

VERMONT HEALTH ACCESS ADVISORY



Linking OVHA and EDS to your Office
OVHA- <http://www.ovha.state.vt.us/>

April 2005, Volume XXXIII; Number 7
EDS- <http://www.vtmedicaid.com>



New Mailing Address for the OVHA Effective May 1, 2005
Office of Vermont Health Access, 312 Hurricane Lane, Ste. 201, Williston, VT 05495

ALL PROVIDERS

Primary Care Plus Program

The following is a program refresher excerpted from the Primary Care Plus Program Manual. Additional articles on the PCP program will appear in forthcoming editions of the Advisory.

Participation as a primary care provider is open to general practitioners, family practitioners, pediatricians and general internists as well as adult, pediatric and family nurse practitioners. Physician specialists may also contract as PCPs as long as they agree to provide the services listed below.

PCPs coordinate their members' health care needs by providing the following services:

- Primary care medical services, covered by Medicaid;
- Referral authorization for needed specialty and other covered medical services;
- Arranged 24 hour-a-day coverage.

Referrals

The goals of the referral process are to:

- Ensure that the PCP is involved in medical decisions affecting enrollees;
- Reduce utilization of unnecessary medical services;
- Reduce duplication of services; and
- Promote continuity of care.

The PCP will be responsible for coordinating care between the beneficiary and any specialty care that the beneficiary may need through the referral system. A referral takes place when a participating PCP refers their **PC Plus** beneficiary for medically necessary Medicaid covered services not normally provided by the PCP. Beneficiaries seeking specialty care without a referral from their PCP may be responsible for the total charges incurred, if they are informed they will be billed directly **prior** to the service being rendered. Claims submitted by specialty providers for services not referred by the beneficiary's PCP will be subject to denial and/or retroactive review for referral documentation.

Cntd on next page

In This Issue	
Primary Care Plus Program.....1	POS Swipe Box Updates.....3
Other Insurance on Detail Level.....2	Premium Payment Schedule Change.....3
	Pre-Op Exams Billed as Consultations.....4

Referrals may be made verbally or in writing. Both the PCP and the specialty providers that the PCP is referring to are required to keep documentation of the referral in the patient's medical record. The referral must include the following information: patient identification information; reason for referral; requested service (evaluate, evaluate and treat). Providers who make referrals in writing may use their own form or the OVHA referral form available from EDS.

Referral forms do not need to be attached when submitting claims. The specialty provider will be reimbursed on a fee-for-service basis for Medicaid covered services.

The following services **do not** require a referral from the PCP:

- Chiropractic services; (non-covered for adults, children 0 to 12 years requires prior authorization)
- Dental services;
- Emergency services;
- Family planning services – defined as those services that either prevent or delay pregnancy;
- Gynecological services;
- Personal care for children;
- Prenatal and maternity care;
- Routine eye exams (for adults and children) and eyeglasses; (for children);
- Mental health services;
- School-based health services;
- Services rendered by the PCP or those providing back-up coverage for the PCP;
- Substance abuse services;
- Transportation services

To enroll in the PCP Program call EDS Provider Enrollment: 802-857-2966

Other Insurance On Detail Level Of ALL Electronically Submitted Claims

Effective May 1, 2005, **all** electronically submitted claims will need to report the amount of other insurance at the detail level. Providers who bill electronically can expect faster and more accurate payments as a result of this upgrade. Providers will still be permitted to 'roll-up' their insurance to the header level when billing Inpatient, Nursing Homes, and Institutional Crossover (X & W) claim types.

This system enhancement requires all Providers to bill each detail of the claim to the other insurance before submitting the claim to EDS and to then reflect the detail reimbursement from the other insurance at the detail level of the claim being sent to EDS. Providers can no longer total and report other insurance payments only on the header level of the claim.

This may require some Providers to make minor changes to their billing systems. Providers should continue to submit other insurance denials to EDS on paper with the attached EOB which explains the denial.

The effective date of this change is May 1, 2005 but you can switch to detail billing of other insurance today. Claims received after May 1, 2005 will be denied if other insurance charges are not reported on the detail level.

For specific instructions on how to bill the detail other insurance on PES go to: www.vtmedicaid.com; "Downloads"; "Software"; *Provider Electronic Solutions Guide*; see 6.2 "Other Insurance and Medicare Crossovers".

Important Update on POS Swipe Boxes

As previously announced, the Point of Service Omni terminal devices (POS Swipe Boxes) used by some providers to verify Vermont Medicaid eligibility are not HIPAA-compliant. New POS devices, installed with upgraded software, are now available for processing HIPAA-compliant transactions in accordance with Federal mandates.

The old, non-HIPAA compliant POS boxes will be disabled effective close of business on **April 1st, 2005**. They are obsolete and should be disposed of. Please do **not** return them to OVHA or EDS.

Providers who have already placed orders for new swipe boxes will be contacted by separate letter regarding receipt and set-up of the new boxes. Providers were told of these upgrades and given the opportunity to order new boxes in a letter sent in May 2004 and in the October 2004 Vermont Health Access Advisory. You can read these prior notifications regarding POS upgrades on our website:

www.vtmedicaid.com under the "Information" section.

If you have not already ordered a replacement box and would like to do so, please fill out and mail the Omni 3740 Terminal Device order form available on-line at: www.vtmedicaid.com or by calling EDS Provider Services at (802) 878-7871 or 1-800-925-1706 (in Vermont only).

The POS swipe boxes are manufactured by Verifone and must be ordered by Vermont Medicaid in lots of 100. An order can not be sent to Verifone until 100 orders have been received from providers. Please be aware that due to this ordering requirement, there may be a delay in placing your order and shipping your device.

Please be aware that there are alternative methods of checking eligibility.

- The Voice Response System (VRS or Malcolm) can be used by calling 1-800-925-1706 (in Vermont only) or (802) 878-7871.
- A growing number of providers use our website: www.vtmedicaid.com to check eligibility in addition to accessing other resources that facilitate their billing process.

Premium Payment Schedule Change

Beginning in May, Medicaid beneficiaries who are required to pay a premium will be subject to a new payment schedule. This change will only affect recipients. Providers are reminded that they must always check eligibility with EDS. They can do so through our website or VRS. Letters of eligibility or other documents which a recipient may show to a provider are **not** considered verification of eligibility and coverage.

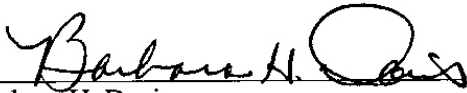
PHYSICIANS

Pre-Op Exams Being Billed as Consultations

EDS receives many incorrect claims for consultations (procedure codes 99241-99255) with a diagnosis indicating pre-op examination. The only time a consultation code is properly billed for a pre-op exam is when the surgeon is not the patient's primary physician and is assessing the need for surgery. In these cases the billed diagnosis must indicate the medical condition, not the pre-op V-code.

When the surgery is already scheduled, the physician who performs the pre-op exam (history and physical) is to bill the appropriate E&M code, not a consultation code.

Consultation codes will be denied where the diagnosis or other information indicates the service was a pre-op exam.



Barbara H. Davis
Program Director, EDS



Joshua Slén
Director, Office of Vermont Health Access