

Banner Pages for March 12th, 2010

Help Desk Calls

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

HCPCS Code J9212 & J1825

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

CMS 1500 Claim Form - Billing Provider Name Field

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

February 5th, 2010

Prior Authorization Form - Medical Benefit

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

ICD-9 Procedure Code Updates

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

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

HCPCS Code J1743

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

February 26, 2010

2006 ADA Dental Claim Form

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

February 19, 2010

CSHN Dental Notice

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

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

CPT Code J7303 – Rate & Unit Change

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

Diagnoses Restrictions on Mastectomy Procedures

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

February 12, 2010

Never Events

Effective 30 days from notification, 2010 Vermont Medicaid will follow Medicare's guidelines pertaining to non payment of never events. This will include a surgical or other invasive procedure to treat a particular medical condition when the practitioner performs in error: 1) a different procedure altogether; 2) the correct procedure but on the wrong body part; or 3) the correct

procedure but on the wrong patient. The hospitalizations and other related services will also not be covered.

Hospitals should bill inpatient claims with type of bill 110.

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

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

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

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

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

PA- Surgery wrong body part

PB- Surgery wrong patient

PC- Wrong surgery on patient

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

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

Ladies First Newsgram

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

New Provider Enrollment Agreement

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

February 5th, 2010

OCR

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

OCR (Dental Providers only)

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

Patient Share Adjustments

Adjustment requests for nursing home claims that involve a DCF change to the patient share amount currently require manual handling for reprocessing. Please send an adjustment request form to: HP Enterprise Services, P.O. Box 888, Williston, VT 05495 Attn: Patient Share Adjustments to ensure proper handling of the request. HP is working on an enhancement to automate this process in the future. We apologize for any inconvenience this may cause in the interim.

www.vtmedicaid.com website updated periodically

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

CLIA

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

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

CLOSED FOR THE HOLIDAY

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

2009 Provider Annual Survey

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

January 29th, 2010

Ladies First Extension for Late Claim Submissions

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

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

New Aid Categories

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

SH-Children with Special Health Needs (CSHN)

FI-Family Infant and Toddler Program (FITP)

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

January 22nd, 2010

CMS 1500 Medicare Attachment Summary Form

When submitting a CMS 1500 claim form with more than 6 details that Medicare had already paid as primary, you must complete an additional Medicare Attachment Summary Form for every 6 details. The number of details on the claim form(S) must match the number of details on the Medicare Attachment

Summary Form(s).When submitting this type of multiple page CMS claim, the total Medicare paid amount should be recorded only once on page 1, field 3 of the Medicare Attachment Summary form.

The Vermont Prescription Monitoring System (VPMS) Presentation

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

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

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

January 15th, 2010

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

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

CLOSED FOR THE HOLIDAY

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

Billing Provider Name Field (Clarification)

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

January 8th, 2010

Acupuncture, not a Medicaid covered service

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

Urine Toxicology Screen Coverage (80101)

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

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

Providers Can Now Verify Ladies First Eligibility

Eligibility Verification Ladies First

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

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

Providers can verify eligibility for the current date, up to, one year prior. Providers can rely on the accuracy of the EVS response, for up to nine days beyond the date of the coverage inquiry. Providers should retain the authorization number issued by the system to assure that the information received can be verified by the system. The authorization number is not a guarantee of payment. The member must be eligible on the date of service and the service provided must be a covered service by the Ladies First program.

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

Billing the Ladies First Member

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

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

Ladies First Timely Filing

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

The following exceptions apply:

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

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