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**October 2011 MITS Provider Training FAQs**

**November 16, 2011**

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*\*Please Note: Responses are current as of 11/16/2011, and are subject to updates.*

## OCTOBER 2011 MITS TRAINING FREQUENTLY ASKED QUESTIONS (FAQS)

Question Number	Type of Question	Attendee Questions/Comments	Answer
1	Claims	What is the Referring Provider ID? Is it the provider NPI or is it their Medicaid ID #?	To identify the Referring Provider on your claims you may use the Referring Provider's NPI.
2	Claims	When a claim is denied and you pull it up with the ICN do you have to change the detail section?	If you are trying to correct a denied claim you need to change whatever it was on the claim that denied it. Please review the EOB codes on the denial for the reasons the claim denied. The denials may have been caused by an error in the detail section of the claim, the header area or both.
3	Claims	The provider training doesn't show how to correct the common error code 16 and 125 which comes again and again. I have tried to read everything at <a href="http://jfs.ohio.gov/mits/index.stm">http://jfs.ohio.gov/mits/index.stm</a> .	Unfortunately this is not something that can be addressed without looking at the specific claim. For any questions you have, regarding specific claim denials, you will need to call the provider reps on the IVR. When you call please have the ICN of the claim so that the representative may look at the claim and assist you.

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Question Number	Type of Question	Attendee Questions/Comments	Answer
4	Claims	What does it mean when you get a message that say's Provider not eligible for this type of service?	You should speak with provider Enrollment and verify that your provider contract is correct for the services you are billing.
5	TPL/COB	Other payer details and adjustment reasons, are they different for MC/Med vs. HMO/Med crossovers?	All Payers should be using HIPAA compliant ARC and CAS codes. For a listing of the current codes please go to the Washington Publishing Company website at <a href="http://www.wpc-edi.com">www.wpc-edi.com</a> .
6	MITS Account	We seem to be having problems with the password continually getting locked out. What is the problem? What are we doing wrong?	This is a provider specific issue with your MITS account and we would need to speak to you individually about this problem. Please contact our call center at 1-800-686-1516 and speak with a provider rep.
7	MITS Account	Can the Administrator email be identified if there are questions related to access? For a large facility it would be helpful to know who to go to.	You need to speak with the manager of your office to obtain the name of the Administrator of the MITS account. Please remember that the MITS Web Portal is a web based application and access to any Administrator or Agent accounts are to be HIPAA compliant and secure, therefore we cannot divulge any email or password information.

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Question Number	Type of Question	Attendee Questions/Comments	Answer
8	Attachments	When we upload something, we get a tracking number, however we then get a denial on our EOB that says waiting on upload. Are we doing something wrong?	There was an issue that should have now been corrected, so you may now try your upload again. If you still have problems please contact a Provider rep at 1-800-686-1516.
9	Eligibility	For eligibility search - Is ODJFS exploring the opportunity to expand the limited 6 month search window to 12 months?	No, this is not something that is being discussed. Providers are able to get eligibility information for a 12 month span. You just need to search for the information by putting the From DOS and To DOS in by 6 month increments. Also, by limiting, or scaling down, your search criteria you will have your search results faster.
10	Claims	How do we void a bill that is older than 3 years old?	Please contact the Adjustment Unit at 614-466-5080 for assistance with claims over 3 years old.

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Question Number	Type of Question	Attendee Questions/Comments	Answer
11	Attachments	What is proper way to submit Permedion claims with attachments - hard copy or electronic submission?	All claims with attachments need to be submitted electronically, either through the Web portal or your EDI process. Please see the MITS Information Release, on the ODJFS Website, dated September 30, 2011 - Attachments for Electronic Claims.
12	TPL/COB	Our ESRD Medicare EOB doesn't show line item detail. When entering the secondary claims online that don't automatically crossover, how do we enter the Medicare info without doing line level detail?	If the primary payer EOB indicates that they paid their claim at the header level, and not the line item detail, then you would enter the information at the header level of the crossover or secondary claim.
13	Claims	Can you correct a claim thru our electronic vendor or do all corrections need to take place on MITS?	Providers can correct, or make adjustments to, claims either through the EDI process or the MITS Web portal.
14	Prior Authorization	Do medical inpatient claims require authorization? Is there a list of services that require authorization?	There have not been any changes to services that require prior authorization. Providers will be notified if there are any changes in the future. Please review your eManuals for information on Prior Authorization.
15	MITS Account	How long does access take after user id and password are created?	You should be able to get into the system immediately. If access is not immediate, it possible you have not completed all of the steps required to activate your account. Please review the training information related to MITS access at <a href="http://jfs.ohio.gov/mits/MITS%20Provider%20Training.stm">http://jfs.ohio.gov/mits/MITS%20Provider%20Training.stm</a> .

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			In addition to the training material there are eTutorials also available on the training page that will walk you through a step by step process. If you still encounter problems you will need to call the IVR for further assistance.
16	Claims	How are the AN condition codes identified on the claim submission?	Please note that on the MITS Web Portal there are several areas of the claim that need to be accessed by clicking on a "hyperlink". For institutional claims these include condition codes, value codes, ICD-9 codes, etc. These "hyperlinks" are located at the bottom of a panel and are in blue font. You need to click on the hyperlink so that the panel can open up for you to enter the information. If you need more assistance please review your hospital billing instructions and if necessary contact the IVR.
17	Claims	We received a denial stating valid dx code required. Are there certain CPT codes that require certain dx codes?	Please make sure you are using a current valid diagnosis code, and also that you are reporting it at the highest specificity. If you previously reported it as a 3 digit code, it may now need to be reported with the 4th or 5th digit. <a href="#">For information on codes, see the EDI Companion Guide for Institutional Claims in MITS.</a> Also see "The Uniform Language of Code Sets" (a MITS Supplemental Policy Release): <a href="http://jfs.ohio.gov/mits/Code%20Sets%2003.11.pdf">http://jfs.ohio.gov/mits/Code%20Sets%2003.11.pdf</a> , and check <a href="#">Appendix A of Ohio Administrative Code rule 5101:3-2-02.</a>

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Question Number	Type of Question	Attendee Questions/Comments	Answer
18	Claims	Do you only accept modifiers 25 and 50?	Please review the MITS Keys, <a href="#">Answer Key # 3</a> dated 8/16/2011 on the ODJFS website at <a href="http://jfs.ohio.gov/mits/MITS%20Provider%20Training.stm">http://jfs.ohio.gov/mits/MITS%20Provider%20Training.stm</a> for more information on Code Sets. You may also refer to the eManuals to obtain information for all valid modifiers.
19	Financial	Since the new MITS has been active, we have not received any Medicaid payments. I have been told that we have been loaded in the MITS system wrong. We are a Public Health Clinic and the place of service code was a 71, we have been entered as a 50. It is my understanding that this correction supposed to have been done, but how long should we wait to submit claims?	Contact the provider enrollment unit to verify the correction has been completed. If the correction has been made, you can resubmit your claims.

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Question Number	Type of Question	Attendee Questions/Comments	Answer
20	Claims	What is a converted claim? Please clarify.	A converted claim is a claim that was submitted and processed through the old MMIS. All MMIS claims information has been converted over to the new MITS system.
21	MITS Account	I am set up as the administrator on the account but the MITS portal will not allow me to complete the PA process. It does stop me before I have a chance to enter provider notes or add attachments, so how do I resolve this?	Make sure you put the correct individual NPI in the service provider field. Once this is correct you can ignore the error message regarding PA may not be required and advance through the necessary panels. Please review the <a href="#">e-Tutorial</a> on the ODJFS website on submitting a PA. Make sure you are not clicking on or entering items you do not need. If you continue to have difficulty please call the IVR for assistance.

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22	Attachments	If I choose to send in an x-ray with EDMS cover sheet for prior auth, does anything else need to accompany it?	No, you do not need to send anything additional. When you download and print the EDMS coversheet it will contain the information necessary to identify and attach the x-ray to the correct claim for review.
23	Prior Authorization	If you submit a prior authorization with modifiers such as LT and RT, do you need to have those modifiers on the claim or will the claim deny?	If you are required to have modifiers with the code you are billing then yes, you will need to put them on the claim. Please review the eManuals for further assistance on billing codes with modifiers.
24	Forms	What is a 6614?	Please go to the Forms section of the website and look up 6614 form. It will explain what it is for and how to fill out and submit the form.

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Question Number	Type of Question	Attendee Questions/Comments	Answer
25	Recipient	We had a patient come in with a Medicaid card, we got a picture id and realized patient did not look like the patients ID. What do we need to do?	Please contact the County caseworker. If you submitted any claims and received payment we would recommend voiding those claims until there is a resolution to this issue.
26	Prior Authorization	When submitting a PA do we need to attach a RX?	PA policy and the requirements for what is needed for supporting documentation has not changed with the implementation of MITS. Providers will be notified if there is a change to policy in the future.
27	Prior Authorization	If a PA services has not been provided yet (pending receipt of a PA), what do you recommend we enter for "to-from" dates?	The date of submission to year out, less one day. For example: 11/1/11 – 10/31/12

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Question Number	Type of Question	Attendee Questions/Comments	Answer
28	TPL/COB	How do you send a claim where Medicaid is the Third Carrier for a PT?	Please review the COB information on our MITS website for information on billing secondary and tertiary claims.
29	Prior Authorization	What does it mean if a PA is approved but there is a "0" under Authorized dollars?	This is a known issue. You can perform the service as long as it was approved. You will get paid the Medicaid maximum.
30	General	We are brand new to MITS. We are wondering if there is an area in the MITS system for all charting on recipients.	MITS is a system designed specifically for the management of Ohio Medicaid claims and is not designed to assist providers maintain and manage their individual office charts.

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Question Number	Type of Question	Attendee Questions/Comments	Answer
31	Prior Authorization	Under what circumstances would the Assignment option "Physician Services" be selected when requesting a PA?	There may be times when a physician may submit a claim that includes an attachment that supports the physician services billed (if required). Therefore, the physician would choose the "Physician Services" assignment option. NOTE: To avoid confusion, select the Assignment Option that is appropriate for the situation.
32	General	There are three addresses to send coversheets for claims. Please explain the differences in the three addresses.	Send the cover sheet and attachment to the address related to the situation. If the situation relates to prior authorizations, send the attachment and cover sheet to the Prior Authorization address, etc. For additional information please see the MITS Supplemental Release " <a href="#">ODJFS PO Box Changes</a> " dated 07/13/2011 on the ODJFS website.
33	TPL/COB	I have a Medicare supplement plan that only accepts paper claims as secondary payer. I called them and they don't have a carrier code as they don't accept electronic claims. What do I put for a carrier code if they don't have one?	All payers have PAYER IDs. Please ask the other payers for their PAYER IDs. For additional information please see <a href="#">Answer Key #7</a> provided for you under MITS Keys on the website.

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Question Number	Type of Question	Attendee Questions/Comments	Answer
34	TPL/COB	Anesthesia crossover claims are all denied for decimal units not billable for procedure. How do I correct these claims?	This is a known problem by Medicare and Medicaid, and is being worked on. You may submit these claims via the Web Portal.
35	Eligibility	If a recipient gets retro Medicaid and it is beyond the 1 year timely filing period, do we still need to get a 365 day letter from the case manager in order to bill? If not what information is needed to file the claim?	You will need to submit the claim via the 6653 process through MITS and include proof of timely filing (e.g., 365 day letter).
36	General	Who is the provider representative for Cincinnati OH physicians?	Ohio Medicaid does not have Provider Representatives assigned to specific providers. If provider's have questions and/or concerns, providers need to contact a Provider Assistance representative at 1-800-686-1516.

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Question Number	Type of Question	Attendee Questions/Comments	Answer
37	Prior Authorization	If you are not able to check the Web Portal for authorization request status is there someone you can call?	Yes, you can call the Prior Authorization number at 614-466-6734.
38	Claims	Medicare pays under J codes and Medicaid wants NDC, how do you bill for that?	Claims will still require the J code in the detail line section of the claim and providers will then be required to enter the NDC information on the claim. For additional information on NDC's please see <a href="http://jfs.ohio.gov/mits/information_releases.stm">Information Release #10</a> , titled National Drug Codes, that was published on the website in May 2011 at <a href="http://jfs.ohio.gov/mits/information_releases.stm">http://jfs.ohio.gov/mits/information_releases.stm</a>
39	Claims	Why would a diagnosis code be denied?	Please review all of the information regarding diagnosis codes and code sets on the website under MITS Keys for more specific billing information and updates to codes with MITS. You may also contact a Provider Services Rep at 1-800-686-1516.

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Question Number	Type of Question	Attendee Questions/Comments	Answer
40	Claims	What is the Attending Physician number?	Please review definitions and directions in the e-manuals with regards to the Attending Physician field on claims.
41	Eligibility	On the MITS eligibility screen, will it ever state the specific Nursing Home a patient resides in or will it always just say Nursing Home?	Not at this time, but please monitor the ODJFS website for information on future updates to the MITS eligibility information.
42	Eligibility	In the Medicaid eligibility section, what is the meaning QI1/QI2 & QMB? Will Medicaid make a payment or will that be patient responsibility?	For QMB recipients Medicaid will only pay Medicare Co-insurance and/or deductible. For QI1 and QI2 recipients Medicaid will only pay the Medicare Part B premium.

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Question Number	Type of Question	Attendee Questions/Comments	Answer
43	TPL/COB	When entering secondary claims to Medicare and we have to convert the CPT codes from global to non global. Do we enter it as non global and use a form?	Please refer to the MITS Keys, specifically Answer Keys #11 and 12 on the website.
44	MITS Web Portal	We have an account but no icons to click on once in the web portal. I have left numerous messages on the Medicaid CSR line with no return call since the date of Go Live and also emailed and no help has been forthcoming. How do I get to speak to someone to get us up and running?	The agent for the account must first choose the provider they want to be their Default Provider. This step needs to be completed even if you only do MITS work for one provider. Once the default is set this will be the provider that will automatically pull up when the agent logs into the Portal. Once a default provider has been determined then the agent must then log out of the Portal and then log back in. If this process is not completed then the agent will not see the headings for the roles that have been assigned to them, i.e. Claims, Eligibility, etc. For information on how to set the Default Provider you may go to the MITS Online eTutorials for Providers at <a href="http://www.odjfs.state.oh.us/tutorials/MITS-External-Training/">http://www.odjfs.state.oh.us/tutorials/MITS-External-Training/</a> and choose the flash version of the Web Portal Fundamental eTutorial where there is . You will see an option listed in the index on the left for "Set a Default Provider".

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Question Number	Type of Question	Attendee Questions/Comments	Answer
45	Eligibility	How do QMB patients affect provider reimbursement?	If a patient or recipient is QMB Medicaid will only look at paying the Medicare premium, and/or co-insurance and or deductible. Again, this will depend on the type of service you are providing.
46	Claims	Why do claims go into a suspended status and how are they taken out of the suspended status and processed as either denied or paid?	Claims will suspend if an individual at the State needs to review the claim for attachments or for a 6653 as an example. Once the claim and any attachments have been reviewed, to support medical necessity and the appropriateness of the claim, then the claim will be released from suspense status and processed either to pay or deny.
47	Claims	Is there a way check CPT codes to make sure they are payable?	You can review the fee schedule on line or you may call the automated IVR and enter the CPT code to obtain the information. You may also review the information about code sets on the website under MITS Keys for more specific billing information and updates to codes with MITS.

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Question Number	Type of Question	Attendee Questions/Comments	Answer
48	Claims	Is there a list of CPT codes that require prior auth/pre-cert?	The fee schedule will indicate if a code requires a PA. You may also call the IVR and enter the specific code and the information will be returned to you.
49	MITS Web Portal	Can you use copy claim for same procedure code but different date? What if the paid amounts are different because of deductibles met?	Yes, you may use the copy claim option. You will need to make sure to change all information that is different for the new claim.
50	Provider Demographics	Our provider enrollment phone number area code is incorrect. What to do?	Providers are able to change and update their demographic information via the MITS Web Portal. For more information on updating provider demographic information please go to the MITS Provider Training page at <a href="http://jfs.ohio.gov/mits/MITS%20Provider%20Training.stm">http://jfs.ohio.gov/mits/MITS%20Provider%20Training.stm</a> . You will see another link for MITS Online Tutorials for Providers where there are several <a href="#">eTutorials</a> to choose from. Select the "Flash Version" for Web Portal Fundamentals and then choose the eTutorial "Modify Provider Demographic Information".

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Question Number	Type of Question	Attendee Questions/Comments	Answer
51	General	Our agency does not take Medicare clients. We do, however take Medicaid clients. Do I still need to do the MITS?	You can use a clearing house to process your claims or the MITS portal. That is a business decision for your office.
52	Claims	Why are modifiers 59, 76, and 77 no longer accepted-all are being denied?	Please review Answer Key #3 on the website under MITS Keys for information on the use of modifiers. You may also review MITS Information Release: Procedure Modifiers and Place-of-Service Restrictions for Professional Claims (Supplemental Provider Information Release, 01/28/2011) at <a href="http://jfs.ohio.gov/mits/Modifiers%201.28.11.pdf">http://jfs.ohio.gov/mits/Modifiers%201.28.11.pdf</a>
53	TPL/COB	When billing a secondary medical claim Medicaid is denying for a third party on file. When we check MITS for coverage they are showing prescription only and no other health insurance. Why are these being denied?	This is a known issue. Please be patient while this is being resolved.

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Question Number	Type of Question	Attendee Questions/Comments	Answer
54	Claims	When billing for vision services we cannot use the 52 modifier which denotes 1/2 a service and it will not recognize our UB codes?	If a patient breaks their eyeglass frame and requires a replacement before the end of the limitation period, the use of modifier 52 is not sufficient in MITS. The provider must have an authorized PA number on their claim in order to be reimbursed. You may also review the Information Release " <a href="#">Special Notice for Vision Providers</a> " dated 9/23/2011 at <a href="http://jfs.ohio.gov/mits/information_releases.stm">http://jfs.ohio.gov/mits/information_releases.stm</a>
55	Claims	What about the UB modifier denoting age of patient, we can't use this either?	Please review the listing of modifiers that are acceptable in the eManuals. Also please review the <a href="#">MITS Keys</a> on the website for additional information.
56	Prior Authorization	Can we access PAs submitted by another provider? Anesthesia billing has to have PAs for sterilizations.	No you cannot.

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Question Number	Type of Question	Attendee Questions/Comments	Answer
57	Claims	What are valid modifiers to use for Radiology?	Please refer to the e-manuals on our website for this specific information. You may also review specific publications on the website, such as MITS <a href="#">Answer Key #3</a> , related to HIPAA-compliant code sets.
58	Claims	If you have the same procedure done on the same day and interpreted by the same & different radiologists, that are not duplicates, how do we get this paid?	Please refer to your e-manuals and policy as this has not changed with the implementation of MITS.
59	Prior Authorization	Are we required to put the CLIA number on our submission?	Your CLIA certification should be linked with your provider number with OHP and the MITS system will validate that information when submitting claims. If you are getting a CLIA denial please contact Provider Enrollment to verify that your CLIA information is on file.

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60	Prior Authorization	Why would a prior auth request be listed as an "I" or a "C" insted of P, D, or A?	If the status of a Prior Authorization is "I", that indicates it is non-finalized and pending additional information. Please review the notes panels to see if information has been requested. If the Status is "C" then the PA request has been cancelled. Please note that if you submit a PA request and indicate you are submitting attachments, either by the upload or mail process, that information must be received within 30 days or it will cancel. If additional information is requested of the provider by the PA reviewer then the provider has 30 days, from the date of the reviewers request, to submit the requested information before the PA is cancelled. Please review the status of your Prior Authorization requests frequently to ensure you are meeting these deadlines for attachments and additional information.
61	Prior Authorization	I received a cancel next to a PA status after 5 weeks? What does this mean?	Prior Authorization requests will auto deny if supporting documents are not received within 30 days. This may be why your PA was cancelled. Please verify that you submitted the required supporting documentation either by the upload process in the MITS portal or mailed the paper attachments with the EDMS cover sheet. If you have further questions please contact the PA unit at 614-466-6734 .

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Question Number	Type of Question	Attendee Questions/Comments	Answer
62	Prior Authorization	When submitting a PA for therapy services for once a week services, am I submitting a total of units over a several month period with a cost total or am i submitting a request for each individual date of service?	You may put in your request either way and the PA unit will determine how to approve that request.
63	Prior Authorization	If we've submitted a prior auth and selected "mail attachment", is there a way for us to edit that pending request so that we can upload the attachment. (I ask for we now have scanning capability)	You may search for the PA in question and upload your documents any time during pending status.
64	Claims	How do you submit spenddown claim?	Please refer to the eManuals on the website for these specific billing instructions.

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Question Number	Type of Question	Attendee Questions/Comments	Answer
65	Prior Authorization	Why was I not able to print the needed forms for provider when I was trying to do provider enrollment?	Paper applications for Provider Enrollment are no longer accepted. Provider enrollment is now to be completed on line so you will need to input all information in the MITS webportal and submit it. For additional information please see the Web Portal fundamentals eTutorials on the website where there is a tutorial for Submitting a Provider Enrollment Application. Please choose the Flash Version when taking the tutorial. Also please read the MITS Portal User Manuals for enrollment information, also found on the website at <a href="http://jfs.ohio.gov/mits/MITS%20Provider%20Training.stm">http://jfs.ohio.gov/mits/MITS%20Provider%20Training.stm</a> .
66	Eligibility	What is the timeframe for the MITS system to be updated, reflecting coverage and eligibility updates?	MITS updates recipient eligibility information on a regular basis. However, there have been recent problems with updating this information and it will be resolved in the near future.
67	Claims	You indicated when an error is present when submitting a claim, it is a hyperlink and it will automatically take you to the area that needs corrected. This does not happen, why?	At this time the links aren't functioning properly. This is being worked on but until this is resolved please correct the claim based on the error message and information given for the denial.

## OCTOBER 2011 MITS TRAINING FREQUENTLY ASKED QUESTIONS (FAQS)

Question Number	Type of Question	Attendee Questions/Comments	Answer
68	Provider	How do you correct the taxonomy code that is showing in demographic info?	You will need to contact Provider Enrollment at 1-800-686-1516 to get this corrected.
69	Prior Authorization	We need clarification relating to obtaining prior authorization and pre certification for services rendered by providers in a hospital setting. On the Base Information screen, should we always select the FACILITY NPI? Or the PHYSICIANS GROUP NPI? Under which circumstances would we select the Facility NPI instead of the Provider/Physician Group NPI?	To avoid confusion, please contact Provider Assistance at 1-800-686-1516 because each situation is different.
70	Prior Authorization	If we receive the message "Service may not require PA" without the ignore button, can we be confident in billing for the service without a PA?	To avoid confusion, please contact a Provider Assistance representative (1-800-686-1516) to verify you are submitting the PA information correctly.

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71	Provider	Should each provider in your practice be under their own # on MITS web site with own account set up? One of our doctors works and other does not, should they both be on the same and use the switch provider panel?	Groups should have individual practitioners associated with the group using the 6777 form. All providers need to have their own Medicaid and NPI numbers noted in MITS. Please note that if you use the group NPI as the billing, or pay to, NPI then the individual providers would be listed as the rendering provider on the claim, depending on who actually performed the service.
72	Claims	Should a physician assistant billing still use modifier id or sign up with their own NPI?	Please refer to eManuals regarding physician assistants, because the rule will give you information regarding the appropriate modifiers. Also, if needed, contact Provider Enrollment regarding enrollment for physician assistants.
73	TPL/COB	If a claim is crossed over from Medicare with a PR 204 Denial Medicaid will pay the claim. Why am I receiving denials when I submit a claim to Medicaid on paper that PR 204 is not a payable code?	First of all you can no longer submit TPL/COB claims on paper and they will be returned to the provider if we receive them. They must be submitted either through the Web Portal or via EDI through your clearinghouse. If Medicare denied a claim for reasons other than lack of medical necessity, submit the claim via the 6653 process.

## OCTOBER 2011 MITS TRAINING FREQUENTLY ASKED QUESTIONS (FAQS)

Question Number	Type of Question	Attendee Questions/Comments	Answer
74	Prior Authorization	Do Home Health and Hospice services need to have a pre authorization?	No. However, Medicaid will NOT pay State plan Home Health and Hospice services if they are provided on the same day.
75	Remittance Advices	Are there any plans to provide standard 835 remits?	We are not aware of any differences from the 835 we supply providers with now.