# Frequently Asked Questions (FAQs)

**June 30 Ohio Medicaid Enterprise System (OMES) New Features Implementation**

Ohio Department of Medicaid

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# Claims

### What are the possible claim statuses that I could see listed for a claim in PNM?

Below is a summary of claim statuses and their definitions.

- **Adjudicated** – The claim has run through initial review of business rules and applied edits but has not gone through the payment process.
- **Denied** – The claim has failed business rules and has gone through the payment process.
- **Deny** – The claim has failed header and/or line-level business rules and has not been submitted to the payment process.
- **Open** – The claim has been received and is in process but has not been adjudicated.
- **Paid** – The claim has been finalized and has gone through the payment process.
- **Pay** – The claim has been adjudicated and all edits have been satisfied. It is now ready to go through the payment process.
- **Pend** – The claim has been set aside for review to determine if it should be paid or denied.
- **Pending Submission** - This is the status of a claim before submission.
- **Rev** – This is a real-time, non-finalized, financial status for a reversed/adjusted claim.
- **Reversed** – The claim has been finalized. Checks have been printed and the payment process is complete, but errors have been identified and a mirror image of the claim has been created to correct the errors.
- **RevSynch** – This is a real-time, non-finalized, financial status for a reversed claim that is synchronized to go through the payment cycle the same time as the adjustment claim.
- **Void** – This is a finalized status for a claim that has been voided. The claim has been canceled.
- **WaitDeny** – The claim has failed business rules and has been submitted for payment, but the payment process is not complete.
- **WaitPay** – The claim has been approved for payment and submitted to the payment process, but that process has not yet been completed.
- **WaitRev** – A reversal claim has been created and submitted to the payment process, but that process is not yet complete.

- **Warn** – An informational message that does not affect claim payment or denial.

### What are the different claim submission types that can be completed through PNM?

For dental, professional, and institutional claim types, the following submissions can occur using PNM:

- New claim submission – Enter first-time data for a new claim and click 'Submit.'
- Adjustment – This is the replacement for a paid claim (finalized claim). Complete a search for the claim in PNM, select the ICN, click 'Adjust' to modify as needed *(billing provider, payer name and claim type cannot be changed)* and click 'Submit.'
- Void – This is the reversal for a paid claim (finalized claim). Complete a search for the paid claim in PNM, select the ICN, and click 'Void.'

### With the launch of this next stage of PNM, will ODM begin accepting 275 Claim Attachment Transactions from trading partners/clearinghouses, utilizing the 837 PWK segment?

ODM will not be able to accept 275 transactions. All attachments will need to be submitted through the PNM portal. You would still indicate an attachment is forthcoming in the PWK segment.

### When submitting or searching for a claim, do you need to access the self-service option under the group name or under each individual provider's name?

You can submit or search for a claim under the group or individual provider name. This will be dependent on who the bill to provider is. It is important to choose the provider or Registration ID (Reg ID) from your dashboard before completing a submission or search in PNM.

### If we are a Provider Agent user and already have the "claims" hyperlink, will we need to have our Administrator add additional access added for claims submission and claims search?

If you are an Agent and you already have the 'Claims' hyperlink listed under your Self Service Selections, then you can either search for claims, submit claims or both. You will still see the claims link if you only have one of the two or both. For example, if you are supposed to be able to submit claims and search for previously submitted claims, then you will see the 'Claims' hyperlink. If you are supposed to only be able to search for previously submitted claims, you will also see the 'Claims' hyperlink.

### Will the Managed Care Organization claims be submitted through the PNM website?

Managed Care Organization claims will continue to be submitted the way they are today, either using the managed care plan portals or EDI. As of June 30, 2024, PNM is only set up to receive fee-for-service claim submissions.

### What ID number do I need to enter for the recipient?

The Medicaid ID (or MMIS ID) must be the ID number used for fee-for-service claims processing.

### What is the Patient Control Number and where do we find it?

The patient control number is a number which providers can create. If you have a client or patient number in your office, you may enter it on claims for that individual as well as search by that number.

### What if you do not have their Medicaid Billing Number? Is there a way to get around this section and provide that information later?

Unfortunately, no. The Medicaid Billing Number (MMIS Number) is a required field that needs to be entered under the Recipient Information panel. This must be filled out to submit the claim.

If you do not know the number at the time of submission, you can leave it blank and 'save' the claim submission to finish it later, but you will not be able to submit the claim without something entered in that field.

### Will any information pre-populate from prior month's claims with the implementation of the FI in PNM?

Currently when submitting a new claim in PNM, there will not be information that pre-populates other than the recipient information which populates after entering the Medicaid Billing Number and Date of Birth under the 'Recipient Information' section.

If you wish to copy Service Detail/Service Line information, there is a 'copy' button displayed in PNM after you add a service line. You can use that button to copy the previously added service detail information to use on another service line.

If searching for a previously paid claim, you do have the ability to select 'Copy' to copy the claim and then edit any information needed prior to submitting a new claim.

### Is there ever a time that a 'situational' entry may be required once you try to submit the claim?

Yes, that is possible. PNM is coded to understand the information you select, so if a 'situational' section becomes required, based on a selection you make during the claims submission process, the system will make sure that information is entered before you submit the claim. If the information is not entered, PNM will display an error message letting you know details are required in that specific panel to submit.

An example of this could be that if you select a Destination Payer Responsibility Sequence of "Secondary," PNM understands that information will then be required to be entered under the 'Other Payer Information' section.

### What if you know the billing code but not the dollar amount? Will it automatically populate the dollar amount for you?

PNM will not populate the dollar amount for the claim submission. This will need to be entered by the user submitting the claim.

### Is there a workaround if a file is more than 10 MB in size?

10 MB is the maximum file upload size within PNM. While there is no 'work around' for the size limit, PNM does allow for the ability to upload different file types, where a combined pdf or zip file could be uploaded, containing multiple documents, if that file does not exceed the 10 MB limit.

### What is the deadline to submit claims to be paid the following week?

Payment dates are determined on the claim processing time, not the claim submission time. The Ohio Department of Medicaid follows the CFR related to timely claims payment. eCFR :: 42 CFR 447.45 -- Timely claims payment.

### Will submitting this way bypass the configuration issues?

The PNM portal claims will be processed in the FI system just like the current EDI submitted claims. You will be able to submit claims through the PNM portal or EDI and claims will be processed in the FI system. If there is a known issue on the FI side currently, then yes, these claims would hit that same issue.

### Do PNM errors need fixed before you can submit the claim?

The PNM errors that show up with the red text are ones that must be fixed first before the claim can be submitted and processed initially. They will display in red text and are clickable, directing you to the section/field that needs to be addressed. Once the errors have been addressed, you would then just click 'Submit' again.

### Will payment and denial information be available immediately upon submission?

Adjudication happens in near-real time. A 'Pay', 'Deny', or 'Pend' status should show at the top-right of the claim submission page once the adjudication occurs.

### Is the ICN for the claim provided to you as soon as you click 'Submit'?

The ICN is assigned when the claim is adjudicated. That should happen in near-real time (a few seconds), but possibly could take up to 5 minutes.

### Is there an opportunity to print a copy of the claim once submitted?

PNM itself does not have a print option for the claim submission. Since it is a web-based system, you could select 'File' and then print from the web browser, if needed.

The information for the claim submission can always be viewed by completing a search for the submitted claim in PNM.

### Can I attach more documents after I submit the claim?

If the claim is not yet in a finalized status (ex. paid or denied), you are able to attach additional documents, by selecting 'Attachments' from the Self Service selections.

### Am I able to view or edit in PNM any claim that I have submitted previously?

Providers wanting to view or edit a claim (submitted via PNM or EDI transaction), can complete this process in PNM, except for claims submitted to Managed Care Organizations. Fee-for-service claims submitted via EDI transactions, PNM, or previously through the now decommissioned MITS can be accessed through the Fiscal Intermediary (FI) when completing a claim search within the PNM module. FI will return data to PNM for claim searches up to 3 years prior to the inquiry date.

### Is there a way to search claims submitted within a span date where results show member name instead of ID?

You can search using date spans; however, the results don't populate with the member's name. The billing number and patient account number will be visible in the results section, not the member's name.

### With a denied claim, is the entire claim editable, or only the sections that are relevant to the denial?

Clicking ‘Resubmit’ on a denied claims allows you to make edits to any fields on the claim submission page.

### Will claims submitted via a clearinghouse be submitted via PNM?

Yes, in PNM you will be able to see claims submitted in PNM/MITS and claims submitted via other Electronic Data Interchange (EDI) transactions, that were submitted both before 6/30/2024 and after 6/30/2024.

### Since a clearinghouse claim has a letter E in the ICN, do we just enter the numerical portion to pull up in PNM?

You will need to enter the full ICN (including any letters) when searching for any submitted EDI claims or claims submitted through PNM. If obtaining claim status information through the Ohio Department of Medicaid Integrated Help Desk (1-800-686-1516) only ICN digits (not letters) can be entered.

### Can I look up claims submitted to Managed Care Organizations in PNM?

No, only fee-for-service submitted claim information can be viewed in PNM. The only payor name that can be selected on the claim search screen is “Ohio Department of Medicaid.”

### If you void a claim, can you resubmit it right away or do you have to wait?

You should be able to resubmit a new claim right away without having to wait.

### If a claim denies for documentation, does PNM show what is required?

Yes, PNM will display this information once the claim is adjudicated. Details about the adjudication can be found under the ‘Claims Adjudication’ section, ‘Reviewer Notes’ section, and CARC and RARC Information’ section of the claim submission page.

### Will I see the specific amount for each service, or is it just the total paid claim amount?

The total amount paid is listed at the top of the page on the right, but if there are multiple service lines entered, each service line will have a specific amount paid listed next to it.

### To send attachments, do we need to have the "Attachment" option under the Self-Service Selections?

The ‘Attachment’ link on the self-service panel is a way to submit attachments, if needed, after the claim is submitted. The ‘Attachment’ section/panel within the claim submission page is where you can upload, up to 10 documents, on the claim submission.

### How do we switch to different providers?

To submit a claim under a different provider/Medicaid ID, you can return to your dashboard by clicking the 'home' icon in the top toolbar of PNM and select the other provider from your dashboard.

If you are submitting claims under a group/organization/agency for different providers, you can indicate those different providers under the different 'Provider' sections/panels on the claim submission page.

### How do you retrieve a 'saved' claim?

A claim that has been saved can be accessed by completing a claim search. This search would need to be completed under the same provider/Medicaid ID in which the claim was entered. When searching, selecting "Pending Submission" in the 'Claim Status' field.

## Dental

### Dentistry has different payers, such as Dentaquest/Skygen etc., will those payers show up on the drop-down menu for?

The claims submission in the PNM system is only for fee-for-service currently. The only Destination Payer option to select is "Ohio Department of Medicaid." The submission of claims for Managed Care Organizations should continue through the managed care plan portals.

### Is a Control Number & Diagnosis Pointers/Code required for the Dental Claims on the PNM?

A Patient Control Number field, located under the 'Recipient Information' section/panel is required to be completed on a dental claim submission. The 'Diagnosis Code' section/panel is not required to be completed on a dental claim submission. The Diagnosis Pointer field, located under the 'Service Details' section/panel, is not required on a dental submission claim.

### Will Federally Qualified Health Centers (FQHCs) continue to submit dental claims using the professional claim submission form?

Yes. If an FQHC is submitting a dental claim through PNM, the selection of 'Professional' needs to be selected as the claim type.

## Institutional

### Are ICF-IID claim submissions entered as institutional claims?

Yes, ICF-IID claims are Long-Term Care claims and are entered as **an** institutional claim **type** within PNM.

## Professional

### Can you bill multiple providers on one claim for each charge?

No, you must bill charges for providers on separate claims. You can only submit one rendering provider per professional claim form. The rendering provider must be at the header level.

Of note, this does not apply to FQHC or RHC claims. To align with federal and state regulations, FQHCs and RHCs must report individual rendering practitioners on the detail lines of most of their claims. Reporting requirements for individual rendering practitioners employed by FQHCs and RHCs can be found in MAL 622/622A. ODM is currently updating FI to require the reporting of rendering providers on the detail lines of most FQHC and RHC claims (except on the T1015).

### T1015 is always line/item number one for an FQHC and RHC, will this remain the same in PNM?

Yes, for FQHC and RHC services, HCPCS code T1015 is still used as the procedure code as this identifies an all-inclusive clinic visit.

### Should other payer information be added at the claim/header level or at the detail/line level?

Dependent on how the other payer adjudicated the claim will determine where the provider should enter the information (header vs. detail). Providers should refer to the other payer's remittance advice to determine if the claim was adjudicated at the header or detail (line by line) level.

### For hospice services (T2042) and hospice room & board (T2046) are these submitted under professional or institutional?

All fee-for-service hospice claims are submitted through PNM on a professional claim, including T2042 and T2046 (for room and board). Hospice providers should follow the instructions from the plans on how to bill hospice services for individuals enrolled in a managed care plan.

### What if I have more than one note to enter, how do I do that?

PNM currently only allows a single (maximum of 80 character) provider note to be entered on a professional claim submission. The notes being entered must conform to that requirement. If you need to provide additional information, you can attach a document (such as a Word document with notes) under the 'Attachment' section/panel.

### Can we change the sequence of the diagnosis codes?

The diagnosis codes are sequenced in the order they are entered and cannot be altered.

### Do we list the same provider as the Rendering Provider and Referring Provider on the claim submission?

The Rendering Provider is the person or company (laboratory or other facility) who rendered the care. The Referring Provider is the individual who directed the patient for care to the provider rendering the services being reported. In most cases, this would not be the same provider.

### Is a rendering provider the same as an ordering provider?

No, the Rendering Provider is the person or company (laboratory or other facility) who rendered the care. The Ordering Provider is the individual who requested the services or items being reported on the service line.

### Do hospice providers need to list ordering provider information?

Yes, hospice providers are required to add the ordering provider information on each service line item. For example, if you have three claim detail lines, you will have to enter the ordering provider three times, once for each detail line.

### How does PNM decipher TU and U2 billing?

Procedure code modifiers will be used in adjudication by the Fiscal Intermediary (FI). PNM is collecting the information for modifiers under the 'Service Details' section/panel.

### Does ODM have a list of acceptable modifiers that can be used on claim submissions?

Yes, a list of acceptable ODM modifiers can be found here.

# Prior Authorization

### Will providers still be able to submit prior authorizations through the Managed Care Organizations?

Prior authorizations for Managed Care Organizations will continue to be submitted through the managed care plan portals. Prior authorizations for fee-for-service are the only PAs that can be submitted through PNM.

### What is the maximum file size for an attachment on a prior authorization submission?

10 MB is the maximum file size per document upload in PNM. A maximum of 10 documents can be uploaded on a submission.

### When do I obtain the prior authorization number?

The Prior Authorization number is returned once the authorization has been submitted and accepted by fee-for-service for processing. This should occur in near real-time from the time of submission and the prior authorization number will display on the submission confirmation message.

### On Service Detail section, what is FDOS and TDOS and what date span should be used?

These are the abbreviations for “From Date of Service” and “To Date of Service”. This is the timeframe that you would enter for the Prior Authorization request. The date span for a prior authorization should be based on services being requested or ODM policy for services being requested.

### For residential treatment are we entering the social worker’s NPI or the organization's NPI under Service Provider Information?

The service provider is the provider that is rendering the service. The organization is not licensed to perform a service, so the social worker would be listed under the Service Provider Information.

### Under which prior authorization type does outpatient hospital physical, occupational and speech therapy fall?

If the hospital is being paid for the therapy because it is their staff performing the service, the prior authorization would be entered as Institutional. Only select ‘institutional’ if the service is being performed in the hospital setting and that procedure code (either CPT/HCPCS or ICD-10PCS) requires a prior authorization.

For any outpatient hospital services that do require PA, you would select prior authorization for outpatient hospital. The EAPG covered code list on the ODM website identifies which procedure codes require a PA.

### What if we are submitting a specific procedure code for a specific physician, but work for an institution? Do you submit under an Institutional or Professional prior authorization?

If you are a professional medical group performing the service, the prior authorization should be entered as a Professional type. The prior authorization type should match the claim type that is submitted for those services.

### Which provider type is chosen for Behavioral Health organization-residential treatment?

Residential treatment for substance use disorders is currently covered by Medicaid and available through Substance Use Disorder Treatment facilities certified by the Ohio Department of Mental Health and Addiction Services. SUD Facilities bill for services rendered using a professional claim.

**Under the required section of Recipient Information on the prior authorization submission, if Date of Birth (DOB) was not entered when client registered for Medicaid initially, can this be bypassed?**

Since this is listed as a required field during the prior authorization submission, it cannot be bypassed. The date of birth field must be completed under the Recipient Information section.

**Does the 'requested dollars' field need to be completed for multiple outpatient therapy visits?**

Providers are required to submit their Usual and Customary Charge on prior authorizations. This is the same amount that you request and bill from all payers, whether it be cash, commercial insurance, or Medicaid.

The requested dollar amount should be entered for all units being requested. For example, if your Usual and Customary Charge is $5 per unit and you are submitting a prior authorization for 5 units, you indicate the number of units and then the requested dollar amount would be the total of $25.

**As an outpatient hospice provider that services patients at home and in multiple long-term care facilities, which type of prior authorization should be submitted?**

Hospice services under fee-for-service do not require prior authorization.

**Regarding to the Reconsideration Process: Is the time limit of 60 days from the denial of the prior authorization and the date of the letter of denial?**

According to the OAC 5160-1-31 Prior Authorization rule, the request for reconsideration must be received by the Ohio Department of Medicaid, or its designee, within sixty (60) calendar days of the notification to the provider of an adverse determination.

**Will the prior authorization decisions be faxed or mailed to providers?**

For fee-for-service prior authorizations, those letters are mailed. Letters can also be accessed through the Provider Correspondence link/option under the Self Service panel in PNM.

**Is there an estimated turnaround time for prior authorizations to be completed?**

There is a 10-calendar-day turnaround time for non-urgent services. For urgent services, turnaround time is 48 hours. Timeframes are stipulated in Section 5160.34 of the Ohio Revised Code.

**Would an inpatient psychiatric admission be considered an urgent request?**

All fee-for-service psychiatric admissions require pre-certification unless Medicare is the primary payer. FFS psychiatric pre-certification requests must be submitted within two business days of admission. The only exceptions for accepting pre-certification requests beyond two business days of the admission is if the individual is ineligible or pending Medicaid eligibility at the time of admission, or Medicaid eligibility occurs subsequent to admission. Please refer to OAC rule 5160-2-40 for the complete pre-certification program requirements.

**For reconsideration faxes, is there an option in PNM to print original completed PA so it can also be faxed?**

PNM does not have an option to 'print' prior authorizations within the system.

### How are pharmacy prior authorizations submitted?

The Single Pharmacy Benefit Manager (SPBM) prior authorization team is responsible or responding to prior authorization requests received from pharmacy and physical providers. PNM portal and FI do not handle pharmacy PAs. Those prior authorization requests can be received via:

- A telephone call to the Pharmacy Clinical Help Desk
- Fax
- A paper PA form
- Secure Web Portal (SPBM)

### Can we set templates for prior authorizations in PNM?

PNM does not offer the ability to set templates for prior authorizations, but for approved prior authorizations, a 'Copy' button does display in PNM giving you the ability to copy the approved prior authorization.

### Do hospice providers or palliative care need to submit a prior authorization?

Hospice services under fee-for-service do not require prior authorization. Palliative care services that are not part of the FFS hospice benefit will follow normal policy.

### Will authorizations for Managed Care Organizations (MCOs) eventually be added to PNM?

Yes, that is a function that is planned for a future enhancement to PNM, but there is no date currently on when that function will be available. Prior Authorization submissions for MCOs will continue as they are today (even after June 30, 2024).

### If requesting more therapy visits on a prior authorization, how would this be indicated?

When creating the new prior authorization, enter the previous/related prior authorization number under the "Associate PA No" box under the 'Service Information' section to indicate to the reviewer that the new prior authorization submitted is related to a previously submitted prior authorization. This could be done for a continuation of service, for example.

### For the 'Place of Service' field, what if services can be in office or telehealth?

For Fee for Service, the Ohio Department of Medicaid has a billing guide on its website where details regarding that entry are listed.

### If someone started service on a weekend, can it be done retroactive on Monday morning?

A retroactive prior authorization can be entered in PNM.

### Can multiple service details be entered in PNM? For example, can I indicate multiple stays over the period of a week?

PNM does allow for multiple service lines of service details to be entered on the prior authorization submission.

### Can we initiate prior authorizations in PNM for chemotherapy cases?

Yes, these can be completed through PNM.

### If a provider bills for occupational therapy and speech therapy for children, can this be submitted on the same prior authorization, or does it need to be two separate entries?

Fee-for-service prior authorizations can accommodate one service provider, but multiple disciplines (procedure codes and service lines) on one prior authorization request.

### If the initial prior authorization request is denied, will we need to appeal or do we need to resubmit new with information to support the medical necessity?

If your initial prior authorization request is denied, there is an option to do an appeal/reconsideration with more supporting information for the request. The general provider appeal procedure is listed in the Ohio Department of Medicaid's (ODM) updated Prior Authorization rule, OAC 5160-1-31, effective 11/27/22. ODM will also post directions on their website as well as in the communication for a denied prior authorization request. As part of the appeal, new information to support the medical necessity can be submitted along with the appeal request.

### If we had a prior authorization approved, but it is for the wrong units or date span, do we need to start a new prior authorization or is there any way to make those changes to the approved prior authorization?

Fee-for-service asks providers to submit a new prior authorization with the changes to the original prior authorization and use the "Associate PA No" field with the original approved PA submission number entered.

### If the PNM portal goes down, is there an alternate process for prior authorization submissions during the downtime?

The Ohio Department of Medicaid's new amendments to the current prior authorization rule (5160-1-31 of the Ohio Administrative Code) provides ODM with the authority to retroactively approve prior authorizations in the case of a system outage or other extraordinary situation. ODM will put out a broad notice to providers to inform them that they will be accepting retroactive prior authorizations if such a situation occurs. As for emergency service situations, the retroactive emergency approval option will continue to exist as it does today.

### We currently are completing a Notice of Admissions form for SUD Residential admission. Will this be completed in PNM?

This function will not be in PNM. You will use the same channels as you do today to submit that information.

### What is the correct prior authorization type to use when requesting prior authorization for SUD Residential and PHP?

PNM displays 'Assignment' options to select for a SUD Partial Hosp Services, SUD Residential Services, and Mental Health Service when submitting a professional prior authorization.

### Is the 'Save' button used if you get called away while entering the authorization or if you find you are missing material needed?

Yes. Both PNM and the OH|ID account have periods where you will be timed out. The 'Save' button will ensure that any data entry that you have made on the prior authorization submission page will be saved for up to 72-hours, where you can come back to PNM and retrieve the 'in progress' submission.

### As a Federally Qualified Health Center (FQHC), how do we submit a prior authorization for dental services?

A FQHC can submit a prior authorization request for fee-for-service dental services through PNM. Review the Dental Prior Authorization Submission (FQHC) Quick Reference Guide posted on the Provider Education & Training Resources page in PNM.

# Hospice Recipient Enrollment

### When will Hospice Enrollment be available in PNM?

Hospice Recipient Enrollment application submission and search functions are available in PNM beginning on June 30, 2024.

### Will hospice allow independent providers to apply?

Independent providers cannot apply to be a hospice provider.

### Where will Hospice Recipient Enrollments take place?

MITS has been completely decommissioned as of June 30th, 2025. The Hospice Recipient Enrollment process is now located in Fiscal Intermediary (FI).

### The Election Date that is required to be entered on the Enrollment and Disenrollment section, is that the same as the effective date?

The Election Date that is entered in that section is the date that the patient elected hospice. This is often the same date as the Effective Date of the hospice benefit span.

### For an additional benefit period, if the initial enrollment was approved can you update that enrollment with the new benefit period information?

Yes, you will add the next benefit period to that HTN once the previous benefit period is processed.

### Will hospices be required to attach the CTIs etc. or will we use the 'Attachment' section/panel in PNM only if Medicaid requests the documents?

A requirement of uploaded documents on a hospice recipient enrollment is a process that has not yet been implemented by the Ohio Department of Medicaid but is planned for some time in the future. Once implemented by ODM, a communication will go out to inform users, and you will use the 'Attachment' section of the hospice recipient enrollment to attach your documents.

### Would the Current Service Span still be chosen if it is a transfer?

If there is a transfer situation, both providers will utilize the same benefit period.

### If an Election Date needs to be corrected or a Hospice Tracking Number (HTN) needs to be removed, do we still need to email as we do today?

Yes, if these processes need to be completed, you will still send an email.

### Are there plans to enroll managed care hospice recipients in the future?

We are not aware of any plans to enroll managed care hospice recipients currently. If that does change, communications will be sent out regarding any new information.

### Will each benefit period require a separate enrollment?

The benefit periods for the same provider and same patient, that are continuous, will go under the same Hospice Tracking Number (HTN).

### If the physician NPI is not listed in PNM to select, who do providers contact?

If there is an NPI discrepancy, providers will need to update first with the NPPES registry as PNM uses the registry to validate what's entered.

### Will the physician information need to be reentered for each benefit period?

Yes, the physician information will need to be re-entered for each benefit period that is added to the hospice enrollment.

### How do providers accurately enter benefit periods for transfer situations, if they cannot select the same day?

They cannot select the same day presently. The current guidance is that the day of transfer is typically a day for the receiving hospice to bill unless it states otherwise in the transfer document.

### Are the hospice spans and provider information going to show in the patient eligibility information in PNM, when clicking 'Check Eligibility'? If so, under which section/panel will this display?

Yes, hospice spans will display under the Benefit/Assignment Plans panel and the hospice provider information will display under the Lock In panel.

## Provider Financials/Remittance Advice

### How far back can Fee-For-Service Remittance Advice documents be pulled in the PNM Portal?

Remittance Advices for Fee-for-Service submitted claims are available in PNM. RAs from the Fiscal Intermediary are available going back to February 1, 2023, while historical Remittance Advice documents can be searched for in PNM going back to August 11, 2011. If an RA cannot be found in PNM, please contact the ODM Integrated Help Desk at 1-800-686-1516 (Option 2) for assistance.

### Will only Ohio Department of Medicaid 1099's be accessible in PNM, or would we be able to pull a 1099 for a Managed Care Organization as well?

Both Ohio Department of Medicaid (ODM) and Managed Care Organization (MCO) 1099s are accessible via PNM.

### How far back can a 1099 document be accessed in PNM?

As of June 30, 2024, a 1099 can be pulled going back to the year 2023. Providers who require a 1099 prior to calendar year 2023 should contact the FI Integrated Help Desk (IHD) at 1-800-686-1516 (Option 1 followed by Option 5).

### If we are already set up to receive Electronic Remittance Advice from Medicaid and the Managed Care Plans, do we have to re-enroll or make changes to our enrollment to continue to receive Electronic Remittance Advice?

If the provider is set up to receive Electronic Remittance Advice from fee-for-service Medicaid, that enrollment will continue and will also direct all their payments from the Managed Care Plans moving forward. No reenrollment is needed.

### Will Remittance Advice for claims that aren't submitted via the PNM Portal be available within PNM?

Yes, claims submitted via the PNM portal or through EDI are available on the ODM produced Remittance Advice via the PNM portal. Managed Care Organization produced Remittance Advice will also be available in PNM. If you have multiple group NPIs how do you toggle back and forth between them?

You will need to make the selection from your dashboard. You can click the 'home' icon to return to your homepage, and then select the other NPI/Medicaid ID that you wish to view.

### Is the provider financials area where we would go to look for claim information for a specific client/patient?

This area is more of the provider financial document information. You can see a summary of claims, using the transaction summary. To see a specific claim that was submitted, you can use the claim search function in PNM, after choosing the Medicaid ID/NPI under which the claim was submitted.

### If a provider has claims amounts that are being recouped from overpayment would that amount appear in the Credit Balance section of Transaction History?

Yes. Amounts to be recouped once a receivable is created would appear here.

### Is the payment schedule for claims after June 30, 2024, the same as it is today?

The payment schedule as of June 30, 2024, will not differ from the current payment schedule.

### If we download a remittance advice, will that document still be available for others as well?

Yes, other users with access (Provider Administrator or Provider Agents) to that Medicaid ID will be able to pull that information also. You won't 'remove' it by downloading it.

### Will the transaction history be based on date of service; date claim is submitted, or date claim is paid?

The Transaction History is based on the date claim is paid or in other words Paid Claim Date. The Transaction History data is pulled based on the date of the inquiry, as there are no date search options for this feature.

### Once this next stage of PNM goes live for claims, will these rejection and denial responses continue to be returned together in the same 277 response pathway, or will there be a separation and more clear differentiation between these two populations of claims (rejected vs. denied)?

In the new EDI, the trading partner will still get the 999 to identify whether their File has been accepted. They will also get an 824 transaction to identify individual claims which have been REJECTED. The U277 (unsolicited) will continue to only report claims which will either be paid or will be denied once adjudicated by FI. Further information for future state EDI can be found on the ODM companion guides found on the ODM website: Companion Guides | Medicaid (ohio.gov) (https://medicaid.ohio.gov/resources-for-providers/billing/hipaa-5010-implementation/companion-guides).

# Recipient Eligibility

### How far back can we pull eligibility for?

When searching for a recipient's eligibility in PNM, the search page allows for a 'From Date of Service' to be entered up to 4 years (48 months) prior to the date you are searching.

### If you are the Provider Administrator for multiple providers, can you check the eligibility for anyone under one of those providers? Or do you have to choose the specific provider from your dashboard?

You will not have to change providers (click on different Reg ID or Providers from your dashboard) to view different recipients. If you can get to the self-service selections and click on the Recipient Eligibility link, you can look up any recipient if you have their information (Medicaid Billing Number or SSN and Date of Birth).

### Is the MMIS number the number that should be used as the billing number for all plans?

Yes, if by "MMIS" number you are referring to the Member Medicaid ID, that is the only number you need for billing going forward.

### I see there is a Procedure Code search in PNM, will we be able to search how many times a client has had (H2036 or H2034) billed for the calendar year so that we can determine if we need to submit a PA request for our SUD Residential Stay?

The 'Procedure Code' option within the eligibility search is used for searching specifically for Service Limitations that the recipient may have for that procedure (Ex. Timeframes, or certain number of visits). The results only return data based on claims received to date and may not reflect all services a member has received.

### Does the procedure code field accept revenue codes as well for providers that don't use HCPCS?

Only HCPCS codes (including CPT codes) can be entered in the 'Procedure Code' field, which would return information related to any service limitations in place for that procedure code. Neither revenue codes nor ICD 10 procedure codes can be entered in this field and those codes do not appear on the eligibility response.

### Will we still be able to see the Patient Liability for Long-Term Care?

Patient Liability is a section/panel of information that is returned from the Fiscal Intermediary (FI) to PNM during the eligibility search.

### I am an Agent in PNM but do not see the 'Recipient Eligibility' option appearing under my self-service selections. Why is this?

To have the 'Recipient Eligibility' link/option appear under self-service selections as an Agent, the Administrator for the Medicaid ID number you selected from your homepage/dashboard will need to assign you the *'Eligibility'* role/action under the Account Administration button.

### How can eligibility be searched if there are no providers to choose from on the dashboard to get to the eligibility button?

A user of PNM (Administrator or Agent) will need to have at least one provider showing on their homepage/dashboard to access the Self-Service selections, where the 'Recipient Eligibility' option is chosen.

**As far as Benefit/Assignment Plan information that displays, is there one for Mental Health Coverage?**

The Benefit/Assignment Plan display should be very similar to what you are used to seeing today. For example, one Benefit/Assignment Plan for mental health is Ohio Mental Health, another one is Psychiatric Res Treat Fac.

**With this new PNM eligibility, will the managed care websites go away? Will all the managed care information be acquired in PNM instead of each individual website?**

Although you can check for managed care eligibility using PNM, the managed care websites will remain active.

**Will the dates auto-populate in PNM to the date of search?**

The 'From DOS' and 'To DOS' fields will require manual entry when completing an eligibility search.

**How far in advance can you set the 'TO DOS (Date of Service)' date on the eligibility search?**

The 'TO DOS' date cannot be entered past today (the date of the inquiry). However, in the response received, if there is eligibility through the end of the month, the 'End Date' will display the last day of the month.

**Will Medicaid Schools show under Benefit/Assignment Plan section?**

The Benefit/Assignment Plan display should be like the PNM displayed information. Medicaid Schools display as "Medicaid Schools."

**Where do you see if the recipient is a Qualified Medicare Beneficiary (QMB) or a Specified Low-Income Medicare Beneficiary (SLMB), etc.?**

The Benefit/Assignment Plan display should be like the PNM displayed information. QMB displays as "Qualified Medicare Beneficiaries" and SLMB is "SLMB." Primary insurance information will be in the TPL or Medicare field.

**If a Medicaid recipient goes to jail their coverage changes to Inpatient Hospital Services Plan and will not pay for Behavioral Health. Will this information be shown on the eligibility?**

The Benefit/Assignment Plan display should be like the PNM displayed information. Incarcerated members coverage will show as "Inpatient Hospital Services Plan."

**When searching by criteria other than Medicaid Billing Number, will PNM return multiple active Medicaid Billing Numbers when they are active at the same time?**

In rare circumstances, if a search is conducted using a Social Security Number (SSN) and Date of Birth (DOB), there could be multiple records returned if the accounts have not been merged.

**If/when Third-Party Liability/Commercial Insurance information is returned, is this only sourced from Ohio Medicaid or is it sourced from the Managed Care Entities?**

Third-Party Liability information is provided from Ohio Medicaid. Updates received from the Managed Care entities or self-disclosed is provided to ODM and updated within the system and reported with the next inquiry.

**How can I update Third-Party Liability eligibility for Medicaid?**

You can send the 6614 Health Insurance Fact Request form in an email to tplfax@medicaid.ohio.gov or send a fax to 614-728-0757.

### What information will show for the Managed Care plan when searching for recipient eligibility?

The Managed Care Plans panel will show all managed care plans the provider is enrolled in for the DOS searched, including OhioRISE. OhioRISE information may, in addition, display under the Benefit/Assignment Plan panel/section.

The Plan Name, Payer ID, Plan Description, Effective Date, End Date, and Managed Care Benefit information is what displays within the returned data under the Managed Care Plans.

Dual benefits are not identified in the current system and the results will simply provide the Anthem plan if there is one. If there is Third-Party Liability and Medicare, that information is provided as well.

If the recipient is not enrolled with a Managed Care Plan, the panel will still display, but it would be blank (no information showing under the section heading).

### Which Medicaid Billing Number will display under the Associated Child(ren) section?

Each child associated to the recipient will have their own Medicaid Billing Number that will display in the section.

### Is a Long Term Care (LTC) restricted period considered a "Service Limitation" where we'd have to enter a procedure code?

An LTC restricted period would display under the 'Restricted Coverage' panel/section and would not need to have a procedure code listed.

### Will the Medicare section/panel show the name of the Medicare HMO Plan C?

No, the name of the Part C plan is not a data point returned from the Fiscal Intermediary (FI). Although this information will not be displayed when the new features launch in PNM on June 30, 2024, it is planned to be added in the future.

## Glossary

**ATN – Application Tracking Number**
An identification number was formerly used to track applications in the now decommissioned MITS portal.

**CLIA – Clinical Laboratory Improvement Amendments**
A body regulating laboratory testing and requirements for clinical laboratories to be certified by the Center for Medicare and Medicaid Services (CMS) before they can accept human samples for diagnostic testing.

**Covered Services**
Those medical services set forth in rule 5160-26-03 of the Administrative Code or a subset of those medical services.

**CPC – Comprehensive Primary Care**
A patient-centered medical home program, which is a team-based care delivery model led by a primary care practice that comprehensively manages a patient's health needs.

**CTI – Certification of Terminal Illness**
A summary or narrative designed to explain clinical findings that support a life expectancy of six months or less which is composed by the hospice physician.

**DODD – Ohio Department of Developmental Disabilities**
An administrative department of the Ohio state government is responsible for overseeing a statewide system of supportive services that focuses on ensuring health and safety for people with developmental disabilities.

**EFT – Electronic Funds Transfer**
A digital transfer of monetary funds through an online payment system.

**EOB – Explanation of Benefits**
Otherwise known as "explanation of payment (EOP)," or "remittance advice (RA)," means the information sent to providers and/or members by any other third-party payer, or MCE, to explain the adjudication of a claim.

**FI – Fiscal Intermediary**
A data storage system that serves as an intermediary between Medicare and health care providers and beneficiaries.

**FQHC – Federally Qualified Health Center**
An entity that meets the definition of FQHC set forth in 42 U.S.C. 1395x(aa)(4) (October 1, 2021).

(1) "FQHC look-alike" is an FQHC that does not receive Public Health Service Act (PHSA) grant funding.
(2) "Government-operated FQHC" is an FQHC operated by a state, county, or local government agency.

**HCPCS – Healthcare Common Procedure Coding System**
A collection of standardized codes that represent medical procedures, supplies, products and services.

**HTN – Hospice Tracking Number**
An identification number used to track hospice recipient enrollment applications.

**ICN – Internal Control Number**
A unique identification number assigned to each Medicaid claim to track and process payment for services provided to beneficiaries.

**IHD – Integrated Help Desk**
A support phone number, 1-800-686-1516, users can contact for assistance with Ohio Department of Medicaid questions or using the PNM system.

**IOP – InnovateOhio Platform**
Fuels online access to state data and government services with nationally recognized digital products, self-service data analytics capabilities and secure data sharing.

**JFS – (Sometimes as ‘ODJFS’) The Ohio Department of Job and Family Services**
The state of Ohio entity that develops and supervises the state's public assistance, workforce development, unemployment insurance program, child and adult protective services, adoption, child care, and child support programs.

### MCD ID – Medicaid Login Identification

The username login a user enters to access the MITS portal.

### MCE – Managed Care Entities (also referred to as MCP – Managed Care Plans or MCO – Managed Care Organizations)

Managed care entity (MCE) means a managed care organization, the single pharmacy benefit manager, a MyCare Ohio plan as defined in rule 5160-58-01 of the Administrative Code, and the OhioRISE plan as defined in rule 5160-59-01 of the Administrative Code. Managed care organization (MCO)" has the same definition as in 42 C.F.R 438.2 (October 1, 2021) and is a health insuring corporation (HIC) licensed in the state of Ohio that enters into a managed care provider agreement with ODM.

### Medicaid Wraparound Payment

An amount that is paid by ODM to augment the payment made by an MCE to an FQHC or RHC. It equals any positive difference obtained when the MCE payment is subtracted from the per-visit payment amount (PVPA) for the visit.

### MITS – Medicaid Information Technology System

The system previously used as the primary portal to access data for enrolled Medicaid providers or to apply as a newly enrolling Medicaid provider. MITS will be phased out as the primary portal and has now been decommissioned entirely, replaced by as the Provider Network Management (PNM) System as the single source of truth.

### MMIS – Medicaid Managed Information System

An integrated group of procedures and computer processing operations (subsystems) developed at the general design level to meet principal objectives.

### NPPES – National Plan and Provider Enumeration System

A database which provides basic information about all organizations and individual providers with a National Provider Identifier (NPI).

### NPI – National Provider Identifier

A unique identification number for covered health care providers.

### ODA – Ohio Department of Aging

An administrative department of the Ohio state government responsible for delivery of services and support that improves and promotes quality of life and personal choice for older Ohioans, adults with disabilities, their families, and their caregivers.

### ODH – Ohio Department of Health

An administrative department of the Ohio state government responsible for coordinating activities for child and family health services, children with medical handicaps, early intervention services, nutrition services, and community health services; ensure the quality of both public health and health care delivery systems; and evaluates health status, prevents, and controls injuries and diseases (chronic and infectious) and promotes good health.

### ODM – Ohio Department of Medicaid

An administrative department of the Ohio state government responsible for improving wellness and health outcomes for individuals and families by delivering health care coverage to more than 3 million residents of Ohio through a network of more than 165,000 providers.

**OH|ID – Ohio's Digital Identity**
A single account allows users to access various websites used by agencies throughout the State of Ohio.

**OMES – Ohio Medicaid Enterprise System**
Group of systems used to complete enrollment, claims processing, and other transactions for the Ohio Department of Medicaid.

**PCW – Provider Certification Wizard**
A web poral used by providers to access information and complete processes for the Ohio Department of Aging.

**PHE – Public Health Emergency**
A declaration made by the Secretary of the Department of Health and Human Services to take certain actions in response to the handling of an actual or potential public health crisis. The PHE referred to in this document is related to COVID-19.

**PNM – Provider Network Management (System)**
The system was used as of October 1, 2022, to access data for enrolled Ohio Medicaid providers or to apply as a newly enrolled Medicaid provider.

**PSM – Provider Services Management**
A web poral used by providers to access information and complete processes for the Ohio Department of Developmental Disabilities.

**RA – Remittance Advice**
*See EOB – Explanation of Benefits.*

**Reg ID – Registration ID**
An identification number used to track applications in the PNM system.

**RHC – Rural Health Clinic**
An entity that meets the definition of RHC set forth in 42 U.S.C. 1395x(aa)(2) (October 1, 2021).

**TPL – Third Party Liability**
The payment obligations of the TPP for health care services rendered to a member when the member also has third party benefits as described in paragraph (EEE) of this rule.

**USPS – United States Postal Service**
The database from which addresses are verified in PNM.