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▶ MEDICARE CROSSOVER NPI INFORMATION

As a reminder, if you are not seeing your Medicare crossover claims being automatically submitted to Vermont Medicaid, there may be a discrepancy with the NPI numbers used when billing Medicare. To ensure that your crossover claims are processed correctly and in a timely manner, please submit the appropriate taxonomy codes to Medicare. Although Medicare does not require or process taxonomy codes, Medicare claims should contain taxonomy codes for correct processing as crossovers to Vermont Medicaid. Please note: The most critical taxonomy codes is the *group* taxonomy codes and EDS recommends that providers enter their *group* taxonomy code wherever there is an option to enter a taxonomy.

Contact the EDS Provider Enrollment Help Desk at: (802) 879-4450, option #4, to submit all of your Medicare NPI numbers and/or if you have any further questions.

▶ VPHARM PILOT PROGRAM: STATINS & PROTON PUMP INHIBITORS

Providers were notified that effective July 15, 2009, for beneficiaries enrolled in the VPharm programs, the OVHA will only cover the cost-sharing (deductible, donut hole and coinsurance) for select generic and/or OTC statins (HMG COA reductase inhibitors) and proton pump inhibitors (PPIs). The effective date of this change was moved to August 1, 2009 to provide prescribers and pharmacies additional time to implement this change. As a reminder, most of the drugs covered under this program do not require prior authorization (PA) from the Part D Plans.

However, if a beneficiary has obtained a PA from his/her Part D Plan prior to August 1, 2009, the drug continues to be covered by VPharm through its PA process. Our research suggests that the only affected drug Lipitor for those enrolled in First Health Part D Premier Plan and First Health Part D Secure Plan.

▶ OPTICAL CHARACTER READING SYSTEM (OCR)

EDS will be implementing an Optical Character Reading (OCR) system in the fourth quarter of 2009. This system will replace the current manual Data Entry system used to process paper claim receipts. The success of this implementation will depend on the condition of the source documents received. As of November 1, 2009, at a minimum, the claim forms must comply with the following:

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 than that 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.

In addition, page 2 of this publication indicates the changes that will be made to billing instructions to accommodate the OCR system.

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 u-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>



► OCR CHANGES TO BILLING INSTRUCTIONS

Claim form UB04:

Field 39A (Value Codes): If billing for Covered Days for Nursing Home, Inpatient, or an Institutional Crossover claim, enter the Value Code and Value Amount (Covered Days).

Field 44 (HCPCS/Rate/HIPPS Code): If applicable for the services being billed, enter the appropriate HCPCS in field 44.

Field 47 (Total Charges): Enter on line 23 in the TOTALS field, the total charges for all details being billed.

Claim Form DENTAL:

Field 3 (Primary Payer Information):

Direction: Enter "VT Medicaid"

Field 22 will be deleted, no need to enter this information

Field 24 (Procedure Date in MM/DD/CCYY format)

Direction: Enter the date of service provided

Field 32 (Other Fees)

Direction: Enter the amount paid by other insurance including contract allowance, if applicable

Field 35 will be deleted, do not enter any dollar amounts

**Field 48 (Name/Billing Address
Billing Dentist/Group)**

Direction: Enter individual dentist with last name, first name format.
Enter group name as it appears on your enrollment form

Field 52A (Additional Provider ID)

Direction: Enter the applicable taxonomy for the billing provider (individual or group)

Field 54 (NPI)

Direction: Enter the NPI of the attending dentist who performed the service

Field 56A (Provider Specialty Code)

Direction: Enter the taxonomy of the attending dentist who performed the service

Claim Form CMS1500

Field 11D (Is there another health benefit plan?)

Direction: Check the appropriate box. If yes, complete 11a - c

Field 15 (If patient has had same/similar illness)

Direction: Enter the therapy start date in MMDDYY format if billing physical, occupational or speech therapy

Field 20 (Outside Lab)

Direction: If lab services billed, check the appropriate box

Field 24D (Procedures/Services or Supplies)

Direction: Enter the appropriate procedure code to explain the service rendered. See page 28 in the CMS1500 manual for NDC instructions. Enter the modifiers in the appropriate boxes and see page 27 for additional instructions

Field 24J (Rendering Provider)

Direction: If Atypical, enter the 7-digit VT Medicaid ID number in the top shaded portion. If not Atypical, enter the attending physician's NPI in the bottom section. Enter the billing provider NPI for independent labs and DME suppliers in the bottom section

Field 26 (Patient's Account Number)

Direction: Enter the account number you have assigned to the beneficiary. EDS can accept up to 20-digits; alpha, numeric, or alpha/numeric in this field. This information will print on the RA summary for your accounting purposes

Field 33 (Billing Provider)

Direction: Enter individual provider with last name, first name format
Enter group name as it appears on your enrollment form.



► MEDICARE ATTACHMENT SUMMARY FORM

In an effort to standardize and simplify the processing of **Medicare paid** crossover claims, Vermont Medicaid has introduced the "Medicare Attachment Summary Form". This form is the *only* acceptable attachment for billing Medicare crossover claims on *paper*. Please do not submit this form in place of any other insurance EOB— only Medicare. The Explanation of Medicare Benefits (EOMB) form for *paper* crossover submissions are no longer accepted. However, the EOMB is still required for claims *denied* by Medicare. **Please make sure you split the claims that have details that were paid and details that were denied by Medicare.** It is *imperative* that the details on the Medicare Attachment Summary Form match the **exact** details on your claims. If they do not match, the claims will be returned to you. Please do not include any details that were not billed to Medicare.

In addition, please ensure that the correct form is attached, as one is only for CMS1500 and one is for UB04. The attachment summary forms do not have the same information, therefore it is essential that the correct form is attached to the claim.

Field locator 29 on the CMS1500 and 54 on the UB04 claim forms should contain any payments (including contractual adjustments) by any commercial insurances secondary to Medicare. The amount paid by Medicare should NEVER be on the front of your claims. Non-compliance with these two steps may cause your claims to pay incorrectly.

Please note: Claims will continue to be returned to the provider when the Medicare Attachment Summary Form is not attached to *paper claims*.

The forms are available at: www.vtmedicaid.com under *Downloads/Forms* (CMS1500 Medicare Attachment Summary Form and UB04 Medicare Attachment Summary Form), and may be completed electronically and printed. We would like to encourage you to do this in order to ensure correct processing of your claims. If you do not have access to the internet, you may contact the EDS Provider Services Help Desk at (800) 925-1706 (in-state) or (802) 878-7871 (out-of-state) to request a copy.

Medicare claims should automatically crossover to Vermont Medicaid electronically. If you do not receive the Vermont Medicaid balance, it is mandatory to wait six full weeks from the *Medicare paid date* to submit your paper claims to EDS.

► 90-DAY PRESCRIPTIONS FOR MAINTENANCE DRUGS

Providers were notified that effective July 15, 2009, when the Office of Vermont Health Access (OVHA) is the primary payer, pharmacies will be required to dispense designated classes of maintenance drugs in 90-day supplies after the first fill. The effective date of this change was moved to August 1, 2009 to provide prescribers and pharmacies additional time to implement this change.

As a reminder, when the OVHA is the primary payer, after the first fill, prescriptions written for maintenance drugs must be rewritten for 90 days for the drug to be covered. The maximum quantity limit of 102 days still applies. This rule does not apply to beneficiaries who have other primary insurance, including Part D.

The full list of classes of drugs affected by this change is posted on the OVHA's website at: <http://ovha.vermont.gov/for-providers>.

See the OVHA's Clinical Criteria document for drugs with other quantity limits: <http://ovha.vermont.gov/for-providers/preferred-drug-list-clinical-criteria>.

EDS

Electronic Data Systems
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

Email:
vtprovserv@eds.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) 879-5919

Website:
www.ovha.vermont.gov



► OUT-OF-STATE PSYCHIATRIC ADMISSION REQUESTS

Beginning August 1, 2009, the Office of Vermont Health Access implemented concurrent reviews of all psychiatric inpatient admissions (excluding beneficiaries enrolled in CRT) for Vermont Medicaid primary beneficiaries at out-of-state hospitals. The procedure for CRT admissions and concurrent review remains unchanged. All children and adolescents up to the age of 18 will continue to require a screening by the local Community Mental Health Center prior to admission. For adults, prior to admission the referring physician should notify the OVHA Clinical Unit directly at: (802) 879-5903.

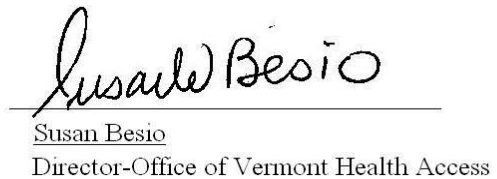
► IN-STATE PSYCHIATRIC ADMISSION REQUESTS

Beginning August 1, 2009, the Office of Vermont Health Access implemented concurrent reviews of all in-state psychiatric inpatient admissions for Vermont Medicaid primary children and adolescents, and young adults ages 18 and up to the age of 22 (excluding beneficiaries enrolled in CRT) to the Brattleboro Retreat. All admissions will continue to require a screening by the local Community Mental Health Center prior to admission. The procedure for CRT admissions and concurrent review remains unchanged.

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Cherie Bergeron
Account Manager-EDS



Susan Besio
Director-Office of Vermont Health Access
