

VERMONT HEALTH ACCESS ADVISORY



Linking OVHA and EDS to your Office

OVHA- <http://www.ovha.state.vt.us/>

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EDS- <http://www.vtmedicaid.com>



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Website Updates

Fee Schedules (including 2006 Dental), PAC-9 list, Active Provider List, FAHC & DHC Staff list, Aid Categories, Provider & CMS-1500 manuals, Enrollment forms, GCR Medical Necessity form, Carrier Code list, Provider Survey form.

Survey? What Survey?

The OVHA began operating as an MCO on October 1st, 2005. As an MCO, the OVHA is required to collect new information about providers to better inform beneficiaries. *This new data will be used to develop our new, on-line provider look-up, thus it is important that providers return their completed surveys immediately.* Surveys were mailed to most providers in early December to comply with the MCO requirements. Completed surveys were to be returned to EDS by December 21st, 2005.

We would like to thank the providers that returned their information on time. However, there are still 4,000 outstanding surveys! If you have not completed and returned your survey please do so immediately. If you need a new survey, you can print them from our website: www.vtmedicaid.com.

Completed surveys can be returned as an email attachment to: vtmcdirectorysurvey@eds.com or sent via fax: 1-802-878-3440; or mailed to: EDS, PO Box 888, Williston, VT 05495

Coming Soon: Web-based Provider Look-up

EDS will soon introduce a new web-based provider look-up that will be available to beneficiaries and program professionals. In addition to increased access to a wider range of users, the provider look-up will include comprehensive search capabilities, expanded information collected from the recent survey, the option to map routes to service locations, and the ability for providers to update their files. This new on-line resource will replace the hardcopy PCP Directory.

The provider look-up will mark another expansion of services available to the provider community on the Vermont Medicaid web portal. This growth of on-line resources supports three primary goals: state initiatives established in 2001 to maximize the potential of the Internet as a source of quality health care information and services; the 'preferred future' of communicating via user-friendly, informative web-sites as outlined by the Agency of Human Services 2005 Strategic Plan; and the OVHA's effort to increase access to care and improve the accuracy of care-related information. Providers can expect continued development of the resources available at: vtmedicaid.com

ClaimCheck® Communications

If you have called Provider Services and determined that your claims issue is related to ClaimCheck®, and you disagree with the determination of your claim or seek further information, please direct your ClaimCheck® questions to: Claimcheckcommunications@eds.com. ClaimCheck® denials can be easily identified with 4-digit EOB codes that begin with an 8. If you disagree with the ClaimCheck® policy determination and have a source (i.e. NCCI, CMS, Ingenix) to support your findings, please reference that source in your email.

CPT/HCPC Grace Period

This is a reminder that the AMA no longer allows a 90-day grace period for terminated CPT/HCPC codes. CPT/HCPC codes deleted for 2006 are not valid after December 31, 2005. You must bill using valid CPT/HCPC codes for services performed.

Contacting MedMetrics

MedMetrics Health Partners (MHP) began processing Vermont Medicaid pharmacy claims on January 1, 2006. Please direct your pharmacy-related questions to the following numbers:

Claims-related questions should be directed to MHP Pharmacy help desk at: (800) 918-7545.

The MHP Clinical Center can be reached at: (800) 918-7549.

Questions regarding Prior Authorization should be sent to this fax number: 866-767-2649.

For additional information, please visit the OVHA website at: <http://www.ovha.state.vt.us/ProviderPharmacyServices.cfm>

T1015 & Co-Pay

Physicians can bill Medicaid for the patient's co-pay obligation only if the primary insurance coverage is under a capitation agreement with the provider. These co-payments can be billed using procedure code T1015. If the service is not capitated by the primary insurance the provider may not use T1015 for the co-pay. Those services should be billed with a regular E&M code showing the primary's payment. Medicaid will pay that claim at the difference between the primary insurance payment and the Medicaid allowed amount for that service.

RHCs & FQHCs can only use procedure code T1015 for an encounter claim. If a co-payment is due for a capitated service of the primary insurance, then bill this amount using the T1015 code (co-pay) using the non-RHC/FQHC provider number.

Adjustments Review

Providers must file all claims within the timely filing limit, as outlined in the [Provider Manual, Sec. 1.2.15](#).

Once a claim has been processed and placed in a "Paid" status, providers have one year from the original paid date to adjust claims that would result in a positive financial outcome for provider.

Adjustments and recoupments to claims billed incorrectly that result in a negative financial outcome for the provider must be done within three years of the original date of service. If the claim is more than three years old, the provider must refund the overpayment and attach the check to the completed "Refund" form, found in the [Provider Manual, Sec. 4.2.2.1](#) or on our website at: <http://www.vtmedicaid.com/Downloads/forms.html>

Billing Overview

The following information is a review 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 (VRS/Malcolm), on-line [Transaction Services](#) or by calling the provider services help desk. The eligibility response includes the beneficiary's category code, which will help you identify program coverage if in question. The response will also show if other insurance is on file as the primary. If the beneficiary tells you that the other insurance information is not correct, have the beneficiary correct this with the Department for Children and Families to avoid claim processing delay.

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. The old Form 287 or any similar documentation of the agreement to pay should be 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 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.

Want Faster Claims Processing?: Bill Electronically

Are you consumed by paperwork? Electronic billing can alleviate your paperwork problems. The majority of providers bill electronically for faster processing and payment. Electronic billing reduces errors and enables better record tracking. Plus, our electronic billing software is FREE! More than 800 providers can testify to the benefits of using EDS PES software to bill Medicaid directly.

Even if you use other software to *bill* your claims, you can use PES to process electronic adjustments, secondary claims, re-submit claims, or verify eligibility. Providers who currently submit claims on paper and would like to take advantage of electronic billing please contact Rich, the EDI Coordinator at: 802-879-4450, option 3, or vtedicoordinator@eds.com to discuss electronic billing options.



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