

VERMONT HEALTH ACCESS ADVISORY



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

December 2004, Volume XXXI; Number 5
EDS- <http://www.vtmedicaid.com>



ALL PROVIDERS

Who is Responsible for Payment?

The following is a restatement of current policy from the Provider Manual.

Verifying eligibility before service:

Providers are expected to verify eligibility for every beneficiary prior to providing the service or item to be clear about who has financial responsibility for the service. Eligibility can be verified up to nine days in advance. Eligibility can be verified through the POS/swipe box, the automated voice response system (Malcolm), on-line Transaction Services (vtmedicaid.com) or by calling the provider services help desk. When an eligible aid category code is given, the provider should determine that the service to be provided is covered within that aid category. This will also show what other insurance is on file. To ensure timely processing of your claim, validate other insurance with recipient or refer them to the Department of Children and Families.

Billing the Beneficiary:

If the provider bills Medicaid for a service or item, the provider may not bill the patient for any reason except the following:

- The amount due is for unpaid Medicaid co-payments and deductibles;
- The claim was denied for lack of eligibility and the date of service was greater than 60 days beyond the loss of eligibility date;
- The claim was denied because another insurer's rules were not followed;
- The claim is submitted to Medicaid by Medicare for a patient enrolled in a Medicaid pharmacy only plan; or,
- If the EDS system reports that a beneficiary has other insurance, the provider must bill the service or item to the other medical insurance prior to billing Medicaid. If the beneficiary is no longer enrolled with the other insurer, and the beneficiary does not report the insurance change to Medicaid within 30 days and after the 30 days have lapsed, the EDS system still reports that the patient has other insurance, the provider may bill the beneficiary.

The provider may not bill a beneficiary for missed appointments under any circumstances.

Under the provider agreement, failure to give advance notice that Medicaid payment will not be accepted prevents the provider from billing the beneficiary. If the beneficiary is eligible for Medicaid and the provider does not want to accept Medicaid payment for the service or item requested, the beneficiary must be informed in advance of providing the service. Form 287 or other appropriate documents should be completed and signed by the beneficiary or parent to document that proper notice was given to the patient and the responsible adult has accepted the financial responsibility to pay for the service or item. Such documentation prevents future disputes based on recollection of conversations. If the beneficiary has accepted financial responsibility, the claim should not be submitted to EDS for payment.

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Timely Filing

If Medicaid is the **primary** payer then you have six months from the date of service to file your claim. The only exception is if the service is for Global Maternity Codes (59400,59425,59426,59510,59610 and 59618) or Global Orthodontia codes (D8070,D8080,D8090). If you are billing for these services you have up to 12 months from the date of service to file your claim.

If Medicaid is the **secondary** payer (non-Medicare) you have 12 months from the date of service to file your claim UNLESS the service is considered 'Pay and Chase' or if the client has court ordered insurance. These services MUST be billed within 6 months from the date of service with NO exceptions.

- Pay and Chase are services reimbursed by VT Medicaid and billed to the primary insurance by the EDS TPL unit. Pay and Chase services include: EPSDT procedure codes 99381-99385, 99391-99394, and 99173 and Preventative/Prenatal diagnosis codes 640-648 series; 651-658 series, 671 series, 673 series, 675-676 series; V01-V07 series, V20 series, V22-V23 series, V28 series, V30-31 series, V33-34 series, V36 series, V73-75 series, V700 code, V770-V777 codes, V782 code, V783 code, V792 code, V793 code, V798 code, V823 code and V824 code.
- Beneficiaries covered by court ordered insurance can be identified by using the voice response system that says "The recipient has other insurance with (name) with coverage type code D1, D2, D3, D5, D8, D9.

If Medicaid is the secondary payer to **Medicare** you will have up to two years from the date of service to file the claim.

NOTE: If you are a MH or DS facility and the services you provide are being funded by either the Department of Aging and Independent Living (DAIL) or the Department of Health (DOH) then your filing limit is six months from the date of service with NO exceptions.

If a claim has a date or dates of service past the filing limit, it may be submitted for payment directly to EDS if one or more of the following conditions is met:

- EDS denied the claim within the timely filing limit, for a reason other than exceeding the time limit. If EDS has the originally denied claim in history and you are not changing the procedure code, recipient, provider or dates of service then you can resubmit your claim electronically. EDS will match the new claim against the previously denied claim as proof of timely filing. Exceptions to the automated match process include those services that have a firm 6 month filing limit as discussed above (Pay and Chase, Court Ordered Insurance, MH and DS services).
- A beneficiary's eligibility was made retroactive; the date of service is within the retroactive period; and the claim is submitted within the first six months from the date on the Notice of Decision. Please attach a copy of the Notice of Decision with your submitted claim.
- The OVHA will consider paying an untimely claim in unusual circumstances that are beyond the provider's control. A request for an exception can be made by sending the claim and a detailed explanation of why an exception should be granted to EDS Attn: Appeals PO Box 888, Williston, VT 05495.

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Proof of Timely Filing

Acceptable methods for proving timely filing are:

- A remittance advice with a denial in the timely filing period
- A Notice of Decision showing retroactive eligibility. Claim must be submitted within 6 months from the date of the notice.
- A copy of the claim status screen from the web showing the claim was processed in the timely filing period
- A copy of the submission report for the EDS PES software showing the submission in the timely filing period.

EDS will NOT accept any other documents as proof of timely filing.

Two-Year Limit

Federal law prohibits the OVHA from paying any claim with a date of service greater than 2 years with very few exceptions. Only in very rare cases will a claim be considered if the date of service is greater than two years prior to the OVHA's receipt of the claim. Most often the exception is granted when adjustments are made at, or beyond, the limit and the provider has diligently sought the corrected payment.

Modifiers 53 & 25

The OVHA has approved the use of Modifiers 53 and 25.

Modifier 53, "discontinued procedure" can be used with date of service effective November 1, 2004. This modifier is to be used following correct coding guidelines as defined by CPT. Modifier 53 will pay 25% of the allowed amount of the billed procedure code.

Modifier 25, "significant, separately identifiable E & M service by the same physician on the same day of procedure or service" has already been listed as an appropriate modifier and can now be billed when appropriate.

Webpage Updates

We continue to develop our website as a valuable resource for the provider community. Recent additions include updated Fee Schedules, an updated Active Providers List, the current PCP Directory, *ClaimCheck*® information, and the updated Prior Authorization Supplement. The Prior Authorization list has been substantially revised and should be reviewed to see if the requirements for your service have changed.

If you would prefer to receive the Advisory via email instead of a paper copy please send your e-address to: vtadvisorycommunications@eds.com.

CLINICAL LABORATORIES

Modifier 90

The OVHA has approved the use of Modifier 90 for Laboratory Claims effective September 1, 2004. Modifier 90 is to be used only by clinical laboratories when laboratory tests performed for a patient are performed by an outside or reference laboratory. This modifier is used to indicate that the actual testing component was a service from an outside or reference laboratory.

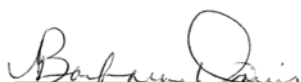
PSYCHOLOGISTS


Additional Codes for Doctorate Level Ph.D.s

The OVHA has authorized four additional codes for the allowed procedures for Doctorate level Ph.D.s. These codes must be billed with modifier AH when provided by a Doctorate level Ph.D.:

- 96150 Health and behavior assessment, clinical interview, observation each 15 minutes
- 96151 Health and behavior re-assessment, each 15 minutes
- 96152 Health and behavior intervention face to face, individual each 15 minutes
- 96153 Health and behavior assessment face to face, group (2 or more pts) each 15 minutes

Best Wishes for a safe and healthy holiday season.


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