

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

Nursing facility provider orientation

Agenda

- Ohio Medicaid Managed Care (OMMC):
 - Next Generation managed care plan, enrollment, credentialing, provider revalidations
- Social drivers of health (SDOH)
- Value-added benefits
- Ventilators
- Bed hold days
- Modified Adjusted Gross Income (MAGI) Group VIII members
- Private rooms
- Claims and billing
- Preapproval
- Floor to skilled nursing facility (SNF) process
- Reconsideration and authorization appeals
- Availability Essentials
- Staying connected

OMMC



Anthem in Ohio

- Before the implementation of the Next Generation of Ohio Medicaid Managed Care, we have proudly served as one of the nation's leading health plans individuals in Ohio with our commercial and Medicare plans.
- We now also support Medicaid members in all 88 counties.
- Our Medicaid plan aligns with the Ohio Department of Medicaid's (ODM) goals of putting the individual at the center of focus and improving the design, delivery, and timeliness of care coordination.



Next Generation of Ohio Medicaid Managed Care

ODM has successfully launched:

- **Ohio Resilience through Integrated Systems and Excellence (OhioRISE):** a specialized managed care program for youth with complex behavioral health and multi-system needs:
- **Single pharmacy benefit manager (SPBM):** improved management and administration of pharmacy benefits for managed care recipients:
- **Centralized credentialing and Provider Network Management (PNM):** ODM's single, centralized provider credentialing which allows providers to credential and recredential once at the state level versus a separate additional process done by each managed care entity (MCE) for Medicaid
- **Note:** This does not replace the credentialing and recredentialing process for Medicare or Commercial lines of business.

Next Generation program (cont.)

On February 1, 2023, ODM launched the [Next Generation Managed Care Plans](#) and program requirements, including improvements that support members in accessing the healthcare services and support they need. Also implemented was the new [Electronic Data Interchange \(EDI\)](#), which has increased transparency and visibility of member care and services.

Enrollment and credentialing

Obtain an OH|ID:

- All Ohio Medicaid providers will need an OH|ID, the state of Ohio's digital identity standard, to access Medicaid's new provider network management (PNM) module. To create a new OH|ID, visit ohid.ohio.gov/wps/portal/gov/ohid/home/home.

Enrollment and credentialing:

- All provider enrollment applications must be submitted using Ohio Medicaid's provider network management (PNM) module. The PNM module is the single point for providers to complete provider enrollment, centralized credentialing, and provider demographic updates:
 - To begin the credentialing process, visit [ODM's Credentialing Application homepage](#).

Provider revalidations

- All care providers are subject to either three- or five-year time-limited provider agreements. Before the end of the provider agreement term, letters are both mailed and emailed 120 days, 90 days, 60 days, and a final notice at 30 days.
- Care Providers who do not submit their revalidation could experience the end of their provider agreement at the state level, which would cascade to the MCEs causing claim denials as a non-participating provider. Emails will come from OHPNM@maximus.com.
- Revalidation notices are posted in the Provider Network Management (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 prior to the Medicaid agreement end date. Care providers can locate this under the *Manage Application*, then the *Enrollment Actions* option within the provider file. Select the **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.

Social drivers of health (SDOH)

SDOH programs — employment services

Program overview:

- Support members from those with complex needs to skilled job seekers Who are unemployed/underemployed, seeking career exploration, or looking for educational opportunities.
- Youth between the ages of 6 and 18.

Strategy:

- **Employment Flex Funds** — Flexible funds to support members with Employment-related expenses.
- **University of Cincinnati** — Coursework offered in Career Exploration or Job Search, University of Cincinnati instructors also provide coaching and 1-1 support.
- **TutorMe** — 24/7 online tutoring platform. Connects students with live tutors in over 300 subjects, including a writing lab (ages 6 to 18)

To make a referral:

- Employment referrals at [anthemoh.findhelp.com](https://www.anthemoh.findhelp.com). Enter Zip Code and search **Anthem Blue Cross and Blue Shield**. Select the *Anthem Program card* to see specific program details and referral requirements. Select **Refer** or **Apply Now** and complete the screening form with referral details and contact information.

SDOH — Transportation program

Standard benefit:

We offer non-emergency medical transportation through Access2Care for members needing to travel 30 miles or more for Medicaid-covered medical, vision, dental, and pharmacy appointments.

Value-added benefits (VABs):

We provide 30 round-trips or 60 one-way trips per year for members traveling less than 30 miles to medical appointments and community resources like grocery stores and WIC.

Transportation can include ambulatory sedans, vans, rideshare, bus passes and tickets, wheelchair-accessible vans, mileage reimbursement, and other appropriate modes of transportation. Car seats and wheelchairs are not provided.

Provider scheduling number: 800-304-4953

Transportation services line:

- **800-282-9720** Option 2 for Where's My Ride/Ride Assist. TTY 711 (Monday to Friday, 8 a.m. to 7 p.m. ET)

Member Services:

- **844-912-0938** 48 hours before, up to 30 days in advance (Monday to Friday 7 a.m. to 8 p.m. ET) TTY 711

Urgent or same-day requests are provided for:

- Trips to urgent care
- Hospital/facility discharge
- Chemotherapy
- Radiation
- Dialysis
- OhioRISE members

SDOH — Housing Flex Fund program

The Housing Flex Fund program is intended to prevent, divert, or resolve homelessness among our members by paying housing-related expenses:

- The program is a partnership between us and community organizations that recognize housing as a critical need in our community.
- One-time intervention to help overcome a specific need, such as:
 - Unexpected expenses
 - A health/accident-related loss of work
 - A monetary amount that is a barrier to exiting homelessness

Join our preferred referral network:

- You can email Housingohio@anthem.com to set up a training and overview of program guidelines and make referrals to the Housing Flex Fund program.
- Due to the limited amount of funds; interventions must lead to permanent stable housing.

Common fund requests:

Rental costs

Utility costs

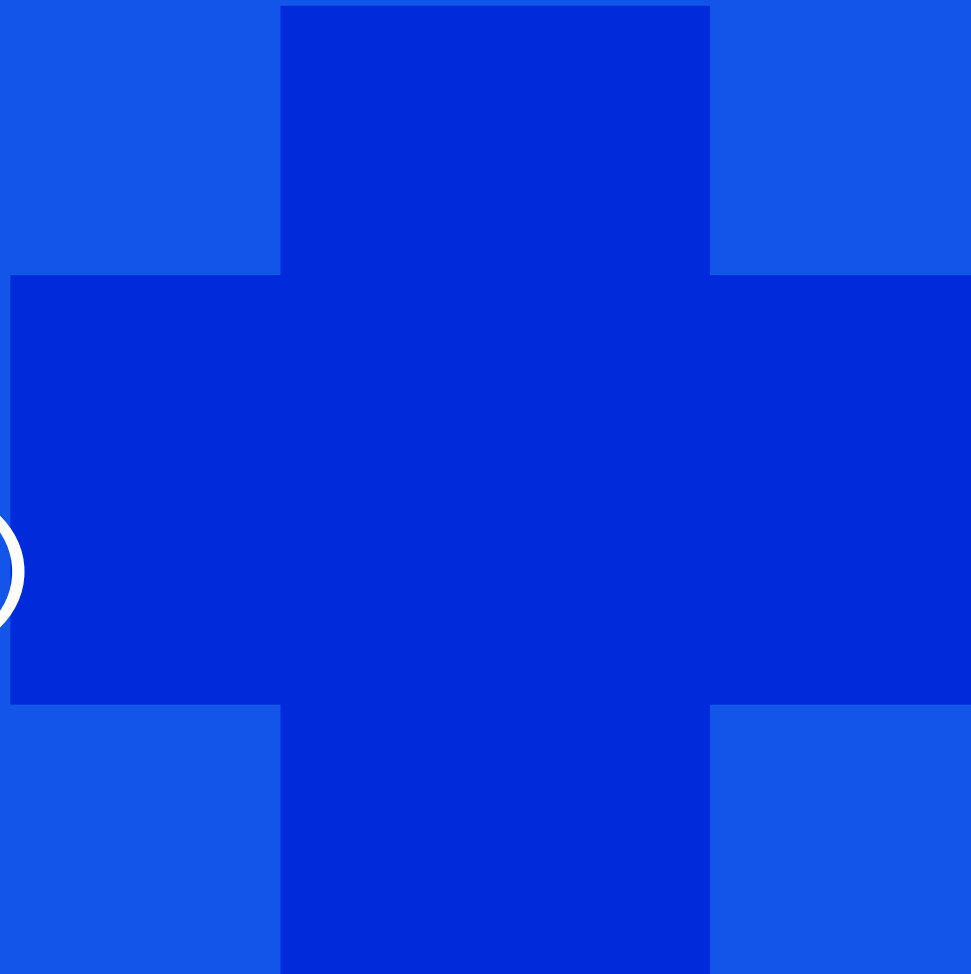
Security deposit

Essential move-in items

Others as approved

Support for a specific critical need

Value-added benefits (VABs)



VABs

- VABs give us the tools — beyond just traditional physical and behavioral care — to help Ohioans reach their health goals. It is about keeping members connected to their community: finding or advancing employment, learning new skills, and even getting organized financially.
- To learn more about VABs visit:
 - [Medicaid Consumer Hotline - Medicaid Managed Care \(ohiomh.com\)](https://ohiomh.com)

Ventilators and Ohio Medicaid Ventilator program

Ventilators and Ohio Medicaid Ventilator program

- OMMC follows [ODM guidance](#) or ventilator billing.
- OMMC acknowledges the facilities participating in the ODM Ventilator program.
- New applicants for the ventilator program will not be approved if they meet at least one of the criteria below:
 - Those who are on Table A or D of the CMS Special Focus Facility (SFF) list
 - Those with a one-star overall rating on the CMS five-star rating system
- [Ventilator Fact Sheet](#)

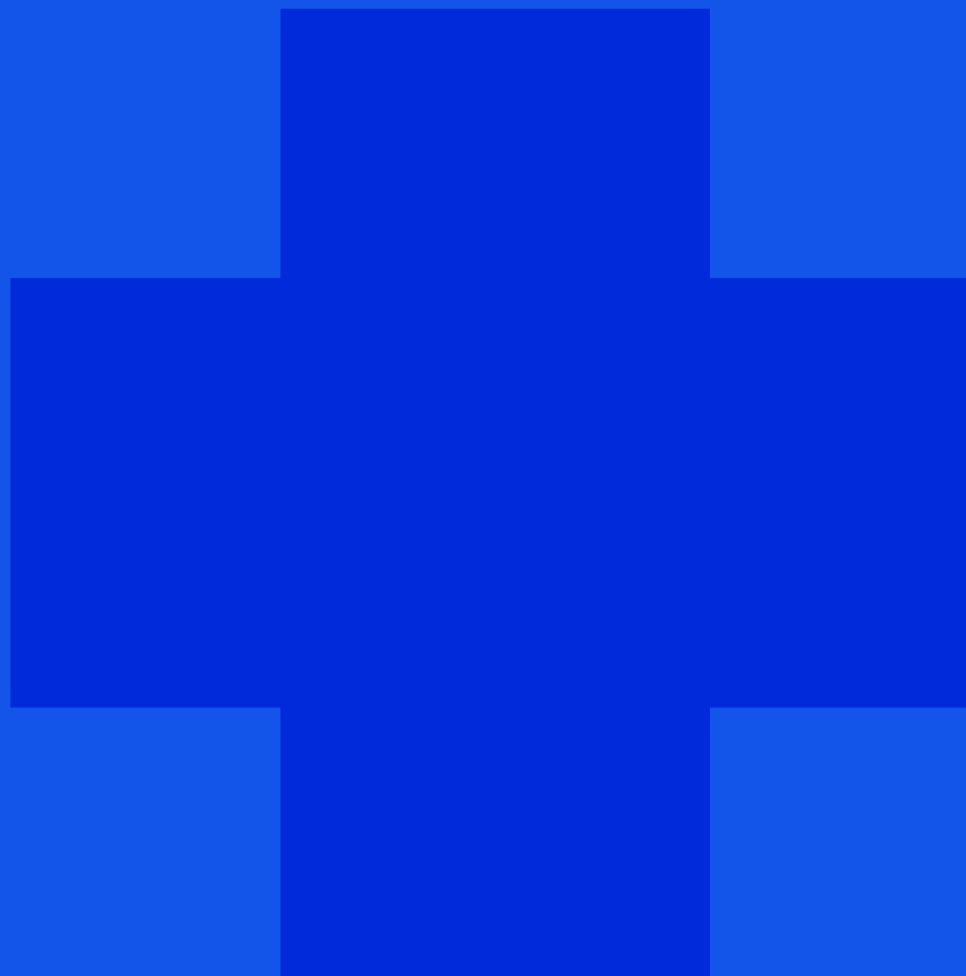
Ventilators and Ohio Medicaid Ventilator program (cont.)

Nursing facilities already approved for the Nursing Facility Ventilator program:

- Starting January 1, 2024, NFs in the ventilator program with a one-star CMS rating or on the SFF list are reimbursed the regular NF per diem rate.
- Facilities removed from the SFF list or improving their rating will regain eligibility for enhanced reimbursement on the date they qualify.

For more information on the CMS SFF List visit: <https://www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcompliance/downloads/sfflist.pdf>

Bed hold days



Bed hold days

We allow 30 calendar days of bed hold per member per calendar year:

- Notification is only required when a member is out of an SNF within 24 hours and returns before midnight.
- If a member is out of the SNF for more than a 24-hour day, a new authorization is required
- Days are covered when:
 - The individual is temporarily absent from the NF for hospitalization, therapeutic leave days, or visits with friends or relatives.
 - Residents intend to return to the facility.
- Payment is regarded as fully compensated. The NF provider must not request any additional payment from the resident.

Bed hold days (cont.)

Bed-hold day exclusions:

- Hospice.
- Institutions for mental diseases (IMDs).
- Home- and community-based services (HCBS) waiver individual using NF for short-term respite care.
- Restricted Medicaid coverage.
- Facility closure and resident relocation.

Bed-hold days are not available to individuals who are discharged, including:

- Those residents who are temporarily or permanently admitted to another NF.
- Exhaustion of NF bed-hold days
- Decision to reside in a community-based setting.
- Death.

Residents eligible for payment of NF bed-hold days must:

- Be Medicaid-eligible and meet patient liability and financial eligibility.
- Meet a NF level of care (LOC) or be using Medicare Part A SNF benefit.
- Not be participating in any excluded categories as indicated in (K) of this rule.

MAGI Group VIII members

MAGI Group VIII members

MAGI Group VIII members are members who had their Medicaid extended in 2016:

- These members had a change in circumstances and didn't report it to the county
- Nursing facilities are responsible for helping the member and the family in notifying the county of any changes the member has had since 2016
- These members will likely qualify for another Medicaid eligibility category
- Individuals and household individuals can report changes they receive for medical assistance using the form below.

Direct link to form:

<https://dam.assets.ohio.gov/image/upload/medicaid.ohio.gov/Resources/Publications/Forms/ODM10203fillx.pdf>



Nursing Facility Private Room

<https://medicaid.ohio.gov/resources-for-providers/enrollment-and-support/provider-types/nursing-facilities/nursing-facilities>

Nursing facility private room

- ODM gave notice on December 4, 2024, that they will begin reimbursing for private rooms at qualifying NFs after December 4, 2024, with dates of service starting December 18, 2024.
- ODM began accepting private room applications on January 1, 2024, for Category 1 rooms, defined as having unshared access to a toilet and sink.
- NFs approved as private room care providers will be assigned a provider specialty code by ODM that allows them to bill for Category 1 private rooms, Category 2 private rooms, or both, based on their application approval.
- ODM has a fact sheet located on the Nursing facility [webpage](#) that explains how NF can apply for private room approval and other helpful information.

Claims and billing

Submitting claims

Providers who have an established ODM trading partner:

- Submit claims and associated attachments through ODM's fiscal intermediary via an approved trading partner.
- Anthem payer ID: 0002937:
 - ODM TP website: medicaid.ohio.gov/resources-for-providers/billing/trading-partners/trading-partners

Providers who do not have an established ODM trading partner:

- Providers will enter claims via direct data entry on Availity Essentials (<https://Availity.com>).
- Registration and contact information:
 - Submit an email to EDI-TP-Comments@medicaid.ohio.gov.
 - Call the Integrated Health Desk at **800-686-1516, option 3**.

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 stated differently in your contract.
 - If the member has other health insurance that is primary, timely filing is 180 days from the date of the *Explanation of Payment* of the other carrier.

Submitting claims for private room

Private Room Service	Specialty Code	Center Code	Rates Effective with 12/18/2024 DOS
Category 1	86A	0119	\$30 add-on per day
Category 2	86B	0129	\$20 add-on per day

Note: Private room add-on days must not be included in the NF's value day reporting of covered and non-covered days on a claim.

Checking claim status

- Providers can check claim status via the following methods:
 - Submit an inquiry via EDI through their approved ODM trading partner.
 - Use Availity Essentials at <https://Availity.com>. Select **Login** or **Register** to access the secure site. From the Availity Essentials homepage, select **Claims & Payments > Claims Status:**
 - Watch for and confirm plan electronic reports from your vendor/clearinghouse or, if you are using Availity Essentials as your clearinghouse, view reports under *EDI Clearinghouse/Send and Receive Files* to ensure your claims have been accepted by Anthem.
 - Call Provider Services at **844-912-1226**.
 - Call the ODM Integrated Help Desk at **800-686-1516**.

Returned claims

We will send providers a request for additional information when the claim cannot be processed due to incomplete, missing, or incorrect information.

We may also request additional information retroactively for a claim already paid.

- Providers with an ODM EDI-approved trading partner:
 - To submit additional or corrected information, you should send directly to your ODM EDI-approved trading partner.
- Providers without an ODM EDI-approved trading partner:
 - To submit additional or corrected information, you should send the following through Availity Essentials.
 - If we request additional information or a correction to a claim, a claim follow-up is needed, and you must submit a corrected claim through your ODM EDI approved trading partner or Availity Essentials within 365 days from the date of service.

Claims overpayment recovery and refund procedure

- We seek recovery of all excess claim payments from the person or entity to whom the benefit check was made payable. When an overpayment is discovered, we initiate the overpayment recovery process by sending written notification.
- If you are notified by us of an overpayment or discover that you have been overpaid, mail a refund check, along with a copy of the notification or other supporting documentation, to the following address:

Anthem
PO Box 933657
Atlanta GA 31193-3657
Fax **866-920-1874**

- If you need to find *The Recoupment Notification Form* and the *Overpayment Refund Notification Form*, they are located on our provider site at <https://providers.anthem.com/oh> > Claims Forms.

Claims overpayment recovery and refund procedure (cont.)

- If a payment, request for extended payment arrangement, or dispute request is not received within 30 calendar days from the date we notify a provider of an overpayment, we will process the recovery and overpaid funds will be applied to the provider's account as a negative balance:
 - If you believe the overpayment notification was created in error, contact Provider Services at **844-912-1226**.
 - For claims re-evaluation, send your correspondence to the address indicated on the overpayment notice. If we do not hear from you or receive payment within 60 days, the overpayment amount will be deducted from future claim payments.

Claim payment — dispute and appeal process

- First level — claim payment dispute:
 - The initial request for an investigation into the outcome of the claim
 - Most issues are resolved during this process
 - If a provider is dissatisfied with the outcome of a dispute determination, the provider may submit a claim payment appeal.
- Second level — claim payment appeal:
 - If the dispute did 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 from all parties.
 - Submit within 12 months from the date of service or 60 calendar days after the payment, denial, or partial denial of a timely claim submission, whichever is later.

Claim payment — dispute and appeal process (cont.)

- The provider or the provider's authorized representative may submit a claim payment dispute or appeal in one of three ways:
 - **Online:** Use the Provider Availity Essentials Payment Dispute Tool at <https://Availity.com>. Through Availity Essentials, you can upload supporting documentation and receive immediate acknowledgement of your submission.
 - **Mail:** Include any necessary supporting documentation and mail to:
 - Anthem
Provider Payment Disputes Unit
P.O. Box 62500
Virginia Beach, VA 23466-1599
 - **Phone:** Call Provider Services at **844-912-1226** Monday through Friday, from 8 a.m. to 5 p.m.:
 - **Note:** If you need to include supporting documentation (for example, *EOB*, *Consent Form*, or medical records), do not use this option.

Claim payment — dispute and appeal process (cont.)

- The request should include:
 - Your name, address, phone number, email, and either your NPI number or TIN.
 - The member's name and their ID number.
 - A list of disputed claims, including the claim number and the date(s) of service(s).
 - All supporting statements and documentation.

Member copayments and balance billing

- There is no cost-share for members enrolled in Medicaid. Members may not be balance-billed by providers for Medicaid-covered services. This means that providers may not collect payment from a member for covered services above the amount we pay to the provider.
- A member may request a noncovered service or a covered service where preapproval was not eligible for reimbursement. When preapproval of a covered service is not eligible for reimbursement, the provider must establish and demonstrate compliance before collecting payment from the member.
- See the provider manual for a complete list of items needed to demonstrate compliance.

Preapproval



Medical Policies and Clinical Utilization Management Guidelines

The decision-making process is based on health plan and state guidelines, as well as NCQA guidelines, and reflects the most up-to-date medical management standards. Authorizations are based on the following:

- Benefit coverage.
- Established ODM-developed criteria or, in the absence of ODM-developed criteria; *MCG; Medical Policies and Clinical Utilization Management Guidelines*; and/or CarelonRx, Inc. criteria, as applicable.
- Community standards of care.

Decisions are based on the appropriateness of care, service, and coverage. We do not reward practitioners for withholding coverage or care, and there are no financial incentives for utilization management decision-makers to promote underutilization.

Preapproval

Definitions:

- Skilled nursing services refers to specific tasks that must, in accordance with *Chapter 4723* of the *Revised Code*, be provided by a licensed practical nurse (LPN) at the direction of a registered nurse or by a registered nurse directly.
- Skilled rehabilitation services refers to specific tasks that must, in accordance with *Title 47* of the *Revised Code*, be provided directly by a licensed or other appropriately certified technical or professional healthcare personnel.

ODM level of care:

- Protective level of care (LOC) is described in the *Ohio Administrative Code (OAC) rule 5160-3-06*; Medicaid will not pay for a nursing facility stay if the individual only meets a protective level of care.
- Intermediate LOC is described in *OAC rule 5160-3-08*; Medicaid will pay for a nursing facility stay if the individual meets an intermediate level of care.
- Skilled LOC is described in *OAC rule 5160-3-08*; Medicaid will pay for a nursing facility stay if the individual meets a skilled level of care.
- *ODM FAQ Nursing Facility Definitions*: [NF-Definitions-Common-Terminology.pdf \(ohio.gov\)](#)
- *ODM FAQ Managed Care and Nursing Facility-Based Levels of Care*: [FAQ-NF-LOC.pdf \(ohio.gov\)](#)

Preapproval (cont.)

How to submit

Care providers can submit an authorization two ways:

- Availity Essentials: <https://Availity.com>
- Fax: 877-643-0671

Timelines:

- Nonurgent preservice: 10 calendar days
- Urgent preservice: 48 hours
- Urgent requests **must** include the word *expedited*.

Note: Preapproval is not required if a member has other health insurance (OHI) or is receiving hospice.

Care providers who receive a denial from the primary payer for authorization should submit a claim with the denial and current medical documentation.

Preapproval (cont.)

Documents needed:

- *Preadmission Screening and Resident Review* -(PASRR) (federally required)
- *Ohio Medicaid Managed Care/MyCare Ohio Nursing Facility Request Form* (federally required)
- Hospital discharge notes
- Nursing facility assessment notes
- Therapy notes (if applicable)
- Medication administration records (MARs)
- Physician signed orders
- Treatment plan including discharge plan
- Any other documentation that will support the member's condition

Note: This documentation is also needed for concurrent reviews.

Out-of-network (OON) provider's process:

- We will pay OON nursing facilities.
- OON providers will need authorization for all services.
- OON providers will follow the normal preapproval process.
- OON rate reimbursement is 100% of the Ohio Medicaid Fee Schedule.

Preapproval status

- Providers can check the status of an authorization by using the Interactive Care Reviewer located within Availity Essentials at <https://Availity.com>.

Floor to SNF process



Floor to SNF process:

- The floor to SNF process helps members move to a skilled nursing facility faster.
- Hospitals and nursing facilities must be in a network for the SNF process.
- All documentation previously mentioned is required in the SNF process.
- Patients should not be transferred without obtaining authorization.
- The authorization must specify the requesting floor and the SNF (Skilled Nursing Facility).
- Certain exclusions apply to this process.

Floor to SNF process (cont.)

Hospital, individual practitioner, or SNF liaison:

- Identifies the member's need for SNF.
- Contacts the SNF to refer the member.
- Evaluates the member by completing the SNF worksheet.
- Verifies member has OMMC.
- Confirms member's six-click score is 18 or below:
 - A six-click score is the measurement of a patient's functional status.

If member qualifies for floor to SNF, we must receive notification of admission within 48 hours or the next business day after admission to the SNF.

SNF sends all documentation: SNF worksheet, initial six-click score, Preadmission Screening and Resident Review (PASRR), and detailed hospital/outpatient clinicals.

Documentation must be sent to us within 72 hours or three business days on weekends or holidays.

Initial therapy evaluation notes must be completed within 24 hours of SNF admission.

If all documentation is received, we will then prenote seven days.

Floor to SNF inpatient Preapproval process

- We require the documentation of the [PASRR form](#) for initial and concurrent stay preapproval requests to an in-network SNF for OMMC members.
- The floor-to-in-network SNF inpatient preapproval process requires the nursing facility and provider to be in-network. A member needs to have a six-click score of 18 or below (physical and occupational therapy) and the member must not meet any of the following criteria for exclusion:
 - Transfer from an acute rehab facility
 - Transfer from a long-term acute care hospital (LTACH) facility
 - Transfer from a psychiatric/geropsychiatric hospital unit
 - Member whose prior level of function (PLOF) is non-ambulatory
 - Member has been admitted to a hospital from a SNF or acute rehabilitation facility.
 - Member was denied an LTACH admission
 - Member was denied a standard SNF precertification request

Floor to SNF inpatient preapproval process (cont.)

- The referring care provider/facility or SNF is required to submit the [Ohio Medicaid Managed Care/MyCare Ohio Nursing Facility Request Form](#) and PASRR form in the initial 24-hour therapy evaluation period and clinical information within three business days after the date of admission to aid in members' care coordination, discharge planning, and member management.
- Documentation listed is required before a final determination is made by the health plan.
- PASRR regulations (Ohio Administrative Code Rule 5160-3-14) require that all individuals seeking admission to a Medicaid-certified nursing facility, regardless of payer source, be assessed for indications of serious mental illness and/or a developmental disability unless the member meets requirements for a hospital exemption.
- If the member does not qualify for the floor-to-SNF preapproval, the referring provider/facility must go through the standard pre-certification process.

Reconsideration and authorization appeals

Reconsideration

Reconsideration process :

- With 30 days from the initial ineligible reimbursement, A reconsideration process is available to care providers following an adverse determination.
- During the reconsideration process, care providers will have an opportunity to submit additional, -new clinical information to substantiate medical necessity for a previously unapproved pre-service or concurrent Inpatient stay
- To submit a reconsideration, please submit new clinical information and place *reconsideration* on the cover sheet
- The reconsideration process is the same for OON providers

Peer-to-peer consultations

Peer-to-peer consultations

Providers have up to seven calendar days after the issuance of the decision to request a peer-to-peer review:

- For behavioral health, call **844-441-1506**
- For Medical Management department, call **833-308-3035**

If you request a peer-to-peer discussion, we will acknowledge your request within 24 hours and arrange a conversation at a mutually convenient time.

Provider — preservice appeals

If an authorization is unapproved prior to the service being rendered to the member:

- The care provider also has the option to file an appeal directly with us, not requiring member consent.
- Provider appeals can be submitted in the following ways:
 - Electronically: Availity Essentials at <https://Availity.com>.
 - Fax: directly to the Appeals department at **866-587-3316**.

Appeals must be submitted within 30 calendar days of the initial determination. We will send a written acknowledgment of the appeal to the member and their representatives within three business days of receipt.

We will issue a decision within 10 calendar days for non-urgent services and 48 hours for urgent care services.

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

The appeals process is the same for OON care providers.

Provider post service authorizations

If services have been rendered to the member:

- Care providers should file a claim payment dispute so a medical necessity review can be initiated. Care providers must include medical records and provide the extenuating circumstances for not submitting the preapproval.
- Disputes are to be submitted within 12 months from the date of service (DOS) or 60 calendar days from the date on the *Explanation of Payment*, whichever was later.
- Should the care provider disagree with the outcome of the review, an appeal can be submitted:
 - Appeals must be submitted within 30 calendar days of the initial denial. We will send a written acknowledgment of the appeal to the care provider within three business days of receipt.
 - We will respond to appeals associated with an unapproved claim within 30 days.
 - Care providers who have exhausted appeal rights can request an external Medical review (see electronic medical record process).
- Disputes and utilization management (UM) appeals can be submitted:
 - **Electronically:** Using Availity Essentials at <https://Availity.com>
 - **Fax:** Directly to the appeals department at **866-587-3316**

External medical review

- Services that are unapproved for reasons other than lack of medical necessity (for example, the service is 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 to limit, reduce, suspend, or discontinue 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, and to do this, providers must complete the Medicaid MCE External Review Request Form located at hmspermedion.com.
- Providers should upload the request form and all supporting documentation to Permedion's provider website located at ecenter.hmsy.com.
- New users will send their documentation through secured email at IMR@gainwelltechnologies.com to establish website access.

State fair hearings

- A request for a state hearing is defined as a clear expression, by the individual or authorized representative, to the effect that he or she wishes to appeal a decision or wants the opportunity to present their case to a higher authority. The request may be either made orally or submitted written or electronically.
- Members must exhaust our appeals process before requesting a state hearing.
- If we fail to adhere to notice and timing requirements as set forth in *OAC rule 5160-26-08.4*, the member is deemed to have exhausted the appeal process and may request a state hearing:
 - Members enrolled in the Coordinated Services Program (CSP) are not subject to this requirement and may request a state hearing without first appealing with us.
- A member or a member's authorized representative may request a state hearing within 120 calendar days from the date of an adverse appeal resolution.

State fair hearings (cont.)

Continuation of benefits:

- We will continue a member's benefits when all the following conditions are met:
 - The member requests an appeal within 15 days of the issuance of the *Notice of Action*.
 - The appeal involves the cancellation, suspension, or reduction of services prior to the member receiving the previously authorized services.
 - The services were ordered by an authorized provider.
 - The authorization period has not expired.

Availity Essentials

Availity Essentials resources and Custom Learning Center

- Availity Essentials (<https://Availity.com>) is a web platform used by care providers to securely access patient information, such as eligibility, benefits, claim status, authorizations, and other proprietary information.
- Care providers can use a single login to access multiple health plans at no cost.
- The registration process is easy, and multiple resources and trainings about site navigation are available.
- More information regarding Availity Essentials training and resources can be found [here](#).

Total Member View

- Total Member View (TMV) is a dashboard that simplifies administration by coordinating access to member-centric patient information.
- This application allows care providers, who are part of a patient's care and service team, to easily access the patient's record through *Payer Spaces* in Availity Essentials.
- Care providers can view clinical and case management data about a particular member's record including demographic information, care summaries, claims details, authorization details, pharmacy information, and care management-related activities.
- Care providers have the option to include feedback for each gap in care that is listed on the patient's Active Alerts that are posted in the *Member Summary*.
- The *Total Member View Availity User Guide* illustrates step-by-step instructions on accessing and navigating through the Availity Essentials platform and how to use the system. This guide is available through the [Digital Solutions Learning Hub](#).

Request for additional information (RAFI)

- Digital RAFI is the easiest way to submit attachments requested by your payer. There is no need to fax or mail paperwork to complete your claim submissions anymore; just use the digital channels provided for your organization.
- The notification center is located on the top of the Availity Essentials home page. If your payer has requested documentation, there will be a message stating requests in your work queue. Select the hyperlink to navigate to the Attachment Dashboard and view the request.

Requests:

- To check if you have a request for attachments, visit the notification center or navigate to **Claims & Payments > Attachments New**.
- To locate a specific RAFI request, the request number will begin with RAFI. If you notice multiple requests in your dashboard, take advantage of the filters. You have the option to search, filter, and sort for multiple values such as tax ID, NPI, and request type.

RAFI (cont.)

- Select **Upload Attachment** to view the type of document requested. Your uploaded requests will be visible in the *History* tab once accepted.
- Select the **Record History** icon on the right side of the request to view the Availity Transaction ID for specific Availity Essentials questions, or select **Health Plan Transaction ID** if you need to contact your payer for questions.
- This dashboard, located in Payer Spaces, allows your organization to understand how many digital requests have been sent, how many finalized claims there are based on your attachment submissions and the average turnaround time from the initial payer request to the claim finalization.
- To view your Digital RAFI Progress Dashboard application, select **Payer Spaces** from the drop-down menu and choose your payer tile:
 - Training is available on the Availity Essentials website.

Staying connected



Provider advisory council

We invite care providers to participate in our Provider advisory council. The Provider advisory council collaborates with our care provider community to gather input, discuss trends, identify challenges, and remove barriers — ultimately improving the healthcare delivery system.

If you are interested in participating, please complete our [application](#).

Stay in touch

Register to stay in touch and receive all provider communications and our monthly provider newsletter, *Provider News*, via email. Register now by going to our website at <https://providers.anthem.com/oh>.

Note: *Provider News* emails will come from providercommunications@email.anthem.com.

Helpful links



Helpful links

- Availity: <https://apps.availity.com/web/onboarding/availity-fr-ui/ - /login>
- PNM: ohpnm.omes.maximus.com/OH_PNM_PROD/Account/Login.aspx
- Find Help: <https://anthemoh.findhelp.com/ FindHelp>
- OAC rules for nursing facilities: <codes.ohio.gov/ohio-administrative-code/chapter-5160-3>
- OAC NF covered days and bed hold days: <codes.ohio.gov/ohio-administrative-code/rule-5160-3-16.4>
- OAC on coverage: <codes.ohio.gov/ohio-administrative-code/rule-5160-26-03>
- OAC rule on PASRR: <codes.ohio.gov/ohio-administrative-code/rule-5160-3-15.1>
- Nursing Facility Private Room Fact Sheet Link:
https://dam.assets.ohio.gov/image/upload/medicaid.ohio.gov/Providers/ProviderTypes/LongTermCare/NursingFacility/NF_Fact_Sheet_Private_Rooms.pdf

Thank you

- We appreciate you taking the time to attend our training and hope the information covered today answered any of your questions:
 - Please send any questions not covered in this presentation or our *Frequently Asked Questions* to OHMedicaidENCPESupport@elevancehealth.com.
- We look forward to working with you to continue this education and provide valuable healthcare to our members — your patients.
- General contact information:
 - Provider website: <https://providers.anthem.com/oh>
 - Provider Services: **844-912-1226**



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