

Questions and Answers

****Note Important Information Regarding NPI #. Please Read Below.****

Questions: Is there a deadline date for the NPI number application?

Answer: The transition from performing provider numbers to NPI number will happen on May 23, 2007 at EDS. The recommendation is that you go ahead and get the NPI number as soon as possible. There will be a lot of people requesting a number and the sooner you have yours the better. Also, we need to be able to crosswalk the numbers in the MRSIS system. The application is fairly easy. You can go onto the Medicaid web-site and complete the application on-line. Once you have the number there is a request that you send the NPI number along with additional documentation to EDS and when you do this we request that you send DMR a copy as well. As a point of clarification, this is a national registry where you are registering yourself on a national registry so it is not something that the Division or even EDS has control over. Medicaid and EDS has the link on their web-site, but it is to the National registry. You can find the application on the following web link <http://www.medicaid.alabama.gov/billing/NPI.aspx?tab=6>

Questions presented on or after 08/25/2006 Stakeholder Call

****Note: Please review 08/25/2006 Minutes for more information regarding NPI. There will be an internal meeting on 08/28/2006 to clarify this matter. Once a decision has been made we will notify all providers.****

Question: In addition to the application for the NPI could you elaborate further on the supporting documentation for EDS?

Answer: We don't know so we can't give you advice for that. We believe you can go on-line and get additional information. The letter from EDS should explain everything. However, it appears that many of our stakeholders have not received the letter or the letter went to someone else in the agency. If you go onto the AL Medicaid web site and search NPI many documents will be available to view including the on-line application. If you didn't get the letter you need to look for it.

Question: I've scanned the Stakeholders Conference Call Minutes & the FAQ's and can't find my answer. Maybe you can help.

We provide EI, Day Hab, Residential, & Case Management Services. I have to apply for an NPI # for EI Services, do I need to apply for another NPI # for our other services to use with Harmony?

Answer: We have been in deep discussion with EDS and Medicaid regarding the NPI number for our providers. To be specific we're discussing how many NPI #'s providers should have (our initial impression is one but we are not absolutely sure) and the best strategy for having the provider obtain their NPI # and get that number to the appropriate agencies. We will discuss this issue on our stakeholder conference call this Friday. Call in information is posted on the website. We are also meeting internally Monday to discuss issues such as where the NPI # should go on the electronic claims to EDS. I would ask that you hold off applying for the NPI # until we can give you further direction which will come very shortly. If you have any more questions please feel free to contact me.

Questions presented on or after 05/19/2006 Stakeholder Call

Question: There is a concern with scanning documentation into MRSIS. Is MRSIS HIPAA compliant?

Answer: Yes, Harmony is designed to be HIPAA compliant so MRSIS is every bit as secure and compliant as Harmony. There should be no concerns with security even if a document is scanned into the system.

Question: Are providers being required to bill weekly?

Answer: No, providers are not being asked to bill weekly. If a provider would like to bill weekly it can, but it is an only an option.

Question: Will we be scanning in the Summary of Habilitation and other items that are to be printed off of the computer?

Answer: I don't think we intend for you to scan in anything other than the Plan of Care and the Dissatisfaction of Services because both of these documents require signatures from the consumer and/or witness. The Summary of Habilitation will be a form in MRSIS and you should be able to complete the form and it will be part of the consumer's record. The Level of Care form will no longer need to be completed because MRSIS will automatically generate the form for the regional office and they then will sign the form and scan it into MRSIS. We intend for Medicaid to have a full license so that they can view everything on-line.

Questions presented on or after 04/21/06 Stakeholder Call

Question: Does this case management training have anything to do with the on-line case management training that is on the web? I haven't looked into it because there is not a supervisor's preview.

Answer: No, this has nothing to do with MRSIS. The web site you are talking about has been designed by another company. The case manager training web-site is up and primarily complete. Case managers can go into the web site for training and testing. They will need to pay for the training and pass the test. The supervisors can not get into the system without paying for the test. We will be meeting in the next few weeks to begin Phase 2 which will allow the agency to enroll as a case management entity and all the people in that agency will be able to go into the web site to review the material. Some of the material is new. The second phase should be up and running in a few months. The plan is to have a case management agency subscribe to the service and all of the case managers in that agency will have access to view all the posted material, as well as participate in the forum. There will also be questions and answers and notification of new material via e-mail.

Question: On the spreadsheet that the fiscal managers sent to us regarding client services, do we need to include targeted case management in our list of services for waiver consumers? I noticed that targeted case management was listed for state only funding.

Answer: No, you do not need to include targeted case management as a service for waiver participants because we assume that all waiver participants receive case management. We are not going to prior authorize targeted case management.

Question: When factoring units for day habilitation do you want the absentee factor included?

Answer: Yes.

Question: Will the copy of the new Plan of Care be available on the web site in May?

Answer: Yes, but we'll put it in a different place on the DMHMR web site. We have a separate link on the DMR web page called forms and instructions. This is where we will post the new Plan of Care and instructions.

Questions presented on or after 04/07/06 Stakeholder Call

Question: Previous to today (4/7/06) the decision was made that if an ineligible was being funded by local match funds only there would be no need for that person to be entered into MRSIS because there would be no prior authorization. Today, you said you would want the person in the system. Is the decision now that the person will need to be entered into MRSIS?

Answer: Yes, I think we want you to put the client into MRSIS and that involves keying in demographic and contact data, but you don't have to do an ICAP and that sort of thing unless you want to put them on the waiting list. We had a discussion with several providers about this and what we were told was that these providers did ICAPs on everybody routinely because if they are serving folks with local funds at some point they may need to apply to the waiver. We decided we need to incorporate these people into MRSIS, but if there is no financing from the Department or Medicaid or the person is not on the waiting list we don't need extensive data and we don't want to cumber you will the need for extensive data.

Question: How will we be paid in the new system? Will it be a couple of times a month? It may create a cash flow problem for some providers depending on when they get paid.

Answer: The intent is to pay the state match in the same check as the federal. No one has expressed concerns so far. Let's say you bill weekly, which you can do, you would be paid twice a month with half you're billing in the first half of the month and the second half of your billing at the end of the month.

Question: We will get the 1/12th payment in the months of October, November, and December. In January we will be billing for December services so if we bill in January we should get a check in January.

Answer: Yes, most providers try to time their billing to hit the first billing time cycle in the month following the month of services. In other words I anticipate providers will try to bill for most of their services from the month of December in the first EOP in January and if they do this they should receive payment somewhere around January 20th.

Question: I understand there is not going to be a total contract amount this year, could you talk about the timing of knowing about amounts for budgeting purposes. Also, you mentioned absentee days, I'm not sure if we are going to go about the budgeting process the same. Could you talk about this more?

Answer: I would think that you would go about the same planning process for your budget. We don't intend to change rates and we don't anticipate clients leaving a program. We are assuming that folks will pretty much stay where they are. What we will do is give you a 3 month contract through December for services being provided in September, October and November. For the remainder of the year there will be a different contract. It won't have a grand total state or federal amount of dollars. It is a matter of transition that you will get two different contracts this coming fiscal year.

You will still work with the regional office by giving them the list of clients, where they live, and the rates. There will be a calculation for the absentee rate for day habilitation for each individual and this will be taken into account in the prior authorization. This is designed to maintain flexibility for your benefit so that you can be certain that we will have enough units in each prior authorization to cover all the services that you provide. Absentee rates in residential is already calculated in the IRBI. Other services beyond day habilitation (to include supported employment) will not require an absentee rate.

Once we have an allocation we will start the contracting process just as we have in the past.

Question: If a person is living in a three person home and his/her absentee rate is much greater than the others, for example he/she is in and out of the hospital, is there a mechanism to renegotiate the rate?

Answer: This was discussed in the MR Sub-Committee meeting. If a person goes into the hospital or a nursing home for a month or two we would need to terminate them from the waiver, but we would want to hold that spot. They are not using their waiver money so the Division would work with the provider to re-do the IRBI rate for the other two people for the amount of time the person is out and the provider could recoup the cost for the loss of the third person.

Questions presented on or after 03/10/06 Stakeholder Call

Question: Why will two prior authorization numbers be required? Only one number is required annually for the Living at Home Waiver or in our Early Intervention Program.

Answer: In the implementation plan to date, the Prior Authorization is seen as covering one year that crosses fiscal years. To provide the ability to unencumber and move units, we are looking at breaking the Prior Authorization into two PAs, corresponding with the fiscal year. You would need a prior authorization number for each Authorization. In the Living at Home Waiver, currently, only one PA number is required for a year's plan, but there also is not much need to move units around. Also, note that the current system with the LAH waiver does require you to obtain two prior authorization numbers per fiscal year.

Question: Will projected daily absentee rates for Day Habilitation be a projected individual absentee rate or will it be an average agency absentee rate?

Answer: The projected absentee rate should be an individual absentee rate. The intent is to project the prior authorization as accurately as possible.

Question: Why is the Regional Office approving the changes in the Plan of Care? The Regional Office frequently loses information we have previously submitted.

Answer: The Regional Office will need to approve the Plan of Care if it is going to change the prior authorization. The Regional Office will have a standard procedure to follow in order to change the prior authorization in accordance with changes in the plan of care, if those changes are approved. Needed changes which do not require additional state funding will normally be routinely approved. Changes which require additional state funding will be considered in light of the criticality of the need for the change and will take into account the state funding available to the Division at that time.

Question: How will errors be corrected if we don't re-key?

Answer: In two-part Harmony, it is proposed that you will see your claim as it was submitted. There will also be a code to tell you what was incorrect, and you will be given the ability to change your claim without re-keying the document, and then to re-submit the corrected claim. If you are using your own system and submitting an 837, your error will post back to you on an 835, and you will, we propose, also be able to correct the claim from the 835 and re-submit.

Question: Sometimes it takes up to 90 days before DHR local match hits our account. Mrs. Wilson was supposed to meet with DHR regarding their interest in facilitating this system state wide. Has this been discussed yet?

Answer: No, Mrs. Wilson has not had a chance to further discuss the MRSIS system and its impact on local match (to include DHR) yet, nor has she spoken to them regarding a statewide implementation of the system. Mrs. Wilson will re-establish a meet time with DHR to discuss this.

In addition, DMR has had good luck establishing the protocol with DHR and their central office is being responsive. If we explain the criticality of getting local match to the community services account they will accommodate us. They also mentioned at our last meeting that for case management they can send us the money from their central office which would be very quick. If we can pull that off for case management at least we'd have very speedy claims processing.

Question: We have local funds coming from our county commission one pays quarterly and the other pays at the end of the year. We don't have control over this.

Answer: We will, as best we can, set up a system that spends state money first to give you time to get the local match in. The county commission that pays at the end of the fiscal year however, I think it would be good to talk to them about sending it sooner. You don't want to hold on to all of your billing until the end of the fiscal year. On our end it is clearly illegal for us to pay a claim when there is no match to draw down the federal money. We know that you are good for it and you'll get it so we'll authorize the service(s), but we can't make the payment for the claim until we have the match in hand.

Question: Is there a possibility that a letter could be sent out to all contributing local match donors explaining the criticality of this issue.

Answer: Fordyce would be happy to send a letter to any donor explaining the criticality of sending donations on a timely basis. Please let him know who you would like to receive the letter.

Question: Have you begun to plan for the training or how you will handle the training? Is it going to be regionally or will you come to sites? We would like to request being trained in Montgomery because it is closer than our regional community services office.

Answer: We're in the process of discussing transitioning and the training will be in the month of September as of this date. We'll keep you informed the closer we get. We'll be training in small groups much like previous training because of travel.

Question: It was my understanding that there would be a Harmony person at your door for training.

Answer: We are going to offer training, we'll have super users as a liaison, a trained regional person, and a help desk person at central office that is in contact with Harmony, but a Harmony representative will not be visiting providers for training.

Question: Will there be a person at every center to train regardless of who they are?

Answer: That is incorrect. Perhaps that is what has been said for ASAIS but that is not true for MRSIS. ASASIS has planned provider visits to talk about transition issues. They are planning on-site visits to talk about specific issues.

Question: Will the Harmony system generate the same detailed reports as the EDS system?

Answer: Yes, we've asked the provider representatives on the JAD team to give us back recommendations of how to improve the detailed report that actually comes from the department (green bar). You will get an electronic report. If you submit claims with an 837 you will get an 835 response. If you submit claims via 2-part harmony you will get an electronic Remittance Advise which will have at least the green bar report detail if not more.

Question: Has the list of questions presented to you by the MR Sub-committee been answered and posted on the web? I wanted to note that there are concerns about the 1/12th payment going away within that document.

Answer: The answers have not been posted on the web as of yet. It is recommended that you review the prior authorization material on the web because it goes over ways that we will attempt to mitigate concerns regarding 1/12th payments.

Questions presented on or after 2/24/06 Stakeholder Call

Question: If you are going to ask providers to take a daily census using bubble sheets how much time will it take to complete this task?

Answer: We really haven't gone through this scenario fully but we wouldn't require a lot of information just whether or not a person was there or not. A lot of the information will automatically be in the bubble sheet such as program information. This is just one idea of how we can unencumber unused units in order to create flexibility in the prior authorization system. We need a faster way to know what units are uses and therefore available than relying on billed claims. Again, this is a short-term problem that will be corrected over time.

Question: Will Medicaid continue to use EDS as its fiscal agent?

Answer: Yes, we understand that they will for the present and foreseeable future. They have to bid that out so it is locked in for the next few years.

Question: Will harmony be used by all Medicaid services providers or is it unique to MH?

Answer: At this point it is unique to MH.

Question: Will the claims be submitted to Medicaid directly for processing or is Harmony linked to EDS or some other fiscal agent for the claim processing?

Answer: What you will do is bill the claim to MRSIS (our system) and MRSIS will run the claims through the pre-edits based on adjudication rules and the prior authorization and will approve or reject claims. Claims that have been approved will be forwarded to EDS automatically and rapidly. EDS will process the claims based on their rules. EDS will send a remittance advice (RA) report and an 835 back to MRSIS. MRSIS will post claims and pay you the way they currently do.

Question: Will the 837 still be used for billing?

Answer: You can use the 837 to bill or you will be able to use the Two-part Harmony for direct entry of your claim. The 837 will be sent to MRSIS for adjudication or you can do a direct entry for claims, either way you will no longer send claims to EDS.

Question: Will we be changing the sponsor that we currently indicate on the claim, for instance if it is Medicaid or DMH, will every consumer have the sponsor of MRSIS? Will MR be looking for Medicaid eligibility?

Answer: No, this is a substance abuse requirement. We know that 98% of our people are Medicaid eligible so we won't be looking for that. We have decided to go through the process of submitting a 270/271 to Medicaid on a routine basis like substance abuse, but we would be looking for folks that have been on the waiver and are eligible and for some reason have suddenly lost their eligibility in order to give providers notice.

Question: Will Harmony require new enrollment with Medicaid?

Answer: No.

Question: Will Harmony provide up front edits to assist in billing such as incorrect dates or incorrect codes?

Answer: Yes we will try to provide up front editing much like what EDS provides with the CSR report however you need to know that Medicaid and EDS are revising their system and the CSR report will go away. So even if you were to bill EDS by May of '07 the CSR would not exist. So what we will build into MRSIS is upfront edits based on the most common errors from the CSR. We will do this as a convenience to you the submitting provider. We probably won't have every edit that Medicaid/EDS have so some claims will make their way through MRSIS and Medicaid may reject the claim. We want to bring this down to the very minimal because it is an extra headache for both of us.

Question: Will Harmony give a claim response to let us know if it has been accepted or not?

Answer: Yes, you will receive a 997 (HIPAA transaction that says yes your file was received and we can read it claims) response that will come electronically. There will be a paper report that will be available on-line for people that can not support the electronic 997.

Question: We have no control of local match. One of our top contributors sends it to us in one lump sum and that has frequently been at the end of the year.

Answer: I would say that at the end of the fiscal year may be too late. We'll try to work with you. I am trying to capture all the scenarios like this and have the regional folks that have attended the JAD sessions review each scenario to brainstorm ideas on solutions. My gut feeling is that having local funds sent at the end of the fiscal year is a problem that can not be solved. We'll look to see if we can help with that problem though.

Question: Will billing codes change?

Answer: No, not at this time.

Question: When will Harmony be implemented?

Answer: January 1, 2007.

Question: When will the training be provided?

Answer: We are looking at the whole month of September. There will be training manuals and super users in each region. In addition, there will be a regional contact person to be named.

Question: Will a regional contact person be available for assistance?

Answer: To an extent, they will not do your billing for you. They can walk you through the system itself and we'll have someone in Central Office that will be able to assist with system type problems.

Question: Will I know how much is going to be in my contract for different services? For instance, as a provider I know that I have a set number of units for a specific service and if that service is not being utilized I can use those units for other services. How will this work with the new system?

Answer: Your contract will not be nearly as specific. You won't have units of service in a contract you will have units of service in individual prior authorizations. If you need to move units then you move units literally from a person to another person.

Question: So it may be moving units from agency to agency so that if I have a need I present that and get prior approval.

Answer: The potential is there to move units from agency to agency but during the transition we're going to try to keep people afloat so we will try to keep the units authorized specific to a provider.

Question: At the beginning of a contract year will we have a set amount or not?

Answer: You will not know a certain amount other than pulling a report of all your authorizations. You can do this through a crystal report. It will tell you how much federal, state, and local you have.

Question: I understand Fordyce to say that you will be identifying local match funds with specific clients based on the funds that flow through the local community services account. Keep in mind there are some funds that don't necessarily flow through that account but can still be counted toward Medicaid match specifically Education Trust Fund and local DHR money.

Answer: We actually do have your ETF dollars in that local community account and the DHR dollars in that account as well. It's taken a few years to get this set up but we are fully going to count and track those.

Question: If we have an implementation date of January 1, 2007 are the contracts that start October 2006 going to be 1/12th for 3 months?

Answer: They will be 1/12th through December (that is the same system that we are on now). We'll do the prior authorizations starting in November or sooner. Those authorization start dates will be December 06. You'll have the 1/12th payment in December 06. Starting January you will bill against the prior authorization for December services.

Question: When will providers be able to look at the software?

Answer: We are still in the design phase and a final product is not available. We'll start validating screens in April. Then we'll move on to testing. The training manuals will be created prior to training. You should be able to look for this sometime in the summer.

Question: Will we be given a copy or will we have to download it?

Answer: It is web-based so you will be given a user name and password.

Question: We are a provider but contract with a 310. Will we be able to see that software soon or as soon as the 310 or will we have to rely on the 310 to filter information to us? One of the issues we have is that we are fairly sophisticated in what we do in terms of technology but our 310 is somewhat behind us. This might be a problem for us.

Answer: Our plan is to provide contractors with the license. We were not planning on buying every sub-contractor a license. You might be able to purchase a license on your own. What we are providing to contractors is Two-part Harmony for billing. They will be able to submit claims and receive report and submit incidents, but if a sub-con has 2-part they can't bill into harmony because they are not a contractor and we only pay money to contractors that then split the money out to sub-contractors.

Question: Can a dial up connection be used to support this web-based software?

Answer: A dial up connection will not support MRSIS you will need a high speed connection.

Question: Will harmony shorten the time between the claims submission and the receipt of the check?

Answer: We anticipate that Harmony will shorten the time but we haven't gotten far enough into the design to be sure of this. What we are sure of is that it won't lengthen the time. It is as good as or better than what you are using now.

Question: Will harmony make billing easier for providers?

Answer: If you are currently sending an 837 not too much will change. You will send your 837 to MRSIS instead of EDS.

Questions presented on or after 2/10/06 Stakeholder Call

Question: Is the cost of Two-Part Harmony going to be covered by DMH/MR?

Answer: DMH/MR will cover the cost of Two-Part Harmony license for a set number of users per provider.

Question: What are the hardware and operating system requirements?

Answer: You can click on the Hardware and Software Requirements link to view system recommendations.

Question: Some rural areas use a dial-up connection for internet access. Is this acceptable?

Answer: You must have a high speed internet connection in order to access MRSIS.

Question: What if DSL or Broadband is not available in our area?

Answer: There are satellite companies that offer high speed connection to the internet in rural areas. DMHMR is researching such companies to provide recommendations.

Question: How will MRSIS handle Day Habilitation "sick days"?

Answer: The prior authorization will authorize an overall number of units for a fiscal year and this figure will be adjusted by an absentee percentage for residential and day habilitation to be suggested by the provider. As the last month of an authorization approaches, the regional office will run a standard report to show unused units. Unused units will be unencumbered and put in a pool, to be reassigned to clients who may be using more than their projected units. You can click on the Prior Authorization System link to view a detailed description.

Question: We are using local funds for our ineligibles. We have not been having those local funds certified by DMH and their check comes directly to us. Are we handling this correctly?

Answer: If there is no financial transaction between the DMHMR or Medicaid and the certified provider, there is no need to either get "match" sent to the Department or to set up a plan of care/prior authorization for that person.

Question: How will the local match work with MRSIS if we use a portion to fund our supported employment program?

Answer: If you are using both state and local funding for a service there will need to be a prior authorization for each funding source. You can click on the Prior Authorization System link to view a detailed description.

Question: When will the software be distributed to providers?

Answer: MRSIS is a web-based solution. Providers will be assigned a user name and password. During the design phase there will be different levels of screen validation and testing. Once testing has concluded training will begin for MRSIS users. Dates have not been established for the release of user names and passwords but training is scheduled for the month of September.

Question: Will there be any “hands on” training?

Answer: Yes, training for phase 1 is tentatively scheduled for the month of September.

Question: Is there a user manual available for providers to read over?

Answer: There is not a user manual available for providers because we are still in the design phase. Once MRSIS has been tested training manuals will be distributed and the training process will begin.

Question: Who will be the state representative in our region and how do we contact him/her?

Answer: The plan is to have a group of “super users” that will know how to operate the entire MRSIS system. These users will be available to help providers in the beginning. A regional office staff will also be sufficiently familiar with the system to provide technical assistance. In addition, there will be Central Office staff dedicated to answering “help desk” questions. This person or persons will triage calls. If he/she is unable to answer a question then Harmony will be contacted.

Question: Will there be a tickler system built into the system to minimize log jams at the Regional level.

Answer: Yes, but the goal is to provide enough efficiency that the regional offices can meet the timelines specified in Standards.

Question: How flexible will internal access to client files be?

Answer: There are many levels of security that can be turned on or off depending on what level of client information is appropriate for an end user to see. This will be part of the MRSIS set-up and providers will be critical to determining accessibility levels.

Question: Will we still have to print a hard copy of the Plan of Care and obtain signatures?

Answer: Yes, the Plan of Care signatures are a Medicaid requirement. We are continuing to work with Medicaid on the new format of the Plan of Care. Nothing has been finalized at this point.

Questions presented on or after 1/27/2006 Stakeholder Call

Question: Was there any consideration of the prior authorization going through central office and not going through regional offices?

Answer: The reason for the prior authorization going to the regional offices is because the plan of care needs to be reviewed and approved (or not) based on the appropriateness of the plan,

that it meets AL Medicaid requirements and that we have money in the budget to support the plan. In short, the staff is in the regional offices. We don't have the staff in central office to perform those functions.

Question: For those of us that already have a billing system how will the two systems interface so that we don't have to enter billing information into two different systems?

Answer: If an agency has their own system that is capable of producing the 837, then they will continue to submit all claims (now to MRSIS instead of Medicaid) via the 837. There may be minor changes in their current format (though we hope not). They will probably have some new numbers to use (maybe a new provider number, we are not sure about this yet). For those agencies that don't have a system that can produce the 837 (i.e. currently using the EDS PES entry method) we will want them to use Two-part Harmony for their data entry.

Question: Will we have to use two different systems to bill with (i.e. Harmony and EDS) or are the two systems intertwined?

Answer: No, MRIS will replace EDS. You will use Two-part Harmony for billing if you are currently using PES (EDS) entry method and will bill MRSIS if you currently produce the 837.

Questions: Will MRSIS send error reports to us the way EDS currently does?

Answer: The way EDS sends errors back to you will soon be going away. The new version of EDS will no longer have the CSR after their new MMIS is implemented. We are going to try to build in the same up front edits into MRSIS as EDS so that if you bill using Two-part Harmony you will get the same upfront report that says there is an error that needs to be resubmitted.

Question: Once this system goes live we will be doing away with the 1/12th payment for the match that the state has put up. What happens to the money that we get for ineligible clients that are not eligible for Medicaid? Will they need to be put into this system?

Answer: Yes, if we are paying money for non-waiver clients we have a program code for this group to be put into this system. We will prior authorize those services too. And if it is prior authorized then you will get paid for it.

Question: Could I get my name on the distribution list?

Answer: Yes, send your current e-mail address to Daphne Rosalis at Daphne.Rosalis@mh.alabama.gov

Question: Will the provider number change?

Answer: You'll have a performing provider number just like you do now (in fact it may be the same as you have now). The state (payee) provider number will remain the same. The Department is the sole Medicaid provider so you will be using the Department's provider number to bill with just as you currently do.

Question: Currently we use the same system and procedures for billing infant and adult case management. When Harmony is fully implemented, will we have to bill using two systems, i.e., Harmony for adult CM and the present system for infants?

Answer: MRSIS would not include the Early Intervention Children, largely because of the totally different contracting and reimbursement system, and the interrelationship with ADRS. Consequently, I would have to say yes, you will need to use two systems.