



THE ANSWER KEY

A COMPENDIUM OF SOLUTIONS TO PROBLEMS ENCOUNTERED BY PROVIDERS IN SUBMITTING MEDICAID CLAIMS

Note: All information was current at the time of publication but is subject to change.

Code Sets

All HIPAA-compliant national code sets will be implemented in MITS, although not all of the individual codes and code values will be used in processing claims. Implementation of these code sets does not establish or replace existing payment rules; rather, it supports current reimbursement methodologies and reinforces current policies.

- Professional claims for physician-administered medications and injectables must include an appropriate National Drug Code (NDC). Such claims submitted without an NDC will be denied, regardless of provider type.
- Some diagnostic and therapeutic procedures reported on professional claims are reimbursable only when they are performed in certain locations. Guidance regarding these place-of-service restrictions can be found in Ohio Administrative Code rule 5101:3-4-11.
- Diagnosis codes are required on most professional claims. The code entered on a claim must represent the diagnosis with the highest degree of specificity and must include the number of digits indicated in the International Classification of Diseases, Ninth Edition (ICD-9).

For more information, see these MITS Information Releases:

The Uniform Language of Code Sets

(Supplemental Policy Release on MITS Code Sets, 03/01/2011)

<http://jfs.ohio.gov/mits/Code%20Sets%2003.11.pdf>

Are Your Billing Processes and System Ready for MITS?

(Provider Readiness Release #6)

http://jfs.ohio.gov/mits/Reminder_Release_6_RA_%28revised%29.pdf

Ohio Medicaid Claims That Include Provider-Administered Drugs

(Provider Information Release #10 on National Drug Codes)

http://jfs.ohio.gov/mits/CCR_10_11_Medicaid_Drug_Program.pdf

Procedure Code Modifiers

The fact that all HIPAA-compliant code sets will be implemented in MITS does not mean that every code will be accepted on Medicaid claims. For instance, Ohio Medicaid uses many—but not all—of the modifiers promulgated by national organizations such as the American Medical Association, the U.S. Centers for Medicare and Medicaid Services, and the American Society of Anesthesiologists. In addition, Ohio Medicaid defines certain modifiers (such as the modifiers beginning with the letter U) in ways that are specific to program rules and policies in Ohio.

Some claims or line items may be denied if a valid but unrecognized modifier is present; other claims may be denied if certain modifiers are absent. For example, professional claims for services rendered by advanced practice nurses must include the modifier SA (nurse practitioner), SB (nurse midwife) or UC (clinical nurse specialist). Professional claims submitted by advanced practice nurses that lack one of these modifiers will be denied.

For more information, see this MITS Information Release:

Procedure Modifiers and Place-of-Service Restrictions for Professional Claims

(Supplemental Provider Information Release, 01/28/2011)

<http://jfs.ohio.gov/mits/Modifiers%201.28.11.pdf>

Coordination of Benefits

To be adjudicated successfully in MITS, a claim involving a third-party payer (TPP) such as Medicare or a commercial insurance company must include certain information. Claims that do not contain complete TPP information will be denied.

When a claim is adjudicated at the detail level, and Medicare or another TPP did not pay 100 percent of the detail billed charge, additional information must be reported to explain the non-paid portions. This information consists of a CAS Group Code, an Adjustment Reason Code (ARC) and an associated monetary amount. The sum of the amount paid by the TPP and any non-paid amounts reported with ARCs must equal the total billed charges for the detail (line item).

For more information, see this MITS Information Release:

Subject: Coordination of Benefits

(Supplemental Policy Release, 07/15/2011)

http://www.jfs.ohio.gov/mits/Supplemental_Policy_Release-Coordination_of_Benefits.pdf

Group Affiliation

Medicaid providers that submit claims on behalf of their affiliated practitioners (such as hospitals, ambulatory surgery centers, hospice providers and group practices) need to report the affiliations to ODJFS and keep those reports current. In MITS, the link between billing and rendering providers will be verified. 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.

For more information, see these MITS Information Releases:

Pointers for Providers: Claims in MITS

(Supplemental Release on Claims in MITS, 08/09/2011)

http://jfs.ohio.gov/mits/Pointers_for_Providers_Claims_in_MITS.pdf

MITS Is Coming! Getting Ready for the New Medicaid Information Technology System

(Supplemental Release on Claims Processing and the Web Portal, 09/27/2010)

http://jfs.ohio.gov/mits/PrepMITSV.9_27_10.pdf