General Billing Guide for Ohio MyCare Next Generation

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1. Introduction

This guide is designed to assist MyCare providers in understanding the billing process for the services they provide under Ohio's MyCare Next Generation (HMO D-SNP) programs. It explains the billing codes, helpful tips, and how to receive reimbursement.

2. Provider Network Management (PNM) Module

Before submitting claims, it is critical to validate the eligibility of the member receiving service and verifying that provider information is accurately reflected in ODM's PNM system. Information such as provider enrollment status and the association with the billing group.

Providers may submit eligibility inquiries through the Provider Network Management (PNM) system< https://managedcare.medicaid.ohio.gov/managed-care/centralized-credentialing.>

ODM's expectation is that for each **Medicaid** provider, CareSource's system and data are current and consistent with information held by ODM's system of record, the PNM system. Therefore, it is important that providers keep their records up to date in ODM's PNM system. With the PNM system as the ODM's system of record, MCOPs have been instructed to direct providers to update their ODM record in the PNM system when discrepancies are identified between the MCOP's data and the PNM PMF. CareSource is instructed by ODM to not accept changes from providers into their own systems that are inconsistent with PNM system data shared through the PNM for their **Medicaid** line of business.

- The Provider Network Management (PNM) module is a component of the Ohio Medicaid Enterprise System (OMES), which replaced the Medicaid Information Technology System (MITS) provider enrollment subsystem and provider portal.
- CareSource is required to use provider data from the Provider Network Management (PNM) module as it is the official system of record.
- To ensure the provider data sent from the PNM module to CareSource is accurate, it is imperative that providers update all address and affiliation information in the PNM module so that claims payments, provider directories, and network adequacy measurements are not negatively impacted.
- Click on the following links for step-by-step instructions on how to complete these actions:
    - Updating or Adding Owner Information
    - Updating or Adding Practice Locations
    - Updating or Adding a Specialty in PNM

2.1 PNM Support:

- Phone: ODM Integrated Helpdesk (IHD) 800-686-1516
- Email: IHD@medicaid.ohio.gov
- Website: PNM & Centralized Credentialing | Ohio Medicaid Managed Care

3. Billing Methods Date Interchange (EDI) Submission of Provider Claims

As part of Ohio Department of Medicaid's (ODM) effort to modernize the Ohio Medicaid Enterprise System (OMES), the Electronic Data Interchange (EDI) transaction process has been streamlined. Trading partners facilitating electronic claims reimbursement for Ohio Medicaid providers now exchange all EDI transactions through a single connection. This applies to the ODM fee-for-service (FFS), managed care entities (MCEs), and OhioRISE transactions. Please note providers continue to submit MyCare claims and prior authorizations to the MyCare managed care plans. <https://medicaid.ohio.gov/resources-for-providers/billing/trading-partners/content>

Providers may submit claims, eligibility inquiries, claim status inquiries and using Electronic Data Interchange (EDI) by being a trading partner (TP) authorized by ODM or by contracting with an ODM- authorized TP: Medicaid.ohio.gov/resources-for-providers/billing/trading-partners/trading-partners.

Providers submitting claims through an ODM-authorized TP must utilize the CareSource ODM Payer ID, '0021599' to ensure appropriate routing of the claim records.

- Each file must only contain the claims for the MCOP identified by the Receiver ID
- Claims must include the appropriate Payer ID in the 2010BB loop, so claims are appropriately routed by the receiving MCOP.
- Information on the Receiver ID and 2010BB Payer ID can be found in Section 7 of the ODM Companion Guides: *https://medicaid.ohio.gov/resources-for-providers/billing/hipaa-5010-implementation/companion-guides/guides*

More information on EDI billing including companion guides can be found on the State's website at Fiscal Intermediary | Ohio Managed Care https://managedcare.medicaid.ohio.gov/managed-care/fiscal-intermediary/ and Ohio Medicaid Enterprise System Ohio https://medicaid.ohio.gov/resources-for-providers/billing/trading-partners/content.

Portal Submission of Provider Claims

Providers may also electronically submit claims through CareSource Provider Portal. The portal provides the ability to manually key claim data elements through its intuitive screen layout or upload claims written or keyed into a standard claim form that is saved on the user's computer network. In addition to the first claim entry, providers can submit claim corrections and void request through the interface.
CareSource Portal Access: Claims | Ohio – MyCare | CareSource

Paper Submission of Provider Claims

Providers unable to submit electronically can submit claims via mail using standard claim billing forms. The CMS-1500 claim form is utilized for submission of Professional claims while the UB-04 (also known as the CMS-1450) form is used for Institutional claims. Paper claims may be sent using standard or certified mail to:

CareSource
Attention: Claims Department
P.O. Box 8730
Dayton, OH 45401-8730

4. Billing Codes and Modifiers

HIPAA specifies that the health care industry use the following four code sets when submitting health care claims electronically. CareSource also requires HIPAA-compliant codes on paper claims. Adopting a uniform set of medical codes is intended to simplify the process of submitting claims and reduce administrative burdens on providers and health plans. Local or proprietary codes are no longer allowed.

- International Classification of Diseases, 10th Edition, Clinical Modification (ICD-10-CM). Available from the U.S. Government Printing Office at (202) 512-1800, (202) 512-2250 (fax) and from many other vendors.
- Current Procedural Terminology, 4th Edition, (CPT-4). Available at www.ama-assn.org/amaone/cpt-current-procedural-terminology.
- HCFA Common Procedure Coding System (HCPCS). Available at https://www.cms.gov/medicare/coding-billing/healthcare-common-procedure-system?redirect=/%20medhcpcsgeninfo/%20www.cms.gov/.
- Procedures and Nomenclature. 2nd Edition. (CDT-2). Available from the American Dental Association at 1-800-947-4746 or www.ada.org.
- NDC available at http://www.fda.go

5. Other Billing Tips and Requirements

- Your National Provider Identifier (NPI) number and Tax Identification Number (TIN) are required on all claims.
- ORP is an ODM requirement for certain provider types for both electronic and paper claim submissions. Providers should submit this information under Box 17 of CMS 15000A
- CareSource will coordinate benefits between Medicare and Medicaid on the same claim
- Prior Authorization requirements will be validated during claim processing. Claims will be matched to authorizations on file and processed accordingly.

6. Timely Filing

Providers will have 365 days to timely file a claim, including any timely filing exceptions, in accordance with Ohio Administrative Code (OAC) rule 5160-1-19. We will not be able to pay a claim if there is incomplete, incorrect or unclear information on the claim.

For claim denials, providers must adhere to the following time frames for submitting a dispute:

- Providers may file a claim dispute within 12 months from the date of service or 60 calendar days after the payment, denial, or partial denial of a timely claim submission, whichever is later. Providers may submit claim disputes verbally or in writing, including through the Provider Portal.
- If you believe a claim was processed incorrectly due to incomplete, incorrect or unclear information on the claims, you should submit a corrected claim. You should not file a dispute or appeal. A Correct Claim should be submitted. Refer to the Claims page or the Provider Manual for further information related to claims submission.
- Please note: All non-participating providers should submit their claim issues as Claim Appeals and not as a Payment Dispute.

7. Provider Claims Dispute Process

Provider claim disputes are any provider inquiries, complaints, or requests for reconsiderations ranging from general questions about a claim to a provider disagreeing with a claim denial. They include any level of dissatisfaction with claims determination, such as reconsiderations, appeals, and escalated provider claim inquiries. While these disputes can come in through any avenue (e.g., provider services call center, provider advocates, MCOP's provider portal), they do not include inquiries that come through ODM's ProviderWeb portal (HealthTrack). Providers may file a claim dispute within 12 months from the date of service or 60 calendar days after the payment, denial, or partial denial of a timely claim submission, whichever is later. Providers may submit claim disputes verbally or in writing, including through the Provider Portal.

External Medical Review: After exhausting CareSource's provider claims dispute resolution process, a provider may request an external medical review (EMR) if the claim payment denial, limitation, reduction, suspension, or termination was based on medical necessity. For more information on EMR, please see the Utilization Management section of this manual.

- Additional information regarding the submission of a Dispute or Appeal is located here: Provider Disputes or Appeals | Ohio – MyCare | CareSource

Provider Grievances: If you have an issue, please contact Provider Services at **1-833-230-2176**

8. Claim Processing Guidelines

- Providers have 365 calendar days from the date of service or discharge to submit a claim. If the claim is submitted after 365 calendar days, the claim will be denied for timely filing.
- If a member has other primary insurance and CareSource is secondary, the provider may submit for secondary payment within 365 calendar days of the original date of service.
- If a claim is denied for coordination of benefits (COB) information needed, the provider must submit the primary payer's explanation of benefits (EOB) for paper claims or primary carrier's payment information for EDI claims within the remainder of the initial claims timely filing period. If the initial timely filing period has elapsed, the EOB must be submitted to us within 90 calendar days from the primary payer's EOB date. If a copy of the claim and EOB is not submitted within the required time frame, the claim will be denied for timely filing.

- To obtain another payer's information for a member, visit the CareSource Provider Portal at:

https://www.caresource.com/providers/provider-portal

- If you believe a claim was processed incorrectly due to incomplete, incorrect or unclear information on the claims, you should submit a corrected claim. **You should not file a dispute or appeal.** A Correct Claim should be submitted. Refer to the Claims page or the Provider Manual for further information related to claims submission, which is located here: https://www.caresource.com/oh/providers/provider-portal/appeals/mycare/.

Please note: All Non-participating providers should submit their claim issues as Claim Appeals and not as a Payment Dispute.

8.1 Monitoring Claims

Per 42 CFR 455.20, CareSource has a responsibility to monitor services billed by providers and to verify the receipt of such services with our members. This is accomplished through various methods including Explanation of Benefit mailings, data analytics and follow up calls to members when discrepancies are found. Providers should ensure they are billing for services appropriately to support this process.

8.2 Checking Claim Statuses

Claim statuses are updated daily on our <Provider Portal>, and you can check claims that were submitted for the previous 24 months. You can search by member ID number, member name and date of birth or claim or patient number.

Additional Claim Enhancements on the Provider Portal

- Claim history available up to 24 months from the date of service
- Submission of claim appeals
- Reasons for payment, denial or adjustment
- Checking for numbers and dates
- Procedure/diagnostic
- Claim payment date
- Dental claim information
- Submission of attachments for denied claims
- Easy submission for corrected claim when the claim was submitted online via the portal
- Accessibility to claim recovery letter

9. Reimbursement Guidelines

CareSource follows the Ohio Department of Medicaid fee schedule and reimbursement guidelines per the Ohio Administrative Code (OAC) Rules: 5160-46-06; 5160-12-05

- **Timely Filing Requirement:** Providers must submit claims within 365 calendar days from the date of service
- **Forms** and instructions for Claims Refund Check Form and Overpayment Recovery Form can be found at https://www.caresource.com/oh/providers/tools-resources/forms/
- We may request an itemized bill and medical records per our administrative policies. Please visit our website for further information.< https://www.caresource.com/oh/providers/tools-resources/health-partner-policies/administrative-policies/mycare/ >.

10. Electronic Visit Verification (EVV)
Electronic Visit Verification, or EVV, is a process for electronically capturing point-of- service information for certain home and community-based services. CMS established requirements for all states to use EVV in accordance with the 21st Century Cures Act.

This act requires CareSource to use EVV when processing Personal Care Services claims and Home Health Care Services claims. CareSource complies with the requirements of CMS and the applicable state regulatory body as required by EVV and is dedicated to helping providers navigate this process successfully

EVV is part of a federal law that requires direct care workers (DCW) who provide certain personal care and home healthcare services to electronically report the following to make sure individuals are receiving the services they need:

✓The type of service performed
✓The individual receiving the service
✓The date of the service
✓The location of service delivery
✓The DCW providing the service
✓The time the service begins and ends

- ❖ Independent Providers must use the state-provided Sandata system to document visit capture
- ❖ Claims may deny if required EVV data is incomplete or a mismatch occurs
- ❖ Each visit/service date should be billed on a separate claim line in order for EVV validation to work correctly. Claim with lines billed with date of service spans will be rejected or denied for improper billing.

11.1 EVV Support:
- If you need additional help regarding the EVV processes, please visit the Electronic Visit verification page located on CareSource.com https://www.caresource.com/oh/providers/education/patient-care/electronic-visit-verification/mycare/.
- Phone: 855-805-3505
- Email: ODMCustomerCareEmail@Sandata.com
- Website: Electronic Visit Verification | Medicaid

12. Electronic Funds Transfer:

CareSource offers electronic funds transfer (EFT) as a payment option. We work with ECHO Health Inc. as our claims processing vendor. Visit the Provider Portal for additional information about the program and to enroll in EFT. Providers who elect to receive EFT payment will receive an EDI 835 (electronic remittance advice). Providers can download their explanation of payment (EOP) from the Provider Portal or receive a hard copy via the mail.

Choose EFT as your payment preference for CareSource. Enroll with ECHO by visiting https://enrollments.echohealthinc.com/EFTERADirect/CareSource

You can also complete the ECHO enrollment form and fax, email, or mail it back to ECHO. https://www.caresource.com/documents/cs-p-0447-eft-enrollment-form

Benefits of EFT:

- **Simple** – Receive fully reconciled remittances electronically; eliminate paper checks and EOPs, which will increase efficiency with payment processing.
- **Convenient** – Available 24/7; free training is also offered for providers.
- **Reliable** – Claim payments electronically deposited into your bank account.
- **Secure** – Access your account through CareSource's secure Provider Portal to view (and print if needed) remittances and transaction details.
- **Enhanced Information** – Receive member specific third-party liability (TPL) information.

CareSource follows the Council for Affordable Quality Healthcare (CAQH) CORE operating rules for information exchange, with specific Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) on the 835.

Please Note: TPL/coordination of benefits (COB) information can be found in loop xxx/segment xxx on the 835 file.

CareSource provides TPL/COB information for EFT. This can be found in segment 2100 Claim Payment Information and loop 2110 Service Payment Information on the 835 file in this format:

- NM1*PR*AETNA US HEALTHCARE
- NM1*GB*1*YARBORO*JUSTIN
- REF*6P*W246632770
- The NM1*PR (COB carrier), NM1* GB (other subscriber information from other payer) and REF*6P (other insurance group number)

To enroll in EFT, complete the enrollment form, available on CareSource.com > Providers > Claims and fax it back to our payment processing vendor, ECHO Health Inc. Providers may also call ECHO support at

1-888-834-3511 for assistance with registration.

13. Non-Contracted Providers

In February 2023, Ohio Medicaid implemented the Electronic Data Interchange (EDI) system alongside the Fiscal Intermediary (FI) as part of the Next Generation Ohio Medicaid program. Below are the steps and important information you need to know to submit MyCare Next Generation claims effectively:

1. **Understanding EDI and FI**:
    - The EDI serves as the central hub for all claims-related activities, providing transparency and visibility into care and services.
    - The FI processes claims through the EDI. Please note that providers, trading partners, and managed care entities do not interact directly with the FI.
2. **Streamlined Claims Process**:
    - The EDI transaction process was modernized as part of the Ohio Department of Medicaid's (ODM) efforts to enhance the Ohio Medicaid Enterprise System (OMES).
    - All electronic claims for MyCare Ohio Plans are exchanged through a single connection with authorized trading partners.
    - CareSource MyCare Ohio providers may submit just one claim for Medicare and Medicaid covered services. CareSource will process all services under one claim.
3. **Prior Authorization Requirement**:
    - Nonparticipating (out-of-network) providers must obtain prior authorization for any services rendered to CareSource members, except in emergency situations.
    - To request prior authorization, call CareSource at **1-833-230-2176**.
4. **Enrollment Requirement**:
    - All providers billing for services to MyCare Ohio-enrolled members must enroll with ODM through the Provider Network Management (PNM) system. For more information, visit the PNM & Centralized Credentialing.
5. **Claim Submission Process**:
    - Claims can be submitted electronically through the EDI using an ODM-authorized trading partner (TP). Trading Partners
    - When submitting claims, ensure you use the CareSource ODM Payer ID: **'0021599'** to guarantee proper routing of your claim records.
    - Please note members with MyCare Medicaid Only ID cards have another payor for their Medicare. Please ask for the member's Medicare ID card and submit Medicare claims to the plan on their Medicare ID card. Once you have done so, you may submit a claim to CareSource MyCare Ohio for the secondary Medicaid services.
6. **Need Help?**:
    - If you have any questions about submitting claims for services rendered to a CareSource member, please contact CareSource Provider Services at **1-800-488-0134**.

    For more detailed information about the Ohio Medicaid Enterprise System and EDI transactions, please visit the Ohio Medicaid Enterprise System Transactions Overview page.

14. Member Billing Policy

State and federal regulations prohibit providers from billing CareSource Next Generation MyCare Ohio members for services provided to them except under limited circumstances. CareSource monitors this activity based on reports of billing from members. We will implement a stepped approach in working with our providers to resolve any member billing issues that includes notification of excessive member complaints and education regarding appropriate practices.

A MyCare recipient cannot be billed when a medical claim has been denied for any of the following reasons: unacceptable or untimely submission of a claim; failure to request a prior authorization; or a retroactive finding by a peer review organization (PRO) that rendered services was not medically necessary.
Failure to comply with regulations after intervention may result in potential termination of your agreement with CareSource.

Failure to comply with regulations after intervention may result in potential termination of your agreement with CareSource.

15. Regulations on Billing CareSource Ohio Next Generation MyCare Members

Federal regulations as well as the Medicaid Addendum, part of your executed contract with CareSource, prohibit providers from billing members except in very limited situations. To bill a member all the following must have occurred:

- Provider has submitted a prior authorization request to CareSource and CareSource has denied the prior authorization request.
- After receipt of denial and prior to rendering the services, the provider has notified the member, in writing, of the financial liability to the member should member elect to proceed with the services.
- The written notification must be specific to the services to be provided and clearly state the member is financially responsible for the specific service. A general patient liability statement signed by all patients at your practice does not meet this requirement.
- The written notification must be signed and dated by the member; date must be prior to date of service.

In compliance with federal and state requirements, CareSource Next Generation MyCare Ohio members cannot be billed for missed appointments. CareSource encourages members to keep scheduled appointments and call to cancel, if needed. CareSource provides transportation for many doctor’s visits to help ensure our members make it to needed appointments.

Providers should call Provider Services for guidance to determine if billing members for any services is appropriate. You can reach Provider Services by calling **1-800-488-0134**.

Payment in Full

CareSource requires, as a condition of payment, that a provider (network or out-of-network) accepts the amount paid by the MCOP or appropriate denial made by the MCOP (or, if applicable, payment by the MCOP that is supplementary to the member's third-party payer), and, in addition, any applicable co-payment or patient liability amount due from the member as payment in full for the service. Except for collecting member copayments, providers may not charge members or ODM any additional copayment, cost sharing, down payment or similar charge, refundable or otherwise.

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:

- 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;
- 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;
- The Medicaid recipient agrees to be liable for payment of the service and signs a written statement to that effect before the service is rendered; and
- The Medicaid covered service is not a prescription for a controlled substance as defined in section 3719.01 of the Revised Code.
- 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 conditions in paragraphs (C)(2) t o (C)(4) of this rule are met.
- 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 accordance with section 5168.14 of the Revised Code.

Member Co-Payments

Except for collecting member copayments, providers may not charge members or ODM any additional copayment, cost sharing, down payment or similar charge, refundable or otherwise.

16. MyCare Waiver Providers

16.1 Claims Submission

- Claims for Waiver services can be submitted through the Provider Portal; however, the view and claims submission process are different than standard Medicaid claims.
  - How to Submit a Claim
  - How to Submit a Corrected Claim

16.2 Waiver payments

- CareSource will pay according to the Ohio Administrative Rules (OAC) - Rule 5160-46-06 - Ohio Administrative Code | Ohio Laws and all other waiver service statutes listed here:<https://medicaid.ohio.gov/families-and-individuals/citizen-programs-and-initiatives/hcbs/waivers/waiver-comparison-chart>.
- Payments are made through ECHO and initial check will be sent via paper but strongly recommend contacting ECHO to setup Electronic Funds Transfer (EFT) 1-888-485-6233.
  - Opt out of the V-card option – these cards cannot be used at a local retail store
  - Once you sign up for EFT, it can take up to 2 pay cycles to switch to EFT
- Checks are generated twice a week, normally on Tuesday and Saturday.

CareSource follows payer sequencing. Waiver is the payer of last resort following Medicare and Medicaid if the service is medically necessary.

For more detailed billing guidance on specific Long-Term Services and Support (LTSS) services, please refer to the billing guide for the LTSS service you are performing, which is located on the claims page, on CareSource.com.< https://www.caresource.com/providers/provider-portal/claims/>.

17. Provider Support

17.1 Provider Services

To support our providers, we have dedicated Provider Services teams specialized with each plan to help assist with questions and concerns. Additionally, an external team of Provider Relations Account Managers is available to provide onsite training and work with our providers in their communities.

Provider Services

Provider Services	
Provider Services Number	**1-800-488-0134**
Hours of Operation	Monday through Friday, 8 a.m. to 6 p.m. ET
Provider Portal	**ProviderPortal.CareSource.com/OH**

Holiday Hours
Representatives are available by telephone Monday through Friday, except on observed holidays. <Please visit CareSource.com > Providers > Contact Us for the holiday schedule or contact Provider Services for more information.

17.2 Website

Accessing our website, **CareSource.com** is quick and easy. On the Provider section of the site, you will find:
Commonly used forms
Frequently asked questions
Clinical and preventive guidelines
CareSource preventive services member rewards information
And more!

17.3 Network Notification

CareSource communicates updates to our provider network regularly via network notifications available on the Updates & Announcements page at **CareSource.com** > Providers > Tools & Resources > Updates and Announcements and on our secure Provider Portal at **CareSource.com** > Login > Provider.

17.4 Provider Policies

CareSource maintains medical, pharmacy, reimbursement and administrative policies on our website. Approved policies may be found at <**CareSource.com** > Providers > Tools & Resources > Provider Policies.> Policies are regularly reviewed, updated, withdrawn or added; and therefore, subject to change. CareSource providers notice to providers regarding a change in policy at least <30 calendar days> prior to implementation.

Providers may access plan forms at <CareSource.com > Providers > Tools & Resources > Forms.> Select

forms are highlighted below and linked for your convenience.

17.5 Newsletters

Our provider newsletter contains operational updates, clinical articles and new initiatives underway at CareSource. Newsletters are found on our website at CareSource.com > Providers > Education > Newsletters & Communications.

18. Provider Manual

This content has been reviewed; however, changes and/or revisions occur frequently. The provider should check the Provider Manual and Updates & Announcements pages on CareSource.com for the most up-to-date information.

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