



UB-04 Supplement

to the Provider Manual



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



HP Enterprise Services

SUMMARY OF UPDATES

*Please note: All changes/updates will be indicated in **red font**.
For a detailed summary of all updates made to this Supplement, please refer to page 55.

The following information has been added to this Supplement:

<u>DATE UPDATED</u>	<u>TOPIC</u>	<u>PAGE NUMBER</u>
09/1/2010	Medicare Crossover Claims	11
	Field Locator 8a – Billing Instructions	17,21,28,32,37,41,45,52
07/28/2010	The Office of Vermont Health Access name change	
	Home Health – Field Locators 13 & 14	28
05/06/2010	Present on Admission (POA) - Inpatient Admissions	13
	Field Locators 67 & 67 a-q - Hospital Inpatient Billing	19
05/3/2010	Field Locators 18-28 - Condition Codes	17, 20, 28 & 32
	Medicare Crossover Claims	10
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	Field Locator 47 – Billing Instructions	21, 29, 32, 38 42, 46, & 52
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INTRODUCTION

The Vermont Medicaid UB-04 Manual contains an alphabetical listing of benefits, billing information and specific instructions for completion of the UB-04 claim form.

REIMBURSABLE SERVICES

HOSPITAL: INPATIENT

Reimbursable services include: medically necessary care in a semi-private room; private room and intensive care when medically necessary; nursing and related services; use of hospital facilities, supplies, appliances and equipment; blood transfusions; therapeutic services; drugs furnished by the hospital; rehabilitation services; diagnostic services.

HOSPITAL: OUTPATIENT

Reimbursable services include the use of facilities in connection with accidental injury or minor surgery, diagnostic tests, rehabilitative therapies and emergency room care.

HOME HEALTH

Reimbursable services include nursing care services when the services are related to the care of patients who are experiencing acute or chronic periods of illness if ordered by and included in the treatment plan established by the physician.

Reimbursable services include physical, occupational and speech therapy services. Therapy services must be directly related to an active treatment plan, of a level that a qualified therapist is required, and reasonable and necessary to the treatment of the patient's condition.

Reimbursable services also include Services of a home health aide.

HOME HEALTH-HOSPICE

Reimbursable services include: nursing, Home Health Aide, homemaker, rehabilitative therapy, social service, nutrition services, bereavement assessment and counseling, drugs, equipment, medical supplies, inpatient care and respite services in the home.

Vermont Medicaid pays a Per Diem rate.

ASSISTIVE COMMUNITY CARE SERVICES

Reimbursable services include: case management, personal care services, nursing assessment & routine tasks, medication assistance, on-site assistive therapy and restorative nursing.

CHOICES FOR CARE

1. **Enhanced Residential Care Services include:** personal care, meal preparation, medication management, nursing overview, activities, 24-hour supervision, and laundry/housekeeping.
2. **Long Term Care Services include:** personal care, meals/nutritional services, 24-hour skilled nursing, rehab & therapy, activities, 24-hour supervision, social services, laundry/housekeeping.

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3. **Home Based Waiver Services include:** case management, personal care, respite or companion care, adult day services, personal emergency response systems.

SECTION 1.0

GENERAL HOSPITAL

ABORTIONS

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

1. **Vermont Medicaid**

Vermont Medicaid, with the completion of Physician Certification form DVHA 219A, reimburses for abortions performed because the pregnancy is a result of rape or incest, or when the mother's life is endangered were the fetus carried to term. This consent form and the medical documentation of the situation are required to be sent to HP with each claim. Payment for these abortions will continue to be made by HP and reported on the remittance advice. Spontaneous and missed abortions completed surgically are billable under Vermont Medicaid with use of the appropriate procedure and diagnosis codes. A certification form is not required. These abortion services will be billed to HP for all beneficiaries.

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

2. **State Funds**

Abortions considered medically necessary are billable to HP upon completion of a Physician Certification Form DVHA 219B, but are paid by the Department for Children and Families (DCF) funding.

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

ABORTION DIAGNOSIS CODES

Diagnosis codes in the 637 group (Unspecified Abortion) will not be accepted by Vermont Medicaid. When billing, use a more specific abortion diagnosis code. Providers should refer to the current ICD-9-CM manual under spontaneous, missed, or induced abortions for the correct code.

ADMISSION INDICATOR

The billing field locator 14 requires one of four codes. If there is a question of which code to use, it is the decision of the Admitting Physician.

ANESTHESIA

The anesthesiologist must bill for these services on a CMS-1500 claim form.

ATTENDING PHYSICIAN

When the attending physician is the physician or practitioner who actually performs the services for the patient, he or she must be enrolled as a participating Vermont Medicaid provider. When the

attending physician is the referring or prescribing provider, he or she must be enrolled as a participating or a non-participating Vermont Medicaid provider. When billing Vermont Medicaid on the UB-04 claim form, the attending physician number or NPI (with Taxonomy code when applicable) must appear in field locator 76.

BILLING/SUPPLYING PROVIDER

The billing/supplying provider name and address on your enrollment application must appear in the field locator 1 and the actual billing NPI (with taxonomy code when applicable) to which payment will be made must appear in field locator 56. If an atypical provider, use the Vermont Medicaid number in locator 57C.

BORDER HOSPITALS

Border hospitals are subject to the same Vermont Medicaid policy as are those located within the geographical confines of the state. Their physicians must be enrolled with Vermont Medicaid. Out-of-state hospitals not designated as Border Hospitals may use Vermont Medicaid Provider ID # 0009999 as the attending provider in field locator 76, if the attending providers are not enrolled with Vermont Medicaid. Please refer to the billing instructions at the end of this manual. For purposes of Vermont Medicaid reimbursement, the following hospitals are designated as “border hospitals”:

Alice Peck Day Hospital	Lebanon, NH
Cottage Hospital	Woodsville, NH
Glens Falls Hospital	Glens Falls, NY
Littleton Hospital	Littleton, NH
Mary Hitchcock Memorial Hospital	Lebanon, NH
North Adams Hospital	North Adams, MA
Upper Connecticut Valley Hospital	Colebrook, NH
Valley Regional Hospital	Claremont, NH
Weeks Memorial Hospital	Lancaster, NH

CARDIAC REHABILITATION

Cardiac rehabilitation is billable under revenue code 943. This code must be billed with one unit equal to one day regardless of the number of encounters. There is a limit of 36 units within 12 weeks.

CAST, SPLINT AND STRAPPING MATERIALS

Materials for casting, splinting and strapping, etc., are billable under revenues code 270- Medical Surgical Supplies and Devices for Inpatient Ancillary and Outpatient Codes.

CO-PAYMENT

See [Provider Manual](#).

CPT CATEGORY III PROCEDURE CODES

See [CMS 1500 Supplement](#).

DENTAL PROCEDURES

Pre-certification of dental procedures by the Department of Vermont Health Access (DVHA) is required for selected procedures. Pre-certification review of hospital admission for dental procedures is not required. When submitting claims for dental services, use the appropriate dental HCPCS coding (D----).

HCPCS/CPT/REV CODES

HCPCS/CPT codes are required to be entered on the detail line of the UB 04 claim form for outpatient billing. Please refer to the Vermont Medicaid website (www.vtmedicaid.com under Downloads and Manuals) for a list of revenue codes that require HCPCS/CPT codes.

INHALATION THERAPY

Vermont Medicaid will cover oxygen needed intermittently after a recipient has been discharged from acute care. Payment will be made to the hospital for this outpatient service.

OUT-OF-STATE INPATIENT CARE

Elective out-of-state inpatient care is reimbursable only with prior authorization. If the type of admission on an out-of-state claim is emergent or urgent, prior authorization is not required. These claims are subject to retrospective review. See also Border Hospitals.

Preadmission Review: A preadmission review by the DVHA is required for many types of elective hospital admissions.

Emergency Care; Out-of-State: Inpatient hospital care due to an emergency is reimbursable out-of-state.

INPATIENT/OUTPATIENT OVERLAP EXAMPLES

The general rule is when the patient does not leave the hospital campus going from the outpatient to inpatient setting, then all of the outpatient charges should be rolled into the inpatient claim and there should be no separate outpatient claim. The following scenarios are to assist you in billing for out/inpatient overlap claims.

- A patient comes into the ER Friday at 10:00 pm; patient is seen and stays in the ER for 8 hours while tests and consults are performed. On Saturday morning, the physician feels it is necessary to admit that patient as inpatient.

When a patient receives continuous outpatient care and then is admitted as an inpatient, all of the outpatient charges should be rolled into the inpatient claim.

- A patient comes into the ER Thursday at 8:00 pm and is admitted as an outpatient in the observation room. By Friday pm, the physician determines it is best to admit that patient as an inpatient.

When a patient is in the observation room, then transferred to an inpatient status, the admission date is the date of service the patient was admitted into the observation room. All of the charges associated with the observation room should be rolled into the inpatient claim.

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- A patient comes in as an outpatient on Thursday am for services and leaves, then later in the day, is admitted as an inpatient

Some hospitals may treat the outpatient and inpatient stay as one event and bill all charges on the inpatient claim. Other hospitals may treat these as two separate events since the patient left after the outpatient and bill one outpatient and one inpatient claim. Either method is acceptable.

- A patient comes in at 10:00 pm on Tuesday for ER services and leaves. Wednesday morning the patient is admitted as inpatient.

These services are billed as two separate claims, one outpatient and one inpatient, as they are different service events.

- A patient is discharged on Tuesday am, but is readmitted Tuesday pm.

The services from the second admission are added to the first admission; the claim will be inclusive of all inpatient days.

- A patient is discharged on Tuesday am but comes in for outpatient services Tuesday pm.

These are billed separately, one inpatient claim and one outpatient claim, as they are different service events.

INPATIENT CLAIMS: NO MEDICARE PART A; HAS MEDICARE B COVERAGE

When a Vermont Medicaid recipient has Medicare part B and no Medicare part A coverage, providers are instructed to bill as follows:

1. Days not covered under Medicare part A must be billed to Medicare B for payment of covered ancillary charges. Claims will crossover to Vermont Medicaid for payment of coinsurance and deductible.
2. Add together Medicare's part B payment, Medicare contractual adjustment amount on part B EOMB and Vermont Medicaid's crossover payment (part B) in field locator 54 (Prior Payments) of the UB-04 claim form.
3. Submit your claim and all attachments to your Vermont Medicaid Provider Representative. (See www.vtmedicaid.com under [Information/Provider Representative Map](#)).

DVHA does not recognize Provider Liable charges, and therefore the charges are not to be deducted from the billed amount.

Note the Provider Liable amount in field locator 54c (prior payments), with payer names of "VT Medicaid" in field locator 50c. Not the Provider Liable amounts in field locator 80 (example: Provider Liable for Part A is \$XXX, for Part B is \$XXX).

INPATIENT CLAIMS: MEDICARE PART A EXHAUSTS

When a Vermont Medicaid recipient has Medicare part B coverage and Medicare part A has exhausted, providers are instructed to bill as follows:

1. Bill part A charges to Medicare.
2. A claim for Inpatient dates of service not covered under Medicare part A must be billed to Medicare B for payment of covered charges. Claim will crossover to Vermont Medicaid for payment of coinsurance and deductible.

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3. The inpatient claim for the ***entire stay*** should be billed to Vermont Medicaid with “Medicare benefits exhausted on mm/dd/yy” indicated in field locator 80 on the UB.
 4. Add together the Medicare B payment, the Medicare B contractual adjustment, and the Vermont Medicaid crossover payment. Indicate this total amount in field locator 54a on the UB.
 5. Attach both the part A and B EOBs. On part A EOMB, write “Medicare benefits exhausted on mm/dd/yy”. The charges will not match on part B EOB. Sign and date part A EOMB.
 6. Submit your claim and all attachments to your Vermont Medicaid Provider Representative. (See www.vtmedicaid.com under [Information/Provider Representative Map](#))

If a patient exhausts their Medicare coverage during an inpatient stay, DVHA will pay the coinsurance and deductible for the Medicare-covered days and a separate DRG payment for the days where Medicaid is primary payer. The DRG payment will be prorated based on the number of Medicaid-covered to total days on the claim.

INTERIM CLAIMS: INTERIM INPATIENT CLAIMS

Inpatient acute care hospitals that have a long term patient may bill interim claims in at least 60-day intervals. Subsequent bills must be in the **electronic** adjustment bill format. Each bill must include all applicable diagnoses and procedures. Indicate in the note field: long term inpatient stay greater than 60 days.

Providers are instructed to bill as follows:

1. Type of bill 112 – interim bill-first claim, patient status 30 – still a patient.
2. Type of bill for subsequent claims will be 117 - **electronic** replacement claim. Patient status will be either patient status 30, or a discharged patient status code.

Also See [Subacute Care](#).

LAB SERVICE

Lab related charges must include the corresponding CPT or HCPCS code with the laboratory revenue code on the UB-04 claim form.

LABOR/DELIVERY ROOM (see observation room page 13)

LATE CHARGES

Late charges to the original paid claims must be submitted as adjustments. These adjustments must be submitted either using the HP paper adjustment form or electronically through the HP Provider Electronic Solutions (PES) Application. Paper claims with type of bill 117 (adjustment inpatient) or 137 (adjustment outpatient) will not be accepted.

MEDICARE CROSSOVER CLAIMS

A Vermont Medicaid recipient may be eligible for both Medicaid and Medicare. When dual eligibility exists, Medicare must be billed first. Vermont Medicaid is the payer of last resort. Vermont Medicaid will pay co-insurance and deductible, minus any applicable co-payment amounts on institutional crossovers.

Hospitals: For in-state and border hospitals, claims submitted to the Medicare carrier will crossover automatically to Vermont Medicaid for payment. Medicaid eligibility information must be clearly indicated on the Medicare claim submitted. If you do not receive Medicaid payment within 30 days of the Medicare payment date, or if you are an out-of-state (except New Hampshire) who has billed and received payment from your regional Medicare carrier for services to Vermont residents who are eligible for both Medicare and Vermont Medicaid, submit the crossover claim to HP as follows:

- Send an electronic Medicare Crossover Claim or Send a copy of the Medicaid claim with a copy of the Medicare summary form.
- Supplemental insurance payments should be entered in field locator 54.
- If a copy of the Medicare claim is not available, you may complete a UB-04 claim form and attach a copy of the Medicare summary form, or attach documentation that Medicare does not cover the service to a claim filled out following Vermont Medicaid rules.
- The Medicare payment date must appear on the Medicare summary form.

When a service is denied by Medicare and is covered by Vermont Medicaid, submit a Medicaid claim completed to Vermont Medicaid specifications within the following guidelines:

- To submit third party liability denials electronically, see the Provider Manual section 1.3.12 Third Party Liability (TPL)/Other Insurance (OI), for billing instructions.
- Attach the remittance document from Medicare or a copy of the blanket denial showing that Medicare does not cover the service
- Send to HP within two years of the date of service on the Medicare summary form.

NDC (NATIONAL DRUG CODE)

Vermont Medicaid requires the collection and submission of data on all drugs dispensed or administered other than by a pharmacy as a result of the Deficit Reduction Act of 2005. The purpose is to allow for the collection of Medicaid drug rebates from manufacturers on all drugs dispensed in any outpatient setting as required by § 1927 of the Social Security Act. The NDC billed to Vermont Medicaid must be the NDC that was dispensed to the beneficiary.

Drugs supplied by manufacturers currently participating in the rebate program will be the only drugs reimbursed by Vermont Medicaid. A list of these manufacturers, by code and name, can be found at http://www.cms.hhs.gov/MedicaidDrugRebateProgram/10_DrugComContactInfo.asp.

In order to collect rebates from the correct manufacturers, Vermont Medicaid will require data elements at the detail level in addition to the HCPCS codes. These elements are the NDC indicator code N4, 11 digit National Drug Code (NDC) number, the Unit of Measurement Qualifier code, and the unit quantity. These must be reported on paper and electronic submissions of all outpatient claims.

The NDC billing requirement will apply to all details where HCPCS reporting is required.

If the above statement is true:

A provider may submit a separate claim for baby under the mother's ID number, for a maximum of 7 consecutive days, once the mother's claim has been processed.

The provider must include the following information on the UB-04 claim form:

Field Locator

8b.-Baby's name

10-Baby's date of birth

58-Mother's name

60-Mother's Vermont Medicaid number (SSN)

80-Write "Billing for baby under mother's ID number"

2) The provider can wait for the child's temporary or permanent ID number to be issued.

NINE NINE CODES "---99" CODES

Procedure codes ending in ---99 are for "unlisted" services. Procedure codes that do not identify a specific item or service or described as 'unlisted' require prior authorization unless specific instructions are given indicating otherwise. Claims for these codes require documentation of the nature of the service and the illness or injury being treated. Pertinent operative notes, office records and the patient charts are necessary in assessing a payment for your services. If documentation does not accompany the "---99" code, the claim will be denied.

See PRIOR AUTHORIZATION for additional information.

NURSE-MIDWIFE SERVICES

The nurse-midwife provider number should be entered in field locator 76 on the UB-04 claim form. The provider number of an associated physician should NOT be used as the attending.

Enrolled licensed lay person midwives cannot bill for inpatient hospital services.

OBSERVATION ROOMS

Effective with the implementation of Outpatient Perspective Payment System (OPPS) 5/1/2008, Vermont Medicaid is packaging observation services with OPPS primary procedures. There are no exceptions for certain conditions as there are in Medicare. Charges for observation however will be included in the determination of whether or not the claim is eligible for an outlier payment.

Alternatively, Vermont Medicaid will pay for observation separately when there is *NO primary procedure*. Vermont Medicaid will pay the observation line on the claim using the hospital's CCR, provided that the G0378 HCPCS appears on the labor room or observation room revenue code detail line and the number of hours in observation appears in the units field. Lab details as well as other CPT/HCPCS for which there is a separate OPPS fee assigned but are not designated as primary procedures in the OPPS will be paid separately.

PRESENT ON ADMISSION (POA) - Inpatient Admissions

Effective May 16, 2010 the present on admission indicator (POA) will be required for all inpatient admissions. Vermont Medicaid will follow Medicare's guidelines. The indicator options are: Y (diagnosis was present at time of the admission), N (diagnosis was not present at time of admission), U (documentation was insufficient to determine if present at time of admission), W (clinically undetermined), 1 (exempt from POA reporting). The POA indicator is the eighth digit and is required on all diagnoses codes listed on the UB 04 (principal field 67 and secondary field 67 A through Q). This is not required for the admit diagnosis (69). For electronic claims using the 837 institutional, submit the POA indicator in segment K3 in the 2300 loop, data element K301. POA is always required first, followed by the principal diagnosis. The last secondary diagnosis indicator is followed by the letter Z to indicate the end of the data element. e.g.: POAYNUW1YZ

PRIVATE ROOM

Private rooms are allowed only if certified medically necessary by a physician to avoid jeopardizing the health of the patient or to protect the health and safety of other patients.

PSRO SIGNATURE

Vermont Medicaid no longer requires the signature of an authorized Professional Standard Review Organization/ Utilization Review (PSRO/UR) representative on paper claim forms. The provider is only allowed to bill for dates of services that are medically necessary and must keep documentation supporting the medical necessity.

The PSRO approval must be indicated in form locator 18-28 with either a C1 (approved as billed) or C5 (post-payment review).

PRIOR AUTHORIZATION (PA)

Prior authorization (PA) is required for certain surgical procedures. See the Prior Authorization Supplement for instructions on obtaining PA for these services. For a complete list of codes that require PA, see the fee schedule at: www.vtmedicaid.com under Downloads/Manuals. The Pre-Admission Request Form and the Pre-Procedure Request Form are available for download at www.vtmedicaid.com under Downloads/Forms.

REIMBURSEMENT

Refer to the Fee Schedule for a complete listing of services that are reimbursable by Vermont Medicaid. Implementation of OPSS pricing has not changed the Vermont Medicaid policy regarding non-covered services.

Inpatient services will be paid according to DRG payment methodology. Go to www.vtmedicaid.com under Downloads/Manuals for the Vermont-based Relative Weights chart.

Outpatient services will be paid according to OPSS methodology. Go to www.vtmedicaid.com under Downloads/Manuals for a listing of revenue codes that are required to be billed with a HCPCS/CPT code. The full fee schedule for hospitals is also listed. The number of units billed on a detail line with the revenue code will represent the number of units for the HCPCS code.

DRG Hospital Reimbursement-Vermont Medicaid Ineligibility:

With the DRG reimbursement methodology in effect, any claims for beneficiaries who become

ineligible for Vermont Medicaid during the duration of an inpatient stay must be billed to HP in its entirety. HP will prorate these claims based on beneficiary eligibility and partially reimburse for the days the beneficiary was eligible for Vermont Medicaid.

Providers are instructed to bill the inpatient stay, including the Vermont Medicaid ineligible days for reimbursement, then balance bill the beneficiary for the remainder. Vermont Medicaid will not reimburse for days which the beneficiary was ineligible, thus it becomes the beneficiary's financial responsibility.

SAME-DAY STAYS

One day stays are defined as patients who are admitted and discharged from the same acute care facility on the same calendar day.

- Example: Patient is admitted 5:00 am on 12/4/07 and released 11:30 pm on 12/4/07. This is a same-day stay.
- Example: Patient is admitted at 10:00 pm on 12/4/07 and released at 7:00 am on 12/5/07. This is not a same day stay.

These claims will be paid the lesser of the cost of the case or the DRG payment.

SPENDDOWN

Some persons eligible for Vermont Medicaid benefits may be eligible only upon meeting spend-down requirements. This involves a determination by the district office that the person has a surplus of income over necessary expenses, which could be applied to medical expenses. This is referred to as the spend-down amount.

The Medicaid eligibility for this type of case begins on any day of the month in which the person reaches an incurred Medicaid expense amount that equals or exceeds the specified spend-down amount. When the person is determined to be eligible for Vermont Medicaid, the district worker sends a letter to the provider informing them that the spend-down amount has been met or that a remaining amount should be deducted from a particular bill before billing Vermont Medicaid for the remainder.

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

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

- Complete the claim as usual
- Enter the spend-down amount shown on the Notice of Decision in field locator 54b. If there was a payment by a third party insurance, add the other insurance payment and spend-down amount in field locator 54b.
- Write "Spend-down deducted \$(amount)" in field locator 80, labeled Remarks.
Attach a copy of the Notice of Decision to the claim and submit to HP for processing. The Notice of Decision must be specific to the provider that is submitting the claim.

SUBACUTE CARE

Swing bed hospitals should bill revenue code 16X on a separate claim from the acute care episodes (use appropriate discharge code.) Waiting for placement hospitals should bill revenue code 19X on the same claim as the acute care episodes.

Payment to hospitals for subacute care is made either for swing bed care or while a patient is waiting placement in a nursing facility. Vermont approved swing bed facilities are eligible for swing bed payments but not waiting placement payments.

Swing bed payments will be made only if the following conditions are met:

- The person must be found eligible for long-term care Medicaid during the period for which payment is requested; and
- The person's income must be applied toward the cost of care, as determined by the district office.

Medicare part B must be billed for those services usually billable. On the Medicare B EOMB, write: "Recipient is not eligible for Medicare A, ancillary charges billed to Medicare B & Vermont Medicaid. Charges do not match. Medicare B and Vermont Medicaid payment combined in field locator 54." Sign and date the Medicare B EOMB.

The following hospitals have been approved to offer swing bed services:

Copley, Gifford, Grace Cottage, MT. Ascutney, North Country, Northeastern Regional, Porter and in New Hampshire: Alice Peck Day, Cottage and Weeks.

Hospitals not authorized to bill swing beds may bill for waiting placement for those days after it is determined that a patient no longer requires acute care. If the patient continues to be hospitalized while awaiting placement in a nursing facility and no bed within the area is available, the hospital must be actively seeking placement. Payment is the same as a swing bed day.

Medicare part B must be billed for those services usually billable. Any payment received from part B for A, ancillary charges must be indicated in field locator 54 on the UB-04 claim form. On Medicare B EOMB write : "Recipient is not eligible for Medicare A, ,ancillary charges billed to Medicare B & Vermont Medicaid." Sign and date the Medicare B EOMB.

TRANSFER CASES

Transfer cases are defined as patients who initiate an inpatient stay in one hospital and are discharged/admitted from one acute care facility to another in the same day.

- The receiving hospital will be paid under normal DRG payment logic.
- The transferring hospital will be paid the lesser of the cost of the case or the DRG payment (including any eligible outlier payment).

UNITS

When billing for revenue codes that are required to be billed with a HCPCS code, the number of units billed with the revenue code will represent the number of units associated with the HCPCS/CPT code.

SECTION 1.1

HOSPITAL INPATIENT BILLING INSTRUCTIONS

All information on the UB-04 claim form should be typed or legibly printed. The fields listed below are used by HP when processing Vermont Medicaid claims. The fields designated by an asterisk (*) are mandatory; other fields are required when applicable. Only the fields listed below are used in the Vermont Medicaid Program; other fields do not need to be completed.

FIELD LOCATORS

1. UNLABELED FIELD*

2. UNLABELED FIELD

3a. PATIENT CONTROL #

3b. MEDICAL RECORD #

4. TYPE OF BILL*

6. STATEMENT COVERS PERIOD*

8a. PATIENT'S ID #*

8b. PATIENT'S NAME*

10. BIRTHDATE

12. ADMISSION DATE*

13. ADMISSION HOUR*

14. ADMISSION TYPE*

16. DISCHARGE HOUR

17. STAT*

REQUIRED INFORMATION

Enter the Hospital name and address as it appears on the Vermont Medicaid Provider Enrollment form.

Enter "Vermont Medicaid Hospital Inpatient"

For accounting purposes, enter the patient control # in the field locator. The number may consist of up to 24 characters, alpha/numeric. This information will appear on the Remittance Advice (RA).

Enter patient's medical record #.

Enter the code indicating the specific type of bill for Inpatient. The sequence is as follows:

1. Type of facility

1-Hospital

2. Bill Classification

1-Inpatient

3. Frequency

1-Admit through discharge claim

2-Interim-first claim

3-Interim-continuity claim

4-Interim-last claim

Enter the from and through service dates

Enter patient's Vermont Medicaid ID #.

Enter the patient's last name, first name and middle initial.

Enter the date of birth

Enter date of admission

Enter the hour in which patient was admitted

Enter the code indicating the priority of the admission:

1-Emergency

2-Urgent

3-Elective

4-Nursery

Enter the hour in which the patient was discharged.

Enter the two digit code indicating the patient's status as of the 'through date' of the statement period.

-
- 01-Discharged to Home or Self Care
 - 02-Discharged/Transferred to Another Short-Term General Hospital
 - 03-Discharge/Transferred to Skilled Nursing Facility (SNF)
 - 04-Discharged/Transferred to an Intermediate Care Facility (ICF)
 - 05-Discharged/Transferred to another Type of Institution (e.g. Hospice, Rehab Facility)
 - 06-Discharged/Transferred to Home Under Care of Organized Home Health Service Organization
 - 07-Left Against Medical Advice
 - 20-Expired
 - 21-Discharged/Transferred to Court/Law Enforcement
 - 30-Still A Patient (for awaiting placement claims or long term inpatient care (electronic adjustment claims greater than 60 days).
 - 40-Expired at Home (Hospice Only)
 - 41-Expired in Hospital, SNF, ICF, or Free Standing Hospice (Hospice Only)

18-28. CONDITONS CODES*

Enter code to identify if condition is related to the following (*PSRO code is mandatory):

- 02- Condition is Employment Related
- A1-EPSDT Related Services
- A4-Family Planning Related Services
- C1-PSRO Approved as Billed
- C5-PSRO Post-Payment Review

31-34. OCCURRENCE CODE & DATE*

Enter one of the following two digit accident codes, and the corresponding occurrence date, if applicable or 52 if no other applies:

- 01-Auto Accident
- 02-Auto Accident/No Fault Insurance Involved
- 03-Accident/Tort Liability
- 04-Accident/Employment Related
- 05-Other Accident
- 06-Crime Victim
- 11-No Accident/Onset of Symptoms or Illness
- 42-Date of Discharge
- 50-Medical Emergency-Non-accidental
- 51-Outpatient Surgery Related
- 52-Not an Accident

39. VALUE CODES AMOUNT*	Enter the number of covered days in the amount/dollar column. Do not count the day of discharge or the date of death. (The sum of all the days should be equal to the amount of days being billed.)
42. REVENUE CODES*	Enter the appropriate revenue code for the service provided.
45. SERVICE DATE*	Enter the 'FROM' date of the span of consecutive service dates being billed.
46. SERVICE UNITS*	Enter the quantitative measure of service rendered per revenue code.
47. TOTAL CHARGES*	Enter the total charges pertaining to each revenue code billed for the current billing period. Add the total charges for all revenue codes being billed and enter at the bottom of column 47 in the total field. (detail line 23)
50. PAYER*	On 50a, enter the primary payer name or "Spend Down" if spend down amount applies to the claim. On 50b, enter the other insurance name if applicable. Enter "Vermont Medicaid" on 50c.
54. PRIOR PAYMENTS*	Enter the payment amount associated with the payer listed in field locator 50. Attach spend down Notice of Decision. Documentation must be attached if there was no payment, if the services are not covered by the primary, or if the payment by the primary is \$3.00 or less.
55. ESTIMATED AMOUNT DUE	Enter the amount due after deducting any amount entered in field locator 54 from the total entered at the bottom of column 47.
56. NPI*	Enter the BILLING provider's NPI number.
57a. TAXONOMY CODE(S)	Enter the BILLING provider's Taxonomy Code when applicable.
57c. VERMONT MEDICAID ID #	Atypical providers, enter your Vermont Medicaid billing provider number.
67. PRINCIPAL DIAGNOSES CODE* POA*(see page 13 for billing instructions)	Enter the primary diagnosis code. Use the appropriate ICD-9-CM code.
67 a-q. OTHER DIAGNOSES CODES POA*(see page 13 for billing instructions)	Enter the appropriate ICD-9-CM codes for any condition other than primary, which requires supplementary treatment.
69. ADMITTING DIAGNOSES CODE*	Enter the admitting diagnosis code.

74. PRINCIPAL PROCEDURE CODE & DATE	Enter the appropriate ICD-9-CM procedure code and corresponding date.
74 a-e. OTHER PROCEDURE CODE & DATE	Enter the appropriate ICD-9-CM procedure codes and dates other than the principal procedure performed.
76. ATTENDING PHYSICIAN*	Enter the individual Attending Physician's NPI number. If billing with a Vermont Medicaid ID #, leave the NPI field blank and enter the Vermont Medicaid ID # to the right of the qualifier box.
78-79. OTHER PHYSICIAN. NPI	Enter the Vermont Medicaid ID # of the physician who the patient was referred to for further treatment, if applicable.
80. REMARKS	Enter any notations relating specific information necessary to adjudicate the claim.
81CCa.	Enter the taxonomy code for the attending provider. Must correspond with the NPI number in field locator 76.

SECTION 1.2

HOSPITAL OUTPATIENT BILLING INSTRUCTIONS

All information on the UB-04 claim form should be typed or legibly printed. The fields listed below are used by HP when processing Vermont Medicaid claims. The fields designated by an asterisk (*) are mandatory; other fields are required when applicable. Only the fields listed below are used in the Vermont Medicaid Program; other fields do not need to be completed.

FIELD LOCATOR

REQUIRED INFORMATION

1. UNLABELED FIELD*	Enter the Hospital name and address as it appears on the Vermont Medicaid Provider Enrollment form.
2. UNLABELED FIELD	Enter "Vermont Medicaid Hospital Inpatient"
3a. PATIENT CONTROL #	For accounting purposes, enter the patient control # in the field locator. The number may consist of up to 24 characters, alpha/numeric. This information will appear on the Remittance Advice (RA).
3b. MEDICAL RECORD #	Enter patient's medical record #.
4. TYPE OF BILL*	Enter the code indicating the specific type of bill for Inpatient. The sequence is as follows:

	<u>1. Type of facility</u> 1-Hospital
	<u>2. Bill Classification</u> 3-Outpatient 4-Patient not present
	<u>3. Frequency</u> 1-Admit through discharge claim 5-Late charges; this code is to be used only when submitting charges that were not included on a previously filed claim.
6. STATEMENT COVERS PERIOD*	Enter the from and through service dates.
8a. PATIENT'S ID #*	Enter patient's Vermont Medicaid ID #.
8b. PATIENT'S NAME*	Enter the patient's last name, first name and middle initial.
10. BIRTHDATE	Enter the date of birth
12. ADMISSION DATE*	Enter date of admission
13. ADMISSION HOUR	If billing for emergency services that are the result of an accident, enter the admission hour.
14. ADMISSION TYPE*	<u>Enter the code indicating the priority of the admission:</u> 1-Emergency 2-Urgent 3-Elective 4-Nursery
16. DISCHARGE HOUR	Enter the hour in which the patient was discharged.
17. DISCHARGE STATUS*	Enter the appropriate discharge code.
18-28. CONDITIONS CODES	<u>Enter code to identify if condition is related to the following</u> (*PSRO code is mandatory): 02-Condition is Employment Related A1-EPSDT Related Services A4-Family Planning Related Services
31-34. OCCURRENCE CODE & DATE*	<u>Enter one of the following two digit accident codes and the corresponding occurrence date, if applicable or 52 if no other applies:</u> 01-Auto Accident 02-Auto Accident/No Fault Insurance Involved 03-Accident/Tort Liability 04-Accident/Employment Related 05-Other Accident 06-Crime Victim

	11-No Accident/Onset of Symptoms or Illness 35-Physical Therapy 44-Occupational Therapy 45-Speech Therapy 50-Medical Emergency- Non-accidental 51-Outpatient Surgery Related 52-Not an Accident
42. REVENUE CODES*	Enter the appropriate revenue code for the service provided.
43. NDC CODE*	Enter the NDC code of the drug that was dispensed. Use a "N4" indicator preceding the NDC to identify the information in FL 43 as an NDC.
44. HCPCS/CPT	Enter the appropriate HCPCS/CPT code.
45. SERVICE DATE*	Enter the actual date the service was rendered. If the service was rendered on more than one day, you must bill a separate charge for each day.
46. SERVICE UNITS*	Enter the quantitative measure of service.
47. TOTAL CHARGES*	Enter the total charges pertaining to each code billed for the current billing period. Add the total charges for all revenue codes being billed and enter at the bottom of column 47 in the total field. (detail line 23)
50. PAYER*	On 50a, enter the primary payer name or "Spend Down" if spend down amount applies to the claim. On 50b, enter the other insurance name if applicable. Enter "Vermont Medicaid" on 50c.
54. PRIOR PAYMENTS*	Enter the payment amount associated with the payer listed in field locator 50. Attach spend down Notice of Decision. Documentation must be attached if there was no payment, if the services are not covered by the primary, or if the payment by the primary is \$3.00 or less.
55. ESTIMATED AMOUNT DUE	Enter the amount due after deducting any amount entered in field locator 54 from the total entered at the bottom of column 47.
56. NPI*	Enter the BILLING provider's NPI number.
57a. TAXONOMY CODE(S)	Enter the BILLING provider's Taxonomy Code when applicable.

57c. VERMONT MEDICAID ID #	Atypical providers, enter your Vermont Medicaid billing provider number.
67. PRINCIPAL DIAGNOSES CODE*	Enter the primary diagnosis code. Use the appropriate ICD-9-CM code.
67 a-q. OTHER DIAGNOSES CODES	Enter the appropriate ICD-9-CM codes for any condition other than primary, which requires supplementary treatment.
76. ATTENDING PHYSICIAN NPI*	Enter the individual Attending Physician's NPI number. If billing with a Vermont Medicaid ID #, leave the NPI field blank and enter the Vermont Medicaid ID # to the right of the qualifier box.
77. OPERATING PHYSICIAN NPI	Enter the Vermont Medicaid ID # of the Operating Physician
78-79. OTHER PHYSICIAN NPI	Enter the Vermont Medicaid ID # of the physician who the patient was referred to for further treatment if applicable.
80. REMARKS	Enter any notations relating specific information necessary to adjudicate the claim.
81CCa.	Enter the taxonomy code for the attending provider. Must correspond with the NPI number in field locator 76.

SECTION 2.0

HOME HEALTH AGENCY SERVICES

CONDITIONS FOR PAYMENT

If all conditions for Medicare are met and the patient is Medicare eligible, Medicare must be billed before Vermont Medicaid reimbursement is requested. Payment for covered home health care services is authorized when the conditions for Medicare (Part A or Part B) payment are met or when all of the following conditions are met:

- The service or item is furnished in the recipient's place of residence. (A place of residence includes recipient's own dwelling, an apartment, congregate such as senior citizen or adult day center, a community care home, and a hospital, but the last only for the purpose of an initial observation, assessment and evaluation visit.); and
- Items and services are ordered and furnished under a written plan, signed by the attending physician and incorporated into the agency's permanent record for the patients, which relates the items and services to the patient's condition, as follows:
 - Includes the diagnosis and description of the patient's functional limitation resulting from illness or injury; and

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- Specifies the type and frequency of needed service, e.g., nursing services, drugs and medications, special diet, permitted activities, rehabilitation and therapy services, home health aide services, medical supplies and appliances; and
 - Provides a long-range forecast of likely changes in the patient's condition; and
 - Specifies changes in the plan in writing, signed by the attending physician or by a registered professional nurse on the agency staff pursuant to the physician's verbal orders; and
 - Is reviewed by the attending physician, in consultation with professional agency personnel every 60 days, or more frequently as the severity of the patient's condition requires, and shows the day of each review and physician's signature; and
 - The attending physician certifies that the services and items specified in the treatment plan can, as a practical matter, be provided through a Home Health Agency in the patient's place of residence.

For Vermont Medicaid reimbursement, there is no homebound restriction, nor a three day prior hospitalization required. Patient's condition may be either an episode of acute illness or injury, or a chronic condition requiring home health care under a physician's order.

DURABLE MEDICAL EQUIPMENT

The rental of durable medical equipment, such as crutches, wheelchairs, bedpans, trapeze bars, etc. owned by the home health agency and used by a patient as part of the plan of care, is a covered service.

Medical supplies include items which are essential in enabling home health agency personnel to effectively carry out the care and treatment which has been ordered for the patient by the physician. These items include catheters, needles, syringes, surgical dressings, and materials used for dressings such as cotton gauze and adhesive bandages. Other medical supplies include, but are not limited to, irrigating solution, intravenous fluid and oxygen. No prior authorizations will be given for medical supplies for Vermont Medicaid recipients receiving Home Health care.

HOSPICE

Vermont Medicaid reimburses for hospice services provided to patients in nursing homes. Under federal regulations, hospice providers who contract with nursing homes to provide services become responsible for management of the patient's care and billing for all services, including the room and board normally paid to the nursing home. The revenue code 659 should be used for these hospice services and the name of the nursing home should be entered in field locator 80. Vermont Medicaid pays the hospice a rate which is equal to 95% of the nursing home's established per diem rate, and the hospice in turn, pays the nursing home.

INTERPRETER SERVICES

Vermont Medicaid providers paying interpreter services for a beneficiary (who does not speak the same language as the provider or for sign language for an hearing impaired beneficiary), in person or over the phone, may bill using revenue code 940 with procedure code T1013 for every 15 minutes of service provided.

RESPITE BILLING

Only provider types of Aged/Disabled Waiver, with Waiver indicated as provider specialty, may bill for respite care. Providers billing for respite must select a type of bill from the following:

1. Type of Facility

8-Hospice or Special Facility

2. Bill Classification

6-Respite

3. Frequency

1-Admit through discharge claim

2-Interim-first claim

3-Interim-continuity claim

4-Interim-last claim

For additional information, please refer to: <http://ddas.vermont.gov/ddas-policies/policies-cfc/policies-cfc-highest/policies-cfc-highest-manual>.

REIMBURSABLE SERVICES

General Information: Home health services are provided by certified home health agencies under a plan of treatment authorized and approved by a physician. The objective of the home health services is to restore, rehabilitate, or maintain patients in their own homes or in a domiciliary facility by providing professional care and/or supervision. Approved home health services include nursing care services, services of home health aides, speech therapy, physical therapy, occupational therapy, and medical supplies.

Services provided by the home health agency, except for the initial evaluation visit, must be furnished under a physician's plan of care. The physician establishes a written plan of care for the patient and supervises the plan in conjunction with the home health agency. The physician must sign the plan of care initially and review and sign it every 60 days. The plan of care becomes a permanent part of the patient's records. It must be kept on file at the home health agency. If any changes in the plan of treatment are ordered by the physician, these changes must also be signed. They may be given verbally by the physician, and then reduced to writing by the registered nurse or qualified therapist (who must date and sign the changes); however, the physician must countersign the order as soon as possible thereafter.

The plan of care must cover all pertinent diagnoses and include the following information:

- Mental status
- Types of professional services needed
- Frequency of visits
- Prognosis as a result of the services
- Rehabilitation potential
- Functional limitations
- Activities permitted
- Nutritional requirements
- Medication and treatments
- Any safety measures to protect against injury
- Instruction for timely discharge or referral

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- Specific therapy services- This should include the specific procedures and modalities to be used, and the amount, frequency and duration of the therapies.

The plan of care is reviewed periodically by the physician and home health agency personnel. The agency professional staff is responsible for promptly reporting to the physician any changes in the patient's condition which would warrant altering the plan of care.

Nursing Care Services: Nursing care services provided on a part-time or intermittent basis by a home health agency or, in the case where no agency exists in the area, by a registered nurse employed or contracted by the home health agency, are covered. Nursing services must be provided in accordance with the physician's plan of care.

Registered Nurse Services: Skilled nursing care consists of those services reasonable and necessary to the treatment of an illness or injury and for evaluation and assessment of the patient's condition. These services must be performed by or under the direct supervision of a licensed nurse in accordance with the current Nurse Practice Act (State Law) and the individual home health agency policy. Skilled services are covered for patients who have reached a maintenance level but are able to remain in the home if supervised periodically by an RN or therapist.

Licensed Practical Nurse Services: Intermittent or part-time nursing services may be provided to a patient by a licensed practical nurse when these services are ordered by the patient's physician and the licensed practical nurse is working under the direction of the registered nurse. LPN services are assigned and provided in accordance with the current Nurse Practice Act (State Law) and individual home health agency policy. Duties of a licensed practical nurse may include preparing clinical and progress notes, assisting the physician and/or registered nurse in performing specialized procedures, preparing equipment and materials for treatment, observing aseptic techniques as required, and assisting the patient in learning appropriate self-care techniques.

Home Health Aide Services: Home health aide services can be provided even if a skilled service is not needed; however, a registered nurse or appropriate therapist must make a supervisory visit every 2 weeks. The primary function of a home health aide is the personal care of a patient. The home health aide is assigned to a particular patient by the nurse or therapist. Written instructions for the patient's care are prepared by a registered nurse or therapist as appropriate. Routine small cost items such as cotton balls and tongue depressors, are included in the home visit charges and will not be paid for separately.

Personal Duties: Personal duties provided in accordance with the written plan of care by the home health aide include medical assistance, assistance in the activities of daily living, such as helping the patient to bathe, to get in and out of bed, to care for hair and teeth, to exercise, assisting the patient in taking medicines specifically ordered by the physician which are ordinarily self-administered, retraining the patient in necessary self-help skills, and assisting with provision and maintenance of a desirable physical environment for the patient in his home.

Medical Duties: Medical duties include taking temperature, pulse, respirations and blood pressure, weighing the patient, reporting changes in the patient's conditions and needs, and completing appropriate records for the home health agency.

Household Services: Household services that are essential to the patient's health care and incidental to the medical care of the patient, such as light housekeeping, meal preparation, laundering essential to the comfort of the patient, etc. are considered covered services of a home health aide when these activities can be documented as a necessary adjunct to the patient's prescribed therapeutic plan of care. Light housekeeping may include, changing the bed, light cleaning, and rearrangement of room furnishings to accommodate patient's needs. Meal preparation, meeting patient's nutritional needs, may include purchase of food, meal preparation, and washing of utensils. Laundering may include

being sure the patient has clean articles such as stump socks for amputees, elastic stockings, sleepwear, or undergarments for the incapacitated patient.

PATIENT SHARE (APPLIED INCOME) REPORTING

The DCF District office will send the facility a copy of the notification sent to the beneficiaries. This notification includes the amount of the patient's share, if any, that the beneficiary must apply toward the cost of his or her care. Patient Share obligations will be automatically deducted from Vermont Medicaid claims starting with the first claims of the month.

VISITS

Covered services under the Vermont Medicaid Home Health Service Program are those which are necessary to restore, rehabilitate or maintain health, including care for the terminally ill, when provided under professional supervision in the home. Following are descriptions of home health visits covered under the Vermont Medicaid Program:

Visit at Patient's Place of Residence: A visit is a personal contact in the patient's place of residence for providing a covered home health service by a health worker on the staff of the home health agency or by others under contract or arrangement with the home health agency.

Initial Evaluation Visit: A visit to evaluate the patient, the patient's status, the physical environment and facilities available, attitudes of family members, availability of family members to assist in the care and to assess the appropriateness of home health care for the patient.

SECTION 2.1

HOME HEALTH AGENCY SERVICES-GENERAL BILLING INSTRUCTIONS

All information on the UB-04 claim form should be typed or legibly printed. The fields listed below are used by HP when processing Vermont Medicaid claims. The fields designated by an asterisk (*) are mandatory; other fields are required when applicable. Only the fields listed below are used in the Vermont Medicaid Program; other fields do not need to be completed.

FIELD LOCATORS

- 1. UNLABELED FIELD*

- 2. UNLABELED FIELD

- 3a. PATIENT CONTROL #

- 3b. MEDICAL RECORD #

- 4. TYPE OF BILL*

REQUIRED INFORMATION

- Enter the Home Health Agency name and address as it appears on the Vermont Medicaid Provider Enrollment form.

- Enter pay to name and pay to address

- For accounting purposes, enter the patient control # in the field locator. The number may consist of up to 24 characters, alpha/numeric. This information will appear on the Remittance Advice (RA).

- Enter patient's medical record #.

- Enter the code indicating the specific type of bill for Home Health. The sequence is as follows:

	<u>1. Type of facility</u> 3-Home Health 8-Hospice or Special Facility <u>2. Bill Classification</u> 1-Hospice (Non-hospital based) 2-Hospice (Hospital based) 3-Home Health 4-Ambulatory Surgical Center 6-Respite <u>3. Frequency</u> 1-Admit through discharge claim 2-Interim-first claim 3-Interim-continuity claim 4-Interim-last claim 5-Late charge(s) only
6. STATEMENT COVERS PERIOD*	Enter the from and through service dates
8a. PATIENT'S ID #*	Enter the patient's Vermont Medicaid ID #.
8b. PATIENT'S NAME*	Enter the patient's last name, first name and middle initial.
10. BIRTHDATE	Enter the date of birth
12. ADMISSION DATE*	Enter date of admission
13. ADMISSION HOUR	Enter the hour in which patient was admitted.
14. ADMISSION TYPE	Enter the code indicating the priority of the admission: 1-Emergency 2-Urgent 3-Elective 4-Nursery
17. STAT*	Enter the two digit code indicating the patient's status as of the statement period. 01-Discharged to Home or Self Care 02-Discharged/Transferred to Another Short-Term General Hospital 03-Discharge/Transferred to Skilled Nursing Facility (SNF) 04-Discharged/Transferred to an Intermediate Care Facility (ICF) 05-Discharged/Transferred to another Type of Institution (e.g. Hospice, Rehab Facility) 06-Discharged/Transferred to Home Under Care of Organized Home Health Service Organization 07-Left Against Medical Advice 20-Expired

18-28. CONDITIONS CODES

30-Still A Patient
40-Expired at Home (Hospice Only)
41-Expired in Hospital, SNF, ICF, or Free
Standing Hospice (Hospice Only)

Enter code to identify if condition is related to the following (*PSRO code is mandatory):

02-Condition is Employment Related
A1-EPSTD Related Services
A4-Family Planning Related Services
*If the patient is found to have Medicare benefits that would not cover the home health visit for one of the following reason, enter the condition code:
M3-Not home bound
M4-Non-chronic
M5-Non-acute

31-34. OCCURRENCE CODE & DATE*

Enter one of the following two digit accident codes, and the corresponding occurrence date, if applicable or 52 if no other applies:

01-Auto Accident
02-Auto Accident/No Fault Insurance
Involved
03-Accident/Tort Liability
04-Accident/Employment Related
05-Other Accident
06-Crime Victim
11-No Accident/Onset of Symptoms or
Illness
35-Physical Therapy
42-Date of Discharge
44-Occupational Therapy
45-Speech Therapy
50-Medical Emergency- Non-accidental
51-Outpatient Surgery Related
52-Not an Accident

42. REVENUE CODES*

Enter the appropriate revenue code for the service provided. Each date of service must be entered separately at the detail.

45. SERVICE DATE*

Enter the actual date the service was rendered. Enter the from date of the span of consecutive service dates being billed.

46. SERVICE UNITS*

Enter the number of visits or units of time for which reimbursement is being requested. Nursing care and therapy services are reimbursed on a per visit basis. One visit= 1 unit. Home Health Aide services are

	reimbursed in 15 minute units, therefore, enter total number of units the aide was in the home (i.e. 45 minutes= 3 units.)
47. TOTAL CHARGES*	Enter the total charges pertaining to each code billed for the current billing period. Add the total charges for all revenue codes being billed and enter at the bottom of column 47 in the total field. (detail line 23)
50. PAYER*	Enter "Medicare" or "Spend Down" (if spend down amount applies to the claim.) on 50a if Medicare is the primary payer. On 50b, enter the other insurance name if applicable. Enter "Vermont Medicaid" on 50c.
54. PRIOR PAYMENTS*	Enter the payment amount associated with the payer listed in field locator 50. Attach spend down Notice of Decision. Documentation must be attached if there was no payment, if the services are not covered by the third party.
55. ESTIMATED AMOUNT DUE	Enter the amount due after deducting any amount entered in field locator 54 from the total entered at the bottom of column 47.
56. NPI*	Enter the BILLING provider's NPI number.
57a. TAXONOMY CODE(S)	Enter the BILLING provider's Taxonomy Code.
57c. VERMONT MEDICAID ID #	Atypical providers, enter your Vermont Medicaid billing provider number.
67. PRINCIPAL DIAGNOSES CODE*	Enter the primary diagnosis code. Use the appropriate ICD-9-CM code.
67 a-q. OTHER DIAGNOSES CODES	Enter the appropriate ICD-9-CM codes for any condition other than primary, which requires supplementary treatment.
74. PRINCIPAL PROCEDURE CODE & DATE	Enter the appropriate ICD-9-CM procedure code and corresponding date.
74 a-e. OTHER PROCEDURE CODE & DATE	Enter the appropriate ICD-9-CM procedure codes and dates other than the principal procedure performed.
76. ATTENDING PHYSICIAN NPI*	Enter the individual Attending Physician's NPI number. If billing with a Vermont Medicaid ID #, leave the NPI field blank and enter the Vermont Medicaid ID # to the right of the qualifier box.

78-79. OTHER PHYSICIAN NPI

Enter the Vermont Medicaid ID # of the physician who the patient was referred to for further treatment if applicable.

80. REMARKS

Enter any notations relating specific information necessary to adjudicate the claim.

81CCa.

Enter the taxonomy code for the attending provider. Must correspond with the NPI number in field locator 76.

SECTION 3

HOSPICE & ADULT DAY SERVICES

BILLING INSTRUCTIONS

All information on the UB-04 claim form should be typed or legibly printed. The fields listed below are used by HP when processing Vermont Medicaid claims. The fields designated by an asterisk (*) are mandatory; other fields are required when applicable. Only the fields listed below are used in the Vermont Medicaid Program; other fields do not need to be completed.

FIELD LOCATOR

1. UNLABELED FIELD*

2. UNLABELED FIELD

3a. PATIENT CONTROL #

3b. MEDICAL RECORD #

4. TYPE OF BILL*

REQUIRED INFORMATION

Enter your Provider name and address as it appears on the Vermont Medicaid Provider Enrollment form.

Enter pay to name and pay to address

For accounting purposes, enter the patient control # in the field locator. The number may consist of up to 24 characters, alpha/numeric. This information will appear on the Remittance Advice (RA).

Enter patient's medical record #.

Enter the code indicating the specific type of bill for Enhanced Residential Care. The sequence is as follows:

1. Type of facility

3-Home Health

2. Bill Classification

1-Hospice (Non-hospital based)}

2-Hospice (Hospital based)

3-Home Health

4-Ambulatory Surgical Center

3. Frequency

1-Admit through discharge claim

2-Interim-first claim

	3-Interim-continuity claim 4-Interim-last claim 5-Late charge(s) only
6. STATEMENT COVERS PERIOD*	Enter the from and through service dates.
8a. PATIENT'S ID #*	Enter the patient's Vermont Medicaid ID #.
8b. PATIENT'S NAME*	Enter the patient's last name, first name, middle initial.
10. BIRTHDATE	Enter the date of birth
12. ADMISSION DATE*	Enter date of admission
13. ADMISSION HOUR*	Enter the hour in which patient was admitted
14. ADMISSION TYPE*	Enter the code indicating the priority of the admission: 1-Emergency 2-Urgent 3-Elective 4-Nursery
17. STAT*	Enter the two digit code indicating the patient's status as of the 'through date' of the statement period. 01-Discharged to Home or Self Care 02-Discharged/Transferred to Another Short-Term General Hospital 03-Discharge/Transferred to Skilled Nursing Facility (SNF) 04-Discharged/Transferred to an Intermediate Care Facility (ICF) 05-Discharged/Transferred to another Type of Institution (e.g. Hospice, Rehab Facility) 06-Discharged/Transferred to Home Under Care of Organized Home Health Service Organization 07-Left Against Medical Advice 20-Expired 30-Still A Patient 40-Expired at Home (Hospice Only) 41-Expired in Hospital, SNF, ICF, or Free Standing Hospice (Hospice Only)
18-28. CONDITONS CODES*	Enter code to identify if condition is related to the following (*PSRO code is mandatory): 02-Conditon is Employment Related A1-EPSTD Related Services A4-Family Planning Related Services *If the patient is found to have Medicare

	benefits that would not cover the home health visit for one of the following reasons, enter the condition code
	M3-Not home bound M4-Non-chronic M5-Non-acute
31-34. OCCURRENCE CODE & DATE*	Enter one of the following two digit accident codes, and the corresponding occurrence date, if applicable or 52 if no other applies: 01-Auto Accident 02-Auto Accident/No Fault Insurance Involved 03-Accident/Tort Liability 04-Accident/Employment Related 05-Other Accident 06-Crime Victim 11-No Accident/Onset of Symptoms or Illness 42-Date of Discharge 50-Medical Emergency-Non-accidental 51-Outpatient Surgery Related 52-Not an Accident
39. VALUE CODES AMOUNT*	Enter the number of covered days mandatory for Residential Care Facility only in the amount/dollar column.
42. REVENUE CODES*	Enter the appropriate revenue code for the service provided.
45. SERVICE DATE*	Enter the 'FROM' date of the span of consecutive service dates being billed.
46. SERVICE UNITS*	Enter the number of units which reimbursement is being requested.
47. TOTAL CHARGES*	Enter the total charges pertaining to each revenue code billed for the current billing period. Add the total charges for all revenue codes being billed and enter at the bottom of column 47 in the total field. (detail line 23)
50. PAYER NAME*	Enter "Medicare" or "Spend Down" (if spend down amount applies to the claim.) on 50a if Medicare is the primary payer. On 50b, enter the other insurance name if applicable. Enter "Vermont Medicaid" on 50c.
54. PRIOR PAYMENTS*	Enter the payment amount associated with the payer listed in field locator 50. Attach spend down Notice of Decision. Documentation must be attached if there was

	no payment, if the services are not covered by the third party.
55. ESTIMATED. AMTOUNT DUE	Enter the amount due after deducting any amount entered in field locator 54 from the total entered at the bottom of column 47.
56. NPI*	Enter the BILLING provider's NPI number.
57a. TAXONOMY CODE(S)*	Enter the BILLING provider's Taxonomy Code when applicable.
57c. VERMONT MEDICAID ID #	Atypical providers, enter your Vermont Medicaid billing provider number.
67. PRINCIPAL DIAGNOSES CODE*	Enter the primary diagnosis code. Use the appropriate ICD-9-CM code.
67 a-q. OTHER DIAGNOSES CODES	Enter the appropriate ICD-9-CM codes for any condition other than primary, which requires supplementary treatment.
69. ADMITTING DIAGNOSES CODE*	Enter the admitting diagnosis code.
74. PRINCIPAL PROCEDURE CODE & DATE	Enter the appropriate ICD-9-CM procedure code and corresponding date.
74 a-e. OTHER PROCEDURE CODE & DATE	Enter the appropriate ICD-9-CM procedure codes and dates other than the principal procedure performed. If billing with a Vermont Medicaid ID #, leave the NPI field blank and enter the Vermont Medicaid ID # to the right of the qualifier box.
77. OPERATING PHYSICIAN. NPI	Enter the Vermont Medicaid ID # of the Operating Physician
78-79. OTHER PHYSICIAN NPI	Enter the Vermont Medicaid ID # of the physician who the patient was referred to for further treatment if applicable.
80. REMARKS	Enter any notations relating specific information necessary to adjudicate the claim.
81CCa.	Enter the taxonomy code for the attending provider. Must correspond with the NPI number in field locator 76.

SECTION 4

ASSISTIVE COMMUNITY CARE SERVICES

ATTENDING PHYSICIAN

When billing ACCS services on the UB-04, a valid number must appear in field locator 76. ACCS providers do not receive a physician order when accepting a beneficiary into care. Therefore, if the seven digit provider number of the ordering physician is not known, ACCS providers may enter the DAIL seven digit billing provider number 9000175 in field locator 76.

BENEFICIARIES IN HEALTH CARE INSTITUTIONS

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

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

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

BILLING/SUPPLYING PROVIDER

The billing/supplying provider name and address on your enrollment application must appear in field locator 1, and the actual billing NPI/provider number to which payment will be made must appear in field locator 57c.

REVENUE CODE & DATE SPAN BILLING

ACCS providers must bill revenue code 0098 assigned by the Department of Disabilities, Aging and Independent Living (DAIL) in field locator 42. Only consecutive days may be billed in field locator 6. If there is a gap in service during a billing period, you must submit separate claims for each span of days. The day of admission is paid but the day of discharge is not paid. Please find the examples below.

Example one: (Continuous Stay)

Patient in the facility July 1, 2007 through July 31, 2007.

You would submit as follows:

Green Mountain Care
UB04

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9/1/2010

Single claim Field locator 6= 07/01/07 to 07/31/07
 042=0098
 Field locator 46= 31 units

Example two: (Leave Days)

Patient in the facility July 1, 2007 but leaves on July 15th to visit with family members. Patient returns on July 20th through July 31, 2007.

Submit two claims as follows:

First claim Field locator 6=07/01/07 to 07/15/07
 Field locator 42= 0098
 Field locator 46= 15 units

Second claim Field locator 6= 07/20/07 to 07/31/07
 Field locator 42= 0098
 Field locator 46= 5 units

Example three: (Hospital Visit)

Patient in the facility July 1, 2007 but is discharged to the hospital on July 10th. Patient returns on July 27th through July 31, 2007.

Submit two claims as follows:

First claim Field locator 6= 07/01/07 to 07/10/07
 Field locator 42= 0098
 Field locator 46= 9 units

Second claim Field locator 6= 07/27/07 to 07/31/07
 Field locator 42= 0098
 Field locator 46= 12 units

Example four: (Multiple Breaks)

Patient in the facility July 1, 2007 but is discharged to the hospital on July 10th. Patient returns on July 13th but leaves with family on July 16th. Patient returns on July 18th through July 31, 2007.

Submit three claims as follows:

First claim Field locator6= 07/01/07 to 07/10/07
 Field locator 42= 0098
 Field locator 46= 9 units

Second claim Field locator 6= 07/13/07 to 07/16/07
 Field locator 42= 0098
 Field locator 46= 4 units

Third claim Field locator 6= 07/18/07 to 07/31/07
 Field locator 42= 0098
 Field locator 46= 14 units

SECTION 4.1

ASSISTIVE COMMUNITY CARE SERVICES

BILLING INSTRUCTIONS

All information on the UB-04 claim form should be typed or legibly printed. The fields listed below are used by HP when processing Vermont Medicaid claims. The fields designated by an asterisk (*) are mandatory; other fields are required when applicable. Only the fields listed below are used in the Vermont Medicaid Program; other fields do not need to be completed.

FIELD LOCATORS

REQUIRED INFORMATION

1. UNLABELED FIELD*

Enter your Provider name and address as it appears on the Vermont Medicaid Provider Enrollment form.

2. UNLABELED FIELD

Enter "Assistive Community Care Services".

3a. PATIENT CONTROL #

For accounting purposes, enter the patient control # in the field locator. The number may consist of up to 24 characters, alpha/numeric. This information will appear on the Remittance Advice (RA).

3b. MEDICAL RECORD #

Enter patient's medical record #.

4. TYPE OF BILL*

Enter the code indicating the specific type of bill for Enhanced Residential Care. The sequence is as follows:

1. Type of facility

3-Home Health or Residential Care Facility

2. Bill Classification

3-Outpatient or Home Health

3. Frequency

1-Admit through discharge claim

2-Interim-first claim

3-Interim-continuity claim

4-Interim-last claim

5-Late charge(s) only

6. STATEMENT COVERS PERIOD*

Enter the beginning and ending service dates included on the bill.

8a. PATIENT'S ID #*

Enter the patient's Vermont Medicaid ID #.

8b. PATIENT'S NAME*

Enter the patient's last name, first name, middle initial.

10. BIRTHDATE

Enter the date of birth

12. ADMISSION DATE*

Enter date of admission

13. ADMISSION HOUR*

Enter the hour in which patient was admitted

14. ADMISSION TYPE*	Enter the code indicating the priority of the admission: 1-Emergency 2-Urgent 3-Elective 4-Nursery
16. DISCHARGE HOUR	Enter the hour in which patient was Discharged
17. STAT*	Enter the two digit code indicating the patient's status as of the 'through date' of the statement period. 01-Discharged to Home or Self Care 02-Discharged/Transferred to Another Short-Term General Hospital 03-Discharge/Transferred to Skilled Nursing Facility (SNF) 04-Discharged/Transferred to an Intermediate Care Facility (ICF) 05-Discharged/Transferred to another Type of Institution (e.g. Hospice, Rehab Facility) 06-Discharged/Transferred to Home Under Care of Organized Home Health Service Organization 07-Left Against Medical Advice 20-Expired 30-Still A Patient 40-Expired at Home (Hospice Only) 41-Expired in Hospital, SNF, ICF, or Free Standing Hospice (Hospice Only)
18-28. CONDITONS CODES*	Enter code to identify if condition is related to the following (*PSRO code is mandatory): 02-Conditon is Employment Related A1-EPSDT Related Services A4-Family Planning Related Services
31-34. OCCURRENCE CODE & DATE*	Enter one of the following two digit accident codes, and the corresponding occurrence date, if applicable or 52 if no other applies: 01-Auto Accident 02-Auto Accident/No Fault Insurance Involved 03-Accident/Tort Liability 04-Accident/Employment Related 05-Other Accident 06-Crime Victim 11-No Accident/Onset of Symptoms or

	Illness 42-Date of Discharge 50-Medical Emergency-Non-accidental 51-Outpatient Surgery Related 52-Not an Accident
39. VALUE CODES AMOUNT*	Enter the number of covered days mandatory for Residential Care Facility only in the amount/dollar column. Do not count the day of discharge or the date of death. (The sum of all days should be equal to the amount of days being billed.)
42. REVENUE CODES*	Enter the appropriate revenue code for the service provided.
45. SERVICE DATE*	Enter the 'FROM' date of the span of consecutive service dates being billed.
46. SERVICE UNITS*	Enter the number of units which reimbursement is being requested. One visit= 1 units. Home Health Aide services are reimbursed in 15 minute units, therefore, enter total number of units that aide was in the home (i.e. 45 minutes= 3 units).
47. TOTAL CHARGES*	Enter the total charges pertaining to each revenue code billed for the current billing period. Add the total charges for all revenue codes being billed and enter at the bottom of column 47 in the total field. (detail line 23)
50. PAYER NAME*	Enter "Medicare" or "Spend Down" (if spend down amount applies to the claim.) on 50a if Medicare is the primary payer. On 50b, enter the other insurance name if applicable. Enter "Vermont Medicaid" on 50c.
54. PRIOR PAYMENTS*	Enter the payment amount associated with the payer listed in field locator 50. Attach spend down Notice of Decision. Documentation must be attached if there was no payment, if the services are not covered by the third party.
55. ESTIMATED AMOUNT DUE	Enter the amount due after deducting any amount entered in field locator 54 from the total entered at the bottom of column 47.
56. NPI*	Enter the BILLING provider's NPI number.
57a. TAXONOMY CODE(S)	Enter the BILLING provider's Taxonomy Code when applicable.

57c. VERMONT MEDICAID ID #	Atypical providers, enter your Vermont Medicaid billing provider number.
67. PRINCIPAL DIAGNOSES CODE*	Enter the primary diagnosis code. Use the appropriate ICD-9-CM code.
67 a-q. OTHER DIAGNOSES CODES	Enter the appropriate ICD-9-CM codes for any condition other than primary, which requires supplementary treatment.
69. ADMITTING DIAGNOSES CODE*	Enter the admitting diagnosis code.
74. PRINCIPAL PROCEDURE CODE & DATE	Enter the appropriate ICD-9-CM procedure code and corresponding date.
74 a-e. OTHER PROCEDURE CODE & DATE	Enter the appropriate ICD-9-CM procedure codes and dates other than the principal procedure performed.
76. ATTENDING PHYSICIAN NPI*	Enter the individual Attending Physician's NPI number. If billing with a Vermont Medicaid ID #, leave the NPI field blank and enter the Vermont Medicaid ID # to the right of the qualifier box.
77. OPERATING PHYSICIAN NPI	
78-79. OTHER PHYSICIAN NPI	Enter the Vermont Medicaid ID # of the physician who the patient was referred to for further treatment if applicable.
80. REMARKS	Enter any notations relating specific information necessary to adjudicate the claim.
81CCa.	Enter the taxonomy code for the attending provider. Must correspond with the NPI number in field locator 76.

SECTION 5

CHOICES FOR CARE

ENHANCED RESIDENTIAL CARE (ERC)/Nursing Facilities Home Based Waiver (HBW)

Due to the implementation of the long-term care 1115 waiver, patient share obligations will be automatically deducted from Vermont Medicaid claims starting with the first claim of the month for nursing homes, ERC and home-based providers. All nursing home claims will cost avoid for Medicare unless the provider has indicated why the service was not covered by Medicare.

ERC: BILLING ISTRUCTIONS

All information on the UB-04 claim form should be typed or legibly printed. The fields listed below are used by HP when processing Vermont Medicaid claims. The fields designated by an asterisk (*) are mandatory; other fields are required when applicable. Only the fields listed below are used in the Vermont Medicaid Program; other fields do not need to be completed.

FIELD LOCATOR

1. UNLABELED FIELD*

2. UNLABELED FIELD

3a. PATIENT CONTROL #

3b. MEDICAL RECORD #

4. TYPE OF BILL*

6. STATEMENT COVERS PERIOD*

8a. PATIENT'S ID #*

8b. PATIENT'S NAME*

10. BIRTHDATE

12. ADMISSION DATE*

13. ADMISSION HOUR*

14. ADMISSION TYPE*

16. DISCHARGE HOUR

REQUIRED INFORMATION

Enter your Provider name and address as it appears on the Vermont Medicaid Provider Enrollment form.

Enter "Enhanced Residential Care".

For accounting purposes, enter the patient control # in the field locator. The number may consist of up to 24 characters, alpha/numeric. This information will appear on the Remittance Advice (RA).

Enter patient's medical record #.

Enter the code indicating the specific type of bill for Enhanced Residential Care. The sequence is as follows:

1. Type of facility

3- Home Health or E.R.C

2. Bill Classification

3-Home Health or E.R.C

3. Frequency

1-Admit through discharge claim

2-Interim-first claim

3-Interim-continuity claim

4-Interim-last claim

5-Late charge(s) only

Enter the beginning and ending service dates included on the bill.

Enter the patient's Vermont Medicaid ID #.

Enter the patient's last name, first name, middle initial.

Enter the date of birth

Enter date of admission

Enter the hour in which patient was admitted

Enter the code indicating the priority of the admission:

1-Emergency

2-Urgent

3-Elective

4-Nursery

Enter the hour in which patient was admitted.

17. STAT*

Enter the two digit code indicating the patient's status as of the 'through date' of the statement period.

- 01-Discharged to Home or Self Care
- 02-Discharged/Transferred to Another Short-Term General Hospital
- 03-Discharge/Transferred to Skilled Nursing Facility (SNF)
- 04-Discharged/Transferred to an Intermediate Care Facility (ICF)
- 05-Discharged/Transferred to another Type of Institution (e.g. Hospice, Rehab Facility)
- 06-Discharged/Transferred to Home Under Care of Organized Home Health Service Organization
- 07-Left Against Medical Advice
- 20-Expired
- 30-Still A Patient
- 40-Expired at Home (Hospice Only)
- 41-Expired in Hospital, SNF, ICF, or Free Standing Hospice (Hospice Only)

18-28. CONDITONS CODES*

Enter code to identify if condition is related to the following (*PSRO code is mandatory):

- 02-Condition is Employment Related
- A1-EPSDT Related Services
- A4-Family Planning Related Services

29. ACCIDENT STATE

31-34. OCCURRENCE CODE & DATE*

Enter one of the following two digit accident codes and the corresponding date when applicable or 52 if no other applies:

- 01-Auto Accident
- 02-Auto Accident/No Fault Insurance Involved
- 03-Accident/Tort Liability
- 04-Accident/Employment Related
- 05-Other Accident
- 06-Crime Victim
- 11-No Accident/Onset of Symptoms or Illness
- 42-Date of Discharge
- 50-Medical Emergency-Non-accidental
- 51-Outpatient Surgery Related
- 52-Not an Accident

39. VALUE CODES AMOUNT

Enter the number of covered days in the amount/dollar column. **Do not count the day**

	of discharge or the date of death. (The sum of all days should be equal to the amount of days being billed.)
42. REVENUE CODES*	Enter the appropriate revenue code for the service provided.
45. SERVICE DATE*	Enter the 'FROM' date of the span of consecutive service dates being billed.
46. SERVICE UNITS*	Enter the number of units which reimbursement is being requested.
47. TOTAL CHARGES*	Enter the total charges pertaining to each revenue code billed for the current billing period. Add the total charges for all revenue codes being billed and enter at the bottom of column 47 in the total field. (detail line 23)
50. PAYER NAME*	Enter "Medicare" or "Spend Down" (if spend down amount applies to the claim.) on 50a if Medicare is the primary payer. On 50b, enter the other insurance name if applicable. Enter "Vermont Medicaid" on 50c.
54. PRIOR PAYMENTS*	Enter the payment amount associated with the payer listed in field locator 50. Attach spend down Notice of Decision. Documentation must be attached if there was no payment, if the services are not covered by the third party.
55. ESTIMATED AMOUNT DUE	Enter the amount due after deducting any amount entered in field locator 54 from the total entered at the bottom of column 47.
56. NPI*	Enter the BILLING provider's NPI number.
57a. TAXONOMY CODE(S)	Enter the BILLING provider's Taxonomy Code when applicable.
57c. VERMONT MEDICAID ID #	Atypical providers, enter your Vermont Medicaid billing provider number.
67. PRINCIPAL DIAGNOSES CODE*	Enter the primary diagnosis code. Use the appropriate ICD-9-CM code.
67 a-q. OTHER DIAGNOSES CODES	Enter the appropriate ICD-9-CM codes for any condition other than primary, which requires supplementary treatment.
74. PRINCIPAL PROCEDURE CODE & DATE	Enter the appropriate ICD-9-CM procedure code and corresponding date.
74 a-e. OTHER PROCEDURE CODE & DATE	Enter the appropriate ICD-9-CM procedure codes and dates other than the principal procedure performed.

76. ATTENDING PHYSICIAN NPI*

Enter the individual Attending Physician's NPI number.

If billing with a Vermont Medicaid ID #, leave the NPI field blank and enter the Vermont Medicaid ID # to the right of the qualifier box.

80. REMARKS

Enter any notations relating specific information necessary to adjudicate the claim.

81CCa.

Enter the taxonomy code for the attending provider. Must correspond with the NPI number in field locator 76.

SECTION 5.1

CHOICES FOR CARE

NURSING FACILITIES BILLING INSTRUCTIONS

All information on the UB-04 claim form should be typed or legibly printed. The fields listed below are used by HP when processing Vermont Medicaid claims. The fields designated by an asterisk (*) are mandatory; other fields are required when applicable. Only the fields listed below are used in the Vermont Medicaid Program; other fields do not need to be completed.

FIELD LOCATORS

1. UNLABELED FIELD*

REQUIRED INFORMATION

Enter your Nursing Home name and address as it appears on the Vermont Medicaid Provider Enrollment form.

2. UNLABELED FIELD

Enter "Vermont Medicaid Nursing Home".

3a. PATIENT CONTROL #

For accounting purposes, enter the patient control # in the field locator. The number may consist of up to 24 characters, alpha/numeric. This information will appear on the Remittance Advise (RA).

3b. MEDICAL RECORD #

Enter patient's medical record #.

4. TYPE OF BILL*

Enter the code indicating the specific type of bill for Enhanced Residential Care. The sequence is as follows:

1. Type of facility

- 2-Skilled Nursing
- 6-Intermediate Care
- 8-Respite Special Facility

2. Bill Classification

- 1-Inpatient (Part A)
- 2-Hospital Based or Inpatient (Part B)

	(Included HHA visits under a Part B plan of treatment)
	5-Intermediate Care-Level I
	6-Intermediate Care-Level II
	7-Sub-Acute Inpatient (Revenue code 19X required)
	8-Swing Bed (used to indicate billing for SNF level of care in a hospital with an approved swing bed agreement).
	<u>3. Frequency</u>
	1-Admit through discharge claim
	2-Interim-first claim
	3-Interim-continuity claim
	4-Interim-last claim
	5-Late charge(s) only
6. STATEMENT COVERS PERIOD*	Enter the from and through service dates
8a. PATIENT'S ID #*	Enter the patient's Vermont Medicaid ID #.
8b. PATIENT'S NAME*	Enter the patient's last name, first name and middle initial.
10. BIRTHDATE	Enter the date of birth
12. ADMISSION DATE*	Enter date of admission
13. ADMISSION HOUR*	Enter the hour in which patient was admitted
14. SOURCE OF ADMISSION	Enter the appropriate source of admission
	1. Physician referral
	2. Clinic referral
	3. HMO referral
	4. Transfer from a Hospital
	5. Transfer from a Skilled Nursing Facility
	6. Transfer from another Health Care Facility
	7. Emergency Room
	8. Direction of the Court or Law Enforcement
	9. Information is not available.
	A. Transfer from a Critical Access Hospital
	B. Transfer from a Home Health Agency
16. DISCHARGE HOUR*	Enter the hour in which patient was discharged
17. STAT*	Enter the two digit code indicating the patient's status as of the 'through date' of the statement period.
	01- Discharged to Home or Self Care
	02-Discharged/Transferred to Another Short-Term General Hospital

	03-Discharge/Transferred to Skilled Nursing Facility (SNF)
	04-Discharged/Transferred to an Intermediate Care Facility (ICF)
	05-Discharged/Transferred to another Type of Institution (e.g. Hospice, Rehab Facility)
	06-Discharged/Transferred to Home Under Care of Organized Home Health Service Organization
	07-Left Against Medical Advice
	20-Expired
	30-Still A Patient
	40-Expired at Home (Hospice Only)
	41-Expired in Hospital, SNF, ICF, or Free Standing Hospice (Hospice Only)
18-28. CONDITONS CODES*	Enter code to identify if condition is related to the following (*PSRO code is mandatory):
	M1- Benefits Exhausted
	M2- Non Qualifying Stay
31-34. OCCURRENCE CODE & DATE*	Enter one of the following two digit accident codes and corresponding occurrence date if applicable or 52 if no other applies:
	01-Auto Accident
	02-Auto Accident/No Fault Insurance Involved
	03-Accident/Tort Liability
	04-Accident/Employment Related
	05-Other Accident
	06-Crime Victim
	11-No Accident/Onset of Symptoms or Illness
	42-Date of Discharge
	50-Medical Emergency-Non-accidental
	51-Outpatient Surgery Related
	52-Not an Accident
39. VALUE CODES AMOUNT*	Enter the number of covered days in the amount/dollar column. Do not count the day of discharge or the date of death. (The sum of all days should be equal to the amount of days being billed.)
42. REVENUE CODES*	Enter the appropriate revenue code for the service provided. Acceptable room revenue codes are as follows:

	0120= Room/Board/Semi-private, 2 beds 0128= Short-term stay/Rehab 0130= Room/Board/Semi-private, 3-4 beds 0182= Leave of Absence 0185= Hold Bed Days
45. SERVICE DATE*	Enter the appropriate start date of the revenue code being billed for this detail charge.
46. SERVICE UNITS*	Enter the number of days being billed for this detail charge for the room charge and units of service for any ancillary charges.
47. TOTAL CHARGES*	Enter the total charges pertaining to each revenue code billed for the current billing period. Add the total charges for all revenue codes being billed and enter at the bottom of column 47 in the total field. (detail line 23)
50. PAYER*	Enter "Patient Share" in 50a, "Medicare" on 50b (if Medicare is the primary payer after patient share.) If other third party, enter name of insurer in 50b. Enter "Vermont Medicaid" on 50c. As of DOS 10/01/05, claims do not need to list patient share. This field will be auto-populated.
54. PRIOR PAYMENTS*	Enter the payment amount associated with the payer listed in field locator 50.
55. ESTIMATED AMOUNT DUE	Enter the amount due after deducting any amount entered in field locator 54 from the total entered at the bottom of column 47.
56. NPI*	Enter the BILLING provider's NPI number.
57a. TAXONOMY CODE(S)	Enter the BILLING provider's Taxonomy Code when applicable.
57c. VERMONT MEDICAID ID #	Atypical providers, enter your Vermont Medicaid billing provider number.
67. PRINCIPAL DIAGNOSES CODE*	Enter the primary diagnosis code. Use the appropriate ICD-9-CM code.
67a-q. OTHER DIAGNOSES CODES	Enter the appropriate ICD-9-CM codes for any condition other than primary, which requires supplementary treatment.
69. ADMITTING DIAGNOSES CODE	Enter the admitting diagnosis code.
74. PRINCIPAL PROCEDURE CODE & DATE	Enter the appropriate ICD-9-CM procedure code and corresponding date.
74 a-e. OTHER PROCEDURE CODE & DATE	Enter the appropriate ICD-9-CM procedure codes and dates other than the principal procedure performed.

76. ATTENDING PHYSICIAN*

Enter the individual Attending Physician's NPI number.

If billing with a Vermont Medicaid ID #, leave the NPI field blank and enter the Vermont Medicaid ID # to the right of the qualifier box.

80. REMARKS

Enter any notations relating specific information necessary to adjudicate the claim.

81CCa.

Enter the taxonomy code for the attending provider. Must correspond with the NPI number in field locator 76.

AUTHORIZATION FOR CARE

Eligibility for long-term care is based on income available for care, admission/discharge status and the medical need for the long-term care.

The provider must complete the DVHA 280 or 281 form and submit the form to the local DCF office in order for the long-term care eligibility to be determined. The DCF district office will send the facility a copy of the notification that is also sent to the beneficiary.

Personal comfort items, such as the following, are not covered under the Vermont Medicaid program:

- Radio
- Television
- Telephone
- Air conditioner
- Beauty and barber services
- Deodorant
- Denture cream
- Hair brush

If the beneficiary requests any personal comfort items, the beneficiary must be advised that he or she will be charged. The facility may charge the beneficiary for store items secured for the beneficiary such as magazines, newspapers, candy, tobacco and dry cleaning.

BILLING/SUPPLYING PROVIDER

The billing/supplying NPI, provider name and address must appear in field locator 1 and the actual billing provider number to which payment will be made must appear in field locator 57c.

DURATION OF COVERAGE

A continuous period of long-term care residence begins in any long-term care facility with the most recent:

- Day of admission to the facility
- Initial date of Vermont Medicaid eligibility

-
- First day medical need for long-term care is established by the Utilization Review committee decision

Payment ends on the last day of eligibility, or the day before the day of discharge or death.

HOLD BEDS

A facility may bill for hold bed days when the following criteria are met:

1. While the patient is Medicaid eligible
2. When the patient has been a resident of the nursing home and has been admitted directly to a hospital
3. When the patient’s attending physician attests that the patient is expected to be readmitted to the nursing home in ten days or less or when the hospital’s discharge planning unit provides notice that the discharge will occur on a day within the 10-day time limit AND
4. When the facility has no other licensed bed available that is also suitable to the gender of the patient for whom the bed will be held.

(Example of item # 4: If the hospitalized patient is male and there is no other male beds available, a hold bed day can be billed even if one female bed is empty.)

Under hold bed restrictions, the Vermont Medicaid Program will not reimburse for the following:

- Leave of absences during a hold bed stay
- Hold bed days for beneficiaries with MR or MH admissions
- Hold bed days for swing bed facilities.

Payment for hold bed days, when a patient is hospitalized, is limited to six consecutive days.

A Discharge Notice (DVHA 280) must be completed if the beneficiary is unlikely to be able to return to the nursing home or, if during the ten days, the beneficiary’s condition changes such that he/she will not be able to return within the ten days. The date of discharge when a hospital admission is needed is the date of admission to the hospital. If the beneficiary’s condition changes the date of discharge is the day on which the determination was made or the tenth day.

To bill for a hold bed situation, enter the appropriate revenue code (0185) in field locator 42 (Revenue Code). The hold bed start date is entered in field locator 45 (Service Date) and the total number of days to be billed should be entered in field locator 46 (Service Units). Enter total at the bottom of column 47 in the totals field.

NOTE: If separate nonconsecutive services occur, the provider must enter a separate detail line with the appropriate revenue code for the service. For example:

<u>Rev. Code</u>	<u>Description</u>	<u>Start Date</u>	<u>Days/Units</u>	<u>Billed Amount</u>
120	Room/Board	02/01/07	15	\$1500.00
185	Hold Bed	02/16/07	3	\$ 300.00
120	Room/Board	02/19/07	10	\$1000.00

If you are billing for Hold Beds electronically, the information below is required in the claim note section.

Claims Note section:

The information in the notes segment must state: CERT FORM and the dates the facility was at maximum licensed occupancy. Electronic claims submitted without this information will be denied.

LEAVE OF ABSENCE

Leave days are counted by nights away from the facility for the purpose of a home visit. If a patient is gone the night of the 4th, both the start date and the end date would be the 4th. If the patient leaves the 4th and returns on the 6th, the start date would be the 4th and the end date would be the 5th. The patient is considered back at the facility to sleep the night of the 6th.

To bill for a leave of absence situation, enter the appropriate revenue code (0182) in field locator 42 (Revenue Code). The leave of absence start date is entered in field locator 45 (Service Date) and the total number of days to be billed should be entered in field locator 46 (Service Units). Enter total at the bottom of column 47 in the totals field. The maximum number of leave days is 24 per calendar year.

If separate non-consecutive services occur, the provider must enter a separate detail line with the appropriate revenue code for the service. For example:

<u>Rev. Code</u>	<u>Description</u>	<u>Start Date</u>	<u>Days/Units</u>	<u>Billed Amount</u>
120	Room/Board	02/01/07	15	\$1500.00
182	Leave of Absence	02/16/07	3	\$ 300.00
120	Room/Board	02/19/07	10	\$1000.00

MEDICARE AND VERMONT MEDICAID 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 coinsurance and deductibles for crossover claims.

PRIOR PAYMENTS

Providers are required to report all prior payments made on a claim. This includes Patient Share, Medicare and all Third Party payments are totaled together and recorded in field locator 54b.

RECIPIENT PLACEMENT LEVELS (RPL)

The following placement levels should be used for specific classifications of long-term care beneficiaries:

- 010-NH Highest Coverage
- 011-ERC Highest Coverage
- 012-HCBS Highest Coverage
- 014-NH Highest Special
- 015-ERC Highest Special
- 016-Cash& Counseling High
- 020-NH High Coverage
- 021-ERC High Coverage
- 022-HCBS High Coverage
- 026-Cash & Counseling
- 030-HCBS Mod Coverage
- 040-NH Highest Rehab

The RPL is determined by DAIL and entered into the Access system by DCF. This is based on the request of the long-term care facility. When the Long Term Care facility is requesting placement, they

must utilize the above list when applying for an authorized placement level. Placement level is not equal to the level of care of the Long Term Care facility and is not reported on the UB-04 claim form.

SERVICES INCLUDED IN PER DIEM RATE

The services included in the per diem rate for the long-term care facility are described in the Division of Rate Setting's reimbursement regulations. Please contact that division if you are in need of a copy of the regulations.

SHORT TERM STAYS

In an effort to better track accurate Medicaid expenditures associated with short and long-term stays, Vermont Medicaid admissions with anticipated stay of less than 100 days should be coded as short-term stays using revenue code 128.

SECTION 5.2

CHOICES FOR CARE - HOME BASED WAIVER (HBW)

BILLING INSTRUCTIONS

All information on the UB-04 claim form should be typed or legibly printed. The fields listed below are used by HP when processing Vermont Medicaid claims. The fields designated by an asterisk (*) are mandatory; other fields are required when applicable. Only the fields listed below are used in the Vermont Medicaid Program; other fields do not need to be completed.

FIELD LOCATORS

1. UNLABELED FIELD*
2. UNLABELED FIELD
- 3a. PATIENT CONTROL #
- 3b. MEDICAL RECORD #
4. TYPE OF BILL*

REQUIRED INFORMATION

Enter your Provider name and address as it appears on the Vermont Medicaid Provider Enrollment form.

Enter "Home Based Waiver".

For accounting purposes, enter the patient control # in the field locator. The number may consist of up to 24 characters, alpha/numeric. This information will appear on the Remittance Advice (RA).

Enter patient's medical record #.

Enter the code indicating the specific type of bill for Enhanced Residential Care. The sequence is as follows:

1. Type of facility

3-Home Health or H.B.W

2. Bill Classification

1-Hospice (Non-hospital based)

2-Hospice (Hospital based)

	3-Home Health or H.B.W 4-Ambulatory Surgical Center
	<u>3. Frequency</u> 1-Admit through discharge claim 2-Interim-first claim 3-Interim-continuity claim 4-Interim-last claim 5-Late charge(s) only
6. STATEMENT COVERS PERIOD*	Enter the from and through service dates
8a. PATIENT'S ID #*	Enter the patient's Vermont Medicaid ID #.
8b. PATIENT'S NAME*	Enter the patient's last name, first name and middle initial.
10. BIRTHDATE	Enter the date of birth
12. ADMISSION DATE*	Enter the date patient care started for Home Based Waiver.
13. ADMISSION HOUR*	Enter the hour in which patient was admitted
14. ADMISSION TYPE*	Enter the code indicating the priority of the admission: 1-Emergency 2-Urgent 3-Elective 4-Nursery
17. STAT*	Enter the two digit code indicating the patient's status as of the 'through date' of the statement period. 01-Discharged to Home or Self Care 02-Discharged/Transferred to Another Short Term General Hospital 03-Discharge/Transferred to Skilled Nursing Facility (SNF) 04-Discharged/Transferred to an Intermediate Care Facility (ICF) 05-Discharged/Transferred to another Type of Institution (e.g. Hospice, Rehab Facility) 06-Discharged/Transferred to Home Under Care of Organized Home Health Service Organization 07-Left Against Medical Advice 20-Expired 30-Still A Patient 40-Expired at Home (Hospice Only) 41-Expired in Hospital, SNF, ICF, or Free Standing Hospice (Hospice Only)

18-28. CONDITIONS CODES*

Enter code to identify if condition is related to the following (*PSRO code is mandatory):

02-Condition is Employment Related
A1-EPSDT Related Services
A4-Family Planning Related Services

31-34. OCCURRENCE CODE & DATE*

Enter one of the following two digit accident codes, and the corresponding occurrence date, if applicable or 52 if no other applies:

01-Auto Accident
02-Auto Accident/No Fault Insurance Involved
03-Accident/Tort Liability
04-Accident/Employment Related
05-Other Accident
06-Crime Victim
11-No Accident/Onset of Symptoms or Illness
42-Date of Discharge
50-Medical Emergency-Non-accidental
51-Outpatient Surgery Related
52-Not an Accident

39. VALUE CODES*

Enter the number of covered days. **Do not count the day of discharge or the date of death. (The sum of all days should be equal to the amount of days being billed.)**

42. REVENUE CODES*

Enter the appropriate revenue code for the service provided.

45. SERVICE. DATE*

Enter the 'FROM' date of the span of consecutive service dates being billed.

46. SERVICE. UNITS*

Enter the number of units which reimbursement is being requested.

47. TOTAL CHARGES*

Enter the total charges pertaining to each revenue code billed for the current billing period. Add the total charges for all revenue codes being billed and enter at the bottom of column 47 in the total field. (detail line 23)

50. PAYER NAME*

Enter "Patient Liability" in 50a, "Medicare" on 50b (if Medicare is the primary payer after Patient Share). If other third party, enter name of insurer in 50b. Enter "Vermont Medicaid" on 50c. As of DOS 10/01/05, Claims do not need to list patient share. This field will be auto-populated.

54. PRIOR PAYMENTS*

Enter the payment amount associated with the payer listed in field locator 50. Attach

	spend down Notice of Decision. Documentation must be attached if there was no payment, if the services are not covered by the third party.
55. ESTIMATED AMOUNT DUE	Enter the amount due after deducting any amount entered in field locator 54 from the total entered at the bottom of column 47.
56. NPI*	Enter the BILLING provider's NPI number.
57a. TAXONOMY CODE(S)	Enter the BILLING provider's Taxonomy Code when applicable.
57c. VERMONT MEDICAID ID #	Atypical providers, enter your Vermont Medicaid billing provider number.
67. PRINCIPAL DIAGNOSES CODE*	Enter the primary diagnosis code. Use the appropriate ICD-9-CM code.
67a-q. OTHER DIAGNOSES CODES	Enter the appropriate ICD-9-CM codes for any condition other than primary, which requires supplementary treatment.
69. ADMITTING DIAGNOSES CODE*	Enter the Admitting Diagnoses Code
74. PRINCIPAL PROCEDURE	Enter the appropriate ICD-9-CM procedure code and corresponding date.
74a-e. OTHER PROCEDURE	Enter the appropriate ICD-9-CM procedure codes and dates other than the principal procedure performed.
76. ATTENDING PHYSICIAN*	Enter the individual Attending Physician's NPI number. If billing with a Vermont Medicaid ID #, leave the NPI field blank and enter the Vermont Medicaid ID # to the right of the qualifier box.
80. REMARKS	Enter any notations relating specific information necessary to adjudicate the claim.
81CCa.	Enter the taxonomy code for the attending provider. Must correspond with the NPI number in field locator 76.

DETAILED SUMMARY OF UPDATES 09/1/2010

*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

FIELD LOCATOR – All Billing Instructions (pages 17,21,28,32,37,41,45,52)

8a. PATIENT'S ID #* Enter patient's Vermont Medicaid ID #.

Added: **asterisks**(Field Locator 8a. is now required for all billing.)

MEDICARE CROSSOVER CLAIMS (page 11)

A Vermont Medicaid recipient may be eligible for both Medicaid and Medicare. When dual eligibility exists, Medicare must be billed first. Vermont Medicaid is the payer of last resort. Vermont Medicaid will pay co-insurance and deductible, minus any applicable co-payment amounts on institutional crossovers.

Hospitals: For in-state and border hospitals, claims submitted to the Medicare carrier will crossover automatically to Vermont Medicaid for payment. Medicaid eligibility information must be clearly indicated on the Medicare claim submitted. If you do not receive Medicaid payment within 30 days of the Medicare payment date, or if you are an out-of-state (except New Hampshire) who has billed and received payment from your regional Medicare carrier for services to Vermont residents who are eligible for both Medicare and Vermont Medicaid, submit the crossover claim to HP as follows:

- **Send an electronic Medicare Crossover Claim or Send a copy of the Medicaid claim with a copy of the Medicare summary form.**
- Supplemental insurance payments should be entered in field locator 54.
- If a copy of the Medicare claim is not available, you may complete a UB-04 claim form and attach a copy of the Medicare summary form, or attach documentation that Medicare does not cover the service to a claim filled out following Vermont Medicaid rules.
- The Medicare payment date must appear on the Medicare summary form.

When a service is denied by Medicare and is covered by Vermont Medicaid, submit a Medicaid claim completed to Vermont Medicaid specifications within the following guidelines:

- **To submit third party liability denials electronically, see the Provider Manual section 1.3.12 Third Party Liability (TPL)/Other Insurance (OI)**
- Attach the remittance document from Medicare or a copy of the blanket denial showing that Medicare does not cover the service
- Send to HP within two years of the date of service on the Medicare summary form.

Added: red text

07/28/2010

Replaced: The Office of Vermont Health Access (OVHA) with the **Department of Vermont Health Access (DVHA)**, throughout supplement.

Green Mountain Care
UB04

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9/1/2010

SECTION 2.1

HOME HEALTH AGENCY SERVICES-GENERAL BILLING INSTRUCTIONS (page 28)

- 13. ADMISSION HOUR* Enter the hour in which patient was admitted
- 14. ADMISSION TYPE* Enter the code indicating the priority of the admission:
 - 1-Emergency
 - 2-Urgent
 - 3-Elective
 - 4-Nursery

Removed: asterisk from Field Locator 13 & 14. These fields are not required.

05/6/2010

PRESENT ON ADMISSION (POA) - Inpatient Admissions (page 13)

Effective May 16, 2010 the present on admission indicator (POA) will be required for all inpatient admissions. Vermont Medicaid will follow Medicare's guidelines. The indicator options are: Y (diagnosis was present at time of the admission), N (diagnosis was not present at time of admission) U (documentation was insufficient to determine if present at time of admission), W (clinically undetermined), 1 (exempt from POA reporting). The POA indicator is the eighth digit and is required on all diagnoses codes listed on the UB 04 (principal field 67 and secondary field 67 A through Q). This is not required for the admit diagnosis (69). For electronic claims using the 837 institutional, submit the POA indicator in segment K3 in the 2300 loop, data element K301. POA is always required first, followed by the principal diagnosis. The last secondary diagnosis indicator is followed by the letter Z to indicate the end of the data element. e.g.: POAYNUW1YZ

Added: section

HOSPITAL INPATIENT BILLING – FIELD LOCATOR (page 22)

- 67. PRINCIPAL DIAGNOSES CODE* Enter the primary diagnosis code. Use the appropriate ICD-9-CM code.
POA*(see page 13 for billing instructions)
- 67 a-q. OTHER DIAGNOSES CODES Enter the appropriate ICD-9-CM codes for any condition other than primary, which requires supplementary treatment
POA*(see page 13 for billing instructions)

Added: red text

05/3/2010

MEDICARE CROSSOVER CLAIMS (page 10)

If you do not receive Medicaid payment within six weeks of the Medicare payment date, or if you are an out-of-state (except New Hampshire) who has billed and received payment from your regional Medicare carrier for

services to Vermont residents who are eligible for both Medicare and Vermont Medicaid, submit the crossover claim to HP as follows.

Replaced: six weeks with 30 days

Replaced: EOMB with summary form

HOSPITAL OUTPATIENT BILLING - FIELD LOCATOR (page 21)

17. DISCHARGE STATUS* Enter the appropriate discharge code

Added: new field locator & description

FIELD LOCATOR 18-28. CONDITONS CODES* (page 17, 20, 28 & 32)

Deleted: A3-Ladies First

INTERPRETER SERVICES (page 24)

Vermont Medicaid providers paying interpreter services for a beneficiary (who does not speak the same language as the provider or for sign language for an hearing impaired beneficiary), in person or over the phone, may bill using revenue code 940 with procedure code T1013 for every 15 minutes of service provided.

Added: section

03/2010

CHOICES FOR CARE (moved from page 8 to page 5)

Added:

4. **Enhanced Residential Care services** include: personal care, Meal Preparation, Medication Management, Nursing Overview, Activities, 24-hour Supervision, Laundry/Housekeeping.
5. **Long Term Care services** include: Personal Care, Meals/Nutritional Services, 24-hour Skilled Nursing, Rehab & Therapy, Activities, 24-hour Supervision, Social Services, and Laundry/Housekeeping.
6. **Home Based Waiver services** include: Case Management, Personal Care, Respite or Companion Care, Adult Day Services, Personal Emergency Response Systems.

ASSISTIVE COMMUNITY CARE SERVICES (page 5)

Added: Reimbursable services include: Case Management, Personal Care Services, Nursing Assessment & Routine Tasks, Medication Assistance, on-site Assistive Therapy and Restorative Nursing.

Deleted: All providers are reminded that billing may not be done in advance of any service to be performed or supplied.

ABORTIONS (page 5)

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

3. Vermont Medicaid

Added: These abortion services will be billed to HP for all beneficiaries.

Deleted: These abortion services will be billed to HP for all Beneficiaries with the exception that inpatient services for VHA_-Limited beneficiaries will not be reimbursed.

Deleted: Payment for abortions performed when the mother's life is in danger or when the pregnancy is a result of incest or rape will continue to be made by EDS and reported on the RA.

4. State Funds

Added: Abortions considered medically necessary are billable to HP upon completion of a Physician Certification Form OVHA 219B, but are paid by the Department for Children and Families (DCF) funding.

Deleted: Abortions considered medically necessary are billable to EDS with the completion of physician certification form OVHA 219B. Physicians who have billed for a "medically necessary" abortion will not find that claim on the Remittance Advice (RA). "Medically necessary abortions must be paid using state dollars only. This means that the payment for a "medically necessary abortion will be paid by a State check and will not be included on the RA with your other Medicaid claims.

CHOICES FOR CARE: (page 8)

ENHANCED RESIDENTIAL CARE

LONG TERM CARE

HOME BASED WAIVER

Deleted: All providers are reminded that billing may not be done in advance of any service to be performed or supplied. Payment may be considered for the following Long-Term Care rendered to an eligible Vermont Medicaid beneficiary:

- Services provided in a non-Medicare Facility
- Services provided in a Medicare Participating Facility

Moved CHOICES FOR CARE to page 5

INPATIENT/OUTPATIENT OVERLAP EXAMPLES (page 8)

Deleted: (3rd paragraph): your inpatient admission date will become the date that the patient was admitted as an outpatient.

SECTION 1.1

HOSPITAL INPATIENT BILLING INSTRUCTIONS

Added: FIELD LOCATOR 21. STAT* Code 21–Discharge/Transferred to Court/Law Enforcement (page 17)

RESPITE BILLING (page 24)

Only provider types of Aged/Disabled Waiver, with Waiver indicated as provider specialty, may bill for respite care. Providers billing for respite must select a type of bill from the following:

Page change: Topic was on page14, moved to page 24 under Home Health

INTERIM CLAIMS; INTERIM INPATIENT CLAIMS (page 10)

Inpatient acute care hospitals that have a long term patient may bill interim claims in at least 60-days intervals. Subsequent bills must be in the **electronic** adjustment bill format. Each bill must include all applicable diagnoses and procedures. Indicate in the note field: long term inpatient stay greater than 60 days.

Providers are instructed to bill as follows:

1. Type of bill 112 – interim bill-first claim, patient status 30 – still a patient.
2. Type of bill for subsequent claims will be 117 - **electronic** replacement claim. Patient status will be either patient status 30, or a discharged patient status code.

Also See Subacute Care.

Added topic

SAME-DAY STAYS (page 14)

One day stays are defined as patients who are admitted and discharged from the same acute care facility on the same calendar day.

- Example: Patient is admitted 5:00am on 12/4/07 and released 11:30pm on 12/4/07. This is a same-day stay.
- Example: Patient is admitted at 10:00pm on 12/4/07 and released at 7:00am on 12/5/07. This is not a same day stay.

These claims will be paid the lesser of the cost of the case or the DRG payment.

Added topic

TRANSFER CASES (page 15)

Transfer cases are defined as patients who initiate an inpatient stay in one hospital and are discharged/admitted from one acute care facility to another in the same day.

- The receiving hospital will be paid under normal DRG payment logic.
- The transferring hospital will be paid the lesser of the cost of the case or the DRG payment (including any eligible outlier payment).

Added topic

NDC (NATIONAL DRUG CODE) (page 11 & 21)

NDC indicator N4 identifies NDC (page 11)

FIELD LOCATOR

43. NDC CODE* (page 21)

Enter the NDC code of the drug that was dispensed. Use a "N4" indicator preceding the NDC to identify the information in FL 43 as an NDC.

Added red text

HOSPITAL INPATIENT BILLING INSTRUCTIONS (page 17)

Field Locator - 4.Type of Bill 3. Frequency: **removed**: 5 - late charges; this code is to be used only when submitting charges that were not included on a previously filed claim.

FIELD LOCATOR 47 – ALL BILLING INSTRUCTIONS (pages 19, 21, 29, 32, 38 42, 46, & 52)

47. TOTAL CHARGES*

Enter the total charges pertaining to each revenue code billed for the current billing period. Add the total charges for all revenue codes being billed and enter at the bottom of column 47 in the total field. (detail line 23)

(09/01/2009)

RESPITE BILLING (Page 14)

Only provider types of Aged/Disabled Waiver, with Waiver indicated as provider specialty, may bill for respite care. Providers billing for respite must select a type of bill from the following:

1. Type of Facility

8-Hospice or Special Facility

2. Bill Classification

6-Respite

3. Frequency

1-Admit through discharge claim

2-Interim-first claim

3-Interim-continuity claim

4-Interim-last claim

For additional information, please refer to: <http://ddas.vermont.gov/ddas-policies/policies-cfc/policies-cfc-highest/policies-cfc-highest-manual>.

Added Topic

(06/10/2009)

ABORTIONS (Page 6)

2. State Funds

Abortions considered medically necessary are billable to HP with the completion of the physician certification form OVHA 219B...

***Deleted:** ...are billable to HP and paid by the Administrative Services (OVHA, 103 South Main Street, Waterbury, VT 05671) with the completion of physician certification form PATH 219B)*

INPATIENT CLAIMS; NO MEDICARE PART A-HAS MEDICARE B COVERAGE (Page 10)

3. Submit your claim and all attachments to your Vermont Medicaid Provider Representative. (See www.vtmedicaid.com under Information/Provider Representative Map).

***Deleted:** 3. Write on EOB "No Medicare A". The charges will not match, only billing ancillaries to Medicare B which will crossover to Vermont Medicaid. Sign and date the EOMB.*

PRIOR AUTHORIZATION (Page 14)

Prior authorization is required for certain surgical procedures. See the Prior Authorization Supplement for instructions on obtaining prior authorization for these services. For a complete list of codes that require PA, see the fee schedule at: www.vtmedicaid.com under Downloads/Manuals. The Pre-Admission Request Form and the Pre-Procedure Request Form are available for download at www.vtmedicaid.com under Downloads/Forms.

REVENUE CODE AND DATE SPAN BILLING (Page 36)

ACCS providers must bill revenue code 0098 assigned by the Department of Aging and Disabilities in field locator 42...

***Deleted:** ACCS providers must bill revenue code 0098 by the Department of Disabilities, Aging and Independent Living...*