P-2404 Delivery of Benefits

A. ID's

There are five types of ID.

1. Plastic Card ID (DSW 225C)

This is a green plastic card with "Vermont AIM" (Automated Identification Management) printed on it.

ID's are issued and mailed by EDS once each month. (See ACCESS Manual, Deadlines.) Each ID is attached to an informational mailer and individually mailed to the recipient.

Note: There are only 25 spaces on the card for a name, so some names will not be completely printed. This does not affect the use of the card.

An ID is issued:

a) when you approve a grant for a person in the group who has not been eligible for Medicaid/Dr. Dynasaur in the past; or

b) when you request a replacement ID through REPL.

The ID does not certify eligibility. Providers use the ID to verify eligibility through EDS for the date of service.

Changes in a person's first and last name or social security number will generate a new ID at the next monthly run.

2. ACCESS-Generated Paper ID (DSW 225P)

The first page of this ID is printed in the district office. Enclose a DSW 225P P.2 as the second page. It is generated for the same reason as the plastic ID (#1 above), for use until receipt of the plastic ID.

This ID does not certify eligibility. Providers will verify eligibility through EDS for each date of service.

3. ACCESS-Generated Paper Temporary ID (DSW 225M-T(2))

This ID is printed in the district office through the TEMP command. (See ACCESS Manual, UPDT 7/1/93 re: PP ELIG 63.) Issue one when a client has a medical need or needs it to cash a DSW benefit check prior to receipt of the paper ID (#2 above).

It certifies eligibility beginning the date it was issued and up to ten days, but not to exceed a scheduled closure date.

P-2404 Delivery of Benefits

A. ID's

4. Paper Temporary ID (DSW 225M-T)

Issue this ID when ACCESS is down and the client has a need as described in #3 above. **Make the ID valid for up to ten days, but not to exceed a scheduled closure date.**

This ID is a certification of eligibility.

5. Managed Health Care Plan ID

This ID is issued by the health plan within two weeks of acceptance into a plan. Until the permanent ID is received, the recipient may use the confirmation letter from the benefits counselor as a temporary ID.

If an ID is lost, the recipient must contact the health plan for a replacement.

This ID does not certify eligibility. Providers use the ID to verify eligibility through the health plan or EDS for the date of service.

P-2404 Delivery of Benefits (Continued)

D. Vermont Medicaid Recipient Complaint Form (DSW 287A)

If a Medicaid recipient contacts the District Office to complain about a billing matter:

1) The District Office worker should give the client a Vermont Medicaid Recipient Complaint Form (DSW 287A) and assist the client, if necessary, in completing it. A copy of the bill(s) in question must be attached to the DSW 287A and forwarded to the Medicaid Division Complaint Unit at State Office.

2) Upon receipt of the completed form, the Medicaid worker at State Office will:

a) research the facts.
b) resolve the matter.
c) send written notification to the recipient, the District Office and the provider.

NOTE: Original bills are to be returned to recipient with notification.

P-2404 Delivery of Benefits

E. Recipient Reimbursement - Paid Medical Bills (Gearwar vs. Wilson)

The Department is required to reimburse Medicaid recipients for 100 percent of the out-of-pocket expenses paid for medical services when the conditions specified in M152 exist.

1. Allowable Reimbursements

See M152 for conditions for allowable reimbursements.

2. Recipient Action

Recipient must submit copies of paid bills to the appropriate district office showing the date and type of service received, the name of the provider and the date that the bill was paid.

3. Worker Action

Complete a DSW 220MR which will serve as a worksheet and a notice. List all submitted bills. Bills not eligible for reimbursement must be coded with the "exception" amount and reason. Deduct the total exception amount from the total submitted amount to arrive at the amount of reimbursement due.

A district check must be written for the allow reimbursement as follows:

- At Select Function enter

  Function Code: CHCK
  Processing Mode: C
  Reporting Group ID: SSN
  Reporting Month: leave blank
  Command: OTHER

- At the next screen, enter the amount of the check and put an X in the field before Medicaid. Enter the start and end dates.

- The next screen is the check approval screen. Enter your worker number, password and type in APP

for approval.

The original of the 220MR is mailed (or given) to the recipient with the check and the original paid bills (after making copies for the file).

P-2404 Delivery of Benefits; E. (Continued)

The district copy of the 220MR is filed with the copies of the paid bills in the case file.

The Administrative Services copy of the 220MR is sent to the attention of: Account Clerk, Administrative Services, Waterbury.

NOTE: Should the request for reimbursement occur more than three years after the date of payment for services, records may need to be requested from the Assistant Attorney Office in Waterbury. If necessary information is not available to determine the amount of the reimbursement, (or in fact that a reimbursement is even appropriate), refer the case to Operations to assist with the evaluation.

P-2404 Delivery of Benefits (Continued)

F. Medicaid Exceptions and Prior Authorizations

Exceptions for coverage under the Medicaid Program are submitted to the Medicaid Division by the provider of service. Once the decision is made regarding the payment, EDS generates the DSW 220PAR (Notice of Decision - Medicaid/Dr. Dynasaur Prior Authorization Request) and sends 4 originals to the Medicaid Division. The Medicaid Division keeps one and sends one each to the provider, the client, and you. File your copy in the case record.

Appeals of this decision generally go through the Medicaid Division (see P-2127 B#5.

P-2404 Delivery of Benefits

G. Admission to Out-of-State Hospitals

If it is determined a client needs non-emergency treatment in an out-of-state hospital (excluding border hospitals), prior authorization must be obtained in the following manner:

The Vermont referring physician must write to the Director, Medicaid Division, and include the following information:

1. medical history
2. to whom the client is being referred
3. treatment plan
4. time estimate
5. reason the service is not available in Vermont and
6. plan for follow-up on return to Vermont.

This procedure is also required for alcoholic detoxification treatment or psychiatric treatment unless it is emergency treatment.