



State of Vermont Launches Green Mountain Care

Quality, Comprehensive Coverage for Uninsured Vermonters

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The State of Vermont launches Green Mountain Care, a family of low-cost and no-cost health coverage programs offered by the state of Vermont and its partners to reduce the number of uninsured Vermonters.

Green Mountain Care programs offer quality, comprehensive health coverage at a reasonable cost for health services such as doctor visits, hospital stays, emergency care, check-ups, immunizations, prescription medications and more. Green Mountain Care includes programs that may already be familiar, such as Medicaid, Dr. Dynasaur and the Vermont Health Access Plan (VHAP)

As of October 1, 2007, Green Mountain Care also includes:

New! Catamount Health

For adults who have been uninsured for 12 months or more (certain exceptions apply). Catamount Health also offers help with paying premiums depending on the individual's income. Although individuals under age 18 cannot purchase Catamount Health, they may be covered under a family plan. Individuals must choose their Catamount plan from either MVP or BCBS of Vermont.

Employer-Sponsored Insurance (ESI)

Assistance is now available for adults who have been uninsured for 12 months or more (certain exceptions apply), who have not accessed their employer's plan. Individuals can receive help paying for their ESI premiums depending on their income.

VHAP

-VHAP now offers assistance to individuals in order to access their ESI plan.

-As of January 1, 2008, VHAP Limited coverage will be effective as of the date of application if the individual is later deemed eligible and if any required premium is paid.

For more information visit www.GreenMountainCare.org or call 1-800-250-8427.

To order free Green Mountain Care brochures, posters and magnets go to: www.GreenMountainCare.org/outreach_center/outreach_materials.html

Web Updates:

- Provider Self-Maintenance
- DME Restrictions and Guidelines
- TPL Change Request Form
- OPPS Revenue Codes Requiring HCPCS/CPT

Communications

Alignment on Paper Claims

EDS has been observing numerous claims being submitted out of alignment which may cause the information on the claim to be in the wrong fields. This could be a result of font size or how vendors have set up billing software to input information. Please correct this alignment issue and be sure to verify the correct fields are being populated on claims prior to submission.

Be aware, effective 11/05/2007, claims submitted out of alignment will not be accepted if the data required for keying is not in the designated fields.

This issue can be eliminated by submitting claims electronically. To find out more information regarding electronic claim submission, you can contact the EDI Coordinator via email (vtedicoordinator@eds.com) or by calling 802-879-4450 Option #3. You will be required to download the EDI registration form on our website under *Downloads* and *Forms* before any submission.

ICD-9 Codes

As a reminder, it is imperative providers use the current ICD-9-CM manual in determining the appropriate diagnosis codes for the service rendered. Please be aware, all inactive or invalid diagnosis codes are being eliminated and will no longer be valid for billing.

Provider Services VS. Member Services

Providers, please be aware that when dilemmas arise such as:

- Recipient eligibility (reasoning for termination of coverage, types of coverage etc.)
- Conflicting information (date of birth, name spelling etc.)
- Issues with coverage under another insurance plan (No longer covered or coverage EDS was not made aware of), the patient should be directed to *Member Services* not *Provider Services*.

Member Services will either update the beneficiary's file or inform the appropriate benefits program specialist of the needed update. Once the update is entered, the eligibility system updates the EDS files within 24 hours. EDS does not have the ability to change or update any patient information. Please refer the beneficiary to **1-800-250-8427** for further assistance.

Appropriate Billing

Providers should always code their services and charges in accordance with the correct coding procedures by implementing all reference materials available. This includes current CPT, HCPCS and ICD-9 manuals which should always be used in determining correct and valid coding prior to consulting the on-line published fee schedules.

Providers should never bill with a specific code simply because it is currently valid or will reimburse at a higher rate than another, possibly more appropriate procedure code. The fee schedule, which is available on the Vermont Medicaid website, published by EDS/OVHA, contains all currently accepted, covered and non-covered CPT and HCPCS codes. If the code you are intending to bill is not currently on the fee schedule, you may request the OVHA, with reasoning, to consider accepting it by sending an email to: vermonthipaacontact@eds.com.

However, if there are concerns about coverage policies or payment levels on the current coding guidelines set by the state, the provider must submit all requests in writing to the OVHA for consideration.

Important Websites & Email Addresses:

vermonthipaacontact@eds.com

NPI Look-UP:
<https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do>

OVHA Coverage Guidelines:
<http://OVHA.Vermont.gov/providers/clinical-coverage-guidelines>

OVHA DME Guidelines:
<http://OVHA.Vermont.gov/providers/clinical-coverage-guidelines>

Notifications From the Clinical Unit at OVHA

Ultraviolet Light Therapy

Guidelines for coverage of Ultraviolet Light Therapy are available on the OVHA website:

<http://OVHA.Vermont.gov/for-providers/durable-medical-equipment-s-u>

Coverage is limited to dermatological conditions and requires prior authorization. This coverage does NOT include phototherapy in the home (the bilirubin light, HCPCS code E0202). This treatment is usually ordered for neonatal jaundice which is not considered a dermatological condition and which necessitates closer medical monitoring than can be safely provided in the home.

Rehabilitative Therapies

PT/OT/ST-The revised guidelines are now available on the OVHA website at:

<http://OVHA.Vermont.gov/for-providers/clinical-coverage-guidelines>

It is imperative that you review the diagnosis restrictions in these guidelines.

Procedure Code S3855

Temporary National (non-Medicare) procedure code S3855, for presenilin gene testing, is non-covered by VT Medicaid. This test is considered experimental and investigational and not medically necessary.

At this time, performance of this test does not improve a patient's clinical outcome or change their medical management.

Prior Authorization Reminder

Unlisted/miscellaneous procedure codes require prior authorization unless specific instructions are given indicating otherwise. This is not a change; VT Medicaid has always required prior authorization for codes with non-specific descriptions. Providers were also reminded of this on the RA dated 3/10/2006.

Attention Providers

Banner Page Email Addresses

All providers are aware that weekly banner pages are available via email. However, several of the email addresses that have been provided to the EDS Communications Coordinator, are no longer valid, resulting in an inability to receive these weekly notifications.

If you wish to continue receiving banner pages via email, please send updated address information to: VTMedicaidBanners@eds.com

Contact Us

To request notifications
via email:

Vtmedicaidbanners@eds.com

For EDI assistance:

vtedicoordinator@eds.com or 802-879-4450, #3

For EDS Provider
Services:

802-879-4450 or
vtprovserv@eds.com

For claims assistance:

In State: 800-925-1706
or: 802-878-7871
or Fax: 802-878-3440

OVHA

312 Hurricane Lane,
Ste. 201
Williston, VT 05495

Phone: 802-879-5900

Fax: 802-879-5919

Hours of Operation:
Monday-Friday

7:45 — 4:30, excluding
holidays.

Reimbursement Methodology

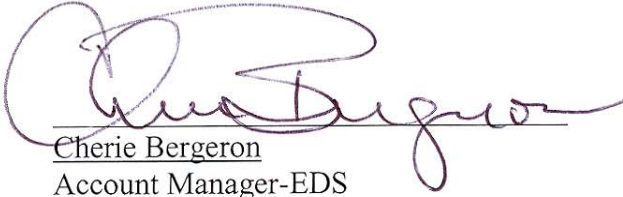
The OVHA intends to change payment methods for both inpatient and outpatient care. Effective January 1, 2008, the OVHA will implement DRG pricing logic for all inpatient claims. During the review and analysis of the historical claims data, the following issues surfaced that will impact the DRG payment methodology:

- Correct coding of the discharge code-particularly when the patient is discharged (transferred) to another hospital
- Interim billing will no longer be supported under DRG model as the payment is based on the entire length of stay.


*Please note that the following requested changes in billing will not change our current pricing methods.

Effective April 1, 2008, the OVHA will implement the Outpatient Prospective Payment System (OPPS) modeled after Medicare. To determine the full financial impact of this payment system, the OVHA will require an additional level of detailed information on outpatient claims. The following changes to billing requirements will be effective 11/01/2007.

- Discontinue the billing instruction to 'roll-up' services at the revenue code level
- Require HCPCS/CPT for a distinct list of revenue codes (available at www.vtmedicaid.com click on *Downloads* and then *Manuals*)
- Ensure only valid ICD-9 diagnosis codes are reported
- Late charges to original claims will need to be submitted as an adjustment.



Cherie Bergeron
Account Manager-EDS



Joshua Glen
Director-Office of Vermont Health Access

There may be instances where there is more than one NDC code to a HCPCS code.

Example: J code → NDC/Manufacturer #1
→ NDC/Manufacturer #2 }
→ NDC/Manufacturer #3

Choose the NDC from the manufacturer that was physician-administered to the patient at that time.

If a HCPCS code being billed for a drug that is physician administered, then that drug can be cross walked to an NDC. If the drug is self administered, it does not require an NDC or HCPCS

Please note the following:

If an NDC is billed with a CMS Termination Date, (product that has been replaced, discontinued, shelf life expiration of the last batch sold or pulled from the market because of health or safety reasons), in effect for the service dates, the HCPCS detail will be denied.

When a drug is billed with a DESI (Drug Efficacy Study Implementation) value, the HCPCS detail will be denied. The DESI value indicates the drug is less than effective for all indications or is less than effective and has been withdrawn from the market.

When a manufacturer or labeler does not have a rebate agreement with CMS in effect for service dates billed or NDC is not rebate-eligible, the HCPCS detail will be denied. The following link has a list of manufacturers/labelers who have a rebate agreement with CMS at the present time, http://www.cms.hhs.gov/MedicaidDrugRebateProgram/10_DrugComContactInfo.asp

You can find other information regarding Medicaid Drug Rebate Program by visiting: <http://www.cms.hhs.gov/MedicaidDrugRebateProgram/>

Please note that NUBC (National Uniform Billing Committee), has adopted reporting instructions for Medicaid Drug Rebate Information and can be found at www.NUBC.org under “What’s New.”

**Updated information will be provided through banner pages and advisories.