BH Managed Care Discussion – Billing and Coding Webinar Agenda
January 16, 2024

11:00 Resources, Updates, and Discussion

- **Key Resources**
  - Current BH Provider Manual (12/22/2023)
  - OhioRISE Provider Manual (12/18/23)
  - CME Manual (6/21/22)
  - ODM Press Release (12/22/23)
  - Medicaid Managed Care News for Providers – sign up for these communications specific to procurement at the bottom of the page here.
  - If you do not receive the BH Bulletin you can sign up HERE.

Ohio Medicaid Rate Increases for CY24 – Updated BH & OhioRISE Manuals

Ohio's recent State Fiscal Year 2024-2025 budget included historic rate increases for Medicaid providers, including Community Behavioral Health providers. Rate increases are scheduled to become effective January 1, 2024 for fee-for-service and managed care Medicaid.

To help providers prepare for the upcoming rate increases, the Behavioral Health Provider Manual and the OhioRISE Provider Enrollment and Billing Guidance Manual were released with several updates, including the proposed 2024 rates. Other changes to the BH Manual include content updates and clarifications, removing outdated information, and incorporating the Opioid Treatment Program Manual.

Ohio Medicaid's BH Coding Workbook also has been updated to include 2024 rates. Please note that the workbook includes two worksheets (tabs); one for rates currently in effect and one for the rates to be effective in 2024. All resources are available online at Manuals, Rates, and Resources | Medicaid (ohio.gov).

Has your organization billed claims with a date of service in 2024 yet? If so, were you paid at the new increased rates? If not, which plans are paying incorrectly?

PNM Refresher Training Documents

Slides from the November PNM Refresher trainings and FAQ documents are linked below and are available in the Maximus training platform, myabsorb.

Slides

- Updating an Individual Practitioner's Record

- Updating a Group/Organization Medicaid Record
- Updating and Managing Affiliations
- Provider Administrator User
- Provider Agent User
- Maintaining BH Provider Records

FAQ documents

- Provider Administrator User Refresher
- Provider Agent User Refresher
- Updating Affiliations Refresher
- Updating Group-Organization Records Refresher
- Updating Individual Practitioner Records Refresher
- Maintaining Behavioral Health Provider Refresher

Helpful Information from the PNM Refresher Slides and FAQs

Contact Information

Phone Number	
Ohio Dept of Medicaid Integrated Help Desk	**1-800-686-1516** PNM Assistance/Error Messages: *Option 2 followed by Option 3* Ohio Medicaid Enrollment/Credentialing Questions: *Option 2 followed by Option 2*

Emails	
ODM Integrated Help Desk	**ihd@medicaid.ohio.gov**
PNM Troubleshooting/ Error Messages	**pnmsupport@medicaid.ohio.gov**
Ohio Medicaid Enrollment (for updates to specialties)	**Medicaid_Provider_Update@medicaid.ohio.gov**
Ohio Medicaid Credentialing Questions	**credentialing@medicaid.ohio.gov**
Training Assistance and Resources	**ohiotrainingteam@maximus.com**

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Ohio | Department of Medicaid | Provider Network Management | Medicaid Home | Learning

PNM 'Learning' Tab Resources

- Frequently Asked Questions (FAQ)
- **Provider Category User Guide:**
  - Group/Organization
- **Quick Reference Guides:**
  - Updating or Adding Practice Locations
  - Updating or Adding Owner Information

- The 'Learning' page (Provider Education & Training Resources) offers a wealth of information and user guides to complete a variety of processes in PNM.
- Each of the documents listed under the Quick Reference Guides section allows you to complete a process/function within 9 steps.
- These are accessible to any person accessing PNM; the user does not have to log in to access these documents.

Provider Education & Training Resources

Frequently Asked Questions (FAQ)
- Frequently Asked Questions

PNM Status Definitions
- PNM Statuses

Provider Category User Guides
- Behavioral Health Individual
- Behavioral Health Organization
- Change of Operator (CHOP) Entry
- Comprehensive Maternal Care (CMC)
- Comprehensive Primary Care (CPC)
- Delegated Credentialing
- DODD Waiver and Non-Medicaid
- Group/Organization
- Individuals
- Long Term Care Facility
- ODA Waiver
- OhioRISE

Quick Reference Guides

Logging into PNM and Enrolling with ODM, ODA, or DODD
- Creating OH ID for IOP PNM Login
- General Application
- PNM Initial Login

New Users *(never been a provider with ODM, ODA, or DODD)*
- DODD New Provider Application
- ODA New Provider Application
- New Provider Application
- New Provider Application Type 19

Existing Medicaid Records

Account Administration
- Agent Assignment & Actions
- Changing Provider Administrators
- Provider Homepage

Behavioral Health
- Behavioral Health - Adding Specialties and Changing Provider Types

Revalidation
- Revalidation

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Completing the Update Process

Information Updated	Review Type
Change in Provider Name	Manual
Change in Ownership	Manual
Change to Primary Service Location	Manual
Change to other address pages; including Other Service Locations	Automatic
Updating Primary Contact Information	Automatic
Adding Specialties	Manual
Confirming, Adding, or Removing Affiliations	Automatic
Editing or Adding Professional License Information (Ohio License)	Automatic *(with e-license check)*
Editing or Adding Professional License Information (Out of State Lic.)	Manual
Editing or Adding Board Certification	Automatic
Editing or Adding Work History	Automatic
Editing or Adding Education/Training Information	Automatic
Editing or Adding a Medicare Number/Out of State Medicaid Number	Automatic

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Items listed as "manual" require ODM staff to complete the workflow. These updates can take up to 30 **business** days.

Adding an Individual Affiliate

- This page asks you to indicate any individual practitioners that your group/organization/agency is affiliated with.
- To add an individual provider, click **Add New.**
- Having the employing agency perform the affiliation of individual practitioners is the recommended best practice – meaning fewer steps than if the individual affiliates with the agency and the agency confirms.

Individual Providers Associated with Your Group

In the table below, enter or confirm each individual provider that is associated with your group.For Active affiliations, click on the Individual provider's name to update the Individual's enrollment profile.

Note: If the affiliation status displays as 'Individual Enrollment Pending Approval' or as 'Individual Requires Revalidation', the individual provider must create an account in PNM and complete their application for enrollment or re-validation.

Always verify that NPI you enter for Individuals are correct.

Display Active Only ○ Yes ◉ No

Name	NPI	Provider Type	Specialty Type	Start Date	End Date	Affiliation Status	Revalidation Due Date	Medicaid ID	Rendering Location	Directory OptOut	EDIT	DELETE	Reg ID
No affiliations found.													

Add New

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Confirming an Individual Affiliate

Individual Providers Associated with Your Group

In the table below, enter or confirm each individual provider that is associated with your group.For Active affiliations, click on the Individual provider's name to update the Individual's enrollment profile.

Note: If the affiliation status displays as 'Individual Enrollment Pending Approval' or as 'Individual Requires Revalidation', the individual provider must create an account in PNM and complete their application for enrollment or re-validation.

Always verify that NPI you enter for Individuals are correct.

Display Active Only ○ Yes ◉ No

Name	NPI	Provider Type	Specialty Type	Start Date	End Date	Affiliation Status	Revalidation Due Date	Medicaid ID	Rendering Location	Directory OptOut	Edit	Delete	Reg ID
Thom Diggs	1811669669			9/26/2023	12/31/2299	Pending Approval	1/1/1900					✖	

Add New

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- Currently in PNM, there is a system bug that is displaying some Revalidation Due Dates for the year 1900.
- While the confirmation process should work, if you receive an error when trying to confirm, there is a workaround.
  - Note the affiliate's first name, last name, and NPI.
  - Click the red 'X' to remove the 'pending' affiliate.
  - Then, click **Add New** to add the affiliate and follow the process to add an affiliate.

Removing an Individual Affiliate

- Select the plus (+) icon to expand the section titled 'Enrollment Actions'.
- Click the hyperlink for 'Begin ODM Enrollment Profile Update'.
- A pop-up appears informing you that you have 10 days to submit your update.

You will have 10 days to submit your update. After 10 days, your information will be removed, and you will have to restart your update.

Ok

Manage Application

Enrollment Actions	+	Enrollment Action Selections:
Programs	+	Program Selections:
Self Service	+	Self Service Selections:

Enrollment Actions - Enrollment Action Selections:
Begin ODM Enrollment Profile Update
Edit Key Provider Identifiers
Request Disenrollment

***Disenrolling a practitioner from Ohio Medicaid is not the same as removing them as an affiliated practitioner!**

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Currently, it is not recommended to end date/remove an individual practitioner from your organization until all claims have been billed and paid.

Affiliation Status

Name	NPI	Provider Type	Specialty Type	Start Date	End Date	Affiliation Status
Cherry Abary	1821019712	Physician/Osteopath Individual	Family Practice	10/24/2023	12/31/2299	Active

- **Active** – The individual affiliate's Medicaid record is active and linked with the group/organization.
  - An 'Active' status is needed for affiliate information to be successfully communicated from ODM to the Managed Care Organizations.
- **Confirmed** – The individual has been confirmed as an affiliate of the group/organization.
- **Pending Approval –** The individual has indicated affiliation with the group/organization and must be confirmed.
- **Removed** – The individual is no longer an affiliate with the group/organization

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Why don't all our affiliates appear on the Provider Master File (PMF) document sent to the Managed Care Organizations?

- Only individual affiliates with an Affiliation Status of 'Active' will appear on the PMF. An update must be fully processed (submitted and reviewed) before the status will change to 'Active.' If an affiliate is displaying with any status, other than 'Active', their information will not be included on the PMF

How does a provider know once their manual update is complete and will show on the Provider Master File for Managed Care Organizations?

- Under Self Service Selections, the option of "View Provider File" can be chosen. Once this is chosen, the user can go to the 'Group, Organization, and Hospital Affiliations' page to view the status of an individual affiliate. An individual affiliate must display with an Affiliation Status of 'Active' to be included on the provider Master File sent to Managed Care Organizations.

PNM Statuses

Provider Status	Status Description	'Enrollment Action' Link
Not Submitted	Provider has initiated data entry but has not submitted new data	*"Continue Registration"*
Submitted	Screening, Review, Credentialing, Site Visit, BCII reviews are taking place	*No enrollment action links display*
Processing	PNM is finalizing the application	*No enrollment action links display*
Denied	ODM has denied this application (initial applications)	*"Request Reconsideration" "Begin Reapplication"*
Return to Provider	Application/Record has been returned to the provider to act/provide additional information	*"Continue Registration"*
Terminated	ODM has denied this application resulting in a Termination (active provider)	*"Request Reconsideration" "Begin Reapplication"*

Provider Status	Status Description	'Enrollment Action' Link
Approved/ Complete	Provider is active and able to submit updates for the record	*"Begin ODM Enrollment Profile Update"*
Disenrolled	Provider has voluntarily disenrolled	*"Begin Reapplication"*
Suspended	Provider is suspended by ODM	*"Request Reconsideration"*
Pending Closure	Processing is pending for the facility closure	*Once submitted, no links are available until complete*
Pending CHOP	Processing is pending for the change of operator	*Once submitted, no links are available until complete*
Not Processed	Application is incomplete and provider must reapply	*"Begin Reapplication"*

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Does your organization have provider enrollments/updates that have been in the submitted status for more than 30 business days (submitted prior to 11/30/23)? Does your organization have claims coming up on timely filing due to PNM related issues? If so, include the Organization, Provider Name, Medicaid ID and submitted date in this excel document and email to Soley. Please note, there are separate tabs for each question.

Provider Terminations to resume effective January 23, 2024, for failure to complete Medicaid Agreement Revalidations in the Provider Network Management module

If your providers/organization are currently due for a revalidation in the Provider Network Management (PNM) module, it is imperative that you take immediate action to complete and submit your revalidation application to renew your Ohio Medicaid Provider Agreement. Ohio Department of Medicaid (ODM) will begin terminating providers who fail to complete their revalidation prior to their specified deadline, starting January 23, 2024.

ODM resumed provider revalidation notices in June 2023 as part of the federally required unwinding process from the COVID public health emergency. ODM issues a series of notices with the first one delivered 120 days prior to your Medicaid agreement end date. Subsequent reminders are issued at 90 days, 60 days, and a final notice at 30 days. If you receive a revalidation notice, it is imperative that you take action to complete your revalidation on time. All providers are subject to either three- or five-year time-limited provider agreements.

How do you know if you are due for revalidation?

1. Check mail and email – these communications are sent to the provider's primary contact(s).

Revalidation reminder notices are mailed and emailed to providers who are due for revalidation prior to the end of their Medicaid agreement. The email will be sent from OHPNM@maximus.com to advise you of a revalidation notice in the PNM Correspondence folder. Please check your spam folder for this email.

2. View the Correspondence folder in the PNM module.

Revalidation notices are posted in the PNM module and can be accessed in the Correspondence folder. Please be sure to select the type of correspondence from the drop down (in this case <Enrollment Notices>), and search for the "Revalidation Notices." Review the Accessing Communications within PNM Quick Reference Guide for step-by-step instructions.

NOTE: If you think you are due for revalidation but have not received notices, please login to the PNM module and verify that the primary contact information is accurate in accordance with your Ohio Medicaid Provider Agreement. **All mail and email notices are directed to the primary contact individual or address identified in the system.**

If I am due for revalidation, what action do I need to take?

A "Begin Revalidation" option appears in the PNM Enrollment Action Selections 120 days prior to the Medicaid Agreement end date. This can be found under the "Manage Application", "Enrollment Actions" option within the provider file. Review the Revalidation/Reenrollment Quick Reference Guide for step-by-step instructions. **Once a revalidation application is submitted, changes to the provider are unable to be made until the provider has been approved by ODM.**

For more information

For technical support or assistance, contact Ohio Medicaid's Integrated Helpdesk (IHD) at 800-686-1516 and follow the prompts for Provider Enrollment (option two, option two) or email IHD@medicaid.ohio.gov. Representatives are available Monday-Friday, 8:00 a.m.-4:30 p.m. Eastern time.

Medicaid Revalidation Site Visits

BH provider organizations are required to revalidate with Medicaid every 5 years. PT 84/95 are considered moderate risk providers, and this requires a site visit as part of revalidation. For revalidation purposes, PCG will likely conduct the site visit, they may contact the primary contact for the organization in PNM the week of the site visit, but this is no longer scheduled in advance, scheduling was a COVID policy. Please be responsive to PCG if they contact you. PCG may send you materials to prepare for the visit in advance. Below are examples of what other organizations have received.

- Site Visit Letter
- PCG Informational Flyer
- PCG Site Visit FAQ

Some organizations have been told by PCG staff that background checks are required annually. However, the annual background check requirement is specific to the providers of specific services outlined in the PCG informational flyer linked above. Note that it specifically lists Ohio Administrative Code (OAC) 5160-45- 07, (OAC) 5123-2-02 and/ or (OAC) 4766- 3-13. It does not apply to BH providers, unless you are also a waiver services provider, DD provider or Ambulette provider. Although background checks are not required annually, provider exclusion list checks are recommended at regular intervals as outlined in 5160.1.17.8, paragraph D(1). It is best practice to check these lists regularly as anyone listed is not able to be employed by a Medicaid provider.

To check your organization's revalidation status, check the PNM under the pending workflows at the bottom of the PNM screen (once you click on the group record), you should see "site visit" as the status and a date. That status means that ODM has ordered the site visit from PCG and has moved that process to them. They should have the order on file to complete the scheduling. If the date in the row is more than 7 days ago then you can contact PCG at the dedicated phone #: 1-877-908-1746; Option 5 or the dedicated Email Inbox: OH_Provider_Screening@pcgus.com

In addition to these site visits. ODM also conducts unannounced site visits as a requirement to limit fraud and ensure program compliance. These site visits are typically conducted by Public Consulting Group (PCG).

Marriage & Family Therapists and Mental Health Counselors: Enroll in Medicare Now to Become a Medicare Provider

The Centers for Medicare and Medicaid Services (CMS) implemented two new provider types on January 1, 2024:

1. Marriage & Family Therapist (MFTs)
    a. Possesses a master's or doctor's degree which qualifies for licensure or certification as a MFT pursuant to State law of the State in which such individual furnishes marriage and family therapist services.
    b. Is licensed or certified as a MFT by the State in which such individual furnishes such services.
    c. After obtaining such degree has performed at least 2 years of clinical supervised experience in marriage and family therapy; and
    d. Meets such other requirements as specified by the Secretary.
2. Mental Health Counselor (MHCs)
    a. Possesses a master's or doctor's degree which qualifies for licensure or certification as a mental health counselor, clinical professional counselor, or professional counselor under State law of the State in which such individual furnishes MHC services.
    b. Is licensed or certified as a mental health counselor, clinical professional counselor, or professional counselor by the State in which the services are furnished;

c. After obtaining such degree has performed at least 2 years of clinical supervised experience in mental health counseling; and
d. Meets such other requirements as specified by the Secretary.
e. CMS will allow addiction counselors or drug and alcohol counselors who meet the applicable requirements to be an MHC to enroll in Medicare as MHCs

New in 2024 is the ability for MFTs and MHCs as well as addiction counselors who meet MHC requirements to enroll in Medicare as a MHC and bill for services starting January 1, 2024. Starting for dates of Service January 1, you can bill for services furnished for the diagnosis and treatment of mental illness. CMS Released a FAQ Sheet in September outlining additional information about how to enroll as a new Medicare MFT/MHC provider. **While counselors and therapists were added as eligible providers, they are not eligible supervisors of incident to services in the outpatient clinic setting. However, they were added as incident to supervisors in hospitals, FQHCs, and RHCs.**

To enroll, providers must first complete the application. You can complete an electronic version of the application in PECOS or can submit a paper application by filling out the CMS-855I (PDF) paper application and mailing it to your local Part B Medicare Administrative Contractor (MAC). MACs are specific to the region where you practice and may have additional requests for information while they process your application. CGS is the MAC for Ohio. You can also contact your MAC if you need help enrolling, or for updates regarding your enrollment status. CGS has resources related to provider enrollment. CMS and CGS have stated that documentation of 2 years or 3,000 hours is required at enrollment. However, when the experience is part of the requirement for that license, you should not have to submit proof of experience. See question 32 of the CMS FAQ. This means for LPCCs and IMFTs their license will suffice. LICDCs will require documentation of their experience. It is still unclear if LPCs/MFTs that meet the years/hours of experience will be eligible to enroll in Medicare. ***Has anyone attempted to enroll an LPC that meets the requirements?***

The Ohio Council met with ODM to discuss these changes and how they will impact the bypass list and payment for services that are covered by both Medicare and Medicaid. ODM is waiting for confirmation from CMS regarding eligible providers (specifically dependently licensed providers that meet the experience requirements). ODM will be issuing a communication regarding coordination of benefits requirements in the coming weeks. However, if a provider is eligible to bill original Medicare, they must do so in order to guarantee Medicaid payment. The Ohio Council will share additional information as it becomes available.

Medicare Advantage Plans

As a reminder, Medicare Advantage (MA) plans are commercial insurance plans and do not necessarily follow the same policies as Original Medicare. The services BH organizations provide under Original Medicare are covered under the Part B (medical insurance) plan. Medicare Advantage plans are known as Part C plans. MA plans contract with Medicare and provide the same services to Medicare members. However, they have flexibility and

control over their covered network, prior authorization and utilization management policies, and are managed by private insurance companies that require contracting. Additionally, for dually eligible patients with MA plans and Medicaid, organizations must follow the TPL bypass process for coordination of benefits, not the Medicare bypass process.

Coordination of Benefits with Third Party Payers and BH Bypass Process

As a reminder, coordination of benefits (COB) is the process of determining which health plan or insurance policy will pay first and determining the payment obligations of each health plan, insurance policy or third-party resource when two or more resources cover the same benefits for a Medicaid recipient. Coordination of Benefits is a federal requirement that providers are responsible for determining as part of the conditions of accepting Medicaid and ODM and MCOs are required to enforce because Medicaid must be the payer of last resort. **Generally, COB is specific to covered services, rather than specific to covered providers (with the current exception of Original Medicare).**

Organizations must submit claims to the third-party payer (TPP) prior to sending the claim to ODM/MCOs, except for codes identified on the "BH TPL Bypass list". When the claim is not paid, or a partial payment is made, ODM or the MCP will do a cost sharing analysis and may pay an additional amount. The BH TPL bypass list and COB/TPL FAQ are located at https://medicaid.ohio.gov/resources-for-providers/bh under Manuals, Rates, and Resources>Billing Resources> Third Party Liability Resources.

The BH Bypass list is a list of codes that are not commonly covered by TPPs. The list is separated into three sections – **Medicare**, **Medicare Opioid Treatment Program (OTP), and TPL Bypass (for commercial payers, including Medicare Advantage plans).**

- The TPL bypass tab is a list of **specific service procedure codes** that are covered by Ohio Medicaid but are not typically covered by commercial payers (including MA plans).
- The Medicare bypass tab is a list of **specific service procedure codes *and* providers** that are covered by Ohio Medicaid but may not be covered by Original Medicare.

When a patient has a third-party commercial payer, the provider should be in network with that TPP to guarantee secondary Medicaid payment. When the provider is not in network with that insurer, the insurer may pay the claim at the out-of-network (nonparticipating) rate, or they may deny the claim. It is in the provider's best interest to be in-network with the individual's primary insurance plan because Medicaid/MCOs may not pay the difference between the out-of-network or non-participating rate and the Medicaid maximum payment.

The BH TPL bypass list was created to allow for payment for certain services ODM identified that are not typically covered by TPPs***. However, if TPP coverage is later discovered through ODM's or a MCO's post payment recovery process, payment may be recouped in accordance with federal Medicaid requirements. Therefore, if a provider is unsure of a specific TPP's coverage policy for any of these service***

procedure codes, the provider should confirm coverage prior to billing for the service directly to Medicaid to avoid a future recoupment.

Plan Specific Updates/Issues

• Anthem has a known issue impacting claims on the TPL bypass list denying for primary insurance. This should be fixed in February.
• CareSource – The Provider Resource Guide from the last CareSource Connections meeting is available here. The next CareSource Connections is scheduled Thursday 1/25 from 12:30p-1:30p if you would like to be added to the meeting invite contact Caresource_OH_BH@caresource.com.
• Molina has posted their 2024 Next Generation Molina Medicaid Provider Manual and the Significant Update by Chapter: 2024 Medicaid Provider Manual reference document on the Manual page of their Provider Website.

As a reminder, the MCOs CPSE reports are available to determine their system level billing issues:

- Molina Claims Payment System Error Report is publicly available
    - https://www.molinahealthcare.com/providers/oh/medicaid/comm/Claims-Payment-System-Error.aspx
- Buckeye Claims Issues:
    - https://www.buckeyehealthplan.com/providers/resources/forms-resources.html
- Caresource Claims Issues: On the provider portal – must have log in first
    - https://providerportal.caresource.com/OH/User/Login.aspx
- UHC Claims Issues:
    - https://www.uhcprovider.com/en/health-plans-by-state/ohio-health-plans/oh-comm-plan-home/oh-cp-claims.html
- Aetna Claims Issues: On the provider portal –
    - https://www.aetnabetterhealth.com/ohio/providers/notices
- Paramount Claims Issues: On the provider portal –
    - https://www.paramounthealthcare.com/services/providers/provider-news
- Anthem Claim Issues:
    - https://providers.anthem.com/ohio-provider/claims
- Humana Claim Issues:
    - https://www.humana.com/provider/medical-resources/ohio-medicaid/claims
- AmeriHealth Claim Issues:
    - https://www.amerihealthcaritasoh.com/provider/claims-billing/cpse-reports.aspx
- Ohio Rise
    - https://www.aetnabetterhealth.com/ohiorise/providers/notices-newsletters.html

Provider Issues and Escalation:

- Continue to report PNM issues directly to ODM via the IHD contacts
- Continue to send specific claims issues and examples (ICNs) directly to the MCPs and escalate if no response within 72 hours. (***MCO Escalation Contact List***)
- ODM Escalation via the **ODM Managed Care Provider Complaint Form: https://providercomplaints.ohiomh.com/**

<u>Please use the MCP escalation contact and report unresolved issues directly to ODM</u> – ODM uses these complaints to track and understand provider complaints.
This process is the best opportunity to document the extent of the continuing billing and payment issues. If you have an assigned ODM primary contact person – use them!

NEXT WEBINAR:
Ohio Council Monthly Billing Webinar - Tuesday February 13, 2024, from 11:00am-12:30pm. Registration will be sent closer to the date of the webinar.

SAVE THE DATES:
The Ohio Council's Compliance and Quality Conference – March 5 & 6, 2024 – Columbus, OH. Join us to hear the latest on topic such as:

- **Anti-trust regulations**
- **Payer audits, overpayments, and revalidation**
- **Labor and employment law updates**
- **Telehealth regulations**
- **Medical & recreational cannabis policies & best practices**
- **Documentation best practices**
- **Patient experience and outcomes measurement**

Registration information will be sent in the coming weeks.

2:30 Adjourn

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