



Virginia Early Intervention Services

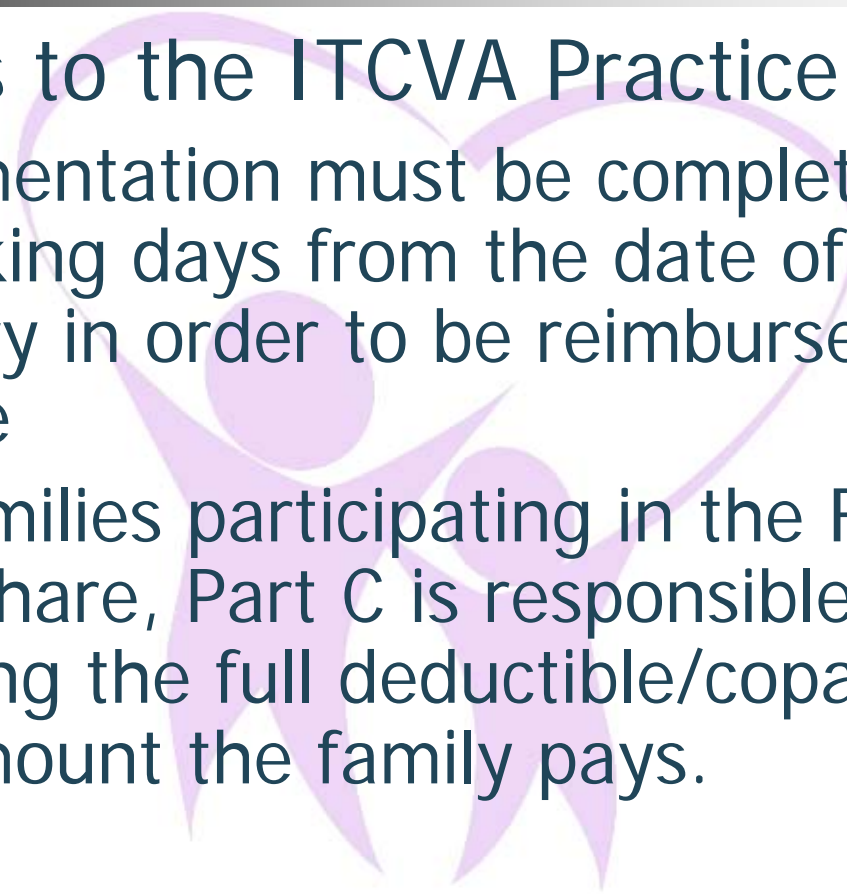
12-18-09

System Transformation Updates

Medicaid Billing Updates



System Transformation Updates

- 
- Updates to the ITCVA Practice Manual
 - Documentation must be completed within 3 working days from the date of service delivery in order to be reimbursed for the service
 - For families participating in the Family Cost Share, Part C is responsible for covering the full deductible/copay minus the amount the family pays.

Personnel Requirements

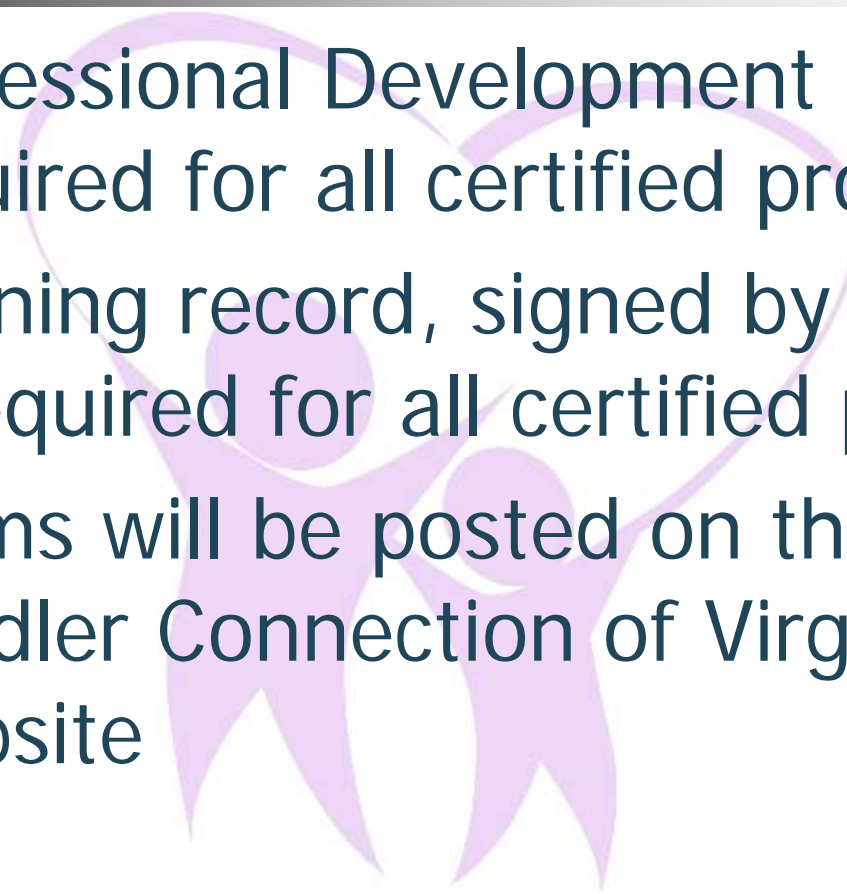
- State emergency regs went into effect 11/23/09
- Emergency regulations will expire 11/2/2010
- Public comment will be accepted in writing through December 23. Send to:

Karen A. Durst
DBHDS, Part C Office
P. O. Box 1797
1220 Bank Street
Richmond, Virginia 23218

- <http://townhall.virginia.gov/L/ViewStage.cfm?stageid=5174>



Professional Development Procedures and Documentation

- 
- Professional Development Plan required for all certified providers
 - Training record, signed by supervisor is required for all certified providers
 - Forms will be posted on the Infant & Toddler Connection of Virginia Website



Practitioner Certification

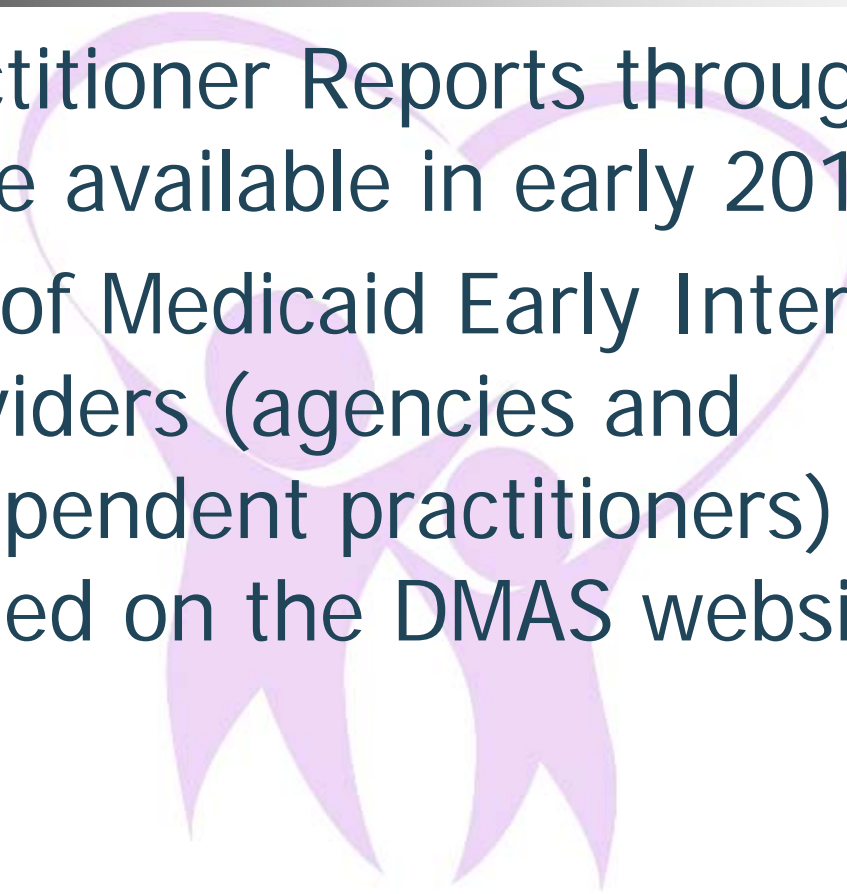
- Inclusion of Elementary Education (preK-6) for educator qualifications
- New Providers – click on <http://www.infantva.org/documents/ovw-st-ProvInfoSheet.pdf> for information

Practitioner Certification - Questions

- Re: educational requirements – Contact Bev Crouse at btcrouse@vt.edu or 540-231-0803
- Re: the online application process – contact David Mills at david.mills@dbhds.virginia.gov or 804-371-6593
- Re: status of certification- contact Tamara Wilder at tamara.wilder@dbhds.virginia.gov or 804-786-0992

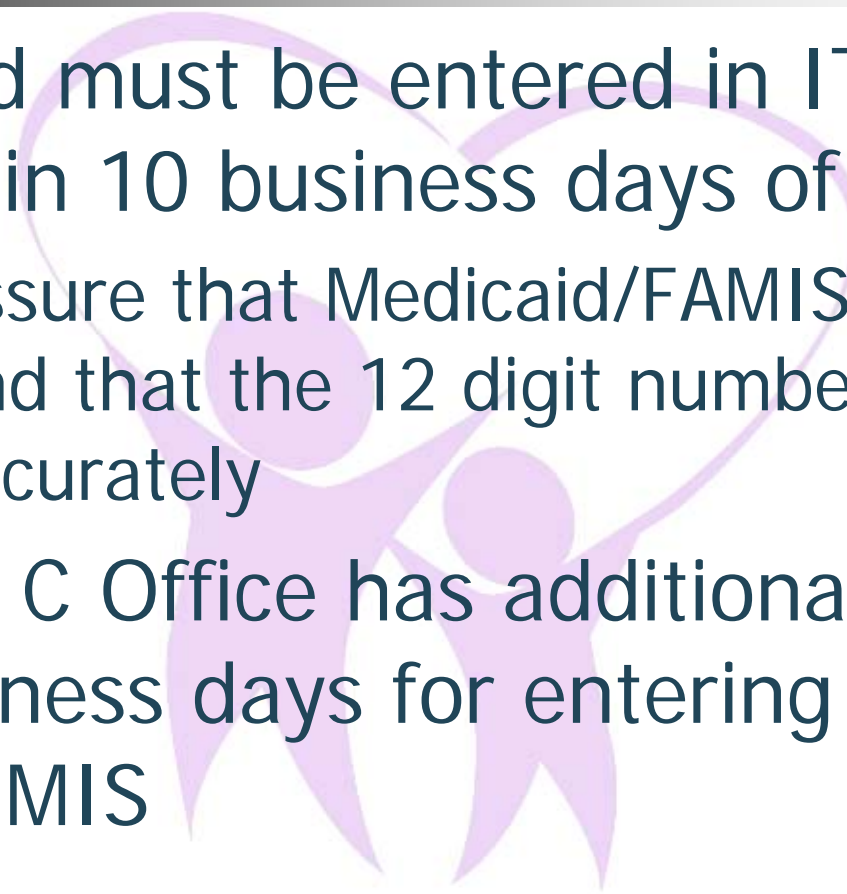


Practitioner Database

- Practitioner Reports through ITOTS to be available in early 2010
 - List of Medicaid Early Intervention Providers (agencies and independent practitioners) will be posted on the DMAS website
- 



Enrollment in VaMMIS

- 
- Child must be entered in ITOTS within 10 business days of IFSP
 - Assure that Medicaid/FAMIS is checked and that the 12 digit number is entered accurately
 - Part C Office has additional 5 business days for entering child in VaMMIS



Enrollment in VaMMIS

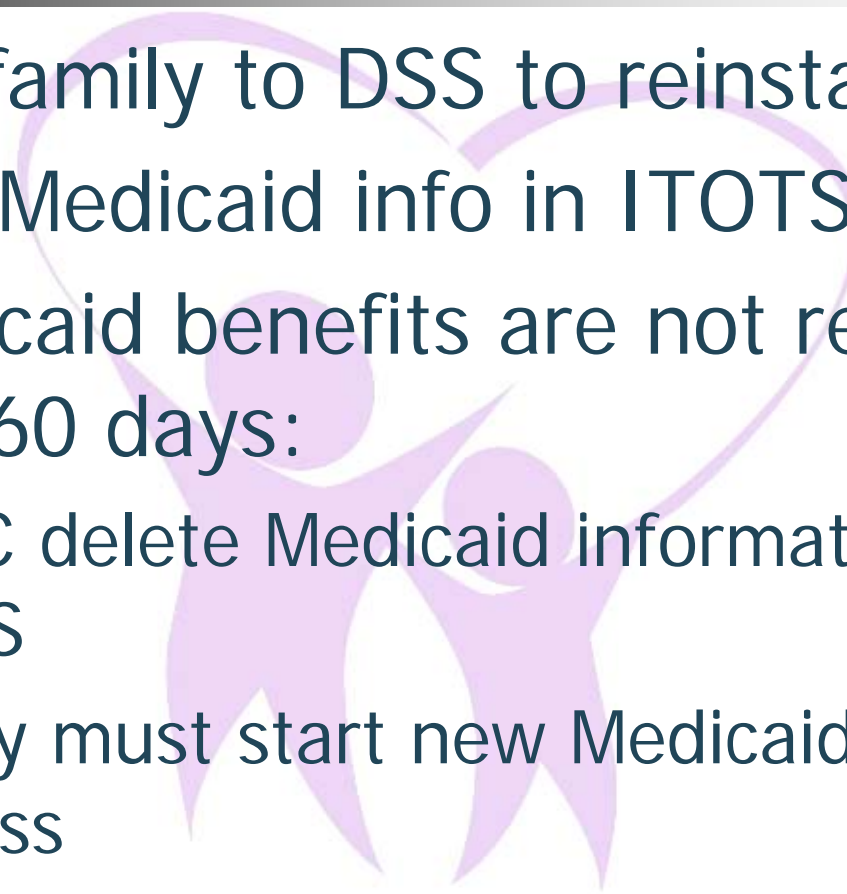
- If child info entered accurately in VaMMIS within 10 business days:
 - Part C staff enters the date of evaluation as the start date for Medicaid EI Services
 - Assessment for service planning and IFSP meeting are covered
- If ITOTS data entry is after 10 business days, Medicaid EI coverage starts the day of ITOTS data entry

When a Child Loses Medicaid Coverage

- Part C determine if loss is temporary or permanent
 - Was loss due to change in financial status or failure to complete paperwork
- If permanent:
 - Update Financial Fee Agreement
 - Update Third Party Coverage in ITOTS



Temporary Loss of Medicaid

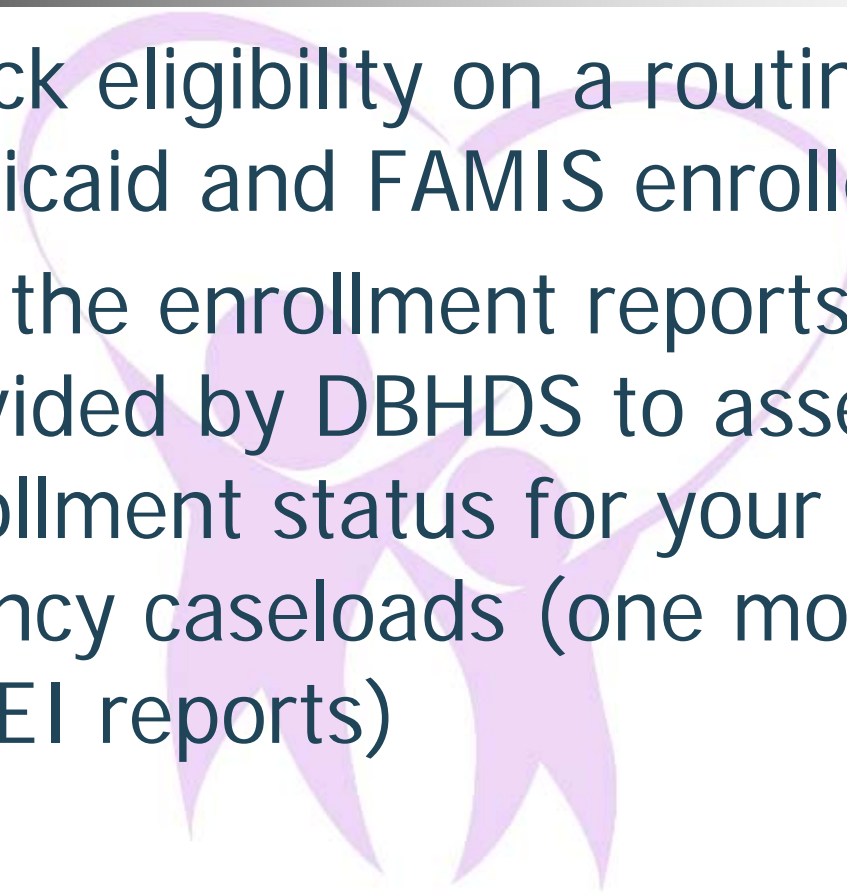
- Direct family to DSS to reinstate benefits
 - Retain Medicaid info in ITOTS
 - If Medicaid benefits are not reinstated within 60 days:
 - Part C delete Medicaid information from ITOTS
 - Family must start new Medicaid enrollment process
- 

Enrollment Processing and Checking Eligibility

- This function is a joint responsibility of the LLA and the service provider
- Reminder: Part C funds are not available for children who are Medicaid and/or FAMIS eligible



Enrollment Problem Solving

- 
- Check eligibility on a routine basis for Medicaid and FAMIS enrollees
 - Use the enrollment reports as provided by DBHDS to assess the enrollment status for your Local Lead Agency caseloads (one month lag in the EI reports)



Enrollment Problem Solving

- 
- Contact DBHDS technical consultants for enrollment processing questions
 - Ensure ITOTS enrollment is complete according to DBHDS requirements
 - DBHDS staff suggest that you monitor your ITOTS enrollments on a weekly basis

Questions about Medicaid Coverage for Specific Children

- Contact David Mills at david.mills@dbhds.virginia.gov or 804-371-6593
- OR
- Tamara Wilder at tamara.wilder@dbhds.virginia.gov or 804-786-0992

The IFSP, Billing and Reimbursement

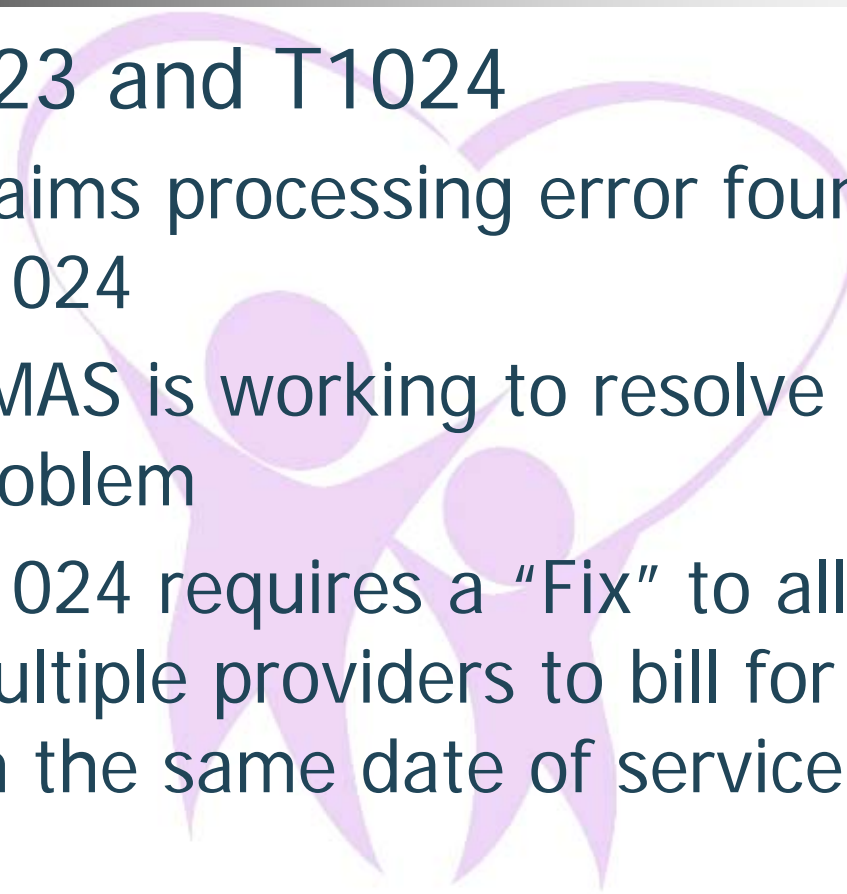
- IFSP must be signed by Physician (or PA or NP) in order for services (after ASP and IFSP) to be reimbursed
 - Signature on IFSP, or
 - Signature on letter that accompanies copy of IFSP, or
 - Signature on letter that summarizes info from IFSP



Billing Codes



T1023 and T1024

- Claims processing error found on T1024
 - DMAS is working to resolve this problem
 - T1024 requires a “Fix” to allow multiple providers to bill for this code on the same date of service
- 



Billing Codes

■ T1023 and T1024

- Must combine units on one line if more than one employee provides the assessment service on the same day
- Option: to allow one agency to be reimbursed on multiple claim lines for the same code on the same date of service the provider must enroll as group provider and bill using NPI processing rules



Billing Units

- Cannot round up time
- Can bill minutes across several sessions by billing them on one line
 - Sessions must be in the same month



Common Claim Errors

- 0774 error message occurs when the child is not enrolled into the DMAS EI system
- 0301/0302 denials
 - Issued when the same provider bills for the service on the same date
(Ex: units not combined for T1023)



Resources

- Infant & Toddler Connection of Virginia Website: <http://www.infantva.org>
 - Practice Manual: <http://www.infantva.org/documents/pr-PM-PracticeManual.pdf>
 - Practitioner Application: <https://www.eicert.dbhds.virginia.gov/>
 - Training Modules: <http://www.eitraining.vcu.edu/>



Resources

- Brian Campbell, EPSDT Services Supervisor

brian.campbell@dmas.virginia.gov

804-786-0342

- Beth Tolley, Technical Assistance Consultant

beth.tolley@dbhds.virginia.gov

804-371-6595



Billing Updates



The following information is meant to facilitate training of the subject matter in Chapter V-Billing Instructions of the Virginia Medicaid Early Intervention Services Manual.

This training contains only highlights from the manual and is not meant to substitute for or take the place of the Medicaid Manuals.

Providers are responsible for reviewing and adhering to all Medicaid manual requirements.

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- 
- Third Party Liability (TPL)
 - Adjustments and Voids
 - Claims Timeline
 - Resources

Third Party Liability (TPL)





Third Party Liability (TPL)

- VA Medicaid is always the payer of last resort
- Participating providers are required to bill any and all other third party carriers
- VA Medicaid requires providers to verify primary carrier coverage for each service prior to billing
- Services not covered by the primary carrier will require a current denial or confirmation of non covered services attached to claims submitted to VA Medicaid



Verification of Primary Carrier

- 
- Client
 - MediCall
 - Automated Response System
 - Remit



MediCall

 **800-884-9730**

 **800-772-9996**

 **804-965-9732**

 **804-965-9733**



Verifying Primary Carrier-MediCall

■ Requirements

- 10 digit NPI or API
- Enrollee's 12 digit Medicaid ID number OR Social Security Number **and** Date of Birth (mmddyyyy)
- From and Thru Date(s) of Service
- Press "1" for enrollee eligibility verification
- Dates can not be more than one year in the past

Verifying Primary Carrier-MediCall

■ MediCall will:

- state if Medicare is primary
- give an insurance code for commercial carriers

Insurance Code list on DMAS website

http://www.dmas.virginia.gov/downloads/pdfs/pr-Numeric_Ins_code.pdf



Automated Response System

- Registration

virginia.fhsc.com

- Questions concerning registration process

Web Support Helpline

800-241-8726

Verifying Primary Carrier - ARS



Requirements

- User ID
- Password
- 10 digit NPI or API

 From the Main Menu select Eligibility Benefit Verification and Service Limits

Verifying Primary Carrier - ARS

- You will be prompted for the following
 - enrollee Medicaid ID number; **or**
 - any two of the following:
 - Enrollee social security number (without dashes)
 - Enrollee date of birth (mmddyyyy)
 - Enrollee name (Middle initial is optional)

Provider Name Last/Org Name (Current MCO/PCP):

Provider Name Last/Org Name (Previous MCO/PCP):

Benefit Plan (Plan Coverage Desc) - CoPay Indicator	Begin-End (Date Time Period)	Eligibility or Benefit Info	Patient Pay (Benefit Amt)	Provider ID or PCP (Benefit Related Entity ID)	Phone Number Communication Number
MEDICAID FFS - A	06/08/2008-06/08/2008	1	0.00	000000000	000-000-0000
IFDDS WAIVER - B	06/08/2008-06/08/2008	1	0.00	000000000	000-000-0000
HIPP PREMIUM - A	06/08/2008-06/08/2008	1	0.00	000000000	000-000-0000

TPL Information

Carrier Name (Plan Coverage Desc)	Carrier Code	Coverage Type (Service Type Code)	Begin-End (Date Time Period)	Deductible (Benefit Amt)	Copay (Benefit Amt)	Policy Number (Ref ID)
ANTHEM BLUE CROSS & BLUE	00739	35	11/01/2005-12/31/9999	0.00	0.00	YTP [REDACTED]
ANTHEM BLUE CROSS & BLUE	00739	88	11/01/2005-12/31/9999	0.00	0.00	YTP [REDACTED]
ANTHEM BLUE CROSS & BLUE	00739	30	11/01/2005-12/31/9999	0.00	0.00	YTP [REDACTED]

Service Limits

Service Type Code	Quantity Remaining (Quantity Approved)	Limitation Begin-End Date Time Period
No Service Limits		

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Contact Primary Carrier

Verification of Coverage

- Service Covered

- Bill Primary Carrier/receive EOB

- Service Not Covered

- Bill Primary Carrier/receive EOB or,
- Document on letterhead

- Policy no longer active

- Bill Primary Carrier/receive EOB or,
- Document on letterhead

Billing TPL on the CMS-1500



Locator 11d - Is There Another Health Benefit Plan?

- Providers should **always** check 'YES' if there is verification of Third Party Liability
- If there is no other coverage check no or leave blank



Block 11d - Is There Another Health Benefit Plan?

d. IS THERE ANOTHER HEALTH BENEFIT PLAN?

YES NO *If yes, return to and complete item 9 a-d.*

DMAS does not require items **9 a-d** to be completed.



TPL Billing Scenarios



- No other insurance
 - Check 'NO' in Locator 11D or leave blank
- Primary Carrier pays covered service
 - Receive an EOB
 - Check 'YES' in Locator 11D
 - Document primary payment information in the shaded red area of 24A on the claim

TPL Information - Block 24A (shaded red area)

If a third party carrier paid for services:

- Qualifier '**TPL**' will be used followed by dollars/cents amount
- No spaces between the qualifier and dollars and no \$ symbol used
- Decimal between dollars and cents is **required** to read paid amount correctly
- Must be left justified

Block 24A: Dates of Service



24. A.						
DATE(S) OF SERVICE						
From			To			
MM	DD	YY	MM	DD	YY	
TPL27.08						
1	11	01	08	11	01	08
2	12	01	08	12	03	08

The primary carrier paid \$27.08



TPL Billing Scenarios

- Primary Carrier does not pay
 - Denied claim/applied payment to deductible
 - Receive EOB
 - Check 'YES' in Locator 11D
 - Attach EOB showing non payment of the claim
 - Do not document any information in the shaded red area of 24A



TPL Billing Scenarios

- Primary Carrier does not pay
 - Service not covered
 - Check 'YES' in Locator 11D
 - Attach EOB **or** letter verifying the service is not covered
 - Do not document any information in the shaded red area of 24A



TPL Billing Scenarios

- Primary Carrier does not pay
 - Policy is no longer active
 - Check 'YES' in Locator 11D
 - Attach EOB or letter verifying the policy is not active
 - Do not document any information in the shaded red area of 24A
 - Caseworker at DSS must remove TPL info



TPL Billing Scenarios

- Primary carrier does not pay
 - Provider not enrolled with primary carrier
 - Check 'YES' in Locator 11d
 - Attach letter documenting the provider is not enrolled with primary carrier
 - **Do not** document any information in the shaded red area of 24A

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TPL Exceptions

- T1023, T1024, T1027, T1015
- These codes do not require TPL information on the claim when billed separately
- If billed on the claim form with other codes, TPL billing procedures apply



Adjustments and Voids



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Block 22: Adjustments and Voids

22. MEDICAID RESUBMISSION CODE	ORIGINAL REF. NO.
1032	XXXXXXXXXXXXXXXXXXXX

**Adjustment or Void
Resubmission Code**

**ICN number from
original remittance**

**Chap. V, Medicaid Early Intervention Services
Manual has code list.**



Claims Processing Timeline



Paper Claims

- The cutoff for claims to be processed on the following Fri. remit is Tues. at noon
 - Ex. Claims received Dec. 8th by noon will be on the Dec. 18th remit, claims received after that will be on the Dec 25th remit.
- Allow time for postal delivery, mailroom distribution and scanning



Electronic Claims

- The cutoff for claims to be processed on the following Fri. remit is the previous Fri. at 4pm
 - Ex. Claims received Dec. 11th will be on the Dec. 18th remit
- Claims must be received from your vendor by this cutoff, any delay in receipt will result in a delay in **payment.**



Resources



Electronic Billing

Electronic Claims Coordinator- Mailing Address

First Health Services Corporation
Virginia Operations
Electronic Claims Coordinator
4300 Cox Road
Glen Allen, VA 23060

E-mail: edivmap@fhsc.com

Phone: (800) 924-6741

Fax: (804) 273-6797



Contacts

- DMAS Website:
 - <http://www.dmas.virginia.gov/>
 - Provider Manuals
 - Provider Enrollment
- Provider Call Center
 - 1-800-552-8627 or 804-786-6273
- Provider Enrollment
 - 1-888-829-5373



THANK YOU
