



**Department of
Medicaid**

John R. Kasich, Governor
Barbara R. Sears, Director

Basic Billing for Hospitals

External Business Relations

2018

AGENDA

- Medicaid Services
- Programs & Cards
- Managed Care/MyCare Ohio
- Provider Responsibilities
- Policy
- MITS & Claims
- Websites & Forms

External Business Relations Team

Sarah Bivens

Ava Cottrell

Ed Ortopan

Janene Rowe

Chezré Willoughby



Manager - Meagan Grove



❑ Ohio Medicaid covers:

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

Medicaid Medical Necessity: OAC 5160-1-01

Is the fundamental concept underlying the Medicaid Program



All Services must meet accepted standards of medical practice

Covered Services (not limited to)

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



☐ Helpful phone numbers

➤ Adjustments

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)





Programs & Cards

□ Ohio Medicaid

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

<p>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.</p> <p>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.</p> <p>Note: Use the Medicaid ID for all claim submissions.</p> <p><u>medicaid.ohio.gov</u></p> <p>Consumer's Signature: _____</p>	<p style="text-align: center;">Fold</p> <table border="1"><tr><td>County</td><td>ALLEN</td><td rowspan="4" style="text-align: right;">Ohio Medicaid</td></tr><tr><td>Case Number</td><td>5082482</td></tr><tr><td>Eligibility Begin Date</td><td>01/01/2018</td></tr><tr><td>Void After Date</td><td>01/31/2018</td></tr></table> <p>Ohio Department of Medicaid medicaid.ohio.gov</p> <p>Consumer Hotline: 1-800-324-8680 [or TTY 1-800-292-3572]</p>	County	ALLEN	Ohio Medicaid	Case Number	5082482	Eligibility Begin Date	01/01/2018	Void After Date	01/31/2018
County	ALLEN	Ohio Medicaid								
Case Number	5082482									
Eligibility Begin Date	01/01/2018									
Void After Date	01/31/2018									

Supplemental Security Income (SSI)

- Automatically Eligible for Medicaid as long as eligible for SSI

Modified Adjusted Gross Income (MAGI)

- Children, parents, caretakers, and expansion

Aged, Blind, Disabled (ABD)

- 65+, or blind/disabled with no SSI

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

- Consumers must cooperate with requests from third-party insurance companies to provide additional information needed in order to authorize coverage
- Consumers must cooperate with requests from a Medicaid provider; managed care plan; or a managed care plan's contracted provider for additional information which is needed in order to bill third party insurances appropriately

□ Conditions of Eligibility and Verifications

- Providers may contact local CDJFS offices to report non-cooperative consumers
- CDJFS may terminate eligibility if an individual fails or refuses, without good cause, to cooperate by providing necessary verifications or by providing consent for the administrative agency to obtain verification

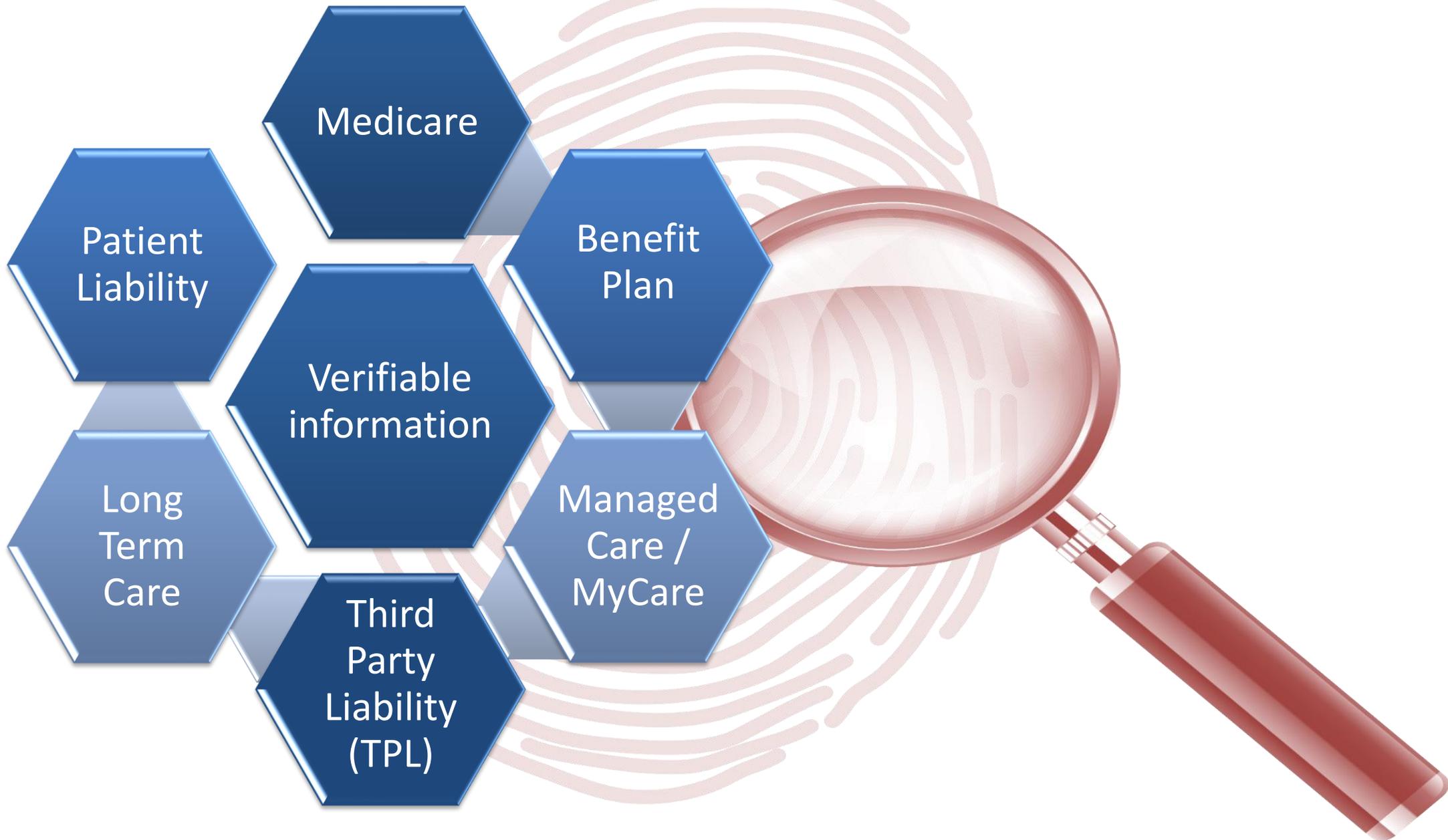
Full Medicaid eligibility on the MITS Portal will show **four** (or more) benefit spans:

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



Additional spans when applicable:

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





Eligibility 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	<input type="text" value="MM/DD/YYYY"/>
Procedure Code	<input type="text"/>	From DOS	<input type="text" value="01/11/2018"/>
		To DOS	<input type="text" value="01/11/2018"/>

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



Eligibility Verification Request

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

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 <input type="button" value="v"/>
Procedure Code	<input type="text"/>	From DOS	01/12/2015
		To DOS	01/11/2018

*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

Last Name

First Name

Gender

Date of Birth

Date of Death

SSN

County of Residence CUYAHOGA

County of Eligibility

County Office http://jfs.ohio.gov/County/County_Directory.pdf

Number Bed Hold Days Used Paid CY



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	AUDREY		DOE	FEMALE	11/20/2004
987654321012	ALEX		DOE	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
		09/01/2017	NF; NF WAIVER; RSS	INTERMEDIATE (ILOC)	12/01/2017	12/08/2017
		08/23/2017	NF; NF WAIVER; RSS	INTERMEDIATE (ILOC)	12/01/2017	12/08/2017
				UNKNOWN LEVEL OF CARE	12/01/2017	12/07/2017

Patient Liability

Financial Payer	Monthly Amount	Type	Effective Date	End Date
DEFAULT	\$491.00	Pro-rated Nursing Home	12/01/2017	12/08/2017

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	07/25/2017	12/01/2017	12/08/2017	

Recipient Restricted Coverage

*** No rows found ***

Special Program

*** No rows found ***



Presumptive Eligibility



Covers children up to age 19 and pregnant women

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

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



Presumptive Eligibility



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



Other members will receive a Presumptive Eligibility Card

<p>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.</p> <p>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 1-800-688-1518.</p> <p>Inpatient hospital services are not covered.</p> <p>Note: Use the Medicaid ID for all claim submissions.</p> <p>medicaid.ohio.gov</p> <p>Consumer's Signature: _____</p>	<p>County BUTLER</p> <hr/> <p>Case Number 012345678910</p> <hr/> <p>Eligibility Begin Date 07/01/2013</p> <hr/> <p>Void After Date 08/30/2013</p> <hr/> <p>Ohio Department of Medicaid medicaid.ohio.gov</p> <p>Consumer Hotline: 1-800-324-8680 [or TTY 1-800-292-3572]</p> <p>Presumptive Medicaid</p> 
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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						



Medicaid Pre-Release Enrollment Program

- Institutionalized individuals close to release are enrolled into a Medicaid Managed Care plan, prior to release
- Individual must agree and be eligible for the program
- MCP Care Manager will develop a transition plan
- More than **20,000** individuals have benefited from this program

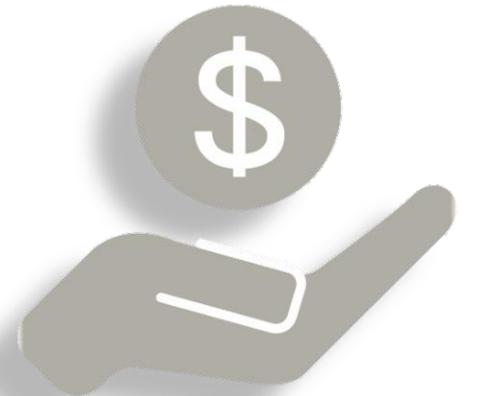


Qualified Medicare Beneficiary (QMB)

Issued to
qualified
Individuals who
receive
Medicare

Reimbursement
policy is set
under 5160-1
and can result in
a payment of
zero dollars

Medicaid only
covers their monthly
Medicare premium,
co-insurance and/or
deductible after
Medicare has paid



Can I bill them?

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

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

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



**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**

Healthchek: OAC 5160-1-14

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

Minimum services include:

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

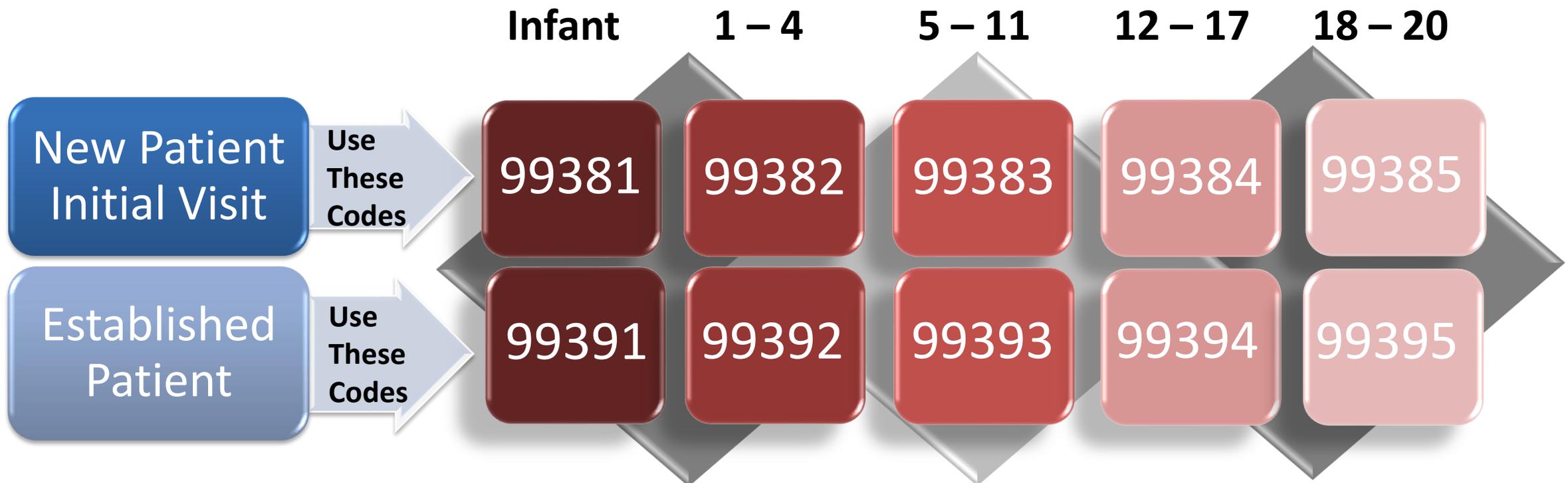
Healthchek

- Hearing Screening
- Immunization Screening
- Lead Toxicity Screening
- Lab Tests
- Dental Screening



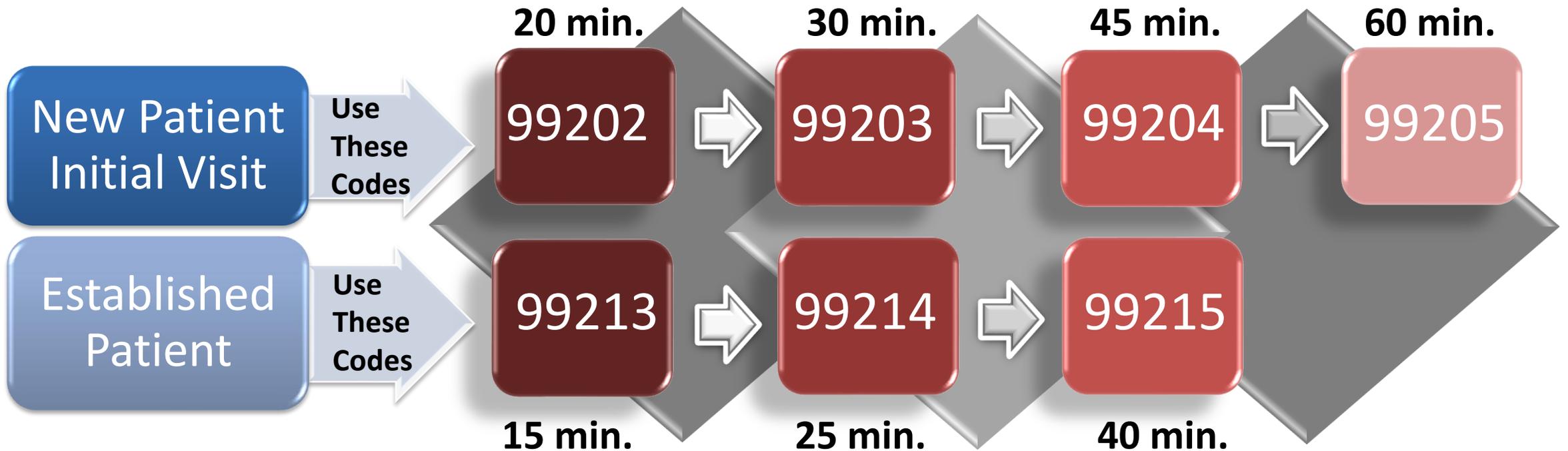
HealthChek Procedure Codes

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



HealthChek Procedure Codes

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



Managed Care/MyCare Ohio

Aetna logo in green lowercase letters with a registered trademark symbol.

AETNA BETTER HEALTH® OF OHIO

buckeye
health plan.

CareSource®

PARAMOUNT
HEALTH
CAREA blue icon of three stylized human figures.
MOLINA®
HEALTHCAREA blue icon of a stylized 'U' shape.
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



Managed Care Day One

- New individuals will be assigned to a Managed Care Plan the first day of the current month when a individual is found eligible for Medicaid

	'The old way'	Day One
Recipient completes Application	4/3/2018	4/3/2018
Determined eligible for Medicaid	5/17/2018	5/17/2018
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)

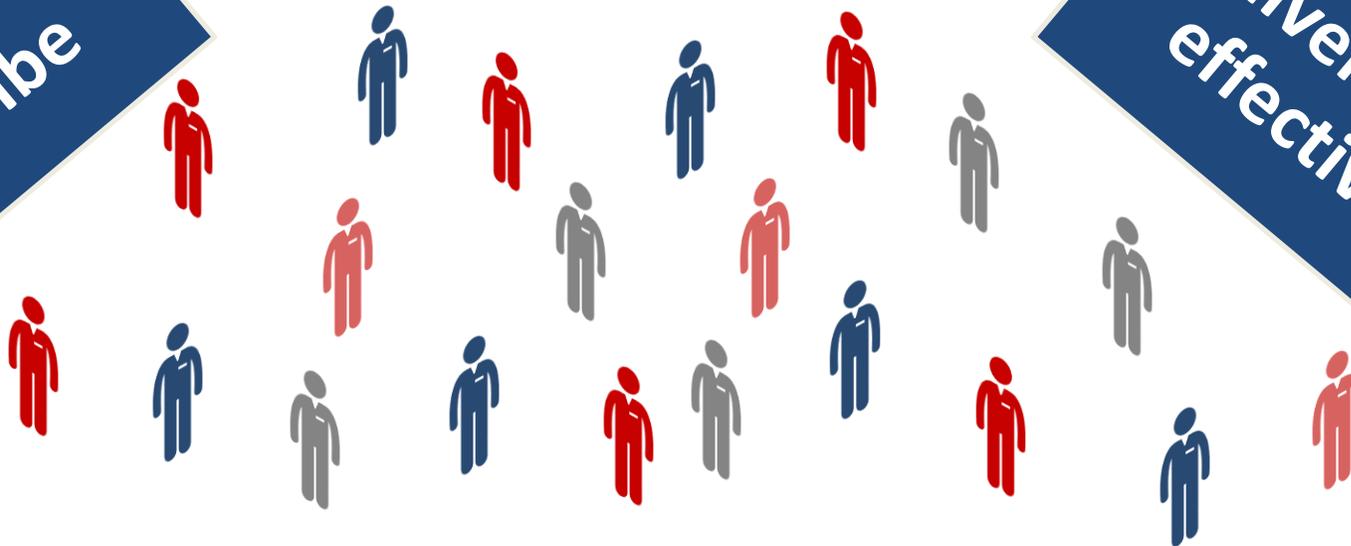
Population added for mandatory enrollment in 2017

- 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





Traditional Managed Care Benefit Package



Managed Care Plans must cover all medically necessary Medicaid covered services

Some value-added
services:



On-line searchable provider directory



Access to toll-free 24/7 hotline for medical advice, staffed by nurses



Expanded benefits including additional transportation options, and other incentives (varies among the MCPs)



Care management to help members coordinate care and ensure they are getting the care that they need

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

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

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



MITs Eligibility screen

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	

Traditional Managed Care Sample Card

 PARAMOUNT ADVANTAGE www.paramountadvantage.org	GROUP NUMBER ADV0010011
HEALTH PLAN (80840) 7952304120	EFF. DATE 01/01/2015
ID NUMBER A9999999901	MMIS NUMBER 000000000000
MEMBER NAME Jane Doe	CVS/CAREMARK RXGRP RX6407
PRIMARY CARE PROVIDER John Smith (419) 5551212	RXBIN 004336 RXPCN ADV
PROVIDERS CALL FOR PRIOR AUTH 800-891-2500/419-887-2520	



Traditional Managed Care Contracting

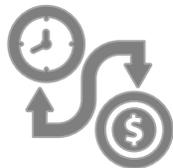


Providers who are interested in delivering services to a Managed Care member must be fully enrolled with Medicaid and have a contract or agreement with the plan

Things to know:



Each plan has a list of services that require prior authorization



Each plan will have their own billing requirements; therefore, contact the plan for the specific requirements



ABD/CFC Managed Care plan contracts may be separate from MyCare Ohio plan contracts

Traditional Managed Care Plans



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



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



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
- This includes Long Term Services and Supports (LTSS) and Behavioral Health
- Plans may elect to include additional **value-added benefits** in their health care packages

MyCare Ohio Eligibility

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

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

Over the age of 18

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

Groups that are not eligible for enrollment in MyCare Ohio:

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

Individuals enrolled in the PACE program

Individuals who have third-party insurance, including retirement benefits

HOW DO YOU KNOW IF SOMEONE IS ENROLLED IN MYCARE?

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

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

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



MITS Eligibility screen

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-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

MedicareRx
Prescription Drug Coverage

RxBin: 004336
RxPCN: MEDDADV
RxGRP: RX5045

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

Member Service:	1-855-475-3163 (TTY: 1-800-750-0750 or 711)	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



MITs Eligibility screen

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
Alcohol and Drug Addiction Services	10/01/2017	01/31/2018		\$0.00	\$0.00
Ohio Mental health	10/01/2017	01/31/2018		\$0.00	\$0.00
Medicaid	10/01/2017	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	10/01/2017	01/31/2018	Medicaid Only



Lock-In

*** No rows found ***

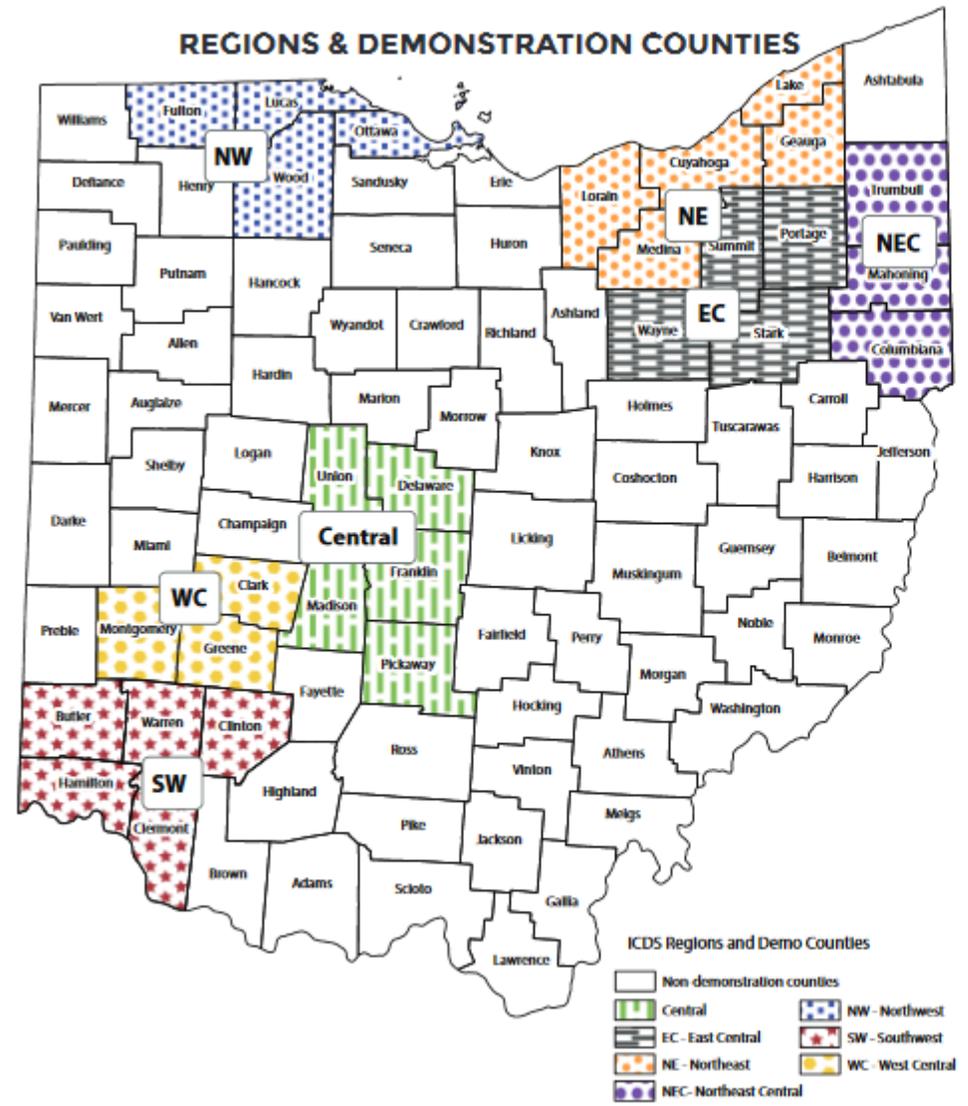
Medicare

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 Opt-Out Sample Card

 	<p>RxBin: 004336 RxPCN: ADV RxGRP: RX3292</p>														
<p>Member Name: <Cardholder Name> Member ID #: <Cardholder ID#> MMIS Number: <Medicaid Recipient ID#> PCP Name: <PCP Name> PCP Phone: <PCP Phone></p>	<p>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.</p> <table><tr><td>Member Service:</td><td>1-855-475-3163 (TTY: 1-800-750-0750 or 711)</td></tr><tr><td>Behavioral Health Crisis:</td><td>1-866-206-7861 (TTY: 1-800-750-0750 or 711)</td></tr><tr><td>Care Management:</td><td>1-855-475-3163 (TTY: 1-800-750-0750 or 711)</td></tr><tr><td>24-Hour Nurse Advice:</td><td>1-866-206-7861 (TTY: 1-800-750-0750 or 711)</td></tr><tr><td>Provider/Pharmacy Questions:</td><td>1-800-488-0134</td></tr><tr><td>Website:</td><td>CareSource.com/MyCare</td></tr><tr><td>Mail medical claims to: CareSource Attn: Claims Department P.O. Box 8730 Dayton, OH 45401-8738</td><td>Mail pharmacy claims to: CVS Caremark P.O. Box 52066 Phoenix, AZ 85072-2066</td></tr></table>	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
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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 Managed Care Contracting



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

Things to know:



Each plan has a list of services that require prior authorization



Each plan will have their own billing requirements; therefore, contact the plan for the specific requirements



MyCare Ohio Managed Care plan contracts may be separate from ABD/CFC plan contracts

MyCare Ohio Managed Care Plans



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



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



AETNA BETTER HEALTH® OF OHIO

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



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



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

PROVIDER COMPLAINTS

Work directly with the Plan first

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

<http://www.ohiomh.com/ProviderComplaintForm.aspx>

Certification issues

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

Provider credentialing concerns

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

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

Not seek reimbursement for service(s) from the patient, any member of the family, or any other person

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

Inform us of any changes to your provider profile within 30 days

Abide by the regulations and policies of the state

Recoup any third party resources available

Maintain records for 6 years

Render medically necessary services in the amount required

**General
Reimbursement
Principles:
OAC 5160-1-02**



**Medicaid Payment:
OAC 5160-1-60**

**The department's payment constitutes
payment-in-full for any of our covered
services**

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

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

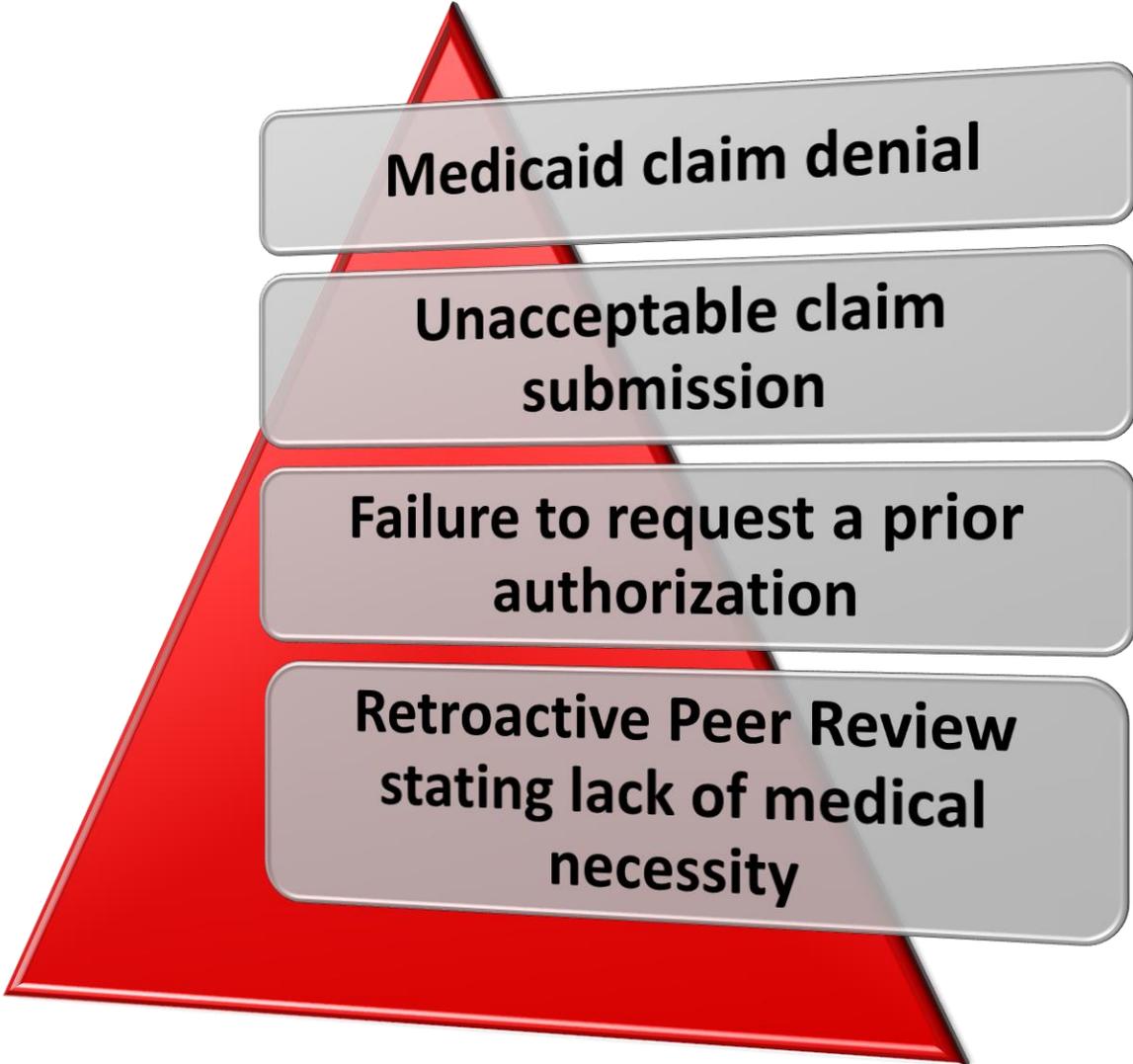
Coordination of Benefits: OAC 5160-1-08

- 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:



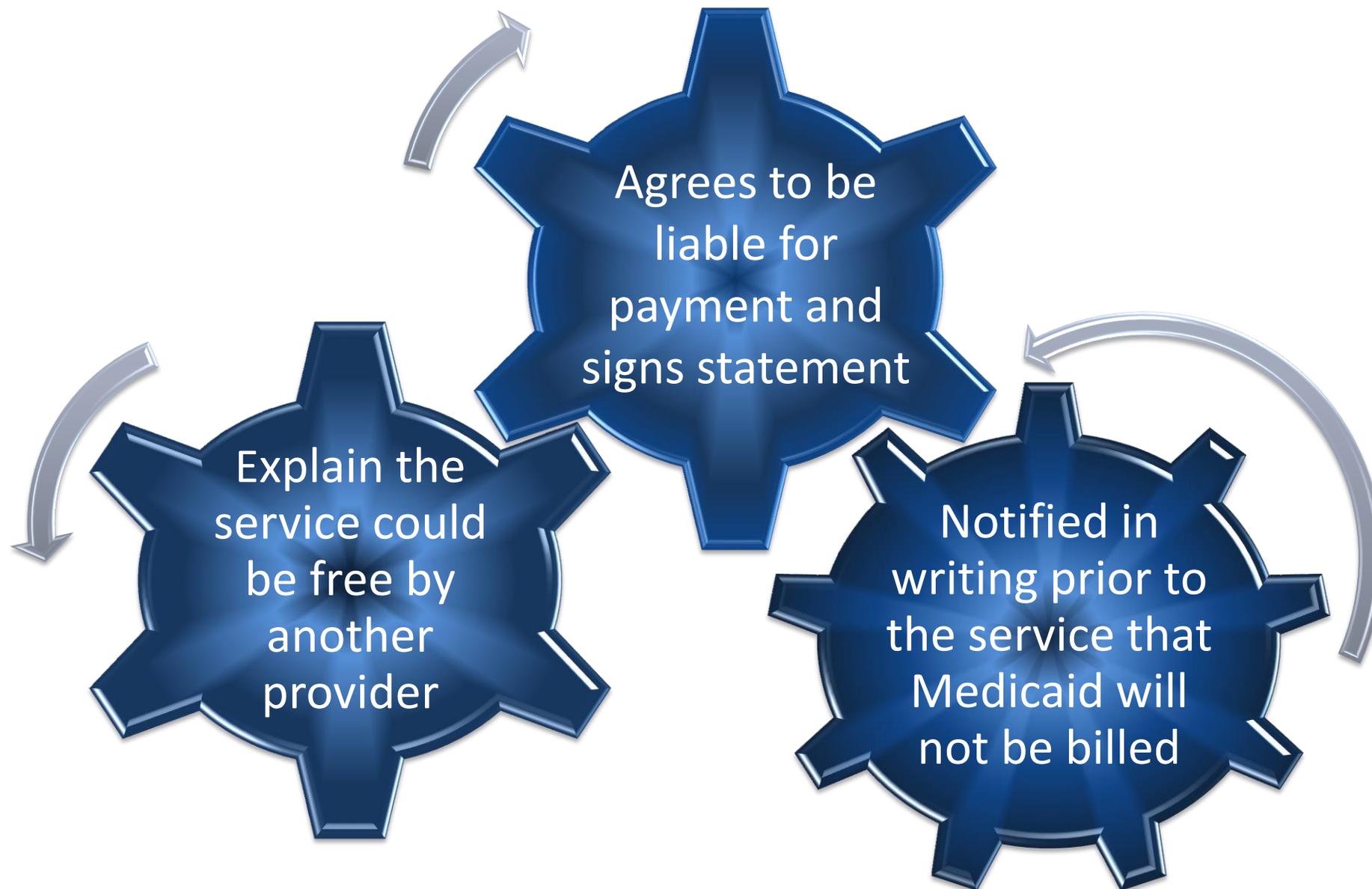
Medicaid claim denial

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.

Provider Responsibilities

The screenshot shows the Ohio Department of Medicaid website. At the top left is the Ohio logo and the text "Department of Medicaid". On the right, there are options for "Text Size: +A -A", "Select Language", and "Powered by Google Translate" with a "Translation Disclaimer" link. A dark blue navigation bar contains the following menu items: HOME, MEDICAID 101, FOR OHIOANS, PROVIDERS, INITIATIVES, NEWS, RESOURCES, CAREERS, and CONTACT. The main content area features a large blue 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 of Barbara Sears, Director of the Ohio Department of Medicaid. Below the banner are two promotional boxes: "Are you uninsured? Ohio Benefits" and "Are you unemployed? Ohio MEANS Jobs." At the bottom, there are three blue buttons: "Managed Care Plans 2016 Report Card" (with a star icon), "Information for Independent Providers" (with a magnifying glass icon), and "Payment Innovation Ohio's SIM Grant" (with a lightbulb icon). On the right side of the page, there is a "Tweets by @OH_Medicaid" section featuring a tweet from John Kasich about disposing of unused prescriptions. At the bottom right, there is a "Testimony & Presentations" section with a circular logo.

Provider Responsibilities



Text Size: +A -A  Powered by  Google Translate [Translation Disclaimer](#)

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

Provider News

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

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

Related Content

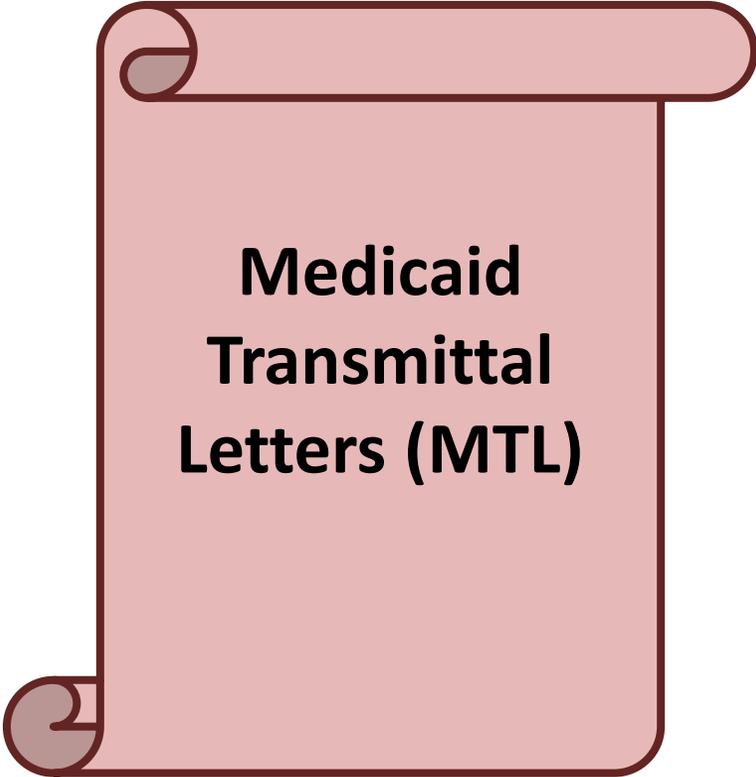
- Benefit Coordination & Recovery
- Fee Schedules/Rates
- Medicaid Forms
- ODJFS Forms
- MITS EDMS Cover Page
 - Instructions
- Healthcek Screening Forms
- e-Manuals
- Helpful Links
- Get a National Provider Identifier (NPI)
- Transmittal Letter Notification
- Medicaid Provider Incentive Program (MPIP)
- ICD-10



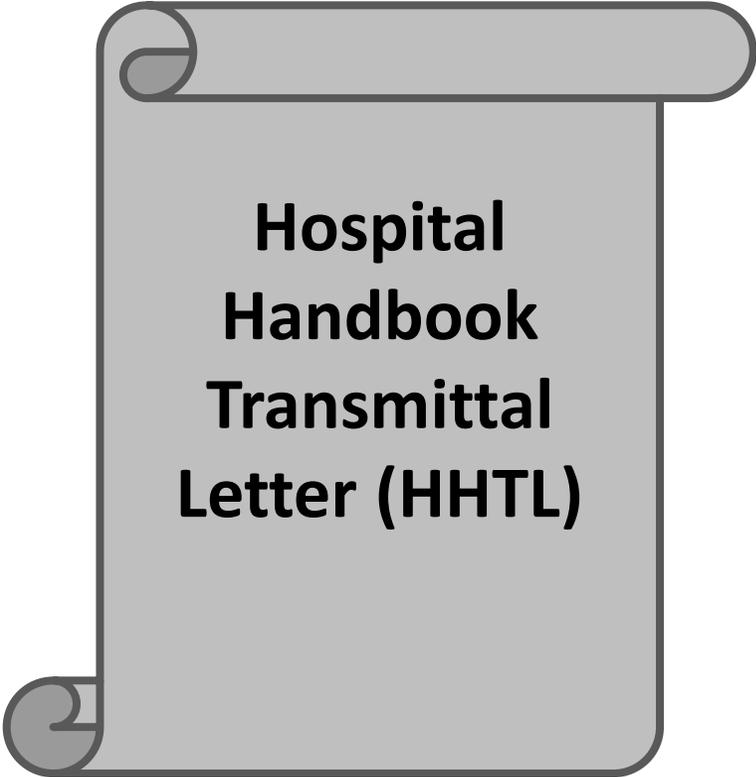
Access the
MITS Portal

Policy

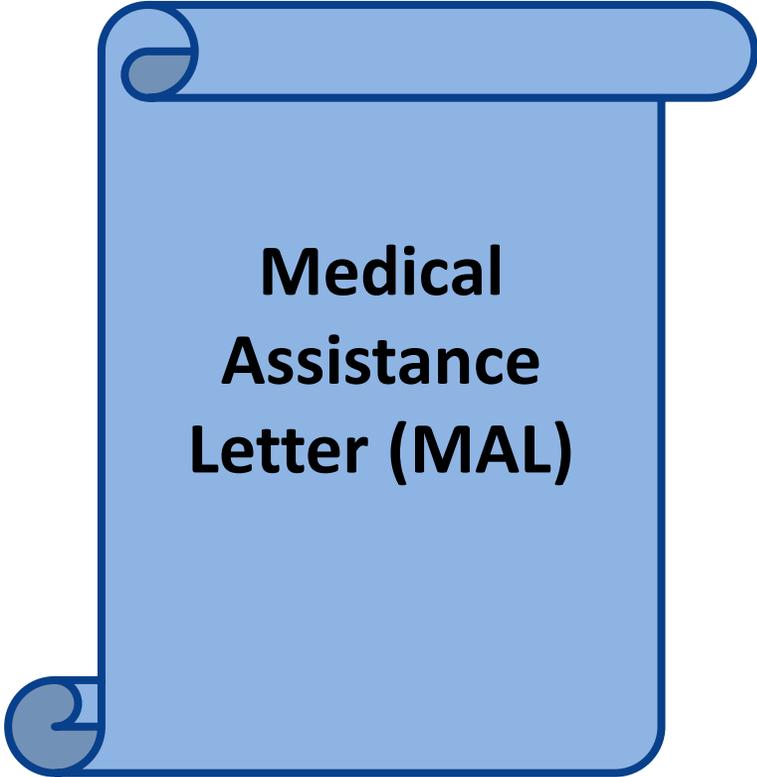
Policy updates from Ohio Medicaid announce the changes to the Ohio Administrative Code that may affect providers. There are three types of letters:



**Medicaid
Transmittal
Letters (MTL)**



**Hospital
Handbook
Transmittal
Letter (HHTL)**



**Medical
Assistance
Letter (MAL)**

Medicaid Transmittal Letter (MTL) No. 3336-18-01

- Effective 4/1/2018 the following modifiers will be used for APRNs:
 - **SA** indicates a service performed by a **CNP**
 - **SB** indicates a service performed by a **CNM**
 - **UC** indicates a service performed by a **CNS**
 - **QX** indicates an anesthesia service performed by a **CRNA** (or anesthesiologist assistant) with the medical direction of an anesthesiologist
 - **QZ** indicates an anesthesia service performed by a **CRNA** without the medical direction of an anesthesiologist
 - **AS** indicates a service performed by an assistant-at-surgery
 - ❖ No additional modifier (SA, SB, or UC) is used to indicate an APRN (the practitioner is identified by NPI as the rendering provider)

Medicaid Advisory Letter (MAL) No. 612

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

**OAC 5160-
21-02.2**

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

**OAC 5160-
17-01**

- **ODM 03197** Abortion Certification Form(formerly ODJFS 03197)

Medicaid Advisory Letter (MAL) No. 612

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

- The individual is at least twenty-one years old at the time consent is obtained
- The individual is not mentally incompetent
- The individual is not institutionalized
- The individual has voluntarily given informed consent

Medicaid Advisory Letter (MAL) No. 612

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

CPT

59840

59841

59850

59851

59852

59855

59856

59857

59866

ICD-10

10A00ZZ

10A03ZZ

10A04ZZ

10A07ZX

10A07Z6

10A07ZW

10A07ZZ

10A08ZZ

New Explanation of Benefits Codes for Hospitals HHTL 3352-16-02

- Effective January 2016
- **No longer using the 6653 process**
- Must use “utilization/tpl vendor approved resubmission” as the reason
- Must use the 56 ICN for the takeback

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>	
Previously Denied ICN or TCN <input type="text"/>	Reason
	DELAYED SUBMISSION/RESUBMISSION
	UTILIZATION/TPL VENDOR APPROVED RESUBMISSION
Claim Status Information	
Claim Status	Not Submitted yet

How to Find Modifiers Recognized by Ohio Medicaid

The screenshot shows the Ohio Department of Medicaid website. At the top left is the Ohio Department of Medicaid logo. To the right is a search bar with a 'GO' button and a Twitter icon. Below the logo is a navigation menu with the following items: HOME, MEDICAID 101, FOR OHIOANS, PROVIDERS, INITIATIVES, NEWS, RESOURCES, CAREERS, and CONTACT. The 'PROVIDERS' menu item is selected, and a dropdown menu is open. The dropdown menu contains the following items: Enrollment and Support, Fee Schedule and Rates, Billing (highlighted), Training, Managed Care, Provider Types, MITS, Payment Innovation, and DRA Attestation. A sub-menu is open for 'Billing', containing: Direct Deposit, Billing Instructions (highlighted), HIPAA and EDI Information, Trading Partners, How to Refund Overpayments, Remittance Advice, Answers for MITS Problems, HIPAA 5010 Implementation, Behavioral Health Integration Project, and ICD-10. On the right side of the page, there are two blue boxes: 'Need technical assistance? Provider Hotline: (800) 686-1516' and 'Access the MITS Portal'. Below these is a 'Related Content' section with a list of links: Benefit Coordination & Recovery, Fee Schedules/Rates, Medicaid Forms, ODJFS Forms, and MITS EDMS Cover Page.

PROVIDERS

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

- Enrollment and Support >
- Fee Schedule and Rates
- Billing >**
- Training >
- Managed Care
- Provider Types
- MITS >
- Payment Innovation

- 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

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

How to Find Modifiers Recognized by Ohio Medicaid

➤ Scroll to the bottom of the page

The screenshot shows the 'RESOURCES' dropdown menu on the Ohio Medicaid website. The menu items are: EDI Companion Guide for Professional Claims; INSTITUTIONAL OR FACILITY-BASED CLAIMS: Web Portal Billing Guide for Institutional Claims, EDI Companion Guide for Institutional Claims, ODM Hospital Billing Guidelines (with sub-items for discharge dates before and after 7/31/2017); DENTAL CLAIMS: Web Portal Billing Guide for Dental Claims, EDI Companion Guide for Dental Claims; and MODIFIERS: Modifiers recognized by ODM. The 'MODIFIERS' section and its link are circled in red.

- HOME
- MEDICAID 101 ▾
- FOR OHIOANS ▾
- PROVIDERS ▾
- INITIATIVES ▾
- RESOURCES ▾
- CAREERS
- CONTACT

- EDI Companion Guide for Professional Claims

INSTITUTIONAL OR FACILITY-BASED CLAIMS:

- Web Portal Billing Guide for Institutional Claims
- EDI Companion Guide for Institutional Claims
- ODM Hospital Billing Guidelines
 - For Dates of Discharge and Dates of Service On or Before 7/31/2017
 - For Dates of Discharge and Dates of Service On or After 8/1/2017

DENTAL CLAIMS:

- Web Portal Billing Guide for Dental Claims
- EDI Companion Guide for Dental Claims

MODIFIERS:

- Modifiers recognized by ODM

➤ New Utilization Review Vendor

- KEPRO (Keystone Peer Review Organization) will be handling all utilization reviews
- Effective *7/1/17*
- KEPRO will be doing all Prior Authorizations and Hospital reviews
- Your process will not be changing



Medicaid Payment: OAC 5160-1-60

- Rates for ASCs will no longer be maintained in this rule
 - 8/1/2017 ASC rates were moved to OAC 5160-22-01
 - ASC claims will process through 3M's Enhanced Ambulatory Patient Group (EAPG) software
 - EAPGs use procedure codes, not diagnosis codes, as initial classification
- Payment for neonatal and newborn care services will be increased to seventy-five percent of the Ohio Medicare allowed amount



Medicaid Payment: OAC 5160-1-60



➤ ASC EAPG Payment

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

➤ ASC Base Rate = \$74.83 and ASC Cost-to-Charge Ratio = .18

- ASC base rate and CCR is equal to 80% of statewide average Outpatient Hospital base rate and CCR

Medicaid Payment: OAC 5160-1-60

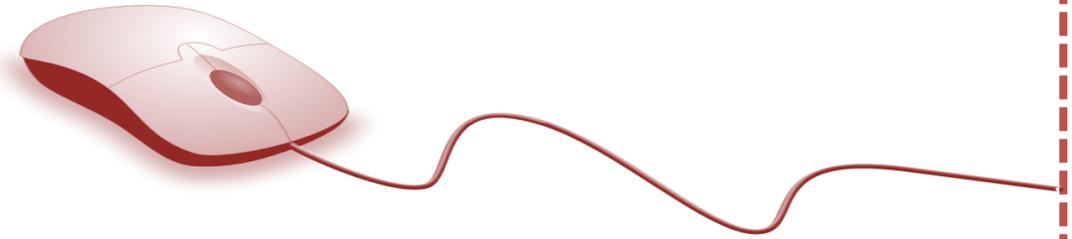
- Prior Authorization (PA) will need to be requested for select codes
 - The covered code list has a PA indicator on the codes that now require a PA
- Use the MITS provider portal to request a PA
- ASCs are PA assignment type 57



Medicaid Payment: OAC 5160-1-60

- The expanded code list can be found at:

<http://medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates/SchedulesandRates.aspx>



- Two webinars available for ASC's

- PA training webinar

<https://attendee.gotowebinar.com/recording/1363716958699805953>

- EAPG training webinar

<https://attendee.gotowebinar.com/recording/5547934847121846795>



DRC Inpatient Hospitalization

Process Overview



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

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

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



Inpatient Hospital Services Plan (IHSP)

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

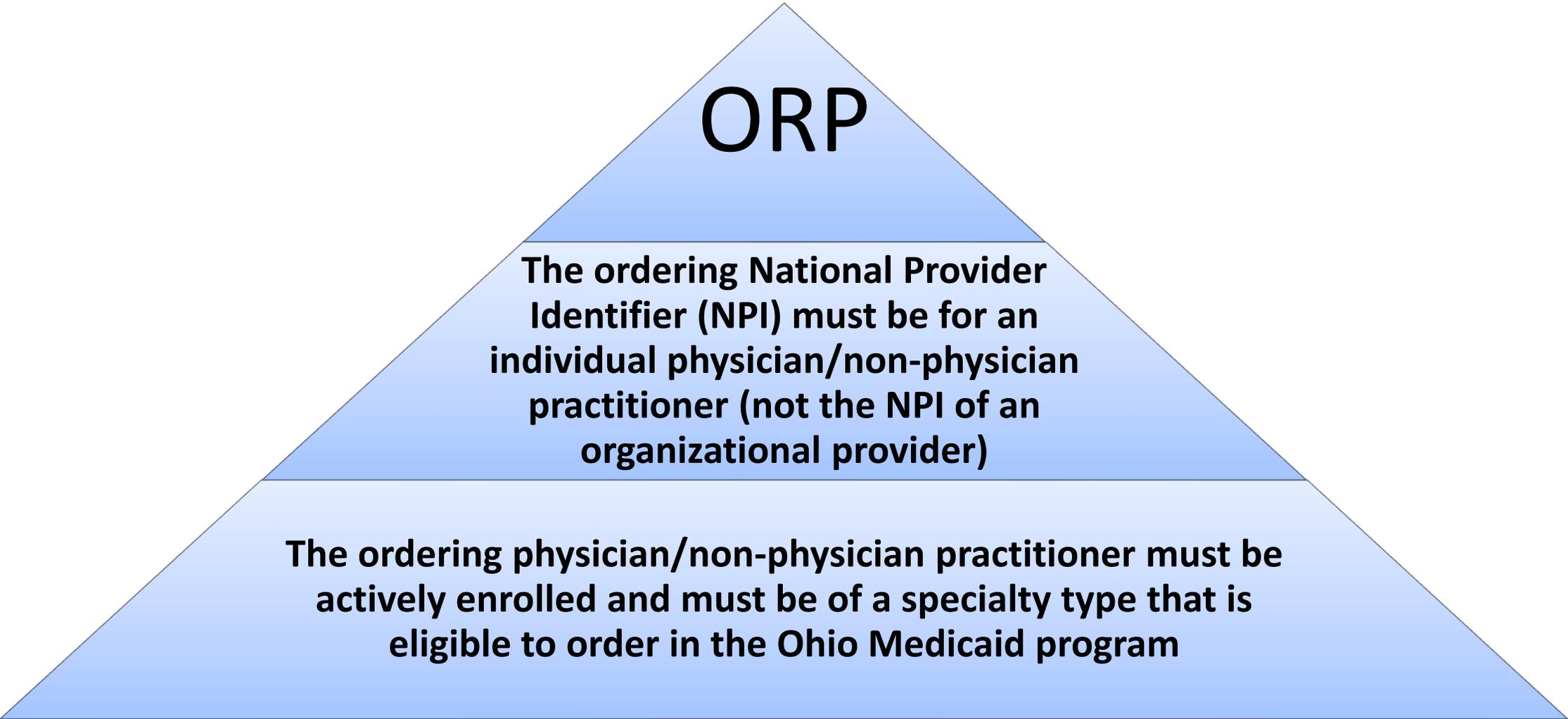
72 hour roll-in for outpatient services does not apply for IHSP individuals

Outpatient services prior to the date of admission must be submitted to DRC or the correctional facility for payment



24 hours

OAC 5160-1-17.9 Ordering, Referring and Prescribing Providers



ORP

The ordering National Provider Identifier (NPI) must be for an individual physician/non-physician practitioner (not the NPI of an organizational provider)

The ordering physician/non-physician practitioner must be actively enrolled and must be of a specialty type that is eligible to order in the Ohio Medicaid program

OAC 5160-1-17.9 Ordering, Referring and Prescribing Providers

Providers should ensure that services are being ordered, referred, or prescribed by an eligible provider who is enrolled in Medicaid

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

ORP-only providers have an expedited screening process

Online applications can be found on our website

Eligible Providers: OAC 5160-2-01

Changes to be effective for discharges on or after *7/1/17*

– Added Paragraph “C”

- Allows MCP to now cover inpatient psychiatric services
- Only for individuals aged 21 - 64
- This change does not apply to traditional FFS Medicaid



General Provisions: OAC 5160-2-02

– Three Calendar Day Roll-In



- Effective 1/1/16
- Outpatient (OP) services provided within three calendar days prior to the date of admission will be covered as inpatient (IP) services
- Including emergency room and observation services
- “From Date” should start with the first date of OP and the “Through Date” should be the date of discharge
- “Admit Date” field is the day the patient was admitted as IP

Classification of Hospitals: OAC 5160-2-05

- As of 1/1/18 nineteen hospitals were reclassified from the Rural to Urban peer groups and were set to receive the new peer group base rate
- The rule will be updated with the following effective **8/1/18**:
 - ❖ Beginning on or after **1/1/19** any hospital geographically located in an Ohio county that has been newly included or newly excluded from a Core Based Statistical Area (CBSA) will be placed into either the rural peer group or, based on geographical location of the hospital, the urban peer group. The hospital's new base rate will be the average cost per discharge of the new peer group without stop loss/gain provisions included.

A blue diamond-shaped sign with the words "CHANGE AHEAD" in white capital letters on a blue background.

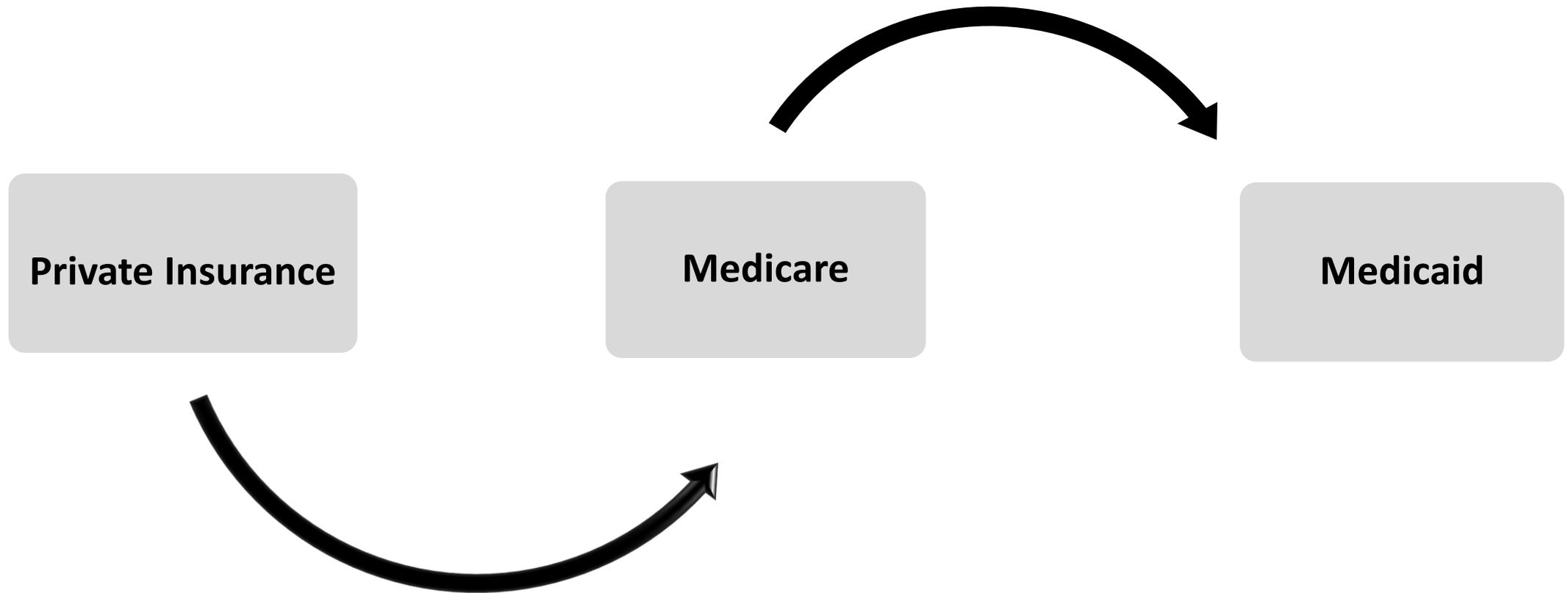
CHANGE
AHEAD

Potentially Preventable Readmissions (PPR) Program: OAC 5160-2-14

- Reduces payment for clinically-related and clinically-preventable readmissions
 - Encourages underperforming hospitals to improve the level of care provided during a patient's inpatient admission
 - A hospital with excess readmissions* will be subject to a reduction of their hospital-specific base rate by one percent
- * Defined as an actual-to-expected readmission ratio of greater than one

Coordination of Benefits: Hospital Services: OAC 5160-2-25

HHTL 3352-17-04



Payment to be made only after any available third-party benefits are exhausted

Inpatient Hospital Services: OAC 5160-2-65

Updated fixed cost outlier thresholds for dates of discharge on or after **7/4/17**

Neonate and tracheostomy DRGs = \$25,000

Major Teaching or Children's Peer Group Hospitals = \$60,000

All other DRGs/Peer Groups = \$75,000

Inpatient Hospital Services: OAC 5160-2-65

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

All Interim Bills (Bill Type 112 & 113) must be for periods of 30 days or more

DRG-Exempt provider may submit a Final Interim (Bill type 114) to close out the stay

DRG Hospital must void all Interim Bills and submit a final admit through discharge bill (Bill Type 111) for the entire stay

DRG Hospitals will pay their hospital-specific inpatient cost-to-charge ratio for Bill Types 112 and 113

Transfer Billing : Located in the hospital billing guidelines

Section

2.1.1

- Transfer between Acute Care and Medicare Distinct Part Psychiatric Units

Section

2.1.2

- Multiple Transfers between Acute Care and Medicare Distinct Part Psychiatric Units

Section

2.1.3

- Transfers between Acute and Distinct Part Rehabilitation Units

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

- Changes effective for dates of services on or after **8/1/17**
- Establishes the Enhanced Ambulatory Patient Groups (EAPG) as the reimbursement logic for outpatient services
- Due to the initial EAPG implementation, hospitals cannot submit a claim that spans from **7/31/17** through **8/1/17**
- CPT codes are updated annually on January 1st, so hospitals cannot submit a claim that spans **12/31** and **1/1** of any year

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

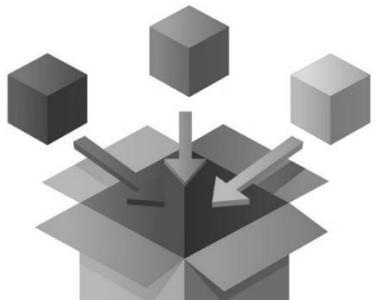
➤ EAPG Packaging

- Uniform list of EAPGs that always package with significant procedures or medical visit EAPGs
 - Example: Incidental medical supplies (i.e. gauze, dressings, sutures, etc.) on a surgery claim
 - Example: Lab test on same day as a surgery
- If ancillary service is on the claim on its own, packaging may or may not apply



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

- Significant Procedure Consolidation
 - When a patient has multiple significant procedures, some of the significant procedures may require minimal additional time or resources
 - Significant procedure consolidation collapses multiple related significant procedure EAPGs into a single EAPG for payment
 - *Example:* EAPG 063 Level II Endoscopy would pay 100%, but if EAPG for Level I Endoscopy was on the same claim, it would consolidate with EAPG 063 (no separate payment)



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

- Discounting pricing logic is used when:
 - Multiple unconsolidated significant procedures are on the claim; highest weighted EAPG is paid 100%, secondary 50%
 - Multiple unpackaged ancillaries are on the claim; highest weighted EAPG is paid 100%, secondary 50%
 - Modifiers (e.g. 50, bilateral procedure) are present; code with modifier 50 is paid at 150% of standard rate



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

➤ Payment Formula:

- Detail Payment = Base Rate * EAPG relative weight * Discount percentage (if applicable)
- Total claim payment = sum of all detail payments
- Lab and radiology services are paid the lesser of the EAPG payment or billed charges
- Items consolidated or packaged are paid \$0.00

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

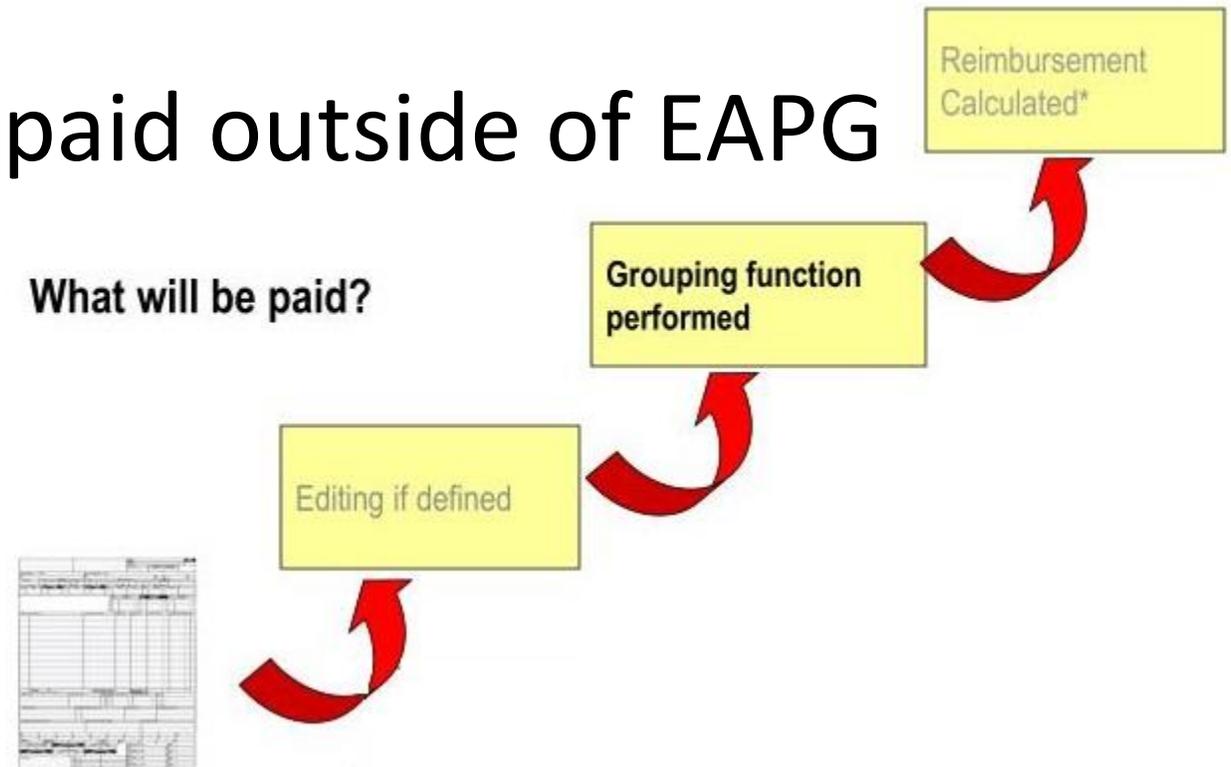
- Example payment calculation for 2 gastrointestinal EAPGs, 134-Diagnostic Upper GI Endoscopy or Intubation, and 149-Screening Colorectal Services and EGD:

Code	Description	Current Payment	EAPG	Relative Weight	Cleveland Clinic Base Rate	RW * Base Rate	Discounting	Final Payment
43239	EGD BIOPSY SINGLE/MULTIPLE	\$692.00	134	4.6595	\$101.12	\$471.17	100%	\$471.17
45380	COLONOSCOPY AND BIOPSY	\$346.00	149	3.8031	\$101.12	\$384.57	50%	\$192.29
		\$1,038.00						\$663.46

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

➤ Pricing Outside of EAPG

- Certain services may be paid outside of EAPG



Pricing Outside of EAPG: Dental Services

- Medicaid now accepts select CDT D codes in outpatient hospital setting
- Hospitals should bill the same CDT D codes that the dentist uses on corresponding professional claim
- The outpatient hospital setting is ***NOT*** the designated place for dental procedures
 - Should only be utilized when medically necessary



Pricing Outside of EAPG: Observation

- We now accept observation code **G0378** which is an hourly code this is the preferred code
 - Limited to 48 hours
 - May span across 3 days
- Observation services reported with CPT codes **99218 - 99220, 99224 - 99226, 99234 - 99236** will continue to be *limited* to one unit per day, for a maximum of two consecutive days



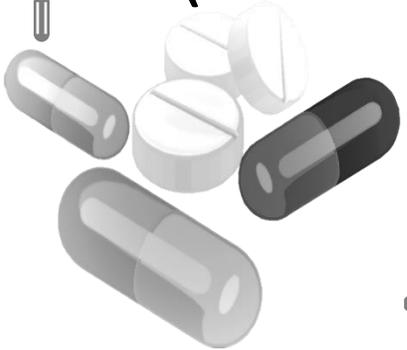
Pricing Outside of EAPG: Durable Medical Equipment (DME)

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



Pricing Outside of EAPG: Pharmaceuticals

- Pharmaceuticals that are not packaged or consolidated will reimburse the lesser of charges or the payment amount listed on the Provider Administered Pharmaceutical Fee Schedule
- If a pharmaceutical is not on the fee schedule or is listed as 'By Report' the detail will reimburse at 60% of the hospital cost (60%*CCR*billed charges)



Pricing Outside of EAPG: Vaccines

- Vaccines for Children (VFC) may be reimbursed for individuals 18 years of age or younger
 - \$10 reimbursement for administration
 - No payment for the vaccine itself



Pricing Outside of EAPG: Independently Billed Services

- Option to have only high cost items reimbursed and forego payment for any other procedure and ancillary services performed on the same date
 - Bill the **UB** modifier on the surgery code or main procedure code provided on the date of service
 - Submit all procedures, drugs, and medical supplies on the claim



Pricing Outside of EAPG: Independently Billed Services

- Pharmaceutical pricing is based on provider administered fee schedule when a rate exists
 - Otherwise, the payment is calculated as drug charges multiplied by the hospital's cost to charge ratio, multiplied by 60%
- Independently billed medical supplies are calculated as billed charges multiplied by the hospital's cost to charge ratio, multiplied by 60%



Pricing Outside of EAPG

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

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

Behavioral Health

- Carve-in for hospitals and MyCare Ohio was **8/1/2017**, full managed care carve-in will be effective **7/1/2018**
- The following DRGs became effective **7/1/2017** for detox services provided in Psychiatric hospitals:
 - 770 – Drug & Alcohol Abuse or Dependence
 - 773 – Opioid Abuse and Dependence
 - 774 – Cocaine Abuse and Dependence
 - 775 – Alcohol Abuse and Dependence
 - 776 – Other Drug Abuse and Dependence



* Psych hospitals should submit only one claim for all inpatient services *

Behavioral Health Redesign OAC 5160-2-75 (G)(2)

- All hospitals that meet the Medicare conditions of participation may provide Outpatient BH and Substance Use Disorder (SUD) services
- Payment will match Community Mental Health Center (CMHC)/SUD agency reimbursement
 - Rates based upon the level of the professional providing the services



Behavioral Health Redesign OAC 5160-2-75 (G)(2)

- Payment will match CMHC/SUD agency reimbursement
 - Rates based upon the level of the professional providing the services
- Mental Health and SUD services are *excluded* from the 72-hour inpatient roll-in
 - Medical service provided in the 72 hours before an IP stay must be submitted with the IP claim



Behavioral Health Redesign OAC 5160-2-75 (G)(2)

- Each claim for MH or SUD must contain the following:
 - Modifier **HE** at the detail level for each MH or SUD CPT/HCPCS code
 - Revenue center code **0671, 0900, 0904, 0906, 0907, 0911, 0912, 0913, 0914, 0915, 0916, 0918, 0919** or **1002** for each MH or SUD detail line
 - A MH or SUD diagnosis code
 - Modifier signifying the highest level of practitioner who performed the service



Behavioral Health Redesign OAC 5160-2-75 (G)(2)

RCC	Description	Covered under EAPG	Covered in Outpatient Hospital for BH redesign services (with HE modifier) effective 8/1/17
0900	BH Treatment/Services	X	X
0904	Activity Therapy		X
0906	IOP - Chemical Dependency		X
0907	Day Treatment		X
0911	Rehabilitation	X	X
0912	Partial Hospitalization - Less Intensive (Half Day)		X
0913	Partial Hospitalization - Intensive (Full Day)		X
0914	Individual Therapy	X	X
0915	Group Therapy	X	X
0916	Family Therapy	X	X
0918	Testing	X	X
0919	Other Psych Services	X	X
1002	Residential Treatment – Chemical Dependency		X
0671	Outpatient Special Residence Charges - All Home or Community Based Services		X

Behavioral Health Redesign OAC 5160-2-75 (G)(2)

Service Date On or After	Type of Medicaid Enrollment	Outpatient Services			Inpatient Services			
		Claims for Appendix F* Services	Claims for BH Services with modifier 'HE'	Claims for Medical Services	Patient Age Under 21 or Over 65		Patient Age 21-64	
					General Hospital	Freestanding Psychiatric Hospitals	General Hospital	Freestanding Psychiatric Hospitals
7/1/2017	FFS	FFS	Not Available	FFS	FFS	FFS	FFS	Excluded
	MCP	MCP	Not Available	MCP	MCP	FFS	MCP	MCP
	MyCare	MyCare	Not Available	MyCare	MyCare	MyCare	MyCare	MyCare
8/1/2017	FFS	FFS	FFS	FFS	FFS	FFS	FFS	Excluded
	MCP	MCP	FFS	MCP	MCP	FFS	MCP	MCP
	MyCare	MyCare	MyCare	MyCare	MyCare	MyCare	MyCare	MyCare
1/1/2018**	FFS	FFS	FFS	FFS	FFS	FFS	FFS	Excluded
	MCP	MCP	MCP	MCP	MCP	MCP	MCP	MCP
	MyCare	MyCare	MyCare	MyCare	MyCare	MyCare	MyCare	MyCare

*Appendix F services relate to services described in Appendix F of Ohio Administrative Code rule 5160-2-21, which include some behavioral health services, will continue to be available via EAPG beginning 8/1/17

**Managed Care carve-in date subject to the legislative process

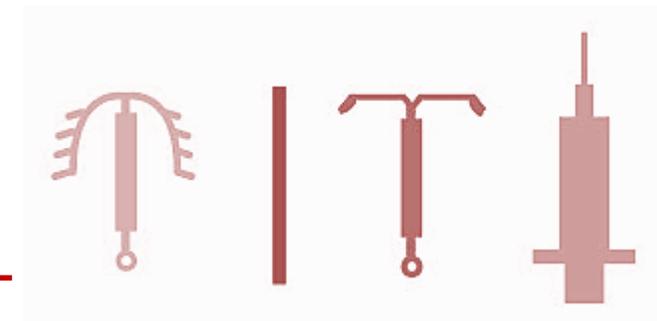
FFS = Fee-for-Service Medicaid

MCP = Medicaid Managed Care

MyCare = MyCare Ohio (dual-eligible) Plan

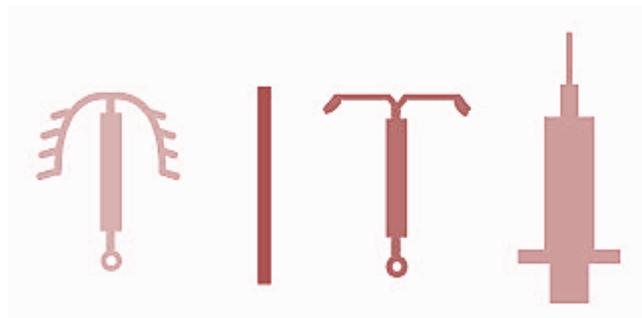
Reimbursement for LARC devices: OAC 5160-2-79

- Effective *7/6/17*
- Result of Sub. S.B. 332 of the Ohio 131st General Assembly
- Implements recommendations made by the Commission on Infant Mortality
- Includes intrauterine devices (IUD) and subdermal contraceptive implants



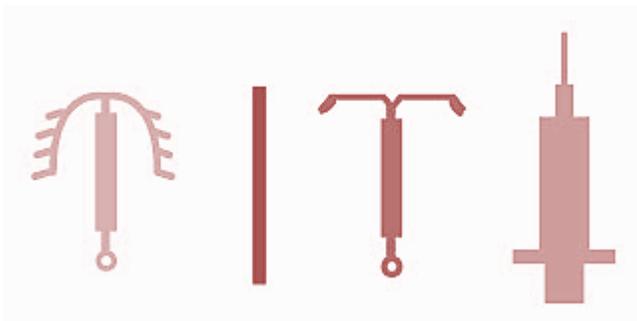
Reimbursement for LARC devices: OAC 5160-2-79

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



Reimbursement for LARC devices: OAC 5160-2-79

- LARC device or implant must be billed using Type of Bill 131
Only 1 detail line on claim and **NO** other procedure codes listed
- Paid in-patient claim must include a secondary ICD-10 CM diagnosis code for the Z37- Outcome of Delivery Range Codes



Reimbursement for LARC devices: OAC 5160-2-79

- LARC device or implant must be reported using:
 - Revenue Center Code 0278
 - Medical/Surgical Supplies and Devices
- MITS configured to pay for separate inpatient postpartum LARC claims effective 7/12/17
- MITS configured to pay retroactive for dates of service on or after 7/6/17



Inpatient Facility Stay During A Change

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

Who do I BILL?

Admit Plan	Enrollment Change	Responsible Plan*
FFS	FFS -> MCP	FFS
MCP	MCP -> FFS	MCP
MCP ₁	MCP ₁ -> MCP ₂	MCP ₁

340B Drugs

- Hospitals recognized as a 340B entity are required to notify ODM when 340B purchased drugs are provided to a Medicaid individual
 - 340B reporting is for outpatient claims only
 - RCC 25X or 636 should be billed with a pharmaceutical *J* or *Q* code, an NDC, and modifier SE
 - SE modifier *must* be used for dates of service 1/1/2018 and later
 - If a non-340B entity submits the SE modifier edit 3203 – modifier restriction will post and pay on their claims for dates of service on or after 4/1/18 through 9/30/18
 - Starting 10/1/18 non-340B entities using the SE modifier will have their claims denied with edit 3203

RCC 25X and/or 636 with HCPCS J-Code or Q-Code

- Effective DOS **1/1/16** covered vaccine/toxoid CPT codes are reimbursable with RCC 25X or 636
- Effective DOS **10/1/16** covered immune globulins, serum, recombinant products CPT codes are reimbursable when submitted with RCC 25X or 636
- Refer to Hospital Billing Guidelines, section 2.16.2

Modifier JW – Drug amount discarded/not administered to patient

- Effective for dates of service on or after *July 1, 2017*
 - Informational only edit, will not affect reimbursement
- If a claim (one date of service) contains **two** detail lines with the same RCC, same pharmaceutical HCPCS code, and same NDC but **one** detail line contains modifier **JW**, the second detail line will not deny as a duplicate
- EOB 9950 will post on the detail containing modifier **JW** which will result in payment of \$0 for that line

Physician Assistants: OAC 5160-4-03

- Physician assistants are allowed to practice within their scope of practice as authorized by state law
- Physician assistants are allowed to practice within the scope of practice of the physician assistant's supervising physician
- Physician assistants may receive payment for serving as assistant-at-surgery with an **AS** modifier alone, when listed as the rendering provider



Advanced Practice Registered Nurse Services: OAC 5160-4-04

- APN is now Advanced Practice Registered Nurse (APRN)
- Unless a specific exception is noted, all other Medicaid rules that pertain to services by a physician apply to APRNs
- APRNs may receive payment for serving as assistant-at-surgery with an **AS** modifier alone, when listed as the rendering provider



Radiology and Imaging Services: OAC 5160-4-25

- When more than one imaging procedure is performed, the payment amounts remain the same for the following:
 - Covered primary procedure, additional covered total procedure, and technical component alone of an additional covered procedure
 - Must be performed by the same provider or provider group for the same patient in the same session
- The maximum payment amount for the professional component alone was increased from 75% to 95%

Gynecological Service change

NEW CODES

G0101

Q0091



REPLACING

S0612

S0610



MTL No. 3334-16-18 notified providers of a coding change for gynecological services



Pregnancy Related Services: OAC 5160-21-04

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

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

H1000 – At Risk Assessment

H1002 – Care Coordination

H1001 – Antepartum Management

H1003 – At Risk Education

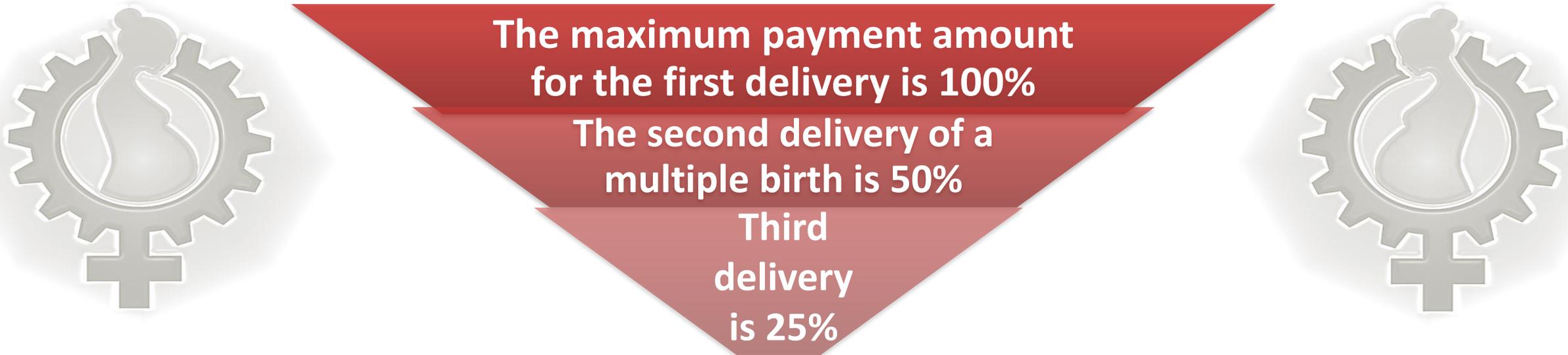
S9436 – Childbirth Preparation/Lamaze

S9452 – Nutrition Class for pregnant women

Pregnancy Related Services:(MAL No. 605)

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

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



The maximum payment amount
for the first delivery is 100%

The second delivery of a
multiple birth is 50%

Third
delivery
is 25%

ODM form 03535 “Prenatal Risk Assessment” has been replaced by ODM form 10207 and the online NurtureOhio PRAF 2.0 system

MITTS 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



Ohio
Department of Medicaid

About ODM | Our Services | Resources | News & Events

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

Home Consumers **Providers** Trading Partners Public Information Publications

enrollment enrollment tracking search long-term care account setup

Ohio Department of Medicaid

Provider Home

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

Login to secure site

- Click Here to Login

Once directed to this page, click the link to "Login"



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



Ohio.gov | Medicaid Information Technology System

Sign In
Medicaid Information Technology System

To sign in, please enter your User ID and Password

User ID:

Password:

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

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

Yes, I have read the agreement

Login

[Help FAQ](#)
[Help Reset Password?](#)
[Forgot Your User ID?](#)

MITIS Navigation

“COPY”, “PASTE”, and “PRINT” features all work in the MITIS 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**

MITIS 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 weekend adjudication**

MITIS Portal

Free submission

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

**We can help with
your claim
submission issues!**

Technical Questions/EDI Support Unit

Trading
partners
contact DXC
for EDI
Support



844-324-7089
or

[OhioMCD-EDI-
Support@dxc.com](mailto: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

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](#) [professional](#)

Claims

- Search
- Search Detail
- Dental
- Institutional (for Inpatient, Outpatient, Long Term Care)
- Professional

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



Submission of an Institutional Claim

Institutional Claim: ? ^

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



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

Diagnosis

Sequence	Diagnosis Code	Description	Present on Admission	
A	Principal	J440	CHRONIC OBSTRUCTIVE PULMON DISEASE W ACUTE LOWER RESP INFCT	YES

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

*Sequence *Diagnosis Code [Search]

Present on Admission

Header - Other Payer

Last Name	First Name	MI	Date of Birth	Relationship	Gender	Policy ID	Paid Amount	Paid Date	Electronic Payer ID
A									

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

*Claim Filing Indicator

*Insurance Carrier Name

*Policy Holder Relationship to Insured

*Electronic Payer ID

*Policy Holder Last Name

Insured's Policy ID

*Policy Holder First Name, MI

*Payer Sequence

Policy Holder Date of Birth

Medicare ICN

Gender

*Paid Amount

*Paid Date

Allowed Amount

Header - Other Payer Amounts and Adjustment Reason Codes



Detail Panel

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
A	1			0	\$0.00	\$0.00	\$0.00						

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

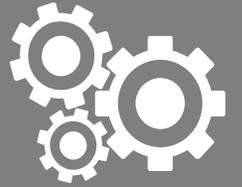
delete
add an item
copy

Item	1		*Units	<input type="text" value="0"/>
Date of Service	<input type="text"/>		*Units Of Measurement	<input type="text" value="v"/>
To DOS			Per Diem Rate	<input type="text" value="\$0.00"/>
*Revenue Code	<input type="text"/>	[Search]	*Total Charges	<input type="text" value="\$0.00"/>
HCPCS/HIPPS Rate Codes	<input type="text" value="v"/>	<input type="text"/>	Non Covered Charges	<input type="text" value="\$0.00"/>
Modifiers	<input type="text"/>	[Search]	Medicaid Allowed Amount	\$0.00
	<input type="text"/>	[Search]	Status	
Submitted EAPG	<input type="text"/>		Final EAPG	
Initial EAPG			Pay Action	

NDC
Detail - Other Payer



Procedure Codes



Multiple surgery codes have a payment limit of one unit per line



- If billed with multiple units the claim will deny

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



When applicable modifiers may be needed in order to bill certain surgical procedures

National Drug Code (NDC)



Drug products are identified and reported using a unique, three-segment number which serves as a universal product identifier for drugs



Providers billing HCPCS codes in the **J** series and **Q** or **S** series, that represent drugs and CPT codes 90281 – 90399 series (immune globulins) must include the 11 digit NDC number

National Drug Code (NDC)

-  If the NDC number printed on a drug package consists of only 10 digits, add a leading zero to the appropriate segment
-  If the NDC number is missing or invalid, the claim line will deny
-  The FDA publishes the listed numbers



National Drug Code (NDC)

*Revenue Code	<input type="text"/> [Search]	*Total Charges	<input type="text" value="\$0.00"/>
HCPCS/HIPPS Rate Codes	<input type="text"/> [Search]	Non Covered Charges	<input type="text" value="\$0.00"/>
Modifiers	<input type="text"/> [Search]	Medicaid Allowed Amount	\$0.00
Submitted EAPG	<input type="text"/>	Status	
Initial EAPG	<input type="text"/>	Final EAPG	
		Pay Action	



NDC							
Detail Item	NDC Sequence Number	NDC	Drug Name	Unit of Measure	Prescription Number	Drug Unit Price	Unit Quantity Submitted
A 1	1	64406080701	ELOCTATE	UN-Unit		\$1.71	1000.000

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

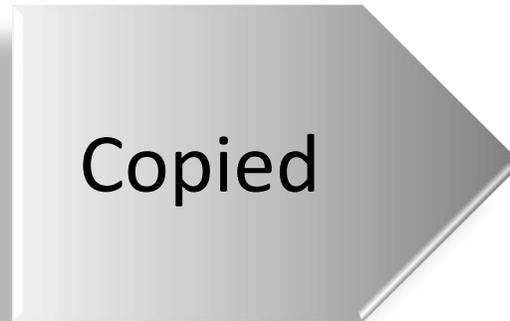
*Detail Item	1						
*NDC	<input type="text" value="64406080701"/>	[Search]				*Drug Unit Price	<input type="text" value="\$1.71"/>
Drug Name	ELOCTATE					*Unit Quantity Submitted	<input type="text" value="1000.000"/>
*Unit of Measure	UN-Unit						
Prescription Number	<input type="text"/>						



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



Paid claims can be:



All 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

Claim Portal Errors



MITTS 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.			

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

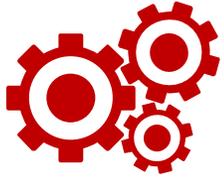
An additional 180 days from the resubmit date is given for attempts to correctly submit a denied claim prior to the end of the 365 days

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.

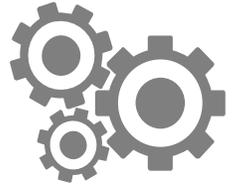
Previously Denied ICN or TCN

Reason

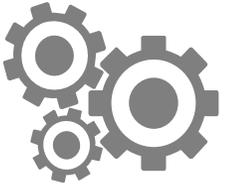
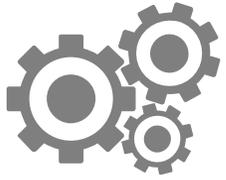




Special Billing Instructions – Eligibility Delay



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



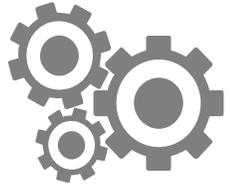
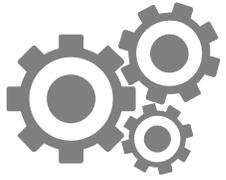
Special Billing Instructions – Eligibility Delay

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

Medicaid CoPay Amount

\$0.00

Note Reference Code



Special Billing Instructions – Eligibility Delay

- Hearing Decision: APPEALS ■ ##### ■ CCYYMMDD
is the hearing number and ■ CCYYMMDD is the date on the hearing decision
- Eligibility Determination: DECISION ■ CCYYMMDD
CCYYMMDD is the date on the eligibility determination notice from the CDJFS

Must use
the
spacing
shown

Notes

DECISION ■ 20171225



Medicare Denials



- If Medicare issues a denial and indicates that the patient is responsible for the payment, submit the claim to ODM by following these steps:
 - Enter a claim in MITS
 - Do not enter any Medicare information on the claim
 - Complete and upload a ODM 06653 and a copy of the Medicare EOB



Uploading an Attachment



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

Attachments	
Type of Document	Transmission Type
A	
Type data below for new record.	
<input type="button" value="delete"/>	<input type="button" value="add"/>
<p>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.</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, doc, xls, pdf, txt, and mdi can be uploaded.</p>	
*Type of Document	<input type="text"/>
*Transmission Type	<input type="text"/>



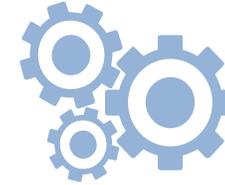
Uploading an Attachment



- 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



Adjusting a Paid Claim



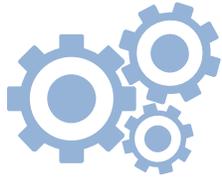
cancel

adjust

void

copy claim

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



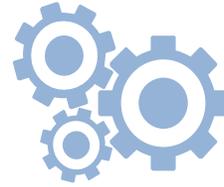
Adjusting a Paid Claim



- Once you click the “adjust” button a new claim is created and assigned a new ICN
- Refer to the information in the “Claim Status Information” and “EOB Information” area at the bottom of the page to see how your new claim has processed



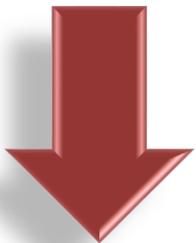
Example



2218180234001
5818185127250

Originally paid \$45.00
Now paid \$50.00

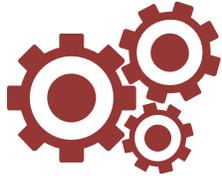
Additional payment of \$5.00



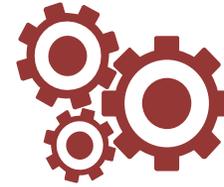
2018172234001
5018173127250

Originally paid \$50.00
Now paid \$45.00

Account receivable (\$5.00)



Voiding a Paid Claim



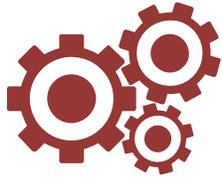
cancel

adjust

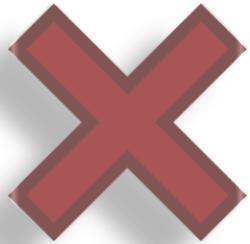
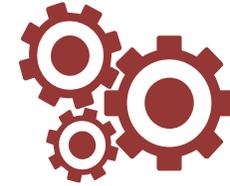
void

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



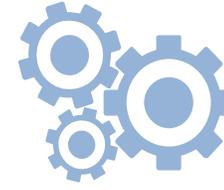
2218180234001
5818185127250

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

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



Copying a Paid Claim



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



cancel

adjust

void

copy claim



ClaimCheck Edits



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

The National Correct Coding Initiative (NCCI)

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



The National Correct Coding Initiative (NCCI)

- Procedure to procedure (PTP) “Incidental” edit which determines whether a pair of procedure codes should not be reported together because one procedure is incidental to (performed as a natural consequence or adjunct to) the other
- Medically unlikely edit (MUE) determines whether the units of service exceed maximum units that a provider would be likely to report under most circumstances



Third Party Liability (TPL) Claims



Other payer information can be reported at the claim level (header) or at the line level (detail), depending on the other payer's claim adjudication

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

MITS will automatically calculate the allowed amount



Third Party Liability (TPL) Claims



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

Header - Other Payer										
Last Name	First Name	MI	Date of Birth	Relationship	Gender	Policy ID	Paid Amount	Paid Date	Electronic Payer ID	
A	SMITH	JOHN	A	01/01/1950	FATHER	MALE	987654	\$200.00	01/05/2018	01234

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

*Claim Filing Indicator	COMMERCIAL INSURANCE	<input type="button" value="v"/>	*Insurance Carrier Name	BLUE CROSS BLUE SHIELD
*Policy Holder Relationship to Insured	FATHER	<input type="button" value="v"/>	*Electronic Payer ID	01234
*Policy Holder Last Name	SMITH		Insured's Policy ID	987654
*Policy Holder First Name, MI	JOHN	A	*Payer Sequence	PRIMARY <input type="button" value="v"/>
Policy Holder Date of Birth	01/01/1950		Medicare ICN	
Gender	MALE	<input type="button" value="v"/>		
*Paid Amount	\$200.00			
*Paid Date	01/05/2018			
Allowed Amount	\$0.00			

Header - Other Payer Amounts and Adjustment Reason Codes



Third Party Liability (TPL) Claims



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

Header - Other Payer										
Last Name	First Name	MI	Date of Birth	Relationship	Gender	Policy ID	Paid Amount	Paid Date	Electronic Payer ID	
A	SMITH	JOHN	A	01/01/1950	SELF	MALE	987654	\$200.00	01/05/2018	43210

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

*Claim Filing Indicator	HMO, MEDICARE RISK	<input type="button" value="v"/>
*Policy Holder Relationship to Insured	SELF	<input type="button" value="v"/>
*Policy Holder Last Name	SMITH	
*Policy Holder First Name, MI	JOHN	A
Policy Holder Date of Birth	01/01/1950	
Gender	MALE	<input type="button" value="v"/>
*Paid Amount	\$200.00	
*Paid Date	01/05/2018	
Allowed Amount	\$0.00	

*Insurance Carrier Name	HUMANA MEDICARE
*Electronic Payer ID	43210
Insured's Policy ID	456789
*Payer Sequence	PRIMARY <input type="button" value="v"/>
Medicare ICN	

Header - Other Payer Amounts and Adjustment Reason Codes

Header vs Detail

Header level

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

Detail level

- A COB claim is considered to be adjudicated at the line/detail level if figures are reported for individual line items



Third Party Liability (TPL) Claims



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

Header - Other Payer Amounts and Adjustment Reason Codes

Electronic Payer ID	CAS Group Code	ARC	Amount
A 01234	PR-Patient Responsibility	1	\$50.00
A 01234	CO-Contractual Obligations	45	\$150.00

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

delete

add an item

Payer Header Level Adjustment Reason Codes (ARC) and Amounts

*Electronic Payer ID 01234

*CAS Group Code PR-Patient Responsibility

*ARC 1

*Amount \$50.00



Third Party Liability (TPL) Claims



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

Detail - Other Payer Amounts and Adjustment Reason Codes

Detail - Other Payer Amounts and Adjustment Reason Codes

Detail Item/Electronic Payer ID	CAS Group Code	ARC	Amount
A 1/43210	PR-Patient Responsibility	1	\$50.00
A 1/43210	CO-Contractual Obligations	45	\$150.00

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

delete

add an item

*Detail Item/Electronic Payer ID 1/43210

*CAS Group Code CO-Contractual Obligations

*ARC 45

*Amount

Payer Line Level Adjustment Reason Codes(ARC) and Amounts

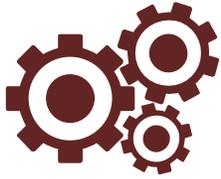
ARC Codes

The X12 website provides adjustment reason codes (ARCs)

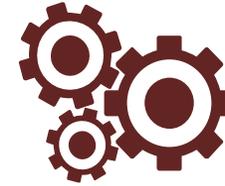
**COMMON
ARCs:**



- 1 • Deductible
- 2 • Coinsurance
- 3 • Co-payment
- 45 • Contractual Obligation/Write off
- 96 • Non-covered services



Remittance Advice (RA)



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

Welcome,

[Super User](#) [Providers](#) [Cost Report](#) [Account](#) [Claims](#) [Eligibility](#) [Prior Authorization](#) **Reports** [Portal Admin](#) [Publications](#)

Provider Reports



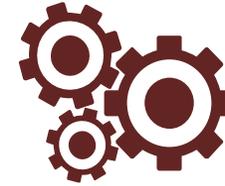
*Report

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





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:

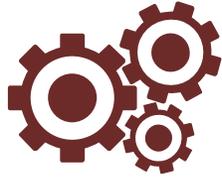
RA Number:

Check/EFT Number:

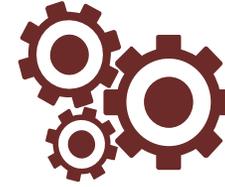
Please select the row to show the report

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

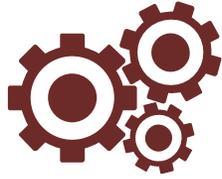
Expenditures - Non-claim payments

Accounts receivable - Balance of claim and non-claim amounts due to Medicaid

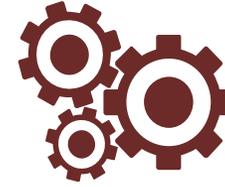


Summary

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

Prior Authorization (PA)

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



Prior Authorization (PA)

- Within the Prior Authorization subsystem providers can:
 - Submit a new Prior Authorization
 - Search for previously submitted Prior Authorizations
- Within the Prior Authorization panel providers can:
 - Attach documentation
 - Add comments to a Prior Authorization that is in a pending status
 - View reviewer comments
 - View Prior Authorization usage, including units and dollars used



Prior Authorization (PA)

- A PA will auto deny if supporting documentation is not received within 30 days (including EDMS coversheet and paper attachments)
- When reviewers request additional documentation to support the requested PA, the 30 day clock is reset



Prior Authorization (PA)

- External Notes Panel
 - Used by the PA reviewer to communicate to the provider
 - Multiple notes may reside on this panel
 - Panel is read-only for providers
- If a PA is marked approved with an authorized dollar amount of \$0.00, it will still pay at the Medicaid maximum allowable reimbursement rate



Websites and Forms

 **Websites** 

- Ohio Department of Medicaid home page

<http://Medicaid.ohio.gov>

- Ohio Department of Medicaid provider page

WWW.Medicaid.Ohio.Gov/Providers.aspx

- MALs & MTLs

<http://medicaid.ohio.gov/RESOURCES/Publications/ODMGuidance.aspx#161542-medicaid-policy>

- LAWriter

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

Websites

➤ Provider Enrollment

<http://www.medicaid.ohio.gov/PROVIDERS/EnrollmentandSupport/ProviderEnrollment.aspx>

➤ MITS home page

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

➤ Electronic Funds Transfer

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

➤ Information for Trading Partners (EDI)

<http://medicaid.ohio.gov/PROVIDERS/Billing/HIPAAandEDIInformation.aspx>

🖥️ Websites 🖥️

➤ Companion Guides (EDI)

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

➤ National Drug Code (NDC) Search

<http://www.accessdata.fda.gov/scripts/cder/ndc/default.cfm>

➤ Healthchek

<http://medicaid.ohio.gov/FOROHIOANS/Programs/Lead.aspx>

➤ X12 Website (ARC Codes)

<http://www.x12.org/codes/claim-adjustment-reason-codes/>

Websites

➤ ORP

<http://www.medicaid.ohio.gov/PROVIDERS/EnrollmentandSupport/ProviderEnrollment/ORP.aspx>

➤ PRAF 2.0 Information on the ODM site

<http://medicaid.ohio.gov/PROVIDERS/PRAF.aspx>

➤ PRAF 2.0 login

<http://www.nurtureohio.com/login>

➤ Hospital Billing Guide

<http://medicaid.ohio.gov/Portals/0/Resources/Publications/Guidance/BillingInstructions/HospitalBillingGuidelines-20170801.pdf>

 **FORMS** 

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

<http://medicaid.ohio.gov/RESOURCES/Publications/MedicaidForms.aspx>

- HHS-687 – Consent for Sterilization



ANY
QUESTIONS
?