

## Banner Pages for December 31, 2010

### Spider Veins (Reminder)

Providers are reminded that per Vermont Medicaid Rule 7310, cosmetic surgery and related expenses are not covered. This includes the treatment of spider veins. Cosmetic surgery and related expenses are not to be billed to Vermont Medicaid.

### Reminder about Payment Error Rate Measurement (PERM) Program Audits

Vermont Medicaid is participating with the Centers for Medicare and Medicaid Services (CMS) in the FY2010 Payment Error Rate Measurement (PERM) project, which will continue into 2011. CMS will randomly sample Vermont Medicaid provider and pharmacy claims from FFY 2010 to test for data processing accuracy and medical necessity. Provider interactions in this process will be primarily with the CMS contractor, A+ Government Solutions, who will review Medicaid and CHIP claims to determine if the claims were correctly paid.

It is important that providers cooperate by submitting all requested documentation in a timely manner because no response or insufficient documentation will count against the State of Vermont as an error. Thus, the State will need to recoup the paid amount from the Provider to comply with CMS requirements. We thank you in advance for your support of the PERM program.

A+ Government Solutions will initially establish contact with the provider via telephone, then fax or email the provider a letter which describes the medical record or prescription documentation they need the provider to submit to support the claim. Once you receive the request for medical records, you must submit the information electronically or in hard copy within 60 calendar days. During this 60 day timeframe, A+ Government Solutions will follow up to ensure that you submit the documentation before the timeframe has expired. Staff from the Department of Vermont Health Access (DVHA) may contact you to assist in the process. Please note that it will be the responsibility of the provider to ensure that any and all supporting medical records are submitted in a timely manner.

For reviews that require extra information, the contractor will contact you for additional documentation. You will then have 15 calendar days to submit the requested additional documentation.

Additional information is available at [www.cms.gov/PERM](http://www.cms.gov/PERM) (click on the Providers link in the Overview panel). You may also contact your Department of Vermont Health Access PERM Representative, [judith.jamieson@ahs.state.vt.us](mailto:judith.jamieson@ahs.state.vt.us), with any questions.

## December 24, 2010

### Medicaid Lock in Program Name Change to Team Care Program

Beginning January 1, 2011, the Medicaid Lock-in Program will be renamed as the Team Care Program. The Team Care Program will continue to help beneficiaries achieve appropriate care through coordination with their PCP, pharmacy, and specialists when necessary.

Program beneficiaries are assigned to one provider and one pharmacy. In order for Medicaid to pay for their prescriptions, beneficiaries must receive medical services from those providers.

The Team Care Program will be addressed in more detail in the February Advisory.

## Contractual Allowance Update on 837 Electronic Claims

The primary insurance contractual allowance amount will now be processed directly from the electronic transaction. HP has implemented the following updates to 837 electronic claims:

- On 837 Professional transactions when the value in CAS01 is CO, the amounts entered in the CAS segments of the 2340 loop will be added to the amount in the SVD02.
- On 837 Institutional transactions when the value in CAS01 is CA, the amounts entered in the CAS segments of the 2320 loop will be added to the amount in the AMT02 when AMT01 is C4.
- On 837 Dental transactions when the value in CAS01 is CO, the amounts entered in the CAS segments of the 2430 loop will be added to the amount in the SVD02.

Providers are no longer required to add the contractual allowance to the primary insurance paid amount. Continuing to do so may result in a lower reimbursement amount.

This change does not apply to paper claim submission. Providers are still required to enter the total of the contractual allowance and paid amounts in box 29 of the CMS-1500 form.

### December 17, 2010

#### RR Modifier No Longer Allowed for the Following Codes

Effective January 17, 2011, The RR modifier is no longer allowed for the following Codes: E0983, E0984, E0985, E0986, E1002, E1003, E1005, E1006, E1008, E1009, E1010, E1028, E1029, E1030, E2201, E2202, E2203, E2204, E2310, E2311, E2321, E2322, E2323, E2324, E2325, E2326, E2327, E2328, E2329, E2330, E2340, E2341, E2342, E2343, E2351, E2500, E2502, E2504, E2506, E2508, E2510, S8999, & E1399. The RR modifier is allowed with code E2201 for the billing of crossover claims (only). In addition, some rental equipment rates will be updated.

#### Closed for the Holiday

The DVHA and HP Enterprise Services offices will be closed on Friday, December 24th and Friday December 31st, in observance of the Holidays. Please submit all claims by the Thursday prior to each Holiday closure.

#### Injection Filgrastim (480 MCG) (Date Correction)

Effective January 10, 2011; HCPCS Code J1441 will no longer allow diagnosis 279.00 and 288.0. This HCPCS code is not open to all diagnoses.

#### Scrotoplasty Diagnosis Restriction (Date Correction)

Effective January 10, 2011; billing for CPT Code 55175 is restricted to the following diagnoses: 911.6, 911.7, 911.8 and 911.9.

### December 10, 2010

#### Electronic Claim Submission Interruption

Providers will be unable to complete the following transactions: submit claims electronically, eligibility verification via 270/271, claim status (276/277) or Remittance (835) on December 12, 2010 between the hours of 1:00am and 8:00am; due to maintenance being performed on the EDI Translator. Eligibility can be verified through The Voice Response System and the web portal. We apologize for any inconvenience this may cause.

### Injection Filgrastim (480 MCG)

Effective January 10, 2010; HCPCS Code J1441 will no longer allow diagnosis 279.00 and 288.0. This HCPCS code is not open to all diagnoses.

### Scrotoplasty Diagnosis Restriction

Effective January 10, 2010; billing for CPT Code 55175 is restricted to the following diagnoses: 911.6, 911.7, 911.8 and 911.9.

### Disability Determination Services

Disability Determination Services (DDS)  
93 Pilgrim Park Road, Suite 6  
Waterbury, VT 05676  
802-241-2463

DCF Rule 4215 for Determining Disability or Blindness indicates that disability and blindness determinations are made by the Office of Disability Determination Services (DDS) in accordance with the applicable requirements of the Social Security Administration based on information supplied by the applicant, by reports obtained from the physicians & other health care professionals who have treated the applicant. The department has primary responsibility, through the DDS, for assuring that adequate information is obtained upon which to base the determination.

If the DDS finds that additional information is needed to determine whether individuals are disabled or blind according to the Social Security Act, the DDS orders and schedules consultative examinations with providers who have agreed with the DDS to perform these services for a specific fee.

Payments for any "disability related" examinations not ordered directly by DDS are the responsibility of the individual. Healthcare professionals should not order or perform such examinations without first receiving written confirmation from the DDS that the DDS will pay for the service. Please do not bill Vermont Medicaid for work hardening/functional capacity evaluations as these are not covered by Medicaid. DDS does not generally order these exams and will pay for these or any other examinations, only if ordered by the DDS directly.

## December 3, 2010

### Vaccines not covered by Vermont Medicaid

Vaccines represented by CPT codes 90644, 90661, 90664, 90666, 90667, and 90668 are not reimbursable by Vermont Medicaid because they are not FDA-approved. This is retroactively effective to July 1, 2010 (when the codes first came into existence).

## OPPS Related Payment Practices Effective October 1, 2010

Effective for dates of service on or after October 1, 2010, The Department of Vermont Health Access (DVHA) will utilize the Medicare Outpatient Prospective Payment System (OPPS) 2010 Fee Schedules with some exceptions.

1. As previously practiced, Composite pricing will not be used in the DVHA's payment methodology.
2. Payment for high level emergency room CPTs 99284 & 99285 has changed in the updated OPPS claims processing. The emergency room code and the other primary service code will now be eligible for reimbursement when submitted on the same claim. There are no other changes to packaging logic.
3. For OPPS-paid services, fees paid by the DVHA will utilize the national median rates set by Medicare, less 17.00% per the Final Rule released November 20, 2009.
4. Non-OPPS services will be paid using the Medicaid Fee Schedule.

## November 26, 2010

### Closed for the Holiday

The DVHA and HP Enterprise Services offices will be closed on Thursday, November 25th and Friday, November 26th in observance of the Thanksgiving Holiday. Please submit all claims by Wednesday November 24th for processing.

## Ladies First Provider Survey Deadline Extension

Ladies First has extended the deadline for providers to complete the Ladies First Provider Feedback Survey.

Simply click on the survey link below by December 15th, 2010:

<https://www.surveymonkey.com/s/62D7S7C>

If you have questions or would like more information on the Ladies First Program, call our Ladies First Provider Support Line at 1-800-510-2282 or go to [www.LadiesFirstVt.org](http://www.LadiesFirstVt.org).

## The Billing of Accessories - Components

Effective December 27, 2010, DME providers are no longer allowed to bill accessories/components separately for standers and commodes. The generic procedure code E1399 will no longer be allowed for these items. These accessories/components will be included in the base rate. The codes will be manually priced unless they are PAC I.

Please include all pricing documentation when available at the time of the prior authorization to expedite your request.

## November 19, 2010

### Mental Health Provider Claim Submissions

Providers are reminded that all claim forms, electronic transactions, Adjustment Forms, Refund Forms, Medicare Attachment Summary Forms, Inquiry Forms and appeal letters, regardless of the date of service must contain the beneficiary's new UID number.

Also note that when completing the CMS-1500 claim form to list the provider's last name first in box 33. Failure to follow either of these instructions will cause your claim to be denied.

### General Assistance Voucher

It has come to our attention that dental claims submitted with a General Assistance Voucher continue to be billed with the beneficiaries 9 digit identifier (SSN). ALL claims submitted to HP for processing must contain the beneficiary's new Unique ID Number entered in box 15. Claims submitted without the UID Number will continue to be denied.

November 12, 2010

### Vaccine Policy - Clarification

This is a reminder, that all in-state providers must obtain select vaccines from the Vermont Department of Health (VDH) Children's Program for all children through the age of 18. When billing for a state supplied vaccine an SL modifier must be used in conjunction with the CPT or HCPCS code representing the vaccine.

The following is a list of VDH Children's program in-state provider billing codes requiring the SL modifier: 90700 DTAP; 90723 DTAP-Hep B-IPV; 90698DTAP-IPV/Hib; 90696 DTAP-IPV; 90714 and 90718, Td; 90715 Tdap; 90743 Hep B; 90713 IPV; 90647 and 90648, Hib; 90707 MMR; 90716 Var; 90669 PCV; 90732 PPV; 90734 MCV 4; 90632 and 90633 Hep A; 90680 and 90681 RV; 90649 HPV

### Transcutaneous Electrical Nerve Stimulation (TENS)

Effective December 13, 2010, VT Medicaid will require prior authorization for the rental and purchase of TENS units/devices. Consideration of purchase requires documentation of a successful trial period of 30 to 60 days. The rental of a TENS unit will be considered for trial periods and when used for the treatment of acute postoperative pain (less than 30 days post-op) which is not relieved by parenteral or oral pain medication.

### Vermont Medicaid Website

HP Enterprise Services experienced periodic interruptions in service through the Vermont Medicaid Portal from Sept 24th – Oct 3rd. This issue was temporary and has been resolved. Providers are advised to contact a Provider Services Help Desk Representative at 800-925-1706 (in-state) or 802-878-7871 (Out-of-state) to report any future outage. Thank you for your patience.

### CMS-1500 Medicare Crossover Claims

HP Enterprise Services can no longer accept a CMS-1500 crossover claim submitted with multiple Medicare Attachment Summary Forms. When submitting a CMS-1500 crossover claim that contains more than 6 details, each 6 details must be submitted as an individual claim with its Medicare Summary Attachment Form, indicating the number of details and the total. The total must equal only the sum of the detail lines listed on that claim form.

## Closed for the Holiday

The DVHA and HP Enterprise Services offices will be closed on Thursday, November 11th, 2010 in observance of Veteran's Day.

### November 5, 2010

#### Vision Reminder: Repair and Refitting

Vision providers are instructed in accordance with correct billing, not to bill for repair and refitting services (CPT code 92370) on the same day as new lenses and/or frames.

Refitting services as described by CPT code 92370 are only to be used in conjunction with the repair of glasses.

There are several "fitting of spectacles" codes available for use when fitting a new pair of eyeglasses to the beneficiary and does not involve repair. When billing for this service, please view the CPT descriptions to select the most appropriate billing code.

### October 29, 2010

#### HIPAA Requests

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

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

#### Ladies First Provider Feedback Survey

Are you an active Ladies First clinician, office staff member, biller or a hospital, lab, or mammography facility? Ladies First invites you to express your opinions about the Ladies First program and to share your ideas on how to make it better!

Simply click on survey link below and complete the 10 minute survey by November 5th, 2010:

<https://www.surveymonkey.com/s/62D7S7C>

If you have questions or would like more information on the Ladies First Program, call our Ladies First Provider Support Line at 1-800-510-2282 or go to [www.LadiesFirstVt.org](http://www.LadiesFirstVt.org).

### October 22, 2010

#### Timely Filing Appeals (Reminder)

When appealing a timely filing denial, providers are reminded of the following: Write timely filing on the envelope being sent to HP Enterprise Services, resolve all claim issues; if one detail denies for something

other than timely filing the entire claim will be denied, include a brief letter stating the reason for the timely filing request and all corresponding Medicare or other insurance RAs, if applicable. For detailed information regarding timely filing limits see the Provider Manual, sections: 1.2.23 Timely Filing, 1.3.11 Medicaid & Medicare Crossover Billing and 1.3.13 Workers Compensation/Accident Liability Billing located at (<http://vtmedicaid.com/Downloads/manuals.html>).

Mail to: HP Enterprise Services, PO Box 888, Williston, VT 05495-0888. Attn: Timely Filing

### PA & MedSolutions - Correct Facility Name Required

Providers requesting prior authorization from MedSolutions are reminded to use the proper name of the facility to perform the imaging scan. For example: Central Vermont Medical Center will not be recognized by MedSolutions if referred to as Central Vermont Hospital.

### Continuous Positive Airway Pressure (CPAP)

Effective November 23, 2010, the DVHA will require prior authorization (PA) for the purchase and rental of all CPAP devices. Requests must include all appropriate documentation of medical need per best-practice guidelines. In addition, quantities of CPAP-related supplies will be limited. Providers are referred to <http://www.vtmedicaid.com/Downloads/Manuals/DMERestrictions.pdf> for specific allowances per supply item.

### Claim Submission & Correspondence Mailing Addresses

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

PO Box 999 – UB04 Claim Forms  
PO Box 777 – CMS 1500 Forms  
PO Box 1710 – Dental and Vision Claim Forms  
PO Box 1645 – All Checks  
PO Box 888 – All Other Mail & Inquiries  
Williston, VT 05495-0888

### October 15, 2010

#### Prior Authorization – Procedure Changed at Time of Service

The DVHA Clinical Operations Unit enters prior authorizations with the exact procedure code(s) given by the requesting provider on the request form. In those instances when the procedure code to be billed does not exactly match the code requested/authorized, the provider must notify the Clinical Unit in writing prior to claim submission. Include the DVHA prior authorization number, the rationale for the code change and signature. Fax information to (802) 879-5963.

### Speech Generating Device

Effective November 16, 2010, CPT Code 92607 is limited to one unit per 365 days without obtaining prior authorization. One unit equals the first hour of face-to-face evaluation.

CPT Code 92608 is used to bill each additional 30 minutes of evaluation time and is limited to a maximum of 10 units (5 hours); additional time will require prior authorization.

### CPT Code 88141 - Ladies First and Medicaid Providers

Effective November 16, 2010, in accordance with correct coding procedure, HP Enterprise Services will update CPT code 88141 and no modifier will be required. All Claims submitted with the 26 modifier will be denied.

October 8, 2010

### Provider Workshop

HP Enterprise Services will be holding workshops on Medicaid 101, HP Website, and Claim Forms. New billers are encouraged to attend and any other billers wishing a refresher course are welcome. The workshop will be held on Wednesday, October 20th from 10:00am to 12:00 noon at the Southwestern Vermont Medical Center (100 Hospital Drive, Bennington, VT 05201) in conference room C. Please contact Betty Parent at 802-857-2959 to reserve your seat, as space is limited.

### Smoking Cessation Counseling Benefits

Effective October 1, 2010 the DVHA will cover face-to-face counseling for smoking cessation for pregnant Vermont Medicaid beneficiaries. The maximum number of visits allowed per calendar year is 16. Providers who can bill Vermont Medicaid for smoking cessation counseling are physicians, nurse practitioners, licensed nurses, nurse midwives, and physician's assistants. "Qualified" Tobacco Cessation Counselors are also allowed (requires at least eight hours of training in tobacco cessation services from an accredited institute of higher education).

October 1, 2010

### PES Version 2.23 is Now Available

The new release of PES (version 2.23) is now available on the Vermont Medicaid website (<http://vtmedicaid.com/Downloads/Software.html>). PES version 2.23 contains the following changes:

PES has been modified to use the new unique client ID (UID) instead of the social security number on all transactions. The client list and policy holder list has been changed to only allow an ID from one to eight digits. The submission function will not allow the user to submit claims that have more than eight digits.

Providers must use the new Client ID on all electronic transactions beginning October 1, 2010. Our claims processing system will not be able to accept the new ID prior to October 1. Do NOT upgrade unless you do not plan to submit claims prior to October 1, 2010.

Note: When upgrading PES, the upgrades must be completed incrementally. You cannot skip versions without risking database corruption. For example, if you are running version 2.21, you must upgrade to 2.22, then 2.23. To see which version of PES you are currently running, log on to PES, click on Help, About.

### Other Insurance – PA Not Required From MedSolutions

Beneficiaries with other insurance (including Medicare) do not require prior authorization from MedSolutions for out-patient elective diagnostic scans, when the service is covered by a primary insurance. The MedSolutions website is updated daily and only reflects the names of Vermont Medicaid beneficiaries with no other insurance. When a provider is advised by MedSolutions that a beneficiary is not on file, please verify primary insurance with the beneficiary.

### Manual Update Available on Web

The following Provider Manual(s) have been updated and are available on the Vermont Medicaid website at <http://www.vtmedicaid.com/Downloads/manuals.html>.

- Provider Manual
- UB-04 Supplement
- CMS-1500 Supplement
- PA Supplement
- MedSolutions Diagnostic Imaging Program Guidelines and other provider resources. ("New" to the VTMedicaid web site.)

### Diagnoses Restriction

Effective November 1, 2010, the following Diagnoses codes: 611.81, 611.82, 611.83, 672.54, 785.6, 922.0 and 998.13 will no longer be valid, when billed with CPT/HCPCS Codes: 76645, 77058, 77059, C8903, C8904, C8905, C8906, C8907 and C8908.

### September 24, 2010

#### Medicare Crossover Claims to be Recouped

HP Enterprise Services will recoup a claim submitted to Vermont Medicaid as primary payer, if after reimbursement; HP receives the same claim as a Medicare Crossover Claim and/or is notified that Medicaid should not have been billed as the primary payer.

### September 3, 2010

#### CPT Code 55150 Restricted Diagnoses

Effective October 4, 2010, CPT code 55150 will be restricted to the following diagnoses codes: 187.7, 198.82, 222.4, 233.6, 236.6, 239.5, 608.89, 878.2, and 878.3.

### August 27, 2010

#### Electronic Remittance Advices

This notice serves to remind all providers submitting claims electronically to Vermont Medicaid that their remittance advice (RA) is posted to the website. Providers may access their RA via the View RA Files function on the Vermont Medicaid Portal. If you are unable to access your web RA, please contact the EDI Coordinator via email at: [vtedicoordinator@hp.com](mailto:vtedicoordinator@hp.com) for assistance.

## Closed for the Holiday

The DVHA and HP Enterprise Services offices will be closed on Monday, September 6, 2010 in observance of Labor Day.

## August 20, 2010

### Beneficiary Call Referrals

HP has seen an increase in beneficiary calls related to referrals made by providers. Please note beneficiaries should be directed to the Vermont Health Access Member Services (Maximus) for all questions and concerns at 1-800-250-8427 (in-state) or 802-651-1577 (out-of-state). Please do not refer beneficiaries to the HP Provider Services Help Desk.

## August 13, 2010

### Termination of the POS Device (swipe box)

Due to the implementation of the Unique Identification Number (UID) and the removal of the Social Security number from member ID cards, providers will no longer be able to verify eligibility & service limitations through the POS Device (swipe card box). This service will be discontinued as of October 1, 2010, in its place providers are advised to access the automated eligibility verification systems to check eligibility with either a Social Security number or the unique ID number. Use either the online Transaction Services (<http://www.vtmedicaid.com/Interactive/login2.html>) or the HP Voice Response System (Malcolm) 802-878-7871, option 1. If you only have access to a member's Social Security number, these automated systems will provide you with the unique ID number for your claim.

### Attendance at Delivery

This is a revision to the banner titled, Family Practice - CPT Code 99464, effective August 16, 2010. Attendance at delivery services (as described by current CPT CODE 99464) will be covered by Vermont Medicaid for physician family practitioners as well as pediatricians. Providers should document in the patient's medical record that attendance at delivery was requested by the delivering provider and initial stabilization of the newborn occurred. The medical records are not required to be submitted with the claim; however, in accordance with the DVHA'S Program Integrity Process Post Utilization Review, audits may be performed.

## August 6, 2010

### Other Insurance & HIPAA Compliance

To be HIPAA compliant, providers are asked that when submitting a claim that includes Other Insurance attachments, they need to blackout or cross out patient names that do not apply to the claim being submitted for reimbursement to Vermont Medicaid. Do not highlight any information on the claim or its attachments, doing so will cause the highlighted information to be illegible, once it has been scanned into the OCR System.

## MedSolutions Orientation

As part of Vermont Medicaid's efforts to provide its members with access to high-quality, cost-effective care, it has selected MedSolutions to provide a utilization management program for radiology services. The program will take effect August 23, for dates of service beginning September 1, 2010.

MedSolutions will be leading orientation sessions to assist providers with the new radiology management program. Providers will have the option of attending the web-based and/or town hall sessions. During these sessions, MedSolutions will discuss the prior authorization requirements for <health plan>members and the functionality of the MedSolutions website, [www.medsolutionsonline.com](http://www.medsolutionsonline.com). Topics include: the new prior authorization process, accessing information from the website, and a review of the Quick Reference Guide, followed by a question-and-answer session.

Providers planning to attend the Town Hall are asked to RSVP by August 17th, by faxing (866) 226-1335; include your session preference and the number of people attending. Questions can be emailed to Andrew Cline at [andrew.cline@medsolutions.com](mailto:andrew.cline@medsolutions.com). It is recommended that Providers not able to attend the Town Hall Orientation refer to the web orientations.

**Town Hall Orientation, Session 1:** 2 PM to 4 PM, Thursday - August 19, Fletcher Allen Hospital- Davis Auditorium, 111 Colchester Ave. Burlington, VT.

**Town Hall Orientation, Session 2:** 9AM to 11AM, Friday – August 20, Rutland Regional – CVPS Leahy Conference Center – Rooms B & C, 160 Allen St., Rutland VT.

### **Web Orientation Sessions – Date Information & Registration**

Please go to <http://medsolutions.webex.com/> and follow the training path tab/ the "Upcoming" tab and look for Vermont Provider Orientation Session

## Manual Update Available on Web

The following Manual & Supplements have recently been updated and are available on the Vermont Medicaid website at <http://www.vtmedicaid.com/Downloads/manuals.html>.

- Provider Manual
- UB-04 Supplement
- CMS-1500 Supplement
- PA Supplement

July 30, 2010

## Patient Share Adjustments (Reminder)

Adjustment requests for nursing home claims that involve a DCF change to the patient share amount currently require manual handling for reprocessing. Please send an adjustment request form to: HP Enterprise Services, P.O. Box 888, Williston, VT 05495  
Attn: Patient Share Adjustments to ensure proper handling of the request.

## 2006 ADA Dental Claim Form

Providers completing the 2006 ADA Dental Claim Form are advised that the Total Fee in box 33 is the sum of all detail charges entered in field number 31. Other insurance payments should not be deducted from

this total. If other payments are deducted, it will cause the claim to automatically deny due to the total charges not equaling the total of the details listed in field 31.

July 23, 2010

### Dentists- Procedure Code D1206 Denials

Dental Providers may continue to submit claims for reimbursement for procedure code D1206 for beneficiaries ages, 0 - 20 years (the age restriction for all Providers, other than Dentists is 0 – 5 years).

Dental providers whose paper claims were recently denied in error for reimbursement of D1206 will not need to resubmit their claims. HP Enterprise Services is taking responsibility for resubmitting these claims.

Unfortunately, HP Enterprise Services cannot resubmit a claim that was submitted electronically. An HP Enterprise Services help desk representative will call all dental providers whose electronic claim(s) denied in error, to ask that providers resubmit electronically.

### Payment Error Rate Measurement (PERM) Program

#### Provider Education Conference Call

The Centers for Medicare & Medicaid Services (CMS) is hosting a PERM Provider Education Conference Call to provide an opportunity for live dialogue between CMS and the Medicaid provider community in Vermont, New Hampshire, West Virginia, and Utah on Wednesday, August 4, 2010 at 2:00pm to 3:30pm. Details are below.

See NOTE below regarding replay of recorded conference call for a two-day period, 8/4 to 8/6.

The PERM program is designed to measure improper payments in the Medicaid and CHIP programs, as required by the Improper Payments Information Act of 2002 (IPIA; Public Law 107-300). The purpose of the Perm Provider Education conference call is to educate Medicaid providers about PERM and their specific responsibilities during the PERM process.

Provider forum participants will learn:

- An overview of the PERM program, the PERM process and what you may be required to do during a PERM review
- The documentation request letter/what are your responsibilities when the documentation request letter is received
- The follow up schedule and the requirements
- Frequent mistakes and best practices.

The following materials will be discussed and are available at the PERM Providers page of the CMS Website, <http://www.cms.gov/PERM/>

- PERM 101 for Medicaid Providers
- Sample document request letter.

Joining the conference:

1. In the 10 minutes prior to the call, lines will be available by calling the Participant Dial-In # (800) 603-1774. The conference ID # is 87754610. Please provide the following information: State, Organization, # of persons in the room.
2. Provide the Operator with the Conference ID number.

3. Helpful keypad commands:

\*0 – Operator Assistance

\*5 – Group Mute/Unmute

\*6 – Self Mute/Unmute

\*7 – Lock conference to additional participants.

NOTE: Encore is available for this call. Encore is a digital recording of the conference and will be available for replay two hours after the call's completion. The date range that the conference replay will be available, by dialing the Encore Dial In # (800) 642-1687, is 8/4/10 15:00 to 8/6/10 23:59.

There will be time available for Q&A's; however, CMS encourages your questions be submitted in advance to the CMS PERM provider email address of PERMProviders@cms.hhs.gov.

You may also contact the Vermont PERM Representative, bill.clark@ahs.state.vt.us.

Please check the CMS Website's PERM Provider page regularly for additional Provider Education information and updates at <http://www.cms.gov/PERM/>.

## July 16, 2010

### Urine Toxicology Screen Coverage (80101/G0431)

CPT Code 80101 and HCPCS Code G0431 represent the same drug screen test. All restrictions that apply to 80101 also apply to G0431, when billed individually and in combination.

As of October 4th, 2009 Vermont Medicaid restricted it's coverage for the urine toxicology screen (CPT code 80101) to nine units.

Vermont Medicaid no longer covers the following substances utilizing the urine drug screen: Propoxyphene, LSD, PCP and Ethanol. Alternative methods such as a breathalyzer can be utilized for Ethanol testing.

Due to the 2011 State Budget Act E.309.01a(2), Bill #H.789, page # 354:

Effective July 1, 2010, The DVHA has imposed the following limitations and process requirements on benefits for ADULTS in Medicaid and VHAP; Urine drug screens (80101 & G0431) are subject to a limit of 8 billings per calendar month.

### System Maintenance

Please note: HP Enterprise Services will be performing maintenance on hardware utilized to receive Eligibility Verification and Claim Status transactions via the swipe card boxes and independent vendors during the hours of 1:00 am through 3:00 am on Sunday August 8th. During this time your transactions will not be processed. It is recommended that you utilize either the Web at [www.vtmedicaid.com](http://www.vtmedicaid.com) or our Voice Response system at 1-800-925-1706 or 802-878-7871 to submit transactions during this time.

### Family Practice - CPT Code 99464

Effective August 16, 2010, CPT Code 99464 will include Provider Specialty – Family Practice. Reimbursement will be paid only when an actual service(s) is provided; providers are instructed to bill with notes to confirm the service(s) provided. Failure to include the requested information will cause your claim to be denied.

## Checks to Vermont Medicaid

Effective immediately, all checks to Vermont Medicaid need to be paid to the order of HP or HP Enterprise Services.

July 9, 2010

### Utilization Review Approval Criteria

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

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

Providers and members can access DVHA clinical guidelines and Vermont Medicaid Rules on the DVHA website at <http://dvha.vermont.gov/for-providers>. InterQual guidelines are available to providers, members and their representatives upon request when questions arise about clinical rational (InterQual requests must be provider and beneficiary specific). To obtain a copy of the InterQual guidelines please call the clinical unit at 802-879-5903.

### Billing Provider Name Field Reminder

Individual billing providers completing the CMS-1500 Claim Form are required to list their last name first in "box 33".

Individual providers completing the 2006 ADA Dental Claim Form are required to list their last name first in "box 48".

Failure to follow the above directions will cause your claim to be denied.

### Ladies First Billing Reminder

Use of the Ladies First Program indicators is no longer valid. If your claims are being denied as provider not eligible for date of service please verify your claim. Does it have the Ladies First program indicator on it? CMS (Paper) EPSDT/Family Planning [24.H.] 5, CMS (Electronic) Special Program Code Field 03, UB (Paper and Electronic) Any Condition Code Fields 18-28 A3. IF AN INDICATOR IS PRESENT, DELETE AND RESUBMIT THE CLAIM FOR PAYMENT.

July 2, 2010

### Therapists Restricted from Billing E&M Codes (web address correction)

As of July 12, 2010, Therapists are no longer allowed to bill E&M Codes. Providers are directed to consult the Physical, Occupational & Speech Therapy Coverage Guidelines located at

<http://ovha.vermont.gov/for-providers/clinical-coverage-guidelines> or to contact the HP Provider Services Help Desk at 800-925-1706 (in-state) or 802-878-7871 (Out-of-state) with any questions or concerns.

### The Office of Vermont Health Access (OVHA) will become Department of Vermont Health Access (DVHA)

On July 1, 2010, the Office of Vermont Health Access (OVHA) will become the Department of Vermont Health Access (DVHA). This change will not have an impact on our benefit programs and will not change the way you contact us for information and assistance. Please continue to use our existing contact numbers and address (with our new department name).

### Manual Update Available on Web

The following Manual & Supplement has recently been updated and are available on the Vermont Medicaid website at <http://www.vtmedicaid.com/Downloads/manuals.html>.

- **Provider Manual**
- **Dental Supplement**

### 90853 Group Therapy

Effective August 1, 2010, 90853 - Group Therapy; 1 unit = 15 minutes, limited to a maximum of eight (8) units per day, limited to 1 session per day and 3 sessions per week, for each recipient.

June 25, 2010

### Vaccine Policy Reminder

All in-state providers MUST obtain vaccines through the Vermont Department of Health (VDH) Vaccine for Children Program, for children through age 18. Influenza and H1N1 vaccines may be obtained through VDH, however it is not a requirement. The SL modifier must be used when billing the CPT or HCPCS code representing the free vaccine.

Vaccines provided to adults over 18 or vaccines provided by out of state providers to patients of any age, do not have to be obtained by the VDH Vaccine Program. The SL modifier will not be required in either of these circumstances and payment will be based on the current fee schedule.

### Timely Filing Appeals (Clarification)

When appealing a timely filing denial, providers must fully research and document the request in a cover letter along with sending a new claim to submit. The cover letter needs to include the provider name, address, provider number, and extenuating circumstances surrounding the claim (e.g. submission dates, adjusted dates, and denial dates). If there is no cover letter and or the documentation is insufficient to validate extenuating circumstances for the late submission, your appeal will be denied. Please send your appeal request to: HP Enterprise Services, PO Box 888, Williston, VT 05495. Attn: Timely Filing Appeals

### Dispense as written (DAW) Codes

Vermont law requires that when available, the therapeutically equivalent generic product should be dispensed. This requirement may be overridden by the provider in the following conditions:

The prescriber has mandated brand, noting "Brand Medically Necessary" or "Dispense as Written" on the prescription. In this case, the pharmacy provider should submit a Dispense as Written Code (DAW) of "1".

- Brand product is dispensed as a generic: When a pharmacy provider dispenses a brand as their "house generic" instead of the generic equivalent, the provider should submit a DAW of "5."
- OVHA prefers the brand product: In select situations, the state reserves the right to make the determination that a branded product is the preferred product when a newly FDA-approved generic equivalent agent proves more costly to the State than its branded counterpart. These claims should be submitted using a DAW of "6."
- The generic is not available in the marketplace: In this case, the pharmacy provider should submit a DAW of "8". Note that this does not mean that it is not available in the store. DAW8 may only be used when the generic is not generally available in the community. The provider should keep appropriate documentation to support this condition.

Important: DAW1 cannot be used to override the requirements of the OVHA Preferred Drug List.

Pharmacy providers should not bill OVHA for multi-source (innovator) brand drugs using a DAW2 code, which indicates that the beneficiary prefers the brand. These claims will be subject to recoupment.

### Denied Paper Claims

This notification serves to remind providers that all denied paper claims must be resubmitted on a red and white claim form.

### Closed for the Holiday

The OVHA and HP Enterprise Services offices will be closed on Monday, July 5, 2010 in observance of Independence Day.

### 2011 State Budget Act

The following benefit changes resulted from the 2011 State Budget Act passed by the Vermont Legislature.

**For Adults** (Medicaid beneficiaries age 21 & older and VHAP beneficiaries age 18 & older.) Effective for services delivered as of July 1, 2010:

- **Physical, Occupational and Speech Therapy** - limited to 30 (combined) visits per calendar year. Prior authorization (PA) may allow more visits for individuals with a diagnosis of spinal cord injury, traumatic brain injury, stroke, amputation, or severe burn. The limit will not apply to therapy services provided by home health agencies.
- **Urine Drug Tests** - limited to 8 tests per calendar month.

**For All Ages** (Medicaid and VHAP) - Effective for services delivered as of September 1, 2010: (This is a correction to the previously stated effective date of July 1, 2010.)

- **High-Tech Imaging** - CT, MRI, PET, CTA, MRA, and PET/CT scans and some other similar high-tech imaging will require prior authorization (PA). The PA process does not apply to x-rays, mammograms, ultrasounds or images ordered in emergency rooms or for hospital inpatients or during an inpatient admission.

June 18, 2010

### 3SquaresVT - Better Food & Health for Vermont Seniors

Vermonters. 3 Squares VT, an entitlement program of the U.S. Department of Agriculture, is working to help ensure 3 square meals a day on Vermont tables. This extra help is especially important for older Vermonters, many of whom are living on fixed incomes. As doctors, nurses, pharmacists, and other health care professionals, you have the unique opportunity to encourage your patients to eat wholesome foods as a pathway to better health and to help spread the word about this important nutrition program. For more information and outreach materials about 3SquaresVT for all ages, go to [www.vermontfoodhelp.com](http://www.vermontfoodhelp.com).

### Providers Submitting Paper Claims

Providers completing paper claim forms need to enter the entire dollar amount including cents in the appropriate box, examples include: \$5.00, \$10.01, \$129.34 and \$5,000.00. If there is no cent value in the billed amount, please use zeros to indicate that information. Failure to do so will cause your claim to be processed incorrectly

### Therapists Restricted from Billing E&M Codes

(Please see July 2, 2010 banner for revised web address)

Effective July 12, 2010, Therapists will no longer be allowed to bill E&M Codes. Providers are directed to consult the Physical, Occupational & Speech Therapy Coverage Guidelines located at <http://ovha.vermont.gov/for-providers/therapy-guidelines-r-11-2-09.pdf> or to contact the HP Provider Services Help Desk at 800-925-1706 (in-state) or 802-878-7871 (Out-of-state) with any questions or concerns.

### E&M Codes Priced at 100% of the 2006 Medicare Rates

Effective July 19, 2010, the 2009 E&M Codes will be reimbursed at a level equivalent to the Medicare rates as mandated by the 2006 legislation; <http://www.leg.state.vt.us/docs/legdoc.cfm?URL=/docs/2006/acts/ACT191.htm> see Sec. 9 Medicaid Reimbursement.

June 11, 2010

### The New Release of PES is Now Available

The new release of **PES** (version 2.22) is now available on the Vermont Medicaid website ([www.vtmedicaid.com](http://www.vtmedicaid.com) under Downloads/Software). PES version 2.22 contains the following changes:

- PES 2.22 has been modified to accept additional Types of Bill. For Inpatient claims: a prefix of 12 is allowed with the third digit of 1-5, 7, or 8. For a prefix of 11 a third digit of 0 is now allowed (i.e. 110). For Home Health claims a prefix of 82 is allowed with the third digit of 1-5, 7, or 8.
- The Revenue Code field, which is found on all Institutional forms: Home Health, Nursing Home, Institutional Inpatient and Institutional Outpatient, has been expanded from three to four digits. Four digits must now be entered for all Revenue Codes. Previously, a zero prefix was assumed, that is no longer the case, if the Revenue code you are billing starts with a zero, the zero must now be entered.

**Note:** When upgrading PES, the upgrades must be completed incrementally. You cannot skip versions without risking database corruption. For example, if you are running PES version 2.20, you must upgrade to 2.21, then 2.22. To see which version of PES you are currently running, log on to PES; then click on Help, About.

### Electronic Billing of Third Party Liability Denials

Providers are now able to submit claims electronically to HP that have been denied by a third party payer when that payer has denied the claim using certain adjustment reason codes. If another insurance company has denied the claim with one of these codes, providers may bill the claim electronically. Providers are required to include the adjustment reason code used by the primary payer when submitting the claim but will not need to send a copy of the primary insurance attachment. The list of adjustment reason codes that will be accepted electronically is available on the Vermont Medicaid website at [www.vtmedicaid.com](http://www.vtmedicaid.com), select downloads, select manuals and then select 837 adjustment reason codes. HP may select your claim for post payment review and request a copy of the explanation of benefits, if so; providers are required to supply all supporting documentation in a timely manner. Failure to do so will result in the recoupment of your paid claim.

### CPT Code 52260 Restricted Diagnoses

Effective July 12, 2010, CPT code 52260 will be restricted to the following diagnosis codes: 595.1, 599.70, 599.71, 599.72, 788.1 and 788.41.

### Provider Billing of Medicaid Patients

Under the Provider Agreement (Conditions of Participation #9) and the Provider Manual (section 1.2.10), failure to give advance notice that a Vermont Medicaid payment will not be accepted prevents the provider from billing the beneficiary. If the beneficiary is eligible for Vermont Medicaid and the provider has made the decision not to bill Vermont Medicaid for the service or item requested, the beneficiary must be informed in advance of providing the service.

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

June 4, 2010

### CMS-1500 Claim Form (Revision)

The banner previously published on May 14, 2010 stated providers are to stop printing information on the top right hand corner of the CMS-1500 claim form. Due to provider concerns regarding the difficulty of changing the placement of the Vermont Medicaid address, HP Enterprise Services is requesting instead, that providers lower the placement of the HP address ½ inch below the top right hand side of the claim form, for paper claim submissions. The OCR system will utilize the top ½ inch of the right hand side of the CMS-1500 claim form to print information necessary to process your claim.

### Manual Updates Available On-line

The following manuals & supplements have recently been updated and are available on the Vermont Medicaid website at <http://www.vtmedicaid.com/Downloads/manuals.html>.

-CMS 1500

-UB04

-Provider Manual

-Psychiatric Inpatient Supplement ("New" to the VTMedicaid web site)

## HP Provider Representative Territory Update

The following is a detailed listing of the Provider Representative Team and the counties they service:

**Betty Parent:** DHMC, FAHC, Bennington and Rutland counties (802-857-2959).

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

**Spring Shover:** Caledonia, Essex, Orange, Washington, Windham and Windsor counties (802-857-2956).

For a full-colored detailed map depicting each Provider Representative and their corresponding counties, please visit [www.vtmedicaid.com](http://www.vtmedicaid.com) under Information/Provider Representative Map.

### May 28, 2010

#### Rate Change – HCPCS Code E0730

Effective June 28, 2010, the reimbursement rate for HCPCS Code E0730 will be reduced to \$389.09.

### May 21, 2010

#### HCPCS Code D1206

Effective June 21, 2010, the scope of HCPCS Code D1206 will be expanded to allow the following additional provider types: physicians, naturopaths, nurse practitioners & physicians assistants along with these additional specialty types: general practice, family practice, internal medicine, pediatric medicine, nurse practitioner, family practitioner, naturopathic physician with childbirth endorsement & without childbirth endorsement and pediatric practitioner. HCPCS Code D1206 is limited to children ages 0-5 (prior to 6th birthday).

#### Rate Change - CPT Code 83909

Effective June 21, 2010, the reimbursement rate for CPT Code 83909 will be reduced to \$10.08.

### HP Enterprise Services Correspondence

Vermont Medicaid Providers have started to receive VT Medicaid billing correspondence printed with the new HP Enterprise Services (HP) name & logo. This notice serves as a reminder that HP purchased EDS in 2008. As of January, 2010 EDS officially changed their name to HP Enterprise Services. HP Enterprise Services is the claims processing agent for Vermont Medicaid. Providers are reminded to open and review all correspondence received from HP or HP Enterprise Services.

### Consult Codes; 99241, 99242, 99243, 99244 & 99245

Effective June 21, 2010, Medicare Crossover claims received by HP with a date of service on or after

01/01/2010 with any of the following Consult Codes; 99241, 99242, 99243, 99244 & 99245 will be denied. Medicare requires these codes to be billed as an office visit.

Providers billing the above Consultant Codes directly to Medicaid are instructed to continue doing so. These Consult Codes will be reimbursed at the corresponding office visit rate, plus 2%.

### CLOSED FOR THE HOLIDAY

The OVHA and HP Enterprise Services offices will be closed on Monday, May 31, 2010 in observance of Memorial Day.

May 14, 2010

### Stapled Claims Will be Returned to Providers

Effective immediately; due to time constraints and possible damage to the OCR system, providers are instructed not to use staples when submitting claims to HP. All claims received with staples will be returned to providers.

### Red Ink Printed Claim Forms are Now Required

Effective immediately; due to the Optical Character Recognition (OCR) technology, the only acceptable claim forms are those printed in Flint OCR Red, J6983, (or exact match) ink. Photocopies cannot be scanned into the OCR system and therefore will be returned to providers. The National Uniform Claim Committee (NUCC) is responsible for the design and maintenance of the CMS-1500 & UB-04 claim forms but does not supply either form to providers for claim submission. In order to purchase claim forms, providers should contact the U.S. Government Printing Office at 1-866-512-1800, local printing companies in your area, and/or office supply stores.

This is consistent with the Medicare print specifications published in Chapter 26 of the Medicare Claims Processing Manual (Pub.100-04).

### Extraspinal Chiropractic Manipulation

Providers are reminded of the notification given on the 06/19/09 Remittance Advice that Vermont Medicaid only covers CPT codes 98940, 98941 and 98942. The OVHA will not reimburse for CPT code 98943 because coverage is only provided for spinal manipulation.

### CPT Code 17110

Effective June 14, 2010, CPT Code 17110 will be limited to one unit per occurrence. One unit allows the removal of up to 14 benign lesions, other than skin tags or cutaneous vascular proliferative lesions.

### CMS-1500 Claim Form

As of June 14, 2010, HP will require that providers stop printing information on the top right hand corner of the CMS-1500 claim form and instead to use the top left hand side of the claim form for additional information. The OCR system uses the top right hand side of the CMS-1500 claim form to print information necessary to process your claim.

May 7, 2010

### Inpatient Admissions - POA Indicator (clarification)

Notification will be sent to providers advising when the new version of the Provider Electronic Solutions Software (PES) containing the present on admission (POA) indicators is available for download. Until then, providers can continue to use the version available that does not include the POA field.

### Claim Edit Survey – Complete by May 10, 2010

Since 2008, a group of health care professionals, practice managers and insurers has been working to simplify the process clinicians use to submit claims to and receive payment from insurers.

Last year a law passed that included a requirement that all insurers use edits that are not more restrictive than NCCI, HCPCS, CPT, national specialty society guidelines or other edits approved by the Department of Banking, Insurance, Securities and Health Care Administration (BISHCA). The effective date for this law is July 2011.

In the interim, to address stakeholder concerns about the proposed standard (NCCI, HCPCS, CPT or national specialty society guidelines), the legislature requested MVP Healthcare to convene stakeholders to review the laws and standards applicable to clinical claim edits, including edit standards required by national class action law suits and edit standards and transparency requirements established by other states. The group is charged with determining whether changes are needed to current Vermont laws that address claim edits and the group is requested to report back to the legislature on or before January 1, 2011.

To assist the workgroup, this survey was prepared by the Vermont Medical Society with assistance from MBA HealthGroup. The survey is available on the Vermont Medical Society web site homepage at [www.vtmd.org](http://www.vtmd.org). Responses will be compiled by the Vermont Medical Society and reported to the study group. Please distribute this memo and the link to the survey as appropriate.

Please contact Madeleine Mongan ([mmongan@vtmd.org](mailto:mmongan@vtmd.org)) or Colleen Magne ([cmagne@vtmd.org](mailto:cmagne@vtmd.org)) of the Vermont Medical Society at 802-233-7898 or 800-640-8767 regarding questions about this survey. Thank you for taking the time to complete this survey and for your assistance with this work.

April 30, 2010

### Wheelchair Documentation Tools

Medicaid DME providers who provide wheelchairs, and physicians/therapists who evaluate for and prescribe wheelchairs, are directed to the OVHA website [www.ovhavermont.gov](http://www.ovhavermont.gov) to obtain updated documentation tools for wheelchair acquisition. The documentation includes evaluation and prescription tools, definitions and coding information. Please take time to read the introductory document as well. Use of these tools is recommended to facilitate the prior authorization process.

### Unique Identification Numbers To Replace Social Security Numbers

October 1, 2010 is the start date for use of the unique identification number (UID) that must be used for each beneficiary. Use of the UID number allows removal of the Social Security number currently used for member cards and claim submission. This change will help protect our members' personal information. In September, all beneficiaries will receive their new health plan ID cards in the mail; however, do not begin billing with the new ID number until October 1. In order to facilitate this transition, our automated

eligibility verification systems will allow you to check eligibility with either a Social Security number or the unique ID number. Use either the online Transaction Services (<http://www.vtmedicaid.com/Interactive/login2.html>) or the HP Voice Response System (Malcolm) 802-878-7871, option 1. If you only have access to a member's Social Security number, these automated systems will provide you with the unique ID number for your claim.

### The New Vermont Medicaid Provider Recertification Process

The Office of Vermont Health Access (OVHA) and HP Enterprise Services (HP) plan to streamline the recertification process, making it both easier and quicker for our provider community.

The current process requires providers to review a 10-page document at the time of recertification. The new process will require a provider to complete the new comprehensive Provider Enrollment Form one time; subsequent recertification will require only forwarding a copy of the renewed provider license.

Please wait for your provider type's recertification period and for HP to request that you complete the new form. HP will begin sending recertification notices in the next few months. To eliminate confusion and assist in implementing the new recertification process, do not send the form until you receive your recertification notice.

Providers that recently enrolled using the 01/29/2010 Enrollment Form will only be asked to forward a copy of their renewed provider license and recertification letter request when their provider type is due for recertification. Your recertification letter will include the information and directions necessary for you to complete your recertification process. You may preview and download the new form at <http://www.vtmedicaid.com/Downloads/forms.html> Provider Enrollment; the form date is 01/29/2010.

### Quarterly Training

The Provider Services Help Desk will be closed for quarterly training on Friday, May 21, 2010. Providers with urgent questions are instructed to call the Help Desk and leave a detailed message. The HP Enterprise Services Help Desk will be monitoring and returning provider calls throughout the day.

### Medicare Crossover Paper Claims

Effective May 31, 2010, the mandatory wait time for submitting paper crossover claims, to Vermont Medicaid, will change from six weeks to 30 days. Any claim received prior to the new 30 day wait time will be denied. This new process is to prevent duplicate payments and/or denials, which will expedite claims processing.

**April 23, 2010**

### HCPCS J1453 - Prior Authorization Required (revision)

Effective May 24, 2010, HCPCS Code J1453 will require prior authorization, in addition to the billing instructions stated on the 12/18/2009 banner page. The General Prior Authorization Request Form is accessible at [ovha.vermont.gov/for-providers/pharmacy-prior-authorization-request-forms](http://ovha.vermont.gov/for-providers/pharmacy-prior-authorization-request-forms). Submit completed request forms via fax to MedMetrics at 1-866-767-2649. Providers with questions or concerns are instructed to call the MedMetrics prescriber call center at 1-800-918-7549.

### HCPCS Code L8501 – Unit Update

Effective May 24, 2010, HCPCS Code L8501, Tracheostomy speaking valve, will be restricted to 2 units every six months.

### April 16, 2010

#### Updated Medicare Attachment Summary Forms

In order to clarify collection of Medicare payment information, the CMS 1500 and UB 04 Medicare Attachment Summary Forms have been updated and are available for download on the VTMedicaid website at <http://www.vtmedicaid.com/Downloads/forms.html>. Please begin using the revised Medicare Attachment Forms dated 04/06/10.

#### Inpatient Admissions - Present on Admission Indicator (revision)

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

### April 9, 2010

#### Eyeglass Prior Authorization/Medical Necessity Form

The Eyeglass Medical Necessity Form (MNF) is now available for use by Providers requesting prior authorization for eyeglasses. The form is available online at <http://ovha.vermont.gov/for-providers/forms-1> under Clinical Prior Authorization Forms, or from the single source eyeglass contractor, Chadwick Optical Inc. Once the form is completed, please follow routing instructions 1 thru 4, noted in the upper left-hand corner of the MNF

### April 2, 2010

#### UB 04 Form Locator 17-STAT

Providers when completing the UB04 Claim Form it is now required that the patient discharge status code be entered in form locator 17 – STAT, for all outpatient claims.

#### HCPCS Codes Place of Service Change

Effective May 2, 2010, coverage for the following HCPCS codes: J7187, J7189, J7190, J7192, J7193, J9194, J7199, J8520, J8521, J7682 & J8700 will be limited to the following places of service: inpatient hospital, outpatient hospital, emergency room hospital and ambulatory surgical center.

## HCPCS Code J1750 – Intravenous Iron Dextran

This is a reminder that Vermont Medicaid coverage of the intravenous (IV) infusion of large doses of iron dextran is contingent upon administration by qualified medical professionals who follow current best-practice guidelines. Each Medicaid beneficiary's medical record must clearly document the severity of an established diagnosis of iron-deficiency anemia, the reason(s) why oral and/or enteral iron cannot be used, the exact quantity of iron dextran administered each time and timely reviews of the effectiveness of this treatment. Documentation will be required to be submitted with the claim for doses exceeding 2 grams (40 units of current HCPCS code J1750).

Minimum units = 10 (ten)

Maximum units = 40 (forty)

Restricted to the following diagnoses: 2800, 2801, 2808, 2809, 28521, 28522.

Restricted to the following provider types: hospitals, physicians, nurse practitioners and physicians assistants.

Place of service will now include office in addition to those already allowed: inpatient hospital, outpatient hospital and ER.

## Continuous Glucose Monitoring (CGM) in the Interstitial Fluid

As of 2/25/2010, the OVHA covers continuous glucose monitoring (CGM) in the interstitial fluid when prior authorization (PA) is obtained before rendering the service or dispensing the supply or equipment. Coverage guidelines have been written and are available via the internet at <http://ovha.vermont.gov/for-providers/clinical-coverage-guidelines>.

Interpretation of the results of any monitoring (CPT code 95251) is limited to physicians and nurse practitioners (per their scope of practice). Short-term monitoring (codes 95250 & 95251) is limited to once per 30 days and a maximum of 4 times per calendar year. Per the CPT, one unit of code 95250 or code 95251 represents a 72-hour monitoring episode.

DME vendors need to be aware that transmitters (HCPCS code A9277) are limited to a maximum of one per year. Receivers/monitors (HCPCS code A9278) are limited to a maximum of one per 2 years. Fax prior authorization requests to 802-879-5963 at least one week in advance. Be sure to include the procedure code and clinical documentation substantiating the medical need for CGM.

March 19<sup>th</sup>, 2010

## Electronic 837 Professional Claims Special Program Code Field Value - 03

As of April 1, 2010, HP Enterprise Services requests Ladies First Providers to stop using the value 03 in the special program code field. The HP system has been modified to identify a Ladies First beneficiary's enrollment information and funding source to process claims under Ladies First. Failure to remove value 03 from the special program code field will cause your claim to be denied.

## EPSDT/Family Planning Indicator (Field 24.H on Paper CMS1500 Claims)

Effective April 1, 2010 HP Enterprise Services will require Ladies First Providers to stop using the value of 5 in the EPSDT/ Family Planning field when submitting a paper CMS1500 claim. The EPSDT/Family Planning field with a value of 5 will no longer be needed to identify a Ladies First claim. Failure to follow the above requirement will cause your claim to be denied.

### Ladies First Remittance Advices

Ladies First Payments will transition to the Vermont Medicaid Remittance Advice (RA) beginning with RA date April 9, 2010. HP will no longer produce separate remittance advices for the Ladies First Program. Ladies First claims can be identified by the EOB 1175 (code) - SERVICE PROCESSED BY THE LADIES FIRST PROGRAM.

### Institutional Claims (Paper and Electronic) Condition Code Field Value - A3

As of April 1, 2010, HP Enterprise Services requests Ladies First Providers to stop using the value of A3 in the Condition Code field when submitting claims. The HP system has been updated to identify a Ladies First beneficiary's enrollment information to process claims under Ladies First. Failure to remove value A3 from the Condition Code field will cause your claim to be denied.

### Termination of Ladies First Provider Numbers

All Ladies First Provider Numbers beginning with 800 will be closed March 31, 2010. Beginning April 1, 2010 Ladies First claims will be processed using Ladies First member information and funding source. A Vermont Medicaid Provider Number will be required to process Ladies First claims but Ladies First providers may choose to provide services only to Ladies First beneficiaries. Please contact HP Provider Enrollment Unit at 802-878-7871 (out-of-state) or 800-925-1706 (in-state), to enroll as a Vermont Healthcare Programs provider.

### Provider Eligibility Verification

Providers are expected to verify eligibility for each beneficiary prior to providing a service. Eligibility can be verified through the POS/swipe box, the automated Voice Response System (VRS/Malcolm), online Transaction Services ([www.vtmedicaid.com](http://www.vtmedicaid.com)) or by calling the Provider Services Unit help desk. The HP system is updated with each beneficiary's termination of benefits, nine days prior to the effective date. Therefore, verification can be made with certainty up to nine days in advance of the appointment. Please be sure to check only the beneficiary's scheduled appointment date and not a span of dates. When an eligible aid category code is given, please determine that the service to be provided is covered within that aid category.

March 12<sup>th</sup>, 2010

### Help Desk Calls

In order to quickly respond to Provider calls and to reduce call wait times, the Provider Services Help Desk is requesting providers to have the following information when calling a Help Desk Representative: Your Name, Provider Number, Patient ID Number, Date of Service (if date span we will need to know the date range) and Procedure Code, if applicable. Help Desk Representatives are available Monday thru Friday 8am-5pm at 802-878-7871 (In-state - 800-925-1706; Out-of-state - 802-878-7871).

## HCPCS Code J9212 & J1825

Effective April 12, 2010, HCPCS code J9212 & J1825 will be limited to the following places of service: Inpatient Hospital, Outpatient Hospital and Emergency Room Hospital. These drugs are eligible for reimbursement through the Specialty Pharmacy Benefit and will not be reimbursed through the medical benefit.

## CMS 1500 Claim Form - Billing Provider Name Field

When completing the CMS1500 Claim Form all individual billing providers are required to list their last name first, in "box 33". Failure to do so will cause your claim to be denied.

March 5, 2010

## Prior Authorization Form - Medical Benefit

When completing the OVHA Prior Authorization Request Form to request medication needing prior approval please be sure to check the correct "billed through information box". If the medication is to be billed under the medical benefit please check the medical benefit box and not the pharmacy benefit box. Selecting the incorrect billed through benefit box will inhibit the processing of your claim. The General Prior Authorization Request Form is accessible at <http://ovha.vermont.gov/providers/pharmacy-prior-authorization-request-forms>. Submit completed request Forms via fax to MedMetrics at 1-866-767-2649. Providers with questions or concerns are instructed to call the MedMetrics prescriber call center at 1-800-918-7549.

## ICD-9 Procedure Code Updates

Effective April 5th, 2010, ICD-9 procedure codes 8593 and 8599 require prior authorization.

Effective immediately, ICD-9 procedure codes 852, 853, 854, 855, 858 and 859 are discontinued because a fourth digit is required.

## HCPCS Code J1743

Effective April 5th, 2010, HCPCS code J1743 will only be billable as a Specialty Pharmacy benefit and limited to the following places of service: Inpatient hospital, Outpatient hospital and Emergency room hospital.

February 26, 2010

## 2006 ADA Dental Claim Form

When completing the 2006 ADA Dental Claim Form it is required that you enter the beneficiary's name (box 20) and the amount paid by other insurance including contractual allowance, if applicable (box 32 other fees). Failure to enter this information in the appropriate box numbers may cause a delay or denial in the processing of your claim. For more detailed information regarding OCR requirements please refer to the August 2009 Advisory posted on Vermont Medicaid website at [www.vtmedicaid.com](http://www.vtmedicaid.com) under Downloads.

February 19, 2010

### CSHN Dental Notice

Aid Category Code - SH-Children with Special Health Needs, is only used when submitting medical claims for Physical, Occupational, and Speech Therapy (ST), or Nutritionist (NU) and Autism Specialist (AU) services.

**Dental claims for Children with Special Health needs will continue to be processed through the Vermont Department of Health PO Box 70 Burlington, VT 05402.**

### CPT Code J7303 – Rate & Unit Change

Effective 30 days of notification, CPT Code J7303 will be limited to a total of 12 units per 365 days. Also note, this product is typically packaged with 3 in each box. Claims should be submitted for each individual unit, or units of 3 when supplying a box. Reimbursement will be \$11.05 for each unit.

### Diagnoses Restrictions on Mastectomy Procedures

Effective 30 days after this notification, mastectomy procedures will be restricted to a diagnoses involving benign and malignant neoplasm of the breast. When the primary diagnosis is any other, documentation is required to be submitted with the claim to substantiate medical necessity.

February 12, 2010

### Never Events

Effective 30 days from notification, 2010 Vermont Medicaid will follow Medicare's guidelines pertaining to non payment of never events. This will include a surgical or other invasive procedure to treat a particular medical condition when the practitioner performs in error: 1) a different procedure altogether; 2) the correct procedure but on the wrong body part; or 3) the correct procedure but on the wrong patient. The hospitalizations and other related services will also not be covered.

Hospitals should bill inpatient claims with type of bill 110.

Inpatient and outpatient claims should be billed with one of the following ICD-9 CM diagnosis codes reported in diagnosis position 2-9 on the claim form:

E876.5- Performance of wrong operation (procedure) on correct patient

E876.6- Performance of operation (procedure) on patient not scheduled for surgery

E876.7- Performance of correct operation (procedure) on wrong side/body part

In addition, Outpatient Hospitals, Ambulatory Surgical Centers and practitioners will also be required to use one of the following modifiers on the HCPCS/CPT codes to indicate the services associated with the never event:

PA- Surgery wrong body part

PB- Surgery wrong patient

PC- Wrong surgery on patient

## Medical Nutrition Therapy (revision 12/18/09 banner)

This information serves as a correction to the December 18, 2009 Medical Nutrition Therapy banner. It was previously stated that registered dietitians will enroll in the Vermont Medicaid Program as non-participating providers, that is incorrect, registered dietitians will enroll as participating MEDICAID providers, only for the purpose of reimbursement of codes 97802, 97803 and 97804, when billed under a participating group, physician or hospital billing provider.

## Ladies First Newsgram

The February 2010 Ladies First Provider Newsgram is now available, Topics include: 2010 Ladies First Fees Released, Consult Codes, HPV DNA Testing, Ladies First Identifiers No Longer Required Effective April 1, 2010, Ladies First Claim Level Details Still Required, Provider Enrollment and Re-Certification and more. To access this information please go to [http://healthvermont.gov/prevent/ladies\\_first/news\\_updates.aspx](http://healthvermont.gov/prevent/ladies_first/news_updates.aspx)

## New Provider Enrollment Agreement

In order to improve and simplify the enrollment process, the new editable Provider Enrollment Agreement is now available on the Vermont Medicaid Website @ [www.vtmedicaid.com/Downloads/Forms](http://www.vtmedicaid.com/Downloads/Forms). The new editable enrollment form will allow providers to input the enrollment information directly onto the form. Once the form is completed providers can then choose to save the completed form, in their electronic files. As of March 1, 2010 HP Enterprise Services will require all providers to utilize the new enrollment form when submitting their enrollment application to participate in the Vermont Medicaid program. Return the completed enrollment agreement by mail along with the required signatures and licensing documentation to: HP Enterprise Services, Enrollment/Recertification, P.O. Box 888, Williston, VT 05495. Please contact the enrollment unit with any concerns or questions you may have at 802-879-4450.

## February 5th, 2010

### OCR

We are currently implementing the Optical Character Reading (OCR) system. If you are an individual billing provider your last name should always be first in the billing provider name field. For more detailed information regarding OCR requirements, please refer to the August 2009 Advisory posted on the Vermont Medicaid website at: [www.vtmedicaid.com](http://www.vtmedicaid.com) under Downloads.

### OCR (Dental Providers only)

Please be advised, due to the implementation of the Optical Character Reading (OCR) we ask that you enter in the amount paid by other insurance including, contract allowance if applicable, in field 32 (other fees) of the 2006 ADA Dental Claim Form. For more detailed information regarding OCR requirements, please refer to the August 2009 Advisory posted on the Vermont Medicaid website at: [www.vtmedicaid.com](http://www.vtmedicaid.com) under Downloads.

### Patient Share Adjustments

Adjustment requests for nursing home claims that involve a DCF change to the patient share amount currently require manual handling for reprocessing. Please send an adjustment request form to: HP

Enterprise Services, P.O. Box 888, Williston, VT 05495 Attn: Patient Share Adjustments to ensure proper handling of the request. HP is working on an enhancement to automate this process in the future. We apologize for any inconvenience this may cause in the interim.

### [www.vtmedicaid.com](http://www.vtmedicaid.com) website updated periodically

Our [www.vtmedicaid.com](http://www.vtmedicaid.com) website is updated periodically. When visiting our website please make sure to hit the refresh button or F5 on your keyboard upon opening the site to ensure you are viewing the most recent information posted.

### CLIA

Reminder: The implementation of the CLIA requirement was effective 12/01/2009. As of that date, any provider submitting claims for laboratory services are required to have a CLIA certificate on file with HP. The services being submitted must be covered by the certificate and within the effective dates. HP requires a copy of the most current CLIA certificate used by each individual provider, group or facility be sent directly to HP Enterprise Services, Provider Enrollment Unit, PO Box 888 Williston, VT 05495. Please be sure to include your NPI and Taxonomy Code(s) when mailing your copy to HP.

Additionally, Vermont Medicaid will utilize the QW modifier to indicate a CLIA waived following CMS guidelines for billing waived tests. To determine if your lab service requires a QW modifier please refer to the list published at: <http://www.cms.hhs.gov/CLIA/downloads/waivetbl.pdf>.

### CLOSED FOR THE HOLIDAY

Please be advised, the OVHA and HP Enterprise Services offices will be closed on Monday, February 15th in observance of Presidents Day.

### 2009 Provider Annual Survey

HP Enterprise Services would like to invite providers to participate in the 2009 Provider Survey! You can help HP to enhance services and to better serve you and the provider community by responding to this survey by February 19th! Join us at [www.vtmedicaid.com](http://www.vtmedicaid.com) under [Information](#) to participate in our new online version of the Provider Survey! If you do not have access to the internet, request a paper copy by contacting the Help Desk at 802-878-7871 (In-state - 800-925-1706; Out-of-state - 802-878-7871) and one will be provided. All completed 2009 Surveys need to be returned to HP Enterprise Services by February 19th, 2010.

### January 29th, 2010

#### Ladies First Extension for Late Claim Submissions

On February 1, 2010 Ladies First will be implementing a six-month timely filing limit based on date of service. To assist with this transition, any claims submitted after February 1st with a date of service prior to August 1, 2009 must be submitted to Ladies First. Ladies First will be paying all past bills manually. Please submit all late filing claims to Tanya Beaudoin, Vermont Department of Health, PO Box 70 Drawer 38, Burlington, VT 05402. Those claims should be submitted by April 30, 2010 for payment.

Submit all claims with dates of service on or after August 1st, 2009 to HP Enterprise Services within 6 months of Date of Service.

## New Aid Categories

Please be advised, the Office of Vermont Health Access has issued two new aid categories that cover Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST), Nutritionist (NU), Autism Specialist (AU) services only for the following programs:

SH-Children with Special Health Needs (CSHN)

FI-Family Infant and Toddler Program (FITP)

A child can be covered by Vermont Medicaid, along with CSHN or FITP or by both programs. If the child has a Vermont Medicaid benefit, CSHN, and/or FITP the aid categories will be listed on the voice response system (VRS), the website [www.vtmedicaid.com](http://www.vtmedicaid.com), or you can contact HP Enterprise Services' help desk at 1-800-925-1706. When SH and/or FI aid categories are the lone coverage listed the child is covered under CSHN or FITP for PT, OT, ST, NU, and AU services only.

## January 22nd, 2010

### CMS 1500 Medicare Attachment Summary Form

When submitting a CMS 1500 claim form with more than 6 details that Medicare had already paid as primary, you must complete an additional Medicare Attachment Summary Form for every 6 details. The number of details on the claim form(s) must match the number of details on the Medicare Attachment Summary Form(s). When submitting this type of multiple page CMS claim, the total Medicare paid amount should be recorded only once on page 1, field 3 of the Medicare Attachment Summary form.

### The Vermont Prescription Monitoring System (VPMS) Presentation

Meika Zilberberg from the Vermont Department of Health will give a presentation on the Vermont Prescription Monitoring System (VPMS) on February 12, 2010 from 12:00PM – 1:00 PM at OVHA, in the large conference room, 312 Hurricane Lane, Williston, VT.

This presentation is open to all physicians, dentists and pharmacists. The VPMS maintains a database of all controlled drugs (Schedule II, III, and IV) sold in Vermont. The VPMS tracks how the drug was paid for – Medicaid, Medicare, third party insurance, or cash – and informs providers of all controlled medications a patient/client has received from all doctors. This information can help providers work to effectively manage their patients' treatment.

Please join us for this informative and important presentation. If you have any questions, please call Meika Zilberberg at 802/652-4147 or Kyle Mooney at 802/879-5923.

## January 15th, 2010

### Maximum of One Dispensing Fee per Month for Maintenance Drugs Not Subject to the 90-Day Refill Requirement.

As a reminder, select maintenance drugs are required to be refilled in increments of 90 days. As always, other maintenance drugs not requiring a 90-day refill must be refilled in increments of 30 days unless the prescriber has clearly identified extenuating circumstances that justify a more frequent refill. In those rare cases where extenuating circumstances occur, please remember that only one dispensing fee per month may be billed to the Medicaid program.

CLOSED FOR THE HOLIDAY

Please be advised, the OVHA and HP Enterprise Services will be closed on Monday, January 18th in observance of Martin Luther King Jr.'s Birthday.

### Billing Provider Name Field (Clarification)

Due to the Optical Character Reading (OCR) system requirements, if you are an individual billing provider your last name should always be first in the billing provider name field. For more detailed information regarding OCR requirements, please refer to the August 2009 Advisory posted on the Vermont Medicaid website at [www.vtmedicaid.com](http://www.vtmedicaid.com) under Downloads.

January 8th, 2010

### Acupuncture, not a Medicaid covered service

This serves as a reminder that Acupuncture is not a Medicaid covered service.

### Urine Toxicology Screen Coverage (80101)

The following is a clarification on the Urine Toxicology Screen Coverage banner page published on 9/4/2009. As of October 4th, 2009 Vermont Medicaid restricted its coverage for the urine toxicology screen (CPT code 80101) to nine units. Vermont Medicaid will no longer cover the following substances utilizing the urine drug screen: Propoxyphene, LSD, PCP and Ethanol. Alternative methods such as a breathalyzer can be utilized for Ethanol testing.

In addition, practitioners ordering urine toxicology screens are being asked to tailor their requests to address the needs of each beneficiary individually, testing only for those substances that are relevant to their specific care. OVHA will not penalize providers for not ordering a urine drug screen panel. CLIA waived rapid drug screens are a more cost effective and accurate mechanism for testing and may improve compliance with immediate results. Please contact Carol Drawbough with the Vermont Department of Health at 802-862-7240, to become a CLIA waived provider and for inquiries on what tests are approved CLIA waived tests as required by CMS. Remember if utilizing a CLIA waived test it is necessary for the provider to report on the claim the "QW" modifier, identifying the test utilized was a CLIA waived test. ([www.vtmedicaid.com](http://www.vtmedicaid.com)).

### Providers Can Now Verify Ladies First Eligibility

#### **Eligibility Verification Ladies First**

The VermontAIM Eligibility Verification System (EVS) now includes Ladies First member information for providers. This automated system provides eligibility status information clearly, concisely and rapidly 24 hours a day, seven days a week. All three functions of EVS; point-of-sale devices [key-in option ONLY], the Vermont Medicaid website, and voice response (in state toll free 1-800-925-1706 or out of state 1-802-878-7871), are complete and ready to be utilized. Ladies First encourages all providers to take full advantage of this system to verify a patient's eligibility status before services are rendered. This system offers the following functionality:

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

Providers can verify eligibility for the current date, up to, one year prior. Providers can rely on the accuracy of the EVS response, for up to nine days beyond the date of the coverage inquiry. Providers

should retain the authorization number issued by the system to assure that the information received can be verified by the system. The authorization number is not a guarantee of payment. The member must be eligible on the date of service and the service provided must be a covered service by the Ladies First program.

If for any reason you are unable to use the EVS system, you may call the Ladies First provider support line to verify eligibility at 1-800-510-2282.

### **Billing the Ladies First Member**

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

- If the HP system reports that a member has other insurance, the provider must bill the service or item to the other medical insurance prior to billing Ladies First
- Ladies First is the payer of last resort

### **Ladies First Timely Filing**

Ladies First will be implementing a six-month timely filing limit, effective for all dates of service, February 1st, 2010 and thereafter. All claims must be submitted to HP Enterprise Services for processing prior to the six-month filing limit.

The following exceptions apply:

- Claims billed to to other health insurance must be filed within 24 months from the date of service.
- HP Enterprise Services denied a claim within the timely filing limit, for a reason other than exceeding the time limit. A copy of the remittance advice showing the denial must be attached to each claim.

Ladies First will consider paying an untimely claim in unusual circumstances. An exception request can be made by sending the claim and a detailed explanation of why an exception should be granted to the Director, Ladies First, PO Box 70, Burlington, Vermont 05402.