

**Ohio Department of Job and Family Services (ODJFS)**  
**Medicaid Provider Assistance**  
**Frequently Asked Questions (FAQ's)**

**1. Question: What is a Provider Personal Identification Number (PIN)?**

**Answer:** The first time an Ohio Medicaid Provider/Trading Partner or Billing Entity calls the Interactive Voice Response (IVR), the system will require the caller to enter a temporary PIN, which is the last 4 digits of their state reported Social Security Number (SSN) or Employer Identification Number (EIN). After doing this process you will be prompted to change your temporary PIN to a 4-digit numeric PIN.

**2. Question: How do I reset my Provider PIN?**

**Answer:** To reset a PIN, through the IVR enter the 7-digit Ohio Medicaid Provider Number. You will be prompted to enter the Provider's 9-digit EIN or SSN. Then the IVR system will state "the PIN has been reset for Provider ID (it will give your 7-digit provider number)". The temporary PIN for this Provider has been set to the last 4-digits of the Provider's EIN/SSN. The temporary PIN for this account will need to be changed during the next login.

**3. Question: Who can reset a PIN?**

**Answer:** Only Providers can reset a PIN, review active Billing Entities/Trading partners, add Billing Entity/Trading Partners access, delete Billing Entities/Trading Partners access, or reset a PIN for a Billing Entity/Trading Partner. Remember that the Providers are responsible for granting & maintaining IVR access for their Billing Entities/Trading Partner. You are responsible for the integrity of your Provider PIN. You are responsible for anyone you allow access to your PIN.

**4. Question: Does the IVR give Health Management Organization HMO information?**

**Answer:** Yes, the system will tell you if the consumer is eligible for Managed Care. It will then give you the option to get the name and address of the HMO.

**5. Question: What claim type option does an Advanced Practitioner Nurse select?**

**Answer:** An Advanced Practitioner Nurse would select option # 2 - "Physician claim type".

**6. Question: What information should I have on hand when wanting to speak with a representative?**

**Answer:** Please have the following:

- ❖ your 7-digit Ohio Medicaid Provider number
- ❖ the Patient's 12-digit Billing ID
- ❖ the earliest date of service in question on claim
- ❖ the amount/total of the claim
- ❖ and if the claim denied, the transaction control number (TCN) found on your remittance advice
- ❖ any other pertinent information related to your call.

**Ohio Department of Job and Family Services (ODJFS)**  
**Medicaid Provider Assistance**  
**Frequently Asked Questions (FAQ's)**

**7. Question: Can a Billing Entity/Trading Partner change their PIN number?**

**Answer:** They can change their temporary PIN, but they can not reset their PIN.

**8. Question: After attempting to log in with my PIN, I was refused access to the IVR, can you tell me why?**

**Answer:** After several unsuccessful attempts, you will be unable to access the IVR until the next business day. This also applies to other options (i.e. Ohio Medicaid Provider, Billing Entity/Trading partner SSN & EIN number.)

**9. Question: What is Hospital Care Assurance Program (HCAP)?**

**Answer:** HCAP is the mechanism the State of Ohio uses to fulfill its Federal obligation to provide disproportionate share funding to Ohio general/acute care hospitals which provide indigent care (Medicaid consumers, people with incomes below poverty, and people without health insurance). As part of the program, all general/acute care hospitals in the state are required to provide basic, medically necessary hospital-level services without charge to patients whose income is at or below the Federal poverty level and to patients enrolled in the Disability Assistance program (DA) (see Question 11). Funding for HCAP is derived from an assessment on Ohio Hospitals & Federal matching funds. *(HHTL-3352-05-08-Rule 5101:3-2-7.17)*

**10. Question: What is a "Spendedown"?**

**Answer:** "Spendedown" is the amount the patient has to incur each month towards their medical expenses before their Medicaid becomes effective.

*(Rule: 5101: 1:-39-10)*

**11. Question: What does Ohio Disability Assistance only mean?**

**Answer:** A patient with an Ohio Disability Assistance card, is restricted to only having certain services through Ohio Medicaid Program. these services are: Dental (with restrictions), Prescription Drugs, Hospital Services (through HCAP), Lab & Radiology, Physician (a Psychologist is not a MD., so these services are not covered), Medical Supplies (with restrictions).

**NON-COVERED SERVICES:**

- ❖ chiropractic
- ❖ home health
- ❖ ambulance
- ❖ ambulette
- ❖ physical therapy in free standing therapy center
- ❖ vision exams & glasses
- ❖ psychology
- ❖ private duty nursing & nursing home payment.

*(Chapter-3334)- (5101:3-23-01)*

**Ohio Department of Job and Family Services (ODJFS)**  
**Medicaid Provider Assistance**  
**Frequently Asked Questions (FAQ's)**

**12. Question: What does Qualified Medicare Beneficiary (QMB) on the medical card mean?**

**Answer:** It means that Medicare would be Primary, and that Medicaid would be required to pay Medicare premiums, deductibles & co-insurance only. If Medicare denies services, Medicaid would not pay either. *(Rule 5101:1-39-53.1)*

**13. Question: How many different Ohio Medicaid cards are there?**

**Answer:** There are 7 different cards, they are:

- ❖ Ohio Medicaid
  - ❖ Healthy Start Healthy Families
  - ❖ Ohio Disability Assistance Medical Program
  - ❖ Ohio Disability Assistance Program-Restricted Status
  - ❖ PACT Medicaid
  - ❖ Expedited Medicaid Limited Coverage
  - ❖ Ohio Qualified Medicare Beneficiary.
- (Rule 5101:3-1-15)*

**14. Question: What option does Ohio Home Health Providers (including Aides, Nurses & Agencies) use for claim status?**

**Answer:** Home Health Provider would select option # 2 under "Physician claim type".

**15. Question: How can I get directly to an Operator for assistance?**

**Answer:** Please follow the prompts at the log in menu or refer to the IVR user guide.

**16. Question: What are the hours of operation for Prior Authorization?**

**Answer:** The hours of operation for Prior Authorization are 8:00 am to 4:30 pm Monday thru Friday.

**17. Question: Why does the claim payment amount on the remittance advice read "Zero pay"?**

**Answer:** The payment amount on the remittance advice will read "zero pay" when:

- ❖ Third Party paid more than Ohio Medicaid maximum amount
- ❖ prior payment on Medicare Crossover claim is more than Medicaid maximum
- ❖ anesthesia codes billed without a modifier
- ❖ claim is billed with more units than the Medicaid Management Information System (MMIS) allows
- ❖ system problems with Diagnostic Related Group (DRG) assignment
- ❖ error in entering reimbursement amount in the Procedure, Drug & Diagnosis (PDD) fee schedule.

**Ohio Department of Job and Family Services (ODJFS)**  
**Medicaid Provider Assistance**  
**Frequently Asked Questions (FAQ's)**

**18. Question: Do Providers need to notify Ohio Medicaid of address changes?**

**Answer:** Yes, per the Medicaid Provider agreement, a Provider must inform the department within thirty days of any changes in:

- ❖ licensure
- ❖ certification or registration status
- ❖ ownership
- ❖ specialty
- ❖ additions, deletions or replacements in group membership
- ❖ hospital-based physicians
- ❖ address changes
- ❖ mail to & pay to changes

**19. Question: As a Provider am I allowed to bill the patient for missed appointments?**

**Answer:** Per CMS (Centers for Medicare & Medicaid Services) providers are NOT permitted to bill patients for missed appointments.

**(CMS-Chicago Regional State Letter # 36-95)**

**20. Question: What is National Provider Identifier (NPI)?**

**Answer:** NPI is the National Provider Identifier, a HIPAA requirement. The NPI will be used by healthcare providers in filing and processing claims & other related transactions.

**21. Question: When does NPI happen?**

**Answer:** Per the Health Insurance Portability & Accountability (HIPAA) NPI Final Rule, providers must use only the NPI in standard transactions by May 23, 2007. Beginning November, 2006 through May 22, 2007, OHP will accept both Ohio Medicaid Provider number & the NPI as identifiers on claims & other related transactions.

**Note: Beginning May 23, 2007, provider must use only their NPI.**

**22. Question: Who is required to obtain the NPI?**

**Answer:** Individuals or Organizations that render health care and are HIPAA-cover entities are required to obtain the NPI. They are as follows:

- ❖ Individuals (such as Physicians, nurses, dentist, chiropractors, physical therapists or pharmacists)
- ❖ Organizations (such as hospitals, home health agencies, clinics, nursing homes, residential treatment centers, laboratories, ambulance companies, group practices, Health Maintenance Organizations (HMO), supplies of durable medical equipment, pharmacies)

**Ohio Department of Job and Family Services (ODJFS)**  
**Medicaid Provider Assistance**  
**Frequently Asked Questions (FAQ's)**

- ❖ HIPAA- cover entities are health care providers who transmit any health information in electronic form, even if the health care provider uses a business associate to do so (E.g., a Billing Entity or Trading Partner).

**23. Question: How does a provider get the NPI?**

**Answer:** Information on how to apply is available through the Centers for Medicare & Medicaid Services (CMS) website: <http://www.cms.hhs.gov/nationalprovidentstand>. Then click on "How to Apply".

*Health care Providers can apply now through May 2007 for their NPI.*

**24. Question: Will the NPI replace the Ohio Medicaid enrollment process?**

**Answer:** No, the NPI will not change or replace the enrollment process. Any Provider who wishes to be an Ohio Medicaid Provider & who has not previously enrolled as an Ohio Medicaid Provider will need to apply through the Provider Enrollment Unit in the Bureau of Plan Operations. This information is available at 1- (800) 686-1516 (enrollment prompt).

**25. Question: What is Payment Error Rate Measurement (PERM)?**

**Answer:** PERM is a comprehensive, on-going Federal audit to measure how frequently errors may occur when Providers' claims are submitted and paid by state Medicaid programs. All 50 states will be measured over a three-year period. PERM is authorized by the Improper Payments Information Act of 2002. Any Ohio Medicaid Provider who is selected must comply with the Federal audit. Medicaid Providers will be required to submit documentation that supports the Medicaid claim and payment. If you are one of the Providers required to participate in the PERM audit, ODJFS will contact you in writing to inform you of your selection and the information you will be required to submit. It is critical that you submit complete medical records to support the accuracy of claims payments. For additional information, visit either of the following sites: [www.cms-perm.org](http://www.cms-perm.org) or <http://jfs.ohio.gov/OHP/providers/perm.stm>.

**26. Question: What is the Ohio Medicaid Payer ID for Electronic Data Interchange (EDI)?**

**Answer:** The Ohio Medicaid Payer ID (receiver Id) is: **MMISODJFS**

**27. Question: What is the Primary Alternative Care and Treatment Medicaid (PACT)?**

**Answer:** Medicaid recipients in this program are limited to a primary Physician and/or Pharmacy. The telephone number the PACT Unit is (614) 466-9689. ***(Rule 5101:3-20-01, 02, 03)***

**28. Question: What is Expedited Medicaid?**

**Answer:** This program is available to pregnant women so they can obtain early prenatal care. Recipients eligible for this program will be issued one Medicaid card that is good for 60 days. These recipients receive the full Medicaid benefit package, except for inpatient hospital services.

***(Rule 5101:1-40-60)***

**Ohio Department of Job and Family Services (ODJFS)**  
**Medicaid Provider Assistance**  
**Frequently Asked Questions (FAQ's)**

29. **Question:** How long do I have to submit a claim?

**Answer:** Claims must be received by The Department of Job & Family Services (ODJFS) within 365 days of the date of service or hospital discharge date. The "date of receipt" is defined as the date the department receives a claim and assigns a TCN (transaction control number). If the service date on a claim is more than 365 days old but, less than 730 days old, the claim will be considered for payment only if:

- ❖ It is being resubmitted less than 180 days after an ODJFS denial
- ❖ A third party or Medicare payment or denial was made less than 180 days prior to submission
- ❖ A county eligibility determination or court decision was made less than 180 days prior to submission.

**(Rule 5101:3-1-19-.3)**

30. **Question:** When is the Recipient liable?

**Answer:** Medicaid Payment is "**Payment in Full**". The Provider may not bill the consumer for any difference between the Medicaid payment & the Provider's charge. The provider may not of the department unless:

- ❖ The consumer is notified in writing prior to ***each*** service being rendered that the Provider will not bill the department for the covered service
- ❖ The consumer agrees to be liable and signs a written statement to that effect, prior to the ***each*** service being rendered

**(Rule 5101:3-1-13.1)**

31. **Question:** What is the difference between "Prior Authorization (PA) and Pre-Certification?

**Answer:** ***Prior Authorization*** is determined by the department to establish the medical necessity of a Treatment or procedure. When prior authorization is granted, a 6 digit Prior Authorization number is provided. **(Rule 5101:3-1-31)**

***Pre-Certification*** is determined by a contractor to assure that covered medical and psychiatric services, and covered surgical procedures are medically necessary and are provided in the most appropriate and cost effective setting. **(Rule 5101:3-2-40)**

**Note:** You may refer to **HHTL 3352-04-10** for the most current list of procedures and admissions that require pre-certification.

32. **Question:** Does Ohio Medicaid cover for an oral interpreter or sign language interpreter?

**Answer:** Ohio Medicaid does not pay for an oral interpreter or sign language interpreter.

**Ohio Department of Job and Family Services (ODJFS)**  
**Medicaid Provider Assistance**  
**Frequently Asked Questions (FAQ's)**

**33. Question: What is the Program of All-Inclusive Care for the Elderly (PACE)?**

**Answer:** Pace is based on a managed care model that was developed by Onlok Senior Services in San Francisco 25 years ago. PACE sites receive full capitation from both Medicare and Medicaid. PACE sites also provide the participants with all of their needed health care, medical care and ancillary services in acute, sub-acute, institutional, and community settings. Each site has a multi-disciplinary team that directs and provides the care of the participant. To be eligible for PACE, participants must:

- 1) live in the service area of the PACE site
- 2) qualify for Medicaid coverage under the institutional financial eligibility standards
- 3) need an intermediate or skilled level of care
- 4) be 55 or older
- 5) be willing to receive all of their care from PACE program Providers. In addition, a participant must be able to remain safely in a community setting at the time of initial enrollment, participants can dis-enroll, but most choose to remain in the program until death.

**Note:** Ohio has two PACE sites:

- ❖ TriHealth SeniorLink is located in Cincinnati. It serves Hamilton County and certain zip codes in Warren, Butler, Clermont counties.
- ❖ Concordia Care is located in Cleveland Heights and serves all of Cuyahoga County.  
**(Rule 5101:3-56-02)**

**34. Question: If my Medicaid Provider number is inactive/terminated, will I be able to access information on the IVR?**

**Answer:** You will be able to access any information that does not require you to enter your Provider number and PIN. For information such as claim status or eligibility, you would have to speak to a representative.