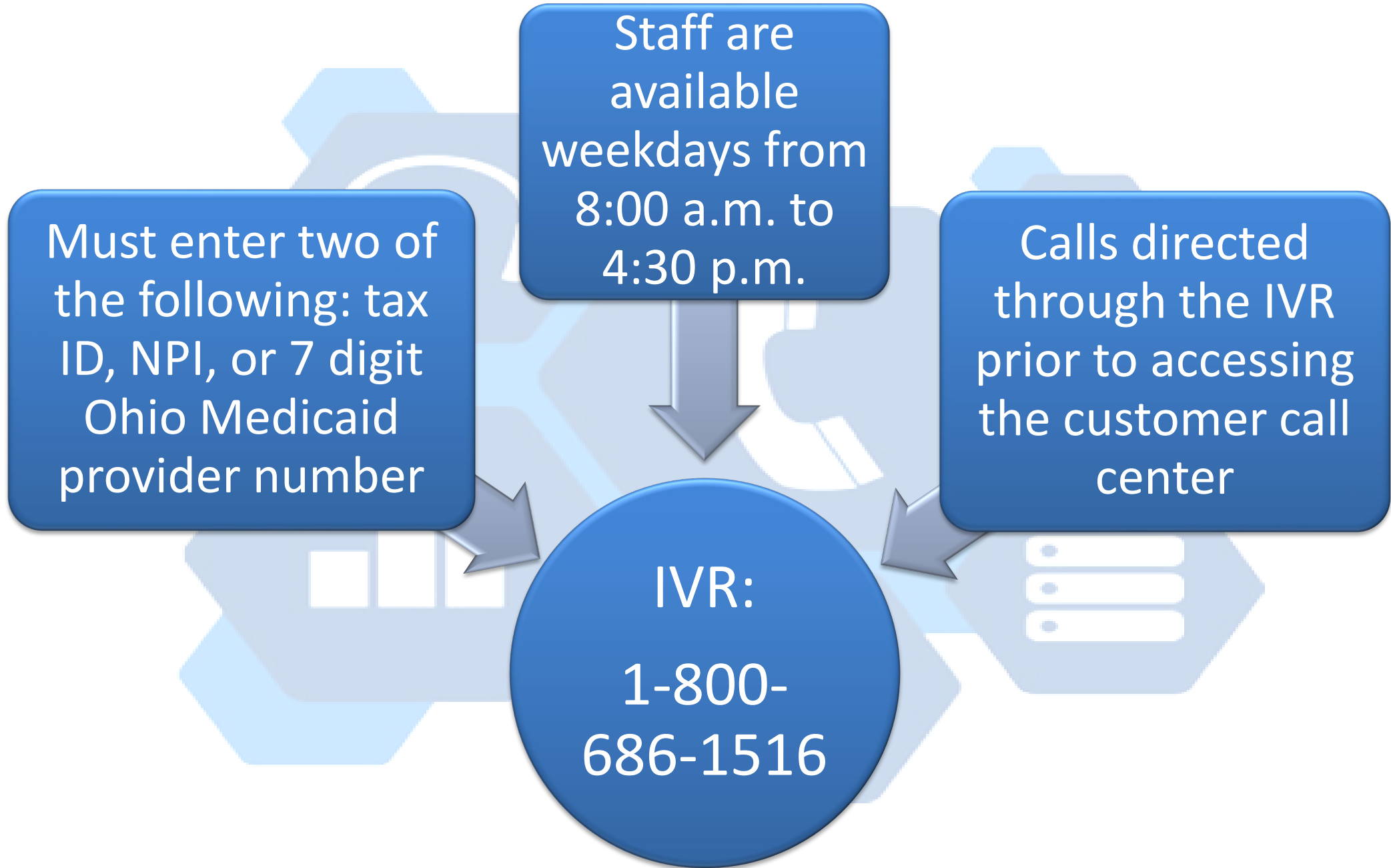


Basic Billing for Hospice

Provider Relations

2022



Helpful Phone Numbers

- OSHIIP (Ohio Senior Health Insurance Information Program)
1-800-686-1578

- Coordination of Benefits Section
614-752-5768
614-728-0757 (fax)



Medicaid Medical Necessity: OAC 5160-1-01

Is the fundamental concept underlying the
Medicaid Program



All services must meet accepted standards of
medical practice

Ohio Medicaid Covers:



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

Programs & Cards

Programs & Cards

- Ohio Medicaid
 - » This card is the traditional fee-for-service Medicaid card
 - » Issued annually as of October 1, 2018

Tear on Perforation

<p>Notice to Consumer: Please carry this card with you at all times and present this card whenever you request Medicaid services. If this card is lost or stolen, contact the county department of job and family services at once.</p> <p>Notice to Providers of Medical Services: If there is evidence of tampering or if this card is mutilated, contact the local county department of job and family services or check the Provider MITS Portal for eligibility. Questions regarding claims for service or eligibility should be directed to Provider Services at 1-800-686-1516.</p> <p>Note: Use the Medicaid ID for all claim submissions.</p> <p>medicaid.ohio.gov</p> <p>Consumer's Signature: _____</p>	<p>County BUTLER</p> <p>Case Number 012345678910</p> <p>Eligibility Begin Date 07/01/2013</p> <p>Void After Date 08/30/2013</p> <p>Ohio Department of Medicaid medicaid.ohio.gov</p> <p>Consumer Hotline: 1-800-324-8680 [or TTY 1-800-292-3572]</p>
--	--

Tear on Perforation

Fold

Tear on Perforation

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

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





Full Medicaid eligibility on the MITS Portal will show **four** benefit spans:

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

Additional spans when applicable:

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

Eligibility Verification Request

The screenshot shows the Ohio Department of Medicaid website. At the top, there is a navigation bar with the Ohio Department of Medicaid logo and several menu items: FAMILIES & INDIVIDUALS, RESOURCES FOR PROVIDERS (which is underlined), STAKEHOLDERS & PARTNERS, and OUR STRUCTURE ABOUT US. There are also icons for Help and Search. Below the navigation bar, there is a section titled 'Resources for Providers >' with a brief introductory paragraph. A grid of resource cards follows, with 'Billing' and 'Training' highlighted by red boxes. Below the grid, there are four more resource cards: 'Fee Schedule & Rates', 'Training' (highlighted), 'TPL Carrier List', and 'Direct Deposit'. At the bottom of the screenshot, there is a section titled 'Training Videos' with a list of links, including 'Eligibility Search' which is also highlighted by a red box.

Billing > COVID-19 > Enrollment & Support > Managed Care >

Provider billing and data exchange related instructions, policies, and resources. Ohio Department of Medicaid COVID-19 Resources and Guides for Providers. Ohio Medicaid is changing the way we do business. We are streamlining provider enrollment and support services to make it easier for you to. The next generation of Ohio Medicaid managed care is designed to improve wellness and health outcomes, support providers in better.

MITS > Policies & Guidelines > Programs & Initiatives >

Medicaid Information Technology Information System (MITS) Resources. Ohio Medicaid policy is developed at the federal and state level. It guides how we operate our programs and how we regulate our. The Ohio Department of Medicaid has many programs and initiatives to enhance the quality of care for patients and support our providers in the.

Fee Schedule & Rates
Disclaimer about fee schedule and rates available for providers.

Training
Training presentations, videos, and handouts.

TPL Carrier List
Click download to obtain the full listing of Third Party Carrier list and numbers

Direct Deposit
OBM Shared Services is a business processing center that processes common administrative

Training Videos
Ohio Medicaid has created a compilation of training videos that cover a variety of topics for providers. If questions remain after reviewing these videos, contact Ohio Medicaid Provider Assistance at 1-800-686-1516.
Check back frequently as training videos will be added as needed. If there are issues viewing these videos, make sure your pop-up blocker is turned off.

- [Presumptive Eligibility \(PE\) Portal Walk Through for Qualified Entities](#)
- [How to Setup a MITS Agent Account and Access Reports](#)
- [Eligibility Search](#)

Eligibility Verification Request

You can search up to 4 years back

The screenshot shows the Ohio Department of Medicaid website interface. At the top left is the Ohio Department of Medicaid logo. To the right is a search bar with a 'Search' button. Below the logo is a navigation menu with links: Welcome, Super User, Providers, Cost Report, CPC Performance, Account, Trading Partners, Claims, Episode Claims, Eligibility (highlighted), Prior Authorization, Reports, Portal Admin, Security, Trade Files, and Admin. Under the 'Eligibility' link, there are sub-links: eligibility search (highlighted), deemed eligible newborn, presumptively eligible child, presumptively eligible pregnant woman, psychiatric admission, and hospice enrollment. The main section is titled 'Eligibility Verification Request' and contains the following fields: Medicaid Billing Number, SSN, Procedure Code, Birth Date, DOS Date Format (dropdown menu), From DOS (07/16/2017), and To DOS (07/15/2021). There are 'search' and 'clear' buttons at the bottom right of the form. A note at the bottom states: '*This information is only valid for 'from date' to end of the month searched.'

TIP: Always check eligibility prior to billing

Eligibility Verification Request

- The effective and end dates of will be based off the dates used in the search
- The associated child(ren) search will bring up any child associated with the member's ID

Recipient Information	
Medicaid Billing Number	SSN
Last Name	County of Residence
First Name	County of Eligibility
Gender	County Office http://jfs.ohio.gov/County/County_Directory.pdf
Date of Birth	Number Bed Hold Days Used Paid CY
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	07/01/2017	07/31/2021		\$0.00	\$0.00
MRDD Targeted Case Mgmt	07/01/2017	07/31/2021		\$0.00	\$0.00
Alcohol and Drug Addiction Services	07/01/2017	07/31/2021		\$0.00	\$0.00
Ohio Mental health	07/01/2017	07/31/2021		\$0.00	\$0.00
Medicaid	07/01/2017	07/31/2021		\$0.00	\$0.00

Associated Child(ren)					
Medicaid Billing Number	First Name	MI	Last Name	Gender	Date of Birth
910700745972	IMPERIAL		SMITH	MALE	09/07/2012
910700745973	CARTIER		JONES	MALE	01/15/2008

Eligibility Verification Request

If an individual has a third-party payer, you can find that information under the TPL panel

TPL									
Carrier Name	Carrier Number	NAIC	Policy Number	Policy Holder	Coverage Type	Coverage	Effective Date	End Date	Group Number
AARP HEALTH CARE	00570		082020820-1		IND	INPATIENT COVERAGE	01/30/2021	01/31/2021	PLAN-NV
AARP HEALTH CARE	00570		082020820-1		IND	PHYSICIAN/OUTPATIENT COVERAGE	01/30/2021	01/31/2021	PLAN-NV
AETNA US HEALTH	00250		W116611666		IND	INPATIENT COVERAGE	01/30/2021	01/31/2021	724775
AETNA US HEALTH	00250		W116611666		IND	PHYSICIAN/OUTPATIENT COVERAGE	01/30/2021	01/31/2021	724775

Managed Care				
Plan Name	Plan Description	Effective Date	End Date	Managed Care Benefits
CARESOURCE	HMO, CFC	01/01/2021	01/31/2021	

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

Medicare					
Coverage	Effective Date	End Date	Plan Name	Plan ID	Medicare ID
PART A	12/01/2020	12/08/2020			272027209D6
PART B	12/01/2020	12/08/2020			272027209D6

Service Limitation	
*** No rows found ***	

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

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
- Combined effort with ODRC, Ohio MHAS, ODH, and MCPs
- All DRC facilities activated by January 2017
- More than 20,000 individuals have benefited from this program

DRC Inpatient Hospitalization



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

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

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

Inpatient Hospital Services Plan (IHSP)

If an individual has an IHSP benefit, the benefit / assignment plan panel will show this:

Recipient Information						
Medicaid Billing Number						SSN
Last Name						County of Residence
First Name						County of Eligibility
Gender						County Office http://jfs.ohio.gov/county/cntydir.stm
Date of Birth						Number Bed Hold Days Used Paid CY
Date of Death						
Benefit / Assignment Plan						
Benefit / Assignment Plan	Effective Date	End Date	Provider Name		Dental Co-Pay Amount	Vision Co-Pay Amount
Inpatient Hospital Services Plan	07/01/2021	07/31/2021			\$0.00	\$0.00

Presumptive Eligibility


Covers children up to age 19 and pregnant women



Was expanded to provide coverage for parent and caretaker relatives and extension adults



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



Presumptive Eligibility

- Hospitals and Federally Qualified Health Centers (FQHCs) are eligible to participate in Ohio's presumptive eligibility initiative
- To become a Qualified Entity complete the steps described here:
 - <https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/billing/presumptive-eligibility-training/presumptive-eligibility-training>

Presumptive Eligibility

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

Presumptive Eligibility

MISSISSIPPI RIVERS
21 S FRONT ST
COLUMBUS, OH 43215

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 household income, U.S. citizenship or qualified alien status, Ohio residency, and pregnancy (if applicable).

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
MISSISSIPPI RIVERS	01/01/1987	PE PREGNANT	05/09/2021	910001331813

Presumptive Eligibility

Other members will receive this Presumptive Eligibility letter:

CDJFS Presumptive Eligibility

John Doe
123 Main St.
Anytown, OH 43210

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

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

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

APPROVED:

Name (First, M.I., Last Name)	Date of Birth	PE Type	Date Coverage Begins	Medicaid ID
John Doe	11/19/1959	PE Adult	06/25/2021	910194194194

Presumptive Eligibility

The benefit/assignment plan will look like this:

Recipient Information	
Medicaid Billing Number	SSN
Last Name	County of Residence
First Name	County of Eligibility
Gender	County Office http://jfs.ohio.gov/county/cntydir.stm
Date of Birth	Number Bed Hold Days Used Paid CY
Date of Death	

Benefit / Assignment Plan					
Benefit / Assignment Plan	Effective Date	End Date	Provider Name	Dental Co-Pay Amount	Vision Co-Pay Amount
PRESUMPTIVE:MRDD Targeted Case Mgmt	02/14/2019	09/30/2021		\$0.00	\$0.00
PRESUMPTIVE:Alcohol and Drug Addiction Services	02/14/2019	09/30/2021		\$0.00	\$0.00
PRESUMPTIVE:Medicaid	02/14/2019	09/30/2021		\$0.00	\$0.00
PRESUMPTIVE:Ohio Mental health	02/14/2019	09/30/2021		\$0.00	\$0.00

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: MM11230 Revised Release Date of Revised Article:
July 3, 2019**

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 for covered items and services (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 system updates are part of CMS' ongoing efforts to help providers comply with QMB billing prohibitions.



QMB

Qualified Medicare Beneficiary will show up in the benefit/assignment plan panel

Recipient Information						
Medicaid Billing Number				SSN		
Last Name				County of Residence		
First Name				County of Eligibility		
Gender	0			County Office http://jfs.ohio.gov/County/County_Directory.pdf		
Date of Birth				Number Bed Hold Days Used Paid CY		
Date of Death						
						Associated Child(ren) Search
Benefit / Assignment Plan						
Benefit / Assignment Plan	Effective Date	End Date	Provider Name	Dental Co-Pay Amount	Vision Co-Pay Amount	
Qualified Medicare Beneficiaries	10/24/2016	06/30/2021		\$0.00	\$0.00	

**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**

SLMB and QI 1 / QI 2

This is what will appear in the benefit/assignment plan panel if the individual has SLMB:

Benefit / Assignment Plan						
Benefit / Assignment Plan	Effective Date	End Date	Provider Name	Dental Co-Pay Amount	Vision Co-Pay Amount	
SLMB	05/01/2017	07/31/2021		\$0.00	\$0.00	

This is what will appear if the individual has QI 1/QI 2:

Benefit / Assignment Plan						
Benefit / Assignment Plan	Effective Date	End Date	Provider Name	Dental Co-Pay Amount	Vision Co-Pay Amount	
QI 1/QI 2	04/26/2017	07/31/2021		\$0.00	\$0.00	

Managed Care & MyCare Ohio

aetna[®]

AETNA BETTER HEALTH[®] OF OHIO


buckeye
health plan.


CareSource[®]


PARAMOUNT
HEALTH
CARE


MOLINA[®]
HEALTHCARE

 UnitedHealthcare[®]

Oversight of Managed Care Plans

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

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)

Managed Care Benefit Package

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

Some value-added services:



Online searchable provider directory



Toll-free 24/7 hotline for medical advice



Expanded benefits including additional transportation options plus other incentives



Care management to help members coordinate care

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

MITS Managed Care Eligibility

If an individual is enrolled in a Managed Care Plan, the plan information will be shown in the Managed Care panel along with the effective and end dates.

Benefit / Assignment Plan					
Benefit / Assignment Plan	Effective Date	End Date	Provider Name	Dental Co-Pay Amount	Vision Co-Pay Amount
MRDD Targeted Case Mgmt	01/01/2019	10/31/2021		\$0.00	\$0.00
Alcohol and Drug Addiction Services	01/01/2019	10/31/2021		\$0.00	\$0.00
Ohio Mental health	01/01/2019	10/31/2021		\$0.00	\$0.00
Medicaid	01/01/2019	10/31/2021		\$0.00	\$0.00
MRDD Targeted Case Mgmt	10/24/2018	12/31/2018		\$0.00	\$0.00
Alcohol and Drug Addiction Services	10/24/2018	12/31/2018		\$0.00	\$0.00
Ohio Mental health	10/24/2018	12/31/2018		\$0.00	\$0.00
Medicaid	10/24/2018	12/31/2018		\$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, CFC	10/24/2018	10/31/2021		

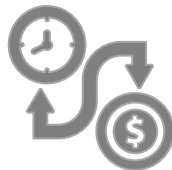
Traditional Managed Care Contracting

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, 2022

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

MITS Eligibility MyCare Opt-In

If an individual's Medicaid **and** Medicare benefits are covered by the Managed Care Plan, you will see **dual benefits**.

Managed Care					
Plan Name	Plan Description	Effective Date	End Date	Managed Care Benefits	
BUCKEYE COMMUNITY HEALTH PLAN	HMO, MyCare Ohio	10/24/2018	09/30/2021	Dual Benefits	

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

Medicare					
Coverage	Effective Date	End Date	Plan Name	Plan ID	Medicare ID
PART A	10/24/2018	10/31/2019			2YU3Q39WU99
PART B	10/24/2018	10/31/2019			2YU3Q39WU99
PART C	10/24/2018	09/30/2021	BUCKEYE HEALTH PLAN - MYCARE OHIO	H0022	2YU3Q39WU99
PART D	10/24/2018	10/31/2019	*H0022/001	001	2YU3Q39WU99

MIT S Eligibility MyCare Opt-Out

If the Managed Care Plan covers **only** the individual’s Medicaid benefits, you will see **Medicaid Only**.

Managed Care				
Plan Name	Plan Description	Effective Date	End Date	Managed Care Benefits
MOLINA HEALTHCARE OF OHIO INC	HMO, MyCare Ohio	07/01/2018	09/30/2021	Medicaid Only

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

Medicare					
Coverage	Effective Date	End Date	Plan Name	Plan ID	Medicare ID
PART A	10/30/2016	10/31/2019			9RG7AP3AF00
PART B	10/30/2016	10/31/2019			9RG7AP3AF00
PART C	08/01/2017	09/30/2021	AARP MEDICARERX PREFERRED (PDP)	013	9RG7AP3AF00
PART D	06/01/2018	09/30/2021	CVS CAREMARK VALUE (PDP)	028	9RG7AP3AF00

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>

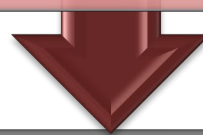


800-600-9007 <https://www.uhccommunityplan.com/>

PROVIDER COMPLAINTS

Provider licensure issues

Send to Ohio Department of Insurance (ODI)



Certification issues

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



Work directly with the Plan first

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

Medicaid.ohio.gov > Resources for Providers > Managed Care

Submitting a Managed Care Complaint

The screenshot shows the Ohio Department of Medicaid website. The top navigation bar includes the Ohio Department of Medicaid logo and links for FAMILIES & INDIVIDUALS, RESOURCES FOR PROVIDERS (which is underlined), STAKEHOLDERS & PARTNERS, and OUR STRUCTURE ABOUT US. There are also Help and Search icons. Below the navigation bar is the 'Resources for Providers' section, which includes a sub-header and a paragraph of text. A grid of links is displayed, with 'Managed Care' highlighted by a red box. The 'Managed Care' link has a description: 'The next generation of Ohio Medicaid managed care is designed to improve wellness and health outcomes, support providers in better...'. Other links include Billing, COVID-19, Enrollment & Support, Managed Care, MITS, Policies & Guidelines, and Programs & Initiatives.

Provider Inquiries

Providers should contact the associated managed care organization (MCO) for assistance before submitting a complaint (see hyperlink below) to the Ohio Department of Medicaid (ODM).

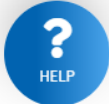
Providers should [contact](#) the MCO's provider services line and/or their regional provider relations representative. Providers are encouraged to use the appeals, grievance, or arbitration processes as outlined in their individual contract with that MCO. If the MCO or MCO's representative do not return a provider's call within five business days, the provider may complete the provider complaint form below.

All complaints submitted are sent immediately to the corresponding MCO for response. Please note the MCOs will have up to 15 business days to respond.

The provider inquiry guidance document and inquiry form are located [HERE](#). Ensure your pop-up blocker is turned off.

Need Technical Assistance?
Give us a call on our Provider Hotline 800-686-1516.

Access the MITS Portal
Medicaid Information Technology System



Submitting a Managed Care Complaint

Provider Complaint Form Guidance

The Ohio Department of Medicaid (ODM) maintains a managed care organization (MCO) complaint form. This can be used by any provider who has first attempted to work directly with the plan but has been unsuccessful in getting an appropriate response. Before submitting a complaint, providers should check the plan's Claims Payment Systemic Errors (CPSE) report for the issue in question.

MCO's receive these complaints directly, in real time, and have **15 business days to respond to the provider with a resolution**. Providers are encouraged to utilize the appeals, grievance, or arbitration processes as outlined in their individual contract with the plan. ODM staff review complaints to verify whether the plan has contacted the provider and given an answer to their question(s). ODM staff cannot arbitrate between the plan and providers.

Please note: ODM does not follow-up with all providers on complaints submitted. ODM reviews all complaints and tracks trends.

Submitting a Managed Care Complaint

Submission Tips:

Providers may add supporting documentation directly onto the provider complaint form.

If multiple individuals are affected by a single issue with a plan, the provider is to submit only one complaint for all individuals, however, up to 5 attachments may be uploaded on a single complaint.

NEW If the provider submits multiple complaints for the same issue (different individuals, dates of service, practitioners, or files affected), ODM will cancel all duplicate complaints, contact the provider, and request that a single new complaint be submitted for all files affected.

NEW If a group provider is submitting a complaint, the “Filing Party Name” on the complaint should list the group’s name and not the individual practitioner.

NEW Proper contact information for the person listed in the “Follow-up Name” field must be entered. The plans may attempt to contact the provider via telephone conversation, voicemail left, or email sent. If the plan is continuously unable to reach the listed contact, ODM may close the complaint without direct provider contact.

Submitting a Managed Care Complaint

Fill out the complaint form completely. You will receive a confirmation email once submitted with a confirmation number (C#####).

OH Medicaid *Managed Care* Provider Complaint Form

Instructions

This form is for Managed Care providers only. Providers must challenge the decision of all denied claims and prior authorizations with the Managed Care Organization (MCO) using the appropriate processes (appeal, dispute, etc.) before the Ohio Department of Medicaid will process a complaint. If your complaint involves multiple MCOs, please complete one form per MCO. The resolution time frame for Managed Care complaints is 15 business days. If you have a complaint regarding Medicaid Fee For Service please call 1-800-686-1516.

Complaint Details

MCO Name: *

Complaint Reason: *

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

Provider/Follow-up Details

Provider Name: * Follow-up Name: *

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

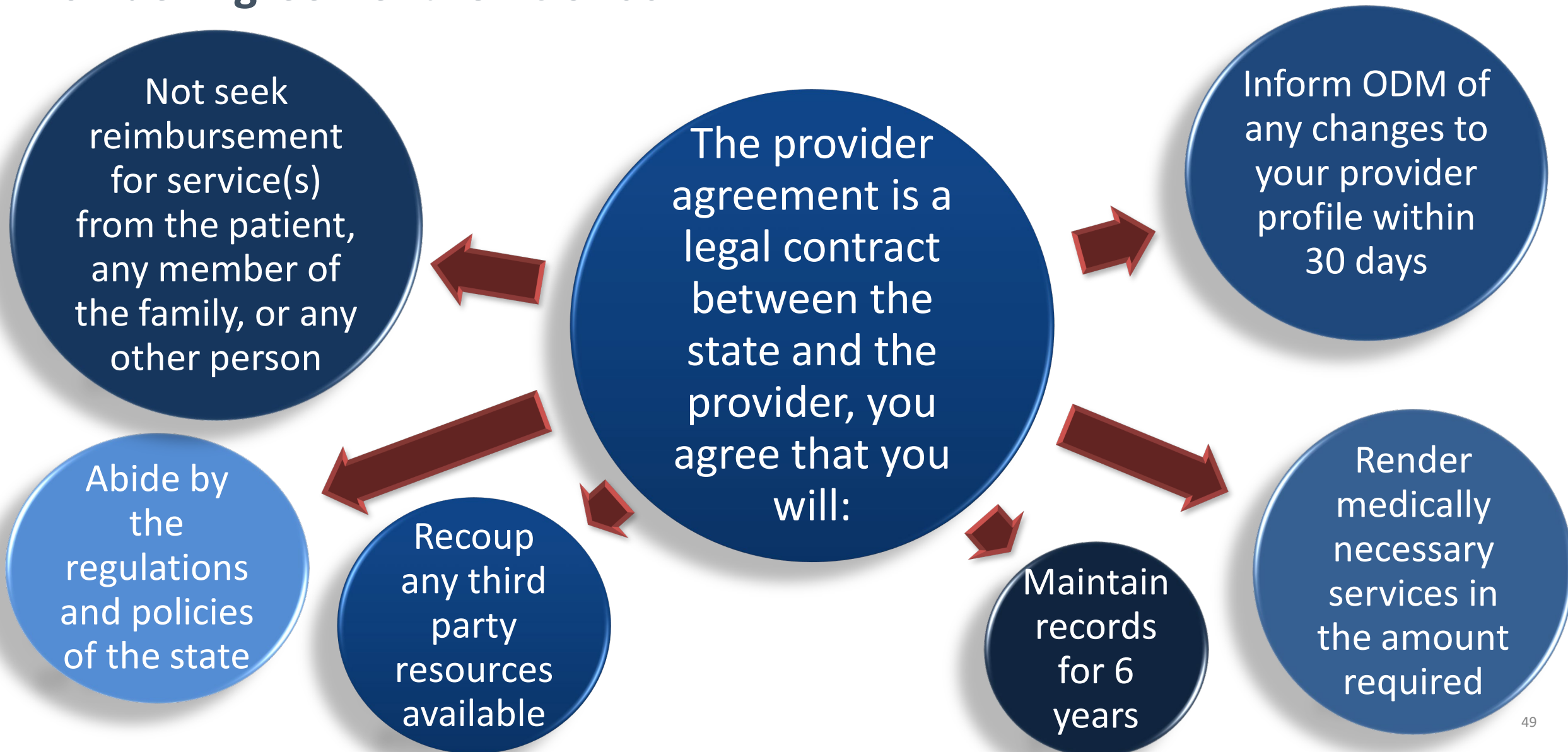


Providers may enroll as an ORP-only provider or as a Medicaid billing provider



Online applications can be found on our website

Provider Agreement: OAC 5160-1-17.2



Updating Demographic Information in MITS

Per OAC 5160-1-17.2(F), providers must inform ODM of any changes within 30 days

Welcome

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

demographic maintenance 1099 information provider faq mits days report correspondence self attestation ordering/referring/ prescribing search group affiliation group members cpc group cpc group members cpc accreditations cpc attestations attestations

Service Location > Location Name Address > Service Language > 1099 Mailing Address

Provider Information			
Medicaid Provider ID	0404040 MCD	Address Type	PRACTICE LOCATION
National Provider ID	1578515763 NPI	Address	1111 COLONY RD
Practice Type	OTHER		
Provider Type	86 - NURSING FACILITY	City	WESTERVILLE
Ownership	NO	County	FRANKLIN
Medicaid Effective Date	08/03/1979	State/Zip	OH 43081-3624
Medicaid End Date	05/19/2021	Phone	614-505-5055

Provider Reimbursement: OAC 5160-1-02 & 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 Recipient Liability: OAC 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:

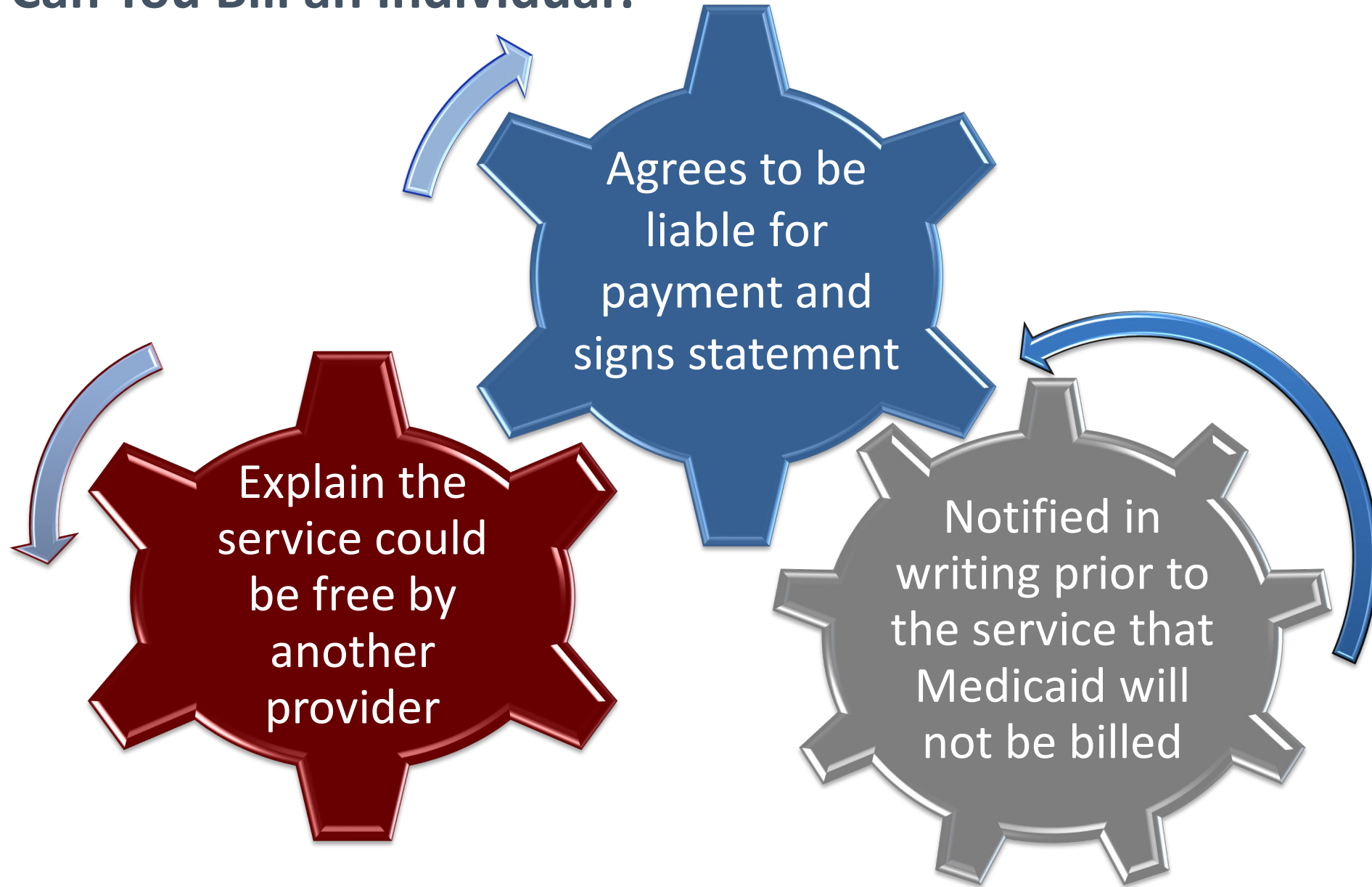
Missed appointment fee

Unacceptable or untimely claim submission

Failure to request a prior authorization

Retroactive Peer Review stating lack of medical necessity

When Can You Bill an Individual?



When Can You Bill an Individual?

- The statement must be signed before the service is rendered. If the service requires multiple visits, this must be done prior to each visit.
- This cannot be done if the service is a prescription for a controlled substance

5160-1-13.1 Medicaid recipient liability

Date of service: _____

Type of service: _____

Name & account number: _____

Billing number: _____

(C) A provider may bill a Medicaid recipient for a Medicaid covered service in lieu of submitting a claim to the Ohio department of Medicaid (ODM) only if all of the following conditions are met:

- _____ (1) The provider explains to the Medicaid recipient that the service is a covered Medicaid service and other Medicaid providers may render the service at no cost to the individual;
- _____ (2) Prior to each date of service for the specific service rendered, the provider notifies the Medicaid recipient in writing that the provider will not submit a claim to ODM for the service;
- _____ (3) The Medicaid recipient agrees to be liable for payment of the service and signs a written statement to that effect before service is rendered; and
- _____ (4) The Medicaid covered service is not a prescription for a controlled substance as defined in section 3719.01 of the Revised Code.

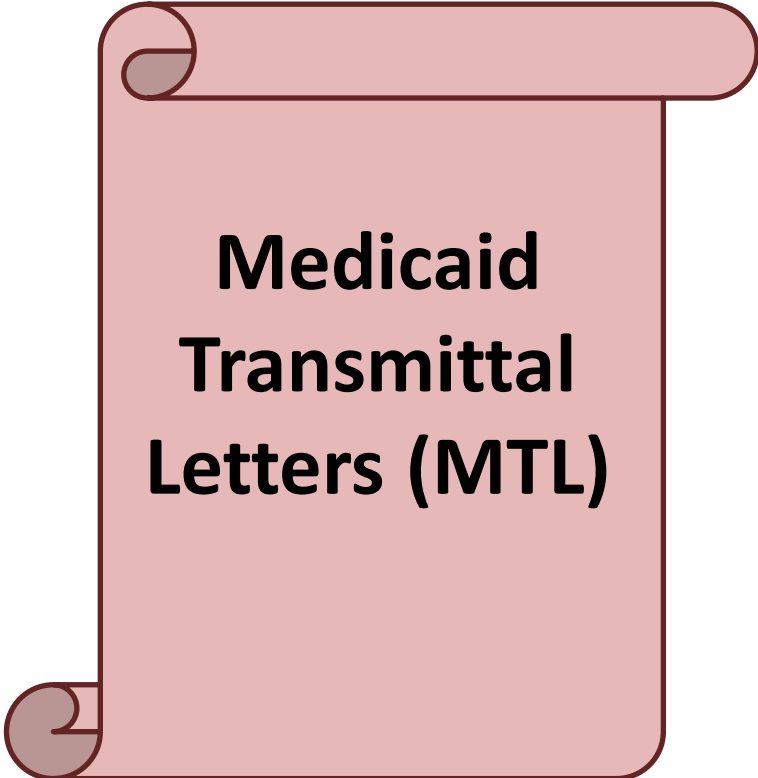
(D) Services that are not covered by the Medicaid program, including services requiring prior authorization that have been denied by ODM, may be billed to a Medicaid recipient when the condition in paragraphs (C)(2) through (C)(4) of this rule are met.

(E) Any individual not covered by Medicaid on the date of service is financially responsible for those services unless the individual qualifies for the hospital care assurance program (HCAP) in accordant with section 5168.14 of the Ohio Revised Code.

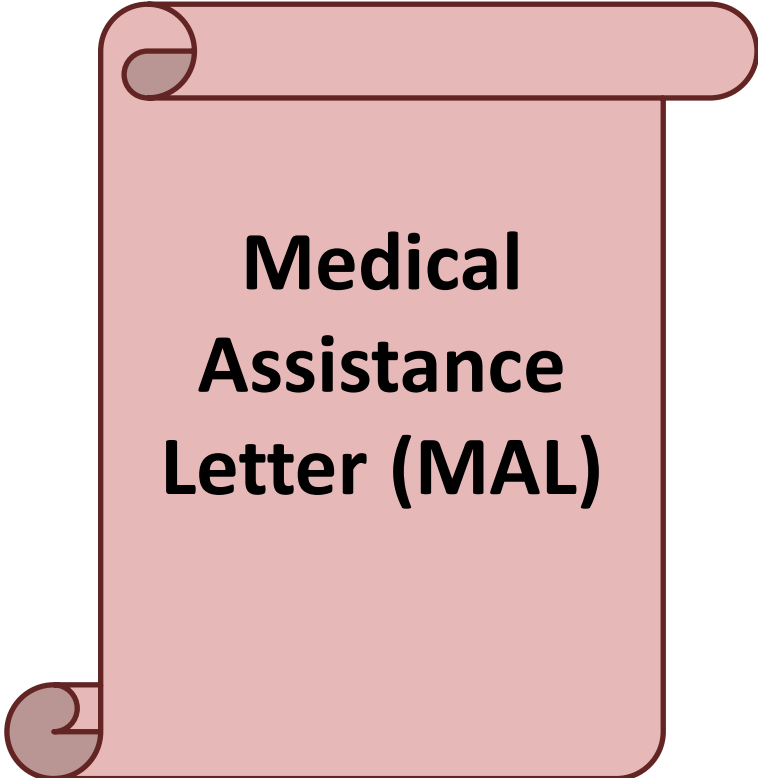
Signature _____ Date _____

Policy

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



**Medicaid
Transmittal
Letters (MTL)**



**Medical
Assistance
Letter (MAL)**

Policy

Resources for Providers >

The relationship between Ohio Medicaid and its provider network is critical to ensuring the individuals we serve receive quality care when they need it. We are listening to your feedback and easing administrative burden to allow more time for you to spend with patients. After all, Ohio Medicaid is i...

Billing Provider billing and data exchange related instructions, policies, and resources.	COVID-19 Ohio Department of Medicaid COVID-19 Resources and Guides for Providers	Enrollment & Support Ohio Medicaid is changing the way we do business. We are streamlining provider enrollment and support services to make it easier for you to	Managed Care The next generation of Ohio Medicaid managed care is designed to improve wellness and health outcomes, support providers in better
MITS Medicaid Information Technology Information System (MITS) Resources	Policies & Guidelines Ohio Medicaid policy is developed at the federal and state level. It guides how we operate our programs and how we regulate our	Programs & Initiatives The Ohio Department of Medicaid has many programs and initiatives to enhance the quality of care for patients and support our providers in the	

Prior Authorization Requirements Prior Authorization Requirements	Medicaid Eligibility Procedure Letters (MEPLs) Announcements of non-OAC policy changes that affect Medicaid eligibility	Medicaid Eligibility Manual Transmittal Letters (MEMTLs) Summaries of OAC rule changes concerning Medicaid eligibility	Medicaid Transmittal Letters (MTLs), Medicaid Handbook Summaries of OAC rule changes concerning non-institutional services
Medicaid Advisory Letters (MALs) Clarifications of non-institutional services policy not related directly to OAC rule changes	Hospital Handbook Transmittal Letters (HHTLs) Summaries of OAC rule changes concerning hospital services	eManuals (Pre-July 2015) Archive of policy documents dating from a time when Medicaid was part of the Ohio	Managed Care Policy Guidance Letters Clarifications of policy pertaining to Medicaid managed care



Policy

Stakeholders & Partners >

Ohio Medicaid achieves its health care mission with the strong support and collaboration of our stakeholder partners - state health and human services agencies, associations, advocacy groups, and individuals who help us administer the program today and modernize it for the next generation of ...

CMP Reinvestment Program >

Civil money penalties (CMPs) are fines imposed on nursing facilities that do not meet federal health and safety standards.

Helpful Links >

Not seeing what you are looking for? We want to help you find the information you need. Check out these links to federal and state

Initiatives >

The Ohio Department of Medicaid is dedicated to being a national leader in health care coverage innovation. In collaboration with our

Legal and Contracts >

We want to make it easier for you to do business with us. This page includes important information and links for vendors and others

Reports & Research >

Ohio Medicaid values transparency and accountability in all we do. We are committed to providing our stakeholders and partners with

Ohio Revised Code.

If you would like more information on the Ohio Department of Medicaid rule-making process, please contact Rules@medicaid.ohio.gov.

Rules in Effect

These are the rules that the Ohio Department of Medicaid has adopted and added to the Ohio Administrative Code.

- [Medicaid Program Rules, Section 5160](#)
- [Medicaid Program Rules, Section 5160:1](#)

In addition, you can view these rules from our on-line program manuals.

Draft Rules

These are rules that Ohio Medicaid staff are drafting and editing, but have not yet been formally proposed for adoption. As part of the public participation process, the Ohio Department of Medicaid solicits and encourages input from affected organizations and individuals.

Rules Statutes

- [ORC - Ohio Revised Code](#)
- [CFR - Code of Federal Regulations](#)
- [Title 19 - Compilation Of The Social Security Laws](#)
- [OAC - Ohio Administrative Code](#)

Rule Renumbering

- [Rules Renumbering](#)

Medicaid Regulatory Restriction Inventory

- [Medicaid Regulatory Restriction Inventory](#)

Rule Related Sites

- [Common Sense Initiative Office](#)



Policy

<https://codes.ohio.gov>

OHIO LAWS & ADMINISTRATIVE RULES
LEGISLATIVE SERVICE COMMISSION

HOME LAWS ABOUT CONTACT RELATED SITES

Welcome! Effective April 1, 2021, the Legislative Service Commission has assumed publication of the Ohio Revised Code and the Ohio Administrative Code at this site. The Lawriter site has expired.

Ohio's Official Online Publication of State Laws and Regulations

Ohio law consists of the [Ohio Constitution](#), the [Ohio Revised Code](#) and the [Ohio Administrative Code](#). The Constitution is the state's highest law superseding all others. The Revised Code is the codified law of the state while the Administrative Code is a compilation of administrative rules adopted by state agencies. Use the tools on this site to search or browse them all.

[Learn More](#)

Ohio Constitution | Browse

Keyword Search

Ohio Revised Code | Browse

Keyword Search

Ohio Administrative Code | Browse

Keyword Search

Hospice Services Reporting Requirements: 5160-56-03.3

➤ Hospice Enrollment

- Must be completed and processed on the MITS Provider Portal
- Only for Individuals in fee-for-service Medicaid, not those enrolled into a managed care plan
- All Individuals in which hospice is seeking reimbursement after all other payers
- Must provide all required information in order for the hospice enrollment to process or billed claims will not pay

Hospice Services Reporting Requirements: 5160-56-03.3

➤ Hospice Enrollment

- All individuals with routine home care, T2042, for DOS on or after 1/1/16
- Any individual, for any hospice service, where an original claim needs to be submitted
- Any individual, for any hospice service, where a claim needs to be adjusted

Hospice Services Reimbursement: OAC 5160-56-06

➤ Service Intensity Add-On (SIA) Codes

- Payment for routine home care by an RN or licensed social worker within the last 7 days of life, when the discharge from hospice is due to death
- Billed using code G0299, for direct care by in-person visit from an RN
- Billed using code G0155, for direct care by in-person visit from a social worker
 - Should not be billed until after the individual has passed away
 - May be billed individually as long as T2042 was already billed and paid
 - Can be billed on the same claim as T2042 for those days

Hospice Services Reimbursement: OAC 5160-56-06

- Hospice procedure codes based on level of care:
 - Code **T2042** used for one unit per day to bill routine home care for an individual not receiving continuous home care
 - Reimbursement is paid using a two-tiered system based on the Episode of Care:
 1. During the first episode, the per diem is paid at a higher rate; the lower rate is paid for days 61 and after
 2. A gap in hospice services of more than 60 days is required to reset the counter that determines which per diem to apply
 3. A subsequent episode begins after a break in services of 60 days or more; the higher rate will again be paid for the first 60 days of the new episode

Hospice Services Reimbursement: OAC 5160-56-06

- Hospice procedure codes based on level of care:
 - Code **T2043** used for one unit per hour, with a minimum of eight hours per day, for continuous home care
 - Code **T2044** used for one unit per day for inpatient respite care
 - Code **T2045** used for one unit per day for general inpatient care
 - **GT** modifier used when any component of service is delivered via telehealth, in addition to the appropriate procedure code
 - T2044 and T2045 are not eligible to be provided via telehealth

Hospice Services Reimbursement: OAC 5160-56-06

- Hospice may receive R&B payments for individuals who are residents, overnight, of nursing facilities or ICF-IID facilities
 - Bill for R&B using procedure code T2046
 - Reimbursed at 95% of the rate established for the Long-Term Care Facility (LTCF)
- Only for days the individual receives routine home care or continuous care
- Bill even if the days are compensated via patient liability

Hospice Services Reimbursement

- When a hospice member is residing in a nursing facility (NF) and discharges from hospice, the date of discharge is billable by the hospice provider
- If a hospice member is residing in a NF and passes away, room and board on the date of death is not billable by the hospice provider
 - Routine home care services are billable for the date of death

MIT S

Billing Resources

Resources for Providers >

The relationship between Ohio Medicaid and its provider network is critical to ensuring the individuals we serve receive quality care when they need it. We are listening to your feedback and easing administrative burden to allow more time for you to spend with patients. After all, Ohio Medicaid is i...

Billing >

Provider billing and data exchange related instructions, policies, and resources.

COVID-19 >

Ohio Department of Medicaid COVID-19 Resources and Guides for Providers

Enrollment & Support >

Ohio Medicaid is changing the way we do business. We are streamlining provider enrollment and support services to make it easier for you to

Managed Care >

The next generation of Ohio Medicaid managed care is designed to improve wellness and health outcomes, support providers in better

MITS >

Medicaid Information Technology Information System (MITS) Resources

Policies & Guidelines >

Ohio Medicaid policy is developed at the federal and state level. It guides how we operate our programs and how we regulate our

Programs & Initiatives >

The Ohio Department of Medicaid has many programs and initiatives to enhance the quality of care for patients and support our providers in the



Fee Schedule & Rates



Trading Partners



How To Refund Payments



PHARMACY CLAIMS:

- [ODM Pharmacy Benefits](#)



Need Technical Assistance?

Give us a call on our Provider Hotline 800-686-1516.



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)

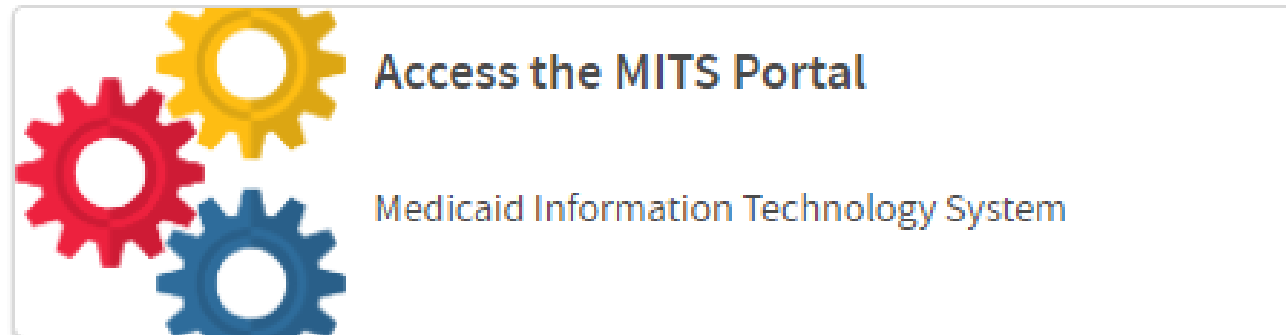
Internet Explorer version 10 or higher and current versions of Firefox or Chrome

Mac users use current version of Safari, Firefox, or Chrome

Turn **OFF** pop up blocker functionality

How to Access the MITS Portal

- Go to <https://Medicaid.ohio.gov>
- Select the “Resources for Providers” tab at the top
- Click on “MITS”
- Scroll down and click “Access the MITS Portal” on the right



Ohio Department of Medicaid

About ODM | Our Services | Resources | News & Events

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

enrollment enrollment tracking search long-term care account setup

Ohio Department of Medicaid

Provider Home

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

Login to secure site

Click Here to Login

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

You will be directed to another page where you will need to enter your user ID and password

Ohio.gov Medicaid Information Technology System

Sign In
Medicaid Information Technology System

To sign in, please enter your User ID and Password

User ID:

Password:

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

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

Yes, I have read the agreement

Login

Help FAQ
Help Reset Password?
Forgot Your User ID?

MITS Navigation

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

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

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

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

Electronic Funds Transfer

ODM will start requiring Electronic Funds Transfer (EFT) for payment instead of paper warrants

Benefits of direct deposit include:

- Quicker funds-** transferred directly to your account on the day paper warrants are normally mailed
- No worry-** no lost or stolen checks or postal holidays delaying receipt of your warrant
- Address change-** your payment will still be deposited into your banking account

**Electronic
Data
Interchange
(EDI)**

**Fees for claims
submitted**

**Claims must be received
by Wednesday at Noon
for the next payment
cycle**

MITs Portal

Free submission

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

**We can help with
your claim issues**

Technical Questions / EDI Support Unit

Trading
partners
contact DXC
for EDI
Support



844-324-7089
or
[OhioMCD-EDI-
Support@dxc.c
om](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

Hospice Enrollment

Hospice Enrollment



Welcome,

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

Trade Files Admin

demographic maintenance 1099 information provider faq mits days report cor on hospital cost report
ordering/referring/ prescribing search group affiliation group members

Name :

Provider ID 05/05/2011-12/31/2299 NPI

Medicare

Zip Code 45040

- Eligibility Search
- Health Homes
- Deemed Eligible Newborn
- Presumptively Eligible Child
- Presumptively Eligible Pregnant Woman
- Psychiatric Admission
- Hospice Enrollment**



You can view your Remittance Advices, your 835 transactions, by clicking reports on the menu bar.

Hospice Enrollment

Hospice Enrollment

Ohio Department of Medicaid

Search

Welcome,

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

eligibility search health homes deemed eligible newborn presumptively eligible child presumptively eligible pregnant woman psychiatric admission **hospice enrollment**

Hospice Enrollment Search: NPI - ? ^

Hospice Tracking Number

Medicaid Billing Number

search

clear

add

Hospice Enrollment

 Search

Welcome,

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

eligibility search health homes deemed eligible newborn presumptively eligible child presumptively eligible pregnant woman psychiatric admission hospice enrollment

Hospice - Application: NPI -	
*Type of Action	<input type="text" value="Change of Hospice Provider (no changes.)"/> <input type="text" value="New Enrollment"/>
Hospice Provider Name	<input type="text"/>
Hospice Provider ID	<input type="text"/>
Medicaid Billing Number	<input type="text"/>
Consumer Date of Birth	<input type="text"/>
Consumer Name	<input type="text"/>
County of Record	<input type="text"/>
Submission Date	08/07/2017

Hospice Enrollment

Hospice - Application: NPI - []

*Type of Action [v]
(Changing this selection will remove any unsaved changes.)

Hospice Provider Name
Hospice Provider ID
Medicaid Billing Number
Consumer Date of Birth
Consumer Name
County of Record FRANKLIN
Submission Date 07/19/2017

County and State of Recipient's Hospice Service Location

County of Service	State of Service	Effective Date	End Date
FRANKLIN	OH	07/18/2017	10/15/2017

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

[delete] [add]

State of Service AA [v]
County of Service [v]
Effective Date []
End Date []

Consumer name will populate once you enter a correct billing number and DOB

Hospice Enrollment

County and State of Recipient's Hospice Service Location	
*** No rows found ***	
Select row above to update -or- click Add button below.	
<input type="button" value="delete"/>	<input type="button" value="add"/>
Enrollment - Disenrollment	
*Election Date	<input type="text"/>
Date of Disenrollment	<input type="text"/>
Hospice Benefit Period	
*** No rows found ***	
Select row above to update -or- click Add button below.	
<input type="button" value="delete"/>	<input type="button" value="add"/>
Hospice Episode of Care	
*** No rows found ***	
Hospice Other Payer Spans	
*** No rows found ***	
Select row above to update -or- click Add button below.	
<input type="button" value="delete"/>	<input type="button" value="add"/>
Hospice Terminal Illness Diagnosis	
*** No rows found ***	
Select row above to update -or- click Add button below.	
<input type="button" value="delete"/>	<input type="button" value="add"/>
Provider Service Span	
*** No rows found ***	
Select row above to update -or- click Add button below.	
<input type="button" value="delete"/>	<input type="button" value="add"/>

Hospice Enrollment

- Must enter benefit periods in chronological order, start at the beginning with the 1st 90 day period

Hospice Benefit Period				
Benefit Period Segment Indicator	Benefit Period Effective Date	Benefit Period End Date	Status	Reason for Updating Benefit Period
FIRST 90 DAY PERIOD	07/18/2017	10/15/2017	PROCESSED	

Type changes below.

delete
add

Benefit Period Segment Indicator FIRST 90 DAY PERIOD

Benefit Period Effective Date

Benefit Period End Date

CERTIFYING PHYSICIAN INFORMATION

Hospice IDG Physician

NPI

Oral Certification Date

Written Certification Date

Update Benefit Period

Reason For Updating Benefit Period

Benefit Plans [Search]

Attending Physician

NPI

Oral Certification Date

Written Certification Date

Hospice Enrollment

- Provider has the ability to search eligibility while completing the hospice enrollment

Hospice Benefit Period

Benefit Period Segment Indicator	Benefit Period Effective Date	Benefit Period End Date	Status	Reason for Updating Benefit Period
FIRST 90 DAY PERIOD	01/01/2016	03/30/2016	PROCESSED	
SECOND 90 DAY PERIOD	03/31/2016	06/15/2016	INCOMPLETE	

Type changes below.

delete
add

Benefit Period Segment Indicator: SECOND 90 DAY PERIOD

Benefit Period Effective Date: 03/31/2016

Benefit Period End Date: 06/15/2016

CERTIFYING PHYSICIAN INFORMATION

Hospice IDG Physician

NPI: 1386628931

Oral Certification Date: []

Written Certification Date: 03/30/2016

Update Benefit Period:

Reason For Updating Benefit Period: []

Benefit Plans: [Search]

Enter the dates in question

Benefit Plans [Close]

Search ? ^

Effective Date: 03/31/2016

End Date: 06/15/2016

search clear

Search Results

Health program	Effective Date	End Date
MCAID	20140101	22991231

Hospice Enrollment

Hospice Episode of Care					
Episode of Care	First Date	Last Date	Number of Calendar Days in Episode	Number of Benefit Days in Episode	Date of 61st Day
Episode 1	07/18/2017	10/15/2017	90	90	09/16/2017

Hospice Terminal Illness Diagnosis						
Benefit Period	Primary Hospice Terminal Diagnosis	Terminal Diagnosis 2	Terminal Diagnosis 3	ICD Version	Diagnosis Effective Date	Diagnosis End Date
07/18/2017 - 10/15/2017	A010			10	07/18/2017	10/15/2017

Type changes below.

delete
add

Benefit Period	07/18/2017 - 10/15/2017		▼	
*ICD Version	10		▼	
	Code		Diagnosis Description	
*Primary Hospice Terminal Diagnosis	<input type="text" value="A010"/>	[Search]		TYPHOID FEVER
Terminal Diagnosis 2	<input type="text"/>	[Search]		
Terminal Diagnosis 3	<input type="text"/>	[Search]		
*Diagnosis Effective Date	<input type="text" value="07/18/2017"/>			
*Diagnosis End Date	<input type="text" value="10/15/2017"/>			

Hospice Enrollment

Provider Service Span		
Hospice Provider	Effective Date ▼	End Date
	07/18/2017	10/15/2017

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

Effective Date

End Date

HLTCF Provider Service Span		
*** No rows found ***		

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

Hospice Enrollment

- After completing all fields, click 'submit' at the bottom
- Once processed, additional benefit periods may be entered

Confirmation

Your Hospice application has been updated on 07/18/2017

Your Hospice Tracking Number is

***IMPORTANT - This Hospice Tracking Number (HTN) is necessary for accessing the status of submitted enrollments. Please write this number down or print this page and keep it for your records PRIOR TO EXITING. Applications submitted after 4 PM will not be processed until the next business day.**

Please remember to submit the following required documents:

WHAT'S NEXT?

- To upload required document (or to obtain a cover page), select: Upload required documents

Hospice Enrollment

- HLTCF Provider Search Span panel
 - Hospice provider must enter the LTC provider and dates in the hospice enrollment so claims pay correctly
 - The claim will deny if this field is left blank

HLTCF Provider Service Span				
HLTCF Provider Medicaid ID	HLTCF Provider NPI ID	Provider Name	Effective Date	End Date
A				
Type data below for new record.				
<input type="button" value="delete"/>		<input type="button" value="add"/>		
*HLTCF Provider Medicaid ID	<input type="text"/>	[Search]	Provider Name	
HLTCF Provider NPI ID				
*Effective Date	<input type="text"/>			
*End Date	<input type="text"/>			

Hospice Enrollment

- Steps on adding an additional benefit period
 - Enter the tracking number and/or Medicaid billing number, click search

The screenshot shows the Ohio Department of Medicaid website interface. At the top left is the Ohio Department of Medicaid logo. To the right is a search bar with a 'Search' button. Below the logo is a 'Welcome,' banner. A navigation menu includes 'Super User', 'Providers', 'Cost Report', 'Account', 'Trading Partners', 'Claims', 'Episode Claims', 'Eligibility' (highlighted), 'Prior Authorization', 'Reports', 'Portal Admin', and 'Security'. Below this is 'Trade Files Admin'. A secondary menu includes 'eligibility search', 'health homes', 'deemed eligible newborn', 'presumptively eligible child', 'presumptively eligible pregnant woman', 'psychiatric admission', and 'hospice enrollment' (highlighted). The main section is 'Hospice Enrollment Search', which has a blue header with a help icon and an up arrow. It contains two input fields: 'Hospice Tracking Number' and 'Medicaid Billing Number'. A red arrow points to the 'Hospice Tracking Number' field. To the right are three buttons: 'search', 'clear', and 'add'. A red arrow points to the 'search' button. Below is a 'Search Results' section with a table header: 'Hospice Tracking Number', 'Medicaid Billing Number', 'Name', 'Date Received', 'Status', and 'Denial Reason'. One row is visible with 'Date Received' as '07/19/2017' and 'Status' as 'PROCESSED'.

Hospice Enrollment

- Chose 'Maintain Hospice Record'

Hospice - Application:	
*Type of Action	<div style="border: 1px solid black; background-color: yellow; padding: 5px;"><p>Benefit Termination</p><p>Close Current Service Span for a change of provider (es.)</p><p>Death</p><p>Maintain Hospice Record</p><p>Revocation</p></div>
Hospice Provider Name	
Hospice Provider ID	
Medicaid Billing Number	
Consumer Date of Birth	
Consumer Name	
County of Record	CUYAHOGA
Submission Date	07/07/2017

Hospice Enrollment

- Proceed to add a matching span in each appropriate panel

County and State of Recipient's Hospice Service Location			
County of Service	State of Service	Effective Date	End Date
ALLEN	OH	07/21/2017	10/18/2017
ALLEN	OH	01/17/2018	03/17/2018
ALLEN	OH	10/19/2017	01/16/2018

Type changes below.

State of Service ▼

County of Service ▼

Effective Date

*End Date

Hospice Enrollment

- Previous benefit period must have a 'PROCESSED' status first

Hospice Benefit Period				
Benefit Period Segment Indicator	Benefit Period Effective Date	Benefit Period End Date	Status	Reason for Updating Benefit Period
FIRST 90 DAY PERIOD	07/21/2017	10/18/2017	PROCESSED	
SUBSEQUENT 60 DAY PERIOD	01/17/2018	03/17/2018	PROCESSED	
SECOND 90 DAY PERIOD	10/19/2017	01/16/2018	PROCESSED	

Type changes below.

Benefit Period Segment Indicator SUBSEQUENT 60 DAY PERIOD

Benefit Period Effective Date

Benefit Period End Date

CERTIFYING PHYSICIAN INFORMATION

Hospice IDG Physician

NPI

Oral Certification Date

Written Certification Date

Update Benefit Period

Reason For Updating Benefit Period

Benefit Plans [Search]

Attending Physician

NPI

Oral Certification Date

Written Certification Date

Hospice Enrollment

- Episode of Care will calculate and populate automatically

Hospice Episode of Care					
Episode of Care	First Date	Last Date	Number of Calendar Days in Episode	Number of Benefit Days in Episode	Date of 61st Day
Episode 1	07/21/2017	03/17/2018	240	240	09/19/2017

Hospice Other Payer Spans			
Payer Type	Payer Name	Effective Date	End Date
Medicare	MEDICARE PART B	02/01/2017	12/31/2299

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

delete
add

Payer Type

Effective Date

Payer Name

End Date

Hospice Enrollment

- Both dates must match the dates entered in the benefit period panel

Provider Service Span		
Hospice Provider	Effective Date ▼	End Date
	01/17/2018	03/17/2018
	10/19/2017	01/16/2018
	07/21/2017	10/18/2017

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

Effective Date

End Date

Hospice Enrollment

Hospice Terminal Illness Diagnosis						
Benefit Period	Primary Hospice Terminal Diagnosis	Terminal Diagnosis 2	Terminal Diagnosis 3	ICD Version	Diagnosis Effective Date	Diagnosis End Date
07/21/2017 - 10/18/2017	E11			10	07/21/2017	10/18/2017
01/17/2018 - 03/17/2018	E11			10	01/17/2018	03/17/2018
10/19/2017 - 01/16/2018	E11			10	10/19/2017	01/16/2018

Type changes below.

delete
add

Benefit Period ▼

*ICD Version ▼

Code

*Primary Hospice Terminal Diagnosis [Search]

Terminal Diagnosis 2 [Search]

Terminal Diagnosis 3 [Search]

*Diagnosis Effective Date

*Diagnosis End Date

Diagnosis Description

TYPE 2 DIABETES MELLITUS

Hospice Enrollment

- Example of numerous episodes of care
 - Two gaps of more than 60 days between benefit periods

Hospice Benefit Period					
Benefit Period Segment Indicator	Benefit Period Effective Date	Benefit Period End Date	Status	Reason for Updating Benefit Period	
SUBSEQUENT 60 DAY PERIOD	06/15/2017	08/13/2017	PROCESSED		
SECOND 90 DAY PERIOD	01/01/2017	03/31/2017	PROCESSED		
FIRST 90 DAY PERIOD	07/21/2016	10/18/2016	PROCESSED		

Type changes below.

delete
add

<p>Benefit Period Segment Indicator SUBSEQUENT 60 DAY PERIOD <input type="checkbox"/></p> <p>Benefit Period Effective Date <input type="text" value="06/15/2017"/></p> <p>Benefit Period End Date <input type="text" value="08/13/2017"/></p> <p>CERTIFYING PHYSICIAN INFORMATION</p> <p>Hospice IDG Physician</p> <p>NPI <input type="text"/></p> <p>Oral Certification Date <input type="text"/></p> <p>Written Certification Date <input type="text" value="06/15/2017"/></p> <p>Update Benefit Period <input type="checkbox"/></p> <p>Reason For Updating Benefit Period <input type="text"/></p> <p>Benefit Plans [Search]</p>	<p>Attending Physician</p> <p>NPI <input type="text"/></p> <p>Oral Certification Date <input type="text"/></p> <p>Written Certification Date <input type="text" value="06/15/2017"/></p>
--	--

Hospice Episode of Care					
Episode of Care	First Date	Last Date	Number of Calendar Days in Episode	Number of Benefit Days in Episode	Date of 61st Day
Episode 1	07/21/2016	10/18/2016	90	90	09/19/2016
Episode 2	01/01/2017	03/31/2017	90	90	03/02/2017
Episode 3	06/15/2017	08/13/2017	60	60	<61

Hospice Enrollment

- Gap of 60 days or less and more than 60 days between benefit periods

Hospice Benefit Period					
Benefit Period Segment Indicator	Benefit Period Effective Date	Benefit Period End Date	Status	Reason for Updating Benefit Period	
FIRST 90 DAY PERIOD	04/01/2016	06/29/2016	PROCESSED		
SECOND 90 DAY PERIOD	06/30/2016	09/27/2016	PROCESSED		
SUBSEQUENT 60 DAY PERIOD	09/30/2016	11/28/2016	PROCESSED		
SUBSEQUENT 60 DAY PERIOD	11/29/2016	01/27/2017	PROCESSED		
SUBSEQUENT 60 DAY PERIOD	01/28/2017	03/28/2017	PROCESSED		
SUBSEQUENT 60 DAY PERIOD	06/02/2017	07/31/2017	PROCESSED		
SUBSEQUENT 60 DAY PERIOD	08/01/2017	09/29/2017	PROCESSED		

Type changes below.

Benefit Period Segment Indicator FIRST 90 DAY PERIOD

Benefit Period Effective Date

Benefit Period End Date

CERTIFYING PHYSICIAN INFORMATION

Hospice IDG Physician

NPI

Oral Certification Date

Written Certification Date

Update Benefit Period

Reason For Updating Benefit Period

Benefit Plans [Search]

Attending Physician

NPI

Oral Certification Date

Written Certification Date

Hospice Episode of Care					
Episode of Care	First Date	Last Date	Number of Calendar Days in Episode	Number of Benefit Days in Episode	Date of 61st Day
Episode 1	04/01/2016	03/28/2017	362	360	06/02/2016
Episode 2	06/02/2017	09/29/2017	120	120	08/01/2017

Hospice Enrollment

➤ Updating a Hospice Enrollment

- Use the 'Update Benefit Period' box when adding a new benefit period under the action of "New Enrollment" or "Maintain Hospice Record"
 - When it is known that the benefit period end date is less than what the system assigned
- Open the enrollment record and check the 'Update Benefit Period' box

Written Certification Date

Update Benefit Period

Reason For Updating Benefit Period

Benefit Plans [Search]

Hospice Enrollment

➤ Updating a Hospice Enrollment

- Must provide a reason for why benefit period dates are being changed:
 - First 5 options would be used if criteria was met for termination
 - Data correction - should not be used at this time, for future use
 - Medicare alignment - May be used to have the Medicaid benefit period dates fit Medicare's

Written Certification Date

Update Benefit Period

Reason For Updating Benefit Period

Benefit Plans

Hospice Episode of Care

Episode of Care	First Date	Last Date
Episode 1	05/02/2014	07/30/2014

Hospice Other Payer Spans

Death

Individual no longer meets the enrollment criteria

Individual is no longer terminally ill

Individual moved out of the service area

Individual entered a non-contracted facility

Individual revoked the Medicaid hospice benefit

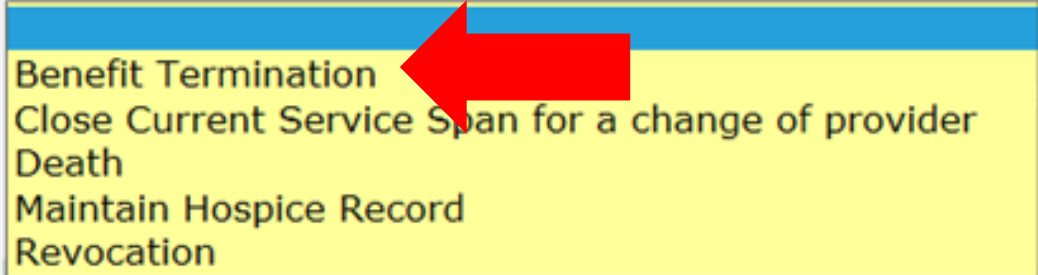
Data correction - to fix erroneous start or end date of enrollment

Alignment with Medicare Spans

Hospice Enrollment

- Ending a Hospice Enrollment
 - Choose the appropriate 'Type of Action'
- Use when someone dies, revokes hospice, or a provider terminates hospice during a benefit period in 'processed' status

Hospice - Application:

*Type of Action	
Hospice Provider Name	
Hospice Provider ID	
Medicaid Billing Number	
Consumer Date of Birth	
Consumer Name	
County of Record	CUYAHOGA
Submission Date	07/07/2017

Hospice Enrollment

➤ Ending a Hospice Enrollment

- You are now able to complete the 'Enrollment - Disenrollment' date of disenrollment and click 'submit'

The screenshot displays a web application interface with three main sections:

- County and State of Recipient's Hospice Service Location:** A table with the message "*** No rows found ***" and a "Select row above to update -or- click" instruction. It includes "delete" and "add" buttons.
- Enrollment - Disenrollment:** A form with two input fields: "*Election Date" (containing "04/01/2016") and "*Date of Disenrollment". A yellow arrow points from the "Date of Disenrollment" field in the left sidebar to this field in the main form. A yellow star is positioned to the right of this field.
- Hospice Benefit Period:** A table with the message "*** No rows found ***" and a "Select row above to update -or- click Add button below." instruction. It includes "delete" and "add" buttons.

Hospice Enrollment

➤ Hospice Enrollment Denial Letters

- You may leave all the search fields blank and then click 'search' to populate all denial letters

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

demographic maintenance 1099 information provider fa correspondence self attestation hospital cost report ordering/referring/ prescribing search group affiliation group m efs

Letter Search ? ^

Letter Name **Hospice Application Denial Errors Letter** Date Type [v] Date From [] Date To [] Period Type [v] Records 20 [v]

search **clear**

Search Results

Document Number	Letter Name	Period Type	Date Sent
6517217200002	Hospice Application Denial Errors Letter		08/04/2017
6517207200008	Hospice Application Denial Errors Letter		07/25/2017
6517207200009	Hospice Application Denial Errors Letter		07/25/2017

Hospice Enrollment

➤ Hospice Enrollment Denial Letter Codes

Error Code	Error Description
2049	GeoStan Validate Address Error - contact SysArchitect
2067	LTC Vendor Pay end date must be on or before the Elig end date
2069	Invalid Lockin end date
2121	Source Code is not on file
2167	Invalid Other Recipient ID
2355	Begin Date must be a valid date
2356	End Date must be a valid date
2453	Recipient not a part of a valid Case/Cat/Seq
2999	System error encountered during PS/2 process, contact EDS


Hospice Enrollment

➤ Hospice Enrollment Denial Letter Codes

Error Code	Error Description
4068	Effective Date Received Begins Before The Plan is Active
4390	Medicaid Coverage Missing
4400	No medicaid coverage found
4901	Hospice not allowed with PACE
4902	Hospice Coverage already exists
4903	Hospice Not allowed with RSS AID Category
4904	Recipient enrolled in Managed Care
5015	Invalid HOSPC EligCase data
5016	Invalid HOSPC Lockin data

Hospice Enrollment

➤ Hospice Enrollment Denial Letter Example



Ohio
Department of Medicaid
John R. Kasich, Governor
Barbara R. Sears, Director

July 26, 2017

████████████████████
████████████████████
CINCINNATI, OH 45246-4113

Subject: Notification of the Medicaid Hospice benefit enrollment errors

The following lists the application processing errors.

<u>Recipient ID</u>	<u>Hospice Tracking Number</u>	<u>Submission Date</u>	<u>Recipient Name</u>	<u>Error Code</u>	<u>Error Description</u>
██████████	5807	07/25/2017	██████████	2069	Invalid Lockin end date

Please make the corrections needed to correct the application.

<u>Error Code</u>	<u>Error Description</u>
2069	Invalid Lockin end date

Claim Submission

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

Professional Claim: NPI -	
BILLING INFORMATION	
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="button" value="v"/>
Patient Amount Paid	<input type="text" value="\$0.00"/>
*ICD Version	10 <input type="button" value="v"/>
SERVICE INFORMATION	
*Release of Information	NOT ALLOWED TO RELEASE DATA <input type="button" value="v"/>
From Date	
To Date	
Signature Source	<input type="text"/> <input type="button" value="v"/>
Accident Related To	<input type="text"/> <input type="button" value="v"/>
Accident State	<input type="text"/> <input type="button" value="v"/>
Accident Country	<input type="text"/> [Search]
Accident Date	<input type="text"/>
EPSDT Referral	<input type="text"/> <input type="button" value="v"/>
Prior Authorization #	<input type="text"/>
Hospital Discharge Date	<input type="text"/>
Last Menstrual Period	<input type="text"/>
TOTAL CHARGES	
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="button" value="v"/>
Notes	<input type="text"/>
Diagnosis	
*** 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"/>
Header - Other Payer	
*** 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"/>

Submission of a Professional Claim



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

demographic maintenance 1099 information provider faq mits days report
ordering/referring/ prescribing search group affiliation group members c
attestations

Search
Search Detail
Dental
Institutional
Professional

Name
Provider ID
Medicare
Zip Code

NPI
Taxonomies

You can view your Remittance Advices by clicking Reports on the menu bar.

Claim Submission

The 'Patient Amount Paid' field is used to report a consumer's monthly patient liability amount

The screenshot shows a web-based form for submitting a Professional Claim. The form is divided into two main sections: BILLING INFORMATION and SERVICE INFORMATION. The BILLING INFORMATION section includes fields for ICN, Claim Received Date, Claim Type (M - PROFESSIONAL), Provider ID (NPI), *Medicaid Billing Number, *Date of Birth, Last Name, First Name, MI, *Patient Account # (0), Medical Record #, Referring Provider #, Rendering ID, *Medicare Assignment (NOT ASSIGNED), and *ICD version (10). The SERVICE INFORMATION section includes *Release of Information (NOT ALLOWED TO RELEASE DATA), From Date, To Date, Signature Source, Accident Related To, Accident State, Accident Country (with a search box), Accident Date, EPSDT Referral, Prior Authorization #, Hospital Discharge Date, Last Menstrual Period, and a section for TOTAL CHARGES. The TOTAL CHARGES section includes 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), and Note Reference Code. The 'Patient Amount Paid' field is highlighted with a red box and contains the value \$0.00.

Field	Value
ICN	
Claim Received Date	
Claim Type	M - PROFESSIONAL
Provider ID	NPI
*Medicaid Billing Number	
*Date of Birth	
Last Name	
First Name, MI	
*Patient Account #	0
Medical Record #	
Referring Provider #	
Rendering ID	
*Medicare Assignment	NOT ASSIGNED
Patient Amount Paid	\$0.00
*ICD version	10
*Release of Information	NOT ALLOWED TO RELEASE DATA
From Date	
To Date	
Signature Source	
Accident Related To	
Accident State	
Accident Country	[Search]
Accident Date	
EPSDT Referral	
Prior Authorization #	
Hospital Discharge Date	
Last Menstrual Period	
TOTAL CHARGES	
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	
Notes	

Diagnosis Codes

- Are required on hospice claims
 - Must include the number of characters specified by ICD
 - MITS does not accept decimal points, only enter numbers & letters
 - System edits and audits will be applied to those codes

Diagnosis			
Sequence	Diagnosis Code	Description	Present on Admission
Principal	F0390	UNSPECIFIED DEMENTIA WITHOUT BEHAVIORAL DISTURBANCE	
Admitting	F0390	UNSPECIFIED DEMENTIA WITHOUT BEHAVIORAL DISTURBANCE	
Other	F419	ANXIETY DISORDER, UNSPECIFIED	
Other	H269	UNSPECIFIED CATARACT	

1 2 Next >

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

delete
add an item

Sequence

Diagnosis Code

Present on Admission

Entering Ordering Provider Information

Medicaid Allowed Amount	\$0.00	Diagnosis Code Pointer	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Rendering Provider	<input type="text"/>	Modifiers	<input type="text" value="U2"/>	[Search]	<input type="text" value="TU"/>	[Search]
Submitted EAPG	<input type="text"/>		<input type="text"/>	[Search]	<input type="text"/>	[Search]
Initial EAPG		Final EAPG				
Status		Pay Action				

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

Additional Provider Information

Detail Item	Type of Provider	Provider #	Last Name	First Name, MI
A 0				

Type data below for new record.

***Detail Item** 1

***Type of Provider** Ordering Provider

***Provider #**

***Last Name**

***First Name, MI**

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



Claim Portal Errors

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

Portal errors return the claim with a “fix” needed

Portal errors will show up at the top of the page

Claim shows a ‘NOT SUBMITTED YET’ status still

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

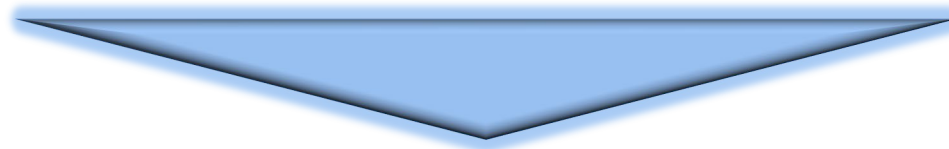
Claim Suspense

- Non room and board services (T2042-T2045) are paid the hospice rate that is applicable for the county that is listed on the enrollment panel effective 01/01/2016
- If the needed state/county code is not loaded into MITS claims will suspend for no rate
- Providers will need to contact ODM to have this information updated



Claim Submission

All claim submissions are assigned an ICN



2221170357321

Region Code	Calendar Year	Julian Day	Claim Type/ Batch Number	Claim Number in Batch
22	21	170	357	321

Providers have 365 days to submit Fee For Service claims

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

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

Claims over 2 years old will be denied

There are exceptions to the 365 day rule



Timely Filing

Submitting a Claim Over 365 Days Old

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

Supporting Data for Delayed Submission / Resubmission

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

Previously Denied ICN or TCN

Reason





Timely Filing Exceptions: OAC 5160-3-39.1

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



How to Bill After a Delay

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

Total Medicaid Paid Amount	\$0.00
Medicaid CoPay Amount	\$0.00
Note Reference Code	ADD - Additional Information 
Notes	

How to Bill After a Delay

Hearing Decision: APPEALS#####CCYYMMDD

- ##### is the hearing number and CCYYMMDD is the date on the hearing decision

Eligibility Determination: DECISIONCCYYMMDD

- CCYYMMDD is the date on the eligibility determination notice from the CDJFS



Note Reference Code	ADD - Additional Information <input type="button" value="v"/>
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 to your claim in MITS

Attachments

Type of Document	Transmission Type
A	

Type data below for new record.

For attachments submitted via mail, not electronically attached, please send to the appropriate address. A button for printing a cover page and a button to view mailing addresses will appear after the claim has been submitted.

For documents transmitted via Upload, an upload button will appear after the claim has been submitted. Only file types of gif, tiff, bmp, jpg, ppt, doc, xls, pdf, txt, and mdi can be uploaded.

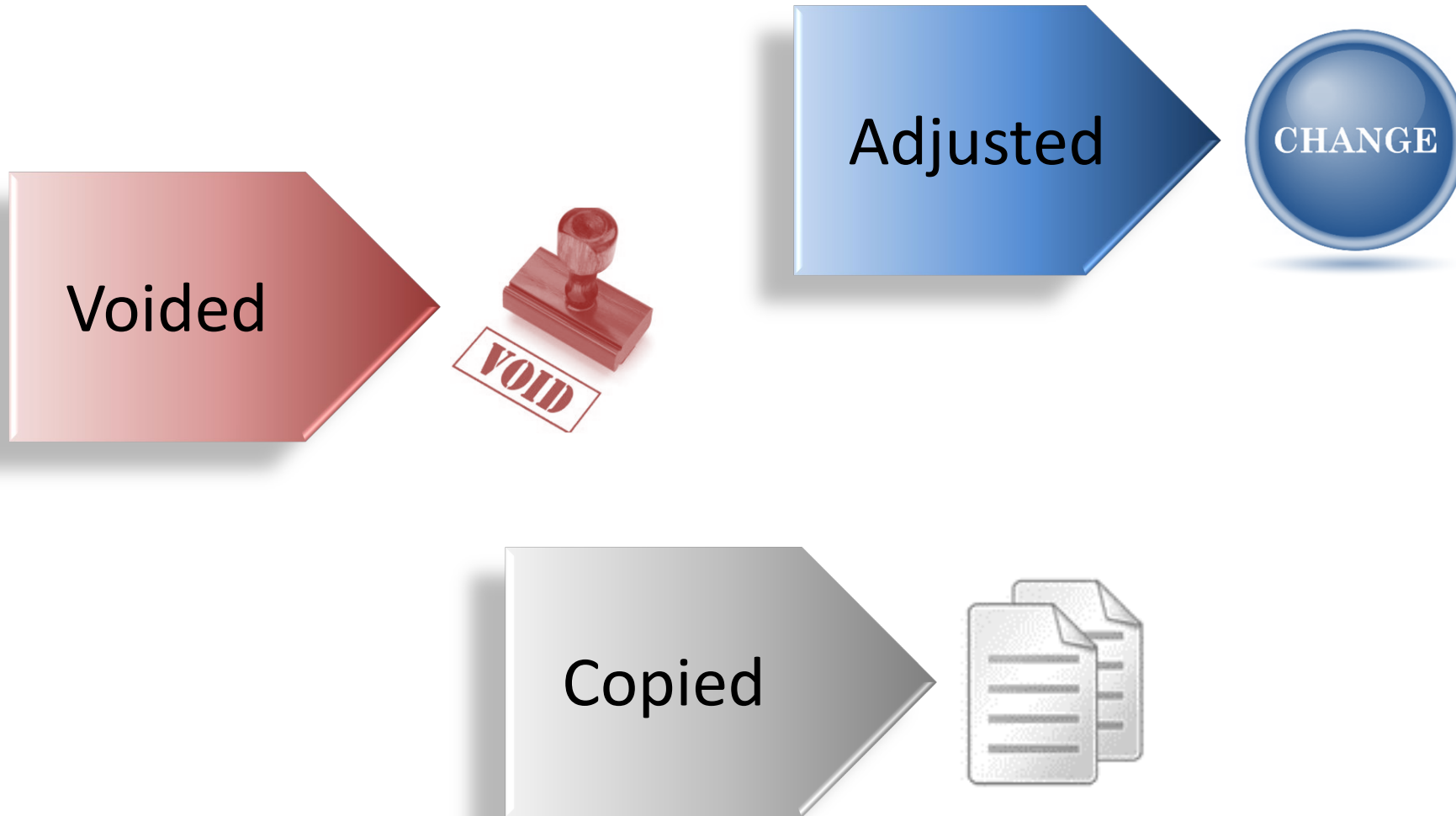
*Type of Document

*Transmission Type

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 less than 50 MB in size
- Each file must pass an anti-virus scan in MITS
- A maximum of 10 attachments may be uploaded

Paid Claims Can Be:

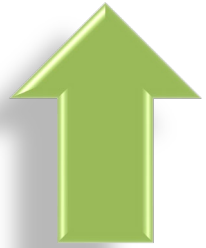


Adjusting a Paid Claim



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

Adjusting a Paid Claim: Example

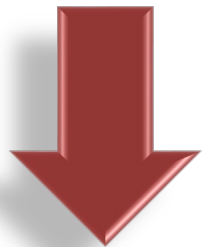


2221180234001
5821185127250

Originally paid \$45.00

Now paid \$50.00

Additional payment of \$5.00



2021172234001
5021173127250

Originally paid \$50.00

Now paid \$45.00

Account receivable (\$5.00)

Voiding a Paid 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”

Voiding a Paid Claim: Example



2221180234001
5821185127250

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

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

Copying a Paid Claim



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

ClaimChek 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	08/07/2021	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** 08/07/2021

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	FATHER	MALE	987654	\$200.00	08/07/2021	01234

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

***Claim Filing Indicator** HMO, MEDICARE RISK

***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** 08/07/2021

Allowed Amount \$0.00

***Insurance Carrier Name** HUMANA MEDICARE

***Electronic Payer ID** 01234

Insured's Policy ID 987654

***Payer Sequence** PRIMARY

Medicare ICN

Header - Other Payer Amounts and Adjustment Reason Codes

Header vs. Detail

Header level

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

Detail level

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

Adjustment Reason Codes (ARCs)

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

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

***Electronic Payer ID** 01234

***CAS Group Code** PR-Patient Responsibility

***ARC** 1

***Amount**

Payer Header Level Adjustment Reason Codes (ARC) and Amounts

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

Payer Line Level Adjustment Reason Codes(ARC) and Amounts

*Detail Item/Electronic Payer ID: 1/43210

*CAS Group Code: CO-Contractual Obligations

*ARC: 45

*Amount: \$150.00

Remittance Advice (RA)

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

The screenshot shows the MITS Portal interface. At the top, a red banner says "Welcome,". Below it is a navigation bar with links: Super User, Providers, Cost Report, Account, Claims, Eligibility, Prior Authorization, Reports (highlighted in red), Portal Admin, and Publications. The "Provider Reports" dropdown menu is open, showing a list of report types. A red arrow points to "REMITTANCE ADVICE" at the bottom of the list. To the right of the dropdown, there are "search" and "clear" buttons.

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

search clear

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

Websites, Forms

Websites

- Ohio Department of Medicaid home page

<http://Medicaid.ohio.gov>

- Ohio Department of Medicaid provider page

<https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers>

- MALs & MTLs

<https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/policies-guidelines>

- Ohio Administrative Codes

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

Websites

➤ Provider Enrollment

<https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/enrollment-and-support/enrollment-and-support>

➤ MITS home page

https://www.ohmits.com/prosecure/authtam/handler?TAM_OP=login&URL=%2FPortal%2FDesktopModules%2FiC_Authenticate%2FSignIn.aspx%3FReturnUrl%3D%252fPortal%252f

➤ Electronic Funds Transfer

<https://obm.ohio.gov/wps/portal/gov/obm/areas-of-interest/ohio-suppliers/supplier-forms/>

Websites

➤ Companion Guides (EDI)

<https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/billing/trading-partners/companion-guides/companion-guides>

➤ Electronic Visit Verification (EVV)

<https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/special-programs-and-initiatives/electronic-visit-verification/electronic-visit-verification>

➤ Healthchek

<https://medicaid.ohio.gov/wps/portal/gov/medicaid/families-and-individuals/srvcs/healthchek>

➤ X12 Website (ARC Codes)

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

Forms

ODM 06614 – Health Insurance Fact Request

ODM 06653 – Medical Claim Review Request

Forms

Stakeholders & Partners >

Ohio Medicaid achieves its health care mission with the strong support and collaboration of our stakeholder partners - state health and human services agencies, associations, advocacy groups, and individuals who help us administer the program today and modernize it for the next generation of ...

CMP Reinvestment Program >

Civil money penalties (CMPs) are fines imposed on nursing facilities that do not meet federal health and safety standards.

Helpful Links >

Not seeing what you are looking for? We want to help you find the information you need. Check out these links to federal and state

Initiatives >

The Ohio Department of Medicaid is dedicated to being a national leader in health care coverage innovation. In collaboration with our

Legal and Contracts >

We want to make it easier for you to do business with us. This page includes important information and links for vendors and others

Reports & Research >

Ohio Medicaid values transparency and accountability in all we do. We are committed to providing our stakeholders and partners with

To receive notifications of Ohio Department of Medicaid rule changes, please subscribe via the Common Sense Initiative eNotifications Sign Up. The Department of Medicaid will use this list to notify subscribers when draft rules are posted for public comment.

<https://www.apps.das.ohio.gov/RegReform/enotify/subscription.aspx>

Medicaid Forms

Ohio Department of Medicaid Forms Library

For Medicaid Vendors

Provides information on invoices and computer use.

Request for Proposals

The Ohio Department of Medicaid is committed to using competitive procurement

Single Pharmacy Benefit Manager (SPBM) Request For Proposal

This page contains public responses to the Single Pharmacy Benefit Manager (SPBM)






Forms

Medicaid Forms

Ohio Department of Medicaid Forms Library

Order Forms/Email Requests

Share this   

Form Number	Order Form	Form Name
ODM 07216	(ORDER FORM)	Application for Health Coverage & Help Paying Costs
ODM 03528	(ORDER FORM)	Healthcek & Pregnancy Related Services Information Sheet
ODM 10129	(ORDER FORM)	Long-Term Services and Supports Questionnaire (LTSSQ) - Email Request
ODM 02399	(ORDER FORM)	Request for Medicaid Home and Community Based Services (HCBS)

Search: x

Show entries

File Name	Language	Form Name
ODM 06653	English	Medical Claim Review Request
ODM 06653i	English	Medical Claim Review Request - Instructions

Showing 1 to 2 of 2 entries (filtered from 199 total entries)

