Ohio | Department of Medicaid

Basic Billing for Durable Medical Equipment Providers

Provider Relations

2021

AGENDA

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

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

Providers will be required to enter two out of the following three pieces of data: tax ID (or SS#), NPI, or 7 digit Ohio Medicaid provider number

1-800-686-1516

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

Provider Assistance

If you call provider assistance you will be given your number in line upon entering the queue

Medicaid Services

- Helpful phone numbers
  - » Adjustments
    - LTCPaymentSection@medicaid.ohio.gov
  - » OSHIP (Ohio Senior Health Insurance Information Program)
    - 1-800-686-1578
  - » Coordination of Benefits Section
    - 614-752-5768
    - 614-728-0757 (fax)

Programs & Cards

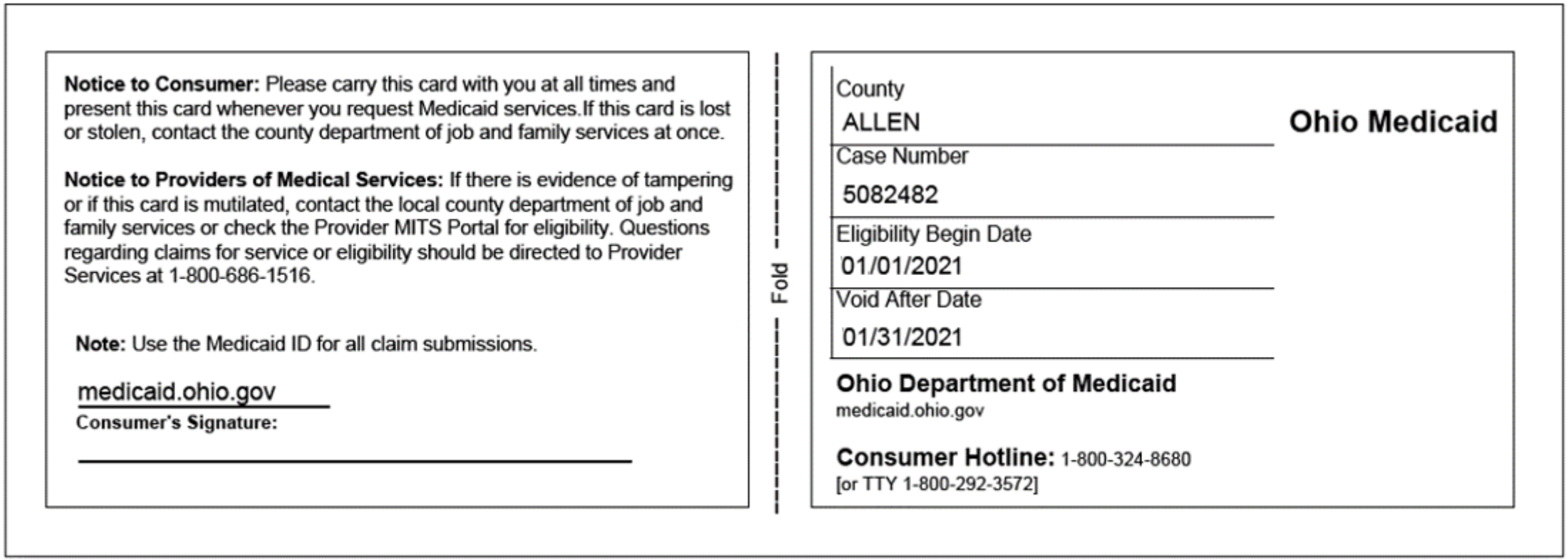
Medicaid Medical Necessity: OAC 5160-1-01

Is the fundamental concept underlying the Medicaid Program

All Services must meet accepted standards of medical practice

Ohio Medicaid

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



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.

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.

Note: Use the Medicaid ID for all claim submissions.

medicaid.ohio.gov

Consumer's Signature:

Fold

County
ALLEN

Ohio Medicaid

Case Number
5082482

Eligibility Begin Date
01/01/2021

Void After Date
01/31/2021

Ohio Department of Medicaid
medicaid.ohio.gov

Consumer Hotline: 1-800-324-8680
[or TTY 1-800-292-3572]

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

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

Ohio Medicaid

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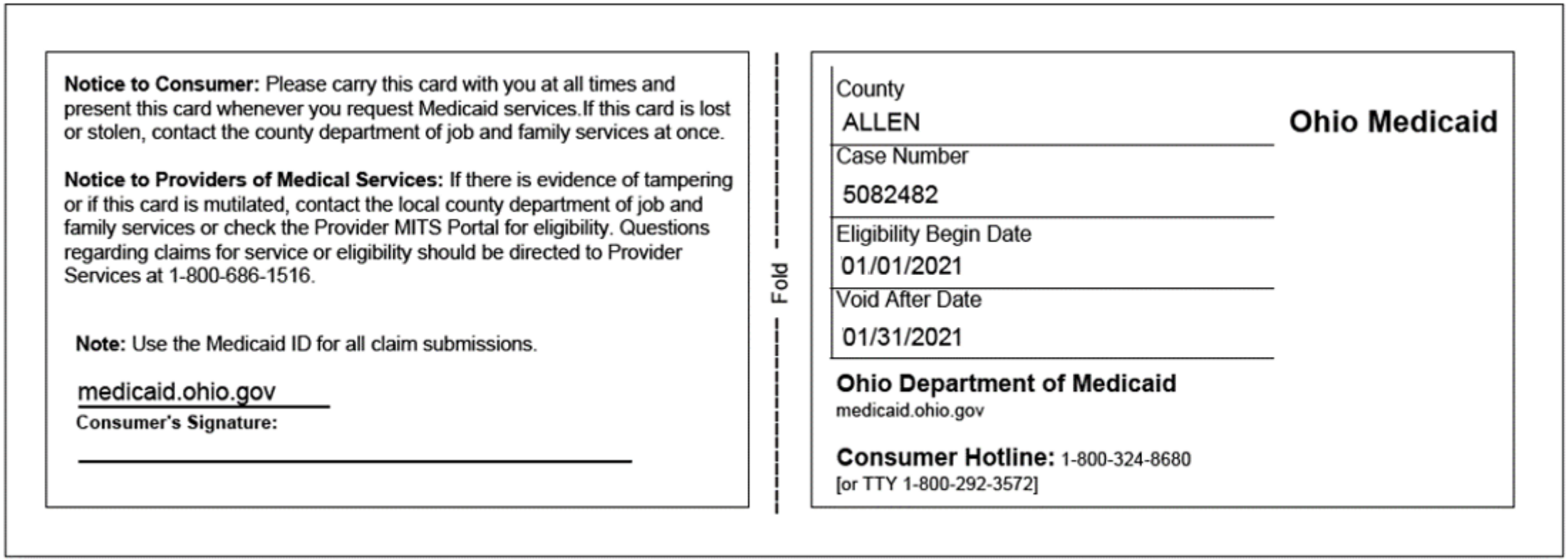

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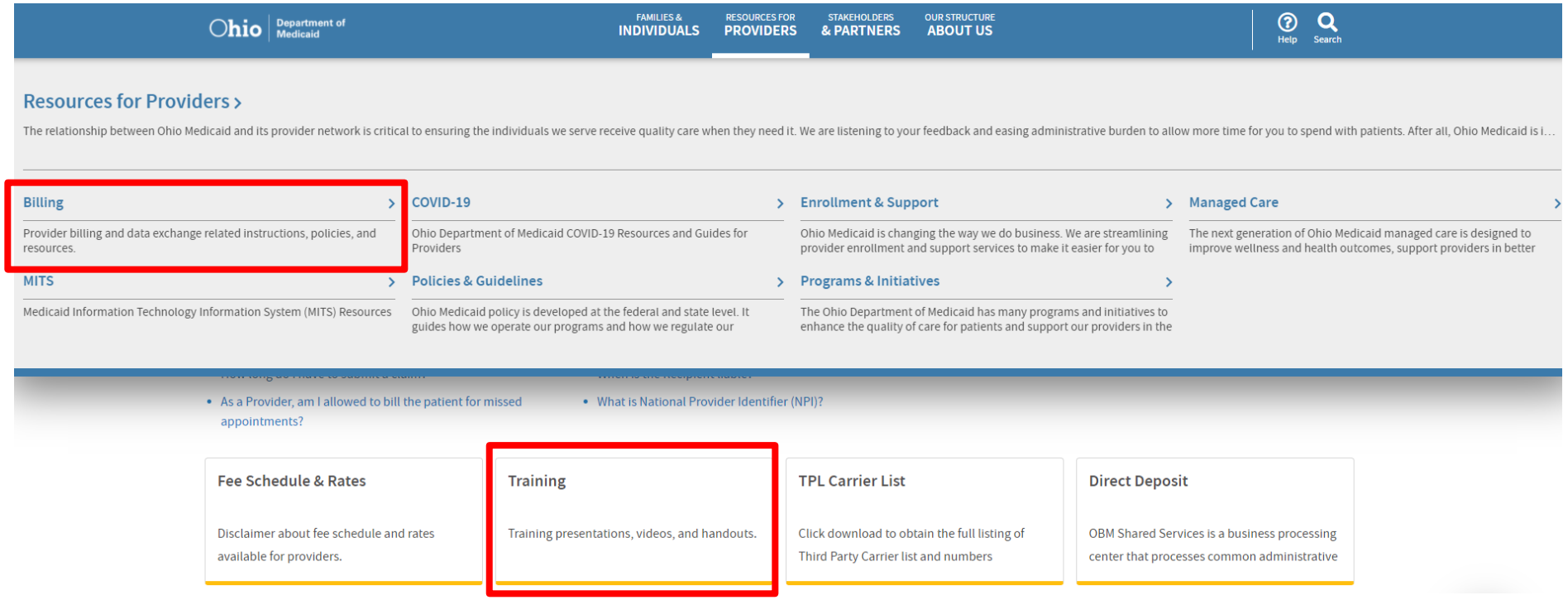
Programs & Cards

- Conditions of Eligibility and Verifications: OAC 5160:1-2-10
  - »Consumers must cooperate with requests from third-party insurance companies to provide additional information needed in order to authorize coverage
  - »Consumers must cooperate with requests from a Medicaid provider; managed care plan; or a managed care plan's contracted provider for additional information which is needed in order to bill third party insurances appropriately

Eligibility Verification Request



Training Videos

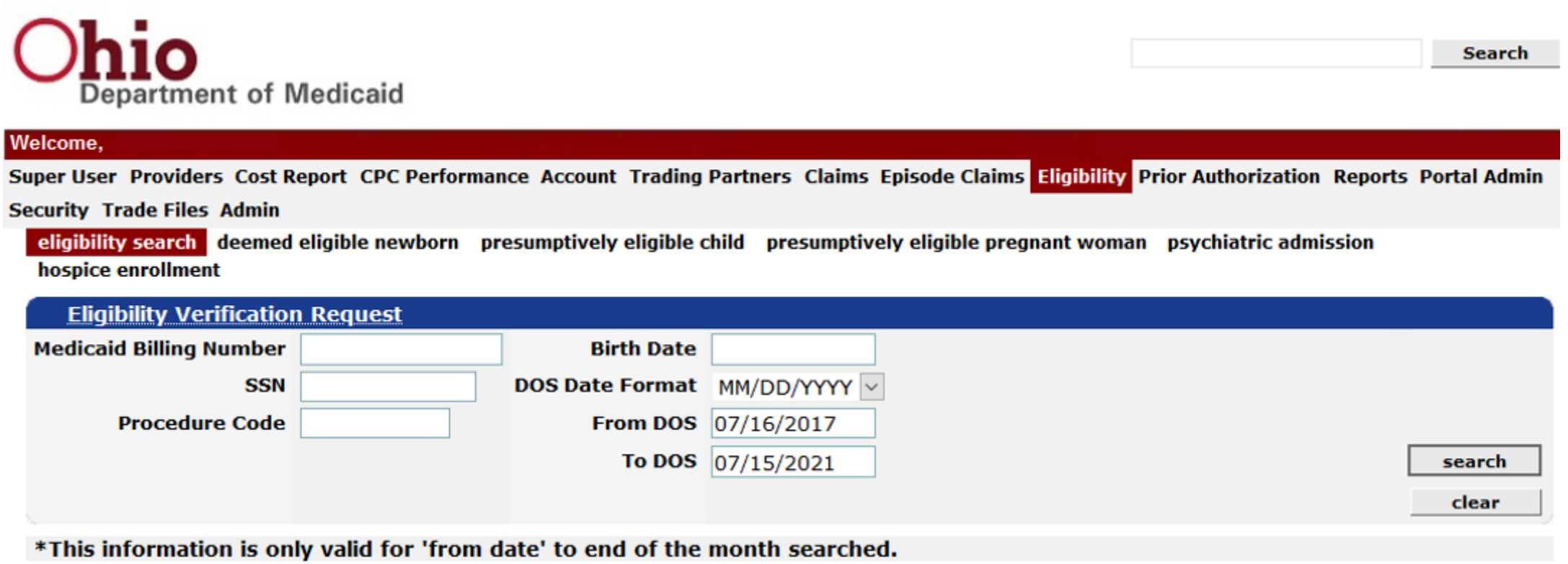
Ohio Medicaid has created a compilation of training videos that cover a variety of topics for providers. If questions remain after reviewing these videos, contact Ohio Medicaid Provider Assistance at 1-800-686-1516.

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



TIP: Always check eligibility prior to billing

Eligibility Verification Request

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

Inpatient Hospital Services Plan (IHSP)

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

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

QMB

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

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 updatesare part of CMS' ongoing efforts to help providers comply with QMB billing prohibitions.

SLMB

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			

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

QI-1

Recipient Information

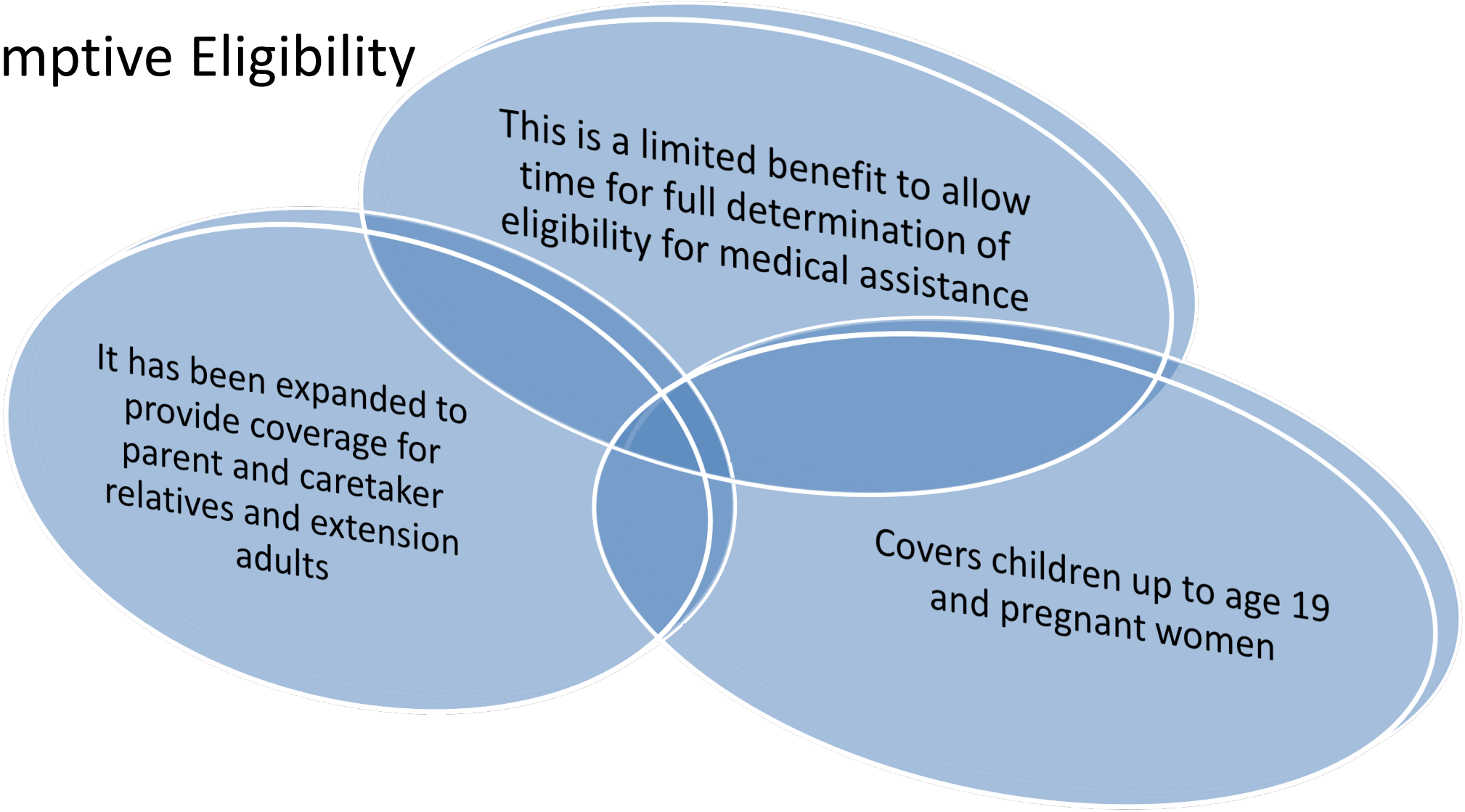
Medicaid Billing Number	SSN
Last Name	County of Residence
First Name	County of Eligibility
Gender	County Office http://jfs.ohio.gov/county/cntydir.stm
Date of Birth	Number Bed Hold Days Used Paid CY
Date of Death	

Benefit / Assignment Plan

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

Programs & Cards

- Presumptive Eligibility



Presumptive Eligibility

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

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 Medicaid
- OAC 5160-58: MyCare Ohio
- Each MCP has a Contract Administrator at the Ohio Department of Medicaid

MITS Managed Care Eligibility

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 ***

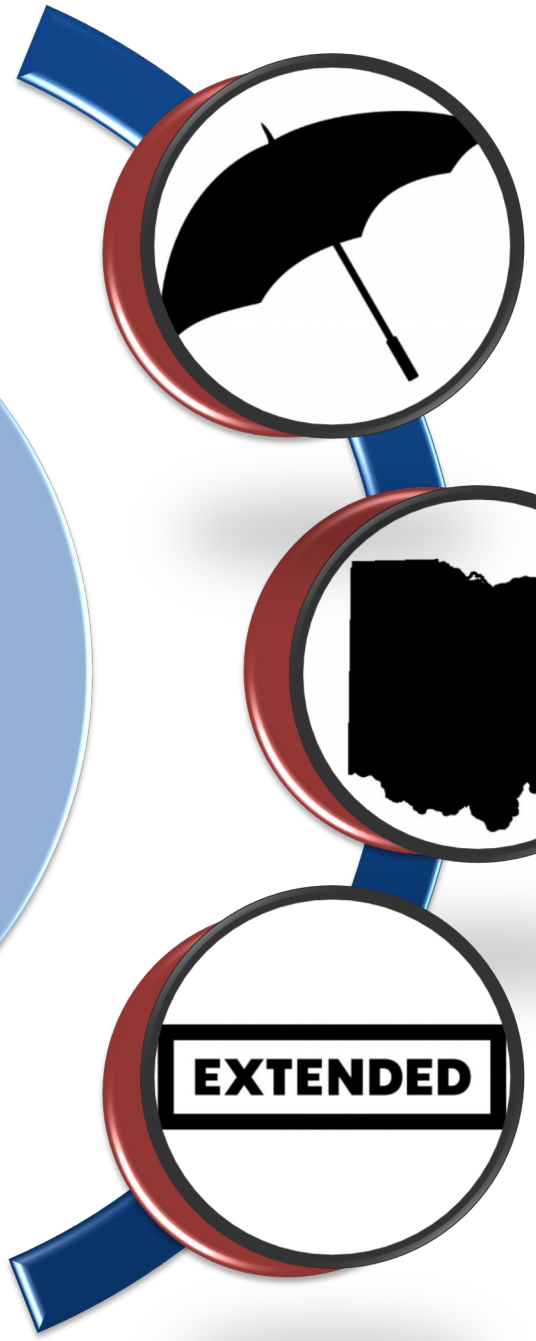
TPL

*** 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	

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

The project is currently slated to end on December 31, 2022

MITS Eligibility MyCare Opt-In

Benefit / Assignment Plan

Benefit / Assignment Plan	Effective Date	End Date	Provider Name	Dental Co-Pay Amount	Vision Co-Pay Amount
MRDD Targeted Case Mgmt	10/24/2018	09/30/2021		$0.00	$0.00
Alcohol and Drug Addiction Services	10/24/2018	09/30/2021		$0.00	$0.00
Ohio Mental health	10/24/2018	09/30/2021		$0.00	$0.00
Medicaid	10/24/2018	09/30/2021		$0.00	$0.00
MyCare Ohio Waiver	10/24/2018	09/30/2021		$0.00	$0.00

Case/Cat/Seq Spenddown

*** No rows found ***

TPL

*** No rows found ***

Managed Care

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

Benefit / Assignment Plan

Benefit / Assignment Plan	Effective Date	End Date	Provider Name	Dental Co-Pay Amount	Vision Co-Pay Amount
MRDD Targeted Case Mgmt	10/24/2018	09/30/2021		$0.00	$0.00
Alcohol and Drug Addiction Services	10/24/2018	09/30/2021		$0.00	$0.00
Ohio Mental health	10/24/2018	09/30/2021		$0.00	$0.00
Medicaid	10/24/2018	09/30/2021		$0.00	$0.00
MyCare Ohio Waiver	10/24/2018	09/30/2021		$0.00	$0.00

Case/Cat/Seq Spenddown

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TPL

*** No rows found ***

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

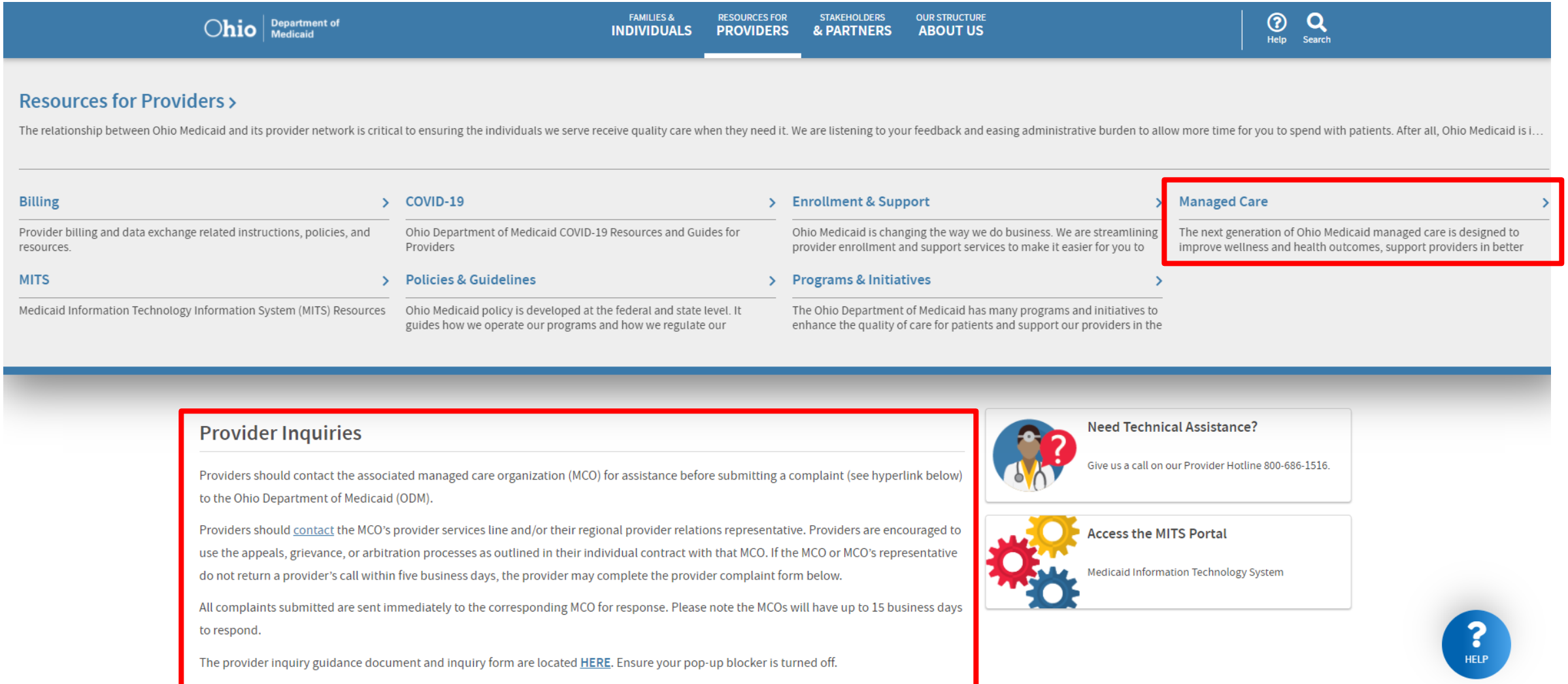
Lock-In

*** 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

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.

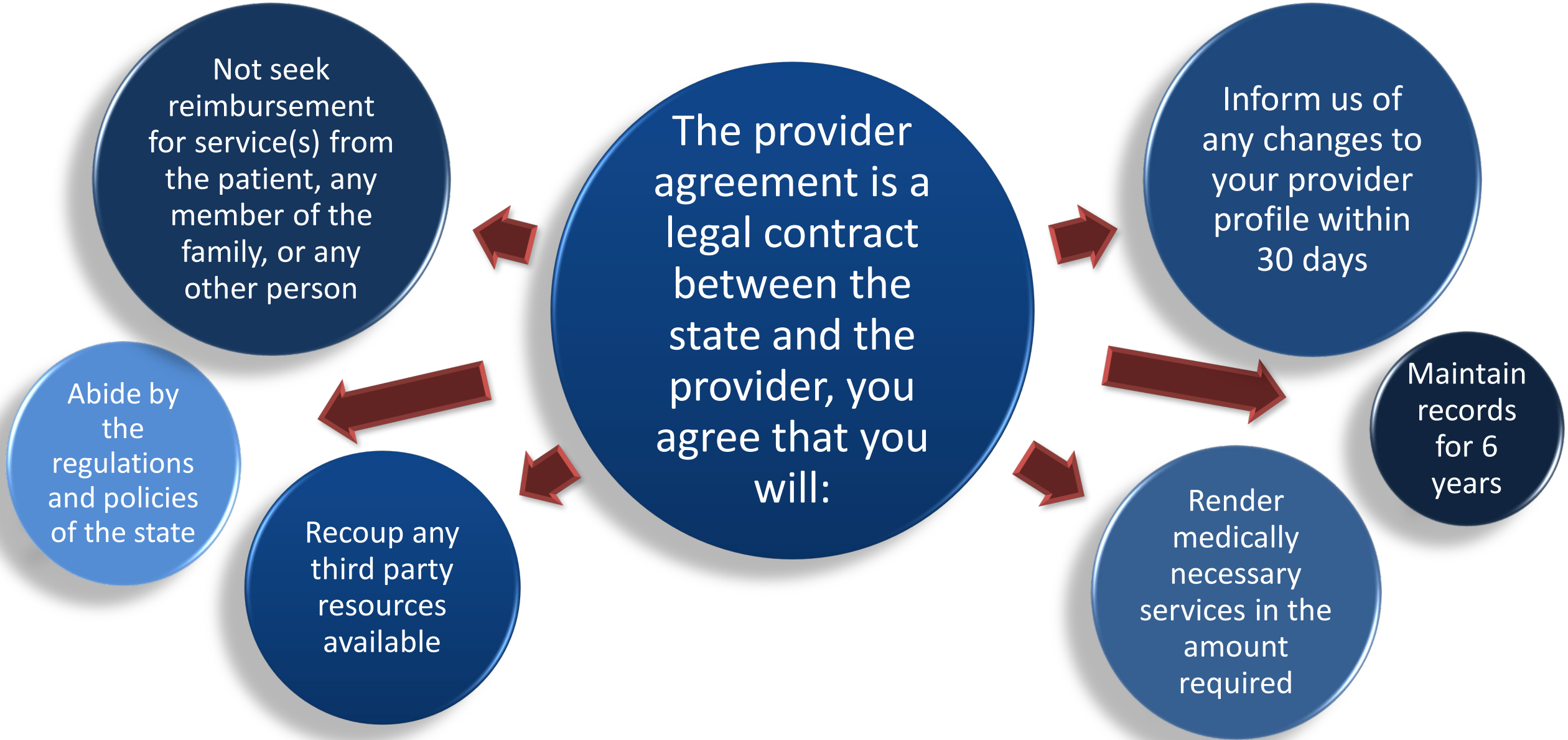
NEW If the provider submits multiple complaints for the same issue (different individuals, dates of service, practitioners, or files affected), ODM will cancel all duplicate complaints, contact the provider, and request that a single new complaint be submitted for all files affected.

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.

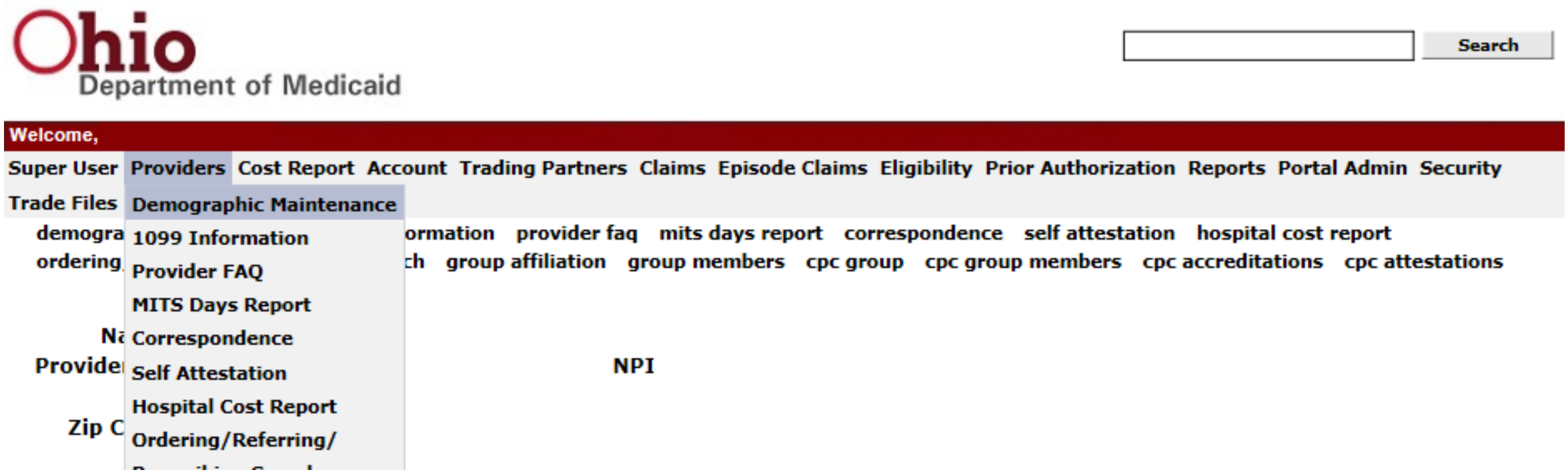
Provider Responsibilities

❑ Provider Agreement: OAC 5160-1-17.2



Provider Responsibilities

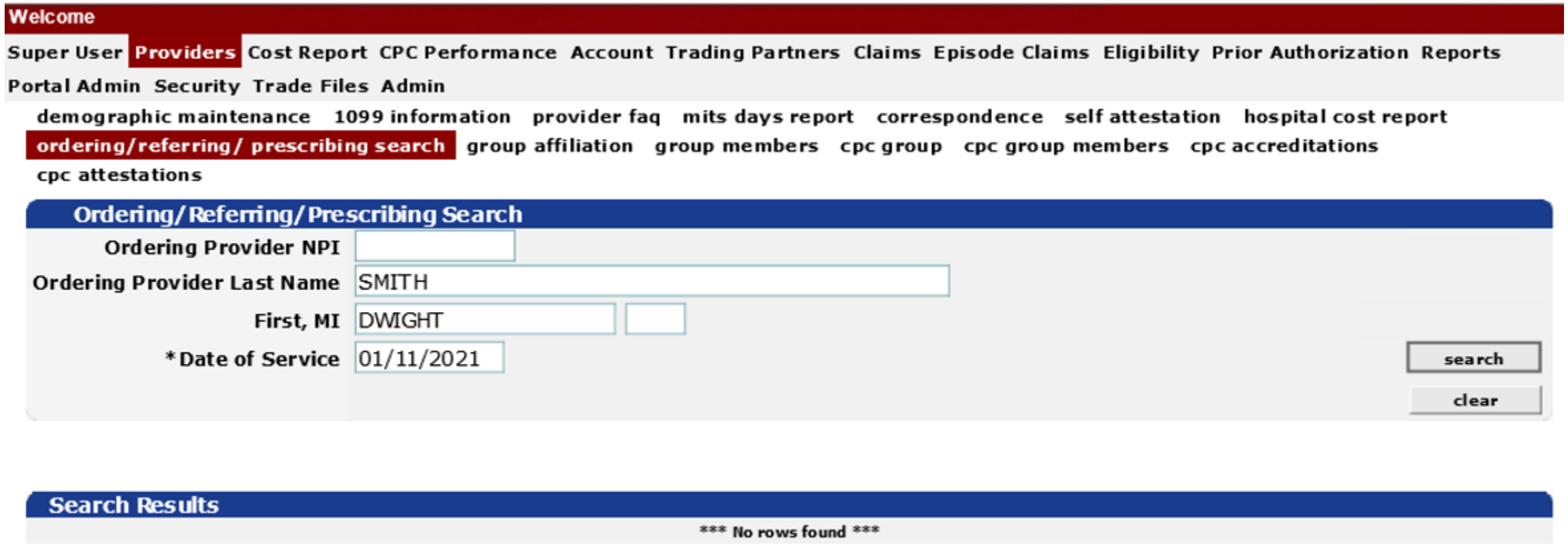
- Demographic Maintenance in MITS



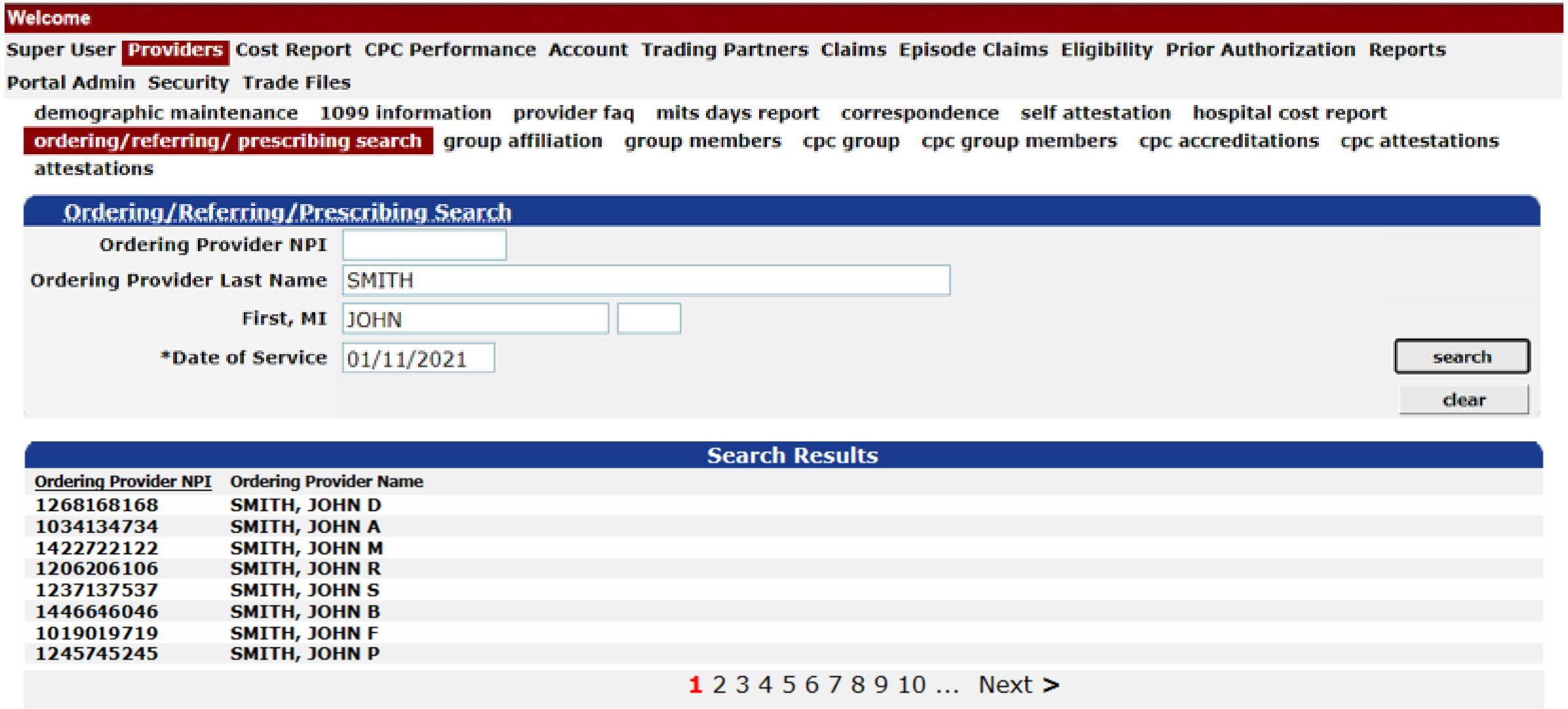
Provider Responsibilities

- Demographic Maintenance in MITS, cont.

ORP 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
demographic maintenance 1099 information provider faq mits days report correspondence self attestation hospital cost report
ordering/referring/ prescribing search group affiliation group members cpc group cpc group members cpc accreditations
cpc attestations
Ordering/Referring/Prescribing Search
Ordering Provider NPI
Ordering Provider Last Name SMITH
First, MI DWIGHT
*Date of Service 01/11/2021
search
clear
Search Results
*** No rows found ***

ORP Search


Welcome
Super User Providers Cost Report CPC Performance Account Trading Partners Claims Episode Claims Eligibility Prior Authorization Reports
Portal Admin Security Trade Files
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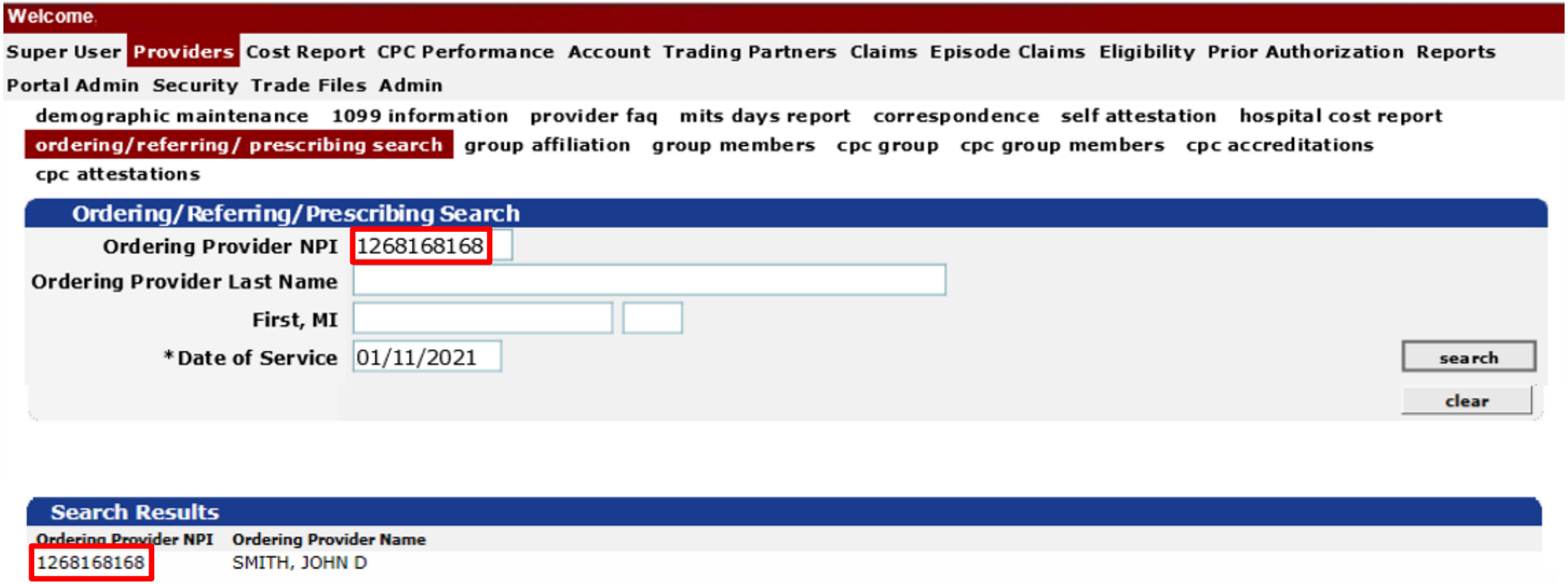
ordering/referring/ prescribing search group affiliation group members cpc group cpc group members cpc accreditations cpc attestations
attestations
Ordering/Referring/Prescribing Search
Ordering Provider NPI
Ordering Provider Last Name SMITH
First, MI JOHN
*Date of Service 01/11/2021
search
clear
Search Results
Ordering Provider NPI Ordering Provider Name
1268168168 SMITH, JOHN D
1034134734 SMITH, JOHN A
1422722122 SMITH, JOHN M
1206206106 SMITH, JOHN R
1237137537 SMITH, JOHN S
1446646046 SMITH, JOHN B
1019019719 SMITH, JOHN F
1245745245 SMITH, JOHN P
1 2 3 4 5 6 7 8 9 10 ... Next >

ORP Search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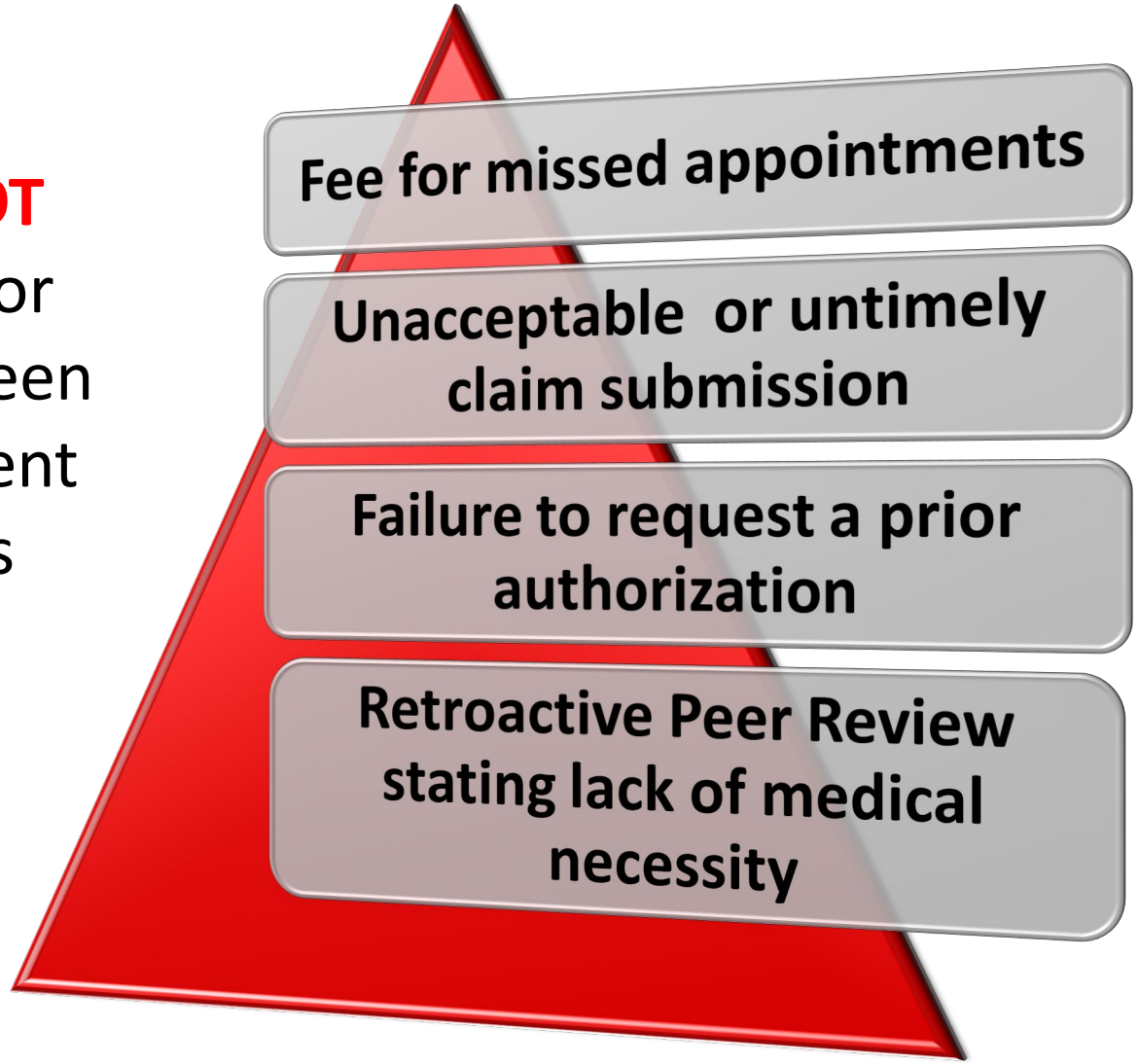
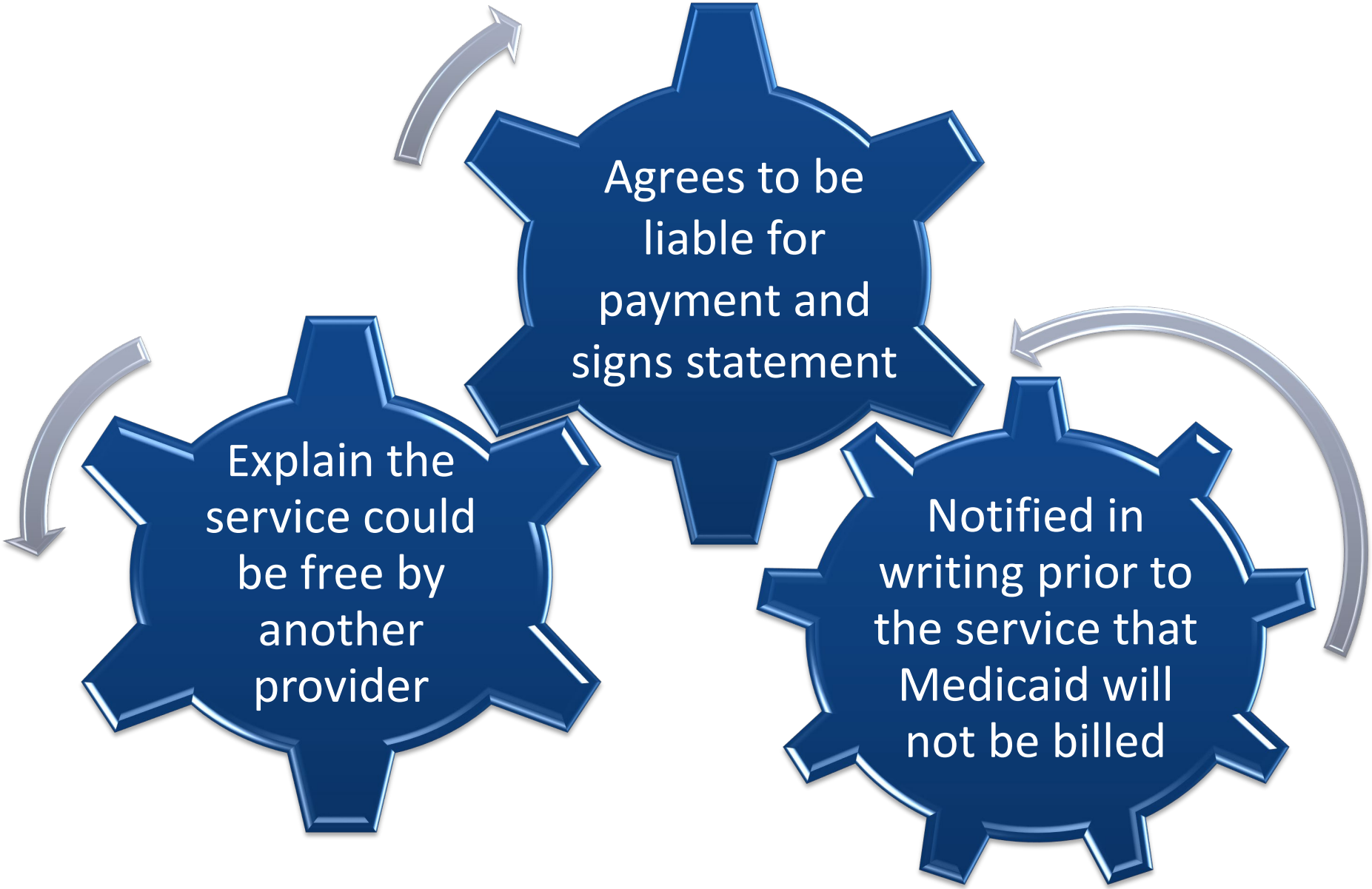
ordering/referring/ prescribing search group affiliation group members cpc group cpc group members cpc accreditations
cpc attestations
Ordering/Referring/Prescribing Search
Ordering Provider NPI 1268168168
Ordering Provider Last Name
First, MI
*Date of Service 01/11/2021
search
clear
Search Results
Ordering Provider NPI
Ordering Provider Name
1268168168
SMITH, JOHN D

Medicaid Consumer Liability 5160-1-13.1

A provider may **NOT** collect and/or bill for any difference between the Medicaid payment and the provider's charge, or for the following:



When Can you Bill an Individual?



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.

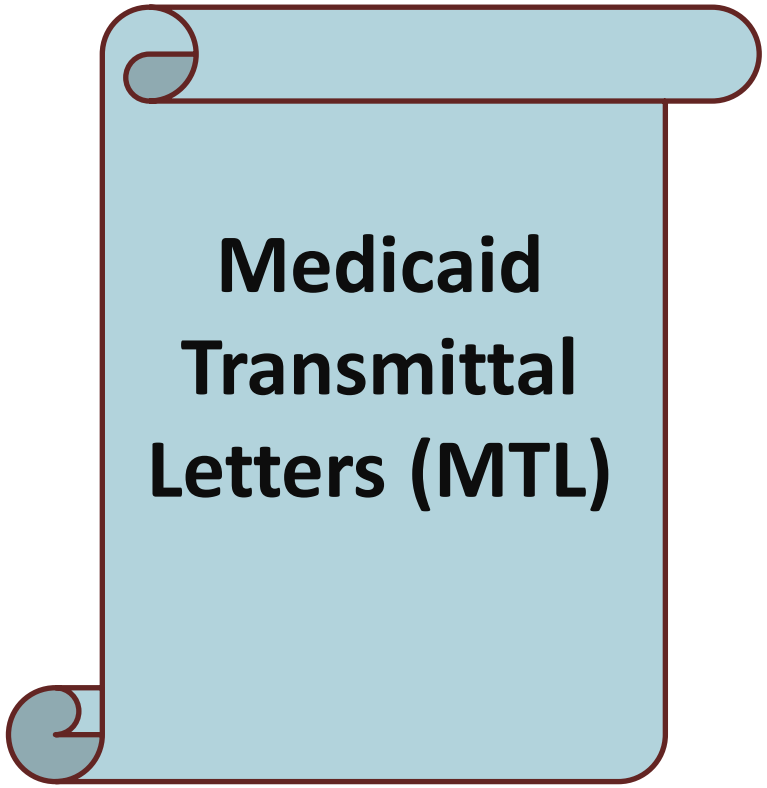
☐ (D) Services that are not covered by the Medicaid program, including services requiring prior authorization that have been denied by ODM, may be billed to a Medicaid recipient when the condition in paragraphs (C)(2) through (C)(4) of this rule are met.

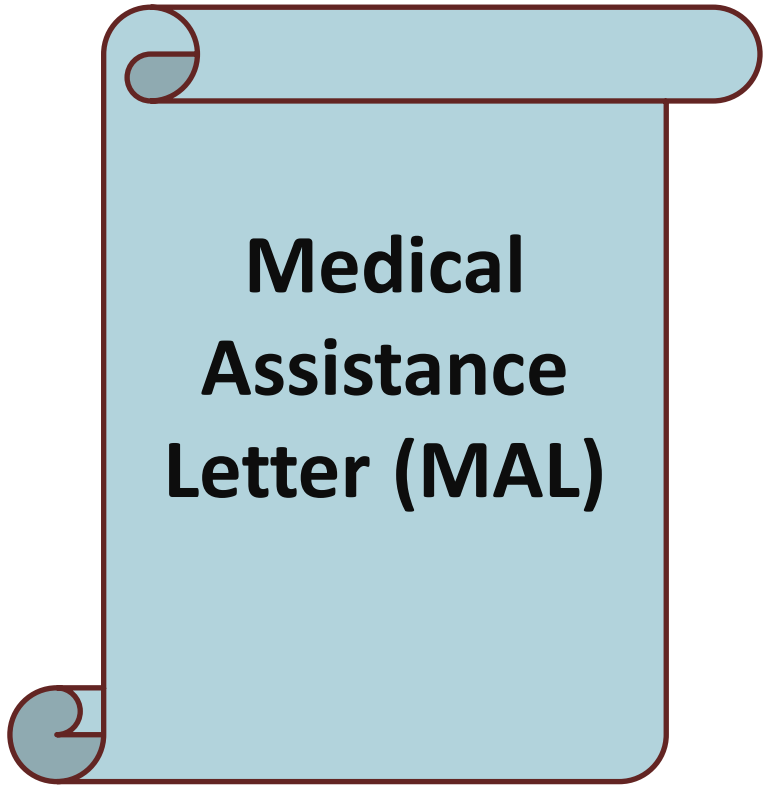
☐ (E) Any individual not covered by Medicaid on the date of service is financially responsible for those services unless the individual qualifies for the hospital care assurance program (HCAP) in accordant with section 5168.14 of the Ohio Revised Code.

Signature _____ Date _____

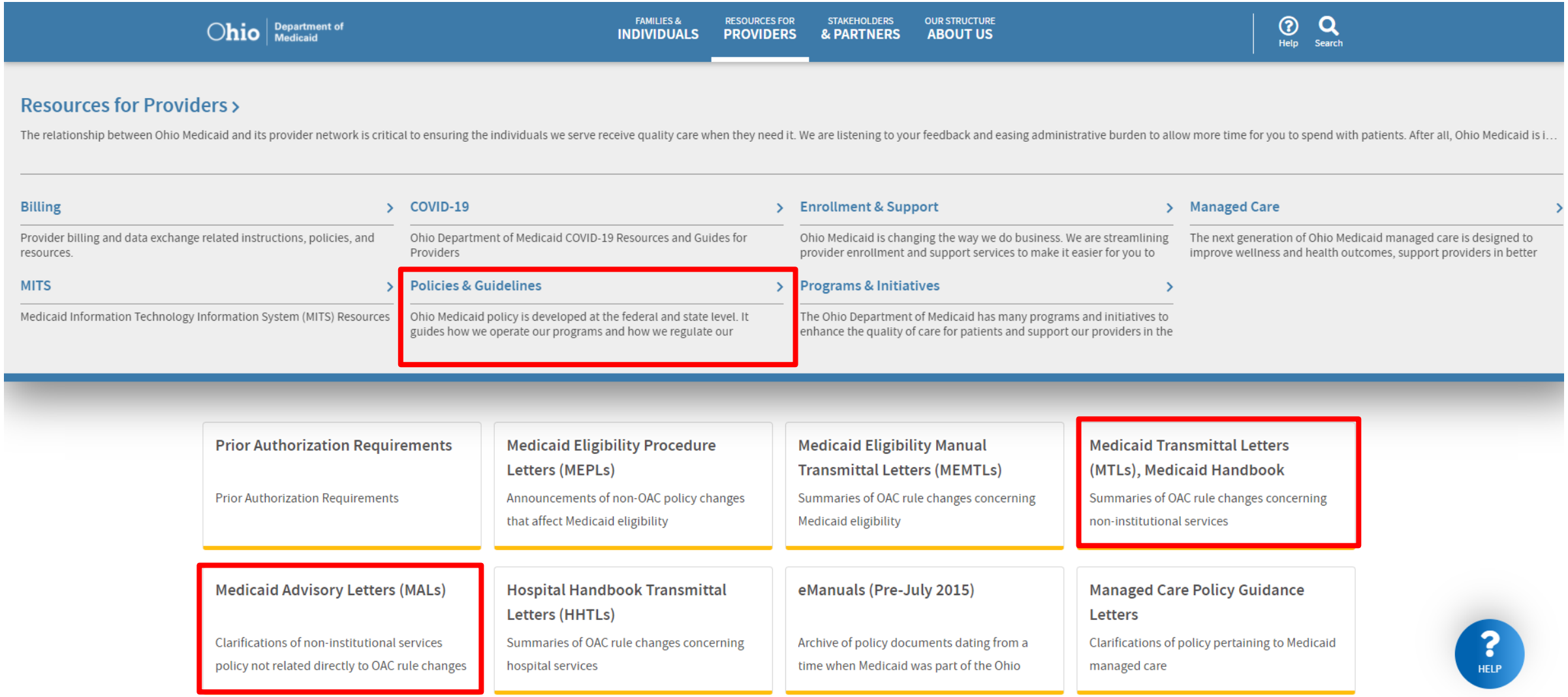
Policy

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

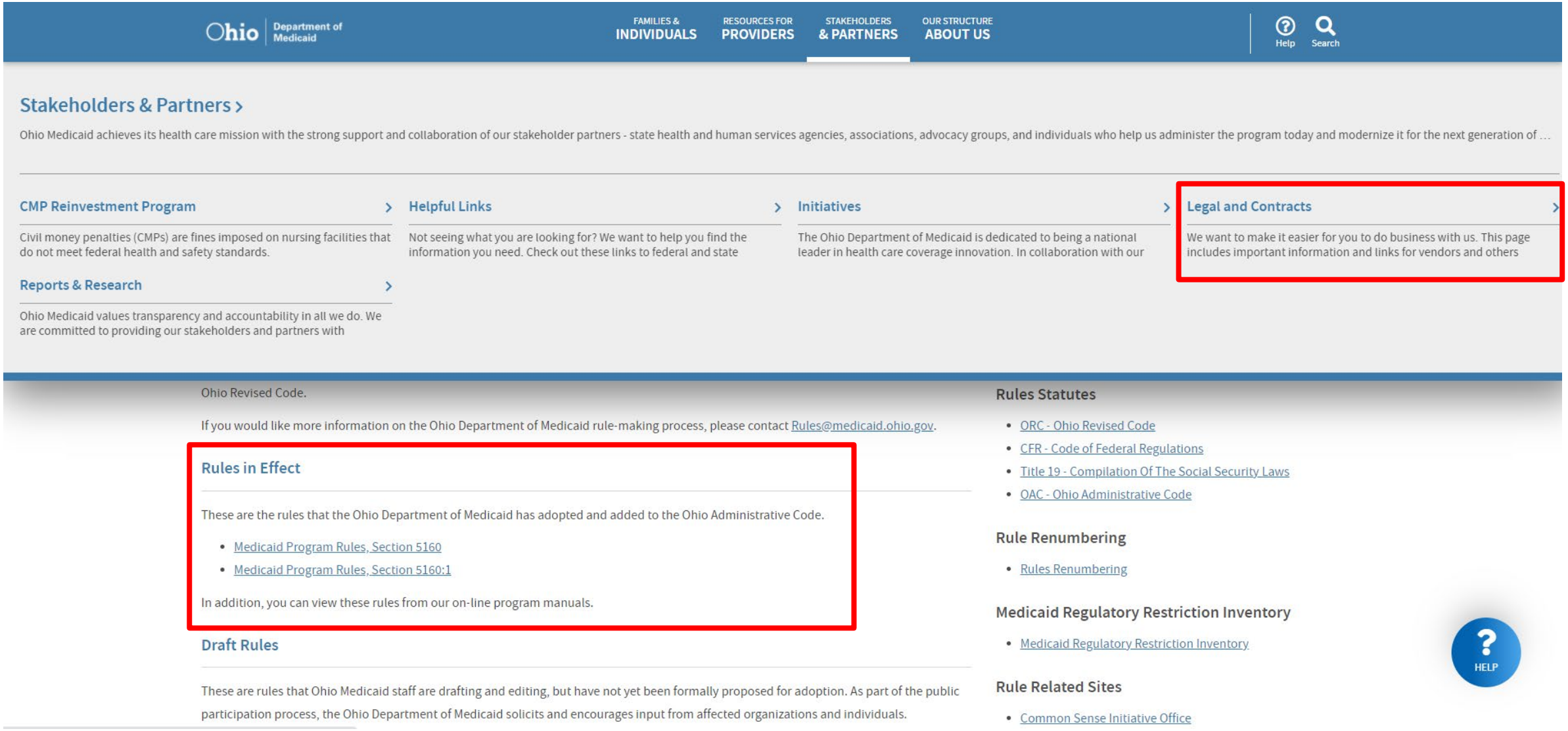




Policy


Ohio Department of Medicaid
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
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
HELP

Policy


Ohio | Department of Medicaid
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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
HELP

Policy

https://codes.ohio.gov

Policy

The DME rules are in Chapter 5160-10 of the OAC

OHIO LAWS & ADMINISTRATIVE RULES
LEGISLATIVE SERVICE COMMISSION

HOME | LAWS | ABOUT | CONTACT | RELATED SITES | GO TO 101-1-01 Go | Keyword Search

This website publishes administrative rules on their effective dates, as designated by the adopting state agencies, colleges, and universities.

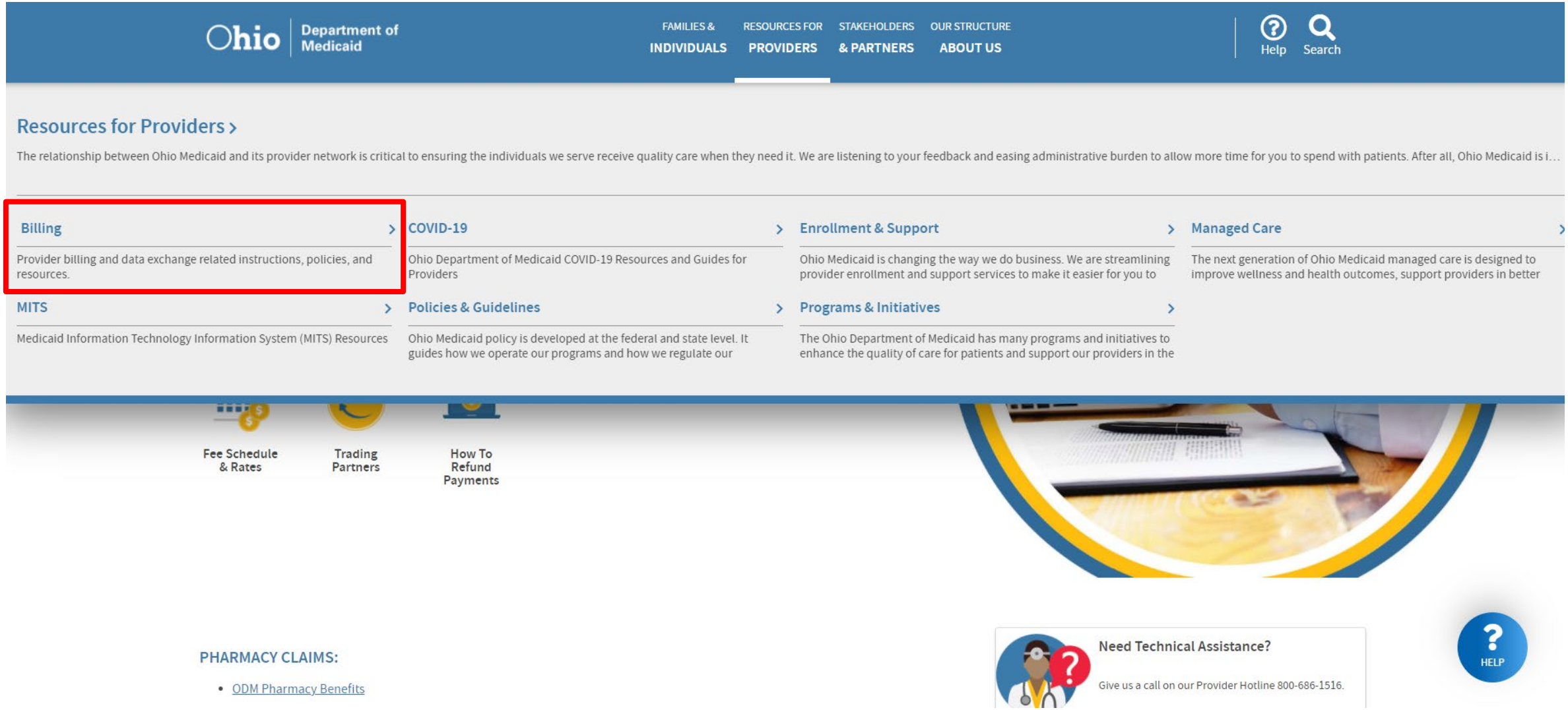
Chapter 5160-10 | Medical Supplies, Durable Medical Equipment, Orthoses, and Prosthesis Providers

Ohio Administrative Code / 5160

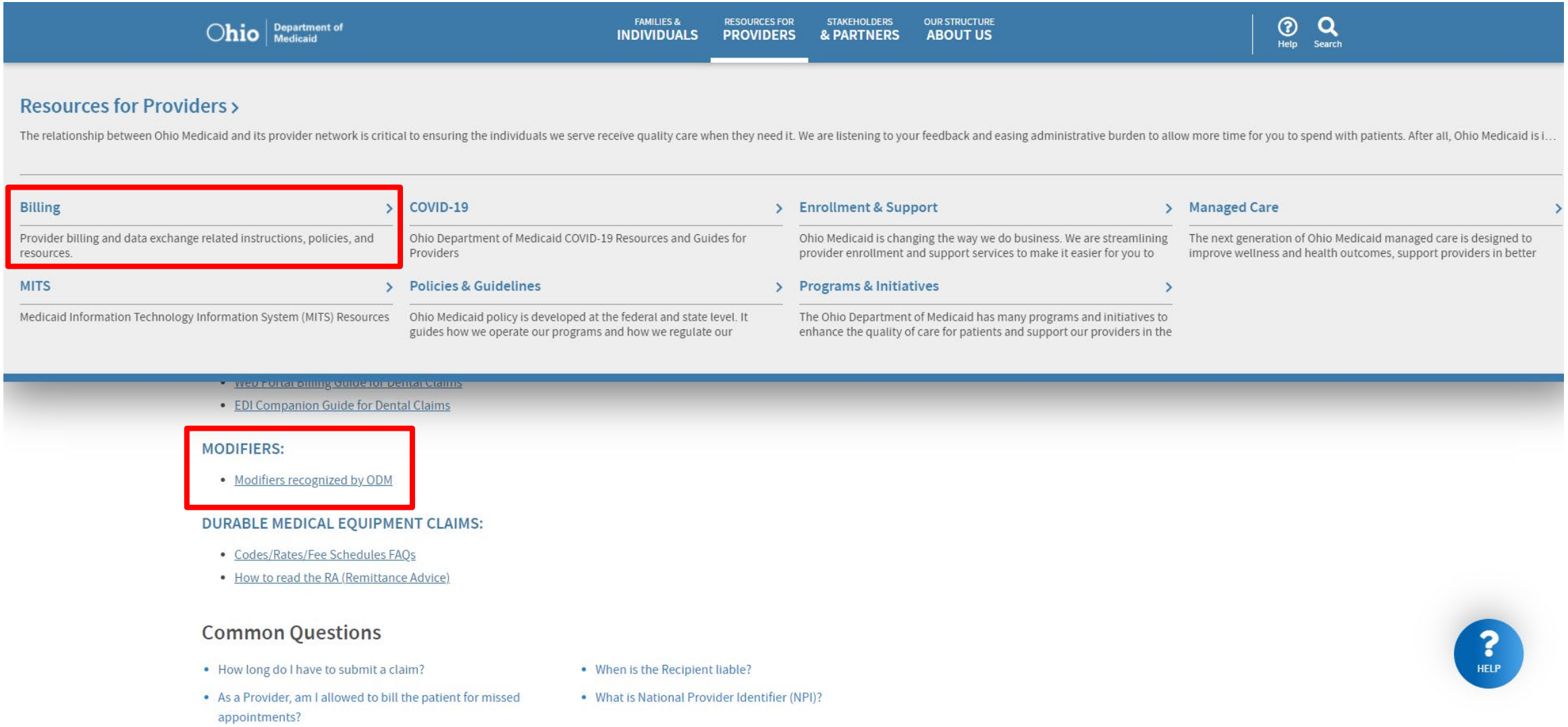
Expand All | Close All

Rule
Rule 5160-10-01 | Durable medical equipment, prostheses, orthoses, and supplies (DMEPOS): general provisions.
Rule 5160-10-02 | DMEPOS: repair.
Rule 5160-10-06 | DMEPOS: wearable cardioverter-defibrillators.
Rule 5160-10-07 | DMEPOS: bathing seats.
Rule 5160-10-08 | DMEPOS: high-frequency chest wall oscillation (HFCWO) devices.
Rule 5160-10-09 | DMEPOS: apnea monitors.
Rule 5160-10-11 | DMEPOS: hearing aids.

Billing Resources

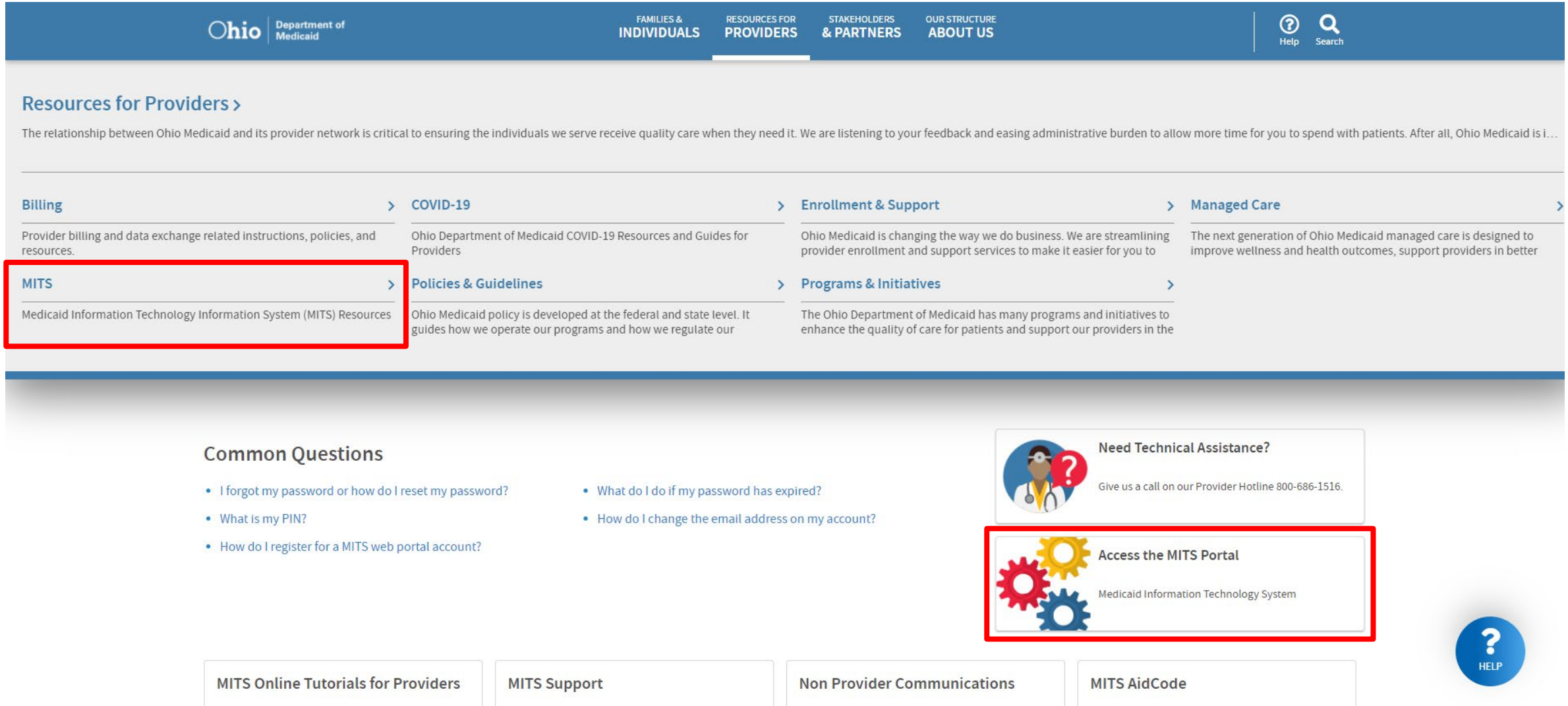


How to Find Modifiers Recognized by Ohio Medicaid

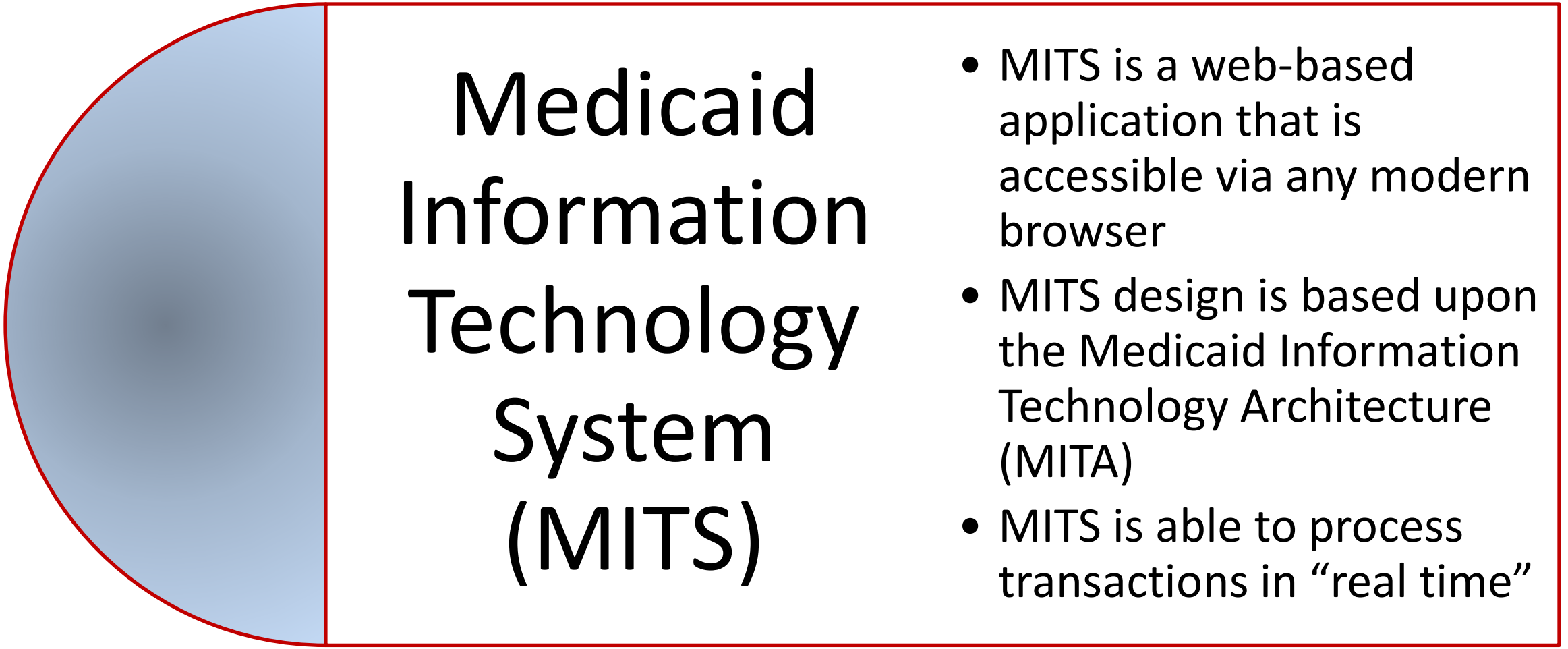


MITS & Claims

MITS Provider Portal

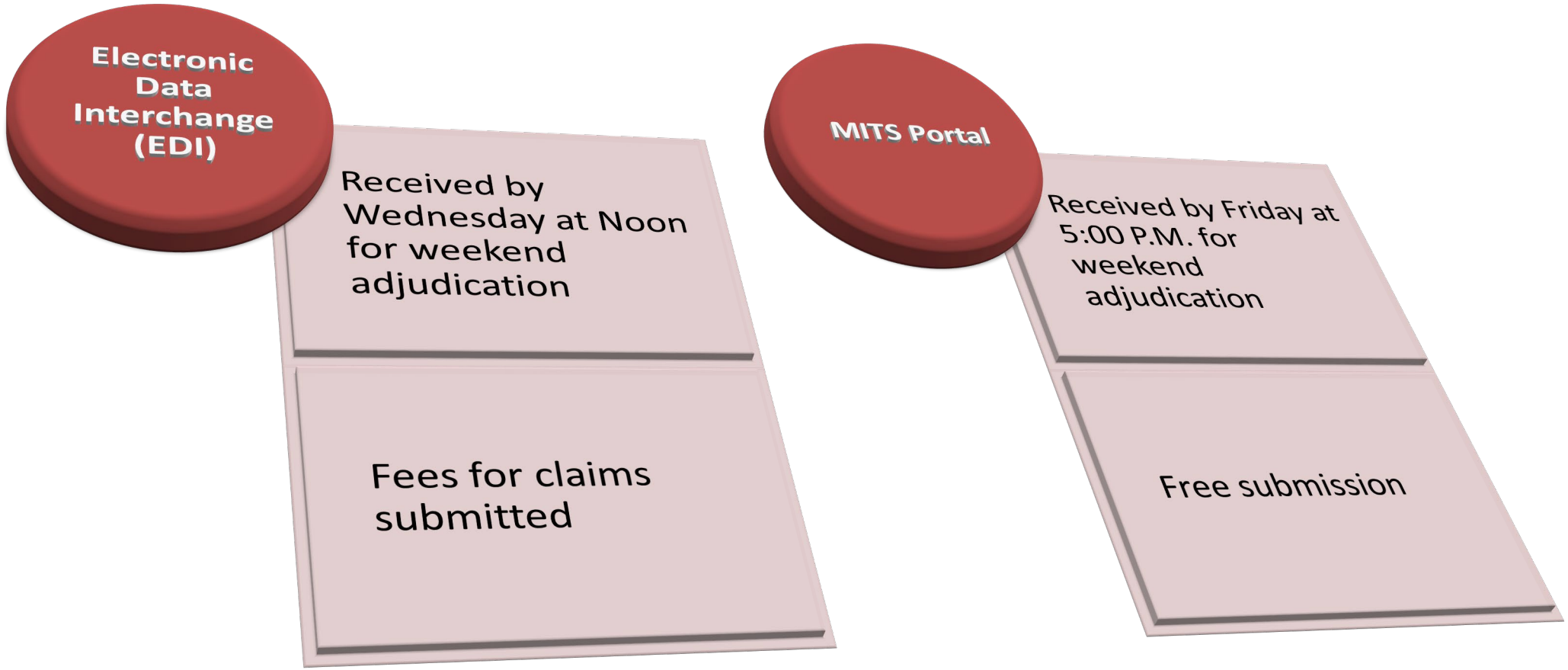


MITS and Claims



MITS and Claims

- Methods of Claim Submission



MITS and Claims

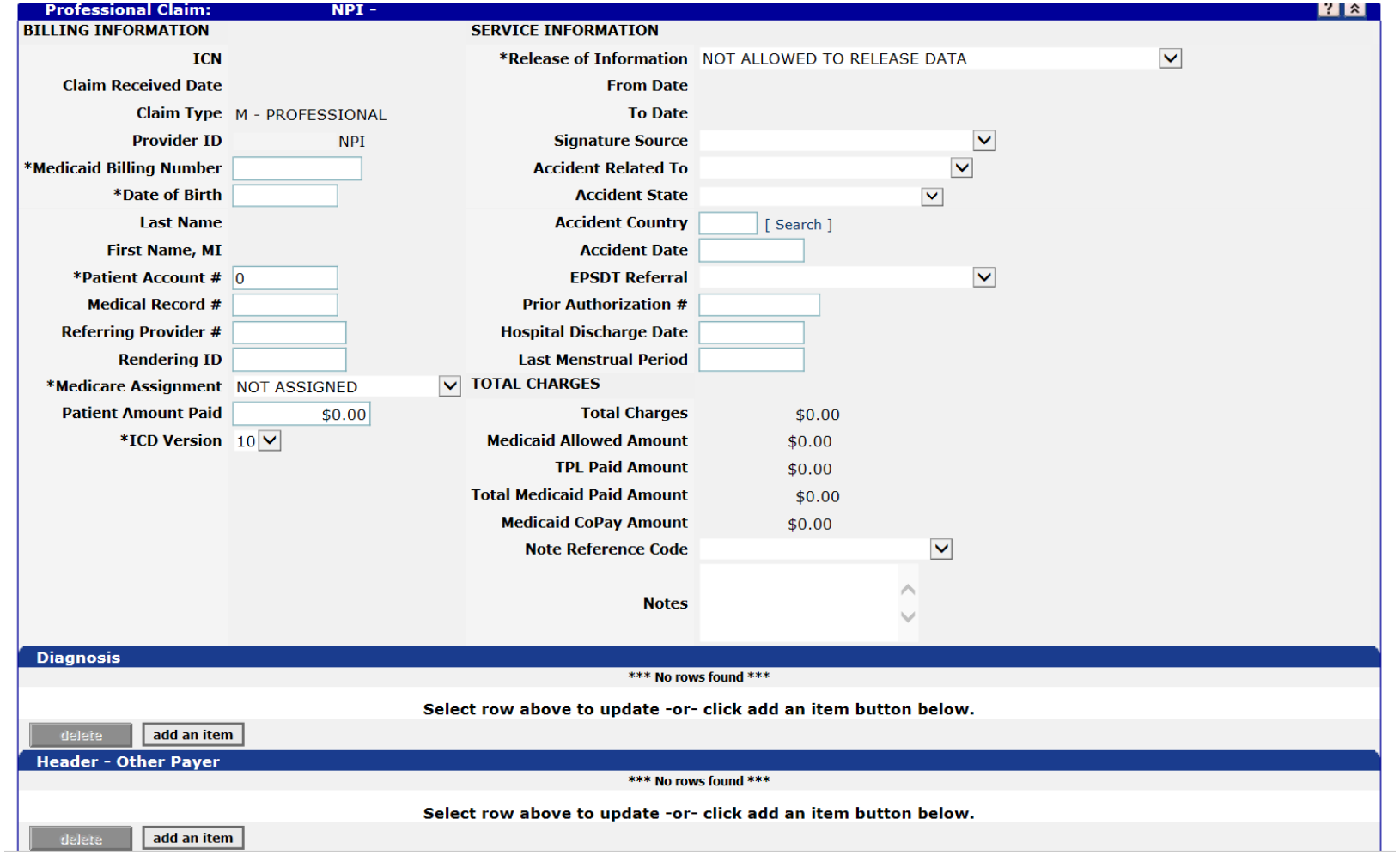
- Claim Submission
  - »Claim entry format is divided into sections or panels
  - »Each panel will have an asterisk (*) denoting that the fields are required
    - ▪Some fields are situational for claims adjudication and do not have an asterisk

MITS and Claims

- Submission of a Professional Claim

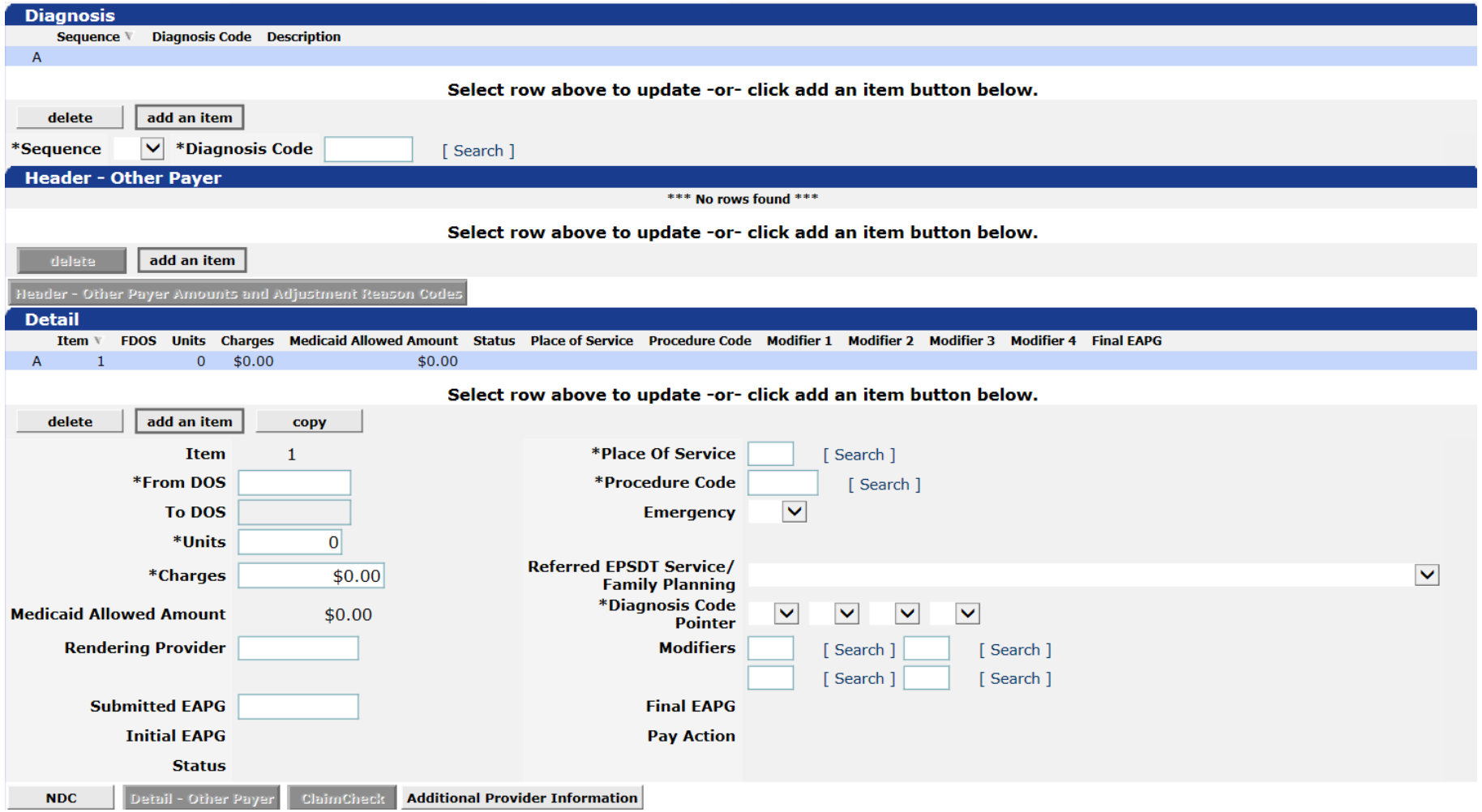
MITS and Claims

- Submission of a Professional Claim, cont.

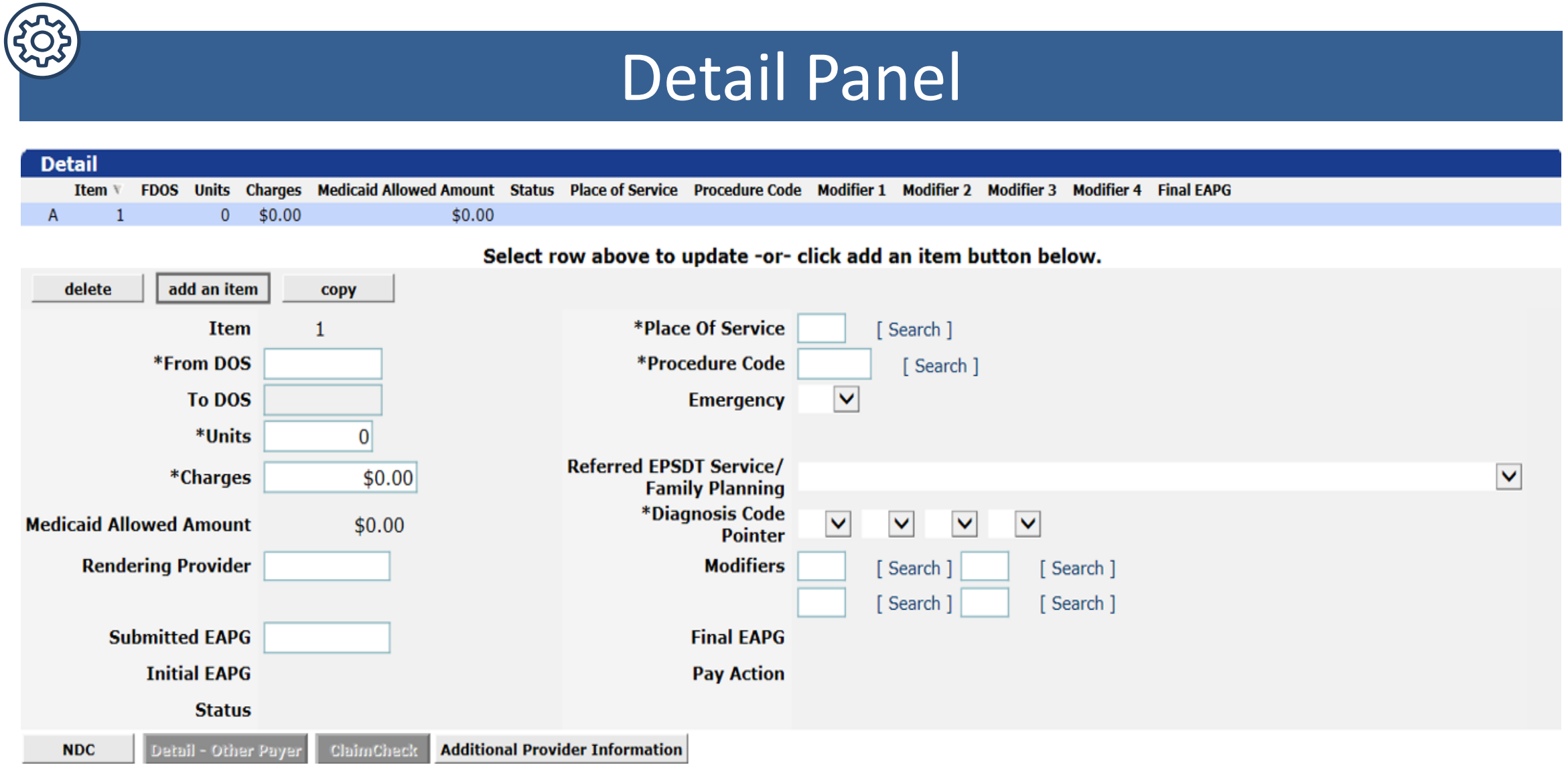


MITS

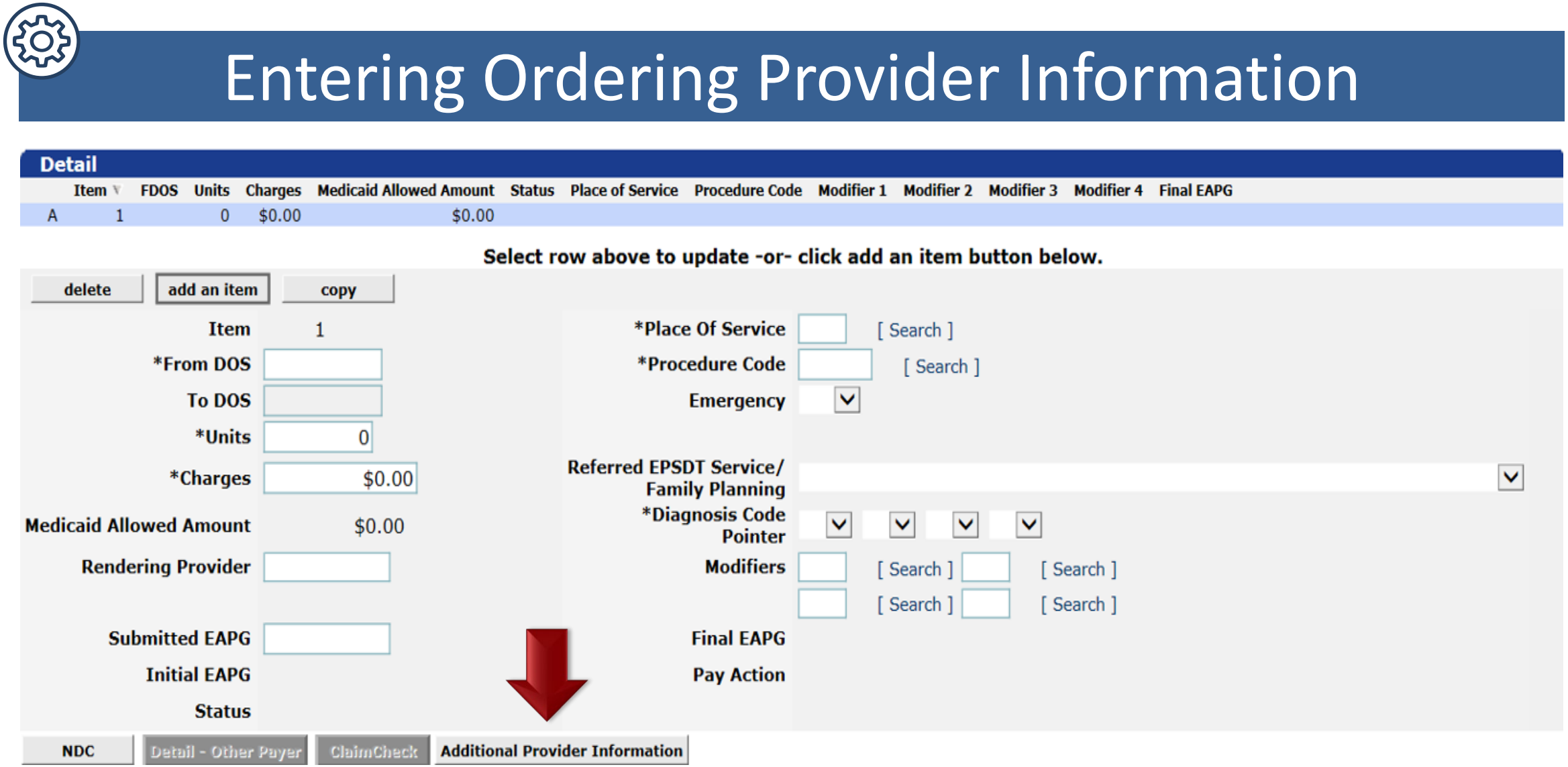
- Submission of a Professional Claim, cont.



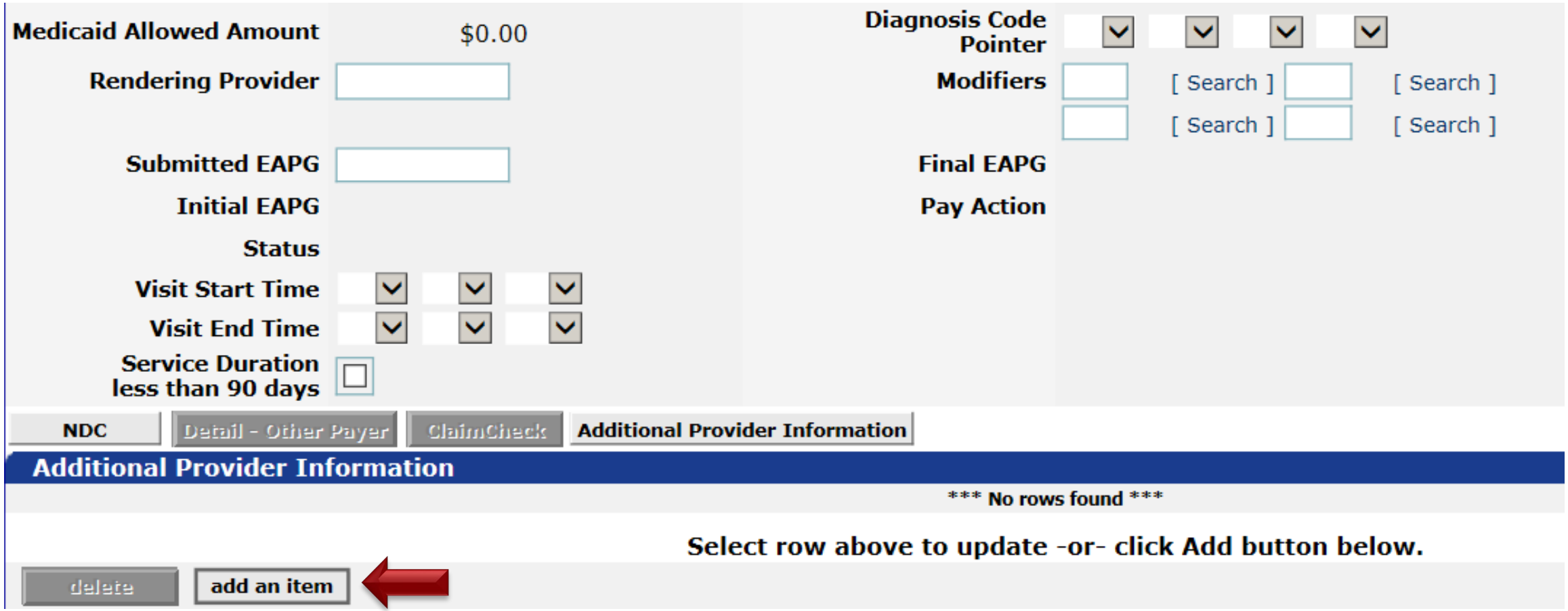
Detail Panel



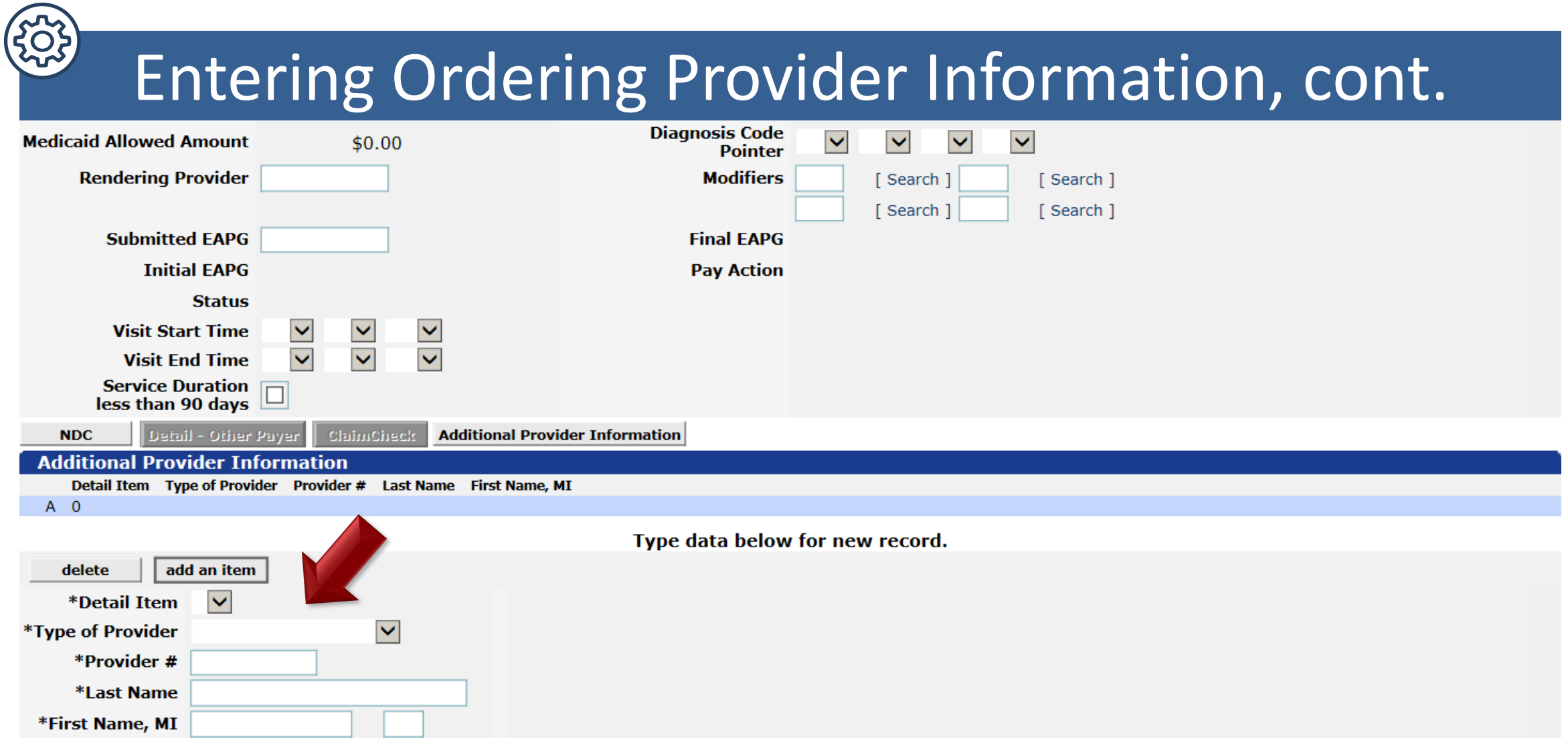
Entering Ordering Provider Information



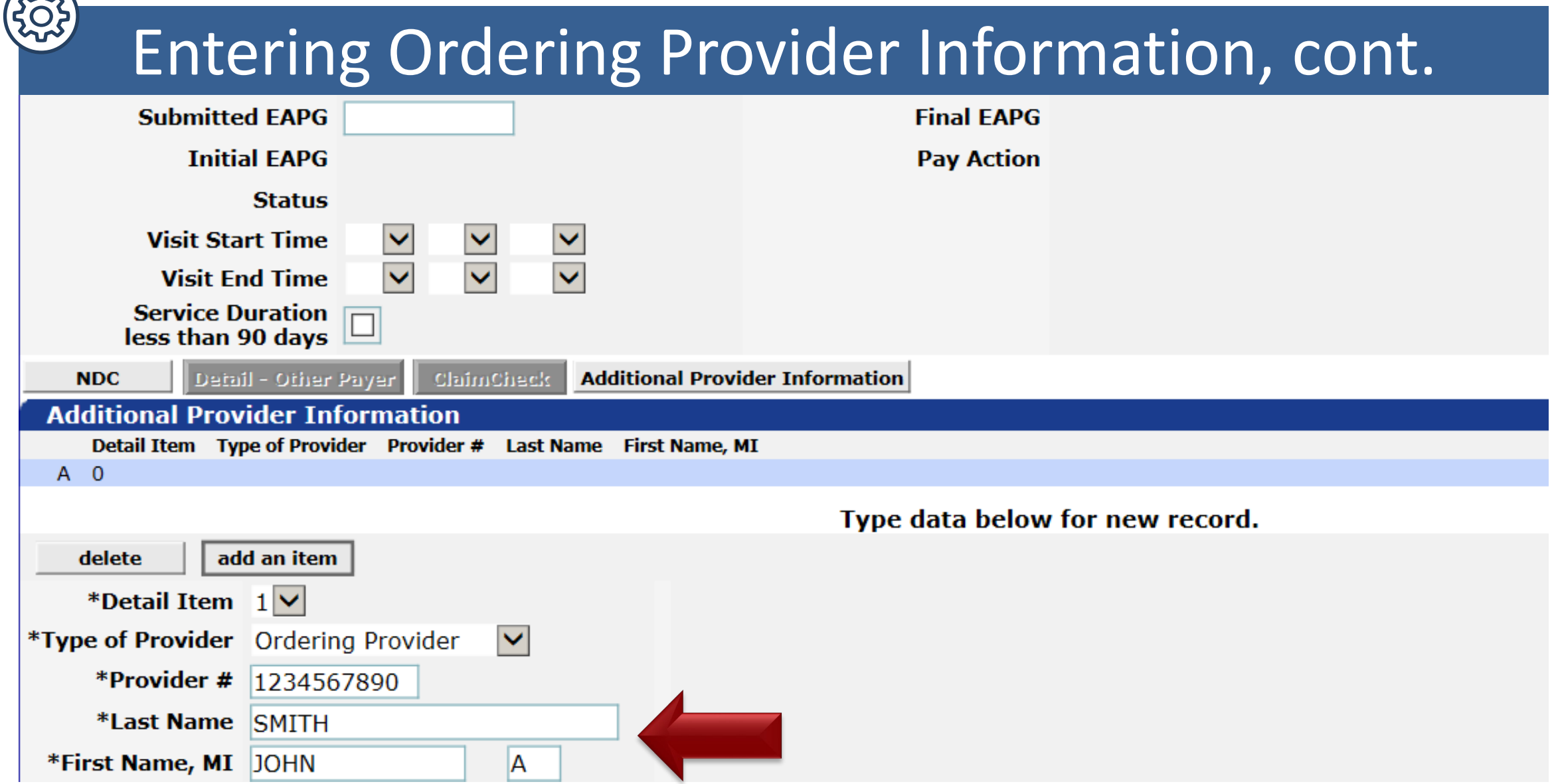
Entering Ordering Provider Information, cont.



Entering Ordering Provider Information, cont.



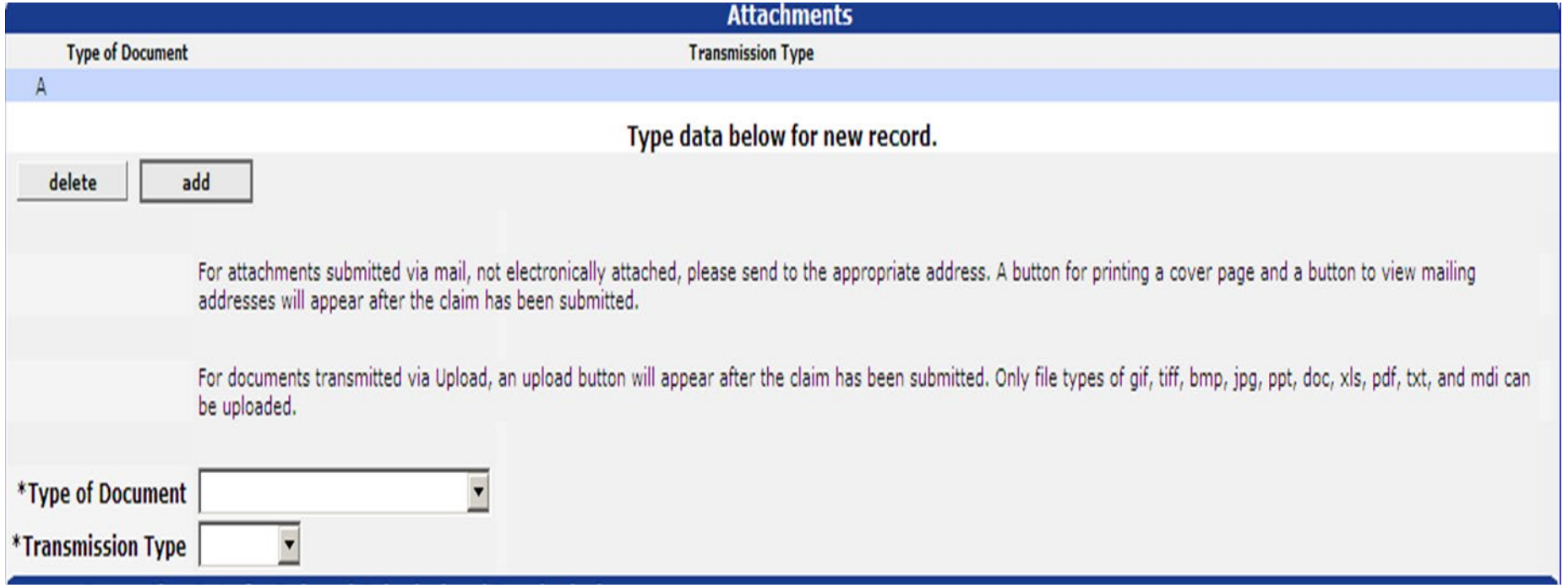
Entering Ordering Provider Information, cont.



MITS and Claims

- Attachment Panel

  » This panel allows you to electronically upload an attachment onto your claim in MITS



MITS and Claims

- Attachment Panel, cont.
  - » Electronic attachments are accepted for Claims, Prior Authorization, Enrollment, and Re-enrollment processing
  - » Acceptable file formats:
    - BMP, DOC, DOCX, GIF, JPG, PDF, PPT, PPTX, TIFF, TXT, XLS, and XLSX
  - » Each attachment must be <50 MB in size
  - » Each file must pass an anti-virus scan in MITS
  - » A maximum of 10 attachments may be uploaded

- Click the “submit” button at the bottom right

- You may “cancel” the claim at anytime, but the information will not be saved in MITS

MITS and Claims

- Adjudication will happen in “real time”, the claim status will show:
  - » Paid
  - » Denied
  - » Suspended

MITS and Claims

- Internal Control Number (ICN)
  - » The ICN replaced the Transaction Control Number (TCN)
  - » Each claim will be assigned a separate ICN

2021170357321

20	21	170	357	321
Region Code	Calendar Year	Julian Date	Claim Type/Batch Number	Number of Claim in Batch

MITS and Claims

- Internal Control Number (ICN), cont.

  » Primary region codes on a new claim submission

  20 Electronic (EDI) 837 without attachment
  21 Electronic (EDI) 837 with an attachment
  22 Web Portal without attachment
  23 Web Portal with an attachment

  * Region codes in 50's indicate an adjustment to your claim

MITS and Claims

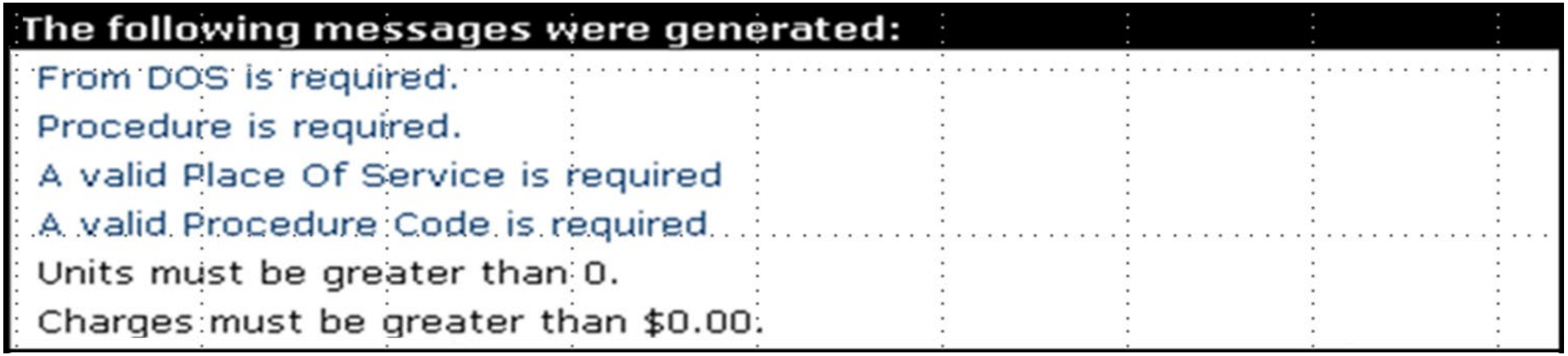
- Adjudication happens in “real time”
  - If there are no errors, the claim status will show:
    - Paid
    - Denied
    - Suspended

Claim Portal Errors

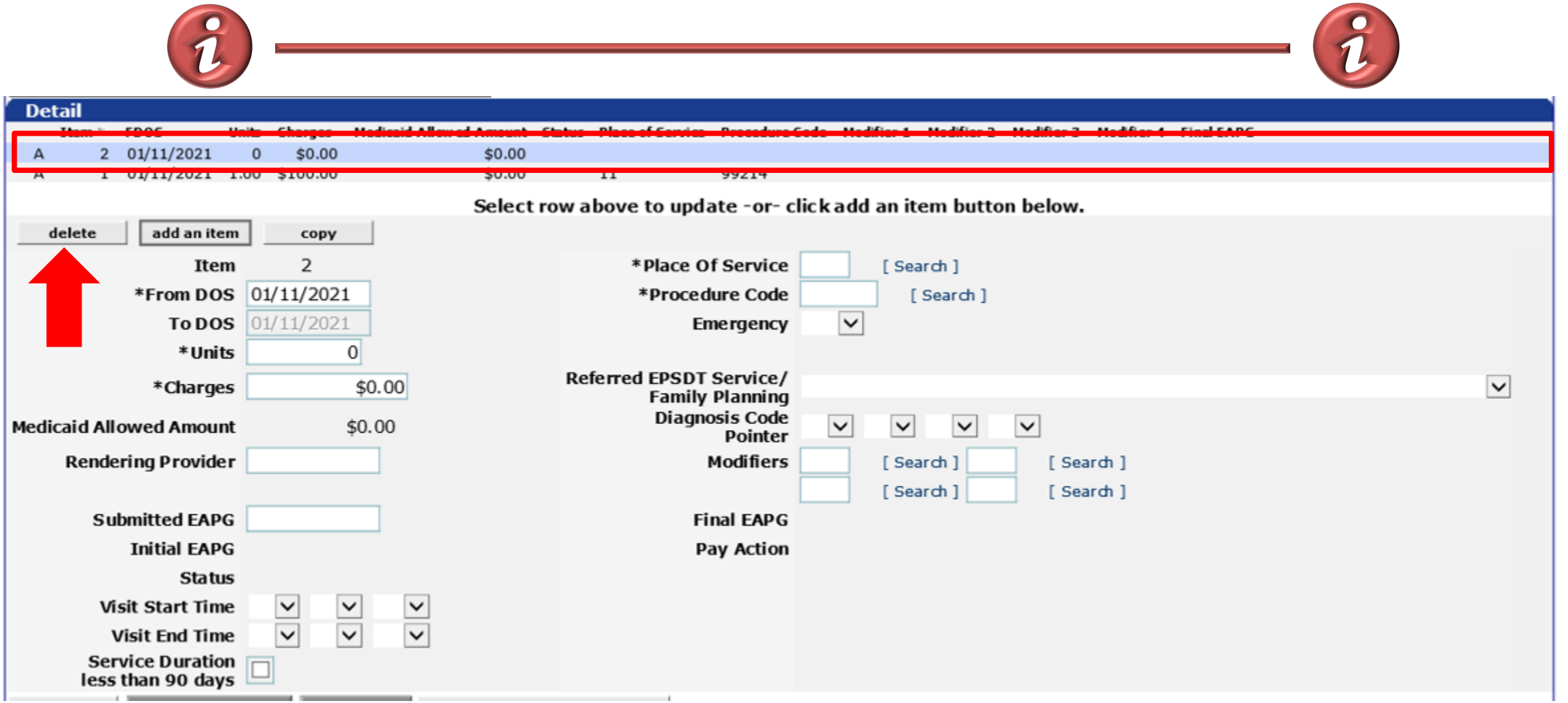
Claim Portal Errors, cont.

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

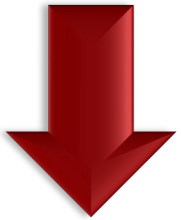
Scroll to the top of the claim



Claim Portal Errors, cont.



Adjusting a Paid Claim

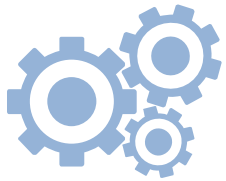


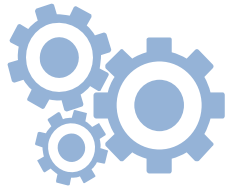
- Open the claim requiring an adjustment
- Change and save the necessary information
- Click the “adjust” button

Adjusting a Paid Claim, cont.

- Once you click the “adjust” button a new claim is created and assigned a new ICN
- Refer to the information in the “Claim Status Information” and “EOB Information” area at the bottom of the page to see how your new claim has processed

Example, cont.





Detail

	Item	FDOS	Units	Charges	Medicaid Allowed Amount	Status	Place of Service	Procedure Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Final EAPG
A	1	01/11/2021	1.00	$5.00	$0.00		12	A4452					

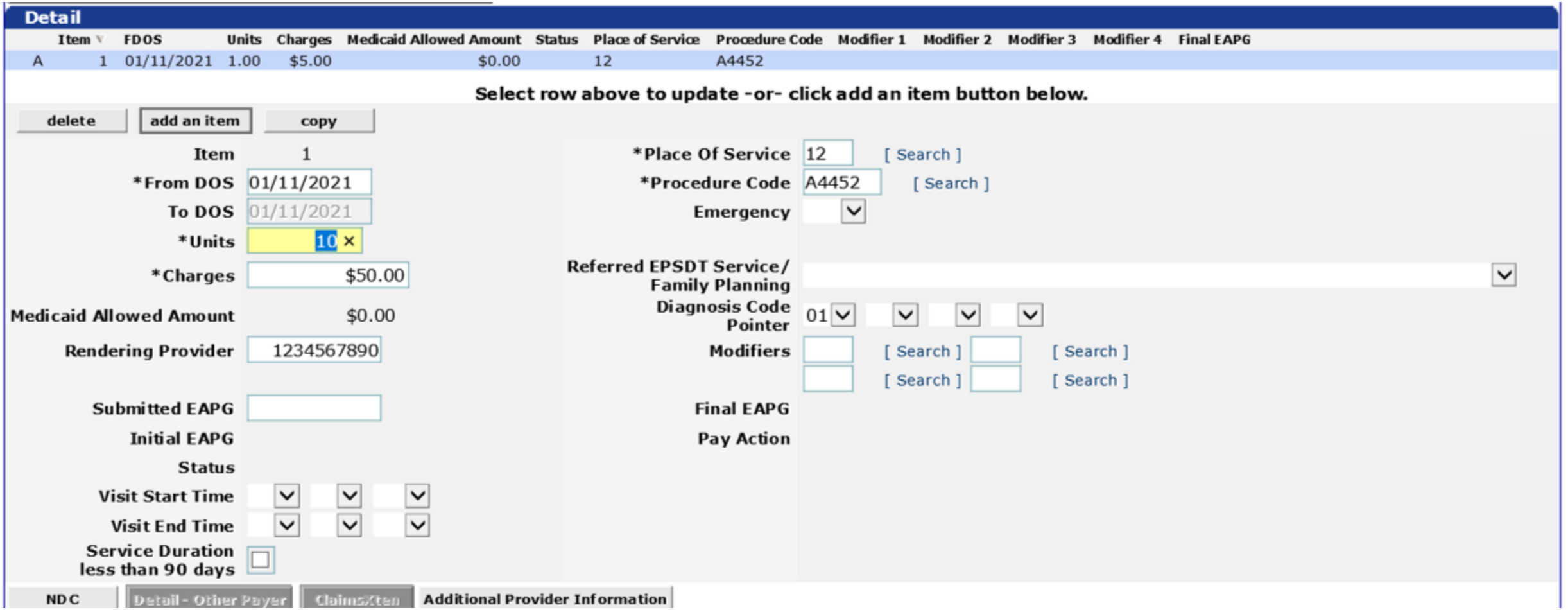
Select row above to update -or- click add an item button below.

delete | add an item | copy

Item	1	*Place Of Service	12 [Search]
*From DOS	01/11/2021	*Procedure Code	A4452 [Search]
To DOS	01/11/2021	Emergency	
*Units	1.00		
*Charges	$5.00	Referred EPSDT Service/ Family Planning	
Medicaid Allowed Amount	$0.00	Diagnosis Code Pointer	01
Rendering Provider	1234567890	Modifiers	[Search] [Search] [Search] [Search]
Submitted EAPG		Final EAPG	
Initial EAPG		Pay Action	
Status			
Visit Start Time			
Visit End Time			
Service Duration less than 90 days			

NDC | Detail - Other Payer | Claims/Ten | Additional Provider Information

Example, cont.



Example, cont.

Claim Status Information

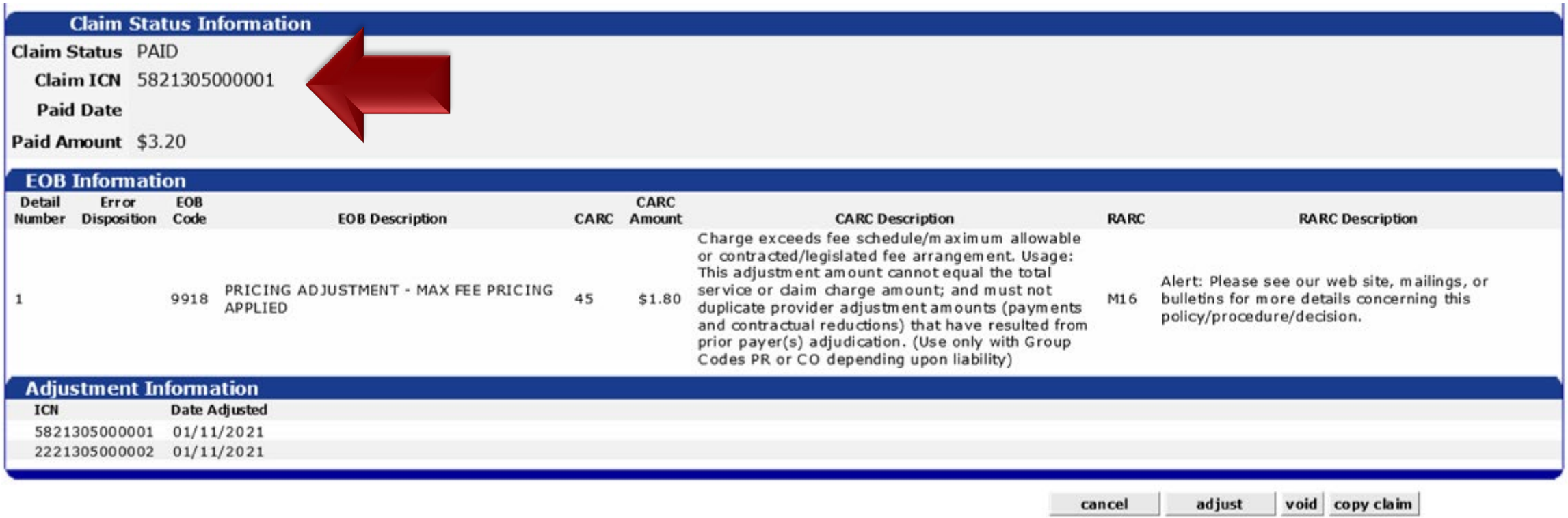
Claim Status	PAID
Claim ICN	2221305000002
Paid Date	
Paid Amount	$0.32

EOB Information

Detail Number	Error Disposition	EOB Code	EOB Description	CARC	CARC Amount	CARC Description	RARC	RARC Description
1		9918	PRICING ADJUSTMENT - MAX FEE PRICING APPLIED	45	$4.68	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability)	M16	Alert: Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision.

cancel | adjust | void | copy claim

Example, cont.



Claim Status Information

Claim Status	PAID
Claim ICN	5821305000001
Paid Date	
Paid Amount	$3.20

EOB Information

Detail Number	Error Disposition	EOB Code	EOB Description	CARC	CARC Amount	CARC Description	RARC	RARC Description
1		9918	PRICING ADJUSTMENT - MAX FEE PRICING APPLIED	45	$1.80	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability)	M16	Alert: Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision.

Adjustment Information

ICN	Date Adjusted
5821305000001	01/11/2021
2221305000002	01/11/2021

cancel | adjust | void | copy claim

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”

Example, cont.

Claim Status Information

Claim Status PAID

Claim ICN 5821305000001

Paid Date

Paid Amount $3.20

EOB Information

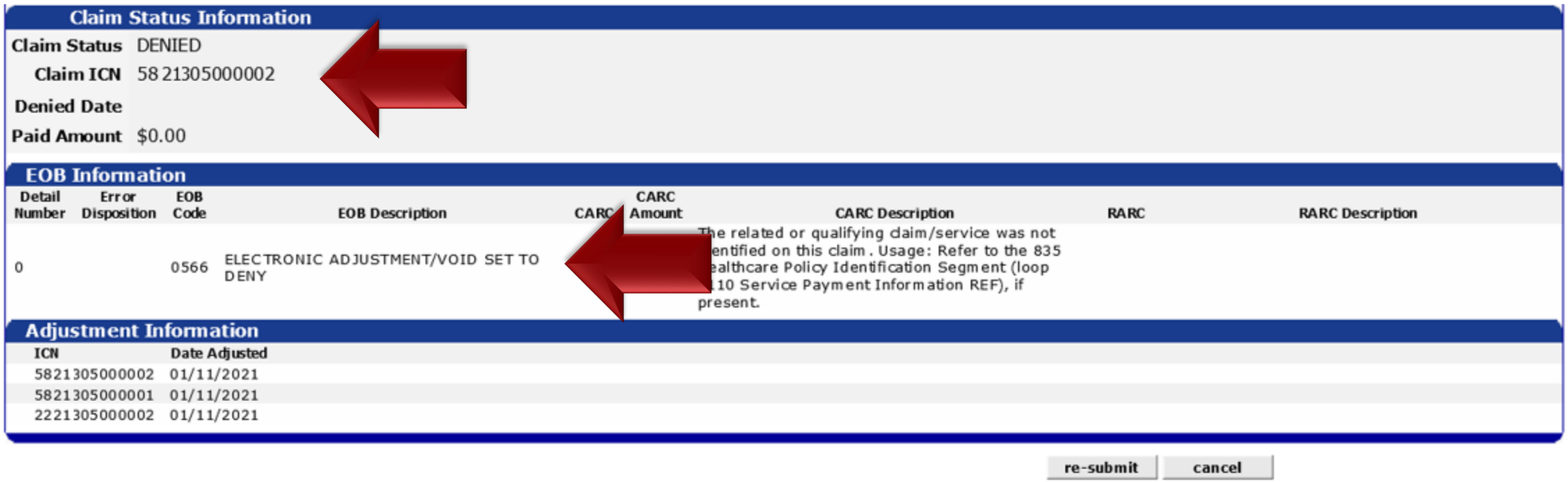
Detail Number	Error Disposition	EOB Code	EOB Description	CARC	CARC Amount	CARC Description	RARC	RARC Description
1		9918	PRICING ADJUSTMENT - MAX FEE PRICING APPLIED	45	$1.80	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability)	M16	Alert: Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision.

Adjustment Information

ICN	Date Adjusted
5821305000001	01/11/2021
2221305000002	01/11/2021

cancel | adjust | void | copy claim

Example, cont.



Claim Status Information

Claim Status	DENIED
Claim ICN	58 21305000002
Denied Date	
Paid Amount	$0.00

EOB Information

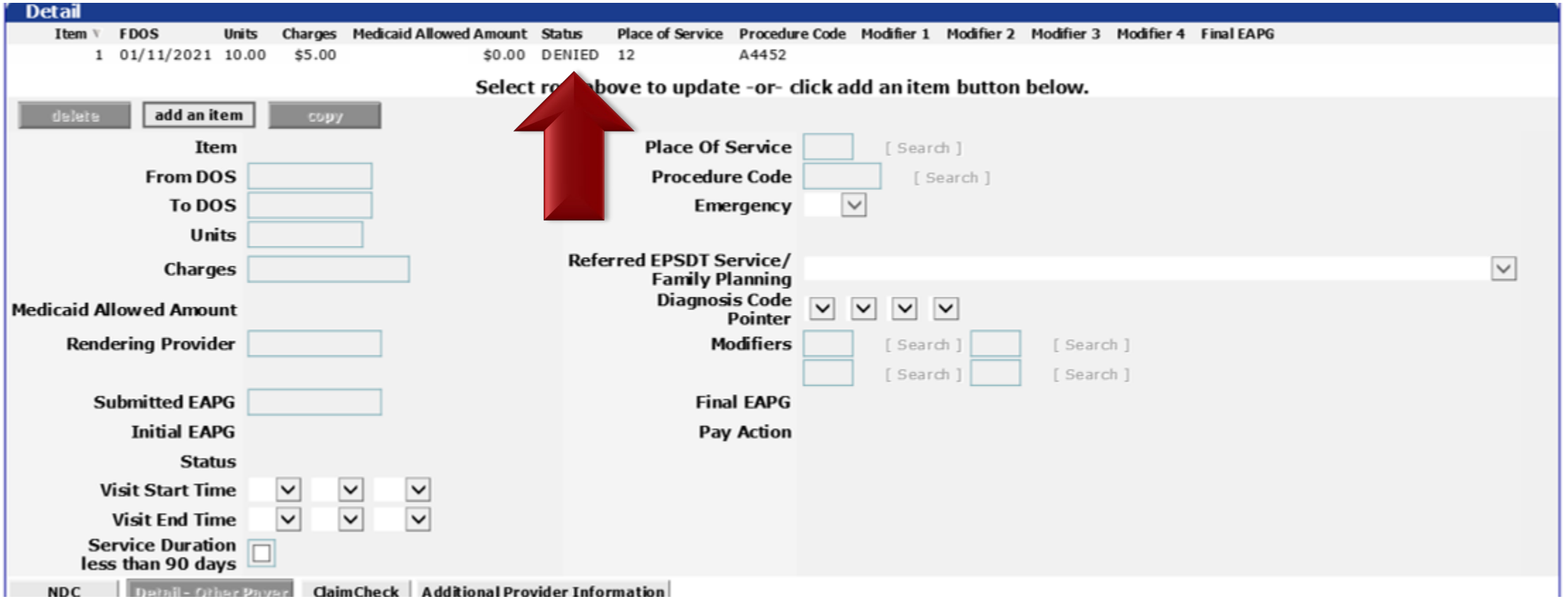
Detail Number	Error Disposition	EOB Code	EOB Description	CARC	CARC Amount	CARC Description	RARC	RARC Description
0		0566	ELECTRONIC ADJUSTMENT/VOID SET TO DENY			The related or qualifying claim/service was not identified on this claim. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		

Adjustment Information

ICN	Date Adjusted
5821305000002	01/11/2021
5821305000001	01/11/2021
2221305000002	01/11/2021

re-submit cancel

Example, cont.



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

Providers have 365 days to submit FFS claims

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

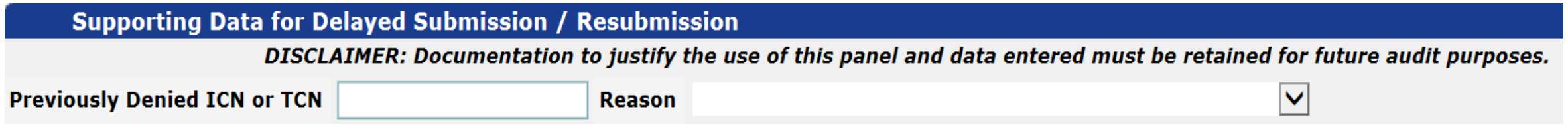
An additional 180 days from the resubmit date is given for attempts to correctly submit a denied claim prior to the end of the 365 days

Claims over 2 years old will be denied

There are exceptions to the 365 day rule

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



Special Billing Instructions – Eligibility Delay

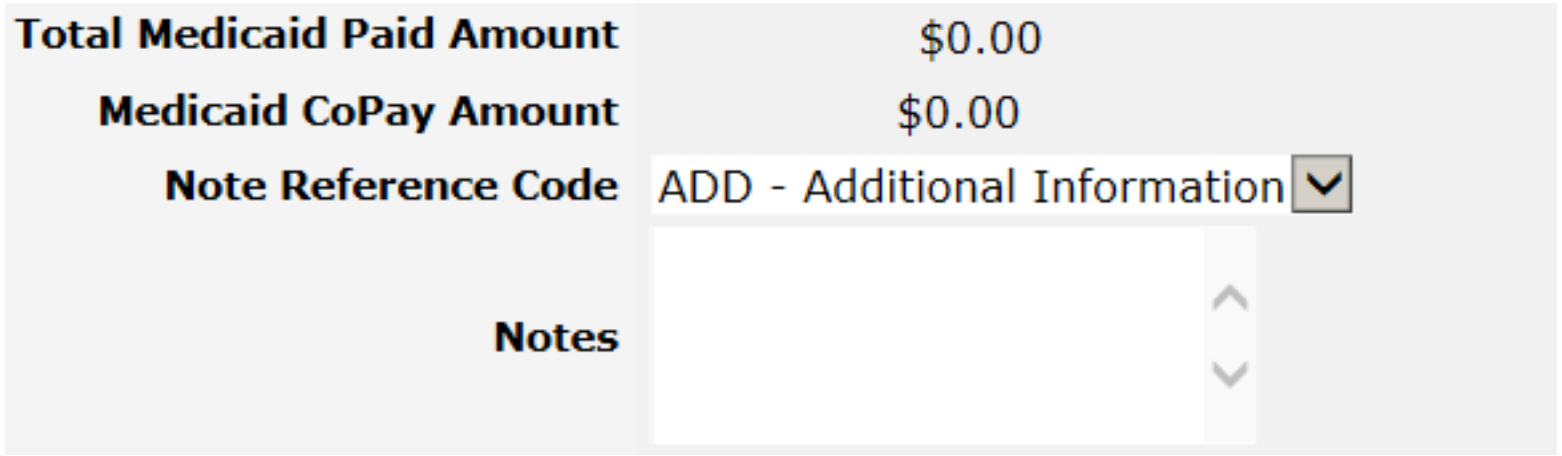
- If you are submitting a claim that is more than 365 days after the date of service due to a hearing decision or delay in the individual's eligibility determination

- The claim must be submitted within 180 days of the hearing decision or eligibility determination date

Special Billing Instructions – Eligibility Delay

- In the Notes box you will need to enter the hearing decision or eligibility determination information

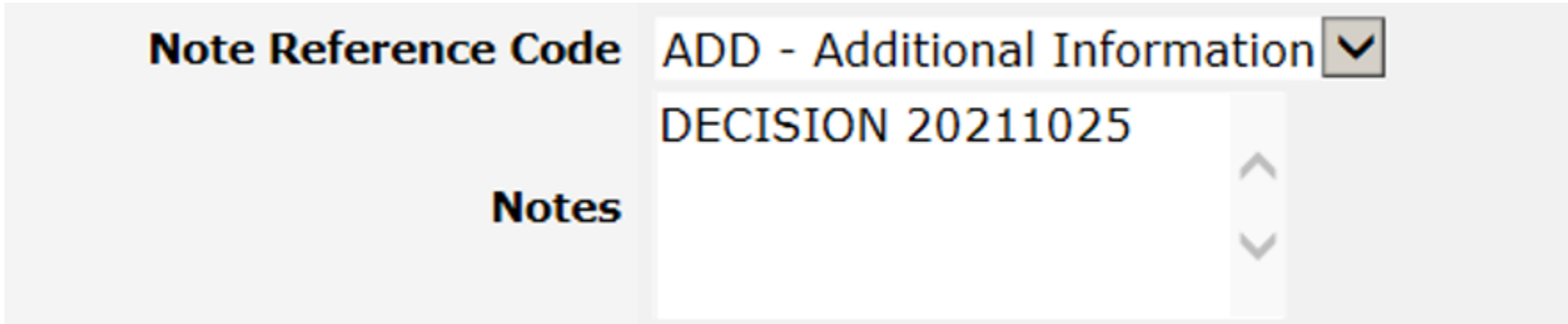
- In the Note Reference Code dropdown menu select "ADD"



Special Billing Instructions – Eligibility Delay

- Hearing Decision: APPEALS ######## CCYYMMDD
  ######## is the hearing number and CCYYMMDD is the date on the hearing decision
- Eligibility Determination: DECISION CCYYMMDD
  CCYYMMDD is the date on the eligibility determination notice from the CDJFS

Must use the spacing shown



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

ClaimCheck Edits

- Clinically oriented software tool that automatically identifies inappropriate code combinations and discrepancies in claims
- Will look at the coding accuracy of procedures, not medical necessity, and will prevent inappropriate payment for certain services which include:
  - Duplicate services (same person, same provider, same date)
  - Individual services that should be grouped or bundled
  - Mutually exclusive services
  - Services rendered incidental to other services
  - Services covered by a pre or post-operative period
  - Visits in conjunction with other services

The National Correct Coding Initiative (NCCI)

- Developed by the Centers for Medicare & Medicaid Services
  - To control inappropriate payment of claims from improper reporting of CPT and HCPCS codes
  - NCCI serves as a common model and standard for handling claims for procedures and services that are performed by one provider for one individual on a single date of service

The National Correct Coding Initiative (NCCI)

- Procedure to procedure (PTP) “Incidental” edit which determines whether a pair of procedure codes should not be reported together because one procedure is incidental to (performed as a natural consequence or adjunct to) the other
- Medically unlikely edit (MUE) determines whether the units of service exceed maximum units that a provider would be likely to report under most circumstances

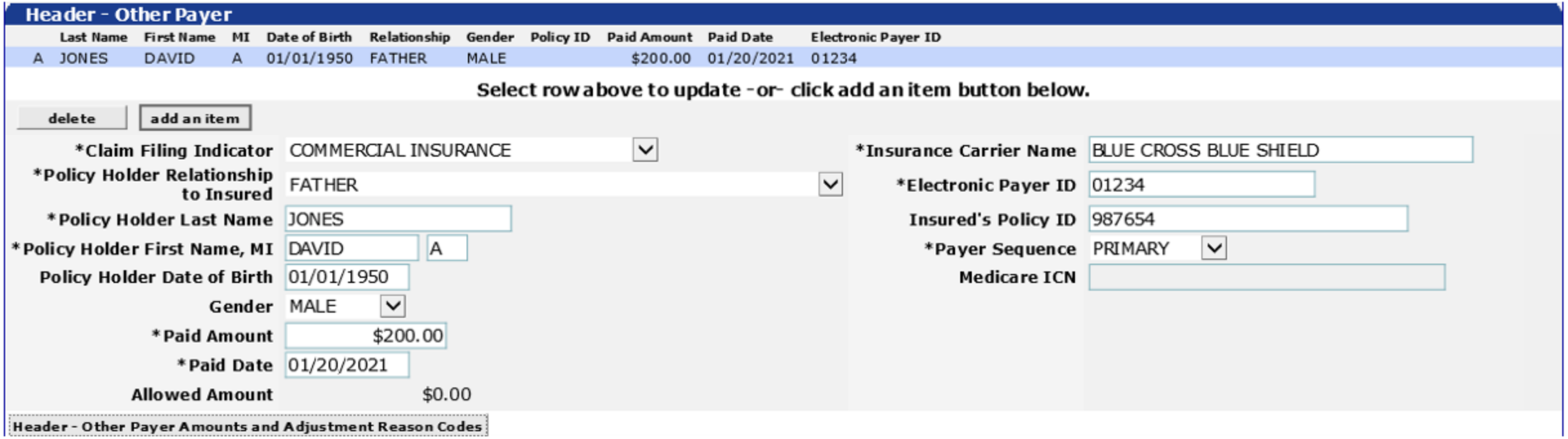
CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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

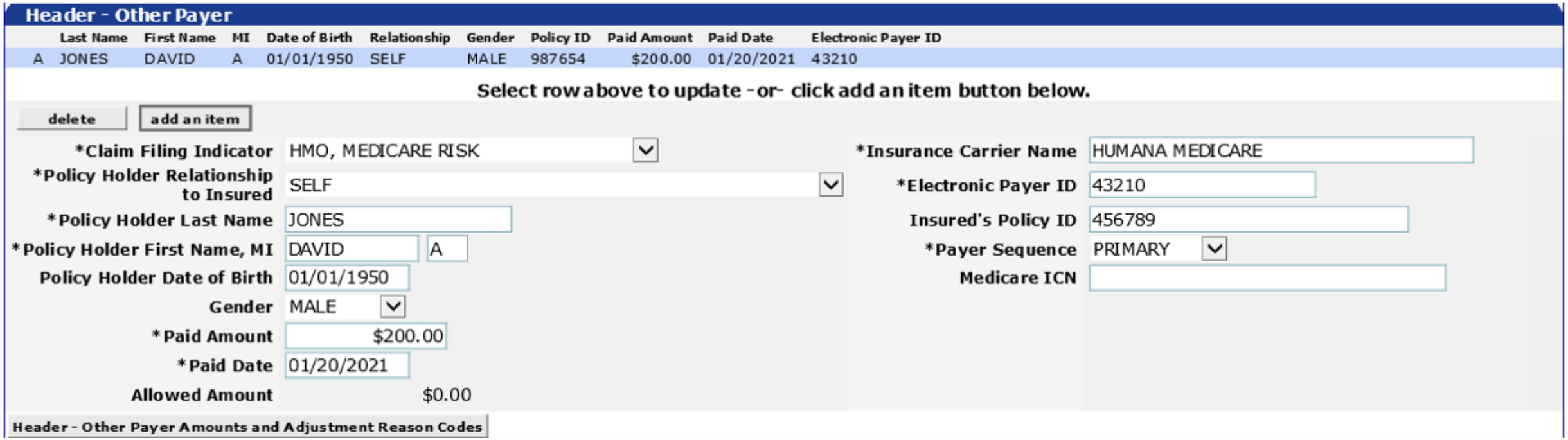
Third Party Liability (TPL) Claims

Other payer information is entered in the Header – Other Payer panel



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 vs Detail

Header level

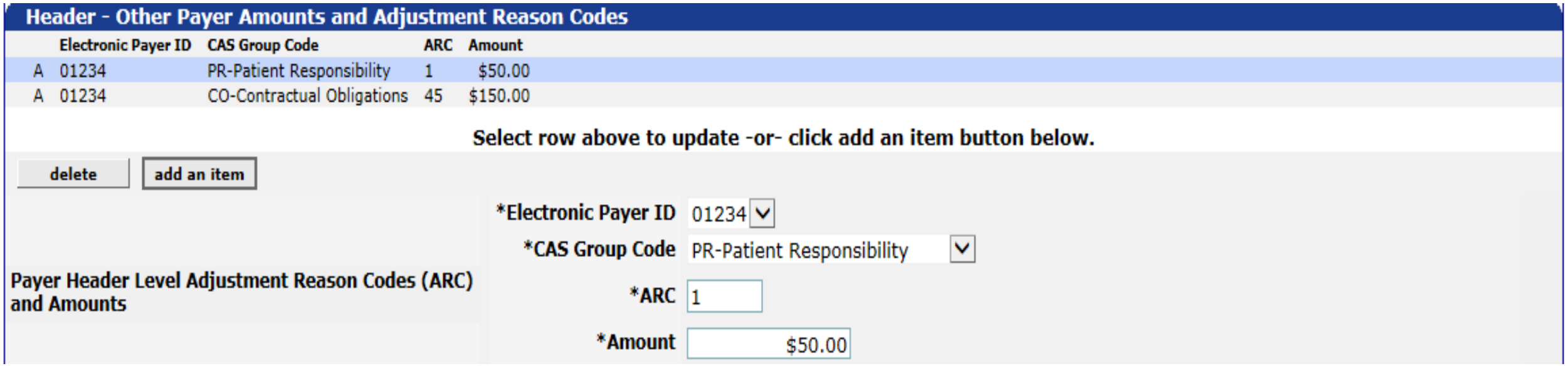
- A COB claim is considered to be adjudicated at the header/claim level if only one set of figures is reported for the entire claim

Detail level

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

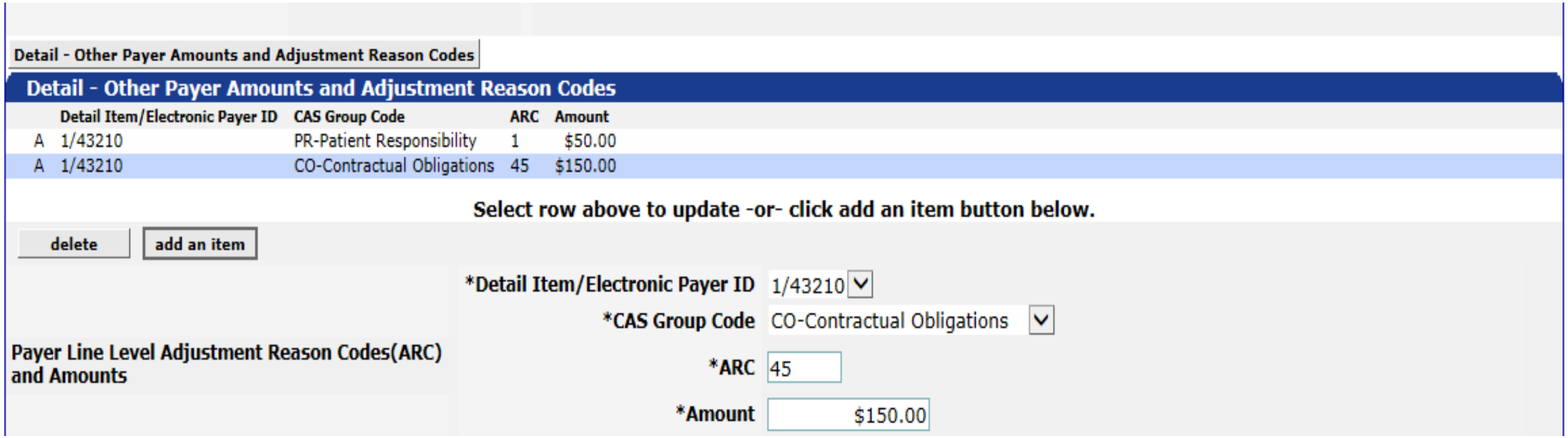
Third Party Liability (TPL) Claims

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



Third Party Liability (TPL) Claims

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



ARC Codes

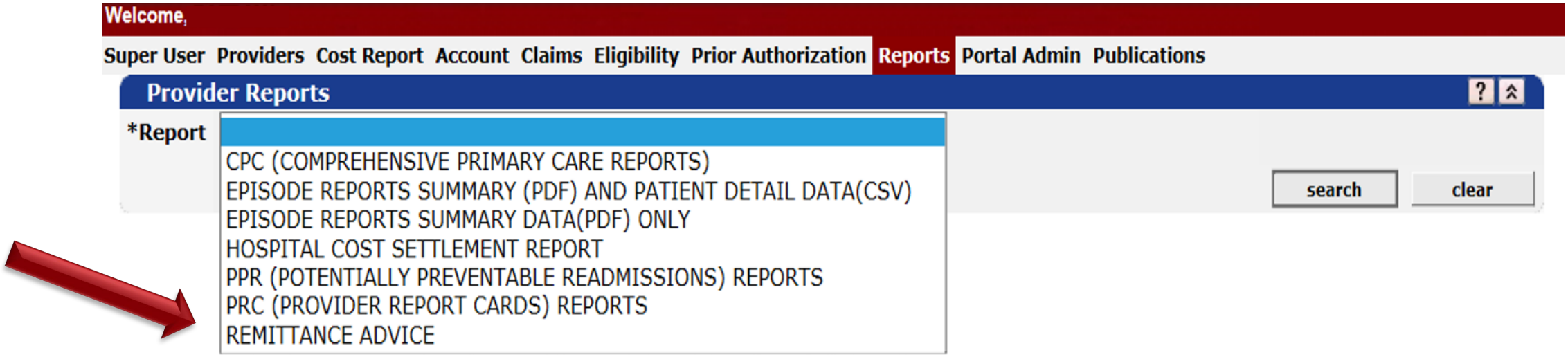
The X12 website provides adjustment reason codes (ARCs)

COMMON ARCs:

- 1 • Deductible
- 2 • Coinsurance
- 3 • Co-payment
- 45 • Contractual Obligation/Write off
- 96 • Non-covered services

Remittance Advice (RA)

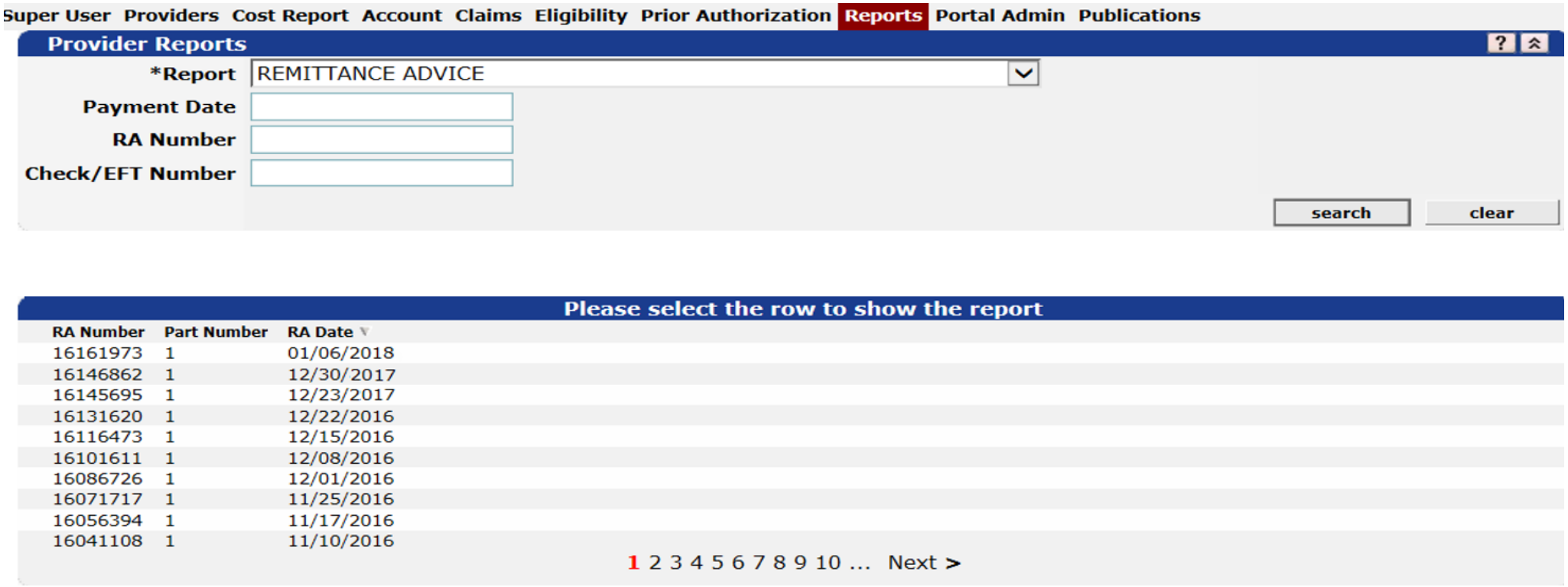
- All claims processed are available on the MITS Portal
- Weekly reports become available on Wednesdays



Remittance Advice (RA)

- Select “Remittance Advice” and click “Search”

- To see all remits to date, do not enter any data, and click search again



Remittance Advice (RA)

Paid, denied, and adjusted claims

Financial transactions

Expenditures - Non-claim payments

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

Summary

Current, month, and year to date information

Remittance Advice (RA)

Information pages

Banner messages to the provider community

EOB code explanations

Provides a comparison of codes to the description

TPL claim denial information

Provides other insurance information for any TPL claim denials

Prior Authorization (PA)

- All prior authorizations must be submitted via the MITS Portal
- PAs will not enter the queue for review until at least one attachment has been received
  - Medical notes should be uploaded
- Each panel will have an asterisk (*) denoting fields that are required
  - Some fields are situational and do not have an asterisk
- The “real time” status of a PA can be obtained in MITS

Prior Authorization (PA)

- Within the Prior Authorization subsystem providers can:
  - Submit a new Prior Authorization
  - Search for previously submitted Prior Authorizations
- Within the Prior Authorization panel providers can:
  - Attach documentation
  - Add comments to a Prior Authorization that is in a pending status
  - View reviewer comments
  - View Prior Authorization usage, including units and dollars used

Prior Authorization (PA)

- A PA will auto deny if supporting documentation is not received within 30 days (including EDMS coversheet and paper attachments)

- When reviewers request additional documentation to support the requested PA, the 30 day clock is reset

Prior Authorization (PA)

- External Notes Panel
  - Used by the PA reviewer to communicate to the provider
  - Multiple notes may reside on this panel
  - Panel is read-only for providers
- If a PA is marked approved with an authorized dollar amount of $0.00, it will still pay at the Medicaid maximum allowable reimbursement rate

Websites & 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/

MITS home page

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

Ohio Laws & Administrative Rules

http://codes.ohio.gov

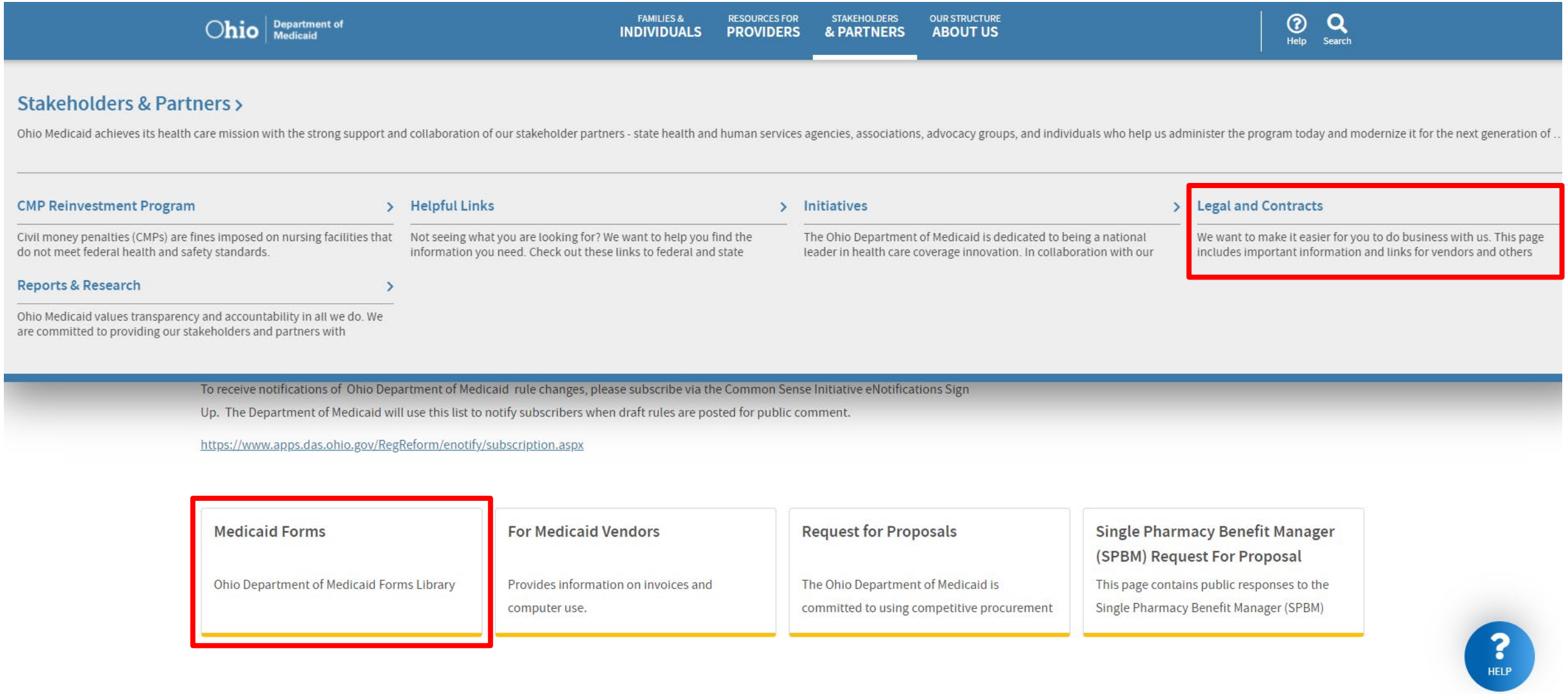
Websites

- Electronic Data Interchange (EDI)
  - » Information for Trading Partners

    https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/billing/trading-partners/trading-partners
  - » Companion Guides

    https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/billing/trading-partners/companion-guides/companion-guides
  - » Technical Questions/EDI Support Unit
    - Transitioned partners contact DXC EDI Support
      - ❖844-324-7089
      - ❖OhioMCD-EDI-Support@dxc.com

Forms


Ohio Department of Medicaid
FAMILIES & INDIVIDUALS
RESOURCES FOR PROVIDERS
STAKEHOLDERS & PARTNERS
OUR STRUCTURE ABOUT US
Help
Search
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)
HELP

Forms

Medicaid Forms

Ohio Department of Medicaid Forms Library

Order Forms/Email Requests

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)

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Show 25 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)

< 1 >

HELP