Ohio | Department of Medicaid

Basic Billing for Independent Home Health Providers

Provider Relations

2021

Programs & Cards

Managed Care/MyCare Ohio

Provider Responsibilities

Policy

MITS & Claim Submission

Websites & Forms

Helpful phone numbers

- OSHIIP (Ohio Senior Health Insurance Information Program)
  1-800-686-1578

- Coordination of Benefits Section
  614-752-5768
  614-728-0757 (fax)

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

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

1-800-686-1516

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

Provider Assistance

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

Medicaid Services

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

Programs & Cards

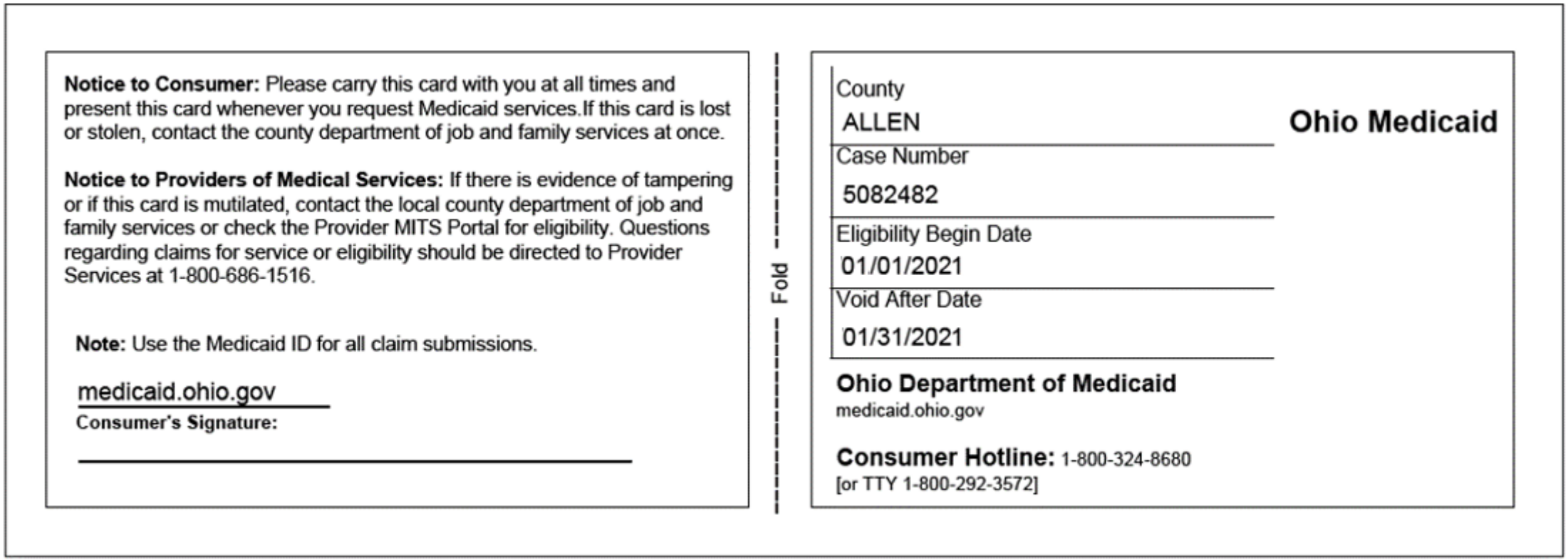
Medicaid Medical Necessity: OAC 5160-1-01

Is the fundamental concept underlying the Medicaid Program

All services must meet accepted standards of medical practice

Ohio Medicaid

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



Notice to Consumer: Please carry this card with you at all times and present this card whenever you request Medicaid services.If this card is lost or stolen, contact the county department of job and family services at once.

Notice to Providers of Medical Services: If there is evidence of tampering or if this card is mutilated, contact the local county department of job and family services or check the Provider MITS Portal for eligibility. Questions regarding claims for service or eligibility should be directed to Provider Services at 1-800-686-1516.

Note: Use the Medicaid ID for all claim submissions.

medicaid.ohio.gov

Consumer's Signature:

Fold

County
ALLEN

Ohio Medicaid

Case Number
5082482

Eligibility Begin Date
01/01/2021

Void After Date
01/31/2021

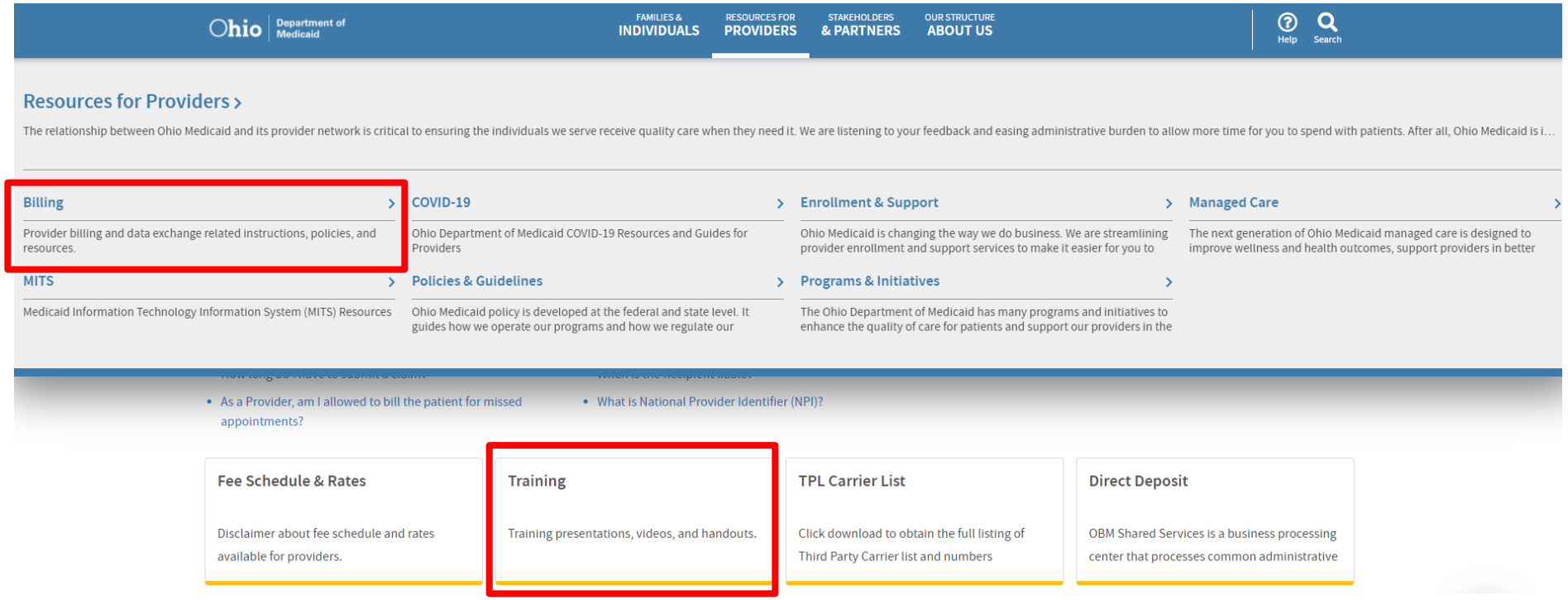
Ohio Department of Medicaid
medicaid.ohio.gov

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

Programs & Cards

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

Eligibility Verification Request



Training Videos

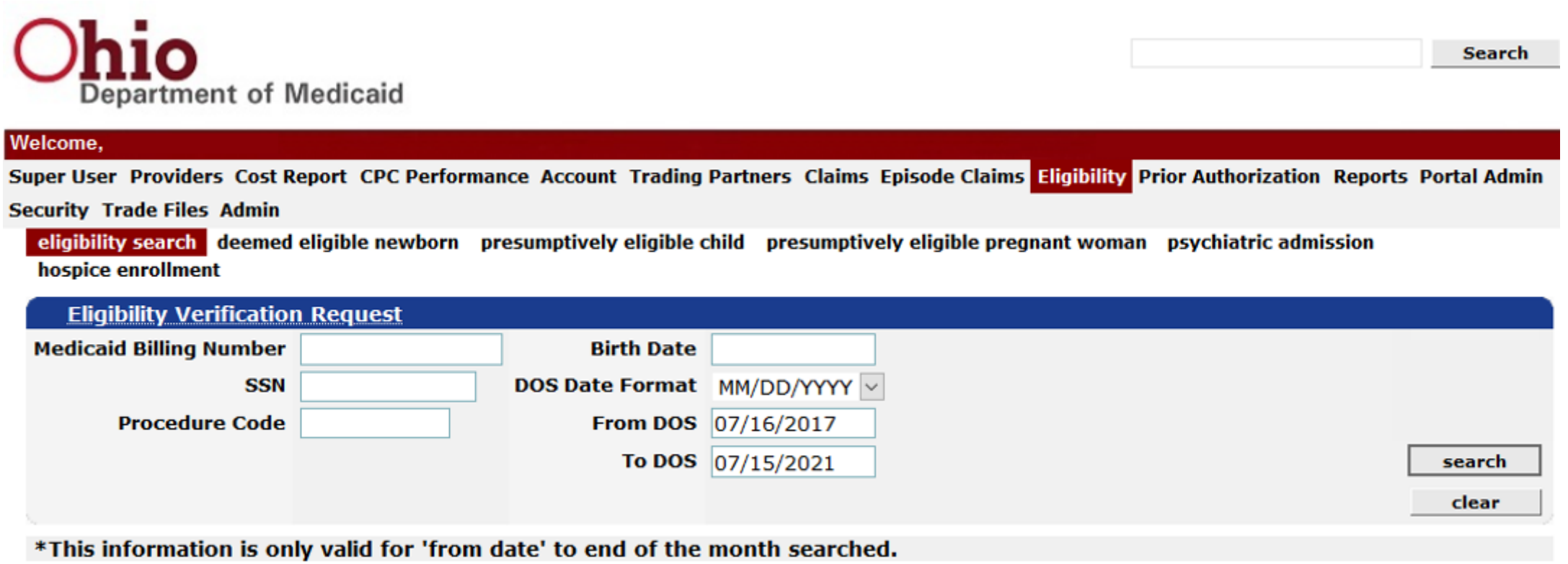
Ohio Medicaid has created a compilation of training videos that cover a variety of topics for providers. If questions remain after reviewing these videos, contact Ohio Medicaid Provider Assistance at 1-800-686-1516.

Check back frequently as training videos will be added as needed. If there are issues viewing these videos, make sure your pop-up blocker is turned off.

- Presumptive Eligibility (PE) Portal Walk Through for Qualified Entities
- How to Setup a MITS Agent Account and Access Reports
- Eligibility Search

Eligibility Verification Request

You can search up to 4 years back



TIP: Always check eligibility prior to billing

Eligibility Verification Request

Recipient Information

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

Associated Child(ren) Search

Benefit / Assignment Plan

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

Associated Child(ren)

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

Inpatient Hospital Services Plan (IHSP)

Recipient Information

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

Benefit / Assignment Plan

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

Presumptive Eligibility

Recipient Information

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

Benefit / Assignment Plan

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

QMB

Recipient Information

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

Associated Child(ren) Search

Benefit / Assignment Plan

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

Can I bill them?

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

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

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

SLMB

Recipient Information

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

Benefit / Assignment Plan

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

QI-1

Recipient Information

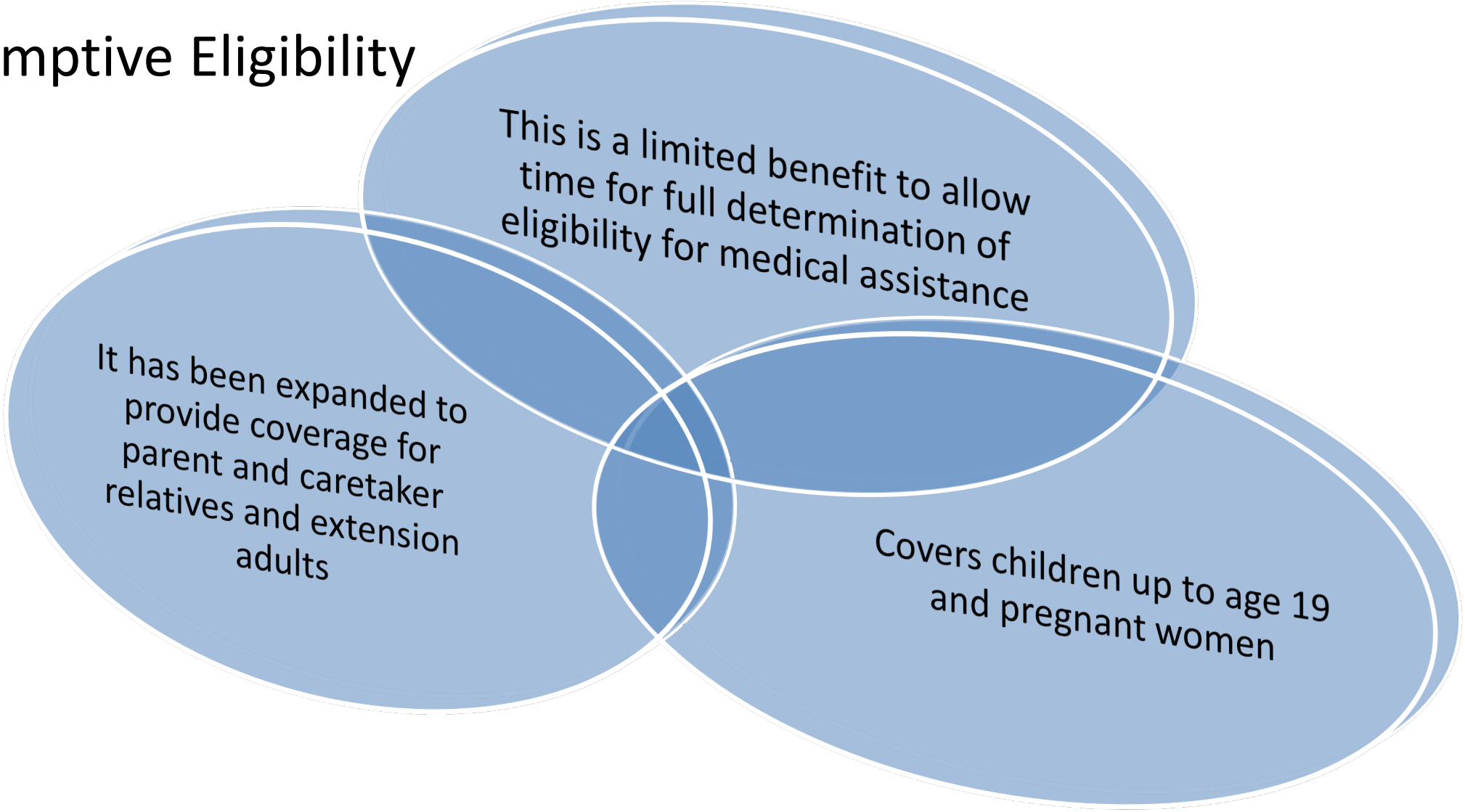
Medicaid Billing Number	SSN
Last Name	County of Residence
First Name	County of Eligibility
Gender	County Office http://jfs.ohio.gov/county/cntydir.stm
Date of Birth	Number Bed Hold Days Used Paid CY
Date of Death	

Benefit / Assignment Plan

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

Programs & Cards

- Presumptive Eligibility



Presumptive Eligibility

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

Presumptive Eligibility

MISSISSIPPI RIVERS
21 S FRONT ST
COLUMBUS, OH 43215

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

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

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

APPROVED:

Name (First, M.I., Last Name)	Date of Birth	PE Type	Date Coverage Begins	Medicaid ID
MISSISSIPPI RIVERS	01/01/1987	PE PREGNANT	05/09/2021	910001331813

Presumptive Eligibility

Other members will receive this Presumptive Eligibility letter

CDJFS Presumptive Eligibility

John Doe
123 Main St.
Anytown, OH 43210

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

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

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

APPROVED:

Name (First, M.I., Last Name)	Date of Birth	PE Type	Date Coverage Begins	Medicaid ID
John Doe	11/19/1959	PE Adult	06/25/2021	910194194194

Managed Care & MyCare Ohio

aetna®

AETNA BETTER HEALTH® OF OHIO

buckeye health plan

CareSource®

PARAMOUNT HEALTH CARE

MOLINA® HEALTHCARE

UnitedHealthcare®

Oversight of Managed Care Plans

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

MITS Managed Care Eligibility

Benefit / Assignment Plan

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

Case/Cat/Seq Spenddown

*** No rows found ***

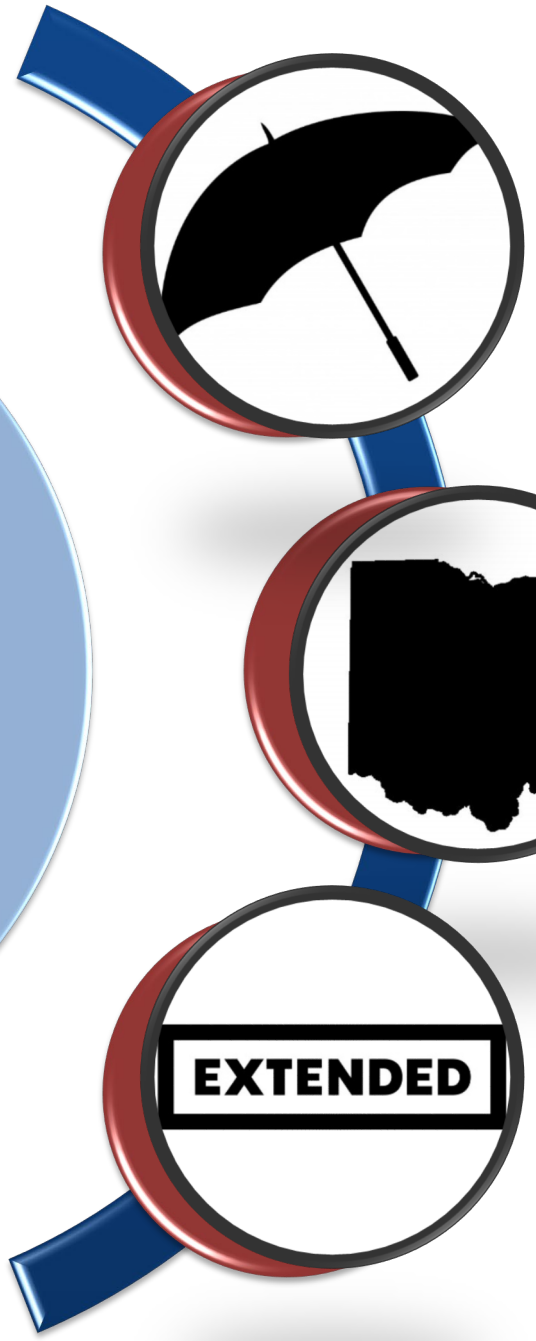
TPL

*** No rows found ***

Managed Care

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

MyCare Ohio



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

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

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

MITS Eligibility MyCare Opt-In

Benefit / Assignment Plan

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

Case/Cat/Seq Spenddown

*** No rows found ***

TPL

*** No rows found ***

Managed Care

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

Lock-In

*** No rows found ***

Medicare

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

MITS Eligibility MyCare Opt-Out

Benefit / Assignment Plan

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

Case/Cat/Seq Spenddown

*** 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

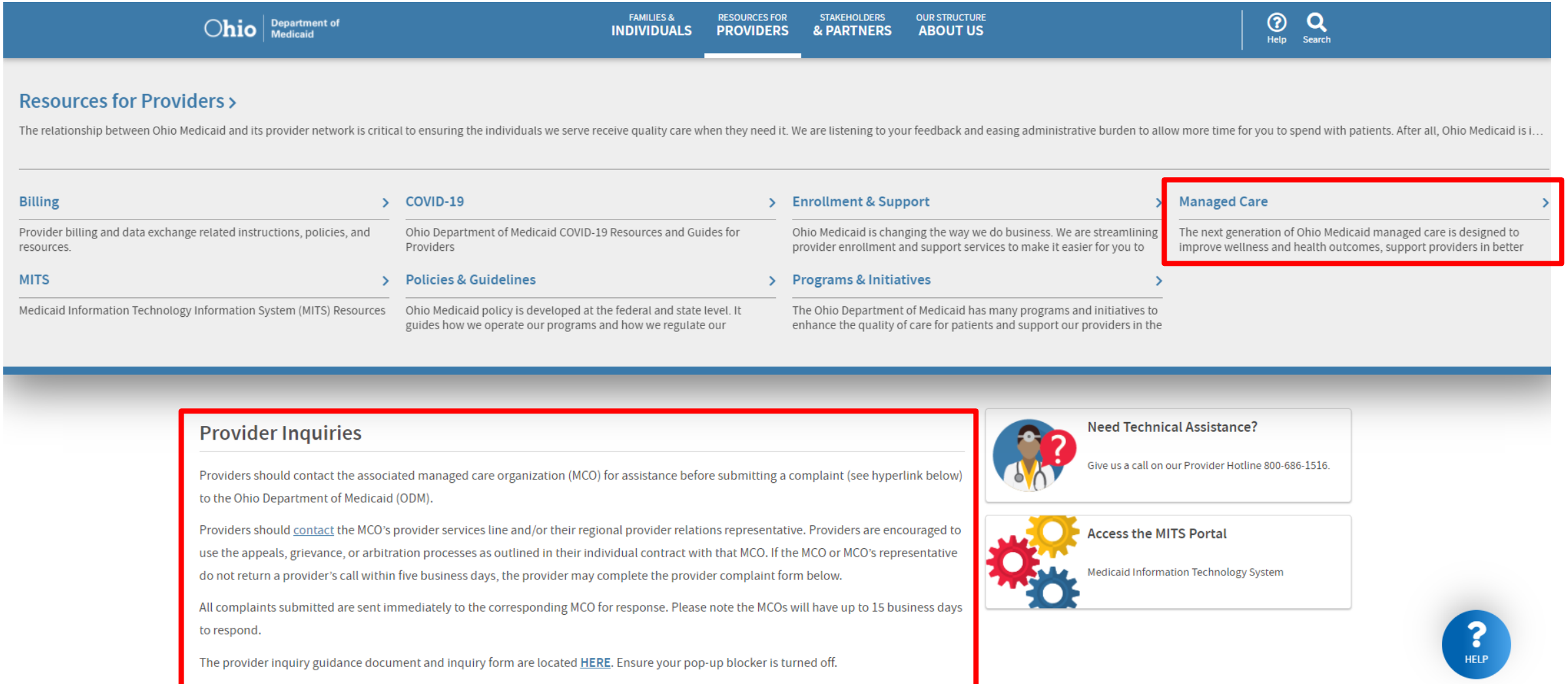
Lock-In

*** 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

Submitting a Managed Care Complaint



Submitting a Managed Care Complaint

Provider Complaint Form Guidance

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

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

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

Submitting a Managed Care Complaint

Submission Tips:

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

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

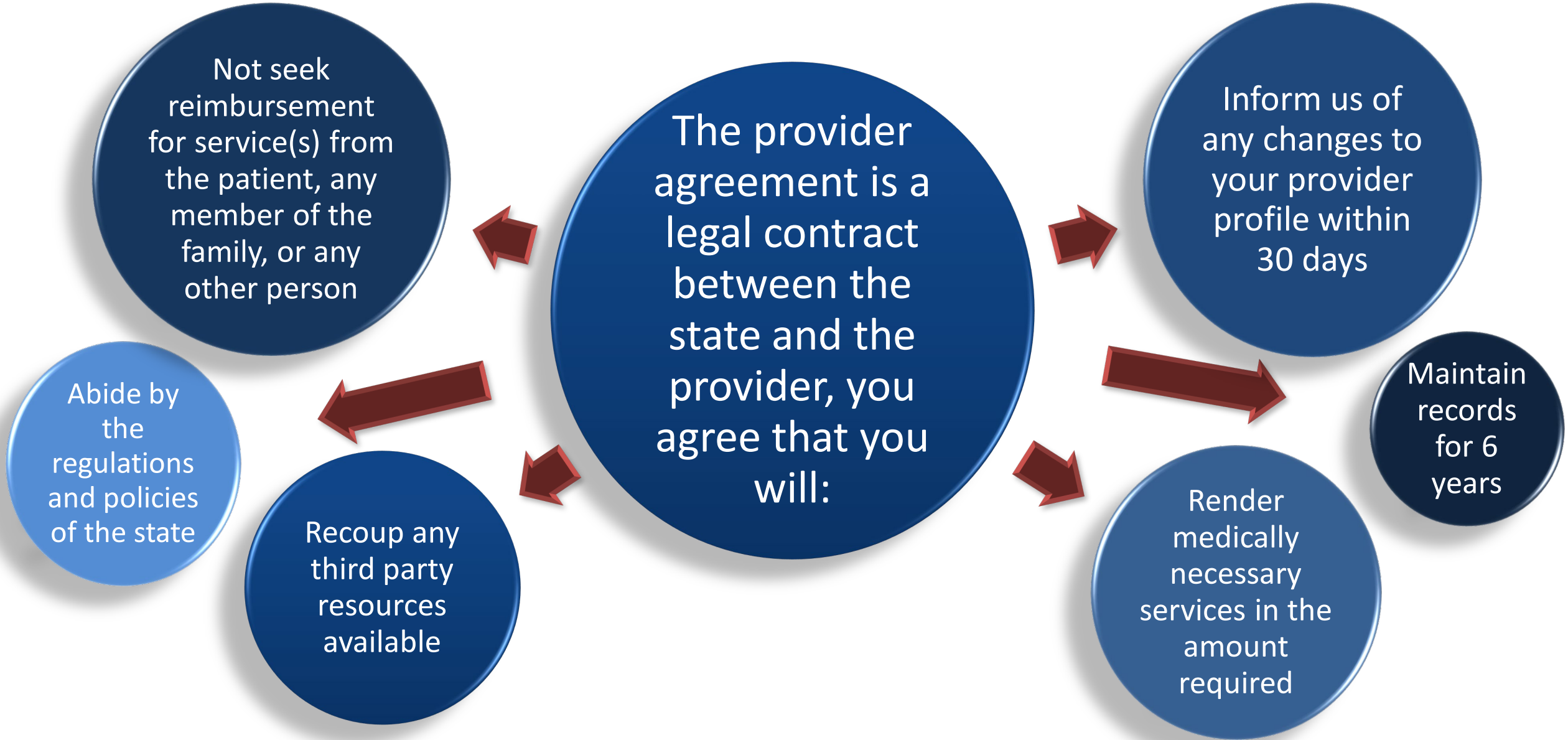
NEW If the provider submits multiple complaints for the same issue (different individuals, dates of service, practitioners, or files affected), ODM will cancel all duplicate complaints, contact the provider, and request that a single new complaint be submitted for all files affected.

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

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

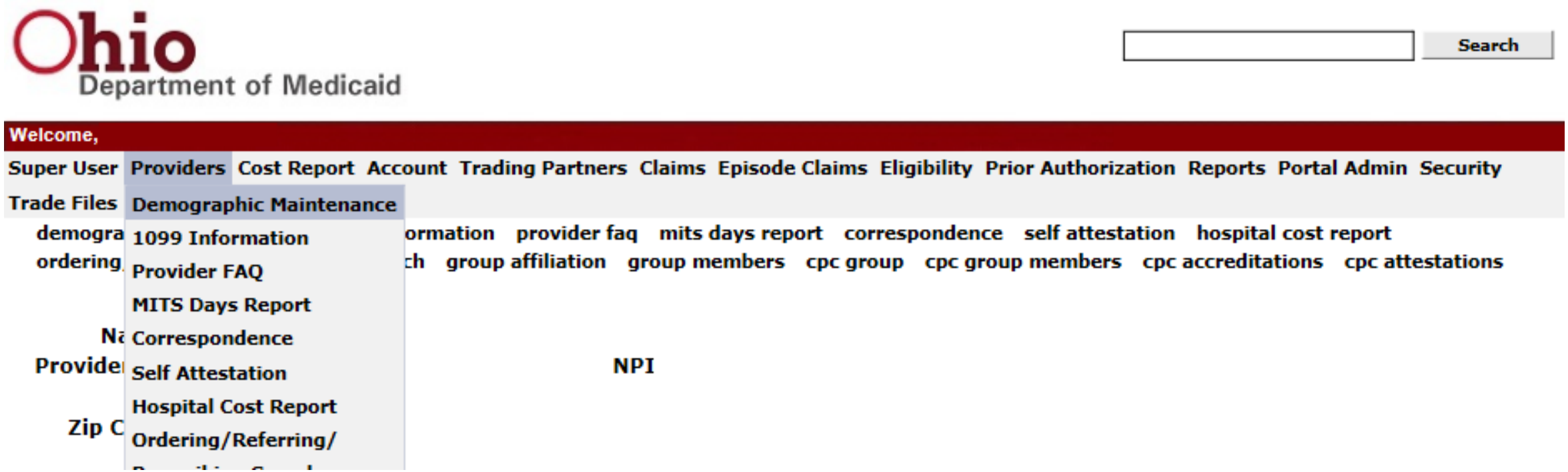
Provider Responsibilities

❑ Provider Agreement: OAC 5160-1-17.2



Provider Responsibilities

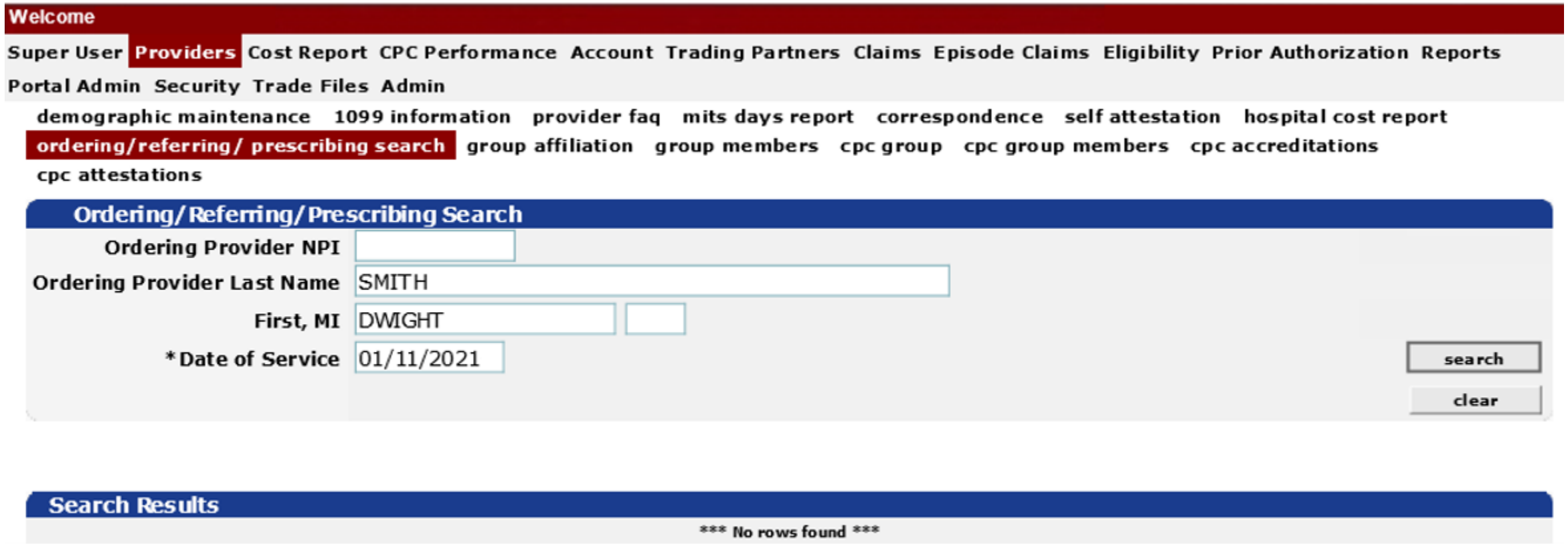
- Demographic Maintenance in MITS



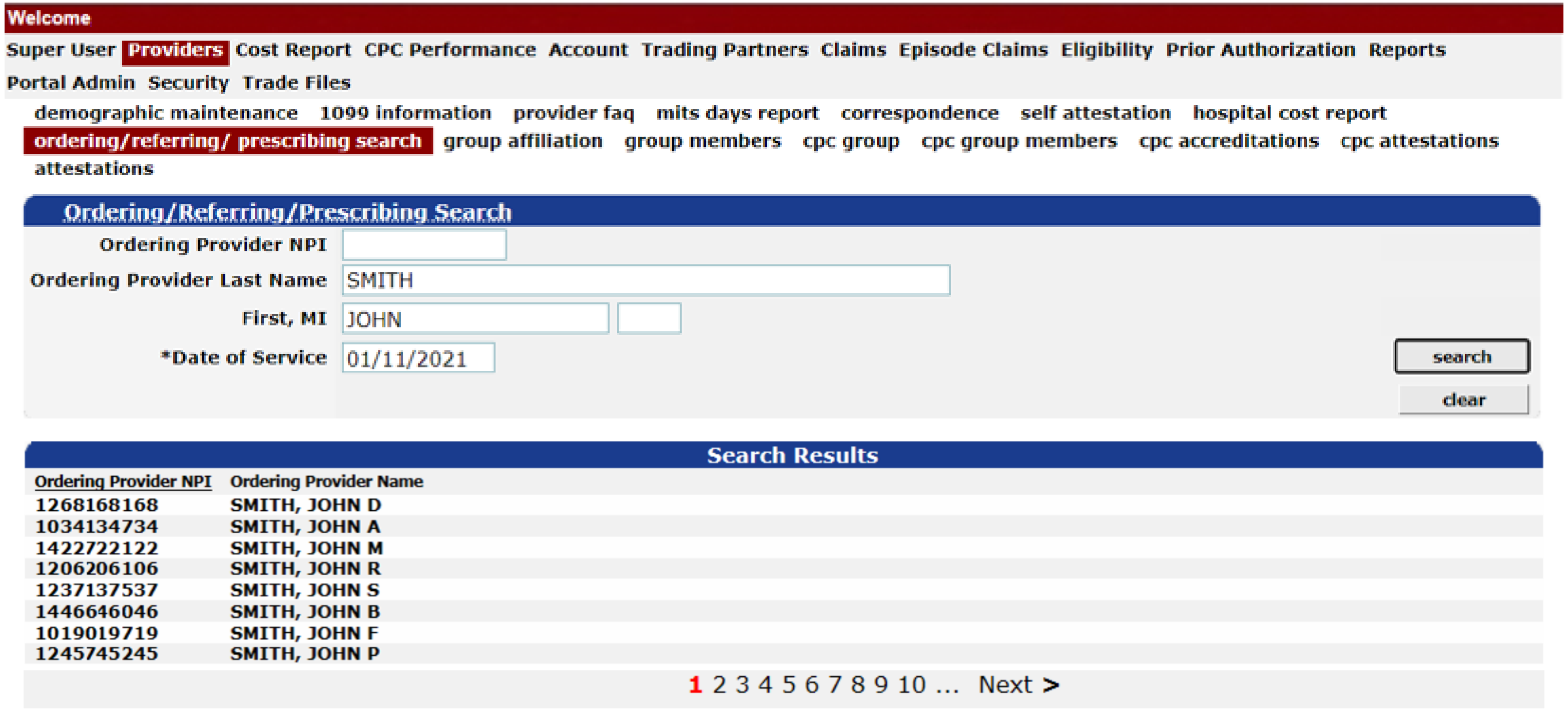
Provider Responsibilities

- Demographic Maintenance in MITS, cont.

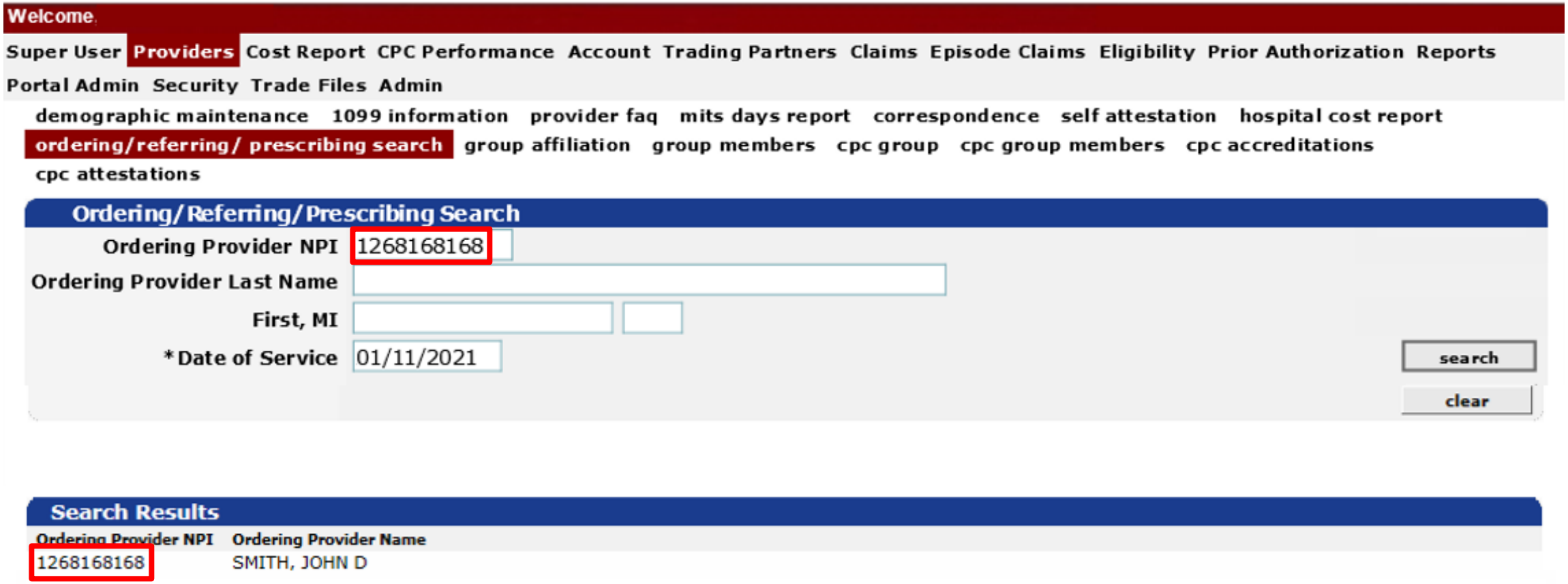
ORP Search


Welcome
Super User Providers Cost Report CPC Performance Account Trading Partners Claims Episode Claims Eligibility Prior Authorization Reports
Portal Admin Security Trade Files Admin
demographic maintenance 1099 information provider faq mits days report correspondence self attestation hospital cost report
ordering/referring/ prescribing search group affiliation group members cpc group cpc group members cpc accreditations
cpc attestations
Ordering/Referring/Prescribing Search
Ordering Provider NPI
Ordering Provider Last Name SMITH
First, MI DWIGHT
*Date of Service 01/11/2021
search
clear
Search Results
*** No rows found ***

ORP Search

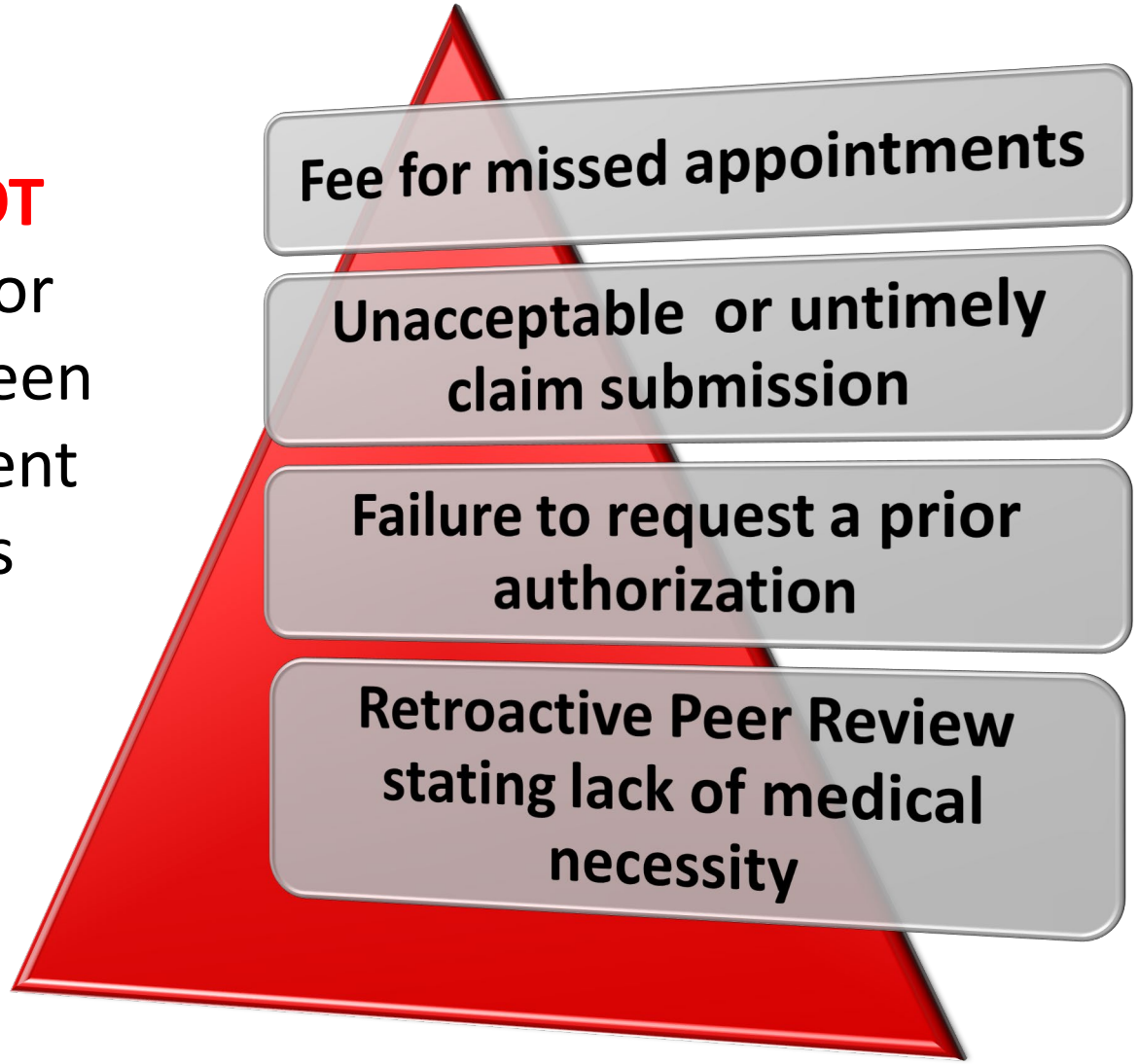

Welcome
Super User Providers Cost Report CPC Performance Account Trading Partners Claims Episode Claims Eligibility Prior Authorization Reports
Portal Admin Security Trade Files
demographic maintenance 1099 information provider faq mits days report correspondence self attestation hospital cost report
ordering/referring/ prescribing search group affiliation group members cpc group cpc group members cpc accreditations cpc attestations
attestations
Ordering/Referring/Prescribing Search
Ordering Provider NPI
Ordering Provider Last Name SMITH
First, MI JOHN
*Date of Service 01/11/2021
search
clear
Search Results
Ordering Provider NPI Ordering Provider Name
1268168168 SMITH, JOHN D
1034134734 SMITH, JOHN A
1422722122 SMITH, JOHN M
1206206106 SMITH, JOHN R
1237137537 SMITH, JOHN S
1446646046 SMITH, JOHN B
1019019719 SMITH, JOHN F
1245745245 SMITH, JOHN P
1 2 3 4 5 6 7 8 9 10 ... Next >

ORP Search

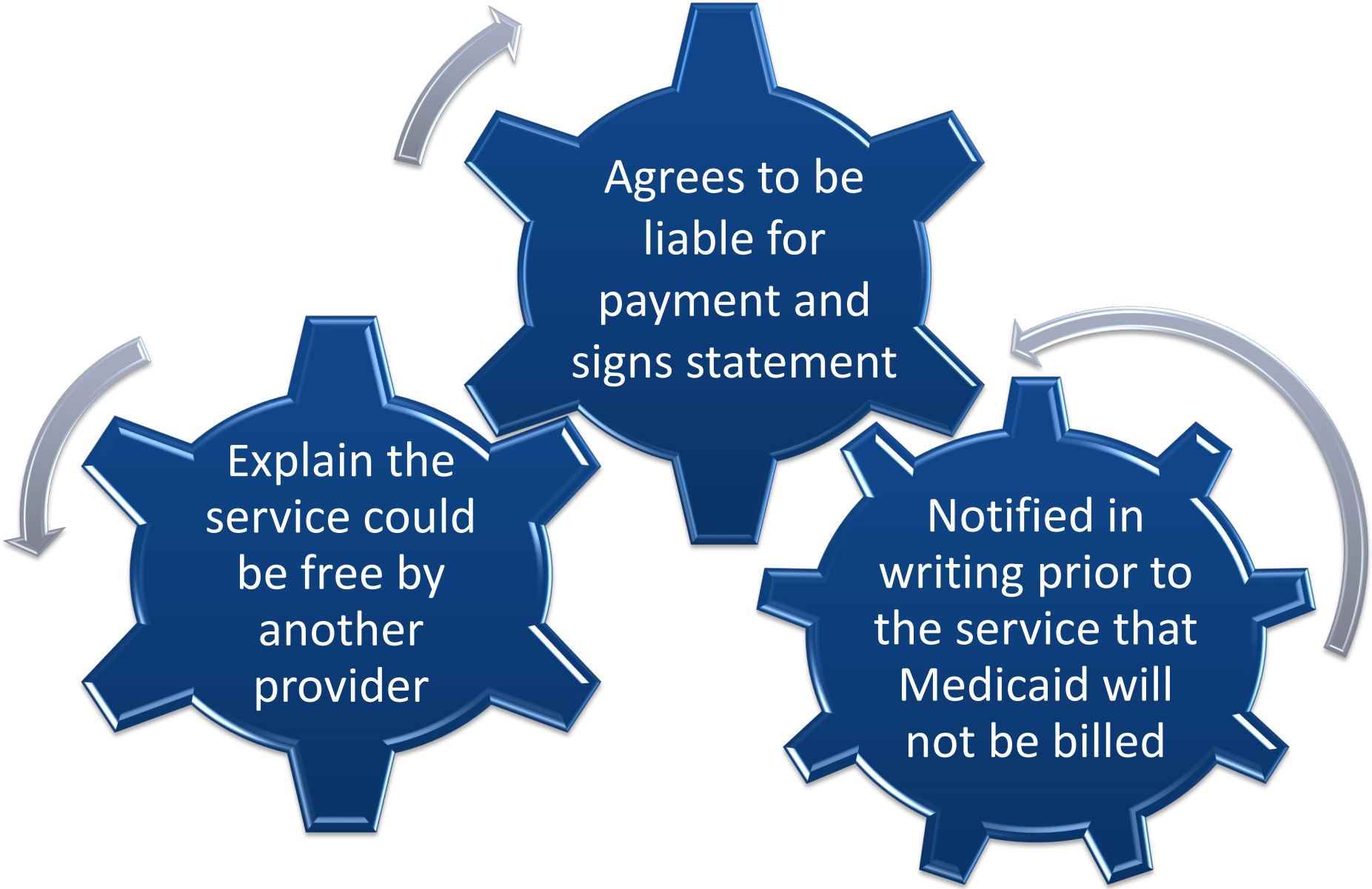

Welcome
Super User Providers Cost Report CPC Performance Account Trading Partners Claims Episode Claims Eligibility Prior Authorization Reports
Portal Admin Security Trade Files Admin
demographic maintenance 1099 information provider faq mits days report correspondence self attestation hospital cost report
ordering/referring/ prescribing search group affiliation group members cpc group cpc group members cpc accreditations
cpc attestations
Ordering/Referring/Prescribing Search
Ordering Provider NPI 1268168168
Ordering Provider Last Name
First, MI
*Date of Service 01/11/2021
search
clear
Search Results
Ordering Provider NPI
Ordering Provider Name
1268168168
SMITH, JOHN D

Medicaid Consumer Liability 5160-1-13.1

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



When Can you Bill an Individual?



5160-1-13.1 Medicaid recipient liability

Date of service: _____

Type of service: _____

Name & account number: _____

Billing number: _____

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

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

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

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

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

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

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

Signature _____ Date _____

What is the Person-Centered Services Plan?

- A document the case manager (CM) and others develop with the individual
- It specifies all the services which are currently necessary for an individual to remain at home
- It lists the goals, needed services, cost of services, who is liable for payment, service providers, home care team members, and any decision regarding individual options
- The individual and all providers need to receive a copy and understand it
- The plan authorizes the service units (hours) providers can be reimbursed and may specify the schedule of visits

Provider Responsibilities

- Person - Centered Services Plan (formally known as the All Services Plan)

Ohio Department of Medicaid-Administered Waiver
ALL SERVICES PLAN

Consumer's name	*Consumer's billing number*	0	4	32
CONSUMER NAME (last, first mi)	MMIS NUMBER	PROGRAM CODE	CM REGION	COUNTY CODE

GOAL #	GOALS / OBJECTIVES / METHODS
1-PCA	GOAL: PERSONAL CARE AIDE OBJECTIVE: *Consumer name* will be safe, clean, healthy, and comfortable in the home environment. He will live in his home setting as independently and safely as possible. The home will be clean and free of clutter. All personal care needs will be met, and Consumer will be clean and wear clean clothing appropriate for the weather. He will remain hydrated and well-nourished. METHOD: CURRENT AUTHORIZATION: Effective 1/17/2017 Aide to visit 1 time per day, 5 days per week, 3 hrs each visit Mon-Fri. *Provider name*, IP, to work Monday-Friday 3 hours each visit. Billing: Pt liability and Waiver ********** PREVIOUS AUTHORIZATION: Effective 12/26/2016 Aide to visit 1 time per day, 5 days per week, 3 hrs each visit Mon-Fri. *Provider* to work Mon, Wed, and Fri Preservation of funding for Tues and Thurs hours. Billing: Pt liability and Waiver ********** PREVIOUS AUTHORIZATION: 5 shifts per week, 1 shift per day (Monday through Friday)for 2 hours each shift. BILLING: 1 shift to State Plan/G0156, remaining shifts to Waiver/T1019 ********** Aides to assist with transfers and locomotion as needed, including monitoring for falls and fall risks. Personal care to include bathing, dressing, hair care, oral care, and skin care as needed and requested. Homemaking to include dusting, sweeping, mopping, cleaning of kitchen and bathroom, dishes, bed making, linen changes, laundry, meal prep, and trash removal as needed and requested. Access to the community as needed and allowed by agency policy. Aides are to only tend to Consumer's personal items and areas.

GOAL #	GOALS / OBJECTIVES / METHODS
14-HDM	GOAL: HOME DELIVERED MEALS OBJECTIVE: *Consumer* will be well nourished and hydrated with access to nutritious food when alone at meal times which will enable him to remain healthy and maintain nutritional levels as recommended by his physician.

Provider Responsibilities

❖ Person - Centered Services Plan, cont'd

ALL SERVICES PLAN
Units
Display Past 2 Months

Consumer's billing number	*Consumer's name and address*		1/13/2017 4:40:28 PM	3/14/2016 - 3/13/2017
MMIS NUMBER	CONSUMERNAME (last,first)	COST LEVEL CODE	DATE THIS PLAN ACTIVATED	EFFECTIVE DATE m/d/yyyy

GOAL #	SERVICE	UNITS/ MONTH	START DATE	END DATE	PROVIDER/CONTACT	NT	PHONE # & FAX # & EMAIL	PAYMENT SOURCE	ESTIMATED COST/MO (COMPLETE FOR OHC costs only)
3-BUP, 11-IS	Other:		3/14/2016		*Spouse's name* Wife *Address*	☐	P xxx-xxx-xxxx	Gratis/ Volunteer -no pymt	
7-MD	Medical Care		3/14/2016		*Physician's name* MD General Practice *Address*	☐	Pxxx-xxx-xxxx F xxx-xxx-xxxx	Medicaid	
1-PCA	Wvr PCA/Agency T1019	B=18 S=72	4/6/2016	12/25/2016	0000000 To be determined All, Ohio 00000	☐	P xxx-xxx-xxxx	Medicaid	$672.66
1-PCA	HHAide/StPl G0156	B=5 S=20	4/6/2016	12/25/2016	Provider Pending 0000000 To be determined All, Ohio 00000	☐	P xxx-xxx-xxxx	State Plan	$186.85
17 LIA	Wvr PCA/NAP T1019	B=4 S=32	12/26/2016		*Provider's name* OETP *Provider number* *Address*	☐	P xxx-xxx-xxxx E email@gmail.com	Patient Liability Provider may NOT bill Medicaid for this amount. Consumer is to be billed this amount prior to billing	$151.00

Provider Responsibilities

❖ Person - Centered Services Plan, cont'd

ALL SERVICES PLAN

TeamTeam Members Initial Participating in Plan Development

Name/Relationship	Consumer / Guardian / Representative	Participation Date	Participation Method
Consumer	Consumer	3/4/2016	In person
Other provider	*Guardian's name*	3/4/2016	Assigned
Name/Relationship	Case Manager	Participation Date	Participation Method
Other provider #2		4/6/2016	In person
Name	Signature; If Present	Participation Date	Participation Method
Provider's name		1/13/2017	Email
Name	Signature; If Present	Participation Date	Participation Method
Therapy provider's name		12/23/2016	
Name	Signature; If Present	Participation Date	Participation Method
Physician's name		3/14/2016	Fax
Name	Signature; If Present	Participation Date	Participation Method

This plan will be reviewed according to the following schedule:
6 Months 1-3 Monthly Visits 4-6 Monthly Visits 2 Calls Mo, 1, 1 call 2-6 Mos.

CM Monitoring will occur according to the following schedule:
6 Months 1-3 Monthly Visits 4-6 Monthly Visits 2 Calls Mo, 1, 1 call 2-6 Mos.

I understand that I ☑ have ☐ do not have monthly patient liability of $151 per month I understand that this means that I must pay $151 each month to:

Provider's name

Provider Responsibilities

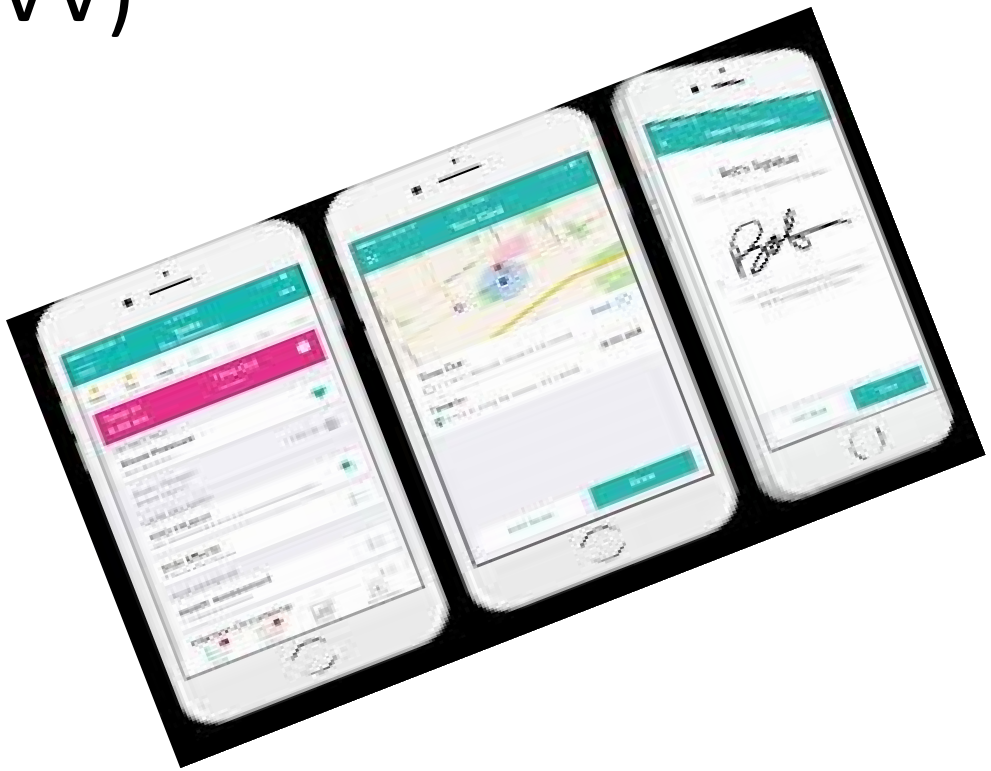
- Work week
  - The work week begins Sunday at 12:00 AM and ends Saturday at 11:59 PM
- Overtime
  - Independent providers delivering services in excess of 40 hours (160 units) are eligible for overtime compensation
    - Only time spent delivering services under an ODM waiver program, Ohio Department of Aging, Ohio Department of Developmental Disabilities, as well as Private Duty Nursing (PDN) as an independent provider are eligible

Provider Responsibilities

- Overtime, cont'd
  - Personal Care Aide, Home Care Attendant, waiver nursing under the Ohio Home Care Waiver, and PDN services must add a TU or UA modifier when billing overtime
    - TU indicates entire visit is overtime
    - UA indicates some units of a visit were overtime
      - Effected codes are T1019, S5125, T1002, T1003, and T1000

Electronic Visit Verification (EVV)

STARTED 1/8/18



Included services:

- State Plan Home Health Aide
- State Plan Home Health Nursing
- Private Duty Nursing (PDN)
- Ohio Home Care Waiver Nursing
- Ohio Home are Waiver Personal Care Aide
- Home Care Attendant
- RN Assessment

What to do as a provider:

- Sign up for a training class
  - Registration opens in October for November and December classes
  - Classroom setting, webinar or self paced classes
- Visit the ODM webpage often for updates
- Keep your email updated in MITS

What does EVV mean for agency and non-agency providers?

- There is no cost to providers who use Sandata's system.
- EVV will capture and log visit data electronically.
- Claim submission process will not change but more information may be required on the claim.
- ODM encourages all providers to use Sandata's EVV system but it is open to providers using their own EVV systems.
- ODM will post all information pertaining to the phase-in of the EVV system on the webpage. Please visit it often.

TIME LINE:

- Design Sessions Began 9/2016
- Training Began 11/1/17
- EVV Program Launched 1/8/18

Provider Responsibilities

- Surveillance and Utilization Review Section (SURS)
  - Review records and/or claims for compliance with ODM rules, which include:
    - Unauthorized services
    - Up-coding
    - Unbundling
    - Documentation issues

Provider Responsibilities

- SURS, cont'd
  - Top five provider types reviewed:

1. **Home Health Services**
2. Durable Medical Equipment
3. Skilled Nursing Facilities
4. Physician Services
5. Private Duty Nursing

Provider Responsibilities

- SURS, cont'd
  - Limited Scope Reviews can be accomplished by:
    - Data mining algorithms
    - Record requests
    - Desk reviews
    - Onsite reviews

Provider Responsibilities

- SURS, cont'd
  - Review Details:
    - Up to 6 years can be reviewed by SURS

  - Potential outcomes of Limited Scope Reviews:
    - No identified overpayment
    - Overpayment identification or a referral to Ohio Attorney General (Medicaid Fraud Control Unit)

Provider Responsibilities

- SURS, cont'd

Dear *Provider*:

The Surveillance and Utilization Review Section of the Ohio Department of Medicaid (ODM) has conducted a limited review of your Medicaid billings of T1000 – Private Duty Nursing Services. This review was based on information provided by the Bureau of Long Term Care Services & Support and the Ohio Home Care program (formerly CareStar).

We found that you were overpaid by Medicaid because you billed for visits without a signed physician's order. This violated Ohio Administrative Code Section 5101:3-45-01(RR). Please see the included claims detail report for further information.

The overpayment identified is $4,068.31, plus interest of $690.89, to the date of this letter. Additional interest is accruing at $0.39 per day. Interest is calculated pursuant to Ohio Administrative Code (OAC) Section 5160-1-25.

This review is limited to your paid claims for the review period noted above and is not a full review of your practice. Additionally, this current review does not bar ODM from conducting a new review, a final fiscal audit, or initiating collections for other incorrect or improper payments for the review period of this identified overpayment.

Provider Responsibilities

- SURS, cont.

SURS Interest Calculation Spreadsheet

	PROVIDER NAME:			
	PROVIDER #:			
Enter Findings Amount:	$4,068.31			
Interest Rate:	**3.50%**			
Enter last date of payment:	12/7/2011			
Enter Date of Letter/Memo:	10/12/2016			
Number of days:	1,771			
Interest to be paid:	**$690.89**		Per Diem Rate:	**$0.3901**

As of 4/1/20 the interest rate was set at 3.25%

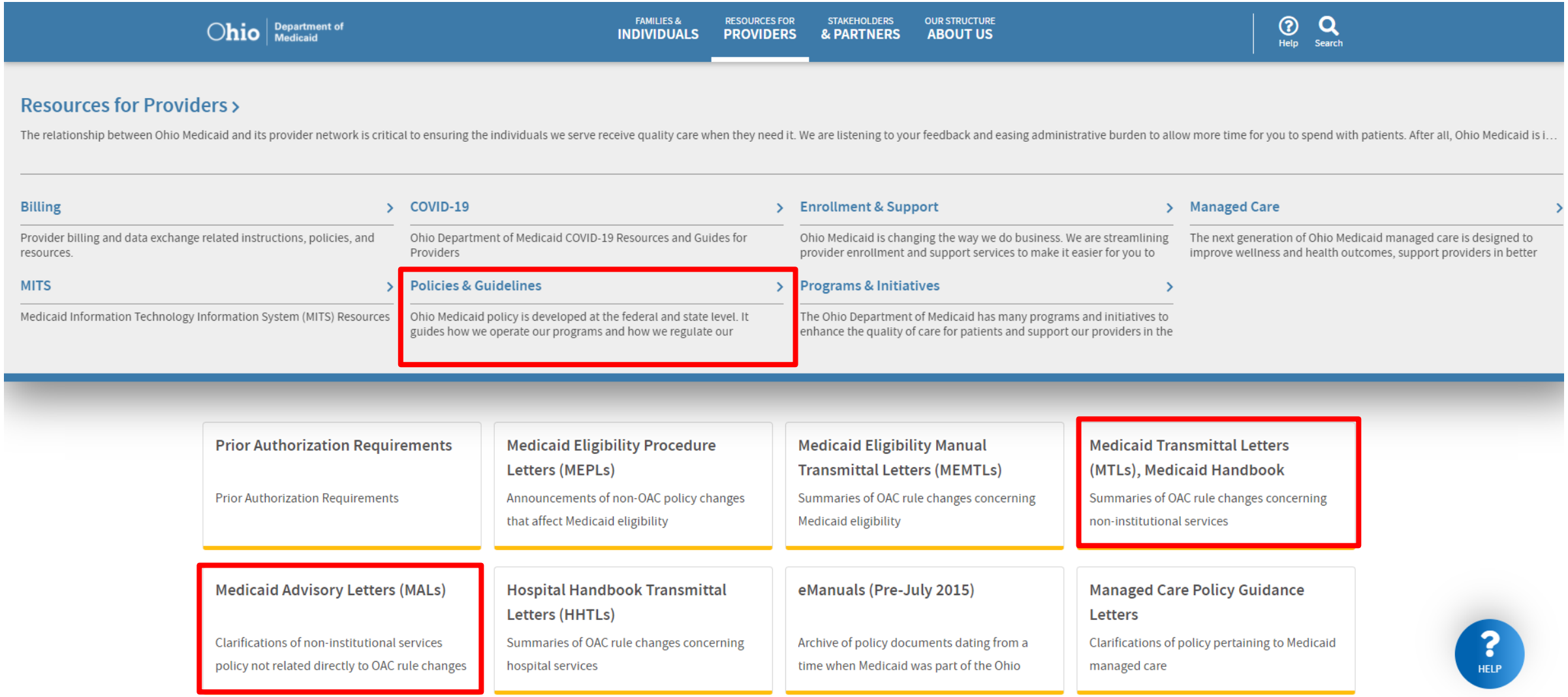
Policy

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

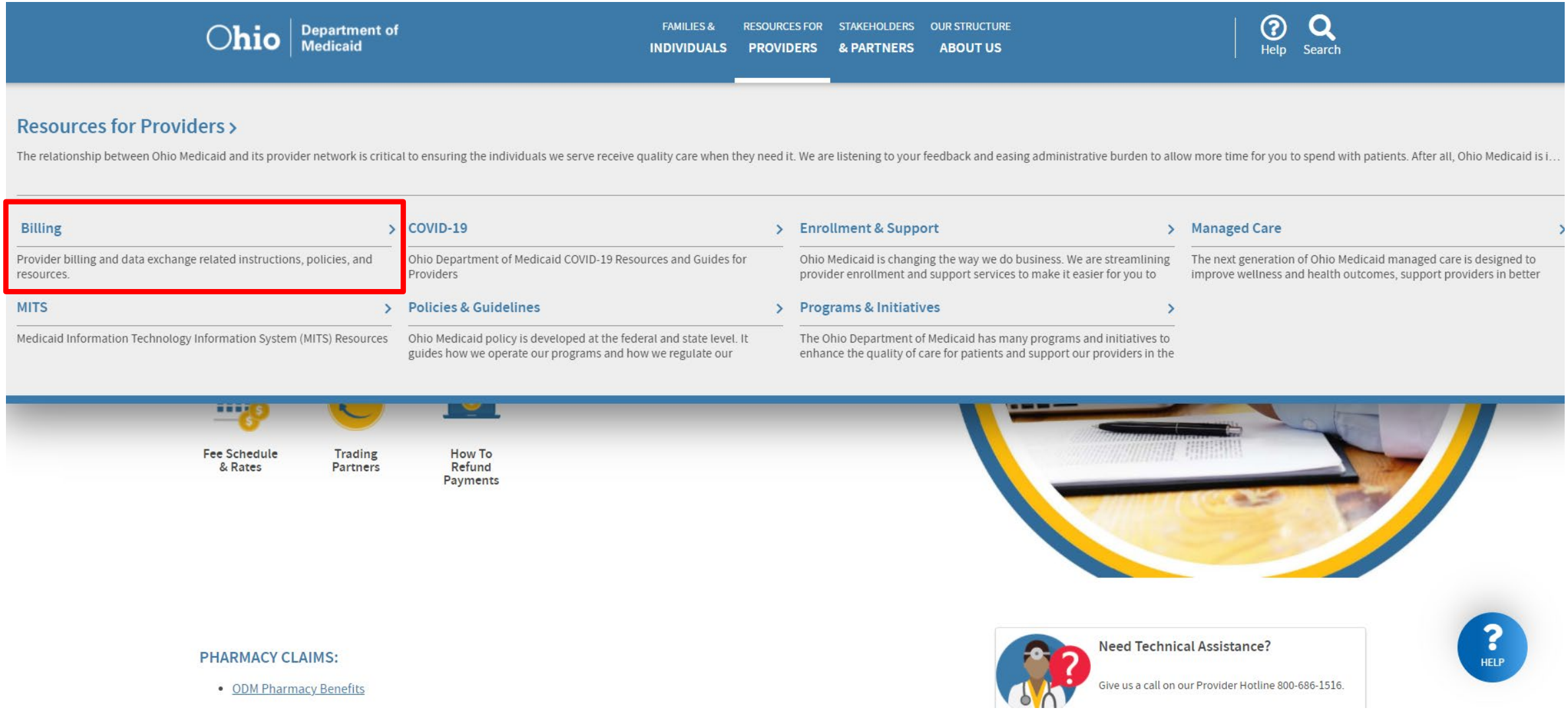
Medicaid Transmittal Letter (MTL)

Medical Assistance Letter (MAL)

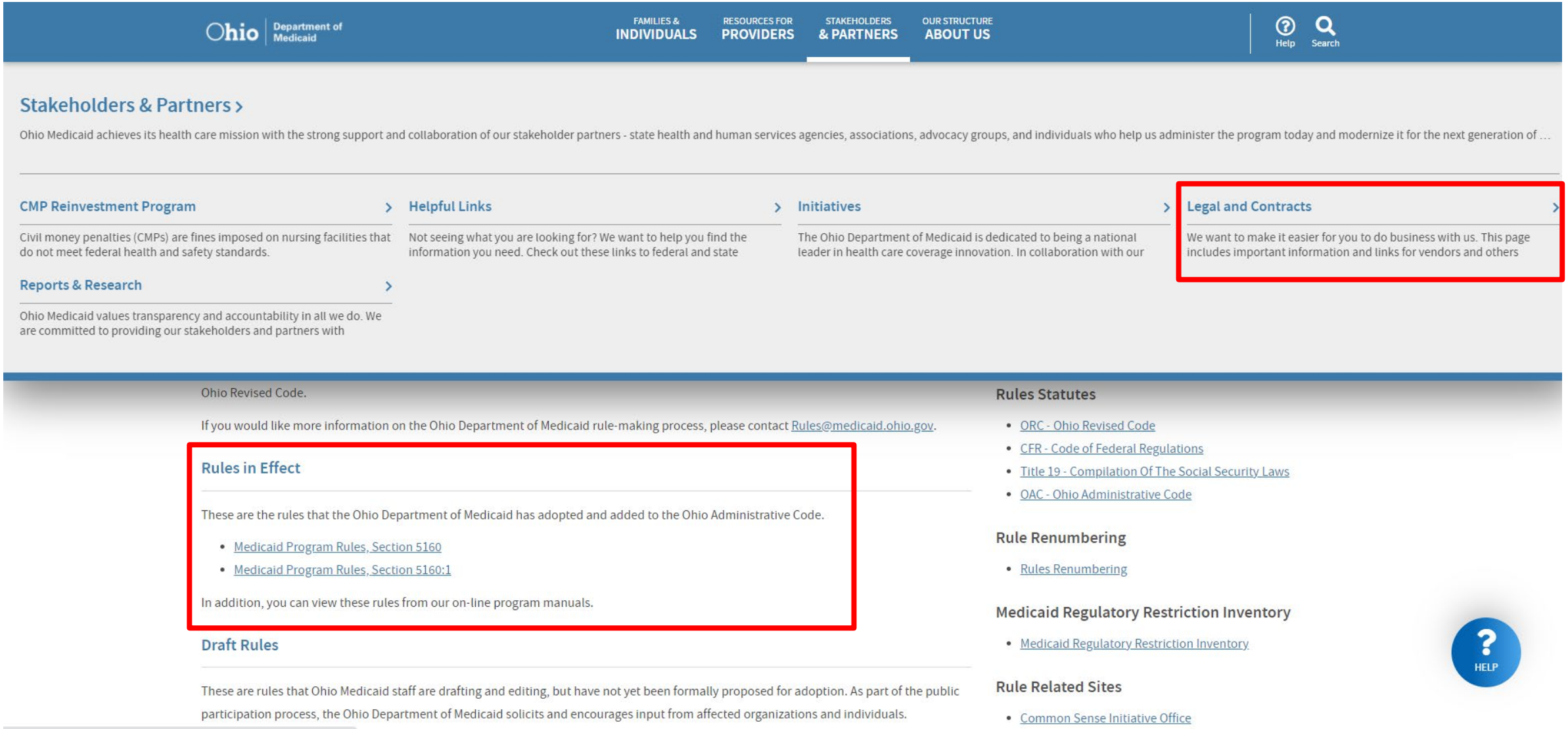
Policy


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

Billing Resources



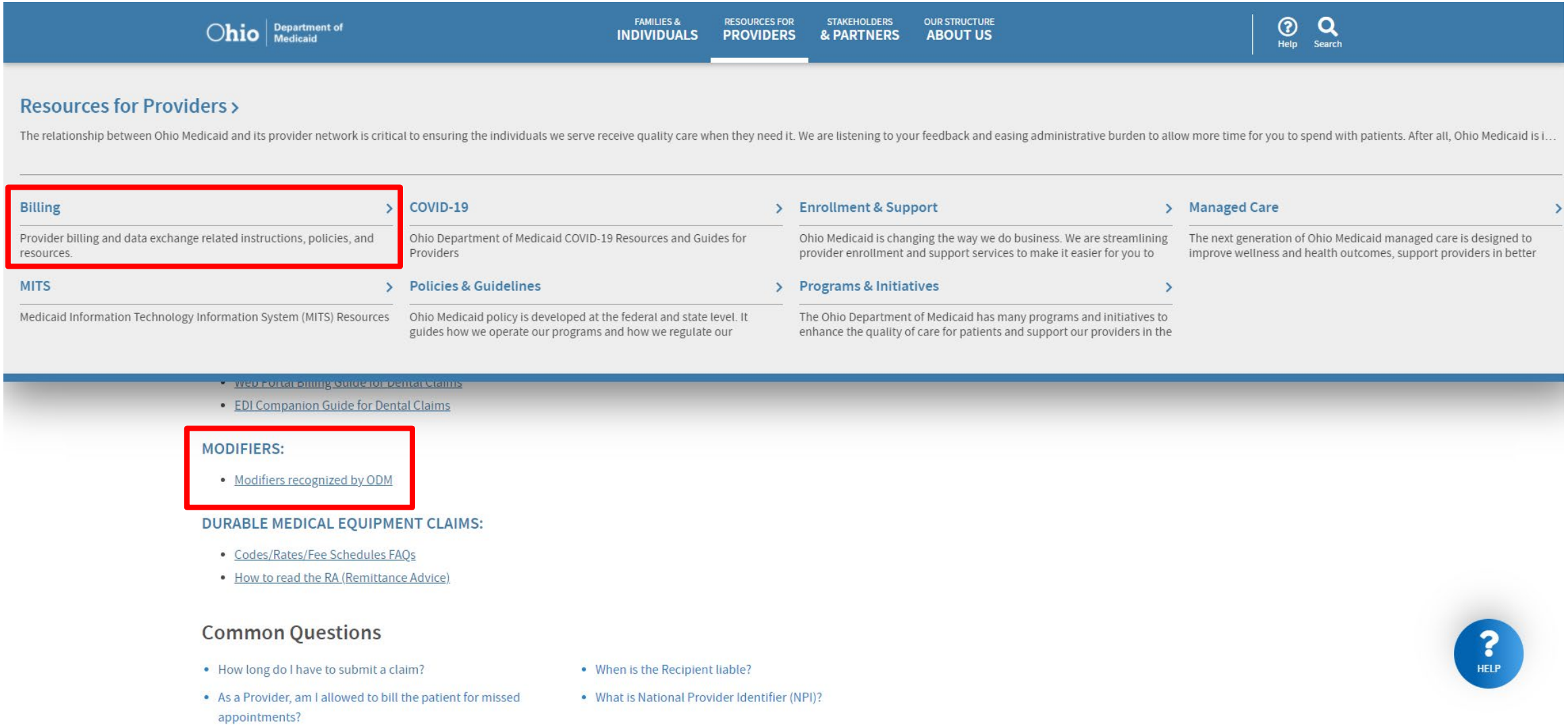
Policy


Ohio | Department of Medicaid
FAMILIES & INDIVIDUALS
RESOURCES FOR PROVIDERS
STAKEHOLDERS & PARTNERS
OUR STRUCTURE ABOUT US
Help
Search
Stakeholders & Partners ›
Ohio Medicaid achieves its health care mission with the strong support and collaboration of our stakeholder partners - state health and human services agencies, associations, advocacy groups, and individuals who help us administer the program today and modernize it for the next generation of …
CMP Reinvestment Program ›
Civil money penalties (CMPs) are fines imposed on nursing facilities that do not meet federal health and safety standards.
Helpful Links ›
Not seeing what you are looking for? We want to help you find the information you need. Check out these links to federal and state
Initiatives ›
The Ohio Department of Medicaid is dedicated to being a national leader in health care coverage innovation. In collaboration with our
Legal and Contracts ›
We want to make it easier for you to do business with us. This page includes important information and links for vendors and others
Reports & Research ›
Ohio Medicaid values transparency and accountability in all we do. We are committed to providing our stakeholders and partners with
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

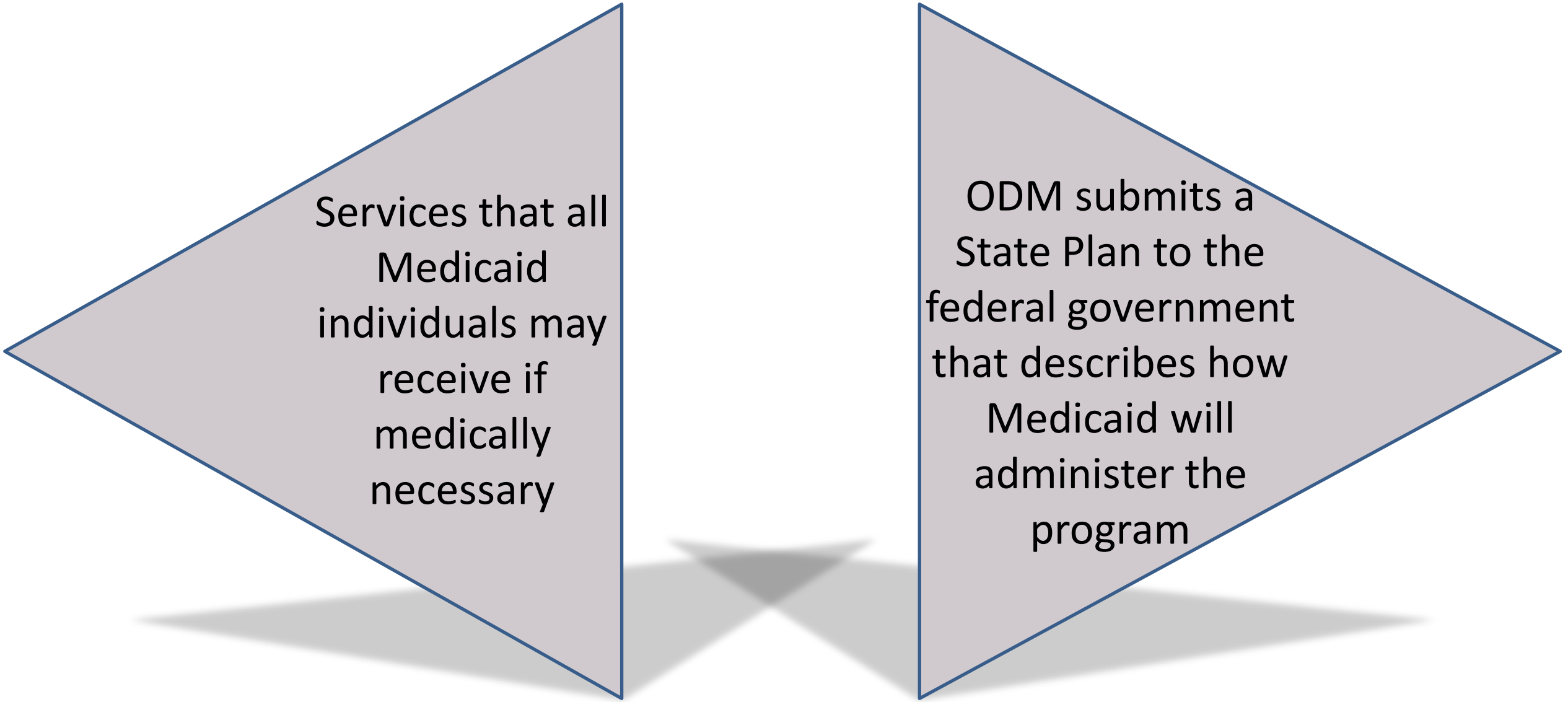
Policy

https://codes.ohio.gov

How to Find Modifiers Recognized by Ohio Medicaid



State Plan Services: OAC 5160-12



What are Private Duty Nursing Services?

- Medicaid State Plan Nursing Services provide home health services when a medical need for part-time intermittent skilled nursing or aide care and therapies is needed for an individual
- Private Duty Nursing Services (PDN) provides those continuous and complex nursing services in a home setting
  - PDN is performed by a RN or LPN
- Continuous care is defined as more than four hours but less than 12 hours-per visit
- These services must be prior authorized
  - ODM determines eligibility for PDN along with the amount, scope, and duration of services

Who Can/Cannot Receive PDN Services?

CAN

An individual who is:

- Medicaid eligible
- Requires continuous skilled nursing services
- Has a comparable institutional level of care
- Is not receiving hospice services

CANNOT

Someone who has elected hospice care must access their nursing services through the hospice benefit

- Except for children under age 21 who are receiving concurrent curative treatment with hospice

State Plan PDN Services Reimbursement: OAC 5160-12-06

T1000 Private Duty Nursing

Base Rate – for initial 35 to 60 minutes of delivered service

Unit Rate – each 15 minute units of delivered service when initial visit is:

Greater than 60 minutes or less than or equal to 34 minutes in length

Appropriate modifiers may be required by policy and needed for proper reimbursement

Ohio Home Care Program: OAC 5160-12-02

Post Hospital PDN Services

Up to 56 hours a week
More than 4 but max of 12 hours/visit/nurse per day/24 hour period
Up to 60 consecutive days post hospital discharge

Not provided for: habilitative care, RN assessment services, and RN consultation services

What Are Waiver Services?

- Waiver refers to an exception to federal law that waives certain Ohio Medicaid eligibility requirements and allows eligible Medicaid individuals to live in the community instead of in a nursing facility or other institution
- An individual must be determined eligible for waiver services
- ODM administers one waiver known as Ohio Home Care Wavier (OHC)
- The Department of Developmental Disabilities (DODD) and The Ohio Department of Aging (ODA) administer additional waiver programs

ODM-Administered Waiver Programs: OAC 5160-45-10

- Ensure individuals are protected from abuse, neglect, exploitation, and other threats to their health, safety and well-being
- Work with the individual and care manager to coordinate care
  - Agree to provide services in the person-centered services plan
  - Participate in developing a back-up plan of care
- Maintain and retain all required documentation
- Verify service delivery using an ODM-approved EVV system

Ohio Home Care (OHC) Waiver: OAC 5160-46-04(A)

Waiver Nursing Services

Nursing tasks and activities requiring skills of a registered nurse (RN) or licensed practical nurse (LPN) if directed by an RN

Examples include: Intravenous (IV) insertion, IV medication administration, central line dressings, blood product administration, and medical pump programming

Ohio Home Care (OHC) Waiver: OAC 5160-46-04(B)

Personal Care Aide Services

Assists individuals with activities of daily living and instrumental activities of daily living

Examples include: bathing, dressing, range of motion exercises, general homemaking activities, household chores, paying bills, accompanying or transporting the individual, and meal preparation

Waiver Services Reimbursement

Use the appropriate procedure code for the service

Base Rate – for initial 35 to 60 minutes of delivered service

Unit Rate – each 15 minute units of delivered service when initial visit is:

Greater than 60 minutes or less

than or equal to 34 minutes in length

Appropriate modifiers may be required by policy and needed for proper reimbursement

Common Waiver Services Procedure Codes

- **T1002** - Waiver nursing by RN
- **T1003** - Waiver nursing by LPN
- **T1019** - Personal care aide services
- **S5125** - Home care attendant (HCAS)

Rates found in OAC 5160-46-06 and 5160-46-06.1

Possible Modifiers

Modifiers	Description
U1	Infusion therapy (RNs only)
U2	Second visit
U3	Three or more visits
U4	12 hours to 16 hours per visit
U5	Healthtrack (EPSDT)
U7	Over 14 hours
U8	HCAS in lieu of intermittent nursing services 4 hours or less

Additional Modifiers

Modifiers	Descriptions
U9	RN consultation with T1001
HQ	Group visit
TD	RN visit
TE	LPN visit
UA	Non-agency RN or LPN visit if portion of visit is overtime
TU	Non-agency RN or LPN visit if entire visit is overtime

Structural Reviews of Providers and Investigation of Provider Occurrences: OAC 5160-45-06

Providers are subject to structural reviews during each of the first three years of furnishing billable services

- Thereafter structural reviews may be conducted biennially if all of the following apply to the provider:
  - There were no findings during the most recent review
  - Was not substantiated to be the violator in an incident
  - Was not the subject of more than one provider occurrence during the previous 12 months
  - Does not live with an individual receiving ODM - administered waiver services

MITS & Claims

Medicaid Information Technology System (MITS)

- MITS is a web-based application that is accessible via any modern browser
- MITS is available to all Ohio Medicaid providers who have been registered and have created an account
- MITS is able to process transactions in “real time”

Technical Requirements

Internet Access (high speed works best)

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

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

Turn **OFF** pop up blocker functionality

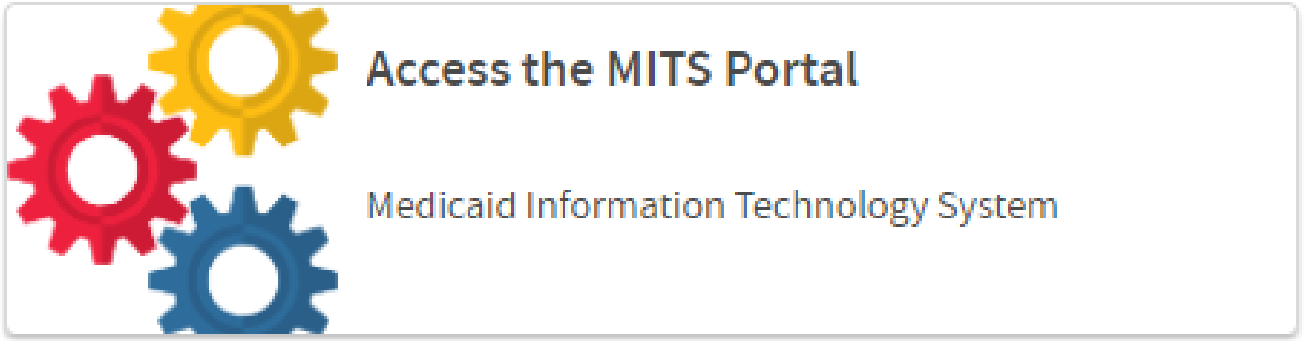
How to Access the MITS Portal

» Go to https://Medicaid.ohio.gov

» Select the “Resources for Providers” tab at the top

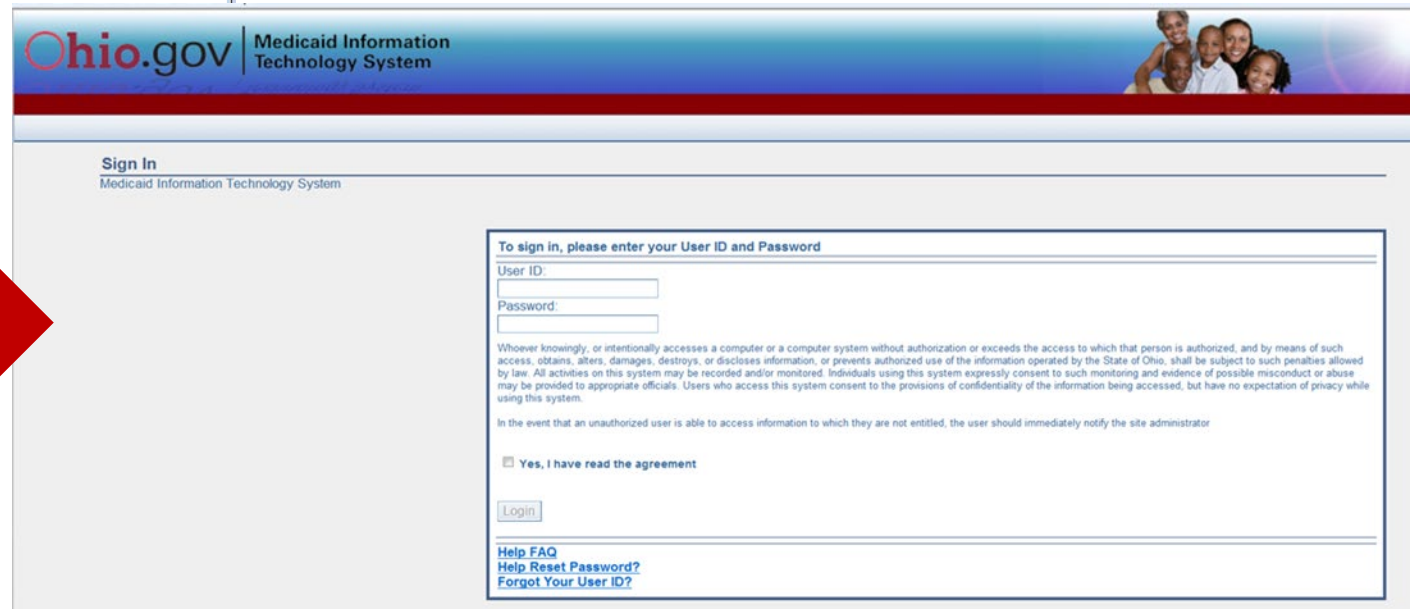
» Click on “MITS”

» Scroll down and click “Access the MITS Portal on the right



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

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



MITS Navigation

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

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

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

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

Electronic Funds Transfer

ODM will start requiring Electronic Funds Transfer (EFT) for payment instead of paper warrants

Benefits of direct deposit include:

- **Quicker funds-** transferred directly to your account on the day paper warrants are normally mailed
- **No worry-** no lost or stolen checks or postal holidays delaying receipt of your warrant
- **Address change-** your payment will still be deposited into your banking account

Electronic Data Interchange (EDI)

Fees for claims submitted

Claims must be received by Wednesday at Noon for the next payment cycle

MITS Portal

Free submission

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

We can help with your claim issues

Technical Questions/EDI Support Unit

Trading partners contact DXC for EDI Support

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

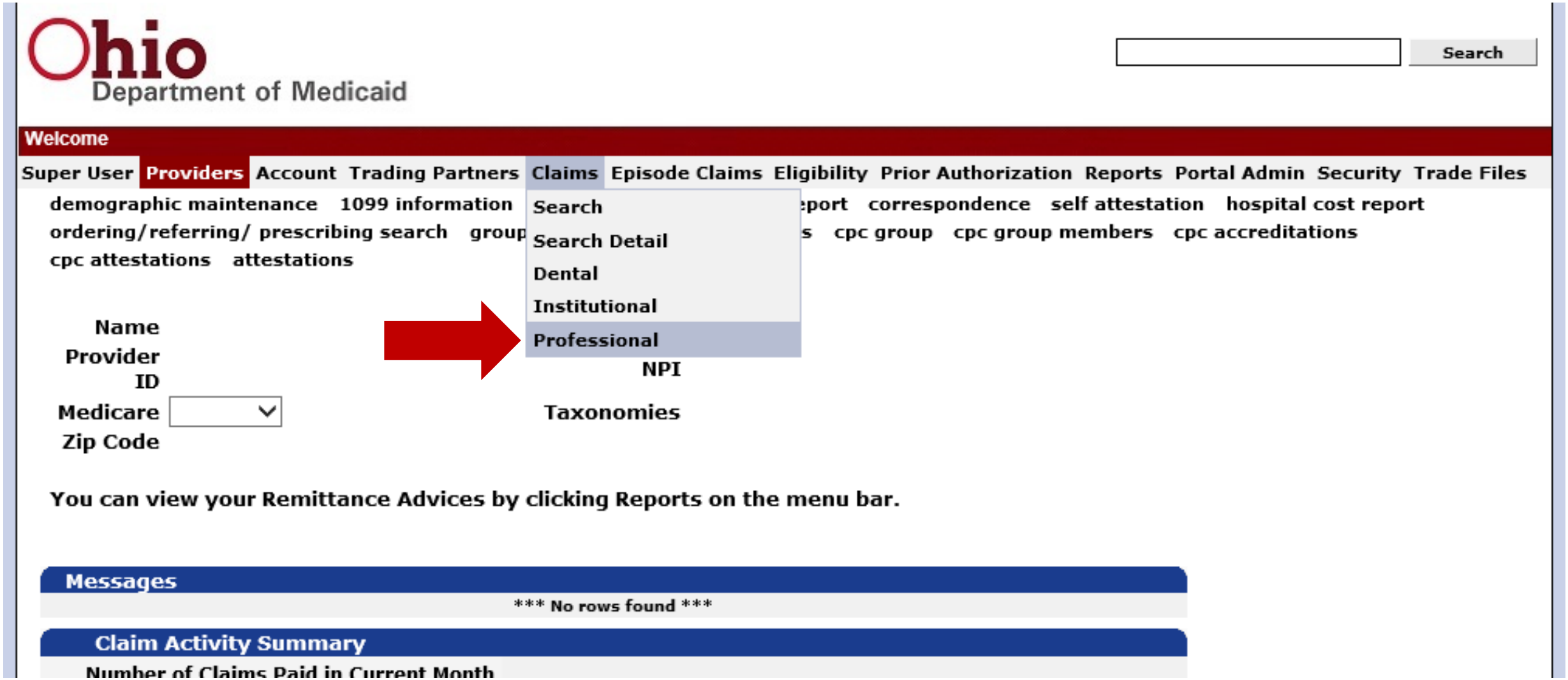
MITS Web Portal Claim Submission

Claim entry format is divided into sections or panels

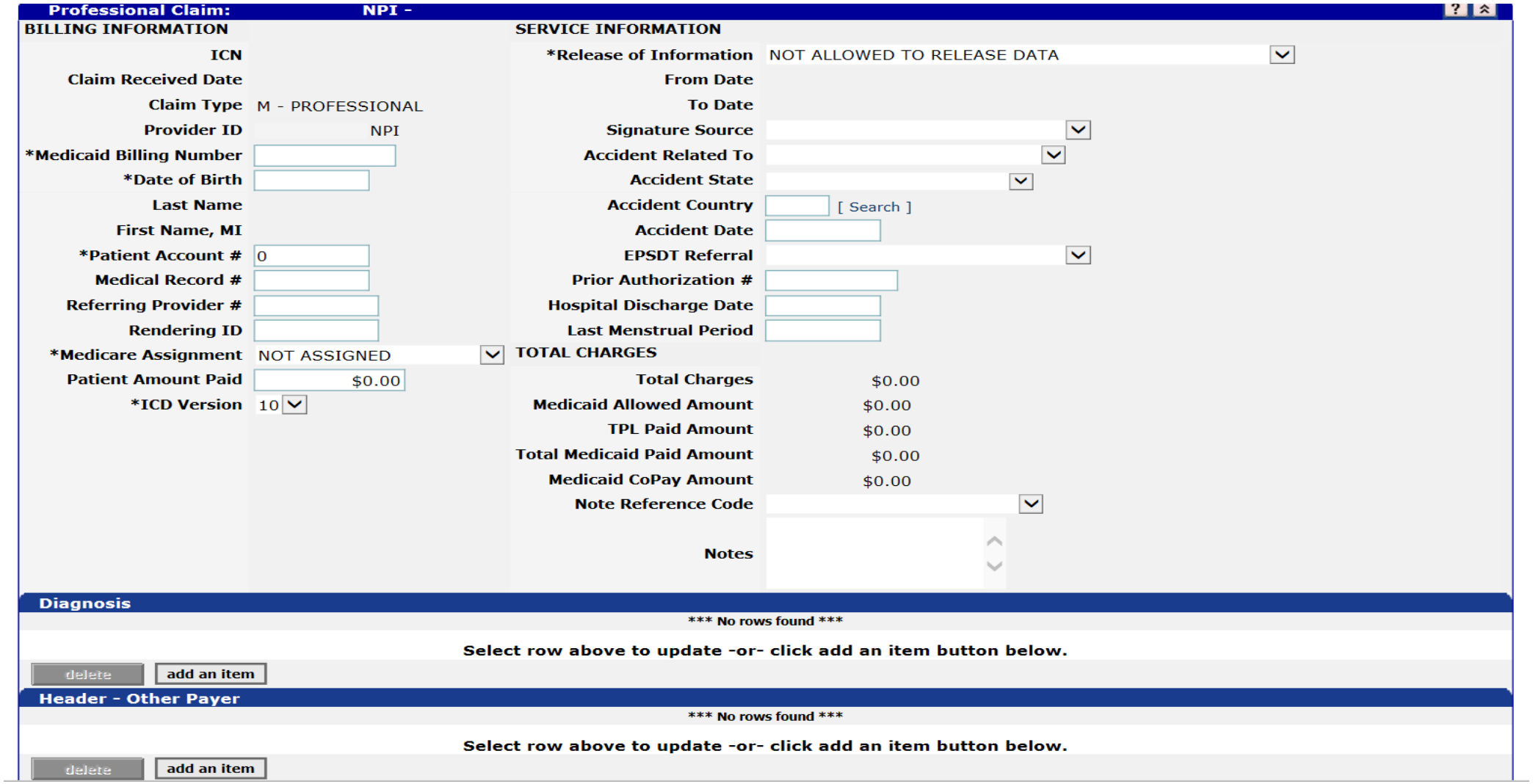
Each panel will have an asterisk (*) denoting that the fields are required

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

Submission of a Professional Claim



Submission of a Professional Claim



Professional Claim: NPI -

BILLING INFORMATION

ICN	
Claim Received Date	
Claim Type	M - PROFESSIONAL
Provider ID	NPI
*Medicaid Billing Number	
*Date of Birth	
Last Name	
First Name, MI	
*Patient Account #	0
Medical Record #	
Referring Provider #	
Rendering ID	
*Medicare Assignment	NOT ASSIGNED
Patient Amount Paid	$0.00
*ICD Version	10

SERVICE INFORMATION

*Release of Information	NOT ALLOWED TO RELEASE DATA
From Date	
To Date	
Signature Source	
Accident Related To	
Accident State	
Accident Country	[Search]
Accident Date	
EPSDT Referral	
Prior Authorization #	
Hospital Discharge Date	
Last Menstrual Period	

TOTAL CHARGES

Total Charges	$0.00
Medicaid Allowed Amount	$0.00
TPL Paid Amount	$0.00
Total Medicaid Paid Amount	$0.00
Medicaid CoPay Amount	$0.00
Note Reference Code	
Notes	

Diagnosis

*** No rows found ***

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

delete | add an item

Header - Other Payer

*** No rows found ***

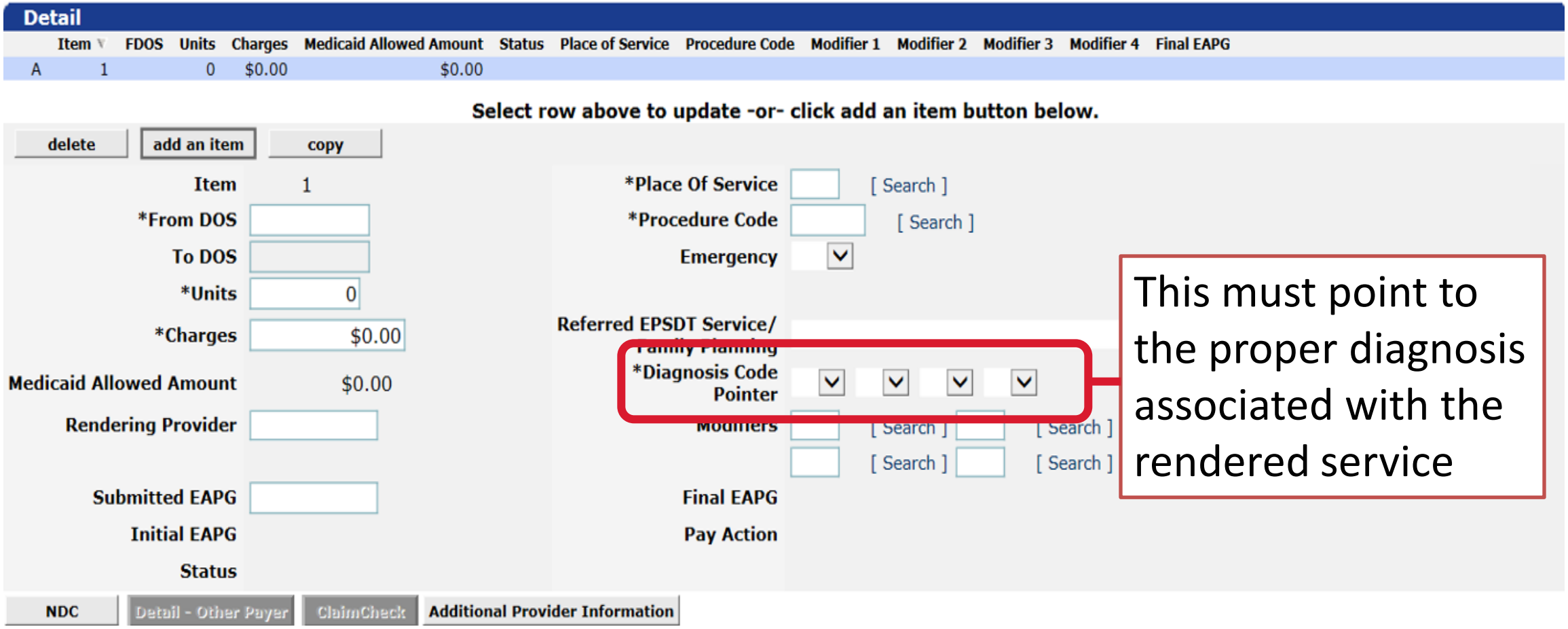
Select row above to update -or- click add an item button below.

delete | add an item

Diagnosis Codes: Medicaid Advisory Letter (MAL) No. 626-A

- Effective 1/1/2020
- To comply with current HIPAA standards, diagnosis codes must be reported for all Medicaid covered services
- Required on professional claims only

Diagnosis Code Pointer



This must point to the proper diagnosis associated with the rendered service

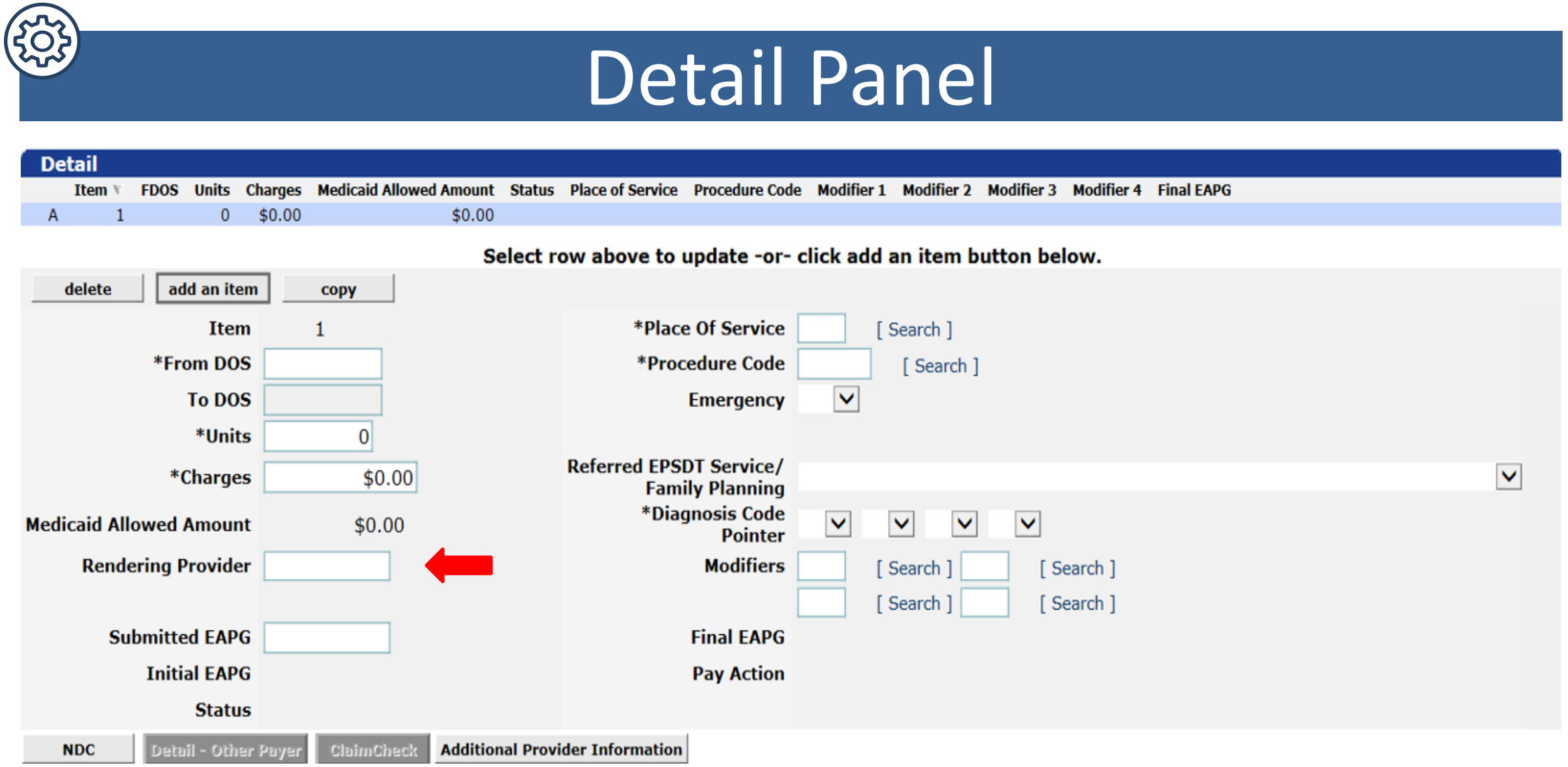
Multiple Visits

- If providing multiple visits on the same day, all of the visits must be entered on the same claim
  - U2 and U3 indicate additional visits
- If overtime occurs during a day with multiple visits, the overtime must be billed on the same claim as the other visits
  - Overtime can be achieved during the middle of a visit

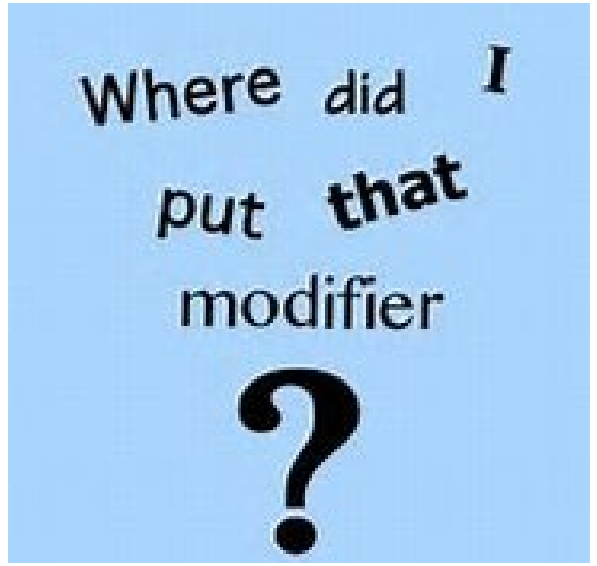
Appropriate Modifiers

- TU indicates the entire visit is overtime
- UA indicates some units of a visit were overtime
- HQ indicates services were delivered in a group setting
- U2 indicates a second visit on Ohio Home Care Waiver for the same day
- U3 indicates three or more visits on Ohio Home Care Waiver for the same day
- U4 indicates a single visit for more than 12 hours but less than 16 hours

Detail Panel



Claim Submission



❖ Appropriate Modifiers

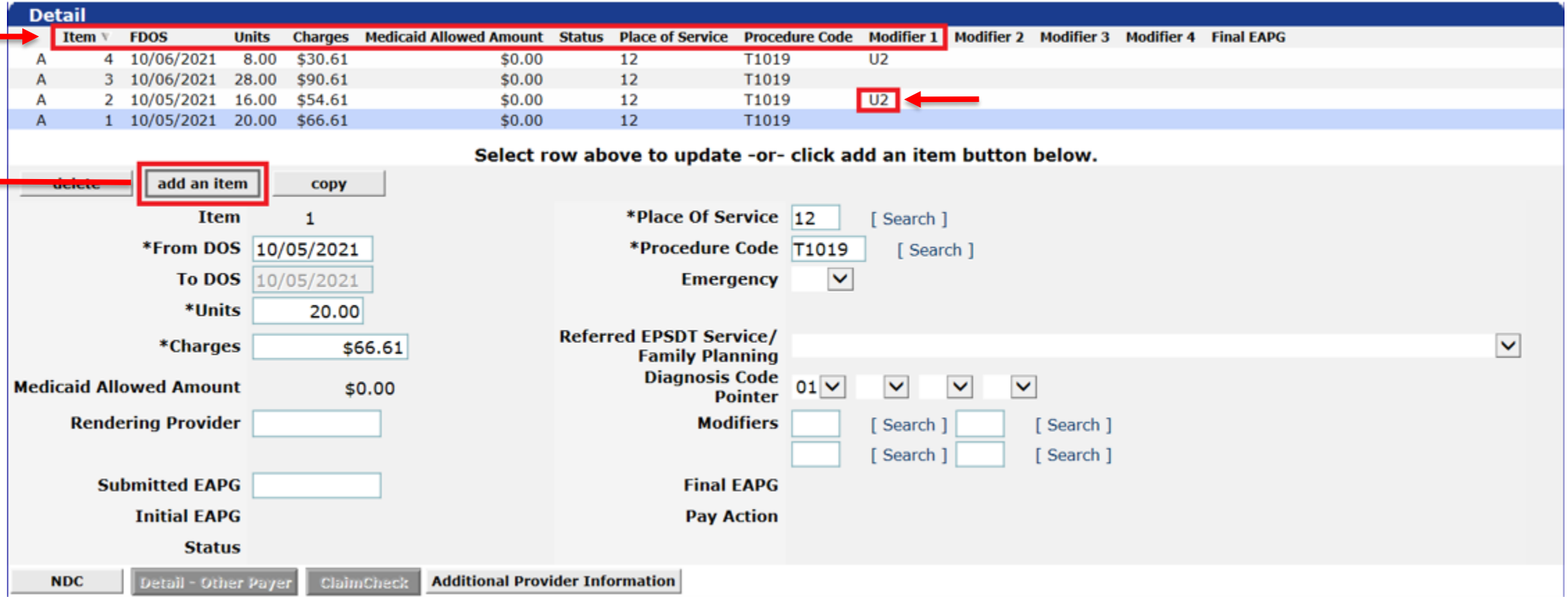
- TU indicates entire visit is overtime
- UA indicates some units of a visit were overtime
- HQ indicates services were delivered in group setting
- U2 indicates a second visit on Ohio Home Care Wavier for same day
- U3 indicates three or more visits on Ohio Home Care Wavier for same day
- U4 indicates single visit for more than 12 hours but less then 16 hours

Claim Submission

- Multiple Visits on the same date of service
  - If a provider is providing multiple visits on the same day, all of the visits must be noted on a single claim
    - Ensure proper modifier used for each visit

Claim Submission

- Multiple Visits on the same date of service, cont'd

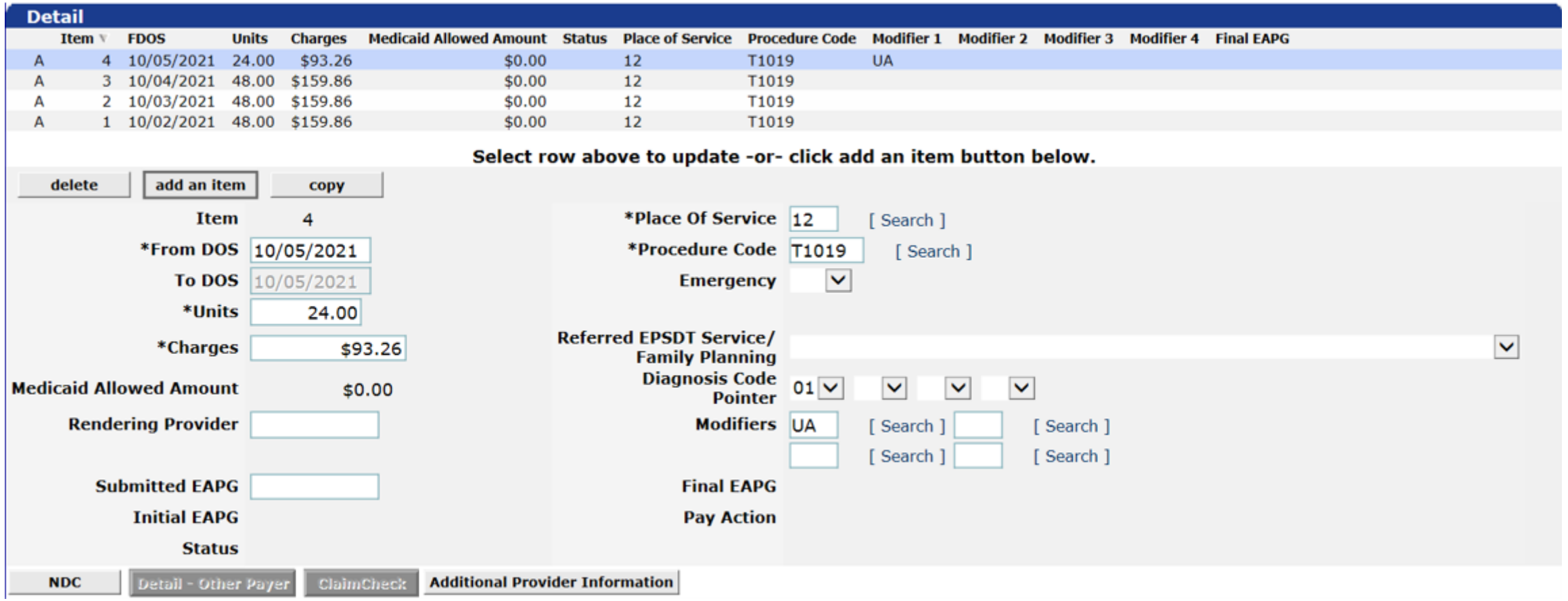


Claim Submission

- Overtime during the work week
  - If a provider exceeds 40 hours working within a work week they must submit the hours over 40 for the week as overtime
    - Providers use the UA modifier to indicate overtime

Claim Submission

- Overtime during the work week, cont'd (some units)



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	4	10/05/2021	24.00	$93.26	$0.00		12	T1019	UA				
A	3	10/04/2021	48.00	$159.86	$0.00		12	T1019					
A	2	10/03/2021	48.00	$159.86	$0.00		12	T1019					
A	1	10/02/2021	48.00	$159.86	$0.00		12	T1019					

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

delete | add an item | copy

Item 4

*From DOS 10/05/2021

To DOS 10/05/2021

*Units 24.00

*Charges $93.26

Medicaid Allowed Amount $0.00

Rendering Provider

Submitted EAPG

Initial EAPG

Status

*Place Of Service 12 [Search]

*Procedure Code T1019 [Search]

Emergency

Referred EPSDT Service/ Family Planning

Diagnosis Code Pointer 01

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

Final EAPG

Pay Action

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

Claim Submission

- Overtime during the work week, cont'd (entire visit)

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	5	10/05/2021	32.00	$159.86	$0.00		12	T1019	U2	TU			
A	4	10/05/2021	16.00	$53.29	$0.00		12	T1019					
A	3	10/04/2021	48.00	$159.86	$0.00		12	T1019					
A	2	10/03/2021	48.00	$159.86	$0.00		12	T1019					
A	1	10/02/2021	48.00	$159.86	$0.00		12	T1019					

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

delete | add an item | copy

Item	5	*Place Of Service	12 [Search]
*From DOS	10/05/2021	*Procedure Code	T1019 [Search]
To DOS	10/05/2021	Emergency	
*Units	32.00		
*Charges	$159.86	Referred EPSDT Service/ Family Planning	
Medicaid Allowed Amount	$0.00	Diagnosis Code Pointer	01
Rendering Provider		Modifiers	U2 [Search] TU [Search]
			[Search] [Search]
Submitted EAPG		Final EAPG	
Initial EAPG		Pay Action	
Status			

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

Claim Submission

- Entering the Ordering Provider's information

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	5	10/05/2021	32.00	$159.86	$0.00		12	T1019	U2	TU			
A	4	10/05/2021	16.00	$53.29	$0.00		12	T1019					
A	3	10/04/2021	48.00	$159.86	$0.00		12	T1019					
A	2	10/03/2021	48.00	$159.86	$0.00		12	T1019					
A	1	10/02/2021	48.00	$159.86	$0.00		12	T1019					

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

delete | add an item | copy

Item 5

*From DOS 10/05/2021

To DOS 10/05/2021

*Units 32.00

*Charges $159.86

Medicaid Allowed Amount $0.00

Rendering Provider

Submitted EAPG

Initial EAPG

Status

*Place Of Service 12 [Search]

*Procedure Code T1019 [Search]

Emergency

Referred EPSDT Service/ Family Planning

Diagnosis Code Pointer 01

Modifiers U2 [Search] TU [Search]

[Search] [Search]

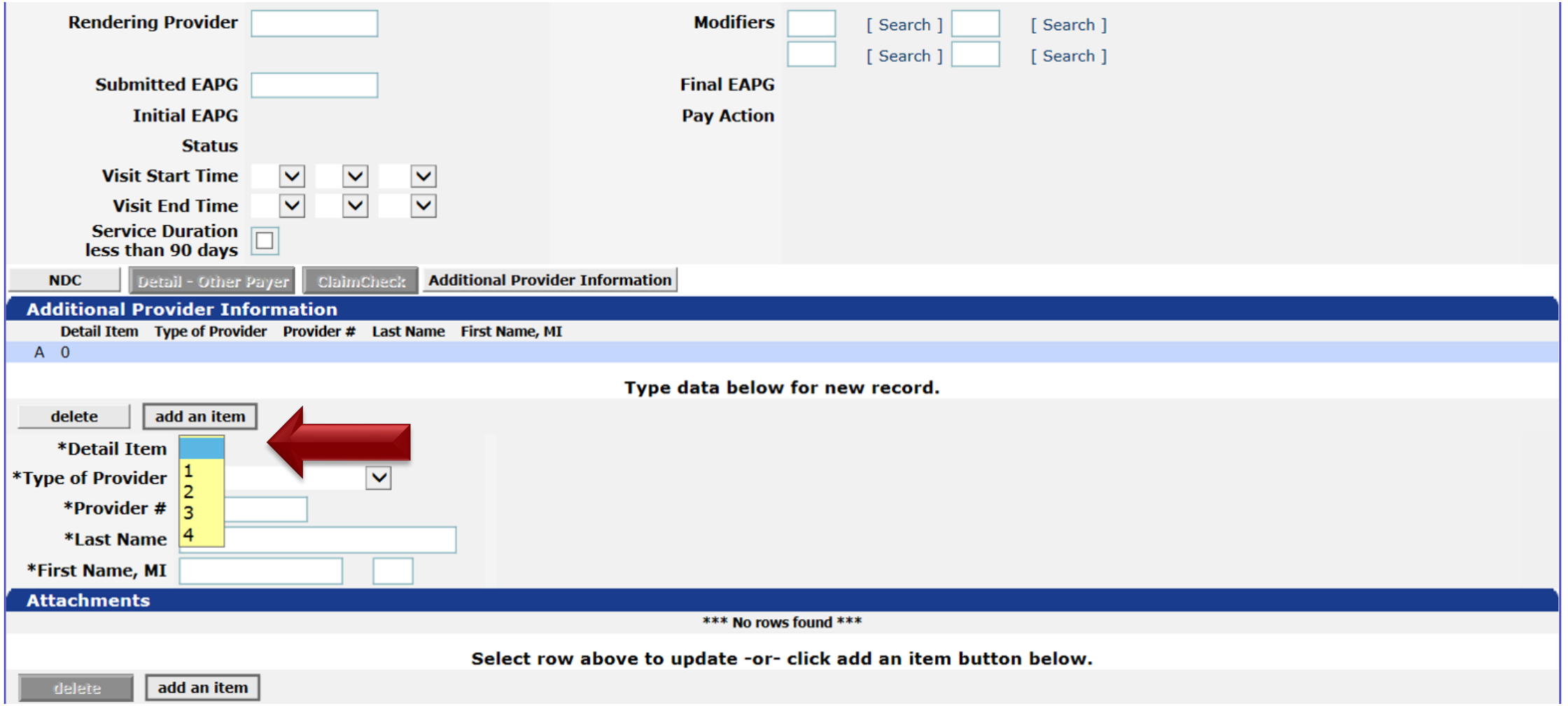
Final EAPG

Pay Action

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

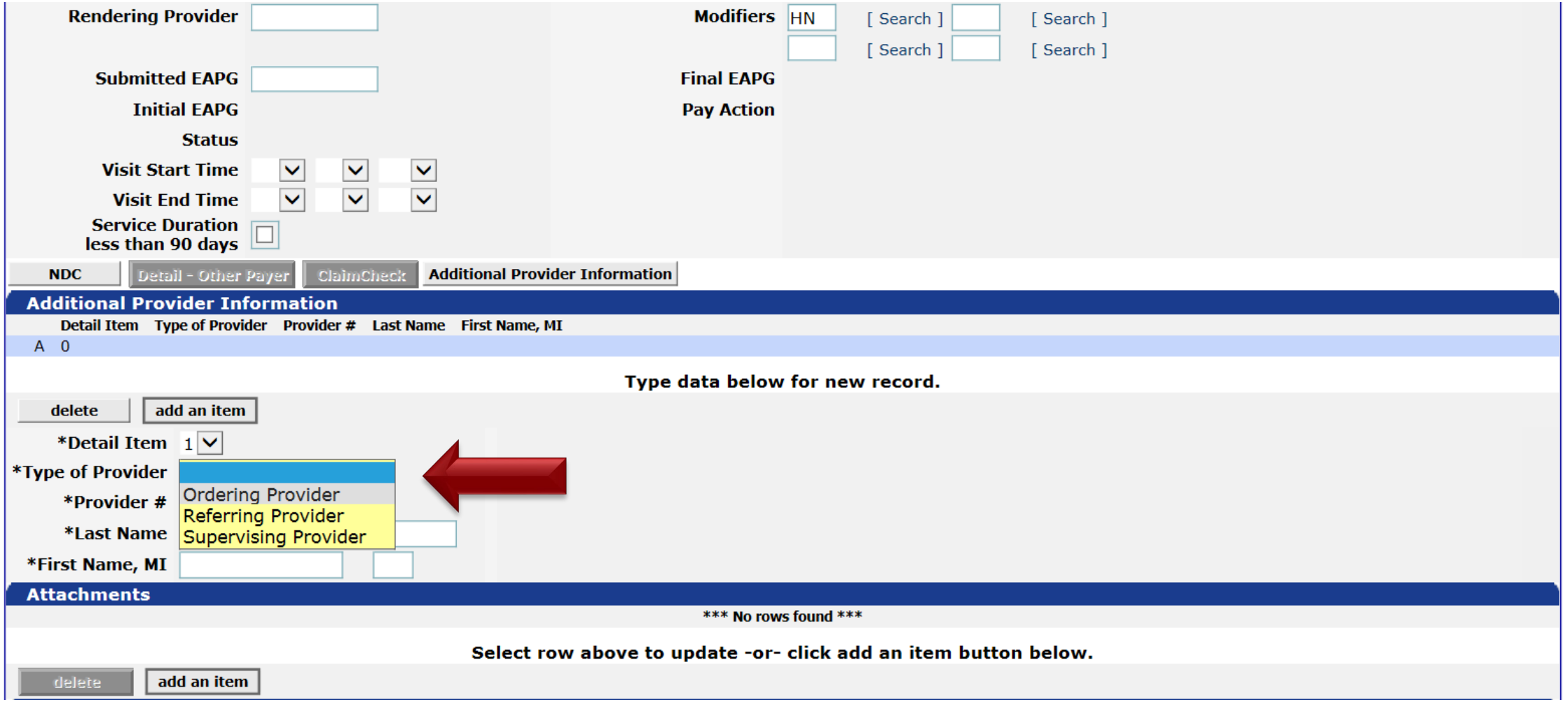
Claim Submission

❖ Entering the Ordering Provider's information, cont.



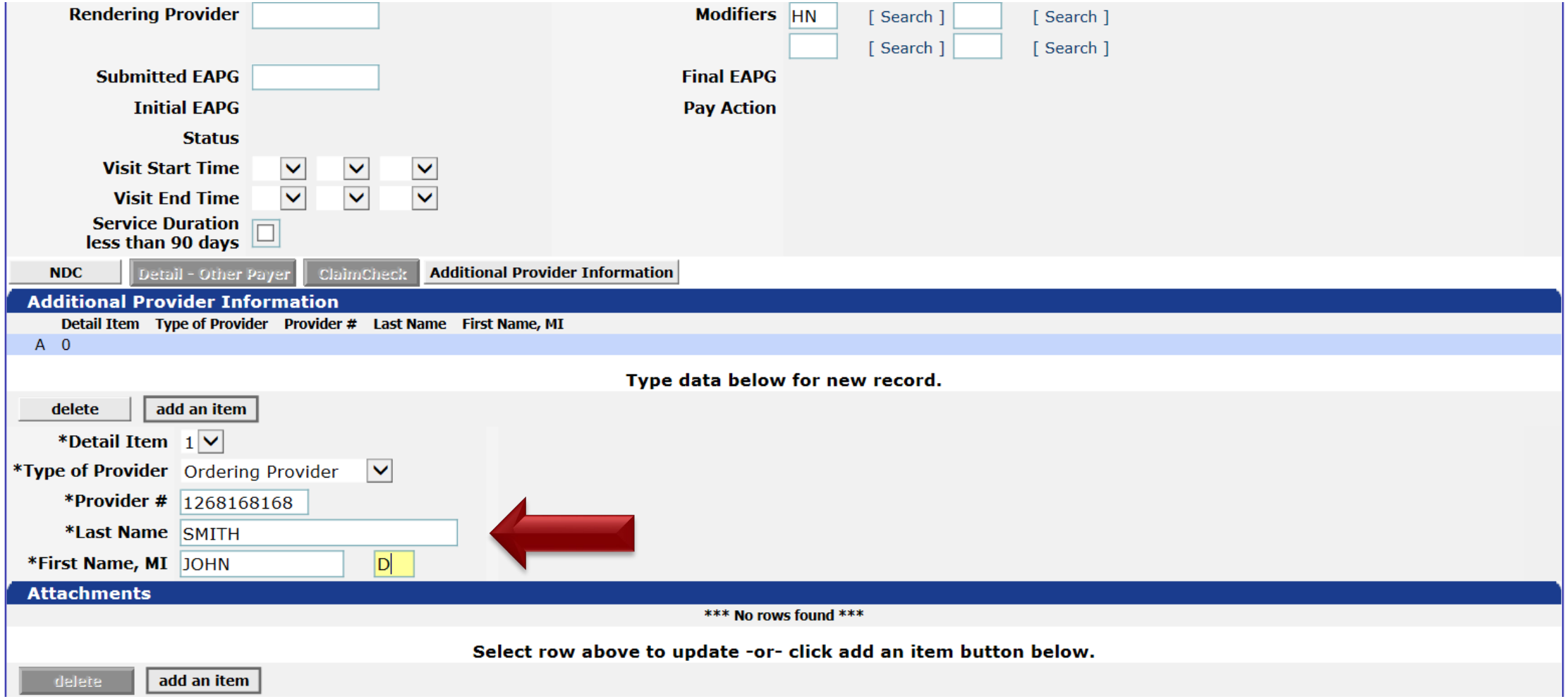
Claim Submission

❖ Entering the Ordering Provider's information, cont.



Claim Submission

❖ Entering the Ordering Provider's information, cont.



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

Paid claims can be:

Voided

Adjusted

Copied

All claims are assigned an ICN

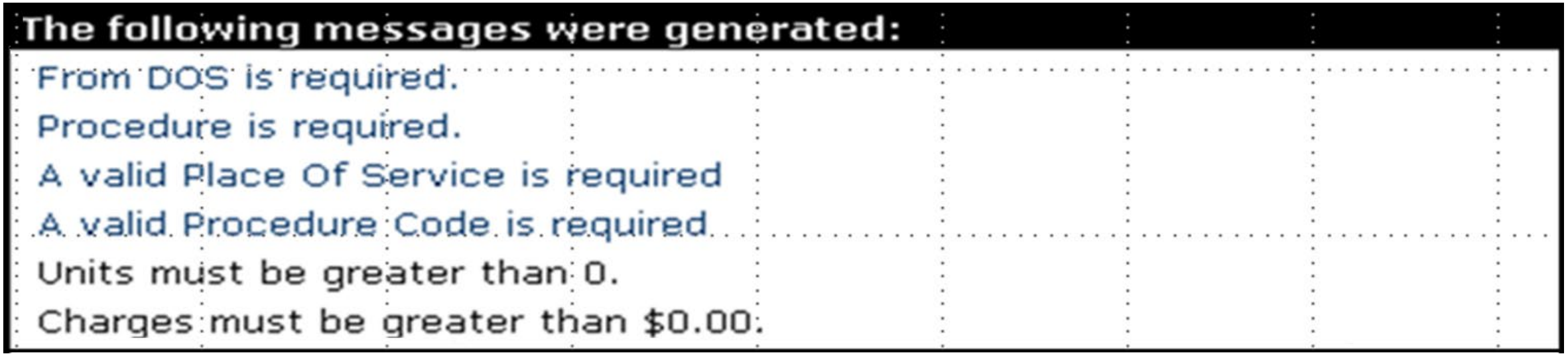
2221170357321

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

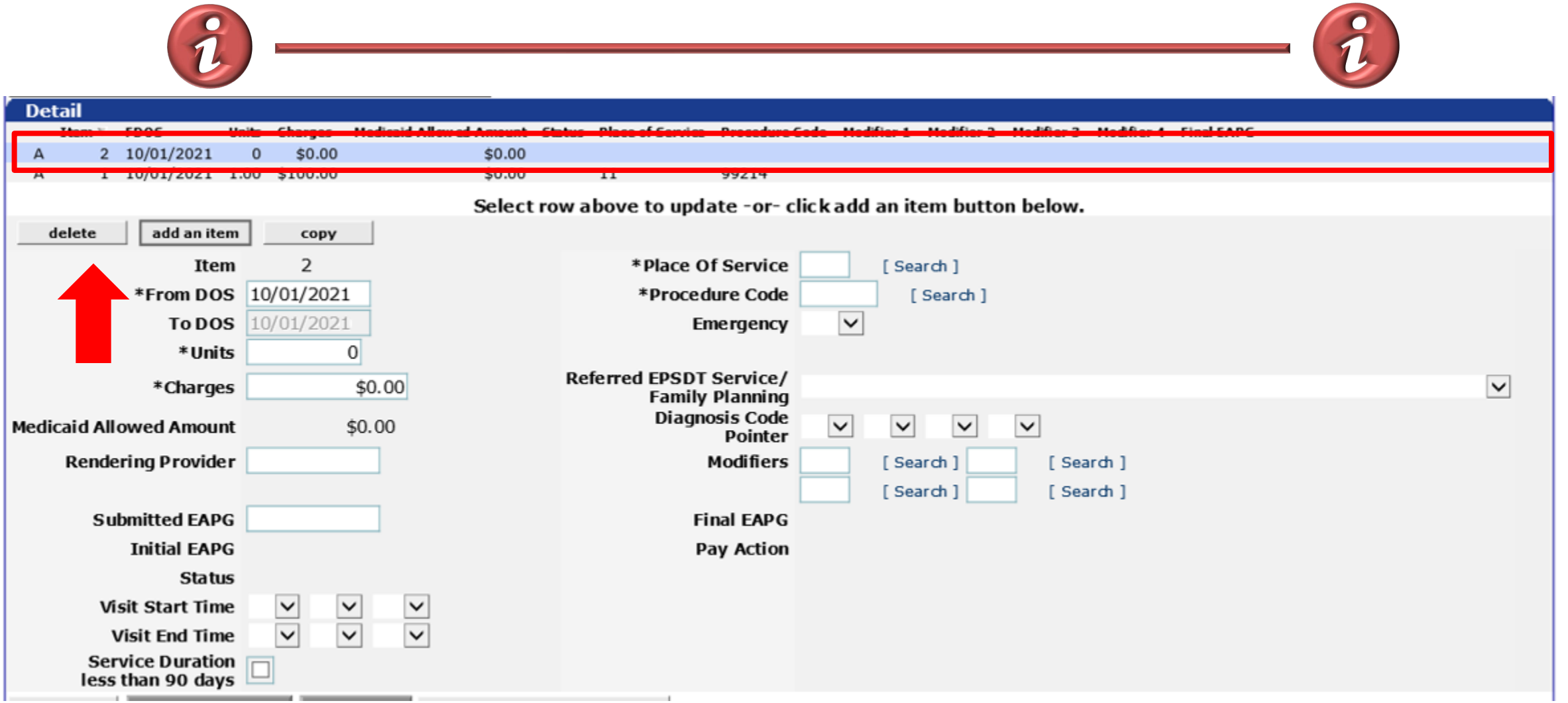
Claim Portal Errors, cont.

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

Scroll to the top of the claim



Claim Portal Errors, cont.



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

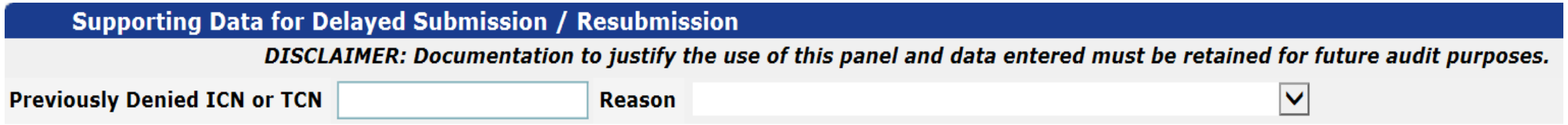
An additional 180 days from the resubmit date is given for attempts to correctly submit a denied claim prior to the end of the 365 days

Claims over 2 years old will be denied

There are exceptions to the 365 day rule

Submitting a Claim Over 365 Days Old

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



Special Billing Instructions – Eligibility Delay

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

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

Special Billing Instructions – Eligibility Delay

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

- In the Note Reference Code dropdown menu select "ADD – Additional Information"

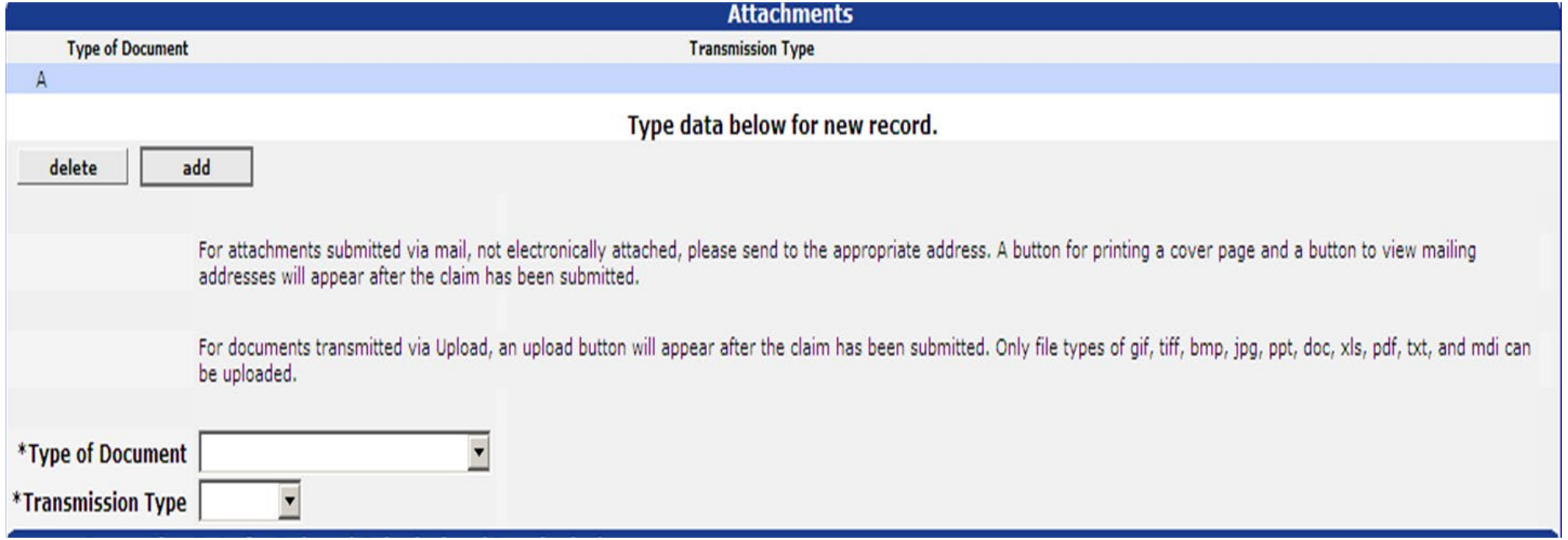
Special Billing Instructions – Eligibility Delay

- 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

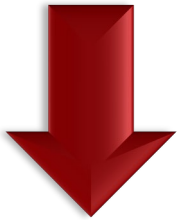
- This panel allows you to electronically upload an attachment onto your claim in MITS



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

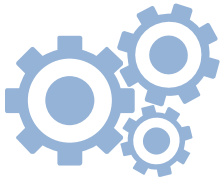


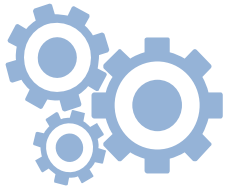
- Open the claim requiring an adjustment
- Change and save the necessary information
- Click the “adjust” button

Adjusting a Paid Claim, cont.

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

Example, cont.





Detail

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

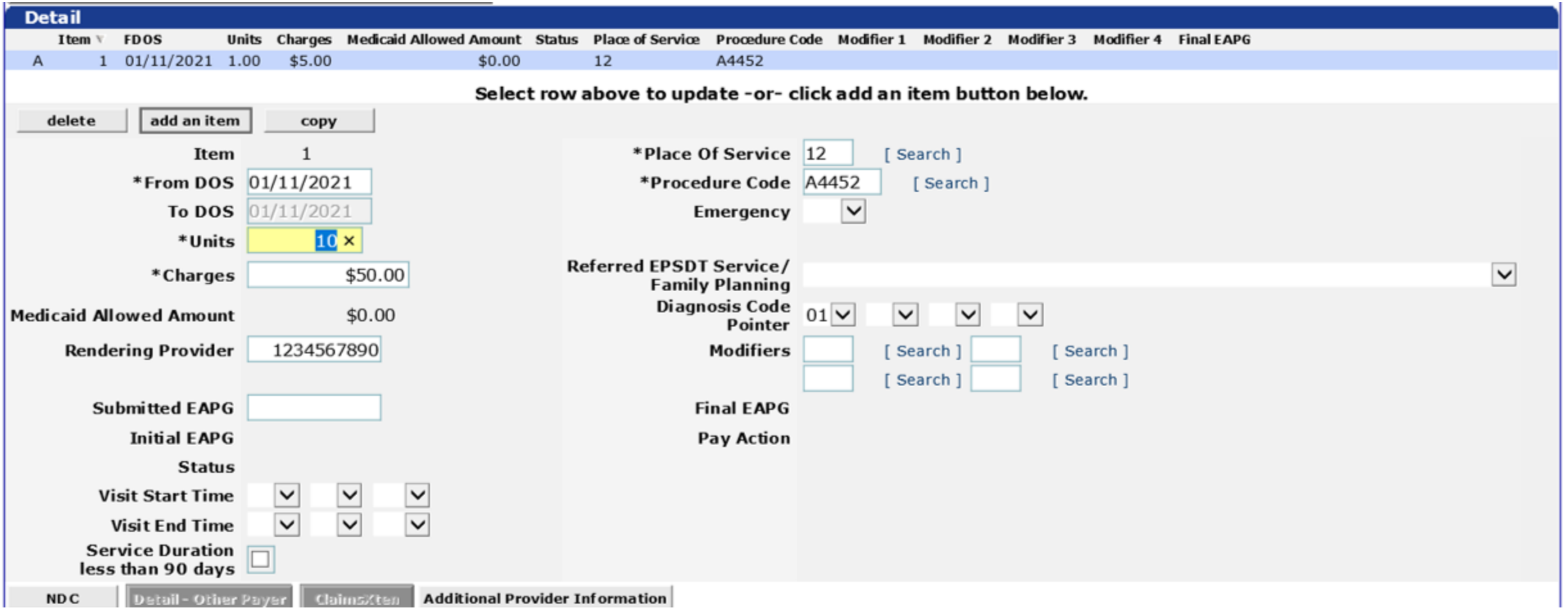
Select row above to update -or- click add an item button below.

delete | add an item | copy

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

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

Example, cont.



Example, cont.

Claim Status Information

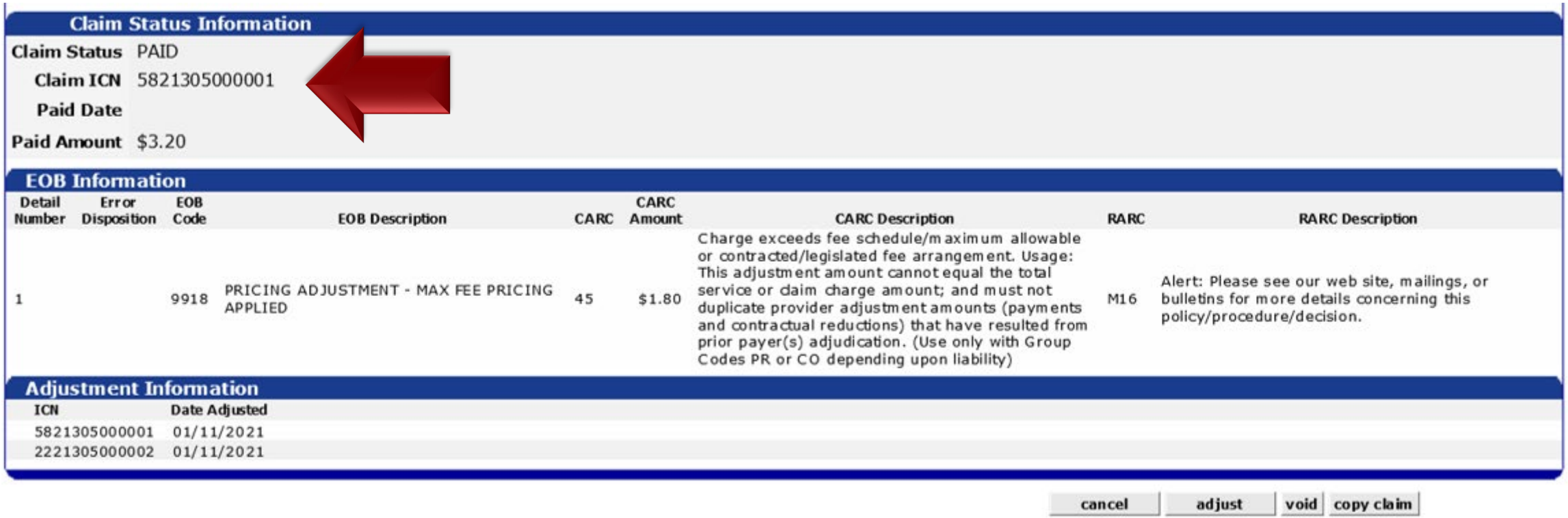
Claim Status	PAID
Claim ICN	2221305000002
Paid Date	
Paid Amount	$0.32

EOB Information

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

cancel | adjust | void | copy claim

Example, cont.



Claim Status Information

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

EOB Information

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

Adjustment Information

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

cancel | adjust | void | copy claim

Voiding a Paid Claim

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

Example, cont.

Claim Status Information

Claim Status PAID

Claim ICN 5821305000001

Paid Date

Paid Amount $3.20

EOB Information

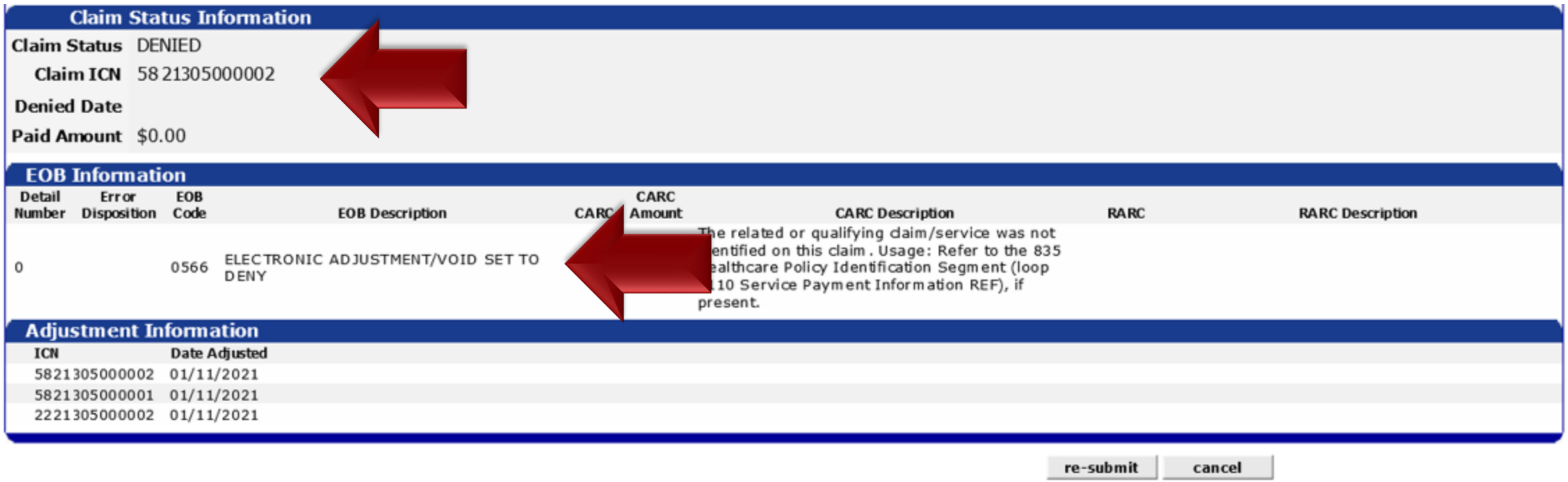
Detail Number	Error Disposition	EOB Code	EOB Description	CARC	CARC Amount	CARC Description	RARC	RARC Description
1		9918	PRICING ADJUSTMENT - MAX FEE PRICING APPLIED	45	$1.80	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal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

Adjustment Information

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

cancel | adjust | void | copy claim

Example, cont.



Claim Status Information

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

EOB Information

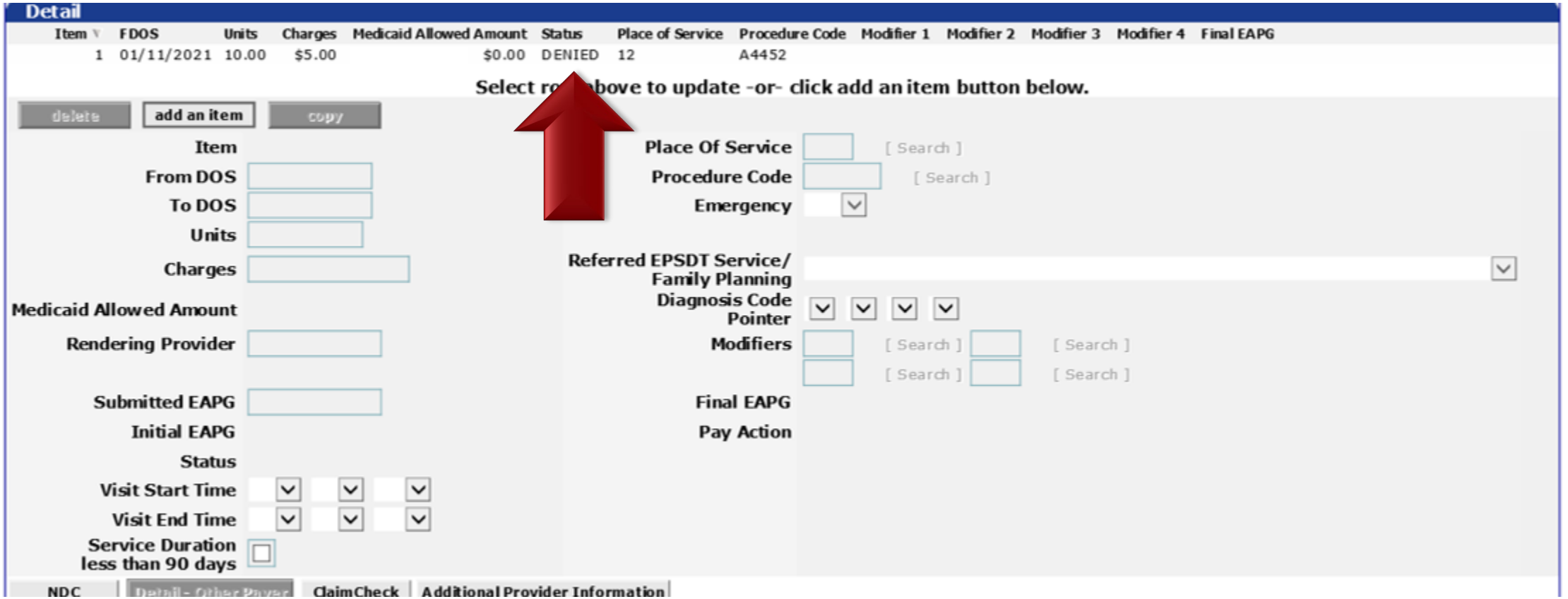
Detail Number	Error Disposition	EOB Code	EOB Description	CARC	CARC Amount	CARC Description	RARC	RARC Description
0		0566	ELECTRONIC ADJUSTMENT/VOID SET TO DENY			The related or qualifying claim/service was not identified on this claim. Usage: Refer to the 835 Healthcare Policy Identification Segment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

Adjustment Information

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

re-submit cancel

Example, cont.



Copying a Paid Claim

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

ClaimCheck Edits

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

The National Correct Coding Initiative (NCCI)

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

The National Correct Coding Initiative (NCCI)

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

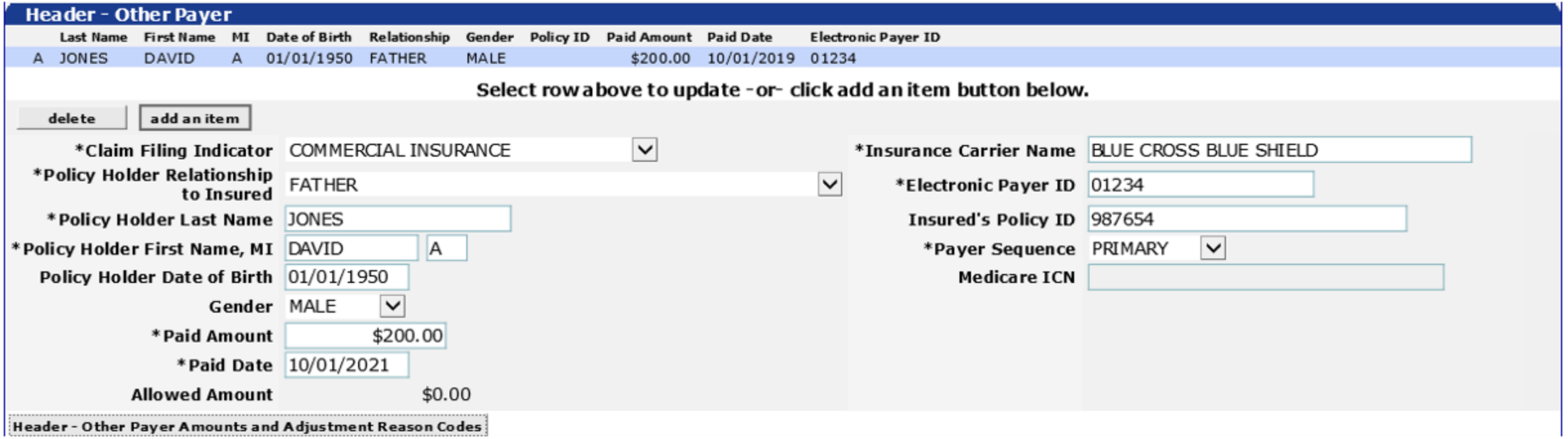
CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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

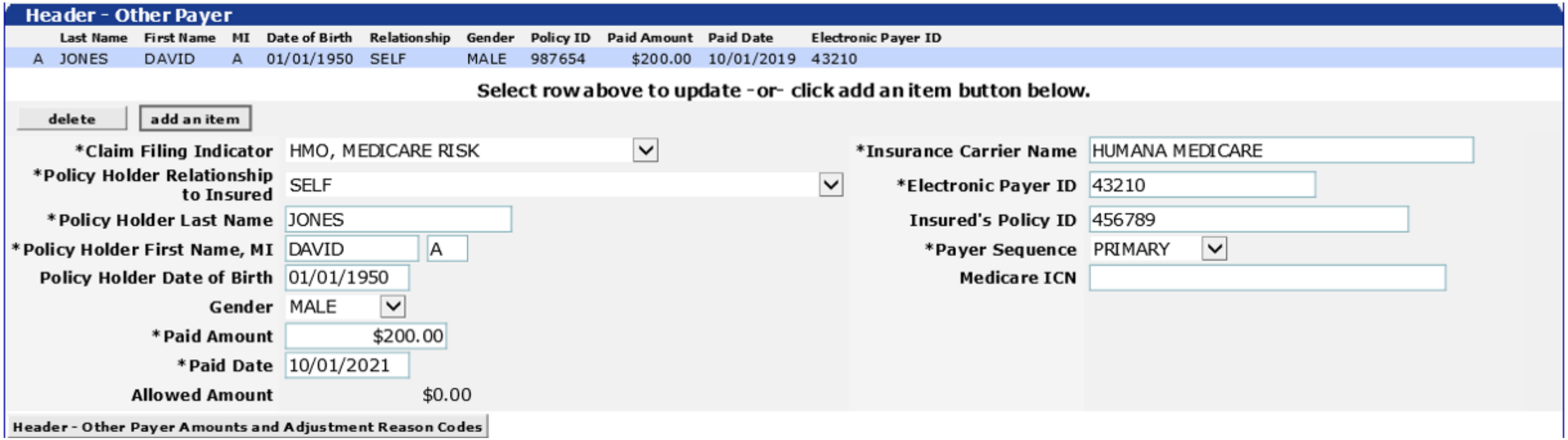
Claims with Other Payers, cont.

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



Claims with Other Payers, cont.

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



Claims with Other Payers, cont.

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, cont.

Header vs Detail

Header level

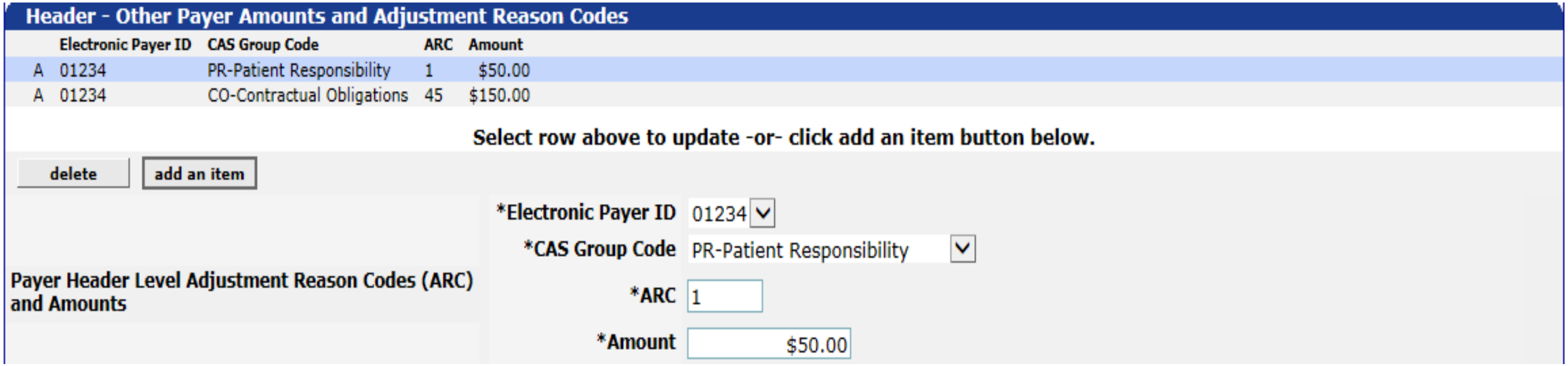
- A COB claim is considered to be adjudicated at the header/claim level if only one set of figures is reported for the entire claim

Detail level

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

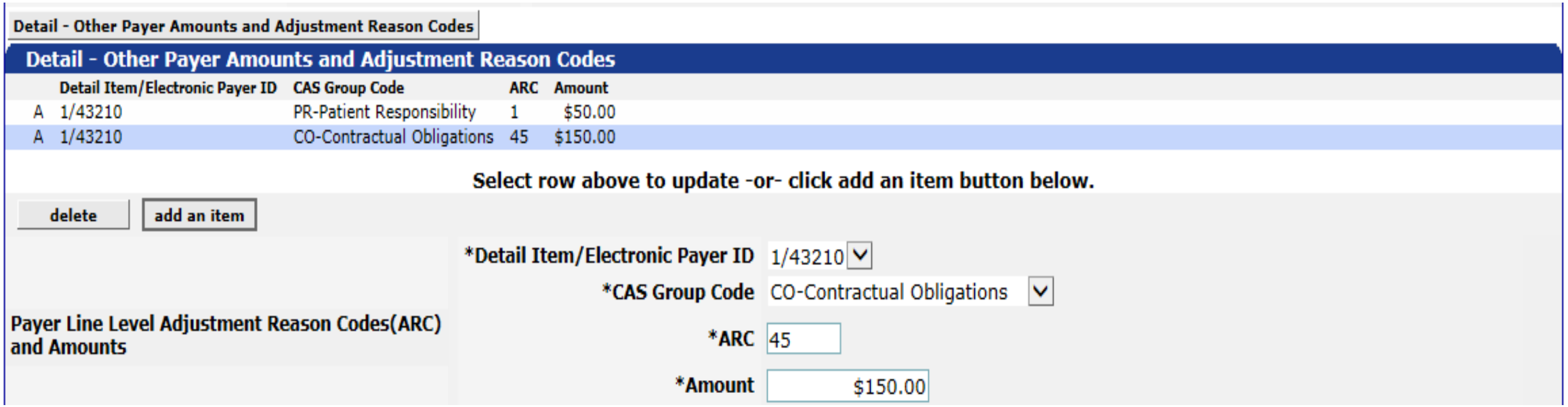
Claims with Other Payers, cont.

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



Claims with Other Payers, cont.

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



Claims with Other Payers, cont.

Claims with Other Payers, cont.

Header - Other Payer

	Last Name	First Name	MI	Date of Birth	Relationship	Gender	Policy ID	Paid Amount	Paid Date	Electronic Payer ID
A	SMITH	JOHN	A	01/01/1950	FATHER	MALE		$200.00	03/01/2018	0077193

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

delete | add an item

*Claim Filing Indicator	COMMERCIAL INSURANCE	*Insurance Carrier Name	BLUE CROSS BLUE SHIELD
*Policy Holder Relationship to Insured	FATHER	*Electronic Payer ID	0077193
*Policy Holder Last Name	SMITH	Insured's Policy ID	
*Policy Holder First Name, MI	JOHN A	*Payer Sequence	
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	0077193	PR-Patient Responsibility	1	$50.00

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

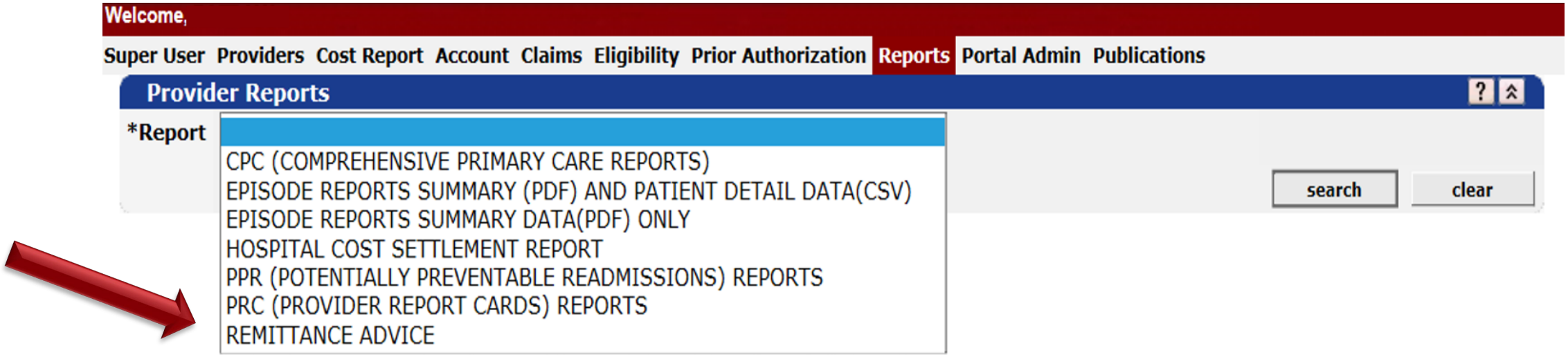
delete | add an item

Payer Header Level Adjustment Reason Codes (ARC) and Amounts

*Electronic Payer ID	0077193
*CAS Group Code	PR-Patient Responsibility
*ARC	1
*Amount	$50.00

Remittance Advice (RA)

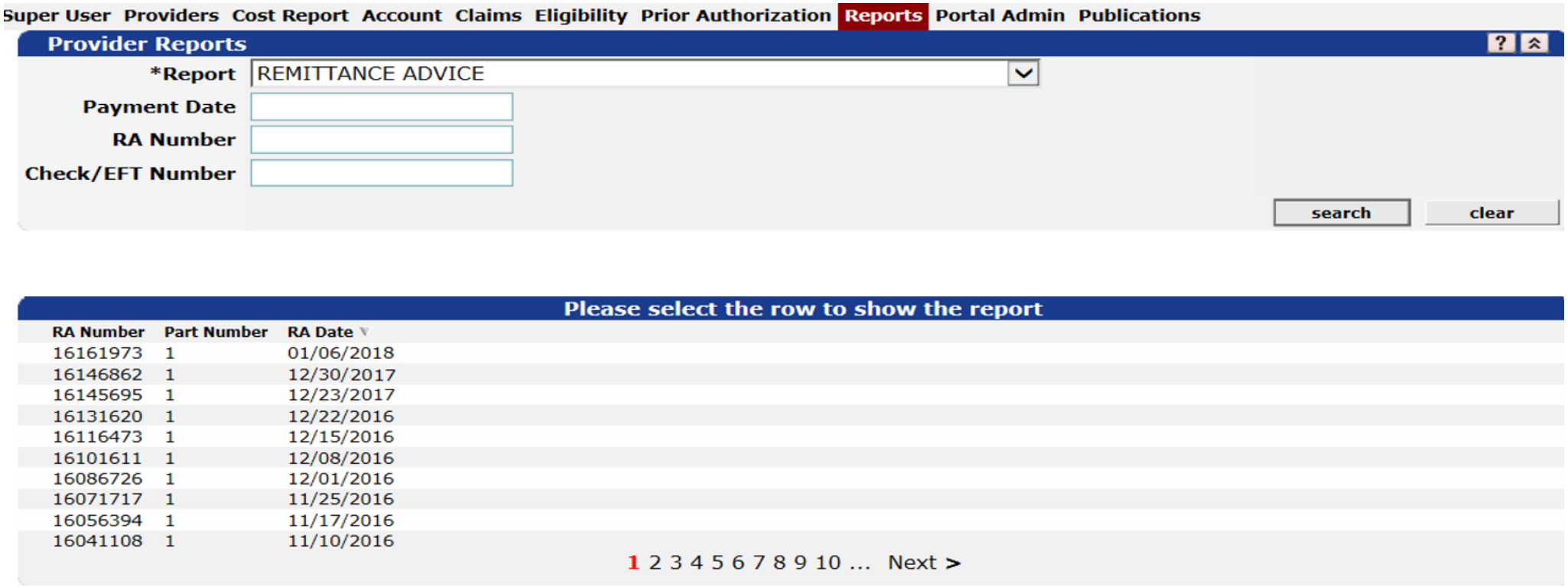
- All claims processed are available on the MITS Portal
- Weekly reports become available on Wednesdays



Remittance Advice (RA)

- Select “Remittance Advice” and click “Search”

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



Remittance Advice (RA)

Paid, denied, and adjusted claims

Financial transactions

Expenditures - Non-claim payments

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

Summary

Current, month, and year to date information

Remittance Advice (RA)

Information pages

Banner messages to the provider community

EOB code explanations

Provides a comparison of codes to the description

TPL claim denial information

Provides other insurance information for any TPL claim denials

Prior Authorization (PA)

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

Prior Authorization (PA)

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

Prior Authorization (PA)

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

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

Prior Authorization (PA)

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

Websites & Forms

Websites

- Ohio Department of Medicaid home page

http://Medicaid.ohio.gov

- Ohio Department of Medicaid provider page

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

- MALs & MTLs

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

- Ohio Administrative Codes

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

Websites

- Provider Enrollment

https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/enrollment-and-support/enrollment-and-support

- MITS home page

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

Electronic Funds Transfer

https://obm.ohio.gov/wps/portal/gov/obm/areas-of-interest/ohio-suppliers/supplier-forms/

Websites

- Companion Guides (EDI)

https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/billing/trading-partners/companion-guides/companion-guides

- Electronic Visit Verification (EVV)

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

- Healthchek

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

- X12 Website (ARC Codes)

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

Forms

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

https://medicaid.ohio.gov/wps/portal/gov/medicaid/stakeholders-and-partners/legal-and-contracts/forms/forms