

Basic Billing for Pharmacists

Provider Relations
2021

Medicaid Medical Necessity: OAC 5160-1-01

Is the fundamental concept underlying the Medicaid
Program

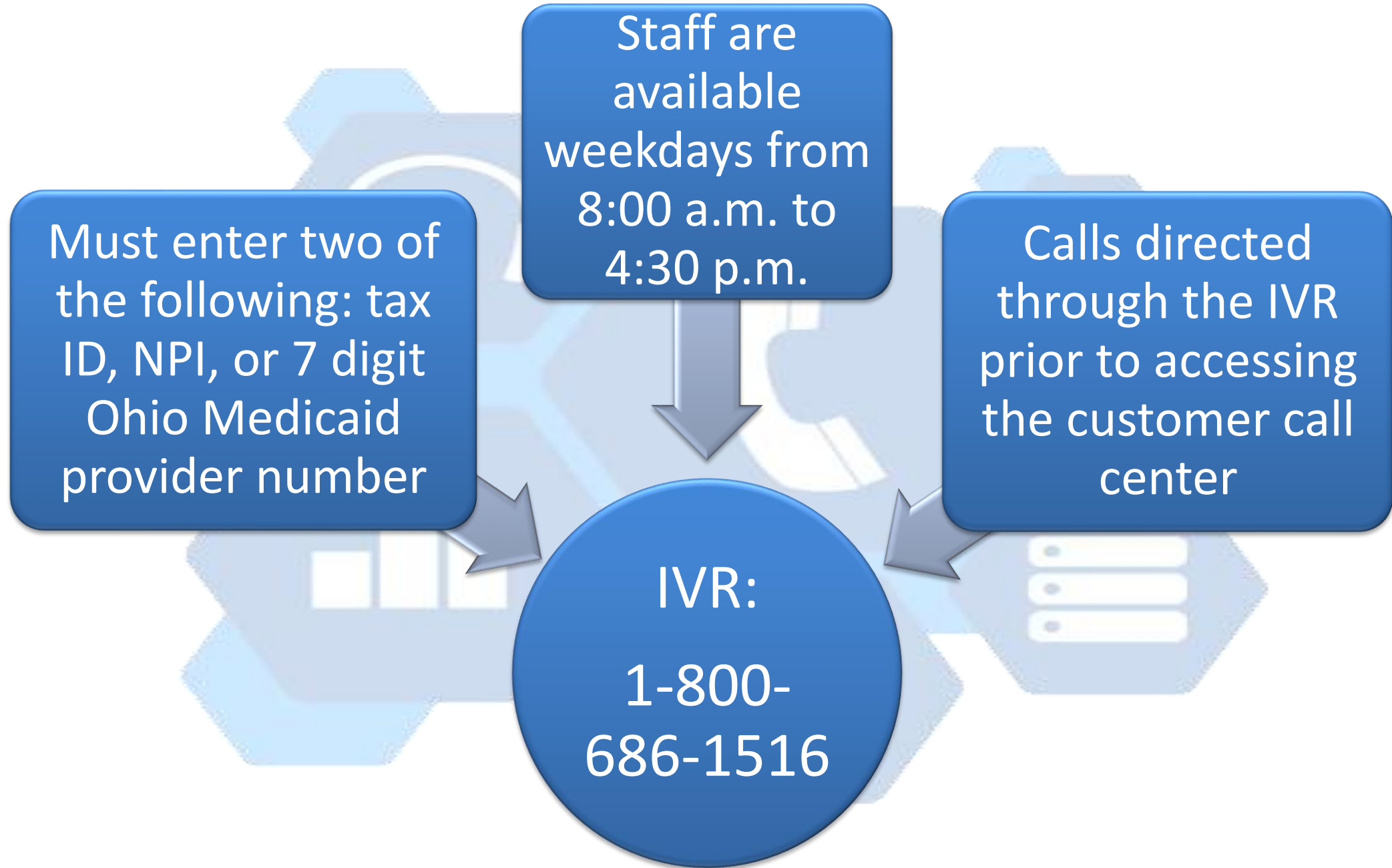


All Services must meet accepted standards of medical
practice

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)





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>_____</p>	<p>Fold</p> <table border="1"><tr><td>County</td><td>ALLEN</td><td rowspan="5">Ohio Medicaid</td></tr><tr><td>Case Number</td><td>5082482</td></tr><tr><td>Eligibility Begin Date</td><td>01/01/2020</td></tr><tr><td>Void After Date</td><td>01/31/2020</td></tr><tr><td colspan="2">Ohio Department of Medicaid medicaid.ohio.gov</td></tr><tr><td colspan="3">Consumer Hotline: 1-800-324-8680 [or TTY 1-800-292-3572]</td></tr></table>	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]		
County	ALLEN	Ohio Medicaid													
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Ohio Department of Medicaid medicaid.ohio.gov															
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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 Search

FAMILIES & INDIVIDUALS
RESOURCES FOR PROVIDERS
STAKEHOLDERS & PARTNERS
OUR STRUCTURE ABOUT US

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	

Fee Schedule & Rates
Disclaimer about fee schedule and rates available for providers.

Training
Training presentations, videos, and handouts.

TPL Carrier List
Click download to obtain the full listing of Third Party Carrier List and numbers

Direct Deposit
OBM Shared Services is a business processing center that processes common administrative

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



Search

Welcome,

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

Security Trade Files Admin

eligibility search deemed eligible newborn presumptively eligible child presumptively eligible pregnant woman psychiatric admission hospice enrollment

Eligibility Verification Request

Medicaid Billing Number	<input type="text"/>	Birth Date	<input type="text"/>
SSN	<input type="text"/>	DOS Date Format	MM/DD/YYYY <input type="text"/>
Procedure Code	<input type="text"/>	From DOS	<input type="text" value="07/16/2017"/>
		To DOS	<input type="text" value="07/15/2021"/>

*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 of 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

Last Name

First Name

Gender

Date of Birth

Date of Death

SSN

County of Residence

County of Eligibility

County Office http://jfs.ohio.gov/County/County_Directory.pdf

Number Bed Hold Days Used Paid CY

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 Eliqibility Verification Request panel to search for Service Limitations.

Eligibility Verification Request

Click on a payer to verify their provider ID

TPL

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

Managed Care

Plan Name	Plan Description
CARESOURCE	HMO, C
MOLINA HEALTHCARE OF OHIO INC	HMO, C
MOLINA HEALTHCARE OF OHIO INC	HMO, C

Lock-In

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

Message from webpage


!

Provider ID: 0077186 MCD

Mailing Address: 3000 CORPORATE EXCHANGE DRIVE
City: COLUMBUS
State: OH
Zip: 43231-7689
Email:

OK

Message from webpage



Provider ID: 0077186 MCD

Mailing Address: 3000 CORPORATE EXCHANGE DRIVE
 City: COLUMBUS
 State: OH
 Zip: 43231-7689
 Email:

OK

Inpatient Hospital Services Plan (IHSP)

If an incarcerated, Medicaid eligible individual is admitted to a hospital for at least 24 hours, this will show in the benefit/assignment plan panel. This will only cover services provided during the inpatient hospital stay.

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

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

Presumptive Eligibility

Covers children up to age 19 and pregnant women



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



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



Presumptive Eligibility

- Hospitals and Federally Qualified Health Centers (FQHCs) are eligible to participate in Ohio's presumptive eligibility initiative

- To become a Qualified Entity complete the steps described here:
 - » <https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/billing/presumptive-eligibility-training/presumptive-eligibility-training>

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

NOTE TO MEDICAID PROVIDERS:

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

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

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

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

Signature of Qualified Entity Designee : _____ Date: _____

Presumptive Eligibility

Other members will receive this Presumptive Eligibility letter:

CDJFS Presumptive Eligibility

John Doe
123 Main St.
Anytown, OH 43210

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

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

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

APPROVED:

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



Qualified Medicare Beneficiary (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

Gender0

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 & QI 1/QI

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 BETTER HEALTH® OF 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

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		

MyCare Ohio



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



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



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

MITS Eligibility MyCare Opt-In

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

Third-Party Duties; Medicaid Managed Care Organizations: ORC 5160.40

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

Recoupment of Overpayment: ORC 5167.22

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

Some ways the MCOs **can** differ from Fee for Service

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

** Check your agreement with the plan for specifics

Some ways the MCOs **cannot** differ from Fee for Service

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

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

FAMILIES &
INDIVIDUALS
RESOURCES FOR
PROVIDERS
STAKEHOLDERS
& PARTNERS
OUR STRUCTURE
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Help
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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	

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

HELP

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




[FAMILIES & INDIVIDUALS](#)
[RESOURCES FOR PROVIDERS](#)
[STAKEHOLDERS & PARTNERS](#)
[OUR STRUCTURE ABOUT US](#)

Resources for Providers >

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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	


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

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.

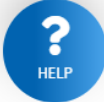
Long Term Care
 Resources for Long Term Care providers.

Provider Types
 Supplementary Information by Provider Service Type.

Provider Network Management (PNM) & Centralized Credentialing
 Provider Network Management is a new modular component of OMES supporting the

Federal Requirement for Revalidation Re-Enrollment
 Describes the requirement for all providers to revalidate or renew their Medicare and/or

Provider Exclusion & Suspension List
 A list of providers who were excluded or that are currently suspended from the Ohio



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

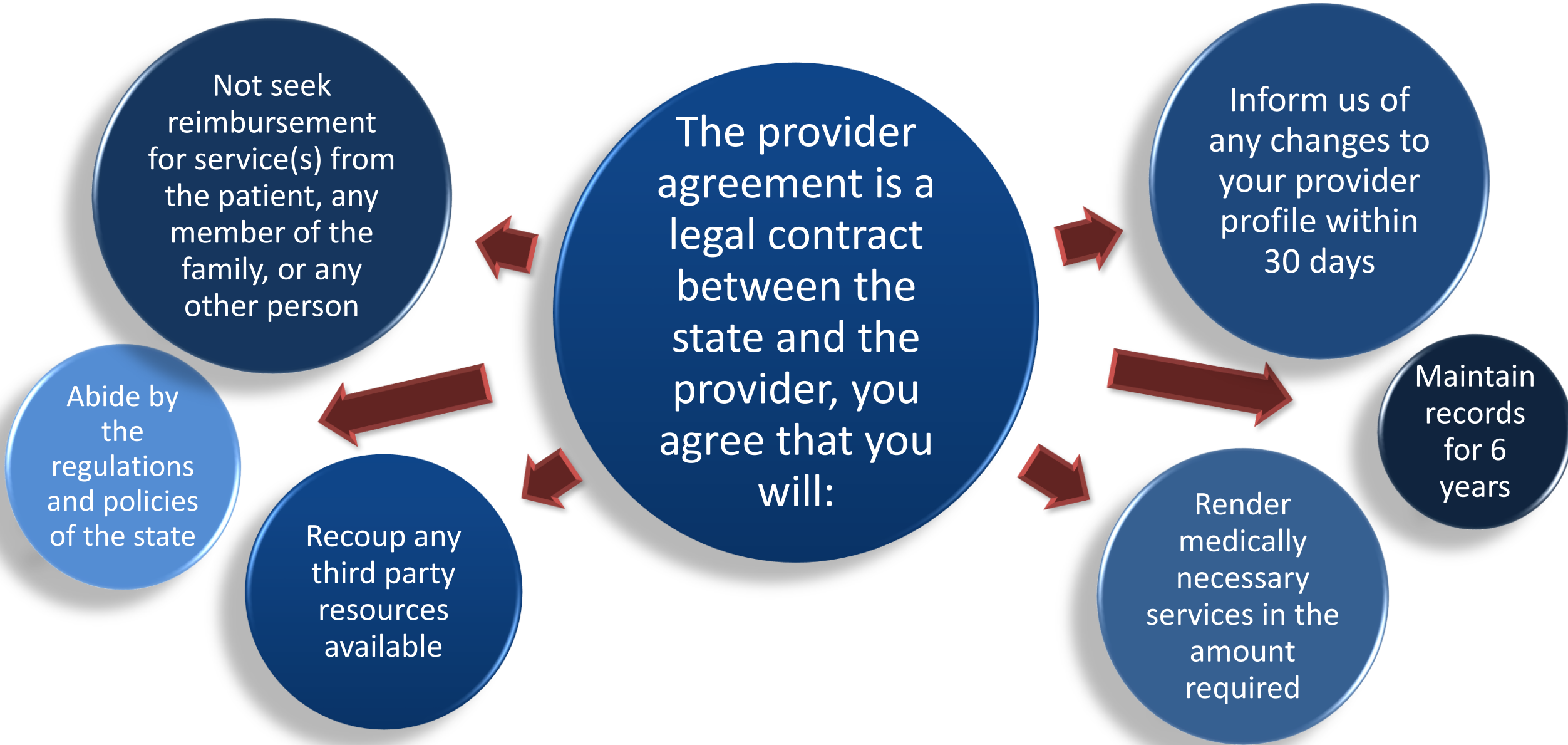


Providers may enroll as an ORP-only provider or as a Medicaid billing provider



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

Ordering, Referring, Prescribing (ORP) Providers

- OAC 5160-1-17.9
- Federal regulation was implemented under Section 6401 of the Patient Protection and Affordable Care Act of 2010
- Went into effect 1/12/2015

Ordering, Referring, Prescribing (ORP) Providers

- It is recommended that you search for an ORP by using their NPI
- If searching by name, it **must** be entered exactly as the provider had entered it in MITS, including middle initial if applicable

Welcome.

Super User **Providers** Cost Report CPC Performance Account Trading Partners Claims Episode Claims Eligibility Prior Authorization Reports

Portal Admin Security Trade Files Admin

demographic maintenance 1099 information provider faq mits days report correspondence self attestation hospital cost report

ordering/referring/ prescribing search group affiliation group members cpc group cpc group members cpc accreditations

cpc attestations

Ordering/ Referring/ Prescribing Search

Ordering Provider NPI

Ordering Provider Last Name

First, MI

* Date of Service

Search Results

Ordering Provider NPI	Ordering Provider Name
1268168168	SMITH, JOHN D

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:



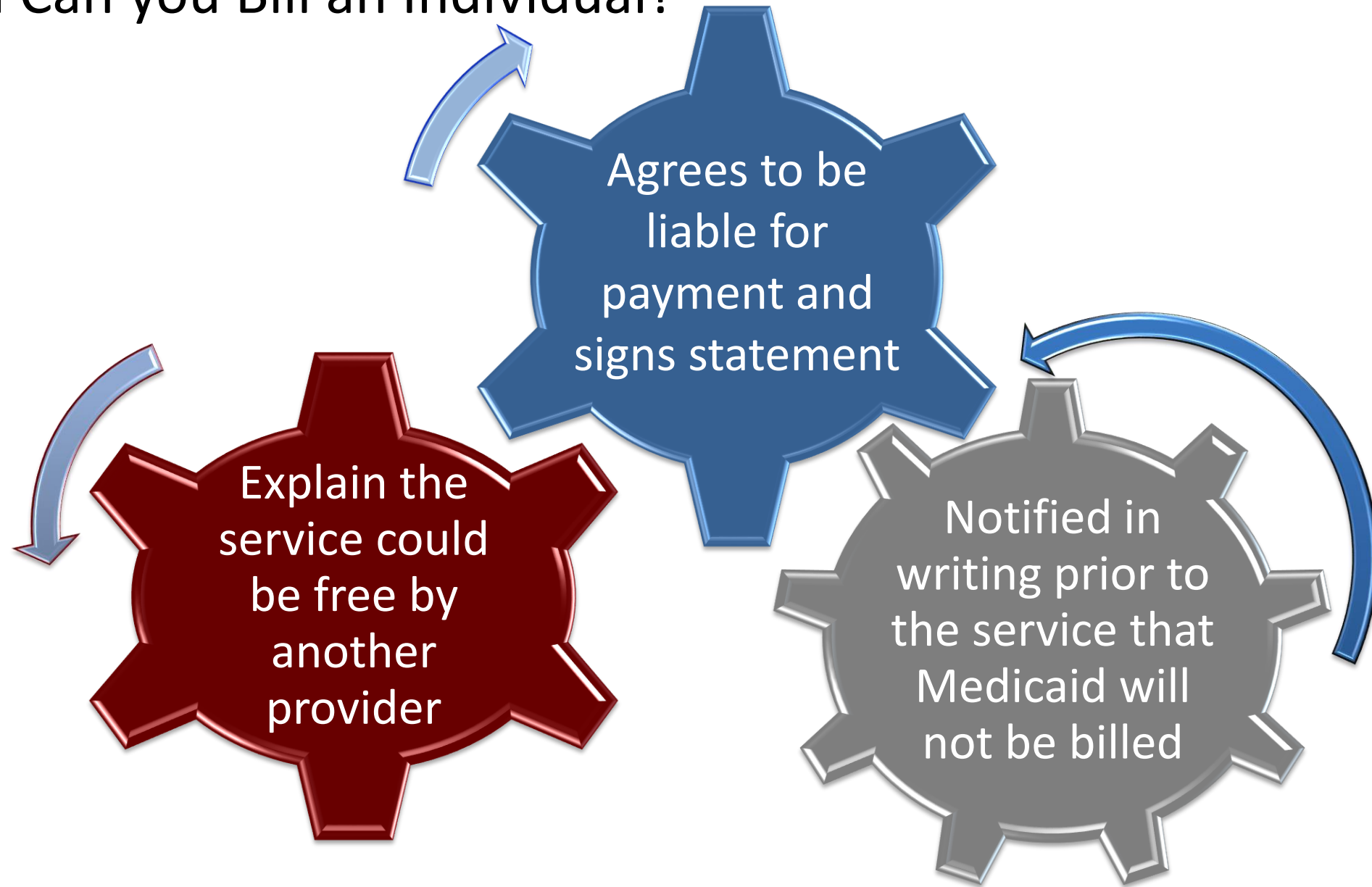
Missed appointment fee

**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 _____

Provider News and Responsibilities





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




Welcome Providers




Access the MITS Portal




Enrollment & Support




Maximus Cybersecurity Incident






The American Rescue Plan Act (ARPA) gives states new funding to invest in home- and community-based services. And, we want your ideas!



Do Not Send Paper Claims

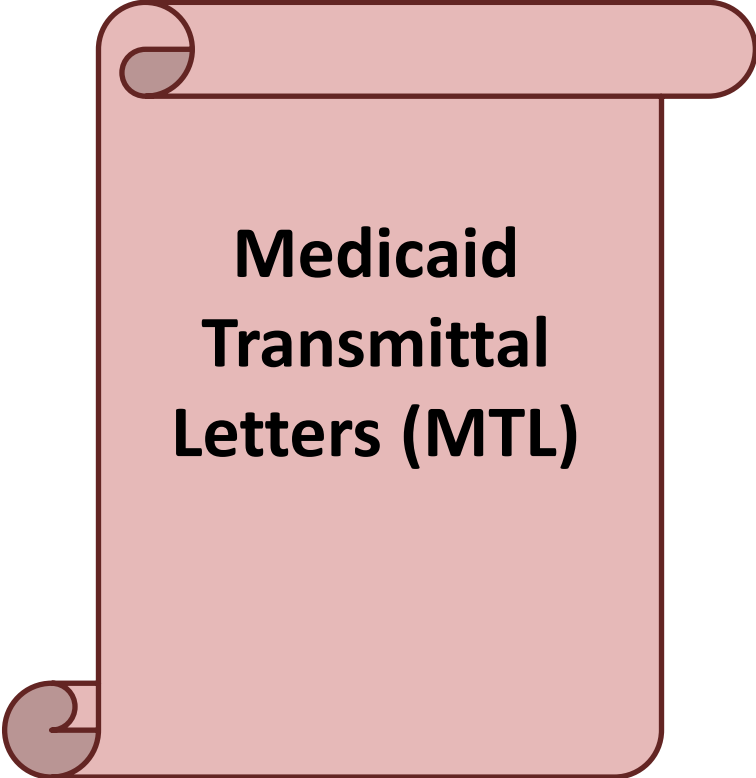
Do not send hard copy/paper claims.



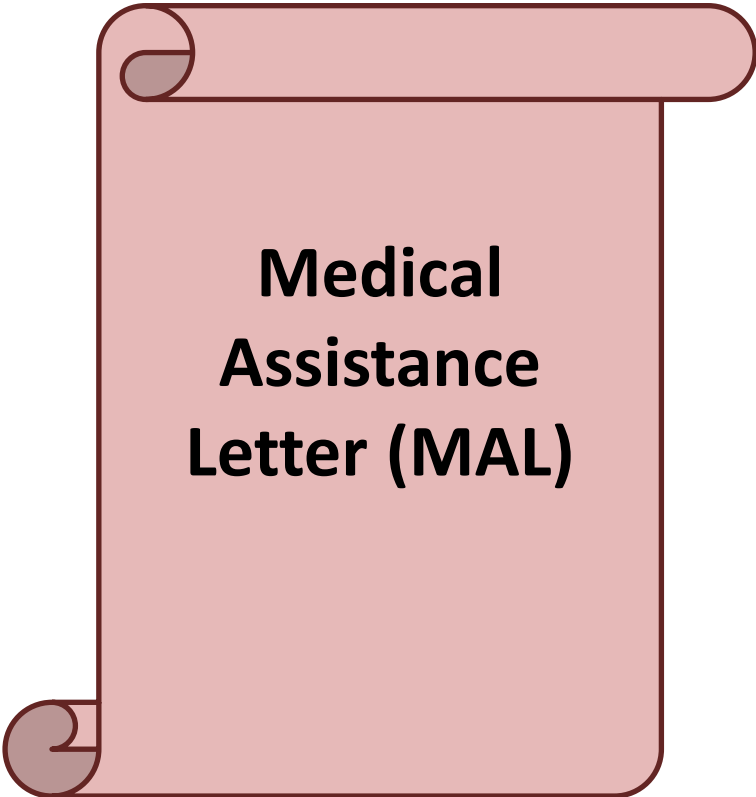
HELP

Policy

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



**Medicaid
Transmittal
Letters (MTL)**



**Medical
Assistance
Letter (MAL)**

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 >

Provider billing and data exchange related instructions, policies, and resources.

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Ohio Department of Medicaid COVID-19 Resources and Guides for Providers

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Medicaid Information Technology Information System (MITS) Resources

> Policies & Guidelines

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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

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.

Reports & Research >

Ohio Medicaid values transparency and accountability in all we do. We are committed to providing our stakeholders and partners with

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

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

Ohio Revised Code | Browse

Ohio Administrative Code | Browse

How to Find Modifiers Recognized by ODM

FAMILIES & INDIVIDUALS
RESOURCES FOR PROVIDERS
STAKEHOLDERS & PARTNERS
OUR STRUCTURE ABOUT US

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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- [Web Portal Billing Guide for Dental Claims](#)
- [EDI Companion Guide for Dental Claims](#)

MODIFIERS:

- [Modifiers recognized by ODM](#)

DURABLE MEDICAL EQUIPMENT CLAIMS:

- [Codes/Rates/Fee Schedules FAQs](#)
- [How to read the RA \(Remittance Advice\)](#)

Common Questions

- How long do I have to submit a claim?
- As a Provider, am I allowed to bill the patient for missed appointments?

- When is the Recipient liable?
- What is National Provider Identifier (NPI)?

HELP

57

Modifiers Recognized by ODM

Release: 11/28/2011

Revision: 06/01/2019

Modifiers Recognized by Ohio Medicaid

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

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

Services Provided by a Pharmacist: OAC 5160-8-52

- Public hearing is scheduled for 11/30/2020
- Services may be rendered through standing order or protocol described in Chapter 4729 of the Ohio Administrative Code (OAC)
- Payment may be made for covered telehealth services in accordance with OAC 5160-1-18

Services Provided by a Pharmacist: OAC 5160-8-52

- Payment may be made for a pharmacist service that meets the following criteria:
 - The service is within the pharmacist's scope of practice
 - The service is medically necessary in accordance with OAC 5160-1-01
 - The pharmacist obtains an order issued by a practitioner having appropriate prescriptive authority and maintains documentation

Services Provided by a Pharmacist: OAC 5160-8-52

- The service is rendered for one of the following purposes:
 - Managing medication therapy under a consulting agreement with a prescribing practitioner pursuant to ORC section 4729.39
 - Administering immunizations in accordance with ORC section 4729.41
 - Administering medications in accordance with ORC section 4729.45

Services Provided by a Pharmacist: OAC 5160-8-52

- Payment may be made for service rendered at a FQHC or rural health center (RHC) in accordance with OAC 5160-28
- For covered immunization, injection of medication, or provider-administered pharmaceutical payment is made in accordance with OAC 5160-4-12
- For all other covered pharmacist services payment is the lesser of the submitted charge or eighty-five percent of the amount specified in appendix DD to OAC 5160-1-60
- No separate payment will be made for pharmacist services provided in an inpatient or outpatient hospital, emergency department, or inpatient psychiatric facility

Services Provided by a Pharmacist: OAC 5160-8-52

- Provider-Administered Pharmaceuticals
 - Lists the current coverage and fees for vaccines, injectable medications, and other drugs administered by practitioners, that may be performed by a pharmacist

<https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates>

Vision & Goals for Telehealth

A regulatory framework that expands **clinically appropriate** telehealth services while maintaining the **fiscal sustainability** and **integrity** of Ohio's Medicaid program

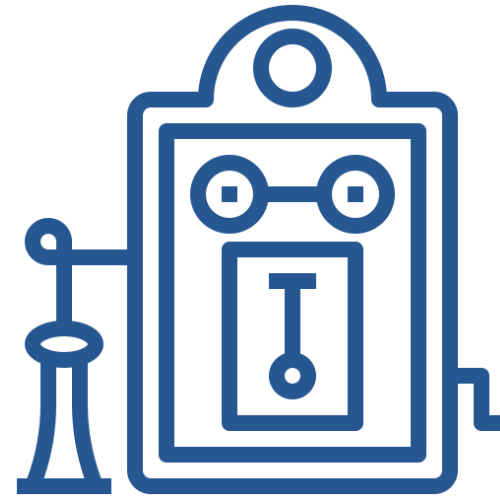
GOALS

- 1 *Maintain quality of care*
- 2 *Enhanced access for patients*
- 3 *Improved health outcomes*
- 4 *Flexibility for providers and patients*



History of Ohio Medicaid's Telehealth Policy

- November 2014: First Telehealth policy implemented
 - » Hub and spoke model
 - » Narrow list of eligible practitioners and services
 - Limited to psychiatric services, evaluation and management
 - » Patient must present to an eligible originating site
 - » Patient and practitioner location must be >5 miles apart
- July 2019: Adoption of expanded policy
 - » Added more eligible practitioners and services
 - » Home and school become valid patient site locations
 - » No restrictions on practitioner site location
- March 2020: Emergency rules implemented
 - » Emergency rules (effective for 120 days) adopted through Governor's executive order
 - » Followed up with formal rule filing process to extend the policy beyond 120 days



COVID-19 Response



Expanded telehealth services and eligible medical and behavioral health practitioners



Eased technology restrictions on patient-practitioner interaction to deliver telehealth services



Issued telehealth billing guidelines and other resources to assist providers



Pharmacists included as eligible telehealth providers as of 1/17/2021



Nursing facility care, hospice and home health services included as eligible telehealth services

Emergency Provisions

Ohio Administrative Code (OAC) Rule	Effective date	Expiration Date	Description
5160-1-21 <i>Telehealth During a State of Emergency</i>	3/20/2020	7/19/2020	Expanded eligible practitioner types and services, modified definition of telehealth, removed certain restrictions
5160-1-21.1 <i>Telehealth During a State of Emergency, expanded</i>	6/12/2020	10/11/2020	Includes additional procedure codes and practitioners that were added after 5160-1-21 took effect.
5160-1-18 <i>Telehealth</i> (emergency rule)	7/16/2020	11/14/2020	Includes all provisions from the two above emergency rules
5160-1-18 <i>Telehealth</i>	11/15/2020	TBD	“Permanent” rule to ensure expanded provisions apply beyond expiration after 120 days

Current Telehealth Policy

Ohio Administrative
Code Rule [5160-1-18](#)
(effective 11/15/2020)



- » Patients can access telehealth in most places: home, school, temporary housing, etc.
- » Wide array of eligible services and practitioner types
- » Communication can be synchronous or asynchronous
 - Real-time interaction with audio/video
 - Telephone or audio only
 - Secure patient portal communication
- » Telehealth services are paid at the same rate as if provided in-person

Telehealth Definition in Response to COVID-19

- "Telehealth" is the direct delivery of health care services to a patient related to diagnosis, treatment, and management of a condition.
 - » Definition prior to COVID: Telehealth is the interaction with a patient via synchronous, interactive, real-time electronic communication comprising both audio and video elements; or
 - » Added in response to COVID: The following activities that are asynchronous or do not have both audio and video elements:
 - (i) Telephone calls;
 - (ii) Remote patient monitoring; and
 - (iii) Communication with a patient through secure electronic mail or a secure patient portal.

Eligible Provider Types

Prior to COVID-19

- Physician, Psychiatrist
- Podiatrist
- Psychologist
- Physician Assistant
- Advanced Practice Registered Nurse
 - Clinical Nurse Specialist
 - Certified Nurse Midwife
 - Certified Nurse Practitioner
- Licensed Independent behavioral health practitioners:
 - Social worker
 - Chemical dependency counselor
 - Marriage and family therapist
 - Clinical Counselor

Added in response to COVID-19

- Ophthalmologist, Optometrist
- Audiologist, Audiology aide
- Occupational Therapist, OT Assistant
- Physical Therapist, PT Assistant
- Speech-Language Pathologist, SLP aides, conditional licensees
- Medicaid School Program practitioners
- Dietitians
- Dentist
- Private duty nurse
- Home health and hospice agencies
- Pharmacist
- Residents and interns as defined in [OAC 5160-4-05](#)
- Supervised or dependently licensed behavioral health practitioners and trainees defined in [OAC 5160-8-05](#)

Eligible Services

Prior to COVID-19

- Evaluation and management of new patients when provided by a Comprehensive Primary Care (CPC) program provider or BH agency
- Evaluation and management of established patients
- Inpatient or office consultation for new or established patients
- Psychiatric diagnostic evaluations and psychotherapy

Added in response to COVID-19

- Remote evaluation of recorded video or images
- Virtual check-ins
- Online digital evaluation and management services
- Remote patient monitoring
- Therapies: Audiology, speech-language, physical, and occupational
- Medical nutrition services
- Lactation counseling provided by dietitians
- Testing: Psychological, neuropsychological, developmental
- Smoking and tobacco use cessation counseling
- Limited oral evaluation
- Hospice services
- Private duty nursing services
- State plan home health services
- Eye exam, orthoptic/Pleoptic training
- Dialysis related services
- Specialized Recovery Services (SRS) program services

Stakeholder Feedback

*Since the signing of Executive Order 2020-05D, Ohio Medicaid has received **overwhelming support** for its rapid expansion of telehealth services from **both patients and providers.***

“The relaxation of rules regarding telehealth has undoubtedly led to significantly better care for our patients during these challenging times.



- Dr. Robert Stone, MD

Senior Medical Director of
Ambulatory Services
Central Ohio Primary Care Physicians



Early data shows telehealth use skyrocketed during initial months of the COVID-19 State of Emergency.

Physical Health Service Telehealth claims

1,000	→	200,000
average claims per month before March 2020		claims made in April 2020

Mental Health and Addiction Service telehealth claims


4,000	→	270,000
average claims per month before March 2020		claims made in April 2020

Telehealth Resources

- Administrative Code Rule 5160-1-18 filings, including appendix with covered procedure codes:
<http://www.registerofohio.state.oh.us/rules/search/details/314341>
- COVID-19 Emergency Telehealth Resources including billing guidelines and webinar slides: <https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/covid/odm-emergency-telehealth>
- All telehealth billing guidelines (2014-present):
<https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/billing/billing>

MITTS & Claim Submission

Billing Resources



 **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...

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 **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)

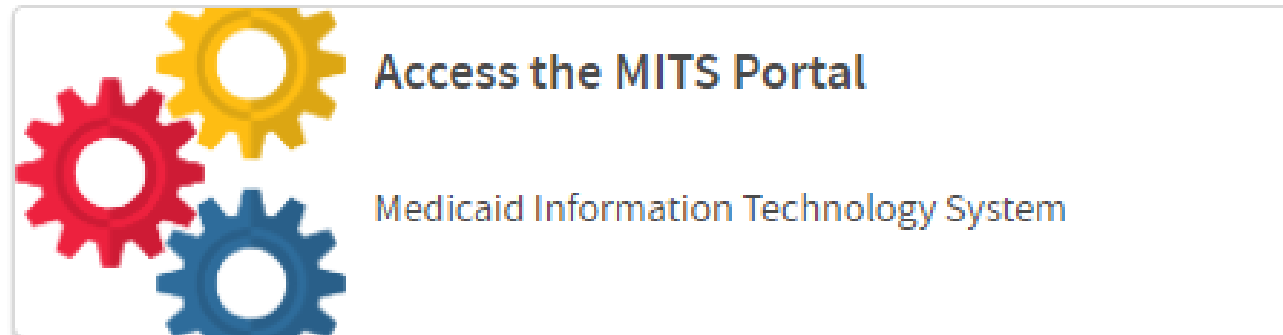
Internet Explorer version 10 or higher and current versions of Firefox or Chrome

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



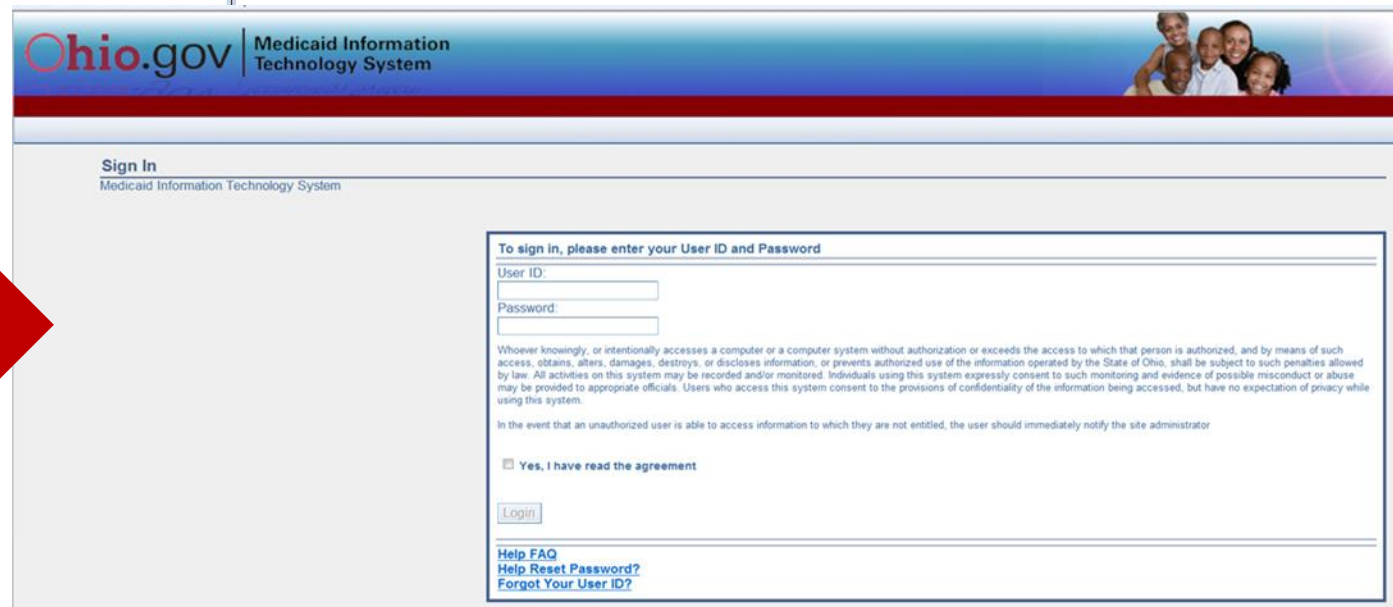


The screenshot shows the Ohio Department of Medicaid website. At the top left is the "Ohio Department of Medicaid" logo. To the right is a search bar with a "Search" button. Below the logo are navigation links: "About ODM", "Our Services", "Resources", and "News & Events". A secondary navigation bar includes "Home", "Consumers", "Providers" (highlighted in red), "Trading Partners", "Public Information", and "Publications". Below this are links for "enrollment", "enrollment tracking search", "long-term care", and "account setup". The date and time "Tuesday 06/16/2015 11:34:38 AM" are displayed. A "Provider Home" section contains text about the enrollment wizard. A "Login to secure site" box with a "Click Here to Login" link is highlighted with a red border.

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



The screenshot shows the login page for the Ohio.gov Medicaid Information Technology System. The header includes the "Ohio.gov" logo and "Medicaid Information Technology System". Below the header is a "Sign In" section with the text "Medicaid Information Technology System". A form titled "To sign in, please enter your User ID and Password" contains fields for "User ID:" and "Password:". Below the fields is a checkbox labeled "Yes, I have read the agreement". A "Login" button is at the bottom of the form. Links for "Help FAQ", "Help Reset Password?", and "Forgot Your User ID?" are at the bottom right. A disclaimer about unauthorized access is visible above the checkbox.

MITS Navigation

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

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

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

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

**Electronic
Data
Interchange
(EDI)**

**Fees for claims
submitted**

**Claims must be received
by Wednesday at Noon
for 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](mailto:OhioMCD-EDI-Support@dxc.com)

MITIS Web Portal Claim Submission

Claim entry format is divided into sections or panels

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

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

Submission of a Professional Claim

Ohio
Department of Medicaid

Welcome

Super User

Providers

Account

Trading Partners

Claims

Episode Claims

Eligibility

Prior Authorization

Reports

Portal Admin

Security

Trade Files

demographic maintenance

1099 information

ordering/referring/ prescribing search

cpc attestations

attestations

group

Search

Search Detail

Dental

Institutional

Professional

NPI

Taxonomies

Name

Provider ID

Medicare

Zip Code

report

correspondence

self attestation

hospital cost report

s

cpc group

cpc group members

cpc accreditations

You can view your Remittance Advices by clicking Reports on the menu bar.

Messages

*** No rows found ***

Claim Activity Summary

Number of Claims Paid in Current Month

Submission of a Professional Claim

Professional Claim: NPI -

BILLING INFORMATION

ICN

Claim Received Date

Claim Type M - PROFESSIONAL

Provider ID NPI

*Medicaid Billing Number

*Date of Birth

Last Name

First Name, MI

*Patient Account # 0

Medical Record #

Referring Provider #

Rendering ID

*Medicare Assignment NOT ASSIGNED

Patient Amount Paid \$0.00

*ICD Version 10

SERVICE INFORMATION

*Release of Information NOT ALLOWED TO RELEASE DATA

From Date

To Date

Signature Source

Accident Related To

Accident State

Accident Country [Search]

Accident Date

EPSDT Referral

Prior Authorization #

Hospital Discharge Date

Last Menstrual Period

TOTAL CHARGES

Total Charges \$0.00

Medicaid Allowed Amount \$0.00

TPL Paid Amount \$0.00

Total Medicaid Paid Amount \$0.00

Medicaid CoPay Amount \$0.00

Note Reference Code

Notes

Diagnosis

*** No rows found ***

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

delete

add an item

Header - Other Payer

*** No rows found ***

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

delete

add an item

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

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

Diagnosis		
Sequence ▼	Diagnosis Code	Description
A 02	E559	VITAMIN D DEFICIENCY, UNSPECIFIED
A 01	R5081	FEVER PRESENTING WITH CONDITIONS CLASSIFIED ELSEWHERE

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

*Sequence 02 ▼
 *Diagnosis Code

Detail Panel

Detail

Item ▾	FDOS	Units	Charges	Medicaid Allowed Amount	Status	Place of Service	Procedure Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Final EAPG
A	1	11/19/2021	2.00	\$500.00		11	J9019					

delete

add an item

copy

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

Item

1

*From DOS

11/19/2021

To DOS

11/19/2021

*Units

2.00

*Charges

\$500.00

Medicaid Allowed Amount

\$0.00

Rendering Provider

Submitted EAPG

Initial EAPG

Status

Visit Start Time

Visit End Time

Service Duration less than 90 days

☐

*Place Of Service

11

[Search]

*Procedure Code

J9019

[Search]

Emergency

Referred EPSDT Service/ Family Planning

*Diagnosis Code Pointer

01

Modifiers

[Search]

[Search]

[Search]

Final EAPG

Pay Action

NDC

Detail - Other Payer

ClaimsXten

Additional Provider Information

National Drug Code






Drug products are identified and reported using a unique, three-segment number which serves as a universal product identifier for drugs



Providers billing HCPCS codes in the **J** series and **Q** or **S** series, that represent drugs and CPT codes 90281 – 90399 series (immune globulins) must include the 11 digit NDC number

National Drug Code (NDC)

-  If the NDC number printed on a drug package consists of only 10 digits, add a leading zero to the appropriate segment
-  If the NDC number is missing or invalid, the claim line will deny
-  The FDA publishes the listed numbers

National Drug Code (NDC)

Submitted EAPG	<input type="text"/>	Final EAPG	
Initial EAPG		Pay Action	
Status			
Visit Start Time	<input type="text"/> <input type="text"/> <input type="text"/>		
Visit End Time	<input type="text"/> <input type="text"/> <input type="text"/>		
Service Duration less than 90 days	<input type="checkbox"/>		
NDC	Detail - Other Payer	ClaimCheck	Additional Provider Information



NDC							
Detail Item	NDC Sequence Number	NDC	Drug Name	Unit of Measure	Prescription Number	Drug Unit Price	Unit Quantity Submitted
A 1	1	64406080701	ELOCTATE	UN-Unit		\$1.71	1000.000

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

*Detail Item

*NDC [Search]

Drug Name

*Unit of Measure

Prescription Number

*Drug Unit Price

*Unit Quantity Submitted

Entering ORP Information

Rendering Provider

Submitted EAPG

Initial EAPG

Status

Visit Start Time

Visit End Time

Service Duration less than 90 days

Modifiers

Final EAPG

Pay Action

[Search]

[Search]

[Search]

[Search]

NDC

Detail - Other Payer

ClaimCheck

Additional Provider Information

Additional Provider Information

Detail Item	Type of Provider	Provider #	Last Name	First Name, MI
A 0				

Type data below for new record.

delete

add an item

*Detail Item

1

*Type of Provider

Ordering Provider

*Provider #

1268168168

*Last Name

SMITH

*First Name, MI

JOHN

D

Attachments


*** No rows found ***

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

delete

add an item

Third Party Liability (TPL) Claims



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



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



MITS will automatically calculate the allowed amount

Third Party Liability (TPL) Claims

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

Header - Other Payer

Last Name	First Name	MI	Date of Birth	Relationship	Gender	Policy ID	Paid Amount	Paid Date	Electronic Payer ID	
A	SMITH	JOHN	A	01/01/1950	FATHER	MALE	987654	\$200.00	08/07/2021	01234

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

delete

add an item

*Claim Filing Indicator

COMMERCIAL INSURANCE

▼

*Policy Holder Relationship to Insured

FATHER

▼

*Policy Holder Last Name

SMITH

*Policy Holder First Name, MI

JOHN

A

Policy Holder Date of Birth

01/01/1950

Gender

MALE

▼

*Paid Amount

\$200.00

*Paid Date

08/07/2021

Allowed Amount

\$0.00

*Insurance Carrier Name

BLUE CROSS BLUE SHIELD

*Electronic Payer ID

01234

Insured's Policy ID

987654

*Payer Sequence

PRIMARY

▼

Medicare ICN

Header - Other Payer Amounts and Adjustment Reason Codes

Third Party Liability (TPL) Claims

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

Header - Other Payer

Last Name	First Name	MI	Date of Birth	Relationship	Gender	Policy ID	Paid Amount	Paid Date	Electronic Payer ID	
A	SMITH	JOHN	A	01/01/1950	FATHER	MALE	987654	\$200.00	08/07/2021	01234

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

delete

add an item

*Claim Filing Indicator

HMO, MEDICARE RISK

▼

*Policy Holder Relationship to Insured

FATHER

▼

*Policy Holder Last Name

SMITH

*Policy Holder First Name, MI

JOHN

A

Policy Holder Date of Birth

01/01/1950

Gender

MALE

▼

*Paid Amount

\$200.00

*Paid Date

08/07/2021

Allowed Amount

\$0.00

*Insurance Carrier Name

HUMANA MEDICARE

*Electronic Payer ID

01234

Insured's Policy ID

987654

*Payer Sequence

PRIMARY

▼

Medicare ICN

Header - Other Payer Amounts and Adjustment Reason Codes

Adjustment Reason Codes (ARCs)

The X12 website provides adjustment reason codes (ARCs)

**COMMON
ARCs:**



1	• Deductible
2	• Coinsurance
3	• Co-payment
45	• Contractual Obligation/Write off
96	• Non-covered services

Header vs. Detail

Header level

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

Detail level

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

Third Party Liability (TPL) Claims

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

Header - Other Payer Amounts and Adjustment Reason Codes			
Electronic Payer ID	CAS Group Code	ARC	Amount
A 01234	PR-Patient Responsibility	1	\$50.00
A 01234	CO-Contractual Obligations	45	\$150.00

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

delete

add an item

Payer Header Level Adjustment Reason Codes (ARC) and Amounts

*Electronic Payer ID

01234

▼

*CAS Group Code

PR-Patient Responsibility

▼

*ARC

1

*Amount

\$50.00

Third Party Liability (TPL) Claims

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

Detail - Other Payer Amounts and Adjustment Reason Codes

Detail - Other Payer Amounts and Adjustment Reason Codes

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

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

delete

add an item

Payer Line Level Adjustment Reason Codes(ARC) and Amounts

*Detail Item/Electronic Payer ID

1/43210

*CAS Group Code

CO-Contractual Obligations

*ARC

45

*Amount

\$150.00



- Once all fields have been completed:
- Click the “submit” button at the bottom right
 - You may “cancel” the claim at anytime, but the information will not be saved in MITS



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

➤ Adjudication happens in “real time”

■ If there are no errors, the claim status will show:

- Paid
- Denied
- Suspended



Claim Portal Errors

Select row above to update -or- click add

delete

add an item

Supporting Data for Delayed Submission / Resubmission

DISCLAIMER: Documentation to justify the use of this panel and data ent

Previously Denied ICN or TCN

Reason

Claim Status Information

Claim Status

Not Submitted yet

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

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.					

Medicare Denials **

If Medicare issues a denial and indicates that the patient is responsible for the payment, submit the claim to ODM by following these steps:

- Enter a claim in MITS
- Do not enter any Medicare information on the claim
- Complete and upload a ODM 06653 and a copy of the Medicare EOB

****Pharmacists cannot currently enroll as Medicare providers and only need to submit their claims to Medicaid as primary. If Medicare allows them to enroll in the future, they will need to bill Medicare first****

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



Special Billing Instructions – Eligibility Delay

- If you are submitting a claim that is more than 365 days after the date of service due to a hearing decision or delay in the individual's eligibility determination
- The claim must be submitted within 180 days of the hearing decision or eligibility determination date

Special Billing Instructions – Eligibility Delay

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

Medicaid CoPay Amount

\$0.00

Note Reference Code

Special Billing Instructions – Eligibility Delay

- Hearing Decision: APPEALS^#####^CCYYMMDD
is the hearing number and CCYYMMDD is the date on the hearing decision
- Eligibility Determination: DECISION^CCYYMMDD
CCYYMMDD is the date on the eligibility determination notice from the CDJFS

Must use
the
spacing
shown

Notes

DECISION^20211225

Uploading an Attachment

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

Attachments	
Type of Document	Transmission Type
A	
Type data below for new record.	
<div>delete</div> <div>add</div>	
<p>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.</p> <p>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.</p>	
*Type of Document	<input type="text"/>
*Transmission Type	<input type="text"/>

Uploading an Attachment

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

Adjusting a Paid Claim



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

Adjusting a Paid Claim

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

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 weekend's adjudication cycle to submit a new, corrected claim if one is needed

Copying a Paid Claim

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



cancel

adjust

void

copy claim

ClaimsXten

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

The National Correct Coding Initiative (NCCI)

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



The National Correct Coding Initiative (NCCI)

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



Remittance Advice (RA)

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

Welcome,


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

Provider Reports ? ^

*Report

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

search clear



Remittance Advice (RA)

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

Websites & Forms

Websites

- Ohio Department of Medicaid home page
 - » <http://Medicaid.ohio.gov>
- Ohio Department of Medicaid provider page
 - » <https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers>
- MITS home page
 - » <https://portal.ohmits.com/Public/Providers/tabId/43/Default.aspx>
- Ohio Administrative Codes
 - » <http://codes.ohio.gov/oac/5160>
- X12 Website (ARC Codes)
 - » <http://www.x12.org/codes/claim-adjustment-reason-codes/>

Forms

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

Forms

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

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

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)	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)

Share this



Search:

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)