OFFICE OF VERMONT HEALTH ACCESS

ADVISORY

Linking OVHA and HP to your Office

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New Vermont Medicaid Provider Recertification Process

The Office of Vermont Health Access (OVHA) and HP Enterprise Services (HP) plan to streamline the recertification process, making it both easier and quicker for our provider community.

The current process requires providers to review a 10-page document at the time of recertification. The new process will require a provider to complete the new comprehensive Provider Enrollment Form one time; subsequent recertification will require only forwarding a copy of the renewed provider license.

Please wait for your provider type's recertification period and for HP to request that you complete the new form. HP will begin sending recertification notices in the next few months. To eliminate confusion and assist in implementing the new recertification process, do not send the form until you receive your recertification notice.

Providers that recently enrolled using the 01/29/2010 Enrollment Form will only be asked to forward a copy of their renewed provider license and recertification letter request when their provider type is due for recertification. Your recertification letter will include the information and directions necessary for you to complete your recertification process. You may preview and download the new form at www.vtmedicaid.com/downloads/forms, titled Provider Enrollment; the form date is 01/29/2010.

Medication Prior Authorization Form - Medical Benefit

When completing the OVHA General Prior Authorization Request Form to request medication needing prior approval, be sure to check the correct "billed through" information box. If the medication is to be billed under the medical benefit, check the medical benefit box and not the pharmacy benefit box. Selecting the incorrect box will inhibit the processing of your claim. The General Prior Authorization Request Form is accessible at ovha.vermont.gov/for-providers/pharmacy-prior-authorization-request-forms. Submit completed request forms via fax to MedMetrics at 1-866-767-2649. Providers with questions or concerns are instructed to call the MedMetrics prescriber call center at 1-800-918-7549.

Eyeglass Medical Necessity Form

The Eyeglass Medical Necessity Form (MNF) is now available for use by Providers requesting prior authorization for eyeglasses. The form is available online at ovha.vermont.gov/for-providers/forms-1 under Clinical Prior Authorization Forms or from the single source eyeglass contractor, Chadwick Optical Inc. Once the form is completed, please follow routing instructions 1 thru 4, noted in the upper left-hand corner of the MNF.

PROVIDER MANUALS

There will be a banner page covering changes to the provider manuals at the top of the remittance advice (RA) on a monthly basis. In the case where there are no updates, the RA will reflect "NONE" for that month.

Provider manuals can be accessed at:

BANNER PAGE

http://www.vtmedicaid.com/Downloads/manuals.html

The banner page included with your remittance advice (RA) is your resource for the most up-to-date billing, policy and operational information. Be sure to read the banner page, paying close attention to any date specific and implementation information.

The "banner archives" can be accessed at: http://www.vtmedicaid.com/Information/whatsnew.html

Unique Identification Numbers to Replace Social Security Numbers

October 1, 2010 is the start date for use of the unique identification number (UID) that must be used for each beneficiary. Use of the UID number allows removal of the Social Security number currently used for member cards and claim submission. This change will help protect our members' personal information. In September, all beneficiaries will receive their new health plan ID cards in the mail; however, do not begin billing with the new ID number until October 1. In order to facilitate this transition, our automated eligibility verification systems will allow you to check eligibility with either a Social Security number or the unique ID number. Use either the online Transaction Services (www.vtmedicaid.com/Interactive/login2.html) or the HP Voice Response System (Malcolm) 802-878-7871, option 1. If you only have access to a member's Social Security number, these automated systems will provide you with the unique ID number for your claim.

Continuous Glucose Monitoring (CGM) in the Interstitial Fluid

As of 2/25/2010, the OVHA began coverage of continuous glucose monitoring (CGM) in the interstitial fluid when prior authorization (PA) is obtained before rendering the service or dispensing the supply or equipment. Coverage guidelines have been written and are available via the internet at ovha.vermont.gov/for-providers/clinical-coverage-guidelines. Interpretation of the results of any monitoring (CPT code 95251) is limited to physicians and nurse practitioners (per their scope of practice). Short-term monitoring (codes 95250 & 95251) is limited to once per 30 days and a maximum of 4 times per calendar year. Per the CPT, one unit of code 95250 or code 95251 represents a 72-hour monitoring episode.

DME vendors need to be aware that transmitters (HCPCS code A9277) are limited to a maximum of one per year. Receivers/monitors (HCPCS code A9278) are limited to a maximum of one per 2 years. Fax prior authorization requests to 802-879-5963 at least one week in advance. Be sure to include the procedure code and clinical documentation substantiating the medical need for CGM.

New Billing Information & Requirements

- **UB 04 Form Locator 17- STAT**
  When completing the UB04 Claim Form, it is now required that the patient discharge status code be entered in form locator 17 – STAT for all outpatient claims.
- **UB 04 Form Locator 67– (POA)**
  Present on Admission **(**POA) will be required on all inpatient admissions & diagnoses codes listed on the UB04; enter POA in form locator 67, 8th position in the shaded area.
- **CMS 1500 Claim Form - Billing Provider Name Field**
  When completing the CMS1500 Claim Form, all individual billing providers are required to list their last name first in “box 33”.
- **2006 ADA Dental Claim Form**
  When completing the 2006 ADA Dental Claim Form, it is required that you enter the beneficiary’s name in **box 20** and the amount paid by other insurance including contractual allowance, if applicable in **box 32,** other fees. In addition, individual billing providers are required to list their last name first in **box 48.**

  For more detailed information regarding OCR requirements, please refer to the August 2009 Advisory posted on Vermont Medicaid website at www.vtmedicaid.com under Downloads
- **CSHN Dental Notice**
  Aid Category Code - SH-Children with Special Health Needs, is only used when submitting medical claims for Physical, Occupational, and Speech Therapy (PT,OT,ST) or Nutritionist (NU) and Autism Specialist (AU) services.

  Dental claims for Children with Special Health Needs will continue to be processed through the Vermont Department of Health, PO Box 70, Burlington, VT 05402.

Provider Eligibility Verification

Providers are expected to verify eligibility for each beneficiary prior to providing a service. Eligibility can be verified through the automated Voice Response System (VRS/Malcolm), online Transaction Services (www.vtmedicaid.com) or by calling the Provider Services Unit help desk. The HP system is updated with each beneficiary's termination of benefits nine days prior to the effective date. Therefore, verification can be made with certainty up to nine days in advance of the appointment. Please be sure to check only the beneficiary's scheduled appointment date and not a span of dates. When an eligible aid category code is given, please determine that the service to be provided is covered within that aid category.

New Ladies First Billing Information & Reminders

Institutional Claims (Paper and Electronic) Condition Code Field Value - A3
HP Enterprise Services requested Ladies First providers to stop using the value of A3 in the Condition Code field when submitting claims as of April 1, 2010. The HP system has been updated to identify a Ladies First beneficiary's enrollment information to process claims under Ladies First.

Termination of Ladies First Provider Numbers
All Ladies First Provider Numbers beginning with 800 were closed on March 31, 2010. Ladies First claims are now being processed using Ladies First member information and funding source. A Vermont Medicaid Provider Number is now required to process Ladies First claims but Ladies First providers may choose to provide services only to Ladies First beneficiaries.

Please contact HP Provider Enrollment Unit at 802-878-7871 (out-of-state) or 800-925-1706 (in-state) to enroll as a Vermont Healthcare Programs provider.

Ladies First Remittance Advice
Ladies First Payments will transition to the Vermont Medicaid Remittance Advice (RA) beginning with RA date April 9, 2010. HP will no longer produce a separate remittance advice for the Ladies First Program. Ladies First claims can be identified by the EOB 1175 (code) - SERVICE PROCESSED BY THE LADIES FIRST PROGRAM.

EPSDT/Family Planning Indicator (Field 24.H on Paper CMS 1500 Claims)
As of April 1, 2010, HP Enterprise Services required Ladies First Providers to stop using the value of 5 in the EPSDT/ Family Planning field when submitting a paper CMS 1500 claim. The EPSDT/Family Planning field with a value of 5 will no longer be needed to identify a Ladies First claim.

Electronic 837 Professional Claims Special Program Code Field Value – 03
HP Enterprise Services requested Ladies First Providers to stop using the value 03 in the special program code field as of April 1, 2010. The HP system has been modified to identify a Ladies First beneficiary's enrollment information and funding source to process claims under Ladies First.

*__Failure to follow the above Ladies First Billing procedures will cause your Ladies First claims to be denied.__

HP

HP Enterprise Services
312 Hurricane Lane
Suite 101
Williston, VT 05495

Hours of Operation
(Provider Services)
Monday-Friday
8:00 a.m-5:00 p.m

Out-of State Phone:
(802) 878-7871
In-State Phone:
(800) 925-1706, #1

Fax:
(802) 878-3440

Website:
www.vtmedicaid.com

OVHA

Office of Vermont
Health Access
312 Hurricane Lane
Suite 201
Williston, VT 05495

Hours of Operation
Monday-Friday
7:45 a.m-4:30 p.m

Phone:
(802) 879-5900

Fax:
(802) 879-5651

Website:
www.ovha.vermont.gov

Inpatient Admissions—Present on Admission Indicator

Effective May 16, 2010, the present on admission indicator (POA) will be required for all inpatient admissions. Vermont Medicaid will follow Medicare's guidelines. The indicator options are: Y (diagnosis was present at time of the admission), N (diagnosis was not present at time of admission), U (documentation was insufficient to determine if present at time of admission), W (clinically undetermined), 1 (exempt from POA reporting). The POA indicator is the eighth digit and is required on all diagnoses codes listed on the UB 04 (principal field 67 and secondary field 67 A through Q). This is not required for the admit diagnosis (69). For electronic claims using the 837 institutional, submit the POA indicator in segment K3 in the 2300 loop, data element K301. POA is always required first, followed by the principal diagnosis. The last secondary diagnosis indicator is followed by the letter Z to indicate the end of the data element, e.g., POAYNUW1YZ.

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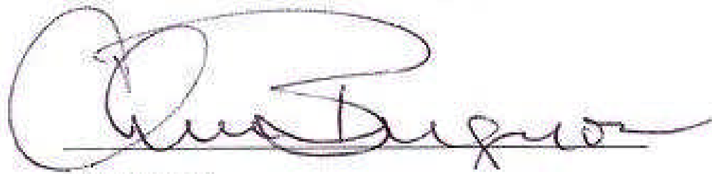
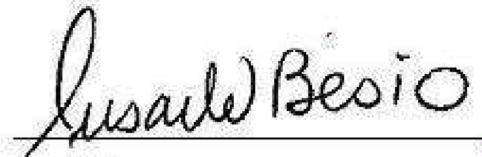


Cherie Bergeron
Account Executive · HP Enterprise Services



Suzan Bezio
Director · Office of Vermont Health Access