure they have a written and mutually agreed compensation schedule prior to rendering service.

MCPs may deny claims for coordination of benefits (having primary insurance), because Medicaid, including Medicaid-contracting MCPs, is the payor of last resort, except services provided under Title V and similar programs outline in OAC 5160-26-09.1. **MCPs must provide**

coordination of benefits as outlined in the rule. If the patient denies having primary insurance, please contact the MCP's customer service/regional provider relations representative to obtain further information regarding the primary payer.

Submitting an Inquiry or Complaint

All inquiries submitted through the portal are immediately sent to MCPs and MCOPs for response, so as not to add additional delay. MCPs are required to provide an initial response, not necessarily a resolution, to the ODM within 15 working days, unless the complaint is access related. Access related complaints must be resolved within 2 working days.

ODM staff investigates each complaint thoroughly and works to ensure the MCP or MCOP is compliant with current state and federal regulations.

ODM uses the online provider complaint form as a mechanism to convey provider complaints to the plans and a way to track and trend complaints, to aid in the identification of large scale systems issues, or issues in which a plan might be denying Medicaid-covered services as noncovered, etc. Issues are tracked and trended for potential noncompliance and/or access issues.

If you have read all of the above and would still like to make a complaint please access the Provider Complaint Form [here](#). Please make sure the pop-up blocker is turned off in your Internet Browser, so you will receive a tracking number for your complaint.

Frequently Asked Questions: Nursing Facility Provider Payment Changes

OHIO DEPARTMENT OF MEDICAID

OCTOBER 2017

The Office of Budget and Management (OBM) is restructuring the timing of payments across all state agencies. Specifically, Nursing Facility payments will occur approximately two weeks later than normal on an ongoing basis beginning in November 2017, in order to synchronize with managed care plan payments. Please see the questions we have received from Providers below.

1. Is the current schedule that nursing facilities are paid on the second Thursday of the month (which may or may not be in the first full week)? Nursing facilities are paid the following Thursday for any claims submitted by the previous Wednesday.

Beginning in November, no payment will occur earlier than the third Thursday of the month.

2. What is the cutoff for billing if nursing facilities will be paid on Thursday of the third full week, and will the payment date still be Thursday?

The cutoff for billing will be Wednesday before the second Thursday of the month in order to receive payment on the third Thursday of the month.

3. Currently, nursing facilities can bill for newly eligible Medicaid beneficiaries at any time and are paid on the following Thursday (or, if the claim is submitted after Thursday, the Thursday after the following Thursday). What is the process for these individuals under the new schedule?

Please see the previous answers.

4. The schedule for paying the bed tax (the 15th of the month) was designed with the date nursing facilities receive their Medicaid payments in mind. Now that the payment date is changing, shouldn't the due date for the bed tax change too, so that it will continue to be after the payment date (this would take a statute change)?

This payment is not being affected by the claims payment change.

5. When will EDI Trading Partners and other interested parties be informed of the nursing facility payment change and the revised calendar? Will the revised calendar include the holiday payment schedule?

The calendar has been updated on our website and an email was sent on 10/16/17 to ALL Trading Partners, included Managed Care Plans. The calendar can be found at the following link: <http://medicaid.ohio.gov/PROVIDERS/Billing/TradingPartners.aspx>

6. Will nursing facilities be able to adjust or resubmit claims that are submitted and appear to be processed in MITS but not yet paid to the nursing facility?

Yes

7. If a claim can be adjusted or resubmitted before the nursing facilities has been paid for that claim, will both claims appear on the same remittance advice and be paid in Week Three?

Yes

8. What if a nursing facility does not submit their claims until the second week of the month? Will those claims be paid in Week Three or will the payment be deferred until the following month?

If submitted in week two before Wednesday of that week, the payment will occur in week three.

9. Will nursing facilities receive a remittance advice and payment only in week three regardless of when claims are submitted or adjusted?

The remittance advice will match the payment when paid. The remittance advice will reflect all claims included in the payment and will be issued on Monday of payment week. If that Monday is a Holiday, the remittance advice will be available on Tuesday.

NF Provider Notice – 8/4/16 (rev 9/15/16)
LTC Claim Revenue Center Codes for NFs

Policy Change: Effective with 7/1/16 DOS ([ORC 5165.152](#)), three new Revenue Center Codes (RCCs) were added to the three existing flat fee RCCs to direct different reimbursement for Nursing Facility (NF) Medicaid residents from the lowest acuity groups (PA1 and PA2), based on the most recent MDS assessment completed prior to the claim DOS. The regular low acuity flat rate fee has been adjusted to \$115.00 for a full covered day. However, the flat fee reimbursement is reduced to \$91.70 if the provider is not cooperative with the Long Term Care Ombudsman Program efforts to direct appropriate care for the NF resident*.

The following Revenue Center Codes (RCCs) are currently in use for NFs billing Long Term Care (LTC) Claims:

- RCC 0101 – Full Covered Day
- RCC 0160 – Full Day: Short-Term Stay for Waiver Consumer
- RCC 0183 – Leave Day: Therapeutic
- RCC 0185 – Leave Day: Hospital

- RCC 0220* – Flat Fee Full Covered Day
- RCC 0169* – Flat Fee Full Day: Short-Term Stay for Waiver Consumer
- RCC 0189* – Flat Fee Leave Day

- RCC 0229* – Flat Fee Full Covered Day (reduced rate)
- RCC 0769* – Flat Fee: Short-Term Stay for Waiver Consumer (reduced rate)
- RCC 0180* – Flat Fee Leave Day (reduced rate)

***Flat Fee Reimbursement Rates:**

Effective with 7/1/12 DOS, three RCCs were implemented to direct different reimbursement for NF Medicaid residents from the lowest acuity groups (PA1 and PA2), as identified by the most recent MDS assessment completed prior to the claim DOS. A low acuity flat rate fee of \$130.00 was paid for DOS 7/1/12 – 6/30/16 in place of the facility's per diem rate for a full covered day.

Effective with 7/1/16 DOS, the regular low acuity flat rate fee has been adjusted to \$115.00 for a full covered day. Additionally, three new RCCs were added to direct different reimbursement for NF Medicaid residents from the lowest acuity groups (PA1 and PA2) when the provider is not cooperative with the LTC Ombudsman Program efforts to direct appropriate care for the NF resident. The flat fee reimbursement is reduced to \$91.70 for a full covered day in this situation. (This is a determination made by the Department and if the lower rate codes should be billed, the Department will notify the appropriate parties. If there is no notification from the Department that the rate should be reduced, the regular flat rate codes should be billed.)

NFs are required to bill the appropriate flat fee RCC on claims submitted for low acuity residents.

Nursing Facility (NF) Billing Clarification for Hospital Stays

Dec. 14, 2012

Revised

August 2018

Policy Summary:

Nursing Facility (NFs) may be paid for Hospital Leave Days at a reduced daily rate to reserve a bed for the resident who intends to return to that facility following a hospitalization. If a resident is in the NF for 8 hours or more on the day they were transferred to the hospital, the NF is eligible for reimbursement at the full per diem rate instead of the Leave Day rate. Medicaid NF residents are eligible for up to 30 Leave Days per calendar year.

NF Coverage Policy:

Ohio Administrative Code (OAC) rule 5160-3-16.4 Nursing Facilities (NF): covered days and bed-hold days.

Claim Denials – Possible Duplicates:

When billed correctly, the Hospital and NF Leave Days billed in common will bypass the duplicate claim edits, to allow payment up to the Leave Day limit. NF Leave Days do not apply to a person enrolled in a HCBS waiver program who is using the NF for a short-term respite care as a waiver service.

Billing Directions:

- Hospitals bill the admission date through the discharge date at the Header of the claim. If outpatient services are rendered within three calendar days of the inpatient admission, then those dates must be reflected in the From Date of Service (FDOS) field.
- NFs bill the entire month on a single claim for their residents. Hospital Leave Days are identified by a Revenue Center Code (RCC) at the detail line of the claim.

Nursing Facility (NF) Billing Clarification for Hospital Stays

NF Billing Scenarios

Scenario 1: NF resident to Hospital for more than two days

A NF resident who is hospitalized on the 5th of June and returns to the NF on the 18th

1A) Resident in NF less than 8 hours on date of transfer to hospital

Line 1) 06/01/2018 – 06/04/2018 Revenue Center Code (RCC) 101

Line 2) 06/05/2018 – 06/17/2018 RCC 185 (hospital leave days)

Line 3) 06/18/2018 – 06/30/2018 RCC 101

1B) Resident in NF for 8 hours or more on date of transfer to hospital

Line 1) 06/01/2018 – 06/05/2018 RCC 101

Line 2) 06/06/2018 – 06/17/2018 RCC 185 (hospital leave days)

Line 3) 06/18/2018 – 06/30/2018 RCC 101

Scenarios 1A and 1B illustrate the difference in billing for a full day versus a Leave Day on the day of hospital admission. A full covered day may be billed (RCC 101) for the day the resident returns to the NF. Billing properly allows the duplicate edit to be bypassed so that both the NF and hospital can be paid appropriately for the covered days they bill in common.

Scenario 2: NF resident to Hospital for overnight stay

A NF resident who is hospitalized on the 13th of May and returns to the NF on the 14th

2A) Resident in NF less than 8 hours on date of transfer to hospital

Line 1) 05/01/2018 – 05/12/2018 RCC 101

Line 2) 05/13/2018 – 05/13/2018 RCC 185 (hospital leave day)

Line 3) 05/14/2018 – 05/31/2018 RCC 101

2B) Resident in NF 8 hours or more on date of transfer to hospital

Line 1) 05/01/2018 – **05/13/2018** RCC 101

Line 2) **05/14/2018** – 05/31/2018 RCC 101

Scenario 2B illustrates that the dates must be split into two different detail lines, even though no Leave Days are being billed. A full covered day may be billed (RCC 101) for the day the resident returns to the NF. **Splitting the covered days into two different lines allows the duplicate edit to be bypassed so that both the NF and hospital can be paid appropriately for the covered days they bill in common.**

NF Billing Scenarios (cont.)

Scenario 3: Waiver Consumer in NF for short-term stay to Hospital for more than two days: Consumer is hospitalized on the 20th of July and returns to the NF on the 24th

3A) Waiver Consumer in NF less than 8 hours on date of transfer to hospital

Line 1) 07/01/2018 – 07/19/2018 Revenue Center Code (RCC) 160

Line 2) 07/20/2018 – 07/23/2018 RCC 185

Line 3) 07/24/2018 – 07/31/2018 RCC 160

3B) Waiver Consumer in NF 8 hours or more on date of transfer to hospital

Line 1) 07/01/2018 – 07/20/2018 RCC 160

Line 2) 07/21/2018 – 07/23/2018 RCC 185

Line 3) 07/24/2018 – 07/31/2018 RCC 160

Scenarios 3A and 3B illustrate the difference in billing for a full day versus a Leave Day on the day of hospital admission. RCC 160 must be billed instead of RCC 101 for HCBS Waiver consumers in a short-term NF stay (i.e., consumers with an active waiver span for DOS billed by NF). Hospital Leave Days must be billed with RCC 185.

Scenario 4: Waiver Consumer in NF for short-term stay to Hospital for an overnight stay: Consumer is hospitalized on the 2nd of August and returns to the NF on the 3rd

4A) Resident in NF less than 8 hours on date of transfer to hospital

Line 1) 08/01/2018 – 08/01/2018 Revenue Center Code (RCC) 160

Line 2) 08/02/2018 – 08/02/2018 RCC 185

Line 3) 08/03/2018 – 08/31/2018 RCC 160

4B) Resident is in NF 8 hours or more on date of transfer to hospital

Line 1) 08/01/2018 – **08/02/2018** RCC 160

Line 2) **08/03/2018** – 08/31/2018 RCC 160

Scenario 4B illustrates that the dates must be split into two different detail lines, even though no Leave Days are being billed. Splitting the covered days into two different lines allows the duplicate edit to be bypassed so that both the NF and hospital can be paid for the date of admission (8/02/18). RCC 160 must be billed instead of RCC 101 for HCBS Waiver consumers in a short-term NF stay (i.e., consumers with an active waiver span for DOS billed by NF). Hospital Leave Days must be billed with RCC 185.

Special Scenarios:

NF Resident Has Outpatient Services within 72 Hours of an Inpatient Admission

A NF resident receives outpatient services within three calendar days of an inpatient admission. The hospital claim's FDOS – TDOS should reflect the entire inpatient stay, along with the dates in which outpatient services were rendered within three days of the inpatient admission. Just like normal billing procedure, the NF claim should reflect the appropriate room and board days as well as the hospital leave days. Depending on which claim (hospital or NF) is paid first, the second claim will deny as a duplicate due to a systems configuration that compares the FDOS on the hospital claim against dates on the detail lines of the NF claim. As a workaround, if your claim is denied as a duplicate, please resubmit your claim via the 6653 process for manual review. In box 6 of the 6653 form, when requesting the duplicate edits to be overridden, please make sure to add that it is the 72-hour rule per hospital policy.

NF Resident is Discharged from a Hospital and then Readmitted within 24 Hours

A NF resident is admitted to the hospital for an inpatient stay, then discharged from the hospital and readmitted to the NF, and then returns to the hospital within 24 hours of discharge for admission (i.e., is readmitted to the hospital on the same day of discharge or next day). The hospital must collapse their claim if the patient is readmitted within 24 hours of discharge. Depending on which claim (hospital or NF) is paid first, the second claim will deny as a duplicate due to a systems configuration limitation that will not process two claims with overlapping dates of service (i.e., the day the patient is readmitted to the NF). As a workaround, if your claim is denied as a duplicate, please resubmit your claim via the 6653 process for manual review. In box 6 of the 6653 form, when requesting the duplicate edits to be overridden, please make sure to add that it is a hospital readmission situation.

Uploading a 6653 in MITS

Scroll down to the Attachments panel and click add an item

Attachments

*** No rows found ***

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

delete add an item

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

Claim Status Information

Claim Status Not Submitted yet

submit cancel

First select Referral Form (Ohio 6653) from Type of Document bar

Rendering Provider
Status
NDC Detail -
Attachments
Type of Document
A
delete add an item

- ADMISSION SUMMARY
- CERTIFICATION
- COMPLETED REFERRAL FORM
- DENTAL MODELS
- DIAGNOSTIC REPORT
- DISCHARGE SUMMARY
- EXPLANATION OF BENEFITS
- MODELS
- NURSING NOTES
- OPERATIVE NOTE
- PHYSICAL THERAPY CERTIFICATION
- PHYSICAL THERAPY NOTES
- PHYSICIAN ORDER
- PRESCRIPTION
- PROSTHETICS OR ORTHOTIC CERTIFICATION
- RADIOLOGY FILMS
- RADIOLOGY REPORTS
- REFERRAL FORM (OHIO 6653)**
- REPORT OF TESTS AND ANALYSIS REPORT
- SUPPORT DATA FOR CLAIM

*Type of Document
*Transmission Type

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

Claim Status Information

Claim Status Not Submitted yet

Next select upload under the Transmission Type bar

Attachments	
Type of Document	Transmission Type
A	
Select row above to update -or- click add an item button below.	
<input type="button" value="delete"/>	<input type="button" value="add an item"/>
<p>For attachments submitted via mail, not electronically attached, please send to the appropriate address. A button for printing a cover page and a view mailing addresses will appear after the claim has been submitted.</p> <p>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, p docx, xls, xlsx, pdf, txt, and mdi can be uploaded.</p> <p>*Type of Document REFERRAL FORM (OHIO 6653) ▼</p> <p>*Transmission Type ▼</p> <p>Supporting Data for Delayed Submission / Resubmission <i>DISCLAIMER: Documentation to justify the use of this panel and data entered must be retained for future audit purposes.</i></p> <p>Previously Denied ICN or TCN <input type="text"/></p>	
Claim Status Information	
Claim Status	Not Submitted yet

Once you select upload, click on the light blue panel

Attachments	
Type of Document	Transmission Type
A REFERRAL FORM (OHIO 6653)	UPLOAD
Select row above to update -or- click add an item button below.	
<input type="button" value="delete"/>	<input type="button" value="add an item"/>
<p>For attachments submitted via mail, not electronically attached, please send to the appropriate address. A button for printing a cover page and a view mailing addresses will appear after the claim has been submitted.</p> <p>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, p docx, xls, xlsx, pdf, txt, and mdi can be uploaded.</p> <p>*Type of Document REFERRAL FORM (OHIO 6653) ▼</p> <p>*Transmission Type UPLOAD ▼</p> <p>Supporting Data for Delayed Submission / Resubmission <i>DISCLAIMER: Documentation to justify the use of this panel and data entered must be retained for future audit purposes.</i></p> <p>Previously Denied ICN or TCN <input type="text"/></p>	

Once saved, click the SUBMIT button

Professional Claim:

BILLING INFORMATION

ICN 23141010C0001

Claim Type M - PROFESSIONAL

Provider ID NPI

*Medicaid Billing Number

*Date of Birth 09/16/1983

Last Name

First Name, MI

*Patient Account # 1234

Medical Record #

Referring Provider #

Rendering ID

*Medicare Assignment NOT ASSIGNED

Patient Amount Paid \$0.00

SERVICE INFORMATION

*Release of Information INFORMATION ON FILE

From Date 08/13/2013

To Date 08/13/2013

*Signature Source GENERATED BY PROVIDER

Accident Related To

Accident State

Accident Country [Search]

Accident Date

EPSDT Referral

Prior Authorization #

Hospital Discharge Date

Last Menstrual Period

TOTAL CHARGES

Total Charges \$30.00

Medicaid Allowed Amount \$0.00

TPL Paid Amount \$0.00

Total Medicaid Paid Amount \$0.00

MITS will populate an ICN and now the claim status will show suspended

Claim Status Information

Claim Status SUSPENDED

Claim ICN 23141010C0001

Paid Amount \$0.00

EOB Information

Detail Number	Error Disposition	EOB Code	EOB Description	ARC Code	ARC Amount	ARC Description
0	SUSPEND	06E1	WAITING FOR PAPER ATTACHMENT FROM PROVIDER	133	\$0.00	The disposition of the claim/service is pending further review. (Use only with Group Code OA). This change effective 11/01/2014: The disposition of this service line is pending further review. (Use only with Group Code OA). If this code requires a reversal and correction when line is finalized (use only in Loop 2110 CAS segment 835 or Loop 2430 of the 837).
0	SUPERSUSPEND	95E7	CLAIMS REQUIRE REVIEW - PORTAL AND EDI	133	\$0.00	The disposition of the claim/service is pending further review. (Use only with Group Code OA). This change effective 11/01/2014: The disposition of this service line is pending further review. (Use only with Group Code OA). If this code requires a reversal and correction when line is finalized (use only in Loop 2110 CAS segment 835 or Loop 2430 of the 837). Non-covered charge(s). At least one Remark Code

Please note that the EOB information shows SUSPENDED

Next, scroll back to the ATTACHMENT panel and submit upload

Attachments

Type of Document REFERRAL FORM (OHIO 6653)

Transmission Type UPLOAD

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

add an item upload cover page mailing addresses

upload

For attachments submitted via mail, not electronically attached, please send to the appropriate address. A button for printing a cover page and a 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, p docx, xls, xlsx, pdf, txt, and mdi can be uploaded.

Type of Document

Transmission Type

Click on the Type of Document panel

Attachment Upload		
Type of Document	Reference	Received
REFERRAL FORM (OHIO 6653)	2314101000001 267308510659647599920140411081059008401	NO

Please note the following important parameters when uploading files:

- File size cannot be greater than 50MB (51200KB).
- Only file types of gif, tiff, bmp, jpg, ppt, pptx, doc, docx, xls, xlsx, pdf, txt, and mdi can be uploaded.
- For claim attachments: Select row from the list above and then use the below panel to select the file for upload.

Attachment Upload		?	⌵
<input type="text" value="upload attachment"/>			
Type of Document			
Reference			
*File to Upload	<input type="text"/>	Browse...	

After clicking on this panel, this becomes light blue

Attachment Upload		
Type of Document	Reference	Received
REFERRAL FORM (OHIO 6653)	2314101000001 267308510659647599920140411081059008401	NO

Please note the following important parameters when uploading files:

- File size cannot be greater than 50MB (51200KB).
- Only file types of gif, tiff, bmp, jpg, ppt, pptx, doc, docx, xls, xlsx, pdf, txt, and mdi can be uploaded.
- For claim attachments: Select row from the list above and then use the below panel to select the file for upload.

Attachment Upload		?	⌵
<input type="text" value="upload attachment"/>			
Type of Document	REFERRAL FORM (OHIO 6653)		
Reference	2314101000001 267308510659647599920140411081059008401		
*File to Upload	<input type="text"/>	Browse...	

Next, select the Browse button

Attachment Uploads - Microsoft Internet Explorer provided by ODJFS

Choose File to Upload

Look in: Desktop

My Recent Documents
Desktop
My Documents
My Computer
My Network Places

My Documents
My Computer
My Network Places

6653 Form

File name:
Files of type: All Files (*.*)

Open
Cancel

UAT (R16.0) Friday 04/11/2014 8:12:46 AM

tion Reports Portal Admin Security Trade Files Admin

Received
08401 NO

f, txt, and mdi can be uploaded.
c below panel to select the file for upload.

upload attachment

Type of Document REFERRAL FORM (OHIO 6653)

Reference 2314101000001 267308510659647599920140411081059008401

*File to Upload Browse...

Now select the 6653 document that you wish to upload. You may also upload the Medicare EOB as well in this step if needed.

Click on the light blue line under Type of Document to save

Attachment Upload

Type of Document	Reference	Received
REFERRAL FORM (OHIO 6653)	2314101000001 267308510659647599920140411081059008401	NO

Please note the following important parameters when uploading files:

- File size cannot be greater than 50MB (51200KB).
- Only file types of gif, tiff, bmp, jpg, ppt, pptx, doc, docx, xls, xlsx, pdf, txt, and mdi can be uploaded.
- For claim attachments: Select row from the list above and then use the below panel to select the file for upload.

Attachment Upload

upload attachment

Type of Document REFERRAL FORM (OHIO 6653)

Reference 2314101000001 267308510659647599920140411081059008401

