

BANNER PAGES for 2006

January 13, 2006

J Codes Update

Unit limitations for the following J codes have been removed. Please re-bill any claim effected by these changes.

J7042 --IV SOLUTION: 5% DEXTROSE/NORMAL SALINE, PER 500 ML {IN OFFICE OR PHYSICIAN-BASED CLINIC ONLY}

J7051--STERILE SALINE OR WATER, UP TO 5 CC. (FOR TRACH CARE, NEBULIZER TREATMENTS; MORE THAN 200/MONTH NEEDS PA)

J7120 INFUSION OF IV SOLUTION: RINGERS LACTATE, UP TO 1,000 CC (ML) {FOR IN OFFICE OR PHYSICIAN-BASED CLINIC ONLY}

CPT Codes 63650-63688 and 64553-64595

Effective with date of service January 15, 2006, CPT codes 63650-63688 and 64553-64595 [spinal and peripheral neurostimulators] will require Prior Authorization.

Enhanced Security for the Vermont Voice Response System

Effective 1/3/2006, accessing the Vermont Voice Response System (Malcolm) now requires a four digit PIN in addition to the provider number. This security enhancement further safeguards the privacy of users by granting system access only to those with valid PIN/provider number combinations.

Creating your PIN is a simple process. You need only call the VRS at 800-925-1706 and follow the prompts that will direct you through the necessary steps for PIN creation. Directions for creating your PIN were included in the December Advisory. If you do not have a hardcopy Advisory, it can be accessed at: www.vtmedicaid.com.

Additional questions can be directed to Provider Services at: 802-878-7871 or 800-925-1706.

New Adjustment Forms On-line

EDS & the OVHA have created new adjustment forms that are currently available at: www.vtmedicaid.com

Effective date of receipt, January 23, 2006, you must use the new form. Any adjustments received on the old forms after the 23rd will be returned.

Pharmacy Payments for January 13, 2006

With the reinstatement of the Vermont program coverage for Medicare eligibles, the OVHA did not complete all the financial activities to report claims processed by MedMetrics on your weekly RA this week. As a result, payouts were authorized to assure revenues to pharmacies. Since payouts are being used, they are not solely based on the MedMetrics claims but are based on average weekly payments January 1. In this way your payout includes an advance to cover claims for the Vermont program reinstatement. As the new claims are finalized, recoupments will be applied beginning on the RA dated 1/20/06.

January 20, 2006

Pharmacy Payments for January 20, 2006

OVHA has opted not to institute recoupments in this week's cycle for the payouts made on 1/13/06. This is being done to assure that pharmacy payments stabilize with the reinstatement of the Vermont program coverage for Medicare eligibles. At this point OVHA plans to apply these recoupments beginning on RAs for 1/27/06.

PSU Quarterly Training

The provider help desk will be closed on January 31st for employee quarterly training. Messages will be checked throughout the day, if your call is urgent, please state that in your message and someone will get back to you the same day. Otherwise, your call will be returned on February 1st.

January PES Training

There is still space for Electronic Adjustment training using the EDS software Provider Electronic Solutions Software (PES) on January 25, 2006 at Brattleboro Memorial Hospital from 10:00 to 12:00am. Please call Betty Parent at 802-775-9261 to reserve a seat.

February PES Adjustment Workshop

EDS is offering free Adjustment workshops on using PES (Provider Electronic Software) in February, at two locations. If you would like to learn how to do your own adjustments electronically sign-up early to reserve a seat.

The first workshop will be held in Bennington at the Vermont Veterans Home, on February 9th from 10:00am to 12:00pm . To reserve a seat contact Betty Parent at: (802) 775-9261.

The second workshop will be held in Williston, on Friday, February 17th, from 9am-11am. To reserve a seat contact Sandy Mesick at (802) 879-2956.

Primary Insurance Co-payments

If the service is not capitated by the primary insurance the provider may not bill Medicaid using procedure code T1015.

Instead the provider may bill the primary insurer, record the payment, and then bill Medicaid for the difference between the primary insurance and the Medicaid allowed amount for that service. If the provider accepts Medicaid as a source of payment for the visit, the provider can not bill the patient.

If the provider has decided not to bill Medicaid for the difference, the provider must inform the beneficiary in advance of providing the service. Form 287 [Provider Notification Form to Recipients], available at vtmedicaid.com, or your own form, should be completed and **signed by the beneficiary (or parent, if a minor) to document that proper notice was given to the patient and the responsible adult has accepted the financial responsibility to pay for the copay.** If the beneficiary has accepted financial responsibility, the claim should not be submitted to EDS for payment.

Patient Share

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

Anesthesia Billing

The OVHA has agreed to enroll and process claims for services rendered by licensed and enrolled Anesthesia Assistants. In order to process these claims, we have had to modify our system to allow new modifiers.

Effective February 1st, all Anesthesia claims are required to use a modifier. The valid modifiers are AA, QK, QY, AD, QX or QZ. Modifier details were mailed to Anesthesia providers on December 14, 2005. We will follow the billing requirements of Medicare.

Please contact the provider help desk with any further questions:

800-925-1706 or local and out of state 802-878-7871.

New Codes and Rate Change

Effective date of service 2/1/2006 procedure code E0240 [bath/shower chair, with or without wheels, any size] will be a manually priced code. You must attach a manufacturers invoice when submitting this type of claim for reimbursement.

February 3, 2006

Recoupments to recover 1/13/06 Payouts/Claims Overpayments from 1/9-1/10/06

Beginning with your old claims payments this week, we will begin recouping for the payouts authorized for the 1/13/06 payouts. The recoupments will be recovered at a rate of 25% of your currently weekly payments beginning with the 1/27/06 payment and continue until the full payout is recouped. The amount of your payout can be identified in your 1/13/06 remittance advice.

Pharmacy claims pay at the lesser of AWP—11.9% + dispensing; FUL + dispensing; MAC + dispensing; or U& C including dispensing. This “lesser of” logic was incorrectly applied on claims processed for certain NDCS for adjudication dates between 1/9/06 and 1/10/06. Claims incorrectly processed were systematically reversed and reprocessed on 1/12/06 and 1/13/06 and are reflected in this RA. If you have difficulty in identifying these specific claims call 800-644-4079.

1115 Waiver & Adjustments

Adjustment requests for Choices for Care claims that involve a change to the patient share deduction currently need manual handling for reprocessing.

Please send this type of claim to:

EDS, PO Box 888, Williston, VT 05495 Att: Jean Gadue.

EDS is working on rectifying this systems processing issue. We apologize for any inconvenience this may cause.

2006 Dental Fee Schedules

Dental providers can expect to receive a mailed packet containing the 2006 dental fee schedule, aid category list, and dental fax form with instructions. These documents were mailed on January 17th. You can also access and print these forms from our website:

www.vtmedicaid.com

CLAIMCHECK COMMUNICATIONS

If you have called Provider Services and determined that your claims issue is related to ClaimCheck, and you disagree with the determination of your claim or seek further information, please direct your ClaimCheck questions to: Claimcheckcommunications@eds.com. ClaimCheck denials can be easily identified with 4-digit EOB codes that begin with an 8. If you disagree with the ClaimCheck policy determination and have a source (e.g. NCCI, CMS, Ingenix) for your findings, please reference that source in your email.

Provider Survey

The OVHA began operating as an MCO on October 1st, 2005. As an MCO, the OVHA is required to collect new information about providers. Surveys were mailed to most providers in early December to comply with the MCO requirements. Completed surveys were to be returned to EDS by December 21st, 2005.

We would like to thank the providers that returned their information on time. However, there are still 4,000 outstanding surveys! If you have not completed and returned your survey please do so immediately. If you need a new form you can print them from our website: www.vtmedicaid.com.

Completed forms can be returned as an attachment to: vtmcodirectorysurvey@eds.com or sent via fax: 1-802-878-3440 or mailed to: EDS, PO Box 888, Williston, VT 05495

February 10, 2006

Survey Clarification

Please be aware that the provider survey currently conducted by EDS on behalf of the OVHA is ONLY conducted using a paper form that providers have received via mail or downloaded from: www.vtmedicaid.com

Under no circumstances is this survey being conducted by phone. This is the only provider survey currently being conducted or sponsored by EDS

The survey asks the following five questions:

- *The handicap accessibility of service locations,
- *The languages accommodated at the provider's service location,
- *The gender of provider,
- *The age range of beneficiaries that the provider will work with (e.g. all =-0-99, or 15 - 55 only, etc, --not the age range of current patients),
- *If the provider is accepting new Medicaid patients,

*The provider's available forms of communication: email, fax, or office web page.

Advance Directives

Providers can attain Advance Directive [AD] forms and additional information on AD from the Vermont Ethics Network website: <http://www.vtethicsnetwork.org/> or by mailing your request to:

Vermont Ethics Network
64 Main Street, Rm. 25
Montpelier, VT 05602-2951

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Effective date for adjustments on these codes is 09/01/2005

Preferred Drug List Updates

The PDL has been updated as of 2/1/06. Several new products have been added to the Preferred Drug List including: Namenda, ActoPlusMet, Zofran, Teveten, Benicar, Imitrex, Geodon, Avodart, Tricor, Triglide, Betaseron, Patanol, Alamast, Fosamax, Ditropan XL, Vesicare, Asmanex and Lunesta.

Products which are no longer preferred effective 2/1/06 include: Nexium, Detrol LA, Kytril, Metadate CD, Ritalin-LA, Focalin (IR), Dynacirc/CR, Zomig, Uroxatral, Altoprev, Zaditor, Azopt, and Aggrenox, For new patient starts, all of these agents will need prior authorization. Grandfathering rules have been established for existing patients on many of these medications; however current Detrol-LA and Nexium users will only be grandfathered for a limited time period.

Always refer to the Preferred Drug List and Drugs that Require PA web page at www.ovha.state.vt.us/Preferred_drugs.cfm for the most recent PDL and criteria for PAs.

February 17, 2006

Vision Billing Update

Effective 1/1/2006, the AMA has deleted procedure code 92390. Vision providers may continue billing for the fitting of spectacles using CPT codes: 92340, 92341, 92342, etc. This includes the combined reimbursement you were receiving under previous billing guidelines. Usual and Customary fees should be billed when submitting these codes to ensure appropriate reimbursement.

Eyeglass cases are now billed separately using procedure code V2756.

This change in policy adheres to correct coding and the goals of standardized practices as outlined by the CMS Correct Coding Initiative.

February 24, 2006

Occupancy Certification Form Update

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

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

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

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

Missed Appointments

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

March 3, 2006

Workshop-Billing Secondary Insurance Claims and Submitting Adjustments
for Secondary Insurance Claims

There will be a workshop using Provider Electronic Solutions Software (PES) for billing secondary insurance claims and submitting adjustments for secondary insurance claims. The workshop will be at Dartmouth Hitchcock Medical Center on March 20, 2006 from 10:00 to 12:00. Call Betty Parent at 802-775-9261 to reserve a seat and for directions.

Vision Code Updates

Effective immediately, the OVHA will reimburse for the fitting of spectacles once every two years. Please use one of the following procedure codes appropriately when billing for this procedure: 92340, 92341, 92342, 92352, 92353, or 92354. Reimbursement for additional services (replacement or repair) is still limited to the following circumstances:

- When eyeglasses (frames or lenses) have been lost, broken beyond repair, or determined by a dispensing provider to be scratched to the extent that visual acuity is compromised.
- When the dispensing provider on the Medicaid order form documents a change of at least one-half diopter in lens strength.

March 10, 2006

43999 & Prior Authorization

Effective immediately, CPT Procedure Code 43999 [unlisted procedure, stomach] requires prior authorization.

Please be aware that unlisted, miscellaneous procedure codes require prior authorization unless specific instructions are given indicating otherwise.

March 17, 2006

Annual Adult Dental Cap

The Governor has signed the Budget Adjustment Act which instructed the OVHA to restore the Annual Adult Dental Cap limitation to the previous limit of \$475.00 effective for 2/1/2006. In essence, this eliminates the reduction for calendar year 2006. EDS will adjust any claim that was reduced to the \$400.00 cap to now allow payment up to \$475.00. If you had a claim detail fully deny for exceeding the cap you will need to resubmit the claim for payment consideration.

March 24, 2006

Ostomy Pouches and Barriers Clarification

Effective 4/1/06, up to a maximum of 15 ostomy pouches and 15 barriers are allowed per calendar month. This is a change from allowing a combined maximum of 15 pouches and barriers.

Code 98943

Effective with date of service 4/1/06, Procedure Code 98943 [Chiropractic Manipulative Treatment] is no longer a service covered by Vermont Medicaid.

Prior Authorization Updates

Effective immediately, procedure codes:

E0641 [STANDING FRAME SYSTEM, MULTI-POSITION(EG. 3 WAY STANDER) ANY SIZE INCLUDING PEDIATRIC, W W/O WHEELS]

and

E6402 [STANDING FRAME SYSTEM, MOBILE(DYNAMIC STANDER) ANY SIZE INCLUDING PEDIATRIC]

require Prior Authorization.

Procedure code E0638 [STANDING FRAME SYSTEM, ANY SIZE, WITH OR WITHOUT WHEELS] no longer requires Prior Authorization.

April 7, 2006

Provider Name/Number Review

Your Vermont Medicaid provider name and number must be on your claim *exactly* as it appears on our provider file.

Vermont Medicaid provider numbers contain no alpha "O's" – only zeros. **Claims received on and after June 1st, 2006, must include a complete seven digit number. Claims without a complete seven digit number will be returned.**

The provider name and 7 digit Medicaid provider number submitted on your paper claims must be entered correctly as follows:

CMS-1500 Form: Box 33

UB-92 Form: Form Locator 1

1994 Dental Form: Box 21 for Provider Name and Number.

1999 Dental Form: Box 42 for the Provider Name. Box 44 for the Provider Number.

2002 Dental Form: Box 48 for the Provider Name. Box 49 for the Provider Number.

April 28, 2006

Patient Share & Nursing Homes

Nursing homes that bill bi-monthly and have had patient share deducted will need to recoup their entire claim if the patient status changes to anything other than 30-39 (still a patient) during that monthly billing period. A new claim with the full date span will need to be submitted to ensure that the patient share deduction is removed from the initial payment.

Example: The nursing home bills from the 1st through the 15th and the patient share was deducted. The next billing period is the 16th through the 30th. The patient expires or left the nursing home on the 19th. The nursing home must recoup the claim from the 1st through the 15th and re-bill from the 1st through the 19th.

PA & Procedure Codes K0011 & K0011RR

Due to a recent review by the OVHA Surveillance and Utilization Review (SUR) Unit regarding the utilization of standard weight frame motorized/power wheelchairs (HCPCS procedure code K0011), this equipment will again require prior authorization from the OVHA Clinical Unit for both rental and purchase effective with date of service 06/01/06.

May 5, 2006

Copying Charts

Medicaid does not cover the copying of patient charts. Providers may not bill Medicaid for this service.

Dental Code D7560 Update

Effective date of service 3/01/2006 Dental Code D7560 [Maxillary Sinusotomy for Removal of Tooth Fragment or Foreign Body] has been added to the list of reimbursable dental services. This procedure is covered for adults and children. The procedure is not subject to the Adult Program \$475 annual maximum benefit or to the 6% fee reduction.

Procedure Code 99050 Update

During a recent review of covered services, procedure code 99050 [Services Requested After Office Hours In Addition To Basic Service] was identified as a service that is not reimbursable under Vermont Medicaid. Therefore, effective date of service 1/1/2006 procedure code 99050 is non-covered

May 19, 2006

Use of Electronic Notes

Providers who bill electronically: If you need to add an instructional note to a claim, please use the electronic notes field instead of dropping your claim to paper. Electronic notes can replace any information handwritten on the paper claim.

Examples of common notes include:

“Billing for baby under Mother’s ID”

“Not a Duplicate”

“½ Diopter Change”

This does not apply to claims that require an attachment.

Mass Adjustments & Medicare Rate Changes

Congress passed the Debt Reduction Act which updates the 2006 rates for services paid under the Medicare Physician Fee Schedule. Medicare will mass adjust claims that were processed prior to this legislation beginning with date of service of January 1, 2006.

EDS will not receive the adjusted crossover claims electronically from Medicare. However, if your adjustment is greater than \$1.00 you may submit your adjustment to EDS for corrected payment.

We encourage you to submit your adjustments electronically for faster payment.

Provider Services Help Desk Closed

The PSU provider help desk will be closed for quarterly training on Tuesday May 23rd. If you have an urgent question please leave a message briefly describing your issue and someone will call back within a few hours.

Otherwise, please feel free to leave a message and your call will be returned on the 24th.

Nursing Facility Discharge Notice 804A Update

When a Choices for Care (CFC) nursing facility resident is discharged, please send the Nursing Facility Discharge Notice (804A) to the local DCF/ESD office. The discharge date is the day after bed hold status expires or the actual date of discharge if the bed is not being held.

Hospitals must report all Swing Bed discharges using the CFC Nursing Facility (or Hospital Swing Bed) Discharge Notice Form (804A).

Nursing Facility Change Report Form 804B Update

Admissions from any Choices for Care (CFC) setting to hospice in a nursing facility must be reported by the nursing facility to the local DCF/ESD office on the CFC Nursing Facility Change Report Form (804B). Please indicate the appropriate insurance coverage in Section B and note "Hospice" in the comments section.

When a CFC nursing facility resident is admitted to a hospital, please send the CFC Nursing Facility Change Report Form (804B) to the local DCF/ESD office.

June 23, 2006

Name/Number Correction

Please note this correction to previous notification regarding provider name and number.

In the April 2006 Advisory, providers using the UB-92 billing form were incorrectly instructed to enter the billing provider name and number in Form Locator 1.

The corrected instructions are as follows: When using the UB-92 form enter the billing provider name in Form Locator 1, the billing provider number in Form Locator 51 and the attending provider name and number in Form Locator 82.

We apologize for any inconvenience this oversight may have caused.

June 9, 2006

PES Update, v2.17

A new release of Provider Electronic Solutions (PES 2.17) is now available on www.VTMedicaid.com under Downloads, Software.

Included in PES version 2.17 are the following system enhancements:

- Modification of the Dental claim form to accept current supernumerary tooth values. Valid tooth values include: 01 – 32 for Permanent, 51 – 82 for Permanent Supernumerary, A – T Primary, and AS-TS for Primary Supernumerary.
- Admit Source on an Institutional Inpatient claim (found on the Hdr 6 tab) is now a required field.

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 2.14, you must upgrade to 2.15, then 2.16, then 2.17. To see which version of PES you are running, after you log on to PES, click on Help, About.

New Therapy Extension Requirement

Effective date of service June 12, 2006, all requests for Physical, Occupational, and Speech Therapy services will require physician signature. This is necessary for the OVHA to be compliant with Medicaid regulation M710.5. The physician may sign the Therapy Extension form or a form that the physician already signs (such as Home Health 485) provided the signature date is within one month of the therapy extension date. Therapists are responsible for forwarding the required documentation with the physician's signature and the request for the extension of therapy services to the OVHA office.

A copy of the updated Therapy Extension form with instructions is available on-line at :
www.vtmedicaid.com, under Information, Downloads, Forms.

Please address any questions to Susan Mason PT MEd, Clinical Consultant, OVHA. 312
Hurricane Lane, Williston, VT 05495. Phone: 802 857 2942, fax 802 879 5963.

Timely Filing

When appealing a timely filing denial, providers must fully research and document in the request the extenuating circumstances surrounding the claim (e.g. submission dates, adjusted dates, and denial dates).

If there is no documentation or the documentation is insufficient to validate extenuating circumstances for the late submission, your appeal will be denied.

Please send your appeal request to:

EDS, PO Box 888, Williston, VT 05495 . Attn: OVHA Appeals

June 2, 2006

Antiembolism Stocking Limits

Effective date of service 6/1/06, Antiembolism stockings are now limited to 6: each 365 days

These stockings cannot be billed in pairs. The allowed amount is 3 left stockings and 3 right stockings each 365 days. These; these stockings cannot be billed in pairs.

LT or RT is required when billing these items.

Updated Limits for Catheters

Effective date of service 6/1/06, Procedure codes:

A4326 [male external catheter specialty type with integral collection chamber, each]

and

A4349 [male external catheter, with/without adhesives disposable, each] are now limited to 10 per calendar month.

DME Payment Review

When the OVHA is the primary payer, payment amounts for DME and supplies will be calculated in the following manner:

1) When the rate on file is a specific dollar amount, the OVHA pays the lesser of the actual charge or rate on file.

2) If the rate is manually priced and the product has a published MSRP (e.g. a page from a catalog) the OVHA will pay 85% of the MSRP. You must attach the MSRP from the manufacturer of the item.

3) If the product does not have an MSRP then you must supply the original invoice including name, address, item and price of the product being billed. It will be paid at the lesser of the actual charge or the invoice cost plus 67%. If there are multiple items listed on the invoice, you must indicate the item(s) for which you are billing.

For complete policy on DME payment please review page 3 of the DME Supplement at: www.vtmedicaid.com

Memorial Day Closing

The offices of EDS and the OVHA will be closed for Memorial Day on Monday, May 29, 2006.

July 7, 2006

Provider ID Update

Claims received on or after July 14th must include a complete 7-digit Vermont Medicaid provider ID. Claims without a complete Vermont Medicaid provider ID will be returned.

A **Vermont Medicaid provider ID** is seven characters. There are only numeric zeros in Vermont Medicaid provider IDs, there are no alpha "O's" .

Please verify your Vermont Medicaid provider ID by visiting the Active Provider list posted at: <http://www.vtmedicaid.com/Downloads/manuals.html>

Please refer to this on-line resource before calling provider services.

The seven character Vermont Medicaid provider ID and seven character Vermont Medicaid attending provider ID submitted on your paper claims must be entered correctly as follows:

CMS-1500 form: Box 24K for attending provider ID; Box 33 for billing provider ID; and Box 17A (referring physician) if applicable.

UB-92 form: Box 51 for billing provider ID; and Box 82 for attending provider name and ID.

1994 Dental form: Box 21 for billing provider name and ID; Box 22 for attending provider ID (on the address line after the address).

1999 Dental form: Box 42 for the billing provider name; Box 44 for the billing provider

ID; and Box 46 for the attending provider ID (on the address line after the address).

2002 Dental form: Box 48 for the billing provider name; Box 49 for the billing provider ID; and Box 54 for the attending provider ID.

July 14, 2006

Rehabilitation Therapy Update

Beginning **July 15th, 2006** [date of receipt], providers billing for Physical, Occupational and/or Speech therapy may put the appropriate occurrence code [35=physical therapy, 44=occupational therapy, 45=speech therapy] for the therapy with the start date in the occurrence code fields [form locators 33-35]. These occurrence codes require the therapy start date in the same box.

Form locator 32 will continue to be used for the accident code/date.

Vermont Medicaid will still accept ICD-9 code 9389 in form locator 80 with the therapy start date, however, using the appropriate occurrence code/date fields instead will provide more accurate reporting for this data.

A reminder: rehabilitative therapy greater than 4 months still requires Prior Authorization.

July 21, 2006

Current Enrollment Form

Providers are reminded to use the current Vermont Medicaid enrollment form that is posted on-line at: www.vtmedicaid.com. Providers are required to supply the following information for each service location(s): handicap accessibility of the service location(s), language(s) spoken at that location, age range of patients that the provider will see (not the age range of current patients), and if the provider is accepting new Medicaid patients.

PT/OT/ST Services and Medicare Cap Update

Due to the Deficit Reduction Act 03, Medicare took the unusual step of limiting benefits for physical, occupational and speech therapy services provided by a certain provider type: independent therapists.

Please be advised that when a patient reaches the payment cap imposed by Medicare, Medicaid will **NOT** become the primary payer because these rehabilitative therapy services are available from other sources.

Vermont Medicaid will continue to reimburse coinsurance and deductible on approved crossover claims.

Procedure Code S9009

Effective immediately, procedure code S9009 has been reviewed and replaced with the HIPAA-compliant procedure code T1028. If you have claims that have been denied for using S9009 please resubmit those claims using procedure code T1028. Please remember to attach proof of timely filing to resubmitted claims.

July 28, 2006

Notice to Nursing Home Providers-Adjustments Section

EDS inadvertently performed mass adjustments for some nursing home providers that were not impacted by a rate change request. We apologize for any inconvenience as a result. This mass adjustment will not have any financial impact but will report in the adjustment section with a net adjustment of zero.

If you have any questions regarding these adjustments, please contact the EDS Help Desk.

Medicare Hospice Coverage Cost Avoidance

Effective date of service 8/01/2006, EDS will deny claims for services that should be included in the hospice daily rate for recipients who are Medicare Hospice eligible when the service provided is related to the terminal diagnosis. Providers should submit those claims directly to the Hospice provider for reimbursement. In addition, for EDS to consider reimbursement for services not related to the terminal diagnosis there must be a Medicare payment present on the claim or, if Medicare denies a paper claim, the paper claim should be submitted to EDS with the Medicare EOMB attached.

Web Site Status

Web site status is being added to the Vermont Medicaid Portal to inform you about any ongoing issues. This information will appear on the Home page. Please be advised that if you have shortcuts (e.g. a book mark that takes you directly to Production Login) you may not see the status information. Therefore we recommend you book mark the Home page (<http://www.vtmedicaid.com>) so you can view the web site status information.

Procedure Code 90806 Update

Providers are reminded that the unit of service for procedure code 90806 is:
1 unit = 45-74 minutes.

This code allows only 1 unit per day. It is NOT to be billed in 15 minute units.
If the session is less than 45 minutes or exceeds 74 minutes then you will need to select the appropriate alternative procedure code.

August 4, 2006

COBA Crossovers

EDS has identified an issue with crossover claims that were submitted to Medicaid via the new COBA carrier. This issue resulted in claims paying zero based on other insurance payments. These claims appear on Remittance Advices dated 7/21/06, 7/28/06, and 8/4/06. If you received zero payments as a result of this issue, please **do not** resubmit these claims. EDS will reprocess these claims during the week of 7/31/06. Corrected payments should be received in your Remittance Advice dated 8/11/06. We apologize for any inconvenience this has caused.

Psychotherapy Modifier Billing

When billing for services provided by a Psychologist Master level, LCSW, LMHC or LMFT providers should use modifier AJ. When services are provided by a Doctorate level Psychologist providers should use modifier AH. Please refer to the CMS 1500 Supplement to the VT. Medicaid billing manual for a list of reimbursable procedure codes.

August 18, 2006

Procedure Code 90806 Recoup Update

Procedure code 90806 [INDIVIDUAL PSYCHOTHERAPY, INSIGHT ORIENTED, BEHAVIOR MODIFYING &/OR SUPPORTIVE, FACE-TO-FACE W/PT.; 45-50 MINS] allows one unit to be billed per day per CPT (see banner page reminder dated 7/21/06).

This code may not be billed in 15 minute units. The OVHA has requested that EDS recoup any payments made for excess units for dates of service 1/1/06 forward.

EDS has identified these claims and will recoup and repay these claims for one unit only.

Gradient Compression Stockings Update

Effective date of service 9/1/06, Gradient Compression stockings are now limited to 6: 3 left stockings and 3 right stockings each 365 days. These stockings can not be billed in pairs.

LT or RT is required when billing these items.

Prior Authorization is required when the quantity limits given here are exceeded within 365 days.

Effected codes: A6530-8, A6542, A6543, and A6549

A6533 Standard Gradient Compression Stockings Update

Effective immediately, STANDARD compression stockings [A6533], no longer require Prior Authorization unless the quantity limitation (3 left, 3 right per 365 days) is exceeded.

Mass Adjustment Update

In July, a technical mass adjustment was applied and reflected on the 7/28/06 Remittance Advice [RA]. It did not implement as anticipated. As a result, some providers found a net adjustment on their RA that they did not expect. EDS is currently identifying and researching those claims that reflect a net adjustment and will contact the affected providers once the review is complete.

External Catheter Update

The OVHA has increased the quantity limitations for Male External Catheters [A4326, A4348, A4349] from 10 to a maximum of 31 per month effective date of service 6/1/2006.

Please be advised that Prior Authorization is required for quantities exceeding 31.

Prior Authorization for Rehabilitation Therapies

Prior Authorization [PA] for physical, occupational and speech therapies is required for services lasting longer than four months from the start of the service. Once a beneficiary's other insurance benefit exhausts, the OVHA becomes the primary insurer and PA rules apply, as necessary. PA rules provide a 30-day transition period to assure continuity of service. **Effective 9/01/06, the OVHA will not pay claims beyond the transition period unless the service has received prior authorization.** If the primary insurance is indicated on your prior authorization notice, the provider is not obligated to attach that insurance denial to each submission. This will enable electronic billing of the claims covered in the PA period. For further details see the Prior Authorization Supplement, page 5.

Please be aware that Medicaid will **NOT** become the primary payer when a patient reaches the payment cap imposed by Medicare to limit benefits for Rehabilitation therapies. This is because these therapy services are available from other sources.

Wheelchair codes & PA Update

DME and Pharmacy providers, please be aware that many wheelchair codes now require Prior Authorization [PA]. Please refer to the current list of PA requirements found in the PA Supplement and the Fee Schedule posted on-line at: vtmedicaid.com.

September 1, 2006

Replacement Batteries

Effective immediately, batteries for home blood glucose monitors, external infusion pumps, and hearing devices no longer have a quantity limitation.

This pertains only to special batteries that are specifically designed to provide power for a covered and currently medically necessary home blood glucose monitor, external infusion pump, or hearing device. 'Off the shelf' batteries that can also be used to power non-medical items are not considered DME and are therefore, not covered.

September 8, 2006

Updated Refund Form

An updated Provider Refund Form with additional reason codes has been posted on-line at: <http://www.vtmedicaid.com/Downloads/forms.html>

Providers must choose the most appropriate reason code from the list offered or EDS can not process the refund request.

Changes in Beneficiary Status

Please notify your local Department of Children and Families [DCF] office of any change in the beneficiary status such as discharges, hospitalization, bed holds, etc. Notification should be done ASAP but no later than ten days to allow timely update of the beneficiary file and notification of the appropriate providers regarding patient liability.

Please use the Choices for Care Discharge Notice Form available at:
<http://www.dad.state.vt.us>

Enuresis Alarm [S8270] Update

Effective immediately, Enuresis alarm [S8270] no longer requires Prior Authorization.

T5001 and Prior Authorization

Effective date of service 9/10/06, T5001 [positioning seat for persons with special orthopedic needs for use in vehicles], requires Prior Authorization.

Procedure Code 50547 and Prior Authorization

Effective date of service September 8, 2006 procedure code 50547 [Laparoscopy, surgical; donor nephrectomy (including cold preservation), from living donor] will require Prior Authorization.

CPT Code Reductions

The Budget Act of 2005 requires the OVHA to reduce reimbursement for many CPT codes. The base rate for CPT codes: 90804, 90806, and 90808 will be reduced by 7.5% beginning with date of service 10/01/2006. These reductions are consistent with the physician reimbursement reduction of July 1, 2005.

September 22, 2006

90846 & 90847 Unit Update Clarification

It was recently pointed out that the CPT coding for procedure codes 90846 and 90847 list these codes as visit codes yet the OVHA was paying them on a 15-minute unit basis. We updated the system but inadvertently failed to send proper notice to providers before making the system change. After discovering this oversight, the OVHA has reinstated the previous 15 minute unit pricing and payments for these two codes. Claims that were paid incorrectly due to the change will be reprocessed by EDS. We will change to correct coding, but not until complete notice of the intended change and a changeover date have been sent to the affected providers. Notice of the change will be sent out shortly by direct mail. We regret the oversight.

90846 & 90847 Units Update

Effective date of service 11/1/06, the units for codes 90846 and 90847 have been changed to: **1 unit = 1 day.**

90846 [FAMILY MEDICAL PSYCHOTHERAPY (WITHOUT THE PATIENT PRESENT)]

and

90847 [FAMILY PSYCHOTHERAPY (CONJOINT) WITH THE RECIPIENT PRESENT]

Please be advised that these codes are no longer considered 'time-based codes' for VT Medicaid.

Resubmitting Corrected Claims

If you have a claim that was denied please resubmit the corrected claim to:

EDS, PO Box 888, Hurricane Lane, Williston, VT 05495

DO NOT send these corrected claims to the attention of the Adjustments Unit or submit corrected claims with an adjustment cover sheet. Doing so will delay the payment of your claim.

Please keep the following basic instructions in mind when resubmitting corrected claims: If the claim is within the first 6 months of the date of service, then simply resubmit the corrected claim to the address given above. If the claim was denied within the first 6 months, and you are resubmitting after the first 6 months, you must attach a copy of the original denial to prove timely filing and then submit to the address given above.

Please refer to the Provider Manual Section 4 at:

<http://www.vtmedicaid.com/Downloads/manuals.html> for more information on submitting corrected claims, timely filing and adjustments.

New Informational Modifiers

The OVHA has approved the use of the following “Informational Only” modifiers with a start date of 1/1/2004:

62-Two Surgeons

66-Surgical Team

78-Return to the operating room for a related procedure during the post-operative period.

These modifiers are to be used in accordance with correct coding guidelines as indicated in the CPT manual

September 29, 2006

Ladies First Expected Adjustments

Providers may see adjustments on upcoming RA's for claims related to the Vermont Department of Health program, Ladies First. As you know, the Ladies First program is structured at the federal level to only allow reimbursements at the Medicare Part B rate. It has come to our attention that claims with a 2006 date of service processed between Jan 1, 2006 and March 20, 2006, were reimbursed at the 2005 Medicare Part B rate. The adjustment reflects a correction to the allowable 2006 Medicare Part B rate. We apologize in advance for this error and any inconvenience that this may cause.

October 6 , 2006

25th Anniversary Open House for EDS

October 1, 2006 is the 25th anniversary of the partnership between Vermont Medicaid and EDS. To mark the occasion, EDS will hold an open house at the EDS offices at 312 Hurricane Lane in Williston on October 13th, 2006 from 12:00 to 4:00 pm for the provider community, the OVHA and representatives from other state offices, Governor and legislators.

If you plan to attend the open house please RSVP at: 800-925-1706 or by going to <http://www.vtmedicaid.com> and emailing your RSVP to EDS at the address given at the bottom of the homepage.

October 13, 2006

CMS1500 Form Updated for NPI

The CMS 1500 billing form has been updated to accommodate the National Provider Identification number. Until EDS accepts NPI numbers, please follow these instructions when filling out the new CMS 1500 form.

Box 17A: Enter the referring Vermont Medicaid provider number here.

Box 24C: This is not a mandatory field at this time but please note that the EMG box has been moved. Box 24 J: Enter the attending physician's Medicaid number in the gray area.

Box 33 B: Please enter your Vermont Medicaid provider number here.

Electronic Adjustment Workshop for Nursing Homes

There will be a workshop on using Provider Electronic Solutions Software (PES) to complete adjustments for nursing home claims. The workshop will be held at EDS in Williston on October 25, 2006 from 1:00 to 3:00. Seating is limited. Please call Betty Parent at 802-857-2959 or Wendy Haskell at 802-857-2963 to reserve your seat.

Workshop-Billing Secondary Insurance Claims and Doing Adjustments for Secondary Insurance Claims

There will be a workshop on using Provider Electronic Solutions Software (PES) for billing secondary insurance claims and doing adjustments for secondary insurance claims. The workshop will be held at EDS in Williston on November 8, 2006 from 1:00 to 3:00 for experienced billers. Seating is limited. Call Deb Safford at 802-857-2957 or Carrie Germaine at 802-857-2964 to reserve your seat.

October 20, 2006

Procedure Codes V5241, V5011, and V5160 Updates

The OVHA will make the following coding changes and clarification effective date of service 10/27/2006.

V5241 [DISPENSING FEE, MONAURAL HEARING AID, ANY TYPE] has replaced V5090. V5090 has been terminated by the OVHA and considered non-covered.

V5241 requires modifiers RT and LT; and is limited to 1 unit per ear every 3 years (1 RT and 1 LT). 1 unit = \$100

V5011 [FITTING/ORIENTATION/CHECKING OF HEARING AID] requires modifiers RT and LT; and is limited to 1 unit per ear every 3 years (1 RT and 1 LT). 1 unit = \$150.00.

V5160 [HEARING AID DISPENSING FEE FOR BINAURAL HEARING AIDS]: 1 unit =\$200.]

Claims with the date of service prior to the effective date will be priced at the above rates, and will not be subject to the modifier requirement, and will not be subject to the audits.

Procedure Codes E0618 RR and E0619 RR and PA

Effective date of service 10/27/2006 Procedure Codes E0618 RR and E0619 RR [Apnea Monitor] do not require Prior Authorization for ages 0-1 (The child is considered 1 until the second birthday).

Prior Authorization is only required on or after the beneficiaries' second birthday.

PES Upgrades

Providers who use PES software to bill electronically are reminded to stay current with the latest version of PES. The current version is PES 2.17. It is available at no charge on www.VTMedicaid.com under Downloads, Software. Upgrade instructions are also available on the same web page.

Please be aware that PES upgrades **must be completed incrementally**. You cannot skip versions without risking database corruption. For example, if you are running PES version 2.14, you must upgrade to 2.15, then 2.16, then 2.17. To see which version of PES you are running, after you log on to PES, click on Help, About.

October 27, 2006

Eligibility Verification

Providers are reminded that after obtaining the Aid Category of the recipient's policy from the Voice Response System [Malcolm], they are responsible for verifying whether that policy (as defined by the specific category) covers the service for which they have inquired. If the recipient has ANY Medicaid policy, Malcolm will indicate recipient eligibility.

Providers can access the VTMedicaid Aid Category list on-line at:

<http://www.vtmedicaid.com/Information/whatsnew.html>

Mass Adjustment on Procedure Code H0001

The OVHA will mass adjust rates for Procedure Code H0001 from:

15 minutes=\$27.05 to 15 minutes=\$28.13.

These changes are effective with date of service 7/1/2006.

Procedure Code V5014 Update

HCPC's code V5014 [Repair/Modification of a Hearing Aid] is a manually priced code. When the aid is sent out for repair, providers must submit the invoice for the repair and OVHA will pay invoice plus \$25.00; if the repair was done in-house the OVHA will pay 80% of the billed amount up to a maximum of \$200.00.

Breast Pump Updates

The OVHA has made the following changes effective date of service 11/17/06:

Procedure Code E0602 [Breast pump, manual, any type (purchase only)] excludes RR modifier.

Procedure Code E0603 [Breast pump, electric, (AC and/or DC,) any type (rental only)] requires RR modifier. PA needed after 3 months.

Procedure Code E0604 [Breast pump, hospital-grade electric pump in home usage is not covered.

Procedure Codes E0602 & E0603 must be used in accordance with the HCPCS coding guidelines and therefore are limited to Maternity, ages 12-55. These codes may not be billed with an infant Beneficiary's MID.

Prior Authorization is not required for the first 3 months for E0603, however providers and suppliers are responsible to ensure that medical necessity is met & should refer to the recently updated Coverage Guidelines for Electric Breast Pumps posted on the OVHA website: <http://www.ovha.state.vt.us/providers.cfm>

Retrospective review may be performed and if the item is found to be not medically necessary claims recoupment may be done.

November 3, 2006

VTMedicaid Now Accepting NPI Numbers!

Providers may begin submitting their NPI numbers to VTMedicaid by using the Excel data collection form now posted at:

<http://www.vtmedicaid.com/Information/whatsnew.html>

Please be sure to read the instructions included with the form.

For further information on NPI please refer to the NPI FAQ posted at:

<http://www.vtmedicaid.com/Information/whatsnew.html> or visit the CMS web site: www.cms.hhs.gov/NationalProvIdentStand.

E0986 and Prior Authorization

Effective date of service 11/24/06, E0986 [manual wheelchair accessory, push activated power assist, each], requires Prior Authorization.

QS Modifier Update

Effective date of service 2/1/2004 modifier QS [monitored anesthesia care service] is recognized by the OVHA as a HCPCs level II modifier to be used in accordance with correct coding guidelines.

A4670 Update

Procedure Code A4670 [automatic blood pressure monitor] can not be rented, it is a purchase only item. Medical necessity must be met.

The OVHA covers ambulatory blood pressure monitoring as medically necessary based on one or more of the following criteria:

- -Resistant hypertension in patients who are being treated with three or more medications.
- -Episodic hypertension suspected when office blood pressure measurements are normal and symptoms (excessive sweating, palpitations, apprehension) suggest episodic hypertension secondary to an existing condition.
- -Hypertensive patients with hypotensive symptoms thought to be related to antihypertensive medications or neurological syndromes.
- -Arm cuffs only; no wrist cuffs.

Though this Procedure Code does not require, Prior Authorization, all records are subject to retrospective review by the OVHA.

Procedure Code T1023 Update

The OVHA has determined temporary Procedure Code T1023 [screening to determine the appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol, per encounter] to be PAC-9; non-covered.

November 10, 2006

99503 PAC 9; Non-Covered

Providers,

Please be aware that the OVHA has made Procedure Code 99503 [home visit for respiratory therapy care (e.g. bronchodilator, oxygen therapy, respiratory assessment apnea evaluation) PAC-9, non-covered-effective immediately as this service is included with the equipment.

VTMedicaid Holiday Schedule

The VTMedicaid offices will be closed on November 10, 2006 for Veteran's Day. Please be aware that claims submitted on Friday the 10th will not be processed until the following week. EDS recommends that providers submit their claims by close of business on Wednesday the 8th.

The offices will also be closed on November 23 & 24 for the Thanksgiving Holiday. EDS recommends that providers submit their claims by close of business on Wednesday the 22nd.

Pharmacy Adjustments

The OVHA will be adjusting approximately 1,300 claims on the next 3 remittance advises. This adjustment is for our reporting purposes only and there should not be any change to your net payment. If you have any questions please contact MedMetrics at 1 800 918-7545.

November 17, 2006

Procedure Codes 47140-2 Updates

Effective date of service 12/16/06 the following procedure codes require Prior Authorization:

47140 [DONOR HEPATECTOMY (INCLUDING COLD PRESERVATION), FROM LIVING DONOR; LT LATERAL SEGMENT ONLY(SEGMENTS II &III)]

47141 [DONOR HEPATECTOMY (INCLUDING COLD PRESERVATION), FROM LIVING DONOR; TOTAL LT LOBECTOMY(SEGMNTS I III & 5)]

47142 [DONOR HEPATECTOMY (INCLUDING COLD PRESERVATION), FROM LIVING DONOR; TOTAL RT LOBECTOMY(SEGMENTS V,VI,VII&VIII)]

November 24, 2006

Banner Pages by Email

Providers can now receive the weekly VTMedicaid communications (Banner Pages) via email. This is the fastest way to receive VTMedicaid program and policy updates. Providers interested in receiving banner notifications via email should send their request to: VTmedicaidbanners@eds.com

In addition to appearing on the weekly remittance advice report, banner notifications are also posted on-line at: www.vtmedicaid.com under Information.

System Maintenance Notice

Providers,

Please be aware that each Monday night between the hours of 8 p.m. EST and 10 p.m. EST, our interactive translator will be shutdown and unavailable in order to process the weekly electronic 835 file.

Any eligibility 270 / 271 requests sent between those hours will not be processed.

Providers may check eligibility during these hours by calling Malcolm at:

1-800-925-1706 (in state), option 1, option 1

or

1-802-878-7871 (out of state), option 1, option 1.

We are sorry for any inconveniences this may cause, but it will allow us the opportunity to post each provider's electronic RA file to their account more expeditiously.

Advance Directives Update

Providers can attain the updated Advance Directives [AD] form and additional information on AD from the Vermont Ethics Network website: <http://www.vtethicsnetwork.org/> or by mailing your request to:

Vermont Ethics Network
64 Main Street, Rm. 25
Montpelier, VT 05602-2951

Revenue Code 905 Update

The OVHA has reviewed Revenue Code 905 [Intensive outpatient services-psychiatric] and determined that it should not be reimbursed as an institutional claim. This service is covered as a professional service only and should be billed on a CMS 1500 form using the appropriate CPT/HCPC's codes. These codes may require prior authorization so be sure to refer to www.vtmedicaid.com to determine if prior approval should be obtained.

Rate Changes PAC V Changed to PAC L

Providers,

It was been brought to our attention that there was inconsistency in pricing laboratory codes. Modifications were made in mid-October to make all Laboratory Codes consistent.

Please refer to the fee schedule posted on: www.VTMedicaid.com for current pricing.

Procedure Code E1087 RR Update

Effective date of service 1/1/07 procedure code E1087RR [high strength lightweight wheelchair; fixed full-length arms, swing-away, detachable, elevating leg rests] requires prior authorization.

Procedure Code 43326 Update

Effective date of service 1/1/07 procedure code 43326 [Esophagogastric fundoplasty; with gastroplasty (eg. Collis)] requires prior authorization.

Compression Stocking Updates

Effective date of service 12/16/06 the following limitations apply to these procedure codes:

A6539 [gradient compression stocking, waist length 18-30 mm Hg, each]; 3 units per 365 days

A6540 [gradient compression stocking, waist length 30-40 mm Hg, each]; 3 units per 365 days

A6541 [gradient compression stocking, waist length 40-50 mm Hg, each]; 3 units per 365 days

A6544 [gradient compression stocking, garter belt]; 3 units per 365 days

Effective date of services 12/16/06, the following procedure codes require prior authorization:

A6549 [gradient compression stocking, not otherwise specified]

A6542 [gradient compression stocking, custom made]

S8420 [gradient pressure aid (sleeve and glove combination), custom made]

S8422 [gradient pressure aid (sleeve), custom made, medium weight]

S8423 [gradient pressure aid (sleeve) custom made, heavy weight]

S8425 [gradient pressure aid (glove), custom made, medium weight]

S8426 [gradient pressure aid (gloves), custom made, heavy weight]

December 1, 2006

1115 Waiver & Adjustments Reminder

Adjustment requests for Choices for Care claims with dates of service 10/1/05 and after, that involve a change to the patient liability amount, currently need manual handling for reprocessing.

Please send this type of claim to:

EDS, PO Box 888, Williston, VT 05495 Att: Jollene Root

EDS is working on rectifying this systems processing issue. We apologize for any inconvenience this may cause.

December 8, 2006

Nursing Home Physician Visit

Physician visits to nursing homes are limited to 1 per month. Exceptions will be granted for additional visits by the OVHA if documentation of reasonable cause accompanies the excess visit(s) claims.

Procedure Code 48160 Update

Effective date of service 1/1/04, the OVHA has determined procedure code 48160 [pancreatectomy, total/subtotal, w autologous transplant of pancreas or pancreatic islet cells] to be investigational and therefore PAC 9; non-covered.

Holiday Schedule

The OVHA and EDS offices will be closed for the holidays on Monday, December 25, 2006 and Monday, January 1, 2007.

Procedure Code 30540 Update

Effective date of service 1/1/07 Procedure Code 30540 [Repair Choanal Atresia; intranasal] requires prior authorization.

December 15, 2006

Dental Providers and ECS

Are you consumed by paperwork? You don't have to be: Electronic claims submission allows for faster processing and payment while reducing errors and enabling better record tracking. Plus, our electronic billing software is FREE! More than 800 providers can testify to the benefits of using EDS PES software to bill Medicaid directly.

Even if you use other software to *bill* your claims, you can use PES to process electronic adjustments and secondary claims, re-submit claims, check claim status or verify eligibility. Providers who currently submit claims on paper and would like to take advantage of electronic billing please contact the EDS EDI Coordinator at: 802-879-4450, option 3, or email: vtedicoordinator@eds.com to discuss electronic billing options.

December 22, 2006

PES V. 2.18-Time to Upgrade!

A new release of Provider Electronic Solutions (PES 2.18) is now available on the VT Medicaid web site under Downloads, Software. See PES News, at the same location, for a description of 2.18 enhancements.

Provider Notification Form Update-“PATH 287”

The OVHA has discontinued the use of PATH form 287 “Provider Notification”.

Providers are encouraged to create their own form with the following information:

- Provider's name and VT Medicaid Provider ID or NPI
- Beneficiary name and signature (or signature of a parent if the beneficiary is a minor).
- Description of service(s) sought
- A clear statement that the provider is unwilling to accept Medicaid payment for the specific service(s) sought and if the beneficiary wants to get this service from

- this provider, the beneficiary or responsible adult must accept full financial responsibility.
- Date of signing

If a provider does not intend to bill Medicaid for specific services, the patient must be fully informed of the decision and its consequences prior to rendering the service. Patients must understand that they will be financially responsible for payment for the service(s). The OVHA strongly encourages providers to document (using your own form) this agreement/understanding between beneficiary and provider.

The provider should give a copy to the beneficiary or responsible adult and retain a copy of any such documentation.

Procedure Code 90649 Update

Effective back to date of service 1/1/06, procedure code 90649 [HUMAN PAPILLOMA VIRUS (HPV) VACCINE, TYPES 6,11,16,18(QUADRIVALENT),3 DOSE SCHEDULE, FOR INTRAMUSCULAR USE] will be priced manually. Therefore, an invoice must be attached to the submitted claim.

Rural Health Providers Billing Electronically

When billing electronically, rural health and FQHC providers must enter the other insurance paid amount on the detail containing the encounter procedure code. Rural health and FQHC providers must also bill all other procedure codes with a zero paid amount at each detail level. If billing Medicaid secondary to Medicare, do not bill the encounter code. Medicaid will only reimburse for co-insurance and deductible.

Nursing Home Providers Respite Type of Bill

Effective immediately nursing home providers billing respite services should use their respite provider number with the type of bill 861 through 864. If using EDS' provider electronic solutions software (PES) you must upgrade to version 2.18 and use 837 Institutional Home Health. The upgrade and instructions can be found on our website www.vtmedicaid.com

December 29, 2006

CPT Code Update

In the last legislative session, the OVHA was appropriated over \$2 million to increase pricing for E&M codes to Medicare 2006 fee levels subject to the availability of funds. 76 E&M codes will be converted to the Resource Based Relative Value System payment method. Seven of the codes will be reduced from current pricing to the 2006 Medicare level (using a coefficient of \$37.8975) and the remaining codes will be increased and use a unique Medicaid coefficient of \$34.8100.

Please be aware that EPSDT, PCPlus, and Psychiatric programs will no longer receive enhancements.

The new rates can be found at www.vtmedicaid.com in the download section.

Inpatient Per Diem Rates Update

Providers,

A 2006 legislative appropriation increased Vermont Medicaid's payment to hospitals. As a result, inpatient per diem rates will be increased effective date of service 1/1/07.

Providers should have already received a notification letter from the OVHA listing the per diem rate increases.