Agenda

Avatar Implementation User Forum

Date: 9/15/2011
Time: 1:00-2:30
Location: 7001 East Parkway, Sacramento, Conference room 1

Facilitator: Kacey Vencill

Scribe: Cat Keeley

Attendees: (See sign in sheet)

Time	Agenda topic	Presenter
5	**Welcome/Introductions**	Dawn
10	**Claiming and Issues Update** We will provide a status on the current claim status for Mental Health and ADS. Current Claim Status: • MH – Fiscal is still working on July claims. Fiscal will start work on the August claim on Monday, 9/19/2011 • ADS – Fiscal is done with the July claim and will start on the August claiming tomorrow, 9/16/2011 • Medi/Medi – Fiscal is still working on the Medi-Medi rebills. The deadline has been extended but at this time we do not know the new date. - We will also be discussing the results of our testing with the direction that came from State ADP regarding what to do when providing ADS minor consent services to a full scope (non Minor Consent) youth. • Minor consent clients with full scope MediCal – testing is complete and a memo will be sent out regarding the process to follow for clients that fall in that category. - In addition, we will be covering the results of our testing regarding what needs to occur when an adult ADS client is receiving services that are not covered by their Other Health Care Coverage. • Testing is also complete on this item and a memo will go out with the new process.	Melony/Robert
30	**Back to Basics** The purpose of this agenda item is to review the critical and basic information that is needed to ensure a solid fundamental understanding of the system and its behavior. This will also include some basic review of the Phase II claiming requirements of DHCS. This information is discussed in training, but due to the critical nature of its contents we want to	Kacey

make sure that it is revisited and all questions are addressed.

We will review the following areas:

Financial Eligibility and the importance of accurate information.

- Remember the Financial Eligibility option is Episode specific so it is specific to each Agency/Program
- The 2nd Tab is the 'Guarantor Selection' tab should be where data is entered first
  - On the 'Guarantor Selection' select the 'Add New Item' button to add a Guarantor
- Remember all red fields are required
- The 'Customized Guarantor Plan' radio button is a required field that should usually be "no" unless eligibility has lapsed.
- Never change the 'Date of Contract'
- On page 2 the Eligibility Verified radio button has to be set to yes
- The Coverage Effective Date is critical. You can use the Admit date if you know that the client's eligibility began prior to admission
- On Page 3>Subscriber Policy # is the CIN number for Medi-Cal, the HIC # for Medicare & the policy # for OHCs
- On Page 4> Subscriber Assignment of Benefits, Release of Info, Coordination of Benefits are all required to be set to yes.
- Nothing is needed on Page 5 and 6>nothing needed.

- Now return to the 1st Tab, 'Financial Eligibility' and select the guarantor order. This effects liability distribution.

  - There are three claiming statuses: Open, Unbilled, Claimed
    - Unbilled - Charges have been locked. Closed but not claimed (closed in Fiscal)
    - Open – this is the best time to make changes
    - Claimed – submitted to the State or another guarantor for adjudication

Q: Can a correction be made to an unbilled claim?

A: Unless the diagnosis or policy number is missing for the Guarantor there isn't really time to make a change while the claim is in this status.

- Unbilled Report – remember to check the Avatar website to verify that it is a good time to run the Unbilled Report

The client ledger, this useful tool can be the answer to many of the 'unknowns' we have experienced.

It was reported that the margins of the Client Ledger Report are not set properly. When issues like this are encountered, please send these types of observations/comment to the Avatar mailbox at Avatar@saccounty.net so they can be corrected. If we don't know about them we can't fix them.

- Phase II billing rules, specifically the following:
  - How to correctly bill Other Health Care Coverage and why that's important.
    - The guarantor should be listed in the Guarantor selection tab
    - The policy number must be entered
    - Submit a claims Correction spreadsheet.
  - Timelines for submission
    - MH-6 months from the date of service to the day the State receives the claims (not 6 months to enter into Avatar)
    - ADS- 30 days from the month of service.
    - MH-97 days to replace a denied claim
    - ADS- no timeline at this time.
      - Remember to make sure that ALL denial reasons have been addressed prior to replacing.

Reviewed the Phase II Transaction Type document found on the Avatar webpage.

- Current timelines:
  - Initial - 6 month from date of service. If claim is submitted after 6 months from initial date of service the service needs a delay reason code or it is subject to denial (for MH).
  - ADS Providers have 30 days from the month of service to get all information entered correctly.
  - Void Transaction – Use this to 'Void' a previously approved (paid) claim. MH would use this to void a previously approved service.
    - ADS can void a denied and approved service. MH must make sure the incorrect CIN number is identical to the one that needs to be voided. This is a challenge and must be checked carefully. There are no timelines to submit a void.
  - Replacement Claim – This type of transaction is used to replace a previously approved or denied claim.
    - MH has 97 days from the date of denial (original denial date). ADS Providers have 6 months of the original date of denial (at this time the State is not enforcing this timeline).
    - Replace an approved service to correct inaccuracies (wrong provider, wrong number of units, etc)
  - It takes a long time for PCCN number – State is taking 6-8 weeks to give us back denials and this takes longer than it should but it is out of the County's control. AS soon as we get the info (835) we are posting it in Avatar within 1 week.

Bill with the EQRO Audit Team gave an update on processing times:

- The State is trying to improve and enhance the processing system. Look for some relief by the end of the year.

- How to use a claims correction spreadsheet and the reasons that you would want to.
  - To VOID an erroneous claim
  - To replace an approved or denied claim
    - If a claim contains inaccuracies such as the wrong provider, wrong number of units, etc use the Replacement process found on the Phase II Transaction Types document discussed above under timeline review
  - To indicate that a delay reason code be included on the claim to avoid being denied for late submission.

Claims Correction Spreadsheet(CCS)

- The instructions can be found on the 1st tab and it is imperative that all information requested be submitted. Fiscal must have accurate information in order to process in a timely manner. Please NEVER delete columns. All columns are utilized during processing. With the implementation of CWS the CCS will be updated.
- Delay reason code (#14 on CCS) –code 7 and 8 are most frequently used. Others are rarely used. Shaded rows indicate that the county must get prior approval.
- Delete Original Service (#11 on CCS) yes or no?
  - If it is a Replacement service then you don't need to answer in this column.
  - If it is a Void then identify whether the original service should be deleted

The CCS must have the PCCN and Claim number for processing.

If entering a new service. Best practice is to enter the new service in Avatar and the fill out and submit the CCS right away. Otherwise there is a risk that the service will possibly go out as an original claim and could be denied as a duplicate. It is better to send them in timely manner rather than to wait and send in on a less frequent basis.

20	Common questions received – **Attendees were asked to review the common questions below. This Agenda item will be added to the October User Forum Agenda.** The purpose of this agenda item is to review the common questions that have been received. Make sure that the attendees are clear on the answers and understand why that is the case. The questions we will be covering include: - **What is the client ledger used for?** The client ledger shows how liability is distributed and the status and history of a charge. It only displays services for which there is a cost. - **How often should the Unbilled Report be generated?** The Unbilled report should be generated monthly, but before running it be sure to review the claim status page on the Avatar website to ensure that you have accurate date in capturing the most updated information. - **How do I know when the Unbilled Report should be generated?** The claim status page on the Avatar website provides this information. - **What happens if I run the Unbilled Report when the status page indicates not to?** **Since Unbilled is a 'closed' but not claimed status, all services prior to claiming are '**Unbilled' running the report when the claim status page indicates not to will result in an overinflated number of services displaying and will not be a useful tool. - **Can you review the purpose of customizing the guarantor plan?** The plan customization is a feature to indicate periods of eligibility and ineligibility. - **How should retro-active eligibility be handled? Should I hold the services or enter them into Avatar?** It is never advised to hold services, instead please ensure that there is a guarantor to assign the liability (UMDAP, MHSA, etc.) once the client obtains eligibility the guarantor should be adjusted. In the event that the charges have been closed, Fiscal can work with you to move the charges to a Medi-cal guarantor and the services will be claimed with the next claim process.	Kacey/Uma
5	**Reminder of things to come – This Agenda item will be added to the October User Forum Agenda.** - HIPAA 5010 – Must be implemented prior to 12/31/2011 - MyAvatar – ETA 2/2012	Kacey
10	**SacHIE Update** • CHW Pilot began 9/13/2011 CHW – the first pilot site rollout went live this week and Cheryl Brant gave an update. ▪ Training for Clinical staff took about 1 ½ days. ▪ It was decided to verify the accuracy of all Progress notes before finalizing ▪ The staff did not have much context at first but once they start to work within Avatar it does become clearer and easier.	Kacey
5	**Reports/Reporting - This Agenda item will be added to the October User Forum Agenda.** - The issue reported regarding duplication of services on the Missing CSI Service Information has been resolved.	Kacey (on behalf of John)
25	**Open Forum** • Please remember that there is a drop-in Session on the second Tuesday of each month at the Tech Center from 2:00 – 4:00. Please bring any Avatar questions along with real world scenarios for help and review. The sessions are held at our training location on Tech Center drive and the address can be found on the Avatar web page: http://www.sacdhhs.com/default_old.asp?WOID=MBR Update on SOC training that was scheduled to take place during today's User Forum • Policy is not quite complete and will be shared as soon as available	All

	Thank you to the Providers that utilized the Drop-in session last Tuesday! We will cover the skipped agenda items first during the next User Forum	
Next User Forum : 10/20/2011, 1:00-2:30, 7001 East Parkway, Conf Rm 1		