

Payer Update Unanswered Questions

The answers noted below should not take the place of contacting Ohio Medicaid regarding specific questions and/or issues.

1. The 25 claims submitted per day, is that per provider or per login????

RESPONSE: The 25 claims per day limit for submitting claims via the portal is per provider.

2. Why is it that when a patient has a private insurance and ODJFS is a secondary, the private insurance pays their part and the provider cannot collect the remaining amount?

RESPONSE: If a patient has private insurance, Medicaid will pay for services up to the Medicaid maximum for each service minus the amount received from the private payer. If the provider received more than the Medicaid maximum from the private payer, Medicaid will “pay” the provider “\$0.00.” Please note that \$0.00 is considered a payment by Ohio Medicaid.

3. Please advise how to file a claim to Medicaid for co-pays-coinsurance-deductibles when Medicare Advantage is primary?

RESPONSE: Refer to the attached Part C billing instructions.

4. The Portal and IVR (Interactive Voice Response system) will not give eligibility on some patients. It refers you to the patient’s caseworker and indicates “duplicate in system.” Some patients are in managed care so they do not have a monthly card.

RESPONSE: Correct. There are Medicaid recipients in foster care that have more than one Medicaid billing number (aka, recipient identification number). Therefore, when providers check a Medicaid recipient’s eligibility (via the IVR or the portal) using the recipient’s social security number and date of birth, those systems will indicate that there’s “more than one match.”

When recipients have more than one Medicaid billing number, providers must obtain the recipient’s Medicaid billing number from the Medicaid recipient, the Medicaid recipient’s caseworker at the county department of job and family services, or contact a Provider Assistance representative at 1-800-686-1516.

5. Does the e-portal list if a patient has eligibility QMC only like VRI? If the e-portal has wrong payer info can it be updated thru the e-portal?

QMC RESPONSE: I assume this question involves the Qualified Medicare Beneficiary (QMB) program. If so, the portal will denote eligibility for a client on the QMB program as QMB ONLY or QMB & MEDICAID. If the question involves QMC, please clarify.

If a client is QMB ONLY (for the date of service), the client isn’t a Medicaid recipient. However, Medicaid will pay the client’s Medicare coinsurance and/or deductible as a Medicare Crossover claim. Refer to the attached “Medicare/Medicaid Crossover Billing Instructions” and Part C billing instructions for details.

If a client is QMB & MEDICAID (for the date of service), the client is a Medicaid recipient. Therefore, Medicaid will pay the client's Medicare coinsurance and/or deductible as a Medicare Crossover claim. If the service isn't a covered Medicare service, the provider can submit the claim to Medicaid as a fee-for-service claim.

UPDATING VIA THE PORTAL RESPONSE: Providers cannot update client or provider information via the portal.

- 6. I understand that all groups/providers will be required to re-enroll every 3 years. After the initial period, wouldn't it make more sense to require that existing Medicaid numbers be renewed rather than require that a new REENROLLMENT APPLICATION be completed?**

RESPONSE: Until providers can reenroll via MITS (Medicaid Information Technology System), providers must complete a new hard-copy application for reenrollment. When MITS is implemented, the reenrollment process will be more user friendly, and providers can update their provider information online rather than submitting a hard-copy application.

- 7. Regarding new physician credentialing (i.e., enrollment process for Medicaid providers), and a physician completes residency program June 30, 2008:**
- a. Can we start the credentialing process before residency is completed or do we need residency certificate before we can submit the credentialing packet?**
 - b. How long is the credentialing process?**
 - c. Will you back date the effective date???**

7a RESPONSE: A physician can enroll as a Medicaid provider after the physician receives a valid physician's license. Completing a residency isn't a requirement for Ohio Medicaid.

7b RESPONSE: The enrollment process takes approximately 13 weeks from the date the application is received. If applications have to be returned to the provider, the enrollment process will take longer. If providers have questions regarding their enrollment applications, they should contact a Provider Enrollment representative at 1-800-686-1516.

7c RESPONSE: The effective date of a provider agreement can be backdated no later than one year from the application date. However, no agreement will be backdated any later than the effective date of the provider's license.

- 8. Are you ever going to get providers credentialed in fewer than 4 ½ months?**

RESPONSE: When MITS is implemented, providers can enroll and reenroll online. Therefore, the enrollment/credentialing process will be much quicker.

- 9. You mentioned you need both the legacy and NPI for claim submission. If I add a new physician in August and the individual does not have a legacy number, can claims be submitted through the portal without a legacy #?**

RESPONSE: Rendering and group providers must have a legacy and NPI (National Provider Identifier) number to receive payment from Ohio Medicaid, and those provider numbers must be noted on each claim submitted to Ohio Medicaid.

10. We are a group practice of 3 doctors. We didn't register the practice as a group. If I reenroll as a group practice, will this create a 3 year reenroll date the same for all 3 physicians?

RESPONSE: The 3 physicians and the group may have separate time-limited agreements. Therefore, their enrollment and reenrollment dates may be different.

If the 3 physicians don't have time-limited agreements, they will receive a conversion letter between January 29, 2009 and December 10, 2010 that will give them more information regarding reenrollment. Please note that the 3 physicians could have different reenrollment dates, because their reenrollment dates are based on the effective date of their provider agreement.

The newly enrolled group will automatically have a time-limited agreement. The details regarding the time-limited agreement will be included with the information received from Ohio Medicaid when the group receives its legacy number.

11. How is it determined (month to month) what coverage a patient will have? Example: If a patient is on Medicaid one month and switched to CareSource the next month.

RESPONSE: Medicaid recipients' individual situations determine coverage from month to month. Therefore, providers should check each client's eligibility prior to rendering services. The portal is a good resource for checking eligibility.

For example, a client received services through a Medicaid Managed Care plan (MCP) with eligibility ending in March, and the county caseworker reestablishes eligibility in May. In this situation, the client would not be a Medicaid recipient in April. In May, the client would be enrolled in traditional (fee-for-service) Medicaid and would transfer to a MCP in June.

12. Is it still necessary to use the legacy provider # for referrals vs. just the NPI?

RESPONSE: If appropriate, providers should denote a referring provider's legacy provider number and NPI on claims. However, if a referring provider doesn't have a legacy provider number (i.e., not an Ohio Medicaid provider), only denote the NPI on the claim. Providers will be notified if this process changes.

13. For patients on spenddowns: If they incur expenses in excess of their spenddown on the first day, will coverage begin that day or the next?

RESPONSE: For clients with a spenddown obligation, Medicaid coverage begins the date the spenddown obligation is met. For example, if the spenddown obligation is met on June 3, the client will be eligible for Medicaid on June 3 until the end of the month.

14. Providers are currently being denied on any claim where a modifier 25 exists. Will the new MITS system change that? We understand that a 2nd CPT code may be denied as bundled but we don't find it appropriate to reject the entire claim upfront due to the existence of a standard modifier. We currently have to resubmit the claim to be paid on any of the services?

MODIFIER 25 RESPONSE: Modifier 25 isn't a valid modifier for Ohio Medicaid, and MITS will not change that. Therefore, follow the process noted below to avoid denied claims for invalid modifiers.

BUNDLED SERVICE RESPONSE: Since modifier 25 isn't a valid modifier for Ohio Medicaid, providers should refer to the eManuals website (<http://emanuals.odjfs.state.oh.us/emanuals>) when providing services that relate to a situation that involves using modifier 25 (or other invalid modifiers). If you have questions regarding the eManuals website, please contact a Provider Assistance representative at 1-800-686-1516.

15. When Medicaid is 2nd insurance patient is saying they don't pay any copay because Medicaid will pick it up but Medicaid has never picked up a copay as 2nd insurance.

RESPONSE: Please refer to the attached billing instructions (arrangements 1, 2 & 3 in form locator 24f) regarding co-payments for commercial payers (i.e., 2nd insurance).

Item	Name	Instructions
1	Medicaid	Check Medicaid as the type of health insurance.
1a	Insured's I.D. Number	Enter the 12 digit Billing Number from the consumer's Medical card (Ohio Medicaid, Disability Assistance, etc.). Do not use any number other than the one designated on the medical card as "Billing Number."
2	Patient's Name	Enter the consumer's last name, first name, and middle initial, if any, as shown on the medical card.
3	Patient's Birth Date and Sex	Leave blank.
4	Insured's Name	Leave blank. Consumer and insured must always be the same.
5	Patient's Address	Leave blank other than for abortion claims.
6	Patient Relationship to Insured	Leave blank. For Medicaid and Disability Assistance, consumer and insured will always be the same
7	Insured's Address	Leave blank.
8	Patient Status	Leave blank.
9	Other Insured's Name	If the consumer is covered by a private health insurance policy (other than Medicare), enter the name of the person who holds the insurance policy. For example, Jane Doe is covered under her father's (John's) Blue Cross plan. The name of Jane's father (John Doe) would go in this space.
9a	Other Policy or Group Number	Enter the policy and/or group number of the private insurance policy (other than Medicare) referred to in Item 9.
9b	Date of Birth/Sex	Leave blank.
9c	Employer Name	If available, enter the name of the employer or holder of an individual private insurance policy.
9d	Insurance Plan or Program Name	Enter the name of the insurance plan listed in 9a.
10a-c	Patient's Condition	Check "YES" or "NO" to indicate whether employment, auto, or other accident involvement applies to one or more of the services described in Item 24. Transportation Provider: Leave blank.
10d	Reserved for Local Use (aka: Other Source)	Medicaid uses this space for information regarding other sources of payment for services. Only one character may be entered in this space. Enter 1-8 from the other source code below if you have received payment for the service from a source other than Medicaid or Medicare. When 1-8 is entered in this block, the amount collected must be entered in block 29. Hospice Agency: When billing hospice room and board (T2046) for a consumer residing in a long term care

Item	Name	Instructions
		<p>facility, do not use an indicator to report patient liability. See the instructions in the dates of service block 24(a) on how to apply patient liability amounts.</p>
	1 Self/Family/Spenddown	
	2 Blue Cross/Blue Shield	
	3 Private Carrier	
	4 Employer or Union	
	5 Public Agency	
	6 Other (enter the name and address of the source in the provider remarks section)	
	7 Psychiatric Reduction	
	8 FQHC/Rural Health Center Managed Care Supplemental Payment (See FQHC rule: 5101:3-28-07)	
		<p>Enter R, P, F, L, E, S, or X if you have billed all third-party insurers first and you have not received payment from a third party insurer within ninety days, but there are indications of private (non-Medicaid/non-Medicare) health insurance coverage for any eligible individual that is listed on the Medical card of the consumer. Documentation to justify use of codes R, P, F, L, S, E, and X must be retained for future audit purposes.</p>
		<p>R No Response From Carrier--There was no response from the insurance carrier for 90 days. A claim with this code may not be submitted until 91 days after the date of treatment.</p>
		<p>P No Coverage for this Consumer Billing Number--The provider has confirmed there is private health insurance (other than Medicaid or Medicare) for some eligible individuals listed on the consumer's Medical card, but the consumer is not covered. If the Medical card indicates the consumer has third-party insurance but you have verified that the consumer does not have third-party insurance, complete the JFS 06614 form.</p>
		<p>F No coverage for All Consumer Billing Numbers--There is no private health insurance (other than Medicaid or Medicare) for any eligible individual listed on the medical card. If the medical card indicates all the eligible individuals listed on the medical card have third-party insurance and you have verified all the eligible individuals listed on the card do not have third-party</p>

Item	Name	Instructions
		<p>insurance, complete the JFS 06614 form.</p> <p>L Disputed or Contested Liability--The provider has confirmed there is private health insurance (other than Medicaid or Medicare), but the coverage for the billed service is disputed or contested by the insurance carrier due to a pre-existing condition or other policy limitation. Do not use this code for when the insurance carrier is requesting additional information.</p> <p>S Non-Covered Services--The provider has confirmed there is private health insurance (other than Medicaid or Medicare), but the policy does not cover the services being billed. This code should also be used when the policy does not cover the services being billed or when the amount billed has been applied to the insurance deductible.</p> <p>E Insurance Benefits Exhausted--The provider has confirmed there is private health insurance (other than Medicaid or Medicare), but the policy benefits for the billed services have been exhausted.</p> <p>X Non-Cooperative Consumer--The provider has confirmed there is private health insurance (other than Medicaid or Medicare), but the consumer refused to cooperate in the collection effort. Providers are expected to take reasonable measures to ascertain any third-party resource available to the consumer and to file a claim with that third-party insurer.</p> <p>Leave Blank, if there is not a payment from another source and there is no indication of private health insurance coverage (non-Medicaid/non-Medicare) for the consumer.</p>
11	Insured's Policy Group	Leave blank. This is always the consumer's Billing Number and is only reported in Item 1a.
11a-c		Leave blank.
11d		Check "YES" or "NO" to indicate if there is any insurance other than Medicaid or Medicare. If yes, complete Item 9.
12	Signature	May be left blank if consumer does not have third-party insurance or any other payment source (See note below).
13	Signature	May be left blank if the consumer does not have third-party or any other payment source (See note below).
Note: Signatures in items 12 and 13 are not required by Medicaid. However, if the		

Item	Name	Instructions
		consumer has third-party coverage in addition to Medicaid, the signatures may be necessary for reimbursement from the third-party insurer. Medicaid does not reimburse for services denied by the third-party insurer or uncollected payments due to a providers failure to secure the appropriate signatures on the claim.
14	Date of Current Illness, Injury or Pregnancy	Complete this field for pregnancy only. Enter the six digit (MMDDYY) or eight digit (MMDDCCYY) date of the last menstrual period.
15	Same or Similar Illness	Leave blank.
16	Dates Patient Unable to Work in Current Occupation	Leave blank.
17	Name of Referring Physician	If the consumer was referred to you, enter the referring physician's name and complete both 17a and 17b as instructed.
17a	ID Number of Referring Physician	<p>Please read these instructions carefully. Failure to enter the appropriate identifiers when required will result in a claim denial.</p> <p>If the consumer was referred to you, enter the referring physician's Medicaid legacy number. If the referring provider's Medicaid legacy number is not available, enter 9111115 in this space unless the instructions for this field specify otherwise.</p> <p>This field is required when billing for consultative visit codes or other diagnostic and laboratory procedure codes that indicate a consultative service. Enter the referring physician's Medicaid legacy number in this field (or 9111115 if the number is not available).</p> <p>This field is required when billing for services provided to a PACT consumer, for whom you are not the designated PACT provider. Contact the PACT provider listed on the consumer's Medical card when a PACT consumer is referred to you. Enter the designated PACT provider's Medicaid legacy number in this field.</p> <p>FQHC's and RHC Supplemental Payments: This field is required when billing on paper claims for Medicaid Managed Care Plan (MCP) supplemental payments per rule 5101:3-28-07. Enter the MCP's Medicaid legacy number.</p> <p>Medical Supply Provider: Enter the Medicaid legacy number of the prescribing provider.</p>

Item	Name	Instructions				
		<p>Transportation Provider: For all non-emergency transport, a physician must certify that all ambulance and ambulette non-emergency transport services are medically necessary. Enter the Medicaid legacy number of the attending or ordering physician.</p>				
17b	<p>NPI of Referring Physician</p>	<p>Enter the NPI of the referring provider associated with the name of the referring physician in field 17. This field is required when the referring provider's Medicaid legacy number is required as instructed in field 17a, with the exception of FQHC and RHC supplemental payments. Leave this field blank when billing for Medicaid Managed Care Plan (MCP) supplemental payments and enter the Medicaid legacy number for the MCP in 17a.</p>				
18	<p>Hospitalization Dates</p>	<p>Leave blank except for:</p> <p>Home Health and Private Duty Nursing Provider: Enter the six digit (MMDDYY) date of discharge in the "To" field when billing services provided after as a result of a post-hospital stay. The date of discharge can never be greater than 60 days from the date of service recorded in item 24a.</p>				
19	<p>Reserved for Local Use (aka: Remarks) Medicaid Co-Payments</p>	<p>Leave blank unless the service you are billing for is subject to a co-payment as described in rule 5101:3-1-09 of the Administrative Code. If a co-payment does apply, but meets one of the exclusions described in the above rule, and a co-payment should not be charged/collected, providers must bill ODJFS using one of the 10-byte exclusion codes provided in the table below to indicate that a co-payment should not be taken for the service provided to the Medicaid consumer.</p> <p>Note: If an exclusion applies and must be entered into the remarks field, no other remarks may be entered prior to the copayment exclusion code on the claim. Co-payment exclusion codes must always come first in the remarks field to ensure proper adjudication of the claim.</p> <table border="1" data-bbox="667 1633 1365 1837"> <thead> <tr> <th data-bbox="667 1633 1015 1707">Exclusion Description</th> <th data-bbox="1015 1633 1365 1707">Exclusion Code (Enter into Remarks Field)</th> </tr> </thead> <tbody> <tr> <td colspan="2" data-bbox="667 1707 1365 1837"> <p>Important: The caret (^) denotes that a space must be placed between the qualifier (e.g. COPAY) and the exclusion code (e.g. PREG). This space must be entered for the claim to adjudicate correctly and must</p> </td> </tr> </tbody> </table>	Exclusion Description	Exclusion Code (Enter into Remarks Field)	<p>Important: The caret (^) denotes that a space must be placed between the qualifier (e.g. COPAY) and the exclusion code (e.g. PREG). This space must be entered for the claim to adjudicate correctly and must</p>	
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Item	Name	Instructions						
		<p>be entered regardless of the exclusion code being sent for payment.</p> <table border="1" data-bbox="673 359 1365 709"> <tr> <td data-bbox="673 359 1019 499">If the consumer is pregnant or the pregnancy ended recently (up to 90 days ago)</td> <td data-bbox="1026 359 1365 499">COPAY ^ PREG</td> </tr> <tr> <td data-bbox="673 506 1019 569">If the consumer is receiving hospice services</td> <td data-bbox="1026 506 1365 569">COPAY ^ HSPC</td> </tr> <tr> <td data-bbox="673 575 1019 709">If the consumer received services subject to a copayment due to an emergency</td> <td data-bbox="1026 575 1365 709">COPAY ^ EMER</td> </tr> </table>	If the consumer is pregnant or the pregnancy ended recently (up to 90 days ago)	COPAY ^ PREG	If the consumer is receiving hospice services	COPAY ^ HSPC	If the consumer received services subject to a copayment due to an emergency	COPAY ^ EMER
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		<p>Note: Exclusions for consumers either under the age of 21, or who are receiving family planning services or who are institutionalized (i.e. reside in a nursing facility or ICF-MR) will not need to be indicated in the remarks field for the co-payment exclusion to take effect. ODJFS' adjudication system will automatically detect these exclusions and will not take a copayment on services rendered to these consumers.</p>						
20	Outside Lab	Leave blank.						
21	Diagnosis or Nature of Illness or Injury	<p>Enter all the ICD-9 diagnosis codes in order of significance, up to a maximum of four, that apply for the services listed in item 24.</p> <p>Note: Medicaid will read only primary and secondary codes. A diagnosis code must be present on all claims other than independent laboratory, physiological laboratory, portable x-ray, transportation, and waiver claims.</p>						
22	Medicaid Resubmission Number	<p>Under "Original Ref. No." enter the 17-digit transaction control number (TCN) associated with any claim being resubmitted that is older than 1 year (365 days). If additional space is needed, use Block 19. These claims must be submitted with a JFS 06653 Medical Claim Problem form to:</p> <p style="text-align: center;">Provider Network Management Section P.O. Box 1461 Columbus, Ohio 43216-1461</p>						
23	Prior Authorization Number	<p>Complete only if prior/payment authorization is required for any of the services billed. Use the ODJFS assigned six digit number from the approved "Prior Authorization" notification. Refer to the appropriate Medicaid program</p>						

Item	Name	Instructions
		<p>rules to determine what services require prior authorization.</p> <p>Transportation Provider: Complete only if Prior Authorization is required for the services billed.</p> <p>ODJFS Administered Waiver Provider: Complete for supplemental adaptive assistive device services (T2029) or home modification services (S5165) using the instructions listed above.</p> <p>Private Duty Nursing Provider: Prior authorization number is required on dates of service on or after 10/01/06 when billing the procedure code/modifier combination of T1000 and U5 or U6 unless the consumer is enrolled on a ODJFS-administered home and community based waiver.</p>
24a	Date(s) of Service	<p>Enter the date the service was rendered in the "From" section. The date is entered using the six-digit (MMDDYY) format. Enter all six digits consecutively without dashes, slashes, or spaces. Do not enter a date under the "To" section.</p> <p>Note: A separate line is required for each date of service.</p> <p>Note: Failure to enter a date in "From" column will cause the line item to reject.</p> <p>Note: All services must be billed to Medicaid within 365 days of the date of service.</p> <p>Home Health, Private Duty Nursing, and ODJFS Administered Waiver Provider: Each line must represent a single visit. Multiple visits of the same service must be billed on separate lines but on the same claim. A visit for the provision of the same service or service with the same scope of service must be separated by two hours, unless the private duty nursing service has the exceptions found in rules 5101:3-12-02 and 5101:3-12-04 of the Administrative Code. Note: If a visit begins in the late evening and continues after midnight, the visit must be billed as a single visit with the date of service being the date the visit began.</p>

Item	Name	Instructions
		<p>Hospice Agency: When billing for hospice room and board (T2046), do not bill for the room and board days covered by the patient liability if the consumer resides in a long term care facility (LTCF) and has a patient liability amount.</p> <p>For example, if the consumer enrolled in hospice resides in a LTCF for a month (i.e., 30 days) with a patient liability amount of \$1300 and 95% of the per-diem is \$100, the hospice agency should not bill for the first 13 days of the month (i.e., the days that the patient liability covers the charges). The hospice agency should only bill for the room and board days not paid by the patient liability amount, days 14-30.</p> <p>If the consumer enrolled in hospice resides in a LTCF for a month (i.e., 30 days) with a patient liability amount of \$525 and 95% of the per-diem is \$100, the hospice agency should not bill for the first five days of the month (i.e., the days that the patient liability covers the charges). The hospice agency must reduce the charges (i.e., \$100) for the sixth day by the remaining \$25. Therefore on day six, the hospice agency should bill \$75.</p> <p>If the consumer becomes enrolled in hospice in the middle of the month and resides in a LTCF, the hospice agency must request the unpaid patient liability amount from the LTCF. Any unpaid patient liability should be treated according to the above examples.</p>
24b	Place of Service	<p>All claims, other than those submitted by independent laboratories, portable x-ray suppliers, transportation providers and independent physiological laboratories, require a place of service. Enter the appropriate place of service from the list below:</p> <ul style="list-style-type: none"> 11 Office 12 Home 21 Inpatient Hospital 22 Outpatient Hospital 23 Emergency Room - Hospital 24 Ambulatory Surgical Center 25 Birth Center 26 Military Treatment Facility 31 Skilled Nursing Facility 32 Nursing Facility

Item	Name	Instructions
33	Custodial Care Facility	
34	Hospice	
41	Ambulance - Land	
42	Ambulance - Air or Water	
51	Inpatient Psychiatric Facility	
52	Psychiatric Facility-Partial Hospitalization	
54	Intermediate Care Facility/Mentally Retarded	
55	Residential Substance Abuse Treatment Facility	
56	Psychiatric Residential Treatment Center	
61	Comprehensive Inpatient Rehabilitation Facility	
62	Comprehensive Outpatient Rehabilitation Facility	
71	State or Local Public Health Clinic	
72	Rural Health Clinic	
73	Clinic, Not Otherwise Specified	
81	Independent Laboratory	
99	Other Unlisted Facility	
<p>Home Health Provider (Medicaid Certified Home Health Agency): Enter 12 for services rendered in the home. Enter 99 only for services rendered in a licensed child day-care center or in a setting where the child receives early intervention services (EI) as indicated in the individualized family service plan (IFSP).</p>		
<p>Private Duty Nursing Provider: Enter 12, since services are usually delivered in the home unless community exceptions are met. Enter 99 if community exceptions are met.</p>		
<p>ODJFS Administered Waiver Provider: Enter 12 for services rendered in the home, 99 for services rendered outside the consumer's home unless the service is out-of-home respite. For out-of-home respite enter either 31, 32, 33, or 54 as appropriate.</p>		
24c	EMG	Leave blank.
24d	Procedures/Services /Supplies	<p>PROCEDURE CODES</p> <p>Enter the five character/digit Healthcare Common Procedure Coding System (HCPCS) code which corresponds to the service rendered.</p> <p>FQHC, RHC, and OHF's: Bill the appropriate five-digit encounter code followed immediately on the next line by the HCPCS code(s) that correspond to the services rendered. HCPCS codes must follow the encounter code</p>

Item	Name	Instructions
		<p>to which they relate.</p> <p>Home Health, Private Duty Nursing, and ODJFS Administered Waiver Provider: Please note that codes specific to home health, private duty nursing, waiver (nursing/personal care) or waiver (other waiver services) cannot be billed on the same claim. For example, procedure codes G0154, T1000, T1019 or H0045 cannot be billed on the same claim.</p> <p>MODIFIERS</p> <p>In certain instances a two character/digit modifier will be required depending on the service. When entering a code with the modifier, enter the two character/digit modifier directly behind the solid hash line using no spaces, dashes or slashes.</p> <p>In other instances, multiple two character/digit modifiers will be required depending on the service. Up to four modifiers may be entered per line. When entering a code with multiple modifiers, enter the first character/digit modifier directly behind the solid hash line using no spaces, dashes or slashes. Enter any additional modifiers, up to six characters of two character/digit modifiers, behind the next hash line using no spaces, dashes or slashes.</p> <p>FQHCs: See the listing of HIPAA compliant code and modifiers for each type of encounter in MAL 442. RHCs: Bill T1015 modified by U1. See MAL 440 for more details. OHFs: See the listing of HIPAA compliant code and modifiers for each type of encounter in MAL 441.</p> <p>Transportation Provider: For example, if a consumer is a second passenger (U1) and is receiving an ambulette service in an ambulance (U3) and is being transported from a residence to a physician's office (RP) and upon arrival finds the physician is unavailable and has cancelled the appointment (U6). Using the instructions above the entered line would look like: A0428 RP U1U3U6.</p> <p>Home Health, Private Duty Nursing, and ODJFS</p>

Item	Name	Instructions
		<p>Administered Waiver Provider: For example, if a consumer (child) is receiving increased hours of the home health nursing service (U5), for the second nursing visit that day (U2), for home infusion (U1), in a group setting (HQ), the entered line (visit) would look like: G0154 U5 U2U1HQ. Modifiers can be presented in any order. Note: The Medicaid maximum will be 75% of the unmodified total Medicaid maximum when the "HQ," group setting modifier is billed. The entire line (visit) is modified with the HQ group setting even if only a portion of the visit met the definition of group setting/visit. Modifiers for multiple visits U2 and U3 are only used on when the same service/procedure code is used.</p>
24e	Diagnosis Code Indicator	Leave blank.
24f	Charges	<p>Enter your usual and customary fee for the service listed on this line. See "Billing Note" below.</p> <p>Note: Provider types (04) OHF, (05) RHC, and (12) FQHC do not enter charges for line items subsequent to the encounter code. No deductible, coinsurance, or co-payment amounts are to be collected from Medicaid consumers whether Medicaid is the consumer's primary insurance or secondary insurance. Deductibles and co-payments should be reported as instructed below.</p> <p>Note: The department recognizes three private insurance arrangements:</p> <p>Arrangement 1: A fee-for-service plan where the provider has no agreement with the payer to accept a certain fee. For Arrangement 1, the provider would enter the usual and customary charge in item 24f and the amount paid by the private insurer in item 29. For example, if Dr. Smith charges \$30 for a visit and the insurance company pays \$20, Dr. Smith would enter \$30 in item 24f and \$20 in item 29.</p> <p>Arrangement 2: A fee-for-service plan where the provider has entered into an agreement to accept a rate (usually a fee below the provider's usual and customary rate). For Arrangement 2, the provider would enter the agreed fee amount in item 24f and the amount paid by the insurer in item 29. For example, Dr. Smith's usual and customary rate for code 99201 is \$20 but she has an agreement with Blue Cross to accept \$15. Blue Cross</p>

Item	Name	Instructions
		<p>pays Dr. Smith \$10 of the \$15 and the remaining \$5 is the co-payment. In this case, Dr. Smith must enter \$15 in item 24f for any Medicaid consumer covered under this Blue Cross policy and \$10 in item 29.</p> <p>Arrangement 3: A managed care plan (e.g., HMO, PPO, IPA) where the plan pays the provider on a fee-for-service basis. For Arrangement 3, the provider would enter the fee-for-service payment made by the managed care plan plus the co-payment amount required by the managed care plan in item 24f, and the fee-for-service amount paid by the managed care plan in item 29. For example, Dr. Smith is paid \$15 by the managed care plan for every visit and there is a \$10 co-payment. In this case Dr. Smith would enter \$25 (fee-for-service payment plus the co-payment) in item 24f and \$15 in item 29.</p>
24g	Units	<p>Enter the number of units of service provided if more than one. Only whole numbers may be reported. The following services may be reported in multiple units on one line: Allergy tests, Add-on codes specified in Appendix D of the CPT book, time-based codes, Medical Supplier Services, J codes, or Q Codes for injectables, and certain diagnostic and therapeutic services.</p> <p>Anesthesia Provider: Enter the number of actual anesthesia minutes in the unit field.</p> <p>Transportation Provider: For loaded mileage codes, enter the total number of loaded miles. For all other codes, enter a "1" (i.e., base rate codes).</p> <p>FQHCs, OHFs, and RHCs: Leave blank unless the service is anesthesia. For anesthesia, enter the number of minutes.</p> <p>Note: OHFs: Laboratory and radiology services must be billed as an encounter. Do not bill units of service for these services.</p> <p>Hospice Provider/Agency: For procedure codes T2042, T2044, T2045 and T2046, enter only a "1". For procedure code T2043, enter the number of hours in the visit.</p> <p>Home Health, Private Duty Nursing, and ODJFS Administered Waiver Provider: Enter the appropriate</p>

Item	Name	Instructions
		<p>number of units for the service/visit rendered. The visit is billed using a time/unit structure and base/unit rate combination based on the total length of the visit, and is reimbursed up to the Medicaid maximum.</p>
24h	EPSDT/Family Planning	<p>HEALTHCHEK/EPSDT</p> <p>Enter an "E" in this block if the service is a Healthchek and no follow-up services were required.</p> <p>Enter an "R" in this block if the service was Healthchek and follow-up is required and a referral is made.</p> <p>FAMILY PLANNING</p> <p>Enter an "F" in this blank if the service is related to family planning.</p> <p>Transportation Provider: Leave blank.</p> <p>Hospice Provider: Leave blank.</p> <p>Home Health, Private Duty Nursing, and ODJFS Administered Waiver Provider: Leave blank.</p>
24i	ID QUAL	<p>Enter the 2 digit qualifier "1D" in the red shaded area above "NPI." The qualifier will always be "1D" when submitting claims to Medicaid.</p>
24j	Rendering provider ID	<p>This field is required. Please read carefully and enter the appropriate Medicaid legacy number and corresponding NPI as instructed for this split field. Failure to enter the appropriate identifiers will result in a denial or incorrect payment.</p> <p>Do not submit claims to Ohio Medicaid with multiple rendering providers on a single claim form. Submit a unique claim for each rendering provider, even if the services were rendered by members of the same group practice (billing provider). Claims submitted with multiple rendering providers on a single claim will adjudicate using the first set of provider identifiers (Medicaid legacy number and NPI) listed in column 24j.</p> <p>TYPICAL PROVIDERS</p> <p>Private duty nurse (PDN): Enter the Medicaid legacy</p>

Item	Name	Instructions
		<p>number that is assigned to the PDN provider that rendered the service in the red shaded area of the this split field (next to the “1D” listed in 24i and above the broken line in 24j).</p> <p>Enter the corresponding NPI assigned to the PDN in the unshaded area of this split field (next to the field labeled NPI in 24i and below the broken line in 24j).</p> <p>Complete field 33 with the same Medicaid legacy and NPI numbers listed in 24j. Note PDN providers: the rendering and pay-to/billing provider fields must contain the same provider identifiers. The identifiers submitted must be the identifiers assigned to the individual nurse.</p> <p>See instructions for Home Health Agency when PDN services are provided by a nurse employed by a home health agency or other accredited agency.</p> <p>Individual professional provider in sole proprietary practices: Enter the Medicaid legacy number that is assigned to the individual professional provider that rendered the service in the red shaded area of the this split field (next to the “1D” listed in 24i and above the broken line in 24j).</p> <p>Enter the corresponding NPI assigned to the individual professional provider in the unshaded area of this split field (next to the field labeled NPI in 24i and below the broken line in 24j).</p> <p>Complete field 33 with the same Medicaid legacy and NPI numbers listed in 24j. Note for individual (sole proprietary) professional practices, the rendering and pay-to/billing provider fields must contain the same provider identifiers.</p> <p>Professional group practice: Enter the Medicaid legacy number that is assigned to the individual professional provider that rendered the service for the group professional practice in the red shaded area of this split field (next to the “1D” listed in 24i and above the broken line in 24j).</p> <p>Enter the corresponding NPI that is assigned to the</p>

Item	Name	Instructions
		<p>individual professional provider that rendered the service for the professional group practice in the unshaded area of this split field (next to the field labeled NPI in 24i and below the broken line in 24j).</p> <p>Complete field 33 with the Medicaid legacy and NPI identifiers assigned to the professional group practice. Note: When services are provided by a professional group practice or a hospital-based practice, the pay-to/billing provider field must contain a different set of legacy and NPI identifiers from the individual identifiers listed in 24j. The identifiers submitted in field 33 must be assigned to a professional group practice or the employing hospital.</p> <p>Ambulatory Surgery Centers (ASC): When billing for facility charges, enter the Medicaid legacy number assigned to the facility in the red shaded area of this split field (next to the “1D” qualifier entered in 24i and above the broken line in 24j).</p> <p>If an ASC is billing for a surgeon, enter the individual Medicaid legacy number assigned to the surgeon in the red shaded area of this split field (next to the “1D” qualifier entered in 24i and above the broken line in 24j).</p> <p>When billing for facility charges, enter the corresponding NPI for the ASC in the unshaded area of this split field (next to the field labeled NPI in 24i and below the broken line in 24j).</p> <p>When billing for a surgeon, enter the corresponding NPI for the individual in the unshaded area of this split field (next to the field labeled NPI in 24i and below the broken line in 24j).</p> <p>Complete field 33 with the Medicaid legacy and NPI identifiers assigned to the ASC facility. Note for ASC facility charges: the rendering and pay-to/billing provider fields must contain the same provider identifiers. When billing for a surgeon, the pay-to/billing provider field 33 must contain a different set of Medicaid legacy and NPI identifiers from the individual identifiers listed in 24j. The identifiers entered in field 33 must be the identifiers assigned to the ASC facility.</p>

Item	Name	Instructions
		<p>Hospice Agency: When the hospice is billing for the per diem rate, enter the Medicaid legacy number assigned to the hospice agency in the red shaded area of this split field (next to the Medicaid qualifier “ID” entered in 24i and above the broken line in 24j).</p> <p>Enter the corresponding NPI for the hospice agency in the unshaded area of this split field (next to the field labeled NPI in 24i and below the broken line in 24j).</p> <p>When a hospice agency is billing for the provision of physician services, enter the Medicaid legacy number assigned to the rendering provider in the red shaded area of this split field (next to the Medicaid qualifier “ID” entered in 24j and above the broken line in 24j).</p> <p>Enter the corresponding NPI for the rendering physician or APN in the unshaded area of this split field (next to the field labeled NPI in 24i and below the broken line in 24j).</p> <p>Complete field 33 with the Medicaid legacy and NPI identifiers assigned to the hospice agency. Note for the hospice per-diem rate: the rendering and the pay-to/billing provider fields must contain the same provider identifiers. When billing for the provision of physician services, the pay-to/billing provider field must contain a different set of Medicaid legacy and NPI identifiers from the individual identifiers listed in 24j. The identifiers in field 33 must be the identifiers assigned to the hospice agency.</p> <p>Ambulance, Home Health Agency, Independent Laboratory, Independent X-Ray Laboratory, Clinics, DME Supplier, FQHC, RHC, and OHF’s: Enter the health care organization or facility provider identifiers and never a rendering individual’s provider identifier. Enter the Medicaid legacy number assigned to the health care organization or facility in the red shaded area of this split field (next to the Medicaid qualifier “ID” entered in 24i and above the broken line in 24j).</p> <p>Enter the corresponding NPI for the health care organization or facility in the unshaded area of this split field (next to the field labeled NPI in 24i and below the broken line in 24j).</p>

Item	Name	Instructions
		<p>Complete field 33 with the Medicaid legacy and NPI identifiers assigned to the health care organization or facility. Note: the rendering fields in 24j and the pay-to/billing provider field in 33 must contain the same provider identifiers for the health care organization or facility.</p>
		<p>ATYPICAL PROVIDERS</p>
		<p>Atypical providers are not required to obtain an NPI nor are they expected to bill with an NPI (unless the atypical provider has obtained an NPI). Atypical providers must continue to use their Medicaid legacy number only (or both a Medicaid legacy number and an NPI if the atypical provider has obtained an NPI).</p>
		<p>Ambulette provider: Enter the Medicaid legacy number assigned to the ambulette provider in the red shaded area of this split field (next to the “1D” qualifier entered in 24i and above the broken line in 24j).</p>
		<p>If an ambulette provider has not obtained an NPI (NPI is not required by ODJFS), leave the NPI field blank. If an ambulette provider has obtained an NPI, enter the corresponding NPI in the unshaded area of this split field (next to the field labeled NPI in 24i and below the broken line in 24j).</p>
		<p>Complete field 33 with the same Medicaid legacy and NPI numbers listed in 24j. Note for ambulette providers: the rendering and pay-to/billing provider fields must contain the same provider identifiers.</p>
		<p>Independent waiver aide, independent waiver non-aide, independent waiver personal care provider (Individual waiver provider in independent practice): (Provider types 17, 18, and 25) Enter the Medicaid legacy number that is assigned to the individual waiver provider that rendered the service in the red shaded area of the this split field (next to the “1D” entered in 24i and above the broken line in 24j).</p>
		<p>If an individual waiver provider has not obtained an NPI</p>

Item	Name	Instructions
		<p>(NPI is not required by ODJFS), leave the NPI field blank. If the individual waiver provider has obtained an NPI, enter the corresponding NPI in the unshaded area of this split field (next to the field labeled NPI in 24i and below the broken line in 24j).</p> <p>Complete field 33 with the same Medicaid legacy and NPI numbers listed in 24j. Note for individual waiver providers: the rendering and pay-to/billing provider fields must contain the same provider identifiers.</p> <p>Waiver provider (Provider type 45): Enter the Medicaid legacy number assigned to the waiver provider in the red shaded area of this split field (next to the ID qualifier entered in 24i and above the broken line in 24j).</p> <p>If a waiver provider has not obtained an NPI (NPI is not required by ODJFS), leave the NPI field blank. If a waiver provider has obtained an NPI, enter the corresponding NPI in the unshaded area of this split field (next to the field labeled NPI in 24i and below the broken line in 24j).</p> <p>Complete field 33 with the same Medicaid legacy and NPI numbers listed in 24j. Note for waiver providers: the rendering and pay-to/billing provider fields must contain the same provider identifiers.</p>
25	Federal Tax I.D. Number	Leave blank.
26	Patient's Account No.	(Optional) This is for the provider's use in identifying consumers and allows use of up to nine numbers or letters (no other characters are allowed.) If used, this number will appear on the remittance advice under "Med Rec."
27	Accept Assignment	<p>Leave blank.</p> <p>Note: Providers must always accept assignment for Medicaid consumers.</p>
28	Total Charge	Enter the total charge for all services on this invoice. This number should be the sum of charges in column F.
29	Amount Paid (aka Other Source)	Enter the amount collected from all sources other than Medicare. If the amount collected from all sources other than Medicare exceeds the maximum payment that Medicaid will make for the service, Medicaid will not make any additional payment. (When an amount is

Item	Name	Instructions
		<p>entered in this item, item 10d must also be completed.) For claims involving Medicare coverage, see Medicaid/Medicare Crossover JFS 06780 billing instructions.</p> <p>Hospice Agency: When billing for hospice room and board (T2046), do not enter the patient liability amount in this block if the consumer resides in a long term care facility (LTCF) and has a patient liability amount. See the instructions in the dates of service block 24(a) on how to apply patient liability amounts.</p>
30	Balance Due (aka Net Charge)	Enter the difference between the total charge (Item 28) and the amount received from other sources (Item 29).
31	Signature	The provider or his representative should sign and date the claim form here.
32	Name and Address of Facility Where Services Were Rendered	Leave blank.
33	Provider Number, Name and Address	Enter the provider's name, mailing address, city, state, and zip code.
33a	NPI	<p>TYPICAL PROVIDERS</p> <p>Professional Group Practice: When the billing provider is a group practice (e.g., physician group, podiatry group, chiropractic group, APN group etc.), the NPI assigned to the group must be entered in this field. The individual that rendered the service must be identified as instructed in field 24j.</p> <p>Ambulatory Surgery Centers (ASC): Enter the NPI assigned to the facility in this field. When billing facility charges, the identifiers in 24j and 33 must be the same. When billing surgeon charges, the identifiers in 24j and 33 must be different (see the instructions for field 24j).</p> <p>Hospice Agency: Enter the NPI assigned to the hospice agency in this field. When billing per diem charges, the identifiers in 24j and 33 must be the same. When billing for physician services, the identifiers in 24j and 33 must be different (see the instructions for field 24j).</p> <p>Ambulance, Home Health Agency, Independent Laboratory, Independent X-Ray Laboratory, Clinics, DME Supplier, FQHC, RHC, and OHF's: Enter the</p>

Item	Name	Instructions
		<p>NPI assigned to the health care organization or facility in this field (and in field in 24j as instructed). The rendering provider fields in 24j and the pay-to/billing provider fields in 33 must contain the same provider identifiers.</p> <p>ATYPICAL PROVIDERS</p> <p>Atypical providers are not required to obtain an NPI nor are they expected to bill with an NPI (unless the atypical provider has obtained an NPI). Atypical providers that have not obtained an NPI must leave this field blank and enter their Medicaid legacy number as instructed in field 33b and 24j. Atypical providers that have obtained an NPI must enter the NPI assigned in this field.</p> <p>Ambulette provider, independent waiver aide, independent waiver non-aide, independent waiver personal care provider, and waiver provider: If the atypical provider has not obtained an NPI, leave this field blank. If the atypical provider has obtained an NPI, the identifiers in 24j must match the identifiers in 33a and 33b.</p>
33b	Medicaid Legacy Number	<p>This field is required. Enter the Medicaid legacy number assigned to the billing provider that corresponds with the NPI in field 33a. Do not enter the two digit qualifier located in field 24i. in this field. Enter only the Medicaid legacy number. Any alpha-numeric numbers in this field will result in a claim denial.</p> <p>Professional Group Practice: When the billing provider is a group practice (e.g., physician group, podiatry group, chiropractic group, APN group etc.), the Medicaid legacy number assigned to the group must be entered in this field. The individual that rendered the service must be identified in 24j as instructed.</p> <p>Ambulatory Surgery Center (ASC): Enter the Medicaid legacy number assigned to the facility. When billing facility charges, the identifiers in 24j and 33 must be the same. When billing surgeon charges, the identifiers in 24j and 33 must be different (see the instructions for field 24j).</p>

Item	Name	Instructions
		<p>Hospice Provider: Enter the Medicaid legacy number assigned to the Hospice Agency. When billing per diem charges, the identifiers in 24j and 33 must be the same. When billing for physician services, the identifiers in 24j and 33 must be different (see the instructions for field 24j).</p> <p>Ambulance, Home Health Agency, Independent Laboratory, Independent X-Ray Laboratory, Clinics, DME Supplier, FQHC, RHC, and OHF's: Enter the Medicaid legacy number assigned to the health care organization or facility in this field (and in field in 24j as instructed). The rendering provider fields in 24j and the pay-to/billing provider fields in 33 must contain the same provider identifiers.</p> <p>ATYPICAL PROVIDERS</p> <p>Ambulette Provider: Enter the Medicaid legacy number assigned to the ambulette provider in this field.</p> <p>Independent waiver aide, independent waiver non-aide, independent waiver personal care provider (Individual waiver provider in independent practice) Provider types 17, 18, and 25: Enter the Medicaid legacy number that is assigned to the individual waiver provider that rendered the service in this field and in 24j (see instructions for 24j). The rendering and pay-to/billing provider fields must contain the same provider identifiers.</p> <p>Waiver Provider (Provider type 45): Enter the Medicaid legacy number assigned to the waiver provider in this field and in 24j (see instructions for 24j). The rendering and pay-to/billing provider fields must contain the same provider identifiers.</p>
<p>MAIL CMS 1500 CLAIMS TO: The Ohio Department of Job and Family Services P.O. Box 7965 Akron, Ohio 44306</p>		

DO NOT FOLD CLAIM FORM

BIN.1101. Medicare/Medicaid Crossover Billing Instructions

Note: for Medicare/Medicaid Crossover Claims, Use the JFS 06780 Claim Form Only

- Item 1 **PROVIDER'S NAME AND ADDRESS:** The provider's name, mailing address, city, state, and zip code must be typed on each invoice.
- Item 2 **PROVIDER NUMBER:** Enter the seven (7) digit Medicaid Provider Number assigned to the individual provider who performed the service.
- Item 3 **GROUP NUMBER:** If you are billing for a group practice, enter the seven (7) digit Medicaid Provider Number assigned to the group. Item 2 (Individual Provider number of the servicing provider) must also be completed when billing for a group practice. If Item 3 is completed, the Ohio Department of Job and Family Services will send any payment for the billed services to the provider group.
- Item 4 **PROVIDER SERVICE CODE:** For Medicare Crossover services enter a CAPITAL "F" in Item 4. Also a large capital letter "F" must be handwritten or typed in the provider service code block located in the left hand corner.
- Item 5 **MEDICAL RECORD NUMBER:** (Optional) This is for provider's use in identifying patients and allows use of up to nine numbers or letters (no other characters are allowed). If used, this number will appear on the remittance advice under "Med Rec."
- Item 6 **PATIENT'S LAST NAME:** Enter the last name of the patient. USE CAPITAL LETTERS ONLY.
- Item 7 **PATIENT'S FIRST NAME:** Enter the first name of the patient. USE CAPITAL LETTERS ONLY.
- Item 8 **PRIOR AUTHORIZATION NUMBER:** Leave Blank
- Item 9 **BILLING NUMBER:** Enter the twelve (12) digit number found in the column marked "Billing Number" on the Ohio Medicaid Card for the individual who received services.
- Item 10 **PRIMARY DIAGNOSIS CODE:** Leave Blank
- Item 11 **REFERRAL NUMBER:** Leave Blank
- Item 12 **EPSDT INDICATION:** Leave Blank
- Item 13 **FAMILY PLANNING:** Leave Blank
- Item 14 **ACCIDENT RELATED:** Leave Blank
- Item 15 **OTHER SOURCE:** Only one number or alpha letter may be entered in this space. Your claim will deny if more than one source code is listed. When 1-6 is entered in this block the amount collected must be entered in block 22. When R, P, F, L, E, S, or X is entered in this block the provider must maintain documentation to support the use of these codes.

If you have received payment for the service from another source other than

Medicare, please enter the appropriate one (1) character source code found below:

OTHER SOURCE CODES

- 1 Self / Family/Spend down liability
- 2 Blue Cross/Blue Shield
- 3 Private Carrier
- 4 Employer or Union
- 5 Public Agency
- 6 Other (enter the name and address of the source in the provider remarks section)

Bill all third-party insurers first. If you have not received payment from a third party insurer, but there are indications of private (non-Medicaid/non-Medicare) health insurance coverage in the case, please enter the appropriate one (1) character reason code found below:

- R** No Response From Carrier-No response from the insurance carrier for 90 days (see ODJFS Medicaid Handbook 3334). A claim with this code may not be submitted until 91 days after the date of treatment.
- P** No Coverage for This Recipient Number-The provider has confirmed there is health insurance (other than Medicaid or Medicare) for some members of the Medicaid case, but the particular patient is not covered. If the medical card indicates that the recipient has third-party insurance but you have verified that the recipient does not have third-party insurance, complete the JFS 06614 form in **BIN.1207**.
- F** No Coverage for All Recipient Numbers-There is no health insurance (other than Medicaid or Medicare) for any member of the Medicaid case. If the medical card indicates that all the individuals listed on the card have third-party insurance and you have verified that is not the case, complete the JFS 06614 form in **BIN.1207**.
- L** Disputed or Contested Liability-The provider has confirmed there is health insurance (other than Medicaid or Medicare), but the coverage for the billed service is disputed or contested by the insurance carrier.
- S** Non-covered Services-The provider has confirmed there is health insurance (other than Medicaid and Medicare), but the policy does not cover the services being billed. This code should also be used when the amount billed has been applied to the insurance deductible.
- E** Insurance Benefits Exhausted-The provider has confirmed there is health insurance (other than Medicaid or Medicare), but the policy benefits for the billed services have been exhausted.
- X** Non-cooperative Recipient-The provider has confirmed there is health insurance (other than Medicaid or Medicare), but the patient refused to cooperate in collection effort. Providers are expected to take reasonable measures to ascertain any third-party resource available to the recipient and to file a claim with that third-party insurer.

Note: Documentation to justify use of codes R, P, F, L, S, E, and X must be retained for future audit purposes. The department will monitor the use of these codes by providers.

If you have not received payment from another source and there is no indication of private health insurance coverage (non-Medicaid/non-Medicare) for the case, leave this item blank.

Item 16 SECONDARY DIAGNOSIS CODE: Leave Blank

Note: The body of this invoice consists of twelve (12) numbered lines and eight (8) alphabetized columns. The following instructions are the same for all twelve lines.

Column A Service Date: Enter the six-digit dates of service (MMDDYY) in chronological order (first to last). Enter all six characters consecutively without dashes, slashes, or spaces; Example: Enter 070702 for the date July 7, 2002.

Column B Service Code: Enter the procedure code and applicable modifier as found on the Medicare Summary Notice.

Column C Place of Service Code: Enter the place of service code as found on the Medicare Summary Notice.

Column D Leave Blank

Column E Enter the units of service as shown on the Medicare Summary Notice.

Column F Leave Blank

Column G Leave Blank

Column H Charges: Enter your usual and customary fee for the service as submitted to Medicare.

Item 17 BILLING DATE: Enter the invoice preparation date. Use six(6) digit format. Example: Enter 070702 for the date, July 7, 2002.

Item 18 APPROVED AMOUNT: Enter the total dollar amount approved by Medicare indicated on the Summary Notice from Medicare.

Item 19 DEDUCTIBLE: Enter the dollar amount shown in the Deductible Column on the Summary Notice of Medicare Benefits. If there is no deductible, leave this item blank.

Item 20 CO-INSURANCE:

1. For all services except for psychiatric services subject to the Medicare payment limitation, enter the dollar amount shown in the coinsurance column on the Summary of Notice of Medicare Benefits received from Medicare; or
2. For all mental health services subject to the Medicare payment limitation (e.g., all psychotherapy services), calculate the correct coinsurance amount using the following formula and enter that calculated amount in this space:

Reported coinsurance [(Medicare allowed amount *.625)-(deductible)]
*.20

Item 21 TOTAL CHARGE: Enter the sum of the line item charges listed in Column H.

Item 22 OTHER SOURCE AMOUNT: Enter the amount collected from all sources other than Medicare. If the amount collected from all sources other than Medicare exceeds the maximum payment that Medicaid will make for the service, Medicaid will not make any additional payment. (When an amount is entered in this Item, Item 15 must also be completed.) If the sum of the coinsurance and deductible is less than the third-party payment, no money amount will be paid by Medicaid.

Item 23 NET CHARGE: Leave Blank

Item 24 Leave Blank

Item 25 DATE PAID BY MEDICARE: Enter the payment date shown in the upper right hand corner of the Summary Notice of Medicare Benefits, using the six (6) digit format. (MMDDYY)

REMARKS-FOR PROVIDER USE: This section may be used to clarify information on this invoice.

PROVIDER CERTIFICATION: The signature of the provider rendering the service billed on this invoice is required.

MAILING INSTRUCTIONS: Remove perforated strips and separate invoices. Retain yellow copy of completed invoice for your files.

Mail the original (pink) invoice **with Summary Notice of Medicare Benefits** attached to the invoice to:

Ohio Department of Job and Family Services

P.O. Box 2338

Columbus, Ohio 43216-2338

DO NOT FOLD INVOICE

BIN.1103. Medicare Part C Cost Sharing Billing Instructions

Note: Use only the ODJFS 6780 claim form.

- Item 1 **PROVIDER'S NAME AND ADDRESS:** The provider's name, mailing address, city, state, and zip code must be typed on each invoice.
- Item 2 **PROVIDER NUMBER:** Enter the seven (7) digit Medicaid Provider Number assigned to the individual provider who performed the service.
- Item 3 **GROUP NUMBER:** If you are billing for a group practice, enter the seven (7) digit Medicaid Provider Number assigned to the group. Item 2 (Individual Provider number of the servicing provider) must also be completed when billing for a group practice. If Item 3 is completed, the Ohio Department of Job and Family Services will send any payment for the billed services to the provider group.
- Item 4 **PROVIDER SERVICE CODE:** When the claim is to collect Medicare cost sharing payments (e.g., Medicare deductible, coinsurance and/or copayment amounts); enter a CAPITAL "F" in Item 4. Also a large capital letter "F" must be handwritten or typed in the provider service code block located in the left hand corner.
- Item 5 **MEDICAL RECORD NUMBER:** (Optional) This field may be used to submit a provider-specific patient identifier. The identifier may be up to nine numbers or letters (no other characters are allowed). The information provided in this field is not used for Medicaid claims processing. If this field is completed, the information submitted in this field will appear on the remittance advice under "Med Rec."
- Item 6 **PATIENT'S LAST NAME:** Enter the last name of the patient. USE CAPITAL LETTERS ONLY.
- Item 7 **PATIENT'S FIRST NAME:** Enter the first name of the patient. USE CAPITAL LETTERS ONLY.
- Item 8 **PRIOR AUTHORIZATION NUMBER:** Leave Blank
- Item 9 **BILLING NUMBER:** Enter the twelve (12) digit number found in the column marked "Billing Number" on the Ohio Medicaid Card for the individual who received services.
- Item 10 **PRIMARY DIAGNOSIS CODE:** Leave Blank
- Item 11 **REFERRAL NUMBER:** Leave Blank
- Item 12 **EPSDT INDICATION:** Leave Blank
- Item 13 **FAMILY PLANNING:** Leave Blank
- Item 14 **ACCIDENT RELATED:** Leave Blank
- Item 15 **OTHER SOURCE:** Required on all Medicare Part C crossover claims. Only "M" or "H" is valid per note listed below. Your claim will deny if more than one source code is listed.

Important Part C Note:

If the individual is enrolled in a Medicare Part C Plan and the Medicare Part C Plan does not pay the provider under a capitation arrangement, enter the letter "M" in block 15. **"M" would apply to most providers** because most providers **are not** paid under a capitation arrangement.

If the individual is enrolled in a Medicare Part C Plan and the Medicare Part C Plan pays the provider under a capitation arrangement, enter the letter "H" in block 15.

OTHER SOURCE CODES

H Medicare Part C claim-provider paid under capitation arrangement

M Medicare Part C claim-provider is **not** paid under capitation arrangement

Item 16 SECONDARY DIAGNOSIS CODE: Leave Blank

Note: The body of this invoice consists of twelve (12) numbered lines and eight (8) alphabetized columns. The following instructions are the same for all twelve lines.

Column A Service Date: Enter the six-digit dates of service (MMDDYY) in chronological order (first to last). Enter all six characters consecutively without dashes, slashes, or spaces, Example: Enter 040704 for the date April 7, 2004.

Column B Service Code: Enter the procedure code and applicable modifier

Column C Place of Service Code: Enter the place of service code

Column D Leave Blank

Column E Enter the units of service

Column F Leave Blank

Column G Leave Blank

Column H Charges: Enter your usual and customary fee for the service as submitted

Item 17 BILLING DATE: Enter the invoice preparation date. Use six(6) digit format. Example: Enter 041004 for the date, April 10, 2004.

Item 18 APPROVED AMOUNT: Enter the total dollar amount approved by the Medicare Part C Plan. For the completion of this block, "approved" amounts are synonymous to "allowed" amounts, "negotiated rate" amounts, or "covered" amounts issued by the plan.

Some Medicare Part C Plans do not issue this amount on the claim remittance. They issue, instead, a "discount" amount, an "adjustment" amount, or a "non-covered charge" amount. The approved amount can be computed by subtracting the "discount/adjustment/non-covered charges" amount from the billed charges. Providers submitting Medicare Part C crossover claims will be expected to calculate the approved amount if the approved amount (or any of the other synonymous amounts) was not specifically issued.

When the "other source" field contains the letter "M," the approved amount must be greater than zero.

When the provider is reimbursed under a capitation arrangement (i.e., denoted

by the letter "H" in Item 15), the approved amount may be blank or zero, because claim-specific payments are not usually made under these arrangements.

Item 19 DEDUCTIBLE: Enter the total dollar amount of the claim that was allocated by the Medicare Part C Plan as the deductible amount. If there is no deductible amount for the services submitted on this claim, leave this item blank.

For claims with the letter "H" in Item 15, "OTHER SOURCE," the provider may enter the negotiated deductible amount as established under the capitation arrangement.

Item 20 CO-INSURANCE: Enter the *total* dollar amount the Medicare Part C Plan issued as the coinsurance and/or the copayment amount for the entire claim (i.e., the total of all line item coinsurance and/or copayment amounts or the claim level coinsurance and/or copayment amounts).

For claims with the letter "H" in Item 15, "OTHER SOURCE," the provider may enter the negotiated copayment amount as established under the capitation arrangement.

Item 21 TOTAL CHARGE: Enter the sum of the line item charges listed in Column H.

Item 22 OTHER SOURCE AMOUNT: Enter the amount paid by the Medicare Part C plan plus the amount paid by all other third party payers (if the consumer has coverage in addition to Medicare and Medicaid and a payment was made).

For claims with the letter "M" in Item 15, "Other Source," this amount must be greater than zero unless the sum of Item 19 (deductible) and Item 20 (coinsurance/copayment) is greater than or equal to Item 18 (approved amount).

When the provider is reimbursed under a capitation arrangement (i.e., denoted by the letter "H" in Item 15), a payment of zero is allowed in item 22 because no service-specific payments are made under these arrangements. In this situation, ODJFS expects this field to be completed with an amount greater than zero only when the Medicaid consumer has health care coverage under another insurance plan (e.g., Medical Mutual and Medicare Part C Plan).

Item 23 NET CHARGE: Leave Blank

Item 24 Leave Blank

Item 25 DATE PAID BY MEDICARE PART C PLAN:

For providers not paid under a capitation payment arrangement: Enter the date the claim was paid by the Medicare Part C Plan, using the six (6) digit format. (MMDDYY)

For providers paid under a capitation arrangement:

Enter the date of submission to Medicaid. This date must match the date in Item 17. This date may not be older than 365 days from the date of service.

REMARKS-FOR PROVIDER USE: This section may be used to clarify information on this invoice.

PROVIDER CERTIFICATION: The signature of the provider rendering the service

billed on this invoice is required.

MAILING INSTRUCTIONS: Remove perforated strips and separate invoices. Retain yellow copy of completed invoice for your files.

Mail the original (pink) invoice to:

Ohio Department of Job and Family Services

P.O. Box 2338

Columbus, Ohio 43216-2338

DO NOT FOLD INVOICE