

Banner Pages for **December 26, 2008**

Intravenous Infusions Clarification

Please be advised of the following clarification regarding intravenous infusions:

When intravenous infusion is performed for hydration, therapy, prophylaxis or diagnosis (not in conjunction with another procedure, when infusion is incidental, and not for chemotherapy), see CPT codes 90760, 90761 and/or 90765-90768. These codes are used for hospital outpatient billing as well as for IV infusion administered in the physician's office.

The first hour of infusion is represented by CPT code 90760 or 90765 and is limited to one unit (per the code's description, "initial").

The codes for "each additional hour" must have documentation attached to the claim when the number of units billed exceeds the limit (unless the situation is an emergency and the claim's coding reflects that).*

When the intravenous infusion for therapy or hydration lasts longer than 4 hours, notes must be submitted with the claim clearly documenting the total amount of time the infusion lasted.

*Claims clearly marked as an emergency will not require documentation to justify the multiple units unless specifically requested for a particular case or cases (e.g., post-payment review).

Prior Authorization Requirement: Hospital Beds

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

The only exception is the "Immediate Needs" exception as explained in the Prior Authorization Supplement on the VT Medicaid website (www.vtmedicaid.com under Downloads/Manuals) under section 1.5.2.

This prior authorization requirement is not new as semi-electric and electric/electronic hospital beds have required prior authorization for many years.

December 19, 2008

Closed for the Holidays

Please be advised, the OVHA and EDS will be closed on Thursday, December 25th for the Christmas holiday. Both offices will reopen on Friday, December 26th.

In addition, both offices will be closed on Thursday, January 1, 2009 for the New Year's holiday and will reopen on Friday, January 2nd.

P.O. Boxes Reminder

As an important reminder, EDS updated the P.O. boxes for all incoming mail received. It is imperative that providers use the following P.O. boxes accordingly for submission of claims and other mail:

P.O. Box 999 Williston, Vermont 05495-0999 – UB04 forms only

P.O. Box 777 Williston, Vermont 05495-0777 – CMS 1500 08/05 forms only

P.O. Box 1710 Williston, Vermont 05495-1710 – Dental and Vision forms only

P.O. Box 1645 Williston, Vermont 05495-1645 – Checks only

P.O. Box 888 Williston, Vermont 05495-0888 – All other mail and inquiries only.

EDS requests that providers verify all information mailed and ensure it is addressed to the correct P.O. box. Your cooperation in this matter is greatly appreciated.

December 12, 2008

PSU Wait Time

Please be aware that after a recent analysis of hold times for the Provider Services Help Desk, the average provider wait time is 3-5 minutes longer, when calling between the hours of 9:30-10:00 am, 12:00-1:00 pm and 2:30-3:00 pm.

If you are experiencing greater wait times during these peak periods, we suggest calling outside peak periods to alleviate congestion of the queue line. Thank you for your patience.

December 5, 2008

Update: Billing for Missed Appointments

Update! Physicians who have been billing 99199 for missed appointments, thank you for your support. Upon receipt of this notification, the voluntary tracking initiative for the recording of missed appointments is no longer necessary. However, dental providers should continue to provide input by billing D0999 for missed appointments, as we will continue to track these beneficiaries.

Electric Bed Codes-Updates

Please be advised, as of 06/25/2007, the OVHA requires prior authorization for all electric beds.

Effective 01/05/2009, HCPCS procedure codes E0328 & E0329 have been added as a covered service and will also require prior authorization.

Nursing Home Rate Changes

The OVHA has issued final retro Nursing Home rates dating back to July 1, 2007. Please note, you will start seeing these adjustments over a 3 week period, beginning December 19, 2008. The schedule will be as follows, in alphabetical order by provider name:

Week 1: A-E

Week 2: F-M

Week 3: N-Z

If you have any questions or concerns regarding these adjustments, please contact your EDS Provider Representative.

Transportation: Out-of-Area/Out-of-State Referrals

Effective immediately, all in-state, out-of-area/out-of-state Medicaid transportation referrals must now be faxed to the OVHA for approval or denial; the fax number is 802-879-5919.

The Vermont Public Transportation Association (VPTA) will no longer be handling these referral requests. All referrals must be submitted on the updated Out-of-State/Out-of-Area Medicaid Transportation Physician Referral Form. This form can be found at: <http://ovha.vermont.gov/for-providers>. The updated submission and contact information is also located on this form. Please contact Peter McNichol at Peter.McNichol@ahs.state.vt.us or 802-879-5935 with any questions.

Medicare Payments Reminder

As a reminder, if a beneficiary is covered by Medicare part C or MCR HMO, providers need to indicate this information on the claim form (box 9D on CMS 1500 08/05 and box 50 on UB04) when submitting paper claims to EDS.

Also, if services are provided to a beneficiary who has Medicare part A, B, or C, it is very important that providers do NOT include any payments made by Medicare on the claim form when submitting claims on paper. The prior payment field (box 29 on CMS 1500 08/05 and box 54 on UB04) is strictly designated for other insurance payments (i.e. Cigna, BC/BS, etc.) EXCLUDING Medicare. If present on the claim, the Medicare payment could be considered another primary insurance and the claim could pay incorrectly or pay at \$0.00.

Providers need to submit a paper claim to Vermont Medicaid with the Medicare EOMB attached if Medicare denied services in order for claims to process correctly.

November 28, 2008

Closed for The Holiday

Please be advised, the OVHA and EDS offices will be closed on Thursday, November 27th and Friday, November 28th for the Thanksgiving holiday. Both offices will reopen on Monday, November 24, 2008.

Other Insurance Requirements

Effective immediately, when submitting Ladies First paper claims that involve payments by a commercial health insurance company, it is mandatory to enter the paid amount in the prior payment field (form locator 54 on the UB04 claim or form locator 29 on the CMS 1500 08/05 claim).

For Ladies First paper claims that involve other insurance, it is mandatory to submit one claim for each service. This is required to appropriately process the payment from the insurance company. This policy is different from the Medicaid policy.

Billing Beneficiaries for Missed Appointments

Please be advised, as a matter of policy, providers are not permitted to bill recipients for missed scheduled appointments.

November 14, 2008

Oral Anticoagulation Therapy Monitoring

The OVHA covers in-home monitoring of Prothrombin Time (PT)/International Normalized Ratio (INR) only when approved by the OVHA prior to the dispensing of the equipment. Purchase of the monitoring device (often called a "ProTime Monitor") can be requested using the unlisted HCPCS procedure code E1399. Once the monitor has been approved, test materials can be billed using HCPCS code G0249. The OVHA recognizes HCPCS procedure codes G0248 & G0250 for the physician services involved.

Specific coverage criteria apply and need to be reviewed by both the physician and DME providers. The OVHA Coverage Criteria (Guidelines) can be reviewed on the OVHA website at: <http://ovha.vermont.gov/for-providers/durable-medical-equipment-p-r> or will be sent as a hardcopy upon request.

OPPS Denials With EOB 1116/8111

Please be advised, EDS has completed system changes that will eliminate the failure of your claim when you have an incidental procedure. Please resubmit your claims that had the 1116/8111 EOB remark code. The code that is denied as incidental, will not be paid.

License Renewals Reminder

As a reminder, in an effort to work with physicians and the Medical Practice Board to ensure all license renewals are issued prior to *11/30/2008* for Vermont Medicaid providers, please be advised of the following:

On December 1, 2008, the OVHA must be able to verify that your updated license has been issued by the Medical Practice Board in order to authorize the filling of prescriptions and processing of claims. The Medical Practice Board mailed license renewal packets in August. Please be sure to return your license renewal application and fee to the Medical Practice Board prior to *11/30/2008* in order to allow the Board sufficient time to process your renewal application and issue your renewal license prior to December 1, 2008. Your active license on file with the Medical Practice Board ensures that the licensure requirement is met.

The OVHA and EDS will work in collaboration with the Medical Practice Board to verify your renewed license is on file.

Compression Bandages

Please be advised, effective *12/15/2008*, the OVHA limits compression bandages to a maximum of eight (8) yards within 30 days. The current HCPCS procedure codes involved are A6448-A6455 & A6457. One unit of each code equals one yard.

These codes are also restricted by diagnosis codes involving edema and lymphedema. A prior authorization is required from the OVHA for excess units or other diagnoses.

Update to Blanket Denials for Other Insurance

Please be advised, effective January 1, 2009, the OVHA has updated the process for submitting blanket denials from a primary insurer to EDS. The current directive validates blanket denials for up to one year from the EOB date.

The updated process will require providers to obtain a blanket denial from a primary insurance every calendar year. For example: A blanket denial issued on July 7, 2008, will only be valid until December 31, 2008 and a new denial will be required as of January 1, 2009.

Obtaining a blanket denial every calendar year will inform EDS of any changes or updates, if any, made to a recipient's primary insurance coverage each year.

Intravenous Infusions

When intravenous infusion is performed for hydration, therapy, prophylaxis, or diagnosis (not in conjunction with another procedure where infusion is incidental), see CPT codes 90760, 90761 and/or 90765-90768. These codes are now used for hospital

outpatient billing as well as when the IV infusion is administered in the physician's office. The first hour of infusion is represented by code 90761 or 90765 and is limited to one unit per the code's description ("initial"). The codes for "each additional hour" are also limited to one unit because it is unusual for these infusions to last longer than 2 hours when performed in the office.

When an office infusion lasts longer than 2 hours, office notes must be submitted with the claim, clearly documenting the total amount of time the infusion lasted.

Non-emergency hospital outpatient claims billing for more than 2 hours of infusion must also be submitted with outpatient notes, clearly documenting the total amount of time the infusion lasted. When the hospital outpatient claim is clearly marked as an emergency, notes will not be required to justify the multiple units billed with IV infusion codes unless specifically requested for a particular case or cases (e.g., post-payment review).

Provider Workshop

EDS will be holding a Medicaid 101, website, and claim forms workshop for new billers or as a refresher course for anyone that would like to attend. The workshop will be held on Thursday, December 4th from 1:30pm to 3:30pm at **Northwestern Medical Center** (133 Fairfield Street, St. Albans, VT 05478) in conference room #1.

Directions:

From the north or south, take exit 19 off of I-89. At the end of the off-ramp, turn right onto Fairfax Road/Rte. 104. Go about a ½ mile to a traffic light/4-way intersection. Turn left onto Fairfield Street (Rte 36). The hospital entrance is the next right. For more detailed information on directions, please contact Northwestern Hospital's information desk at 802-524-5911.

Please contact Deb Safford at 802-857-2957 to reserve your seat as space is limited.

ICD-9 Surgical Code 8693

Please be advised, effective 12/15/2008, the insertion of tissue expanders (for example, CPT code 11960 and ICD-9 surgical code 8693) continues to require prior authorization from the OVHA before the procedure is performed.

November 7, 2008

Revenue Code Adjustments

Please be advised that claims with the following revenue codes were automatically adjusted by EDS due to a 2.7% rate increase effective 07/01/2008:

072, 073 & 095

If your payment on these adjustments remained the same, it's because you were submitting a billed amount equal to the old rate. In order for you to receive the rate increase on these claims, you will need to contact your Provider Representative for assistance.

Chris Lyon-802-857-2963, for Bennington, Orange, Rutland, Windham and Windsor counties,

Deb Safford-802-857-2957, for Addison, Chittenden, Franklin and Grand Isle counties,

Spring Shover-802-857-2956, for Caledonia, Essex, Lamoille, Orleans and Washington counties.

Closed for Holidays

Please be advised, EDS and the Office of Vermont Health Access will be closed on Tuesday, November 11, 2008 for the Veteran's Day holiday. Both offices will reopen on Wednesday, November 12th.

Not Receiving or Seeing Your Ladies First Remittance Advices?

If you submit claims electronically for Ladies First, you are no longer receiving paper Remittance Advice's (RAs) as of 09/05/08. RAs are now exclusively available at www.vtmedicaid.com under Transaction Services/Production Logon/View RA Files.

If you are not seeing your NPI numbers for Ladies First in the drop-down menu, please contact the EDI Coordinator at 802-879-4450, option #3 to verify that your EDI registration for Ladies First is accurate.

The EDI Registration is available on the VTMedicaid website under Downloads/Forms/EDI Registration. This information is important to share with you, as some providers have already given Web RA access to their clearinghouses.

Medicare Attachment Summary Form

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

The benefits include:

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

This form will be available on December 1, 2008 at www.vtmedicaid.com under Downloads/Forms. EDS offers FREE electronic billing software! Provider Electronic Solutions (PES) is available and easy to download. All providers are highly encouraged to use PES for electronic claim submissions.

MS-DRG Grouper Version 26

Please be advised, EDS implemented the MS-DRG Grouper Version 26 effective with dates of service 10/01/2008. An updated list of Vermont Based Relative Weights Table is available on the www.vtmedicaid.com website under Downloads/Manuals/Relative Weights.

J1300 & J2357 Pharmacy Benefits

Please be advised, as of 09/15/2008, HCPCS code J2357 is no longer a medical benefits and will not be reimbursed as such. This item must be billed by a pharmacy and prior authorization is required.

In addition, HCPCS code J1300 follows the same guidelines stated above, as of 07/17/2008.

October 31, 2008

Sterilizations Updates

Please be advised, effective 12/01/2008, the following 3-digit ICD-9 procedure codes are invalid because a fourth digit is required:

624, 626, 629, 630, 635, 637, 638, 639, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 665, 666, 667 & 669.

Procedure on review:

The follow CPT procedure codes require that procedure/OP notes and the history substantiating the need for the procedure, are included with the claim to EDS:

54520, 54690, 54900, 54901 & 55400 (including any procedure-modifier combinations).

October 17, 2008

Procedure Code 77084 Restrictions

Please be advised, effective 11/17/2008, procedure code 77084 will be restricted to allow only one unit per billing and allow provider types T37 (Physician Assistant), T06 (Nurse Practitioner), 043 (Naturopathic Physician), 005 (Physician) and 001 (General Hospital) only.

NDC Requirements

Please be advised, effective 11/17/2008, the following HCPCS/CPT codes will NO LONGER require an NDC when submitted on a CMS 1500 08/05 or UB-04 claim:

-90655, 90656, 90657, 90658, 90660, 90669, 90732, 90740, 90743, 90744, 90746, 90747, A9576, A9577, A9578, A9579, C9352, C9353, J7321, J7322, J7323, J7324, J7343, J7344, J7346, J7347, J7348, J7349, Q9953, Q9954, Q9956, Q9957, Q9958, Q9960, Q9961, Q9963, Q9964, Q9965, Q9966 & Q9967

Please be advised, effective 11/17/2008, the follow HCPCS/CPT codes WILL require an NDC when submitted on a CMS 1500 08/05 or UB-04 claim:

- C9113, J0128, J0380, J0960, J0945, J1055, J1435, J1436, J1565, J1620, J1730, J1960, J2180, J2460, J2950, J3305, J3320, J7100, J7110, J7191, J7302, J7307, J7613, J7614, J9215, S0023, S0145, S0146, S0162 & S0164

Please note, this is a list of updates to the NDC billing requirements. See "HCPCS Codes That Require An NDC Code" at www.vtmedicaid.com under *Information*.

Implantable Infusion Pump Restrictions

Please be advised, effective 11/17/2008, Vermont Medicaid covers implantable infusion pumps when medically necessary per current best practice and surgically implanted in the hospital setting.

For hospital outpatient billing purposes, HCPCS procedure codes E0782, E0783, E0785 & E0786 have been updated with the following restrictions:

- a maximum of one unit per billing
- allow provider type 001 (general hospital) only
- allow place of service codes 21 (inpatient) and 22 (outpatient) only
- modifiers RR and NU are not accepted.

DME Supply Returns

Please note, Durable Medical Equipment (DME) purchased by Vermont Medicaid for eligible beneficiaries, remains the property of Vermont Medicaid. If a beneficiary no longer has a medical need for equipment purchased by Vermont Medicaid, the

beneficiary should be instructed to contact the OVHA Clinical Review Unit at 802-879-6396. DME suppliers should also contact this number if Vermont Medicaid owned DME is returned to them.

Prior Authorization Updates

Please note, effective 11/17/2008, all wheelchairs and power-operated vehicles medically indicated (new, used and rentals) will require prior authorization from the OVHA.

October 10, 2008

Procedure Code 97113—Aquatic Therapy

Please be advised, effective immediately, procedure code 97113 (Aquatic Therapy) will require a prior authorization from the OVHA if therapy is necessary beyond a 4 month (120 day) period.

Please verify that the therapy start date is present on the claim when submitting to Vermont Medicaid.

Assistive Technology Suppliers

Just a reminder, as of June 1, 2008, Vermont Medicaid will follow Medicare's lead in requiring that certain wheelchairs must come from a supplier employing a RESNA-certified Assistive Technology Supplier (ATS) who is directly involved in the wheelchair selection for the patient. This applies to the following wheelchairs: Group 2 single- or multiple-power option power wheelchairs, any Group 3 or Group 4 power wheelchair or a push-rim power assist device for a manual wheelchair. All suppliers who have obtained their ATS certification should sign all documentation regarding the above wheelchairs with their ATS designation. All ATS certified suppliers must send a copy of their certification to Vermont Medicaid Enrollment Department before June 1 and on an annual basis thereafter to demonstrate that they have kept their certification current.

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

Clarification: Other Insurance Denials & Appeals

In the most recent edition of the Advisory (August 2008), an article was published titled "Prior Authorization When Primary Insurer Denies".

In summary, this article instructed providers to appeal to the primary insurance if a primary insurer denies claims for reasons such as "non-covered", "benefits exhausted" and "not medically necessary", and service needs prior authorization.

This article was worded incorrectly, therefore, EDS would like to apologize for the miscommunication regarding this information. Providers may access the correct version

of this article, which can be found on the www.vtmedicaid.com website under Downloads/Bulletins/August 2008.

October 3, 2008

License Renewals

In an effort to work with physicians and the Medical Practice Board to ensure all license renewals are issued prior to 11/01/2008 for Vermont Medicaid providers, please be advised of the following:

On December 1, 2008, the OVHA must be able to verify that your updated license has been issued by the Medical Practice Board in order to authorize the filling of prescriptions and processing of claims.

The Medical Practice Board mailed license renewal packets in August. Please be sure to return your license renewal application and fee to the Medical Practice Board prior to November 14, 2008 in order to allow the Board sufficient time to process your renewal application and issue your renewal license prior to December 1, 2008. Your active license on file with the Medical Practice Board ensures that the licensure requirement is met.

The OVHA and EDS will work in collaboration with the Medical Practice Board to verify your renewed license is on file.

If you have questions, please contact Mary A. Gover at OVHA 802-879-5937.

September 19, 2008

EDS Provider Representative Territory Update

EDS would like to welcome Chris Lyon as our newest addition to the Provider Representatives. Please be advised of the following updates made to the Provider Representative team:

Betty Parent: DHMC & FAHC (802-857-2959)

Chris Lyon: Bennington, Orange, Rutland, Windham and Windsor counties (802-857-2963)

Deb Safford: Addison, Chittenden, Franklin and Grand Isle counties (802-857-2957)

Spring Shover: Caledonia, Essex, Lamoille, Orleans and Washington counties (802-857-2956)

Jean Gadue: In-House Representative

For a full-colored detailed map depicting each Provider Representative and their corresponding territories, please visit www.vtmedicaid.com under Information/Provider Representative Map.

Procedure Code 87999

Please be advised, effective 10/20/2008, procedure code 87999 (Trophile Assay) has been updated with the following restrictions:

- Allow a maximum of one unit per lifetime,
- Allow ages 16 and older,
- Allow provider types 012 (Independent Lab) and 001 (General Hospital).

In addition, procedure code 87999 will require a prior authorization from the OVHA prior to services being rendered.

Medicare Crossover Requirements

If you are not seeing your Medicare/Vermont Medicaid crossover claims being automatically submitted to Vermont Medicaid, there may be an issue with the NPI numbers used to bill Medicare.

Here are some steps you can take to ensure your claims are processed correctly and timely:

1. Submit the appropriate taxonomy codes to Medicare. Even though Medicare does not require or process taxonomy codes, Medicare claims should contain taxonomy codes for correct processing as crossovers to Vermont Medicaid. The most critical taxonomy code is the *group* taxonomy code and EDS recommends that providers enter their group taxonomy code wherever there is an option to enter a taxonomy.
2. Contact the EDS Provider Enrollment Help Desk at 802-879-4450, option# 4, to verify the NPI information registered with Vermont Medicaid.

Medicare NDC Crossover Billing

Effective immediately, pharmacies are required to bill the Medicaid Pharmacy Benefit through Medmetrics for Medicare B crossover balances on drugs and supplies normally billed using an NDC.

Some examples of these drugs and supplies include, but not limited to, lancets, test strips and inhalation solutions. These claims will be processed through Medmetrics electronically the same way as Medicare Part D balances are currently processed by indicating the Medicare coinsurance amount in the patient pay field.

Please contact Medmetrics Technical Center at 1-800-918-7549 with any questions.

Procedure Code A4550

Please be advised, effective 10/20/2008, procedure code A4550 (Surgical Trays) will no longer be reimbursable by Vermont Medicaid, as it is considered included within the reimbursement rate for surgical procedures.

September 12, 2008

90853 Retraction

On August 8th, 2008, provider notification was issued to providers regarding procedure code 90853 and the correct billing of units. This directive, effective 09/08/2008, instructed providers to bill one unit per visit and sessions would be limited to one session per day, 3 sessions per week.

Effective immediately, the OVHA has authorized EDS to retract and delay the implementation of billing requirements for procedure code 90853 until further notice.

Hearing Services Updates

Please be advised, effective 10/13/2008, updates have been made to the following hearing services:

Procedure codes V5011, V5014, V5200, V5240 & V5241: Use modifier RT or LT. If billing for both, providers must bill on separate lines using LT or RT. Combinations such as RTLT or LTRT are no longer accepted.

Procedure codes V5050 & V5060: Allows modifiers RT or LT. If providers must bill for both ears, please refer to codes V5130 & V5140.

Procedure cod V5257: Modifier combinations TJRT & TJLT are no longer accepted. The correct order to bill is RTTJ & LTTJ.

Procedure code V5264: Modifier AM will no longer be accepted by itself. Providers need to code each side and RTAM and LTAM is acceptable. In addition, modifier combinations RTLT & LTRT will no longer be accepted. Providers must bill on separate lines, if billing for both, use RT or LT.

Procedure code V5267: Is a non-specified code, and as such, requires a prior authorization.

September 5, 2008

Procedure Code 77073

Please be advised, effective 10/06/2008, procedure code 77073 will be limited to a maximum of one unit per billing and provider types T37 (physician assistant), T06 (nurse practitioner), 005 (physician) and 001 (general hospital).

Procedure Code D9974

Please be advised, effective 10/06/2008, procedure code D9974 is limited to Vermont Medicaid recipients ages 0-20, once per tooth per lifetime.

Limitations to Procedure Codes 17106-17108

Please be advised, effective 10/06/2008, procedures codes 17106, 17107 & 17108 require a prior authorization. Please fax the completed "Pre-Procedure Request" form and all supporting documentation to the OVHA Clinical Operations Unit at 802-879-5963 prior to scheduling or performing these procedures.

LT & RT Modifier Combinations

Please be advised, effective 11/05/2008, modifier combinations LTRT and RTLTL will no longer be accepted by Vermont Medicaid. When Correct Coding allows one of these combinations on the base procedure code and the service/item is rendered/supplied bilaterally, providers must bill two separate details/lines: one with the modifier RT and another with the modifier LT.

August 29, 2008

Electronic Remittance Advices

As a reminder for all providers who submit claims electronically, remittance advices dated August 29, 2008, will be the final remittance advice received via mail. They will be exclusively available at www.vtmedicaid.com under Transaction Services.

August 22, 2008

Provider Workshop

EDS will hold a Medicaid 101, website, and claim forms workshop for new billers' or as a refresher course for anyone that would like to attend. The workshop will be held on September 25th from 10am-12pm in the downstairs meeting room at North Country Hospital (189 Prouty Drive, Newport, VT).

Please contact Spring Shover at 802-857-2956 to reserve your seat as space is limited.

Procedure Code Restrictions

Please be advised, effective 09/22/2008, the following procedure codes will be restricted to a maximum of one unit per billing and provider types T37 (physician assistant), T06 (nurse practitioner), 005 (physician) and 001 (general hospital):

77054, 77053, 77078, 77079, 77080, 77083, 77076, 77075, 77074 & 77072.

Procedure code 77071 will be restricted to one unit per billing and provider types 005 (physician) and 001 (general hospital).

August 15, 2008

PSU Training Day/Labor Day Holiday

Please be advised, the Provider Services help desk will be closed for quarterly training on Friday, August 29th. If you have an urgent question, please leave a message as we will return calls throughout the day.

Also, the Office of Vermont Health Access and EDS will be closed Monday, September 1st to celebrate the Labor Day holiday. Both offices will re-open on Tuesday, September 2nd.

Chiropractic Services

Act 65 of the 2007 Legislature instructed the Agency of Human Services to reinstate chiropractic coverage for adults in the Vermont Medicaid and VHAP programs, effective July 1, 2008.

This coverage is to be consistent with Title 8, §4088a, and within the scope of chiropractic services, as defined in Chapter 10 of Title 26 of Vermont statutes. Beginning with a date of service of July 1, 2008, allowable and medically necessary services from enrolled providers for child and adults will be the same.

Please visit www.vtmedicaid.com under Downloads/Information for additional information regarding covered services. Also, the Prior Authorization for Chiropractic Services request form is available under Downloads/Forms. Please be aware, this request form is currently for temporary use until the revised version becomes available.

Procedure Code 59866

Please be advised, effective 09/08/2008, procedure code 59866 will be a reimbursable service. Because this procedure code represents an abortion, a completed Abortion Consent Form must be attached to each claim submitted to EDS.

Procedure Codes 75805 & 93976 Restrictions

Please be advised, effective 09/08/2008, procedure codes 75805 & 93976 have been updated to allow place of service codes 21 (inpatient) and 22 (outpatient) only.

August 8, 2008

RA & Weekly Check Amount Now Available on the Web!

All providers who submit electronic claims to Vermont Medicaid, will be required to obtain their remittance advice (RA) by downloading it from the web. For a short period of time, we will continue to mail the paper RA. We ask that you make sure you can successfully obtain your web RA prior to the discontinuation of the paper version.

We recently mailed information to providers who submit electronically outlining the necessary steps for web RA functionality. If you have already completed this, you should be able to access your RA beginning 07/28/2008. If you are unable to access your web RA, please contact the EDI Coordinator via email at: vtedicoordinator@eds.com

Drugs Requiring Prior Authorization

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

Amevive (alefacept), Boniva (ibandronate), Botox (botulinum Type A), Myobloc (botulinum Type B), Orenzia (abatacept), Reclast (zoledronic acid injection), Remicade (infliximab) and Tysabri (natalizumab).

This does not apply to Medicare crossover claims. This change is being made so that there is consistency in prior authorization requirements between the medical and pharmacy benefits. The following J codes (listed in numerical order) are affected: J0129, J0215, J0585, J0587, J1740, J1745, J2323 & J3488.

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

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

Elaprase (idursulfase), Soliris (eculizumab), Somatuline Depot (lanreotide), Synagis (palivizumab) and Xolair (omalizumab). Therefore, the following J codes, C codes and other codes (listed in numerical order) will not be accepted: 90378, C9003, C9237, J1300, J1743 & J2357. These medications must be billed through the pharmacy benefit using NDC's. Please note that these medications do require prior authorization for payment through the pharmacy benefit.

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

Procedure Code 77082 Update

Please be advised, effective 09/08/2008, procedure code 77082 will allow place of service codes 21 (inpatient), 22 (outpatient) and 11 (office) and allow provider types T37 (physician assistant), T06 (nurse practitioner), 005 (physician) and 001 (general hospital).

Procedure Codes 53020 & 43520 Update

Please be advised, effective 09/08/2008, procedure code 53020 & 43520 will allow place of service codes 21 (inpatient) and 22 (outpatient) and provider types 005 (physician) and 001 (general hospital).

Procedure Code 61537 Update

Please be advised, effective 09/08/2008, procedure code 61537 will be restricted to place of service code 21 (inpatient) only.

Non-Covered Services

Please be advised, effective 09/08/2008, procedure codes 93745, K0606-K0609 will no longer be reimbursable services by Vermont Medicaid.

37 Codes Requiring Prior Authorization

Please be advised, effective 09/08/2008, the following codes for “Prosthetics w/Myoelectric/Microprocess Components” will require a prior authorization from the OVHA:

L5856, L5857, L5858, L6025, L6638, L6646, L6648, L6881, L6882, L6920, L6925, L6930, L6935, L6840, L6945, L6950, L6955, L6960, L6965, L6970, L6975, L7007-L7009, L7040, L7045, L7170, L7180, L7181, L7185, L7186, L7190, L7191, L7260, L7261, L7266 & L7274.

Procedure Code L8010 Update

Please be advised, effective 09/08/2008, procedure code L8010 will require a modifier of either RT or LT and will be limited to 3 per arm per year (365 days).

Procedure Code A4211 Update

Please be advised, effective 09/08/2008, procedure code A4211 will no longer be a reimbursable service by Vermont Medicaid.

Missed Dental Appointments Update

Are you sending a claim to report a missed appointment by a recipient participating in Vermont Medicaid? To date, the following missed appointments have been submitted to EDS for data collection:

<u>Month</u>	<u>Missed Appointments Reported</u>
January	58
February	209
March	182
April	102
May	349
June	621
<u>Total:</u>	<u>1521</u>

To ensure that your facility is accurately being represented in this data collection process, you will need to bill procedure code D0999 with a \$0.00 billed amount. This code will be for reporting purposes only and there is NO reimbursement associated with it. The OVHA plans to evaluate this data with the intent of developing processes to reduce missed appointments in the future.

Procedure Code 90853 Update

Please be advised, per Correct Coding Initiative, procedure code 90853 should be billed as one unit per visit. Previous directives allowed 90853 to be billed in 15 minute increments.

Effective 09/08/2008, providers will be required to bill only one unit per visit and sessions will be limited to one session per day and 3 sessions per week.

August 1, 2008

Naturopathic Physician Coverage

On March 6, 2008, Vermont Legislature authorized the Office of Vermont Health Access to provide coverage for medically necessary health care services within the Vermont Medicaid and VHAP Benefit Packages provided by a Naturopathic Physician (ND). NDs must be licensed in Vermont and provide treatment within the scope of their practice.

NDs must provide additional required information if they wish to enroll as a Primary Care Provider (PCP) in the Primary Care Plus Program with Vermont Medicaid. This includes having a formal arrangement with a physician who has local hospital admitting privileges. NDs seeking to enroll as PCP's must complete the Agreement for Participation for Naturopathic Physicians available at: www.vtmedicaid.com under Downloads/Forms. For additional information, please refer to the Provider Manual under Downloads/Manuals.

NDs who do not meet the above conditions to become a PCP for Vermont Medicaid are considered Specialists and services will require a PCP referral.

NPI Form Locators—CMS 1500 08/05

As a reminder, effective 07/01/2008, Vermont Medicaid began accepting the referring/prescribing physician NPI number in field locator 17b for claims processing. The DME service provider NPI number should appear in form locators 33a and 24j. This will be a mandatory requirement effective 08/01/2008.

July 25, 2008

Procedure Code 80101

Please be advised, effective 08/18/2008, procedure code 80101 has been updated by the OVHA with restrictions to allow a maximum of 13 units per billing.

Notes will be required in order to substantiate the number of units if more than the maximum of 13 units are billed per date of service.

Procedure Codes J7340-J7349 Limits

Please be advised, effective 08/18/2008, procedure codes J7340-J7349 will be restricted to allow provider type 001 (general hospital) and place of service 21 (inpatient) and 22 (outpatient) only.

Procedure Codes 95875 & 43842

Please be advised, effective 08/18/2008, procedure codes 95875 & 43842 will no longer be reimbursable services by Vermont Medicaid.

Limitations for Procedure Code S2079

Please be advised, effective 08/18/2008, procedure code S2079 will be restricted to allow provider type 005 (physician) and provider specialty 002 (surgeon) only.

Unit Restrictions

Please be advised, effective 08/18/2008, many of the procedure codes that are under the "Physical Medicine and Rehabilitation" section of the current CPT book, have been updated and will be limited by Vermont Medicaid to the following:

-One unit per billing:

92506-92508, 97001-97004, 97010, 97012, 97014, 97016, 97018, 97022, 97024, 97026, 97028, 97150, 97546, 97597, 97598, 97602, 87605 & 97606.

-Four units per billing:

97032-97036, 97110, 97112, 97113, 97116, 97124, 97140, 97530, 97532, 97533, 97535, 97537, 97542, 97750, 97755, 97760-97762.

If any of the above procedure codes are billed to Vermont Medicaid with more than the maximum units allowed, notes will be required to substantiate the number of units being billed.

Procedure Code S2083

The Office of Vermont Health Access recognizes Temporary National Code S2083 for adjusting the gastric lap band diameter. This adjustment cannot be billed separately (additionally) during the 90-day post-op (global) period. After the 90 days, the physician provider may bill S2083 for adjusting the lap band in addition to billing for the concurrent medical visit. Prior authorization is not required. Current best practice for band adjustment must be followed.

Hyperthermia Restrictions

Please be advised, effective 08/18/2008, the OVHA has updated procedure codes 77600, 77605, 77610, 77615 & 77620 with restrictions to allow only:

-Place of service codes 21 (inpatient) and 22 (outpatient)

-Provider types 001 (general hospital) and 005 (physician) and;

-Provider specialty 030 (diagnostic radiology) and 063 (portable x-ray supplier).

Medicare NPI Information

With NPI-only billing, please be advised of the following:

All providers who were required by Medicare to obtain more than one NPI number (due to multiple service locations, for example), must supply EDS with all NPI numbers used when billing Medicare.

When billing crossover claims for instances where Medicare required more than one NPI number, it is imperative that EDS has all current NPI information on file. Otherwise, the NPI number on your crossover claim may not correspond with the information in the EDS system resulting in possible delays in reimbursement.

Please submit all Medicare NPI numbers to Provider Enrollment in order for your provider file to be updated. If you have any further questions, you may contact Provider Enrollment at 802-878-7871.

Attention: Electronic Claim Submitters

With the implementation of NPI-only claims processing for all providers who are not considered atypical, be advised of the following:

If you are submitting your claims electronically using your billing NPI and the NPI is either invalid or not registered with Vermont Medicaid, your claims will have to be deleted from the system. This is a result of your provider information being unidentifiable by EDS. If you have multiple taxonomies associated with your NPI, you must utilize the correct NPI/Taxonomy combination in order for us to crosswalk to your Vermont Medicaid provider number.

If you are the submitter, make sure your .ACK and .SUB report indicates the files were accepted. Provided that they are, you should be able to view your claims on the website (www.vtmedicaid.com) under Claim Status one to two days after submission. If you cannot locate your claims, please contact Provider Services at 802-878-7871. If they are unable to locate these claims as well, please verify your NPI by referring to the information posted on the website under Downloads/Provider Listings, then Active Provider List.

The NPI information provided on the claim must match the EDS database. If it does not, please correct and resubmit your claims for processing. However, if your claims cannot be located and your NPI information is correct, please contact the EDI Coordinator at 802-879-4450, Option 3.

July 11, 2008

2004 SSI Income Rule Changes

In July 2007, VT Legal Aid contacted the Agency of Human Services regarding a 2004 supplemental security income rule change and its impact on some VTMedicaid beneficiaries. This change resulted in the denial of benefits for nearly 900 recipients. The AHS has reviewed the involved beneficiaries and has granted retroactive Medicaid coverage for coinsurance and deductible balances effective 01/01/2006.

How does this effect the provider community?

Claims for this group of beneficiaries, processed by Medicare B will automatically be reprocessed through EDS from Medicare. It will not be necessary to bill or document these claims. Reimbursement will be made to the provider VIA the normal claims processing method. These payments should be applied to the patient's account whether paid, written off or unpaid. If a payment is posted to an account that the beneficiary has already paid, the provider must reimburse the beneficiary any payment they made for the service. If beneficiaries want reimbursement for DME, hospital, RHC/FQHC and Home Health services, they will need to supply documentation that they paid for the service. Beneficiaries have been told that they need proof of payment, so may your office for proof of payment for specific dates of service. They then have to submit the proof to AHS for reimbursement of Medicare coinsurance/deductible balances. The documentation of proof of payment you can supply to the beneficiary is essential to the process and will expedite their reimbursement.

Thank you for your help with this project to reimburse these vulnerable citizens with money they should not have to pay. For more information, links to the beneficiary notifications will be available soon at www.vtmedicaid.com. Provider questions should be directed to the EDS Provider Help Desk at 800-925-1706 our out-of-state 802-878-7871. Beneficiary questions should be directed to 1-800-MEDICARE (800-633-4227). For a summary of services, or for additional questions, beneficiaries can call 802-879-8223.

Pharmacy Assessment Form

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

Vision Coverage – Lens Restrictions

Please be advised, effective 08/01/2008, procedure codes V2750, V2755 & V2761 will no longer be reimbursable services with Vermont Medicaid.

In addition, procedure codes V2025, V2745 & V2781 will only be authorized for reimbursement with a prior authorization from the Office of Vermont Health Access.

Vision Services Reminder

Please be advised, CPT defines procedure code 92370 as being a reimbursable service when used for billing a repair of existing glasses and a refitting once the repair is complete. This code should not be used for replacing lost or replacement glasses.

Multiple Surgery Payments

As a reminder, in an ongoing effort to standardize guidelines and be more consistent with other payers, Vermont Medicaid changed rules governing multiple surgery payments. Vermont Medicaid will pay in order of Relative Value Unit and will pay all surgical procedures in decreasing percentages of 100%, 50%, 40%, 30%, 30%...This includes surgical procedures billed with multiple units.

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

Procedure Codes 20550 & 20551

Please be advised, effective 08/01/2008, procedure codes 20550 & 20551 will be priced at the multiple surgery rate. These codes will no longer be reimbursed with 10 units at 100%.

Procedure Code K0455

Please be advised, effective 08/01/2008, the OVHA has updated procedure code K0455 with the following restrictions:

- Allow place of service 12 (home) only
- Allow provider type 009 (pharmacy) and provider specialty 087 (all other suppliers) only and;
- Allow a minimum of one unit and a maximum of two units per billing.

Procedure Code A4465

Please be advised, effective immediately, procedure code A4465 is a reimbursable service by the OVHA for the billing of lymphedema garments such as the CircAid leggings.

Prior authorization is required for this service and must be obtained from the OVHA prior to the ordering and/or supplying of these garments.

The prior authorization request must clearly document why this type of lymphedema garment is required, fully explaining why less expensive compression wraps/stockings/garments are insufficient for the medical needs of the beneficiary.

In addition, for pricing and payment purposes, an invoice must accompany the claim.

Procedure Code K0462

Please be advised, effective 08/01/2008, procedure code K0462 will no longer be a reimbursable service by Vermont Medicaid.

Procedure Code 76140

Effective 08/01/2008, CPT procedure code 76140 will no longer be a reimbursable service by Vermont Medicaid. When a consultation is performed, the consulting physician can bill with one of the physician's consult codes (99241-99255). The consultant's written report must be kept in the patient's medical record.

Procedure Codes 17110 & 17111

Please be advised, effective 08/01/2008, procedure codes 17110 & 17111 will be restricted to allow place of service 11 (office) and 72 (rural health clinic) only.

Continuous Glucose Monitoring

Please be advised, effective 08/01/2008, procedure codes 95250, 95251, A9276-A9278, S1030 & S1031 will no longer be authorized for reimbursement with Vermont Medicaid.

Updated Place of Service Codes

Please be advised, effective 08/01/2008 the following procedure codes have been updated to allow place of service 21 (inpatient hospital) only:

48152, 62147, 43326, 32659 & 40816.

Provider Type Restrictions

Please be advised, effective 08/01/2008, procedure codes 21685, 35122 & 33217 will be updated to restrict provider type 005 (physician) to be the only provider type authorized for these services.

Procedure Code 91111

Please be advised, effective 08/01/2008, procedure code 91111 will no longer be a reimbursable service by Vermont Medicaid.

Procedure Code E0189

Please be advised, effective 08/01/2008, procedure code E0189 will no longer be a reimbursable service by Vermont Medicaid.

Orthotic Footwear

Please be advised, effective 08/01/2008, the following procedure codes will be limited to 2 pair per year (365 days):

L3201-L3204, L3206, L3207, L3215-L3217, L3219, L3221, L3222, L3224, L3225, L3230, L3251-L3253, L3265, L3208-L3214 & L3649.

If additional units are medically necessary, a prior authorization will be required from the OVHA. All codes listed above, will only be reimbursable when billed with an appropriate modifier.

Enteral Supplies Clarification

Please be advised, the per diem payments on “enteral feeding supply kits” (procedure codes B9998, B4035 & B4036) include any and all items medically necessary for the provision of the enteral feeding. This includes the extension sets required for low-profile gastrostomy feeding buttons/tubes.

Procedure Codes A8000-A8003

Please be advised, effective 08/01/2008, procedure codes A8000-A8003 will be limited to 2 units per year (365 days).

July 4, 2008

Back & Seat Cushion Updates

Please be advised, effective 07/23/2008, procedure codes K0734-K0737 & E2601-E2610 (seat cushions) and E2611-E2617 & E2620-E2621 (back cushions) are limited to a maximum of one cushion (one unit) per 365 days.

Type 2 (Group/Organization) NPI

All providers who have a type 2 (group or organization) NPI, please be advised of the following:

If you have an active type 2 NPI but do not have a *group* Vermont Medicaid provider ID#, you will be unable to submit claims using your type 2 NPI. You must become enrolled with EDS in order to:

1. Obtain a group Vermont Medicaid provider ID# and;
2. Enroll your type 2 NPI

Providers must follow these steps to ensure that Vermont Medicaid has all NPI information necessary on file.

Please refer to our website at www.vtmedicaid.com, under Downloads/Forms, to download the Provider Enrollment Agreement packet. While visiting our site, you may also download the Electronic Funds Transfer (EFT) registration form and/or the EDI registration form (to obtain access to the Web Portal). If you have further questions or concerns, please contact EDS Provider Enrollment at: 802-878-7871 or 800-925-1706.

Updated Online Forms

Please be advised, the Vermont Medicaid Pre-admission Request Form and the Pre-procedure Request Form have been updated and are now available for download at www.vtmedicaid.com under Downloads/Forms.

NPI Form Locators – CMS 1500 08/05

Please be advised, effective 07/01/2008, Vermont Medicaid will begin accepting the referring/prescribing physician NPI number in form locator 17b for claims processing. The DME service provider NPI number should appear in form locators 33a and 24j. This directive will be a mandatory requirement effective 08/01/2008.

June 27, 2008

Revenue Code 402

Effective 01/01/2008, procedure code 93976 may be billed as needed with revenue code 402.

Dental Procedure Codes on UB04 Claim Forms

Please be advised, as of November 2007, procedure code 41899 was updated to require a prior authorization. If services provided for procedure code 41899 were denied and were intended for dental services, you can resubmit the date of service using the appropriate dental procedure codes (D----) in order for your claims to process correctly.

OVHA's Adult Ages

Please be advised, effective 07/11/2008, the following procedure codes will only be authorized for ages 15 and up:

19030, 33720, 33910, 33915, 33916, 77053, 77054, 82757, 89300, 89310, 89320, 89321 & 89325.

Maternity Ages

As a reminder, the maternity age range is defined as 12-55. If you are billing for maternity related services for beneficiaries outside of this age range, additional supporting documentation may be required.

June 13, 2008

DRG Hospital Reimbursement—Medicaid Ineligibility

Please be advised, with the DRG reimbursement methodology in effect, any claims for recipients who become ineligible for Vermont Medicaid during the duration of an inpatient stay, must be billed to EDS in its entirety. EDS will prorate these claims based on recipient eligibility and partially reimburse for the days the recipient 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 recipient for the remainder. Vermont Medicaid will not reimburse for days which the recipient was ineligible, thus it becomes the recipient's financial responsibility.

Refund Forms

As a reminder, when sending a refund check to Vermont Medicaid for paid claims, duplicate payments and/or overpayments, it is imperative that the refund check be sent with the refund form. You may access this form by visiting www.vtmedicaid.com and clicking on Downloads/Forms.

If a refund check is sent to Vermont Medicaid without the appropriate form, your check may be returned for insufficient processing information.

Crossover Claims

Please note as a reminder to wait a minimum of six weeks, following Medicare payment date, prior to submitting crossover claims to Vermont Medicaid to prevent possible duplicate payments and/or denials.

Procedure Code 32664

Please be advised, effective 07/14/2008, procedure code 32664 will be updated to allow place of service 21 (inpatient) in addition to the existing place of service 22 (outpatient) and will be restricted to allow provider type 005 (physician) only.

Cosmetic Surgery Coverage

Providers are reminded that cosmetic surgery and expenses incurred in connection with such surgery, are not covered by Vermont Medicaid.

Coverage is available only when such surgery is required for the prompt repair of accidental injury or the improvement of the functioning of malformed body member (that coincidentally serves some cosmetic purpose). Examples of such required surgeries include the treatment of severe burns, facial repair following an auto accident and severe congenital malformations.

Revenue Code 636

Please be advised, effective immediately, the Office of Vermont Health Access has reviewed and updated revenue code 636. The previous edit limiting 636 to specific conditions or diagnosis codes, has been removed and will be reimbursable when billed with an appropriate HCPCS code.

May 30, 2008

Refund Questions

Did you send Vermont Medicaid a refund check?...Has it been received?...Processed?...
Not sure how to complete the required refund form?

If these are questions you may have and would like assistance regarding the Vermont Medicaid refund process, you may email VTFinancial@eds.com and someone will be available to answer all of your questions.

NDC on Medicare Crossover Claims

Please be advised, when billing a claim for physician administered drugs to Medicare for a beneficiary that also has Vermont Medicaid, it is imperative that the NDC be included in the claim to Medicare even though the reporting of an NDC is not a Medicare requirement. This will prevent Vermont Medicaid denials from drug rebate information on your crossover claims.

Accessing NPI

The implementation deadline for billing Vermont Medicaid using an NPI number has arrived. Providers have two options for obtaining provider NPI information.

- 1.) Available on the Vermont Medicaid website is a listing of all active providers with their associated NPI numbers. This file is available at www.vtmedicaid.com under Downloads/Provider Listings, Active Providers or;
- 2.) The National Plan & Provider Enumeration System (NPPES), has made all provider NPI information available. The link below is for the NPI Registry Search which will enable providers to access all NPI information. This link will allow searching with an individual provider's name, a facility name or by address only. <https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do>

Procedure Code S2075

Please be advised, effective 06/19/2008, procedure code S2075 will be restricted to allow provider type 005 (physician) only. In addition, place of service 21 (inpatient) will be reimbursable.

Procedure Code S2079

Please be advised, effective 06/19/2008, procedure code S2079 will be restricted to allow only provider type Physician and provider specialty Surgeon to perform this procedure. This code will also be restricted to one unit per billing, allow place of service codes 21 (inpatient) and 22 (outpatient) and is only reimbursable when billed with diagnosis code 5300.

Gastric Neurostimulators

Please be advised, effective 06/19/2008, the Office of Vermont Health Access has reviewed and updated procedure code L8680 to the following:

- Allow only provider type 001 (General Hospital)
- Allow only place of service 21 (inpatient) and 22 (outpatient)
- Allow a maximum of 2 units per billing
- Require a prior authorization

In addition, current Category III codes 0155T-0158T & 0162T will no longer be reimbursable services by Vermont Medicaid.

May 16, 2008

Procedure Code 76140

Effective 06/16/2008, procedure code 76140 will no longer be a reimbursable service by Vermont Medicaid.

When a consultation is performed, the consulting physician can bill with one of the physician consult codes (99241-99255). The consultant's written report must be kept in the patient's medical record.

Procedure Code 90875

Please be advised, effective 06/16/2008, Vermont Medicaid will no longer authorize payment for procedure code 90875.

Prior Authorization When Primary Insurer Denies

The following clarification pertains to services that require prior authorization from the Office of Vermont Health Access and have been denied by the primary insurer and/or Medicare.

- 1.) When the Vermont Medicaid beneficiary's primary insurer denies a claim as "non-covered" or "benefits exhausted", the provider needs to request authorization from the OVHA in the regular manner (fax all standard documentation required for a clinical review and a copy of the other insurer's or Medicare denial). These two denials can be reviewed by the OVHA without going through the other insurer (OI)/Medicare/BISHCA appeals process.
- 2.) For all other primary insurer's denials, including "not medically necessary", "pre-existing condition" or "waiting period not met", the provider must first appeal to the primary insurer. Only after all OI/Medicare (through the Qualified Independent Contractor level) and BISHCA (if eligible and available) appeals are denied can the provider request authorization from the OVHA. All documentation showing the appeals denials must be attached to the request along with the standard documentation required for a clinical review.
- 3.) The OVHA will reject a request if there is reason to believe that the OI received incorrect or incomplete information on which to base its decision.
- 4.) It is highly recommended that providers determine OI/Medicare benefits before rendering the service to minimize the risk of non-coverage by both OI or Medicare and the OVHA.

Email Notifications

In an effort to expand provider notifications on changes made by EDS, (i.e. billing manual updates and changes, website updates, etc.), EDS will offer real-time email notifications in addition to the weekly banner pages.

If you would like to receive notifications when updates become available, please send your current email address to VTMedicaidBanners@eds.com. For questions or concerns, please contact your provider representative. Betty Parent at 857-2959, Spring Shover at 857-2956 or Deb Safford at 857-2957.

May 2, 2008

Procedure Code 90649

Please be advised, effective 06/01/2008, the OVHA has updated procedure code 90649 as being a covered medical benefit for females ages 19-26 years old and will be reimbursed by Vermont Medicaid. If the patient is ages 9-18 years old, this will be provided free by the Department of Health and should not be billed to EDS.

Neonate Procedure Codes

Please be advised, effective 06/14/2008, the following Neonate codes may be billed for ages up to 31 days:

31520, 36450, 36510, 36660, 39503, 53831, 54000, 88014, 88016, 88029, 99295, 99296, 99431, 99432, 99433, 99435, 99436, 99440, 99502 & A0225.

Procedure Code E0635

Please be advised, effective 06/01/2008, procedure code E0635 & E0635RR will require a prior authorization from the OVHA.

Procedure Code Restrictions

Please be advised, effective 06/01/2008, procedure codes 49419, 54352 & 62141 will be restricted to allow provider types 005 (physician) and 001 (hospital) only.

Procedure Code 90989

Please be advised, effective 06/01/2008, the OVHA will no longer reimburse for procedure code 90989.

New Diagnosis List for Ablation of Liver Tumors

Please be advised, effective 06/01/2008, procedure codes 47370, 47380, 47382, 77022, 76940 & 77013 will only be reimbursable with specific diagnosis codes.

For the complete listing of supported diagnosis codes, please contact EDS Provider Services at 802-878-7871 (Out of state) or 800-925-1706 (Instate).

April 25, 2008

Medicare Payments

Please be aware, if a beneficiary is covered by Medicare part C or MCR HMO, providers need to indicate this information on the claim form (box 9D on CMS 1500 08/05 and box 50 on UB04) when submitting paper claims to EDS.

As a reminder, if services are provided to a beneficiary who has Medicare part A, B, or C, it is very important that providers do NOT include any payments made by Medicare on the claim form when submitting claims on paper. The prior payment field (box 29 on CMS 1500 08/05 and box 54 on UB04) is strictly designated for other insurance payments (i.e. Cigna, BC/BS, etc.) EXCLUDING Medicare. If present on the claim, the Medicare payment could be considered another primary insurance and the claim could pay incorrectly or pay at \$0.00.

Providers need to submit a paper claim to Vermont Medicaid with the Medicare EOMB attached if Medicare denied services in order for claims to process correctly.

April 11, 2008

HCPCS Codes Requiring NDC

Now available on the Vermont Medicaid website is a list of HCPCS codes representing drugs that may be dispensed or administered in an office or outpatient setting and will require an NDC. Not all codes listed are currently active and payable by Vermont Medicaid nor do they reflect reimbursement. See our fee schedule for current covered services at <https://ovha.vermont.gov/for-providers/claims-processing-1>.

Reminder – New NDC Billing Requirements for Physicians

In November 2007, Vermont Medicaid announced that the collection and submission of data on all drugs dispensed or administered other than by a pharmacy, would be required. This is a program change that is a result of the Deficit Reduction Act of 2005. The purpose of this is to allow for the collection on Medicaid drug rebates from manufacturers on all drugs dispensed in any office setting as required by §1927 of the Social Security Act.

The effective date for reporting NDC's for 837p electronic or CMS 1500 08/05 paper submission, is March 1, 2008. Drugs supplied by manufacturers currently participating in the rebate program, will be the only drugs reimbursed by Vermont Medicaid. A list of these manufacturers, by code and name, can be found at:

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 11 digit NCDC, the unit of measurement qualifier code and the unit quantity.

These must be reported on paper and electronic submissions of all professional claims.

See our website www.vtmedicaid.com under Downloads/Manuals for additional billing information.

P.O. Boxes (UB-04 Only)

As a reminder, effective 02/01/2008, EDS will have updated the PO boxes for all incoming mail received. Please use the following PO boxes accordingly for submission of claims and other mail:

PO BOX 999 Williston, Vermont 05495-0999 -UB forms

PO BOX 1645 Williston, Vermont 05495-1645 –Checks

PO Box 888 Williston, Vermont 05495-0888 -All other mail and inquiries

P.O. Boxes (CMS-1500 08/05 Only)

As a reminder, effective 02/01/2008, EDS will have updated the PO boxes for all incoming mail received. Please use the following PO boxes accordingly for submission of claims and other mail:

PO BOX 777 Williston, Vermont 05495-0777 - HCFA forms

PO BOX 1645 Williston, Vermont 05495-1645 -Checks

PO Box 888 Williston, Vermont 05495-0888 -All other mail and inquiries

P.O. Boxes (Dental/Vision Only)

As a reminder, effective 02/01/2008, EDS will have updated the PO boxes for all incoming mail received. Please use the following PO boxes accordingly for submission of claims and other mail:

PO BOX 1710 Williston, Vermont 05495-1710 -Dental and Vision forms

PO BOX 1645 Williston, Vermont 05495-1645 -Checks

PO Box 888 Williston, Vermont 05495-0888 -All other mail and inquiries

April 4, 2008

NDC Requirement

Effective March 1, 2008 for the CMS 1500, the NDC is required to be in the shaded portion of box 24D. It should include the 11 digit NDC number, unit of measurement qualifier and unit quantity. Please put a space between the NDC and the unit measurement qualifier and a space between the unit measurement qualifier and the unit quantity.

Drugs supplied by manufacturers currently participating in the rebate program will be the only drugs reimbursed by Vermont Medicaid. For specific billing directions and additional information, visit www.vtmedicaid.com under Information, NDC/Drug Rebate.

March 28, 2008

VHAP & Elective Inpatient Coverage

Clarification: Effective 11/01/2007, the OVHA determined that elective inpatient admissions, with acceptable reasoning for admission, were covered for VHAP patients. However, admission to an institution for mental disease (IMD) is not a covered benefit for VHAP Limited recipients. Out of state elective admissions will continue to require a prior authorization.

If you have had claims deny as being a non-covered service for VHAP eligible recipients for elective inpatient admissions and the date of service is 11/01/2007 to current, please resubmit your claims for processing.

System Edits Updates

The OVHA has reviewed and updated many of the Vermont Medicaid system edits to follow best practice in coding procedures. The updated edits listed below will be in effect beginning 04/28/2008:

-Obsolete codes (procedures that are no longer done under current medical standards) will suspend for review. The codes listed below are considered obsolete:

-30210, 38530, 51020, 51030, 51605, 52250, 55705, 55720, 55725, 82965, 93514 and 93528.

-The General Medical edit follows the CMS guidelines for general medical visits and pre-post op care. These guidelines do not allow the separate reporting of most evaluations and management services when a substantial diagnostic or therapeutic procedure is performed.

March 21, 2008

Procedure Code 99436

Effective for dates of service beginning 05/01/2008, procedure code 99436 has been restricted to only:

- Allow provider type 005 (physician)
- Allow provider specialties Pediatrician and Neonatologist
- Allow place of service 21 (inpatient), 22 (outpatient) and 25 (birthing center)
- Allow a maximum of one unit per billing

New GA Voucher Emergency Dental Treatment Codes

General Assistance Vouchers are issued by The Economic Services Division of The Department for Children and Families as a means of providing emergency treatment to relieve pain, bleeding and/or infection. Payment for covered services is based on the current OVHA Dental Procedure/Fee Schedule.

The guidelines and procedure codes that are deemed reimbursable for beneficiaries with valid General Assistance Vouchers, have been updated for 2008. The guidelines and list can be found on the Vermont Medicaid website www.vtmedicaid.com under Information.

Procedure Code V2756

Please be advised, the Office of Vermont Health Access has updated procedure code V2756 to be limited to one unit per 2 years (730 days).

2006 ADA Claim Form

As the NPI deadline nears, EDS would like to remind providers that effective May 1, 2008, the 2006 ADA dental claim form will be the only acceptable claim form for billing Vermont Medicaid, as it allows for the use of the NPI number. All other dental claim forms will not be accepted and will be returned.

Procedure Codes E0700 & E0705

Effective 05/01/2008, procedure codes E0700 and E0705 will be limited to a maximum of one unit per billing and procedure code E0700 will require a prior authorization from the Office of Vermont Health Access.

March 14, 2008

Taxonomy Reconsideration for Single NPI/Taxonomy Providers

EDS and the OVHA have received feedback from many provider organizations expressing their concerns regarding the difficulty they are experiencing with the system modifications necessary to accommodate the VT Medicaid requirement to supply both an NPI and taxonomy combination. EDS has evaluated options that would eliminate the need for most providers to supply the taxonomy code. The OVHA will allow providers to use just their NPI if they have a one-to-one NPI to their VT Medicaid ID. However, those providers who have multiple Medicaid ID numbers that map to a single NPI, will be required to continue using NPI/taxonomy combinations.

The start date will be April 1, 2008 for 837I electronic claims and UB 04 paper claims and May 1, 2008 for 837P, CMS 1500 08/05 paper claims, 837D and 2006 ADA claim forms. If you have already implemented the use of NPI/Taxonomy for Vermont Medicaid claim submission, you will not need to make any changes to your current process.

Please contact your provider rep directly with any questions; Spring Shover 857-2956, Betty Parent 857-2959 and Deb Safford at 857-2957.

February 29, 2008

Selection/Assignment of a Dental Home for Children

Effective 02/01/2008, the Office of Vermont Health Access will provide for the selection/assignment of a primary dentist to each child, allowing for the same continuity of oral health care as assigning a Primary Care Physician (PCP) for health improvement. A dental home is a direct way to emphasize the importance of oral health care, and begins an early thought process that oral health and seeing a dentist are just as important as a regular physical and seeing a physician.

Medicaid/Dr. Dynasaur enrollees between the ages of 1-21 who are already seeing a dentist, will have the option to list that dentist, along with a physician when they enroll with Member Services. Otherwise, enrollees have two other options to select a dental home: 1.) go to the Medicaid website www.vtmedicaid.com and click on Provider Look-Up to select a dentist currently accepting patients, or 2.) call Member Services at 1-800-250-8427 for assistance in finding a dentist that is currently accepting patients.

Dentists: Update Your Information with EDS

With the newly added capability to provide for the selection/assignment of a primary dentist for children, it is important to have accurate information for dental providers. Your demographic information should reflect current office policies concerning acceptance of Medicaid/Dr. Dynasaur patients. This will ensure appropriate selection/assignment of dental homes for Medicaid/Dr. Dynasaur children. There is no better time for you to update your demographic information with EDS.

You may visit www.vtmedicaid.com under Transaction Services/Provider Self-Maintenance. You will need to log in using either the VT Medicaid provider ID# **and** Tax ID# OR NPI/Taxonomy code/Tax ID# combination. However, if EDS has your NPI/Taxonomy code current in our system and you are attempting to log in using your provider ID#, an error message appears and you will be unable to proceed until you use your NPI/Taxonomy combination. Also, if the provider is currently inactive, they will be unable to log in.

If you have issues signing in, you may contact EDS Provider Enrollment at 802-878-7871, and they will be glad to assist you.

Eligibility Verification

Please be advised that Eligibility Verification via the POS devices, PES Interactive and Vender Interactive as well as Claim Status requests via PES Interactive and Vendor Interactive, will be unavailable on Sunday March 16th from 1:00 AM EDT to 1:00 PM EDT due to hardware maintenance. If you must verify beneficiary eligibility during this time period, please use the Vermont Automated Voice Response system. If you have signed a Trading Partner agreement with EDS, you may also use the Vermont Medicaid webpage at www.vtmedicaid.com to verify beneficiary eligibility and check claim status.

February 22, 2008

NDC Drug Code Requirement (Institutional)

The effective date for reporting NDC for electronic claim submissions, 837I or paper submission (UB04 claim form) is July 1, 2008, extended from the original January 1, 2008 start date.

A list of manufacturers, by code and name that are currently participating in the rebate program, can be found at:

http://www.cms.hhs.gov/medicaiddrugrebateprogram/10_drugcomcontactinfo.asp.

Pharmaceuticals supplied by these manufacturers will be the only drugs reimbursed by Vermont Medicaid. See our website www.vtmedicaid.com under Downloads/Manuals for additional information.

NDC Drug Code Requirement (Professional)

The effective date for reporting NDC for electronic submissions, 837P, or paper submission (CMS 1500 08/05 claim form) is March 1, 2008, extended from the original January 1, 2008 start date.

A list of manufacturers, by code and name that are currently participating in the rebate program, can be found at:

http://www.cms.hhs.gov/medicaiddrugrebateprogram/10_drugcomcontactinfo.asp.

Pharmaceuticals supplied by these manufacturers will be the only drugs reimbursed by Vermont Medicaid. See our website www.vtmedicaid.com under Downloads/Manuals for additional information.

February 15, 2008

Closed For Holiday

Please be aware, the OVHA and EDS will be closed on Monday, February, 18 2008 for President's Day. Both offices will re-open on Tuesday the 19th.

Taxonomy Reconsideration for Single NPI/Taxonomy Providers

EDS and the OVHA have received feedback from many provider organizations expressing their concerns regarding the difficulty they are experiencing with the system modifications necessary to accommodate the VT Medicaid requirement to supply both an NPI and taxonomy combination. EDS has evaluated options that would eliminate the need for most providers to supply the taxonomy code. The OVHA will allow providers to use just their NPI if they have a one-to-one NPI to their VT Medicaid ID. However, those providers who have multiple Medicaid ID numbers that map to a single NPI, will be required to continue using NPI/taxonomy combinations.

The start date will be April 1, 2008 for 837I electronic claims and UB 04 paper claims and May 1, 2008 for 837P, CMS 1500 08/05 paper claims, 837D and 2006 ADA claim forms. If you have already implemented the use of NPI/Taxonomy for Vermont Medicaid claim submission, you will not need to make any changes to your current process.

Please contact your provider rep directly with any questions; Carrie Germaine 857-2964, Betty Parent 857-2959 and Deb Safford at 857-2957.

NPI Implementation Dates (CMS 1500/837P/Dental)

May 1, 2008, 837P electronic claims, CMS 1500 08/05 paper claims, 837D and 2006 ADA claim forms billed without an NPI/taxonomy combination (See Reconsideration of Taxonomy banner page) in the required fields identifying the billing and attending providers, will be rejected. You may no longer submit claims containing a Vermont Medicaid provider number unless you are considered to be an atypical provider.

Failure to comply by this date will result in your claim being rejected or returned as not being able to be processed.

NPI Implementation Dates (UB04/837I)

April 1, 2008, 837I electronic claims and UB04 paper claims billed without an NPI/taxonomy combination (See Reconsideration of Taxonomy banner page) in the required fields identifying the billing and attending providers, will be rejected. You may no longer submit claims containing a Vermont Medicaid provider number unless you are considered to be an atypical provider.

Failure to comply by this date will result in your claim being rejected or returned as not being able to be processed.

February 8, 2008

Staples Reminder

As a reminder, EDS would like providers to refrain from the use of staples to attach additional information to paper claims. The staples used to attach documentation to claims are removed manually prior to the scanning process. If the claim tears from the removal of the staple, this may cause the scanner to jam, which may result in a delay in the overall process time of your claim.

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

PES 2.20 Upgrade

PES 2.20 is now available for download on the Vermont Medicaid website under Downloads, Software. This new release adds the ability to enter NDC information and has an enhancement to bill multiple taxonomy codes associated with a single NPI. Also, please read PES News (under Software) for further details.

January 18, 2008

Adult Dental Dollars

The adult dental benefit amounts are now available via the Voice Response System option #5 and Transaction Services on the website www.vtmedicaid.com.

While verifying eligibility, you will now be able to see the total dollars paid to date (including pending to pay claims) and the total billed dollars in suspense awaiting claims processing.

Which to use??

The VRS is limited to five transactions only and is limited to current year information only. The website offers the previous years limitations when requested.

National Drug Code Requirement (UB 04)

The effective date for reporting NDC for electronic submissions, 837I or paper submission (UB 04 claim forms) is July 1, 2008, extended from the original January 1, 2008 start date.

A list of manufacturers, by code and name that are currently participating in the rebate program, can be found at:

http://www.cms.hhs.gov/MedicaidDrugRebateProgram/10_DrugComContactInfo.asp

Pharmaceuticals supplied by these manufacturers will be the only drugs reimbursed by Vermont Medicaid.

See our website www.vtmedicaid.com under Downloads/Manuals for additional information.

National Drug Code Requirement (CMS 1500 08/05)

The effective date for reporting NDC for electronic submissions, 837P or paper submission (CMS 1500 08/05 claim forms) is March 1, 2008, extended from the original January 1, 2008 start date.

A list of manufacturers, by code and name that are currently participating in the rebate program, can be found at:

http://www.cms.hhs.gov/MedicaidDrugRebateProgram/10_DrugComContactInfo.asp

Pharmaceuticals supplied by these manufacturers will be the only drugs reimbursed by Vermont Medicaid.

See our website www.vtmedicaid.com under Downloads/Manuals for additional information.

Taxonomy Reconsideration for Single NPI/Taxonomy Providers

EDS and the OVHA has received feedback from many provider organizations expressing their concerns with the difficulty they are experiencing with the system modifications necessary to accommodate the Vermont Medicaid requirement to supply both an NPI and Taxonomy combination. EDS is currently evaluating options that would eliminate the need for most providers to supply the taxonomy code. The decision to implement an alternate process should be made by the end of January 2008.

Please watch for further updates from EDS regarding the proposed change in this claim submission process. If you have already implemented the use of NPI/Taxonomy for

Vermont Medicaid submission, you will not need to make any changes to your current process.

However, those providers who have **multiple Medicaid ID numbers** that map to a single NPI, would be required to continue using your NPI/Taxonomy combination.

Please contact your Provider Representative directly with any questions: Carrie Germaine 857-2964, Betty Parent 857-2959 and Deb Safford 857-2957.

January 11, 2008

Closed for Holiday

Please be aware, EDS and the OVHA will be closed Monday, January 21, 2008 for Martin Luther King Day.

January 4, 2008

Attention Hospital Billers

You can find the latest DRG/OPPS billing information on the Vermont Medicaid website under Downloads /Manuals. This site includes: payment policies for neonatal and swing bed, relative weights, OPPS revenue codes, DRG Q&A and 2008 diagnosis/surgical code mapping.

December 21, 2007

Closed for Holiday

Please be aware, EDS and the OVHA will be closed Tuesday, December 25th for the Christmas holiday and Tuesday, January 1st for New Year's.

P.O. Boxes (UB-04 Only)

Please be aware effective 02/01/2008, EDS will have updated the PO boxes for all incoming mail received. Please use the following PO boxes accordingly for submission of claims and other mail:

PO BOX 999-UB forms

PO BOX 1645-Checks

PO Box 888-All other mail and inquiries

P.O. Boxes (CMS-1500 08/05 Only)

Please be aware effective 02/01/2008, EDS will have updated the PO boxes for all incoming mail received. Please use the following PO boxes accordingly for submission of claims and other mail:

PO BOX 777- HCFA forms
PO BOX 1645-Checks
PO Box 888-All other mail and inquiries

P.O. Boxes (Dental/Vision Only)

Please be aware effective 02/01/2008, EDS will have updated the PO boxes for all incoming mail received. Please use the following PO boxes accordingly for submission of claims and other mail:

PO BOX 1710-Dental and Vision forms
PO BOX 1645-Checks
PO Box 888-All other mail and inquiries