AAHAM

Vermont Medicaid

Margaret Haskins (Margaret.Haskins@dxc.com) – Provider Relations Representative
Jennifer Hanfield (Jennifer.Hanfield@dxc.com) – Provider Relations Representative

Agenda

1. Suspended Claims
2. Timely Filing
3. Timely Filing Reconsiderations
4. PMM – Provider Management Portal
5. PERM – Payment Error Rate Measurement
6. ACO Prior Authorization Requirements
7. You First/Ladies First
8. Reminders

Suspended Claims

Suspended claims happen when a claim comes into our system, but gets held to be processed by one of our Resolution Clerks.

The following are the top ten reasons for suspended claims for hospitals who participate in Vermont Medicaid.

- Detail Procedure Code Requires PA
- Header Primary Diagnosis/Revenue Code Mismatch
- Recipient has Medicare Part B coverage on date of Service
- Outpatient HCPCS/Diagnosis Code Mismatch
- Further PT/OT/ST services require a PA
- Total Days do not match
- Service requires a PA through Evicore
- Procedure Code/Modifier Code not on File
- Units Billed do not meet min/max requirements
- Suspect Duplicate Inpatient/Outpatient Claim

If you need help, or have questions about any of these examples, please be sure to outreach to your VT Medicaid Provider Representative. If you don't know who your Provider Representative is for your practice, please see the VT Medicaid website (http://www.vtmedicaid.com/assets/manuals/ProviderRepMap.pdf.)

Timely Filing

Timely filing guidelines effective February 1, 2019

- **When Medicaid is the primary insurer providers have 6 months from the date of service to submit a claim.**
- **When Medicare is the primary insurer providers have 6 months from Medicare's paid date to submit a claim or 6 months from Medicare's denied date to submit a claim.**
- **When other insurance (excluding Medicare) is the primary insurer providers have 12 months from the date of service to submit a claim.**
- **For an inpatient claim, providers have 6 months from the discharge date to submit a claim.**
- **When a provider has been granted retro-enrollment they have up to 12 months from the date of service, or an additional 45 days from the date of notice of enrollment to submit a claim.**
- **When a recipient has been granted retro-eligibility providers have 12 months from the date of service to submit a claim.**
- **Providers have 6 months from the initial Medicaid denial to submit a corrected claim.**
- **Providers have 3 months from the initial Medicaid timely filing denial to submit a timely filing reconsideration request.**

Timely Filing Related to an Adjustment

- **Providers must request an adjustment to a PAID claim within 12 months from the original paid date when the adjustment would result in a positive financial outcome for the provider.**
- **Providers may request an adjustment to a PAID claim within 3 years from the original date of service when the adjustment would result in a negative financial outcome for the provider. If the claim is more than 3 years old, providers must refund the overpayment by completing the refund form and attaching the refund check.**

Timely Filing Reconsideration Requests

Requirements

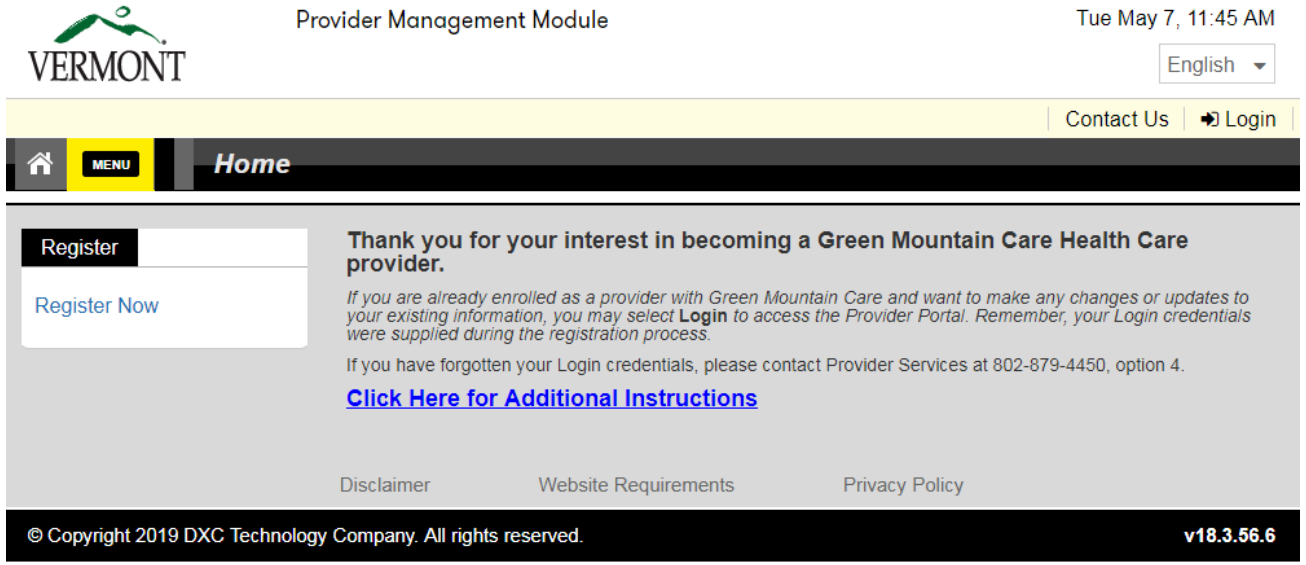
- **Timely Filing Reconsideration Request Form**
- **Appeal Request Letter explaining why the claim is being submitted past the Timely Filing Guidelines and detailing the steps already made to get the claim paid**
- **Denial on file for Timely Filing**
- **New claim form so the claim can be sent for processing, if the override is approved**

Helpful Tips

- **Make the Appeal Request Letter as detailed and clear as possible**
- **Consistency between the new claim and the TF Reconsideration Request Form (ie: DOS, Amount Billed)**

Provider Management Module

This module will allow providers to enroll, revalidate and make changes to existing provider data. With the implementation of the module providers will no longer be required to mail paper enrollment applications and supporting documentation. The module will allow online enrollment and revalidation, which will decrease the amount of time it currently takes to enroll or revalidate with Vermont Medicaid. This will reduce the time, effort and paperwork required of providers to enroll today.



PERM Payment Error Rate Measurement

The Department of Vermont Health Access (DVHA) announces that the Payment Error Rate Measurement (PERM) audit has commenced for SFY2019 (which runs from July 1, 2018 to June 30, 2019).

- **Providers selected for the audit are required to submit all requested claim medical records and documentation.**
- **Providers have 30 days from date of receipt of notice to submit required claims medical records and adjoining documentation to AdvanceMed.**
  - If additional information is needed, providers have 7 days from the date of receipt of notice to send in the information.
- **DVHA will enforce a 10% withholding from all providers that do not submit the required medical record and adjoining documents within 30 days or the additional documentation within 7 days.**
- **Please refer to http://dvha.vermont.gov/for-providers/payment-error-rate-measurement-perm/view for examples of the request letters from AdvanceMed.**

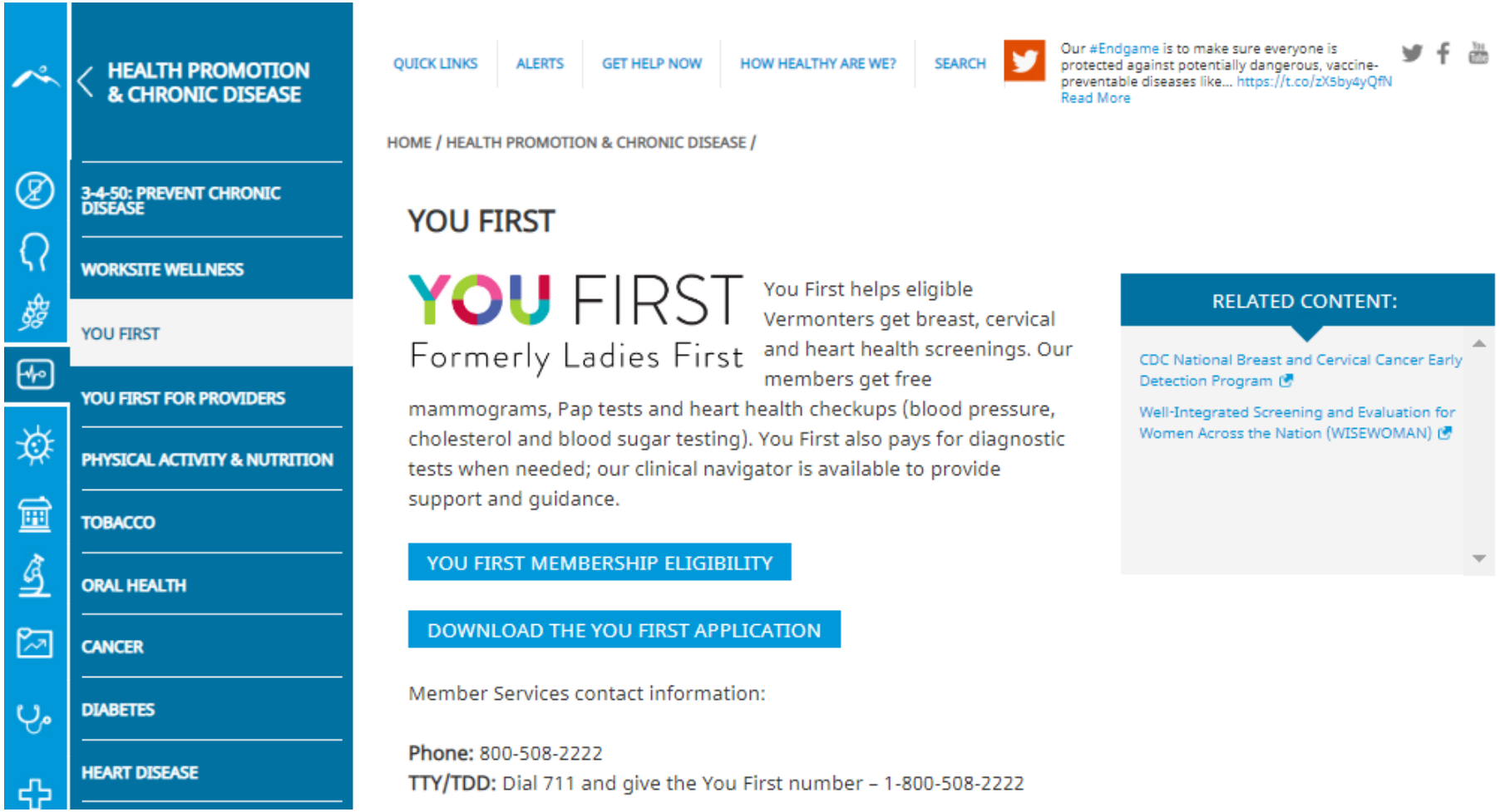
ACO Prior Authorization Requirements

Under the Vermont Medicaid Next Generation ACO program, prior authorization requirements were waived in 2018 for all Vermont Providers for ACO-attributed members and services.

Beginning in January 1, 2019, prior authorization for ACO-attributed members and ACO covered services are completely waived, and adjustments have been made to the MMIS to no longer require PA forms of any kind for ACO-attributed members and ACO-covered services, EXCEPT for a small number of codes that will always require prior authorization, even for ACO-attributed members. Providers will always need to use the traditional (not short) DVHA prior authorization forms for these exception codes.

Further information and a code-level list of ACO-covered services and equipment and whether they require prior authorization can be found at http://dvha.vermont.gov/for-providers/clinical-coverage-guidelines.

Ladies First Now Known as You First



Reminders

- Check Vermont Medicaid Banner and DVHA Advisory
- DXC Call Center – Eligibility, Prior Authorization status, Claim Status, General Policy Questions, Remittance Advice Requests
- Voice Response System (VRS) – available 24 hours a day, 7 days a week for eligibility, other insurance (OI) information or to determine if service limits have been reached, often faster than calling into the Call Center (802.878.7871, option 1 and then option 1 again)
- PMM Guides are available on www.vtmedicaid.com

Thank you!