Ohio | Department of Medicaid

Fiscal Intermediary Frequently Asked Questions

December 2022

This frequently asked questions (FAQ) document is designed to provide answers to the most common questions regarding the Fiscal Intermediary (FI) initiative at Ohio Department of Medicaid (ODM). The FI focuses on the system and operation capabilities needed for claims processing and ODM financial management.

Fiscal Intermediary Frequently Asked Questions

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Will providers directly access the FI?

No – providers, trading partners, and managed care entities (MCE) will not directly interact with the FI.

Can providers continue to work with managed care entities related to claims?

Providers and trading partners can continue to work with the MCEs when they have questions about submitted transactions, adjudication decisions, and payments.

How will managed care claims be submitted and paid?

Beginning February 1, 2023, all managed care claims submitted by trading partners, with dates of service on and after February 1 must be sent to the new Electronic Data Interchange (EDI), flow through the FI, and then route to the selected MCEs for processing and payment. Providers who submit managed care claims through direct data entry (DDE) will do so via the appropriate managed care portal.

How will managed care prior authorizations be submitted?

Beginning February 1, 2023, all managed care prior authorizations will continue to be submitted to the respective managed care portals or through their respective process.

How will fee-for-service claims be submitted and paid?

Beginning February 1, 2023, all fee-for-service (FFS) claims submitted by trading partners must be sent to the new EDI and flow to the FI for processing and payment. Providers who submit FFS claims through DDE will continue to do so through the Provider Network Management (PNM) module via a link to the Medicaid Information Technology System (MITS). FFS claims submitted through the PNM module will continue to be paid by the Ohio Administrative Knowledge System (OAKS), the State of Ohio's accounting system.

Can adjustments/voids be submitted via a different method than the original claim?

No. Adjustments/voids should be submitted via the same method as the original claim. For example, a claim submitted to the PNM module via a link to MITS must be adjusted through the PNM module via a link to MITS.

How will fee-for-service prior authorizations be submitted?

On February 1, 2023, all FFS prior authorizations must be submitted through the PNM module via a link to MITS.

Does this change the time it takes to process a claim?

Claims will be processed on the same frequency that they are currently. Transactions are being shared within the Ohio Medicaid Enterprise System (OMES) and MCEs in near real-time frequency.

How frequently will payments be made?

FFS claims will adjudicate daily, and payments will be made weekly in accordance with established policies. Each MCE has its own payment calendar.

How will providers receive their remittance advice?

Providers will receive their remittance electronically, delivered as an 835 transaction from the new EDI if

they have signed up to receive it in this manner. Providers must have enrolled using the ODM-06306 835 designation form. By using this form, providers will receive all 835 electronic remittance advices (ERA) from all payers, i.e., FFS and MCEs. The PDF versions of the remittance advices from all payers will be available via the PNM portal.

Will ODM accept paper claims or prior authorizations?

ODM will not accept paper claims and prior authorizations. For the Single Pharmacy Benefit Manager (SPBM), ODM will allow paper/fax prior authorization submissions in accordance with ORC 5160.34. MyCare will continue to allow providers to submit with paper as the processes for claims and prior authorizations for MyCare is not changing.

Will MCEs need to interact directly with the Ohio Administrative Knowledge System (OAKS)?

No, beginning February 1, 2023, MCEs will not interact directly with OAKS as the Fiscal Intermediary will begin making capitation payments to the MCEs.

Will providers need to interact directly with the Ohio Administrative Knowledge System?

On February 1, 2023, if providers submit claims through the PNM module via a link to MITS, OAKS will be responsible for making payment. Therefore, electronic fund transfer (EFT) updates will need to continue to be sent to Ohio Shared Services (OSS). If providers utilize a trading partner to submit claims on their behalf via the EDI the FI will pay, therefore EFT updates will need to be made in the PNM module.

Will all payers be mandated to pay clean claims within 30 days?

Under the Next Generation program, MCOs and OhioRISE are subject to the following requirements:

- 90% of all submitted clean claims must be paid or denied within 21 days of receipt.
- 99% of all submitted clean claims must be paid or denied within 60 calendar days of receipt.
- 100% of all submitted clean claims must be paid or denied within 90 days of receipt.

These requirements ensure faster claims processing than what is required by 42 CFR 447.46.

How will the managed care entities receive third-party liability information?

The new FI will store third-party liability (TPL) information. The FI vendor will transmit TPL information to the MCEs on a weekly basis. If the MCEs discover TPL that the FI has not identified, the MCEs will need to transmit the data back to FI in the weekly file the MCE sends to ODM.

Will Ohio Medicaid mandate that the managed care entities use the same groupers used by Ohio Medicaid for fee-for-service?

Yes, it is a requirement in the provider agreement, or contract, that the MCEs have with ODM.

What changes should ordering, referring, or prescribing providers know about?

For claims requiring an ordering, referring, or prescribing (ORP) provider, the ORP provider identified on a claim for Medicaid-covered services must be enrolled with ODM. Unenrolled providers will cause claim submissions to fail when submitted to EDI for routing and payment for both FFS and MCE claims.

Are there any submission changes related to MyCare claims and encounters?

MyCare providers should continue to submit claims and prior authorizations directly to the appropriate payer, either the MyCare managed care plan or Medicare. Providers who work with MyCare members must be enrolled as a Medicaid provider in the new PNM module and follow the new enrollment processes implemented on October 1. Encounter data from the MyCare managed care plans to ODM with unknown providers will result in rejections of those encounters. Beginning February 1, 2023, encounters from the MyCare managed care plans must be submitted to ODM utilizing the Post Adjudicated Claims Data Reporting (PACDR) format and will undergo snip-level editing on submission.

Is provider affiliation required?

Billing and rendering provider submitted on the claim must have a recognized and enrolled affiliation with each other in the PNM module to be accepted on a claim for OMES. Claims without appropriate affiliations will be rejected and will not be paid.

Will Ohio Medicaid Enterprise System process Federally Qualified Health Center/Rural Health Clinic wraparound claims?

Yes, providers can direct data enter these claims in the PNM module via a link to MITS for adjudication. Trading partners can submit through EDI and claims for wraparound payments will be adjudicated by the FI.

What is new rule about rending providers on EDI claims?

For EDI-related claims submissions beginning February 1, 2023, ODM will require one rendering provider per claim at the header level, rather than the detail level, for professional claims for both FFS and managed care recipients. This is to ensure claims can be properly priced and paid. Different rendering providers at the detail level are no longer acceptable. Exceptions for FFS Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) providers are detailed in the Medicaid Advisory Letter 622.