

# Minutes



## Avatar Implementation User Forum

**Date:** 05/20/2010

**Time:** 1:00-2:30

**Location:** 7001 East Parkway, Sacramento, Conference room 1

**Facilitator:** Kacey Vencill

**Scribe:** John Sawyer

**Attendees:** (See sign in sheet)

Time	Agenda topic	Presenter
5	Welcome/Introductions	Kacey
5	Issue/Bug Status <ul style="list-style-type: none"><li>Group Services Cost of Service<ul style="list-style-type: none"><li>Any report which returns a "cost of service" value will be inaccurate for Group service codes if those services were edited after data entry. This should be resolved after a patch that was implemented on 4/27.</li></ul></li><li>Unable to add delay reason codes – Impacts primarily ADS</li></ul>	John/Kacey
15	Claiming Update <ul style="list-style-type: none"><li>Medicare/Medi-cal eligible clients – impact to UNBILLED report (MH)<ul style="list-style-type: none"><li>January Medi-Medi clients will show up on the Unbilled report, but we are attempting to change the settings for coordination of benefits to get around it for February, March and April claims.</li><li>We still don't have a definitive answer from the State on how this will be handled long-term, but they are working on it and discussing it weekly</li></ul></li><li>Now Accepting VOID and REPLACEMENTS (Claims Correction Spreadsheets MH Only)<ul style="list-style-type: none"><li>Submit requests on the new spreadsheet.</li><li>Phase 2 denials do require the PCCN (i.e. a response from the state) before they can be processed</li><li>ADS providers please hold on to any corrections at this time</li></ul></li><li>Phase I Denials<ul style="list-style-type: none"><li>County Fiscal staff will be working on corrections and re-billing when possible for Phase I denials.</li><li>Phase I denial details reports with denial reason codes were passed out by Agency to those agencies present.</li></ul></li><li>Other Healthcare Coverage (OHC) Remittance Advice/EOB<ul style="list-style-type: none"><li>There are cases of OHC providers sending EOB notices back to the provider address rather than the billing address</li><li>If you get any EOBs directly, please forward them to Avatar Fiscal as soon as possible</li></ul></li></ul>	Kacey

	<ul style="list-style-type: none"> <li>○ As the OHC requirements continue to unfold we have that in some instances Insurance Companies are requesting the chart notes to support the claiming activities. The County will develop a process to request the supporting documentation and this process will be communicated as soon as the information is available.</li> </ul>	
5	Now Processing OCDRs (for non-claimed services)	Kacey
10	<b>Reports/Reporting</b> <ul style="list-style-type: none"> <li>• Summary of Services by program <ul style="list-style-type: none"> <li>○ Added cost of service by service code</li> <li>○ See issue above regarding group services.</li> </ul> </li> <li>• Testing new reporting platform <ul style="list-style-type: none"> <li>○ Significant performance improvement in testing</li> <li>○ Requires an upgrade of the Avatar software as well</li> <li>○ No ETA on implementation at this point</li> </ul> </li> </ul>	John
15	<b>Open Forum</b> <p><b>Q. What do we do for OHC if the client says they don't have it? Can we put it in anyway?</b></p> <p>A. If MEDS indicates OHC is present, then they WILL deny claims without OHC information. The client will need to work with their eligibility worker to resolve the situation. If you do enter the OHC, it would be claimed to them, denied and then could be billed to Medi-Cal.</p> <p><b>Q. When do we change the pregnancy indicator on perinatal clients?</b></p> <p>A. Please do not change the indicator until Fiscal has completed the claim for the month of services including the perinatal services.</p> <p><b>Q. For Minor Consent services where we do not want to bill the OHC, should we enter them and get denied by Medi-Cal?</b></p> <p>A. We are not in a position to suggest how you handle this. If you choose not to gather OHC information at this time, either services will be billed, denied, and you will have the option of re-billing using the original claim date based on the re-billing guidelines. Or you can not bill at all and hope that ADP will issue delay reason codes to allow late billing based on OHC related problems.</p> <p><b>Q. How long should it take providers to get reimbursed on re-bills?</b></p> <p>A. At this time, we are experiencing an average 45 day turnaround from the state.</p>	Kacey

**Q. If we don't know the effective date of the OHC guarantor what do we use?**

A. Effective date is the date the guarantor was effective for billing for your episode of service. As long as it precedes any services for which that guarantor is valid, then it would be acceptable. Whether that means using the admission date, or the service coordinator start date, that is a program decision.

**Next User Forum :** 06/17/10, 1:00-2:30, 7001 East Parkway, Conf Rm 1