



Medicaid Information
Technology System

October MITS Training FAQs

December 22, 2010

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OCTOBER MITS TRAINING FREQUENTLY ASKED QUESTIONS (FAQS)

Question Number	Attendee Questions/Comments	Answer
1	Even if we have a billing service and Medicaid is requesting additional info or attachments, can we upload attachments and info here or should we still upload to the billing service and let them submit to Medicaid?	It is providers' responsibility to manage who has access to the national provider identifier (NPI) that is associated with their organization and how they manage the processes available within the new portal.
2	How will claims be submitted for surgical procedures that require a consent form, i.e., tubal ligation and hysterectomy?	Providers will be able to submit these types of claims using either the 837 HIPAA Transaction or via the MITS Web Portal, including uploading or mailing in the consent forms. Providers that do not have the available tools to scan and upload documents will need to fill out the EDMS cover sheet, which is required when attachments are submitted by mail.
3	How do providers bill denied Medicare claims that are currently sent with a 6653 Problem Claim Form?	The provider will follow the current process at Go-Live.
4	Will providers who provide only HCP waiver services use the new portal to view their financials?	Yes

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5	Will electronic funds transfer (EFT) payments still be made weekly or changed in any way after this change to MITS? Will provider EFT information as it exists right now be transferred after Go-Live?	Ohio Medicaid will continue to make weekly EFT payments based upon processed transactions within the weekly financial cycle. Current provider EFT information will be transferred into MITS.
6	One of the annoying features of the current MMIS portal system is that providers need to change the log-in password every two months. Will that still happen in MITS?	In order to meet HIPAA security standards, the new MITS Web Portal passwords will expire every 30 days.
7	How will infusion drug claims be submitted within MITS? Currently, they are submitted with the Medicaid provider number and pharmacy NABP number.	These claims must be submitted through ACS as pharmacy claims.
8	When entering a claim, where do we put the patient liability?	In the “Patient Amount Paid” field on the primary panel of the institutional claim. The claim will deny if the “Coordination of Benefits Patient Paid Amount” field is used for patient liability.

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9	Does MITS have a recipient management screen that repopulates the ID number, name, etc., to the new claim?	The MITS Web Portal is a direct data entry portal, and only one claim at a time can be submitted. There is no save feature within the portal. However, the MITS Web Portal does have the “copy claim” function. If a paid claim is copied for the same recipient, then only the information needed to be changed – such as the dates of service, procedure codes and/or units – would need to be edited. This feature is helpful when you provide the same service to a recipient on a daily or weekly basis.
10	Are all services on the All Services Plan for home health patients going to require a prior authorization in MITS?	No
11	Home health care providers have never had to get prior authorization for Medicaid State Plan services, up to 14 hours per week (i.e., HHA, PT, SN). Has this changed?	No, state plan home health services do not need to be prior authorized.
12	Will source codes be used within the new system? They are currently an option in MMIS, but are they on the CMS 1500 form?	Yes, source codes will be used in the new system. This information will be captured through the drop-down options available through the third-party liability section of the claim type being submitted.
13	With infants not having a 5.5H, it makes it impossible to locate a Medicaid ID. Will there be a way to locate them, when use of the IVR is not successful?	At Go-Live, MITS will be unable to locate Medicaid ID numbers, but it is something that will be pursued in the future.

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14	Will Permedion have full answers as to why a reversal of payment was done? As of now, only one person is permitted to be a “liaison” for Permedion, which makes it difficult to get answers.	For reversals initiated by Permedion, providers will receive a letter of explanation, and Permedion will be able to answer questions. For reversals of payment initiated by ODJFS, ODJFS will be able to answer questions. If you are not sure who initiated the reversal, contact 1-800-686-1516.
15	Will there be a printable confirmation page after a claim is submitted?	Once you submit a claim via the MITS Web Portal, the claim will come back within a few seconds as paid, denied or suspended. When this information comes back, it will contain an Internal Control Number (ICN), which will be confirmation that the MITS system received the claim. This page can be printed, or the ICN can be recorded.
16	Can room and board and co-insurance be sent together on the same claim?	No. Coinsurance must be submitted on Medicare crossover claims, not room-and-board claims. For third-party-lender-only claims, providers should submit claims directly to Medicaid with “other insurance” identified on the claim.
17	Will providers still be able to search by name for eligibility and not just date of birth?	When checking eligibility, there are only two ways to look up a recipient within the new MITS Web Portal: <ul style="list-style-type: none"> • Recipient's Medicaid ID number, date of birth and a valid date of service. • Recipient's social security number, date of birth and a valid date of service.

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18	Is form 6780 going away?	The 6780 form will be discontinued upon Go-Live. The information formerly entered on this form should be entered in the new MITS Web Portal using the “Other Payer” panels.
19	Will providers have a way to look up newborns that do not have a date of birth, but do have a social security number?	At this time, providers will not have access to Healthchek. Providers will be able to search for a recipient by security number, the child's billing number or name. *Answer Revised 1/19/2011
20	How will trading partners get access to and switch between client national provider identifiers (NPIs)?	Medicaid providers must first set up their trading partners as agents in order for them to get access to their portal accounts. Once that is done, it is very easy for trading partners to switch between authorized provider IDs as agents.

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21	For audit purposes, will you be able to determine or view which agent entered a claim or a prior authorization (PA) request?	There is no way to determine who submitted a claim or PA request through the MITS Web Portal. Only those who have been granted “submit access” to either claims, PA requests or both will be able to submit claims or PA requests.
22	Will date of birth be required to submit a waiver claim?	Yes, a date of birth is required to submit a waiver claim.
23	Will current PAs created in MMIS be viewable in MITS? How will providers track PAs?	Current PAs within MMIS will be transferred into the MITS system. Providers will be able to track PAs through the MITS Web Portal. Once a PA is submitted and accepted into MITS, a tracking number will be provided. The tracking number is a confirmation number, not an approval or denial of the request.
24	Can you back-date PAs?	Policy defines what needs to be prior authorized. Only in extreme, special circumstances is something authorized after service delivery.

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27	Can we still use the generic provider ID 911115 if we have a valid NPI number on the claim?	No, you will not be able to use the generic provider ID. In July, the associations were notified that Ohio Medicaid will no longer accept the generic “dummy ID” 911115 in lieu of an NPI on claims. This applies specifically to medical practitioner ID fields, such as the referring provider ID on professional and dental claims and the attending provider ID on institutional claims. The medical practitioner’s NPI should be used in these fields, even if the practitioner is not a participating provider. As a result, everyone who provides a medical service is required to have an NPI. If you do not have an NPI, you will need to get one. You can go to the Centers for Medicare and Medicaid Services’ National Plan and Provider Enumeration System (NPPES) Web site and apply for one.
28	If a recipient has more than one Medicaid ID number, will the system show both?	Yes, MITS will show all recipients’ Medicaid ID numbers.
29	Will it be possible to cancel a prior authorization request in the system if a recipient's condition changes (for example, if a baby gains weight or a hospice patient becomes acute).	Once a PA has been approved or denied, no changes can be made by the provider. If you wish to make a change to the PA, you will need to submit a new PA request. If you wish to cancel the PA, you can contact the PA area and request in writing that the PA be canceled.
30	Will there be a code on the 837 to indicate that you are uploading an attachment electronically?	Notification of a forthcoming attachment for a claim may be provided in the PWK segment of the 2300 loop.

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31	If you submit a drug on the NDC panel, will it be routed back to ACS, so providers no longer have to send the universal drug claim form?	Pharmacy claims must be submitted to ACS directly.
32	Is the system capable of tracking hospital leave days?	Yes, for long-term care claims providers will be able to verify the number of leave days used/paid through the MITS Web Portal. For hospital claims, MITS can track the source of admission and the discharge status. ODJFS does not pay the hospital for days of leave from the hospital.
33	Will it be possible to query MITS via “back door access” and retrieve results (such as claim info)?	The new MITS Web Portal is a direct data entry system. The only entry is through the main portal log-in process. If providers would like to use batch transactions, then they should use HIPAA transactions. For more information about this, go to the Office of Ohio Health Plans’ EDI Web site.
34	Does the state plan to implement Correct Coding Initiative (CCI) edits?	Yes. Section 6507 of the federal Affordable Care Act requires Medicaid programs to incorporate compatible national CCI methodologies. The Office of Ohio Health Plans is currently reviewing federal guidance and analyzing the impact on our systems.
35	If attachments are sent in, how long will they be available for providers to view, if needed?	Initially, when MITS goes live, providers will not be able to see attachments that they have uploaded; however, they will have that ability at a later date. At Go-Live, the only attachments able to be seen by providers through the portal will be letters sent to them by the Office of Ohio Health Plans.

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36	Can providers look up procedure codes for consumers to see if they can receive services not delivered by that provider? For example, if a consumer asks a home care aide if the aide can find out when the consumer's next dental cleaning will be due, can the aide look up a dental code for this consumer?	The recipient's dental information would be available to any Medicaid provider accessing the Web Portal, including a personal care aide. However, unless the information is being used to provide treatment, because of the HIPAA confidentiality provisions, the information should be accessed only with authorization from the recipient.
37	Will MITS claims accept the modifiers RT and LT?	Yes, but they are appropriate only for certain procedures.
38	Will the claims that are now going to be on the UB04 still have the same restrictions as the 92s as far as 50 lines per claim if submitted by paper?	Yes.
39	Will you be alerted if you are approaching the 50-claim limit?	The messages are the same on the Web Portal for dental, institutional and professional claims. The error message for the "copy claim" and "submit" buttons is as follows: "May not exceed 50 new claims per day, per Provider ID. New claims must wait until next day - reached daily maximum per Provider ID."

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40	Will there be changes to the prior authorization list?	Ohio Medicaid will maintain the same coverage policies in MITS. Services that currently require prior authorization or pre-certification will continue to require prior authorization.
41	Will urgent and emergent admissions now need pre-certification?	The pre-certification list has not changed, and there will be no additional precertification requirements in MITS.
42	Is the “My Ohio” site going away for all-service plans (CareStar)?	No, this will remain.
43	If we provide non-medical services for developmental disabilities for personal care and homemaker service, does this go through MITS?	Claims for consumers enrolled in developmental disability waiver programs will not be directly billed to MITS. Billing practices within the developmental disability system will remain as is. Claims for consumers enrolled in waiver programs administered by ODJFS will be directly submitted to MITS. Home health and private duty nursing claims will be submitted directly to MITS.
44	Will any of the home health billing procedure codes change with the MITS system?	No, the procedure codes and modifiers for home health remain the same.
45	Can we earn continuing education credits (CEUs) by attending MITS training Webinars?	Neither Ohio Medicaid nor HP is tracking trainee attendance. Please check with the people who monitor your CEUs for this answer.

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46	When should we request a prior authorization for a Medicaid home health service?	Prior authorization policies are not changing with the implementation of MITS. Please reference your companion documents on the ODJFS Web site for a description of services requiring prior authorizations. Medical necessity for post-hospital home health services, not a prior authorization request, is required for Medicaid home health services above 14 hours a week; complete ODJFS Form 07137, “Certificate of Medical Necessity Home Care Certificate,” and retain it in the recipient's medical record.
47	Will we be able to enter hospice service span information directly into MITS instead of keying this information into the IVR?	Not yet. When MITS goes live, hospice care will be processed the same way it is today. You will be notified by the state when that changes. Until then, hospice providers must continue to use the IVR process.
48	I have not submitted any test claims yet. Do I still have time to do that? Is it the same test site that was used with MMIS?	If the state opens up a site for sending test claims, providers will be notified in advance. This is currently not an option.
49	Will the MITS Web Portal have a contact button where we can submit billing questions?	No, the portal will not have a “button” or area to submit questions. Billing and other questions should be submitted the same way you submit questions today: via the Provider Call Center. However, at Go-Live a special MITS Phone Help Desk number will be provided for an undetermined amount of time. Please watch the ODJFS Web site for more information.

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50	Will nursing home rates be available online?	No, not at the Go-Live date.
51	What version of .Net does the application use?	The version of .Net does not impact providers' access or portal abilities.
52	Should we still fax "FACT" forms with third-party information changes?	No.
53	If you submit a claim online and want to mail attachments, where do you mail the attachments to and how will they get attached to the claim?	During the claim submission process in MITS, at the "Attachments" panel section, you will be prompted to print the Electronic Document Management System (EDMS) cover sheet, which you will be required to include when mailing attachments. Instructions are on the EDMS form. The MITS system will automatically join your attachment to the claim when it is received.
54	We have two Medicaid numbers, one for injectables and one for regular children's mental health services. Do we have to complete the account set-up process for both? Today, we submit some claims using the 6780 form. Will we continue that in the new portal?	If you have two provider numbers and they send claims through the current MMIS portal, then yes, you will have to complete the provider set-up process for both numbers. If one of the numbers is used for pharmacy claims, you should continue to submit your pharmacy claims the same way you do today. The 6780 form is being discontinued. After Go-Live, crossovers can be billed through the MITS Web Portal by completing the "Other Payer" panels on the claim.

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55	Will encounter data from managed care claims be available in the MITS Web Portal for providers to see when they look up a recipient, date of service or procedure code?	Claim information submitted to a managed care plan will not be available on the MITS Web Portal. Providers will need to contact the recipient's managed care plan for claim information.
56	Will we still use 137 and 138 TOB claims?	Yes, with EDI claims only.
57	Do we have to re-link all individual providers to group providers at Go-Live?	If your providers are linked to a group provider in the MMIS today, you will not have to re-link this information. The provider information in the MMIS will be moved into the new MITS as is. Please verify that all providers are linked correctly to the group to ensure that the information that is moved into MITS is correct. Professional physician services delivered to hospice recipients and billed by hospice providers must have the physicians affiliated with the hospice NPI; this is new and must be done by completing the ODJFS Form 6777 Group Practice Provider Information form.
58	Is there a limit on how many agents from one facility can be active on the MITS Web Portal at one time?	There is no limit to the number of agents that can be logged into the MITS system.
59	How many days prior to the first of the month can we verify eligibility?	The MITS Web Portal provides current eligibility only. You cannot look up eligibility for future dates.

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60	What is the defined difference between pre-certification and prior authorization?	Pre-certification is the approval of services to be provided in a specific location, such as an inpatient hospital or an outpatient setting. For hospitals, prior authorization (PA) is the approval of non-covered services, such as medically necessary cosmetic surgery. For non-institutional services, Ohio Medicaid requires PA for certain durable medical equipment, for certain dental and vision services, for private duty nursing, and for items and services that will be provided to children in excess of established coverage limits. Additionally, PA is needed for certain pharmaceuticals; pharmacy PAs are handled through ACS instead of ODJFS.
61	For those who aren't paid by direct deposit, will any outstanding checks be visible in the financials section?	The only financial information available to providers on the new MITS Web Portal will be the 1099 information and remittance advices. Providers will be able to call the IVR to retrieve payment information from the last three financial cycles. For other questions regarding payments or outstanding checks, providers should continue to follow current processes.
62	Will it be possible to see pending eligibility? For example, will case pending information show up under "Verification" or the name of the case worker?	No.

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63	Who will see the 12-month claims history information, the administrator or the agent?	The administrator will be able to see all provider information. Agents will be able to see claims history information if they are given the “Claims Search” role.
64	Slide #23 discussed paper claims with attachments (Region Code 11). Because after Go-Live only straight Medicaid claims will be accepted, however, will Region Code #11 go away?	This region will not be used after Go-Live.
65	Will the managed care plan policy number appear in MITS?	MITS will show the managed care plan policy number and third-party liability number if applicable.
66	How long does a claim hold in “Pending” status until it denies?	When a claim is pending, Office of Ohio Health Plans staff will review it to determine how it should be properly adjudicated.
67	If a psychiatric inpatient requires a medical procedure such as an MRI or CT scan under a secondary medical diagnosis, would that have to be preauthorized through the MITS Web Portal?	All psychiatric inpatient admissions require precertification. However, most medical procedures, such as MRIs and CT scans, do not require prior authorization or pre-certification. The only time additional authorization may be needed is if a patient is transferred from a psychiatric unit to a medical unit within the same institution and a non-routine surgery requiring PA is needed.

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68	For claims by independent providers, how does this new system allow providers who share limited visits per year know the total remaining benefits (units) prior to claim submission? For example, if occupational therapy and physical therapy share 30 visits a year, what happens if the client has received physical therapy services for several weeks and also needs occupational therapy? How can each therapist know initially and on an ongoing basis how many services remain? What happens if each discipline provides services in good faith but doesn't know if units/visits have been used? Payment would be on a first-come, first serve basis, correct? Can the system warn occupational and physical therapy providers when few visits remain?	By using the MITS Web Portal, providers can learn how many units a consumer has received of a procedure code or a covered service.