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## CMS Medicaid Integrity Program Provider Audits

The Deficit Reduction Act (DRA) of 2005 created the Medicaid Integrity Program (MIP) under section 1936 of the Social Security Act. The MIP is a comprehensive federal strategy aimed at reducing provider fraud, waste and abuse in the Medicaid program. Starting in October the Centers for Medicare and Medicaid Services (CMS) Medicaid Integrity Group (MIG) will commence the Medicaid Integrity Program (MIP) provider audits in Vermont. There are three Medicaid Integrity Contractors (MICs) that will be conducting different aspects of the audits: (1) Review of Medicaid claims data will be conducted by Thomson Reuters to identify aberrant claims and potential billing vulnerabilities, (2) IPRO is under contract with CMS to conduct audits in this region and (3) Strategic Health Solutions will provide education for providers.

All Medicaid providers are subject to these audits. The audits will be done on a monthly basis, continuing for an undetermined period.

The objectives of the MIP provider audits are to audit provider claims and identify overpayments by ensuring that claims are paid:

- for items and services provided and properly documented;
- for items and services billed using the appropriate procedure codes;
- for covered items and services; and
- in accordance with Federal and State laws, regulations and policies.

At the beginning of an audit, the Audit MIC (IPRO) sends the provider a notification letter. Most of the audits are desk audits, where the Audit MIC requests provider documentation and reviews the records at the Audit MIC's office. On some occasions, Audit MICs conduct field audits, in which the auditors actually conduct the audits at the provider's location. All audits are being conducted according to Generally Accepted Government Auditing Standards (Yellow Book). If the Audit MIC concludes, based on the evidence, that there is a potential overpayment, the Audit MIC prepares a draft report which is shared with the State and the provider for comment. Based on these comments, the audit report may be revised.

The MIG makes the final decision on any revisions or changes. When the audit report with any associated overpayment is finalized, the MIG sends the final audit report to the state. The state pursues collection of the overpayment from the provider in accordance with the Federal & State laws, regulations and procedures.

## Medicare Attachment Summary Form

In order to further improve collection of Medicare payment information, the CMS 1500 and UB 04 Medicare Attachment Summary Forms have been updated.

A new column for other insurance (non Medicare) was added to the UB 04 and an amount field was added for the other insurance to both the CMS 1500 and UB 04 summary attachment forms.

Please be sure to use form version (REV-10/27/09), previous versions of this form will no longer be accepted.

## 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: <http://www.vtmedicaid.com/Downloads/manuals.html>

## Banner Page

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>



## Interim Inpatient Claims

Inpatient acute care hospitals who have a long term patient may bill interim claims in at least 60-day intervals. Subsequent bills must be in the electronic adjustment bill format. Each bill must include all applicable diagnoses and procedures. Indicate in the note field: long term inpatient stay greater than 60 days.

The patient status code must be 30 (still a patient) and for the first claim use the type bill 112 (interim bill-first claim). When billing the next subsequent claim adjust and replace the original claim with either an interim or discharged claim as listed below:

- Subsequent interim claims should have a type of bill 117 (electronic adjustment) with the patient status 30 (still a patient).
- The discharge claim should have type of bill 117 (electronic adjustment) with a patient status indicating discharged.

## Vaccine Policy Change

The OVHA recently announced a policy change concerning vaccines which are available through the Vermont Department of Health (VDH) Children's Program free of charge. Effective immediately, all in-state providers must obtain these vaccines through the VDH Children's Program, for children up to and through the age of 18.

As always, when billing for a state supplied vaccine, the SL modifier must be used when billing the CPT or HCPCS code representing the vaccine.

Vaccines provided to adults aged 19 and up, that are not obtained through the VDH adult program, or vaccines provided by out of state providers to patients at any age are not required to obtain vaccine supplies from VDH Children's Program. The SL modifier will not be required in either of these circumstances, and payment will be based on the current fee schedule. For additional information on available vaccines call VDH at 802-863-7638.

## Dr. Michael Farber is New OVHA Medical Director

Michael C. Farber, M.D., joined OVHA as Medical Director on October 1st. Dr. Farber, who is board certified in internal medicine, also joined the faculty of the University of Vermont College of Medicine. He serves as chief clinical liaison to legislators, insurance providers and other state program units, and provides medical leadership for key policy decisions and the shaping of administrative strategies to enhance the operating efficiency both of Medicaid and related healthcare initiatives across the state.

Dr. Farber most recently served as Medicaid Medical Director and Medical Policy Chief for the California Medicaid (Medi-Cal) Managed Care Division in the California Department of Health Care Services, a position he held since 2006. In that role, he had responsibility for setting statewide medical standards, developing quality improvement policies, and advising the State on program legislation and regulations for the Medi-Cal Managed Care program. He also directed statewide policy efforts relating to quality of care and access to care by contract health plans, and set statewide clinical practice guidelines and medical standards for managed care contractors.

Having joined the California Department of Health Services in 1993, Dr. Farber served as senior medical consultant in the Medi-Cal Policy Section in the fee-for-service division, with responsibility for all Medi-Cal policy on internal medicine and subspecialty medicine, radiology, hospice and pain management, home health agencies, infectious diseases and HIV/AIDS medicine. He played a key role in shaping legislation and formulating California policy in telemedicine.

Dr. Farber earned his undergraduate and medical degrees at the University of Cincinnati, completed his residency at Jewish Hospital in Cincinnati, and was a fellow in infectious diseases at the University of Southern California/Rancho Los Amigos Hospital and then at Mt. Sinai College of Medicine/Beth Israel Medical Center in New York City.



## Medicaid Rules on the Web

Medicaid Rules, in addition to all OVHA and Department of Children & Families (DCF) Rules, are now available on the web at <http://humanservices.vermont.gov/on-line-rules>. The web version of the rules is searchable, making it easier to locate information. A rule numbering conversion table (old to new number) is also on the website.

## Optical Character Reading System

HP Enterprise Services will be implementing an Optical Character Reading (OCR) system in January 2010. This system will replace the current manual data entry system used to process paper claims. The result will be faster claims processing and the elimination of data entry errors. The success of this implementation will depend on the condition of the source documents received. The claim forms must comply with the following requirements in order to be processed through OCR:

1. Be submitted on original red claim forms (copies will not be accepted in OCR).
2. Be printed in black ink (handwritten claims will not be accepted in OCR).
3. Be properly aligned (information out of alignment will not be accepted in OCR).
4. Font size must be at least 10 point (any font smaller will not be accepted in OCR).

If any one of these conditions are not satisfied, the claims will fail in the OCR process and will require manual intervention, causing a delay in the overall processing timeframe.

## Update to NDC Code Reporting on UB 04 Claim Submissions

When recording an 11 digit National Drug Code number (NDC) in the Description field, form locator number 43 of the UB 04 claim form, the two characters "N4" must be recorded in the first two positions of the field, followed immediately by the 11 digit number. The "N4" will be used to identify the information in form locator number 43 as the NDC number. This will allow the Optical Character Reader (OCR) to distinguish NDC codes from any other information entered into field locator 43, and help ensure the correct processing of claims where an NDC code is required.

## DME Equipment Agreement Form

The DME Equipment Ownership, Operation, and Maintenance Agreement Form required as of July 15, 2009, needs to be signed by the vendor and the beneficiary or their legal guardian. This form should be kept on file at the vendor's office and be available for inspection and a copy provided to the beneficiary for their records. This form is available on the HP website [www.vtmedicaid.com/downloads/forms](http://www.vtmedicaid.com/downloads/forms) and is listed as the Durable Medical Equipment Ownership, Operation, and Maintenance Agreement Form.

## New Name, Same Faces

You will begin to see the HP logo or the HP Enterprise Services name on correspondence and hear the HP name when calling our office. You will begin to receive emails from an @HP.com email address rather than an @EDS.com address. However, we are the same people who are working hard to deliver the outstanding services you are accustomed to.

## 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](http://www.vtmedicaid.com)

Email:  
[vtprovserv@HP.com](mailto:vtprovserv@HP.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](http://www.ovha.vermont.gov)



## CPT 99464

CPT code 99464 is only payable when the following criteria are met:

- Each billing of CPT code 99464 requires documentation.
- This documentation must show that the delivering physician requested the attendance of a pediatrician.
- This documentation must show that the delivering physician believed there was a significant risk factor which necessitated the presence of a pediatrician.
- This documentation must show that the billing pediatrician was in attendance at the time of the newborn's delivery, performed an evaluation of the newborn, and remained with the newborn until the pediatrician determined that the newborn was stable or transferred to appropriate care.

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**Cherie Bergeron**  
Account Executive • HP Enterprise Services



**Susan Besio**  
Director • Office of Vermont Health Access

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