

Provider Frequently Asked Questions (FAQs)

1) I believe the managed care plan (MCP) has violated the terms of my contract. Who should I report my complaint to?

Although the Ohio Department of Job and Family Services (ODJFS), Bureau of Managed Care (BMC) is responsible for overseeing the Medicaid managed care program, House Bill (HB) 125, 127th General Assembly has given the Ohio Department of Insurance (ODI) the responsibility to respond to certain Medicaid managed care provider complaints that are related to provider subcontracts. If the terms of your contract with the MCP have been violated by the MCP in that the MCP is:

- not paying claims at the rate outlined in the your contract with the MCP;
- not credentialing in accordance with ORC 3963.05 and 3963.06;
- renting or selling access to your services not in accordance with ORC 3963.02; or
- making material changes to your contract not disclosed properly pursuant to ORC 3963.04

and if you are a provider* as defined by HB 125, please fill out a Credentialing and Contracting provider complaint form on the Ohio Department of Insurance (ODI) website:

<http://www.ohioinsurance.gov/Company/insprmp5.htm>.

*Provider is defined in ORC 3963.01 to include physician, podiatrist, dentist, pharmacist, chiropractor, optometrist, psychologist, physician assistant, advanced practice nurse, occupational therapist, massage therapist, physical therapist, professional counselor, professional clinical counselor, hearing aid dealer, orthotist, prosthetist, home health agency, hospice care program, or hospital, or a provider organization or physician-hospital organization that is acting exclusively as an administrator on behalf of a provider to facilitate the provider's participation in health care contracts.

If you are a hospital or nursing home and you believe that the MCP has violated the terms of your contract as outlined above, please fill out a BMC provider complaint form at the following link: https://www.odjfs.state.oh.us/ohp/bmhc/provider_complaint/complaint.asp

Please note that the BMC cannot become involved in contractual disputes between the MCP and the provider, however, we will work to get you in contact with the appropriate staff member at the MCP who will be able to assist you with your concerns.

2) I believe the MCP is violating the federal prompt pay provisions. Who should I complain to?

The Bureau of Managed Care requires that MCPs notify providers who have submitted claims of claims status [paid, denied, pending (suspended)] within one month of receipt. Additionally, MCPs must follow federal managed care prompt pay requirements, which state that MCPs are to

pay 90% of all clean claims within 30 days and 99% of all clean claims within 90 days, unless otherwise mutually agreed upon in the contract between the MCP and the provider. This prompt pay requirement is an aggregate number claims from ALL providers, and is not on an individual provider basis. If your claims were submitted cleanly (submitted without need for corrections or additional information), and you have not received claims status information or payment from your MCP, providers should wait until 90 days have passed before contacting the BMC. If the provider was required to make a correction to a claim before resubmitting it, the 90 days starts over again at the date of the most recent resubmission. Please do not file a formal provider complaint with the BMC until 90 days have passed since your most recent clean claim submission/re-submission. If you have submitted claims and they have been denied, you must first appeal those claims through the MCP prior to filing a formal complaint with the BMC. Please follow the MCP appeals process. (Please note: Federally Qualified Health Centers (FQHC) and Rural Health Clinic (RHC) claims are to receive expedited reimbursement. Please contact the Bureau of Managed Care if you are an FQHC or RHC and are experiencing difficulty with claims payment).

Please note that ODI is not responsible for monitoring the federal prompt pay provisions and is not also not responsible for monitoring any violations of the claims payment terms of the provider's contract with the MCP if the provider is a hospital or nursing home (See Question #1 above).

3) I am being reimbursed at a lower rate than what I was reimbursed by Medicaid fee-for-service (FFS). Doesn't the managed care plan (MCP) have to reimburse me the same amount as FFS?

With the exception of non-contracting providers of emergency services and qualified family planning providers (QFPPs), the reimbursement amount must be negotiated between the provider and the managed care plan (i.e., the reimbursement amount may or may not be the same as fee-for-service Medicaid). Providers that are not contracted with the MCP, but are authorized by the MCP to provide services, should ensure that they have a mutually agreed upon compensation amount in writing. The reimbursement amount for contracted providers must be specified in the contract between the MCP and the provider. Non-contracting providers of emergency services and QFPP providers must be reimbursed as specified in Ohio Administrative Code rule 5101:3-26-03. (Please also see Questions #1 and #2 above).

4) I am trying to bill for claims using the same codes as Medicaid fee-for-service (FFS), yet the managed care plan (MCP) is denying my claims saying they contain invalid codes. Aren't the MCPs required to code the same way that FFS does?

No. Although the MCP must provide access to all medically-necessary Medicaid covered services, they are not required to use the same coding system as FFS. All plans, however, must be HIPAA compliant. If you are unsure which codes to use, please contact the MCP's provider services line or your regional provider relations representative. You can also request information through the MCPs' website. You can access the MCP websites under "Participating Plans" at: <http://jfs.ohio.gov/OHP/bmhc/index.stm>

5) I have submitted claims for my patient, but they are being denied for coordination of benefits / having a primary insurer. Doesn't the managed care plan (MCP) have to automatically pay me because I am a Medicaid provider?

Medicaid, which includes Medicaid-contracting managed care plans (MCPs), is the payor of last resort with the exception of services provided under Title V and similar programs as outlined in Ohio Administrative Code (OAC) rule 5101:3-26-09.1. MCPs must provide coordination of benefits as outlined in OAC rule 5101:3-26-09.1. Additional information regarding coordination of benefits can be found in the Managed Care Weekly Archive Issue #39 May 4, 2007 on the Bureau of Managed Care's consumer website <http://jfs.ohio.gov/OHP/bmhc/newsletter.stm>. If the patient denies having primary insurance, please contact the MCP's customer service/regional provider relations representative to obtain further information regarding the primary payor.

6) I am a non-contracting provider and have continued seeing my Medicaid patients, assuming that they were still on Medicaid fee-for-service (FFS). When I submitted their claims, they were denied stating that the patient was on a managed care plan (MCP). When I billed the MCP, the claims were denied because I am a non-contracting provider. Isn't the MCP obligated to pay these claims since the patient is on Medicaid?

No. Providers are responsible for checking the patient's eligibility on the first visit of each month, even if the patient states that they are still on FFS. Patients who are to be mandatorily enrolled, are assigned to an MCP even if they do not self select one themselves. Providers can check their patient's eligibility using the Interactive Voice Response (IVR) telephone number at 1-800-686-1516. Information regarding the IVR can also be accessed on the following website <http://jfs.ohio.gov/OHP/providers/IVR.stm>. (Please note: Although the beginning of the IVR recording may state that the patient is Medicaid eligible, you must listen further to determine if the consumer is on managed care. Then select option 1 to determine which MCP the consumer is enrolled in). Providers can also access eligibility via the Ohio Department of Job and Family Services (ODJFS) online eligibility web portal at: <https://medicaidremit.ohio.gov/default/home.jsf>.

MCPs are not required to pay for those services provided while the patient was on the MCP if you are not a contracted provider with them or have not otherwise established a non-contracting provider reimbursement agreement. If you are interested in becoming a contracting provider or have outstanding claims concerns, please contact the MCP directly. If the MCP does not agree to pay your outstanding claims, your office is responsible for those claims and you are not permitted to direct bill the patient in this situation.

7) I work with a Federally Qualified Health Center (FQHC). How do we locate the managed care plan (MCP) provider number to bill for the wrap-around payment?

When submitting claims for wrap-around payment, FQHC providers should use the provider number designated for the appropriate managed care plan (MCP) population you are serving – Covered Families and Children (CFC) or Aged, Blind or Disabled (ABD), and the region in which you are located. This information is available through the Ohio Department of Job and Family Services (ODJFS) Interactive Voice Response (IVR) System by calling (800) 686-1516

or by accessing the ODJFS online eligibility web portal at:
<https://medicaidremit.ohio.gov/default/home.jsf> .

8) The managed care plan (MCP) is requiring me to obtain prior authorization (PA) for certain services that Medicaid fee-for-service (FFS) never required me to obtain PA for. Is this acceptable?

Yes. Although the MCP must provide access to all medically necessary Medicaid covered services, their utilization management requirements can be different from FFS. Therefore, the MCPs are allowed to require prior authorization for non-emergency services that FFS does not require PA for, as long as they are not specifically excluded from requiring PA by the Ohio Department of Job and Family Services (ODJFS).

9) I submitted a prior authorization (PA) request, but the managed care plan (MCP) has not gotten back to me and the patient needs the requested services. Is there a timeframe in which the MCP must respond to my PA request?

MCPs are required to provide a decision to a standard PA request within 14 calendar days, or as expeditiously as the member's healthcare needs require. PA decisions regarding outpatient covered drugs must be made within 24 hours. Excluding outpatient drugs, for all other PAs, a provider can request an expedited decision to be made as expeditiously as possible, but within 3 working days if the provider believes that the standard decision timeframe could seriously jeopardize the member's life, health or ability to attain, maintain or regain maximum function. Providers must ensure that they submit all of the necessary documentation to the MCP detailing the medical necessity as well as any documentation to expedite the decision.

10) When we call the Interactive Voice Response System (IVR) or check eligibility via the Ohio Department of Job and Family Services (ODJFS) online eligibility web portal for providers, we are told that our patient is eligible on a specific managed care plan (MCP), yet when we contact the MCP or bill for this patient's services we are told that the patient is not eligible with the MCP. (This includes newborns that may not be showing in the MCP system at all). How do we verify eligibility in this instance?

A managed care member's eligibility may be changed retroactively due to one of the following: eligibility for Medicare, eligibility for a Medicaid waiver program, or if the member was an inpatient at a hospital or nursing facility on their effective date of enrollment. Covered Families and Children (CFC) members under 19 years of age may request disenrollment from the MCP if they are receiving assistance from Supplemental Security Income (SSI), Bureau of Children with Medical Handicaps (BCMh), Title IV-E adoption assistance or foster care, or are found to be in the custody of a public or private children's services agency. If, after contacting the MCP, you believe there is a discrepancy between the eligibility information provided by the MCP and the IVR/eligibility web portal, you can contact the Enrollment Section staff within the Bureau of Managed Care (BMC). They will be able to verify eligibility for you and will contact the MCP if necessary to ensure that their system is updated with the correct information. Enrollment Section staff can be reached by calling (614) 466-4693.

11) I have been trying to contract with the managed care plan (MCP) for months now and have not heard back from them regarding the status of my contract or credentialing. Aren't they required to complete my credentialing paperwork within a certain period of time? What do I do about my patients who are on that MCP if I am unable to establish a contract with them?

If a MCP has requested a new provider to submit a credentialing form, the credentialing process must be completed no later than 90 days after the provider has submitted **both** the credentialing form and the provider's national provider identification number issued by the Centers for Medicare and Medicaid Services to the MCP. The 90 day timeframe is inapplicable to providers that are hospitals, all providers that have not been solicited to be credentialed, and any individual or entity that is not listed in the definition of "provider" in Ohio Revised Code 3963.01 (P). Additional information concerning the credentialing process, including a Credentialing and Contracting Provider Complaint Form and key definitions, is available on the Ohio Department of Insurance website at: <http://www.insurance.ohio.gov/Consumer/Pages/InsPrmpt5.aspx>

It is up to the provider to establish a non contracting reimbursement agreement with the MCP, if they wish to continue seeing that MCP's consumers and they have not yet completed contracting and credentialing. If the MCP is not willing to establish that agreement with the provider, the consumers must seek services from a contracted provider until you are credentialed. In most situations, providers are not allowed to direct bill the patient, even if the MCP refuses to reimburse the provider, and the provider chooses to continue seeing the patient anyway. Additional information regarding consumer cost sharing can be found in the Managed Care Weekly Issue #41 May 18, 2007 on the Bureau of Managed Care's consumer website <http://jfs.ohio.gov/OHP/bmhc/newsletter.stm>.

12) I am a Community Mental Health Center (CMHC) psychiatrist who is exempt from the prior authorization requirements for 2nd generation atypical antipsychotics. Why are the managed care plans (MCPs) still denying my claims for no authorization?

ODJFS exempts CMHC psychiatrists from prior authorizing the standard tablet/dosage forms of certain 2nd generation antipsychotic medications when they are prescribed for an Aged, Blind, or Disabled (ABD) consumer enrolled in a Medicaid managed care plan. To qualify for the exemption, CMHC psychiatrists must submit certain information to the Ohio Department of Mental Health. If you have had a claim denied for "no authorization" it may be due to one of the following reasons:

- You are not a psychiatrist (note: the exemption does not apply to advanced practice nurses or residents);
- You are prescribing for a consumer belonging to the Covered Families and Children (CFC) rather than the Aged, Blind, or Disabled (ABD) Medicaid category of assistance;
- You are prescribing a non standard form of a 2nd generation antipsychotic medication;
- You are prescribing a 2nd generation antipsychotic medication that is not exempt under this policy;
- You have not submitted your information to ODMH;
- You submitted incomplete or inaccurate information to ODMH;

- Your exemption is still being processed by the managed care plan (note: it takes approximately 15 business days for the managed care plan to implement the exemption after you have submitted your information to ODMH).

The 2nd generation antipsychotic medications that are exempt under this policy may be found at: http://jfs.ohio.gov/ohp/bmhc/documents/pdf/BMHC_Antipsychotic_Drugs_052008.pdf

To submit your information to ODMH, please read the instructions and use the report form located at: <http://www.mh.state.oh.us/what-we-do/protect-and-monitor/medicaid/index.shtml>

To confirm that your information was received by ODMH, please call ODMH at (614) 644-1513.

For further information regarding this policy, please see:

http://jfs.ohio.gov/ohp/bmhc/documents/pdf/BMHC_Antipsychotic_Drugs_052008.pdf

If you have additional questions/concerns regarding the 2nd generation antipsychotic exemption that are not addressed here, please contact the BMC at (614) 466-4693 or electronically submit the provider complaint form available on this website.

13) I have been trying to contact the managed care plan (MCP) and no one is returning my calls. How am I supposed to get the information that I need?

It is imperative that providers document dates, times and names of each individual that they speak with at the MCP. If you have submitted paperwork via fax or mail, please keep copies of cover pages, the items sent and certified mail receipts if applicable. If you have contacted both the MCP's customer service line and your regional provider relations representative and neither have returned your calls within a reasonable timeframe, please fill out the provider complaint form on this website. The BMC will contact you and ask you to fax supporting documentation if needed.

14) I have submitted a provider complaint to the Bureau of Managed Care (BMC) and/or the Ohio Department of Insurance (ODI). When will I hear back from them regarding my complaint? How do the BMC and ODI make the determination that a complaint is resolved?

ODI Timeframes:

When ODI receives a credentialing or contract complaint, the Department will work with the provider to expedite resolution of the issue and provide the appropriate guidance regarding use of our online provider complaint system as appropriate. Information regarding this process and access to the online form can be found on our website at:

<http://www.insurance.ohio.gov/Consumer/Pages/InsPrmpt5.aspx> . ODI can also be reached by calling 1-800-686-1526.

Providers submit complaints through our online provider complaint system directly to the MCP. The MCP will have 15 business days to respond to the provider's complaint. After the provider receives the response and evaluates it, they have the opportunity to communicate with ODI on any additional concerns they may have. The Department will facilitate further communication between the provider and the MCP until the complaint has been fully addressed. Altogether, the initial complaint process will take 21 to 30 days and follow up issues may take another 21 days.

The Department makes the ultimate decision on closure of the complaint files, taking any applicable law into consideration with the information that has been exchanged through the complaint process.

Please contact the Ohio Department of Insurance Provider Complaint Unit with any questions regarding their process by calling 1-800-686-1526.

BMC Timeframes:

The BMC will submit your complaint to the Managed Care Plan (MCP) or forward it to ODI (for ODI-related complaints), as soon as it is received.

For the complaints that BMC forwards to the MCPs, MCPs are required to provide an initial response, not necessarily a resolution, to the BMC within 15 working days, unless the complaint is access related. Access related complaints must be resolved within 2 working days. Complaints (non-access related) that are non-claims related are typically resolved within 30 working days. Complaints (non-access related) that are claims related are typically resolved within 90 working days or by the due date specified by the BMC, dependent upon the volume of claims under review.

The BMC investigates each complaint thoroughly and will work with the provider to ensure that they are in contact with the appropriate managed care plan (MCP) staff, and to ensure that the MCP is compliant with current state and federal regulations. However, the BMC cannot intervene in contractual issues between the MCP and the provider. The provider is asked to follow the grievance/appeal procedures outlined in their subcontract with the MCP prior to contacting the BMC. If it is determined that the issues are contractual in nature and are beyond the BMC's jurisdiction based on state and federal regulations, the BMC will close out the complaint.

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