

**PROVIDER QUESTIONS RELATED TO NEW MEDICAID ELECTRONIC
PATIENT PAY PROCESS AND NEW DMAS-225 FORM**

1. Will the system automatically split the patient pay based on per diem for a split stay for the month or if the patient expires?

There is no automated process for prorating patient pay based on discharge or expiration of the patient. If a recipient dies or is discharged home with no waiver services in place, the worker will end the patient pay segment but will not recalculate the patient pay. If a recipient is discharged from one provider and receives services from another, the eligibility worker will recalculate patient pay for the month of discharge from the former provider and determine patient pay for the current provider.

2. Once Medicare pays and leaves Coinsurance that crosses over to Medicaid, will they now look at the patient pay to determine if there is a low level rug and process the claim accordingly?

N/A – no linkage to billing/claims system upon initial implementation.

3. If the system pays on an incorrect patient pay, how do I correct my bill?

Currently, there is no linkage between patient pay, billing and claims. Use the DMAS-225 to report incorrect patient pay.

4. How do I get the patient pay corrected in the system? (i.e.: patient has an insurance premium that changes mid year and the patient pay needs adjusted accordingly)

Complete DMAS-225 and forward request to LDSS.

5. What is the time limit as to when an eligibility worker can no longer change a patient pay? For instance we do our Medicaid billing usually by the 5th of the month, when can the eligibility worker NOT change the patient pay for the month we would be billing for?

The local department of social services cannot make a change in patient pay for the current month. For example, patient pay for March for a current recipient cannot be changed in the month of March. In order to increase patient pay for March, the LDSS worker would have had to make the change no later than February 15th. Workers must provide at least 10 days advance notice to the recipient before an increase in patient pay can become effective. There are no

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advance notice requirements regarding patient pay decreases, so workers can make those changes up to the last day of the month before the change is to take place. However, we are working toward having the eligibility staff make ALL patient pay changes by the 15th of the month prior to the month the change is to become effective.

6. We bill our patient pay in advance so what is the time limit for inputting the correct patient pay for the current month?

See response to question number 5.

7. How is this system going to interact with the billing system?

The implementation of the capability to link the patient pay information with the claims/billing system has been postponed. Stay tuned.

8. Patient is in Nursing Home A has a \$1000.00 patient pay, transfers to Nursing Home B on the 8th of the month. Will the system split the patient pay between Nursing Homes?

Yes, once the eligibility worker makes the change. This is not an automatic change. The eligibility worker will have to change patient pay to reflect the recipient's discharge from Nursing Home A and admission to Nursing Home B.

9. If we notify LDSS of change in income, how will we know if the change has ever been received if we don't receive some type of notification back?

Lower portion of the DMAS-225 is to be returned to the provider as verification if the change causes a change in the recipient's eligibility status. The provider will need to verify whether the patient pay amount changed via either ARS or Medicaid. If an individual's income amount changes, there should always be a corresponding change to his patient pay amount.

10. What about the fact that there is no "trigger" or "flag" when changes to the Map-122 information occurs. If the info was uploaded into the DMAS billing database this step would not be necessary but as it is the Managers in these buildings would have to review on line all patient pay amounts for those Medicaid primary patients on a monthly basis to ensure accurate billing. We like the idea of having this information online as opposed to paper, but a notification step is missing.

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See response to question number 7. The provider will need to verify patient pay via ARS or Medical prior to billing.

11. Facility dealing with a Tidewater area DSS. Our business manager was inquiring with the DSS about a Medicaid resident and they mentioned that if a resident dies or is discharged we will use the new map 225 to communicate this change, but it will not have the adjusted patient pay on it. They said that the state is leaving it up to us (the provider) to bill the resident/responsible party correctly using our Medicaid per diem rate. They will not give us a new patient liability since those statuses are not entered into the ARS system. We're seeking confirmation that the information provided by our local DSS is correct.

The information provided by the local DSS office is correct.

12. It was mentioned previously that DMAS might be able to generate a report monthly showing changes in patient pay. As I understand it now if we wanted to see changes, we would need to look up each resident's name, one by one. That could be a long process for us! Have you heard anymore on this?

DMAS will be revising the current AS-O-317 report that you receive monthly to include patient pay information. This report is issued at the end of each month and the revised report will be implemented in late October 2009. The revised report will be a listing of all recipients we have in our records as being in your facility and will list the patient pay amount for that month. If the report is for the month of November 2009, it will list everyone we say was in your facility for November as well as any patient pay amount the individual had for the month of November.

13. During previous discussions, I believe I heard that there would be some training available soon to the facilities (providers) about accessing the ARS system to obtain a map 122 (DMAS 225). If so, do you know if this will happen soon? A few folks have tried to access this site, but really didn't know where to go to view and print a MAP.

We have asked about training for providers on the ARS system. However, at this time, we have not been informed if or when training is planned. The provider memo issued on March 4, 2009, provided detailed instructions on accessing ARS to verify both eligibility and patient pay.

14. We have been getting many concerns about the 225 and patient pay determination process. The facilities are getting DMAS-225s notifying of changes to April Patient Pay but the web site is not showing what it is. They are asking when will the website be updated with the new amounts. Also one facility reported that the

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amounts showing for March are changing even though changes cannot be made to the current month Patient Pay. They have an ongoing MAP122, but the amount listed on the Patient Pay section of the ARS for March is different than the prior month MAP amount. One of our Office Managers from Lynchburg was reporting that. In the question and answer section of this process, it states that changes cannot be made after the 16th but the worker is telling her that the 16th is the date they have to close a case not make changes. They (LDSS) have until the 31st to make changes if it is not an adverse change, if it is an adverse change then they have until the 22nd on a 31 day month (10 day notice period) to make the change. Can we get clarification on when the patient pay amounts need to be in the system for the next month's billing?

All changes related to an increase in patient pay must be made by the 15th of the month prior to the month the change is to become effective. Local agency staff do not have until the 22nd of a 31 day month to make the change if it involves an increase in patient pay. Increases in patient pay must be done by the 15th of the month prior to the month the change is effective in order to provide the federally required advance notice of the increase. Decreases in patient pay can be done up until the last day of the month prior to the month the change is effective. This is not a change in policy; it has always been this way because we do not have to give the 10 day advance notice. While we are not federally required to provide advance notice of decreases in patient pay, we are working toward having local agency staff complete all changes (both increases and decreases) by the 15th of the month prior to the month the change is effective.

Patient pay amounts will show up on both ARS and Medicall within 24 hours of the time they were entered into the MMIS. This is because notices to the recipient or his authorized representative must be generated overnight and that is done at the end of each day. So, if the worker in the local agency enters patient pay information into the system on a Monday, it will be available in ARS or Medicall the next day, Tuesday.

If a provider has a specific issue with a patient pay amount, please contact Cindy Olson at 804-225-4282 or by email at cindy.olson@dmas.virginia.gov

15. How will facilities know what private portion (patient pay) to bill and collect? We have encountered one already - who we got a form 225 back on but we 1) do not know what his new private portion for March is (not on the ARS website, the form 225, and the DSS worker did not say) and 2) have nothing in writing to document his private portion. My concern is that if each local DSS has until December 2009 to get the ARS site updated, but yet DMAS 122 is obsolete

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March 1, 2009 - how will we bill, collect, and document the correct private portions in the mean time?

Each LDSS worker is required to send the provider a DMAS-225 at the time the case is entered into MMIS for the first time. This will alert the provider that patient pay information will be obtained through the system from that point on. If you received a DMAS-122 in December, January or February listing a 2009 patient pay amount, you will continue to collect that amount until you receive a DMAS-225 informing you that patient pay is now being entered into the system.

16. ARS system needs a patient pay history so that you don't have to go in each service date.

ARS is designed to provide eligibility verification and patient pay information for the date of service.

17. You cannot see the future service date until after the Medicaid cutoff.

Correct.

18. The DMAS-225 is not descriptive enough. It should contain specific explanations of the changes.

With the exception of the addition of the NP/API numbers and the removal of patient pay amounts, the DMAS-225 contains the same information as the DMAS-122. If there is other information you would like to see on the form, please send your suggestions to us and we will review.

19. Notices of Obligation are not being mailed promptly from Richmond. Sometimes it is a number of days between the time that the notices are dated and when they are mailed. Example - Notice of Obligation dated 3/06/09, mailed 3/20/09, received 3/23/09.

Thank you for bringing this issue to our attention. We were not aware that the Notices of Obligation were not being mailed timely. This issue has been corrected.

20. We were told by a social worker that if the resident is in the nursing home and has been there for awhile, if nothing is on the website, we should assume that the Patient liability is what it was on the last Map 122. Can Cindy verify this?

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Correct. Until you receive a DMAS-225 from the LDSS worker, you are to collect the patient pay amount listed on the DMAS-122 for 2009.

21. How will a newly approved Medicaid resident be handled – what time period does the SS Department have in order to get the Patient Liability on line? If they (DMAS) are considering a report, would it be possible to query by NPI number? That would help some of the home office people who may be working on several facilities at a time. It seems to me that they would have to do this to facilitate the Clifton Gunderson audit until they implement the billing portion of the change.

Policy has not changed with regard to time frames for processing cases. For new cases, the federal time standard for processing is 45 days from the date of application unless a disability determination is needed and then the federal time standard is 90 days from the date of application. The processing time can take longer if the individual has difficulty providing necessary information or additional medical information for the disability determination is needed.

The report that we are revising will be printed by provider. There is no online query by NPI number. We are working with Provider Reimbursement staff to determine how to facilitate GG audits in the wake of this change.

22. Will the DMAS 225 communication form be sent to the nursing home when the SS Department has initiated a change as the nursing home would be required to submit to them when we have a change.

The LDSS worker is required to send a DMAS-225 to the provider upon initial application approval, upon patient pay entry into the MMIS and when a change in income or circumstances affects eligibility.

23. When they implement the billing portion of the change in the future, what is the Provider's responsibility for errors in patient liability i.e. the Clifton Gunderson audit? Since Medicaid will be controlling the amount of Patient Liability deducted, would the Provider have any responsibility for accuracy in billing it other than billing the correct amount to the resident? How will Medicaid handle retro patient Liability adjustments?

We are still researching the billing portion of this process and do not have any new information to give you at this time.

24. Was the ARS system designed with the intent that providers only be able to see one month at a time, or was there some other factor that made this necessary? If by intent, what was the reason? In MMIS the DSS can see on the screen at one

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time multiple months. Why can't providers be given the capability to see multiple months?

ARS was designed to be a web-based way to verify eligibility for date of service. It was not designed for providers to verify multiple months of eligibility.

25. On the ARS Medicaid system will Zero Patient pay be shown as 0.00 or nothing there?

A zero patient pay will show up as a zero amount. The only time there will be no amount shown is when there is no patient pay in the system.

26. In ARS, is there a list of status codes besides A = active?

The only two status codes used for patient pay are "A" for active and "V" for void. The one that is applicable to collection of patient pay is the "A" status code.

27. When a new person becomes Medicaid eligible, the provider receives a 225 form from the LDSS. What about a redetermination or annual review, will facilities receive a 225 from the LDSS for these folks?

A new DMAS-225 will only be completed at the time of initial approval, upon conversion to the MMIS and when a change in income or circumstances affects eligibility status.

28. Please confirm that for a decrease in patient pay, facilities will not receive a 225, but for an increase a form will be provided.

Eligibility workers will complete a new DMAS-225 at the time of the initial application approval, initial conversion to MMIS and changes in eligibility status. There will be no new DMAS-225 issued to the facility when a patient pay either increases or decreases unless it is accompanied by a corresponding change in eligibility status. It is important to verify patient pay amounts via ARS or Medicaid to keep current on patient pay amounts.

29. Would it be possible for DMAS to put a transaction date next to the patient pay in ARS so we are aware of when the patient pay change was made?

Changes to patient pay must be made in the month prior to the month the change is to be effective. Increases in patient pay must be made by the 15th of the month prior to the month the change is to be effective, and we are working on getting all

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changes made by that date. There is no way to put a transaction date in ARS at this time.

30. We have a patient that we have looked up in the ARS system and he has 2 co-pays listed for 3/1/09-3/31/09. One shows a status of A and the other shows a status of V, they are different dollar amounts, which one is correct?

See the response to question #26. Only the "A" code is applicable for collection of patient pay.