WORKING WITH CARESOURCE® MYCARE OHIO (HMO D-SNP)

LTSS/HCBS PROVIDER ORIENTATION

OHIO NEXT GENERATION MYCARE WAIVER

CareSource®

Agenda

- Next Generation MyCare
- About CareSource MyCare Ohio
- Provider Support
- Working with CareSource
- Getting Started
- Provider Portal
- Waiver Service Plans and Claims Submission
- Electronic Visit Verification
- Provider Resources

CareSource Mission:
To make a lasting difference in our members' lives by improving their health and well-being.

Thank you for being a CareSource MyCare Ohio Partner!

Next Generation *MyCare*

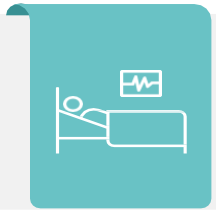
The Next Generation MyCare program is an improved health care program for Ohioans who have both Medicaid and Medicare. This program helps members get the care they need all in one plan. Through the Next Generation MyCare plan a member chooses, they will get all benefits available through the traditional Medicare and Medicaid programs.

The Next Generation MyCare program is scheduled to go live on January 1, 2026, and to achieve the following goals:

Focus on the individual

Support providers in continuously improving care

Improve individual and population wellness and health outcomes



Improve care for individuals with complex needs to promote independence in the community

Create a personalized care experience

Increase program transparency and accountability

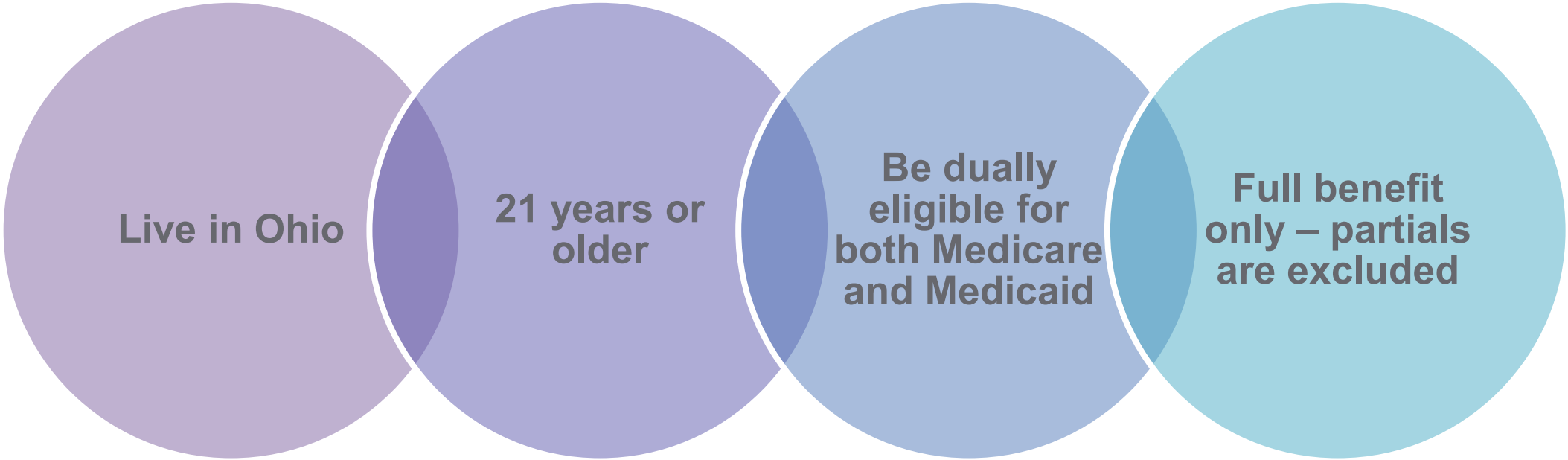
What is Next Generation ***MyCare***?

Ohio's Fully Integrated Dual Eligible Special Needs Plan for dually eligible people with both Medicare & Medicaid

Covers medical, behavioral and long-term services in one plan

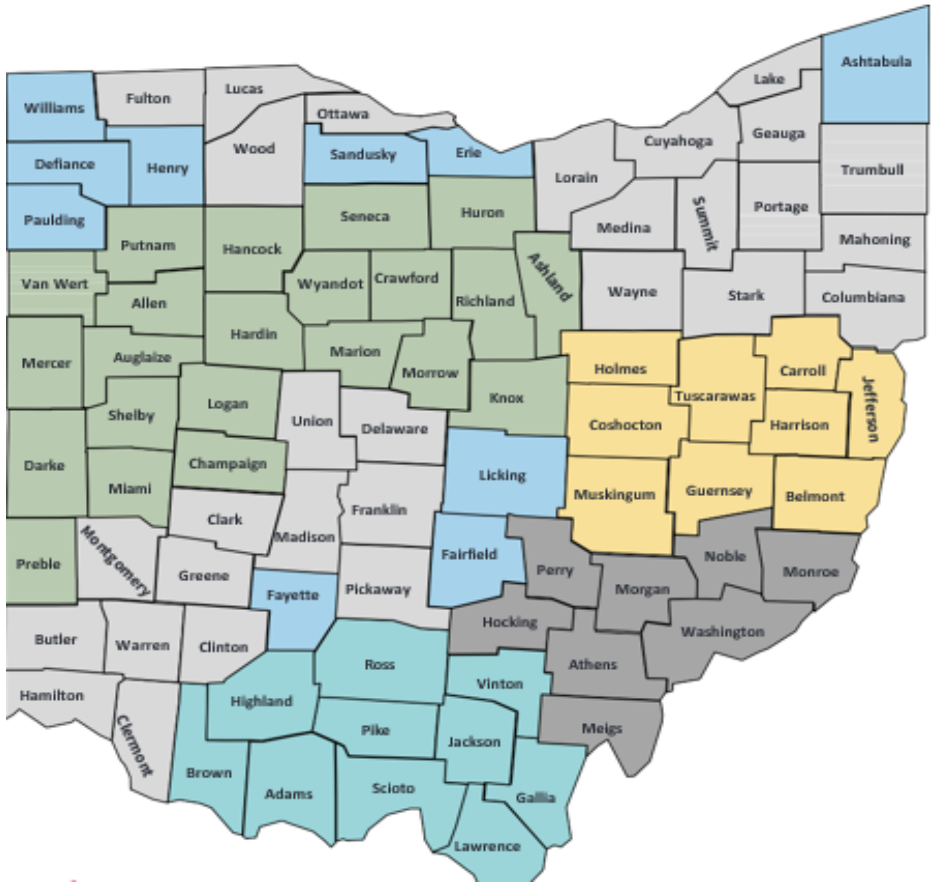
One care plan, one ID card, one care team

Who is ***Eligible***?



Next Generation *MyCare Program Roll-Out*

The Next Generation MyCare program will be rolled out in two phases, enabling Ohio Department of Medicaid (ODM) to collaborate with all stakeholders effectively in preparation for the program's expansion while minimizing disruption to members.



Roll out based on county member lives

Phase 1: Current MyCare Counties On January 1, 2026, ODM will roll out the Next Generation MyCare program in the 29 counties where MyCare is currently available today.	
January 1, 2026	AAA1: Butler, Warren, Clinton, Hamilton, Clermont AAA2: Montgomery, Clark, Greene AAA6: Franklin, Delaware, Union, Madison, Pickaway AAA4: Lucas, Fulton, Ottawa, Wood AAA10a: Lorain, Cuyahoga, Medina, Lake, Geauga AAA10b: Summit, Portage, Stark, Wayne AAA11: Columbiana, Mahoning, Trumbull
Phase 2: Remaining Counties Starting on April 1, 2026, and continuing through the year, ODM will roll out the Next Generation MyCare program in the remaining counties.	
April 1, 2026	AAA4: Sandusky, Erie, Henry, Williams, Defiance, Paulding AAA6: Fayette, Fairfield, Licking AAA11: Ashtabula
May 1, 2026	AAA2: Preble, Darke, Miami, Shelby, Champaign, Logan AAA3: Van Wert, Putnam, Hancock, Allen, Mercer, Auglaize, Hardin AAA5: Seneca, Huron, Wyandot, Crawford, Richland, Ashland, Marion, Morrow, Knox
June 1, 2026	AAA7: Ross, Vinton, Highland, Pike, Jackson, Gallia, Brown, Adams, Scioto, Lawrence
July 1, 2026	AAA9: Holmes, Tuscarawas, Carroll, Jefferson, Coshocton, Harrison, Belmont, Guernsey, Muskingum
August 1, 2026	AAA8: Hocking, Perry, Morgan, Noble, Monroe, Washington, Athens, Meigs

What This Means for ***Members and Providers***

Members

- Easier: one plan, one team
- Coordinated care
- Extra support for long-term care
- No change to Medicare benefits

Providers

- One point of contact for Medicaid and Medicare services
- Consistent processes for claims and authorizations

Next Generation MyCare ***Member Term Definitions***

Member Reference	Description of Term
Dual Benefits Members	Individuals who receive both Medicare and Medicare benefits through their Next Generation MyCare plan.
Medicaid-Only Members	Individuals who only receive their Medicaid benefits through their Next Generation MyCare plan and have a separate plan for their Medicare benefits.

What does "Medicaid-Only" mean?

- The member is a dual eligible benefit member enrolled in CareSource ONLY for Medicaid
- This means they have chosen Medicare FFS or another Medicare Advantage (MA) plan to administer their Medicare benefits

What does this mean for the member?

- They are not enrolled in an integrated plan, which means that they may have another care coordinator in their MA plan that will need to work with their Care Coordinator in their CareSource Medicaid plan

What does this mean for the providers?

- Providers will need to understand what to look for on the ID card to indicate if the member is aligned or Medicaid only
- ***Medicaid only billing will mean billing the member's Medicare coverage first and CareSource Medicaid last.***

Enrollment with *ODM and Plan Contract Requirements*

To provide services to members in the Next Generation MyCare program, you **must** be enrolled with ODM **and** contracted with the member's plan by completing the following steps:

- Enroll with ODM by visiting the Medicaid Provider Portal and completing the online application (credentialing, if required, will occur automatically during application processing)

- Contract with the Next Generation MyCare plans by contacting each of the plans you wish to contract with:
  - Anthem Blue Cross and Blue Shield: 1-833-727-2170
  - Buckeye Health Plan: 1-833-998-4892
  - CareSource: Complete the New Health Partner Contract Form. Call **1-800-488-0134** for assistance.
  - Molina HealthCare of Ohio: 1-855-322-4079

Note: Enrollment with ODM does not automatically contract with the plans; you must initiate a contract with the plan in addition to enrollment with ODM.

Source: https://medicaid.ohio.gov/resources-for-providers/special-programs-and-initiatives/mycareohio/mycare-ohio

Next Generation MyCare – ***ODM Provider Resources***

ODM provides comprehensive information about Next Generation MyCare Program and Provider Tools and Resources.

ODM Provider Resources:

- MyCare Ohio | Medicaid
- NextGen_MyCare_Provider_Frequently_Asked_Questions_Updated_October_2025.pdf

Please also subscribe to the ODM Press:

Please visit News for Ohio Medicaid Providers which will provide access to published news releases as well as information on subscribing to the ODM Press Newsletter.

About CareSource

CareSource®

Our *Mission*

MISSION

To make a lasting difference in our members' lives by improving their health and well-being

PLEDGE

- Partner with providers to help members make healthy choices
- Make it easy for you to work with us
- Direct communication
- Timely and low-hassle medical reviews
- Accurate and efficient claims payment

Health Care with ***Heart***

MISSION-FOCUSED

Comprehensive, member-centric health and life services.

EXPERIENCED

With over 30 years of service, CareSource is a leading nonprofit health insurance company.

DEDICATED

We serve over 2.1 million members through our Medicaid, Marketplace, MyCare, Dual Special Needs Plans (D-SNP) and PASSE programs.

Our ***Responsibilities***

- Ensure an effective member/provider appeal and grievance process.
- Provide support for every provider through the Provider Services call center and our Long-Term Services and Supports (LTSS) Provider Relations team.
- Comply with all state and federal regulations.
- Coordinate benefits for members with primary insurance.
- Notify providers 30 days before policy changes and new edits or system changes related to claims adjudication or payment key processing.

Please refer to your contract and the Provider Manual for more information regarding expectations and responsibilities.

CareSource ***Expectations of Providers***

Provider Network Management (PNM) enrollment active and up to date. Complete revalidations timely.	Treat CareSource MyCare Ohio members with respect.	Participate in members' Interdisciplinary Care Team.	Provide notification to terminate the contract 90 days in advance of desired termination date.
Do not balance bill CareSource MyCare Ohio members.	Comply with service delivery wait time standards.	Provide services in accordance with the members' Person Centered Service Plan.	Provide medical records or supporting documentation upon request.
Submit claims or corrected claims within 365 days of date of service or date of discharge.	Use Electronic Visit Verification where required for applicable services.	Complete Orientation, Model of Care training, annual trainings and ODM required trainings.	Offer translation service or utilize CareSource MyCare Ohio translation services.

Please refer to your contract and the Provider Manual for more information on provider expectations and responsibilities.

Dedicated ***Provider Support***

Provider Services:

1-800-488-0134

Monday through Friday, 8 a.m. to 8 p.m. Eastern Time (ET)

Dedicated LTSS Provider Relations Account Manager & Support Team

CareSourceOHLTSSHCBSSupport@CareSource.com

LTSS/HCBS ***Provider Relations Team***

Personalized Assistance

The Long-Term Services and Supports (LTSS)/Home and Community-Based Services (HCBS) Provider Relations team provides tailored help to guide providers through onboarding and policies, ensuring a smooth start.

Comprehensive Orientation and Training

Providers receive detailed orientation covering services, billing processes and compliance information for clear understanding.

Ongoing Account Manager Support

Dedicated Account Managers are available to resolve questions, offer assistance and build confidence throughout the partnership.

Our team is here for you!

CareSourceOHLTSSHCBSSupport@CareSource.com

Peer Support Program

Peer Support Program Summary
The Peer Support Program connects HCBS providers with experienced peers who offer guidance and support. This initiative aims to improve care quality and help providers navigate administrative requirements effectively.

Program Highlights:
- Mentorship pairing with experienced Peer Support Providers.
- Interactive training sessions on service delivery and compliance.
- Sharing of useful resources and effective strategies.
- Continuous support for advice and problem-solving whenever needed.

This program ensures that providers receive practical, peer-driven support to deliver high-quality care while managing administrative tasks confidently.

Program Goals:

If you are interested in becoming a Peer Support Mentor, please reach out to us at CareSourceOHLTSSHCBSSupport@CareSource.com

Working with CareSource

Steps to Providing Services
Member Rights
Member Benefits
Member ID Cards
Billing Order/Rate/Reimbursement
Electronic Payments
Service Plans
Service Delivery Time Standards
Incident Management
Provider Training
Translation/Interpreter Services

CareSource®

3 Easy Steps to Start Servicing Members

1. Enroll with ODM via PNM

- Providers start by enrolling with ODM using the Provider Network Management system.
- PNM Resource Guide.

2. Contract with CareSource

- Complete Provider Contract Request Form.
- Refer to the Step-by-Step Guide to Completing Contract Request Form.
- Keep Application Number:
  - This allows you to check the status of your application.
- Sign Contract upon receipt.

3. Receive Welcome Letter

- Welcome letter will include your effective date and CareSource Provider ID number.

! *ODM prohibits payment to Ohio Medicaid and MyCare providers who are not affiliated through registration within the PNM module.*

Member ID Cards: *CareSource MyCare Ohio*

MYCARE

Front

CareSource <CareSource® MyCare Ohio (HMO D-SNP)>

Member Name:
<Cardholder Name>
Member ID #: <Cardholder ID#>
MMIS Number: <Medicaid Recipient ID#>
PCP Name: <PCP Name>
PCP Phone: <PCP Phone>

MedicareRx Prescription Drug Coverage
RxBIN: <RxBIN #>
RxPCN: <RxPCN#>
RxGRP: <RxGRP#>
RxID: <RxID#>

MEMBER CANNOT BE CHARGED Copays: $0
<CMS Contract #> <Plan Benefit Package #>

Back

FOR EMERGENCIES: DIAL 911 OR GO TO THE NEAREST EMERGENCY ROOM.
If you are not sure if you need to go to the ER, call the 24-Hour Nurse Advice Line.

Member Services: <1-855-475-3163 (TTY: 1-833-711-4711 or 711)>
Dental: <1-833-778-7003 (TTY: 711) >
Vision: <1-844-206-6383 (TTY: 711) >
Hearing: <1-833-564-6222 (TTY: 711)>
Pharmacy Help Desk: <1-800-416-3628>
Behavioral Health Crisis: <1-855-202-1087>
Care Coordination: <1-855-475-3163>
Provider Questions: <1-855-475-3163 >
Claim Inquiry: <1-800-488-0134>
Eligibility Verification: <1-855-475-3163>
24-Hour Nurse Advice: <1-866-206-7861 (TTY: 1-833-711-4711 or 711)>

Send claims to:
<Attn: Claims Department
P.O. Box 8730
Dayton, OH 45401-8738>
Send Pharmacy claims to:
<Express Scripts
ATTN: Medicare Part D
P.O. Box 52023
Phoenix, AZ 85082>

Ohio Department of Medicaid
Next Generation MyCare

Website: <CareSource.com/MyCare-SNP>

MYCARE (MEDICAID SERVICES ONLY)

CareSource <CareSource® MyCare Ohio>

Member Name:
<Cardholder Name>
Member ID #: <Cardholder ID#>
MMIS Number: <Medicaid Recipient ID#>
PCP Name: <PCP Name>
PCP Phone: <PCP Phone>

MedicareRx Prescription Drug Coverage
RxBIN: <RxBIN #>
RxPCN: <RxPCN#>
RxGRP: <RxGRP#>
RxID: <RxID#>

MEMBER CANNOT BE CHARGED Copays: $0
Medicaid-Only Member

FOR EMERGENCIES: DIAL 911 OR GO TO THE NEAREST EMERGENCY ROOM.
If you are not sure if you need to go to the ER, call the 24-Hour Nurse Advice Line.

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<Attn: Claims Department
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Dayton, OH 45401-8738>
Send Pharmacy claims to:
<Express Scripts
ATTN: Medicare Part D
P.O. Box 52023
Phoenix, AZ 85082>

Ohio Department of Medicaid
Next Generation MyCare

Website: <CareSource.com/MyCare-SNP>

Member ***Benefit Highlights***

MyCare Ohio (MEDICARE + MEDICAID)	MyCare Ohio (Medicaid Only)
Our CareSource® MyCare Ohio (HMO D-SNP) provides members with Medicare and Medicaid coverage with no copays and extra perks that help save them money.	Our Medicaid-Only plan provides standard coverage with no copays and select services.
HIGHLIGHTS	**HIGHLIGHTS**
All standard Medicare and Medicaid benefits	All standard Medicaid benefits
No copays for Medicaid services, Medicaid-covered drugs or Medicare Part D drugs	No copays for Medicaid services and Medicaid-covered drugs
Enhanced transportation	Basic Transportation
Dental coverage for oral exam and cleaning, fluoride treatments, plus implants	Dental coverage for oral exam and cleaning
$287 each month for a Healthy Benefits+ allowance	
My CareSource Rewards Program®	
Fitness Benefits through Silver&Fit®	

Knowing members' benefits and covered services allows you to support members in accessing needed services.

Member Benefits and Services: Plan Documents | Ohio – Next Generation MyCare | CareSource

Member ***Rights***

Providers must be aware and adhere to member rights to enhance the quality of care and support they offer to our members. These rights are essential to promoting a patient-centered care environment and ensuring that members feel empowered, supported and respected in their health care journey.

- Members have the right to receive clear, comprehensive information about their benefits, services and rights.
- Members are entitled to timely access to medically necessary services and supports.
- Members should be treated with respect and dignity, without discrimination based on race, ethnicity, gender or disability.
- Members have the right to privacy regarding their health information and personal records.
- Members must provide informed consent before receiving treatment or services.

Please refer to the Provider Manual for additional information concerning member rights or go to **CareSource.com** > Member > Rights and Responsibilities.

OAC 5160-58.01.1, 5160-26.08.3

Member ***Communications***

HELP YOUR CARESOURCE PATIENTS UNDERSTAND THEIR COVERAGE.

Please encourage your patients to visit **CareSource.com**, where they can access:

- CareSource MyLife member portal
- Member benefits
- Searchable online formulary and prescription cost calculator
- Find a Doctor tool
- Evidence of Coverage & Schedule of Benefits
- Member Handbook
- Total Cost Navigator
- Forms and more

For more information, visit: Member Overview | Ohio – Next Generation MyCare | CareSource.

Next Generation MyCare ***Claims Submission & Contract Rates Guide***

CareSource Member	Claims Submission	Contract Reimbursement
Dual Benefit Member (Medicare & Medicaid)	**Provider submits claim through the CareSource Provider Portal** ✓Claim entered directly into the CareSource Provider Portal Provider Portal-Online Claim Submission **or** ✓Paper claim uploaded into the Caresource Provider Portal, mail or fax **or** **Provider submits EDI Claim** ✓Claim submitted through ODM's One Front Door to Ohio Medicaid Enterprise System (OMES). One Front Door Provider Training ✓When submitting claims, ensure you use the CareSource ODM Payer ID: **'0021599'**	Providers' MyCare and Medicaid rates apply. CareSource contracted rates apply to both Medicare and Medicaid portions of the claim based on covered services.
Medicaid-Only (Medicaid is Primary)	**Provider submits claim through the CareSource Portal** ✓Claim entered directly into the CareSource Provider Portal Provider Portal-Online Claim Submission **or** ✓Paper claim uploaded into the Caresource Provider Portal, mail or fax **or** **Provider submits EDI Claim** ✓Claim submitted through ODMs One Front Door to Ohio Medicaid Enterprise System (OMES). One Front Door Provider Training ✓When submitting claims, ensure you use the CareSource ODM Payer ID: **'0021599'**	CareSource Medicaid rate applies to the Medicaid portion of the claim.
Medicaid-Only* (Medicare is Primary)	Provider submits claim to Medicare and the Medicaid portion will be automatically crossed over to CareSource	Providers' Medicare contract rate applies first. CareSource Medicaid rate applies to the Medicaid portion of the claim.
Medicaid-Only* (Medicare Advantage is Primary)	Provider submits claims to the Medicare Advantage plan and then the Medicaid portion can be submitted through the CareSource Provider Portal or ODM's FI.(One Front door)	Providers' Medicare Advantage contract rate applies first. CareSource contract rate applies to the Medicaid portion of the claim.

The Medicaid portion of a claim pays only if the Medicare or Medicare Advantage payment is less than the allowed Medicaid rate.

Get Paid ***Electronically***

CareSource has partnered with ECHO Health, Inc. to deliver provider payments.

ECHO offers three payment options:

1. Electronic fund transfer (EFT) – **preferred**
2. Virtual Card Payment (QuicRemit) – Standard bank and card issuer fees apply*
3. Paper Checks

**Payment processing fees are what you pay your bank and credit card processor for use of payment via credit card*.

Enrollment Instructions

Enroll with ECHO for payment and choose EFT as your payment preference for CareSource.

You can enroll using your Provider Portal Account or your Tax ID Number

Questions? Call ECHO Customer Support at 1-888-834-3511.

Waiver ***Person-Centered Service Plans***

A Waiver Person-Centered Service Plan (PCSP) helps CareSource members receive extra support to live independently in their community. This plan clearly outlines goals and steps to improve the member's health and daily life. It details the assistance provided by both formal and informal caregivers. The focus is on meeting the member's physical and medical needs, such as personal care or home modifications to make life easier. CareSource covers services according to the LTSS MyCare Waiver, as defined in the Ohio Administrative Code Rule 5160-58-04.

All covered waiver services require prior authorization through the PCSP

Providers must ensure that services are rendered in accordance with the approved plan

CareSource will monitor compliance to verify that all services are provided and billed correctly as per the PCSP

You can access the member's PCSP via the CareSource Provider Portal. We will cover the Provider Portal functions later in the presentation.

LTSS *Wait Time Standards*

- In accordance with ODM requirements, CareSource must ensure members' access to services within these time standards.
- Providers are expected to deliver approved services within these time frames and should perform all services in the amount, scope and duration that have been approved by the care manager and included in the service plan.
- CareSource will monitor service plans and service dates to ensure these services are delivered in full and within these standards by the assigned providers.

Service Type	Wait Time to Receive Service
Home Delivered Meals	**No more than 20 business days** from the waiver service plan request or authorization.
Home Modification	**No more than 60 business days** from the waiver service plan request or authorization.
Personal Emergency Response Services	**No more than 30 business days** from the waiver service plan request or authorization.
Private Duty Nursing	**No more than 20 business days** from the time-of-service order or authorization.
Home Health Nursing	**No more than 20 business days** from the time-of-service order or authorization.
Waiver Nursing	**No more than 20 business days** from the waiver service plan request or authorization.
Specialized Medical Equipment and Supplies	For common items, **no more than 30 business days** and for highly specialized items, no more than 120 business days from waiver service plan request or authorization.
Non-Medical Transportation	**No more than 20 business days** from the waiver service plan request or authorization.
Home Health Aide	**No more than 20 business days** from the time-of-service order or authorization.
Personal Care	**No more than 20 business days** from the waiver service plan request or authorization.
Homemaker	**No more than 20 business days** from the time-of-service order or authorization.

Incident Management

Providers are required to assure the immediate health and safety of members when becoming aware of abuse, neglect, exploitation, misappropriation greater than $500 and accidental/unnatural deaths.

If actions were not taken to assure the immediate health and safety of the member, the provider will do so immediately. Such actions may include calling police or EMS, reporting to county Adult Protective Services (APS), the county Public Child Services Agency (PCSA) or regulatory agencies such as the Ohio Department of Health.

Providers are required to report these types of incidents to CareSource immediately within 24 hours of becoming aware of the incident in accordance with OAC Rule 5160-44-05

How to Submit an Incident to CareSource

Any provider-related concerns are relayed to the member's assigned Care Manager, who will report the incident per CareSource's internal processes. Or you can report the incident to IncidentManagement@CareSource.com. Per provider conditions of participation rules, providers are required to report any health and safety issues involving our waiver members immediately within 24 hours of occurrence or discovery.

Provider *Training & Resources*

We know your time is valuable and that you are working with multiple insurance plans. To improve your access to provider training, CareSource has established a learning management system (LMS) called **HealthPlanResources.com** where we house and manage our custom education program. All live training sessions are hosted and recorded, then posted to this platform for viewing by those unable to attend the presentation.

Accessing **HealthPlanResources.com** is easy!

- **Single Sign-On:** If you are registered to use our Provider Portal, you can single sign-on from that platform by choosing HealthPlanResources.com in the left menu bar.
- **No Current Provider Portal Access:** Go to **HealthPlanResources.com** to sign in using your NPI* and use the password provided in your Welcome Letter.
- **Office Managers/Administrators:** Managing a group of providers? Sign in through the Provider Portal or create an account using your unique email address and the password of your choice to complete training and manage accounts for all providers in your TIN.

CareSource Providers are also required to attend any ODM mandated trainings

Model of Care *Training*

CareSource Next Generation MyCare Ohio providers are required to complete an initial and annual refresher training on delivering the quality care that meets our standards. Access the on-demand training via our Learning Management System **HealthPlanResources.com**.

Model of Care Training includes the following:

Identify Gaps in Care	**Integrated Care Team**
Learn the medical, cognitive, behavioral and functional domains to be assessed	Learn how you can work with the CareSource staff to support the model of care
Holistically Address Patient Care	**Performance & Health Outcomes**
Learn about developing treatment plans informed by health assessment results	Learn how CareSource will work with you to improve the model of care delivery

Fraud, Waste & ***Abuse***

Help CareSource stop fraud.
Contact us to report any suspected fraudulent activities.

Note: Providers are required to attest to completing the training after viewing.

CALL the Fraud Waste and Abuse Hotline at **1-844-415-1272**

FAX 800-418-0248

EMAIL Fraud@CareSource.com

MAIL CareSource Attn: Program Integrity

P.O. Box 1940

Dayton, OH 45401-1940

Fraud, Waste and Abuse On-Demand Training

Please log in to **HealthPlanResources.com** to attest that you've completed the Fraud, Waste and Abuse training.

Fraud, Waste & ***Abuse***

You may also report fraud, waste or abuse directly to the state of Ohio by using one of the methods below:

- **Ohio Department of Medicaid (ODM):** Call 1-614-466-0722 or visit the Ohio Department of Medicaid Reporting Suspected Medicaid Fraud page.
- **Ohio Attorney General's Office Medicaid Fraud Control Unit (MFCU):** Call 1-800-282-0515 or visit the Ohio Attorney General Report Medicaid Fraud page.
- **Ohio Auditor of State (AOS):** Call 1-866-FRAUD-OH or email fraudohio@ohioauditor.gov.

Thank you for your assistance in keeping fraud, waste and abuse out of health care.

Cultural *Humility*

Providers are expected to provide services in a culturally competent manner accordance with 42 CFR 438.206 (2) including:

- Removing all language barriers to service
- Accommodating unique cultural, ethnic and social needs of members
- Understanding that social determinants of health are recognized as significant contributors to member health outcomes and quality of life
- Meeting the requirements of all applicable state and federal law, including contractual requirements

RESOURCES

We provide cultural humility training resources in the Provider Manual and online at **CareSource.com**. The National Culturally and Linguistically Appropriate Services (CLAS) Standards provides specific guidelines to assist you in developing a culturally competent practice.

CLAS Standards - Think Cultural Health

Please log into **HealthPlanResources.com** to attest that you've reviewed and understand Culture Humility/CLAS Standards training.

Ensuring Access to ***Equitable Care***

CareSource must ensure that services are provided in a culturally competent manner and promote equitable access to services to underserved populations such as:

- People with limited English proficiency or reading skills
- People of ethnic, cultural, racial or religious minorities
- People with disabilities
- Aged
- People who identify as lesbian, gay, bisexual or other diverse sexual orientations
- People who live in rural areas and other areas with high levels of deprivation
- People otherwise adversely affected by persistent poverty or inequality

Translation ***Services***

CareSource offers onsite sign and language interpreters as well as over-the-phone (OPI) and video remote interpreting (VRI) when appropriate, for medical appointments outside of the surgical, hospital or emergency room setting*.

These services are available to CareSource members who are hearing impaired, do not speak English, or have limited English-speaking proficiency. These services are available at no cost to the member or provider.

As a provider, you are required to identify the need for interpreter services for your CareSource patients and offer assistance to them appropriately.

To request an interpreter for your patient, please use the Propio self-service portal. First-time users may begin the process of creating an account through Propio.

For questions, please contact our Provider Services department at **1-800-488-0134**. We ask that you let us know of members in need of interpreter services, as well as any members that may receive interpreter services through another resource.

Submit the Interpreter Service Request Form to request interpretation services for an upcoming appointment for a CareSource member.

Request Patient Services | Ohio – MyCare | CareSource

Provider ***Resources***

Provider Resources	Quick Reference Guides
Provider Manual A reference tool for providers to understand their roles, responsibilities, and the operational framework of CareSource.	PNM Resource Guide for LTSS HCBS Providers A resource guide specifically designed for independent providers of LTSS/Home and Community-Based Services (HCBS) to assist with ODM Enrollment Process and Requirements.
Provider Policies A set of established guidelines and protocols that govern provider conduct and service delivery within CareSource.	Step-by-Step Guide to Become a CareSource Provider A detailed guide outlining the necessary steps and requirements for health care providers to join the CareSource network.
Updates & Announcements A section dedicated to the latest news, changes, and important notifications to keep providers informed about critical updates that may affect your practices, business, and patient care.	Provider Claim Submission Guide for LTSS HCBS Providers A guide to ensure accurate and efficient claim submissions, helping LTSS/HCBS providers navigate the claims process effectively.
Claims Information Detailed instructions and information regarding the submission and processing of claims for services rendered.	Billing Guide - General Billing Guidance A general resource providing overarching billing instructions and best practices applicable to various service types.
Provider Claim Disputes or Appeals A process for providers to challenge or appeal decisions made regarding claims submitted to CareSource, ensuring providers have recourse to address issues with claim denials or adjustments.	Billing Guide - State Plan Private Duty Nurse A comprehensive guide detailing the billing procedures assist providers in correctly billing for private duty nursing services, ensuring compliance with state regulations and timely reimbursement.
Member Benefits Covered benefits and services so providers can support members in accessing needed services.	Billing Guide - Home Care Attendant A guide that outlines billing practices and requirements for services provided by home care attendants to provide clarity and facilitating accurate claims submission.
Newsletters & Communications Regular publications that provide insights, updates, and resources for CareSource providers.	Billing Guide - Independent Non-Agency Personal Care Aide A guide focused on billing procedures to assist independent personal care aides in navigating the billing process, ensuring compliance and prompt payment for services rendered.

Self-Direction ***Services***

Self-direction is a service model for Ohioans served by certain Medicaid waivers that empowers their individual choice and control over the long-term services and support needed to live at home. People involved in self-direction make decisions about the type of care they receive, the way certain services are delivered and the caregivers who provide those services.

For more information and resources on Self-Direction Services and how to enroll as a caregiver, please visit Self-Direction Services and Information.

You may also email selfdirection@medicaid.ohio.gov with any questions.

Provider Portal

Registration
Member Eligibility
Service Plans
Claims Submission via Service Plan
Corrected Claims
Provider Sourcing

CareSource®

Provider Portal – ***Unlock On-Demand Access***

We are excited to introduce our Provider Portal, a powerful and user-friendly platform designed to empower you with seamless access to essential information and tools whenever you need them. Our portal offers you the ability to:

- ✓ Instantly verify member eligibility
- ✓ Connect with member's assigned Case Manager via contact information
- ✓ Access member's Person-Centered Service Plan effortlessly
- ✓ Access Provider Sourcing Tool for service opportunities
- ✓ Submit claims, check the status of a claim
- ✓ View your Explanation of Payment (EOP)
- ✓ Correct and resubmit claims with ease
- ✓ File a claim dispute or appeal if you disagree with an adverse claim determination
- ✓ Explore comprehensive training resources
- ✓ And much more to streamline your workflow and enhance your productivity

Experience the convenience and efficiency of this vital resource, created with your needs in mind.

Register today! Our Provider Services and LTSS Provider Relations team are available to assist.

Provider Portal Registration Guide

Register for the ***Provider Portal***

[Provider Portal Registration Guide]

[Provider Portal Login]

Go to **CareSource.com.** Click Provider from the Log-in drop-down.

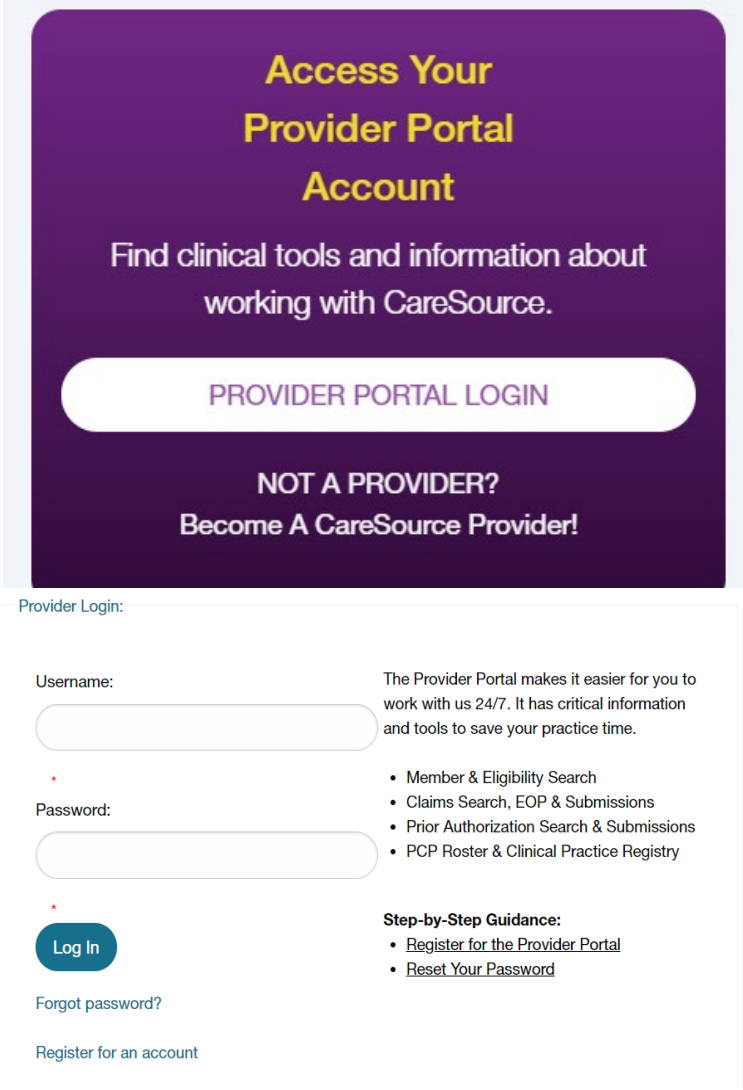
Select **Ohio.**

Click Register Here under **Register for the Provider Portal.**

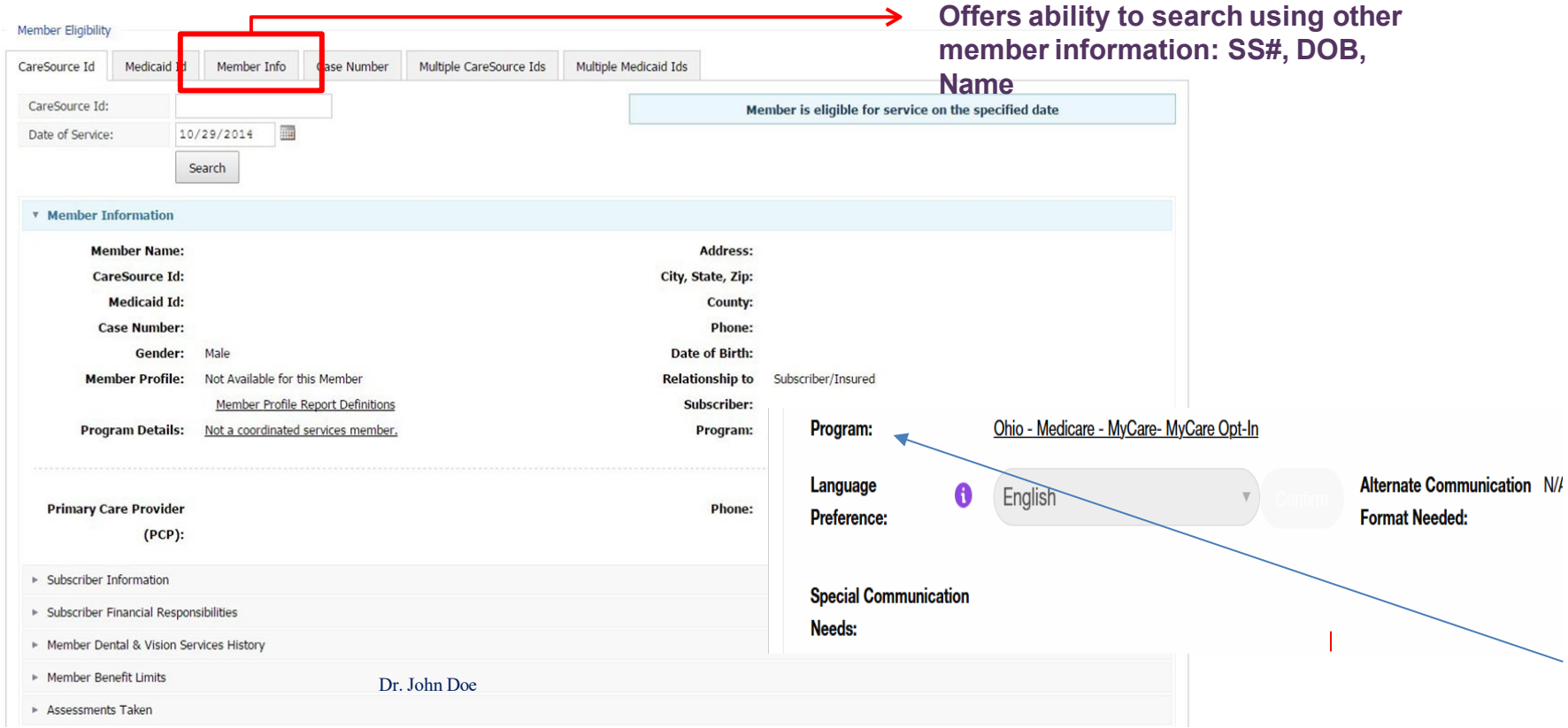
Enter your information, including your CareSource Provider Number (located in your Welcome Letter).

Follow remaining steps to register.

If you are a traditional and waiver provider, you will need to make sure you are logging in with the correct CareSource ID. If you do not use your Waiver CareSource ID, you will not be able to view your waiver member information.



Member *Eligibility*



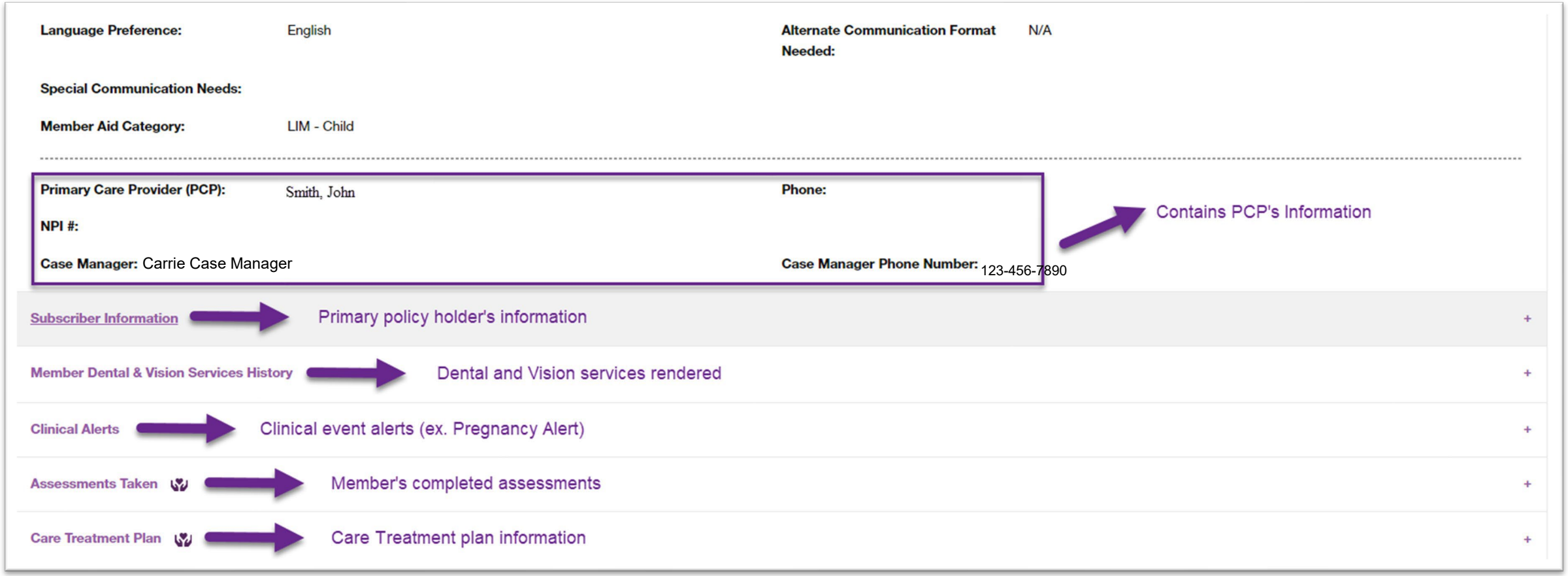
Offers ability to search using other member information: SS#, DOB, Name

[Log-In](#) to the CareSource Provider Portal and on the left-hand side Under Member services select Member Eligibility.

It is important to verify that CareSource members are eligible for care on the date of service; therefore, the date of service is required to conduct a search. This helps prevent unpaid claims. Please select one of the following search methods and enter the requested information. Then select "Search." You can verify eligibility for dates of service up to 24 months ago.

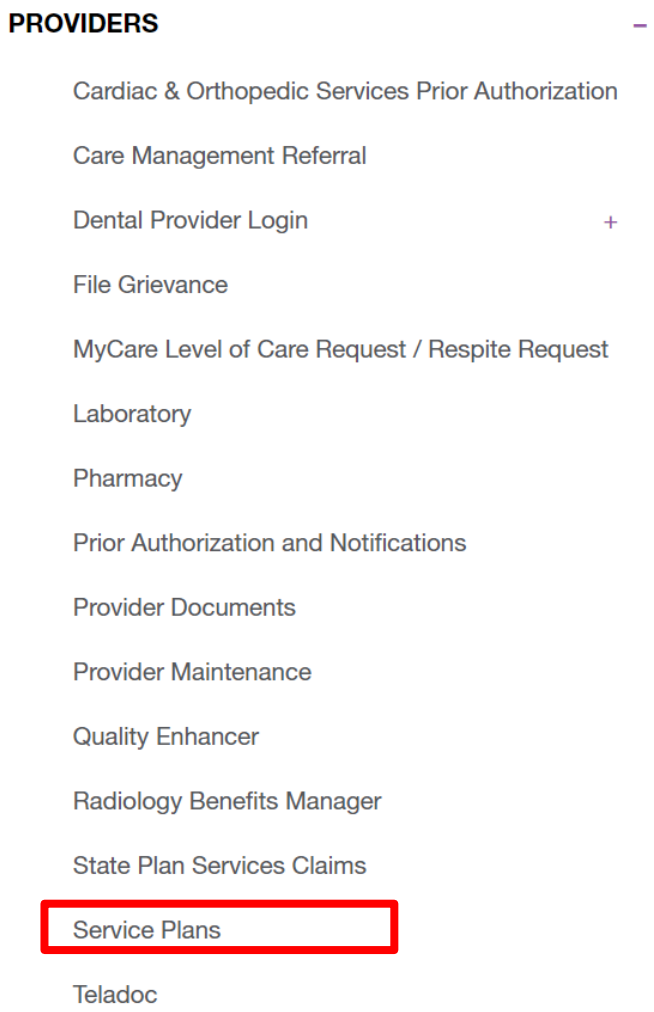
Program shows member's coverage plan, members language preference and other special communication needs.

Member *Eligibility*



Providers will be able to see the member's Case Manager and their contact information

Next Generation MyCare Waiver Provider ***Service Plans***



Waiver Provider-Services Plans

On the left-hand side locate the **Providers** navigation menu which will provide access to Services Plans.

All Waiver Services require Prior Authorization.

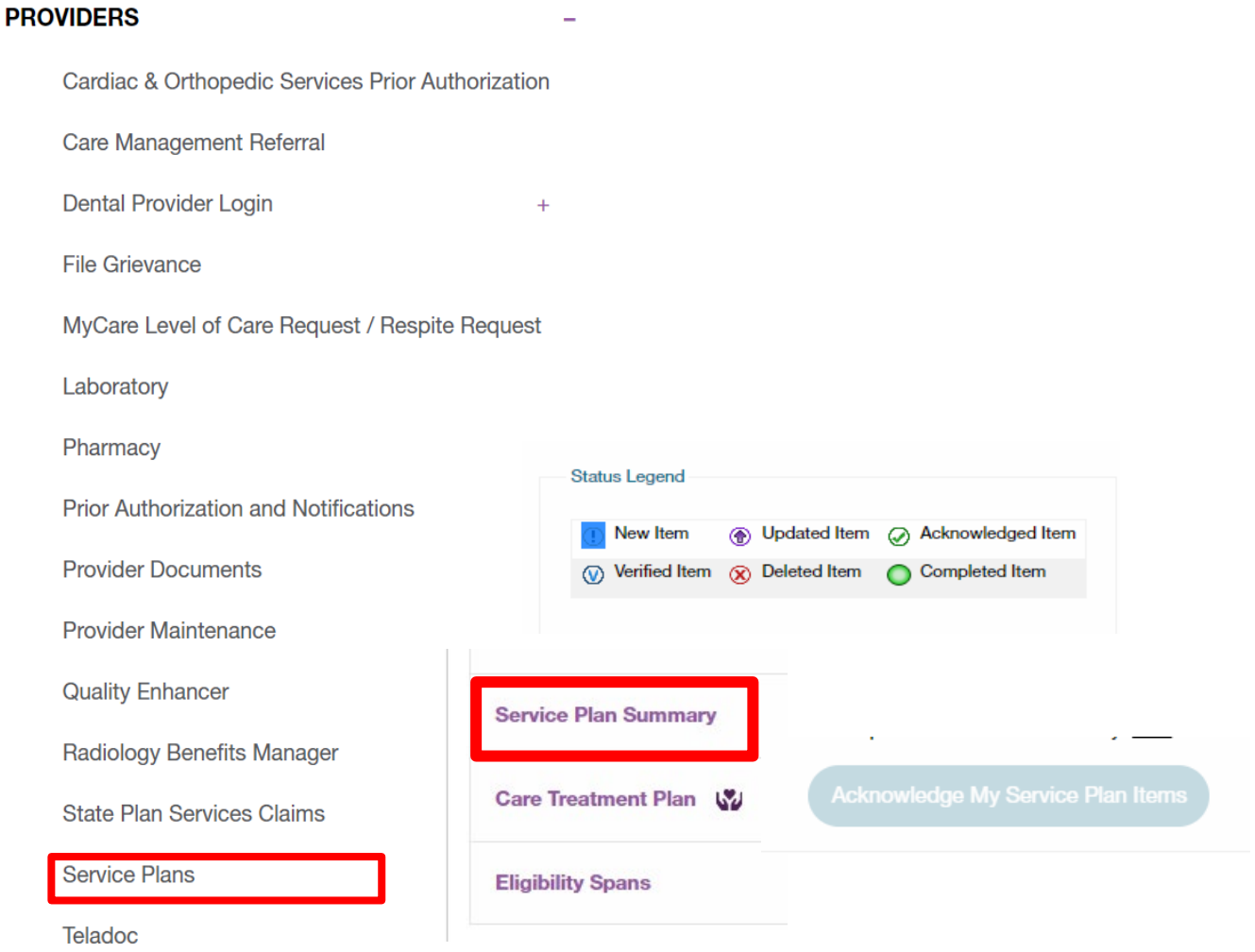
The authorization is reflected in the Waiver Person Centered Service Plan.

Member's Care Manager is the point of contact regarding Waiver Service Plans and authorizations.

Care Manager name and contact is in the Member Eligibility screen.

CareSource allows submission of claim(s) for services rendered via the approved service plan. Quick, easy, improves accuracy and saves you time!

Next Generation MyCare Waiver Provider ***Signature***



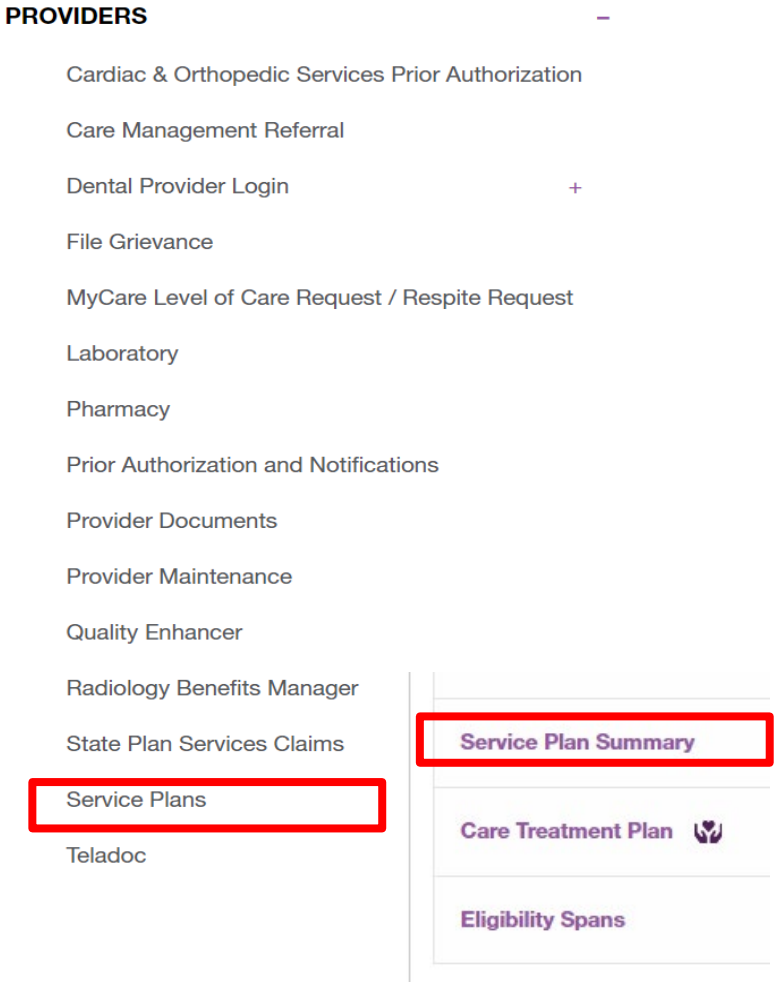
Waiver Provider Signature

In accordance with federal regulations, CareSource must **obtain a signature** from any waiver service provider acknowledging and affirming agreement to provide the service as authorized on the person-center service plan per ODMs Specifications.

- On the left-hand side locate the **Providers** navigation menu which will provide access to Services Plan.
- Then select the member. You can use the legend to see who has a new/updated service plan, but those icons stay for a specific number of days no matter if it's acknowledged or not.
- Scroll down and select **Service Plan Summary**.
- If you agree to provide the services as authorized on the waiver service plan, acknowledge by clicking the **Acknowledge My Service Plan Items.**
- *Acknowledge My Service Plan Items* it will be grayed out like the screenshot (to the right) if the provider has already acknowledged or will be blue if acknowledgement is still needed.
- There is a status legend which can give details about the service plan. If the service plan is inaccurate, please contact the Care Manager to address the issue.

Waiver Provider ***Claims Submission via the Service Plan***

CareSource makes it easy for you to submit a claim for authorized waiver services via the Patient Centered Service Plan!

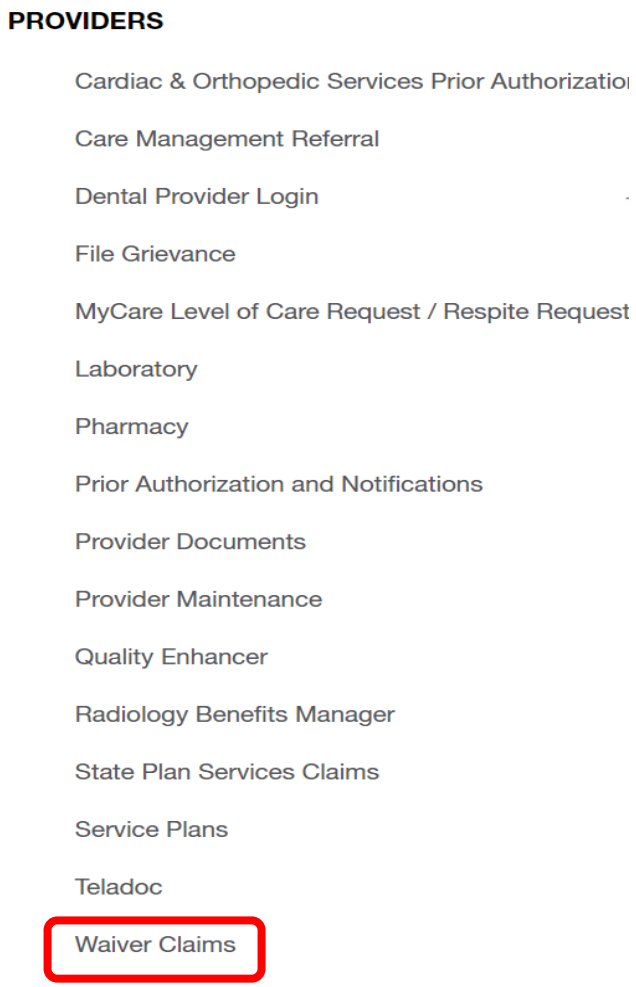


1. Scroll down to the bottom of the page and you will see all members who have authorized services with you.
2. Click on the member's **last name**.
3. Scroll down again and you will see their member information.
4. Choose the "**Service Plan Summary**" option (screen shot below).
5. Then choose "**View Summary**" and scroll down a little to see the detailed information.
6. This will show you the procedure code authorized and the service narrative.
7. To the right of that line, you will see an option to "**Submit Claim**."
8. That will populate the member information which will need to be reviewed and once complete, click on "**Confirm Patient Selection**."
9. You will then need to enter the date of service, the total units and total cost and once verified, click on the **Green plus sign**.
10. **Claim is now submitted!**

IMPORTANT NOTE:

- Enter all units and costs for one visit in one line. If you enter multiple lines for the same date of service, CareSource will deny for duplicate.
- You can enter multiple dates of service on one claim. However, each claim can only have one procedure code.

Waiver Provider Claims – ***How to Submit a Corrected Claim***



1. On the left-hand side locate the **Providers** navigation menu and choose Waiver Claims.
2. This will show the list of claims that have been submitted.
3. At the end of each row is the option to click on the “Correct Claim” link.
4. That will take you back into the claim and you can make the corrections – the same as submitting a new claim, but with the corrected data.
5. Enter the updated information and submit.

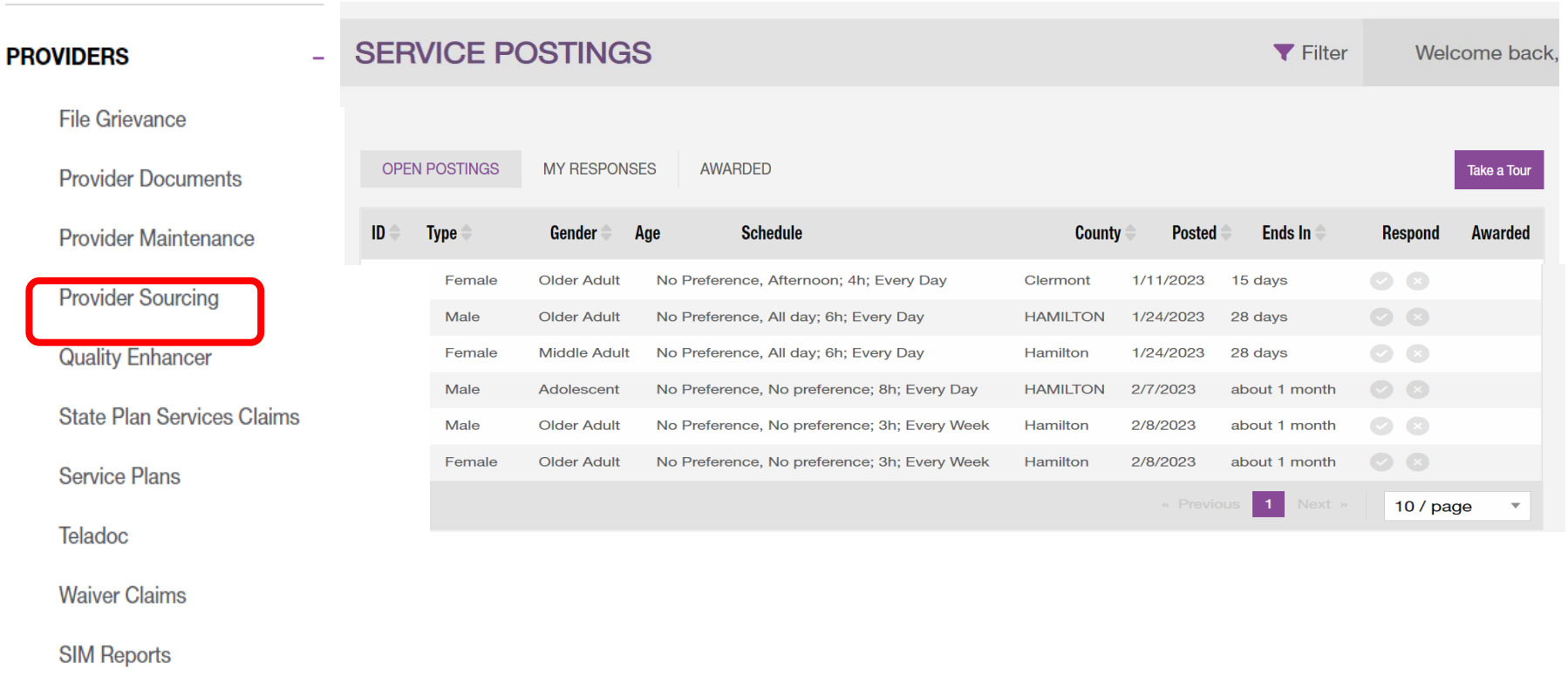
VERY IMPORTANT

1. **The corrected information should contain the TOTAL corrected units and charge. We will subtract what we already paid and pay you the difference.**
2. **If you only submit the amount that you did not get paid, we will recover the original payment and reprocess the claim based only on the new time submitted.**

This corrected claim process is applicable only if the original claim was submitted via the portal.

Waiver – ***Provider Sourcing***

We appreciate the services provided to our members. To ensure our members have access to needed services, our Provider Sourcing Tool allows providers to view available service opportunities based on their specialty.



1. On the left-hand side locate the Provider Sourcing.
2. Review the service request and simply select interested or not interested.
3. If you select interested, the member's Case Manager will reach out with additional details and confirm it is a good fit. The Case Manager will then create a service plan.
4. When new service postings are created, an email will be sent to you as a notification that a new service opportunity is available.

Electronic Visit Verification (EVV)

CareSource®

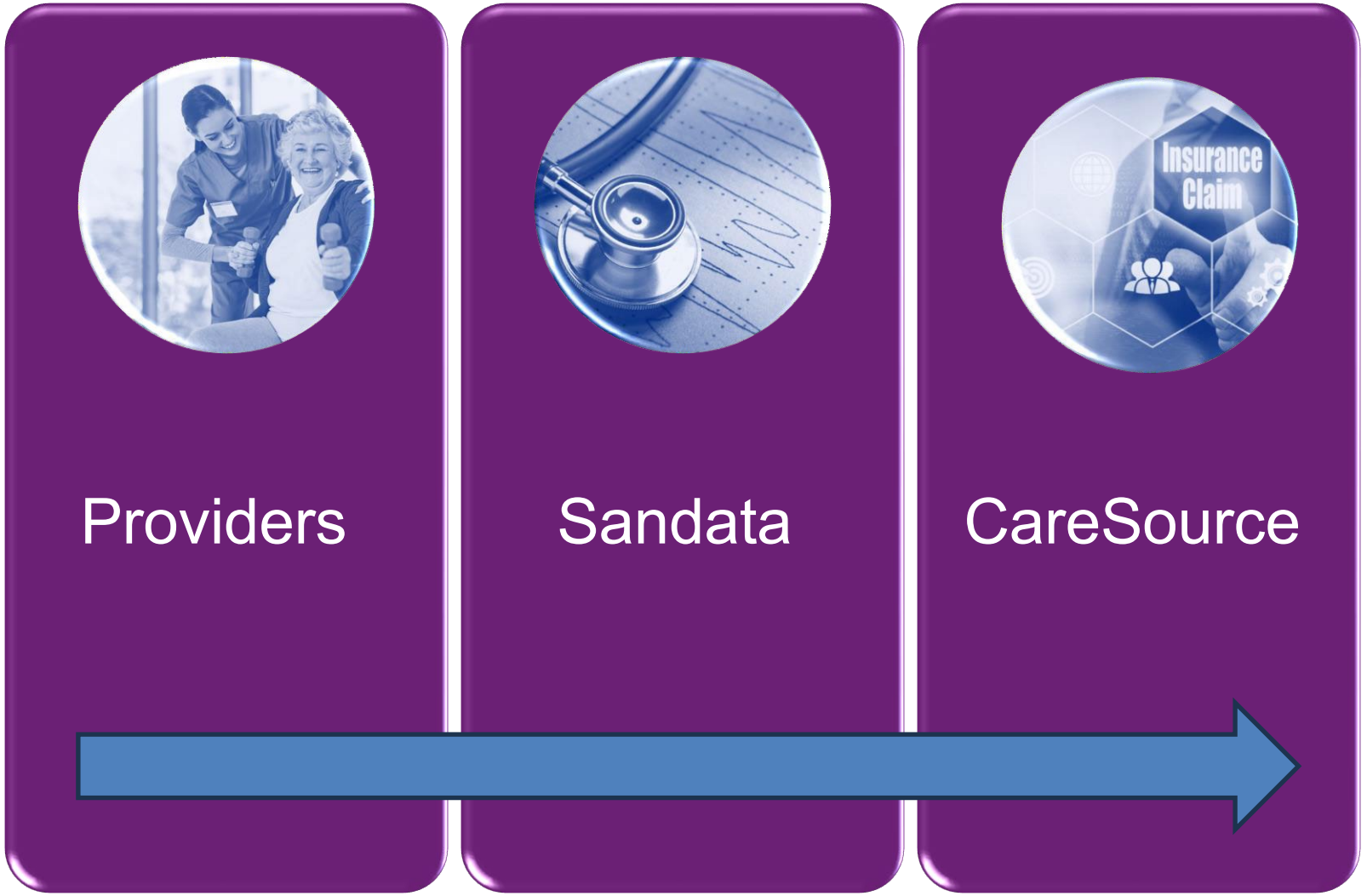
INTRODUCTION

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 follows the rules set by CMS and the state regulators for EVV. We are committed to supporting providers throughout this process to ensure you are successful.



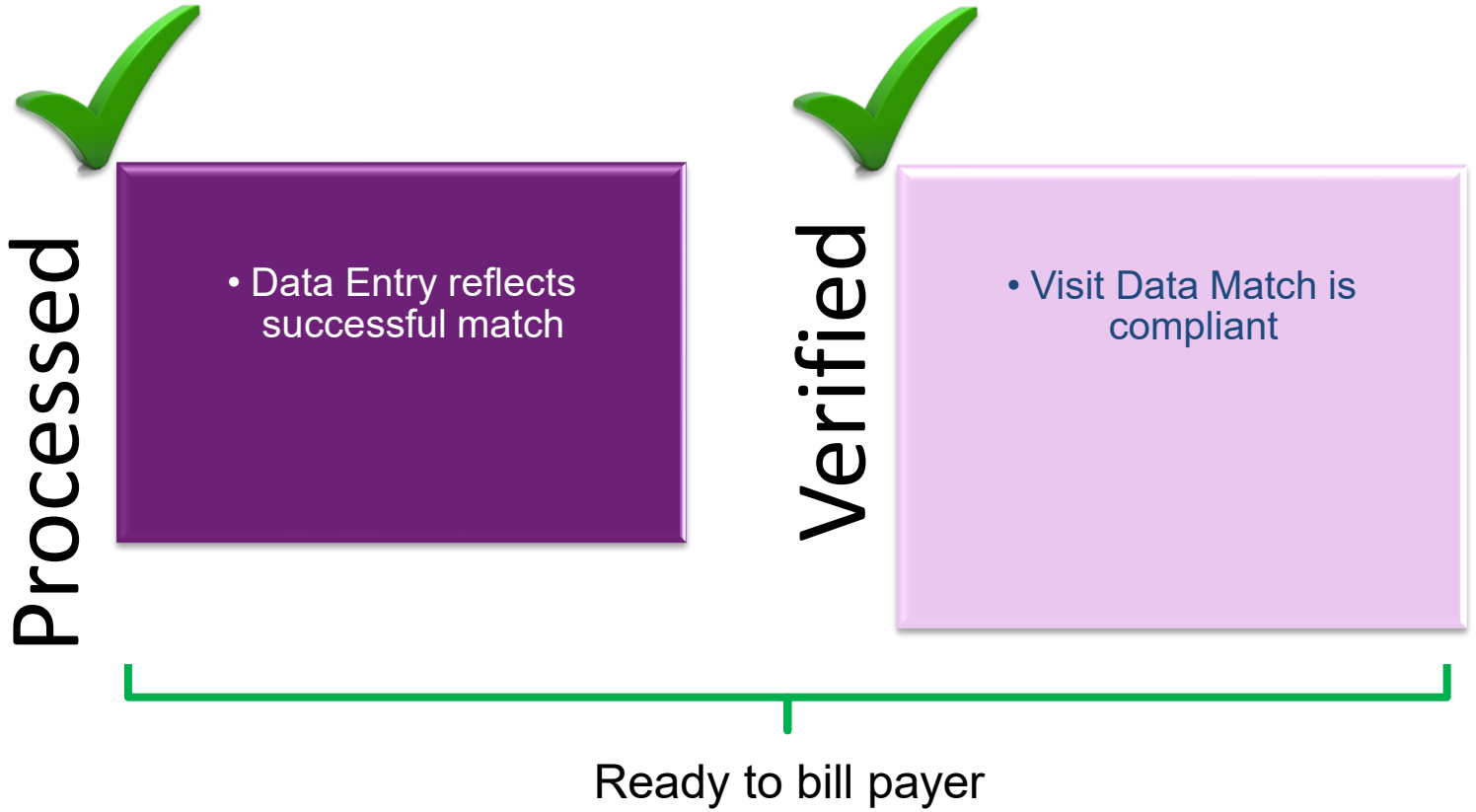
EVV SERVICES: NEXT GENERATION MYCARE OHIO WAIVER

Waiver Nursing, Waiver Home Health and Choices Home Care Attendant (CHCA):

- S5125
- T1002
- T1003
- T1019
- T2025 (UB/U1)

SANDATA VISIT VERIFICATION STATUS

Visit data will reflect in the Sandata Aggregator system as follows:



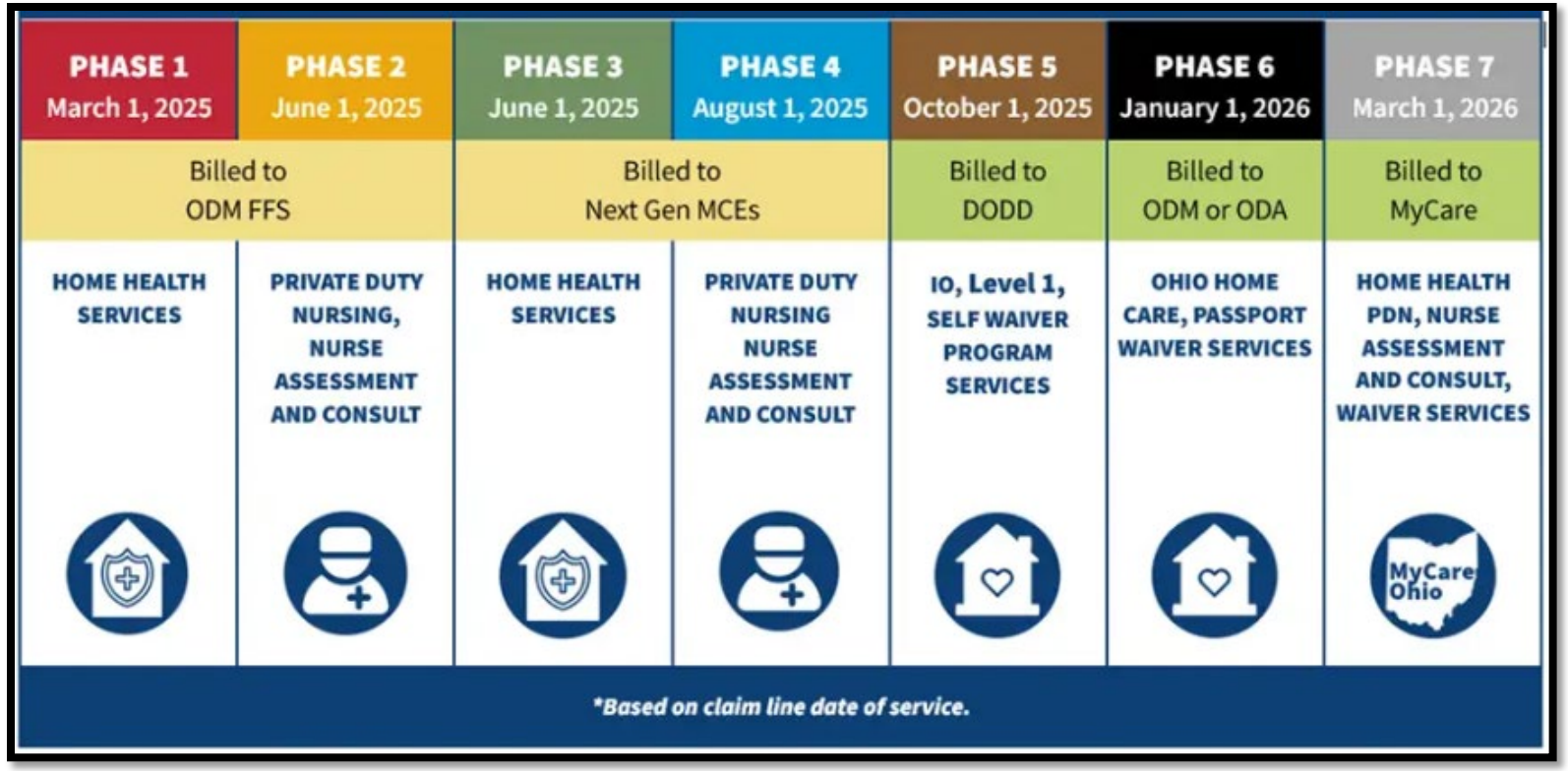
Incomplete

- Visit Data is non-compliant
- Verify the following:
  - Missing Time
  - CPT coding
  - Wrong payer, right service
    - This is where the wrong payer is listed for the client, but visit details are correct (ultimately billed to the correct payer)
  - Units rendered are greater than what is available

PROVIDER EVV: UPCOMING CHANGES

Non-Compliant Claim Denials:

- ODM rolled out EVV processing claims changes in seven phases, beginning with home health service providers on March 1, 2025. Ohio MyCare Next Generation Waiver will roll out on March 1, 2026.
- This will require that EVV claim lines must have a matching EVV visit record.
  - **Claims that do not match will be denied**.



Affected Codes:

- S5125
- T1002
- T1003
- T1019
- T2025 (UB/U1)

PROVIDER EVV EOB CODES AND EXPLANATIONS

For claims with a service date before **March 1, 2026**, if you submit claims for Waiver Nursing, Waiver Home Health, and Choices Home Care Attendant (CHCA) Services without a valid matching EVV visit record on file with Sandata, the current Facets EOP process will apply until the March 1, 2026, go-live date.

For claims with a service date on or after **March 1, 2026**, the following codes: S5125, T1002, T1003, T1019, and T2025 (UB/U1) that do not have a valid matching EVV visit record on file with Sandata will be denied.

Non-Compliance Reason	RARC effective March 1, 2026	CARC effective March 1, 2026	What Does This Mean?
Provider ID does not match	N521 Mismatch between the submitted provider information and the provider information stored in our system	272 Coverage or program guidelines were not met	The provider Medicaid ID on the claim request does not have an EVV account in Sandata's system
Recipient ID does not match	N819 Patient not enrolled in EVV system	272 Cover or program guidelines were not met	The recipient Medicaid ID on the claim is not in the provider's EVV account
Procedure code does not match	N56 Procedure code billed is not correct or valid for the services billed, or for the date of the service billed	272 Cover or program guidelines were not met	A verified visit was not found in the provider's EVV account with the following details from the claim: recipient Medicaid ID, date of service, payer and service
Unmatched Unites	N820 EVV system units do not meet requirements of visit	272 Cover or program guidelines were not met	A verified visit was found but has fewer units than what was on the claim

! *RARC & CARC codes will appear on your Explanation of Payment to advise why the claims is not payable*

Claim Denial Guidance-*Provider and Recipient ID does not match*

This guide will help you to address each reason for denial.

Denial Reason	Guidance
Provider ID does not match-EVI **RARC/CARC:** **N521:** Mismatch between the submitted provider information and the provider information stored in our system **272**: Coverage/program guidelines were not met	The error message “Provider ID Does Not Match” means the Medicaid ID on your claim is not in the Sandata EVV system or the Sandata Aggregator. • First, identify what Medicaid ID is associated with the account you are using to record visits. • Then, compare this value to the Medicaid ID associated with the claim.

Denial Reason	Guidance
Recipient ID does not match-EVH **RARC/CARC:** **N819**: Patient not enrolled in EVV system **272:** Coverage/program guidelines were not met	When a visit is recorded without a recipient name or ID, the visit will be flagged with an Unknown Recipient exception. • Visits with Unknown Recipient exceptions will need to have the recipient updated to resolve the exception and make the visit billable.

Claim Denial Guidance-*Procedure Code Does Not Match and Unmatched Units*

Denial Reason	Guidance
Unmatched Units-EV9 RARC/CARC: N820: EVV system units do not meet requirements of visit 272: Coverage/program guidelines were not met **Unmatched Units-EV8** RARC/CARC: N820: EVV system units do not meet requirements of visit 272: Coverage/program guidelines were not met	*When a claim line is denied, it can often be attributed to several key factors. To ensure successful claim submissions, it is essential to verify five critical data points required for each visit:* • ***Recipient*** • ***Direct Care Worker/Employee*** • ***Location*** • ***Call In and Call Out Times*** • ***Date of Service*** *In some cases, specific services and tasks may also be required. If any of these elements are missing or incorrect, it will result in **Exceptions**. Missing or incorrect information is indicated by colored dots on the visit screen in the Sandata aggregator:* • ***Red Dots**: These indicate visits with missing or incorrect information that must be addressed before submission.* ***Examples include:*** • *Missed call in or call out times* • *Missing or unauthorized services* • *Unknown Recipient* • *Unknown Direct Care Worker/Employee* • ***Grey/Yellow Dots**: These indicate visits with missing or incorrect information where acknowledgment of exceptions is sufficient.* ***Examples include:*** • *Missing or incorrect location* • *Skipped Visit Verification* • *Missing Client Signature* *For a claim submission to be successful, the visit must reflect a **"Verified"** status in the Sandata aggregator.* *If you require additional assistance, please refer to the Sandata Zendesk article on **Managing Exceptions**, available at the following link: Sandata Zendesk.* ***To access the article:*** *1.Click on **Payer Programs*** *2.Select **Ohio (OH ODM)*** *3.Choose **Ohio User Guides*** *4.Click on **Visit Maintenance*** *5.Select **Managing Exceptions***

EVV: ADDITIONAL RESOURCES

EVV: Getting Started Checklist

- Providers using Sandata's system should ensure they've completed the below steps to ensure successful and compliant EVV claims submissions.

1. Complete EVV Training
   a) Agency Training
   b) Independent (Non-Agency) Training
2. Receive email with credentials to sign into Sandata eTrac website
3. Sign in and download your unique Sandata Welcome Kit
4. Log into EVV Portal
5. Set up correct individuals, services, employees, etc., as applicable in EVV Portal
6. Start capturing visits when providing services to Individuals

Please Note: Agency providers using an Alternate EVV system may require a different Getting Started process.

EVV: ADDITIONAL RESOURCES

Ohio Department of Medicaid EVV links:

- Ohio Medicaid EVV Program and Service Code Guide
- EVV Fact Sheet

Welcome to Our Partnership!

Thank you for joining us and becoming a partner. We appreciate you providing services to our members and we are here to help you every step of the way!

Valued Partnership

We welcome you as a valued partner and appreciate your commitment to our shared goals.

Team Support

Our team is dedicated to supporting you at every stage for a successful and meaningful partnership experience.

Achieving Success Together

Together, we can achieve remarkable results for our members.

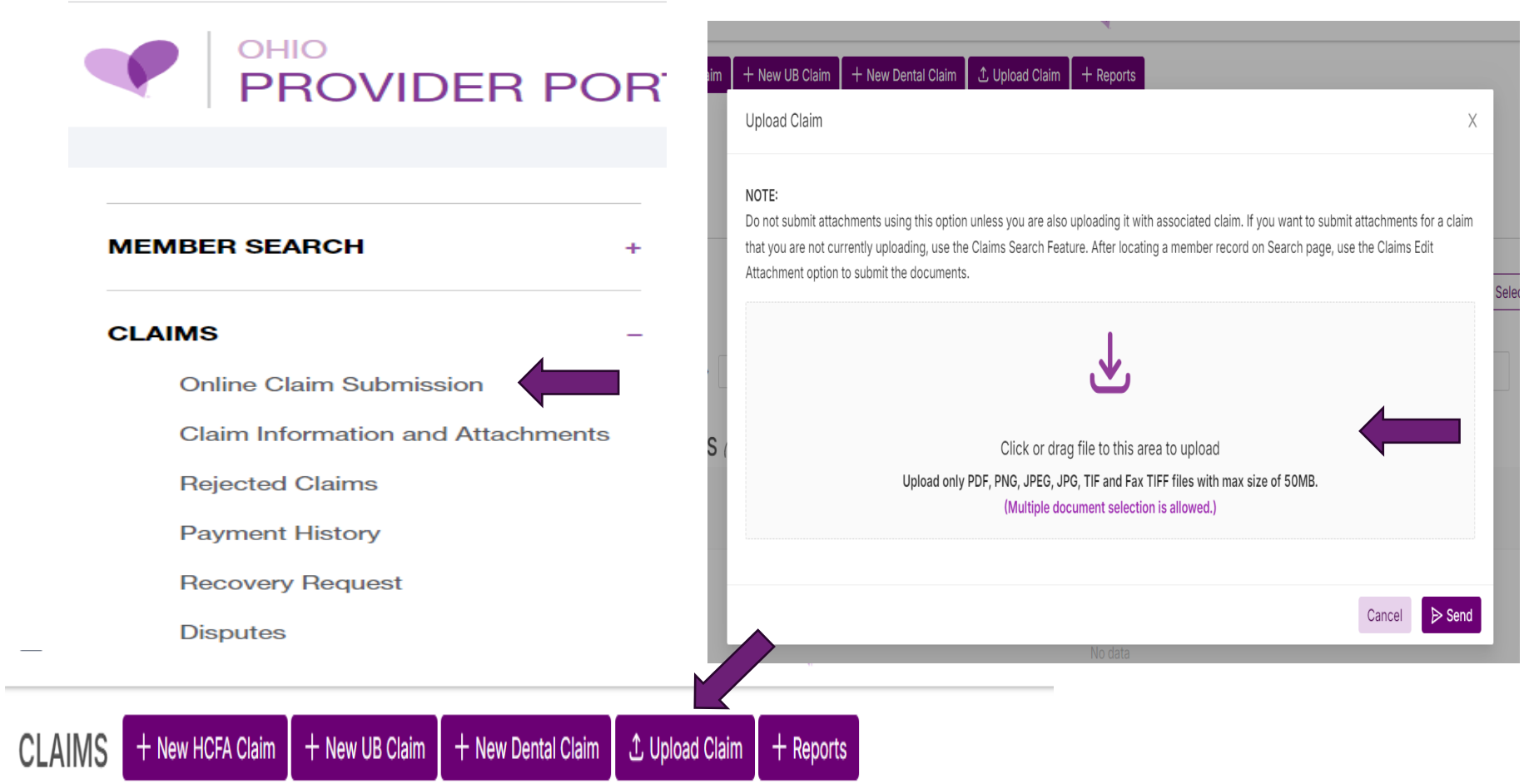
[Welcome | Ohio – Next Generation MyCare]

LTSS/HCBS Orientation Appendix of Important Information and Guidance

CareSource

Appendix: Table of Contents

Claims ***Portal Submission***



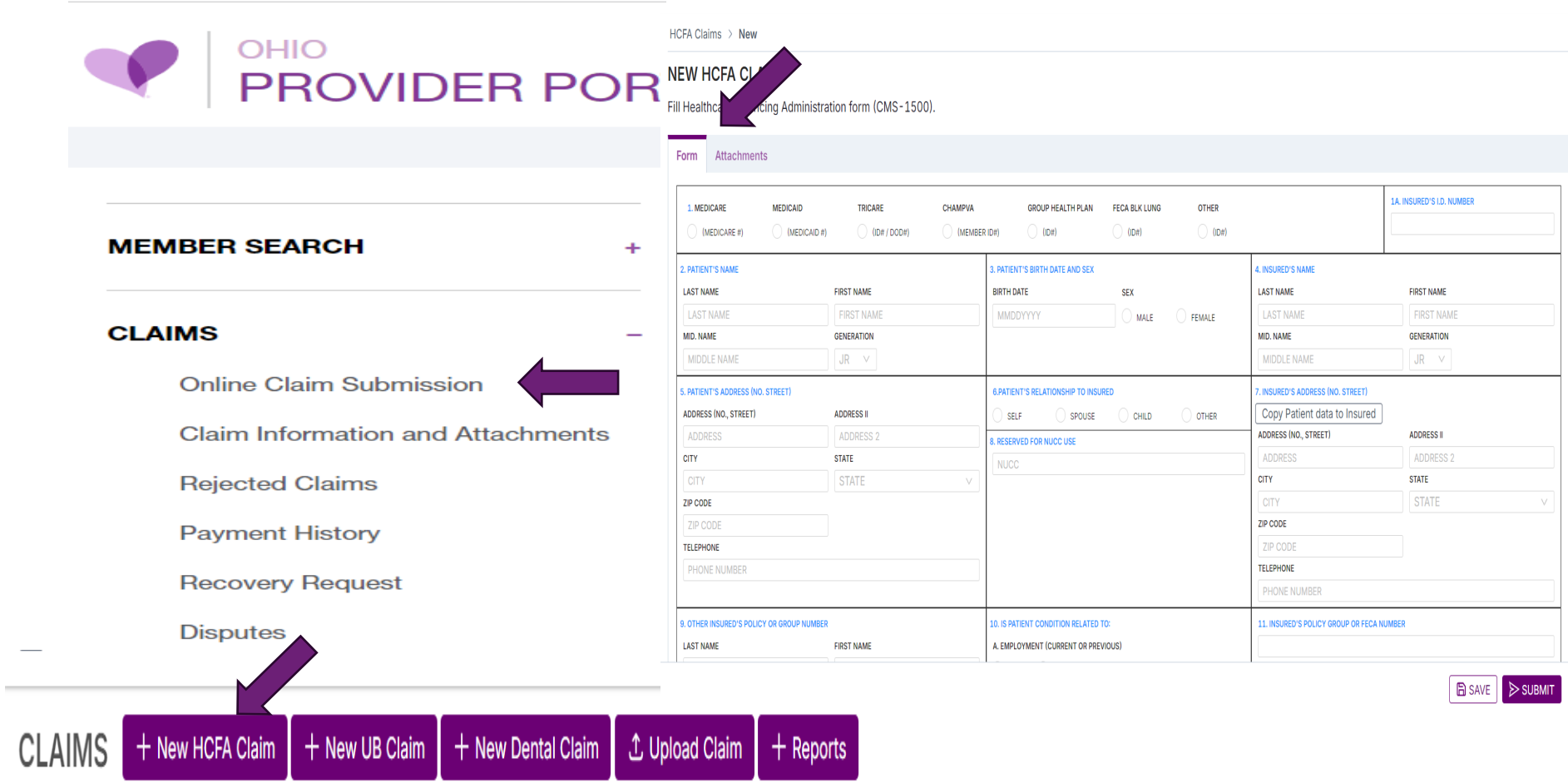
Online Claim Submission

Under the claims section, choose ***Online Claim Submission***. After that is selected, choose ***Upload Claims***. Provider will upload the paper claim and then choose ***Send*** to send the claim into the CareSource system to be processed.

Providers may also create a claim under the following tabs:
- New HCFA Claim
- New UB Claim
- New Dental Claim

Providers can also pull claim reports under the report tab if the claim was keyed through the Provider Portal.

Claims ***Portal Submission***



Online Claim Submission

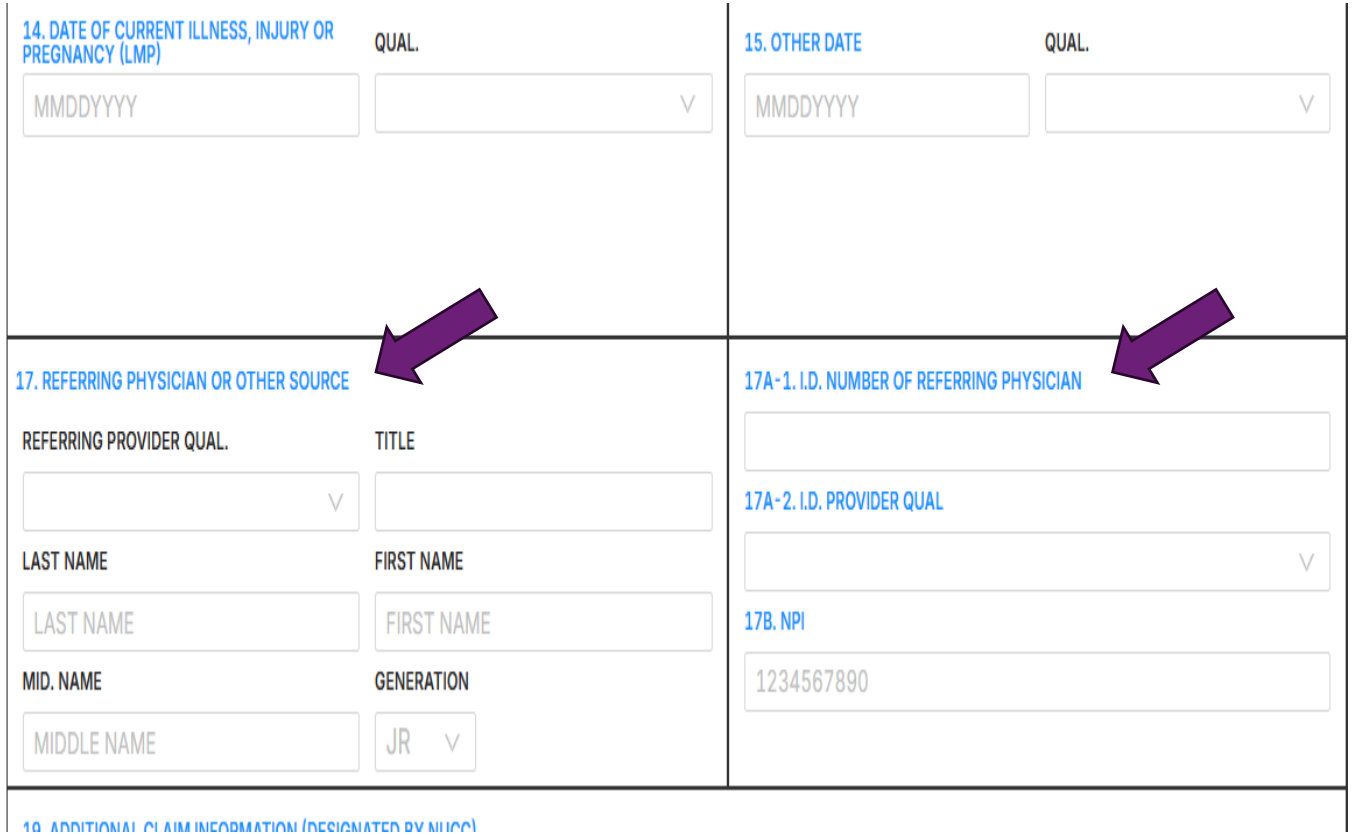
Under the ***Claims*** section, choose ***Online Claim Submission***, and then choose ***New HCFA Claim***. Provider will then be able to enter the HCFA claim into the CareSource system to be processed.

Choose the Form tab and then enter all the data required for a HCFA claim.

Providers can also add attachments to the claim prior to clicking ***Submit***.

Please see an example of a HCFA (CMS 1500) form.

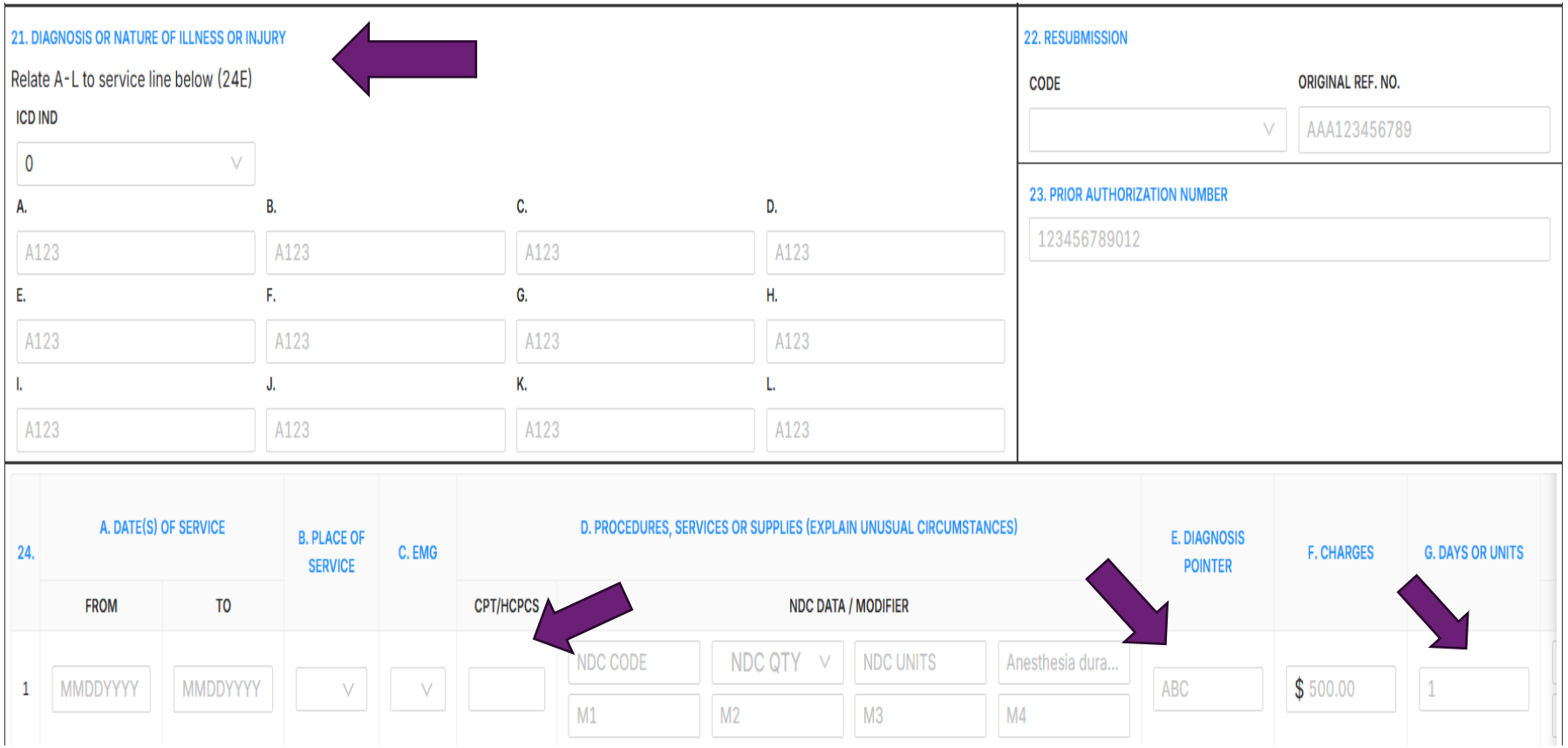
Claims ***Portal Submission***



Online Claim Submission
Using CMS HCFA 1500:

Referring/Ordering Physician (ORP): Make sure to enter the Referring or Ordering Physicians information on the claim. Claims without the OPR information are subject to claim rejections Referring Physician or Other Source Section 17 and 17A.

Claims ***Portal Submission***



Online Claim Submission
Using CMS HCFA 1500:

Diagnosis Codes: Please enter these in Section 21.

Date of Services (DOS): This should be recorded in Section 24A.

Place of Services (POS): This should be recorded in Section 24B.
POS:
04-Homeless Shelter
11-Office
12-Home
14-Group Home
For addition POS please see the CMS Code Sets
Place of Service Code Set | CMS

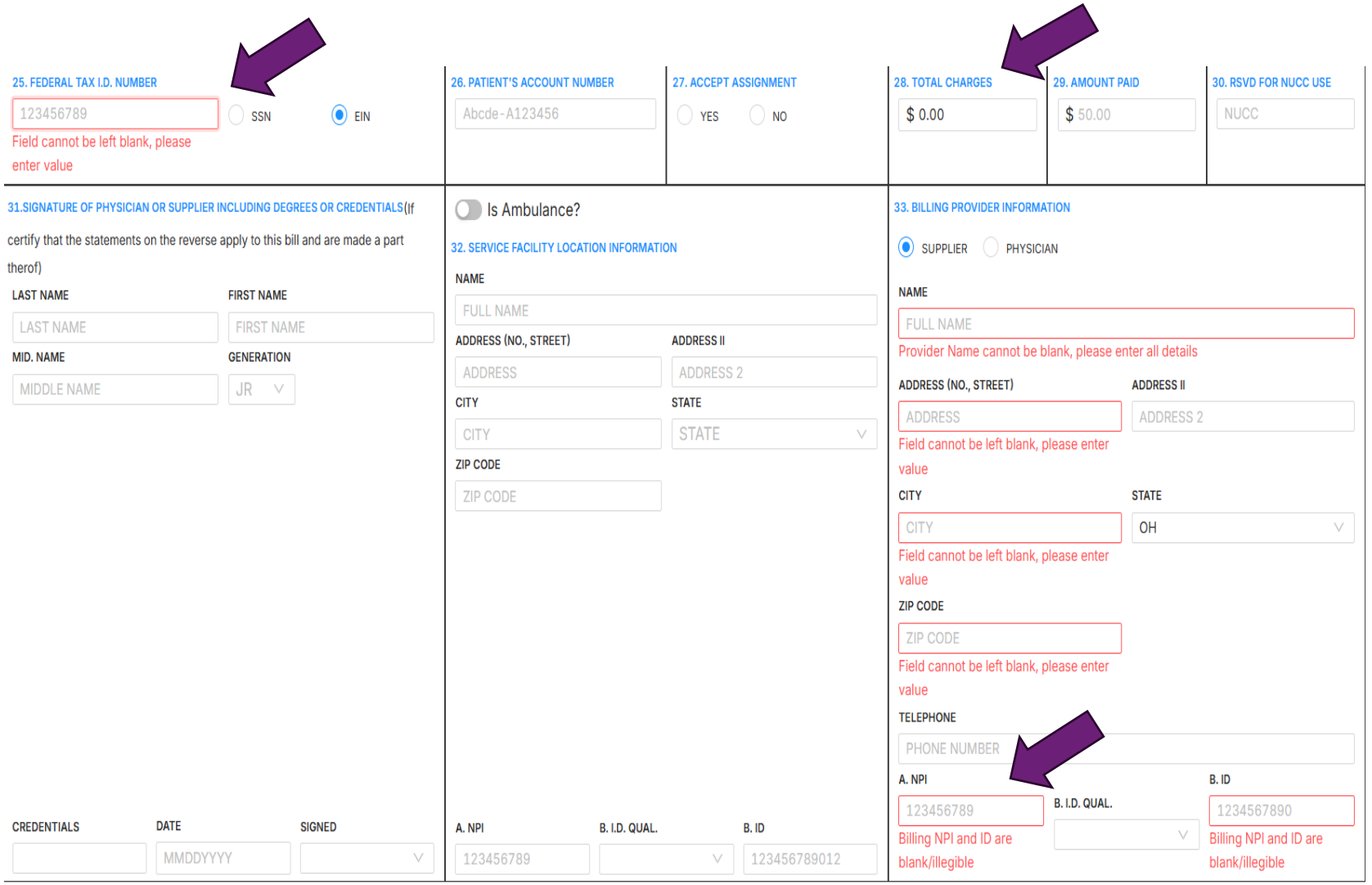
CPT/HCPCS Codes: Make sure to enter these in Section 24D.

Diagnosis Pointer: Make sure to enter the corresponding letter (A,B,C) as the primary diagnosis.

Charges: Make sure to enter the amount you are billing under Charges Section 24F.

Units: Make sure to enter all units for the Date of Service in Section 24G.

Claims ***Portal Submission***



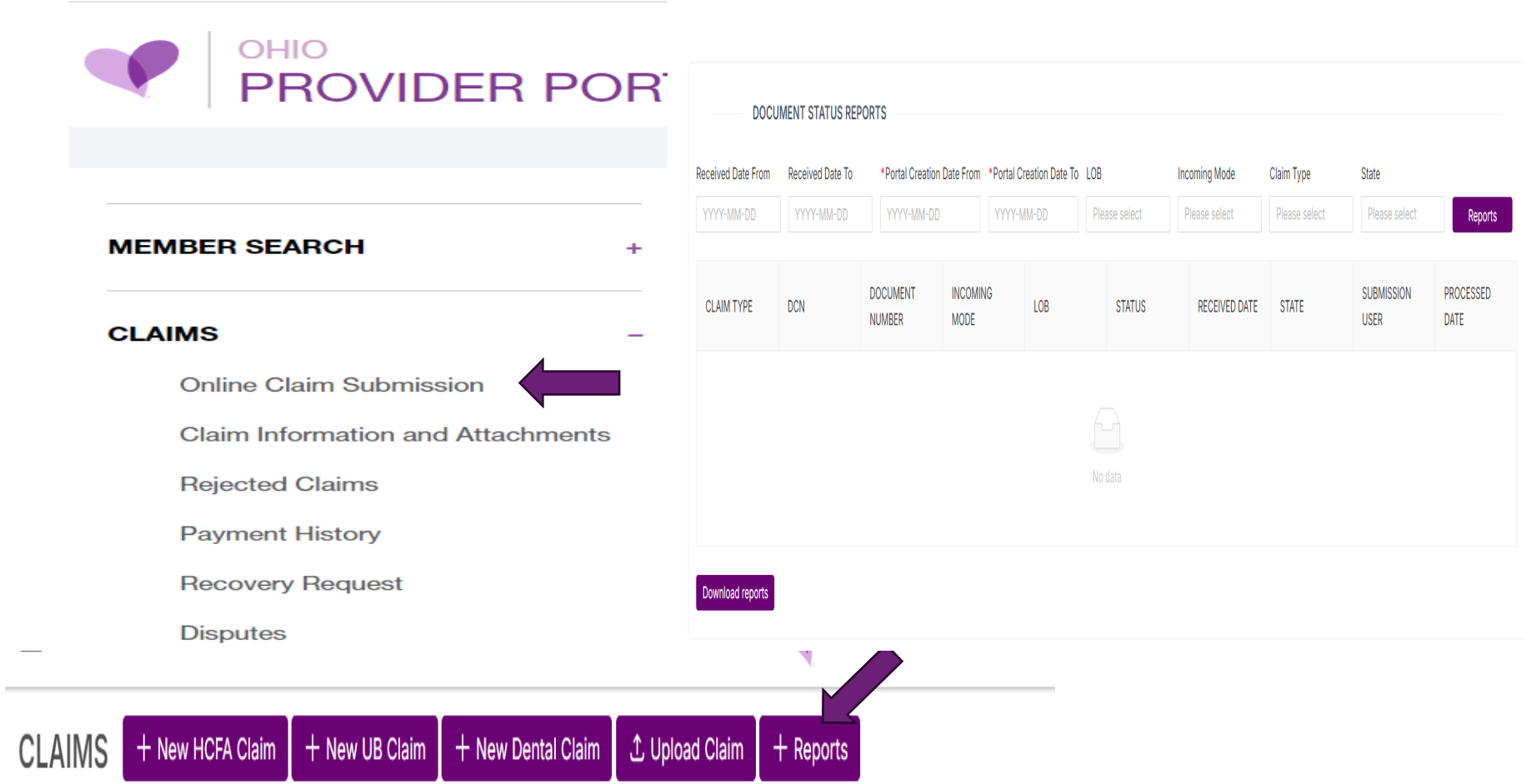
Online Claim Submission
Using CMS HCFA 1500:

Federal Tax ID Number: Please enter these in Section 25.

Total Charges: This should be recorded in Section 28.

NPI: This should be recorded in Section 33A.

Claims ***Portal Submission***



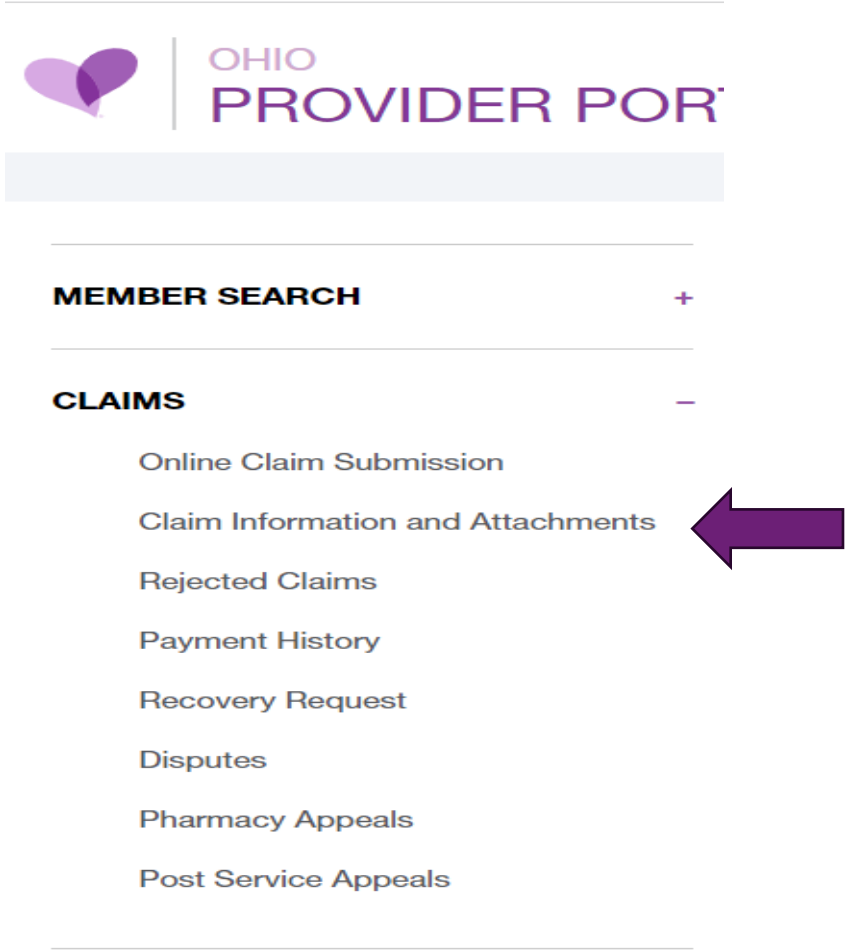
Online Claim Submission-Reports

Providers can run claim reports on all Claims that were **electronically** submitted through the portal.

Under the ***Claims*** section, choose ***Online Claim Submission***, and then choose ***Reports***.

Provider will then be able to review all claims and claims status that were submitted.

Claims *Information Tab*



The **Claims** section provides an invaluable **Claim Information and Attachments** feature. Providers can search and access comprehensive details regarding all claims.

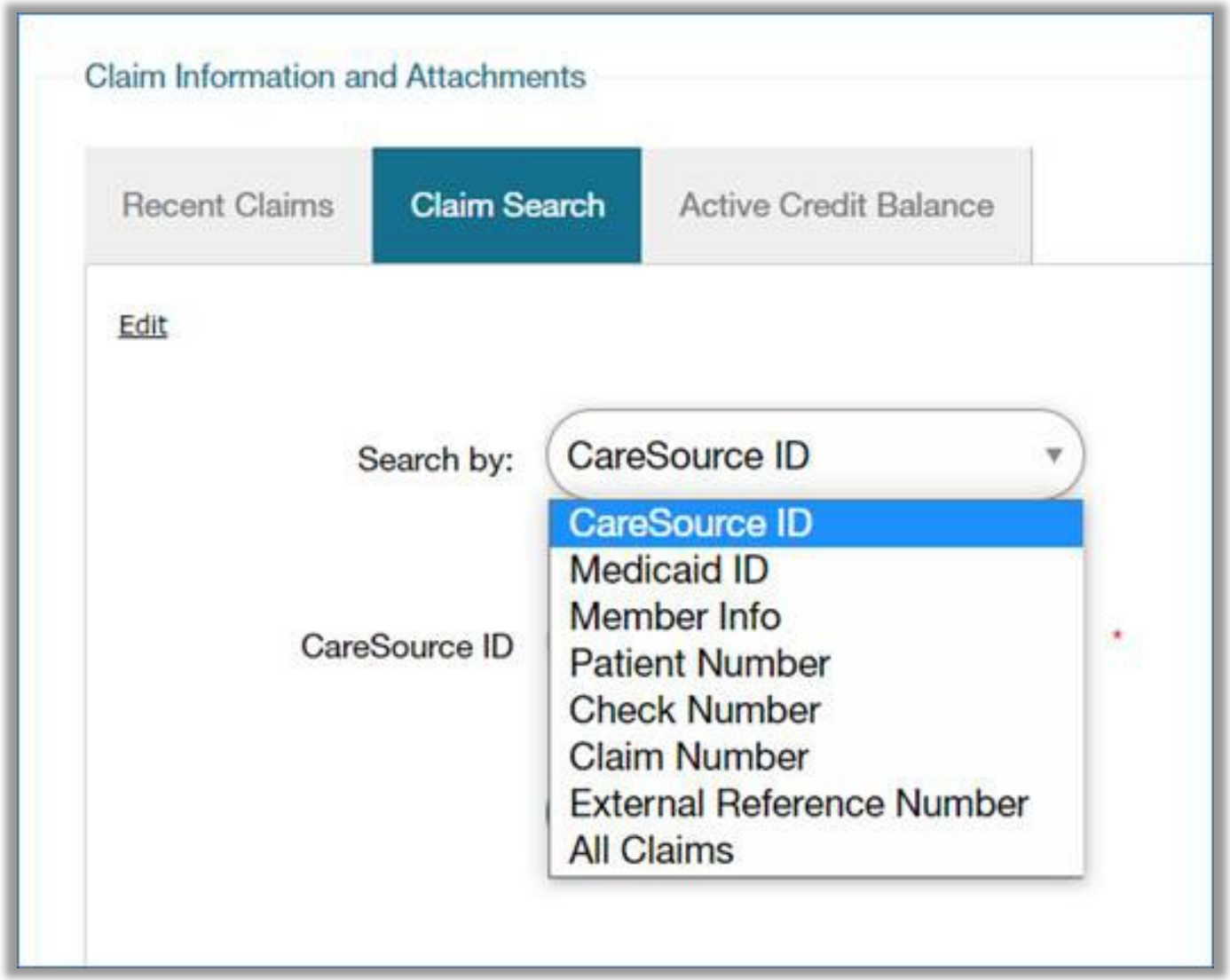
Within this section, you will find tabs for the following categories:

- Claim Information
- Payment History
- Claim Denials
- Disputes
- Claim Provider Documentation

Each tab allows providers to navigate through their claims efficiently and obtain the necessary information for better management of their cases.

Claim Search

- An updated claim search menu has been added. This can be accessed by clicking **Claims** > **Claim Information and Attachments** > **Claim Search** tab. The search menu items have been consolidated into a drop-down list to select:
    - CareSource ID
    - Medicaid ID
    - Patient Number
    - Check Number
    - Claim Number
    - External Reference Number
    - Search All Claims



Claims *Enhanced Claim Messaging*

Line Number: 1			
Status:	Processed	**Date of Service:**	9/14/2025
Amount Charged:	$57.92		
Process Reason:	9NP - Disallow; service not payable for provider type or specialty		
Adjustment Reason:	170 - Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		
Remittance Reason:	N95 - This provider type/provider specialty may not bill this service.		
Procedure:	G0156 - Services of home health/hospice aide in home health or hospice settings, each 15 minutes	**Patient Responsibility:**	$0.00
Diagnosis:	R2681 - Unsteadiness on feet		
Place of Service:	Home	**Recovery Amount:**	$0.00
Disallowed Amount:	$57.92	**Amount Paid:**	$0.00
Withhold Amount:			

Status:	Processed	**Date of Service:**	10/17/2[redacted]
Amount Charged:	$957.00		
Process Reason:	p03 - Submitted claim is missing or has invalid data per regulatory or ICD10 updates. - The ICD-10-CM code Z3800 may only be used as first-listed or primary diagnosis position.		
Adjustment Reason:	B22 - This payment is adjusted based on the diagnosis.		
Remittance Reason:	M64 - Missing/incomplete/invalid other diagnosis.		
Procedure:	99480 - Subsequent intensive care, per day, for the evaluation and management of the recovering infant (present body weight of 2501-5000 grams)	**Patient Responsibility:**	$0.00
Diagnosis:	P961 - Neonatal withdrawal symptoms from maternal use of drugs of addiction	**Amount Paid:**	$0.00
Place of Service:	Inpatient Hospital		

ENHANCED CLAIMS MESSAGING

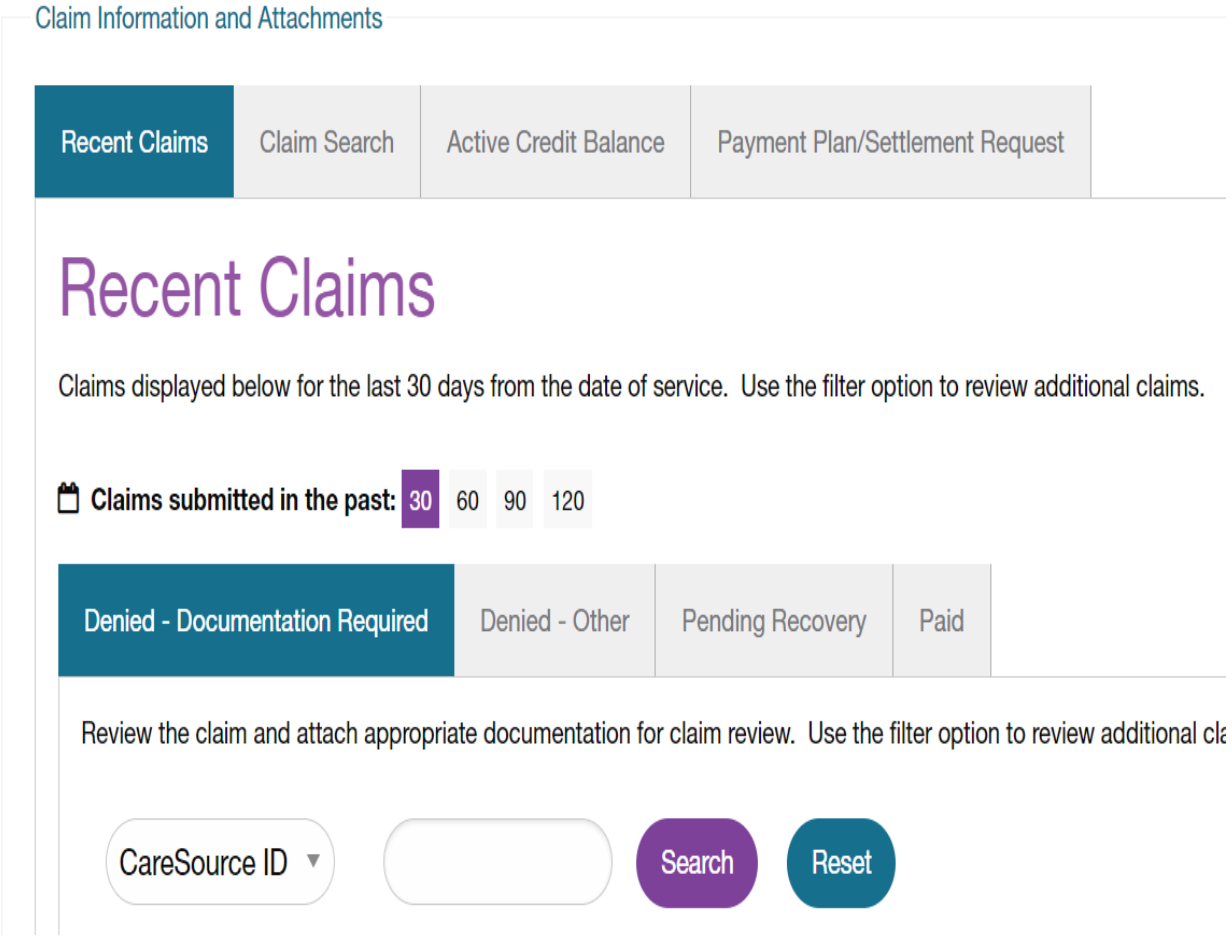
Additional detail is now available when viewing denied claims on the Provider Portal. Clinical edits, which provide detailed information regarding the claim denial, can be viewed in the **Process Reason** when viewing the claim details.

Claims *Denied – Documentation Required*

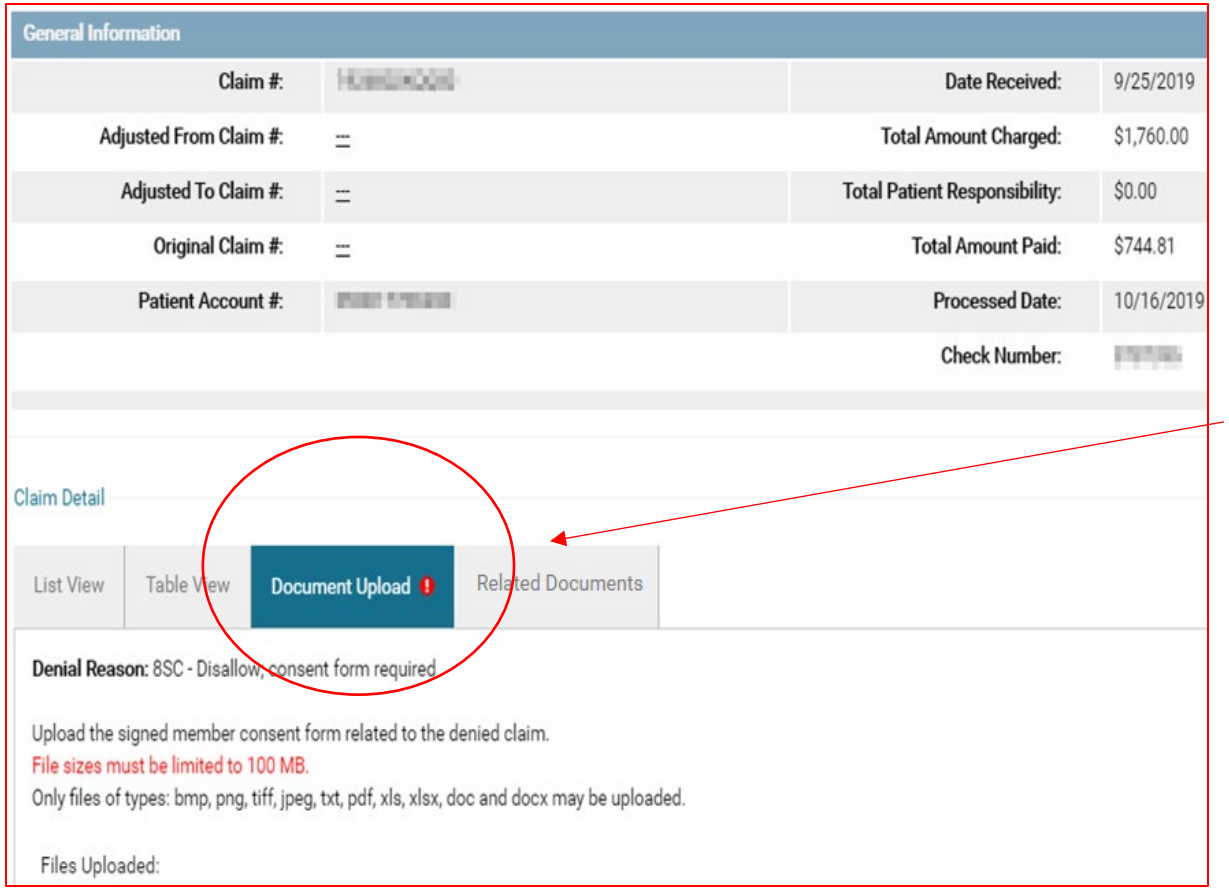
CLAIM INFORMATION & ATTACHMENTS

A new option is now available to providers, called *Recent Claims*, that will proactively show providers specific high viewed claims. This new option can be accessed by clicking **Claims** > **Claim Information and Attachments** > **Recent Claims** tab. There are two options available to view, described below:

Denied Documentation Required – Providers will be able to view all claims that currently require a document to be submitted for review with the ability to upload the documentation. As shown in the screenshot below, providers can filter the claim view by 30, 60, 90 or 120 days and this will be based on the date of service of the claim. By clicking **Attached Required Documentation**, the provider may upload the necessary documentation.



Claims ***Document Upload***



SUBMIT MEDICAL RECORDS FOR DENIED CLAIMS

A **Document Upload** tab is available on the **Claims Detail** view when a claim is denied due to missing medical records. Use this option to upload documentation instead of submitting an appeal or corrected claim.

Next Generation MyCare ODM Claims Submission Updates

ODM One Front Door Provider Training
Next Generation MyCare Claims Processing Workflow
ODM MyCare Provider Resources

CareSource®

One Front Door Provider Training

Provider Claim Submission Guidelines

What you'll learn…

- ✓ Where to start.
- ✓ How to determine the first entry point for claims.
- ✓ How to submit claims for payment.
- ✓ How to determine the payer.
- ✓ Where to go for remittance information.
- ✓ Who to call for assistance.

Department of Medicaid
Next Generation MyCare

Provider Claims Submission

Step One: Confirm who is eligible.

The individual member must meet January 1 Next Generation MyCare Member eligibility requirements listed below.

- ✓ Individual lives in one of the Ohio counties where MyCare Ohio is available.
- ✓ Individual is eligible for full Medicaid coverage.
- ✓ Individual is eligible for Medicare parts A, B and D.
- ✓ Individual is age 21 or older.

Jan 1	Butler, Warren, Clinton, Hamilton, Clermont, Montgomery, Clark, Greene, Franklin, Delaware, Union, Madison, Pickaway, Lucas, Fulton, Ottawa, Wood, Lorain, Cuyahoga, Medina, Lake, Geauga, Summit, Portage, Stark, Wayne. Columbiana, Mahoning, Trumbull
Apr 1	Sandusky, Erie, Henry, Williams, Defiance, Paulding, Fayette, Fairfield, Licking, Ashtabula
May 1	Preble, Darke, Miami, Shelby, Champaign, Logan, Van Wert, Putnam, Hancock, Allen, Mercer, Auglaize, Hardin, Seneca, Huron, Wyandot, Crawford, Richland, Ashland, Marion, Morrow, Knox
June 1	Ross, Vinton, Highland, Pike, Jackson, Gallia, Brown, Adams, Scioto, Lawrence
July 1	Holmes, Tuscarawas, Carroll, Jefferson, Coshocton, Harrison, Belmont, Guernsey, Muskingum
Aug 1	Hocking, Perry, Morgan, Noble, Monroe, Washington, Athens, Meigs

NOTE: Next Generation MyCare One Front Door is based on the member's county go-live date.

*Individuals are not eligible for the Next Generation MyCare program if they participate in the Program for All-Inclusive Care for the Elderly (PACE), are supported by Developmental Disabilities waiver (Individual Options, Self-Empowered Life Funding, or Level One) or have health insurance coverage both inpatient hospital stays and doctor visits.

Department of Medicaid
Next Generation MyCare

Provider Claims Submission

Step 2: Determine how the member is enrolled in the Next Generation MyCare program.

There are two Next Generation MyCare enrollment types:

Type 1: Dual enrollment, formerly known as “Opt In,” means the member-selected Next Generation MyCare plan is responsible for both Medicare and Medicaid coverage.

Type 2: Medicaid only enrollment, formerly known as “Opt Out,” means the member-selected Next Generation MyCare plan is only responsible for Medicaid coverage. For Medicare coverage, these enrollees have two options:

a. Traditional Medicare, Part A and Part B coverage is provided by CMS.
b. Part C coverage is provided by a Medicare Advantage Plan.

Type 1 - Dual Enrollment Claims Submission Entry Points

Step 3: Determine what to submit with your claim.

TYPE 1 dual enrollment claims are submitted through one of two methods based on provider preference and status.

Direct Data Entry

- Log into Next Generation MyCare Plan's Provider Portal.
- Manually enter the claim details.

Electronic Data Interchange

- An authorized trading partner submits the EDI 837 claim transaction via ODM's One Front Door.
- Enter the Next Generation MyCare plan's Receiver ID and Payer ID (see EDI Companion Guides for more).
- Next Generation MyCare plan processes the claim for both Medicare and Medicaid reimbursements.

NOTE: EDI claims transactions must only contain claims destined for the same Next Generation MyCare plan. Each payer has specific identifiers that must be included in the file enabling EDI to accurately direct the claim for adjudication. Payer identifiers are available in the EDI Companion Guides.

Type 2 - Medicaid Only Claims Submission Entry Points

Step 3: Determine what to submit with your claim.

Type 2 Medicaid only claims are submitted through one of two methods based on the type of Medicare plan selected.

Traditional Medicare Part A and Part B MyCare Enrollment

1. **Submit claim to CMS for automatic crossover to MyCare plan**
   - CMS provides remittance advice via normal workflow. No submission needed for Medicaid share of cost.
2. **Remittance Advice**
   - MyCare plan sends 835 ERA to provider-designated trading partner when Medicaid processing completes.
   - Providers not enrolled in 835s access remittance advice via PNM Portal.

Part C Medicare Advantage Plan MyCare Enrollment

1. **Submit claim to member-selected plan.**
   - Automatic crossover to MyCare plan does not occur.
2. **Plan provides remittance advice through normal workflow, forwards to provider once processed.**
3. **Provider submits claim via OMES EDI one front door, includes the prior payer results.**
   - Coordination of 837 benefit loops 2320, 2330A and 2330B loops must contain all prior payer results.
4. **Remittance Advice**
   - If provider is enrolled for 835s, MyCare plan sends 835 ERA to designated trading partner when the Medicaid processing is complete.
   - Remittance advice available via PNM Portal for providers not 835 enrolled.

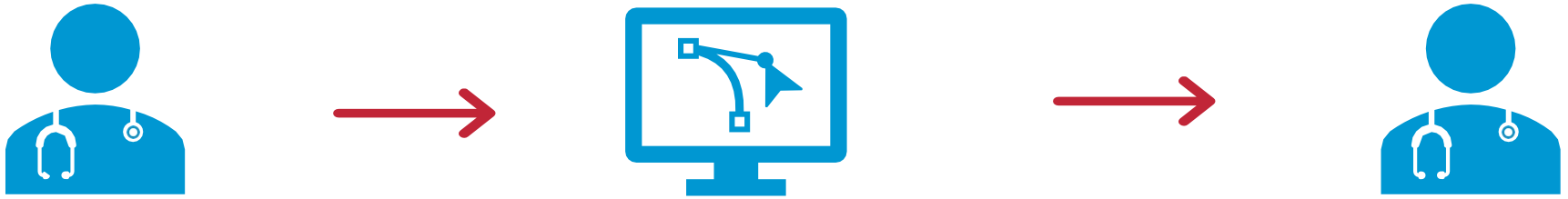
Next Generation MyCare
Claims Processing Workflows

Type 1 - Provider to Next Generation MyCare Plan – Direct Data Entry

Claims submission when it is the same plan for Medicare and Medicaid.

Single Step Process

Provider connects to the plan's hosted online portal to enter a claim



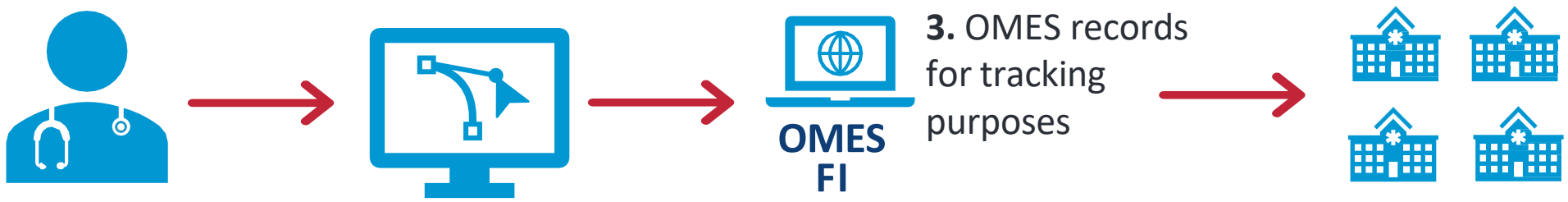
Provider	Next Gen MyCare Plan	Provider
Logs into the plan hosted portal, using their plan assigned credentials	Receives and adjudicates both the Medicare and the Medicaid payments	Receives payment for services

A direct data entry claim does not pass through OMES One Front Door.

Department of Medicaid
Next Generation MyCare

Type 1 - 837 Workflow (1 of 2)

Provider |Trading Partner |OMES EDI |Next Generation MyCare Plan.



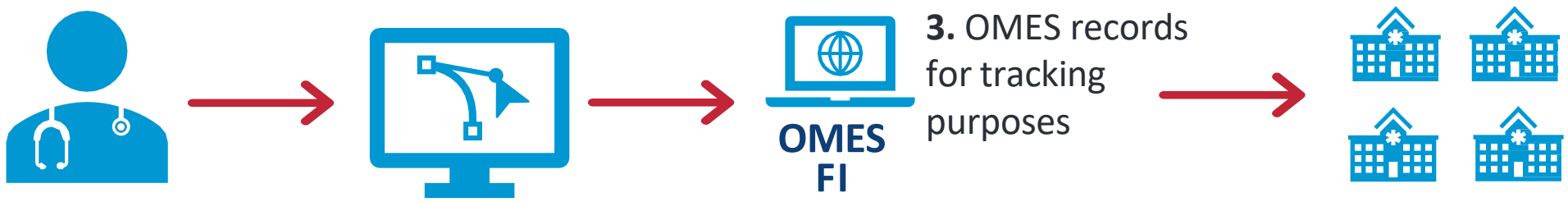
Provider	Trading Partner		
1. Submits Claim to Trading Partner	**2.** Submits 837 to OMES EDI	**OMES EDI** **4**. Submits 837 to Next Generation MyCare Plans	**Next Generation MyCare Plans**

EDI claims transactions must only contain claims destined for the same Next Generation MyCare plan. Each payer has specific identifiers that must be included in the file enabling EDI to accurately direct the claim for adjudication. Payer identifiers are available in the EDI Companion Guides.

Department of Medicaid
Next Generation MyCare

Type 1 - 837 Workflow (2 of 2)

Provider |Trading Partner |OMES EDI |Next Generation MyCare Plan.



Provider	Trading Partner	OMES EDI	Next Generation MyCare Plans
1. Submits Claim to Trading Partner	**2.** Submits 837 to OMES EDI	**4.** Submits 837 to Next Generation MyCare Plans	

Receiver ID (ISA08)	
0022147 – Anthem Blue Cross/Blue Shield	0021599 – CareSource
0021583 – Buckeye Community Health Plan	0021586 – Molina Healthcare of Ohio Inc.

- Sender ID ISA06 = ODM Assigned Trading Partner ID
- Receiver ID ISA08 = ODM Assigned Receiver ID
- Payer ID 2010BB = See EDI Companion Guides

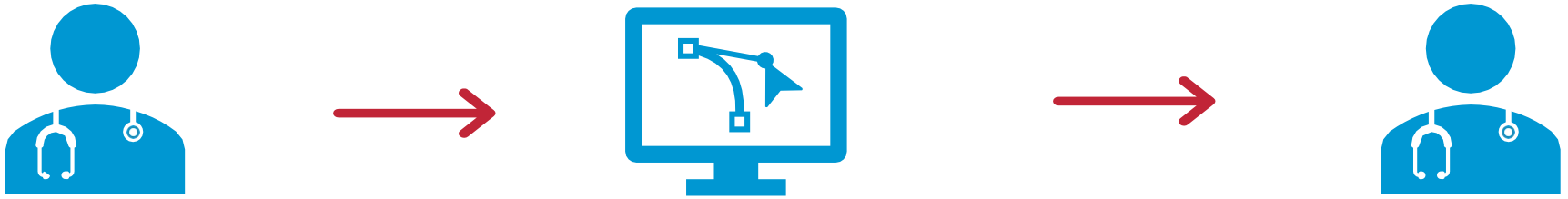
Department of Medicaid
Next Generation MyCare

Type 2 - Provider to CMS Medicare Part A/B coverage

Medicaid Only Members.

Single Step Submission Process

Provider submits claim to Medicare Administrative Contractor (MAC)



Provider	CMS	Provider
Submits the EDI claim to their regional MAC provider	Automatically forwards the claim to the MyCare Medicaid plan for adjudication	Receives payment in their approved formats

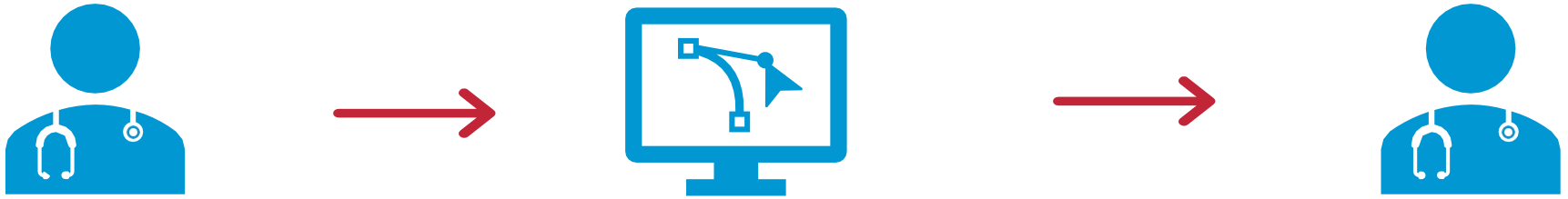
A CMS primary payer claim does not pass through the OMES One Front Door

Type 2 - Provider to Part C – Medicare Advantage

Medicaid Only Members.

Two Step Submission Process

STEP 1: Provider submits claim to Part C – Medicare Advantage Plan



Provider	Part C – Medicare Advantage Plan	Provider
1. Submits Claim to Part C – Medicare Advantage Plan	**2.** Plan returns 835 ERA/RA to Provider	3. Adds the primary payer coordination of benefits information to the claim and submits it to Medicaid.

STEP 2: Provider submits to OMES EDI one front door.

See slide 10. The claim will now come through the One Front Door with the Next Generation MyCare ID.

Next Generation MyCare

MyCare Provider Resources

Where to find more information or get help.

MyCare Ohio provider resources

- ☑ MyCare Ohio provider frequently asked questions
  Highlights common questions about the program such as provider enrollment and program overview.
- ☑ MyCare Ohio program provider one-pager
  Provides information for providers about the program, including its impact and benefits.
- ☑ MyCare Ohio provider help desk one-pager
  Provides guidance about which help desk to contact for different kinds of questions or issues.
- ☑ MyCare Ohio provider webpage on medicaid.ohio.gov
  Shares more resources for providers including updates about the program, action required and the conversion charter. ODM regularly updates this page.

MyCare Ohio provider help desks

- For questions about PASSPORT or Assisted Living claims and/or service authorizations
  Contact the local Area Agency on Aging at 866-243-5678.
- For questions or comments related to the MyCare Ohio program
  Email us at MyCareConversionQuestions@medicaid.ohio.gov.
- For providers interested in contracting with the Next Generation MyCare plans
  Contact the plan you wish to contract with:
  - Anthem Blue Cross and Blue Shield
  - Buckeye Health Plan
  - CareSource
  - Molina HealthCare of Ohio

Ohio Medicaid
Next Generation MyCare

PNM Registration, Validation and Revalidation Requirements

CareSource®

ODM Provider PNM Registration & Enrollment Requirement

ODM prohibits payment to Ohio Medicaid and MyCare providers who are not affiliated through registration within the PNM module (that affiliation is evidenced by the Provider Master File [PMF]). CareSource will reject the claims when the provider does not meet the matching validation of the PMF.

CareSource is required by ODM to reject if any the following requirements are not met:
a) The rendering provider on the claim is listed as an active provider in the PMF as of the claim's Date of Service.
b) The billing provider on the claim is listed as an active provider in the PMF as of the claim's Date of Service.
c) The rendering provider is affiliated with the billing provider on the PMF as of the claim's Date of Service.

The rejection codes are as follows:
• 562 - Invalid National Provider Identifier (NPI) (Billing and Rendering Rejections)
• 677 - Entity Not Affiliated (Affiliation Rejection).

Important reminder: Update addresses and affiliations in the PNM module.

It is imperative that providers update all address and affiliation information in the PNM 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

Review and confirm your information with ODM to ensure your data is correct. Contact ODM via one of the following methods.
• Through the PNM Module - Log In (maximus.com)
• Contact Ohio Medicaid's Integrated Helpdesk (IHD) at 800-686-1516 and follow the prompts for Provider Enrollment (option two, option two)
• Email: IHD@medicaid.ohio.gov. ODM Representatives are available Monday through Friday, 8 a.m. to 4:30 p.m. ET.

ODM Provider Revalidation-Medicaid and Next Generation MyCare

IMPORTANT UPDATE: Revalidation action needed to avoid Provider Agreement termination.

ODM resumed provider revalidation notices in June 2023 as part of the federally required unwinding process from the COVID-19 Public Health Emergency. ODM issues a series of notices with the first one delivered 120 days before your Medicaid agreement end date. Subsequent reminders are issued at 90 days, 60 days, and a final notice at 30 days ahead. If you receive a revalidation notice, it is imperative that you take action to complete your revalidation on time. All providers are subject to either three- or five-year time-limited provider agreements.

How do you know if you are due for revalidation?

Check your mail and email. ODM mails and emails reminder notices to providers who are due for revalidation before the end of their Medicaid agreement. The email will be sent from OHPNM@maximus.com to advise you of a revalidation notice in the PNM Correspondence folder. Please check your spam folder for this email.
View the Correspondence folder in the PNM module. ODM posts revalidation notices in the Correspondence folder in the PNM module. Please be sure to select the type of correspondence from the drop down (in this case Enrollment Notices), and search for the "Revalidation Notices." Review the Accessing Communications within PNM Quick Reference Guide for step-by-step instructions.

NOTE: If you think you are due for revalidation but have not received notices, please login to the PNM module and verify that the primary contact information is accurate in accordance with your Ohio Medicaid Provider Agreement. All mailers and email notices are directed to the primary contact individual or address identified in the system.

If you are due for revalidation, what action do you need to take?

A "Begin Revalidation" option appears in the PNM Enrollment Action Selections 120 days prior to the Medicaid Agreement end date. You can find this under the "Manage Application," "Enrollment Actions" option within the provider file. Review the Revalidation/Reenrollment Quick Reference Guide for step-by-step instructions.

What should you do if you did not complete your revalidation, and your Ohio Medicaid Agreement has been terminated?

In most cases, you will still be able to see the "Begin Revalidation" button by following the same instructions described above. After completing those steps, ODM will review and determine the effective date. If you are a provider type that does not have the "Begin Revalidation" option, please select the "Begin Reapplication" option, complete your application by updating any relevant information, and submit for review and re-enrollment.

For more information

For technical support or assistance, contact Ohio Medicaid's Integrated Helpdesk (IHD) at 800-686-1516 and follow the prompts for Provider Enrollment (option three, option three) or email IHD@medicaid.ohio.gov. Representatives are available Monday-Friday, 8 a.m. to 4:30 p.m. ET.
To learn more about the PNM module and Centralized Credentialing, visit the PNM and Centralized Credentialing page on the Next Generation website.

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