Note: This document includes instructions on medical claim reviews for community Medicaid behavioral health providers (MITS provider types 84 and 95). It is a continuation of the MITS Bits entitled, "Denied Claims Review Process Involving Community SUD Residential Treatment Services." This MITS Bits can be found at: http://www.bh.medicaid.ohio.gov/Provider#52339-mits-bits.

ODM Form 06653 Instructions for Community Medicaid Behavioral Health Providers

Rather than creating and implementing a new process and forms for community Medicaid behavioral health providers, ODM is adapting the existing process for requesting a medical claim review for this specific behavioral health claim or claims denial situation.

You cannot attach form ODM 06653 to the denied claim. You must submit a new claim, either by using the MITS web portal or by electronic data interchange (EDI). Prior to using either method to submit a new claim, you must fill out form ODM 06653 and have it available in an acceptable format for uploading.

1) Obtain the fillable .pdf version of form ODM 06653 "Medical Claim Review Request" Form. You may do so by going to the ODM Medicaid Forms website here: http://medicaid.ohio.gov/RESOURCES/Publications/MedicaidForms.aspx and searching for form number 6653. This will return two files, form ODM 06653 and the instructions for form ODM 06653. **Do not use the instructions document but use the following information to assist in filling out form ODM 06653.**

2) Complete form ODM 06653. In situations where more than one claim has been denied, you must fill out and submit a separate ODM 06653 for each denied claim. Examples of completed ODM 06653s are included at the end of these instructions.

3) Please be sure to do the following when submitting an ODM 06653:
   a. Instead of 17-digit *transaction control numbers* (TCNs), MITS uses 13-digit *internal control numbers* (ICNs). You must include ICNs in number 4 "claim history information" instead of TCNs.
   b. Please put the agency's 7-digit Ohio Medicaid assigned provider number in the "Individual Provider #" field.
   c. When submitting the form for a denied SUD residential treatment claim:
      i. If it is for the date of admission, please put the date of admission in number 3 in the "Service Date" field.
      ii. If it is for the date of discharge, please put the date of discharge in number 3 in the "Discharge Date" field.
   d. When submitting the form for a denied other specific community behavioral health (OSCBH) service:
      i. If the service was provided on the date of admission to SUD residential treatment, please put the date of admission in number 3 in the "Service Date" field.
      ii. If the service was provided on the date of discharge from SUD residential treatment, please put the date of discharge in number 3 in the "Discharge Date" field.
   e. In addition to providing the "Explanation of Request" in number 6 on the form, please also include the following statement "SEND TO BH POLICY WORKSTATION FOR REVIEW" so ODM can efficiently route the form and supporting documentation for review and payment consideration.

4) Send a new claim to ODM. As noted earlier, there are two methods to submit a new claim, via direct entry using the MITS Web Portal or by EDI.
   a. MITS Web Portal entry instructions
      i. Enter the claim information.
      ii. In the 'Attachments' panel, click the 'add' button.
      iii. In the 'Type of Document' field, select 'REFERRAL FORM (OHIO 6653)' from the drop-down list. In the 'Transmission Type' field, select either 'MAIL' or 'UPLOAD' from the drop-down list. Click the display row for the document (highlighted in light blue) to record the information selected from the drop-down lists.
      iv. In the 'Attachments' panel, click the 'add' button.
      v. In the 'Type of Document' field, select 'EXPLANATION OF BENEFITS' from the drop-down list. In the 'Transmission Type' field, select either 'MAIL' or 'UPLOAD' from the drop-down list. Click the display row for the document (highlighted in light blue) to record the information selected from the drop-down lists.
      vi. Click 'submit'. Your claim will be placed in suspension.
      vii. Follow these steps to upload the attachments:
         1. In the 'Attachments' panel, click the 'upload' button. An 'Attachment Upload' panel will open.
         2. Click the display row (highlighted in light blue) for the document you are uploading. The 'Type of Document' field will be populated automatically, and the MITS Web Portal will generate a unique number for the 'Reference' field.
         3. In the 'File to Upload' field, click the 'Browse' button to find and select the document.
         4. Click the 'upload attachment' button.
         5. Click the display row for the next document and repeat the process.
            a. Note: No more than ten documents can be uploaded as attachments to a single claim. Each electronic document can be no more than 50 megabytes (50MB) in size and must be in one of ten formats: BMP, DOC, GIF, JPG, MDI, PDF, PPT, TIFF, TXT, or XLS. Attachments found to have viruses will be discarded without notification to providers. The MITS Web Portal does not currently support the DOCX format introduced in Word 2007 for Windows and Word 2008 for the Macintosh. Save a DOCX file in DOC format before uploading it.
   b. Electronic Data Interchange instructions
      i. Complete the 837 transaction as you would for any other non-crossover claim. Enter information into the PWK segment of loop 2300 to indicate that an attachment is forthcoming.
         1. In PWK01, specify the type of attachment. For the ODM06653, enter 'B4' (Referral Form).
         2. In PWK02, specify the method of transmission. When sending the attachment via the MITS Web Portal, enter 'FT'.
      ii. Once an ICN has been assigned and the claim has been placed in suspension, use the ICN to find the suspended claim in the MITS Web Portal.
      iii. In the 'Attachments' panel, click the 'add' button if another attachment is needed. Select appropriate information for the 'Type of Document' and 'Transmission Type' field.
      iv. In the 'Attachments' panel, click on a display row (highlighted in light blue). Follow the steps for sending attachments as described in the preceding 'MITS Web Portal' section.

Note: Please be sure to follow the instructions provided above regarding specific information needed for efficient processing of this type of claim review request. This example is for a denied SUD residential treatment claim on the date of admission.

Ohio Department of Medicaid
MEDICAL CLAIM REVIEW REQUEST

SAMPLE COMPLETED FORM FOR DENIED SUD RESIDENTIAL TREATMENT CLAIM(S)

1. PROVIDER INFORMATION

Provider Name Community BH Program
Address 123 East Glenmoraine Road
City Anytown
State Ohio   Zip 43996-3572
Contact Person Firstname Lastname

2. SUBMISSION DATE OF THIS FORM
03 / 13 / 18

Individual Provider # 1 2 3 4 5 6 7

Group Provider # 1 2 3 4 5 6 7 (When appropriate)

Telephone # (999) 259-3368 extension 98320

3. CLAIM INQUIRY INFORMATION

Recipient Name Medicaid Benificiary
Billing # (12 digits) 123456789012
Service Date 1/4/2018
or
Discharge Date

4. CLAIM HISTORY INFORMATION

Transaction Control Numbers
TCN 2218000000000
TCN
TCN
Please note: All transaction control #s are 17 digits

5. Please enter all applicable Medicaid E.O.B. denial codes, which apply to the attached claim.

EOB 5080   EOB   EOB   EOB

(Please include all necessary documentation, e.g. remittance advices, Medicare and/or Insurance EOBs).

6. Explanation of request:

Community BH Program provided SUD residential at ASAM level of care 3.5 for TCN 2218000000000
and it was denied for EOB 5080. Patient admitted on this date of service.

SEND TO BH POLICY WORKSTATION FOR REVIEW please

Internal Use Only

Date of Receipt Stamp

MEDICAID USE ONLY   ☐ Claim not approved for processing, please see the attached letter.

Reviewer ID

Each claim requires a separate ODM 06653 Medical Claim Review Request Form
Please call our Interactive Voice Response Unit (IVR) at 1-800-686-1516 for claim status verification.

Note: Please be sure to follow the instructions provided above regarding specific information needed for efficient processing of this type of claim review request. This example is for a denied SUD residential treatment claim on the date of discharge.

Ohio Department of Medicaid
MEDICAL CLAIM REVIEW REQUEST

SAMPLE COMPLETED FORM FOR DENIED SUD RESIDENTIAL TREATMENT CLAIM(S)

1. PROVIDER INFORMATION

Provider Name   Community BH Program
Address   123 East Glenmoraine Road
City   Anytown
State   Ohio   Zip   43996-3572
Contact Person   Firstname Lastname

2. SUBMISSION DATE OF THIS FORM
03 / 13 / 18

Individual Provider #   1   2   3   4   5   6   7

Group Provider # 1   2   3   4   5   6   7 (When appropriate)

Telephone # (999) 259-3368 extension 98320

3. CLAIM INQUIRY INFORMATION

Recipient Name   Medicaid Benificiary
Billing # (12 digits)   123456789012
Service Date _____
or
Discharge Date   2/21/2018

4. CLAIM HISTORY INFORMATION

Transaction Control Numbers
TCN   2218000000000
TCN _____
TCN _____

Please note: All transaction control #s are 17 digits

5. Please enter all applicable Medicaid E.O.B. denial codes, which apply to the attached claim.

EOB 5080_____   EOB _____   EOB _____   EOB _____
(Please include all necessary documentation, e.g. remittance advices, Medicare and/or Insurance EOBs).

6. Explanation of request:

Community BH Program provided SUD residential at ASAM level of care 3.1 for TCN 2018000000000 and it was denied for EOB 5080. Patient discharged on this date of service.

SEND TO BH POLICY WORKSTATION FOR REVIEW please

Internal Use Only

Date of Receipt Stamp

MEDICAID USE ONLY   ☐ Claim not approved for processing, please see the attached letter.

Reviewer ID_____

Each claim requires a separate ODM 06653 Medical Claim Review Request Form
Please call our Interactive Voice Response Unit (IVR) at 1-800-686-1516 for claim status verification.

ODM 06653 (7/2014)
Formerly JFS 06653 (Rev. 5/2010)

Note: Please be sure to follow the instructions provided above regarding specific information needed for efficient processing of this type of claim review request. This example is for a denied OSCBH claim on the date of admission to SUD residential treatment.

Ohio Department of Medicaid

MEDICAL CLAIM REVIEW REQUEST

SAMPLE COMPLETED FORM FOR DENIED OSCBH TREATMENT CLAIM

1. PROVIDER INFORMATION

Provider Name Community BH Program
Address 123 East Glenmoraine Road
City Anytown
State Ohio   Zip 43996-3572
Contact Person Firstname Lastname

2. SUBMISSION DATE OF THIS FORM
03 / 13 / 18

Individual Provider # 1 2 3 4 5 6 7

Group Provider # 1 2 3 4 5 6 7 (When appropriate)

Telephone # (999) 259-3368 extension 98320

3. CLAIM INQUIRY INFORMATION

Recipient Name Medicaid Benificiary
Billing # (12 digits) 123456789012
Service Date _____
or
Discharge Date 2/21/2018

4. CLAIM HISTORY INFORMATION

Transaction Control Numbers
TCN 2218111111111
TCN _____
TCN _____
Please note: All transaction control #s are 17 digits

5. Please enter all applicable Medicaid E.O.B. denial codes, which apply to the attached claim.

EOB 5088   EOB _____   EOB _____   EOB _____
(Please include all necessary documentation, e.g. remittance advices, Medicare and/or Insurance EOBs).

6. Explanation of request:

Community BH Program provided crisis psychotherapy on date of admission to SUD residential treatment.

SEND TO BH POLICY WORKSTATION FOR REVIEW please

Internal Use Only

Date of Receipt Stamp

MEDICAID USE ONLY

☐ Claim not approved for processing, please see the attached letter.

Reviewer ID_____

Each claim requires a separate ODM 06653 Medical Claim Review Request Form
Please call our Interactive Voice Response Unit (IVR) at 1-800-686-1516 for claim status verification.