Basic Billing for Hospice

Provider Relations

2022

Staff are available weekdays from 8:00 a.m. to 4:30 p.m.

Must enter two of the following: tax ID, NPI, or 7 digit Ohio Medicaid provider number

Calls directed through the IVR prior to accessing the customer call center

IVR:

1-800-686-1516

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

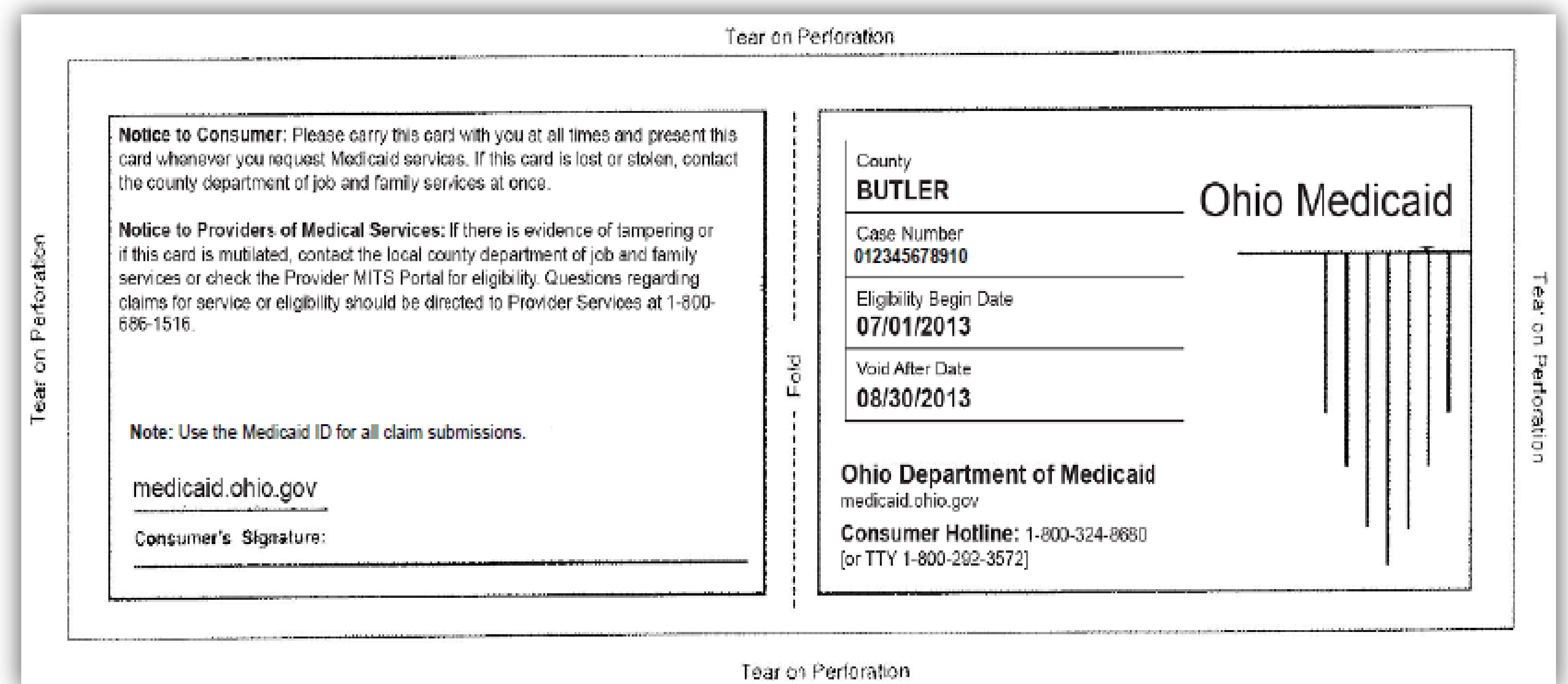
Ohio Medicaid Covers:

- 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



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

FAMILIES & INDIVIDUALS | RESOURCES FOR PROVIDERS | STAKEHOLDERS & PARTNERS | OUR STRUCTURE ABOUT US | Help | Search

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

- As a Provider, am I allowed to bill the patient for missed appointments?
- What is National Provider Identifier (NPI)?

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

Ohio
Department of Medicaid

Search

Welcome,

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

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

Eligibility Verification Request

Medicaid Billing Number		Birth Date	
SSN		DOS Date Format	MM/DD/YYYY
Procedure Code		From DOS	07/16/2017
		To DOS	07/15/2021

search

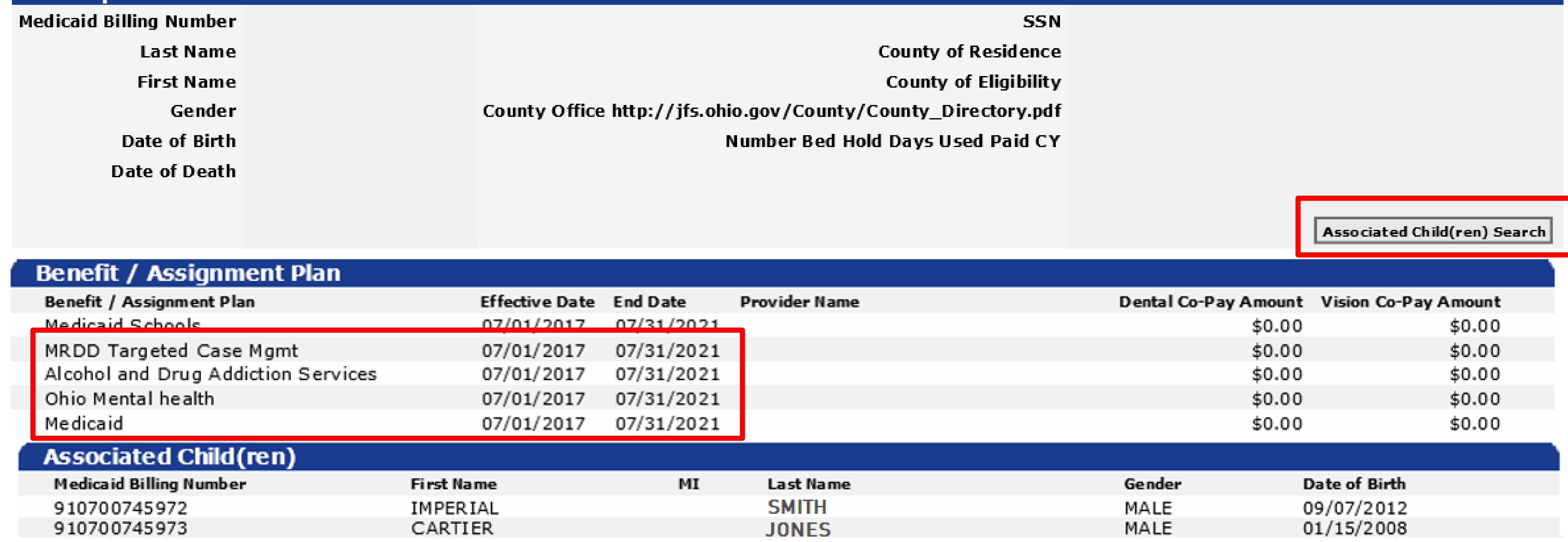
clear

*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



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

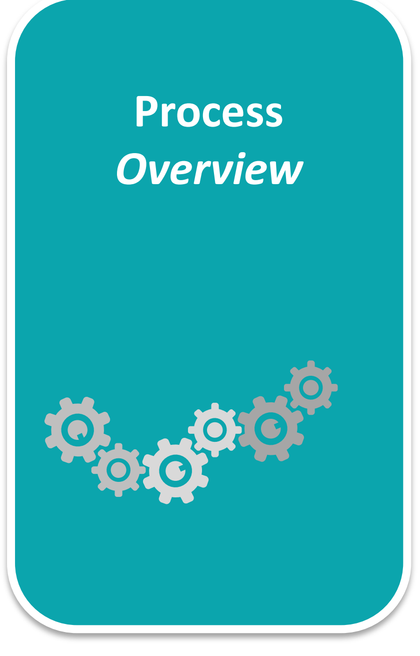
*** No rows found ***

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

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)

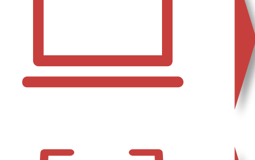
Medicaid Managed Care Adult MAGI (expansion population)

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


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

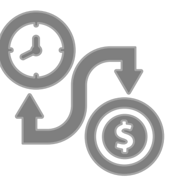
Plan Name	Plan Description	Effective Date	End Date	Managed Care Benefits
CARESOURCE	HMO, CFC	10/24/2018	10/31/2021	

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

Plan	Phone	Website
buckeye health plan	866-296-8731	https://www.buckeyehealthplan.com
CareSource®	800-488-0134	https://www.CareSource.com/
PARAMOUNT HEALTH CARE	855-522-9076	https://www.paramounthealthcare.com/
MOLINA® HEALTHCARE	855-322-4079	https://www.molinahealthcare.com
UnitedHealthcare®	800-600-9007	https://www.uhccommunityplan.com

MyCare Ohio

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

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

EXTENDED

The project is currently slated to end on December 31, 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

MITS 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

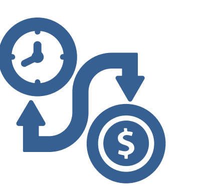
Coverage	Effective Date	End Date	Plan Name	Plan ID	Medicare ID
PART A	10/30/2016	10/31/2019			9RG7AP3AF00
PART B	10/30/2016	10/31/2019			9RG7AP3AF00
PART C	08/01/2017	09/30/2021	AARP MEDICARERX PREFERRED (PDP)	013	9RG7AP3AF00
PART D	06/01/2018	09/30/2021	CVS CAREMARK VALUE (PDP)	028	9RG7AP3AF00

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

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

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

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

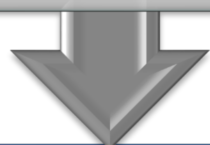
PROVIDER COMPLAINTS

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

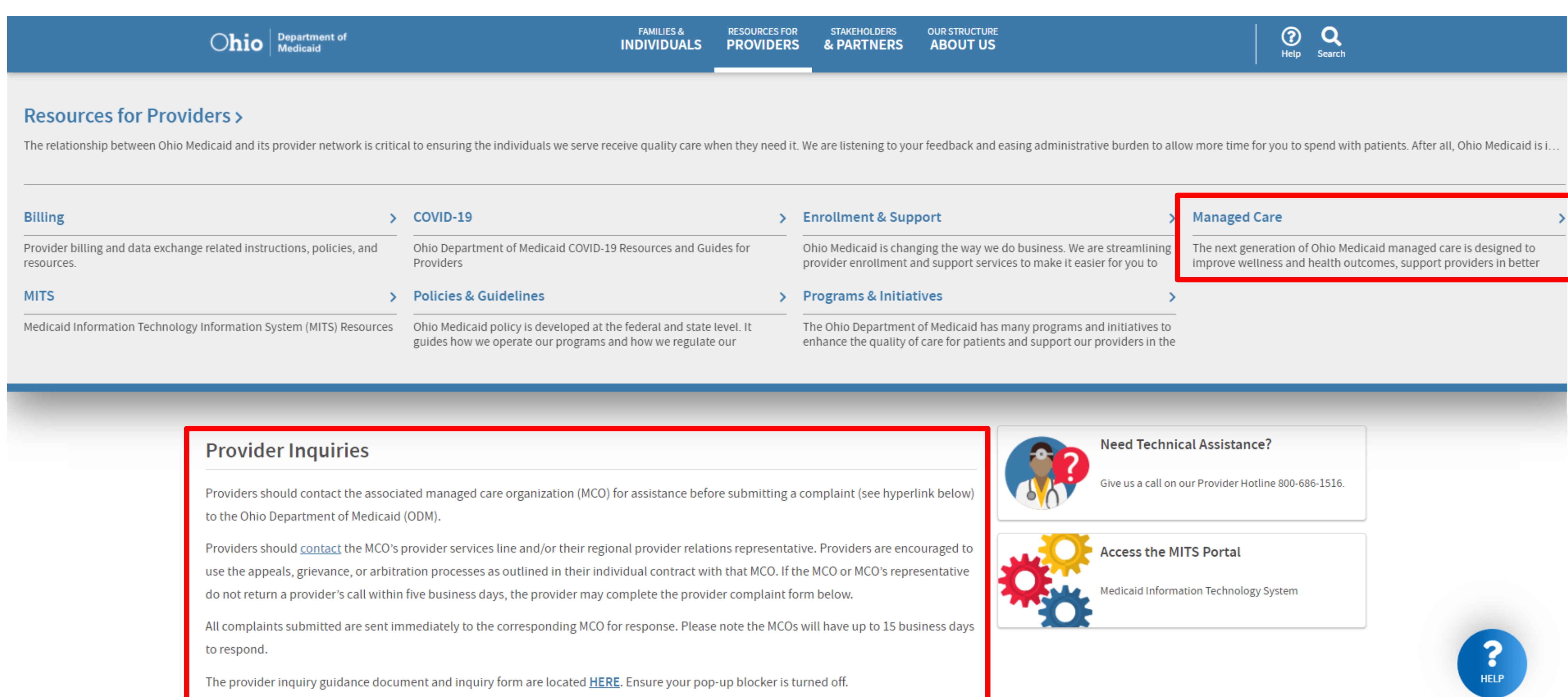


Work directly with the Plan first

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



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.

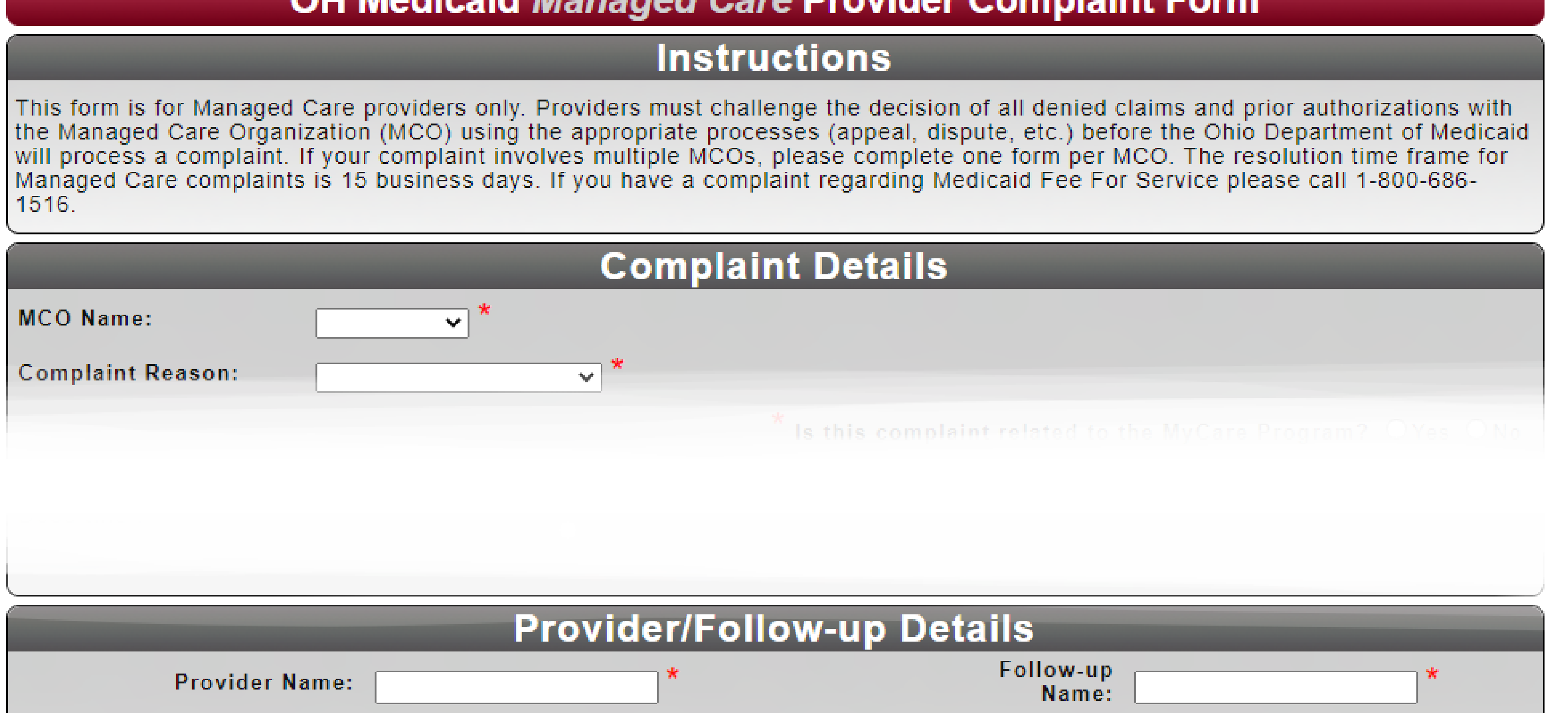
***NEW* If the provider submits multiple complaints for the same issue (different individuals, dates of service, practitioners, or files affected), ODM will cancel all duplicate complaints, contact the provider, and request that a single new complaint be submitted for all files affected.**

***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######).



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

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

- Not seek reimbursement for service(s) from the patient, any member of the family, or any other person
- Inform ODM of any changes to your provider profile within 30 days
- Abide by the regulations and policies of the state
- Recoup any third party resources available
- Maintain records for 6 years
- Render medically necessary services in the amount required

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

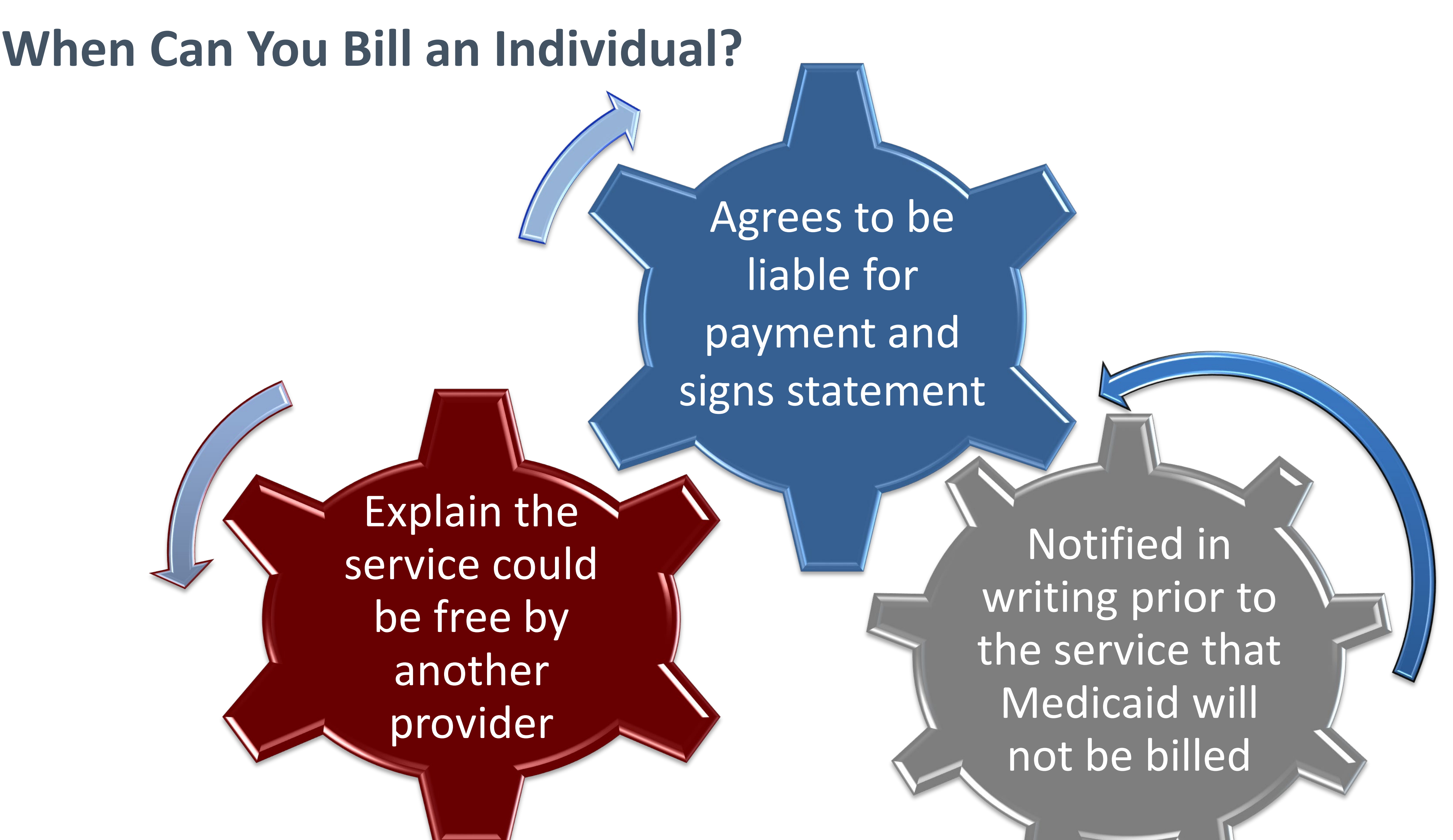
- The Ohio Administrative Code requires that a Medicaid consumer provide notice to the department prior to initiating any action against a liable third party
- The department will take steps to protect its subrogation rights if that notice is not provided
- For questions, contact the Coordination of 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.

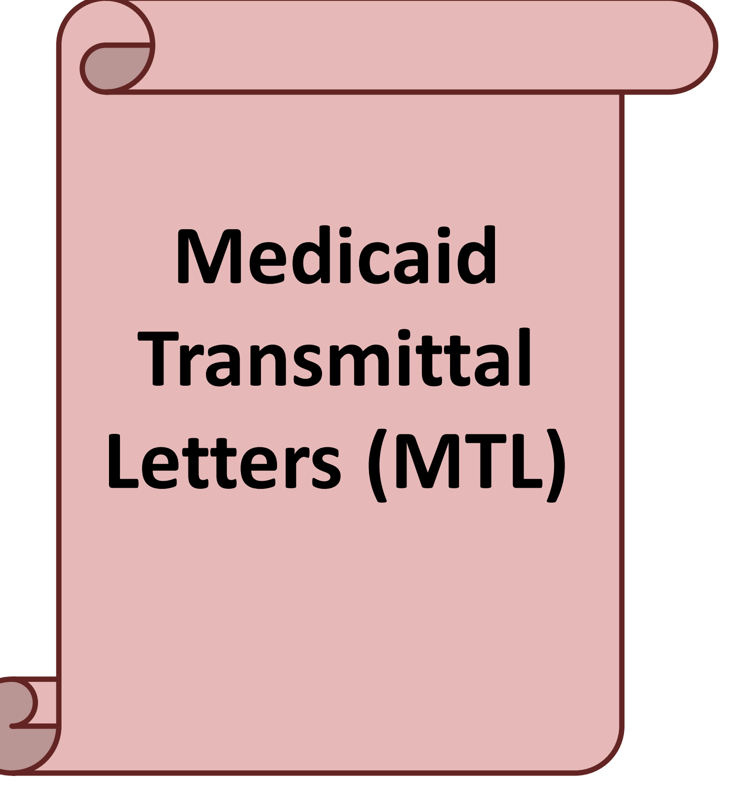
☐ (E) Any individual not covered by Medicaid on the date of service is financially responsible for those services unless the individual qualifies for the hospital care assurance program (HCAP) in accordant with section 5168.14 of the Ohio Revised Code.

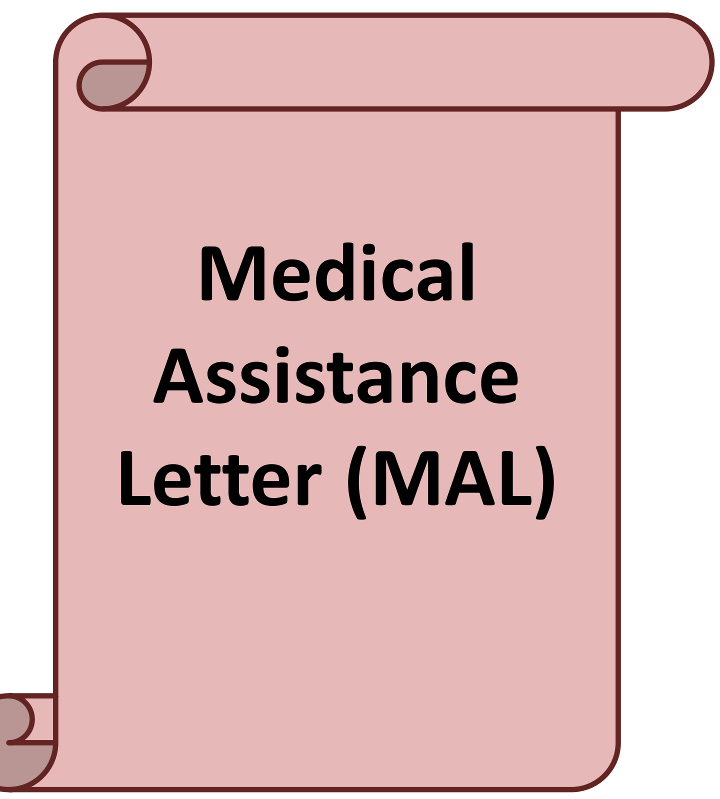
Signature ______________________________ Date ____________

EXAMPLE

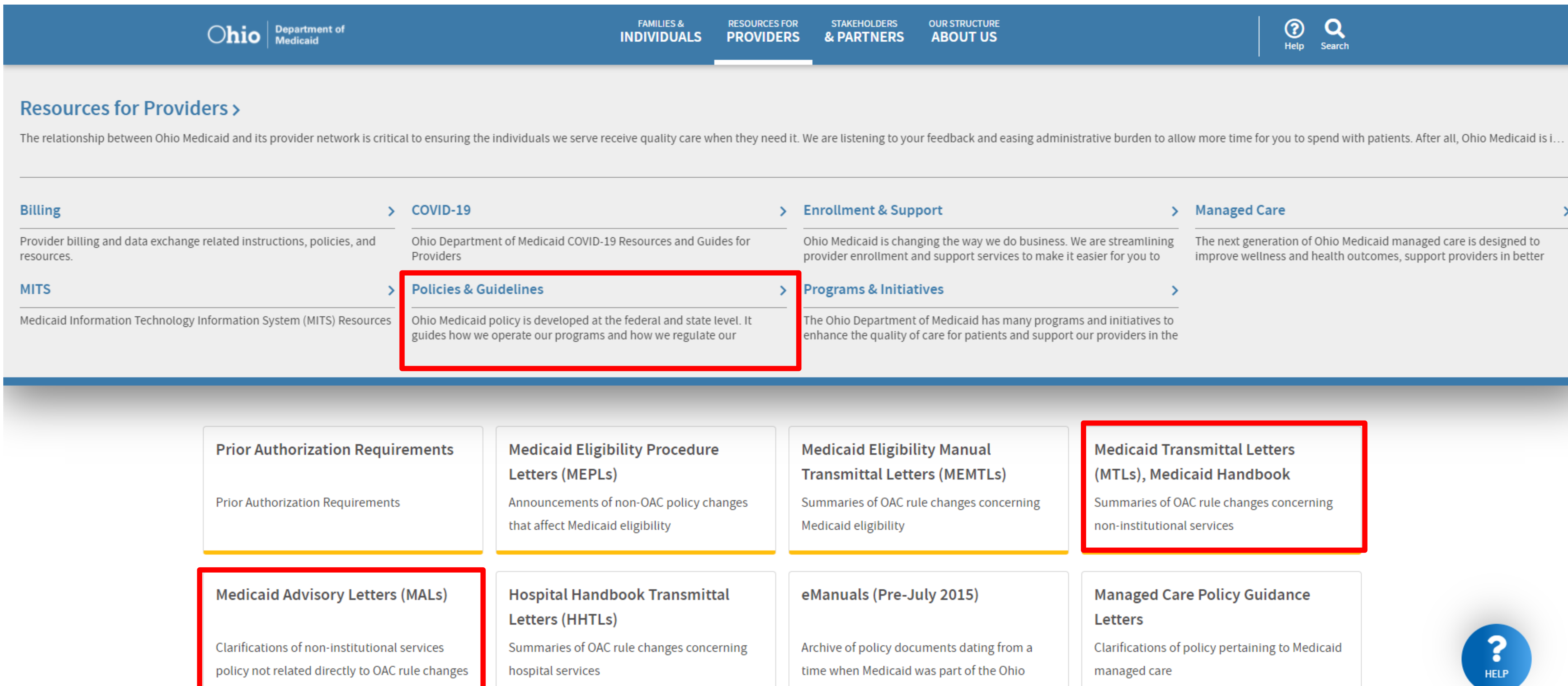
Policy

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

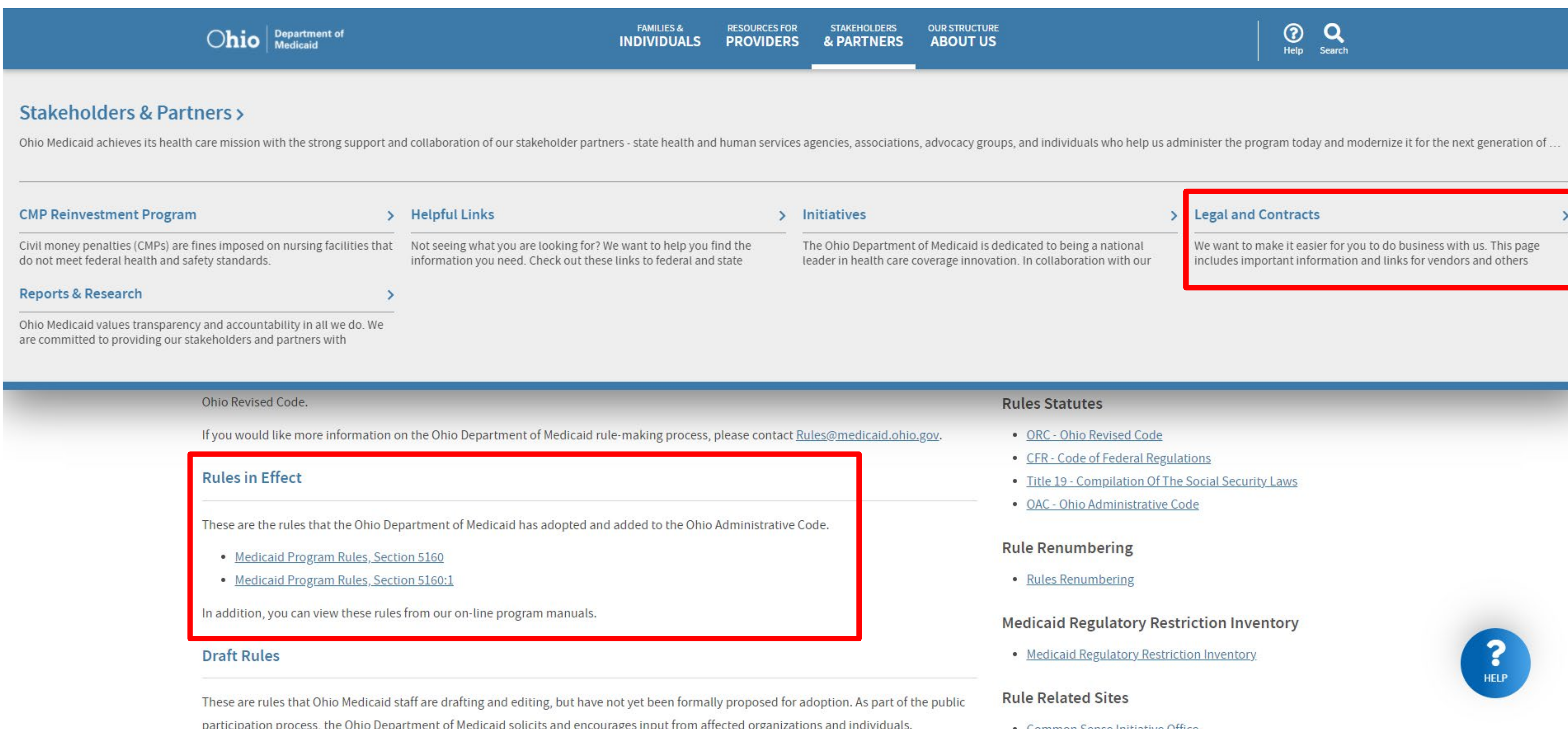




Policy



Policy



Policy

https://codes.ohio.gov

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

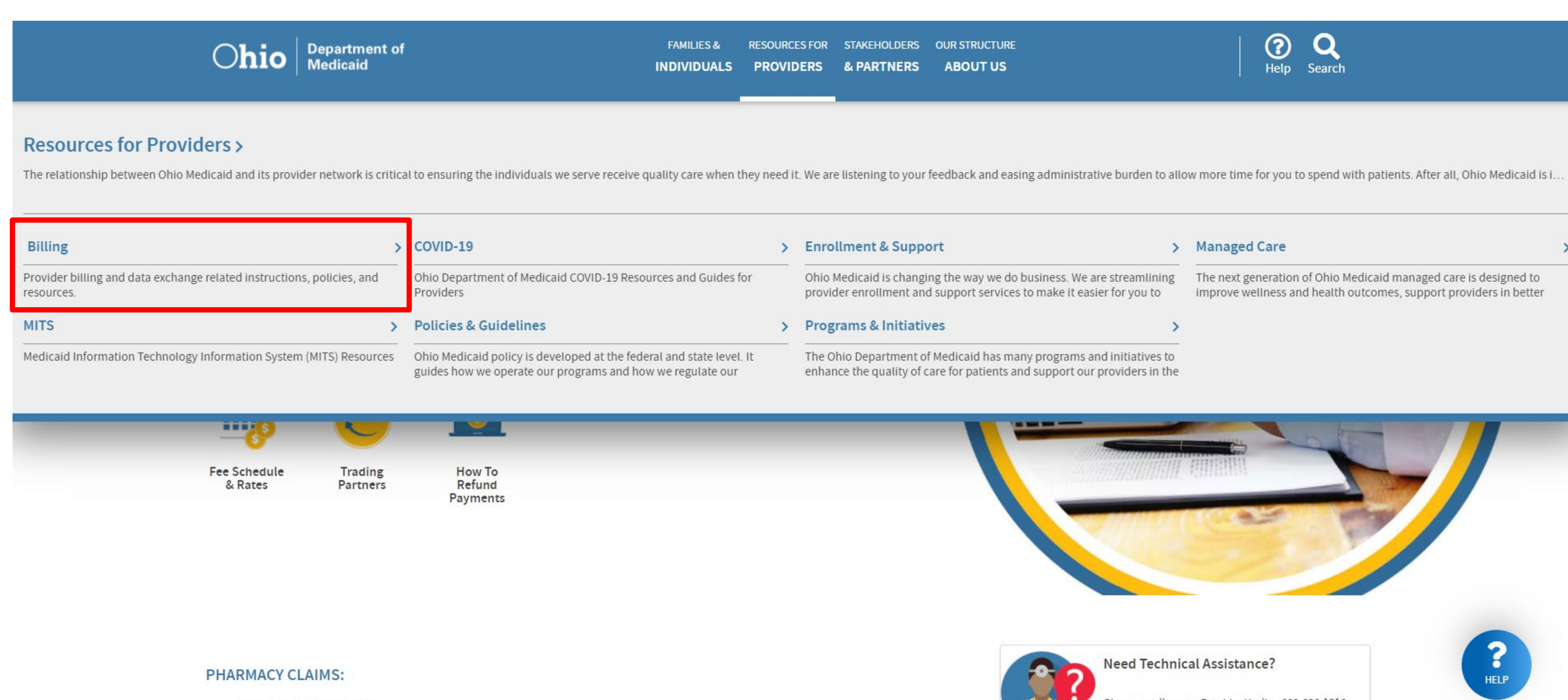
- Hospice may receive R&B payments for individuals who are residents, overnight, of nursing facilities or ICF-IID facilities
  - Bill for R&B using procedure code T2046
  - Reimbursed at 95% of the rate established for the Long-Term Care Facility (LTCF)
- Only for days the individual receives routine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

MITS

Billing Resources



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)

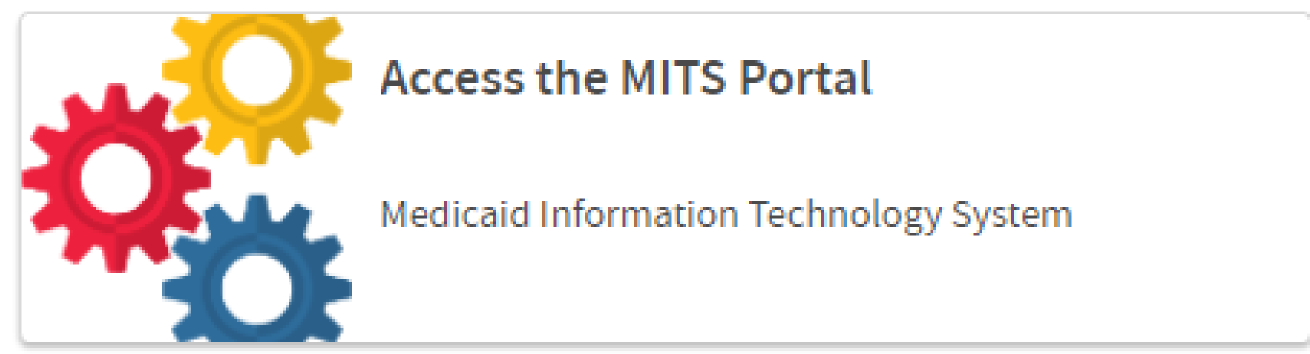
Internet Explorer version 10 or higher and current versions of Firefox or Chrome

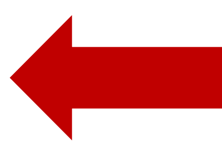
Mac users use current version of Safari, Firefox, or Chrome

Turn **OFF** pop up blocker functionality

How to Access the MITS Portal

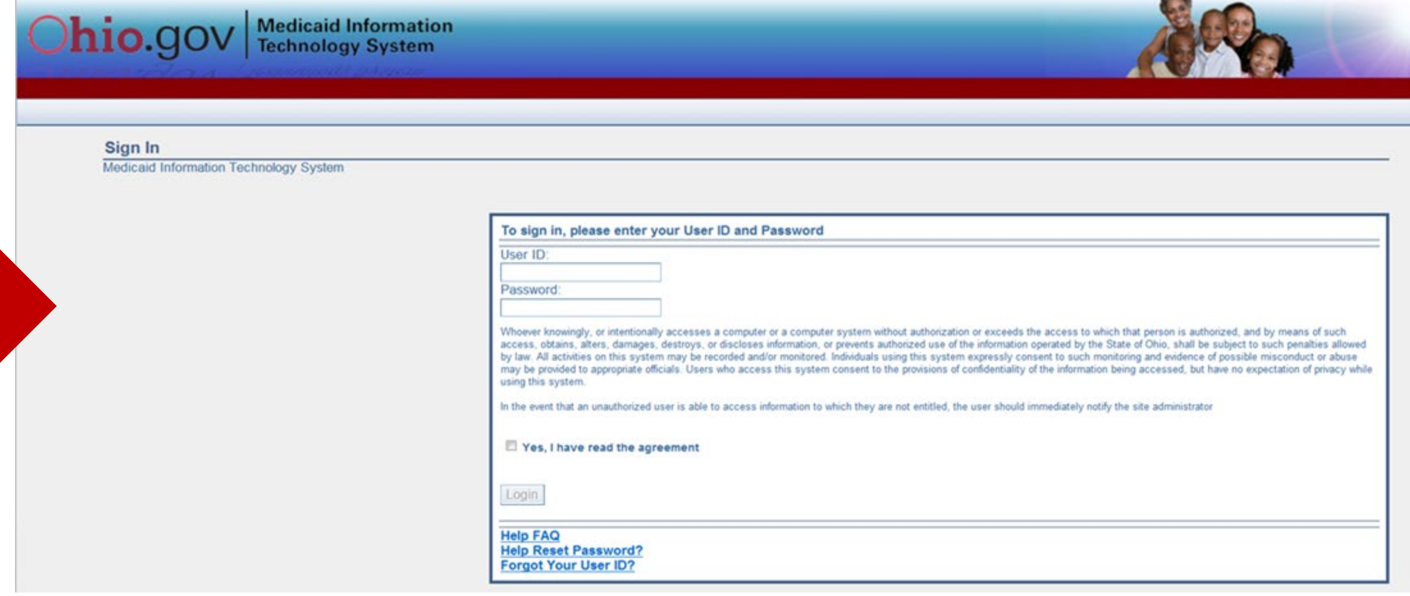
- Go to https://Medicaid.ohio.gov
- Select the “Resources for Providers” tab at the top
- Click on “MITS”
- Scroll down and click “Access the MITS Portal” on the right





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



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.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

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

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

You can view your Remittance Advices, your 835 transactions, by ...king 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

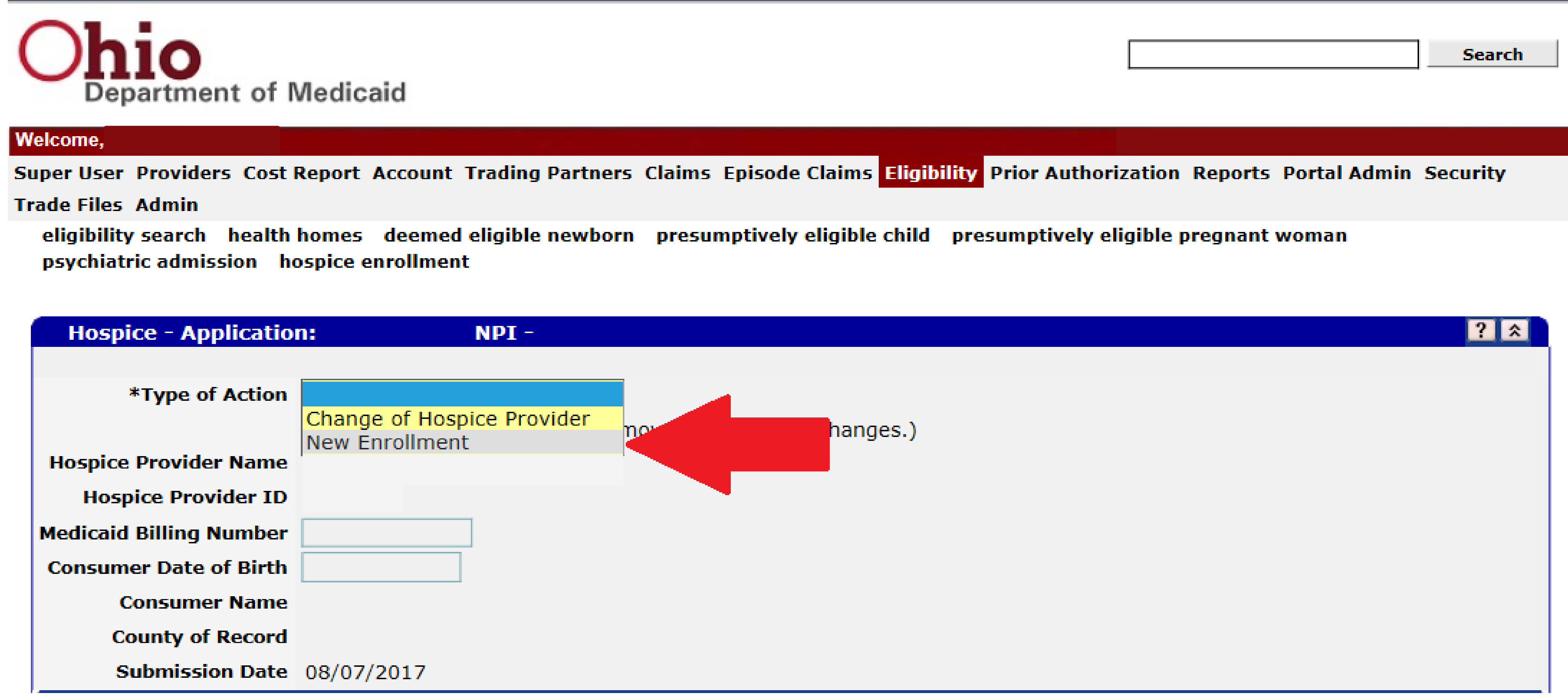
Medicaid Billing Number

search

clear

add

Hospice Enrollment



Hospice Enrollment

Hospice - Application: **NPI -**

***Type of Action**

(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

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

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

County of Service

Effective Date

End Date

Hospice Enrollment

County and State of Recipient's Hospice Service Location

*** No rows found ***

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

delete | add

Enrollment - Disenrollment

*Election Date

Date of Disenrollment

Hospice Benefit Period

*** No rows found ***

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

delete | 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.

delete | add

Hospice Terminal Illness Diagnosis

*** No rows found ***

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

delete | add

Provider Service Span

*** No rows found ***

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

delete | 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 07/18/2017

Benefit Period End Date 10/15/2017

CERTIFYING PHYSICIAN INFORMATION

Hospice IDG Physician		Attending Physician	
NPI		NPI	
Oral Certification Date	07/01/2017	Oral Certification Date	07/01/2017
Written Certification Date	07/10/2017	Written Certification Date	07/10/2017
Update Benefit Period	☐		
Reason For Updating Benefit Period			
Benefit Plans	[Search]		

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	A010	[Search]	TYPHOID FEVER
Terminal Diagnosis 2		[Search]	
Terminal Diagnosis 3		[Search]	
*Diagnosis Effective Date	07/18/2017		
*Diagnosis End Date	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.

delete add

Effective Date

End Date

HLTCF Provider Service Span

*** No rows found ***

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

delete add

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.**

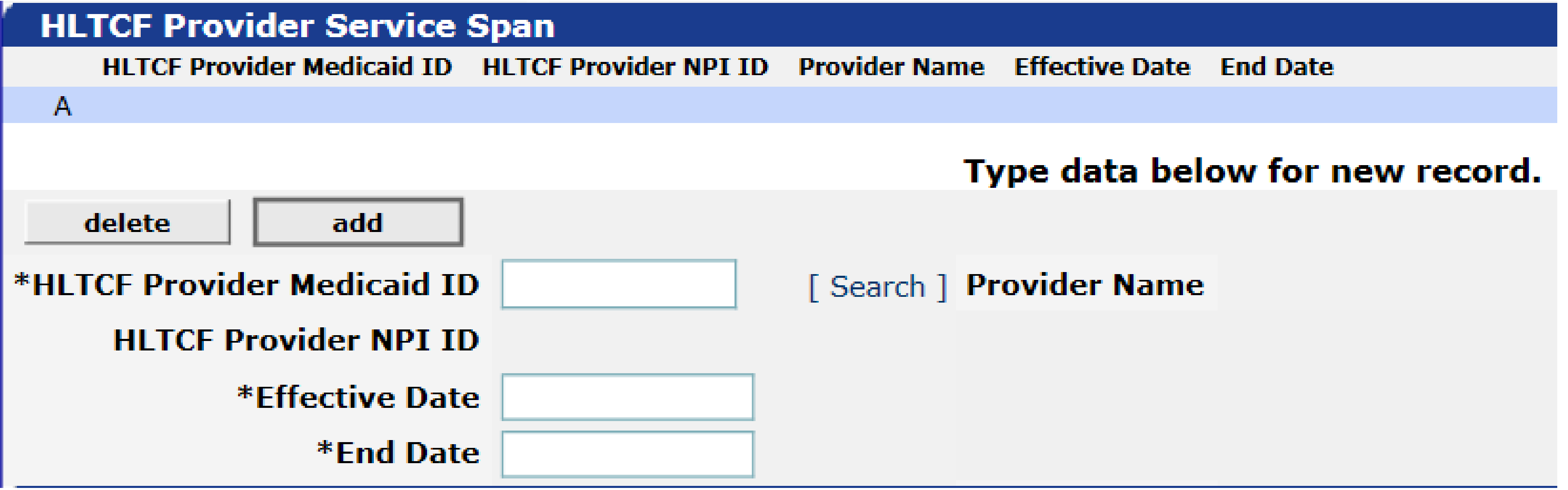
Please remember to submit the following required documents:

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



Hospice Enrollment

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

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

Hospice Tracking Number

Medicaid Billing Number

search

clear

add

Search Results

Hospice Tracking Number	Medicaid Billing Number	Name	Date Received	Status	Denial Reason
			07/19/2017	PROCESSED	

Hospice Enrollment

- ➢ Chose ‘Maintain Hospice Record’

Hospice - Application:

*Type of Action	Benefit Termination Close Current Service Span for a change of provider Death Maintain Hospice Record Revocation
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.

delete add

State of Service: OH

County of Service: ALLEN

Effective Date: 10/19/2017

*End Date: 01/16/2018

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.

delete add

Benefit Period Segment Indicator: SUBSEQUENT 60 DAY PERIOD

Benefit Period Effective Date: 01/17/2018

Benefit Period End Date: 03/17/2018

CERTIFYING PHYSICIAN INFORMATION

Hospice IDG Physician		Attending Physician	
NPI		NPI	
Oral Certification Date		Oral Certification Date	
Written Certification Date	01/17/2018	Written Certification Date	01/17/2018

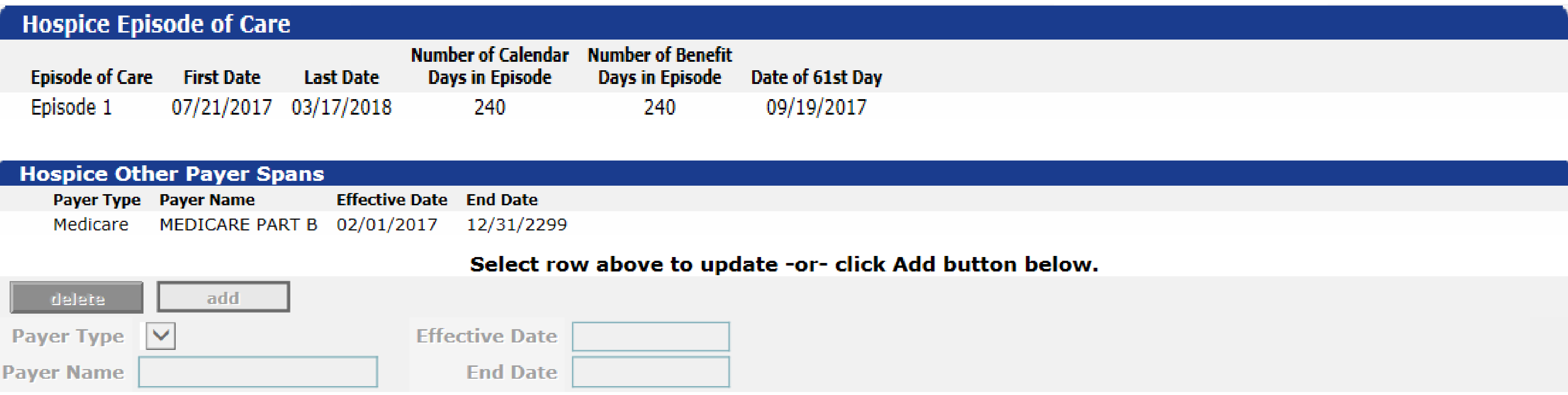
Update Benefit Period ☐

Reason For Updating Benefit Period

Benefit Plans [Search]

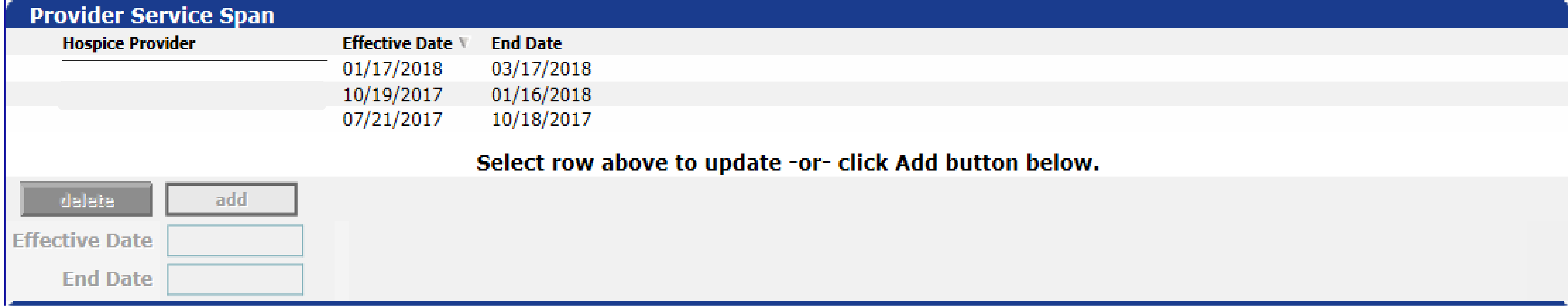
Hospice Enrollment

- Episode of Care will calculate and populate automatically



Hospice Enrollment

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



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: 01/17/2018 - 03/17/2018

*ICD Version: 10

	Code		Diagnosis Description
*Primary Hospice Terminal Diagnosis	E11	[Search]	TYPE 2 DIABETES MELLITUS
Terminal Diagnosis 2		[Search]	
Terminal Diagnosis 3		[Search]	

*Diagnosis Effective Date: 01/17/2018

*Diagnosis End Date: 03/17/2018

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

Benefit Period Segment Indicator: SUBSEQUENT 60 DAY PERIOD

Benefit Period Effective Date: 06/15/2017

Benefit Period End Date: 08/13/2017

CERTIFYING PHYSICIAN INFORMATION

Hospice IDG Physician		Attending Physician	
NPI		NPI	
Oral Certification Date		Oral Certification Date	
Written Certification Date	06/15/2017	Written Certification Date	06/15/2017

Update Benefit Period ☐

Reason For Updating Benefit Period

Benefit Plans [Search]

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.

delete add

Benefit Period Segment Indicator FIRST 90 DAY PERIOD

Benefit Period Effective Date 04/01/2016

Benefit Period End Date 06/29/2016

CERTIFYING PHYSICIAN INFORMATION

Hospice IDG Physician		Attending Physician	
NPI	1972622348	NPI	1972622348
Oral Certification Date	04/04/2016	Oral Certification Date	04/04/2016
Written Certification Date	04/05/2016	Written Certification Date	04/05/2016

Update Benefit Period ☐

Reason For Updating Benefit Period

Benefit Plans [Search]

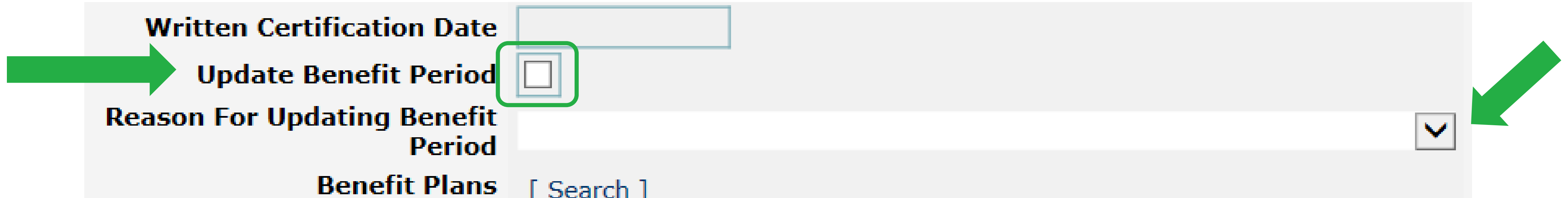
Hospice Episode of Care

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

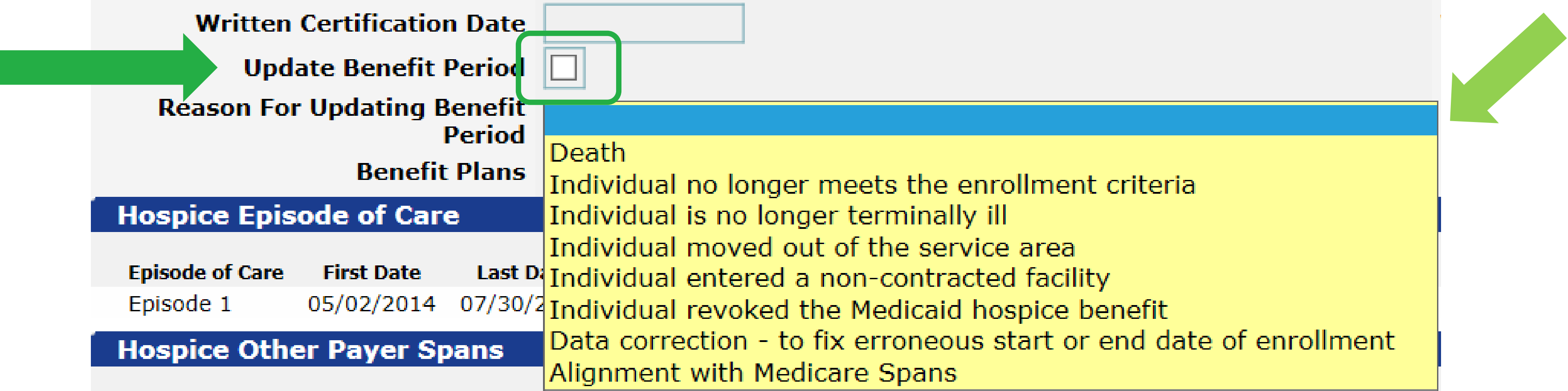
➢ Updating a Hospice Enrollment

- 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



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



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**
- Benefit Termination
- Close Current Service Span for a change of provider
- Death
- Maintain Hospice Record
- Revocation

Hospice Provider Name

Hospice Provider ID

Medicaid Billing Number

Consumer Date of Birth

Consumer Name

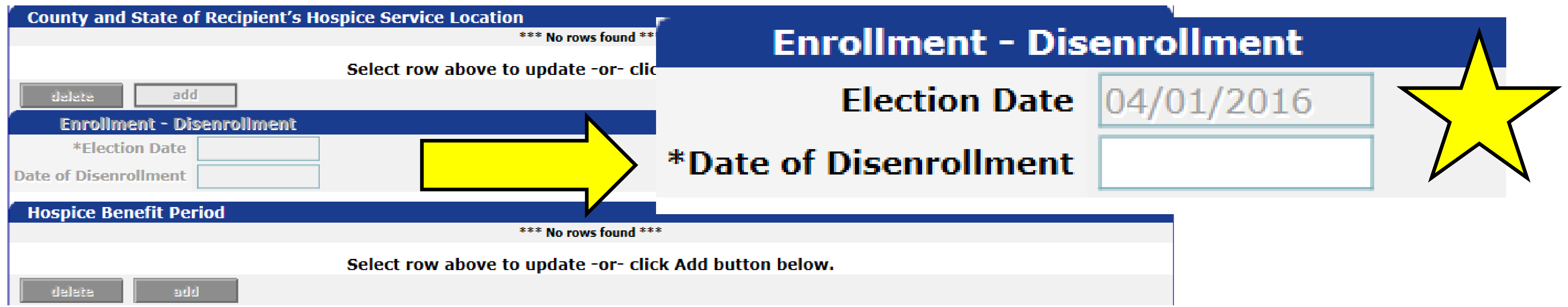
County of Record CUYAHOGA

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’



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… | …t | correspondence | self attestation | hospital cost report | ordering/referring/ prescribing search | group affiliation | group m…ers

Letter Search

Letter Name: Hospice Application Denial Errors Letter

Date Type:

Date From:

Date To:

Period Type:

Records: 20

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.

Recipient ID	Hospice Tracking Number	Submission Date	Recipient Name	Error Code	Error Description
[redacted]	5807	07/25/2017	[redacted]	2069	Invalid Lockin end date

Please make the corrections needed to correct the application.

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

*** No rows found ***

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

delete | add an item

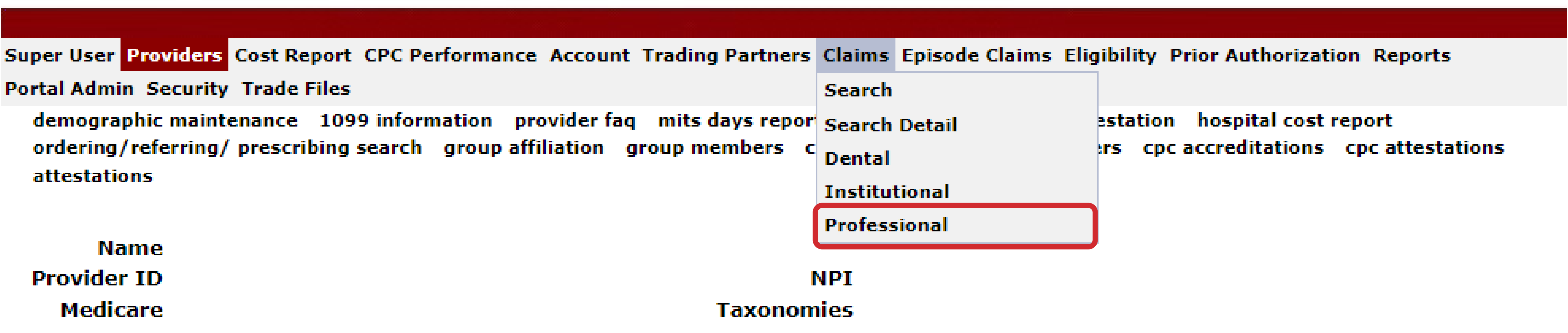
Header - Other Payer

*** No rows found ***

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

delete | add an item

Submission of a Professional Claim



Claim Submission

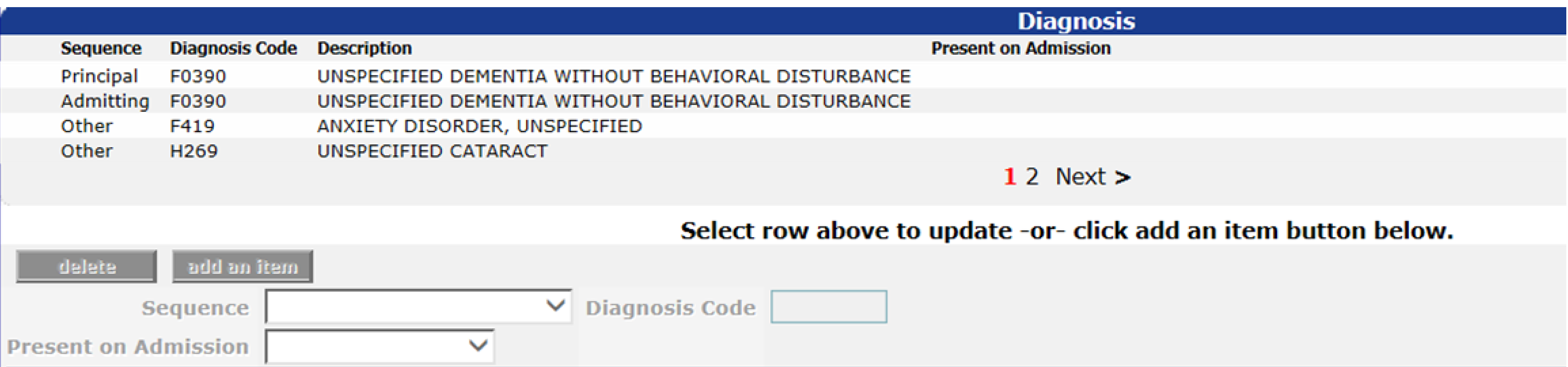
The ‘Patient Amount Paid’ field is used to report a consumer’s monthly patient liability amount

Professional Claim: NPI -

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



Entering Ordering Provider Information

Medicaid Allowed Amount	$0.00	Diagnosis Code Pointer	
Rendering Provider		Modifiers	U2 [Search] TU [Search]
			[Search] [Search]
Submitted EAPG		Final EAPG	
Initial EAPG		Pay Action	
Status			

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

Additional Provider Information

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

Type data below for new record.

delete | add an item

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

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

submit | cancel

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

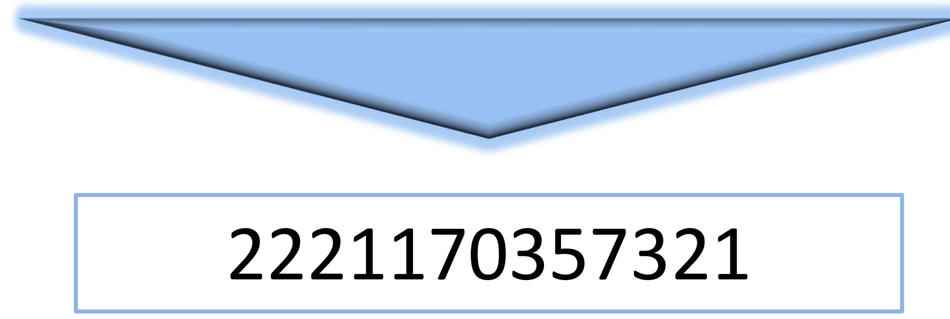
The following messages were generated:
From DOS is required.
Procedure is required.
A valid Place Of Service is required
A valid Procedure Code is required
Units must be greater than 0.
Charges must be greater than $0.00.
A valid Medicaid Billing Number is required
A valid Medicaid Billing Number and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

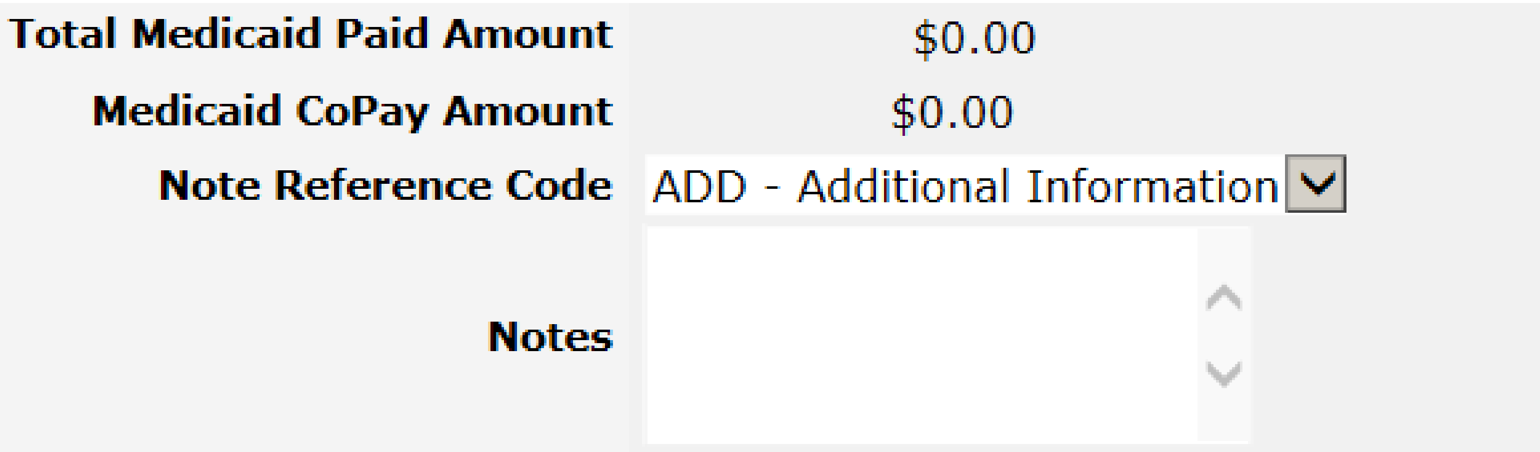
Previously Denied ICN or TCN [ ] **Reason** [▾]

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”



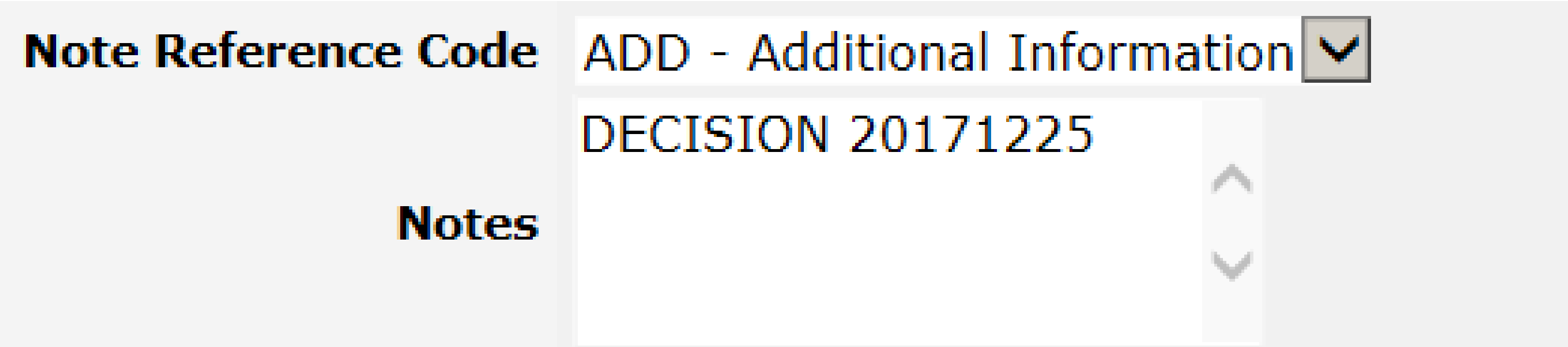
How to Bill After a Delay

Hearing Decision: APPEALS ######## CCYYMMDD

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

Eligibility Determination: DECISION CCYYMMDD

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



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.

delete | add

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.

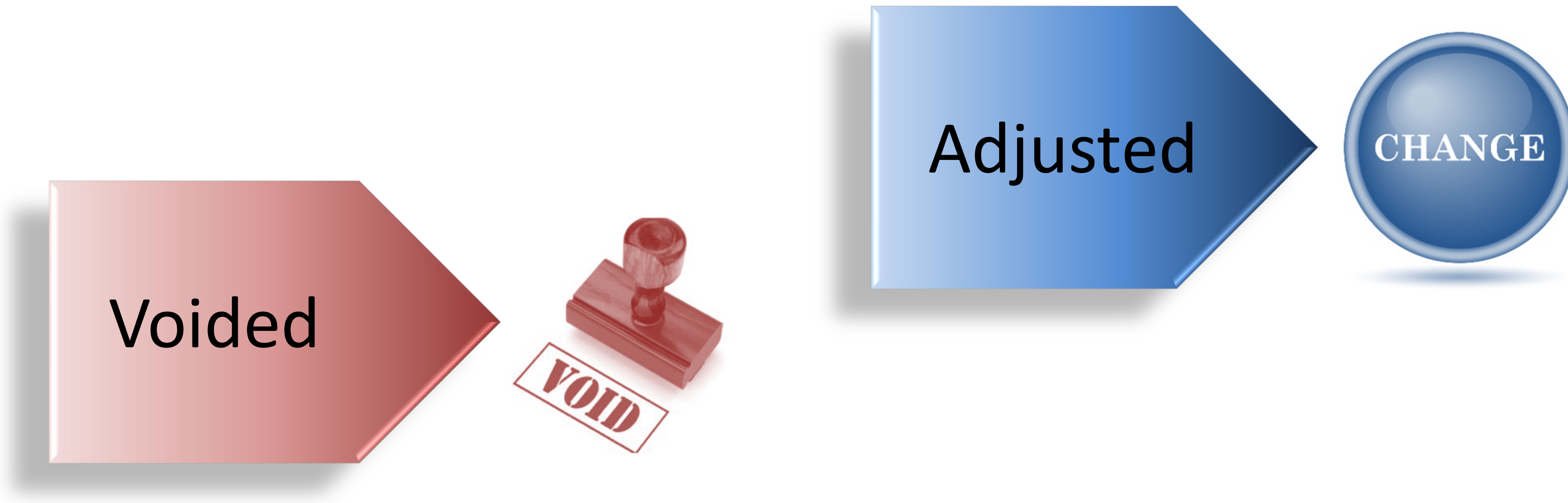
*Type of Document

*Transmission Type

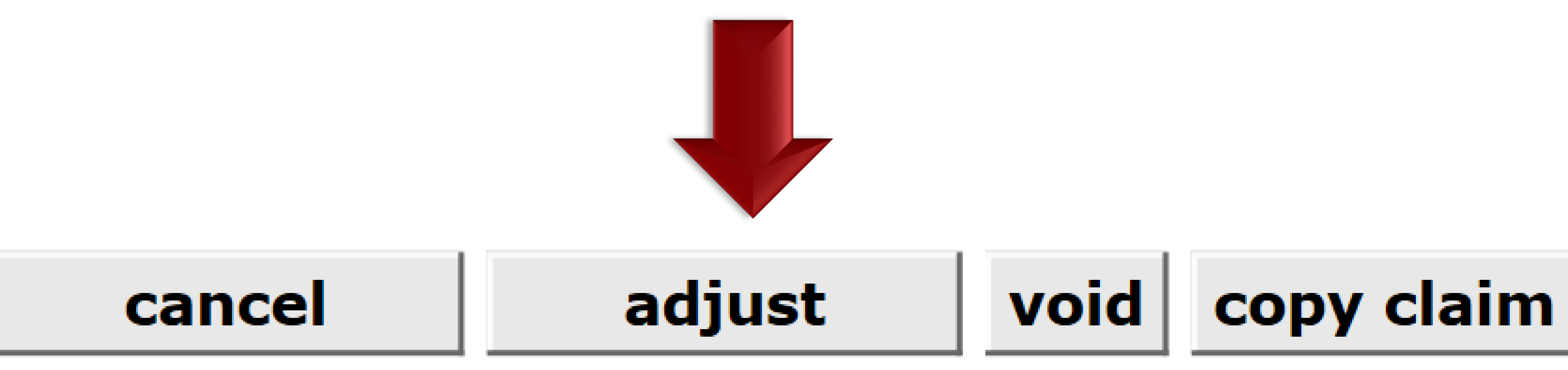
Uploading an Attachment

- 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:

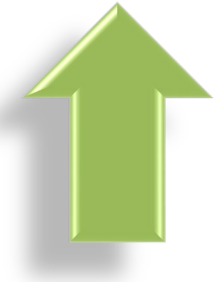


Adjusting a Paid Claim



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

Adjusting a Paid Claim: Example



2221180234001 — Originally paid $45.00

5821185127250 — Now paid $50.00

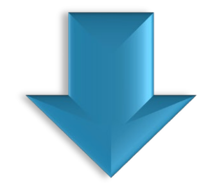
Additional payment of $5.00

2021172234001 — Originally paid $50.00

5021173127250 — Now paid $45.00

Account receivable ($5.00)

Voiding a Paid Claim



cancel | adjust | void | copy claim

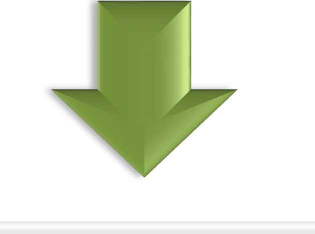
- Open the claim you wish to void
- Click the "void" button at the bottom of the claim
- The status is flagged as "non-adjustable" in MITS
- An adjustment is automatically created and given a status of "denied"

Voiding a Paid Claim: Example

2221180234001	Originally paid $45.00
5821185127250	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



cancel | adjust | void | copy 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.

delete | add an item

Field	Value	Field	Value
*Claim Filing Indicator	COMMERCIAL INSURANCE	*Insurance Carrier Name	BLUE CROSS BLUE SHIELD
*Policy Holder Relationship to Insured	FATHER	*Electronic Payer ID	01234
*Policy Holder Last Name	SMITH	Insured's Policy ID	987654
*Policy Holder First Name, MI	JOHN A	*Payer Sequence	PRIMARY
Policy Holder Date of Birth	01/01/1950	Medicare ICN	
Gender	MALE		
*Paid Amount	$200.00		
*Paid Date	08/07/2021		
Allowed Amount	$0.00		

Header - Other Payer Amounts and Adjustment Reason Codes

Third Party Liability (TPL) Claims

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

Header - Other Payer

	Last Name	First Name	MI	Date of Birth	Relationship	Gender	Policy ID	Paid Amount	Paid Date	Electronic Payer ID
A	SMITH	JOHN	A	01/01/1950	FATHER	MALE	987654	$200.00	08/07/2021	01234

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

delete | add an item

Field	Value	Field	Value
*Claim Filing Indicator	HMO, MEDICARE RISK	*Insurance Carrier Name	HUMANA MEDICARE
*Policy Holder Relationship to Insured	FATHER	*Electronic Payer ID	01234
*Policy Holder Last Name	SMITH	Insured's Policy ID	987654
*Policy Holder First Name, MI	JOHN A	*Payer Sequence	PRIMARY
Policy Holder Date of Birth	01/01/1950	Medicare ICN	
Gender	MALE		
*Paid Amount	$200.00		
*Paid Date	08/07/2021		
Allowed Amount	$0.00		

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

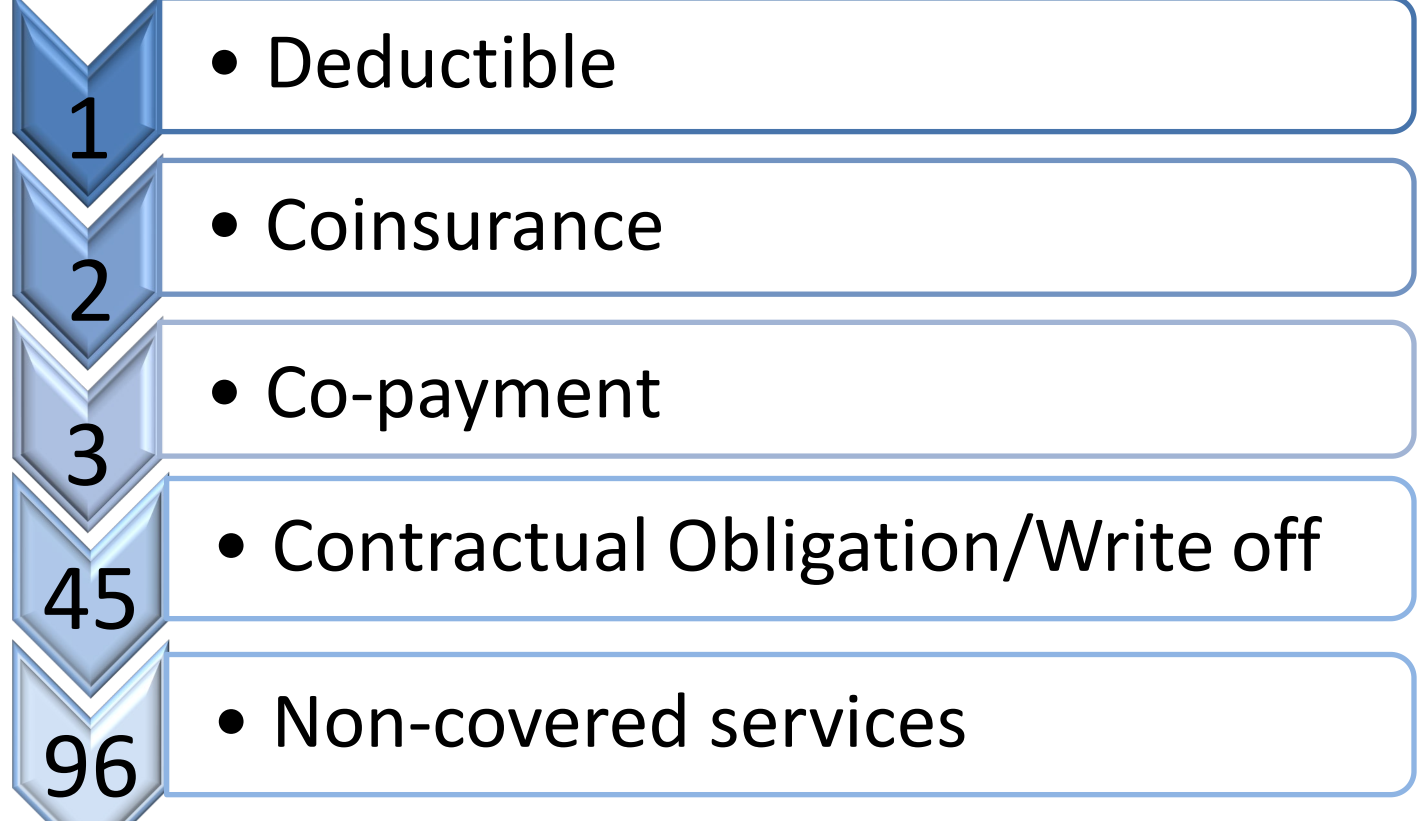
Detail level

- 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:



Third Party Liability (TPL) Claims

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

Header - Other Payer Amounts and Adjustment Reason Codes

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

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

delete | add an item

Payer Header Level Adjustment Reason Codes (ARC) and Amounts

*Electronic Payer ID: 01234
*CAS Group Code: PR-Patient Responsibility
*ARC: 1
*Amount: $50.00

Third Party Liability (TPL) Claims

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

Detail - Other Payer Amounts and Adjustment Reason Codes

Detail - Other Payer Amounts and Adjustment Reason Codes

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

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

delete | add an item

Payer Line Level Adjustment Reason Codes(ARC) and Amounts

*Detail Item/Electronic Payer ID: 1/43210

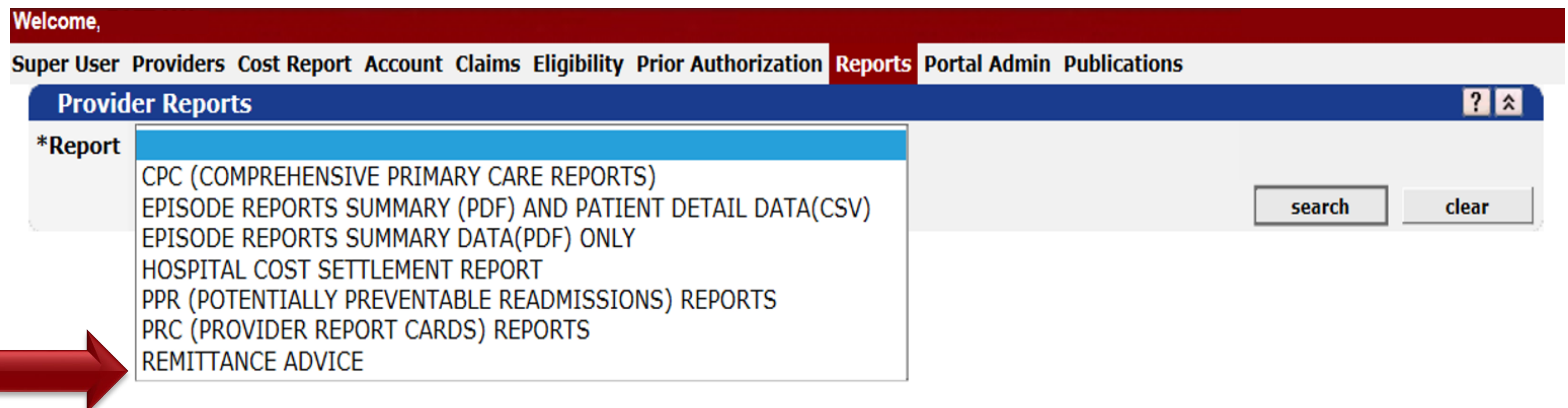
*CAS Group Code: CO-Contractual Obligations

*ARC: 45

*Amount: $150.00

Remittance Advice (RA)

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



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)

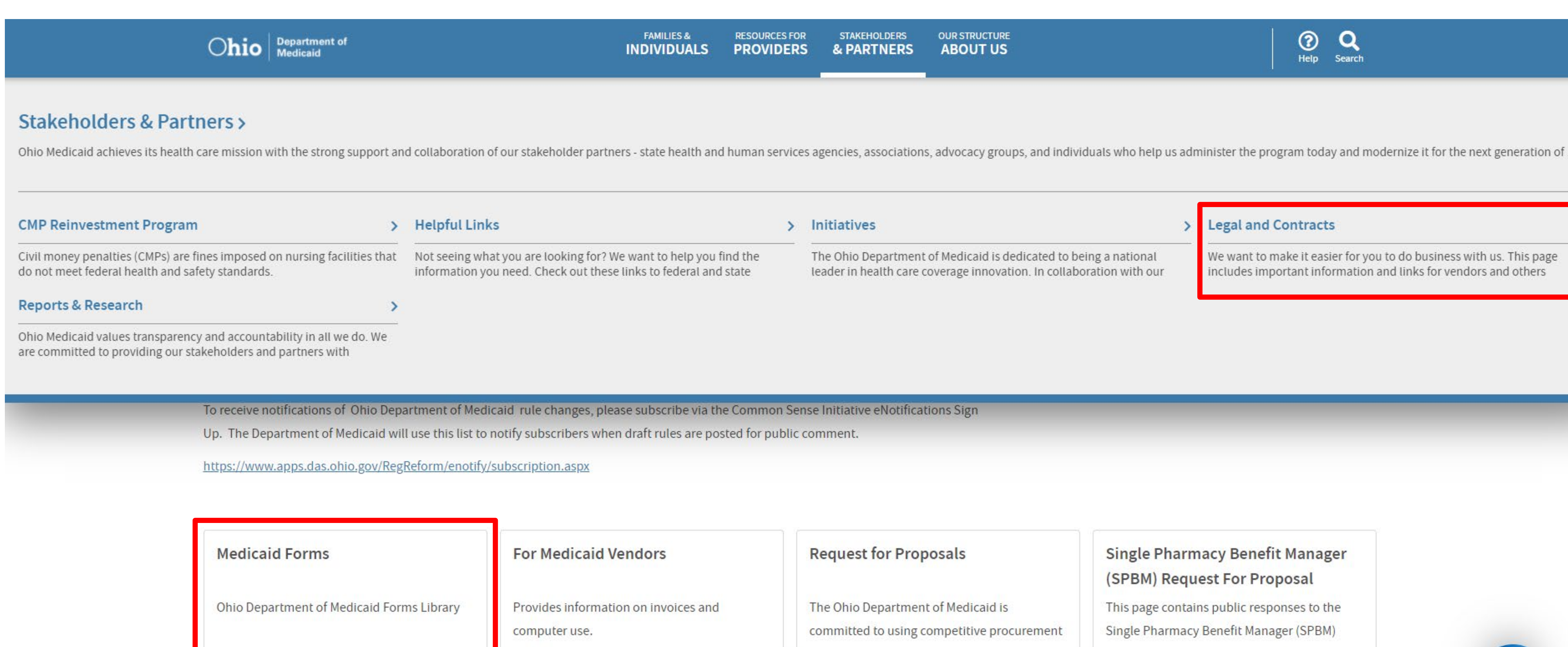
https://x12.org/codes/claim-adjustment-reason-codes

Forms

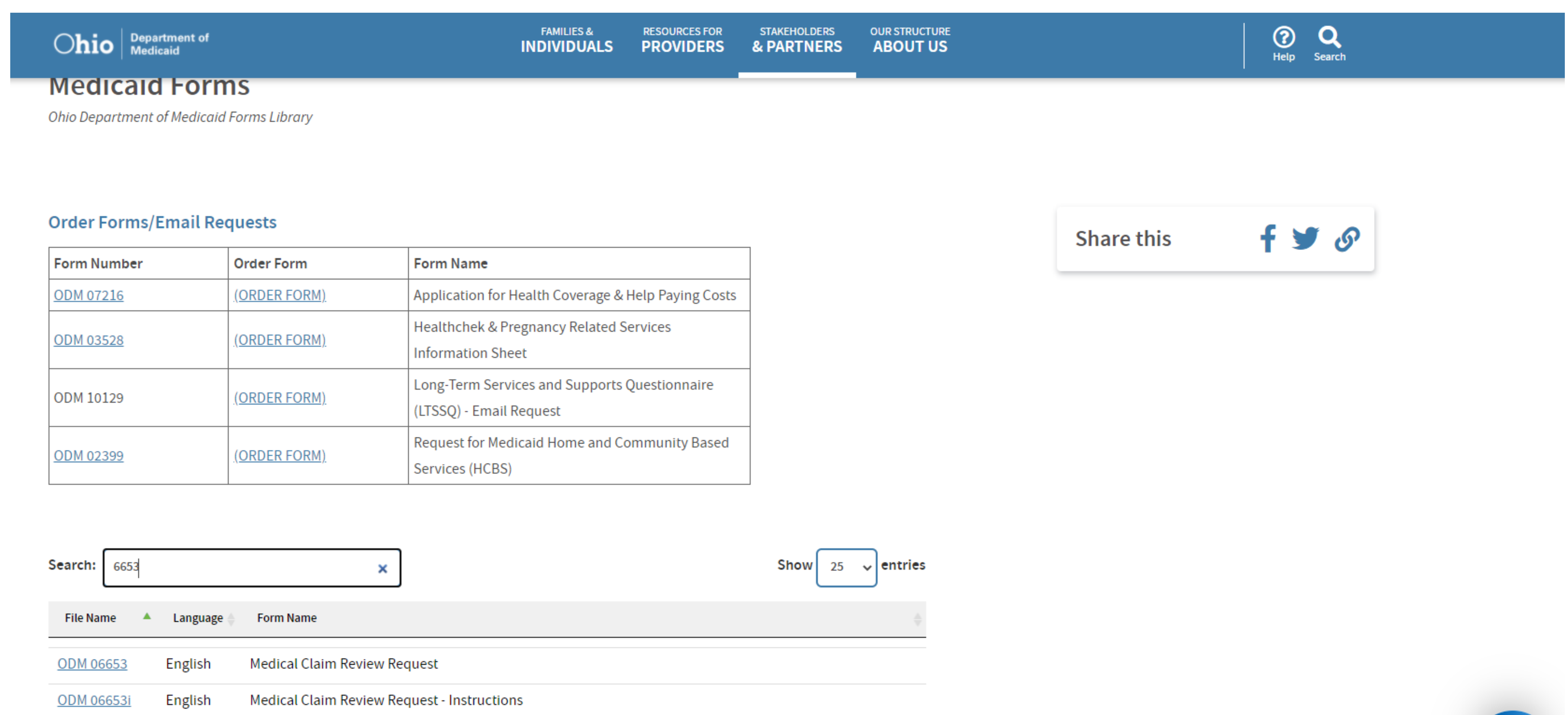
ODM 06614 – Health Insurance Fact Request

ODM 06653 – Medical Claim Review Request

Forms



Forms



Form Number	Order Form	Form Name
ODM 07216	(ORDER FORM)	Application for Health Coverage & Help Paying Costs
ODM 03528	(ORDER FORM)	Healthchek & 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)

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