Q&A: EDI/IT BH Redesign Workgroup

(Updated 5/10/2017)

Question	Answer
General Questions	
1. Where can I obtain a copy of the presentation and materials from this workgroup?	Materials from the EDI/IT BH Redesign workgroup may be found on the BH Redesign website under “IT Resources”: http://bh.medicaid.ohio.gov/manuals
2. Whom do I contact if I have questions related to the material covered in this workgroup?	You may submit questions or topics for discussion to: Joan.Schlagheck@medicaid.ohio.gov and Nichole.Small@medicaid.ohio.gov
3. Updated 5/10/2017: Where can I access the webinar recordings if I am unable to attend these meetings?	The recording for the May 10th meeting can be found here: https://attendee.gotowebinar.com/recording/6417705717879442957 The recording for the April 29th meeting can be found here: https://attendee.gotowebinar.com/register/7112600363774810371 The recording for the April 12th meeting can be found here: https://attendee.gotowebinar.com/recording/7235626919604541959 The recording for the March 29th meeting can be found here: https://attendee.gotowebinar.com/register/8716312839676602115
4. New 3-30-2017 Is there any consideration for moving the 7/1/2017 Go Live date?	No, there are no plans to delay implementation.
EDI/Trading Partners	
Updated 5-10-2017 1. Whom do I contact for support with the new EDI translator?	DXC EDI support desk: OhioMCD-EDI-Support@dxc.com - HPE is now named DXC Technology If your issue has not been resolved, you may contact ODM EDI support desk: EDI-TP-Comments@medicaid.ohio.gov
2. Where can I find trading partner resources such as user guides and manuals?	Trading partner resources including companion guides can be accessed here: http://medicaid.ohio.gov/PROVIDERS/Billing/TradingPartners.aspx HTTPS and SFTP User guides for the new EDI translator can be accessed here: http://medicaid.ohio.gov/PROVIDERS/Billing/TradingPartners/HPVendorInformation.aspx

3. Updated 5-1-2017 When can trading partners start testing their claims?	Trading partner testing will begin on May 10th. The following MITS Bits contains details: http://mha.ohio.gov/Portals/0/assets/Funding/MACSIS/MITS-BITS/BH-MITS-Bits%205-1-17_Medicaid-Trading-Partner-Testing.pdf Please note, this will coincide with ODM's ongoing UAT work.
4. Is there a maximum number of claims allowed to be submitted for testing?	5,000 claims per file is the limit, same as production. No limit to number of files that can be submitted for testing.
5. Where can I find a list of ODM's authorized trading partners?	The list of current trading partners who offer EDI services to providers can be found here: http://medicaid.ohio.gov/PROVIDERS/Billing/TradingPartners/AuthorizedTradingPartners.aspx
6. Can we start doing a regular meeting series for MITS trading partners?	For those who are interested in having these meetings, please send agenda topics to ODM EDI support desk: EDI-TP-Comments@medicaid.ohio.gov
7. Can previously paid claims (production) be used in the testing environment?	Generally that is the process to use. However, with new codes and new requirements, previously paid claims will not fully test new claim requirements in the BH redesign. Need to ensure testing covers new codes and new requirements.
8. Does the test file have to include all services offered or new with Medicaid redesign?	This is up to the tester. Presumably one would want to test all new BH redesign codes that are in their lines of business.
9. Updated 3-20-17: What dates of service should be used for testing?	Trading partners should use dates of service within the following range: January 1, 2017 through March 31, 2017. These dates will be "forwarded" by the system to reflect July 1 and after dates of service.
10. Updated 3-20-17: Does the enrollment of rendering practitioners need to coincide with the dates of service used for testing?	See response to #9. When the dates on these testing claims are "forwarded", they will be tested against enrolled practitioners with an effective date of 7-1-2017 or earlier. There is no need to change effective date of practitioner enrollment.
11. Are trading partners being migrated to new translator automatically?	Trading partners are being migrated automatically and should have been contacted. ODM expects all trading partners to be transitioned to the new translator by March 13, 2017. If you have not been contacted, please contact the ODM EDI support desk (EDI-TP-Comments@medicaid.ohio.gov) and ensure your contact information is up to date with Ohio Medicaid.

12. Updated 4-10-2017 Can new providers start applying to be a trading partner now or if not, when can we? We currently manually enter claims and want to begin electronic submissions.	In March, ODM submitted 10 trading partner agreements (whose applications have been previously submitted to ODM) to HPE. HPE needs to complete its process to add new trading partners. For further information on these applications, contact OhioMCD-EDI-Support@hpe.com. For those wanting to submit a brand new application to be a trading partner, please wait until further instructions are released from ODM. ODM will monitor the HPE process mentioned above and proceed with new applications at a later date. Update 4-10-17: ODM is now accepting new trading partners. For information on how to become a new trading partner, please visit: http://medicaid.ohio.gov/PROVIDERS/Billing/TradingPartners.aspx
13. New 3-30-2017: Is HP beefing up cert testing capacity? During the switch to HP when we were "asked" to test, the testing site was frustratingly slow.	All Ohio Medicaid trading partners were impacted by the recent transition of EDI services to HPE (now DXC) therefore volumes in the testing region were high. We do not anticipate the same volume of trading partners accessing the testing region in May and we are working with HPE to ensure the testing region will be functioning optimally.
14. New 4-12-2017 Buckeye trading partner testing information for MyCare	Buckeye trading partner testing can begin May 1 https://sites.edifecs.com/index.jsp?centene The provider will be walked through the process once they click on the link and register for testing.
15. New 4-17-2017 Aetna trading partner testing information for MyCare	Buckeye trading partner testing can begin May 15 Submit test files to OH_BH_Redesign@AETNA.com
16. New 5-1-2017 Where can I find information related to MyCare testing for 7-1-17?	Testing information for each MyCare plan can be found in the slides from the April 26th EDI/IT Workgroup meeting. Access the presentation here: http://bh.medicaid.ohio.gov/training
837	
1. Updated 5-10-2017 When will vendors have the available 837 companion guides?	The 837 companion guides (837P Fee-for-Service and MyCare Encounter) will be updated to include the appropriate loop for supervisor. The additional notes that are specific to behavioral health providers will not be added to the 837 companion guide since HPE does not include notes specific to certain provider types. ODM is looking at other means of making this information available to all trading partners.

	Final companion guides will be posted to the ODM website on 7/1/2017. HPE is the owner of these documents and ODM cannot release in draft form. To view what language that will be provided in a separate document, please review slides from the 11/9/2016 EDI/IT workgroup meeting: http://bh.medicaid.ohio.gov/training
2. Updated 4-10-17 Will ODM be providing the loops and segments for the claim fields that will be required as of 7/1/2017?	Yes, loops and segments for supervising, ordering, rendering and billing provider have been added to the "Supervisor-Rendering-Ordering-Fields" document found on the BH Redesign website under "IT Resources": http://bh.medicaid.ohio.gov/manuals Additional guidance for cross walking the CMS-1500 paper claim form fields to EDI loops and segments can be found here: http://www.cgsmedicare.com/pdf/5010_jobaid.pdf
3. Updated 4-12-2017 Do you have to suppress the unlicensed staff member information in 2310B if 2310D is populated? The spec indicates NA. Or, can we send the Rendering in the 2310B along with the Supervisor in 2310D?	In order to be compliant with HIPAA, the supervisor must be in the header, loop 2310D. ODM is recommending that only one supervisor be reported on a claim in order to ensure proper adjudication. Any claim with a supervisor then should not have a detail line requiring rendering provider.
4. Updated 4-12-2017 Where should the Supervisor NPI be reported? Can you send the Supervisor in the 2310B?	In order to be compliant with HIPAA, the supervisor must be in the header, loop 2310D. ODM is recommending that only one supervisor be reported on a claim in order to ensure proper adjudication.
5. Can ODM provide sample files for both claims (837) and remittance advice (835)?	See examples provided at the end of this document.
6. In the rendering field for non-independent credentials, it is indicated N/A. What does this mean? Can we put in rendering in this loop and supervising in Loop 2310D where it is indicated N/A?	You are not required to add the rendering NPI in loop 2310B when the service is rendered by an unlicensed practitioner. This field should be left blank when rendered by an unlicensed practitioner. Under certain circumstances, the Supervising Provider must be included in loop 2310D in order to be paid. See manual for further information.
7. New 3-30-2017: Could the scenario exist where an enrolled and a non-enrolled rendering provider would be present on the same claim? In that case, one provider would require a supervisor while the	Yes, this is a scenario that would exist under BH redesign. ODM is testing this and several similar scenarios to ensure it is processed correctly.

other provider would Not require a supervisor.	
8. Updated 4-10-17: During trading partner testing in May, if a defect is found and fixed, does ODM re-run all files in UAT automatically? Or would the trading partner need to re-submit their file?	ODM will not automatically re-submit trading partner files. Trading partners should identify which files may be impacted by any changes and re-submit for testing.
Third Party Liability	
1. For procedures that are never billed to Medicare or Commercial Insurance, how do I report this on the claim to bypass the third party liability edits?	In these instances, providers should bill Ohio Medicaid as the primary payer and should not include the third party payer information on the claim. For these codes, providers are not required to bill the third party payer to receive a denial CAS code. The Ohio Medicaid system automatically overlooks any other third party payers on the individual record when these codes are submitted. A list of behavioral health services for which ODM does not require providers to bill Medicare or commercial insurance can be found here under "IT Resources": http://bh.medicaid.ohio.gov/manuals For all other procedure codes, providers must bill all third party payers before billing to Medicaid unless conditions set forth in Administrative Code rule 5160-1-08 are met. Additional information on how to bill for these instances can be accessed here: http://medicaid.ohio.gov/Portals/0/Providers/MITS/Answer%20Keys/Answer_Key_12.pdf
2. Do I report MACSIS or ADAMH as additional payers on a claim?	The only time an additional payer should be reported on the claim is when the claim has been adjudicated by the third party payer and you have received a remittance advice.
3. If a third party payment was received or the third party payer denied, how do I report this on the claim?	Providers should follow the Coordination of Benefits process which can be accessed here: http://medicaid.ohio.gov/Portals/0/Providers/MITS/Answer%20Keys/Answer_Key_11.pdf Additional answer keys can be accessed here: http://medicaid.ohio.gov/PROVIDERS/MITS/AnswerKeysProblemswhileSubmittingClaims.aspx
4. Who is billed if an agency is not a Medicare provider but the clinician working for the agency is a licensed Medicare provider?	The agency must be enrolled in Medicare if services being provided to Medicare-eligible recipients by any of its staff could be covered by Medicare. In addition, if the individual

	practitioner can enroll in Medicare, they need to be enrolled in Medicare.
5. Is there plan to update the TPL to show the name of the primary payer? Currently it does not show the name, but the payer ID.	There are no plans at this time to modify this field.
6. New 3-30-2017 It was discussed during the March 2nd meeting that MITS will not accept claims where there is a secondary payer to Medicaid, for example MACSIS or other County payer systems. Is this edited on the EDI level and would reject the entire file, or is it edit during the adjudication process resulting in a denied claim?	First to clarify, ODM did not say MITS will not accept claims when there is a secondary payer. The other payer must have received and adjudicated the claim prior to Medicaid submission. If MACSIS or other county payer is included on the claim, it would be EDI-accepted because it is compliant with the 837P Companion Guide. Having this information as secondary payer could impact the MITS claim adjudication.
7. New 3-30-2017 The provider agencies that provide both MH and SUD services are required to use two separate NPI numbers for claims submission. In our system, this has to be done by having two separate payers set up, one for MH and one for SUD. When the client has both services, the client has both payers “attached” to them; therefore, MITs SUD could be listed as secondary to MITS MH primary or the other way around depending on the service. Will this deny the claim and or file based on the answer to the previous question?	From Medicaid perspective, this is not a separate payer. Rather, these would be two different billing providers and should not appear on the same claim.
Miscellaneous Questions	
1. How will OTPs report NDCs?	Refer to following correspondence from OhioMHAS: The Ohio Department of Medicaid (ODM) and the Ohio Department of Mental Health and Addiction Services (OhioMHAS) were made aware that the MITS OTP build is denying claims, specifically for the take home administration of buprenorphine based medications using either the S5000 or S5001, when different National Drug Codes (NDCs) are submitted on multiple claim detail lines using the same “S” code. This has been identified as a configuration issue and ODM and OhioMHAS are working with Hewlett-Packard Enterprises (HPE) to implement the following correction. HPE has been instructed to temporarily disable the duplicate edit associated with medication codes S5000,

	S5001 and J8499 specifically for the OTP MITS provider type 95 and specialties 951/953. The edit will be disabled retroactively to dates of service on and after January 1, 2017 to align with the implementation of the OTP coverage expansion. OTPs may continue to submit all OTP claims using either the EDI or portal processes, but will need to resubmit or re-adjudicate claims that have been denied due to the duplicate edit after the duplicate edit is disabled. The temporary disabling of the duplicate edit is projected be in the MITS production environment by next Friday, February 3, 2017. The duplicate edit will be reinstated with a broader NDC project slated for MITS implementation on July 1, 2017. The broader NDC project will also apply to outpatient hospital claims, professional claims (including claims from all behavioral health provider type 84s and 95s) along with dialysis claims. If you are submitting OTP medication claims correctly for dates of service on and between January 1, 2017 and June 30, 2017 by reporting the different NDCs on separate claim detail lines using the same medication code, then the reinstatement of the duplicate edit should have no effect on appropriate adjudication of those claims.
2. Please define effective date of 7/1/17. I'm assuming all claims with dates of service prior to 7/1/17 will need to be in the old format (paid at old rates) and dates of service 7/1/17 and later need to be in the new format to be paid at the new rates.	When we indicate that new coding structure to support BH redesign "goes live" July 1, 2017, we are referencing dates of service on and after July 1, 2017. Claims for these dates of service will need to be submitted using the new coding structure. Professional claims submitted through EDI and the portal are adjudicated at the detail level, so one line could be 6/30/2017 date of service and another could be 7/1/2017 date of service. Rendering, ordering and supervising provider information is entered at the detail level, therefore the 6/30/2017 line is not required to have a rendering but the 7/1/2017 line must have a rendering when service delivered by Medicaid enrolled practitioner.

3. Updated 5-1-17: I had inquired about the CPST phone calls and was advised they should not be billed with the GT modifier effective July 1st. Can you confirm that not only is the GT modifier removed for CPST but that the phone contact is now not billable at all? I was under the impression it was billable but no longer identified with the GT modifier. We do quite a bit of CPST phone contact currently using the GT modifier.	The GT modifier is to be used for secure video conferencing and should not be used for telephone calls. We are not changing our policy on CPST. Please ensure medical documentation reflects how the service is delivered. As of 7/1/2017, CPST should not be billed with modifiers HK to indicate face-to-face and GT for telephone. As of 7/1/2017, CPST should only be billed with the modifiers indicated in the provider materials found on the BH.Medicaid.ohio.gov website. The GT modifier should only be used if the service was provided via secure video conferencing. The means of service delivery should still be documented in the client's medical record.
4. Added 5-10-2017 The court ordered modifier is not listed on anything with the re-design. Does that mean we no longer need to list items as court ordered?	Under the Behavioral Health Redesign, you should only report modifiers that are indicated in the provider materials found on the BH.medicaid.ohio.gov website. If you previously used a modifier to indicate court-ordered or any other special circumstances, this should be documented in the client's medical record.
5. New 3-20-17: Why aren't there practitioner modifiers for all provider types listed? Will you be providing these remaining practitioner modifiers in next update of the Behavioral Health Provider Manual?	Table 1-3 of the BH Provider Manual lists those practitioners that require a modifier because they do not have an NPI. For the practitioners not in Table 1-3, their NPI will determine the rate according to the rate chart in the manual. Refer to the Supervisor Ordering Rendering spreadsheet for identification of how rates will be determined for each code/practitioner combination.
6. New 3-20-17: Not all clients qualify for Medicaid but many may qualify for other funding such as levy dollars from local boards. If services such as IOP, PH and Residential are to be billed directly to Medicaid and not all clients qualify for Medicaid but do qualify for board funding, will there be a prior authorization process put into place for boards?	Please refer to your local board for answer to this question.
7. New 5-10-17:	Setting aside the supervisor scenarios, multiple services can be on the same claim, different detail lines. Each detail line

Are HCPC codes where the services and modifiers are different supposed to be on separate claims or one claim with multiple line items?	could have different codes, same or different modifiers. Rendering is reported at the detail level, so multiple HCPC codes with different renderings could be on the same claim. When a supervisor NPI is added to the header to indicate direct supervision occurred, that claim should only contain those services that were provided under direct supervision by that supervisor. You should never provide the supervisor NPI for a CPT code if the service was provided under general supervision. When the supervisor NPI is provided at the header, it is assumed all services billed on the claim were provided under direct supervision. Including the supervisor NPI for HCPC codes is optional and there is no rate differential for general vs. direct supervision for such services.
Prior Authorization	
1. New 3-30-2017: For partial hospitalization, a client may be in a partial hospitalization group anywhere from 2 – 7 days depending on their schedule and only billed a per diem for the days the PH group actually occurred with other services making up the balance of 20+ hours meeting that 2.5 ASAM level requirement. From a prior authorization perspective, is that for 30 days or 30 units (per diems) billed for that client?	Prior authorization for the partial hospitalization level of care is not limited to either 30 days or 30 units. The prior authorization allows the individual to receive 20+ hours of services, which includes H0015 TG Partial Hospitalization. The prior authorization will be in place for at least six months.
2. New 3-30-2017: For partial hospitalization level of care, prior authorization is required. That LOC can consist of several different codes. How is this PA configured for claims purposes? Is the PA authorization needed for each code on a claim? Or is it only needed for H0015 TG?	The claim only needs to include the prior authorization for billing H0015 TG. Other services that comprise the partial hospitalization level of care (such as SUD nursing, individual counseling) do not need the prior authorization on the claim
3. New 3-30-2017: I have some billing questions about Day Treatment services. With reference to " MH Day Treatment Group Activities / Hourly—pg. 11- 301 Fundamentals of BH Redesign "under Additional Details it states that if a person attends for the minimum needed to bill the unit (30+	To answer your question, please refer to the Behavioral Health Provider Manual available on http://bh.medicaid.ohio.gov/manuals. Refer to section titled Time Based CPT Codes. The second chart is the conversion chart for hour-based services, which H2012 hourly day treatment is. This chart will show how to convert the scenario of 102 minutes of MH Day Treatment into the appropriate number of units.

minutes) service is billed in whole units only… So, on the HCFA form or for billing, if a person only stays in group 102 minutes (1 hour and 42 minutes) do we bill for 1 hr. and 42 minutes or 2 hours, and how would our billing department code the number of units under # 24 G (Days or Units) on the HCFA form? Also for Day Treatment Group with staff that are independently licensed and staff with LSW masters, can we only put in agency NPI for rendering provider, #24 J?	As to the second question, refer to the same website, look under IT Resources for the spreadsheet titled Supervisor, Rendering Ordering Fields. This spreadsheet outlines each code and possible practitioner and what is needed for rendering.
4. New 4-10-2017: For Prior Authorizations – If a client admits with Medicaid and the program requires an authorization and we request it. Is the approval based on the submitted date for the authorization since that is the day they were admitted to the program with Active Medicaid?	Prior authorizations are approved for the requested date which would be the submitted date or the requested effective date if in the future.
Provider Enrollment	
1. ODM Provider Enrollment returned my application because I did not include SSN. I provided that information in an email 3 weeks ago, but I am still waiting to be enrolled in Medicaid. Why is it taking so long?	ODM Provider Enrollment is prioritizing initial applications in their current workload. This is to ensure adequate time for those applications that may need additional information. If you have responded with the necessary information, there is no need to re-send the information. ODM will review the documents and complete your enrollment once they have eliminated the backlog of initial applications.
2. We are having problems getting our providers connected on the AoD side. They are all enrolled and connected to the agency on the MH side, but we can't get them connected to our AoD enrollment for the agency? Any suggestions?	Licensed Independent Chemical Dependency Counselors (LICDCs) are unable to affiliate with agencies via the portal. These practitioners must email ODM Provider Enrollment with the following information: practitioner name and NPI, agency NPI and name of agency or agencies to be affiliated with. Send this information to Medicaid_provider_update@medicaid.ohio.gov. If you are experiencing this issue for other practitioners, please notify provider enrollment through the above mentioned email address.
3. We are one of the smaller agencies and have not been properly trained on the practitioner enrollment	MITS BITS have been issued on this topic - these can be found at: http://bh.medicaid.ohio.gov/Providers1#4276-mits-bits .

process...with whom should I speak about this?	The behavioral health provider enrollment webinar and frequently asked questions can be found at: http://bh.medicaid.ohio.gov/training For individuals who need additional assistance related to behavioral health practitioner enrollment, questions can be sent to: BH-Enroll@medicaid.ohio.gov
4. When behavioral health services move into Managed Care on 1/1/2018, what happens to the practitioner enrollment/update process? Will ODM keep managing that or will that process also be managed by the managed care entities?	This process is not expected to change. On 1/1/2018, ODM will be enrolling practitioners as we do today. It is possible that some providers are only enrolled with the plans and not ODM. This will change due to 42 C.F.R. 438.602 which is effective 1/2019 and requires all providers to be enrolled with ODM.
5. New 3-30-2017: When I am completing a new individual Medicaid application in MITS and I list the "group" provider # that I need to affiliate with, does the group also have to go in under the group and affiliate?	If you affiliate with a group provider, no additional steps are needed to be affiliated with that group provider. Likewise, if a group affiliates a practitioner under their group provider number, no additional steps are needed to be affiliated with that group provider.
6. New 3-30-2017: Is there a way for agencies to get a report of who is affiliated with their agency?	Yes. Agencies may view a list of practitioners affiliated with their agency by accessing the MITS provider portal under “Providers” → “Group Members”.
7. New 3-30-2017: Can ODM identify what the primary issues are with provider enrollment that cause the application to be returned for additional information?	Two common reasons for applications being returned for additional information are: 1. FEIN is submitted instead of SSN on the W9 for individual applicants 2. Someone (credentialist, office manager, etc.) other than the individual applicant signing the application
8. New 3-30-2017: How many provider types 84 and 95 are currently going through revalidation?	Seventeen agencies have revalidation applications submitted currently. An additional 61 agencies are due for revalidation later this year. The majority of agencies were revalidated in 2016 and are not due for revalidation until 2021.
Rolling Claims	
1. Do you have to have both diagnoses? Can you use only one for rolled services?	If more than one diagnosis was addressed in the services being rolled up, all diagnoses addressed should be listed. You can associate up to four (4) diagnoses per detail line.
2. Will services no longer be rolled together, if the same service is provided by 2 different practitioners? (i.e., morning and evening psychotherapy provided by different LISWs.)	Refer to examples in the Behavioral Health Provider Manual: Claims Detail Rollup for Same Day Services. Manual can be found at http://bh.medicaid.ohio.gov/manuals.

3. If there are claims for the same DOS, service, and individual but the practitioner is different, it would seem this should be separate claims since they would have different NPI #s.	Refer to examples in the Behavioral Health Provider Manual: Claims Detail Rollup for Same Day Services. Manual can be found at http://bh.medicaid.ohio.gov/manuals.
4. New 4-7-17: If a client is seen by two separate non-enrolled clinician (with same license levels), supervised by the same enrolled practitioner, on the same day, at the same POS, providing the same service (HCPCS), addressing two different DX codes (let's say both SUD); should the services roll up to one claim detail line, or should we have two different detail lines with the different DX codes as DX1? If they need to roll up, how should the DX codes be reported on the single claim detail line?	Diagnosis is not a criteria for determining when to roll up claims. So, in your example, the two services should be rolled up and both diagnoses should be listed on the detail line.
Eligibility	
1. Updated 4-10-17 We work regularly with jail diversion programs. A client released from jail or prison will not have Medicaid. Is there a recommendation for handling these clients (from a service perspective) since they will not have Medicaid upon entry into the program and prior authorizations cannot be retroactively applied for once the client obtains Medicaid? First thought is they would be fee for service until their Medicaid is active but we wanted to check and see if a recommended course of action has been put together.	If the individual is not Medicaid-eligible at the time the services are delivered, Medicaid fee for service is NOT an option. Individual needs to apply for Medicaid through CDJFS. The individual may receive a same-day presumptive eligibility determination from a qualified entity such as a CDJFS, WIC Clinic, Hospital, Department of Youth Services, FQHC and FQHC look-alikes. This allows eligible individuals to have active Medicaid and receive services while their full Medicaid application is being processed. Please note: Ohio's DRC Medicaid Pre-Release Enrollment Program expanded to all 27 Ohio prisons in November 2016. This program offers individuals the chance to enroll in Medicaid managed care program prior to their release.
NCCI	

1. New 3-30-2017: How is ODM structuring NCCI edits for dependently licensed providers (LPC, LSW, etc) that will bill CPT codes using modifiers to indicate the clinical license? Can you provide some examples for same day services that would be allowed using modifiers for clinicians that may have the same license type? For example: client sees Sally MSW, LSW for a 90837 and later the same day attends a group 90853 with Jack MSW, LSW.	NCCI edits against the client ID and the individual practitioner's NPI. If rendering NPI is left blank, as would be the case with a dependently licensed practitioner delivering the service, this field is auto-populated with agency NPI. So, in this instance, because of the auto-populating, NCCI would edit against agency NPI. ODM is not structuring the NCCI edits. CMS has structured the edits and Ohio Medicaid applies this set of edits to claims. In your example, there is a procedure to procedure edit for 90837 and 90853, blocking these two codes from being provided to same recipient by same rendering practitioner on the same day. And in your example, NCCI would view this as being the same practitioner as explained above. Additional information on NCCI is provided in the Provider Manual.

837P v5010 Enrolled Practitioner Billing CPT or HCPCS Codes

```
ISA*00*          *00*          *ZZ*SENDER ID      *ZZ*MMISODJFS
*161201*1406*^*00501*000000133*0*P*:~
GS*HC*SEND ID*MMISODJFS*20161201*1406*11946*X*005010X222A1~
```

TRANSACTION SET HEADER

```
ST*837*000000001*005010X222A1~
BHT*0019*00*239*20161201*1406*CH~
```

LOOP 1000A – SUBMITTER NAME

```
NM1*41*2*TRADING PARTNER NAME*****46*SEND ID~
PER*IC*JULIE ELLIS*TE*4409980722*FX*4409921699~
```

LOOP 1000B – RECEIVER NAME

```
NM1*40*2*OHIO DEPT OF MEDICAID*****46*MMISODJFS~
```

LOOP 2000A – BILLING PROVIDER / HL

```
HL*1**20*1~
```

LOOP 2010AA BILLING PROVIDER NAME

```
NM1*85*2*AGENCY NAME*****XX*9999999999~
N3*50 W TOWN STREET~
N4*COLUMBUS*OH*432151234~
REF*EI*123456789~
```

This is the Agency NPI.

LOOP 2000B – SUBSCRIBER LOOP / HL

```
HL*2*1*22*0~
SBR*P*18*******MC~
```

P = Primary, S = Secondary, T = Tertiary. SBR01 identifies the ODM Payer responsibility.

LOOP 2010BA – SUBSCRIBER NAME

```
NM1*IL*1*DOE*JOHN****MI*123456789123~
N3*123 S MAIN STREET~
N4*ANYTOWN*OH*440040000~
DMG*D8*19800204*M~
```

LOOP 2010BB – PAYER NAME

```
NM1*PR*2*OHIO DEPT OF MEDICAID*****PI*MMISODJFS~
N3*30 EAST BROAD STREET~
N4*COLUMBUS*OH*432153414~
```

LOOP 2300 – CLAIM INFORMATION

```
CLM*2330590*72***11:B:1*Y*A*Y*Y~
DTP*431*D8*20141003~
REF*EA*8A486D4A9FA8414DB2ED8A75653A2DFE~
HI*ABK:F1120~
```

LOOP 2320 – OTHER SUBSCRIBER INFORMATION

ONLY include the 2320 / 2330B loops WHEN another payer received and adjudicated this claim. If Medicaid is Primary these loops should not be included.

```
SBR*P*18*******CI~
CAS*CO*45*40
AMT*D*32
OI***Y***Y~
```

LOOP 2330A – OTHER SUBSCRIBER NAME

```
NM1*IL*1*DOE*JOHN****MI*3996257~
N3*50 WEST TOWN STREET~
N4*ANYTOWN*OH*440040000~
```

LOOP 2330B – OTHER PAYER NAME

```
NM1*PR*2*SOME INSURANCE*****PI*INS ID~
N3*123 HIGH STREET*SUITE 203~
N4*ANYTOWN*OH*440041234~
DTP*573*20141201
```

LOOP 2400 – SERVICE LINE NUMBER

```
LX*1~
SV1*HC:H0005*15*UN*6***1~
DTP*472*D8*20161129~
REF*6R*CPMIL6C8BHSI~

LX*2~
SV1*HC:H0005*15*UN*12***1~
DTP*472*D8*20161110~
REF*6R*CPMI2LCTVA4H~
```

This loop is required for all rendering providers on each detail.

LOOP 2420A – RENDERING PROVIDER NAME

```
NM1*82*1*LAST NAME*FIRST NAME****XX*7891234567
```

LOOP 2420E – ORDERING PROVIDER NAME

```
NM1*DK*1*LAST NAME*FIRST NAME****XX*4567891234
```

TRANSACTION SET TRAILER

When an RN or LPN is the Rendering Provider, the Ordering Provider loop with provider name and NPI is required.

```
SE*3993*000000001~
GE*1*11946~
IEA*1*000000133~
```

837P v5010 Non-Enrolled Practitioner Billing CPT or HCPCS Codes

```
ISA*00*          *00*          *ZZ*SENDER ID      *ZZ*MMISODJFS
*161201*1406*^*00501*000000133*0*P*:~
GS*HC*SEND ID*MMISODJFS*20161201*1406*11946*X*005010X222A1~
```

TRANSACTION SET HEADER

```
ST*837*000000001*005010X222A1~
BHT*0019*00*239*20161201*1406*CH~
```

LOOP 1000A – SUBMITTER NAME

```
NM1*41*2*TRADING PARTNER NAME*****46*SEND ID~
PER*IC*JULIE ELLIS*TE*4409980722*FX*4409921699~
```

LOOP 1000B – RECEIVER NAME

```
NM1*40*2*OHIO DEPT OF MEDICAID*****46*MMISODJFS~
```

LOOP 2000A – BILLING PROVIDER / HL

```
HL*1**20*1~
```

LOOP 2010AA BILLING PROVIDER NAME

```
NM1*85*2*AGENCY NAME*****XX*9999999999~   (AGENCY NPI)
N3*50 W TOWN STREET~
N4*COLUMBUS*OH*432151234~
REF*EI*123456789~
```

LOOP 2000B – SUBSCRIBER LOOP / HL

```
HL*2*1*22*0~
SBR*P*18*******MC~
```

P = Primary, S = Secondary, T = Tertiary. SBR01 identifies the ODM Payer responsibility.

LOOP 2010BA – SUBSCRIBER NAME

```
NM1*IL*1*DOE*JOHN****MI*123456789123~
N3*123 S MAIN STREET~
N4*ANYTOWN*OH*440040000~
DMG*D8*19800204*M~
```

LOOP 2010BB – PAYER NAME

```
NM1*PR*2*OHIO DEPT OF MEDICAID*****PI*MMISODJFS~
N3*30 EAST BROAD STREET~
N4*COLUMBUS*OH*432153414~
```

LOOP 2300 – CLAIM INFORMATION

```
CLM*2330590*72***11:B:1*Y*A*Y*Y~
DTP*431*D8*20141003~
```

If service requires Supervisor practitioner, report this at header level.

```
REF*EA*8A486D4A9FA8414DB2ED8A75653A2DFE~
HI*ABK:F1120~
```

LOOP 2310D – SUPERVISING PROVIDER NAME
NM1*DQ*1*LAST NAME*FIRST NAME****XX*2345678912

LOOP 2320 – OTHER SUBSCRIBER INFORMATION
SBR*P*18*******CI~
CAS*CO*45*40
AMT*D*32
OI***Y***Y~

DO NOT include the 2320 / 2330B loops UNLESS another payer received and adjudicated this claim before sending to Medicaid. If Medicaid is Primary these loops should not be included.

LOOP 2330A – OTHER SUBSCRIBER NAME
NM1*IL*1*DOE*JOHN****MI*3996257~
N3*50 WEST TOWN STREET~
N4*ANYTOWN*OH*440040000~

LOOP 2330B – OTHER PAYER NAME
NM1*PR*2*SOME INSURANCE*****PI*INS ID~
N3*123 HIGH STREET*SUITE 203~
N4*ANYTOWN*OH*440041234~
DTP*573*20141201

LOOP 2400 – SERVICE LINE NUMBER
LX*1~
SV1*HC:H0005:U2*15*UN*6***1~
DTP*472*D8*20161129~
REF*6R*CPMIL6C8BHSI~

Practitioner Modifiers should be sent on the Service Line

LX*2~
SV1*HC:H0005:U4*15*UN*12***1~
DTP*472*D8*20161110~
REF*6R*CPMI2LCTVA4H~

TRANSACTION SET TRAILER
SE*3993*000000001~
GE*1*11946~
IEA*1*000000133~