

Paperless prior authorization features will be available in the new Medicaid Information Technology System (MITS) and MITS Web Portal, coming in December 2010!

Note: This information is for fee-for-service providers. Managed care providers will continue to use their current prior authorization processes for consumers who are covered under managed care plans.

Prior authorization (PA) is a process used to review, assess, and preapprove or deny selected nonemergency medical services prior to payment. Prior authorization does not guarantee payment; it only determines medical necessity or the appropriateness of a service. Consumers must be Medicaid-eligible for services to be covered.

As of December 2010, all prior authorization requests must be submitted via the MITS Web Portal. Paper requests will no longer be accepted.

How will submitting prior authorization requests through the MITS Web Portal benefit providers?

- Providers will key in and submit PA requests themselves, which will help reduce errors in data entry.
- Using the MITS Web Portal for PA submissions will eliminate paper PA requests and mailing costs.
- MITS will allow providers to quickly and easily identify the status of their PA requests. The Web Portal will show all requests as being "approved," "denied" or "pending review."
- The MITS Web Portal will allow providers to see the claims that were paid under a specific PA, including the number of units and dollars used. This will help them manage the remaining authorized units or dollar amounts as claims are processed.

What are some other advantages of the new MITS Web Portal prior authorization process?

- PA requests can be submitted electronically, at any time of the day or night, through a user-friendly interface.
- The system will generate PA request approval letters, which will be sent only to providers, and PA request denial letters, which will be sent to both providers and consumers.
- The Web Portal will be integrated with claims processing, to provide online, real-time processing and adjudication of claims against approved PA requests.

- MITS will generate a unique prior authorization number when a PA request is successfully submitted through the Web Portal. Using this PA number, providers will be able to search for a variety of information, including:
 - Requested Effective Date or End Date
 - Requested Units or Dollars
 - Authorized Effective Date or End Date
 - Authorized Units or Dollars
 - Payment Method
 - Balance of Units or Dollars
 - Quantity Used Units or Dollars

What quality-control measures will be applied to prior authorization requests?

PA requests will be subject to several checks — called *edits* and *audits* — before they can be saved or submitted via the Web Portal. Here are some examples:

- When a PA request is entered online, the system will determine whether the service is included in the list of procedures the provider is authorized to perform. This list is referred to as the *provider contract*.
- An *exact duplicate* check will prevent a PA request from entering the system if it is a copy of another request in PA history. Two PA requests are exact duplicates if they specify the same consumer, the same provider, the same effective and end dates, the same procedure code, the same modifiers, and (if applicable) the same tooth number.
- A *possible duplicate* check will alert the provider that the current PA request may be a duplicate of a request that already exists in the PA history. Two PA requests are possible duplicates if they specify the same consumer, the same or overlapping effective and end dates, and the same procedure code.
- The requested effective and end dates on the incoming request will be compared to the authorized effective and end dates in the PA history.
- A basic consumer date-span eligibility check will be done. However, this check does not guarantee payment.
- A check will be done to determine whether the consumer has a current spenddown. (Spenddown is a predetermined amount of money some consumers must either pay or incur, usually for medical expenses, before obtaining Medicaid eligibility for the month.)
- The consumer's residential setting will be verified to determine whether it is appropriate for the delivery of durable medical equipment (DME) services.
- The effective date of the requested service will be checked. If it is more than 365 days in the past, then the PA request cannot be entered.
- A check will be done for service limitations.

How will providers submit supporting documentation for PA requests?

After submitting a PA request, providers will be able to submit supporting documentation via the MITS Web Portal, either by electronic file upload or by fax.

Note: The full process for submitting supporting documentation will be outlined during provider training sessions in the fall of 2010.

What is the new process for requesting prior authorization of transplant services?

The process for requesting prior authorization of transplant services will remain unchanged for providers. They will continue to contact the appropriate consortium — the Ohio Solid Organ Transplant Consortium or the Ohio Hematopoietic Stem Cell Transplant Consortium — to obtain prior authorization. ODJFS will continue to generate the approval and denial notices and send them to providers and consumers.

Who will review pre-certification requests for psychiatric inpatient admissions?

The psychiatric pre-certification process will remain unchanged for providers. Health Care Excel, the current vendor, will continue to review and make determinations on all pre-certification requests for psychiatric inpatient admissions. Health Care Excel will also continue to generate Pre-Certification Decision Notices and send them to providers and consumers.

What is the new process for requesting pre-certification or prior authorization of special services?

Ohio Health Plans will be using Permedion, the current vendor, to review special services, as well as to perform hospital pre-certifications. **Note:** Providers will no longer contact Permedion directly for authorization numbers.

Here is the process hospital providers will use when submitting pre-certification or PA requests for special services:

1. The provider will submit a request for the service via the MITS Web Portal, where it will be assigned an authorization number.
2. Permedion will then review the request and either approve or deny it.
3. If the request is approved, the provider will submit a claim for the special service. The authorization number must appear on the claim.
4. MITS will look in the PA subsystem for a valid hospital authorization number for the specified consumer on the specified date of service.
5. If an authorization number exists, then the claim will continue processing for payment. If no authorization number is found in the system for the specified consumer on the specified date of service, then the claim will be denied.

Important Information about Claim Submission

Use of correct codes

In the powerful new MITS, claims will be processed more rigorously, and small details can affect payment. To avoid rejection of claims for inappropriate procedure code billing, providers must submit claims using **only** authorized procedure codes.

National Provider Identifier (NPI)

Medical practitioners who are required to have a National Provider Identifier (NPI) and who submit professional, dental, or institutional medical claims must enter their NPI on those claims. This change is effective now.

When MITS goes live, ODJFS will no longer accept the generic provider ID 9111115 on claims. Providers and trading partners currently using 9111115 must begin using the practitioner's NPI in the provider ID fields on the claim form.

Provider enrollment updates

Many Medicaid providers, such as medical group practices, submit claims on behalf of their group members. It is very important that providers review their group membership information and verify its accuracy prior to MITS implementation. ODJFS should be notified of any changes, such as additions and separations of Medicaid-enrolled practitioners. All questions and requests to verify group membership information should be directed to the ODJFS Medicaid Provider Enrollment Unit at 1-800-686-1516.

Software vendor information

Providers should work with their software vendors to implement the following changes:

- The National Provider Identifier (NPI) must be used in provider and practitioner ID fields.
- Some providers must submit claims in newer formats.
 - Institutional providers currently using the UB92 will use the UB04.
 - Dental providers currently using the ADA version 2000 will use the ADA version 2006.
 - Professional providers will continue to use the CMS 1500.

Training for providers and other stakeholders

- An extensive statewide outreach and training strategy is in development, with training to begin in the fall of 2010.
- Watch for the most current news on the MITS Web site, <http://jfs.ohio.gov/mits/index.stm>. It will offer information about training and registration for seminars and webinars.

Providers and their support staff are encouraged to attend the statewide MITS implementation training sessions to ensure that all staff members are trained on the MITS Web Portal functionality and features. Providers can attend any of the statewide provider training sessions, and all statewide MITS training classes are free of charge. Learning more now means more success when MITS goes live!

Tip: Providers should read all training material, put it in a safe place, and use it as a point of reference when MITS goes live.

MITS Web site

For the most current updates about provider training information, MITS functionality, tools and enhancements, providers should bookmark the MITS Web site: <http://jfs.ohio.gov/mits/index.stm>.