![Ohio Department of Medicaid logo — John R. Kasich, Governor; Barbara R. Sears, Director]

FAQs-CODES/RATES/FEE SCHEDULES

(For DME PROVIDERS)

These frequently asked questions and answers are intended to serve as a guide to assist Durable Medical Equipment (DME) providers regarding commonly asked questions. The information provided is intended to assist providers in navigating the Ohio Department of Medicaid (ODM) website, provide answers for recent program changes, and help to avoid the making of unnecessary calls to the Interactive Voice Response (IVR) phone line.

1. **Where do I find a new procedure code?**

   Recently added or deleted CPT and HCPCS level II procedure codes can be found on the ODM website at http://medicaid.ohio.gov at PROVIDERS > Fee Schedule and Rates > Schedules and Rates under CPT and HCPCS level II procedure codes.

2. **Where do I find an existing procedure code?**

   DME procedure codes are located in the appendices of Ohio Administrative Code (OAC) rule 5160-10-03 and Orthotic and Prosthetic codes are located in the appendices of rule 5160-10-20. They can be accessed on the Lawriter website at http://codes.ohio.gov/oac/.

   Codes are also located in Appendix DD of rule 5160-1-60. This rule, along with the appendix, can be found on the Lawriter website. The appendix can be found on the ODM website by following the pathway; PROVIDERS > Fee Schedule and Rate (click "I agree") > Schedules and Rates. It is found in the table of links under "Medicine, Surgery, Radiology and Imaging, and Additional Procedures (Non-Institutional Services)."

3. **Where do I find the reimbursement rate?**

   The reimbursement rates are located in the current appendices of OAC rules 5160-1-60, 5160-10-03, 5160-10-20 in MITS and the provider contracts on the MITS Portal at https://portal.ohmits.com/Public/Providers/tabId/43/Default.aspx. If no rate is listed, the item will be required to have pricing verification submitted.

4. **How do I know if a code is covered?**

This information on covered codes is located in the current appendices of rules 5160-1-60, 5160-10-03, 5160-10-20, the provider contracts, and in MITS.

Procedure codes are also found under MITS provider contracts on the ODM website. These are located by following the link, https://portal.ohmits.com/Public/Providers/tabId/43/Default.aspx or by clicking the MITS portal icon from the Providers tab, from there, click on fee schedules.

5. **How do I know which providers can cover a specific code?**

    This information is found within the MITS provider contracts at https://portal.ohmits.com/Public/Providers/tabId/43/Default.aspx. There are multiple contracts for different provider types. Specific providers can refer to their contracts. For DME, there are three contracts; Basic (DME) Durable, Durable Medical Equipment, and Special Licensed (DME). Codes can be individually checked in MITS.

6. **Where do I find the MITS contract rates?**

    The DME contract rates are at https://portal.ohmits.com/Public/Providers/tabId/43/Default.aspx.

7. **How do I know if a code is covered in a Long Term Care Facility (LTCF)?**

    This information is located in the specific rule and/or in the appendix of the rule and in MITS.

8. **Why can't I enter this prior authorization (PA)? I used to be able to enter it.**

    As a result of a departmental PA project that concluded with the removal of PA requirements for many codes in April 2016, the MITS system has been configured to prevent the entry of PA requests for items that do not require PA. Previously, MITS was configured to permit a PA submission for items that did not require a PA submission, now only PA required items can be submitted.

9. **How do I know which codes have been removed from PA as a result of the PA project?**

    When MITS does not permit the entry of a code, this generally indicates that a code has been removed from PA. The provider contracts indicate which items require a PA or not and which codes are considered to be situational.

10. **Where are the wheelchair codes?**

    The wheelchair codes are located in the appendix of the wheelchair rule with an effective date of 01.01.17.

11. **How do I know which items are direct bill first, then PA after?**

    This information is provided within the MITS contracts referenced in question 3.

    For example, code A4214, under the DME basic contract, shows an "S," which designates it as being situational; meaning that it is direct bill until the frequency limit is exceeded.

12. **What if I know I'm going to exceed the situational limit the first time I submit a PA? How do I submit it?**

This will require two separate submissions; first complete the direct bill process and once the limit is exceeded, complete the PA process.

13. **How do I know the reimbursement price when one isn't listed? How do I submit it?**

Previously, many items on PA required a price submission as part of the prior approval process. Many items have now been removed from PA, but still have no reimbursement price. While these codes no longer not require PA, they still require the submission of pricing verification.

The submission process remains the same as before, except prior approval is not needed. The submission of pricing is needed as no set fee has been established for the item in question.

14. **How do I check MITS to find the reimbursement rate? If the item is covered?**

MITS can be accessed by clicking on the "Provider Tab" on the Ohio Medicaid website home page. From there, click on the MITS icon. Next click on the "login" area, then log in. After you are logged in, click on "MMIS." You will arrive on the "Welcome" page, from here click on "Reference" on the upper tool bar. Next, click on "Procedure," this produces the "Reference Procedure Search" panel. Next to the word "Procedure" in the box within the panel, enter the code in question and hit "enter." This will bring up the next page with several panels containing information regarding the code. The first panel provides procedure information, the second panel provides the option to request more information regarding the code. Within the panel, click "Contract Billing Rules," "Max Fee," and "Reimbursement Rules." Clicking on these items will open up the corresponding panels further down the page. The "Max Fee" panel shows the amount that Ohio Medicaid can reimburse for the code in question; if there is no fee listed, the code will require pricing to be submitted. In order to receive reimbursement from Ohio Medicaid, the provider must be listed in both the "Contract Billing Rules" and the "Reimbursement Rules" panels.

15. **Why do I get a "not a valid group" response when entering a PA?**

Ohio Medicaid has removed the majority of codes from PA. In the past, the agency utilized "soft edits," meaning that although a code did not require PA, the system would permit the code to be entered for a PA. With the removal of codes from PA, the soft edits have been replaced with "hard edits." Now if a code does not require PA, the system will not permit it to be entered and an error message will be received.

Also of note, submissions that have both PA and non-PA items will be required to be entered separately; PA items through the PA process and non-PA items through the direct bill process.

16. **What if there is conflicting information between the above mentioned sources?**

If there is conflicting information, the most recent update would be considered the most accurate. For example, if a code is listed on appendix DD of 5160-1-60 as currently covered since 01.01.01 and the same code is listed as not covered in the CPT/HCPCS Level II Procedure Code Changes section on the ODM website as of 01.01.15, the code would be not covered as

the most recent update changed it from covered to non-covered. If there are still any questions, you may call the DME hotline at 1.614.466.1503 or e-mail the non-institutional mailbox at NONINSTITUTIONAL_POLICY@medicaid.ohio.gov (Note: the phone line and mailbox do not address specific PA questions).

17. **What is an audit?**

The term audit, when used in context with MITS, is the history (current and past) of a rule. It is the electronic configuration in MITS that ensures information is processed according to current rules and frequency limitations. For example, if code Z1234 has a utilization frequency of 1 item per month, MITS would be configured to permit the payment of this code to equal one per month.

If code Z1234 was part of a recent change where the previous utilization frequency was 1 item every 3 months, there would be a history showing that the item was on a different payment frequency prior to the current one at 1 item every 3 months. Although MITS would not be configured to pay at that frequency, that information would remain in the audit history.