



Inside this issue:

| | |
|---|---|
| -Out-of-State Transportation Referral Form | 1 |
| -Optical Character Reading System | 1 |
| -Chiropractic Services | 2 |
| -2004 SSI Income Rule Changes | 2 |
| -New Dental Fee/Procedure Code Schedule | 3 |
| -PCP Reimbursement | 3 |
| -GA Vouchers | 3 |
| -Missed Appointments/Late Cancellations | 3 |
| -NDC Requirement (Institutional) | 3 |
| -NPI Implementation | 3 |
| -Attention Electronic Claims Submitters | 4 |
| *Insert* | |
| -Vermont Expands Health Coverage. New! Catamount Health | |

Web Updates

- Fee Schedules
- Active Provider List
- PAC 8 and 9 Codes
- Out-of-State Pre-Admission Request Form
- Pre-Procedure Request Form
- July 1, 2008 Dental Procedure/Fee Schedule

Out of State Transportation Referral Form

In order for beneficiaries to access transportation to out-of-state facilities, the Office of Vermont Health Access (OVHA) has established eligibility criteria that *must* be met before out-of-state transportation will be authorized. This eligibility criteria is outlined in the Medicaid Transportation Procedure Manual beginning on page 9; the process for obtaining authorization for out-of-state transportation is included in the Manual beginning on page 19. The Medicaid Transportation Procedure Manual is available online at:

<http://ovha.vermont.gov/for-providers/1transmanualeffective4-1-08.pdf>

Before out-of-state transportation can be arranged and authorized, the “Out-of-State Medicaid Transportation Physician Referral Form” must be completed by the primary care physician, psychiatrist, or treating physician and faxed directly to the OVHA at (802) 879-5919. The form is used to convey information such as the nature of and need for the requested service, the reason why the service can not be obtained in-state, the beneficiary’s possible ongoing history with the out-of-state provider, and the medical necessity for this service. It is important to include as much information as possible when submitting the form—beneficiary information, the need for accompanying family members, how many nights stay must be arranged, and the time/date of the set appointment. Without this information, the OVHA will be unable to authorize the arrangements being requested. Upon receipt, the OVHA reviews the referral form and determines whether to authorize the trip and cover such items as travel, lodging and/or meal reimbursement. Upon OVHA’s authorization, the transportation broker or the Vermont Public Transportation Association (VPTA) will make the arrangements.

Please contact Peter McNichol at (802) 879-5935 with any questions or for further information.

Optical Character Reading System (OCR)

EDS will be implementing an Optical Character Reading (OCR) system in the near future. 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. 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 with 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.

Chiropractic Services

Act 65 of the 2007 Legislature instructed the Agency of Human Services to reinstate chiropractic coverage for adults in the Medicaid and VHAP programs, effective July 1, 2008. This coverage is to be consistent with Title 8, §4088a, and within the scope of chiropractic services, as defined in Chapter 10 of Title 26 of Vermont statutes. Beginning with a date of service of July 1, 2008, allowable and medically necessary services from enrolled providers for children and adults will be the same. Coverage is limited to the description of services below.

According to the statute, services of a chiropractor include:

- 1) Diagnosis of conditions related to subluxations, joint dysfunctions, neuromuscular and skeletal disorders to detect, correct or refer in order to restore and maintain health, without providing drugs or performing surgery;
- 2) The use of physical and clinical examinations, conventional radiological procedures and interpretation (X-rays), as well as the use of diagnostic imaging (such as MRI or CT scans) read and interpreted by a person so licensed, and laboratory tests to determine if the chiropractic care is appropriate; and
- 3) Adjunctive therapies approved by the state board of chiropractic, by rule, to be used in conjunction with chiropractic treatment, and limited to physiotherapy modalities (these include ultrasound, diathermy- heat treatment using electricity, laser therapy for pain, heat, cold, electricity, and traction) and rehabilitative exercises; and
- 4) Treatment by adjustment or manipulation of the spine or other joints and connected neuromusculoskeletal tissues and bodily articulations.

The following benefit limits will apply to chiropractic services effective July 1st 2008:

- A. Coverage for all beneficiaries is limited to ten visits per patient per calendar year. For more visits, the chiropractor must submit a prior authorization request, accompanied by sufficient documentation to support the medical necessity of continued care. This may include full clinical data, x-rays, progress notes, or other documentation.
- B. Chiropractic services will not be subject to a referral from a primary care provider. However, Chiropractors will send primary care providers their case notes within 10 days of the first visit.
- C. Chiropractic services for children under the age of 12 will continue to require prior authorization and related documentation.

2004 SSI Income Rule Changes

In July 2007 Vermont Legal Aid contacted the Agency of Human Services regarding a 2004 Supplemental Security Income rule change and its impact on some Vermont Medicaid beneficiaries. This change resulted in the denial of benefits for nearly 900 recipients. The AHS has reviewed the involved beneficiaries and has granted retroactive Medicaid coverage for coinsurance and deductible balances, effective January 1st, 2006.

How does this effect the provider community?

Claims for this group of beneficiaries, processed by Medicare B, will automatically be reprocessed through EDS from Medicare. It will **not** be necessary to bill or document these claims. Reimbursement will be made to the Provider via the normal claims processing method. These payments should be applied to the patients account whether paid, written off or unpaid. If a payment is posted to an account that the beneficiary has already paid, the provider must reimburse the beneficiary any payment they made for the service.

If beneficiaries want reimbursement for DME, Hospital, RHC/FQHC and Home Health services they will need to supply documentation that they paid for the service. These services can not be billed by the Medicare Intermediary through the normal Medicare claims processing. Beneficiaries have been told that they need proof of payment, so may approach your office for proof of payment for specific dates of service. They then have to submit the proof to AHS for reimbursement of Medicare coinsurance and deductible balances. The documentation of proof of payment you can supply to the beneficiary is essential to the process and will expedite their reimbursement.

Thank you for your help with this project to reimburse these vulnerable citizens with money they should not have had to pay. For more information links to the beneficiary notifications will be available soon at www.vtmedicaid.com.

Provider questions should be directed to the EDS provider help desk at 1-800-925-1706 or out of state 802-878-7871. Beneficiary questions should be directed to 1-800-MEDICARE (1-800-633-4227) for a summary of services or for additional questions beneficiaries can call 1-802-879-8223.

New Dental Procedure/Fee Schedule for July 1, 2008

A new Dental Procedure/Fee Schedule will be effective for services provided on or after July 1, 2008. The new Dental Procedure/Fee Schedule is posted on the Vermont Medicaid website: www.vtmedicaid.com.

This new Dental Procedure/Fee Schedule reflects an overall dollar increase of approximately \$1,412,400 authorized by the State to help stabilize the dental provider network, encourage new dentists to enroll as Vermont Medicaid providers and encourage enrolled dentists to accept more Vermont Medicaid beneficiaries. The OVHA has worked in concert with the Vermont State Dental Society (VSDS) and the Vermont Department of Health (VDH), Office of Oral Health, to apply the increases.

PCP Reimbursement for Oral Health Risk Assessments

The OVHA reimburses Primary Care Providers (PCPs) for performing Oral Health Risk Assessments (OHRAs) to promote preventive care and increase access for children from 0-3.

An American Dental Association code, D0145 (Oral Evaluation for a Patient under Three Years of Age w/Primary Caregiver) was established for dentists last year. PCPs are able to bill this code as dentists would, one unit per 180 days, for children ages 0-3. The code allows for evaluation and counseling with the PCP. The Vermont Department of Health and the Office of Oral Health, in coordination with the American Academy of Pediatrics and the American Academy of Family Physicians, has identified training opportunities/requirements to educate PCPs on claiming the D0145 code. For more information, contact the Office of Oral Health at (802) 863-7341 or (800) 464-4343, ext. 7341.

General Assistance (GA) Voucher Emergency Dental Treatment Codes

GA Vouchers are issued by the Economic Services Division of the Department for Children and Families as a means of providing emergency treatment to relieve pain, bleeding and/or infection. Payment for covered services is based on the current OVHA Dental Procedure/Fee Schedule. The guidelines and procedure codes that are deemed reimbursable for beneficiaries with valid GA Vouchers have been updated for 2008. The guidelines and list can be found at: www.vtmedicaid.com under Information.

Missed Appointments/Late Cancellations

Take advantage of the capability to report missed appointments and late cancellations. Since January 2008, the OVHA included procedure codes D0999 (dental) and 99199 (medical) for reporting these problems. To ensure that your facility is accurately being represented in this data collection process, you will need to bill procedure codes D0999 or 99199 with a \$0.00 billed amount. These codes are for reporting purposes only and will not provide for reimbursement.

The OVHA intends to evaluate this data with the intent of developing processes to reduce costly missed appointments and late cancellations in the future.

NDC Requirement (Institutional)

As a reminder, the effective date for reporting NDC for electronic claim submissions, 837I or paper submission (UB04 claim form) is July 1, 2008, extended from the original January 1, 2008 start date. A list of manufacturers, by code and name that are currently participating in the rebate program, can be found at: http://www.cms.hhs.gov/medicaiddrugrebateprogram/10_drugcomcontactinfo.asp.

Pharmaceuticals supplied by these manufacturers will be the only drugs reimbursed by Vermont Medicaid. See our website www.vtmedicaid.com under Downloads/Manuals for additional information.

NPI Implementation

EDS and the OVHA would like to take a moment to express their gratitude and thank all providers for their cooperation and patience during the implementation of NPI. Although the transition was difficult and time consuming, your efforts were greatly appreciated.

Contacting EDS

EDS

312 Hurricane Lane,
Suite 101
Williston, VT 05495

Phone: 802-879-4450

Provider Services:

Out-of-State:

802-878-7871

In-State:

800-925-1706

Fax:

802-878-3440

Email:

VTProvServ@eds.com

EDI Assistance:

802-879-4450, #3

Contacting OVHA

The Office of Vermont Health Access

312 Hurricane Lane,
Suite 201
Williston, VT 05495

Phone:

802-879-5900

Fax:

802-879-5919

Hours of Operation:

Monday-Friday 7:45-4:30, excluding holidays

Attention Electronic Claim Submitters

With the implementation of NPI-only claims processing for all providers who are not considered atypical, be advised of the following: If you are submitting your claims electronically using your billing NPI, and the NPI is either invalid or not registered with Vermont Medicaid, your claims will have to be deleted from the system. This is a result of your provider information being unidentifiable by EDS. If you have multiple taxonomies associated with your NPI, you must utilize the correct NPI/taxonomy combination in order for EDS to crosswalk to your Vermont Medicaid provider number.


If you are the claim submitter, make sure your .ACK and .SUB reports indicate the files were accepted. Provided that they are, you should be able to view your claims on the website, www.vtmedicaid.com, under Claim Status one to two days after submission. If you cannot locate your claims, please contact Provider Services at (802) 878 7871. If they are unable to locate these claims as well, please verify your NPI by referring to the information posted on the website under Downloads/Provider Listings, then Active Provider list.

The NPI information provided on the claim must match the EDS database. If it does not, please correct, and resubmit your claims for processing. However, if your claims cannot be located and your NPI information is correct, please contact the EDI Coordinator at: (802) 879-4450 Option 3.

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Cherie Bergeron
Account Manager-EDS



Joshua Slen
Director-Office of Vermont Health Access

Vermont Expands Health Coverage *All Pre-Existing Conditions Covered Until November 1!*

There are even more coverage options in the Catamount Health insurance plans which are offered through BCBS of Vermont and MVP Health Care! Now you can get coverage for pre-existing conditions if you act before November 1, 2008. Additionally, if you have a very high-deductible health plan, you may also be able to purchase Catamount Health. These changes came into effect on June 10, 2008.

1. What is Catamount Health?

Catamount Health is a new health insurance plan within **Green Mountain Care** that became available October 1, 2007 for uninsured Vermonters. It offers comprehensive, quality benefits with low co-payments and premiums to keep out-of-pocket costs reasonable. The plan is offered, in cooperation with the state of Vermont, by BCBS of Vermont and MVP Health Care. Coverage was effective November 1, 2007.

2. Who can qualify for Catamount Health?

Generally, Vermont residents who have been uninsured for 12 or more months and who are not eligible for employer-sponsored coverage. You do not need to have been without health insurance for 12 months to be eligible for Catamount Health if you:

- (a) Have insurance that only covers hospital care or doctor's visits (but not both);
- (b) Had Medicaid, Vermont Health Access Plan (VHAP) or Dr. Dynasaur but became ineligible for those programs;
- (c) Within the last 12 months, you had insurance but lost it because you:
 - Lost your job or your employer reduced your work hours;
 - Got divorced or your civil union dissolved;
 - Had insurance through someone who died;
 - No longer continue your health insurance through Consolidated Omnibus Budget Reconciliation Act (COBRA) or state continuation coverage ("VIPER");
 - Are no longer a dependent on your parent or caretaker's health insurance;
 - Were getting your insurance through college and can no longer do so because you graduated, took a leave of absence, reduced your credits or stopped attending college.
- (d) Have been enrolled for at least six months in a non-group insurance plan (i.e., a policy that is not sponsored by an employer or association) with an annual deductible of no less than \$10,000 for single coverage or \$20,000 for two-person or family coverage. Please note that you will not be eligible for Premium Assistance until you have been on Catamount Health for 12 months.

3. Who is eligible for Premium Assistance under Catamount Health?

If you qualify for Catamount Health, you may be eligible to receive Premium Assistance if your family's income is at or below 300% of the federal poverty level. Generally, this means that you may be eligible for Premium Assistance if you have a monthly income of up to \$2,800 (or higher for larger households). For questions regarding eligibility for premium assistance, contact Green Mountain Care at 1-800-250-8427, TDD: 1-888-834-7898.

4. What services are covered through Catamount Health?

Catamount Health provides comprehensive coverage including doctor visits, checkups, screenings, hospital visits, emergency care, care for chronic diseases, prescription medicines and more.

Vermont Expands Health Coverage

All Pre-Existing Conditions Covered Until November 1!

5. How much does Catamount Health cost?

The current monthly premium for Catamount Health is between \$60-\$393. This price varies based on income and is subject to change. Catamount Health, like most insurance policies, is subject to cost-sharing requirements, including co-payments and deductibles. Refer to your Certificate of Coverage or contact MVP or BCBS of Vermont for specific questions about cost-sharing requirements. Currently, co-payments for office visits are \$10, prescriptions range between \$10-\$50. Deductibles are \$250 for individuals / \$500 for families (in-network).

6. Can I qualify for Catamount Health if I work?

Yes. However, it depends on whether your employer offers insurance and your monthly income. If your employer does not offer insurance, you can apply for Catamount Health regardless of your income.

7. If I make more than \$2,613* a month, but I have access to my employer's insurance, can I enroll in Catamount Health?

No. If you can have access to your employer's health insurance and make more than \$2,613 a month, you cannot enroll in Catamount Health. (*You may still qualify if your monthly income is up to \$200/month higher if you have earned income and/or child care expenses, higher for larger households).

8. What is Catamount Health's policy on pre-existing conditions and what is pre-existing condition amnesty?

A pre-existing condition is a physical or mental condition for which medical advice, diagnosis, care or treatment was recommended by or received from a provider. Generally, coverage under Catamount Health is subject to a pre-existing condition waiting period of up to one year (this is waived if you have not had a break in coverage longer than 63 days). However, there is currently a pre-existing condition amnesty:

- If you have a pre-existing condition and you apply for Catamount Health before November 1, 2008, that condition will be covered.
- If you apply for Catamount Health after November 1, 2008, you may have to wait up to 12 months for your pre-existing condition to be covered.
- If you already have Catamount Health, you are covered for services you receive related to a pre-existing condition on or after June 10, 2008. However, you are responsible for any payment for services you received for your pre-existing condition prior to June 10, 2008.

There are other important exceptions to pre-existing waiting periods under Catamount Health:

- Pregnancy is not considered a pre-existing condition and is not a reason for denial of coverage for pregnancy-related services.
- Waiting periods for certain pre-existing conditions will be waived if you participate in a chronic care management program.

If you have any questions about pre-existing conditions, waiting periods or chronic care programs, contact Catamount Blue at 1-888-445-5805 or MVP Catamount Choice at 1-888-687-6277.

9. Is pregnancy a pre-existing condition?

Pregnancy is not a pre-existing condition. In other words, if someone is pregnant at the time of application, Catamount Health plans will cover expenses related to the pregnancy.

10. If I have a high-deductible health plan, can I still buy Catamount Health?

Yes...