Ohio | Anthem Blue Cross and Blue Shield Medicaid
Ohio Medicaid Managed Care

Doulas

Anthem

Enrollment

Prerequisites:

- Obtain an NPI.
- Obtain an Ohio Board of Nursing certification.
- All Medicaid care providers in Ohio need an Ohio Identification (OHID), the state of Ohio's digital identity standard, to access Medicaid's Provider Network Management (PNM) module. To create a new OHID, visit OHID (ohio.gov).

All care provider enrollment applications are submitted using Medicaid's Provider Network Management (PNM) module. The PNM module is the single point for care providers to complete care provider enrollment, centralized credentialing, and demographic updates.

To begin enrolling, visit the Ohio Department of Medicaid (ODM) credentialing application homepage: Provider Network Management module.

Enrollment (cont.)

Independent doulas — professional claim payments (PT09)

Care providers — Professional claims can be submitted on behalf of a doula, either independent or nondependent, for services covered by the doula:

- Ambulatory healthcare clinic (PT 21)
- Federally qualified health center (FQHC) (PT 12)
- Freestanding birth center (PT 11)
- Hospital (PT 02)
- Professional medical group (PT 21)
- Rural health clinic (RHC) (PT 05)

All individual care providers and professional medical groups who bill for Ohio Medicaid services must have an Ohio Medicaid number. A doula may be independent, meaning they will bill services under their own tax ID, or be affiliated with a professional medical group that bills services on their behalf. Any doula affiliated with a professional medical group must make that affiliation on the PNM website. More information can be found at PSE Provider Registration Portal — Resources (OHPNM).

Contracting

To initiate contracting, visit our website, select Join Our Network, and follow the prompts for your care provider type.

Care providers already contracted with us for Medicaid in Ohio and wish to add a care provider to their group should submit their information through the PNM module and select **Anthem** on the MCP affiliation page.

Care provider revalidations

All care providers are subject to provider agreements limited to three or five years. Before termination, letters are mailed and emailed every 120 days, 90 days, and 60 days, with a final notice every 30 days. Care providers who do not submit their revalidation could experience termination at the state level, which would cascade to the managed care entities (MCEs), causing claim disapproval as a nonparticipating provider. Emails will come from ohpnm@maximus.com.

Revalidation notices are posted in the PNM module and can be accessed in the correspondence folder. Care providers will also see a begin revalidation option in the PNM Enrollment Action Selection 120 days before the Medicaid Agreement end date. Care providers can locate this under the Manage Application, then the Enrollment Actions option within the provider file. Select **Revalidation/ Reenrollment Quick Reference Guide** for step-by-step instructions.

Care providers who need technical assistance can contact ODM's Integrated Help Desk at **800-686-1516** and follow the prompts for provider enrollment or email ihd@medicaid.ohio.gov.

Member eligibility

Member ID cards

People enrolled with us for Medicaid in Ohio have a Medicaid ID card and have access to an electronic member ID card through the Sydney app.

Note: Unlike the Commercial and Medicare ID cards, the Medicaid for Ohio cards do not have an alpha prefix before the member ID number.

Determining eligibility

Care providers who have an ODM-approved established trading partner can check eligibility through:

- ODM's Provider Network Management (ohio.gov)
- https://Availity.com

Care providers who do not have a relationship with an established ODM trading partner can check eligibility through:

- https://Availity.com
- Contacting Provider Services at **844-912-1226**, TTY 711

Working with us to serve Medicaid members in Ohio

Doula claim reimbursement

T1032:

- Services performed by a doula birth worker per 15-minute unit
- $12.50 per unit, up to $600
- Up to 48 15-minute units at any time from the first prenatal visit to 12 months postpartum
- Telehealth services require appending the GT modifier

For more information visit:
Rule 5160-8-43 — Doula Services (ohio.gov)

T1033:

- Services performed by a doula during a member's delivery
- $600 flat rate, regardless of the length of the birth

Submitting claims

Care providers who have an established ODM trading partner

Submit claims and associated attachments through ODM's fiscal intermediary through an approved trading partner:

- Our payer ID: 0002937
- Trading Partners (ohio.gov)

Care providers who do not have an established ODM trading partner

Care providers will enter claims via direct data entry at https://Availity.com.

An Ohio Medicaid doula claims submission course is available in Availity Essentials here.

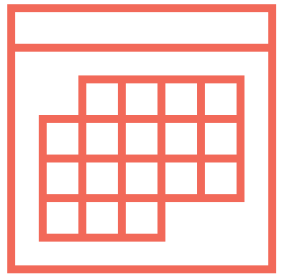
Doula claim submission FAQ: Doula claim submission FAQ - Provider News

Submitting claims (cont.)

Timely filing requirements

Filing limits are determined as follows:

- If we are the primary payer, timely filing is 365 days from the date of service or date of discharge on the claim, unless your contract states otherwise.



Checking claim status

Care providers can check claim status via the following methods:

- Submit an inquiry by way of EDI through their approved ODM trading partner.
- Check the claim status on https://Availity.com:
  - Select **Login** or **Register** to access the secure site.
  - Homepage > Claims & Payments > Claims Status
- Watch for and confirm plan electronic reports from your vendor/clearinghouse. If you use Availity Essentials as your clearinghouse, view reports under EDI Clearinghouse/Send and Receive Files to ensure your claims have been accepted.
- Calling Provider Services at **844-912-1226**.
- ODM Integrated Help Desk at **800-686-1516**.

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EFT and ERA

EFT

Electronic claims payment through EFT is a secure and fast way to receive payment, reducing administrative processes. EFT deposits are assigned a trace number matched to the 835 ERA for simple payment reconciliation.

Use EFT Enrollment Hub (payeehub.org) to register and manage EFT account changes.

Note: Commercial policies with us continue to be registered and managed by Availity Essentials.

ERA (835)

The 835 eliminates the need for paper remittance reconciliation.

The ERA (835) must be registered with ODM for the Medicaid plan.

Please work with your vendor or clearinghouse to enroll your 835s with ODM.

Use Designation of an 835 Trading Partner (PDF) to submit your 835 registration to ODM.

Claim payment — dispute and appeal process

First level — claim payment dispute

This is the initial request for an investigation into the claim's outcome. Most issues are resolved during this process.

If a care provider is dissatisfied with the outcome of a dispute determination, they may submit a claim payment appeal.

Second level — claim payment appeal

If the dispute does not resolve the issue, a more thorough analysis will occur using all applicable statutory, regulatory, contractual, and subcontract provisions, our policies and procedures, state policies, and all pertinent facts submitted by all parties.

Appeals must be submitted within 12 months from the date of service or 60 calendar days after the payment, the disapproval, or the partial disapproval of a timely claim submission, whichever is later.

Claim payment — dispute and appeal process (cont.)

The care provider or the care provider's authorized representative may submit a claim payment dispute, or appeal in one of three ways:

- **Website request:** Use the Availity Essentials Payment Dispute Tool at https://Availity.com. Through Availity Essentials, you can upload supporting documentation and receive immediate acknowledgment of your submission.
- **Written request:** Include any necessary supporting documentation and mail to:
  - Anthem
    Provider Payment Disputes Unit
    P.O. Box 62500
    Virginia Beach, VA 23466-1599
- **Verbal requests: 844-912-1226**, Monday through Friday, 8 a.m. to 5 p.m. ET
  Note: Do not use this option to include supporting documentation (for example, an EOB, Consent Form, or medical records).

The request should include:

- Your name, address, phone number, email, and NPI or TIN.
- The member's name and ID number with us.
- A list of disputed claims, including the claim number and the date(s) of service(s).
- All supporting statements and documentation.

Prior authorization

Prior authorization lookup tool

Requirements for outpatient services can be viewed using the prior authorization lookup tool at our provider website. Search by market, member product, CPT®/HCPCS code, code description, or drug name.

Services may be listed as requiring prior authorization that may not be covered benefits for a particular member. Please verify benefit coverage before rendering services.

Prior authorization submissions and status

To request prior authorization, a doula can submit through the Interactive Care Reviewer (ICR) located in Availity Essentials (https://Availity.com) or by faxing to **877-643-0672**.

The authorization status can be checked by using ICR in Availity Essentials.

Authorization review timeframes

Timeliness of utilization management decisions:

- Nonurgent preservice requests — 10 calendar days
- Urgent preservice requests — 48 hours
- Concurrent reviews — 0 to 72 hours

Emergency medical services:

- We do not require prior authorization to treat emergency medical conditions or post-stabilization services. Members may remain in an observation status for 48 hours. In an emergency, members may access emergency services 24/7. If the ER visit results in the member's admission to the hospital, care providers must contact us within 48 hours.

Preservice appeals

If an authorization is not approved before the service is rendered to the member, the care provider also has the option to file an appeal directly with us, not requiring the member's consent.

Care provider appeals can be submitted in the following ways:

- Electronically, using ICR in Availity Essentials on https://Availity.com
- Fax **866-587-3316** (Appeals Department)

If filing without member consent, appeals must be submitted within 30 calendar days from the initial determination. If filing on behalf of a member, care providers have 60 calendar days from the initial determination to submit their clinical appeal along with the member’s consent.

We will decide within 10 calendar days for nonurgent services and 48 hours for urgent care services.

Appeals submitted by care providers without the member's consent are not eligible for state fair hearings; however, care providers may request an additional external medical review (see external medical review process).

Provider post-service authorizations

If services have been rendered to the member, care providers should file a claim payment dispute so that a medically necessary review will be completed. Care providers must include medical records and provide the extenuating circumstances for not submitting the prior authorization.

Disputes are to be submitted within 12 months from the date of service or 60 calendar days from the date on the Explanation of Payment, whichever is later.

Should the care provider disagree with the outcome of the review, a clinical appeal can be submitted:

- Appeals must be submitted within 30 calendar days from the initial determination. We will send the care provider a written acknowledgment of the appeal within three business days of receipt.
- We will respond to these appeals within 30 days.
- Care providers who have exhausted appeal rights can request an external medical review. (See EMR process.)

For instructions on how to file a claim payment dispute, refer to the claim payment dispute slide.

To file a clinical appeal:

- Electronically: Use ICR in Availity Essentials at https://Availity.com.
- Fax: **866-587-3316** (Appeals Department)

External medical review

Services not approved for reasons other than lack of medical necessity (for example, not covered by Medicaid) are not subject to external medical review.

You have the right to request an external medical review within 30 calendar days of our decision not to approve, limit, reduce, suspend, or conclude a covered service for lack of medical necessity. The external medical review is available at no cost to you.

The request for external review must be submitted to Permedion within 30 calendar days of the written notification that the internal appeals process has been exhausted. Care providers must complete the Ohio Medicaid MCE External Review Request at Permedion - Gainwell Technologies.

Care providers must upload the request form and all supporting documentation to Permedion's provider website at ecenter.hmsy.com (current users); new users will send their documentation through secured email at imr@gainwelltechnologies.com to establish website access.

Availity Essentials and resources

Availity Essentials and training resources

Availity Essentials

Availity Essentials (https://Availity.com) is a website used by care providers to securely access patient information, such as eligibility, benefits, claim status, authorizations, and other proprietary information.

Healthcare providers can use a single login to access multiple health plan care providers at no cost. The registration process is easy, and multiple resources and trainings are available about site navigation and powerful tools.

Digital Solutions Learning Hub

Provider Education and Training (on24.com) is a one-stop shop for care provider training. It consolidates resources from Availity Essentials and us in an organized, easily accessible format, offering both the latest updates and foundational knowledge:

- Courses
- Live webinars
- On-demand video
- User guides

Resources

- Ohio Department of Medicaid (ohio.gov)
- Doulas
- Our provider website | home
- Provider News
- Provider reference guide: claims disputes and appeals, and clinical appeals for UM decisions | Provider News
- Prior authorization lookup tool
- Provider manuals and guides
- Training academy
- Value Added Services (ohiomh.com)
- https://Availity.com
- Place of Service Code Set (cms.gov)

Thank you

We appreciate you taking the time to attend this training and hope the information covered today answers any of your questions.

In a world of escalating healthcare costs, we work to educate our members about the appropriate access to care and their involvement in all aspects of their healthcare.

We look forward to working with you to continue this education and provide valuable healthcare to our members — your patients.

Contact information:

- Provider website
- Provider Services: **844-912-1226**

Send any questions not covered in this presentation or the FAQ to ohiomedicaidprovider@anthem.com.

Provider Relations territory map (PDF)

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