MEDICAL ASSISTANCE BULLETIN

COMMONWEALTH OF PENNSYLVANIA ● DEPARTMENT OF PUBLIC WELFARE

ISSUE DATE	EFFECTIVE DATE	NUMBER
June 14, 2007	July 1, 2007	99-07-10

SUBJECT	
The Elimination of Paper Vouchers	By Michael Nardone, Acting Deputy Secretary Office of Medical Assistance Programs

PURPOSE:

The purpose of this bulletin is to inform providers that, **effective July 1, 2007**:

1. The Department of Public Welfare (Department) is discontinuing the paper voucher system for adult Medical Assistance (MA) and adult General Assistance (GA) recipients;

2. The Eligibility Verification System (EVS) has been enhanced to inform providers of the number of certain office, clinic and home visits remaining within the scope of benefits for adult MA and adult GA recipients, pursuant to the 18 visit limit, during the July 1 though June 30 state fiscal year service period.

NOTE: THIS BULLETIN OBSOLETES INSTRUCTIONS REGARDING THE PAPER VOUCHER SYSTEM AND PAPER VOUCHER USE UNDER MA BULLETINS 01-94-03 ET AL, AND 01-93-12 ET AL. THESE BULLETINS OTHERWISE REMAIN IN EFFECT.

SCOPE:

This bulletin applies to all providers enrolled in the MA Program. Providers who render services in either the HealthChoices or voluntary managed care delivery systems should contact the appropriate managed care organization with questions related to benefit limits.

BACKGROUND:

As described in MA Bulletin 99-92-07, the Department implemented the GA Basic Health Care Package on January 1, 1993, for adult recipients, age 21 to 65, who receive MA benefits funded solely by state funds. This health care package limited certain office, clinic and home visits to 18 per State fiscal year (July1 through June 30). In order to keep both recipients and providers informed of an MA recipient's usage of these visits, the Department implemented a paper voucher system. Under this paper voucher system, GA recipients were issued booklets containing 18 vouchers each fiscal year that were to be used for the countable 18 visits.

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

The appropriate toll-free number for your provider type.

Visit the Office of Medical Assistance Programs website at www.dpw.state.pa.us/omap

Presentation of a voucher verified to the provider that the recipient had not exceeded his/her 18 visit limit and therefore, the provider would be eligible for payment for the service provided.

On August 29, 2005, as authorized by Act 42 of 2005, the Department revised the scope of benefits for adult MA recipients, 21 years of age and older. MA regulations at 55 Pa. Code § 1101.31, relating to scope, were amended to limit certain office, clinic and home visits to 18 visits per state fiscal year for both adult MA and GA recipients, with the exception of pregnant women. The Department also extended the paper voucher system to those adult MA recipients subject to the 18 visit limit.

DISCUSSION:

In an effort to eliminate the administrative burden of paper vouchers from the recipient and provider communities, decrease the Department's administrative costs associated with the paper vouchers and provide a more accurate means of tracking recipient use of the office, clinic and home visits subject to the 18 visit limit, the Department has decided to eliminate the paper voucher system. In place of the paper vouchers, providers will use EVS to verify the number of countable visits a recipient has remaining within the 18 visit limit. This will eliminate the need for providers to collect paper vouchers at the time of service.

Providers should share the 18 visit limit information returned through EVS with the recipient so that the recipient is aware of his or her countable office visit use and the number of visits remaining within the 18 visit limit. Recipients have also been notified to ask their provider for this information. The Department is currently developing a process that would allow recipients to directly confirm their own countable visit use and will issue additional guidance on this process in a future MA Bulletin.

While the Department is discontinuing the paper voucher system, the scope of benefits for adult MA and GA recipients has not changed. The 18 visit limit still applies for certain routine office, clinic and home visits when performed by physicians, certified registered nurse practitioners, podiatrists, optometrists, chiropractors, outpatient hospital clinics, outpatient medical clinics, Rural Health Clinics, or Federally Qualified Health Centers. A complete list of the provider type/specialties and specific office, clinic or home visit procedure codes that are subject to the 18 visit limit is available as an attachment to this bulletin and on the Department's website at:
http://www.dpw.state.pa.us/Resources/Documents/Pdf/18VisitLimit.pdf

All providers indicated above, who render countable visits subject to the 18 visit limit, shall follow the procedures described below.

PROCEDURE:

Effective July 1, 2007, the Department will no longer issue paper vouchers to adult MA and GA recipients for the 18 visit benefit limit. Instead, EVS has been programmed to inform providers that a recipient has exceeded the 18 visit limit and to indicate the number of countable outpatient office, clinic or home visits remaining within the scope of benefits for adult

MA and adult GA recipients during the July 1 through June 30 fiscal year period. EVS will provide timely validation of the number of countable visits remaining based on actual claims paid at the time of the inquiry.

Visits to a recipient's Primary Care Physician (PCP) or PCP referred specialist that exceed the 18 visit limit are automatically approved for a Benefit Limit Exception by the Department and do not require an additional request unless the visit is to an optometrist, chiropractor or podiatrist.

Instructions for Verifying Office Visit Limitation via EVS:

Prior to rendering the service, providers should access EVS through one of the current available methods; Automated Voice Response System (AVRS), Internet, Value Added Network (VAN)/batch, or the Provider Electronic Solutions (PES) software to determine the number of office, clinic and home visits an adult MA and an adult GA recipient has remaining within the scope of benefits for the state fiscal year at the time of the inquiry. To receive information from EVS on the number of visits remaining within the 18 visit limit, it is necessary to submit a valid procedure code and qualifier with the EVS transaction for all access methods except AVRS.

EVS Inquiry

Based on how the EVS system is accessed, the instructions for entering an office visit procedure code and qualifier will vary slightly.

AVRS (1-800-766-5387)

After entering your provider identification number, recipient information and date of service, select menu option 2 for office visit eligibility information. The system will respond with the following information:

- The number of countable visits remaining based on paid claims;
- Office visits are not limited for the recipient based on their age or because they are covered by a managed care plan;
- The recipient has exceeded the 18 visit limit and a Benefit Limit Exception may be required.

Internet

When submitting an Internet EVS transaction, in addition to the required EVS information, enter the qualifier of "HC" (to indicate a procedure code) in the Procedure/Drug Type field and the appropriate 5-digit procedure code for an office visit in the Procedure/Drug Code field.

Provider Electronic Solutions (PES) Software

Complete the EVS request information and also enter a valid office visit procedure

code into PES on the HDR1 Window in the Procedure/NDC field. It will also be necessary to enter the "HC" qualifier in the Procedure Code qualifier field.

Value Added Network (VAN)/Batch

Please contact your software vendor for instructions on how to submit a procedure code on your eligibility transaction using your proprietary software. A valid office visit procedure code and the "HC" qualifier must be submitted.

EVS Response

EVS will respond with the following general messages when valid office visit procedure code information is submitted based on specific recipient eligibility criteria. If a procedure code and qualifier are present on the EVS inquiry, the system will determine if the procedure code submitted is for an office visit that is subject to the 18 visit limit. If the procedure code and qualifier are not valid for countable office visits, no information related to the recipient's remaining office visits will be returned. The 18 visit limit does not apply to recipients under 21 years of age and EVS will only return office visit limitation information for adult recipients age 21 or older.

1. If the recipient is enrolled in a MA managed care organization, EVS will return the message:

   "Limitation information returned applies only for services covered by fee-for-service. Please contact this recipient's managed care plan for services not covered by fee-for-service."

2. If the recipient is not enrolled in a MA managed care organization and has not exceeded 18 visits, the message will be:

   "Recipient limited to 18 office visits per fiscal year. ## visits remaining based on paid claims status."

3. If the recipient is not enrolled in a MA managed care organization and has exceeded the maximum number of office visits for the fiscal year, the following message will be returned:

   "Recipient has exceeded the 18 visit limit. Benefit Limit Exception may be required. Please call 1-800-537-8862, option #4 with questions."

The telephone number above connects the provider to the Department's Provider Services Center staff who will assist in determining if a Benefit Limit Exception is needed and if an exception is needed, direct the provider's call to the Prior Authorization/Benefit Limit Exception Unit who will process the exception request.

4. Prior to conducting the visit, the provider should share the benefit limit information returned from EVS with the recipient and, if applicable, that a Benefit Limit Exception is required.

Please note that the visits remaining information returned by EVS response is based on claims data contained in PROMISe™. Additional visits may have been incurred and not yet billed to the Department. Therefore it is possible a provider may receive a denial of their claim due to exceeding the 18 visit limit. If this should happen, the provider should follow the Benefit Limit Exception process indicated below.

Benefit Limit Exceptions:

If a recipient needs additional services beyond the 18 visit limit, the recipient or provider may request an exception to the benefit limit through the Department. As established under MA regulations at 55 Pa. Code § 1101.31(f), the Department is authorized to grant exceptions to the 18 visit limit when it determines that one of the following criteria applies:

- The recipient has a serious chronic illness or other serious health condition and denial of the exception will jeopardize the life of or result in the serious deterioration of the health of the recipient.
- Granting the exception is a cost-effective alternative for the MA Program.
- Granting the exception is necessary in order to comply with Federal law.

A request for a Benefit Limit Exception may be made to the Department by:

- Calling the Provider Prior Authorization/Benefit Limit Exception line at 1-800-558-4477, or
- The recipient may call the Recipient Hotline at 1-800-433-1324, or
- Providers may mail or fax a written request to:

Office of Medical Assistance Programs
Fee for Service Programs
Benefit Exception Review
PO Box 8047
Harrisburg, PA 17105-2675
Fax: 866-874-7998

When requesting the Benefit Limit Exception, please provide the following information:

- The recipient's name, address, and telephone number.
- The recipient's MA ID number.
- The service for which the exception is being requested.
- The reason the exception is needed.
- Provider's name and telephone number.

The Department will inform the provider in writing within 21 days of getting the Benefit Limit Exception request if the request is approved or denied.

Attachment: 18 Visit Limit Chart