Provider Manual Appendix

Contents

Section 1 Important Addresses & Contact Information

Administration of Vermont's public health insurance system

Department of Vermont Health Access (DVHA)
280 State Drive
Waterbury, VT 05671
Tel: (802) 879-5900
Fax: (802) 879-5651
http://dvha.vermont.gov/

DXC Technology (DXC)
Fiscal Agent
312 Hurricane Lane, Suite 101
Williston, Vermont 05495
Tel: (802) 878-7871 or (800) 925-1706
Fax: (802) 878-3440
http://www.vtmedicaid.com/#/home

Dept. of Disabilities, Aging & Independent Living (DAIL)
289 Hurricane Lane
Williston, VT 05495
Tel: (802) 871-3350
Fax: (802) 871-3281
http://www.dail.vermont.gov/

Office of Oral Health - Department of Health
PO Box 70
Burlington, Vermont 05402
Tel: (802) 241-2604
Fax: (802) 241-3052
http://healthvermont.gov/family/dental/services.aspx

Office of the Healthcare Advocate
264 North Winooski Avenue
P.O. Box 1367
Burlington, Vermont 05402
Tel: (800) 917-7787

Member Eligibility & Other Information
Economic Services Division (ESD) Benefits Service Call Center, *Department for Children and Families*

Tel: (800) 479-6151
Providers can stay on line after the message for service
http://dcf.vermont.gov/esd/contact_us

District Offices (locations below) Tel: (800) 479-6151

Online at **mybenefits.vt.gov**, the official State of Vermont website for public benefits such as state health insurance programs http://dcf.vermont.gov/mybenefits.

Green Mountain Care Member Services Unit, *Maximus*
Tel: (800) 250-8427, TTY: (888) 834-7898, Fax: (802) 651-1528
101 Cherry Street, Suite 320, Burlington, VT 05401-9823

Benefits Service Center & District Offices: Telephone (800) 479-6151

District Office Locations
General information is available at http://dcf.vermont.gov/esd/contact_us

To find a district office location by town, go to http://dcf.vermont.gov/esd/contact_us/towns

Section 2 Glossary of Terms & Phrases

Actual Charge
The dollar amount charged for each medical service or item to patients before discounts, contractual allowances or similar reductions.

Administrative Agent
An organization that processes and pays provider claims on behalf of the department.

Advance Directives Law
An advance directive is a legal document that allows individuals to give instructions for a broad range of health care decisions and appoint an agent to make those decisions if they become unable or unwilling to do so. It may also be known as a Living Will or Durable Power of Attorney for Health Care. Federal law requires hospitals, nursing facilities, home health agencies, hospices and prepaid health care organizations to provide patients with information regarding advance directives. Vermont Advance Directive Registry (VADR) is a secure database service that stores a scanned copy of an advance directive electronically so that it can be found immediately by any hospital or doctor in an emergency. Information on advance directives is available from the Vermont Ethics Networks at http://www.vtethicsnetwork.org/decisions.html or the Health Department at 1-800-548-9455 or http://healthvermont.gov/vadr/index.aspx#what

Agent
Any person who has been delegated the authority to obligate or act on behalf of the provider.

AIDS Medication Assistance Program
A specific program designed to assist HIV positive individuals with AIDS pharmaceutical costs.
http://healthvermont.gov/prevent/aids/aids_index.aspx

Affiliate(s)
Person(s) having an overt or covert relationship such that any one of them directly or indirectly controls or has the power to control another.

Assignment
The term used where a member assigns right to compensation to a provider. Providers must accept as payment in full the program's payment and may not "balance bill" or charge the member any additional amount, other than nominal cost-sharing amounts the benefit program may impose for certain services.

Audit
A computer-based or manual comparison of each claim to the member's claims history.

Center for Medicare and Medicaid Services (CMS)
The agency in the Department of Health and Human Services responsible for administering the Medicaid, State Children's Health Insurance, and Medicare programs at the federal level program. Formerly known as HCFA.

Children's Health Insurance Program (CHIP)
Enacted in the 1997 Balanced Budget Act of Title XXI of the Social Security Act, CHIP is a federal-state matching program of health care coverage for uninsured low-income children.

Closed-End Medicaid Provider Agreement
An agreement that is for a specified period of time not to exceed twelve months.

Co-Payment
A fixed dollar amount paid by a Medicaid member at the time of receiving a covered service from an enrolled provider. This nominal cost-sharing is for certain programs, groups of beneficiaries and services.

Crossover Claim
A claim created by Medicare and sent to Medicaid for payment of deductible and co-payment amounts. This occurs when the Medicare member is also covered by Vermont Medicaid or is a Qualified Medicare Member (QMB) and the Medicare claim so indicates.

Current Procedural Terminology (CPT) Guide
The CPT Guide, developed by the American Medical Association, is a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians and other providers. The manual is designed to provide a uniform language that accurately describes surgical, medical, and diagnostic services to provide an effective means for reliable nationwide communication.

Deferment of Payments
The withholding of payments due a provider pending resolution of a specified problem. It may be taken or continued as a sanction or imposed as an administrative precaution upon discovery of a provider discrepancy.

Department For Children And Families (DCF)
The Department for Children and Families; formerly the Department of Prevention, Assistance, Transition and Health Access, and before that, the Department of Social Welfare.

Department Of Vermont Health Access (DVHA)
The department is responsible for administration of the Vermont public health insurance system.

Detail Number
Each line on a claim is numbered and is called the detail number. Most claims are processed and paid at the detail level, which means that a problem with one line will not stop processing or payment on the other lines.

Diagnosis Codes
Diagnosis codes come from Volume 1 of the ICD-9-CM Manual. This manual lists the three, four or five digit code used to indicate the member's diagnosis. Enter the complete code. Any variation to the actual codes, such as leading or trailing zeroes, may delay payment.

Disclosing Entity
A Medicaid provider (other than an individual practitioner or group of practitioners) (i.e. the health plan) or a fiscal agent.

Disproportionate Share Hospital (DSH) Payments
Payments made by a state's Medicaid program to hospitals that state the state designates as serving a "disproportionate share" of low-income or uninsured patients.

Dual Eligible Beneficiary
A member may be entitled to Medicare and eligible for some form of Medicaid benefit. There are various categories: Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Medicare Beneficiaries (SLMBs) and Qualifying Individuals (QI-1s). Please see Section 2.4 Medicare Savings Program (MSP) of the Provider Manual for additional information.

Early And Periodic Screening, Diagnosis And Treatment (EPSDT) Services
One of the services that states are required to include in their basic benefits package for all Medicaid eligible children under age 21. EPSDT is a federally mandated program that in is administered by the Department of Health. EPSDT services include periodic screenings to identify physical and mental conditions, vision, hearing, dental problems and follow-up diagnostic and treatment services.

Edit
An edit is a computer system inspection of claim data for validity, accuracy and the relationship of information within the claim.

Electronic Claims Submission (ECS)
ECS is a paperless method of submitting claims to DXC for processing.

Electronic Funds Transfer (EFT)
EFT is a paperless method of paying providers where payments are deposited directly into their bank accounts. This payment method is mandatory for all providers.

Eligibility
Every member must first be found to be eligible for benefits. These determinations are made by eligibility specialists at the Health Access Eligibility Unit (HAEU).

Eligibility Verification System (EVS)
The EVS refers to the automated systems that inform enrolled providers about member eligibility. Eligibility is to be confirmed by the provider prior to providing services using either the DXC Voice Response System (VRS) or the website (www.vtmedicaid.com/#/) under Transactions and choose the appropriate Login.

Exclusion from Participation
Termination of a provider's participation in the Vermont Medicaid Program, with the probability that it is permanent.

Explanation of Medicare Benefits (EoMB)
An EOMB is a notice issued by Medicare to the member that explains in detail the payment or non-payment of a specific claim submitted on behalf of the member to Medicare.

Family Planning Services
Any item or course of treatment furnished to a member of childbearing age for purposes of enabling the individual to freely determine the number and spacing of children.

Federal Financial Participation (FFP)
The term for federal Medicaid matching funds paid to states for allowable expenditures for Medicaid services or administrative costs. States received FFP for expenditures for services at different rates, or Federal Medical Assistance Percentage (FMAP), depending on per capita incomes.

Fee-For-Service (FFS)
A traditional method of payment for medical services in which providers are paid for each service provided.

Fiscal Agent (FA)
A contractor that processes and reimburses for claims on behalf of the State of Vermont;
A contractor that processes and pays vendor claims on behalf of the Medicaid Agency.

Federally Qualified Health Center (FQHC)
States are required to include services provide by FQHC's in their basic Medicaid benefits package. FQHC services are primary care and other ambulatory care services provided by community health centers.

Green Mountain Care
The umbrella brand for the State of Vermont family of health insurance programs, Green Mountain Care includes plans such as, Vermont Health Access Plan (VHAP), Dr. Dynasaur, Medicaid, a number of pharmacy assistance and premium assistance programs.

GMC Member Card
Each member receives a **Green Mountain Care** member identification card with their unique ID. Beneficiaries generally receive the card two to three weeks after being determined eligible; however, the notice of eligibility will confirm status initially.

Health Access Eligibility Unit (HAEU)
A unit within the Department for Children and Families responsible for processing eligibility applications for health care insurance coverage.

Health Insurance Portability And Accountability Act (HIPAA)
Federal law requires each state's Medicaid management information system (MMIS) and medical providers to use transaction standards when electronically exchanging health information of health plan beneficiaries.

Healthcare Common Procedure Coding System (HCPCS)
A comprehensive coding system adopted by the Centers for Medicare and Medicaid Services to provide a common system for referencing health care procedures performed under the Medicare and Medicaid programs. It incorporates both Current Procedural Terminology (CPT) and Current Dental Terminology (CDT) codes.

Hospice
A program that provides palliative and supportive care for terminally ill patients and their families.

Identification Number
A unique number assigned to each Vermont Medicaid Member that may be referred to as the UID or MID. The number appears on the member's **Green Mountain Care** Card.

Indirect Ownership Interest
An ownership interest in an entity that has an ownership interest in the disclosing entity or in an entity that has an indirect ownership interest in the disclosing entity.

Individual Consideration (IC)
The code used to indicate that the reimbursement amount will be calculated on a case-by-case basis.

Internal Control Number (ICN)
A unique fifteen-digit number assigned to each claim by the claims processing system for identification and tracking purposes.

International Classification of Diseases-Clinical Modification (ICD-9-CM)
A classification and coding structure of diseases that is used by health care providers to code diagnoses for billing purposes. Providers should use the current edition. ICD-10 will be effective as of 10/1/14. For more information on ICD-10 visit http://dvha.vermont.gov/for-providers/icd-10.

Julian Date
A chronological date of the year, 001 through 365 (or 366), beginning with a four-digit year designation, (e.g. 2012121= May 1, 2012).

Lock-In
An action that restricts a member's choice of medical provider for a reasonable time because of over-utilization of certain services. Lock-in is also used to designate the member's primary care physician when one is required. The locked in provider can be identified by using the automated eligibility verification systems: the DXC Voice Response System (VRS), 802-878-7871, option 1; or the online at Transactions and choose the appropriate Login at http://www.vtmedicaid.com/#/.

Managed Care Entity
The federal term for a managed care plan participating in Medicaid.

Managing Employee
A general manager, business manager, administrator, director or other individual who exercises operational or managerial control over or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency.

Member
An individual who is eligible for and enrolled in the state health benefit program managed by the Department of Vermont Health Access. A member is a member **of Green Mountain Care**.

Member Services Unit
The DVHA has a dedicated unit that is prepared to respond to member inquiries regarding eligibility and coverage for all of the health care benefit programs. The **Green Mountain Care** Member Services Unit can be reached at (800) 250-8427.

Medicaid Management Information System (MMIS)
A state's computer system for tracking Medicaid enrollment, claims processing and payment information.

Notice Of Decision (NOD)
A written notification used to inform beneficiaries and providers of its decisions, such as eligibility or prior authorization requests.

National Provider Identifier (NPI)
The 10-digit National Provider Identifier.

Offsetting of Payments
A reduction or other adjustment of the amounts paid to a provider on deferred, pending, or future bills for purposes of recovering over-payments previously made to the provider.

Other Disclosing Entity
Any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII or XX of the Act. This includes: (a) any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic or health maintenance organization that participates in Medicare (title XVIII); (b) any Medicare intermediary or carrier; and (c) any entity (other than an individual practitioner or group of practitioners) that furnishes or arranges for furnishing of health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.

Ownership Interest
The possession of equity in the capital, the stock or the profits of the disclosing entity.

Palliative Care
Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial, and spiritual.

PC Plus
The name for Vermont's primary care case management program in which a member must select a primary care provider to assist in the management of medical care. This managed health care delivery system is administered by the DVHA.

Person
Any natural person, company, firm, association, corporation or other legal entity.

Person with Ownership or Control Interest
A person or corporation that:
- Has an ownership interest totaling 5% or more in a disclosing entity;
- Has an indirect ownership interest equal to 5% or more in a disclosing entity;
- Has a combination of direct and indirect ownership interests equal to 5% or more in a disclosing entity;
- Owns an interest of 5% or more in any mortgage, deed of trust, note or other obligation secured by the disclosing entity;
- Is an officer or director of the disclosing entity that is organized as a corporation;
- Or is a partner in the disclosing entity that is organized as a partnership.

Primary Care Case Management (PCCM)
A type of managed care entity, which in Vermont is called **PC *Plus***. Beneficiaries select their Primary Care Provider (PCP) and access health services through their PCP who works with the member to assure high quality medical care. The DVHA administers **PC *Plus***.

Prior Authorization (PA)
A mechanism used to monitor and control use of covered items or services. When an item or services is subject to prior authorization, DVHA will not pay unless approval is given in advance by the DVHA Clinical Unit, using specific criteria for making utilization review decisions http://dvha.vermont.gov/for-providers/clinical-coverage-guidelines. Prior authorizations are determined on a case-by-case basis.

Private Litigation
Providers are asked to notify the DVHA if they receive any information regarding private litigation in which the DVHA may have an interest. These private litigations might include malpractice suits involving DVHA beneficiaries, accident suits or personal injury suits.

Procedure Code
A five-character description of a medical service or other health care service. Vermont Medicaid requires providers to use a procedure code when billing Vermont Medicaid (see CPT, CDT and HCPCS).

Provider
Any individual, firm, corporation, association or institution that is currently approved to provide medical assistance to a beneficiary pursuant to the Vermont Medicaid Program.

Provider Enrollment Agreement
The form that sets out the terms and conditions agreed to as a part of the enrollment or annual re-certification process. It must be completed by each provider and the provider accepted for enrollment by DVHA in order to bill DXC for the service or item.

Provider Number
The unique seven-digit number assigned to each enrolled provider.

Qualified Medicare Member (QMB)
Is an aged or disabled individual who is eligible for payment of Medicare premiums, deductibles and co-insurance but not for any other payments. A QMB is not issued a Green Mountain Care identification card and cannot be identified using Electronic Verification System (EVS).

Remittance Advice (RA)
A computer generated report available to providers indicating the status of all claims that have been submitted and entered into the system for processing. Providers should review the RA weekly and contact DXC with questions.

Retro-Eligibility
The 90-day period prior to the date that eligibility was approved.

Review Methods
The methods by which the department or its administrative agent determines whether payment errors have been made.

Rural Health Clinic (RHC)
States are required to include services provided by RHC's, certified as a RHC for Medicare purposes, in basic Medicaid benefits package.

Spend-Down
Spend-down, as determined by the Department for Children and Families, is a specific amount of medical expenses for which the member must be responsible before eligibility is granted. A spend-down member becomes eligible for Vermont Medicaid on the day of the month in which he or she reaches the incurred medical expense amount that equals or exceeds the specified "spend-down" amount.

Subcontractor
(a) An individual, agency or organization to which a disclosing entity (i.e. the health plan) has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or
(b) An individual, agency or organization with which a fiscal agent has entered into a contract, agreement purchase order or lease (or leases of real property) to obtain space, supplies, equipment or services provided under the Medicaid agreement (i.e. the agreement with the health plan).

Suspension from Participation
Temporary expulsion from participation in the Vermont Medicaid Program for a specified period of time or until specified conditions are met.

Third Party Liability (TPL)
TPL is used to refer to another source of payment for covered services provided to a Medicaid member. For example, the member may have additional resources such as Medicare, private health insurance, automobile or other liability insurance.

Usual And Customary Rate (UCR)

Various claim forms (CMS 1500, UB04 and 837) require the submission of "Charge" or "Total Charges" or "Charge Amount" to be reported for each service billed. The provider's "usual and customary charge" or "uniform charge" is a dollar amount in effect at the time of the specific date of service. This is the amount to be reported on the claim. This usual and customary charge is the amount that the provider bills to insure and private-pay persons for the same service. If the provider has more than one charge for a service, the lowest charge will be reported to Vermont Medicaid; except, if the charge has been reduced on an individual basis because of a sliding-fee scale based on the patient's documented inability to pay. Sale prices should be used during the sale period. If a service or item is offered free-of-charge by the provider, no charge will be made to Vermont Medicaid. Providers may not discriminate against Vermont Medicaid beneficiaries by charging a higher fee for the same service than that charged to a private-pay patient, except as noted above regarding sliding-fee scale.

Version Number

The processing version of a claim. The first claim paid for the services rendered is version 00. The first adjustment to any paid claim is version 01, etc.

Voice Response System (VRS)

A system which allows Vermont Medicaid providers to verify member eligibility, dental dollars spent, third party liability information, limitation status and remittance amount by using a touch tone telephone.

Section 3 Acronyms/Abbreviations

Acronym/Abbreviations	Meaning
AABD	Aid to the Aged, Blind and Disabled
ADA	American Dental Association
ADAP	Alcohol and Drug Abuse Program
AHS	Agency of Human Services
AMA	American Medical Association
AMAP	Aids Medication Assistance Program
ANFC	Aid to Needy Families with Children
AWP	Average Wholesale Price
BC/BS	Blue Cross/Blue Shield
CMS	Centers for Medicare and Medicaid Services-Formerly HCFA
CPT	Physician's Current Procedural Terminology
CSHN	Children with Special Health Needs
DCF	Department for Children and Families
DME	Durable Medical Equipment
DDMHS	Department of Developmental and Mental Health Services
DOB	Date of Birth
DOS	Date of Service
DVHA	Department of Vermont Health Access
DMH	Department of Mental Health
DXC	DXC Technology
EAC	Estimated Acquisition Cost
ECS	Electronic Claims Submission
EDI	Electronic Data Interchange
EFT	Electronic Funds Transfer
EVS	Eligibility Verification System
EOB	Explanation of Benefits
EOMB	Explanation of Medicare Benefits
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
FA	Fiscal Agent
FFP	Federal Financial Participation
FFS	Fee-for-Service
FDA	Food and Drug Administration
FQHC	Federally Qualified Health Centers
HAEU	Health Access Eligibility Unit
HCPCS	Healthcare Common Procedure Coding System
HHA	Home Health Agency
HHS	Department of Health and Human Services (federal)
HIPAA	Health Insurance Portability & Accountability Act
IC	Individual Consideration
ICD-9-CM	International Classification of Disease-9th Edition
ICD-10-CM	International Classification of Desease-10th Edition
ICF/MR	Intermediate Care Facility for the Mentally Retarded
ICN	Internal Control Number
ID	Identification
MC	Medicare
MCO	Managed Care Organization
MFRAU	Medicaid Fraud & Residential Abuse Unit
MNF	Medical Necessity Form
MSU	Member Services Unit
NDC	National Drug Code

NEMT	Non-Emergency Medical Transportation
NF	Nursing Facility
NOD	Notice of Decision
NP	Nurse Practitioner or Naturopathic Physician
NPI	National Provider Identifier
OTC	Over the Counter
PA	Prior Authorization or Physician's Assistant
PCCM	Primary Care Case Management
PCP	Primary Care Provider
PC PLUS	Primary Care Plus
PI	Program Integrity Unit (of DVHA)
POC	Plan of Care
POS	Place of Service
QMB	Qualified Medicare Member
RA	Remittance Advice
RN	Registered Nurse
RPL	Recipient Placement Level
SCHIP	State Children's Health Insurance Program
SLMB	Specified Low-Income Medicare Member
SNF	Skilled Nursing Facility
SSI	Supplemental Security Income
TPL	Third Party Liability
UCR	Usual and Customary Rate
UID	Unique Identification Number
VDH	Vermont Department of Health
VRS	Voice Response System
YTD	Year to Date

Section 4 Insurance Coverage Matrix

COVERAGE CODE

SERVICE (Code)	Crossover A	Crossover B	Dental	DME	EPSDT	Home Health	Hospice	Independent Lab	Inpatient	Nursing Home LVL 01	Nursing Home LVL 02-04	Outpatient	Pharmacy	Physician / Ambulance	Vision
1	Y								Y						
2		Y										Y			
3	Y	Y						Y	Y			Y			
4		Y			Y			Y						Y	
5	Y	Y		Y		Y	Y	Y	Y			Y		Y	
6	Y	Y		Y		Y	Y	Y	Y			Y		Y	
7			Y												
8		Y												Y	Y
9													Y		
10	Y	Y	Y	Y	Y	Y	Y	Y	Y			Y		Y	
11	Y	Y		Y	Y	Y	Y	Y	Y			Y		Y	Y
12	Y	Y		Y	Y	Y	Y	Y	Y			Y	Y	Y	
13	Y	Y		Y	Y	Y	Y	Y	Y	Y		Y		Y	
15	Y	Y		Y	Y	Y	Y	Y	Y			Y		Y	
16	Y	Y		Y	Y	Y	Y	Y	Y			Y		Y	
17	Y	Y	Y	Y	Y	Y	Y	Y	Y			Y		Y	
18	Y	Y		Y	Y	Y	Y	Y	Y			Y		Y	Y
19	Y	Y		Y	Y	Y	Y	Y	Y			Y		Y	
20	Y	Y	Y	Y	Y	Y	Y	Y	Y			Y		Y	Y
21	Y	Y	Y	Y	Y	Y	Y	Y	Y			Y		Y	Y
22	Y								Y	Y					
23		Y		Y	Y	Y	Y	Y				Y		Y	
25	Y	Y		Y	Y	Y	Y	Y	Y			Y	Y	Y	
26										Y	Y	Y			
27										Y	Y	Y			
29	Y	Y		Y		Y	Y	Y	Y	Y		Y		Y	
A1				Y		Y		Y	Y	Y		Y			
B1								Y				Y			
C1		Y		Y	Y	Y	Y	Y	Y	Y		Y		Y	
C2				Y	Y	Y	Y	Y	Y	Y		Y		Y	
D1				Y	Y	Y	Y	Y	Y			Y		Y	
D2				Y	Y	Y	Y	Y	Y			Y	Y	Y	
D3									Y			Y			
D4				Y	Y	Y	Y	Y	Y			Y		Y	
D5			Y												
D8															Y
D9													Y		
P1													Y	Y	

Section 5 Web Eligibility Request & Response Screens

The web 270 (Eligibility Request) includes a Service Type drop down display. The new Service Type drop down display default is set at 30 (Health Benefit Plan Coverage). The default setting will provide the eligibility response for all service types listed in Table 1. When a specific service type is selected from Table 2, you will be provided with the eligibility response for only that selected service type.

TABLE #1

Service Type Code	Service Description
1	Medical Care
33	Chiropractic
35	Dental Care
47	Hospital
48	Hospital - Inpatient
50	Hospital - Outpatient
86	Emergency Services
88	Pharmacy
98	Professional (Physician) Visit - Office
AL	Vision (Optometry)
MH	Mental Health
UC	Urgent Care

TABLE #2

Service Type Code	Service Description
1	Medical Care
2	Surgical
4	Diagnostic X-Ray
5	Diagnostic Lab
6	Radiation Therapy
7	Anesthesia
8	Surgical Assistance
12	Durable Medical Equipment Purchase
13	Ambulatory Service Center Facility
18	Durable Medical Equipment Rental
20	Second Surgical Opinion
33	Chiropractic
35	Dental Care
40	Oral Surgery
42	Home Health Care
45	Hospice
47	Hospital
48	Hospital - Inpatient
50	Hospital - Outpatient
51	Hospital - Emergency Accident

52	Hospital - Emergency Medical
53	Hospital - Ambulatory Surgical
62	MRI/CAT Scan
65	Newborn Care
68	Well Baby Care
73	Diagnostic Medical
76	Dialysis
78	Chemotherapy
80	Immunizations
81	Routine Physical
82	Family Planning
86	Emergency Services
88	Pharmacy
93	Podiatry
98	Professional (Physician) Visit - Office
99	Professional (Physician) Visit - Inpatient
A0	Professional (Physician) Visit -
A3	Professional (Physician) Visit - Home
A6	Psychotherapy
A7	Psychiatric - Inpatient
A8	Psychiatric - Outpatient
AD	Occupational Therapy
AE	Physical Medicine
AF	Speech Therapy
AG	Skilled Nursing Care
AI	Substance Abuse
AL	Vision (Optometry)
BG	Cardiac Rehabilitation
BH	Pediatric
MH	Mental Health
UC	Urgent Care

Section 6 Voice Response System (VRS)

Providers access member eligibility and other information using the VRS.

Call one of the following VRS numbers using a touch-tone phone:

- Local and Out-of-State: (802) 878-7871 (select option 1)
- In-state only: (800) 925-1706

The VRS answers the phone with the following welcome message:
"Good morning/good afternoon/good evening, thank you for calling the Vermont Medicaid voice information service. For eligibility verification, service limits or current remittance advice payment amount, press 1. For assistance from a DXC representative, press 0."

The system must check the user's Vermont Medicaid provider number to determine if the user is authorized to access information. The system prompts the user to enter a provider number as follows:

> **"Good morning/good afternoon/good evening, thank you for calling the Vermont Medicaid voice information service. Please listen carefully because some of our prompts have changed."**

The system prompts the user to enter a provider number as follows:
> **"If your Vermont Medicaid Voice Response User ID contains digits only, press 1."**
> **"If your Vermont Medicaid Voice Response User ID contains digits and letters, press 2."**
> **"For assistance from provider services press 0"**
> **"To repeat these choices press *"**

Providers with a Voice Response User ID that contains both digits and letters will be instructed to do the following:
> **"Using your touch tone key pad please enter your VT Medicaid Voice Response User ID followed by the pound sign, use 7 for the letter Q and 9 for the letter Z."**

You have two attempts to enter a valid provider number. If you enter an invalid number on your first attempt, you will hear:
> **"Invalid provider number."**

If you enter an invalid provider number on your second attempt, you will hear one of the two following messages, depending on whether it is during business hours, after hours or on a holiday:
> **"Invalid provider number. We are sorry, you have not entered the required data at this step. If you would like assistance from a DXC representative-press zero."**
>
> **"We're sorry, provider number (XXXXXXX) is not authorized. For assistance from a DXC representative, please call back between 8:00 a.m. and 5:00 p.m., except weekends and holidays, and we will be happy to assist you".**

If your provider number is valid, you will be asked to:
> **"Enter your four-digit PIN followed by a pound sign".**

To create your PIN number-enter 9999-pound sign-you will hear:
> **"Wait while your PIN number is verified. The PIN value you have entered -9999- has expired. You will need a new PIN number before proceeding. Please enter a new four digit PIN number that is different from your previous PIN number and its not all the same (e.g. "1111") followed by the pound sign.**
> **Please wait while your PIN number is updated. Your PIN number has been successfully changed. Your new PIN# is XXXX. Please write this number down for future use."**

You will then return to the following options:
> **"For eligibility verification, press 1, for service limits, press 2…"**

*It is important to remember that you have **three** attempts to enter a valid PIN number. After the third failed attempt, your number will be suspended and will need to be reset by a DXC representative.*

If the provider and PIN number combination that you have entered is invalid, and it is your first or second attempt of the three, you will hear:

> **"We're sorry, provider number XXXXXXX with PIN XXXX is not authorized" "Please enter your seven digit provider number followed by a pound sign. Enter your four digit PIN number followed by a pound sign."**

If on your third attempt, your provider number/PIN number combination is still invalid, you will hear the following message depending on whether it is during business hours, after hours or a holiday:

> **"We're sorry, provider number XXXXXXX with PIN number XXXX has been suspended. Please hold for a DXC representative."**

> OR

> **"We're sorry; provider number XXXXXXX with PIN number XXXX is not authorized. For assistance from and DXC representative, please call back between 8:00 a.m. and 5:00 p.m. except on weekends and holidays and we will be happy to assist you."**

RESET PIN NUMBER

When you have had your PIN number reset by a DXC representative, you will create a new PIN number by entering 9999- pound sign- you will hear:

> **"Wait while your PIN number is verified. The PIN value you have entered- 9999- has expired. You will need a new PIN number before proceeding. Please enter a new four digit PIN number that is different from your previous PIN number, followed by the pound sign.**
> **"Please wait while your PIN number is updated. Your PIN number has been successfully changed. Your new PIN number is XXXX. Please write this number down for future use."**

You will then be returned to the following options: "**For eligibility verification, press 1…**"

Providers will be required to change their PIN numbers every 90 days. If you enter a PIN that has expired, you will be prompted to change your PIN with the following message:

> **"The PIN value you have entered has expired. You will need to enter a new PIN before proceeding. Please enter a new four digit PIN, different from your previous PIN, followed by a pound sign."**

REMEMBER

Valid PIN numbers must be four numbers (cannot be all same e.g. 2222)

The new PIN number must be different from your expired number.

After entering your new PIN number, you will hear:

> **"Please wait while your PIN number is being updated."**

If your new PIN number is accepted and successfully updated in the database, you will hear:

> **"Your PIN number has been successfully changed. Your new PIN is XXXX. Please write this number down for future use."**

A provider may change their PIN number before the 90 day expiration by choosing option #4-change PIN#. Once you have entered a new PIN number that is not the same as the previous or is not all the same number, e.g. 888- you will hear:

> **"Your PIN number has been successfully changed. Your new PIN is XXXX. Please write this number down for future use."**

Please note that some provider numbers will require an alpha to numeric conversion in order to enter their provider number.

When the user enters a provider number, the system performs an edit to ensure that it is **seven** digits. After the user enters a provider number in the correct format, the system verifies that the user's provider number is on the Provider Master File. The system asks the user to wait:

> **"Please wait while your authorization is verified."**

Once the system has verified the user's authorization, the VRS presents the following menu of services:

> **"For eligibility verification, press 1. For service limits, press 2. For current remittance advice payment amount, press 3. For assistance from a DXC representative, press 0."**

The system ensures that the user enters a valid number and performs the requested function.

ELIGIBILITY INQUIRY

To obtain member eligibility information, you will need to enter a valid member ID number, from date-of-service and to date-of-service. The ID uses the same format as all Medicaid IDs. First, the system prompts the user for the member ID as follows:

> **"Please enter the nine-digit Medicaid member number followed by the pound sign."**

When the system receives a correctly formatted member identification number, it prompts the user for a from date-of-service:

> **"Please enter the six digits from date-of-service in a month, day, year format followed by the pound sign or enter a pound sign only for today's date."**

Enter the date-of-service in a MMDDYY format followed by the pound sign (#). The system edits the date to ensure it is in the correct format and if a future date, within nine days.

When the system receives a correctly formatted from date-of-service, it prompts the user for a to date-of-service:

> **"Please enter the six digit to date-of-service in a month, day, year format followed by the pound sign or enter the pound sign only if the to date-of-service is the same as the from date-of-service."**

Enter the to date-of-service in a MMDDYY format followed by the pound sign (#). The system edits the date to ensure it is in the correct format, greater than or equal to the from date-of-service, and is valid.

If the member identification number does not exist on the Member Eligibility Master file, the system informs the user:

> **"Member (member ID) is not on file. To inquire on another member's eligibility, press 1. To return to the main menu, press 9. For assistance from a DXC Representative, press 0. If this concludes your call, you may hang up."**

If the member is not eligible on the specified date-of-service or a date of service within a date range, the system responds with the following message:

> **"Member (member ID) is not eligible for benefits from (From Date-of-Service) through (To Date-of-Service). To inquire on another member's eligibility, press 1. To return to the main menu, press 9. For assistance from a DXC representative, press 0. If this concludes your call, you may hang up."**

Since the member is not eligible for services, the system does not provide any more eligibility information.

If the member is eligible, the system responds with one of the following messages specific to program eligibility, depending on the aid category. An example of this is:

> **"Member (member ID) is eligible for VScript benefits with aid category (aid category) from (From Date-of-Service) through (To Date-of-Service). The member date of birth is (DOB). The member last name is (last name) and the first name is (first name). This benefit allows coverage for -------"**

The VRS responds with up to three different eligibility segments per inquiry.

If co-payment may be required, the system speaks the following message:

> **"Possible Co-pay"**

Please refer to the Co-payment requirements in Section 1

If the member is locked into less than three providers, the system responds with one of the following messages, depending on the lock-in type:

HMO Lock-in
> **"Member number (Member ID) is locked into MVP."**

- or -
> **"Member number (Member ID) is locked into The Vermont health Plan."**

- or -

Medical Services Lock-in
> **"For medical care, member number (Member ID) is locked into provider last name (Provider Last Name) and first name (Provider First Name)."**

Provider last name for ten characters and provider first name for five characters.

- or -

Case Managers Lock-in
> **"Member number (Member ID) is locked into Case Manager. Services must be prior approved or referred by a Case Manager."**

- or -

Pharmacy services Lock-in
> **"For Pharmacy services, member number (Member ID) is locked into pharmacy name (Pharmacy Name), provider number (Provider Number)."**

If the member is locked in to more than two providers, the system responds with one of the following messages, depending on whether it is during business hours, after hours or a holiday:
> **"Member number (Member ID) is locked into more than two providers. For assistance from a DXC representative, press 0. To continue, press 2."**

- or -
> **"Member number (Member ID) is locked into more than two providers**
> **Further information is not available because our office is closed. We are open from 8:00 a.m. to 5:00 p.m. except weekends and holidays. Please call back and we will be happy to assist you or to continue, press 2."**

The VRS reports any third party liability information available. It provides information

for up to five third party liability insurance carriers per member.

If the member does not have an insurance policy with another insurance company, the system informs the user as follows:
> **"The member is not insured by another carrier."**

For beneficiaries with other insurance carriers, the system first informs the caller of how many insurance carriers the member has with the following message:
> **"The member has insurance policies with (Number of Other Insurance Carriers) carriers."**

If the carrier number is "4D", the system responds:

"This individual has insurance through a child support order. Carrier number is (Member-Other Insurance Company Name-Company Code). If there are any problems in billing this insurance, you may bill Medicaid and Medicaid will pursue."

-otherwise-

The system tells the user the company name for another insurance carrier.

"The member has an insurance policy with (Other Insurance Company Name)."

If the insurance company name is on the list of the 50 most frequently used carrier names, the system speaks the recorded company name. If the insurance company name is not on the list, the system speaks the company code:

"(Member -Other Insurance-Company-Name) with coverage type (Coverage-Type)."

- or -

"Carrier number (Member-Other Insurance Company Code)."

If the system has information for another insurance carrier, it pauses to give the user a chance to record the information from the last response. The system then provides the following options:

"There is/are (Number-Other Insurance-Remaining) carrier/carriers remaining. To hear information for the next insurance carrier, press 1. To skip the remaining carrier information, press 2."

The system will speak five TPL segments and on the sixth segment the system will provide the user with the following options:

"There is/are (Number-Other Insurance-Remaining) carrier/carriers remaining. For assistance from an DXC representative, press 0. To skip the remaining carrier information, press 2."

At this point, the system has completed the Member Eligibility information. The user may now get service limit information on the same member, do another eligibility inquiry or return to the main menu. The system prompts the user accordingly:

"For service limits on the same member, press 2. To inquire on another member's eligibility, press 1. To return to the main menu, press 9. For assistance from a DXC representative, press 0. If this concludes your call, you may hang up."

END OF DATA MARKER

The pound sign key (#) signals to the system that the user has finished entering the requested data. The user should always press the pound sign key to mark the end of the data to get the quickest response from the system.

USE PREVIOUS DATA

The user may also use the pound sign key to tell the system to reuse data previously entered for a specific prompt. The user simply presses only the pound sign key at the prompt. For example, if the user wishes to perform another transaction on the previously entered member number, the provider can enter the pound sign key when the system prompts for the member number. This automatically causes the system to use the previously entered member number. If the system determines that the user has never entered a member number, it prompts the user again to enter one.

REPEAT RESPONSE OF PROMPT

The VRS interacts with the user by using a series of prompts and responses. It uses prompts to ask the user to enter data or to indicate what action the system should take next. It gives the requested information in the form of a voice response. Sometimes it is necessary to hear a prompt or a response over again. The VRS provides this capability. To tell the system to repeat its last response, press the pound sign key at an options menu prompt. To tell the system to repeat its last prompt, press the asterisk key at an options menu or main menu prompt.

VOID DATA

Two successive asterisks (**) indicate that all data in the current field should be deleted and the data following the asterisks be used in its place. For example, if the user intended to enter 12345 and accidentally keyed 12567, the mistake could be corrected by entering "**" followed by the correct data. The sequence of keystrokes is illustrated below:

1256712345#**

When the VRS examines the input data, it discards all data in the field preceding the two asterisks and takes the data following the double asterisks as the user's intended input. Therefore, the final input to the system would be "12345".

ALPHABETIC DATA

Since the telephone touch-tone keypad has only numeric digits 0-9, a special method must be used to allow users to enter alphabetic characters. To enter alphabetic data, press the asterisk key (*) followed by a two-digit numeric code. This numeric code represents a specific alphabetic character. The first digit corresponds to the key cap number on which the character appears. The second digit corresponds to one of the three alphabetic characters on the key cap. Therefore, the code "*21" is used to input the letter "A" since the "A" appears in position one on key cap, two on the touch-tone keypad.

The characters "Q" and "Z" do not appear on the touch-tone keypad. Therefore, these two characters are treated as though they are the first two characters on key cap one. To enter "Q", the user enters "*11". To enter "Z", the user enters "*12".

SERVICE LIMIT INQUIRY

To obtain member service limit information, you must enter a valid member ID number, from date-of-service and to date-of-service. The ID format is the same for all Medicaid IDs. First, the system prompts the user for the member ID as follows:

"Please enter the nine-digit Medicaid member number followed by the pound sign."

You may press the pound sign to tell the system to use the last member number entered. If this option is used, the system ensures that the user has previously entered a member number before proceeding. In some cases, there may be a slight delay while the system waits for the information to return from the host, so the system informs the user with the message:

"Please wait while the requested information is retrieved."

When the system receives a correctly formatted member identification number, it prompts the user for a from date-of-service:

"Please enter the six digits from date-of-service in a month, day, year format followed by the pound sign, or enter a pound sign only for today's date."

Enter the date-of-service in a MMDDYY format followed by the pound sign (#). The system edits the date to ensure it is in the correct format and is valid.

When the system receives a correctly formatted from date-of-service, it prompts the user for a to date-of-service:

> **"Please enter the six digit to date-of-service in a month, day, year format followed by the pound sign or enter the pound sign only if the to date-of-service is the same as the from date-of-service."**

Enter the date-of-service in a MMDDYY format followed by the pound sign (#). The system edits the date to ensure it is in the correct format, greater than or equal to the from date-of-service, and is valid.

If the member identification number does not exist on the Member Eligibility Master file, the system informs the user:

> **"Member (member ID) is not on file. To inquire on another member's eligibility, press 1. To return to the main menu, press 9. For assistance from a DXC Representative, press 0. If this concludes your call, you may hang up."**

If the member is not eligible on the specified date-of-service or a date of service within a date range, the system responds with the following message:

> **"Member (member ID) is not eligible for benefits from (From Date-of-Service) through (To-Date-of-Service). To inquire on another member's eligibility, press 1. To return to the main menu, press 9. For assistance from a DXC representative, press 0. If this concludes your call, you may hang up."**

Since the member is not eligible for services, the system does not provide any more eligibility information. If none of the member's service limits are exhausted, the system responds:

> **"Member (member ID) has not exhausted service limits based on paid claims as of the last processing cycle."**

If the system has information for another service limit, the system pauses to give the user a chance to record the information from the last response. The system then provides the following options:

> **"There is/are (Number Services Remaining) service limit/limits remaining. To hear the next service limit, press 1. To skip the remaining service limit information, press 2."**

At this point, the system has completed the service limit information. The user may now get service limit information on another member or return to the main menu. The system prompts accordingly:

> **"To inquire on another member's service limits, press 2. To return to the main menu, press 9. For assistance from a DXC representative, press 0. If this concludes your call, you may hang up."**

RA PAYMENT INQUIRY

When the system verifies the provider number, it also obtains remittance advice information. If remittance advice payment information is available for the provider, the system gives the following message:

> **"For provider number (Provider Number), the most recent remittance was issued on (RA Date) in the amount of (Check Amount)."**

If no remittance advice payment information is available for the provider, the system informs the user:

> **"For provider number (Provider Number), no remittance is found."**

After the transaction is complete, the system prompts with the following message:

> **"To return to the main menu, press 9. For assistance from a DXC representative, press 0. If this concludes your call, you may hang up."**

Section 7 Sample Remittance Advice

The following pages illustrate a sample RA.

```
PROV  0007777              VERMONT MEDICAID MANAGEMENT INFORMATION SYSTEM           RA NUM 000333666000
                                   LTC AND PROFESSIONAL                        PAGE NUM: 1
                                   R/A DATE: 06/16/2004


           ******************ATTENTION ALL PROVIDERS**********************

IN OUR EFFORTS TO ASSIST THE PROVIDER COMMUNITY IN CLAIMS SUBMISSION,
WE NOW CAN ACCEPT CLAIMS ELECTRONICALLY VIA TAPE MODEM OR DISKETTE
ELECTRONIC CLAIMS SUBMISSION (ECS) ALLOWS A 7-10 DAY TURN-AROUND TIME
FROM THE DATE OF TRANSMITTAL TO RECEIPT OF PAYMENT. ANYONE INTERESTED
SHOULD CONTACT THE ECS COORDINATOR AT DXC.


           *************************************************************************




COMMONWEALTH PHYSICIANS
125 GEORGE MASON BLVD
BURLINGTON, VT 05401

PROV  0007777              VERMONT MEDICAID MANAGEMENT INFORMATION SYSTEM           RA NUM 000333666000
                                   LTC AND PROFESSIONAL                        PAGE NUM: 2
                                   R/A DATE: 06/16/2004

RECIPIENT NAME  MID   ICN    HVER  PT ACCT/RX#    FRQ

                  BILLED AMT   ALLOWED AMT   OI AMT   LIAB AMT   COPAY AMT   PAID AMT

HEADER MESSAGES (EOB/ADJ RSN/AMT)
DNUM DVER  FDOS  TDOS   PROC+MODS/REV+RPL   QTY BLD

        DETAIL MESSAGES (EOB/ADJ RSN/AMT)

PAID CLAIMS
-----------------------------------------------------------------------------------------------
CLAIM TYPE: CAPITATION
-----------------------------------

SMITH  BOB  XXXXXXXXX  402004999888777  00  166
01  03/01/04  03/31/04  M0401  1.0  5.00  5.00     0.00     0.00     0.00      5.00
   093/000
           CLAIM TOTALS:              5.00  5.00     0.00     0.00      0.00    5.00

TOTALS FOR CLAIM TYPE: CAPITATION   1 CLAIM(S)    5.00    5.00    0.00    0.00    0.00    5.00




PROV  0007777              VERMONT MEDICAID MANAGEMENT INFORMATION SYSTEM RA NUM 000333666000
                                   LTC AND PROFESSIONAL                        PAGE NUM: 3
                                   R/A DATE: 06/16/2004
RECIPIENT NAME  MID   ICN       HVER  PT ACCT/RX#       FRQ

                  BILLED AMT   ALLOWED AMT   OI AMT   LIAB AMT   COPAY AMT   PAID AMT

HEADER MESSAGES (EOB/ADJ RSN/AMT)
```

DNUM DVER FDOS TDOS   PROC+MODS/REV+RPL   QTY BLD

DETAIL MESSAGES (EOB/ADJ RSN/AMT)

PAID CLAIMS

CLAIM TYPE: HCFA1500

SMITH BOB XXXXXXXXX 402004999888777 00 166
01 03/01/04 03/31/04 91411 1.0 5.00   5.00   0.00   0.00   0.00   5.00
  093/000
        CLAIM TOTALS: 5.00   5.00   0.00   0.00   0.00   5.00

JONES BILL XXXXXXXXX 402004555008876 00 167
01 03/15/04 03/15/04 91362 1.0 16.00 12.00   4.00   0.00   0.00   8.00
  093/000
02 03/15/04 03/15/04 98099 1.0 25.00 18.00   0.00   0.00   0.00   18.00
  093/000
        CLAIM TOTALS: 41.00 30.00   4.00   0.00   0.00   26.00

TOTALS FOR CLAIM TYPE: HCFA1500 3 CLAIM(S)   46.00   35.00   4.00   0.00   0.00   31.00

RECIPIENT NAME MID   ICN   HVER PT ACCT/RX#   FRQ

                          BILLED AMT   ALLOWED AMT   OI AMT   LIAB AMT   COPAY AMT   PAID AMT

HEADER MESSAGES (EOB/ADJ RSN/AMT)
DNUM DVER FDOS TDOS   PROC+MODS/REV+RPL   QTY BLD

DETAIL MESSAGES (EOB/ADJ RSN/AMT)

DENIED CLAIMS

CLAIM TYPE: HCFA1500

SMITH BOB XXXXXXXXX 402004999888977 00 199
01 03/01/04 03/01/04 91418 1.0 15.00 0.00   0.00   0.00   0.00   0.00
  408/000
        CLAIM TOTALS: 15.00   0.00   0.00   0.00   0.00   0.00

JONES BILL XXXXXXXXX 402004555008876 00 167

01 03/15/04 03/15/04 92862 1.0 16.00 0.00   0.00   0.00   0.00   0.00
  096/000

02 03/15/04 03/15/04 98299 1.0 25.00 0.00   0.00   0.00   0.00   0.00
  096/000

     CLAIM TOTALS: 41.00   0.00   0.00   0.00   0.00   0.00

TOTALS FOR CLAIM TYPE: HCFA1500   3 CLAIM(S)   56.00   0.00   0.00   0.00 0.00   0.00

DENIED CLAIM TOTALS: 3 CLAIM(S)   56.00   0.00   0.00   0.00   0.00   0.00

PROV 0007777   VERMONT MEDICAID MANAGEMENT INFORMATION SYSTEM RA NUM 000333666000
                        LTC AND PROFESSIONAL   PAGE NUM: 5
                        R/A DATE: 06/16/2004

RECIPIENT NAME MID   ICN   HVER PT ACCT/RX#   FRQ

                  BILLED AMT   ALLOWED AMT   OI AMT   LIAB AMT   COPAY AMT   PAID AMT

HEADER MESSAGES (EOB/ADJ RSN/AMT)
DNUM DVER FDOS TDOS   PROC+MODS/REV+RPL   QTY BLD

     DETAIL MESSAGES (EOB/ADJ RSN/AMT)

SUPSENDED CLAIMS

CLAIM TYPE: HCFA1500

SMITH BOB XXXXXXXXX 402004999885467 00 188

01 06/01/04 06/01/04 99887 1.0 35.00 0.00   0.00   0.00   0.00   0.00
     CLAIM TOTALS: 35.00   0.00   0.00   0.00   0.00   0.00

TOTALS FOR CLAIM TYPE: HCFA1500   1 CLAIM(S)   35.00   0.00   0.00   0.00   0.00   0.00

SUSPENDED CLAIM TOTALS: 1 CLAIM(S)   35.00   0.00   0.00   0.00   0.00   0.00

RECIPIENT NAME MID   ICN   HVER PT ACCT/RX#   FRQ

                  BILLED AMT   ALLOWED AMT   OI AMT   LIAB AMT   COPAY AMT   PAID AMT

HEADER MESSAGES (EOB/ADJ RSN/AMT)
DNUM DVER FDOS TDOS   PROC+MODS/REV+RPL   QTY BLD

     DETAIL MESSAGES (EOB/ADJ RSN/AMT)

ADJUSTED CLAIMS

CLAIM TYPE: HCFA1500

SMITH BOB XXXXXXXXX 402004999885467 00 188
01 06/01/04 06/01/04 99887 1.0 35.00 30.00   0.00   0.00   0.00   30.00
    093/000
        ORIGINAL CLAIM TOTALS: 35.00   30.00   0.00   0.00   0.00   30.00

RECOUPMENT TO ORIGINAL CLAIM-PAID DATE: 06/16/04 RECOUPMENT AMOUNT: 30.00-

SMITH BOB XXXXXXXXX 402004999885467 00 188

01 06/01/04 06/01/04 99887 2.0 65.00 60.00   0.00   0.00   0.00   60.00
    093/000
      ORIGINAL CLAIM TOTALS: 65.00 60.00   0.00   0.00   0.00 60.00

      ADJUSTMENT CLAIM TOTAL: 65.00 60.00   0.00   0.00   0.00 60.00

      ADJUSTMENT REASON: PROVIDER-REQUESTED REPROCESSING   NET ADJUSTMENT AMOUNT: 30.00

ADJUSTED CLAIM TOTALS: 1 CLAIM(S)   65.00   60.00 0.00   0.00
                          0.00   60.00

FINANCIAL ITEMS

CCN   A/L NUM   MID ICN HVER DNUM DVER TXN DATE ORIG AMT TXN AMT BAL AMT RSN

532004096000987 55200476890321 XXXXXXXXX 402004999885467 00 01 00 06/16/04 35.00 35.00   35.00

            149

502004096000992 55200476890321   06/14/04 35.00 35.00- 0.00   103

FINANCIAL ITEMS REASON CODES

103 WEEKLY PAYMENT APPLIED TO ACCOUNTS RECEIVABLE
149 AUTO RECOUPMENT- ORIGINAL CLAIM

TPL INFORMATION

RECIPIENT NAME   ICN   HVER   DVR   DNUM

SMITH BOB   402004356922001 00 01 00

    BLUE CROSS/BLUE SHIELD OF VERMONT   CARRIER CODE: EE
    100 STATE STREET
    MONTPELIER, VT 05606

POLICY NAME: BOB SMITH   RELATIONSHIP SELF   POLICY 109885478773399 GROUP 6789085550

PROV 0007777   VERMONT MEDICAID MANAGEMENT INFORMATION SYSTEM RA NUM 000333666000
                             LTC AND PROFESSIONAL   PAGE NUM: 9
                             R/A DATE: 06/16/2004

EARNINGS DATA

	CURRENT	YEAR-TO-DATE
NUM OF CLAIMS PROCESSED	4	1004
CLAIMS PAID AMOUNT	91.00	25,867
SYSTEM PAYOUT AMOUNT	0.00	0.00
MANUAL PAYOUT AMOUNT	0.00	0.00
RECOUP AMOUNT WITHHELD	35.00	35.00
PAYMENT AMOUNT	56.00	25,832
CREDIT ITEMS	0.00	0.00
NET ADJUSTMENT AMOUNT	35.00-	35.00
NET 1099 ADJUSTMENTS	0.00	0.00
NET EARNINGS	56.00	25,832

    **$56.00 WAS DEPOSITED INTO ACCOUNT NUMBER 0123456789 ON 06/162004

EOB MESSAGE CODES

093 PAYMENT REDUCED TO MAXIMUM ALLOWABLE AMOUNT
096 CLAIM DENIED. EXACT DUPLICATE OF SERVICE PREVIOUSLY PAID
095 CLAIM CUTBACK DUE TO OTHER INSURANCE PAYMENT
408 PLEASE BILL OTHER INSURANCE CARRIER FIRST AND ATTACH COPY OF PAYMENT OR DENIAL

Section 8 Manuals, Resources and Forms

The forms for the Vermont Medicaid program are available on the Vermont Medicaid Portal at: www.vtmedicaid.com/#/home.

MANUALS - www.vtmedicaid.com/#/manuals

- Applied Behavior Analysis, Mental Health and Substance Abuse Services Supplement
- Dental Fee Schedule
- Dental Supplement
- Summary of Dental Supplement Changes
- Fee Schedules
- Provider Manual
- Provider Representative Map
- Appendix to the Provider Manual
- Detailed Summary of Updates
- Archived Summary of Updates Prior to 10-1-12

RESOURCES - www.vtmedicaid.com/#/resources

- Holiday Schedule
- 2012 ADA Dental Claim Form Example
- 2012 ADA Dental Claim Form Reference Guide
- ICD-10 Dental Diagnosis Codes - Quick Reference
- General Assistance - Dental
- Carrier Codes
- Chronic Care Diagnoses
- Clinical Resources
- CMS 1500 Claim Form Presentation (Version 02-12)
- DME CoPay Exclusion Lists
- DME Restrictions
- Ladies First Provider Resource & Training Website
- Medsolutions/Radiology Management
- Diagnostic Imaging Program Guidelines
- NDC/Drug Rebate Instructions
- Drug Manufacturer Information
- Prescriber Info
- Diagnosis Codes Exempt from POA
- OPPS Revenue Code Requiring HCPCS/CPT
- Archived GMC Programs Aid Category & Copay
- Pharmacy Benefit Manager (PBM) Effective 01/01/2015
- Psychiatric and Detoxification Authorization Manual
- Relative Weights
- Vision-Eyeglass FAQ
- Obtaining a Provider Web Services Account
- 837 Adjustment Reason Code

FORMS – www.vtmedicaid.com/#/forms

- Accident Questionnaire
- Alternate Reporter Request
- Adjustment (Single)
- CMS 1500 Medicare Attachment Summary Form
- UB 04 Medicare Attachment Summary Form
- DME Equipment Agreement Form
- Julian Calendar
- Medicaid Refunds
- Multiple Adjustment Request Form
- Provider Inquiry
- Reconsideration Request Form
- Timely Filing Reconsideration Request Form – Single Claim
- Timely Filing Reconsideration Request Form – Multiple Claim
- TPL Change Request Form
- 340B Hospital Enrollment Amendment
- 340B Provider Enrollment Amendment
- 340B Contact Information Sheet
- 340B Medicaid Carve-In Manual
- Medicaid Fraud, Waste and Abuse Referral Form
- Authorization & Notification Request Forms
- Dental Guidelines and Prior Authorization Forms
- In-State Concurrent Review Procedures and Notification Form
- Sterilization Consent Form
- Transportation Form

PROVIDER ENROLLMENT

- Provider Enrollment Instructions - www.vtmedicaid.com/#/provEnrollInstructions
  - Green Mountain Care Instructions for Enrollment & Revalidation
- Provider Application Packets - www.vtmedicaid.com/#/provEnrollAppPackets
  - Provider Enrollment Application Packets
- Provider Enrollment and Revalidation (Medicare Crossover Only) - www.vtmedicaid.com/#/provEnrollCrossover
  - The Provider Enrollment and Revalidation form for Medicare Crossover Only, limitations apply, please read all instructions before completing this application
- Provider Enrollment and Data Maintenance Forms - www.vtmedicaid.com/#/provEnrollDataMaint
  - Enrollment Backdating Form
  - EPCP Self-Attestation Form
  - Provider Update Request Form
  - Web Services Update Form
  - PCPlus Agreement Form
  - PCPlus Naturopathic Form
  - Termination Notice
  - Group Affiliation Form

- - Supervised Billing Five Year Rule Waiver Form
  - EFT Form
- Provider Enrollment Risk Level Classifications - www.vtmedicaid.com/#/provEnrollRiskLevel

Provider Enrollment Information Resources and Notices - www.vtmedicaid.com/#/provEnrollResources

Section 9 Julian Date Calendar

The Julian Date Calendar will assist in interpreting the Internal Control Number DXC assigns to each claim. The calendars for regular and leap years follow:

Julian Calendar - Regular Year

DAY	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	DAY
1	001	032	060	091	121	152	182	213	244	274	305	335	1
2	002	033	061	092	122	153	183	214	245	275	306	336	2
3	003	034	062	093	123	154	184	215	246	276	307	337	3
4	004	035	063	094	124	155	185	216	247	277	308	338	4
5	005	036	064	095	125	156	186	217	248	278	309	339	5
6	006	037	065	096	126	157	187	218	249	279	310	340	6
7	007	038	066	097	127	158	188	219	250	280	311	341	7
8	008	039	067	098	128	159	189	220	251	281	312	342	8
9	009	040	068	099	129	160	190	221	252	282	313	343	9
10	010	041	069	100	130	161	191	222	253	283	314	344	10
11	011	042	070	101	131	162	192	223	254	284	315	345	11
12	012	043	071	102	132	163	193	224	255	285	316	346	12
13	013	044	072	103	133	164	194	225	256	286	317	347	13
14	014	045	073	104	134	165	195	226	257	287	318	348	14
15	015	046	074	105	135	166	196	227	258	288	319	349	15
16	016	047	075	106	136	167	197	228	259	289	320	350	16
17	017	048	076	107	137	168	198	229	260	290	321	351	17
18	018	049	077	108	138	169	199	230	261	291	322	352	18
19	019	050	078	109	139	170	200	231	262	292	323	353	19
20	020	051	079	110	140	171	201	232	263	293	324	354	20
21	021	052	080	111	141	172	202	233	264	294	325	355	21
22	022	053	081	112	142	173	203	234	265	295	326	356	22
23	023	054	082	113	143	174	204	235	266	296	327	357	23
24	024	055	083	114	144	175	205	236	267	297	328	358	24
25	025	056	084	115	145	176	206	237	268	298	329	359	25
26	026	057	085	116	146	177	207	238	269	299	330	360	26
27	027	058	086	117	147	178	208	239	270	300	331	361	27
28	028	059	087	118	148	179	209	240	271	301	332	362	28
29	029		088	119	149	180	210	241	272	302	333	363	29
30	030		089	120	150	181	211	242	273	303	334	364	30
31	031		090		151		212	243		304		365	31
DAY	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	DAY

Julian Calendar - Leap Year

DAY	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	DAY
1	001	032	061	092	122	153	183	214	245	275	306	336	1
2	002	033	062	093	123	154	184	215	246	276	307	337	2
3	003	034	063	094	124	155	185	216	247	277	308	338	3
4	004	035	064	095	125	156	186	217	248	278	309	339	4
5	005	036	065	096	126	157	187	218	249	279	310	340	5
6	006	037	066	097	127	158	188	219	250	280	311	341	6
7	007	038	067	098	128	159	189	220	251	281	312	342	7
8	008	039	068	099	129	160	190	221	252	282	313	343	8
9	009	040	069	100	130	161	191	222	253	283	314	344	9
10	010	041	070	101	131	162	192	223	254	284	315	345	10
11	011	042	071	102	132	163	193	224	255	285	316	346	11
12	012	043	072	103	133	164	194	225	256	286	317	347	12
13	013	044	073	104	134	165	195	226	257	287	318	348	13
14	014	045	074	105	135	166	196	227	258	288	319	349	14
15	015	046	075	106	136	167	197	228	259	289	320	350	15
16	016	047	076	107	137	168	198	229	260	290	321	351	16
17	017	048	077	108	138	169	199	230	261	291	322	352	17
18	018	049	078	109	139	170	200	231	262	292	323	353	18
19	019	050	079	110	140	171	201	232	263	293	324	354	19
20	020	051	080	111	141	172	202	233	264	294	325	355	20
21	021	052	081	112	142	173	203	234	265	295	326	356	21
22	022	053	082	113	143	174	204	235	266	296	327	357	22
23	023	054	083	114	144	175	205	236	267	297	328	358	23
24	024	055	084	115	145	176	206	237	268	298	329	359	24
25	025	056	085	116	146	177	207	238	269	299	330	360	25
26	026	057	086	117	147	178	208	239	270	300	331	361	26
27	027	058	087	118	148	179	209	240	271	301	332	362	27
28	028	059	088	119	149	180	210	241	272	302	333	363	28
29	029	060	089	120	150	181	211	242	273	303	334	364	29
30	030		090	121	151	182	212	243	274	304	335	365	30
31	031		091		152		213	244		305		366	31
DAY	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	DAY

Section 10 Approved Timely Filing Documents

The following examples show the approved formats for proof of timely filing.

```
PROV 0007777 NPI 1234567891   VERMONT MEDICAID REMITTANCE ADVICE      RA NUM 000333666000
                              LTC AND PROFESSIONAL                    PAGE NUM: 4
                              R/A DATE: 06/16/2004

RECIPIENT NAME   MID   ICN    HVER   PT ACCT/RX#     FRQ DRG Code   DRGWeight
                      BILLED AMT   ALLOWED AMT   OI AMT    LIAB AMT   COPAY AMT   PAID AMT
HEADER MESSAGES (EOB/ADJ RSN/AMT)
DNUM  DVER   FDOS    TDOS     PROC+MODS/REV+RPL      QTY BLD
      DETAIL MESSAGES (EOB/ADJ RSN/AMT)
DENIED CLAIMS
------------------------------------------------------
CLAIM TYPE: HCFA1500
---------------------
SMITH BOB  XXXXXXXXX   402004999888977       00    199           0.00
001 00  03/01/04 03/01/04 91418 1.0   15.00   0.00   0.00   0.00   0.00   0.00
  408/000
        CLAIM TOTALS:                  15.00   0.00   0.00   0.00   0.00   0.00
JONES  BILL XXXXXXXXX   402004555008876      00    167           0.00
001 00  03/15/04 03/15/04 92862 1.0   16.00   0.00   0.00   0.00   0.00   0.00
  096/000
002 00  03/15/04 03/15/04 98299 1.0   25.00   0.00   0.00   0.00   0.00   0.00
  096/000
        CLAIM TOTALS                   41.00   0.00   0.00   0.00   0.00   0.00
TOTALS FOR CLAIM TYPE: HCFA1500 3 CLAIM(S) 56.00  0.00   0.00   0.00   0.00   0.00
DENIED CLAIM TOTALS:3 CLAIM(S)         56.00   0.00   0.00   0.00   0.00   0.00
```

```
SUMMARY

ICN                  DATES OF SERVICE              STATUS        CHARGES      PAYMENT
402004999888977      03/01/17 - 03/01/17           F2 /1 /       $15.00       0.00
```

```
CLAIM DETAIL

We are now returning member's unique id, not SSN. The unique id should now be used for all claim
submissions.
HIPAA Status Category:      F2 = Finalized/Denial-The claim/line has been denied.
HIPAA Status Code:          1 = For more detailed information, see remittance advice.
HIPAA Entity Code:
------
Internal Control Number:    402004999888977
Member's ID Number:         XXXXXX              Member's Name:      SMITH, BOB
Date of Birth:              01/01/2000          Gender:             Male
Payer Control Number:       VAV12345            Bill Type:
Dates of Service:           03/01/17 - 03/01/17
Claim Amount:               $15.00              Paid Amount: $0.00
Check Number:                                   Check Date:
Remittance Date:            04/01/2017          Status Date:
```

```
CLAIM LINE ITEM DETAIL

HIPAA Status Category:      F2 = Finalized/Denial-The claim/line has been denied.
HIPAA Status Code:          1 = For more detailed information, see remittance advice.
HIPAA Entity Code:
Vermont Medicaid EOB:       1078 = ORDERING PHYSICIAN NUMBER OR QUALIFIER IS MISSING OR NOT VALID
------
Line Item Control:
Procedure Qual/Ident:       HC/91418            Procedure Mods:     / / /
Dates of Service:           03/01/17 - 03/01/17 Units of Service:   1.00
Claim Amount:               $15.00              Paid Amount:        $0.00
Revenue Code:                                   Status Date:        10/17/2017
```