



GreenMountainCare
A HEALTHIER STATE OF LIVING

CMS 1500 Supplement

to the Provider Manual



**AGENCY OF HUMAN SERVICES
OFFICE OF VERMONT HEALTH ACCESS**



HP Enterprise Services

SUMMARY OF UPDATES

*Please note: All changes/updates will be indicated in **red font**.
For a detailed summary of all updates made to this Supplement, please refer to page 48.

The following information has been added to this Supplement:

<u>DATE UPDATED</u>	<u>TOPIC</u>	<u>PAGE NUMBER</u>
07/24/2009	Maintenance Drug Prescriptions	26
	Apnea Monitors	39
	DME Recycling	40
08/25/2009	BICROS/CROS (Contralateral Routing of Sound)	39
	DME Billing	40
	Special Needs Feeder Bottles	46
12/24/2009	PHARMACY TAX ASSESSMENT FORM	32
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CMS 1500

INTRODUCTION

This supplement to the Provider Manual contains billing information and specific instructions for completion of the CMS-1500 claim form for physicians and other specified practitioners including audiologists, chiropractors, dentists, naturopathic physicians, nurse practitioners, podiatrists, psychologists, and transportation (emergency and non-emergency) providers.

Billable services are located in Section 1.4 and are listed in alphabetical order. The billable services under the Vermont Medicaid programs are too numerous to list in their entirety, and therefore, only a selection of services is noted in detail.

Contact the EDS Provider Services Unit at 1-800-925-1706 should you need assistance with unique billing problems or instructions.

SECTION 1.1

CMS-1500

Billing Instructions

All information on the CMS-1500 claim form should be typed or legibly printed. Only the 08/05 version of this form is accepted for processing. The field locators listed below are used by EDS when processing Vermont Medicaid claims. The field locators designated by an asterisk (*) are mandatory; other field locators are required when applicable. The field locators not listed below are not used in the Vermont Medicaid program and do not need to be completed.

FIELD LOCATOR

REQUIRED INFORMATION

1. CARRIER IDENTIFICATION

Check the Medicaid box.

1a. INSURED'S ID NUMBER*

Enter the nine-digit Vermont Medicaid ID number as shown on the beneficiary's Vermont Medicaid ID card.

2. PATIENT'S NAME*

Enter the beneficiary's last and first name.

10. CONDITION RELATED TO*

Check appropriate box to indicate:
a. If condition is related to employment
b. If condition is related to an auto accident
c. If condition is related to any other type of accident.

If yes is checked in any of these boxes, enter the accident date in field locator 14.

11. INSURED'S POLICY NUMBER

If the beneficiary has other health insurance (excluding Medicare), enter the applicable policy number.
a. Enter the insured's date of birth

	in MMDDYY format; check the appropriate box to indicate insured's sex.
	b. Enter the insured's employer or school name.
	c. Enter the name of the other health insurance carrier.
14. DATE OF CURRENT	If your response indicates a 'yes' in field locators 10a, 10b or 10c, enter the date of the occurrence.
15. SAME OR SIMILAR ILLNESS	Enter the therapy start date in MMDDYY format if billing physical, occupational or speech therapy.
17a. TAXONOMY/REFERRING PROVIDER	Enter the referring provider's taxonomy code when applicable.
17b. NPI/REFERRING PROVIDER*	Enter the referring provider's NPI. Enter the prescribing NPI for independent lab and DME suppliers.
19. LOCAL USE	Use this field to explain unusual services or circumstances.
21. DIAGNOSIS CODE(S)*	Enter the appropriate IDC-9-CM diagnosis code that relates to the service rendered. You may use up to four diagnosis codes.
24a. DATE(S) OF SERVICE*	Enter the date of each service provided. If the From and To dates are the same, the To date is not required.
24b. PLACE OF SERVICE*	Enter the appropriate two digit place of service code.
24c. EMG	Enter '1' to indicate if the service provided was the result of an emergency. *This field is mandatory only if emergency services were provided.
24d. PROCEDURE CODE*	Enter the appropriate procedure code to explain the service rendered.
24e. DIAGNOSIS POINTER*	Enter the appropriate diagnosis 'pointer' that relates to the service rendered (1 or 2 or 3 or 4) and corresponds to the diagnosis from field locator 21.

24f. CHARGES*	Enter the usual and customary charge for the service rendered.
24g. DAYS OR UNITS*	Enter the number of days or units of service which were rendered.
24h. EPSDT/FAMILY PLAN	Enter one of the following Vermont Medicaid EPSDT and Family Planning indicators: 1-Both EPSDT and Family Planning 2-Neither EPSDT nor Family Planning 3-EPSDT Only 4-Family Planning Only 5-Ladies First
24j. ATTENDING PROVIDER*	Enter attending physician's NPI. Enter the billing provider NPI for independent labs and DME suppliers. If Atypical, enter the 7-digit Vermont Medicaid ID number in the shaded area.
26. PATIENT'S ACCOUNT NUMBER	Enter the account number you have assigned to the beneficiary. EDS can accept up to 12 digits; alpha, numeric, or alpha/numeric in this field. This information will print on the Remittance Advice summary for your accounting purposes.
28. TOTAL CHARGE*	Add the charges from field locator 24f for each line and enter the total in this field.
29. AMOUNT PAID*	Enter the amount paid by other health insurance coverage, including contractual allowance if applicable (exclude Medicare payments). If this field is completed, field locators 11a, 11b and 11c must also be completed. Enter spend down if applicable. Documentation must be attached if the services are not covered by the primary, or if the payment by the primary is \$3.00 or less.
31. SIGNATURE*	Enter the provider's signature or facsimile, or signature of the provider's authorized representative. Enter the date of the signature.

33. BILLING PROVIDER*

Enter the **payee** provider name and address.

33a. BILLING PROVIDER'S NPI*

Enter the billing provider's NPI.

33b. BILLING PROVIDER'S TAXONOMY

Enter the billing provider's taxonomy code when applicable. If Atypical, enter the 7-digit Vermont Medicaid ID number in the shaded area.

SECTION 1.2

REIMBURSABLE SERVICES

This supplement applies to all CMS 1500 billers. The OVHA uses CMS Common Procedure Coding System to describe reimbursable items. Certain reimbursable services require prior authorization. For complete details and codes that require prior authorization, see the Fee Schedule available at: www.vtmedicaid.com under Downloads/Manuals.

SECTION 1.3

NON-REIMBURSABLE SERVICES

No payment will be made for a service or item that is not reimbursable, unless authorized by the OVHA for reimbursement via section M108/7104 of Medicaid rules. These authorizations may be made only when serious detrimental health consequences would arise. Any beneficiary interested in applying, may contact the Member Services Unit for the required forms. This process is available to Vermont Medicaid beneficiaries (i.e. not VHAP).

The following list identifies some of the most frequently billed non-reimbursable services:

- Acupuncture
- Biofeedback Therapy
- Cellular Therapy
- Certain prescription drugs
- Cochleostomy with neurovascular transplant for Meniere's disease
- Colonic irrigation
- Cosmetic surgery-Providers are reminded that cosmetic surgery and expenses incurred in connection with such surgery, are not covered by Vermont Medicaid. Coverage is available only when such surgery is required for the prompt repair of accidental injury or the improvement of the functioning of malformed body members (that coincidentally serves some cosmetic purpose). Examples of such required surgeries include the treatment of severe burns, facial repair following an auto accident, or severe congenital malformations.
- Electrosleep therapy
- Endothelial cell photography
- Experimental and/or investigational procedures
- Eyeglasses for adults
- Hair analysis
- Hemodialysis for the treatment of cancer
- Hospital and ancillary services related to a non-covered surgery
- In vitro fertilization
- Laetrile and related substances

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- Low intensity direct current treatment of ischemic skin ulcers
 - Non-medically necessary services
 - Non-rebate National Drug Code (NDC)
 - Oxygen treatment of inner ear/carbon therapy
 - Plethysmography, category II
 - Poison ivy desensitization
 - Prolotherapy, joint sclerotherapy and ligamentous injections with sclerosing agents
 - Repeat sterilizations
 - Reversal of sterilizations
 - Routine foot care
 - Services performed for administrative reasons
 - Services related to any non-reimbursable service, such as services ancillary to the reversal of a sterilization
 - State-supplied vaccines
 - Sterilization under age 21 at the time of signature on the consent form
 - Thermal (capsular) heating/shrinkage procedures/surgery
 - Thermogenic therapy
 - Transvenous (catheter) pulmonary embolectomy

SECTION 1.4 BILLING INFORMATION

ABORTIONS

Induced abortions are billable only with Physician Certification. There are two different payment sources for abortions.

1. Vermont Medicaid

Vermont Medicaid, with the completion of Physician Certification form OVHA 219A, reimburses for abortions performed because the pregnancy is a result of rape or incest, or when the mother's life is endangered were the fetus carried to term. This consent form and the medical documentation of the situation are required to be sent to EDS with each claim. Payment for these abortions will continue to be made by EDS and reported on the remittance advice.

Spontaneous and missed abortions completed surgically are billable under Vermont Medicaid with use of the appropriate procedure and diagnosis codes. A certification form is not required. These abortion services will be billed to EDS for all beneficiaries.

Vermont Medicaid does not reimburse for abortions performed by Certified Nurse Midwives.

2. State Funds

Abortions considered medically necessary (elective), with the completion of Physician Certification form OVHA 219B, are billable to EDS but are paid by the Department for Children and Families (DCF) funding.

Both physician certification forms OVHA 219A & 219B can be obtained online at: www.vtmedicaid.com or by request from EDS (P.O. Box 888, Williston, VT 05495). The form must be completed, signed and attached to the claim when submitted for processing.

Abortion Diagnosis Codes

Diagnosis codes in the 637 group (Unspecified Abortion) will not be accepted by Vermont Medicaid. When billing, use a more specific abortion diagnosis code. Providers should refer to

the current ICD-9-CM manual under spontaneous, missed or induced abortions for the correct code.

AIDS

Vermont residents not covered by the OVHA may be eligible for coverage of AZT and DDI, and/or for benefits through the HIV/AIDS Health Insurance Assistance Program. Application for this benefit may be obtained by writing to: AMAP Coordinator, Department of Health-Aids Medication Assistance Program (AMAP), P.O. Box 70, Burlington, VT 05402.

ALCOHOL/DRUG DETOXIFICATION TREATMENT

Physicians and ADAP (Alcohol & Drug Abuse Programs) provide services for inpatient alcohol/drug detoxification and are payable when provided within the geographical limits of the state. Treatment facilities outside the state that wish to bill the OVHA, including designated border facilities, must receive prior authorization. A request for prior authorization must be made by or on behalf of the referring or admitting physician. No telephone authorizations will be granted.

ADAP providers must bill services using their ADAP NPI (with taxonomy code when applicable) as the attending number, as well as continue to put the ADAP NPI number in field locator 33a.

AMBULANCE SERVICES

All the following conditions must be met before reimbursement will be made:

1. The vehicle and personnel must be certified for participation in Medicare.
2. A physician or nurse must order ambulance transport and certify it as medically necessary (any other mode of transport would have endangered the health of the beneficiary).
3. The beneficiary is transported to the nearest appropriate facility.

Vermont Medicaid is the payer of last resort. All other insurances, Medicare and town or city government must be billed prior to submitting a claim to Vermont Medicaid.

The completed claim must show the total loaded miles, i.e. the full number of miles the beneficiary was on board/transported. Other services incidental to the beneficiary's condition such as disposable supplies, oxygen, tolls and ferry expense are reimbursed when detailed on the claim. The invoice or receipt must be attached.

Ambulance providers must enter their own NPI in field locator 24j for each procedure code. The ambulance provider NPI must also be entered in field locator 33a with the provider name and address.

Basic/base rates include all procedures (e.g. administration of medications, application of splints). The OVHA does not accept the modifiers utilized by Medicare. Air mileage is included within the ambulance service code and is not to be billed out separately.

AMBULANCE SERVICE

<u>FROM</u>	<u>PLACE OF SERVICE</u>	<u>ALLOWED</u>
1. Beneficiary's home or nursing home	Hospital, inpatient admission	Yes
2. Hospital or nursing home or discharged as inpatient	Home, inpatient admission to another hospital, nursing home	Yes
3. Home or nursing home	Hospital and return for specialized diagnostic or therapeutic services (not simple follow-up visits)	Yes
4. Inpatient hospital status	Another hospital and return for specialized diagnostic or therapeutic services not available at first hospital	No*
5. Scene of accident	Hospital for emergency room or inpatient admission	Yes
6. Home or nursing home	Hospital based renal dialysis facility and return	Yes
7. Home	Physician's office	No
8. Physician's office	Home	No
9. Home or hospital	VT Respite House	Yes

*This service is paid for by the hospital where trip originates.

Medicaid does not reimburse for miles accumulated when the beneficiary is not on board, or for waiting time.

Physician Certification: Ambulance providers are required to keep a completed Certification of Medical Necessity (CMN) in every Vermont Medicaid beneficiary's file substantiating each claim submitted for payment. A physician, a registered nurse or a licensed practical nurse must sign this CMN. If the Medicare CMN form is used, the origin and destination must be written on the form.

Physicians are reminded that they are certifying "other methods of transportation are medically contraindicated" or "means of transportation other than ambulance would endanger the beneficiaries health." Since Vermont Medicaid pays for other forms of transportation (e.g., taxi, bus) to and from medically necessary services, beneficiaries are able to access health care with no personal expense. Both the Vermont Medicaid program and Vermont ambulance service providers ask physicians to order and certify only those trips that are medically necessary, and to expedite their handling and return of the forms to the ambulance service.

A copy of the ambulance CMN form is required to be sent in with claims for non-emergency transport services for chemotherapy, dialysis and radiation treatment/services. The certification must state why other means of transportation were not acceptable. A CMN is not required with claims for emergency transport.

ANESTHESIA

Payment is provided for anesthesia administered by an anesthesiologist, Certified Registered Nurse Anesthetist (CRNA) or anesthesia assistant who remains in constant attendance during the surgical procedure, for the sole purpose of providing the anesthesia service. Payment is not reimbursable for the operating physician when billing for the administration of anesthesia. The administration of anesthesia by the operating M.D. is included in the reimbursement for the surgery.

Medical Direction of Anesthesia: When services are performed by non-physician anesthetists and medically directed by the physician anesthesiologist, reimbursement may be made to the physician for medical direction of the anesthetist. In order to be reimbursed for medical direction, the physician must:

1. Direct no more than four concurrent anesthesia procedures
2. Be physically present in the operating suite and available for immediate diagnosis and treatment of emergencies
3. Perform a pre-anesthetic examination and evaluation
4. Prescribe the anesthesia plan
5. Personally participate in the most demanding procedures in the anesthesia plan, including induction and emergent
6. Monitor the course of anesthesia administered at frequent intervals
7. Ensure that a qualified individual performs any procedures in the anesthesia plan not done by the physician
8. Provide indicated post-anesthesia care

All anesthesia services billed to Vermont Medicaid must be billed as one unit = 15 minutes.

Oral surgery billed on a CMS 1500 using CPT coding is subject to the same rules as a physician. The fee for anesthesia provided during oral surgery by the operating physician or dentist is included within the payment for the surgical procedure. This is different from payments for dentistry. See: Oral Surgery

Allowable Modifiers

Billable by the Anesthesiologist:

AA-Services performed by an Anesthesiologist not medically directing.

QY-Medical direction of one case

QK-Medical direction of 2, 3 or 4 cases

AD-More than 4 cases (This change in current Vermont Medicaid policy follows Medicare's reduction in base units from 4 to 3 for this modifier).

Billable by the CRNA or Anesthesia Assistant:

QX-Service with medical direction by Anesthesiologist

Billable by the CRNA only:

QZ-Service without medical direction by Anesthesiologist

Billable by the CRNA or Physician:

QS-Monitored anesthesiology care services

The QS modifier is for informational purposes. Providers must report actual anesthesia time on the claim.

All anesthesia codes must be billed with the appropriate modifier. Reimbursement may be extended to the services of more than one anesthesiologist when written justification is attached to the claim with a copy of the operative report and the anesthesia record. Use modifier 22 (manual review) after the modifiers AA or QZ.

Epidural Catheter-Pain Management: In keeping with Medicare policy, the OVHA cannot pay either spinal cord catheter introduction or pain management on the same date as surgery and/or general anesthesia. Spinal catheter introduction and pain management is included within the surgical and anesthetic reimbursements. Daily management of epidural or subarachnoid drug administration is payable only after the day on which the catheter was introduced.

Units of Service: Anesthesia services (procedure codes which begin with zero in the CPT) must be billed in quarter hour units of service (one unit=15 minutes) for charted time only; do not add in the anesthesia base. Total minutes should be divided by 15 and rounded to nearest unit (i.e. .49 and under, round down and .5 and over, round up). This time begins when the anesthesiologist/CRNA prepares the beneficiary for the introduction of anesthesia and ends when the anesthesiologist/CRNA is no longer in constant attendance. Included within the scope of this payment are pre and post-operative visits, the administration of anesthetic, and the administration of any fluid or blood incident to the anesthesia or surgery.

Local Anesthesia: Reimbursement for local anesthetic is included in the reimbursement for the procedure. Local anesthesia is never reimbursed as a separate service. This includes Novocain or topical anesthesia used by dentists.

Monitoring Services: The services of an anesthesiologist required to monitor the beneficiary during surgery performed under local anesthesia are reimbursable. A narrative justification for the service must accompany the claim.

Spinal Injection/Nerve Block: Nerve blocks performed concurrent with surgery or on the same date of service as surgery are reimbursed as part of the surgical code payment and are not to be billed separately.

When a spinal injection or nerve block (e.g. procedure codes in the 622—and 644—series) is performed as an independent procedure for diagnostic or therapeutic reasons (not concurrent with surgery), it is billed as the surgical procedure. The physician, regardless of specialty (e.g. anesthesiologist, surgeon, etc.) must bill on a CMS 1500 claim form using the specific procedure code for the type of nerve block performed. A unit of service is not time expended: one nerve block=one unit of service.

Pre-Surgical Examination: Pre-surgical examination is reimbursable as part of the surgical procedure code payment. Only when the surgery is cancelled will the pre-surgical examination be reimbursed as a separate service.

ANTINEOPLASTIC DRUGS

Antineoplastic drugs or agents necessary in the treatment of malignant diseases are reimbursed by Vermont Medicaid and are to be billed by the physician/physician group only when the physician/physician group has purchased the drug. Only drugs administered by parenteral infusion, perfusion and intracavity means will be paid. Reimbursement follows Medicare or by invoice. Use the appropriate HCPCS J----code and NDC. For the administration of antineoplastic agents in the office or physician-based clinic, see procedure codes in the 964-- section of the CPT manual. The appropriate-level evaluation and management procedure code for the visit may also be billed.

ASSISTANT SURGEON

Reimbursement of services is limited to the Medicare list of procedures requiring an assistant. It is further limited to one assistant surgeon during an operative session. An assistant surgeon is reimbursed at 25% of the allowed amount paid to the primary surgeon for the procedure. Use the appropriate modifier with the surgical code when billing for assistant surgeons:

- 80-Assistant surgeon (must be an MD)
- AS-Physician's assistant

Many procedure codes do not require an assistant surgeon and therefore, Vermont Medicaid will not reimburse for the service. Assistant surgeon services are not to be billed in cases of co-surgery. In the case of co-surgery, each provider should bill on paper with the appropriate procedure code without a modifier and attach all related operative notes.

ATTENDING PHYSICIAN

The attending provider must be enrolled as an OVHA provider. When a group NPI number is used in field locator 33a, the attending physician must be a member of the group. A group NPI number is never acceptable in field locator 24j as the attending physician. The provider name, address and number to which payment will be made must appear in field locator 33. This can be either a group or an individual provider number. Both field locators 24j and 33a are mandatory.

AUDIOLOGICAL SERVICES

Payment of certain audiological services may be limited depending on the beneficiary's age.

Batteries: One package of 6 batteries is reimbursable per month when there is a written prescription from the physician. Prior authorization is not required. A completed Medical Necessity Form (MNF), substantiating medical need for the hearing aid, must be kept on file for auditing purposes.

Hearing Aid Repairs: Do not require prior authorization. The cost of repairs/modifications should be less than 50% of the cost of replacing the aid. Repairs must never be billed on hearing aids that are still under warranty (new or repair/replacement). A prior authorization is required if a second repair is needed within 365 days of a previous repair.

Only digital hearing aids in code range V5255-V5261 allow modifier "TJ" (child and/or adolescent). The "TJ" modifier triggers a higher allowed amount to cover more sophisticated programming capability when medically necessary. For monaural codes, "TJ" will be the second modifier because modifier RT and LT must be given first (e.g. V5255RT/TJ).

The OVHA does not pay for "CIC" (completely in the canal) hearing aids.

Cochlear Implant (re)Programming: CPT codes 92601-92604 are accepted for diagnostic analysis of cochlear implants with (re)programming. This service (cochlear rehab, cochlear reprogramming, speech processor remapping) is billed as: 1 units=1 hour and is limited to a maximum of 8 hours per session and 18 hours per year (365 days) per beneficiary. Do not bill when (re)programming is not done.

BILATERAL PROCEDURES

When bilateral surgical procedures are performed during the same operative session, and the CPT code's description does not already state "bilateral", bill the CPT code only once using modifier 50. Bill one unit only. The system will allow one 150% payment. Bilateral radiology services do not allow modifier 50.

CAPSULE ENDOSCOPY (Esophagus through Ileum)

Capsule Endoscopy is a reimbursable service by Vermont Medicaid and requires prior authorization from the OVHA. The cost of the capsule and the physician fee are included in the payment. This procedure code should be billed as one unit and includes a global follow-up care period of 90 days post-procedure. Providers should obtain prior authorization before scheduling the procedure.

Capsule endoscopy of only the esophagus is not covered.

CAST, SPLINT AND STRAPPING MATERIALS

Materials for casting, splinting and strapping, etc., are payable. Refer to your HCPCS listing for a full description of the allowed codes. Casting supplies are used by physician and rehabilitative therapy providers and are billed by the provider who incurs the cost.

CHIROPRACTIC SERVICES

Effective as of a July 15, 2009 date of service, reimbursement for adult chiropractic services is reinstated for procedure codes 98940, 98941, and 98942. These chiropractic manipulative treatment codes include a pre-manipulation patient assessment.

The OVHA will not pay for any x-rays necessary to substantiate the subluxation. Physicians, hospitals and other providers should be aware that Vermont Medicaid does not pay for any service ordered by a chiropractor.

Beneficiaries under age 21 may only receive chiropractic services for the manipulation of the spine to correct a subluxation. Chiropractic services for beneficiaries under age 12 require prior authorization from the OVHA. Visits are limited to 10 visits per calendar year. In order for children to get more than ten visits in a calendar year, the chiropractor will need to seek prior authorization from the OVHA. Pertinent clinical data documenting the need for treatment must be submitted in writing.

Guidelines for required data are available from the OVHA at: <http://ovha.vermont.gov/providers>.

CLAIM REQUESTS

When a beneficiary or an attorney for a beneficiary requests a copy of a claim which has been paid, please inform them that copies should be requested in writing from: COB Unit, OVHA 312 Hurricane Lane, Suite 201 Williston, VT 05495.

CLIA

The Clinical Laboratory Improvement Amendments of 1988 (CLIA) require all providers of lab services to meet quality standards and be certified by the U.S. Department of Health and Human Services. CLIA applies to virtually all laboratory testing of human specimens. The OVHA must have documentation of CLIA Certification with each provider enrollment period.

CLINICAL GUIDELINES

For information regarding the OVHA's Clinical Guidelines, visit: <http://ovha.vermont.gov/providers/clinical-coverage-guidelines>.

CPT CATEGORY III PROCEDURE CODES

Many CPT Category III procedure codes are not covered by Vermont Medicaid because they represent emerging technologies, services and procedures. Providers are reminded to verify coverage before performing the service/procedure. If the Category III code is not on the PAC 8 or 9 (non-covered) listing on the fee schedule and the code has a status of "Review" in the system, it has not yet received review by the OVHA for coverage determination. Providers may request a coverage determination review per the usual process.

CONSULTATION

A consultation includes those services provided by a physician whose opinion or advice is requested by the attending physician in the evaluation or treatment of a beneficiary's illness or condition. A consultation may occur in any location or setting. A consultation must include a written report to the referring physician and must be available to Vermont Medicaid upon request. The only time a consultation code is valid for a pre-op exam is when the surgeon is not the beneficiary's primary physician and is assessing the need for surgery. In such a case, the billed diagnosis must indicate the medical condition, not the pre-op V-code.

When the surgery is already scheduled, the physician who performs the pre-op (history and physical) is to bill the appropriate E & M code, not a consultation code. Consultation codes will be denied when the diagnosis or other information indicates the service was a pre-op exam.

To bill for a consultation service, use the CMS 1500 claim form, and refer to the CPT manual for procedure codes and definitions. All initial consults are limited to one per beneficiary per diagnosis. The NPI number of the referring physician is mandatory in field locator 17b when billing a consultation code.

DETAIL PROCESSING

Each line on the CMS 1500 claim form is called a "detail" and is processed individually. All of the details on a claim form have the same Internal Control Number (ICN). However, each detail has its own sequence number that is listed on the remittance advice right after the claim's ICN. Individual processing means that one detail from a claim may appear on the remittance advice in the Paid Claims section while another detail from the same claim may appear in the Suspended and/or Denied Claims section. This type of processing allows each detail to be processed individually. No detail is delayed by the processing of another detail.

DEVELOPMENTAL SCREENING

The AAP recommends that all infants and young children should be screened with valid, reliable screening instruments for developmental delays at regular intervals. To increase the use of standardized screening instruments and to improve detection rates, the OVHA will allow billing for the well-child visit and the developmental screening on the same day when a standardized screening instrument is used. Changes in the billing are to allow a developmental screening to be billed by Primary Care Providers with the preventive medicine services CPT codes on the same day for children less than 21 years of age in Medicaid, Dr. Dynasaur, or SCHIP.

Physicians or Primary Care Providers must use a standardized screening instrument to bill for developmental screening that occurs in conjunction with a well-child visit. Any standardized screening instrument listed in the Academy of Pediatrics policy statement will be accepted. Providers are required to maintain documentation of the screening and the screening instrument used in the beneficiary's record.

Developmental screening is recommended when surveillance indicates the child may be at risk for developmental delay. In addition, all children should have periodic developmental screening at the 9, 18, 24 or 30 month visits.

DIABETIC TEACHING

Routine diabetic teaching is included within payment for the medical visit. When it is medically necessary for the beneficiary to be referred to a Certified Diabetic Educator for more in-depth counseling, billing instructions are provided to the appropriate providers upon enrollment.

DRUGS REQUIRING PRIOR AUTHORIZATION

Effective 09/15/2008, the following medications (listed in alphabetical order) will require a prior authorization when paid through the medical benefit as physician or hospital outpatient billing:

Amevive (alefacept), Boniva (ibandronate), Botox (botulinum Type A), Myobloc (botulinum Type B), Orenzia (abatacept), Reclast (zoledronic acid injection), Remicade (infliximab), and Tysabri (natalizumab). For a list of ongoing changes, please see the OVHA website: <http://ovha.vermont.gov/for-providers>.

This does not apply to Medicare crossover claims. This change is being made so that there is consistency in prior authorization requirements between the medical and pharmacy benefits. The following J codes (listed in numerical order) are affected:

J0129, J0215, J0585, J0587, J1740, J1745, J2323 and J3488.

For beneficiaries with a primary insurance, a prior authorization is not required in the **medical benefit** if the primary insurer pays a portion of the claim. However, if the primary insurer denies the claim, the OVHA will require a prior authorization.

The following medications (listed in alphabetical order) may not be billed through the medical benefit:

Soliris (eculizumab), Somatuline Depot (lanreotide), Synagis (palivizumab) and Xolair (omalizumab). For a list of ongoing changes, please see the OVHA website: <http://ovha.vermont.gov/for-providers>.

Therefore, the following J codes, C codes or other codes (listed in numerical order) will not be accepted:

90378, C9003, C9237, J1300, J1743 and J2357.

These medications must be billed through the pharmacy benefit using NDCs. Please note that these medications do require prior authorization for payment through the pharmacy benefit.

Prescribers are instructed to call or fax the Medmetrics Prescriber Call Center (formerly known as the Clinical Call Center) to request prior authorization for the above mentioned medications regardless of whether the medication will be billed through the medical or pharmacy benefit. Phone: 1-800-918-7549 Fax: 1-866-767-2649. For clinical criteria and either the general or specific prior authorization forms, visit <http://ovha.vermont.gov/for-providers>.

DUAL ELIGIBILITY

See Provider Manual under MEDICARE AND MEDICAID CROSSOVER BILLING.

EMERGENCY INDICATOR

Providers must indicate on the CMS 1500 form if the service provided is the result of an emergency situation. These situations must be indicated in the “EMG” field locator (24c) on the claim form.

EMERGENCY ROOM SERVICES

Emergency room services include, but are not limited to:

- Consultations
- ER physicians charges
- Radiology
- Laboratory services

Payment will not be made for professional services for medical follow-up services in the emergency room.

EPSDT PROGRAM—WELL-CHILD HEALTH CARE

Vermont provides Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services to all Vermont Medicaid beneficiaries under age 21. The goal of the program is to prevent illness, complications and the need for long-term treatment by screening and detecting health problems in the early stages. Services are tracked for appropriate follow-up and reported to CMS by collection of data from Vermont Medicaid claims. The Vermont Department of Health (VDH) assists in EPSDT outreach and education through its’ Partners in Health Program. Under an agreement to implement EPSDT services, the VDH has established protocols and standards for screening services and is available to all providers.

Required EPSDT Screening Components

- A. Comprehensive health and developmental history
- B. Comprehensive unclothed physical exam
- C. Appropriate immunizations
- D. Laboratory tests (includes blood lead level and TB screening)
- E. Health education/anticipatory guidance
- F. Vision screens
- G. Dental screens
- H. Hearing screens

Screening Service Delivery and Content

- A. Screening is provided according to AAP-recommended intervals, Vermont Division of Dental Health Services standards, DOH periodicity schedules and as medically indicated
- B. Eligible individuals have free choice of qualified providers

Screens include developmental and nutritional assessment

Diagnosis and Treatment Services

- A. Diagnostic procedures are reimbursable when medically indicated by a screening examination
- B. Treatment services to correct or improve defects and physical and mental illnesses and conditions discovered by the screening services, are reimbursable, including:
 - 1. Vision services
 - 2. Dental services
 - 3. Hearing services

-
-
4. Physical, Occupational, and Speech therapy (PT, OT and ST)
 5. Supportive nursing service (Medicaid High Tech Program)
 6. Case Management

- C. Treatment services may require prior authorization and are limited to:
1. Medically necessary, as defined by the Medicaid Division
 2. The most economical treatment approach
 3. Authorized providers

EPSDT services are billed to Vermont Medicaid on the CMS 1500 claim form using CPT procedure codes 99381-99385 and 99391-99395 and the appropriate modifiers. Instructions for indicating EPSDT services on the CMS 1500 claim form are in Section 1-Claim Form.

*Valid Modifier: EP

ESRD RELATED SERVICES

Vermont Medicaid reimburses for End Stage Renal Disease (ESRD) related services provided by the physician to beneficiaries in the home, office, outpatient department, skilled nursing facility, or nursing home.

Do not bill “daily” and “per full month” codes for the same calendar month. Documentation (usually the physician notes) must be available in the beneficiary’s record which shows that the service was given by the physician and the dates involved. Providers should refer ESRD beneficiaries to Medicare for possible eligibility.

FAMILY PLANNING SERVICES

Family Planning is defined as any medically approved diagnostic test, treatment, counseling, drug, supply, or device which is prescribed or furnished by a provider to individuals of child-bearing age for purposes of enabling such individuals to freely determine the number and spacing of their children. Abortion is not considered Family Planning.

It is important that physicians and other providers identify such services as family planning in the appropriate field locator on the claim form. Reimbursement for implantation and/or removal of contraceptive devices includes all related services including the surgical tray, anesthetic, and physician visits within 30 days after the procedure. Implantation is reimbursable once every five years.

FEE SCHEDULE

The Fee Schedule is an electronic, web-based report available for providers to access current reimbursement rates on file for all procedure codes accepted by Vermont Medicaid. Other pertinent information includes pricing effective dates, whether the code requires a prior authorization and allowable provider types and specialties.

Specific fee schedules available include:

- CPT/HCPCS
- DME
- E&M codes
- J Codes
- Lab and X-ray
- Ladies First
- OPPS
- Vision

Services that are non-reimbursable by Vermont Medicaid are also available to providers. The PAC 8 & 9 list includes all codes which are on file as “Do not pay”. It is imperative that providers reference this list prior to rendering services to ensure validity of specific procedure codes. When a procedure code is updated to a PAC 8 or 9 status, providers are notified 30 days prior via banner pages. However, the Fee Schedule and PAC 8 & 9 lists are updated on a monthly basis, therefore, it is important to refer to these lists often. The Fee Schedule and the PAC 8 & 9 list can be found at: <http://ovha.vermont.gov/for-providers/provider-manuals>.

FQHC/RHC

Federally Qualified Health Centers and Rural Health Clinics have at least two provider numbers—one for services paid at cost and one paid per fee schedule. Services paid at cost are billed as encounters.

A. Encounters:

An encounter at a FQHC/RHC is defined as a face-to-face visit between a beneficiary and a provider. Face-to-face visits with more than one health professional for similar diagnoses, or face-to-face visits with more than one health professional of the same type, or multiple face-to-face visits with the same health professional on the same day at the same location, generally constitutes a single encounter. Centers must bill procedure code T1015 for the encounter in addition to CPT/HCPCS codes for the services rendered. The T1015 encounter code should be billed with a zero charge amount or a negligible charge amount (i.e., \$.01 or \$1.00) if your software prohibits using a zero charge amount for electronic billings. CPT/HCPCS codes for the services must be billed using your usual and customary charge.

Vermont Medicaid follows the same list of health professionals as Medicare. Multiple encounters on the same day can occur when the beneficiary suffers illness or injury with a different diagnosis or receives a different treatment at a substantially different time of that day; or when the beneficiary sees two different professionals for two very different diagnosis. A Vermont Medicaid encounter does not include total OB care.

Encounter Examples:

The beneficiary is treated for a headache in the morning at the office and returns home. The beneficiary returns a few hours later because the headache is worse, sees the same or a different practitioner, and returns home. The beneficiary returns for the third time for the same problem, is treated by a third physician and returns home.

This would be billed and reimbursed as one encounter since the reason/diagnosis for the multiple visits was the same and was performed at the same office.

1. The beneficiary is treated during a single visit for both a headache and stomach ache.

This can only be billed and reimbursed as one encounter.

2. The beneficiary is treated in the morning for a headache and returns home. The beneficiary returns the same day for treatment of a laceration.

This is billed and reimbursed as two separate encounters. As long as the beneficiary has left the office and returns for an unrelated reason, then the service can be billed and reimbursed as a second encounter.

3. The beneficiary is treated by a physician and a mental health provider any time during the same day.

This is billed and reimbursed as two separate encounters unless the diagnoses are substantially the same, then only one encounter can be billed.

4. The beneficiary sees her OB for a standard pre-natal visit and returns home. The beneficiary returns the same day to see her OB for a separate, pre-natal concern. *Neither of these Antepartum care (pre-natal) visits with an OB are considered an encounter by Vermont Medicaid. Antepartum care visits are typically billed globally after the birth.*

B. Hospital or Nursing Home Services

FQHC/RHC provider services delivered at hospitals may be billed in either of two methods. The billing method should be consistent throughout the fiscal year. *Encounter Method*-If the services are billed as encounters, the facility number should be used. In addition, the time spent by the provider should also be attributed to that account.

Fee for Service Method-If the service is billed with the appropriate CPT code, the non-FQHC/RHC provider number should be used. In addition, these services would not be subject to cost settlement and the provider's time spent at the hospital would not be a FQHC/RHC allowable cost.

FQHC/RHCs shall report the method used to the cost report auditor.

C. Other Insurance

If a FQHC/RHC provides one or more services on the same day to a Vermont Medicaid beneficiary with insurance other than Medicare, the visit should first be billed to the other insurer using the appropriate CPT code(s). The facility may bill Vermont Medicaid for the balance between the other insurance payment and the facility's encounter rate using T1015 as the encounter code. (See also instructions for completing field locator 29 on the CMS 1500 form.)

Insurance plans impose various rules for beneficiaries covered by their plan including a commercial HMO. If a Vermont Medicaid beneficiary has other insurance, the beneficiary must follow the rules (such as network limitation) of that insurer. Vermont Medicaid will not make a payment for which an other-insurer is responsible or would be responsible if the beneficiary had followed that insurer's rules.

If the other insurer requires a copayment for office visits that are paid under the capitated rate, Vermont Medicaid will reimburse the provider for this office visit copay charge only. To bill the copay amount, use procedure code T1015. If FQHC/RHCs want to bill for the copay for visits under capitation, they can claim a T1015 but must use the non-FQHC/RHC provider number.

D. Other Services

Laboratory services provided by a FQHC or RHC should be billed using the non-FQHC/RHC provider number. These services are paid per fee schedule. See Specimen Collection.

Radiology services, except dental films, should be billed using the non-FQHC/RHC provider number.

Dental services provided by FQHC should be billed using the appropriate dental code and the FQHCs dental provider number. These services are paid on the Vermont Medicaid fee schedule, but will be cost settled at year end.

When a FQHC or RHC bills for completing OVHA treatment plans or refugee forms, or providing Healthy Babies services or planning for an IEP, the service should be billed using the non-FQHC/RHC number.

Minor equipment and supplies may be billed as part of the encounter. As a general rule, billings for DME items require a DME provider number and would be paid per fee schedule.

E. Interim Settlements

After a FQHC or RHC files a cost report, it can request that an interim settlement be made by sending a letter either to the OVHA or the OVHA auditor requesting such. The OVHA will pay up to 90% of the balance due to the facility, based on the recommendations of the auditor.

HEADER PROCESSING

Information pertinent to an entire claim, including all details, is contained in the header of each claim. Examples are the beneficiary name and ID number. Errors in the header information may cause the entire claim to deny before the individual details are considered.

HEALTH MAINTENANCE ORGANIZATIONS (HMOS)

HMOS are insurance plans and are treated as such by the OVHA. Vermont Medicaid beneficiaries covered by a commercial HMO must follow the HMO rules. Vermont Medicaid will make no payment for which an HMO is responsible or when the beneficiary has not followed the HMO rules. Providers may notify the beneficiaries that he or she is responsible for payment when the HMO rules are not followed.

Vermont Medicaid will reimburse for HMO co-pay charges for physician office visits when the physician is capitated by the primary HMO. To bill the HMO co-pay only, use the procedure code T1015.

T1015 can be used only to bill Vermont Medicaid for the co-payment required by another primary insurer when that visit was included in a capitation agreement with the primary insurer.

Rural Health Centers and Federally Qualified Health Centers are not allowed to bill EDS for HMO co-payments. These will be included in the yearly cost settlement.

HOSPITAL BASED PHYSICIANS

Vermont Medicaid follows the billing procedures of the regional Medicare carrier.

Reimbursement is made in accordance with the Medicaid fee schedule for services and must be billed on the CMS 1500 claim form.

The CPT codes for hospital inpatient services are used to report evaluation and management services provided to hospital inpatients.

When the beneficiary is admitted as an outpatient, physician visits are billed with either the outpatient CPT codes or observation service CPT codes.

HYSTERECTOMY

All hysterectomy claims require prior approval from the OVHA Clinical Operation Unit. All hysterectomy claims on beneficiaries under the age of 55 also require either:

- A valid hysterectomy consent form, or if a valid consent form is not available
- A valid ‘Notice of Decision’ to provide retroactive eligibility, or
- Operative notes or a statement that the beneficiary was already sterile prior to the hysterectomy.

The hysterectomy consent form is available on the Vermont Medicaid website at: www.vtmedicaid.com under *Downloads/Forms*.

INCIDENT-TO BILLING

See Provider Manual, Guidelines for Billing Incident-To.

INDEPENDENT LABORATORY

The referring physician is the physician or practitioner who actually ordered the tests for the beneficiary; he or she must be enrolled as a participating or non-participating Vermont Medicaid provider. Enter the NPI/taxonomy code combination of the referring physician in field locators 17a and 17b. The billing provider name and address, to which payment will be made, must appear in field locator 33 and the NPI number must appear in field locators 33a and 24j.

INJECTIONS

Flu Shots Immunization for flu and pneumonia are available at little or not cost in Vermont via a program of the Vermont Department of Health. Beneficiaries are encouraged to use this service. Local home health agencies and Area Agencies on Aging will administer flu vaccines in many locations around the state.

Reimbursement for immunization codes is for the cost of the product only. When a vaccine has been provided free of charge to the practice, providers should use modifier SL with appropriate procedure code and report the charge as \$0.00 to assure correct payment.

Prescribers are instructed to call (800-918-7549) or fax (866-767-2649) the Medmetrics Prescriber Call Center to find out which drugs require prior authorization regardless of whether the medication will be billed through the medical or pharmacy benefit. For clinical criteria and either the general or specific prior authorization forms, visit: <http://ovha.vermont.gov/for-providers>.

See also: DRUGS REQUIRING PRIOR AUTHORIZATION.

INPATIENT SERVICES

Vermont Medicaid pays for physician visits provided to inpatients of a general hospital.

Hospital Admission Visits: Payment to physicians for a same-hospital admission visit is limited to once per beneficiary per day for the same or similar diagnosis for acute care, or after denial of acute care by utilization review).

Preadmission Review: Prior authorization is required from the OVHA for all elective, out-of-state inpatient hospital admissions. The request is made by the admitting hospital.

Certain elective procedures also require prior authorization (e.g., hysterectomies, bariatric surgery, etc.). These are usually requested by the physician but the hospital is always/also responsible for

making sure the OVHA approval is in place prior to the procedure being performed. This pertains to all in-state and out-of-state providers.

Elective admissions to out-of-state hospitals require prior authorization. Urgent and/or emergent admissions do not require prior authorization but do require notification of that admission by the next normal business day from that facility. For additional information visit:
http://ovha.vermont.gov/for-providers/out_of_state_admissions_10-16-08.pdf.

INPATIENT NEWBORN SERVICES (For Physicians)

Beneficiaries may apply for a newborn ID for their child at the time of delivery using forms available at the facility or through application at the Department for Children and Families (DCF) office. (Temporary ID numbers are only issued by the DCF and only issued if applying to a state program).

If the baby's MID is not yet available when the provider needs to bill, the mother's MID can be used for this specific circumstance. Failing that, providers have two remaining options:

***Note:** This option is only available if the baby and mother are inpatient together for the duration of the stay, up to 7 consecutive days. The mother's inpatient delivery charge must be paid or claim will deny. This information (of payment) can be verified through the Provider Services help desk at 800-925-1706 or 802-878-7871.

Provided the above statement is true:

A provider may submit a claim for the baby, using the mother's MID number, for a maximum of 7 consecutive days.

EXAMPLE: Mother leaves hospital after three days and baby stays. The mother's MID can be used for the baby only those first three days; further claims for the baby must use the baby's MID.

EXAMPLE: Both are hospitalized for more than seven days. Services for the baby on the eighth day and after must be billed using the baby's MID.

Since birthing room births are also billed as inpatient, the place of service would always be 21.

Please include the following information on the CMS 1500 claim form as indicated below:

<u>Form Locator</u>	<u>Information</u>
1a	Mother's Vermont Medicaid ID
2	Baby's name
3	Baby's date of birth
4	Mother's name
6	Check "child"
19	Write "billing for baby under mother's ID".

The provider will need to use the electronic notes field when billing electronically.

The recommended option is to wait for the child's permanent ID number to be issued.

INTERPRETER

When a Vermont Medicaid provider pays interpreter services for a beneficiary (who does not speak the same language as the provider), in person (at the office) or over the phone – or for the use of sign language (with a hearing impaired beneficiary), the provider may bill procedure code T1013 for every 15 minutes of service provided. FQHC/RHC providers must bill T1013 for interpreter services using their non-FQHC/RHC provider numbers. Home Health Agencies must use revenue code 940 along with the HCPCS code T1013.

LABORATORY CHARGES

The OVHA follows the Medicare billing procedures for physician's billing for laboratory testing. It permits a physician to bill Vermont Medicaid for laboratory testing only when the physician or an employee of the physician performs the test. Physicians who expect to be reimbursed for lab services performed on site must indicate on the claim that the test was performed on site, by completing field locator 20 on the CMS 1500 claim form, and indicate the CLIA certification is on file with OVHA.

The professional component (modifier 26) is valid only when the test requires interpretation by the billing physician. The result from the actual testing of a specimen usually requires no interpretation and in some cases, is done by the lab specialist. The billing of the lab code with modifier 26 is not valid for these services.

In order to be reimbursed for laboratory services furnished in an office setting, providers must furnish a copy of their current CLIA when enrolling/recertifying with Vermont Medicaid. For additional information, please contact EDS Enrollment, P.O. Box 888, Williston, VT 05495, (800) 925-1706 (in state) or (802) 878-7871 (out of state).

LAB HANDLING FEE

Payment for the service of obtaining specimens is included in the reimbursement of the medical visit. For exceptions to this rule and the corresponding procedure codes, please refer to Specimen Collection Fee.

LEAD SCREENING

CMS has mandated that children ages one through five be screened for lead unless the physician determines it to be medically inappropriate. The act of obtaining the sample during a well child or routine office visit is included within payment for that medical visit. The processing laboratory will bill the proper CPT code for the actual testing.

LOCUM TENENS

See Provider Manual.

MAINTENANCE DRUG PRESCRIPTIONS

Effective August 1, 2009: When the OVHA is the primary payer, pharmacies are required to dispense designated classes of maintenance drugs in 90-day supplies after the first fill. In addition, when the OVHA is the primary payer, prescriptions written for maintenance drugs must be rewritten for 90 days for the drug to be covered. The maximum quantity limit of 102 days still applies. This rule does not apply to beneficiaries who have other primary insurance, including Part D. The full list of classes of drugs affected by this change is available at:

<http://ovha.vermont.gov/for-providers>. See OVHA's Clinical Criteria document for drugs with other quantity limits: <http://ovha.vermont.gov/for-providers/preferred-drug-list-clinical-criteria>.

MEDICAL NUTRICIAN THERAPY

This service is paid through the enrolled primary care physician, inpatient hospital, outpatient hospital and school health services. OVHA will enroll Registered Dietitians (RD) as a non-participating provider and assign a Vermont Medicaid Provider number which will allow their provider number to appear on the CMS 1500 claim form as the attending provider, i.e., the provider of the service for that day. The RD may use three codes that are specific to RDs, and that cannot be billed for service by the physician. The billing provider for the CMS 1500 claim form must be a hospital, physician or school.

The Registered Dietitians will be enrolled as participating providers for the Family Infant and Toddler Program & Children with Special Health Needs only. This means when a beneficiary is eligible for FITP or CSHN only, the claim will process when the RD is the attending and billing provider.

MEDICARE AND MEDICAID CROSSOVER BILLING

See Provider Manual, MEDICAID AND MEDICARE CROSSOVER BILLING.

MIDWIFE SERVICES

Vermont Medicaid reimburses for the services of Certified Nurse-Midwives (CNMs) and Licensed-Midwives.

Certified Nurse-Midwife/Licensed (non-nurse)Midwife: CNMs/LMs may be enrolled as independent practitioners or physicians may employ them. The appropriate CPT codes for Licensed Midwives are limited to:

59400, 59409, 59410, 59610, 59612, 59614, 59425, 59426, 59430, 99354, 99355, 99461, and 99381—(99381 requires EPSDT modifiers).

Important Billing Reminder for Licensed Midwives:

1. Delivery codes are valid only for pregnancies with an estimated gestational age of 30 or more weeks (viability)
2. Antepartum visits are limited to a combined total of 15 per pregnancy, regardless of how many different providers have seen the beneficiary. One unit=one visit.
3. Total OB and Partial OB codes cannot be billed for the same pregnancy
4. Only one delivery code can be billed for a beneficiary in a 9-month date span
5. The total payment for any combination of obstetrical CPT codes cannot exceed 50% of the total obstetrical care rate.
6. Licensed Midwives will not be reimbursed for surgery of assistant-at-surgery charges.
7. Episiotomy included in delivery reimbursement
8. The date of service for total OB care is the day delivery even though it includes antepartum care received prior to this date
9. Antepartum visits can only be billed as separate claims.

When the MD, nurse midwife or nurse practitioner monitors the labor in the beneficiary's home (for a planned home birth) but then has to admit the mother to the hospital for delivery, and the delivering MD is not a member of the same provider group, the initial provider can bill code(s) 99354 and/or 99355.

The OVHA will pay codes 99354 and 99355 only when a planned home delivery results in hospital admission and the delivery is done by a different MD/MD group. (These services are included in regular OB billing when the providers are of the same billing group).

The billed units must reflect the actual time spent in face to face contact with the beneficiary in the home and/or on the way to the hospital. Each claim will be suspended for review, so clear copies of the provider's actual records must be submitted with each bill and they must document the number of units being billed.

EXAMPLES:

1. The midwife and MD were present in the beneficiary's home to monitor the labor. Due to a lack of progression and meconium staining in the amniotic fluid, the beneficiary was transported to the hospital and her care transferred to the hospital physician, who delivered the baby. The initial MD was with the beneficiary "for the entire labor, monitoring the baby, the mother and the progress of the labor."

The documented time shows 5 hours. For these services (which include the midwife's attendance), the OVHA can be billed one unit of procedure code 99354 and 8 units of 99355.

2. The nurse midwife monitored the labor in the home for 15 hours, transported the beneficiary by car (1/2 hour) and stayed 4 more hours at the hospital after the transfer. Upon admission to the hospital, the care was assigned to the hospital physician who delivered the baby by C-section. The midwife had started an IV of ringers lactate while still at the home. The nurse midwife's services may be billed with one unit of 99354 and 29 units of 99355. All care given during the face to face contact, including the IV insertion and supplies, is included within the reimbursement of these two procedure codes. There can be no charge for the initial MD/nurse's services as of the admission to the hospital since all care at this point becomes part of the delivery payment.
3. IN SUMMARY: The OVHA will pay codes 99354 and 99355 only when a planned home delivery results in hospital admission and the delivery is done by a different MD/MD group. (These services are included in regular OB billing when the providers are of the same billing group.) The billed units must reflect the actual time spent in face-to-face contact with the beneficiary in the home and/or on the way to the hospital. Each claim will be suspended for review, so clear copies of the provider's actual records must be submitted with each bill and they must document the number of units being billed. The place of service (POS) must be a 12 (home).

Licensed midwives may receive reimbursement for Rhogam injections using code J2790 with the appropriate NDC code and a maximum of one unit. See also: NDC (National Drug Code). Use the appropriate office visit code with diagnosis 626.0 when a beneficiary is seen at the office for a pregnancy test. If you bill a pregnancy diagnosis for the purpose of testing for a pregnancy that has not yet been established, your claim will cause subsequent prenatal claims to be denied as it is considered to be one prenatal visit if a pregnancy diagnosis is recorded on the claim.

MODIFIER 'LT' & 'RT'

Vermont Medicaid does not utilize the modifier combinations 'RTL' or 'LRTL' (both right and left; bilateral). When Correct Coding allows one of these combinations on the base procedure code and the item is supplied bilaterally, the Vermont Medicaid provider must bill two separate line items: one with modifier RT on the base code and another line with modifier LT on the base code.

MULTIPLE SURGERY PRICING

In an ongoing effort to standardize guidelines and be more consistent with other payers, Vermont Medicaid changed rules governing multiple surgery payments. Vermont Medicaid will price in order of Relative Value Unit and will price all surgical procedures in decreasing percentages of 100%, 50%, 40%, 30%, 30%...This includes surgical procedures billed with multiple units. Any codes that are add-on codes, or Modifier 51 exempt, as defined by the CPT, will be priced at 100% of the allowed amount.

NATUROPATHIC PHYSICIANS

On March 6, 2008, the Vermont Legislature authorized the Office of Vermont Health Access to provide coverage for medically necessary health care services within the Vermont Medicaid benefit package provided by a Naturopathic Physician (N.D.). N.D.s must be licensed in Vermont and provide treatment within the scope of their practice as described in chapter 81 of Title 26 of the Vermont Statutes Annotated. N.D.s having either local admitting hospital privileges or a formal agreement with a physician who has local hospital admitting privileges and arranges 24 hour-a-day/seven days-a-week coverage for their beneficiaries, may enroll as primary care providers (PCPs) with Vermont Medicaid. N.D.s who do not meet the above conditions to become a PCP for Vermont Medicaid are considered specialists. Services from an N.D. as a specialist, require a PCP referral.

Please note that you may choose to enroll as a specialist or a primary care provider. If you wish to be a PCP in the Primary Care Plus program, you must provide additional required information. Please complete the Agreement for Participation for Naturopathic Physicians, which includes a section for required information regarding inpatient hospital admissions. You must have an agreement with an admitting physician who will be your inpatient hospital admitting agent.

Please access these forms (available at www.vtmedicaid.com under Downloads/Forms) and mail the completed Provider Enrollment Agreement and the Agreement for Participation for Naturopathic Physicians, along with any additional documentation to: EDS, P.O. Box 888, Williston, VT 05495-0888 Attn: Enrollment/Recertification.

NDC (NATIONAL DRUG CODE)

In November 2007, Vermont Medicaid announced that the collection and submission of rebates for all drugs dispensed or administered by providers other than a pharmacy, would be required. This is a program change that is a result of the Deficit Reduction Act of 2005. The purpose of this is to allow for the collection of Medicaid drug rebates from manufacturers on all drugs dispensed in any office setting as required by § 1927 of the Social Security Act. The NDC billed to Vermont Medicaid MUST be the NDC that was dispensed to the beneficiary. The effective date for reporting National Drug Codes (NDCs) is March 1, 2008.

Drugs supplied by manufacturers, currently participating in the rebate program will be the only drugs reimbursed by Vermont Medicaid. A list of these manufacturers, by code and name, can be found at www.vtmedicaid.com under Information/Drug Manufacturer Information.

In order to collect rebates from the correct manufacturers, Vermont Medicaid will require data elements at the detail level in addition to the HCPCS codes. These elements are the 11 digit National Drug Code (NDC) number, the Unit of Measurement Qualifier code, and the unit quantity. These must be reported on paper and electronic submissions of all professional claims.

Requirements on CMS 1500 Form:

FL 24D: HCPCS code

FL 24D Shaded area: 11 digit NDC number, Unit of Measurement Qualifier, and Unit Quantity

FL 24G: HCPCS unit

24D CPT/HCPCS	Modifier	DX Pointer	Charges	Days or Units
[60126598741][UN][1111.234]				
J1234	XX	1,2,3	\$637.00	5

↑ ↑ ↑
11 digit NDC Unit of Unit Quantity
Measurement
Qualifier *

* Unit of Measurement Qualifier
F2-International Unit
GR-gram
ML-Milliliter
UN-Unit

Some NDCs are displayed on drug packaging in a 10-digit format. Proper billing of an NDC requires an 11-digit number in a 5-4-2 format. Converting NDCs from a 10 to 11-digit format requires a strategically placed zero, dependent upon the 10-digit format. The following table shows common 10-digit NDC formats on packaging and the associated conversion to an 11-digit format with the proper placement of a zero:

10-Digit Format on Package	10-Digit Format Example	11-Digit Format	11-Digit Format Example	Actual 10-Digit NDC Example	11-Digit Conversion Example
4-4-2	9999-9999-99	5-4-2	<u>0</u> 9999-9999-99	0002-7597-01 Zyprexa IM [□] 10mg vial	<u>0</u> 0002-7597-01
5-3-2	99999-999-99	5-4-2	99999- <u>0</u> 999-99	50242-040-62 Xolair [□]	50242- <u>0</u> 040-62
5-4-1	99999-9999-9	5-4-2	99999-9999- <u>0</u> 9	60574-4112-1 Synagis [□] 50mg vial	60574-4112- <u>0</u> 1

NON-SPECIFIC PROCEDURE CODES

All procedure codes with non-specific descriptions (i.e. miscellaneous, unlisted, not otherwise listed, not otherwise classified, not elsewhere classified, etc.) require prior authorization from the OVHA before the service is rendered or items are ordered/dispensed.

NURSE PRACTITIONERS

The OVHA enrolls and reimburses nurse practitioners licensed in Vermont. Payment will be made for reimbursable services that are also contained in protocols approved by the Vermont Board of Medical Practice.

OBSTETRICAL CARE

Vermont Medicaid covers obstetrical care (OB). Total OB care includes prenatal care, delivery, episiotomy, and postpartum care; including complications. A CPT total OB procedure code is used when all OB-related care is provided by the same physician/practitioner or practitioners in the same group practice, provided all care.

When different physician groups provide OB care for the same pregnancy, total OB codes cannot be used. Each prenatal/antepartum visit is billed using code 59425 (visits 1-6) and/or 59426 (visits 7 and up). OB deliveries pertain only to infants who have an Estimated Gestational Age (EGA) of 30 or more weeks (viability). When the fetus is less than 7 months EGA and a non-induced fetal demise occurs, see procedure codes for surgical intervention and/or medical visit codes for medical assistance. Do not use “delivery” codes.

The combination of all partial OB charges for a given pregnancy cannot exceed the reimbursement rate for total OB care.

Twin Deliveries: The OVHA will reimburse for the delivery of twins at 100% and 50% of the prices on file. The provider should bill both deliveries on the same claim and use diagnosis code V272 for both. One code has to be a “delivery only” code.

Assist at Cesarean Delivery: A surgical assistant at a cesarean delivery cannot bill the “Total OB” procedure code, because the assistant did not give the prenatal care. To bill for your service as the assistant, use the “delivery only” procedure code with one of the following modifiers:

80-Assistant surgeon (MD or nurse practitioner)

AS-Physician’s assistant assisting at surgery (Only one assistant is covered per surgery).

ORAL SURGERY

If oral surgery is billed with a CPT code, follow the physician’s rules for billing and bill on a CMS 1500 claim form. If oral surgery is billed using ADA codes, follow the dentist’s rules for billing, and bill on an approved dental claim form.

OXIMETRY SERVICES

When billing any medical visit, for example, an office or emergency visit, the following procedures are considered included within the reimbursement for the visit:

- Ear or pulse oximetry saturation-single determination
- Non-invasive ear or pulse oximetry for oxygen saturation; by multiple determinations
- Non-invasive ear or pulse oximetry for oxygen saturation; by continuous overnight monitoring

These services will be denied with EOB 091—Service denied; not reimbursed by Vermont Health Access Program.

PEAK FLOW METERS

Beneficiaries with a diagnosis of asthma or reactive airway disease may obtain Peak Flow Meters (e.g., Access, MiniWright, Pulmograph) from any qualified provider (physician or DME).

PHARMACY TAX ASSESSMENT FORM

A monthly assessment is due to the State of Vermont for each prescription **fill or refill** sold by retail pharmacies. This applies to all scripts, and not only to Vermont Medicaid scripts. The amount of the assessment is \$0.10 for each prescription **fill or refill**. The completed Pharmacy Assessment Monthly Documentation Form, available online at: <http://ovha.vermont.gov/for-providers/pharmacy-forms> along with additional information regarding the tax, needs to accompany each monthly payment. Chain pharmacies with more than one NPI number should complete a separate form for each facility every month.

Note: The Pharmacy Benefit Management Program Provider Manual is located at <http://ovha.vermont.gov/for-providers> under the Pharmacy section. The Pharmacy Benefit Management Program is for prescription drugs dispensed by retail pharmacies.

PHARMACOLOGIC MANAGEMENT (Psychiatric)

Pharmacologic management is payable only for mental health and developmentally disabled beneficiaries when providers must bill using appropriate procedure code with one unit of service per visit, regardless of time spent.

PHYSICIAN'S ASSISTANT

The services of a physician's assistant are limited to those allowed by their license and approved by the Vermont Board of Medical Practice. Physician's assistants may not bill independently therefore, the attending provider NPI must be that of the responsible physician.

Services rendered by a physician's assistant must be billed with the AM modifier, which indicates the service was performed by the physician assistant him/herself. The responsible physician's NPI number must be given as the attending on the claim.

- Consultations are limited to one unit per date of service
- Initial consultations are limited to one consult per related diagnosis per attending provider

Physician's assistants may bill the following without a modifier, with the responsible physician's NPI number:

- Laboratory tests
- Injected Medications

PHYSICIAN VISIT LIMITS

Pursuant to Medicaid Rule M614/7301.1.1, the following physician visit limits apply:

1. Payment for office or home visits is limited to five visits per beneficiary, per month.
2. Nursing facility visits are limited to one per provider per beneficiary per week.
3. Hospital visits are limited to one per day for the same or similar diagnosis for acute care, or after denial of acute care by utilization review, up to one visit per month for subacute care.

Visits in excess of those listed above, may be reimbursed if the services are medically necessary. A medical exception request documenting the medical necessity must be sent to the OVHA.

Mileage allowances for house calls apply only to the first beneficiary. If more than one beneficiary is seen during the visit, no mileage will apply to those beneficiaries.

PLACE OF SERVICE CODES

Please refer to the CPT coding book.

POST-OPERATIVE FOLLOW-UP VISITS

For all CPT surgical procedure codes, Medicare has assigned a follow-up/global period of either “000”, “010” or “090” days. This means that office visits that are related to the procedure are included within the payment for the procedure and may not be billed during the restricted follow-up period.

PRIOR AUTHORIZATION

See the PA Supplement.

The Pre-Admission Request form and the Pre-Procedure Request forms are available for download at: www.vtmedicaid.com under *Downloads/Forms*.

PSYCHIATRY/PSYCHOLOGY

Drug Management- In keeping with the federal guidelines for Medicare and Vermont Medicaid, services of drug management and psychotherapy cannot be paid for the same beneficiary for the same date of service. Drug management is considered included within the psychotherapy service and is not to be billed separately as an additional charge. Vermont Medicaid is required to follow this policy and deny CPT codes 90862 when it is billed in addition to individual psychotherapy.

Psychiatrists and Psychologists-

Enrolled Providers:

- LCSW
- LMHC
- LMFT
- Physician/psychiatric

Substance Abuse

Psychotherapy claims where the primary diagnosis is substance abuse or dependence (including alcohol or other drugs, excluding tobacco), are paid through the Office of Alcohol and Drug Programs to participants in their provider network of contracted substance abuse programs.

Enrolled Providers:

- ADAP facility/Substance Abuse Treatment facility
- Certified Adolescent ADAP Counselor/Addiction Medicine

Community Mental Health Center Services

Covered services include rehabilitation services provided by qualified professional staff in a community mental health center designated by the Department of Mental Health. These services may be provided by physicians, psychologists, MSWs, psychiatric nurses, and qualified mental health professionals carrying out a plan of care approved by a licensed physician or licensed psychologist.

Beneficiaries receiving Community Rehabilitation and Treatment (CRT) services under the 1115 waiver, are ineligible for this State Plan service.

Accepted Procedure Codes

Psychologists/LCSW/LMHC/LMFT-Only the following procedure codes are allowed:

Codes require a *modifier* of either: AJ=for MA, counselors, LCMHC, LSW, LMFT
AH=for Doctorate level Psychologist.

(AJ is reimbursed at 80% of allowed amount and AH is reimbursed at 88% of allowed amount).

<u>Code</u>	<u>Description</u>	<u>Units</u>
90801	Diagnosis and Evaluation	1 unit=1 visit
90804	Psychotherapy-Less Than One Hour	1 unit=20-30 min.
90806	Psychotherapy	1 unit=45-50 min.
90808	Psychotherapy-More Than One Hour	1 unit=75-80 min.
90846	Family Psychotherapy w/out Patient Present	1 unit=1 day
90847	Family Psychotherapy	1 unit=1 day
90853	Group Therapy Limited to 1 session per day, 3 sessions per week for each recipient	1 unit=15 min.
96102	Psychological Testing w/Qualified Health Care Professional, Interpretation & Report, administered by technician	1 unit=60 min.
96103	Psychological Testing w/Qualified Health Care Professional, Interpretation & Report, administered by computer	1 unit=60 min.
96119	Neuropsychological Testing w/Qualified Health Care Professional, Interpretation & Report, administered by technician	1 unit=60 min.
96120	Neuropsychological Testing w/Qualified Health Care Professional, Interpretation & Report, administered by computer	1 unit=60 min.

The following codes must be billed with modifier AH when provided by a Doctorate level Ph.D:

96101	Psychological Testing, both face-to-face time w/patient & time interpreting test results and preparing the report	1 unit=60 min.
96116	Neurobehavioral status exam, both face-to-face time w/patient & time interpreting test results and preparing the report test results	1 unit=60 min.
96118	Neuropsychological testing, both face-to-face time w/the patient & time interpreting test results and preparing the report	1 unit=60 min.
96150	Health and behavior assessment, clinical review observation	1 unit=15 min.
96151	Health and behavior re-assessment	1 unit=15 min.
96152	Health and behavior intervention face-to-face individual	1 unit=15 min.
96153	Health and behavior assessment face-to-face group w/2 or more patients	1 unit=15 min.

Allowed place of service codes: 11-Office, 03-School (when not part of an IEP), 12-Home, 21-Inpatient Hospital, and 53-Community Mental Health Clinic.

RADIOLOGY

Radiologic Components- The professional component of radiologic services must be billed by the physician when those services are done in a hospital radiology department. The professional component includes any examination of and discussion with the beneficiary, supervision of technologist, interpretation of the results of diagnostic or therapeutic procedures and consultation with the attending physician. Only a radiologist will be paid for the radiology professional component. The appropriate CPT procedure code should be used with the modifier “26” when billing for the professional component.

The **technical component** includes the services of non-radiologist or non-physician personnel, materials, facilities, equipment and space used for diagnostic or therapeutic services. The appropriate CPT procedure code should be used with the modifier “TC” when billing for the technical component.

The **total component** consists of the professional component and the technical component. The total component is reimbursable only for diagnostic or therapeutic radiology procedures done in the physician’s office. The appropriate CPT procedure code without the modifier should be used when a claim for total component services is submitted to Vermont Medicaid.

The use of modifier 50 (bilateral) on CPT radiology codes (7**** series) is not valid because modifier 50 causes payment to be only 1.5 times the price on file. When the same radiology procedure code is done more than once on the same date of service ***and is not done for reasons of comparison***, the provider should bill the appropriate radiology code ***once only with multiple units***. Documentation must be maintained in the beneficiary records substantiating the purpose and number of multiple x-rays. Radiology services performed for comparison are not reimbursable.

REHABILITATION THERAPIES (PT, OT & SLP)

Rehabilitation therapy (PT/OT/SLP) guidelines are 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.

REMITTANCE ADVICE

See: Provider Manual

SPECIMEN COLLECTION FEE

Payment for obtaining specimens is included in the reimbursement of the office visit. Physicians may bill Vermont Medicaid for a specimen collection fee in two situations only; for the collection of blood via venipuncture or for collection of a urine sample by catheterization.

Federal Qualified Health Clinics and Rural Health Clinics have different guidelines for this process:

-Venipuncture (or blood draw fee) and the specimen handling fee are included as part of FQHC services. They are not considered part of the diagnostic laboratory services.

-Blood draws/venipuncture and specimen handling provided by nurses or technicians for services, such as lab tests and blood draws, ***do not*** bill an encounter. These charges are included within the encounter payment when the service was originally ordered. Clinical Diagnostic Laboratory tests performed on site should be billed separately as a fee for service.

SPEND-DOWN (FORM OVHA 220MP)

Some persons become eligible for Vermont Medicaid benefits only after incurring a specific amount of healthcare costs over a specific period. Vermont Medicaid eligibility for this type of case begins on any day of the month in which the person incurs the specified amount.

When the person is determined to be eligible for Vermont Medicaid, the district worker sends a letter to the provider informing the provider that the spend-down amount has been met or that a remaining amount should be deducted from a particular bill before billing Vermont Medicaid for the remainder.

Claims, which are submitted with the first day of eligibility as the date of service, must have the spend-down letter from the district office attached to the claim form. If the spend-down letter is not attached to the claim form, the claim will be denied.

To complete the claim form involving spend-down, the provider must do the following:

1. Indicate "spend down" and the amount in field locator 19.
2. Put your usual and customary charge in field locator 24f.
3. Total all of the charges appearing on the claim form and write the total amount in field locator 28.
4. Put the amount of the spend down in field locator 29.
5. Attach a copy of the Notice of Decision to the claim and submit to EDS for processing.

STERILIZATIONS

Sterilizations of either a male or female beneficiary are covered only when the following conditions are met:

1. The beneficiary has voluntarily given informed consent and has so certified by signing the Sterilization Consent Form
2. The beneficiary is mentally competent
3. The beneficiary is at least 21 years of age at the time consent is obtained
4. At least 31 days but not more than 180 days have passed between the date of informed consent and the date of sterilization except in the case of premature delivery or emergency abdominal surgery. In those cases, at least 72 hours must have passed between the informed consent and the operation.

Operations or procedures performed for the purpose of reversing or attempting to reverse the effects of any sterilization procedure are not covered. Federal law does not permit payment for sterilization of any beneficiaries under the age of 21.

TAMPER-RESISTANT PRESCRIPTION DRUG PADS

CMS has indicated that as of 10/01/2007, all written prescriptions for outpatient covered drugs *must* be written on tamper-resistant prescription paper. CMS requires the Medicaid agencies audit pharmacies to ensure compliance with this regulation. Documentation of compliance will be necessary otherwise, non-compliance will result in a recoupment of payments.

To view the CMS guidelines to follow to be considered compliant with the new tamper-resistant requirements, visit www.vtmedicaid.com under *Information*.

UNITS OF SERVICE

The units of service, field locator 24g, on the CMS 1500 claim form is mandatory. Some service areas have unique requirements for units of service. For more detailed information on the units of service, see the service in question in this section and/or the procedure code's description or contact EDS.

USUAL AND CUSTOMARY RATE (UCR)

Various claim forms (CMS 1500, UB 04 and 837) require the submission of "Charge" or "Total Charges" or "Charge Amount" to be reported for each service billed. The provider's "usual and customary charge" or "uniform charge" is a dollar amount in effect at the time of the specific date of service. This is the amount to be reported on the claim. This usual and customary charge is the amount that the provider bills to insured and self-pay persons for the same service. If the provider has more than one charge for a service, the lowest charge will be reported to Vermont Medicaid; except, if the charge has been reduced on an individual basis.

UNLISTED/MISCELLANEOUS SERVICES

See: NON-SPECIFIC PROCEDURE CODES

VISION CARE

You will not be reimbursed by Vermont Medicaid for services to Medicaid beneficiaries age 21 and over for frames, lenses, dispensing and repairs. This also applies to VHAP beneficiaries 18 years of age and older and to all VHAP Pharmacy beneficiaries.

Eye Exams: Coverage for comprehensive eye exams and interim eye exams are limited to one exam every two years per beneficiary. A repeat comprehensive exam within 24 months requires prior authorization. All refraction exams are covered.

Eyeglasses: Coverage for eyeglasses is limited to one pair of glasses every two years per beneficiary. Earlier replacement requires prior authorization. Eyeglasses must be purchased under the state's sole-source contract.

Reimbursement for additional services is limited to the following circumstances:

- When eyeglasses (frames or lenses) have been lost, broken beyond repair, or scratched to the extent that visual acuity is compromised. (Dispensing providers will make the decision about being broken beyond repair or visual acuity is being compromised.)

- When the dispensing provider on the Medicaid order form documents a change of at least one-half diopter in lens strength.

The following procedure codes should be used when billing for vision services:

Procedure Codes:

Dispensing and fitting fees (limited to one every two years):

92340, 92341, 92342, 92352, 92353, 92354

Repair and Refitting

92370-92371

Eyeglass Cases

V2756

For additional clinical information, see the OVHA's website (<http://ovha.vermont.gov/providers>).

Evaluation and Management: (99--- codes)

The following limits apply:

- Services included within payment for E&M service
- Office visits limited to 5 per calendar month per attending
- New patient visits limited to one per beneficiary/attending/3 years
- One office visit/day for same beneficiary and same attending provider

Order forms, instructions and frame information may be obtained from Chadwick. Chadwick Optical will bill directly to Vermont Medicaid for these items.

Eyeglasses are provided only under the terms of a contract between DCF and a sole source vendor, Chadwick Optical, Inc. All frames and lenses must be ordered from:

Chadwick Optical, Inc.
P.O. Box 485
White River Junction, VT 05001

When an optometrist or ophthalmologist prescribes special frames or lenses not routinely payable by Vermont Medicaid, a description of the special need and the reasons for it should be entered in the special instruction field of the order form to Chadwick. The special need will be met if medically necessary.

Contact Lenses

- Requires prior authorization
- Reimbursement is available from the OVHA for contact lenses for the optimum management of ocular conditions such as aphakia, keratoconus, or corneal transplant
- A single lens, not a pair, is considered one unit. When a physician supplies two contact lenses to a beneficiary, one for each eye. The procedure code must be billed twice; once with modifier LT and once with modifier RT.

Cataract Removal

Cataract procedures are reimbursable and prior authorization is not required.

Non-Reimbursable Items:

- Oversized frames and lenses
- Tints-Unless for ultra violet cataract lens

SECTION 2

DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS AND MEDICAL SUPPLIES

Introduction

This section of the Provider Manual is unique to Durable Medical Equipment (DME), Prosthetics, Orthotics and Medical Supplies. It contains information concerning billing, payment and specific instructions for completion of the CMS 1500 claim form.

*Please note: when a service or an item is limited to, for example, one per year, a year is defined as 365 days, unless otherwise specified.

The Vermont Medicaid website, www.vtmedicaid.com, will have information regarding DME codes, the modifiers allowed, unit limitations (i.e. one unit per 365 days) and pertinent prior

authorization requirements. This information will be located under *Downloads/Manuals/DME Restrictions*.

DME guidelines are 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.

SECTION 2.1

REIMBURSABLE/NON-REIMBURSABLE SERVICES

This supplement applies to all durable medical equipment (DME) including wheelchairs and other mobility devices, augmentative communication devices, prosthetics, orthotics and medical supplies, as described in Medicaid rules in sections M830/7504, M840/7505, M841/7506, M842/7507, and M843/7508, available at local DCF offices and at <http://www.vtmedicaid.com>.

For a complete listing of services that are reimbursable, non-reimbursable and/or require a prior authorization is available on the Office of Vermont Health Access website (<http://ovha.vermont.gov/for-providers/provider-manuals>). No payment will be made for a service or item that is not covered unless authorized for coverage via section M108/7104.

SECTION 2.2 BILLING INFORMATION

ADAPTIVE WEIGHTED EATING UTENSILS

Vermont Medicaid allows for the reimbursement of “Adaptive Weighted Eating Utensils” when medically necessary for individuals who have significant tremors that interfere with daily activities (i.e., ability to feed self).

These utensils must be ordered by a physician, must be medically necessary, supplied by a DME/Pharmacy or DME vendor, and billed using non-specific HCPCS code A9999. Only one of each type of utensil is allowed. The billing/supplying provider must submit an invoice with the claim in order to be reimbursed.

APNEA MONITORS

Vermont Medicaid covers the rental of an Apnea Monitor for use in the home when medically necessary, as per the OVHA Clinical Criteria, however purchase is not covered. The OVHA Clinical Guidelines for Apnea Monitors is available online at: <http://ovha.vermont.gov/for-providers/apnea-monitor-04-01-09.pdf>.

For beneficiaries under the age of one year (infants), prior authorization is not required. When the condition(s) which caused a need for the monitor have been resolved or stable for two to four months, monitor rental must be discontinued.

ASSISTIVE TECHNOLOGY SUPPLIERS (ATS)

As of June 1, 2008, Vermont Medicaid will follow Medicare’s lead in requiring that certain wheelchairs must come from a supplier employing a RESNA-certified Assistive Technology Supplier (ATS) who is directly involved in the wheelchair selection for the beneficiary. This applies to the following wheelchairs: Group 2 single- or multiple-power option power wheelchairs, any Group 3 or Group 4 power wheelchair or a push-rim power assist device for a manual wheelchair. All suppliers who have obtained their ATS certification should sign all documentation regarding the above wheelchairs with their ATS designation. All ATS certified

suppliers must send a copy of their certification to Vermont Medicaid Enrollment department on an annual basis to demonstrate that they have kept their certification current.

It is understood that RESNA will be changing the Supplier certification to a Practitioner certification in the near future. Providers should send a copy of all updated certificates to the OVHA.

BICROS/CROS (Contralateral Routing of Sound)

Vermont Medicaid does not cover CROS (Contralateral Routing of Sound) and BICROS hearing aids and related services.

Per review of current medical literature, the effectiveness of these aids is unproven. Related current HCPCS procedure codes are in the range of V5170-V2540.

BREAST PUMPS

Providers and suppliers are responsible for ensuring medical necessity and should refer to the Coverage Guidelines for Electric Breast Pumps on the OVHA website:
<http://ovha.vermont.gov/for-providers/durable-medical-equipment-a-c>.

CRUTCHES

A physician's order for crutches usually refers to common, wooden, underarm crutches. If other types are dispensed by the DME supplier, the medical necessity form must be specific as to the type ordered and why the common wood crutches are not sufficient.

DATES OF SERVICE

The billed date of service on the claim must be the date that the item was dispensed to the beneficiary. There are two exceptions:

1. When the billings are for monthly DME rentals, the dates of service should span the rental month;
2. When the beneficiary becomes ineligible after a customized item has been ordered but before it can be dispensed, the date may be the actual date of the order.

DME IN HEALTHCARE INSTITUTIONS

With one exception, payment will not be made for DME and supplies ordered by a physician when the beneficiary is an inpatient in a health care institution, specifically a general or psychiatric hospital, nursing facility, or intermediate care facility for the mentally retarded (ICF-MR). In these cases, the all-inclusive payment made to these facilities includes the equipment and supplies used by the beneficiaries.

The one exception is that payment will be made for a seating system, including required accessories, for an individual residing in a long-term care facility when the seating system is prescribed by a masters or doctoral level physical or occupational therapist trained in rehabilitative equipment and is so unique to the individual that it would not be useful to other nursing home residents. Cushions not integral to the seating system are not covered by this exception.

Payment for orthotics and prosthetics, including ostomy supplies and elastic stockings, may be made to the DME vendor when furnished to beneficiaries in residential facilities, other than health care facilities. The doctor and vendor must keep a medical necessity form and/or order, completed by the physician, and/or other documentation of medical need in the beneficiary's record.

DME BILLING

When billing for DME items, the date of service must be the date the item was delivered to the beneficiary. The date of service may not be any earlier than the date of delivery.

For items that are custom ordered, the evaluation, fitting, casting and taking of measurements is included in the allowance of the item. There is no separate payment allowed. Providers may not seek additional reimbursement for this.

DME RECYCLING

(This refers to all vendors of DME who provide the following equipment to Medicaid beneficiaries, with the exception of dual eligible beneficiaries whose primary insurance will cover the cost of the device):

- Manual Wheelchairs
- Power Operated Vehicles
- Power Wheelchairs
- Standers
- Lifts
- Hospital Beds
- Rehab Shower Commode Chairs
- Augmentative Communication Devices/Speech Generating Devices

Beginning July 15, 2009, all vendors who provide this equipment will be required to affix a sticker on the item at the time of service delivery. This sticker will identify Medicaid as the owner of the device and will provide contact information regarding return of the device when it is no longer required by the beneficiary. Medicaid will provide these stickers. Stickers must be applied to an area of the device that is protected from daily wear and tear but is visible without excessive effort.

There will also be an accompanying signature sheet to be signed by the vendor and the beneficiary or their legal guardian. This form shall be kept on file at the vendor's office and be available for inspection and a copy provided to the beneficiary for their records. This form will be available on the OVHA and EDS website and is listed as the Durable Medical Equipment Ownership, Operation, and Maintenance Agreement.

Contact the OVHA at 802-879-6396 to obtain stickers and forms if you have not received them by July 1, 2009 or if you run out.

GLUCOMETERS

The basic glucometer does not require prior authorization. The prescribing provider's medical necessity form must document that the beneficiary is a diagnosed diabetic.

Glucometers with special features (such as voice response) require prior authorization from the Office of Vermont Health Access. The prescribing provider's medical necessity form must

document that the beneficiary is a diagnosed diabetic. Information on the special feature(s) of the unit, why the unit is medically necessary, and pricing information is required.

The Office of Vermont Health Access limits the quantity of diabetic supplies for eligible Vermont Medicaid beneficiaries (such as glucose meters and test strips). Extra equipment and supplies require prior authorization.

Effective February 5, 2008, Vermont Medicaid will reimburse pharmacies only for the following meters and the test strips for those meters:

FreeStyle® Lite, FreeStyle Flash®, FreeStyle Freedom®, Precision Xtra™, One Touch® Ultra® 2, One Touch® UltraMini™ and One Touch® Ultra® Smart.

All other meters and test strips will require a prior authorization.

HOSPITAL BEDS

All semi-electric and electric/electronic hospital beds for use in the home, require prior authorization from the OVHA. This includes rentals and all other modifier-code combinations. Regardless of the procedure code/modifier to be used, prior authorization must be obtained prior to placement of the bed in the home.

The only exception is the “Immediate Needs” exception as explained in the Prior Authorization Supplement on the Vermont Medicaid website (www.vtmedicaid.com under *Downloads/Manuals*). This prior authorization requirement is not new, as semi-electric and electric/electronic hospital beds have required prior authorization for many years.

INCONTINENCE SUPPLIES

Incontinence supplies are covered under HCPCS procedure codes. Dispensing providers are required to maintain a completed and current medical necessity form on file for each item, justifying the medical need and quantities used.

INDIVIDUAL CONSIDERATION/MANUAL PRICING

The rate on file for certain procedure codes does not have a specific dollar amount because no one amount is appropriate (e.g. code A4570, miscellaneous splints). In these cases, the rate on file is set at “IC” (individual consideration) and the allowed amount will be calculated in accordance with the section titled “Payment, OVHA Primary”. This process is often called “manual pricing”.

MEDICAL NECESSITY FORM (MNF)

See the Provider Manual.

MEDICAL SUPPLIES

Medical supplies will be covered when:

- Prescribed by an enrolled physician or other authorized practitioner
- Used in a beneficiary’s home due to a post surgical or chronic condition
- Billed first to Medicare when the beneficiary is eligible
- Billed first to any other insurer or applicable organization
- Prior authorization is obtained for excess quantities

Medical supplies may be dispensed and billed in two-month time periods. The “from” and “to” dates of service on the CMS 1500 claim form must show a two-month span.

MEDICARE CROSSOVER BILLING

See: Provider Manual. MEDICAID/MEDICARE CROSSOVER BILLING

MILEAGE

Mileage incurred by providers associated with the repair of a DME item, is reimbursable by Vermont Medicaid and cannot be charged to the beneficiary. The mileage is billed with procedure code E1340. The mileage should be determined from their closest facility and if the vendor is providing multiple deliveries, the only portion that will be reimbursed is the portion of the mileage specific to the Vermont Medicaid beneficiary.

If the beneficiary is able to take the DME item that needs to be repaired to the vendor, that is the expectation. Charges for delivery of an OVHA reimbursed DME item, cannot be made to Vermont Medicaid or to a beneficiary.

OXYGEN

The rental of respiratory equipment is on a monthly basis and includes all supplies necessary to use the piece of equipment. Supplies in excess of the monthly amounts are covered only when prior authorization from the OVHA has been granted. (This includes changes of supplies related to infection control means).

PAYMENT-OVHA PRIMARY

When the OVHA is the primary payer, payment amounts for DME (except augmentative communication devices and closed circuit TV purchased from the Vermont Association for the Blind and Visually Impaired-VABVI), orthotics, prosthetics and medical supplies will be calculated in the following manner:

1. When the rate on file is a specific dollar amount, the OVHA pays the lesser of the actual charge or the rate on file
2. If the rate on file is “IC” (Individual Consideration), and if there is a Manufacturer’s Suggested Retail Price (MSRP) for the item, the OVHA pays the lesser of the actual charge or 85% of the MSRP for all items
3. If the rate on file is “IC”, and if there is no MSRP, the OVHA pays the lesser of the actual charge or 1.67 times the invoice cost.

The director may approve an exception to the methods, if the director finds that payment for a particular item under the method in #2 or #3 is shown to cause a significant loss to the vendor. In such cases, the director may approve payment at the lesser of the actual charge or the actual cost.

When the OVHA is the primary payer, payment amounts for augmentative communication devices will be calculated in the following manner:

1. When the rate on file is a specific dollar amount, the OVHA pays the lesser of the actual charge or the rate on file
2. If the rate on file is “IC” and if the seller is the manufacturer of the item, the OVHA pays the lesser of the actual charge or 85% of MSRP

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3. If the rate on file is "IC" for the item and if the seller is a distributor or retailer of the item, the OVHA pays the lesser of the actual charge or MSRP.

When the OVHA is the primary payer, payment amounts for closed circuit TV devices purchased from the VABVI will be calculated in the following manner:

1. When the rate on file is a specific dollar amount, the OVHA pays the lesser of the actual charge or rate on file
2. If the rate on file is "IC", the OVHA pays the lesser of the actual charge or 1.67 times the invoice cost.

Payment-Vermont Medicaid is payor of last resort. The OVHA does not reimburse when a primary insurance has been billed incorrectly and/or has insufficient information/coding.

PAYMENT-DUAL ELIGIBLES/MEDICARE PRIMARY

When Medicare is the primary payer, the provider must accept assignment of the claim (except as noted below) in order to receive any OVHA payment. This applies to all claims for services and items. See also Medicare Crossover in the Provider Manual.

If the claim is submitted to Medicare on an assigned basis, when the OVHA receives the crossover claim, it will pay the coinsurance and deductible amounts due.

In order to assure access, the OVHA has created five exceptions to its requirement that claims for dual-eligible individuals be submitted to Medicare on an assigned basis. The exceptions are limited to claims for:

1. Wheelchairs
2. Seating systems
3. Cushions that are part of a seating system
4. Seat lifts, and
5. Repairs to wheelchairs for which Medicare did not participate.

For these items, a provider may submit a prior authorization request to the OVHA asking for a medical necessity determination and waiver of the requirement to bill on an assigned basis. When a provider submits a request for prior authorization of a wheelchair, seating system, cushions that are part of a seating system or seat lift for a dually eligible beneficiary, the OVHA will review the request for medical necessity and sufficient information to support pricing. If the OVHA determines that the request is medically necessary, it will approve the request, enter a Medicaid allowed amount into the system and over-ride the Medicare assignment requirement. If the provider bills Medicare for the requested item on an unassigned basis, when the provider submits to the OVHA evidence of the Medicare payment or denial, the OVHA will pay the difference between the Medicare paid amount and the Vermont Medicaid allowed amount.

In addition, when the primary wheelchair is found by the OVHA to need repair, modification, and/or battery replacement; and Medicare denied or downgraded the purchase of the primary chair; or the OVHA determines that Medicare is unlikely to accept new documentation of medical necessity for the primary chair; the OVHA may approve an over-ride of the assignment requirement. Approved repairs and modifications under this exception may be billed directly to Vermont Medicaid.

To assure access, the OVHA will consider creating additional exceptions for items of DME which cost over \$100.00. Any request to add a service or item to the list (of exceptions for access

reasons) must demonstrate to the satisfaction of the director of the OVHA that the item is inaccessible statewide due to the Medicare payment level.

PRESCRIBING PROVIDER

Doctors of Medicine (M.D.s), Doctors of Osteopathy (D.O.s), Nurse Practitioners (NPs), and certain other licensed practitioners may write prescriptions for DME and medical supplies. Audiologists may prescribe hearing aids. Physical and occupational therapists may prescribe wheelchairs and seating systems (MD endorsement of the prescription is required). Augmentative communication devices require a prescription by a speech/language pathologist with MD endorsement of the prescription. The physician/nurse practitioner prescriber must be enrolled as a participating or non-participating Vermont Medicaid provider and the prescribing/attending NPI number on the CMS 1500 claim must be a valid. When billing for services to Vermont Medicaid, the prescribing/referring physician NPI number should appear in field locator 17b on the CMS 1500 claim form.

DME providers must keep prescriptions on file for five years for beneficiaries in OVHA programs.

PRIOR AUTHORIZATION

See the Fee Schedule posted at: www.vtmedicaid.com under Downloads, Manuals.

PRIOR AUTHORIZATION-NOTICE OF DECISION

See Provider Manual.

PRIVATE LITIGATION

See Provider Manual.

PROCEDURE CODES

A list of procedure codes for DME equipment, orthotics, prosthetics and supplies is available in electronic form which includes the code, rate on file, whether the code requires prior authorization, and other pertinent information. This file is available for download at <http://ovha.vermont.gov/for-providers/provider-manuals> under Fee Schedules. DME Restrictions (also available on the link above) informs DME providers of current restrictions on certain DME items/supplies. Items on the fee schedule with a rate on file of "IC" (individual consideration) are manually priced.

Changes in the price on file will be reflected on the Fee Schedule. The OVHA reserves the right to change the price on file for any item or service without prior notice. For these reasons providers should be careful to retain the changes noted in the RAs and updated versions of the fee schedule. This file is for the convenience of the provider. Although the OVHA will attempt to keep the file 100% accurate, the actual price recorded in the computer system for payment is the only accurate price for the applicable date of service.

For items not prior priced or when a vendor is requesting special pricing consideration, an invoice including the manufacturer's price to the vendor and any discounts, must be submitted with the claim.

See also: **NON-SPECIFIC PROCEDURE CODES**

PURCHASE VS. RENTAL

The decision to rent or purchase is based on the estimated period of medical need.

REHABILITATION EQUIPMENT REVIEW

The OVHA contracts with the Veteran's Administration to provide second opinion consults for select rehabilitation equipment that requires prior authorization. Beneficiaries may be contacted by a VA representative to arrange this consultation. Consultations will take place at the beneficiary's home or at a VA clinic. Beneficiaries and providers will be notified when the OVHA has required a consult.

RENTAL

The OVHA will rent equipment when it is expected to be cost-effective/medically necessary and short-term. The OVHA's monthly rental payment is calculated at one tenth of the OVHA purchase price. Payment will be made in monthly increments for equipment rented for a full month (30-31 days) or any portion thereof.

Certain DME requires prior authorization to begin monthly rental. For rental equipment that does not require prior authorization when first placed, prior authorization is required if the equipment is to be used more than three months.

If an item's code does not specify Rental, use modifier RR. The rental will be priced at a monthly amount and is to be billed at a monthly amount unless stated otherwise.

Medical supplies which are necessary to the functioning of the equipment (e.g., leads and electrodes for TENS Unit) are included in the rental and not to be billed in addition to the rental of the equipment. When billing for supplies on beneficiary owned equipment, the supplier must state on the claim or medical necessity form that the related piece of equipment is not being rented (e.g., "TENS Units is not being rented" or "...is owned by the beneficiary").

REPAIRS

Repairs to covered items are covered when the repairs are necessary to make the items useful, are not included in a warranty, have been ordered by a physician, and do not total more than 50% of replacement cost. Suppliers must check the procedure code listing in the Fee Schedule for the specific code representing the repair being considered to determine the need for prior authorization. Payment will not be made for repairs to equipment for use in skilled nursing homes, ICFs, ICF-MRs, mental or general hospitals or psychiatric facilities.

Hearing aid: See Audiological Services

SPECIAL NEEDS FEEDER BOTTLES

HCPCS procedure code S8265 is accepted by Vermont Medicaid to bill for the Haberman Feeder (special needs bottle with nipple) when medically necessary for dysphasia due to cleft lip/palate. When the cause of the dysphasia is other than cleft lip/palate or the bottle is not Haberman, unlisted procedure code A9999 is allowed.

All special needs feeder bottles are reusable, must be ordered by a physician, and supplied by a DME/pharmacy vendor. Quantity is limited to 10 bottles with nipples per six months. Prior authorization is not required. The medical need must be clearly documented in the patients' medical records and an invoice is required with each claim submission.

SPLINTS

When a miscellaneous splint code must be used because there is no included code available, providers must submit a request for prior authorization and a completed Medical Necessity Form. Claims must also be submitted with an invoice and an invoice for identification and cost.

SUPPLY RETURNS

DME purchased by Vermont Medicaid for eligible beneficiaries, remains the property of Vermont Medicaid. If a beneficiary no longer has a medical need for equipment purchased by Vermont Medicaid, the beneficiary should be instructed to contact the OVHA Clinical Review Unit at: 802-879-6396. DME suppliers should also contact this number if Vermont Medicaid owned DME is returned to them.

TENS/MNES

TENS and MNES units must have a trial period of up to three months to determine effectiveness for the beneficiary. Purchase is to be considered only when the continuing medical need is documented and benefit is proven. Documentation by the physical therapist and/or physician must indicate the length of the trial period and the reasoning to support the effectiveness for each individual beneficiary.

TRACHEOSTOMY CARE KITS

Tracheostomy care kits are not approved unless a compelling clinical case can be established and prior authorization is obtained. The necessary supplies for tracheostomy care come in bulk quantities and providers are advised to furnish bulk supplies when appropriate. All these supplies have individual procedure codes.

UNLISTED/MISCELLANEOUS ITEMS

Some covered items may not be classified or the classification may be difficult to determine. All unlisted or miscellaneous procedure codes that do not identify a specific item or service require prior authorization unless specific instructions are given indicating otherwise.

UPDATES

Periodically, the OVHA will mail updated information directly to DME providers. Providers should retain these updates until the appropriate manual revision is received. This information is also given in the bi-monthly Advisory newsletter and on the weekly remittance advice mailed to the billing address. Each provider should assure that all necessary personnel receive and retain this information to assure proper billing and payment.

VENTRICULAR ASSIST DEVICES

Vermont Medicaid's coverage of Ventricular Assist Devices is based on the CMS National Coverage Determination 20.9, entitled "NCD for Artificial Hearts and Related Devices". Hospital and physician providers are referred to the current CPT and HCPCS manuals for proper coding.

WHEELCHAIRS AND SEATING SYSTEMS

Wheelchairs and seating systems are covered under various procedure codes (see current HCPCS manual). Refer to the Fee Schedule (<http://ovha.vermont.gov/for-providers>) to determine the procedure codes that require prior authorization. To obtain prior authorization and individual

consideration pricing, providers are required to submit a completed medical necessity form and pricing information to the clinical staff at the OVHA. When a beneficiary is also covered by Medicare, see **Payment - Dual Eligibles/Medicare Primary.**

WHEELCHAIR REPAIRS

All repairs on wheelchairs less than one year old require prior authorization from the OVHA. The OVHA expects that these chairs would still be under the manufacturer's warranty and therefore any repairs, regardless of the dollar amount, require prior authorization. For wheelchairs over one year old and not under warranty, prior authorization is required only for repairs greater than \$300.00.

Requests for prior authorization for wheelchair repairs must include a completed Medical Necessity form in addition to the following:

- The date the wheelchair was purchased/delivered
- When the chair is less than 4 years old, the cost of repair vs. cost of replacement
- Equipment guarantees, warranty and denial of third party coverage
- The condition of the existing equipment

DETAILED SUMMARY OF UPDATES

*Please note:

-Sections below containing text in **red font** are *additions* to current policy. Previous verbiage will be noted, when applicable).

-Section headings below in **red font** are *new* sections*

12/31/2009

MEDICAL NUTRICIAN THERAPY (new, page 27)

This service is paid through the enrolled primary care physician, inpatient hospital, outpatient hospital and school health services. OVHA will enroll Registered Dietitians (RD) as a non-participating provider and assign a Vermont Medicaid Provider number which will allow their provider number to appear on the CMS 1500 claim form as the attending provider, i.e., the provider of the service for that day. The RD may use three codes that are specific to RDs, and that cannot be billed for service by the physician. The billing provider for the CMS 1500 claim form must be a hospital, physician or school.

The Registered Dietitians will be enrolled as participating providers for the Family Infant and Toddler Program & Children with Special Health Needs only. This means when a beneficiary is eligible for FITP or CSHN only, the claim will process when the RD is the attending and billing provider.

VISION CARE (Page 37)

You will not be reimbursed by Vermont Medicaid for services to Medicaid beneficiaries age 21 and over for frames, lenses, dispensing and repairs. This also applies to VHAP beneficiaries 18 years of age and older and to all VHAP Pharmacy beneficiaries.

Eye Exams: Coverage for comprehensive eye exams and interim eye exams are limited to one exam every two years per beneficiary. A repeat comprehensive exam within 24 **days** requires prior authorization. All refraction exams are covered.

Eyeglasses: Coverage for eyeglasses is limited to one pair of glasses every two years per beneficiary. Earlier replacement requires prior authorization. Eyeglasses must be purchased under the state's sole-source contract.

Reimbursement for additional services is limited to the following circumstances:

- When eyeglasses (frames or lenses) have been lost, broken beyond repair, or scratched to the extent that visual acuity is compromised. (Dispensing providers will make the decision about being broken beyond repair or visual acuity is being compromised.)
- When the dispensing provider on the Medicaid order form documents a change of at least one-half diopter in lens strength.

Changed: the word days to months

PHARMACY TAX ASSESSMENT FORM (Page 32)

A monthly assessment is due to the State of Vermont for each prescription or refill sold by retail pharmacies. This applies to all scripts, and not only to Vermont Medicaid scripts. The amount of the assessment is \$0.10 for each prescription **and** refill. The completed Pharmacy Assessment Monthly Documentation Form, available online at: <http://ovha.vermont.gov/for->

providers/pharmacy-forms along with additional information regarding the tax, needs to accompany each monthly payment. Chain pharmacies with more than one NPI number should complete a separate form for each facility every month.

Added: the word TAX in title

Added: the word fill and or

Deleted: the word and

8/25/2009

BICROS/CROS (Contralateral Routing of Sound) (Page 40)

Vermont Medicaid does not cover CROS (Contralateral Routing of Sound) and BICROS hearing aids and related services.

Per review of current medical literature, the effectiveness of these aids is unproven. Related current HCPCS procedure codes are in the range of V5170-V2540.

DME BILLING (Page 40)

When billing for DME items, the date of service must be the date the item was delivered to the beneficiary. The date of service may not be any earlier than the date of delivery.

For items that are custom ordered, the evaluation, fitting, casting and taking of measurements is included in the allowance of the item. There is no separate payment allowed. Providers may not seek additional reimbursement for this.

SPECIAL NEEDS FEEDER BOTTLES (Page 46)

HCPCS procedure code S8265 is accepted by Vermont Medicaid to bill for the Haberman Feeder (special needs bottle with nipple) when medically necessary for dysphasia due to cleft lip/palate. When the cause of the dysphasia is other than cleft lip/palate or the bottle is not Haberman, unlisted procedure code A9999 is allowed.

All special needs feeder bottles are reusable, must be ordered by a physician, and supplied by a DME/pharmacy vendor. Quantity is limited to 10 bottles with nipples per six months. Prior authorization is not required. The medical need must be clearly documented in the patients' medical records and an invoice is required with each claim submission.

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(07/24/2009)

MAINTENANCE DRUG PRESCRIPTIONS (Page 26)

Effective August 1, 2009: When the OVHA is the primary payer, pharmacies are required to dispense designated classes of maintenance drugs in 90-day supplies after the first fill. In addition, when the OVHA is the primary payer, prescriptions written for maintenance drugs must be rewritten for 90 days for the drug to be covered. The maximum quantity limit of 102 days still applies. This rule does not apply to beneficiaries who have other primary insurance, including Part D. The full list of classes of drugs affected by this change is available at:

<http://ovha.vermont.gov/for-providers>. See OVHA's Clinical Criteria document for drugs with other quantity limits: <http://ovha.vermont.gov/for-providers/preferred-drug-list-clinical-criteria>.

APNEA MONITORS (Page 39)

in the anesthesia base. Total minutes should be divided by 15 and round to nearest unit (i.e. .49 and under round down .5 and over round up).

CAST, SPLINT AND STRAPPING MATERIALS (Page 15)

Materials for casting, splinting and strapping, etc., are payable. Refer to your HCPCS listing for a full description of the allowed codes.

Casting supplies are used by physician and rehabilitative therapy providers and are billed by the provider who incurs the cost.

CHIROPRACTIC SERVICES (Page 15)

Effective as of a July 15, 2009 date of service, reimbursement for adult chiropractic services is reinstated for procedure codes 98940, 98941, and 98942. These chiropractic manipulative treatment codes include a pre-manipulation patient assessment.

The OVHA will not pay for any x-rays necessary to substantiate the subluxation.

Physicians, hospitals and other providers should be aware that Vermont Medicaid does not pay for any service ordered by a chiropractor.

Beneficiaries under age 21 may only receive chiropractic services for the manipulation of the spine to correct a subluxation. Chiropractic services for beneficiaries under age 12 require prior authorization from the OVHA. Visits are limited to 10 visits per calendar year. In order for children to get more than ten visits in a calendar year, the chiropractor will need to seek prior authorization from the OVHA. Pertinent clinical data documenting the need for treatment must be submitted in writing.

Guidelines for required data are available from the OVHA at: <http://ovha.vermont.gov/for-providers>.

Deleted: As of February 1, 2009, Vermont Medicaid will not reimburse for chiropractic services for Vermont Medicaid beneficiaries age 21 and over. This also applies to VHAP beneficiaries 18 years of age and older.

FOHC/RHC (Page 20)

Federally Qualified Health Centers and Rural Health Clinics have at least two provider numbers-one for services paid at cost and one paid per fee schedule. Services paid at cost are billed as encounters.

F. Encounters:

An encounter at a FQHC/RHC is defined as a face-to-face visit between a beneficiary and a provider. Face-to-face visits with more than one health professional for similar diagnoses, or face-to-face visits with more than one health professional of the same type, or multiple face-to-face visits with the same health professional on the same day at the same location, generally constitutes a single encounter. Centers must bill procedure code T1015 for the encounter in addition to CPT/HCPCS codes for the services rendered. The T1015 encounter code should be billed with a zero charge amount or a negligible charge amount (i.e., \$.01 or \$1.00) if your software prohibits using a zero charge amount for electronic billings. CPT/HCPCS codes for the services must be billed using your usual and customary charge.

INTERPRETER (Page 25)

When a Vermont Medicaid provider pays interpreter services for a beneficiary (who does not speak the same language as the provider), in person (at the office) or over the phone – or for the use of sign language (with a hearing impaired beneficiary), the provider may bill procedure code T1013 for every 15 minutes of service provided. FQHC/RHC providers must bill T1013 for interpreter services using their non-FQHC/RHC provider numbers.

Home Health Agencies must use revenue code 940 along with the HCPCS code T1013.

PHARMACY ASSESSMENT FORM (Page 30)

A monthly assessment is due to the State of Vermont for each prescription or refill sold by retail pharmacies. This applies to all scripts, and not only to Vermont Medicaid scripts. The amount of the assessment is \$0.10 for each prescription and refill. The completed Pharmacy Assessment Monthly Documentation Form, available online at: <http://ovha.vermont.gov/providers/pharmacy-forms> along with additional information regarding the tax, needs to accompany each monthly payment. Chain pharmacies with more than one NPI number should complete a separate form for each facility every month.

PHYSICIAN VISIT LIMITS

Pursuant to **Medicaid Rule M614**, the following physician visit limits apply...

Deleted: ... WAM

TAMPER-RESISTANT PRESCRIPTION DRUG PADS (Page 35)

CMS has indicated that as of 10/01/2007, all written prescriptions for outpatient covered drugs *must* be written on tamper-resistant prescription paper. CMS requires the Medicaid agencies audit pharmacies to ensure compliance with this regulation. Documentation of compliance will be necessary otherwise, non-compliance will result in a recoupment of payments.

To view the CMS guidelines to follow to be considered compliant with the new tamper-resistant requirements, visit www.vtmedicaid.com under *Information*

REIMBURSABLE/NON-REIMBURSABLE SERVICES (Page 37)

This supplement applies to all durable medical equipment (DME) including wheelchairs and other mobility devices, augmentative communication devices, prosthetics, orthotics and medical supplies, as described in **Medicaid rules** in sections M830, M840, M841, M842, and M843, available at local DCF offices.

Deleted: ...as described in the Welfare Assistance Manual (WAM)

ADAPTIVE WEIGHTED EATING UTENSILS (Page 38)

Vermont Medicaid allows for the reimbursement of “Adaptive Weighted Eating Utensils” when medically necessary for individuals who have significant tremors that interfere with daily activities (i.e., ability to feed self).

These utensils must be ordered by a physician, must be medically necessary, supplied by a DME/Pharmacy or DME vendor, and billed using non-specific HCPCS code A9999. Only one of each type of utensil is allowed. The billing/supplying provider must submit an invoice with the claim in order to be reimbursed.

VENTRICULAR ASSIST DEVICES (Page 45)

Vermont Medicaid's coverage of Ventricular Assist Devices is based on the CMS National Coverage Determination 20.9, entitled "NCD for Artificial Hearts and Related Devices". Hospital and physician providers are referred to the current CPT and HCPCS manuals for proper coding.
