

2005 Banner Pages

JANUARY 21, 2005

Enhanced Security for VRS

HIPAA legislation requires additional security enhancements for the Vermont Voice Response System (Malcolm). In the near future, a user accessing the system will be required to enter a four digit PIN in addition to the provider number currently required. This new feature further safeguards the privacy of users by granting system access only to those with valid PIN/provider number combinations.

Creating your PIN is a simple process. When the new system is in place you will only have to call the VRS at 800-925-1706 and follow the prompts that will direct you through the necessary steps. You can change your PIN at anytime but you will be required to change it every ninety days. The VRS system will remind you when it is time to change your number and direct you through that process.

We are pleased to offer this security enhancement. You will be notified when this system is active and you can create your PIN. We strongly encourage you to review the VRS/PIN information that is posted on our website vtmedicaid.com. Additional questions can be directed to Provider Services at 878-7871.

Change of Authorization Procedures for Providers of PT/OT/ST Services

Effective February 1, 2005 Medicaid will require pre-authorization of all therapy services on or before the date of initial service. This authorization will cover 30 visits during the calendar year.

You will soon receive a packet containing detailed information on these changes in addition to the new Therapy Extension Form.

You can also view these documents and download the new form by visiting our website at: vtmedicaid.com.

JANUARY 28, 2005

PT/OT/ST Changes Postponed

Due to unforeseen circumstances, the recently announced Physical, Occupational, and Speech Therapy changes effective February 1, 2005 have been postponed indefinitely. Please disregard the information packet recently mailed to you. We apologize for this inconvenience.

Banner Pages are now On-Line!

You can now read banner pages on-line by visiting our website: vtmedicaid.com. Weekly banner pages will be posted each Friday afternoon under the "What's New" section. They will continue to appear on the weekly Remittance Advices.

We have also posted an indexed archive of all 2004 banner pages.

We continue to develop our website as a useful resource and an effective means of communicating rapidly to the on-line provider community. We encourage providers to visit our website at least once a week for announcements and newly posted resources.

FEBRUARY 11, 2005

Other Insurance On Detail Level Of Electronically Submitted Claims

Effective May 1, 2005, all electronically submitted claims will need to report the amount of other insurance at the detail level.

This system enhancement requires all Providers to bill each detail of the claim to the other insurance before submitting the claim to EDS and to then reflect the detail reimbursement from the other insurance at the detail level of the claim being sent to EDS. Providers can no longer total and report other insurance charges on the header level of the claim.

Please be aware that this may require some Providers to make minor changes to their billing systems.

Providers should continue to submit other insurance denials to us on paper with the attached EOB which explains the denial.

The benefit of this upgrade for Providers billing electronically will be faster and more accurate payments.

The effective date of this change is May 1, 2005 but you can switch to detail billing of other insurance today. After May 1, 2005 claims will be denied if other insurance charges are not reported on the detail level.

FEBRUARY 25, 2005

Important Update on POS Swipe Boxes

As previously announced, the Point of Service Omni terminal devices (POS Swipe Boxes) used by some providers to verify Vermont Medicaid eligibility are not HIPAA-compliant. New POS devices, installed with upgraded software, are now available for processing HIPAA-compliant transactions in accordance with Federal mandates.

The old, non-HIPAA compliant POS boxes will be disabled effective close of business on **April 1st, 2005**. They are obsolete and should be disposed of. Please do **not** return them to OVHA or EDS.

Providers who have already placed orders for new swipe boxes will be contacted by separate letter regarding receipt and set-up of the new boxes. Providers were told of these upgrades and given the opportunity to order new boxes in a letter sent in May 2004 and in the October 2004 Vermont Health Access Advisory. You can read these prior notifications regarding POS upgrades on our website: www.vtmedicaid.com under the "Information" section.

Please be aware that there are alternative methods of checking eligibility.

- The Voice Response System (VRS or Malcolm) can be used by calling 1-800-925-1706 (in Vermont only) or (802) 878-7871.
- A growing number of providers use our website: www.vtmedicaid.com to check eligibility in addition to accessing other resources that facilitate their billing process.

If you have not already ordered a replacement box and would like to do so, please fill out and mail the Omni 3740 Terminal Device order form available on-line at: www.vtmedicaid.com or by calling EDS Provider Services at (802) 878-7871 or 1-800-925-1706 (in Vermont only).

The POS swipe boxes are manufactured by Verifone and must be ordered by Vermont Medicaid in lots of 100. An order can not be sent to Verifone until 100 orders have been received from providers. Please be aware that due to this ordering requirement, there may be a delay in placing your order and shipping your device.

MARCH 11, 2005

Prior Authorization Changes for ICD-9 Codes 2188 and 215

Effective immediately, ICD-9 Surgical Codes 2188 and 215 no longer require prior authorization.

92015 (Refraction) and E & M Codes for VHAP RX Recipients

Medicaid will only reimburse providers for an E & M service provided to VHAP RX recipients when a refraction is done on the same date of service. To avoid denials, providers must bill both codes on the same claim unless the refraction was previously paid.

MARCH 18, 2005

Prescribing Maintenance Drugs

Maintenance drugs can be prescribed for all Vermont Health Access programs for up to 90 days. Maintenance drugs are those medications used for the treatment of chronic conditions and commonly prescribed for periods of 30 days or more. Programs include Medicaid, the Vermont Health Access Plan (VHAP), VHAP Pharmacy, VScript, VScript Expanded, and the Healthy Vermonters Program.

Prescribing for 90 days reduces the number of prescription refills you need to write and reduces the number of trips your Vermont Health Access patients need to make to the pharmacy.

Please consider a 90 day prescription when a patient is using a maintenance drug that has been successful in the treatment of his/her condition.

Medical Necessity Forms (MNF) for DME

Previously the OVHA had required that completed MNFs accompany the claim when billing for certain DME codes. DME providers are reminded that they no longer need to submit MNFs with any DME claims, whether billing on paper or electronically. The OVHA does require that completed MNFs for all DME claims be kept on file in the patient record.

APRIL 1, 2005

Ambien

Ambien is not currently being manufactured by The Pharmacia Corporation (00025) as reported in our February 2005 mailing. Therefore, this product is not currently covered for VScript Expanded Eligibles.

Occupancy Certification Form Update

Effective May 1, 2005 Nursing Home providers billing electronically will no longer need to mail the Occupancy Certification form for patients in a hold bed situation. However, the information must be included in the electronic claim in the BILLING NOTE segment of the 2300 Loop of the 837 transaction.

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

Providers using EDS' Provider Electronic Solutions Software, the note must be entered in the Claim Note field found on the HDR 4 tab.

The Occupancy Certification form must be retained in the patient's file.

Provider Electronic Solutions (PES) Upgrade

A new version of PES is now available on the web. You can upgrade your current version of PES or complete the full installation of PES 2.15 by going to www.vtmedicaid.com; Downloads; Software.

Included in the PES 2.15 release are the following system enhancements:

- A patch that enables the printing of the Home Health detail report.
- The addition of Service Facility and Date of Admission fields to the Dental claim form. These fields are required if the dental service "was rendered in Inpatient Hospital, Outpatient Hospital, Skilled Nursing Facility or Adult Living Care Facility."
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APRIL 8, 2005

New Mailing Address for the OVHA Effective May 1, 2005

The Office of Vermont Health Access
312 Hurricane Lane, Ste. 201, Williston, VT 05495

How to Bill A Multiple Page Paper Claim

When billing a multiple page claim you must indicate the appropriate page number (i.e. page 1 of 3, 2 of 3) in Box 19, "Reserved for Local Use" of the HCFA claim form, in Box 84 "Remarks" of the UB-92 claim form, or in Box 38 "Remarks or Unusual Services" of the Dental claim form. Each claim form must include the required patient information (patient name, social security number, diagnosis, etc). To indicate the conclusion of the entire claim, the last page must include the total billed amount and an authorized signature. On the HCFA claim form the signature will go in Box 31, on the UB-92 the signature will go in Box 84, or Box 29 on the Dental claim form.

APRIL 29, 2005

Premiums Update

Beginning April 28, 2005 new beneficiaries who are subject to a premium cannot receive coverage until the month after the state receives and processes the premium payment. For some VHAP and Dr. Dynasaur cases, coverage may also be made retroactive after the premium is paid and processed. Providers are reminded that they must always check eligibility with EDS. They can do so through our website or VRS. Letters of eligibility or other documents which a recipient may show to a provider are not considered verification of eligibility and coverage. You may encourage your patients to call Health Access Member Services if they have questions. For your information, approximately 40,000 out of 145,000 beneficiaries are currently subject to a premium.

2002 ADA Dental Claim Form

Providers may now use the 2002 ADA form for submission of dental claims. Instructions for filling out this claim form are posted on the web at: www.vtmedicaid.com. Providers who do not have access to the web may call Provider Services at (802) 878-7871 or 1-800-925-1706 (in Vermont only) for a copy of the instructions.

Discontinuation of Modifiers QK02-04

Effective July 1, 2005 providers can no longer use modifier combinations QK02, QK03, and QK04. These modifiers are not HIPAA compliant and will be permanently discontinued. There are no replacement modifiers.

MAY 13, 2005

Hearing Aid Repairs

Hearing aid repairs (V5014) are limited to one repair or modification per hearing aid per year. Prior authorization is needed only when a second or subsequent repair or modification is being requested within 365 days of a previous repair or modification.

Ostomy Pouches

Effective 07/01/05, Ostomy pouches [urinary & intestinal] and barriers will be limited to 12 per calendar month instead of the current allowable of 30 per month. This change is based on current best practice and is in agreement with standards set by the United Ostomy Association and other insurers. Best practice guidelines suggest that pouches be changed no more frequently than every 4-7 days. As always, requests for more than 12 per month will be considered via the prior authorization process. Provider comments may be submitted to the OVHA Program Integrity Unit, 312 Hurricane Lane, Williston, VT 05495 or may be faxed to: 802-879-5963.

MAY 20, 2005

Anesthesia Assistants

Providers may now enroll Anesthesia Assistants. Enrollment may begin but claims can not be processed until the necessary system changes have been completed. Please wait to review our billing instructions before submitting claims. Billing instructions will be mailed directly to providers and posted on-line at www.vtmedicaid.com

Provider Services Closed May 24, 2005

Please be aware that EDS Provider Services will be closed for in-service training on Tuesday, May 24, 2005. If your call is urgent, please leave a message so a Provider Services representative can contact you. Phone messages will be checked periodically throughout the day.

MAY 27, 2005

Clarification of the New OVHA Mailing Address

All mail previously sent to the OVHA at: 103 South Main, Waterbury, VT

should now be sent to: OVHA, 312 Hurricane Lane, Suite 201, Williston, VT, 05495

The address for EDS **has not changed**. Paper claims and inquiries should be submitted to: EDS, PO Box 888, Williston, VT, 05495

JUNE 3, 2005

Final Termination of POS Swipe Boxes

The old, non-HIPAA compliant POS boxes will be disabled effective close of business on **June 1st, 2005**. They are obsolete and should be disposed of. Please do **not** return them to OVHA or EDS.

CPT Code 91110

Please be aware that CPT code 91110 (capsule endoscopy) is to be used instead of 91299. Capsule endoscopy now requires Prior Authorization.

CPT Code 64580

Please be aware that CPT Code 64580 (incision for implantation of neurostimulator electrodes) now requires prior authorization.

Electronic Funds Transfer

The Howard Bank has notified EDS that Citizens Bank has purchased the Charter One Bank. If you normally receive direct deposit to the Charter One Bank, a paper check is included with your remittance advice today. Citizens Bank has requested that EDS change the routing number. After verification that the correct bank information is on your file you will receive direct deposit. No action is required by the providers at this time.

JUNE 17, 2005

HMO Co-Pays & T1015 (non RHC & FOHC)

T1015 (CLINIC VISIT/ENCOUNTER ALL-INCLUSIVE) can only be used to bill Vermont Medicaid for the co-payment required by another primary insurer when that visit was included in a capitation agreement with the primary insurer.

Benefit Limits for Routine Eye Exams

Vermont Medicaid covers Routine Eye Exams once every two years. The benefit limit for eye exams is based on the number of refractions (92015) done. The service limit is one refraction every two years unless there is reason to believe that a half-diopter change has taken place. In these cases an interim refraction/eye exam can be billed but the provider must note in form locator 19 half-diopter change.

When Calling Provider Services

When calling EDS Provider Services please have the following information in hand:

Provider #

Recipient ID #

Date of Service

Procedure Code

Providing this information at the beginning of your call will facilitate the resolution of your particular issue.

Modifiers SL & 52

Effective Date of Service 1/1/2005, SL modifier is to be billed when identifying a State supplied vaccine. In the past, providers were told to use modifier 52 for State supplied vaccines but HIPAA requirements and the need to be consistent with other payors has forced the termination of that practice.

SL modifier is for informational purposes only and will pay \$0.00 regardless of the detail billed amount.

As a result of implementing SL modifier, the OVHA has now implemented the use of Modifier 52 as a reduced services modifier. Effective immediately, you must append Modifier 52 when reduced services are performed. Please attach appropriate documentation.

JULY 1, 2005

Problem Identified with Anthem Crossover Data

Please be aware that we have identified a problem with the files provided by Anthem between early April and early June. Some providers will find that they did not receive any or all Medicare crossover payment from EDS during that period.

If your RA does not reflect all crossover payment for that period please resubmit those claims electronically or on paper. We encourage you to submit electronically for faster payment.

We apologize for any inconvenience this may have caused and thank you for your patience.

Webpage Downtime

PES interactive transactions and POS device box services will be unavailable on Sunday, July 24, 2005 from 12:00 AM to 3:00 AM (EST) while the Vermont Medicaid web portal undergoes system upgrades.

JULY 8, 2005

Dispensing Fee Notification

The OVHA recently sent out a notice to all pharmacy providers detailing the changes in the dispensing fee effective July 1. Please refer to that notice for the details of the fee changes.

Base Rate for CPT Codes

Effective July 1, 2005, the base rate for many CPT codes was reduced to carry out the budget mandate for State fiscal year 2006. The E&M codes received a smaller reduction than other codes used less frequently by primary care providers. The revised fee schedule will be posted on the VTMEDICAID.COM web site no later than July 29, 2005. A more detailed description of the changes made will be covered in our next Advisory.

FQHC/RHC and Interpreter Services

Please be aware that when an FQHC/RHC bills for Interpreter Services using procedure code T1013 they must bill using the NON-FQHC/RHC provider number.

Clarification of Negotiated Discount Notification

On June 20th, 2005 the OVHA mailed a letter regarding negotiated discounts that providers have with other carriers. This letter was meant as a proposal; the OVHA is NOT expecting to have claims submitted in this manner at this time. A decision will be announced prior to August 1st, 2005 with the exact billing instructions for submitting these claims.

Changes to Billing Patient Share on Waiver Claims Submitted Electronically

Effective May 1, 2005, all electronically submitted Waiver claims will need to report the patient share amount at the detail level.

If you are using the PES software, you will need to change the "Service Adjustment Ind" found on the SVR screen to "Y" and indicate the patient share amount on SVR ADJ screen. If there are multiple details to the claim, apply the patient share line by line until it is totally deducted.

Claims submitted with the patient share reported at the header will be auto denied.

MAB Consumer Recruitment

The Vermont Medicaid Advisory Board (MAB) currently has three consumer openings that are to be filled by August, 2005. Please visit the OVHA website at: <http://www.ovha.state.vt.us/> to access additional information and to download the MAB Consumer Application. If providers have any questions about these consumer openings, please contact Stephanie Beck at: StephanB@ahs.state.vt.us

JULY 29, 2005

Medicare Crossover & EOB 1015

Some Medicare crossover drug claims for VHAP Pharmacy beneficiaries continue to deny with EOB 1015 – [THIS IS A NON-COVERED SERVICE FOR VHAPRX BENEFICIARY]. If you receive this denial on your remittance advice and your claim is for a prescription drug please submit the claim and Medicare EOMB to the attention of EDS Provider Services Manager, for review and processing. We apologize for any inconvenience this may cause.

SL Modifier & Immunization Codes

It has come to our attention that the SL modifier was not added to the immunization codes, to indicate state supplied vaccine. We have updated our system. Claims originally submitted on paper will be reprocessed by EDS. Please re-submit any claims originally submitted electronically. We apologize for this inconvenience this may have caused and appreciate your patience in this matter.

Modifier 57

Modifier 57 - 'Decision for Surgery' is now recognized by Vermont Medicaid as a valid modifier for use with Evaluation and Management codes. It will have a retroactive effective date of January 1, 2003. Modifier 57 is commonly used to identify the decision for "major" surgery (90 day post-op) when the decision is made within 24 hours of surgery and results in immediate surgery or surgery within the following 24 hours.

Modifier 57 & ClaimCheck®

When used appropriately, Modifier 57 will override the *ClaimCheck*® pre-operative edit, therefore documentation is not required with submission when Modifier 57 is used. Effective with processing date August 15, 2005, Modifier 57 must be appended to a claim as appropriate or the pre-operative detail of that claim will be denied. Providers are encouraged to bill these services electronically for faster adjudication and payment.

AUGUST 5, 2005

PSU Closed

EDS and the OVHA will be closed on August 16, 2005, Bennington Battle Day.

Modifier 25

Claims submitted with two Evaluation and Management codes on the same date of service for the same recipient and using Modifier 25 must have documentation attached. This is required for correct adjudication and payment. Failure to attach documentation will result in denial.

Prior Authorization

Effective September 1, 2005 procedure codes A4649 (Surgical Supply Misc.), E0637 (Combination sit to stand system, any size, with seat lift feature, with or without wheels), and E0638 (Standing frame system, any size, with or without wheels), require Prior Authorization.

For a complete list of codes that require Prior Authorization see: www.vtmedicaid.com under Information.

AUGUST 12, 2005

Website Printout of Other Insurance Reminder

This is a reminder that EDS accepts a printout from other insurance websites to update a recipient's other insurance. The printout must include the recipient's name, Medicaid ID/SSN, the effective and termination dates, the type of coverage (i.e. dental, medical, vision, etc.) and the policy number(s).

Calling Customer Service

When referring a Vermont Medicaid beneficiary to their customer service representative, the beneficiary must call Maximus at (800) 250-8427.

Providers may contact EDS for assistance by calling (800) 925-1706 or (802) 878-7871.

AUGUST 19, 2005

Dental Co-Pay Deductions

EDS has identified a problem with co-pays failing to be deducted from some electronically submitted dental claims. EDS is correcting the problem and will adjust all affected claims. Providers do not need to take action due to this problem.

SEPTEMBER 2, 2005

Negotiated Discounts Update

In a mailing distributed last June, Vermont Medicaid asked for comments on a proposed change in payment policy for negotiated discounts. We received good feedback. It is now clear that the issue is more complicated than originally anticipated. Therefore no change will be made at this time.

We will continue to follow current policy. Providers were last notified of our policy by the following guidelines that were issued on April 16, 2004:

"To report contractual allowance amounts, note the contractual allowance and any amount paid by the primary carrier(s) in the other insurance field of your claim form, just as you do with any insurance carrier.

We understand that some electronic systems may need revisions to accommodate this change."

Rural Health Providers and Other Insurance

All electronically submitted claims need to report the amount of other insurance at the detail level. Rural Health providers must enter the other insurance amount on the encounter procedure code detail line.

Please be aware that this may require minor changes to your billing systems.

Providers should continue to submit other insurance denials to us on paper with the attached EOB which explains the denial.

The benefit of this upgrade for Providers billing electronically will be faster and more accurate payments.

90846 Family Medical Psychotherapy Without the Patient Present.

After extensive review by the OVHA, the restrictions on this code have been changed.

Effective date of service 8/1/05, the limit for this code has been changed from 3 per lifetime to 12 per calendar year.

SEPTEMBER 9, 2005

S1040 Cranial Orthosis

Please be aware that effective date of service 8/23/2005, S1040 Cranial Orthosis, requires Prior Authorization.

SEPTEMBER 16, 2005

MEDICAID PROVIDER HURRICANE ASSISTANCE

Hurricane Katrina's aftermath may bring some people from Louisiana, Mississippi, Alabama and Florida to seek refuge in Vermont. In the advent of evacuees migrating to Vermont, the Office of Vermont Health Access is involved in coordinating efforts to meet the potential needs of these Medicaid beneficiaries. Vermont providers with a hurricane evacuee/patient in their office should encourage them to call the American Red Cross to help with registration, lodging, and to notify FEMA.

American Red Cross in Vermont

Northern Vermont: 800-660-9130

Central Vermont: 802-773-9159

Southern Vermont: 800-288-3554

Vermont providers caring for these Medicaid beneficiaries can enroll as Louisiana, Mississippi, Alabama and Florida Medicaid providers. Please call the numbers below for information on the programs in these states or visit: vtmedicaid.com for FAQ lists and a full listing of contacts.

Louisiana Medicaid, General: 1-888-342-6207

Mississippi Medicaid, General: 1-800-884-3222 and select option 6 or stay on the line.

Alabama Medicaid, Provider Information: 334-215-0111

Florida Medicaid, Provider Information: 1-888-419-3456

CMS has indicated that it will be flexible in regard to Medicaid program requirements for services provided to victims of Hurricane Katrina. See the CMS website for more information: <http://www.cms.hhs.gov/>

SEPTEMBER 30, 2005

Dental Limit Reduction

The OVHA is proposing a regulatory change to reduce the dental limit for Medicaid adult beneficiaries from \$475 per calendar year to \$375 per calendar year. If final approval is obtained on October 5, this change will become effective November 1, 2005. After November 1, claims for date of service November 1 and beyond will be subject to the new cap.

Website Maintenance

Due to the implementation of new hardware and software upgrades, all forms of Eligibility Verification applications will be unavailable on Sunday, October 2nd from 4:00 p.m. until midnight.

Crossovers and Medicare Numbers

Have you noticed that your crossover claims are not crossing over as they should? The reason could be that EDS does not have your Medicare number on file to cross-reference with your Medicaid provider number.

You can fax EDS your Medicare number at: 802-878-3440 Attn: Provider Enrollment.

OCTOBER 14, 2005

2006 ICD-9-CM Codes

We have implemented all 2006 ICD-9-CM codes. These codes are effective for date of service 10/01/2005.

Ostomy Pouches/Barriers

Due to packaging constraints, the OVHA will allow 30 ostomy (urinary, intestinal) pouches/barriers per 60 days (approximately 15 per month), effective 07/01/2005.

Authorization for more than the allowed 15 per month requires a recent evaluation by an Enterostomal Therapy nurse and her/his written recommendation.

Important Notice

For claims starting with date of service 10/01/2005 DO NOT put the patient share in the other insurance field. This is for both paper and electronic claims. Due to system enhancements EDS will deduct the patient share starting with the first claim(s) of the month instead of the last day of the month. This should greatly reduce the number of credit balances.

OCTOBER 21, 2005

Modifiers 54, 55 & 56

Modifiers 54, 55 & 56 have been approved and made retroactive for use by Vermont Medicaid with an effective date of 1/1/2003.

Modifier 54-‘surgical care only’: When one physician performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified by adding the Modifier 54 to the usual procedure. This will be reimbursed at the lesser of billed or 81% of the rate on file.

Modifier 55-‘postoperative management only’: when one physician performed the postoperative management and another physician performed the surgical procedure, the postoperative component may be identified by adding the Modifier 55 to the usual procedure. This will be reimbursed at the lesser of the billed or 10% of the rate on file.

Modifier 56-‘preoperative management only’: When one physician performed the preoperative care and evaluation and another physician performed the surgical procedure,

the preoperative component may be identified by adding the Modifier 56 to the usual procedure. This will be reimbursed at the lesser of billed or 9% of the rate on file.

Documentation will not be required with claim submission when these modifiers are used. Providers are encouraged to bill these services electronically for faster adjudication and payment. You must follow correct coding guidelines when billing with these modifiers.

NOVEMBER 4, 2005

Dental Limit Update

In a banner page on the September 30th Remittance Advice, the OVHA announced proposed reductions in dental limits for adult Medicaid beneficiaries. These reductions have been postponed. EDS will notify providers when OVHA has reached a final decision on this matter.

Important Notice

For claims starting with date of service 10/01/2005 DO NOT put the patient share in the other insurance field. This is for both paper and electronic claims. Due to system enhancements EDS will deduct the patient share starting with the first claim(s) of the month instead of the last day of the month. *Dates of service on these claims must be within the same calendar month.* This should greatly reduce the number of credit balances.

UB 92 Billing Form Update

Please be aware that there has been a change to form locator 24.

Enter one of the following condition codes if the patient is found to have Medicaid benefits that would not cover the long-term care stay:

M1: Benefits exhausted

M2: Non-qualifying stay

NOVEMBER 11, 2005

Multiple Surgery Payment Rule Change

In an on-going effort to standardize guidelines and be more consistent with other payers VT Medicaid has changed rules governing multiple surgery payment.

Claims prior to dates of service 10/15/2005, Medicaid only reimbursed for two surgical procedures unless there was an exception. Providers would recognize this as EOB code 429. In that process, Vermont Medicaid would only pay 100% of the code with the highest reimbursement and 50% of the second.

Under the new rule that takes effect with date of service 10/15/2005, Vermont Medicaid will pay in order of Relative Value Unit and will pay all surgical procedures in decreasing percentages of 100, 50, 40, 30, 30, 30.....

Any codes that are add-on codes or Modifier 51 exempt as defined by CPT will be paid at 100% of allowable.

Any claims with dates of service prior to 10/15/2005 will be processed according to the old Medicaid guidelines.

Providers can expect additional reimbursement with this new rule change.

Codes on Dental Cap

Effective immediately, the following procedure codes have been removed from the annual adult dental cap:

D0140-Limited oral evaluation, problem focused: an evaluation or re-evaluation limited to a specific oral

D0170-Re-evaluation, limited, problem focused (assessing status of previously existing condition)

D7510-Incision and drainage of abscess

D9110-Palliative (emergency) treatment of dental pain-minor procedures

Cross-Over Claims

Please do not modify crossover claims when submitting them to EDS for processing. Please wait a minimum of 6 weeks before sending it to EDS to prevent duplicate payments and/or denials.

Choices for Care Codes Changed

The following revenue codes for Choices for Care have been changed:

Old	New
071	070
079	074
085	073
086	075
087	080
090	070
091	070
099	not covered by this program

NOVEMBER 18, 2005

Procedure Code 92070

The OVHA is now accepting procedure code 92070 [FITTING OF CONTACT LENS FOR TREATMENT OF DISEASE, INCLUDING SUPPLY OF LENS] effective date of service 9/1/2005.

Procedure Code L8042

The OVHA is now accepting procedure code L8042 [ORBIAL PROSTHESIS, PROVIDED BY A NON-PHYSICIAN] effective retroactive to date of service 1/1/2005.

Dental/Vision Faxes

Due to the high volume of Dental and Vision faxes received daily by EDS, providers should send their faxes to EDS as soon as possible in order for EDS to return the information to you prior to the service date. At a minimum faxes should be to EDS two days prior to the date of service.

NOVEMBER 25, 2005

When Calling Provider Services

When calling EDS Provider Services please have the following information in hand:

Provider #

Recipient ID #

Date of Service

Procedure Code

Providing this information at the beginning of your call will facilitate the resolution of your particular issue.

Health Maintenance Organizations (HMOS)

The following information is a provider-requested refresher on HMOS.

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

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

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

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

Holiday Schedule

EDS offices will be closed on November 24 & 25 for the Thanksgiving Holiday. EDS recommends that providers submit their claims by close of business on Wednesday the 23rd.

Scanner Requirements

Now that EDS has implemented the new scanner for processing paper claims, providers should stop using highlighters on claims or attachments. The scanner does not register highlighter marks. Please underline or circle in pen the particular section you wish to have reviewed.

Please do not use staples or tape to secure claims and attachments.

Forthcoming Provider Survey

Providers will soon receive a survey from the OVHA to collect data on the following:

Handicap accessibility of your service location; languages accommodated at your office; the gender of the practitioner; patient age limits; and if the provider is accepting new patients.

The OVHA is required by Federal law to collect this information in order to meet the requirements of the State of Vermont's Global Commitment to Health Waiver. The data will be added to your provider file and later made accessible to your clients through an on-line provider directory.

Please watch for the colored mailing and return the required information to EDS by December 15, 2005.

Procedure Code A4349

Please be aware that the limits for procedure code A4349 [male external catheter, with or without adhesives, disposable], have been increased to 36 per calendar month.

Clarification Regarding Dental Codes & the Medicaid Adult Program Maximum Benefit

Effectively immediately, the following dental procedure codes are no longer subject to the Adult Program \$475 maximum benefit:

D0140 Limited Oral Evaluation-Problem Focused

D0170 Re-Evaluation-Limited, Problem Focused

D7510 Incision and Drainage of Abscess

D9110 Palliative (Emergency) Treatment of Dental Pain-Minor Procedures

These procedures remain covered services for the Adult Program, but are no longer subject to the \$475 maximum benefit.

DECEMBER 2, 2005

Office of Vermont Health Access Announces Change in Pharmacy Benefit Managers

Effective January 1, 2006, Vermont Medicaid pharmacy claims will be processed by a new pharmacy benefit management company - MedMetrics Health Partners (MHP). Specific information will be sent in December regarding processing Medicaid claims through MedMetrics including a cover sheet detailing changes and an updated Provider Manual.

Until January 1, 2006, First Health Services will continue to provide pharmacy benefit manager services including claims processing and managing prior authorizations. If you require assistance between now and January 1, continue to call First Health.

Claims Processing Assistance:	1-866-664-4511
Prior Authorizations:	1-866-435-1199
Fax:	1-888-603-7696

DECEMBER 9, 2005

Codes J3490 & S8270 Now Requiring Prior Authorization

Effective date of service 1/1/2006, HCPCs code J3490 [unclassified drugs] will require prior authorization.

Effective date of service 1/1/2006, HCPCs code S8270 [Enuresis Alarm] will require prior authorization.

Choices for Care –Moderate Needs-Billing Update

Effective date of service 10/01/2005, Moderate Needs service revenue code 096 [Adult Day Services] has a limitation of 30 hours per week. In order to track these services they must be itemized on the detail level of the claim **by calendar week**. *Billing per calendar week is a change to your current billing practices.*

For example, if the patient is seen on October 4th & 5th you would enter each of those dates in the detail section. This counts as calendar week 1. The same patient is seen again on the 12th, 19th and the 20th. As before, each date of service will be entered in the detail section. The 12th counts as calendar week 2 and the 19th and the 20th are week 3. The date span in the header section would appear as 10/4/2005 to 10/20/2005. The last day in the span given in the header **must** be the last day itemized in the detail section.

DECEMBER 16, 2005

Adult Dental Benefits

Effective 2/1/2006 the Dental maximum benefit for adults with traditional Medicaid or Medicaid managed care will be reduced from \$475.00 per calendar year to \$400.00 per calendar year.

Effective 02/01/2006, there will also be a 6% fee reduction for non-emergency dental procedures for adults.

Co-pay amounts will not be affected.

Please call EDS Member Services at: 1-802-878-7871 or 1-800-925-1706 or The Office of Oral Health at The Vermont Department of Health at: 1-802-863-7341 if you have any questions regarding these changes.

vermonthipaacontact@eds.com

EDS has created a new email address: vermonthipaacontact@eds.com where providers should direct all non-claims specific questions regarding coding combinations such as HCPCs and CPT code/modifier, place of service, provider type, etc. This new address replaces the old OVHA address: hipaacontact@path.state.vt.us

All questions regarding claim specific denials should still be directed to EDS Provider Services at: 800-925-1706 or 802-878-7871.

Holiday Schedule

The OVHA and EDS offices will be closed for the holidays on December 26, 2005 and January 2, 2006.

VPharm Pharmacy Program

The new Medicare Part D prescription drug benefit begins on January 1, 2006. A new pharmacy program called VPharm has been created by the Office of Vermont Health Access to serve beneficiaries who qualify for state pharmacy benefits and are eligible for Medicare Part D. In general, VPharm covers drug classes that are excluded from the Part D benefit.

Beneficiaries with drug coverage available through Medicare will have their VHAP, VScript and VScript Expanded coverage converted to VPharm as of January 1, 2006. VPharm eligible beneficiaries have already been auto-enrolled in Part D prescription drug plans and notified.

Twelve new aid categories [VD-VO] have been created for the different levels of coverage offered by VPharm.

Please check the updated Aid Category list posted on-line at: vtmedicaid.com

Code J2010

Effective immediately, code J2010-Lincocin is approved for use by Dentists. [Lincomycin belongs to the family of medicines called antibiotics. These medicines are used to treat infections. They will not work for colds, flu, or other virus infections]