Ohio | Department of Medicaid

Basic Billing for Federally Qualified Health Centers (FQHCs) & Rural Health Clinics (RHCs)

Provider Relations

December 2021

Programs & Cards

Managed Care & MyCare Ohio

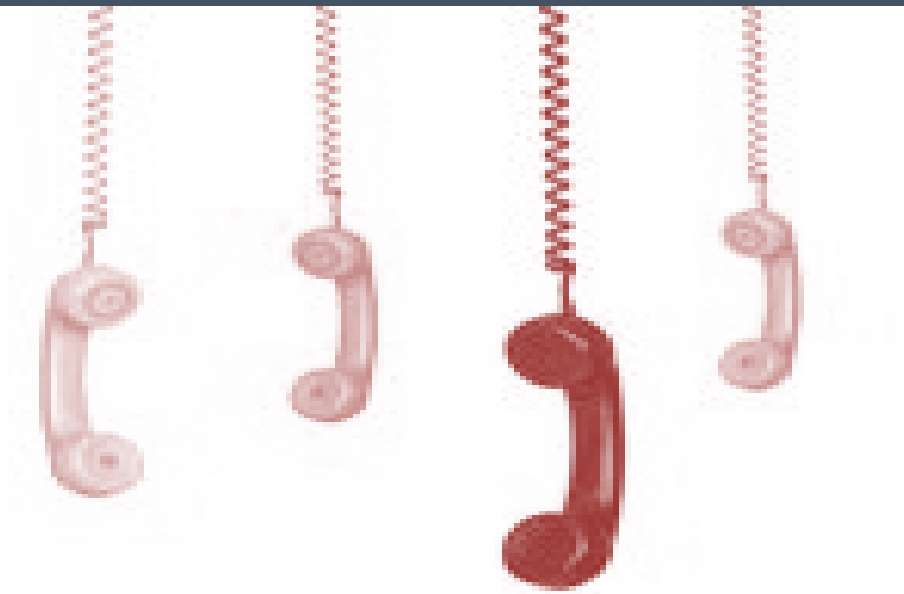
Provider Responsibilities

Policy

MITS & Claim Submissions

Websites & Forms

Helpful phone numbers



OSHIIP (Ohio Senior Health Information Program)

1-800-686-1578

Coordination of Benefits Section

614-752-5768

614-728-0757 (fax)

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

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

1-800-686-1516

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

Provider Assistance

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

Programs & Cards

Medicaid Medical Necessity: OAC 5160-1-01

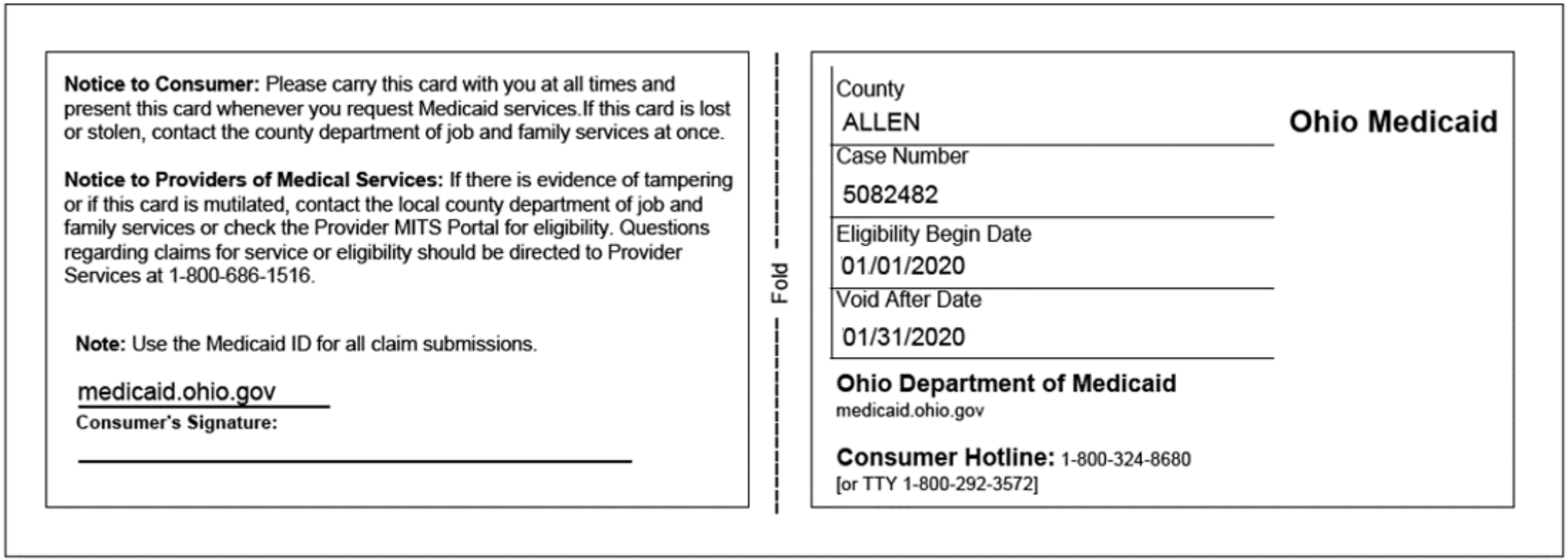
Is the fundamental concept underlying the Medicaid Program

All services must meet accepted standards of medical practice

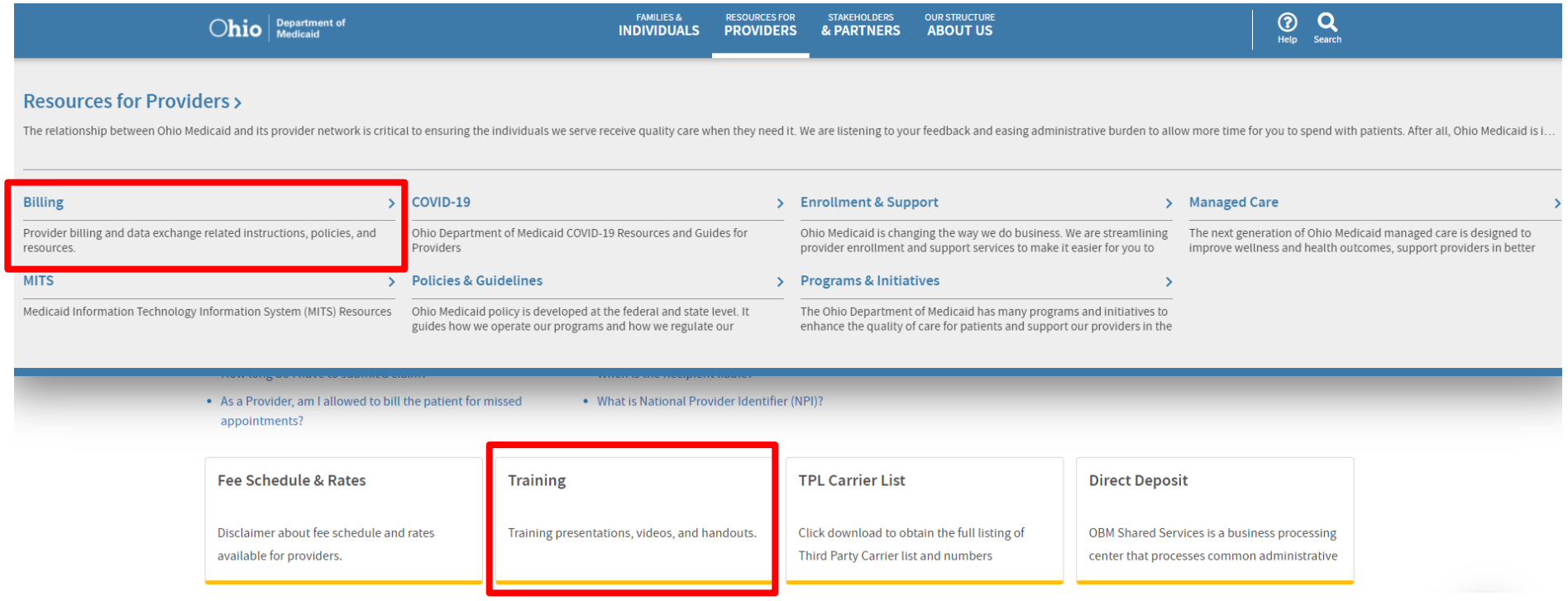
Ohio Medicaid

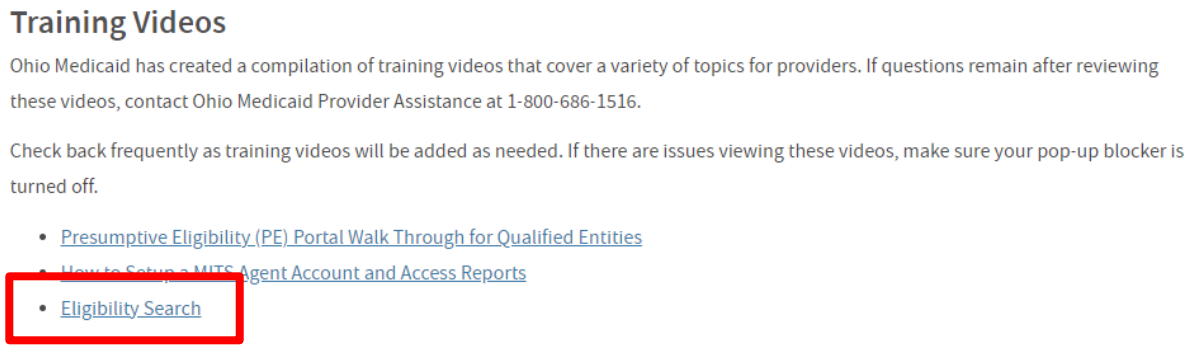
This is the traditional fee-for-service Medicaid card

- Issued annually as of ***October 1, 2018***



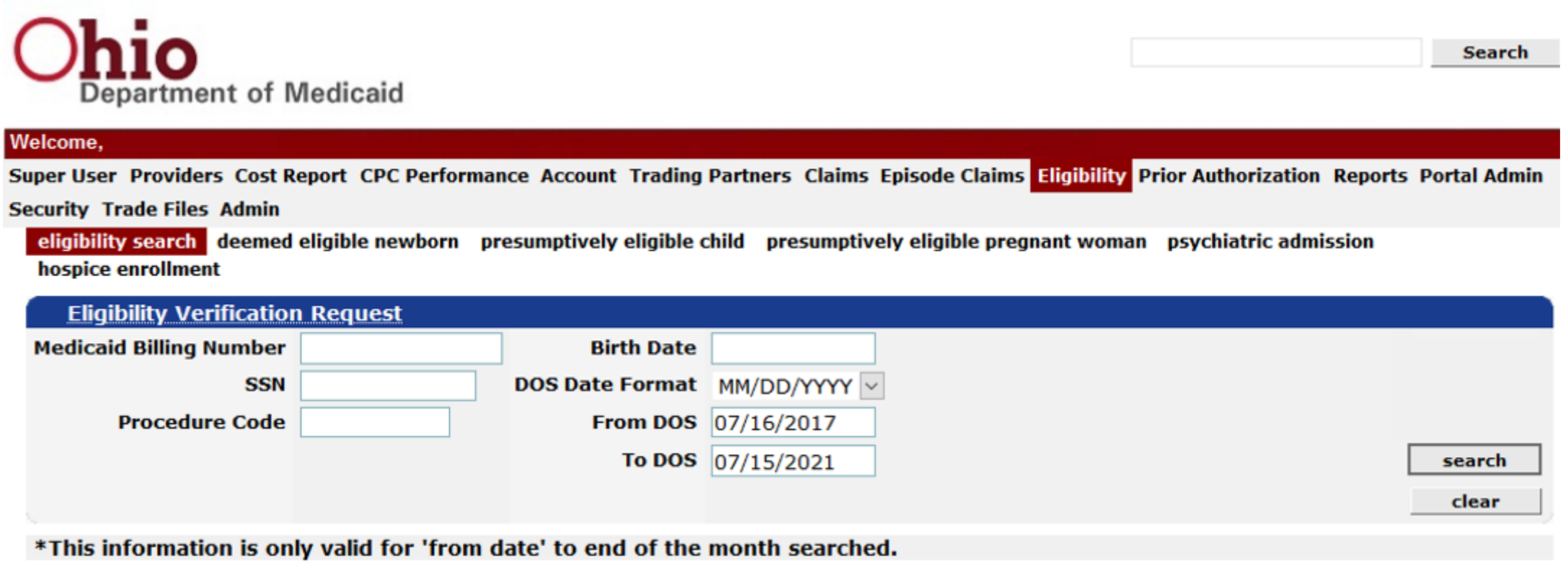
Eligibility Verification Video





Eligibility Verification Request

You can search up to 4 years back



TIP: Always check eligibility prior to billing

Eligibility Verification Request

Take note of the effective and end dates of coverage, the results will depend on the dates used in your search

Recipient Information

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

Associated Child(ren) Search

Benefit / Assignment Plan

Benefit / Assignment Plan	Effective Date	End Date	Provider Name	Dental Co-Pay Amount	Vision Co-Pay Amount
Medicaid Schools	07/01/2017	07/31/2021		$0.00	$0.00
MRDD Targeted Case Mgmt	07/01/2017	07/31/2021		$0.00	$0.00
Alcohol and Drug Addiction Services	07/01/2017	07/31/2021		$0.00	$0.00
Ohio Mental health	07/01/2017	07/31/2021		$0.00	$0.00
Medicaid	07/01/2017	07/31/2021		$0.00	$0.00

Associated Child(ren)

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

Eligibility Verification Request

You can check to see if the individual has Managed Care and/or Medicare coverage

TPL

Carrier Name	Carrier Number	NAIC	Policy Number	Policy Holder	Coverage Type	Coverage	Effective Date	End Date	Group Number
ANTHEM BLUE CROSS/BLUE SHIELD	92405		UTTAN4977127		IND	PHYSICIAN/OUTPATIENT COVERAGE	10/24/2016	10/31/2020	303326401
ANTHEM BLUE CROSS/BLUE SHIELD	92405		UTTAN4977127		IND	INPATIENT COVERAGE	10/24/2016	10/31/2020	303326401

Managed Care

Plan Name	Plan Description	Effective Date	End Date	Managed Care Benefits
CARESOURCE	HMO, CFC	10/24/2016	02/28/2018	
MOLINA HEALTHCARE OF OHIO INC	HMO, CFC	12/01/2018	12/31/2018	
MOLINA HEALTHCARE OF OHIO INC	HMO, CFC	01/01/2019	07/31/2021	

Lock-In

*** No rows found ***

Medicare

Coverage	Effective Date	End Date	Plan Name	Plan ID	Medicare ID
PART A	10/24/2016	07/31/2021			7XH1UW7DK33
PART B	10/24/2016	07/31/2021			7XH1UW7DK33
PART D	08/01/2017	10/31/2019	HUMANA WALMART-PREFERRED RX PLAN (PDP)	137	7XH1UW7DK33
PART D	10/24/2016	07/31/2021	HUMANA WALMART-PREFERRED RX PLAN (PDP)	105	7XH1UW7DK33

Service Limitation

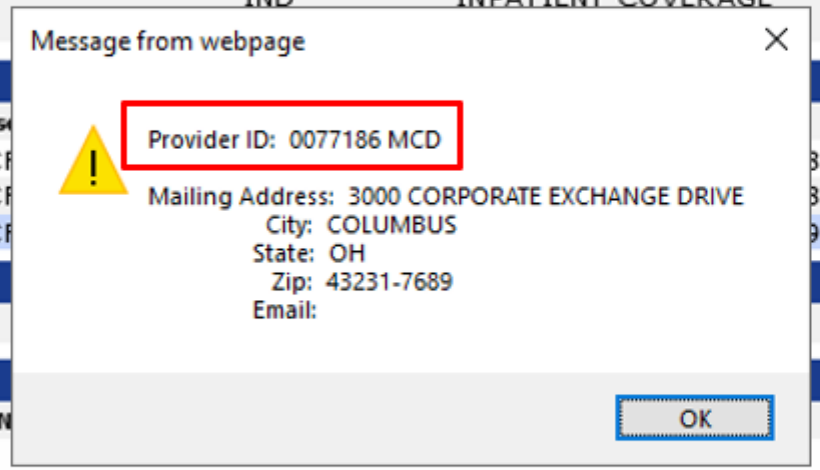
*** No rows found ***

Eligibility Verification Request

By clicking on the managed care plan description, a pop-up box will display their provider ID

TPL

Carrier Name	Carrier Number	NAIC	Policy Number	Policy Holder	Coverage Type	Coverage	Effective Date	End Date	Group Number
ANTHEM BLUE CROSS/BLUE SHIELD	92405		UTTAN4977127		IND	PHYSICIAN/OUTPATIENT COVERAGE	10/24/2016	10/31/2019	303326401
ANTHEM BLUE CROSS/BLUE SHIELD	92405		UTTAN4977127		IND	INPATIENT COVERAGE	10/24/2016	10/31/2019	303326401



Managed Care

Plan Name	Plan Des	Managed Care Benefits
CARESOURCE	HMO, CF	
MOLINA HEALTHCARE OF OHIO INC	HMO, CF	
MOLINA HEALTHCARE OF OHIO INC	HMO, CF	

Lock-In

Medicare

Coverage	Effective Date	End Date	Plan N		Medicare ID
PART A	10/24/2016	10/31/2019			7XH1UW7DK33
PART B	10/24/2016	10/31/2019			7XH1UW7DK33
PART D	08/01/2017	10/31/2019	HUMANA WALMART-PREFERRED RX PLAN (PDP)	137	7XH1UW7DK33
PART D	10/24/2016	07/31/2017	HUMANA WALMART-PREFERRED RX PLAN (PDP)	105	7XH1UW7DK33

Service Limitation

*** No rows found ***

Inpatient Hospital Services Plan (IHSP)

If you see the IHSP benefit plan only services from an inpatient hospital stay will be covered

Recipient Information

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

Benefit / Assignment Plan

Benefit / Assignment Plan	Effective Date	End Date	Provider Name	Dental Co-Pay Amount	Vision Co-Pay Amount
Inpatient Hospital Services Plan	07/01/2021	07/31/2021		$0.00	$0.00

Presumptive Eligibility

Covers children up to age 19 and pregnant women

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

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

Presumptive Eligibility

Ohio's statewide Presumptive Eligibility (PE) initiative provides uninsured residents with the opportunity to receive immediate health care services through Medicaid if they are presumed to be eligible

Hospitals and FQHCs are eligible to participate in Ohio's presumptive eligibility initiative

To become a Qualified Entity complete the steps described here:

https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/billing/presumptive-eligibility-training/presumptive-eligibility-training

*See later slides in the policy section for additional QE information

Presumptive Eligibility

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

Presumptive Eligibility

MISSISSIPPI RIVERS
21 S FRONT ST
COLUMBUS, OH 43215

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

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

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

APPROVED:

Name (First, M.I., Last Name)	Date of Birth	PE Type	Date Coverage Begins	Medicaid ID
MISSISSIPPI RIVERS	01/01/1987	PE PREGNANT	05/09/2019	910001331813

Presumptive Eligibility

Members should share this letter with their pharmacy if filling a prescription on the day it is issued.

NOTE TO MEDICAID PROVIDERS:

Non-pharmacy Medicaid Providers- You must verify eligibility in the MITS system.

Pharmacy Medicaid Providers- This letter is proof of Medicaid eligibility on the date this form is issued. After date of issuance, you must verify eligibility in the Pharmacy system.

Call this number if you are having difficulty processing a pharmacy claim: 1-877-518-1545 (24 hours a day, 7 days a week). Pharmacy staff should use the following billing information: BIN: 015863 PCN: OHPOP Group: not needed.

Qualified Entity Name: REGENCY HOSP OF COLUMBUS LLC
PE Determination Site: PO BOX 644219 PITTSBURGH, PA 15264
Qualified Entity Staff Name: DYAGENT DYAGENT
Contact Number: (222)333-1234

Signature of Qualified Entity Designee : _____ Date: _____

Presumptive Eligibility

Other members will receive this Presumptive Eligibility letter:

CDJFS Presumptive Eligibility

John Doe
123 Main St.
Anytown, OH 43210

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

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

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

APPROVED:

Name (First, M.I., Last Name)	Date of Birth	PE Type	Date Coverage Begins	Medicaid ID
John Doe	11/19/1959	PE Adult	06/25/2019	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/cntydir.stm**	
Date of Birth		**Number Bed Hold Days Used Paid CY**	
Date of Death			

Benefit / Assignment Plan

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

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

Qualified Medicare Beneficiary (QMB)

- Issued to qualified consumers who receive Medicare
- Reimbursement policy is set under 5160-1 and can result in a payment of zero dollars
- Medicaid only covers their monthly Medicare premium, co-insurance and/or deductible after Medicare has paid

Can I Bill Them?

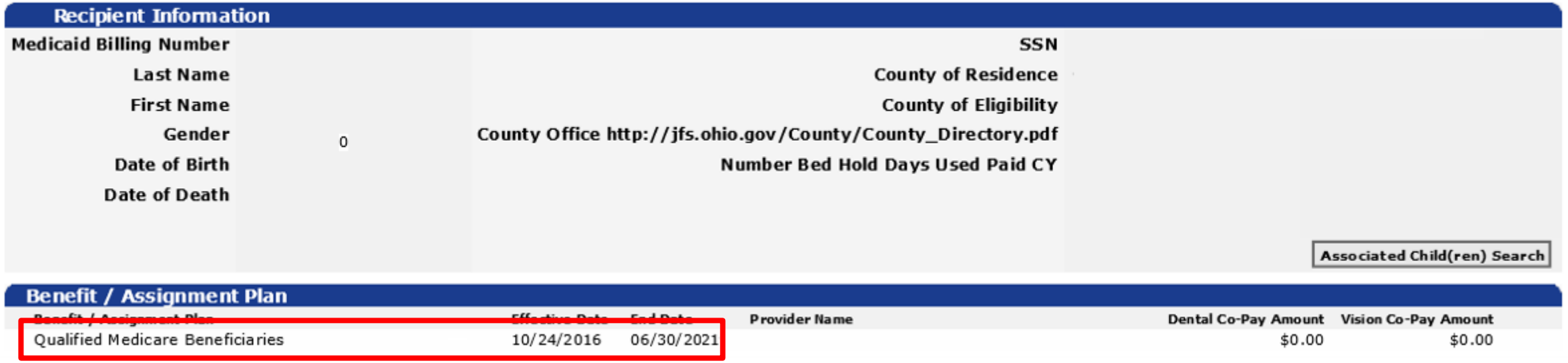
MLN Matters® Number: MM11230 Revised Release Date of Revised Article: July 3, 2019

Billing individuals enrolled in the QMB program is Prohibited by Federal Law

Federal law bars Medicare providers and suppliers from billing an individual enrolled in the QMB program for Medicare Part A and Part B cost sharing for covered items and services (see Sections 1902(n)(3)(B), 1902(n)(3)(C), 1905(p)(3), 1866(a)(1)(A), and 1848(g)(3)(A) of the Social Security Act [the Act]). The QMB system updates are part of CMS' ongoing efforts to help providers comply with QMB billing prohibitions.

QMB

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



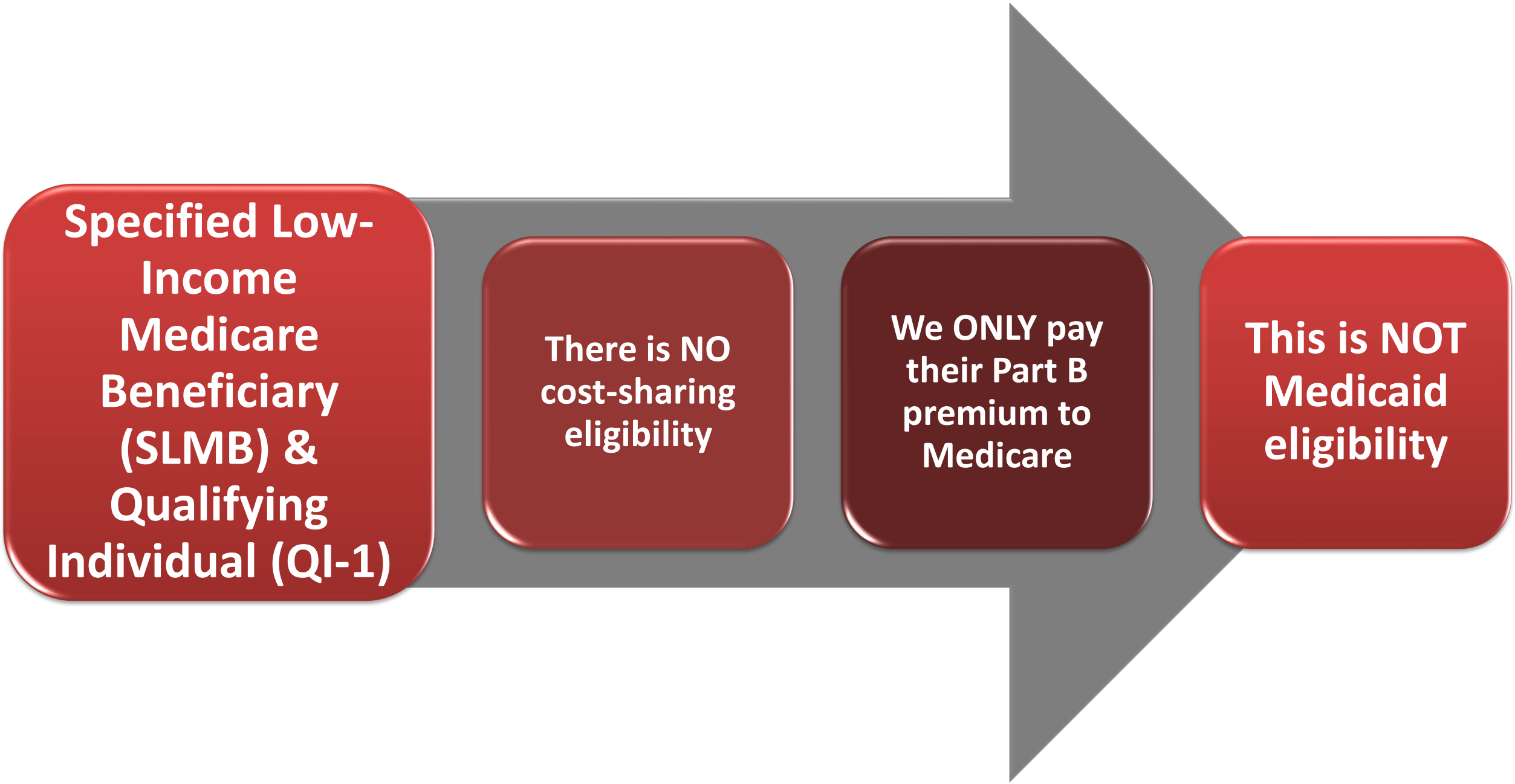
Recipient Information

Medicaid Billing Number		SSN	
Last Name		County of Residence	
First Name		County of Eligibility	
Gender	0	County Office http://jfs.ohio.gov/County/County_Directory.pdf	
Date of Birth		Number Bed Hold Days Used Paid CY	
Date of Death			

Associated Child(ren) Search

Benefit / Assignment Plan

Benefit / Assignment Plan	Effective Date	End Date	Provider Name	Dental Co-Pay Amount	Vision Co-Pay Amount
Qualified Medicare Beneficiaries	10/24/2016	06/30/2021		$0.00	$0.00


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

SLMB and QI 1/QI 2

This is what will appear in the benefit/assignment plan panel if the individual has SLMB or QI 1/QI/2

Benefit / Assignment Plan

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

Benefit / Assignment Plan

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

Managed Care & MyCare Ohio

aetna®

AETNA BETTER HEALTH® OF OHIO

buckeye health plan

CareSource®

PARAMOUNT HEALTH CARE

MOLINA® HEALTHCARE

UnitedHealthcare®

Oversight of Managed Care Organizations (MCOs)

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

Traditional Managed Care Organizations

buckeye health plan

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

CareSource®

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

PARAMOUNT HEALTH CARE

800-891-2542 https://www.paramounthealthcare.com

MOLINA® HEALTHCARE

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

UnitedHealthcare®

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

MITS Managed Care Eligibility

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

Benefit / Assignment Plan

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

Case/Cat/Seq Spenddown

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TPL

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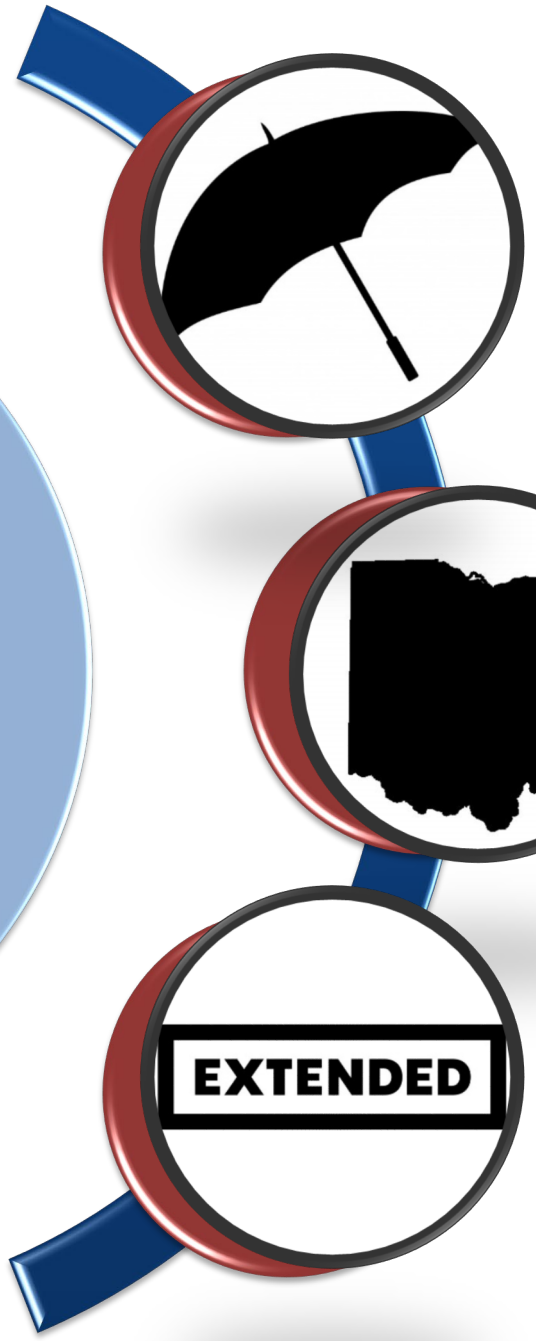
Managed Care

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

MyCare Ohio



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

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

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

MyCare Ohio Eligibility

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

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

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

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

MITS Managed Care Eligibility

If an individual's Medicaid **and** Medicare benefits are covered by the MCO, you will see **dual benefits**

Benefit / Assignment Plan

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

Case/Cat/Seq Spenddown

*** No rows found ***

TPL

*** No rows found ***

Managed Care

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

Lock-In

*** No rows found ***

Medicare

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

MITS Managed Care Eligibility

If the MCO covers **only** the individual's Medicaid benefits, you will see **Medicaid Only**

Benefit / Assignment Plan

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

Case/Cat/Seq Spenddown

*** No rows found ***

TPL

*** No rows found ***

Managed Care

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

Lock-In

*** No rows found ***

Medicare

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

MyCare Ohio Managed Care Organizations

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.uhcprovider.com/en/health-plans-by-state/ohio-health-plans/oh-comm-plan-home.html

Third-Party Duties; Medicaid Managed Care Organizations

Ohio Revised Code 5160.40:

- The department, or Medicaid managed care organization, has right of recovery under section 5160.37
- The claim must be submitted not later than six years after the date of service
- The third party must respond to the department's request for payment not later than 90 business days after the receipt of written proof of claim

Recoupment of Overpayment

Ohio Revised Code 5160.77:

- Effective ***10/17/2019***
- When a managed care organization seeks to recoup an overpayment made to a provider, it shall provide all of the details of the recoupment including the following:
  - Name, address, and Medicaid identification number of the individual
  - Date(s) that the services were provided
  - Reason for the recoupment
  - Method by which the provider may contest the proposed recoupment

Managed Care vs Fee-for-Service (FFS)

Some ways the MCOs are allowed to differ from FFS:

- Whether an item or service requires Prior Authorization
- What modifiers should be used with a specific code
- What fee will be paid to providers **
- How long a provider has to submit their claims timely **

** Check your agreement with each MCO for specifics

Managed Care vs FFS

Some ways the MCOs are *not* allowed to differ from FFS:

- The MCOs should not request the use of improper place of service codes
- The MCOs cannot refuse to cover an item/service that FFS covers (a different code may be used, but the service itself cannot be denied if ODM covers it)

PROVIDER COMPLAINTS

Provider licensure issues

Please send to Ohio Department of Insurance (ODI)

Certification issues

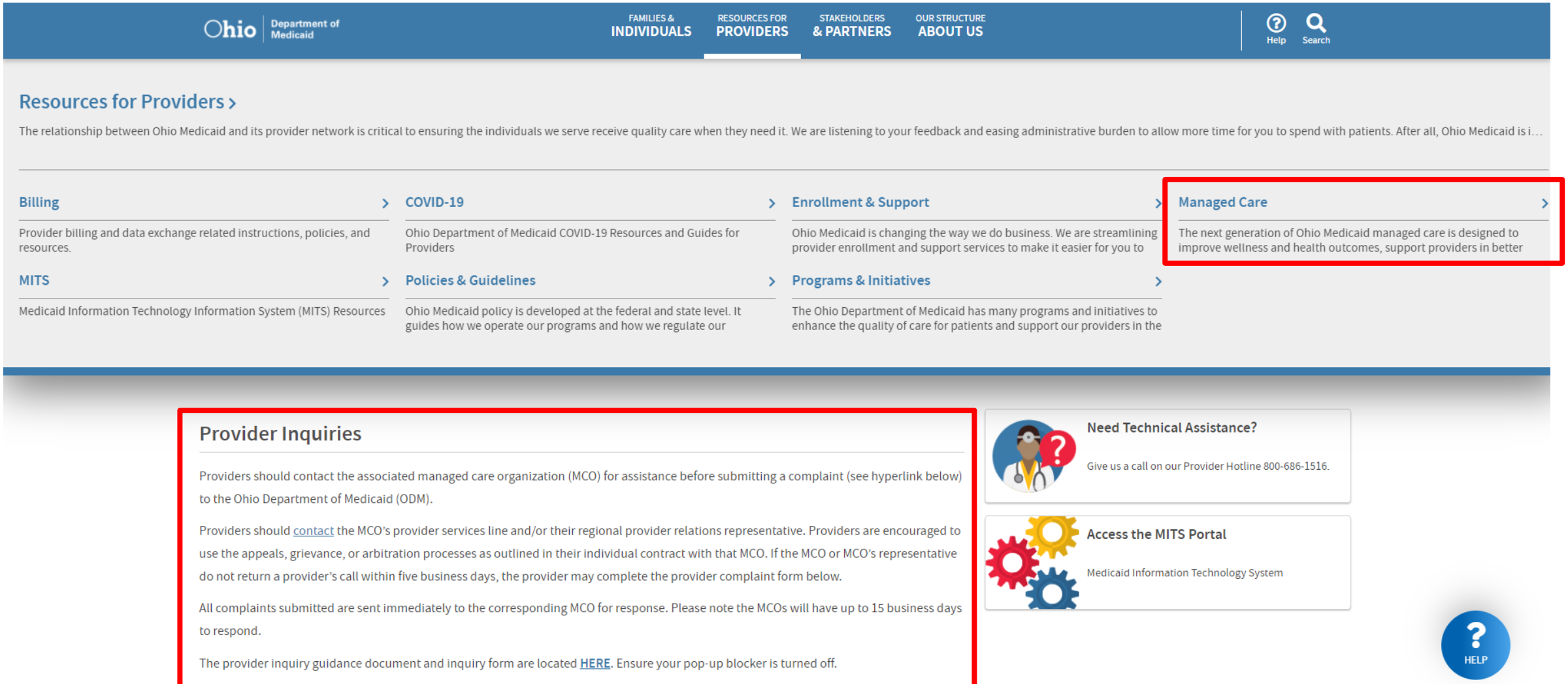
Work with the Area Agency on Aging (AAA) or ODM for MyCare Ohio waiver providers

Work directly with the Plan first

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

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

Submitting a Managed Care Complaint



Submitting a Managed Care Complaint

Provider Complaint Form Guidance

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

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

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

Submitting a Managed Care Complaint

Submission Tips:

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

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

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

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

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

OH Medicaid *Managed Care* Provider Complaint Form

Instructions

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

Complaint Details

MCO Name: *

Complaint Reason: *

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

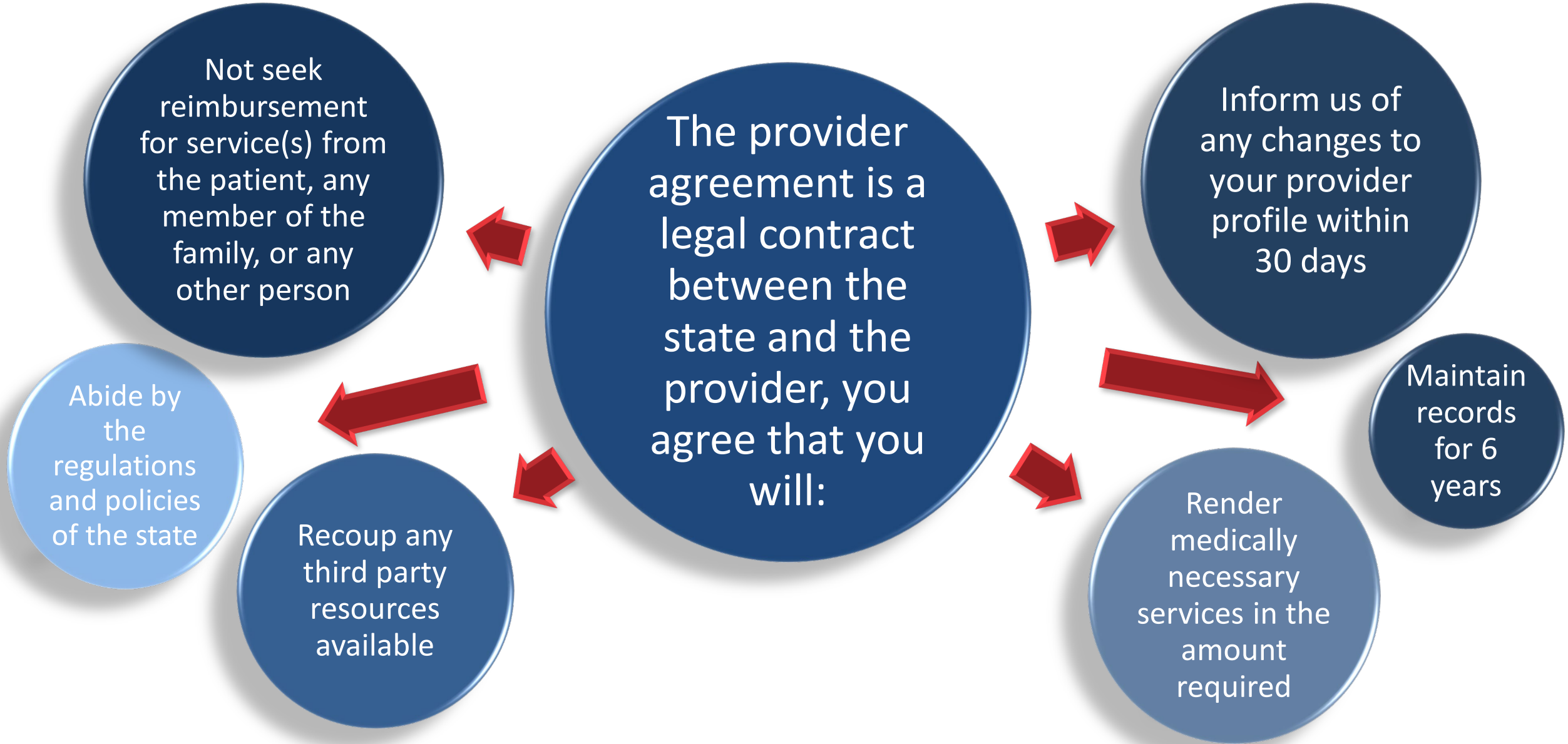
* **Is this complaint related to any previously submitted complaints?** ○ Yes ○ No

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

Please summarize your complaint in the text box below: required

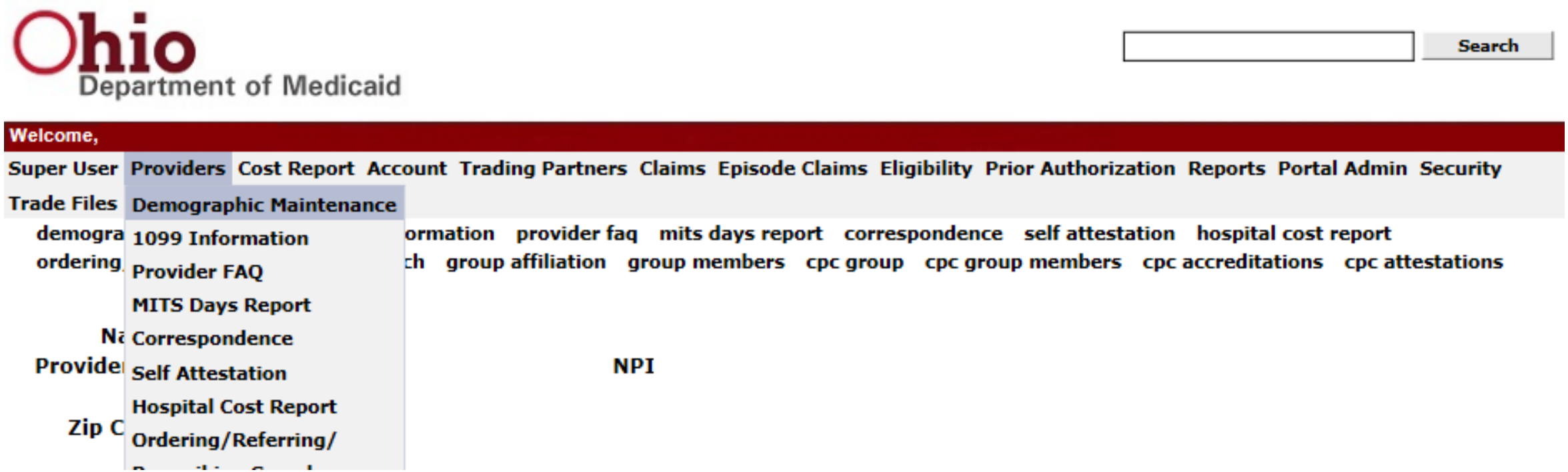
Provider Responsibilities

Provider Agreement: OAC 5160-1-17.2



Demographic Maintenance in MITS

Select the Providers tab and Demographic Maintenance to ensure your information is up to date

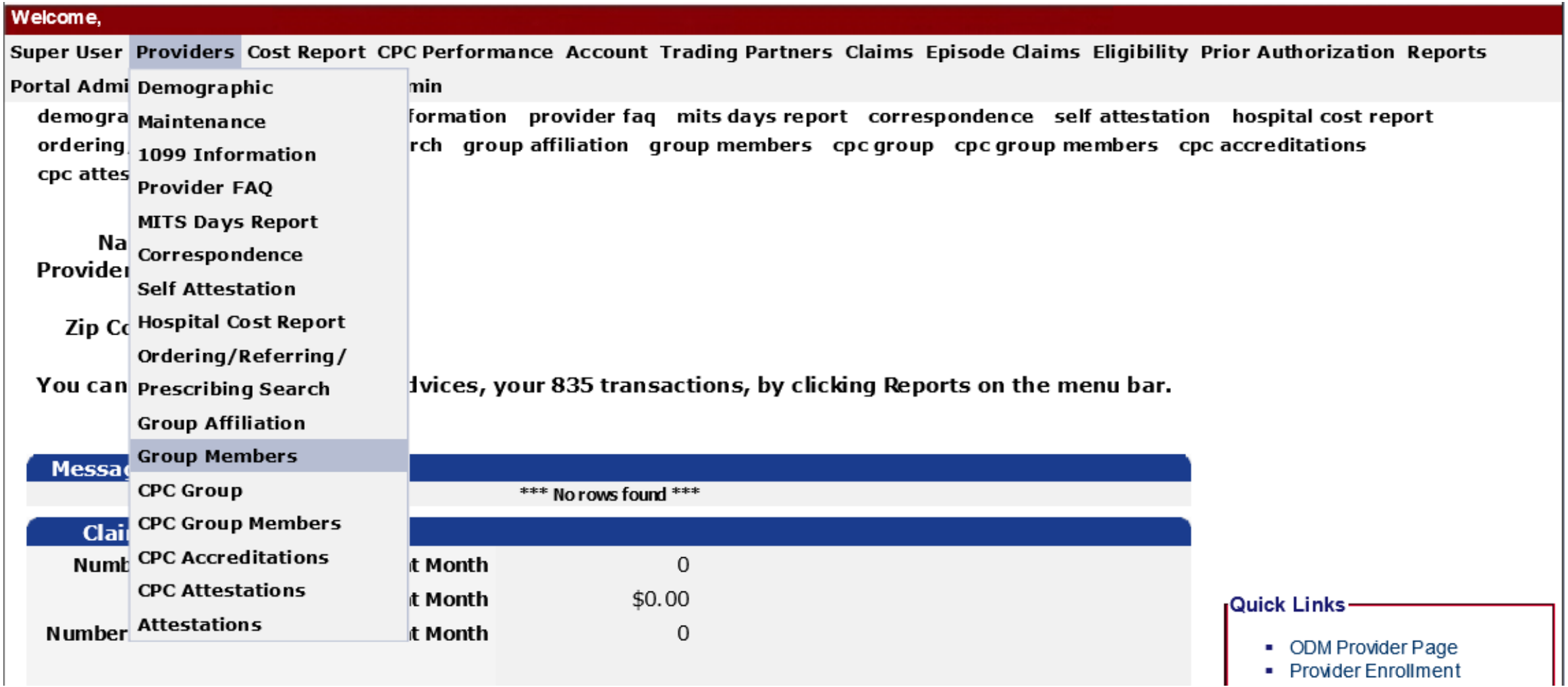


Demographic Maintenance in MITS

Based on your provider agreement you have a requirement to update your demographics within 30 days of changes

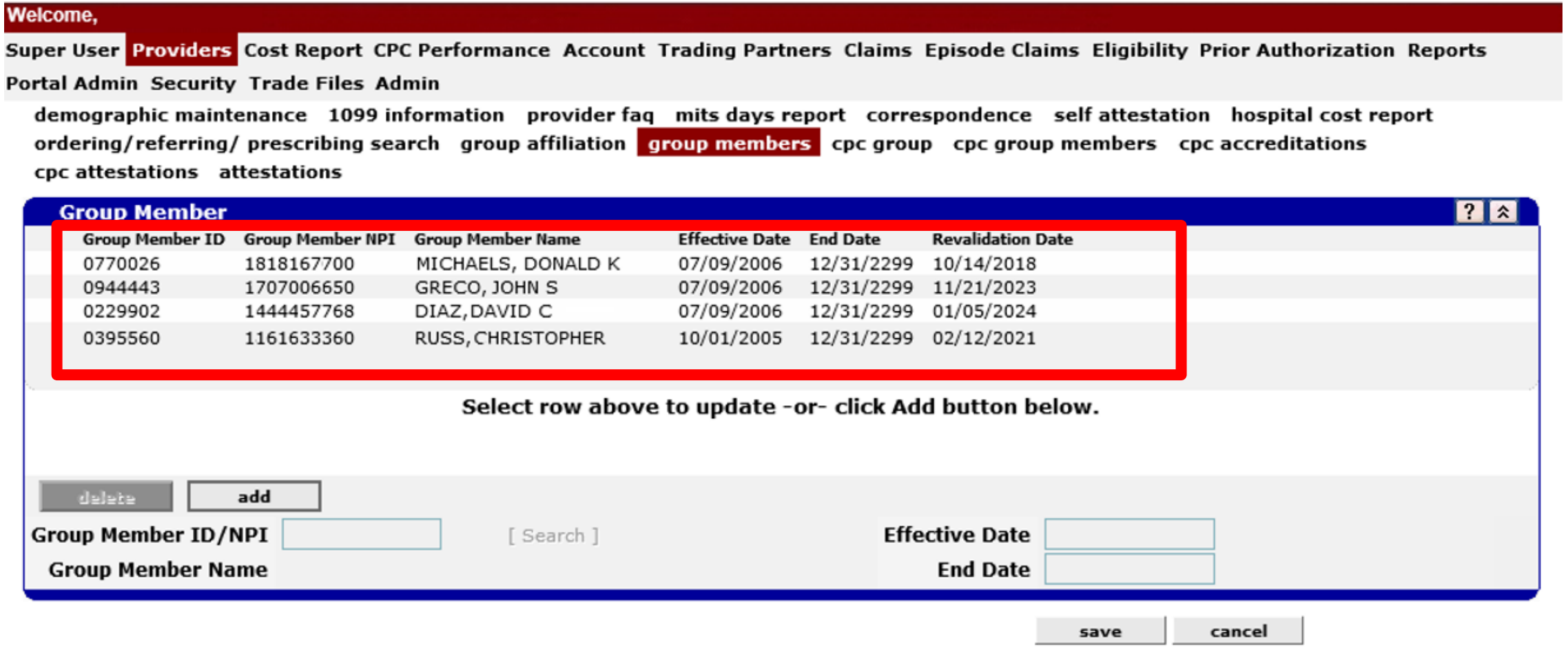
Demographic Maintenance in MITS

Under the Providers tab you will find an option to add group members



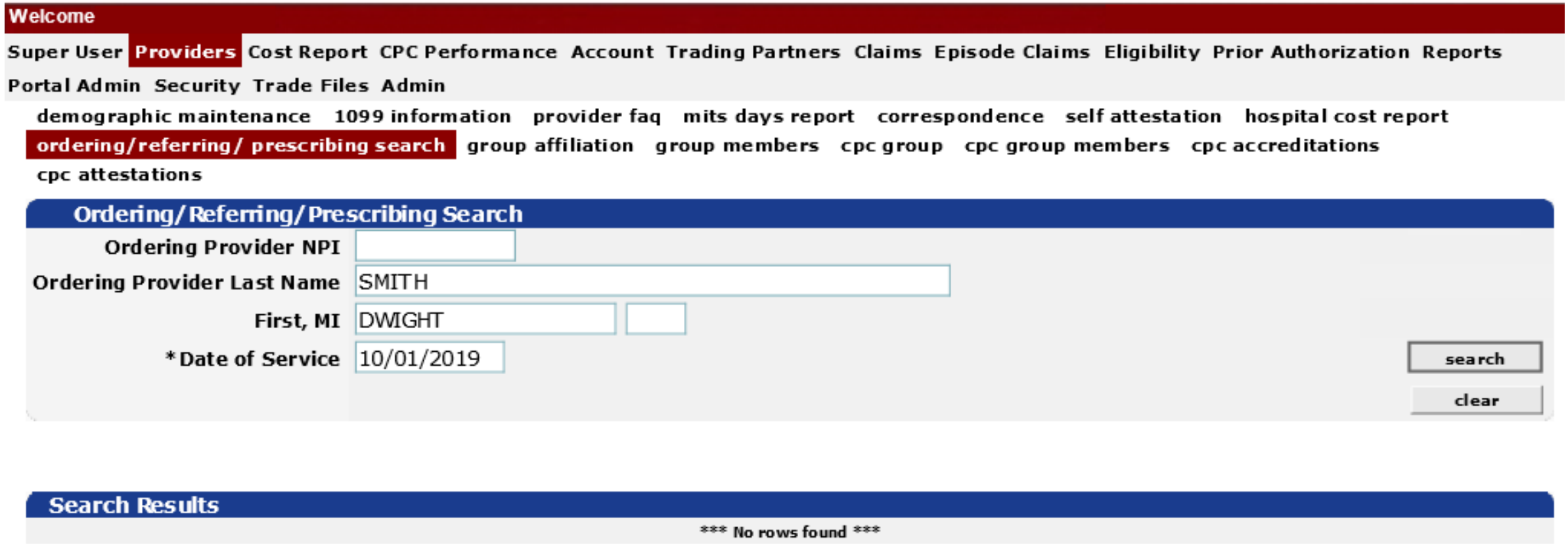
Demographic Maintenance in MITS

Be sure to add all of your group members to ensure claims that list them as the rendering process correctly



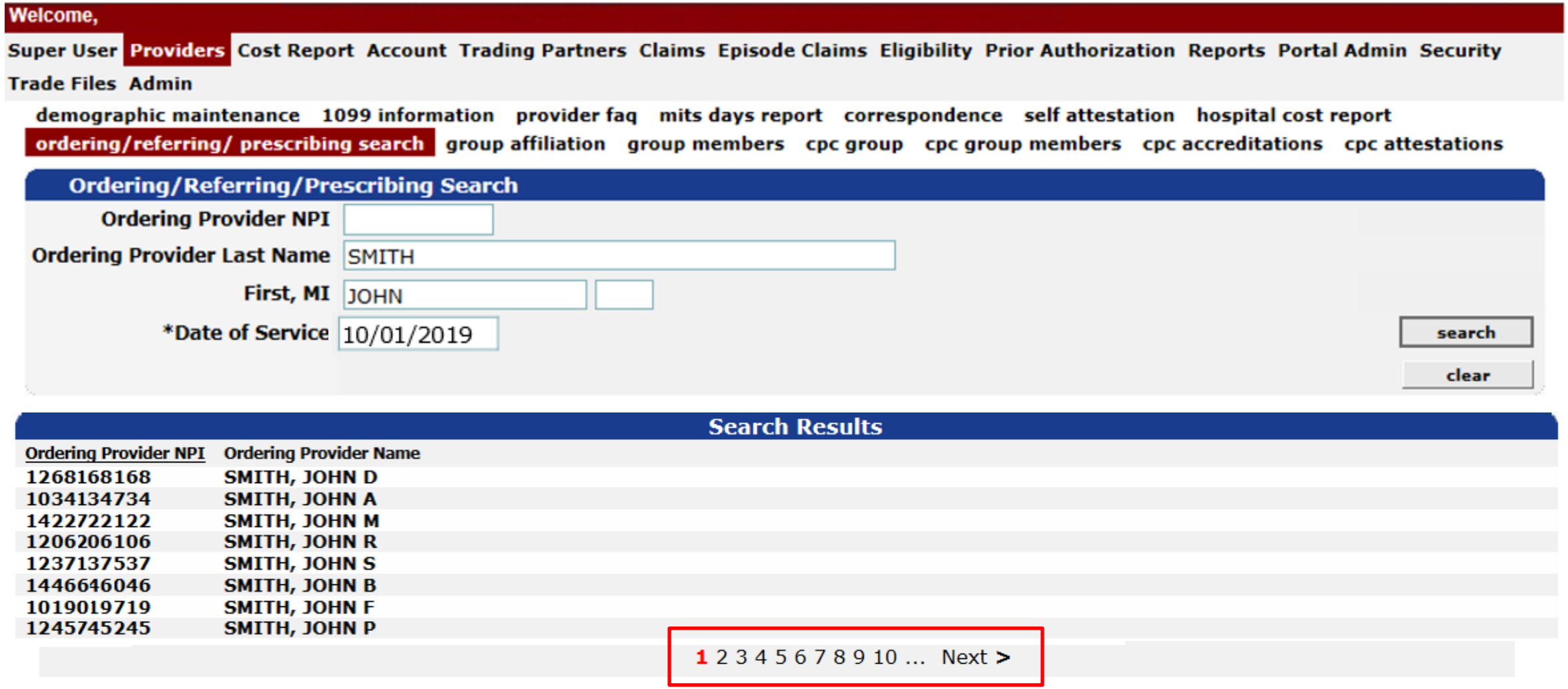
Ordering, Referring, Prescribing (ORP) Search in MITS

An ORP search can be performed in the MITS secure portal to ensure you have the correct information for the ORP provider to include on your claim



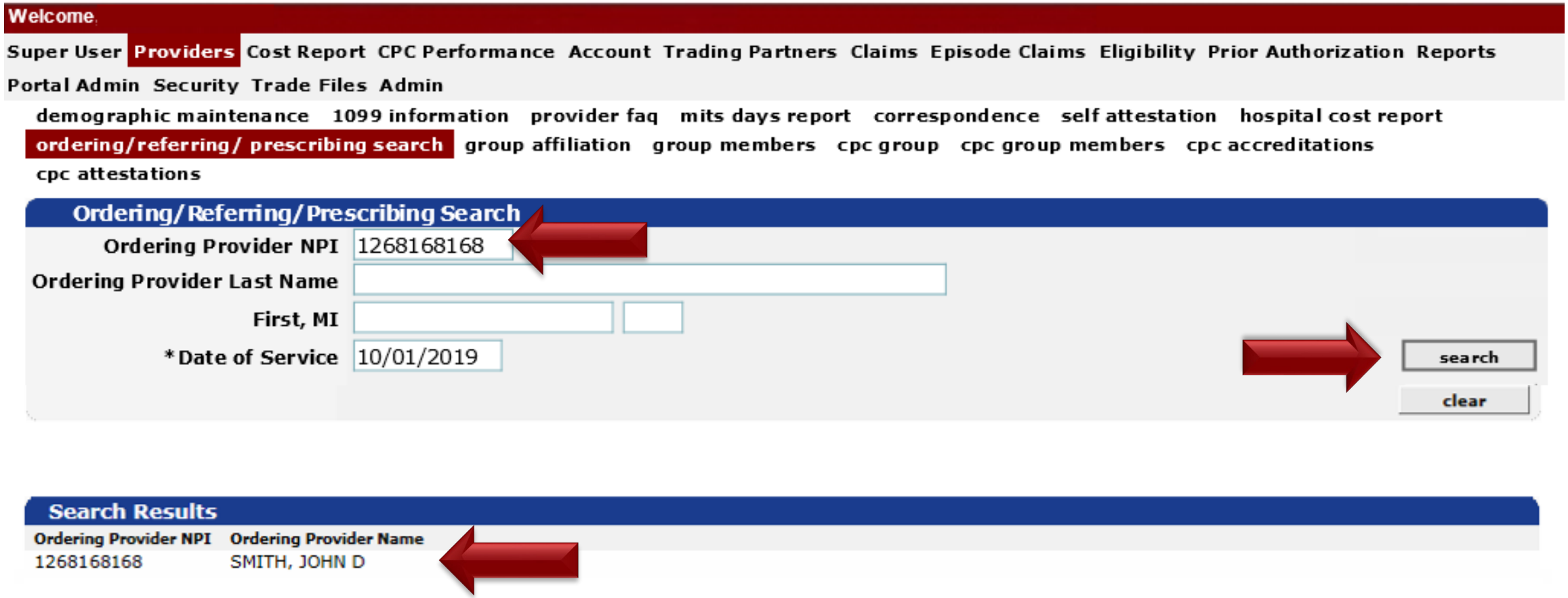
ORP Search in MITS

Searching just using a name may pull up several results



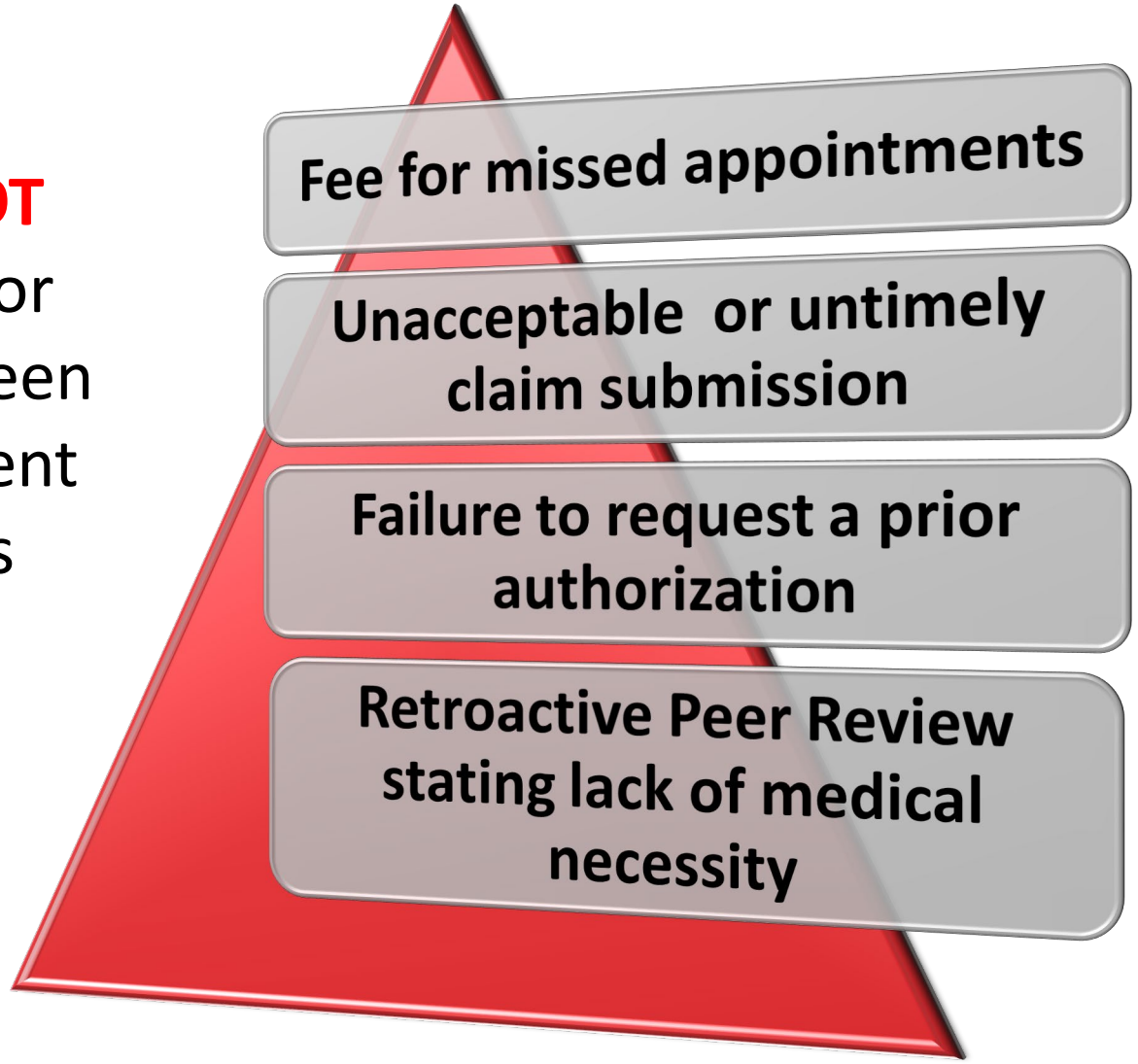
ORP Search in MITS

We recommend using the NPI to get the most accurate results for your search

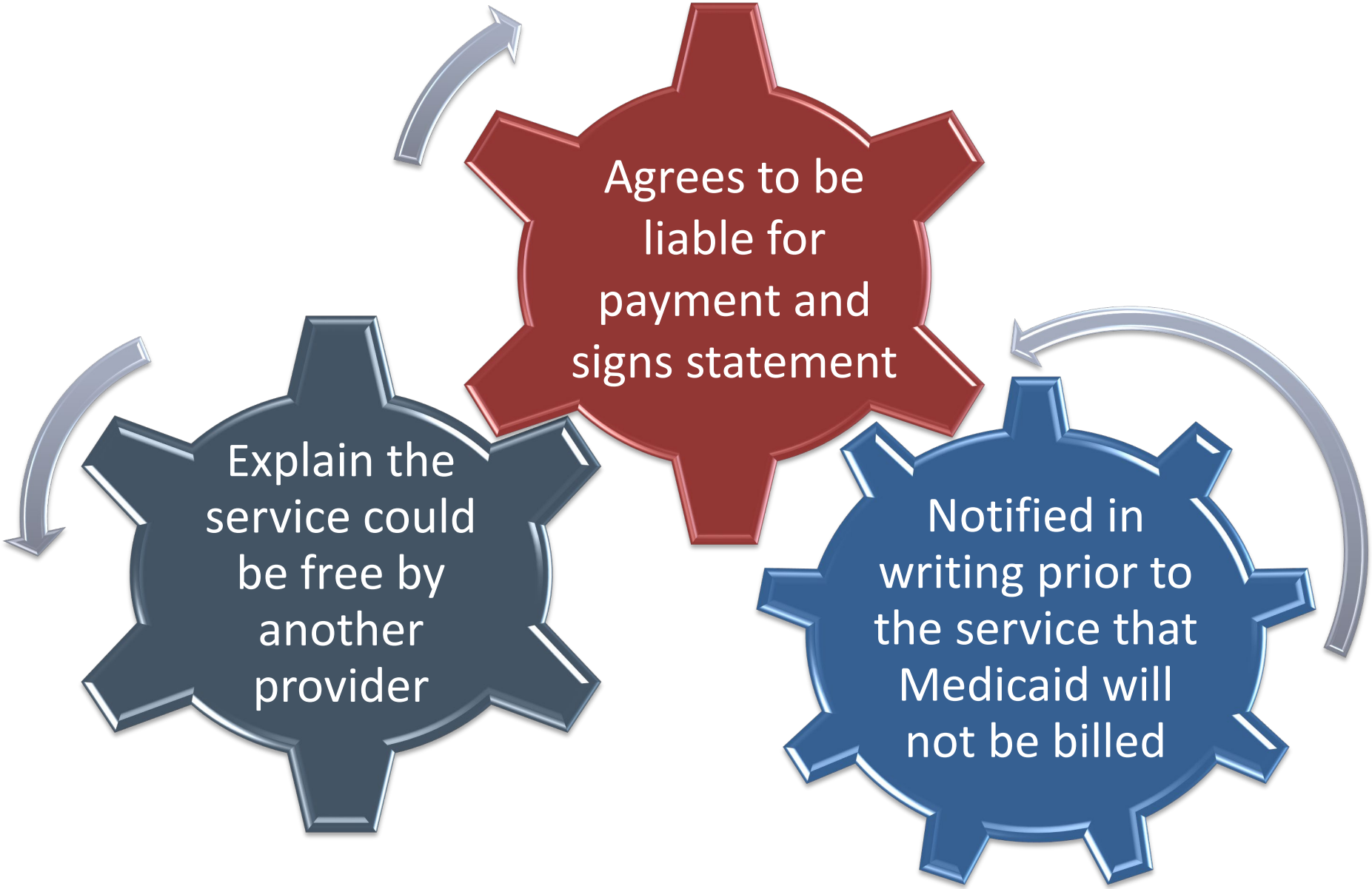


Medicaid Consumer Liability 5160-1-13.1

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

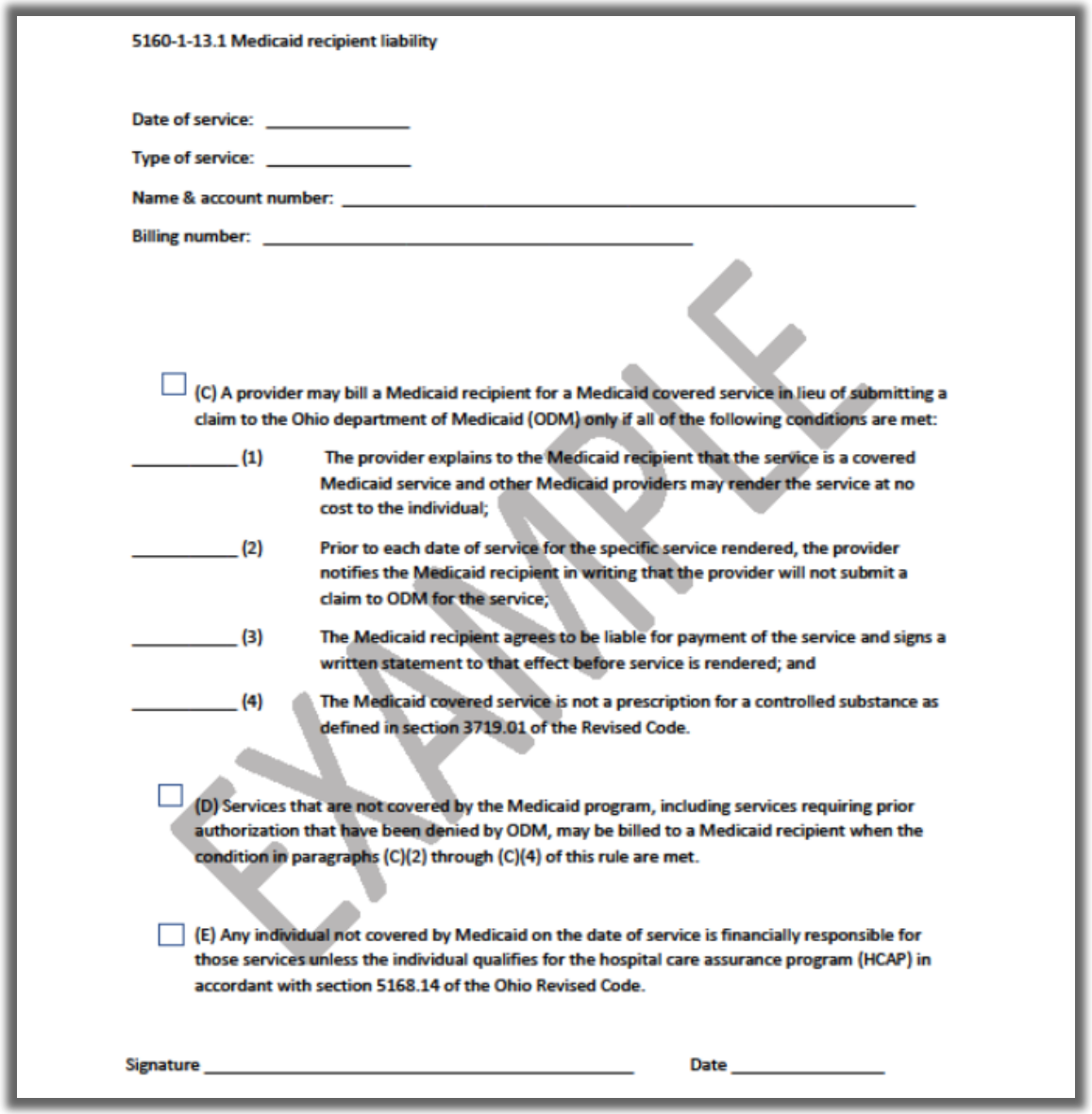


When Can you Bill an Individual?



When Can You Bill an Individual?

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



5160-1-13.1 Medicaid recipient liability

Date of service: _____

Type of service: _____

Name & account number: _____

Billing number: _____

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

_____ (1) The provider explains to the Medicaid recipient that the service is a covered Medicaid service and other Medicaid providers may render the service at no cost to the individual;

_____ (2) Prior to each date of service for the specific service rendered, the provider notifies the Medicaid recipient in writing that the provider will not submit a claim to ODM for the service;

_____ (3) The Medicaid recipient agrees to be liable for payment of the service and signs a written statement to that effect before service is rendered; and

_____ (4) The Medicaid covered service is not a prescription for a controlled substance as defined in section 3719.01 of the Revised Code.

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

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

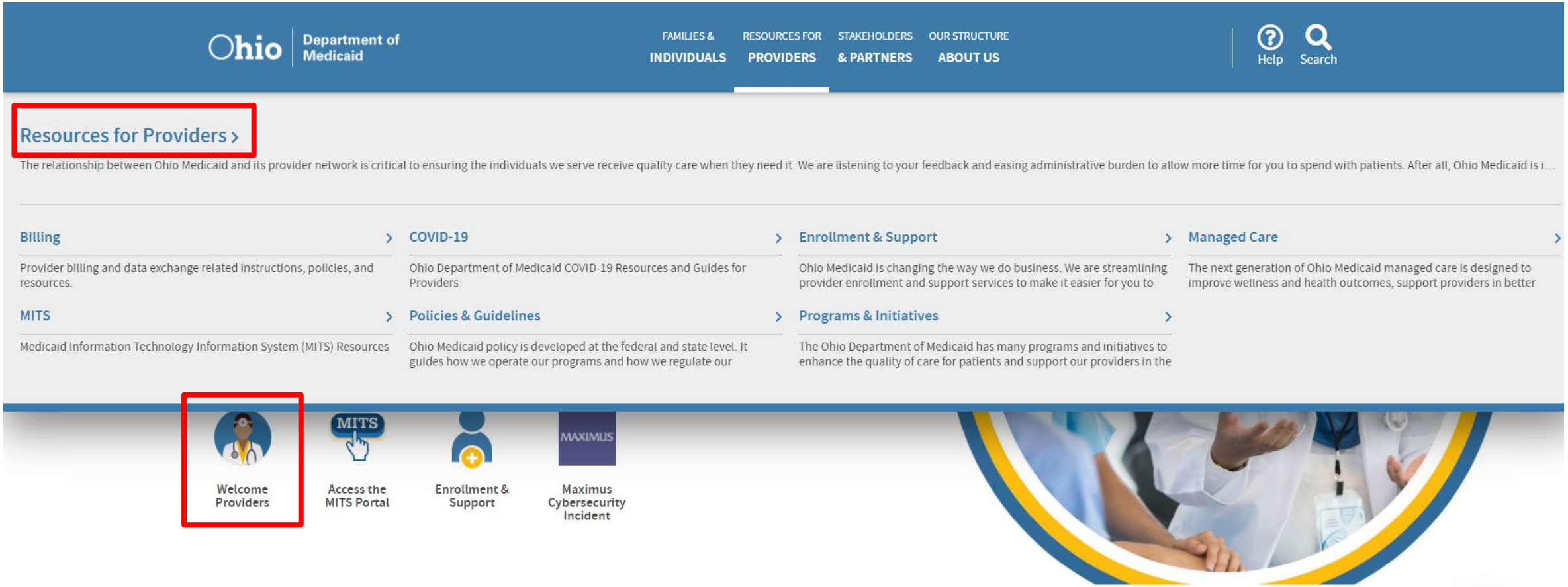
Signature _____ Date _____

EXAMPLE

https://Medicaid.ohio.gov

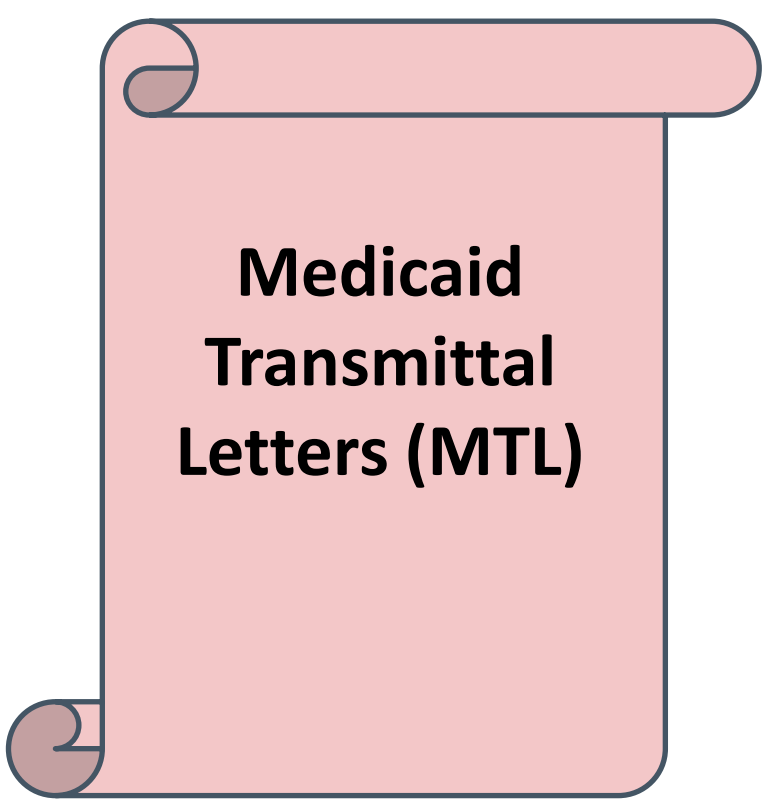
This Ohio Department of Medicaid (ODM) Website

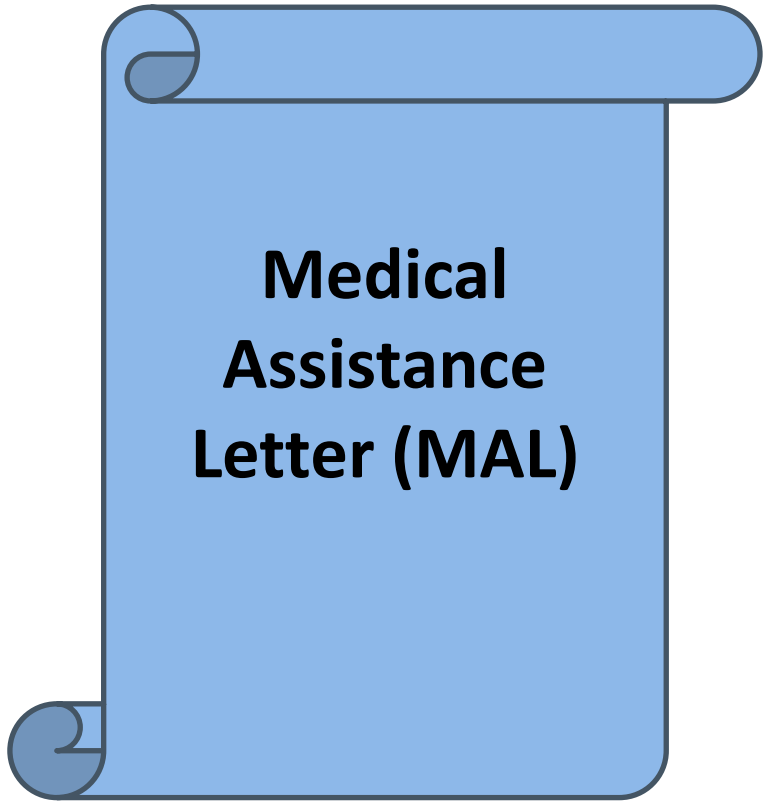
Provider News



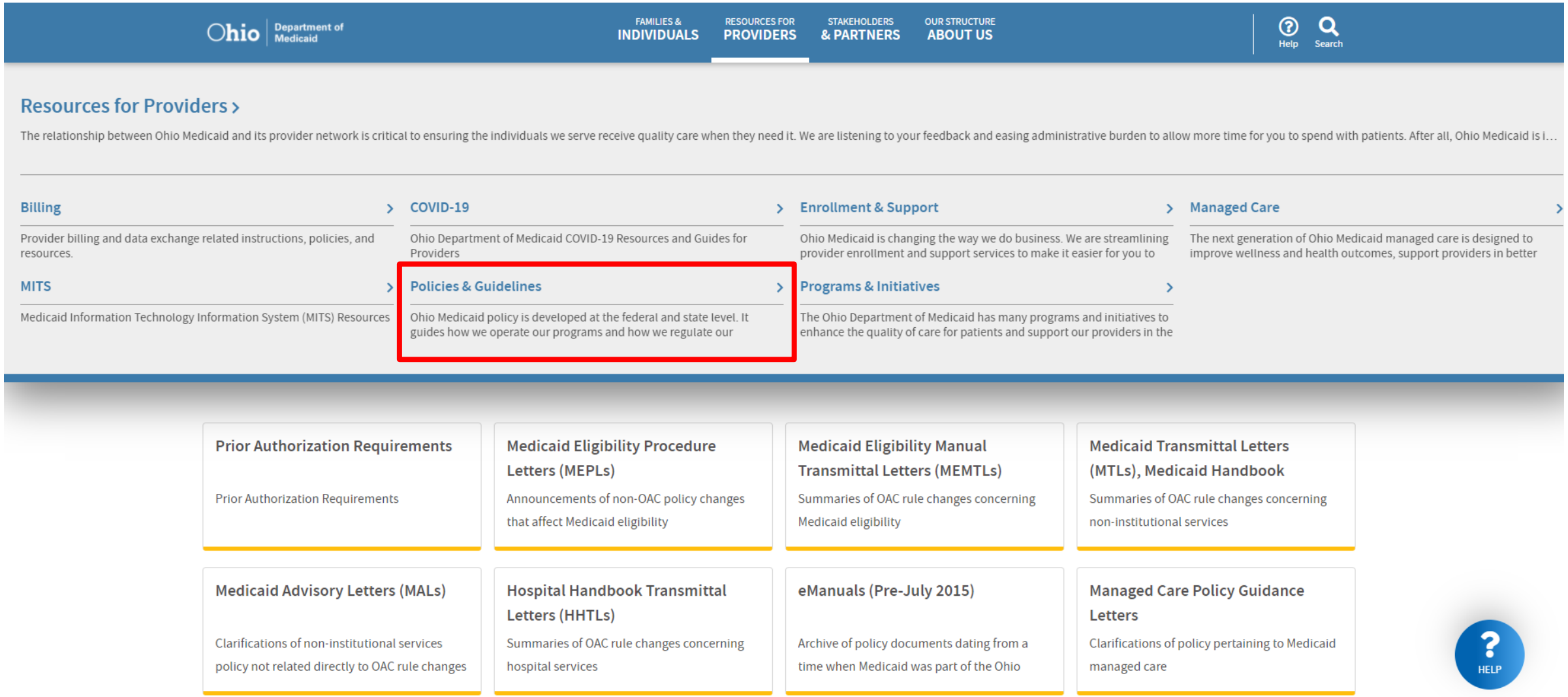
Policy

Ohio Medicaid announces changes to the Ohio Administrative Code and guidance/clarification that may affect providers via letters.
There are two types of letters:





Policy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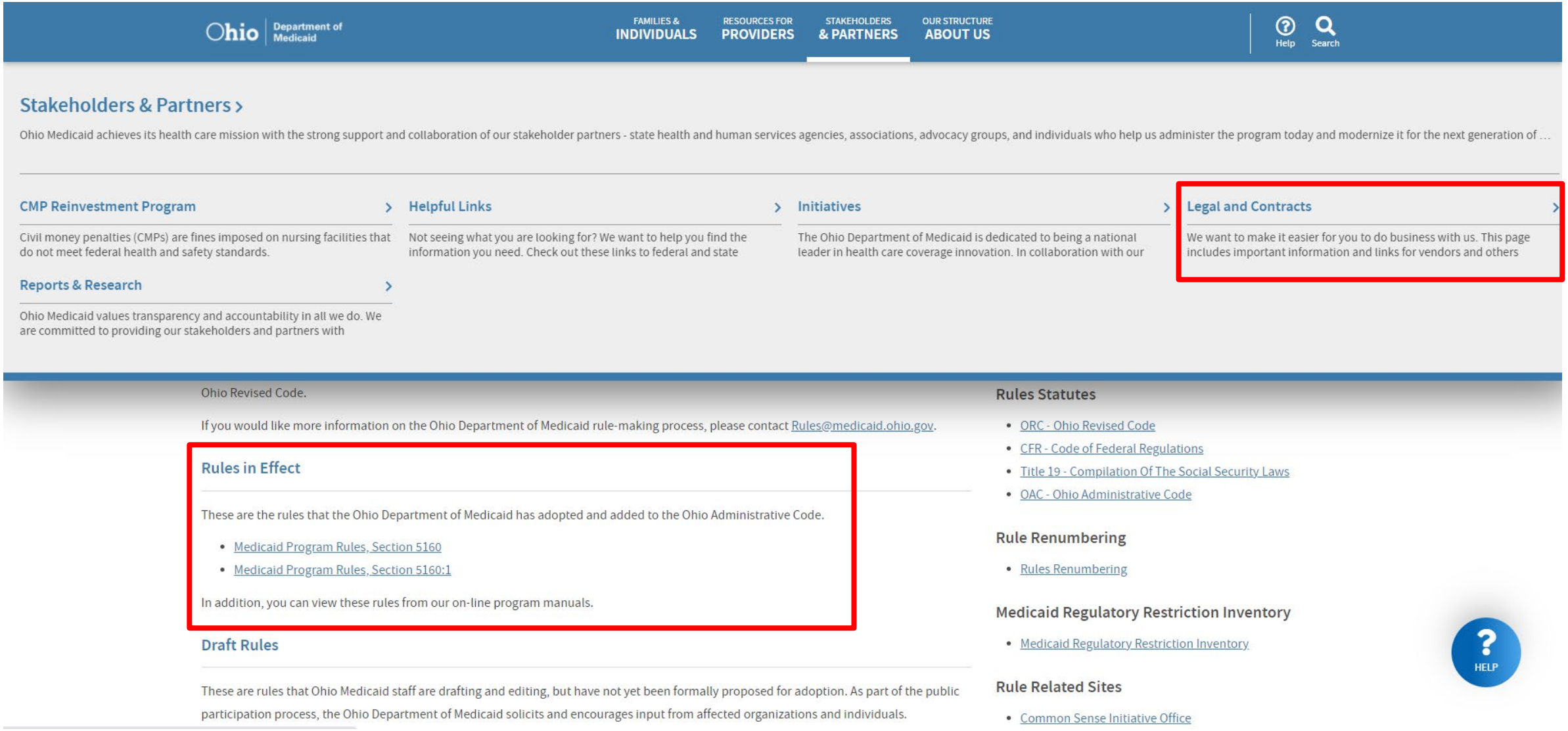
FAMILIES & INDIVIDUALS
RESOURCES FOR PROVIDERS
STAKEHOLDERS & PARTNERS
OUR STRUCTURE ABOUT US
Help
Search
Resources for Providers ›
The relationship between Ohio Medicaid and its provider network is critical to ensuring the individuals we serve receive quality care when they need it. We are listening to your feedback and easing administrative burden to allow more time for you to spend with patients. After all, Ohio Medicaid is i…
Billing ›
Provider billing and data exchange related instructions, policies, and resources.
COVID-19 ›
Ohio Department of Medicaid COVID-19 Resources and Guides for Providers
Enrollment & Support ›
Ohio Medicaid is changing the way we do business. We are streamlining provider enrollment and support services to make it easier for you to
Managed Care ›
The next generation of Ohio Medicaid managed care is designed to improve wellness and health outcomes, support providers in better
MITS ›
Medicaid Information Technology Information System (MITS) Resources
Policies & Guidelines ›
Ohio Medicaid policy is developed at the federal and state level. It guides how we operate our programs and how we regulate our
Programs & Initiatives ›
The Ohio Department of Medicaid has many programs and initiatives to enhance the quality of care for patients and support our providers in the
Prior Authorization Requirements
Prior Authorization Requirements
Medicaid Eligibility Procedure Letters (MEPLs)
Announcements of non-OAC policy changes that affect Medicaid eligibility
Medicaid Eligibility Manual Transmittal Letters (MEMTLs)
Summaries of OAC rule changes concerning Medicaid eligibility
Medicaid Transmittal Letters (MTLs), Medicaid Handbook
Summaries of OAC rule changes concerning non-institutional services
Medicaid Advisory Letters (MALs)
Clarifications of non-institutional services policy not related directly to OAC rule changes
Hospital Handbook Transmittal Letters (HHTLs)
Summaries of OAC rule changes concerning hospital services
eManuals (Pre-July 2015)
Archive of policy documents dating from a time when Medicaid was part of the Ohio
Managed Care Policy Guidance Letters
Clarifications of policy pertaining to Medicaid managed care
HELP

Policy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FAMILIES & INDIVIDUALS
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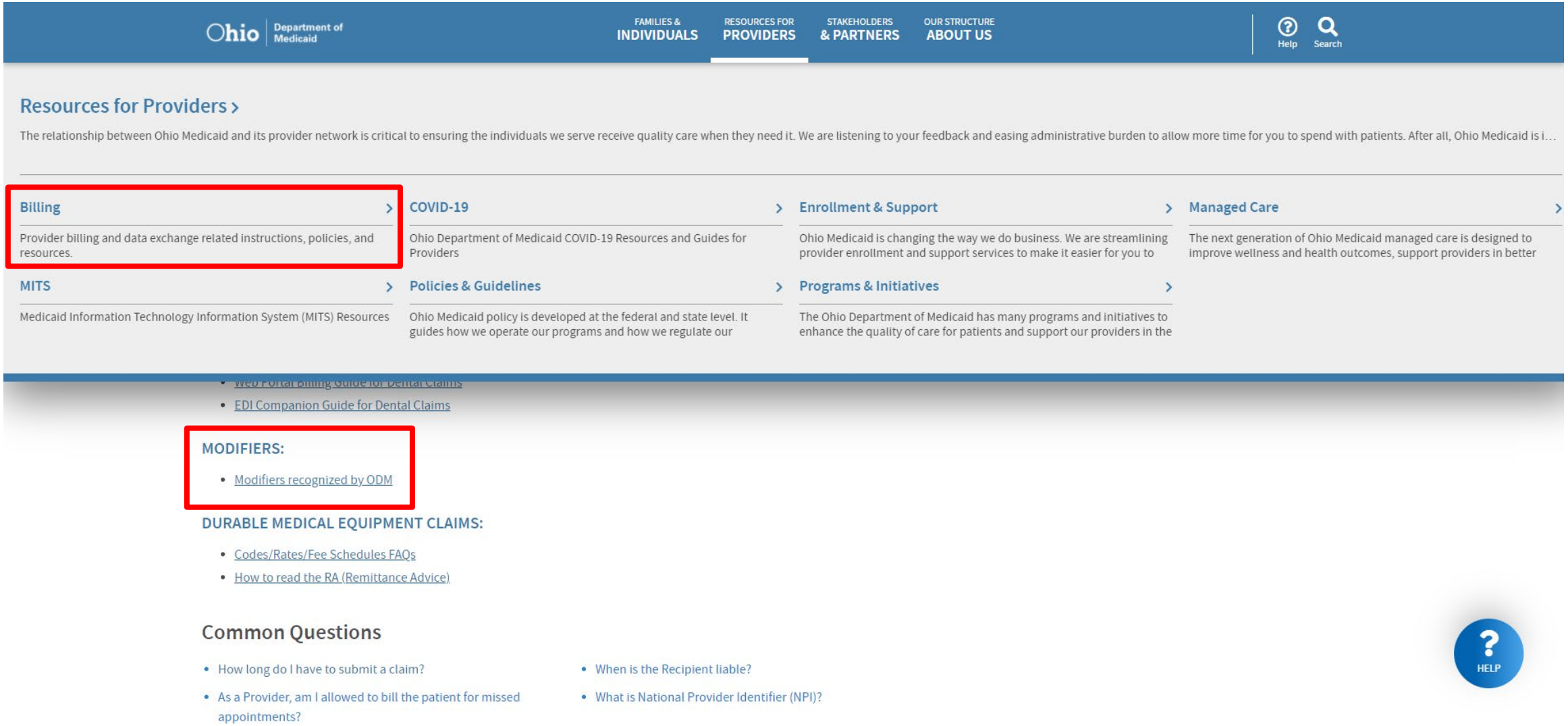
Help
Search
Stakeholders & Partners ›
Ohio Medicaid achieves its health care mission with the strong support and collaboration of our stakeholder partners - state health and human services agencies, associations, advocacy groups, and individuals who help us administer the program today and modernize it for the next generation of …
CMP Reinvestment Program ›
Civil money penalties (CMPs) are fines imposed on nursing facilities that do not meet federal health and safety standards.
Helpful Links ›
Not seeing what you are looking for? We want to help you find the information you need. Check out these links to federal and state
Initiatives ›
The Ohio Department of Medicaid is dedicated to being a national leader in health care coverage innovation. In collaboration with our
Legal and Contracts ›
We want to make it easier for you to do business with us. This page includes important information and links for vendors and others
Reports & Research ›
Ohio Medicaid values transparency and accountability in all we do. We are committed to providing our stakeholders and partners with
Ohio Revised Code.
If you would like more information on the Ohio Department of Medicaid rule-making process, please contact Rules@medicaid.ohio.gov.
Rules in Effect
These are the rules that the Ohio Department of Medicaid has adopted and added to the Ohio Administrative Code.
Medicaid Program Rules, Section 5160
Medicaid Program Rules, Section 5160:1
In addition, you can view these rules from our on-line program manuals.
Draft Rules
These are rules that Ohio Medicaid staff are drafting and editing, but have not yet been formally proposed for adoption. As part of the public participation process, the Ohio Department of Medicaid solicits and encourages input from affected organizations and individuals.
Rules Statutes
ORC - Ohio Revised Code
CFR - Code of Federal Regulations
Title 19 - Compilation Of The Social Security Laws
OAC - Ohio Administrative Code
Rule Renumbering
Rules Renumbering
Medicaid Regulatory Restriction Inventory
Medicaid Regulatory Restriction Inventory
Rule Related Sites
Common Sense Initiative Office
HELP

Policy

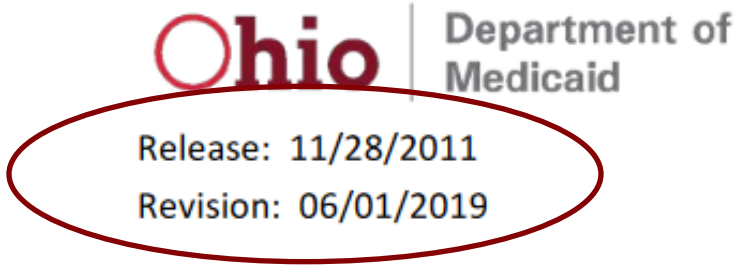
https://codes.ohio.gov

How to Find Modifiers Recognized by Ohio Medicaid



Modifiers Recognized by Ohio Medicaid

Medicaid.ohio.gov -> Providers -> Billing -> Billing Instructions


Ohio | Department of Medicaid

Release: 11/28/2011

Revision: 06/01/2019

Modifiers Recognized by Ohio Medicaid

Modifiers are two-character codes used along with a service or supply procedure code to provide additional information about the service or supply rendered. Care must be taken when reporting modifiers with procedure codes because using a modifier inappropriately can result in the denial of payment or an incorrect payment for a service or supply. The Ohio Department of Medicaid (ODM) accepts many, but not all, modifiers recognized by the American Medical Association (AMA), the Centers for Medicare and Medicaid Services (CMS), and the American Society of Anesthesiologists (ASA).

ODM also recognizes Medicaid state-specific HCPCS modifiers beginning with the letter *U*. These state-specific "U-modifiers" can be tailored to an individual state's Medicaid policy when no other modifier adequately represents the policy purpose. The state determines how each U modifier is to be used and the same U-modifier can take on different meanings when it is used with different service or supply

Prospective Payment System (PPS)

ODM complies with provisions set forth in Section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA)

Requires states to establish a PPS for FQHCs and RHCs

A separate all-inclusive per-visit payment amount (PVPA) is established for each FQHC or RHC service provided at a FQHC or RHC service site

PVPAs are specific to an FQHC or RHC service site

No FQHC or RHC service site may submit claims based on the PVPAs of another service site

MAL No. 621 Prohibition of Commingling in FQHCs and RHCs

- This applies to RHC and FQHC practitioners who are dually enrolled as another provider type (PT) – PT 50 or PT 84/95

- ODM follows Medicare's policy on the prohibition of commingling by FQHC and RHC providers as set forth in Chapter 13 of the "Medicare Benefit Policy Manual"

- Commingling refers to the sharing of FQHC or RHC space, staff (employed or contracted), supplies, equipment, and/or other resources with another onsite provider operated by the same FQHC or RHC

MAL No. 621 Prohibition of Commingling in FQHCs and RHCs

- Commingling is prohibited in order to prevent:
  (1) duplicate Medicaid payment; or
  (2) selectively choosing a higher or lower payment amount for services

- FQHC and RHC providers may only submit claims for non-FQHC and RHC services if the service cannot be claimed as an FQHC or RHC service

- FQHC and RHC practitioners may not render or separately submit claims for FQHC or RHC-covered services as another type of provider in the FQHC or RHC, or in an area outside of the certified FQHC or RHC space such as a treatment room adjacent to the FQHC or RHC, during FQHC or RHC hours of operations

MAL No. 621 Prohibition of Commingling in FQHCs and RHCs

- FQHCs and RHCs that share resources (waiting rooms, telephones, receptionists) with another entity must maintain accurate records to assure that all costs claimed for Medicaid payment are only for the FQHC or RHC staff, space, or other resources
  - Any shared staff, space, or other resources must be allocated appropriately between FQHC or RHC and non-RHC or non-FQHC usage to avoid duplicate payment

MAL No. 622 Requirements to Report Individual Practitioners' NPIs in the Rendering Fields on Claims

- FQHCs and RHCs must report on their claim individual practitioners' National Provider Identifiers (NPIs) in the rendering provider field
- For Electronic Data Interchange (EDI) submissions, the individual rendering providers' NPIs will be reported in the 2310B Rendering Provider loop
- Claims will be rejected if they do not include the individual practitioner's NPI

MAL No. 622-A Requirement to Report Individual Practitioners' NPIs in the Rendering Fields on Claims

Update to MAL No. 622:

- Services rendered by mid-level health care workers (e.g., registered nurses) and unlicensed dependent practitioners (i.e., behavioral health trainees) should continue to be reported under the overseeing practitioner's NPI

- Transportation, DME, laboratory, and radiology should continue to be reported under the organizational NPI

MAL No. 624 Payment of Group Therapy Services

- Group therapy services do not meet the criteria for a face-to-face encounter in a FQHC or RHC
- FQHCs and RHCs may submit claims for group therapy using their ambulatory health care clinic (AHCC – provider type 50) number

MAL No. 627 Transportation Services

- FQHCs are allowed up to 4 transports on the same date of service for the same individual

  Example:

  1. Trip to one FQHC for medical service
  2. Trip to another FQHC for mental health service
  3. Trip back to first FQHC for pick-up of medications
  4. Trip home

- T1015 U9 with up to 4 units and T2003 with up to 4 units

- Tentatively effective ***4/1/2021*** RHCs will also be paid for transportation services under the PPS

MAL No. 628 Payment for Long-Acting Reversible Contraception (LARC)

- In addition to submitting a claim for a medical visit for a LARC insertion procedure, separate payment may be made for a LARC device or implant
  - Claim may be submitted using the AHCC (PT 50) number

MAL No. 632 Payment for Hepatitis A Vaccine Provided Through Non-Participating VFC Providers

- ODM developed an avenue to provide a Hepatitis A vaccination to high risk or exposed individuals as quickly as possible
- Enables providers to be reimbursed for both the administration and the vaccine toxoid component
- Effective 5/1/2019, non-participating VFC providers can also be reimbursed for administration code (CPT 90471) and the Hepatitis A vaccines (CPT codes 90633 and 90634)
- The **SK** modifier must be reported with the appropriate vaccine code

MAL No. 634 Payment for MAT and Take-Home Medications

- Separate payment will be made for Medication-Assisted Treatment (MAT) and take-home medications furnished at a FQHC or RHC
- In order to be paid for office-based opioid treatment, practitioners must:
  - Submit the Drug Addiction Treatment Act of 2000 (DATA 2000) waiver documentation through the MITS provider portal, and
  - Obtain a MITS provider specialty 704

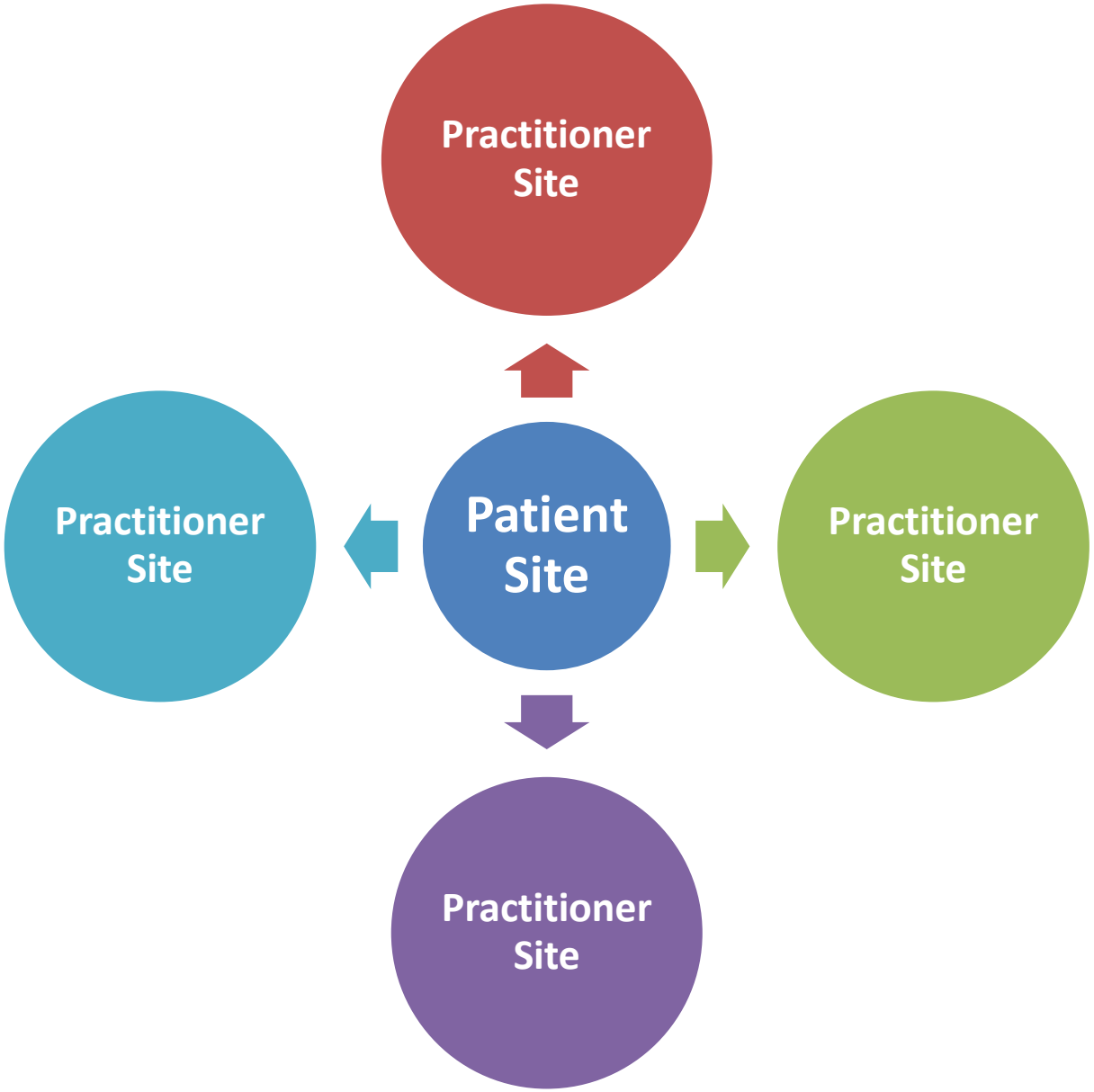
MAL No. 634 Payment for MAT and Take-Home Medications

- FQHC or RHC may be paid for evaluation & management (E&M) service associated with the MAT and the administered pharmaceutical(s)
  - J0571 – J0575, J8499
- In addition, a separate claim for the dispensing of the medication may be submitted under the AHCC (PT 50) number
  - T1502 – Dispensing of the medication
  - S5000, S5000 HD, S5001 – Take home medication

MAL No. 635 Payment for FQHC and RHC Services Rendered Through Telehealth

- FQHCs and RHCs must follow the claims submission guidance in “Telehealth Billing Guidance for Dates of Service On or After 11/15/2020”
- Covered telehealth services and provider requirements can be found in OAC 5160-1-18 Telehealth, Appendix A
- Payment (including wraparound payment) for covered FQHC and RHC services listed in OAC rules 5160-28-03.1 and 5160-28-3.3 is made under the prospective payment system (PPS)

Telehealth: OAC 5160-1-18



- Patient location is flexible and is reported through a modifier for certain settings
- No Distance Requirement between patient and practitioner site
- Practitioner location is flexible and is reported through a modifier for certain settings
- No originating site or patient site fee can be billed

Telehealth: OAC 5160-1-18

Expanded Practitioner type to include:

- Physician Assistant
- Clinical Nurse Specialist
- Certified Nurse Midwife
- Certified Nurse Practitioner
- Podiatrist
- Licensed Independent Behavioral Health Providers (LISW, LICDC, LIMFT, LPCC) and supervised practitioners
- Skilled therapists: OT, PT, SLP, Aud
- Dentist
- Optometrist
- Dietitian
- Pharmacists

Telehealth: OAC 5160-1-18

Practitioner Locations include:

- No restriction on practitioners
- If patient is not *active* or practice is not a CPC practice, practitioner location must be office

If receiving telehealth services for 12 consecutive months, at least one in person exam or assessment of the patient is required

- This could be provided by the telehealth provider, the patient's usual source of care, or the telehealth provider could refer the patient to another practitioner

Telehealth Billing Guidelines

- As set forth in rule 5160-1-18, for a covered telehealth service that is also an FQHC or RHC service, the face-to-face requirement is waived and payment is made in accordance with Chapter 5160-28 of the Administrative Code

- Medical nutrition therapy and lactation services rendered by eligible FQHC and RHC practitioners will be paid under the PPS

  - When these services are rendered by a practitioner not listed in Chapter 5160-28 of the Administrative Code, these services shall be paid through FFS under the clinic provider type 50

Telehealth Billing Guidelines

- Remote patient monitoring will be paid through FFS as a covered non-FQHC/RHC service under the clinic provider type 50
- Group therapy will continue to be paid through FFS as a covered non-FQHC/RHC service under the clinic provider type 50
- Services under the Specialized Recovery Services (SRS) program are not currently covered FQHC or RHC services

Telehealth Billing Guidelines

- When the FQHC or RHC is billing as the practitioner site:

  - The T1015 encounter code must be reported in the first detail line of the claim with the appropriate U modifier indicating the type of visit
  - The next detail line reported on the claim must be the service (procedure code) provided via telehealth
    - Modifier GT must be reported with the procedure code in addition to any other required modifiers
      - If there is more than one modifier, the GT modifier should be reported first
  - The place of service code reported on the claim must reflect the physical location of the practitioner

MAL No. 645 Payment for Laboratory Services

Seven laboratory tests and services for which payment is made under the PPS:

Venipuncture
Chemical examination of urine by stick or tablet method or both
Hematocrit or hemoglobin analysis
Blood sugar analysis
Examination of stool specimens for occult blood
Pregnancy test
Primary culturing for transmittal to a certified laboratory

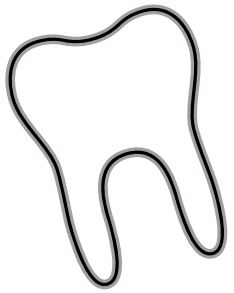
Payment for all other laboratory services must be made outside of the PPS and paid off the fee schedule

- Reported as laboratory services performed by an independent laboratory (PT 80), or
- Reported under the FQHC/RHC clinic (PT 50)

MAL No. 651 Payment for the Application of Topical Fluoride Varnish

- Payment for topical fluoride varnish is made separately outside of the PPS when a non-dental practitioner applies topical fluoride varnish at a FQHC or RHC
  - Reported under the FQHC/RHC clinic provider number (PT 50)
  - Reported on a claim using CPT code 99188

- Payment for topical fluoride varnish furnished by dental practitioners will continue to be made under the PPS:
  - Reported on claims using ADA dental code D1206



MAL No. 653 Payment for Covered Pharmacists' Services

Effective ***1/17/2021*** ODM began covering pharmacists' services in accordance with rule 5160-8-52

Covered pharmacists' services provided by a FQHC or RHC will be treated as medical services under the PPS

MAL No. 655 Payment for Vaccines

- Payment for a vaccine furnished by a FQHC or RHC is paid under the PPS unless it is part of a mass immunization
- On a claim the office visit code 99211 or the appropriate vaccine administration code, plus the vaccine itself may be reported
- The practitioner administering the vaccine should be reported as the rendering provider
  - The exception is if a RN furnished the vaccine, the supervising/overseeing medical practitioner should be reported as the rendering on the claim
- Payment for a vaccine done as part of a mass immunization is made outside of the PPS
  - Reported under the FQHC or RHC clinic provider number (PT 50)

MAL No. 658 Payment for the Completion and Submission of the Report of Pregnancy (ROP) and Pregnancy Risk Assessment (PRAF)

Coverage policy for ROP and PRAF is set forth in 5160-21-04

- Payment may be made for one ROP that is diagnosed in conjunction with an E&M service not associated with a normal obstetrics/gynecology visit
  - Can be submitted on form ODM 10257, ROP, or its web-based equivalent located here: https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/special-programs-and-initiatives/praf/praf
- PRAF may be used to screen an individual for medical and social factors that may place the individual at risk for preterm birth or other poor pregnancy outcomes
  - Payment may be made for one assessment and can be submitted on form ODM 1027 PRAF or its web- based equivalent found here:

  https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/special-programs-and-initiatives/praf/praf

Payment for the ROP and PRAF is made outside of the PPS and should be reported under the FQHC or RHC clinic number (PT 50)

MAL No. 660 Payment for FFS Claims for Electronic PRAF (e-PRAF)

- Changes made to Medicaid payment rule 5160-1-60 effective ***7/1/2021***
- Increased the rate for electronic submission from $12.10 to $90.00
- Instead of using modifier TH, providers should now use modifier 33 for e-PRAFs
- Corrected coding guidance = H1000 + 33 modifier
- Be sure to adjust any FFS claims for e-PRAFS with dates of service 7/1/2021 or later with the correct modifier to be sure to receive the correct reimbursement rate

Qualified Entity Requirements and Responsibilities for Determining Presumptive Eligibility

OAC 5160-1-17.12 effective ***11/9/2019***

To become a Qualifying Entity (QE) a facility must:

- Have an active provider agreement
- Read the presumptive eligibility training guide found on ODM's website
- Attest that it will meet the terms and conditions as a QE by reading, signing, and sending form ODM 10252

Qualified Entity Requirements and Responsibilities for Determining Presumptive Eligibility

Once designated as a QE, a facility must:

- Remain in good standing as an ODM provider
- Follow OAC 5160:1-2-13 & all applicable federal & state laws when determining Medicaid PE
- Verify the individual is not already enrolled
- Without compensation, agree to perform all of the administrative functions associated with PE

Qualified Entity Requirements and Responsibilities for Determining Presumptive Eligibility

Guidelines to remain a QE:

- If the QE is a FQHC and is able to do so, provide thirty-six hours' worth of medically necessary medications to any person enrolled presumptively by the QE at the time of determination if such needs are determined during a medical visit

- At least eighty-five percent of all persons enrolled presumptively by the QE have completed application for full Medicaid

- At least eighty-five of individuals completing application for full Medicaid result in an awarding of Medicaid eligibility

Ambulatory Health Care Clinic (AHCC) – PT 50

FQHCs/RHCs may use a second Medicaid provider number to submit claims for non-FQHC/RHC services and will be paid based on the fee schedule

Examples of AHCC services:

- Inpatient hospital surgery, visits, or consultations
- Medicare crossover claims
- Durable Medical Equipment
- Group Therapy Services
- Chronic Care Management
- Take home drugs billed through pharmacy program per OAC 5160-9
- Medical nutrition therapy services when rendered by a registered dietitian
- Acupuncture when rendered by an acupuncturist

PT 50 is only used for an FQHC or RHC to submit claims for covered non-PPS services furnished to individuals not enrolled in a MCO

Cost-based Clinic: Definitions and Explanations

OAC 5160-28-01

(P)(2) Multiple encounters with one or multiple health professionals constitute a **single visit** if all of the following conditions are satisfied:

(a) All encounters take place on the same day

(b) All contact involves a single cost-based clinic service; and

(c) The service rendered is for a single purpose, illness, injury, condition, or complaint

(3) Multiple encounters constitute **separate visits** if one of the following conditions is satisfied:

(a) The encounters involve different cost-based clinic services; or

(b) the services rendered are for different purposes, illnesses, conditions, or complaints or for additional diagnosis and treatment

Cost-based Clinic: Submission and Payment of FQHC Claims

OAC 5160-28-08.1

(A) Claims for services provided to managed care plan (MCP) enrollees, including requests for prior authorization by an MCP of a FQHC service, must be submitted in accordance with Chapter 5160-26 of the Administrative Code

(B) In claims submitted to the department for all other services, an FQHC must include the following data:

(1) procedure code for an encounter;

(2) appropriate modifier to specify the FQHC service; and

(3) additional codes representing all procedures performed during the encounter, along with any required modifiers

Cost-based Clinic: Submission and Payment of FQHC Claims

(C) In claims submitted to the department for supplemental (wraparound) payment for services provided to an MCP enrollee, an FQHC must also include the following data:

(1) The name of the MCP that paid for the FQHC service;
(2) The identification code of the MCP, assigned by the department;
(3) The MCP payment plus amounts received from any other third-party payers; and
(4) Any other information, such as an adjustment reason code, that is necessary for the coordination of benefits

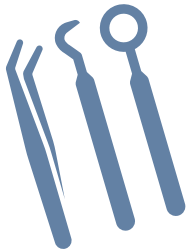
Dental Services: OAC 5160-5-01

Some dental services require tooth or quadrant number distinction (extractions, crowns, scaling & planning etc.)

There is no way to notate this information on the professional claim form

FQHCs and RHCs **cannot** use the tooth or quadrant number fields on the prior authorization (PA)

- This information should be entered in the ‘Provider Notes’ section
- You should also enter a comment stating you are a FQHC or RHC



Acupuncture Services: OAC 5160-8-51

Providers eligible to receive payment for acupuncture:

- An acupuncturist
- A recognized acupuncture provider
- Ambulatory health care clinic as defined in OAC 5160-13
- FQHCs and RHCs
- Professional medical group

- FQHCs and RHCs will receive their PVPA for services rendered by a physician or chiropractor

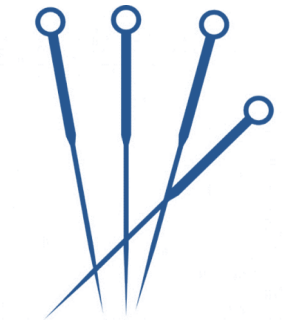
- Acupuncture services furnished by an acupuncturist are paid as a covered non-PPS services under a FQHC or RHC's PT 50

Acupuncture Services: OAC 5160-8-51

Payment may be made for service that meets the following:

- Is medically necessary per OAC 5160-1-01
- Is performed at the written order of a practitioner, during the one-year supervisory period, per section 4762.10 or 4762.11 of the Ohio Revised Code (ORC)
- Is rendered by a practitioner who is enrolled in the Medicaid program
- Is rendered for treatment of:
  - Low back pain
  - Migraine

Payment for more than 30 visits per benefit year requires PA



Acupuncture Services: OAC 5160-8-51

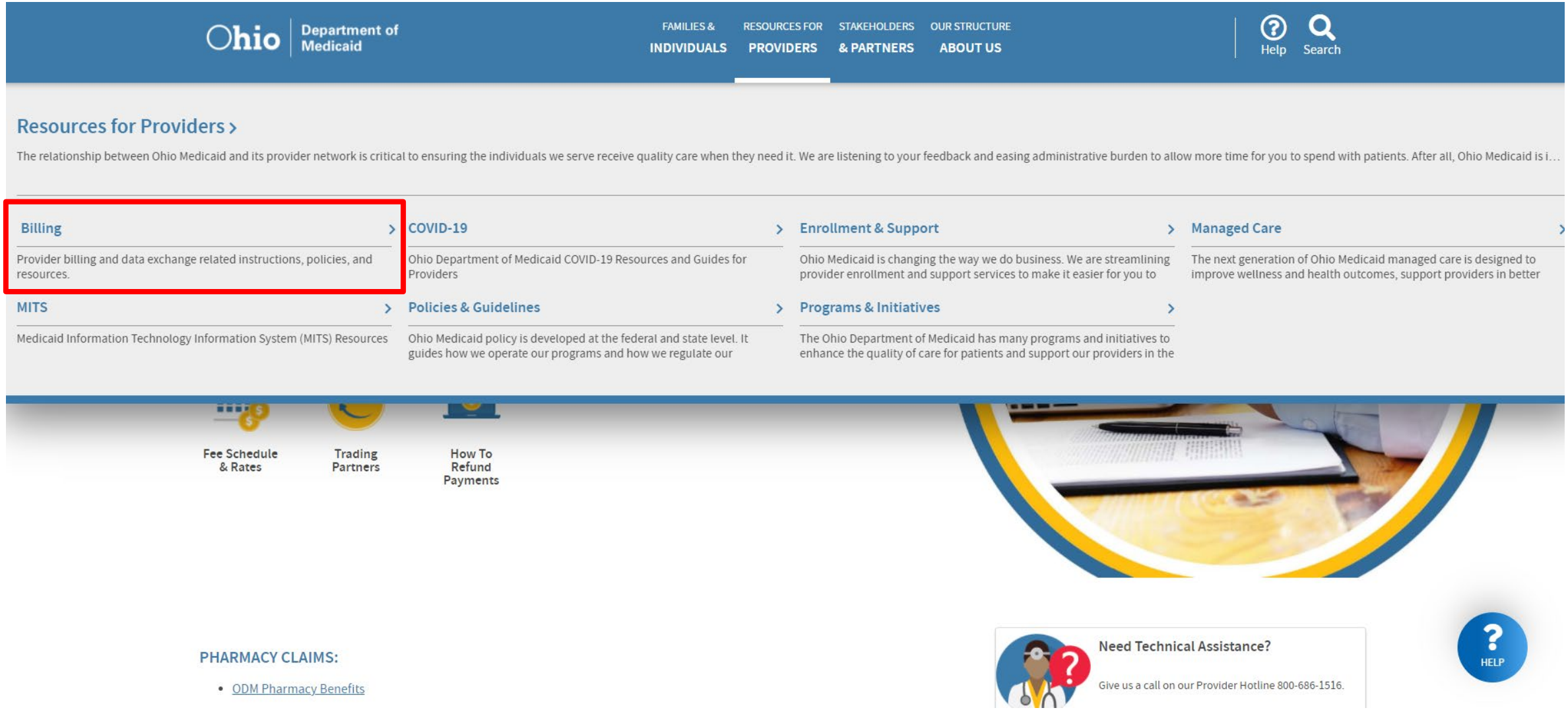
No separate payment will be made for both an E&M service and acupuncture service rendered by the same provider to the same individual on the same day

No separate payment is made for:

- Services that are an incidental part of a visit (e.g., providing instruction on breathing techniques, diet, or exercise)
- Additional treatment in either of the following circumstances:
  - Symptoms show no evidence of clinical improvement after an initial treatment period
  - Symptoms worsen over a course of treatment

MITS & Claim Submissions

Billing Resources



Medicaid Information Technology System (MITS)

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

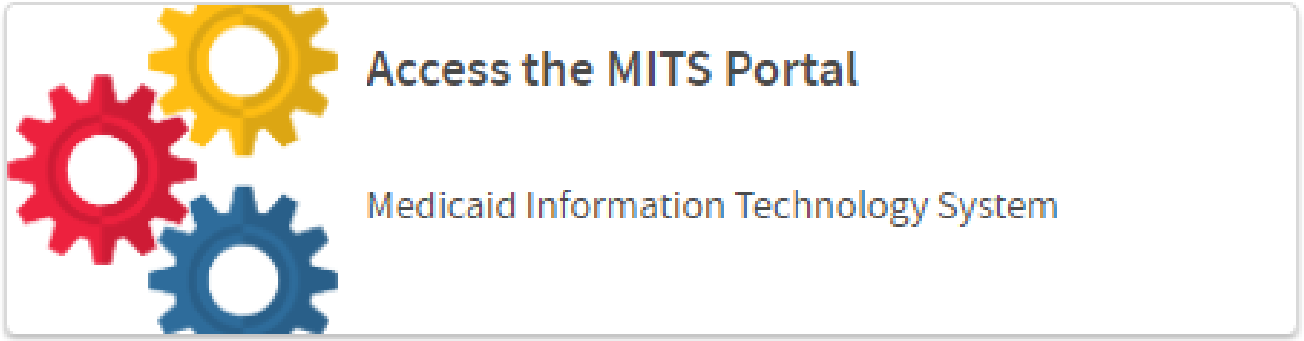
MITS is available to all Ohio Medicaid providers who have been registered and have created an account

MITS is able to process transactions in “real time”

MITS Provider Portals

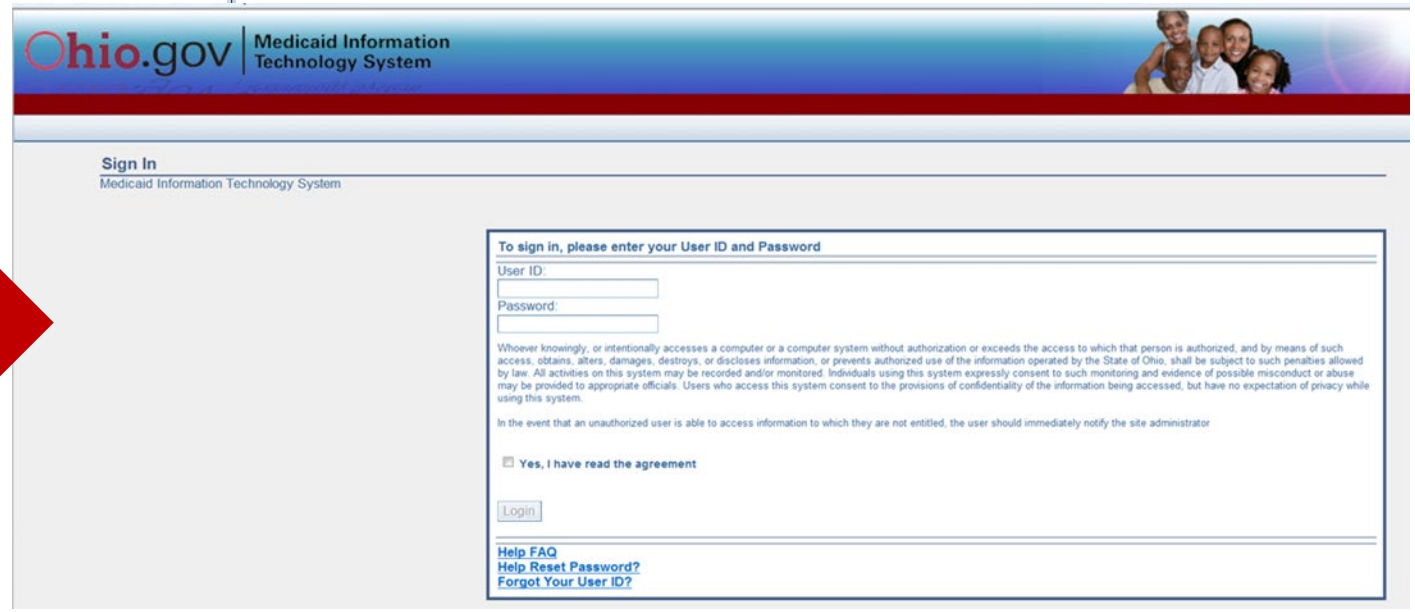
How do I access the MITS Portal?

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



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

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



MITS Navigation

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

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

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

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

Electronic Data Interchange (EDI)

Fees for claims submitted

Claims must be received by Wednesday at Noon for that week's adjudication

MITS Portal

Free submission

Claims must be received by Friday at 5:00 P.M. for that week's adjudication

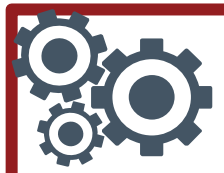
We can help with your claim submission issues!

Technical Questions/EDI Support Unit

Trading partners contact DXC for EDI Support

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

MITS Secure Provider Portal Claim Submission



Claim entry format is divided into sections or panels

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

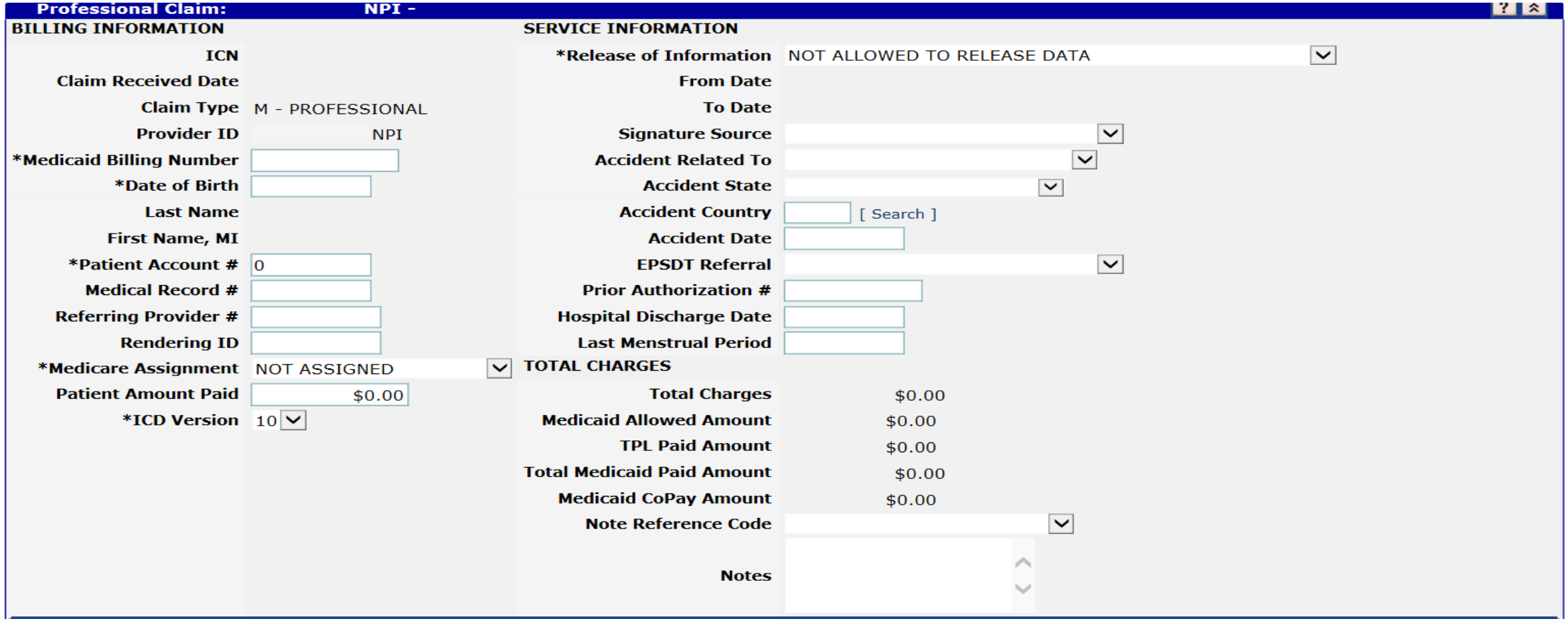
*Some fields are situational for claims adjudication and do not have an asterisk

Submission of a Professional Claim

Once logged into the MITS Secure Provider Portal, click on the Claims tab, then click Professional

Submission of a Professional Claim

Complete the appropriate billing and service information



MAL No. 626-A Diagnosis Code Reporting Required on Claims

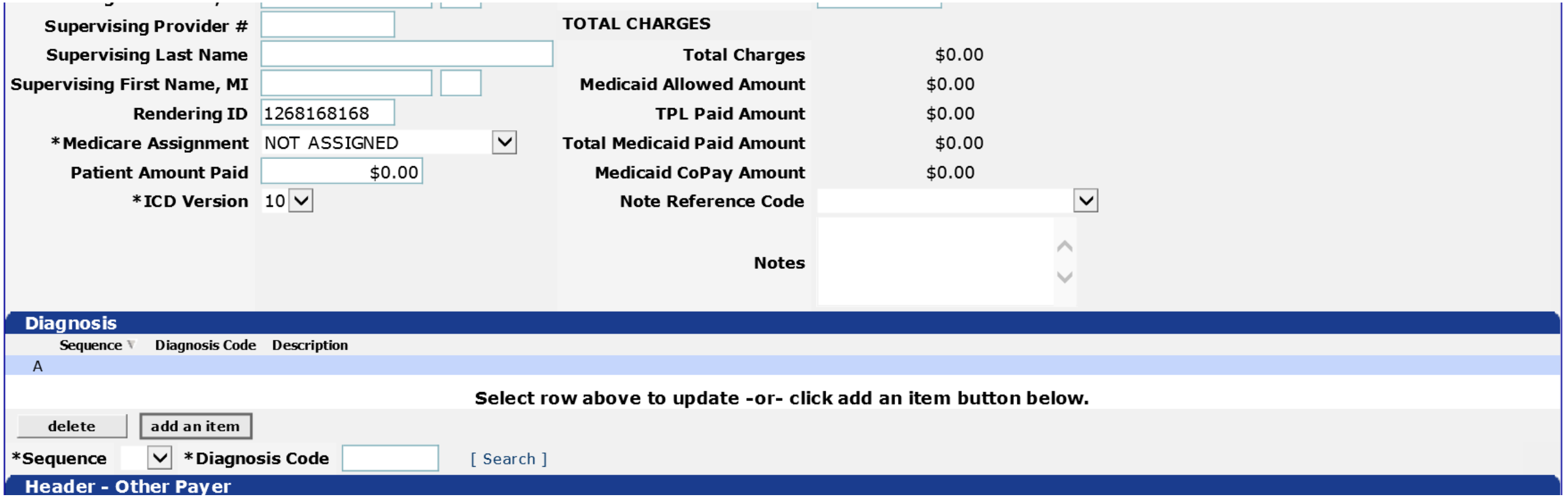
Effective ***1/1/2020***

To comply with current HIPAA standards, diagnosis codes must be reported for all Medicaid covered services

Professional claim form only

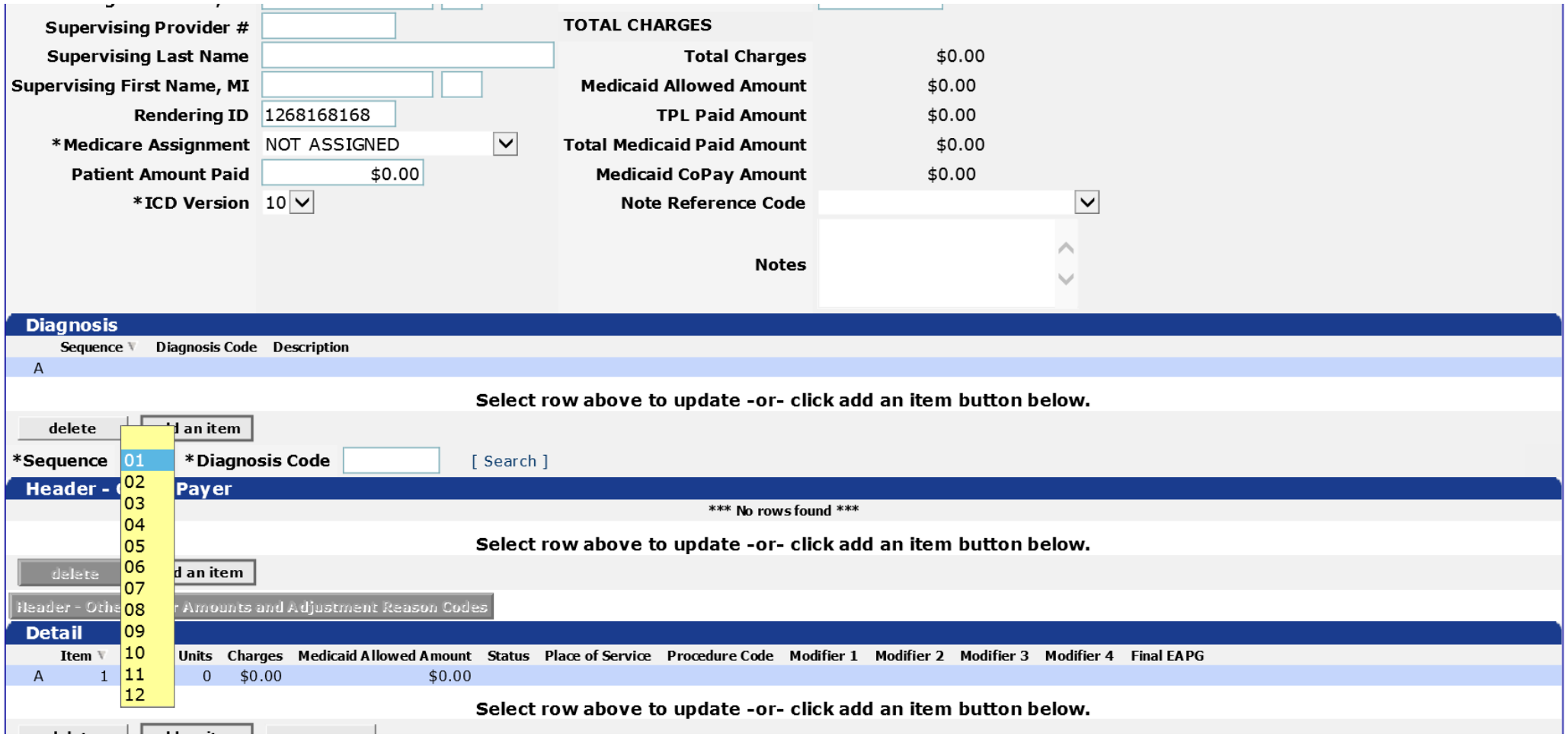
Entering a Diagnosis Code

Enter all diagnosis codes in the diagnosis panel



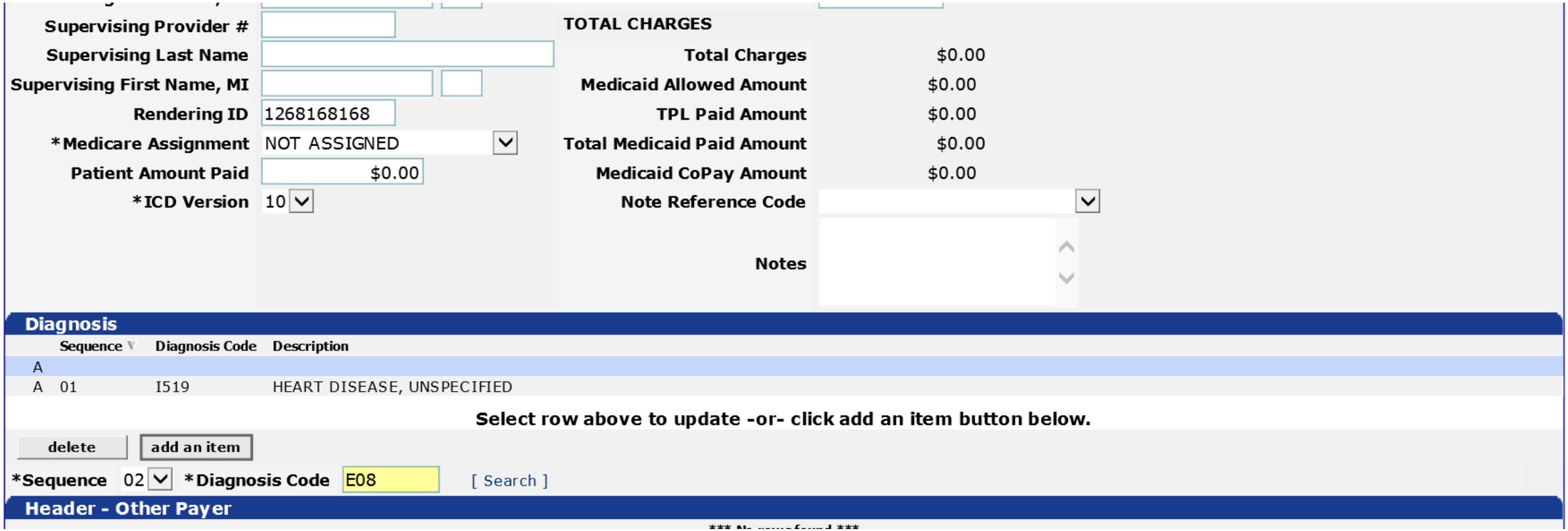
Entering a Diagnosis Code

Select sequence ‘01’ then enter in the diagnosis code with **no** decimal



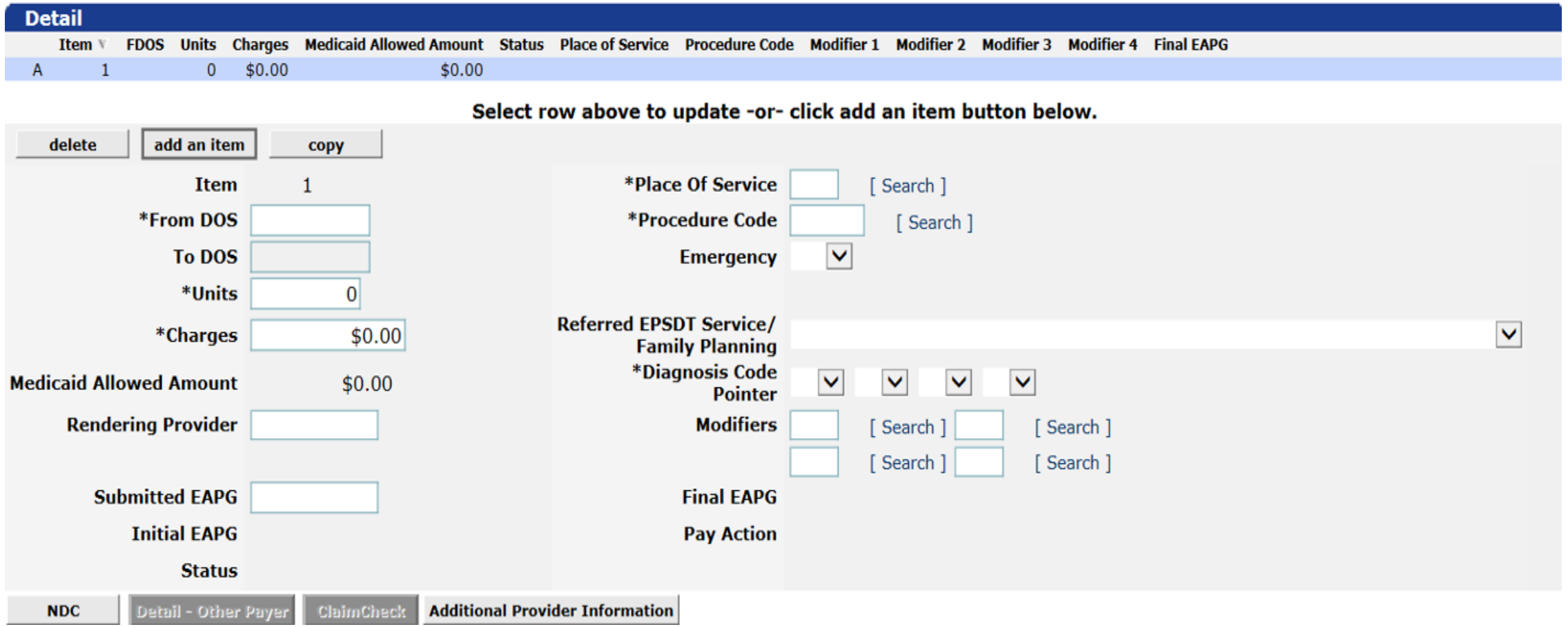
Entering a Diagnosis Code

Once the information is entered, click the blue line to save the information, then click ‘add an item’ to enter the next diagnosis



Completing the Detail Panel

Enter the first detail line information, click the blue line to save, then select ‘add an item’ to enter the second detail line, continuing as needed



Completing the Detail Panel

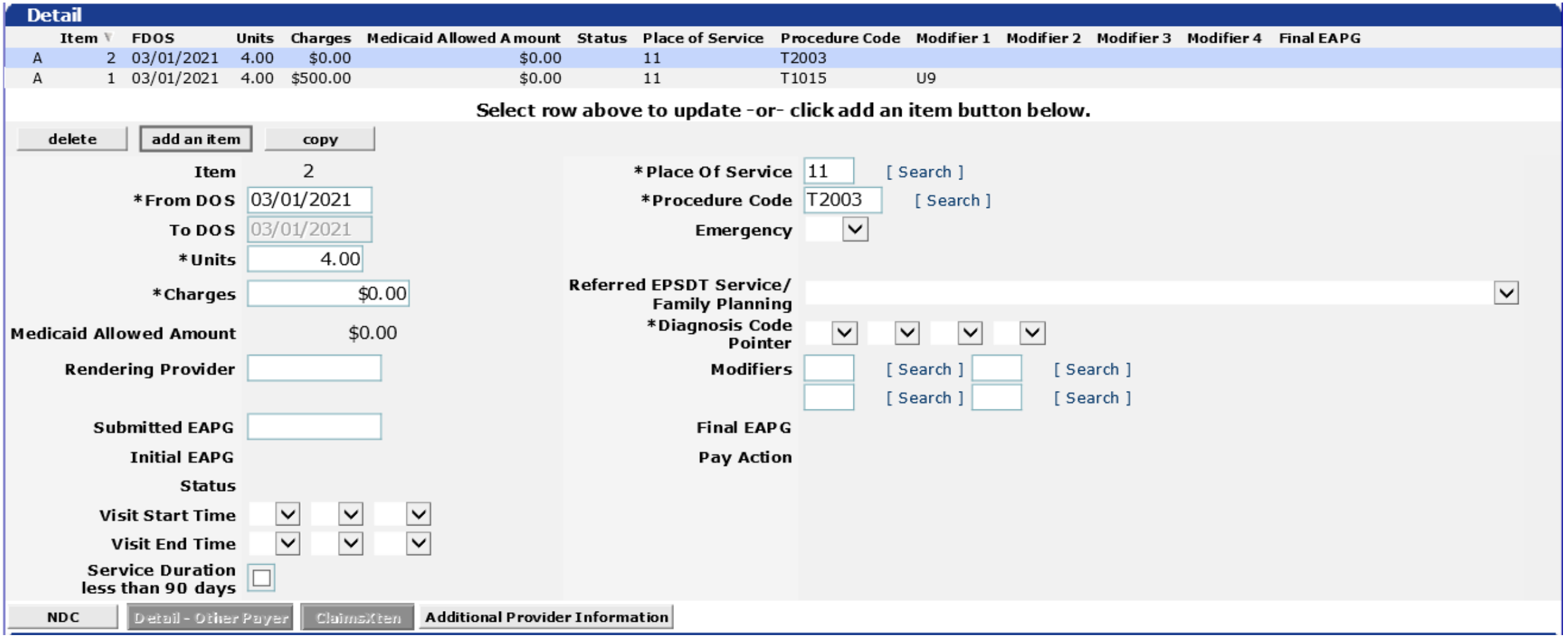
Encounter code T1015 and modifiers

- **U1** – Medical
- **U2** – Dental
- **U3** – Mental Health
- **U4** – PT or OT Services
- **U5** – Speech Pathology
- **U6** - Podiatry
- **U7** - Vision
- **U8** - Chiropractic
- **U9** - Transportation

RHCs can only use modifier U1. They should use it for both medical and mental health services.

Use T1015 with the U1 modifier and procedure code 99406 or 99407 for smoking cessation.

Detail Panel – Transportation Claim Example



Detail

	Item	FDOS	Units	Charges	Medicaid Allowed Amount	Status	Place of Service	Procedure Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Final EAPG
A	2	03/01/2021	4.00	$0.00	$0.00		11	T2003					
A	1	03/01/2021	4.00	$500.00	$0.00		11	T1015	U9				

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

delete | add an item | copy

Item 2

*From DOS 03/01/2021

To DOS 03/01/2021

*Units 4.00

*Charges $0.00

Medicaid Allowed Amount $0.00

Rendering Provider

Submitted EAPG

Initial EAPG

Status

Visit Start Time

Visit End Time

Service Duration less than 90 days

*Place Of Service 11 [Search]

*Procedure Code T2003 [Search]

Emergency

Referred EPSDT Service/ Family Planning

*Diagnosis Code Pointer

Modifiers [Search] [Search] [Search] [Search]

Final EAPG

Pay Action

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

Behavioral Health Service Claims

Mental health services rendered by a psychiatrist

- T1015 with U1 modifier

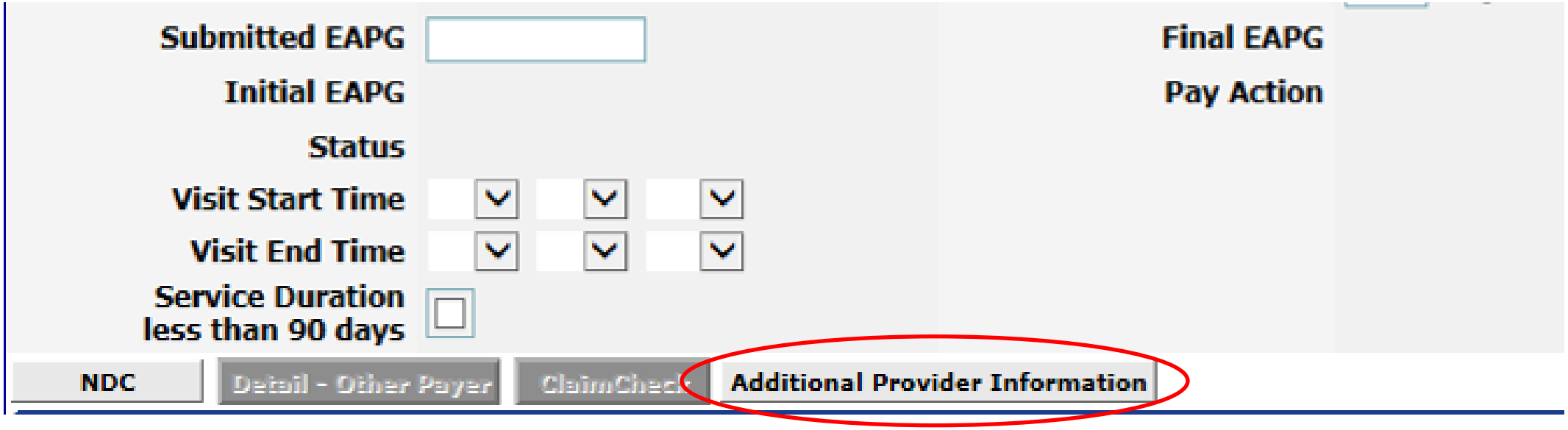
Other licensed practitioners rendering the service

- T1015 with U3 modifier

Trainees and non-licensed practitioners rendering service at a FQHC/RHC must be reported under the overseeing practitioner's NPI

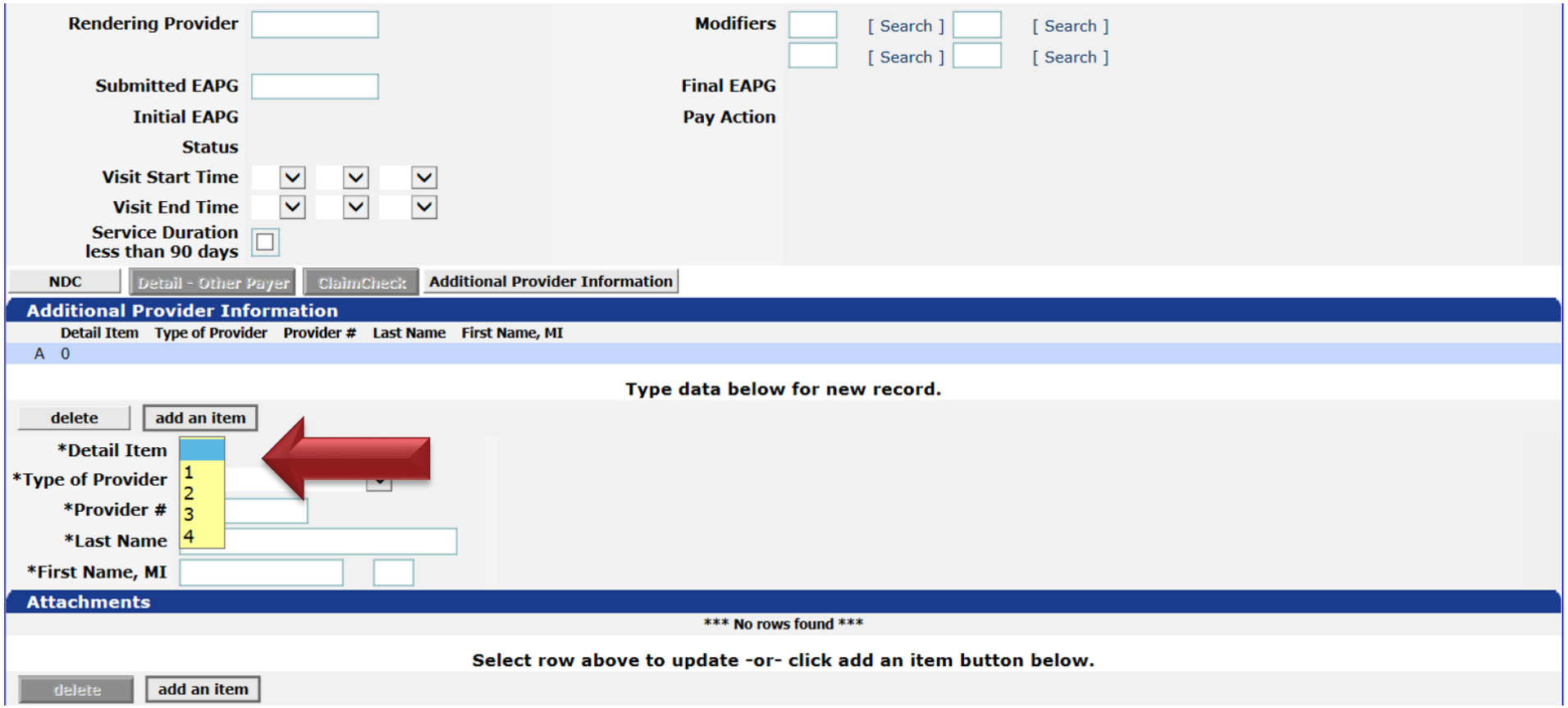
Entering the ORP's Information

At the bottom of the detail panel, click the 'Additional Provider Information' button, to open the additional provider information panel



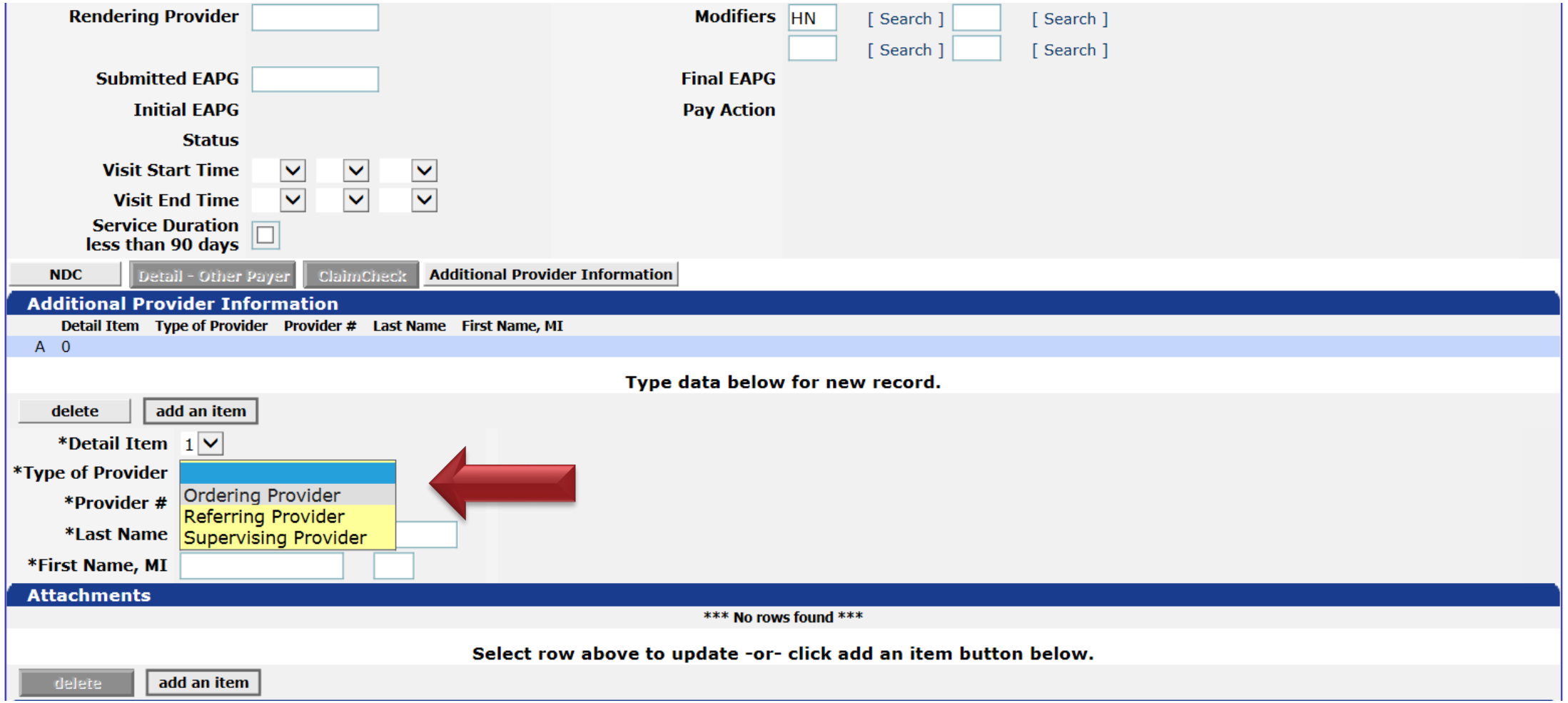
Entering the ORP's Information

Select the appropriate detail item number – the number you select points to that specific detail line above



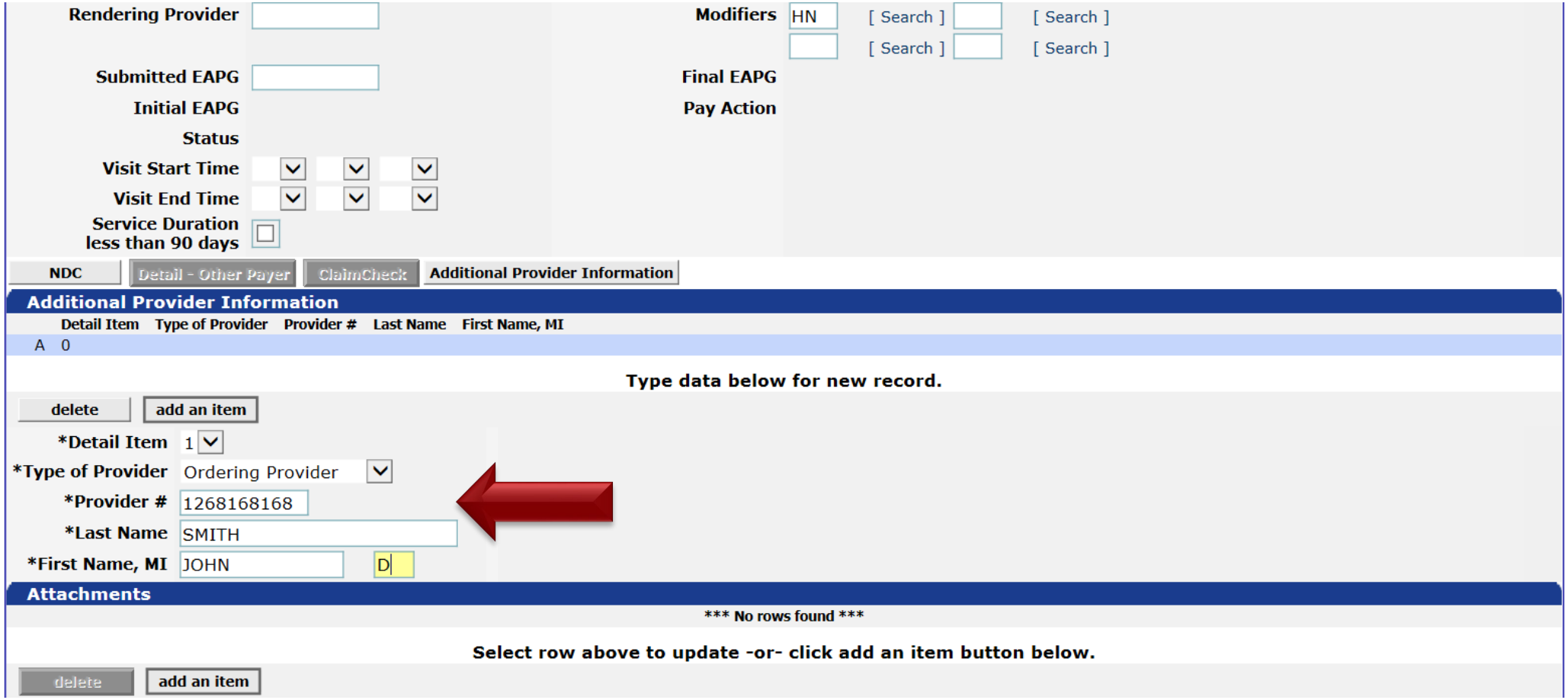
Entering the ORP's Information

Click on the drop down and select the appropriate type of ORP



Entering the ORP's Information

Enter the ORP's information – be sure to complete an ORP search first as you must enter his/her information exactly how it is found in MITS



Dental Services Delivered at FQHCs

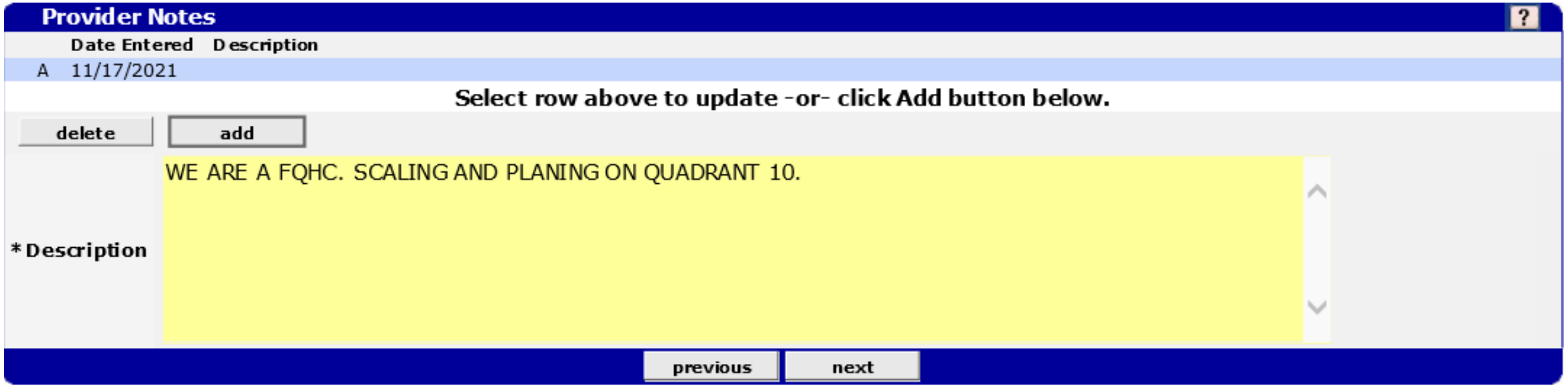
Services requiring prior authorization

- Do **not** enter tooth number or quadrant number in the Line Item Panel on the PA
  - Enter one line with the total number of units for the same procedure code, not multiple lines

- Utilize the Provider Notes panel on the PA
  - Keep your comments short & to the point
  - First sentence should be “We are a FQHC.”
  - Next list the service with identifiers, e.g., “Crowns on #23 & 25”

Dental Services Delivered at FQHCs

Here is an example of how you should enter notes on a PA for dental services



Wraparound Payments

An amount equal to the MCO payment gap that is paid by the department to augment the MCO payment

May only submit a wraparound claim for services that would have been paid to the FQHC or RHC under the PPS payment method

Covered non-PPS services are paid FFS and not eligible for wraparound payments

Wraparound Payment Claim Example

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		$200.00	10/01/2021	87726

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

delete | add an item

*Claim Filing Indicator	HMO	*Insurance Carrier Name	UNITED HEALTHCARE
*Policy Holder Relationship to Insured	SELF	*Electronic Payer ID	87726
*Policy Holder Last Name	SMITH	Insured's Policy ID	
*Policy Holder First Name, MI	JOHN A	*Payer Sequence	PRIMARY
Policy Holder Date of Birth	01/01/1950	Medicare ICN	
Gender	MALE		
*Paid Amount	$200.00		
*Paid Date	10/01/2021		
Allowed Amount	$0.00		

Header - Other Payer Amounts and Adjustment Reason Codes

Header - Other Payer Amounts and Adjustment Reason Codes

	Electronic Payer ID	CAS Group Code	ARC	Amount
A	87726	CO-Contractual Obligations	45	$50.00

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	87726
*CAS Group Code	CO-Contractual Obligations
*ARC	45
*Amount	$50.00

Wraparound Payment Claim Example

Detail

	Item	FDOS	Units	Charges	Medicaid Allowed Amount	Status	Place of Service	Procedure Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Final EAPG
A	2	09/25/2021	0.00	$0.00	$0.00		11	99214					
A	1	09/25/2021	1.00	$0.00	$0.00		11	T1015	U1				

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

delete | add an item | copy

Item	1	*Place Of Service	11 [Search]
*From DOS	09/25/2021	*Procedure Code	T1015 [Search]
To DOS	09/25/2021	Emergency	
*Units	1.00		
*Charges	$0.00	Referred EPSDT Service/ Family Planning	
Medicaid Allowed Amount	$0.00	*Diagnosis Code Pointer	01
Rendering Provider	1234567890	Modifiers	U1 [Search] [Search] [Search] [Search]
Submitted EAPG		Final EAPG	
Initial EAPG		Pay Action	
Status			
Visit Start Time			
Visit End Time			
Service Duration less than 90 days	☐		

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

Medicare Wraparound Claim

When Medicare is the primary payer:

- FQHCs should seek the wraparound payment from Medicare, not Medicaid
  - This includes when an individual has a MyCare Ohio plan
  - FQHCs can claim Medicare wraparound payments from the appropriate Medicare Administrative Contractor in the same manner they would for individuals enrolled in Medicare Advantage

Medicare Wraparound Claim/Medicaid Cost Sharing

When applicable ODM or the MCO will pay cost-sharing after Medicare pays

- ODM Cost-sharing is covered in OAC 5160-1 (Coordination of Benefits)
- For MCOs consult your contract with each one for the specific details

Claims with Other Payers

- 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

Coordination of Benefits for PPS Services

Medicaid fee-for-service (FFS), *no Medicare coverage*

For each NMMTP (Non-Medicare/-Medicaid third party) payer, the NMMTP payment is applied and the NMMTP policyholder liability amount is calculated

ODM pays the lesser of two figures:

- The Medicaid PVPA (per-visit payment amount) less the sum of all NMMTP payments; or

- The sum of all NMMTP policyholder liability amounts

Coordination of Benefits for PPS Services

Medicaid fee-for-service (FFS), *traditional Medicare*

For each NMMTP payer, the NMMTP payment is applied and the NMMTP policyholder liability amount is calculated

Medicare pays the lesser of two figures:

- The Medicare PPS/AIR (all-inclusive rate) covered amount less the sum of all NMMTP payments; or
- The sum of all NMMTP policyholder liability amounts

ODM pays any applicable Medicare cost-sharing

Coordination of Benefits for PPS Services

Medicaid fee-for-service (FFS), *Medicare Advantage Plan (MAP)*

For each NMMTP payer, the NMMTP payment is applied and the NMMTP policyholder liability amount is calculated

The MAP pays the lesser of two figures:

- The MAP allowed amount less the sum of all NMMTP payments; or
- The sum of all NMMTP policyholder liability amounts

Coordination of Benefits for PPS Services

Medicaid fee-for-service (FFS), *Medicare Advantage Plan (MAP)*

The FQHC or RHC receives additional payment

- For an FQHC claim, the Medicare Administrative Contractor pays the Medicare wraparound payment amount
- For an RHC claim, any amount by which the sum of payments made by the NMMTP payers and by the MAP falls short of the Medicare AIR allowed amount is accounted for in the annual AIR cost reconciliation

ODM pays an applicable Medicare cost-sharing

Coordination of Benefits for PPS Services

Medicaid MCO, *no Medicare coverage*

For each NMMTP payer, the NMMTP payment is applied and the NMMTP policyholder liability amount is calculated

The MCO makes payment based on its contract with the provider. Generally, the MCO, pays the lesser of the following two amounts:

- The MCO contracted amount less the sum of all NMMTP payments; or
- The sum of all NMMTP policyholder liability amounts

ODM pays the Medicaid wraparound payment amount

Coordination of Benefits for PPS Services

MCOP opt-out membership *(coordination of Medicaid benefits only),* MCOP region

- There are no NMMTP payments (individuals with NMMTP coverage cannot currently enroll in MyCare Ohio)
- Medicare pays the Medicare PPS/AIR covered amount
- The MCOP pays the applicable Medicare cost-sharing amount

Coordination of Benefits for PPS Services

MCOP opt-in membership *(coordination of both Medicare and Medicaid benefits)*, MCOP region

- There are no NMMTP payments (individuals with NMMTP coverage cannot currently enroll in MyCare Ohio)

- The MCOP pays the MCOP contracted amount

Coordination of Benefits for PPS Services

MCOP opt-in membership *(coordination of both Medicare and Medicaid benefits)*, MCOP region

The FHQC or RHC receives addition payment determined by the Medicare PPS/AIR allowed amount

- For an FQHC claim, Medicare is responsible for the Medicare wraparound payment amount through the Medicare Administrative Contractor

- For an RHC claim, any difference obtained by subtracting the payment made the MCOP from Medicare AIR allowed amount is accounted for in the annual Medicare AIR cost reconciliation

The MCOP pays any applicable Medicare cost-sharing

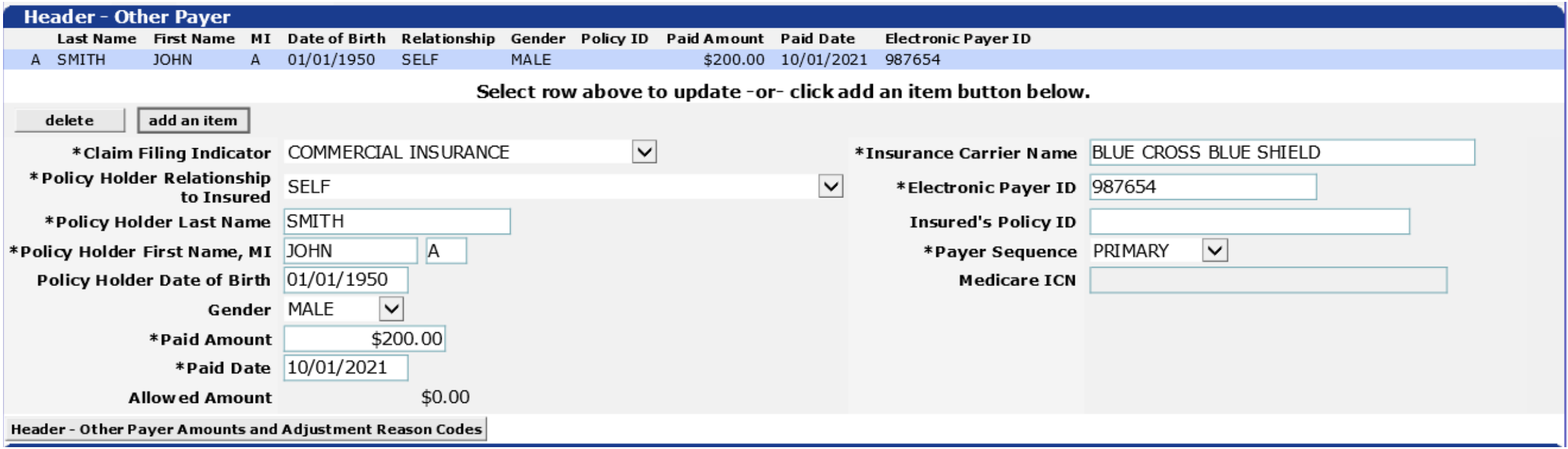
Coordination of Benefits for PPS Services

Services, such as dental treatment or vision care, that are not covered by Medicare and services rendered by a healthcare practitioner who is not eligible to participate in Medicare are handled by Medicaid as if the individual had no Medicare eligibility

- For such claims, an MCOP functions as a Medicaid MCO, and ODM may make a Medicaid wraparound payment

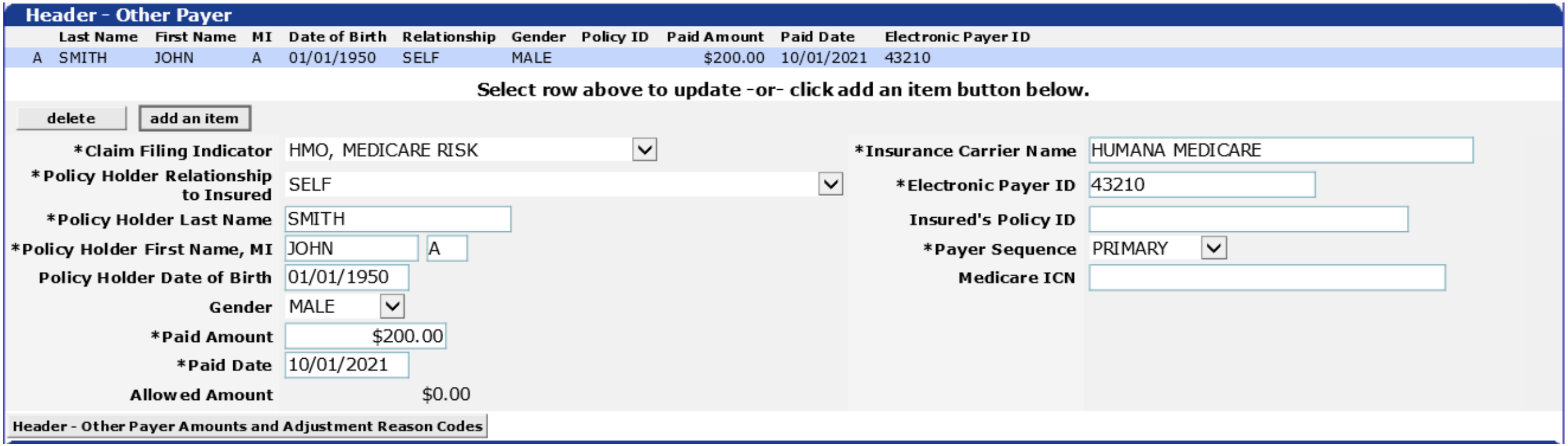
Claims with Other Payers

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



Claims with Other Payers

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



Claims with Other Payers

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

Claims with Other Payers

Header vs Detail

Header level

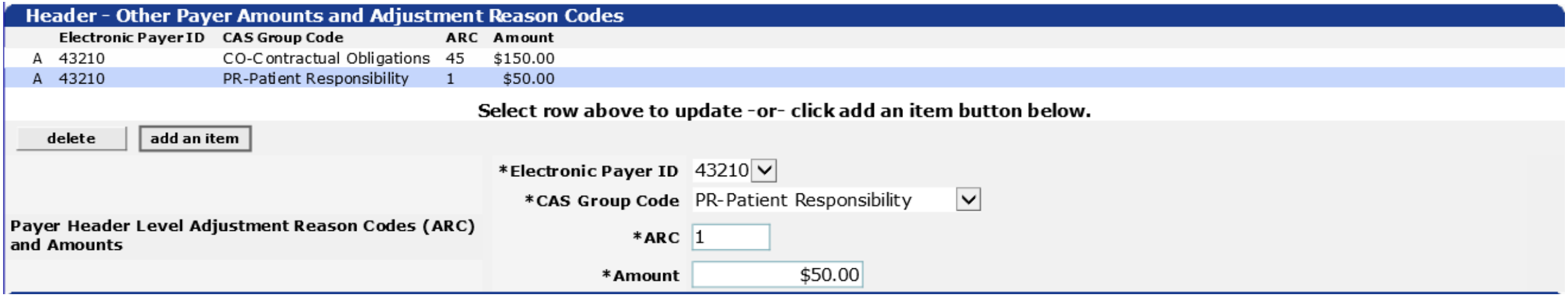
- A COB claim is considered to be adjudicated at the header/claim level if only one set of figures is reported for the entire claim

Detail level

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

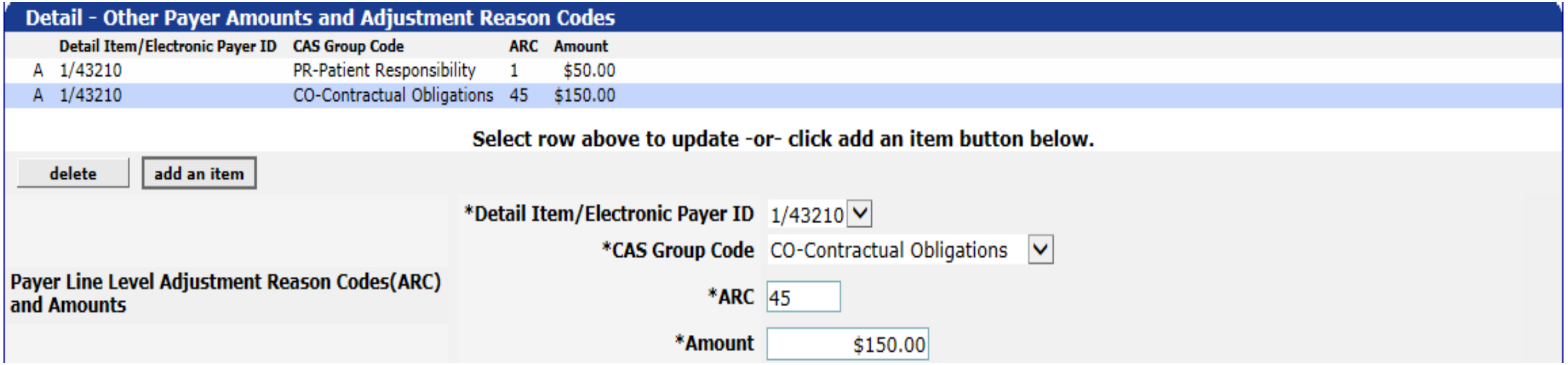
Claims with Other Payers

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



Claims with Other Payers

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



Claim Submission

Once all fields have been completed

- Click the “Submit” button to submit the claim
- You may “Cancel” the claim at anytime but the information will not be saved

Claim Submission

All claim submissions are assigned an ICN

2221170357321

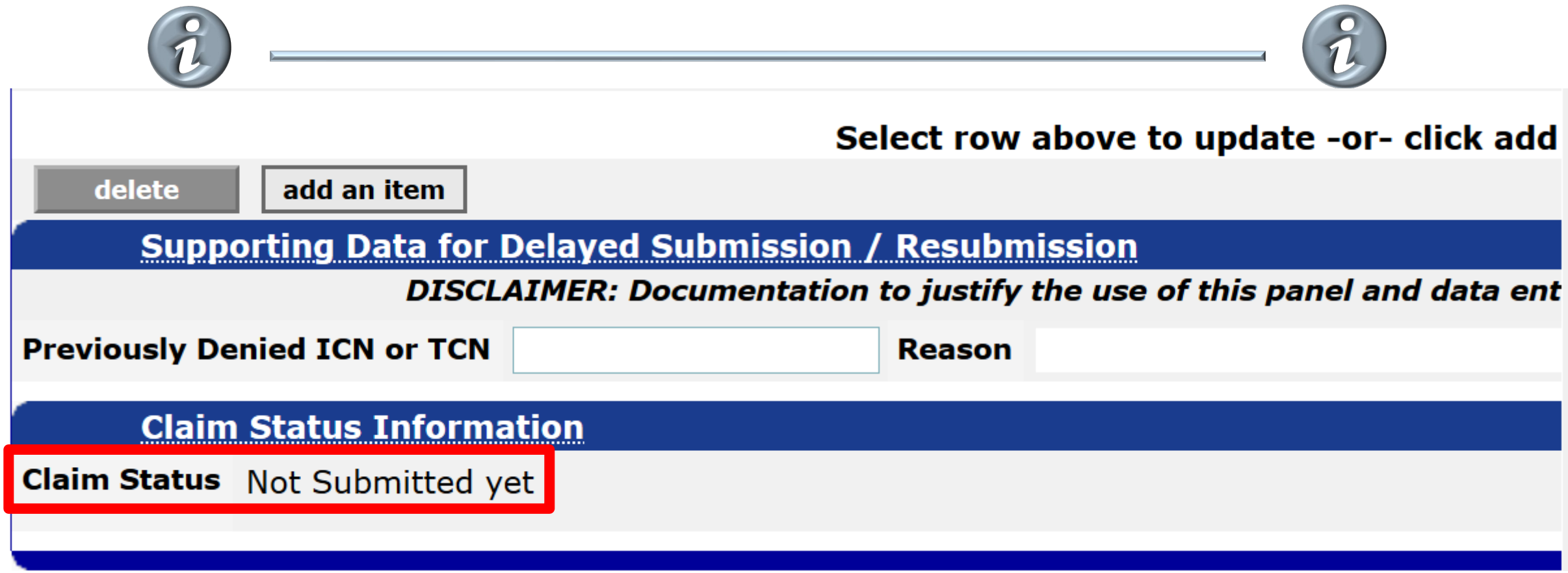
Region Code	Calendar Year	Julian Day	Claim Type/ Batch Number	Claim Number in Batch
22	21	170	357	321

Claim Submission

Adjudication happens in “real time”

- If there are no errors, the claim status will show:
- Paid
- Denied
- Suspended

Claim Portal Errors



Claim Portal Errors

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

Scroll to the top of the claim to see the errors

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.

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

Providers Have 365 Days to Submit FFS Claims

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

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

Providers Have 365 Days to Submit FFS Claims

Claims over 2 years old will be denied

There are exceptions to the 365 day rule

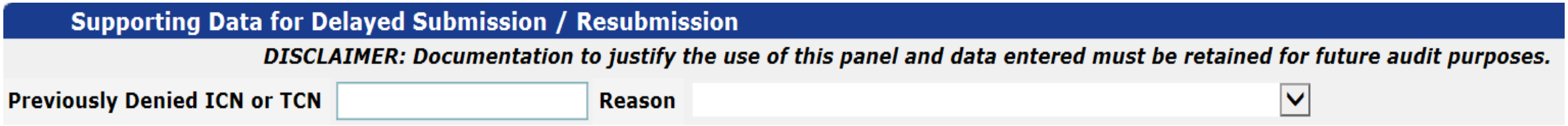
FQHCs & RHCs have 180 days from the MCO paid date to submit a wraparound claim

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

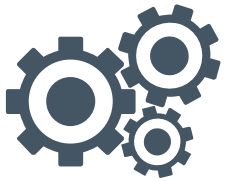
Enter the previously denied ICN and select “DELAYED SUBMISSION/RESUBMISSION” in the Reason drop down menu

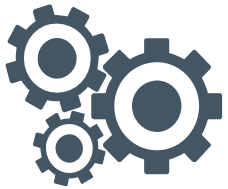
When done correctly, MITS will bypass timely filing edits



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 – Additional Information"

Special Billing Instructions – Eligibility Delay

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

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

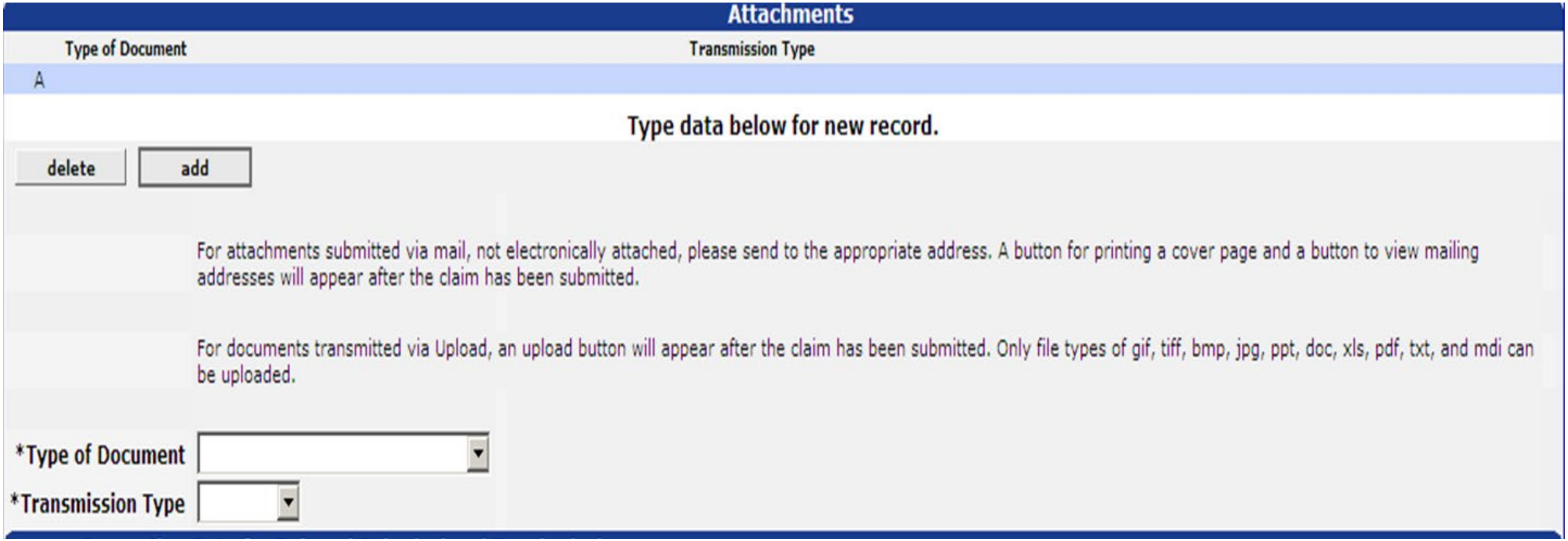
Eligibility Determination: DECISION CCYYMMDD

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

Must use the spacing shown

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

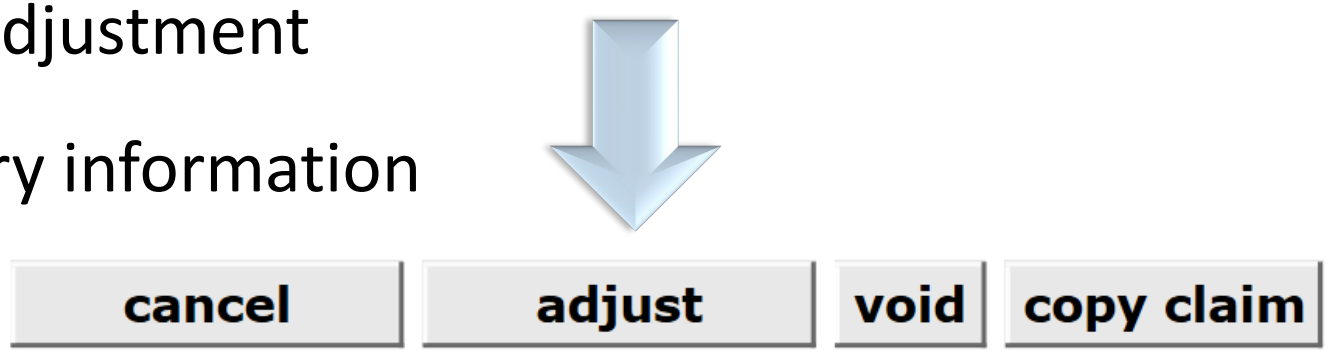
Each attachment must be <50 MB in size

Each file must pass an anti-virus scan in MITS

A maximum of 10 attachments may be uploaded

Adjusting a Paid Claim

1. Open the claim requiring an adjustment
2. Change and save the necessary information
3. Click the “adjust” button



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

Claim Adjustment Example

2221305000002 Originally paid $45.00

5821305000001 Now paid $50.00

Additional payment of $5.00

2021172234001 Originally paid $50.00

5021173127250 Now paid $45.00

Account receivable ($5.00)

Claim Adjustment Example

Original paid claim, prior to making appropriate changes and clicking adjust

Claim Status Information

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

EOB Information

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

cancel | adjust | void | copy claim

Claim Adjustment Example

The adjusted claim now has a new ICN, new status, and new paid amount

Claim Status Information

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

EOB Information

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

Adjustment Information

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

cancel | adjust | void | copy claim

Voiding a Paid Claim

1. Open the claim you wish to void
2. Click the “void” button at the bottom of the claim

The status is flagged as “non-adjustable” in MITS

An adjustment ICN is automatically created and given a status of “denied”

Voided Claim Example

2221305000001
5821305000001

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

Voided Claim Example

An adjusted paid claim, prior to clicking void

Claim Status Information

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

EOB Information

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

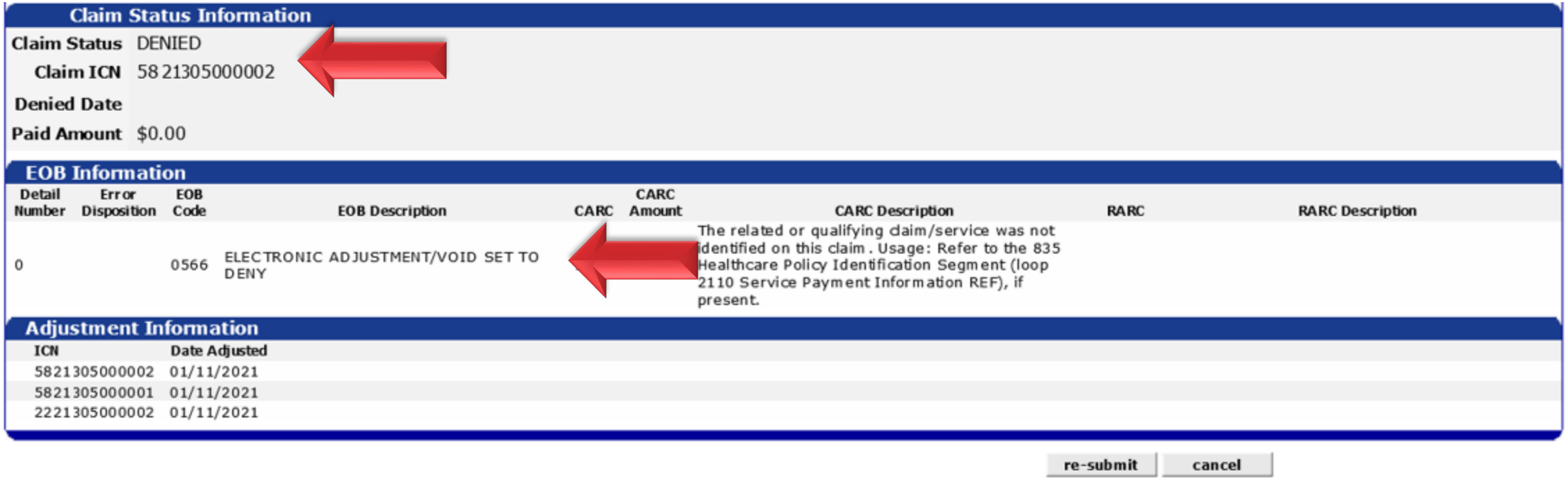
Adjustment Information

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

cancel | adjust | void | copy claim

Voided Claim Example

The voided claim is now in a denied status, with a new ICN, and with the appropriate EOB



Claim Status Information

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

EOB Information

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

Adjustment Information

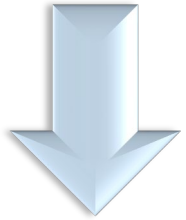
ICN	Date Adjusted
5821305000002	01/11/2021
5821305000001	01/11/2021
2221305000002	01/11/2021

re-submit cancel

Copying a Claim

1. Open the claim you wish to copy
2. Click the “copy claim” button at the bottom of the claim
3. A new duplicate claim will be created, make and save all necessary changes
4. The “submit” and “cancel” buttons will display at the bottom
5. Click the “submit” button

The claim will be assigned a new ICN



ClaimsXten

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

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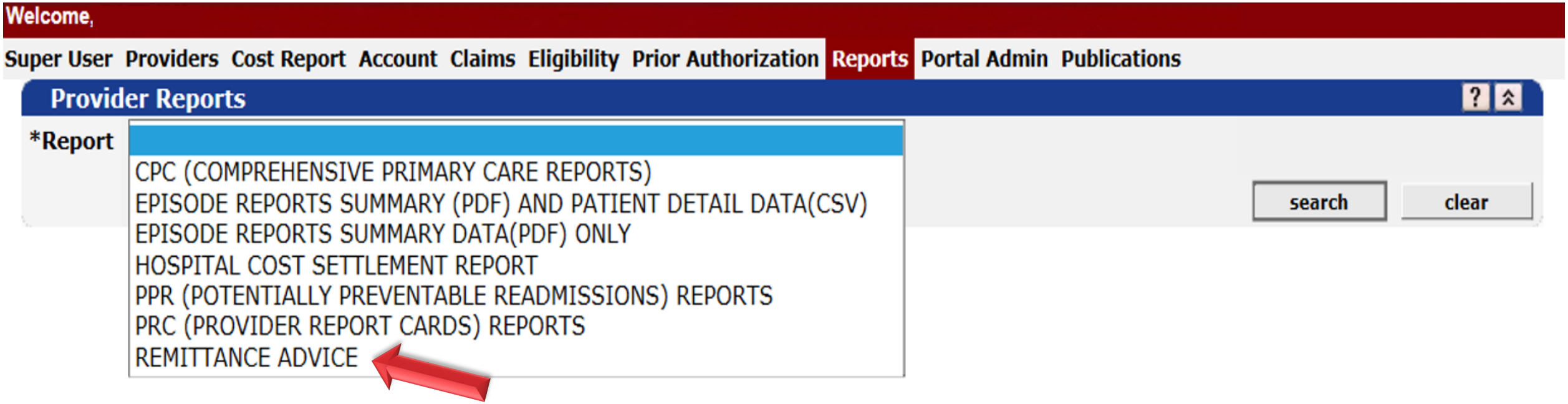
Remittance Advice (RA)

All claims processed are available on the MITS Portal

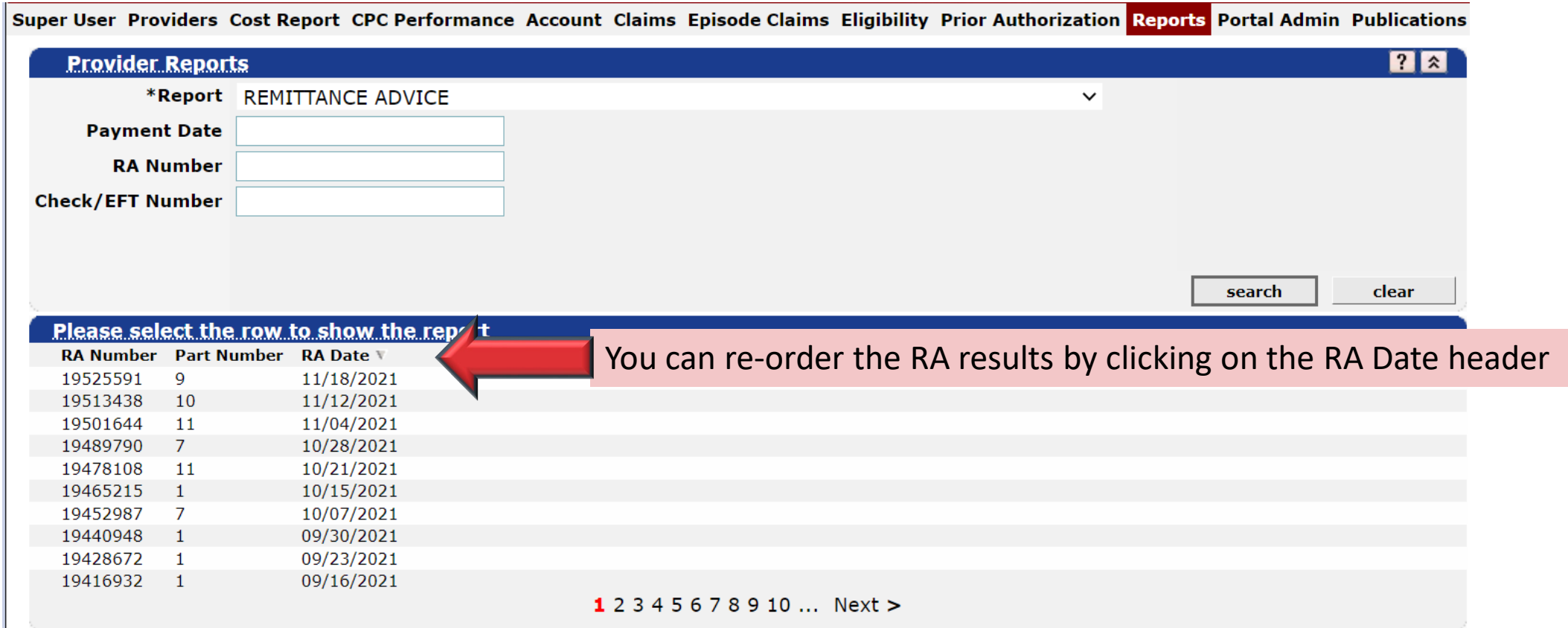
Weekly reports become available on Wednesdays



Remittance Advice (RA)

Select “Remittance Advice” and click “Search”

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



Remittance Advice (RA)

Paid, denied, and adjusted claims

Financial transactions

Expenditures - Non-claim payments

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

Summary

Current, month, and year to date information

Remittance Advice (RA)

Information pages

Banner messages to the provider community

EOB code explanations

Provides a comparison of codes to the description

TPL claim denial information

Provides other insurance information for any TPL claim denials

Websites & Forms

Websites

Ohio Department of Medicaid home page

https://Medicaid.ohio.gov

MALs & MTLs

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

Ohio Administrative Codes

https://codes.ohio.gov/ohio-administrative-code/5160

Websites

Healthchek

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

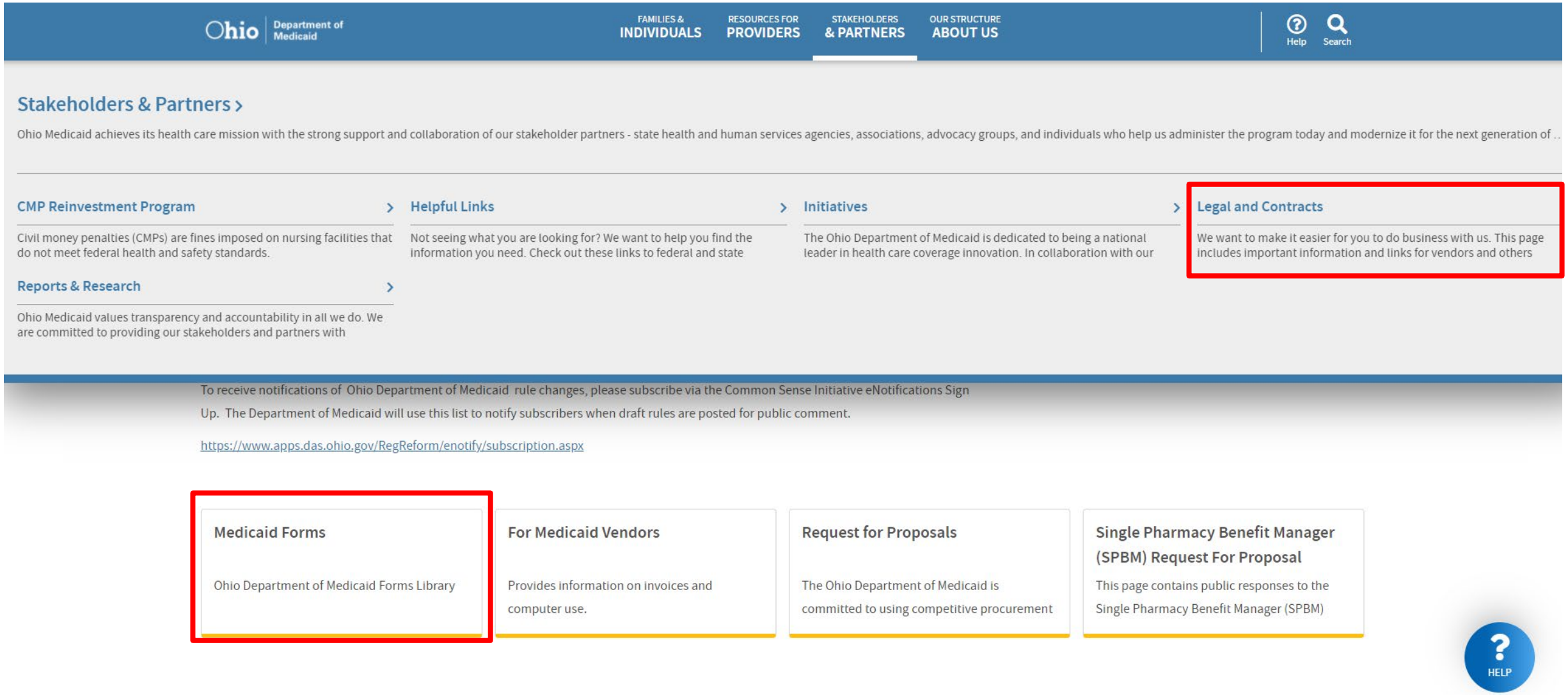
National Drug Code (NDC) Search

http://www.accessdata.fda.gov/scripts/cder/ndc/default.cfm

X12 Website (ARC Codes)

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

ODM Forms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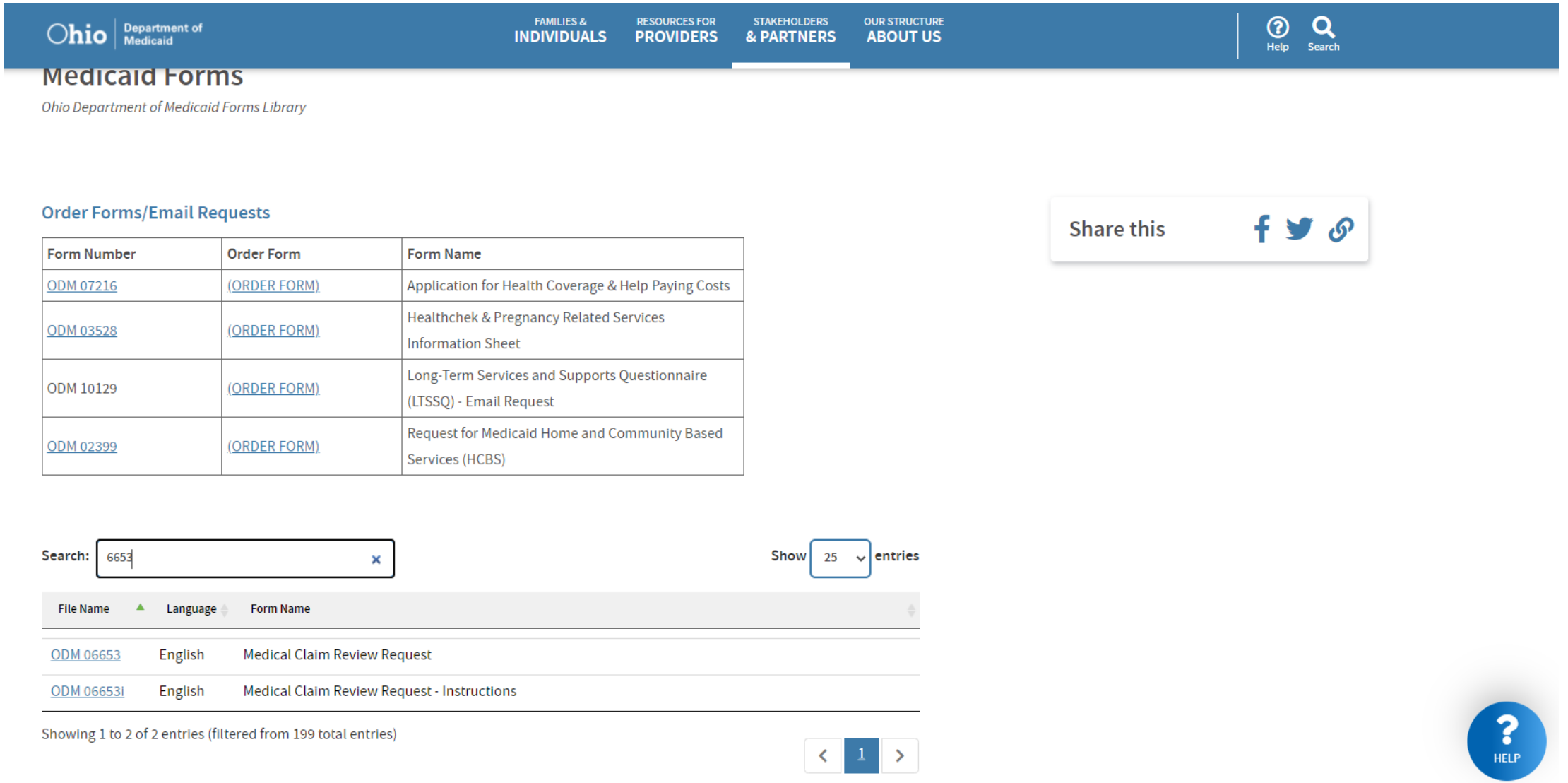
Stakeholders & Partners ›
Ohio Medicaid achieves its health care mission with the strong support and collaboration of our stakeholder partners - state health and human services agencies, associations, advocacy groups, and individuals who help us administer the program today and modernize it for the next generation of ..
CMP Reinvestment Program
Civil money penalties (CMPs) are fines imposed on nursing facilities that do not meet federal health and safety standards.
Helpful Links
Not seeing what you are looking for? We want to help you find the information you need. Check out these links to federal and state
Initiatives
The Ohio Department of Medicaid is dedicated to being a national leader in health care coverage innovation. In collaboration with our
Legal and Contracts
We want to make it easier for you to do business with us. This page includes important information and links for vendors and others
Reports & Research
Ohio Medicaid values transparency and accountability in all we do. We are committed to providing our stakeholders and partners with
To receive notifications of Ohio Department of Medicaid rule changes, please subscribe via the Common Sense Initiative eNotifications Sign Up. The Department of Medicaid will use this list to notify subscribers when draft rules are posted for public comment.
https://www.apps.das.ohio.gov/RegReform/enotify/subscription.aspx
Medicaid Forms
Ohio Department of Medicaid Forms Library
For Medicaid Vendors
Provides information on invoices and computer use.
Request for Proposals
The Ohio Department of Medicaid is committed to using competitive procurement
Single Pharmacy Benefit Manager (SPBM) Request For Proposal
This page contains public responses to the Single Pharmacy Benefit Manager (SPBM)
HELP

ODM Forms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Form Number | Order Form | Form Name
ODM 07216 | (ORDER FORM) | Application for Health Coverage & Help Paying Costs
ODM 03528 | (ORDER FORM) | Healthchek & Pregnancy Related Services Information Sheet
ODM 10129 | (ORDER FORM) | Long-Term Services and Supports Questionnaire (LTSSQ) - Email Request
ODM 02399 | (ORDER FORM) | Request for Medicaid Home and Community Based Services (HCBS)
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Show 25 entries
File Name | Language | Form Name
ODM 06653 | English | Medical Claim Review Request
ODM 06653i | English | Medical Claim Review Request - Instructions
Showing 1 to 2 of 2 entries (filtered from 199 total entries)
1
HELP

Forms

ODM 06614 – Health Insurance Fact Request

ODM 06653 – Medical Claim Review Request

ODM 03197 – Prior Authorization: Abortion Certification

ODM 03199 – Acknowledgement of Hysterectomy Information

HHS-687 – Consent for Sterilization

ODM 03421 FQHC/Outpatient Health Facility Cost Report

ODM 10252 Acknowledgement of Terms and Conditions Governing the Presumptive Eligibility Determinations