Ohio | Department of Medicaid

Basic Billing for Physicians

Provider Relations

2021

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

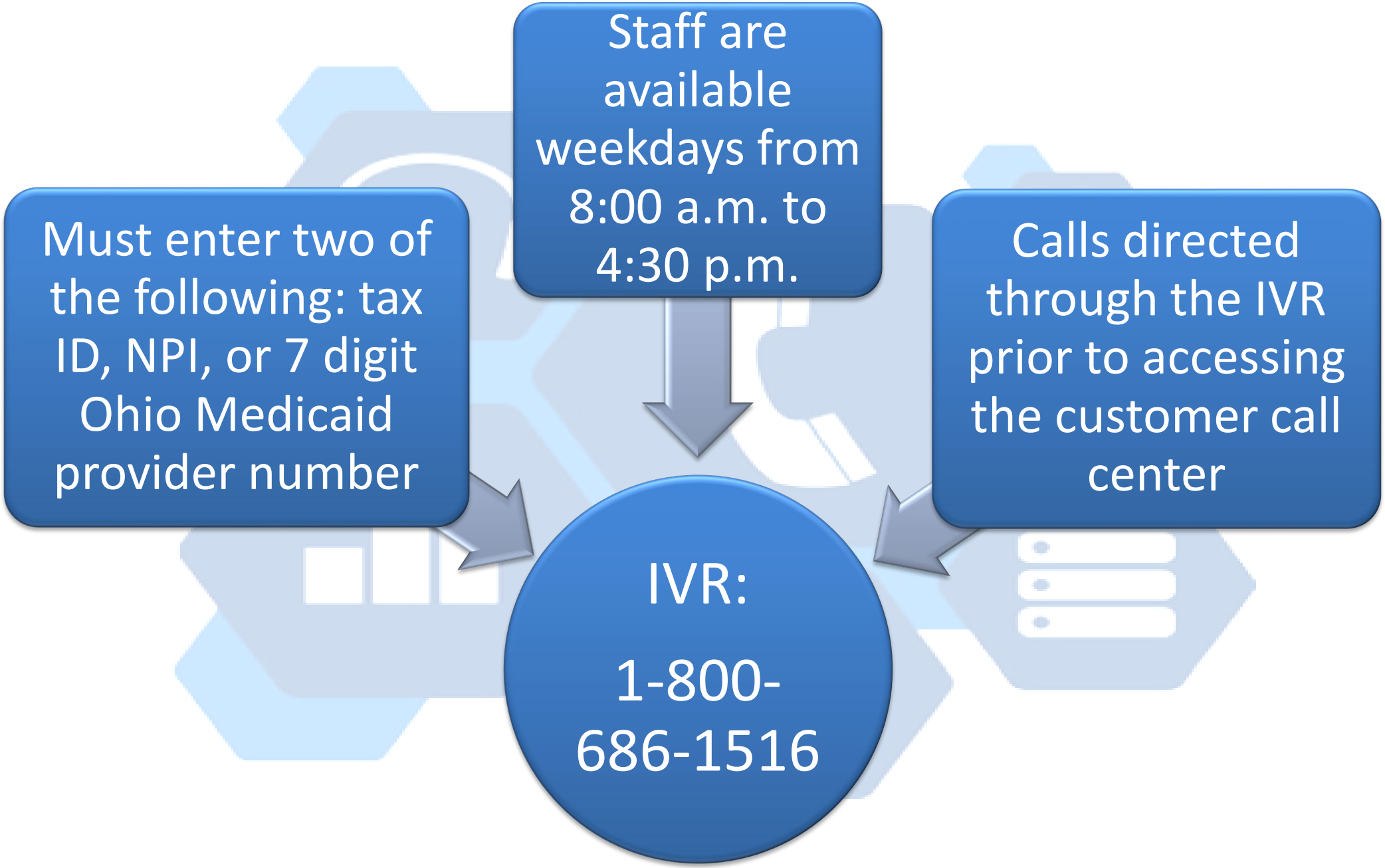
- OSHIIP (Ohio Senior Health Insurance Information Program)

  1-800-686-1578

- Coordination of Benefits Section

  614-752-5768

  614-728-0757 (fax)

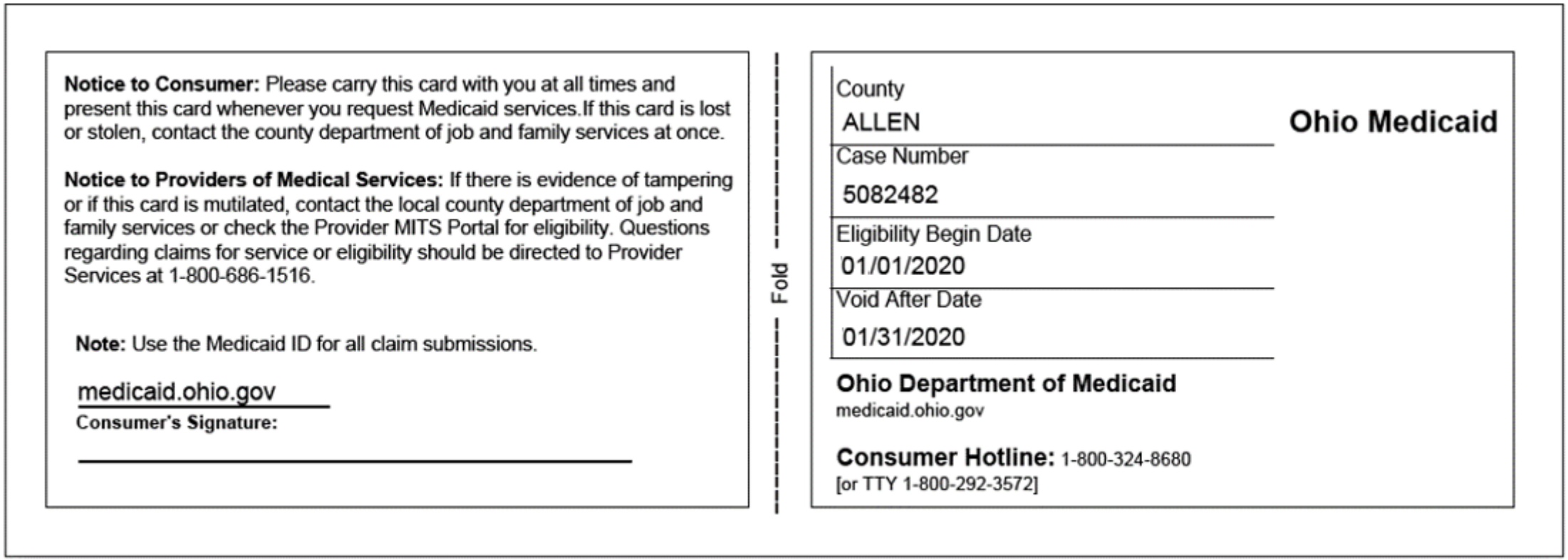

Staff are available weekdays from 8:00 a.m. to 4:30 p.m.
Must enter two of the following: tax ID, NPI, or 7 digit Ohio Medicaid provider number
Calls directed through the IVR prior to accessing the customer call center
IVR:
1-800-686-1516

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]

Supplemental Security Income (SSI)

- Automatically Eligible for Medicaid as long as eligible for SSI

Modified Adjusted Gross Income (MAGI)

- Children, parents, caretakers, and expansion

Aged, Blind, Disabled (ABD)

- 65+, or blind/disabled with no SSI

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

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

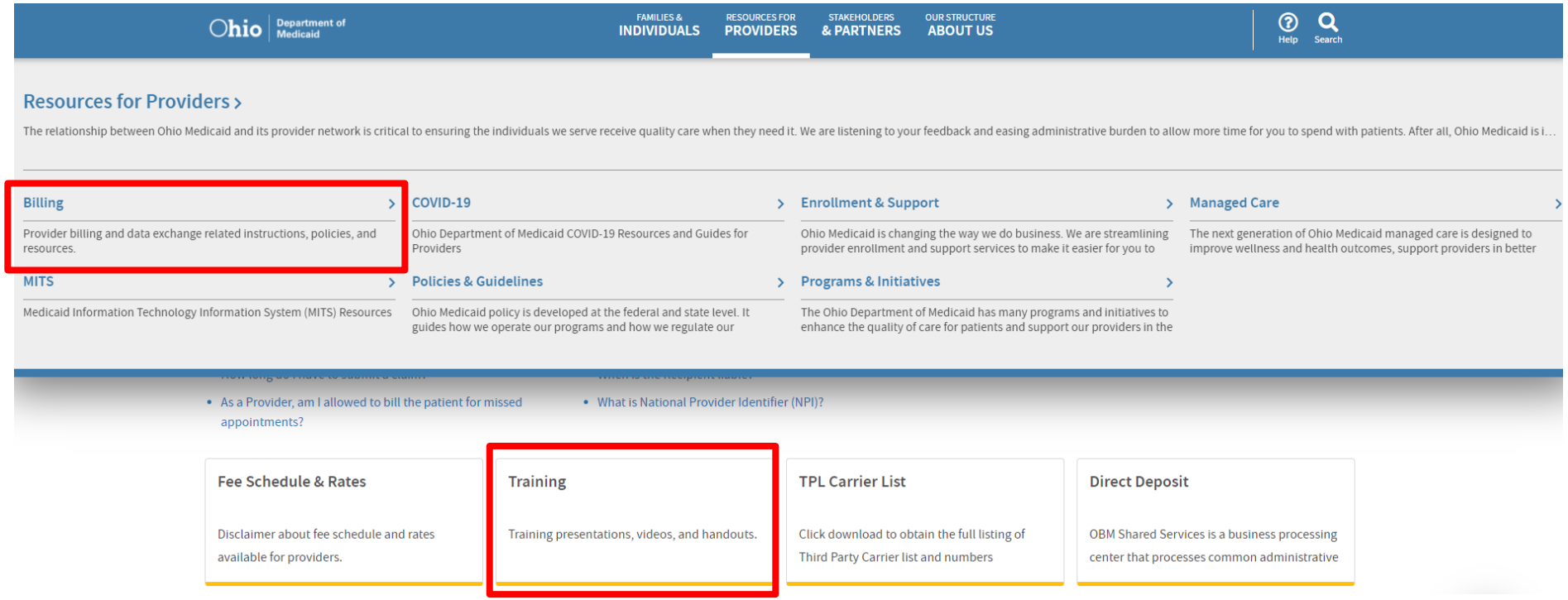
Full Medicaid eligibility on the MITS Portal will show **four** (or more) benefit spans:

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

Eligibility Verification Request



Training Videos

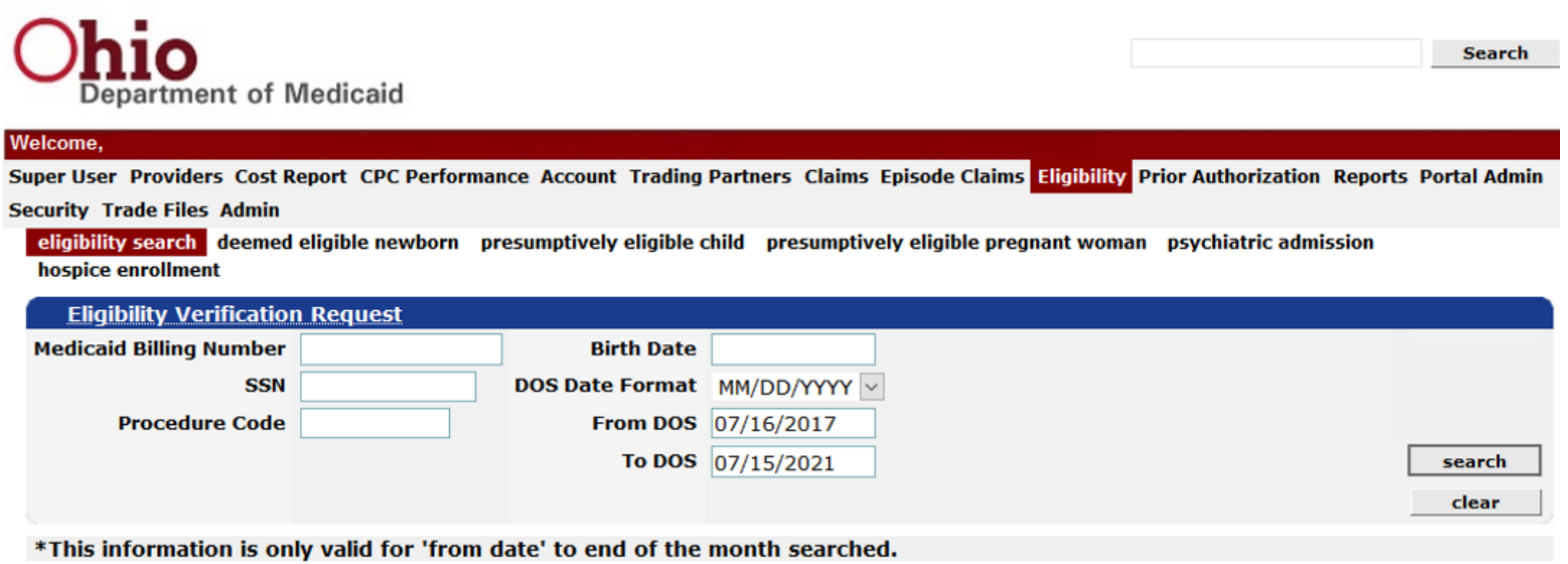
Ohio Medicaid has created a compilation of training videos that cover a variety of topics for providers. If questions remain after reviewing these videos, contact Ohio Medicaid Provider Assistance at 1-800-686-1516.

Check back frequently as training videos will be added as needed. If there are issues viewing these videos, make sure your pop-up blocker is turned off.

- Presumptive Eligibility (PE) Portal Walk Through for Qualified Entities
- How to Setup a MITS Agent Account and Access Reports
- Eligibility Search

Eligibility Verification Request

You can search up to 4 years back



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

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

Level of Care Determinations

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

Patient Liability

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

Long Term Care Facility Placements

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

Recipient Restricted Coverage

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

Special Program

*** No rows found ***

Presumptive Eligibility

Covers children up to age 19 and pregnant women

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

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

Presumptive Eligibility

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

Presumptive Eligibility

MISSISSIPPI RIVERS
21 S FRONT ST
COLUMBUS, OH 43215

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

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

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

APPROVED:

Name (First, M.I., Last Name)	Date of Birth	PE Type	Date Coverage Begins	Medicaid ID
MISSISSIPPI RIVERS	01/01/1987	PE PREGNANT	05/09/2021	910001331813

Presumptive Eligibility

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?

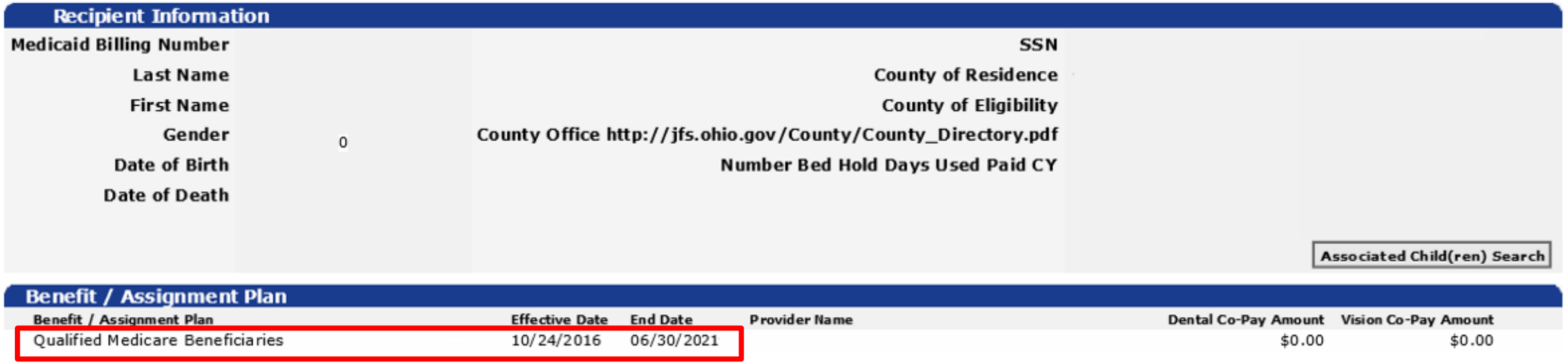
MLN Matters® Number: MM11230 Revised Release Date of Revised Article: July 3, 2019

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



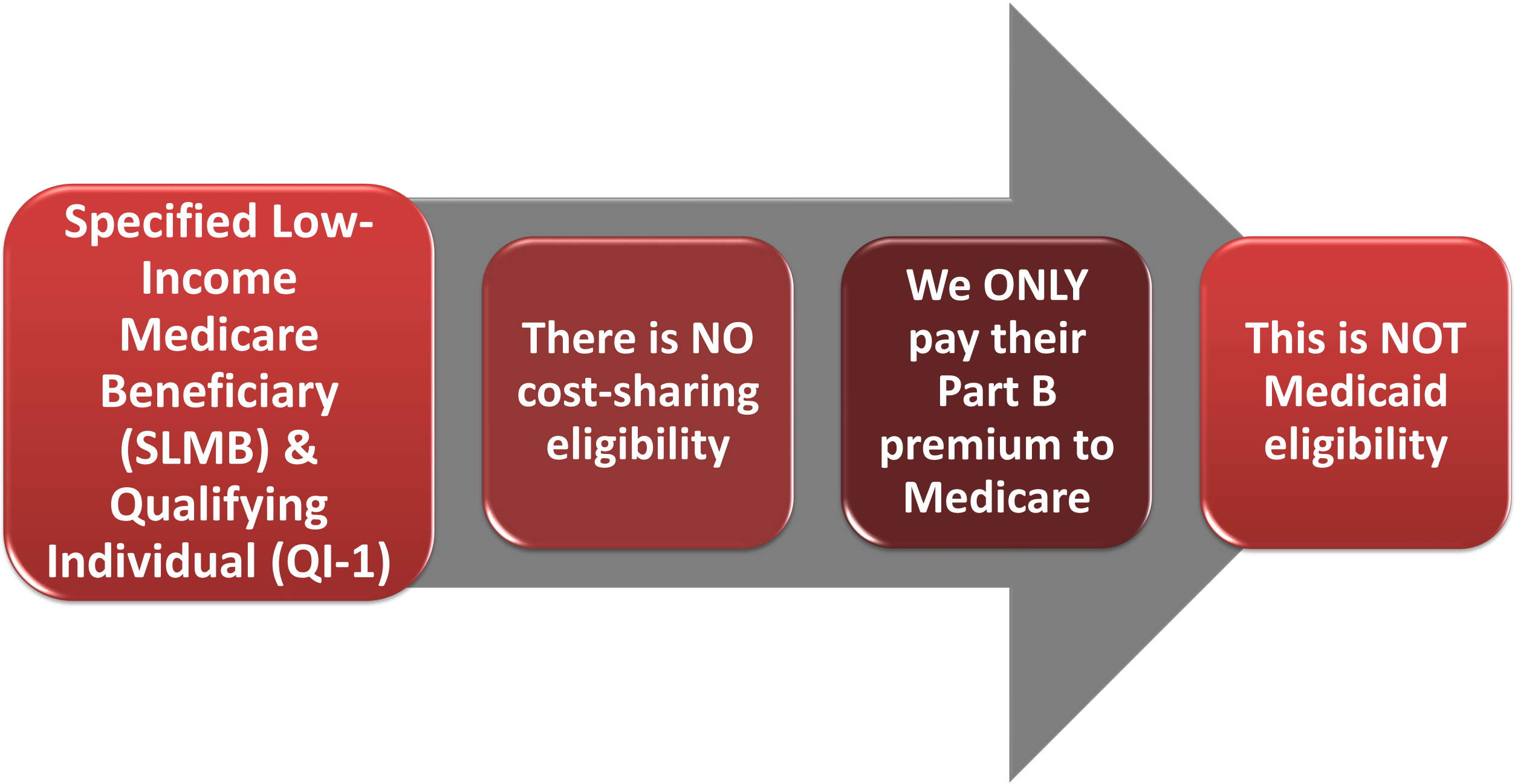
Recipient Information

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 and QI 1 / QI 2

This is what will appear in the benefit/assignment plan panel if the individual has SLMB:

Benefit / Assignment Plan

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

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

Benefit / Assignment Plan

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

HealthChek: OAC 5160-1-14

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

Minimum services include:

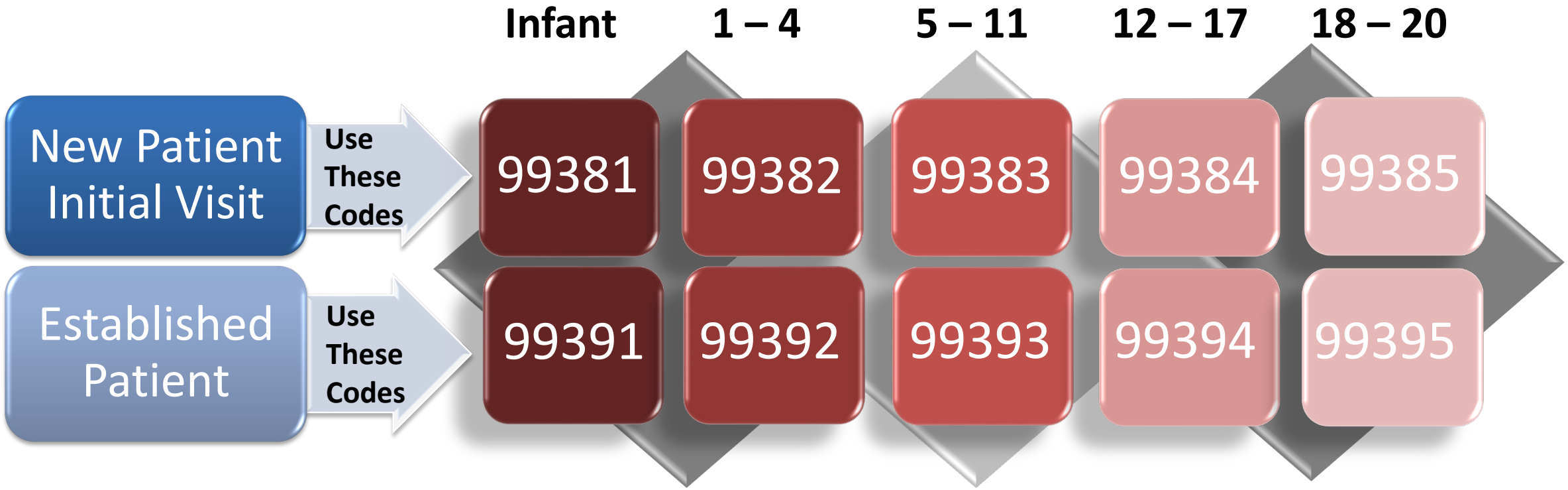
- Comprehensive Health and Developmental History
- Developmental Screening (including mental and physical)
- Nutritional Screening
- Vision Screening

HealthChek: OAC 5160-1-14

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

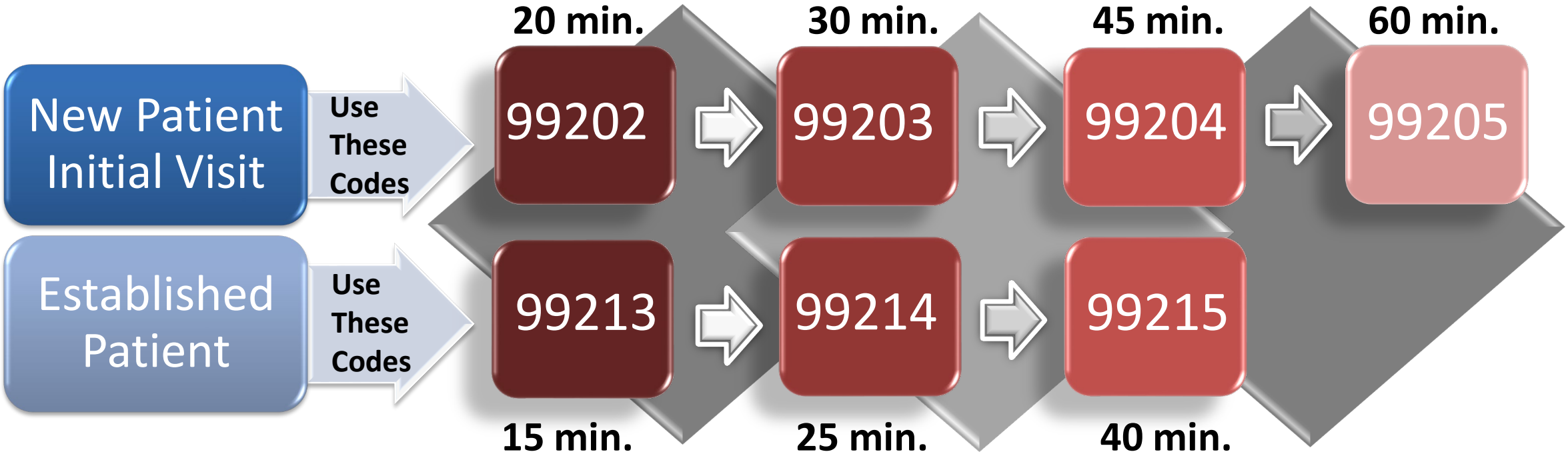
HealthChek Procedure Codes

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

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

Adult Extension and HCBS Waiver

- ✓ Adults eligible via the extension will be able to access a home and community-based waiver (HCBS) if a level of care requirement is met ***(MCEs are responsible for state plan health care services)***
- ✓ HCBS waivers include Passport, Ohio Home Care, and Assisted Living ***(Fee-for-Service Medicaid is still responsible for waiver services)***
- ✓ Current HCBS waiver case management agencies will continue to coordinate waiver services

Managed Care Benefits Package

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

Some value-added services:

Online searchable provider directory

Toll-free 24/7 hotline for medical advice

Expanded benefits including additional transportation options plus other incentives

Care management to help members coordinate care

MITS Managed Care Eligibility

If an individual is enrolled in a Managed Care Plan, the plan information will be shown in the Managed Care panel along with the effective and end dates.

Benefit / Assignment Plan

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

Case/Cat/Seq Spenddown

*** No rows found ***

TPL

*** No rows found ***

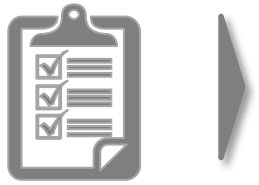
Managed Care

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

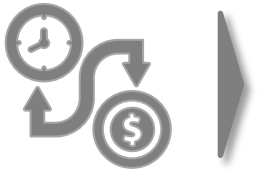
Traditional Managed Care Contracting

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

Things to know:



Each plan has a list of services that require prior authorization



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

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

Traditional Managed Care Plans

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

MyCare Ohio

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

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

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

MyCare Ohio Benefits Package

- 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

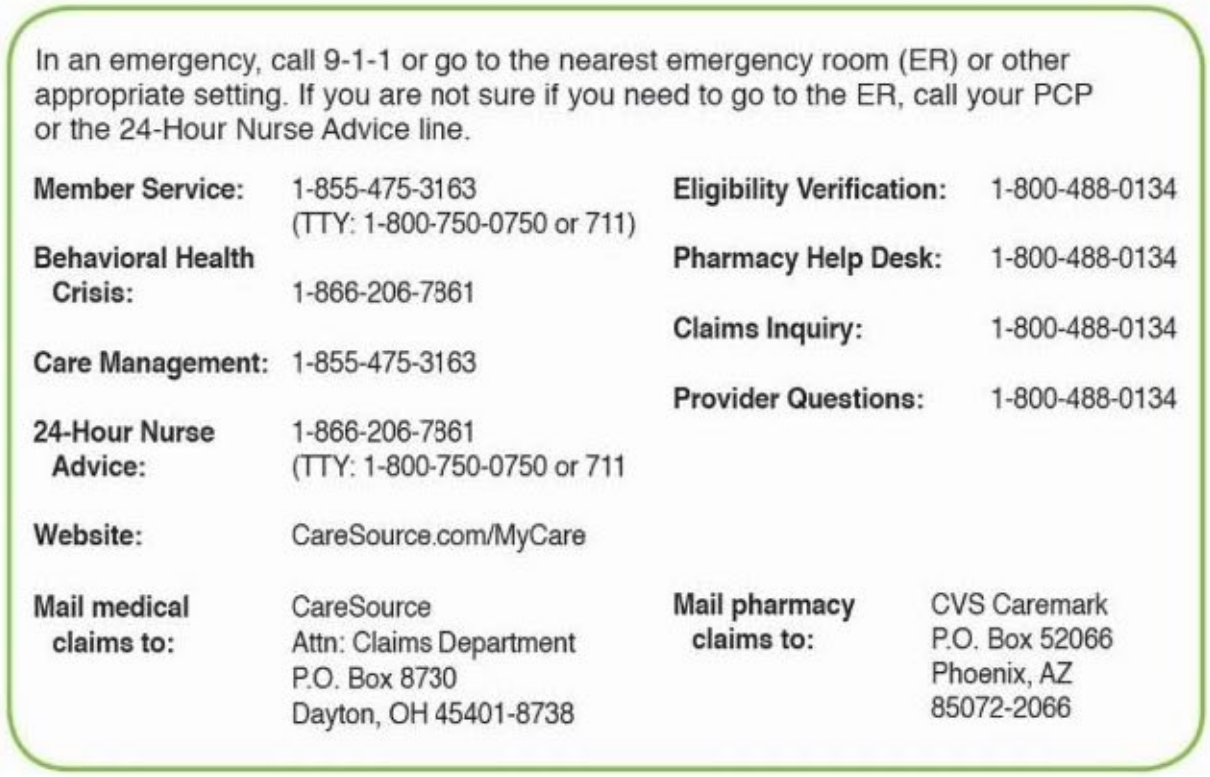
In order to be eligible for MyCare Ohio an individual must be:

- **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

MyCare Ohio Opt-In Sample Card



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

MyCare Ohio Opt-Out Sample Card

MyCareOhio
Connecting Medicare + Medicaid

CareSource

Member Name: <Cardholder Name>
Member ID #: <Cardholder ID#>

MMIS Number: <Medicaid Recipient ID#>

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

RxBin: 004336
RxPCN: ADV
RxGRP: RX3292

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)
Behavioral Health Crisis:	1-866-206-7861 (TTY: 1-800-750-0750 or 711)
Care Management:	1-855-475-3163 (TTY: 1-800-750-0750 or 711)
24-Hour Nurse Advice:	1-866-206-7861 (TTY: 1-800-750-0750 or 711)
Provider/Pharmacy 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

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

Managed Care

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

Lock-In

*** No rows found ***

Medicare

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

MyCare Managed Care Contracting

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

Things to know:

Each plan has a list of services that require prior authorization

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

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

MyCare Ohio Managed Care Plans

buckeye health plan

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

CareSource®

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

aetna®

AETNA BETTER HEALTH® OF OHIO

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

MOLINA® HEALTHCARE

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

UnitedHealthcare®

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

PROVIDER COMPLAINTS

Provider licensure issues

Send to Ohio Department of Insurance (ODI)

Certification issues

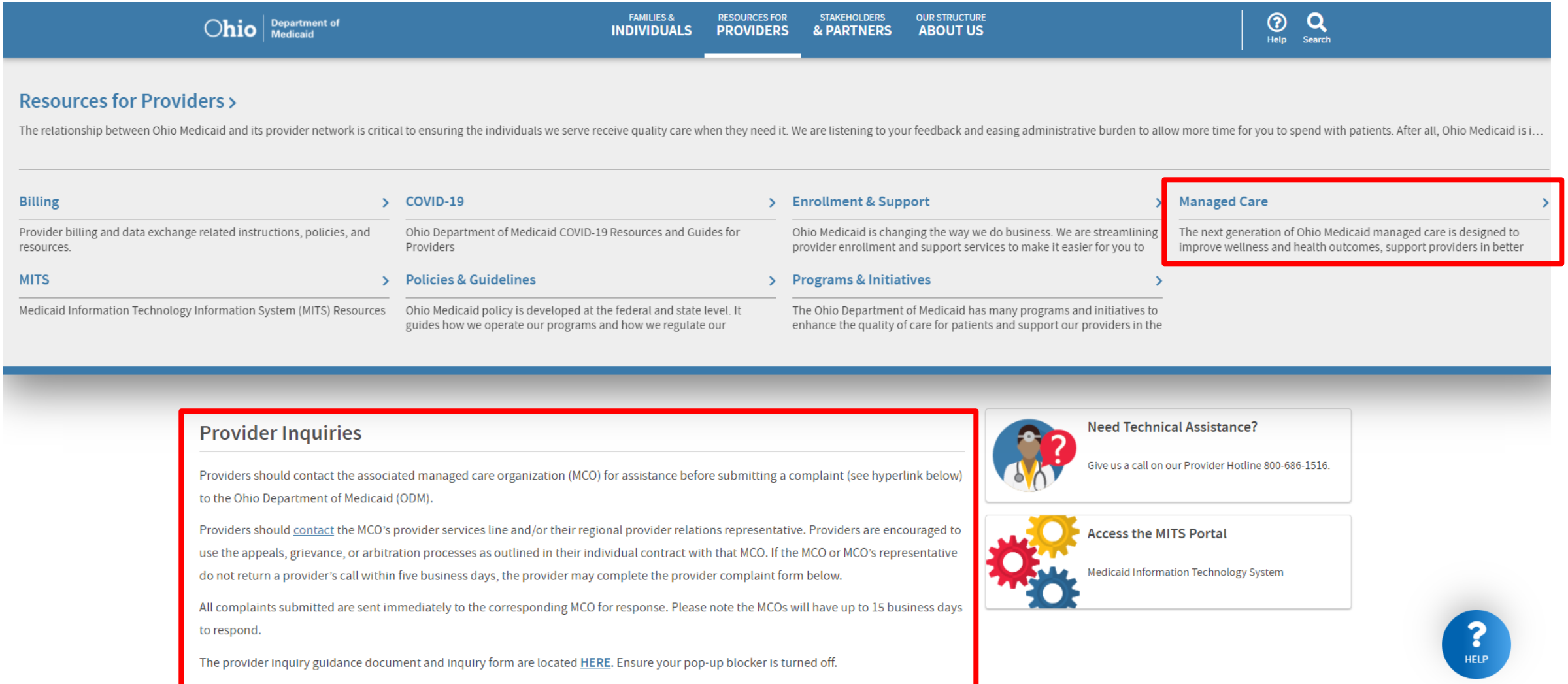
Work with the Area Agency on Aging (AAA) or ODM for MyCare Ohio waiver providers

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

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

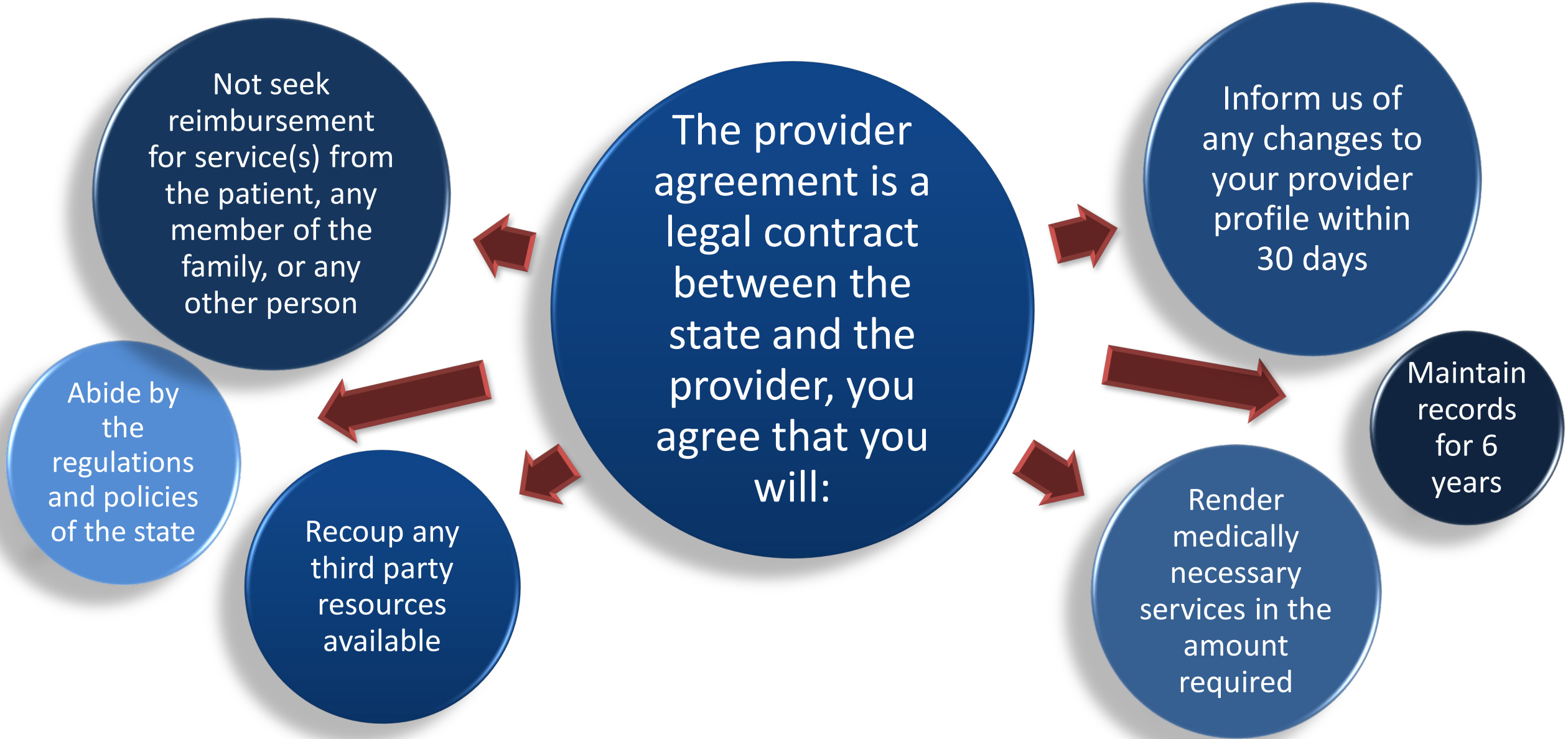
Providers are required to submit an application to become a Medicaid provider

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 Agreement: OAC 5160-1-17.2



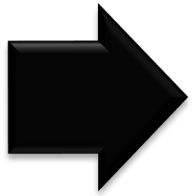
Updating Demographic Information in MITS

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

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)

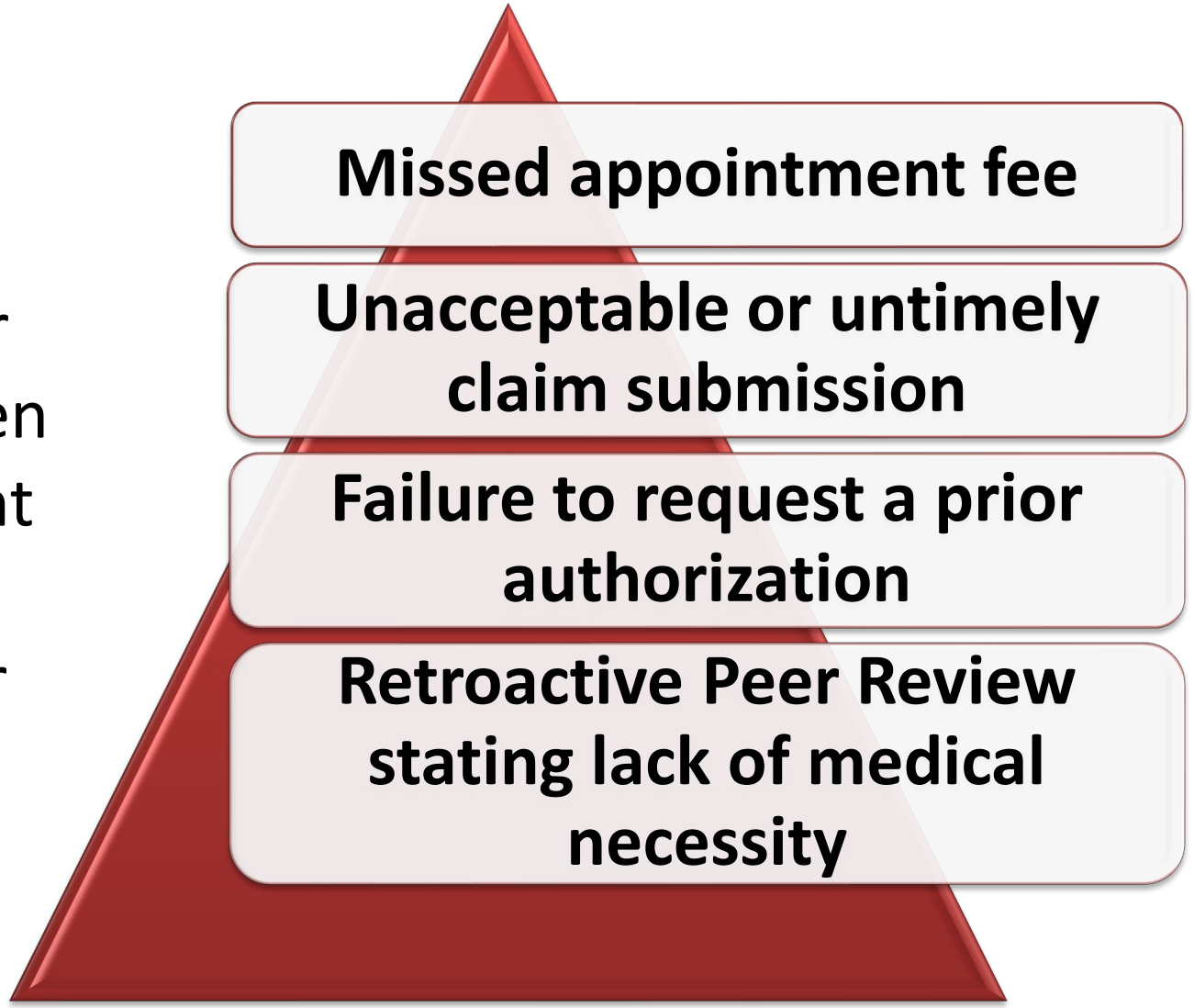
The department will reimburse the provider the lesser of the Medicaid maximum allowable rate (established fee schedule) or the UCC

Coordination of Benefits: OAC 5160-1-08

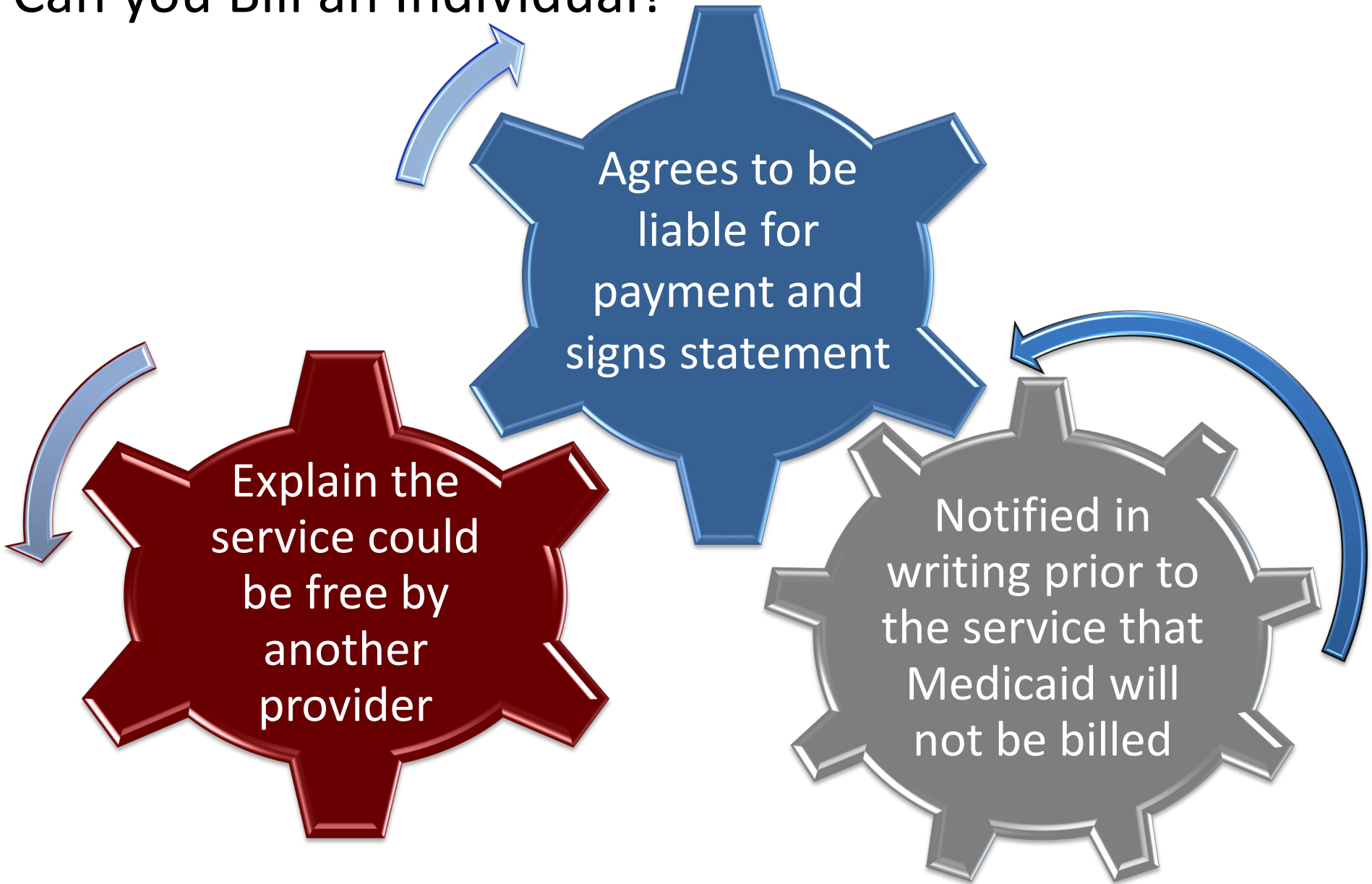
- The Ohio Administrative Code requires that a Medicaid consumer provide notice to the department prior to initiating any action against a liable third party
- The department will take steps to protect its subrogation rights if that notice is not provided
- For questions, contact the Coordination of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

Medicaid 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:

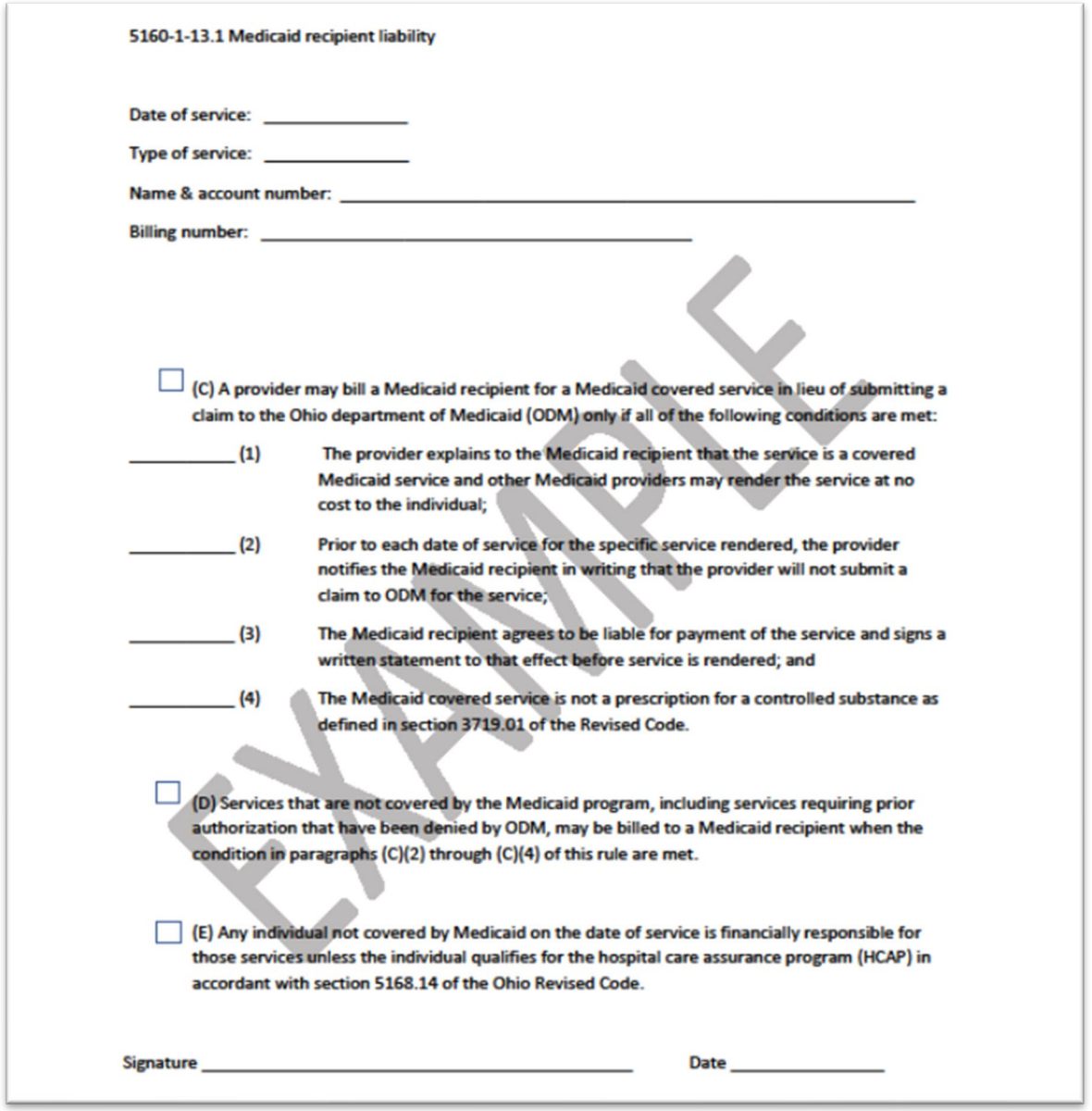


When Can you Bill an Individual?



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.

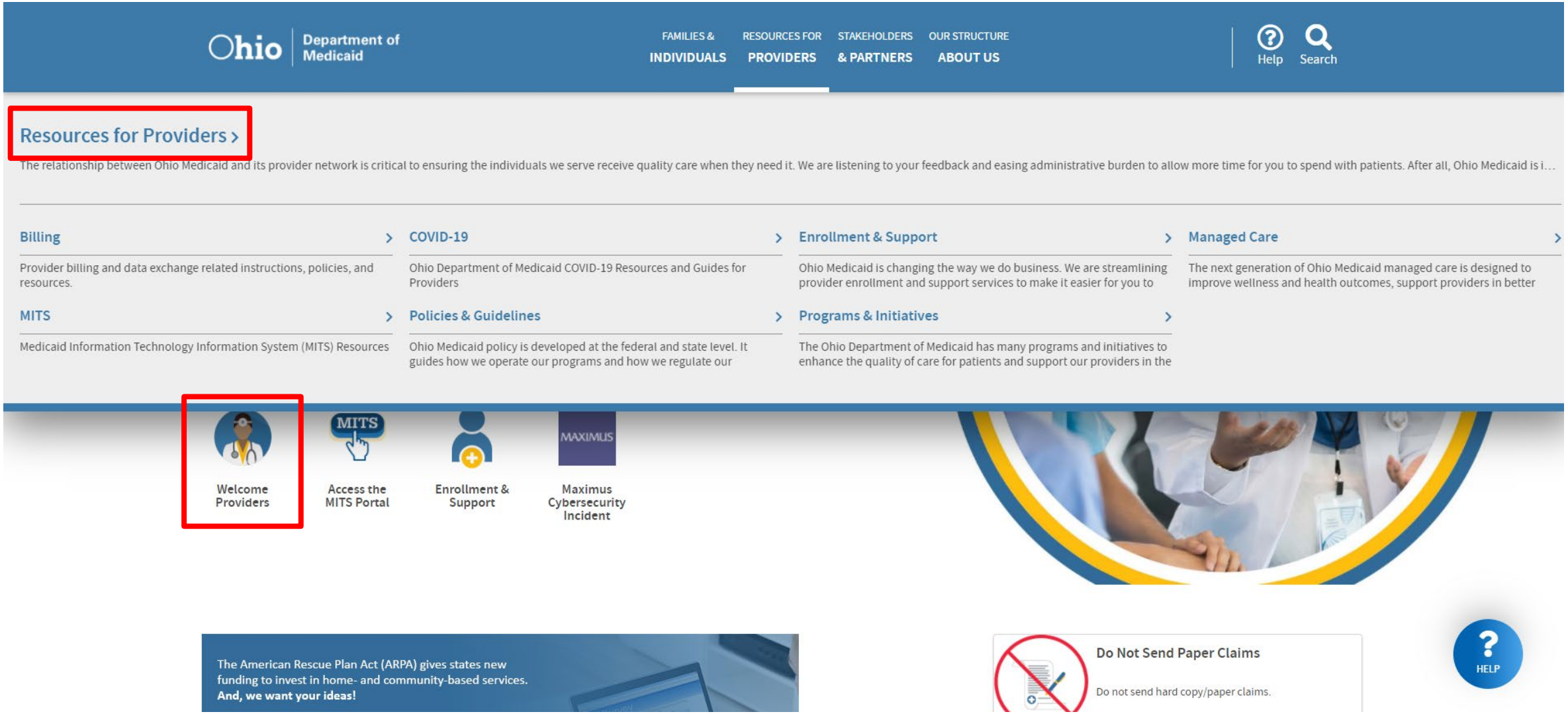
☐ (D) Services that are not covered by the Medicaid program, including services requiring prior authorization that have been denied by ODM, may be billed to a Medicaid recipient when the condition in paragraphs (C)(2) through (C)(4) of this rule are met.

☐ (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



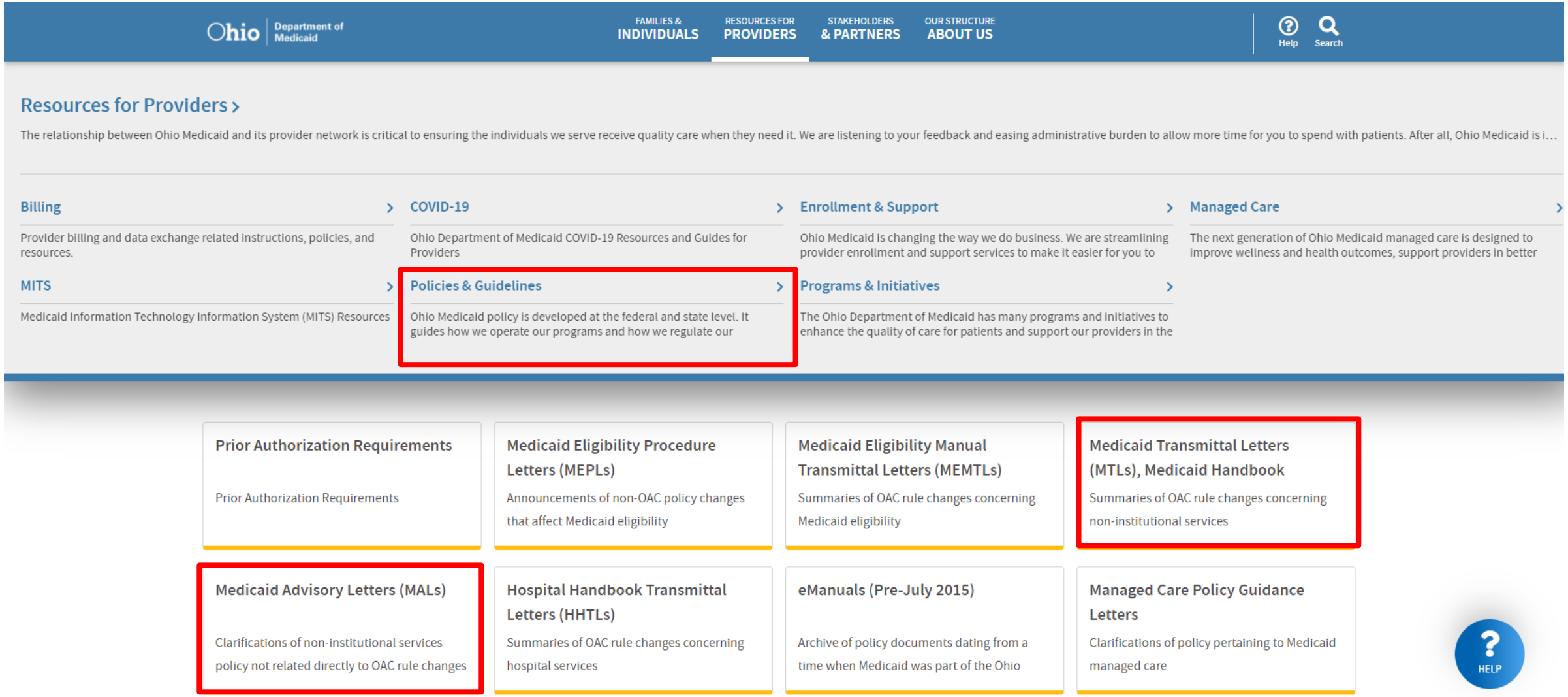
Policy

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

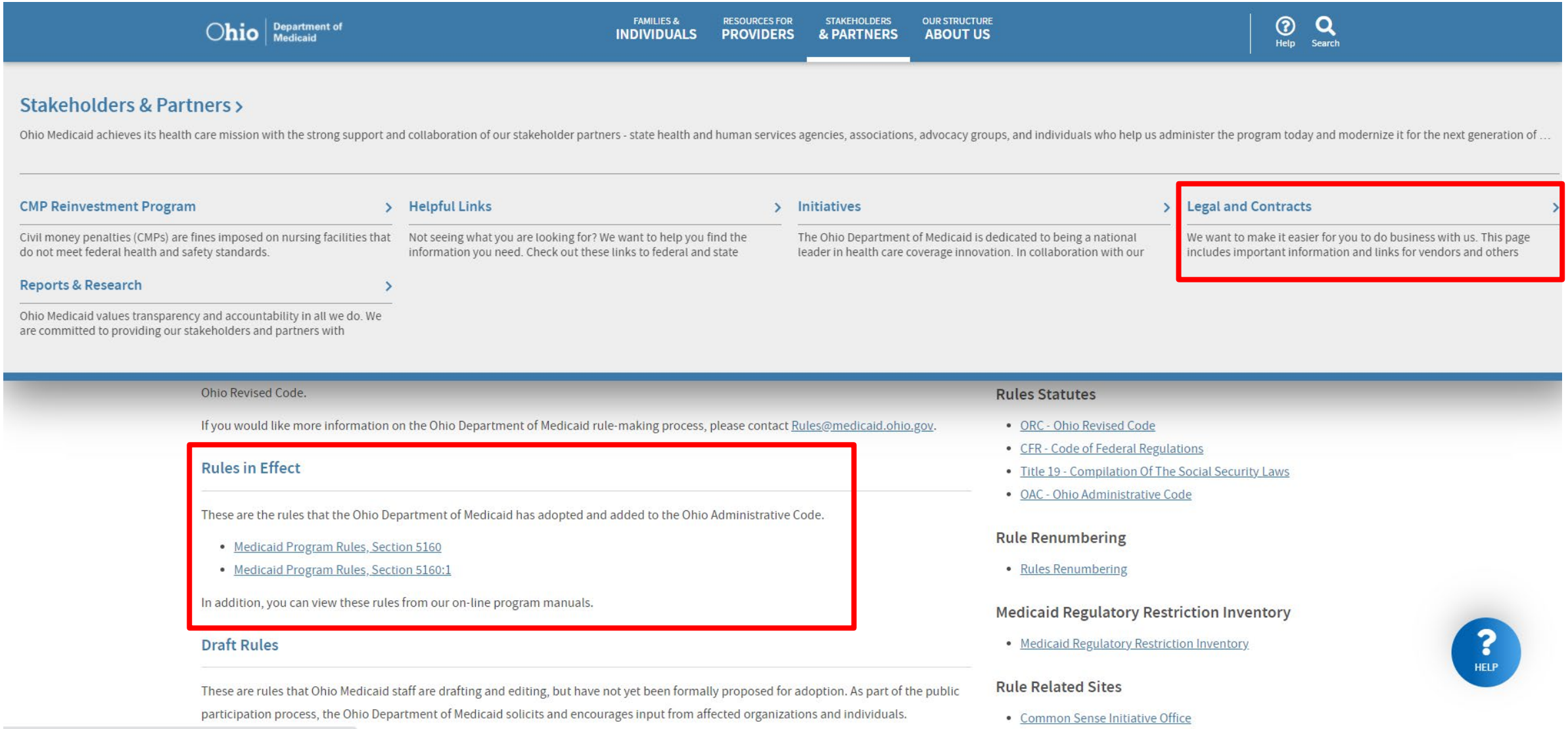
Medicaid Transmittal Letter (MTL)

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

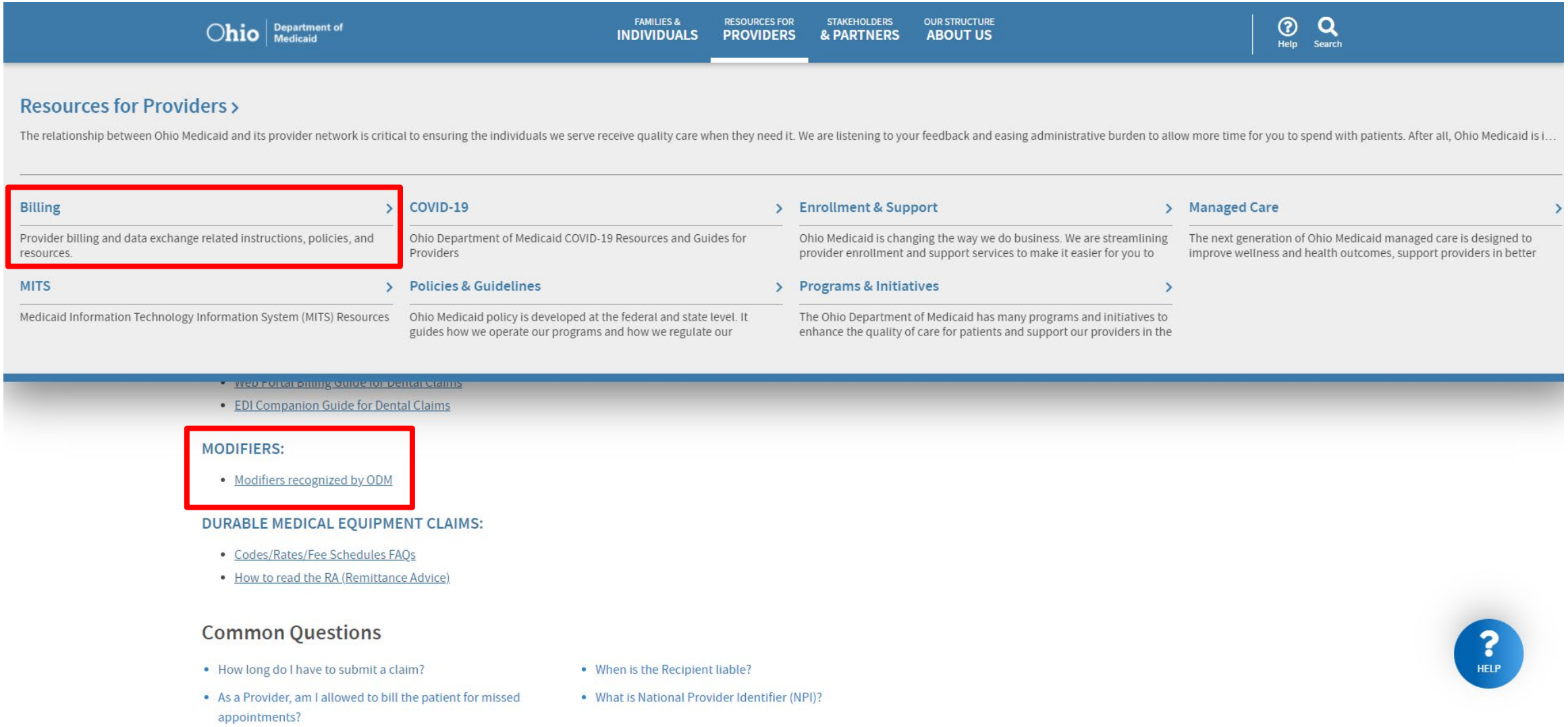
Policy


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



Pregnancy Related Services: MAL No. 605

Three “pregnancy-related services” rules were rescinded and consolidated into this rule, effective ***1/1/17*** and revised ***7/1/21***

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

The maximum payment amount for the first delivery is 100%

Payment for the second delivery of a multiple birth is 50%

Payment for the 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

Gynecological Service change

NEW CODES

G0101	Q0091

REPLACING

S0610	S0612

MTL No. 3334-16-18 notified providers of a coding change for gynecological services

Medicaid Advisory Letter: MAL No. 612

- Guidelines have been developed for completing forms associated with the following rules:
  - 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)

Note: Forms ODM 03197 and 03199 were revised 6/1/221. Instruction forms ODM 03197-I and 03199-I are now obsolete.

Medicaid Advisory Letter: MAL No. 612

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

59840	59850	59852	59856	59866
59841	59851	59855	59857	

- Form ODM 03197 must be completed before payment can be made for the following ICD-10 codes:

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

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

Healthchek: Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Covered Services: OAC 5160-1-14

- Previous rules 5160-14-01, 02, 03, 04, 05, and 09 consolidated into this new rule as of 11/1/17
- Changes include:
  - Definitions – “Bright Future Guidelines” added
  - Providers – Requirements in a single paragraph
  - Screening Visits – Language of rule derived from Social Security Act
  - Claim Submission Instructions – Removed from the rule, to be posted on ODM’s website with other claim submission instructions
  - Coverage – Unnecessary restriction on the coverage of habilitation service removed from the rule

Substitute Practitioners (Locum Tenens): OAC 5160-1-80

- Effective 10/1/2018, revised 1/1/2020
- The substitute practitioner receives payment from the regular practitioner on a fee-for-time basis
- Appropriate procedure code(s) must be accompanied by the **Q6** modifier
- The NPI of the regular practitioner is reported in the rendering provider field of each detail, and the NPI of the substitute practitioner is reported in the rendering provider field of the claim header (or in the notes field for a dental claim)

Services Provided by a Physician Assistant: OAC 5160-4-03

Revision effective 1/1/22

- Payment may be made for a covered service performed by a physician assistant only if the physician assistant practices under either of the following arrangements:
  - The physician assistant provides services under a supervision agreement in accordance with ORC 4730.19; or
  - The physician assistant practices in a health care facility and provides services authorized by the facility.
- For assistant-at-surgery services, payment is 25% of the Medicaid maximum for the covered primary surgical procedure. (Modifier AS is reported on the claim, not UD.)
- For a covered immunization, injection of medication, or provider-administered pharmaceutical, payment is 100% of the schedule amount listed.
- For all other covered services, payment is the lesser of the submitted charge or 85% of the Medicaid maximum.
- Payment for services provided by a hospital-employed physician assistant will be made to the hospital.

Services Provided by an Advanced Practice Registered Nurse (APRN): OAC 5160-4-04

- The form *APN* in the rule was changed to *APRN* on 1/1/17
- Unless a specific exception is noted, all other Medicaid rules that pertain to services provided by physicians apply to APRNs
- For assistant-at-surgery services, payment is 25% of the Medicaid maximum for the covered primary surgical procedure (Modifier AS is reported on the claim, not SA, SB, or UC.)

Radiology and Imaging Services: OAC 5160-4-25

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

Podiatry Services: OAC 5160-7-01

99204

99205

99244

99214

99215

99223

99233

99343

99255

99344

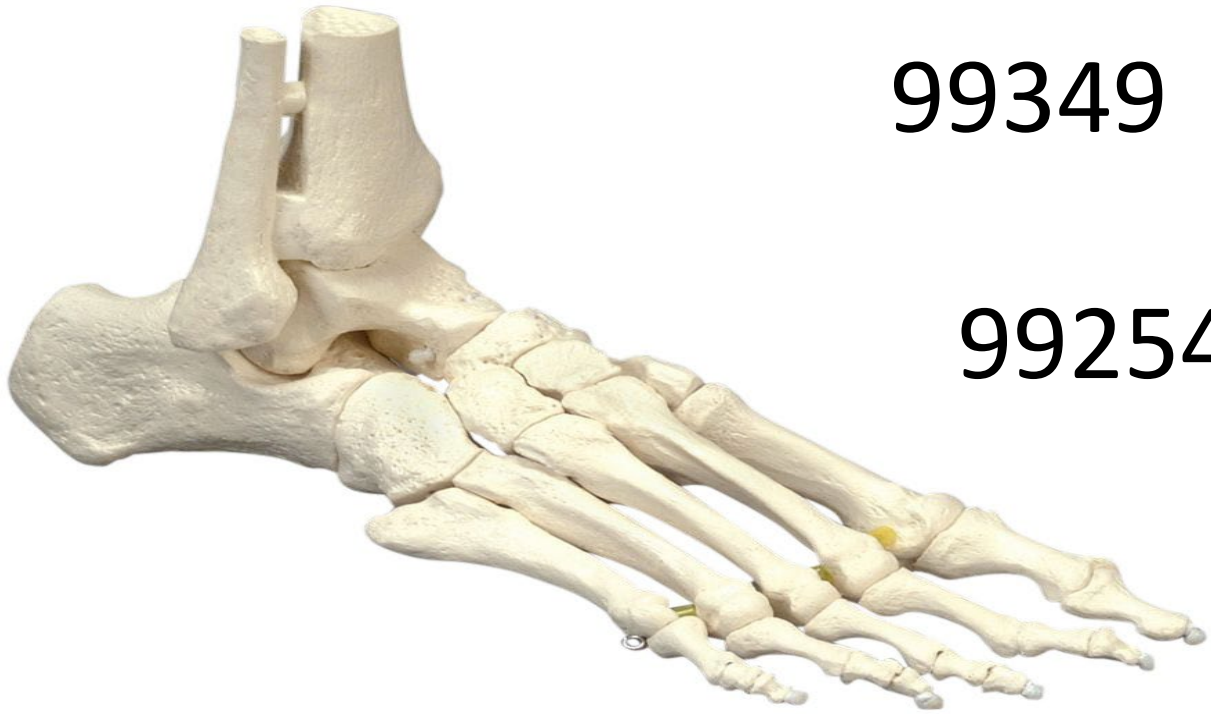
99345

99254

99349

99350

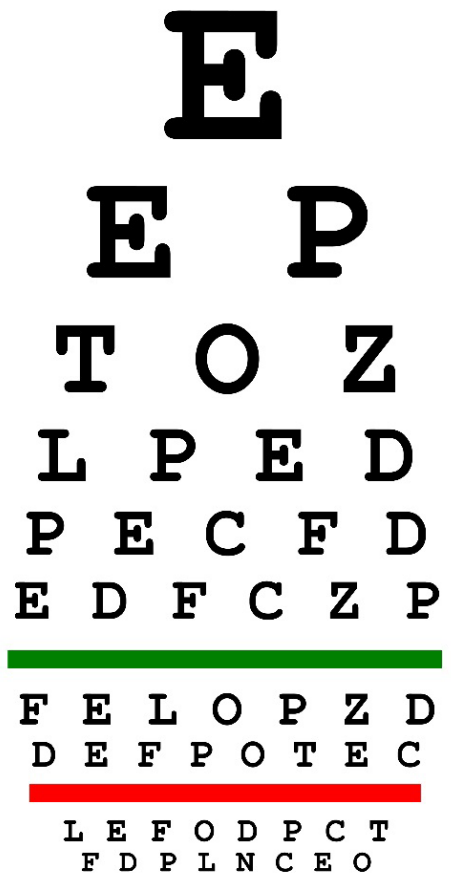
99245



Vision Screening Procedures: OAC 5160-6-01

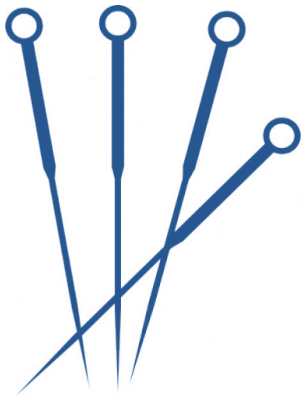
- Effective 1/1/18 coverage was added for the following procedures:
  - 99172
  - 99173
  - 99174
  - 99177

- ODM covers all procedures specified on the US Preventive Service Task Force (USPSTF) A and B recommendation list



Acupuncture Services: OAC 5160-8-51

- Rendering provider
  - An acupuncturist recognized under ORC 4762.02
  - An individual practitioner, other than an acupuncturist (e.g., a physician or a chiropractor), holding a credential specified by law
- Billing ("pay-to") provider
  - An acupuncturist recognized under ORC 4762.02
  - An individual practitioner other than an acupuncturist (e.g., a physician or a chiropractor) holding a credential specified by law
  - An ambulatory health care clinic (OAC Chapter 5160-13)
  - A federally qualified health center (FQHC)
  - A rural health clinic (RHC)
  - An individual practitioner who supervises an acupuncturist or other credentialed acupuncture provider [as of 4/1/21]
  - A professional medical group
  - A hospital [as of 4/1/21]



Acupuncture Services: OAC 5160-8-51

- Payment may be made for a service, performed at the written order of a practitioner, that is rendered for treatment of one of the following conditions:
  - Low back pain
  - Migraine
  - Cervical (neck) pain [as of 4/1/21]
  - Osteoarthritis of the hip [as of 4/1/21]
  - Osteoarthritis of the knee [as of 4/1/21]
  - Nausea or vomiting related to pregnancy or chemotherapy [as of 4/1/21]
  - Acute post-operative pain [as of 4/1/21]
- Payment for more than 30 visits per benefit year requires prior authorization

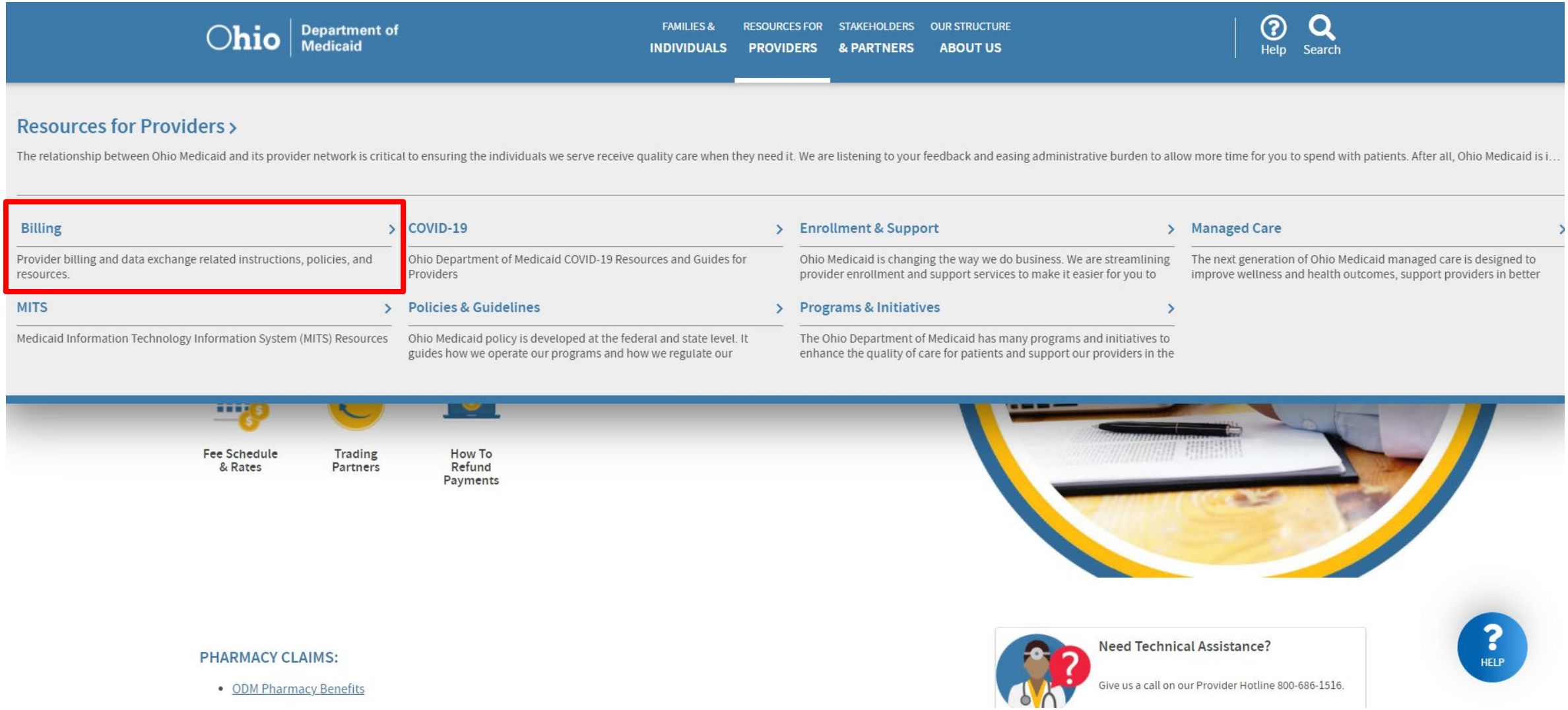
Acupuncture Services: OAC 5160-8-51

- No separate payment will be made for the following services:
  - Both an evaluation and management (E&M) service and an acupuncture service rendered by the same provider to the same individual on the same day
  - Services that are an incidental part of a visit (e.g., providing instruction on breathing techniques, diet, or exercise)
    - An acupuncture service performed by a non-physician in a hospital setting (for which the practitioner must make payment arrangements with the hospital) [as of 4/1/21]
  - Additional treatment in either of the following circumstances:
    - Symptoms show no evidence of clinical improvement after an initial treatment period
    - Symptoms worsen over a course of treatment

Procedure Codes		
Code	**Description**	**Payment**
97810	Acupuncture, one or more needles, without electrical stimulation, initial 15 minutes of one-on-one contact with the patient.	$25 per 15 minute increment
97811	Acupuncture, one or more needles, without electrical stimulation, each additional 15 minute increment of personal one-on-one contact with the patient, with reinsertion. (Listed separately in addition to primary code.)	$17.50 per each additional 15 minute increment
97813	Acupuncture, one or more needles, with electrical stimulation, initial 15 minutes of one-on-one contact with the patient.	$31.15 per 15 minute increment
97814	Acupuncture, one or more needles, with electrical stimulation, each additional 15 minute increment of personal one-on-one contact with the patient, with reinsertion. (Listed separately in addition to primary code.)	$23.65 per each additional 15 minute increment

MITS & Claims

Billing Resources



Medicaid Information Technology System (MITS)

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

Technical Requirements

Internet Access (high speed works best)

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

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

Turn **OFF** pop up blocker functionality

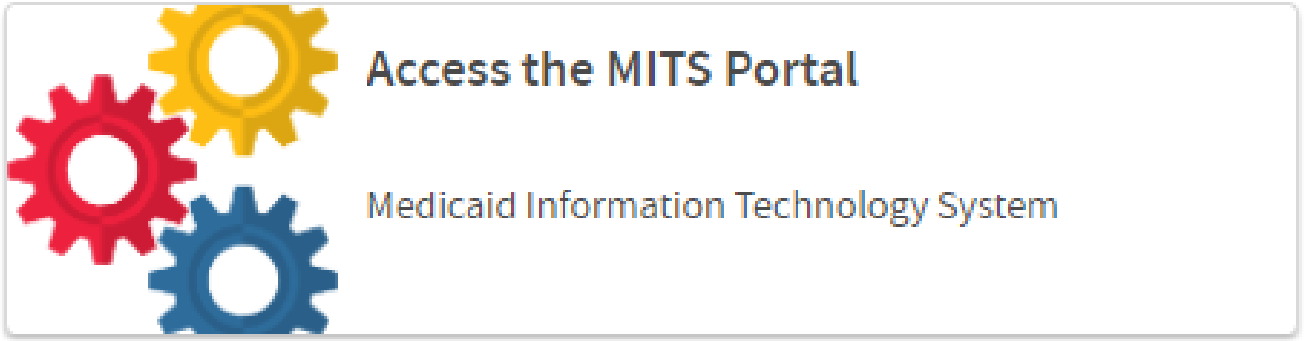
How to Access the MITS Portal

» Go to https://Medicaid.ohio.gov

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

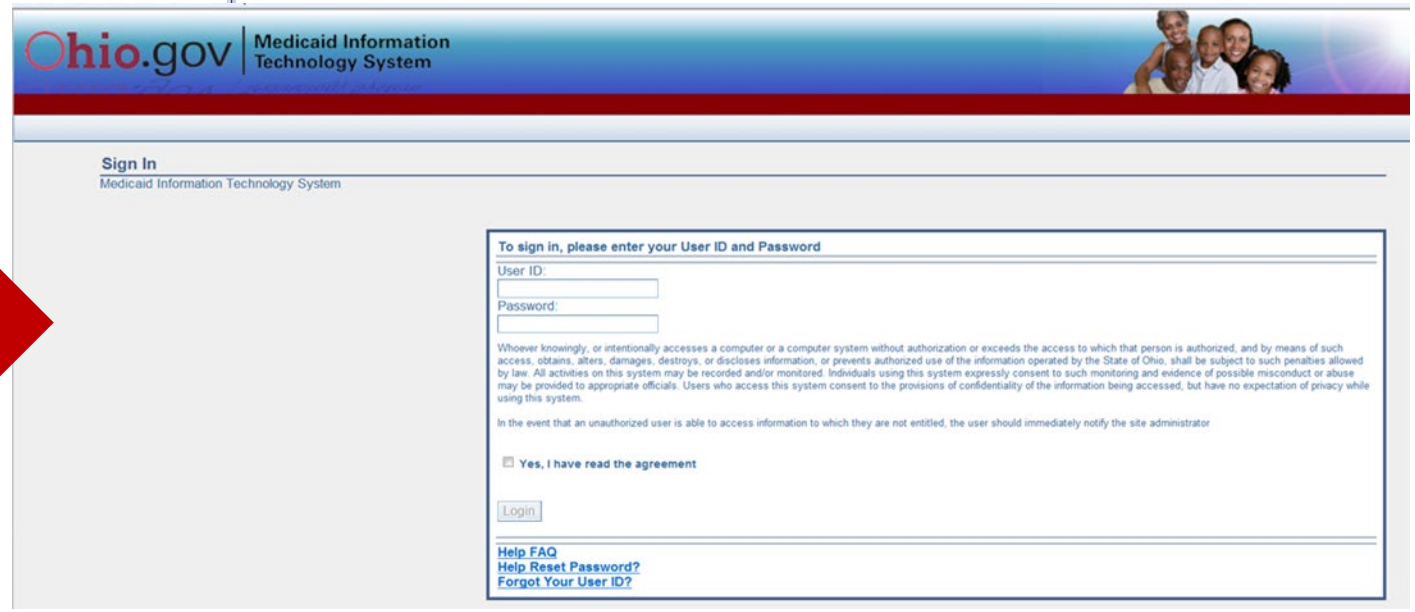
» Click on “MITS”

» Scroll down and click “Access the MITS Portal on the right



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

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



MITS Navigation

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

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

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

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

Electronic Funds Transfer

ODM will start requiring Electronic Funds Transfer (EFT) for payment instead of paper warrants

Benefits of direct deposit include:

- **Quicker funds-** transferred directly to your account on the day paper warrants are normally mailed
- **No worry-** no lost or stolen checks or postal holidays delaying receipt of your warrant
- **Address change-** your payment will still be deposited into your banking account

Electronic Data Interchange (EDI)

Fees for claims submitted

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

MITS Portal

Free submission

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

We can help with your claim issues

Technical Questions/EDI Support Unit

Trading partners contact DXC for EDI Support

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

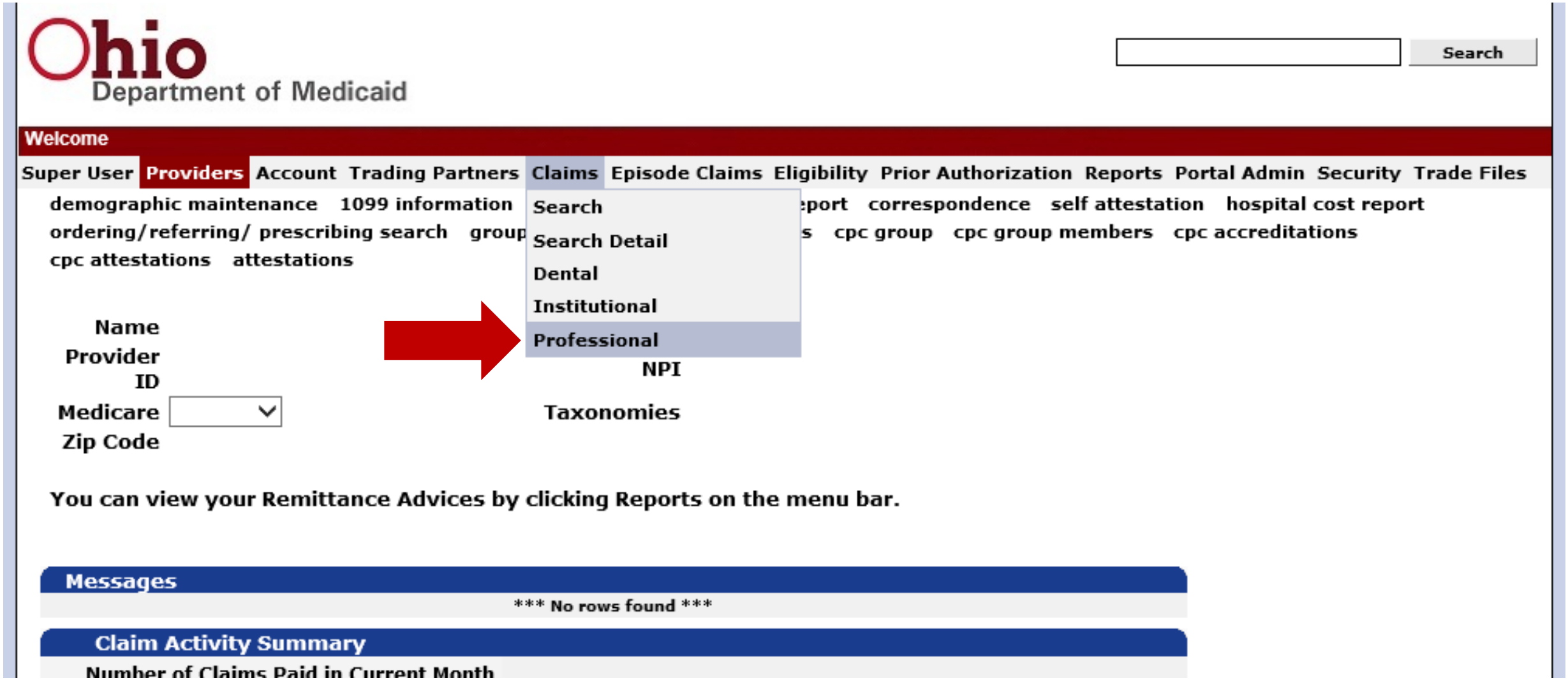
MITS Web Portal Claim Submission

Claim entry format is divided into sections or panels

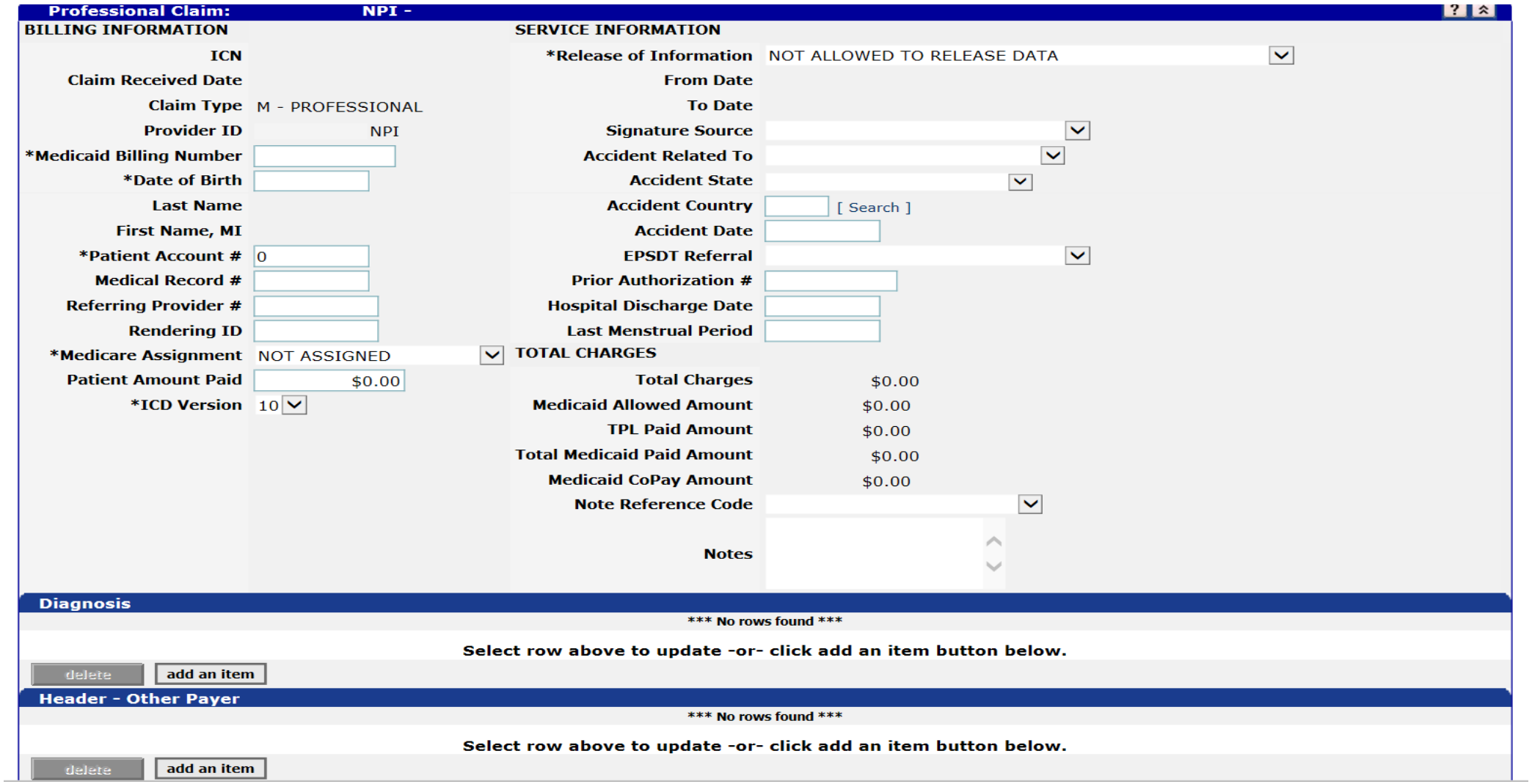
Each panel will have an asterisk (*) denoting that the fields are required

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

Submission of a Professional Claim

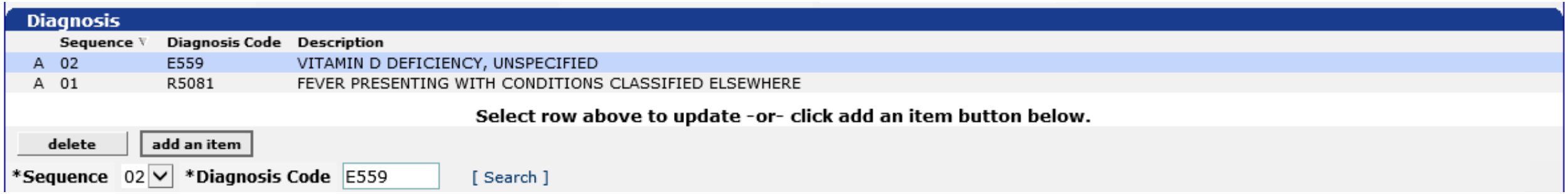


Submission of a Professional Claim

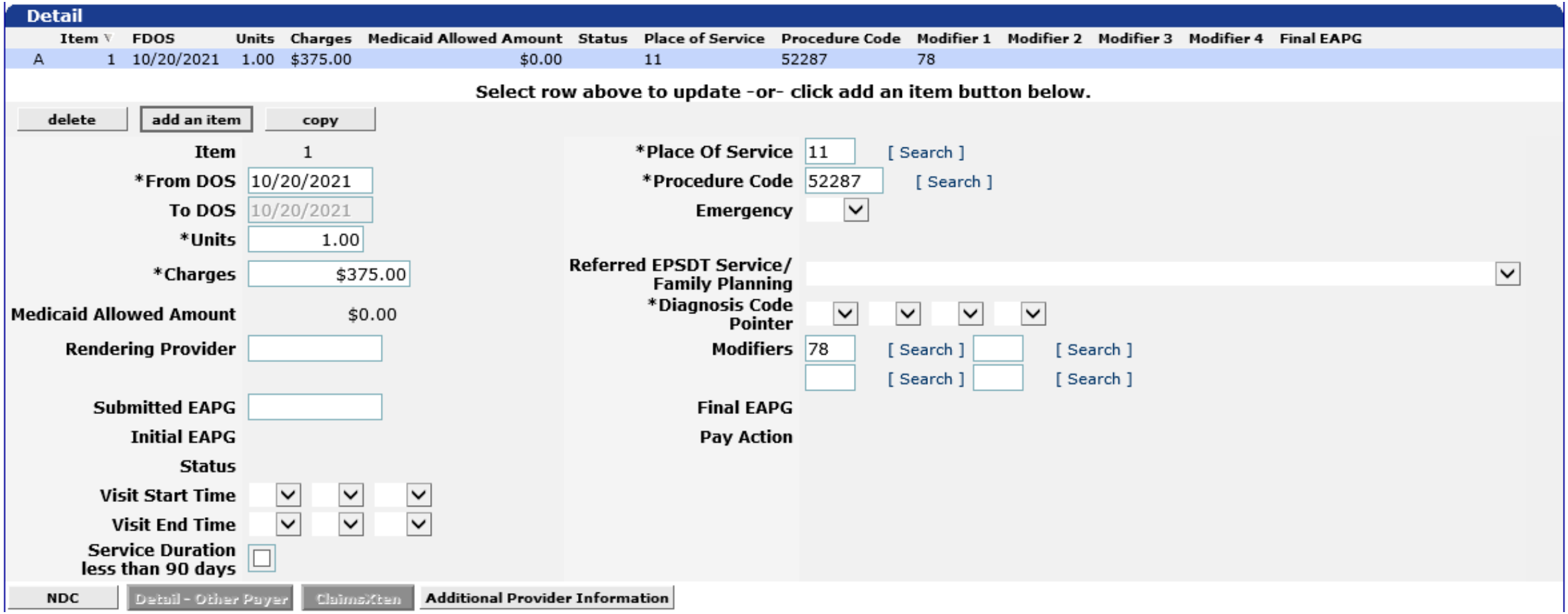


Diagnosis Codes: Medicaid Advisory Letter (MAL) No. 626-A

- 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



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)

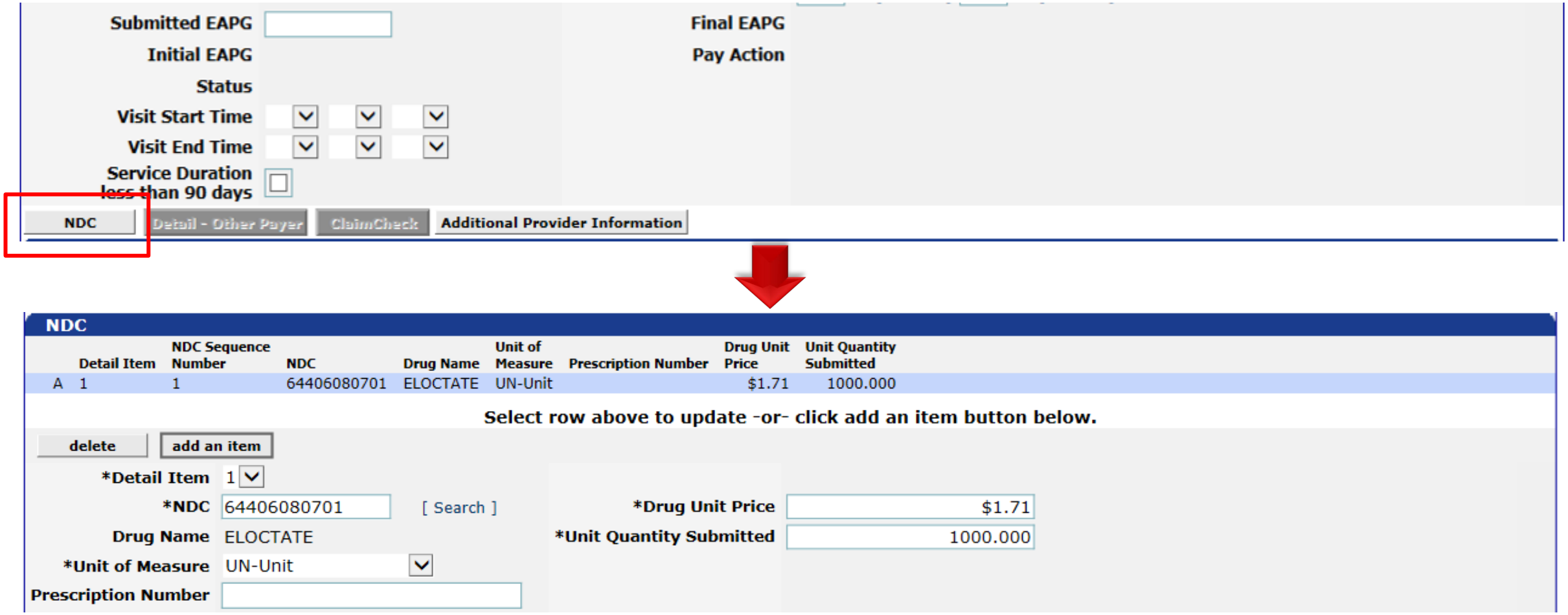
- Drug products are identified and reported using a unique, three-segment number which serves as a universal product identifier for drugs

- 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 claim submissions are assigned an ICN

2221170357321

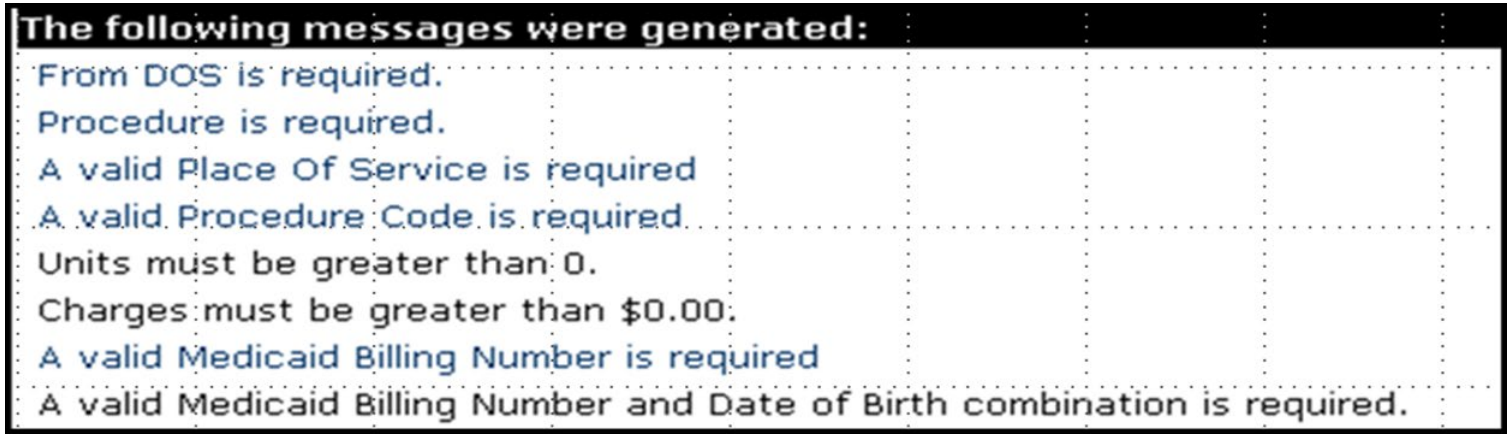
Region Code	Calendar Year	Julian Day	Claim Type/ Batch Number	Claim Number in Batch
22	21	170	357	321

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



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

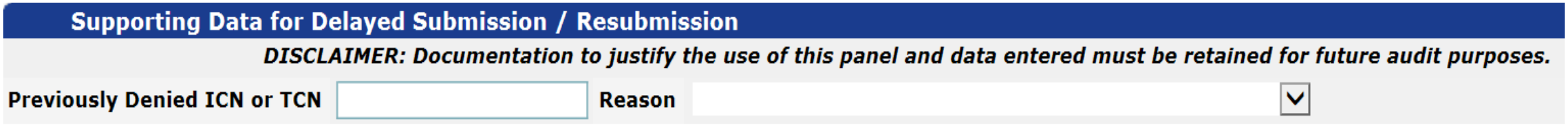
An additional 180 days from the resubmit date is given for attempts to correctly submit a denied claim prior to the end of the 365 days

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

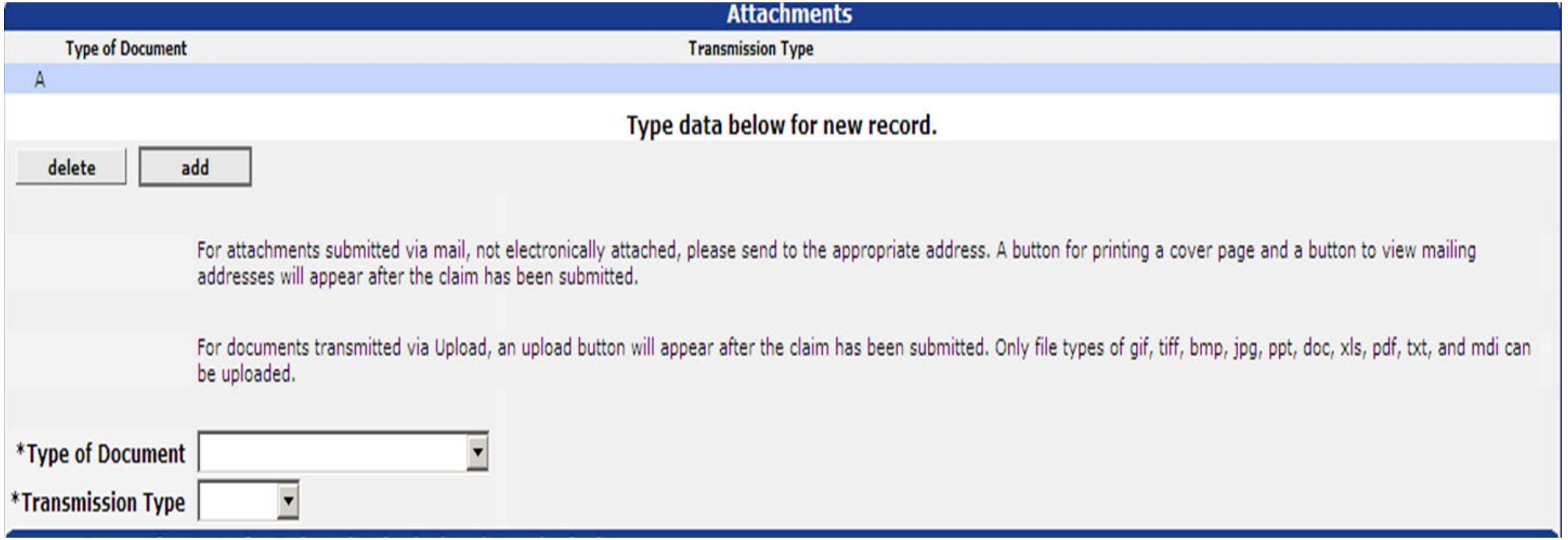
Must use the spacing shown

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

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

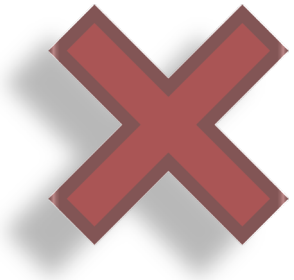
5021173127250 Now paid $45.00

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

ClaimChek 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

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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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

Header vs. Detail

Header level

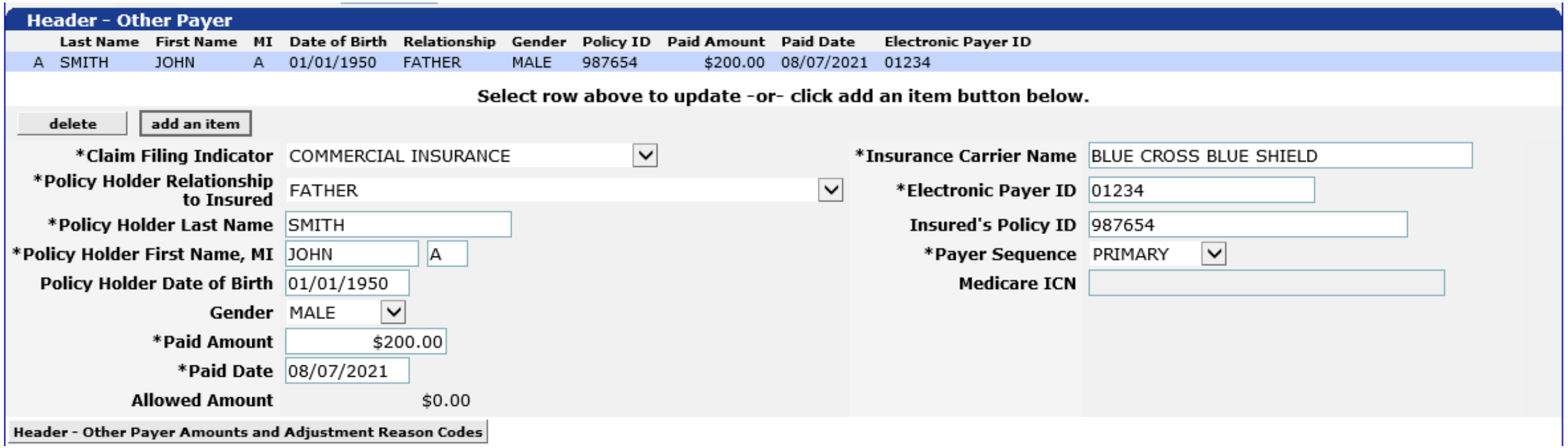
- A COB claim is considered to be adjudicated at the header/claim level if only one set of figures is reported for the entire claim

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

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



Header - Other Payer

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

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

delete | add an item

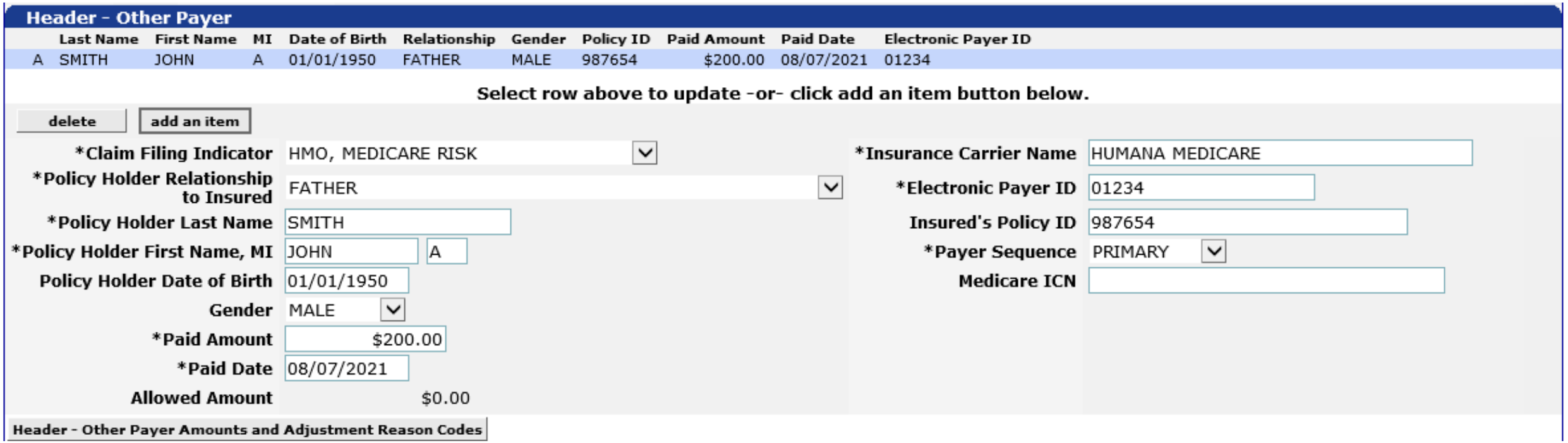
*Claim Filing Indicator: COMMERCIAL INSURANCE
*Policy Holder Relationship to Insured: FATHER
*Policy Holder Last Name: SMITH
*Policy Holder First Name, MI: JOHN A
Policy Holder Date of Birth: 01/01/1950
Gender: MALE
*Paid Amount: $200.00
*Paid Date: 08/07/2021
Allowed Amount: $0.00

*Insurance Carrier Name: BLUE CROSS BLUE SHIELD
*Electronic Payer ID: 01234
Insured's Policy ID: 987654
*Payer Sequence: PRIMARY
Medicare ICN:

Header - Other Payer Amounts and Adjustment Reason Codes

Third Party Liability (TPL) Claims

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



Header - Other Payer

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

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

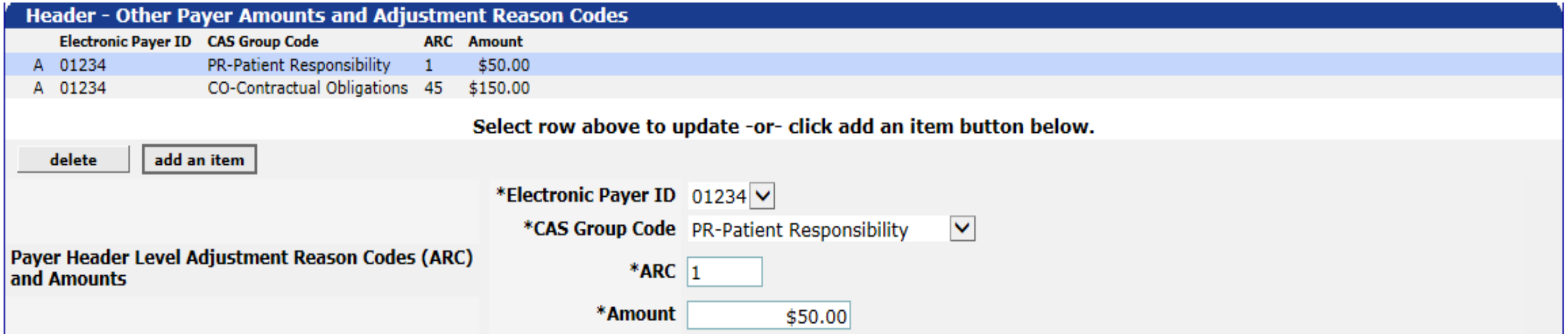
delete | add an item

*Claim Filing Indicator	HMO, MEDICARE RISK	*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

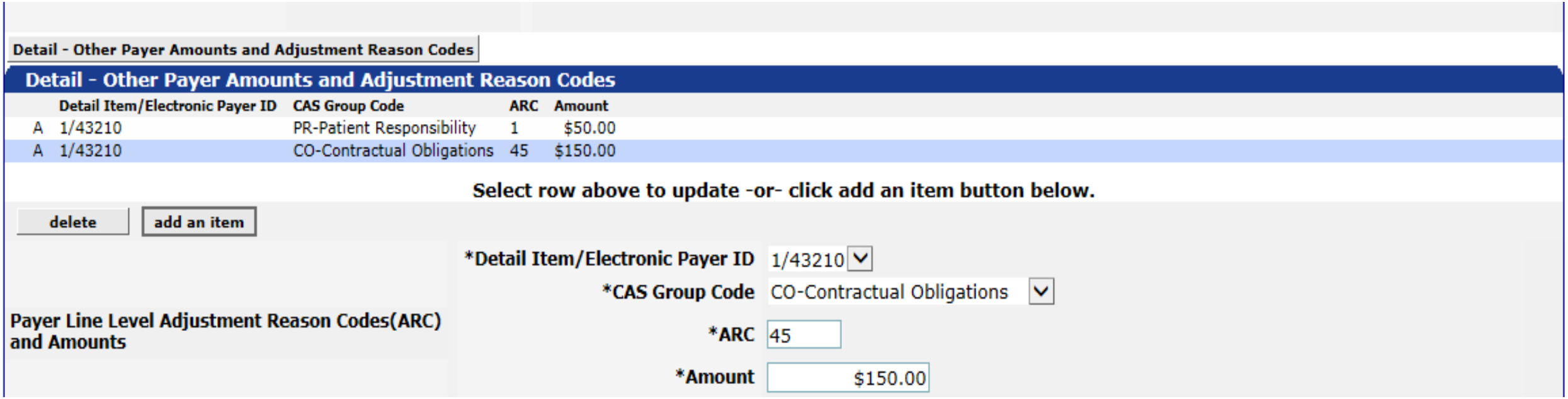
Third Party Liability (TPL) Claims

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



Adjustment Reason Codes (ARCs)

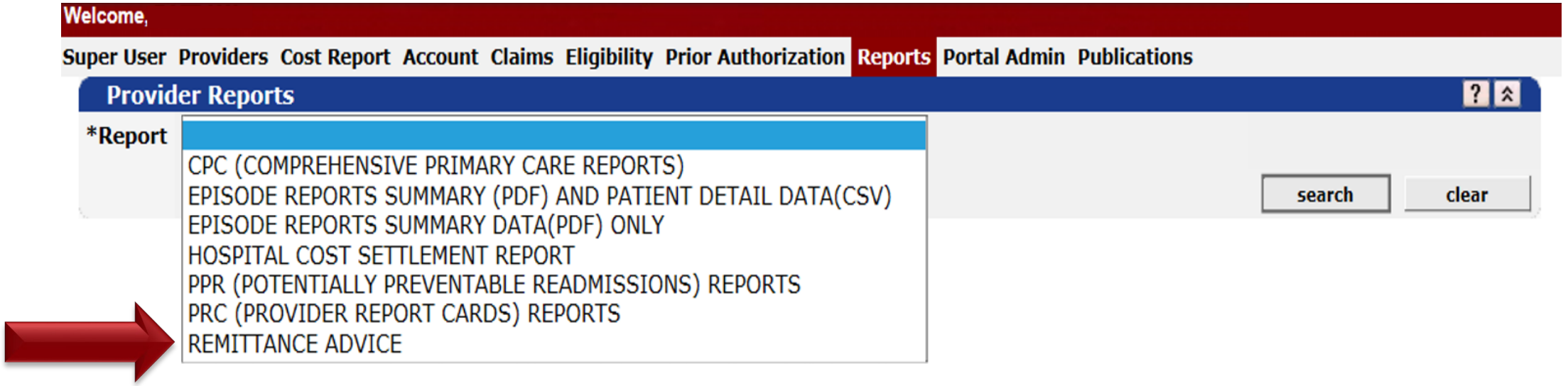
The X12 website provides adjustment reason codes (ARCs)

COMMON ARCs:

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

Remittance Advice (RA)

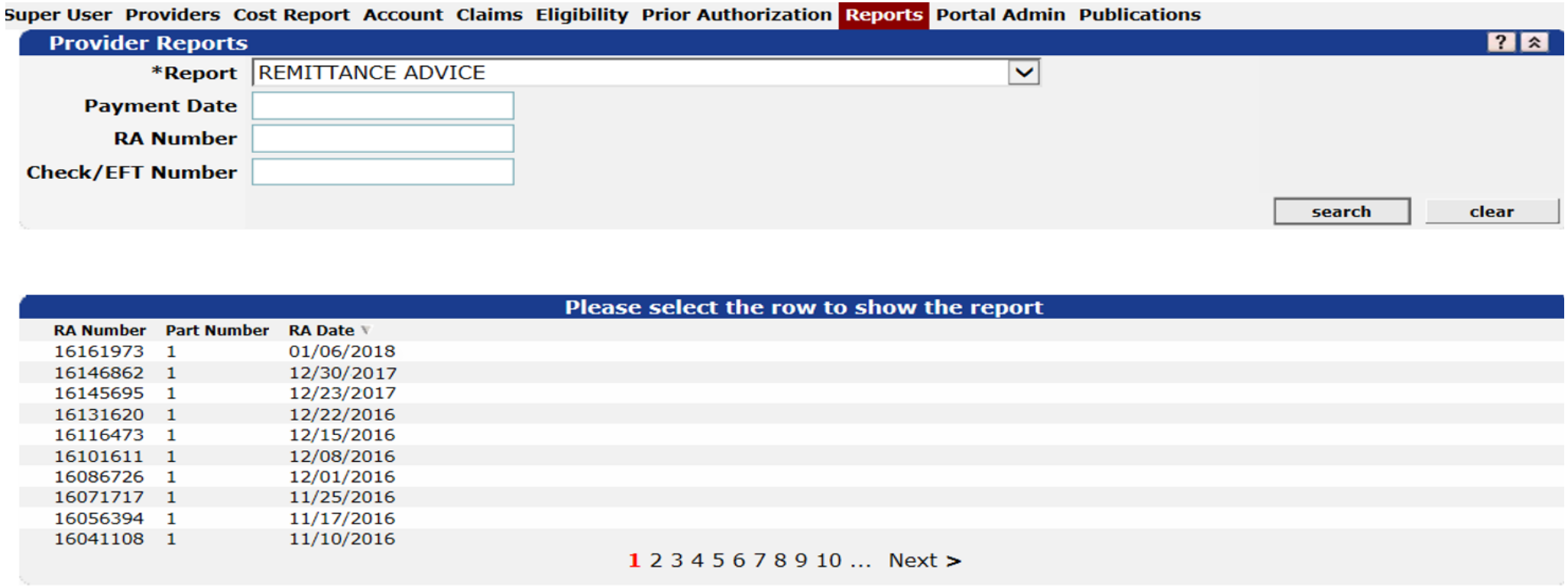
- All claims processed are available on the MITS Portal
- Weekly reports become available on Wednesdays



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

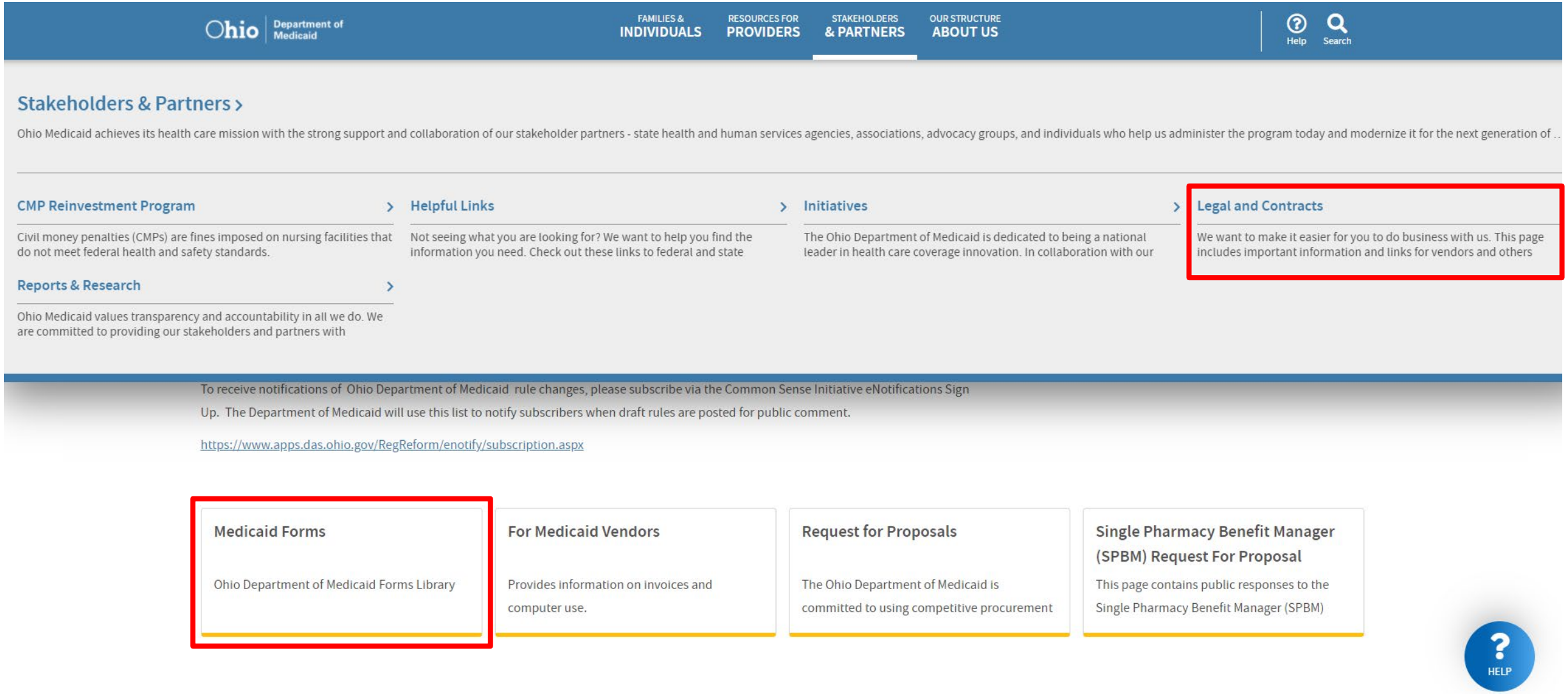
Forms

- 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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RESOURCES FOR PROVIDERS
STAKEHOLDERS & PARTNERS
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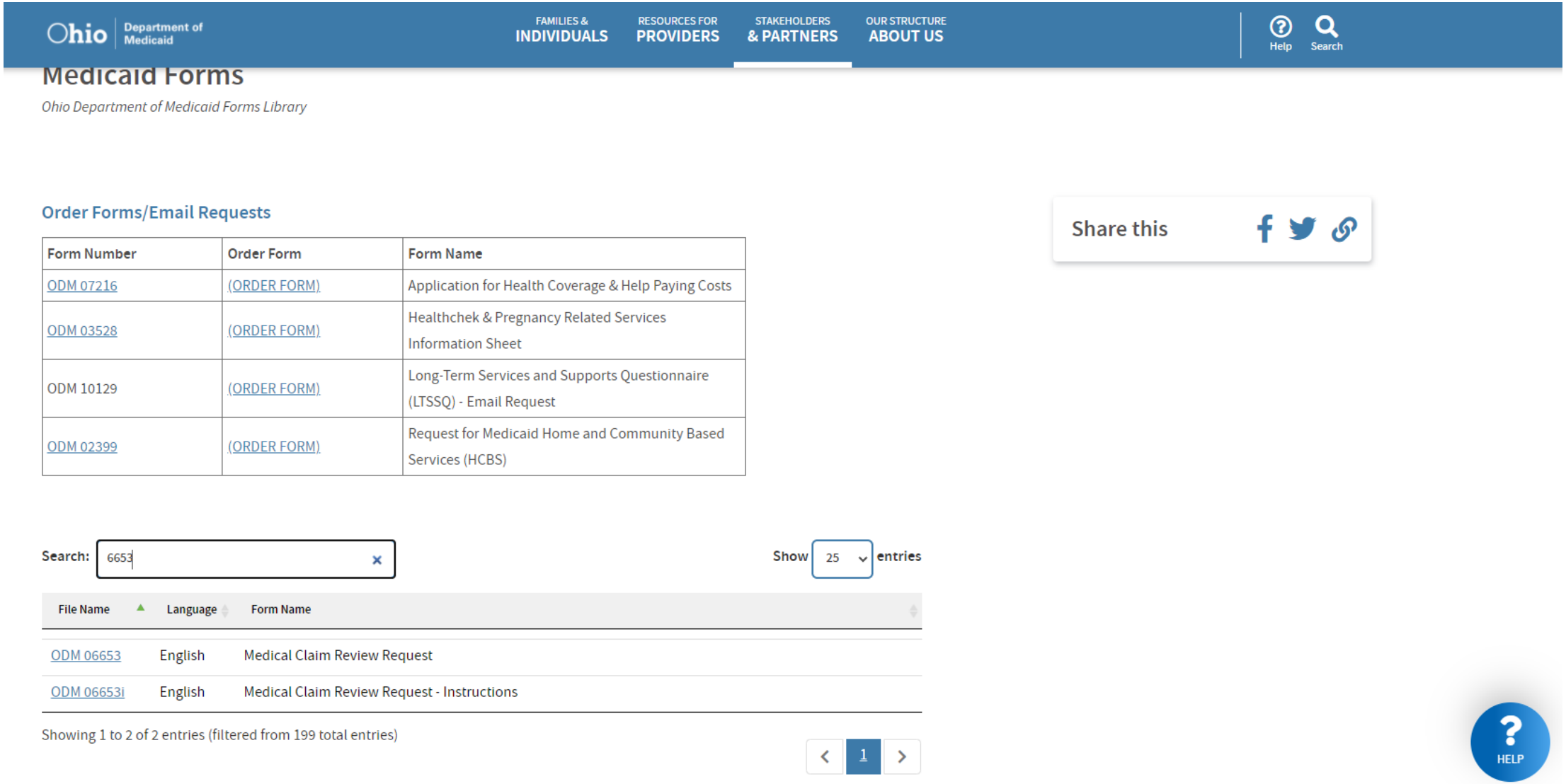
Stakeholders & Partners ›
Ohio Medicaid achieves its health care mission with the strong support and collaboration of our stakeholder partners - state health and human services agencies, associations, advocacy groups, and individuals who help us administer the program today and modernize it for the next 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



Ohio | Department of Medicaid

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Medicaid Forms

Ohio Department of Medicaid Forms Library

Order Forms/Email Requests

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

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Search: 6653 ×

Show 25 entries

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

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

< 1 >

HELP