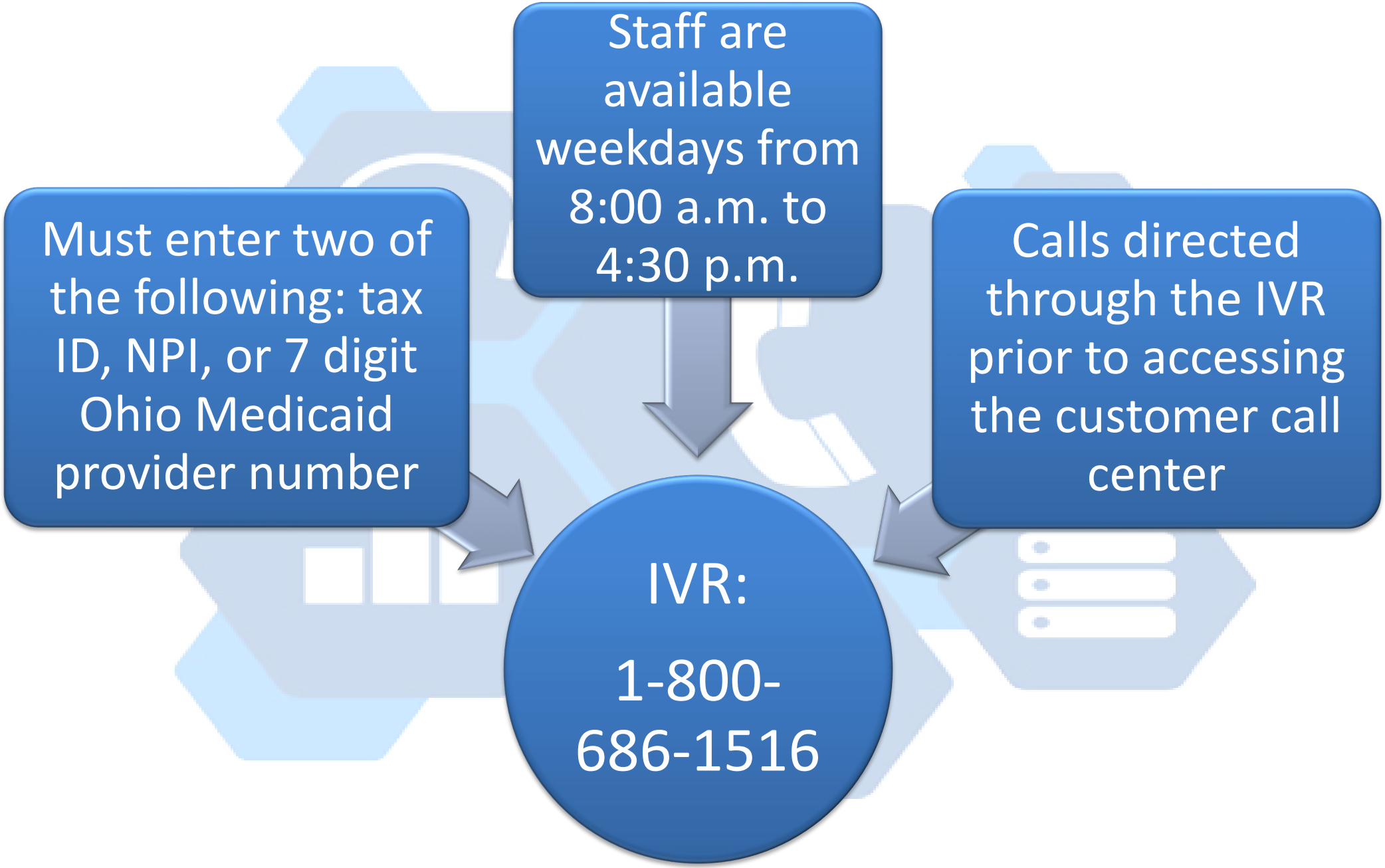
Ohio | Department of Medicaid

Basic Billing for Nursing Facilities

Provider Relations

2022


Staff are available weekdays from 8:00 a.m. to 4:30 p.m.
Must enter two of the following: tax ID, NPI, or 7 digit Ohio Medicaid provider number
Calls directed through the IVR prior to accessing the customer call center
IVR:
1-800-686-1516

Helpful Phone Numbers

- 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

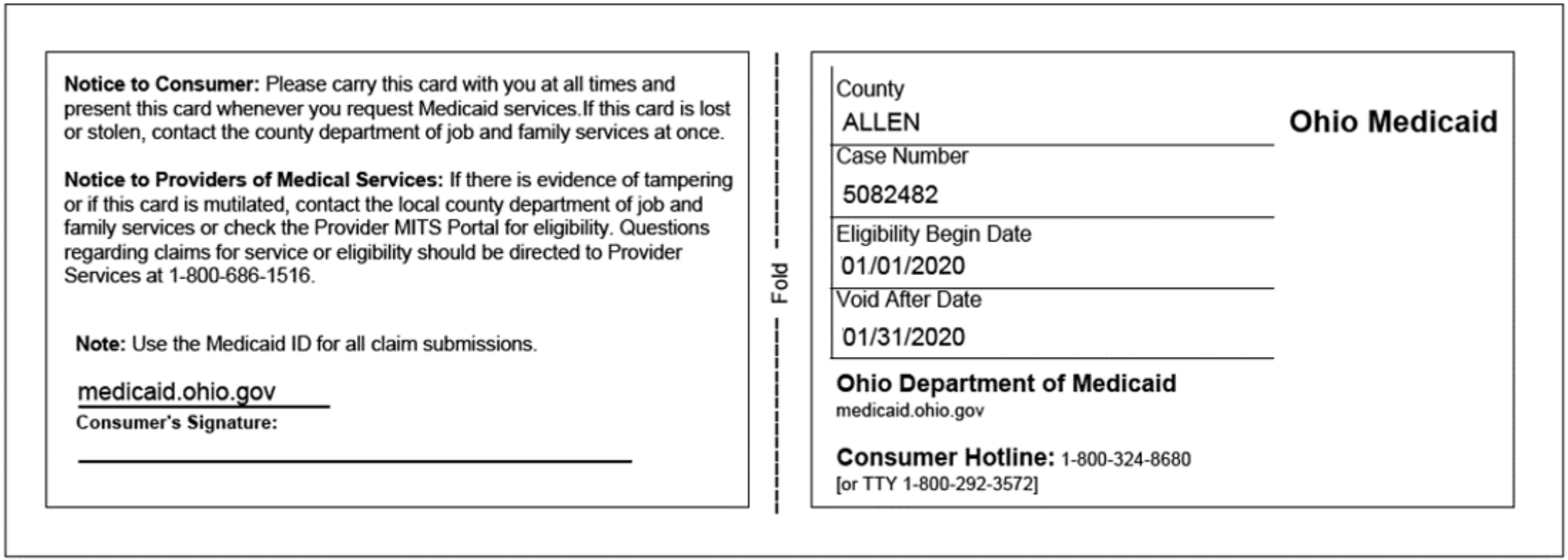
Ohio Medicaid Covers:

- 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



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
01/01/2020

Void After Date
01/31/2020

Ohio Department of Medicaid
medicaid.ohio.gov

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

Supplemental Security Income (SSI)

- Automatically eligible for Medicaid as long as eligible for SSI

Modified Adjusted Gross Income (MAGI)

- Children, parents, caretakers, and expansion

Aged, Blind, Disabled (ABD)

- 65+, or blind/disabled with no SSI

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

- Individuals must cooperate with requests from third-party insurance companies needing to authorize coverage
- Individuals must cooperate with 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

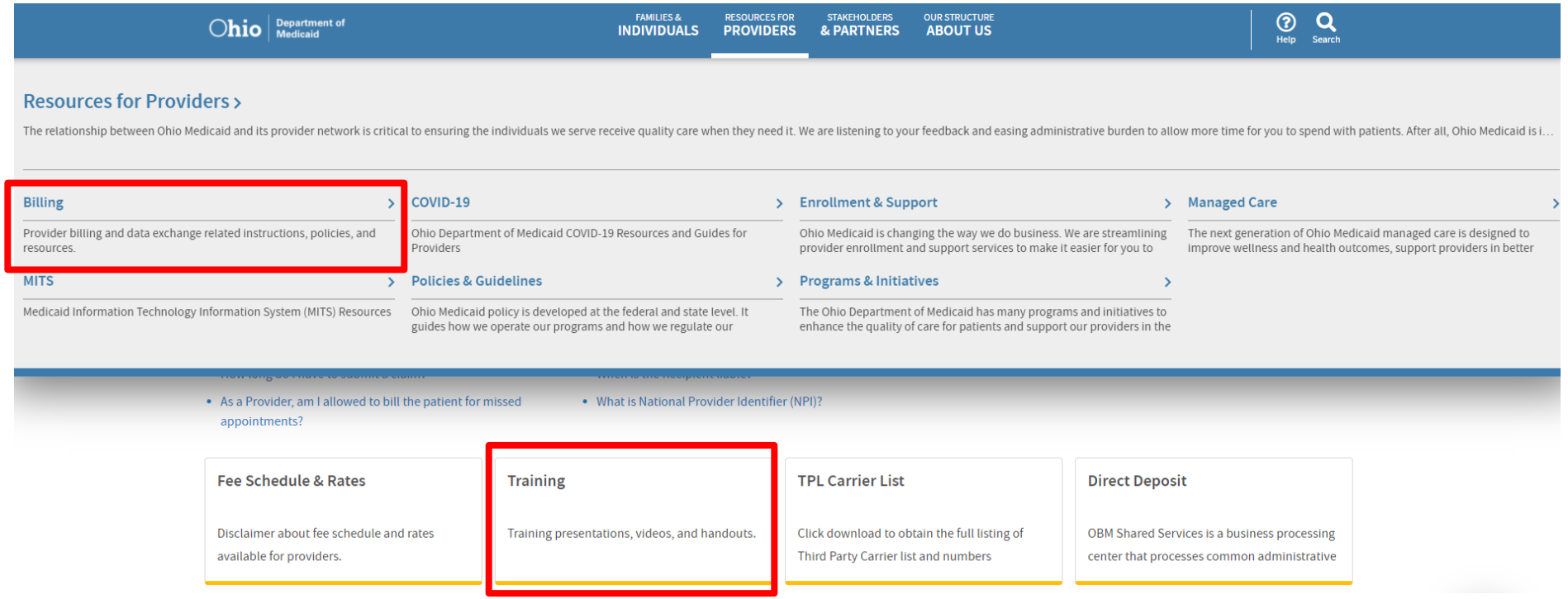
Full Medicaid eligibility on the MITS Portal will show **four** benefit spans:

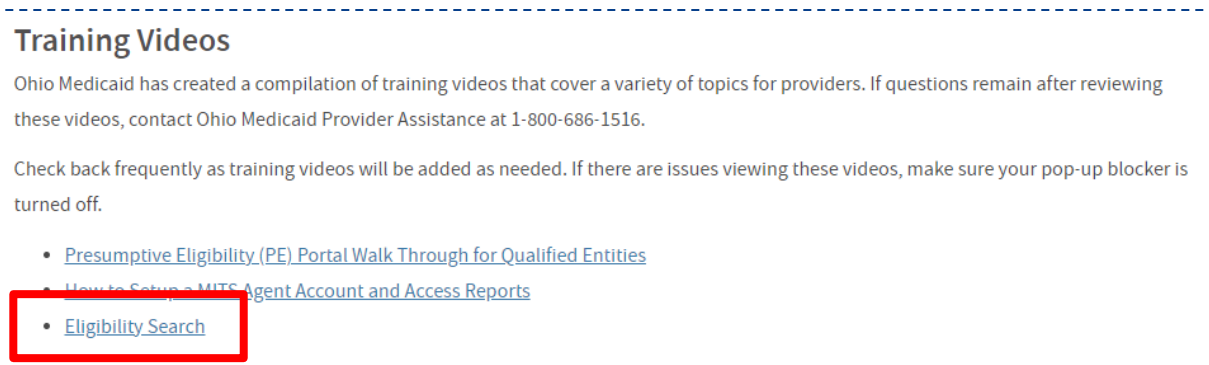
1. Alcohol and Drug Addiction Services
2. MRDD Targeted Case Management
3. Ohio Mental Health
4. Medicaid

Additional spans when applicable:

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

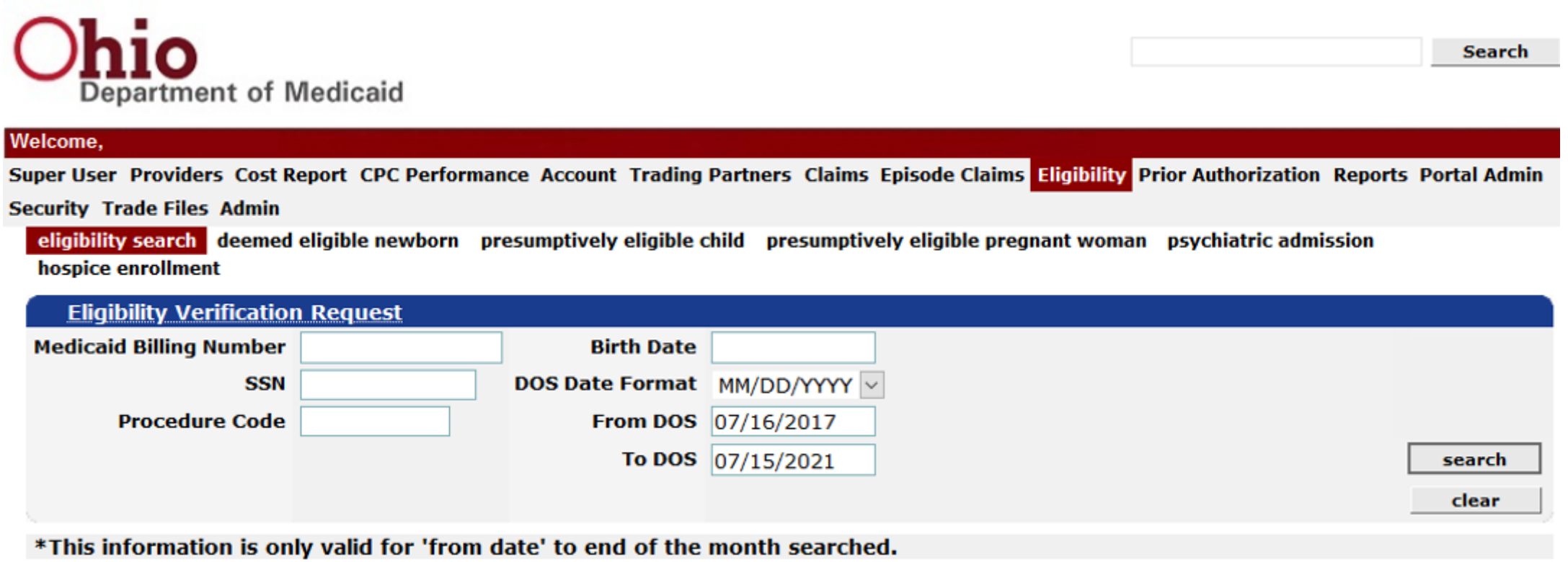
Eligibility Verification Request





Eligibility Verification Request

You can search up to 4 years back



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 contact the CDJFS to verify the patient liability amount and dates

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

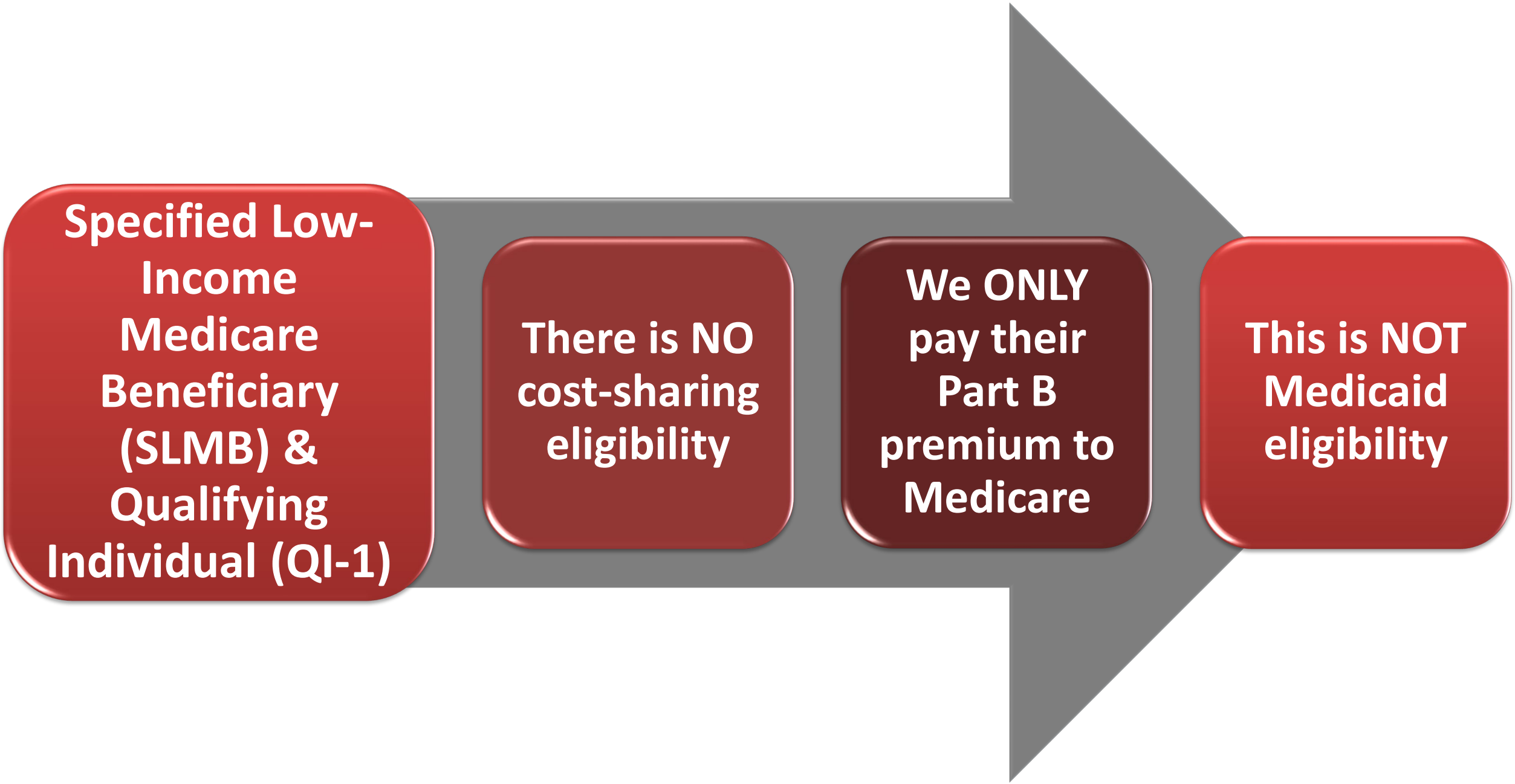
Recipient Information

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

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 ***

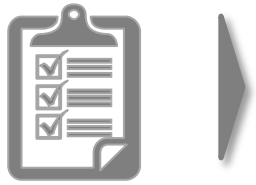
Managed Care

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

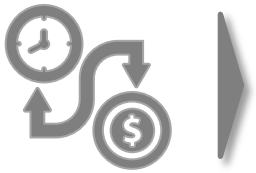
Traditional Managed Care Contracting

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

buckeye health plan	866-296-8731	https://www.buckeyehealthplan.com
CareSource®	800-488-0134	https://www.CareSource.com/
PARAMOUNT HEALTH CARE	855-522-9076	https://www.paramounthealthcare.com/
MOLINA® HEALTHCARE	855-322-4079	https://www.molinahealthcare.com
UnitedHealthcare®	800-600-9007	https://www.uhccommunityplan.com

MyCare Ohio

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

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

The project is currently slated to end on December 31, 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

buckeye health plan

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

CareSource®

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

aetna®

AETNA BETTER HEALTH® OF OHIO

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

MOLINA® HEALTHCARE

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

UnitedHealthcare®

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

PROVIDER COMPLAINTS

Provider licensure issues

Send to Ohio Department of Insurance (ODI)

Certification issues

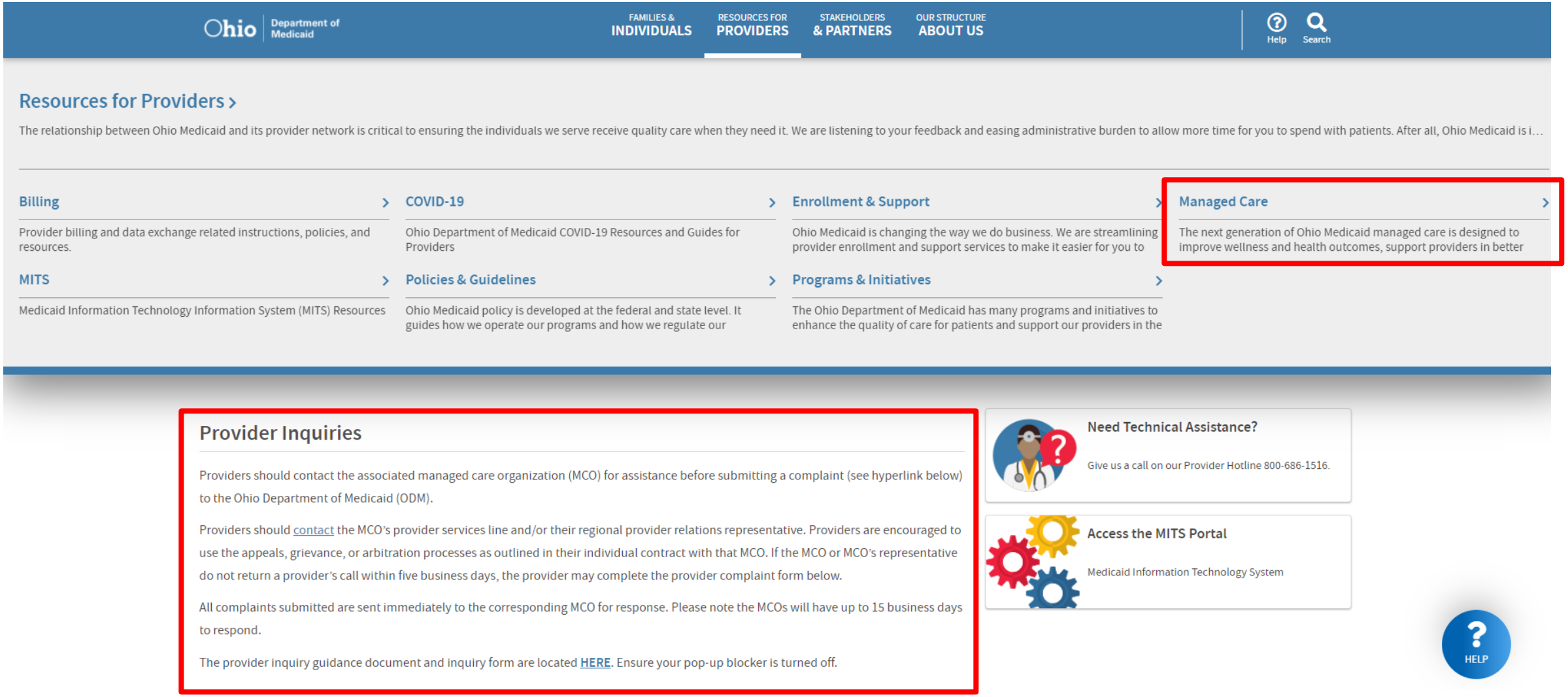
Work with the Area Agency on Aging (AAA) or ODM for MyCare Ohio waiver providers

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



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.

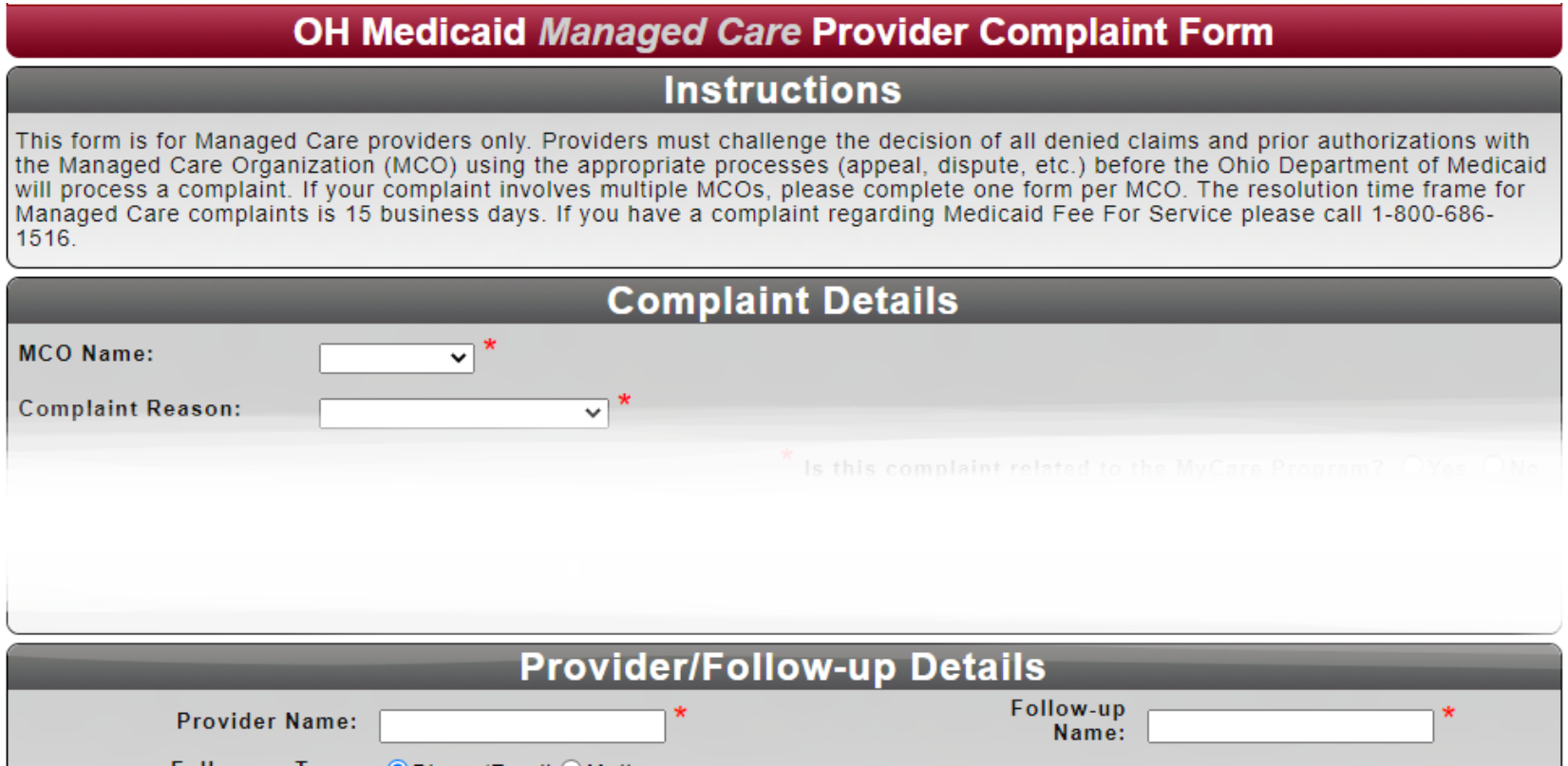
NEW If the provider submits multiple complaints for the same issue (different individuals, dates of service, practitioners, or files affected), ODM will cancel all duplicate complaints, contact the provider, and request that a single new complaint be submitted for all files affected.

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

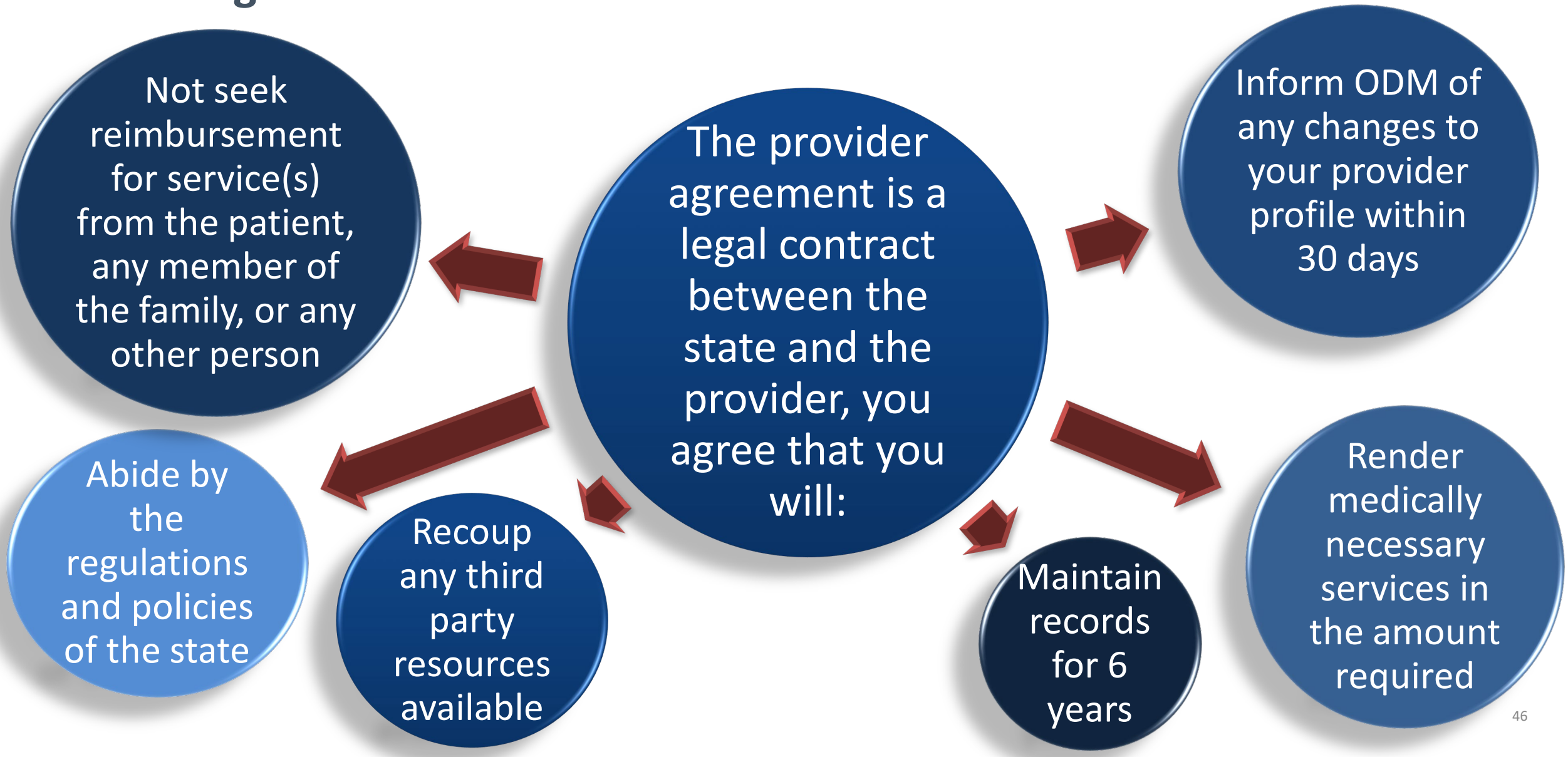
Providers are required to submit an application to become a Medicaid provider

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

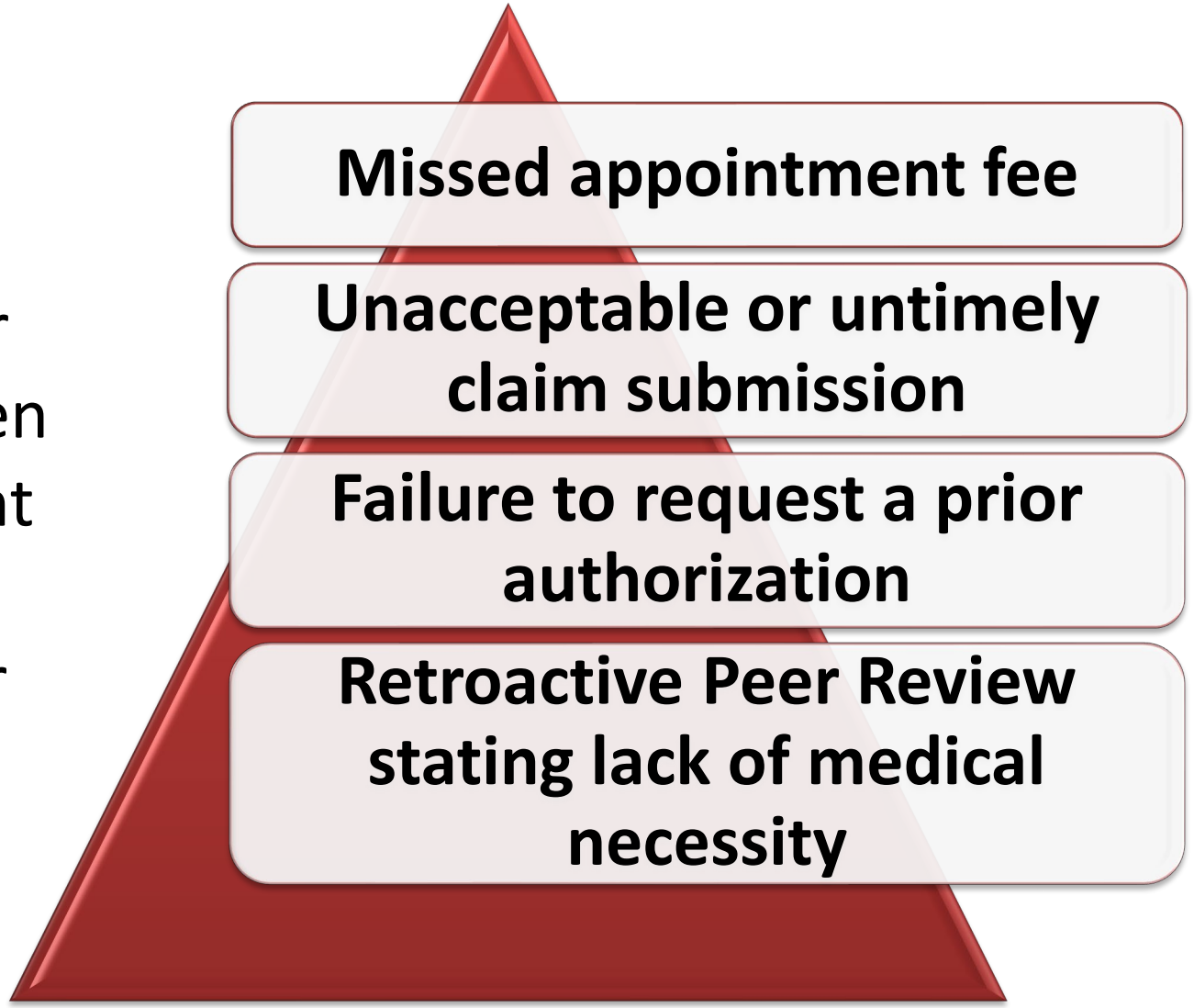
Per OAC 5160-1-17.2(F), providers must inform ODM of any changes within 30 days

Coordination of Benefits: OAC 5160-1-08

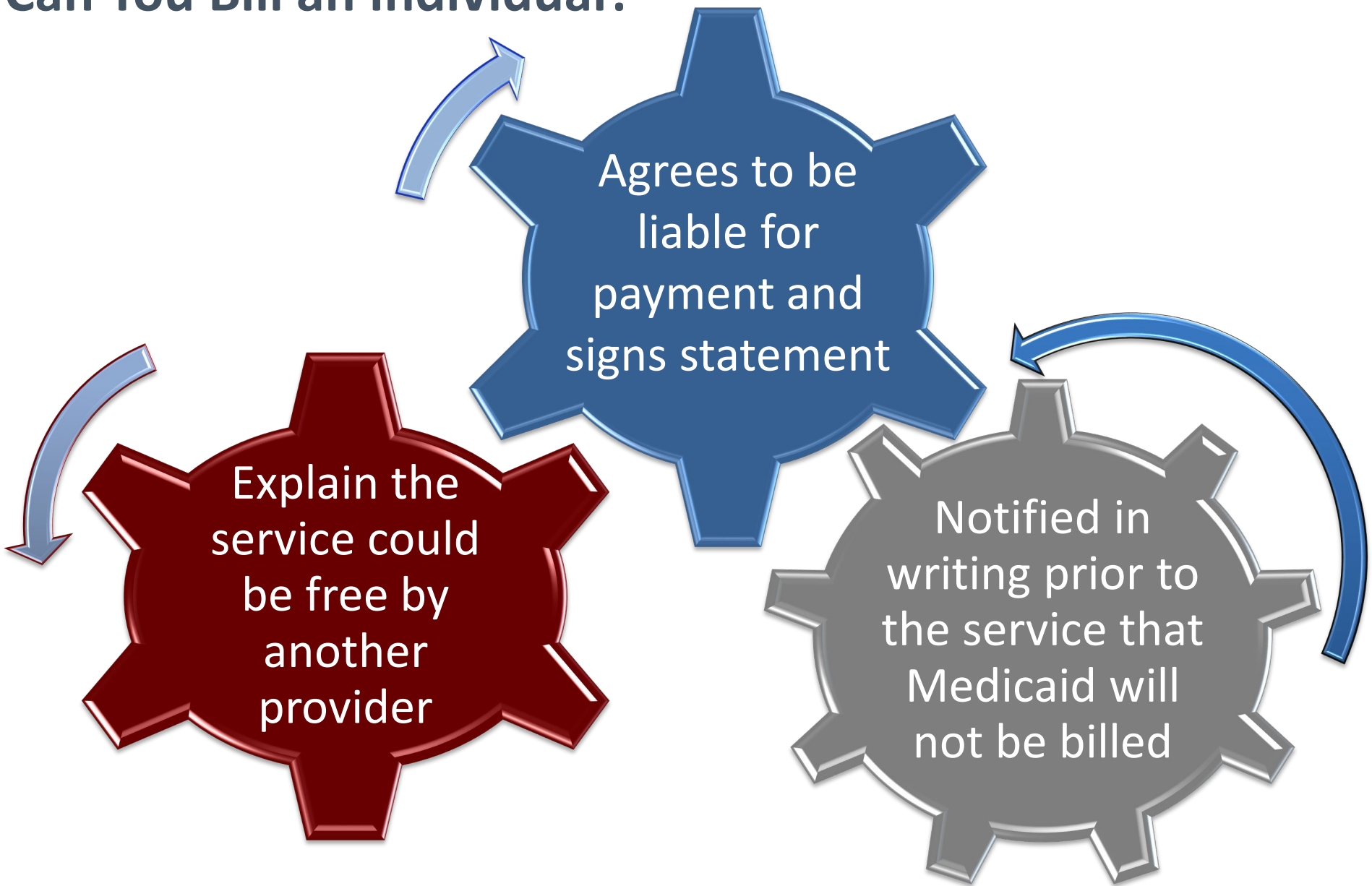
- The Ohio Administrative Code requires that a Medicaid consumer provide notice to the department prior to initiating any action against a liable third party
- The department will take steps to protect its subrogation rights if that notice is not provided
- For questions, contact the Coordination of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

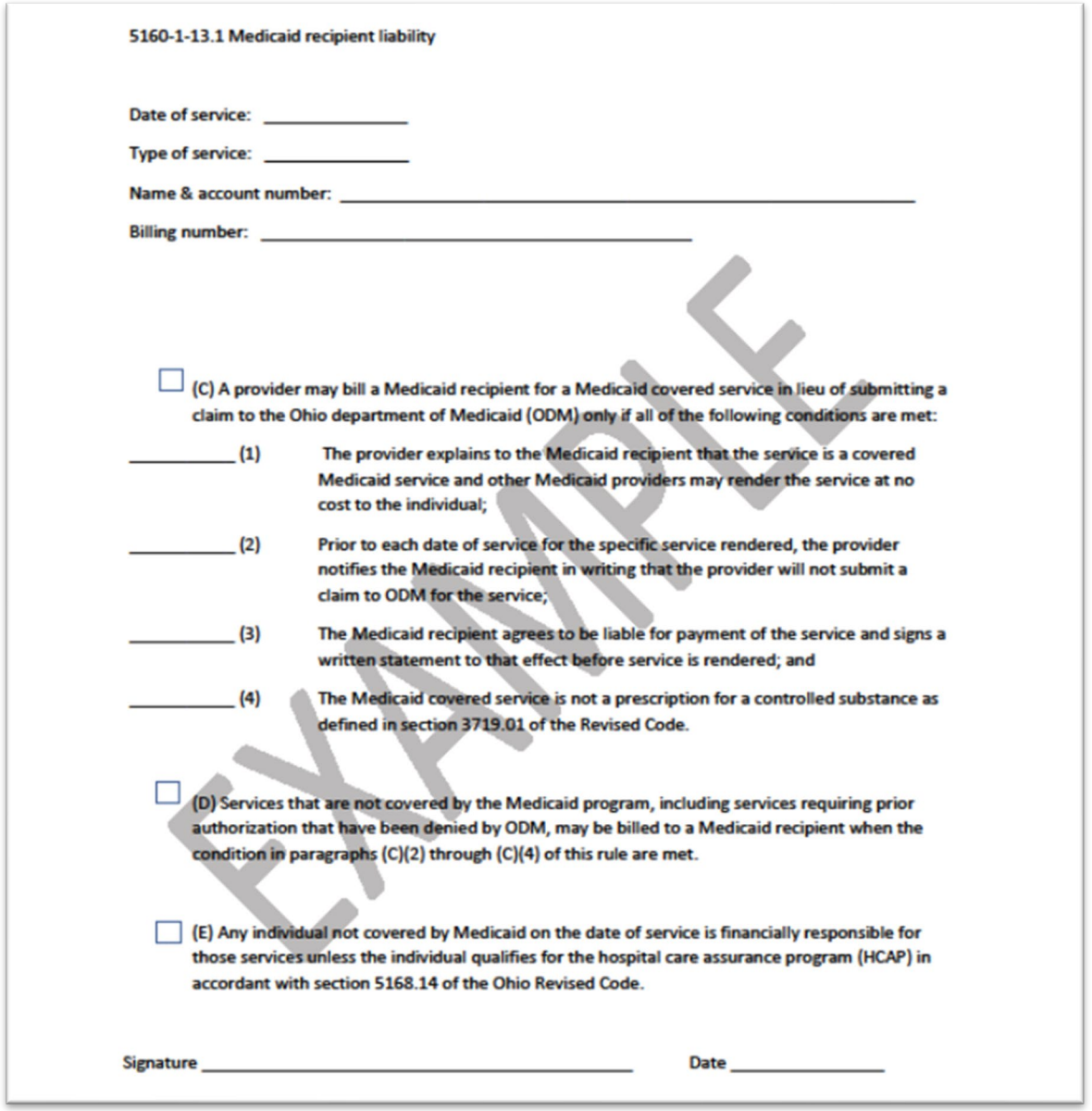


When Can You Bill an Individual?



When Can You Bill an Individual?

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



5160-1-13.1 Medicaid recipient liability

Date of service: _____

Type of service: _____

Name & account number: _____

Billing number: _____

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

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

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

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

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

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

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

Signature _____ Date _____

EXAMPLE

Policy

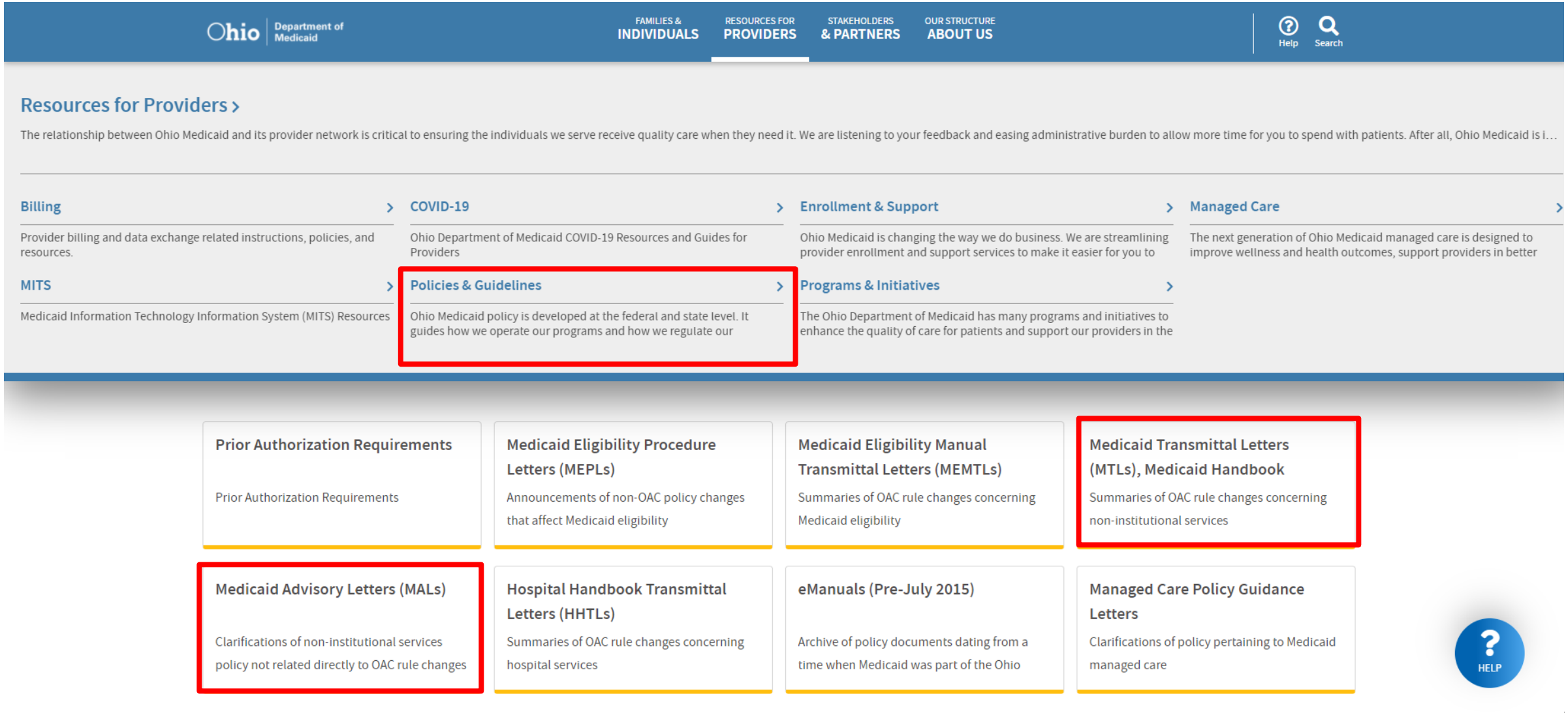
Policy updates from Ohio Medicaid announce the changes to the Ohio Administrative Code that may affect providers.

Nursing Facility Provider Associations and ODM website

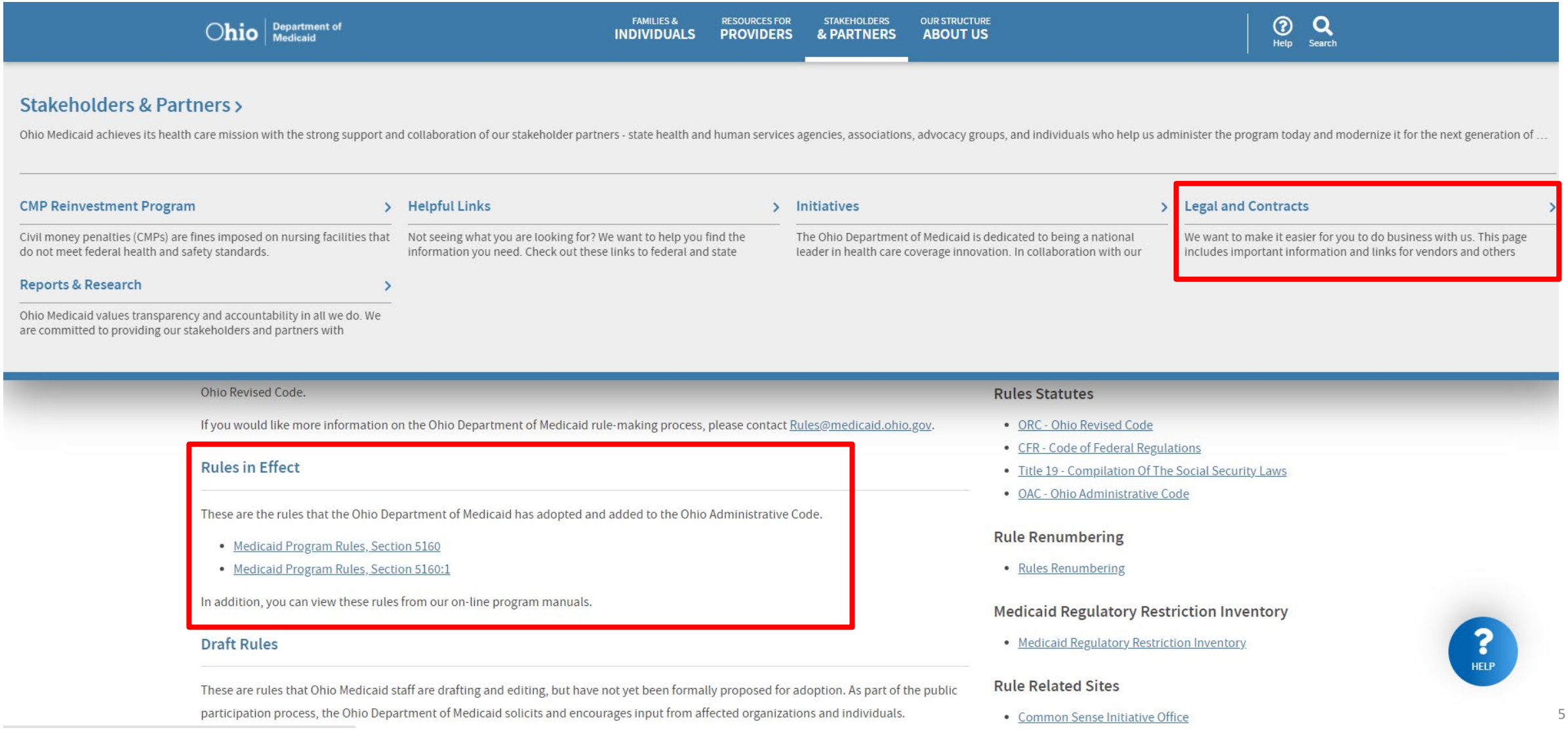
Medicaid Advisory Letter (MAL)

Medical Transmittal Letter (MTL)

Policy


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

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

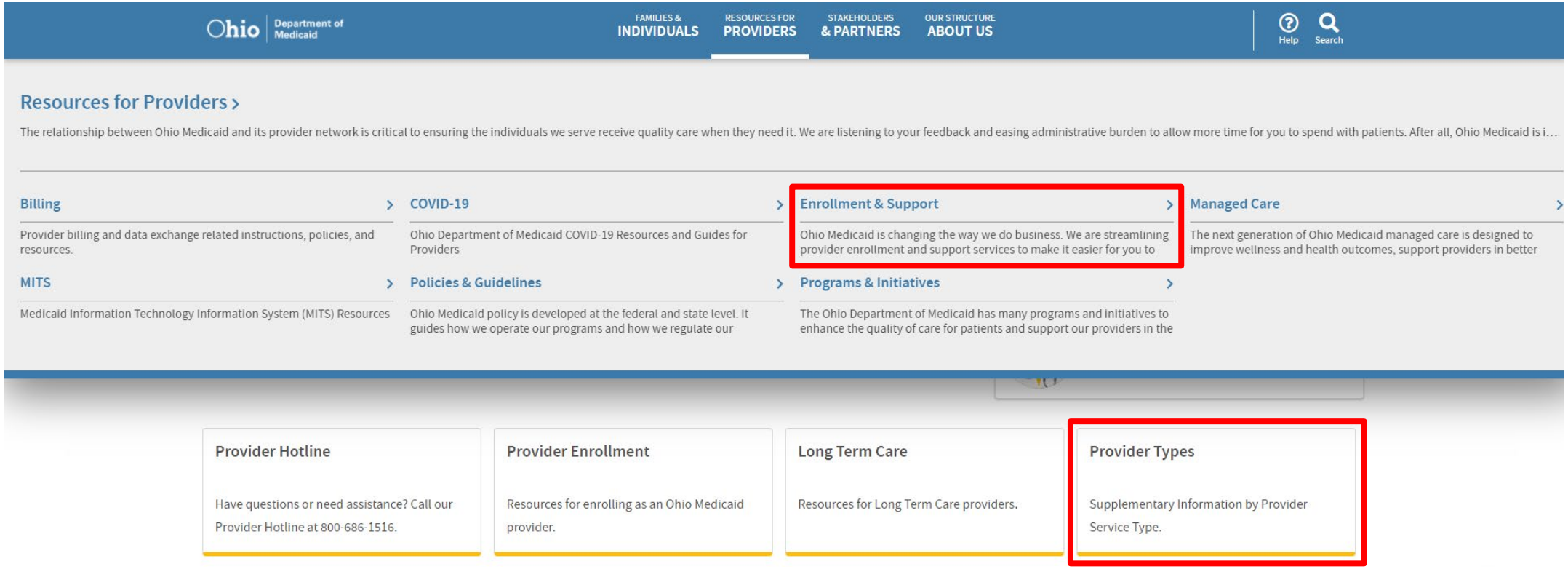
- Common Sense Initiative Office

HELP

Policy

https://codes.ohio.gov

Nursing Facility Information



- 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

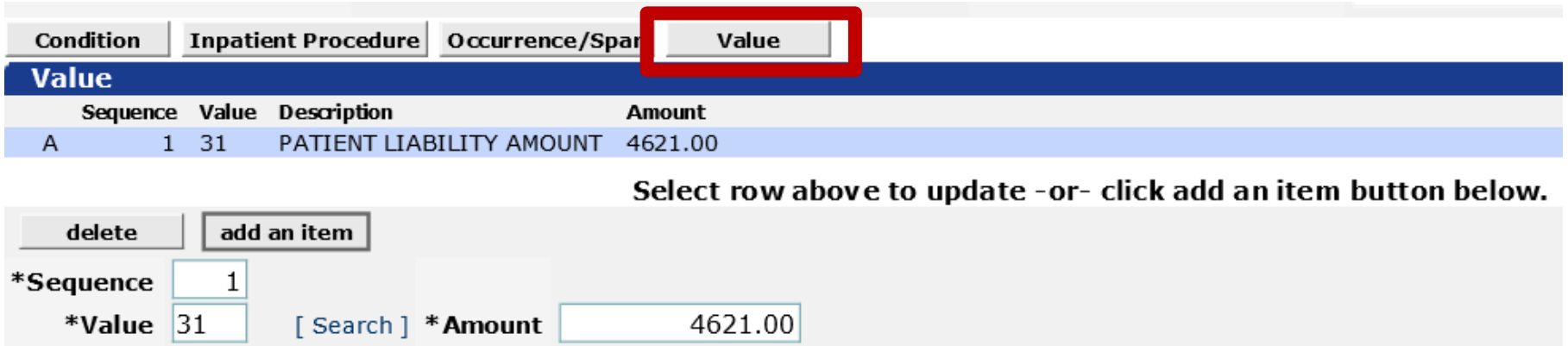
Use this form to report any changes for individuals receiving medical assistance and/or their household members. Check the box for each type of change, provide the requested information for that section, and provide the effective date of the change. The **Individual Information** and **Submitter Information** 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? ☐ Yes ☐ 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.*				
☐ Phone Number Change	Effective Date of Change			
☐ 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



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 of 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

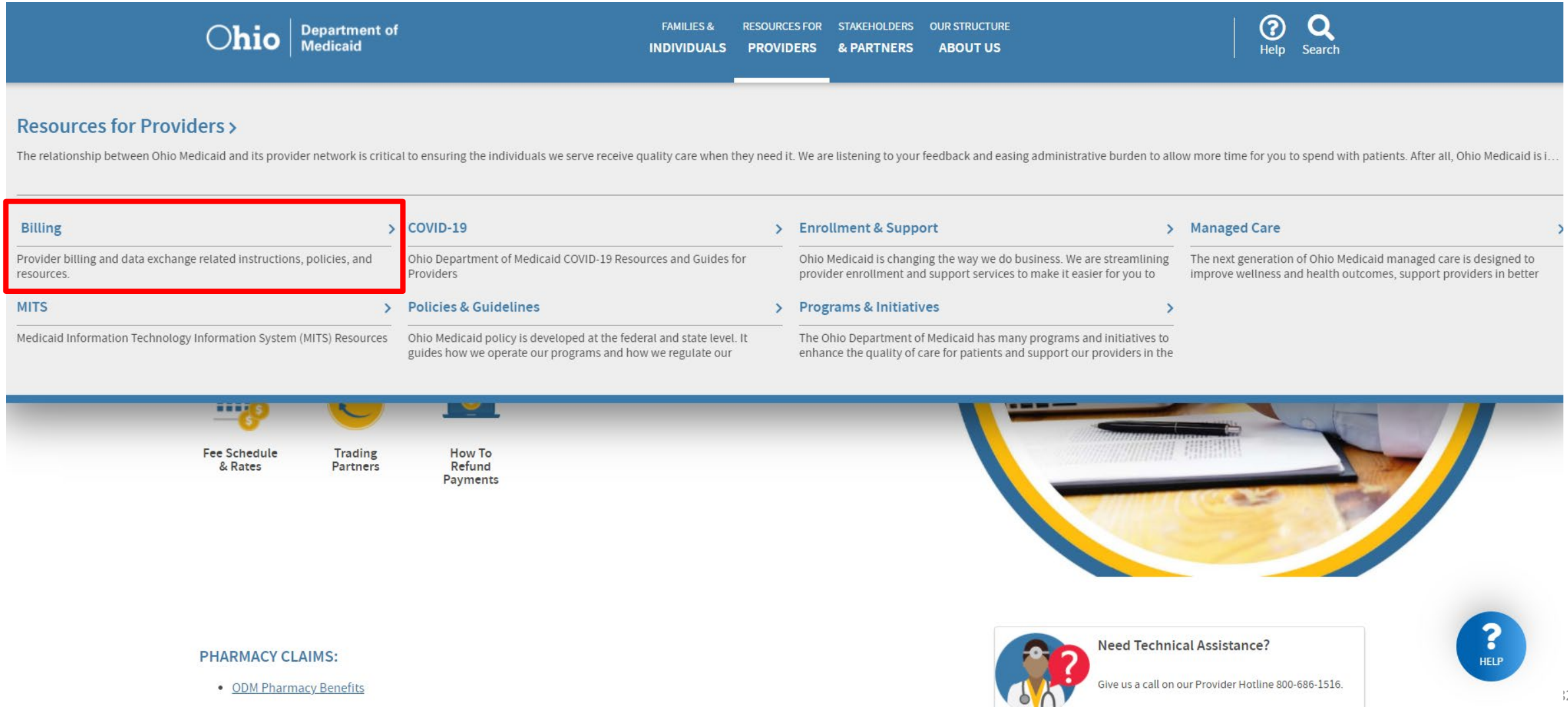
0419 – Vent-dependent services

0410 – Vent weaning services

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

MITS & Claims

Billing Resources



Medicaid Information Technology System (MITS)

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

Technical Requirements

Internet Access (high speed works best)

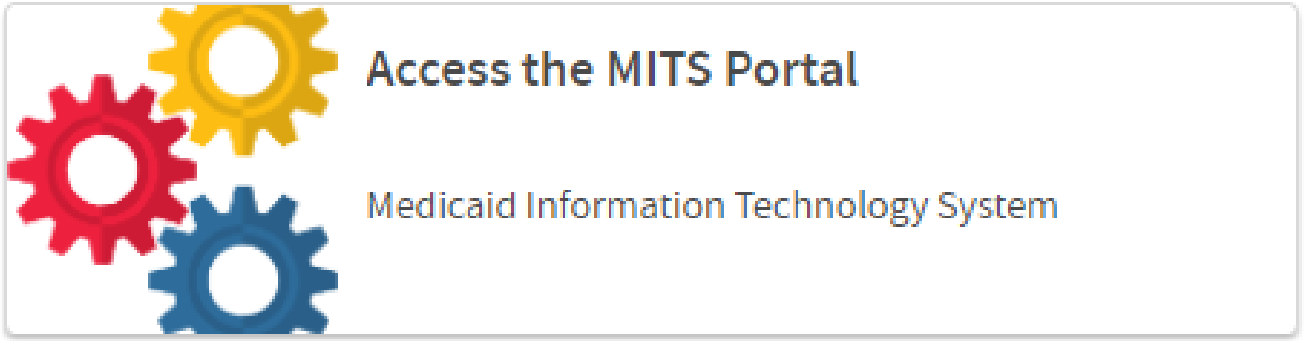
Internet Explorer version 10 or higher and current versions of Firefox or Chrome

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

Turn **OFF** pop up blocker functionality

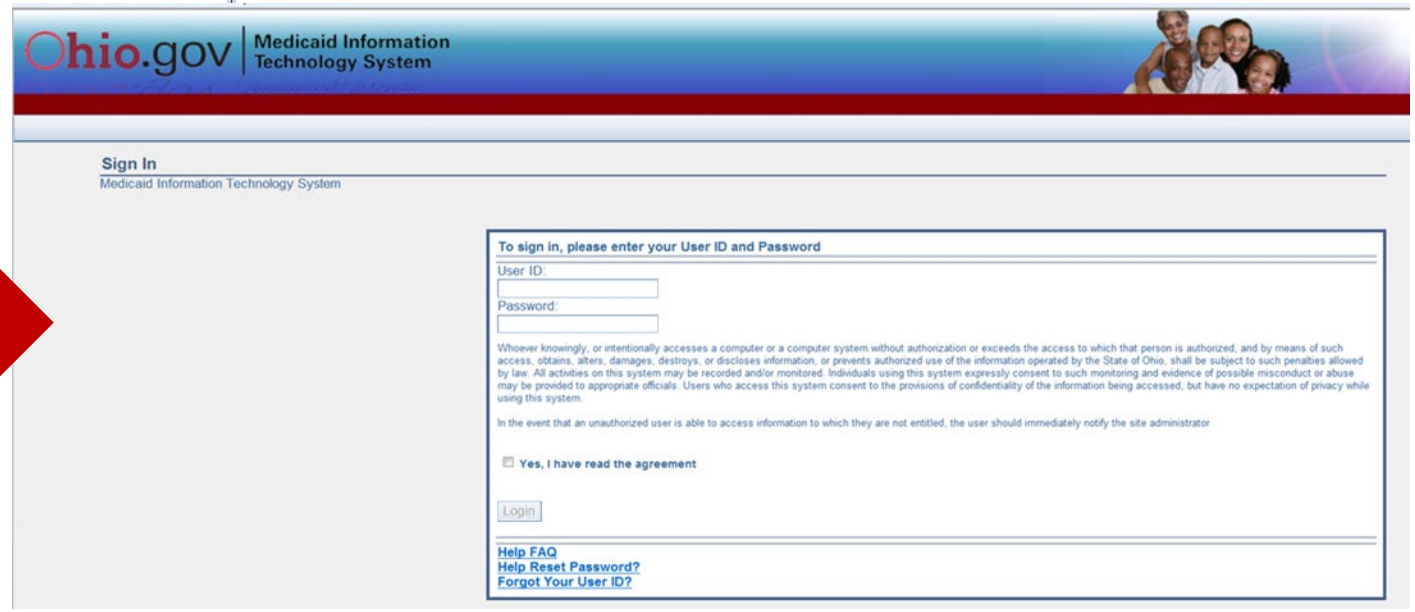
How to Access the MITS Portal

- 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

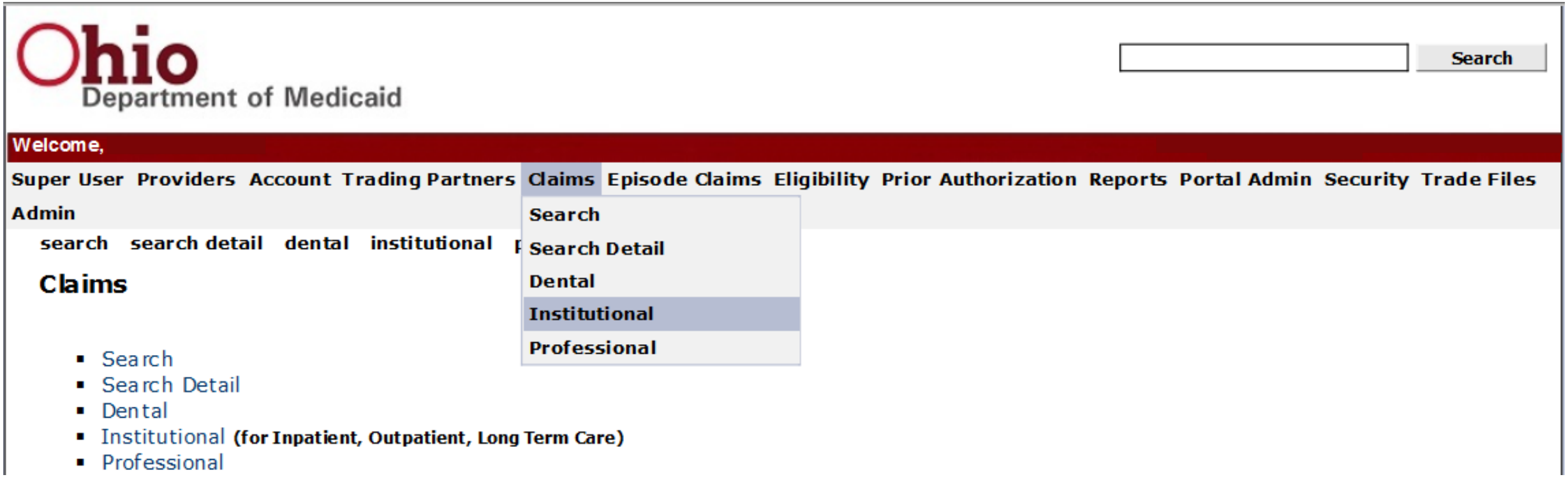
MITS Web Portal Claim Submission

Claim entry format is divided into sections or panels

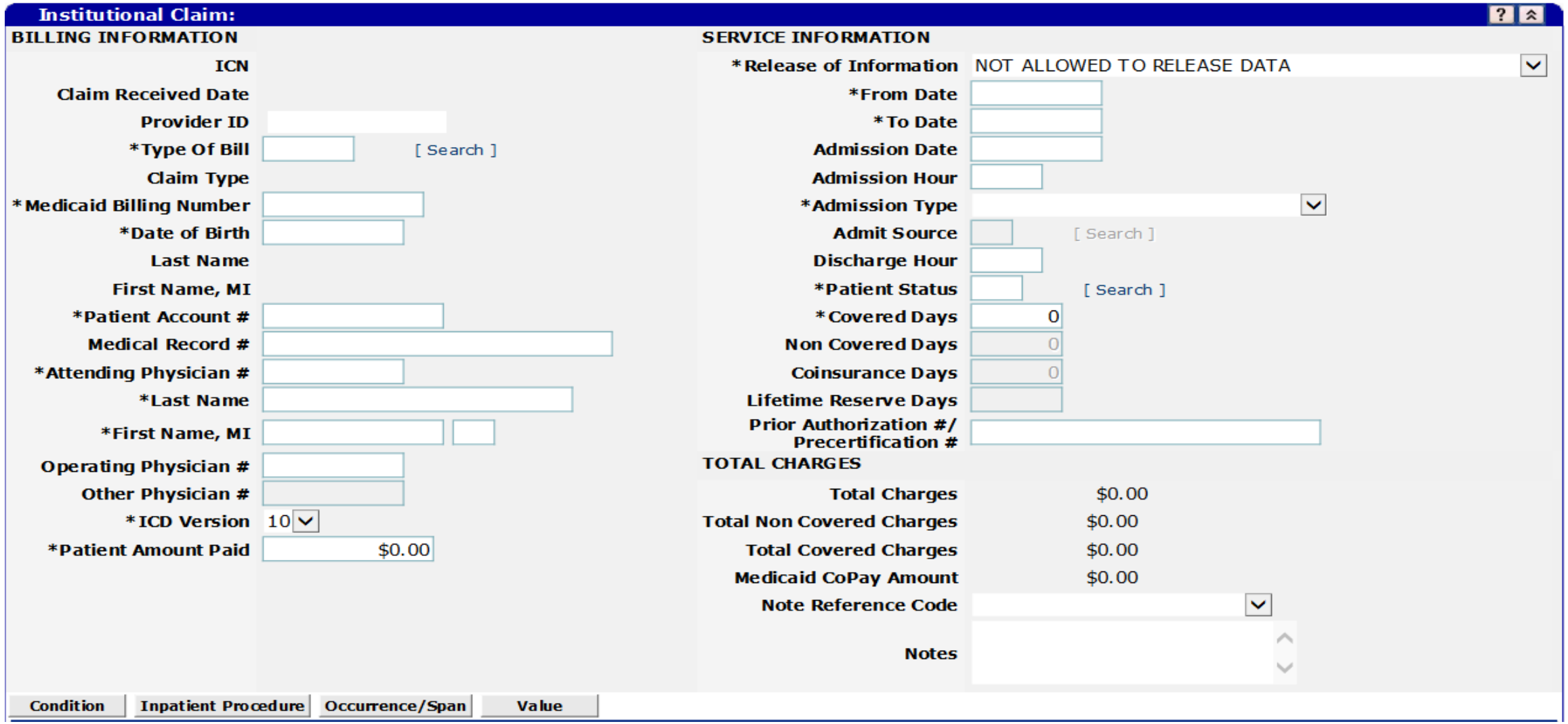
Each panel will have an asterisk (*) denoting that the fields are required

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

Submission of an Institutional Claim



Submission of an Institutional Claim

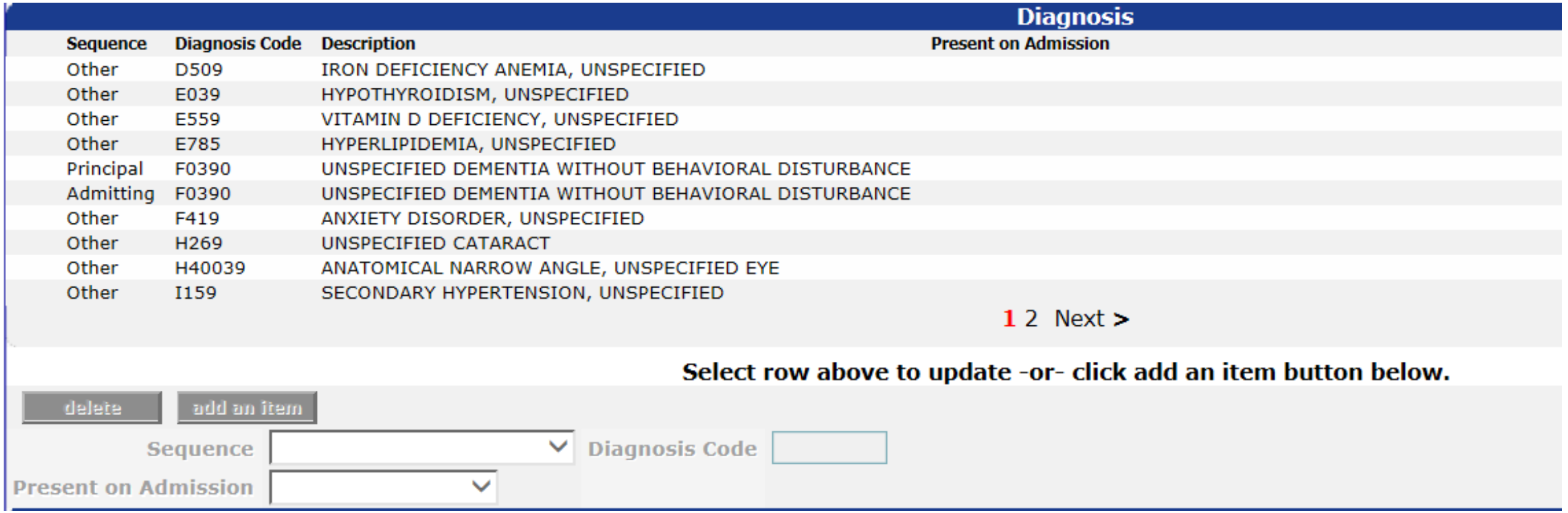


Diagnosis Code: Required on Most Claims

Must include all characters specified by ICD

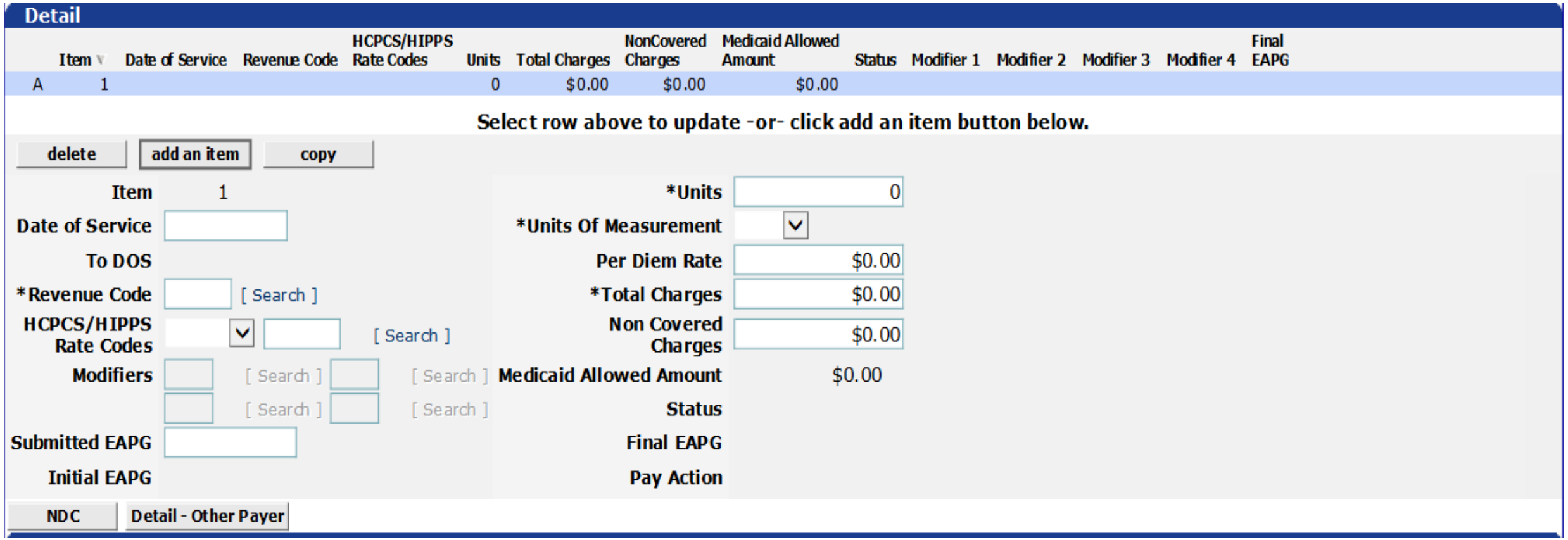
Do **NOT** enter the decimal points

There are system edits and audits against those codes



Detail Panel

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



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

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

Submission of an Institutional Claim

Claim with 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	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	***Units**	6.00
***Date of Service**	08/26/2021	***Units Of Measurement**	Days
To DOS	08/31/2021	**Per Diem Rate**	$0.00
***Revenue Code**	185 [Search]	***Total Charges**	$1,410.00
HCPCS/HIPPS Rate Codes	[Search]	**Non Covered Charges**	$0.00
Modifiers	[Search] [Search] [Search] [Search]	**Medicaid Allowed Amount**	$0.00
		Status	
Submitted EAPG		**Final EAPG**	
Initial EAPG		**Pay Action**	

- Click the “submit” button at the bottom right

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

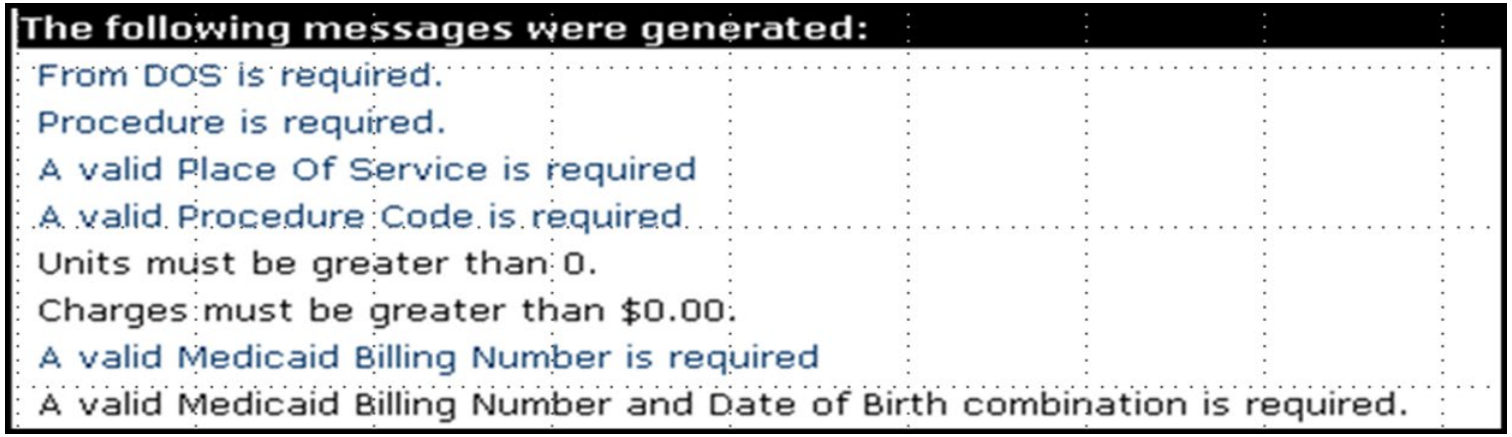
Claim Portal Errors

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



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:

Voided

Adjusted

Copied

Adjusting a Paid Claim

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

Adjusting a Paid Claim: Example

2221180234001 Originally paid $45.00

5821185127250 Now paid $50.00

Additional payment of $5.00

2021172234001 Originally paid $50.00

5021173127250 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

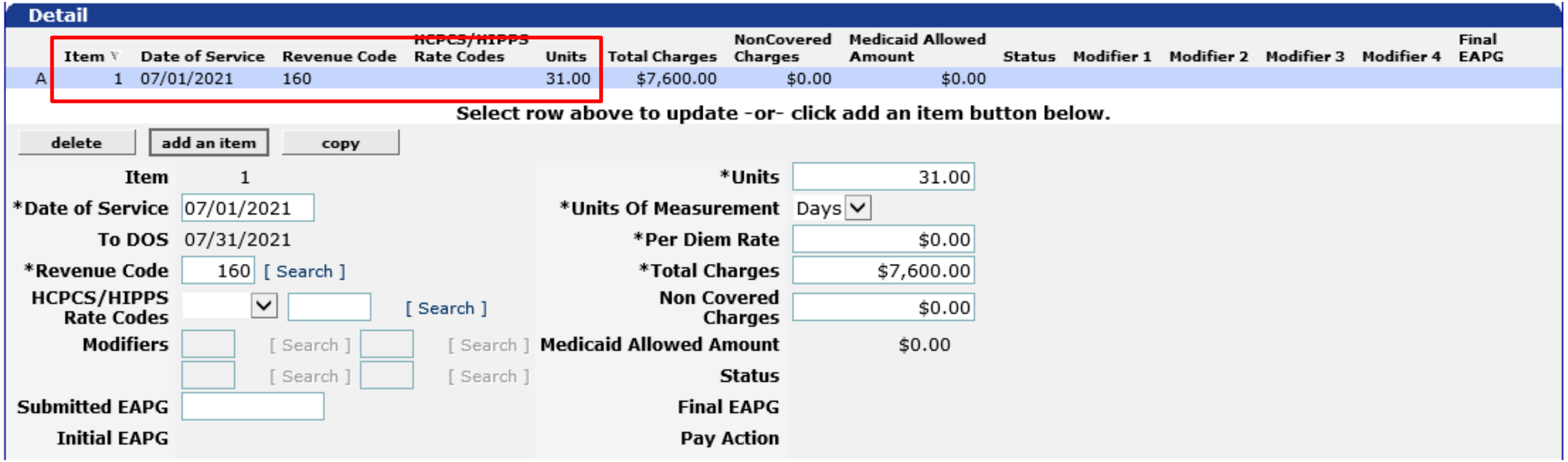
Copying a Paid Claim

- 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



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.

delete | add an item | copy

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] [Search] [Search]	Medicaid Allowed Amount	$0.00
		Status	
Submitted EAPG		Final EAPG	
Initial 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	*Units	3.00
*Date of Service	06/28/2021	*Units Of Measurement	Days
To DOS	06/30/2021	*Per Diem Rate	$0.0000
*Revenue Code	101 [Search]	*Total Charges	$735.00
HCPCS/HIPPS Rate Codes	[Search]	Non Covered Charges	$0.00
Modifiers	[Search] [Search] [Search] [Search]	Medicaid Allowed Amount	$0.00
		Status	
Submitted EAPG		Final EAPG	
Initial 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	17.00
*Date of Service	10/01/2021	*Units Of Measurement	Days
To DOS	10/17/2021	*Per Diem Rate	$0.0000
*Revenue Code	101 [Search]	*Total Charges	$4,165.00
HCPCS/HIPPS Rate Codes	[Search]	Non Covered Charges	$0.00
Modifiers	[Search] [Search] [Search] [Search]	Medicaid Allowed Amount	$0.00
		Status	
Submitted EAPG		Final EAPG	
Initial 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] [Search] [Search] [Search]	Medicaid Allowed Amount	$0.00
		Status	
Submitted EAPG		Final EAPG	
Initial 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	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	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.

delete | add an item | copy

Item	1	*Units	5.00
*Date of Service	04/01/2021	*Units Of Measurement	Days
To DOS	04/05/2021	Per Diem Rate	$0.0000
*Revenue Code	220 [Search]	*Total Charges	$750.00
HCPCS/HIPPS Rate Codes	[Search]	Non Covered Charges	$0.00
Modifiers	[Search] [Search] [Search] [Search]	Medicaid Allowed Amount	$0.00
		Status	
Submitted EAPG		Final EAPG	
Initial 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

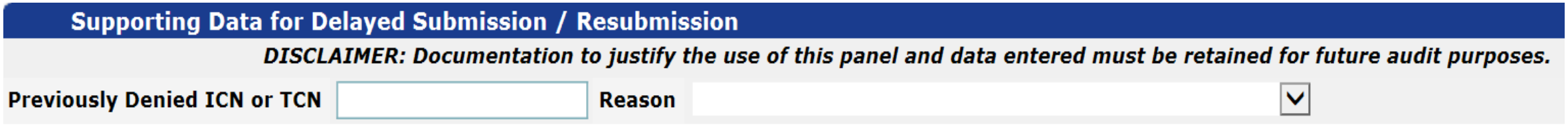
Claims over 2 years old will be denied

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

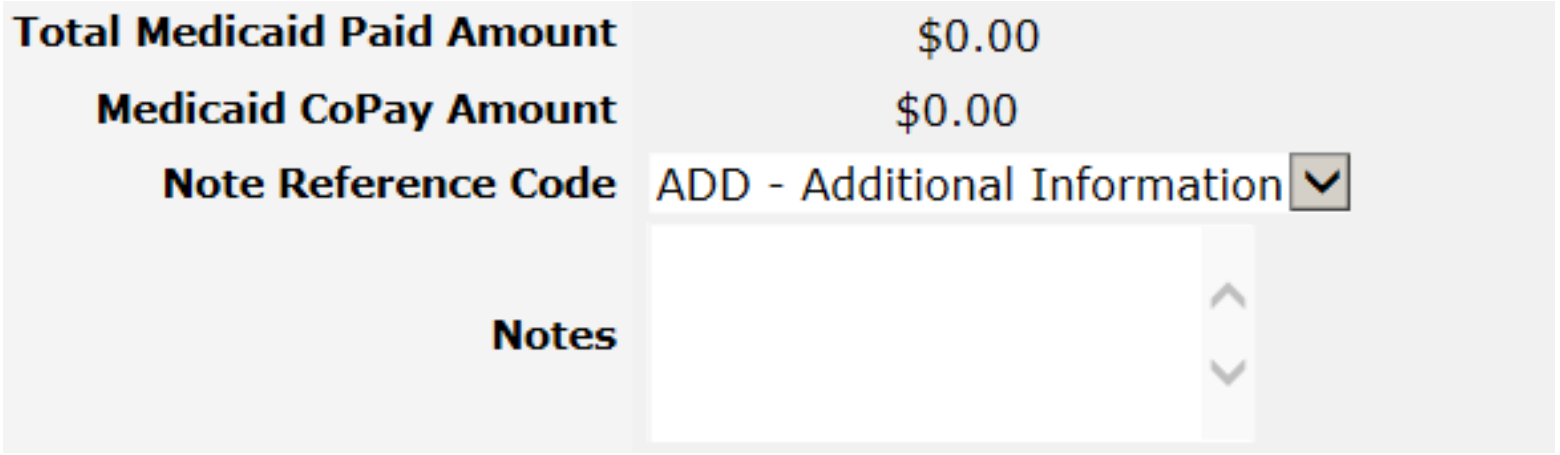


Timely Filing Exceptions: OAC 5160-3-39.1

- 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”



How to Bill After a Delay

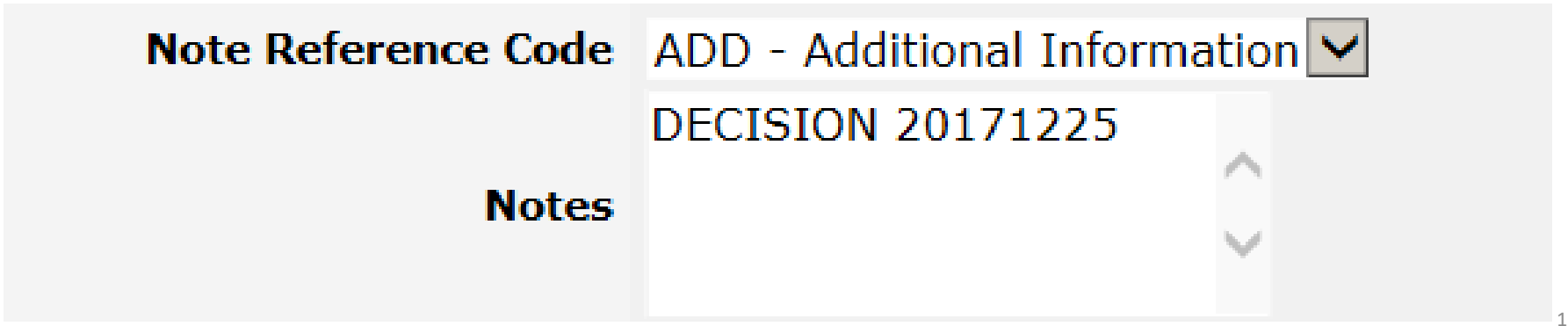
Hearing Decision: APPEALS ######## CCYYMMDD

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

Eligibility Determination: DECISION CCYYMMDD

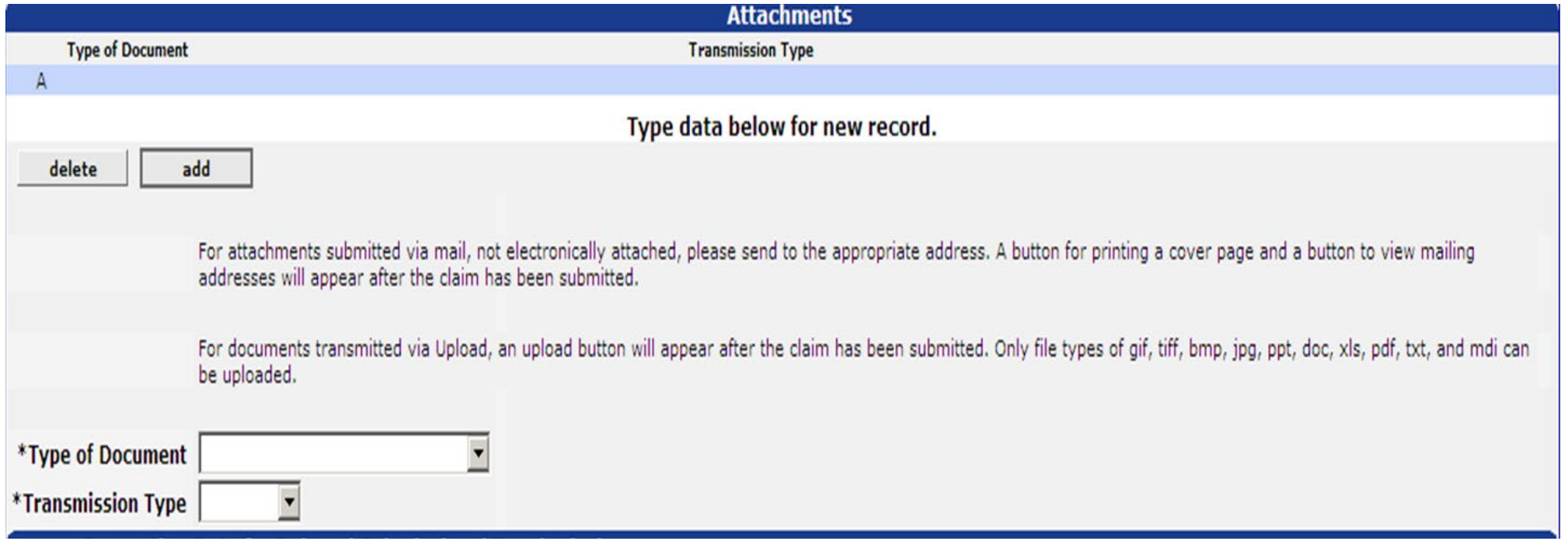
- CCYYMMDD is the date on the eligibility determination notice from the CDJFS

Must use the spacing shown



Uploading an Attachment

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

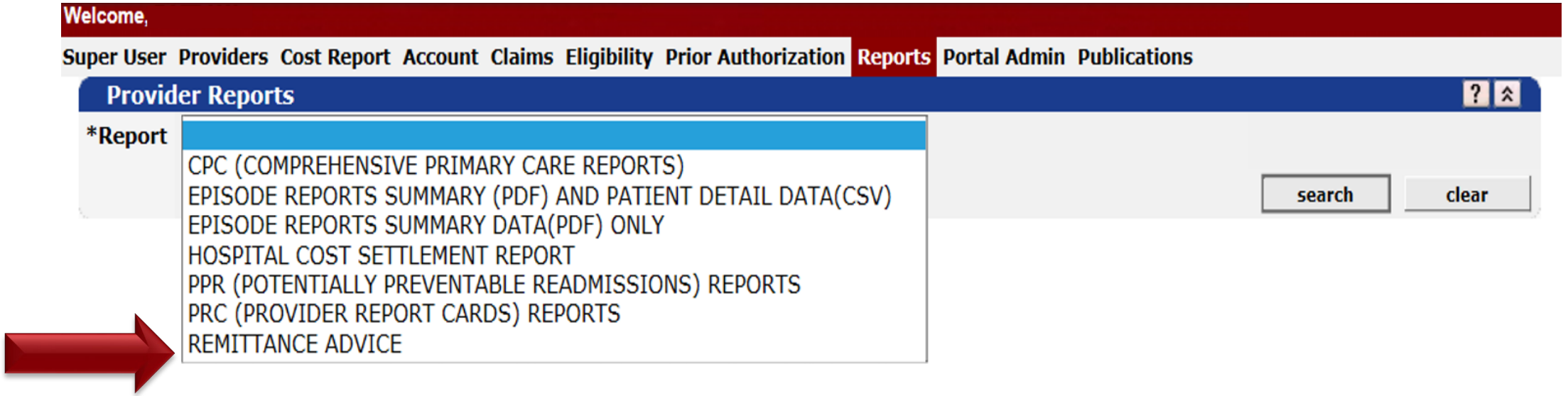


Uploading an Attachment

- 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 less than 50 MB in size
- Each file must pass an anti-virus scan in MITS
- A maximum of 10 attachments may be uploaded

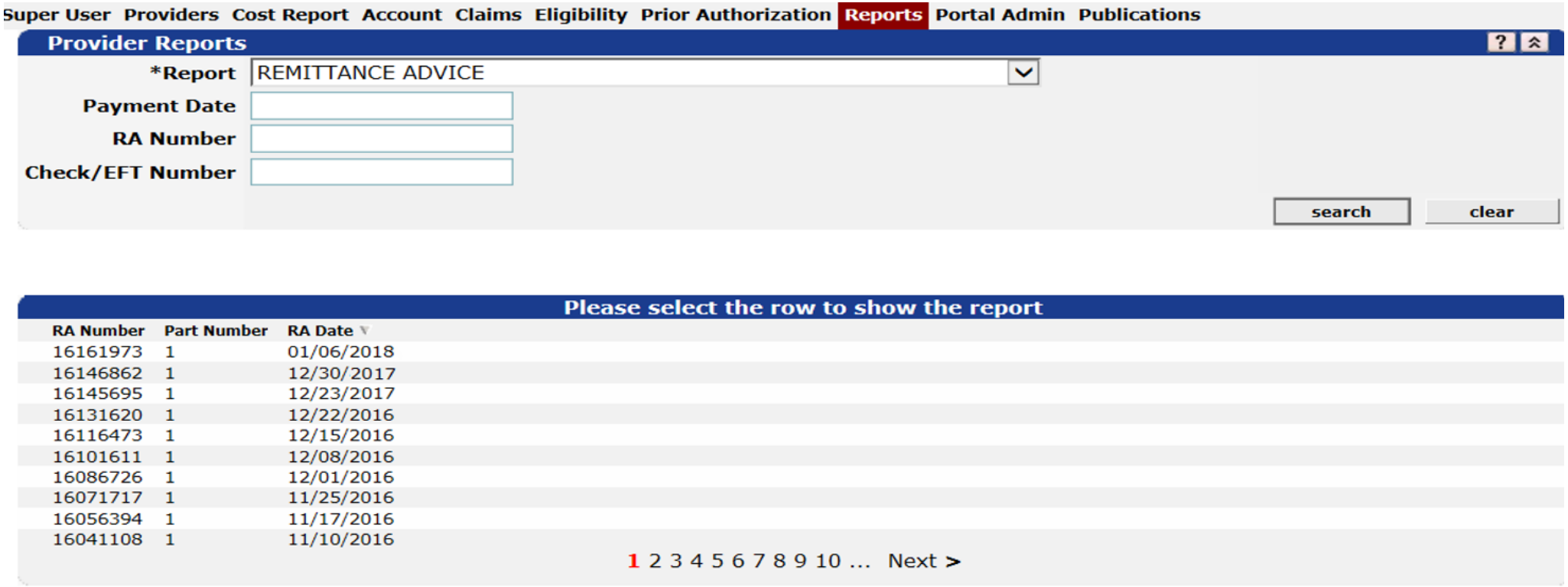
Remittance Advice (RA)

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



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

Remittance Advice (RA)

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

ICN PATIENT NUMBER	SERVICE DATES FROM	COVERED THRU	NON-COVERED DAYS	BILLED AMOUNT	ALLOWED AMOUNT	TPL AMOUNT	PATIENT RESPONSIBILITY	LUMP SUM	PAID 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 CODE	SERVICE DATES FROM	 THRU	COV DAYS	NON-COVERED DAYS	DAILY RATE	BILLED AMOUNT	ALLOWED AMOUNT	TPL AMOUNT	PAID AMOUNT
0101	070118	073118	31	0	174.04	5,735.00	5,395.24	0.00	3,446.24
DETAIL EOBS 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

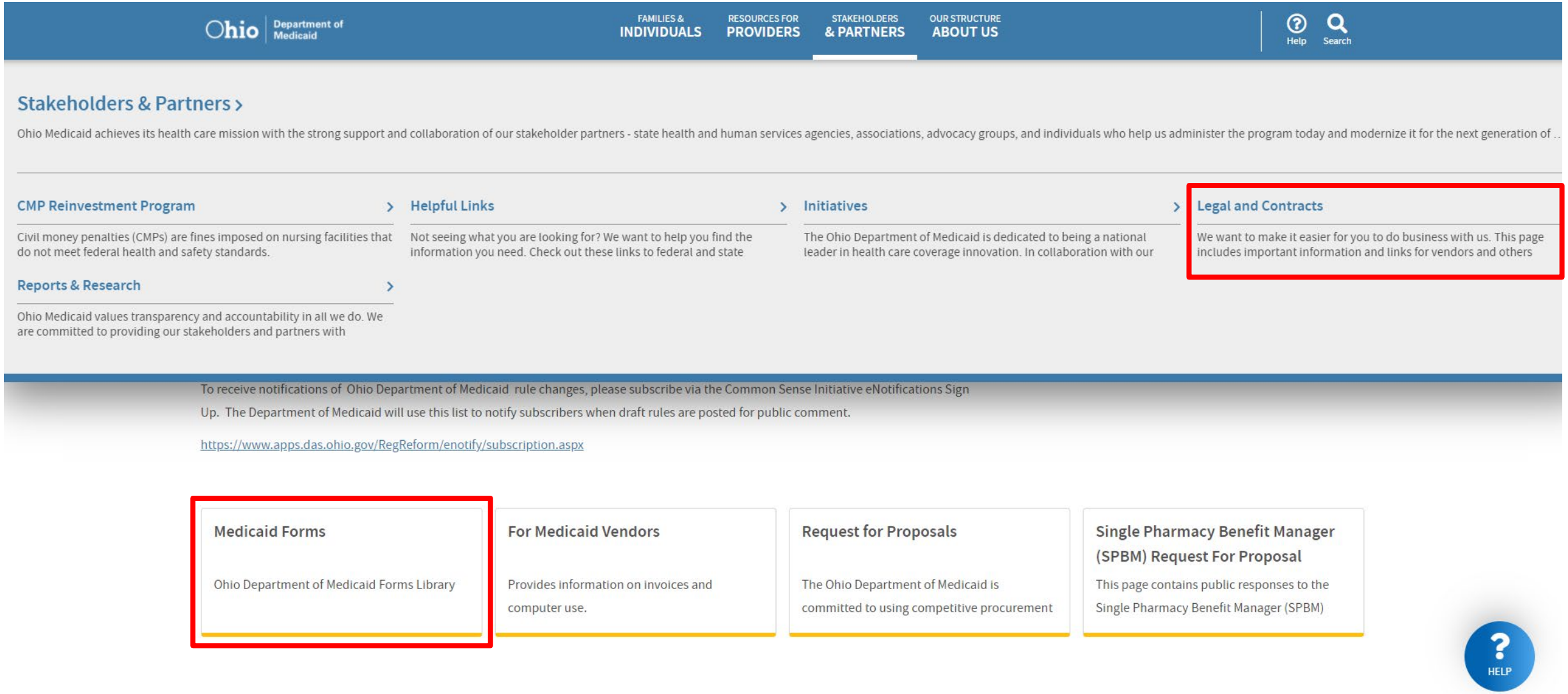
- For Medicaid eligibility and patient liability issues – contact the local County Department of Job and Family Services (CDJFS) that is handling the Medicaid case

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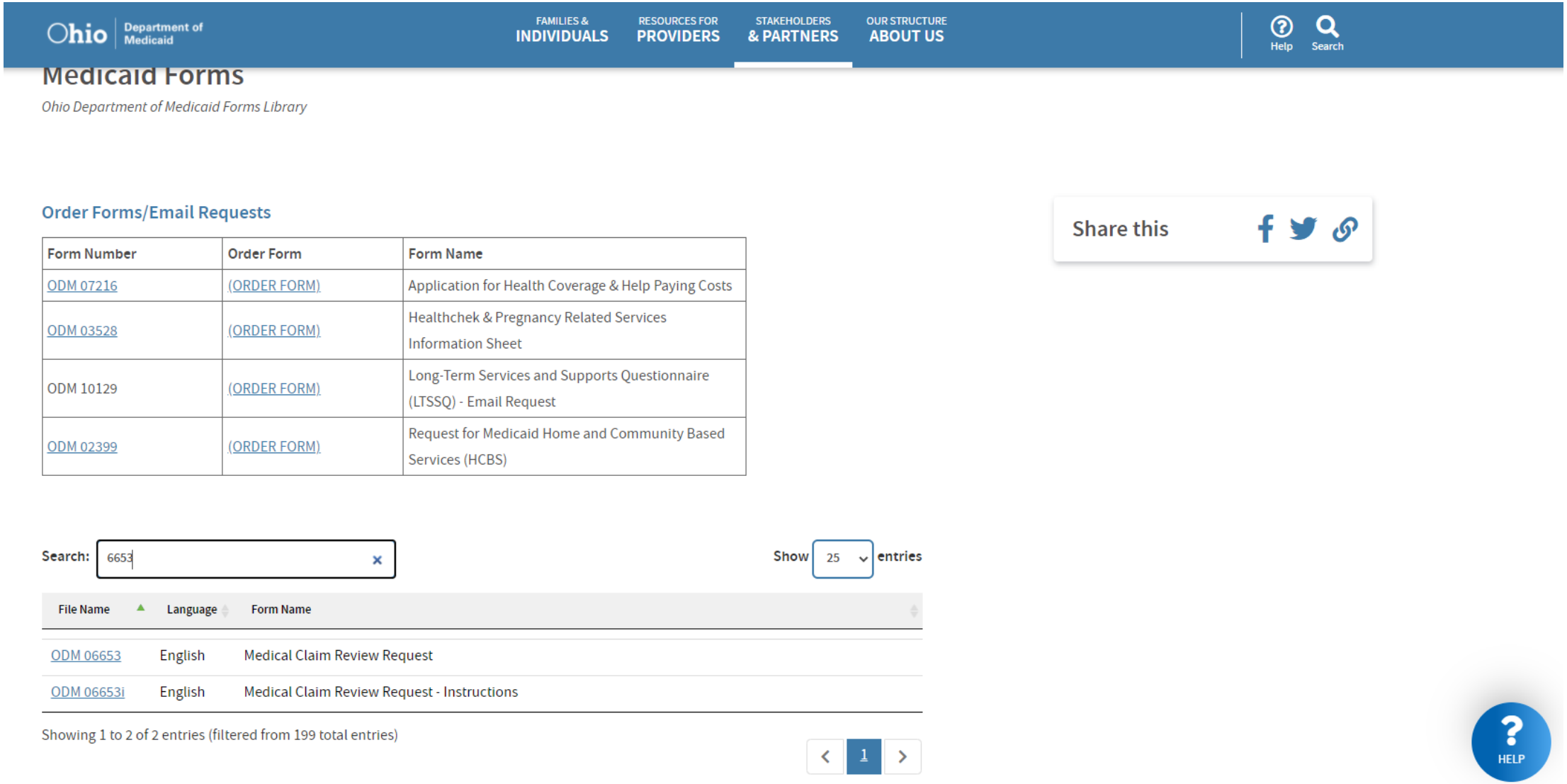
Ohio Medicaid achieves its health care mission with the strong support and collaboration of our stakeholder partners - state health and human services agencies, associations, advocacy groups, and individuals who help us administer the program today and modernize it for the next generation of ..
CMP Reinvestment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

Forms



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Medicaid Forms

Ohio Department of Medicaid Forms Library

Order Forms/Email Requests

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

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Search: 6653 ×

Show 25 entries

File Name	Language	Form Name
ODM 06653	English	Medical Claim Review Request
ODM 06653i	English	Medical Claim Review Request - Instructions

Showing 1 to 2 of 2 entries (filtered from 199 total entries)

< 1 >

HELP

Forms

- ODM 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