



Department of  
Medicaid

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

# Basic Billing for Durable Medical Equipment Providers

External Business Relations

2018

## AGENDA

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

## External Business Relations Team

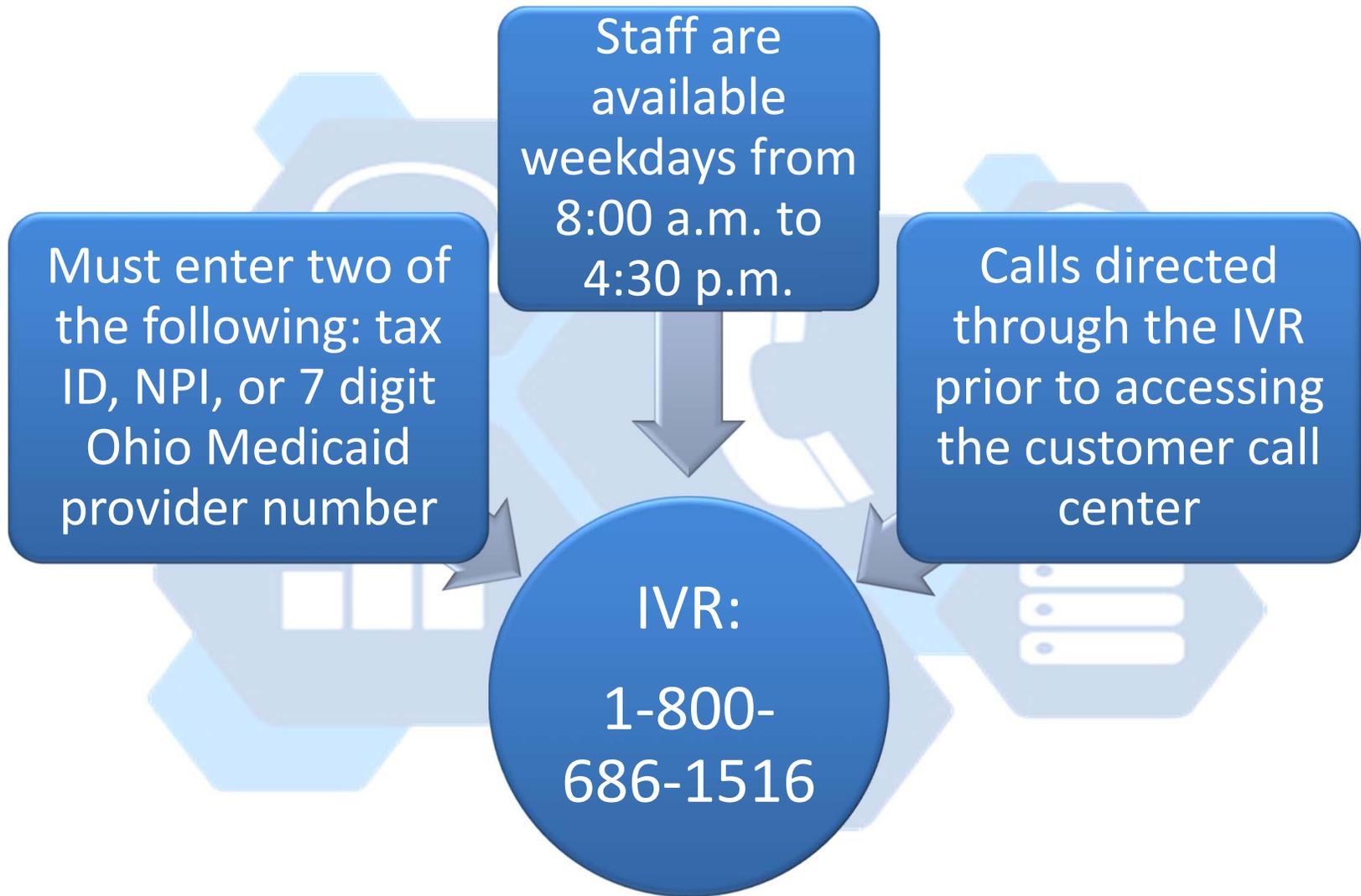
Sarah Bivens

Ava Cottrell

Ed Ortopan



Manager - Meagan Grove



## ☐ Helpful phone numbers

### ➤ Adjustments

614-466-5080

### ➤ OSHIP (Ohio Senior Health Insurance Information Program)

1-800-686-1578

### ➤ Coordination of Benefits Section

614-752-5768

614-728-0757 (fax)



# Medicaid Medical Necessity: OAC 5160-1-01

Is the fundamental concept underlying the Medicaid  
Program



All Services must meet accepted standards of  
medical practice



## Ohio Medicaid covers:

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

## Covered Services (not limited to )

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



# PROGRAMS & CARDS

## ❑ Ohio Medicaid

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

<p><b>Notice to Consumer:</b> 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><b>Notice to Providers of Medical Services:</b> 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><b>Note:</b> Use the Medicaid ID for all claim submissions.</p> <p><u>medicaid.ohio.gov</u></p> <p>Consumer's Signature: _____</p>	<p style="writing-mode: vertical-rl; transform: rotate(180deg);">Fold</p>	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;">County</td> <td style="width: 30%; text-align: right;"><b>Ohio Medicaid</b></td> </tr> <tr> <td>ALLEN</td> <td></td> </tr> <tr> <td>Case Number</td> <td></td> </tr> <tr> <td>5082482</td> <td></td> </tr> <tr> <td>Eligibility Begin Date</td> <td></td> </tr> <tr> <td>01/01/2018</td> <td></td> </tr> <tr> <td>Void After Date</td> <td></td> </tr> <tr> <td>01/31/2018</td> <td></td> </tr> <tr> <td colspan="2" style="text-align: center;"><b>Ohio Department of Medicaid</b></td> </tr> <tr> <td colspan="2" style="text-align: center;">medicaid.ohio.gov</td> </tr> <tr> <td colspan="2" style="text-align: center;"><b>Consumer Hotline:</b> 1-800-324-8680</td> </tr> <tr> <td colspan="2" style="text-align: center;">[or TTY 1-800-292-3572]</td> </tr> </table>	County	<b>Ohio Medicaid</b>	ALLEN		Case Number		5082482		Eligibility Begin Date		01/01/2018		Void After Date		01/31/2018		<b>Ohio Department of Medicaid</b>		medicaid.ohio.gov		<b>Consumer Hotline:</b> 1-800-324-8680		[or TTY 1-800-292-3572]	
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## Supplemental Security Income (SSI)

- Automatically Eligible for Medicaid as long as eligible for SSI

## Modified Adjusted Gross Income (MAGI)

- Children, parents, caretakers, and expansion

## Aged, Blind, Disabled (ABD)

- 65+, or blind/disabled with no SSI

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

- Individuals must cooperate with requests from third-party insurance companies needing to authorize coverage
- Individuals must cooperate with request from a Medicaid provider for information which is needed in order to bill third party insurances
- Providers may contact the local CDJFS office to report non-cooperative individuals
- CDJFS may terminate eligibility



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

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



Additional spans when applicable:

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





# Eligibility Verification Request

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

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
			<input type="button" value="search"/>
			<input type="button" value="clear"/>

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



# Eligibility Verification Request

## Recipient Information

Medicaid Billing Number	SSN
Last Name	County of Residence CUYAHOGA
First Name	County of Eligibility
Gender	County Office <a href="http://jfs.ohio.gov/County/County_Directory.pdf">http://jfs.ohio.gov/County/County_Directory.pdf</a>
Date of Birth	Number Bed Hold Days Used Paid CY
Date of Death	

Associated Child(ren) Search

## Benefit / Assignment Plan

Benefit / Assignment Plan	Effective Date	End Date	Provider Name	Dental Co-Pay Amount	Vision Co-Pay Amount
Medicaid Schools	01/01/2018	01/31/2018		\$0.00	\$0.00
★ MRDD Targeted Case Mgmt	01/01/2018	01/31/2018		\$0.00	\$0.00
★ Alcohol and Drug Addiction Services	01/01/2018	01/31/2018		\$0.00	\$0.00
★ Ohio Mental health	01/01/2018	01/31/2018		\$0.00	\$0.00
★ Medicaid	01/01/2018	01/31/2018		\$0.00	\$0.00

## Case/Cat/Seq Spenddown

\*\*\* No rows found \*\*\*



# Eligibility Verification Request

## Recipient Information

Medicaid Billing Number	SSN
Last Name	County of Residence CUYAHOGA
First Name	County of Eligibility
Gender	County Office <a href="http://jfs.ohio.gov/County/County_Directory.pdf">http://jfs.ohio.gov/County/County_Directory.pdf</a>
Date of Birth	Number Bed Hold Days Used Paid CY
Date of Death	

## Benefit / Assignment Plan

Benefit / Assignment Plan	Effective Date	End Date	Provider Name	Dental Co-Pay Amount	Vision Co-Pay Amount
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★ 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		W1166 35166		IND	INPATIENT COVERAGE	01/30/2018	01/31/2018	724775	
AETNA US HEALTH	00250		W1166 35166		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 was expanded to provide coverage for parent and caretaker relatives and extension adults

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



# Presumptive Eligibility



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

| Benefits

---

**Presumptive Eligibility**

NAME  
ADDRESS  
CITY/STATE/ZIP CODE

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

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

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

**APPROVED:**

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



# Presumptive Eligibility



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

## CDJFS Presumptive Eligibility

John Doe  
123 Main St.  
Anytown, OH 43210

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

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

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

**APPROVED:**

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

# Presumptive Eligibility

Recipient Information		? ^
<b>Medicaid Billing Number</b>		<b>SSN</b>
<b>Last Name</b>		<b>County of Residence</b>
<b>First Name</b>		<b>County of Eligibility</b>
<b>Gender</b>		<b>County Office <a href="http://jfs.ohio.gov/County/County_Directory.pdf">http://jfs.ohio.gov/County/County_Directory.pdf</a></b>
<b>Date of Birth</b>		<b>Number Bed Hold Days Used Paid CY 20170101: 10</b>
<b>Date of Death</b>		



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 have  
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**

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

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



**Specified Low-  
Income  
Medicare  
Beneficiary  
(SLMB) &  
Qualifying  
Individual (QI-1)**

**There is NO  
cost-sharing  
eligibility**

**We ONLY  
pay their  
Part B  
premium to  
Medicare**

**This is NOT  
Medicaid  
eligibility**

# MANAGED CARE/MYCARE OHIO

## Managed Care Day One - Effective January 1, 2018

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

## Managed Care Day One

	'The old way'	Day One
Individual 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	6/1/2017 → 12/31/2299	5/1/2017 → 12/31/2299

Application received  
2/3/18



Medicaid approved  
2/12/18



## OLD WAY

FFS 2/1/18 - 2/28/18  
MCP begins 3/1/18 - ongoing

Application received  
2/3/18



Medicaid approved  
2/12/18



**NEW WAY**

MCP begins 2/1/18

## Day One MCP Assignments



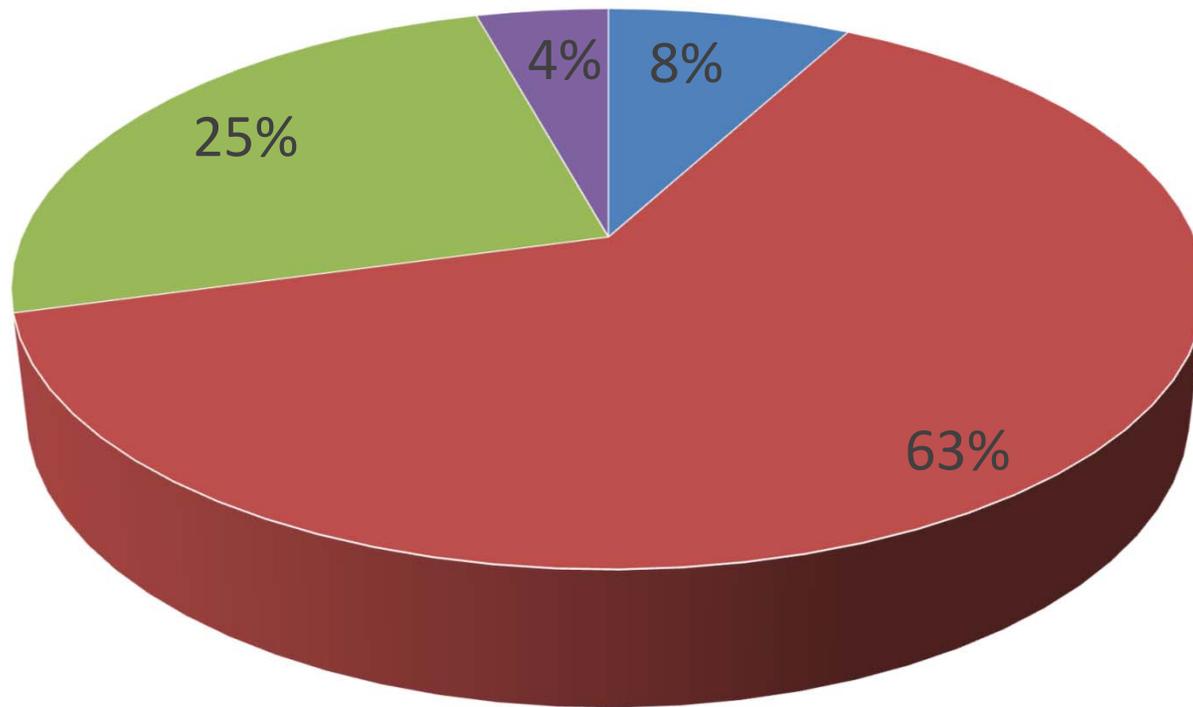
MITS looks for previous MCP in last 90 days

Then MITS looks for anyone on a case with family members assigned to a MCP

Then individual is assigned by an assignment algorithm

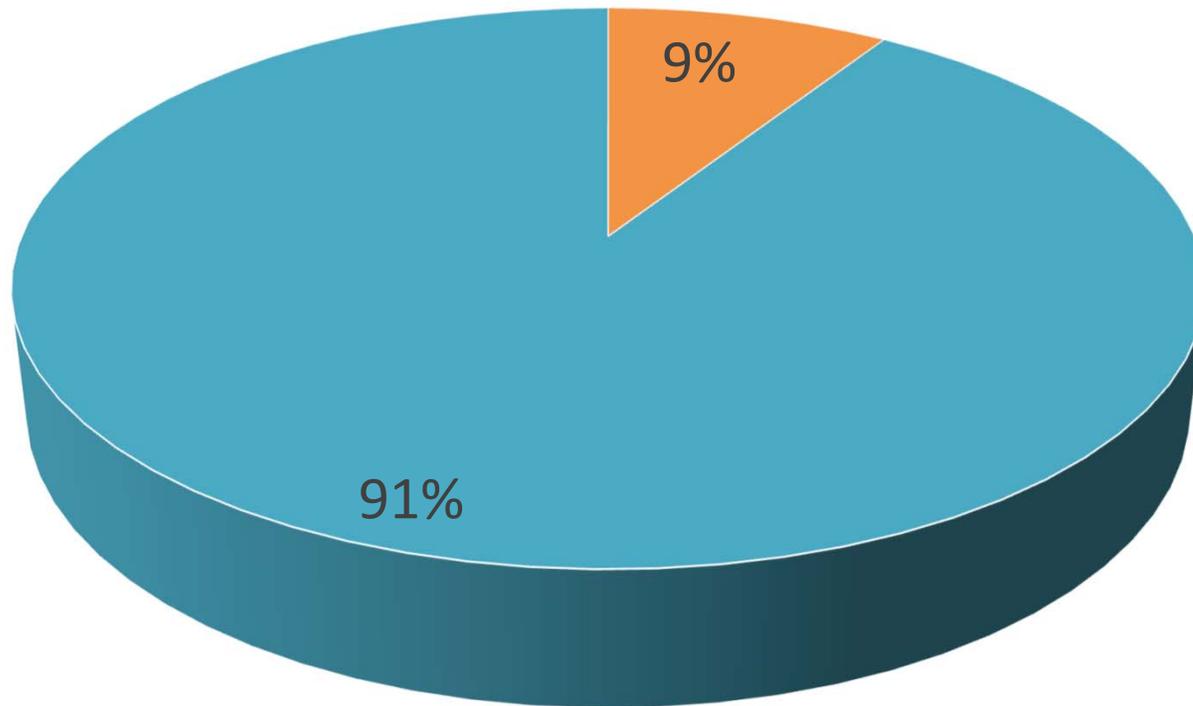
The assigned plan can be changed as desired during first 3 months

# Managed Care Enrollment Groups - 2018



■ ABD ■ CFC ■ Group 8 ■ MyCare

# FFS vs. Managed Care Enrollment - 2018



■ FFS ■ Managed Care

## 3 Population Groups Eligible for Managed Care

Supplemental Security Income (SSI)

Modified Adjusted Gross Income (MAGI)

Aged, Blind, Disabled (ABD)

- Adoption children, Breast and Cervical Cancer Patients (BCCP), Foster children, and Bureau of Children with Medical Handicaps (BCMh)

Individuals with  
optional enrollment  
in Traditional  
Managed Care  
Plans

Native Americans  
that are members  
of a federally  
recognized tribe

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





## Managed Care Benefit Package



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

Some value-added services:



On-line searchable provider directory



Toll-free 24/7 hotline for medical advice



Expanded benefits including additional transportation options plus other incentives



Care management to help members coordinate care

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

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

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



# MITs Managed Care Eligibility

## Benefit / Assignment Plan

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

## Case/Cat/Seq Spenddown

\*\*\* No rows found \*\*\*

## TPL

\*\*\* No rows found \*\*\*

## Managed Care

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



## Managed Care Sample Card



**PARAMOUNT**  
ADVANTAGE

[www.paramountadvantage.org](http://www.paramountadvantage.org)

HEALTH PLAN (80840)  
7952304120

ID NUMBER  
A9999999901

MEMBER NAME  
Jane Doe

PRIMARY CARE PROVIDER  
John Smith  
(419) 5551212

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

GROUP NUMBER  
ADV0010011

EFF. DATE  
01/01/2015

MMIS NUMBER  
000000000000

CVS/CAREMARK  
RXGRP RX6407  
RXBIN 004336  
RXPCN ADV



## Managed Care Ohio Contracting



Providers who are interested in delivering services to a Managed Care individuals must have a contract or agreement with the plan

Things to know:



Each plan has a list of services that require prior authorization



Each plan will have their own billing requirements



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

aetna®

AETNA BETTER HEALTH® OF OHIO

buckeye  
health plan.CareSource®PARAMOUNT  
HEALTH  
CAREMOLINA®  
HEALTHCAREUnitedHealthcare®

## Oversight of Managed Care Plans

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



## Traditional Managed Care Plans



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



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



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



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



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

A magnifying glass with a blue handle and a red and black frame. Inside the lens is a black rectangular sign with the word "EXTENDED" in white, bold, capital letters.

**EXTENDED**

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

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

## MyCare Ohio Eligibility

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

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

Over the age of 18

Residing in one of the demonstration project regions

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

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

Individuals enrolled in the PACE program

Individuals who have third-party insurance, including retirement benefits

## HOW DO YOU KNOW IF SOMEONE IS ENROLLED IN MYCARE?

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

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

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

# MyCare Ohio Opt-In Sample Card

**MyCareOhio**  
Connecting Medicare + Medicaid



**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)

**Behavioral Health  
Crisis:** 1-866-206-7361

**Care Management:** 1-855-475-3163

**24-Hour Nurse  
Advice:** 1-866-206-7361  
(TTY: 1-800-750-0750 or 711)

**Website:** CareSource.com/MyCare

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

**Eligibility Verification:** 1-800-488-0134

**Pharmacy Help Desk:** 1-800-488-0134

**Claims Inquiry:** 1-800-488-0134

**Provider Questions:** 1-800-488-0134

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

# MITS Eligibility MyCare Opt-In

Benefit / Assignment Plan					
Benefit / Assignment Plan	Effective Date	End Date	Provider Name	Dental Co-Pay Amount	Vision Co-Pay Amount
MRDD Targeted Case Mgmt	12/01/2017	01/31/2018		\$0.00	\$0.00
Alcohol and Drug Addiction Services	12/01/2017	01/31/2018		\$0.00	\$0.00
Ohio Mental health	12/01/2017	01/31/2018		\$0.00	\$0.00
Medicaid	12/01/2017	01/31/2018		\$0.00	\$0.00

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

TPL					
*** No rows found ***					

Managed Care					
Plan Name	Plan Description	Effective Date	End Date	Managed Care Benefits	
CARESOURCE	HMO, MyCare Ohio	12/01/2017	01/31/2018	Dual Benefits	

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

Medicare					
Coverage	Effective Date	End Date	Plan Name	Plan ID	Medicare ID
PART A	12/01/2017	01/31/2018			018562948A
PART B	12/01/2017	01/31/2018			018562948A
PART C	12/01/2017	01/31/2018	CARESOURCE MYCARE OHIO	H8452	018562948A
PART D	01/01/2018	01/31/2018	*H8452/001	001	018562948A
PART D	12/01/2017	12/31/2017	*H8452/001	001	018562948A

# MyCare Ohio Opt-Out Sample Card

**MyCareOhio**  
Connecting Medicare + Medicaid

  
**CareSource**

**Member Name:** <Cardholder Name>

**Member ID #:** <Cardholder ID#>

**MMIS Number:** <Medicaid Recipient ID#>

**PCP Name:** <PCP Name>

**PCP Phone:** <PCP Phone>

**RxBin:** 004336

**RxPCN:** ADV

**RxGRP:** RX3292

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

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

**Behavioral Health Crisis:** 1-866-206-7861 (TTY: 1-800-750-0750 or 711)

**Care Management:** 1-855-475-3163 (TTY: 1-800-750-0750 or 711)

**24-Hour Nurse Advice:** 1-866-206-7861 (TTY: 1-800-750-0750 or 711)

**Provider/Pharmacy Questions:** 1-800-488-0134

**Website:** [CareSource.com/MyCare](https://www.caresource.com/MyCare)

**Mail medical claims to:**

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

**Mail pharmacy claims to:**

CVS Caremark  
P.O. Box 52066  
Phoenix, AZ 85072-2066



# MITS Eligibility MyCare Opt-Out

## Benefit / Assignment Plan

Benefit / Assignment Plan	Effective Date	End Date	Provider Name	Dental Co-Pay Amount	Vision Co-Pay Amount
MRDD Targeted Case Mgmt	10/01/2017	01/31/2018		\$0.00	\$0.00
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
BUCKEYE COMMUNITY HEALTH PLAN	HMO, MyCare Ohio	10/01/2017	01/31/2018	Medicaid Only



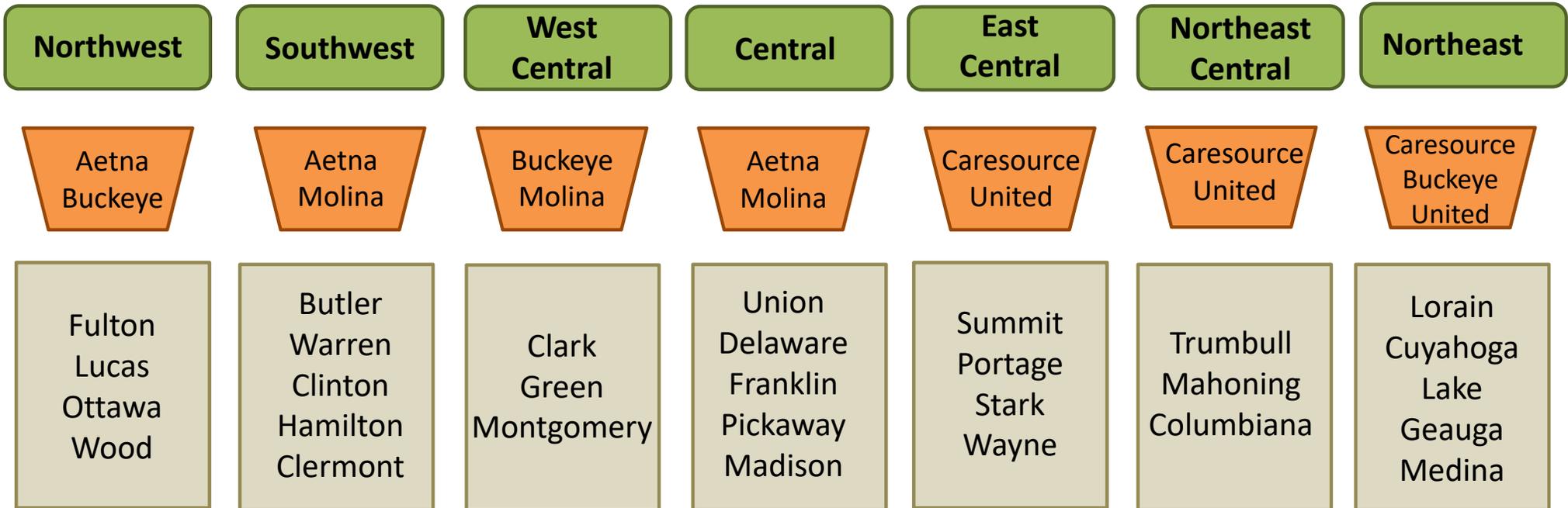
## Lock-In

\*\*\* No rows found \*\*\*

## Medicare

Coverage	Effective Date	End Date	Plan Name	Plan ID	Medicare ID
PART A	10/01/2017	01/31/2018			300685983A
PART B	10/01/2017	01/31/2018			300685983A
PART C	11/01/2017	01/31/2018	ANTHEM SENIOR ADVANTAGE PLUS	H3655	300685983A

# MyCare Ohio Region Breakdown





## MyCare Ohio Managed Care Contracting



Providers who are interested in delivering services to MyCare Ohio individuals must have a contract or agreement with the plan

Things to know:



Each plan has a list of services that require prior authorization



Each plan will have their own billing requirements



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

## MyCare Ohio Managed Care Plans



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



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



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

Certification issues

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

Provider credentialing concerns

Please send to Ohio Department of Insurance (ODI)

## OH Medicaid *Managed Care* Provider Complaint Form

### Instructions

This form is for Managed Care providers only. Providers must appeal denied claims to the MCP before the Ohio Department of Medicaid will process a complaint. If your complaint involves multiple Managed Care Plans (MCPs), please complete one form per MCP. The resolution timeframes for Managed Care complaints are 2 business days for complaints involving access to care, and 15 business days for all other issues. If you have a complaint regarding Medicaid Fee For Service please call 1-800-686-1516.

### Complaint Details

MCP Name:

\*

Complaint Reason:

\*

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

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

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

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

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

\* Is the patient receiving or seeking mental health or substance abuse services?  Yes  No

# 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

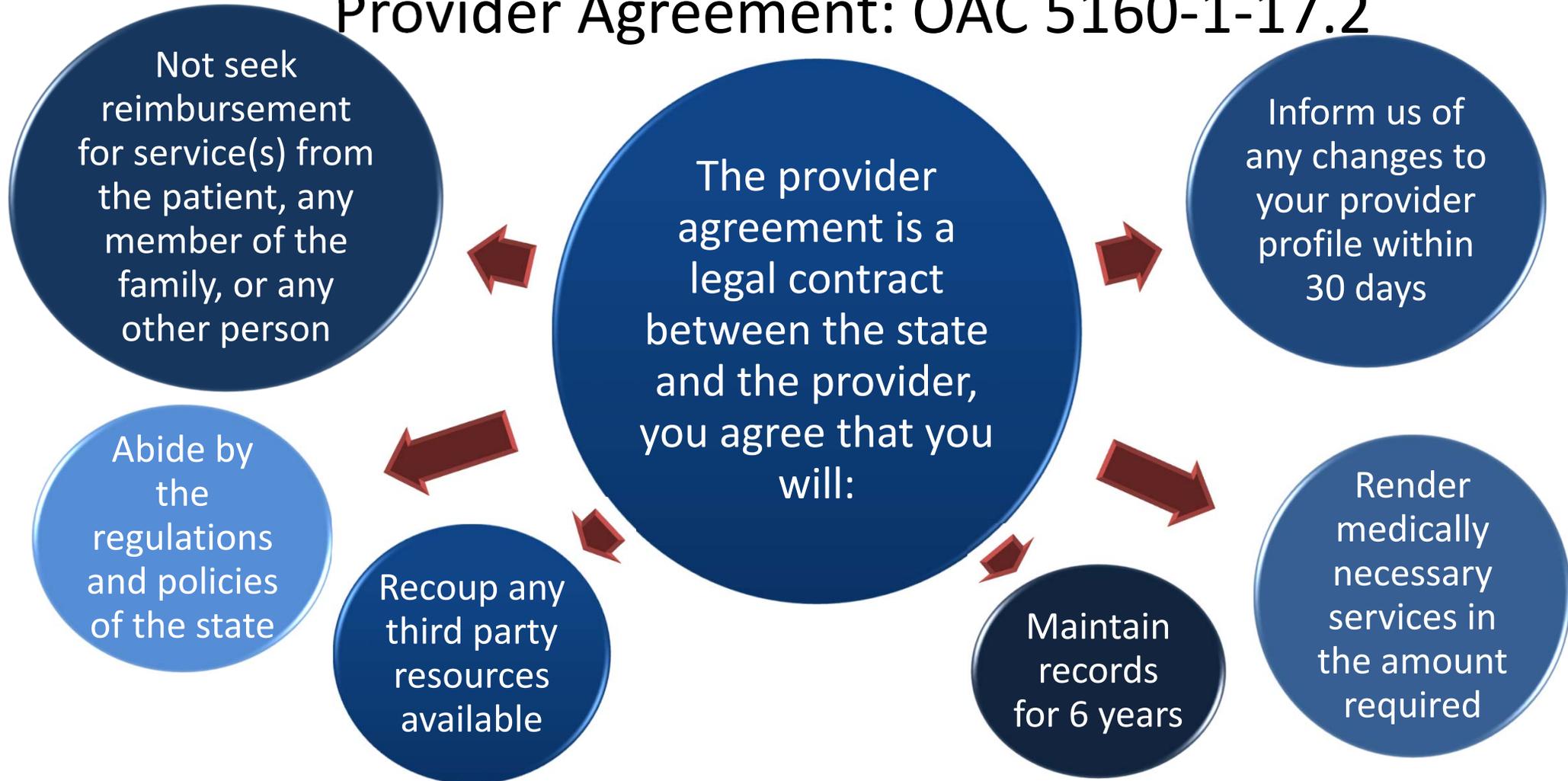


The 2018 fee is \$569.00 per application



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

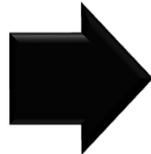
## Provider Agreement: OAC 5160-1-17.2



**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**

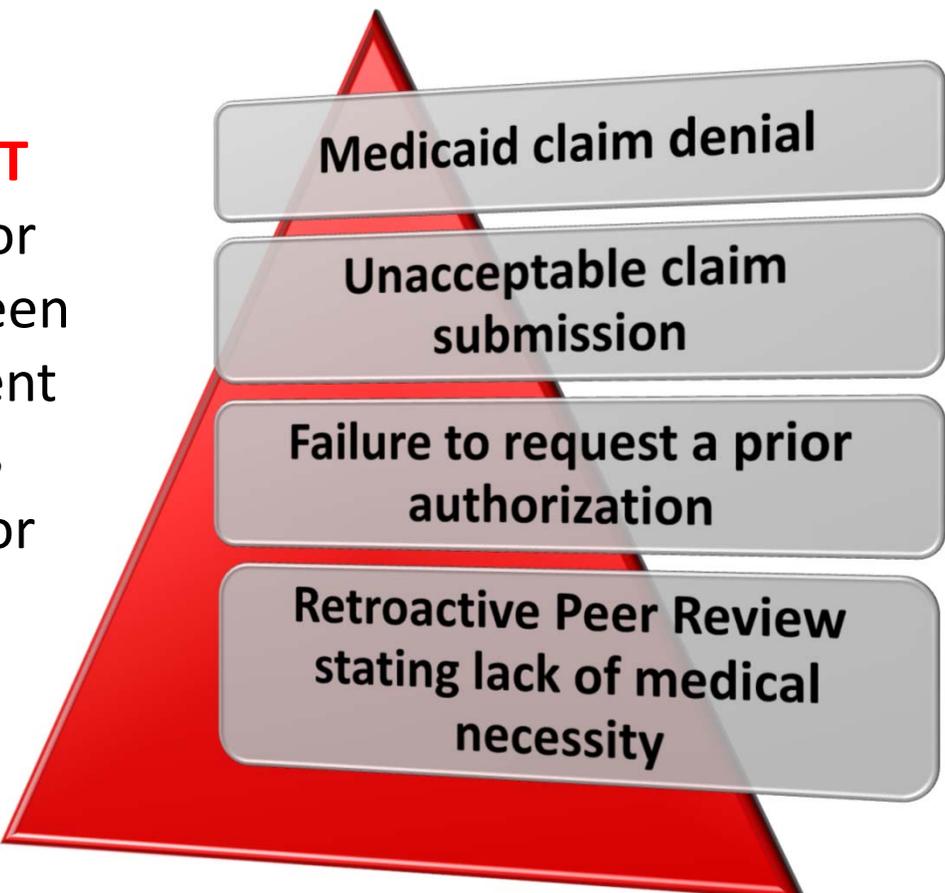
## Coordination of Benefits: OAC 5160-1-08

- 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:



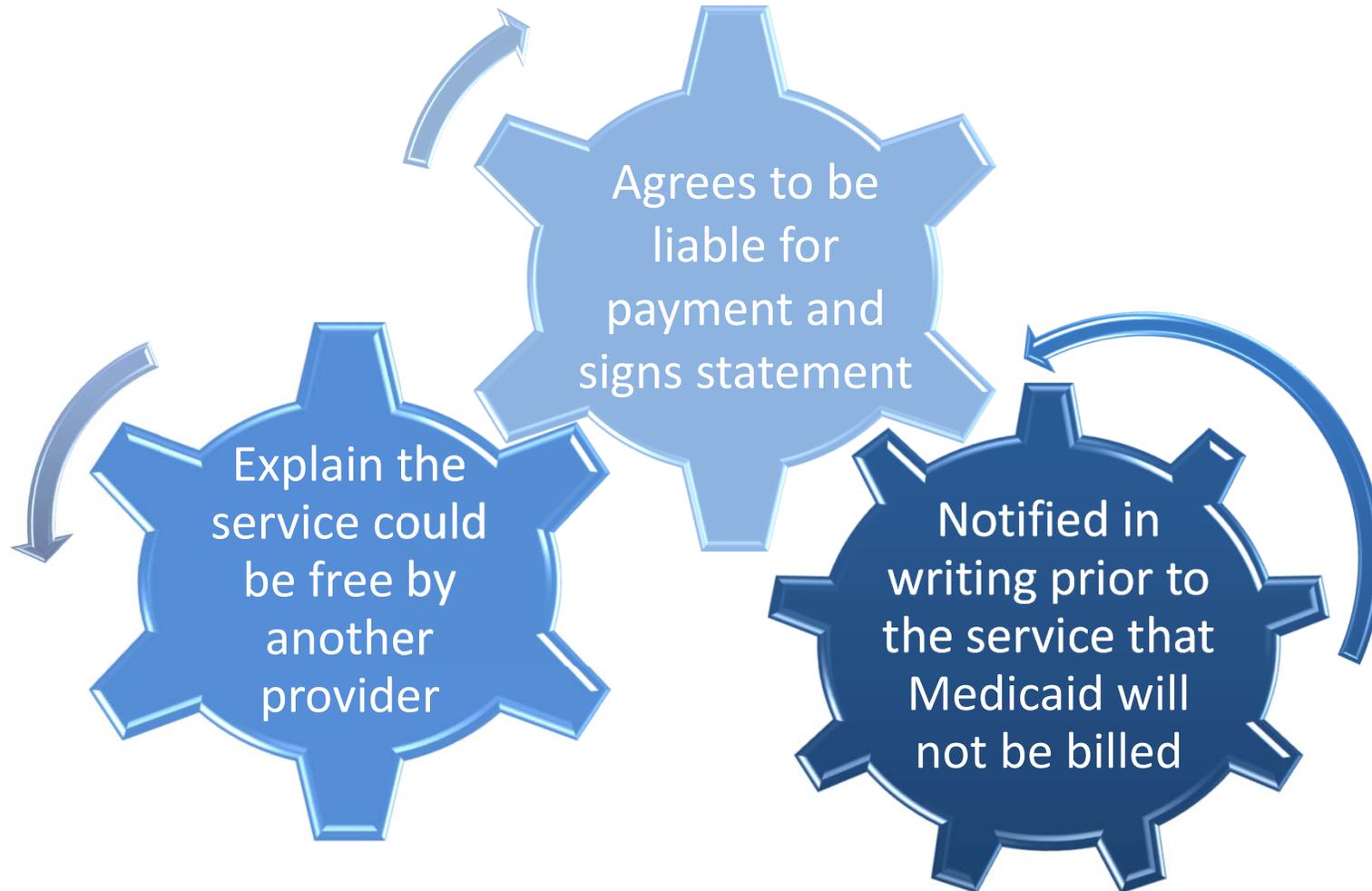
Medicaid claim denial

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.

# The Ohio Department of Medicaid Website

The screenshot shows the Ohio Department of Medicaid website homepage. At the top left is the Ohio Department of Medicaid logo. To the right are utility links for text size adjustment and language selection. A dark blue navigation bar contains 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 is a "Director's Welcome" section with a video thumbnail of Director Barbara Sears. Below this is a "Tweets" section showing a tweet from John Kasich about disposing of unused prescriptions. At the bottom are three blue buttons: "Managed Care Plans 2016 Report Card", "Information for Independent Providers", and "Payment Innovation Ohio's SIM Grant".

**Ohio** | Department of Medicaid

Text Size: +A -A | Select Language | Powered by Google Translate | Translation Disclaimer

HOME MEDICAID 101 FOR OHIOANS PROVIDERS INITIATIVES NEWS RESOURCES CAREERS CONTACT

**Ohio** Department of Medicaid

Learn more about the state's first executive-level Medicaid agency.

Director's Welcome

Director Barbara Sears  
Ohio Department of Medicaid

Tweets by @OH\_Medicaid

Ohio Medicaid Retweeted  
John Kasich @JohnKasich  
Dispose of unused prescriptions TODAY. Find a nearby collection site: [drugs.com/article/medica...](https://drugs.com/article/medica...)  
Getting rid of old Rx drugs can save

Embed | View on Twitter

Testimony & Presentations

Managed Care Plans  
2016 Report Card

Information for Independent Providers

Payment Innovation  
Ohio's SIM Grant

# Provider News



## 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

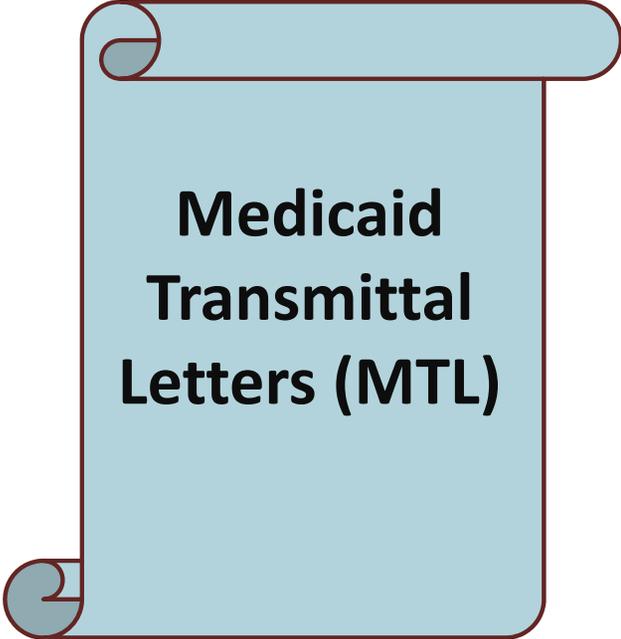
- [Benefit Coordination & Recovery](#)
- [Fee Schedules/Rates](#)
- [Medicaid Forms](#)
- [ODJFS Forms](#)
- [MITS EDMS Cover Page](#)
  - [Instructions](#)
- [Healthchek Screening Forms](#)
- [e-Manuals](#)
- [Helpful Links](#)
- [Get a National Provider Identifier \(NPI\)](#)
- [Transmittal Letter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



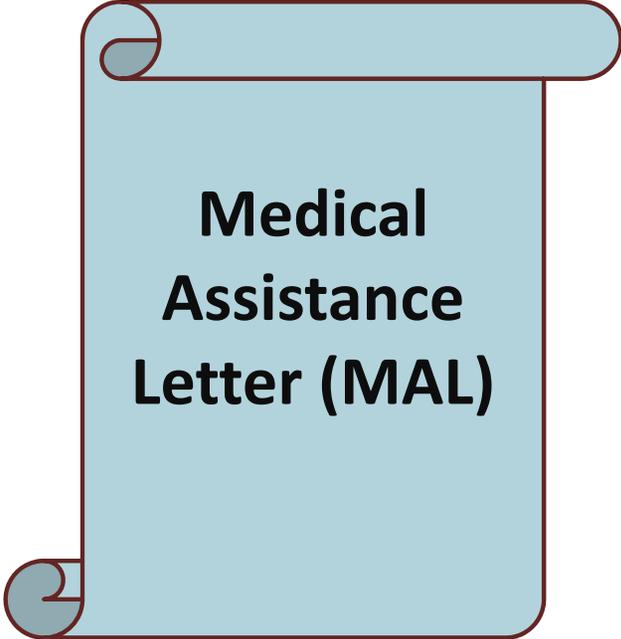
Access the  
**MITS Portal**

**POLICY**

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

A light blue scroll with a dark red outline and rounded corners. The top and bottom edges are rolled up, with the top roll on the left and the bottom roll on the right. The text is centered on the scroll.

**Medicaid  
Transmittal  
Letters (MTL)**

A light blue scroll with a dark red outline and rounded corners. The top and bottom edges are rolled up, with the top roll on the left and the bottom roll on the right. The text is centered on the scroll.

**Medical  
Assistance  
Letter (MAL)**

# Billing Resources

- 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. Our provider network is critical in ensuring reliable and timely care for Ohioans. We will become a go-to resource for learning more about training, billing, rate-setting and other issues that affect the provider community.

### Provider News

- Please listen carefully when calling the IVR as the Ohio Medicaid and its provider network have changed as of 4/17/2016**
- [Notice Regarding Pregnancy Risk Assessment and Notification System \(1/18/2017\)](#)
- [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 \(Rev. 4/1/16\)](#)

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

- 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

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

## Five-year Rule Review Updates



### Combining Appendixes

Rules 5160-10-03 and 5160-10-20 are being rescinded – content being added to 5160-10-01

Will be posted under “Fee Schedules and Rates”



### Certificates of Medical Necessity (CMNs)

All corresponding CMNs to the new rules have been revised/updated

They will be made available prior to the effective date of the new rules

There will be **NO** grace period from old CMNs to the new CMNs

All new CMNs will be expected to be utilized 07/16/18 forward

## Five-year Rule Review Rule Changes

- ✓ **Rule 5160-10-22(B)(2)** has added, "Payment may be made for a ventilator on a rental basis only."
- ✓ **Rule 5160-10-21(B)(1)(c)** has been corrected and changed, "The verification date, which must ~~be~~ not ~~later than nor~~ be more than fourteen days before the dispensing date;"
- ✓ **Rule 5160-10-22(B)(3)** has removed language, "For the rental ~~or purchase~~ of a primary ventilator, the CMN must include the following information:"
- ✓ **Rule 5160-10-22(B)(4)** has removed language, "For the rental ~~or purchase~~ of a secondary or back-up ventilator,"
- ✓ **Rule 5160-10-23(3)** has added language, "The rental or purchase of a pulse oximeter includes the following items and services:"
- ✓ **Rule 5160-10-23(4)** has removed language, "~~During the rental period, separate~~ Separate payment may be made for probes."

## DMEPOS Rule Revisions

Durable medical equipment,  
prostheses, orthoses, and  
supplies (DMEPOS)

Almost all existing rules in  
Chapter 5060-10 concerning  
DMEPOS will be rescinded and  
replaced with new rules

**Planned effective 7/16/18**

New rules will be consistent with  
Section 5002 of the 21<sup>st</sup> Century  
Cures Act - Medicaid payment  
levels to be under Medicare levels

## Five-year Rule Review HCPCS Changes

- Addition of **U2** and **U3** modifiers for A7520 and A7521 with new payment amounts
- Changed MITS from **once every 5 years to once every 8 years** to match the supply list for E0260, E0261, E0255, E0256, E0292, E0293, E0294, E0295, E0302, E0303, and E0304
- Frequency limit increase for V5266 to **48 per year** per hearing aid

## Five-year Rule Review HCPCS Changes, cont.

- Addition of **L1932**=\$570, **L1951**=\$430, **L1971**=\$360, and **L2768** \$100.06
- Addition of **T4544**, same payment as corresponding diaper
- Addition of **T2101** at \$4.75/oz
- Addition of lipase cartridge (Relizorb), requiring **U1** modifier, for B4034 - B4036 with new payment amounts

## Enteral Nutritional Products

### Planned Effective 7/16/18

OAC 5160-10-26 will be rescinded and replaced with a new rule of the same number

Policy statements will be added that specifically address the coverage of and payment for the provision of donor human milk

CMN form, ODM 01907, will be completely 'reworked' - will no longer be an appendix to the rule



# High-Frequency Chest Wall Oscillation Devices (HFCWO)

- Planned effective 7/16/18
- HFCWO removed from PA
- New rule 5160-10-08-sets forth coverage and payment - provisions for HFCWO devices
- New rule articulates and clarifies past practice
- Delineates a range of respiratory conditions that may be covered
- New CMN

## B9998 and B9999

- ❑ The use of B9998 was an internal “one-time” solution
  - Use has gradually increased to include enteral items commonly, causing providers to believe non-covered items are covered
- ❑ Correct coding requires the use of a specific HCPCS code for an item when a code exists

B9998, B9999 are **not** for enterals/parenterals, they are for NOC supplies only

B9998, B9999 ~~→~~ enteral codes

B9998, B9999 ~~→~~ parenteral codes

B9998 → B4034, B4035, B4036

B9999 → B4220, B4222, B4224



## B9998 and B9999 Now

- ❑ Non-covered enteral items are still not covered
  - MITS has been updated to permit enteral HCPCS codes to be entered for EPSDT review
- ❑ Non-covered enteral items *can* be entered in MITS via B9998-B9999, **BUT...**claims with these codes are not proper and will be denied
  - Those claims will need to be resubmitted with the proper HCPCS codes



## Helpful Tips

New codes, as referenced in 5160-1-60(L) are found at,

<http://www.medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates/ScheduleandRates.aspx#1682569-cpt-and-hcpcs-level-ii-procedure-code-changes>

(Under CPT and HCPCS Level II Procedure Code Changes)

All procedure codes can be found under the provider contracts at,

<https://portal.ohmits.com/Public/Public%20Information/Fee%20Schedules/tabId/55/Default.aspx>

# 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



The screenshot shows the Ohio Department of Medicaid website. At the top left is the 'Ohio Department of Medicaid' logo. To the right are navigation links: 'About ODM | Our Services | Resources | News & Events'. Below this is a search bar. A secondary navigation bar includes 'Home Consumers Providers Trading Partners Public Information Publications'. Under 'Providers', there are sub-links: 'enrollment', 'enrollment tracking search', 'long-term care', and 'account setup'. The date and time 'Tuesday 06/16/2015 11:34:38 AM' are displayed. A 'Provider Home' section is highlighted in light blue, containing text about the enrollment wizard. A red box highlights a 'Login to secure site' link with a sub-link '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”



The screenshot shows the 'Sign In' page for the Medicaid Information Technology System. The header includes 'Ohio.gov Medicaid Information Technology System' and a family photo. The page title is 'Sign In Medicaid Information Technology System'. The main content area is titled 'To sign in, please enter your User ID and Password'. It contains input fields for 'User ID:' and 'Password:'. Below these is a disclaimer: '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.' Below the disclaimer is a checkbox labeled 'Yes, I have read the agreement'. A 'Login' button is at the bottom. At the very bottom are links for 'Help FAQ', 'Help Reset Password?', and 'Forgot Your User ID?'.

## MITTS Navigation

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

**MITTS 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  
to be in the next  
payment cycle**

**MIT  
Portal**

**Free  
submission**

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

**Easier for us to help  
you 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 a Professional Claim

Ohio.gov | Medicaid Information Technology System

Welcome,

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

search search detail dental institutional

**Claims**

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

Search

Search Detail

Dental

Institutional

Professional



# Submission of a Professional Claim

? ⌵
Professional Claim: NPI -

BILLING INFORMATION	SERVICE INFORMATION
<p>ICN</p> <p>Claim Received Date</p> <p>Claim Type M - PROFESSIONAL</p> <p>Provider ID NPI</p> <p>*Medicaid Billing Number <input type="text"/></p> <p>*Date of Birth <input type="text"/></p> <p>Last Name</p> <p>First Name, MI</p> <p>*Patient Account # <input type="text" value="0"/></p> <p>Medical Record # <input type="text"/></p> <p>Referring Provider # <input type="text"/></p> <p>Rendering ID <input type="text"/></p> <p>*Medicare Assignment NOT ASSIGNED <input type="checkbox"/></p> <p>Patient Amount Paid <input type="text" value="\$0.00"/></p> <p>*ICD Version 10 <input type="checkbox"/></p>	<p>*Release of Information NOT ALLOWED TO RELEASE DATA <input type="checkbox"/></p> <p>From Date</p> <p>To Date</p> <p>Signature Source <input type="text"/></p> <p>Accident Related To <input type="text"/></p> <p>Accident State <input type="text"/></p> <p>Accident Country <input type="text"/> [ Search ]</p> <p>Accident Date <input type="text"/></p> <p>EPSDT Referral <input type="text"/></p> <p>Prior Authorization # <input type="text"/></p> <p>Hospital Discharge Date <input type="text"/></p> <p>Last Menstrual Period <input type="text"/></p> <p><b>TOTAL CHARGES</b></p> <p>Total Charges \$0.00</p> <p>Medicaid Allowed Amount \$0.00</p> <p>TPL Paid Amount \$0.00</p> <p>Total Medicaid Paid Amount \$0.00</p> <p>Medicaid CoPay Amount \$0.00</p> <p>Note Reference Code <input type="text"/></p> <p>Notes</p>
<b>Diagnosis</b>	
*** No rows found ***	
Select row above to update -or- click add an item button below.	
<input type="button" value="delete"/> <input type="button" value="add an item"/>	
<b>Header - Other Payer</b>	
*** No rows found ***	
Select row above to update -or- click add an item button below.	
<input type="button" value="delete"/> <input type="button" value="add an item"/>	



## 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 the codes



# Detail Panel

## Detail

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

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

delete
add an item
copy

**Item** 1

**\*From DOS**

**To DOS**

**\*Units**

**\*Charges**

**Medicaid Allowed Amount** \$0.00

**Rendering Provider**

**Submitted EAPG**

**Initial EAPG**

**Status**

**\*Place Of Service**  [ Search ]

**\*Procedure Code**  [ Search ]

**Emergency**

**Referred EPSDT Service/ Family Planning**

**\*Diagnosis Code Pointer**

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

**Final EAPG**

**Pay Action**



# Entering Ordering Provider Information

## Detail

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

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

delete
add an item
copy

Item 1

\*From DOS

To DOS

\*Units

\*Charges

Medicaid Allowed Amount \$0.00

Rendering Provider

Submitted EAPG

Initial EAPG

Status

\*Place Of Service  [ Search ]

\*Procedure Code  [ Search ]

Emergency

Referred EPSDT Service/  
Family Planning

\*Diagnosis Code  
Pointer

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

Final EAPG

Pay Action

NDC
Detail - Other Payer
ClaimCheck
Additional Provider Information



# Entering Ordering Provider Information, cont.

Medicaid Allowed Amount \$0.00

Rendering Provider

Submitted EAPG

Initial EAPG

Status

Visit Start Time

Visit End Time

Service Duration  
less than 90 days

Diagnosis Code  
Pointer

Modifiers  [ Search ]  [ Search ]

[ Search ]  [ Search ]

Final EAPG

Pay Action

NDC

Detail - Other Payer

ClaimCheck

Additional Provider Information

## Additional Provider Information

\*\*\* No rows found \*\*\*

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

delete

add an item





# Entering Ordering Provider Information, cont.

Medicaid Allowed Amount \$0.00

Rendering Provider

Submitted EAPG

Initial EAPG

Status

Visit Start Time

Visit End Time

Service Duration less than 90 days

Diagnosis Code Pointer

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

Final EAPG

Pay Action

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

## Additional Provider Information

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

A 0

Type data below for new record.

\*Detail Item

\*Type of Provider

\*Provider #

\*Last Name

\*First Name, MI





# Entering Ordering Provider Information, cont.

Submitted EAPG

Final EAPG

Initial EAPG

Pay Action

Status

Visit Start Time

Visit End Time

Service Duration  
less than 90 days

NDC

Detail - Other Payer

ClaimCheck

Additional Provider Information

## Additional Provider Information

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

A	0			
---	---	--	--	--

Type data below for new record.

delete

add an item

\*Detail Item 1

\*Type of Provider Ordering Provider

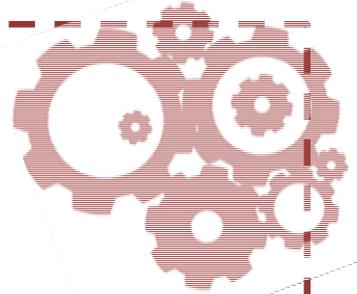
\*Provider # 1234567890

\*Last Name SMITH

\*First Name, MI JOHN A



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



## Claim Portal Errors



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

Portal errors return the claim with a “fix” needed

Claim shows a ‘NOT SUBMITTED YET’ status still



**The following messages were generated:**

From DOS is required.

Procedure is required.

A valid Place Of Service is required

A valid Procedure Code is required.

Units must be greater than 0.

Charges must be greater than \$0.00.

A valid Medicaid Billing Number is required

A valid Medicaid Billing Number and Date of Birth combination is required.



# Claim Example

## BILLING INFORMATION

**ICN** 2018096088462  
**Claim Received Date** 04/06/2018  
**Claim Type** M - PROFESSIONAL  
**Provider ID**  
**Medicaid Billing Number** 123456789000  
**Date of Birth** 04/25/2006  
**Last Name** DOE  
**First Name, MI** JANE  
**Patient Account #** G3199A3382  
**Medical Record #**  
**Referring Provider #** 1234567890  
**Referring Last Name**  
**Referring First Name, MI**  
**Supervising Provider #**  
**Supervising Last Name**  
**Supervising First Name, MI**  
**Rendering ID**  
**Medicare Assignment** ASSIGNED  
**Patient Amount Paid** \$0.00  
**ICD Version** 10

## SERVICE INFORMATION

**Release of Information** SIGNED STMT PERMITTING RELEASE  
**From Date** 03/29/2018  
**To Date** 03/29/2018  
**\*Signature Source** GENERATED BY PROVIDER  
**Accident Related To**  
**Accident State**  
**Accident Country**  
**Accident Date**  
**EPSDT Referral**  
**Prior Authorization #**  
**Hospital Discharge Date**  
**Last Menstrual Period**

**TOTAL CHARGES**

<b>Total Charges</b>	\$237.00
<b>Medicaid Allowed Amount</b>	\$73.75
<b>TPL Paid Amount</b>	\$0.00
<b>Total Medicaid Paid Amount</b>	\$73.75
<b>Medicaid CoPay Amount</b>	\$0.00

**Note Reference Code**  
**Notes**



# Claim Example, cont.

			Diagnosis
Sequence ▾	Diagnosis Code	Description	
03	G40219	LOCAL-REL SYMPTC EPI W CMLX PART SEIZ, NTRCT, W/O STAT EPI	
02	G931	ANOXIC BRAIN DAMAGE, NOT ELSEWHERE CLASSIFIED	
01	K117	DISTURBANCES OF SALIVARY SECRETION	

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

delete

add an item

Sequence

01 ▾

Diagnosis Code

K117

## Header - Other Payer

\*\*\* No rows found \*\*\*

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

delete

add an item

Header - Other Payer Amounts and Adjustment Reason Codes



# Claim Example, cont.

## Detail

Item	FDOS	Units	Charges	Medicaid Allowed Amount	Status	Place of Service	Procedure Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Final EAPG
3	03/29/2018	3.00	\$12.00	\$11.25	PAID	12	A7002					
2	03/29/2018	3.00	\$75.00	\$22.50	PAID	12	A7000					
1	03/29/2018	50.00	\$150.00	\$40.00	PAID	12	A4624					

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

delete
add an item
copy

Item: 1

From DOS: 03/29/2018

To DOS: 03/29/2018

Units: 50.00

Charges: \$150.00

Medicaid Allowed Amount: \$40.00

Rendering Provider: 1234567890

Submitted EAPG:

Initial EAPG:

Status: PAID

Visit Start Time:

Visit End Time:

Service Duration less than 90 days:

Place Of Service: 12

Procedure Code: A4624

Emergency:

Referred EPSDT Service/ Family Planning:

\*Diagnosis Code Pointer: 01  02  03

Modifiers:

Final EAPG:

Pay Action:

NDC

Detail - Other Payer

ClaimCheck

Additional Provider Information



# Claim Example, cont.

## Additional Provider Information

Detail Item	Type of Provider	Provider #	Last Name	First Name, MI
1	Ordering Provider	1234567890	SMITH	JOHN, A
2	Ordering Provider	1234567890	SMITH	JOHN, A
3	Ordering Provider	1234567890	SMITH	JOHN, A

Type changes below.

Detail Item:

Type of Provider:

Provider #:

Last Name:

First Name, MI:

## Attachments

\*\*\* No rows found \*\*\*

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

### 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:



# Claim Example, cont.

## Claim Status Information

**Claim Status** PAID

**Claim ICN** 2018096088462

**Paid Date** 04/26/2018

**Paid Amount** \$73.75

## EOB Information

Detail Number	Error Disposition	EOB Code	EOB Description	CARC	CARC Amount	CARC Description	RARC	RARC Description
1		9918	PRICING ADJUSTMENT - MAX FEE PRICING APPLIED	45	\$110.00	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability)	M16	Alert: Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision.
2		9918	PRICING ADJUSTMENT - MAX FEE PRICING APPLIED	45	\$52.50	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability)	M16	Alert: Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision.
3		9918	PRICING ADJUSTMENT - MAX FEE PRICING APPLIED	45	\$0.75	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability)	M16	Alert: Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision.

# 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

# 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”

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



## 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

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

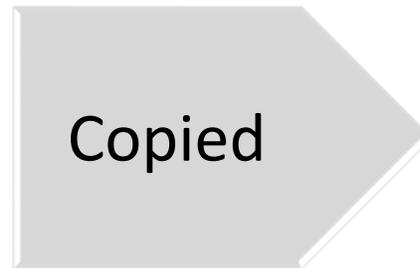


## Uploading an Attachment



- 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

## Paid claims can be:





## Adjusting a Paid Claim



**cancel**

**adjust**

**void**

**copy claim**

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



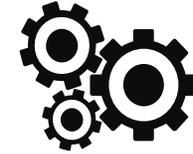
## Adjusting a Paid Claim



- 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



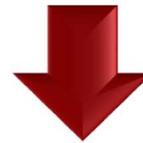
2018172234001  
5018173127250

Originally paid \$50.00  
Now paid \$45.00

Account receivable (\$5.00)



## Voiding a Paid Claim



cancel

adjust

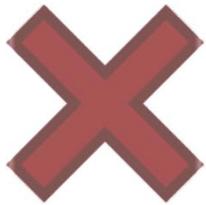
void

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.

delete
add an item

*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.

<input type="button" value="delete"/>	<input type="button" value="add an item"/>
---------------------------------------	--

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

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

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.

**Payer Header Level Adjustment Reason Codes (ARC) and Amounts**

\*Electronic Payer ID

\*CAS Group Code

\*ARC

\*Amount



# 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.

\*Detail Item/Electronic Payer ID

\*CAS Group Code

\*ARC

\*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

search clear



# Remittance Advice (RA)



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

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

<https://Medicaid.ohio.gov>

- MALs & MTLs

<http://medicaid.ohio.gov/RESOURCES/Publications/ODM-Guidance#161542-medicaid-policy>

- LAWriter

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

- MITS home page

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

## Websites

### ➤ Provider Enrollment

<http://medicaid.ohio.gov/Provider/EnrollmentandSupport/ProviderEnrollment>

### ➤ Electronic Funds Transfer

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

### ➤ Information for Trading Partners (EDI)

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

### ➤ X12 Website (ARC Codes)

[www.x12.org/codes/claim-adjustment-reason-codes/](http://www.x12.org/codes/claim-adjustment-reason-codes/)

 FORMS 

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

<http://medicaid.ohio.gov/RESOURCES/Publications/Medicaid-Forms>

