

## **SECTION V.7. Provider Enrollment and Billing Procedures**

### **A. Provider Enrollment**

All Choices for Care (CFC) providers must enroll as a Medicaid provider in the Medicaid claims processing system via Electronic Data Systems (EDS). The following procedures should be used to enroll CFC providers:

1. The interested agency or organization must contact the Department of Disabilities, Aging and Independent Living (DAIL) CFC administration to request DAIL authorization to provide specific CFC services. The interested provider must submit the following information to DAIL in writing:
  - The name of the provider agency or organization
  - The address, phone number, and fax number of the agency or organization
  - Contact person in the agency or organization (for purposes of discussing provider eligibility and provider enrollment)
  - Requested effective date of Medicaid Waiver provider status
  - The service(s) which the agency or organization would like to provide
  - The area(s) in which the service will be provided
2. DAIL may contact the agency or organization to request additional information, and may visit the agency or organization prior to approving or denying the request.
3. If DAIL denies the request, DAIL will communicate this in writing to the organization.
4. If DAIL authorizes the request, DAIL will send an authorization to EDS, the Department for Children and Families (DCF), and the agency or organization, including the following:
  - The name of the provider agency or organization
  - The address, phone number, and fax number of the agency or organization
  - Contact person in the agency or organization (for purposes of provider enrollment)
  - The requested effective date of Medicaid Waiver provider status
  - The service(s) which the agency or organization is authorized to provide
5. CFC providers must obtain applicable sections of the CFC Protocol Manual, brochures and forms (when applicable).
6. EDS Provider Enrollment and Recertification staff (802-879-4450) will assure that the provider has completed a Medicaid provider enrollment agreement and is enrolled as a CFC provider.
7. Any problems or obstacles in provider enrollment will be addressed by negotiation between EDS, DAIL, and the potential service provider.

### **B. Claims**

1. CFC service providers shall only submit claims for reimbursement for services that have been

- provided to eligible individuals in compliance with applicable service definitions, provider qualifications, and standards.
2. CFC service providers shall submit all claims for CFC services through Vermont's Medicaid Management Information System (MMIS), managed by Vermont's Medicaid fiscal intermediary, Electronic Data Systems- (EDS), in accordance with CFC and EDS procedures. Questions about CFC service claims, payments, and claims procedures should be addressed to EDS (802-879-4450).
  3. CFC service providers shall have mechanisms or procedures to assure that claims which are submitted are accurate, and in compliance with all applicable procedures and regulations.
  4. CFC service providers are responsible for preparing and submitting claims for services that they provide.
  5. CFC service providers shall submit claims using the correct revenue code, as described in the following table.
  6. CFC service providers must have a current Moderate Needs Service Authorization approved by DAIL before any claim for CFC Moderate Needs services may be submitted to (Electronic Data Systems [EDS]). Providers shall not bill for services provided after the end date of an expired, overdue Service Authorization.
  7. CFC service providers must obtain and retain copies of the DAIL approved Moderate Needs Service Authorization for every Moderate Needs Group participant to whom CFC services are provided.
  8. If a CFC service provider submits any claims for any CFC services that exceed the dates, types and/or amounts of services that are authorized by DAIL on the Moderate Needs Service Authorization, the service provider must arrange recoupment (or re-payment) to EDS of any payments for services that exceed the dates, types and/or amounts authorized.
  9. If a CFC service provider submits any claims for any CFC services which exceed the types and amounts of services actually provided to an eligible individual (but are within the dates, types and amounts of services which are authorized by DAIL), the service provider must arrange recoupment (or re-payment) to EDS of any payments for services which exceed the amount actually provided.
  11. Case Management services may be provided and billed for up to 180 days after admission and/or preceding discharge from a nursing home or hospital, when such services are clearly documented as facilitating the individual's return to the community. Claims for such case management services must be submitted after the actual date of discharge from the hospital or nursing home, as a single claim.
  12. CFC Moderate Needs provider reimbursement, in addition to Moderate Needs service limitations, reimbursement is limited to a set dollar amount per State fiscal year, (7/1-6/30) per provider, established by DAIL.

**C. Moderate Needs Group Services - Revenue Codes and Rates**

<b>Revenue Codes For Billing</b>	<b>LTCM Services: Home-Based Setting</b>	<b>Units of Time</b>	<b>Max Amount Per Unit</b>	<b>Hourly or Daily Rate</b>	<b>Effective Date</b>
070	Case Management	1 Unit=15 Min.	\$16.86	\$67.44/hr	07/01/2007
096	Adult Day	1 Unit=15 Min.	\$3.25	\$15.00/hr	07/01/2008
095	Homemaker	1 Unit=15 Min.	\$4.67	\$18.68/hr	07/01/2007