# AAHAM

## Vermont Medicaid

Nora Williams (Nora.L.Williams@dxc.com) – Provider Relations Representative
Rebecca Gangl (Rebecca.L.Gangl@dxc.com) – Provider Relations Representative

# Agenda

1. Suspended Claims
2. Timely Filing
3. Prior Authorization Requirements
4. ACO
5. Fee Schedule
6. Enrollment
7. Reminder/Upcoming Events
8. Questions

# Suspended Claims

**Why do claims suspend?**

Claims suspend due to system edits and audits.

**Which can be caused by:**

- Coding issues including CPT/HCPCS, diagnosis codes, modifiers, etc.
- Provider/member eligibility
- Limitations
- Prior Authorizations
- Manual Pricing
- Duplicate Billing

# Suspended Claims Reasons

| | 2018 | 2018 | 2018 | 2018 |
|---|---|---|---|---|
| | January | February | March | April |
| Percentage of claims processed to final status within 15 days of submission | 95% | 94% | 93% | 93% |
| Percentage of claims processed to final status within 30 days of submission | 96.6% | 97.4% | 98.0% | 98.0% |
| Percentage of auto-denied claims | 21% | 22% | 23% | 21% |

# Suspended Claims Report

| ICN | Billed Amount |
|---|---|
| | |

| Day's in Suspense | Total of Claim Per Age Range | Total Billed in Suspense |
|---|---|---|
| 181+ | | |
| 151-180 | | |
| 121-150 | | |
| 91-120 | | |
| 61-90 | | |
| 31-60 | | |
| 0-30 | | |
| Total: | 0 | $0.00 |

| Top 5 Suspension Reasons | # of Detail in Suspense |
|---|---|
| | |
| | |
| | |
| | |
| | |

| Top 4 Oldest Claims Review |
|---|
| |
| |
| |
| |

# Suspended Claims Banner

| | | | | |
|---|---|---|---|---|
| 2017-112017-0822 | November 17, 2017 | Suspended Claims | ALL | Hide |

DXC has traditionally maintained a high percentage of claims that are finalized within 15 days of submission. The 2017 metrics for claims processed within 15 days are as follows: January 94%; February 94%; March 90%; April 89%; May 92%; June 94%; July 94%; August 95%. In addition to this, during this year we consistently processed over 99% of claims within 30 days of receipt. We realize these statistics are based on averages and not all claims are processed within these timelines. If you are experiencing a significant number of outliers and/or have claims that are more than 60 days old that are causing hardship please contact your Provider Relations Representative for assistance.

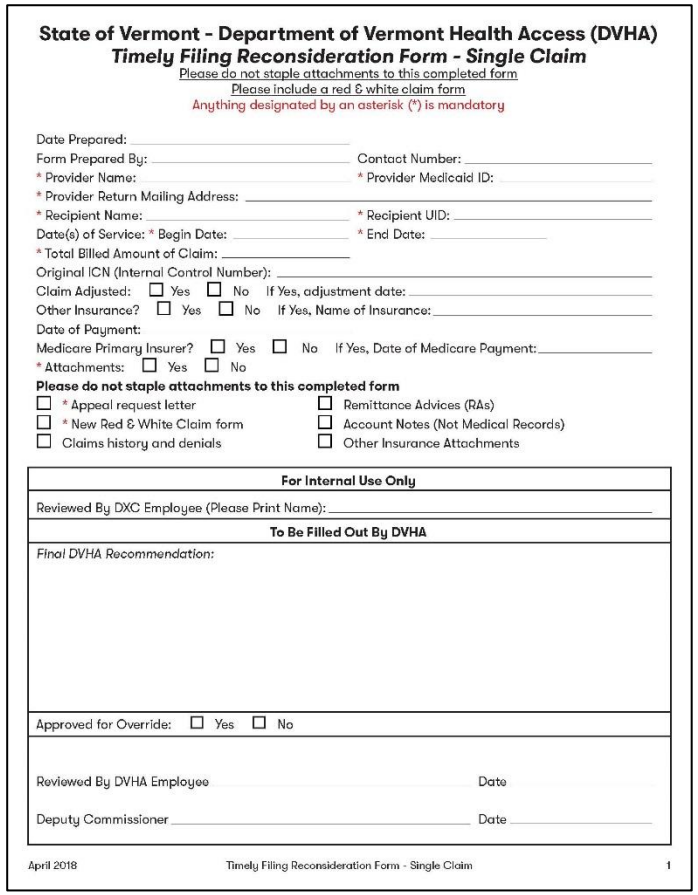
Print

# Timely Filing

- Medicaid Primary – 6 months from the thru date of service
- Commercial Insurance Primary/Medicaid Secondary – One year from thru date of service
- Medicare Primary/Medicaid Secondary – 2 years from the thru date of service
- Adjustments older than ONE year must be submitted on paper
- If DXC denies the claim within timely filing limit for any reason other than exceeding the timely filing limit, a copy of the remittance advice showing the denial must be attached to each claim
- **You must have a timely filing denial in order to appeal a claim for timely filing.**

# Timely Filing Reconsideration Forms

## Single Claim



**State of Vermont - Department of Vermont Health Access (DVHA)**
***Timely Filing Reconsideration Form - Single Claim***
Please do not staple attachments to this completed form
Please include a red & white claim form
Anything designated by an asterisk (*) is mandatory

Date Prepared: _____
Form Prepared By: _____ Contact Number: _____
* Provider Name: _____ * Provider Medicaid ID: _____
* Provider Return Mailing Address: _____
* Recipient Name: _____ * Recipient UID: _____
Date(s) of Service: * Begin Date: _____ * End Date: _____
* Total Billed Amount of Claim: _____
Original ICN (Internal Control Number): _____
Claim Adjusted: ☐ Yes ☐ No If Yes, adjustment date: _____
Other Insurance? ☐ Yes ☐ No If Yes, Name of Insurance: _____
Date of Payment:
Medicare Primary Insurer? ☐ Yes ☐ No If Yes, Date of Medicare Payment: _____
* Attachments: ☐ Yes ☐ No

**Please do not staple attachments to this completed form**

☐ * Appeal request letter
☐ * New Red & White Claim form
☐ Claims history and denials
☐ Remittance Advices (RAs)
☐ Account Notes (Not Medical Records)
☐ Other Insurance Attachments

**For Internal Use Only**

Reviewed By DXC Employee (Please Print Name): _____

**To Be Filled Out By DVHA**

*Final DVHA Recommendation:*

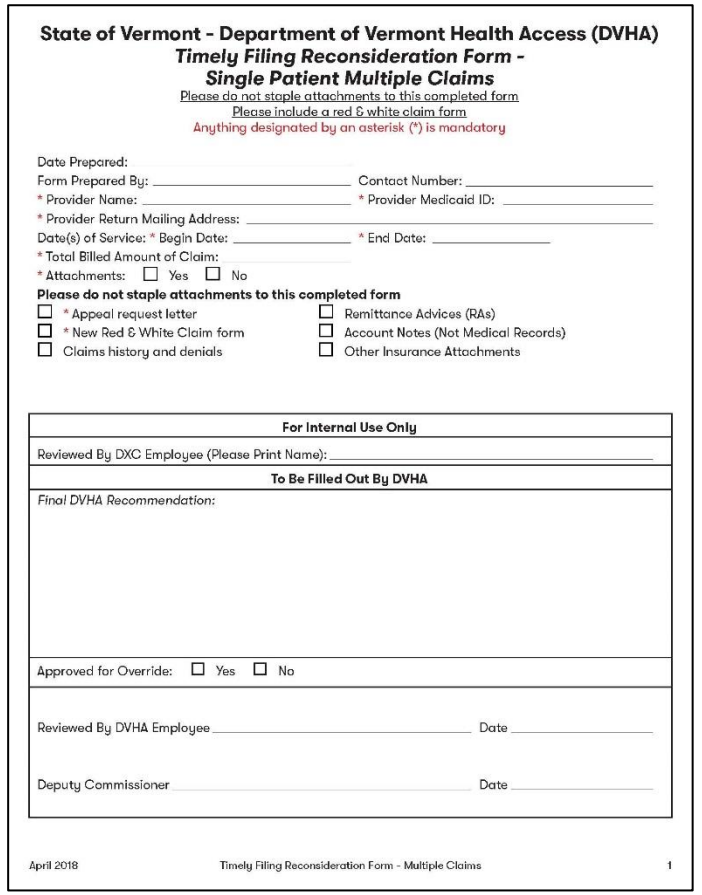
Approved for Override: ☐ Yes ☐ No

Reviewed By DVHA Employee _____ Date _____

Deputy Commissioner _____ Date _____

April 2018 Timely Filing Reconsideration Form - Single Claim 1

## Multiple Claims – Page 1



**State of Vermont - Department of Vermont Health Access (DVHA)**
***Timely Filing Reconsideration Form - Single Patient Multiple Claims***
Please do not staple attachments to this completed form
Please include a red & white claim form
Anything designated by an asterisk (*) is mandatory

Date Prepared:
Form Prepared By: _____ Contact Number: _____
* Provider Name: _____ * Provider Medicaid ID: _____
* Provider Return Mailing Address: _____
Date(s) of Service: * Begin Date: _____ * End Date: _____
* Total Billed Amount of Claim:
* Attachments: ☐ Yes ☐ No

**Please do not staple attachments to this completed form**

☐ * Appeal request letter
☐ * New Red & White Claim form
☐ Claims history and denials
☐ Remittance Advices (RAs)
☐ Account Notes (Not Medical Records)
☐ Other Insurance Attachments

**For Internal Use Only**

Reviewed By DXC Employee (Please Print Name): _____

**To Be Filled Out By DVHA**

*Final DVHA Recommendation:*

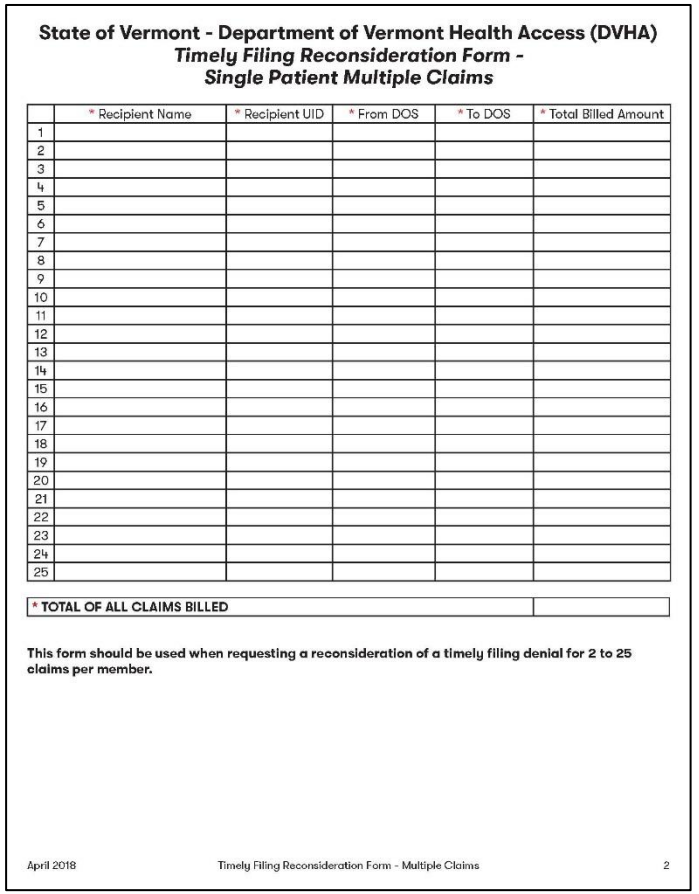
Approved for Override: ☐ Yes ☐ No

Reviewed By DVHA Employee _____ Date _____

Deputy Commissioner _____ Date _____

April 2018 Timely Filing Reconsideration Form - Multiple Claims 1

## Multiple Claims – Page 2



**State of Vermont - Department of Vermont Health Access (DVHA)**
***Timely Filing Reconsideration Form - Single Patient Multiple Claims***

| | * Recipient Name | * Recipient UID | * From DOS | * To DOS | * Total Billed Amount |
|---|---|---|---|---|---|
| 1 | | | | | |
| 2 | | | | | |
| 3 | | | | | |
| 4 | | | | | |
| 5 | | | | | |
| 6 | | | | | |
| 7 | | | | | |
| 8 | | | | | |
| 9 | | | | | |
| 10 | | | | | |
| 11 | | | | | |
| 12 | | | | | |
| 13 | | | | | |
| 14 | | | | | |
| 15 | | | | | |
| 16 | | | | | |
| 17 | | | | | |
| 18 | | | | | |
| 19 | | | | | |
| 20 | | | | | |
| 21 | | | | | |
| 22 | | | | | |
| 23 | | | | | |
| 24 | | | | | |
| 25 | | | | | |

| * TOTAL OF ALL CLAIMS BILLED | |
|---|---|

**This form should be used when requesting a reconsideration of a timely filing denial for 2 to 25 claims per member.**

April 2018 Timely Filing Reconsideration Form - Multiple Claims 2

Forms available at http://www.vtmedicaid.com/#/forms

# Prior Authorization Requirements

- **DVHA does not issue retro prior authorizations (PAs)**
  - Exceptions:
    - The primary insurance denies a service for non-covered or benefits exhausted and that service requires prior authorization through Medicaid
    - An unlisted procedure needs to be performed without prior knowledge during a listed procedure
      - A prior authorization request must be submitted to DVHA prior to claims submission
- **There are only two circumstances in which a claim will be considered without a required prior authorization:**
  - Retroactive eligibility
  - Emergency Services

# Accountable Care Organization

OneCare Vermont (OneCare) is a statewide Accountable Care Organization (ACO) working with Medicare, Vermont Medicaid, Commercial, and Self-Funded insurance programs to improve the health of Vermonters. OneCare comprises an extensive network of providers across the full continuum of care, including hospitals in Vermont and New Hampshire, hundreds of primary and Specialty Care Physicians, Federally Qualified Health Centers, Designated Agencies for Mental Health and Substance Use, skilled nursing facilities, home health agencies, and Area Agencies on Aging. OneCare coordinates the health care for more than 112,000 Vermonters across Medicare, Medicaid, Commercial, and Self-Funded health plans.

# OneCare Vermont FAQ

**Q: How do physicians and hospitals participate in OneCare Vermont?**
**A:** Medicare defines an ACO "Participant" by its Tax Identification Number ("TIN"), therefore a person with authority to do so on behalf of a potential participant TIN will need to sign a OneCare Vermont "Participant Agreement" as well as submit additional information required by Medicare. The participating network is a clinically integrated network across the State of Vermont.

**Q: Can a provider or organization be a part of multiple Medicare ACOs?**
**A:** Given the detailed rules of the MSSP, **a TIN that includes multiple physician providers and services must belong to only one ACO.** Medicare requires all providers billing through a network participant TIN to be part of the ACO. For a provider or provider organization to belong to more than one ACO, the provider would need to bill using different TINs, one for each ACO.

**Q: Is the network for the ACO intended or allowed to apply to commercial contracts or other payers?**
**A:** It is generally contemplated that ACO networks may wish to explore expansion given the investment in clinical integration required under the Medicare program. The OneCare Vermont participant network and participation agreement is open to the Medicare Shared Savings Program (MSSP), Vermont Medicaid Next Generation Program (VMNG), and the Commercial Exchange Shared Savings Program (XSSP).

# OneCare Vermont FAQ

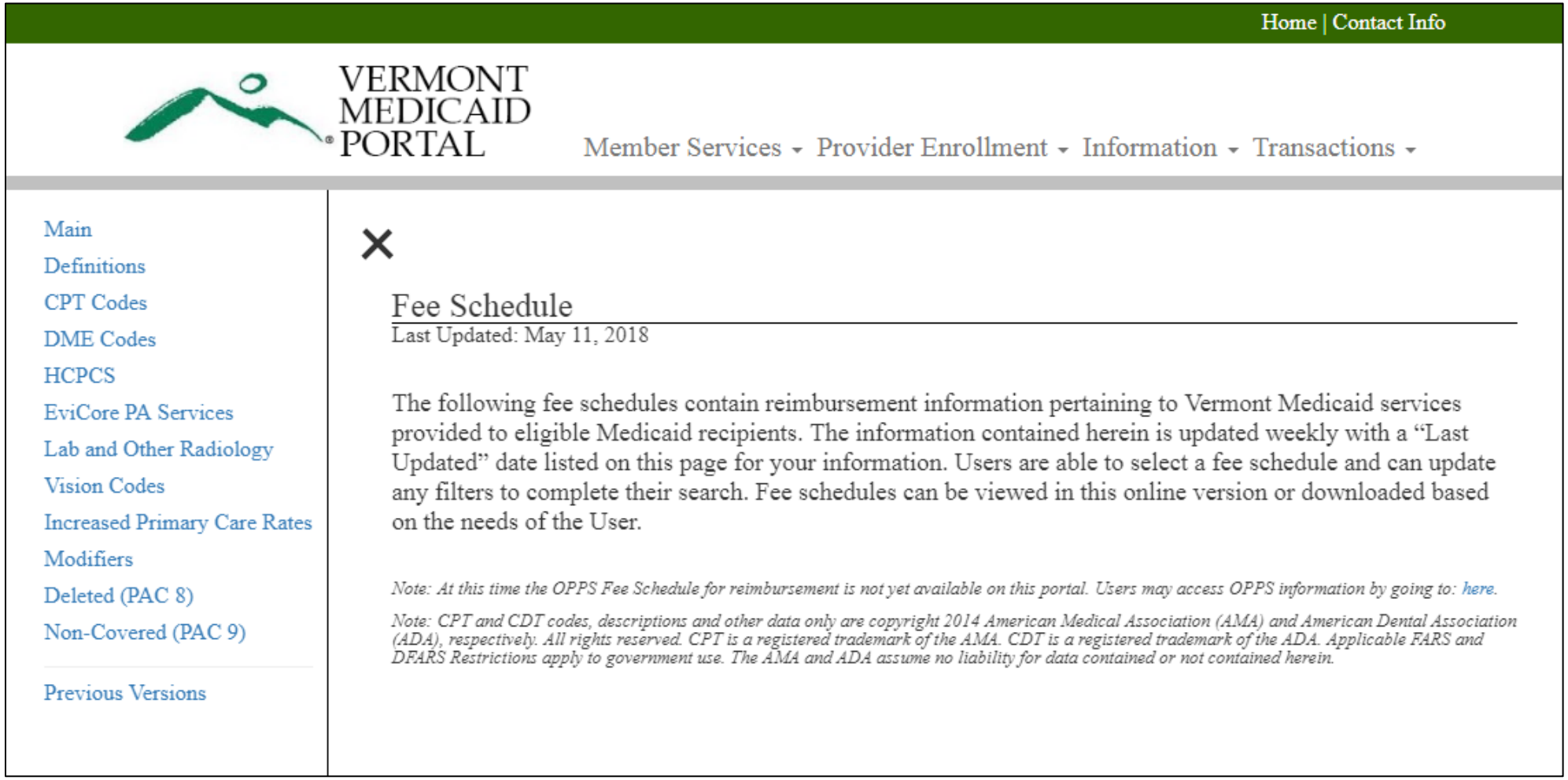
**Q: How does this fit in the overall Vermont approach to Health Care Reform?**
**A:** We are working directly with the Vermont Health Care Reform team which envisions provider payment incentives changing across all payers. The MSSP, which includes population-based targets, shared savings incentives and quality measurement with financial implications, is consistent with the goals of payment reform. How Medicare and the OneCare Vermont MSSP participation may fit into a coordinated multi-payer approach or single payer model will develop over time.

**Q: Can I enter the ACO network later or leave early?**
**A:** The ACO is permitted to add or remove network participants during the three year period; however this is a challenging proposition for the ACO given the change this may represent in attributed Medicare beneficiary populations and performance opportunities. OneCare Vermont envisions at least one additional formal opportunity for new network participants to join the network on January 1, 2014. The ability and circumstances for network participants to resign from the network and the MSSP are defined in the participation agreement.

**ACO Contact: 802-847-7220, Toll Free 877-644-7176**

# Fee Schedule Web Page

# Fee Schedule Web Page



# Provider Enrollment

- As of May 1, 2018, all complete applications older than 120 days have been fully processed.
- Currently, Vermont In-state and border in-network applications are being processed within 60 days.  All other applications will be processed no later than 120 days from receipt of completed application.
- Enrollment start date is the date a complete application is received.
- In the spring of 2019, we will be moving to an online Provider Portal.

# Reminders/Upcoming Events

- 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)
- Trainings

# Questions?

# Thank you.