



POINTERS FOR PROVIDERS: CLAIMS IN MITS

On August 2, 2011, the Ohio Department of Job and Family Services (ODJFS) replaced its nearly 30-year-old Medicaid Management Information System (MMIS) with a new web-based Medicaid Information Technology System (MITS). MITS is designed to have greater flexibility, adaptability and functionality for providers. Provisions of the Ohio Administrative Code (OAC) can be implemented more easily in the MITS structure.

This bulletin is intended to address some common questions you and other providers may ask about how MITS works and how it will affect your Medicaid claims, such as:

- What jargon do I need to learn in order to "speak MITS"?
- Is my Medicaid Provider ID Number still good?
- Can I still generate paper claims and mail them in?
- What specific impact will MITS have on me when I submit claims for professional services, dental services, hospital services or other facility-based services?
- What sorts of things can trigger a claim denial in MITS?
- Where is the instruction manual?

Almost all transactions in MITS are processed through electronic data interchange (EDI) or the MITS Web Portal. If you do not already have a MITS Web Portal account, then now is the time to set one up. To access the MITS Web Portal, go to the Ohio Medicaid website:

<https://portal.ohmits.com/Public/Default.aspx>.

Deciphering Claims Terminology

Because MITS takes a whole new approach to claims processing, some terms are used a little differently than in MMIS. Other terms retain the same meaning, but you may encounter them more frequently. And some terms represent entirely new concepts.

Claim Validation

Edits and **audits** are validation processes; they ensure that claims are adjudicated in accordance with established policies. Edits operate within a single claim. Edits check for presence, format, consistency and reasonableness of data, as well as for allowable values. An edit is essentially a process that asks yes/no questions. (For example: Was the recipient eligible on the date of service? Can this provider be reimbursed for performing this procedure? Is reimbursement allowed for this procedure provided in this place of service? Can this modifier accompany this procedure code?) Audits, on the other hand, check for policy restrictions based on other claim line items. An audit compares the data of a claim being processed with data from the paid claims history to determine appropriateness. One audit, for example, checks to see whether a claim item duplicates another reimbursed service or exceeds a service limit.

Payment-Related Codes

As many as four codes may be associated with a claim adjustment. (A claim adjustment is an action that results in a difference between the charge amount and the reimbursement amount.)

1. When an edit or an audit encounters a validity problem, a corresponding four-digit *Error System Code (ESC)* is generated; informally, the system is said to "post an edit/audit." ESCs are also referred to as "error codes," "edit codes," "audit codes" or "exception codes." In MITS, ESCs in the ranges 0001–4999 and 7000–7199 represent edits, and ESCs in the range 5000–6999 represent audits.
2. When an electronic claim is processed, certain information about a payment adjustment (in particular, the reason why the adjustment was made) is stored in the *Claim Adjustment Source (CAS) segment*, which consists of three parts:
 - A two-letter *Group Code* shows the type of adjustment. Medicare uses this Group Code; Ohio Medicaid does not.
 - CO – Contractual obligation
 - CR – Correction or reversal
 - OA – Other adjustment
 - PI – Payer-initiated reduction
 - PR – Patient responsibility
 - A *Claim Adjustment Reason Code (CARC, or ARC for short)*, as its name suggests, shows the reason for the adjustment. Many payers often informally refer to CARCs simply as "CAS codes." CARCs are reported in remittance advice (RA) transactions and in some coordination of benefits (COB) transactions. These codes are maintained by Accredited Standards Committee (ASC) X12 of the American National Standards Institute (ANSI).
 - A monetary amount or a number of units indicates the quantity.
3. Like a CARC, a *Remittance Advice Remark Code (RARC)* is reported in RA transactions. RARCs are maintained by the U.S. Centers for Medicare and Medicaid Services (CMS).
4. An *Explanation of Benefits (EOB) code* corresponds to a message about the status of a claim or action taken on it. EOB codes are defined by the individual payer. Medicaid EOBs appear on the system-generated RA reports and the MITS Web Portal reports.

The four codes may all be different, as in the following example, which is based on a hypothetical claim submitted directly to Medicaid for a service provided to a Medicare-eligible individual:

ESC 2265 – RECIPIENT COVERED BY MEDICARE PART B

CARC 22 – This care may be covered by another payer per coordination of benefits.

RARC MA04 – Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.

EOB code 0720 – MEDICARE COVERAGE IS PRESENT

Note: Providers do not normally see the ESC. The system-generated RA reports the related EOB code. The 835 EDI transaction reports the related CARC and the RARC. The MITS Web Portal reports the EOB code and the CARC.

Provider Contracts

In MMIS, whether a service was reimbursable often depended on whether the provider had the appropriate provider type and category of service. In MITS, each provider is assigned at least one "provider contract" that includes a list of specific services and supplies for which the provider can submit claims. This provider contract is not the same thing as the Medicaid provider agreement; in fact, it is not a contract at all in the legal sense. Rather, it is a collection of information, based on what a provider submitted at the time of enrollment, that defines the provider as part of a larger group. For example, a provider furnishing orthotic and prosthetic (O&P) devices as well as basic durable medical equipment (DME) will need to be assigned separate O&P and DME provider contracts. A physician furnishing supplies and equipment for use in the

home (rather than during an office visit) will also need to be assigned a DME provider contract in addition to the physician provider contract. *Note: Being assigned a provider contract does not guarantee that you will be reimbursed for providing a service. Providing a service that is not on your provider contract, however, does guarantee that you will not be reimbursed.*

Establishing Identity

Medical practitioners and other "typical" health care providers must enter their National Provider Identifier (NPI) in any claim field that requires provider identification (for example, referring provider, attending provider, operating provider). Claims submitted by typical providers without an NPI will be denied. "Atypical" providers that furnish only non-health-care services are not required to obtain an NPI and can continue to submit claims with only their 7-digit legacy Medicaid provider ID number. An atypical provider that has obtained an NPI, however, must use it on claims.

All claims submitted with the legacy generic "dummy" provider ID number 9111115 will be denied.

Medicaid providers that submit claims on behalf of their affiliated practitioners—such as hospitals, ambulatory surgery centers (ASCs), hospices and group practices—must report the affiliations to ODJFS and keep those reports current. Any claims submitted on behalf of practitioners whose affiliation is not known in MITS will be denied. To report or update practitioner affiliations, complete form JFS 06777, "Group Practice Provider Information," which can be obtained at the ODJFS Forms Central website, www.odjfs.state.oh.us/forms/inter.asp. Submit the form in one of three ways:

1. By mail to ODJFS Provider Enrollment Unit
P.O. Box 1461
Columbus, OH 43216-1461
2. By fax to 614-995-5904
3. As an attachment to an email message with the subject line "JFS 06777, Group Practice Provider Information," addressed to Medicaid_provider_update@jfs.ohio.gov.

Going Paperless

ODJFS will no longer accept the following paper forms:

JFS 03142, Prior Authorization

JFS 03612, Prior Authorization for Dental Services

Provider Enrollment Applications

- JFS 06750, Ohio Health Plan Providers Enrollment Application/Time Limited Agreement for Individual
- JFS 06751, Ohio Health Plan Providers Enrollment Application/Agreement for Organization
- JFS 06752, Ohio Health Plan Providers Enrollment Application/Time Limited Agreement for Practitioner Groups

Note: As of August 2, 2011, provider applications will be accepted only through the MITS Web Portal.

JFS 06768, Claim Credit Reversal Form

JFS 06780, Medicaid Claim Billing Form

Note: Claims adjustments that would previously have been submitted with the JFS 06768 or JFS 06780 will instead be accepted only through EDI or the MITS Web Portal.

American Dental Association (ADA) 1999/2000 claim form

Note: The ADA 1999/2000 claim form is being replaced by the ADA 2006.

Uniform Billing form 92 (UB-92)

Note: The UB-92 claim form is being replaced by the UB-04.

COB claims (Medicare crossover claims and claims involving third-party liability) will no longer be accepted in paper form. These claims must be submitted through the MITS Web Portal or EDI.

Submitting Claims and Other Transactions

The basic process of claim submission remains the same: You submit a claim, and the claim is adjudicated (processed). You will notice a number of differences, however, in requirements of content and form—what information must be submitted and how it must be submitted. Here are some changes to look for, both general and claim-specific:

- Requests for prior authorization (PA) submitted on paper will no longer be processed; such requests must be submitted instead through the MITS Web Portal. Exceptions to this requirement include requests for pre-certification of inpatient psychiatric services, for prior authorization of transplants, and for prior authorization of private duty nursing for individuals enrolled on a waiver administered by the Ohio Department of Aging or the Ohio Department of Developmental Disabilities. Form JFS 03142, "Prior Authorization," will no longer be accepted.
- Claim adjustments must be submitted either through the MITS Web Portal or EDI.
- Supporting documentation for claims, PA requests and provider enrollment applications may be submitted in one of two ways:
 1. Providers can upload documents in electronic format through the MITS Web Portal. 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.
 2. In the MITS Web Portal, providers can generate an Electronic Document Management System (EDMS) cover sheet and then mail the documents along with the cover sheet.
- When resubmitting denied claims, providers must include the 13-digit MITS Internal Control Number (ICN) or the 17-digit MMIS Transaction Control Number (TCN) from the previous claim, whichever is applicable, in order to document timely filing.
- National Drug Code (NDC) information must be submitted through the MITS Web Portal. The NDC must be reported at the detail level on all claims (other than hospital claims) for a procedure code that represents a drug (HCPCS codes in the J series, HCPCS codes in the Q or S series that represent drugs, or CPT codes in the 90281–90399 range). An NDC consists of 11 digits grouped into three segments of five digits, four digits and two digits, respectively. If the NDC printed on a drug package consists of only 10 digits, then add a leading zero to the appropriate segment; omit separators such as hyphens or dashes. In the MITS Web Portal, a claim involving a drug must specify not only the NDC, but also the unit of measure (international unit, gram, milliliter or other unit), the unit price, and the total quantity.

Professional Claims (MITS Web Portal, 837P EDI Transaction, CMS-1500 Claim Form)

- The correct place-of-service code must be specified at the detail level.
- At least one diagnosis code is required on most claims for professional service. On some claims (such as for ambulance service, home health service or waiver service), inclusion of diagnosis codes is optional. On other claims (such as for wheelchair van service), diagnosis codes should be omitted.
- Certain modifiers may be used with specific categories of procedure codes. The appendix to OAC rule 5101:3-4-22 delineates which procedure codes can be used with which modifiers on professional claims. With the implementation of MITS, Ohio Medicaid has adopted 30 additional modifiers, including:
 - Left/right modifiers LT (left side) and RT (right side) — allowed on surgery and specific diagnostic and therapeutic codes; not allowed on codes for radiology procedures or orthotics/prosthetics
 - Site modifiers E1–E4 (eyelids); FA and F1–F9 (fingers); TA and T1–T9 (toes); and LC, LD and RC (coronary arteries) — allowed on surgery and specific diagnostic and therapeutic codes; not allowed on codes for radiology procedures
 - Modifier 25 — used with evaluation and management (E&M) codes, affecting adjudication in select circumstances only

Dental Claims (MITS Web Portal, 837D EDI Transaction, ADA 2006 Claim Form)

- Claims for dental services will be accepted through EDI, through the MITS Web Portal or on paper. (Only Medicaid claims that do not involve payment by a third party may be submitted on paper.) Submitting claims through the MITS Web Portal is a cost-effective and more efficient method that will help to reduce claim-processing time.
- The MITS Web Portal must be used for submitting dental claims with attachments that cannot be uploaded in any of the accepted electronic formats, such as claims for dental services covered and priced by report (BR) that must be accompanied by radiographs and detailed documentation of findings and treatment.
- Form JFS 03612, “Prior Authorization for Dental Services,” will no longer be accepted. Additional documentation necessary to complete the PA request that cannot be uploaded through the MITS Web Portal (such as X-rays and dental molds) must be submitted separately. Such documentation must include the PA number assigned by MITS and must be mailed to the appropriate address.

Institutional Claims (MITS Web Portal, 837I EDI Transaction, UB-04 Claim Form)

Hospitals and other facilities must submit claims in accordance with National Uniform Billing Committee (NUBC) guidelines and the EDI Companion Guides.

Hospital Claims

- The Ohio-specific E and F series of value codes for Medicare Part C claims have been discontinued. These codes were previously used only on paper claims. Providers must report HIPAA-compliant

codes on all COB claims. Standard code lists are available on the Washington Publishing Company website, <http://www.wpc-edi.com>.

- Occurrence code 57, which had been used to report the Medicare Paid Date, has been discontinued. This code was previously used only on paper claims.

Hospital Claims — Inpatient

- Bill Type 12X will be used only for Medicare Part B crossover claims.
- If both covered and non-covered days are reported at the header level, then they must be reported on separate lines at the detail level. All charges associated with non-covered days (such as room and board) must be included in both total charges and non-covered charges at the detail level.
- Interim bills (Bill Types 112 and 113) will be accepted only in 30-day increments.
- A final interim bill (Bill Type 114) will be accepted only from DRG-exempt providers. Psychiatric hospitals can no longer use this bill type.
- Claims involving transfers between acute and distinct-part psychiatric units no longer have to be submitted on paper. Acute stays can be reported together on a single claim transaction, and the distinct-part psychiatric intervals are reported as non-covered days.

Hospital Claims — Outpatient

- Discharge status must be reported.

Long-Term Care Facility (LTCF) Claims

- Nursing facility (NF) claims will be accepted both through the MITS Web Portal and through EDI.
- An adjustment claim submitted with billing errors may result in a "take-back" of the previous reimbursement amount even when the adjustment is denied. In such cases, a provider must "resubmit" a new claim rather than an adjustment claim.
- The JFS 09401 is still required for reporting LTCF admissions, discharges and deaths to a county department of job and family services (CDJFS). Medicaid hospice enrollment must also be reported using the JFS 09401 to ensure proper payment of the hospice provider serving an LTCF resident.
- To receive reimbursement for a short-term convalescent stay by an ODJFS waiver recipient, NFs must do three things:
 - Report the NF admission to the CDJFS on the JFS 09401 form.
 - Request a level of care (LOC) for the admission.
 - Report revenue center code 160 on the claim.

Note: This process does not apply to NFs providing waiver respite services. These NFs must submit claims in accordance with the recipient's approved service plan.
- The Ohio-specific E and F series of value codes for Medicare Part C claims have been discontinued. HIPAA-compliant CARCs and amounts must be used to report Medicare Part C deductible, coinsurance, co-payment and allowed amounts. Standard code lists are available on the Washington Publishing Company website, <http://www.wpc-edi.com>.

Other Institutional Claims

- Occurrence code 51, which had been used in connection with the timing of dialysis claim payment, has instead taken on the new CMS definition (date of last Kt/V reading).

Understanding Claim Denials

Because MITS can ensure more precise adherence to Medicaid rules, you may see some differences in claims adjudication. Here are a few examples of factors that could cause a claim to be denied appropriately in MITS, even though it would have been processed for payment in MMIS:

The provider is enrolled with an incorrect provider type or has not been assigned the right provider contract.

The provider type and specialty of the billing provider conflict with the provider type and specialty of the rendering provider.

The rendering provider is not on file as a member of the billing provider's group.

The service is not separately reimbursable when it is provided in the specified location (place of service).

A code listed on the claim, such as a procedure code or diagnosis code, is invalid because it is not part of the standard code set.

Finding More Information

Medicaid providers need to learn all they can about the procedural changes that will be occurring as a result of MITS implementation. Billing guides for the MITS Web Portal, for EDI, and for paper claim formats are available at <http://emanuals.odjfs.state.oh.us/emanuals/>. Just look for the “Billing Instructions” manual within the “Ohio Health Plans – Provider” folder located on this web page. These guides offer practical suggestions and tips for submitting claims successfully. Many other MITS-related resources—such as provider information releases, provider training material, publications, implementation notices and other communications—that more fully address topics in this bulletin are available on the MITS website:

<http://jfs.ohio.gov/mits/>