

# ADVISORY

Linking DVHA and HP to your Office

June 2011

Volume 36



## INSIDE THIS ISSUE

- ▶ Vermont Medicaid Portal Directory of Resources
- ▶ Radiology Tier Authorization
- ▶ Timely Filing Appeals
- ▶ Tax Assessment Payment Address Change
- ▶ New Billing Information, Requirements & Reminders
- ▶ Limitation On Over The Counter (OTC) Medications
- ▶ Inpatient Admissions POA Indicator Required
- ▶ Unique ID Number is available through the Voice Response System

## Vermont Medicaid Portal Website

### DIRECTORY OF RESOURCES...

New to the Vermont Medicaid Portal is the Provider Directory of Services and Resources. This Directory allows immediate access to all services, manuals, forms and reference materials available through the Vermont Medicaid Portal and includes links to Federal Government, Healthcare, Medicaid, and State Government agencies. Use the Directory to search for a service or resource and then link directly to the web page containing the desired information. Periodic updates will keep the directory current. Individuals wishing to obtain a copy of the new directory may do so at <https://vtmedicaid.com/Information/whatsnew.html>.

## Radiology Tier Authorization

Effective July 1, 2011, the DVHA will implement a multiple procedure payment structure for certain imaging procedures. This structure will apply whenever multiple outpatient imaging services using the same or similar modality (MRI and MRA, CT and CTA) are performed on the same day, by the same provider, on contiguous body areas.

In these cases, the procedure with the highest intensity will be paid at 100% of the fee schedule rate and subsequent procedures will be reimbursed at a lower rate. If two procedures are performed, the second procedure will be reimbursed at 50% of the fee schedule rate. The third and all subsequent procedures will be paid at 25% of the fee schedule rate. This rate structure applies only to the imaging procedure component of the claim. The professional (physician) component is not affected by this change. These changes only apply to CT, CTA, MRI and MRA imaging procedures.

## Timely Filing Appeals

When appealing a timely filing denial, providers are reminded of the following: write timely filing on the envelope being sent to HP Enterprise Services; resolve all claim issues; if one detail denies for something other than timely filing the entire claim will be denied; include a brief letter stating the reason for the timely filing request and all corresponding Medicare or other insurance RAs, if applicable. For detailed information regarding timely filing limits, see the Provider Manual, sections 1.2.23 Timely Filing, 1.3.11 Medicaid & Medicare Crossover Billing and 1.3.13 Workers Compensation/Accident Liability Billing located at (<http://vtmedicaid.com/Downloads/manuals.html>).

Mail to: HP Enterprise Services, PO Box 888, Williston, VT 05495-0888  
Attn: Timely Filing

## PROVIDER MANUALS

Provider Manuals are revised and posted to the VTMedicaid portal monthly; a complete listing of 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 weekly, paying close attention to any date specific and implementation information. The "Banner archives" can be accessed at: <http://www.vtmedicaid.com/Information/whatsnew.html>



## **Tax Assessment Payment Address Change** (Pharmacy, Nursing Home, Home Health and Hospital Providers)

On July 1, 2011, the address will change for payments mailed to the DVHA for provider tax, manufacturer labeler fees and HIT assessment. Please remit these payments to the following address. Providers should include the coupon or invoice with the payments to assure proper credit.

### **Lockbox**

**State of Vermont State Agency of Human Services**

**Supplemental/Tax Assessment**

**PO Box 1335**

**Williston, VT 05495**

## **New Billing Information, Requirements & Reminders**

### One Digit Unique ID Numbers & Electronic Claim Submissions

When submitting an electronic claim for a beneficiary with a one digit Unique ID Number, providers are instructed to insert a zero in front of the single digit UID (04, 05, 06, etc.). Failing to do so will result in your claim not being accepted by the translator. This instruction does not apply to paper claims or pharmacy point of service claims (POS claims require a 9-digit ID, therefore a single digit UID requires 8 leading zeros).

### Negative Pressure Wound Therapy Electrical Pump

Effective June 20, 2011, E2402 will have a change in pricing methodology, changing from a daily to a monthly rate. The rental period will be based on a 30 day interval. Providers are instructed to pro-rate any claims that are less than a 30 day rental to reflect proper charges. Supply codes associated with E2402 RR will be restricted to A6550 (15 unit maximum per month) and A7000 (10 unit maximum per month for use with this device).

These changes reflect Medicare's LCD L11500. The DVHA will continue to reimburse for only device rental and PA is required from the DVHA Clinical Unit.

### Optical Character Recognition (OCR) & Claim Readability

This is a reminder to all providers submitting paper claims that the information contained must appear in the appropriate fields.

Poorly aligned information will cause your claim to fail and be rejected by the OCR system. All OCR rejected claims will be returned to providers unprocessed.

### Eligibility Verification Clarification - Adult Root Canal

The adult dental limitation on root canals is 3 per person per lifetime. Providers wishing to validate a beneficiary's eligibility under the dental benefit are directed to contact HP Enterprise Services Provider Help Desk at 800-925-1706 (in-state) or 802-878-7871 (out-of-state).

### Pulpal Regenerative Treatment

Dental code D3354 requires that X-Ray documentation be forwarded with the claim when this service is provided to a beneficiary over the age of 16.

### Dental Claims Processing

When submitting a claim with a general assistance voucher where the beneficiary is responsible for a portion of the charges (as indicated on the voucher), please include the amount the patient paid in OTHER FEES, Field Locator 32, on the ADA 2006 Dental Claim Form.



Collective Drug Testing Limit

Effective July 11, 2011, billing for CPT codes 80100, 80101, 80104, G0431 and G0434 are collectively limited to 8 dates of service per calendar month.

CPT Code 52310 - Cystourethroscopy

Effective June 27, 2011, CPT code 52310 is restricted to the following diagnoses: 592.1, 594.1, 594.2, 939.0 and 996.39.

CPT Code 28011 - Tenotomy

Effective, June 27, 2011, CPT code 28011 is restricted to the following diagnoses: 735.0 – 735.8, 727.81 and 755.66.

**Limitation On Over-The-Counter (OTC) Medications**

Effective July 1, 2011, coverage of over the counter (OTC) medications will be primarily limited to generics only in categories determined to be medically necessary. All other OTC products will be excluded from coverage without the option for a prior authorization request through the Clinical Call Center. The new coverage guidelines apply to all state pharmacy benefit plans, e.g., Medicaid, Dr. Dynasaur, VHAP, and include VPharm, our Part D “wrap” program. OTC coverage in our “limited OTC” plans such as VScript Expanded and VPharm 3, will not change. As a reminder, DVHA only pays for OTCs when there is a specific medical necessity and you must write a prescription for the OTC product. Some OTC medications are already managed on our Preferred Drug List (PDL) and other restrictions may apply. Though we have restricted OTC medications to primarily generics, beneficiaries will continue to have at least one choice in all medically necessary drug categories. Please refer to our website for a list of covered OTC medication categories at <http://dvha.vermont.gov/for-providers> The PDL can be found at <http://dvha.vermont.gov/for-providers/preferred-drug-list-clinical-criteria>.

**Inpatient Admissions - POA Indicator Required**

It is now required that the present on admission indicator (POA) be included on all inpatient admission claims, regardless of the date of service, as communicated in the April 16, 2010 Banner Page. 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 diagnosis 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.

A list of diagnosis codes that are exempt from requiring the POA indicator can be located at <https://vtmedicaid.com/Information/whatsnew.html>.

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

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

**DVHA**

Department 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

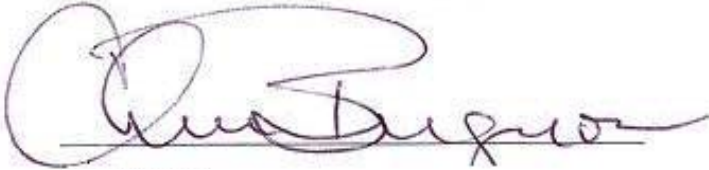
[www.dvha.vermont.gov](http://www.dvha.vermont.gov)

## Unique ID Number Available Through The Voice Response System

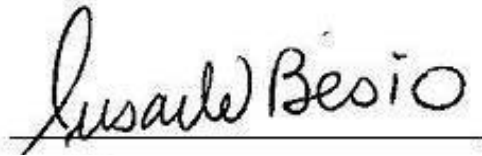
In the event that web services on the Vermont Medicaid Portal are unavailable, providers are advised to check eligibility, receive other insurance information and determine if service limits have been reached by using the automated Voice Response System (VRS). The VRS can be accessed by dialing 802-878-7871, option 1 and then option 1 again. Providers with access only to the beneficiary's social security number will be given the beneficiaries Vermont Medicaid UID Number. The VRS is available 24 hours a day, seven days a week. All providers accessing the VRS will be asked to enter a pin number. Providers accessing the VRS for the first time are advised to use the default pin of 9999. The system will then prompt you to select a pin number to authorize future use. To expedite your request, please have the following information available when making your call:

- ◆ Provider number
- ◆ Provider PIN number
- ◆ Beneficiary Unique ID Number (or social security number)
- ◆ Dates of service

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