Ohio | Department of Medicaid

Basic Billing for Hospitals

Provider Relations

2021

AGENDA

- Medicaid Services
- Programs & Cards
- Managed Care/MyCare Ohio
- Provider Responsibilities
- Policy
- MITS & Claims
- Websites & Forms

Ohio Medicaid covers:

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

Medicaid Medical Necessity: OAC 5160-1-01

Is the fundamental concept underlying the Medicaid Program

All Services must meet accepted standards of medical practice

Covered Services (not limited to)

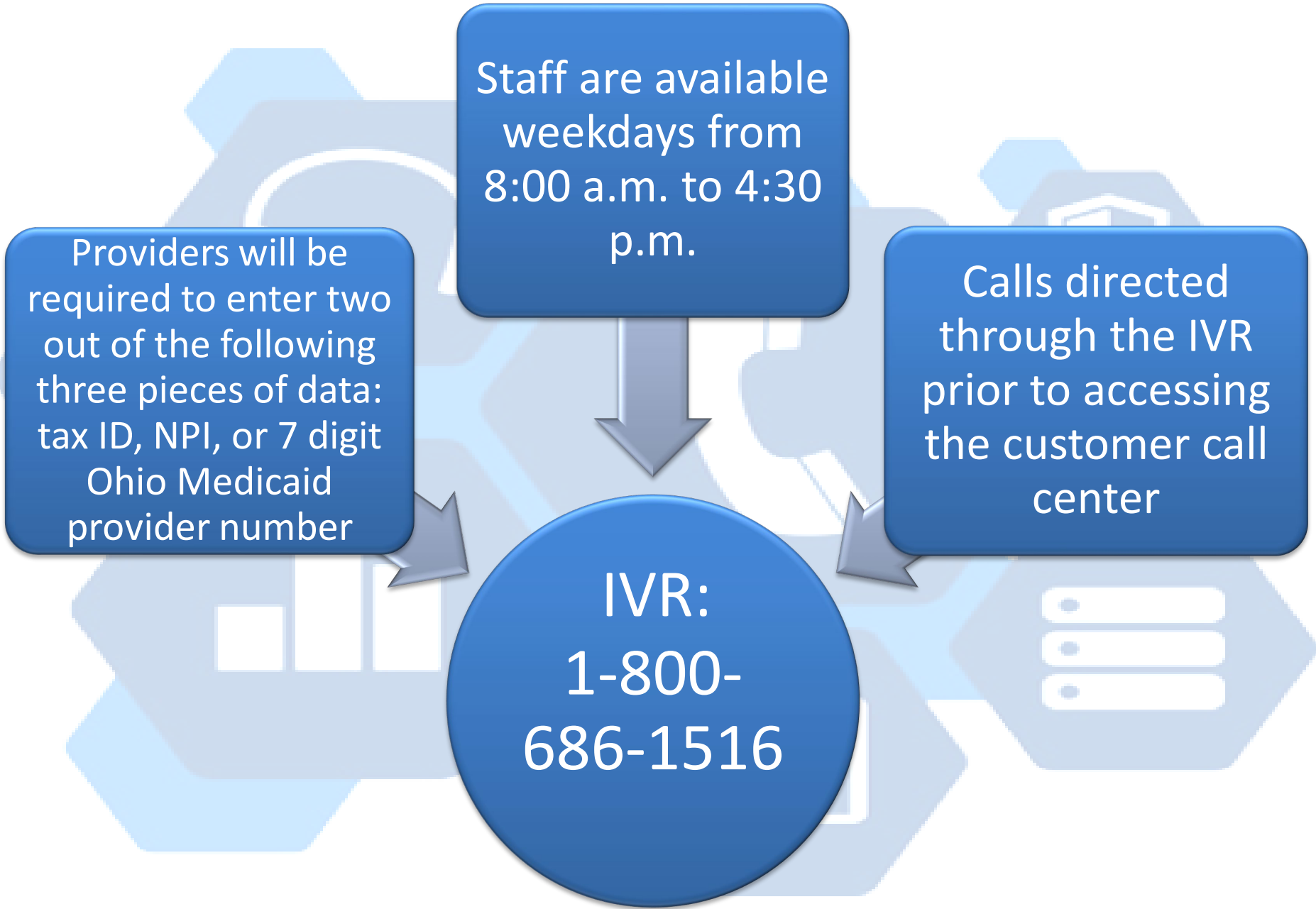
- Acupuncture
- Behavioral Health
- Dental
- Dialysis
- Dietitian
- Durable Medical Equipment
- Home Health
- Hospice
- Hospital (Inpatient/Outpatient)
- ICF-IID Facility
- Nursing Facility
- Pharmacy
- Physician
- Transportation
- Vision

Helpful phone numbers

- Adjustments
  ltcpaymentsection@medicaid.ohio/gov

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

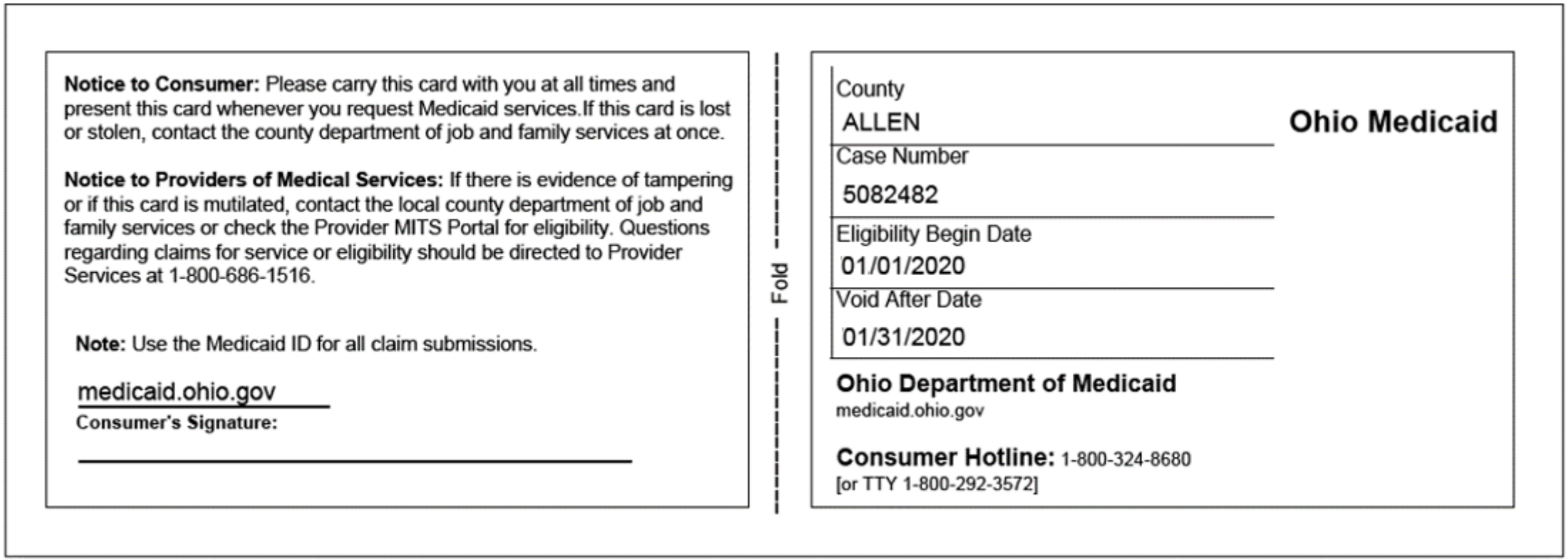
- Coordination of Benefits Section
  614-752-5768
  614-728-0757 (fax)


Staff are available weekdays from 8:00 a.m. to 4:30 p.m.
Providers will be required to enter two out of the following three pieces of data: tax ID, 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]

Supplemental Security Income (SSI)

- Automatically Eligible for Medicaid as long as eligible for SSI

Modified Adjusted Gross Income (MAGI)

- Children, parents, caretakers, and expansion

Aged, Blind, Disabled (ABD)

- 65+, or blind/disabled with no SSI

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

- Consumers must cooperate with requests from third-party insurance companies to provide additional information needed in order to authorize coverage
- Consumers must cooperate with requests from a Medicaid provider; managed care plan; or a managed care plan's contracted provider for additional information which is needed in order to bill third party insurances appropriately

Conditions of Eligibility and Verifications

- Providers may contact local CDJFS offices to report non-cooperative consumers

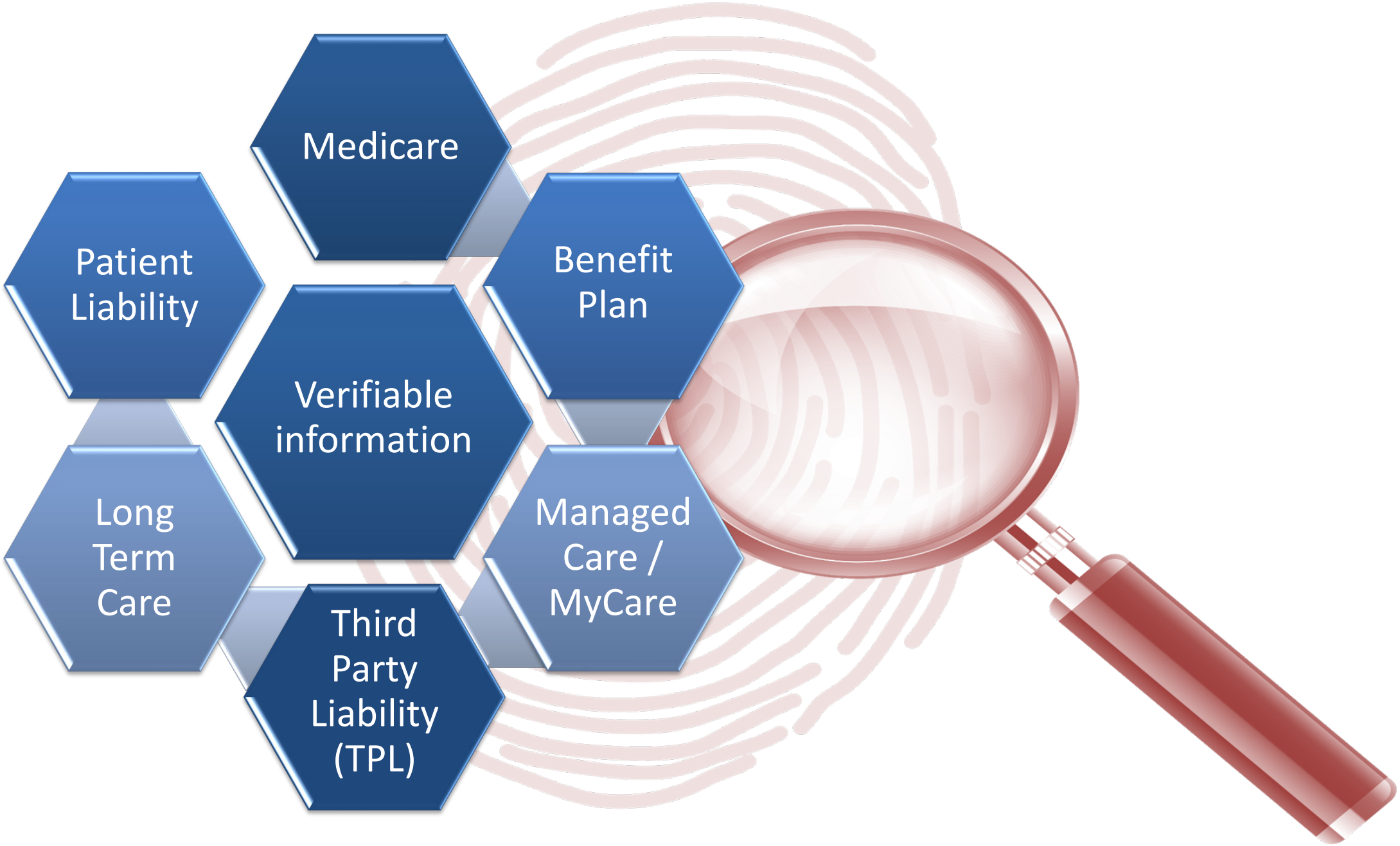
- CDJFS may terminate eligibility if an individual fails or refuses, without good cause, to cooperate by providing necessary verifications or by providing consent for the administrative agency to obtain verification

Full Medicaid eligibility on the MITS Portal will show **four** (or more) benefit spans:

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

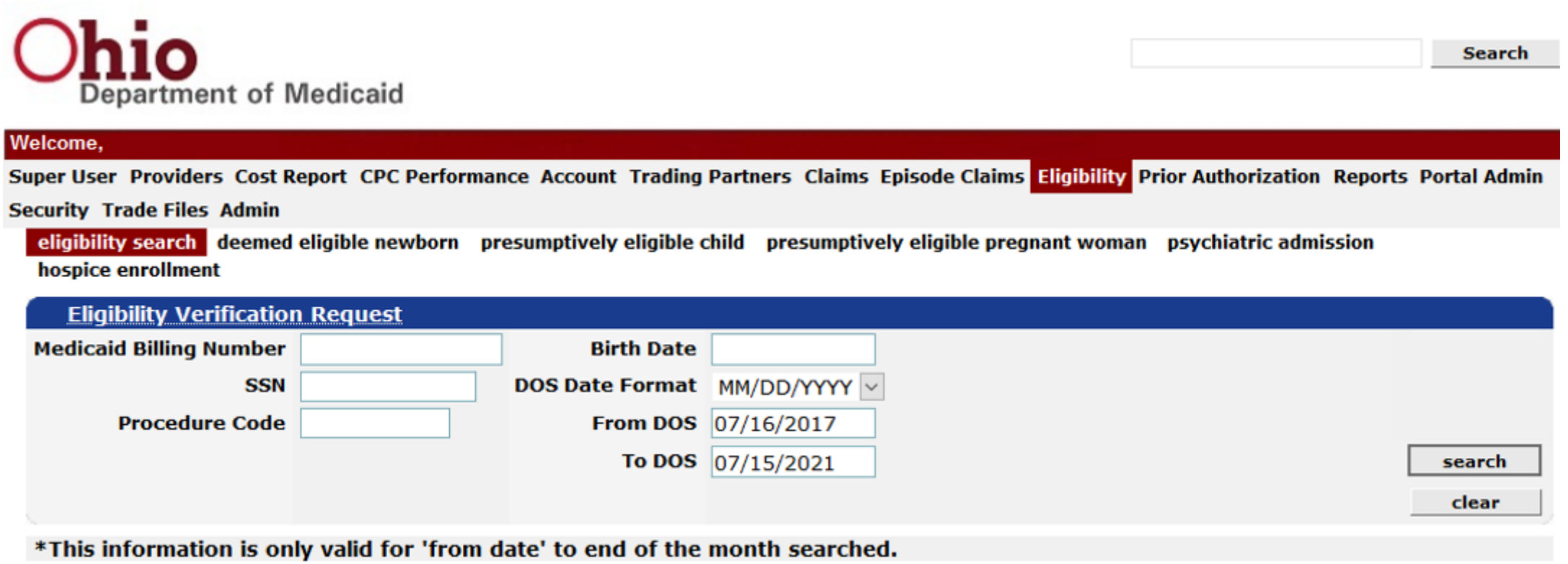
Additional spans when applicable:

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


Medicare
Patient Liability
Benefit Plan
Verifiable information
Long Term Care
Managed Care / MyCare
Third Party Liability (TPL)

Eligibility Verification Request

You can search up to 4 years back



TIP: Always check eligibility prior to billing

Eligibility Verification Request

Recipient Information

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

Associated Child(ren) Search

Benefit / Assignment Plan

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

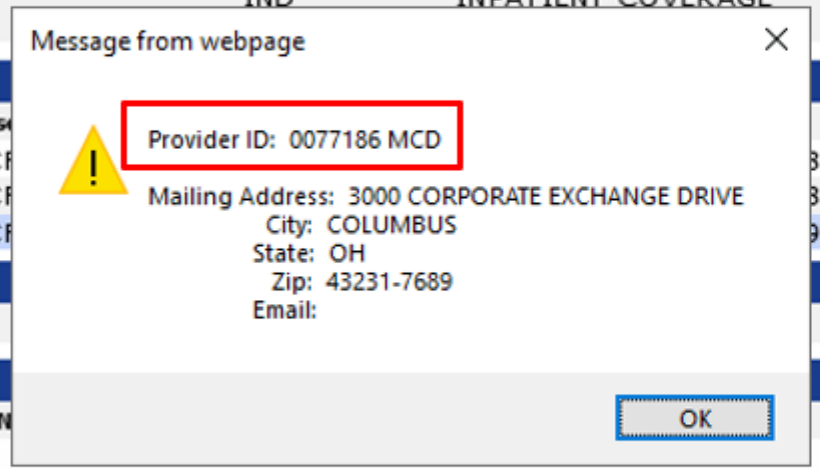
Associated Child(ren)

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

Eligibility Verification Request

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

Service Limitation

*** No rows found ***

Presumptive Eligibility

Covers children up to age 19 and pregnant women

It has been expanded to provide coverage for parent and caretaker relatives and extension adults

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

Presumptive Eligibility

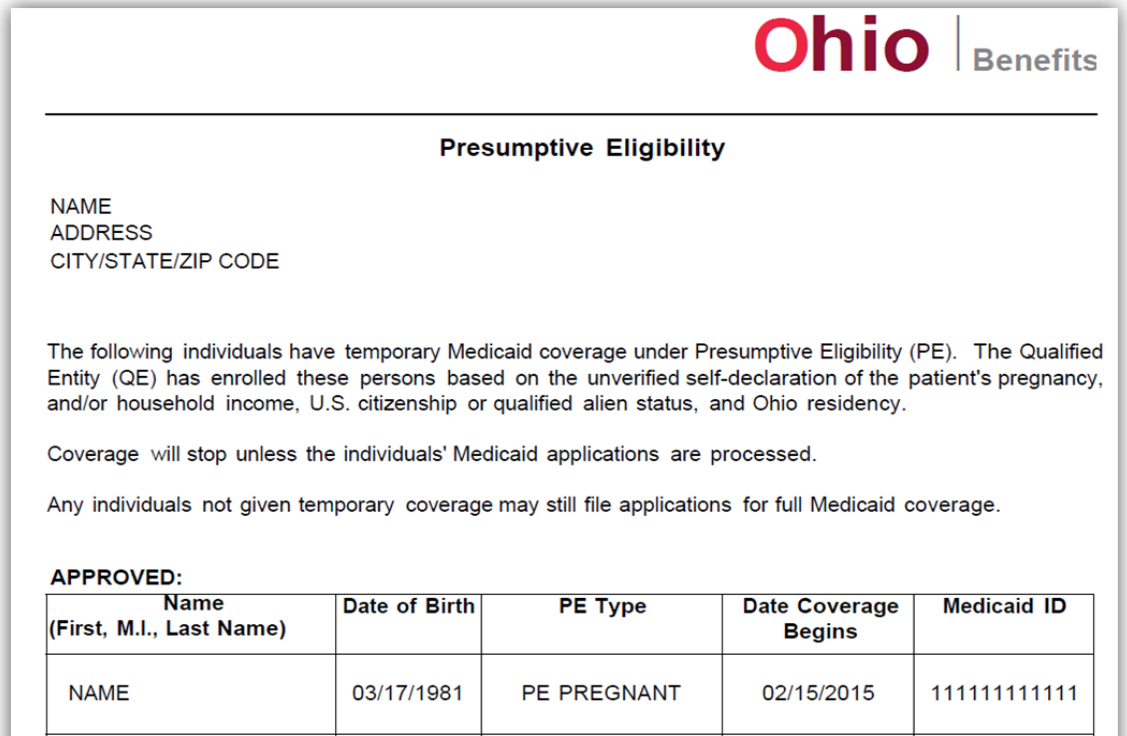
Hospitals and FQHCs are eligible to participate in Ohio's presumptive eligibility initiative

To become a Qualified Entity complete the steps described here:

http://www.medicaid.ohio.gov/Provider/Training/PresumptiveEligibility

Presumptive Eligibility

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



Ohio | Benefits

Presumptive Eligibility

NAME
ADDRESS
CITY/STATE/ZIP CODE

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 pregnancy, and/or household income, U.S. citizenship or qualified alien status, and Ohio residency.

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

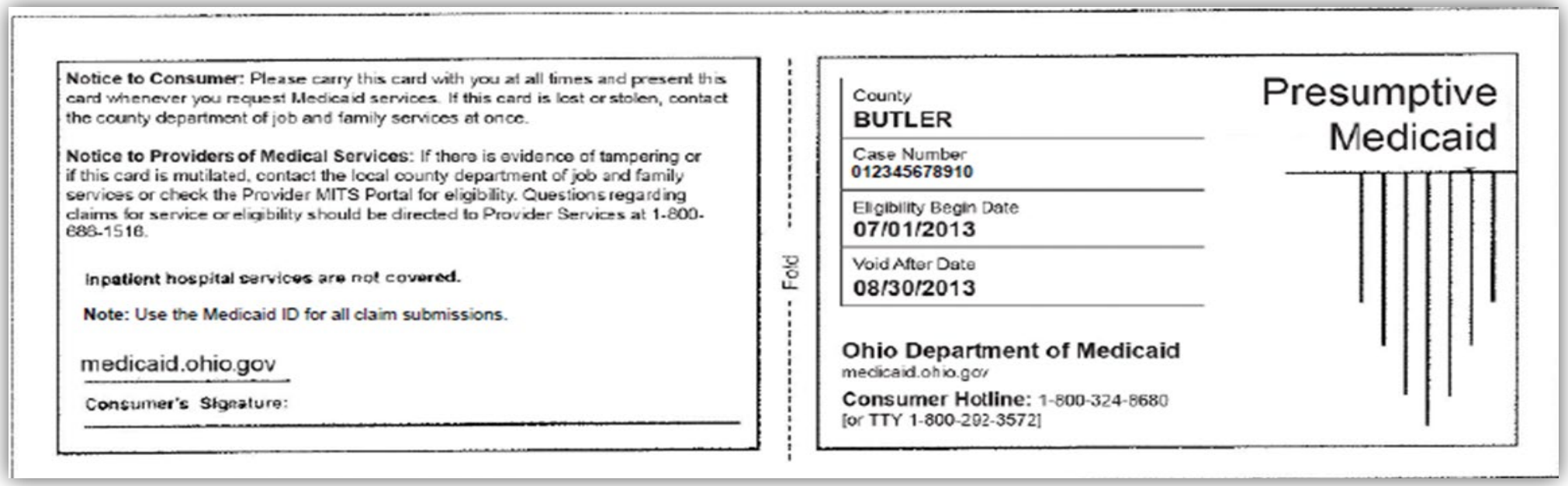
Any individuals not given temporary coverage may still file applications for full Medicaid coverage.

APPROVED:

Name (First, M.I., Last Name)	Date of Birth	PE Type	Date Coverage Begins	Medicaid ID
NAME	03/17/1981	PE PREGNANT	02/15/2015	111111111111

Presumptive Eligibility

Other members will receive a Presumptive Eligibility Card



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.

Inpatient hospital services are not covered.

Note: Use the Medicaid ID for all claim submissions.

medicaid.ohio.gov

Consumer's Signature:

Fold

County
BUTLER

Case Number
012345678910

Eligibility Begin Date
07/01/2013

Void After Date
08/30/2013

Ohio Department of Medicaid
medicaid.ohio.gov
Consumer Hotline: 1-800-324-8680
[or TTY 1-800-292-3572]

Presumptive Medicaid

Presumptive Eligibility

Recipient Information

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

Benefit / Assignment Plan

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

Medicaid Pre-Release Enrollment Program

- Institutionalized individuals close to release are enrolled into a Medicaid Managed Care plan, prior to release
- Individual must agree and be eligible for the program
- MCP Care Manager will develop a transition plan

Qualified Medicare Beneficiary (QMB)

- Issued to qualified Individuals 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: SE1128 Revised Release Date of Revised Article: December 4, 2017

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 under any circumstances (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 program is a State Medicaid benefit that assists low-income Medicare beneficiaries with Medicare Part A and Part B premiums and cost-sharing, including deductibles, coinsurance, and copays.

QMB

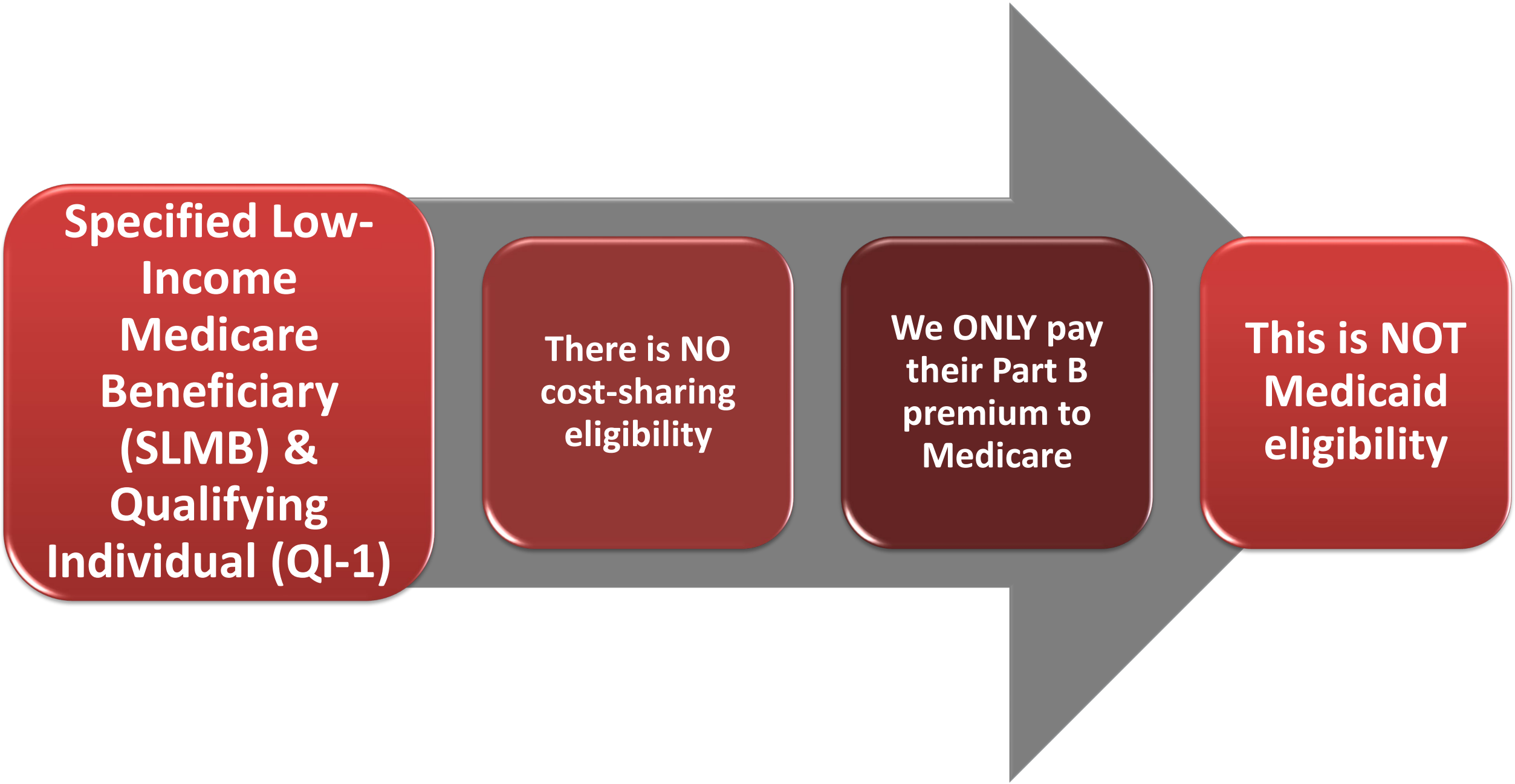
Recipient Information

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

Associated Child(ren) Search

Benefit / Assignment Plan

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


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

Recipient Information

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

Benefit / Assignment Plan

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

QI-1

Recipient Information

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

Benefit / Assignment Plan

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

Healthchek: OAC 5160-1-14

Early & Periodic Screening Diagnosis & Treatment (EPSDT) for children from birth through age 20

Minimum services include:

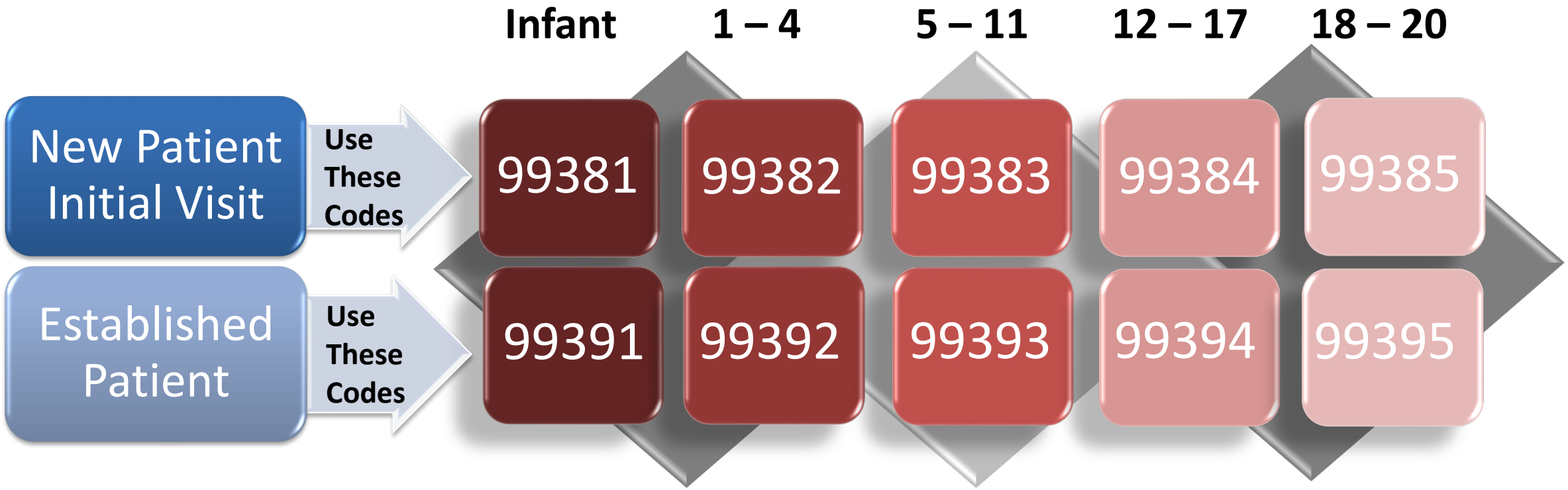
- Comprehensive Health and Developmental History
- Developmental Screening (including mental and physical)
- Nutritional Screening
- Vision Screening

Healthchek

- Hearing Screening
- Immunization Screening
- Lead Toxicity Screening
- Lab Tests
- Dental Screening

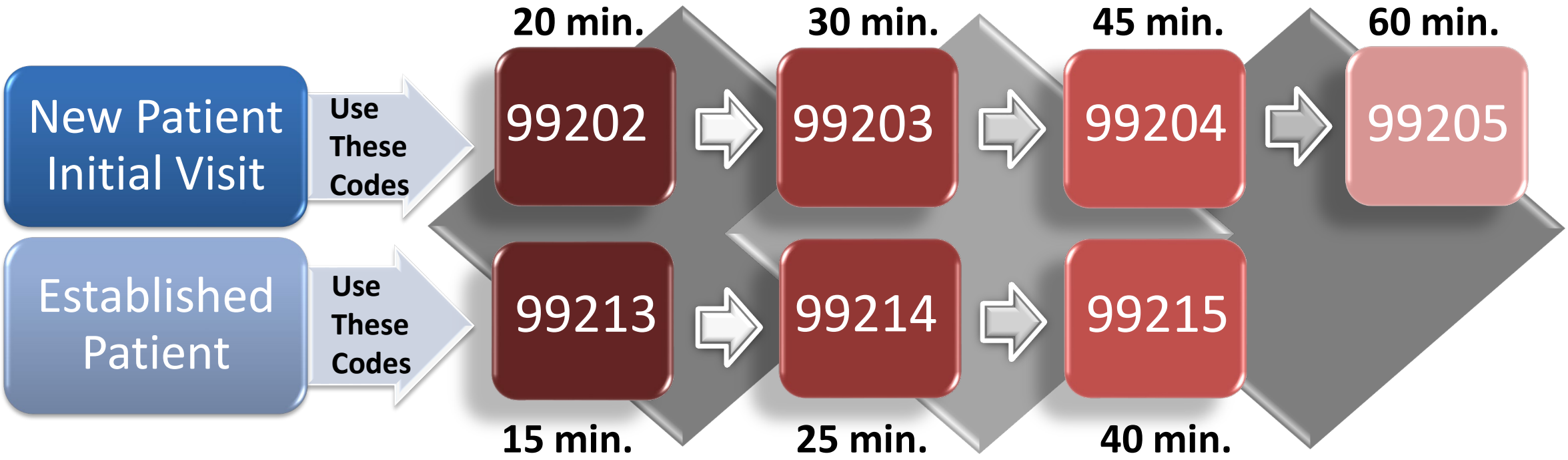
HealthChek Procedure Codes

When completing a HealthChek exam please complete all components of the exam and bill the correct ***Preventive Medicine*** code for the appropriate age group



HealthChek Procedure Codes

When completing a HealthChek exam please complete all components of the exam and bill the correct ***Evaluation and Management*** code for the appropriate time spent



Managed Care & MyCare Ohio

aetna®

AETNA BETTER HEALTH® OF OHIO

buckeye health plan

CareSource®

PARAMOUNT HEALTH CARE

MOLINA® HEALTHCARE

UnitedHealthcare®

Oversight of Managed Care Plans

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

3 Population Groups Eligible for Traditional Managed Care

Medicaid Managed Care MAGI (CFC)

Medicaid Managed Care Non-MAGI (ABD)

Medicaid Managed Care Adult MAGI (expansion population)

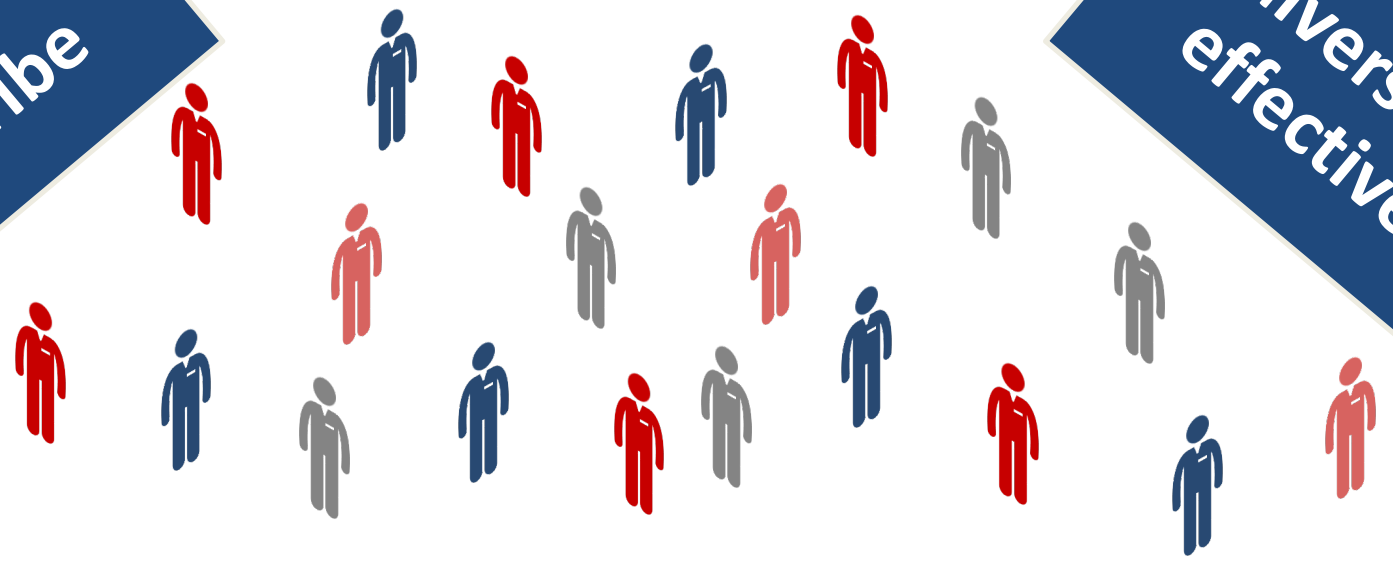
Population added for mandatory enrollment in 2017

- Adoption children, Breast and Cervical Cancer Patients (BCCP), Foster children, and Bureau of Children with Medical Handicaps (BCMH)

Individuals with optional enrollment in Traditional Managed Care Plans

Native Americans that are members of a federally recognized tribe

Home and Community Based waivers thru DODD effective 1/1/17



Traditional Managed Care Benefit Package

Managed Care Plans must cover all medically necessary Medicaid covered services

Some value-added services:

- On-line searchable provider directory
- Access to toll-free 24/7 hotline for medical advice, staffed by nurses
- Expanded benefits including additional transportation options, and other incentives (varies among the MCPs)
- Care management to help members coordinate care and ensure they are getting the care that they need

HOW DO YOU KNOW IF SOMEONE IS ENROLLED IN MANAGED CARE?

Providers need to check the MITS provider portal each time before providing services to a Medicaid individual

The MITS provider portal will show if a individual is enrolled in a Managed Care plan based on the eligibility dates of service you enter

MITS Managed Care Eligibility

Benefit / Assignment Plan

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

Case/Cat/Seq Spenddown

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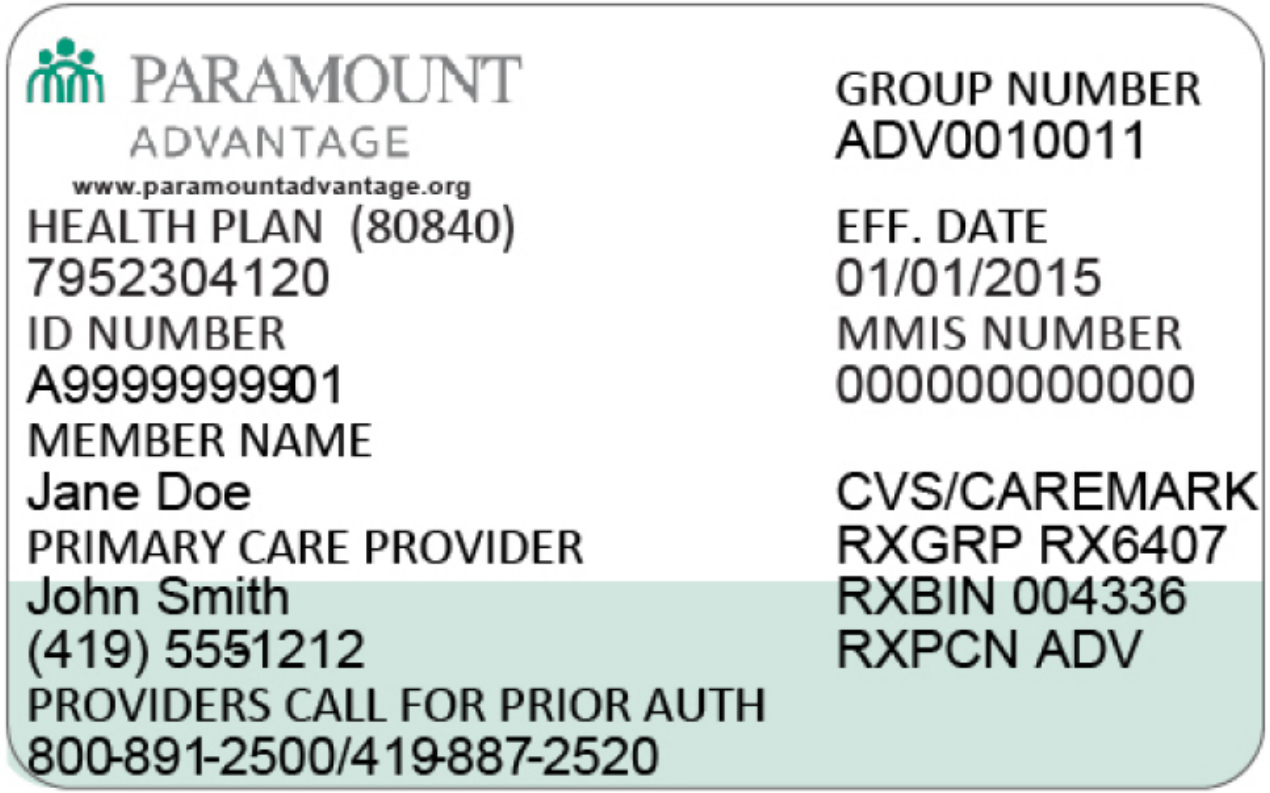
TPL

*** No rows found ***

Managed Care

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

Traditional Managed Care Sample Card



Traditional Managed Care Contracting

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

Things to know:

- Each plan has a list of services that require prior authorization
- Each plan will have their own billing requirements; therefore, contact the plan for the specific requirements
- ABD/CFC Managed Care plan contracts may be separate from MyCare Ohio plan contracts

Traditional Managed Care Plans

buckeye health plan 866-296-8731 https://www.buckeyehealthplan.com

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

PARAMOUNT HEALTH CARE 855-522-9076 https://www.paramounthealthcare.com

MOLINA® HEALTHCARE 855-322-4079 https://www.molinahealthcare.com

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

MyCare Ohio

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

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

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

- Package includes *all* benefits available through the traditional Medicare and Medicaid programs

- This includes Long Term Services and Supports (LTSS) and Behavioral Health

- Plans may elect to include additional value-added benefits in their health care packages

MyCare Ohio Eligibility

In order to be eligible for MyCare Ohio an individual must be:

- Eligible for all parts of Medicare (Parts A, B, and D) and be fully eligible for Medicaid
- Over the age of 18
- Residing in one of the demonstration project regions

Groups that are not eligible for enrollment in MyCare Ohio:

- Individuals with an ICF-IID level-of-care served in an ICF-IID waiver
- Individuals enrolled in the PACE program
- Individuals who have third-party insurance, including retirement benefits

HOW DO YOU KNOW IF SOMEONE IS ENROLLED IN MYCARE?

- Providers need to check the MITS provider portal each time before providing services to a Medicaid individual
- For individuals enrolled in a MyCare Ohio Managed Care plan it will show if they are enrolled for ***Dual Benefits*** OR ***Medicaid Only***
- The MITS provider portal will show if a individual is enrolled in a Managed Care Plan based on the eligibility dates of service you enter

MITS Eligibility MyCare Opt-In

Benefit / Assignment Plan

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

Case/Cat/Seq Spenddown

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TPL

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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

MyCare Ohio Opt-In Sample Card

MyCareOhio
Connecting Medicare + Medicaid

CareSource

Member Name: <Cardholder Name>
Member ID #: <Cardholder ID#>
Health Plan (80840)

MMIS Number: <Medicaid Recipient ID#>

PCP Name: <PCP Name>
PCP Phone: <PCP Phone>

H8452 - 001

MedicareRx
Prescription Drug Coverage

RxBin: 004336
RxPCN: MEDDADV
RxGRP: RX5045

In an emergency, call 9-1-1 or go to the nearest emergency room (ER) or other appropriate setting. If you are not sure if you need to go to the ER, call your PCP or the 24-Hour Nurse Advice line.

Member Service:	1-855-475-3163 (TTY: 1-800-750-0750 or 711)	**Eligibility Verification:**	1-800-488-0134
Behavioral Health Crisis:	1-866-206-7361	**Pharmacy Help Desk:**	1-800-488-0134
Care Management:	1-855-475-3163	**Claims Inquiry:**	1-800-488-0134
24-Hour Nurse Advice:	1-866-206-7361 (TTY: 1-800-750-0750 or 711	**Provider Questions:**	1-800-488-0134
Website:	CareSource.com/MyCare		
Mail medical claims to:	CareSource Attn: Claims Department P.O. Box 8730 Dayton, OH 45401-8738	**Mail pharmacy claims to:**	CVS Caremark P.O. Box 52066 Phoenix, AZ 85072-2066

MITS Eligibility MyCare Opt-Out

Benefit / Assignment Plan

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

Case/Cat/Seq Spenddown

*** No rows found ***

TPL

*** No rows found ***

Managed Care

Plan Name	Plan Description	Effective Date	End Date	Managed Care Benefits
MOLINA HEALTHCARE OF OHIO INC	HMO, MyCare Ohio	07/01/2018	09/30/2021	Medicaid Only

Lock-In

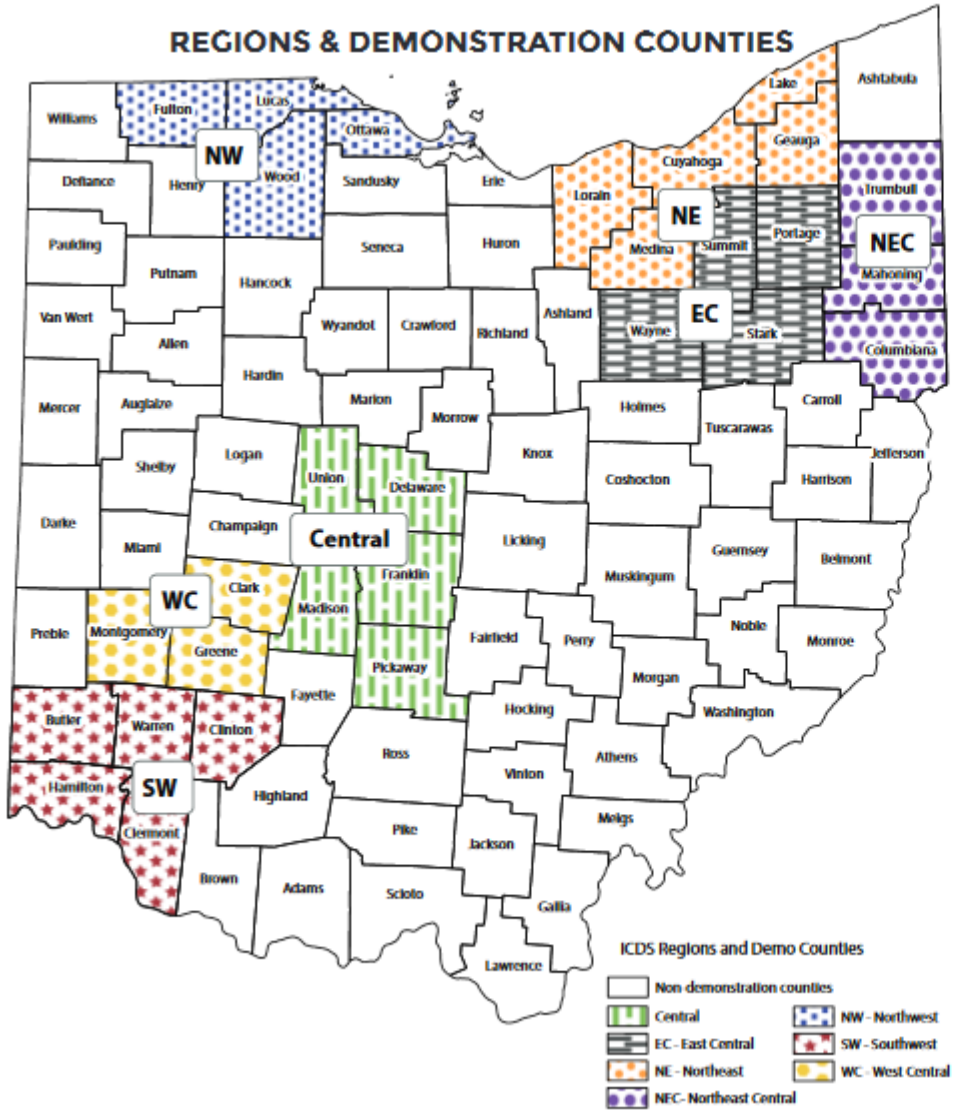
*** No rows found ***

Medicare

Coverage	Effective Date	End Date	Plan Name	Plan ID	Medicare ID
PART A	10/30/2016	10/31/2019			9RG7AP3AF00
PART B	10/30/2016	10/31/2019			9RG7AP3AF00
PART C	08/01/2017	09/30/2021	AARP MEDICARERX PREFERRED (PDP)	013	9RG7AP3AF00
PART D	06/01/2018	09/30/2021	CVS CAREMARK VALUE (PDP)	028	9RG7AP3AF00

MyCare Ohio Opt-Out Sample Card

MyCare Ohio Region Breakdown



- Individuals will have the ability to enroll by phone, online, or by mail.

DEMONSTRATION REGION & POPULATION	MANAGED CARE PLANS AVAILABLE
Northwest: 9,884 Fulton, Lucas, Ottawa, Wood	- Aetna - Buckeye
Southwest: 19,456 Butler, Clermont, Clinton, Hamilton, Warren	- Aetna - Molina
West Central: 12,381 Clark, Greene, Montgomery	- Buckeye - Molina
Central: 16,029 Delaware, Franklin, Madison, Pickaway, Union	- Aetna - Molina
East Central: 16,225 Portage, Stark, Summit, Wayne	- CareSource - United
Northeast Central: 9,284 Columbiana, Mahoning, Trumbull	- CareSource - United
Northeast: 31,712 Cuyahoga, Geauga, Lake, Lorain, Medina	- Buckeye - Caresource - United

MyCare Managed Care Contracting

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

Things to know:

- Each plan has a list of services that require prior authorization
- Each plan will have their own billing requirements; therefore, contact the plan for the specific requirements
- MyCare Ohio Managed Care plan contracts may be separate from ABD/CFC plan contracts

MyCare Ohio Managed Care Plans

buckeye health plan

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

CareSource®

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

aetna®

AETNA BETTER HEALTH® OF OHIO

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

MOLINA® HEALTHCARE

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

UnitedHealthcare®

800-600-9007 https://www.uhcprovider.com/en/health-plans-by-state/ohio-health-plans/oh-comm-plan-home.html

PROVIDER COMPLAINTS

Work directly with the Plan first

If not resolved, submit a complaint to Ohio Department of Medicaid (ODM) at http://www.ohiomh.com/ProviderComplaintForm.aspx

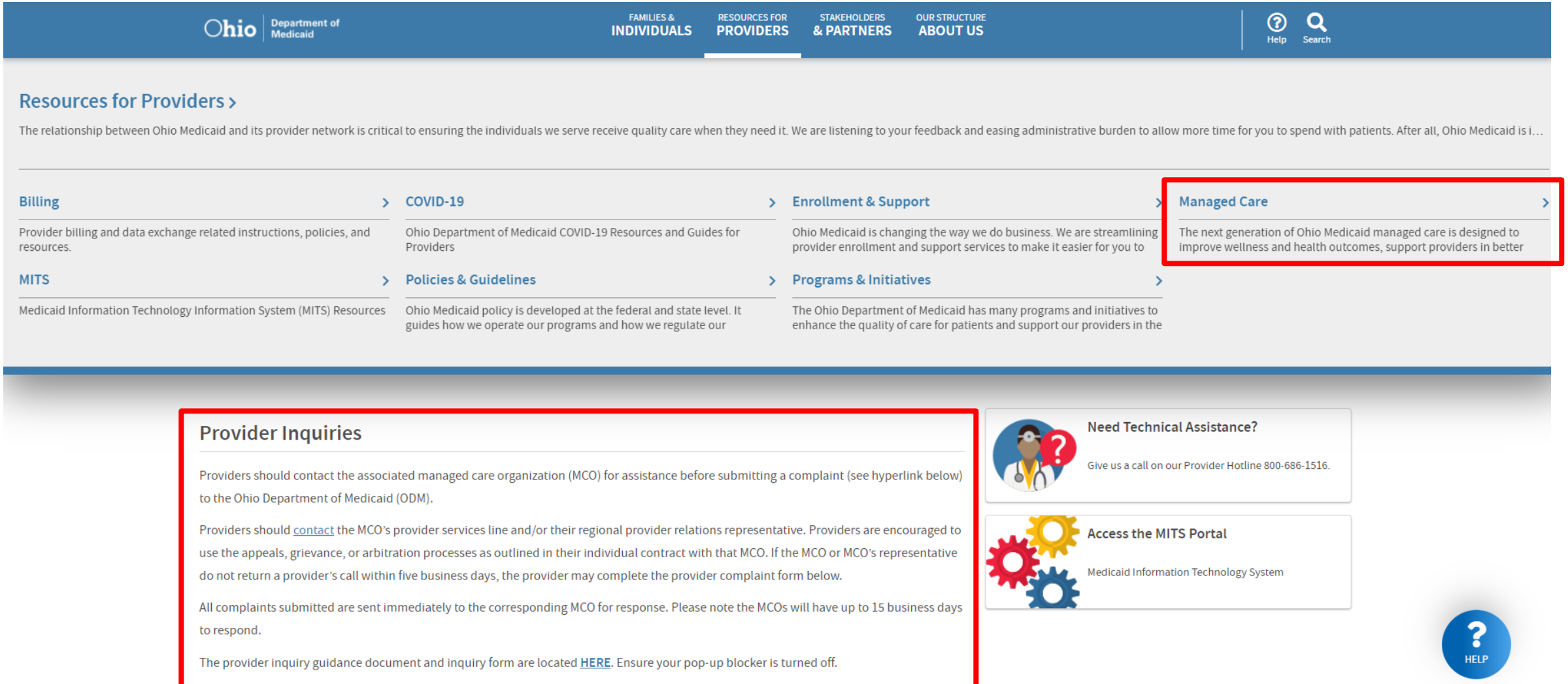
Certification issues

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

Provider credentialing concerns

Please send to Ohio Department of Insurance (ODI)

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.

OH Medicaid *Managed Care* Provider Complaint Form

Instructions

This form is for Managed Care providers only. Providers must appeal denied claims to the MCP before the Ohio Department of Medicaid will process a complaint. If your complaint involves multiple Managed Care Plans (MCPs), please complete one form per MCP. The resolution timeframes for Managed Care complaints are 2 business days for complaints involving access to care, and 15 business days for all other issues. If you have a complaint regarding Medicaid Fee For Service please call 1-800-686-1516.

Complaint Details

MCP Name: *

Complaint Reason: *

* Are you contracted with this Health Plan? ○ Yes ○ No

* Is this complaint related to the MyCare Program? ○ Yes ○ No

* Have you already contacted the MCP about this issue? ○ Yes ○ No

* Is this complaint related to any previously submitted complaints? ○ Yes ○ No

* Is this complaint related to children with special health care needs? ○ Yes ○ No

* Is the patient receiving or seeking mental health or substance abuse services? ○ Yes ○ No

Provider Responsibilities

Provider Enrollment and Revalidation

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

There is also a federally required 5 year revalidation

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

Online applications can be found on our website

Provider Enrollment and Revalidation

There is a federally required, non-refundable application fee when a provider submits a new or revalidation application

The 2018 fee is $569.00 per application

This fee applies to organizational providers only (not individual providers, practitioners, or practitioner groups)

Provider Agreement: OAC 5160-1-17.2

General Reimbursement Principles:

OAC 5160-1-02

+

Medicaid Payment: OAC 5160-1-60

→

The department's payment constitutes payment-in-full for any of our covered services

Providers are expected to bill the department their Usual and Customary Charges (UCC)

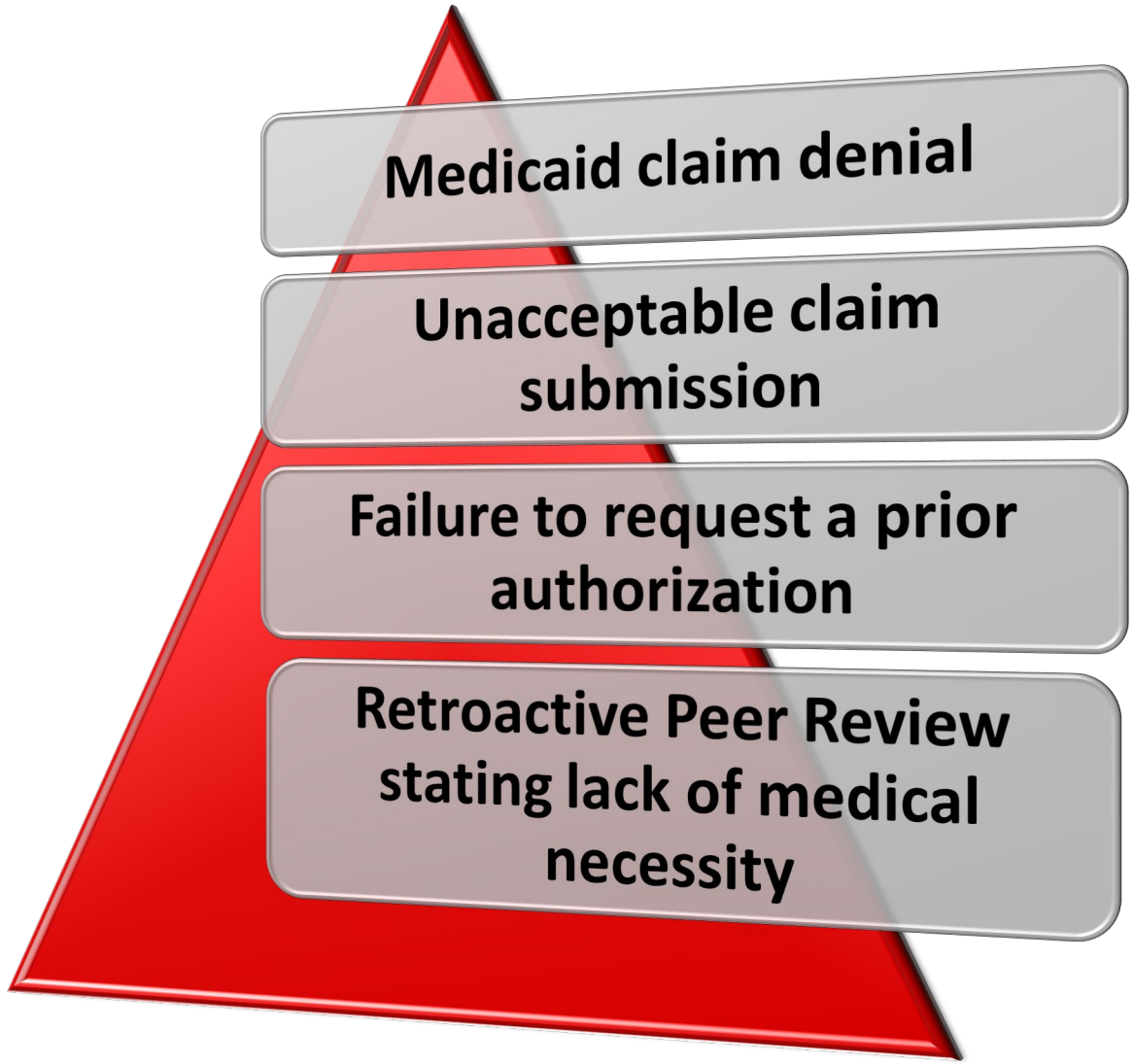
The department will reimburse the provider the lesser of the Medicaid maximum allowable rate (established fee schedule) or the UCC

Coordination of Benefits: OAC 5160-1-08

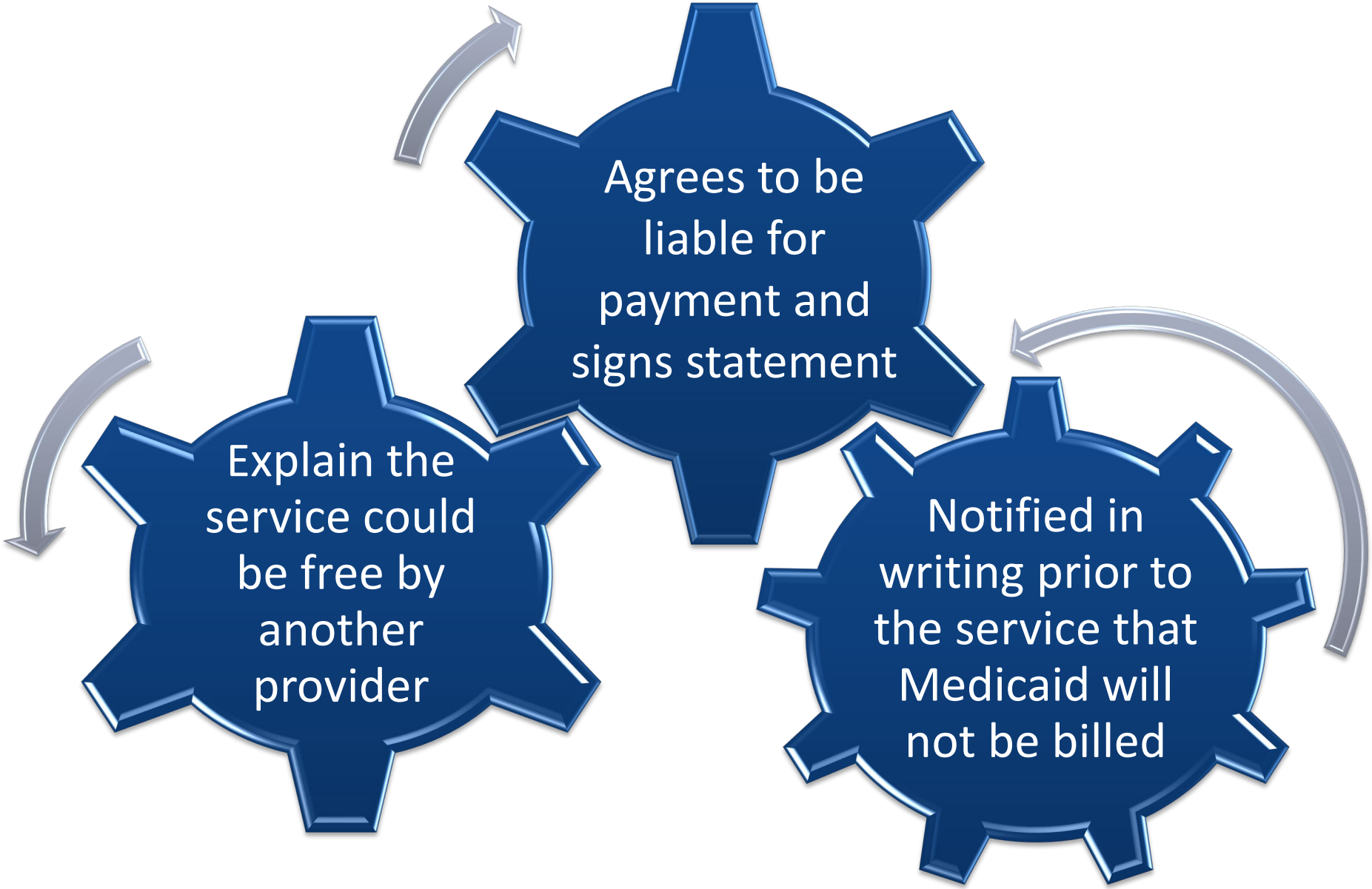
- The Ohio Administrative Code requires that a Medicaid consumer provide notice to the department prior to initiating any action against a liable third party
- The department will take steps to protect its subrogation rights if that notice is not provided
- For questions, contact the Coordination of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

Medicaid Consumer Liability 5160-1-13.1

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

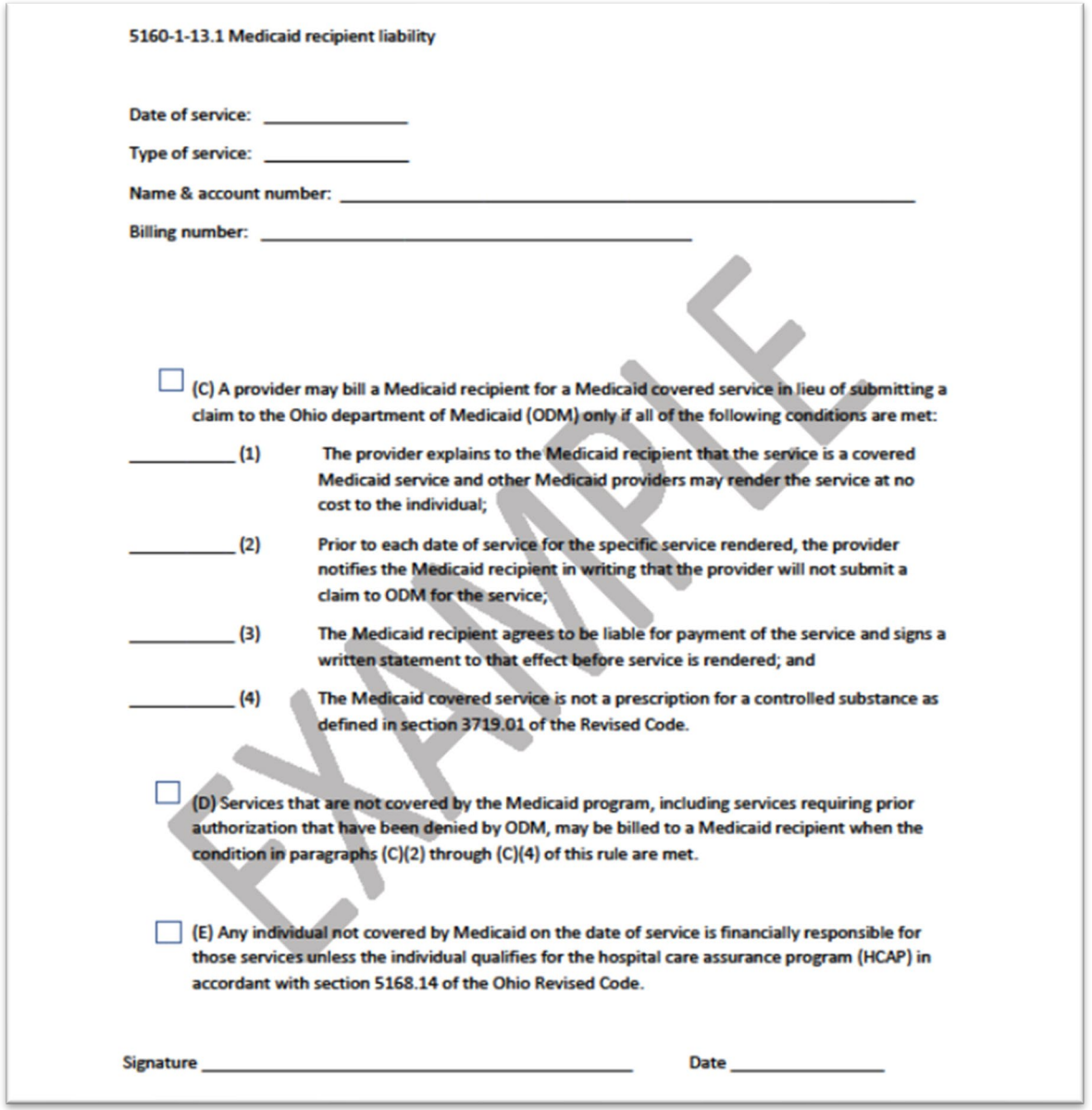


When Can you Bill an Individual?



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.

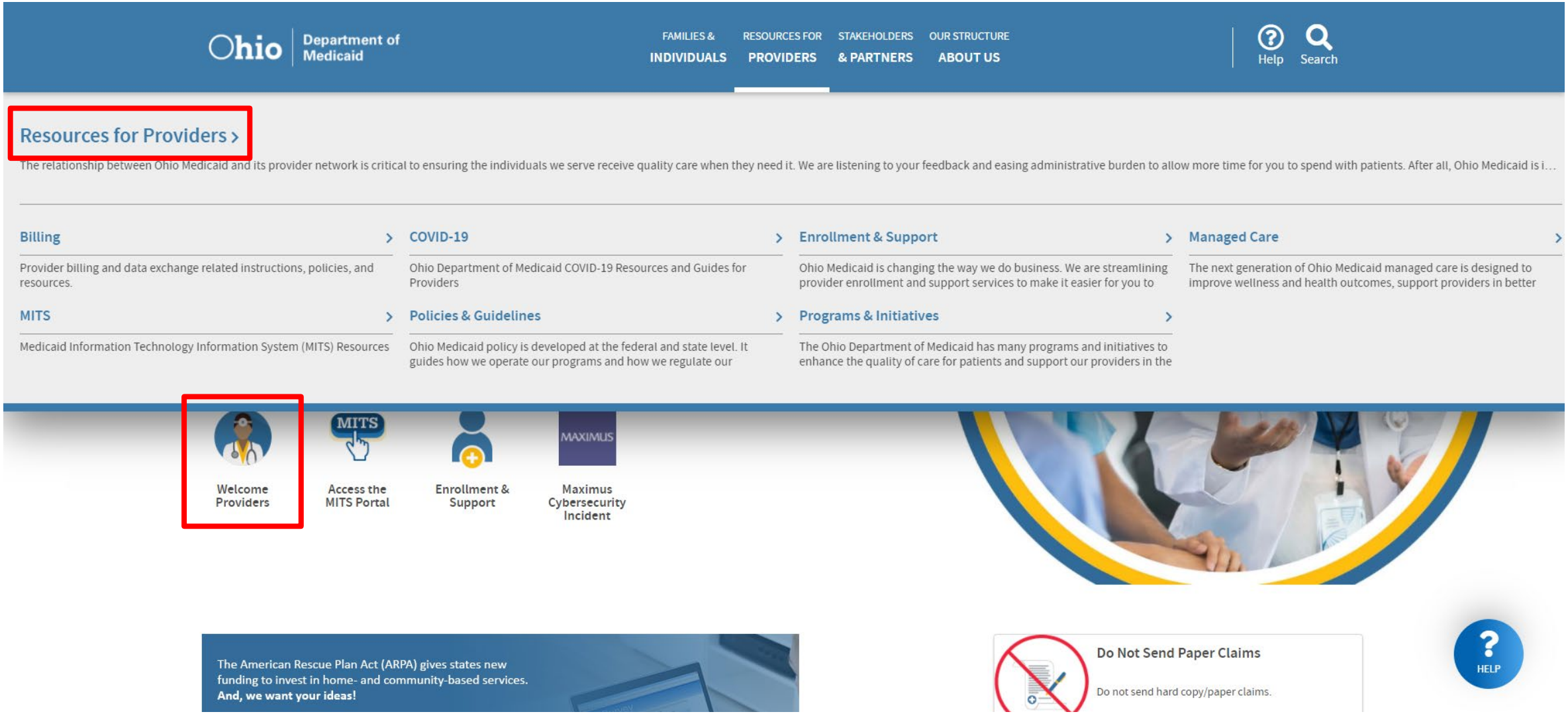
☐ (D) Services that are not covered by the Medicaid program, including services requiring prior authorization that have been denied by ODM, may be billed to a Medicaid recipient when the condition in paragraphs (C)(2) through (C)(4) of this rule are met.

☐ (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 Responsibilities



Policy

Policy updates from Ohio Medicaid announce the changes to the Ohio Administrative Code that may affect providers. There are three types of letters:

- Medicaid Transmittal Letters (MTL)
- Hospital Handbook Transmittal Letter (HHTL)
- Medical Assistance Letter (MAL)

Medicaid Transmittal Letter (MTL) No. 3336-18-01

- Effective 4/1/2018 the following modifiers will be used for APRNs:
  - ***SA*** indicates a service performed by a **CNP**
  - ***SB*** indicates a service performed by a **CNM**
  - ***UC*** indicates a service performed by a **CNS**
  - ***QX*** indicates an anesthesia service performed by a **CRNA** (or anesthesiologist assistant) with the medical direction of an anesthesiologist
  - ***QZ*** indicates an anesthesia service performed by a **CRNA** without the medical direction of an anesthesiologist
  - ***AS*** indicates a service performed by an assistant-at-surgery
    - No additional modifier (SA, SB, or UC) is used to indicate an APRN (the practitioner is identified by NPI as the rendering provider)

Medicaid Advisory Letter (MAL) No. 612

Guidelines on how to complete these forms are found in the rules listed below:

OAC 5160-21-02.2

- **ODM 03199** Acknowledgement of Hysterectomy Information(formerly ODJFS 03199)
- **HHS-687** (OMB 0937 0166) Consent for Sterilization

OAC 5160-17-01

- **ODM 03197** Abortion Certification Form(formerly ODJFS 03197)

Medicaid Advisory Letter (MAL) No. 612

ODM will cover sterilization services if all the following requirements of the OAC and CFR are met:

- The individual is at least twenty-one years old at the time consent is obtained
- The individual is not mentally incompetent
- The individual is not institutionalized
- The individual has voluntarily given informed consent

Medicaid Advisory Letter (MAL) No. 612

Form **ODM 03197** must be completed before payment can be made for the following codes:

CPT

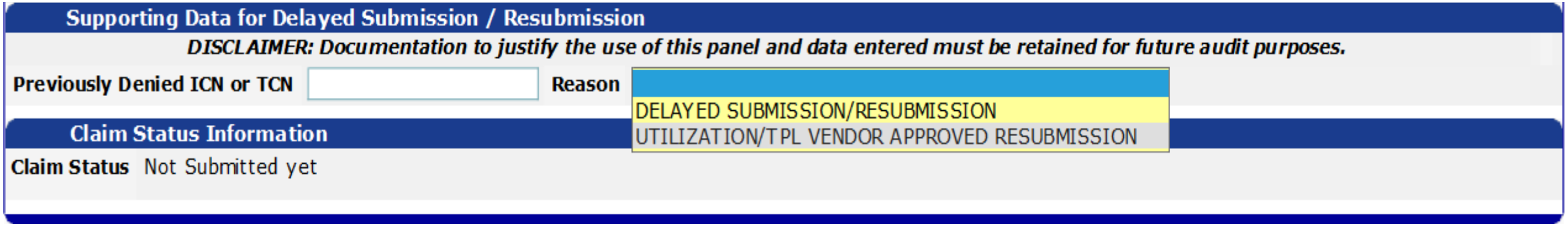
59840	
59841	59850
59851	59852
59855	59856
59857	59866

ICD-10

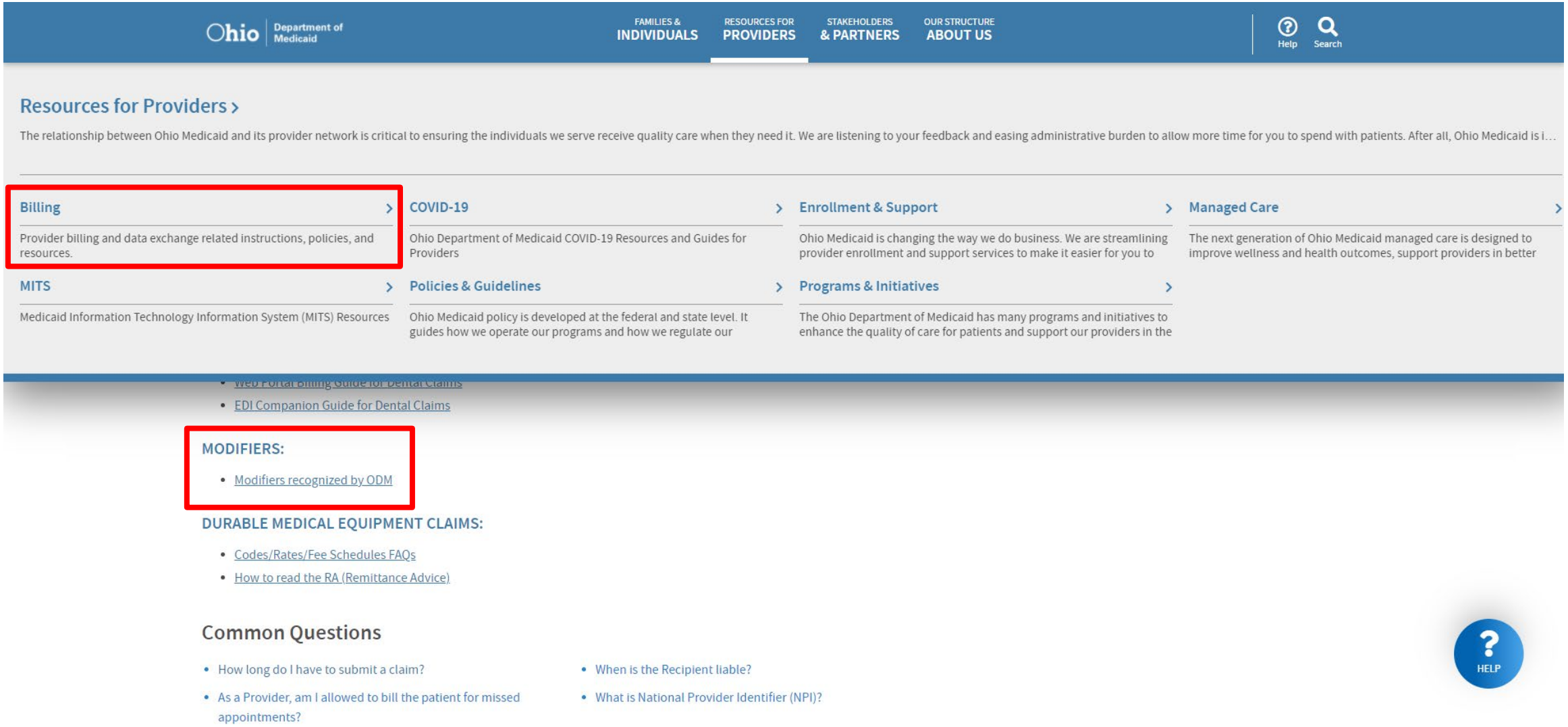
10A00ZZ	10A03ZZ
10A04ZZ	10A07ZX
10A07Z6	10A07ZW
10A07ZZ	10A08ZZ

New Explanation of Benefits Codes for Hospitals HHTL 3352-16-02

- Must use “utilization/tpl vendor approved resubmission” as the reason
- Must use the 56 ICN for the takeback



How to Find Modifiers Recognized by Ohio Medicaid



Ambulatory Surgical Centers (ASC) 5160-22-01

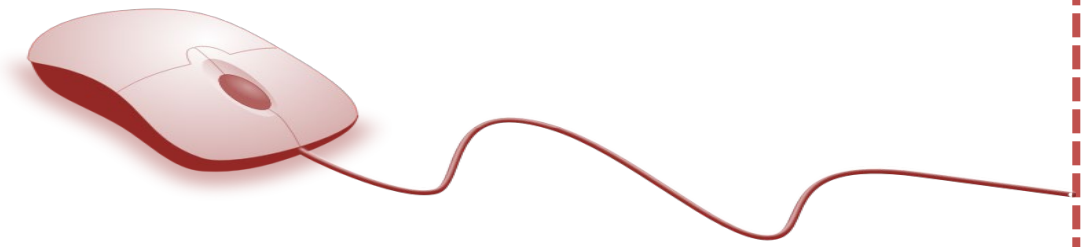
- ASC claims process through 3M's Enhanced Ambulatory Patient Group (EAPG) software
- EAPGs use procedure codes, not diagnosis codes, as initial classification
- ASC EAPG Payment
  - DME and Pharmaceuticals pay outside EAPG
  - Use same EAPG relative weights as outpatient
  - All ASC have same base rate
  - Lab and radiology services are paid the lesser of the EAPG payment or billed charges
- ASC Base Rate = $83.34 and ASC Cost-to-Charge Ratio = 20%
  - ASC base rate and CCR is equal to 80% of statewide average Outpatient Hospital base ra
    CCR

ASCs Payment: OAC 5160-22-01

- Prior Authorizations (PA) need to be requested for select codes
  - The covered code list has a PA indicator on the codes that now require a PA
- Use the MITS provider portal to request a PA
- ASCs are PA assignment type 57

ASCs Payment: OAC 5160-22-01

- The expanded code list can be found at:
  https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates



- Two webinars available for ASC's
  - PA training webinar
    https://attendee.gotowebinar.com/recording/1363716958699805953
  - EAPG training webinar
    https://attendee.gotowebinar.com/recording/5547934847121846795

DRC Inpatient Hospitalization

Process *Overview*

1. ODRC sends applications to ODM Direct Enrollment Unit for offenders who are admitted to a hospital for a period of at least 24 hours

2. ODM Direct Enrollment Unit processes the application and maintains the case in their ODM caseload

3. Eligibility for a full year is approved, then Pre-Termination Review (PTR) to determine if there is a need to keep them on Medicaid

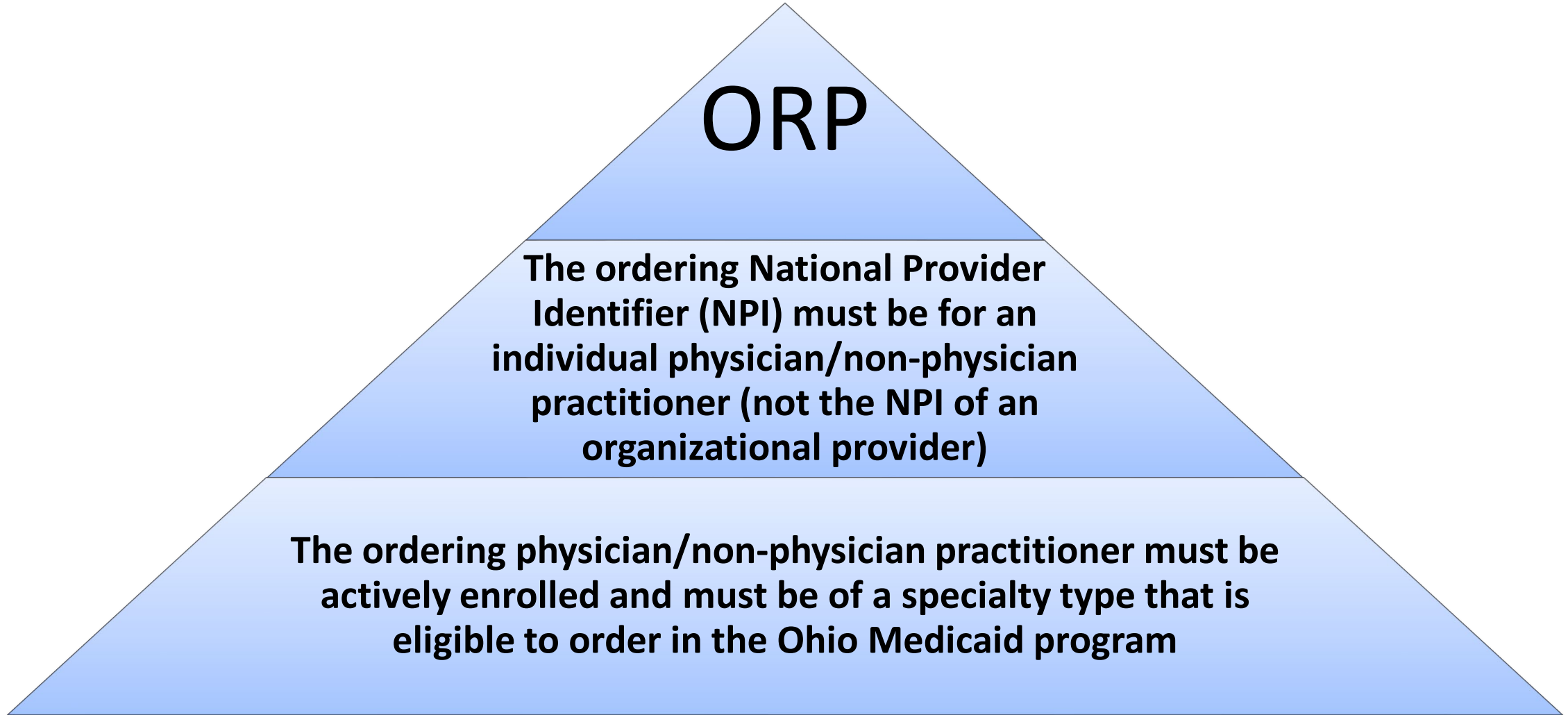
Inpatient Hospital Services Plan (IHSP)

There is *no length of time* limit for services as long as the individual continues to be eligible for Medicaid and is receiving services as an inpatient in the medical facility

72 hour roll-in for outpatient services does not apply for IHSP individuals

Outpatient services prior to the date of admission must be submitted to DRC or the correctional facility for payment

OAC 5160-1-17.9 Ordering, Referring and Prescribing Providers



OAC 5160-1-17.9 Ordering, Referring and Prescribing Providers

Providers should ensure that services are being ordered, referred, or prescribed by an eligible provider who is enrolled in Medicaid		
Providers may enroll as an ORP-only provider or as a Medicaid billing provider	ORP-only providers have an expedited screening process	Online applications can be found on our website

Eligible Providers: OAC 5160-2-01

- Allows MCP to cover inpatient psychiatric services
- Only for individuals aged 21 - 64
- This policy does not apply to traditional FFS Medicaid

General Provisions: OAC 5160-2-02

– Three Calendar Day Roll-In

- Outpatient (OP) services provided within three calendar days prior to the date of admission will be covered as inpatient (IP) services
- Including emergency room and observation services
- “From Date” should start with the first date of OP and the “Through Date” should be the date of discharge
- “Admit Date” field is the day the patient was admitted as IP

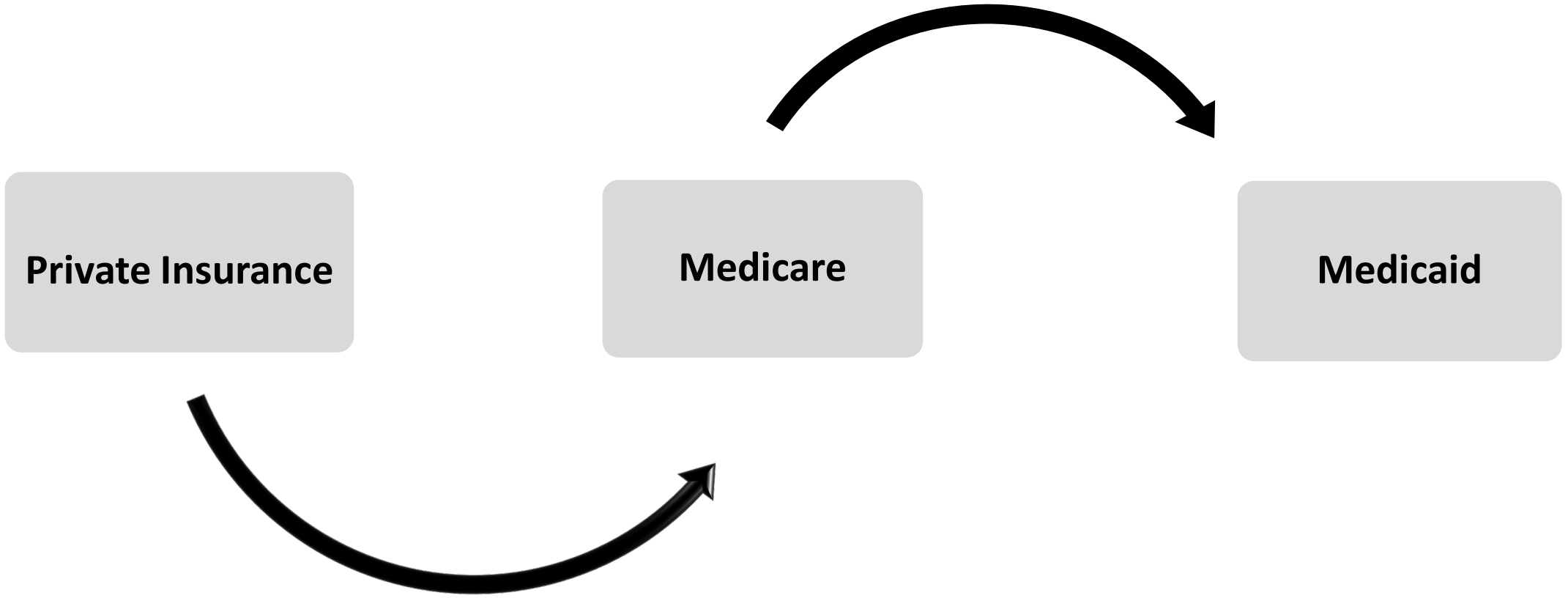
Potentially Preventable Readmissions (PPR) Program: OAC 5160-2-14

- Reduces payment for clinically-related and clinically-preventable readmissions
  - Encourages underperforming hospitals to improve the level of care provided during a patient's inpatient admission
  - A hospital with excess readmissions* will be subject to a reduction of their hospital-specific base rate by one percent

* Defined as an actual-to-expected readmission ratio of greater than one

Coordination of Benefits: Hospital Services: OAC 5160-2-25

HHTL 3352-17-04



Payment to be made only after any available third-party benefits are exhausted

Inpatient Hospital Services: OAC 5160-2-65

Fixed cost outlier thresholds for dates of discharge on or after ***7/4/17***

- Neonate and tracheostomy DRGs = $25,000
- Major Teaching or Children's Peer Group Hospitals = $60,000
- All other DRGs/Peer Groups = $75,000

Inpatient Hospital Services: OAC 5160-2-65

Interim bill is for advanced billing of an extended inpatient hospital stay

- All Interim Bills (Bill Type 112 & 113) must be for periods of 30 days or more
- DRG-Exempt providers may submit a Final Interim (Bill type 114) to close out the stay
- DRG Hospitals must void all Interim Bills and submit a final admit through discharge bill (Bill Type 111) for the entire stay
- DRG Hospitals will be paid their hospital-specific inpatient cost-to charge ratio for Bill Types 112 and 113

Transfer Billing : Located in the hospital billing guidelines

Section 2.1.1
- Transfer between Acute Care and Medicare Distinct Part Psychiatric Units

Section 2.1.2
- Multiple Transfers between Acute Care and Medicare Distinct Part Psychiatric Units

Section 2.1.3
- Transfers between Acute and Distinct Part Rehabilitation Units

Reimbursement for Outpatient Hospital Services: OAC 5160-2-75

- Establishes the Enhanced Ambulatory Patient Groups (EAPG) as the reimbursement logic for outpatient services

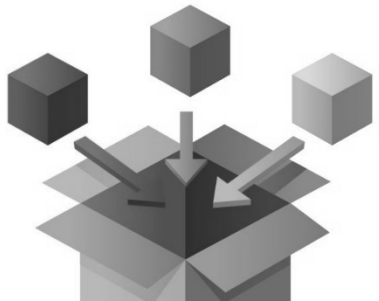
- CPT codes are updated annually on January 1st, so hospitals cannot submit a claim that spans **12/31** and **1/1** of any year

Reimbursement for Outpatient Hospital Services: OAC 5160-2-75

- EAPG Packaging
  - Uniform list of EAPGs that always package with significant procedures or medical visit EAPGs
    - Example: Incidental medical supplies (i.e. gauze, dressings, sutures, etc.) on a surgery claim
    - Example: Lab test on same day as a surgery
  - If ancillary service is on the claim on its own, packaging may or may not apply

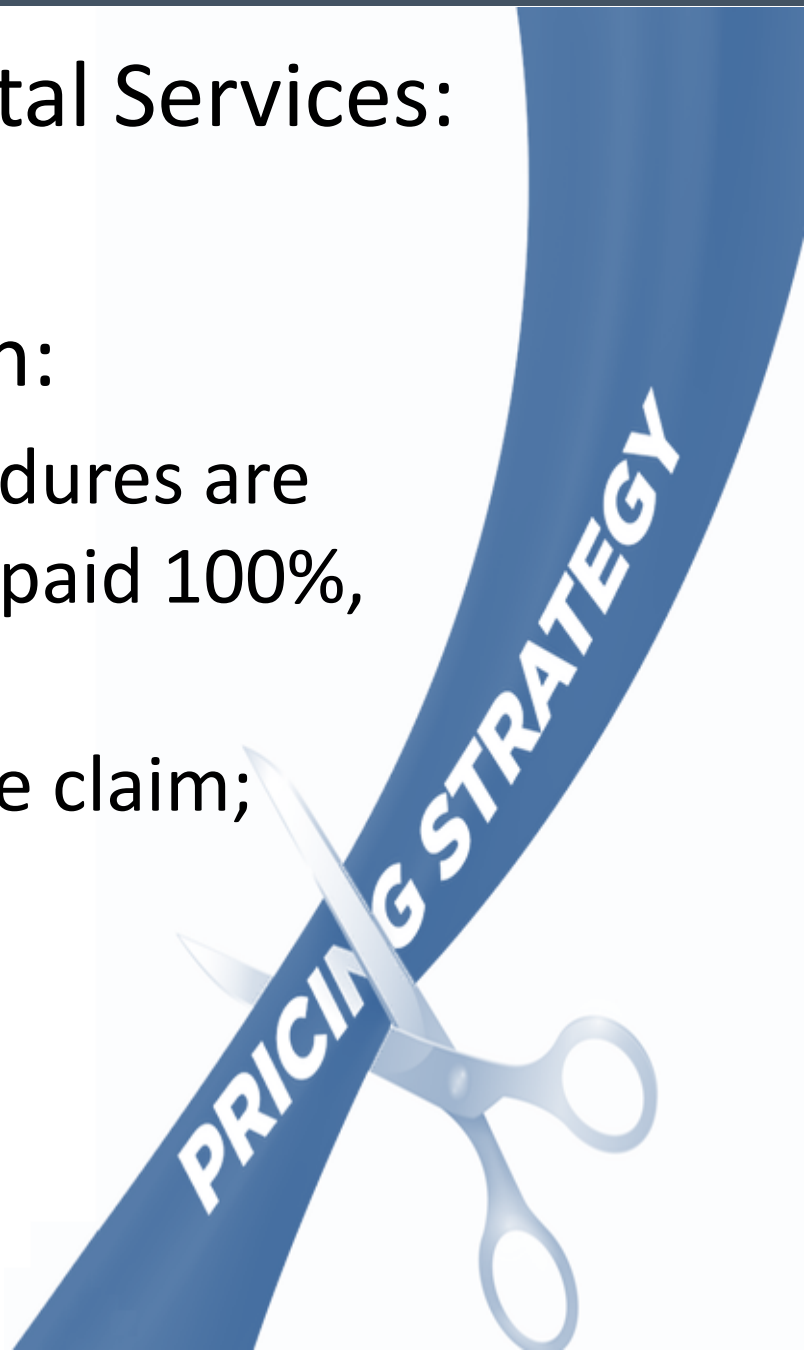
Reimbursement for Outpatient Hospital Services: OAC 5160-2-75

- Significant Procedure Consolidation
  - When a patient has multiple significant procedures, some of the significant procedures may require minimal additional time or resources
  - Significant procedure consolidation collapses multiple related significant procedure EAPGs into a single EAPG for payment
    - *Example*: EAPG 063 Level II Endoscopy would pay 100%, but if EAPG for Level I Endoscopy was on the same claim, it would consolidate with EAPG 063 (no separate payment)



Reimbursement for Outpatient Hospital Services: OAC 5160-2-75

- Discounting pricing logic is used when:
  - Multiple unconsolidated significant procedures are on the claim; highest weighted EAPG is paid 100%, secondary 50%
  - Multiple unpackaged ancillaries are on the claim; highest weighted EAPG is paid 100%, secondary 50%
  - Modifiers (e.g. 50, bilateral procedure) are present; code with modifier 50 is paid at 150% of standard rate



Reimbursement for Outpatient Hospital Services: OAC 5160-2-75

- Payment Formula:
  - Detail Payment = Base Rate * EAPG relative weight * Discount percentage (if applicable)
  - Total claim payment = sum of all detail payments
  - Lab and radiology services are paid the lesser of the EAPG payment or billed charges
  - Items consolidated or packaged are paid $0.00

Reimbursement for Outpatient Hospital Services: OAC 5160-2-75

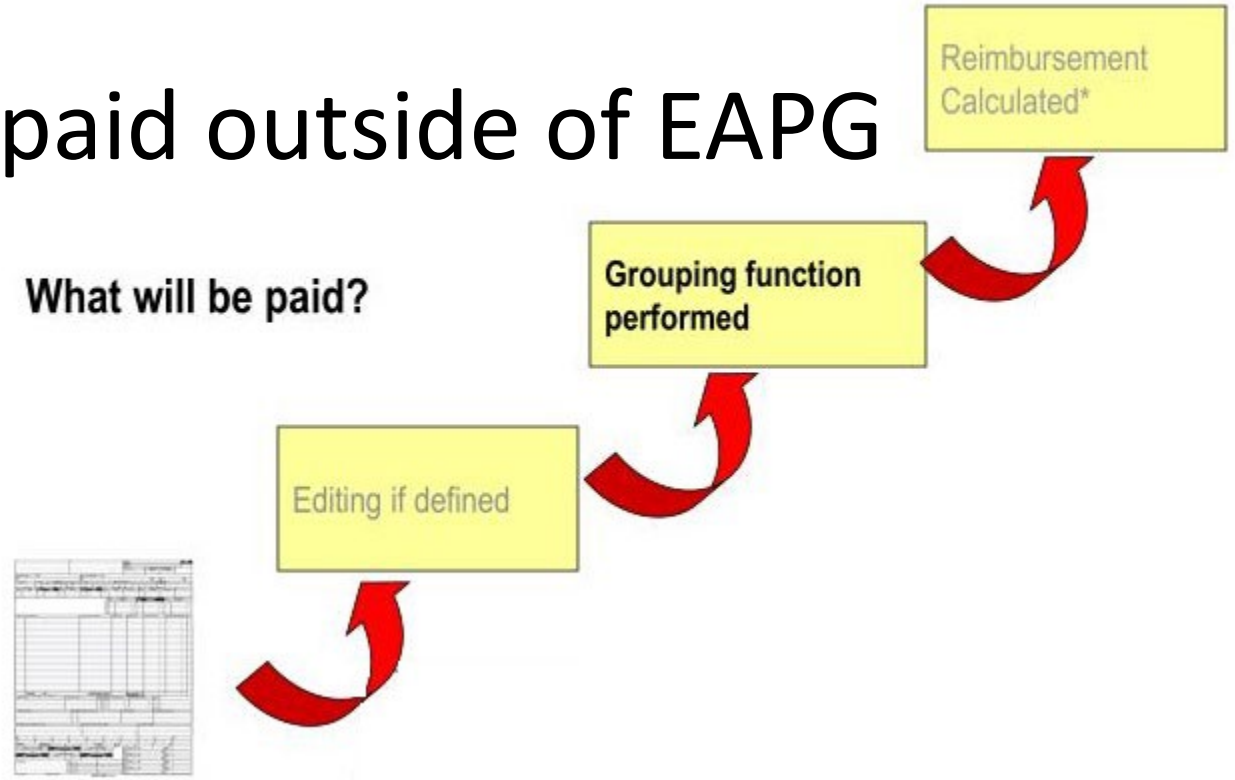
- Example payment calculation for 2 gastrointestinal EAPGs, 134-Diagnostic Upper GI Endoscopy or Intubation, and 149-Screening Colorectal Services and EGD:

Code	Description	EAPG	Relative Weight	Cleveland Clinic Base Rate	RW * Base Rate	Discounting	Final Payment
43239	EGD BIOPSY SINGLE/MULTIPLE	134	4.5552	$146.53	$667.47	100%	$667.47
45380	COLONOSCOPY AND BIOPSY	149	4.3758	$146.53	$641.19	50%	$320.59
							$988.06

Reimbursement for Outpatient Hospital Services: OAC 5160-2-75

➢ Pricing Outside of EAPG

– Certain services may be paid outside of EAPG



Pricing Outside of EAPG: Dental Services

- Medicaid now accepts select CDT D codes in outpatient hospital setting
- Hospitals should bill the same CDT D codes that the dentist uses on corresponding professional claim
- The outpatient hospital setting is ***NOT*** the designated place for dental procedures
  - Should only be utilized when medically necessary

Pricing Outside of EAPG: Observation

- **G0378** is the preferred code to report observation services for EAPG
  - Hourly code, so it cannot exceed 24 units per day
  - Limited to 48 hours
  - May span across 3 days

- Observation services reported with CPT codes **99217 - 99220, 99224 - 99226, 99234 - 99236** will continue to be ***limited*** to one unit per day, for a maximum of two consecutive days

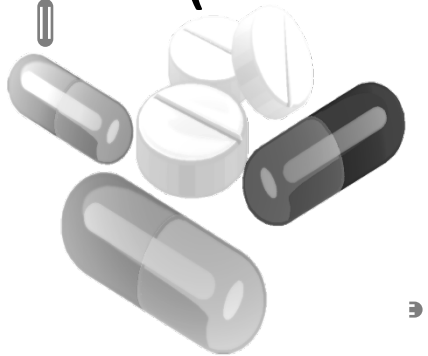
Pricing Outside of EAPG: Durable Medical Equipment (DME)

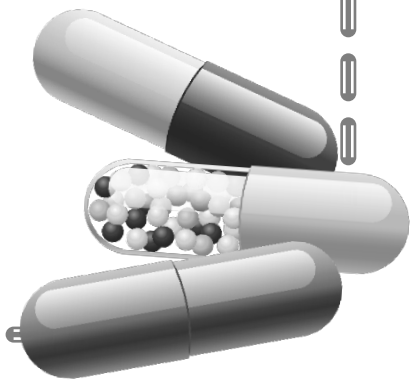
- DME that is not packaged or consolidated will reimburse the lesser of charges or the payment amount listed on the Durable Medical Equipment Fee Schedule
- EAPGs 1001 – 1020 are DME EAPGs
- If a DME item is not priced on the fee schedule, it will pay $0

Pricing Outside of EAPG: Pharmaceuticals

- Pharmaceuticals that are not packaged or consolidated will reimburse the lesser of charges or the payment amount listed on the Provider Administered Pharmaceutical Fee Schedule

- If a pharmaceutical is not on the fee schedule or is listed as 'By Report' the detail will reimburse at 60% of the hospital cost (60%*CCR*billed charges)





Pricing Outside of EAPG: Vaccines

- Vaccines for Children (VFC) may be reimbursed for individuals 18 years of age or younger
  - $10 reimbursement for administration
  - No payment for the vaccine itself

Pricing Outside of EAPG: Independently Billed Services

- Option to have only high cost items reimbursed and forego payment for any other procedure and ancillary services performed on the same date
  - Bill the UB modifier on the surgery code or main procedure code provided on the date of service
  - Submit all procedures, drugs, and medical supplies on the claim

Pricing Outside of EAPG: Independently Billed Services

- Pharmaceutical pricing is based on provider administered fee schedule when a rate exists
  - Otherwise, the payment is calculated as drug charges multiplied by the hospital's cost to charge ratio, multiplied by 60%
- Independently billed medical supplies are calculated as billed charges multiplied by the hospital's cost to charge ratio, multiplied by 60%

Pricing Outside of EAPG

– EAPG Grouper returns Pay Action Flags which tell us whether a procedure is applicable for full payment, discounting, etc.

Pay Action	Description	Affect on Payment	EOB
00	Not processed	0%	
01	Full Payment	100%	9222
02	Consolidated	0%	9221
03	Discounted	50%	9220
04	Packaged	0%	9221
05	No Payment	0%	9221
06	Bilateral	150%	9958
07	Discounted Bilateral	75%	9959
13	Alternate Payment	Flat Payment	9225
18	Lesser of Charges or EAPG Payment	100%	
85	No Payment, No Charges	0%	

Behavioral Health

- Full-managed care carve-in has been in effect since **7/1/2018**

- The following DRGs became effective **7/1/2017** for detox services provided in Psychiatric hospitals:
  - 770 – Drug & Alcohol Abuse or Dependence
  - 773 – Opioid Abuse and Dependence
  - 774 – Cocaine Abuse and Dependence
  - 775 – Alcohol Abuse and Dependence
  - 776 – Other Drug Abuse and Dependence

* Psych hospitals should submit only one claim for all inpatient services *

Behavioral Health Redesign OAC 5160-2-75 (G)(2)

- All hospitals that meet the Medicare conditions of participation may provide Outpatient BH and Substance Use Disorder (SUD) services

- Payment will match Community Mental Health Center (CMHC)/SUD agency reimbursement
  - Rates based upon the level of the professional providing the services

Behavioral Health Redesign OAC 5160-2-75 (G)(2)

- Payment will match CMHC/SUD agency reimbursement
  - Rates based upon the level of the professional providing the services
- Mental Health and SUD services are ***excluded*** from the 72-hour inpatient roll-in
  - Medical service provided in the 72 hours before an IP stay must be submitted with the IP claim

Behavioral Health Redesign OAC 5160-2-75 (G)(2)

- Each claim for MH or SUD must contain the following:
  - Modifier **HE** at the detail level for each MH or SUD CPT/HCPCS code
  - Revenue center code **025X, 0636, 0671, 771, 0900, 901, 0904, 0906, 0907, 0911, 0912, 0913, 0914, 0915, 0916, 0918, 0919 or 1002** for each MH or SUD detail line
  - A MH or SUD diagnosis code
  - Modifier signifying the highest level of practitioner who performed the service

Behavioral Health Redesign OAC 5160-2-75 (G)(2)

Allowable Revenue Center Codes (RCC) for Behavioral Health Services Provided by an OP Hospital

RCC	Description
25X	Pharmacy
636	Pharmacy - Drugs Requiring Detailed Coding
671	Outpatient Special Residence Charges - All Home or Community Based Services
771	Preventative Care Services - Vaccine Administration
780	Telemedicine
900	BH Treatment/Services
901	Electroshock Treatment
904	Activity Therapy
906	IOP - Chemical Dependency
907	Day Treatment
911	Rehabilitation
912	Partial Hospitalization - Less Intensive (Half Day)
913	Partial Hospitalization - Intensive (Full Day)
914	Individual Therapy
915	Group Therapy
916	Family Therapy
918	Testing
919	Other Psych Services
1002	Residential Treatment - Chemical Dependency

Detail lines containing these RCCs must include an 'HE' modifier

Reimbursement for LARC devices: OAC 5160-2-79

- Payment for long-acting reversible contraceptives when provided postpartum
  - Provided in an inpatient setting prior to patient's discharge
  - Billed outpatient, after a separate claim related to labor and delivery has been paid
  - Payment rates per the Provider-Administered Pharmaceuticals fee schedule
  - Not eligible for 340B

Reimbursement for LARC devices: OAC 5160-2-79

- LARC device or implant must be billed using Type of Bill 131

  Only 1 detail line on claim and ***NO*** other procedure codes listed

- Paid in-patient claim must include a secondary ICD-10 CM diagnosis code for the Z37- Outcome of Delivery Range Codes

Reimbursement for LARC devices: OAC 5160-2-79

- LARC device or implant must be reported using:
  - Revenue Center Code 0278
  - Medical/Surgical Supplies and Devices
- MITS configured to pay for separate inpatient postpartum LARC claims effective 7/12/17

Inpatient Facility Stay During A Change

Managed Health Care Program: Eligibility and Enrollment OAC 5160-26-02

Who do I BILL?

Admit Plan	Enrollment Change	Responsible Plan*
FFS	FFS -> MCP	FFS
MCP	MCP -> FFS	MCP
MCP_1	MCP_1 -> MCP_2	MCP_1

340B Drugs

- Hospitals recognized as a 340B entity are required to notify ODM when 340B purchased drugs are provided to a Medicaid individual
  - 340B reporting is for outpatient claims only
  - RCC 25X or 636 should be billed with a pharmaceutical ***J*** or ***Q*** code, an NDC, and modifier SE
  - Non-340B entities using the SE modifier will have their claims denied with edit 3203

RCC 25X and/or 636 with HCPCS J-Code or Q-Code

- Provider-administered pharmaceutical HCPCS J-codes and Q-codes submitted with RCC 25X or 636 will be paid in accordance with the rate listed on the Provider Administered Pharmaceuticals Fee Schedule for that date of service.
- Provider-administered pharmaceuticals are identified on the EAPG Covered Codes List.
- If a non-provider-administered pharmaceutical is billed with RCC 25X or 636, that detail will be assigned an EAPG and will be paid in accordance with the standard EAPG reimbursement methodology.
- Reimbursement for these items are subject to the discounting factors as determined by the EAPG grouper.
- Refer to Hospital Billing Guidelines, section 3.3.1

Modifier JW – Drug amount discarded/not administered to patient

- Effective for dates of service on or after ***July 1, 2017***
  - Informational only edit, will not affect reimbursement
- If a claim (one date of service) contains **two** detail lines with the same RCC, same pharmaceutical HCPCS code, and same NDC but **one** detail line contains modifier **JW**, the second detail line will not deny as a duplicate
- EOB 9950 will post on the detail containing modifier **JW** which will result in payment of $0 for that line

Physician Assistants: OAC 5160-4-03

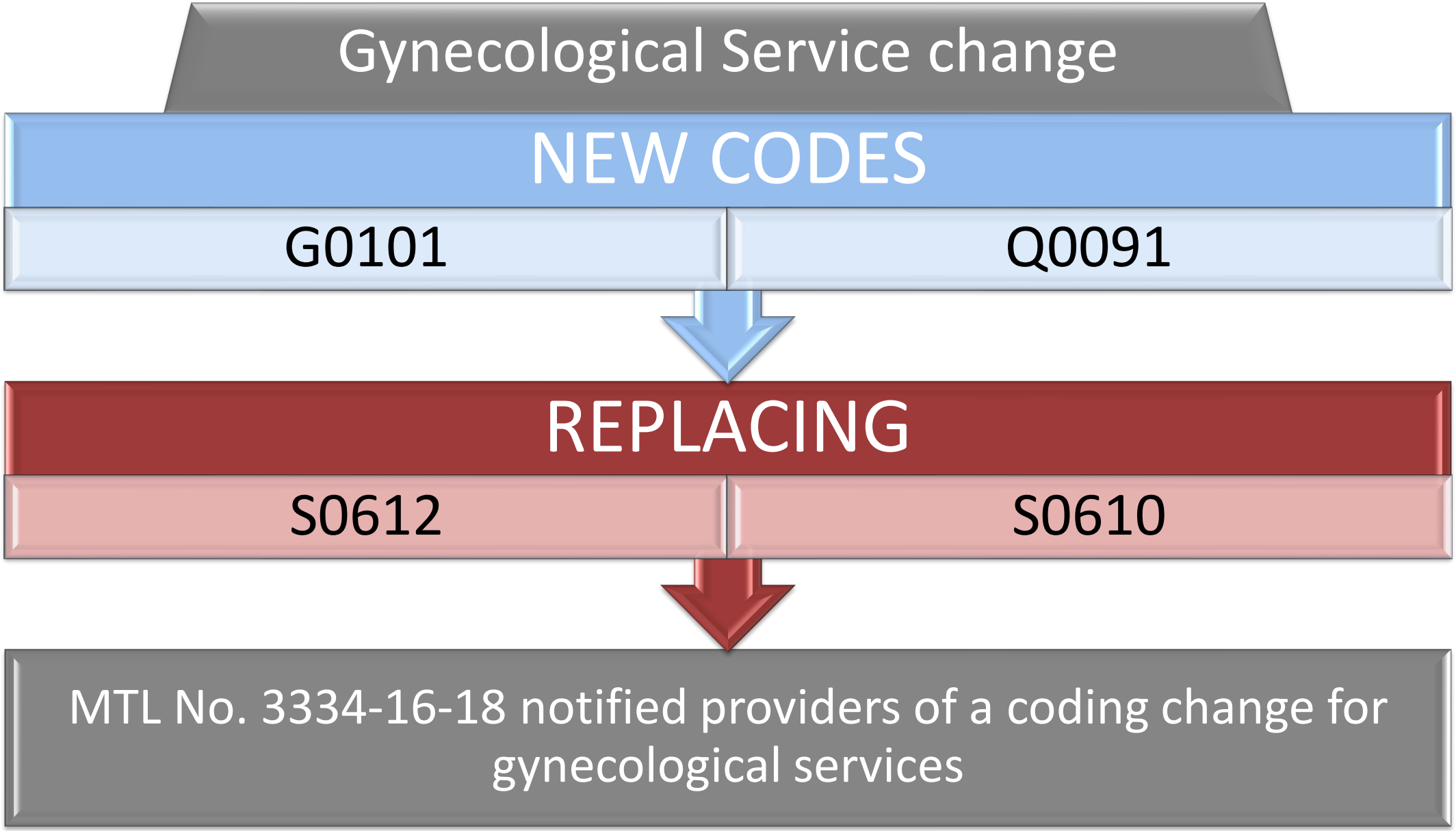
- Physician assistants are allowed to practice within their scope of practice as authorized by state law
- Physician assistants are allowed to practice within the scope of practice of the physician assistant's supervising physician
- Physician assistants may receive payment for serving as assistant-at-surgery with an ***AS*** modifier alone, when listed as the rendering provider

Advanced Practice Registered Nurse Services: OAC 5160-4-04

- APN is now Advanced Practice Registered Nurse (APRN)
- Unless a specific exception is noted, all other Medicaid rules that pertain to services by a physician apply to APRNs
- APRNs may receive payment for serving as assistant-at-surgery with an ***AS*** modifier alone, when listed as the rendering provider

Radiology and Imaging Services: OAC 5160-4-25

- When more than one imaging procedure is performed, the payment amounts remain the same for the following:
  - Covered primary procedure, additional covered total procedure, and technical component alone of an additional covered procedure
  - Must be performed by the same provider or provider group for the same patient in the same session
- The maximum payment amount for the professional component alone was increased from 75% to 95%


Gynecological Service change
NEW CODES
G0101
Q0091
REPLACING
S0612
S0610
MTL No. 3334-16-18 notified providers of a coding change for gynecological services

Pregnancy Related Services: OAC 5160-21-04

Optional preventive health services available to Medicaid eligible women and are intended to promote positive birth outcomes by supplementing regular obstetrical care

In addition to delivery services, reimbursement is available for each of the following services:

- H1000 – At Risk Assessment
- H1001 – Antepartum Management
- S9436 – Childbirth Preparation/Lamaze
- H1002 – Care Coordination
- H1003 – At Risk Education
- S9452 – Nutrition Class for pregnant women

Pregnancy Related Services:(MAL No. 605)

Three “pregnancy-related services” rules were rescinded and consolidated into this rule, effective ***1/1/17***

Provision that allows separate Medicaid payment for delivery services rendered because of multiple births

The maximum payment amount for the first delivery is 100%

The second delivery of a multiple birth is 50%

Third delivery is 25%

ODM form 03535 “Prenatal Risk Assessment” has been replaced by ODM form 10207 and the online NurtureOhio PRAF 2.0 system

MITS & Claims

Medicaid Information Technology System (MITS)

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

Technical Requirements

Internet Access (high speed works best)

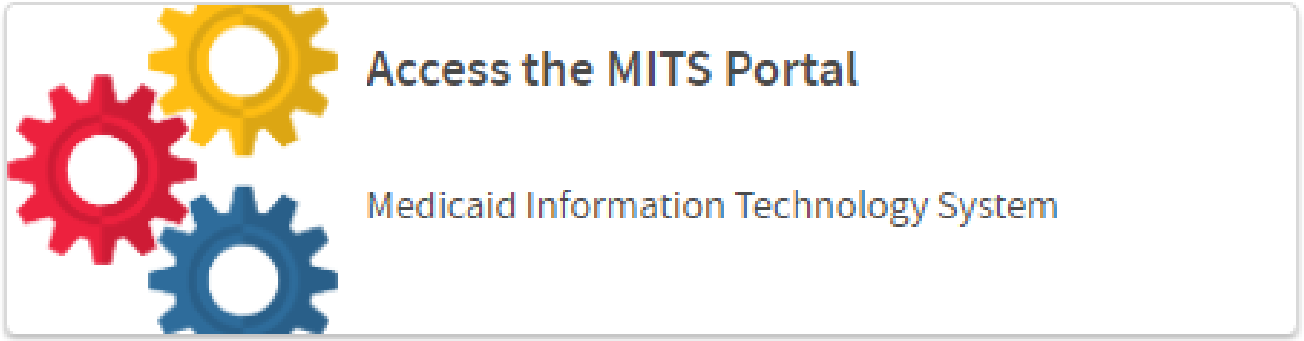
Internet Explorer version 10 or higher and current versions of Firefox or Chrome

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

Turn **OFF** pop up blocker functionality

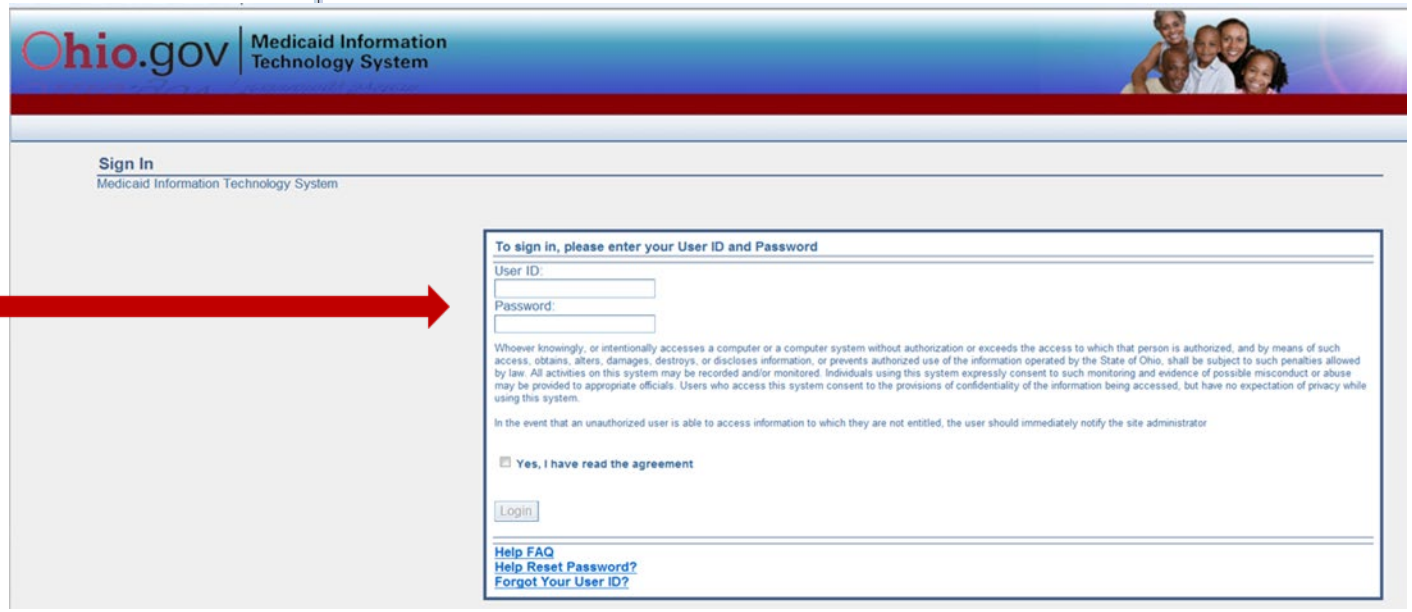
MITS

- How do I 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 then 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 weekend adjudication

MITS Portal

Free submission

Claims must be received by Friday at 5:00 P.M. for weekend adjudication

We can help with your claim submission issues!

Technical Questions/EDI Support Unit

Trading partners contact DXC for EDI Support

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

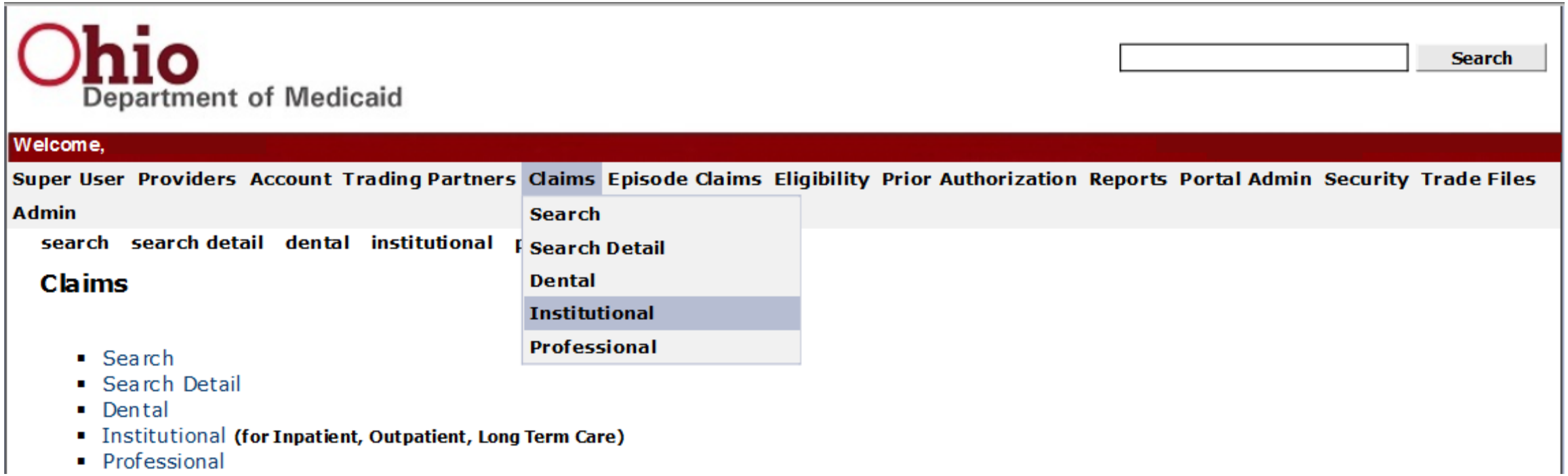
MITS Web Portal Claim Submission

Claim entry format is divided into sections or panels

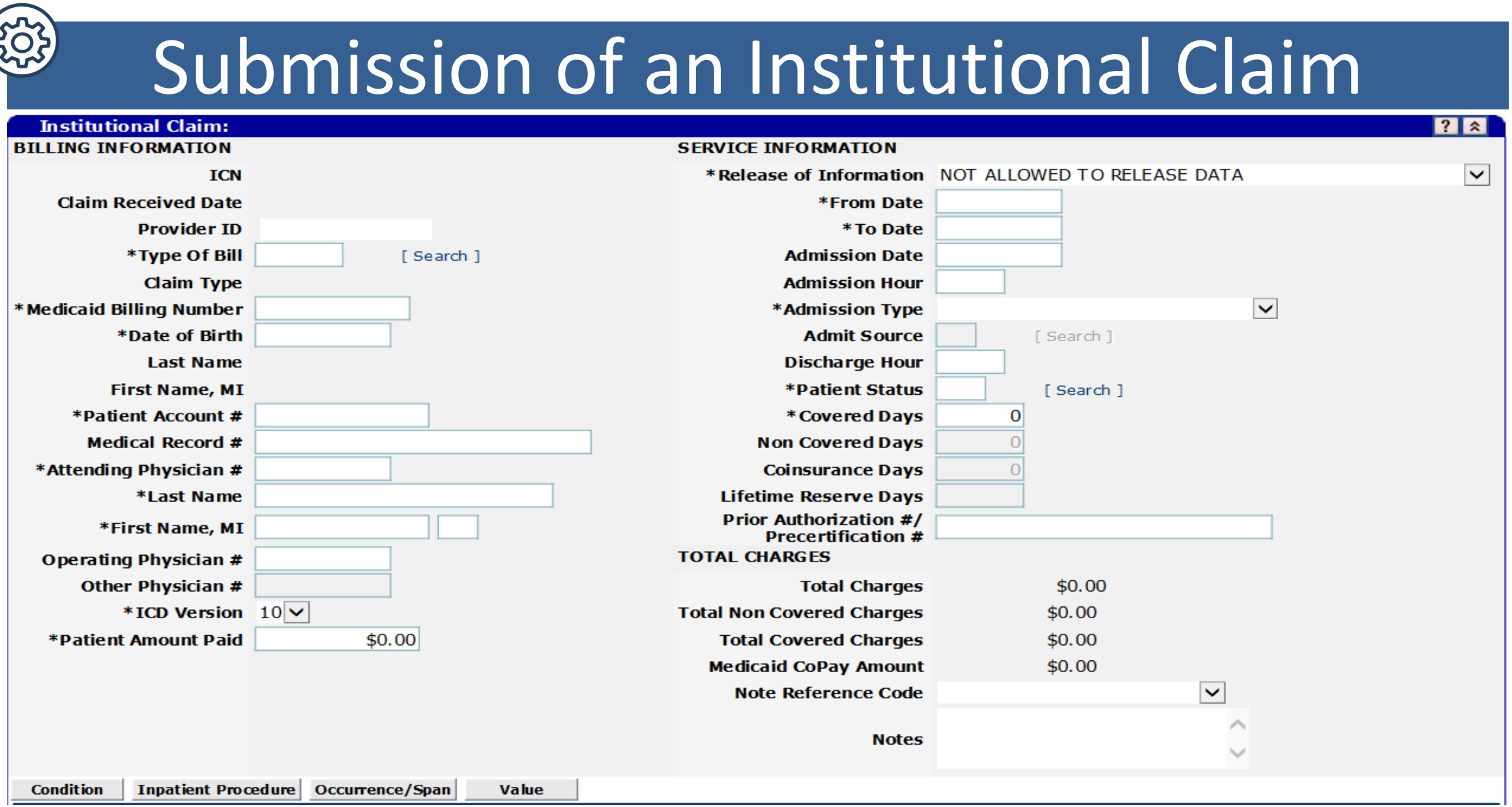
Each panel will have an asterisk (*) denoting that the fields are required

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

Submission of an Institutional Claim



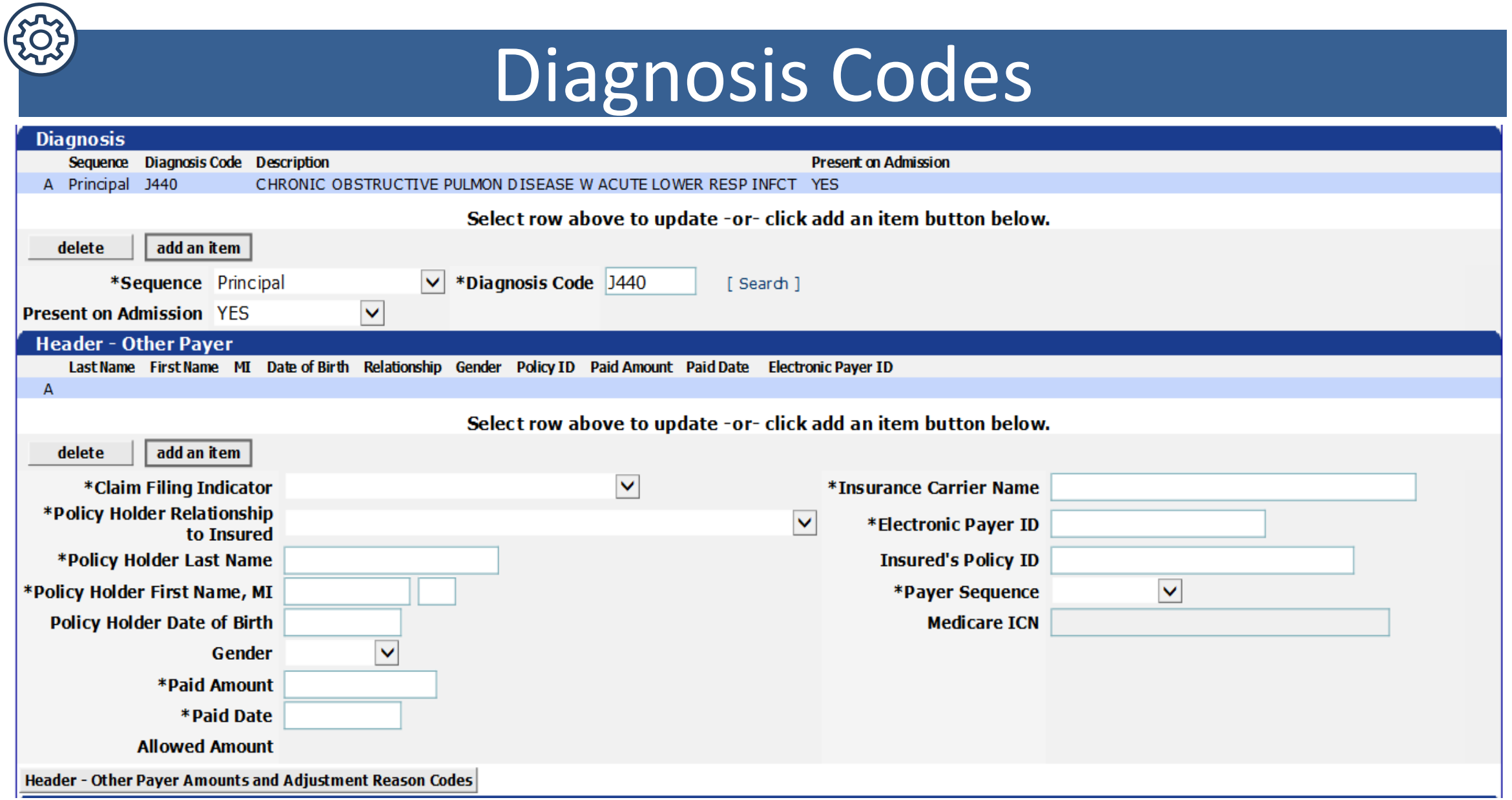
Submission of an Institutional Claim



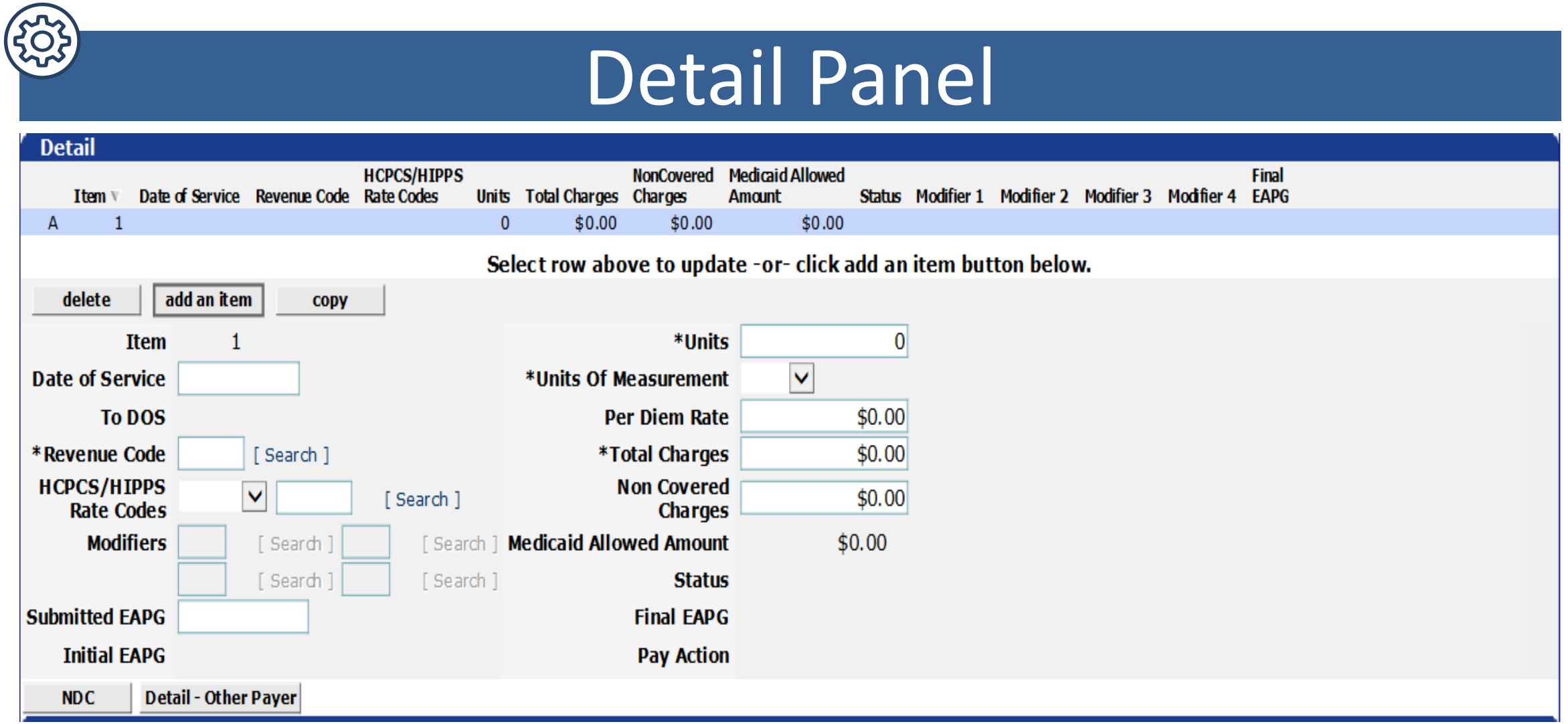
Diagnosis Codes: required on most claims

- Must include all characters specified by ICD
- Do **NOT** enter the decimal points
- There are system edits and audits against those codes

Diagnosis Codes



Detail Panel



Procedure Codes

- Multiple surgery codes have a payment limit of one unit per line
  - If billed with multiple units the claim will deny
- Procedure codes that are not identified as multiple surgery codes may be billed with multiple units
- When applicable modifiers may be needed in order to bill certain surgical procedures

National Drug Code (NDC)

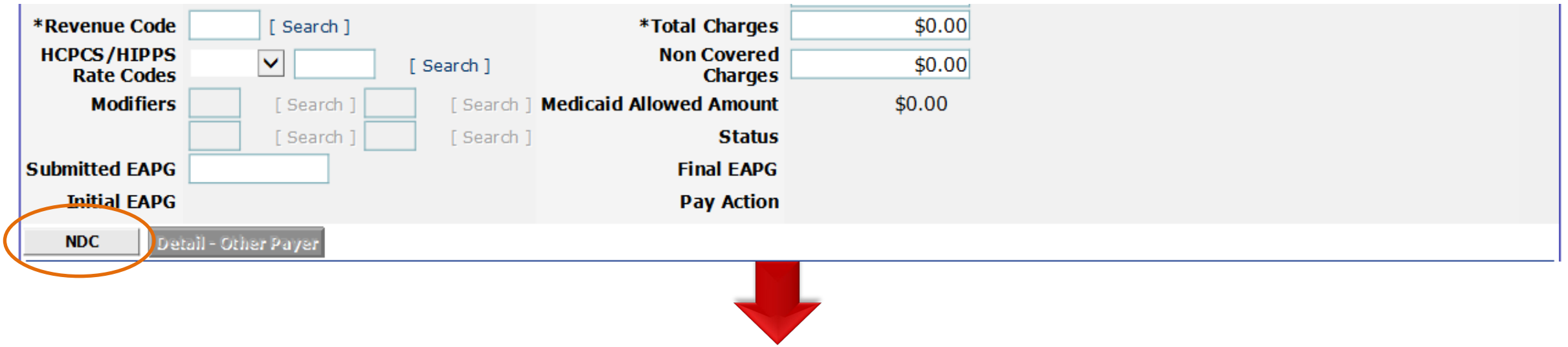
- Drug products are identified and reported using a unique, three-segment number which serves as a universal product identifier for drugs

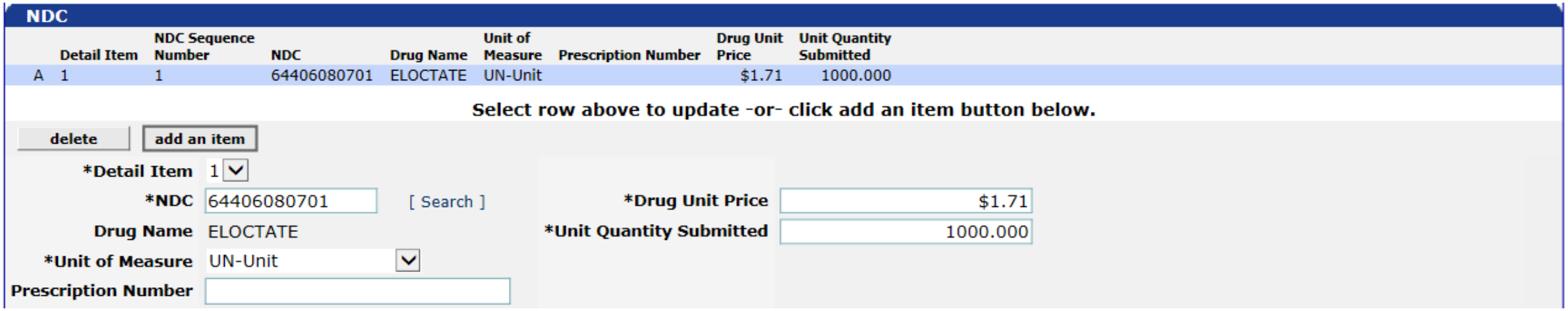
- Providers billing HCPCS codes in the **J** series and **Q** or **S** series, that represent drugs and CPT codes 90281 – 90399 series (immune globulins) must include the 11 digit NDC number

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)





- Click the “submit” button at the bottom right

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

Paid claims can be:

Voided

Adjusted

Copied

All claims are assigned an ICN

2221170357321

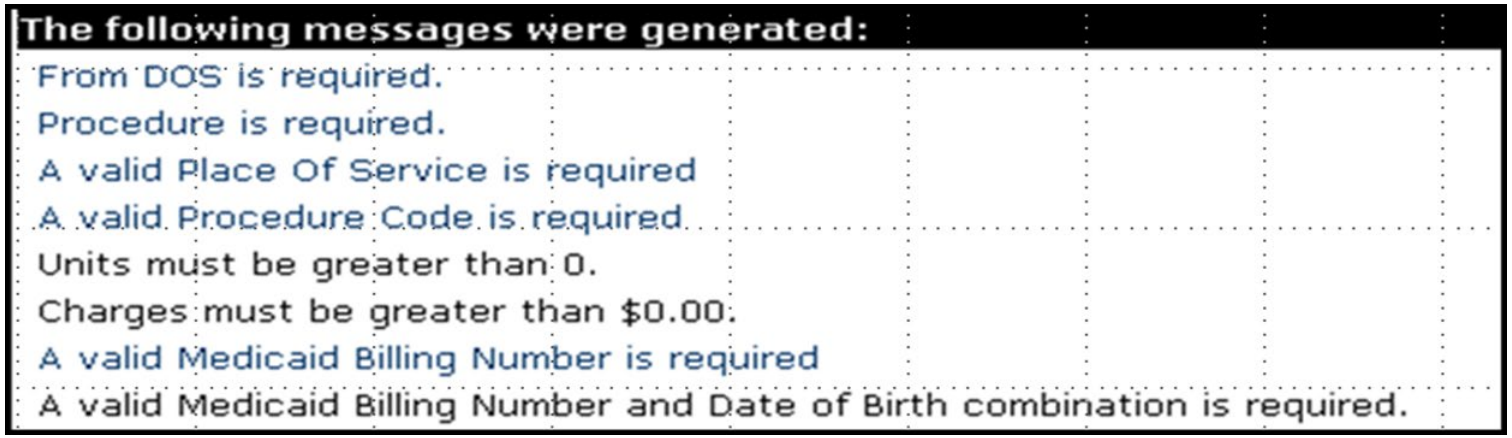
Region Code	Calendar Year	Julian Day	Claim Type/ Batch Number	Claim Number in Batch
22	21	170	357	321

Claim Portal Errors

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

Portal errors return the claim with a “fix” needed

Claim shows a ‘NOT SUBMITTED YET’ status still



Providers have 365 days to submit FFS claims

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

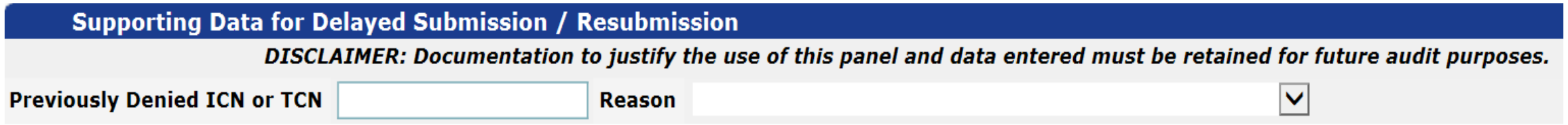
An additional 180 days from the resubmit date is given for attempts to correctly submit a denied claim prior to the end of the 365 days

Claims over 2 years old will be denied

There are exceptions to the 365 day rule

Submitting a Claim Over 365 Days Old

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



Special Billing Instructions – Eligibility Delay

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

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

Special Billing Instructions – Eligibility Delay

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

- In the Note Reference Code dropdown menu select "ADD"

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

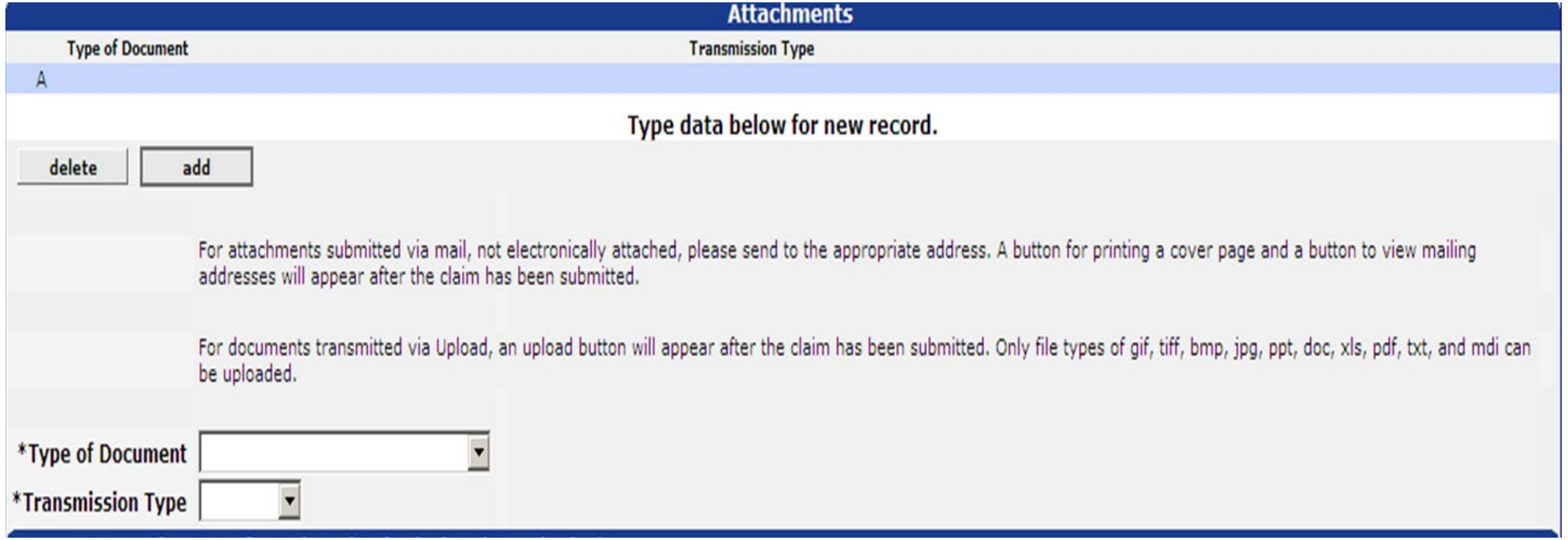
Must use the spacing shown

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

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

Example

2221180234001 Originally paid $45.00

5821185127250 Now paid $50.00

Additional payment of $5.00

2021172234001 Originally paid $50.00

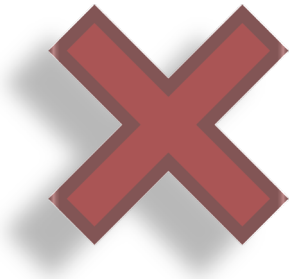
5821173127250 Now paid $45.00

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”

Example



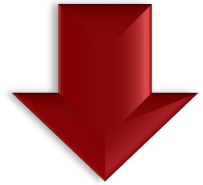
2221180234001
5821185127250

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



ClaimCheck Edits

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

The National Correct Coding Initiative (NCCI)

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

The National Correct Coding Initiative (NCCI)

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

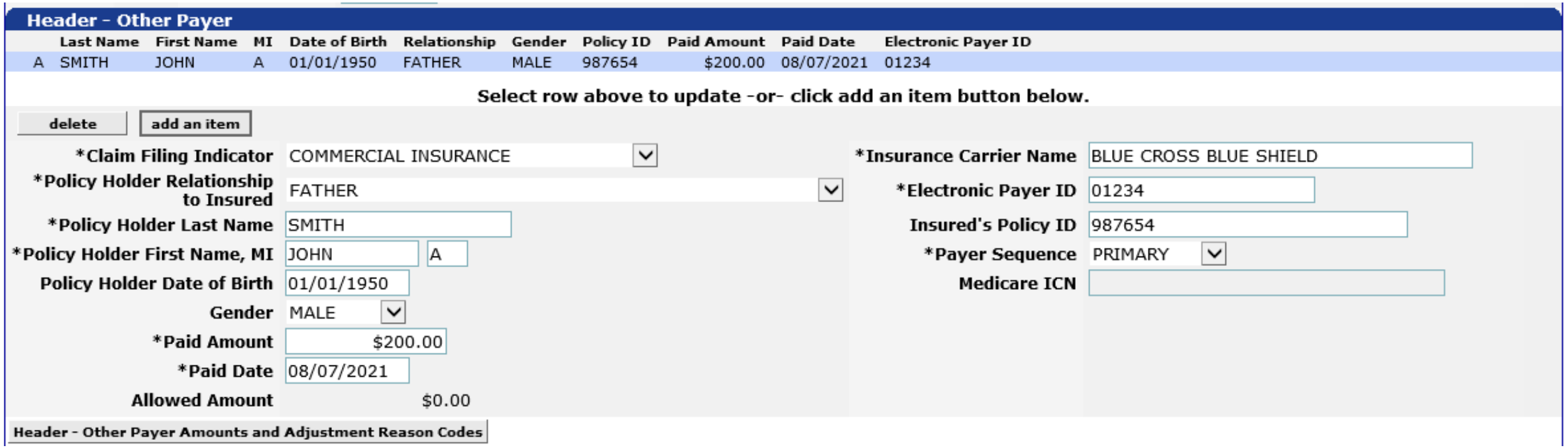
CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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

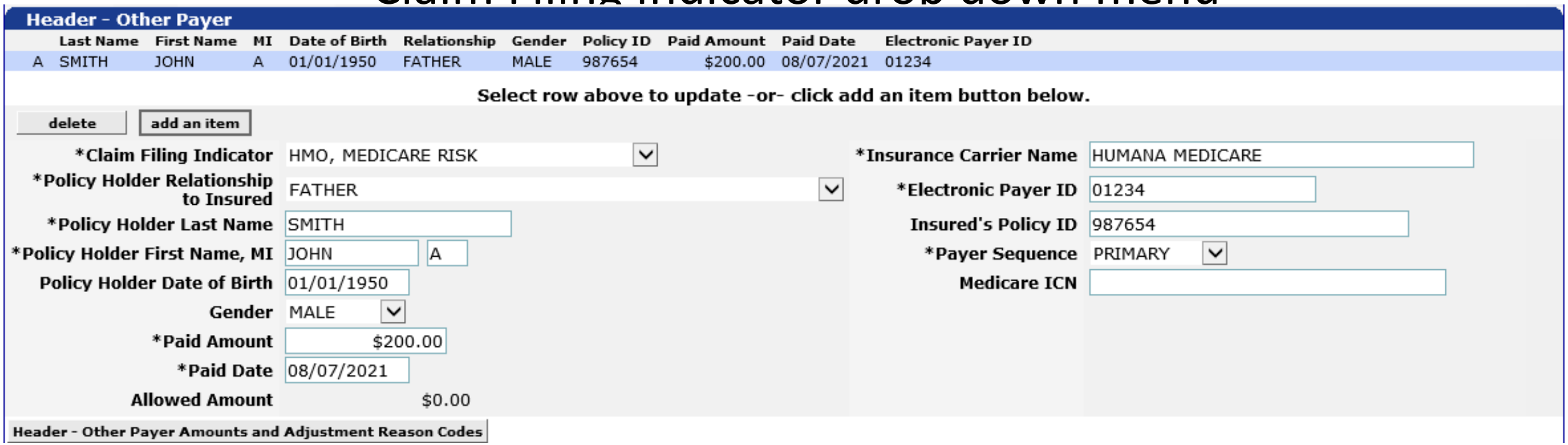
Third Party Liability (TPL) Claims

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



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 vs Detail

Header level

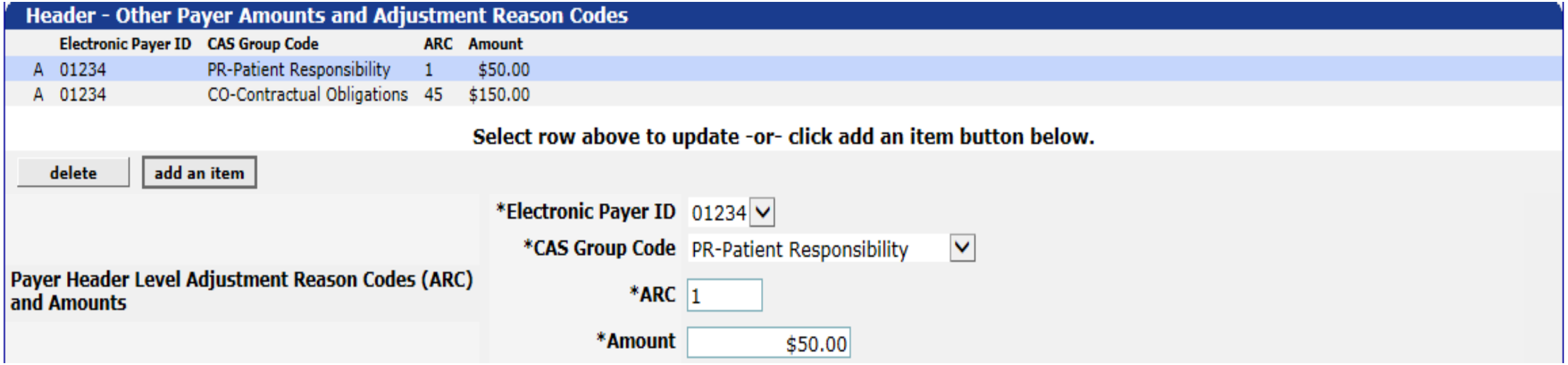
- A COB claim is considered to be adjudicated at the header/claim level if only one set of figures is reported for the entire claim

Detail level

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

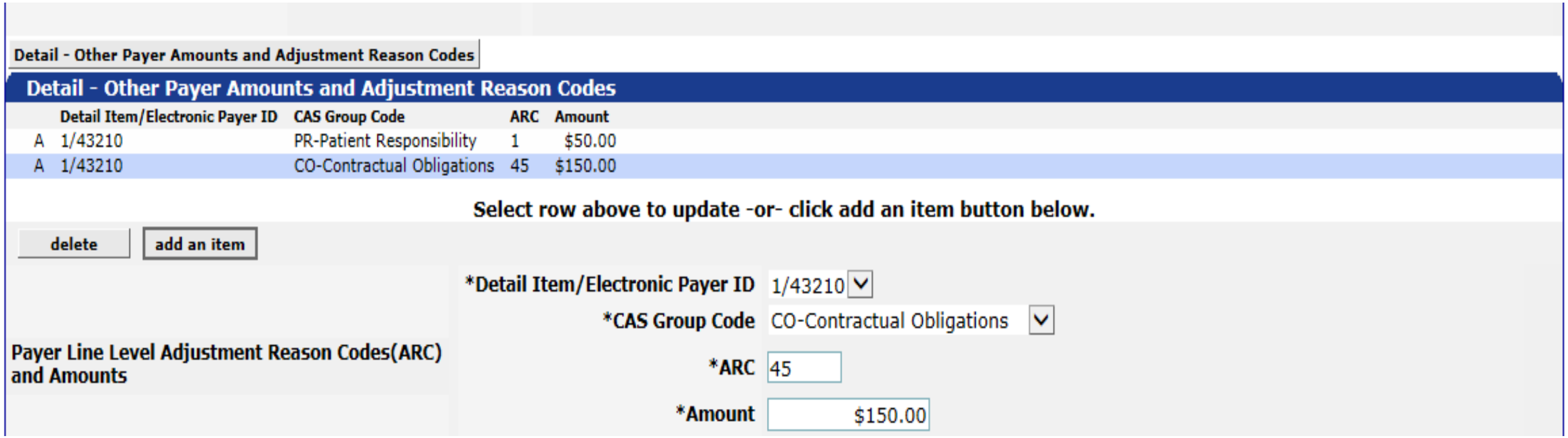
Third Party Liability (TPL) Claims

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



ARC Codes

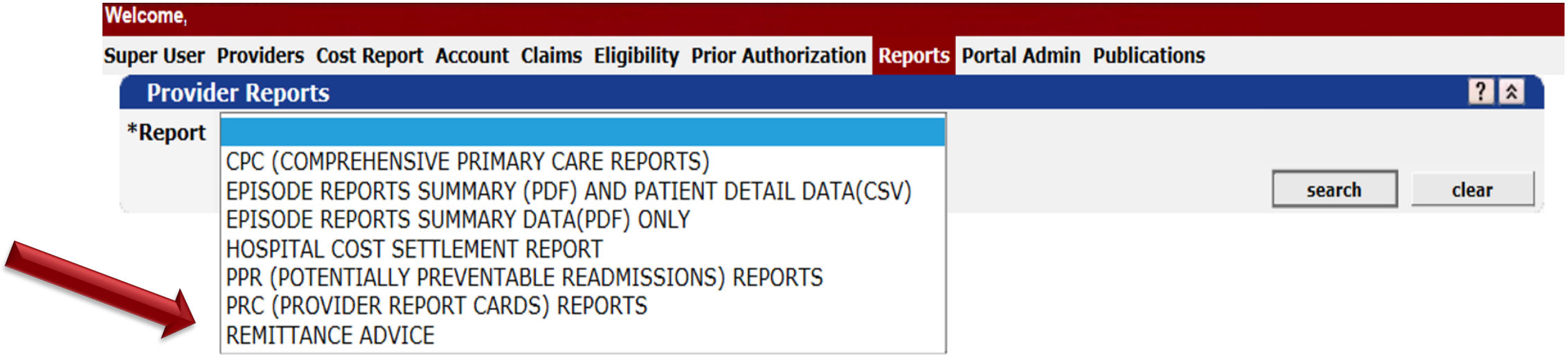
The X12 website provides adjustment reason codes (ARCs)

COMMON ARCs:

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

Remittance Advice (RA)

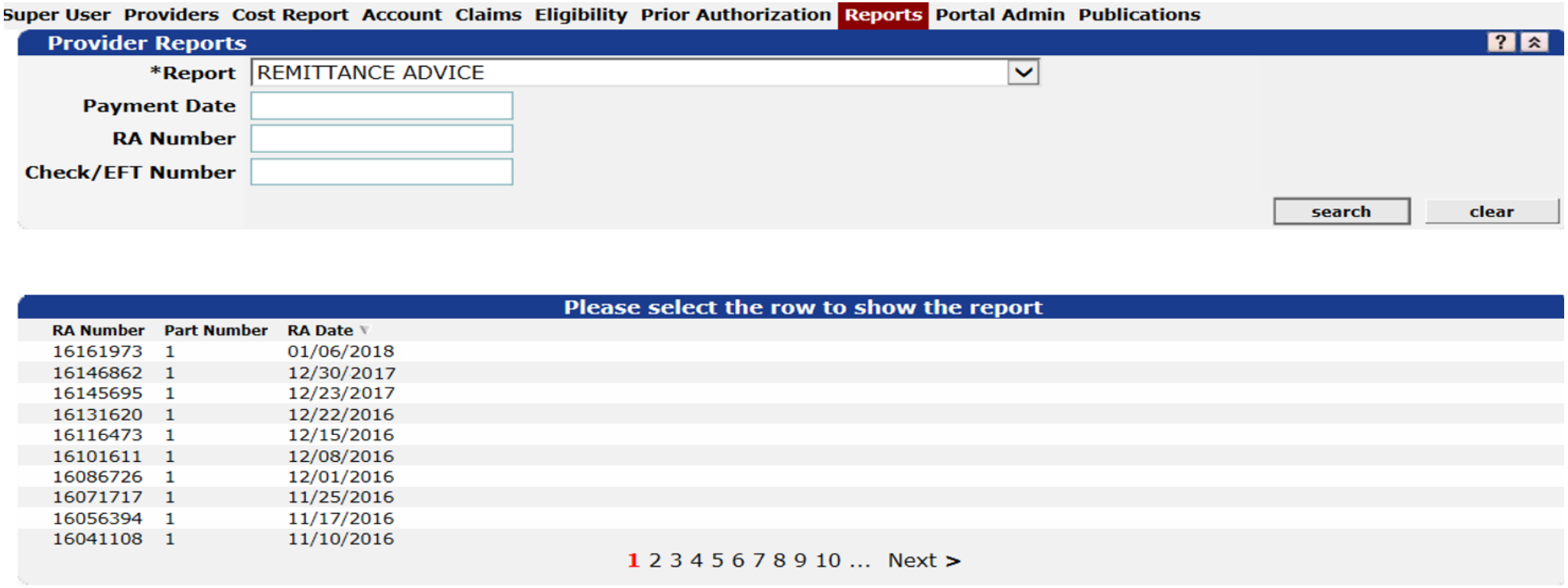
- All claims processed are available on the MITS Portal
- Weekly reports become available on Wednesdays



Remittance Advice (RA)

- Select “Remittance Advice” and click “Search”

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



Remittance Advice (RA)

Paid, denied, and adjusted claims

Financial transactions

Expenditures - Non-claim payments

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

Summary

Current, month, and year to date information

Remittance Advice (RA)

Information pages

Banner messages to the provider community

EOB code explanations

Provides a comparison of codes to the description

TPL claim denial information

Provides other insurance information for any TPL claim denials

Prior Authorization (PA)

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

Prior Authorization (PA)

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

Prior Authorization (PA)

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

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

Prior Authorization (PA)

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

Websites & Forms

Websites

- Ohio Department of Medicaid home page

http://medicaid.ohio.gov

- Ohio Department of Medicaid provider page

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

- MALs & MTLs

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

- Ohio Administrative Codes

https://codes.ohio.gov/ohio-administrative-code/5160

Websites

- Provider Enrollment

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

- MITS home page

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

Information for Trading Partners (EDI)

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

Websites

- Companion Guides (EDI)

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

- National Drug Code (NDC) Search

http://www.accessdata.fda.gov/scripts/cder/ndc/default.cfm

- Healthchek

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

- X12 Website (ARC Codes)

http://www.x12.org/codes/claim-adjustment-reason-codes/

Websites

- PRAF 2.0 Information on the ODM site

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

- PRAF 2.0 login

http://www.nurtureohio.com/login

- Hospital Billing Guide

https://medicaid.ohio.gov/static/Providers/Billing/BillingInstructions/HospitalBillingGuidelines-20210901.pdf

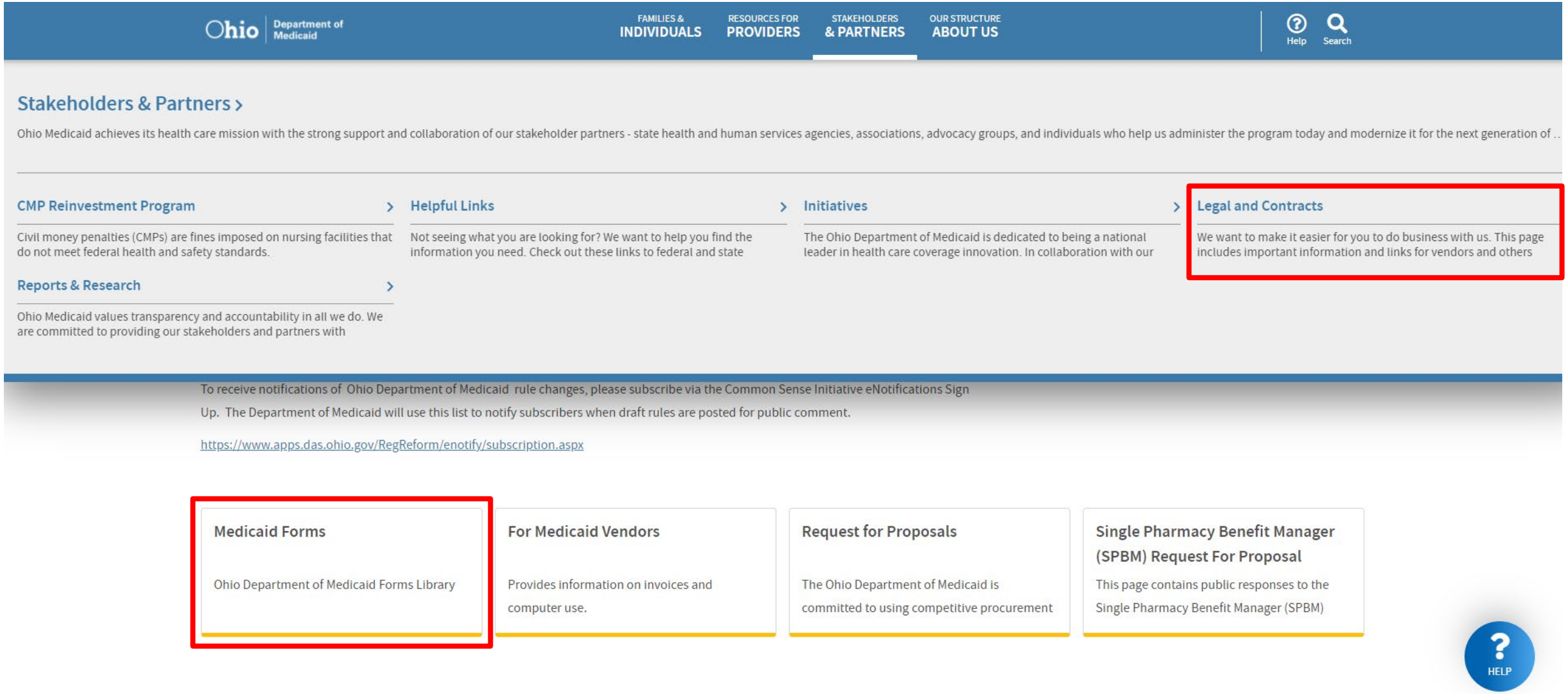
FORMS

- ODM 06614 – Health Insurance Fact Request
- ODM 06653 – Medical Claim Review Request
- ODM 03197 – Prior Authorization: Abortion Certification
- ODM 03199 – Acknowledgement of Hysterectomy Information
- ODM 10207 – Pregnancy Risk Assessment Communication (PRAF)

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

- HHS-687 – Consent for Sterilization

Forms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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)
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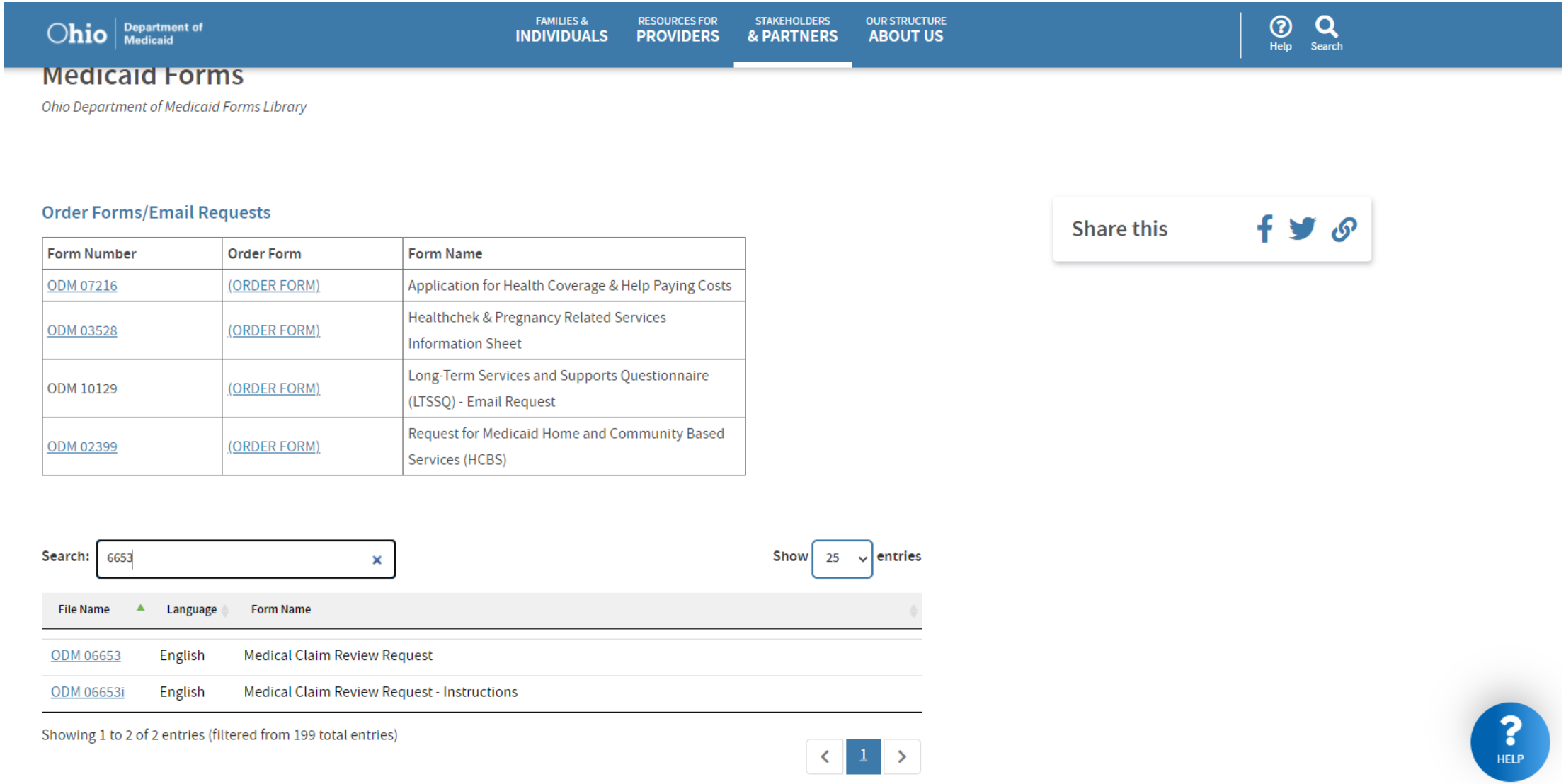

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Form Number	Order Form	Form Name
ODM 07216	(ORDER FORM)	Application for Health Coverage & Help Paying Costs
ODM 03528	(ORDER FORM)	Healthchek & Pregnancy Related Services Information Sheet
ODM 10129	(ORDER FORM)	Long-Term Services and Supports Questionnaire (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

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