Ohio | Department of Medicaid

Basic Billing for Pharmacists

Provider Relations

2021

Medicaid Medical Necessity: OAC 5160-1-01

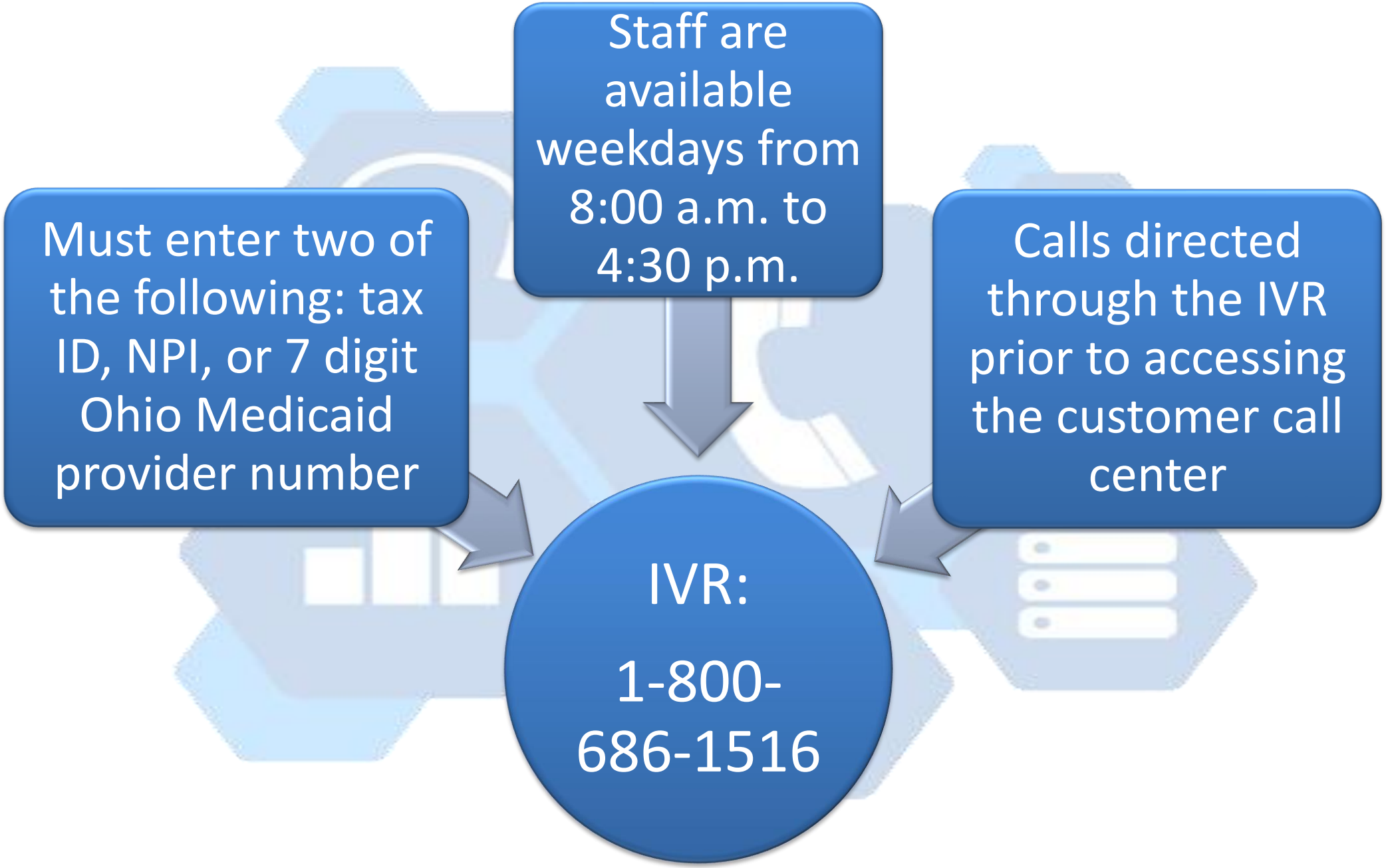
Is the fundamental concept underlying the Medicaid Program

All Services must meet accepted standards of medical practice

Helpful Phone Numbers

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

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

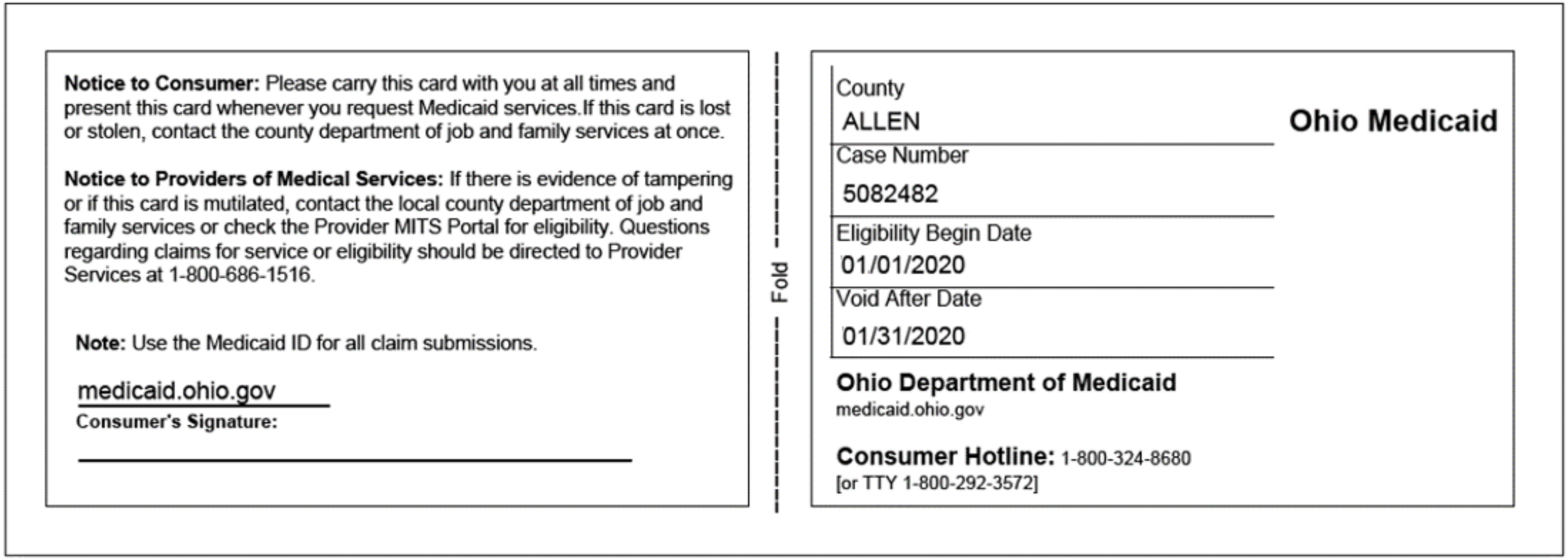

Staff are available weekdays from 8:00 a.m. to 4:30 p.m.
Must enter two of the following: tax ID, NPI, or 7 digit Ohio Medicaid provider number
Calls directed through the IVR prior to accessing the customer call center
IVR:
1-800-686-1516

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]

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

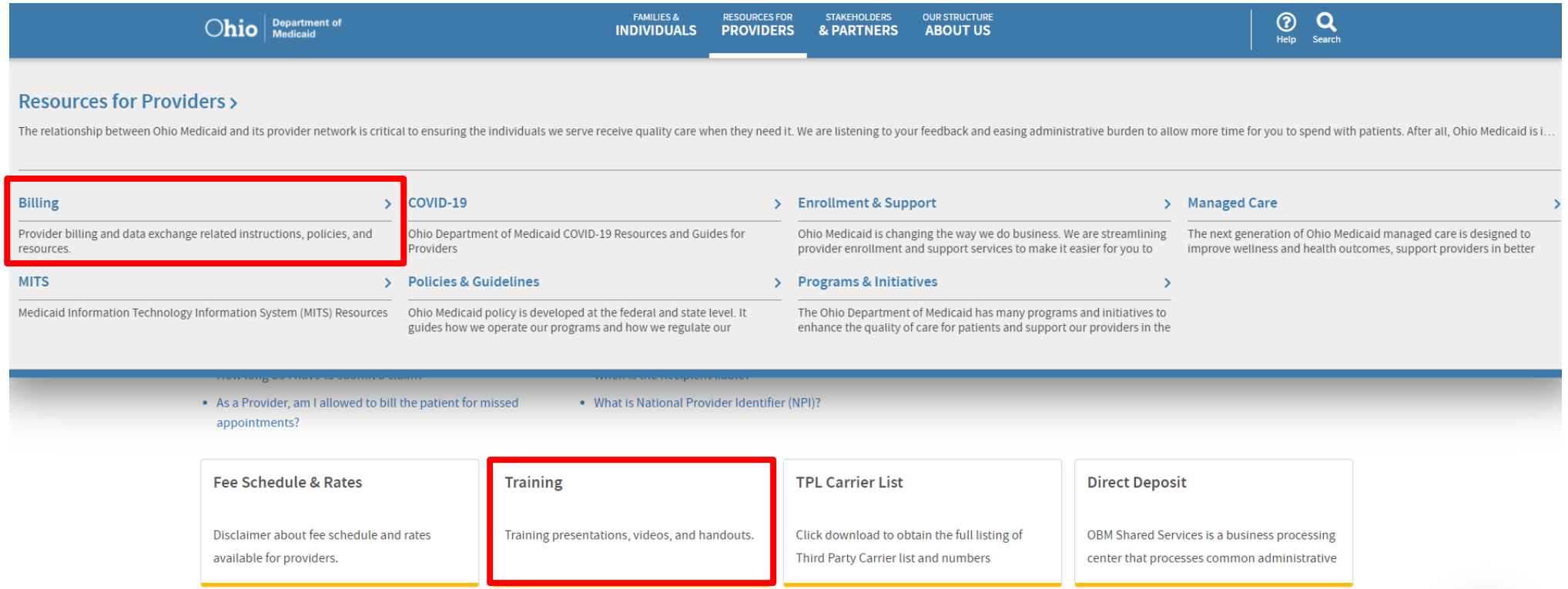
Full Medicaid eligibility on the MITS Portal will show **four** benefit spans:

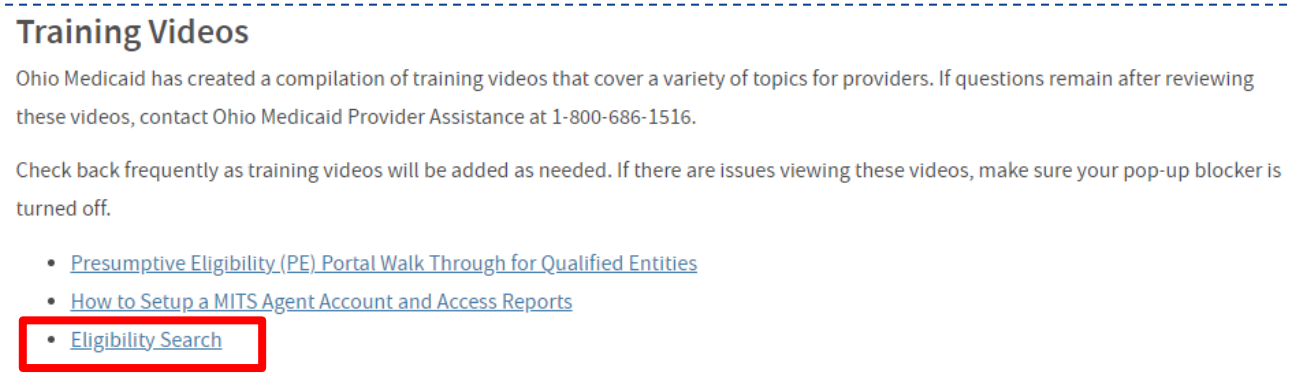
1. Alcohol and Drug Addiction Services
2. MRDD Targeted Case Management
3. Ohio Mental Health
4. Medicaid

Additional spans when applicable:

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

Eligibility Search





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 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	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 ***

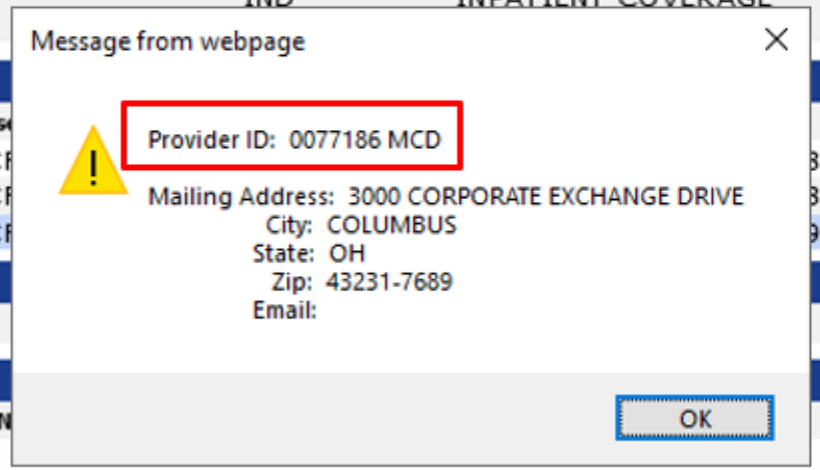
Enter a Procedure Code on the Eligibility Verification Request panel to search for Service Limitations.

Eligibility Verification Request

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 Desc	Managed Care Benefits
CARESOURCE	HMO, CF	
MOLINA HEALTHCARE OF OHIO INC	HMO, CF	
MOLINA HEALTHCARE OF OHIO INC	HMO, CF	

Lock-In

Medicare

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

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

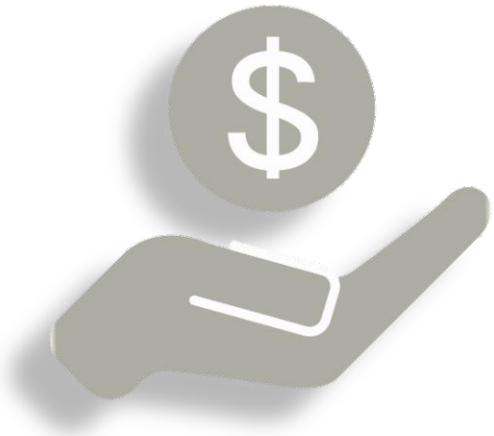
Medicaid Billing Number		SSN	
Last Name		County of Residence	
First Name		County of Eligibility	
Gender		County Office http://jfs.ohio.gov/county/cntydir.stm	
Date of Birth		Number Bed Hold Days Used Paid CY	
Date of Death			

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?

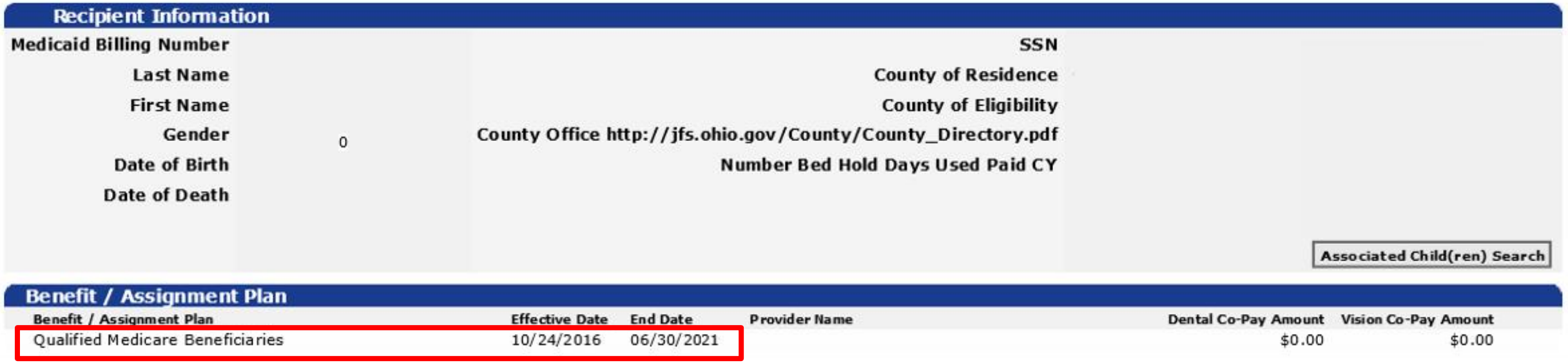
MLN Matters® Number: MM11230 Revised Release Date of Revised Article: July 3, 2019

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



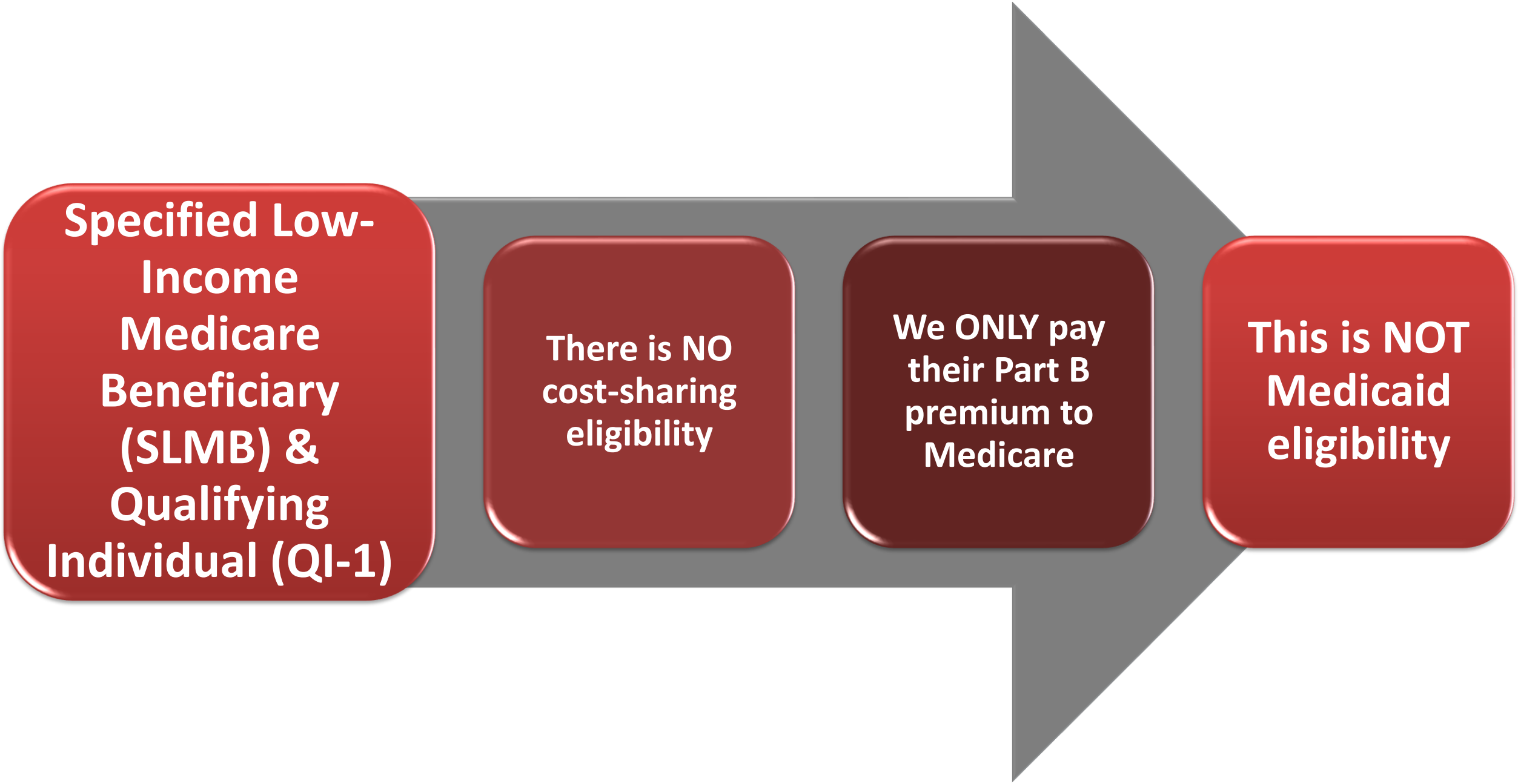
Recipient Information

Medicaid Billing Number		SSN	
Last Name		County of Residence	
First Name		County of Eligibility	
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 & 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

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 ***

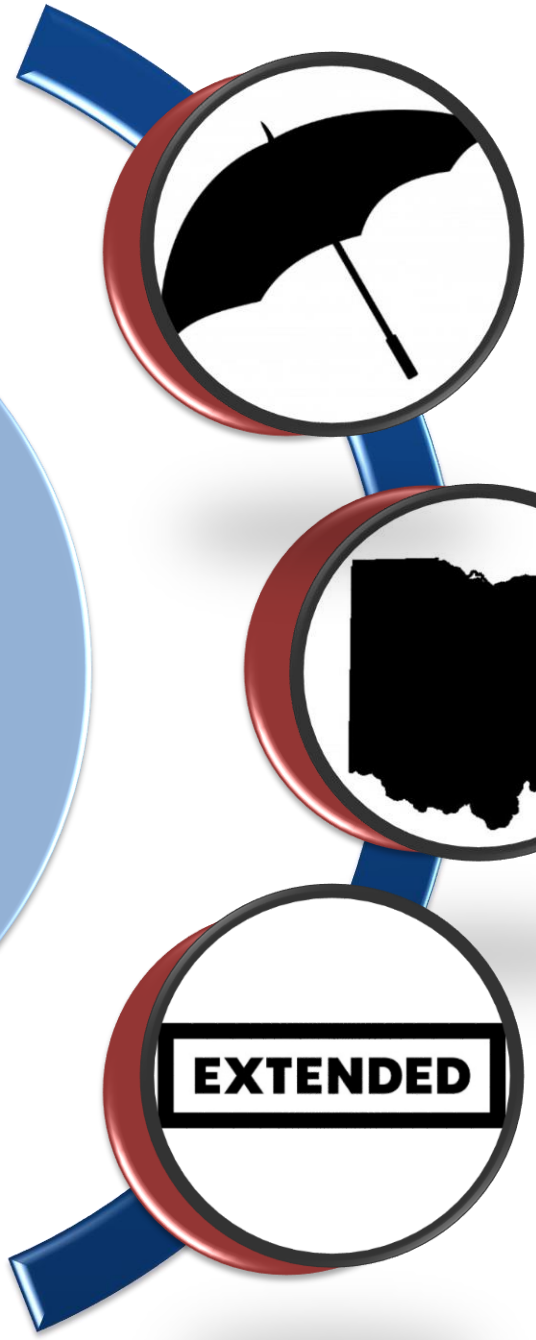
TPL

*** 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

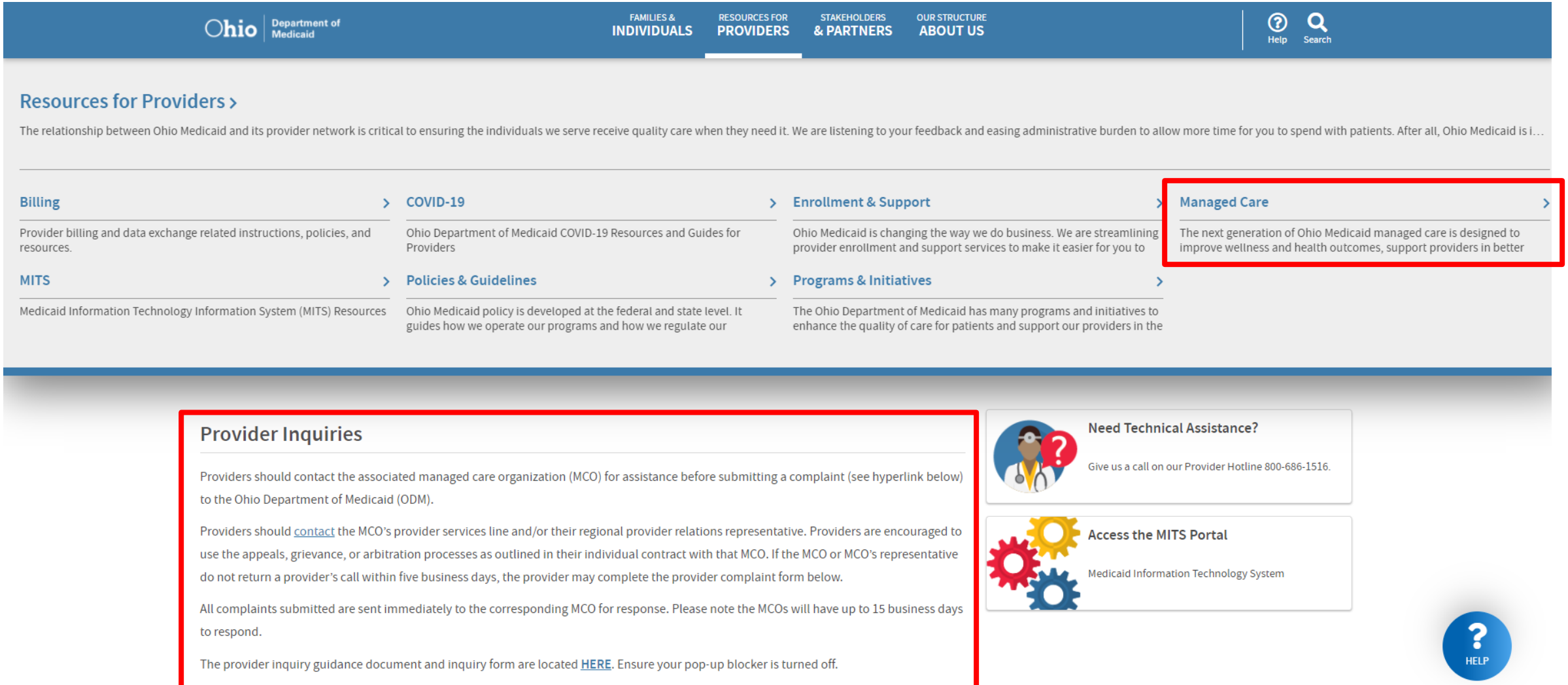
Work with the Area Agency on Aging (AAA) or ODM for MyCare Ohio waiver providers

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



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.

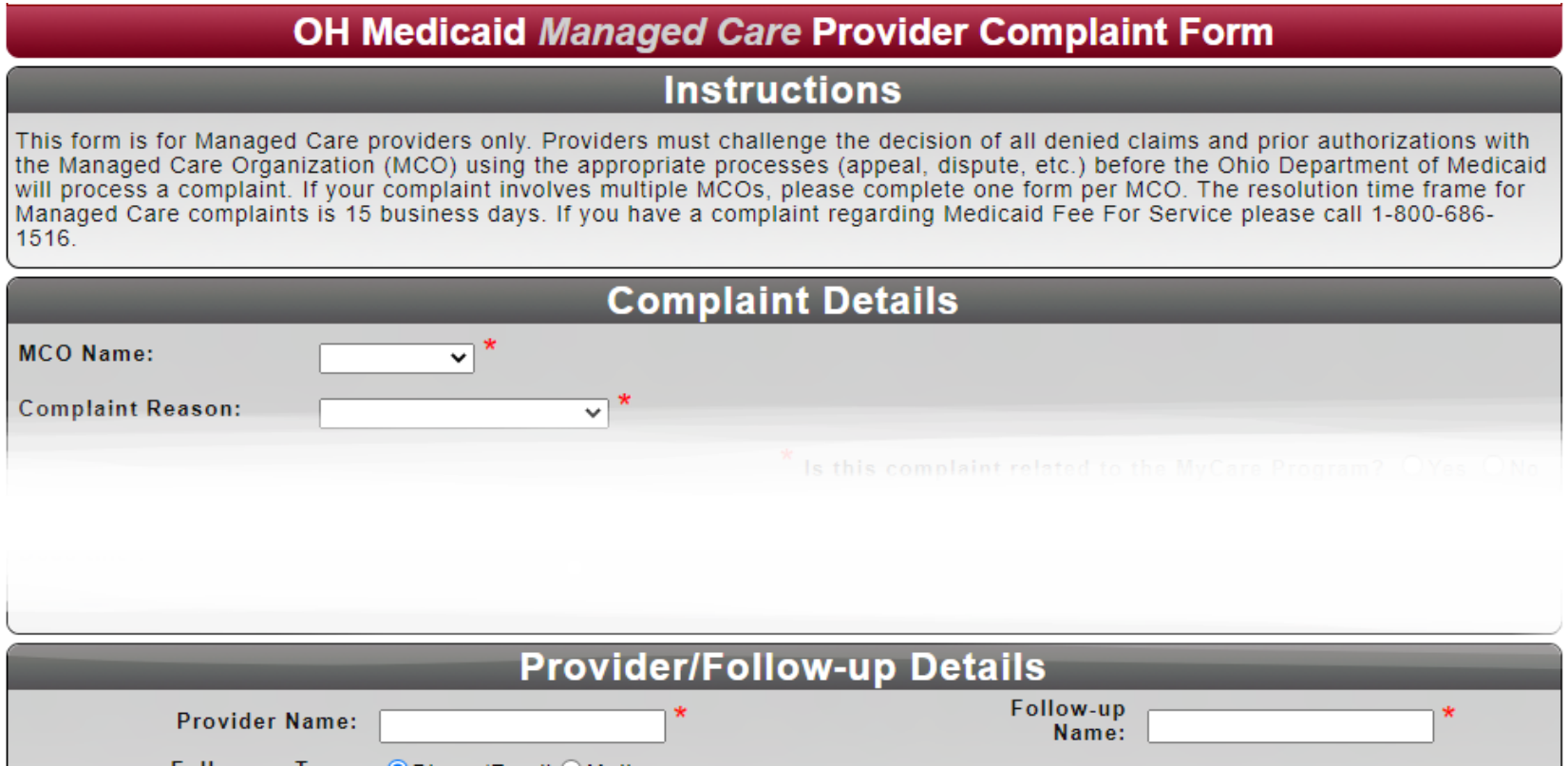
NEW If the provider submits multiple complaints for the same issue (different individuals, dates of service, practitioners, or files affected), ODM will cancel all duplicate complaints, contact the provider, and request that a single new complaint be submitted for all files affected.

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

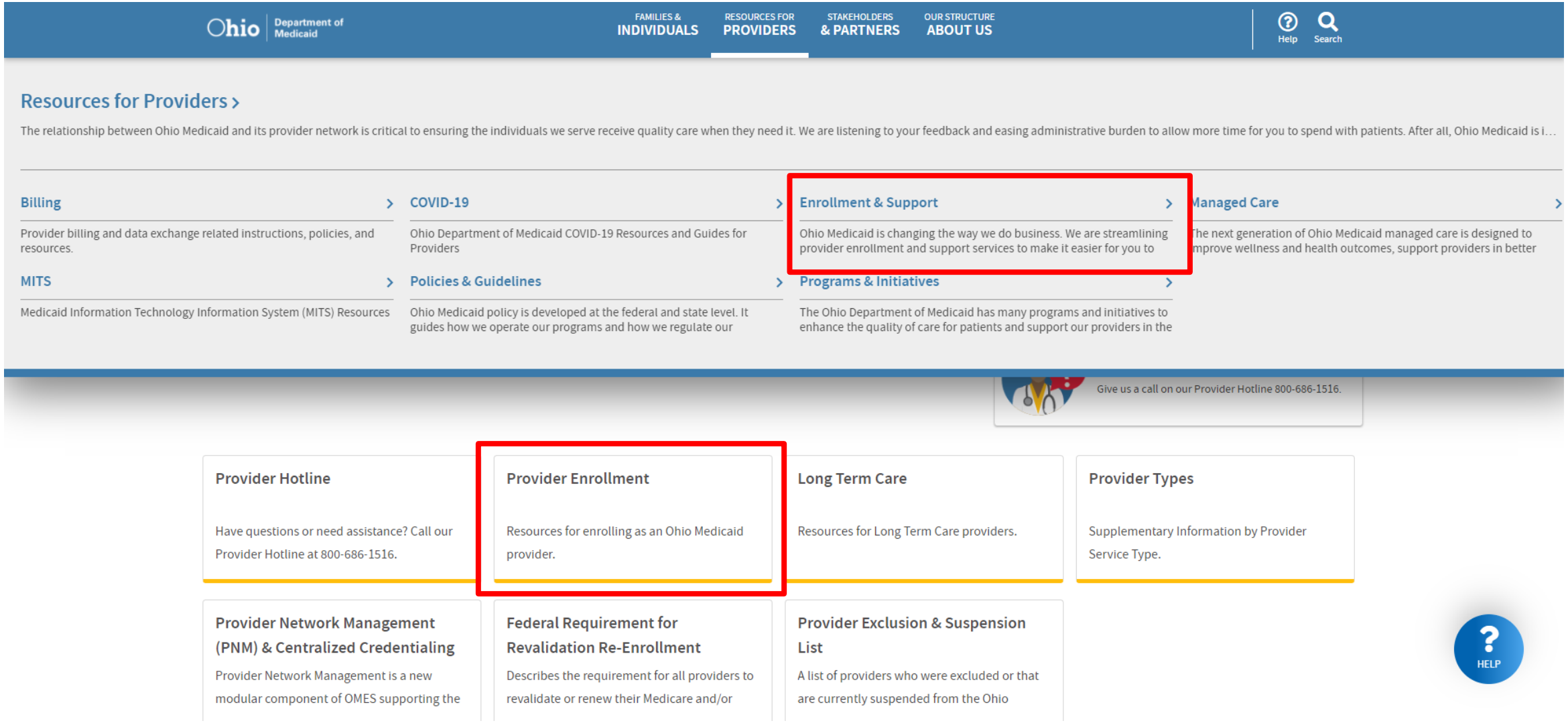
Provider/Follow-up Details

Provider Name: *

Follow-up Name: *

Provider Responsibilities

Provider Enrollment



Provider Enrollment and Revalidation

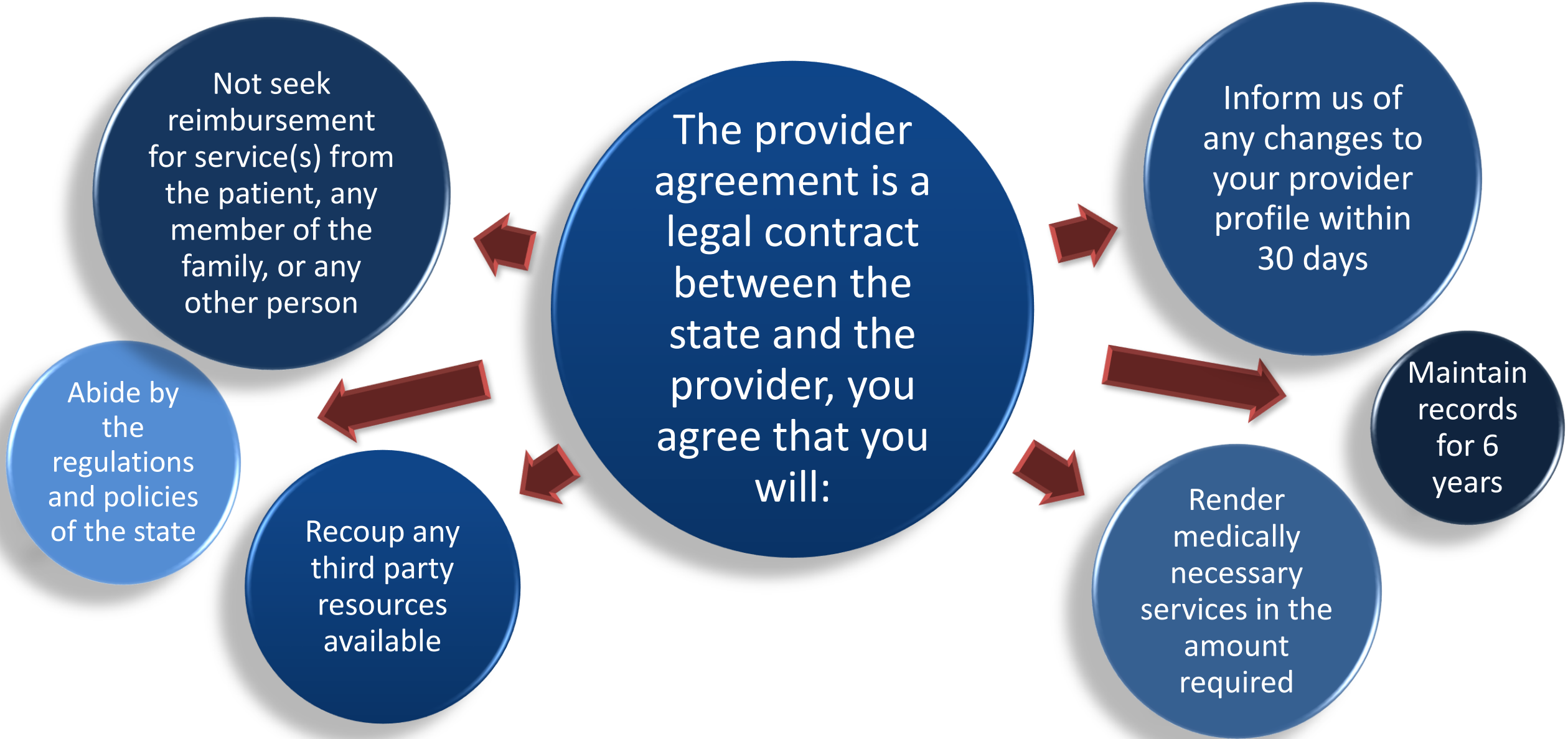
Providers are required to submit an application to become a Medicaid provider

There is also a federally required 5 year revalidation

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

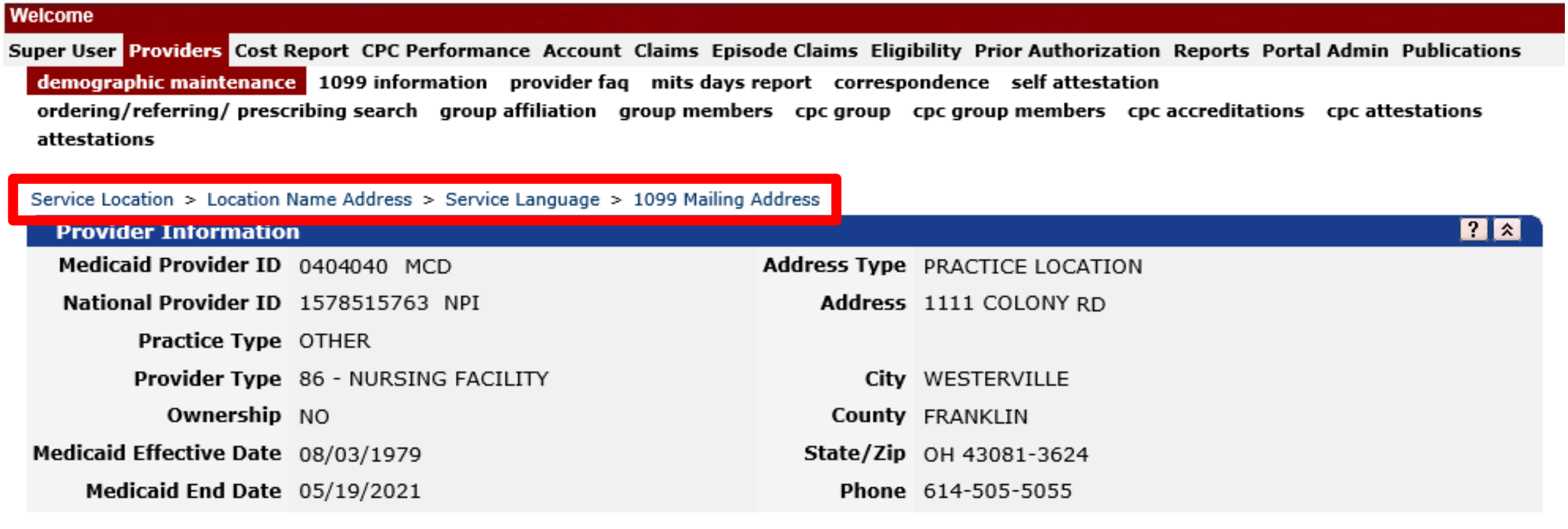
Online applications can be found on our website

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

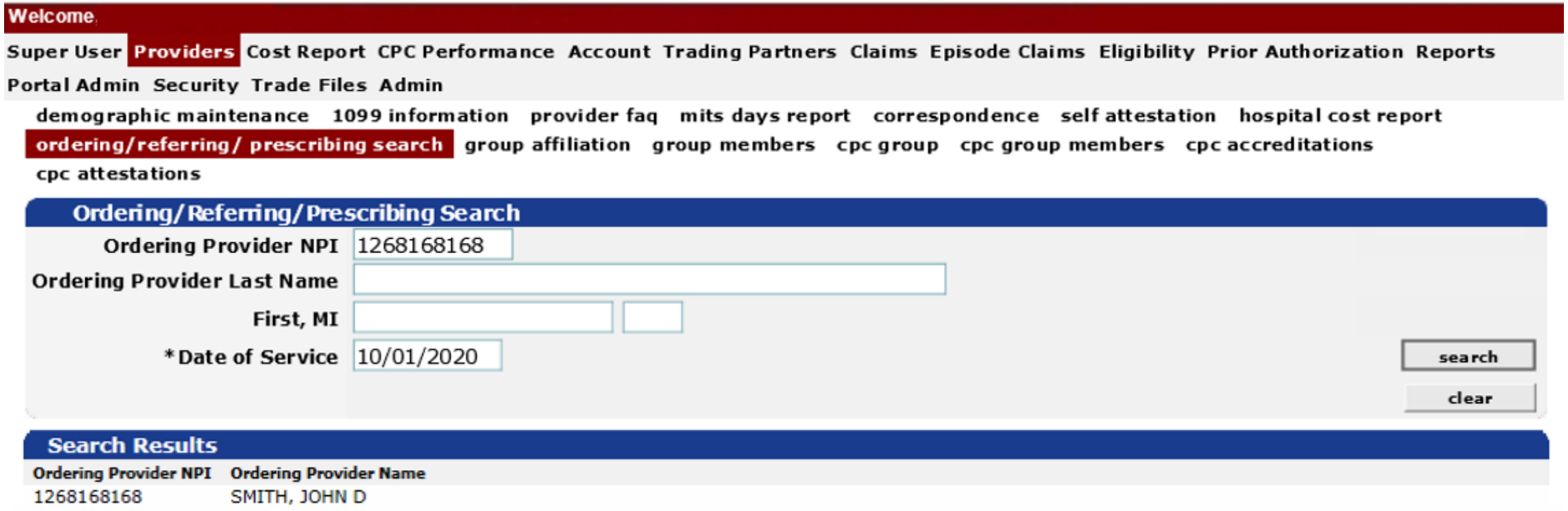


Ordering, Referring, Prescribing (ORP) Providers

- 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

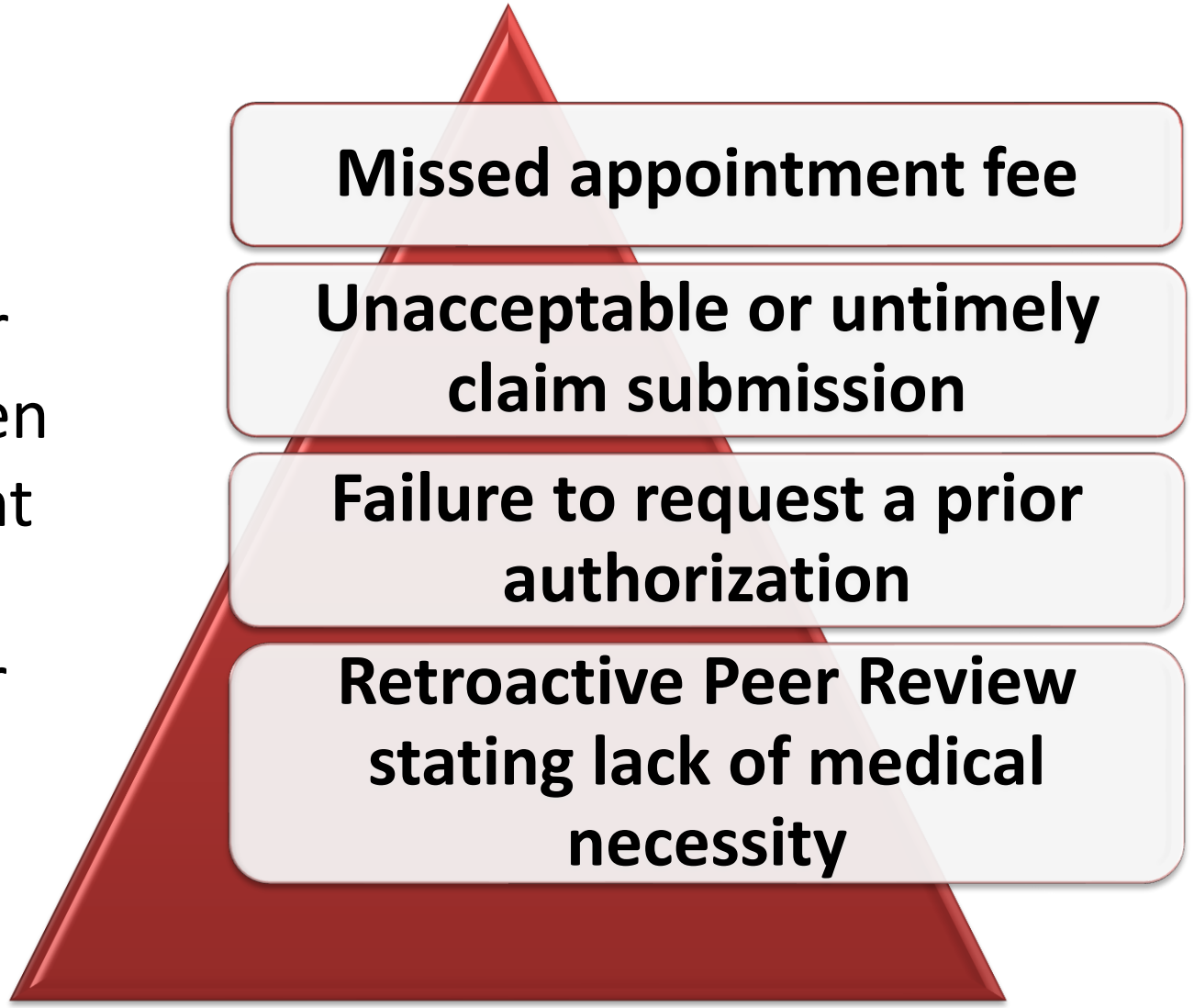
Ordering, Referring, Prescribing (ORP) Providers

- 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

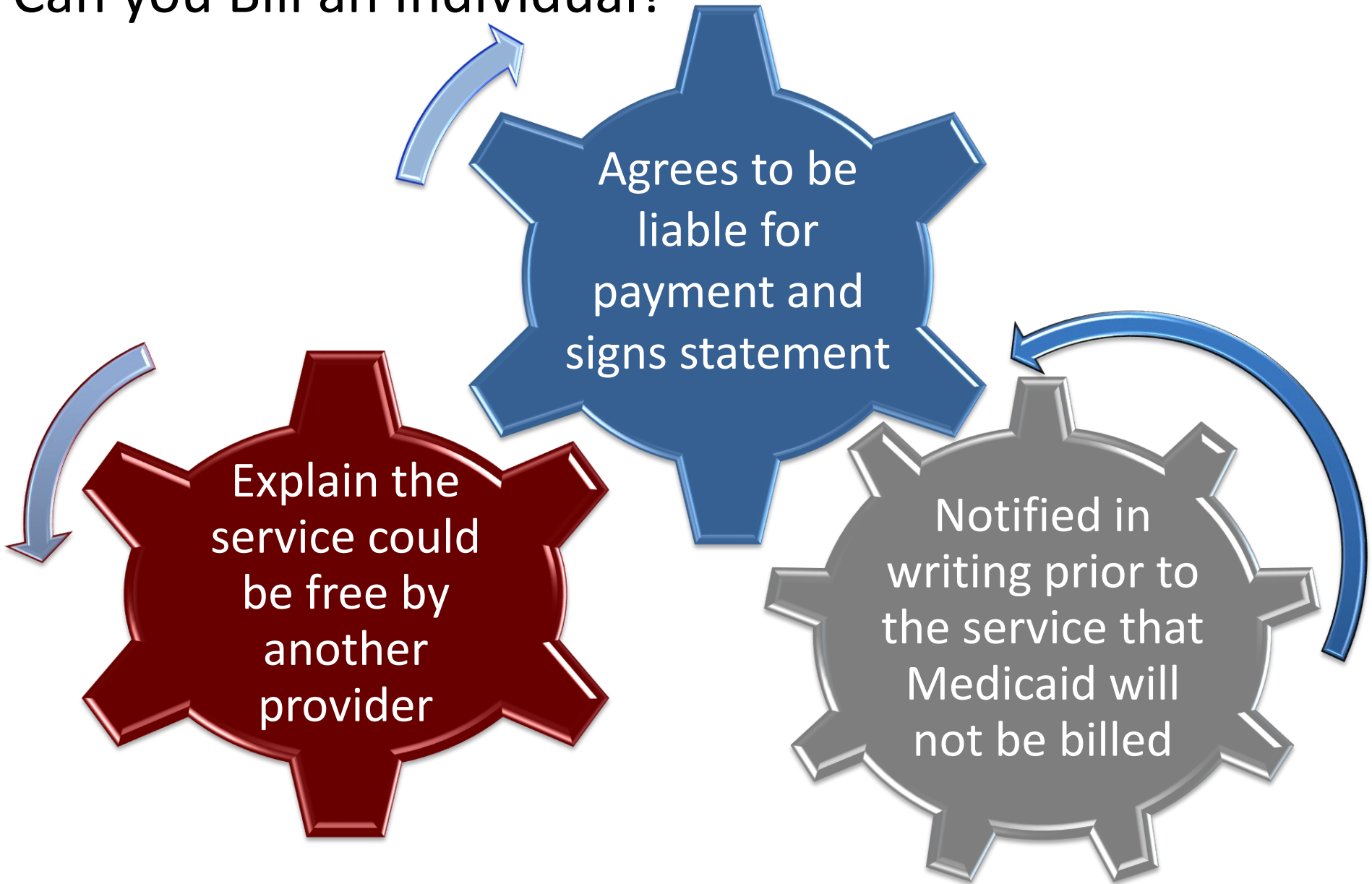


Medicaid Recipient Liability: OAC 5160-1-13.1

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:

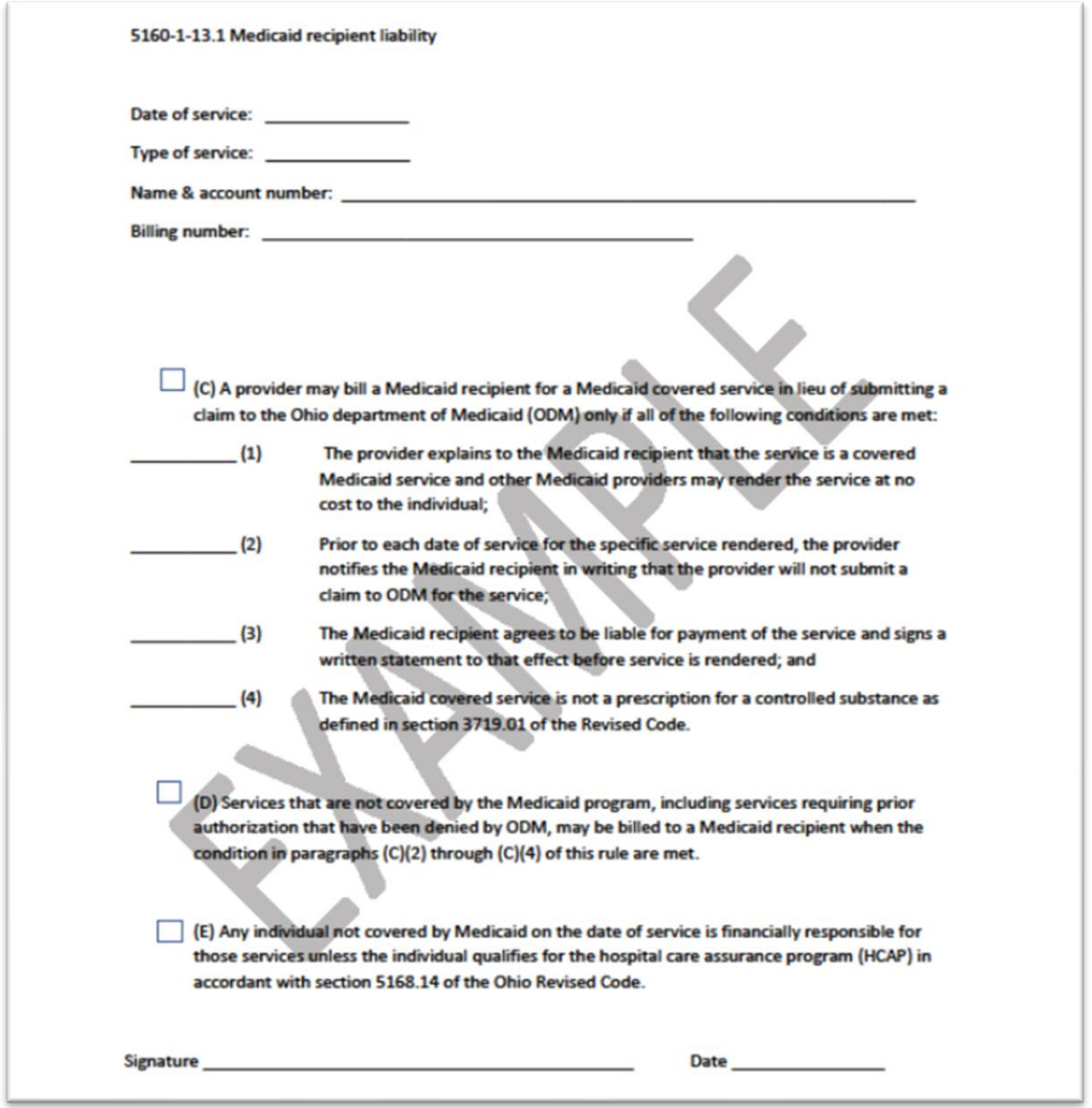


When Can you Bill an Individual?



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.

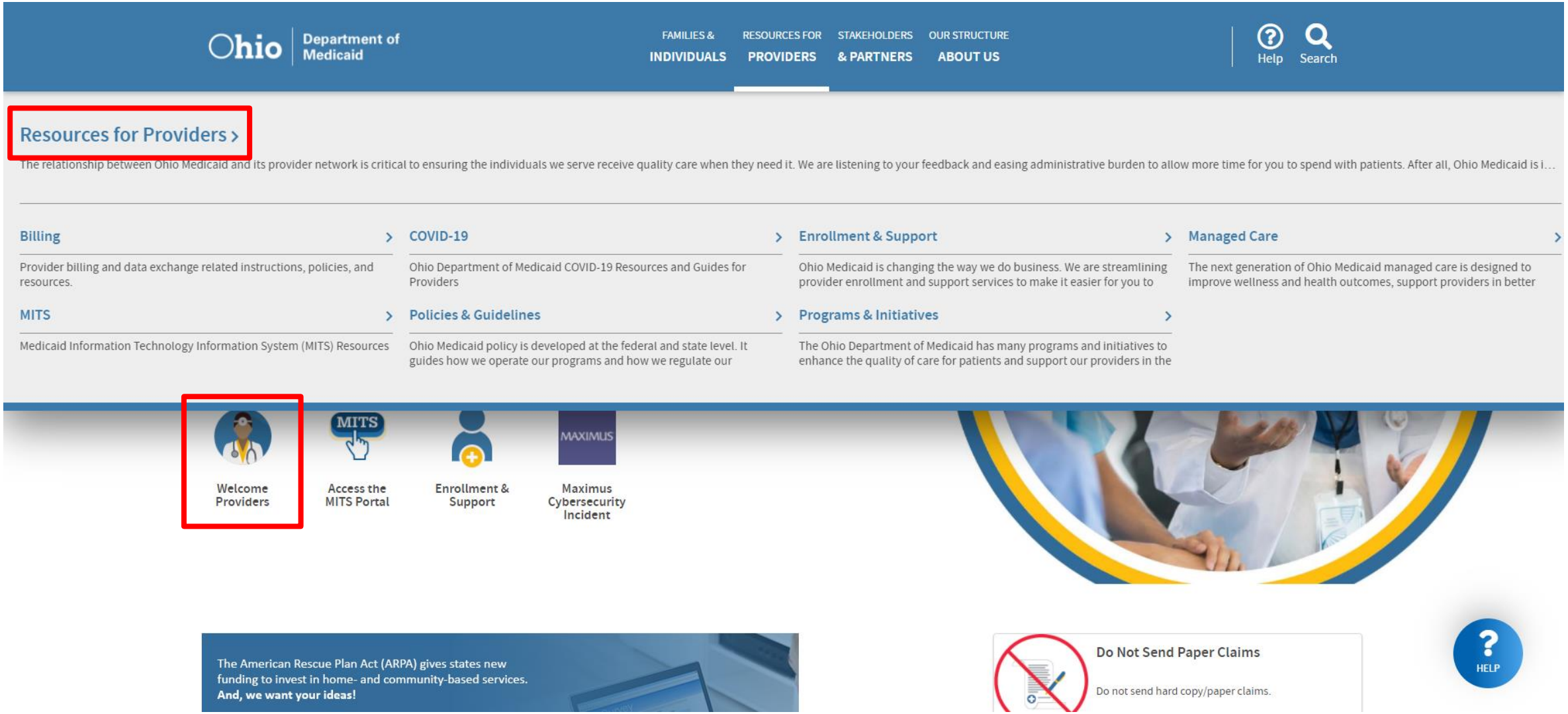
☐ (D) Services that are not covered by the Medicaid program, including services requiring prior authorization that have been denied by ODM, may be billed to a Medicaid recipient when the condition in paragraphs (C)(2) through (C)(4) of this rule are met.

☐ (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

Provider News and Responsibilities



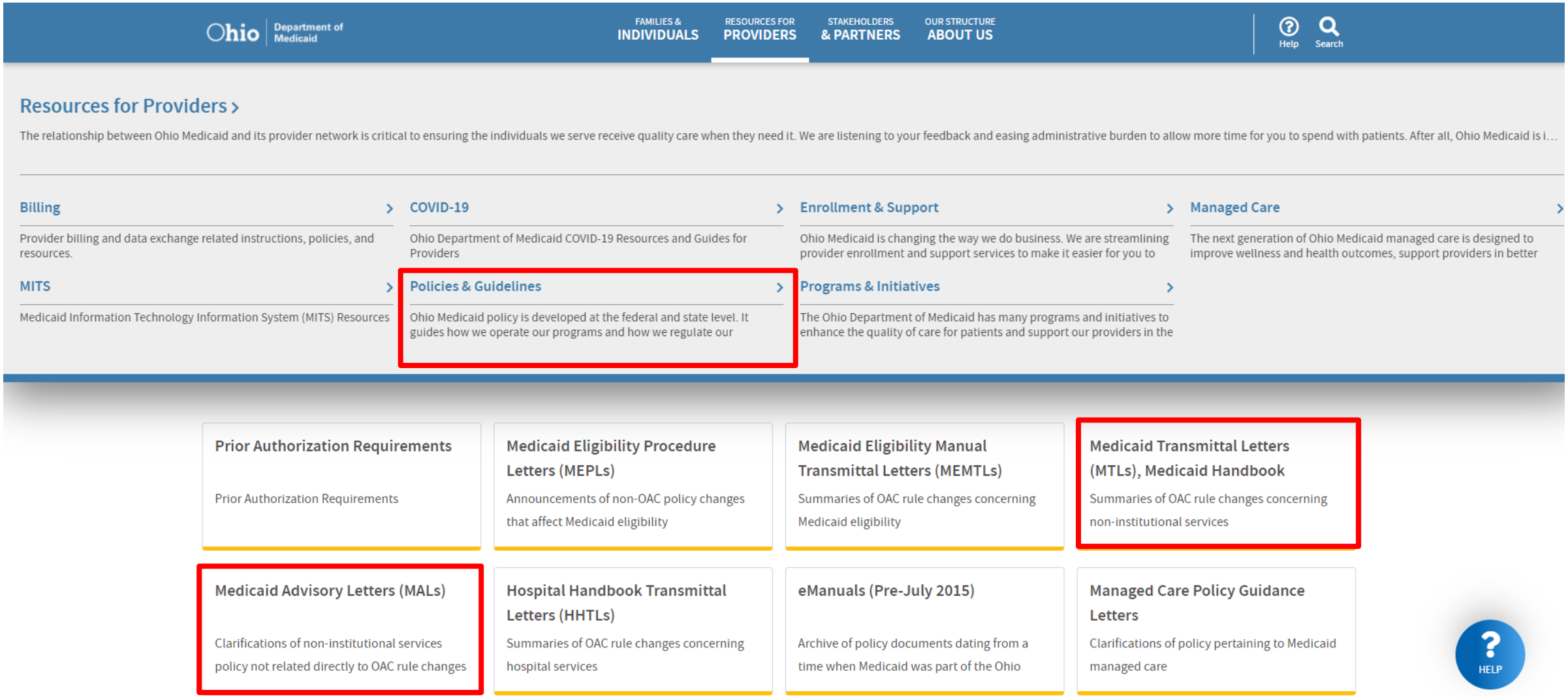
Policy

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:

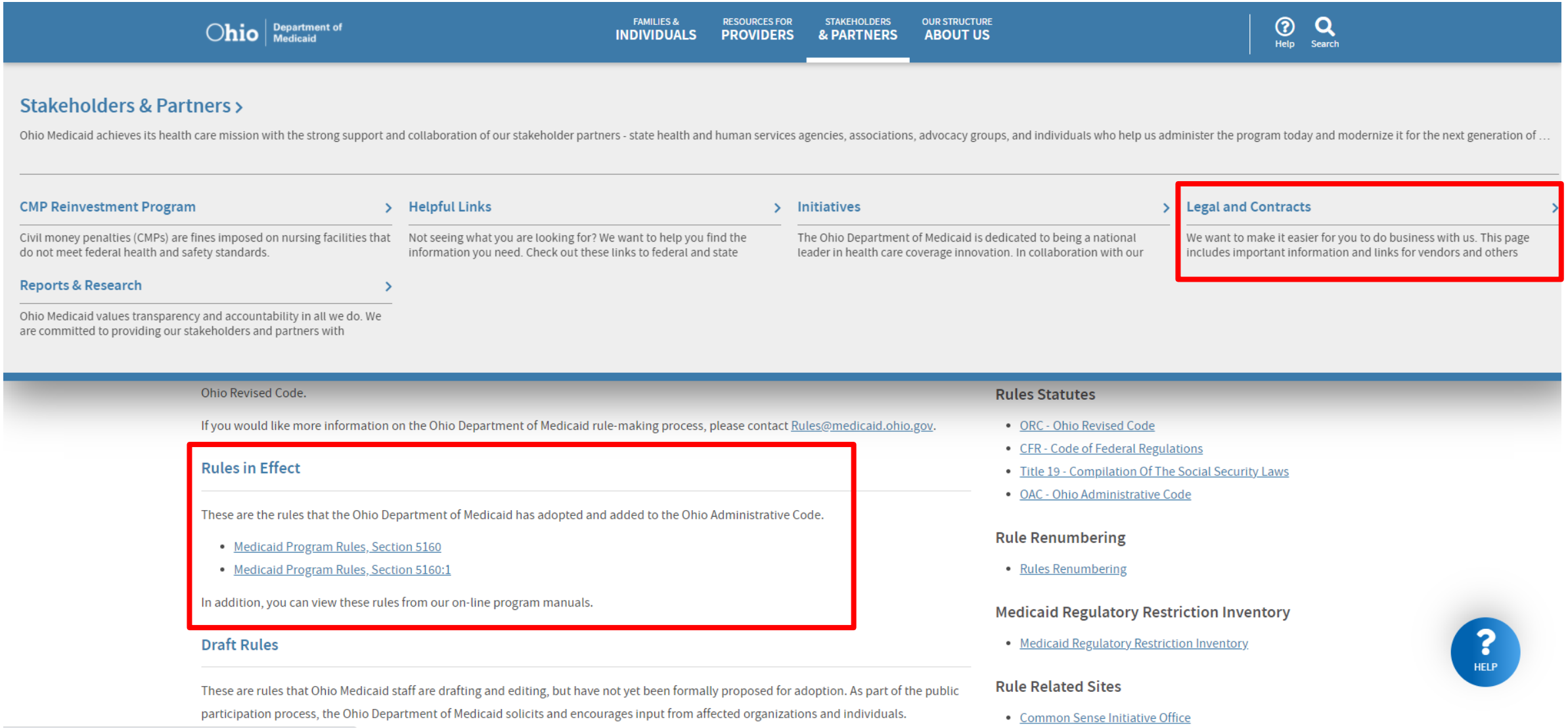
Medicaid Transmittal Letters (MTL)

Medical Assistance Letter (MAL)

Policy


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

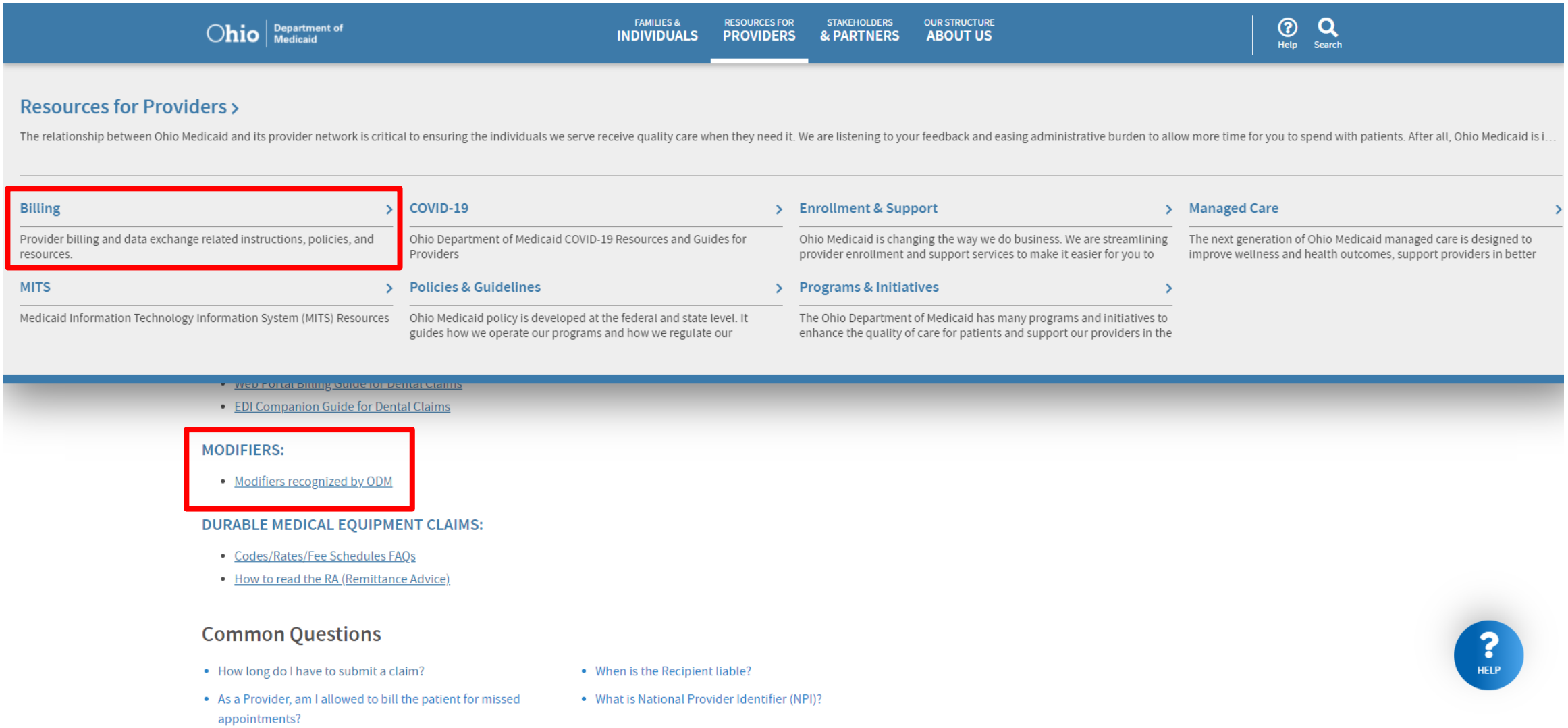
- Common Sense Initiative Office

HELP

Policy

https://codes.ohio.gov

How to Find Modifiers Recognized by ODM



Modifiers Recognized by ODM


Ohio | Department of Medicaid

Release: 11/28/2011

Revision: 06/01/2019

Modifiers Recognized by Ohio Medicaid

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

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

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

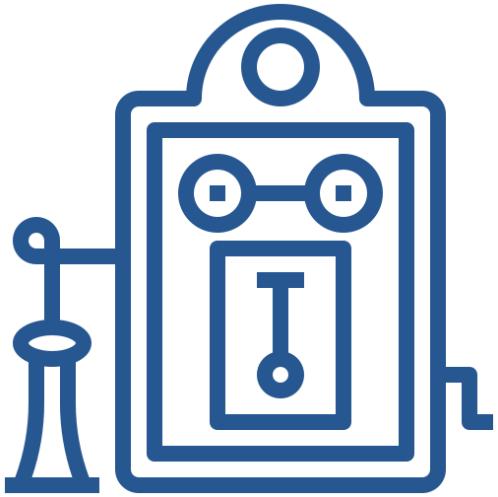
A regulatory framework that expands **clinically appropriate** telehealth services while maintaining the **fiscal sustainability** and **integrity** of Ohio's Medicaid program

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 *Telehealth During a State of Emergency*	3/20/2020	7/19/2020	Expanded eligible practitioner types and services, modified definition of telehealth, removed certain restrictions
5160-1-21.1 *Telehealth During a State of Emergency, expanded*	6/12/2020	10/11/2020	Includes additional procedure codes and practitioners that were added after 5160-1-21 took effect.
5160-1-18 *Telehealth* (emergency rule)	7/16/2020	11/14/2020	Includes all provisions from the two above emergency rules
5160-1-18 *Telehealth*	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****.*

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

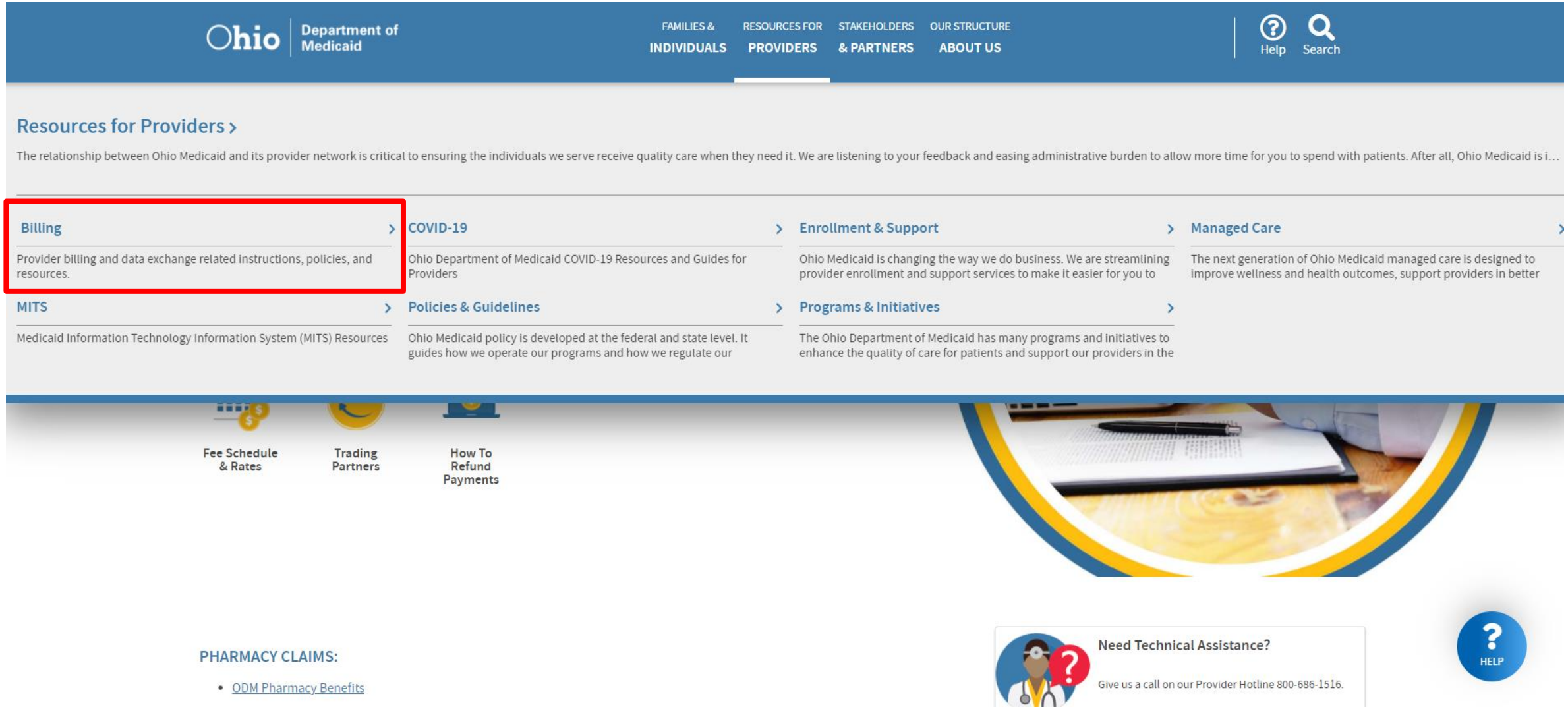
- Administrative Code Rule 5160-1-18 filings, including appendix with covered procedure codes: http://www.registerofohio.state.oh.us/rules/search/details/314341

- 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

MITS & Claim Submission

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

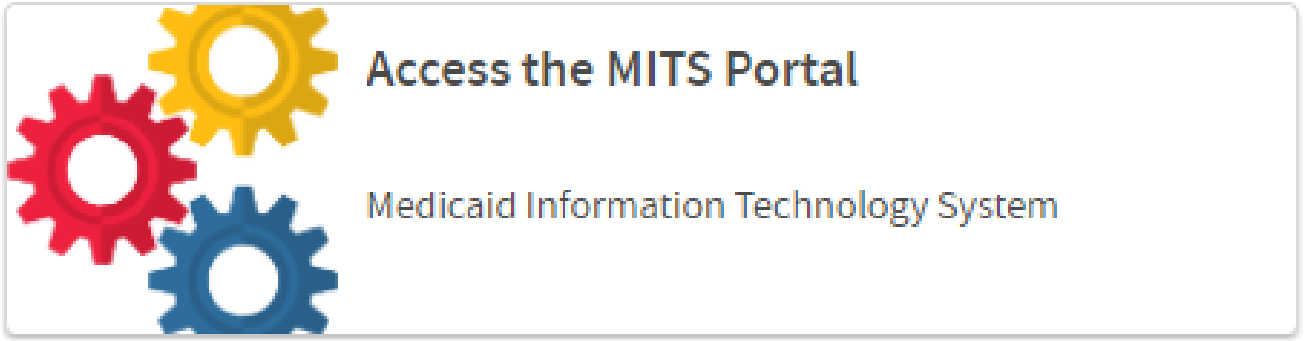
How to Access the MITS Portal

»Go to https://Medicaid.ohio.gov

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

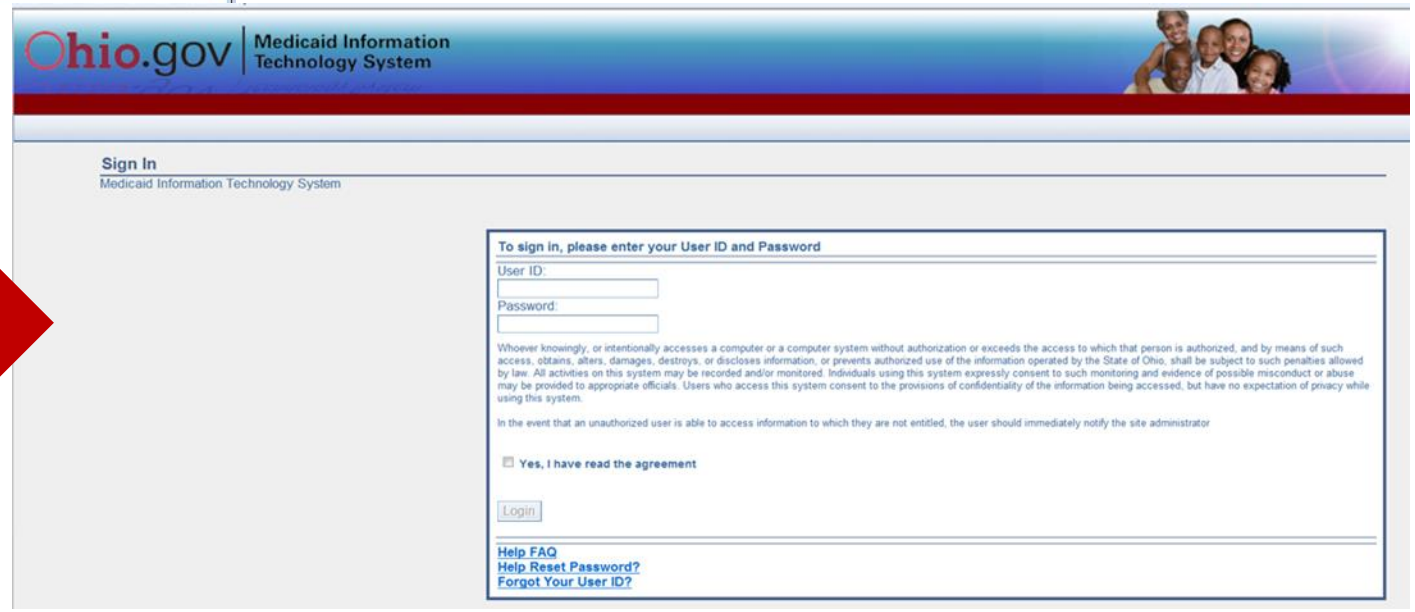
»Click on “MITS”

»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 Data Interchange (EDI)

Fees for claims submitted

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

MITS Portal

Free submission

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

We can help with your claim issues

Technical Questions/EDI Support Unit

Trading partners contact DXC for EDI Support

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

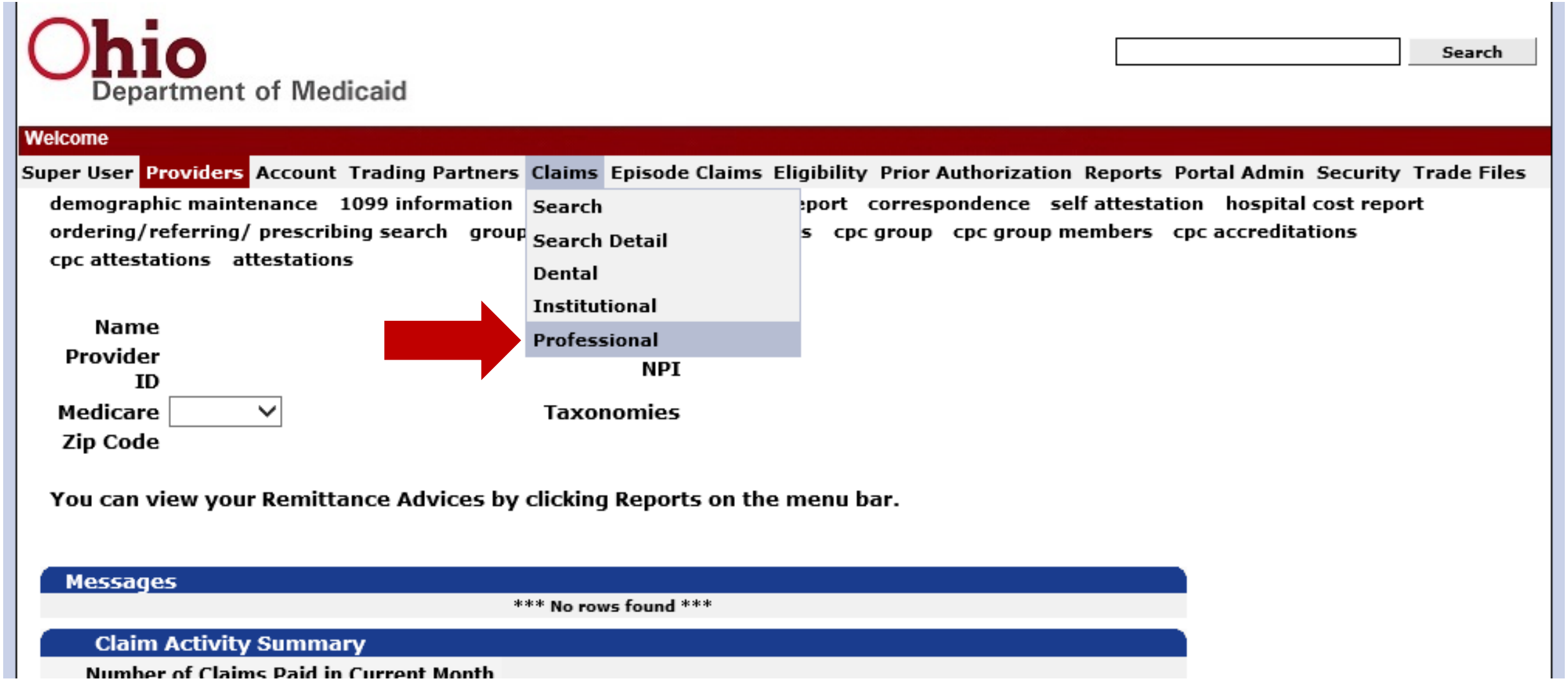
MITS Web Portal Claim Submission

Claim entry format is divided into sections or panels

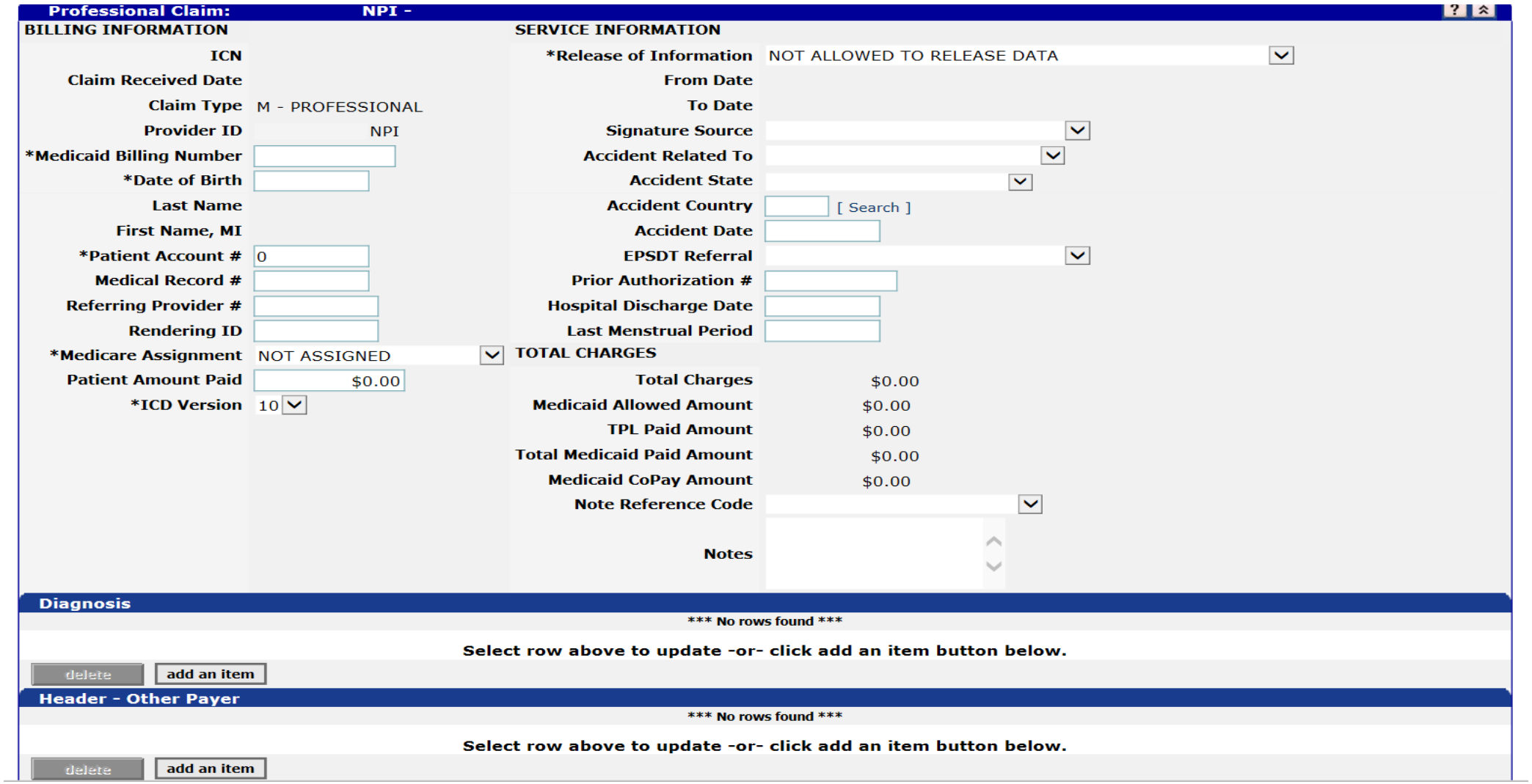
Each panel will have an asterisk (*) denoting that the fields are required

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

Submission of a Professional Claim



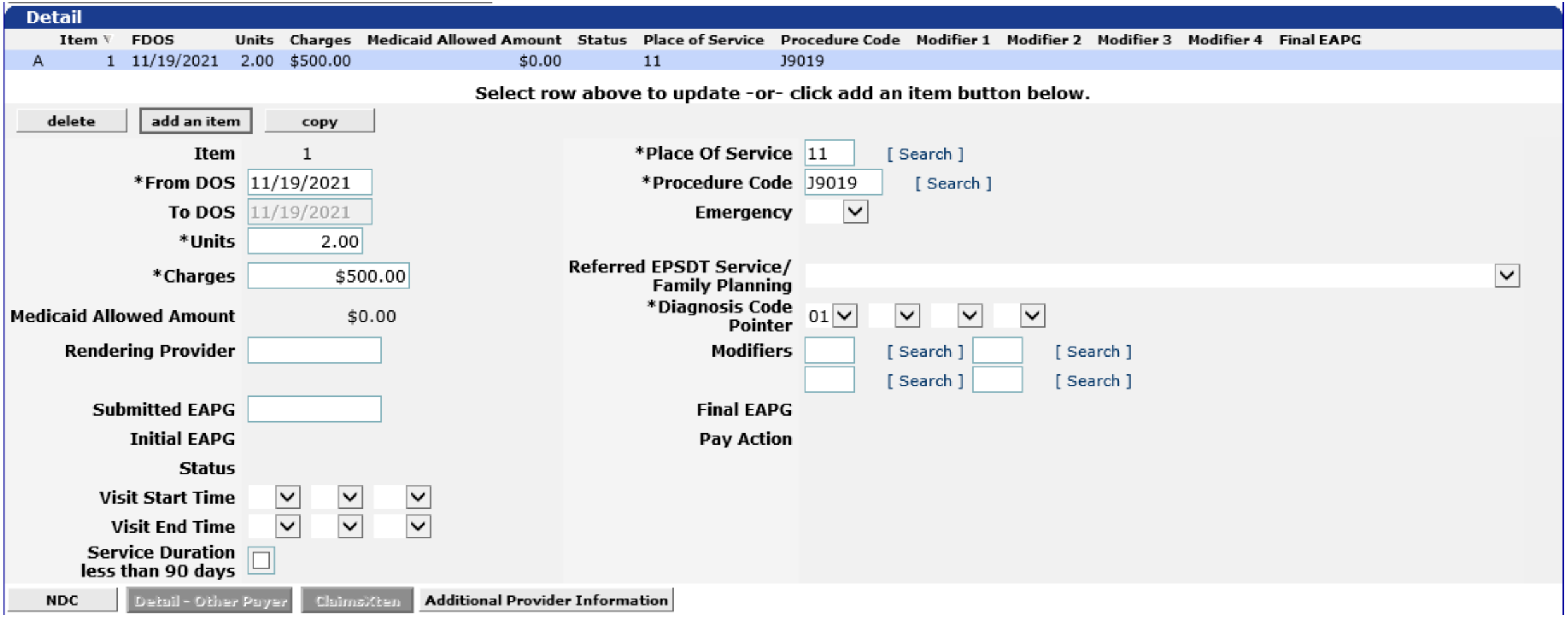
Submission of a Professional Claim



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

Detail Panel



National Drug Code

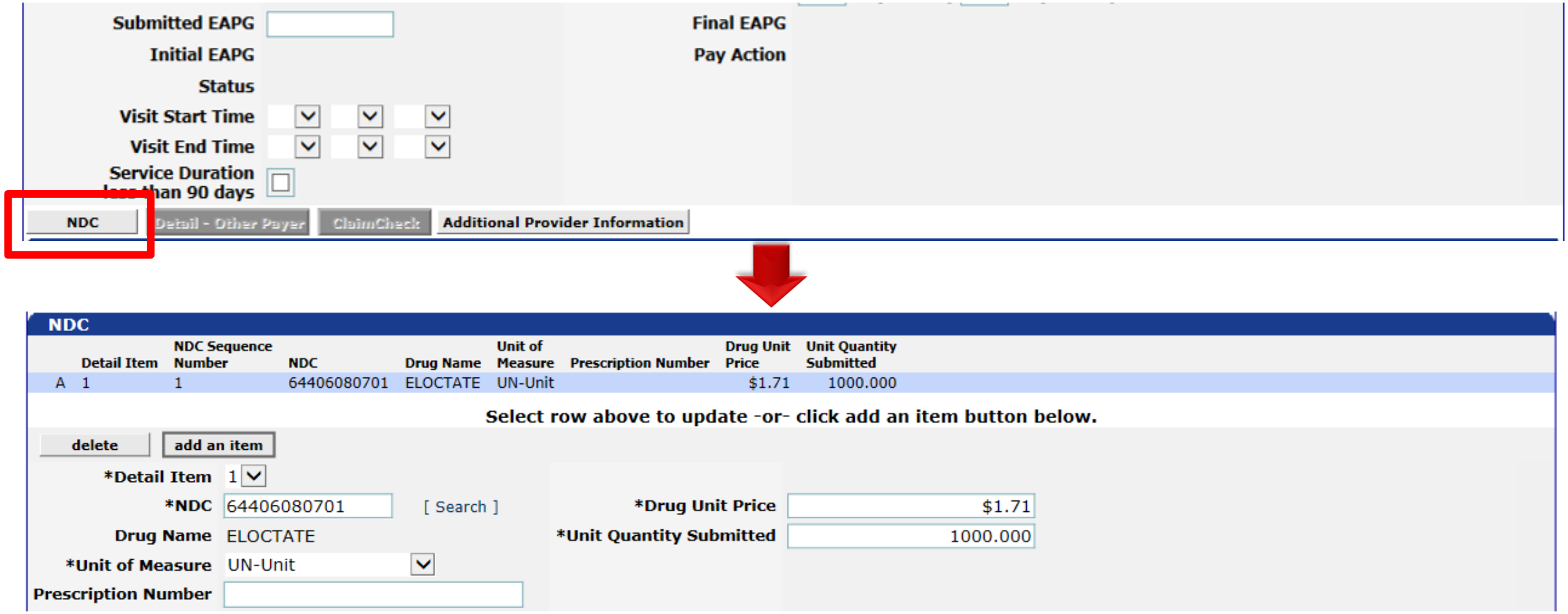
- Drug products are identified and reported using a unique, three-segment number which serves as a universal product identifier for drugs

- 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

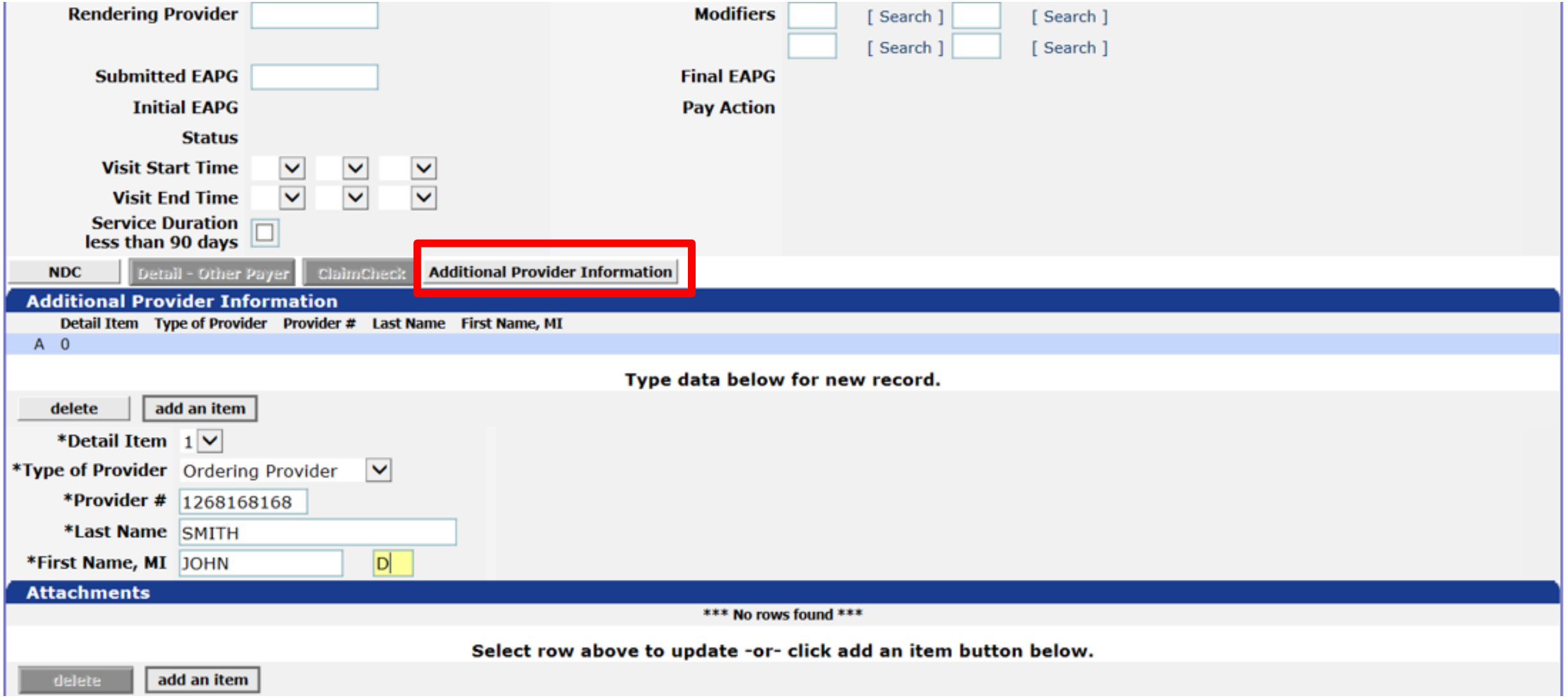
National Drug Code (NDC)

- 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)



Entering ORP Information

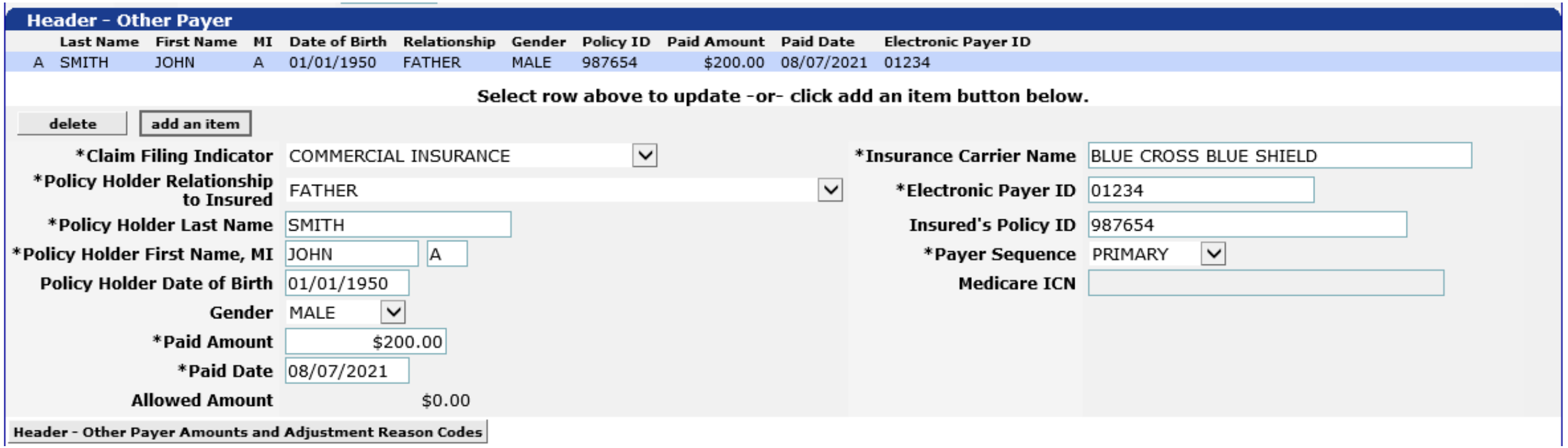


Third Party Liability (TPL) Claims

- 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.

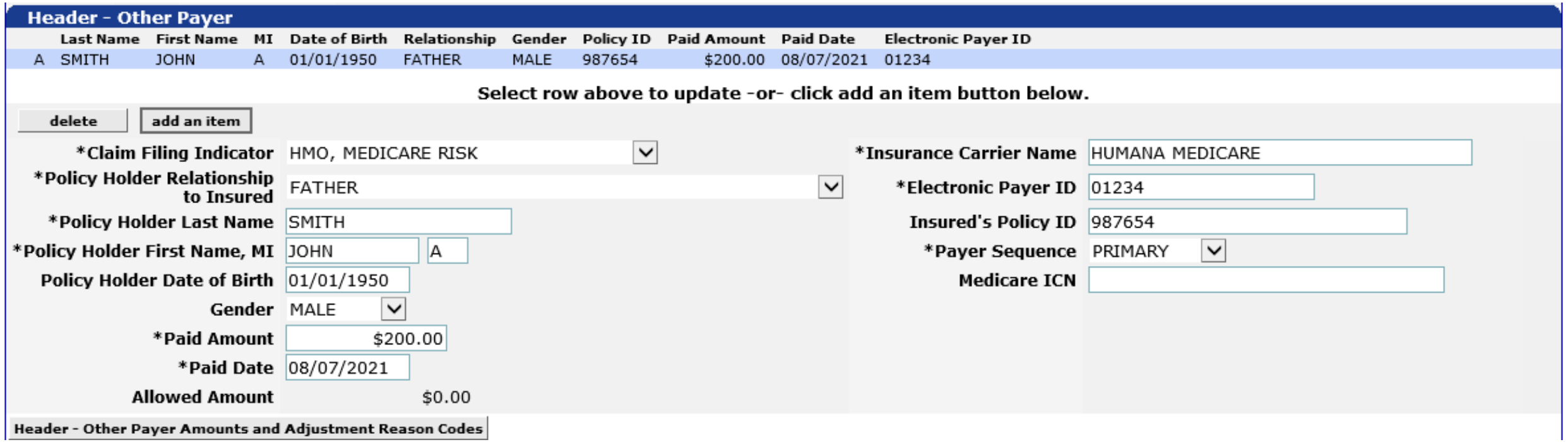
delete | add an item

*Claim Filing Indicator	COMMERCIAL INSURANCE	*Insurance Carrier Name	BLUE CROSS BLUE SHIELD
*Policy Holder Relationship to Insured	FATHER	*Electronic Payer ID	01234
*Policy Holder Last Name	SMITH	Insured's Policy ID	987654
*Policy Holder First Name, MI	JOHN A	*Payer Sequence	PRIMARY
Policy Holder Date of Birth	01/01/1950	Medicare ICN	
Gender	MALE		
*Paid Amount	$200.00		
*Paid Date	08/07/2021		
Allowed Amount	$0.00		

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	*Insurance Carrier Name	HUMANA MEDICARE
*Policy Holder Relationship to Insured	FATHER	*Electronic Payer ID	01234
*Policy Holder Last Name	SMITH	Insured's Policy ID	987654
*Policy Holder First Name, MI	JOHN A	*Payer Sequence	PRIMARY
Policy Holder Date of Birth	01/01/1950	Medicare ICN	
Gender	MALE		
*Paid Amount	$200.00		
*Paid Date	08/07/2021		
Allowed Amount	$0.00		

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

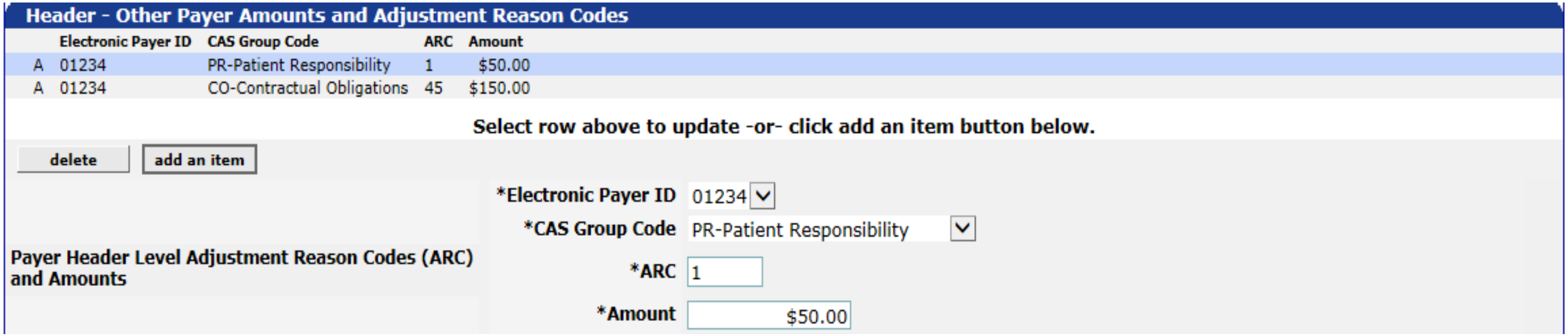
- A COB claim is considered to be adjudicated at the header/claim level if only one set of figures is reported for the entire claim

Detail level

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

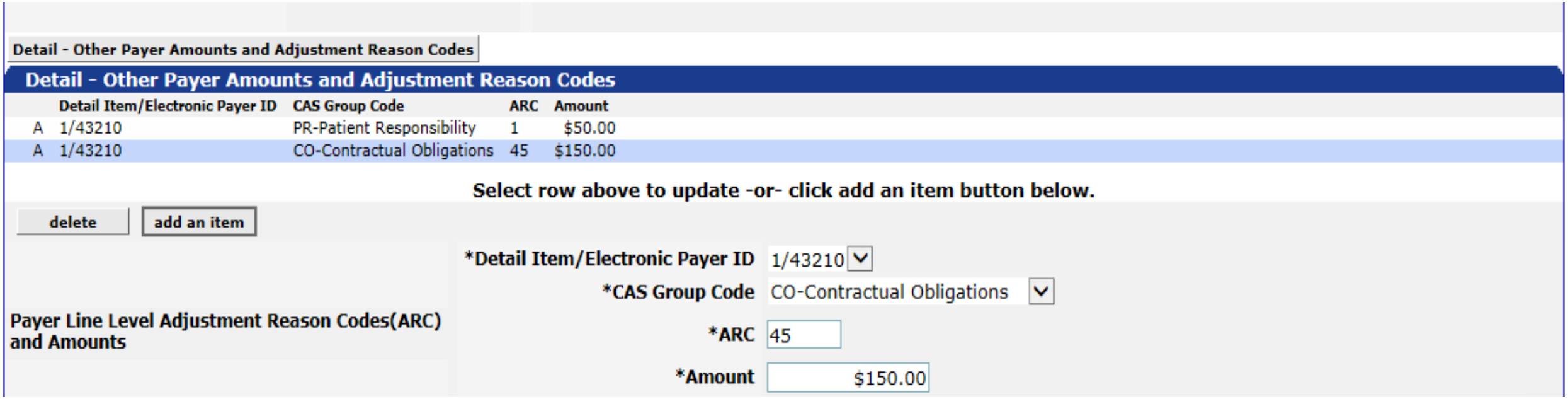
Third Party Liability (TPL) Claims

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



Third Party Liability (TPL) Claims

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



- 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

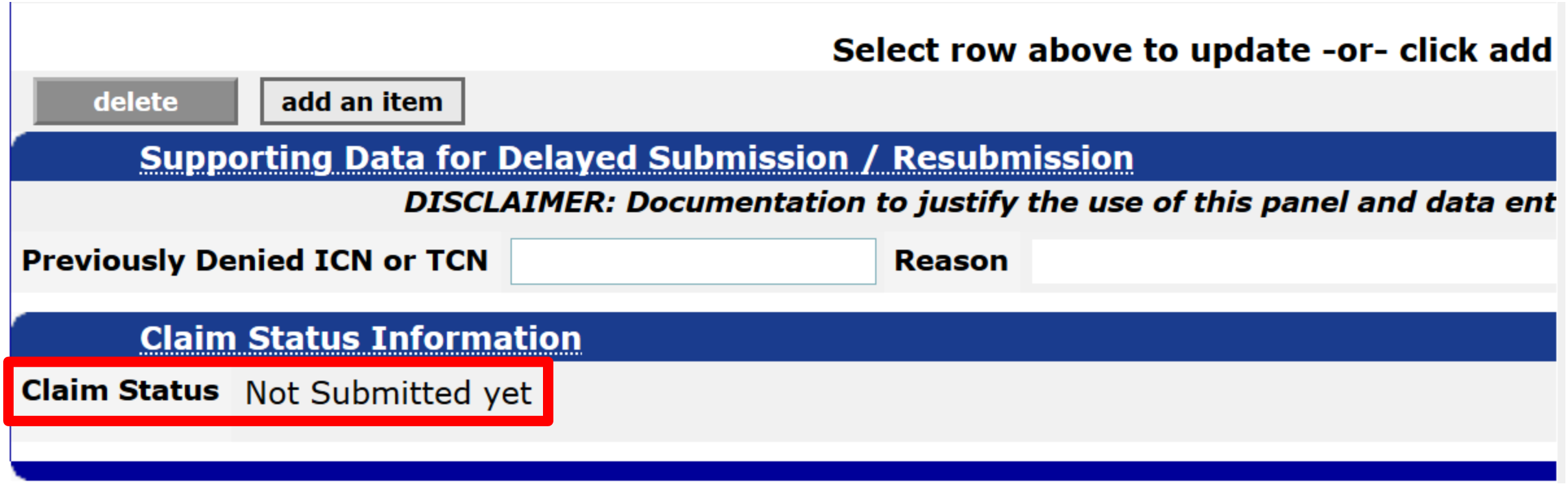
All claim submissions are assigned an ICN

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

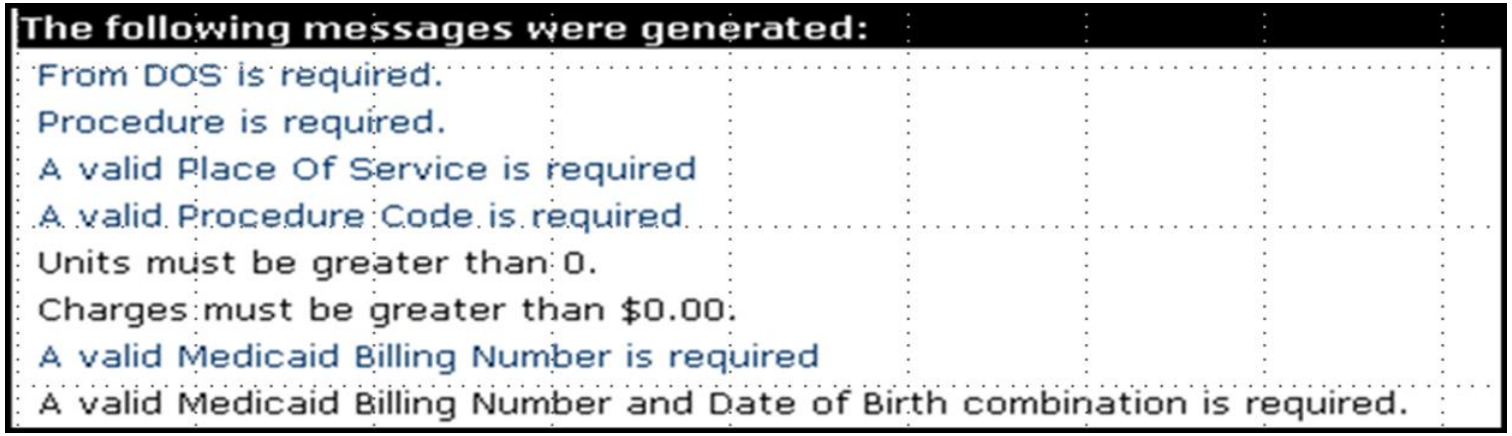


Claim Portal Errors

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



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

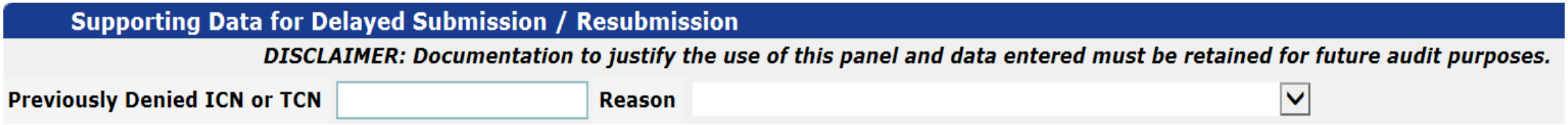
An additional 180 days from the resubmit date is given for attempts to correctly submit a denied claim prior to the end of the 365 days

Claims over 2 years old will be denied

There are exceptions to the 365 day rule

Submitting a Claim Over 365 Days Old

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



Special Billing Instructions – Eligibility Delay

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

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

Special Billing Instructions – Eligibility Delay

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

Special Billing Instructions – Eligibility Delay

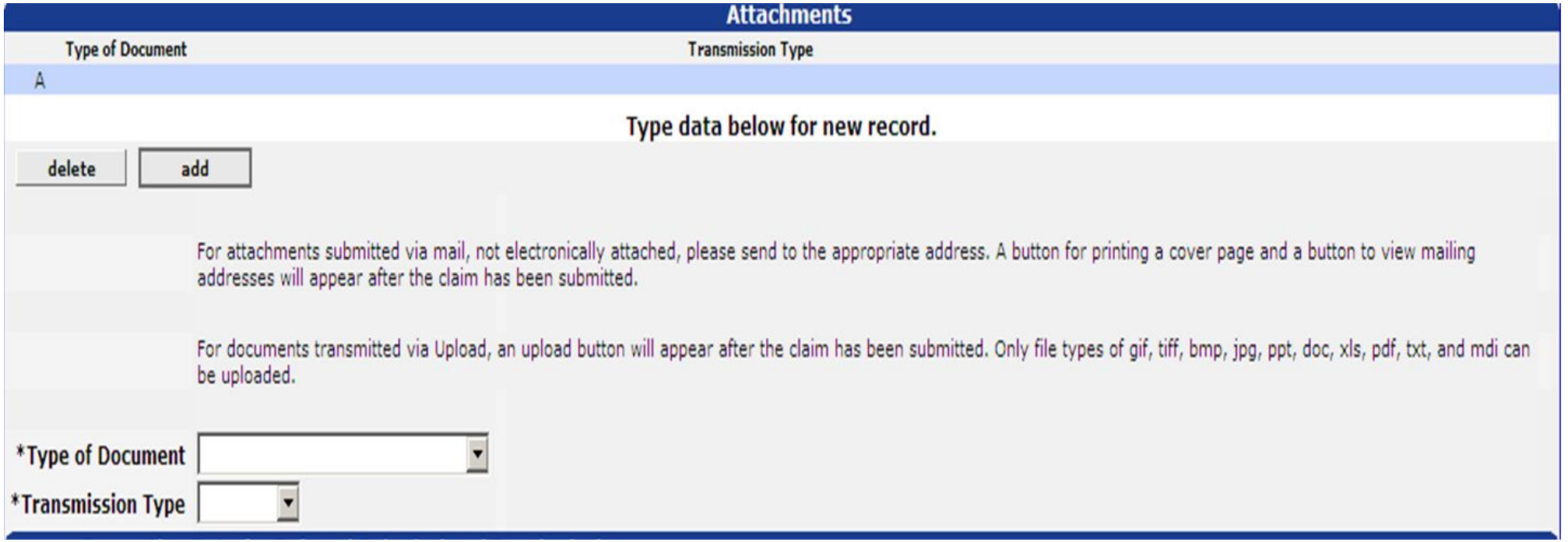
- Hearing Decision: APPEALS^########^CCYYMMDD
  ######## is the hearing number and CCYYMMDD is the date on the hearing decision

- Eligibility Determination: DECISION^CCYYMMDD
  CCYYMMDD is the date on the eligibility determination notice from the CDJFS

Must use the spacing shown

Uploading an Attachment

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



Uploading an Attachment

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

Adjusting a Paid Claim

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

Adjusting a Paid Claim

- 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 Originally paid $45.00

5821185127250 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

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

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

The National Correct Coding Initiative (NCCI)

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

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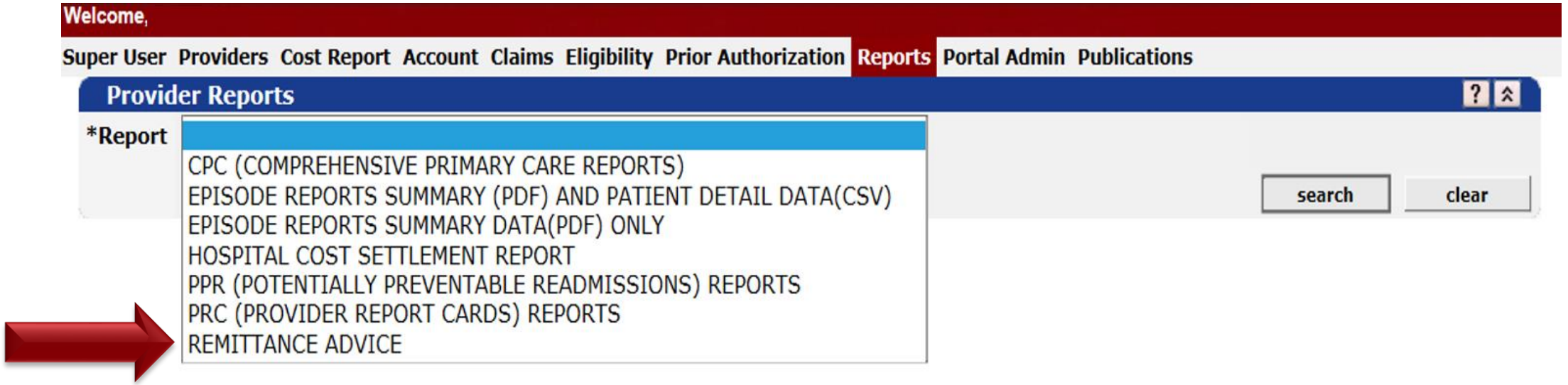
Remittance Advice (RA)

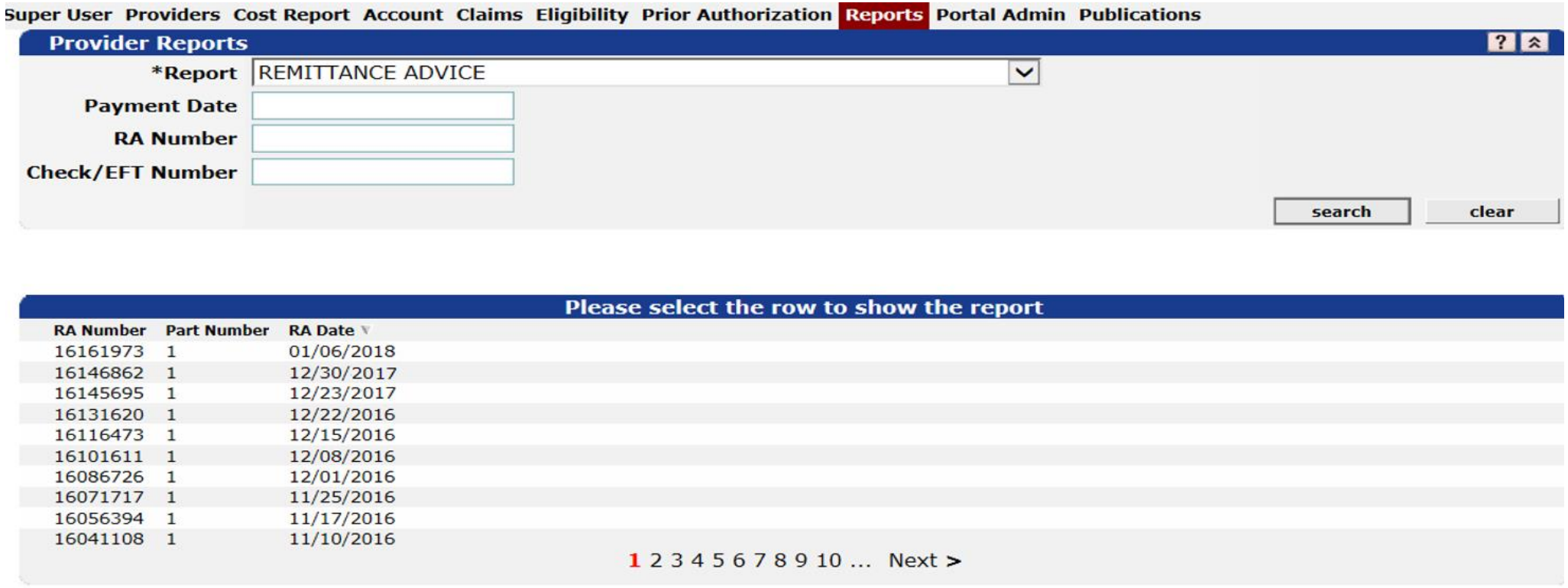
- All claims processed are available on the MITS Portal
- Weekly reports become available on Wednesdays



Remittance Advice (RA)

- Select “Remittance Advice” and click “search”

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



Remittance Advice (RA)

Paid, denied, and adjusted claims

Financial transactions

Expenditures - Non-claim payments

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

Summary

Current, month, and year to date information

Remittance Advice (RA)

Information pages

Banner messages to the provider community

EOB code explanations

Provides a comparison of codes to the description

TPL claim denial information

Provides other insurance information for any TPL claim denials

Websites & Forms

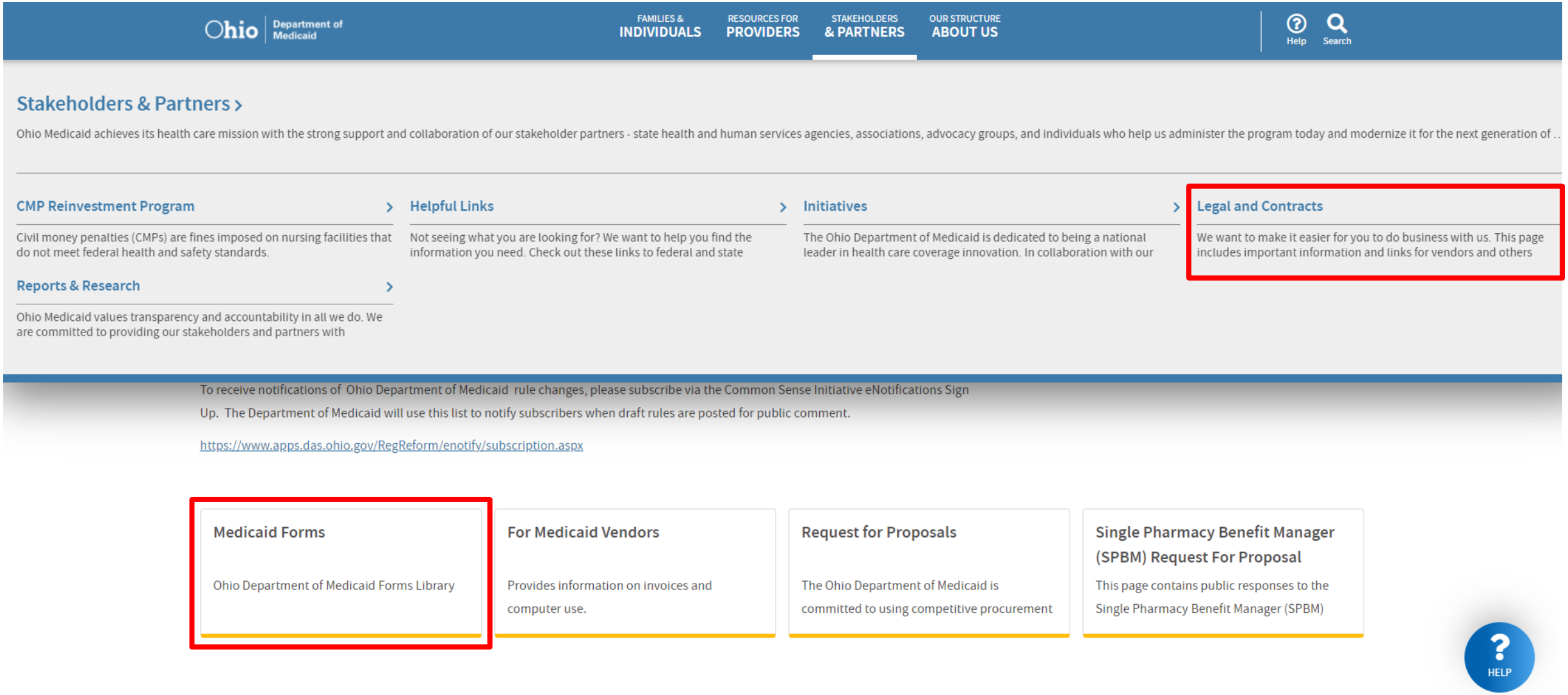
Websites

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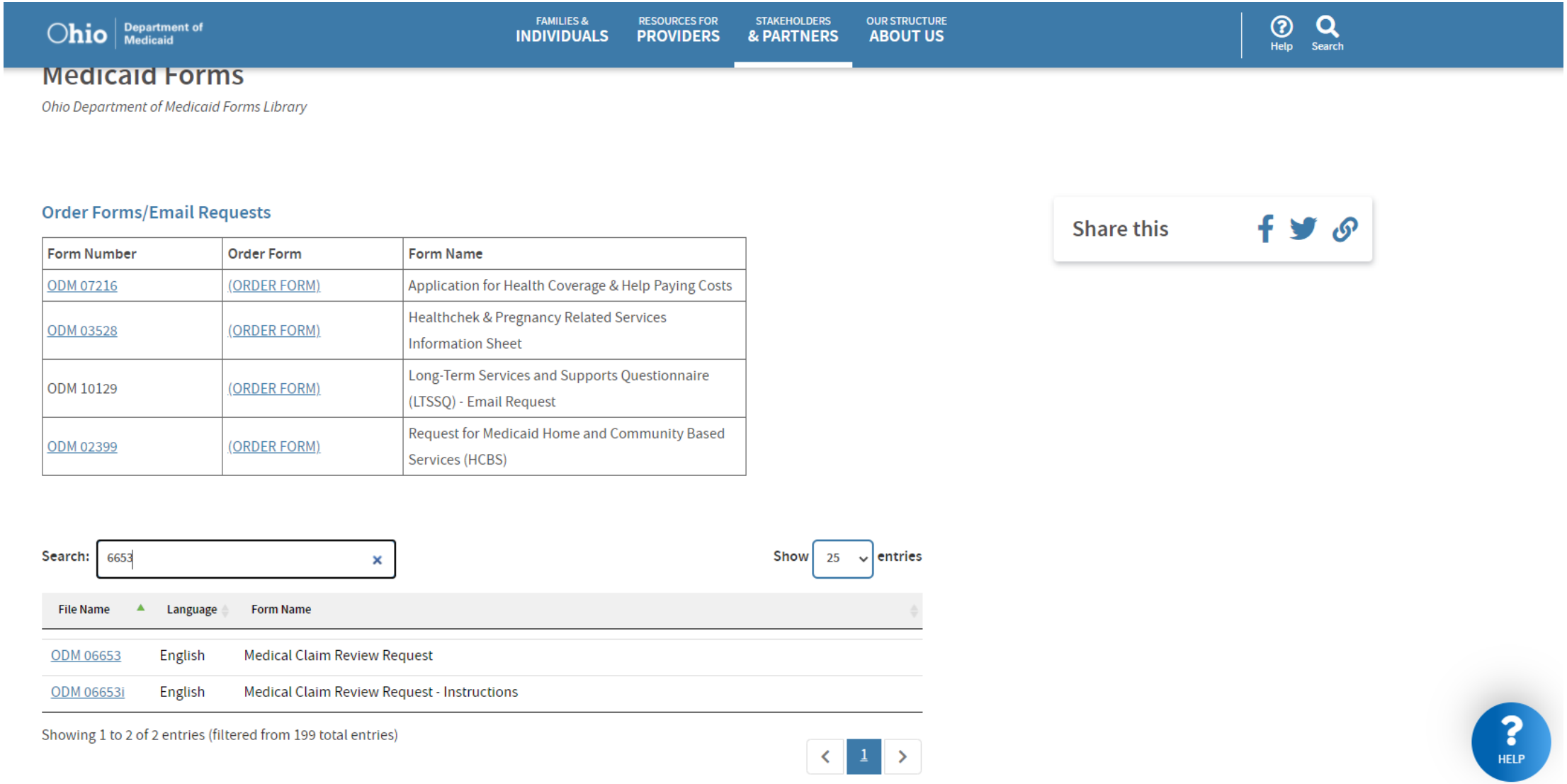
Stakeholders & Partners ›
Ohio Medicaid achieves its health care mission with the strong support and collaboration of our stakeholder partners - state health and human services agencies, associations, advocacy groups, and individuals who help us administer the program today and modernize it for the next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

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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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