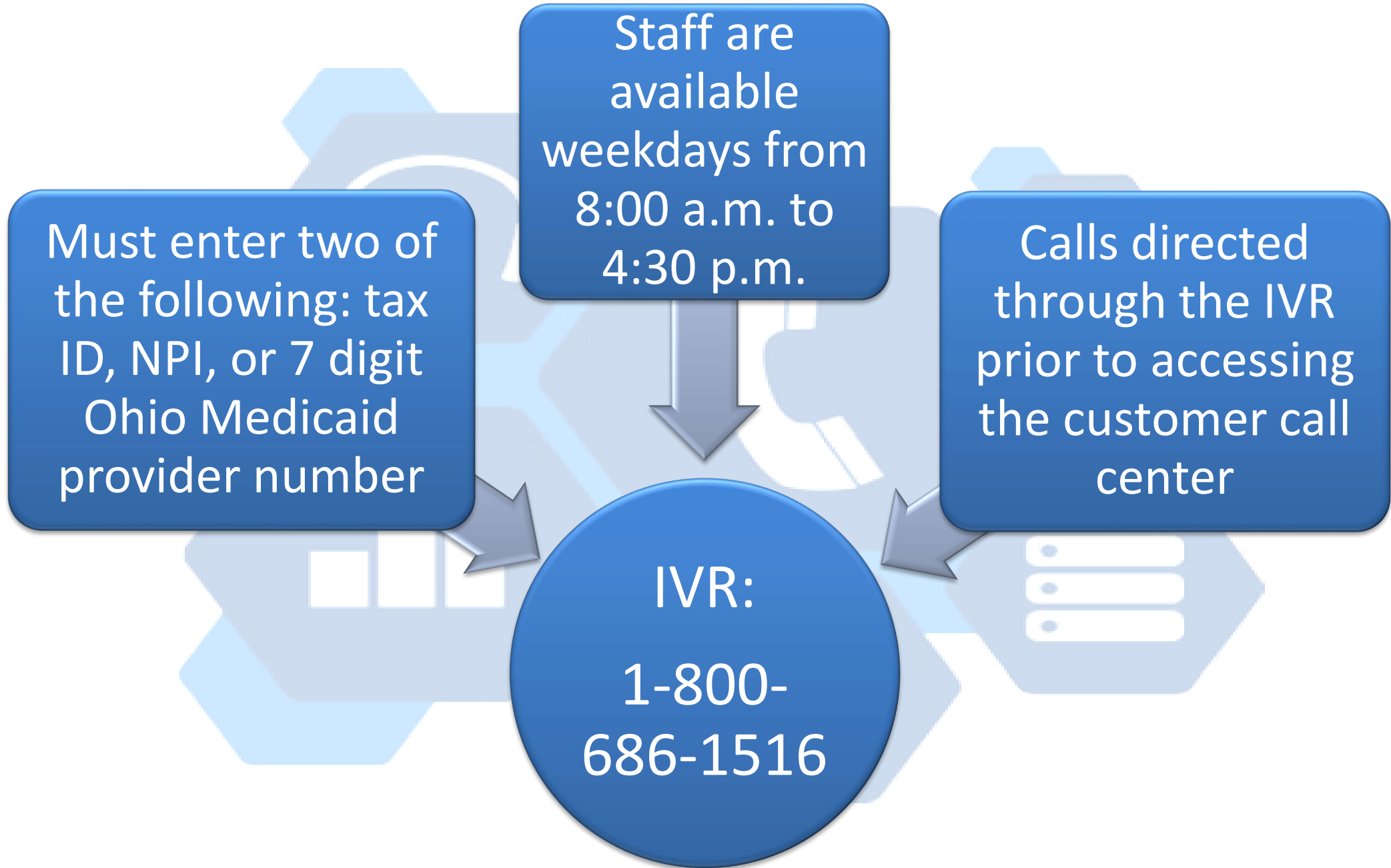


Basic Billing for Nursing Facilities

Provider Relations

2022



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)



Medicaid Medical Necessity: OAC 5160-1-01

Is the fundamental concept underlying the
Medicaid Program



All services must meet accepted standards of
medical practice

Ohio Medicaid Covers:



- Covered Families and Children
- Expansion Population
- Aged, Blind, or People with Disabilities
- Home and Community Based Waivers
- Medicare Premium Assistance
- Hospital Care Assurance Program
- Medicaid Managed Care

Programs & Cards

Ohio Medicaid

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

<p>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.</p> <p>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.</p> <p>Note: Use the Medicaid ID for all claim submissions.</p> <p><u>medicaid.ohio.gov</u></p> <p>Consumer's Signature: _____</p>	<p>County ALLEN</p> <p>Case Number 5082482</p> <p>Eligibility Begin Date 01/01/2020</p> <p>Void After Date 01/31/2020</p> <p>Ohio Department of Medicaid medicaid.ohio.gov</p> <p>Consumer Hotline: 1-800-324-8680 [or TTY 1-800-292-3572]</p> <p>Ohio Medicaid</p>
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Supplemental Security Income (SSI)

- Automatically eligible for Medicaid as long as eligible for SSI

Modified Adjusted Gross Income (MAGI)

- Children, parents, caretakers, and expansion

Aged, Blind, Disabled (ABD)

- 65+, or blind/disabled with no SSI

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

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





Full Medicaid eligibility on the MITS Portal will show **four** benefit spans:

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

Additional spans when applicable:

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

Eligibility Verification Request

The screenshot shows the 'Resources for Providers' page on the Ohio Department of Medicaid website. The page has a blue header with the Ohio Department of Medicaid logo and navigation links: 'FAMILIES & INDIVIDUALS', 'RESOURCES FOR PROVIDERS', 'STAKEHOLDERS & PARTNERS', and 'OUR STRUCTURE ABOUT US'. There are also 'Help' and 'Search' icons. Below the header, the page title is 'Resources for Providers >'. A paragraph of introductory text follows. The main content area features a grid of resource cards. The 'Billing' card is highlighted with a red box; it contains the text 'Provider billing and data exchange related instructions, policies, and resources.' The 'Training' card is also highlighted with a red box; it contains the text 'Training presentations, videos, and handouts.' Other visible cards include 'COVID-19', 'Enrollment & Support', 'Managed Care', 'MITS', 'Policies & Guidelines', and 'Programs & Initiatives'. Below the grid, there are several bullet points, including 'As a Provider, am I allowed to bill the patient for missed appointments?' and 'What is National Provider Identifier (NPI)?'. At the bottom of the grid, there are four more cards: 'Fee Schedule & Rates', 'Training', 'TPL Carrier List', and 'Direct Deposit'. The 'Training' card is highlighted with a red box and contains the text 'Training presentations, videos, and handouts.'

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

The screenshot shows the Ohio Department of Medicaid website interface. At the top left is the Ohio Department of Medicaid logo. To the right is a search bar with a 'Search' button. Below the logo is a navigation menu with links: Welcome, Super User, Providers, Cost Report, CPC Performance, Account, Trading Partners, Claims, Episode Claims, Eligibility (highlighted), Prior Authorization, Reports, Portal Admin, Security, Trade Files, and Admin. Under the 'Eligibility' link, there are sub-links: eligibility search (highlighted), deemed eligible newborn, presumptively eligible child, presumptively eligible pregnant woman, psychiatric admission, and hospice enrollment. The main section is titled 'Eligibility Verification Request' and contains the following fields: Medicaid Billing Number, SSN, Procedure Code, Birth Date, DOS Date Format (dropdown menu), From DOS (07/16/2017), and To DOS (07/15/2021). There are 'search' and 'clear' buttons at the bottom right of the form. A note at the bottom states: '*This information is only valid for 'from date' to end of the month searched.'

TIP: Always check eligibility prior to billing

Eligibility Verification Request

- The effective and end dates will be based off the dates used in the search
- The associated child(ren) search will bring up any child associated with the member's ID

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

If an individual has a third-party payer, you can find that information under the TPL panel

TPL									
Carrier Name	Carrier Number	NAIC	Policy Number	Policy Holder	Coverage Type	Coverage	Effective Date	End Date	Group Number
AARP HEALTH CARE	00570		082020820-1		IND	INPATIENT COVERAGE	01/30/2021	01/31/2021	PLAN-NV
AARP HEALTH CARE	00570		082020820-1		IND	PHYSICIAN/OUTPATIENT COVERAGE	01/30/2021	01/31/2021	PLAN-NV
AETNA US HEALTH	00250		W116611666		IND	INPATIENT COVERAGE	01/30/2021	01/31/2021	724775
AETNA US HEALTH	00250		W116611666		IND	PHYSICIAN/OUTPATIENT COVERAGE	01/30/2021	01/31/2021	724775

Managed Care				
Plan Name	Plan Description	Effective Date	End Date	Managed Care Benefits
CARESOURCE	HMO, CFC	01/01/2021	01/31/2021	

Lock-In	
*** No rows found ***	

Medicare					
Coverage	Effective Date	End Date	Plan Name	Plan ID	Medicare ID
PART A	12/01/2020	12/08/2020			272027209D6
PART B	12/01/2020	12/08/2020			272027209D6

Service Limitation	
*** No rows found ***	

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

Eligibility Verification Request

You can review the level of care and determination date, patient liability amounts, long term care placement, and restrictive coverage in these panels

Level of Care Determinations

LOC Requested	Status	Determination Date	LOC Determination	Description	LOC Begin Date	LOC End Date
		09/29/2021	NF; NF WAIVER; RSS	INTERMEDIATE (ILOC)	01/01/2021	09/30/2021

Patient Liability

Financial Payer	Monthly Amount	Type	Effective Date	End Date
DEFAULT	\$1,949.00	Nursing Home	08/01/2021	09/30/2021
DEFAULT	\$1,949.00	Nursing Home	07/01/2021	07/31/2021
DEFAULT	\$1,949.00	Nursing Home	06/01/2021	06/30/2021
DEFAULT	\$1,949.00	Nursing Home	05/01/2021	05/31/2021
DEFAULT	\$5,319.00	Nursing Home	04/01/2021	04/30/2021
DEFAULT	\$5,319.00	Nursing Home	03/01/2021	03/31/2021

Long Term Care Facility Placements

Facility Type	Date of Admission	Effective Begin Date of Medicaid Coverage	End Date of Medicaid Coverage	Date of Discharge
NURSING FACILITY	09/29/2020	01/01/2021	09/30/2021	

Recipient Restricted Coverage

Effective Date	End Date
01/01/2020	02/28/2020

Special Program

*** No rows found ***

Patient Liability Discrepancy



ALWAYS

Always contact the CDJFS to verify the patient liability amount and dates



MAYBE

If you have made documented multiple attempts to contact the county and there is still a discrepancy, you may reach out to ODM through the “Contact Us” page

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 for full determination of eligibility for medical assistance



Presumptive Eligibility

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

Presumptive Eligibility

The benefit/assignment plan will look like this:

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

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:

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	

This is what will appear if the individual has QI 1/QI 2:

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 Plans

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

Managed Care Benefit Package

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

Some value-added
services:



Online searchable provider directory



Toll-free 24/7 hotline for medical advice



Expanded benefits including additional
transportation options plus other incentives



Care management to help members
coordinate care

MITS Managed Care Eligibility

If an individual is enrolled in a Managed Care Plan, 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					
*** 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		

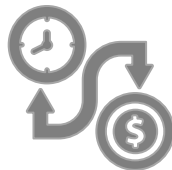
Traditional Managed Care Contracting

Providers who are interested in delivering services to a Managed Care member must be fully enrolled with Medicaid and have a contract or agreement with the plan

Things to know:



Each plan has a list of services that require prior authorization



Each plan will have their own billing requirements; therefore, contact the plan for the specific requirements



ABD/CFC Managed Care plan contracts may be separate from MyCare Ohio plan contracts

Traditional Managed Care Plans



866-296-8731

<https://www.buckeyehealthplan.com>



800-488-0134

<https://www.CareSource.com/>



855-522-9076

<https://www.paramounthealthcare.com/>



855-322-4079

<https://www.molinahealthcare.com>



800-600-9007

<https://www.uhccommunityplan.com>

MyCare Ohio



EXTENDED

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 Eligibility MyCare Opt-In

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

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

If the Managed Care Plan covers **only** the individual's Medicaid benefits, you will see **Medicaid Only**

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 Managed Care Contracting

Providers who are interested in delivering services to a MyCare Ohio member must be fully enrolled with Medicaid and have a contract or agreement with the plan

Things to know:



Each plan has a list of services that require prior authorization



Each plan will have their own billing requirements; therefore, contact the plan for the specific requirements



MyCare Ohio Managed Care plan contracts may be separate from ABD/CFC plan contracts

MyCare Ohio Managed Care Plans



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



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



AETNA BETTER HEALTH® OF OHIO

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



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



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

PROVIDER COMPLAINTS

Provider licensure issues

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

The screenshot shows the Ohio Department of Medicaid website. The top navigation bar includes the Ohio Department of Medicaid logo and several menu items: FAMILIES & INDIVIDUALS, RESOURCES FOR PROVIDERS (which is underlined), STAKEHOLDERS & PARTNERS, and OUR STRUCTURE ABOUT US. On the right side of the navigation bar are icons for Help and Search. Below the navigation bar is a section titled 'Resources for Providers >' with a sub-header: '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...'. Below this is a grid of resource cards. The 'Managed Care' card is highlighted with a red border. It contains the text: 'The next generation of Ohio Medicaid managed care is designed to improve wellness and health outcomes, support providers in better...'. Other cards include 'Billing', 'COVID-19', 'Enrollment & Support', 'Policies & Guidelines', 'Programs & Initiatives', and 'MITS'.

Provider Inquiries

Providers should contact the associated managed care organization (MCO) for assistance before submitting a complaint (see hyperlink below) to the Ohio Department of Medicaid (ODM).

Providers should [contact](#) the MCO's provider services line and/or their regional provider relations representative. Providers are encouraged to use the appeals, grievance, or arbitration processes as outlined in their individual contract with that MCO. If the MCO or MCO's representative do not return a provider's call within five business days, the provider may complete the provider complaint form below.

All complaints submitted are sent immediately to the corresponding MCO for response. Please note the MCOs will have up to 15 business days to respond.

The provider inquiry guidance document and inquiry form are located [HERE](#). Ensure your pop-up blocker is turned off.

Need Technical Assistance?
Give us a call on our Provider Hotline 800-686-1516.

Access the MITS Portal
Medicaid Information Technology System



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.

Submitting a Managed Care Complaint

Fill out the complaint form completely. You will receive a confirmation email once submitted with a confirmation number (C#####).

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

Provider/Follow-up Details

Provider Name: * Follow-up Name: *

Provider Responsibilities

Provider Enrollment and Revalidation

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



There is also a federally required 5 year revalidation

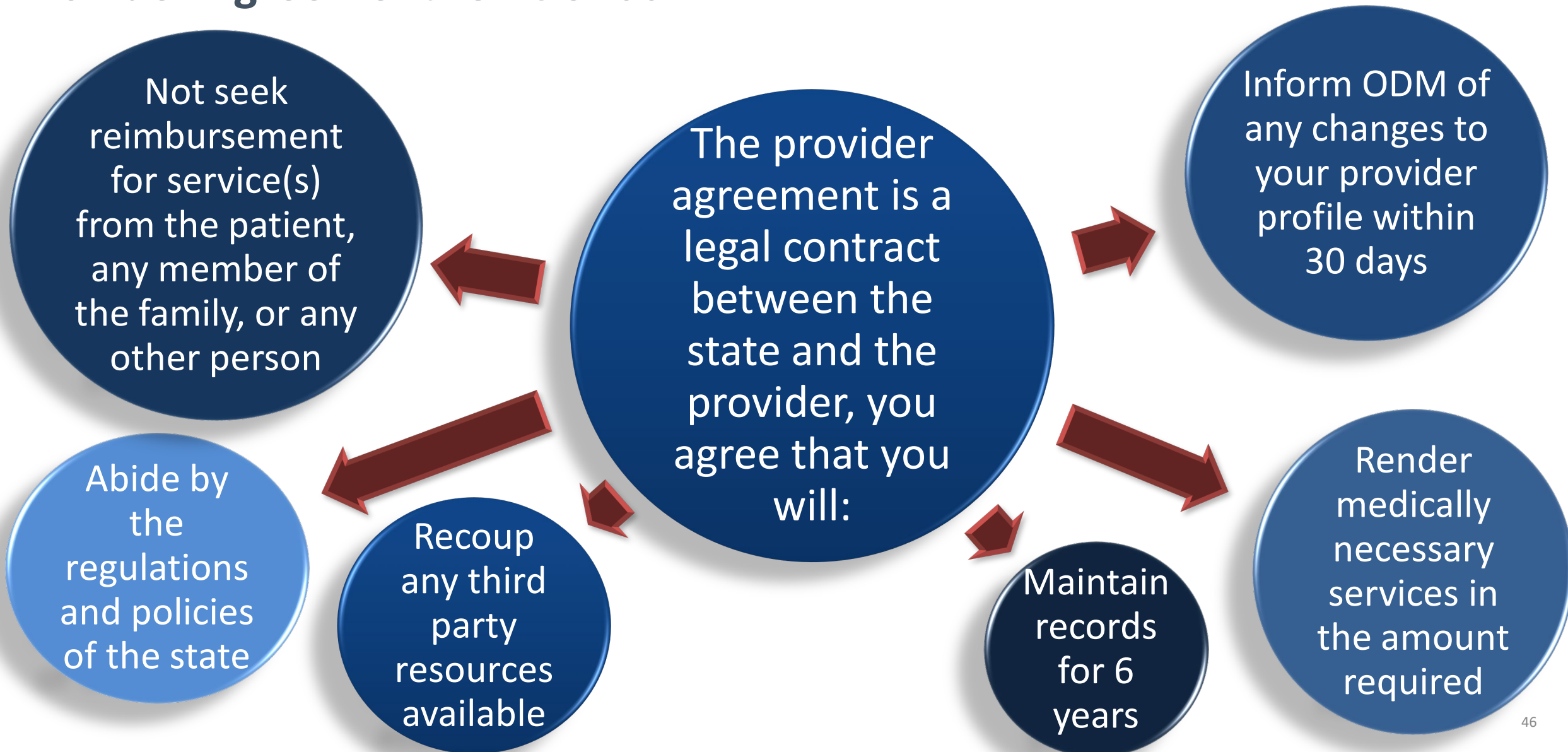


Providers may enroll as an ORP-only provider or as a Medicaid billing provider



Online applications can be found on our website

Provider Agreement: OAC 5160-1-17.2



Updating Demographic Information in MITS

Per OAC 5160-1-17.2(F), providers must inform ODM of any changes within 30 days

Welcome

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

demographic maintenance 1099 information provider faq mits days report correspondence self attestation ordering/referring/ prescribing search group affiliation group members cpc group cpc group members cpc accreditations cpc attestations attestations

Service Location > Location Name Address > Service Language > 1099 Mailing Address

Provider Information			
Medicaid Provider ID	0404040 MCD	Address Type	PRACTICE LOCATION
National Provider ID	1578515763 NPI	Address	1111 COLONY RD
Practice Type	OTHER		
Provider Type	86 - NURSING FACILITY	City	WESTERVILLE
Ownership	NO	County	FRANKLIN
Medicaid Effective Date	08/03/1979	State/Zip	OH 43081-3624
Medicaid End Date	05/19/2021	Phone	614-505-5055

Coordination of Benefits: OAC 5160-1-08

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



Medicaid Recipient Liability: OAC 5160-1-13.1

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



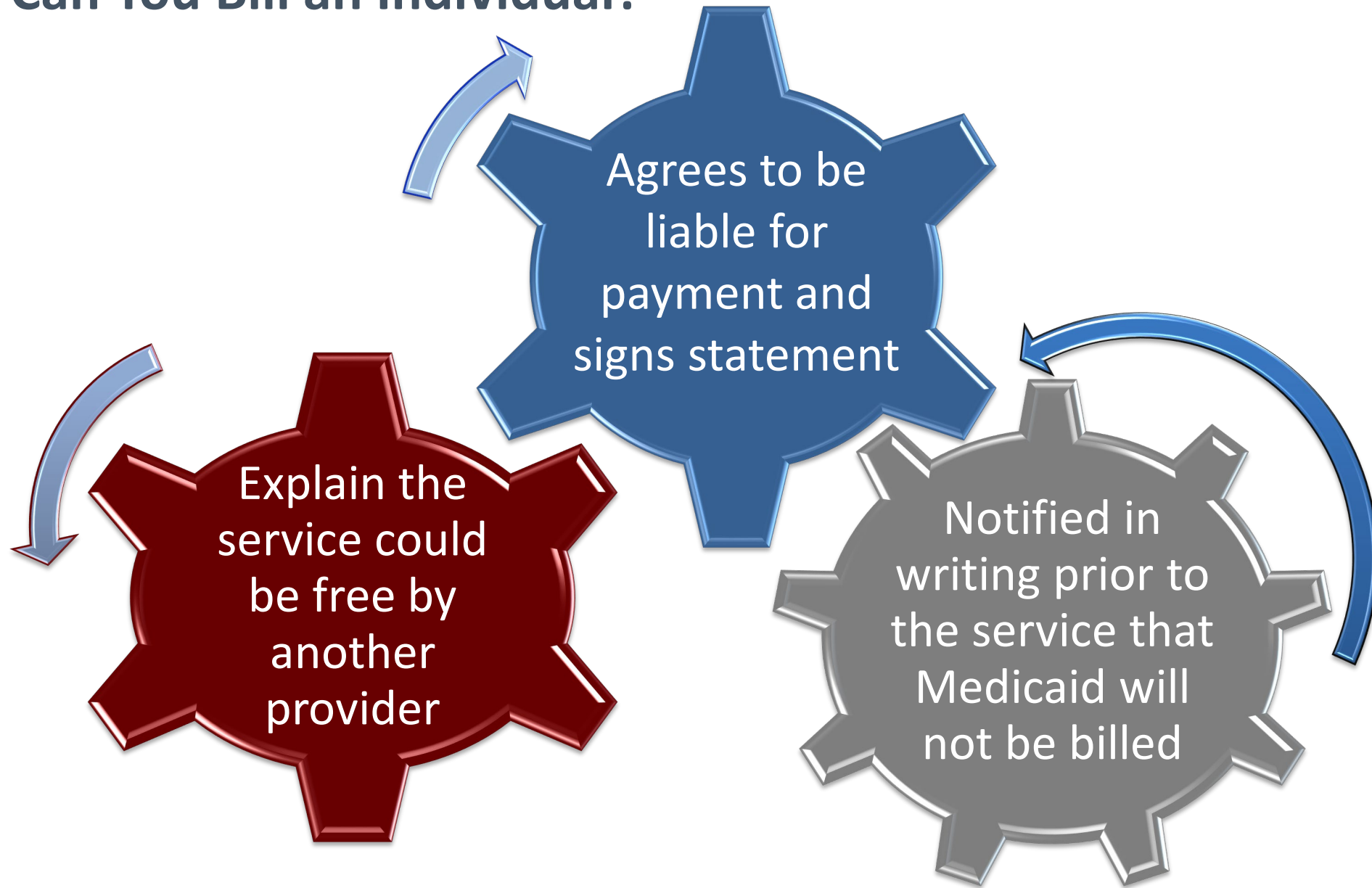
Missed appointment fee

Unacceptable or untimely claim submission

Failure to request a prior authorization

Retroactive Peer Review stating lack of medical necessity

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 _____

Policy

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

**Nursing Facility
Provider
Associations and
ODM website**

**Medicaid
Advisory
Letter (MAL)**

**Medical
Transmittal
Letter (MTL)**

Policy

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	> COVID-19	> Enrollment & Support	> Managed Care
Provider billing and data exchange related instructions, policies, and resources.	Ohio Department of Medicaid COVID-19 Resources and Guides for Providers	Ohio Medicaid is changing the way we do business. We are streamlining provider enrollment and support services to make it easier for you to	The next generation of Ohio Medicaid managed care is designed to improve wellness and health outcomes, support providers in better
MITS	> Policies & Guidelines	> Programs & Initiatives	
Medicaid Information Technology Information System (MITS) Resources	Ohio Medicaid policy is developed at the federal and state level. It guides how we operate our programs and how we regulate our	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



Policy

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](#)



Policy

<https://codes.ohio.gov>

OHIO LAWS & ADMINISTRATIVE RULES
LEGISLATIVE SERVICE COMMISSION

HOME LAWS ABOUT CONTACT RELATED SITES

Welcome! Effective April 1, 2021, the Legislative Service Commission has assumed publication of the Ohio Revised Code and the Ohio Administrative Code at this site. The Lawriter site has expired.

Ohio's Official Online Publication of State Laws and Regulations

Ohio law consists of the [Ohio Constitution](#), the [Ohio Revised Code](#) and the [Ohio Administrative Code](#). The Constitution is the state's highest law superseding all others. The Revised Code is the codified law of the state while the Administrative Code is a compilation of administrative rules adopted by state agencies. Use the tools on this site to search or browse them all.

[Learn More](#)

Ohio Constitution | Browse

Keyword Search

Ohio Revised Code | Browse

Keyword Search

Ohio Administrative Code | Browse

Keyword Search

Nursing Facility Information

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
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Provider Hotline
Have questions or need assistance? Call our Provider Hotline at 800-686-1516.

Provider Enrollment
Resources for enrolling as an Ohio Medicaid provider.

Long Term Care
Resources for Long Term Care providers.

Provider Types
Supplementary Information by Provider Service Type.

- [Medicaid Eligibility Manual](#)
- [Medicaid School Program](#)
- [Nursing Facilities \(More Information\)](#)
- [Ohio Home Care Waiver \(More Information\)](#)
- [Outpatient Health Facility Services \(More Information\)](#)

Nursing Facility Documents

- Nursing Facility Rates and High Occupancy Rates – Updated July 2022
- LTC Claim Revenue Center Codes for NFs – Revised October 2021
- Most Common Scenarios Chart: PASRR and Level of Care (LOC) – Revised May 2016
- Cost Reporting FAQs – Published March 2021
- Nursing Facility Cost Reporting FAQ – Updated March 2021
- Case Mix Questions and Answers – Published April 2018

NF Level of Care (LOC): OAC 5160-3-14

- A LOC determination may occur face-to-face, by a desk review, or by telephone in order to:
 - Authorize Medicaid payment to a NF
 - Approve Medicaid payment of a NF-based home and community-based services (HCBS) waiver or other NF-based level of care program
- A telephone, video conference, or desk review may be conducted in lieu of face-to-face unless the needs require a face-to-face visit.
 - All adverse LOC determinations require a face-to-face visit

Provider Agreement: OAC 5160-1-17.2

➤ Maintaining records

- Providers must maintain all records necessary to fully disclose the extent of services provided
- These records must be maintained for a period of six years from the date of receipt of payment or until any audit initiated within the required six year record maintenance period is completed
- Failure to supply requested records within 30 days shall result in withholding of Medicaid payments and may result in termination from the Medicaid program

Covered Days and Bed-hold Days: OAC 5160-3-16.4

➤ Occupied Day

- A day of admission or readmission
 - A day during which a Medicaid eligible resident's stay in a NF is eight hours or more, and for which the NF receives the full per resident per day payment
 - When NF admission and discharge occur on the same day, even if it is less than eight hours
- A day begins at twelve a.m. and ends at eleven fifty-nine p.m.
- The day of NF discharge is not counted as either a bed-hold or an occupied day

Covered Days and Bed-hold Days: OAC 5160-3-16.4

➤ Limits and payment for NF bed-hold days

- Covered days

- A day in which the individual is temporarily absent from the NF for hospitalization, therapeutic leave days, or visits with friends or relatives
- Resident must intend to return to the facility
- Limited to 30 calendar days per resident, per year
- Payment is considered payment in full, and the NF provider shall not seek supplemental payment from the resident

Covered Days and Bed-hold Days: OAC 5160-3-16.4

➤ Bed-hold days exclusions

- Hospice
- Institutions for mental diseases (IMDs)
- HCBS waiver individual using NF for short-term respite care
- Restricted Medicaid Coverage
- Facility closure and resident relocation

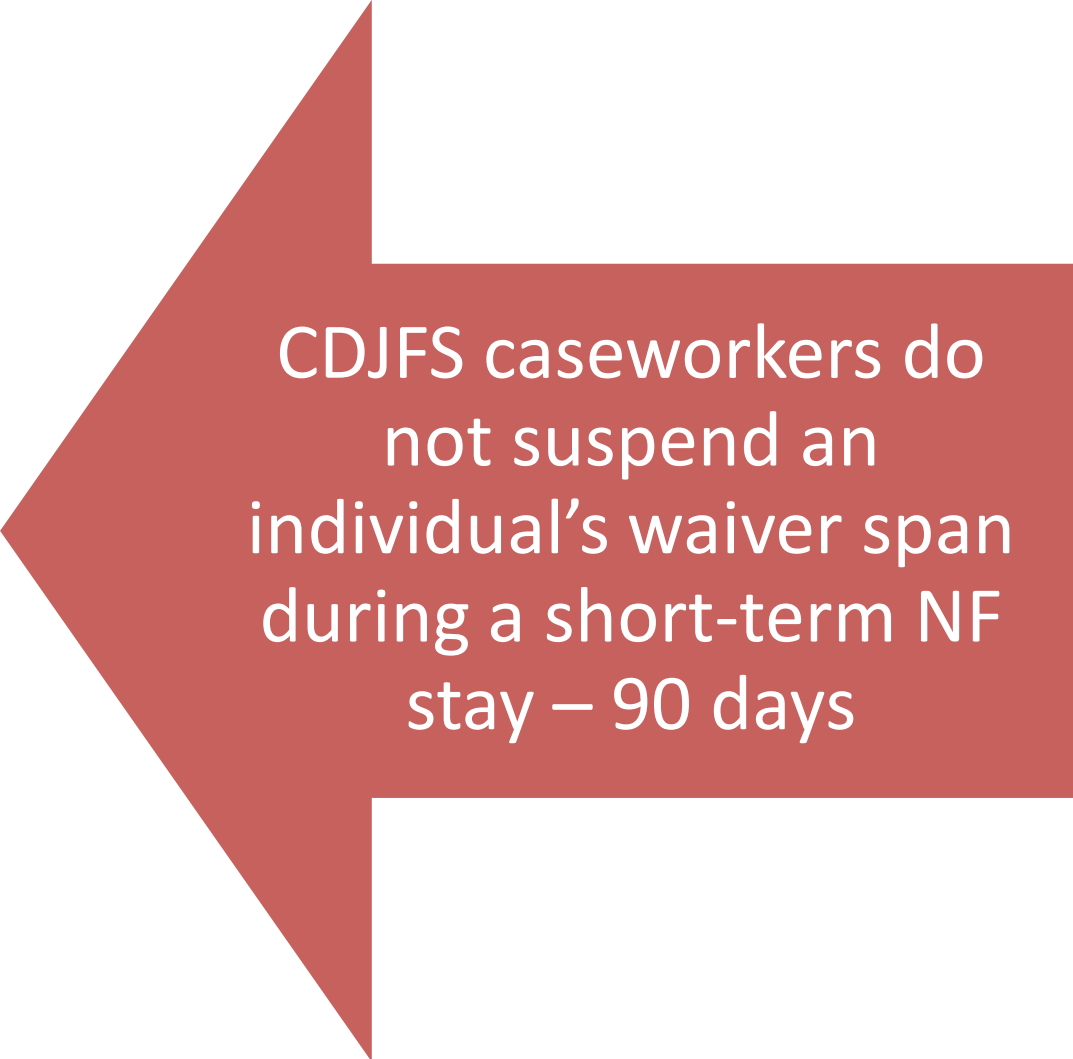
Covered Days and Bed-hold Days: OAC 5160-3-16.4

- Bed-hold days are not available to individuals who are discharged, including:
 - Those residents who are temporarily or permanently admitted to another NF
 - Exhaustion of NF bed-hold days
 - Decision to reside in a community-based setting
 - Death

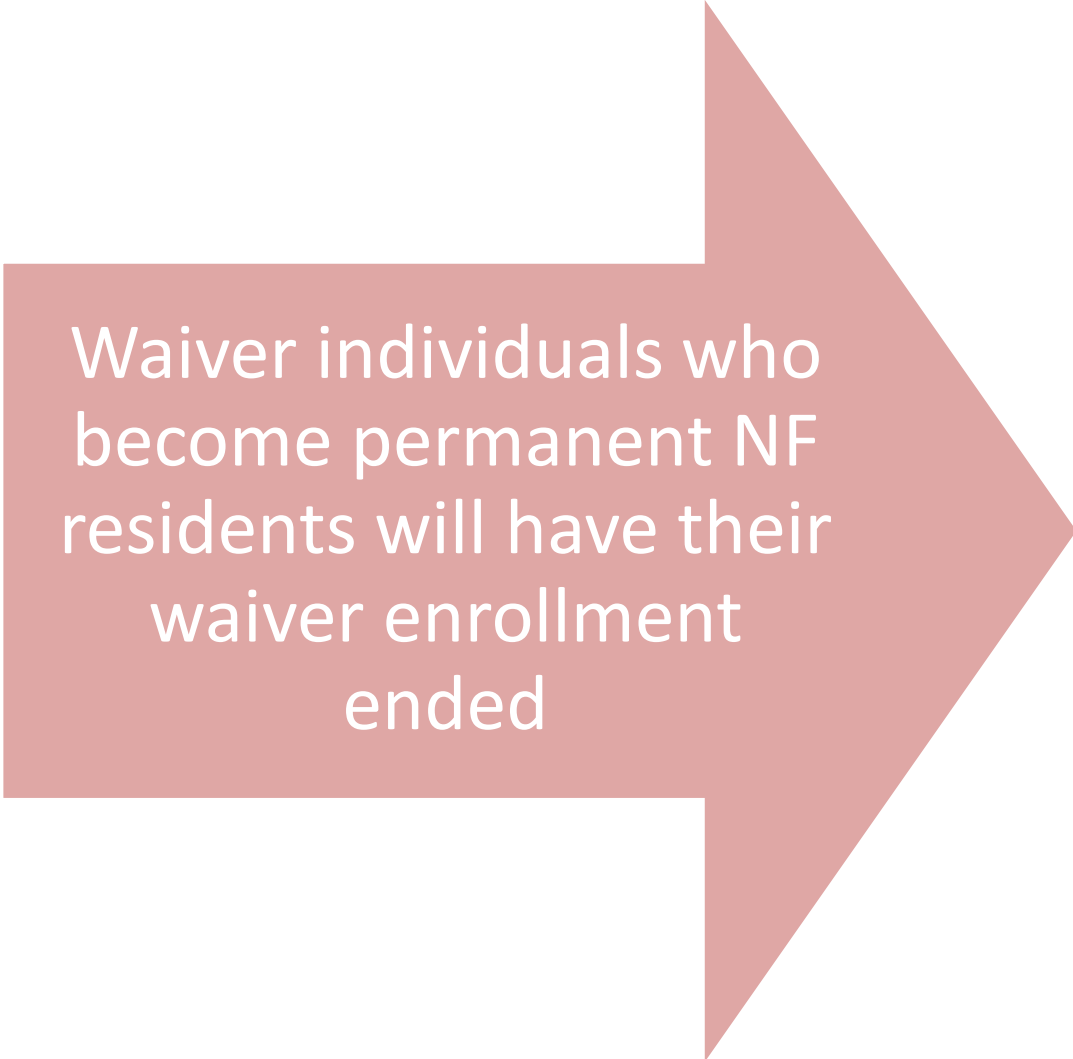
Covered Days and Bed-hold Days: OAC 5160-3-16.4

- Residents eligible for payment of NF bed-hold days must:
 - Be Medicaid eligible and meet patient liability and financial eligibility
 - Meet a NF LOC or be using Medicare part A SNF benefit
 - Not participating in any excluded categories as indicated in (K) of this rule
- Dual-eligible for both Medicare and Medicaid
 - If a resident is both Medicare part A and Medicaid eligible, Medicaid payment shall be made for NF bed-hold days up to 30 calendar days per year
 - A Level of Care evaluation is not necessary if:
 - A resident receives Medicare part A skilled nursing facility (SNF) benefits in the NF
 - A part A SNF resident in a NF is transferred to the hospital, and the NF bills the hospital bed-hold days to Medicaid

Waiver Individuals



CDJFS caseworkers do not suspend an individual's waiver span during a short-term NF stay – 90 days



Waiver individuals who become permanent NF residents will have their waiver enrollment ended

Waiver Individuals

- NF therapeutic leave days and visits with friends and family are not payable for NF residents who are on a HCBS waiver and temporarily leave the NF and do not count towards the annual leave day limit, per OAC 5160-3-16.4(D)(4)(b)(iii)
- When admitting someone who is on a waiver it is best to notify the waiver case management agency
- Need to bill using revenue center code 160 for days during the waiver enrollment

Patient Liability: OAC 5160-3-39.1

- The entire monthly amount of patient liability shall be reported by the NF on the individual's monthly claim
 - In the month of admission, discharge, or death, the entire monthly amount shall still be reported on the claim for that month
 - If the individual is switched from Medicare to Medicaid mid-month, the entire amount shall still be reported on the claim for that month
 - If the patient liability exceeds the amount Medicaid would cover, the claim shall be processed with a payment of zero dollars
 - If the patient liability is adjusted after the initial claim payment, the NF should submit a claim adjustment upon receipt of this change

ODM Form 10203

- Individuals are required to report a change of income, one-time gifts or payments, changes in health insurance coverage, etc.
 - Found in OAC 5160:1-2-08 (B)(1)(d)

- This form can be used to report any of those changes to the CDJFS
 - A Medicaid individual or a designated authorized representative may complete this form

ODM Form 10203

Clear Form

Ohio Department of Medicaid
REPORT A CHANGE FOR MEDICAL ASSISTANCE

Use this form to report any changes for individuals receiving medical assistance and/or their household members. Check the box for each type of change, provide the requested information for that section, and provide the effective date of the change. The **Individual Information** and **Submitter Information** sections on the form **must be completed**. Required fields are marked with an asterisk (*).

You should submit current supporting documents along with this report a change form.

INDIVIDUAL INFORMATION Complete this section for the individual receiving medical assistance. *Indicates required field					
*First Name		*Last Name			MI
*Date of Birth (mm/dd/yyyy)	Medicaid Case Number		*Social Security Number		
Has this person been in an accident in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, explain details in the comment section on page two of this form and provide supporting documentation or verification.)					
CHANGE NOTIFICATIONS Check the box if there has been a change in information and enter the effective date. Only complete the sections below where information has changed.					
<input type="checkbox"/> Phone Number Change		Effective Date of Change			
<input type="checkbox"/> Address Change (attach verification of change such as a rent/mortgage receipt, lease, or utility receipts) Effective Date of Change (mm/dd/yyyy)					
New Street Address				Apartment/Unit Number	
City	State	Zip Code	Phone	County	

Lump Sums: OAC 5160-3-39.1

- If a resident receives a lump sum, report it to the CDJFS
- The CDJFS will work with the resident to determine how the lump sum will be handled and will notify the NF of any amount to be reported on the NF claims
 - Submit adjustments to as many prior months as necessary to offset the amount assigned to the facility
 - Apply any remaining money to current and future claims if needed
 - Report on the claim using **value code 31**
 - Although this value code description indicates “patient liability amount,” it is specifically referring to the lump sum amount and not the individual’s monthly patient liability amount

Condition	Inpatient Procedure	Occurrence/Spar	Value
Value			
Sequence	Value	Description	Amount
A	1 31	PATIENT LIABILITY AMOUNT	4621.00

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

*Sequence
 *Value [Search] *Amount

Lump Sums: OAC 5160-3-39.1

➤ Example:

- A resident receives a \$12,000 lump sum in July 2021
- Their normal PL amount is \$1,000 per month
- Assume the billed amount each month is \$6,000

July Claim: enter the PL of \$1,000 & value code 31 with amount of \$12,000

- Claim will pay \$0 and remaining lump sum will be \$7,000

Aug. Claim: enter the PL of \$1,000 & value code 31 with amount of \$7,000

- Claim will pay \$0 and the remaining lump sum will be \$2,000

Sept. Claim: enter the PL of \$1,000 & value code 31 with amount of \$2,000

- Claim will pay \$3,000

Claim Submission: OAC 5160-1-19

➤ Timely filing limitations

- Claims must be received within 365 days of the actual date the service was provided
- Denied claims may be re-submitted for payment and must be received within 365 days from the actual date of service or 180 days from the date the claim denied, even if this date is beyond 365 days from the date of service
- Claims with prior payment by Medicare or another insurance plan must be received within 180 days from the date Medicare or the insurance plan paid the claim

Adjustments to a Paid Claim: OAC 5160-3-39.1

- Underpaid claims
 - Must submit an adjustment within 180 days of the date the underpaid claim was paid by ODM
- Overpaid claims
 - Must submit an adjustment within 60 days of discovering the overpayment
- ODM may notify a provider an adjustment is needed
 - Providers shall make the adjustment within 60 days of notification
 - If a provider fails to make the adjustment, ODM shall either make the adjustment or void the claim

Payment for Cost-Sharing Other than Medicare Part A: OAC 5160-3-64.1

- The NF per diem rate includes the Medicaid payments for Medicare or other third-party insurance cost-sharing, including coinsurance or deductible payments, associated with services that are included in the NF per diem rate
- Neither the resident nor ODM is responsible for any Medicare or other third-party insurance cost-sharing, including coinsurance or deductibles, associated with services that are included in the NF per diem rate
- The claim should auto-cross from Medicare to Medicaid on an institutional part A claim form
 - If the payment is not received in an appropriate timeframe, submit the claim directly to Medicaid

Resident Relocation: 5160-3-02.7

- A NF may temporarily relocate residents for emergencies of 30 days or less for reasons such as:
 - Tornado, severe storms, floods, or other natural disasters
 - Fire
 - Explosion
 - Loss of electrical power
 - Release of hazardous chemicals or materials
 - Outbreak of contagious disease
 - Civil disturbance such as a riot
 - Labor strike that results in a decrease of staff members below that necessary for resident care

Resident Relocation: 5160-3-02.7

- The residents will remain as active residents for the originating NF who will bill Medicaid
- The originating NF will receive payment and make arrangements to pay the receiving NF for the DOS the displaced resident is in their facility
- The originating NF must follow the guidance provided in the Nursing Facility Temporary Relocation Fact Sheet:
 - <https://medicaid.ohio.gov/static/Providers/ProviderTypes/LongTermCare/FactSheets/TempRelocation.pdf>

Most Common Revenue Center Codes

0101 - Full covered day

0160 – Full day: short-term stay for Waiver consumers

0183 - Leave day: therapeutic

0185 - Leave day: hospital

PA1 / PA2 Revenue Center Codes

0220 – Flat fee full covered day

0169 – Flat fee full day: short-term stay for Waiver consumer

0189 – Flat fee leave day

Vent Weaning Revenue Center Codes

0419 – Vent-dependent services

0410 – Vent weaning services

These days will only pay if the NF is approved for the NF ventilator program

MITIS & Claims

Billing Resources

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

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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

Fee Schedule & Rates

Trading Partners

How To Refund Payments



PHARMACY CLAIMS:

- [ODM Pharmacy Benefits](#)



Need Technical Assistance?

Give us a call on our Provider Hotline 800-686-1516.



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)

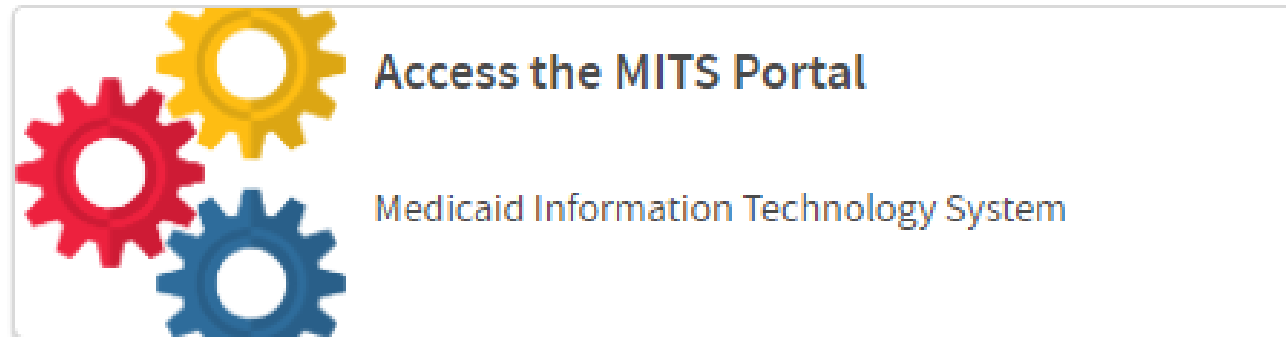
Internet Explorer version 10 or higher and current versions of Firefox or Chrome

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



Ohio Department of Medicaid

About ODM | Our Services | Resources | News & Events

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enrollment enrollment tracking search long-term care account setup

Ohio Department of Medicaid

Provider Home

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

Login to secure site

Click Here to Login

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

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

Ohio.gov Medicaid Information Technology System

Sign In
Medicaid Information Technology System

To sign in, please enter your User ID and Password

User ID:

Password:

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

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

Yes, I have read the agreement

Login

Help FAQ
Help Reset Password?
Forgot Your User ID?

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**

MITIS 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.c
om](mailto: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 an Institutional Claim

The screenshot shows the Ohio Department of Medicaid website interface. At the top left is the logo with the text "Ohio Department of Medicaid". To the right is a search bar with a "Search" button. Below the logo is a dark red banner with the text "Welcome,". Underneath the banner is a horizontal navigation menu with the following items: "Super User", "Providers", "Account Trading Partners", "Claims", "Episode Claims", "Eligibility", "Prior Authorization", "Reports", "Portal Admin", "Security", and "Trade Files". The "Claims" item is highlighted, and a dropdown menu is open, showing the following options: "Search", "Search Detail", "Dental", "Institutional" (which is highlighted in blue), and "Professional". Below the navigation menu, there is a "Claims" section with a list of links: "Search", "Search Detail", "Dental", "Institutional (for Inpatient, Outpatient, Long Term Care)", and "Professional".

Submission of an Institutional Claim

Institutional Claim:
?
⬆

BILLING INFORMATION	SERVICE INFORMATION								
<p>ICN</p> <p>Claim Received Date</p> <p>Provider ID</p> <p>*Type Of Bill <input type="text"/> [Search]</p> <p>Claim Type</p> <p>*Medicaid Billing Number <input type="text"/></p> <p>*Date of Birth <input type="text"/></p> <p>Last Name</p> <p>First Name, MI</p> <p>*Patient Account # <input type="text"/></p> <p>Medical Record # <input type="text"/></p> <p>*Attending Physician # <input type="text"/></p> <p>*Last Name <input type="text"/></p> <p>*First Name, MI <input type="text"/> <input type="text"/></p> <p>Operating Physician # <input type="text"/></p> <p>Other Physician # <input type="text"/></p> <p>*ICD Version 10 <input type="text"/></p> <p>*Patient Amount Paid <input type="text" value="\$0.00"/></p>	<p>*Release of Information NOT ALLOWED TO RELEASE DATA <input type="text"/></p> <p>*From Date <input type="text"/></p> <p>*To Date <input type="text"/></p> <p>Admission Date <input type="text"/></p> <p>Admission Hour <input type="text"/></p> <p>*Admission Type <input type="text"/></p> <p>Admit Source <input type="text"/> [Search]</p> <p>Discharge Hour <input type="text"/></p> <p>*Patient Status <input type="text"/> [Search]</p> <p>*Covered Days <input type="text" value="0"/></p> <p>Non Covered Days <input type="text" value="0"/></p> <p>Coinsurance Days <input type="text" value="0"/></p> <p>Lifetime Reserve Days <input type="text"/></p> <p>Prior Authorization #/ Precertification # <input type="text"/></p> <p>TOTAL CHARGES</p> <table style="width: 100%;"> <tr> <td>Total Charges</td> <td style="text-align: right;">\$0.00</td> </tr> <tr> <td>Total Non Covered Charges</td> <td style="text-align: right;">\$0.00</td> </tr> <tr> <td>Total Covered Charges</td> <td style="text-align: right;">\$0.00</td> </tr> <tr> <td>Medicaid CoPay Amount</td> <td style="text-align: right;">\$0.00</td> </tr> </table> <p>Note Reference Code <input type="text"/></p> <p>Notes <input type="text"/></p>	Total Charges	\$0.00	Total Non Covered Charges	\$0.00	Total Covered Charges	\$0.00	Medicaid CoPay Amount	\$0.00
Total Charges	\$0.00								
Total Non Covered Charges	\$0.00								
Total Covered Charges	\$0.00								
Medicaid CoPay Amount	\$0.00								
<table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <thead> <tr> <th style="width: 25%;">Condition</th> <th style="width: 25%;">Inpatient Procedure</th> <th style="width: 25%;">Occurrence/Span</th> <th style="width: 25%;">Value</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table>		Condition	Inpatient Procedure	Occurrence/Span	Value				
Condition	Inpatient Procedure	Occurrence/Span	Value						

Diagnosis Code: Required on Most Claims

Must include all characters specified by ICD

Do **NOT** enter the decimal points

There are system edits and audits against those codes

Diagnosis			
Sequence	Diagnosis Code	Description	Present on Admission
Other	D509	IRON DEFICIENCY ANEMIA, UNSPECIFIED	
Other	E039	HYPOTHYROIDISM, UNSPECIFIED	
Other	E559	VITAMIN D DEFICIENCY, UNSPECIFIED	
Other	E785	HYPERLIPIDEMIA, UNSPECIFIED	
Principal	F0390	UNSPECIFIED DEMENTIA WITHOUT BEHAVIORAL DISTURBANCE	
Admitting	F0390	UNSPECIFIED DEMENTIA WITHOUT BEHAVIORAL DISTURBANCE	
Other	F419	ANXIETY DISORDER, UNSPECIFIED	
Other	H269	UNSPECIFIED CATARACT	
Other	H40039	ANATOMICAL NARROW ANGLE, UNSPECIFIED EYE	
Other	I159	SECONDARY HYPERTENSION, UNSPECIFIED	

1 2 Next >

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

Sequence
 Diagnosis Code

Present on Admission

Detail Panel

Per OAC 5160-3-39.1(6), a claim is to include all the days of the given month

Detail													
Item	Date of Service	Revenue Code	HCPCS/HIPPS Rate Codes	Units	Total Charges	NonCovered Charges	Medicaid Allowed Amount	Status	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Final EAPG
A	1			0	\$0.00	\$0.00	\$0.00						

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

delete
add an item
copy

<p>Item: 1</p> <p>Date of Service: <input type="text"/></p> <p>To DOS: <input type="text"/></p> <p>*Revenue Code: <input type="text"/> [Search]</p> <p>HCPCS/HIPPS Rate Codes: <input type="text"/> [Search]</p> <p>Modifiers: <input type="text"/> [Search] <input type="text"/> [Search]</p> <p>Submitted EAPG: <input type="text"/></p> <p>Initial EAPG: <input type="text"/></p>	<p>*Units: <input type="text" value="0"/></p> <p>*Units Of Measurement: <input type="text" value="v"/></p> <p>Per Diem Rate: <input type="text" value="\$0.00"/></p> <p>*Total Charges: <input type="text" value="\$0.00"/></p> <p>Non Covered Charges: <input type="text" value="\$0.00"/></p> <p>Medicaid Allowed Amount: <input type="text" value="\$0.00"/></p> <p>Status: <input type="text"/></p> <p>Final EAPG: <input type="text"/></p> <p>Pay Action: <input type="text"/></p>	
--	---	--

NDC
Detail - Other Payer

Submission of an Institutional Claim

Claim with no discharge or leave days

Detail													
Item	Date of Service	Revenue Code	HCPCS/HIPPS Rate Codes	Units	Total Charges	NonCovered Charges	Medicaid Allowed Amount	Status	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Final EAPG
A	1	10/01/2021	101	31.00	\$7,300.00	\$0.00	\$0.00						

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

delete
add an item
copy

<p>Item 1</p> <p>*Date of Service <input type="text" value="10/01/2021"/></p> <p>To DOS <input type="text" value="10/31/2021"/></p> <p>*Revenue Code <input type="text" value="101"/> [Search]</p> <p>HCPCS/HIPPS Rate Codes <input type="text"/> [Search]</p> <p>Modifiers <input type="text"/> [Search] <input type="text"/> [Search]</p> <p>Submitted EAPG <input type="text"/></p> <p>Initial EAPG <input type="text"/></p>	<p>*Units <input type="text" value="31.00"/></p> <p>*Units Of Measurement Days <input type="text"/></p> <p>*Per Diem Rate <input type="text" value="\$0.00"/></p> <p>*Total Charges <input type="text" value="\$7,300.00"/></p> <p>Non Covered Charges <input type="text" value="\$0.00"/></p> <p>Medicaid Allowed Amount <input type="text" value="\$0.00"/></p> <p>Status <input type="text"/></p> <p>Final EAPG <input type="text"/></p> <p>Pay Action <input type="text"/></p>
---	--

Submission of an Institutional Claim

Claim with leave days

Detail													
Item	Date of Service	Revenue Code	Rate Codes	Units	Total Charges	NonCovered Charges	Medicaid Allowed Amount	Status	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Final EAPG
A	2	08/26/2021	185	6.00	\$1,410.00	\$0.00	\$0.00						
A	1	08/01/2021	101	25.00	\$5,875.00	\$0.00	\$0.00						

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

delete
add an item
copy

Item: 2

*Date of Service: 08/26/2021

To DOS: 08/31/2021

*Revenue Code: 185 [Search]

HCPDCS/HIPPS Rate Codes: [Search]

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

Submitted EAPG: [Search]

Initial EAPG: [Search]

*Units: 6.00

*Units Of Measurement: Days

Per Diem Rate: \$0.00

*Total Charges: \$1,410.00

Non Covered Charges: \$0.00

Medicaid Allowed Amount: \$0.00

Status: [Search]

Final EAPG: [Search]

Pay Action: [Search]

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



Claim Portal Errors

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

Portal errors return the claim with a “fix” needed

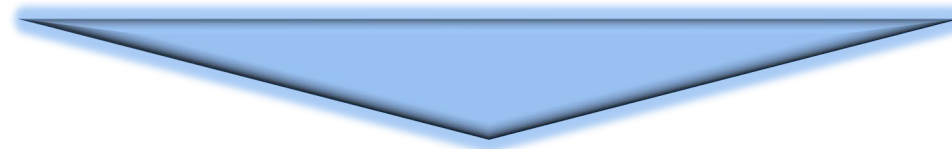
Portal errors will show up at the top of the page

Claim shows a ‘NOT SUBMITTED YET’ status still

The following messages were generated:				
From	DOS	is	required.	
Procedure	is	required.		
A	valid	Place	Of	Service
is	required			
A	valid	Procedure	Code	is
required.				
Units	must	be	greater	than
0.				
Charges	must	be	greater	than
\$0.00.				
A	valid	Medicaid	Billing	Number
is	required			
A	valid	Medicaid	Billing	Number
and	Date	of	Birth	combination
is	required.			

Claim Submission

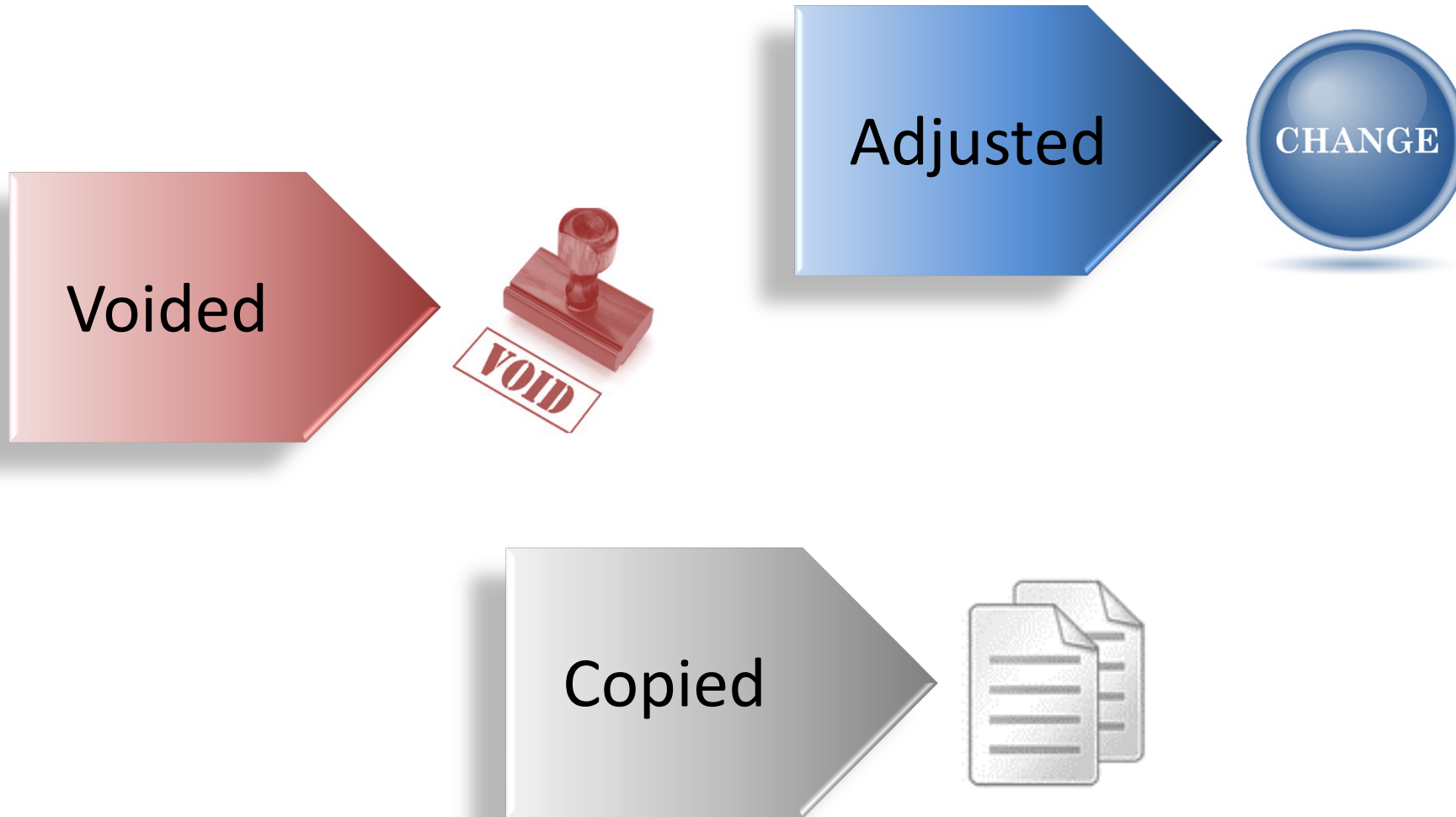
All claim submissions are assigned an ICN



2221170357321

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

Paid Claims Can Be:



Adjusting a Paid Claim



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

Adjusting a Paid Claim: Example

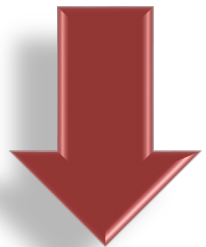


2221180234001
5821185127250

Originally paid \$45.00

Now paid \$50.00

Additional payment of \$5.00



2021172234001
5021173127250

Originally paid \$50.00

Now paid \$45.00

Account receivable (\$5.00)

Voiding a Paid Claim



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

Voiding a Paid Claim: Example



2221180234001
5821185127250

Originally paid \$45.00
Account receivable (\$45.00)

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

Copying a Paid Claim



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

Nursing Facility Claim Examples

Short-Term Waiver Stay – Entire Month Waiver

This individual is on a Waiver benefit and was in the NF for the entire month of their short-term stay

Detail

Item	Date of Service	Revenue Code	HCPCS/HIPPS Rate Codes	Units	Total Charges	NonCovered Charges	Medicaid Allowed Amount	Status	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Final EAPG
A 1	07/01/2021	160		31.00	\$7,600.00	\$0.00	\$0.00						

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

delete
add an item
copy

Item 1

*Date of Service

To DOS

*Revenue Code [Search]

HCPCS/HIPPS Rate Codes [Search]

Modifiers [Search] [Search]

Submitted EAPG

Initial EAPG

*Units

*Units Of Measurement [v]

*Per Diem Rate

*Total Charges

Non Covered Charges

Medicaid Allowed Amount

Status

Final EAPG

Pay Action

Short-Term Waiver Stay – Partial Month Waiver

This individual is on a Waiver benefit that closed effective 8/20/2021 when they became a permanent NF resident

Detail

Item	Date of Service	Revenue Code	HCPCS/HIPPS Rate Codes	Units	Total Charges	NonCovered Charges	Medicaid Allowed Amount	Status	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Final EAPG
A	2	08/21/2021	101	11.00	\$2,695.00	\$0.00	\$0.00						
A	1	08/01/2021	160	20.00	\$4,900.00	\$0.00	\$0.00						

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

Item 2 ***Units** 11.00
***Date of Service** 08/21/2021 ***Units Of Measurement** Days
To DOS 08/31/2021 ***Per Diem Rate** \$0.00
***Revenue Code** 101 [Search] ***Total Charges** \$2,695.00
HCPCS/HIPPS Rate Codes [Search] **Non Covered Charges** \$0.00
Modifiers [Search] [Search] **Medicaid Allowed Amount** \$0.00
Submitted EAPG [Search] **Status**
Initial EAPG [Search] **Final EAPG**
Pay Action

Two Day Hospital Leave Stay

This individual was admitted to the hospital on 6/26/2021 at 6:00am and was discharged back to the NF on 6/28/2021 at noon

Detail														
Item	Date of Service	Revenue Code	HCPCS/HIPPS Rate Codes		Units	Total Charges	NonCovered Charges	Medicaid Allowed Amount	Status	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Final EAPG
A	3	06/28/2021	101		3.00	\$735.00	\$0.00	\$0.00						
A	2	06/26/2021	185		2.00	\$490.00	\$0.00	\$0.00						
A	1	06/01/2021	101		25.00	\$6,125.00	\$0.00	\$0.00						

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

delete
add an item
copy

Item: 3

*Date of Service: 06/28/2021

To DOS: 06/30/2021

*Revenue Code: 101 [Search]

HCPCS/HIPPS Rate Codes: [Search]

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

Submitted EAPG: []

Initial EAPG: []

*Units: 3.00

*Units Of Measurement: Days

*Per Diem Rate: \$0.0000

*Total Charges: \$735.00

Non Covered Charges: \$0.00

Medicaid Allowed Amount: \$0.00

Status: []

Final EAPG: []

Pay Action: []

Overnight Hospital Stay After 8 Hours in NF

This individual was admitted to the hospital on 10/17/2021 at 3:00pm and discharged back to the NF on 10/18/2021

Detail													
Item	Date of Service	Revenue Code	HCPCS/HIPPS Rate Codes	Units	Total Charges	NonCovered Charges	Medicaid Allowed Amount	Status	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Final EAPG
A	2	10/18/2021	101	14.00	\$3,430.00	\$0.00	\$0.00						
A	1	10/01/2021	101	17.00	\$4,165.00	\$0.00	\$0.00						

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

delete
add an item
copy

Item	1	*Units	<input type="text" value="17.00"/>
*Date of Service	<input type="text" value="10/01/2021"/>	*Units Of Measurement	Days <input type="text"/>
To DOS	10/17/2021	*Per Diem Rate	<input type="text" value="\$0.0000"/>
*Revenue Code	<input type="text" value="101"/> [Search]	*Total Charges	<input type="text" value="\$4,165.00"/>
HCPCS/HIPPS Rate Codes	<input type="text"/> <input type="text"/> [Search]	Non Covered Charges	<input type="text" value="\$0.00"/>
Modifiers	<input type="text"/> [Search] <input type="text"/> [Search]	Medicaid Allowed Amount	<input type="text" value="\$0.00"/>
Submitted EAPG	<input type="text"/>	Status	
Initial EAPG		Final EAPG	
		Pay Action	

Overnight Hospital Stay Under 8 Hours in NF

This individual was admitted to the hospital on 6/17/2021 at 3:00am and discharged back to the NF on 6/18/2021

Detail													
Item	Date of Service	Revenue Code	HCPCS/HIPPS Rate Codes	Units	Total Charges	NonCovered Charges	Medicaid Allowed Amount	Status	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Final EAPG
A	3	06/18/2021	101	13.00	\$3,185.00	\$0.00	\$0.00						
A	2	06/17/2021	185	1.00	\$245.00	\$0.00	\$0.00						
A	1	06/01/2021	101	16.00	\$3,920.00	\$0.00	\$0.00						

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

delete
add an item
copy

Item	3	*Units	13.00
*Date of Service	06/18/2021	*Units Of Measurement	Days
To DOS	06/30/2021	*Per Diem Rate	\$0.0000
*Revenue Code	101 [Search]	*Total Charges	\$3,185.00
HCPCS/HIPPS Rate Codes	[Search]	Non Covered Charges	\$0.00
Modifiers	[Search]	Medicaid Allowed Amount	\$0.00
Submitted EAPG		Status	
Initial EAPG		Final EAPG	
		Pay Action	

Low Acuity PA1 / PA2 Individual

This individual has a lower acuity and discharged on 4/6/2021 at 7:00am and returned on 4/11/2021

Note the different revenue codes used for low acuity

Detail													
Item	Date of Service	Revenue Code	HCPES/HIPPS Rate Codes	Units	Total Charges	NonCovered Charges	Medicaid Allowed Amount	Status	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Final EAPG
A	3	04/11/2021	220	20.00	\$3,000.00	\$0.00	\$0.00						
A	2	04/06/2021	189	5.00	\$750.00	\$0.00	\$0.00						
A	1	04/01/2021	220	5.00	\$750.00	\$0.00	\$0.00						

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

Item: 1

*Date of Service: 04/01/2021

To DOS: 04/05/2021

*Revenue Code: 220 [Search]

HCPES/HIPPS Rate Codes: [Search]

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

Submitted EAPG: []

Initial EAPG: []

*Units: 5.00

*Units Of Measurement: Days

Per Diem Rate: \$0.0000

*Total Charges: \$750.00

Non Covered Charges: \$0.00

Medicaid Allowed Amount: \$0.00

Status: []

Final EAPG: []

Pay Action: []

Providers have 365 days to submit Fee For Service claims

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

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

Claims over 2 years old will be denied

There are exceptions to the 365 day rule



Timely Filing

Submitting a Claim Over 365 Days Old

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

Supporting Data for Delayed Submission / Resubmission

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

Previously Denied ICN or TCN

Reason





Timely Filing Exceptions: OAC 5160-3-39.1

- 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



How to Bill After a Delay

- In the Notes box you will need to enter the hearing decision or eligibility determination information
- In the Note Reference Code dropdown menu select “ADD”

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

How to Bill After a Delay

Hearing Decision: APPEALS#####CCYYMMDD

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

Eligibility Determination: DECISIONCCYYMMDD

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



Note Reference Code	ADD - Additional Information <input type="button" value="v"/>
Notes	DECISION 20171225

Uploading an Attachment

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

Attachments

Type of Document	Transmission Type
A	

Type data below for new record.

For attachments submitted via mail, not electronically attached, please send to the appropriate address. A button for printing a cover page and a button to view mailing addresses will appear after the claim has been submitted.

For documents transmitted via Upload, an upload button will appear after the claim has been submitted. Only file types of gif, tiff, bmp, jpg, ppt, doc, xls, pdf, txt, and mdi can be uploaded.

*Type of Document

*Transmission Type

Uploading an Attachment

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

Remittance Advice (RA)

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

The screenshot shows the MITS Portal interface. At the top, a red banner says "Welcome,". Below it is a navigation bar with links: Super User, Providers, Cost Report, Account, Claims, Eligibility, Prior Authorization, Reports (highlighted in red), Portal Admin, and Publications. A blue header for "Provider Reports" contains a search bar and a dropdown menu. The dropdown menu is open, showing a list of report types: CPC (COMPREHENSIVE PRIMARY CARE REPORTS), EPISODE REPORTS SUMMARY (PDF) AND PATIENT DETAIL DATA(CSV), EPISODE REPORTS SUMMARY DATA(PDF) ONLY, HOSPITAL COST SETTLEMENT REPORT, PPR (POTENTIALLY PREVENTABLE READMISSIONS) REPORTS, PRC (PROVIDER REPORT CARDS) REPORTS, and REMITTANCE ADVICE. A red arrow points to the "REMITTANCE ADVICE" option. To the right of the dropdown are "search" and "clear" buttons.

Remittance Advice (RA)

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

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

Provider Reports ? ^

*Report REMITTANCE ADVICE

Payment Date

RA Number

Check/EFT Number

search clear

Please select the row to show the report

RA Number	Part Number	RA Date
16161973	1	01/06/2018
16146862	1	12/30/2017
16145695	1	12/23/2017
16131620	1	12/22/2016
16116473	1	12/15/2016
16101611	1	12/08/2016
16086726	1	12/01/2016
16071717	1	11/25/2016
16056394	1	11/17/2016
16041108	1	11/10/2016

1 2 3 4 5 6 7 8 9 10 ... Next >

Remittance Advice (RA)



Paid, denied, and adjusted claims



Financial transactions

Expenditures - Non-claim payments

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



Summary

Current, month, and year to date information

Remittance Advice (RA)



Information pages

Banner messages to the provider community



EOB code explanations

Provides a comparison of codes to the description



TPL claim denial information

Provides other insurance information for any TPL claim denials

Remittance Advice (RA)

You may use a RA to see how much patient liability was deducted from a claim

ICN	SERVICE DATES		COVERED	NON-COVERED	BILLED	ALLOWED	TPL	PATIENT RESPONSIBILITY	LUMP	PAID
PATIENT NUMBER	FROM	THRU	DAYS	DAYS	AMOUNT	AMOUNT	AMOUNT		SUM	AMOUNT
RECIPIENT ID:			RECIPIENT NAME:			COUNTY: 38 HOLMES MED REC NUM:				
CHARGE SOURCE: LTCLOC										
2018213060229	070118	073118	31	0	5,735.00	5,395.24	0.00	1,949.00	0.00	3,446.24
REV	SERVICE DATES		COV	NON-COVERED	DAILY	BILLED	ALLOWED	TPL	PAID	
CODE	FROM	THRU	DAYS	DAYS	RATE	AMOUNT	AMOUNT	AMOUNT	AMOUNT	
0101	070118	073118	31	0	174.04	5,735.00	5,395.24	0.00	3,446.24	
DETAIL EOB 9919 9922										

Resources, Websites, & Forms

Mailboxes

- NFPolicy@medicaid.ohio.gov – For questions regarding nursing facility rules and policy requirements
- NFStay@medicaid.ohio.gov – For questions regarding nursing facility admissions and/or discharges
- MDSCaseMix@medicaid.ohio.gov – For questions regarding Case Mix
- HCBSPolicy@medicaid.ohio.gov – For questions regarding HCBS Waivers and other long-term services and support
- OhioMCD-EDI-Support@dxc.com or 844-324-7089 – For questions regarding EDI related issues

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>

- Long-Term Care provider page

<https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/enrollment-and-support/long-term-care/long-term-care>

- Managed Care page

<https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/managed-care/managed-care>

Websites

- Ohio Administrative Codes

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

- MITS home page

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

Information for Trading Partners (EDI)

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

- Companion Guides (EDI)

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

Other Resources

- For Medicaid eligibility and patient liability issues – contact the local County Department of Job and Family Services (CDJFS) that is handling the Medicaid case
- For Managed Care issues – Contact the Managed Care Plan directly
Provider complaints can be filed through the Managed Care link listed in previous slides
- For Fee For Service issues, contact the IVR at 800-686-1516

Forms

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)






Forms

Medicaid Forms

Ohio Department of Medicaid Forms Library

Order Forms/Email Requests

Share this   

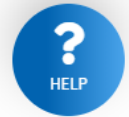
Form Number	Order Form	Form Name
ODM 07216	(ORDER FORM)	Application for Health Coverage & Help Paying Costs
ODM 03528	(ORDER FORM)	Healthcek & Pregnancy Related Services Information Sheet
ODM 10129	(ORDER FORM)	Long-Term Services and Supports Questionnaire (LTSSQ) - Email Request
ODM 02399	(ORDER FORM)	Request for Medicaid Home and Community Based Services (HCBS)

Search: ✕

Show 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)



Forms

- ODM 03623 – Provider Agreement for LTC Facilities
- ODM 10203 – Report a Change for Medical Assistance
 - ODM 06614 – Health Insurance Fact Request
 - ODM 06653 – Medical Claim Review Request

