

## **November 2012 DMAS MMIS WEBEX Q&A**

- 1. Sometimes when making a change to patient pay from one provider to another provider, usually within the same month, the provider number for the previous provider gets overlaid with the new provider's NPI number? We have to go back to patient pay history, pull up the previous provider's active history and change the NPI number back to the correct number. Using the override function mentioned in the MMIS user's guide does not seem to help avoid this "flipping" of the provider number.**

ANSWER: Using the new version of the MMIS User's Guide, Chapter G, you will find a sequential process which minimizes the changing of the Provider ID. This doesn't work in all instances depending on how many changes of provider you are doing in the current month and in the future month.

When you are entering a future segment for a new provider, the rule of thumb is that you always wait until the first segment for the new provider shows in column one before you add additional segments for that provider out in the future. That way, the Provider ID for the original provider is preserved for their segment(s). When you do have a segment in column one for the new provider and add the balance of the segments for that provider, you will change to the new provider ID and all future segments will have the new provider ID. This eliminates having to go out into the History screen and pop back and forth. This is hard to explain over the phone, as there are many ways to handle these cases and we only provide one in the MMIS User's Guide. Feel free to call Lois Brengel at (804) 371-6333 or email the Patient Pay Inbox at [patientpay@dmas.virginia.gov](mailto:patientpay@dmas.virginia.gov) and we will be happy to walk you through the process.

- 2. Do you think it is possible that there could be trainings or Power Point presentation in the future regarding provider changes? I do not do a lot of provider changes in my agency and therefore don't always remember how to proceed.**

ANSWER: We actually have done several of these trainings over the last year. Please visit the Eligibility and Enrollment Unit webpage at [http://dmasva.dmas.virginia.gov/content\\_pgs/dss-elgb\\_enrl.aspx](http://dmasva.dmas.virginia.gov/content_pgs/dss-elgb_enrl.aspx) to find the Power Point presentations or search the Knowledge Center for past trainings.

- 3. When we are adding the newborn we are receiving a lot of duplicate enrollments when we use the "APP" pseudo for the SSN and the date of birth. What can we do to avoid this?**

ANSWER: The duplicate enrollment process needs to run in order to avoid duplicate enrollments. It is better to let the process work in order to avoid the child being enrolled twice. If you are having issues with the process you can send a request to the Enrollment Inbox at [enrollment@dmass.virginia.gov](mailto:enrollment@dmass.virginia.gov) and we will assist you. Remember the APP entered into ADAPT is translated to 999 when the MMIS Member Screen is populated.

- 4. This is a question related to the DMAS 225 communication forms. Is there a way that long-term care (LTC) providers could identify the agency fips code in MMIS to alert them what agency handles a LTC Medicaid case? Agencies receive a fair amount of DMAS 225 forms that have to be forwarded to the correct agency. This delays an agency's response time to making a timely change to alert the Medicaid recipient or her authorized representative and the provider of a potential patient pay change. This would ensure that DMAS 225 forms that providers send to agencies would go to the correct agency instead of being sent to the wrong agency.**

ANSWER: Remember, there is no wrong door. The ARS System does not provide specific information to the provider as to what local agency handles the case. We understand that there is an issue with providers trying to locate the appropriate agency. The providers are generally just forwarding to their local agency. It is the responsibility of the local agency to forward the information onto the correct locality. Unfortunately, this is the current process and we don't have another solution at this point. If you have suggestions for correcting this, please feel free to call us and let us know.

- 5. Is a patient pay adjustment allowable to cover the cost of accompanying a member who resides in a nursing facility to a doctor visit if the nursing facility does not provide this service?**

ANSWER: While this deduction is not specifically precluded by policy, neither is it included in the list of services permitted to be deducted, DMAS is skeptical that it will meet the medical necessity threshold to be allowed as a deduction. Follow the procedure in Medicaid Manual M1470.230 C. 4 to decide if you can deduct the bill.

- 6. Are we going to receive anything in regards to the QI renewals this year or any changes?**

ANSWER: The MMIS process has not been able to be changed at this point. The same process is followed as outlined in the Medicaid Manual. To date, nothing has changed from last year. The same automatic closure will occur at the end of the year. We hope to change this process in the future to avoid these cases having to be reopened by the local agencies.

- 7. Who do you email to advise of other participants in the office?**

ANSWER: You can email the list of participants to the MMIS Inbox at [mmiswebex@dmas.virginia.gov](mailto:mmiswebex@dmas.virginia.gov).

**8. About AC 058, what is special about it as far as it being selected for finding incorrect enrollments?**

ANSWER: This AC was selected because it is frequently used to enter spenddowns. On the initial report run there were approximately 2,700 members enrolled in this AC, which we knew was incorrect. Other projects similar to this one can be expected in the future.

**9. Hasn't the limit for patient pay adjustments been increased to \$1,500 per an earlier transmittal?**

ANSWER: You are thinking of the patient pay underpayment requirement to refer cases to the Recipient Audit Unit. This amount was changed from \$500.00 to \$1500.00.

**10. How long does DMAS have to respond to an adjustment over \$500.00 for patient pay?**

ANSWER: DMAS responses to patient pay adjustment requests are mailed out on the last business day of the month to the facility and the LDSS. The letter will indicate if the request has been approved, denied, or if it is pending. If the patient pay adjustment request is an emergency the emergency services procedure should be followed in order to expedite the process. All incomplete packets will be returned. The adjustment request will be denied 30 days from the date of the packet being returned if a completed packet has not been received by that date.

**11. Where is the Eligibility and Enrollment page located?**

[http://dmasva.dmas.virginia.gov/content\\_pgs/dss-elgb\\_enrl.aspx](http://dmasva.dmas.virginia.gov/content_pgs/dss-elgb_enrl.aspx)

**12. We have multiple dental adjustments coming from a few nursing homes from the service provider: Senior Dental Services of VA. They are sending an invoice and a monthly treatment continuation that does not include actual medical justification. These have only been for monthly cleanings for the same clients. Should we be adjusting for these without medical justification?**

ANSWER: There should be medical justification...they should send a diagnosis and recommended treatment plan sheet with the requests. Without medical justification, which is required in policy, the adjustment cannot be approved. If the diagnosis and recommended treatment plan sheet is included with the adjustment request and all other necessary information is provided, the adjustment should be allowed.

**13. Please clarify the out of state mailing issue. In LTC we often have authorized reps out of state. They go in the 'comment section" and the physical address goes in the case screen. If we put the 'out of state' address in the case screen and the physical address in the comments the client's authorized representative will not get the mail.**

ANSWER: The Power of Attorney name and “In Care Of” address can go on the Case Data and Member Demographic screens. If the Power of Attorney wants the Notice of Obligation it must also go on the Comments screen as the Authorized Representative name and address with “A” as the mail to indicator on screen 1 (refer to Chapter G of the MMIS User’s Guide). If it is a CBC provider, the member’s address can be entered on the Comments screen. If it is a nursing facility provider, the Benefit Program screen shows the address where the member resides.