



## SPECIALTY PHARMACY ANNOUNCEMENT

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In 2007, the Office of Vermont Health Access sought bids from specialty pharmacies to provide services for the treatment of such conditions as hemophilia, growth hormone deficiency and multiple sclerosis and the prevention of respiratory syncytial virus (RSV) (a condition that is the leading cause of pneumonia and bronchitis in infants). Additional potential conditions identified included hepatitis, cystic fibrosis, cancer and deep-vein thrombosis.

Two specialty pharmacies have been selected to service Vermont Medicaid beneficiaries. Effective October 1, 2008, Wilcox Medicaid DBA Wilcox Home Infusion will be the specialty pharmacy for Synagis® (which is administered to prevent RSV). Effective November 3, 2008, ICORE Healthcare, LLC, partnering with our pharmacy benefits administrator, MedMetrics Health Partners, will be the specialty pharmacy for all other conditions. Both providers were selected based on a combination of the value of the services they offered and the price of the products involved. The initial focus will be RSV prevention and Synagis® therapy as provided by Wilcox Home Infusion and the conditions targeted for management by MedMetrics/ICORE: hemophilia, growth hormone deficiency, multiple sclerosis, hepatitis C and Hunter’s Syndrome. The targeted medications may only be obtained from the above mentioned specialty pharmacies.

There will be active outreach to prescribers and patients who are currently maintained on these therapies. New prior authorization/prescription order forms have been created and are available at:

<http://ovha.vermont.gov/for-providers/pharmacy-prior-authorization-request-forms>.

Please contact the appropriate specialty pharmacy listed below if you have any questions regarding the process.

Contact Information:

*Wilcox Medical DBA Wilcox Home Infusion for Synagis®:*  
Phone: (800) 639-1210 Fax: (802) 775-7824

*ICORE Healthcare/MedMetrics Health Partners for hemophilia (factors), growth hormone deficiency, multiple sclerosis (Avonex®, Betaseron®, Copaxone® or Rebif®), hepatitis C (peg-interferons and ribavirin), and Hunter’s Syndrome (Elaprase®):*  
Phone: (800) 327-1392 Fax: (866) 364-2673.

Web Updates:

- Fee Schedules
- PAC 8 & 9 Listing

**HEADERS, DETAILS, & THE “777” DENIAL CODE**

Some providers may notice the ‘777’ denial code on their Remittance Advice (RA) which states “Denied Service, please see header EOB information.” As shown in the sample RA below, the 777 denial code directs you to the header denial code (i.e. 0009); the FIRST number that appears below the patient’s LAST name.

	SMITH, JOHN P	<del>00942114X</del>	402008111222123	00	12952270	
	0009	140	0.00			
Header	001	00	09/08/04	09/08/04	99242	1.000
Denial		0093/42			0.00	153.00
Code	002	00	09/08/04	09/08/04	95904	3.000
		0093/42			0.00	444.00
	003	00	09/08/04	09/08/04	95860	1.000
		0093/42			0.00	279.00
					0777/17	
					0777/17	
	CLAIM TOTALS:					

↑  
Detail Denial Codes

Typically, header denials address problems with basic information, such as beneficiary names or provider numbers. EOB codes commonly found in the header are 008 (Beneficiary number not on file), 009 (Recipient name and number do not match), or 011 (Provider name and number must match that which is on the enrollment form). All EOB codes are explained on the last page of the RA.

**OTHER INSURANCE DENIALS AND APPEALS**

- 1.) When the Vermont Medicaid beneficiary’s primary insurer (including Medicare) denies a claim as “non-covered” or “benefits exhausted”, the provider does not need to appeal to that primary insurer before billing Medicaid. However,
  - a) If the code/service requires prior authorization (PA) from VT Medicaid, then the provider will need to request retrospective authorization from the OVHA in the regular manner (fax all standard documentation required for a clinical review) and include a copy of the other insurer’s (or Medicare’s) denial.
  - b) If the code/service does NOT require prior authorization (PA) from VT Medicaid, then the provider can bill Medicaid directly with a copy of the primary insurer’s denial attached.
  
- 2.) When the Vermont Medicaid beneficiary’s primary insurer (including Medicare) denies a claim for other reasons (such as “not medically necessary”, “pre-existing condition” or “waiting period not met”), the provider must first appeal to the primary insurer. Only after all OI/Medicare appeals (through the Qualified Independent Contractor level and BISHCA if eligible and available) are denied can the provider then request coverage by VT Medicaid. All documentation showing the original and appeals’ denials must be attached. However,
  - a) If the code/service requires prior authorization (PA) from VT Medicaid, then the provider will need to request retroactive authorization from the OVHA in the regular manner (fax all standard documentation required for a clinical review ) and include copies of the other insurer’s or Medicare’s denials and appeals.
  - b) If the code/service does NOT require prior authorization (PA) from VT Medicaid, then the provider can bill Medicaid directly with copies of the primary insurer’s denials (original and appeals) attached.
  
- 3.) For beneficiaries covered by Medicare, the requirement to go through the Medicare Qualified Independent Contractor appeal level applies with the exception of wheelchairs that Medicare denies or downgrades. Upon documentation of the Medicare action, Medicaid will make its own medical necessity and payment determination.
  
- 4.) The OVHA will reject a request if there is reason to believe that the OI received incorrect or incomplete information on which to base its decision.
  
- 5.) It is highly recommended that providers determine OI/Medicare benefits before rendering the service to minimize the risk of non-coverage by both OI or Medicare and the OVHA.

### MEDICARE ATTACHMENT SUMMARY FORM

In an effort to standardize and simplify the processing of **Medicare** paid crossover claims, Vermont Medicaid is introducing the "Medicare Attachment Summary Form". Beginning January 1, 2009 this form will be the only acceptable attachment for billing Medicare crossover claims **on paper**. The Explanation of Medicare Benefits (EOMB) form for paper crossover submissions will no longer be required. However, the EOMB is still required for claims denied by Medicare. Please note, claims received after January 1, 2009 will be returned to the provider if the Medicare Attachment Summary Form is not attached to **paper** claims.

The benefits include:

- A more efficient, accurate and expeditious processing of crossovers
- Aid in complying with HIPAA Privacy regulations
- Eliminate the need to submit EOMBs for paid crossover claims

This form will be available on December 1, 2008 at [www.vtmedicaid.com](http://www.vtmedicaid.com) under Downloads/Forms.

EDS offers FREE electronic billing software! Provider Electronic Solutions (PES) is available and easy to download. All providers are highly encouraged to use PES for electronic claim submissions.

### ATTENTION: ELECTRONIC CLAIM SUBMITTERS

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 us to crosswalk to your Vermont Medicaid provider number.

If you are the submitter, make sure your .ACK and .SUB report indicates the files were accepted. Provided that they are, you should be able to view your claims on the website ([www.vtmedicaid.com](http://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 number 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.

### STAPLES & PAPER CLIPS REMINDER

As a reminder, EDS would like providers to refrain from the use of staples or paper clips to attach additional information to paper claims. The staples and paper clips used to attach documentation to claims are removed manually prior to the scanning process which increases the time needed to process the claims.

Also, if the claim tears from the removal of the staple, this may cause the scanner to jam, which again may result in a delay in the overall process time of your claim.

EDS apologizes for any inconvenience this may cause providers, but in an effort to simplify the claims process, EDS must discourage the use of staples and paper clips.

### EDS, an HP Company

312 Hurricane Lane,  
Suite 101  
Williston, VT 05495

Phone:  
(802) 879-4450

*Provider Services*

Hours of Operation:  
8:00am-5:00pm

Out-of-State:  
(802) 878-7871

In-State:  
(800) 925-1706

Fax:  
(802) 878-3440

Email:  
[VTProvServ@eds.com](mailto:VTProvServ@eds.com)

*EDI Assistance*

Phone:  
(802) 879-4450, #3

Email:  
[VTEDICoordinator@eds.com](mailto:VTEDICoordinator@eds.com)

### The Office of Vermont Health Access

312 Hurricane Lane,  
Suite 201  
Williston, VT 05495

Phone:  
(802) 879-5900

Fax:  
(802) 879-5919

<http://ovha.vermont.gov>

Hours of Operation:

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

## REPORT MISSED APPOINTMENTS/LATE CANCELLATIONS

Dental providers are encouraged to report missed appointments and late cancellations. Since January 2008, the Office of Vermont Health Access has included the procedure code D0999 for reporting these problems. To ensure that your facility is being accurately represented in this data collection process, you will need to bill procedure code D0999 with a \$0.00 billed amount. This code is for reporting purposes only and will *not* provide for reimbursement.

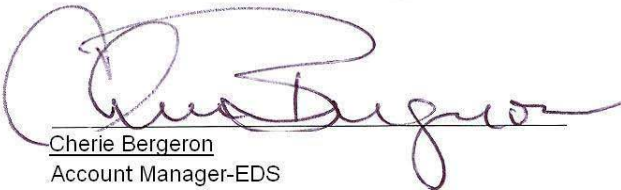
The Office of Vermont Health Access intends to evaluate this data with the intent of developing processes to reduce costly missed appointments and late cancellations in the future.

## AUTOMATED MEDICAID CAP INFORMATION

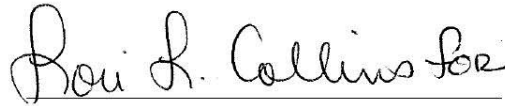
As a reminder, there is a system enhancement available that allows enrolled dental providers to access Medicaid cap information for adult benefits automatically. The annual cap for adult benefits is set at \$495. Adult dental cap information is available through the use of the Web Eligibility Verification Response ([www.vtmedicaid.com](http://www.vtmedicaid.com)) or through the automated Voice Response System (802-878-7871).

Specific instructions on the use of these systems can be found in the Provider Manual at [www.vtmedicaid.com](http://www.vtmedicaid.com) under Downloads/Manuals/Provider Manual.

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Account Manager-EDS



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Director-Office of Vermont Health Access