Ohio | Department of Medicaid

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

Basic Billing for Dental Providers

External Business Relations

2018

AGENDA

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

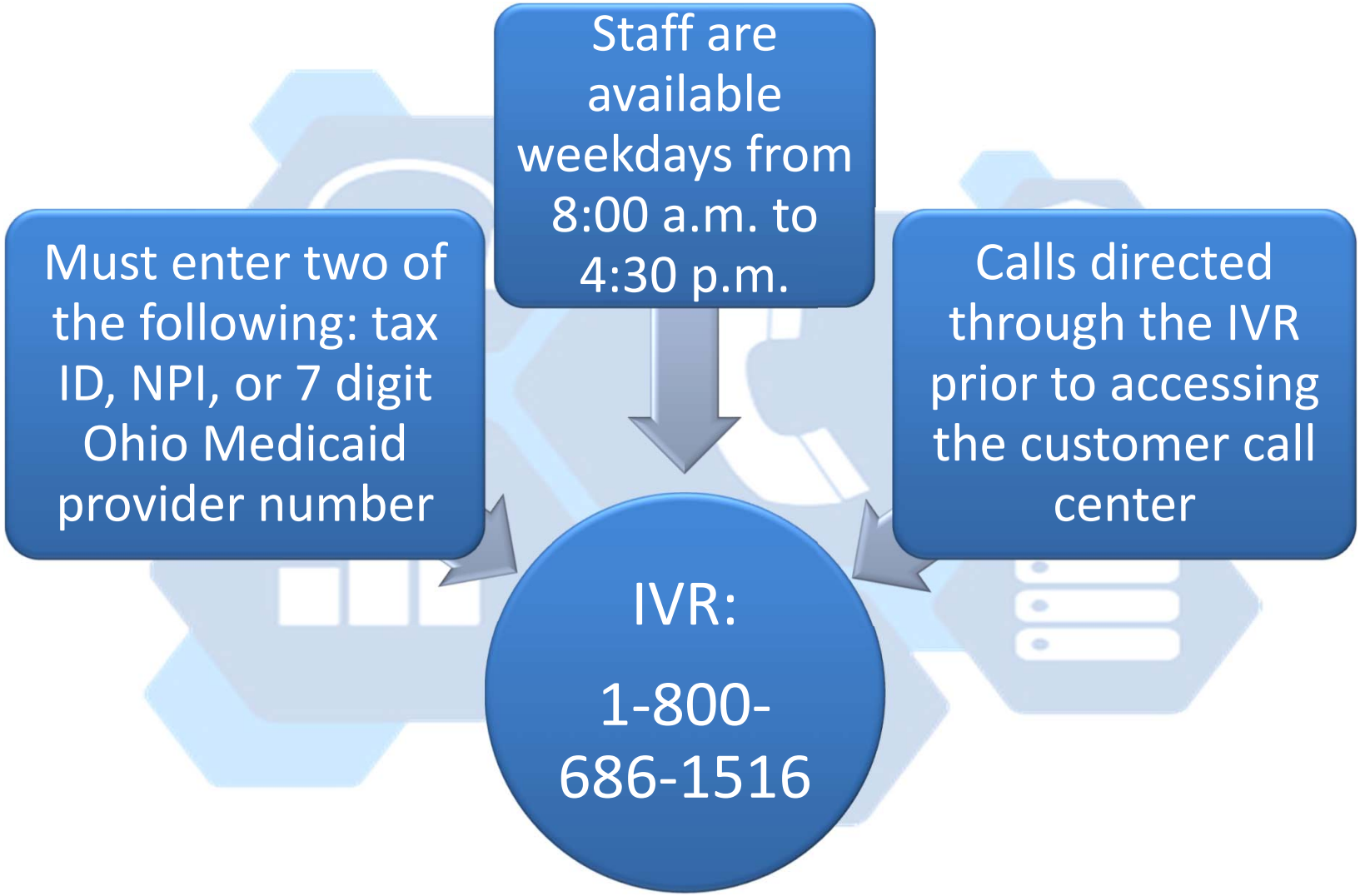
External Business Relations Team

Sarah Bivens

Ava Cottrell

Ed Ortopan

Manager - Meagan Grove


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
  - Adjustments
    614-466-5080
  - OSHIP (Ohio Senior Health Insurance Information Program)
    1-800-686-1578
  - Coordination of Benefits Section
    614-752-5768
    614-728-0757 (fax)

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

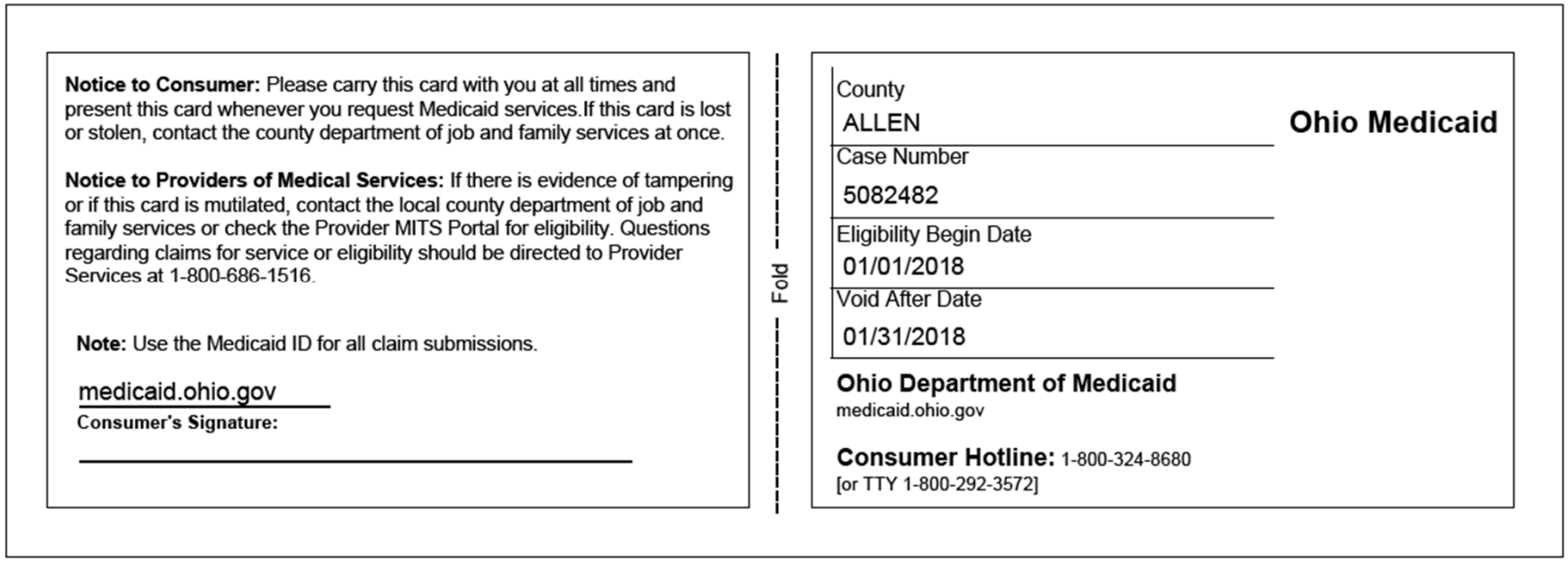
Covered Services (not limited to)

- Acupuncture
- Behavioral Health
- Dental
- Dialysis
- Dietitian
- Durable Medical Equipment
- Home Health
- Private Duty Nursing
- Hospice
- Hospital (Inpatient/Outpatient)
- ICF-IID Facility
- Nursing Facility
- Pharmacy
- Physician
- Transportation
- Vision

PROGRAMS & CARDS

Ohio Medicaid

- This card is the traditional fee-for-service Medicaid card
- **No longer issued monthly**



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
01/01/2018

Void After Date
01/31/2018

Ohio Department of Medicaid
medicaid.ohio.gov

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

Supplemental Security Income (SSI)

- Automatically Eligible for Medicaid as long as eligible for SSI

Modified Adjusted Gross Income (MAGI)

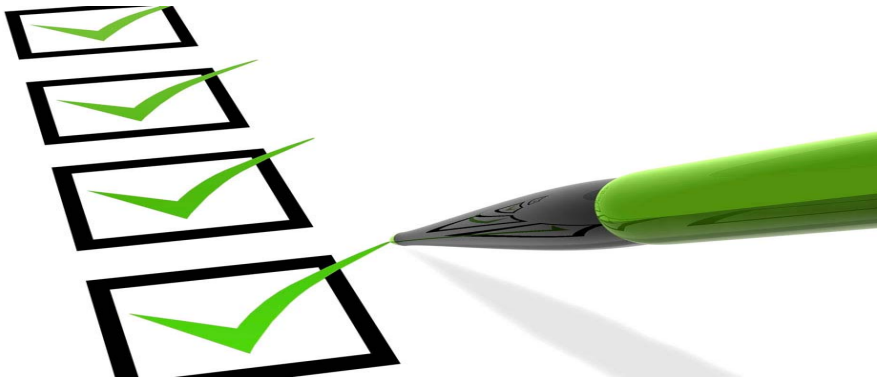
- Children, parents, caretakers, and expansion

Aged, Blind, Disabled (ABD)

- 65+, or blind/disabled with no SSI

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

- 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

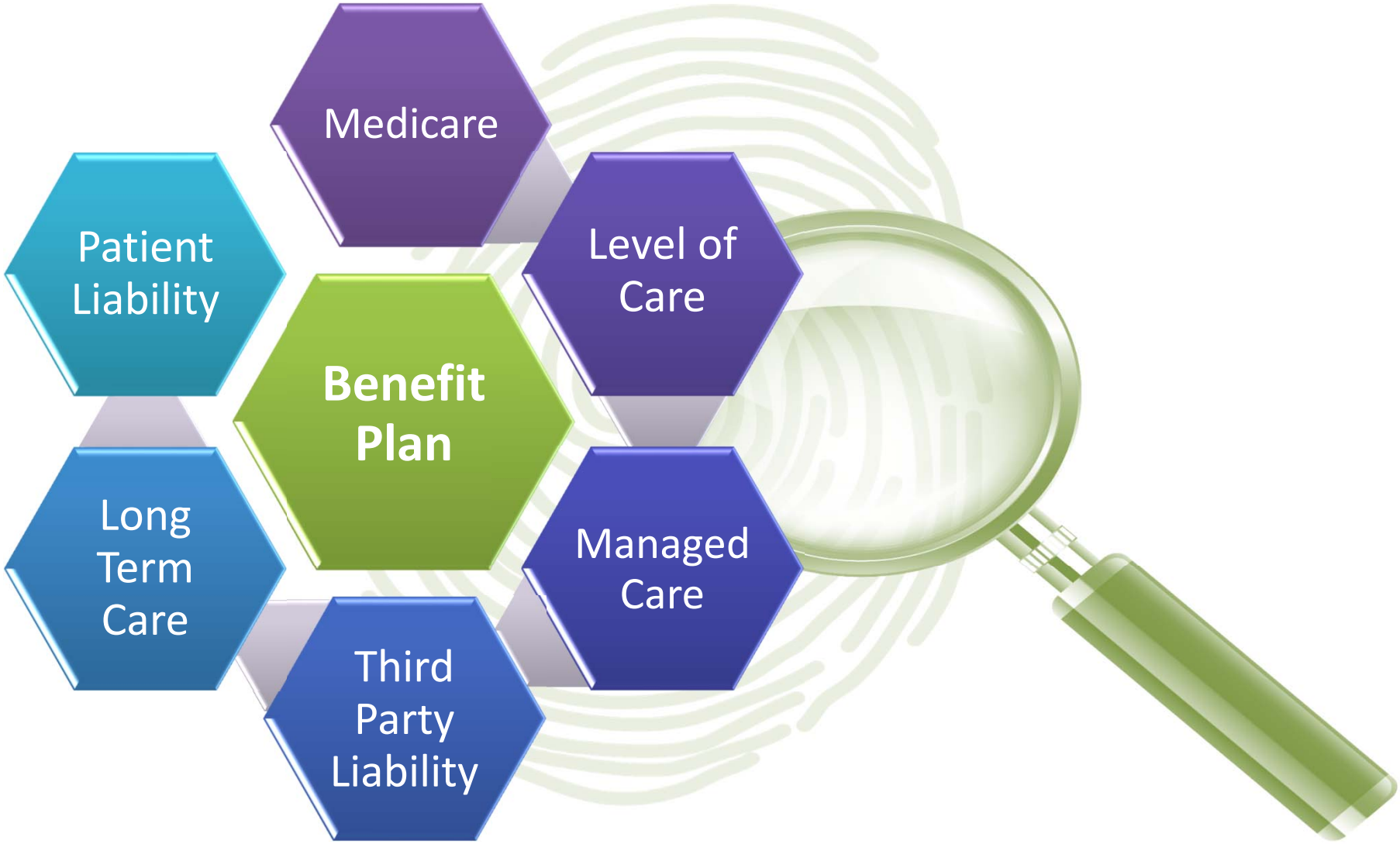


Full Medicaid eligibility on the MITS Portal will show **four** (or more) benefit spans:

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

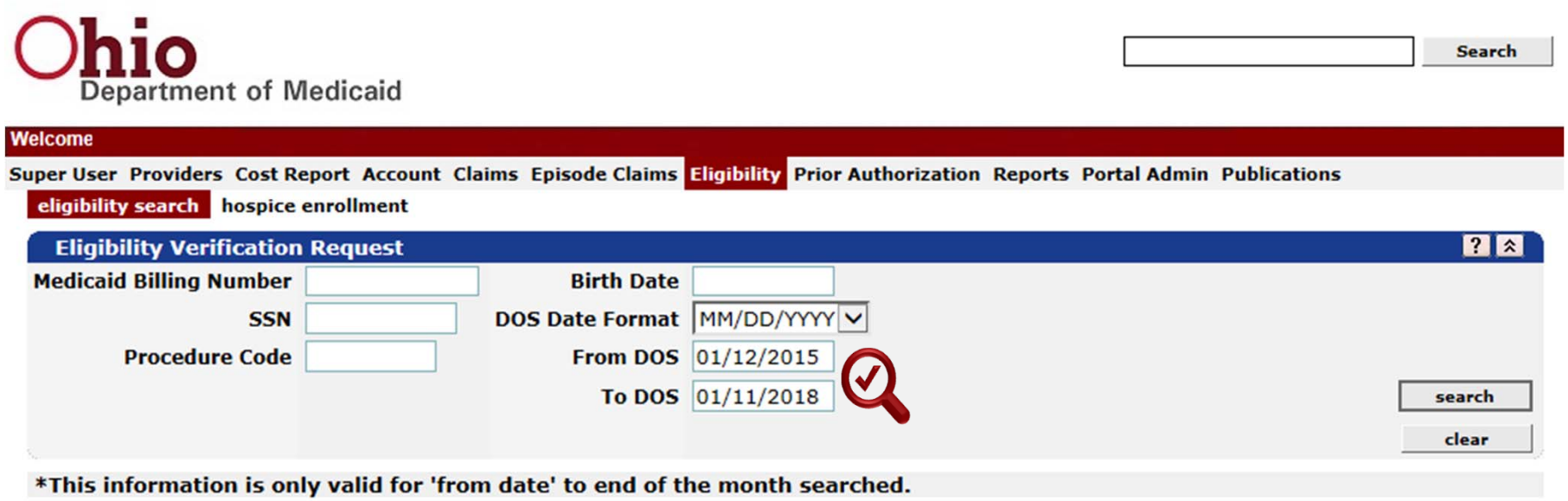
Additional spans when applicable:

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


Medicare
Patient Liability
Level of Care
Benefit Plan
Long Term Care
Managed Care
Third Party Liability

Eligibility Verification Request

- You can search up to 3 years at a time!!



Eligibility Verification Request

Recipient Information

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

Associated Child(ren) Search

Benefit / Assignment Plan

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

Case/Cat/Seq Spenddown

*** No rows found ***

Eligibility Verification Request

Recipient Information

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

Associated Child(ren) Search

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★ Alcohol and Drug Addiction Services	01/01/2018	01/31/2018		$0.00	$0.00
★ Ohio Mental health	01/01/2018	01/31/2018		$0.00	$0.00
★ Medicaid	01/01/2018	01/31/2018		$0.00	$0.00

Associated Child(ren)

Medicaid Billing Number	First Name	MI	Last Name	Gender	Date of Birth
123456789012	AUDREY		DOE	FEMALE	11/20/2004
987654321012	ALEX		DOE	MALE	09/14/2006

Eligibility Verification Request

TPL

Carrier Name	Carrier Number	NAIC	Policy Number	Policy Holder	Coverage Type	Coverage	Effective Date	End Date	Group Number
AARP HEALTH CARE	00570		082029958-1		IND	INPATIENT COVERAGE	01/30/2018	01/31/2018	PLAN-NV
AARP HEALTH CARE	00570		082029958-1		IND	PHYSICIAN/OUTPATIENT COVERAGE	01/30/2018	01/31/2018	PLAN-NV
AETNA US HEALTH	00250		W116635166		IND	INPATIENT COVERAGE	01/30/2018	01/31/2018	724775
AETNA US HEALTH	00250		W116635166		IND	PHYSICIAN/OUTPATIENT COVERAGE	01/30/2018	01/31/2018	724775

Managed Care

Plan Name	Plan Description	Effective Date	End Date	Managed Care Benefits
CARESOURCE	HMO, CFC	01/01/2018	01/31/2018	

Lock-In

*** No rows found ***

Medicare

Coverage	Effective Date	End Date	Plan Name	Plan ID	Medicare ID
PART A	12/01/2017	12/08/2017			27201289D6
PART B	12/01/2017	12/08/2017			27201289D6

Service Limitation

*** No rows found ***

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

Eligibility Verification Request

Level of Care Determinations

LOC Requested	Status	Determination Date	LOC Determination	Description	LOC Begin Date	LOC End Date
		09/01/2017	NF; NF WAIVER; RSS	INTERMEDIATE (ILOC)	12/01/2017	12/08/2017
		08/23/2017	NF; NF WAIVER; RSS	INTERMEDIATE (ILOC)	12/01/2017	12/08/2017
				UNKNOWN LEVEL OF CARE	12/01/2017	12/07/2017

Patient Liability

Financial Payer	Monthly Amount	Type	Effective Date	End Date
DEFAULT	$491.00	Pro-rated Nursing Home	12/01/2017	12/08/2017

Long Term Care Facility Placements

Facility Type	Date of Admission	Effective Begin Date of Medicaid Coverage	End Date of Medicaid Coverage	Date of Discharge
NURSING FACILITY	07/25/2017	12/01/2017	12/08/2017	

Recipient Restricted Coverage

*** No rows found ***

Special Program

*** No rows found ***

Presumptive Eligibility

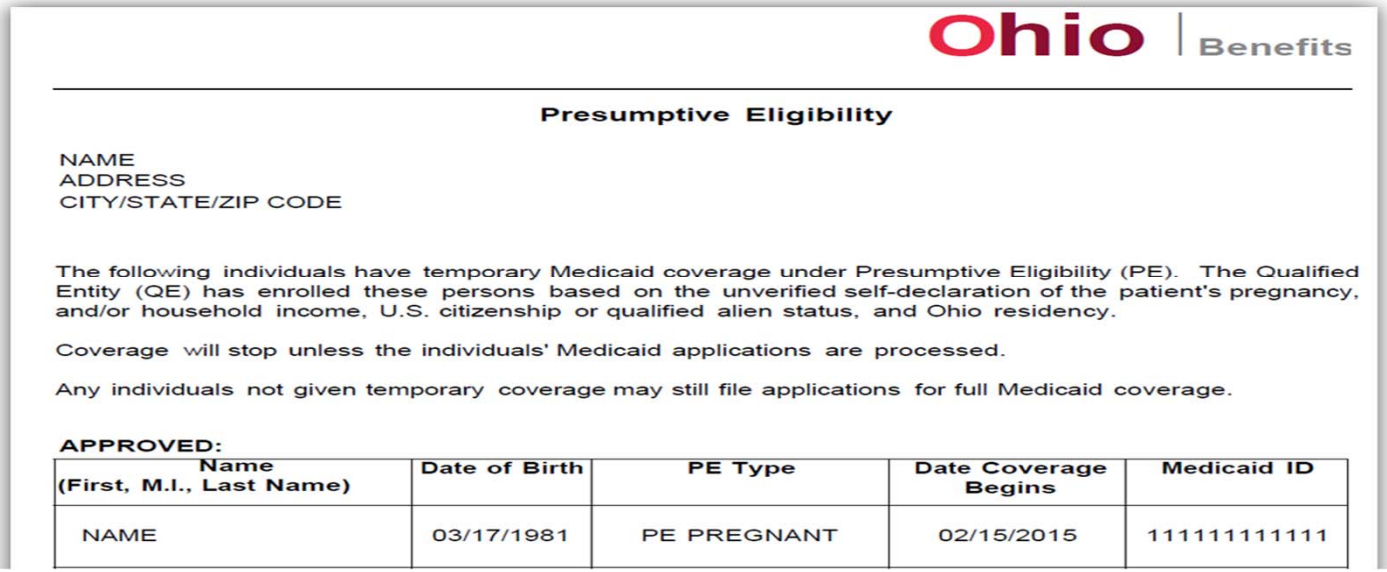
Covers children up to age 19 and pregnant women

It was expanded to provide coverage for parent and caretaker relatives and extension adults

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

Presumptive Eligibility

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



Ohio | Benefits

Presumptive Eligibility

NAME
ADDRESS
CITY/STATE/ZIP CODE

The following individuals have temporary Medicaid coverage under Presumptive Eligibility (PE). The Qualified Entity (QE) has enrolled these persons based on the unverified self-declaration of the patient's pregnancy, and/or household income, U.S. citizenship or qualified alien status, and Ohio residency.

Coverage will stop unless the individuals' Medicaid applications are processed.

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

APPROVED:

Name (First, M.I., Last Name)	Date of Birth	PE Type	Date Coverage Begins	Medicaid ID
NAME	03/17/1981	PE PREGNANT	02/15/2015	111111111111

Presumptive Eligibility

Individuals will receive a similar Presumptive Eligibility letter if a CDJFS worker determines the eligibility

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	06/25/2018	910194194194

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/County_Directory.pdf**	
Date of Birth		**Number Bed Hold Days Used Paid CY**	20170101: 10
Date of Death			

Benefit / Assignment Plan

Benefit Assignment Plan	Effective Date	End Date	Provider Name	Dental Co-Pay Amount	Vision Co-Pay Amount
PRESUMPTIVE:Alternative Benefit Plan Medicaid Expansion	01/01/2017	06/30/2017		$0.00	$0.00
PRESUMPTIVE:MRDD Targeted Case Mgmt	01/01/2017	06/30/2017		$0.00	$0.00
PRESUMPTIVE:Alcohol and Drug Addiction Services	01/01/2017	06/30/2017		$0.00	$0.00
PRESUMPTIVE:Ohio Mental health	01/01/2017	06/30/2017		$0.00	$0.00
PRESUMPTIVE:Medicaid	01/01/2017	06/30/2017		$0.00	$0.00

Case/Cat/Seq Spenddown

Medicaid Pre-Release Enrollment Program

- Institutionalized individuals close to release are enrolled into a Medicaid Managed Care plan, prior to release
- Individual must agree and be eligible for the program
- MCP Care Manager will develop a transition plan
- More than **20,000** individuals have benefited from this program

Qualified Medicare Beneficiary (QMB)

Issued to qualified individuals who have Medicare

Reimbursement policy is set under 5160-1 and can result in a payment of zero dollars

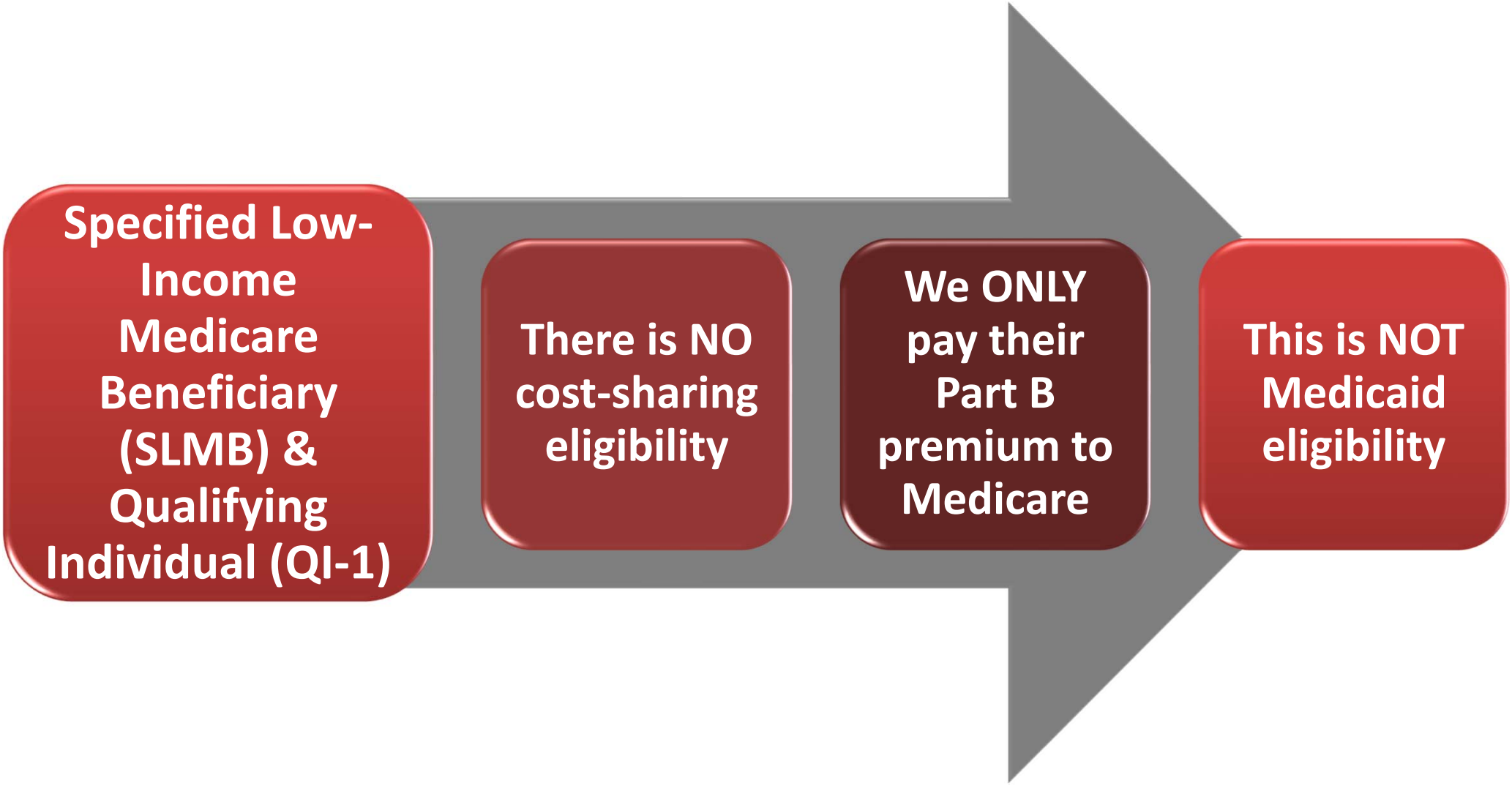
Medicaid only covers their monthly Medicare premium, co-insurance and/or deductible after Medicare has paid

Can I Bill Them?

MLN Matters® Number: SE1128 Revised Release Date of Revised Article: December 4, 2017

The billing of individuals enrolled in the QMB program is prohibited by federal law

Federal law bars Medicare providers and suppliers from billing an individual enrolled in the QMB program for Medicare Part A and Part B cost-sharing under any circumstances (see Sections 1902(n)(3)(B), 1902(n)(3)(C), 1905(p)(3), 1866(a)(1)(A), and 1848(g)(3)(A) of the Social Security Act [the Act]). The QMB program is a State Medicaid benefit that assists low-income Medicare beneficiaries with Medicare Part A and Part B premiums and cost-sharing, including deductibles, coinsurance, and copays


Specified Low-Income Medicare Beneficiary (SLMB) & Qualifying Individual (QI-1)
There is NO cost-sharing eligibility
We ONLY pay their Part B premium to Medicare
This is NOT Medicaid eligibility

MANAGED CARE/MYCARE OHIO

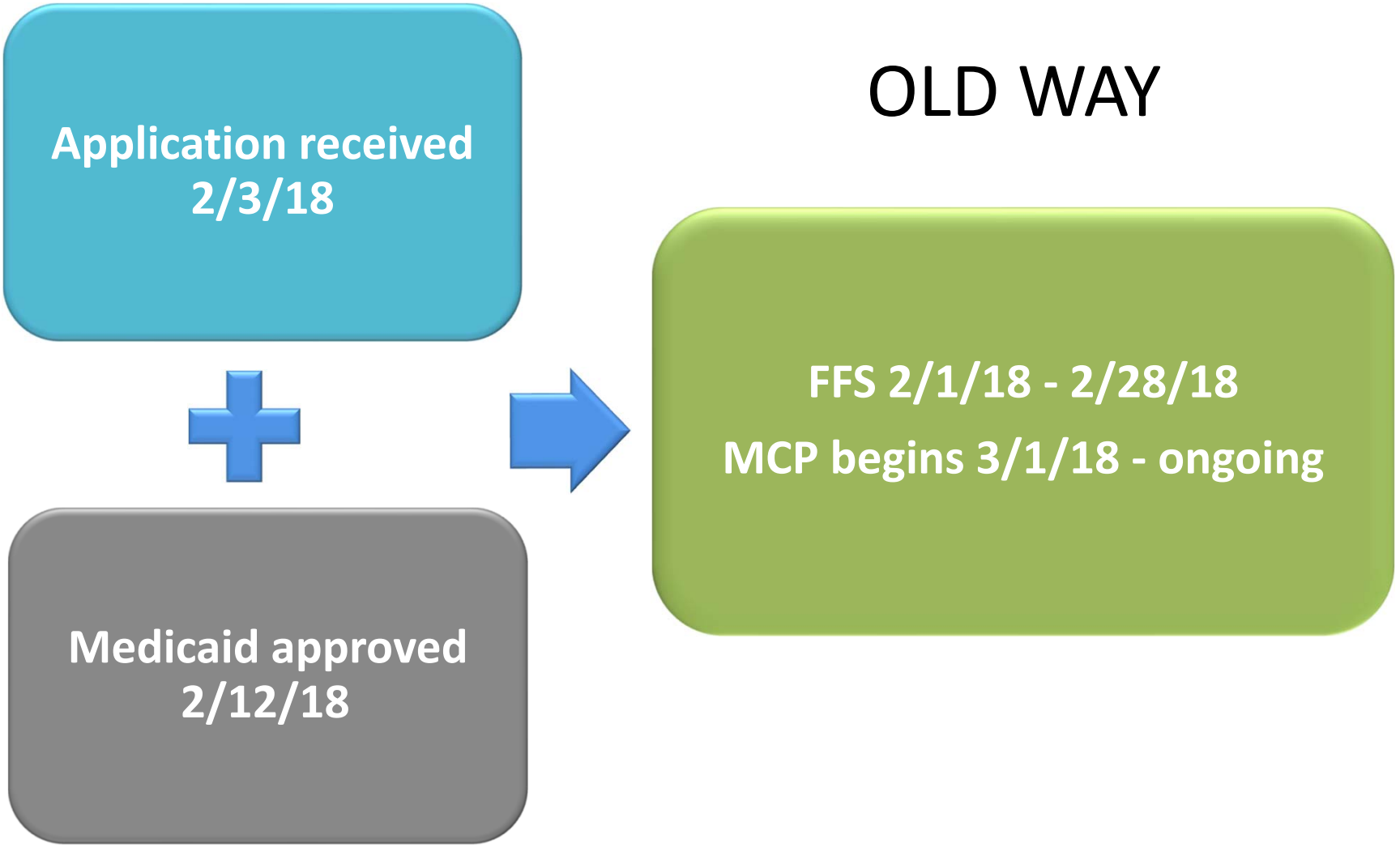
Managed Care Day One - Effective January 1, 2018

- New individuals will be assigned a managed care plan the first day of the current month that MITS receives active Medicaid eligibility
- MITS must receive Medicaid eligibility before Managed Care Assignments can take place
- Medicaid eligibility established prior to the current month will be Fee-for-Service (FFS) for months prior to the current month
- Day one lowers the months of FFS and increases the MCP months
- MyCare Ohio enrollment process stays as-is

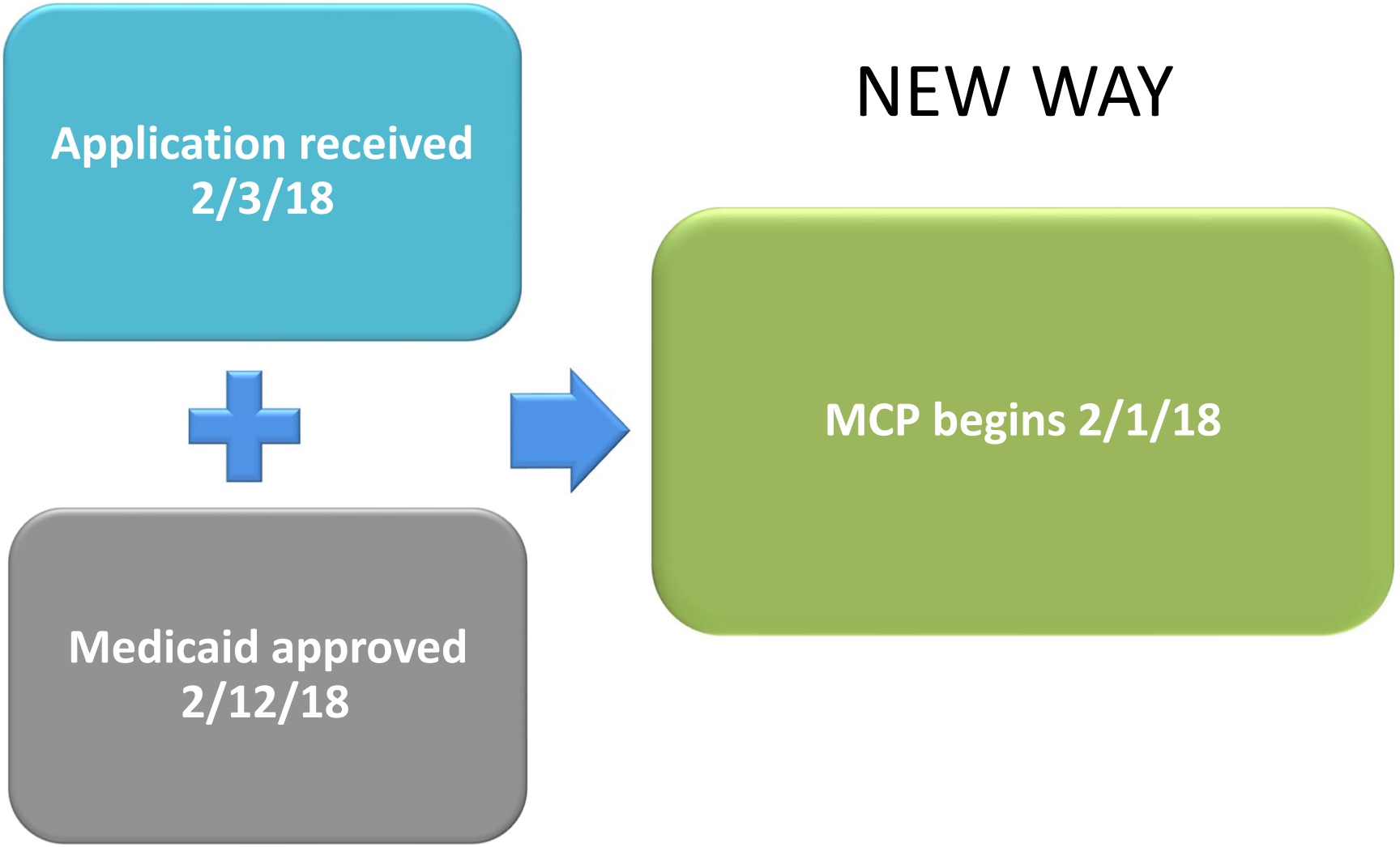
Managed Care Day One

	'The old way'	Day One
Individual completes Application	4/3/2018	4/3/2018
Determined eligible for Medicaid	5/17/2018	5/17/2018
Fee-For-Service	4/1/2018 → 5/31/2018	4/1/2018 → 4/30/2018
Managed Care Plan	6/1/2017 → 12/31/2299	5/1/2017 → 12/31/2299

OLD WAY


Application received
2/3/18
Medicaid approved
2/12/18
FFS 2/1/18 - 2/28/18
MCP begins 3/1/18 - ongoing

NEW WAY


Application received
2/3/18
Medicaid approved
2/12/18
MCP begins 2/1/18

Day One MCP Assignments

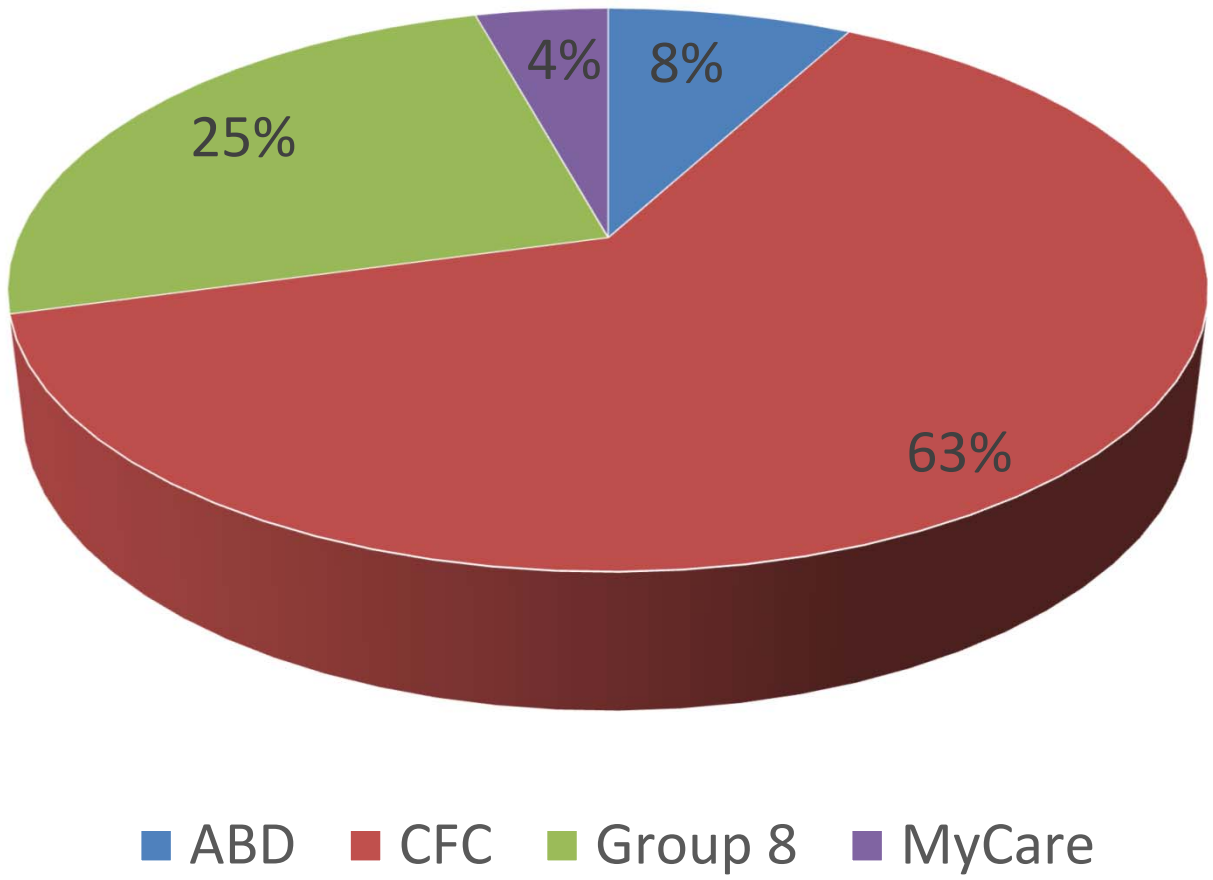
MITS looks for previous MCP in last 90 days

Then MITS looks for anyone on a case with family members assigned to a MCP

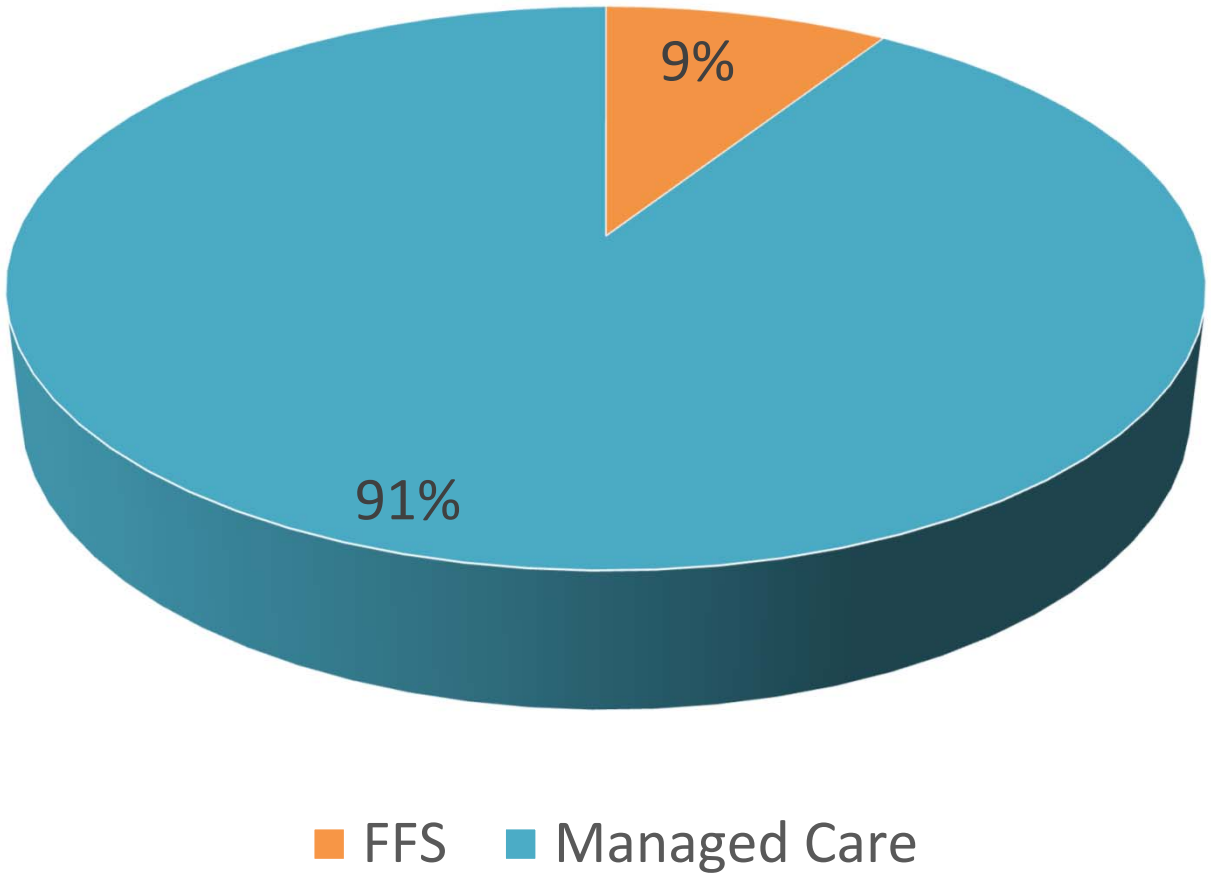
Then individual is assigned by an assignment algorithm

The assigned plan can be changed as desired during first 3 months

Managed Care Enrollment Groups - 2018



FFS vs. Managed Care Enrollment - 2018



3 Population Groups Eligible for Managed Care

Supplemental Security Income (SSI)

Modified Adjusted Gross Income (MAGI)

Aged, Blind, Disabled (ABD)

- Adoption children, Breast and Cervical Cancer Patients (BCCP), Foster children, and Bureau of Children with Medical Handicaps (BCMH)

Individuals with optional enrollment in Traditional Managed Care Plans

Native Americans that are members of a federally recognized tribe

Home and Community Based waivers thru DODD effective 1/1/17

Managed Care Benefit Package

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

Some value-added services:

- On-line 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

HOW DO YOU KNOW IF SOMEONE IS ENROLLED IN MANAGED CARE?

- Providers need to check the MITS provider portal each time before providing services to a Medicaid individual
- The MITS provider portal will show if an individual is enrolled in a Managed Care plan based on the eligibility dates of service you enter

MITS Managed Care Eligibility

Benefit / Assignment Plan

Benefit / Assignment Plan	Effective Date	End Date	Provider Name	Dental Co-Pay Amount	Vision Co-Pay Amount
Medicaid Schools	12/01/2017	02/28/2018		$0.00	$0.00
MRDD Targeted Case Mgmt	12/01/2017	02/28/2018		$0.00	$0.00
Alcohol and Drug Addiction Services	12/01/2017	02/28/2018		$0.00	$0.00
Ohio Mental health	12/01/2017	02/28/2018		$0.00	$0.00
Medicaid	12/01/2017	02/28/2018		$0.00	$0.00

Case/Cat/Seq Spenddown

*** No rows found ***

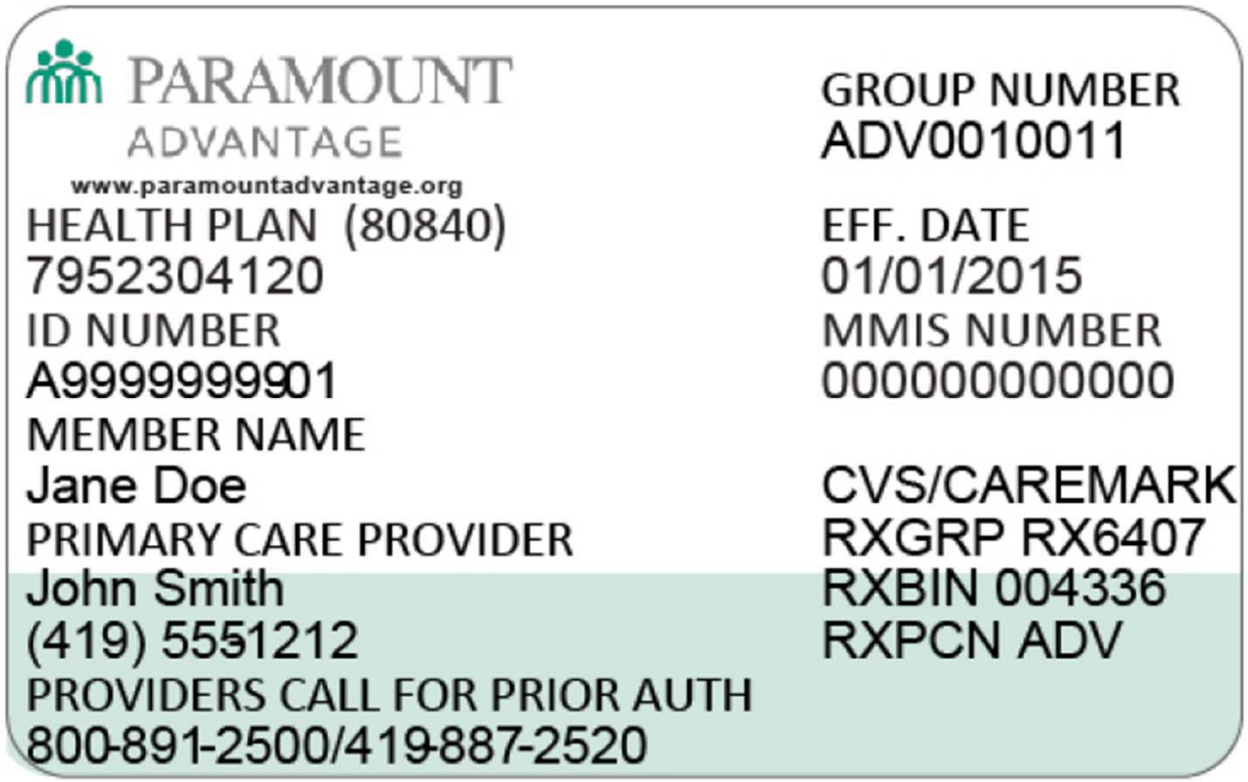
TPL

*** No rows found ***

Managed Care

Plan Name	Plan Description	Effective Date	End Date	Managed Care Benefits
PARAMOUNT ADVANTAGE	HMO, CFC	12/01/2017	02/28/2018	

Managed Care Sample Card



Managed Care Ohio Contracting

Providers who are interested in delivering services to a Managed Care individuals must 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
- MyCare Ohio contracts may be separate or an addendum to the ABD/CFC Managed Care contract

aetna®

AETNA BETTER HEALTH® OF OHIO

buckeye health plan

CareSource®

PARAMOUNT HEALTH CARE

MOLINA® HEALTHCARE

UnitedHealthcare®

Oversight of Managed Care Plans

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

Traditional Managed Care Plans

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

The project is currently slated to end on December 31, 2019

- Package includes ***all*** benefits available through the traditional Medicare and Medicaid programs for opt-in and opt-out

- This includes Long Term Services and Supports (LTSS) and Behavioral Health

- Plans may elect to include additional value-added benefits in their health care packages

MyCare Ohio Eligibility

In order to be eligible for MyCare Ohio an individual must be:

- Eligible for all parts of Medicare (Parts A, B, and D) and be fully eligible for Medicaid
- Over the age of 18
- Residing in one of the demonstration project regions

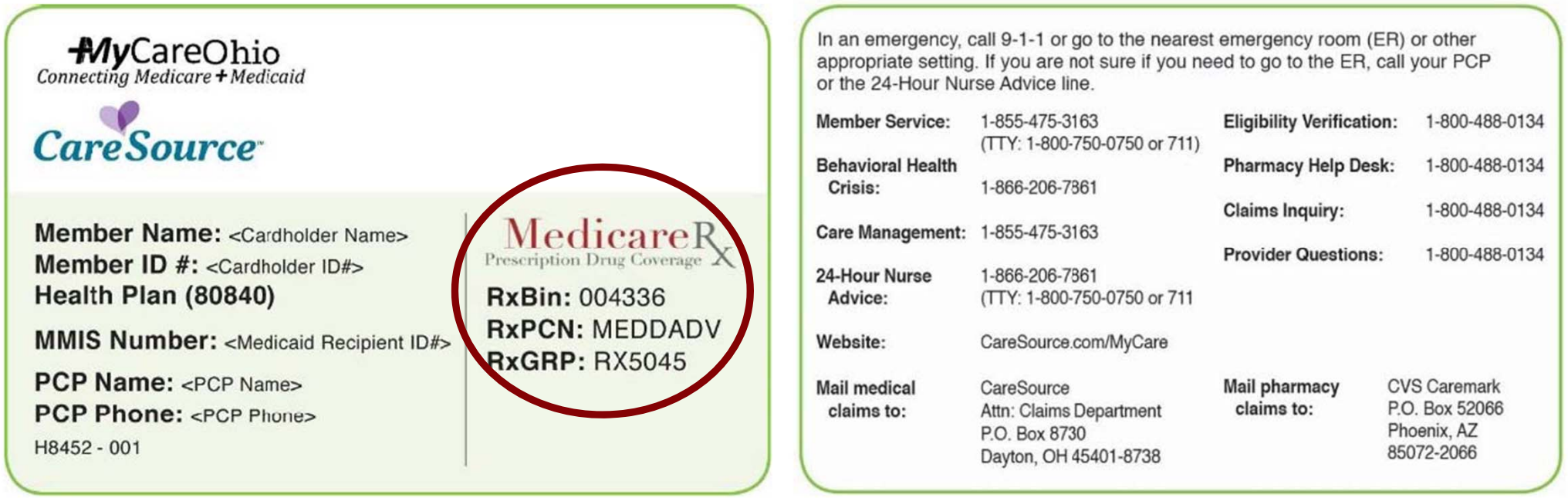
Groups that are *NOT* eligible for enrollment in MyCare Ohio:

- Individuals with an ICF-IID level-of-care served in an ICF-IID waiver
- Individuals enrolled in the PACE program
- Individuals who have third-party insurance, including retirement benefits

HOW DO YOU KNOW IF SOMEONE IS ENROLLED IN MYCARE?

- Providers need to check the MITS provider portal each time before providing services to a Medicaid recipient
- For recipients enrolled in a MyCare Ohio Managed Care plan it will show if they are enrolled for ***Dual Benefits*** OR ***Medicaid Only***
- The MITS provider portal will show if a recipient is enrolled in a Managed Care Plan based on the eligibility dates of service you enter

MyCare Ohio Opt-In Sample Card



MyCareOhio
Connecting Medicare + Medicaid

CareSource

Member Name: <Cardholder Name>
Member ID #: <Cardholder ID#>
Health Plan (80840)

MMIS Number: <Medicaid Recipient ID#>

PCP Name: <PCP Name>
PCP Phone: <PCP Phone>

H8452 - 001

MedicareRx
Prescription Drug Coverage

RxBin: 004336
RxPCN: MEDDADV
RxGRP: RX5045

In an emergency, call 9-1-1 or go to the nearest emergency room (ER) or other appropriate setting. If you are not sure if you need to go to the ER, call your PCP or the 24-Hour Nurse Advice line.

Member Service:	1-855-475-3163 (TTY: 1-800-750-0750 or 711)	**Eligibility Verification:**	1-800-488-0134
Behavioral Health Crisis:	1-866-206-7361	**Pharmacy Help Desk:**	1-800-488-0134
		Claims Inquiry:	1-800-488-0134
Care Management:	1-855-475-3163	**Provider Questions:**	1-800-488-0134
24-Hour Nurse Advice:	1-866-206-7361 (TTY: 1-800-750-0750 or 711		
Website:	CareSource.com/MyCare		
Mail medical claims to:	CareSource Attn: Claims Department P.O. Box 8730 Dayton, OH 45401-8738	**Mail pharmacy claims to:**	CVS Caremark P.O. Box 52066 Phoenix, AZ 85072-2066

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	12/01/2017	01/31/2018		$0.00	$0.00
Alcohol and Drug Addiction Services	12/01/2017	01/31/2018		$0.00	$0.00
Ohio Mental health	12/01/2017	01/31/2018		$0.00	$0.00
Medicaid	12/01/2017	01/31/2018		$0.00	$0.00

Case/Cat/Seq Spenddown

*** No rows found ***

TPL

*** No rows found ***

Managed Care

Plan Name	Plan Description	Effective Date	End Date	Managed Care Benefits
CARESOURCE	HMO, MyCare Ohio	12/01/2017	01/31/2018	Dual Benefits

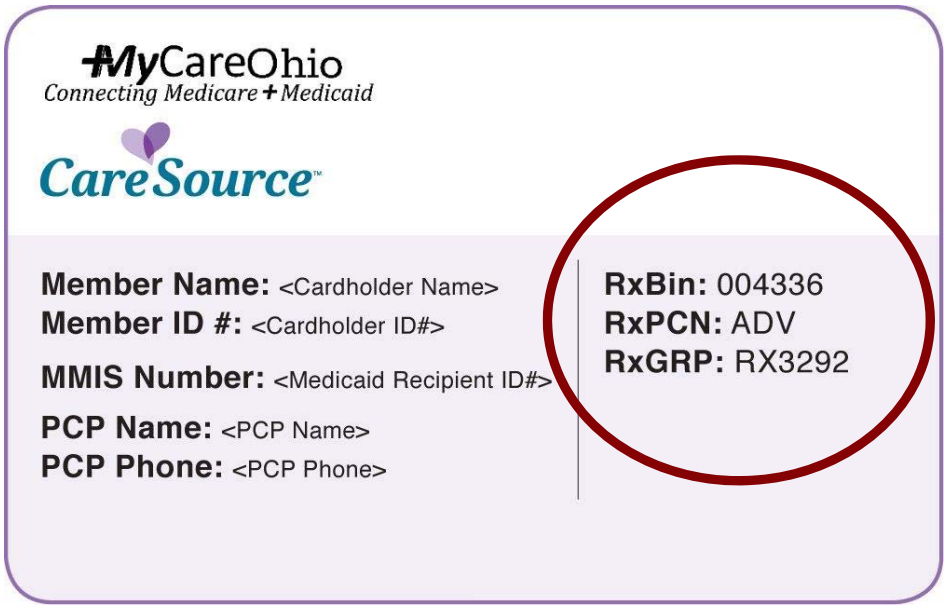
Lock-In

*** No rows found ***

Medicare

Coverage	Effective Date	End Date	Plan Name	Plan ID	Medicare ID
PART A	12/01/2017	01/31/2018			018562948A
PART B	12/01/2017	01/31/2018			018562948A
PART C	12/01/2017	01/31/2018	CARESOURCE MYCARE OHIO	H8452	018562948A
PART D	01/01/2018	01/31/2018	*H8452/001	001	018562948A
PART D	12/01/2017	12/31/2017	*H8452/001	001	018562948A

MyCare Ohio Opt-Out Sample Card



In an emergency, call 9-1-1 or go to the nearest emergency room (ER) or other appropriate setting. If you are not sure if you need to go to the ER, call your PCP or the 24-Hour Nurse Advice line.

Member Service:	1-855-475-3163 (TTY: 1-800-750-0750 or 711)
Behavioral Health Crisis:	1-866-206-7861 (TTY: 1-800-750-0750 or 711)
Care Management:	1-855-475-3163 (TTY: 1-800-750-0750 or 711)
24-Hour Nurse Advice:	1-866-206-7861 (TTY: 1-800-750-0750 or 711)
Provider/Pharmacy Questions:	1-800-488-0134
Website:	CareSource.com/MyCare

Mail medical claims to:
CareSource
Attn: Claims Department
P.O. Box 8730
Dayton, OH 45401-8738

Mail pharmacy claims to:
CVS Caremark
P.O. Box 52066
Phoenix, AZ 85072-2066

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	10/01/2017	01/31/2018		$0.00	$0.00
Alcohol and Drug Addiction Services	10/01/2017	01/31/2018		$0.00	$0.00
Ohio Mental health	10/01/2017	01/31/2018		$0.00	$0.00
Medicaid	10/01/2017	01/31/2018		$0.00	$0.00

Case/Cat/Seq Spenddown

*** No rows found ***

TPL

*** No rows found ***

Managed Care

Plan Name	Plan Description	Effective Date	End Date	Managed Care Benefits
BUCKEYE COMMUNITY HEALTH PLAN	HMO, MyCare Ohio	10/01/2017	01/31/2018	Medicaid Only

Lock-In

*** No rows found ***

Medicare

Coverage	Effective Date	End Date	Plan Name	Plan ID	Medicare ID
PART A	10/01/2017	01/31/2018			300685983A
PART B	10/01/2017	01/31/2018			300685983A
PART C	11/01/2017	01/31/2018	ANTHEM SENIOR ADVANTAGE PLUS	H3655	300685983A

MyCare Ohio Region Breakdown

Northwest	Southwest	West Central	Central	East Central	Northeast Central	Northeast
Aetna Buckeye	Aetna Molina	Buckeye Molina	Aetna Molina	Caresource United	Caresource United	Caresource Buckeye United
Fulton Lucas Ottawa Wood	Butler Warren Clinton Hamilton Clermont	Clark Green Montgomery	Union Delaware Franklin Pickaway Madison	Summit Portage Stark Wayne	Trumbull Mahoning Columbiana	Lorain Cuyahoga Lake Geauga Medina

MyCare Ohio Managed Care Contracting

Providers who are interested in delivering services to MyCare Ohio individuals must 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
- MyCare Ohio contracts may be separate or an addendum to the ABD/CFC Managed Care contract

MyCare Ohio Managed Care Plans

buckeye health plan — 866-296-8731 https://www.buckeyehealthplan.com/

CareSource® — 800-488-0134 https://www.CareSource.com/MyCare

aetna® AETNA BETTER HEALTH® OF OHIO — 855-364-0974 https://www.aetnabetterhealth.com/ohio

MOLINA® HEALTHCARE — 855-322-4079 https://www.molinahealthcare.com/duals

UnitedHealthcare® — 800-600-9007 https://www.uhccommunityplan.com/

PROVIDER COMPLAINTS

Work directly with the Plan first

If not resolved, submit a complaint to Ohio Department of Medicaid (ODM) at https://www.ohiomh.com/ProviderComplaintForm.aspx

Certification issues

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

Provider credentialing concerns

Please send to Ohio Department of Insurance (ODI)

Ohio | Department of Medicaid

OH Medicaid *Managed Care* Provider Complaint Form

Instructions

This form is for Managed Care providers only. Providers must appeal denied claims to the MCP before the Ohio Department of Medicaid will process a complaint. If your complaint involves multiple Managed Care Plans (MCPs), please complete one form per MCP. The resolution timeframes for Managed Care complaints are 2 business days for complaints involving access to care, and 15 business days for all other issues. If you have a complaint regarding Medicaid Fee For Service please call 1-800-686-1516.

Complaint Details

MCP Name: *

Complaint Reason: *

* Are you contracted with this Health Plan? ○ Yes ○ No

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

* Have you already contacted the MCP about this issue? ○ Yes ○ No

* Is this complaint related to any previously submitted complaints? ○ Yes ○ No

* Is this complaint related to children with special health care needs? ○ Yes ○ No

* Is the patient receiving or seeking mental health or substance abuse services? ○ Yes ○ No

PROVIDER RESPONSIBILITIES

Provider Enrollment and Revalidation

Providers are required to submit an application to become a Medicaid provider

There is also a federally required 5 year revalidation

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

Online applications can be found on our website

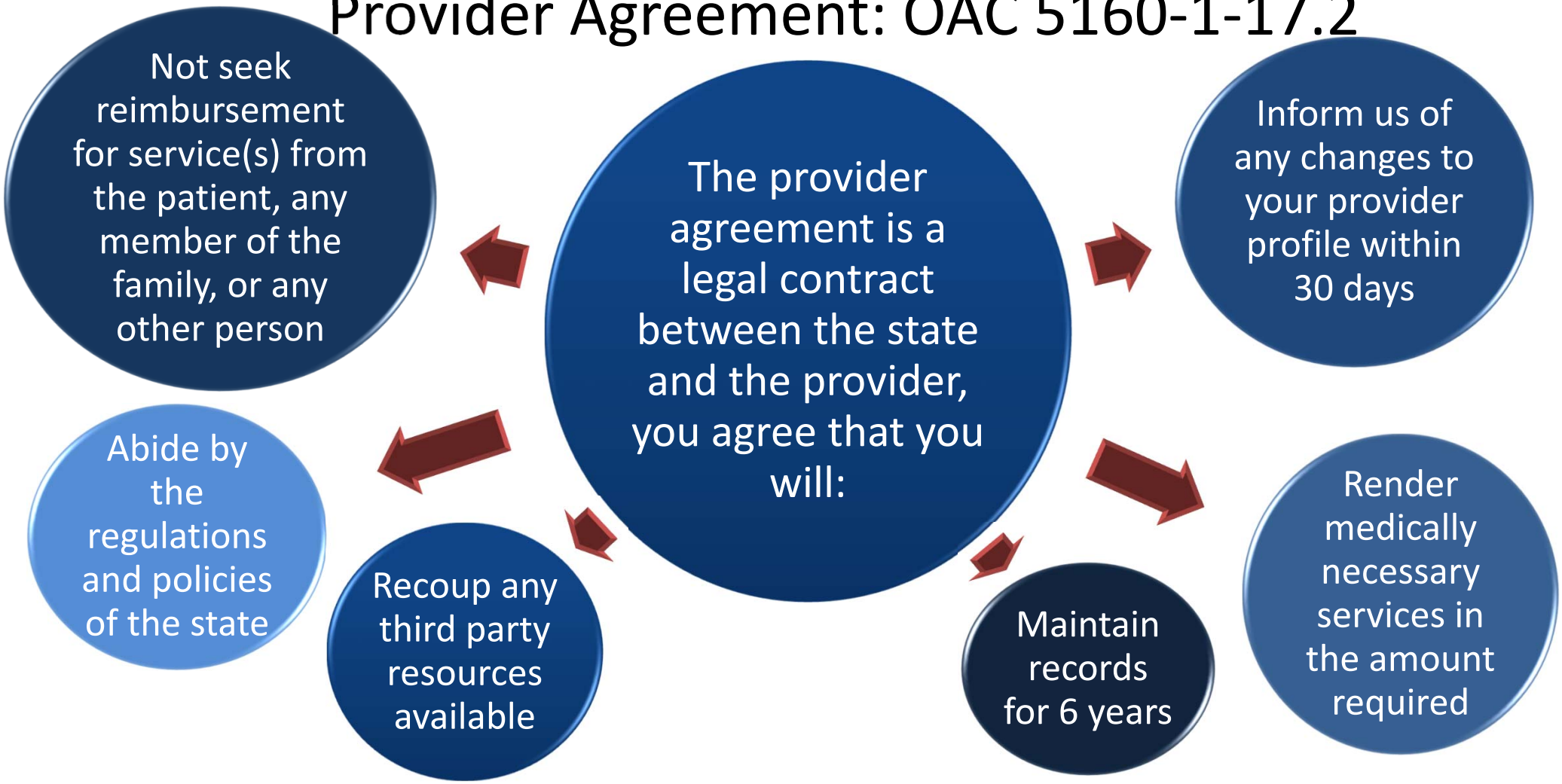
Provider Enrollment and Revalidation, cont.

There is a federally required, non-refundable application fee when a provider submits a new or revalidation application

The 2018 fee is $569.00 per application

This fee applies to organizational providers only (not individual providers, practitioners, or practitioner groups)

Provider Agreement: OAC 5160-1-17.2



General Reimbursement Principles:

OAC 5160-1-02

+

Medicaid Payment:
OAC 5160-1-60

→

The department's payment constitutes payment-in-full for any of our covered services

Providers are expected to bill the department their Usual and Customary Charges (UCC)

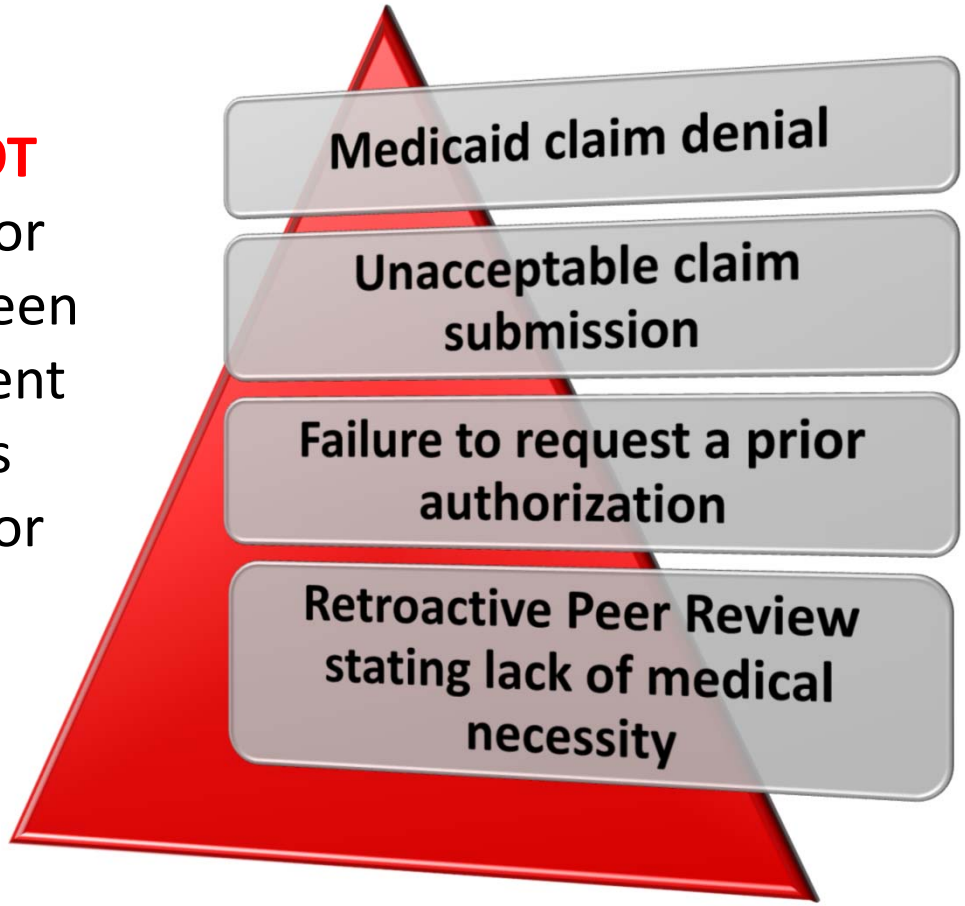
The department will reimburse the provider the lesser of the Medicaid maximum allowable rate (established fee schedule) or the UCC

Coordination of Benefits: OAC 5160-1-08

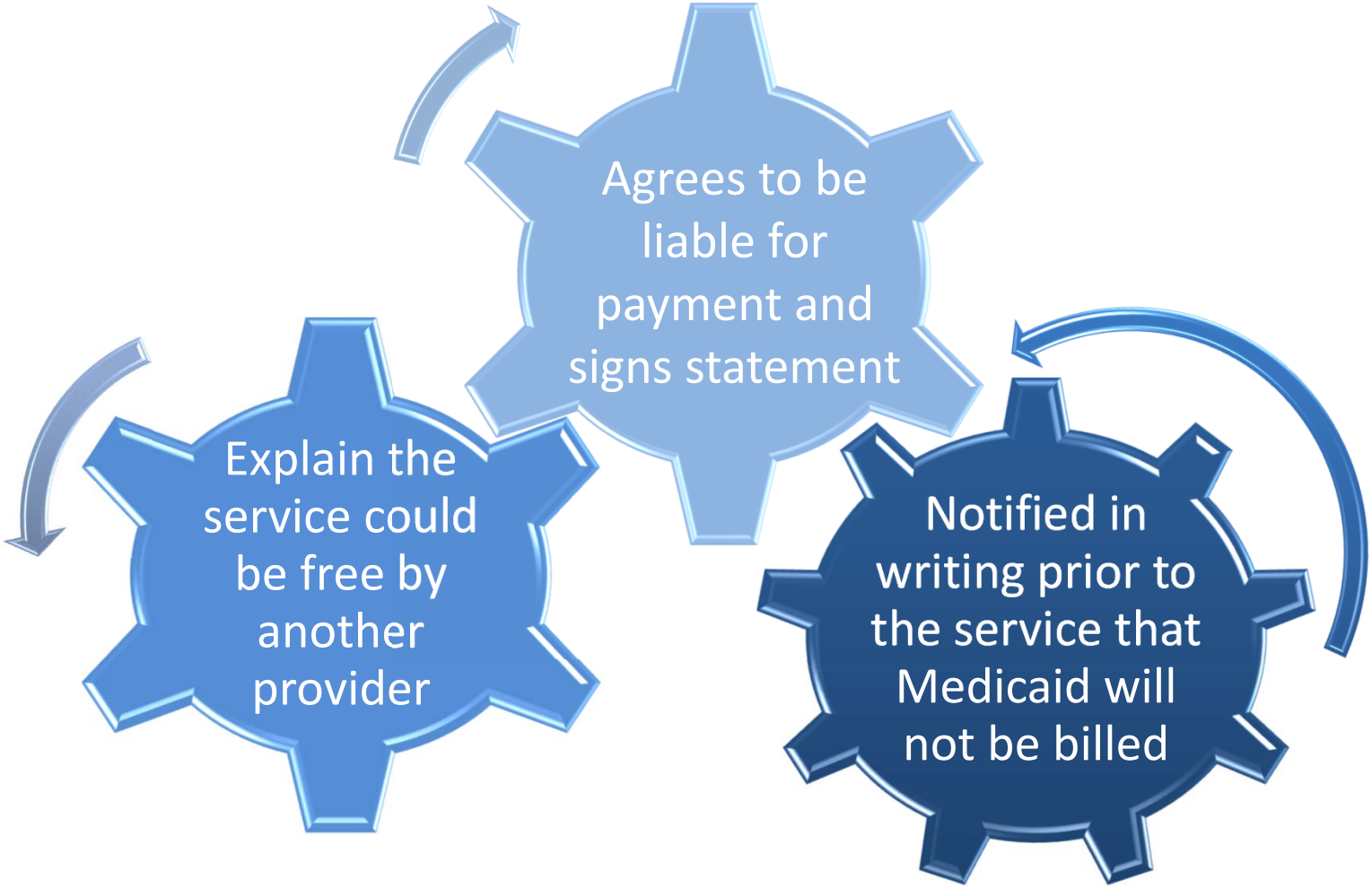
- The Ohio Administrative Code requires that a Medicaid consumer provide notice to the department prior to initiating any action against a liable third party
- The department will take steps to protect its subrogation rights if that notice is not provided
- For questions, contact the Coordination of Benefits Section at 614-752-5768

Medicaid Consumer Liability 5160-1-13.1

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



When Can you Bill an Individual?



If not an ABN, then What?

5160-1-13.1 Medicaid Consumer Liability

Date of service: _____

Type of Service: _____

Name/account number: _____

Billing number: _____

☐ (C) Providers may not bill consumers in lieu of ODJFS unless:

_____ (1) The consumer is notified in writing prior to the service being rendered that the provider will not bill ODJFS for the covered service; and

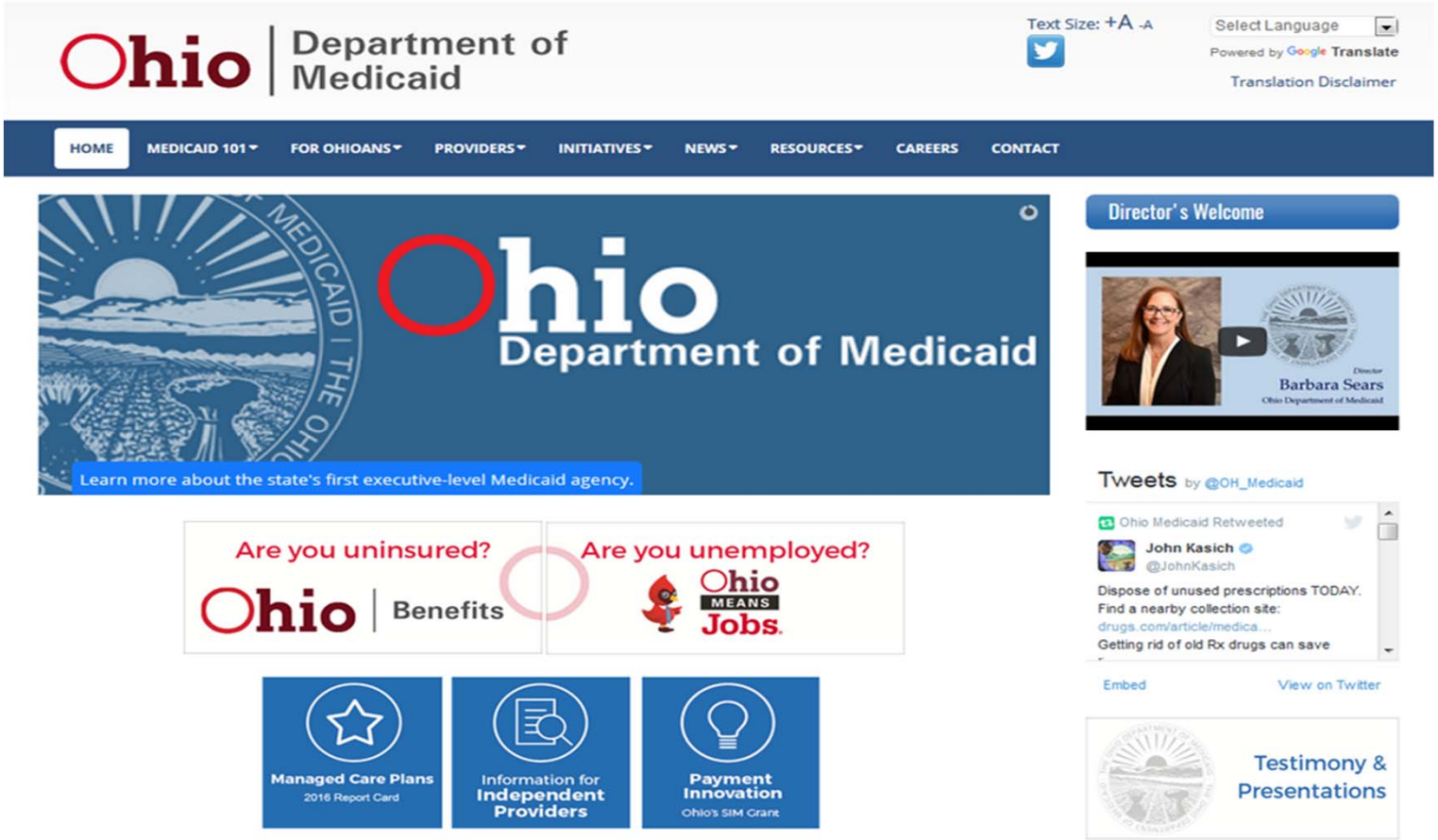
_____ (2) The consumer agrees to be liable for payment of the service and signs a written statement to that effect prior to the service being rendered; and

_____ (3) The provider explains to the consumer that the service is a covered medicaid service and other medicaid providers may render the service at no cost to the consumer.

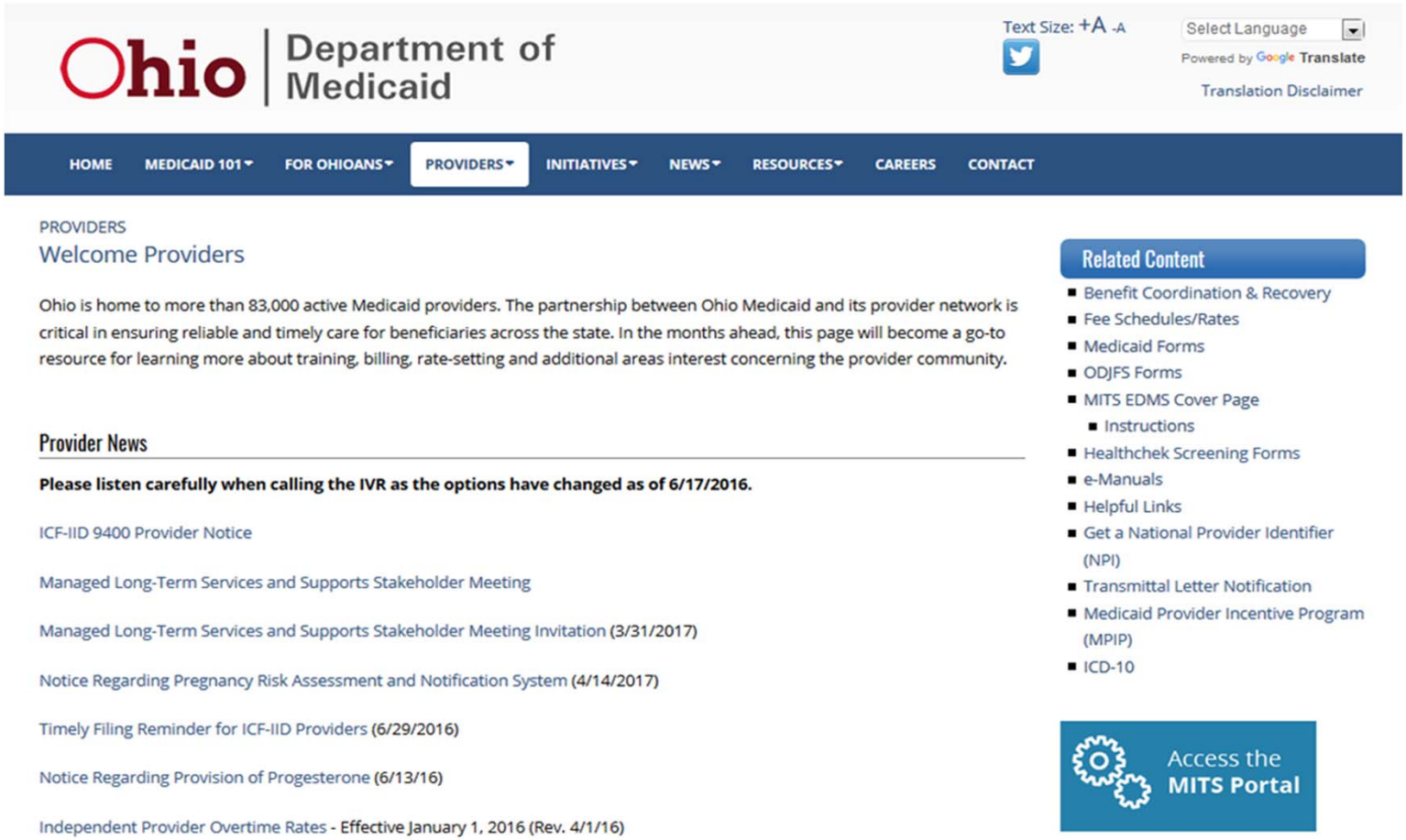
Signature: _____

☐ (D) Services that are not covered by the medicaid program, including services requiring prior authorization that have been denied by ODJFS, may be billed to the consumer when the provisions in paragraphs (C)(1) and (C)(2) of this rule are met.

The Ohio Department of Medicaid Website



Provider News



Ohio | Department of Medicaid

Text Size: +A -A

Select Language

Powered by Google Translate

Translation Disclaimer

HOME | MEDICAID 101 | FOR OHIOANS | PROVIDERS | INITIATIVES | NEWS | RESOURCES | CAREERS | CONTACT

PROVIDERS

Welcome Providers

Ohio is home to more than 83,000 active Medicaid providers. The partnership between Ohio Medicaid and its provider network is critical in ensuring reliable and timely care for beneficiaries across the state. In the months ahead, this page will become a go-to resource for learning more about training, billing, rate-setting and additional areas interest concerning the provider community.

Provider News

Please listen carefully when calling the IVR as the options have changed as of 6/17/2016.

ICF-IID 9400 Provider Notice

Managed Long-Term Services and Supports Stakeholder Meeting

Managed Long-Term Services and Supports Stakeholder Meeting Invitation (3/31/2017)

Notice Regarding Pregnancy Risk Assessment and Notification System (4/14/2017)

Timely Filing Reminder for ICF-IID Providers (6/29/2016)

Notice Regarding Provision of Progesterone (6/13/16)

Independent Provider Overtime Rates - Effective January 1, 2016 (Rev. 4/1/16)

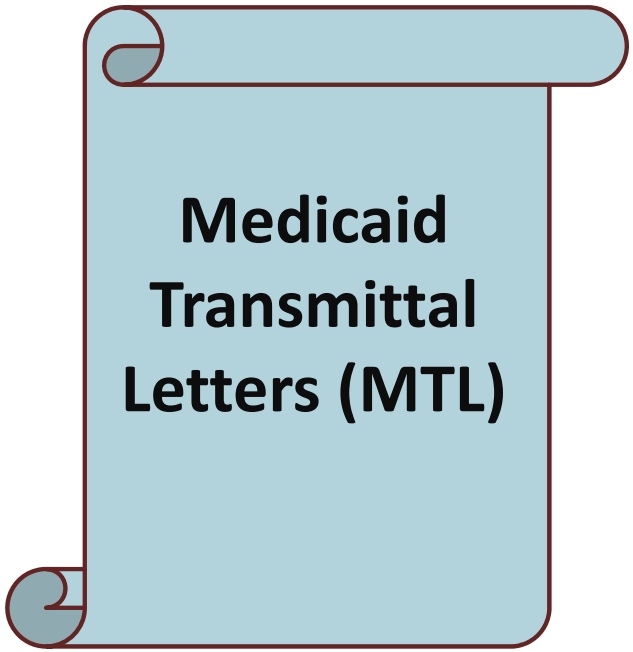
Related Content

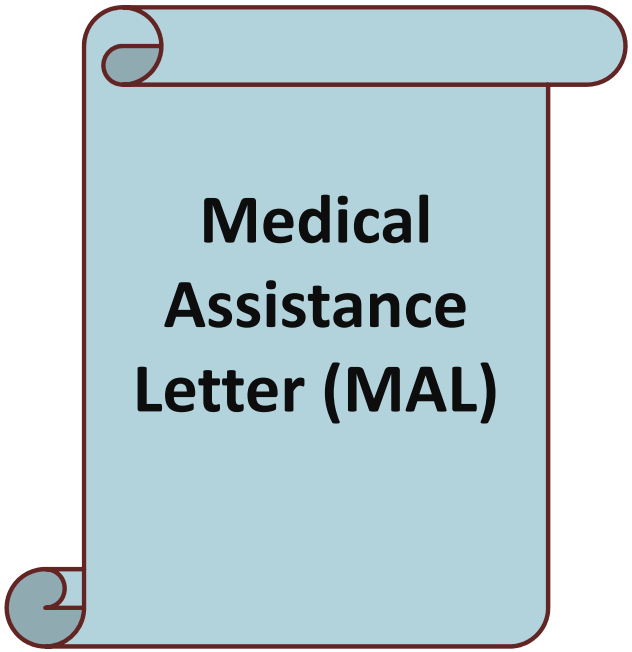
- Benefit Coordination & Recovery
- Fee Schedules/Rates
- Medicaid Forms
- ODJFS Forms
- MITS EDMS Cover Page
  - Instructions
- Healthchek Screening Forms
- e-Manuals
- Helpful Links
- Get a National Provider Identifier (NPI)
- Transmittal Letter Notification
- Medicaid Provider Incentive Program (MPIP)
- ICD-10

Access the MITS Portal

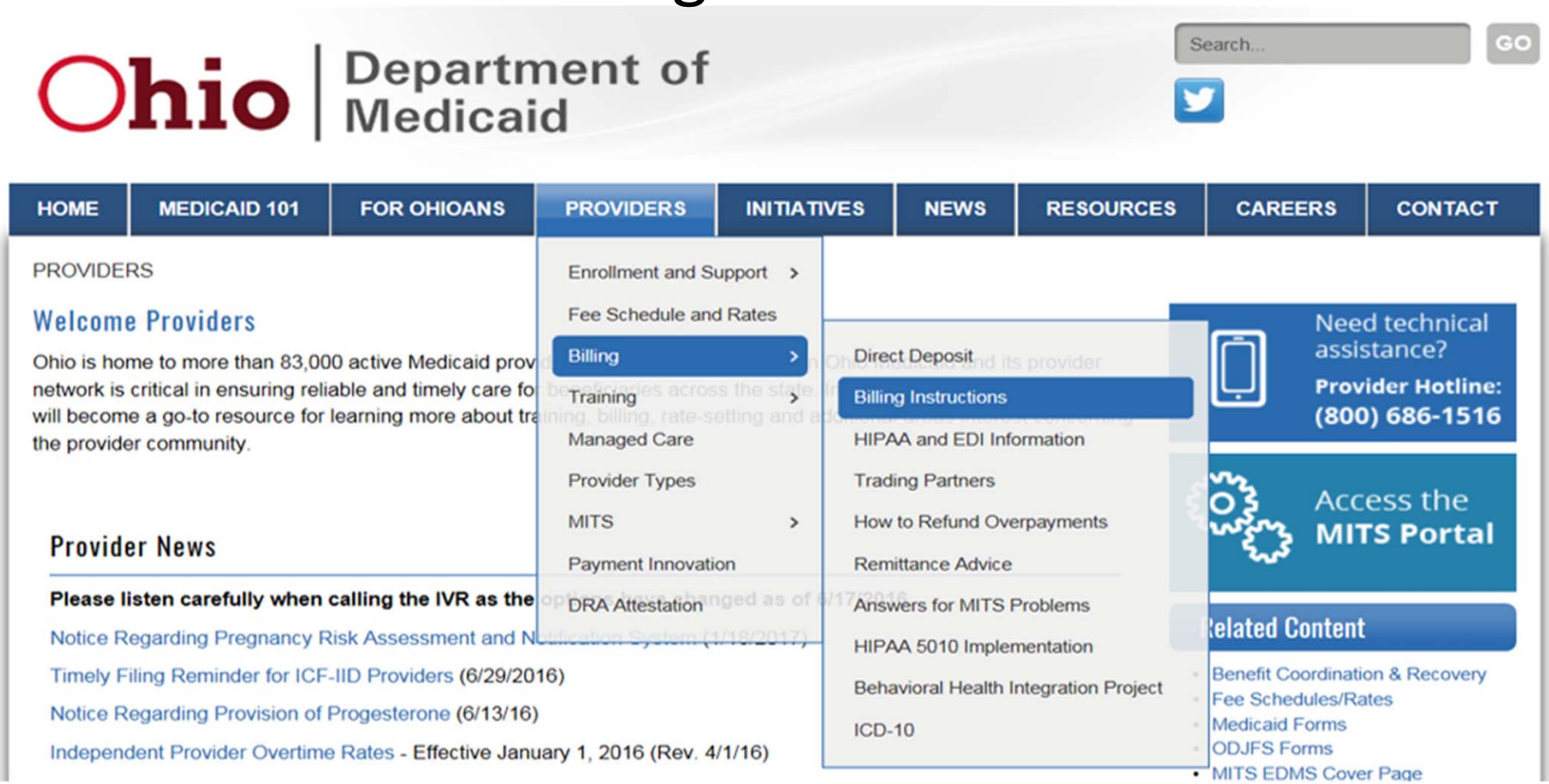
POLICY

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





Billing Resources

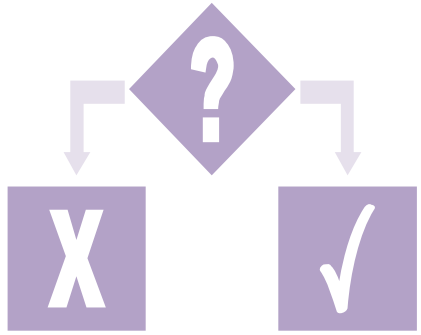


How to Find Modifiers Recognized by Ohio Medicaid

- Scroll to the bottom of the page

Co-Payments and Exclusions: OAC 5160-1-09

- There is a co-payment requirement for dental services
  - This may apply to individuals enrolled in managed care
- Co-Payment exclusions:
  - Under age 21
  - Pregnant or in the post partum period
  - Nursing facility and ICF-IID residents
  - Individuals receiving emergency services
  - Individuals receiving hospice care
  - Individuals received Medicaid under the breast and cervical cancer option



Policy Updates: OAC 5160-5-01

Restoration Audits

- Payment for multiple restorations on the same tooth, on the same date of service, can be made as though done separately
  - Up to a maximum of three restorations
- A tooth surface can only be named once - whether alone or in combination with restorations on other surfaces
  - On maxillary first and second molars, the occlusal surface can be named twice - whether performed alone or in combination with restorations of another surface

Policy Updates: OAC 5160-5-01

- Restoration Audits, cont.
  - On anterior teeth, the facial and lingual surfaces can be named twice
    - Whether performed alone or in combination with restorations of another surface
  - If the incisal angle on an anterior tooth is involved, then only one four surface restoration can be billed for the tooth
    - No additional surfaces or restorations will be allowed

Allowing Payment

- **D0140** "Limited problem focused exam"
  - Allow payment on the same date as other dental treatment services with the exception of other oral exams/evaluations
    - No Payment is made for a limited oral evaluation performed in conjunction with either a comprehensive oral evaluation, periodic oral evaluation or periodontal evaluation

Limitations

D2950 “Core build-up including pins”

Coverage shall be for all permanent teeth except supernumerary (1-32)

Max fee of $76.54

Lifetime limit of 1 per tooth

Limitations

D1354 "Silver Diamine Fluoride"

- Limit of 1 unit per date of service paid regardless of number of tooth numbers submitted
- No age restriction
- Lifetime limit of 6 applications
  - Cannot be paid in conjunction with a restoration or crown on the same tooth

Limitations

D7283 "Placement of device to facilitate eruption of impacted tooth"

Coverage shall be for all teeth excluding supernumerary

Max fee of $75.00

Prior authorization (PA) required

Limitations

- **D7210** "Extraction"
  - Coverage shall be for all teeth including supernumerary
    - 1-32, A-T, 51-82, AS-TS
  - Max fee of $57.69
  - Lifetime limit of 1 per tooth

Limitations

D9612 Therapeutic parenteral drug administration

Two or more administrations, different medications

Establish max fee of $50.36
Establish audit to only allow one unit of D9610 or D9612

Payment Updates

- ☑ **D7670** Alveolus-closed reduction
  Establish max fee of $243.15
- ☑ **D9610** Therapeutic parenteral drug, single administration
  Establish max fee of $25.18
- ☑ **D7671** Alveolus-open reduction
  Establish max fee of $318.75

Reimbursement Updates

- Deep sedation/general anesthesia/intravenous conscious sedation/analgesia services
  - Assure reimbursement of deep sedation/general anesthesia services at a fixed amount
    - Flat rate of one unit, per patient, per DOS
  - Assure reimbursement of intravenous conscious sedation/analgesia services at a fixed amount
    - Flat rate of one unit, per patient, per DOS

MITS AND CLAIMS

Medicaid Information Technology System (MITS)

MITS is a web-based application that is accessible via any modern browser

MITS is available to all Ohio Medicaid providers who have been registered and have created an account

MITS is able to process transactions in “real time”

Technical Requirements

Internet Access (high speed works best)

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

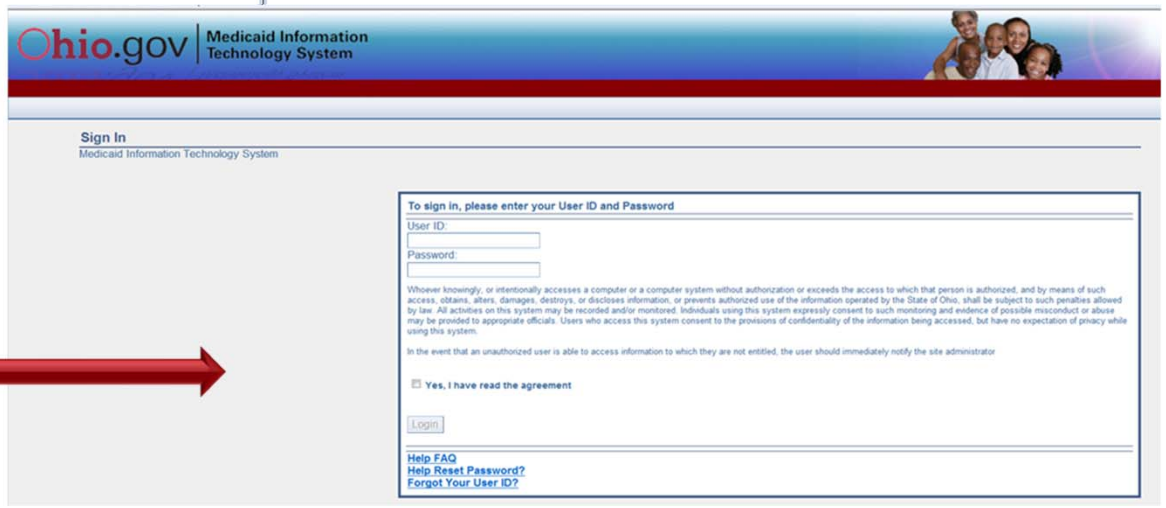
Mac users use current version of Safari, Firefox, or Chrome

Turn **OFF** pop up blocker functionality

- Go to http://Medicaid.ohio.gov
- Select the “Provider Tab” at the top
- Click on the “Access the MITS Portal” image on the right of the page

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

You will then be directed to another page where you will need to enter your "User ID" and "Password"



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 to be in the next payment cycle

MITS Portal

Free submission

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

Easier for us to help you with your claim submission issues!

Technical Questions/EDI Support Unit

Trading partners contact DXC for EDI Support

844-324-7089
or
OhioMCD-EDI-Support@dxc.com

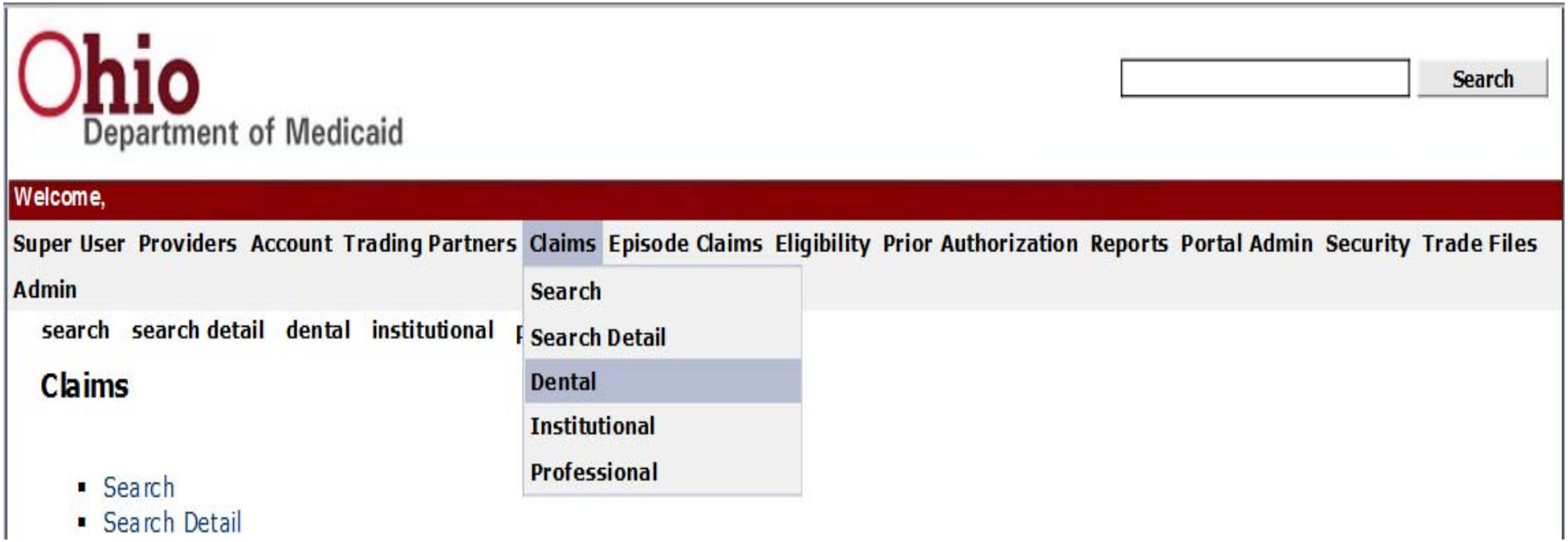
MITS Web Portal Claim Submission

Claim entry format is divided into sections or panels

Each panel will have an asterisk (*) denoting that the fields are required

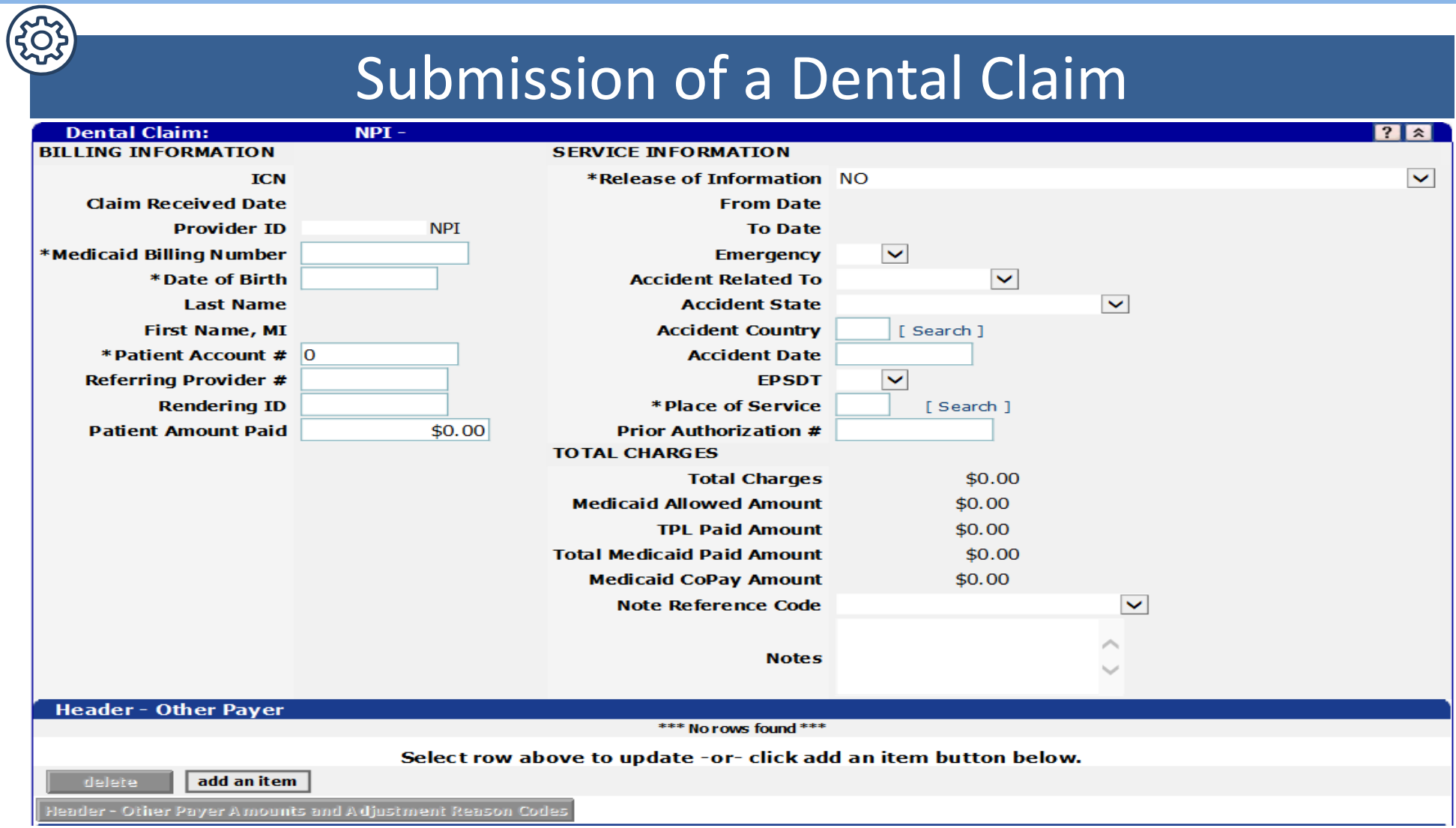
- Some fields are situational for claims adjudication and do not have an asterisk

Submission of a Dental Claim

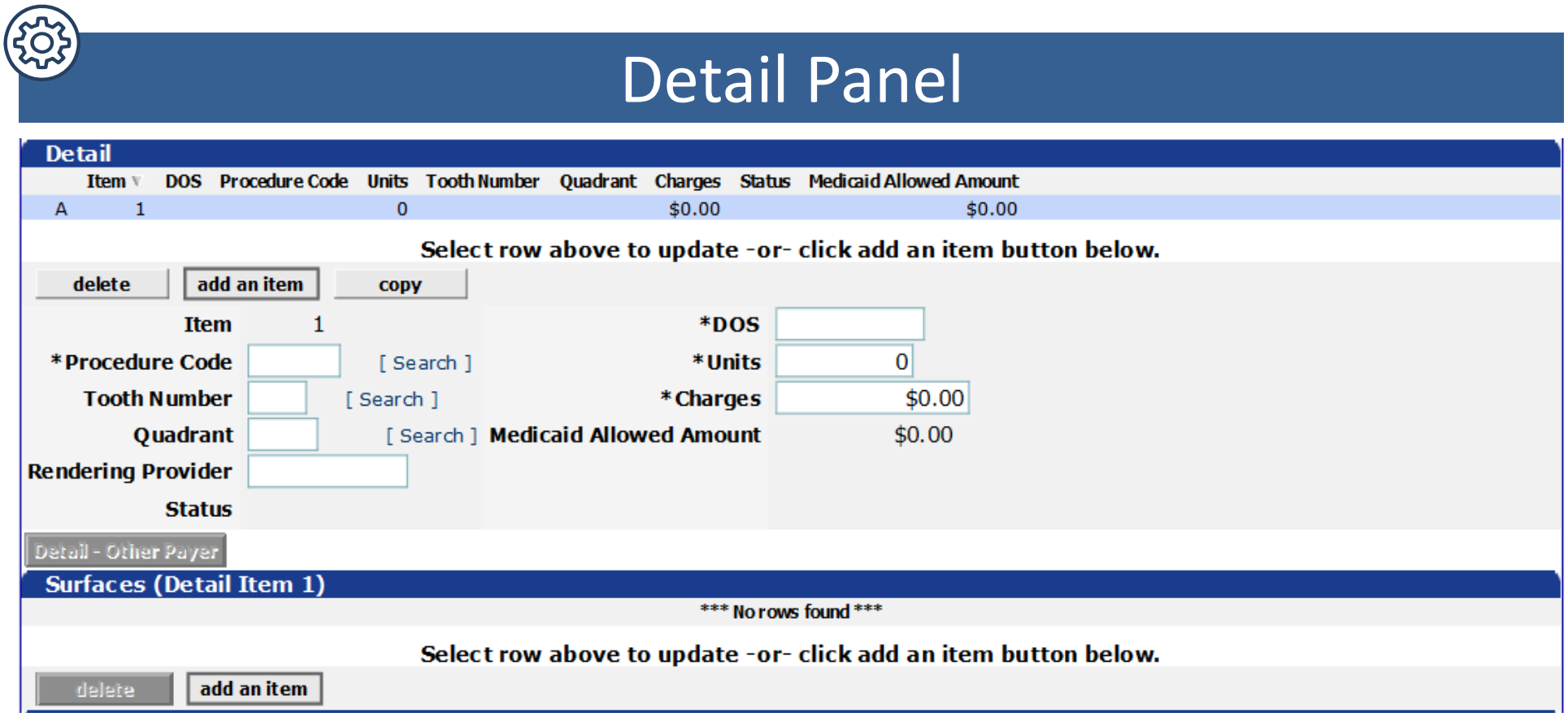


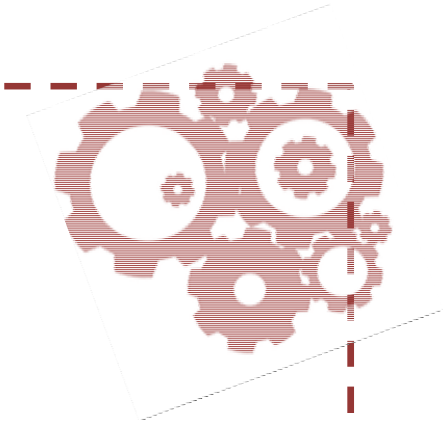
Ohio | Department of Medicaid

Submission of a Dental Claim



Detail Panel





- Click the “submit” button at the bottom right

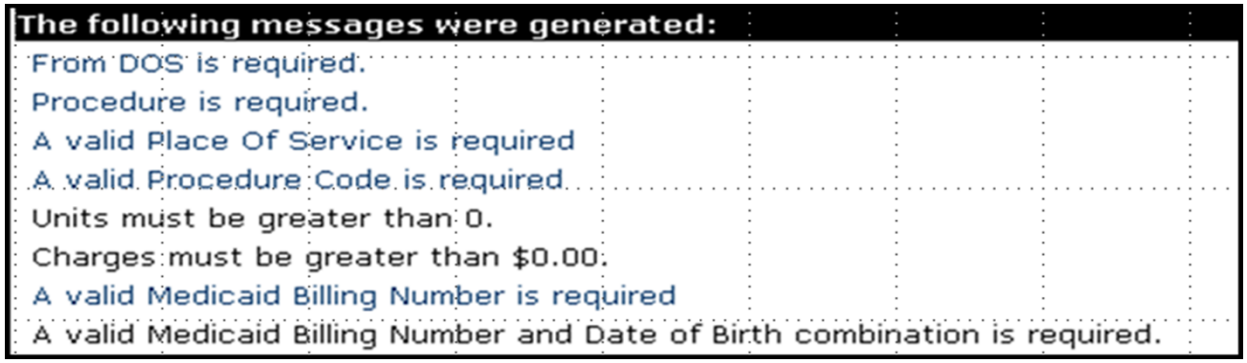
- You may “cancel” the claim at anytime, but the information will not be saved in MITS

Claim Portal Errors

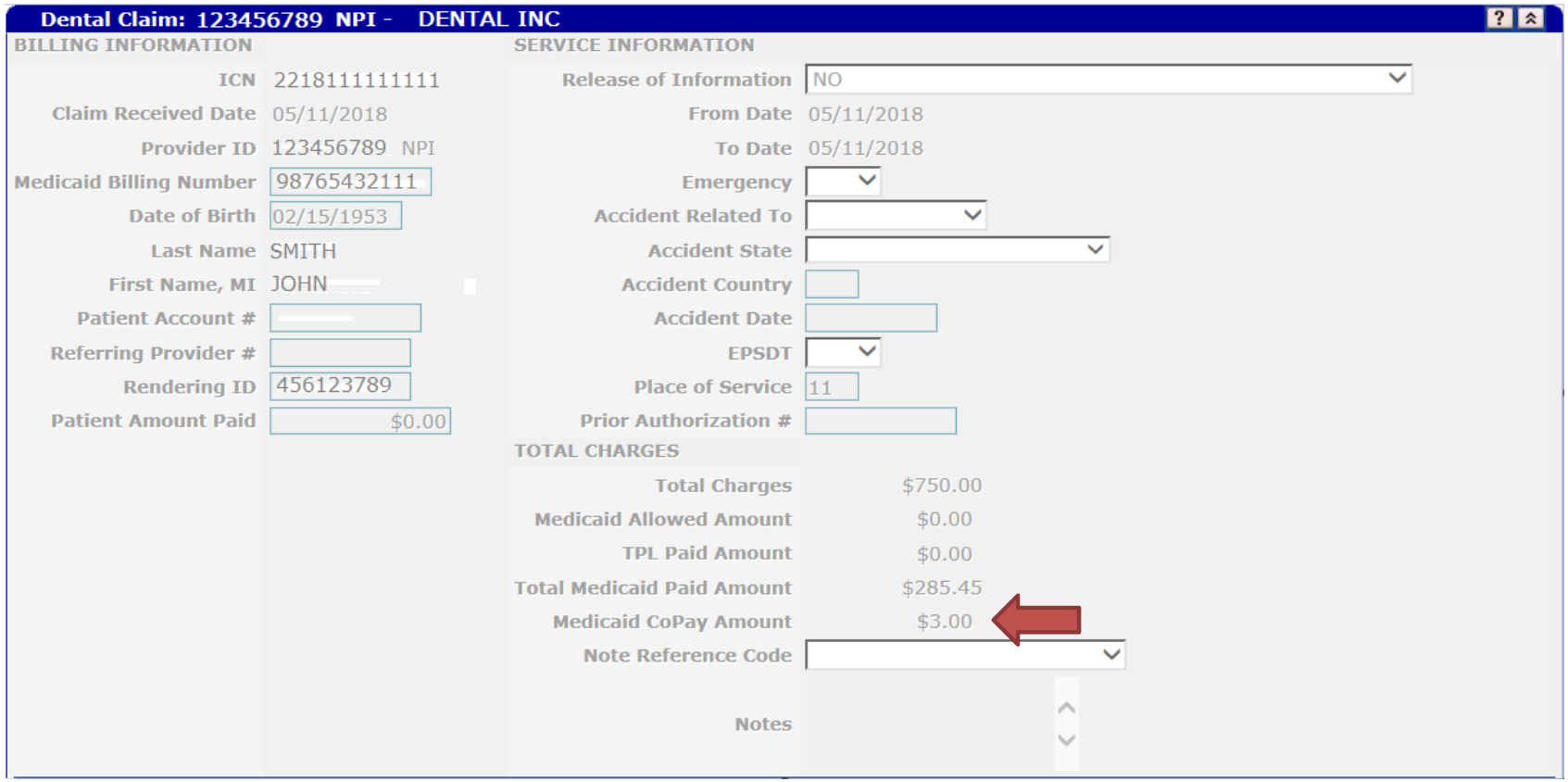
MITS will not accept a claim without all required fields being populated

Portal errors return the claim with a “fix” needed

Claim shows a ‘NOT SUBMITTED YET’ status still



Claim Example



Claim Example, cont.

Header - Other Payer

*** No rows found ***

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

delete | add an item

Header - Other Payer Amounts and Adjustment Reason Codes

Detail

Item	DOS	Procedure Code	Units	Tooth Number	Quadrant	Charges	Status	Medicaid Allowed Amount
5	05/11/2018	D7140	1.00	09		$150.00	PAID	$57.69
4	05/11/2018	D7140	1.00	08		$150.00	PAID	$57.69
3	05/11/2018	D7140	1.00	05		$150.00	PAID	$57.69
2	05/11/2018	D7140	1.00	04		$150.00	PAID	$57.69
1	05/11/2018	D7140	1.00	03		$150.00	PAID	$57.69

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

delete | add an item | copy

Item	5	DOS	05/11/2018
Procedure Code	D7140	Units	1.00
Tooth Number	09	Charges	$150.00
Quadrant		Medicaid Allowed Amount	$57.69
Rendering Provider	456123789		
Status	PAID		

Detail - Other Payer

Claim Example, cont.

Surfaces (Detail Item 5)

*** No rows found ***

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

delete | add an item

Attachments

*** No rows found ***

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

delete | add an item

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

Claim Status Information

Claim Status	PAID
Claim ICN	2218131008506
Paid Date	05/24/2018
Paid Amount	$285.45

Claim Example, cont.

EOB Information

Detail Number	Error Disposition	EOB Code	EOB Description	CARC	CARC Amount	CARC Description	RARC	RARC Description
1		9001	REIMBURSEMENT REDUCED BY THE MEMBERS CO-PAYMENT AMOUNT	3	$3.00	Co-payment Amount	M16	Alert: Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision.
1		9918	PRICING ADJUSTMENT - MAX FEE PRICING APPLIED	45	$92.31	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.

All claims are assigned an ICN

2218170357321

Region Code	Calendar Year	Julian Day	Claim Type/ Batch Number	Claim Number in Batch
22	18	170	357	321

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

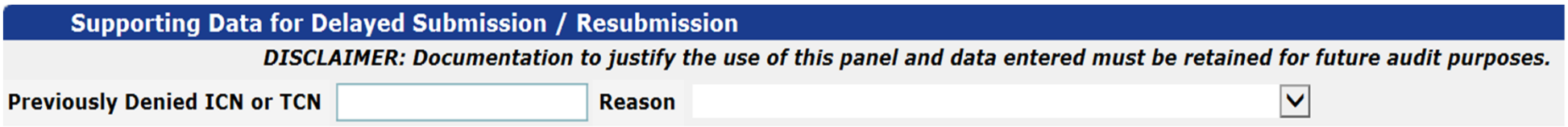
An additional 180 days from the resubmit date is given for attempts to correctly submit a denied claim prior to the end of the 365 days

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

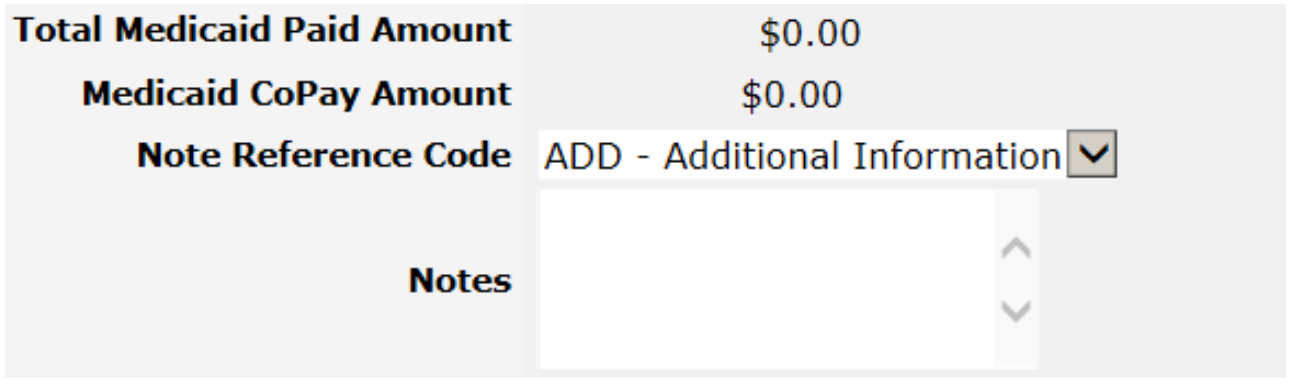
- If you are submitting a claim that is more than 365 days after the date of service due to a hearing decision or delay in the individual's eligibility determination

- 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

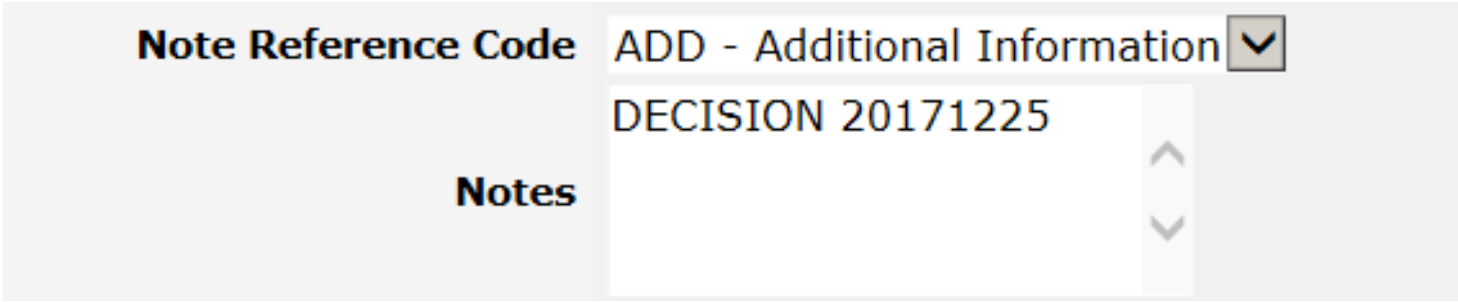
- In the Note Reference Code dropdown menu select "ADD"



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

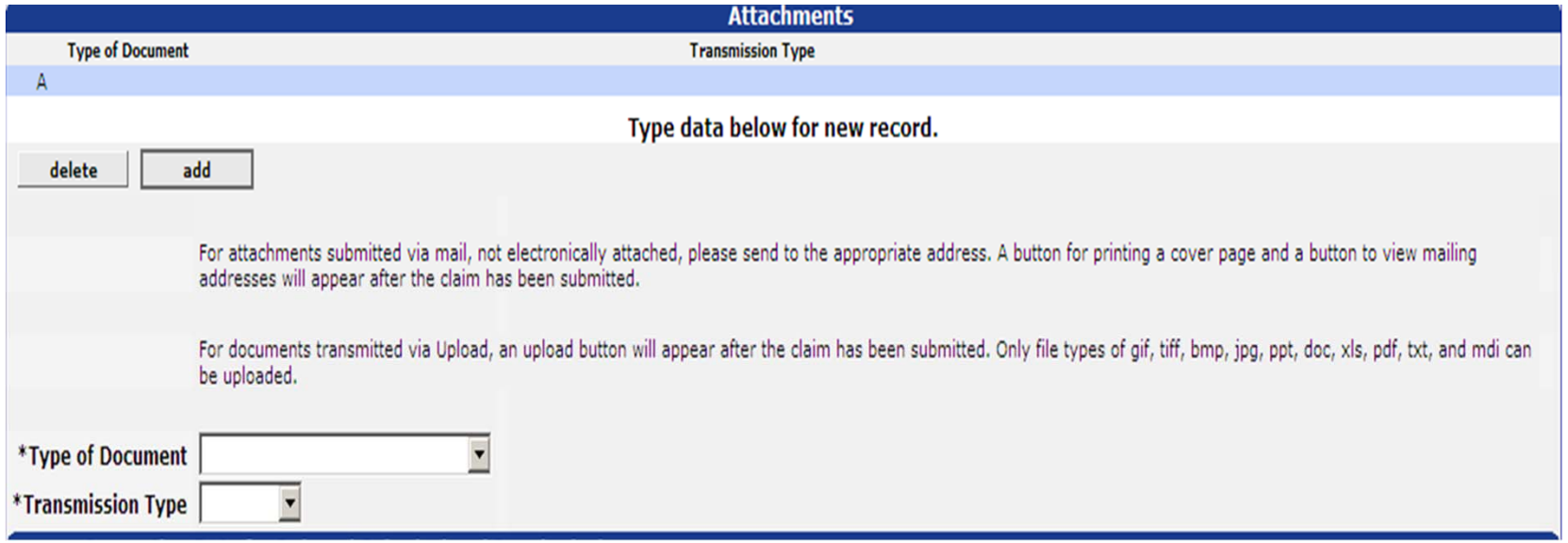


Medicare Denials

- 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

Uploading an Attachment

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



Uploading an Attachment

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

Paid claims can be:

Voided

Adjusted

Copied

Adjusting a Paid Claim

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

Adjusting a Paid Claim

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

Example

2218180234001 Originally paid $45.00

5818185127250 Now paid $50.00

Additional payment of $5.00

2018172234001 Originally paid $50.00

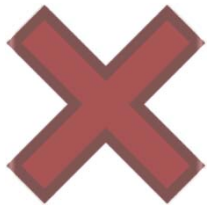
5018173127250 Now paid $45.00

Account receivable ($5.00)

Voiding a Paid Claim

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

Example



2218180234001
5818185127250

Originally paid $45.00
Account receivable ($45.00)

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

Copying a Paid Claim

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

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

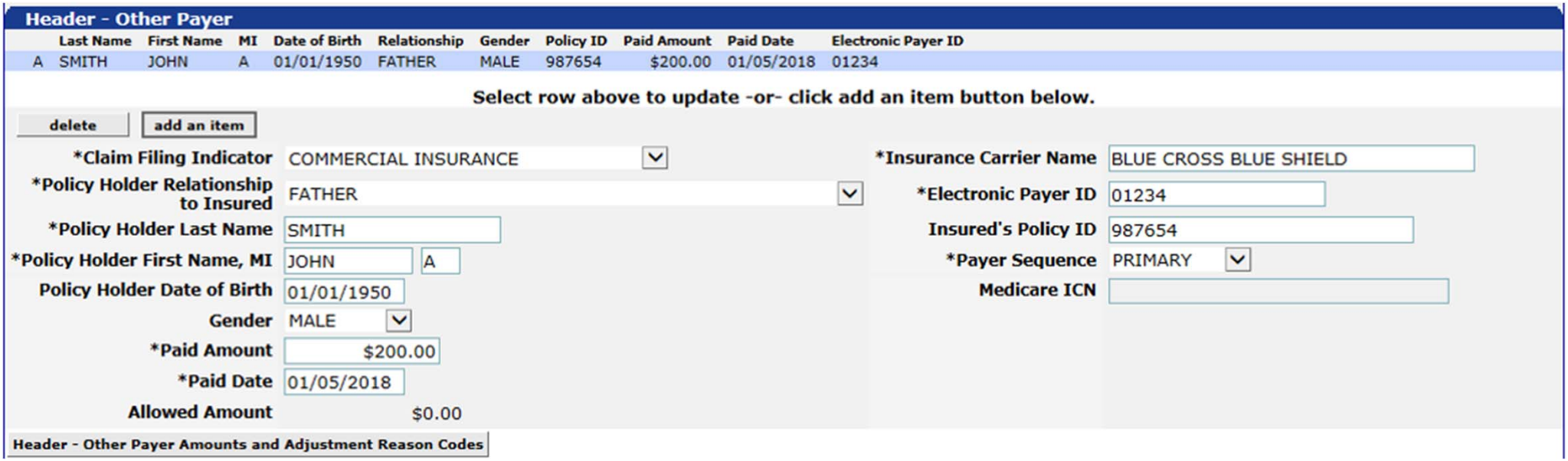
CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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

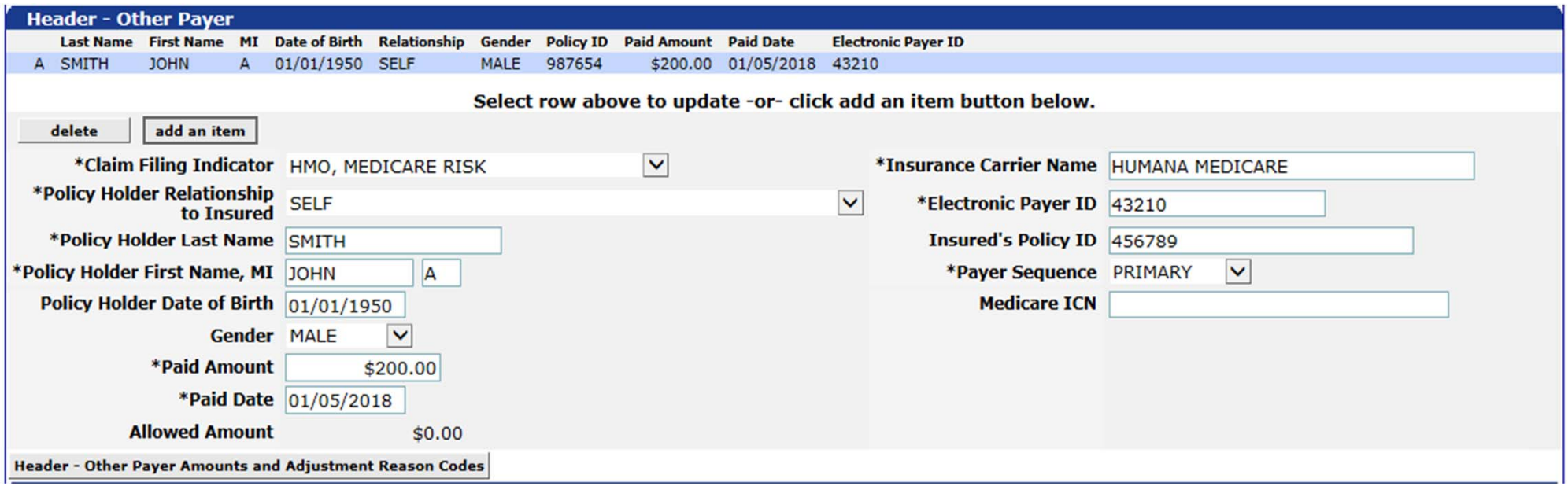
Third Party Liability (TPL) Claims

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

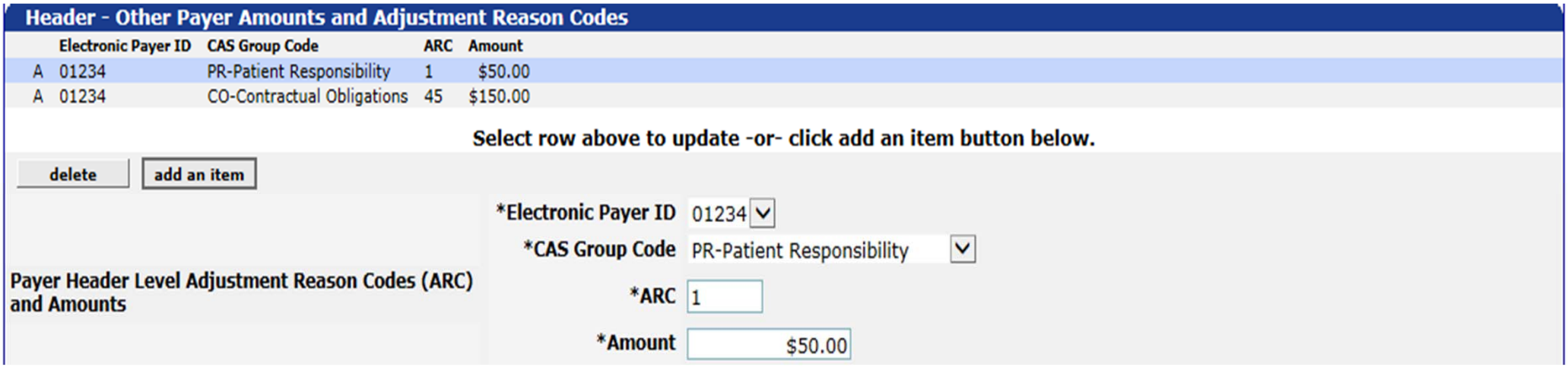
- A COB claim is considered to be adjudicated at the header/claim level if only one set of figures is reported for the entire claim

Detail level

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

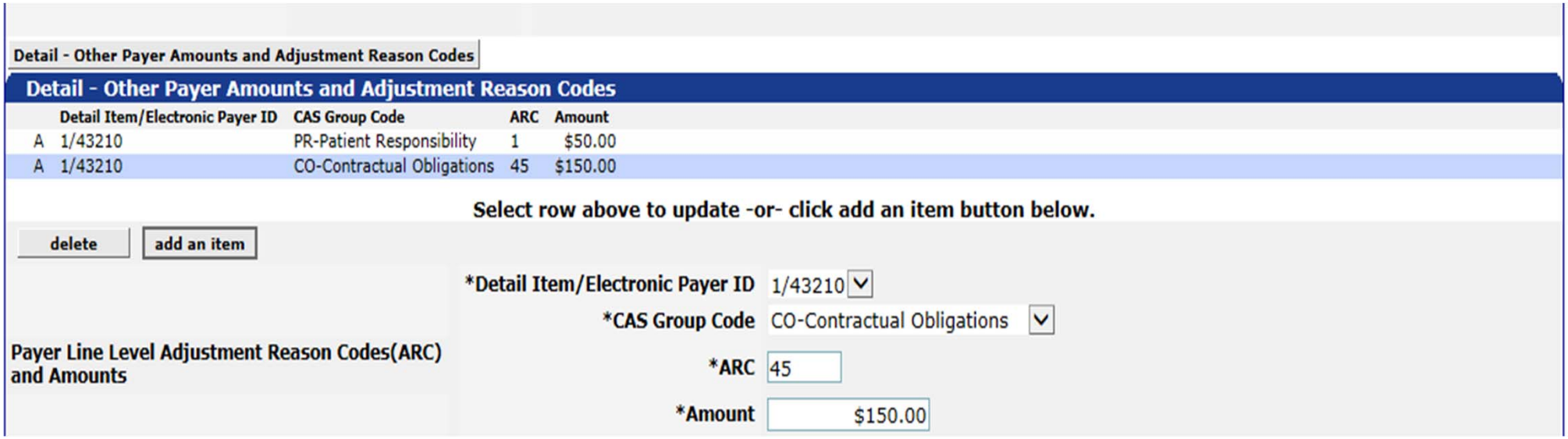
Third Party Liability (TPL) Claims

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

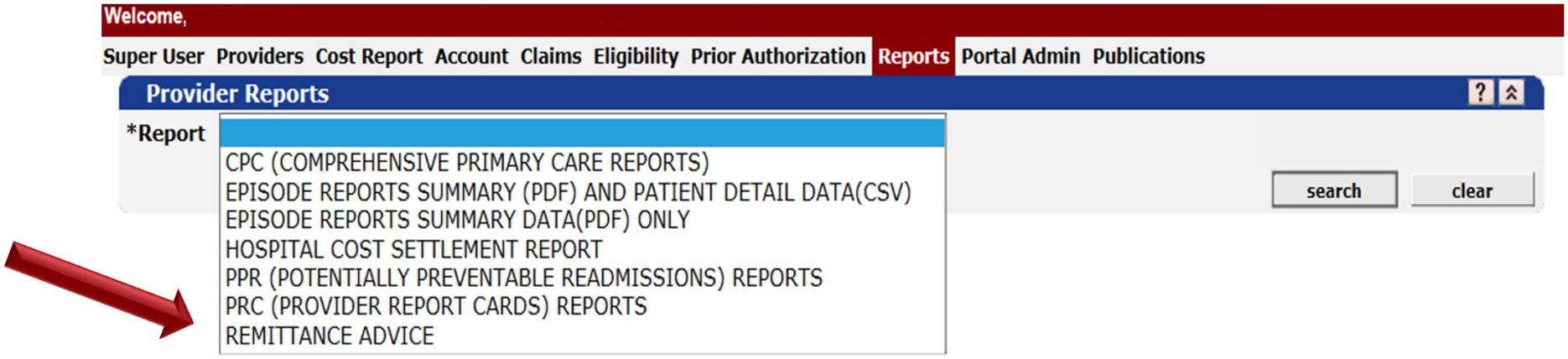
The X12 website provides adjustment reason codes (ARCs)

COMMON ARCs:

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

Remittance Advice (RA)

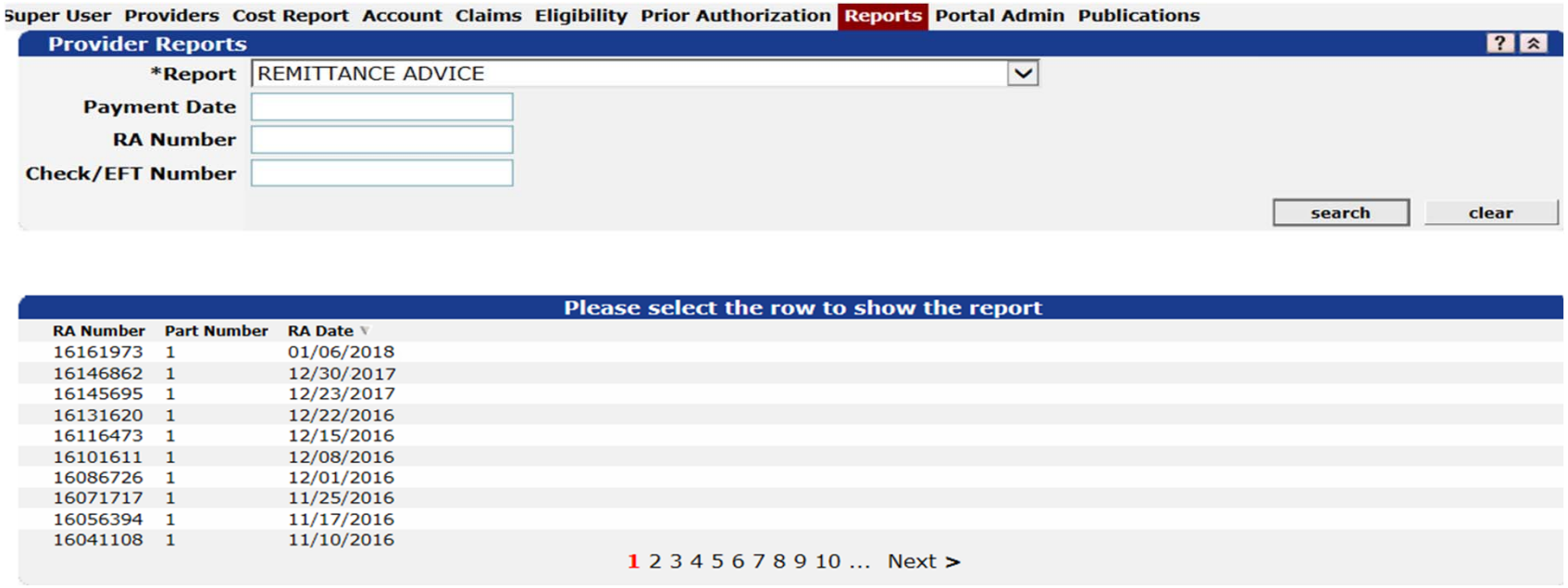
- All claims processed are available on the MITS Portal
- Weekly reports become available on Wednesdays



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 and Forms

Websites

- Ohio Department of Medicaid home page

https://Medicaid.ohio.gov

- MALs & MTLs

http://medicaid.ohio.gov/RESOURCES/Publications/ODM-Guidance#161542-medicaid-policy

- LAWriter

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

- MITS home page

https://portal.ohmits.com/Public/Providers/tabId/43/Default.aspx

Websites

- Provider Enrollment

http://medicaid.ohio.gov/Provider/EnrollmentandSupport/ProviderEnrollment

- Electronic Funds Transfer

http://www.ohiosharedservices.ohio.gov/

- Information for Trading Partners (EDI)

http://medicaid.ohio.gov/Provider/Billing/TradingPartners

- X12 Website (ARC Codes)

www.x12.org/codes/claim-adjustment-reason-codes/

FORMS

- ODM 06614 – Health Insurance Fact Request
- ODM 06653 – Medical Claim Review Request

http://medicaid.ohio.gov/RESOURCES/Publications/Medicaid-Forms


ANY
QUESTIONS
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