

The following were published in the 12/1/11 Weekly

Memo

Question

Answer

<p>We left the TPA Security Webinar on 9/28/11 <b>very concerned</b> with the direction that ESSO and Med3000 is taking with our access to data. Their significant restrictions specific to LES Managers/Supervisor being limited to “view only” on the Program Management facet and not being able to access more than one facet will not work and must be revised.</p>	<p>As a matter of fact, within Early Steps we have had at least one instance of using the data system to fraudulently bill services, but that is not why MED3000's TPA system will have strong internal controls. In any business enterprise that involves the exchange of funds, strong internal controls are the best protection against fraud and are required to be in place and audited under OMB Circular A-133. One of the most important aspects of internal controls is separation of duties. This means having more than one person required to complete a task and having an appropriate level of checks and balances upon the activities of individuals. MED3000 will be audited annually for internal controls and their Security Role assignments are key to having an appropriate system in place to ensure one person could not; create a client, authorize services, bill for services, approve the payment of the bill for services, and end up getting paid. Under the TPA contract, MED3000 is financially liable for any discovered instances of fraud within the TPA system, so they have a great deal at stake if internal controls in the system are not upheld.</p>
<p>I wanted to follow-up with you regarding your explanation that the reason for the extremely restrictive security roles is due to fraud. Has there been fraud in the Early Steps system?</p>	<p>Trust and professionalism are not components of internal control. I have personally testified in court on a fraud case where trusting the employee was the reason they were able to embezzle funds. The employee was the daughter of the director's best friend. The director watched this girl grow up and trusted her integrity and professionalism 100%. The employee had access to all financial transactions of the entity, did the bank deposits and reconciled the bank accounts. Thousands of dollars were siphoned out of the organization before she was caught by a 2nd employee who was asked to do a bank deposit when the trusted employee was out sick. The director was mortified that her trust was violated, but learned the lesson the hard way, of the need for separation of duties. We will work with you to figure out your Security Roles to ensure your program activities are not compromised.</p>

**Question**

**Answer**

<p>I am writing to share my concerns with the TPA roles. At NE LES most managers are cross trained for at least a couple of roles to ensure coverage. Many admin staff have split responsibilities due to decreased funding. I like being able to do whatever is needed (intake, authorizations, data entry, verification, etc.) This will greatly limit our ability to support staff in their roles. We will need to completely reorganize the internal structure of our local program which will not be easy without more money. For example, we have one person primarily doing provider enrollment and that is usually all that is needed. If she is out, I cover until she returns. Since I will not be able to do it, I will need to have one more person with that role and no other that can provide back-up coverage. I have similar concerns for intake and billing. It would be nice for at least the managers to have full access as applicable to their work unit(s). Is there any way this could be considered?</p>	<p>Additionally, there will be extensive training available before and during the TPA implementation where you and your staff will be able to see how your work will change. Please bear with us, the end result will be a more efficient and effective system. We will discuss Security Roles more on the Director's and Coordinator's call.</p>
<p>Is the PM going to be able to bill insurance? Have you heard anything new about that?</p>	<p>We think so, they are working on determining this for sure.</p>
<p>Are you going to have this in our contract that we have to use the PM?</p>	<p>Yes</p>
<p>Once the IFSP is built in the system and we are up and running, how much authority does ESSO have to update and change the IFSP if the need should arise in the future?</p>	<p>I believe that they are aware that as we move down the road that changes will be needed and they will be amenable as long as it isn't out of the scope of the project</p>
<p>you tell me if providers will be expected to purchase software for electronic billing to Med3000?</p>	<p>No, they will submit invoices by, fax, mail and possibly web portal . Submitting electronically via web-portal will result in faster payment.</p>
<p>Will paper claims (CMS 1500) be accepted?</p>	<p>Yes</p>
<p>How will supporting documentation be sent, i.e. eobs, consult forms, travel forms</p>	<p>Faxed, mailed and scanned</p>
<p>What is the process of recouping Part C funds when a child becomes retroactively eligible with Medicaid?</p>	<p>Med3000 has a process associated with refunds. The Local Early Steps Office would update the child's record to reflect that the child's Primary Coverage is Medicaid. A refund is then requested from the provider, and if not received within 45 days the automatic recovery process will begin.</p>
<p>Who determines the budget for Direct Service Expenses that will be held in an account for the TPA to access for the LES?</p>	<p>The LES will develop their line item budget each year for the total amount from the funding allocation methodology, just as you do now. The amount budgeted for Community Direct Services will be withheld in an account for the TPA to access to pay providers.</p>

**Question**

**Answer**

<p>Will Direct Service Staff funds be held at the TPA or LES level?</p>	<p>Direct Service Staff budget funds would remain in the contract and be part of the 1/12 payment that you bill monthly. Direct services of internal staff that are billable to Medicaid will be billed to Medicaid via the TPA in Practice Management. There is a possibility that the TPA will also be set up to bill private insurance for internal staff, but the final decision on that is pending.</p>
<p>How do we close a child in the TPA once they exit out of Early Steps?</p>	<p>A termination date and closure code field will be in the demographic on the IFSP in the TPA.</p>
<p>Once we close a child in the TPA can that information be followed through to the G page and close services dates?</p>	<p>Yes, this functionality will be in the TPA.</p>
<p>Can we insure that the B form of the IFSP have all the required information that would be need for the Practice Management system to be able to bill for services. Similar to the way the G page will give authorization for the TPA to make payments. This would be useful so that we do not have possible duplicate data entry.</p>	<p>You will not need to reenter any information</p>
<p>“The TPA will bill services provided by Local Early Steps Staff to Medicaid and some private health insurance carriers.” Does this include TCM? Is the insurance billing just for ES services/evaluations and not for external community providers?</p>	<p>The TPA will definitely bill Medicaid for all LES staff services, including TCM. Private insurance is a probably, but we haven't gotten confirmation on that. The TPA will not bill any community provider services to third parties.</p>
<p>There are community providers that work across different LESs. What system will be in place to ensure that those CMS ES approved providers that are working in one LES would <u>not</u> be able to services and bill in the TPA for kids registered at another LES where they have not been approved to work for.</p>	<p>Providers working in LES areas with different roll-out dates will have to know which LES is using the TPA when. If they make a mistake and bill, there will be no record of the child being an Early Steps child and no service authorizations so the claim would be denied.</p>

**Question**

**Answer**

The following were published in the 12/29/11 Weekly Memo	
<p>Is anyone considering the possibility of having an IFSP in a language other than English? Will the SC's have enough characters on each response section to include the families' information in Spanish and then translate it to English? Has any of this been considered at all?</p>	<p>The IFSP in Spanish and Creole has been sent to MED3000 for use when IFSPs are printed from the TPA. The total character limit is 255 characters in free text boxes. ESSO has requested that this be increased.</p>
<p>What is the legal responsibility of the LES regarding the funds kept in an separate account for Med3000 to use and how is this stated in the contract?</p>	<p>Attachment I, B.1.I. states: Children's Medical Services is developing a Third Party Administrator (TPA) for the processing of claims for services provided. Full implementation is expected in the spring of 2012. The provider will be responsible for participating in the implementation phases, such as the system pilot, system training and system implementation activities as directed by Children's Medical Services. In anticipation of piloting and full implementation, allocations of funding for direct services will be transferred to the TPA for the payment of claims. The provider will retain the responsibility for ensuring state and federal funds are the payer of last resort and for coordinating all local resources. The provider will still be responsible to ensure the resources are efficiently used and services can continue to be provided for the entire contract year.</p>
<p>What is the cost of the Med3000 for Early Steps?</p>	<p>Beginning with the pilot, Early Steps will begin contributing to the cost of the TPA. The monthly cost from the beginning of pilot until there are a total of 58,559 children in the TPA (inclusive of CMS Network Programs and Early Steps) will be \$650,000 per month. Of that, Early Steps will contribute \$117,000 per month. Once the 58,559 threshold of children is reached, Early Steps will pay \$11.10 per month for each open child.</p>
<p>What is the accountability for Med3000 to each LES that payments are made correctly?</p>	<p>Payments will only be made for a service for which there is an authorization that originates on the IFSP. Any claim submitted for a service without an authorization will not be paid unless it is pended to the LES for approval and LES provides justification or information and approval to pay. LESs will have access to see claims paid for their LES.</p>
<p>How will an LES be able to institute a reduced rate in their area to ensure their funding will last for the fiscal year? For instance, will the TPA be able to 'turn on' a percent of the fee schedule to be paid to all providers in that area?</p>	<p>The TPA has the functionality to apply a percentage of the normal rate to be paid for all services or a set of services. This can be set up to be applied for a specified period of time or indefinitely. However, the application of this rule would have to be on a statewide basis. On a LES level this would not be possible. However, since the Direct Services funds will no longer be hard coded in to each LES contract, the ability to shift Direct Service allocations from LES to LES to ensure statewide solvency will be easy. To date, Early Steps has never ended the year with a statewide deficit. With Early Steps resources being at their tightest, it might be necessary to implement a statewide reduction of rates for certain services to ensure solvency. This will be discussed at length to determine if this is something the Early Steps system of care should consider.</p>

**Question**

**Answer**

<p>When a reduced rate is paid to providers, sometimes the LES has conserved enough funding by the end of the year to pay providers some or all of the balance of the reduced rate. Will there be a mechanism in the TPA for the LES to identify the providers that were paid reduced rates and pay them a portion or all of the balance outstanding?</p>	<p>Yes, if a statewide reduction of the normal taxonomy rate is ever implemented, the TPA has the functionality to re-bill the balance if funds are available later in the year.</p>
<p>Except when a service is an event, such as a physical therapy evaluation, all other Early Steps services are recorded in the UF data system in Hours. Will this be the way time based services will be entered in the TPA? Or do you enter 1 unit = 15 minutes which is the Medicaid method of capturing time based services?</p>	<p>In the TPA IFSP service authorizations, all time based services must be entered in minutes i.e., 15, 45, 60 minutes etc. The TPA will convert the minutes into billing units from the FSPSA into FACETS (the billing system). Providers will bill to the TPA 1 unit = 15 minutes. Events will be entered in the FSPSA and be billed as 1 unit.</p>
<p>Some Local Early Steps currently have their Service Coordinators enter their own TCM billing data in the Early Steps Data System. Will it be allowable for all Service Coordinators in these LESs to have access to the Practice Management System so they can continue entering their own TCM billing data? FYI - TCM is always payable to the LES, not the individual Service Coordinator.</p>	<p>This is a LES policy decision that will require security which permits access to bill services via the Practice Management component of the TPA. Security can be enabled based on the role assignment to Practice Management.</p>
<p>Currently, CMS Enrolled Providers must enter in to a Provider Agreement with the Local Early Steps with which they wish to work. When the CMS Enrolled Providers file is transferred to the Early Steps Data System, the Local Early Steps then pick the providers they obtain Provider Agreements with for their local provider pick list. Will the TPA have a field that can be used to affiliate an enrolled provider to the LES, so the pick list of providers in the LES can be limited to only those that have LES provider agreements?</p>	<p>Previous discussions indicated only a requirement that the provider be credentialed to provide services to LES enrolled children. When providers go through the credentialing process for LES do they not sign the local participation agreement at that time?</p>
<p>If MED3000 bills commercial insurance, will each individual provider need to enroll with insurance?</p>	<p>If they wish to bill for those providers as in network, yes. Otherwise, they'll be paid at the out of network rate.</p>
<p>Will our LES need to enroll, track and update insurance enrollment for our internal staff? Right now this is all done for us by the Practice Plan.</p>	<p>Credentialing of internal staff enrollment with any payers will need to be handled by the LESs.</p>
<p>If we decide not to use MED3000 for commercial insurance billing, can we use the PM system to create a charge ticket but instead of MED3000 billing insurance, we could send the charge ticket to our Practice Plan to bill?</p>	<p>No</p>
<p>Are audit logs accessible by reports? What is on the report?</p>	<p>Reports can be built to provide data on all audits logs. Requirements for those reports should be shared during the reporting design sessions.</p>

Question	Answer
When sending in a non-enrolled provider that must be used for an Early Steps services, how long will it take for the provider to show up in the pick list on the TPA?	The provider is typically loaded within 24 hours of receipt of the appropriate information.
If an authorized provider is out sick or on vacation and an authorized service for that provider is provided by a substitute CMS enrolled provider, how does the payment get affected? Will the claim pay, be pended for approval by the LES, or denied? Will this require the Service Coordinator to amend the service authorization for unforeseen provider substitutions?	If the provider is a member of the same group, covering logic will allow that claim to process as though the service was provided by the originally authorized practitioner.
When a service on the IFSP has a primary payer of private insurance, but private insurance denies payment. How is the denial supporting documentation submitted to the TPA to allow Part C to pay?	The provider submits the Explanation of benefits with their claim to the TPA. Submission of a claim without the appropriate accompanying documentation (EOB or letter) when another insurance has been identified as primary will cause the claim to deny. Providers will be fully trained on how to use the system prior to them being able to submit a claim.
Can a more detailed explanation of the provider claims submission process be provided? Especially the role of a clearing house?	A clearinghouse is simply a mechanism to submit electronic claims. Providers submit claims in exactly the same way that they do to all other insurances. Providers will be fully trained on how to use the system prior to them being able to submit a claim.
If a family has private insurance, but the LES has confirmed that the insurance handbook clearly states that a service is not covered, can the provider send a copy of the IFSP Form G that shows the service as authorized on the IFSP to be paid by Part C to avoid waiting to send claims to the insurance company and getting a denial before Part C will pay?	No, in order to insure appropriate administration of Coordination of Benefit rules, claims must be accompanied by the appropriate denial, or documentation of non coverage. The provider could obtain a letter from the primary payer indicating the service is not covered, or submit a copy of the page of the insurance handbook, and submit that with each claim in order to avoid the delay.
When letters in the TPA are batched. Who do they go to? If there are 20 different letters batched will these be grouped in one 'notification' or 20?	Letters are routed in accordance with the user who requested the letter, and where the letter was directed during the design phase.
Can the ICD9s entered on Form G be transferred to Practice Management for use on the encounter form?	Not at this time.
On the system generated letters: Are we able to delete or block these letters and use ones specific to our LES instead?	By implementing the TPA we are standardizing forms and letters that will be required to be used. If an LES needs letters in addition to those that are currently proposed, let the TPA Team know and we will consider it for inclusion in the forms and letters on the TPA available statewide. LESs can also propose revisions to the current letters.
Our Early Steps program has local community support from Children Services Councils (CSC) that pay for some of the direct services provided to our children. How will the new data system be able to separate out services that need to be paid by Part C dollars (paid by TPA) vs. CSC (paid directly by LES)?	Identify a specific service, or set of services, that occur for approximately the amount of money that you would use CSC funds to pay for those services. Those services would be authorized to be paid with CSC funds in the IFSP. Whenever the CSC funding ran out, then a letter could be provided to the provider that CSC funds are depleted and Part C is now the authorized payer for the provider to bill the TPA.

**Question**

**Answer**

The following were published in the xx/xx/xx Weekly Memo	
Will the IFSP dates be loaded in the TPA with the child's demographics, eligibility and service authorizations?	We will get detail from MED3000, but we are confident that they will load the IFSP dates.
In Practice Management it is my understanding that checks from Medicaid and other Third Party Payers will be sent directly to the LES for Medicaid and Insurance tickets billed via the TPA. How will the system reflect these payments? Will they be entered in the TPA by MED3000 or will the LES be posting these as part of working the back-end of the payment process?	We will get detail from MED3000