



Vermont Medicaid Portal

Banner Page

[December 30, 2011](#)

Request for Waiver from the Implementation of the HIPAA 5010 Standards

The Centers for Medicare and Medicaid Services (CMS) has announced that it would not initiate enforcement action with respect to any HIPAA covered entity non-compliant with the ASC X12 Version 5010, NCPDP Telecom D.0 and NCPDP Medicaid Subrogation 3.0 standards until 90 days after the January 1, 2012 compliance date. Notwithstanding CMS's discretionary application of its enforcement authority, the compliance date for use of these new standards remains January 1, 2012.

VT Medicaid will not approve waivers for any provider who has a 5010 compliant clearinghouse, billing service, software vendor or is using HPES's Provider Electronic Solution (PES). This waiver only applies for the submittal of claims (837 transactions); all other HIPAA transactions require the provider to be 5010 compliant.

The Request for Waiver from the Implementation of the HIPAA 5010 Standards form is available on the Vermont Medicaid Portal at <http://www.vtmedicaid.com/Information/whatsnew.html>. Requests may be faxed to (802) 878-3440. Providers with no internet access can contact the HPES Help Desk at 800 925-1706 (in state) or (802) 878-7871 (out of state) to obtain a copy.

Preventative Care - Reminder

This notice serves to remind providers that preventative services are covered by Medicare at 100%; there will not be any coinsurance or deductible due.

Crossover claims from Medicare will be accepted, but no payments will be made by Vermont Medicaid when a Vermont Medicaid Beneficiary is eligible for benefits under both programs

Closed for the Holiday

The DVHA and HP Enterprise Services offices will be closed on Monday, January 16th, 2012, in observance of Martin Luther King Day.

[December 23, 2011](#)

Provider Electronic Solutions (PES) Software Version 2.25

The PES software release 2.25 (full install & upgrade) will be available December 19, 2011 on the Vermont Medicaid Portal at www.vtmedicaid.com/Downloads/software.html. This release is in support of the 5010 HIPAA Standards for HIPAA Transactions. Please note this upgrade is mandatory for all PES submissions made on or after January 1, 2012.

Important: Providers submitting claims up through the end of the year should continue to use their current PES software version.

Once the upgrade to 2.25 is complete; providers must wait until 1/1/2012 to submit claims. As of 1/1/2012 all PES transactions must be submitted using version 2.25.

December 16, 2011

Change in Implementation of Earlier Oversight for Outpatient
Pediatric Rehabilitative Therapies

Effective December 9, 2011, the requirement for earlier oversight (greater than 8 visits) for outpatient pediatric rehabilitative therapies per Emergency Rule AHS Bulletin 11-11/Secretary of State ID# 11-E09 will be suspended pending formal approval of regular rule change by the legislature. Refer to current Rule 7317 for Rehabilitation Therapy Services. Providers are encouraged to consider continuing to submit requests for medical necessity review sooner than the 4 month requirement date on a voluntary basis. Earlier review by DVHA will help providers to:

Receive earlier guidance regarding medically necessary evidence based practice

Receive earlier assistance regarding Medicaid regulation and procedures

Avoid recoupments that would otherwise be generated through the retroactive utilization review process

DVHA will continue to work through the rulemaking process, with the anticipated approval of the rule change within the next several months. For clinical assistance and support, please contact Susan Mason at 802 879-6396 or susan.mason@state.vt.us.

Closed for the Holiday

The DVHA and HP Enterprise Services offices will be closed on Monday, December 26th and Monday, January 2nd in observance of the Holidays. We would like to extend our thanks to the provider community and wish all a very merry holiday season.

December 9, 2011

5010 HIPAA Transaction Claim Testing

Electronic claim submitters (except PES users) may now upload 5010 HIPAA Transaction test claims in the user acceptance test environment and download response reports from [https://www.vtmedicaid-
uat.com/test/secure/logon.do](https://www.vtmedicaid-uat.com/test/secure/logon.do).

Providers submitting claims electronically utilizing PES software are instructed to wait for the release of the 5010 PES software upgrade, which will be made available prior to the 5010 HIPAA Transaction implementation date of January 1, 2012. PES users will not be required to test 5010 HIPAA claim Transactions.

Advance Notice of ICD-9 Diagnosis Review

Due to the implementation ICD-10, HPES will be conducting a review of all ICD-9 diagnosis codes prior to January 1, 2012. This could result in changes being made to the allowed and excluded diagnosis code lists.

Vermont HIPAA Contact

Please do not include Personal Health Information (PHI) when e-mailing your request to the VT HIPAA contact vermonthipacontact@hp.com. The ICN must be included in your request which will provide the information required to process your request.

November 25, 2011

EDI Translator Maintenance to be Performed

EDI Translator maintenance is scheduled for December 5, 2011 between the hours of 6:00pm and 10:00pm. During this time, Provider Web Services will be unavailable.

Providers wishing to check eligibility, receive other insurance information or determine if service limits have been reached are advised to use the automated Voice Response System (VRS). The VRS can be accessed by dialing 802-878-7871, option 1 and then option 1 again.

Town Hall Meeting at Rutland Regional Medical Center

HP Enterprise Services will hold a Town Hall Meeting on Wednesday, December 7th from 10am-12pm at Rutland Regional Medical Center (room CR C). Provider Representatives will be available to answer your billing questions and discuss VT Medicaid policies and procedures. Please contact Paula Duchaine at 802-857-2957 to reserve your seat, as space is limited; directions can be obtained at http://www.rrmc.org/patients_visitors/visitor_info/directions.html.

Electronic Billing of Third Party Liability Denials

Providers are able to submit claims electronically to HPES that have been denied by a third party payer when that payer has denied the claim using certain adjustment reason codes. 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 Portal at www.vtmedicaid.com/Downloads/manuals.html and then select 837 adjustment reason codes. HPES 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.

November 18, 2011

Correct Form Versions

Effective January 1, 2012, HPES will require providers to use current form versions when submitting requests to HPES. Failure to do so, will result in your request being denied. Please see the VT Medicaid Portal form library located at <http://www.vtmedicaid.com/Downloads/forms.html> and remove all expired forms from your files.

Providers are instructed to immediately start using the updated Sterilization & Hysterectomy Consent Forms available for download.

HCPCS Code E1372 Not Eligible for Rental Reimbursement

Effective December 19, 2011, VT Medicaid will no longer rent immersion external heaters for nebulizers (current HCPCS code E1372).

Closed for the Holiday

The DVHA and HP Enterprise Services offices will be closed on November 24th and 25th, in observance of the Thanksgiving Holiday. Please submit all claims by Wednesday, November 23rd for processing.

HP Provider Representative Territory Update

Providers wishing to expedite their eligibility and claim status inquiries, and download RAs may do so using the VT Medicaid website at www.vtmedicaid.com.

Providers with questions about claim specific denials are directed to call the HP Provider Services Help Desk at 800 925-1706 (in state) or 802 878-7871 (out of state).

Providers needing assistance to resolve complex recurring billing issues are advised to contact the Provider Representative Team. The following is a detailed listing of the Provider Representative Team and the counties they service:

- Betty Parent: FAHC, Addison, Caledonia, Lamoille, Washington, (802-857-2959).
- Spring Shover: Chittenden, Essex, Franklin, Grand Isle, Orleans (802-857-2956)
- Paula Duchaine: DHMC, Bennington, Orange, Rutland, Windham, Windsor, 802-857-2957).

A full-colored detailed map depicting each Provider Representative and their corresponding counties is available for download at <https://www.vtmedicaid.com/Information/whatsnew.html>.

November 4, 2011

Closed for the Holiday

The DVHA and HP Enterprise Services offices will be closed on Friday, November 11th, 2011, in observance of Veterans Day.

Provider Workshop to be Held at Porter Memorial Hospital

HP Enterprise Services will hold a Town Hall Meeting on Friday November 18, 2011, from 10:00am to 12:00pm at Porter Memorial Hospital in Middlebury, Vermont. Provider Representatives will be available to answer your billing questions and discuss VT Medicaid policies and procedures. Please contact Spring Shover at 802-857-2956 to reserve your seat, as space is limited; directions can be obtained at <http://www.portermedical.org/>.

The Processing of Stapled Claims

Providers are reminded not to use staples when submitting claims to HPES. All claims received with staples will be returned to providers. Due to HIPAA requirements, the beneficiaries UID Number is made unidentifiable when stapled claims are returned. Please replace the UID prior to resubmitting your claim for processing.

October 28, 2011

Reimbursement of Overpayments Made by Vermont Medicaid (Hospitals Only)

Providers are reminded of the 2009 Fraud Enforcement and Recovery Act (FERA) which amended the False Claims Act, 31 U.S.C §§3729-3733, by increasing the scope of the false claims liability to include persons who knowingly conceal the retention of any overpayment of government money and the 2010 Patient Protections and Affordable Care Act (PPACA) which directly linked the retention of overpayments to false claims liability. PPACA requires the report and return of all overpayments within 60 days after the date on which the overpayment was identified or the date the corresponding cost report was due, whichever is later. Additionally, providers must submit notification in writing as to the reason of the overpayment.

Currently HP Enterprise Services contracts with AIM HealthCare to audit hospitals for credit balances on accounts. This arrangement does not negate the provider's responsibility to report and return overpayments timely. HPES will forward any cases in which the discovered overpayment was not refunded during the timeline mandated by PPACA to the DVHA Program Integrity Unit for their review.

Reimbursement of Overpayments Made by Vermont Medicaid (All Providers Except Hospitals)

Providers are reminded of the 2009 Fraud Enforcement and Recovery Act (FERA) which amended the False Claims Act, 31 U.S.C §§3729-3733, by increasing the scope of the false claims liability to include persons who knowingly conceal the retention of any overpayment of government money and the 2010 Patient Protections and Affordable Care Act (PPACA) which directly linked the retention of overpayments to false claims liability. PPACA requires the report and return of all overpayments within 60 days after the date on which the overpayment was identified or the date the corresponding cost report was due, whichever is later. Additionally, providers must submit notification in writing as to the reason of the overpayment. HPES will forward any cases in which the discovered overpayment was not refunded during the timeline mandated by PPACA to the DVHA Program Integrity Unit for their review.

October 21, 2011

McKesson Health Solutions InterQual® Guidelines Are Now Available

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

McKesson Health Solutions InterQual® Guidelines are now available to providers behind the Vermont Medicaid secure provider web portal at www.vtmedicaid.com/secure/logon.do. After log-in, look for the link McKesson Smart Sheets on the left window.

DVHA Clinical Guidelines and Vermont Medicaid State Rules will continue to be available at the DVHA website at dvha.vermont.gov/for-providers/clinical-coverage-guidelines.

October 14, 2011

CMS Registration opens for Medicaid Electronic Health Care Reform Incentive Program

As of October 3, 2011, Eligible Professionals (EP) and hospitals can initiate the process of receiving Medicaid EHR incentive payments. EPs can receive up to \$21,250 in the first year of program participation.

Step One: Vermont Medicaid Professionals and hospitals meeting eligibility requirements register with the CMS Incentive Program Registration and Attestation System. (Please be sure to select the Medicaid Incentive Program when completing Step 6 – Incentive Program Questionnaire).

To successfully complete the registration process, have the following information available:

- An active National Provider Number (NPI)
- A NATIONAL Plan and Provider Enumeration System (NPPES) web user account

- A tax ID Number
- A CMS EHR Certification Number from the [ONC Certified Health IT Product List](#)

For additional information about completing Step One, see the [Medicaid Eligible Professional Registration User Guide](#).

Step Two: The incentive payment application will be available on the Vermont Medicaid web portal on October 17, 2011. Following notification that CMS registration has been completed; an email will be received containing information on using Vermont's MAPIR (Medical Assistance Provider Incentive Repository) system in order to complete the attestation process. A Vermont Medicaid Web Portal user ID and password will be needed to log in at www.vtmedicaid.com

MAPIR will require information to be entered to demonstrate that the Eligible Professional:

- Meets Medicaid patient volume thresholds
- Is adopting, implementing or upgrading a federally certified EHR system.
- Meets all other federal program requirements
- Has proof of purchase of a federally certified EHR system

The Medicaid program allows first-year incentives to be paid out if an EHR is on order, and has not yet been installed. Proof of purchase must be submitted, such as: a receipt, invoice, contract, purchase order, etc. Eligible professionals will only be required to attest to adopting, implementing or upgrading. There is no EHR reporting period in year one for Medicaid.

Additional information about the Medicaid EHR Incentive Program is available through the [Vermont Health Care Reform](#) site, the [VITL website](#) and at <http://hcr.vermont.gov/EHRIP>
Applicants wishing to check the status of their MAPIR application may do so by logging back into the MAPIR system. All other inquiries can be e-mailed to: AHS.mapir.vt@state.vt.us.

Pharmacist-Administered Influenza Vaccinations

Effective September 30, 2011, DVHA-enrolled pharmacies may be reimbursed for injectable influenza vaccinations administered by pharmacists to adults 19 years and older enrolled in Vermont's publicly funded programs. Pharmacists must be certified to administer vaccines in the state of Vermont and must be in compliance with all Vermont laws governing vaccine administration. Failure to comply with all Vermont immunization regulations will subject these claims to recoupment. Reimbursement will be based on either a written prescription or a non-patient specific written protocol based on a collaborative practice agreement per state law. These orders must be kept on file at the pharmacy. The billing pharmacy and the ordering prescriber's NPIs are required on the claim for the claim to be paid.

Reimbursement and billing: Under this program, pharmacies are reimbursed for the cost of the vaccine and an administration fee. No dispensing fee is paid for these claims. Pharmacists should bill DVHA using either the paper CMS-1500 claim form or the electronic 837 Professional transaction. A claim for the vaccine must accompany a claim for administration; therefore these vaccinations cannot be billed at POS through the pharmacy benefit. The appropriate billing codes to be used are as follows: Influenza vaccine codes: 90656, 90658 and administration code 90471.

For instructions on billing with a CMS 1500 claim form, see the CMS-1500 Manual at: www.vtmedicaid.com/Downloads/manuals.html.

For information on reimbursement please refer to the Fee Schedule on the DVHA website: <http://dvha.vermont.gov/for-providers/claims-processing-1>

If you have additional billing questions, please contact HP provider services at 800-925-1706. For other questions regarding this benefit, please contact a member of the DVHA pharmacy unit at 802-879-5900.

The New Ladies First Provider Resources and Training Website



The Vermont Department of Health's Ladies First Program is pleased to announce the availability of our new Provider Resource and Training website located at ladiesfirstproviders.vermont.gov. This website offers 12 AMA PRA Category 1 Credits™ and 12 Nursing Contact Hours. The website also offers an additional performance improvement course worth 20 AMA PRA Category 1 Credits™ at no cost to providers; certificates are awarded directly from the website by the University Of Vermont College Of Medicine and the Vermont Department of Health. Features include: claim form tutorials, performance feedback and the most up-to-date reference tools for clinical practice in breast, cervical and cardiovascular screening, diagnostics and treatment. In addition, reference tools and national guidelines are available for hypertension, cholesterol management, and body mass index. We hope you find the new website to be an exciting, informative and convenient addition to the Ladies First Program.

DME Date Span Reminder

DME supplies and rentals are required to be billed with a date span specifying the amount of time the supplies will last or the rental time period; this is usually a month's time (for example; "from" date of 09/15/11 and "to" date of 10/14/11).

DME supplies can be billed for up to two months, at a time. When this is done, the billed dates must reflect the beginning and end dates of the two-month period.

Correct date spans can justify the total units being billed, helping to avoid claim denials.

CSM-1500 Claim Form - Field 11d

Providers are required to complete Field 11d on the CMS-1500 claim form, (Is there another health insurance plan). Health benefits provided under Green Mountain Care are not considered other insurance. Other insurance only pertains to a private health insurance carrier.

If yes is indicated, please complete fields 9 a-c.

Medicare Electronic Adjustments Denied

Medicare recently executed several adjustments in response to rate increases; these adjustments crossed over to HPES from Medicare and were denied by our system. To recoup the original claim(s), providers can either resubmit adjustments electronically or can submit an Adjustment Request (multiple or single); attach a new claim with the appropriate Medicare Attachment Summary Form. All forms are available on the website at www.vtmedicaid.com/Downloads/forms.html.

CPT and ICD-9 Procedure Diagnoses No Longer Covered

Effective November 14, 2011, CPT codes 54900, 54901, 55870, 58540, 58672, 58673 and 76948 and the following ICD-9 Procedure codes: 63.82 – 63.84 and 66.73 are no longer reimbursable by Vermont Medicaid.

October 7, 2011

Server Maintenance to be Performed

Web server maintenance is scheduled for October 10, 2011 between the hours of 7:00pm and 9:00pm. This will result in a 30 minute service outage which will impact all provider web services.

Providers wishing to check eligibility, receive other insurance information or determine if service limits have been reached are advised to use the automated Voice Response System (VRS). The VRS can be accessed by dialing 802-878-7871, option 1 and then option 1 again.

PA Process Change for Pediatric Physical, Occupational & Speech Therapy

As of November 7, 2011, prior authorization for outpatient therapies (PT,OT,ST) will change for Medicaid beneficiaries under age 21. The initial eight visits from the start of the beneficiary's acute care episode/condition are allowed, per therapy discipline before prior authorization is required. Providers must request prior authorization in advance of the 8th visit if additional therapy dates are necessary. Providers must determine the first date of treatment at any outpatient facility, regardless of coverage source

Subsequent authorizations will be required at 4 month intervals, based on the start of care date (no change from the current system).

This change does not apply to home health agencies.

Providers should refer to the Medicaid Rule and Therapy Guidelines for additional clarification.

<http://ovha.vermont.gov/for-providers/clinical-coverage-guidelines>

September 30, 2011

Anesthesiology – Change in Unit Billing

Effective for dates of service on and after January 1, 2012, providers administering anesthesiology services are required to bill units in actual time spent in minutes. For example, one unit equals one minute of actual time spent in attendance. This change to the unit definition for anesthesia services is in line with Medicare billing guidelines for these services and is intended to promote consistency between insurers. A limit of 600 units (10 hours) has been imposed on most anesthesia codes. When submitting a claim for anesthesia services with units greater than the maximum allowed amount for the same date of service; submit a paper CMS 1500 claim form and include the appropriate supporting documentation (e.g. an anesthesia report).

CPT codes 01961, 01967, 01968 and 01969 will be fee for service with a unit limit of one.

September 23, 2011

Interim 5010 Tech Specs Are Available

An interim version of the Vermont Medicaid Tech Specs for the 5010 HIPAA Transactions are available on our web portal at www.vtmedicaid.com/Downloads/tools.html, 5010 Tech Specs. Updates may be made to this information as we progress through the implementation process. Please view the weekly banners for the availability of finalized 5010 Tech Spec information.

National Correct Coding Initiative (NCCI)

In accordance with the National Correct Coding Initiative (NCCI), VT Medicaid is required to implement pre-payment edits and apply NCCI guidelines for claims with a date of service on or after October 1, 2010.

It is the DVHA's intent to conduct a post payment review for claims prior to the required date to ensure overpayments were not made. Providers affected by this post-payment review will be notified.

MUE (Medically Unlikely Edits) have been implemented and apply to all Professional, ASC, Hospital and DME claims.

September 16, 2011

CMS 5010 National Education Call

Centers for Medicare and Medicaid Services will host its national education call regarding Medicare Fee For Service (FFS) implementation of HIPAA Version 5010 and D.O transaction standards on Wednesday, September 14, 2011. For more information and to register for this event please visit www.cms.gov/Versions5010andD0/V50/list.asp#TopOfPage.

The Transitioning of Rental Reimbursement

The Department of Vermont Health Access has transitioned most, but not all rental reimbursements to rental (RR) logic. This logic calculates the rental modifier (RR) to allow 10% of the purchase price (rate on file) for the procedure code. This allows claims to process more timely and without manual intervention. Most but not all rental periods are 30 days. Providers are required to pro rate rentals when the rental period is less than 30 days.

CMS Limits Billing of CPT 80101-Correction

This notice is a correction to the July 29, 2011, CMS Limits Billing of CPT 80101, Banner. Per the guidelines set forth by the Centers for Medicare & Medicaid Services (CMS) effective April 1, 2010, billing for 80101 (urine drug testing) is limited to appropriately accredited clinical laboratories. Providers holding a CLIA Certificate of Waiver are not eligible to be reimbursed for this CPT code. Please see MLN Matters: Number MM7266 located at <http://www.cms.gov/mlnmattersarticles/downloads/MM7266.pdf>.

TPL Provider Change Request Form Fax Number Has Changed

The TPL Change Request Form has been updated and is available at <http://www.vtmedicaid.com/Downloads/forms.html>. Requests are now to be faxed to 802-857-2992.

September 9, 2011

Clarification on Vaccine Administration Codes 90460 & 90461

This notification serves to clarify the April 22, 2011, Immunization Administration Banner. CPT Codes 90460 & 90461 are restricted to the following primary diagnoses (as indicated by the American Academy of Pediatrics): V0381, V0382, V0389, V040, V0481, V0489, V053, V054, V061, V063, V064, V065 and V068. Each administration code is required to have a corresponding vaccine code billed, along with one of the above primary diagnosis code. Billing rules for all other vaccine administration codes have not changed and therefore, are not subject to this requirement.

Timely Filing Appeals - 10 or More Claims

Providers submitting a timely filing appeal request containing 10 or more claims, all with the same late submission reason, are required to complete and attach the Timely Filing Appeal Listing-10 or more claims document, located at <http://www.vtmedicaid.com/Downloads/forms.html>. All timely filing appeal requests meeting the above criteria will be returned to providers if the required documentation is not attached.

VHAP Limited Coverage Now Mirrors VHAP Managed Care

VHAP Limited coverage now mirrors VHAP Managed Care coverage (i.e., PC Plus). For example, if a physician referral or Prior Authorization is required for Managed Care, it is also required for VHAP Limited; therefore, a beneficiary may

need to have selected a Primary Care Physician (PCP) prior to receiving a service. If a beneficiary pays their initial premium, coverage is retroactive to the day eligibility was approved. However, if a beneficiary does not pay their initial premium, the beneficiary will be responsible for the cost of services.

August 26, 2011

Family Planning Option (FPO) Meeting

The DVHA is hosting a meeting to discuss implementation of the FPO and provide an opportunity for public comment. The FPO is a new eligibility group authorized by the Affordable Care Act (federal) and by Act 63 (state); the FPO start date is April 1, 2012.

Agenda topics include: 1) Overview, 2) Eligibility Criteria, 3) Benefits/Coverage, 4) Grievances/Appeals, Fair Hearings, Exception Requests, 5) Rule Process & Schedule, 6) State Plan or Waiver Amendment Process & Schedule, 7) Implementation Activities.

The meeting will be held on August 30, 2011, from 9am-11am, at DVHA, large conference room, 312 Hurricane Lane, Williston, VT. Providers unable to attend in person can attend via conference call by dialing 1-866-642-1665, use conference ID# 737188. Please contact Lorraine Siciliano by e-mail at Lorraine.Siciliano@ahs.state.vt.us or call 802-879-5907 by August, 26, 2011, to confirm your attendance or to ask questions.

August 19, 2011

Closed for the Holiday

The DVHA and HP Enterprise Services offices will be closed on Monday, September 5th, 2011, in observance of Labor Day.

DME Supplies - Intermittent Catheters

Effective August 1, 2011, Vermont Medicaid is increasing the maximum allowed units for intermittent catheters to 120 per calendar month.

August 12, 2011

Termination of the LADC Waiting List Pilot Program

On January 1, 2011 The Division of Alcohol and Drug Abuse Programs (ADAP) initiated for a six month period a "LADC Waiting List Pilot Program". The goal was to provide additional treatment support for Medicaid beneficiaries who through a referral process could not access treatment services through ADAP's preferred provider system within 5 days. Prior Authorization from ADAP was required in order for the LADCs to practice. The LADC pilot program was terminated on June 30, 2011.

Appointment Information to be Verified by Transportation Providers

All providers must confirm beneficiary appointments when requested by Medicaid transportation providers. The appointment information is required by CMS to verify that transportation is to and from only eligible medical appointments. Transportation providers have signed confidentiality agreements with the DVHA allowing them to access basic beneficiary appointment information. At this time, we are only requiring transportation providers to verify 5% of all ride requests so there should be minimal impact on provider practices.

Prior Authorization for Substance Abuse Treatment

On January 1, 2011 The Division of Alcohol and Drug Abuse Programs (ADAP) initiated for a six month period a "LADC Waiting List Pilot Program". Prior Authorization was required in order for the LADCs to practice. This prior

authorization process resulted in claims denials for some private practitioners who provide drug which was not the intent. The Prior authorization has been lifted and those practitioners who have received 063 claim denials are asked to resubmit claims for processing.

August 5, 2011

Provider Town Hall Meeting in Springfield

HP Enterprise Services will hold a Town Hall Meeting on Friday August 26, 2011, from 10:00am to 12 noon, at The Meeting House in Springfield, Vermont. Provider Representatives will be available to answer your billing questions and discuss VT Medicaid policies and procedures. Please contact Spring Shover at 802-857-2956 to reserve your seat, as space is limited.

Directions:

From Route 11, turn east on Park Street, take the next right turn and follow the blue hospital signs. Drive past the main entrance to the hospital and up the road, there will be a small house on your left overlooking the hospital. Parking is available next to the Meeting House.

Provider Town Hall Meeting in St. Albans

HP Enterprise Services will hold a Town Hall Meeting on Friday September 2, 2011, from 10:00am to 12pm, at The Northwestern Medical Center, 133 Fairfield St., St. Albans (conference room #1). Provider Representatives will be available to answer your billing questions and discuss VT Medicaid policies and procedures. Please contact Jean Gadue at 802-857-2948 to reserve your seat, as space is limited.

Directions:

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

Adrenalectomy

Effective September 5, 2011, CPT code 60545 is restricted to the following diagnoses: 194.0, 197.6, 198.7, 211.8, 227.0, 235.4, 237.2, 255.2, 255.3, 255.5 and 255.6.

Endometrial Ablation

Effective September 5, 2011, CPT codes 58356, 58563 & 58353 are restricted to the following diagnoses: 218.0, 617.0, 621.0, 621.30 – 621.35, 625.3, 626.2, 626.5, 626.8, 627.0 and 627.1.

Dilation and Curettage

Effective September 5, 2011, CPT code 58120 is restricted to the following diagnoses: 182.0, 617.0, 621.0, 621.30 - 621.35, 622.4, 622.7, 626.2 - 626.6, 626.8, 627.0 and 627.1.

Urethroplasty

Effective September 5, 2011, CPT code 53430 is restricted to the following diagnoses: 189.3, 598.01, 598.1, 598.2, 598.8, 598.9, 599.1, 599.2, and 599.5.

CPT 51880

Effective September 5, 2011, CPT code 51880 is restricted to the following diagnosis: V55.6.

CPT 51860

Effective September 5, 2011, CPT code 51860 is restricted to the following diagnoses: 596.6, 634.21, 635.22, 636.21, 637.22, 867.0 and 867.1.

CPAP and BIPAP Rental

Effective date of service August 1, 2011, prior authorization is no longer required for rentals of CPAP & BIPAP devices.

The purchase of CPAP and BiPAP devices continues to require prior authorization. Prior authorization requests must include appropriate documentation of medical need to support current best practice guidelines.

July 29, 2011

CPT L8603 Restricted to Physicians

Effective August 29, 2011, HCPCS Code L8603 will be restricted to physicians.

CPT 37785

Effective August 29, 2011, CPT 37785 is restricted to the following diagnoses: 454.0, 454.1, 454.2, 454.8 and 454.9.

Developmental & Autism Screening of Children

There are two changes to CPT 96110 as billed by primary care providers.

First, providers may now bill CPT code 96110 alone or in conjunction with a well-child-visit.

Second, to ensure the appropriate developmental/autism screening tools are being used, the Vermont Child Health Improvement Program reviewed the standardized screening tools listed in the Academy of Pediatrics policy statement Identifying Infants and Young Children with Developmental Disorders in the Medical Home (Pediatrics, Vol. 18, #1, July 2006) resulting in the creation of a "preferred list" of screening tools.

As of January 1, 2011 reimbursement will be limited to those tools listed in preferred list. Updated developmental and autism screening descriptions and the preferred list can be located in the CMS-1500 Provider Supplement at <https://vtmedicaid.com/Downloads/manuals.html>.

System Maintenance to be Performed August 1, 2011

Web server maintenance is scheduled for August 1, 2011 between the hours of 7pm and 9pm. During this time, there is a possibility of a 10 to 30 minute service outage which will impact all provider web services.

Providers wishing to check eligibility, receive other insurance information and determine if service limits have been reached are advised to use the automated Voice Response System (VRS). The VRS can be accessed by dialing 802-878-7871, option 1 and then option 1 again.

Vision Verification Services Available Through VRS & Web Portal

Enhanced vision verification services are now available through the Voice Response System (VRS) 802-878-7871 and the Vermont Medicaid Portal www.vtmedicaid.com. Please immediately discontinue the use of the Vision Eligibility Verification Fax Form.

Closed for the Holiday

The DVHA and HP Enterprise Services offices will be closed on Tuesday, August 16th, 2011, in observance of The Battle of Bennington.

Nutrition Infusion Pumps

Effective August 29, 2011, HCPCS codes for Enteral and Parenteral Nutrition Infusion Pumps (currently codes B9000, B9002, B9004 and B9006) will require the rental modifier RR to be used on all claim submissions. These pumps are not allowed for purchase by Vermont Medicaid and will only be reimbursable when billed as a rental on a per month basis. Infusion pump rentals must be medically necessary in keeping with VT Medicaid guidelines for coverage. See Enteral Nutrition and Parenteral Nutrition at <http://ovha.vermont.gov/for-providers/clinical-coverage-guidelines>.

HP Provider Representative Territory Update

- Providers wishing to expedite their eligibility and claim status inquiries, and download RAs may do so using the VT Medicaid website at www.vtmedicaid.com.
- Providers with questions about claim specific denials are directed to call the HP Provider Services Help Desk at 800 925-1706 (in state) or 802 878-7871 (out of state).
- Providers needing assistance to resolve complex recurring billing issues are advised to contact the Provider Representative Team. The following is a detailed listing of the Provider Representative Team and the counties they service:

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

Spring Shower: Addison, Caledonia, Essex, Orange, Washington, and Windsor (802-857-2956).

Help Desk: Franklin, Grand Isle, Lamoille, and Orleans (802-878-7871).

A full-colored detailed map depicting each Provider Representative and their corresponding counties is available for download at <https://vtmedicaid.com/Information/whatsnew.html>.

CPT 20650 Diagnosis Update

Effective August 29, 2011, CPT 20650 will be restricted to the following diagnoses: 733.11, 733.12, 733.15, 733.16, 733.93, 733.95-733.98, 808.0, 808.1, 808.53, 812.00-812.03, 812.09-812.13, 812.20, 812.21, 812.30, 812.31, 812.40-812.44, 812.49-812.54, 812.59, 813.07, 813.17, 813.42-813.45, 813.52-813.54, 820.00,-820.02, 820.09-820.13, 820.19-820.22, 820.30, 820.31, 820.8, 820.9, 821.00, 821.01, 821.10, 821.11, 821.20-821.23, 821.29-821.33, 821.39, 823.00-823.02, 823.10-823.12, 823.20-823.22, 823.30-823.32, 823.41, 823.42, 823.80, 823.81, 823.82, 823.90-823.92, 996.40, 996.49, 996.67 and 996.78.

Hormone Pellet Implantation

Effective August 29, 2011, CPT 11980 will be restricted to the following diagnoses: 253.4, 253.7, 256.2, 256.31, 256.39, 256.8, 256.9, 257.1, 257.2, 259.0, 627.0, 627.1, 627.2, 627.4, 627.8, 627.9, 733.00 and 733.01.

CMS limits billing of CPT 80101

Per guidelines set forth by the Centers for Medicaid & Medicare Services (CMS) effective April 1, 2010, billing for 80101 (urine drug testing) is limited to appropriately accredited clinical laboratories. Providers holding a CLIA Certificate of Waiver are not eligible to be reimbursed for this CPT code. Please see LMN matters MM6852 located at <http://www.cms.gov/mlnmattersarticles/downloads/MM6852.pdf>

July 22, 2011

Antepartum/Prenatal Care

Due to 2011 rate changes and VT Medicaid's decision to change Antepartum Care billing, there has been some confusion on how to properly submit Antepartum Care claims.

Please note that Global OB Billing has not changed.

Follow the instructions in this banner for all pregnancies beginning January 1, 2011 or later.

For any pregnancy that spans dates in 2010 into 2011, the HP provider services unit will outreach to all impacted providers to explain the process to recoup and resubmit claims that were affected by these changes.

Instructions:

- Antepartum Care, billing 1-3 visits; use appropriate E/M codes for each visit.
- Antepartum Care, billing 4-6 visits; use CPT code 59425 with the range of dates billed as 1 unit.
- Antepartum Care, billing 7 or more visits; use CPT code 59426 with the range of dates billed as 1 unit.

Example A: Beneficiary goes to Dr. A for 3 visits; Dr. A would bill the appropriate E/M code for each visit with each applicable date of service.

Beneficiary moves and switches to Dr. B for the remainder of her pregnancy. Dr. B sees the beneficiary for 6 visits Dr. B bills out ONLY code 59425 with range of days and 1 unit. If Dr. B also delivers he would also bill appropriate delivery code.

Example B: Beneficiary goes to Dr. A for 5 visits. Dr. A only bills 59425. Beneficiary then goes to Dr. B for one visit; Dr. B will ONLY bill the E/M code for that visit he provided. Beneficiary goes to Dr. C for 8 visits; Dr. C would bill 59426 with range of days and 1 unit. Dr. C also delivers he would then bill the appropriate delivery code as well.

July 15, 2011

Limited Distribution Pharmacy Rate Change

Limited Distribution Pharmacies dispense medications that may have special requirements for dosing or close lab monitoring. Because of these special requirements, drug manufacturers sometimes choose to limit the distribution of their drugs to only one or a few select pharmacies or, as part of the drug approval process, the Food and Drug Administration (FDA) may recommend this type of distribution. This type of restricted distribution allows the manufacturer to properly control the inventory of the drug; educate dispensing pharmacists about patient education and monitoring required; and ensure any risks associated with the medication are minimized.

Drugs dispensed by limited distribution pharmacies are paid, as of 07/01/11:

(a) "Multiple Source" drugs are paid at the lowest of:

- AWP-16.5% + dispensing fee;
- CMS Federal Upper Limit (FUL) + dispensing fee;
- State Maximum Allowable Cost (MAC) + dispensing fee; or
- The Usual and Customary (U&C) (includes dispensing fee).

(b) "Single-source" limited distribution drugs are paid at the lowest of:

- AWP- 16.5% + dispensing fee; or
- Usual and Customary (U&C) (includes dispensing fee).

July 8, 2011

Radiology Tier Authorization

Effective July 1, 2011, the DVHA will implement a multiple procedure payment structure for certain imaging procedures. This structure will apply whenever multiple outpatient imaging services using the same or similar modality (MRI and MRA, CT and CTA) are performed on the same day, by the same provider, on contiguous body areas.

In these cases, the procedure with the highest intensity will be paid at 100% of the fee schedule rate and subsequent procedures will be reimbursed at a lower rate. If two procedures are performed, the second procedure will be reimbursed at 50% of the fee schedule rate. The third and all subsequent procedures will be paid at 25% of the fee schedule rate. This rate structure applies only to the imaging procedure component of the claim. The professional (physician) component is not affected by this change. These changes only apply to CT, CTA, MRI and MRA imaging procedures.

Psychologist-Doctorate Providers - Overpayment Corrected

The Department of Vermont Health Access (DVHA) had a number of prospective safeguards in place to ensure that Resource Based Relative Value System (RBRVS) implementation occurred (effective January 1, 2011) without complications. However, retrospective review indicates that provider type 030 (Psychologist-Doctorate) is receiving a 10% overpayment. For Dates of Service, August 8, 2011 and after, pricing will be corrected to remove this overpayment. Because it was a DVHA implementation complication, providers who have received the 10% overpayment will not be required to return the overpayment to DVHA on claims with Dates of Service from January 1, 2011- August 7, 2011.

Contractual Allowance Payments

When billing a claim after the primary insurance has made a payment, it is required to indicate the contractual allowance when submitting your claim to Vermont Medicaid. If the entire allowed amount is applied to the primary insurance deductible do not enter the contractual allowance.

July 1, 2011

Limitation on Over-The-Counter (OTC) Medications (Pharmacies)

Effective July 1, 2011, coverage of Over the Counter (OTC) medications will be primarily limited to generics only in categories determined to be medically necessary. All other OTC products will be excluded from coverage without the option for a prior authorization request through the Clinical Call Center. The new coverage guidelines apply to all state pharmacy benefit plans e.g. Medicaid, Dr. Dynasaur, VHAP, and includes VPharm, our Part D "wrap" program. OTC coverage in our "limited OTC" plans such as VScript Expanded and VPharm 3 will not change. As a reminder, DVHA only pays for OTCs when there is a specific medical necessity and a prescription for the OTC product. Some OTC medications are already managed on our Preferred Drug list (PDL) and other restrictions may apply. Though we have restricted OTC medications to primarily generics, beneficiaries will continue to have at least one choice in all medically necessary drug categories. Please refer to our website for a list of covered OTC medication categories at <http://dvha.vermont.gov/for-providers> The PDL can be found at <http://dvha.vermont.gov/for-providers/preferred-drug-list-clinical-criteria>.

Limitation on Over-The-Counter (OTC) Medications (Physicians/Prescribers)

Effective July 1, 2011, coverage of Over the Counter (OTC) medications will be primarily limited to generics only in categories determined to be medically necessary. All other OTC products will be excluded from coverage without the option for a prior authorization request through the Clinical Call Center. The new coverage guidelines apply to all state pharmacy benefit plans e.g. Medicaid, Dr. Dynasaur, VHAP, and includes VPharm, our Part D "wrap" program. OTC coverage in our "limited OTC" plans such as VScript Expanded and VPharm 3 will not change. As a reminder, DVHA only pays for OTCs when there is a specific medical necessity, and you must write a prescription for the OTC product.

Some OTC medications are already managed on our Preferred Drug list (PDL) and other restrictions may apply. Though we have restricted OTC medications to primarily generics, beneficiaries will continue to have at least one choice in all medically necessary drug categories. Please refer to our website for a list of covered OTC medication categories at <http://dvha.vermont.gov/for-providers> The PDL can be found at <http://dvha.vermont.gov/for-providers/preferred-drug-list-clinical-criteria>.

CPT 64704 – Neuroplasty

Effective August 1, 2011, CPT 64704 is restricted to the following diagnoses: 354.9, 355.0, 355.3, 355.5, 355.6, 355.79, 355.8, 355.9, 357.2, 718.44, 727.03, 727.05, 728.6, 729.2, 735.0, 735.4, 736.29, 927.3, 955.6 and 959.5.

CPT 49250

Effective August 1, 2011, CPT 49250 is restricted to the following diagnoses: 173.5, 195.2, 197.4, 197.6, 198.2, 552.1, 552.20, 553.1, 553.20, 553.1, 553.20, 553.21, 568.0, 686.8, 686.9, 728.84 and 771.4.

CPT 27600 – Decompression Fasciotomy

Effective August 1, 2011, CPT 27600 is restricted to the following diagnoses: 728.0, 728.79, 728.81, 728.86, 729.72, 823.22, 906.4, 906.7, 928.10, 928.11, 945.44, 945.45, 945.49, 958.90 and 958.92.

CPT 27093 – Injection

Effective August 1, 2011, CPT 27093 is restricted to the following diagnoses: 711.05, 711.95, 714.0, 715.15, 715.35, 715.95, 716.15, 716.95, 718.35, 718.75, 719.25, 719.45, 721.3, 722.52, 722.83, 724.02, 724.2, 724.4, 724.6, 726.5, 732.1, 733.42, 754.30, 754.31, 754.32, 755.62, 820.8, 835.00, 959.6 and V43.64.

June 17, 2011

Accessing the Voice Response System

In the event that web services on the Vermont Medicaid Portal are unavailable, providers are advised to check eligibility, receive other insurance information and determine if service limits have been reached by using the automated Voice Response System (VRS). The VRS system can be accessed by dialing 802-878-7871, option 1 and then option 1 again. Providers with access only to the beneficiary's social security number will be given the beneficiary's Vermont Medicaid ID Number. The VRS system is available 24 hours a day, seven days a week. All Providers accessing the VRS system will be asked to enter a pin number. Providers accessing the VRS system for the first time are advised to use the default pin of 9999. The system will then prompt you to select a pin number to authorize future use. To expedite your request, please have the following information available when making your call:

- Provider number
- Provider PIN number
- Beneficiary identification number
- Dates of service

Directory of Vermont Medicaid Web Portal Services

New to the Vermont Medicaid Portal is the Provider Directory of Services and Resources. This directory allows immediate access to all services, manuals, forms and reference materials available through the Vermont Medicaid Portal and includes links to Federal Government, Healthcare, Medicaid, and State Government agencies. This directory will allow you to search for a service or resource and then link you directly to the web page containing the desired information. This directory will be updated periodically as services & resources are updated, removed and

new services & resources are made available. Individuals wishing to obtain a copy of the new directory may do so at <https://vtmedicaid.com/Information/whatsnew.html>.

Inpatient Admissions - POA Indicator Required

It is now required that the present on admission(POA) indicator be included on all inpatient admission claims, regardless of the date of service, as communicated in the April 16, 2010 Banner Page. 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 diagnosis 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

A list of diagnosis codes that are exempt from requiring the POA indicator can be located at <https://vtmedicaid.com/Information/whatsnew.html>.

Closed for the Holiday

The DVHA and HP Enterprise Services offices will be closed on Monday, July 4th, 2011 in observance of Independence Day.

June 10, 2011

Pulpal Regenerative Treatment

Dental code D3354 requires X-Ray documentation to be forwarded with the claim when this service is provided to a beneficiary over the age of 16.

Diagnosis Restriction – CPT 61020

Effective July 11, 2011, CPT code 61020 is restricted to the following diagnoses: 047.8, 047.9, 191.9, 198.3, 198.4, 320.1, 320.2, 320.3, 320.7, 320.82, 320.89, 320.9, 321.2, 321.8, 322.2, 322.9, 331.3, 331.4, 331.5, 431, 432.1, 742.3 and 852.20.

Diagnosis Restriction – Transrectal Drainage of Pelvic Abscess

Effective July 11, 2011, CPT 45000 is restricted to the following diagnoses: 540.1, 566, 567.0, 567.1, 567.21, 567.22, 567.23, 567.29, 567.31, 567.38, 567.39, 567.81, 567.82, 567.89, 567.9, 569.5, 614.3, 614.4, 614.5, and 639.0.

Diagnosis Restriction – Uvulectomy

Effective July 11, 2011, CPT code 42140 is restricted to the following diagnoses: 145.4, 146.8, 198.89, 210.4, 230.0, 235.1, 327.20, 327.23, 327.29, 528.9, 750.26, 780.51, 780.53, 780.57 and 786.09.

Diagnosis Restriction – Inguinal Hernia Repair

Effective July 11, 2011, CPT code 49505 is restricted to the following diagnoses: 550.00, 550.02, 550.10, 550.12, 550.90 and 550.92.

Collective Drug Testing Limit

Effective July 11, 2011, billing for CPT codes 80100, 80101, 80104, G0431 and G0434 are collectively limited to 8 dates of service per calendar month.

June 3, 2011

Eligibility Verification Clarification - Adult Root Canal

The adult dental limitation on root canals is 3 per person per lifetime. Providers wishing to validate a beneficiary's eligibility under the dental benefit are directed to contact HP Enterprise Services Provider Help Desk at 800-925-1706 (in-state) or 802-878-7871 (out-of-state).

May 27, 2011

Optical Character Recognition (OCR) & Claim Readability

This is a reminder to all providers submitting paper claims that the information contained must appear in the appropriate fields.

Poorly aligned information will cause your claim to fail and be rejected by the OCR system. All OCR rejected claims will be returned to providers unprocessed.

DVHA Tax Assessment Payment Address Change

On July 1, 2011 the Department of Vermont Health Access (DVHA) will change their address for payments sent to the DVHA for provider tax, manufacturer labeler fees and HIT assessment. Please forward these payments to the following address, beginning July 1, 2011 forward. Providers should include the coupon or invoice with the payments to assure proper credit to the account.

**Lockbox
State of Vermont State Agency of Human Services
Supplemental/Tax Assessment
PO Box 1335
Williston, VT 05495**

Control Oropharyngeal Hemorrhage – Diagnosis Restriction

Effective, June 27, 2011, CPT Code 42960 is restricted to the following diagnoses: 784.8, 998.11 & 998.2.

CPT Code 52310 – Cystourethroscopy

Effective, June 27, 2011, CPT code 52310 is restricted to the following diagnoses: 592.1, 594.1, 594.2, 939.0 and 996.39.

CPT Code 28011 – Tenotomy

Effective, June 27, 2011, CPT code 28011 is restricted to the following diagnoses: 735.0 – 735.8, 727.81 and 755.66.

May 20, 2011

Negative Pressure Wound Therapy Electrical Pump

Effective June 20, 2011, E2402 will have a change in pricing methodology, changing from a daily to a monthly rate. The rental period will be based on a 30 day interval. Providers are instructed to pro-rate any claims that are less than a 30 day rental to reflect proper charges. Supply codes associated with E2402 RR will be restricted to A6550 (15 unit maximum per month) and A7000 (10 unit maximum per month for use with this device).

These changes reflect Medicare's LCD L11500. The DVHA will continue to only reimburse for device rental and PA is required from the DVHA Clinical Unit.

Dental Claims Processing

When submitting a claim with a general assistance voucher, where the beneficiary is responsible for a portion of the charges (as indicated on the voucher), please include the amount the patient paid in OTHER FEES, Field Locator 32, on the ADA 2006 Dental Claim Form.

Claims for Procedure Code 90806AH

Claims for Procedure code 90806AH continued to deny on the 4/29 RA. This system error has been corrected and all claims processed after 4/26 are processing correctly. We apologize for the inconvenience; please resubmit your denied claims for reprocessing.

HCPCS J1440 & J1441 – Diagnosis Restrictions

Effective June 20, 2011, HCPCS codes J1440 & J1441 are restricted to the following diagnoses: 042, 205.00, 205.02, 238.72 – 238.77, 284.89, 288.00 – 288.09, 289.53, V42.81, and V42.82.

May 13, 2011

Closed for the Holiday

The DVHA and HP Enterprise Services offices will be closed on Monday, May 30, 2011 in observance of Memorial Day.

System Maintenance to be Performed

System maintenance is scheduled to be performed on May 15, 2011, from 12:00am – 6:00am; all web services will be unavailable at this time. We apologize for any inconvenience this may cause.

One Digit Unique ID Numbers & Electronic Claim Submissions

When submitting an electronic claim for a beneficiary with a one digit Unique ID Number, providers are instructed to insert a zero in front of the single digit UID (04, 05, 06 and etc.). Failing to do so will result in your claim not being accepted by the translator. This instruction does not apply to paper claims.

May 6, 2011

Out-of-State Inpatient Hospital Admissions

All out-of-state urgent/emergency inpatient hospital admissions (excluding designated border hospitals) require notification be made to the DVHA Clinical Unit within 24 hours or the next business day of the admission. Notification can be made by faxing a completed Vermont Medicaid Admission Notification Form for Out-of-State Hospitals Urgent

and Emergent Admissions to the DVHA at (802) 879-5963. Please include all clinical documentation. Concurrent review will begin at the time of notification and will continue through the course of the inpatient hospital stay. Failure to notify the DVHA Clinical Unit will result in a retrospective review of the inpatient hospital admission to validate the quality of care, medical necessity, clinical coding, appropriateness of place of service and evaluation of length of stay associated with care. Results of the retrospective review will be utilized to assess refund requests for services that were determined to be inappropriate or not medically necessary.

All elective inpatient admissions require prior authorization from the DVHA Clinical Unit (excluding designated border hospitals) prior to the admission date. The admitting facility must complete and fax a Vermont Medicaid Out-of-State Preadmission Request Form and forward clinical documentation along with an explanation of why this care cannot be performed within the State of Vermont to (802) 879-5963. It is recommended that prior authorization be requested as early as possible but no less than 3 business days prior to the planned date of admission.

For further information and form access, please see the Out-of-State Admission Guidelines located at <http://dvha.vermont.gov/for-providers/clinical-coverage-guidelines>.

All out-of state-hospitals are required to notify the DVHA Clinical Unit of the pending discharge of a Vermont Medicaid beneficiary.

April 22, 2011

Immunization Administration

When billing claims with CPT codes 90460 & 90461, providers should follow the recommendations specified by the American Academy of Pediatrics by coding each vaccine as its own entity and using the appropriate diagnosis code for each. Claims with dates of service 01/01/2011 and forward that were denied incorrectly can now be resubmitted if the vaccines were given for different diagnoses.

Providers are also reminded that Vermont Medicaid requires a diagnosis for well-child-visit when performed on the same day as vaccination. See the American Academy of Pediatrics website at <http://practice.aap.org/content.aspx?aid=2980> and the Vaccine Coding Table at bottom of page.

Inpatient Claims – Medicare Part B Coverage, No Medicare Part A

When billing for an inpatient stay for a Vermont Medicaid beneficiary who has Medicare Part B but no Medicare Part A coverage, the DVHA does not recognize provider liable charges. Therefore, the provider liable charges are not to be deducted from the billed amount and should not be indicated in field locator 54 of the UB-04 Claim Form.

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, Rutland and Windham counties (802-857-2959).
- Deb Safford: Addison, Chittenden, Franklin, Grand Isle, Lamoille and Orleans counties (802-857-2957).
- Spring Shover: Caledonia, Essex, Orange, Washington and Windsor counties (802-857-2956).

A full colored detailed map depicting each Provider Representative and their corresponding counties is available for download at www.vtmedicaid.com under Information/Provider Representative Map.

April 15, 2011

Injection Filgrastim - Diagnosis Restriction

Effective May 16, 2011, VT Medicaid will no longer reimburse HCPCS code J1440 if billed with diagnoses 279.00. This HCPCS code is not open to all diagnoses.

April 8, 2011

Provider Electronic Solutions (PES) Software Version 2.24

A new release of PES (version 2.24) is now available on the Vermont Medicaid website (www.vtmedicaid.com under Download/Software). This new version contains changes to the 837 Institutional Inpatient form for the Present on Admission requirement. Beginning July 1, 2011, Inpatient claims that do not contain the POA information will be denied.

All providers who use PES are encouraged to install this upgrade even if you do not utilize the inpatient claim form.

CPT Codes 76881 & 76882 PA Not Required – MedSolutions

Claims for CPT Codes 76881 & 76882 (ultrasound), may have been denied for requiring prior authorization. Upon further review, it has been determined that these ultrasound procedures are not included in the radiology management program and therefore do not require prior authorization. If you had any claims deny for these two specific procedure codes you may now resubmit the services for reprocessing. We apologize for the inconvenience.

April 1, 2011

System Maintenance to be Performed

EDI and production server maintenance is scheduled to begin on April 9, 2011 at 10am and end on April 10th at 8:00am.

From 10:00pm – 12:00am, providers will unable to submit claims electronically, send/receive other EDI files, check eligibility through the Automated Voice Response System (Malcolm) or check eligibility and claim status through the Vermont Medicaid website.

From 12:00am - 8:00am, providers will still not be able to submit claims electronically or send/receive other EDI files.

From 12:00am – 8:00am, providers will be able to check eligibility through the Voice Response System (Malcolm) and check eligibility and claim status through the Vermont Medicaid website.

All EDI and production server functionality will be back online at 8:00am on April 10, 2011.

Vision Services Verification Form

In order to provide quick, accurate and up to date eligibility verification information, the DVHA has requested system changes to be made to enhance vision verification services, currently used by providers. In the interim, we are requiring vision providers to verify vision service eligibility by completing and faxing the vision fax form located at www.vtmedicaid.com/Downloads/forms.html, listed under the claims related form section. We would like to thank you in advance for your assistance and apologize for any inconvenience this may cause.

Unlisted Procedure Codes

Providers are reminded that all unlisted procedure codes require prior authorization from the DVHA clinical unit. In addition, notes must be attached indicating the usual and customary charge for the service to be performed.

March 25, 2011

Eyeglass/Fitting Medical Necessity Form

Please use the revised Eyeglass/Fitting Medical Necessity Form, dated 03/2011; forms can be obtained on line at <http://dvha.vermont.gov/for-providers/forms-1>.

March 4, 2011

Closed for Town Meeting Day

The DVHA and HP Enterprise Services offices will be closed on Tuesday, March 1, 2011, in observance of Town Meeting Day.

VISION SERVICE & EYEGLOSS – CLARIFICATION

Reimbursement for eye exams is limited to one comprehensive and one interim eye exam within a two-year period. Vermont Medicaid beneficiaries under the age of 21 are entitled to one pair of eyeglasses, and one fitting fee, within two years. (All of Medicaid Rule 7316, Eyeglass and Vision Care Services is online at <http://humanservices.vermont.gov/on-line-rules/dvha/medicaid-covered-services-7100-7700/view>.)

Earlier replacement is covered only if eyeglasses are lost or broken beyond repair and when either of these reasons is indicated on the claim form in the Notes field. Prior Authorization (PA) from the DVHA Clinical Operations Unit is required for replacement for any other reason, including: prescription/diopter change; scratched lenses; frame size change or other special need.

A replacement pair of eyeglasses at any time starts a new two-year limitation period.

PA can be requested by completing the Eyeglass Medical Necessity form (MNF), available at <http://dvha.vermont.gov/for-providers/forms-1>. The requesting/dispensing provider's NPI and Taxonomy combination must be listed on the MNF. The same NPI # and corresponding provider name must be given in fields 7.a. and 7.b. on the Chadwick prescription claim form (Vision Care Invoice).

Prior Authorization change requests must come from the original requesting provider. The PA change request to update an existing prior authorization must be in the form of a detailed letter referencing the PA #, stating the change(s) requested, and explaining why the change is needed. A copy of the existing PA is not necessary.

****REMINDER****

Procedure codes 92370 AND 92371 are to be used only for the in-office repair and refitting of eyeglasses. When new frames and/or lenses are ordered, a fitting fee code from the CPT range 92340 – 92355 must be used.

February 25, 2011

System Maintenance to be Performed - March 2, 2011

Translator maintenance is scheduled for March 2, 2011, from 6pm to 10pm, during this maintenance, providers will be unable to submit claims electronically and send/receive other EDI files. Providers will still be able to check eligibility and claim status through the Vermont Medicaid Web and check eligibility through the Voice Response System (Malcolm).

February 18, 2011

VISION SERVICE CLARIFICATION

Effective March 21, 2011, the same provider number given on the Vision Care Invoice (vision claim form) in field 7.a. (Dispenser NPI #) must also be given on the DVHA Eyeglass Medical Necessity Form (MNF) in item # 7 (Requesting Vision Service Provider). Attention to the detail of using the same NPI # when seeking prior authorization and for filing the claim will help to ensure claims are processed promptly.

All provider numbers must be the NPI #, per federal regulation (do not use the Medicaid ID #).

Dispensing providers must also give the fitting fee code on the PA request/Eyeglass MNF, the same as will be used at time of billing. Do not use CPT code 92370 for new glasses. CPT code 92370 is to be used only when current glasses are repaired and refitted.

FQHC – Place of Service

Place of Service 50 defined as service delivered in a FQHC facility has been adopted by the VT Medicaid Program and is now available for use by FQHC facilities.

CPT Code 88141 – Denied Claims – Ladies First & Medicaid Providers

Claims for CPT Code 88141 submitted as directed in the banner dated October 15, 2010, have been denied in error. This problem has been corrected; please resubmit any denied claims for reprocessing. We apologize for the inconvenience.

Alternate Reporter Request Form

Effective immediately, disregard all previous versions of the “Alternate Reporter Request” forms. The updated version of the Department for Children and Families (DCF), Economic Services Division (ESD) Alternate Reporter Request form to be used is available at: <http://www.vtmedicaid.com/Downloads/forms.html>

The correct version of the form will have the title “Alternate Reporter Request” at the top and the code “R 1/10” in the bottom right corner. DCF Economic Services Division will only accept reports using this version of the Alternative Reported Request form.

February 11, 2011

Hospital Billing for Observation Requires HCPCS Code G0378

Hospitals billing outpatient claims for labor room or other observation must use HCPCS procedure code G0378 on the detail line of the claim.

As indicated when OPPS was implemented on May 1, 2008, DVHA will pay the observation line on an outpatient claim when there is no primary procedure on the claim and the G0378 HCPCS code appears on the labor room or observation room revenue code detail line. The number of hours in observation must be entered in the units field (value cannot be zero).

To ensure that hospitals are using appropriate coding, observation claims with CPT codes 99217-99220 or 99234-99236 will deny as they are not eligible for OPPS reimbursement.

If a hospital bills for observation with G0378 and no primary procedure on the claim, DVHA will pay the lesser of the billed amount times the hospital-specific Cost to Charge Ratio (CCR), or \$1,500.

Hospital claims for observation services after the OPPS implementation on May 1, 2008 are under review. Individual hospitals will be contacted regarding outpatient observation claim details that do not meet the reimbursement policy cited above.

We appreciate your cooperation during this review period.

Consultation Codes: 99241, 99242, 99243, 99244 & 99245

Effective 06/21/10, Medicare Crossover claims received by HP Enterprise Services with a date of service on or after 01/01/2010, containing any of the following Consultation Codes; 99241, 99242, 99243, 99244 & 99245 will be denied. Medicare requires these codes to be billed as an office visit.

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

Closed for the Holiday

The DVHA and HP Enterprise Services offices will be closed on Monday, February 21, 2011 in observance of Presidents Day.

February 4, 2011

Dental Claims & Other Insurance

Providers are reminded that Medicaid is the payer of last resort and to collect other insurance information from Vermont Medicaid Beneficiaries at time of service. When submitting paper claims for beneficiaries with other insurance please enter the total of the contractual allowance and paid amounts in field 32. Do not deduct this amount from the total billed amount. When submitting electronically, providers are no longer required to add the contractual allowance to the primary insurance paid amount. 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.

2011 Fee Schedule - Update

The 2011 fee schedule has been posted to the Vermont Medicaid web portal. Please be aware that the DVHA has assigned allowable amounts to the PAC 9, non-covered services code. This information is intended for reporting purposes only and does not indicate coverage.

HP Enterprise Services Correspondence

Providers are reminded that EDS was purchased by HP Enterprise Services and officially changed their name, as of January, 2010. HP Enterprise Services is the claims processing agent for Vermont Medicaid; please open and review all correspondence received from HP Enterprise Services. HP Enterprise Services' envelopes include the HP logo, however, the actual return address is our office location in Williston, Vermont.

Inpatient Medically Managed Detoxification

Beginning March 1, 2011 the Department of Vermont Health Access will implement concurrent review and authorization of all inpatient medically managed detoxification services provided on a psychiatric floor or in a psychiatric facility. All emergent and urgent admissions will require notification to the DVHA within 24 hours or the next business day of admission and all elective admissions will require notification prior to admission. Please contact the DVHA at (802)879-8232 to notify of an admission and to begin the concurrent review process.

Physician Assistant Status Change – Reminder

As a reminder, January 1st, 2010, physician assistants, with any of the following specialties: General Practice, General Surgery, Otolaryngology, Anesthesiology, Dermatology, Family Practice, Internal Medicine, Neurology, Obstetrics/Gynecology, Orthopedic Surgery, Urology, Pediatric Medicine, Hematology/Oncology, Emergency Medicine and Other Medical Care, are required to enroll with Medicaid as active participating providers and are no longer allowed to bill under the physician's Medicaid provider number with the AM modifier.

January 28, 2011

2010 Annual Provider Survey

HP Enterprise Services would like to invite the provider community to participate in the 2010 Annual Provider Survey! Your participation will assist HP in assessing and enhancing the services we provide. The 2010 survey is available at <http://vtmedicaid.com/Information/whatsnew.html> and can now be saved to your computer, completed and returned by e-mail to vtadvisorycommunications@HP.com. Please return your completed survey by February 19th, 2011. Providers with no internet access can request a paper copy by contacting the HP Provider Help Desk at 802-878-7871 (out-of-state) or 800-925-1706 (in-state).

Bilevel Positive Airway Pressure (BiPAP)

Effective date of service, February 28, 2011, the DVHA will require that prior authorization be submitted to the Clinical Operations Unit for the purchase and rental of Bilevel Positive Airway Pressure (BiPAP) devices. Provider requests for prior authorization must include the appropriate documentation of medical need to support current best practice guidelines.

Recertification of Licensed Medical Doctors

Immediate action may be required! All Vermont licensed medical doctors participating in the Vermont Medicaid Program that have not already recertified are requested to do so immediately, by completing the Provider Enrollment Form located at vtmedicaid.com/Downloads/forms.html. Forward the completed enrollment form along with a copy of your renewed license to HP Enterprise Services, Enrollment/Recertification, and P.O. Box 888, Williston, VT.

If you are not the individual responsible for recertification, please forward to the responsible party.

January 14, 2011

Closed for the Holiday

The DVHA and HP Enterprise Services offices will be closed on Monday, January 17, 2011 in observance of Martin Luther King Day.

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.

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.

Timely Filing & Retroactive Eligibility

HP Provider Services no longer requires a copy of a Notice of Decision (NOD) as proof of timely filing for services rendered to a beneficiary whose eligibility was made retroactive. Providers should attach a note indicating that the reason for the late claim filing was due to the beneficiary being granted retroactive eligibility.

January 7, 2011

Automated Voice Response System & Web Services

Due to scheduled hardware maintenance/upgrades, providers will be unable to access the Voice Response System and all web services on January 9, 2011 between the hours of 12:00am and 8:00am. These upgrades are necessary in order to maintain uninterrupted service throughout the year. We apologize for any inconvenience this may cause.

Tooth Surface Codes Required

Effective February 7, 2011, tooth surface codes will be required for the following procedure codes: D2391, D2392, D2393 and D2394.