VERMONT
DEPARTMENT OF VERMONT HEALTH ACCESS

Standard Operating Procedure

Title: Out-of-Network Emergency and Post Stabilization Services Provider Enrollment and Payment Efforts

Issuance Date: April 20, 2023

(Must be reviewed annually)

Applicable Regulations, Guidelines, and AHS Policy:

Federal statute or rule:

42 CFR 438.114

Purpose:

To document the Member and Provider Services (MPS) Unit process for resolution of out-of-network emergency billing issues for Green Mountain Care members.

Procedure:

DVHA is required to cover and pay for emergency services regardless of the enrollment status of the furnishing provider.

The Member notifies DVHA's third party customer service support center about (out-of-network emergency and/or post-stabilization care bills.

DVHA's third party Customer Service Representative (CSR) collects information related to the member's visit(s):

- Provider name,
- Provider billing address,
- Date of service,
- Account number with provider,
- Member UID,
- Member DOB,
- Member mailing address,
- Amount due.

When the date of service exceeds the two-year timely filing rules (i.e., date of service is two years or more before date of reporting) the CSR will notify the member that DVHA is unable to do outreach and the information is logged in the tracking system.

MPS reviews the system each day for new requests and will outreach the member and the provider within 48 hours. The outreach letter explains the action DVHA may take to serve as the responsible payer for out-of-network emergency and/or post-stabilization care.

If the provider agrees to participate with customer service center and accept their rates as payment in full, a claim is mailed directly to DVHA's MPS Unit.

Once the claim is received, the MPS unit staff updates the tracking spreadsheet for one-time enrollments with the following information:

- Date claim received,
- Institution or group name,
- Beneficiary name,
- Unique identifier,
- Starting date of service,
- Date of service.

Batches of the paper claims are delivered to the State's fiscal agent enrollment team on a weekly basis.

The fiscal agent performs the Provider Enrollment and Claims Processing which takes approximately two weeks. More time is allotted if the fiscal agent enrollment team requires more information for enrollment.

The fiscal agent verifies:

- The provider is not already enrolled in VT Medicaid (MMIS PRNX screen)
- Member eligibility (Member ID, name and date of service (REEL screen)

For providers not enrolled with Vermont Medicaid, the fiscal agent will screen for provider information as needed, sanctions, criminal activity liens with the state of Vermont and money owed to other state Medicaid agencies. Active licenses can also be reviewed on this website.

Also reviewed is the National Plan and Provider Enumeration System (NPPES) website for active provider status, taxonomy code, and active licenses.

For the one-time enrollment, data is entered on the PRGD, PRTS, PRPS fields with the provider name, type and specialty, begin and end date and address. After data entry is finished, work performed is verified. Enrollment is complete and the claim(s) are

submitted to Document Control. An override request accompanies the claim for those past the timely file deadline.

If the provider is already active in the system, the claim is submitted. The fiscal agent enrollment team staff update the shared tracking spreadsheet for one-time enrollments and make the determination to pay or deny. Claims adjudication staff update the shared tracking spreadsheet for one-time enrollments (ICN, paid date, paid amount).

Revision History:

Date	Summary of Revisions
4/5/2022	Submitted to OMU.
5/18/2022	OMU converted to ADA template.

Table 1 Revision History