



Vermont Health Access

Advisory

DEVELOPMENTAL SCREENING FOR CHILDREN

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Improving Developmental Screening for Children

-Developmental Screening for Children

Developmental delays and conditions affect 10% of children and the rates of detection are roughly 50% of prevalence rates. Early development delays are often not identified until well beyond the period in which early intervention is most effective. Many physicians and Primary Care Providers rely on informal developmental milestones and/or observation to monitor a child’s development.

-Claim Submission “Rules”

The research indicates less than 30% of delays are detected through observation. While detection rates increase by using a standardized instrument, national data indicates a low percentage of physicians use a standardized instrument.

-90-Day Prescriptions for Maintenance Drugs

The American Academy of Pediatrics (AAP)/Bright Futures recommends that all infants and young children should be screened for developmental delays at regular intervals, and that valid and reliable screening instruments should be used. Developmental screening is recommended when surveillance indicates the child may be at risk for developmental delay. All children should have periodic developmental screening at the 9, 18, & 24 or 30 month visits, and autism specific screening at 18 and 24 months.

-2008 Provider Survey Results (Overall Performance Chart)

AAP uses the following definitions:

-New Release of PES 2.21

Surveillance: The process of recognizing children who may be at risk for developmental delays.

-Incoming Mail

Screening: The use of standardized tools to identify and refine a recognized risk.

Evaluation: A complex process aimed at identifying specific developmental disorders.

To improve screening, detection, and linkages to services for young children, the Agency of Human Services, the Office of Vermont Health Access (OVHA), and the Vermont Department of Health (VDH) are collaborating on a number of initiatives.

Website Updates

-CMS 1500 Supplement

To increase the use of a standardized screening instrument and improve detection rates, as of January 1, 2009, the OVHA is allowing providers to bill for the well-child visit and the developmental screening (CPT code 96110) on the same day when a standardized screening instrument is used.

-Fee Schedules

Changes in the billing are to allow a developmental screening to be billed by Primary Care Providers with the following preventive medicine CPT codes on the same day: 99381, 99391, 99382, 99392, 99383, 99393, 99384, 99394, 99385, & 99395 for children less than 22 years of age who are enrolled in Vermont Medicaid, Dr. Dynasaur, or SCHIP.

-Medicare Attachment Summary Form

Physicians or Primary Care Providers must use a standardized screening instrument in order to bill for developmental screening that occurs on the same day as a well-child visit. Any standardized screening instrument listed in the AAP policy statement will be accepted for now. Providers are required to maintain documentation of the screening and the screening instrument used in the patient record.

-PES Version 2.21 & PES News

-Interpreter Services Q&A

The OVHA, VDH, and the Vermont Child Health Improvement Program (VCHIP) will be working together to assist in this implementation. VCHIP will assess current practice of surveillance and developmental screening in the next few months, develop a “preferred” list of standardized screening instruments drawn from the AAP list by the fall of 2009, and provide support to practices to improve

-DME Restrictions

CLAIM SUBMISSION "RULES"

In order to reduce the cost involved with the processing of claims for all involved parties, providers included, we would like to remind you of some vital "rules" for claim submission.

- * The most efficient process for submitting claims and getting reimbursed in a timely manner, is to submit them electronically. EDS provides free billing software to all Vermont Medicaid enrolled providers. If you would like additional information visit www.vtmedicaid.com under Downloads/Software.
- * If you must submit paper claims, please ensure that all required information is legibly present in the appropriate field locators. EDS personnel are not permitted to interpret the information submitted on your claims, as they are only allowed to "key what they see". If the information provided is not in the appropriate fields, it will not be keyed.
- * Lately, we have had quite a few claims where the NPI and/or taxonomy numbers were written illegibly, which may cause the claim to suspend, and eventually be returned to the provider. If you verify that all of the information on your claims is written legibly, your claims have a much better chance of going straight through to pay.
- * The total charges on your claim must match the sum of the detail charges. If you change any of the detail charges on your claim, remember to update the total charge, otherwise your claim will deny.
- * Verify with the beneficiary if they have another insurance such as BC/BS, Cigna, or MVP, etc. If the beneficiary is covered by another insurance, remember to either send us an attachment if they denied services, or include the amount paid by the other insurance on the front of the claim form.
- * If the beneficiary is covered by Medicare and there was a payment made by Medicare, coinsurance or deductible, remember to complete the Medicare Attachment Summary Form (located on the Vermont Medicaid website). If Medicare did not pay for the claim and there is no coinsurance or deductible, please send a copy of the Medicare EOMB along with your paper claim.
- * Your Vermont Medicaid provider name and number must be on your claim exactly as it appears on our provider file. If there is a discrepancy between what is on file and what is on the claim, the claim will deny for "Provider Name/Number Mismatch." The purpose of this edit, which effects paper and electronic claims, is to reduce the possibility of processing claims to the wrong provider and eliminate the possibility of exposing Personal Health Information.

90-DAY PRESCRIPTIONS FOR MAINTENANCE DRUGS

Each time a drug is dispensed, a dispensing fee is paid to the pharmacy. Medicaid policy currently allows for the dispensing of maintenance medications in 90-day supplies but few prescriptions are written in this manner. The result is that more fees are paid than are necessary.

A budget proposal is being considered by the Vermont State Legislature this year that would require the dispensing of maintenance drugs in 90-day supplies after the first fill. This limit would not apply to the first fill. That would allow you the opportunity to test for therapeutic effectiveness and patient tolerance before writing a 90-day prescription. However, after the first fill, prescriptions written for maintenance drugs for less than 90 days would have to be rewritten for 90 days for the drugs to be covered.

If approved, this requirement will be effective July 1, 2009. At that time, claims for maintenance drugs will deny if they are written for less than a 90-day supply. We are advising you of this now so that you may consider 90-day supplies for your patients' maintenance medications as you write prescriptions. In that way, you may minimize the activity that will be necessary in changing orders as of July.

In the meantime, please be aware that:

- * Upon final approval, the full list of classes of drugs affected by this change will be posted on the OVHA website at: <http://ovha.vermont.gov/for-providers>. In the interim, please consider prescribing 90-day supplies for any maintenance drug where you believe it to be appropriate for your patient.
- * Certain drugs have maximum quantity limits other than described here. See OVHA's Clinical Criteria document at: <http://ovha.vermont.gov/for-providers/preferred-drug-list-clinical-criteria>.

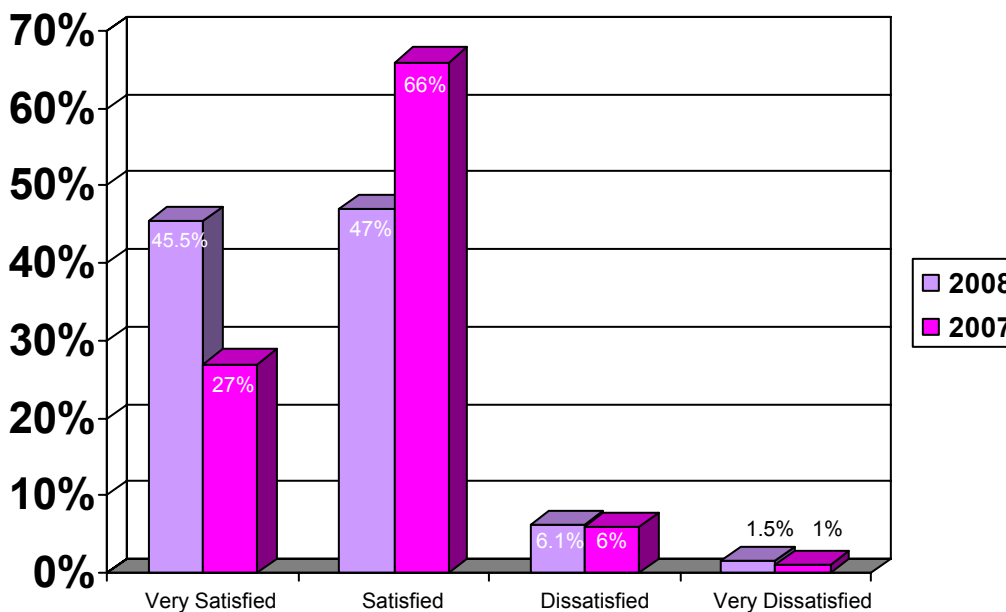
2008 PROVIDER SURVEY RESULTS

In February 2009, the 2008 Provider Survey was made available online to all providers who were interested in participating. A total of 74 providers participated and only 64 providers completed the survey in its entirety, within a 2-week period. Overall, 92.5% (.5% less than 2007) of the providers surveyed, answered that they were either “satisfied” or “very satisfied” with EDS’ performance.

EDS and the Communications/Publications Coordinator would like to thank these providers for taking the time to complete the survey in a timely fashion. All of the responses received will be considered when planning the next year of services to providers.

Overall Performance

EDS’s performance as the claims processing agent for the Office of Vermont Health Access.



NEW RELEASE OF PROVIDER ELECTRONIC SOLUTIONS (PES) AVAILABLE

A new release of PES (version 2.21) is now available on the Vermont Medicaid website (www.vtmedicaid.com under Downloads/Software). PES version 2.21 contains the following changes:

- * The PES “Other Provider” list now allows the addition of different providers with the same EIN *and* taxonomy. This will support the addition of hospital providers who have the same EIN and taxonomy.
- * The default code qualifier value in the PES “Provider” and “Other Provider” lists have been set to XX in order to support the typical (NPI) value. For atypical providers without an NPI, the qualifier can still be changed to 1D in order to support the Vermont Medicaid ID.
- * Place of service 35 is no longer valid for Professional claims. It is valid for Dental claims only and is reflected on the claim forms, drop downs and error codes.

If you are upgrading your existing software, please remember to upgrade incrementally. You cannot skip versions without risking database corruption.

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Hours of Operation:
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INCOMING MAIL

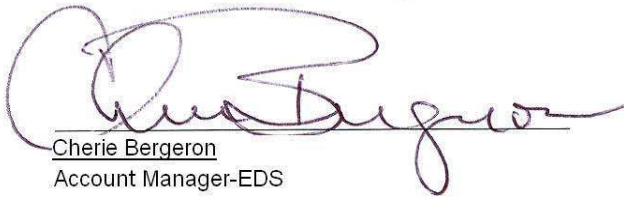
As a reminder, all incoming mail sent to EDS must be addressed according to the following:


- * P.O. Box 1710, Williston, VT 05495-1710 - Dental & Vision claims
- * P.O. Box 777, Williston, VT 05495-0777 - CMS 1500 claims
- * P.O. Box 999, Williston, VT 05495-0999 - UB04 claims
- * P.O. Box 1645, Williston, VT 05495-1645 - Refunds
- * P.O. Box 888, Williston, VT 05495-0888 - All other inquiries

In addition, when appealing a timely filing denial, providers must fully research and document in the request the extenuating circumstances surrounding the claim (e.g. submission dates, adjusted dates, and denial dates). If there is no documentation or the documentation is insufficient to validate extenuating circumstances for the late submission, your appeal will be denied. Please send your appeal request to:

EDS, P.O Box 888, Williston, VT 05495-0888, Attn: OVHA Appeals.

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