



Medicaid Information  
Technology System

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## September MITS Training FAQs

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## SEPTEMBER MITS TRAINING FREQUENTLY ASKED QUESTIONS (FAQs)

Question Number	Attendee Questions/Comments	Answer
1	Is the case number of a recipient available on an eligibility verification panel?	No, the case number will not appear on the MITS Web Portal eligibility verification panel.
2	The provider has not submitted a claim to Medicaid for a particular date of service because the recipient did not have Medicaid at the time. Now, more than one year after the date of service, the provider receives a letter stating that Medicaid eligibility was retro-activated back to the date of service. No previous ICN or TCN exists, so how is the provider to submit this claim through the MITS Web Portal?	You will submit the same information that you currently do, but in MITS the attachments are scanned and uploaded. MITS allows both Web Portal and EDI claims to come in with attachments that have been scanned and uploaded during the claim submission process. To request an exception to the timely-filing limitation, you would submit the claim with the JFS 06653 and any appropriate documentation attached. Refer to rule 5101:3-1-19.3 of the Ohio Administrative Code (OAC), "General claim submission [except for services provided to consumers who are members of a Medicaid managed care program]."
3	Currently we have a lot of problems when case management is not up-to-date and, as a result, MMIS has incorrect codes. Will MITS correct that problem and make the billing process smoother for case management services?	Case management services are not a billable service for anyone except county boards of developmental disabilities, which bill Targeted Case Management.

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4	How can providers get locked in for "Lock-in"?	Refer to rules 5101:3-20-01 through 5101:3-20-03 of the OAC. A provider is associated with the Primary Alternative Care and Treatment (PACT) program when a recipient chooses the primary care physician. There is no actual "lock-in" for providers. In the PACT program, recipients who use medical services without medical necessity are restricted to a designated physician, a designated pharmacy or both.
5	How can approved RAs be adjusted?	Remittance Advices (RAs) provide information on financial transactions that occurred during the indicated financial cycle. An RA itself cannot be adjusted; however, claims can be adjusted or voided, account receivables can be updated, and refunds can be made for items that appear on an RA. These changes will be reflected accordingly on a future RA.
6	Can I add an insurance carrier if the "other payer" I am looking for is not on the drop-down list?	Yes, the list of insurance carriers is not all-inclusive. You may select "Other Insurance" if your other payer is not listed.

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7	Can I assign agents to a group NPI?	Agents may be assigned to any National Provider Identifier (NPI) that has an active provider agreement with Ohio Medicaid. Examples: If you are a group provider and you use the group number as the pay-to billing number, the agent(s) would be set up under the group number. If you are a group of providers that share an office but bill under each individual NPI number, then each number will have agents set up.
8	Can I submit retroactive LTC claims if I am limited to submitting only one claim per month per recipient?	A provider can submit a "retroactive" long-term care (LTC) claim provided that it includes the decision date in the proper format. Refer to the billing and companion guide instructions for how to submit a claim with a decision date on it. Billing software varies, so if you are submitting a claim in this manner for the first time, we recommend that you contact your software vendor to ensure proper placement of the decision date. The one claim per month per recipient rule will not preclude a provider from submitting claims for the same recipient with different dates of service.
9	Will the eligibility portion of the MITS Web Portal show pending Medicaid eligibility within the system?	No.

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10	Will the information on my RA about eligibility come from CRIS-E, or will it come from the information I have put into the system?	The recipient eligibility information will continue to be fed from the CRIS-E system.
11	Each recipient is assessed a \$3 co-payment per dental visit. There is an area on the new Dental RA marked 'Co-pay.' Is the \$3 co-payment displayed in this area?	Yes.
12	Will the CRIS-E waiver codes MA_O, MA_D and MA_J be transferred over to the MITS recipient eligibility subsystem and be seen in real time?	Providers will not see the MA categories in MITS. Instead, they will see the Benefit Plans in which a recipient is enrolled (which correspond to the MA categories). Example: MAJ in CRIS-E means a waiver. MITS will not show MAJ; it will show the specific waiver in which the recipient is enrolled. .
13	Will providers be able to adjust and void straight pharmacy claims in the MITS Web Portal, or will they be able only to view claim status?	Pharmacy claims will be view-only in the MITS Web Portal. The options to copy, adjust or void will not be available, but pharmacy claims will be shown on MITS RAs.
14	Can we submit source codes on a claim via the MITS Web Portal (as we do in box 10d on a CMS 1500)? For example, source code F indicates that the recipient is no longer covered under prior TPL that has terminated.	This information will be captured through the drop-down options available in the third-party liability (TPL) section of the claim type being submitted.

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15	Will Medicare Part B therapy crossover claims be shown on the RA line by line? That approach would make for a large EOB.	Medicare crossover claims will be processed according to the way they are received from Medicare. If a crossover claim is processed by detail by Medicare, then the detailed information will be reflected on the RA.
16	How will Medicare Part A crossover claims be identified as processed on the Remittance Advice? We currently see a "Q" for bad debt.	Medicare crossover claims will continue to be processed automatically. Separate sections of the RA will identify the different Medicare crossover claims as Part A, B or C. The training examples did not include the crossover pages; however, the actual RAs will show the information needed to process bad debt.
17	Ohio MITS is similar to the system in Kentucky. At the top of the RA in Kentucky, Medicare Part A is labeled separately. Will this change be possible for Ohio?	RAs established for Ohio MITS do include separate sections for processed crossover claims.
18	Will MITS accept all modifiers even if they do not affect pricing?	MITS will accept all industry standard modifiers.
19	How does the system update third-party liability information? What steps can providers take to update eligibility?	Recipient eligibility information will continue to be fed into MITS from the CRIS-E system.

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20	What is the approximate turnaround time for prior authorization decisions with MITS?	It is difficult to predict the turnaround time because it is driven by volume. We anticipate, however, that it will be 30 days or less.
21	What is the approximate turnaround time for provider enrollment via the MITS Web Portal?	The turnaround time for enrollments will be affected by the volume of enrollments, but we anticipate that it will be no longer than two weeks.
22	How does a home health provider complete recipient enrollment for hospice?	Only a hospice provider can enroll a consumer in the hospice benefit, however hospice enrollment has been deferred to a later date.
23	If a PA gets approved for 2 units even though the recipient is supposed to have 6 units, can a provider go back in and change the already approved PA so that the recipient can get the other 4 units?	No, a new prior authorization (PA) will need to be requested. The provider can reference the approved PA on the new request.
24	Can a provider add a denied PA as an attachment to a new PA that has been corrected so that it will be approved?	No, each PA stands alone.
25	When using the modifier 50, do I bill 1 or 2 units per line? For example, if I give a recipient injections in both the right and left knee, would I bill them on the same line or bill each one on a separate line?	Modifier 50 indicates a bilateral procedure; on a claim, the procedure code is billed once and only once for one unit. The new version of OAC rule 5101:3-4-22 (effective 12/07/2010) explains the use of such modifiers.

