



**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

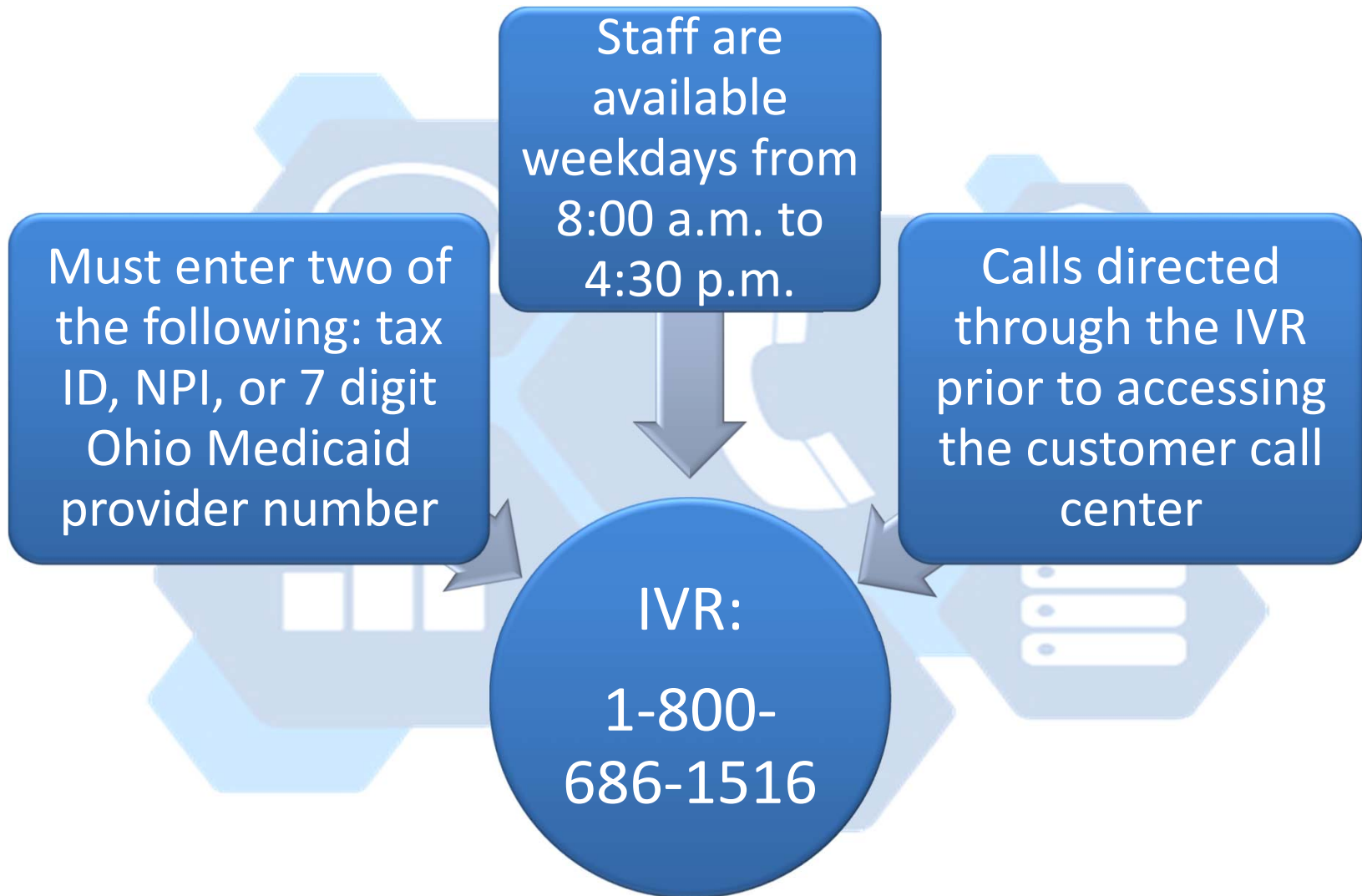
Sarah Bivens

Ava Cottrell

Ed Ortopan



Manager - Meagan Grove



☐ 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. <u>medicaid.ohio.gov</u> Consumer's Signature: _____	Fold	<table><tr><td>County</td><td>ALLEN</td><td rowspan="4">Ohio Medicaid</td></tr><tr><td>Case Number</td><td>5082482</td></tr><tr><td>Eligibility Begin Date</td><td>01/01/2018</td></tr><tr><td>Void After Date</td><td>01/31/2018</td></tr><tr><td colspan="2">Ohio Department of Medicaid medicaid.ohio.gov</td><td></td></tr><tr><td colspan="2">Consumer Hotline: 1-800-324-8680 [or TTY 1-800-292-3572]</td><td></td></tr></table>	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]		
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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



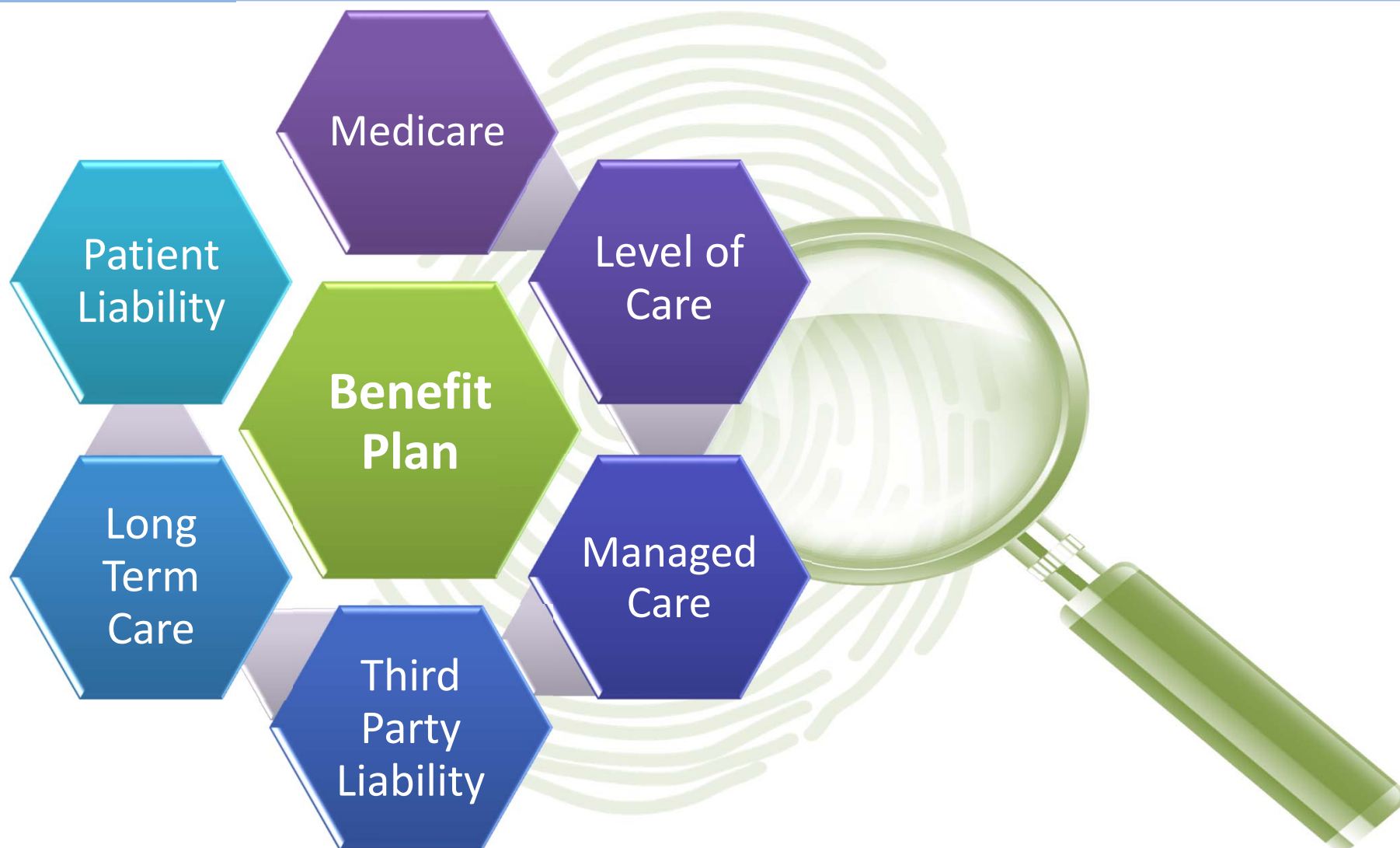
Full Medicaid eligibility on the MITS Portal will show **four** (or more) benefit spans:

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





Eligibility Verification Request

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



Department of Medicaid

Welcome

[Super User](#) [Providers](#) [Cost Report](#) [Account](#) [Claims](#) [Episode Claims](#) **Eligibility** [Prior Authorization](#) [Reports](#) [Portal Admin](#) [Publications](#)

eligibility search hospice enrollment

Eligibility Verification Request



Medicaid Billing Number		Birth Date	
SSN		DOS Date Format	MM/DD/YYYY v
Procedure Code		From DOS	01/12/2015
		To DOS	01/11/2018



*This information is only valid for 'from date' to end of the month searched.



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
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Associated Child(ren) Search

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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

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		W1166 35166		IND	INPATIENT COVERAGE	01/30/2018	01/31/2018	724775
AETNA US HEALTH	00250		W1166 35166		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			272012289D6
PART B	12/01/2017	12/08/2017			272012289D6

Service Limitation

*** No rows found ***

Enter a Procedure Code on the Eligibility 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	910194194 194



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



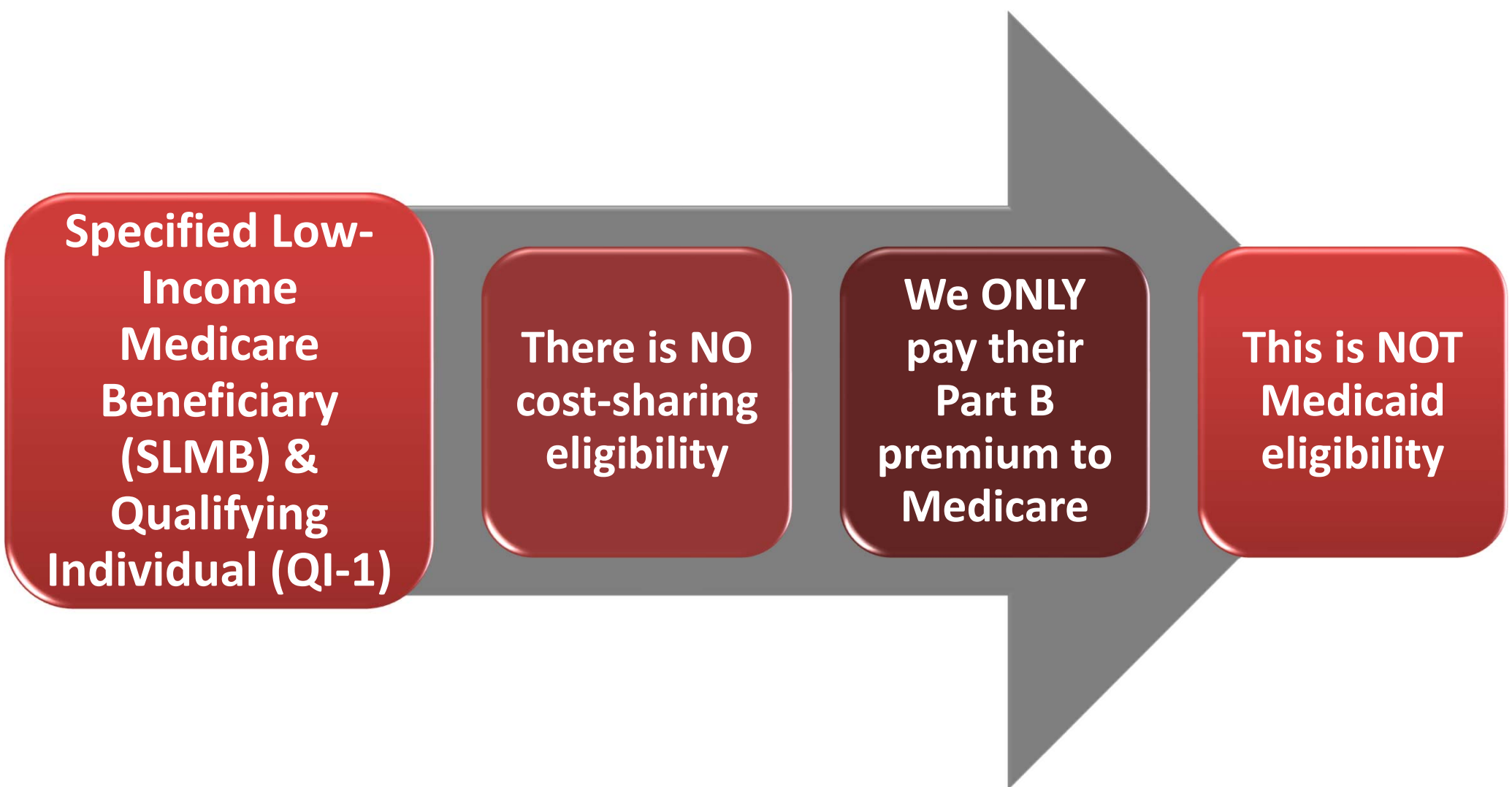
Can I Bill Them?

**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

Application received
2/3/18



Medicaid approved
2/12/18



NEW WAY

MCP begins 2/1/18

Day One MCP Assignments

```
graph TD; A[Day One MCP Assignments] --> B[MITS looks for previous MCP in last 90 days]; B --> C[Then MITS looks for anyone on a case with family members assigned to a MCP]; C --> D[Then individual is assigned by an assignment algorithm]; D --> E[The assigned plan can be changed as desired during first 3 months];
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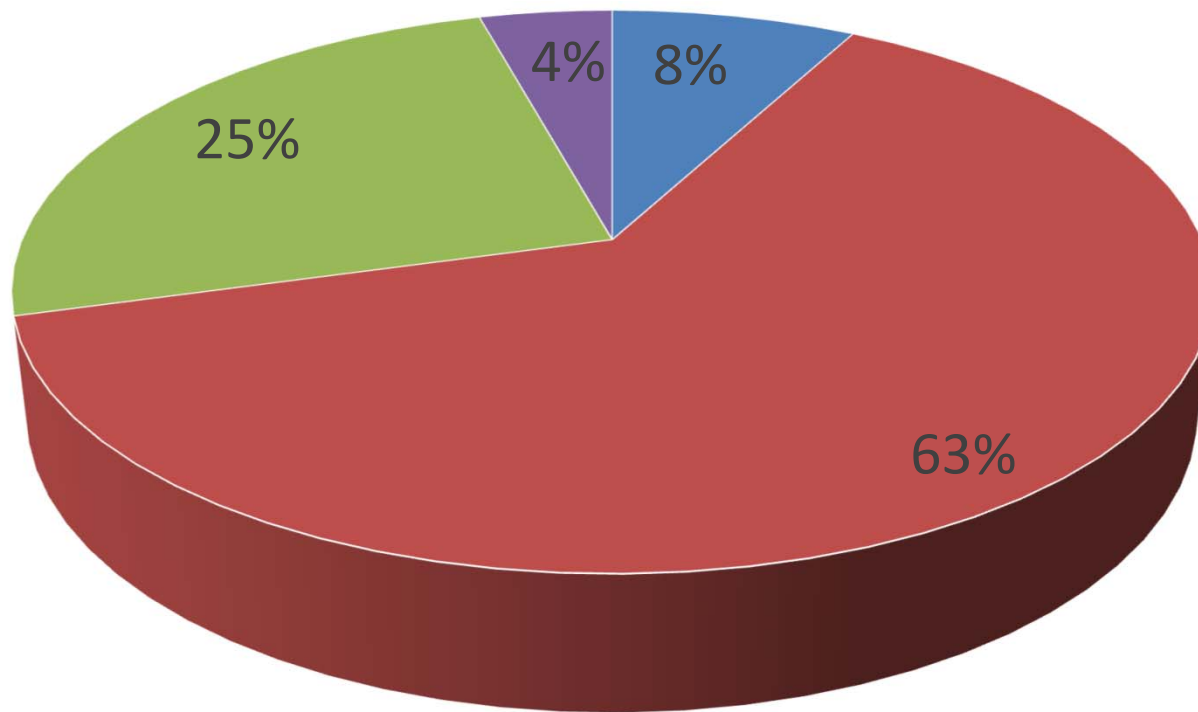
MITS looks for previous MCP in last 90 days

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

Then individual is assigned by an assignment algorithm

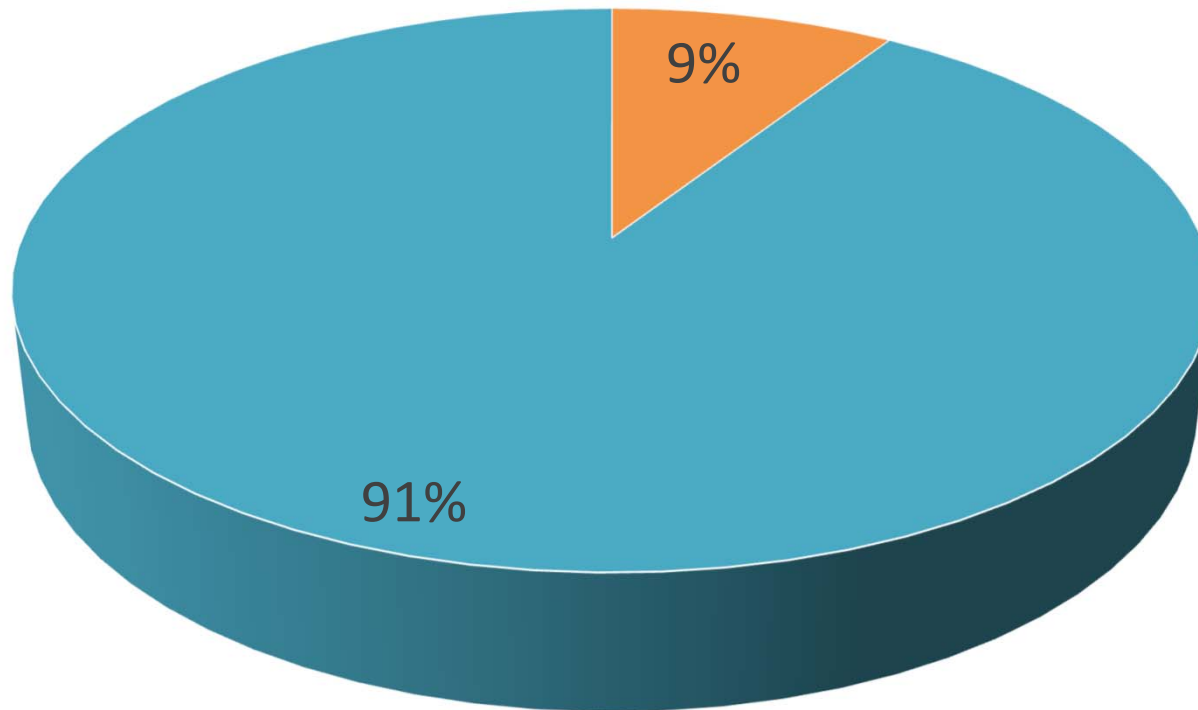
The assigned plan can be changed as desired during first 3 months

Managed Care Enrollment Groups - 2018



■ ABD ■ CFC ■ Group 8 ■ MyCare

FFS vs. Managed Care Enrollment - 2018



■ FFS ■ Managed Care

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



PARAMOUNT
ADVANTAGE

www.paramountadvantage.org

HEALTH PLAN (80840)
7952304120

ID NUMBER
A9999999901

MEMBER NAME
Jane Doe

PRIMARY CARE PROVIDER
John Smith
(419) 5551212

PROVIDERS CALL FOR PRIOR AUTH
800-891-2500/419-887-2520

GROUP NUMBER
ADV0010011

EFF. DATE
01/01/2015

MMIS NUMBER
000000000000

CVS/CAREMARK
RXGRP RX6407
RXBIN 004336
RXPCN ADV



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
CAREMOLINA®
HEALTHCAREUnitedHealthcare®

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



866-296-8731 <https://www.buckeyehealthplan.com>



800-488-0134 <https://www.CareSource.com/>



855-522-9076 <https://www.paramounthealthcare.com/>



855-322-4079 <https://www.molinahealthcare.com>



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

A magnifying glass with a blue handle and red frame, containing a black rectangular box with the word **EXTENDED** in white capital letters.

EXTENDED

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



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)

**Behavioral Health
Crisis:** 1-866-206-7361

Care Management: 1-855-475-3163

**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

Eligibility Verification: 1-800-488-0134

Pharmacy Help Desk: 1-800-488-0134

Claims Inquiry: 1-800-488-0134

Provider Questions: 1-800-488-0134

**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

MyCareOhio
Connecting Medicare + Medicaid



Member Name: <Cardholder Name>

Member ID #: <Cardholder ID#>

MMIS Number: <Medicaid Recipient ID#>

PCP Name: <PCP Name>

PCP Phone: <PCP Phone>

RxBin: 004336

RxPCN: ADV

RxGRP: RX3292

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](https://www.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

Aetna
Buckeye

Fulton
Lucas
Ottawa
Wood

Southwest

Aetna
Molina

Butler
Warren
Clinton
Hamilton
Clermont

**West
Central**

Buckeye
Molina

Clark
Green
Montgomery

Central

Aetna
Molina

Union
Delaware
Franklin
Pickaway
Madison

**East
Central**

Caresource
United

Summit
Portage
Stark
Wayne

**Northeast
Central**

Caresource
United

Trumbull
Mahoning
Columbiana

Northeast

Caresource
Buckeye
United

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



866-296-8731 <https://www.buckeyehealthplan.com/>



800-488-0134 <https://www.CareSource.com/MyCare>



AETNA BETTER HEALTH® OF OHIO

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



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



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

PROVIDER COMPLAINTS

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)



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

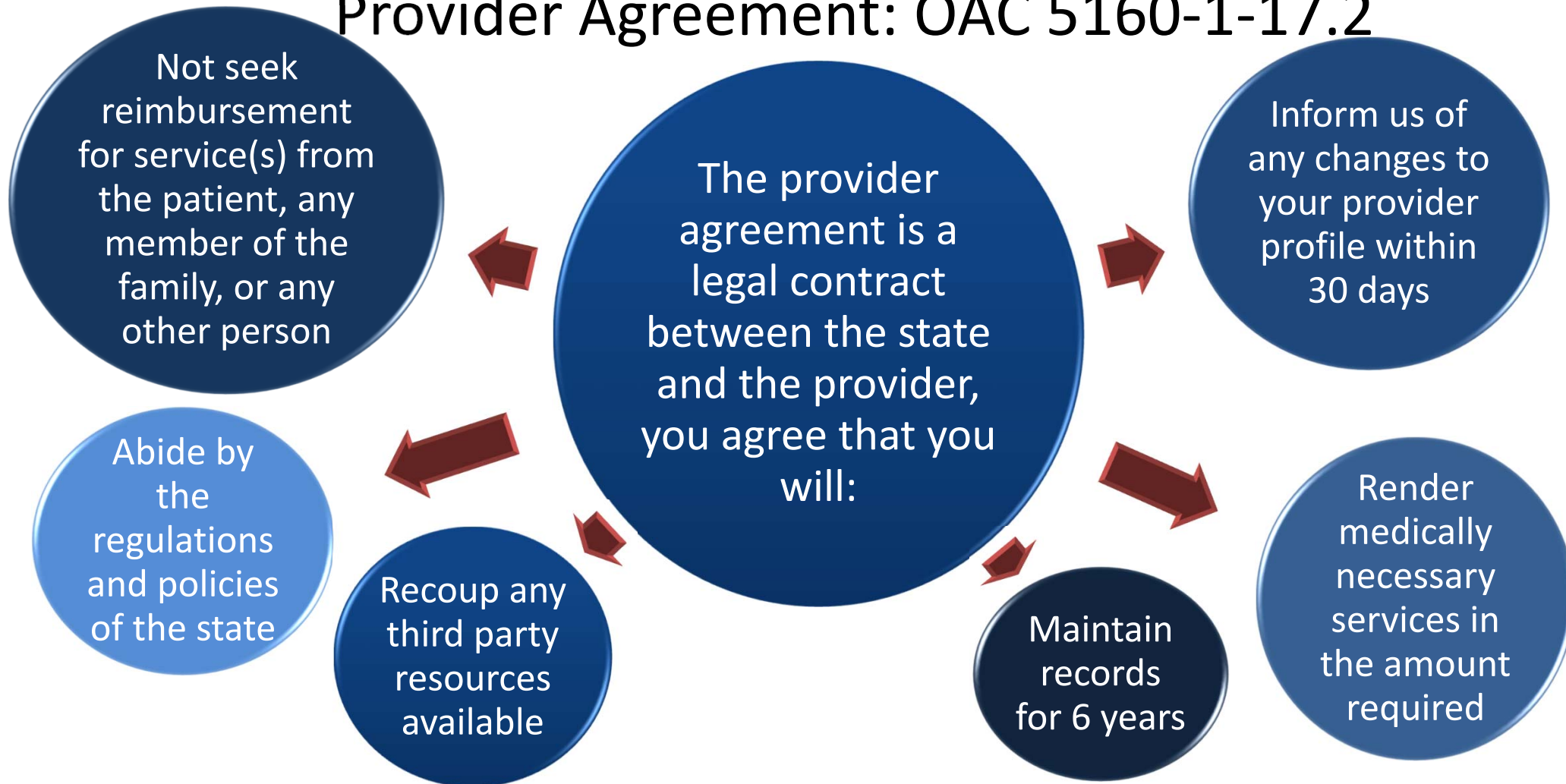


The 2018 fee is \$569.00 per application



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**

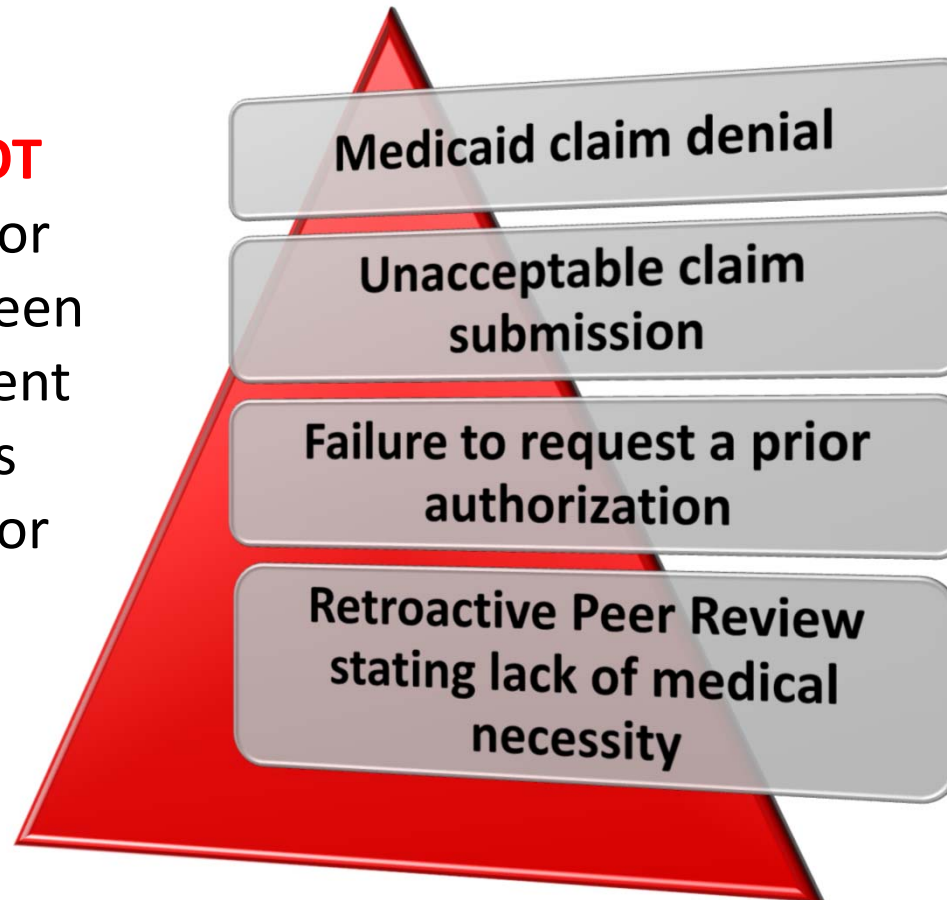
Coordination of Benefits: OAC 5160-1-08

- 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

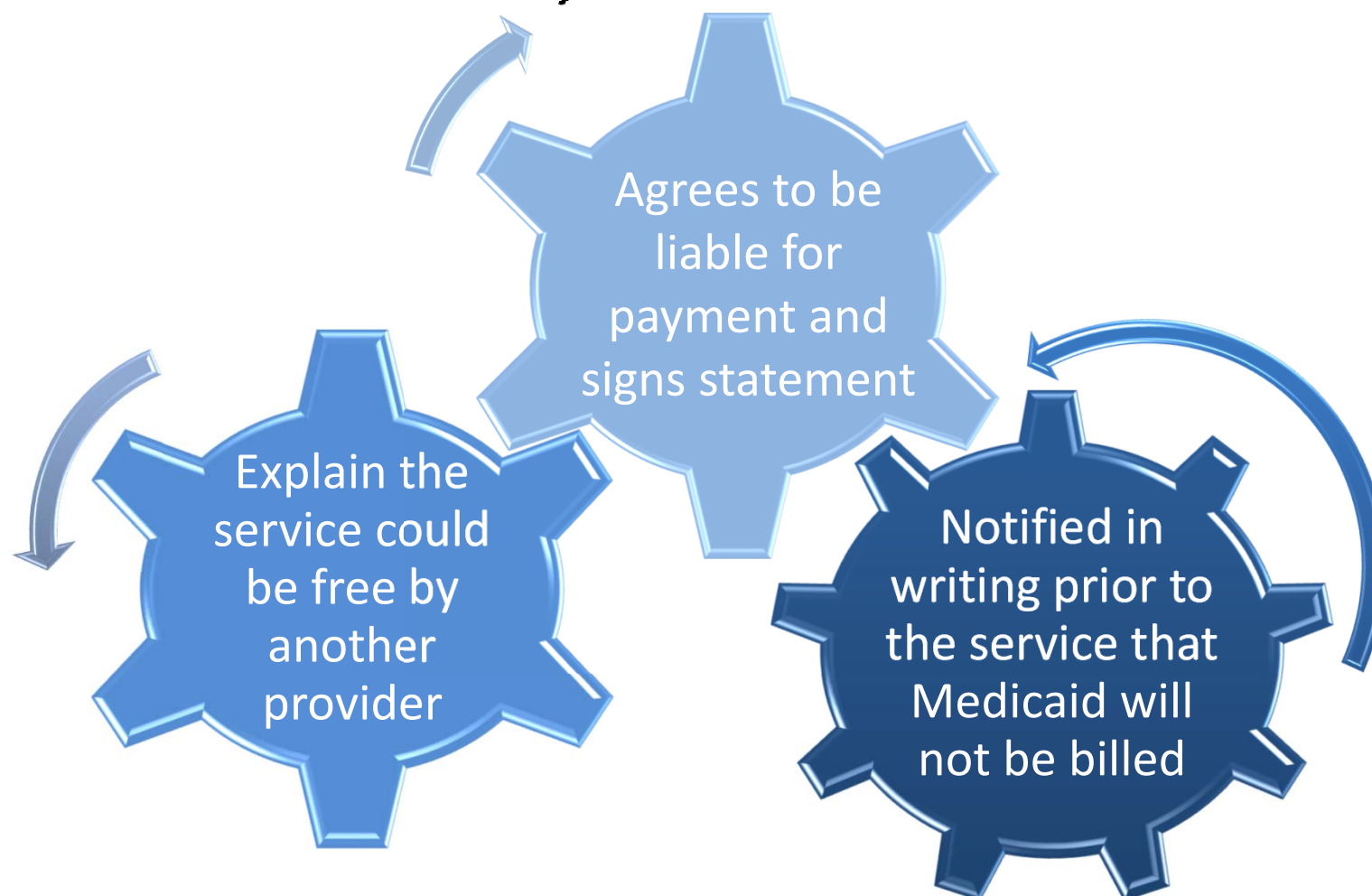


Medicaid Consumer Liability 5160-1-13.1

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

The screenshot displays the Ohio Department of Medicaid website. At the top, the header includes the "Ohio Department of Medicaid" logo, a text size adjustment tool (+A -A), a language selection dropdown, and a "Powered by Google Translate" notice with a "Translation Disclaimer" link. Below the header is a dark blue navigation bar with white links: HOME, MEDICAID 101, FOR OHIOANS, PROVIDERS, INITIATIVES, NEWS, RESOURCES, CAREERS, and CONTACT. The main content area features a large blue banner with the Ohio Department of Medicaid logo and the text "Learn more about the state's first executive-level Medicaid agency." To the right of the banner is a "Director's Welcome" section featuring a video player with a portrait of Barbara Sears, Director of the Ohio Department of Medicaid. Below the banner are two white boxes with red text: "Are you uninsured? Ohio Benefits" and "Are you unemployed? Ohio MEANS Jobs." At the bottom, there are three blue boxes with white icons and text: "Managed Care Plans 2016 Report Card" (star icon), "Information for Independent Providers" (magnifying glass icon), and "Payment Innovation Ohio's SIM Grant" (lightbulb icon). On the right side, there is a "Tweets by @OH_Medicaid" section showing a tweet from John Kasich about disposing of unused prescriptions. At the bottom right, there is a "Testimony & Presentations" section with a circular logo.

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

Ohio Department of Medicaid

Learn more about the state's first executive-level Medicaid agency.

Are you uninsured?
Ohio | Benefits

Are you unemployed?
Ohio MEANS Jobs.

Managed Care Plans
2016 Report Card

Information for Independent Providers

Payment Innovation
Ohio's SIM Grant

Director's Welcome

Tweets by @OH_Medicaid

Ohio Medicaid Retweeted
John Kasich @JohnKasich
Dispose of unused prescriptions TODAY.
Find a nearby collection site:
drugs.com/article/medica...
Getting rid of old Rx drugs can save

Embed View on Twitter

Testimony & Presentations



Provider News



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

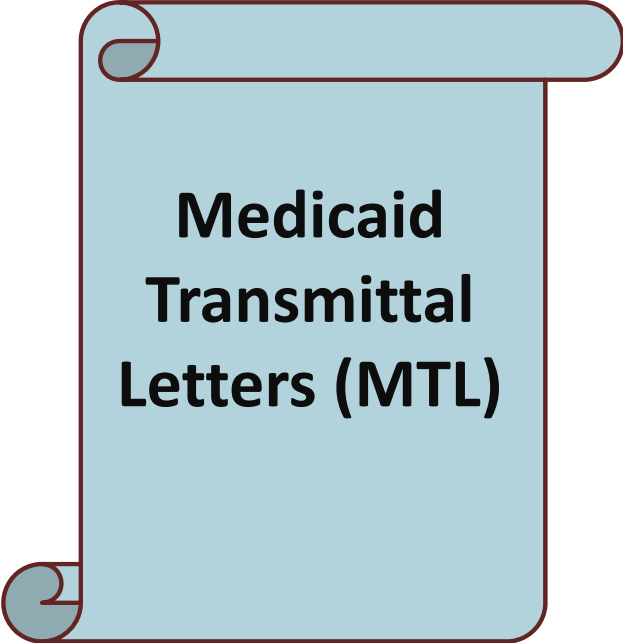
- [Benefit Coordination & Recovery](#)
- [Fee Schedules/Rates](#)
- [Medicaid Forms](#)
- [ODJFS Forms](#)
- [MITS EDMS Cover Page](#)
 - [Instructions](#)
- [Healthchek Screening Forms](#)
- [e-Manuals](#)
- [Helpful Links](#)
- [Get a National Provider Identifier \(NPI\)](#)
- [Transmittal Letter Notification](#)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



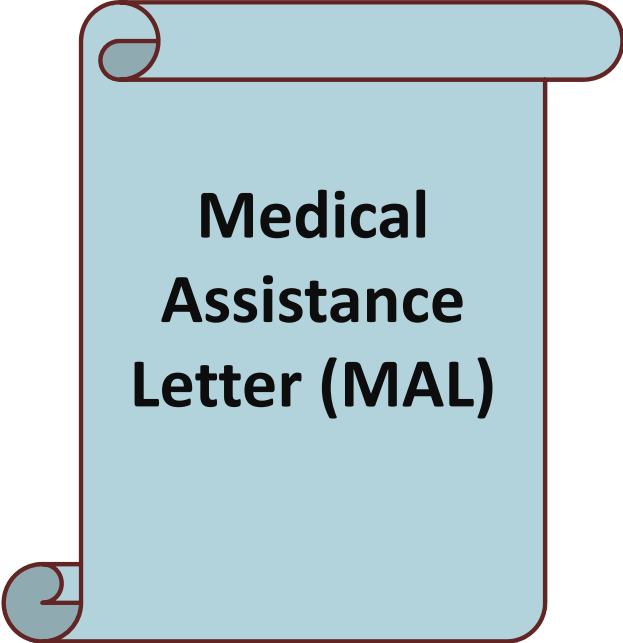
Access the
MITS Portal

POLICY

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

A light blue scroll icon with a dark red outline, featuring a rolled-up top edge and a small circular detail at the bottom left corner.

**Medicaid
Transmittal
Letters (MTL)**

A light blue scroll icon with a dark red outline, featuring a rolled-up top edge and a small circular detail at the bottom left corner.

**Medical
Assistance
Letter (MAL)**



Billing Resources



GO



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. Our network is critical in ensuring reliable and timely care for Ohioans. We will become a go-to resource for learning more about training, billing, rate-setting and other issues affecting the provider community.

Provider News

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Notice Regarding Pregnancy Risk Assessment and Notification

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)

Enrollment and Support >

Fee Schedule and Rates

Billing >

Training >

Managed Care

Provider Types

MITS >

Payment Innovation

DRA Attestation

Direct Deposit

Billing Instructions

HIPAA and EDI Information

Trading Partners

How to Refund Overpayments

Remittance Advice

Answers for MITS Problems

HIPAA 5010 Implementation

Behavioral Health Integration Project

ICD-10



Need technical
assistance?

Provider Hotline:
(800) 686-1516



Access the
MITS Portal

Related Content

- Benefit Coordination & Recovery
- Fee Schedules/Rates
- Medicaid Forms
- ODJFS Forms
- MITS EDMS Cover Page

How to Find Modifiers Recognized by Ohio Medicaid

➤ Scroll to the bottom of the page

HOME MEDICAID 101 ▼ FOR OHIOANS ▼ PROVIDERS ▼ INITIATIVES ▼ RESOURCES ▼ CAREERS CONTACT

- EDI Companion Guide for Professional Claims

INSTITUTIONAL OR FACILITY-BASED CLAIMS:

- Web Portal Billing Guide for Institutional Claims
- EDI Companion Guide for Institutional Claims
- ODM Hospital Billing Guidelines
 - For Dates of Discharge and Dates of Service On or Before 7/31/2017
 - For Dates of Discharge and Dates of Service On or After 8/1/2017

DENTAL CLAIMS:

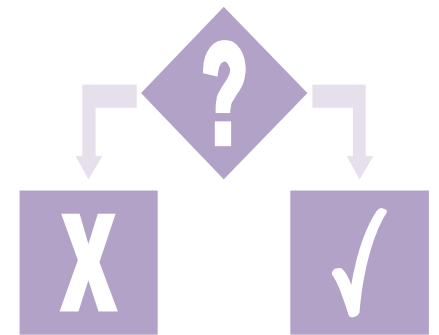
- Web Portal Billing Guide for Dental Claims
- EDI Companion Guide for Dental Claims

MODIFIERS:

- Modifiers recognized by ODM

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

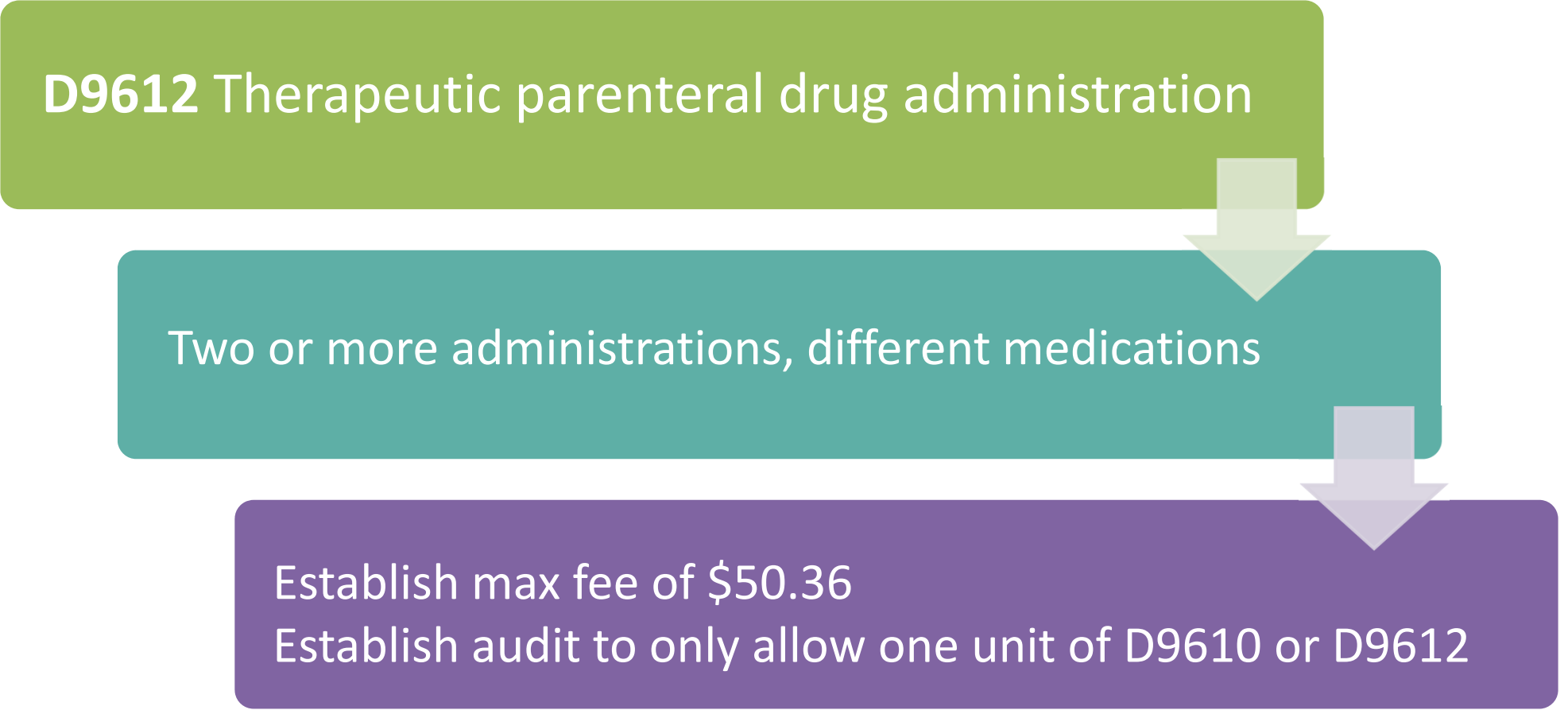
☐ **D7210** “Extraction”

- 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



```
graph TD; A[D9612 Therapeutic parenteral drug administration] --> B[Two or more administrations, different medications]; B --> C[Establish max fee of $50.36<br/>Establish audit to only allow one unit of D9610 or D9612];
```

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



MITTS 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



Ohio
Department of Medicaid

About ODM | Our Services | Resources | News & Events

Tuesday 06/16/2015 11:34:38 AM

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

enrollment enrollment tracking search long-term care account setup

Ohio Department of Medicaid

Provider Home

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

Login to secure site

■ [Click Here to Login](#)

Once directed to this page, click the link to “Login”

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

Ohio.gov | Medicaid Information Technology System

Sign In
Medicaid Information Technology System

To sign in, please enter your User ID and Password

User ID:

Password:

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

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

☐ Yes, I have read the agreement

[Login](#)

[Help FAQ](#)
[Help Reset Password?](#)
[Forgot Your User ID?](#)

MITTS Navigation

“COPY”, “PASTE”, and “PRINT” features all work in the MITTS 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**

MITTS 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.c
om](mailto:OhioMCD-EDI-Support@dxc.com)



MITTS 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



Welcome,

[Super User](#) [Providers](#) [Account](#) [Trading Partners](#) [Claims](#) [Episode Claims](#) [Eligibility](#) [Prior Authorization](#) [Reports](#) [Portal Admin](#) [Security](#) [Trade Files](#)

[Admin](#)

[search](#) [search detail](#) [dental](#) [institutional](#)

Claims

- [Search](#)
- [Search Detail](#)

[Search](#)
[Search Detail](#)
[Dental](#)
[Institutional](#)
[Professional](#)



Submission of a Dental Claim

Dental Claim: NPI -		?	
BILLING INFORMATION		SERVICE INFORMATION	
ICN		*Release of Information	NO
Claim Received Date		From Date	
Provider ID	NPI	To Date	
*Medicaid Billing Number		Emergency	
*Date of Birth		Accident Related To	
Last Name		Accident State	
First Name, MI		Accident Country	[Search]
*Patient Account #	0	Accident Date	
Referring Provider #		EPSDT	
Rendering ID		*Place of Service	[Search]
Patient Amount Paid	\$0.00	Prior Authorization #	
		TOTAL CHARGES	
		Total Charges	\$0.00
		Medicaid Allowed Amount	\$0.00
		TPL Paid Amount	\$0.00
		Total Medicaid Paid Amount	\$0.00
		Medicaid CoPay Amount	\$0.00
		Note Reference Code	
		Notes	
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 Panel

Detail

Item ▼	DOS	Procedure Code	Units	Tooth Number	Quadrant	Charges	Status	Medicaid Allowed Amount
A	1		0			\$0.00		\$0.00

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

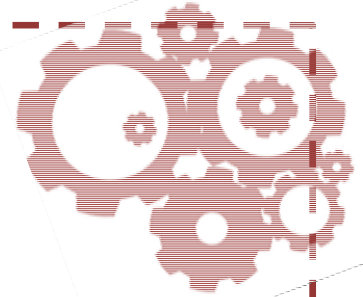
Item	1	*DOS	
*Procedure Code	[Search]	*Units	0
Tooth Number	[Search]	*Charges	\$0.00
Quadrant	[Search]	Medicaid Allowed Amount	\$0.00
Rendering Provider			
Status			

Detail - Other Payer

Surfaces (Detail Item 1)

*** No rows found ***

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



- 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

The following messages were generated:

From DOS is required.

Procedure is required.

A valid Place Of Service is required

A valid Procedure Code is required.

Units must be greater than 0.

Charges must be greater than \$0.00.

A valid Medicaid Billing Number is required

A valid Medicaid Billing Number and Date of Birth combination is required.



Claim Example

Dental Claim: 123456789 NPI - DENTAL INC		?	⬆
BILLING INFORMATION		SERVICE INFORMATION	
ICN	2218111111111	Release of Information	NO
Claim Received Date	05/11/2018	From Date	05/11/2018
Provider ID	123456789 NPI	To Date	05/11/2018
Medicaid Billing Number	98765432111	Emergency	
Date of Birth	02/15/1953	Accident Related To	
Last Name	SMITH	Accident State	
First Name, MI	JOHN	Accident Country	
Patient Account #		Accident Date	
Referring Provider #		EPSDT	
Rendering ID	456123789	Place of Service	11
Patient Amount Paid	\$0.00	Prior Authorization #	
TOTAL CHARGES			
Total Charges	\$750.00		
Medicaid Allowed Amount	\$0.00		
TPL Paid Amount	\$0.00		
Total Medicaid Paid Amount	\$285.45		
Medicaid CoPay Amount	\$3.00		
Note Reference Code			
Notes			



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



Timely Filing



Submitting a Claim Over 365 Days Old



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

Supporting Data for Delayed Submission / Resubmission

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

Previously Denied ICN or TCN

Reason

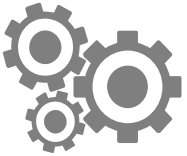




Special Billing Instructions – Eligibility Delay



- 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”

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



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

Note Reference Code	ADD - Additional Information v
Notes	DECISION 20171225 ^ v



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

Attachments	
Type of Document	Transmission Type
A	
Type data below for new record.	
delete add	
For attachments submitted via mail, not electronically attached, please send to the appropriate address. A button for printing a cover page and a button to view mailing addresses will appear after the claim has been submitted. For documents transmitted via Upload, an upload button will appear after the claim has been submitted. Only file types of gif, tiff, bmp, jpg, ppt, doc, xls, pdf, txt, and mdi can be uploaded.	
*Type of Document	
*Transmission Type	

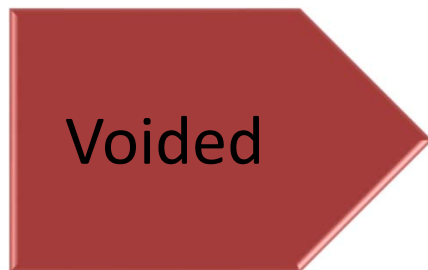


Uploading an Attachment



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

Paid claims can be:





Adjusting a Paid Claim



cancel

adjust

void

copy claim

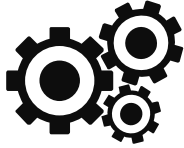
- Open the claim requiring an adjustment
- Change and save the necessary information
- Click the “adjust” button



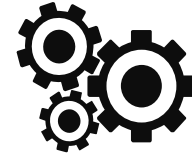
Adjusting a Paid Claim



- 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

5818185127250

Originally paid \$45.00

Now paid \$50.00

Additional payment of \$5.00



2018172234001

5018173127250

Originally paid \$50.00

Now paid \$45.00

Account receivable (\$5.00)



Voiding a Paid Claim



cancel

adjust

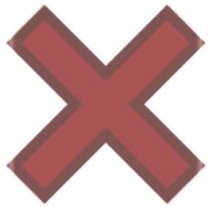
void

copy claim

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



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

**cancel****adjust****void****copy claim**



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



Third Party Liability (TPL) Claims



Other payer information can be reported at the claim level (header) or at the line level (detail), depending on the other payer's claim adjudication

HIPAA compliant adjustment reason codes and amounts are required to be on the claim

MITS will automatically calculate the allowed amount



Third Party Liability (TPL) Claims



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

Header - Other Payer										
Last Name	First Name	MI	Date of Birth	Relationship	Gender	Policy ID	Paid Amount	Paid Date	Electronic Payer ID	
A	SMITH	JOHN	A	01/01/1950	FATHER	MALE	987654	\$200.00	01/05/2018	01234

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

delete

add an item

*Claim Filing Indicator

COMMERCIAL INSURANCE

▼

*Policy Holder Relationship to Insured

FATHER

▼

*Policy Holder Last Name

SMITH

*Policy Holder First Name, MI

JOHN

A

Policy Holder Date of Birth

01/01/1950

Gender

MALE

▼

*Paid Amount

\$200.00

*Paid Date

01/05/2018

Allowed Amount

\$0.00

*Insurance Carrier Name

BLUE CROSS BLUE SHIELD

*Electronic Payer ID

01234

Insured's Policy ID

987654

*Payer Sequence

PRIMARY

▼

Medicare ICN

Header - Other Payer Amounts and Adjustment Reason Codes



Third Party Liability (TPL) Claims



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

Header - Other Payer										
Last Name	First Name	MI	Date of Birth	Relationship	Gender	Policy ID	Paid Amount	Paid Date	Electronic Payer ID	
A	SMITH	JOHN	A	01/01/1950	SELF	MALE	987654	\$200.00	01/05/2018	43210

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

delete

add an item

*Claim Filing Indicator

HMO, MEDICARE RISK

▼

*Policy Holder Relationship to Insured

SELF

▼

*Policy Holder Last Name

SMITH

*Policy Holder First Name, MI

JOHN

A

Policy Holder Date of Birth

01/01/1950

Gender

MALE

▼

*Paid Amount

\$200.00

*Paid Date

01/05/2018

Allowed Amount

\$0.00

*Insurance Carrier Name

HUMANA MEDICARE

*Electronic Payer ID

43210

Insured's Policy ID

456789

*Payer Sequence

PRIMARY

▼

Medicare ICN

Header - Other Payer Amounts and Adjustment Reason Codes

Header vs Detail

Header level

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

Detail level

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



Third Party Liability (TPL) Claims



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

Header - Other Payer Amounts and Adjustment Reason Codes

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

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

delete

add an item

Payer Header Level Adjustment Reason Codes (ARC) and Amounts

*Electronic Payer ID 01234 ▼

*CAS Group Code PR-Patient Responsibility ▼

*ARC 1

*Amount \$50.00



Third Party Liability (TPL) Claims



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

Detail - Other Payer Amounts and Adjustment Reason Codes

Detail - Other Payer Amounts and Adjustment Reason Codes

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

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

delete

add an item

*Detail Item/Electronic Payer ID 1/43210 ▼

*CAS Group Code CO-Contractual Obligations ▼

*ARC 45

*Amount \$150.00

Payer Line Level Adjustment Reason Codes(ARC)
and Amounts

ARC Codes

The X12 website provides adjustment reason codes (ARCs)

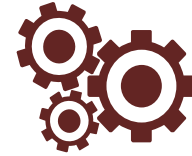
**COMMON
ARCs:**



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

Welcome,

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

Provider Reports ? ^

*Report

- CPC (COMPREHENSIVE PRIMARY CARE REPORTS)
- EPISODE REPORTS SUMMARY (PDF) AND PATIENT DETAIL DATA(CSV)
- EPISODE REPORTS SUMMARY DATA(PDF) ONLY
- HOSPITAL COST SETTLEMENT REPORT
- PPR (POTENTIALLY PREVENTABLE READMISSIONS) REPORTS
- PRC (PROVIDER REPORT CARDS) REPORTS
- REMITTANCE ADVICE

search clear





Remittance Advice (RA)



- Select “Remittance Advice” and click “Search”
- To see all remits to date, do not enter any data, and click search again

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

Provider Reports ? ⌵

*Report REMITTANCE ADVICE ⌵

Payment Date

RA Number

Check/EFT Number

search clear

Please select the row to show the report		
RA Number	Part Number	RA Date ▼
16161973	1	01/06/2018
16146862	1	12/30/2017
16145695	1	12/23/2017
16131620	1	12/22/2016
16116473	1	12/15/2016
16101611	1	12/08/2016
16086726	1	12/01/2016
16071717	1	11/25/2016
16056394	1	11/17/2016
16041108	1	11/10/2016
1 2 3 4 5 6 7 8 9 10 ... Next >		



Remittance Advice (RA)



Paid, denied, and adjusted claims



Financial transactions

Expenditures - Non-claim payments

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



Summary

Current, month, and year to date information



Remittance Advice (RA)



Information pages

Banner messages to the provider community



EOB code explanations

Provides a comparison of codes to the description



TPL claim denial information

Provides other insurance information for any TPL claim denials

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
?