



Provider Manual



HP Enterprise Services

SUMMARY OF UPDATES

All changes/updates will be indicated in **red font**.
For a detailed summary of all changes made to this Supplement, please refer to page 97

The following information has been added to this Supplement:

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SECTION 1 POLICY AND INFORMATION

Green Mountain Care is a family of health coverage programs offered by the State of Vermont and its partners. Plans include Catamount Health, Vermont Health Access Plan (VHAP), Dr. Dynasaur, Medicaid and a number of pharmacy assistance and premium assistance programs. Catamount Health, offered in cooperation with the State of Vermont by Blue Cross Blue Shield of Vermont and MVP Health Care, is not part of this manual.

Programs addressed by this manual, and herein described as Medicaid, encompass many programs including Dr. Dynasaur, Traditional Medicaid, VHAP, VHAP Managed Care, Medicaid Managed Care, VHAP-Pharmacy, VScript, VPharm, Premium Assistance, and Employee Sponsored Insurance. All of these programs are financed by a combination of both federal and state dollars. The Vermont General Assembly appropriates the state funds. The proportion of federal matching funds is determined for each state agency that delegates responsibility for the administration of the program to The Department of Vermont Health Access (DVHA). Other departments involved in program administration are as follows:

- Department of Aging and Independent Living (DAIL)
- Department of Health, including the Office of Alcohol and Drug Abuse Programs
- Department of Mental Health
- Department of Education
- Department for Children and Families

1.1 GENERAL PROGRAM INFORMATION

The State of Vermont uses a fiscal agent to process Medicaid claims. It has a long-term contract with HP Enterprise Services (HP) to process claims and perform other duties as required by the contract.

1.1.1 PROGRAM ADMINISTRATION

Eligible beneficiaries are enrolled in the appropriate Health Care Assistance Program by the eligibility units described in Section 1.1.3. The Department of Vermont Health Access (DVHA) has the primary responsibility for establishing program policy direction. HP adjudicates claims for services rendered. Questions or need for assistance may be directed to The DVHA or HPES listed on the following page. All queries will receive a prompt response.

1.1.2 DIVISION OF RESPONSIBILITIES

The following list identifies the specific areas of responsibility between the State Medicaid Program and its fiscal agent, HPES. Most provider inquiries should be made to HPES. Policy concerns should be addressed to The DVHA. See addresses below.

	Eligibility	Coverage	Reimbursement
State	Establishes eligibility for beneficiaries	Determines what services are covered	Establishes rates for reimbursement to providers. Provides the funds for benefit payment to providers
HP	Verifies beneficiary eligibility for providers, maintains eligibility sub-system	Assigns billing codes to be used	Maintains the rates in the computer system. Issues electronic fund transfers and checks to providers for reimbursement of services

1.1.3 MANUALS, MEDICAID RULE AND STATE PLAN RESOURCES

The Provider Manual and the supplement manuals for Prior Authorization, Dental, CMS-1500, UB-04 and Psychiatric Inpatient are updated frequently, often on a monthly basis. The manuals are available at <http://www.vtmedicaid.com/Downloads/manuals.html>. The Pharmacy Benefit Management Program Provider Manual is located at <http://dvha.vermont.gov/for-providers> under the Pharmacy section. The Pharmacy Benefit Management Program is for prescription drugs dispensed by retail pharmacies.

Medicaid Rule, along with DVHA rules for the programs encompassed under “Medicaid” such as VHAP, pharmacy programs and premium assistance programs, is located online at <http://humanservices.vermont.gov/on-line-rules/dvha>

The State Plan, a guiding document for changes applicable to Vermont’s Medicaid population and includes the populations for the State’s Children’s Health Insurance Program (SCHIP) and the Choices for Care program which are not covered by the Global Commitment (GC) to Health Waiver. State Plan information, is at <http://dvha.vermont.gov/administration> in the Service Administration section. Global Commitment to Health 1115 Demonstration Waiver information is also at <http://dvha.vermont.gov/administration> in the Global Commitment section.

1.1.4 DIRECTORY OF OFFICES

Department of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, VT 05495
Tel: (802) 879-5900
Fax: (802) 879-5651

HP Enterprise Services
312 Hurricane Lane, Suite 101
Williston, VT 05495
Tel: (800) 925-1706 (In-state)
(802) 878-7871
Fax: (802) 878-3440

Applications for eligibility determinations and other information queries can be made at any District Office and the Economic Services Division (ESD) of the Department for Children and Families (DCF). The ESD processes applications when health care is likely to be the only benefit for which an applicant will be eligible. The DVHA also operates a Member Services Unit (MSU) to provide information to applicants and respond to questions and problems from beneficiaries.

ESD Benefits Service Center
Department for Children and Families
103 South Main Street
Waterbury, VT 05671-1201
Tel: (800) 479-6151

Member Services Unit
Maximus
101 Cherry Street, Suite 320
Burlington, VT 05401-9823
Tel: (800) 250-8427
TTY: (888) 834-7898

The Benefits Service Center’s call center interactive voice response (IVR) system services providers and beneficiaries statewide. Providers should stay on the line after the message for a separate queue, and will be serviced directly.

Benefits Service Center and District Offices: Telephone (800) 479-6151

District Office locations:

BARRE
5 Perry Street, suite 150
05641-4160

BENNINGTON
150 Veterans Mem. Dr., Ste. 6
05201-1918

Barre City	Montpelier	Arlington	Rupert
Barre Town	Moretown	Bennington	Sandgate
Berlin	Northfield	Dorset	Searsburg
Braintree	Orange	Glastenbury	Shaftsbury
Brookfield	Plainfield	Landgrove	Stamford
Cabot	Roxbury	Manchester	Sunderland
Calais	Waitsfield	Peru	Winhall
Duxbury	Warren	Pownal	Woodford
East Montpelier	Washington	Readsboro	
Fayston	Waterbury		
Marshfield	Williamstown		
Middlesex	Worcester		

BRATTLEBORO

BURL

232 Main Street P.O. Box 70, 05302

INGTON

101 Cherry St., Ste. 101, 05401-4405

Athens	Putney	Bolton	Richmond
Brattleboro	Somerset	Burlington	St. George
Brookline	Stratton	Charlotte	Shelburne
Dover	Townshend	Colchester	So. Burlington
Dummerston	Vernon	Essex	Underhill
Guilford	Wardsboro	Hinesburg	Westford
Halifax	Westminster	Huntington	Williston
Jamaica	Whitingham	Jericho	Winooski
Marlboro	Wilmington	Milton	
Newfane			

HARTFORD **MIDDL**

224 Holiday Dr. Ste. A
White River Junction 05001-2097

EBURY

700 Exchange St. Ste. 103 05753

Barnard	Randolph	Addison	Monkton
Bethel	Rochester	Bridport	New Haven
Bradford	Royalton	Bristol	Orwell
Bridgewater	Sharon	Buell's Gore	Panton
Chelsea	Stockbridge	Cornwall	Ripton
Corinth	Strafford	Ferrisburg	Salisbury
Fairlee	Thetford	Goshen	Shoreham
Hartford	Tunbridge	Granville	Starksboro
Hartland	Vershire	Hancock	Vergennes
Norwich	West Fairlee	Leicester	Waltham
Pomfret	Woodstock	Lincoln	Weybridge
		Middlebury	Whiting

MORRISVILLE

63 Professional Dr.
05661

NEWPORT

100 Main St. Ste., 240
05855

Belvidere	Jeffersonville	Albany	Holland
Cambridge	Johnson	Averill	Irasburg
Craftsbury	Morristown	Barton	Jay

Eden	Stannard	Bloomfield	Lemington
Elmore	Stowe	Brighton	Lewis
Greensboro	Waterville	Brownington	Lowell
Hardwick	Wolcott	Brunswick	Maidstone
Hyde Park	Woodbury	Canaan	Morgan
		Charleston	Newport City
		Coventry	Newport Town
		Derby	Norton
		Ferdinand	Troy
		Glover	Westfield
			Westmore

RUTLAND

320 Asa Bloomer Building
05701

Benson	Pittsfield
Brandon	Pittsford
Castleton	Poultney
Chittenden	Proctor
Clarendon	Rutland City
Danby	Rutland Town
Fair Haven	Sherburne
Hubbardton	Shrewsbury
Ira	Sudbury
Mendon	Tinmouth
Middletown Springs	Wallingford
Mount Holly	Wells
Mount Tabor	West Haven
Pawlet	West Rutland

ST. ALBANS

20 Houghton St. Rm. 313
05478-2247

Alburgh	Highgate
Bakersfield	Isle Lamotte
Berkshire	Montgomery
Enosburg	North Hero
Fairfax	Richford
Fairfield	St. Albans City
Fletcher	St. Albans Town
Franklin	Sheldon
Georgia	South Hero
Grand Isle	Swanton

ST. JOHNSBURY

67 Eastern Ave. Ste. 7 05819

SPRIN

Barnet	Newbury
Burke	Peacham
Concord	Ryegate
Danville	St. Johnsbury
East Haven	Sheffield
Granby	Sutton
Groton	Topsham
Guildhall	Victory
Kirby	Walden
Lunenburg	Waterford
Lyndon	Wheelock
Newark	

GFIELD

100 Mineral St. Ste. 201 05156

Andover	Reading
Baltimore	Rockingham
Bellows Falls	Springfield
Cavendish	Weathersfield
Chester	Weston
Grafton	West Windsor
Londonderry	Windham
Ludlow	Windsor
Plymouth	

1.1.5 GLOSSARY OF TERMS AND PHRASES

ADVANCE DIRECTIVES LAW-Under Vermont law, advance directives allow individuals to make health care decisions even if they lose their ability to make those decisions on their own. In

Vermont, they are known as Terminal Care Documents, Living Wills and/or Durable Powers of Attorney for Health Care. Federal law requires hospitals, nursing facilities, home health agencies, hospices and prepaid health care organizations to provide patients with information regarding advance directives. Information on advance directives is available from the Vermont Ethics Networks at www.vtethicsnetwork.org/index.htm or the Health Department at 1-800-548-9455.

ACTUAL CHARGE-The dollar amount charged for each medical service or item to patients before discounts, contractual allowances or similar reductions.

AIDS MEDICATION ASSISTANCE PROGRAM-A specific program designed to assist HIV positive individuals with AIDS pharmaceutical costs.

ASSIGNMENT-The term used where a beneficiary assigns right to compensation to a provider.

AUDIT-A computer-based or manual comparison of each claim to the beneficiary's claims history.

BENEFICIARY-A person eligible for a program managed by The Department of Vermont Health Access. Sometimes referred to as a recipient, client or member.

BORDER HOSPITALS-Designated out-of-state hospitals whose payments are determined under the same method as Vermont hospitals. See: UB-04 manual for additional information.

CENTER FOR MEDICARE AND MEDICAID SERVICES (CMS)-A division of the federal Department of Health and Human Services, which oversees the administration of the Medicaid program. Formerly known as HCFA.

CMS COMMON PROCEDURE CODING SYSTEM (HCPCS)-A comprehensive coding system adopted by the Centers for Medicare and Medicaid Services to provide a common system for referencing health care procedures performed under the Medicare and Medicaid programs. It incorporates both Current Procedural Terminology (CPT) and Current Dental Terminology (CDT) codes.

CROSSOVER CLAIM-A claim created by Medicare and sent to Medicaid for payment of deductible and co-payment amounts. This occurs when the Medicare beneficiary is also covered by Vermont Medicaid or is a Qualified Medicare Beneficiary (QMB) and the Medicare claim so indicates.

CURRENT PROCEDURAL TERMINOLOGY (CPT) GUIDE-The CPT Guide, developed by the American Medical Association, is a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians and other providers. The manual is designed to provide a uniform language that accurately describes surgical, medical, and diagnostic services to provide an effective means for reliable nationwide communication.

DCF-The Department for Children and Families; formerly the Department of Prevention, Assistance, Transition and Health Access, and before that, the Department of Social Welfare.

DEPARTMENT OF VERMONT HEALTH ACCESS (DVHA)-The department is responsible for administration of the Vermont Medicaid program.

DETAIL NUMBER-Each line on a claim is numbered and is called the detail number. Most claims are processed and paid at the detail level, which means that a problem with one line will not stop processing or payment on the other lines.

DIAGNOSIS CODES-Diagnosis codes come from Volume 1 of the ICD-9-CM Manual. This manual lists the three, four or five digit code used to indicate the beneficiary's diagnosis. Enter the complete code. Any variation to the actual codes, such as leading or trailing zeroes, may delay payment.

EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT)-

EPSDT is a federally mandated program that is administered by the Department of Health. The program is designed to assure that children with medical needs get screened, diagnosed and treated.

EDIT-An edit is a computer system inspection of claim data for validity, accuracy and the relationship of information within the claim.

ELECTRONIC CLAIMS SUBMISSION (ECS)-ECS is a paperless method of submitting claims to HP for processing.

ELECTRONIC FUNDS TRANSFER (EFT)-EFT is a paperless method of paying providers where payments are deposited directly into their bank accounts. This payment method is mandatory for all providers. See Section 1.4.

ELIGIBILITY-Every beneficiary must first be found to be eligible for benefits. These determinations are made by eligibility specialists at the offices listed in Section 1.1.

ELIGIBILITY VERIFICATION SYSTEM (EVS)-The EVS is an automated system that informs enrolled providers about beneficiary eligibility. This should be used prior to rendering services. Eligibility can be verified with either the HP Voice Response System (VRS) or the website (www.vtmedicaid.com) under Transaction.

EXPLANATION OF MEDICARE BENEFITS (EOMB)-An EOMB is a notice issued by Medicare to the beneficiary that explains in detail the payment or non-payment of a specific claim submitted on behalf of the beneficiary to Medicare.

FAMILY PLANNING SERVICES-Any item or course of treatment furnished to a beneficiary of childbearing age for purposes of enabling the individual to freely determine the number and spacing of children.

FEDERAL FINANCIAL PARTICIPATION (FFP)-FFP describes the funds provided by the federal government to pay its portion of the Medicaid program costs.

FEE-FOR-SERVICE-A method of payment in which providers are paid a predetermined amount for a certain service or item.

FISCAL AGENT (FA)-The contractor that processes and reimburses for claims on behalf of the State of Vermont.

GREEN MOUNTAIN CARE CARD- Each Beneficiary receives a **Green Mountain Care** member card. Beneficiaries generally get cards two to three weeks after being determined eligible, the notice of eligibility will confirm status in the first few weeks.

HEALTH ACCESS ELIGIBILITY UNIT-A unit in the Department for Children and Families responsible for processing eligibility applications when health care coverage is the only benefit being sought.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)-The federal law that governs the uniform electronic submission of claims to all insurer.

HOSPICE-A program that provides palliative and supportive care for terminally ill patients and their families.

IDENTIFICATION NUMBER-A unique number assigned to each Vermont Medicaid beneficiary. The number appears on the beneficiary's **Green Mountain Care Card**.

INDIVIDUAL CONSIDERATION (IC)-The code used to indicate that the reimbursement amount will be calculated on a case-by-case basis.

INTERNAL CONTROL NUMBER (ICN)-A unique fifteen-digit number assigned to each claim by the claims processing system for identification and tracking purposes.

INTERNATIONAL CLASSIFICATION OF DISEASES-CLINICAL MODIFICATION (ICD-9-CM)-A classification and coding structure of diseases published in different editions that is used by health care providers to code diagnoses for billing purposes. Providers should use the applicable edition.

JULIAN DATE-A chronological date of the year, 001 through 365 (or 366), beginning with a four-digit year designation, (e.g. 1999121= May 1, 1999) See also Section 4.

LOCK-IN-An action that restricts a beneficiary's choice of medical provider for a reasonable time because of over-utilization of certain services. Lock-in is also used to designate the beneficiary's primary care physician when one is required. The locked in provider can be identified by using the automated eligibility verification systems: the HP Voice Response System (VRS), 802-878-7871, option 1; or the online Transaction Services at <http://www.vtmedicaid.com/Interactive/login2.html>.

MEMBER SERVICES UNIT-The DVHA has a dedicated unit that is prepared to respond to beneficiary inquiries regarding eligibility and coverage for all of the health care benefit programs. The Member Services Unit can be reached at (800) 250-8427.

NOTICE OF DECISION-A DCF letter is used to notify beneficiaries and providers of its decisions; such as eligibility or prior authorization requests.

NPI-The 10-digit National Provider Identifier.

PC PLUS-The name for Vermont's primary care case management program in which a beneficiary must select a primary care provider to assist in the management of medical care. This managed health care delivery system is administered by the DVHA.

PRIMARY CARE CASE MANAGEMENT (PCCM)-A type of managed care program, which in Vermont is called **PC Plus**. Beneficiaries select their Primary Care Provider (PCP) and access health services through their PCP who works with the beneficiary to assure high quality medical care. The DVHA administers **PC Plus**.

PRIOR AUTHORIZATION (PA)- The decision to authorize or not, is made by the DVHA or the DVHA's utilization review organization and follow specific criteria. Prior authorizations are determined on a case-by-case basis.

PRIVATE LITIGATION-Providers are asked to notify the DVHA if they receive any information regarding private litigation in which the DVHA may have an interest. These private litigations might include malpractice suits involving DVHA beneficiaries, accident suits or personal injury suits.

PROCEDURE CODE-A five-character (larger if modifier is required) description of medical services or other health care. Vermont Medicaid requires providers to use procedure codes for all Vermont Medicaid billings.

PROVIDER ENROLLMENT AGREEMENT-The form that sets out the terms and conditions agreed to as a part of the enrollment or annual re-certification process. It must be completed by each provider in order to bill HPES for the service or item.

PROVIDER NUMBER-The unique seven-digit number assigned to each enrolled provider. As of May 2008 the NPI is required except for Atypical providers.

REMITTANCE ADVICE (RA)-A computer generated report made available to providers by the fiscal agent indicating the status of all claims that have been submitted and entered into the system for processing.

RETRO-ELIGIBILITY-The 90-day period prior to the date that eligibility was approved. See Section 1.3.8

SPEND-DOWN-“Spend-down” is a specific amount of medical expenses determined by the Department for Children and Families for which the beneficiary must be responsible for before eligibility is granted. A spend-down beneficiary becomes eligible for Vermont Medicaid on the day of the month in which he or she reaches the incurred medical expense amount that equals or exceeds the specified “spend-down” amount.

THIRD PARTY LIABILITY (TPL)-In some circumstances, beneficiaries have additional resources beyond Vermont Medicaid, including other health insurance.

USUAL AND CUSTOMARY RATE (UCR)-Various claim forms (CMS 1500, UB04 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 insure and private-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 because of a sliding-fee scale based on the patient’s documented inability to pay. Sale prices should be used during the sale period. If a service or item is offered free-of-charge by the provider, no charge will be made to Vermont Medicaid. Providers may not discriminate against Vermont Medicaid beneficiaries by charging a higher fee for the same service than that charged to a private-pay patient, except as noted above regarding sliding-fee scale.

VERSION NUMBER-The processing version of a claim. The first claim paid for the services rendered is version 00. The first adjustment to any paid claim is version 01, etc.

VOICE RESPONSE SYSTEM (VRS)-A system which allows Vermont Medicaid providers to verify beneficiary eligibility, dental dollars spent, third party liability information, limitation status and remittance amount by using a touch tone telephone.

1.1.6 ABBREVIATIONS

AABD	-Aid to the Aged, Blind and Disabled
ADA	-American Dental Association
AMA	-American Medical Association
AMAP	-Aids Medication Assistance Program
ANFC	-Aid to Needy Families with Children
AWP	-Average Wholesale Price
BC/BS	-Blue Cross/Blue Shield
CMS	-Centers for Medicare and Medicaid Services-Formerly HCFA
CPT	-Physician’s Current Procedural Terminology
DCF	-Department for Children and Families
DME	-Durable Medical Equipment
DDMHS	-Department of Developmental and Mental Health Services
DOB	-Date of Birth
DOS	-Date of Service
DVHA	-Department of Vermont Health Access

EAC	-Estimated Acquisition Cost
ECS	-Electronic Claims Submission
EFT	-Electronic Funds Transfer
EVS	-Eligibility Verification System
EOB	-Explanation of Benefits
EOMB	-Explanation of Medicare Benefits
EPSDT	-Early and Periodic Screening, Diagnosis and Treatment
FA	-Fiscal Agent
FFP	-Federal Financial Participation
FFS	-Fee-for-Service
FDA	-Food and Drug Administration
HAEU	-Health Access Eligibility Unit
HCFA	-Health Care Financing Administration, now known as CMS
HCPCS	-HCFA Common Procedure Coding System
HHA	-Home Health Agency
HHS	-Department of Health and Human Services (federal)
HP	-HP Enterprise Services
IC	-Individual Consideration
ICD-9-CM	-International Classification of Disease-9 th Edition
ICF/MR	-Intermediate Care Facility for the Mentally Retarded
ICN	-Internal Control Number
ID	-Identification
MC	-Medicare
MFCU	-Medicaid Fraud Control Unit
MSU	-Member Services Unit
NDC	-National Drug Code
NF	-Nursing Facility
NOD	-Notice of Decision
OTC	-Over the Counter
PA	-Prior Authorization or Physician's Assistant
PCCM	-Primary Care Case Management
PC PLUS	-Primary Care Plus
POS	-Place of Service
PRO	-Peer Review Organization
QMB	-Qualified Medicare Beneficiary
RA	-Remittance Advice
RPL	-Recipient Placement Level
SLMB	-Specified Low-Income Medicare Beneficiary
SNF	-Skilled Nursing Facility
SRS	-Department of Social and Rehabilitation Services
SSI	-Supplemental Security Income
TPL	-Third Party Liability
UCR	-Usual and Customary Rate
VHAP	-Vermont Health Access Plan
VRS	-Voice Response System
YTD	-Year to Date

1.1.7 IMPORTANT ADDRESSES AND TELEPHONE NUMBERS

Maximus

101 Cherry Street, Ste. 320

Department of Vermont Health Access

312 Hurricane Lane, Suite 201

Burlington, Vermont 05402
Tel: (800) 250-8427
Fax: (802) 651-1528
TTY: 888-834-7898

Williston, Vermont 05495
Tel: (802) 879-5900
Fax: (802) 879-5619

Department of Disabilities, Aging & Independent Living
103 South Main Street
Waterbury, Vermont 05671-1201
Tel: (802) 241-2880
Fax: (802) 241-2897

*Office of Oral Health
Department of Health*
P.O. Box 70
Burlington, Vermont 05402
Tel: (802) 241-2604
Fax: (802) 241-3052

*Ombudsman Program
Vermont Legal Aid*
264 North Winooski Avenue
P.O. Box 1367
Burlington, Vermont 05402
Tel: (800) 917-7787

HP Enterprise Services
312 Hurricane Lane, Suite 101
Williston, Vermont 05495
Tel: (802) 878-7871 or (800) 925-1706
Fax: (802) 878-3440

For paper claim submission to HP, please use the following P.O. Boxes according to claim or inquiry type. All other paper inquiries may continue to be mailed to P.O. Box 888, Williston VT 05495-0888.

CMS-1500 paper claims

HP Enterprise Services
P.O. Box 777
Williston, Vermont 05495-0777

UB-04 paper claims

HP Enterprise Services
P.O. Box 999
Williston, Vermont 05495-0999

Dental and Vision paper claim forms

HP Enterprise Services
P.O. Box 1710
Williston, Vermont 05495-1710

Refund Checks

HP Enterprise Services
P.O. Box 1645
Williston, Vermont 05495-1645

1.1.8 CLAIM SUBMISSION & CORRESPONDENCE MAILING ADDRESSES

To ensure your request is processed in a timely manner, please use the correct PO Box specific to each type of correspondence mailed to HP Enterprise Services.

PO Box 999 – UB04 Claim Forms

PO Box 777 – CMS 1500 Forms

PO Box 1710 – Dental and Vision Claim Forms

PO Box 1645 – All Checks

PO Box 888 – All Other Mail & Inquiries

Williston, VT 05495-0888

1.1.9 CONTRACTUAL ALLOWANCE

Vermont Medicaid is payer of last resort, and as such, will not consider and pay amounts that are considered to be the contractual allowable amount of a primary insurer.

Providers must reduce the expected payment from Vermont Medicaid and note the contractual allowable adjustment of a primary insurer. When another insurance carrier has made a payment,

you must add the contractual allowable adjustment/discount amount to the payment and document the total in the appropriate field on your claim form. If the entire allowed amount is applied to the primary insurance deductible do not enter the contractual allowance.

Vermont Medicaid will consider payment based on the Vermont Medicaid allowed amount after deducting the other insurance payment and contractual allowable adjustment/discount amounts.

1.1.10 FRAUD

Medicaid pays only for services that are actually provided and that are medically necessary. In filing a claim for reimbursement, the code should be chosen that most accurately describes the service that was provided. It is a felony under Vermont law knowingly to do, attempt, or aid and abet in any of the following when seeking for receiving reimbursement from Vermont Medicaid:

- File a claim for services which were not rendered
- File a false claim
- File a claim for unauthorized items or services
- Bill the beneficiary or the beneficiary's family for an amount in excess of that allowed by law or regulation
- Fail to credit the state or its agent for payments received from social security, insurance or other sources
- Receive unauthorized payment

Suspected fraud, waste or abuse should be reported to the DVHA Program Integrity Unit at <http://dvha.vermont.gov/for-providers/program-integrity-reporting-suspected-fraud-waste-and-abuse>, telephone (802) 879-5900 or Medicaid Fraud Control Unit of Vermont's Attorney General's Office, telephone (802) 241-4440.

1.1.11 MEDICAL NECESSITY

Vermont Medicaid only pays for items that are medically necessary. Per the Medicaid Rule, 7103, medically necessary is defined as health care services that are appropriate, in terms of type, amount, frequency, level, setting and duration to the beneficiary's diagnosis or condition. Medically necessary care must be consistent with generally accepted practice parameters as recognized by health care providers in the same or similar general specialty as typically treat or manage the diagnosis or condition and

- Help restore or maintain the beneficiary's health
- Prevent deterioration or palliate the beneficiary's condition
- Prevent the reasonably likely onset of a health problem or detect an incipient problem

Additionally, for EPSDT-eligible beneficiaries, medically necessary includes a determination that a service is needed to achieve proper growth and development or prevent the onset or worsening of a health condition.

1.1.12 MEDICAL NECESSITY FORM (MNF)

A completed DVHA Medical Necessity Form (DVHA 60) is the preferred documentation for Home Respiratory Therapy programs, DME and certain prescribed medical supply items with a few exceptions (see Exceptions below). The ordering physician or nurse practitioner needs to complete the MNF and give a clean copy to the patient or to the DME supplier.

Submission of the form and any necessary information to clearly document medical need is all that is needed to make the request for prior authorization.

If the code/service requires prior authorization, the DME supplier will send the MNF and all pertinent information to the DVHA as a PA request.

Both the ordering physician/nurse practitioner and the DME vendor are required to keep legible copies of all information in the patient record.

The signature date on the MNF/order must be within 6 months (before or after) of the dispensing date (billed DOS) for all items except ostomy and urologic supplies. (The order on these supplies is good for one year).

The DVHA MNFs are Form DVHA 286 and DVHA 60. An Eyeglass Medical Necessity Form is also available. Other medical necessity forms are acceptable as long as the following information is provided:

- Beneficiary name
- Beneficiary date of birth
- Beneficiary Vermont Medicaid ID number (MID)
- Diagnosis code(s) or description or full description of medical condition
- Where equipment/item will be used (home or other; if other, name of facility)
- Length of time it will be used
- Legible name of ordering provider (physician, nurse practitioner, or other allowable practitioner)
- Signature and provider number of ordering provider (physician, nurse practitioner or other allowable practitioner) excluding chiropractors and physicians assistants
- Date that ordering provider reviewed and signed the MNF. The signature date must be within 6 months (before or after) of the dispensing date (billed DOS) for all items except ostomy and urologic supplies. (The order on these supplies is good for one year).

1.1.13 PRIOR AUTHORIZATION AND NOTIFICATION FOR HOSPITAL ADMISSIONS

Select procedures and diagnostic tests require notification to the DVHA Clinical Unit. Notice for elective care should be given at least five days prior to the hospital admission. Services requiring prior authorization from the DVHA in the fee-for-service program will also require prior authorization in **PC Plus** Program. If prior authorization is required and obtained for an inpatient stay, no additional notification is required upon admission.

Emergency in-state inpatient hospital admissions do not require prior authorization. Members are required to notify their PCP of the emergency as soon as possible.

All out-of-state urgent/emergency inpatient hospital admissions (excluding designated border hospitals, see UB-04 Supplement) require notification be made to the DVHA Clinical Unit within 24 hours or the next business day of the admission.

See the UB-04 Provider Manual at <https://vtmedicaid.com/Downloads/manuals.html> for further information regarding out-of-state inpatient hospital admissions.

1.1.14 PRIVATE LITIGATION

Providers are asked to notify Vermont Medicaid if they receive any information regarding private litigation in which the DVHA may have an interest. These private litigations might include malpractice suits involving Vermont Medicaid beneficiaries, accident suits or personal injury suits.

1.1.15 REIMBURSEMENT OF OVERPAYMENTS

Providers are reminded of the 2009 Fraud Enforcement and Recovery Act (FERA) which amended the False Claims Act, 31 U.S.C §§3729-3733, by increasing the scope of the false claims liability to include persons who knowingly conceal the retention of any overpayment of government money and the 2010 Patient Protections and Affordable Care Act (PPACA) which directly linked the retention of overpayments to false claims liability. PPACA requires the report and return of all overpayments within 60 days after the date on which the overpayment was identified or the date the corresponding cost report was due, whichever is later. Additionally, providers must submit notification in writing as to the reason of the overpayment. HPES will forward any cases in which the discovered overpayment was not refunded during the timeline mandated by PPACA to the DVHA Program Integrity Unit for their review.

Hospitals (in addition to the above information) HPES contracts with AIM HealthCare to audit hospitals for credit balances on accounts. This arrangement does not negate the provider's responsibility to report and return overpayments timely. HPES will forward any cases in which the discovered overpayment was not refunded during the timeline mandated by PPACA to the DVHA Program Integrity Unit for their review.

1.2 PROVIDER INFORMATION

1.2.1 PROVIDER TAX

State law requires payments, according to a schedule established by The Department of Vermont Health Access (DVHA), of the provider assessment tax. Effective July 1, 2008, the DVHA was given the authority to deduct delinquent provider taxes from claims. If a health care provider fails to pay its assessments, the commissioner may, after notice and opportunity for hearing, deduct these assessment arrears and any late-payment penalties from Vermont Medicaid payments otherwise due the provider pursuant to 33 V.S.A 1952(f).

The DVHA Commissioner retains the authority to adopt an alternative payment schedule for your organization for good cause shown. If for some reason your financial position demands an alternative payment schedule, you must seek and gain approval from the Commissioner in advance of the due date.

Contact the Reimbursement Administrator if you have questions at (802) 879-5937.

Your payments should be mailed to:

Lockbox
State of Vermont State Agency of Human Services
Supplemental/Tax Assessment
PO Box 1335
Williston, VT 05495

1.2.1.1 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://dvha.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.

1.2.2 ADVISORY

The *Vermont Health Access Advisory* is a bi-monthly publication of HP and The Department of Vermont Health Access. This newsletter provides important information, which is necessary for accurate billing to Vermont Medicaid and is often the only notification of a change in billing procedure. It is recommended that each provider retain copies for the Advisory and consult them whenever a question arises regarding DVHA policy or procedure. The Advisory can be attained through the mail or online at www.vtmedicaid.com. Request email delivery at: vtadvisorycommunications@HP.com.

1.2.3 CHIROPRACTIC SERVICES

Please see CHIROPRACTIC SERVICES in the [CMS 1500 Supplement](#).

1.2.4 ENROLLMENT AND CERTIFICATION

In order for providers to participate in and receive reimbursement from Vermont Medicaid Programs, they must first become enrolled. Licensed or Medicare/Medicaid certified health care providers may be enrolled as Vermont Medicaid providers if at least one service they provide is recognized in the Vermont Medicaid State Plan. Any health care provider who is interested in becoming enrolled in the Vermont Medicaid program, should contact the HP Provider Enrollment Unit. Enrollment requires that the provider submit a signed provider agreement and a copy of the applicable license/certification document. When the DVHA accepts an enrollment, a Vermont Medicaid provider ID number will be issued. No payments may be made until a provider number has been assigned.

Enrollment is limited to the following:

- Regular enrollment is for those participating providers who are in-state or along the border and see Vermont Medicaid beneficiaries on a regular basis.
- Court ordered enrollment is for providers whose services have been ordered by a court, a fair hearing decision or by a Coverage Exception.
- Request (M108/7104) decision of the commissioner. Court ordered providers would only be enrolled for dates consistent with the order/decision..
- Special status is granted for out-of-state providers who have seen a Vermont Medicaid beneficiary in an emergency or urgent situation, or who have been prior approved for out-of-state services. Special status providers will be enrolled for a date or dates, agreed upon by the DVHA and the provider. The DVHA does not deem a provider enrolled in Medicare as enrolled in Vermont Medicaid.
- **Note: Non-participating enrollment is no longer accepted.**

A provider cannot be paid for a date of service when the provider is not enrolled. If a provider has not been enrolled in Vermont Medicaid, the effective date for Vermont Medicaid enrollment is the date on which HP received the completed enrollment application. If a provider has been enrolled in Vermont Medicaid and re-enrollment is completed within 30 days of the last certification date, there will be no lapse in enrollment. If a provider has been enrolled in Vermont Medicaid and re-enrollment is completed in more than 30 days of the last certification date, the new enrollment date is the date on which HP received the completed re-certification application, unless an extension has been granted to a **Primary Care Plus** Primary Care Physician (PCP) for good cause. Special status providers will be enrolled for a date, or dates, agreed upon by the DVHA and the provider. Retroactive enrollment will be allowed to cover urgent or emergent care delivered by a provider outside of Vermont that is not considered a border provider.

A provider must be re-certified in order to continue participation in the program. Approximately 60 days prior to the re-certification date, a recertification request letter will be sent to the provider's address on file. The recertification letter will include the information and directions necessary to complete the recertification process. Providers are required to forward a copy of their current provider license, recertification request letter and in some cases the Provider Enrollment/Recertification Form, at time of notification. Providers providing laboratory services must also include a copy of their current CLIA certification. A complete list of Provider Enrollment Forms can be accessed at www.vtmedicaid.com/Downloads/forms.html.

To assure that provider enrollment is uninterrupted; all requested applicable documentation is required to be returned to HP by the date indicated on the recertification request letter.

Enrollment will be rejected if:

- Mandatory information is not received
- The provider is disbarred or sanctioned from participation in federal programs
- The provider is disbarred or sanctioned by the State of Vermont

CLIA: Providers that provide laboratory services are required to include a current copy of their CLIA certification at time of enrollment or recertification.

1.2.5 PAYMENT CONDITIONS

Providers are entitled to payment for diagnostic, therapeutic, rehabilitative or palliative services when all of the following conditions are met:

- The provider is enrolled with Vermont Medicaid
- The services are covered by the applicable program
- The services are medically necessary
- The services are within the scope of the provider's license
- The services are documented in the patient's medical records
- Prior approval, if required, has been obtained
- The claim is submitted within the timely filing limits and contains all required information
- The provider complies with the Advance Directives Law
- The beneficiary is eligible on the date of service
- Billing may not be done in advance of any service to be performed or supplied.

1.2.6 CONDITIONS OF PARTICIPATION

The Conditions of Participation are stated in the Provider Enrollment/Recertification Agreement. Please consult your current agreement for details.

1.2.7 DOCUMENTATION OF SERVICES

Each provider must keep written documentation for all services that have been performed for beneficiaries. **All documentation must be legible, contain all required information and applicable dates.** Providers must be prepared to submit information on transactions upon request of the State Agency or HHS secretary for records of any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5 year period ending on the date of the request, within 35 days; this includes the actual case record notes for any services performed. The documentation for any service that was billed must be kept for seven years. This information must also be available at any time for on-site audits.

1.2.8 WHO IS RESPONSIBLE FOR PAYMENT

Verifying eligibility before service:

Providers are expected to verify eligibility for every beneficiary prior to providing the service or item to be clear about who has financial responsibility for the service. Eligibility can be verified up to nine days in advance. Eligibility can be verified through the automated Voice Response System (VRS/Malcolm), online Transaction Services (www.vtmedicaid.com) or by calling the Provider Services Unit help desk. When an eligible aid category code is given, the provider should determine that the service to be provided is covered within that aid category. This will also show what other insurance is on file. To ensure timely processing of your claim, validate other insurance with beneficiary or refer them to the Department for Children and Families.

Billing the Beneficiary:

If the provider bills Vermont Medicaid for a service or item, the provider may not bill the patient for any reason except the following:

- The amount due is for unpaid Vermont Medicaid co-payments and deductibles
- The claim was denied for lack of eligibility and the date of service was greater than 60 days beyond the loss of eligibility date
- The claim was denied because another insurer's rules were not followed
- The claim is submitted to Medicaid by Medicare for a patient enrolled in a Medicaid pharmacy only plan or
- If the HPES system reports that a beneficiary has other insurance, the provider must bill the service or item to the other medical insurance prior to billing Vermont Medicaid. If the beneficiary is no longer enrolled with the other insurer and the beneficiary does not report the insurance change to Vermont Medicaid within 30 days and after the 30 days have lapsed, the HPES system still reports that the patient has other insurance, the provider may bill the beneficiary.

Under the Provider Agreement (Conditions of Participation #9), failure to give advance notice that a Vermont Medicaid payment will not be accepted prevents the provider from billing the beneficiary. If the beneficiary is eligible for Vermont Medicaid and the provider has made the decision not to bill Vermont Medicaid for the service or item requested, the beneficiary must be informed in advance of providing the service.

To document that proper notice was given, providers are required to document the notice on their letterhead, have it signed by the beneficiary or the beneficiary's parent/guardian, provide a copy to the beneficiary, and retain a copy in the beneficiary's file. Failure to give advance notice, prevents the provider from billing the beneficiary. When a beneficiary is billed, the claim cannot be submitted to HP Enterprise Services for processing.

Federal Medicaid policy does not permit providers to bill Vermont Medicaid or the beneficiary any fee for missing a scheduled appointment.

1.2.9 WHO IS PRIMARY

When the DVHA is the primary payer (i.e. the HPES system indicates no other insurer) and Vermont Medicaid payment is accepted, the provider should submit all bills to the DVHA's fiscal intermediary and never to the patient. Under the provider agreement, the provider has agreed to accept the DVHA's payment or denial (except as enumerated above) as payment in full.

When the HPES system shows a source other than the DVHA as the primary payer (such as Medicare or any other insurance carrier) the DVHA is the payer of last resort. Under the provider agreement, certain restrictions apply.

-If the third party payment to the provider is greater than the amount payable by the DVHA, the provider cannot bill the beneficiary for any balance

-If the third party payment to the provider is less than the amount payable by the DVHA and the balance is not greater than any applicable co-payment, the provider may bill the beneficiary for the lesser of any applicable co-payments or the difference between the third party payment and the DVHA rate

-If the third party payment to the provider is less than the amount payable by the DVHA but greater than any applicable co-payment amount, the provider may bill the beneficiary for the co-payment and the DVHA for the balance. The amount paid by the DVHA shall not be greater than the DVHA's allowed amount, less any applicable co-payment

-If the third party payment was made directly to the beneficiary, the provider may bill the beneficiary for the amount paid by such third parties. In addition, the provider may bill the beneficiary for applicable co-payments and/or client's liability (spend-down) amounts. If the third party payment to the beneficiary is less than the amount payable by the DVHA, then the requirements of #2 or #3 apply, depending upon the payment amount.

1.2.10 PAYMENT-DVHA PRIMARY

Vermont Medicaid reimbursement policy for the various CMS 1500 billers is as follows:

Ambulance Services-Reimbursement basis is the lower of the provider's charge or Vermont Medicaid rate on file. The unit of service is the loaded mile.

Anesthesia Assistants-Reimbursement basis is 80% of the Vermont Medicaid rate on file.

Audiologist-Reimbursement basis is the lower of the provider's charge or Vermont Medicaid rate on file. The unit of service is the procedure.

Chiropractor-Reimbursement basis is the lower of the provider's charge or Vermont Medicaid rate on file. For additional Chiropractic information, see the CMS 1500 Supplement.

Certified Nurse-Midwife- Reimbursement basis is 100% of the Vermont Medicaid rate on file.

CRNA- Reimbursement basis is 100% of the Vermont Medicaid rate on file.

Dentist-Reimbursement basis for CPT procedures is the lower of the provider's charge or the Vermont Medicaid rate on file. All other billings are on the dental claim form (see Dental Supplement.)

Federally Qualified Health Center:

Primary Care - Reimbursement is on interim, cost-based encounter rates determined using Medicare principles and receiving the higher of encounter cost of PPS payment at the final cost settlement at year's end. There is an upper limit to the encounter rate when applicable.

Dental Services - Reimbursement is fee-for-service with a cost settlement at year's end.

Independent Lab - Reimbursement basis is the lower of the provider's actual charge or the Vermont Medicaid rate on file not to exceed the Medicare maximum allowable amount. There is no cost settlement.

Independent Radiology - Reimbursement basis is the lower of the provider's actual charge for the Vermont Medicaid rate on file not to exceed the Medicare maximum allowable amount. There is no cost settlement. For additional Radiology information, see the CMS 1500 Manual.

Licensed Lay Midwife - Reimbursement basis is the lower of the provider's charge or ninety percent (90%) of the Vermont Medicaid rate on file for a physician providing the same service. Reimbursement is limited to certain procedure codes.

Naturopathic Physicians - Reimbursement basis is the lower of the provider's charge or Vermont Medicaid rate on file.

Nurse Practitioner - Reimbursement basis is the lower of the provider's charge or the Vermont Medicaid rate on file for a physician providing the same service.

Optician - Reimbursement basis is the lower of the provider's charge or Vermont Medicaid rate on file. The unit of service is the procedure.

Optometrist - Reimbursement basis is the lower of the provider's charge or Vermont Medicaid rate on file. The unit of service is the procedure.

Physician:

Attending Physician - Reimbursement basis is the lower of the provider's charge or Vermont Medicaid rate on file. The unit of service is the CPT procedure.

Anesthesiologist - Reimbursement basis is the lower of the provider's charge or Vermont Medicaid rate on file for the procedure. The unit of service is 15 (or 30) minutes.

Assistant Surgeon - Reimbursement is 25% of allowed amount paid to surgeons. Reimbursement is limited to certain surgical procedures needing assistance.

Pathologists - Reimbursement will be made in accordance with Medicare's *Medigram 83-11* and subsequent Medigrams. The unit of service is the CPT procedure.

Psychiatry - Reimbursement basis is the lower of the provider's charge or Vermont Medicaid rate on file. The unit of service is per visit or for time elapsed.

Surgeons - Reimbursement basis is the lower of the provider's charges or the Vermont Medicaid rate on file. The unit of service is the surgical procedure.

Physician Assistant - Reimbursement basis is the lower of the provider's charge or ninety percent (90%) of the Vermont Medicaid rate on file for a physician providing the same service. The unit of service is the procedure.

Podiatrist - Reimbursement basis is the lower of the provider's charge or Vermont Medicaid rate on file. The unit of service is the procedure.

Psychological Services: see CMS-1500 (PSYCHIATRY/PSYCHOLOGY)

Rural Health Clinic:

Primary Care - Reimbursement is on interim, cost-based encounter rates determined using Medicare principles and a final cost settlement at year's end. There is an upper limit to the encounter rate when applicable.

Dental Services - Reimbursement is fee-for-service with a cost settlement at year's end.

Other Ambulatory Services - Reimbursement is Vermont Medicaid fee-for-service rate on file.

1.2.11 PAYMENT-MEDICARE PRIMARY

See: Provider Manual MEDICAID/MEDICARE CROSSOVER BILLING

1.2.12 INDIVIDUAL CONSIDERATION/MANUAL PRICING

The rates on file for certain procedure codes do not have specific dollar amounts because no one amount is appropriate (e.g. code 99070). In these cases, the rate on file is set at "IC" (individual consideration). The fiscal intermediary and the DVHA will calculate the allowed amount. This process is often called "manual pricing". For DME, see PAYMENT – DVHA PRIMARY in the [CMS 1500 Supplement](#).

Providers wishing to request updates to any of the following: place of service, provider type, provider specialty modifier/code combination additions and diagnosis rate review are advised to e-mail their request to vermonthipaacontact@hp.com. Providers must include the following information: the ICN of the denied claim (required), the complete name of the person initiating the request, the specific code, attribute to be updated, provider name and number.

All unit requests must include a brief cover letter containing the following information: ICN of the denied claim (required), complete name of the person initiating the request, units requested, the specific code and the provider name & number. Other required items include: Hard copy of the claim, notes and all medical journal articles sustaining your request. Mail to: HP Enterprise Services, 312 Hurricane Lane, Williston, VT 05495, Attn: HIPAA Request Reviewer.

1.2.13 PRIOR AUTHORIZATION-NOTICE OF DECISION ("PA FORM LETTER")

The Notice of Decision is a system-generated form that the requesting provider receives from the DVHA or HP in response to a Prior Authorization (PA) request. Copies of this form are sent to the beneficiary.

This form contains the following information:

Box 2: The value will be either "A" (approved) or "D" (denied) or "I" (awaiting further information).

Box 3: The dates of service.

Box 4: The procedure code.

Box 5: The number of units and/or occurrences

1.2.14 GUIDELINES

Several services require review before coverage can be granted for additional services. Guidelines have been developed in cooperation with the provider group involved and medical consultants. Each guideline lists that types of information needed for the review, criteria to be met, other pertinent details needed, and documentation required. The guidelines for the following services are available upon request from the DVHA:

-
-
1. Chiropractic services-for children under age 12 or extension of services beyond the initial 10 sessions
 2. Total Enteral Nutrition Home Program
 3. Outpatient Rehabilitative Care (OT, PT, ST)-extension of services for adult beneficiaries beyond the initial 30 combined visits per calendar year can be requested for the following diagnoses: spinal cord injury, traumatic brain injury, stroke, amputation, or severe burn.
 4. Out-of-state hospital inpatient admissions (excludes border hospitals)
 5. Out-of-state general hospital psychiatric admissions (includes border hospitals)
 6. Out-of-state alcohol treatment (Detox and Rehab, includes border facilities)
 7. Rehabilitative Centers-inpatient settings
 8. Respiratory Home Care (Oxygen)

See: [Prior Authorization](#)

1.2.15 RIGHTS AND RESPONSIBILITIES

Participation in Vermont Medicaid is voluntary. Participating health care providers may be selective in terms of the patients or customers they choose to serve and in the service or goods they choose to bill to the State. Discrimination on the basis of race, color, sexual orientation, or national origin is not allowed. A provider may not refuse service to a Vermont Medicaid beneficiary simply because the beneficiary is covered by other health insurance. A provider must meet commonly accepted standards of professional practice.

Providers must submit claims and required documentation in a form acceptable to the State. All claims must be received within the timely filing limits.

Federal Medicaid policy does not permit providers to bill Vermont Medicaid or beneficiaries any fee for missing a scheduled appointment. A missed appointment is not considered a distinct reimbursable service.

1.2.16 SUPPLEMENTATION

Once Vermont Medicaid has been billed for a service or item, the provider may not attempt to collect any additional reimbursement for that service or item from the beneficiary, the beneficiary's family or anyone acting on behalf of the beneficiary, except for:

1. The applicable conditions described in section 1.2.10
2. Permitted deductible and co-payment amounts
3. Specific allowed supplementations authorized in Medicaid Rule 7602

1.2.17 NOTICE THAT MEDICAID WILL NOT BE ACCEPTED

If a provider does not intend to bill Vermont Medicaid for specific services, the patient must be fully informed of the decision and its consequences prior to rendering the service. Patients must understand that they will be financially responsible for the service(s). The DVHA strongly encourages providers to document (using your own form) this agreement/understanding between beneficiary and provider. Comprehensive documentation showing evidence that proper notice was given to the beneficiary should include the following information:

-
-
1. Provider's name and Vermont Medicaid provider ID number
 2. Beneficiary's name and signature (or signature of a parent, if beneficiary is a minor).
 3. Description of service(s) sought
 4. A clear statement that the provider is unwilling to accept Vermont Medicaid payment for the specific service(s) sought and if the beneficiary wants to get this service from this provider, the beneficiary or responsible adult must accept full financial responsibility
 5. Date of signing

The provider should give a copy to the beneficiary or responsible adult and retain a copy of any such documentation. If the beneficiary or responsible adult accepts financial responsibility, the claim should not be submitted to HPES for payment.

1.2.18 SANCTIONS

The DVHA may take administrative action against providers found in violation of Vermont Medicaid policy. See section 7106 of the Medicaid Rules for regulatory details pertaining to sanctions and appeals. A copy of Medicaid Rules is posted at <http://humanservices.vermont.gov/on-line-rules/dvha> and at each DCF District Office and at the state library in Montpelier.

1.2.19 VIOLATIONS

Suspected violations of Vermont Medicaid policies should be reported to the Program Integrity Unit (802) 879-5900. All information will be treated confidentially.

1.2.20 TERMINATION

Providers who no longer wish to participate in the Vermont Medicaid Program may terminate their enrollment at any time by either writing a letter to HP or by indicating in the Vermont Medicaid Provider Identification Record form during annual re-certification. If requested, the provider's enrollment will be closed on the date specified. Providers are required to give their patients 30 days notice prior to termination. Primary care providers in **PC Plus** are required to give 90 days notice before termination of the **PC Plus** agreement.

1.2.21 TIMELY FILING

In no case will a claim be considered if the date of service is greater than two years prior to the DVHA's receipt of the claim.

If a claim has a date or dates of service past the timely filing limit, it may be submitted for payment directly to HPES if one or more of the following conditions are met:

- HPES denied the claim within the timely filing limit for a reason other than exceeding the time limit. A copy of the remittance advice showing the denial must be attached to each claim.
- A beneficiary's eligibility was made retroactive and the date of service is within the retroactive period. The claim must be submitted within the first twelve months of the date on the Notice of Decision. Include a note with the claim stating the retroactive date of eligibility.

-Inpatient claim, the timely filing limit is 180 days from the date of discharge.

When a claim is billed to Medicare with Vermont Medicaid noted as the secondary payer (using the crossover function), the crossover claim will be considered timely if it is received within two years of the date of service.

When the system indicates that Vermont Medicaid is the primary payer, the timely filing limit for such claims is six months from the date of service, except for global bills for maternity and orthodontia, which must be filed within 12 months of the first date of service.

When the system indicates that Vermont Medicaid is not the primary payer, providers can either file all claims (except Medicare crossover claims) within six months, or providers may separate these claims into two groups each with a different timely filing requirement.

-For claims that are not “pay and chase” (see below), the timely filing limit is 12 months from the date of service

-The timely filing limit is six months from the date of service for “pay and chase” claims (i.e. where the system indicates that the beneficiary is covered by court ordered insurance D1, D2, D3, D5, D8 and D9) or the claim is for any of the following procedure and diagnosis codes:

-Procedure codes: 99381-99385, 99391-99394 and 99173

-Diagnosis codes: 640-648 series, 651-658 series, 671 series, 673 series, 675-676 series, V01-V07 series, V20 series, V22-V23 series, V28 series, V30-31 series, V33-34 series, V73-75 series, V700 code, V770-777 code, V783 code, V792 code, V793 code, V798 code, V823 code and V824 code

Beneficiaries covered by court ordered insurance can be identified by using the Voice Response System that says “The recipient has other insurance with (name) with coverage type (coverage code D1 or D2, etc).”

The DVHA will consider paying an untimely claim in unusual circumstances. When appealing a timely filing denial, providers must fully research and document in the request the extenuating circumstances surrounding the claim (e.g. submission dates, adjusted dates, and denial dates). If there is no documentation or the documentation is insufficient to validate extenuating circumstances for the late submission, your appeal will be denied.

Providers submitting a timely filing appeal request that contains 10 or more claims, all with the same late submission reason, are required to complete and submit the *Timely Filing Appeal Claims List for 10 or more claims* form located at www.vtmedicaid.com/Downloads/forms.html.

A request for an exception can be made by sending the claim with a detailed explanation of why an exception should be granted, along with any other required attachments to: HP Enterprise Services, P.O. Box 888, Williston, Vermont 05495-0888 Attn: Timely Filing Appeals. For information on timely filing and adjustment requests see section 4.2.1 ADJUSTMENT REQUESTS & TIMELY FILING.

1.2.22 UTILIZATION REVIEW

The DVHA conducts numerous utilization management and review activities. Reviews are intended to assure that quality services are provided to beneficiaries and that providers are using the program properly. The reviews are generally an examination of records, known as a desk audit, although they may also include an on-site visit from the utilization review unit.

DVHA staff utilizes clinical criteria for making Utilization Review (UR) decisions that are objective and based on sound medical evidence. Approved criteria include the following:

- McKesson Health Solutions InterQual® Guidelines;
- DVHA Clinical Guidelines;
- Vermont State Medicaid Rules;
- Hayes and Cochrane New Technology Assessments; and
- Other Nationally Recognized Evidence Based Criteria
- McKesson Health Solutions InterQual® Guidelines are now available to providers behind the Vermont Medicaid secure provider web portal at www.vtmedicaid.com/secure/logon.do.

DVHA Clinical Guidelines and Vermont Medicaid State Rules will continue to be available at the DVHA website at dvha.vermont.gov/for-providers/clinical-coverage-guidelines.

1.2.23 CLIA CERTIFICATION

Providers who perform laboratory services and who do not have CLIA certification, should contact the Vermont Department of Health, 108 Cherry Street, Burlington, VT 05401 by phone (802) 652-4145 or fax at (802) 865-7701 for information.

1.2.24 CLINICAL PRACTICE GUIDELINES

The Department of Vermont Health Access has adopted various Clinical Practice Guidelines that are based upon evidence based medicine. These guidelines outline the preferred approach for most patients and are used to support the decision making processes. The guidelines can be found at <http://vermont.gov/for-providers> under *Clinical Initiatives*.

1.3 BENEFICIARY INFORMATION

"Beneficiary" is the term used to refer to a person who has been determined eligible for and enrolled in one of the Vermont Medicaid programs. Eligibility is determined at a district office of the Vermont Department for Children and Families, including the Health Access Eligibility Unit in Waterbury, based on a review of the applicant's needs, income and resources. The various Vermont Medicaid programs have differing eligibility requirements and benefits.

Each Beneficiary is assigned a unique identification number (UID) and receives a Green Mountain Care member card. The UID number will be 1 to 8 digits in length. Enter the UID number on your claim exactly as it is shown on the beneficiary's card.

Providers must verify the patient's eligibility and other insurance information using the patient's Medicaid UID number, by accessing either of the automated eligibility verification systems: the HPES Voice Response System (VRS), 802-878-7871, option 1; or the online Transaction Services at <http://www.vtmedicaid.com/Interactive/login2.html>.

In the event, a provider only has access to a member's Social Security Number, these systems will provide the UID number required for claim submission.

1.3.1 PROGRAM STRUCTURE

The Vermont Medicaid program operates both a fee-for-service program and a managed care program. The managed care program is called **Primary Care Plus**, which is the name for the primary care case management program. Vermont requires all traditional Medicaid, Dr. Dynasaur, and VHAP beneficiaries to enroll in **PC Plus**. The only exceptions are if the beneficiary is in a long-term care facility, on another federal waiver program, is in the “High Tech” program, or has other credible health insurance. Many services covered under **PC Plus** need to be authorized by the Primary Care Provider (PCP). Services rendered to a beneficiary enrolled in a primary care case management (PCCM) must follow the guidelines for the PCCM program. See Section 2. Medicaid Managed Care beneficiaries are issued a **Green Mountain Care** card to be used for all services.

1.3.2 HEALTH CARE BENEFIT PROGRAMS

Over the years, the Vermont Medicaid program has expanded from a single program with a single comprehensive benefit package to a variety of programs. A general description of each program follows. Also see Section 2 for general information about the **PC Plus** program.

Traditional Medicaid (Fee for service and PC Plus Medicaid) Traditional Medicaid is the name used for the original Medicaid program that provides coverage for low-income households with dependent children and coverage for aged, blind and disabled Vermonters. Vermont’s Medicaid program began in 1967. It provides the broadest benefit package including acute care, long-term care, dental, pharmacy and if necessary, transportation to medical services. Traditional Medicaid beneficiaries are issued **Green Mountain Care Card**. Some may be enrolled in the **PC Plus** managed care program. Refer to Section 2 for general information about **PC Plus**. Beneficiaries of traditional Medicaid are responsible for certain co-payments for services performed in an inpatient and outpatient hospital setting as well as for pharmacy and dental benefits. See Section 1.3.4 for co-payment amounts.

Dr. Dynasaur The Dr. Dynasaur program was enacted by the 1989 session of the Vermont Legislature to expand the traditional program coverage to pregnant women and children in families with higher income. Today, the Dr. Dynasaur benefits are identical to traditional Medicaid benefits and follow the same rules. Dr. Dynasaur beneficiaries are also issued **Green Mountain Care** identification cards. Some may be enrolled in the **PC Plus** managed care program. Refer to Section 2 for general information about **PC Plus**. Co-payments are required for some beneficiaries, see Section 1.3.4. Providers should follow all Vermont Medicaid policy and billing procedures when treating Dr. Dynasaur beneficiaries.

Vermont Health Access Plan (VHAP) Managed Care The VHAP program was created to expand coverage to certain adults that were otherwise uninsured. It covers low-income, adult Vermonters who have had no health insurance during the past 12 months, or who lost coverage due to a death, a divorce, a job loss, or who no longer qualify as a dependent under a parent’s insurance policy. It operates under a federal waiver, which allows federal financial participation for the coverage of beneficiaries not otherwise eligible for traditional Medicaid. All VHAP beneficiaries are expected to enroll in a managed care program, called **PC Plus**. Refer to Section 2 for general information about **PC Plus**. Prior to enrollment in **PC Plus**, VHAP beneficiaries are enrolled into the VHAP Limited program. The VHAP Managed Care benefits are similar to a commercial managed care benefit. Beneficiaries in **PC Plus** are issued a **Green Mountain Care** identification card to be used for all services. Eligibility may be verified through the VRS. Co-payments are also required, see Section 1.3.4 regarding co-pay requirements.

VHAP-Limited VHAP Limited mirrors VHAP Managed Care, i.e., PC Plus. Physician referrals or Prior Authorizations required for Managed Care are also required for VHAP Limited; therefore, a beneficiary may need to select a Primary Care Physician (PCP) prior to receiving a service. If a beneficiary pays their initial premium, coverage is retroactive to the day eligibility was approved. The beneficiary will be responsible for the cost of services, however, if the initial premium is not paid.

VHAP Pharmacy The VHAP Pharmacy program was created to expand pharmaceutical and vision benefits to low-income, elder or disabled residents of Vermont. The program covers prescription drugs and certain over the counter drugs. Co-payments are required, see Section 1.3.4.

VScript VScript was established to provide pharmaceutical benefits for maintenance drugs to certain elderly or disabled residents of Vermont whose income makes them ineligible for Vermont Medicaid benefits. The program covers prescription maintenance drugs prescribed by an enrolled physician or other practitioner which have been included or approved for inclusion in the latest edition of official drug compendia, including insulin, insulin syringes and insulin needles. The list of covered drugs is reviewed annually by the Drug Utilization Review Board. Benefits exclude drugs determined to be less than effective (DESI drugs), drugs typically prescribed for the treatment of acute illness and drugs used to control psychotic conditions. VScript beneficiaries are issued a **Green Mountain Care** identification card. Some beneficiaries are responsible for a portion of the drug cost, calculated as a percentage of the charge, to be collected by the provider at the time the drugs are dispensed.

VPharm The new Medicare Part D prescription drug benefit began on January 1, 2006. The pharmacy program called VPharm was created by The Department of Vermont Health Access to serve beneficiaries who qualify for state pharmacy benefits and are eligible for Medicare Part D. In general, VPharm covers drug classes that are excluded from the Part D benefit, and may assist with premiums and cost-sharing.

Healthy Vermonter's Is for Vermonters who don't have insurance for prescriptions, or for those whose commercial insurance plan has an annual maximum prescription benefit. The Healthy Vermonters program (HVP) will allow qualified individuals to get a discount on both long-term and short-term drugs. As with all of our pharmacy programs, the preferred drug list applies.

Qualified Medicare Beneficiary A Qualified Medicare Beneficiary (QMB) is an aged or disabled individual who is eligible for payment of Medicare premiums, deductibles and co-insurance but not for any other payments. A QMB is not issued a **Green Mountain Care** identification card and cannot be identified using Electronic Verification System (EVS).

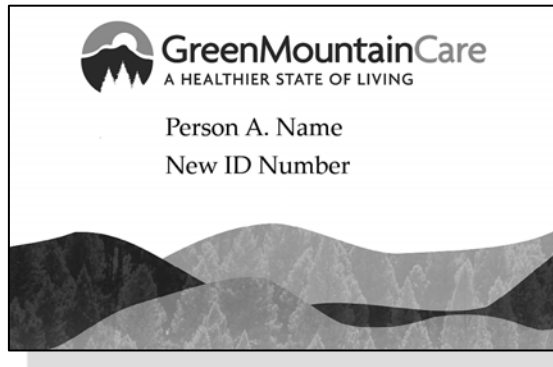
1.3.3 ADVANCE DIRECTIVES

Hospitals, nursing homes, home health agencies, hospices and prepaid health care organizations are required to provide certain patients with information about their right to formulate advance directives and maintain written policies and procedures with respect to advance directives. They are also required to document in patients' files whether or not an advance directive is in effect, provide education for staff and the community on issues concerning advance directives, and ensure compliance with State law on advanced directives at their facilities. Providers are responsible to guard the confidentiality of beneficiary information in a matter consistent with the confidentiality requirements in 45 CFR parts 160 and 164 and as required by state law. <http://www.cms.hhs.gov/securitystandard/downloads/securityfinalrule.pdf>. Providers can obtain Advance Directive (AD) forms and additional information on AD from the Vermont Ethics Network website: <http://www.vtethicsnetwork.org/> or by mailing your request to:

Vermont Ethics Network
61 Elm Street
Montpelier, Vermont 05602

1.3.4 IDENTIFICATION

The **Green Mountain Care** identification card is issued to each person enrolled in Vermont's Medicaid program. Beneficiaries must present their card each time a service is rendered. Because the card is not surrendered when eligibility stops, providers should verify eligibility each time a medical service is delivered to be certain that the beneficiary is eligible on the date that the service is provided. (The system knows of each termination of benefits nine days prior to the effective date). Therefore, verification can be made with certainty up to nine days in advance of the appointment. See Section 3 for the description of the two verification options. Note: There are only 25 spaces on the **Green Mountain Care** card for the beneficiary's name; some names will not be completely printed. In addition to the **Green Mountain Care** card, the department uses the following documents to identify beneficiaries.



1.3.4.1 FORM-DVHA 225P

Vermont Medicaid/Dr. Dynasaur Identification (DVHA225P) is a paper identification issued when eligibility is granted or when a replacement identification is necessary. It is used until such time a **Green Mountain Card** is issued.

DSW 225P
1 7/93

VERMONT DEPARTMENT
OF SOCIAL WELFARE

DISTRICT OFFICE ADDRESS]

[MEDICAID OR DR. DYNASAUR] ID

[CLIENT NAME AND ADDRESS]

USE OF THIS ID
MAY BE RESTRICTED
SEE INFORMATION BELOW

(SIGNATURE - PLEASE SIGN)

THIS ID DOES *NOT* CERTIFY ELIGIBILITY OF THE PERSON(S) LISTED BELOW. FOLLOW STANDARD PROCEDURES TO VERIFY ELIGIBILITY ON DATE OF SERVICE.

.D.#	NAME — FIRST, INITIAL, LAST, MOD	CAT	D.O.B.	M	1ST	2ND	3RD
------	----------------------------------	-----	--------	---	-----	-----	-----

OTHER INSURANCE INFORMATION

COMPANY NAME
AND ADDRESS

GROUP NUMBER

POLICY NUMBER

WARNING ANY ATTEMPT TO ALTER THIS ID IS A VIOLATION OF STATE AND FEDERAL LAW.

TO THE PROVIDER OF [MEDICAID OR DR. DYNASAUR] SERVICES:

THE RIGHT HAND COLUMN SHOWS CODES WHICH INDICATE MEDICARE COVERAGE AND OTHER INSURANCE AS REPORTED BY THE RECIPIENT. THE NAMES OF THE INSURANCE COMPANIES APPEAR IN THE ABOVE SECTION OF THE ID. THESE INSURANCE COMPANIES MUST MAKE PAYMENT FOR YOUR SERVICES BEFORE [MEDICAID OR DR. DYNASAUR] MAY BE BILLED.

Bulletin 93-41

1.3.4.2 FORM-DVHA 225M-T

Temporary Vermont Medicaid/Dr. Dynasaur Identification (DVHA 225M-T) is a paper identification issued when there is an immediate need for identification and the beneficiary's eligibility may not yet be on file. This document specifically lists the period of eligibility and no further eligibility verification is necessary.

Bulletin No. 93-15

TEMPORARY MEDICAID/DR. DYNASAUR IDENTIFICATION CARD
Vermont Department of Social Welfare

DSW 225M-T
R 3/93

Date of Birth: <hr/>	Issued to: <hr/> <p style="text-align: center;">(Name)</p> <hr/> <p style="text-align: center;">(Address)</p> <hr/>	Date Issued: <hr/>
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PLEASE WAIT ONE MONTH
FROM THIS DATE BEFORE
SUBMITTING CLAIM.

The above named individual is eligible for MEDICAID/DR. DYNASAUR from _____ through _____

MEDICARE Yes No Other Health Insurance: _____

Signature of District Director: _____

Bulletin No. 93-15

1.3.4.3 FORM-DVHA 225 M-T(2)

Temporary Vermont Medicaid/Dr. Dynasaur Identification (DVHA 225M-T(2)) is a paper identification issued when there is an immediate need for identification and the beneficiary's eligibility may not yet be on file. This document specifically lists the period of eligibility and no further eligibility verification is necessary.

TEMPORARY [MEDICAID OR DR. DYNASAUR] ID
VERMONT DEPARTMENT OF SOCIAL WELFARE

DSW 225M-T(2)
1/7/83

DATE ISSUED:

PLEASE WAIT TEN DAYS
FROM THIS DATE BEFORE
SUBMITTING CLAIM.

ISSUED TO:

ADDRESS:

DATE OF BIRTH:

THE ABOVE NAMED INDIVIDUAL IS ELIGIBLE FOR [MEDICAID OR DYNASAUR]

FROM [MM DD YY] THROUGH [MM DD YY]

MEDICARE [] YES [] NO

OTHER HEALTH INSURANCE:

Bulletin 93-41

1.3.5 CO-PAYMENTS

Certain beneficiaries must participate in the cost of care for certain services. Co-payments are never required of patients living in a nursing home, individuals under age 18, pregnant women, or women in their 60-day post-pregnancy period. No co-payment is assessed for services to CRT patients in a mental health center. The amounts for the various services follow:

Traditional Medicaid Beneficiaries:

- \$1.00 for prescriptions of \$29.00 or less
- \$2.00 for prescriptions of \$30.00 to \$49.99
- \$3.00 for prescriptions of \$50.00 or more
- \$3.00 per dental visit for adult's age 21 or older
- \$3.00 per day for hospital outpatient services
- \$75.00 per inpatient hospital admission

Co-pays do not apply to children under age 18, pregnant women or patients in long-term care facilities

***Effective 07/01/03:** No inpatient, outpatient or pharmacy co-pays for ANFC related beneficiaries for ages 18-20 (previous to 07/01/03, All Medicaid beneficiaries had a co-payment at age 18 and up).

AID CATEGORIES: AC, AR, BC, BG, CO, CC, CP, CR, DC, DR, FC, GC, GR, HC, HR, IC, IR, KZ, MC, MR, NC, NR, OC, PC, PR, RR, TC, TR, XC, XR, YC

***Effective 07/01/03:** Inpatient co-pay for SSI related beneficiaries begins at age 18

AID CATEGORIES: AA, AB, AD, AZ, BA, BB, BD, BP, C1, C2, CG, C3, CC, DA, DD, EA, EB, EC, ED, ER, GA, GE, HA, HB, HD, HT, HV, HZ, IA, ID, KC, LA, LB, LC, LD, LR, LZ, MA, MB, MD, MH, MP, NA, NB, ND, NP, P1, PA, PB, PD, PP, Q1, Q2, QA, QD, QW, SC, SP

Medicaid Primary Care Plus Beneficiaries:

- \$1.00 for prescriptions of \$29.00 or less
- \$2.00 for prescriptions of \$30.00 to \$49.99
- \$3.00 for prescriptions of \$50.00 or more
- \$3.00 per dental visit for adult's age 21 or older
- \$3.00 per day for hospital outpatient services
- \$75.00 per inpatient hospital admission

Co-pays do not apply to children under age 18, pregnant women or patients in long-term care facilities

***Effective 07/01/03:** No inpatient co-pays for ANFC related beneficiaries for ages 18-20 (Previous to 07/01/03, All Medicaid beneficiaries had a co-pay at age 18 and up).

AID CATEGORIES: A5, A8, B5, BH, C4, C5, C7, C8, D5, D8, F5, G5, G8, H5, H8, I5, K9, M5, M8, O5, P5, P8, R1, T5, T8, X5, X8, Y5

***Effective 07/01/03:** No pharmacy co-pays for SSI related beneficiaries under age 21.

Inpatient and outpatient co-pays for SSI related beneficiaries begins at age 18.
AID CATEGORIES: A3, A4, A6, A9, B3, B4, B6, B7, B8, BH, C6, C9, CH, E5, E8, H3, H4, H6, H9, I8, K5, L3, L4, L5, L6, L8, L9, M3, M4, M6, M7, P2, P3, P4, P6, P7, P9, Q3, Q6, S5, S7, W3, W4, W6, W9, X3, X4, X6

VHAP Primary Care Plus Beneficiaries-Aid Categories J3-J8, U1-U6 and UX:

Effective 01/01/04: Co-pays are eliminated for all services, with the exception of \$25.00 for medically necessary emergency room visits.

VHAP Limited Beneficiaries-Aid Categories UA, UB, UD, UE & UF:

Effective 01/01/04: Co-pays are eliminated for all services, with the exception of \$25.00 for medically necessary emergency room visits.

Exception: Beneficiaries in Aid Category Z9 have only emergency inpatient benefits.

VHAP Pharmacy Beneficiaries-Aid Categories V1, V2, V3, V5 & V6:

Effective 07/15/2009: Copays for prescriptions \$29.99 or less = \$1.00

Prescriptions \$30.00 or more = \$2.00

Vision Coverage: For beneficiaries with category codes V1, V2, V3, V5 & V6, Vermont Medicaid will cover an eye exam (92XXX) and refraction, but will NOT cover a medical eye exam (99XXX) and refraction.

Offers access to drugs at a discounted price, which is the Vermont Medicaid rate.

Crossover Coverage: V5 & V6 only-Beneficiaries are responsible for the Medicare coinsurance and/or deductible.

VScript Beneficiaries-Aid Categories VA, VS, V7 & V8:

Effective 07/15/2009: Copays for prescriptions \$29.99 or less = \$1.00

Prescriptions \$30.00 or more = \$2.00

This plan covers:

Maintenance drugs ONLY and only when the manufacturer has a rebate agreement with the State of Vermont.

When a drug is not covered under the program because it is not a maintenance drug or because there is no rebate agreement, beneficiaries may have coverage through the Healthy Vermonter's Program.

VScript Expanded Beneficiaries-Aid Categories VB, VC, VT & VU:

Effective 07/15/2009: Copays for prescriptions \$29.99 or less = \$1.00

Prescriptions \$30.00 or more = \$2.00

This plan covers:

Maintenance drugs ONLY and only when the manufacturer has a rebate agreement with the State of Vermont.

When the drug is not covered under the program because it is not a maintenance drug or because there is no rebate agreement, beneficiaries may have coverage through the Healthy Vermonter's Program.

VHAP Pharmacy with Medicare-Aid Category V4:

Effective 07/15/2009: Copays for prescriptions \$29.99 or less = \$1.00

Prescriptions \$30.00 or more = \$2.00

Crossover Coverage: Benefits include payment of Medicare coinsurance and deductible only.

Vision Coverage: For beneficiaries with category code V4, Vermont Medicaid will cover an eye exam (92XXX) and refraction but will NOT cover a medical eye exam (99XXX) and refraction.

VPharm Pharmacy-Aid Categories VD, VE, VF, VG, VH, VI, VK, VL, VM, VN & VO:

Effective 07/15/2009: Copays for prescriptions \$29.99 or less = \$1.00

Prescriptions \$30.00 or more = \$2.00

VPharm covers drug classes that are excluded from the Part D benefit.

Medicare Crossover Coverage: For beneficiaries with category codes VG, VH, VI

Vision Coverage: For beneficiaries with category codes VG, VD, VJ & VM.

Healthy Vermonter's Program-Aid Category VP

Offers access to drugs at a discounted price, which is the Vermont Medicaid rate for prescription drugs.

Co-pays in VHAP, VPharm and VermontRX

Effective July 15, 2009, the VScript, VHAP, and VPharm plans will be modified to include a prescription drug copayment. VPharm, VScript, VScript Expanded, VHAP-Pharmacy as well as VHAP beneficiaries at or above 100% of the federal poverty guideline will be affected. The copay will be \$1.00 for prescriptions costing \$29.99 or less and \$2.00 for prescriptions costing \$30.00 or more. However, the beneficiary will still owe the pharmacy any copay that is not paid. The pharmacy may tell the beneficiary that any later prescriptions may not be filled if the beneficiary does not pay what is owed.

1.3.6 NOTICE OF DECISION

The Department for Children and Families notifies beneficiaries in writing of its decisions made regarding eligibility, retroactive eligibility, spend-down requirements and other determinations of status or program changes. These letters are called "Notice of Decision" letters and are issued by the district office, HAEU. A copy of the Notice of Decision is a required attachment for certain claims involving spend-down.

1.3.7 COURT ORDERED SERVICES

If a beneficiary is mandated by a court to seek a service, the service may be covered if it meets the medical necessity and Vermont Medicaid guidelines.

1.3.8 RETROACTIVE ELIGIBILITY

Vermont Medicaid eligibility is occasionally granted retroactively. The provider may bill for services rendered during the retroactive period. A note indicating the date of retroactive eligibility must accompany the claim to waive the timely filing limit. See section 1.2.22.

1.3.9 SPEND-DOWN

In some cases, eligibility is contingent upon the applicant having extraordinary expenses. In these cases, the applicant must first become responsible for a specific dollar amount for medical expenses during a six-month period. The actual amount is known as the "spend-down" amount as calculated by DCF. A spend-down beneficiary becomes eligible for Vermont Medicaid on the day of the month in which the incurred medical expense amount equals or exceeds the specified "spend-down" amount. When the beneficiary becomes eligible, all providers performing a service on that first day of eligibility will receive a Notice of Decision letter (ESD 220MP) from the district office. The letter explains that the spend-down amount has been met by the beneficiary, or

that a portion of the provider's bill remains the responsibility of the beneficiary. The provider must deduct the spend-down amount, if any, shown in the ESD 220MP prior to claim submission.

Providers may obtain a copy of the spend-down notification by contacting the DCF Call Center at 800-479-6151 or Member Services for Green Mountain Care. The case worker will be notified of the request and will provide the information.

1.3.10 TEAM CARE PROGRAM

The Team Care Program restricts a beneficiary to one physician and one pharmacy. If a beneficiary is "locked-in" to a provider, that provider's name is available on the VRS and the Vermont Medicaid website. Claims for services by any provider other than the "lock-in" provider(s) are not reimbursable by Vermont Medicaid, except in the case of an emergency or when a provider performs a service by referral of the named provider.

The "lock-in" procedure also applies to a PC Plus beneficiary. The "lock-in" reflects the beneficiary's choice of primary care physician. This information is also available through the VRS and the Vermont Medicaid web site.

1.3.11 MEDICAID AND MEDICARE CROSSOVER BILLING

An DVHA beneficiary may be eligible for both Vermont Medicaid and Medicare. When dual eligibility exists, Medicare must be billed first on an assigned basis.

After Medicare payment, the DVHA pays deductibles and coinsurance for crossover claims.

Providers must include their NPI and taxonomy code on any claims sent to Medicare in order to assure proper automatic crossover and subsequent Vermont Medicaid processing of your claims. Vermont Medicaid is aware that Medicare does not have this same requirement but will include the taxonomy code, as submitted on the claim, on the crossover file.

Vermont and New Hampshire Providers: In order to crossover, Vermont Medicaid eligibility information must be clearly indicated on the Medicare claim. These claims, as well as any future adjustments to these claims, will crossover automatically to HPES for payment. If you do not receive the DVHA payment within 30 days of the Medicare paid date, submit the claim to HPES with the Medicare Attachment Summary Form.

If a service or item is denied by Medicare as non-reimbursable and is reimbursable by the DVHA, submit a CMS 1500 claim, completed to the DVHA specifications, along with the Medicare denial to HPES within twelve months of the date of service.

Other Out-of-State Providers (Except New Hampshire): All out-of-state providers should first bill their regional Medicare carrier for services to dual eligible Vermont residents. After Medicare payment is received, send a claim to HPES for payment of any coinsurance or deductible as follows:

1. Send a claim completed to the DVHA specifications with a copy of the Medicare Attachment Summary Form. The Medicare payment date must appear on the Medicare Attachment Summary Form.
2. If a service or item is denied by Medicare as non-reimbursable and is reimbursable by the DVHA, submit a CMS 1500 claim with the EOMB, completed to the DVHA specifications to HPES within twelve months of the date of service. See 1.2.23 Timely Filing.

3.

1.3.12 THIRD PARTY LIABILITY (TPL) / OTHER INSURANCE (OI)

Vermont Medicaid is the payer of last resort. Providers are required to pursue and apply all third party payment resources prior to billing Vermont Medicaid. Third party resources include, but are not limited to, Medicare, private/group health insurance plans, military and veteran's benefits, Worker's Compensation and accident (automobile, homeowners, etc.) insurance. (See 1.3.13 specific to Workers Compensation or Accident Liability Billing)

TPL VERIFICATION- The beneficiary's other insurance information, including the name of the other insurance company, address, carrier code and type of coverage, is available on the Vermont Medicaid website, Provider Web Services (www.vtmedicaid.com/secure/logon.do) and the Voice Response System (VRS) when the provider checks the beneficiary's eligibility. Providers will review the beneficiary's eligibility information for the date of service and must bill other insurance carrier(s) before billing Vermont Medicaid. Use of the available information will guide providers in billing.

TIMELY FILING OF OI CLAIMS- Providers will respect the beneficiary's right to receive all medically necessary services and equipment in a timely manner and must submit claims to primary insurers promptly to mitigate issues with beneficiary primary insurance benefits exhausting.

OTHER INSURANCE DENIAL / DVHA AUTHORIZATION REQUEST

The following procedures are required for DVHA authorization requests when the primary insurer has reviewed and denied a claim request for an item or service:

OI Denial for Non-Covered or Benefits Exhausted- The provider is required to submit to the DVHA the authorization request form (Medical Necessity Form or other) with all standard documentation, the notice of denial from the primary insurer that indicates the item or service is not a covered benefit or that the benefit limit was determined to be exhausted, and all necessary documentation to support medical necessity. The DVHA will then review.

- The provider does not need to appeal to the primary insurer before billing Medicaid when the item/service is not covered or benefits are exhausted.

- If the code/service does not require authorization from Vermont Medicaid, then the provider can bill Medicaid directly with a copy of the primary insurer's denial attached.

OI Denial for Not Medically Necessary - The provider and/or beneficiary is required to pursue all levels of reconsideration and appeals with the primary insurer. If the request remains denied by the primary insurer, the provider and/or beneficiary is required to seek review by the BISHCA if the cost of the item or service exceeds \$100. If the denial stands, then the provider may submit the request to the DVHA with copies of all of the original documentation, the denials from the primary insurer and the BISHCA's support of the denial. The provider should not submit any additional documentation than what was reviewed by the primary insurer.

- If the code/service does not require authorization from Vermont Medicaid, then the provider can bill Medicaid directly, with copies of the primary insurer's denials (original and appeals) and the BISHCA's support of the denial attached.

Medicare Qualified Independent Contractor - For beneficiaries covered by Medicare, the requirement to go through the Medicare Qualified Independent Contractor appeal level applies, with the exception of wheelchairs that Medicare denies or downgrades. Upon documentation of the Medicare action, Medicaid will review for medical necessity and payment determination.

The DVHA will reject a request if there is reason to believe that the OI received incorrect or incomplete information from the provider and based its decision on that incorrect or incomplete information. Providers must determine OI/Medicare benefits before rendering the service to minimize the risk of non-coverage by both OI or Medicare and the DVHA.

OTHER INSURANCE ATTACHMENTS- Providers may submit electronically to HPES claims that have been denied by another insurance company (third party payer/primary payer) when that payer has denied the claim using certain adjustment reason codes. Providers are required to include the adjustment reason code used by the primary payer when submitting the claim but will not need to send a copy of the primary insurance attachment. The list of adjustment reason codes that will be accepted electronically is available at www.vtmedicaid.com/Downloads/manuals , select 837 Adjustment Reason Codes. HPES may select your claim for post payment review and request a copy of the explanation of benefits; if so, providers are required to supply all supporting documentation in a timely manner. Failure to do so will result in the recoupment of your paid claim.

When submitting a paper claim, an attachment is needed only when a third party insurance carrier has not made a payment. Providers must attach documentation from the carrier that verifies the beneficiary's name, insurer's name, dates of service, the amount reimbursed and the payment or denial date. If the carrier does not include this information in the documentation (i.e. the carrier issues a blanket statement that the particular service is not covered), the provider must write the necessary information on the attachment, then sign and date the attachment. It must be clear that the attachment relates to the specific services billed on the Medicaid claim.

If there was a payment made by the third party, providers must indicate the amount paid, plus any contractual allowance/discount, in the "prior payments" field. Documentation from the carrier is not required with the claim form if there is a payment amount, thus allowing the claims to be submitted electronically. In cases where a beneficiary has more than one other insurance, providers must indicate on paper, that payment was received (or denied) from each insurance company.

If the other insurance amount is less than \$3.00, the provider must include an "other insurance" attachment verifying that exact payment amount.

Providers may obtain a "blanket statement" from an insurance company that states that the company never covers a particular service for the beneficiary's policy and attach it to the claim when billing for that service. Any blanket statement must be less than one year old and must be attached to each claim submitted. Providers must indicate the beneficiary name and identification number and the applicable dates of service and the provider must sign and date the blanket statement.

EXCEPTIONS: The following services/beneficiaries are excluded from the third party liability requirements applied above:

- Prenatal Care Services: This includes routine supervision of normal pregnancy, prenatal screening of mother or fetus, and care provided in the prenatal period to the mother for complications of pregnancy.
- Preventive Care Services: This includes immunizations, screening tests for congenital disorders, well-child visits, preventive medicine visits, preventative dental care, and screening and preventive treatment for infectious and communicable diseases.
- Court-enforced Medical Support Beneficiaries: This is identified by an insurance coverage type D1 through D9 which indicates "Absent Parent."

Claims exempt from TPL may be submitted directly to HPES. Indicate “not billed” in the “other insurance” field when submitting paper claims. When submitting electronically, simply indicate “no” in the “other insurance” field. The provider should only indicate that other insurance has not been billed if that is, in fact, true.

If the provider chooses to first bill the third party in these cases, he or she must wait 30 days from the date of furnishing the service before billing Vermont Medicaid. Medicaid must be credited with any payments received from the other third party payer.

ACCIDENTS: Claims billed with a “yes” in the accident field and those with a trauma diagnosis will be tracked in the claims processing system and monitored for post payment recovery from liable parties. In order to determine liability information, HPES will send questionnaires to providers regarding some trauma cases.

DISCREPANCY IN TPL INFORMATION: When a provider believes that the other insurance listed in the eligibility file is incorrect, contact the DCF district worker for clarification/correction or have the beneficiary contact Member Services.

HMOs: Are treated as other health insurance. When a Vermont Medicaid beneficiary does not comply with the rules of their HMO, such as securing prior authorization, the HMO may choose not to cover the service. In such cases, Vermont Medicaid will not pay for the service either and the beneficiary will be responsible for payment.

TPL COST AVOIDANCE: HPES maintains eligibility files, which contain beneficiary health insurance information. This data is integrated in the claims processing system to coordinate benefits.

1.3.13 WORKERS COMPENSATION/ACCIDENT LIABILITY BILLING

Providers have two choices regarding billing when a beneficiary is also covered by worker’s compensation or accident insurance, such as auto insurance, homeowners, etc.:

1. Bill Vermont Medicaid or
2. Bill workers compensation/auto insurance.

If the provider chooses to bill the workers compensation or the accident Insurance (i.e., auto insurance, homeowners, etc.), the provider cannot bill Vermont Medicaid simultaneously. (Refer to your provider enrollment/recertification agreement.)

If a provider decides at any point to bill Vermont Medicaid, the provider must withdraw the claim to the workers compensation/auto insurer. The withdrawn claim is still subject to the six-month timely filing limit. Vermont Medicaid will pay the claim and bill the responsible insurance provider. Payments made by the insurance provider will come directly to Vermont Medicaid. No reimbursement will be made to the provider.

When a provider bills worker's compensation or accident insurance, and the claim is denied by workers compensation or accident insurance, the provider then has 1 year from the date of service to submit their claim to Vermont Medicaid for payment.

If a payment is received from a worker’s compensation/accident insurer after the provider has received payment from Vermont Medicaid, the provider must return or refund the payment to Vermont Medicaid.

In regards to billing the beneficiary, 42 USC § 1396a (a)(25)(C) states: “In the case of an individual who is entitled to medical assistance under the State plan with respect to a service for which a third party is liable for payment, the person furnishing the service may not seek to collect

from the individual (or any financially responsible relative or representative of that individual) payment of an amount for that service...”

1.3.14 THIRD PARTY LIABILITY COVERAGE CODES

The VRS and the Vermont Medicaid website use the following codes to describe the type of services covered by a patient’s other insurance. The Coverage Codes (below) and the insurance matrix (next page) will help in understanding how to interpret the information provided about third party liability. For example, if the VRS reports “07” for a beneficiary, the matrix shows that a dental claim for dental services will fail for reason 408 if the third party information is not provided. Contact HPES if you don’t not know whether the coverage code refers to the service you have provided.

<u>CODE TYPE</u>	<u>OF COVERAGE</u>
01	Hospital Inpatient Services
02	Hospital Outpatient Services
03	Hospital Inpatient/Outpatient Services
04	Physician Services
05	Physician Inpatient/Outpatient Services
06	Physician Inpatient/Outpatient Services/Major Medical
07	Dental Coverage
08	Vision Coverage
09	Drug Coverage
10	Physician Inpatient/Outpatient Services/Major Medical/Dental
11	Physician Inpatient/Outpatient Services/Major Medical/Vision
12	Physician Inpatient/Outpatient Services/Major Medical/Drug
13	Medicare Supplement A & B
14	Indemnity Coverage Payment to Client
15	Major Medical
16	Major Medical/Physician
17	Major Medical/Physician/Dental
18	Major Medical/Physician/Vision
19	Major Medical/Physician/Drug
20	Major Medical/Physician/Dental/Vision/Drug
21	Inpatient/Outpatient/Physician/Dental/Major Medical/Drug/Vision
22	Medicare Supplement Part A
23	Medicare Supplement Part B
24	Specialty Coverage (e.g., cancer)
25	HMO
26	Nursing Home
27	Veterans Home
28	Worker's Compensation
50	Absent Parent (4D)
99	Unknown
A1	Medicare A
B1	Medicare B

1.3.14.1 INSURANCE COVERAGE MATRIX

INSURANCE COVERAGE MATRIX

Revised 02/24/1998

SERVICE	COVERAGE CODE																																						
	O1	O2	O3	O4	O5	O6	O7	O8	O9	10	11	12	13	15	16	17	18	19	20	21	22	23	25	26	27	29	A1	B1	D1	D2	D3	D4	D5	D8	D9				
Crossover A			Y	Y	Y					Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y						Y												
Crossover B		Y	Y	Y	Y	Y		Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y														
Dental							Y			Y						Y			Y															Y					
DME					Y	Y				Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y							Y						
EPSDT				Y	Y	Y				Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y								Y					
Home Health					Y	Y				Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y								Y					
Hospice					Y	Y				Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y								Y					
Independent Lab				Y	Y	Y				Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y								Y					
Inpatient	Y		Y	Y	Y	Y				Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y								Y	Y	Y	Y		
Nursing Home / LVL 01													Y													Y	Y	Y											
Nursing Home / LVL 02-04																										Y	Y												
Outpatient		Y	Y	Y	Y	Y				Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y								Y	Y	Y	Y		
Pharmacy								Y																Y	Y										Y			Y	
Physician/Ambulance				Y	Y	Y			Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y									Y	Y	Y	Y	
Vision									Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y											Y		

Y - Claim will fail edit 408

all other insurance information, can be obtained through the Eligibility Verification System (EVS). The complete list can be accessed on the Vermont Medicaid Portal at www.vtmedicaid.com/Downloads/manuals.html.

1.3.16 BENEFICIARY BILL OF RIGHTS

As a Managed Care Organization (MCO), the DVHA must ensure that its enrolled health care providers are aware of our Beneficiary Bill of Rights and that health care providers take these rights into account when providing services to beneficiaries. The Vermont Health Care Programs: Beneficiary Bill of Rights is as follows:

- As a member of a Vermont health care program, a beneficiary has the right to:
- Be treated with respect and courtesy
- Be treated with thoughtfulness for his or her dignity and privacy
- Choose and change providers
- Get facts about program services and providers
- Get complete, current information about his or her health in understandable terms
- Be involved in decisions about his or her health care, including having questions answered and having the right to refuse treatment
- Ask for and get a copy of his or her medical records and ask for changes to be made to them when he or she believes the information is wrong
- Get a second opinion from a qualified provider who is enrolled in Vermont Medicaid
- Complain about the program or his or her health care
- Be free from any form of restraint or isolation used as a means of bullying, discipline, convenience, or retaliation
- Ask for an appeal if services are denied that he or she thinks are needed.

1.4 PROGRAM SERVICES

The Provider Services Unit of HPES consists of four components, Provider Relations/Field Representative, Provider Help Desk, Provider Enrollment and Communications/Publications Coordinator. This unit is available to assist providers and their billing personnel.

1.4.1 INQUIRIES

The Provider Services Unit responds to telephone inquiries from 8:00a.m. to 5:00p.m., Monday through Friday, except on State assigned holidays.

Toll-free in Vermont (800) 925-1706
Local and Out-of-State (802) 878-7871

HPES can give claim or beneficiary information only to enrolled Vermont Medicaid providers. Therefore, providers must always give their provider number at the time of contact. Other information that will be requested, when applicable, includes:

- Beneficiary ID Number
- Internal Control Number (ICN)
- Date of Service
- Date of Remittance Advice (RA)

The Provider Help Desk is limited to 5 questions per call. Callers with more than five inquiries can choose to call again or submit written inquiries.

1.4.2 WRITTEN INQUIRIES

For accurate documentation purposes, HPES requests that providers use the inquiry form, which may be obtained by visiting www.vtmedicaid.com/Downloads/forms.html. Please send completed inquiries to the following address:

HP Enterprise Services Provider Services Unit
P.O. Box 888
Williston, Vermont 05495-0888

Complete boxes one through twelve of the inquiry form and attach appropriate documentation. Provider inquiry forms may not be used to resubmit corrected claims or to request an adjustment on a paid claim or to check on the status of a claim. Corrected claims should be sent directly to HPES with copies of all required attachments, when applicable. If there are no attachments, claims may be resubmitted electronically. See: [Adjustment Requests](#).

1.4.3 GUIDELINES FOR BILLING INCIDENT TO

Note: These guidelines do not apply when the provider has a separate agreement with the DVHA on billing practices.

Also, with the exception of our “on-site” requirements, it is our intention to follow Medicare guidelines.

Doctoral-Level Psychologists Can Bill “Incident To” When:

- Staff/workers who are non-licensed *and* not enrolled with Vermont Medicaid/VHAP such as certain alcohol counselors, provide the service. OR
- Licensed professionals who are not enrolled with Vermont Medicaid/VHAP provide a covered service.

In addition, the doctoral-level psychologist must:

- Provide and document formal case oversight (1-on-1 meetings to review case); and
- Be either on site or immediately available (i.e. 15 minutes or less away)
- Meet all other requirements per the Board of Practice Rules for Psychologists.

Physicians/Nurse Practitioners and Dentists Can Bill “Incident To” When:

- Any practitioner whose provider type does not allow them to enroll with Vermont Medicaid may bill incident to the physician/dentist who assumes total responsibility and accountability.

In addition, the physician/NP/dentist must:

- Provide and document formal case oversight (1-on-1 meetings to review case); and
- Be either on site or immediately available (i.e. 15 minutes or less away), except clinics must have a physician or NP on site at all times.

Incident To Billing by Physicians and Dentists:

Please note, the CMS 1500 claim form says among other items “I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.” The dental claim form does not have such a certification but the expectation remains the same for dentists. Physicians and dentists are expected to follow our “incident to...” guidance set forth by the DVHA.

At this time, the DVHA has agreements with Fletcher Allen Health Care, University of Vermont and Dartmouth Hitchcock Medical Center regarding billing for residents and students enrolled in their training programs. Those agreements govern “incident to...” billing.

Community Mental Health Centers are required to follow the guidance of the Department of Mental Health regarding “incident to...” billing, not the DVHA guidance for Vermont Medicaid services.

For all physicians and dentists not governed by a separate agreement:

- If you employ a licensed provider that can be enrolled in the Vermont Medicaid program, you must enroll that person and bill that person’s services as the attending rather than bill it as “incident to...”
- If you employ staff (licensed or not) that cannot be enrolled and that staff provides a billable service, you may use the supervising, licensed provider’s NPI number as the attending and bill the service as “incident to...”
- If, however, two licensed providers in the practice deliver a single service, the practice may bill for that service using the NPI number as the attending based on the main purpose of the service.

1.4.4 LOCUM TENENS

A Locum Tenens is a physician to “step in” for another provider that is on leave or has permanently left a practice. **The Locum Tenens physician must be licensed in Vermont and be actively enrolled in Vermont Medicaid.**

If a Locum Tenens physician is covering for a physician on leave, they are then allowed to use that physician’s NPI number for up to 60 days. Modifier Q6 (Service rendered by a Locum Tenens physician) should be used to show that the service was provided by a Locum Tenens physician. **The Billing provider is 100% liable for all locum tenens billing.**

1.4.5 PROVIDER RELATIONS FIELD REPRESENTATIVE

The Provider Relations staff employs field representatives who are available to travel throughout the state for problem solving and provider education. These representatives work to increase provider participation by speaking at professional association meetings, scheduling provider visits, and presenting statewide workshops for Vermont Medicaid.

1.4.6 ELECTRONIC CLAIM SUBMISSION

The State of Vermont and HPES encourage the use of Electronic Claim Submission (ECS). ECS allows for efficient, reliable and economic transfer of claims between the provider’s facility and HPES. The same standards and conditions applicable to paper claims, with regard to accuracy and completeness also apply to claims submitted electronically.

ECS is fast, easy to use and eliminates time-extensive paperwork. ECS prevents most errors, allowing providers to submit “clean” claims the first time. Turn-around time for electronic claims is considerably faster than for paper claims. For information on available methods of electronic billing, please contact the Electronic Data Interchange (EDI) Coordinator at HPES.

1.4.7 ELECTRONIC FUNDS TRANSFER (EFT)

Electronic Funds Transfer (EFT) is mandatory for providers enrolled with Vermont Medicaid. Providers can receive payments for “clean” claims in as few as five business days. The money is electronically deposited into the provider’s bank account, avoiding stop payments and reissues due to damaged or misplaced checks.

EFT has no effect on billing procedures and providers are not required to submit claims electronically to receive direct deposits. Providers must enroll in EFT for all claim types submitted. For more information on EFT, please contact the HPES Enrollment Unit.

1.4.8 ELECTRONIC REMITTANCE ADVICE (RA)

Providers that bill electronically will only receive electronic RAs. Please contact the HPES EDI Department at HPES if you are interested in submitting and receiving this information electronically.

1.4.9 FORMS AND MANUALS

The forms and manuals used in the Vermont Medicaid program are available for download from Vermont Medicaid web portal at www.vtmedicaid.com. A Provider Directory of Resources is available for download at www.vtmedicaid.com/Information/whatsnew.html.

The following documents can be printed directly from the website:

[Manuals - www.vtmedicaid.com/Downloads/manuals.html](http://www.vtmedicaid.com/Downloads/manuals.html)

Ladies First Manual (link)
Provider Manual
Prior Authorization Supplement
CMS 1500 Supplement
Dental Supplement
UB04 Supplement
Psychiatric Inpatient Supplement

[Forms – www.vtmedicaid.com/Downloads/forms.html](http://www.vtmedicaid.com/Downloads/forms.html)

Abortion Form
Accident Questionnaire
Alternate Reporter Request
Adjustment (Multiple)
Adjustment (Single)
Admission Notification (Out-of-State Hospital Psychiatric Inpatient Services)
CMS 1500 Medicare Attachment Summary Form
Dental Prior Authorization Forms
DME Equipment Agreement Form
EDI Registration
Eyeglass Prior Authorization Form
Hysterectomy Consent
Medicaid Fraud, Waste, Abuse & Team Care Referral Form
Medicaid Refunds
Medical Necessity
Out of State Pre-Admission Request
Pre-Procedure Request
Prior Authorization for Chiropractic Services

Provider Enrollment Forms: Enrollment, Electronic Funds & Funds Change, Change of Address, Group Affiliation, PCPlus, Termination Notice & Web Services Account E-mail Request Form

Sterilization Consent

Therapy Extension

Timely Filing Appeal Listing

TPL Change Request

Trading Partner Agreement

Transportation Form

UB 04 Medicare Attachment Summary Form

Urine Drug Test Form

340-B Drug Program: Provider Enrollment Amendment, Contact Information Sheet & Provider Presentation

SECTION 2-VERMONT HEALTH ACCESS PLAN- PC PLUS

Introduction

The Department of Vermont Health Access (DVHA) is responsible for administration of the Vermont Medicaid program. The DVHA is also responsible for implementing the Vermont Health Access Plan (VHAP), Medicaid expansion authorized in 1995 by the Vermont General Assembly and supported by a Section 1115 Research and Demonstration Waiver approved by the federal government, and subsequently the Global Commitment 1115 Waiver. The Vermont Health Access Plan is designed to improve the accessibility and quality of health services for Vermont's most vulnerable populations through improved management of care. In addition, the DVHA implemented two other programs beginning on January 1, 1996. VHAP Limited provides a benefit to low income uninsured adults. This is a transition program between initial enrollment and enrollment in managed care. The other program, VHAP Pharmacy, provides pharmacy benefits for low income Vermonters who are elderly or disabled.

Although there are a variety of VHAP programs, this section of the manual focuses on the managed care aspect. **Primary Care Plus (PC Plus)** is a primary care case management program developed by the DVHA as part of the State's Section 1115 waiver. The program allows beneficiaries to choose a Primary Care Provider (PCP) responsible for providing primary care and coordinating specialty care. This program was implemented on October 1, 1999.

The key goals of **PC Plus** are to:

- Enhance the continuity of care through the creation of a "medical home"
- Establish a partnership between the Medicaid administration and community providers
- Maximize dollars spent for medical services

PCPs coordinate their members' health care needs by providing the following services:

- Primary care medical services, covered by Vermont Medicaid
- Referral authorization for needed specialty and other covered medical services
- Arrange 24-hour-a-day/seven days-a-week coverage

PCPs receive a monthly case management fee for each member enrolled with the PCP. This fee is for coordinating members' health care services, regardless of whether the member is seen. When services are provided, the Medicaid fee-for-service reimbursement applies. In addition, PCPs will receive a monthly roster of enrolled members. It is required that incorrect member information is noted and a revised roster be returned to the HPES enrollment unit for updating. This information

may be returned by fax to 802-878-3440, attn: enrollment or mailed to: HP Enterprise Services, attn: Enrollment, PO Box 888, Williston, VT 05495

Membership in **PC Plus** is mandatory for all VHAP uninsured beneficiaries and all Medicaid/Dr. Dynasaur beneficiaries who are not otherwise exempt from managed care enrollment under the provisions of the 1115 waiver. Under the waiver, individuals who have third party insurance, in addition to Medicaid/Dr. Dynasaur, and individuals who are on home and community-based waivers, are exempted from PC Plus enrollment. In addition, individuals enrolled in the Medicaid High Tech Program and individuals living in long-term care facilities are exempt from **PC Plus** enrollment.

Once they are found eligible, beneficiaries who are not exempt are sent an enrollment package from the Health Access Member Services Unit and are asked to select a primary care provider. A primary care provider is assigned to those members who do not make a selection within 30 days.

Members may change their PCP by contacting the Member Services Unit. Beneficiaries can be verified as members of PC Plus using the VRS and the Vermont Medicaid web site.

2.1 PROGRAMS

Beneficiaries are enrolled in **PC Plus** from one of two fee-for-service programs. One program is usually referred to as Traditional Medicaid or Dr. Dynasaur. The second is called VHAP Limited. These programs are described in Section 1.4. Once a beneficiary transitions to **PC Plus**, a Green Mountain Care identification card will be issued.

The benefits in **PC Plus** remain the same for traditional Medicaid and Dr. Dynasaur. However, the benefits in VHAP Limited expand on enrollment in **PC Plus**, but are not the same as traditional Medicaid. The VHAP Managed Care beneficiaries are required to pay small co-payments at the point of service. See Section 1.4 for details.

2.2 CONDITIONS OF PARTICIPATION

A PCP enrolled in the **PC Plus** program must meet all of the following conditions listed in this section.

2.2.1 PRACTITIONER TYPES

The PCP must be enrolled and in good standing in the Vermont Medicaid program and be routinely providing services as a:

- Family Practice Physician
- General Practice Physician
- Internal Medicine Physician (general internists)
- Pediatric Physician
- Adult, Pediatric or Family Nurse Practitioner
- Naturopaths

Physician specialists, with one or more sub-specialties, may enroll as PCPs for members with life-threatening, degenerative or disabling conditions or disease. They must agree to meet the obligations of a PCP and have experience in and are willing to provide primary care services.

2.2.2 APPLICATION

Providers who wish to be a PCP in the **PC Plus** program must be actively enrolled in the Vermont Medicaid program and are required to complete and return the PCP Agreement For Participation.”.

Providers who are enrolling with **PC Plus** as a group, must complete a single “Application for Participation”, signed by a representative of the practice group. The PCP Agreement for Participation and the Provider Enrollment Agreement can be accessed at <https://vtmedicaid.com/Downloads/forms.html>

2.2.3 PROVIDER ENROLLMENT STATUS CHANGES

PCPs must notify HPES in writing should any of the changes listed below occur which will affect participation in the plan. Change requests and notifications may be mailed to HP Enterprise Services, **PC Plus**, and P.O. Box 888, Williston, Vermont 05495-0888 or faxed to (802) 878-3440.

Group Composition: If there is any change in the composition of individual providers in a group that originally agreed to participate in the Primary Care Plus Plan, the moving PCP is required to complete a new Agreement for Participation prior to the effective date of change.

In addition, any provider who has not previously participated in the **PC Plus** plan will need to complete the Agreement for Participation located at vtmedicaid.com/Downloads/forms.html

Office Location: Any change in PCP office address, telephone numbers or name of practice, must be communicated in writing to HPES as soon as possible and prior to the effective date of the change.

2.2.4 CASE MANAGEMENT SERVICES

In addition to providing primary care services, PCPs must provide a number of case management services. See Section 2.4.1 for further explanation of these responsibilities.

2.2.5 HOSPITAL ADMITTING PRIVILEGES

A **PC Plus** PCP must have either local hospital admitting privileges or a formal arrangement with a physician who has local hospital admitting privileges and who agrees to abide by **PC Plus** requirements.

2.2.6 REFERRAL PROVIDERS

Referral of **PC Plus** beneficiaries can be made to any provider currently enrolled in the Vermont Medicaid program.

2.2.7 ENROLLMENT MINIMUM/MAXIMUM

PC Plus PCPs can set a limit on the number of **PC Plus** members to be enrolled in their practice. Maximum enrollment for a PCP is 1500.

Should a PCP desire to increase or decrease the maximum number of members to be managed, the PCP must notify HPES in writing at least 60 days prior to the new change. A new Application for Participation will not be required.

2.2.8 NOTICE OF TERMINATION OF PARTICIPATION IN PC PLUS

All individually participating or group identified PCPs must notify HPES of their intention to withdraw from participation, in writing, at least 90 days prior to the termination date. Providers are required to give their patients 30 days notice prior to termination.

2.3 REFERRALS, PRIOR APPROVAL AND COST SHARING

2.3.1 REFERRALS

The goals of the referral process are to:

- Ensure that the PCP is involved in medical decisions affecting members
- Reduce utilization of unnecessary medical services
- Reduce duplication of services
- Promote continuity of care

The PCP will be responsible for coordinating care between the member and any specialty care that the member may need through the referral system. A referral takes place when a participating PCP refers their **PC Plus** member for medically necessary covered services not normally provided by the PCP. Referrals by the member's PCP will be required for payment of claims submitted by specialty providers. Members seeking specialty care without a referral from their PCP will be responsible for the visit, if they are informed in advance and in writing that because they have no referral, they will have to accept financial responsibility for the visit. See Section 1.2.19 **Notice That Medicaid Will Not Be Accepted**.

Referrals may be made orally or in writing. Both the PCP and the referral to specialty provider are required to keep documentation of the referral in the patient's medical records. The referral must include the following information:

- Patient identification information
- Date
- Reason for referral
- Requested service (evaluate, evaluate and treat)

Providers who make referrals in writing may do use using their own referral form. Referral forms do not need to be attached when submitting claims. The referral provider will be reimbursed on a fee-for-service basis for Vermont Medicaid covered services.

The following services **do not** require a referral from the PCP:

- Chiropractic services
- Dental services (Medicaid/Dr. Dynasaur only)
- Emergency services
- Family planning services, defined as services that prevent or delay pregnancy
- Gynecological services
- Personal care for children
- Prenatal and maternity care

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-
- Routine eye exams for adults/children and eyeglasses for children
 - Mental health services
 - School-based health services
 - Services rendered by the PCP or those providing back-up coverage for the PCP
 - Substance abuse services
 - Transportation services (Medicaid/Dr. Dynasaur only)

2.3.3 COST SHARING

Some **PC Plus** members have some cost sharing obligations. See Section 1.3.4 for details.

2.4 CASE MANAGEMENT RESPONSIBILITIES

Listed below are the primary care provider's case management responsibilities:

- For referrals, the PCP must use Vermont Medicaid participating providers or providers enrolled to serve members enrolled in the **PC Plus** program, unless the required service is not otherwise available from a currently enrolled Vermont Medicaid provider. If the PCP wants to use a provider who is not enrolled, HPES should be notified to solicit the enrollment of the provider.
- The PCP must have provisions for access to 24-hour/seven days-per-week coverage that will assure practitioner availability in person or by phone.
- The PCP (or PCP's practice) must maintain office-visiting hours at least four days per week for at least twenty-five hours per week for member appointments, unless this provision is waived by the DVHA in order to assure access to services and providers. Participating PCPs who work in a practice on a part-time basis, must inform the DVHA of the times they are available to see patients.
- The PCP must assure that all members have a current medical history and record, and must maintain medical records for each member.
- The PCP must agree to adhere to the appointment waiting times standards set out in the Medicaid Rule 7101.3 O (1)(b). These appointment standards state that any member should have immediate access to emergency care and for non-emergent care be seen within: 24 hours for urgent care, 2 weeks for non-urgent care with prompt follow-up and 90 days for preventive and routine physical examinations.
- PCPs must provide all covered primary care services consistent with their qualifications.
- The PCP must assure that every child or adolescent enrolled in the practice is screened according to the requirements of the Vermont Department of Health's EPSDT Periodicity Schedule.
- The PCP must follow the provisions of the Generic Drug Act where it permits substitution and will prescribe the lowest cost equivalent available.
- After consultation with specialists, the PCP will review and approve medically necessary specialty services as appropriate, except for services exempted or those approved by the DVHA or the DVHA's designated prior authorization agent.
- The PCP must participate in quality improvement projects agreed to by participants in the **PC Plus** network and the DVHA.

-
-
- The PCP must cooperate with the DVHA's accessibility surveyors. The DVHA will provide each PCP practice site with the results of any accessibility survey conducted.
 - The PCP must notify the DVHA of any change in his/her office physical plant that might change physical accessibility to The Department.

2.4.1 CASE MANAGEMENT FEE AND TREATMENT PLAN

In addition to fee-for-service reimbursement, PCPs will be paid a monthly case management fee for each member assigned to their practice. The PCP does not need to file a claim for the case management fee. Claims for the monthly fee will be generated by HPES based on the number of members enrolled in the practice and payment will appear on the Remittance Advice (RA). Actual services provided to members will be reimbursed on a fee-for-service basis in accordance with Vermont Medicaid fee-for-service payment policies and procedures.

When a PCP develops a treatment plan for a member, the PCP may submit a claim to HPES for reimbursement for the development of this plan using procedure code G9001. A PCP may submit no more than one treatment plan claim, per member, per calendar year. A covering practitioner cannot bill for a treatment plan. Payment will be made in accordance with the Vermont Medicaid fee schedule for this service. The treatment plan does not have to be submitted with the claim; however, it must be kept in the member's medical records. Treatment plans must include, at a minimum, the following information:

- Presenting clinical problems
- Expected outcomes
- Services required, including level of intensity
- Provider(s) of services

Treatment plan forms are available by contacting HPES' Provider Services Unit.

2.4.2 MONTHLY ENROLLMENT LIST

An enrollment list will be sent monthly to each PCP provider or provider's group, listing the members enrolled in that practice. Though this can be used as a tool for identifying members enrolled in the practice, it does not assure continuing eligibility. Therefore, it is recommended that eligibility be verified for each date of service prior to rendering any service.

SECTION 3-ELIGIBILITY VERIFICATION

Introduction

The **Green Mountain Care** Eligibility Verification System (EVS) provides beneficiary information for providers of health care. The automated system accurately supplies the most current eligibility status information clearly, concisely and rapidly for all beneficiaries 24 hours a day, seven days a week. This system is referred to as EVS throughout this document.

This manual provides instructions for the two functions of EVS – the Vermont Medicaid website, and voice response. It includes a guide for using the permanent identification cards and describes, in detail, the two methods for accessing beneficiary information.

1. **Voice Response System (VRS)** for details, see Section 3.1
2. www.vtmedicaid.com under Transaction Services

If for any reason you are unable to use either method, you may call a provider services phone analyst to verify eligibility at (800) 925-1706 or (802) 878-7871.

The EVS delivers a response that is clear to the user and appropriate for the method of access used in making the inquiry. The DVHA encourages all providers to take full advantage of this system to verify a patient's eligibility status *before* services are rendered. This system offers the following functionality:

- Is available 24 hours every day except for routine maintenance
- Responds with rapid verification information
- Substantially minimizes the risk of non-payment for services rendered to ineligible patients
- Decreases the number of claim resubmissions due to inaccurate eligibility information

Provider should complete all VRS or website transactions to be sure that **all** the pertinent information is captured. Compare the aid category given on the VRS or VTMedicaid website to the aid category listing, in order to determine the program that the beneficiary is enrolled in. This will assist you in determining covered services and co-payment requirements where applicable. Providers may verify eligibility for the current date, up to one year in the past and rely on the accuracy of the response for up to nine days beyond the current date.

Providers should retain the authorization number issued by the system to assure that the information received can be verified by the system. The number is not a guarantee of payment. The beneficiary must be eligible on the date of service and the services provided must be medically necessary and covered.

3.1 VOICE RESPONSE SYSTEM

Providers can obtain eligibility information at any time by using the automated Voice Response System (VRS) with a touch-tone phone. By using the VRS, providers can verify program eligibility, receive information about other insurance and determine if service limits are approaching or reached. In addition, providers can confirm the amount to be paid in the next RA or if that amount is zero, the amount and date of the last payment given. The VRS accesses the most current information available to HP Enterprise Services.

All provider calls to HPES are routed through the VRS. To receive eligibility information from a touch-tone telephone, follow the spoken prompts. To receive eligibility information from a rotary telephone, hold the line and the system will route your call to the HPES Provider Services Unit. The representatives will answer eligibility questions only for those providers who do not have touch-tone telephone service. All providers may continue to contact the HPES Provider Services Unit for information that is not available through VRS or the VTMedicaid website.

At the beginning of each call, touch-tone phone users are asked to enter their Vermont Medicaid provider number followed by their PIN number. The provider number and PIN number are a security measure to ensure the user is authorized to access the requested information. If the provider or PIN numbers entered are not valid or current, access will be blocked.

This section of the manual is designed to provide detailed instructions on how to use the VRS. The following tips will help in successfully placing a call to the VRS:

The VRS is available 24 hours a day, seven days a week.

To expedite the process, have the following information available when making your call:

- Provider number
- Provider PIN number

-
-
- Beneficiary identification number
 - Dates of service

*Note: Ten transactions per call are allowed (Ex: Five eligibility and five service limits)

3.1.1 INFORMATION AVAILABLE

All providers using the VRS have access to the following data:

Eligibility Verification:

- Date-specific eligibility
- Third party liability information (up to five segments)
- Beneficiary lock-in data
- Date of birth
- Co-pay indication

Service Limitations when exhausted:

- Office visits
- Visual refractions
- Visual glasses
- Adult dental benefits (dollars spent)
- Last dental oral exam
- Chiropractic visits
- Current RA check amount

3.1.2 SPECIAL FUNCTION KEYS

There are two special function keys on the touch-tone keypad: the pound sign key (#) and the asterisk (*) key. The VRS takes advantage of these keys to allow the user to perform special functions.

End of Data Marker

The pound sign key (#) signals to the system that the user has finished entering the requested data. The user should always press the pound sign key to mark the end of the data to get the quickest response from the system.

Use Previous Data

The user may also use the pound sign key to tell the system to reuse data previously entered for a specific prompt. The user simply presses only the pound sign key at the prompt. For example, if the user wishes to perform another transaction on the previously entered beneficiary number, the provider can enter the pound sign key when the system prompts for the beneficiary number. This automatically causes the system to use the previously entered beneficiary number. If the system determines that the user has never entered a beneficiary number, it prompts the user again to enter one.

Repeat Response of Prompt

The VRS interacts with the user by using a series of prompts and responses. It uses prompts to ask the user to enter data or to indicate what action the system should take next. It gives the requested information in the form of a voice response. Sometimes it is necessary to hear a prompt or a response over again. The VRS provides this capability. To tell the system to repeat its last response, press the pound sign key at an options menu prompt. To tell the system to repeat its last prompt, press the asterisk key at an options menu or main menu prompt.

Void Data

Two successive asterisks (**) indicate that all data in the current field should be deleted and the data following the asterisks be used in its place. For example, if the user intended to enter 12345 and accidentally keyed 12567, the mistake could be corrected by entering “**” followed by the correct data. The sequence of keystrokes is illustrated below:

1256712345#**

When the VRS examines the input data, it discards all data in the field preceding the two asterisks and takes the data following the double asterisks as the user’s intended input. Therefore, the final input to the system would be “12345”.

Alphabetic Data

Since the telephone touch-tone keypad has only numeric digits 0-9, a special method must be used to allow users to enter alphabetic characters. To enter alphabetic data, press the asterisk key (*) followed by a two-digit numeric code. This numeric code represents a specific alphabetic character. The first digit corresponds to the key cap number on which the character appears. The second digit corresponds to one of the three alphabetic characters on the key cap. Therefore, the code “*21” is used to input the letter “A” since the “A” appears in position one on key cap, two on the touch-tone keypad.

The characters “Q” and “Z” do not appear on the touch-tone keypad. Therefore, these two characters are treated as though they are the first two characters on key cap one. To enter “Q”, the user enters “*11”. To enter “Z”, the user enters “*12”.

3.1.3 ALPHA TO NUMERIC CONVERSIONS

Since the telephone touch-tone keypad has only numeric digits 0-9, a special method is used to allow entry of alphabetic characters. To enter alphabetic data, press the asterisk key (*) followed by a two-digit numeric code. This numeric code represents a specific alphabetic character.

A=*21	B=*22	C=*23	D=*31	E=*32
F=*33	G=*41	H=*42	I=*43	J=*51
K=*52	L=*53	M=*61	N=*62	P=*71
Q=*11	R=*72	S=*73	T=*81	U=*82
V=*83	W=*91	X=*92	Y=*93	Z=*12

Note: There is no alpha O listed above because provider numbers containing alpha characters followed by a zero should be a “zero” NOT an alphabetic character.

3.1.4 ACCESSING VRS

To access VRS, call one of the following VRS numbers using a touch-tone phone:

Local and Out-of-State: (802) 878-7871 (select option 1)
In-state only: (800) 925-1706

When a user calls a Vermont VRS telephone number, the VRS answers the phone and speak the following welcome message:

“Good morning/good afternoon/good evening, thank you for calling the Vermont Medicaid voice information service. For eligibility verification, service limits or current remittance advice payment amount, press 1. For assistance from an HPES representative, press 0.”

To determine whether or not the user is authorized to access information, the system must check the user’s Vermont Medicaid provider number. The system prompts the user to enter a provider number as follows:

“Please enter your seven-digit Medicaid provider number, followed by the pound sign.”

You have two attempts to enter a valid provider number. If you enter an invalid number on your first attempt, you will hear:

“Invalid provider number.”

If you enter an invalid provider number on your second attempt, you will hear one of the two following messages, depending on whether it is during business hours, after hours or on a holiday:

“Invalid provider number. We are sorry, you have not entered the required data at this step. If you would like assistance from an HPES representative-press zero.”

“We’re sorry, provider number (XXXXXXX) is not authorized. For assistance from an HPES representative, please call back between 8:00 a.m. and 5:00 p.m. except weekends and holidays and we will be happy to assist you”.

If your provider number is valid, you will be asked to:

“Enter your four-digit PIN followed by a pound sign”.

To create your PIN number-enter 9999-pound sign-you will hear:

“Wait while your PIN number is verified. The PIN value you have entered -9999-has expired. You will need a new PIN number before proceeding. Please enter a new four digit PIN number that is different from your previous PIN number and its not all the same (e.g. “1111”) followed by the pound sign. Please wait while your PIN number is updated. Your PIN number has been successfully changed. Your new PIN# is XXXX. Please write this number down for future use.”

You will then return to the following options:

“For eligibility verification, press 1, for service limits, press 2...”

*It is important to remember that you have **three** attempts to enter a valid PIN number. After the third failed attempt, your number will be suspended and will need to be reset by an HPES representative.*

If the provider PIN number combination that you have entered is invalid, and it is your first or second attempt of the three, you will here:

**“We’re sorry, provider number XXXXXXXX with PIN XXXX is not authorized”
“Please enter your seven digit provider number followed by a pound sign. Enter your four digit PIN number followed by a pound sign.”**

If on your third attempt, your provider number/PIN number combination is still invalid, you will hear the following message depending on whether it is during business hours, after hours or a holiday:

“We’re sorry, provider number XXXXXXX with PIN number XXXX has been suspended. Please hold for an HPES representative.”

OR

“We’re sorry, provider number XXXXXXX with PIN number XXXX is not authorized. For assistance from and HPES representative, please call back between 8:00 a.m. and 5:00 p.m. except on weekends and holidays and we will be happy to assist you.”

RESET PIN NUMBERS:

When you have had your PIN number reset by an HPES representative, you will create a new PIN number by entering 9999- pound sign- you will hear:

“Wait while your PIN number is verified. The PIN value you have entered- 9999- has expired. You will need a new PIN number before proceeding. Please enter a new four digit PIN number that is different from your previous PIN number, followed by the pound sign.

Please wait while your PIN number is updated. Your PIN number has been successfully changed. Your new PIN number is XXXX. Please write this number down for future use.”

You will then be returned to the following options: **“For eligibility verification, press 1...”**

Providers will be required to change their PIN numbers every 90 days. If you enter a PIN that has expired, you will be prompted to change your PIN with the following message:

“The PIN value you have entered has expired. You will need to enter a new PIN before proceeding. Please enter a new four digit PIN, different from your previous PIN, followed by a pound sign.”

REMEMBER

Valid PIN numbers must be four numbers (cannot be all same e.g. 2222)

The new PIN number must be different from your expired number.

After entering your new PIN number, you will hear:

“Please wait while your PIN number being updated.”

If your new PIN number is accepted and successfully updated in the database, you will hear:

“Your PIN number has been successfully changed. Your new PIN is XXXX. Please write this number down for future use.”

A provider may change their PIN number before the 90 day expiration by choosing option #4-change PIN#. Once you have entered a new PIN number that is not the same as the previous or is not all the same number, e.g. 888- you will hear:

“Your PIN number has been successfully changed. Your new PIN is XXXX. Please write this number down for future use.”

Please note that some provider numbers will require an alpha to numeric conversion in order to enter their provider number. Refer to Section 3.2.3 for instructions.

When the user enters a provider number, the system performs an edit to ensure that it is **seven** digits. After the user enters a provider number in the correct format, the system verifies that the user’s provider number is on the Provider Master File. The system asks the user to wait:

“Please wait while your authorization is verified.”

Once the system has verified the user's authorization, the VRS presents the following menu of services:

“For eligibility verification, press 1. For service limits, press 2. For current remittance advice payment amount, press 3. For assistance from an HPES representative, press 0.”

The system ensures that the user enters a valid number and performs the requested function.

3.1.5 ELIGIBILITY INQUIRY

To obtain beneficiary eligibility information, you will need to enter a valid beneficiary ID number, from date-of-service and to date-of-service. The ID uses the same format as all Medicaid IDs. First, the system prompts the user for the beneficiary ID as follows:

"Please enter the nine-digit Medicaid beneficiary number followed by the pound sign."

When the system receives a correctly formatted beneficiary identification number, it prompts the user for a from date-of-service:

"Please enter the six digits from date-of-service in a month, day, year format followed by the pound sign or enter a pound sign only for today's date."

Enter the date-of-service in a MMDDYY format followed by the pound sign (#). The system edits the date to ensure it is in the correct format and if a future date, within nine days.

When the system receives a correctly formatted from date-of-service, it prompts the user for a to date-of-service:

"Please enter the six digit to date-of-service in a month, day, year format followed by the pound sign or enter the pound sign only if the to date-of-service is the same as the from date-of-service."

Enter the to date-of-service in a MMDDYY format followed by the pound sign (#). The system edits the date to ensure it is in the correct format, greater than or equal to the from date-of-service, and is valid.

If the beneficiary identification number does not exist on the Beneficiary Eligibility Master file, the system informs the user:

"Beneficiary (beneficiary ID) is not on file. To inquire on another beneficiary's eligibility, press 1. To return to the main menu, press 9. For assistance from an HPES Representative, press 0. If this concludes your call, you may hang up."

If the beneficiary is not eligible on the specified date-of-service or a date of service within a date range, the system responds with the following message:

"Beneficiary (beneficiary ID) is not eligible for benefits from (From Date-of-Service) through (To Date-of-Service). To inquire on another beneficiary's eligibility, press 1. To return to the main menu, press 9. For assistance from an HPES representative, press 0. If this concludes your call, you may hang up."

Since the beneficiary is not eligible for services, the system does not provide any more eligibility information.

If the beneficiary is eligible, the system responds with one of the following messages specific to program eligibility, depending on the aid category. An example of this is:

"Beneficiary (beneficiary ID) is eligible for V-Script benefits with aid category (aid category) from (From Date-of-Service) through (To Date-of-Service). The beneficiary

date of birth is (DOB). The beneficiary last name is (last name) and the first name is (first name). This benefit allows coverage for -----“

The VRS responds with up to three different eligibility segments per inquiry.

If co-payment may be required, the system speaks the following message:

"Possible Co-pay"

Please refer to the Co-payment requirements in Section 1

If the beneficiary is locked into less than three providers, the system responds with one of the following messages, depending on the lock-in type:

HMO Lock-in

"Beneficiary number (Beneficiary ID) is locked into MVP."

- or -

"Beneficiary number (Beneficiary ID) is locked into The Vermont health Plan."

- or -

Medical Services Lock-in

"For medical care, beneficiary number (Beneficiary ID) is locked into provider last name (Provider Last Name) and first name (Provider First Name)."

Provider last name for ten characters and provider first name for five characters.

- or -

Case Managers Lock-in

"Beneficiary number (Beneficiary ID) is locked into Case Manager. Services must be prior approved or referred by a Case Manager."

- or -

Pharmacy services Lock-in

"For Pharmacy services, beneficiary number (Beneficiary ID) is locked into pharmacy name (Pharmacy Name), provider number (Provider Number)."

If the beneficiary is locked in to more than two providers, the system responds with one of the following messages, depending on whether it is during business hours, after hours or a holiday:

"Beneficiary number (Beneficiary ID) is locked into more than two providers. For assistance from an HPES representative, press 0. To continue, press 2."

- or -

"Beneficiary number (Beneficiary ID) is locked into more than two providers. Further information is not available because our office is closed. We are open from 8:00 a.m. to 5:00 p.m. except weekends and holidays. Please call back and we will be happy to assist you or to continue, press 2."

The VRS reports any third party liability information available. It provides information for up to five third party liability insurance carriers per beneficiary.

If the beneficiary does not have an insurance policy with another insurance company, the system informs the user as follows:

"The beneficiary is not insured by another carrier."

For beneficiaries with other insurance carriers, the system first informs the caller of how many insurance carriers the beneficiary has with the following message:

"The beneficiary has insurance policies with (Number of Other Insurance Carrier)s carriers."

If the carrier number is "4D", the system responds:

"This individual has insurance through a child support order. Carrier number is (Beneficiary-Other Insurance Company Name-Company Code). If there are any problems in billing this insurance, you may bill Medicaid and Medicaid will pursue."

-otherwise-

The system tells the user the company name for another insurance carrier.

"The beneficiary has an insurance policy with (Other Insurance Company Name)."

If the insurance company name is on the list of the 50 most frequently used carrier names, the system speaks the recorded company name. If the insurance company name is not on the list, the system speaks the company code:

"(Beneficiary -Other Insurance-Company-Name) with coverage type (Coverage-Type)."

- or -

"Carrier number (Beneficiary-Other Insurance Company Code)."

If the system has information for another insurance carrier, it pauses to give the user a chance to record the information from the last response. The system then provides the following options:

"There is/are (Number-Other Insurance-Remaining) carrier/carriers remaining. To hear information for the next insurance carrier, press 1. To skip the remaining carrier information, press 2."

The system will speak five TPL segments and on the sixth segment the system will provide the user with the following options:

"There is/are (Number-Other Insurance-Remaining) carrier/carriers remaining. For assistance from an HPES representative, press 0. To skip the remaining carrier information, press 2."

At this point, the system has completed the Beneficiary Eligibility information. The user may now get service limit information on the same beneficiary, do another eligibility inquiry or return to the main menu. The system prompts the user accordingly:

"For service limits on the same beneficiary, press 2. To inquire on another beneficiary's eligibility, press 1. To return to the main menu, press 9. For assistance from an HPES representative, press 0. If this concludes your call, you may hang up."

3.1.6 SERVICE LIMIT INQUIRY

To obtain beneficiary service limit information, you must enter a valid beneficiary ID number, from date-of-service and to date-of-service. The ID format is the same for all Medicaid IDs. First, the system prompts the user for the beneficiary ID as follows:

"Please enter the nine-digit Medicaid beneficiary number followed by the pound sign."

You may press the pound sign to tell the system to use the last beneficiary number entered. If this option is used, the system ensures that the user has previously entered a beneficiary number before proceeding. In some cases, there may be a slight delay while the system waits for the information to return from the host, so the system informs the user with the message:

"Please wait while the requested information is retrieved."

When the system receives a correctly formatted beneficiary identification number, it prompts the user for a from date-of-service:

"Please enter the six digits from date-of-service in a month, day, year format followed by the pound sign, or enter a pound sign only for today's date."

Enter the date-of-service in a MMDDYY format followed by the pound sign (#). The system edits the date to ensure it is in the correct format and is valid.

When the system receives a correctly formatted from date-of-service, it prompts the user for a to date-of-service:

"Please enter the six digit to date-of-service in a month, day, year form at followed by the pound sign or enter the pound sign only if the to date-of-service is the same as the from date-of-service."

Enter the date-of-service in a MMDDYY format followed by the pound sign (#). The system edits the date to ensure it is in the correct format, greater than or equal to the from date-of-service, and is valid.

If the beneficiary identification number does not exist on the Beneficiary Eligibility Master file, the system informs the user:

"Beneficiary (beneficiary ID) is not on file. To inquire on another beneficiary's eligibility, press 1. To return to the main menu, press 9. For assistance from an HPES Representative, press 0. If this concludes your call, you may hang up."

If the beneficiary is not eligible on the specified date-of-service or a date of service within a date range, the system responds with the following message:

"Beneficiary (beneficiary ID) is not eligible for benefits from (From Date-of-Service) through (To-Date-of-Service). To inquire on another beneficiary's eligibility, press 1. To return to the main menu, press 9. For assistance from an HPES representative, press 0. If this concludes your call, you may hang up."

Since the beneficiary is not eligible for services, the system does not provide any more eligibility information.

If none of the beneficiary's service limits are exhausted, the system responds:

"Beneficiary (beneficiary ID) has not exhausted service limits based on paid claims as of the last processing cycle."

If the system has information for another service limit, the system pauses to give the user a chance to record the information from the last response. The system then provides the following options:

"There is/are (Number Services Remaining) service limit/limits remaining. To hear the next service limit, press 1. To skip the remaining service limit information, press 2."

At this point, the system has completed the service limit information. The user may now get service limit information on another beneficiary or return to the main menu. The system prompts accordingly:

"To inquire on another beneficiary's service limits, press 2. To return to the main menu, press 9. For assistance from an HPES representative, press 0. If this concludes your call, you may hang up."

3.1.7 RA PAYMENT INQUIRY

When the system verifies the provider number, it also obtains remittance advice information. If remittance advice payment information is available for the provider, the system gives the following message:

"For provider number (Provider Number), the most recent remittance was issued on (RA Date) in the amount of (Check Amount)."

If no remittance advice payment information is available for the provider, the system informs the user:

"For provider number (Provider Number), no remittance is found."

After the transaction is complete, the system prompts with the following message:

"To return to the main menu, press 9. For assistance from an HPES representative, press 0. If this concludes your call, you may hang up."

3.1.8 WEB BASED ELIGIBILITY/CLAIM STATUS FUNCTIONALITY

If you have an active production trading partner ID, you can access this information through www.vtmedicaid.com under Transactions Services and log into Production Login and enter your trading partner ID and password. This will bring you to the Interactive Services home page. You will see two new options, "check eligibility status" and "check claim status". For detailed instructions on how to use the screen, you can click on the (?) question mark on either the eligibility search screen or the claims status search screen.

For those individuals that use the Provider Electronic Software (PES) provided by HPES, there is a new upgrade that is available for download (Downloads/Software/Provider Software) on the same link. The new PES will provide you with the capability to perform both interactive and batch submission of eligibility and claim status inquiries.

3.2 PROVIDER SERVICES UNIT

HPES phone analysts are available to answer program eligibility questions, provide service limitation information and current check amount data for those providers who do not have a touch-tone telephone. They are also available to assist with claim inquiries and other information not available through the VRS, or VTMedicaid website. Hours of availability are from 8:00 a.m. to 5:00 p.m. Monday through Friday, except for State assigned holidays. The Provider Services Unit can be reached at one of the following numbers:

Local and Out-of-State (802) 878-7871
In-State Only (800) 925-1706

Please have the following information ready so that your request may be answered efficiently.

- Your provider number
- Beneficiary identification number
- Beneficiary full name
- Date(s) of service

They are also not authorized to verify eligibility for dates 9 days or more beyond the current date.

3.3 AID CATEGORY LISTING (Identifies beneficiary program eligibility)

PROGRAM	DENTAL	AID CATEGORIES
Healthy Vermonters Program	NO	VP (Discount Pharmacy Only)
VPharm	NO	VD, VE, VF, VJ, VK, VL, VM, VN, VO
VPharm with Crossovers	NO	VG, VH, VI (Crossovers are Medicare, co-insurance and deductible claims)
V-Script	NO	VA, VB, VC, VS, VT, VU, V7, V8
VHAP Pharmacy	NO	V1, V2, V3, V5, V6
VHAP Pharmacy with Crossovers	NO	V4 (see above for explanation of Crossovers)
VHAP Limited	NO	UA, UB, UC, UD, UE, UF
VHAP Managed Care	NO	U1, U2, U3, U4, U5, U6, UX, J3, J4, J5, J6, J7, J8
Medicaid Managed Care	YES	A3, A4, A5, A6, A8, A9, B3, B4, B5, B6, B7 B8, BH, C4, C5, C6, C7, C8, C9, CH, D5, D8, E5, E8, F5, G 5, G8, H3, H4, H5, H6, H8, H9, I5, I8, K5, K9, L3, L4, L5, L6, L8, L9, M3, M4, M5, M6, M7, M8, O5, P2, P3, P4, P5, P6, P7, P9, Q3, Q6, R1, R4, R6, R7, R9, RG, RI, RK, S5, S7, T5, T8, W3, W4, W6, W9, X3, X4, X5, X6, X8, Y5
Traditional Medicaid	YES	AA, AB, AC, AD, AR, AZ, BA, BB, BC, BD, BG, BP, BR, CC, CO, C2, C3, CG, CP, CR, DC, DR, FC, GC, GR, HA, HB, HC, HD, HR, HZ, IA, IC, ID, IR, KC, KZ, LA, LB, LC, LD, LR, LZ, MA, MB, MC, MD, MP, MR, NA, NB, NC, ND, NP, NR, OC, P1, PA, PB, PC, PD, PP, PR, QA, QD, RF, RH, RJ, RP, RR, R0, R2, R3, SC, SP, TC, TR, WA, WB, WD, WZ, XA, XB, XC, XD, XR, YC
No Medicaid Coverage	NO	QW, TV, WM, Z3, Z4, Z5, Z6, Z7, Z8
Urgent/Emergent Inpatient Coverage Only	NO	Z9
Specially Funded Categories	NO	GA, GE, HT, HV, LF, MH, PS, QI, Q2 Premiums/Coinsurance/Deductibles: PQ
No Medicaid Coverage - PACE	NO	99
Pending Premium Payment	NO	C\$ (Catamount), P\$ (Dr. Dynasaur), U\$ (VHAP)
ESI (Employee Sponsored Insurance) with VHAP Wrap-around	NO	ZA
ESI (Employee Sponsored Insurance) with Chronic Care Wrap-around	NO	ZB
Premium Assistance	NO	ZC
Sign-Up Process for Catamount	NO	Z#, Z\$, Z*
Children with Special Health Needs (CSHN) for PT, OT, ST, NU & AU services only	NO	SH
Family Infant Toddler Program (FITP) for PT, OT, ST, NU & AU services only.	NO	FI

SECTION 4 - CLAIM DISPOSITION INFORMATION

Introduction

This section will assist providers in reviewing the status of each of their claims on the Remittance Advice (RA). It will also explain steps providers must follow to make adjustments or refunds on paid claims. A strong knowledge of these available resources and procedures will assist providers in maintaining accurate payment records.

4.1 REMITTANCE ADVICE

The Remittance Advice (RA) is a computer-generated report available to providers by the fiscal agent. It indicates the status of all claims that have been submitted for processing. The RA is posted to our website (www.vtmedicaid.com) under Transaction Services on a weekly basis. Your four most current RAs will be available. Providers are responsible for maintaining the information furnished in the banner pages.

4.1.1 BANNER PAGE

The first page of the RA, the weekly report listing the status of each claim and any pertinent financial information, is referred to as the banner page. Messages are printed on this page to keep providers informed of important changes in policy or billing procedures. The banner page is often the only notification of a change in billing procedure. It is the provider's responsibility to obtain this information from The Department/agency that receives their RA. It is recommended that each provider retain copies of the banner pages, use them to update their Provider Manuals and consult them whenever a question arises regarding DVHA policy or procedure. Banner pages are available weekly with RAs and posted online weekly at <http://vtmedicaid.com/Information/whatsnew.html>.

4.1.2 DETAIL PROCESSING

Each detail 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 RA right after the claim's ICN. Individual processing means that one detail from a claim may appear on the RA in the "Paid Claims" section, while another detail from the same claim may appear in the "Suspended Claims" section. This type of processing allows each detail to be processed individually. No detail is delayed by the processing of another detail.

4.1.3 DENIED CLAIMS

The Explanation of Benefits (EOB) codes printed on the RA explain the reason(s) why Vermont Medicaid claims are paid or denied. Full descriptions for each code are printed at the end of the RA.

EOB codes for denials that pertain to the entire claim are printed directly under the patient's name and the ICN on the RA. Detail denials are printed under each billing detail on the RA. The RA contains up to ten header denials per claim and ten detail denials per billing line. Please review all areas of the claim before resubmitting directly to claims processing. If the reason for your denial is unclear, please contact the HPES Provider Services Unit.

4.1.4 RA SECTIONS

The RA is divided into the following sections:

PAID CLAIMS: All claims paid in the current cycle. EOB codes under the claim header and details indicate the reason(s) for the payment amount. There may be as many as ten EOB codes per header and per denial.

DENIED CLAIMS: All claims denied in the current cycle. EOB codes under the claim header and details indicate the reason(s) for the denial. There may be as many as ten EOBs per header and per detail.

SUSPENDED CLAIMS: Claims requiring manual review by either HPES or the DVHA will be identified in this section prior to disposition. The purpose of this section is to inform the provider that HPES has received the claim, and payment or denial will be forthcoming.

ADJUSTED CLAIMS: Claims for which adjustments have been processed to correct information, overpayment, underpayment or payment to the wrong provider.

FINANCIAL ITEMS: Financial transactions such as recoupments, manual payouts and TPL recoveries.

TPL AND MEDICARE INFORMATION: Other insurance and Medicare information for beneficiaries with related denials on the RA.

EARNINGS DATA: This “Earnings Data” section of the RA is provided to show the current RA totals as well as cumulative year-to-date details.

MESSAGE CODES: Definitions of the EOB codes listed on the RA.

4.1.5 RA HEADINGS AND DESCRIPTIONS

RECIPIENT NAME: Beneficiary name is listed in alphabetical order. The name appears in last name, first name format.

MID: The beneficiary’s Medicaid identification number.

ICN: Each claim and any attachments received by HPES are assigned a unique identifying number called the Internal Control Number (ICN). This number is displayed in the third column on the RA. The fifteen digit number aids in identifying, locating or researching the claim, either during or after processing. The following summary describes what each number represents:

<u>DIGIT</u>	<u>DESCRIPTION</u>
1-2	Valid region code values for paper claims are: 10-Paper Claim without attachments. 11-Paper claim with attachments
	Valid region code values for ECS claims are: 40 - ECS The valid region code values for financial items are listed in the description of the financial items section.
3-6	The year the claim was received at HPES.
7-9	Three digits indicating the Julian Date on which HPES received the claim. These numbers correspond with the calendar dates. See Section 4.1.5 - Julian Date Calendar. For example, 001 corresponds with January 1 and 365 corresponds with December 31.
10-15	The last six digits following the date are designed for HPES control purposes. These numbers uniquely identify the claim and allow personnel to access the claim both manually and through the computer.

HVER: The version number of the claim. The original claim paid for the services rendered is version 00. The first adjustment to any payment is version 01, etc.

PT ACCT/RX#: The patient account or medical record number is reported as it appeared on the claim.

BILLED AMT: The amount charged for the service.

ALLOWED AMT: The Vermont Medicaid allowed reimbursement.

OI AMT: The amount paid by another insurance for this claim or detail.

LIAB AMT: The amount for which the patient is responsible, excluding co-pay.

COPAY AMT: The co-payment amount related to the claim.

PAID AMT: The amount included in the payment for this claim.

HEADER MESSAGES: These numbers relate to the EOB codes printed under the header information. These numbers, which are referred to as EOB codes, indicate the reasons for payment or denial for the claim on the header level (top portion of the claim).

DNUM: The detail number.

DVER: The version of the detail. The original detail paid is version 00. The first adjustment to any payment is version 01, etc.

FDOS: The beginning date of service as it appears on the claim.

TDOS: The ending date of service as it appears on the claim.

PROC+MODS: The procedure code and corresponding modifiers as they appear on the claim.

QTY BLD: The number of units of service as it appears on the claim.

DETAIL MESSAGES: The numbers relate to the EOB codes printed under the detail information. These numbers indicate the reasons for payment or denial on the detail level of the claim.

ADJUSTED CLAIMS

This section of the RA includes detailed information on both the original and the adjusted claim. The original claim data is displayed first, followed by the adjusted claim data and an explanation of the effect the adjustment had on the original claim.

RECIPIENT NAME: Beneficiary name on the adjusted claim is listed in alphabetical order. The name appears in last name, first name format.

MID: The beneficiary's Medicaid identification number on the adjusted claim.

ICN: The internal control number of the adjusted claim.

HVER - The version number of the adjusted claim. The original claim paid for the services rendered is version 00. The first adjustment to any payment is version 01 etc.

PT ACCT/RX # - The patient account or medical record number is reported as it appeared on the adjusted claim.

BILLED AMT - The amount charged for the service on the adjusted claim.

ALLOWED AMT - The Medicaid allowed reimbursement on the adjusted claim.

OI AMT - The amount paid by another insurance for this claim or detail on the adjusted claim.

LIAB AMT - The amount for which the patient is responsible, excluding co-pay on the adjusted claim.

COPAY AMT - The co-payment amount related to the adjusted claim.

PAID AMT - The amount included in the payment for this adjusted claim.

HEADER MESSAGES - These numbers relate to the message codes printed under the header information. These numbers, which are referred to as EOBs, indicate the reasons for payment or denial for the claim on the header level (top portion of the claim).

DNUM - The detail number on the adjusted claim.

DVER - The version of the detail on the adjusted claim. The original detail paid is version 00. The first adjustment to any payment is version 01, etc.

FDOS - The beginning date-of-service as it appears on the adjusted claim.

TDOS - The ending date-of-service as it appears on the adjusted claim.

PROC+MODS - The procedure code and corresponding modifiers as they appear on the adjusted claim.

QTY BLD - The number of units of service as it appears on the adjusted claim.

DETAIL MESSAGES - These numbers relate to the message codes printed under the detail information. These numbers indicate the reasons for payment or denial on the detail level of the adjusted claim.

ADJUSTMENT REASON - A text field that explains why the adjustment took place.

NET ADJUSTMENT AMOUNT - This field indicates the net effect the adjustment had on the claim. The value is equal to the difference between the Original Claim Paid Amount and the Adjusted Paid Amount.

FINANCIAL ITEMS

The "Financial Items" section of the RA is printed only when a financial activity other than claims adjudication takes place. Please refer to the sample "Financial Items" section of the RA in this section - Sample Remittance Advice. The following summary describes the information in the "Financial Items" section:

CCN - The Cash Control Number of the financial transaction. The first two digits of the number indicate the type of financial transaction (i.e., system payout, recoupment, refund).

A/L NUMBER - The number assigned to the provider's ledger to account for the transaction.

MID - The beneficiary's ID number is shown if the financial transaction is related to a specific claim. When the transaction does not relate to a specific claim, this space is blank.

ICN - The Internal Control Number of the claim is shown if the financial transaction is related to a specific claim. When the transaction does not relate to a specific claim, this space is blank.

HVER - The version number of the related claim, if applicable.

DNUM - The detail number on the related claim, if applicable.

DVER - The detail version number of the claim, if applicable.

TXN DATE - This field indicates the date the transaction was entered and logged in the provider's account ledger.

ORIG AMT - The original amount to be exhausted by financial transactions.

TXN AMT - The dollar amount corresponding to the transaction. This is the actual amount of money included or withheld from the payment and applied to the original amount.

BAL AMT - The remaining balance to be exhausted by future financial cash transactions (amount still owed against the receivable or payable). This value is equal to the Original Amount less the Transaction Amount.

RSN CD - This field describes why the transaction was performed.

FINANCIAL ITEMS REASON CODE – The financial reason codes and their descriptions listed with any financial transactions on the RA.

TPL AND MEDICARE INFORMATION

The TPL AND MEDICARE INFORMATION REPORT displays the beneficiaries for who claims denied for other insurance during the week. It is generated only when such transactions occur. The report lists only the insurance carrier that caused the claim to fail.

RECIPIENT NAME - The name of the beneficiary who had other insurance coverage for the denied claim.

ICN - The Internal Control Number assigned to each denied claim.

HVER - The header version number corresponds to the ICN and indicates the version of the claim. The original header has a version number of '00'. Subsequent version numbers (01, 02, etc.) are the result of adjustments made to the header.

DVER - The detail version number corresponds to the detail and indicates the version of the detail. The original detail has a version number of '00'. Subsequent version numbers (01, 02, etc.) are the result of adjustments made to the detail.

DNUM - The detail number corresponds to the ICN and indicates the detail of the claim.

OTHER INSURANCE - The name and address of the insurance carrier with whom the beneficiary has other insurance coverage.

CARRIER CODE - The carrier code of the insurance carrier listed above.

POLICY NAME - The name of the person who holds the insurance policy.

RELATIONSHIP DESCRIPTION - The relationship between the beneficiary and the policyholder.

POLICY - The policy number of the insurance policy that the beneficiary holds with the insurance carrier.

GROUP - The group number that the insurance policy falls under. This field is only populated if the beneficiary's insurance policy is a group policy.

MEDICARE - This field indicates the Medicare type. Possible values are 'PART A' and 'PART B'.

MEDICARE ID - The Medicare ID of the beneficiary if applicable.

EARNINGS DATA AND MESSAGE CODES

The EARNINGS DATA AND MESSAGES CODES displays the financial data for the current RA and year-to-date as well as the message codes that were listed with any claims (EOB codes) on the RA.

NUMBER OF CLAIMS PROCESSED (CURRENT) - The total number of claims processed during the past week. This figure includes all paid, denied, suspended, and adjusted claims appearing on the RA.

NUMBER OF CLAIMS PROCESSED (YTD) - The total number of claims processed this calendar year. This figure includes all paid, denied, suspended, and adjusted claims appearing on the RA; it is equal to the sum of the “Number of Claims Processed” fields on each RA year-to-date.

DOLLAR AMOUNT PROCESSED (CURRENT) - The dollar amount paid for claims processed during the past week.

DOLLAR AMOUNT PROCESSED (YTD) - The dollar amount paid for claims processed this calendar year. This figure is equal to the sum of the “Dollar Amount Processed” fields on each RA year-to-date.

SYSTEM PAYOUT AMOUNT (CURRENT) - The dollar amount paid out as a result of system generated financial transactions during the past week.

SYSTEM PAYOUT AMOUNT (YTD) - The dollar amount paid out as a result of system generated financial transactions for this calendar year. This figure is equal to the sum of the “System Payout Amount” fields on each RA year-to-date.

MANUAL PAYMENT AMOUNT (CURRENT) - The dollar amount paid out through manual checks during the past week.

MANUAL PAYMENT AMOUNT (YTD) - The total dollar amount paid out through manual checks for this calendar year. This figure is equal to the sum of the “Manual Payout Amount” fields on each RA year-to-date.

RECOUP AMOUNT WITHHELD (CURRENT) - The dollar amount withheld as a result of recoupment financial transactions during the past week.

RECOUP AMOUNT WITHHELD (YTD) - The dollar amount withheld as a result of recoupment financial transactions for this calendar year. This figure is equal to the sum of the “Recoup Amount Withheld” fields on each RA year-to-date.

PAYMENT AMOUNT (CURRENT) - The total dollar amount paid for paid claims, system or manual payouts, minus recoup amounts.

PAYMENT AMOUNT (YTD) - The total dollar amount paid for claims submitted and financial transactions incurred for the calendar year. This figure is equal to the sum of the “Payment Amount” fields on each RA year-to-date.

CREDIT ITEMS (CURRENT) - The dollar amount relating to any credit items for the past week. Credit items are all Medicaid void transactions, State void transactions, and refund transactions.

CREDIT ITEMS (YTD) - The total dollar amount relating to any credit items for the calendar year. Credit items are all Medicaid void transactions, State void transactions, and refund transactions.

NET ADJUSTMENT AMOUNT (CURRENT) - The total net adjustment amount from adjusted claims processing during the past week. This figure is equal to the sum of the “Net Adjustment Amount” fields located in the “Adjustments” section of the RA for each adjusted claim.

NET ADJUSTMENT AMOUNT (YTD) - The total net adjustment from adjusted claims processing for the calendar year. This figure is equal to the sum of the “Net Adjustment” fields for each RA year-to-date.

NET 1099 ADJUSTMENT (CURRENT) - The net 1099 adjustment incurred from financial transactions during the past week. This figure is equal to the net sum of all positive and negative 1099 transactions during the past week.

NET 1099 ADJUSTMENT (YTD) - The total net 1099 adjustment incurred from financial transactions for the calendar year. This figure is equal to the net sum of the "NET 1099 Adjustment" fields on each RA year-to-date.

COVERED DAYS INCLUDING NURSERY (CURRENT) - This field only applies to hospital claims. It indicates the total number of covered days (including nursery care) billed during the past week.

COVERED DAYS INCLUDING NURSERY (YTD) - This field only applies to hospital claims. It indicates the total number of covered days (including nursery care) billed during the calendar year.

NET EARNINGS (CURRENT) - The net earnings for the past week. This figure is calculated as follows:

Claims Paid Amount

- + System Payout Amount
- + Manual Payout Amount
- Recoup Amount Withheld
- Credit Items
- +/- Net 1099 Adjustment (may be positive or negative)

= Net Earnings

NET EARNINGS (YTD) - The total net earnings for the calendar year. This figure is equal to the sum of all the Net Earnings fields on each RA year-to-date.

ELECTRONIC FUNDS TRANSFER STATEMENT - The dollar amount deposited electronically. This statement includes the account number into which the money was deposited as well as the date the deposit was sent to the provider's bank.

MESSAGE CODES - The (EOB) codes displayed in other sections of the RA and a written explanation for each.

4.1.6 SAMPLE REMITTANCE ADVICE

The following pages illustrate a sample RA.

PROV 0007777 VERMONT MEDICAID MANAGEMENT INFORMATION SYSTEM
RA NUM 000333666000 LTC AND PROFESSIONAL PAGE
NUM: 1 R/A DATE: 06/16/2004

*****ATTENTION ALL PROVIDERS*****
IN OUR EFFORTS TO ASSIST THE PROVIDER COMMUNITY IN CLAIMS SUBMISSION,
WE NOW CAN ACCEPT CLAIMS ELECTRONICALLY VIA TAPE MODEM OR DISKETTE
ELECTRONIC CLAIMS SUBMISSION (ECS) ALLOWS A 7-10 DAY TURN-AROUND TIME

FROM THE DATE OF TRANSMITTAL TO RECEIPT OF PAYMENT. ANYONE INTERESTED SHOULD CONTACT THE ECS COORDINATOR AT HPES.

COMMONWEALTH PHYSICIANS
125 GEORGE MASON BLVD
BURLINGTON, VT 05401

PROV 0007777 VERMONT MEDICAID MANAGEMENT INFORMATION SYSTEM RA NUM
000333666000

LTC AND PROFESSIONAL PAGE NUM: 2
R/A DATE: 06/16/2004

RECIPIENT NAME	MID	ICN	HVER	PT ACCT/RX#	FRQ	BILLED AMT	ALLOWED AMT	OI AMT	LIAB AMT	COPAY AMT	PAID AMT
----------------	-----	-----	------	-------------	-----	------------	-------------	--------	----------	-----------	----------

HEADER MESSAGES (EOB/ADJ RSN/AMT)

DNUM DVER FDOS TDOS PROC+MODS/REV+RPL QTY BLD

DETAIL MESSAGES (EOB/ADJ RSN/AMT)

PAID CLAIMS

CLAIM TYPE: CAPITATION

SMITH BOB	XXXXXXXXXX	402004999888777	00	166								
01	03/01/04	03/31/04	M0401	1.0	5.00	5.00		0.00	0.00	0.00		
5.00												
093/000												
CLAIM TOTALS:							5.00	5.00	0.00	0.00	0.00	5.00
TOTALS FOR CLAIM TYPE: CAPITATION							1 CLAIM(S)	5.00	5.00	0.00	0.00	0.00
5.00												

PROV 0007777 VERMONT MEDICAID MANAGEMENT INFORMATION SYSTEM RA NUM
000333666000

LTC AND PROFESSIONAL PAGE NUM: 3
R/A DATE: 06/16/2004

RECIPIENT NAME	MID	ICN	HVER	PT ACCT/RX#	FRQ	BILLED AMT	ALLOWED AMT	OI AMT	LIAB AMT	COPAY AMT	PAID AMT
----------------	-----	-----	------	-------------	-----	------------	-------------	--------	----------	-----------	----------

HEADER MESSAGES (EOB/ADJ RSN/AMT)

DNUM DVER FDOS TDOS PROC+MODS/REV+RPL QTY BLD

DETAIL MESSAGES (EOB/ADJ RSN/AMT)

PAID CLAIMS

CLAIM TYPE: HCFA1500

SMITH BOB XXXXXXXXXX 402004999888777 00 166
01 03/01/04 03/31/04 91411 1.0 5.00 5.00 0.00 0.00 0.00
5.00
093/000
CLAIM TOTALS: 5.00 5.00 0.00 0.00 0.00 5.00

JONES BILL XXXXXXXXXX 402004555008876 00 167
01 03/15/04 03/15/04 91362 1.0 16.00 12.00 4.00 0.00 0.00
8.00
093/000
02 03/15/04 03/15/04 98099 1.0 25.00 18.00 0.00 0.00 0.00
18.00
093/000
CLAIM TOTALS: 41.00 30.00 4.00 0.00 0.00
26.00

TOTALS FOR CLAIM TYPE: HCFA1500 3 CLAIM(S) 46.00 35.00 4.00 0.00 0.00 31.00

PROV 0007777 VERMONT MEDICAID MANAGEMENT INFORMATION SYSTEM RA NUM
000333666000
LTC AND PROFESSIONAL PAGE NUM: 4
R/A DATE: 06/16/2004

RECIPIENT NAME	MID	ICN	HVER	PT ACCT/RX#	FRQ	BILLED AMT	ALLOWED AMT	OI AMT	LIAB AMT	COPAY AMT	PAID
----------------	-----	-----	------	-------------	-----	------------	-------------	--------	----------	-----------	------

AMT
HEADER MESSAGES (EOB/ADJ RSN/AMT)
DNUM DVER FDOS TDOS PROC+MODS/REV+RPL QTY BLD

DETAIL MESSAGES (EOB/ADJ RSN/AMT)

DENIED CLAIMS

CLAIM TYPE: HCFA1500

SMITH BOB XXXXXXXXXX 402004999888977 00 199
01 03/01/04 03/01/04 91418 1.0 15.00 0.00 0.00 0.00 0.00
0.00
408/000
CLAIM TOTALS: 15.00 0.00 0.00 0.00 0.00 0.00

JONES BILL XXXXXXXXXX 402004555008876 00 167
01 03/15/04 03/15/04 92862 1.0 16.00 0.00 0.00 0.00 0.00
0.00
096/000

02 03/15/04 03/15/04 98299 1.0 25.00 0.00 0.00 0.00 0.00
 0.00
 096/000
 CLAIM TOTALS: 41.00 0.00 0.00 0.00 0.00
 0.00
 TOTALS FOR CLAIM TYPE: HCFA1500 3 CLAIM(S) 56.00 0.00 0.00 0.00 0.00
 0.00
 DENIED CLAIM TOTALS: 3 CLAIM(S) 56.00 0.00 0.00 0.00 0.00
 0.00

PROV 0007777 VERMONT MEDICAID MANAGEMENT INFORMATION SYSTEM RA NUM
 000333666000
 LTC AND PROFESSIONAL PAGE NUM: 5
 R/A DATE: 06/16/2004

RECIPIENT NAME	MID	ICN	HVER	PT ACCT/RX#	FRQ	BILLED AMT	ALLOWED AMT	OI AMT	LIAB AMT	COPAY AMT	PAID AMT
----------------	-----	-----	------	-------------	-----	------------	-------------	--------	----------	-----------	----------

HEADER MESSAGES (EOB/ADJ RSN/AMT)
 DNUM DVER FDOS TDOS PROC+MODS/REV+RPL QTY BLD

DETAIL MESSAGES (EOB/ADJ RSN/AMT)

SUPSENDED CLAIMS

CLAIM TYPE: HCFA1500

SMITH BOB XXXXXXXXXX 402004999885467 00 188
 01 06/01/04 06/01/04 99887 1.0 35.00 0.00 0.00 0.00 0.00
 0.00
 CLAIM TOTALS: 35.00 0.00 0.00 0.00 0.00 0.00
 TOTALS FOR CLAIM TYPE: HCFA1500 1 CLAIM(S) 35.00 0.00 0.00 0.00 0.00
 SUSPENDED CLAIM TOTALS: 1 CLAIM(S) 35.00 0.00 0.00 0.00 0.00
 0.00

PROV 0007777 VERMONT MEDICAID MANAGEMENT INFORMATION SYSTEM RA NUM
 000333666000
 LTC AND PROFESSIONAL PAGE NUM: 6
 R/A DATE: 06/16/2004

RECIPIENT NAME	MID	ICN	HVER	PT ACCT/RX#	FRQ	BILLED AMT	ALLOWED AMT	OI AMT	LIAB AMT	COPAY AMT	PAID AMT
----------------	-----	-----	------	-------------	-----	------------	-------------	--------	----------	-----------	----------

HEADER MESSAGES (EOB/ADJ RSN/AMT)
DNUM DVER FDOS TDOS PROC+MODS/REV+RPL QTY BLD

DETAIL MESSAGES (EOB/ADJ RSN/AMT)

ADJUSTED CLAIMS

CLAIM TYPE: HCFA1500

SMITH BOB XXXXXXXXXX 402004999885467 00 188
01 06/01/04 06/01/04 99887 1.0 35.00 30.00 0.00 0.00 0.00
30.00
093/000
ORIGINAL CLAIM TOTALS: 35.00 30.00 0.00 0.00 0.00
30.00

RECOUPMENT TO ORIGINAL CLAIM-PAID DATE: 06/16/04 RECOUPMENT AMOUNT: 30.00-

SMITH BOB XXXXXXXXXX 402004999885467 00 188
01 06/01/04 06/01/04 99887 2.0 65.00 60.00 0.00 0.00 0.00
60.00
093/000
ORIGINAL CLAIM TOTALS: 65.00 60.00 0.00 0.00 0.00 60.00
ADJUSTMENT CLAIM TOTAL: 65.00 60.00 0.00 0.00 0.00
60.00

ADJUSTMENT REASON: PROVIDER-REQUESTED REPROCESSING NET ADJUSTMENT AMOUNT: 30.00

ADJUSTED CLAIM TOTALS: 1 CLAIM(S) 65.00 60.00 0.00 0.00 0.00 60.00

PROV 0007777 VERMONT MEDICAID MANAGEMENT INFORMATION SYSTEM RA NUM
000333666000
LTC AND PROFESSIONAL PAGE NUM: 7
R/A DATE: 06/16/2004

FINANCIAL ITEMS

CCN A/L NUM MID ICN HVER DNUM DVER TXN DATE ORIG AMT TXN AMT BAL AMT
RSN
532004096000987 55200476890321 XXXXXXXXXX 402004999885467 00 01 00 06/16/04
35.00 35.00 35.00 149
502004096000992 55200476890321 06/14/04 35.00
35.00- 0.00 103

FINANCIAL ITEMS REASON CODES

103 WEEKLY PAYMENT APPLIED TO ACCOUNTS RECEIVABLE
149 AUTO RECOUPMENT- ORIGINAL CLAIM

PROV 0007777
000333666000

VERMONT MEDICAID MANAGEMENT INFORMATION SYSTEM

RA NUM

LTC AND PROFESSIONAL
R/A DATE: 06/16/2004

PAGE NUM: 8

TPL INFORMATION

RECIPIENT NAME ICN HVER DVR DNUM

SMITH BOB 402004356922001 00 01 00

BLUE CROSS/BLUE SHIELD OF VERMONT CARRIER CODE: EE
100 STATE STREET
MONTPELIER, VT 05606

POLICY NAME: BOB SMITH RELATIONSHIP SELF POLICY 109885478773399 GROUP
6789085550

PROV 0007777
000333666000

VERMONT MEDICAID MANAGEMENT INFORMATION SYSTEM

RA NUM

LTC AND PROFESSIONAL
R/A DATE: 06/16/2004

PAGE NUM: 9

EARNINGS DATA

	CURRENT	YEAR-TO-DATE
NUM OF CLAIMS PROCESSED	4	1004
CLAIMS PAID AMOUNT	91.00	25,867
SYSTEM PAYOUT AMOUNT	0.00	0.00
MANUAL PAYOUT AMOUNT	0.00	0.00
RECOUP AMOUNT WITHHELD	35.00	35.00
PAYMENT AMOUNT	56.00	25,832
CREDIT ITEMS	0.00	0.00
NET ADJUSTMENT AMOUNT	35.00-	35.00
NET 1099 ADJUSTMENTS	0.00	0.00
NET EARNINGS	56.00	25,832

**\$56.00 WAS DEPOSITED INTO ACCOUNT NUMBER 0123456789 ON 06/162004

EOB MESSAGE CODES

093 PAYMENT REDUCED TO MAXIMUM ALLOWABLE AMOUNT
096 CLAIM DENIED. EXACT DUPLICATE OF SERVICE PREVIOUSLY PAID
095 CLAIM CUTBACK DUE TO OTHER INSURANCE PAYMENT
408 PLEASE BILL OTHER INSURANCE CARRIER FIRST AND ATTACH COPY OF PAYMENT OR DENIAL

4.1.7 JULIAN DATE CALENDAR

The Julian Date Calendar will assist in interpreting the Internal Control Number HPES assigns to each claim. The calendars for regular and leap years follow:

JULIAN DATE CALENDAR – REGULAR YEAR

DAY	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	DAY
1	001	032	060	091	121	152	182	213	244	274	305	335	1
2	002	033	061	092	122	153	183	214	245	275	306	336	2
3	003	034	062	093	123	154	184	215	246	276	307	337	3
4	004	035	063	094	124	155	185	216	247	277	308	338	4
5	005	036	064	095	125	156	186	217	248	278	309	339	5
6	006	037	065	096	126	157	187	218	249	279	310	340	6
7	007	038	066	097	127	158	188	219	250	280	311	341	7
8	008	039	067	098	128	159	189	220	251	281	312	342	8
9	009	040	068	099	129	160	190	221	252	282	313	343	9
10	010	041	069	100	130	161	191	222	253	283	314	344	10
11	011	042	070	101	131	162	192	223	254	284	315	345	11
12	012	043	071	102	132	163	193	224	255	285	316	346	12
13	013	044	072	103	133	164	194	225	256	286	317	347	13
14	014	045	073	104	134	165	195	226	257	287	318	348	14
15	015	046	074	105	135	166	196	227	258	288	319	349	15
16	016	047	075	106	136	167	197	228	259	289	320	350	16
17	017	048	076	107	137	168	198	229	260	290	321	351	17
18	018	049	077	108	138	169	199	230	261	291	322	352	18
19	019	050	078	109	139	170	200	231	262	292	323	353	19
20	020	051	079	110	140	171	201	232	263	293	324	354	20
21	021	052	080	111	141	172	202	233	264	294	325	355	21
22	022	053	081	112	142	173	203	234	265	295	326	356	22
23	023	054	082	113	143	174	204	235	266	296	327	357	23
24	024	055	083	114	144	175	205	236	267	297	328	358	24
25	025	056	084	115	145	176	206	237	268	298	329	359	25
26	026	057	085	116	146	177	207	238	269	299	330	360	26
27	027	058	086	117	147	178	208	239	270	300	331	361	27
28	028	059	087	118	148	179	209	240	271	301	332	362	28
29	029		088	119	149	180	210	241	272	302	333	363	29
30	030		089	120	150	181	211	242	273	303	334	364	30
31	031		090		151		212	243		304		365	31

JULIAN DATE CALENDAR – LEAP YEAR

DAY	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	DAY
1	001	032	061	092	122	153	183	214	245	275	306	336	1
2	002	033	062	093	123	154	184	215	246	276	307	337	2
3	003	034	063	094	124	155	185	216	247	277	308	338	3
4	004	035	064	095	125	156	186	217	248	278	309	339	4
5	005	036	065	096	126	157	187	218	249	279	310	340	5
6	006	037	066	097	127	158	188	219	250	280	311	341	6
7	007	038	067	098	128	159	189	220	251	281	312	342	7
8	008	039	068	099	129	160	190	221	252	282	313	343	8
9	009	040	069	100	130	161	191	222	253	283	314	344	9
10	010	041	070	101	131	162	192	223	254	284	315	345	10
11	011	042	071	102	132	163	193	224	255	285	316	346	11
12	012	043	072	103	133	164	194	225	256	286	317	347	12
13	013	044	073	104	134	165	195	226	257	287	318	348	13
14	014	045	074	105	135	166	196	227	258	288	319	349	14
15	015	046	075	106	136	167	197	228	259	289	320	350	15
16	016	047	076	107	137	168	198	229	260	290	321	351	16
17	017	048	077	108	138	169	199	230	261	291	322	352	17
18	018	049	078	109	139	170	200	231	262	292	323	353	18
19	019	050	079	110	140	171	201	232	263	293	324	354	19
20	020	051	080	111	141	172	202	233	264	294	325	355	20
21	021	052	081	112	142	173	203	234	265	295	326	356	21
22	022	053	082	113	143	174	204	235	266	296	327	357	22
23	023	054	083	114	144	175	205	236	267	297	328	358	23
24	024	055	084	115	145	176	206	237	268	298	329	359	24
25	025	056	085	116	146	177	207	238	269	299	330	360	25
26	026	057	086	117	147	178	208	239	270	300	331	361	26
27	027	058	087	118	148	179	209	240	271	301	332	362	27
28	028	059	088	119	149	180	210	241	272	302	333	363	28
29	029	060	089	120	150	181	211	242	273	303	334	364	29
30	030		090	121	151	182	212	243	274	304	335	365	30
31	031		091		152		213	244		305		366	31

4.2 PAYMENT ADJUSTMENTS

4.2.1 ADJUSTMENT REQUESTS & TIMELY FILING

Adjustment requests may be submitted to HPES when a claim is paid incorrectly. These requests can be initiated by the provider, HPES or the DVHA. If the error originates with the provider, then the provider must submit the adjustment. When requesting an adjustment, submit an adjustment form. Give a brief description of the reason for the adjustment and the action required.

A new claim form with the correct information is required when changing the pay to, provider number, beneficiary number or funding source. Any request, which does not have the proper attachments, will be returned. If timely filing applies, then attach a copy of the RA.

Denied claims cannot be submitted as adjustment requests. A claim that has been denied should be corrected and resubmitted with all attachments as a new claim.

Adjustments are the preferred method of correction because they eliminate the use of providers' personal checks for repayment of incorrectly processed claims. Adjustments also provide an accurate record of how the claim was processed.

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

Adjustments and recoupments to claims billed incorrectly that result in a negative financial outcome for the provider must be done within three years of the original date of service. If the claim is more than three years old, the provider must refund the overpayment and attach the check to the completed The Refund form is available on our website at <https://vtmedicaid.com/Downloads/forms.html>.

For instructions on completing adjustments using HPES' PES software, please visit www.vtmedicaid.com and follow the links to Downloads, Software, Online Adjustments.

Forms for completing single and multiple adjustments can be downloaded from <https://vtmedicaid.com/Downloads/forms.html>.

4.3 REFUNDS

In the event of a Medicaid overpayment, a refund check may be attached to a Medicaid "Refund Form" and sent to HPES. The Refund Form requires providers to state the reason for the refund and to designate the claim or account against which it should be applied. Refunds will be reflected on the Financial Items page of the RA. The refund amounts will be deducted automatically from the YEAR-TO-DATE total.

When other health insurance payments are received after Medicaid payment has been made, the provider should refund to HPES the lesser of the amount paid by the insurer or the Medicaid payment. Failure to do so may be criminally punishable as Medicaid fraud.

DETAILED SUMMARY OF UPDATES (2/1/2012)

*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*

1.1.3 MANUALS, MEDICAID RULE AND STATE PLAN RESOURCES (page 7)

The State Plan, a guiding document for changes applicable to Vermont's Medicaid population and includes the populations for the State's Children's Health Insurance Program (SCHIP) and the Choices for Care program which are not covered by the Global Commitment (GC) to Health Waiver. State Plan information, is at <http://dvha.vermont.gov/administration> in the Service Administration section. Global Commitment to Health 1115 Demonstration Waiver information is also at <http://dvha.vermont.gov/administration> in the Global Commitment section.

Added: red text

Deleted: section name, **1.1.3 MANUAL AND RULE ACCESSIBILITY**

1.1.5 GLOSSARY OF TERMS AND PHRASES (page 10)

PROVIDER ENROLLMENT AGREEMENT

Deleted: Providers that have the power to prescribe and refer but not bill for services, may enroll as a non-participating provider.

1.2.4 ENROLLMENT AND CERTIFICATION (page 20)

Enrollment is limited to the following:

Note: Non-participating enrollment is no longer accepted.

Added: above red text

Deleted: Non-participating providers enroll in order to have prescriptions for Vermont Medicaid beneficiaries recognized even though the non-participating provider cannot bill Vermont Medicaid.

1.2.7 DOCUMENTATION OF SERVICES (page 21)

All documentation must be legible, contain all required information and applicable dates.

Added: red text to section

1.1.11 NON-PARTICIPATING PROVIDERS

Non-participating physicians, if enrolled, can:

- Be a referring physician on the CMS 1500 and UB-04 claims
- Write an RX under his/her own NPI number
- Sign a MNF for DME or medical supplies

Deleted: section from manual

1.2.8 NON-PARTICIPATING PROVIDER

Some physicians that cannot or do not wish to submit claims for services (such as hospital residents) but they need to be identified for the purpose of referring or prescribing. The DVHA needs HPES to assure that all prescribing physicians are licensed and acting within the scope of their license.

Therefore, a physician may be enrolled as a non-participating provider and assigned a number for use in the above instances only. Enrolling as a non-participating physician, assures that other participating providers and facilities may be reimbursed for such prescribed services or items. A non-participating physician may not submit claims for payment for services. The Non-Participating Enrollment Agreement must be used by physicians who wish to be assigned a Vermont Medicaid provider ID number to be a referring or prescribing physician, even if they do not wish to submit claims for services.

Deleted: section from manual

1.3.9 SPEND-DOWN (page 38)

Providers may obtain a copy of the spenddown notification by contacting the DCF Call Center at 800-479-6151 or Member Services for Green Mountain Care. The case worker will be notified of the request and will provide the information.

Added: above red text

1.4.4 LOCUM TENENS (page 46)

Added: The Locum Tenens physician must be licensed in Vermont and be actively enrolled in Vermont Medicaid.

Added: The Billing provider is 100% liable for all locum tenens billing.

Deleted:, usually hired from out of state,

Deleted: If a Locum Tenens physician is covering for a physician who has permanently left a practice, then the Locum Tenens physician must enroll with Vermont Medicaid.

1.4.9 FORMS AND MANUALS (page 48)

Deleted: the Non-Participating Provider Signature Page listed under Provider Enrollment Forms.

(1/1/2012)

1.3.13 WORKERS COMPENSATION/ACCIDENT LIABILITY BILLING

If a provider decides at any point to bill Vermont Medicaid, the provider must withdraw the claim to the workers compensation/auto insurer. The withdrawn claim is still subject to the six-month timely filing limit. Vermont Medicaid will pay the claim and bill the responsible insurance provider. Payments made by the insurance provider will come directly to Vermont Medicaid. No reimbursement will be made to the provider.

Added: above red text to paragraph

(11/1/2011)

1.1.15 REIMBURSEMENT OF OVERPAYMENTS (page 18)

Providers are reminded of the 2009 Fraud Enforcement and Recovery Act (FERA) which amended the False Claims Act, 31 U.S.C §§3729-3733, by increasing the scope of the false claims liability to include persons who knowingly conceal the retention of any overpayment of government money and the 2010 Patient Protections and Affordable Care Act (PPACA) which directly linked the retention of overpayments to false claims liability. PPACA requires the report and return of all overpayments within 60 days after the date on which the overpayment was identified or the date the corresponding cost report was due, whichever is later. Additionally, providers must submit notification in writing as to the reason of the overpayment. HPES will forward any cases in which the discovered overpayment was not refunded during the timeline mandated by PPACA to the DVHA Program Integrity Unit for their review.

Hospitals (in addition to the above information) HPES contracts with AIM HealthCare to audit hospitals for credit balances on accounts. This arrangement does not negate the provider's responsibility to report and return overpayments timely. HPES will forward any cases in which the discovered overpayment was not refunded during the timeline mandated by PPACA to the DVHA Program Integrity Unit for their review.

Added: above red text

1.2.7 DOCUMENTATION OF SERVICES (page 21)

Each provider must keep written documentation for all services that have been performed for beneficiaries. Providers must be prepared to submit information on transactions upon request of the State Agency or HHS secretary for records of any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5 year period ending on the date of the request, within 35 days; this includes the actual case record notes for any services performed.

Added: above red text

1.2.23 UTILIZATION REVIEW (page 28)

The DVHA conducts numerous utilization management and review activities. Reviews are intended to assure that quality services are provided to beneficiaries and that providers are using the program properly. The reviews are generally an examination of records, known as a desk audit, although they may also include an on-site visit from the utilization review unit.

DVHA staff utilizes clinical criteria for making Utilization Review (UR) decisions that are objective and based on sound medical evidence. Approved criteria include the following:

- McKesson Health Solutions InterQual® Guidelines;
- DVHA Clinical Guidelines;
- Vermont State Medicaid Rules;
- Hayes and Cochrane New Technology Assessments; and
- Other Nationally Recognized Evidence Based Criteria

McKesson Health Solutions InterQual® Guidelines are now available to providers behind the Vermont Medicaid secure provider web portal at www.vtmedicaid.com/secure/logon.do.

DVHA Clinical Guidelines and Vermont Medicaid State Rules will continue to be available at the DVHA website at dvha.vermont.gov/for-providers/clinical-coverage-guidelines.

Added: above red text to section

1.3.2 HEALTH CARE BENEFIT PROGRAMS (page 30)

VHAP Pharmacy The VHAP Pharmacy program was created to expand pharmaceutical and vision benefits to low-income, elder or disabled residents of Vermont. The program covers prescription drugs and certain over the counter drugs. Co-payments are required, see Section 1.3.4.

Replaced: the word eyeglass with **vision**

1.3.5 CO-PAYMENTS (page 35)

AID CATEGORIES: AA, AB, **AD**, AZ, BA, BB, BD, BP, C1, C2, CG, C3, CC, DA, DD, EA, EB, EC, ED, ER, GA, GE, HA, HB, HD, HT, HV, HZ, IA, ID, KC, LA, LB, LC, LD, LR, LZ, MA, MB, MD, MH, MP, NA, NB, ND, NP, P1, PA, PB, PD, PP, Q1, Q2, QA, QD, QW, SC, SP

Added: above red text to section paragraph

(10/1/2011)

1.2.7 DOCUMENTATION OF SERVICES (page 20)

The documentation for any service that was billed must be kept for **seven** years.

Replaced: the word six with **seven**

1.2.13 INDIVIDUAL CONSIDERATION/MANUAL PRICING (page 24)

Providers wishing to request updates to any of the following: place of service, provider type, provider specialty modifier/code combination additions and diagnosis rate review are advised to e-mail their request to vermonthipaacontact@hp.com. Providers must include the following information: the ICN of the denied claim (required), the complete name of the person initiating the request, the specific code, attribute to be updated, provider name and number.

All unit requests must include a brief cover letter containing the following information: ICN of the denied claim (required), complete name of the person initiating the request, units requested, the specific code and the provider name & number. Other required items include: Hard copy of the claim, notes and all medical journal articles sustaining your request. Mail to: HP Enterprise Services, 312 Hurricane Lane, Williston, VT 05495, Attn: HIPAA Request Reviewer.

Added: above red text to section

3.1.1 INFORMATION AVAILABLE (page 54)

Service Limitations when exhausted:

-Last dental oral exam

Added: above red text

(9/1/2011)

1.2.22 TIMELY FILING (page 27)

Providers submitting a timely filing appeal request containing 10 or more claims, all with the same late submission reason, are required to complete and the Timely Filing Appeal Listing-10 or more claims document, located at www.vtmedicaid.com/Downloads/forms.html.

A request for an exception can be made by sending the claim with a detailed explanation of why an exception should be granted, along with any other required attachments to:

Added: above red text to section

1.3.2 HEALTH CARE BENEFIT PROGRAMS (page 29)

VHAP-Limited VHAP Limited mirrors VHAP Managed Care, i.e., PC Plus. Physician referrals or Prior Authorizations required for Managed Care are also required for VHAP Limited; therefore, a beneficiary may need to select a Primary Care Physician (PCP) prior to receiving a service. If a beneficiary pays their initial premium, coverage is retroactive to the day eligibility was approved. The beneficiary will be responsible for the cost of services, however, if the initial premium is not paid.

VHAP-Limited VHAP Limited is a transition program used prior to enrollment in managed care, PC Plus. As soon as beneficiaries are determined eligible and pay any required premium, they are covered for certain services on a fee-for-service basis. The VHAP Limited benefit is more limited than PC Plus. In general, physician services, inpatient and outpatient hospital services as well as prescription drugs are covered. VHAP Limited beneficiaries are issued a **Green**

Replaced: VHAP-Limited paragraph with above red text

1.4.9 FORMS AND MANUALS (page 47)

Added: 340-B Drug Program: Provider Enrollment Amendment, Contact Information Sheet & Provider Presentation and the Timely Filing Appeal Listing

Deleted: the Vision Eligibility Verification Request Fax Form

SECTION 2-VERMONT HEALTH ACCESS PLAN- PC PLUS (page 48)

Introduction

VHAP Limited provides a limited benefit to low income uninsured adults. This is a transition program between initial enrollment and enrollment in managed care. The other program, VHAP Pharmacy, provides pharmacy benefits for low income Vermonters who are elderly or disabled.

Deleted: limited (as underlined in above text)

3.3 AID CATEGORY LISTING (page 64)

PROGRAM	DENTAL	AID CATEGORIES
VPharm with Crossovers	NO	VG, VH, VI (Crossovers are Medicare, co-insurance and deductible claims)
VHAP Pharmacy with Crossovers	NO	V4 (see above for explanation of Crossovers)

Added: above red text to the Aid Category Listing chart

(8/2/2011)

1.2.11 PAYMENT-DVHA PRIMARY (page 23)

Psychologist - Reimbursement basis is the lower of the provider’s charges or 110% of Vermont Medicaid allowed rate on file. The unit of service is time (15 minutes, 30 minutes, 60 minutes)
Master Level Psychologist/Counselor - Reimbursement basis is the lower of the provider’s charge or Vermont Medicaid rate on file. The unit of service is time (15 minutes, 30 minutes and 60 minutes).

Deleted: above text from section

Psychological Services: see CMS-1500 (PSYCHIATRY/PSYCHOLOGY)

Added: above red text

(8/1/2011)

1.2.11 PAYMENT-DVHA PRIMARY (page 22)

Anesthesia Assistants-Reimbursement basis is 80% of the Vermont Medicaid rate on file.

Certified Nurse-Midwife-Reimbursement basis is 100% of the Vermont Medicaid rate on file.

CRNA-Reimbursement basis is 100% of the Vermont Medicaid rate on file.

Added: red above text

Deleted: Anesthesia Assistants-Reimbursement basis is for the procedure at 100% of the CRNA 50%

Deleted: Certified Nurse-Midwife-Reimbursement basis is the lower of the provider’s charges or ninety percent (90%) of Vermont Medicaid rate on file for a physician providing the same service. Reimbursement is limited to only certain procedure codes.

Deleted: CRNA-Reimbursement basis is the lower of the provider’s charge or Vermont Medicaid rate on file for the procedure code at 50%.

3.4 2009 AID CATEGORY LISTING (page 64)

Medicaid Managed Care R4, R6, R7, R9, RG, RI, RK,
Traditional Medicaid RF, RH, RJ, RP, R0, R2, R3,

Added: above red text to section

(7/1/2011)

1.1.9 CONTRACTUAL ALLOWANCE (page 16)

If the entire allowed amount is applied to the primary insurance deductible do not enter the contractual allowance.

Added: above red text to section

1.2.1 PROVIDER TAX (page 18)

Lockbox
State of Vermont State Agency of Human Services
Supplemental/Tax Assessment
PO Box 1335
Williston, VT 05495

Deleted: DVHA cash coordinator, 312 Hurricane Lane, Suite 201, Williston, VT 05495

Added: above red text

1.3.5 CO-PAYMENTS (page 36)

VPharm Pharmacy-Aid Categories VD, **VE**, VF, VG, VH, VI, VK, VL, VM, VN & VO:

Added: above red text

1.4.3 GUIDELINES FOR BILLING INCIDENT TO (page 44)

Deleted: Note: Drug management cannot be billed “incident to”.

2.3.1 REFERRALS (page 51)

Deleted: or the DVHA referral form from section

(6/1/2011)

1.4.9 FORMS AND MANUALS (page 46)

The forms and manuals used in the Vermont Medicaid program are available for download from Vermont Medicaid web portal at www.vtmedicaid.com. A **Provider Directory of Resources** is available for download at <https://vtmedicaid.com/Information/whatsnew.html>.

The following documents can be printed directly from the website:

Added: above red text to section

SECTION 2-VERMONT HEALTH ACCESS PLAN- PC PLUS (page 48)

PCPs receive a monthly case management fee for each member enrolled with the PCP. This fee is for coordinating members' health care services, regardless of whether the member is seen. When services are provided, the Medicaid fee-for-service reimbursement applies. **In addition, PCPs will receive a monthly roster of enrolled members. It is required that incorrect member information is noted and a revised roster be returned to the HPES enrollment unit for updating. This information may be returned by fax to 802-878-3440, attn: enrollment or mailed to: HP Enterprise Services, attn: Enrollment, PO Box 888, Williston, VT 05495**

Added: above red text to section

2.3.2 PRIOR AUTHORIZATION AND NOTIFICATION FOR HOSPITAL ADMISSIONS

Emergency **in-state** inpatient hospital admissions do not require prior authorization. Members are required to notify their PCP of the emergency as soon as possible.

Added: above red text to section

2.2.8 NOTICE OF TERMINATION OF PARTICIPATION IN PC PLUS

All individually participating or group identified PCPs must notify HP of their intention to withdraw from participation, **in writing**, at least 90 days prior to the termination date. **Providers are required to give their patients 30 days notice prior to termination.**

Added: above red text to section

Deleted: Closure of a practice due to the death of a PCP or sale of an individual practice, a group practice or a clinic, will automatically terminate participation in the **PC Plus** plan.

5/1/2011

2.3.2 PRIOR AUTHORIZATION AND NOTIFICATION FOR HOSPITAL ADMISSIONS

Select procedures and diagnostic tests require notification to the DVHA Clinical Unit. Notice for elective care should be given at least five days prior to the hospital admission. Services requiring prior authorization from the DVHA in the fee-for-service program will also require prior authorization in **PC Plus** Program. If prior authorization is required and obtained for an inpatient stay, no additional notification is required upon admission.

Emergency **in-state** inpatient hospital admissions do not require prior authorization. Members are required to notify their PCP of the emergency as soon as possible.

All out-of-state urgent/emergency inpatient hospital admissions (excluding designated border hospitals, see UB-04 Supplement) require notification be made to the DVHA Clinical Unit within 24 hours or the next business day of the admission. See the UB-04 Provider Manual at <https://vtmedicaid.com/Downloads/manuals.html> for further information regarding out-of-state inpatient hospital admissions.

Added: above red text to section.

(5/1/2011)

1.3.5 CO-PAYMENTS (page 35 & 36)

VHAP Primary Care Plus Beneficiaries-Aid Categories J3-J8, U1-U6 and **UX:**

Vision Coverage: For beneficiaries with category codes **VG**, VD, VJ & VM.

Added: above red text to section

3.3 AID CATEGORY LISTING (page 64)

VHAP Managed Care	NO	U1, U2, U3, U4, U5, U6, UX , J3, J4, J5, J6, J7, J8
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Added: red text to section

(4/1/2011)

1.4.9 FORMS AND MANUALS (page 46)

Deleted: Ambulance Certification Form

Added: Abuse & Team Care Referral Form, Vision Eligibility Verification Request Fax Form and Web Services Account E-mail Request Form

(3/1/2011)

1.2.22 TIMELY FILING (page 26)

-Inpatient claim, the timely filing limit is 180 days from the date of discharge.

Added: red text to section

(2/1/2011)

1.1.8 CLAIM SUBMISSION & CORRESPONDECE MAILING ADDRESSES (page 16)

To ensure your request is processed in a timely manner, please use the correct PO Box specific to each type of correspondence mailed to HP Enterprise Services.

PO Box 999 – UB04 Claim Forms

PO Box 777 – CMS 1500 Forms

PO Box 1710 – Dental and Vision Claim Forms

PO Box 1645 – All Checks

PO Box 888 – All Other Mail & Inquiries

Williston, VT 05495-0888

Added: red section

1.2.22 TIMELY FILING (page 26)

-A beneficiary’s eligibility was made retroactive and the date of service is within the retroactive period. The claim must be submitted within the first six months of the date on the Notice of Decision. Include a note with the claim stating the retroactive date of eligibility.

Replace: six months with 12 months

1.4.9 FORMS AND MANUALS (page 49)

Alternate Reporter Request

Added: form to list

(1/1/2011)

1.2.15 GUIDELINES (page 24)

3. Outpatient Rehabilitative Care (OT, PT, ST)-extension of services for **adult beneficiaries** beyond the initial **30 combined visits per calendar year can be requested for the following diagnoses: spinal cord injury, traumatic brain injury, stroke, amputation, or severe burn.**

Added: red text

Deleted: the initial first four months of care

1.2.22 TIMELY FILING (page 26)

For information on timely filing and adjustment requests see section 4.2.1 ADJUSTMENT REQUESTS & TIMLEY FILING.

-A beneficiary's eligibility was made retroactive and the date of service is within the retroactive period. The claim must be submitted within the first six months of the date on the Notice of Decision. **Include a note with the claim stating the retroactive date of eligibility.**

Deleted: Attach a copy of the Notice of Decision.

Added: above red text

1.3.6 NOTICE OF DECISION (page 36)

Deleted: retroactive eligibility or

1.3.8 RETROACTIVE ELIGIBILITY (page 36)

Vermont Medicaid eligibility is occasionally granted retroactively. The provider may bill for services rendered during the retroactive period. A **note indicating the date of retroactive eligibility** must accompany the claim to waive the timely filing limit. See section 1.2.22.

Deleted: A Notice of Decision letter (DVHA220)

Added: red text

1.3.10 LOCK-IN STATUS (page 36)

The term "lock-in" is used to describe a beneficiary whose access to certain services is restricted to one or more designated providers. If a beneficiary is locked into a provider, that provider's name(s) is available on the VRS and the Vermont Medicaid website. Claims for services to "lock-in" beneficiaries (Vermont Medicaid and Dr. Dynasaur) by any provider not named, are not

reimbursable, except in the case of an emergency or when providers perform a service by referral from the named provider.

The same “lock-in” procedure is used to name the primary care provider for a **PC Plus** beneficiary. This “lock-in” reflects the beneficiary’s choice of primary care physician. This information is also available through the VRS and the Vermont Medicaid web site.

Deleted: (above text) *Section name change from Lock-in-Status to Team Care Program*

1.3.10 TEAM CARE PROGRAM (page 36)_

The Team Care Program restricts a beneficiary to one physician and one pharmacy. If a beneficiary is "locked-in" to a provider, that provider’s name is available on the VRS and the Vermont Medicaid website. Claims for services by any provider other than the "lock-in" provider(s) are not reimbursable by Vermont Medicaid, except in the case of an emergency or when a provider performs a service by referral of the named provider.

The “lock-in” procedure also applies to a PC Plus beneficiary. The “lock-in” reflects the beneficiary’s choice of primary care physician. This information is also available through the VRS and the Vermont Medicaid web site.

Added: red text

(12/01/2010)

1.2.9 NATUROPATHIC PHYSICIANS

Please see NATUROPATHIC PHYSICIANS in the [CMS 1500 Supplement](#).

Deleted: section included Naturopathic Physicians under section 1.2.12 PAYMENT – DVHA PRIMARY

1.2.12 PAYMENT – DVHA PRIMARY (page 22)

Naturopathic Physicians – Reimbursement basis is the lower of the provider’s charge or Vermont Medicaid rate on file.

Added: red text

2.2.3 PROVIDER ENROLLMENT STATUS CHANGES (page 50)

Group Composition: If there is any change in the composition of individual providers in a group that originally agreed to participate in the Primary Care Plus Plan, the moving PCP is required to complete a new Agreement for Participation prior to the effective date of change. .

In addition, any provider who has not previously participated in the **PC Plus** plan will need to complete the Agreement for Participation located at vtmedicaid.com/Downloads/forms.html.

Added: above red text

Group Composition: If there is any change in the composition of individual providers in a group that originally agreed to participate in the plan, HP must be notified in writing at least 30 days prior to the effective date of change. In addition, any provider who has not previously participated in the **PC Plus** plan will need to complete an “Application for Participation”.

Deleted: above text

(11/01/2010)

1.2.10 WHO IS RESPONSIBLE FOR PAYMENT (page 20)

Federal Medicaid policy does not permit providers to bill Vermont Medicaid or the beneficiary any fee for missing a scheduled appointment.

Added: red text at end of section

1.3.11 MEDICAID AND MEDICARE CROSSOVER BILLING (page 36)

If a service or item is denied by Medicare as non-reimbursable and is reimbursable by the DVHA, submit a CMS 1500 claim, completed to the DVHA specifications, along with the Medicare denial to HP within **twelve** months of the date of service.

Other Out-of-State Providers (Except New Hampshire): All out-of-state providers should first bill their regional Medicare carrier for services to dual eligible Vermont residents. After Medicare payment is received, send a claim to HP for payment of any coinsurance or deductible as follows:

6. The Medicare payment date must appear on the Medicare Attachment Summary Form. If a service or item is denied by Medicare as non-reimbursable and is reimbursable by the DVHA, submit a CMS 1500 claim, completed to the DVHA specifications, along with the summary form to HP within **twelve** months of the date of service. See 1.2.23 Timely Filing.

Changed: six months to **twelve** months.

(10/01/2010)

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Deleted: above sections from table of contents and deleted all references to the POS Device throughout this manual.

1.1.5 GLOSSARY OF TERMS AND PHRASES (page 10)

GREEN MOUNTAIN CARE CARD- Each Beneficiary receives a **Green Mountain Care** member card. Beneficiaries generally get cards two-three weeks after being determined eligible, the notice of eligibility will confirm status in the first few weeks.

Added: above text

PC PLUS CARD-A gold-colored identification card that can be used with the POS device to confirm the bearer's eligibility. Each **PC Plus** member is required to have one. Beneficiaries generally get cards two-three weeks after being determined eligible, the notice of eligibility will confirm status in the first few weeks.

Deleted: above text

LOCK-IN-An action that restricts a beneficiary's choice of medical provider for a reasonable time because of over-utilization of certain services. Lock-in is also used to designate the beneficiary's primary care physician when one is required. The locked in provider can be identified by using the **automated eligibility verification systems: the HP Voice Response System (VRS), 802-878-7871, option 1; or the online Transaction Services at <http://www.vtmedicaid.com/Interactive/login2.html>.**

Deleted: beneficiary's VermontAIM identification swipe card with the POS device, VRS, and through the website (www.vtmedicaid.com).

Added: above red text

POINT-OF-SALE (POS) DEVICE-A device by which enrolled providers can obtain beneficiary eligibility information by swiping an identification card.

Deleted: above text

VERMONTAIM CARD-A green plastic identification card that can be used with the Eligibility Verification System to confirm the bearer's eligibility.

Deleted: above text

1.3 BENEFICIARY INFORMATION (page 27)

"Beneficiary" is the term used to refer to a person who has been determined eligible for and enrolled in one of the Vermont Medicaid programs. Eligibility is determined at a district office of the Vermont Department for Children and Families, including the Health Access Eligibility Unit in Waterbury, based on a review of the applicant's needs, income and resources. The various Vermont Medicaid programs have differing eligibility requirements and benefits. Each Beneficiary is assigned a unique identification number (UID) and receives a Green Mountain Care member card. The UID number will be 1 to 8 digits in length. Enter the UID number on your claim exactly as it is shown on the beneficiary's card.

Providers must verify the patient's eligibility and other insurance information using the patient's Medicaid UID number, by accessing either of the automated eligibility verification systems: the HP Voice Response System (VRS), 802-878-7871, option 1; or the online Transaction Services at <http://www.vtmedicaid.com/Interactive/login2.html>.

In the event, a provider only has access to a member's Social Security Number, these systems will provide the UID number required for claim submission.

Added: red text

"Beneficiary" is the term used to refer to a person who has been determined eligible for and enrolled in one of the Vermont Medicaid programs. Eligibility is determined at a district office of the Vermont Department for Children and Families, including the Health Access Eligibility Unit in Waterbury, based on a review of the applicant's needs, income and resources. The various Vermont Medicaid programs have differing eligibility requirements and benefits. Providers are able to verify the patient's eligibility, the patient's ID number and other insurance information by

swiping the identification card through the POS device or through use of the VRS or the www.vtmedicaid.com website under Transaction Services.

October 1, 2010 is the start date for use of the unique identification number (UID) that must be used for each beneficiary. Use of the UID number allows removal of the Social Security number currently used for member cards and claim submission. This change will help protect our members' personal information. In September, all beneficiaries will receive their new health plan ID cards in the mail; however, do not begin billing with the new ID number until October 1. In order to facilitate this transition, our automated eligibility verification systems will allow you to check eligibility with either a Social Security number or the unique ID number. Use either the online Transaction Services (<http://www.vtmedicaid.com/Interactive/login2.html>) or the HP Voice Response System (Malcolm) 802-878-7871, option 1. If you only have access to a member's Social Security number, these automated systems will provide you with the unique ID number for your claim

Deleted: above text

(09/01/2010)

1.2.12 PAYMENT-DVHA PRIMARY (page 22)

Independent Radiology-Reimbursement basis is the lower of the provider's actual charge for the Vermont Medicaid rate on file not to exceed the Medicare maximum allowable amount. There is no cost settlement. **For additional Radiology information, see the CMS 1500 Manual.**

Added: red text

1.3.12 THIRD PARTY LIABILITY (TPL) / OTHER INSURANCE (OI) (page 39)

OTHER INSURANCE ATTACHMENTS- Providers may **submit electronically to HP claims that have been denied by another insurance company (third party payer/primary payer) when that payer has denied the claim using certain adjustment reason codes. Providers are required to include the adjustment reason code used by the primary payer when submitting the claim but will not need to send a copy of the primary insurance attachment. The list of adjustment reason codes that will be accepted electronically is available at www.vtmedicaid.com/Downloads/manuals , select 837 Adjustment Reason Codes. HP may select your claim for post payment review and request a copy of the explanation of benefits; if so, providers are required to supply all supporting documentation in a timely manner. Failure to do so will result in the recoupment of your paid claim.**

When submitting a paper claim, an attachment is needed only when a third party insurance carrier has not made a payment. Providers must attach documentation from the carrier that verifies the beneficiary's name, insurer's name, dates of service, the amount reimbursed and the payment or denial date. If the carrier does not include this information in the documentation (i.e. the carrier issues a blanket statement that the particular service is not covered), the provider must write the necessary information on the attachment, then sign and date the attachment. It must be clear that the attachment relates to the specific services billed on the Medicaid claim.

Added: above red text

(07/26/2010)

Replaced: The Office of Vermont Health Access (OVHA) with the **Department of Vermont Health Access (DVHA)**, throughout manual.

1.3.12 THIRD PARTY LIABILITY (OTHER INSURANCE) (page 38)

Providers are required to apply all third party payment resources prior to billing Vermont Medicaid. Third party resources include but are not limited to, Medicare, private/group health insurance plans, accident insurance, military and veteran's benefits and worker's compensation.

TPL VERIFICATION-The beneficiary's other insurance information, including the name of the other insurance company, address, carrier code and type of coverage will be furnished by the POS device, the Vermont Medicaid website or , and VRS when the provider checks the beneficiary's eligibility. Providers should review the beneficiary's eligibility information for the date of service and must bill other insurance carrier(s) before billing Vermont Medicaid.

OTHER INSURANCE DENIALS-

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

In order for providers to determine whose rules will apply, it is imperative that providers understand how to find and interpret the information available. Providers can access this information via the Vermont Medicaid website (www.vtmedicaid.com) or the Voice Response System (VRS). Please see VOICE RESPONSE SYSTEM for further information

Deleted: above text

1.3.12 THIRD PARTY LIABILITY (TPL) / OTHER INSURANCE (OI)

Vermont Medicaid is the payer of last resort. Providers are required to pursue and apply all third party payment resources prior to billing Vermont Medicaid. Third party resources include, but are not limited to, Medicare, private/group health insurance plans, accident insurance, military and veteran's benefits and worker's compensation.

TPL VERIFICATION- The beneficiary's other insurance information, including the name of the other insurance company, address, carrier code and type of coverage, is available on the Vermont Medicaid website, Provider Web Services (www.vtmedicaid.com/secure/logon.do), and the Voice Response System (VRS) when the provider checks the beneficiary's eligibility. Providers will review the beneficiary's eligibility information for the date of service and must bill other insurance carrier(s) before billing Vermont Medicaid. Use of the available information will guide providers in billing.

TIMELY FILING OF OI CLAIMS- Providers will respect the beneficiary's right to receive all medically necessary services and equipment in a timely manner and must submit claims to primary insurers promptly to mitigate issues with beneficiary primary insurance benefits exhausting.

OTHER INSURANCE DENIAL / DVHA AUTHORIZATION REQUEST

The following procedures are required for DVHA authorization requests when the primary insurer has reviewed and denied a claim request for an item or service:

OI Denial for Non-Covered or Benefits Exhausted- The provider is required to submit to the DVHA the authorization request form (Medical Necessity Form or other) with all standard documentation, the notice of denial from the primary insurer that indicates the item or service is not a covered benefit or that the benefit limit was determined to be exhausted, and all necessary documentation to support medical necessity. The DVHA will then review.

- The provider does not need to appeal to the primary insurer before billing Medicaid when the item/service is not covered or benefits are exhausted.

- If the code/service does not require authorization from Vermont Medicaid, then the provider can bill Medicaid directly with a copy of the primary insurer's denial attached.

OI Denial for Not Medically Necessary - The provider and/or beneficiary is required to pursue all levels of reconsideration and appeals with the primary insurer. If the request remains denied by the primary insurer, the provider and/or beneficiary is required to seek review by the BISHCA if the cost of the item or service exceeds \$100. If the denial stands, then the provider may submit the request to the DVHA with copies of all of the original documentation, the denials from the primary insurer and the BISHCA's support of the denial. The provider should not submit any additional documentation than what was reviewed by the primary insurer.

-If the code/service does not require authorization from Vermont Medicaid, then the provider can bill Medicaid directly, with copies of the primary insurer's denials (original and appeals) and the BISHCA's support of the denial attached.

Medicare Qualified Independent Contractor - For beneficiaries covered by Medicare, the requirement to go through the Medicare Qualified Independent Contractor appeal level applies, with the exception of wheelchairs that Medicare denies or downgrades. Upon documentation of the Medicare action, Medicaid will review for medical necessity and payment determination.

The DVHA will reject a request if there is reason to believe that the OI received incorrect or incomplete information from the provider and based its decision on that incorrect or incomplete information. Providers must determine OI/Medicare benefits before rendering the service to minimize the risk of non-coverage by both OI or Medicare and the DVHA.

Added: above text

1.3.13 WORKERS COMPENSATION/ACCIDENT LIABILITY BILLING (page 40)
When a provider bills worker's compensation and the claim is denied the provider then has 1 year from the date of service to submit their claim to Vermont Medicaid for payment.

Added: red text

(06/08/2010)

1.2.4 ENROLLMENT AND CERTIFICATION (page 19)

A provider must be re-certified in order to continue participation in the program. Approximately 60 days prior to the re-certification date, a recertification request letter will be sent to the provider's address on file. The recertification letter will include the information and directions necessary to complete the recertification process. Providers are required to forward a copy of their current provider license, recertification request letter and in some cases the Provider Enrollment/Recertification Form, at time of notification. Providers providing laboratory services, must also include a copy of their current CLIA certification. A complete list of Provider Enrollment Forms can be accessed at <http://www.vtmedicaid.com/Downloads/forms.html>.

To assure that provider enrollment is uninterrupted, all requested applicable documentation is required to be returned to HP by the date indicated on the recertification request letter.

Added: above red text

If a new provider's license end date is within 6 months of the enrollment date, the provider will not be required to complete a recertification form for the short enrollment period. HP will print or request a new license and update the certification status – carrying the provider to the next cycle date to recertify.

Pre-printed provider recertification forms are mailed approximately one month prior to when current state licenses expire. HP should not receive provider recertification forms until the provider is able to attach their new license, otherwise the forms will be returned. Please verify the information provided on the recertification form is valid and make any corrections as needed in red ink.

As a reminder, The Department of Vermont Health Access does not extend providers, nor do they retro-enroll providers. Please contact HP Provider Enrollment for questions or concerns.

Deleted: above text

1.2.10 WHO IS RESPONSIBLE FOR PAYMENT (page 21)

Under the Provider Agreement (**Conditions of Participation #9**), failure to give advance notice that a Vermont Medicaid payment will not be accepted prevents the provider from billing the beneficiary. If the beneficiary is eligible for Vermont Medicaid and the provider **has made the decision not to bill Vermont Medicaid** for the service or item requested, the beneficiary must be informed in advance of providing the service.

To document that proper notice was given, providers are required to document the notice on their letterhead, have it signed by the beneficiary or the beneficiary’s parent/guardian, provide a copy to the beneficiary, and retain a copy in the beneficiary’s file. Failure to give advance notice prevents the provider from billing the beneficiary. When a beneficiary is billed, the claim cannot be submitted to HP Enterprise Services for processing.

Added: above red text

If the beneficiary is eligible for Vermont Medicaid and the provider does not want to accept Vermont Medicaid payment for the service or item requested, the beneficiary must be informed in advance of providing the service. Appropriate documents, prepared by the provider, should be completed and signed by the beneficiary or parent to document that proper notice was given to the patient and the responsible adult has accepted the financial responsibility. The claim should not be submitted to HP for payment.

Deleted: above text

1.4.4 LOCUM TENENS (page 48)

A Locum Tenens is a **physician**, usually hired from out of state, to “step in” for another provider that is on leave or has permanently left a practice. The Locum Tenens **physician** must have a license to practice in Vermont.

If a Locum Tenens **physician** is covering for a physician on leave, they are then allowed to use that physician’s NPI number for up to 60 days. Modifier Q6 (Service rendered by a Locum Tenens physician) should be used to show that the service was provided by a Locum Tenens **physician**.

If a Locum Tenens **physician** is covering for a physician who has permanently left a practice, then the Locum Tenens **physician** must enroll with Vermont Medicaid.

Replaced the word provider with physician

(05/14/2010)

1.4.1 INQUIRIES (page 45)

The Provider Services Unit responds to telephone inquiries **and email** from 8:00a.m. to 5:00p.m., Monday through Friday, except on State assigned holidays.

Deleted: and email

1.4.3 GUIDELINES FOR BILLING INCIDENT TO (page 47)

Note: These guidelines do not apply when the provider has a separate agreement with the DVHA on billing practices.

Also, with the exception of our “on-site” requirements, it is our intention to follow Medicare guidelines.

When a provider bills for a physician’s assistant using an AM modifier, the provider will be reimbursed at 90% of the allowed amount and is not considered “incident-to”. Therefore, the Medicare “incident-to” rules do not apply.

Deleted: red text

(05/05/2010)

1.1.4 DIRECTORY OF OFFICES (page 7)

Added: (800) 479-6151

Deleted: Tel: (802) 241-3978

1.1.3 MANUAL AND RULE ACCESSIBILITY (page 7)

The most recent published version of this Provider Manual is located at www.vtmedicaid.com/Downloads/manuals.html. The following manual supplements are also viewable: Prior Authorization, CMS 1500 and UB 04.

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

Medicaid Rule, and rules for the programs encompassed under “Medicaid”, is located online at humanservices.vermont.gov/on-line-rules/ovha.

Added: red text

1.1.12 MEDICAL NECESSITY FORM (MNF) (page 17)

The OVHA MNFs are Form OVHA 286 and OVHA 60. **An Eyeglass Medical Necessity Form is available (April 2010).** Other medical necessity forms are acceptable as long as the following information is provided:

Added: red text

1.2.1.1 PHARMACY TAX ASSESSMENT FORM (page 18)

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.

Added section

1.2.5 PAYMENT CONDITIONS (page 20)

Added: - Billing may not be done in advance of any service to be performed or supplied.

1.2.25 CLIA CERTIFICATION (Page 27)

Providers who perform laboratory services and who do not have CLIA certification, should contact the **Vermont Department of Health, 108 Cherry Street, Burlington, VT 05401** by phone at (802) 652-4145 or by fax at (802) 865-7701 for information.

Added: red text

Removed: Vermont Department of Disabilities, Aging and Independent Living, Division of Licensing and Protection (802) 241-2345

1.3 BENEFICIARY INFORMATION (Page 27)

October 1, 2010 is the start date for use of the unique identification number (UID) that must be used for each beneficiary. Use of the UID number allows removal of the Social Security number currently used for member cards and claim submission. This change will help protect our members' personal information. In September, all beneficiaries will receive their new health plan ID cards in the mail; however, do not begin billing with the new ID number until October 1. In order to facilitate this transition, our automated eligibility verification systems will allow you to check eligibility with either a Social Security number or the unique ID number. Use either the online Transaction Services (<http://www.vtmedicaid.com/Interactive/login2.html>) or the HP Voice Response System (Malcolm) 802-878-7871, option 1. If you only have access to a member's Social Security number, these automated systems will provide you with the unique ID number for your claim

Added: red text

1.3.11 MEDICAID AND MEDICARE CROSSOVER BILLING (Page 37)

Changed: 6 weeks to 30 days

Changed: EOMB to summary form

1.4.9 FORMS AND MANUALS (page 49)

Manuals - www.vtmedicaid.com/Downloads/manuals.html

Psychiatric Inpatient Supplement

Forms – www.vtmedicaid.com/Downloads/forms.html

Admission Notification (Out-of-State Hospital Psychiatric Inpatient Services)

CMS 1500 Medicare Attachment Summary Form

Dental Prior Authorization Forms

Eyeglass Prior Authorization Form

Medicaid Fraud Waste & Abuse Referral Form

Medical Necessity

Provider Enrollment Forms: (Electronic Funds & Funds Change, Change of Address, Group Affiliation, PCPlus, & Termination Notice)

Transportation

UB 04 Medicare Attachment Summary Form

3.4 2009 AID CATEGORY LISTING (page 74 & 75)

Added 2 additional programs:

- Children with Special Health Needs (CSHN) for PT, OT, ST, NU & AU services only. (Aid Category SH)
- Family Infant Toddler Program (FITP) for PT, OT, ST, NU & AU services only. (Aid Category FI)

(01/08/2010)

3.4 2009 AID CATEGORY LISTING (page 74)

PROGRAM	DENTAL	AID CATEGORIES
Healthy Vermonters Program	NO	VP (Discount Pharmacy Only)
VPharm	NO	VD, VE, VF, VJ, VK, VL, VM, VN, VO
VPharm with Crossovers	NO	VG, VH, VI
V-Script	NO	VA, VB, VC, VS, VT, VU, V7, V8
VHAP Pharmacy	NO	V1, V2, V3, V5, V6
VHAP Pharmacy with Crossovers	NO	V4
VHAP Limited	NO	UA, UB, UC, UD, UE, UF
VHAP Managed Care	NO	U1, U2, U3, U4, U5, U6, J3, J4, J5, J6, J7, J8
Medicaid Managed Care	YES	A3, A4, A5, A6, A8, A9, B3, B4, B5, B6, B7 B8, BH, C4, C5, C6, C7, C8, C9, CH, D5, D8, E5, E8, F5, G5, G8, H3, H4, H5, H6, H8, H9, I5, I8, K5, K9, L3. L4, L5, L6, L8, L9, M3, M4, M5, M6, M7, M8, O5, P2, P3, P4, P5, P6, P7, P9, Q3, Q6, R1, S5, S7, T5, T8, W3, W4, W6, W9, X3, X4, X5, X6, X8, Y5
Traditional Medicaid	YES	AA, AB, AC, AD, AR, AZ, BA, BB, BC, BD, BG, BP, BR, CC, CO, C2, C3, CG, CP, CR, DC, DR, FC, GC, GR, HA, HB, HC, HD, HR, HZ, IA, IC, ID, IR, KC, KZ, LA, LB, LC, LD, LR, LZ, MA, MB, MC, MD, MP, MR, NA, NB, NC, ND, NP, NR, OC, P1, PA, PB, PC, PD, PP, PR, QA, QD, RR, SC, SP, TC, TR, WA, WB, WD, WZ, XA, XB, XC, XD, XR, YC
No Medicaid Coverage	NO	QW, TV, WM, Z3, Z4, Z5, Z6, Z7, Z8
Urgent/Emergent Inpatient Coverage Only	NO	Z9
Specially Funded Categories	NO	GA, GE, HT, HV, LF, MH, PS, QI, Q2 Premiums/Coinsurance/Deductibles: PQ
No Medicaid Coverage - PACE	NO	99
Pending Premium Payment	NO	C\$ (Catamount), P\$ (Dr. Dynasaur), U\$ (VHAP)
ESI (Employee Sponsored Insurance) with VHAP Wrap-around	NO	ZA
ESI (Employee Sponsored Insurance) with Chronic Care Wrap-around	NO	ZB
Premium Assistance	NO	ZC
Sign-Up Process for Catamount	NO	Z#, Z\$, Z*

1.1.3 MANUAL AND RULE ACCESSIBILITY (new section Page 7)

The most recent published version of this Provider Manual is located at <http://www.vtmedicaid.com/Downloads/manuals.html>. The following manual supplements are also viewable: Prior Authorization, CMS 1500 and UB 04.

Added to section 1.1

1.1.4 DIRECTORY OF OFFICES (page 7)

Deleted: DCF maintains local district offices to process all other eligibility applications. The district offices to process all other eligibility applications. The district offices and towns under their jurisdiction are as follows.

Deleted: District office telephone numbers.

Added: A call center/interactive voice response (IVR) system services providers and beneficiaries statewide. Providers should stay on the line after the message for a separate queue and will be serviced directly.

Call Center/IVR system

Tel: 800-479-6151

1.2.20 SANCTIONS (page 25)

The OVHA may take administrative action against providers found in violation of Vermont Medicaid policy. See section M155/7106 of the Medicaid Rules for regulatory details pertaining to sanctions and appeals. A copy of Medicaid Rules is posted at <http://humanservices.vermont.gov/on-line-rules>, and at each DCF District Office and at the state library in Montpelier.

Deleted: kept at DCF District Office and at the state library.

Added: posted at <http://humanservices.vermont.gov/on-line-rules>, and at each DCF District Office and at the state library in Montpelier.

(09/04/2009)

1.3.16 BENEFICIARY BILL OF RIGHTS (Page 43)

As a Managed Care Organization (MCO), the OVHA must ensure that its enrolled health care providers are aware of our Beneficiary Bill of Rights and that health care providers take these rights into account when providing services to beneficiaries. The Vermont Health Care Programs: Beneficiary Bill of Rights (March 2009) is as follows:

As a member of a Vermont health care program, a beneficiary has the right to:

- Be treated with respect and courtesy
- Be treated with thoughtfulness for his or her dignity and privacy
- Choose and change providers

-
- Get facts about program services and providers
 - Get complete, current information about his or her health in understandable terms
 - Be involved in decisions about his or her health care, including having questions answered and having the right to refuse treatment
 - Ask for and get a copy of his or her medical records and ask for changes to be made to them when he or she believes the information is wrong
 - Get a second opinion from a qualified provider who is enrolled in Vermont Medicaid
 - Complain about the program or his or her health care
 - Be free from any form of restraint or isolation used as a means of bullying, discipline, convenience, or retaliation
 - Ask for an appeal if services are denied that he or she thinks are needed.

(09/04/2009)

1.2.26 CLINICAL PRACTICE GUIDELINES (Page 27)

The Department of Vermont Health Access has adopted various Clinical Practice Guidelines that are based upon evidence based medicine. These guidelines outline the preferred approach for most patients and are used to support the decision making processes. The guidelines can be found at <http://ovha.vermont.gov/for-providers> under *Clinical Initiatives*.

(08/25/2009)

OTHER INSURANCE DENIALS (Page 37)

1.) When the Vermont Medicaid beneficiary’s primary insurer (including Medicare) denies a claim as “non-covered” or “benefits exhausted”, the provider does not need to appeal to that primary insurer before billing Medicaid.

a.) If the code/service requires prior authorization from Vermont Medicaid, then the provider will need to request authorization from the OVHA in the regular manner (fax all standard documentation required for a clinical review) and include a copy of the other insurer’s (or Medicare’s) denial.

b.) If the code/service does NOT require prior authorization from Vermont Medicaid, then the provider can bill Medicaid directly with a copy of the primary insurer’s denial attached.

2.) When the Vermont Medicaid beneficiary’s primary insurer (including Medicare) denies a claim for other reasons (such as “not medically necessary”, “pre-existing condition” or “waiting period not met”), the provider must first appeal to the primary insurer. Only after all OI/Medicare appeals (through the Qualified Independent Contractor level and BISHCA if eligible and available) are denied can the provider then request coverage by Vermont Medicaid. All documentation showing the original and appeals’ denials must be attached.

a.) If the code/service requires prior authorization from Vermont Medicaid, then the provider will need to request retroactive authorization from the OVHA in the regular manner (fax all standard documentation required for a clinical review) and include copies of the other insurer’s or Medicare’s denials and appeals.

b.) If the code/service does NOT require prior authorization from Vermont Medicaid, then the provider can bill Medicaid directly with copies of the primary insurer’s denials (original and appeals) attached.

3.) For beneficiaries covered by Medicare, the requirement to go through the Medicare Qualified Independent Contractor appeal level applies with the exception of wheelchairs that Medicare denies or

downgrades. Upon documentation of the Medicare action, Medicaid will make its own medical necessity and payment determination.

4.) The OVHA will reject a request if there is reason to believe that the OI received incorrect or incomplete information on which to base its decision.

5.) It is highly recommended that providers determine OI/Medicare benefits before rendering the service to minimize the risk of non-coverage by both OI or Medicare and the OVHA.

In order for providers to determine whose rules will apply, it is imperative that providers understand how to find and interpret the information available. Providers can access this information via the Vermont Medicaid website (www.vtmedicaid.com) or the Voice Response System (VRS). Please see VOICE RESPONSE SYSTEM for further information

(06/30/2009)

SECTION 1-POLICY AND INFORMATION (Page 6)

Introduction

Green Mountain Care, herein described as Medicaid, encompasses many programs including Dr. Dynasaur, Traditional Medicaid, VHAP, VHAP Managed Care, Medicaid Managed Care, VHAP-Pharmacy, VScript, VPharm, **Premium Assistance**, and Employee Sponsored Insurance. All of these programs are financed by a combination of both federal and state dollars. The Vermont General Assembly appropriates the state funds. The proportion of federal matching funds is determined for each state agency that delegates responsibility for the administration of the program to The Department of Vermont Health Access (OVHA). Other departments involved in program administration are as follows:

- Department of Aging and Independent Living (DAIL)
- Department of Health, including The Department of Alcohol and Drug Abuse Programs
- Department of Mental Health**
- Department of Education
- Department for Children and Families

Deleted: *The Vermont Medical Assistance Program
.....Drug Abuse Programs and Mental Health Services...*

1.1.3 DIRECTORY OF OFFICES (Page 7)

BARRE

255 N. Main Street, Ste 5
05641-4160
Tel: 479-1041, 800-499-0113

Deleted: *Ste. 7
05641-4189
479-4260*

BENNINGTON

150 Veterans Mem. Dr., Ste 6
05201-1918
Tel: 442-8541, 800-775-0527

Deleted: *200 Veterans Mem. Dr., Ste. 14
05201-1956
442-8138*

1.1.4 GLOSSARY OF TERMS AND PHRASES (Page 10)

CROSSOVER CLAIM-A claim created by Medicare and sent to Medicaid for payment of deductible and co-payment amounts. This occurs when the Medicare beneficiary is also covered by Vermont Medicaid **or is a Qualified Medicare Beneficiary (QMB)** and the Medicare claim so indicates.

1.1.6 IMPORTANT ADDRESSES AND TELEPHONE NUMBERS (Page 15)

Maximus

101 Cherry Street, Ste. 320

Burlington, Vermont 05402

Tel: (800) 250-8427

Fax: (802) 651-1528

TTY: 888-834-7898

Deleted: 5 Burlington Square, Floor 5

Department of Disabilities, Aging & Independent Living

Waterbury, Vermont 05671-1201

Tel: (802) 241-2880

Fax: (802) 241-2897

Deleted: Department of Developmental & Mental Health Services

1.2.4 ENROLLMENT AND CERTIFICATION (Page 19)

... Retroactive enrollment will be allowed to cover urgent or emergent care delivered by a provider outside of Vermont that is not considered a border provider.

If a new provider's license end date is within 6 months of the enrollment date, the provider will not be required to complete a recertification form for the short enrollment period. EDS will print or request a new license and update the certification status – carrying the provider to the next cycle date to recertify.

Court ordered providers would only be enrolled for dates consistent with the order/decision. A provider must be re-certified in order to continue participation in the program. Approximately one month prior to the re-certification date, a new provider agreement will be sent to the provider's address on file. The new provider agreement must be completed, signed and dated by the provider, and returned to EDS with a copy of the current license or certification documents. To assure that provider enrollment is uninterrupted, the form should be sent to EDS by the return date indicated.

Enrollment will be rejected if:

- Mandatory information is not received
- The provider is disbarred or sanctioned from participation in federal programs
- The provider is disbarred or sanctioned by the State of Vermont

Pre-printed provider recertification forms are mailed approximately one month prior to when current state licenses expire. EDS should not receive provider recertification forms until the provider is able to attach their new license, otherwise the forms will be returned. Please verify the information provided on the recertification form is valid and make any corrections as needed in red ink.

As a reminder, The Department of Vermont Health Access does not extend providers, nor do they retro-enroll providers. Please contact EDS Provider Enrollment for questions or concerns.

CLIA:

Providers that provide any laboratory services, must include a current copy of the CLIA certification with the provider recertification form.

1.2.18 SUPPLEMENTATION (Page 25)

...3. Specific allowed supplementations authorized in Medicaid Rule 910.2/7601.2.

1.2.24 TIMELY FILING (Page 27)

...The OVHA will consider paying an untimely claim in unusual circumstances. A request for an exception can be made by sending the claim and a detailed explanation of why an exception should be granted to: **EDS, P.O. Box 888, Williston, Vermont 05495-0888 Attn: Timely Filing Appeals.**

Deleted: *The Department of Vermont Health Access, 312 Hurricane Lane, Suite 201, Williston, Vermont 05495*

1.3.2 HEALTH CARE BENEFIT PROGRAMS (Page 28-29)

VHAP-Limited VHAP Limited is a transition program used prior to enrollment in managed care, **PC Plus**. As soon as beneficiaries are determined eligible **and pay any required premium**, they are covered for certain services on a fee-for-service basis.

VHAP Limited beneficiaries are issued a VermontAIM identification card. **Premiums** are required.

Deleted: *Co-payments, see Section 1.3.4*

VPharm The new Medicare Part D prescription drug benefit began on January 1, 2006. The pharmacy program called VPharm was created by The Department of Vermont Health Access to serve beneficiaries who qualify for state pharmacy benefits and are eligible for Medicare Part D. In general, VPharm covers drug classes that are excluded from the Part D benefit, **and may assist with premiums and cost-sharing.**

Healthy Vermonters Is for Vermonters who don't have insurance for prescriptions, or for those whose commercial insurance plan has an annual maximum prescription benefit.

Deleted: *Beneficiaries with drug coverage available through Medicare, will have their VHAP, VScript, and VScript expanded coverage converted to VPharm as of January 1, 2006. VPharm eligible beneficiaries have already been auto-enrolled in Part D prescription drug plans and notified.*

Qualified Medicare Beneficiary ...A QMB is not issued a VermontAIM identification card and cannot be identified using Electronic Verification System (EVS).

Deleted: *The beneficiary must present a Qualified Medicare Beneficiary Identification form (OVHA 289A) to be eligible for benefits.*

1.3.3 ADVANCE DIRECTIVES (Page 29)

Hospitals, nursing homes, home health agencies, hospices and prepaid health care organizations are required to provide certain patients with information about their right to formulate advance directives and maintain written policies and procedures with respect to advance directives. They are also required to document in patients' files whether or not an advance directive is in effect, provide education for staff and the community on issues concerning advance directives, and ensure compliance with State law on advanced directives at their facilities. **Providers are responsible to guard the confidentiality of beneficiary information in a manner consistent with the confidentiality requirements in 45 CFR parts 160 and 164 and as required by state law.** <http://www.cms.hhs.gov/securitystandard/downloads/securityfinalrule.pdf>.

1.3.4 CO-PAYMENTS (Page 34)

VHAP Pharmacy Beneficiaries-Aid Categories V1, V2, V3, V5 & V6:

Effective **07/15/2009: Copays for prescriptions \$29.99 or less = \$1.00**

Prescriptions \$30.00 or more = \$2.00

Deleted: *01/01/04 Zero co-pay for covered medications.*

VScript Beneficiaries-Aid Categories VA, VS, V7 & V8:

Effective **07/15/2009: Copays for prescriptions \$29.99 or less = \$1.00**

Prescriptions \$30.00 or more = \$2.00

Deleted: 01/01/04: Co-pays eliminated.

VScript Expanded Beneficiaries-Aid Categories VB, VC, VT & VU:

Effective 07/15/2009: Copays for prescriptions \$29.99 or less = \$1.00

Prescriptions \$30.00 or more = \$2.00

Deleted: 01/01/04: Co-pays eliminated.

VHAP Pharmacy with Medicare-Aid Category V4:

Effective 07/15/2009: Copays for prescriptions \$29.99 or less = \$1.00

Prescriptions \$30.00 or more = \$2.00

Deleted: 01/01/04 Zero co-pay for covered medications.

VPharm Pharmacy-Aid Categories VD, VF, VG, VH, VI, VK, VL, VM, VN & VO:

Effective 07/15/2009: Copays for prescriptions \$29.99 or less = \$1.00

Prescriptions \$30.00 or more = \$2.00

Deleted: 01/01/04 Zero co-pay for covered medications.

VPharm covers drug classes that are excluded from the Part D benefit.

Vision Coverage: For beneficiaries with category codes VD, VG, VJ & VM.

1.3.8 SPEND-DOWN (Page 35)

In some cases, eligibility is contingent upon the applicant having extraordinary expenses. In these cases, the applicant must first become responsible for a specific dollar amount for medical expenses during a six-month period. The actual amount is known as the “spend-down” amount as calculated by DCF. A spend-down beneficiary becomes eligible for Vermont Medicaid on the day of the month in which the incurred medical expense amount equals or exceeds the specified “spend-down” amount. When the beneficiary becomes eligible, all providers performing a service on that first day of eligibility will receive a Notice of Decision letter (ESD 220MP) from the district office. The letter explains that the spend-down amount has been met by the beneficiary, or that a portion of the provider’s bill remains the responsibility of the beneficiary. The provider must deduct the spend-down amount, if any, shown in the ESD 220MP prior to claim submission.

Deleted: OVHA 220MP

1.3.10 MEDICAID AND MEDICARE CROSSOVER BILLING (Page 36)

Vermont and New Hampshire Providers: In order to crossover, Vermont Medicaid eligibility information must be clearly indicated on the Medicare claim. These claims will crossover automatically to EDS for payment. If you do not receive the OVHA payment within six weeks of the Medicare paid date, submit the claim to EDS **with the Medicare Attachment Summary Form.**

Deleted: submit the claim to EDS as follows:

These items need to match on both the claims and the EOMB...

1. Dates of services
2. Beneficiary name
3. Procedure/Revenue Code
4. Billed amount
5. Attending physician NPI

Other Out-of-State Providers (Except New Hampshire): All out-of-state providers should first bill their regional Medicare carrier for services to dual eligible Vermont residents. After Medicare payment is received, send a claim to EDS for payment of any coinsurance or deductible as follows:

1. **Send a claim completed to the OVHA specifications with a copy of the Medicare Attachment Summary Form attached.**
2. If a copy of the Medicare claim is not available, you may complete a CMS 1500 claim form and attach a copy of the **Medicare Attachment Summary Form**, or attach documentation that Medicare does not cover the service.
3. The Medicare payment date must appear on the **Medicare Attachment Summary Form**.

If a service or item is denied by Medicare as non-reimbursable and is reimbursable by the OVHA, submit a CMS 1500 claim, completed to the OVHA specifications, along with the **Medicare Attachment Summary Form** to EDS within six months of the date of service.

~~Deleted:~~ EOMB/Medicare payment sheet

1.4.3 GUIDELINES FOR BILLING INCIDENT-TO (Page 45)

Note: These guidelines do not apply when the provider has a separate agreement with the OVHA on billing practices.

Also, with the exception of our “on-site” requirements, it is our intention to follow Medicare guidelines. **When a provider bills for a physician’s assistant using an AM modifier, the provider will be reimbursed at 90% of the allowed amount and is not considered “incident-to”. Therefore, the Medicare “incident-to” rules do not apply**

SECTION 2-VERMONT HEALTH ACCESS PLAN – PC PLUS (Page 48)

The Department of Vermont Health Access (OVHA) is responsible for administration of the Vermont Medicaid program.

~~Deleted:~~ ,which is part of the Department for Children and Family Services (DCF)

The OVHA is also responsible for implementing the Vermont Health Access Plan (VHAP), Medicaid expansion authorized in 1995 by the Vermont General Assembly and supported by a Section 1115 Research and Demonstration Waiver approved by the federal government, **and subsequently the Global Commitment 1115 Waiver.**