



**Department of  
Medicaid**

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

# Basic Billing for Physicians

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)

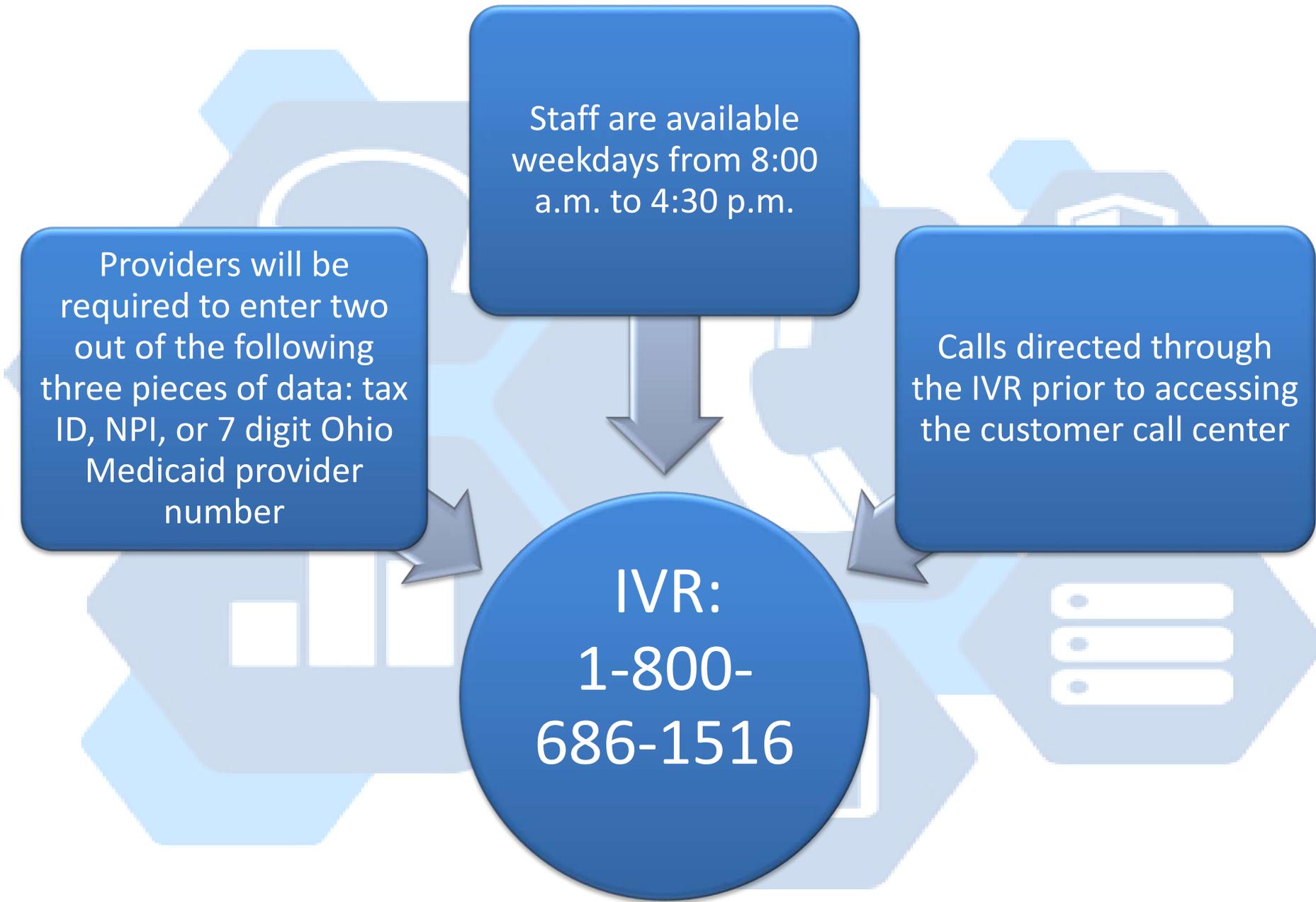
1-800-686-1578

### ➤ Coordination of Benefits Section

614-752-5768

614-728-0757 (fax)





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# Programs & Cards

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# Ohio Medicaid

- This card is the traditional fee-for-service Medicaid card
- 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="text-align: center;">Fold</p> <table border="1"><tr><td>County</td><td>ALLEN</td><td rowspan="5" style="text-align: right;"><b>Ohio Medicaid</b></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><tr><td colspan="2"><b>Ohio Department of Medicaid</b> medicaid.ohio.gov</td></tr></table> <p><b>Consumer Hotline:</b> 1-800-324-8680 [or TTY 1-800-292-3572]</p>	County	ALLEN	<b>Ohio Medicaid</b>	Case Number	5082482	Eligibility Begin Date	01/01/2018	Void After Date	01/31/2018	<b>Ohio Department of Medicaid</b> medicaid.ohio.gov	
County	ALLEN	<b>Ohio Medicaid</b>										
Case Number	5082482											
Eligibility Begin Date	01/01/2018											
Void After Date	01/31/2018											
<b>Ohio Department of Medicaid</b> medicaid.ohio.gov												

## 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

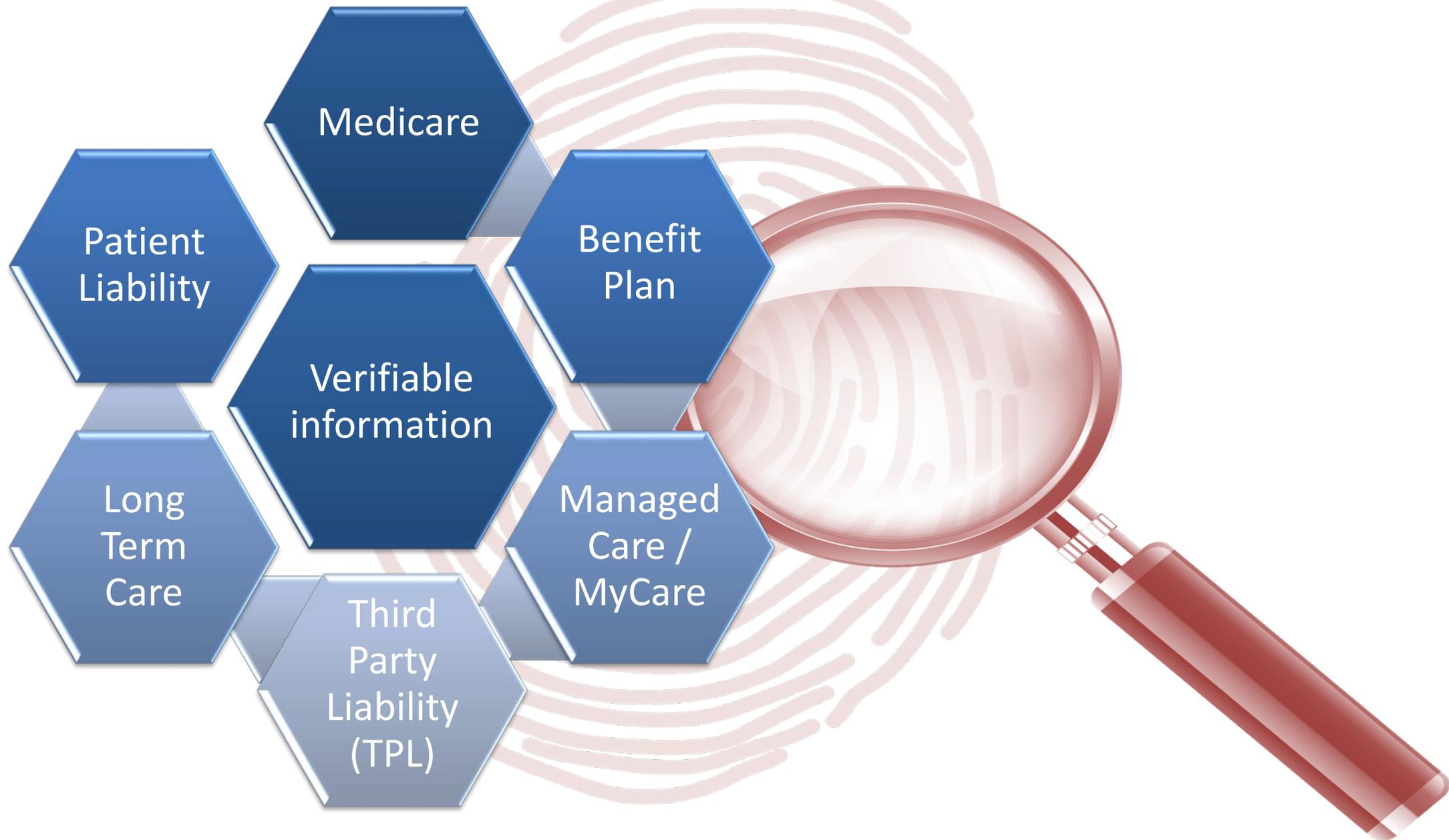
Full Medicaid eligibility on the MITS Portal will show **four** (or more) benefit spans:

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](http://jfs.ohio.gov/County/County_Directory.pdf)

Date of Birth

Number Bed Hold Days Used Paid CY

Date of Death

Associated Child(ren) Search

## Benefit / Assignment Plan

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

## Case/Cat/Seq Spenddown

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



# Eligibility Verification Request

## Recipient Information

### Medicaid Billing Number

### SSN

Last Name

County of Residence CUYAHOGA

First Name

County of Eligibility

Gender

County Office [http://jfs.ohio.gov/County/County\\_Directory.pdf](http://jfs.ohio.gov/County/County_Directory.pdf)

Date of Birth

Number Bed Hold Days Used Paid CY

Date of Death



Associated Child(ren) Search

## Benefit / Assignment Plan

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

## Associated Child(ren)

Medicaid Billing Number	First Name	MI	Last Name	Gender	Date of Birth
123456789012	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



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

**Ohio** | Benefits

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**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><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 1-800-688-1518.</p> <p><b>Inpatient hospital services are not covered.</b></p> <p><b>Note:</b> Use the Medicaid ID for all claim submissions.</p> <p><a href="http://medicaid.ohio.gov">medicaid.ohio.gov</a></p> <p>Consumer's Signature: _____</p>	Fold	<table border="1"><tr><td>County</td><td><b>BUTLER</b></td></tr><tr><td>Case Number</td><td><b>012345678910</b></td></tr><tr><td>Eligibility Begin Date</td><td><b>07/01/2013</b></td></tr><tr><td>Void After Date</td><td><b>08/30/2013</b></td></tr></table> <p><b>Ohio Department of Medicaid</b> <a href="http://medicaid.ohio.gov">medicaid.ohio.gov</a> <b>Consumer Hotline:</b> 1-800-324-8680 [or TTY 1-800-292-3572]</p> <p style="text-align: right;"><b>Presumptive Medicaid</b></p> 	County	<b>BUTLER</b>	Case Number	<b>012345678910</b>	Eligibility Begin Date	<b>07/01/2013</b>	Void After Date	<b>08/30/2013</b>
County	<b>BUTLER</b>									
Case Number	<b>012345678910</b>									
Eligibility Begin Date	<b>07/01/2013</b>									
Void After Date	<b>08/30/2013</b>									



# Presumptive Eligibility



Recipient Information	
Medicaid Billing Number	SSN
Last Name	County of Residence
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 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  
consumers 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 5160-14-03

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

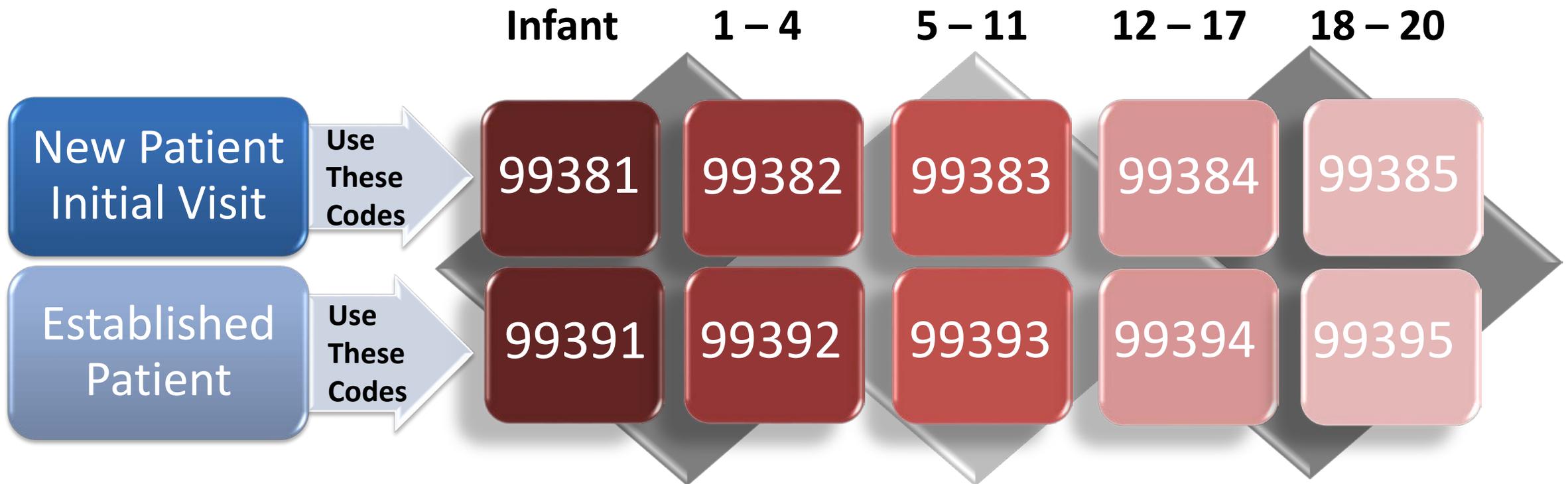
# Healthchek

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



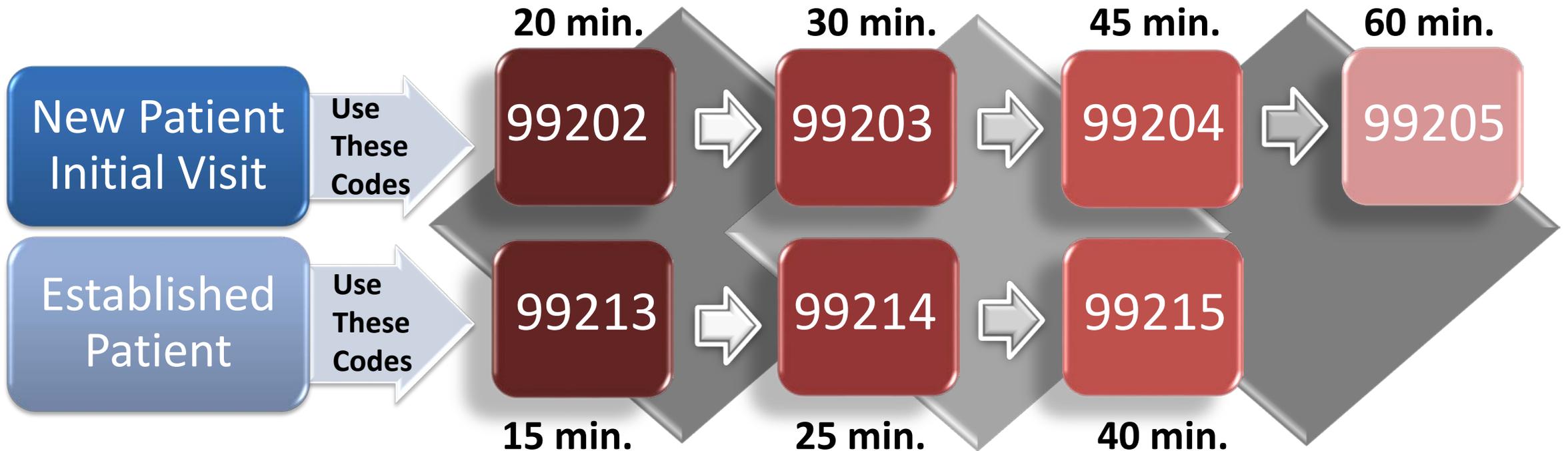
# HealthChek Procedure Codes

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®

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



## Managed Care Day One

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

	'The old way'	Day One
Recipient completes Application	5/3/2017	5/3/2017
Determined eligibility for Medicaid	5/17/2017	5/17/2017
Fee-For-Service	5/1/2017 → 5/31/2017	X
Managed Care Plan	6/1/2017 → 12/31/2299	5/1/2017 → 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)

## Adult Extension and HCBS Waiver

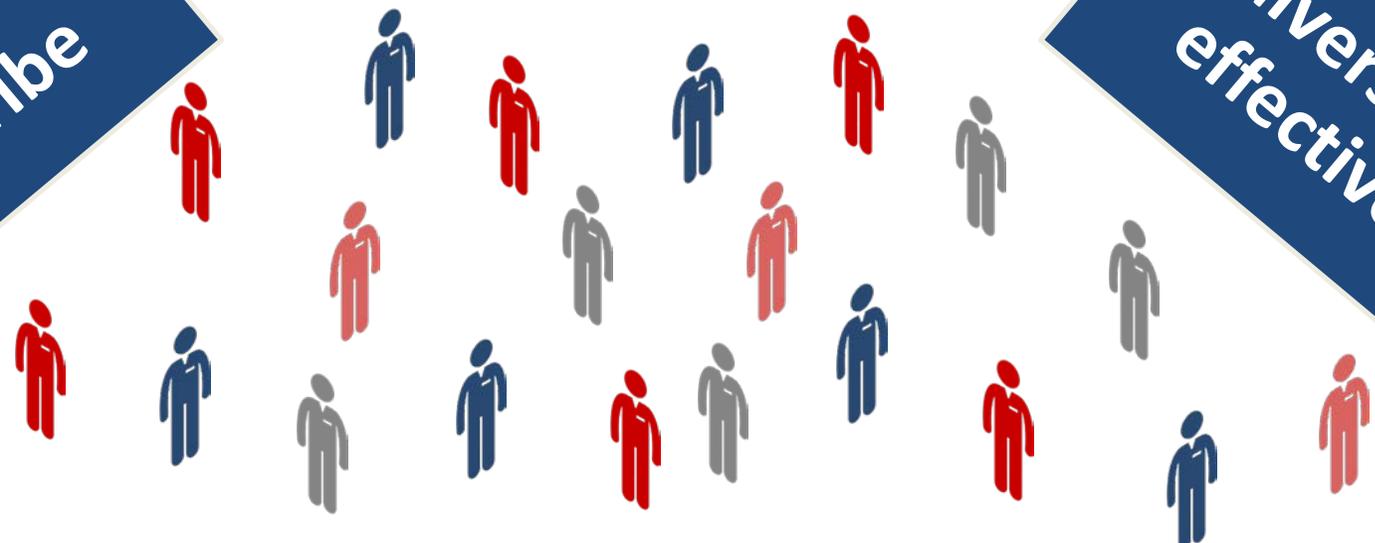


- ✓ Adults eligible via the extension will be able to access a home and community based waiver (HCBS) if a level of care requirement is met *(MCPs are responsible for state plan health care services)*
- ✓ HCBS waivers include: Passport, Ohio Home Care, and Assisted Living *(Fee-for-Service Medicaid is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

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 recipient

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



# 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

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



## Traditional Managed Care Contracting

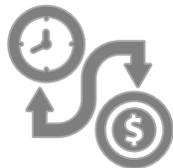


Providers who are interested in delivering services to a Managed Care member must be fully enrolled with Medicaid and have a contract or agreement with the plan

### 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



**EXTENDED**

MyCare Ohio is a demonstration project that integrates Medicare and Medicaid services into one program, operated by a Managed Care Plan

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

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

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 a recipient 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)

**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 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 \*\*\*

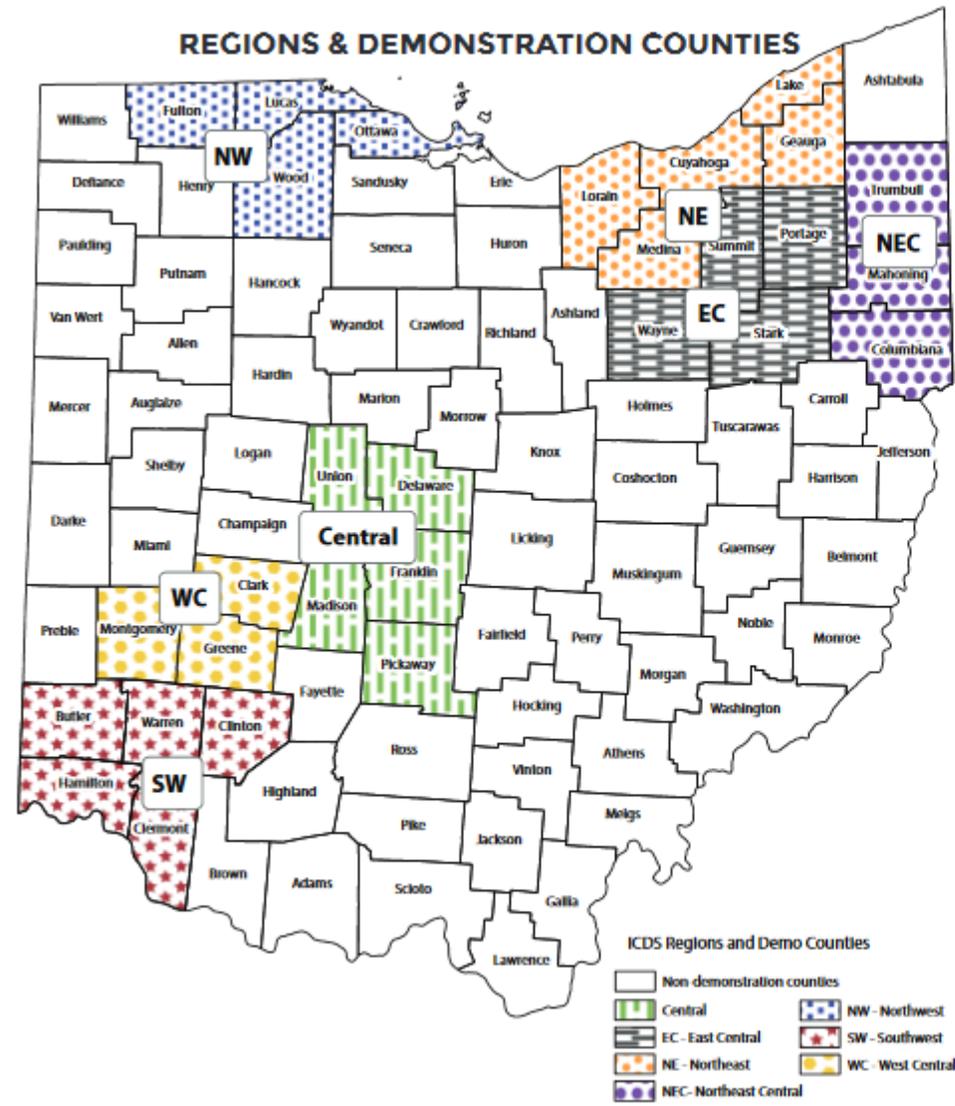
## Medicare

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

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

# MyCare Ohio Region Breakdown



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

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

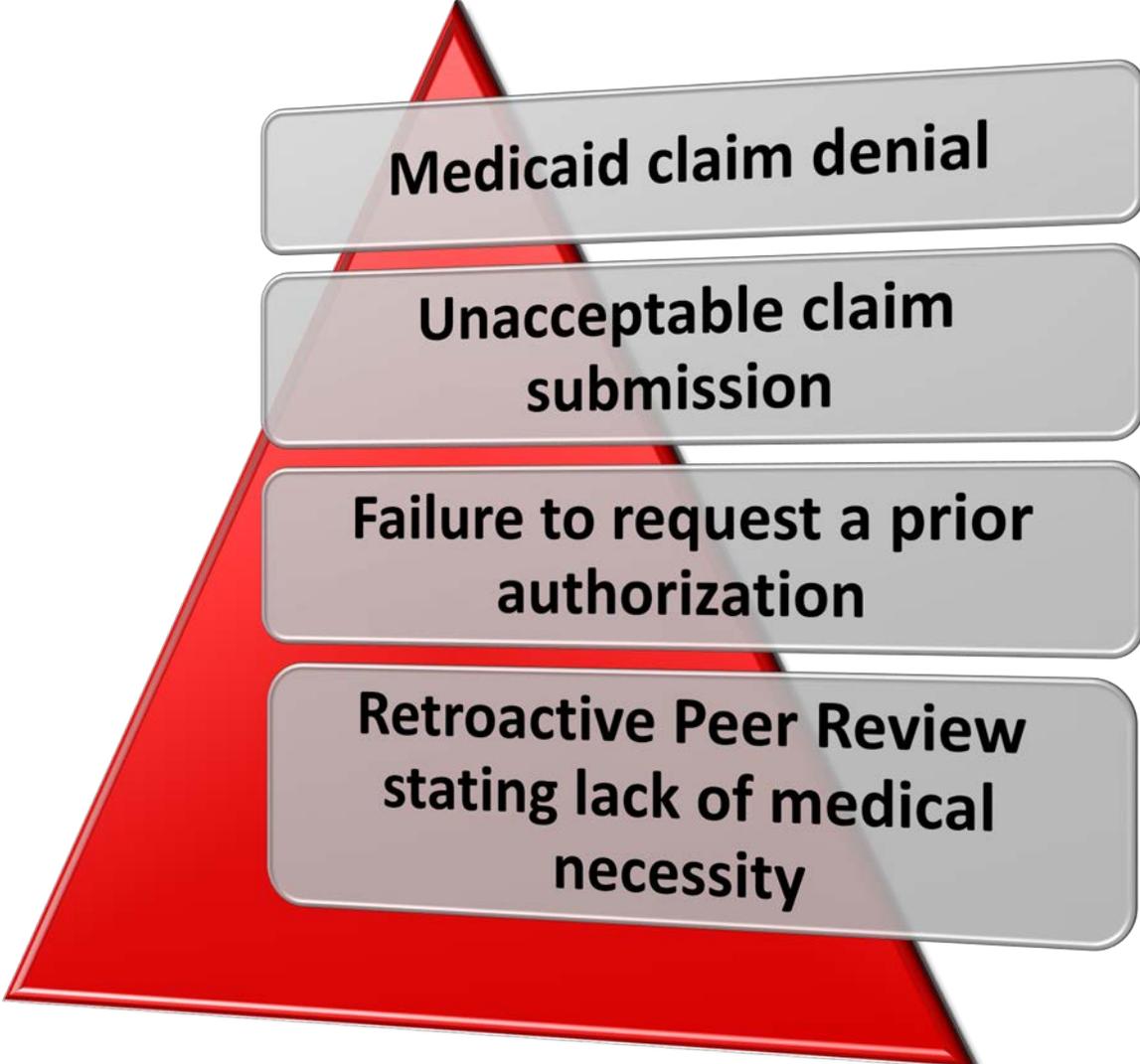
## Coordination of Benefits: OAC 5160-1-08

- 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:



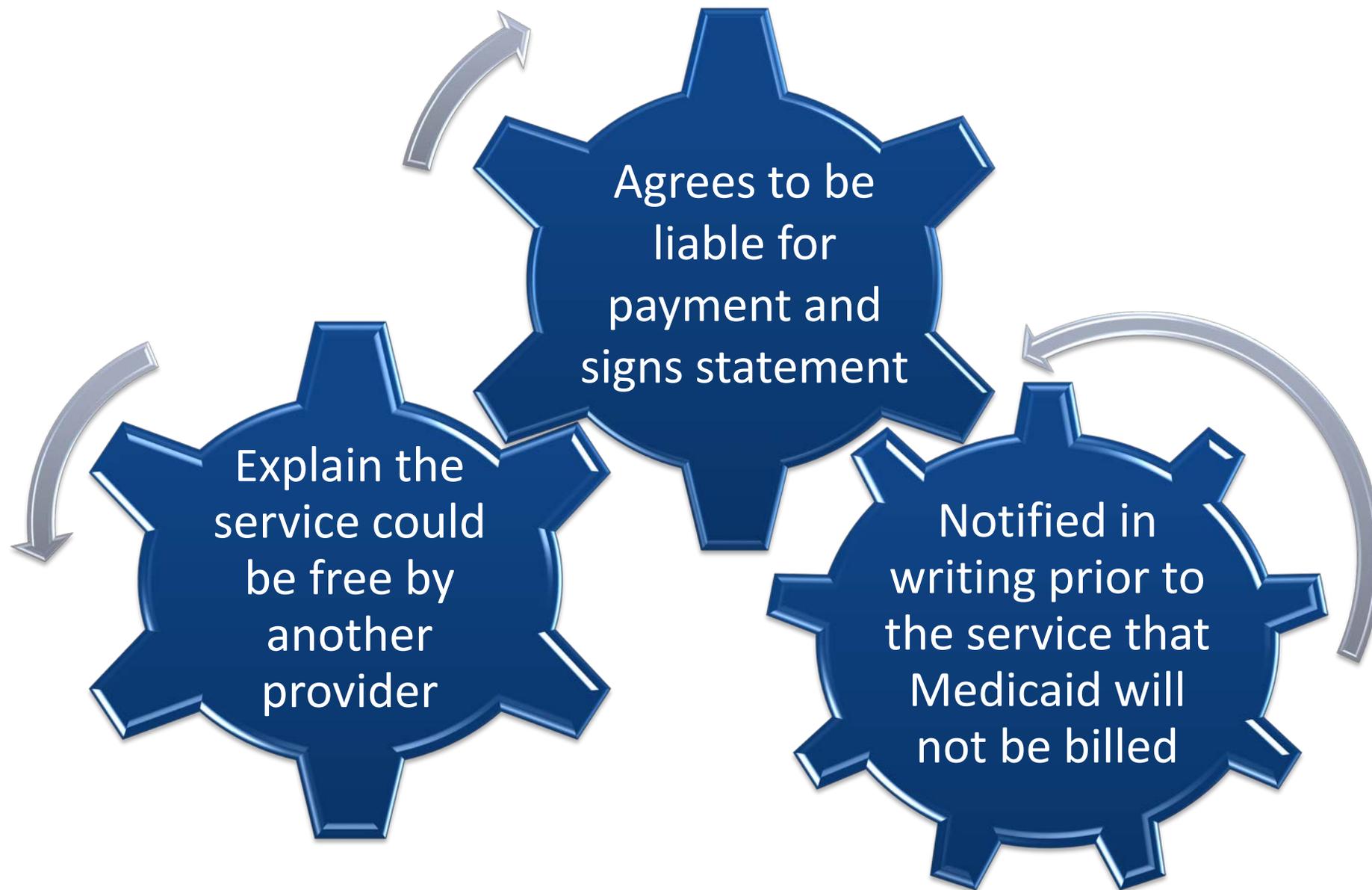
Medicaid claim denial

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". To the right are utility links for "Text Size: +A -A", "Select Language", "Powered by Google Translate", and "Translation Disclaimer". 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 tiles: "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 seal icon.

# Provider Responsibilities

Text Size: +A -ASelect LanguagePowered by Google TranslateTranslation 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 \(Rev. 4/1/16\)](#)

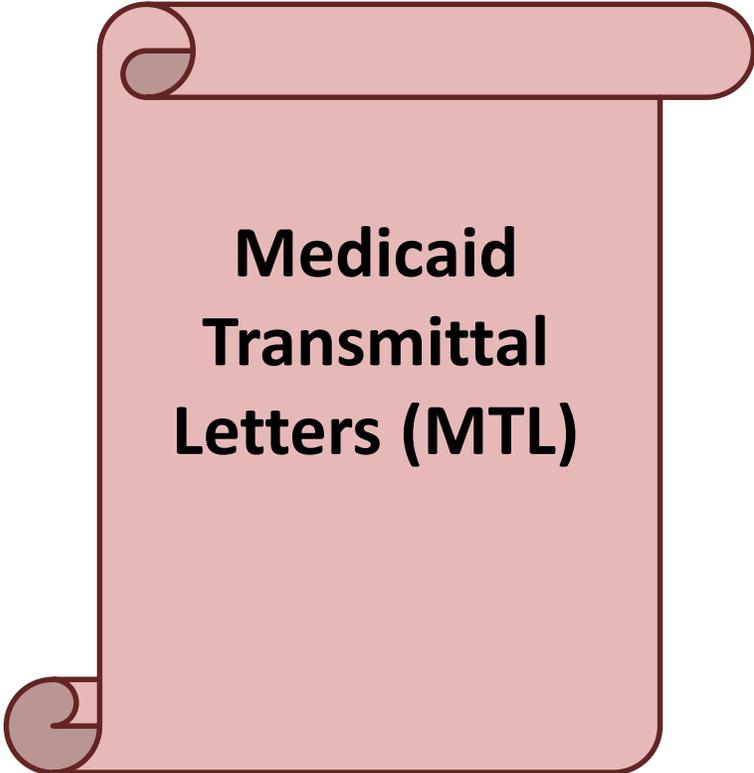
### Related Content

- 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

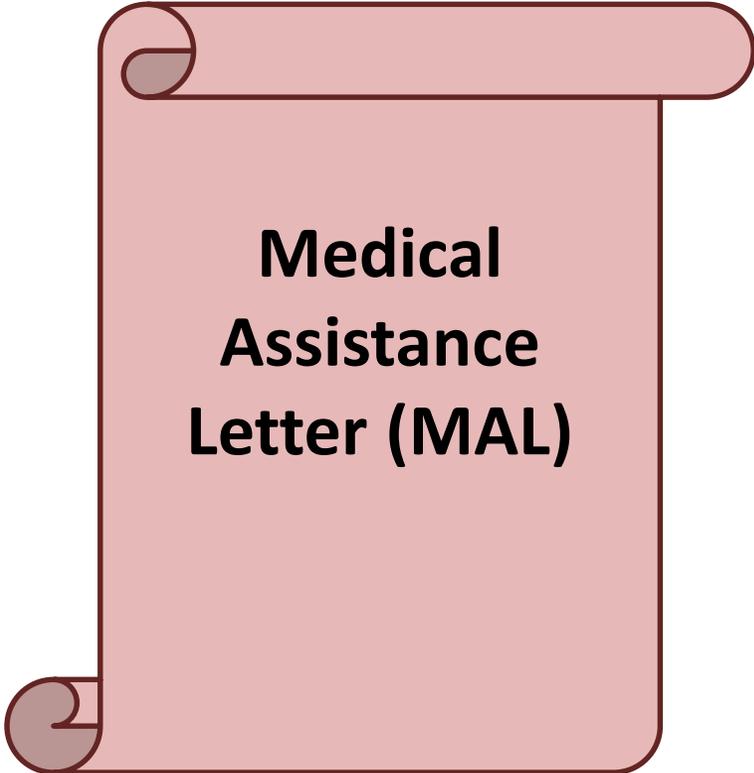
Access the  
MITS Portal

**Policy**

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



**Medicaid  
Transmittal  
Letters (MTL)**



**Medical  
Assistance  
Letter (MAL)**

# 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 the text "Search..." and 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 >, Training >, Managed Care, Provider Types, MITS >, and Payment Innovation. The "Billing" item is highlighted in blue. To the right of the dropdown menu, there is a sidebar with several sections: "Need technical assistance? Provider Hotline: (800) 686-1516" with a smartphone icon; "Access the MITS Portal" with a gear icon; and "Related Content" 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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- [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

## 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

# Covered Podiatric Services & Associated Limitations: OAC 5160-7-03



Payment for additional evaluation & management services when provided by a podiatrist



New procedure codes which require decision making of moderate complexity



99349

99344



99343

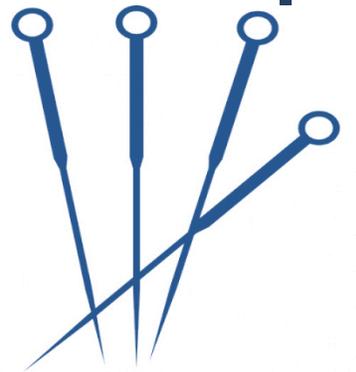
99214



99204

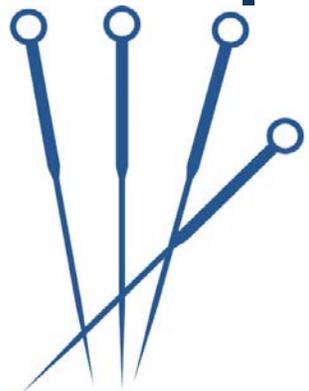
## Acupuncture Services: OAC 5160-8-51

- Providers eligible to receive payment for acupuncture:
  - An acupuncturist
  - A recognized acupuncture provider
  - Ambulatory health care clinic as defined in OAC 5160-13
  - Cost-Based Clinics (FQHC, RHC)
  - Professional medical group



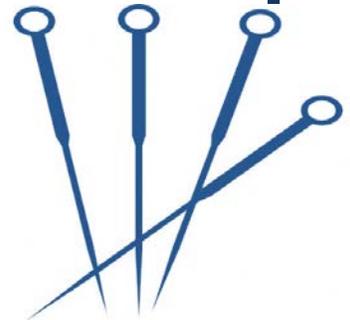
# Acupuncture Services

- Payment may be made for service that meets the following:
  - Is medically necessary per OAC 5160-1-01
  - Is performed at the written order of a practitioner, during the one year supervisory period, per section 4762.10 or 4762.11 of the Ohio Revised Code
  - Is rendered by a practitioner who is enrolled in the Medicaid program
  - Is rendered for treatment of:
    - Low back pain
    - Migraine
- Payment for more than 30 visits per benefit year requires prior authorization



# Acupuncture Services

- No separate payment will be made for both an evaluation & management service and acupuncture service rendered by the same provider to the same individual on the same day
- No separate payment is made for services that are an incidental part of a visit (e.g., providing instruction on breathing techniques, diet, or exercise)
- No separate payment will be made for additional treatment in either of the following circumstances:
  - Symptoms show no evidence of clinical improvement after an initial treatment period
  - Symptoms worsen over a course of treatment



## Procedure Codes

Code	Description	Payment
97810	Acupuncture, one or more needles, without electrical stimulation, initial 15 minutes of one-on-one contact with the patient.	\$25 per 15 minute increment
97811	Acupuncture, one or more needles, without electrical stimulation, each additional 15 minute increment of personal one-on-one contact with the patient, with reinsertion. (Listed separately in addition to primary code.)	\$17.50 per each additional 15 minute increment
97813	Acupuncture, one or more needles, with electrical stimulation, initial 15 minutes of one-on-one contact with the patient.	\$31.15 per 15 minute increment
97814	Acupuncture, one or more needles, with electrical stimulation, each additional 15 minute increment of personal one-on-one contact with the patient, with reinsertion. (Listed separately in addition to primary code.)	\$23.65 per each additional 15 minute increment

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# MITIS and Claims

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## 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 logo. To its right is a search bar with the word "Search" inside. Below the logo is the text "Department of Medicaid". A navigation menu includes "About ODM", "Our Services", "Resources", and "News & Events". A secondary menu has "Home", "Consumers", "Providers" (highlighted in red), "Trading Partners", "Public Information", and "Publications". Below this are links for "enrollment", "enrollment tracking search", "long-term care", and "account setup". A teal banner reads "Ohio Department of Medicaid". Below the banner is a "Provider Home" section with a teal header and text: "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." To the right of this text is a box titled "Login to secure site" containing a 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. At the top is the "Ohio.gov" logo and "Medicaid Information Technology System" text. Below is a "Sign In" header. The main content area is titled "To sign in, please enter your User ID and Password" and contains two input fields: "User ID:" and "Password:". Below the fields is a paragraph of legal disclaimer text. Underneath is a checkbox labeled "Yes, I have read the agreement". At the bottom of the form is a "Login" button. Below the form are links for "Help FAQ", "Help Reset Password?", and "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**

**MITS 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 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 -	
<b>BILLING INFORMATION</b>	
ICN	
Claim Received Date	
Claim Type	M - PROFESSIONAL
Provider ID	NPI
*Medicaid Billing Number	<input type="text"/>
*Date of Birth	<input type="text"/>
Last Name	
First Name, MI	
*Patient Account #	0 <input type="text"/>
Medical Record #	<input type="text"/>
Referring Provider #	<input type="text"/>
Rendering ID	<input type="text"/>
*Medicare Assignment	NOT ASSIGNED <input type="checkbox"/>
Patient Amount Paid	<input type="text"/> \$0.00
*ICD Version	10 <input type="checkbox"/>
<b>SERVICE INFORMATION</b>	
*Release of Information	NOT ALLOWED TO RELEASE DATA <input type="checkbox"/>
From Date	
To Date	
Signature Source	<input type="text"/> <input type="checkbox"/>
Accident Related To	<input type="text"/> <input type="checkbox"/>
Accident State	<input type="text"/> <input type="checkbox"/>
Accident Country	<input type="text"/> [ Search ]
Accident Date	<input type="text"/>
EPSDT Referral	<input type="text"/> <input type="checkbox"/>
Prior Authorization #	<input type="text"/>
Hospital Discharge Date	<input type="text"/>
Last Menstrual Period	<input type="text"/>
<b>TOTAL CHARGES</b>	
Total Charges	\$0.00
Medicaid Allowed Amount	\$0.00
TPL Paid Amount	\$0.00
Total Medicaid Paid Amount	\$0.00
Medicaid CoPay Amount	\$0.00
Note Reference Code	<input type="text"/> <input type="checkbox"/>
Notes	<input type="text"/>
<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 those codes



# Diagnosis Codes

**Diagnosis**

Sequence ▾	Diagnosis Code	Description
A 01	I519	HEART DISEASE, UNSPECIFIED

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

delete
add an item

\*Sequence 01 ▾ \*Diagnosis Code  [ Search ]

**Header - Other Payer**

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

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

delete
add an item

**Header - Other Payer Amounts and Adjustment Reason Codes**

**Detail**

Item ▾	FDOS	Units	Charges	Medicaid Allowed Amount	Status	Place of Service	Procedure Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	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

\*Place Of Service  [ Search ]

\*Procedure Code  [ Search ]

Emergency

Referred EPSDT Service/  
Family Planning

\*Diagnosis Code Pointer



# 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

<p>Item <input type="text" value="1"/></p> <p>*From DOS <input type="text"/></p> <p>To DOS <input type="text"/></p> <p>*Units <input type="text" value="0"/></p> <p>*Charges <input type="text" value="\$0.00"/></p> <p>Medicaid Allowed Amount <input type="text" value="\$0.00"/></p> <p>Rendering Provider <input type="text"/></p> <p>Submitted EAPG <input type="text"/></p> <p>Initial EAPG <input type="text"/></p> <p>Status <input type="text"/></p>	<p>*Place Of Service <input type="text"/> [ Search ]</p> <p>*Procedure Code <input type="text"/> [ Search ]</p> <p>Emergency <input type="text" value="v"/></p> <p>Referred EPSDT Service/ Family Planning <input type="text" value="v"/></p> <p>*Diagnosis Code <input type="text" value="v"/> <input type="text" value="v"/> <input type="text" value="v"/> <input type="text" value="v"/></p> <p>Pointer <input type="text" value="v"/></p> <p>Modifiers <input type="text"/> [ Search ] <input type="text"/> [ Search ]</p> <p><input type="text"/> [ Search ] <input type="text"/> [ Search ]</p> <p>Final EAPG <input type="text"/></p> <p>Pay Action <input type="text"/></p>
---	--



# 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



# 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	01/20/2018	1.00	\$350.00		11	52287					

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

**Item** 1  
**\*From DOS** 01/20/2018  
**To DOS** 01/20/2018  
**\*Units** 1.00  
**\*Charges** \$350.00  
**Medicaid Allowed Amount** \$0.00  
**Rendering Provider**   
**Submitted EAPG**   
**Initial EAPG**   
**Status**   
**Visit Start Time**     
**Visit End Time**     
**Service Duration less than 90 days**

**\*Place Of Service** 11 [ Search ]  
**\*Procedure Code** 52287 [ Search ]  
**Emergency**    
**Referred EPSDT Service/ Family Planning**   
**Diagnosis Code Pointer** 01      
**Modifiers**  [ Search ]  [ Search ]  
 [ Search ]  [ Search ]  
**Final EAPG**   
**Pay Action**



# Detail Panel

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	01/20/2018	1.00	\$350.00		11	52287	78				

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

**delete** **add an item** **copy**

**Item** 1

**\*From DOS** 01/20/2018

**To DOS** 01/20/2018

**\*Units** 1.00

**\*Charges** \$350.00

**Medicaid Allowed Amount** \$0.00

**Rendering Provider**

**Submitted EAPG**

**Initial EAPG**

**Status**

**Visit Start Time**

**Visit End Time**

**Service Duration less than 90 days**

**\*Place Of Service** 11 [ Search ]

**\*Procedure Code** 52287 [ Search ]

**Emergency**

**Referred EPSDT Service/ Family Planning**

**Diagnosis Code Pointer** 01

**Modifiers** 78 [ Search ]  [ Search ]

[ Search ]  [ Search ]

**Final EAPG**

**Pay Action**

NDC
Detail - Other Payer
ClaimCheck
Additional Provider Information

# 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)

Submitted EAPG

Initial EAPG

Status

Visit Start Time

Visit End Time

Service Duration less than 90 days

Final EAPG

Pay Action

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



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.

delete | add an item

\*Detail Item 1

\*NDC  [ Search ]

Drug Name ELOCTATE

\*Unit of Measure UN-Unit

Prescription Number

\*Drug Unit Price

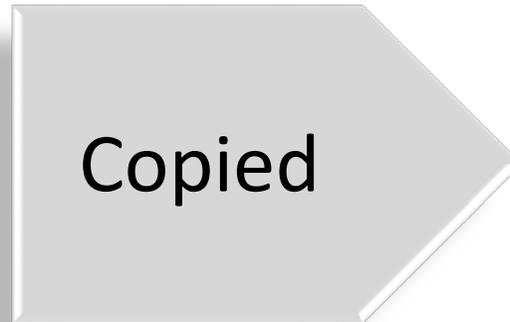
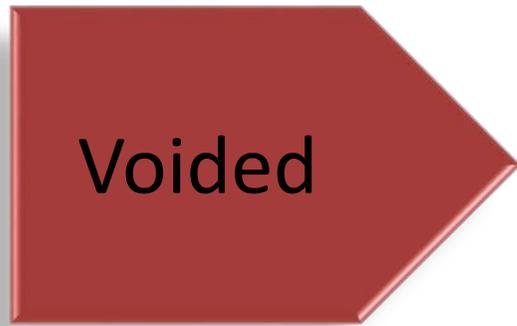
\*Unit Quantity Submitted



- 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
<b>22</b>	<b>18</b>	<b>170</b>	<b>357</b>	<b>321</b>

# 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

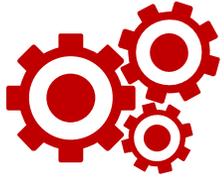
An additional 180 days from the resubmit date is given for attempts to correctly submit a denied claim prior to the end of the 365 days

Claims over 2 years old will be denied

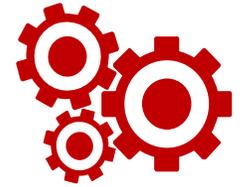
There are exceptions to the 365 day rule



**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

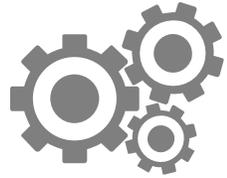
### Supporting Data for Delayed Submission / Resubmission

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

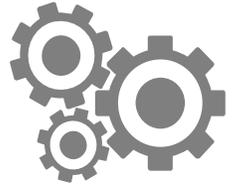
Previously Denied ICN or TCN

Reason

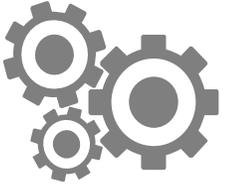
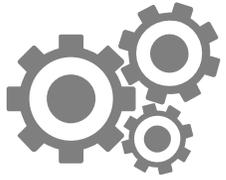




## Special Billing Instructions – Eligibility Delay



- 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



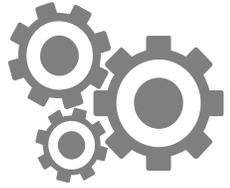
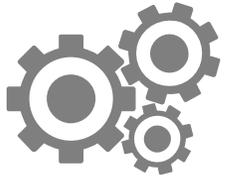
## Special Billing Instructions – Eligibility Delay

- 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



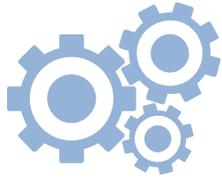
**cancel**

**adjust**

**void**

**copy claim**

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



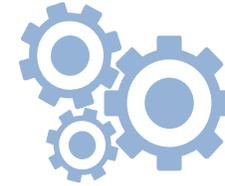
## Adjusting a Paid Claim



- 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

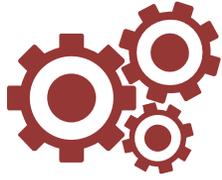
Additional payment of \$5.00



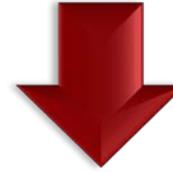
2018172234001  
5018173127250

Originally paid \$50.00  
Now paid \$45.00

Account receivable (\$5.00)



# Voiding a Paid Claim



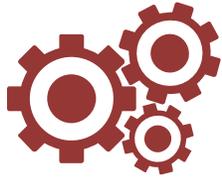
**cancel**

**adjust**

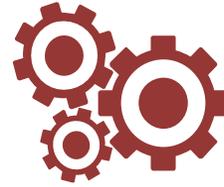
**void**

**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”



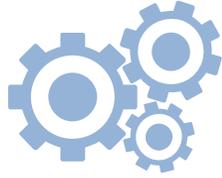
## Example



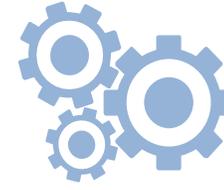
2218180234001  
5818185127250

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

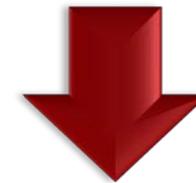
\* Make sure to wait until *after* the weekend's adjudication cycle to submit a new, corrected claim if one is needed



## 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

**\*Policy Holder Relationship to Insured** FATHER

**\*Policy Holder Last Name** SMITH

**\*Policy Holder First Name, MI** JOHN A

**Policy Holder Date of Birth** 01/01/1950

**Gender** MALE

**\*Paid Amount** \$200.00

**\*Paid Date** 01/05/2018

**Allowed Amount** \$0.00

**\*Insurance Carrier Name** BLUE CROSS BLUE SHIELD

**\*Electronic Payer ID** 01234

**Insured's Policy ID** 987654

**\*Payer Sequence** PRIMARY

**Medicare ICN**

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.

<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.

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

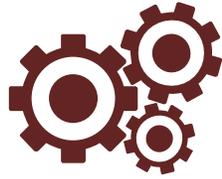
# ARC Codes

The X12 website provides adjustment reason codes (ARCs)

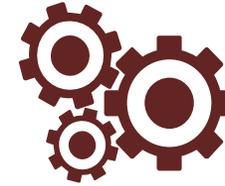
**COMMON  
ARCs:**



- 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

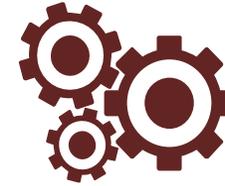
search

clear





# Remittance Advice (RA)



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

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

### Provider Reports

\*Report: REMITTANCE ADVICE

Payment Date:

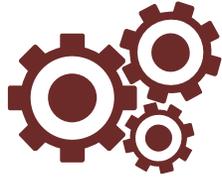
RA Number:

Check/EFT Number:

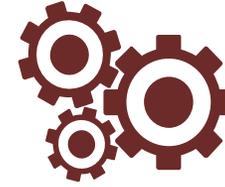
Please select the row to show the report

RA Number	Part Number	RA Date
16161973	1	01/06/2018
16146862	1	12/30/2017
16145695	1	12/23/2017
16131620	1	12/22/2016
16116473	1	12/15/2016
16101611	1	12/08/2016
16086726	1	12/01/2016
16071717	1	11/25/2016
16056394	1	11/17/2016
16041108	1	11/10/2016

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



# Remittance Advice (RA)



**Paid, denied, and adjusted claims**



**Financial transactions**

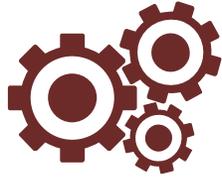
Expenditures - Non-claim payments

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

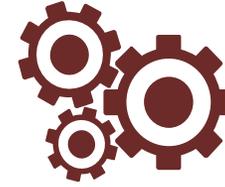


**Summary**

Current, month, and year to date information



# Remittance Advice (RA)



## Information pages

Banner messages to the provider community



## EOB code explanations

Provides a comparison of codes to the description



## TPL claim denial information

Provides other insurance information for any TPL claim denials

# 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](http://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

- PRAF 2.0 Information on the ODM site

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

- PRAF 2.0 login

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

 **FORMS** 

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

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

- HHS-687 – Consent for Sterilization

