



Vermont Medicaid General Billing and Forms Manual

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Section 1 Coordination of Benefits/Vermont Medicaid Payment Liability/Third Party Liability

1.1 Contractual Allowance

Vermont Medicaid is payer of last resort, and as such, will not consider and pay amounts that exceed the Vermont Medicaid rate, even when payment is combined with payments from primary insurance.

When another insurance carrier has made a payment, document the total payments received by other insurance carriers in the appropriate field on your claim form.

When the entire allowed amount is applied to the primary insurance deductible, the claim may be submitted to Vermont Medicaid but must be accompanied by an Explanation of Benefit (EOB). Vermont Medicaid will consider payment based on the Vermont Medicaid allowed amount after deducting any payment made by a primary insurer.

The provider is prohibited from collecting an amount that exceeds the contractual amount that is agreed upon in the contract with primary payer.

1.2 Reimbursement of Overpayments

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. DXC Technology will forward to the PI Unit cases for review when it's discovered that overpayment was not refunded during the timeline mandated by PPACA.

In addition to the above information DXC Technology 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. DXC Technology will forward cases for review to the DVHA Program Integrity Unit, when or if the discovered overpayment was not refunded during the timeline mandated by PPACA.

1.3 Who is Responsible for Payment?

1.3.1 Verifying eligibility before service

Providers are expected to verify eligibility for every member prior to providing the service or item to be clear about who has financial responsibility for the service. Eligibility can be verified up to nine days in advance however, this is not a guarantee of payment. Eligibility can be verified through the automated Voice Response System (VRS/Malcolm), 802.878.7871, option 1 and then option 1 again, online Transaction Services (<http://www.vtmedicaid.com/#/home>) or by calling the Provider Services Unit help desk. When an eligible aid category code is given, the provider should determine that the service to be provided is covered within that aid category. This will also show what other insurance is on file. To ensure timely processing of your claim, validate other insurance with member or refer them to the Department for Children and Families.

1.3.2 Billing the Member

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

- The amount due is for unpaid Vermont Medicaid co-payments and deductibles
- The claim was denied for lack of eligibility and the date of service was greater than 60 days beyond the loss of eligibility date
- The claim was denied because another insurer's rules were not followed
- The claim is submitted to Vermont Medicaid by Medicare for a patient enrolled in a Vermont Medicaid pharmacy only plan or
- If the DXC Technology system reports that a member has other insurance, the provider must bill the service or item to the other medical insurance prior to billing Vermont Medicaid. If the member is no longer enrolled with the other insurer and the member does not report the insurance change to Vermont Medicaid within 30 days and after the 30 days have lapsed, the DXC Technology system still reports that the patient has other insurance, the provider may bill the member.
- Under the Provider Enrollment Agreement (Conditions of Participation #9), failure to give advance notice that a Vermont Medicaid payment will not be accepted prevents the provider from billing the member. If the member is eligible for Vermont Medicaid and the provider has made the decision not to bill Vermont Medicaid for the service or item requested, the member must be informed in advance of providing the service.

Federal Medicaid policy does not permit providers to bill Vermont Medicaid or the member any fee for missing a scheduled appointment.

1.3.3 Supplementation

Once Vermont Medicaid has been billed for a service or item, the provider may not attempt to collect any additional reimbursement for that service or item from the member, the member's family or anyone acting on behalf of the member, except for:

- The applicable conditions described below in Section 1.4, Who is Primary
- Permitted deductible and co-payment amounts
- Specific allowed supplementations authorized in Medicaid Rule 7602

1.4 Who Is Primary

When the DVHA is the primary payer (i.e. the DXC Technology system indicates no other insurer) and Vermont Medicaid payment is accepted, the provider should submit all bills to the DVHA's fiscal intermediary and never to the patient. Under the provider agreement, the provider has agreed to accept the DVHA's payment or denial (except as enumerated above) as payment in full.

When the DXC Technology system shows a source other than the DVHA as the primary payer (such as Medicare or any other insurance carrier) the DVHA is the payer of last resort. Under the provider agreement, certain restrictions apply.

When Vermont Medicaid is secondary to a **private insurer** and a co-payment is required by the primary insurer at time of service, the provider is to bill the claim to Vermont Medicaid and indicate the amount paid by the primary insurance. Vermont Medicaid reimburses their allowed amount, minus the amount the other insurer has paid.

Providers that do not wish to bill Vermont Medicaid for the co-payment are only allowed to bill the member if they notify the member in writing, prior to rendering the service, that they will not bill Vermont Medicaid for the co-payment. The member must sign and date this notification; please retain documentation in the member's file.

If the third-party payment was made directly to the member, the provider may bill the member for the amount paid by such third parties. In addition, the provider may collect patient liability or spend-down amounts.

1.5 Notice That Vermont Medicaid Will Not Be Accepted

If a provider does not intend to bill Vermont Medicaid for specific services, the patient must be fully informed of the decision and its consequences prior to rendering the service. Patients must understand that they will be financially responsible for the service(s). To document that proper notice was given; providers are required to document the agreement/understanding between member and provider on their letterhead. Comprehensive documentation showing evidence that proper notice was given to the member should include the following information:

1. Provider's name and Vermont Medicaid provider ID number
2. Member's name and signature (or signature of a parent, if the member is a minor)
3. Description of service(s) sought
4. A clear statement that the provider is unwilling to accept Vermont Medicaid payment for the specific service(s) sought and if the member wants to get this service from this provider, the member or responsible adult must accept full financial responsibility
5. Date of signing

The provider is to give a copy to the member or responsible adult and retain a copy in the member's file. Failure to give advance notice prevents the provider from billing the member. When the member or responsible adult accepts financial responsibility, the claim cannot be submitted to DXC Technology for processing.

1.6 Vermont Medicaid & Medicare Crossover Billing

A **Green Mountain Care** member may be eligible for both Vermont Medicaid and Medicare. When dual eligibility exists, Medicare must be billed first on an assigned basis.

After Medicare payment, the DVHA pays deductibles and coinsurance for crossover claims.

Providers must include their NPI and taxonomy code on any claims sent to Medicare in order to assure proper automatic crossover and subsequent Vermont Medicaid processing of your claims. Vermont Medicaid is aware that Medicare does not have this same requirement but will include the taxonomy code, as submitted on the claim, on the crossover file.

DXC Technology does not accept a CMS-1500 crossover claim submitted with multiple Medicare Attachment Summary Forms. When submitting a CMS-1500 crossover claim that contains more than 6 details, each 6 details must be submitted as an individual claim with its Medicare

Summary Attachment Form; indicate the number of details and the total. The total must equal only the sum of the detail lines listed on that claim form.

The Department of Vermont Health Access reviews all Medicare crossover claims where the Vermont Medicaid allowed amount (coinsurance / deductible) is over \$10,000.00. These claims require DVHA's review and approval prior to payments being made. To facilitate the processing of these claims, please attach the following information to your claim if the expected coinsurance /deductible payment from Vermont Medicaid is over \$10,000.00: the Medicare Attachment Summary Form, the Medicare EOMB and the discharge summary at the time of submission. Any claims submitted without the required supporting documentation will be denied.

A Medicare Attachment Summary Form should not be attached if an item or service is non-reimbursable by Medicare. If the service or item is denied by Medicare, a completed claim along with the Medicare EOB should be submitted within 6 months from Medicare's processing date.

The Medicare Attachment Summary Form is only to be used for beneficiaries who are enrolled in both Medicare and Vermont Medicaid. It is not to be used for reporting actions by any other insurers.

1.6.1 Vermont and New Hampshire Providers:

In order to crossover, Vermont Medicaid eligibility information must be clearly indicated on the Medicare claim. These claims, as well as any future adjustments to these claims, will crossover automatically to DXC Technology for payment. If you do not receive the DVHA payment within 30 days of the Medicare paid date, submit the claim to DXC Technology with the *Medicare Attachment Summary Form*. <http://www.vtmedicaid.com/#/forms>

If a service or item is denied by Medicare as non-reimbursable and is reimbursable by the DVHA, submit a CMS-1500 claim, completed to the DVHA specifications, along with the Medicare denial to DXC Technology within twelve months of the date of service.

1.6.2 Other Out-of-State Providers (Except New Hampshire)

All out-of-state providers should first bill their regional Medicare carrier for services to dual eligible Vermont residents. After Medicare payment is received, send a claim to DXC Technology for payment of any coinsurance or deductible as follows:

- Send a claim completed to the DVHA specifications with a copy of the Medicare Attachment Summary Form. The Medicare payment date must appear on the Medicare Attachment Summary Form.
- If a service or item is denied by Medicare as non-reimbursable and is reimbursable by the DVHA, submit a CMS-1500 claim with the EOMB, completed to the DVHA specifications to DXC Technology within twelve months of the date of service; see Section [3.2 Timely Filing](#).

1.7 Third Party Liability (TPL)/Other Insurance (OI)

Vermont Medicaid is the payer of last resort. Providers are required to pursue and apply all third-party payment resources prior to billing Vermont Medicaid. Third party resources include, but are not limited to, Medicare, private/group health insurance plans, military and veteran's benefits, Worker's Compensation and accident (automobile, homeowners, etc.) insurance. See [Section 1.8](#) for information specific to Workers Compensation and Accident Liability Billing.

1.7.1 TPL-Verification

The member's other insurance information, including the name of the other insurance company, address, carrier code and type of coverage, is available on the Vermont Medicaid website, Provider Web Services (<http://www.vtmedicaid.com/#/home>, Transactions→Login) and the Voice Response System (VRS) when the provider checks the member's eligibility. Providers will review the member's eligibility information for the date of service and must bill other insurance carrier(s) before billing Vermont Medicaid. Providers may use the available information to guide billing.

1.7.2 Timely Filing of OI Claims

Providers will respect the member's right to receive all medically necessary services and equipment in a timely manner and must submit claims to primary insurers promptly to mitigate issues with member primary insurance benefits exhausting.

1.7.3 Other Insurance Denial/DVHA Authorization Request

The following procedures are required for DVHA authorization requests when the primary insurer has reviewed and denied a claim request for an item or service:

1.7.4 OI Denial for Non-Covered or Benefits Exhausted

The provider is required to submit to the DVHA the authorization request form (Medical Necessity Form or other) with all standard documentation, the notice of denial from the primary insurer that indicates the item or service is not a covered benefit or that the benefit limit was determined to be exhausted, and all necessary documentation to support medical necessity. The DVHA will then review.

- The provider does not need to appeal to the primary insurer before billing Vermont Medicaid when the item/service is not covered, or benefits are exhausted.
- If the code/service does not require authorization from Vermont Medicaid, then the provider can bill Vermont Medicaid directly with a copy of the primary insurer's denial attached.

1.7.5 OI Denial for Not Medically Necessary

The provider and/or member is required to pursue all levels of reconsideration and appeals with the primary insurer. If the request remains denied by the primary insurer, the provider and/or member is required to seek review by the Vermont Department of Financial Regulation if the cost of the item or service exceeds \$100. If the denial stands, then the provider may submit the request to the DVHA with copies of all of the original documentation, the denials from the primary insurer and the Department of Financial Regulation's support of the denial. The provider should not submit any additional documentation other than what was reviewed by the primary insurer.

- If the code/service does not require authorization from Vermont Medicaid, then the provider may bill Vermont Medicaid directly, with copies of the primary insurer's denials (original and appeals) and the Department of Financial Regulation's support of the denial attached.

1.7.6 OI Blanket Denials

Providers are required to submit blanket denials from a primary insurer to DXC Technology every calendar year, for example: a blanket denial issued on July 7, 2018, will only be valid until December 31, 2018 and a new denial will be required as of January 1, 2019. Blanket Denials are required each calendar year as health insurance benefits are reviewed and health care policies are generally, renewed yearly.

Vermont Medicaid will accept a blanket denial for the same calendar year as the date(s) of service of the claim(s) being submitted for payment.

All Blanket Denials are to include the following:

- Name of the insurance company
- Member name
- Date(s) of service
- Rev/Procedure code or description of service

Providers may obtain a “blanket statement” from an insurance company that states that the company never covers a particular service for the member’s policy and attach it to the claim when billing for that service. Blanket statement must be less than one year old and must be attached to each claim submitted. Providers must indicate the member’s name and identification number and the applicable dates of service and the provider must sign and date the blanket statement.

1.7.7 Medicare Qualified Independent Contractor

For members covered by Medicare it is required that the Medicare Qualified Independent Contractor appeal level be applied, with the exception of wheelchairs that Medicare denies or downgrades. Upon documentation of the Medicare action, Vermont Medicaid will review for medical necessity and payment determination.

The DVHA will reject a request if there is reason to believe that the OI received incorrect or incomplete information from the provider and based its decision on that incorrect or incomplete information. Providers must determine OI and Medicare benefits before rendering the service to minimize the risk of non-coverage by both OI or Medicare and the DVHA.

1.7.8 Other Insurance Attachments

Providers may submit electronically to DXC Technology claims that have been denied by another insurance company (third party payer/primary 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 at <http://www.vtmedicaid.com/#/resources>, select 837 Adjustment Reason Codes. DXC Technology 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.

When submitting a paper claim, an attachment is needed only when a third-party insurance carrier has not made a payment. Providers must attach documentation from the carrier that

verifies the member's name, insurer's name, dates of service, service code or exact description of service, the amount reimbursed and the payment or denial date. If the carrier does not include this information in the documentation (i.e. the carrier issues a blanket statement that the particular service is not covered), the provider must write the necessary information on the attachment, then sign and date the attachment. It must be clear that the attachment relates to the specific services billed on the Vermont Medicaid claim.

If there was a payment made by the third party, providers must indicate the amount paid in the "prior payments" field. Documentation from the carrier is not required with the claim form if there is a payment amount, thus allowing the claims to be submitted electronically. In cases where a member has more than one other insurance, providers must indicate on paper, that payment was received (or denied) from each insurance company.

If the other insurance amount is less than \$3.00, the provider must include the "other insurance" attachment verifying that exact payment amount.

Exceptions: Members are excluded from the third-party liability requirements specified above for the following services:

- **Prenatal Care Services:** This includes routine supervision of normal pregnancy, prenatal screening of mother or fetus, and care provided in the prenatal period to the mother for complications of pregnancy
- **Preventive Care Services:** This includes immunizations, screening tests for congenital disorders, well-child visits, preventive medicine visits, preventative dental care, and screening and preventive treatment for infectious and communicable diseases
- **Court-enforced Medical Support Members:** This is identified by an insurance coverage type D1 through D9 which indicates "Absent Parent"

Claims exempt from TPL may be submitted directly to DXC Technology. Indicate "not billed" in the "other insurance" field when submitting paper claims. When submitting electronically, simply indicate "no" in the "other insurance" field. The provider should only indicate that other insurance has not been billed if that is, in fact, true.

If the provider chooses to first bill the third party in these cases, he or she must wait 30 days from the date of furnishing the service before billing Vermont Medicaid. Vermont Medicaid must be credited with any payments received from the other third-party payer.

1.7.9 Accidents

The Vermont Medicaid program must recover payment from liable third parties in accident cases. The information contained on a claim form is vital in researching these accident cases.

When filing a Vermont Medicaid claim when an accident may be involved, check the appropriate box in the accident fields and enter the date of the accident according to the appropriate billing instructions, if applicable. The claim will deny if all accident fields are not completed.

Claims billed with a "yes" in the accident field and those with a trauma diagnosis will be tracked in the claims processing system and monitored for post payment recovery from liable parties. In order to determine liability information, DXC Technology will send questionnaires to members regarding some trauma cases.

1.7.10 Discrepancy in TPL Information

When a provider believes that the other insurance listed in the eligibility file is incorrect, contact the DCF district worker for clarification/correction or have the member contact Member Services.

1.7.11 HMOs

Are treated as other health insurance. When a Vermont Medicaid member does not comply with the rules of their HMO, such as securing prior authorization, the HMO may choose not to cover the service. In such cases, Vermont Medicaid will not pay for the service either and the member will be responsible for payment.

1.7.12 TPL Cost Avoidance

DXC Technology maintains eligibility files, which contain member health insurance information. This data is integrated in the claims processing system to coordinate benefits.

1.7.13 Third Party Liability Coverage Codes

The VRS and the Vermont Medicaid website use the following codes to describe the type of services covered by a patient's other insurance. The Coverage Codes (below) and the insurance matrix (see Appendix) will help in understanding how to interpret the information provided about third party liability. For example, if the VRS reports "07" for a member, the matrix shows that a dental claim for dental services will fail for reason 408 if the third-party information is not provided. Contact DXC Technology if you do not know whether the coverage code refers to the service you have provided.

Code	Type of Coverage
01	Hospital Inpatient Services
02	Hospital Outpatient Services
03	Hospital Inpatient/Outpatient Services
04	Physician Services
05	Physician Inpatient/Outpatient Services
06	Physician Inpatient/Outpatient Services/Major Medical
07	Dental Coverage
08	Vision Coverage
09	Drug Coverage
10	Physician Inpatient/Outpatient Services/Major Medical/Dental
11	Physician Inpatient/Outpatient Services/Major Medical/Vision
12	Physician Inpatient/Outpatient Services/Major Medical/Drug
13	Medicare Supplement A & B

14	Indemnity Coverage Payment to Client
15	Major Medical
16	Major Medical/Physician
17	Major Medical/Physician/Dental
18	Major Medical/Physician/Vision
19	Major Medical/Physician/Drug
20	Major Medical/Physician/Dental/Vision/Drug
21	Inpatient/Outpatient/Physician/Dental/Major Medical/Drug/Vision
22	Medicare Supplement Part A
23	Medicare Supplement Part B
24	Specialty Coverage (e.g., cancer)
25	HMO
26	Nursing Home
27	Veterans Home
28	Worker's Compensation
50	Absent Parent (4D)
99	Unknown
A1	Medicare A
B1	Medicare B

1.8 Workers Compensation/Accident Liability Billing

Providers have two choices regarding billing when a member is also covered by worker's compensation or accident insurance, such as auto insurance, homeowners, etc.

1. Bill Vermont Medicaid

-or-

2. Bill workers compensation/auto insurance.

If the provider chooses to bill the workers compensation or the accident Insurance (i.e., auto insurance, homeowners, etc.), the provider cannot bill Vermont Medicaid simultaneously. (Refer to your provider enrollment/recertification agreement.)

If a provider decides at any point to bill Vermont Medicaid, the provider must withdraw the claim to the workers compensation/auto insurer. The withdrawn claim is still subject to the 180 days timely filing limit. Vermont Medicaid will pay the claim and bill the responsible insurance

provider. Payments made by the insurance provider will come directly to Vermont Medicaid. No reimbursement will be made to the provider.

When a provider bills worker's compensation or accident insurance, and the claim is denied by workers compensation or accident insurance, the provider then has 1 year from the date of service to submit their claim to Vermont Medicaid for payment.

If a payment is received from a worker's compensation/accident insurer after the provider has received payment from Vermont Medicaid, the provider must return or refund the payment to Vermont Medicaid.

In regards to billing the member, 42 USC § 1396a (a)(25)(C) states: "In the case of an individual who is entitled to medical assistance under the State plan with respect to a service for which a third party is liable for payment, the person furnishing the service may not seek to collect from the individual (or any financially responsible relative or representative of that individual) payment of an amount for that service..."

Section 2 Prior Authorization for Medical Services

Prior authorization (PA) is a process used to assure the appropriate use of health care services. The goal of PA is to assure that the proposed health service, item or procedure as per Medicaid Rule 7102.2.

A request for prior authorization of a covered health service will be approved if the health service:

- is medically necessary (see rule 7103)
- is appropriate and effective to the medical needs of the beneficiary
- is timely, considering the nature and present state of the beneficiary's medical condition
- is the least expensive, appropriate health service available
- is FDA approved, if it is FDA regulated
- is subject to a manufacturer's rebate agreement, if a drug
- is not a preliminary procedure or treatment leading to a service that is not covered
- is not the repair of an item uncovered by Medicaid
- is not experimental or investigational
- is furnished by a provider with appropriate credentials

Prior Authorization involves a request for clinical review of each health service that is designated as requiring prior approval before the service is rendered. Please review the fee scheduled at: <http://dvha.vermont.gov/for-providers/claims-processing-1> for services that require a PA. Authorization will not be granted after the service is rendered.

The DVHA PA regulations can be found in Medicaid Rule 7102. These rules and procedures govern PAs performed by the DVHA and its agents. DVHA rules are available online at <http://dvha.vermont.gov/budget-legislative>.

DVHA criteria can be found at <http://dvha.vermont.gov/for-providers/clinical-coverage-guidelines>.

No retroactive prior authorization will be granted. The DVHA PA requirements apply when the DVHA is known to be the primary payer for the service or item or the service or item is not a covered benefit by the member's primary insurer.

The start date of a PA commences with the receipt of all the administrative information required to process the PA request (an "actionable request"). In order to prevent a delay in the start date, the request **must** have all the information on the latest version of the appropriate form completed, including the PA request form signed by the Vermont Medicaid enrolled Provider. Forms can be found at <http://dvha.vermont.gov/for-providers/clinical-prior-authorization-forms>.

Waiver of Prior Authorization (Exceptions):

Medicaid Rule 7102.3 allows two general exceptions to securing authorization prior to the date of service.

- **Emergency Services:** Services normally requiring PA do not require PA when treating an emergency condition.

- **Retroactive Eligibility:** Covered services that normally require PA, which are provided to an individual in the retroactive period (defined as eligibility start date to eligibility segment update date), do not require PA.

2.1 Clinical Coverage Guidelines

The Department of Vermont Health Access has adopted various Clinical Coverage Guidelines that are based upon evidence-based medicine. These guidelines outline the preferred approach for most patients and are used to support the decision-making processes. The guidelines can be found <http://dvha.vermont.gov/forproviders/clinical-coverage-guidelines>.

2.2 Prior Authorization Requirements

The DVHA Clinical Operations Unit (COU) enters prior authorizations with the exact procedure code(s) given by the requesting provider on the request form. In those instances when the procedure code to be billed does not exactly match the code requested/authorized, the provider must notify the COU in writing prior to claim submission. Include the DVHA prior authorization number, the rationale for the code change and signature. Fax information to 802.879.5963.

All unlisted procedure codes require prior authorization from the DVHA COU prior to the service being rendered.

If it is determined during a surgical procedure that an unlisted procedure is appropriate and medically necessary, authorization must be requested **prior** to claim submission. Fax information to 802.879.5963. Surgical procedure notes must be attached with the claim indicating the usual and customary charge for the service.

2.2.1 Required Documentation

At a minimum, the documentation required to support a PA request must include a completed and legible copy of a medical necessity form, or other appropriate form (<http://dvha.vermont.gov/for-providers/forms-1>), with the prescribing provider's signature, and all documents necessary for identification and pricing of the service requested, when applicable. Providers are required to keep the original legible copy of the medical necessity form in the patient's record. It is not necessary to submit a completed claim form with a PA request. If a request for PA is denied and a provider has questions or needs additional information, contact the DVHA Clinical Unit at 802.879.5903.

Notwithstanding any other review, the State reserves the right to review medical records at any time and without advance notice.

2.2.2 Immediate Need Exception

1. **URGENT:** Authorization in advance does not have to occur if the service or item is rendered for urgently needed care as defined below and if the urgent care is required outside of normal DVHA business hours. If a request for authorization is shown to be for urgently needed care, and if the request for authorization is made on the next business day, the request will be considered timely. Payment for such services or items will further depend on a determination that they are medically necessary. If any such item is not considered medically necessary, the DVHA will provide normal reimbursement for a reasonable quantity of consumable items actually provided and/or the DVHA will provide normal reimbursement for the rental of such items in the minimum allowable period for the service.

2. IMMEDIATE: Authorization in advance does not have to occur if the service or item is rendered for immediately needed care as defined below. However, the request for PA must be faxed to the DVHA Clinical Unit by the next business day. The provider must submit documentation of medical necessity and evidence that the care or item was immediately needed. This may take the form of an order or a discharge plan. Payment for such services or items will further depend on a determination that the service(s) are medically necessary. If any such item is not considered medically necessary, the DVHA will provide normal reimbursement for a reasonable quantity of consumable items actually provided and/or the DVHA will provide normal reimbursement for the rental of such items in thirty-day increments.

Definitions:

“Emergency Medical Condition” means an illness or medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the beneficiary’s physical or mental health, serious impairment of bodily functions, or serious dysfunction of any bodily organ or part. HCAR rule 4.102.

“Post Emergency Stabilization” is the care required after an emergency to stabilize the patient for transfer or discharge. The attending emergency physician determines when a patient has been sufficiently stabilized for transfer or discharge. Post-emergency stabilization care is covered 24 hours per day, 7 days per week as necessary to stabilize a patient after an emergency.

“Urgently-Needed Care” or “Urgent Care” means those health care services that are necessary to treat a condition or illness of an individual that if not treated within twenty-four (24) hours presents a serious risk of harm.

“Immediately Needed” means that action is needed on the same day to avoid delay in discharge or to allow the member to remain in a community setting.

These definitions are consistent with Medicaid rule and HCAR.

2.3 Determination Time

Determination timeframes now correspond to 42 CFR §438.210. DVHA will continue to issue a notice of decision within 3 business days of receipt of all the necessary information. However, the longest time to wait for a decision is now 28 days, not 30. A request must be decided within 14 calendar days of receipt of the request, but that time frame may be extended up to another 14 calendar days if the beneficiary or provider request the extension, or if the extension is needed to obtain additional information and an extension is in the beneficiary’s interest.

Also, when a provider indicates, or DVHA determines, that following this timeframe could seriously jeopardize the beneficiary’s life, health, or ability to attain, maintain, or regain maximum function, DVHA must make an expedited decision and provide notice as expeditiously as the beneficiary’s health condition requires and no later than 3 business days after receipt of the request. This may be extended up to 14 calendar days if the beneficiary so requests, or if the extension is needed to obtain additional information and an extension is in the beneficiary’s interest. Under federal law, the department is obligated to provide a response within 24 hours of a request for PA of a drug.

2.3.1 DVHA PA Decision Reconsiderations

The DVHA will conduct a review of a denied prior authorization (**prior to submission of claims**) at the request of a provider. The DVHA will conduct the following types of reviews if requested by the provider (**prior to submission of claim**):

- PA denial by the DVHA at the request of a provider
- Peer to Peer review with DVHA Physician
- PA denial about the “immediate need” for durable medical equipment
- PA denial because documentation was inadequate
- Purchase versus rental decisions for durable medical equipment

The DVHA will not review any decision other than those listed above. All request for the above reconsiderations must be faxed to 802.879.5963.

Prior Authorization Contact information:

DVHA Clinical Unit 802.879.5903
Fax 802.879.5963
Dental 802.879.5903

Prescription Drugs are reviewed by the Pharmacy Benefit Manager, Change Healthcare:

Change Healthcare Prescriber Help Desk	844.679.5363	7:30am - 6:30pm, M-F
	844.679.5366	after hours on call 24/7 365 day/year
Change Healthcare Pharmacy Help Desk	844.679.5362	24/7 365 day/year

All drugs and supplies requiring prior authorization can be identified on the Preferred Drug List (PDL) which can be found at <http://dvha.vermont.gov/for-providers/pharmacy>.

Some outpatient elective diagnostic imaging procedures require prior authorization; please see the Diagnostic Imaging Program Guidelines & list of radiology CPT codes requiring prior authorization located at <http://www.vtmedicaid.com/#/resources>.

Elective Diagnostic Outpatient High Tech Imaging:

eviCore Customer Service 888.693.3211
eviCore Fax 888.693.3210
Web based PA Requests <http://www.medsolutionsonline.com>

Fax forms can be obtained at <http://www.medsolutionsonline.com> or by calling eviCore (formerly MedSolutions) Customer Service 888.693.3211, 8a.m. to 9 p.m., Monday through Friday. Diagnostic Imaging Program Guidelines and a complete list of CPT codes requiring prior authorization can be accessed at <http://dvha.vermont.gov/for-providers/claims-processing-1>.

2.4 Medical Necessity

Vermont Medicaid only pays for items that are medically necessary. Per Medicaid Rule 7103, medically necessary is defined as health care services that are appropriate, in terms of type, amount, frequency, level, setting and duration to the member’s diagnosis or condition. Medically

necessary care must be consistent with generally accepted practice parameters as recognized by health care providers in the same or similar general specialty as typically treat or manage the diagnosis or condition and

- Help restore or maintain the member's health **-or-**
- Prevent deterioration or palliate the member's condition **-or-**
- Prevent the reasonably likely onset of a health problem or detect an incipient problem

Additionally, for EPSDT-eligible members, medically necessary includes a determination that a service is needed to achieve proper growth and development or prevent the onset or worsening of a health condition.

2.4.1 Medical Necessity Form (MNF)

A completed DVHA Medical Necessity Form (DVHA 60) is the preferred documentation for Home Respiratory Therapy programs, DME and certain prescribed medical supply items with a few exceptions. The ordering provider **must** complete the MNF and give a clean copy to the patient or to the DME supplier.

Submission of the form and any necessary information to clearly document medical need is all that is needed to make the request for prior authorization.

If the code/service requires prior authorization, the DME supplier will send the MNF and all pertinent information to the DVHA as a PA request.

Both the ordering providers and the DME vendor are required to keep legible copies of all information in the patient record per medical documentation rules.

The signature date on the MNF/order must be within 6 months (before or after) of the dispensing date (billed DOS) for all items except ostomy and urologic supplies. (The order on these supplies is good for one year).

Medical Necessity and other prior authorization forms are available at <http://dvha.vermont.gov/for-providers/forms-1>.

2.5 Utilization Review

The DVHA conducts numerous utilization management and review activities. Reviews are intended to assure that quality services are provided to members and that providers are using the program properly. The reviews are generally an examination of records, known as a desk audit, although they may also include an on-site visit from the DVHA staff.

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:

- Change Healthcare InterQual® Guidelines
- DVHA Clinical Guidelines
- Vermont State Medicaid Rules
- Hayes and Cochrane New Technology Assessments
- Other Nationally Recognized Evidence Based Criteria

Change Healthcare InterQual® Guidelines are available to providers on the Vermont Medicaid secure provider web portal at <https://www.vtmedicaid.com/secure/logon.do>. After log-in, look for the link **Change Healthcare Smart Sheets** on the left window. InterQual® Guidelines are updated annually.

DVHA Clinical Guidelines are available at the DVHA website at <http://dvha.vermont.gov/for-providers/clinical-coverage-guidelines>. Vermont Medicaid State Rules are available at <http://dvha.vermont.gov/budget-legislative>.

2.6 Prior Authorization Notice of Decision

The Notice of Decision (NOD) is a system-generated form that is sent to the requesting and supplying provider, and the beneficiary, in response to a Prior Authorization (PA) request.

The NOD contains the following information:

- Member Information: “The Department of Vermont Health Access has taken the following action on your request for medical services: ‘Approved’, ‘Denied’, or ‘Information’ (awaiting further information). Your request for service is: ‘Approved’, ‘Denied’, or ‘Information’. The dates of service are as follows: Start to be filled in as appropriate; Stop to be filled in as appropriate.”
- Box 2: The value will be either “A” (approved) or “D” (denied) or “I” (awaiting further information)
- Box 3: The dates of service
- Box 4: The revenue code, procedure code, NDC, or diagnosis
- Box 5: The number of units and/or occurrences
- A comments section with information specific to the authorization

2.7 Services Requiring Prior Authorization

All Vermont hospitals, including in-network border hospitals, are not required to submit faxed daily census sheets to the Department of Vermont Health Access (DVHA) Clinical Operations Unit (COU). Please note: Continue to use the File Transfer Protocol (FTP) for submitting information as required by other DVHA programs. This requirement only applies when Vermont Medicaid is the primary payer. This requirement does not apply to Inpatient Rehabilitation stays, psychiatric unit and psychiatric hospital admissions. In addition, notification of patient discharge is required.

2.7.1 Out-of-Network Elective Inpatient Hospital Admissions

(Excluding Designated Border Hospitals)

All elective inpatient admissions to out-of-network hospitals require prior authorization from the DVHA COU prior to admission. The admitting facility must fax a completed Vermont Medicaid Out of State Preadmission Form located at <http://dvha.vermont.gov/for-providers/clinical-coverage-guidelines>, clinical documentation, and an explanation as to why this care cannot be performed within the State of Vermont or at an in-network facility to fax number 802.879.5963. The prior authorization must be requested as early as possible and no less than 3 business days prior to the planned admission.

2.7.2 Out-of-Network Elective Outpatient Referrals

Prior authorization is required for referrals to out-of-network medical visits that are elective/non-emergency, for codes 99201-99215, 99381-99456, and 99341-99360; however, PA is not required for referrals for office visits to:

- Providers affiliated with Extended-network hospitals
- Providers affiliated with Out-of-state In-network hospitals

All other PA requirements will apply. A list of Green Mountain Care in-network and extended network hospitals is available at <http://dvha.vermont.gov/for-providers/green-mountain-care-network>.

Referring providers must submit requests using the OON Medical Office Request Form located at <http://dvha.vermont.gov/for-providers/clinical-coverage-guidelines>.

Fax all requests to the DVHA COU: 802.879.5963

Note: Only office visit(s) are being approved. Do not proceed with any non-emergent outpatient procedure until you have first determined and documented that the service cannot be performed by an in-network provider.

2.7.3 In-State & Out of State Psychiatric & Detoxification Inpatient Services

The Department of Vermont Health Access (DVHA) in collaboration with the Department of Mental Health (DMH) requires concurrent review for psychiatric and detoxification inpatient admissions. This includes all children and adults, including those enrolled in CRT. Admitting facilities must complete the Vermont Medicaid Admission Notification form for Inpatient Psychiatric and Detoxification Services and fax it to the DVHA at 855.275.1212 within 24 hours of an urgent or emergent admission. Elective or planned admissions will require prior authorization by the DVHA. The admitting facility must fax a completed Vermont Medicaid Prior Authorization form to 855.275.1212. Forms are available at: <http://dvha.vermont.gov/for-providers/clinical-prior-authorization-forms>.

2.7.4 Out-of-Network Urgent/Emergent Inpatient Hospital Admissions

(Excluding Designated Out-of-Network Hospitals)

All urgent and emergent inpatient admissions to out-of-network hospitals require notification to the DVHA Clinical Unit of the admission within 24 hours or the next business day. Concurrent review will begin at the time of notification and throughout the course of the inpatient hospital stay. The admitting hospital must fax a completed Out-Of-Network Urgent and Emergent Hospital Admissions form located at <http://dvha.vermont.gov/for-providers/clinical-coverage-guidelines> and clinical documentation to the DVHA at 802.879.5963. The hospital is required to notify the DVHA upon patient discharge.

2.7.5 Rehabilitative and Habilitative Therapy

Vermont Medicaid does not cover any treatments or any portions of a treatment, when the efficacy and/or safety of that treatment is not sufficiently supported in current, peer reviewed medical literature.

All treatment must demonstrate medical necessity.

Examples of treatment that do not have sufficient support in current medical literature at this time include, but are not limited to: sensory integration therapy, craniosacral therapy,

myofascial release therapy, visceral manipulation therapy, auditory integration training, and facilitated communication.

Treatment with goals related to leisure, sports, play, recreation, and avocation are not covered benefits because they do not meet the bar of medical necessity.

Treatment with goals related to vocation and education are not covered benefits because there are other resources for coverage, including the Department of Vocational Rehabilitation, Worker's Compensation, and the Department of Education.

Procedure Codes: Per National Correct Coding regulations, treatment must be billed under the most specific code. Billing a non-covered service under a less specific code in order to obtain coverage could constitute fraud and could expose the provider to recoupment and fraud investigation.

Diagnosis Codes: Per National Correct Coding regulations, treatment must be billed under the most specific code. "Unspecified" diagnosis codes must be avoided whenever possible. The primary diagnosis code submitted must be the code for the underlying condition driving the care plan. Other pertinent diagnoses, including "therapy diagnoses" can be included but cannot be listed as the primary diagnosis code. A list of diagnosis codes that are not covered as primary diagnoses is included in the DVHA Therapy guidelines, available at: <http://dvha.vermont.gov/providers/clinical-coverage-guidelines>

2.7.6 Obtaining SAME DAY coverage

If the beneficiary has been seen in the past for the condition, and 8 pediatric outpatient visits, 30 adult combined therapy outpatient visits, or 4 months of Home Health services have already been performed in the past, the current provider shall:

- See the beneficiary for the initial evaluation
- Contact the DVHA on the SAME DAY as the visit
- Submit documentation to request coverage WITHIN ONE BUSINESS DAY, to meet Prior Authorization requirements.

2.7.7 Adult Coverage

Outpatient Services: Physical, Occupational, and Speech Language Pathology (PT, OT, ST) outpatient services for Vermont Medicaid eligible adults are limited to 30 combined visits per calendar year.

Prior authorization for therapy visits beyond 30 combined visits in a calendar year may be requested for members with the following diagnoses: spinal cord injury, traumatic brain injury, stroke, amputation, or severe burn.

Changing programs or eligibility status within the calendar year does not reset the number of available visits. Limitations and prior authorization requirements do not apply when Medicare is the primary payer.

The limit does not apply to services provided in inpatient facilities or by home health agencies.

2.7.8 Members under age 21

Home Health Services: Pediatric Physical, Occupational, and Speech Language Pathology home health services are covered for up to 4 months based on a physician's order, for a medical

condition. Provision of therapy services beyond the initial 4-month period is subject to prior authorization.

Outpatient services: Eight therapy visits from the start of care date per diagnosis/condition for each therapy discipline are covered based on a physician's order. Provision of therapy services beyond the initial 8 visits is subject to prior authorization. Providers must request prior authorization in advance of the 8th visit if additional therapy services are necessary. Providers are required to determine the first date of treatment at any outpatient facility, regardless of coverage source. It is the responsibility of the therapist to track therapy visit/service history.

For members with a primary insurance, a prior authorization is not required if the primary insurer pays a portion of the claim. However, if the primary insurer denies the claim for being a non-covered service, if the primary insurance benefit has exhausted, or if the primary insurance was applied to the deductible, prior authorization is required for over 8 visits. If the primary insurance denies for lack of medical necessity, all levels of appeal are required before requesting prior authorization from Vermont Medicaid.

Per the Physical, Occupational and Speech Therapy guidelines posted at <http://dvha.vermont.gov/forproviders/clinical-coverage-guidelines>, therapy providers can bill a maximum of 4 units of timed therapy procedures codes treatment session. The 4-unit maximum is the combined total of timed units, not a per-procedure code limit. Evaluation, re-evaluation and other non-timed codes are not subject to the limit and may be billed in addition to the 4 timed codes during a single session. The code for wheelchair management, direct one-on-one patient contact, each 15 minutes is an exception and is excluded from the 4-unit limit.

Providers should refer to Medicaid Rule and Therapy Guidelines for additional information at <http://dvha.vermont.gov/for-providers/clinical-coverage-guidelines>

Authorization Requests: Therapists should utilize the DVHA Medicaid Request for Extension of Rehabilitation Therapy Services form. Be sure to include the original start of care date by any facility or provider, for the condition listed. The latest version of this form is available at: <http://dvha.vermont.gov/for-providers/forms-1>. Always use the most recent version of the form.

Physical, Occupational and Speech Therapists who choose to submit extension requests on forms other than the DVHA Therapy Extension Request form are strongly encouraged to use the new DVHA Cover Sheet, available at <http://dvha.vermont.gov/for-providers/forms-1>.

Use of this form with your alternative request documentation will ensure that DVHA receives the information required to process your prior authorization (PA) request. DVHA expects that the use of this form will speed the PA process.

2.7.9 Outpatient Therapy Modifiers

Vermont Medicaid follows Medicare's requirement that speech, occupational and physical therapists bill with modifier GN, GO or GP to identify the discipline of the plan of care under which the service is delivered.

- GN = Services delivered under an outpatient speech-language pathology plan of care
- GO = Services delivered under an outpatient occupational therapy plan of care
- GP = Services delivered under an outpatient physical therapy plan of care

Medicare provides a link to the list of applicable therapy procedure codes. This list is updated annually by CMS. Vermont Medicaid therapists need only reference the code list itself; do not use the column information.

<http://www.cms.gov/Medicare/Billing/TherapyServices/AnnualTherapyUpdate.html>.

All therapy services (including codes listed as “Sometimes Therapy”) that are performed by a therapist (and billed with the therapist as the attending) must be part of an outpatient therapy plan of care and the billing codes must use one of the above therapy modifiers to bill.

Some codes on this list are “Always Therapy” services regardless of who performs them. These services must be part of an outpatient therapy plan of care and the Billing codes must use one of the above therapy modifiers to bill.

Practitioners other than therapists must use these modifiers when performing listed services which are delivered under an outpatient therapy plan of care.

These modifiers are not to be used with codes that are not specified on the list of applicable therapy codes.

Modifiers may be reported in any order.

Prior Authorization Requests must give the exact codes and modifiers in the same order as they will be billed on the claim.

Section 3 Reimbursement, Billing Procedures and Claim Processing

DVHA does not arbitrarily deny or reduce the amount, duration or scope of a required covered service solely because of diagnosis, type of illness or condition of the member.

DVHA does not incentivize or provide rewards to employees, providers or contractors for denial of services or prior authorizations.

3.1 Denied Claims

The explanation of benefits (EOB) codes printed on the Remittance Advice (RA), explains the reason(s) why Vermont Medicaid claims are paid or denied. Full descriptions for each code are printed at the end of the RA.

EOB codes for denials, which pertain to the entire claim, are printed directly under the patient's name and the Internal Control Number (ICN) on the RA. Detail denials are printed under each billing detail on the RA. The RA contains up to ten header denials per claim and ten detail denials per billing line. Please review all areas of the claim before resubmitting directly to claims processing. If the reason for your denial is unclear, please contact the Provider Services Unit (In-state, 800.925.1706, Out-of-state, 802.878.7871).

3.2 Adjustments Requests

Adjustment requests may be submitted to DXC Technology when a claim is paid incorrectly. These requests can be initiated by the provider, DXC Technology or the DVHA. If the error originates with the provider, then the provider must submit the adjustment. When requesting an adjustment, submit an adjustment form. Give a brief description of the reason for the adjustment and the action required.

A new claim form with the correct information is required when changing the pay to, provider number, member number or funding source. Any request, which does not have the proper attachments, will be returned. If timely filing also applies, then attach a copy of the RA.

Denied claims cannot be submitted as adjustment requests. A claim that has been denied should be corrected and resubmitted with all attachments as a new claim.

Adjustments are the preferred method of correction because they eliminate the use of providers' personal checks for repayment of incorrectly processed claims. Adjustments also provide an accurate record of how the claim was processed.

Once a claim has been processed and placed in a PAID status, providers have one year from the original paid date to adjust claims that would result in a positive financial outcome for the provider.

Providers can request adjustments and recoupments to claims billed incorrectly that result in a negative financial outcome for the provider within three years of the original date of service; the entire claim will be recouped. Partial recoupment requests are to be submitted as refunds. If the claim is more than three years old, the provider must refund the overpayment by completing the refund form and attaching the refund check. The Vermont Medicaid Refund form is available on our website at <http://www.vtmedicaid.com/#/forms>.

3.2.1 Late Charges (Applies to UB-04 Hospital charges)

Late charges to the original paid claims must be submitted as adjustments. These adjustments must be submitted either using the DXC Technology paper adjustment form or electronically through the DXC Technology Provider Electronic Solutions (PES) Application. Paper claims with type of bill 117 (adjustment inpatient) or 137 (adjustment outpatient) will not be accepted.

For instructions on completing adjustments using DXC Technology's PES software, please visit <http://www.vtmedicaid.com/#/pes>.

Forms for completing single and multiple adjustments can be downloaded from <http://www.vtmedicaid.com/#/forms>.

3.3 Timely Filing

Below are the timely filing limitations.

Please note that one month equals 30 days on average, therefore 6 months equals 180 days.

- When Medicaid is the primary insurer providers have 6 months from the date of service to submit a claim
- When Medicare is the primary insurer providers have 6 months from Medicare's paid date to submit a claim or 6 months from Medicare's denied date to submit a claim
- When Other Insurance (excluding Medicare) is the primary insurer providers have 12 months from the date of service to submit a claim
- For an inpatient claim, providers have 6 months from the discharge date to submit a claim
- For global maternity and orthodontia claims, providers have 6 months from the date of service to submit a claim
- When a provider has been granted retro-enrollment (backdate) they have up to 12 months from the date of service, or an additional 45 days from the date of notice of enrollment, whichever is later, to submit a claim. The Medicaid Enrollment Backdate form is available on our website at <http://vtmedicaid.com/#/provEnrollDataMaint>
- When a recipient has been granted retro-eligibility providers have 12 months from the date of service to submit a claim
- Providers must request an adjustment to a PAID claim within 12 months from the original paid date when the adjustment would result in a positive financial outcome for the provider
- Providers may request an adjustment to a PAID claim within 3 years from the original date of service when the adjustment would result in a negative financial outcome for the provider. If the claim is more than 3 years old, the provider must refund the overpayment by completing the refund form and attaching the refund check. The Medicaid Refund form is available on our website at <http://www.vtmedicaid.com/#/forms>
- Providers have 6 months from the initial Medicaid denial to submit a corrected claim

- Providers have 3 months from the initial Medicaid timely filing denial to submit a timely filing reconsideration request. The Medicaid Timely Filing Reconsideration Request form is available on our website at <http://www.vtmedicaid.com/#/forms>

3.3.1 Timely Filing Reconsideration Requests

Providers can submit a timely filing reconsideration request within 3 months from the initial timely filing denial. Documentation to support the extenuating circumstance to override the timely filing denial must be submitted (e.g. account notes, emails, denials or other insurance correspondence). Please do not attach medical records with your timely filing reconsideration requests. Instead attach any account notes showing the follow-up actions that were taken resulting in the late submission. If the Agency of Human Services (AHS) feels that an extenuating circumstance justifies the override of the timely filing denial the AHS will approve the request. Understaffing, misplaced claims (including claims lost in the mail or not received electronically) or claims that have not been consistently followed up on are not examples of extenuating circumstances and the original denial will be upheld.

Providers that have been granted retro-enrollment must attach the enrollment approval letter to their claim(s).

Requests for review of untimely filing denials will be reviewed on a case-by-case basis. If the request is denied requesting additional information, the provider must resubmit a new timely filing reconsideration with the additional supporting documentation no later than 60 days from the date of the denial letter. Providers must also include a copy of the reconsideration denial letter to prevent unnecessary denials. Failure to respond within the time allotted will result in a final denial decision and no further review will be granted. If the denial is reversed, the claim will be processed for consideration on a future Remittance Advice. Please be aware that an approval for the timely filing request does not preclude the mandates for correct coding, prior authorization, supporting documentation or any claims processing requirements. Failure to complete forms correctly or attach the approval letter to the resubmitted claim **will** cause the claim to deny.

Providers submitting a timely filing reconsideration request for a single claim should use the “Timely Filing Reconsideration Form – Single Claim”. For reconsideration requests that contain more than one claim **for a single member**, providers should use the “Timely Filing Reconsideration Form – Single Patient Multiple Claims”. No more than 25 claims per member can be submitted per multiple claims request. Requests containing multiple members will be returned to the provider. Both forms are located at <http://www.vtmedicaid.com/#/forms>. Completion instructions are included with the form.

All Timely Filing Reconsideration Requests should be mailed to:

DXC Technology
Attn: Timely Filing
PO Box 888
Williston, VT 05495-0888

For non-timely filing reconsideration requests, please refer to Section 1.2.11, Provider Reconsideration Requests, in the Vermont Medicaid General Provider Manual.

<http://www.vtmedicaid.com/#/manuals>

3.4 Usual & Customary Rate (UCR)

Various claim forms (CMS-1500, UB-04 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 insured and self-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.

3.5 Incident-To Billing for Licensed Physicians

Incident-to billing is a way of billing for services in an office setting only, provided by a non-physician practitioner (NPP) whose provider type does not allow them to enroll with Vermont Medicaid. There is no incident-to billing in a facility. NPPs that are eligible to enroll in Vermont Medicaid must enroll and bill using their own provider number and cannot bill incident-to.

When NPPs who are not eligible for enrollment in Vermont Medicaid provide services that are incident-to a physician or other practitioner’s service, they may bill under the physician/practitioner’s Vermont Medicaid provider ID (NPI/Taxonomy) if they are employed by the billing provider (part-time, full-time, leased, contracted) and when the service are:

- An integral, although incidental, part of the professional services
- Commonly rendered without charge or included in the physician’s bill
- Of the type that is commonly furnished in physician offices or clinics
- Furnished by the physician or auxiliary personnel under the physician’s direct supervision

Documentation is critical for patient care and must clearly link the service to the clinically-supervising provider, including for example, co-signature and credentials of both practicing and clinically supervising provider and notation within the medical record of the clinically supervising provider’s involvement. Services billed in this manner may be subject to post payment review.

The billing/clinically supervising provider must:

- Be actively enrolled with Vermont Medicaid
- Have seen the patient first, made a diagnosis and created a plan of care
- Provide formal case oversight (documented one-on-one meetings to review the case)
- Be present in the office suite on site or immediately available within 15 minutes commute to provide assistance and direction throughout the time the service is performed

The service must:

- Be within the scope of practice of person providing the service;
- Follow the plan of care created by the billing/clinically supervising provider
- Be only for the diagnosis in the original plan of care
- If the patient requires a service for another diagnosis, the visit does not qualify for “incident-to” billing

- The billing/clinically supervising provider must see the patient to make a new diagnosis and create a plan of care before s/he can bill incident-to for a different diagnosis.

Incident-to billing is NOT Allowed if:

- It is a new patient visit
- It is an established patient with a new problem/diagnosis
- There is no clinically supervising provider present in the office suite and immediately available within 15 minutes

3.6 Supervised Billing for Behavioral Health Services

Supervised billing (formerly known as “Incident-To” billing) requirements as described below apply only to clinical services, and are not applicable to case management, specialized rehabilitation or Emergency Care and Assessment Services.

Health Care Administrative Rule 9.103 Supervised Billing and related rules can be found on the Agency of Human Services website at: <http://humanservices.vermont.gov/on-line-rules>.

Providers use of supervised billing practices are subject to the requirements of administrative rule. Information contained in rule will not be repeated in the provider manuals.

Individuals who have been on the roster that is maintained by the Office of Professional Regulation in the Office of the Secretary of State for more than five years after January 1, 2016 will no longer be eligible under Vermont Medicaid to provide clinical services.

3.6.1 Billable Services Provided by Supervised Non-Licensed Providers

Clinical services within the provider’s scope of practice, including:

- Diagnosis & Evaluation
- Individual Therapy
- Group Therapy
- Family Therapy
- Medical Evaluation/ Management
- Medication/ Psychotherapy

3.6.2 Procedures for Billing

1. Practices/Agencies must maintain documentation on unlicensed master’s level individuals providing clinical services that includes the following:
 - a. Name of rostered, unlicensed provider
 - b. Degree and discipline
 - c. Name of supervising provider
 - d. Status of license-eligibility:
 - i. License-eligible
 - ii. Rostered non-licensed and noncertified psychotherapists

- iii. Psychiatric Nurse Practitioners fulfilling 24 months and 2,400 hours of supervised practice.
 - iv. Addiction counselors fulfilling required hours of supervised work experience.
 - e. Date when individual was entered on the roster that is maintained by the Office of Professional Regulation in the Office of the Secretary of State, if applicable.
2. Supervising provider must use their unique provider number for services provided by unlicensed providers.
- a. For claims submitted to Vermont Medicaid, the following pricing modifiers must be used:

Modifier	Definition	Information
AH	Licensed Clinical Psychologist	<i>This modifier should <u>not</u> be used when the claim is for supervised billing.</i>
AJ	Licensed Clinical Social Worker	<i>This modifier should <u>not</u> be used when the claim is for supervised billing.</i>
HO	Master's Degree Level	<i>This modifier <u>is required</u> when the claim is for supervised billing when the non-enrolled provider that is rendering the service is "Master's Degree Level."</i>
HN	Bachelor's Degree Level	<i>This modifier <u>is required</u> when the claim is for supervised billing when the non-enrolled provider that is rendering the service is "Bachelor's Degree Level."</i>

- b. Effective 1/1/2019, for Designated Agencies and Specialized Service Agencies: For claims submitted to DMH fund sources, the modifiers in the above table are required unless billing to Eldercare, Reach Up, or Success Beyond Six.
3. In the event of a supervisor's short-term absence (e.g. vacation) where another licensed provider is providing supervision, the documented licensed supervisor should continue to be included on the claim as the provider using the appropriate modifier indicated above. Length of absence appropriate for this approach should be defined in provider's internal policy.
4. For neuropsychological testing, the supervising provider must conduct an initial face-to-face neurobehavioral status exam to determine the medical necessity for neuropsychological testing and the extent of such testing. Evaluations, including initial neurobehavioral status exam, administration of all tests, final report, and feedback session, if held, should be billed to Vermont Medicaid at the conclusion of the process on a single claim. The patient's record should include documentation of dates and times of face-to-face ongoing supervision to the unlicensed clinician. For other documentation requirements and best practice guidelines

please see Local Coverage Determination (LCD) *Psychological and Neuropsychological Testing (L31990)*.

NONCOMPLIANCE WITH POLICY

VERMONT MEDICAID CONTRACTED PROVIDERS MAY BE AUDITED REGARDING THESE REQUIREMENTS AND MAY BE REQUESTED TO REIMBURSE DVHA THE MONIES BILLED FOR THE NON-LICENSED PROFESSIONAL.

3.7 Locum Tenens

A Locum Tenens is a physician to “step in” for another provider that is on leave or has permanently left a practice. The Locum Tenens physician must be licensed in Vermont and be actively enrolled in Vermont Medicaid.

If a Locum Tenens physician is covering for a physician on leave, they are then allowed to use that physician’s NPI number for up to 60 days. Modifier Q6 (Service rendered by a Locum Tenens physician) should be used to show that the service was provided by a Locum Tenens physician. The Billing provider is 100% liable for all locum tenens billing.

3.8 Time-based Procedure Codes – Billing Guidelines

Please follow the below guidelines below when billing time-based procedure codes.

3.8.1 Critical Care Procedure Codes that are Time-based

- The billed units must reflect the actual time spent in face-to-face contact with the member in the home and/or on the way to the hospital.
- The duration of time to be reported by a physician is the actual time spent evaluating, managing and providing the critically ill or injured patient’s care. Services are not to be provided to any other patient. Your full attention is limited to the critically ill or injured patient’s care.
- In a facility setting, duration of time reflects time spent at the patient’s bedside or elsewhere on the floor or unit. You must be immediately available to the patient. More than one physician may bill for critical care services rendered to a patient during any billable period of time. Code 99292 may be reported alone when critical care is reported by another physician of the same group and specialty on the same date as another provider reporting 99291. Time counted toward critical care may be continuous clock time or intermittent aggregated time.
- Paper claims will be required if the number of units billed exceeds the allowed number of units. It is required that clear copies of the provider’s actual records be submitted with each claim. The number of units billed must be documented.
- The total number of minutes and date of service must be clearly written in the documentation and circled.
- Failure to clearly mark the number of minutes will result in claim denial.

3.8.2 All Other Time-based Procedure Codes

- The billed units must reflect the actual time spent.

- Paper claims will be required if the number of units billed exceeds the allowed number of units. It is required that clear copies of the provider's actual records be submitted with each claim. The number of units billed must be documented.
- The total number of minutes and date of service must be clearly written in the documentation and circled.
- Failure to clearly mark the number of minutes will result in denial of the claim.

3.9 Electronic Claim Submission

The State of Vermont and DXC Technology encourage the use of Electronic Claim Submission (ECS). ECS allows for efficient, reliable and economic transfer of claims between the provider's facility and DXC Technology. The same standards and conditions applicable to paper claims, with regard to accuracy and completeness also apply to claims submitted electronically.

ECS is fast, easy to use and eliminates time-extensive paperwork. ECS prevents most errors, allowing providers to submit "clean" claims the first time. Turn-around time for electronic claims is considerably faster than for paper claims. For information on available methods of electronic billing, please contact the Electronic Data Interchange (EDI) Coordinator at 802.879.4450, option 3 or send an email to vtedicoordinator@dx.com.

3.10 Electronic Funds Transfer (EFT)

Vermont Medicaid requires health care provider payments to be made through Electronic Funds Transmission (EFT), as stated in the Conditions of Participation of the Provider Enrollment Agreement/Recertification Agreement. Failure to do so may result in the suspension of payments.

EFT allows payment for "clean" claims within five business days. Funds are electronically deposited into a specified bank account, avoiding stop payments and reissues due to damaged or misplaced checks.

EFT has no effect on billing procedures but does apply to all claim types submitted. Providers are not required to submit claims electronically to receive direct deposits.

At time of enrollment, complete the Electronic Funds Transfer Request Form located on the Vermont Medicaid Portal at <http://www.vtmedicaid.com/#/provEnrollDataMaint>. This form is also used to facilitate a change or cancelation of EFT enrollment.

Select the above link to open the forms page of the Vermont Medicaid Web Portal; scroll down to Enrollment, click the Electronic Funds Transfer Request Form. Once opened, select "save as" from the file drop down menu and rename the document to save a copy to your PC. Open the saved Electronic Funds Transfer Request Form from your PC. Light blue fields indicate where text can be entered. Please remember to save the form whenever changes are made, complete all required sections and obtain the authorized signature.

One of the following documents must be attached to both new EFT enrollment and change enrollment requests for verification of account owner and account number: (1) voided check or (2) a signed letter from your bank that lists the account holder's name, and the appropriate financial institution's account and routing numbers.

Return your completed Electronic Funds Transfer Request Form by mail to:

DXC Technology
P.O. Box 888
Williston, VT 05495

-or-

Fax to 802.878.3440

Please direct all questions and EFT status requests to the DXC Technology Enrollment Unit at 802.879.4450 (option 4).

3.11 Claim Disposition Information Introduction

This section will assist providers in reviewing the status of each of their claims on the Remittance Advice (RA). It will also explain steps providers must follow to make adjustments or refunds on paid claims. A strong knowledge of these available resources and procedures will assist providers in maintaining accurate payment records.

3.12 Remittance Advice (RA)

The Remittance Advice (RA) is a computer-generated report provided by the fiscal agent. It indicates the status of all claims that have been submitted for processing. The RA is posted at <http://www.vtmedicaid.com/#/home> on a weekly basis, with your four most current RAs available. The banner page of the RA provides important information about policy and billing. See [Section 7](#), Sample Remittance Advice.

The Explanation of Benefits (EOB) codes printed on the RA explain the reason(s) why Vermont Medicaid claims are paid or denied. Full descriptions for each code are printed at the end of the RA.

EOB codes for denials that pertain to the entire claim are printed directly under the patient's name and the ICN on the RA. Detail denials are printed under each billing detail on the RA. Please review all areas of the claim before resubmitting directly to claims processing. If the reason for your denial is unclear, please contact the DXC Technology Provider Services Unit.

Providers that bill electronically will only receive electronic RAs. Please contact the EDI Department at DXC Technology if you are interested in submitting and receiving this information electronically.

3.12.1 RA Sections

The RA is divided into the following sections:

Paid Claims - All claims paid in the current cycle. EOB codes under the claim header and details indicate the reason(s) for the payment amount. There may be as many as ten EOB codes per header and per denial.

Denied Claims - All claims denied in the current cycle. EOB codes under the claim header and details indicate the reason(s) for the denial. There may be as many as ten EOBs per header and per detail.

Suspended Claims - Claims requiring manual review by either DXC Technology or the DVHA will be identified in this section prior to disposition. The purpose of this section is to inform the provider that DXC Technology has received the claim, and payment or denial will be forthcoming.

Adjusted Claims - Claims for which adjustments have been processed to correct information, overpayment, underpayment or payment to the wrong provider.

Financial Items - Financial transactions such as recoupments, manual payouts and TPL recoveries.

TPL & Medicare Information - Other insurance and Medicare information for members with related denials on the RA.

Earnings Data - This “Earnings Data” section of the RA is provided to show the current RA totals as well as cumulative year-to-date details.

Message Codes - Definitions of the EOB codes listed on the RA.

3.12.2 RA Headings & Descriptions

Recipient Name - Member name is listed in alphabetical order. The name appears in last name, first name format.

MID - The member’s Vermont Medicaid Identification Number also known as the UID.

ICN - Each claim and any attachments received by DXC Technology are assigned a unique identifying number called the Internal Control Number (ICN). This number is displayed in the third column on the RA. The fifteen-digit number aids in identifying, locating or researching the claim, either during or after processing.

The following summary describes what each number represents:

Digit	Description
1-2	Valid region code values for paper claims are: 10-Paper Claim without attachments. 11- Paper claim with attachments Valid region code values for ECS claims are: 40 - ECS The valid region code values for financial items are listed in the description of the financial items section
3-6	The year the claim was received at DXC Technology
7-9	Three digits indicating the Julian Date on which DXC Technology received the claim. These numbers correspond with the calendar dates; see the Appendix document. For example, 001 corresponds with January 1 and 365 correspond with December 31
10-15	The last six digits following the date are designed for DXC Technology control purposes. These numbers uniquely identify the claim and allow personnel to access the claim both manually and through the computer

HVER - The version number of the claim. The original claim paid for the services rendered is version 00. The first adjustment to any payment is version 01, etc.

PT ACCT/RX# - The patient account or medical record number is reported as it appeared on the claim.

BILLED AMT - The amount charged for the service.

ALLOWED AMT -The Vermont Medicaid allowed reimbursement.

OI AMT - The amount paid by another insurance for this claim or detail.

LIAB AMT - The amount for which the patient is responsible, excluding co-pay.

COPAY AMT - The co-payment amount related to the claim.

PAID AMT - The amount included in the payment for this claim.

HEADER MESSAGES - These numbers relate to the EOB codes printed under the header information. These numbers, which are referred to as EOB codes, indicate the reasons for payment or denial for the claim on the header level (top portion of the claim).

DNUM - The detail number.

DVER - The version of the detail. The original detail paid is version 00. The first adjustment to any payment is version 01, etc.

FDOS - The beginning date of service as it appears on the claim.

TDOS - The ending date of service as it appears on the claim.

PROC+MODS - The procedure code and corresponding modifiers as they appear on the claim.

QTY BLD - The number of units of service as it appears on the claim.

DETAIL MESSAGES - The numbers relate to the EOB codes printed under the detail information. These numbers indicate the reasons for payment or denial on the detail level of the claim.

ADJUSTED CLAIMS - This section of the RA includes detailed information on both the original and the adjusted claim. The original claim data is displayed first, followed by the adjusted claim data and an explanation of the effect the adjustment had on the original claim.

RECIPIENT NAME - Member name on the adjusted claim is listed in alphabetical order. The name appears in last name, first name format.

MID - The member's Vermont Medicaid identification number on the adjusted claim.

ICN - The internal control number of the adjusted claim.

HVER - The version number of the adjusted claim. The original claim paid for the services rendered is version 00. The first adjustment to any payment is version 01 etc.

PT ACCT/RX # -The patient account or medical record number is reported as it appeared on the adjusted claim.

BILLED AMT - The amount charged for the service on the adjusted claim.

ALLOWED AMT - The Vermont Medicaid allowed reimbursement on the adjusted claim.

OI AMT - The amount paid by another insurance for this claim or detail on the adjusted claim.

LIAB AMT - The amount for which the patient is responsible, excluding co-pay on the adjusted claim.

COPAY AMT - The co-payment amount related to the adjusted claim.

PAID AMT - The amount included in the payment for this adjusted claim.

HEADER MESSAGES - These numbers relate to the message codes printed under the header information. These numbers, which are referred to as EOBs, indicate the reasons for payment or denial for the claim on the header level (top portion of the claim).

DNUM - The detail number on the adjusted claim.

DVER - The version of the detail on the adjusted claim. The original detail paid is version 00. The first adjustment to any payment is version 01, etc.

FDOS - The beginning date-of-service as it appears on the adjusted claim.

TDOS - The ending date-of-service as it appears on the adjusted claim.

PROC+MODS - The procedure code and corresponding modifiers as they appear on the adjusted claim.

QTY BLD - The number of units of service as it appears on the adjusted claim.

DETAIL MESSAGES - These numbers relate to the message codes printed under the detail information. These numbers indicate the reasons for payment or denial on the detail level of the adjusted claim.

ADJUSTMENT REASON - A text field that explains why the adjustment took place.

NET ADJUSTMENT AMOUNT - This field indicates the net effect the adjustment had on the claim. The value is equal to the difference between the Original Claim Paid Amount and the Adjusted Paid Amount.

3.12.3 Financial Items

The “Financial Items” section of the RA is printed only when a financial activity other than claims adjudication takes place. Please refer to the sample “Financial Items” section of the RA in [Section 7](#), Sample Remittance Advice. The following summary describes the information in the “Financial Items” section:

CCN - The Cash Control Number of the financial transaction. The first two digits of the number indicate the type of financial transaction (i.e., system payout, recoupment, refund).

A/L NUMBER - The number assigned to the provider's ledger to account for the transaction.

MID - The member's ID number is shown if the financial transaction is related to a specific claim. When the transaction does not relate to a specific claim, this space is blank.

ICN - The Internal Control Number of the claim is shown if the financial transaction is related to a specific claim. When the transaction does not relate to a specific claim, this space is blank.

HVER - The version number of the related claim, if applicable.

DNUM - The detail number on the related claim, if applicable.

DVER - The detail version number of the claim, if applicable.

TXN DATE - This field indicates the date the transaction was entered and logged in the provider's account ledger.

ORIG AMT - The original amount to be exhausted by financial transactions.

TXN AMT - The dollar amount corresponding to the transaction. This is the actual amount of money included or withheld from the payment and applied to the original amount.

BAL AMT - The remaining balance to be exhausted by future financial cash transactions (amount still owed against the receivable or payable). This value is equal to the Original Amount less the Transaction Amount.

RSN CD - This field describes why the transaction was performed.

FINANCIAL ITEMS REASON CODE – The financial reason codes and their descriptions listed with any financial transactions on the RA.

TPL & MEDICARE INFORMATION - The TPL AND MEDICARE INFORMATION REPORT displays the members for whose claims denied for other insurance during the week. It is generated only when such transactions occur. The report lists only the insurance carrier that caused the claim to fail.

RECIPIENT NAME - The name of the member who had other insurance coverage for the denied claim.

ICN - The Internal Control Number assigned to each denied claim.

HVER - The header version number corresponds to the ICN and indicates the version of the claim. The original header has a version number of '00'. Subsequent version numbers (01, 02, etc.) are the result of adjustments made to the header.

DVER - The detail version number corresponds to the detail and indicates the version of the detail. The original detail has a version number of '00'. Subsequent version numbers (01, 02, etc.) are the result of adjustments made to the detail.

DNUM - The detail number corresponds to the ICN and indicates the detail of the claim.

OTHER INSURANCE - The name and address of the insurance carrier with whom the member has other insurance coverage.

CARRIER CODE - The carrier code of the insurance carrier listed above.

POLICY NAME - The name of the person who holds the insurance policy.

RELATIONSHIP DESCRIPTION - The relationship between the member and the policy holder.

POLICY - The policy number of the insurance policy that the member holds with the insurance carrier.

GROUP - The group number that the insurance policy falls under. This field is only populated if the member's insurance policy is a group policy.

MEDICARE - This field indicates the Medicare type. Possible values are 'PART A' and 'PART B'.

3.12.4 Earnings Data & Message Codes

The EARNINGS DATA AND MESSAGES CODES - displays the financial data for the current RA and year-to-date as well as the message codes that were listed with any claims (EOB codes) on the RA.

NUMBER OF CLAIMS PROCESSED (CURRENT) - The total number of claims processed during the past week. This figure includes all paid, denied, suspended, and adjusted claims appearing on the RA.

NUMBER OF CLAIMS PROCESSED (YTD) - The total number of claims processed this calendar year. This figure includes all paid, denied, suspended, and adjusted claims appearing on the RA; it is equal to the sum of the "Number of Claims Processed" fields on each RA year-to-date.

DOLLAR AMOUNT PROCESSED (CURRENT) - The dollar amount paid for claims processed during the past week.

DOLLAR AMOUNT PROCESSED (YTD) - The dollar amount paid for claims processed this calendar year. This figure is equal to the sum of the “Dollar Amount Processed” fields on each RA year-to-date.

SYSTEM PAYOUT AMOUNT (CURRENT) - The dollar amount paid out as a result of system generated financial transactions during the past week.

SYSTEM PAYOUT AMOUNT (YTD) - The dollar amount paid out as a result of system generated financial transactions for this calendar year. This figure is equal to the sum of the “System Payout Amount” fields on each RA year-to-date.

MANUAL PAYMENT AMOUNT (CURRENT) - The dollar amount paid out through manual checks during the past week.

MANUAL PAYMENT AMOUNT (YTD) - The total dollar amount paid out through manual checks for this calendar year. This figure is equal to the sum of the “Manual Payout Amount” fields on each RA year-to-date.

RECOUP AMOUNT WITHHELD (CURRENT) - The dollar amount withheld as a result of recoupment financial transactions during the past week.

RECOUP AMOUNT WITHHELD (YTD) - The dollar amount withheld as a result of recoupment financial transactions for this calendar year. This figure is equal to the sum of the “Recoup Amount Withheld” fields on each RA year-to-date.

PAYMENT AMOUNT (CURRENT) - The total dollar amount paid for paid claims, system or manual payouts, minus recoup amounts.

PAYMENT AMOUNT (YTD) - The total dollar amount paid for claims submitted and financial transactions incurred for the calendar year. This figure is equal to the sum of the “Payment Amount” fields on each RA year-to-date.

CREDIT ITEMS (CURRENT) - The dollar amount relating to any credit items for the past week. Credit items are all Vermont Medicaid void transactions, State void transactions, and refund transactions.

CREDIT ITEMS (YTD) - The total dollar amount relating to any credit items for the calendar year. Credit items are all Vermont Medicaid void transactions, State void transactions, and refund transactions.

NET ADJUSTMENT AMOUNT (CURRENT) - The total net adjustment amount from adjusted claims processing during the past week. This figure is equal to the sum of the “Net Adjustment Amount” fields located in the “Adjustments” section of the RA for each adjusted claim.

NET ADJUSTMENT AMOUNT (YTD) - The total net adjustment from adjusted claims processing for the calendar year. This figure is equal to the sum of the “Net Adjustment” fields for each RA year-to-date.

NET 1099 ADJUSTMENT (CURRENT) - The net 1099 adjustment incurred from financial transactions during the past week. This figure is equal to the net sum of all positive and negative 1099 transactions during the past week.

NET 1099 ADJUSTMENT (YTD) - The total net 1099 adjustment incurred from financial transactions for the calendar year. This figure is equal to the net sum of the “NET 1099 Adjustment” fields on each RA year-to-date.

COVERED DAYS INCLUDING NURSERY (CURRENT) - This field only applies to hospital claims. It indicates the total number of covered days (including nursery care) billed during the past week.

COVERED DAYS INCLUDING NURSERY (YTD) - This field only applies to hospital claims. It indicates the total number of covered days (including nursery care) billed during the calendar year.

NET EARNINGS (CURRENT) - The net earnings for the past week. This figure is calculated as follows:

Claims Paid Amount

- + System Payout Amount
- + Manual Payout Amount
- Recoup Amount Withheld
- Credit Items
- +/- Net 1099 Adjustment (may be positive or negative)
- = Net Earnings

NET EARNINGS (YTD) - The total net earnings for the calendar year. This figure is equal to the sum of all the Net Earnings fields on each RA year-to-date.

ELECTRONIC FUNDS TRANSFER STATEMENT – The dollar amount deposited electronically. This statement includes the account number into which the money was deposited as well as the date the deposit was sent to the provider’s bank.

MESSAGE CODES - The (EOB) codes displayed in other sections of the RA and a written explanation for each.

3.13 Refunds

In the event of a Vermont Medicaid overpayment, a refund check may be attached to a Vermont Medicaid “Refund Form” (<http://www.vtmedicaid.com/#/forms>) and sent to DXC Technology. The Refund Form requires providers to state the reason for the refund and to designate the claim or account against which it should be applied. Refunds will be reflected on the Financial Items page of the RA. The refund amounts will be deducted automatically from the YEAR-TO-DATE total.

When other health insurance payments are received after Vermont Medicaid payment has been made, the provider should refund to DXC Technology the lesser of the amount paid by the insurer or the Vermont Medicaid payment. Failure to do so may be criminally punishable as Medicaid fraud.

Check mailing address:

DXC Technology
P.O. Box 1645
Williston, VT 05495

Section 4 Billing Procedures CMS-1500 & UB-04 Claim Types

4.1 Abortions

Abortions are subject to the requirements of administrative rule. Information contained in rule will not be repeated in the provider manuals. See Health Care Administrative Rule 4.223 Abortion at: <http://humanservices.vermont.gov/on-line-rules>.

Induced abortions are billable only when the Abortion Certification Form has been submitted and approved by the appropriate funding source prior to the procedure being rendered. Forms can be found by clicking on the applicable Abortion Certification link at <http://dvha.vermont.gov/for-providers/forms-1>. The two funding source forms are described below.

1. Vermont Medicaid

Completion of form DVHA 219A is required for abortions performed if the pregnancy is a result of rape or incest, or when the mother's life is endangered by carrying the fetus to term. This consent form and the medical documentation of the situation must be sent to DXC Technology with each claim.

2. State Funds

Abortions considered medically necessary require the completion of Physician Certification form DVHA 219B and are paid by the Department for Children and Families (DCF) funding.

The form must be completed, signed and attached to the claim when submitted for processing.

Spontaneous and missed abortions completed surgically are billable under Vermont Medicaid with use of the appropriate procedure and diagnosis codes. A certification form is not required.

Vermont Medicaid does reimburse for abortions performed by Certified Nurse Midwives.

3. Abortion Diagnosis Codes

Unspecified abortion diagnosis codes will not be accepted by Vermont Medicaid. When billing, use a more specific abortion diagnosis code. Providers should refer to a current ICD-10-CM manual for the correct code.

4.2 Aids/HIV

Vermonters living with HIV infection who meet certain income guidelines may be eligible for help with Vermont Medicaid co-payments for treatment drugs through the Vermont Medication Assistance Program (VMAP) http://healthvermont.gov/prevent/aids/aids_index.aspx#Anchor-Th-57625.

Vermont residents not covered by Vermont Medicaid may be eligible for coverage of HIV medications, and/or for benefits. Application for this benefit may be obtained by writing to:

VMAP Coordinator

Department of Health-Vermont Medication Assistance Program (VMAP)

P.O. Box 70

Burlington, VT 05402

4.3 Organ Transplant

Vermont Medicaid covers organ transplantation services once the procedure is no longer considered experimental or investigational. Reimbursement will be made for medically necessary health care services provided to an eligible beneficiary or a live donor and for the harvesting, preservation, and transportation of cadaver organs. Post-transplant services for live organ donors are covered under the recipients Vermont Medicaid benefit and should be billed under the recipient's Vermont Medicaid ID as both the patient and the insured and include the date of birth.

4.3.1 Organ Transplant Donor Complication

The instructions below are only for billing donor complications related to the transplant surgery.

Institutional Electronic Claims for organ donor complications:

- Enter patient relationship code 18 in Form Locator 59 (Patient's Relation to Insured)
- Enter the Vermont Medicaid beneficiary's (organ recipient) information in Form Locators: 08 (Patient Name/Identifier), 09 (Patient Address), 10 (Patient Birth Date), and 11 (Patient Sex)
- Add a value of 39 along with the Donor's name to the 837I Loop 2300, Billing Note Segment NTE02 (NTE01 = ADD)
- Include Occurrence Code 36 (Date of Inpatient Hospital Discharge for covered transplant patients)

Paper UB-04 claims:

- Enter patient relationship code 39 in Form Locator 59 (Patient's Relation to Insured)
- Enter the Vermont Medicaid beneficiary (organ recipient) information in Form Locators: 08 (Patient Name/Identifier), 09 (Patient Address), 10 (Patient Birth Date), and 11 (Patient Sex)
- Enter the Donor's name Form Locator 80 (remarks)
- Include Occurrence Code 36 (Date of Inpatient Hospital Discharge for covered transplant patients);

Electronic Professional Claims:

- Enter the recipient's Vermont Medicaid number 2010BA Loop. Subscriber Name, NM1 Segment, Element 9
- Enter the recipient's name 2010BA Loop- Subscriber Name, NM1 Segment, Element 3-5
- Enter 39 and the Donor's Name and address 2300 Loop- Claim Note, NTE segment or 2400 Loop-Line Note, NTE segment

For Paper CMS-1500 claims:

- Enter the recipient's Vermont Medicaid number on Item 1A- Insured's I.D. Number
- Enter the recipient's name on Item 2- Patient's Name
- Enter 39 and the Donor's Name and Address on Item 19- Reserved for Local Use

4.4 CPT Category III Procedure Codes

Category III codes are non-covered because they represent “emerging technology, services and procedures”. These services are universally considered experimental or investigational and therefore not covered by Vermont Medicaid. Should a service/procedure represented by a Category III code become accepted medical practice, providers may send written documentation to the DVHA Clinical Operations Unit (fax: 802.879.5963) requesting a coverage review.

4.5 Factor HCPCS Codes

Factor HCPCS Codes are typically submitted through the pharmacy benefit (except in cases of emergency). Claims for services billed through the medical benefit require notes be included. All claims submitted for emergency room services are exempt from this requirement.

4.6 Fee Schedule

The Fee Schedule is published at <http://dvha.vermont.gov/for-providers/claims-processing-1> for providers to access current reimbursement rates on file for all procedure codes accepted by Vermont Medicaid. Other pertinent information includes pricing effective dates, whether the code requires a prior authorization and allowable provider types and specialties.

Services that are non-reimbursed by Vermont Medicaid are also identified. The PAC 8 (invalid codes) & 9 (non-covered) lists include all codes which are on file as “Do not pay”. It is imperative that providers reference this list prior to rendering services to ensure validity of specific procedure codes. When a procedure code is updated to a PAC 9 status, providers are notified 30 days prior to the change via banner.

4.7 Health Examination of Defined Subpopulation

DVHA will only accept diagnosis code Z02.89 (ICD-10) (Health examination of defined subpopulations) when it is billed as the primary diagnosis for the subpopulation “Refugees”. All other claims containing diagnosis code Z02.89 will be denied. Diagnosis code Z02.89 is acceptable billing for new refugees, but only when used for their first domestic health examination and related diagnostic tests; and when medically necessary for a follow-up visit. Each claim must indicate Z02.89 as the primary diagnosis and must contain the notation “Refugee – Initial Exam” or “Refugee – Second Visit”. All subsequent care must be billed with an appropriate medical diagnosis per standard billing practice.

4.8 Interpreter Services/Limited English Proficiency (LEP)

Providers are required under federal and State laws to provide interpreters for patients with limited English proficiency (LEP) and for those who are deaf or hard of hearing.

- Title VI of the Civil Rights Act of 1964
- Title VI regulations, prohibiting discrimination based on national origin
- Executive Order 13166 issued in 2000
- Vermont’s Patients’ Bill of Rights (18 VSA 1852)
- Vermont Public Accommodations (9 VSA 4502)

4.8.1 Informed Consent

The Vermont Patients' Bill of Rights provides that "the patient has the right to receive from the patients' physician information necessary to give informed consent prior to the start of any procedure or treatment." Additionally, failing to obtain informed consent may be a factor in medical malpractice litigation, although there are some exceptions. For the purposes of medical malpractice actions, "lack of informed consent" is defined as a failure to disclose to the patient reasonably foreseeable risks, benefits, and alternatives to the proposed treatment, in a manner permitting the patient to make a knowledgeable evaluation. In addition, patients are entitled to reasonable answers to specific questions about foreseeable risks and benefits. [12 V.S.A. § 1909] Using interpreters, translations services or other communication aids and services may be necessary to ensure that patients with LEP, who are deaf or hard-of-hearing receive appropriate information about the proposed treatment to enable them to give informed consent to treatment.

4.8.2 HIPAA

An interpreter or bilingual employee is covered under the health care operations exception for purposes of HIPAA, and the patient's written authorization to disclose protected health information is not required. Providers who utilize a private company for interpretation on an ongoing contractual basis should ensure that their contract conforms to the HIPAA Privacy Rule business associate agreement requirements. In other situations, with disclosures to family members, friends, or other persons identified by an individual as involved in his or her care, when the individual is present, the health care professional or facility may obtain the individual's agreement or reasonably infer, based on the exercise of professional judgment, that the individual does not object to the disclosure of protected health information to the interpreter.

4.8.3 Vermont Medicaid Billing

A provider who pays for interpreter services for Vermont Medicaid members may bill procedure code T1013 for each 15 minutes of paid interpreter services provided, on-site or via telephone. This may include interpreter service outside of the actual healthcare provider encounter in order to fill out forms or review information/instructions.

The provider may not bill Vermont Medicaid or the member for a missed appointment per federal policy.

Claims are submitted using the CMS 1500 claim form with HCPCS code T1013, with the exception that Home Health Agencies use the UB04 claim form with revenue code 940 with the HCPCS code T1013.

Claims for services provided to multiple recipients during the same group therapy session should be reported using T1013 on multiple claims with the appropriate modifier to indicate how many patients were served.

- The first claim should be reported with procedure code T1013 without a modifier and include the total number of units for all patients served within the group session as well as the charge amount for the total session.
- Additional claims should be reported with procedure code T1013 with one of the appropriate modifiers listed below with 1 unit and no charge amount.

Please see the example for further clarification.

Appropriate Modifiers on claims 2-6:

- UN – 2 patients served
- UP – 3 patients served
- UQ – 4 patients served
- UR – 5 patients served
- US – 6 or more patients served

Same Group Session for Multiple Recipients Example:

Member	Appt Time	Date of Service	HCPCS Code	Modifier	Charge	# of Units
Member 1	8:30 am to 9:55 am	1/1/2015	T1013		\$75.00	6
Member 2	8:30 am to 9:55 am	1/1/2015	T1013	UP	\$0.00	1
Member 3	8:30 am to 9:55 am	1/1/2015	T1013	UP	\$0.00	1

FQHC/RHC providers must bill T1013 for interpreter services using their non-FQHC/RHC provider numbers.

When a member receives services that are not eligible for reimbursement, the interpreter services are ineligible for reimbursement.

4.8.4 Limited English Proficiency (LEP) Resources

Organization: AT&T On Demand Interpreter (PHONE)

Web: www.att.com/interpreter

Organization: Voiance (PHONE)

Phone/Web: 866.743.9010 www.voiance.com

Organization: Language Line Services (PHONE)

Phone/Web: 877.866.3885 www.language.com

Organization: Vermont Refugee Resettlement Program (IN-PERSON)

Phone/Email: 802.655.1963 vrrp@uscrvt.org

4.8.5 Deaf and Hard of Hearing Resources

Organization: Language Services Associates (IN-PERSON)

Phone/Web: 800.305.9573 www.lsaweb.com

Organization: Vermont Interpreter Referral Service (IN-PERSON)

Phone/Web: 802.254.3920 www.virs.org

Organization: Registry of Interpreters for the Deaf

Phone/Web: 703.838.0030 www.rid.org

Vermont Agency of Human Services: In-house contract for interpretation services.

4.8.6 Additional Online Information

<http://www.vtmd.org/interpreter-issues-and-resources>

<http://www.aot.state.vt.us/civilrights/Documents/VermontTranslationServices-GeneralPublic.pdf>

4.9 Inpatient Newborn Services

Members may apply for a newborn ID for their child at the time of delivery using forms available at the facility or by application, at the Department for Children and Families (DCF) office. It is recommended providers wait for the child's ID number to be issued before billing Vermont Medicaid.

If the baby's MID is not yet available when the provider needs to bill, the mother's ID can be used only if the baby and mother are inpatient together for the duration of the stay, up to 7 consecutive days. The mother's inpatient delivery charge must be paid, or claim will deny. This information (of payment) can be verified through the Provider Services help desk at 800.925.1706 or 802.878.7871.

Example: Mother leaves hospital after three days and baby stays. The mother's ID can be used for the baby only those first three days; further claims for the baby must use the baby's ID.

Example: Both are hospitalized for more than seven days. Services for the baby on the eighth day and after must be billed using the baby's ID.

Since birthing room births are also billed as inpatient, the place of service would always be 21.

The following information is required on the CMS-1500 Claim Form:

Field Locator - Information

1a - Mother's Vermont Medicaid ID number

2 - Baby's name

Use the following name format to indicate twin and multiple-birth babies.

- ABaby
- BBaby
- CBaby

3 - Baby's date of birth

4 - Mother's name

6 - Check "child"

19 - Write "billing for baby under mother's ID number".

The following information is required on the **UB-04 Claim Form:**

Field Locator - Information

8b. - Baby's name

Use the following name format to indicate twin and multiple-birth babies.

- ABaby
- BBaby
- CBaby

10 - Baby's date of birth

58 - Mother's name

60 - Mother's ID number

80 - Write "Billing for baby under mother's ID number"

Option 2: The provider can wait for the child's permanent ID number to be issued.

4.10 Interrupted Psychiatric Stays and Rapid Re-admission

Psychiatric inpatient admissions are considered "interrupted" when a patient is admitted to a psychiatric floor in a general hospital, transferred to a medical floor within the same facility and transferred back to the psychiatric floor. These stays are considered continuous for the purpose of applying the variable per diem adjustment and is considered one continuous stay for payment.

Rapid re-admissions are authorized and billed in different ways to account for the days a member may be on a medical floor during a stay, days spent out of the hospital, or if a member discharges and then re-admits on the same day. When a member re-admits to a psychiatric floor of a different hospital within 3 midnights, DVHA Utilization Review (UR) clinicians review documentation to determine if the second admission should start at day 1 (new episode) or should continue as an extension of the first admission. This affects the rate of reimbursement for the second admission.

See the Vermont Medicaid Applied Behavior Analysis, Mental Health and Substance Abuse Services Supplement, Section 10, Interrupted Psychiatric Stays and Rapid Re-admission for additional information. <http://www.vtmedicaid.com/#/manuals>

4.11 Modifier 'LT' & 'RT'

Vermont Medicaid does not utilize the modifier combinations 'RTL' or 'LRTL' (right and left; bilateral). When Correct Coding allows one of these combinations on the base procedure code and the item is supplied bilaterally, the Vermont Medicaid provider must bill two separate line items: one with modifier RT on the base code and another line with modifier LT on the base code. The RT and LT modifier must appear first when used in combination with another modifier.

4.12 Place of Service (POS) Codes

POS codes are 2-digit codes placed on health care professional claims to indicate the setting in which a service was provided. CMS maintains the nationwide use of POS codes.

DVHA follows CMS POS instruction when determining the correct facility/non-facility reimbursement. As an entity covered under HIPAA, DVHA must comply with standards and implementation guides adopted by regulations for ASC X12N 837 electronic claim transactions. All electronic and paper CMS-1500 claim forms are required to include a POS code.

A POS Code reflects the actual place where the member receives the face-to-face service and determines whether the facility or non-facility rate is paid. The correct POS code ensures that reimbursement for the overhead portion of the payment is not paid incorrectly to the physician when the service is performed in a facility setting. POS assigned by the physician/practitioner is the setting in which the member received the technical component service.

Further information is included in these CMS publications: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/>
https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html

The list of settings where Professional services are paid at the **facility** rate:

Inpatient hospital (POS 21)	Skilled nursing facility (POS 31)	Psychiatry facility – partial hospitalization (POS 52)
Outpatient hospital (POS 22)	Hospice for inpatient care (POS 34)	Community mental health facility (POS 53)
Emergency room-hospital (POS 23)	Ambulance – Land (POS 41)	Psychiatric Residential Treatment Center (POS 56)
ASC for HCPCS on list of approved procedures (POS 24)	Ambulance – Air or water (POS 42)	Comprehensive Inpatient Rehabilitation Facility (POS 61)
Military treatment facility (POS 26)	Inpatient Psychiatry facility (POS 51)	Telemedicine (POS 02)

Professional services are paid at **non-facility** rates for procedures in the following settings:

School (POS 03)	Birthing Center (POS 25)	Comprehensive Outpatient Rehabilitation Facility (POS 62)
Office (POS 11)	Nursing facility (POS 32)	End-Stage Renal Disease Treatment Facility (POS 65)
Home or private residence (POS 12)	Custodial Care Facility (POS 33)	State or local Health Clinic (POS 71)
Assisted living facility (POS 13)	Federally Qualified Health Center (POS 50)	Rural Health Clinic (POS 72)
Mobile Unit (POS 15)	Intermediate Health Care Facility Developmentally disabled (54)	Independent Lab (POS 81)
Well Child Clinic (POS 17) (CMS Walk-in Retail Clinic)	Residential Substance Abuse Treatment Facility (POS 55)	Other Place of Service (POS 99)

4.13 Spend-Down

In some cases, eligibility is contingent upon the applicant having extraordinary expenses. In these cases, the applicant must first become responsible for a specific dollar amount for medical expenses during a six-month period. The actual amount is known as the “spend-down” amount as calculated by DCF. A spend-down member becomes eligible for Vermont Medicaid on the day of the month in which the incurred medical expense amount equals or exceeds the specified “spend-down” amount. When the member becomes eligible, all providers performing a service on that first day of eligibility will receive a Notice of Decision letter (ESD 220MP) from the district office. The letter explains that the spend-down amount has been met by the member, or that a portion of the provider’s bill remains the responsibility of the member. The provider must deduct the spend-down amount, if any, shown in the ESD 220MP prior to claim submission.

The following aid category codes indicate Notice of Decision (Spend Down) applies to services provided on the first day of a member’s eligibility: PA, PB, PC, PD, PP PR, P3, P4, P5, P6, P7 and P8.

When completing the UB-04 Claim Form involving spend-down, the provider must do the following:

1. Enter the spend-down amount shown on the Notice of Decision in field locator 54b. If there was a payment by a third-party insurance, add the other insurance payment and spend-down amount in field locator 54b.
2. Enter the spend down amount on the UB-04 Medicare Attachment Summary Form (MASF) for Medicare crossover claim types: X and W.
 - a. If no Other Insurance payment, check box for NO (6b) on MASF; the provider is to enter the spend down amount in the other insurance field on the MASF.
 - b. If there is an Other Insurance payment, check box for YES (6a) on MASF; the provider is to enter the total combined amount of the other insurance payment and the spend down in the other insurance field (6c) on the MASF.
3. Write “Spend-down deducted \$(amount)” in field locator 80, labeled Remarks. If any or the entire spend-down amount has been satisfied, write the applicable Internal Control Number (ICN) and the total spend-down amount met by the member.
4. Attach a copy of the Notice of Decision to the claim and submit to DXC Technology for processing. The Notice of Decision must be specific to the provider that is submitting the claim.

When submitting a CMS-1500 Claim Form involving spend-down, the provider must do the following:

1. Indicate “spend-down” and the amount in field locator 19. If any or the entire spend-down amount has been satisfied, write the applicable Internal Control Number (ICN) and the total spend-down amount met by the member.
2. Put your usual and customary charge in field locator 24f.
3. Total all of the charges appearing on the claim form and write the total amount in field locator 28.
4. Put the amount of the spend-down in field locator 29.

5. Enter the spend-down amount on the Medicare Attachment Summary Form (MASF) for Medicare crossover claim type: Y.
 - a. If no Other Insurance payment, check box for NO (1b) on MASF; the provider is to enter the spend-down amount in the other insurance field on the MASF.
 - b. If there is an Other Insurance payment, check box for YES (1a) on MASF; the provider is to enter the total combined amount of the other insurance payment and the spend down in the other insurance field (1c) on the MASF.
6. Attach a copy of the Notice of Decision to the claim and submit to DXC Technology for processing.

4.14 Long Acting Reversible Contraceptives Provided in an Inpatient Hospital Post-Partum Setting

Vermont unintended pregnancy rate is 47%. Through the Vermont Department of Health, Long Acting-Reversible Contraceptives (LARC) utilization is being promoted as an efficient means to eliminate unplanned pregnancy. Women facing an unplanned pregnancy are at greater risk for a number of social, economic and health problems.

Effective dates of service with a discharge date of January 1, 2016 or after, when a LARC is provided in an inpatient hospital setting, post-partum, providers must submit claims utilizing the appropriate code from each category listed in the below table. The claim will adjudicate and a LARC add-on payment of \$200.00 will be made in addition to the diagnosis-related group (DRG) portion.

ICD-10-PCS Inpatient Procedure Codes	ICD- 10-CM Diagnosis Codes
0UH97HZ	Z30.014
0UH98HZ	Z30.430
0UHC7HZ	
0UHC8HZ	
0UL74CZ	
0UL74DZ	
0UL74ZZ	
0UL78DZ	
0UL78ZZ	

Section 5 CMS-1500 Claim Submissions

This section contains billing information and instruction specific to the CMS-1500 Claim Form used to bill physician and other specified practitioner services, providers include: audiologists, chiropractors, dentists, naturopathic physicians, nurse practitioners, podiatrists, psychologists, and transportation (emergency and non-emergency) providers.

An alphabetical list of billable services is located in the following section. The billable services under the Vermont Medicaid programs are too numerous to list in their entirety; therefore, only a selection of services is noted in detail.

5.1 Payment DVHA Primary

The DVHA uses the CMS Common Procedure Coding System to describe reimbursable items. Certain reimbursable services require prior authorization. For complete details and a list of codes that require prior authorization, see the Fee Schedule available at <http://www.vtmedicaid.com/#/manuals>.

Vermont Medicaid reimbursement policy for the various CMS-1500 billers is as follows:

Ambulance Services - Reimbursement basis is the lower of the provider's charge or Vermont Medicaid rate on file. The unit of service is the loaded mile, see [Section 5.3.2](#), Ambulance Services.

Anesthesia Assistants - Reimbursement basis is 100% of the Vermont Medicaid rate on file.

Audiologist - Reimbursement basis is the lower of the provider's charge or Vermont Medicaid rate on file. The unit of service is the procedure.

Chiropractor - Reimbursement basis is the lower of the provider's charge or Vermont Medicaid rate on file. For additional Chiropractic information, see [Section 5.3.10](#), Chiropractic Services.

Certified Nurse-Midwife - Reimbursement basis is 100% of the Vermont Medicaid rate on file.

CRNA - Reimbursement basis is 100% of the Vermont Medicaid rate on file.

Dental Hygienist - Reimbursement basis for CPT procedures is the lower of the provider's charge or the Vermont Medicaid rate on file when billing on a CMS-1500 Claim Form. All other billings are on the ADA Dental Claim Form.

See the Vermont Medicaid Dental Supplement: <http://www.vtmedicaid.com/#/manuals>

Dentist - Reimbursement basis for CPT procedures is the lower of the provider's charge or the Vermont Medicaid rate on file when billing on a CMS-1500 Claim Form. All other billings are on the ADA Dental Claim Form.

See the Vermont Medicaid Dental Supplement: <http://www.vtmedicaid.com/#/manuals>

Federally Qualified Health Center:

Primary Care - Reimbursement is on interim, cost-based encounter rates determined using Medicare principles and receiving the higher of encounter cost of PPS payment at the final cost settlement at year's end. There is an upper limit to the encounter rate when applicable.

Dental Services - Reimbursement is fee-for-service with a cost settlement at year's end.

Independent Lab - Reimbursement basis is the lower of the provider's actual charge or the Vermont Medicaid rate on file not to exceed the Medicare maximum allowable amount. There is no cost settlement.

Independent Radiology - Reimbursement basis is the lower of the provider's actual charge for the Vermont Medicaid rate on file not to exceed the Medicare maximum allowable amount. There is no cost settlement. For additional Radiology information, see the CMS-1500 Manual.

International Board-Certified Lactation Consultants (IBCLCs) - Effective June 1, 2018, in-home lactation consulting services provided by International Board-Certified Lactation Consultants (IBCLCs) will be covered by Vermont Medicaid. IBCLCs must be licensed and enrolled Vermont Medicaid providers and hold an IBCLC certificate. Provider enrollment in Vermont Medicaid may take up to 60 days. Eligible IBCLCs may begin enrolling prior to the June 1st effective date but will not be able to bill for services prior to that date.

Licensed Lay Midwife - Reimbursement basis is the lower of the provider's charge or ninety percent (90%) of the Vermont Medicaid rate on file for a physician providing the same service. Reimbursement is limited to certain procedure codes.

Naturopathic Physicians - Reimbursement basis is the lower of the provider's charge or Vermont Medicaid rate on file.

Nurse Practitioner - Reimbursement basis is the lower of the provider's charge or ninety percent (90%) of the Vermont Medicaid rate on file for a physician providing the same service. The unit of service is the procedure.

Optician - Reimbursement basis is the lower of the provider's charge or Vermont Medicaid rate on file. The unit of service is the procedure.

Optometrist - Reimbursement basis is the lower of the provider's charge or Vermont Medicaid rate on file. The unit of service is the procedure.

Physician:

Attending Physician - Reimbursement basis is the lower of the provider's charge or Vermont Medicaid rate on file. The unit of service is the CPT procedure.

Anesthesiologist - Reimbursement basis is the lower of the provider's charge or Vermont Medicaid rate on file for the procedure. The unit of service is 1 unit equals 1 minute.

Assistant Surgeon - Reimbursement is 25% of allowed amount paid to surgeons. Reimbursement is limited to certain surgical procedures needing assistance.

Pathologists - Reimbursement will be made in accordance with Medicare's *Medigram 83-11* and subsequent *Medigrams*. The unit of service is the CPT procedure.

Psychiatry - Reimbursement basis is the lower of the provider's charge or Vermont Medicaid rate on file. The unit of service is per visit or for time elapsed.

Surgeons - Reimbursement basis is the lower of the provider's charges or the Vermont Medicaid rate on file. The unit of service is the surgical procedure.

Physician Assistant - Reimbursement basis is the lower of the provider's charge or ninety percent (90%) of the Vermont Medicaid rate on file for a physician providing the same service. The unit of service is the procedure.

Podiatrist - Reimbursement basis is the lower of the provider's charge or Vermont Medicaid rate on file. The unit of service is the procedure.

Psychological Services - see [Section 5.3.47](#), Psychiatry/Psychology

Rural Health Clinic:

Primary Care - Reimbursement is on interim, cost-based encounter rates determined using Medicare principles and a final cost settlement at year's end. There is an upper limit to the encounter rate when applicable.

Dental Services - Reimbursement is fee-for-service with a cost settlement at year's end.

Other Ambulatory Services - Reimbursement is Vermont Medicaid fee-for-service rate on file.

5.2 Non-Reimbursable Services

No payment will be made for a service or item that is not eligible for reimbursement, unless authorized by the DVHA for reimbursement via section 7104 of Medicaid rules. These authorizations may be made only when serious detrimental health consequences would arise. Any member interested in applying, may contact the **Green Mountain Care** Member Services Unit for the required forms.

5.3 CMS-1500 Claim Type – Billing Information

5.3.1 Alcohol/Drug Detoxification Treatment

Physicians and Alcohol & Drug Abuse Programs (ADAP) provide services for inpatient alcohol/drug detoxification and are payable when provided within the geographical limits of the state. Treatment facilities outside the state that wish to bill the DVHA, including designated border facilities, must receive prior authorization. A request for prior authorization must be made by or on behalf of the referring or admitting physician. No telephone authorizations will be granted.

ADAP providers must bill services using their ADAP NPI (with taxonomy code when applicable) as the attending number, as well as continue to put the ADAP NPI number in field locator 33a.

5.3.2 Ambulance Services

All the following conditions must be met before reimbursement will be made:

1. The ambulance service must be certified for participation in Medicare.
2. A physician or nurse must order ambulance transport and certify it as medically necessary (any other mode of transport would have endangered the health of the member).
3. The member is transported to the nearest appropriate facility.

5.3.2.1 Vermont Medicaid is the Payer of Last Resort

All other insurances, Medicare and town or city government must be billed prior to submitting a claim to Vermont Medicaid.

The completed claim must show the total loaded miles, i.e. the full number of miles the member was on board/transported.

Mileage must be rounded to the nearest whole number. When the digit following the decimal point is 0, 1, 2, 3, or 4, round down [keep the digit(s) before the decimal point and drop the digits

following the decimal point]. When the digit is 5, 6, 7, 8, or 9, round up by one number. Examples: 36.3 miles becomes 36 miles; 36.5 miles becomes 37 miles.

Other services incidental to the member’s condition such as disposable supplies, oxygen, tolls and ferry expense are reimbursed when detailed on the claim. The invoice or receipt must be attached.

Ambulance providers must enter their own NPI in field locator 24j for each procedure code. The ambulance provider NPI must also be entered in field locator 33a with the provider name and address.

Basic/base rates include all procedures (e.g. administration of medications, application of splints). The DVHA does not accept the modifiers utilized by Medicare. Air mileage is no longer included within the ambulance service code and may be billed out separately.

Some service may be covered under Non–Emergency Transportation (NEMT), [Section 5.3.40](#).

<u>SERVICE FROM</u>	<u>SERVICE TO</u>	<u>ALLOWED</u>
1. Member’s Home or Nursing Home	Hospital, inpatient admission	Yes
2. Hospital or Nursing Home or Discharged As Inpatient	Home, inpatient admission to another hospital, nursing home	Yes
3. Home or Nursing Home	Hospital and return for specialized diagnostic or therapeutic services (not simple follow-up visits)	Yes
4. Inpatient Hospital Status	Another hospital and return for specialized diagnostic or therapeutic services not available at first hospital	No*
5. Scene of Accident	Hospital for emergency room or inpatient admission	Yes
6. Home or Nursing Home	Hospital based renal dialysis facility & return	Yes
7. Home or Nursing Home	Physician’s office**	Yes
8. Physician’s Office	Home or nursing home**	Yes
9. Home or Hospital	VT Respite House	Yes

*This service is paid for by the hospital where trip originates.

**Must be medically necessary, requires a Physician Certification Statement (PCS).

Vermont Medicaid does not reimburse for miles accumulated when the member is not on board, or for waiting time.

5.3.2.2 Physician Certification

Ambulance providers are required to keep a completed Certification of Medical Necessity (CMN) in every Vermont Medicaid members file substantiating each claim submitted for payment. A physician, a registered nurse or a licensed practical nurse must sign this CMN. If the Medicare CMN form is used, the origin and destination must be written on the form.

Physicians are reminded that they are certifying “other methods of transportation are medically contraindicated” or “means of transportation other than ambulance would endanger the member’s health.” Since Vermont Medicaid pays for other forms of transportation (e.g., taxi, bus) to and from medically necessary services, members are able to access health care with no personal expense. Both the Vermont Medicaid program and Vermont ambulance service providers ask physicians to order and certify only those trips that are medically necessary, and to expedite their handling and return of the forms to the ambulance service.

A copy of the ambulance CMN form is required to be sent in with claims for non-emergency transport services for chemotherapy, dialysis and radiation treatment/services. The certification must state why other means of transportation were not acceptable. A CMN is not required with claims for emergency transport.

See [Section 5.3.40](#), Non-Emergency Medical Transportation (NEMT) for information regarding transportation for eligible members to and from medically necessary medical services that are Vermont Medicaid billable.

5.3.3 Anesthesia

Payment is provided for anesthesia administered by an anesthesiologist, certified registered nurse anesthetist (CRNA) or anesthesia assistant that remains in constant attendance during the surgical procedure, for the sole purpose of providing the anesthesia service. Payment is not reimbursable for the operating physician when billing for the administration of anesthesia. The administration of anesthesia by the operating M.D. is included in the reimbursement for the surgery.

Medical Direction of Anesthesia: When services are performed by non-physician anesthetists and medically directed by the physician anesthesiologist, reimbursement may be made to the physician for medical direction of the anesthetist. In order to be reimbursed for medical direction, the physician must:

- Direct no more than four concurrent anesthesia procedures
- Be physically present in the operating suite and available for immediate diagnosis and treatment of emergencies
- Perform a pre-anesthetic examination and evaluation
- Prescribe the anesthesia plan
- Personally participate in the most demanding procedures in the anesthesia plan, including induction and emergent
- Monitor the course of anesthesia administered at frequent intervals
- Ensure that a qualified individual performs any procedures in the anesthesia plan that is not done by the physician

- Provide indicated post-anesthesia care

Oral surgery billed on a CMS-1500 using CPT coding is subject to the same rules as a physician. The fee for anesthesia provided during oral surgery by the operating physician or dentist is included within the payment for the surgical procedure. This is different from payments for dentistry. See: Oral Surgery

5.3.3.1 Allowable Modifiers

Billable by the Anesthesiologist

- AA-Services performed by an Anesthesiologist not medically directing
- QY-Medical direction of one case
- QK-Medical direction of 2, 3 or 4 cases
- AD-More than 4 cases (This change in current Vermont Medicaid policy follows Medicare's reduction in base units from 4 to 3 for this modifier)

5.3.3.2 Billable by the CRNA or Anesthesia Assistant

- QX-Service with medical direction by Anesthesiologist

5.3.3.3 Billable by the CRNA only

- QZ-Service without medical direction by Anesthesiologist

5.3.3.4 Billable by the CRNA or Physician

- QS-Monitored anesthesiology care services
- The QS modifier is for informational purposes. Providers must report actual anesthesia time on the claim.

All anesthesia codes must be billed with the appropriate modifier. Reimbursement may be extended to the services of more than one anesthesiologist when written justification is attached to the claim with a copy of the operative report and the anesthesia record.

5.3.3.5 Epidural Catheter-Pain Management

In keeping with Medicare policy, the DVHA cannot pay either spinal cord catheter introduction or pain management on the same date as surgery and/or general anesthesia. Spinal catheter introduction and pain management is included within the surgical and anesthetic reimbursements. Daily management of epidural or subarachnoid drug administration is payable only after the day on which the catheter was introduced.

5.3.3.6 Units of Service

Anesthesia services (procedure codes which begin with zero in the CPT) are required to bill units in actual time spent in minutes. For example, one unit equals one minute of actual time spent in attendance. A limit of 600 units (10 hours) has been imposed on all anesthesia codes, with the exception for CPT codes 00211 and 00567 the unit limit is 480, and CPT code 01967 the unit limit is 360. 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), except for code 01967 for which the unit cap is set.

The DVHA payment methodology for anesthesia services is the lower of the actual charge or the Vermont Medicaid rate on file. Under Level III PAC A pricing is the Medicare payment formula of (units of service + base unit) multiplied by a conversion factor. The units of service billed are based on Medicare billing requirements. The base unit values used by DVHA are those put in place by Medicare effective January 1, 2012. For ongoing updates, the DVHA will follow Medicare's update schedule each January 1.

Time begins when the anesthesiologist/CRNA prepares the member for the introduction of anesthesia and ends when the anesthesiologist/CRNA is no longer in constant attendance. Included within the scope of this payment are pre and post-operative visits, the administration of anesthetic, and the administration of any fluid or blood incident to the anesthesia or surgery.

5.3.3.7 *Local Anesthesia*

Reimbursement for local anesthetic is included in the reimbursement for the procedure. Local anesthesia is never reimbursed as a separate service. This includes Novocain or topical anesthesia used by dentists.

5.3.3.8 *Monitoring Services*

The services of an anesthesiologist required to monitor the member during surgery performed under local anesthesia are reimbursable. A narrative justification for the service must accompany the claim.

5.3.3.9 *Spinal Injection/Nerve Block*

Nerve blocks performed concurrent with surgery or on the same date of service as surgery are reimbursed as part of the surgical code payment and are not to be billed separately.

When a spinal injection or nerve block is performed as an independent procedure for diagnostic or therapeutic reasons (not concurrent with surgery), and the code is covered by Vermont Medicaid, it is billed as the surgical procedure. The physician, regardless of specialty (e.g. anesthesiologist, surgeon, etc.) must bill on a CMS-1500 claim form using the specific procedure code for the type of nerve block performed. A unit of service is not time expended: one nerve block equals one unit of service. Please refer to the Fee Schedule for covered codes.

5.3.3.10 *Pre-Surgical Examination*

Pre-surgical examination is reimbursable as part of the surgical procedure code payment. Only when the surgery is cancelled will the pre-surgical examination be reimbursed as a separate service.

5.3.4 *Antineoplastic Drugs*

Antineoplastic drugs or agents necessary in the treatment of malignant diseases are reimbursed by Vermont Medicaid and are to be billed by the physician/physician group only when the physician/physician group has purchased the drug. Only drugs administered by parenteral infusion, perfusion and intracavity means will be paid. Reimbursement follows Medicare or by invoice. Use the appropriate HCPCS J----code and NDC. For the administration of antineoplastic agents in the office or physician-based clinic, see procedure codes in the 964-- section of the CPT manual. The appropriate-level evaluation and management procedure code for the visit may also be billed.

5.3.5 Assistant Surgeon

Reimbursement of services is limited to the Medicare list of procedures requiring an assistant. It is further limited to one assistant surgeon during an operative session. An assistant surgeon is reimbursed at 25% of the allowed amount paid to the primary surgeon for the procedure. Only one of the assistant surgeon modifiers is allowed to be billed with a procedure code since each modifier indicates a different provider type and/or situation.

Use the appropriate modifier with the surgical code when billing for assistant surgeons:

- 80 - Assistant Surgeon (For physicians; not intended for Physician Assistants, Nurse Practitioners, etc.)
- 81 - Minimum Assistant Surgeon (Used when assistance required is minimal or for only a portion of the surgery) (For physicians; not intended for Physician Assistants, Nurse Practitioners, etc.)
- 82 - Assistant Surgeon (when qualified resident surgeon not available) (For physicians; not intended for Physician Assistants, Nurse Practitioners, etc.)
- AS - Physician Assistant (PA), Nurse Practitioner (NP), or Clinical Nurse Specialist (CNS) for assistant at surgery

Many procedure codes do not require an assistant surgeon and therefore, Vermont Medicaid will not reimburse for the service. Assistant surgeon services are not to be billed in cases of co-surgery. In the case of co-surgery, each provider should bill on paper with the appropriate procedure code with the appropriate modifier (not 80, 81, 82, AS) and attach all related operative notes.

5.3.6 Audiological Services/Hearing Aids

Health Care Administrative Rule 4.213 Audiology Services can be found on the Agency of Human Services website at: <http://humanservices.vermont.gov/on-line-rules>. Audiology services are subject to the requirements of administrative rule. Information contained in rule will not be repeated in the provider manuals.

5.3.6.1 Batteries

12 batteries per month/per side for Clear in Canal (CIC) and Contralateral Routing of Signals (CROS) and BiCROS. A completed *Medical Necessity Form* (MNF) substantiating the medical need for the hearing aid must be kept on file for auditing purposes. For all other hearing aid types, it remains 6 batteries per month.

5.3.6.2 Hearing Aid Repairs

Prior authorization is required if a second repair/modification is needed within 365 days of a previous repair or any repair in excess of \$100. The cost of repairs/modifications should be less than 50% of the cost of replacing the aid. Repairs must never be billed on hearing aids that are still under warranty (new or repair/replacement).

Digital Hearing Aids using codes V5170, V5180, V5210, V5220, V5254, V5255, V5256, V5257, V5258, V5259, V5260 and V5261 allow modifier "TJ" (child and/or adolescent). The "TJ" modifier triggers a higher allowed amount to cover more sophisticated programming capability when

medically necessary. For monaural codes, “TJ” will be the second modifier because modifier RT and LT must be given first (e.g. V5255RT/TJ).

5.3.7 Bilateral Procedures Physician/Professional Billing

When bilateral surgical procedures are performed during the same operative session, and the CPT code’s description does not already state “bilateral”, bill the CPT code only once using modifier 50 and bill one unit only. The system will allow one 150% payment.

Modifier 50 is not to be used on claims submitted for bilateral radiology services.

5.3.8 Capsule Endoscopy (Esophagus through Ileum)

Capsule Endoscopy is a reimbursable service by Vermont Medicaid and requires prior authorization from the DVHA. The cost of the capsule and the physician fee are included in the payment. This procedure code should be billed as one unit and includes a global follow-up care period of 90 days post-procedure. Providers should obtain prior authorization before scheduling the procedure.

Capsule endoscopy of only the esophagus is not covered.

5.3.9 Children with Special Health Needs Infant Toddler Programs

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

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.

5.3.10 Chiropractic Services

Health Care Administrative Rule 4.220 Chiropractic Services can be found on the Agency of Human Services website at: <http://humanservices.vermont.gov/on-line-rules>. Chiropractic Services are subject to the requirements of administrative rule. Information contained in rule will not be repeated in the provider manuals.

5.3.11 Consultation

A consultation includes those services provided by a physician whose opinion or advice is requested by the attending physician in the evaluation or treatment of a member’s illness or condition. A consultation may occur in any location or setting. A consultation must include a written report to the referring physician and must be available to Vermont Medicaid upon request. A consultation code is valid for a pre-op exam only when the surgeon is not the member’s primary physician and is assessing the need for surgery. In such a case, the billed diagnosis must indicate the medical condition, not the pre-op Z-code.

When the surgery is already scheduled, the physician who performs the pre-op (history and physical) is to bill the appropriate E & M code, not a consultation code. Consultation codes will be denied when the diagnosis or other information indicates the service was a pre-op exam.

To bill for a consultation service, use the CMS-1500 claim form, and refer to the CPT manual for procedure codes and definitions. All initial consults are limited to one per member per diagnosis. The NPI number of the referring physician is mandatory in field locator 17b when billing a consultation code.

5.3.12 Detail Processing

Each line on the CMS-1500 claim form is called a “detail” and is processed individually. All of the details on a claim form have the same Internal Control Number (ICN). However, each detail has its own sequence number that is listed on the remittance advice right after the claim’s ICN. Individual processing means that one detail from a claim may appear on the remittance advice in the Paid Claims section while another detail from the same claim may appear in the Suspended and/or Denied Claims section. This type of processing allows each detail to be processed individually. No detail is delayed by the processing of another detail.

5.3.13 Developmental & Autism Screening of Young Children

See the developmental and Behavioral Screening Guidelines and Preferred Tool List for additional information. <http://dvha.vermont.gov/for-providers/developmental-screening-for-young-children>

The American Academy of Pediatrics recommends that all infants and young children be screened with valid, reliable screening instruments for developmental delays at regular intervals. To improve detection rates through the use of standardized screening instruments by primary care providers, the DVHA will reimburse for a developmental screening (CPT 96110) with a standardized screening tool to be billed on the same day as a well-child visit or other E & M codes.

All infants or young children should have a general periodic developmental screening at the 9th, 18th, 24th or 30th month well child visits. Developmental screening is recommended when surveillance indicates an infant or young child may be at risk for developmental delay.

When billing for a general developmental screening of an infant or young child at the 9th, 18th, 24th or 30th month visits providers should use CPT Code 96110 and the appropriate "Z" diagnosis code. Providers are required to maintain documentation in the patient medical record of the screening, the screening tool used, and evidence of screening result or screening score.

To ensure children are screened with the most appropriate tools, the Vermont Child Health Improvement Program reviewed information on developmental screening tools identified in the AAP policy statement and coordinated a committee of developmental and primary care pediatricians to review and comment on this information resulting in a “preferred list” of developmental screening tools.

For most primary care physicians, tools that fall under the general screening category are going to be most useful and appropriate for young children. There will be instances where secondary screening tools, or domain specific tools, may be appropriate, and the decision to use such tools should be based on individual practice needs, physician experience, population needs, etc.

5.3.13.1 General Screening Tools

- Ages & Stages Questionnaire (ASQ) Third Edition (2009) <https://agesandstages.com/>
- Battelle Developmental Inventory: 2nd Edition (BDI-II) - Screening Test (2006) <https://www.hmhco.com/classroom-solutions/assessment>
- Bayley Scales of Infant and Toddler Development: 3rd Edition (Bayley-III) Screener (2005) <https://www.pearsonassessments.com/>
- Brigance Early Childhood Screens (2005) <https://www.curriculumassociates.com/>

- Infant Development Inventory (IDI) (1998) <https://childdevrev.com/>
- Parents' Evaluation of Developmental Status (PEDS) (1997) <http://www.pedstest.com/default.aspx>
- PEDS: Developmental Milestones (2006) <http://www.pedstest.com/default.aspx>

5.3.13.2 Secondary Screening Tools

- Ages & Stages Questionnaires: Social-Emotional (ASQ:SE) <https://agesandstages.com/>
- Child Behavior Checklist (CBCL) Achenbach System <http://www.aseba.org/>
- Communication and Symbolic Behavior Scale-Developmental Profile (CSBS-DP): Infant Toddler Checklist <http://www.brookespublishing.com/store/books/wetherby-csbsdip/index.htm>
- Early Language Milestone Scale (ELM Scale-2) <https://www.proedinc.com/Products/6580/early-language-milestone-scale-elm-scale2.aspx>
- Language Development Survey <http://www.aseba.org/>
- Alberta Infant Motor Scale (AIMS) (1994) <https://www.us.elsevierhealth.com/alberta-infant-motor-scale-score-sheets-aims-9780721647210.html>

5.3.13.3 Autism Screening

The AAP recommends that young children should be screened with valid, reliable screening tool for autism at regular intervals. All children should have an autism specific screening at the 18th and 24th month well child visits. To improve detection rates through the use of standardized screening tool by primary care providers, the DVHA will allow for an autism screening (CPT 96110) with a standardized screening tool to be billed on the same day as a well-child visit or other E & M codes.

Primary care providers must use a standardized screening tool to bill for autism screening that occurs in conjunction with a well-child visit or other visit. Any standardized screening tool 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) can be used through December 31, 2011. As of January 1, 2012, reimbursement for child autism specific screening at the 18th and 24th month visits should only be requested when the standardized screening tool listed at the bottom of this guidance is used.

When an autism screening is completed in addition to a developmental screening, using two separate standardized screening instruments, bill both on the same claim form using the developmental screening 2013 CPT 96110 with two (2) units. Submit the claim with the required diagnosis for the routine child health check (well child visit) plus an additional diagnosis to indicate that a second screen for special screening for developmental delays in early childhood has been performed. This is necessary to differentiate for reporting purposes.

Required documentation must be maintained in the child's health record and at a minimum, includes the name of the screening instrument(s) used, the score(s) and the anticipated guidance related to the results.

5.3.14 Diabetic Teaching

Routine diabetic teaching is included within payment for the medical visit. When it is medically necessary for the member to be referred to a Certified Diabetic Educator for more in-depth counseling, billing instructions are provided to the appropriate providers upon enrollment.

5.3.15 Drugs Requiring Prior Authorization

The following medications (listed in alphabetical order) will require a prior authorization when paid through the **medical benefit** as physician or hospital outpatient billing. This allows the consistency of prior authorization requirements between the medical and pharmacy benefits:

- Amevive (alefacept)
- Boniva (ibandronate)
- Botox (botulinum Type A)
- Myobloc (botulinum Type B)
- Orencia (abatacept)
- Reclast (zoledronic acid injection)
- Remicade (infliximab)
- Tysabri (natalizumab)

For a list of ongoing changes, please see the DVHA website at <http://dvha.vermont.gov/for-providers/pharmacy>.

Effective for dates of service on and after 10/01/13, all claims submitted for Zoledronic Acid must be billed using HCPCS code Q2051.

- Prior authorization is required from Change Healthcare when this medication is to be used for Osteoporosis or Paget's disease, and
- Prior authorization is not required when this medication is used to treat Hypercalcemia of Malignancy and Multiple Myeloma with bone metastasis from solid tumors.

This does not apply to Medicare crossover claims. The following J codes (listed in numerical order) are affected: J0129, J0215, J0585, J1740, J1745, and J2323

For members with a primary insurance, a prior authorization is not required in the medical benefit if the primary insurer pays a portion of the claim. However, if the primary insurer denies the claim, the DVHA will require a prior authorization.

The following medications (listed in alphabetical order) may not be billed through the medical benefit:

Soliris (eculizumab), Somatuline Depot (lanreotide), Synagis (palivizumab) and Xolair (omalizumab). For a list of ongoing changes, please see the DVHA website at <http://dvha.vermont.gov/for-providers/pharmacy>.

Therefore, the following J codes, C codes or other codes (listed in numerical order) will not be accepted: 90378, C9003, C9237, J1300, J1743 and J2357.

These medications must be billed through the pharmacy benefit using NDCs. Please note that these medications do require prior authorization for payment through the pharmacy benefit.

Prescribers are instructed to call or fax the Change Healthcare Call Center to request prior authorization for the above-mentioned medications regardless of whether the medication will be billed through the medical or pharmacy benefit. Phone: 844.679.5363; fax: 844.679.5366. For clinical criteria and either the general or specific prior authorization forms at <http://dvha.vermont.gov/for-providers/pharmacy>.

5.3.16 Dual Eligibility

See [Section 1.6](#), Medicare & Vermont Medicaid Crossover Billing

5.3.17 Emergency Indicator

Providers must indicate on the CMS-1500 form if the service provided is the result of an emergency situation. These situations must be indicated in the “EMG” field locator (24c) on the claim form.

5.3.18 Emergency Room Services

Emergency room services include, but are not limited to:

- Consultations
- ER physicians’ charges
- Radiology
- Laboratory services

Payment will not be made for professional services for medical follow-up services in the emergency room.

5.3.19 EPSDT Program Well – Child Health Care

Vermont provides Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services to all Vermont Medicaid members up to age 21. EPSDT is a federal mandate that requires the state to provide all medically necessary services, regardless of whether the service is covered for adults. The goal of EPSDT is to prevent illness, complications and the need for long-term treatment by screening and detecting health problems early. Services are tracked for appropriate follow-up and reported to CMS by collection of data from Vermont Medicaid claims. The Vermont Department of Health (VDH) assists in EPSDT outreach and education.

Required EPSDT Screening Components

- a. Comprehensive health and developmental history
- b. Comprehensive unclothed physical exam
- c. Appropriate immunizations
- d. Laboratory tests (includes blood lead level and TB screening)
- e. Health education/anticipatory guidance
- f. Vision screens
- g. Dental screens
- h. Hearing screens

Screening Service Delivery and Content

- a. Screening is provided according to the American Academy of Pediatrics Bright Futures preventive screening guidelines found at https://www.aap.org/en-us/Documents/periodicity_schedule.pdf and the Vermont Dental Periodicity Schedule found at <http://www.healthvermont.gov/sites/default/files/documents/pdf/Vermont%20Dental%20Periodicity%20Schedule.pdf> and as medically indicated.
- b. Eligible individuals have free choice of qualified providers
Screens include developmental and nutritional assessment.

Diagnosis and Treatment Services

- a. Diagnostic procedures are reimbursable when medically indicated by a screening examination.
- b. Treatment services to correct or improve defects and physical and mental illnesses and conditions discovered by the screening services, are reimbursable, including:
 - Vision services
 - Dental services
 - Hearing services
 - Physical, Occupational, and Speech therapy (PT, OT and ST)
 - Supportive nursing service (Medicaid High Tech Program)
 - Case Management
- c. Treatment services may require prior authorization and are limited to:
 - Medically necessary, as defined by the Medicaid Division
 - The most economical treatment approach
 - Authorized providers

EPSDT services are billed to Vermont Medicaid on the CMS-1500 claim form using CPT procedure codes 99381-99385 and 99391-99395 and the appropriate modifiers, “EP”.

Provider-Based Billing requires EPSDT services to be billed on the UB-04 claim form using CPT procedure codes 99381-99385 and 99391-99395 and the appropriate modifier, “EP”.

5.3.20 ESRD Related Services

Vermont Medicaid reimburses for End Stage Renal Disease (ESRD) related services provided by the physician to members in the home, office, outpatient department, skilled nursing facility, or nursing home.

Do not bill “daily” and “per full month” codes for the same calendar month. Documentation (usually the physician notes) must be available in the member’s record which shows that the service was given by the physician and the dates involved. Providers should refer ESRD members to Medicare for possible eligibility.

5.3.21 Evaluation & Management Services (Post-Operative Care)

Evaluation and Management: (99--- codes)

The following limits apply:

- Services included within payment for E&M service
- Office visits limited to 5 per calendar month per attending
- New patient visits limited to one per member/attending/3 years
- One office visit/day for same member and same attending provider

5.3.21.1 Post-Operative Care

When reporting a surgical procedure with a 90-day, 30-day or a 10-day global period any E&M service billed during the global period by the same provider will be included within the surgical procedure payment and not reimbursed separately. Payments for surgical procedures with a 0-day global period will include established patient E&M services.

5.3.22 Family Planning Services

Family Planning is defined as any medically approved diagnostic test, treatment, counseling, drug, supply, or device which is prescribed or furnished by a provider to individuals of child-bearing age for purposes of enabling such individuals to freely determine the number and spacing of their children. Abortion is not considered Family Planning.

It is important that physicians and other providers identify such services as family planning in the appropriate field locator on the claim form. Reimbursement for implantation and/or removal of contraceptive devices includes all related services including the surgical tray, anesthetic, and physician visits within 30 days after the procedure. Implantation is reimbursable once every five years.

5.3.23 FQHC/RHC

Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) have at least two provider numbers: one for services paid at cost, and one for services paid per fee schedule. Services paid at cost are billed as encounters.

See the Vermont Medicaid FQHC/RCH Supplement for more information.

<http://www.vtmedicaid.com/#/manuals>

5.3.24 Health Maintenance Organization (HMO)

HMOs are insurance plans and are treated as such by the DVHA. Vermont Medicaid members covered by a commercial HMO must follow the HMO rules. Vermont Medicaid will make no payment for which an HMO is responsible or when the member has not followed the HMO rules. Providers may notify the members that he or she is responsible for payment when the HMO rules are not followed.

Vermont Medicaid will reimburse for HMO co-pay charges for physician office visits when the physician is capitated by the primary HMO. To bill the HMO co-pay only, use the procedure code T1015.

T1015 can be used only to bill Vermont Medicaid for the co-payment required by another primary insurer when that visit was included in a capitation agreement with the primary insurer.

Rural Health Centers and Federally Qualified Health Centers are not allowed to bill DXC Technology for HMO co-payments. These will be included in the yearly cost settlement.

5.3.25 Hospital Based Physicians

Vermont Medicaid follows the billing procedures of the regional Medicare carrier. Reimbursement is made in accordance with the Medicaid fee schedule for services and must be billed on the CMS-1500 Claim Form.

The CPT codes for hospital inpatient services are used to report evaluation and management services provided to hospital inpatients. When the member is admitted as an outpatient, physician visits are billed with either the outpatient CPT codes or observation service CPT codes.

5.3.26 Hysterectomy

See Health Care Administrative Rule 4.224 Sterilizations and Related Procedures for the conditions for coverage for sterilizations and related procedures. The rule can be found on the Agency of Human Services website at: <http://humanservices.vermont.gov/on-line-rules>.

All hysterectomy claims require prior approval from the DVHA Clinical Operation Unit. All hysterectomy claims on members under the age of 55 also require either:

- A valid hysterectomy consent form, or if a valid consent form is not available
- A valid ‘Notice of Decision’ to provide retroactive eligibility
- Operative notes or a statement that the member was already sterile prior to the hysterectomy

The hysterectomy consent form is available on the Department of Vermont Health Access site at <http://dvha.vermont.gov/for-providers/clinical-prior-authorization-forms>

Note: No prior authorization is required, if the procedure billed is hysterectomy with the primary diagnosis indicating cancer of the genital system.

5.3.27 Immunization

State supplied vaccines must be billed with modifier SL. When a vaccine is State supplied and billed with SL modifier, billed amount can be either \$0.00 or \$0.01. Reimbursement amount will be \$0.00.

All vaccines and administrations for service provided on the same day, must be billed on one claim. Codes for vaccine administrations must be rolled up and billed on one line with the appropriate number of units. Number of units will depend on number of vaccines and components given.

If a claim where a billed immunization service is partially paid and partially denied, and either the vaccine or the administration services must be re-billed, the paid part of the claim must be recouped, and the whole claim must be rebilled at once. Otherwise, the partial new claim will be denied.

5.3.27.1 Immunization Administration Codes

There are several immunization administration codes, depending on age of the patient, whether counseling has been provided or not, and depending on route of administration. There are also codes for the first vaccine component and for each additional vaccine component. When more

than one vaccine is administered at the same visit, it is imperative that number of immunization administration units matches the number of vaccine components given.

5.3.27.2 Administration Coding Example

A 1-year old boy presents for a preventive visit (99382). In addition, the child’s father is counseled by the physician on risks and benefits of the Pneumococcal (90670), MMR (90707) and Haemophilus influenza (90648) vaccines. The father signs consent to administration of these vaccines. A nurse prepares and administers each vaccine, completes chart documentation and vaccine registry entries, and verifies there is no immediate adverse reaction.

- 99382 - Preventative visit, age 1 through 4
- 90670 - Pneumococcal vaccine
- 90460 - Administration first component (1 unit)
- 90707 - Measles, mumps, and rubella (MMR) vaccine
- 90460 - Administration first component (1 unit)
- 90461 - Each additional component (1 unit)
- 90461 - Each additional component (1 unit)
- 90648 - Haemophilus influenza vaccine
- 90460 - Administration first component (1 unit)

Dates of service		Place		Type	Procedures, Services or Supplies	Diagnosis	\$ Charges	Daysepsdt	EMG	COB
From	To	of	of	CPT/HCPCS	Modifier	Code		Units	fampl	reserved
07 09 16 07 06 16 11		1		99382	EP 25	A	150.00	1		1234567893
07 09 16 07 09 16 11		1		90460		B	60.00	3		1234567893
07 09 16 07 09 16 11		1		90461		B	40.00	2		1234567893
07 09 16 07 09 16 11		1		90670	SL	B	00.1	1		1234567893
07 09 16 07 09 16 11		1		90707	SL	B	00.1	1		
07 09 16 07 09 16 11		1		90648	SL	B	00.1	1		
Total Charge								Amount Paid	Balance Due	

When billing Vermont Medicaid program claims, you MUST use the billing method as explained here.

5.3.28 Independent Laboratory

The referring physician is the physician or practitioner who actually ordered the tests for the member; he or she must be enrolled as a participating Vermont Medicaid provider. Enter the NPI/taxonomy code combination of the referring physician in field locators 17a and 17b. The billing provider name and address, to which payment will be made, must appear in field locator 33 and the NPI number must appear in field locators 33a and 24j.

The DVHA follows the Medicare billing procedures for physician’s billing for laboratory testing. It permits a physician to bill Vermont Medicaid for laboratory testing only when the physician or an employee of the physician performs the test. Physicians who expect to be reimbursed for lab

services performed on site must indicate on the claim that the test was performed on site, by completing field locator 20 on the CMS-1500 claim form and indicate the CLIA certification is on file with DVHA.

The professional component (modifier 26) is valid only when the test requires interpretation by the billing physician. The result from the actual testing of a specimen usually requires no interpretation and, in some cases, is done by the lab specialist. The billing of the lab code with modifier 26 is not valid for these services.

The Clinical Laboratory Improvement Amendments of 1988 (CLIA) require all providers of lab services to meet quality standards and be certified by the U.S. Department of Health and Human Services. CLIA applies to virtually all laboratory testing of human specimens.

The DVHA must have documentation of CLIA Certification with each provider enrollment period. Lapsed certificates will result in claim denials. Immediately forward renewed/current CLIA certificates to DXC Technology upon receipt.

Providers who perform laboratory services that have not obtained the appropriate CLIA certification are instructed to contact the Vermont Department of Health, 108 Cherry Street, Burlington, VT 05401 by phone 802.652.4145 or fax at 802.865.7701 for information.

In order to be reimbursed for laboratory services furnished in an office setting, providers submitting claims for laboratory services are required to have a CLIA certificate on file with DXC Technology. The services being submitted must be covered by the certificate and within the effective dates. DXC Technology requires a copy of the most current CLIA certificate used by each individual provider, group or facility be sent directly to DXC Technology, 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 DXC Technology.

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

5.3.28.1 Lab Handling

Payment for the service of obtaining specimens is included in the reimbursement of the medical visit. For exceptions to this rule and the corresponding procedure codes, please refer to Specimen Collection Fee.

5.3.29 Injections

5.3.29.1 Flu Shots

Immunization for flu and pneumonia are available at little or no cost in Vermont via a program of the Vermont Agency of Human Services Department of Health. See the Vermont Immunization Manual at <http://www.healthvermont.gov/disease-control/immunization-providers>. Members are encouraged to use this service. Local home health agencies and Area Agencies on Aging will administer flu vaccines in many locations around the state.

All in-state providers MUST obtain vaccines through the Vermont Department of Health (VDH) Vaccine for Children Program, for children through age 18. Influenza and H1N1 vaccines may be obtained through VDH; however, it is not a requirement. The SL modifier must be used with an

appropriate procedure code when billing the CPT or HCPCS code to assure correct payment. Report the charge as \$0.00 to represent the free vaccine.

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

All vaccine administration fees must be supported with a vaccine code, even when there is no amount to be reimbursed.

Prescribers are instructed to call (844.679.5363) or fax (844.679.5366) the Change Healthcare Clinical Call Center to find out which drugs require prior authorization regardless of whether the medication will be billed through the medical or pharmacy benefit. For clinical criteria and either the general or specific prior authorization forms, visit <http://dvha.vermont.gov/for-providers/pharmacy>.

5.3.29.2 Pharmacist-Administered

Flu Shots for Adults 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 NPI is 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 837 electronic CMS-1500 Claim Form. 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 Provider Manual at: <http://www.vtmedicaid.com/#/manuals>

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 DXC Technology 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.

5.3.30 Inpatient Services

Certain elective procedures also require prior authorization (e.g., hysterectomies, bariatric surgery, etc.). These are usually requested by the physician, but the hospital is always/also responsible for making sure the DVHA approval is in place prior to the procedure being performed. This pertains to all in-state and out-of-network providers.

See [Section 2](#), Prior Authorization of Medical Services for a complete listing of in-state and out-of-network hospital admissions prior authorization and notification requirements. Additional information is also available at <http://dvha.vermont.gov/for-providers>.

5.3.31 Lead Screening

CMS has mandated that children ages one through five be screened for lead unless the physician determines it to be medically inappropriate. The act of obtaining the sample during a well-child or routine office visit is included within payment for that medical visit. The processing laboratory will bill the proper CPT code for the actual testing.

5.3.32 Maintenance Drug Prescriptions

When the DVHA is the primary payer; pharmacies are required to dispense designated classes of maintenance drugs in 90-day supplies after the first fill. When the DVHA is the primary payer, prescriptions written for maintenance drugs must be rewritten for 90 days for the drug to be covered. The maximum quantity limit of 102 days still applies. This rule does not apply to members who have other primary insurance, including Part D.

Maintenance drugs must be prescribed and dispensed for not less than 30 days and not more than 90 days, to which one dispensing fee will be applied. Excluded from this requirement are medications which the member takes or uses on an "as needed" basis or generally used to treat acute conditions. If there are extenuating circumstances in an individual case that, in the judgment of the prescriber, dictate a shorter prescribing period for these drugs, the supply may be for less than 30 days as long as the prescriber prepares in sufficient written detail a justification for the shorter period. The extenuating circumstance must be related to the health and/or safety of the member and not for convenience reasons. It is the responsibility of the pharmacy to maintain in the member's record the prescriber's justification of extenuating circumstances. In these circumstances, regardless of whether or not extenuating circumstances permit more frequent dispensing, only one dispensing fee may be billed.

For a complete listing of pharmacy related information and the Pharmacy Provider Manual, go to <http://dvha.vermont.gov/for-providers/pharmacy>. See DVHA's Clinical Criteria document for drugs with other quantity limits at <http://dvha.vermont.gov/for-providers/preferred-drug-list-clinical-criteria>.

5.3.33 Mastectomy

Mastectomy procedures will be restricted to a diagnosis 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."

Prior Authorization is not required for reconstructive breast surgery if the primary diagnosis indicates malignant neoplasm of the breast/breast cancer.

5.3.34 Medical Nutrition Therapy

This service is paid through the enrolled primary care physician, inpatient hospital, outpatient hospital, registered dietitians (RD) and school health services. Registered Dietitian billing is restricted to three codes specific to RD services. These services are not reimbursable when billed by a physician.

5.3.35 Obstetrical Care

Vermont Medicaid covers obstetrical (OB) care (traditional and midwife services) by one of two methods outlined in the CPT book under the Surgery/Maternity Care & Delivery section and as stated here in the Provider Manual. Services can be billed as total OB care (global billing) or partial (non-global billing). Charges for both Total OB codes and Partial OB codes cannot be billed for the same pregnancy. The combination of all partial OB charges for a given pregnancy cannot exceed the reimbursement rate for total OB care.

A total OB procedure code is used when all OB-related care is provided by the same physician/practitioner or practitioners in the same group practice. A total OB procedure code encompasses the services normally provided in uncomplicated maternity cases, which include antepartum care, delivery, and postpartum care. *The date of service for total OB care is the day of delivery.*

When different physician groups provide OB care for the same pregnancy, total OB codes cannot be used.

Please note: Confirmation of pregnancy during a preventative or a problem-oriented visit is not considered part of antepartum care and should be reported using the appropriate E/M service code.

Antepartum care includes: “initial and subsequent prenatal history and physical examinations; recording of weight, blood pressures, fetal heart tones, routine chemical urinalysis, and monthly visits up to 28 weeks gestation; biweekly visits to 36 weeks gestation; and weekly visits until delivery”

Delivery includes: “admission to the hospital, the admission history and physical examination, management of uncomplicated labor, vaginal delivery (with or without episiotomy, with or without forceps), or cesarean delivery”

Postpartum includes: “office or other outpatient visits following vaginal or cesarean section delivery”

5.3.35.1 Partial OB code billing Instructions

The combination of all partial OB charges for a given pregnancy cannot exceed the reimbursement rate for total OB care.

Antepartum Care

- 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

Delivery Care - Only one delivery code can be billed for a member in a 9-month date span (with the exception of multiples. Please see special instructions below)

Postpartum Care - Only one unit of the postpartum care only code can be billed for a member, per pregnancy, using a single date of service (use the date of the final encounter completing postpartum care). This code includes all after-delivery E/M visits related to the pregnancy (office or other outpatient visits) following a vaginal or cesarean section delivery.

5.3.35.2 *New Instructions for OB Code Billing Instructions for ICD-10*

Global billing:

The date of service for total OB care is the day of delivery even though it includes antepartum care received prior to this date and the postpartum check-up performed after the day of delivery.

Non-global billing:

Billing instructions for antepartum care:

- 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 DOS of the sixth visit billed as 1 unit
- Antepartum Care, billing 7 or more visits; use CPT code 59426 with the DOS of the last visit billed as 1 unit

Billing instructions for delivery:

- Only one delivery code can be billed for a member in a 9-month date span (with the exception of twin deliveries. Please see special instructions below). The delivery date is the DOS.

Billing instructions for postpartum care:

- Only one postpartum code can be billed for a member in a 9-month date span. This code includes office or other outpatient visits following a vaginal or cesarean section delivery. Please use the 6-week check-up as the DOS.
- This code includes all after-delivery E/M visits related to the pregnancy

5.3.35.3 *Special Instructions*

The Fetal Non-Stress Test

1 unit will cover the non-stress test for both twin A and twin B when billed with modifier 22. Notes are not required when a twin diagnosis is indicated on the claim.

Twin Deliveries

The DVHA will reimburse for the delivery of twins at 100% (twin A) and 50% (twin B) of the prices on file. The provider should bill both deliveries on the same claim and use a twin diagnosis code for both. One code has to be a “delivery only” code.

Assist at Cesarean Delivery

A surgical assistant at a cesarean delivery cannot bill the “Total OB” procedure code because the assistant did not give the prenatal care. To bill for service as the assistant, use the “delivery only” procedure code with one of the following modifiers:

80 - Assistant surgeon (MD or nurse practitioner)

AS - Physician’s assistant assisting at surgery (Only one assistant is covered per surgery).

External cephalic version (ECV) is only eligible for reimbursement for pregnancies at or beyond 36 weeks gestational age. Notes are required to confirm the service was performed. Only one ECV (successful or not) is reimbursable per pregnancy.

Abortion

Abortion includes miscarriages (“spontaneous abortion”), missed abortion, and induced abortion.

OB deliveries pertain only to infants who have an Estimated Gestational Age (EGA) of 30 or more weeks (viability). When the fetus is less than 7 months EGA and a non-induced fetal demise occurs, see procedure codes for surgical intervention and/or medical visit codes for medical assistance. Do not use “delivery” codes.

Example A

Member 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.

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

Example B

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

A Member may see more than one attending provider when billing multiple antepartum visits (CPT 59425 or CPT 59426) within the same billing group/practice. It is up to the practice to determine which attending provider number to use when submitting the claim.

5.3.36 Midwife Services

A "Licensed Midwife" means anyone who has met the requirements set down by the American College of Nurse-Midwives and by the North American Registry of Midwives and who meets the eligibility criteria set forth in rule. These are the two types of Licensed Midwives that Vermont Medicaid recognizes and reimburses:

1. “Certified (Nurse) Midwives” are advanced practice nurses and are licensed independent providers who possess a degree from a Vermont graduate program and are certified by the American College of Nurse-Midwives. Nurse Midwives are subject to the nursing and midwifery rules
2. “Licensed (Professional) Midwives” are laypersons certified by North American Registry of Midwives who possesses a high school degree or its equivalent; subject only to the midwifery rules.

Licensed Certified Nurse Midwives may be enrolled as independent practitioners or physicians may employ them.

Important Billing Reminder for Licensed Midwives (Nurse and Professional):

Delivery codes are valid only for pregnancies with an estimated gestational age of 30 or more weeks (viability)

Licensed Midwives (Nurse and Professional) will not be reimbursed for surgery of assistant-at-surgery charges

See [Section 5.3.35](#), Obstetrical Care for Total OB and Partial OB billing instructions. Total OB codes and Partial OB codes cannot be billed for the same pregnancy.

When the MD, Licensed midwife (Nurse and Professional), or nurse practitioner monitors labor in the member's home (for a planned home birth) but then has to admit the mother to the hospital for delivery, and the delivering MD is not a member of the same provider group, the initial provider can bill for the prolonged services in the office or other outpatient setting.

The DVHA will reimburse prolonged services only when a planned home delivery results in a hospital admission and the delivery is done by a different Medical Doctor/Medical Doctor group (these services are included in regular OB billing when the providers are of the same billing group).

The billed units must reflect the time spent in face-to-face contact with the member in the home and/or on the way to the hospital. Each claim will suspend for review. Please submit copies of the provider's record(s) with each bill documenting the number of units billed.

5.3.36.1 Examples

The Licensed midwife (Nurse and Professional) and MD were present in the member's home to monitor the labor. Due to a lack of progression and meconium staining in the amniotic fluid, the member was transported to the hospital and her care transferred to the hospital physician, who delivered the baby. The initial MD was with the member "for the entire labor, monitoring the baby, the mother and the progress of the labor."

The documented time shows 5 hours. For these services (which include the midwife's attendance), the DVHA can be billed one unit of procedure code 99354 and 8 units of 99355.

The Licensed midwife (Nurse and Professional) monitored the labor in the home for 15 hours, transported the member by car (1/2 hour) and stayed 4 more hours at the hospital after the transfer. Upon admission to the hospital, the care was assigned to the hospital physician who delivered the baby by C-section. The midwife had started an IV of ringers lactate while still at the home. The nurse midwife's services may be billed with one unit of 99354 and 29 units of 99355. All care given during the face to face contact, including the IV insertion and supplies, is included within the reimbursement of these two procedure codes. There can be no charge for the initial MD/midwives services as of the admission to the hospital since all care at this point becomes part of the delivery payment.

5.3.36.2 Summary

The DVHA will reimburse prolonged services codes only when a planned home delivery results in hospital admission and the delivery is done by a different MD/MD group (these services are included in regular OB billing when the providers are of the same billing group.) The billed units must reflect the actual time spent in face-to-face contact with the member in the home and/or on the way to the hospital. Each claim will suspend for review, so clear copies of the provider's records must be submitted with each bill documenting the number of units billed. The place of service (POS) must be a 12 (home).

Licensed midwives (Nurse and Professional) may receive reimbursement for RhoGAM injections using the appropriate HCPCS & NDC code with a maximum of one unit. See NDC (National Drug Code).

Use the appropriate office visit and diagnosis codes when a member is seen at the office for a pregnancy test. If you bill a pregnancy diagnosis for the purpose of testing for a pregnancy that has not yet been established, your claim will cause subsequent prenatal claims to be denied as it is considered to be one prenatal visit if a pregnancy diagnosis is recorded on the claim.

5.3.37 Multiple Surgery Pricing

Vermont Medicaid will price multiple surgery payments in order of the procedure code's Relative Value Unit and will price all surgical procedures in decreasing percentages of 100%, 50%, 40%, 30%, 30%...This includes surgical procedures billed with multiple units. Any codes that are add-on codes, or Modifier 51 exempt, as defined by the CPT, will be priced at 100% of the allowed amount.

Providers are required to bill multiple surgeries on a single claim. Any subsequent claims that are billed for multiple surgeries on the same day will be denied. If any billing changes need to be made, the original claim will need to be adjusted by the provider. Claims should be sent with surgery procedure codes in the RVU order from highest to lowest.

5.3.38 Naturopathic Physicians

Medically necessary health care services within the Vermont Medicaid benefit package provided by a Naturopathic Physician (N.D.) are a covered service. N.D.s must be licensed in Vermont and provide treatment within the scope of their practice as described in Chapter 81 of Title 26 of the Vermont Statutes. N.D.s having local admitting hospital privileges or a formal agreement with a physician who has local hospital admitting privileges and arranges 24 hour-a-day/seven days-a-week coverage for their members may enroll as primary care providers (PCPs) with Vermont Medicaid.

Naturopathic physicians wishing to participate in the PCP in the Primary Care Plus Program, must provide additional information. Please complete the Agreement for Participation for Naturopathic Physicians form (inpatient hospital admission information is required).

Please access forms at: <http://www.vtmedicaid.com/#/provEnrollDataMaint> and mail the completed Provider Enrollment Application, General Provider Agreement and the Agreement for Participation for Naturopathic Physicians, along with any additional documentation, to:

DXC Technology
Attn: Enrollment Unit
P.O. Box 888
Williston, VT 05495-0888

5.3.39 NDC (National Drug Code)

Vermont Medicaid requires the collection and submission of rebates for all drugs dispensed or administered by providers other than a pharmacy. This allows for the collection of Vermont Medicaid drug rebates from manufacturers on all drugs dispensed in any office setting. The NDC billed to Vermont Medicaid must be the NDC that was dispensed to the member.

Drugs supplied by manufacturers currently participating in the rebate program will be the only drugs reimbursed by Vermont Medicaid. A list of these manufacturers, by code and name, can be found at <http://www.vtmedicaid.com/#/resources>.

In order to collect rebates from the correct manufacturers, Vermont Medicaid will require data elements at the detail level in addition to the HCPCS codes. These elements are the 11-digit

National Drug Code (NDC) number, the Unit of Measurement Qualifier code, and the unit quantity. These must be reported on paper and electronic submissions of all professional claims.

5.3.39.1 NDC Requirements on CMS-1500 Form

When entering an NDC on your claim form, please enter the following data elements in the following order: NDC, measurement qualifier code and unit quantity. Do not insert brackets, spaces or dashes. Claims formatted incorrectly will be denied.

FL 24D: HCPCS code

FL 24D Shaded area: 11-digit NDC number, Unit of Measurement Qualifier, and Unit Quantity

FL 24G: HCPCS unit

<u>24D</u> CPT/HCPCS	Modifier	<u>E</u> DX Pointer	<u>E</u> Charges	<u>G</u> Days or Units
[60126598741][UN][1111.234]				
J1234	XX	1,2,3	\$637.00	5
↑ ↑ ↑ <u>11 Digit NDC</u> <u>Unit of</u> <u>Measurement</u> <u>Qualifier *</u>				

* Unit of Measurement Qualifier

F2-International Unit

GR-gram

ML-Milliliter

UN-Unit

Some NDCs are displayed on drug packaging in a 10-digit format. Proper billing of an NDC requires an 11-digit number in a 5-4-2 format. Converting NDCs from a 10 to 11-digit format requires a strategically placed zero, dependent upon the 10-digit format. The following table shows common 10-digit NDC formats on packaging and the associated conversion to an 11-digit format with the proper placement of a zero:

10-Digit Format on Package	10-Digit Format Example	11-Digit Format	11-Digit Format Example	Actual 10-Digit NDC Example	11-Digit Conversion Example
4-4-2	9999-9999-99	5-4-2	<u>0</u> 9999-9999-99	0002-7597-01 Zyprexa IM [□] 10mg vial	<u>0</u> 0002-7597-01
5-3-2	99999-999-99	5-4-2	99999- <u>0</u> 999-99	50242-040-62 Xolair [□]	50242- <u>0</u> 040-62
5-4-1	99999-9999-9	5-4-2	99999-9999- <u>0</u> 9	60574-4112-1 Synagis [□] 50mg vial	60574-4112- <u>0</u> 1

5.3.40 Non-Emergency Medical Transportation (NEMT)

Non-Emergency Medical Transportation (NEMT) is a covered service for members enrolled in traditional, Primary Care Plus (PC Plus) Vermont Medicaid and the Dr. Dynasaur programs. NEMT is a statewide service, providing transports for eligible members to and from medically necessary medical services that are Vermont Medicaid billable. It is provided through personal services contracts between the State of Vermont, Agency of Human Services (AHS), Department of Vermont Health Access (DVHA) and local public transit brokers.

All providers are required to confirm a member's appointment when verification is requested from a Vermont Medicaid transportation provider. CMS requires transportation providers to verify that transportation is to and from eligible medical appointments. At this time, the DVHA requires transportation providers to verify 5% of all ride requests made by members.

For further NEMT information and requirements go to <http://dvha.vermont.gov/for-providers/transportation>.

5.3.41 Oral Surgery

If oral surgery is billed with a CPT code, follow the physician's rules for billing and bill on a CMS-1500 claim form. If oral surgery is billed using ADA codes, follow the dentist's rules for billing, and bill on an approved dental claim form.

5.3.42 Over-The-Counter (OTC) Medications

Coverage of Over the Counter (OTC) medications is 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 coverage guidelines apply to Vermont Medicaid, Dr. Dynasaur and VPharm. DVHA pays for OTCs only when there is a specific medical necessity and requires a prescription for the OTC product. Some OTC medications are already managed on our Preferred Drug list (PDL) and other restrictions may apply. Though the DVHA has restricted OTC medications to primarily generics, members will continue to have at least one choice in all medically necessary drug categories. Please refer to the DVHA website for a list of covered OTC medication categories at <http://dvha.vermont.gov/for-providers/pharmacy>. The PDL can be found at <http://dvha.vermont.gov/for-providers/preferred-drug-list-clinical-criteria>.

5.3.43 Oximetry Services

When billing any medical visit, the following procedures are considered included within the reimbursement for the visit:

- Ear or pulse oximetry saturation-single determination
- Non-invasive ear or pulse oximetry for oxygen saturation; by multiple determinations
- Non-invasive ear or pulse oximetry for oxygen saturation; by continuous overnight monitoring

These services will be denied with EOB 091—Service denied; not reimbursed by Vermont Health Access Program.

5.3.44 Pharmacologic Management (Psychiatric)

Pharmacologic management is payable only for mental health and developmentally disabled members when providers must bill using appropriate procedure code with one unit of service per visit, regardless of time spent.

5.3.45 Physician Visit Limits

Pursuant to Medicaid Rule 7301.1.1, the following physician visit limits apply:

1. Payment for office or home visits is limited to five visits per member, per month.
2. Nursing facility visits are limited to one per provider per member per week.
3. Hospital visits are limited to one per day for the same or similar diagnosis for acute care, or after denial of acute care by utilization review, up to one visit per month for subacute care.

Visits in excess of those listed above may be reimbursed if the services are medically necessary. A medical exception request documenting the medical necessity must be sent to the DVHA. Forms for prior authorization are located at <http://dvha.vermont.gov/for-providers/forms-1>.

Non-emergency (elective) out-of-network medical visits will require prior authorization from DVHA (In network, but out-of-state (OOS) hospitals are excluded from this requirement). In network referring providers are to submit requests using the OOS Medical Office Request Form located at <http://dvha.vermont.gov/for-providers/clinical-coverage-guidelines>.

Mileage allowances for house calls apply only to the first member. If more than one member is seen during the visit, no mileage will apply to those members.

5.3.46 Post-Operative Follow-up Visits

For all CPT surgical procedure codes, Medicare has assigned a follow-up/global period of either "000", "010" or "090" days. This means that office visits that are related to the procedure are included within the payment for the procedure and may not be billed during the restricted follow-up period.

5.3.47 Psychiatry/Psychology

- If no E/M services are provided, use the appropriate psychotherapy code (90832, 90834, 90837)
- Psychotherapy with E/M is now reported by selecting the appropriate E/M service code and the appropriate psychotherapy add-on code.
- The E/M code is selected on the basis of the site of service and the key elements performed.
- The psychotherapy add-on code is selected on the basis of the time spent providing psychotherapy and does not include any of the time spent providing E/M services

Prescribing health care professionals, conducting pharmacologic management, will now use the appropriate E/M code. When psychotherapy is done during the same session as the pharmacologic management, one of the new psychotherapy codes should be used along with the E/M code. The psychiatrist or other qualified health care professional will specify the level

of E/M work done and add the psychotherapy component based on the time spent delivering psychotherapy.

- Vermont licensure for CPs (Clinical Psychologists) is limited to the provider’s scope of practice which does not include prescription and medication management
- Providers that are approved to bill E/M series codes are to report this service using the appropriate E/M series code
- Vermont Medicaid enrolls the following provider types for Mental Health service. Proper use of the below modifiers is required to assure accurate reimbursement. Failure to use the correct modifier for license type may result in post payment review of your claims
- Vermont Medicaid is continuing to require the use of modifier AJ and AH. Modifier AJ is reimbursed at 76% of allowed amount modifier AH at 93% of allowed amount
- *Designated Agencies, Specialized Service Agencies and ADAP Preferred provider are not required to use the modifiers from the below table*

Provider Type	License	Modifier Required
Psychologist - Doctorate Level	Psychologist Doctorate	AH - Clinical Psychologist
Psychologist - Masters Level	Psychologist – Master	AJ - Clinical Social Worker
Licensed Mental Health Counselor	LMHC	AJ - Clinical Social Worker
Licensed Clinical Social Worker	LCSW	AJ - Clinical Social Worker
Licensed Marriage & Family Therapist	LMFT	AJ - Clinical Social Worker
Licensed Drug and Alcohol Counselor	LADC	AJ - Clinical Social Worker
Physician – Psychiatric	Physician	No Mental Health Modifier Required
Nurse Practitioner - Psychiatric	Advanced Practice Registered Nurse	No Mental Health Modifier Required

5.3.47.1 *Psychiatric Diagnostic Evaluation*

- A distinction has been made between diagnostic evaluations without medical services and evaluations with medical services
- Interactive services are captured using an add-on code
- These codes can be used in any setting

- These codes can be used more than once in those instances where the patient and other informants are included in the evaluation
- These codes can be used for reassessments
- Psychiatrists and other medical providers have the option of using the appropriate E&M code in lieu of the 90792

Code Descriptions specifying “With medical services” refers to medical “thinking” as well as medical activities, such as: physical examination, prescription of medication, and review & ordering of medical diagnostic tests. Medical thinking must be documented, e.g. consideration of a differential diagnosis, medication change, change in dose of medication, drug-drug interactions, etc.

5.3.47.2 Psychotherapy

The new series of psychotherapy codes (90832 – 90838) was established to replace individual psychotherapy codes (90804 – 90829). Site of service is no longer a criterion for code selection and time specifications were changed to be consistent with CPT convention.

- Psychotherapy codes are no longer site specific
- Psychotherapy time includes face-to-face time spent with the patient and/or family member and/or legal guardian
- Time is chosen according to the CPT time rule
- Interactive psychotherapy is reported using the appropriate psychotherapy code along with the interactive complexity add-on code
- Group therapy (90853) is limited to no more than 3 sessions per week. Reimbursement is limited to one session per day, per group and no more than 10 in a group

5.3.47.3 Crisis Psychotherapy

Crisis is defined as:

“An urgent assessment and history of a crisis state, a mental status exam, and a disposition. The treatment includes psychotherapy, mobilization of resources to defuse the crisis and restore safety, and implementation of psychotherapeutic interventions to minimize the potential for psychological trauma. The presenting problem is typically life threatening or complex and requires immediate attention to a patient in high distress.”

A new subsection, Psychotherapy for Crisis, with guidelines was established to report these services. These are timed codes and additional instruction on the appropriate use of the new codes is included in the 2013 AMA CPT4 codebook.

- 90839, Psychotherapy for crisis, first 60 minutes (CPT Rule applies: 30-74 minutes)
- +90840 (add-on), Psychotherapy for crisis each additional 30 minutes

5.3.47.4 Important Billing Concepts to Consider

CPT Time Rule

“A unit of time is attained when the mid-point is passed”

“When codes are ranked in sequential typical times and the actual time is between two typical times, the code with the typical time closest to the actual time is used.”

Example: 90832, 90833 is 16–37 minutes
90834, 90836 is 38–52 minutes
90837, 90838 is 53 minutes and more

5.3.47.5 *Interactive Complexity*

A new subsection has been added to the Psychiatry section for reporting interactive complexity. Interactive complexity is specific and recognized communication difficulties for various types of patients and situations that represent significant complicating factors that may increase the intensity of the primary psychiatric procedure.

Add-on Code 90785 is used to report interactive complexity services when provided in conjunction with psychotherapy codes. See the 2013 AMA CPT4 codebook for further explanation of when and how this code should be used. The guidelines include a list of requirements or factors to consider when determining appropriate use of the interactive complexity code.

1. “Interactive” in previous codes was limited in use to times when physical aids, translators, interpreters, and play therapy was used.
2. “Interactive Complexity” extends the use to include other factors that complicate the delivery of a service to a patient and may be reported when at least one of the following is present:
 - Arguing or emotional family members in a session that interfere with providing the service
 - Third party involvement with the patient, including parents, guardians, courts, and schools
 - Need for mandatory reporting of a sentinel event
 - Impaired patients
 - Young and verbally undeveloped
3. When performed with psychotherapy, the interactive complexity component (+90785) relates only to the increased work intensity of the psychotherapy service but does not change the time for the psychotherapy service.

5.3.47.6 *Documentation Standards for Mental Health and Substance Abuse Health Records*

At a minimum, the documentation in a mental health/substance abuse health record will include the following core components:

1. Identifying data
 - Name/unique ID, date of birth, and other demographic information as needed
2. Dates of service
 - Documentation by the primary treatment provider of all dates and the amount of time clinical services were provided
3. Comprehensive clinical assessment (e.g., biopsychosocial, medical history, etc.)

- Evidence that a comprehensive clinical assessment has been completed, with documentation of a presenting problem and patient placement to support clinical level of care, such as:
 - a. Outpatient
 - b. Intensive outpatient
 - c. Partial hospitalization
 - d. Residential
 - e. Inpatient
 - Evidence of ongoing reassessment as needed
4. Treatment and continued care planning
- Documentation of treatment plan, including the following:
 - a. Prioritization of problems and needs,
 - b. Evidence that goals and objectives are related to the assessment,
 - c. Evidence that goals and objectives are individualized, specific, and measurable, with realistic timeframes for achievement,
 - d. Specific follow-up planning, including but not limited to anticipated response to treatment, additional or alternative treatment interventions, and coordination with other treatment providers (e.g., PCP)
5. Progress Notes
- Documentation supporting continued need for services based on clinical necessity, including the following:
 - a. Dated progress notes that link to initial treatment plan,
 - b. Updates or modifications to treatment plan,
 - c. Interventions provided and client’s response,
 - d. Printed staff name and signature or electronic equivalent.

For additional information concerning DVHA’s *Mental Health and Substance Abuse Health Record Documentation Standards* and resources see <http://dvha.vermont.gov/for-providers> and click on “Clinical Initiatives”.

5.3.47.7 *Community Mental Health Center Services*

Covered services include rehabilitation services provided by qualified professional staff in a community mental health center designated by the Department of Mental Health. These services may be provided by qualified mental health providers as identified by the Vermont Department of Mental Health (DMH). For further information, see the DMH manual at <http://mentalhealth.vermont.gov/reports-forms-and-manuals>.

5.3.48 Radiology

5.3.48.1 Radiologic Components

The professional component of radiologic services must be billed by the physician when those services are done in a hospital radiology department. The professional component includes any examination of and discussion with the member, supervision of technologist, interpretation of the results of diagnostic or therapeutic procedures and consultation with the attending physician. Only a radiologist will be paid for the radiology professional component. The appropriate CPT procedure code should be used with the modifier “26” when billing for the professional component.

5.3.48.2 Technical component

Includes the services of non-radiologist or non-physician personnel, materials, facilities, equipment and space used for diagnostic or therapeutic services. The appropriate CPT procedure code should be used with the modifier “TC” when billing for the technical component.

5.3.48.3 Total component

Consists of the professional component and the technical component. The total component is reimbursable only for diagnostic or therapeutic radiology procedures done in the physician’s office. The appropriate CPT procedure code without the modifier should be used when a claim for total component services is submitted to Vermont Medicaid.

The use of modifier 50 (bilateral) on CPT radiology codes (7**** series) is not valid because modifier 50 causes payment to be only 1.5 times the price on file. The only exception is CPT codes 76641 and 76642, which will allow modifier 50 to be appended.

When the same radiology procedure code is done more than once on the same date of service ***and is not done for reasons of comparison***, the provider should bill the appropriate radiology code ***once only with multiple units***. Documentation must be maintained in the member records substantiating the purpose and number of multiple x-rays. Radiology services performed for comparison are not reimbursable.

High-tech outpatient elective diagnostic imaging scans require prior authorization from eviCore (formerly MedSolutions). Diagnostic Imaging Program Guidelines and other provider resources are available at <http://www.vtmedicaid.com/#/resources>.

The DVHA implemented a multiple procedure payment structure for CT, CTA, MRI and MRA 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.

Providers who choose to bill worker's compensation or accident insurance first, instead of Vermont Medicaid, will not be eligible for reimbursement if prior authorization is not obtained prior to the service being rendered.

5.3.49 Smoking Cessation Counseling

Face-to-face smoking cessation counseling is covered for eligible Vermont Medicaid members of any age who use tobacco. The maximum number of visits allowed per calendar year is 16. This coverage applies when furnished by (or under the direction of) a physician or by any other health care professional who is legally authorized to furnish such services under state law and licensure. “Qualified” Tobacco Cessation Counselors are also allowed, (requires at least eight hours of training in tobacco cessation services from an accredited institute of higher education).

Providers must code each claim with the correct diagnosis for tobacco use.

5.3.49.1 Pharmacological Coverage

See the most recent Clinical Criteria document at <http://dvha.vermont.gov/providers/preferred-drug-list-clinical-criteria> for Smoking Cessation Therapy information, preferred drug list and PA requirements.

5.3.50 Specimen Collection Fee

Payment for obtaining specimens is included in the reimbursement of the office visit. Physicians may bill Vermont Medicaid for a specimen collection fee in two situations only; for the collection of blood via venipuncture or for collection of a urine sample by catheterization. Federal Qualified Health Clinics and Rural Health Clinics have different guidelines for this process:

- Venipuncture (or blood draw fee) and the specimen handling fee are included as part of FQHC services. They are not considered part of the diagnostic laboratory services.
- Blood draws/venipuncture and specimen handling provided by nurses or technicians for services, such as lab tests and blood draws, do not bill an encounter. These charges are included within the encounter payment when the service was originally ordered. Clinical Diagnostic Laboratory tests performed on site should be billed separately as a fee for service.

5.3.51 Sterilizations

See Health Care Administrative Rule 4.224 Sterilizations and Related Procedures for the conditions for coverage for sterilizations and related procedures. The rule can be found on the Agency of Human Services website at: <http://humanservices.vermont.gov/on-line-rules>.

The Sterilization Consent Form can be found on the web here <http://www.vtmedicaid.com/#/forms>.

5.3.52 Team Care Program

The Team Care Program restricts a member to one physician and one pharmacy. If a member is “locked-in” to a provider, that provider’s name is available on the Voice Response System and the Vermont Medicaid website. Claims for services by any provider other than the “lock-in” provider(s) are not reimbursable by Vermont Medicaid, except in the case of an emergency or when a provider performs a service by referral of the named provider.

The “lock-in” procedure also applies to a Primary Care (PC) Plus member. The “lock-in” reflects the member’s choice of primary care physician. This information is also available through the VRS and the Vermont Medicaid web site.

5.3.53 Telemedicine Services

Health Care Administrative Rule 3.101 Telehealth can be found on the Agency of Human Services website at: <http://humanservices.vermont.gov/on-line-rules>. Providers use of telehealth practices are subject to the requirements of administrative rule. Information contained in rule will not be repeated in the provider manuals.

Billing Rules for Telemedicine:

1. All providers are required to follow correct coding rules, including application of modifiers, and only bill for services within their scope of practice that can be done via telemedicine.
2. All claims with services billed for telemedicine must have POS 02.
3. Facilities delivering “live” telemedicine services via interactive audio and video must apply the GT modifier - CMS and/or Encoder Pro telemedicine codes excluding non-covered services.
4. Originating facility site providers (patient site) may be reimbursed a facility fee (Q3014).
 - a. Facility fees will not be reimbursed if the provider is employed by the same entity as the originating site.

DVHA will not reimburse for teleophthalmology or teledermatology by store and forward means.

5.3.54 Topical Fluoride Varnish

Physicians, naturopaths, nurse practitioners, and physicians’ assistants with one of the following specialty types: general practice, family practice, internal medicine, pediatric medicine, nurse practitioner, family practitioner, naturopathic physician with childbirth endorsement & without childbirth endorsement, and pediatric practitioner are allowed to administer and bill for Topical Fluoride Varnish treatments for children ages 0-5.

5.3.55 Vision Care & Eyeglasses

HCAR 4.214, Eyewear and Vision Care Services can be found on the Agency of Human Services website at: <http://humanservices.vermont.gov/on-line-rules>. All eyewear and vision services are subject to the requirements of administrative rule. Information contained in the rule will not be repeated in the provider manuals.

See the Vermont Medicaid Vision Supplement for additional coverage information.

<http://www.vtmedicaid.com/#/manuals>

Section 6 UB-04 Claim Submissions

6.1 Reimbursable Services

6.1.1 Hospital Inpatient

Reimbursable services include: medically necessary care in a semi-private room; private room and intensive care when medically necessary; nursing and related services; use of hospital facilities, supplies, appliances and equipment; blood transfusions; therapeutic services; drugs furnished by the hospital; rehabilitation services; diagnostic services.

See [Section 7](#), Prior Authorization for Medical Services.

6.1.2 Hospital Outpatient

Reimbursable services include the use of facilities in connection with accidental injury or minor surgery, diagnostic tests, rehabilitative therapies and emergency room care.

Pre-certification review of hospital admissions for dental procedures is not required. When submitting claims use the appropriate dental HCPCS coding (D...).

Medicare restricts certain medical services that should be only performed in an inpatient hospital setting. These services are not eligible for reimbursement when provided by a physician in an outpatient setting. A list of Vermont Medicaid Outpatient MUE of Zero procedures (Inpatient only list) is available at <https://www.medicaid.gov/medicaid/program-integrity/ncci/index.html>; see the links under Medicaid NCCI edit files.

6.1.3 Home Health

Reimbursable services include nursing care services when the services are related to the care of patients who are experiencing acute or chronic periods of illness if ordered by and included in the treatment plan established by the physician.

Reimbursable services include physical, occupational and speech therapy services. Therapy services must be directly related to an active treatment plan, of a level that a qualified therapist is required, and reasonable and necessary to the treatment of the patient's condition.

Reimbursable services also include Services of a home health aide.

6.1.4 Home Health Hospice

Reimbursable services include: nursing, Home Health Aide, homemaker, rehabilitative therapy, social service, nutrition services, bereavement assessment and counseling, drugs, equipment, medical supplies, inpatient care and respite services in the home.

Vermont Medicaid pays a Per Diem rate.

Beginning January 1, 2016, a service intensity add-on (SIA) payment was authorized under the "FY 2016 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements" published on August 5, 2015. CMS implemented payments to reflect changes in resource intensity in the provisions of care services during hospice care.

6.1.5 Assistive Community Care Services

Reimbursable services include: case management, personal care services, nursing assessment & routine tasks, medication assistance, on-site assistive therapy and restorative nursing.

Choices for Care

1. Enhanced Residential Care Services include: personal care, meal preparation, medication management, nursing overview, activities, 24-hour supervision, and laundry/housekeeping.
2. Long Term Care Services include: personal care, meals/nutritional services, 24-hour skilled nursing, rehab & therapy, activities, 24-hour supervision, social services, laundry/housekeeping.
3. Home Based Waiver Services include: case management, personal care, respite or companion care, adult day services, personal emergency response systems.

6.2 Reimbursement Policy

The Fee Schedule contains a complete list of services that are reimbursable by Vermont Medicaid. Implementation of OPPS pricing has not changed the Vermont Medicaid policy regarding non-covered services.

Providers are allowed to compliantly bill the correct monthly code that meets the definition of the actual services provided for members subject to partial eligibility in any given month. However, providers may only bill the dates of service in which the member is actively eligible for Vermont Medicaid.

Inpatient services will be paid according to DRG payment methodology. Vermont-based Relative Weight Information is available at <http://www.vtmedicaid.com/#/resources>

Outpatient services will be paid according to OPPS methodology. Go to <http://www.vtmedicaid.com/#/resources> for a listing of revenue codes that are required to be billed with a HCPCS/CPT code. The full fee schedule for hospitals is also listed. The number of units billed on a detail line with the revenue code will represent the number of units for the HCPCS code.

DRG Hospital Reimbursement-Vermont Medicaid Ineligibility:

With the DRG reimbursement methodology in effect, any claims for members who become ineligible for Vermont Medicaid during the duration of an inpatient stay must be billed to any third-party liability provider prior to billing Vermont Medicaid/DXC Technology in its entirety. DXC Technology will prorate these claims based on member eligibility and partially reimburse for the days the member was eligible for Vermont Medicaid.

Providers are instructed to bill the inpatient stay, including the Vermont Medicaid ineligible days for reimbursement, then balance bill the member for the remainder. Vermont Medicaid will not reimburse for days which the member was ineligible, thus it becomes the member's financial responsibility.

6.3 Patient Share (Applied Income) Reporting

The DXC Technology claims processing system captures changes made to patient share amounts, the highest paid providers and when the patient has moved to a new facility. Providers can submit electronic replacement claim adjustments, for any claim that had deducted a different patient share amount, or if you are now the highest paid provider or if you are no longer the highest paid provider. Providers can also submit electronic adjustments when the patient was discharged to a new facility and no longer owes their patient share to the previously admitted facility. DXC Technology will generate a monthly report detailing these changes; we will adjust

these claims. However, to receive your corrected payment quicker, we recommend you submit electronic adjustments.

The DCF District office will send the facility a copy of the notification sent to the members. This notification includes the amount of the patient's share, if any, that the member must apply toward the cost of his or her care. Patient Share obligations will be automatically deducted from Vermont Medicaid claims starting with the first claims of the month.

6.4 General Hospital Billing Information

6.4.1 Bilateral Billing Procedures

CPT codes that are not defined as bilateral but are performed bilaterally must be billed on one detail, using modifier 50 with 1 unit. Billing on one detail will result in the 150% reimbursement. Modifier 50 is not to be used on claims submitted for bilateral radiology services.

6.4.2 In-Network & Extended Network Hospitals

In-Network Hospitals are subject to the same Vermont Medicaid policy as are those located within the geographical confines of the state of Vermont. Their physicians must be enrolled in Vermont Medicaid. A complete list of **Green Mountain Care** In-Network & Extended Network Hospitals is available at <http://dvha.vermont.gov/for-providers/green-mountain-care-network>.

Out-of-state hospitals not designated as an In-Network Hospital must bill using the attending provider's NPI number in field locator 76, when the attending provider is not enrolled with Vermont Medicaid.

6.4.3 Inpatient/Outpatient Overlap Examples

The general rule is when the patient does not leave the hospital campus going from the outpatient to inpatient setting, then all of the outpatient charges should be rolled into the inpatient claim and there should be no separate outpatient claim. The following scenarios are to assist you in billing for out/inpatient overlap claims.

- A patient comes into the ER Friday at 10:00 pm; patient is seen and stays in the ER for 8 hours while tests and consults are performed. On Saturday morning, the physician feels it is necessary to admit that patient as inpatient.

When a patient receives continuous outpatient care and then is admitted as an inpatient, all of the outpatient charges should be rolled into the inpatient claim.

- A patient comes into the ER Thursday at 8:00 pm and is admitted as an outpatient in the observation room. By Friday pm, the physician determines it is best to admit that patient as an inpatient.

When a patient is in the observation room, then transferred to an inpatient status, the admission date is the date of service the patient was admitted into the inpatient room. All of the charges associated with the observation room should be rolled into the inpatient claim.

- A patient comes in as an outpatient on Thursday am for services and leaves, then later in the day, is admitted as an inpatient

Some hospitals may treat the outpatient and inpatient stay as one event and bill all charges on the inpatient claim. Other hospitals may treat these as two separate events

since the patient left after the outpatient and bill one outpatient and one inpatient claim. Either method is acceptable.

- A patient comes in at 10:00 pm on Tuesday for ER services and leaves. Wednesday morning the patient is admitted as inpatient.

These services are billed as two separate claims, one outpatient and one inpatient, as they are different service events.

- A patient is discharged on Tuesday am, but is readmitted Tuesday pm.

The services from the second admission are added to the first admission; the claim will be inclusive of all inpatient days.

- A patient is discharged on Tuesday am but comes in for outpatient services Tuesday pm.

These are billed separately, one inpatient claim and one outpatient claim, as they are different service events.

6.4.4 Inpatient Claims: No Medicare Part A; Has Medicare B Coverage

When a Vermont Medicaid member has Medicare part B and no Medicare part A coverage, providers are instructed to bill as follows:

1. Days not covered under Medicare part A must be billed to Medicare B for payment of covered ancillary charges. Claims will crossover to Vermont Medicaid for payment of coinsurance and deductible.
2. Add together Medicare's part B payment, Medicare contractual adjustment amount on part B EOMB and Vermont Medicaid's crossover payment (part B) in field locator 54 (Prior Payments) of the UB-04 claim form.
3. If ancillary charges occurred prior to the Medicare exhaust, a service date is required in field locator 45.
4. If ancillary charges occurred after the Medicare exhaust, follow the instructions in section 6.4.5 of this manual.
5. Submit your claim and all attachments to your Vermont Medicaid Provider Representative. (See <http://www.vtmedicaid.com/#/manuals> and click the Provider Representative Map link).

DVHA does not recognize Provider Liable charges, and therefore the charges are not to be deducted from the billed amount. Do not indicate Provider liable charges in field locator 54 of the UB-04 Claim Form.

6.4.5 Inpatient Claims: Medicare Part A Exhausts or Begins During the Inpatient Stay

When a Vermont Medicaid member has Medicare part B coverage and Medicare part A has exhausted, providers are instructed to bill as follows:

1. Bill part A charges to Medicare. Claim will crossover to Vermont Medicaid for payment of deductible and/or coinsurance.
2. A claim for Inpatient dates of service not covered under Medicare part A must be billed to Medicare B for payment of covered ancillary charges. Claim will crossover to Vermont Medicaid for payment of coinsurance and deductible.

3. The inpatient claim for the *entire stay* should be billed to Vermont Medicaid with “Medicare benefits exhausted or began on mm/dd/yy” indicated in field locator 80 on the UB-04.
4. Add together the Medicare B payment, the Medicare B contractual adjustment, and the Vermont Medicaid crossover payment. Indicate this total amount in field locator 54a on the UB-04. Do not indicate any payment by Medicare A.
5. Attach both the part A and B EOBs. On part A EOMB, write “Medicare benefits exhausted or began on mm/dd/yy”. The charges will not match on part B EOMB. Sign and date part A EOMB.
6. If ancillary charges occurred prior to the Medicare exhaust, a service date is required in field locator 45.
7. If ancillary charges occurred after the Medicare exhaust, follow the instructions in section 6.4.5 of this manual.
8. Submit your claim and all attachments to your Vermont Medicaid Provider Representative. See <http://www.vtmedicaid.com/#/manuals> and click the Provider Representative Map link.

If an inpatient claim submitted to Medicare as primary payer is denied by Medicare because the patient’s Medicare covered benefits are exhausted, DVHA will pay the exhausted day(s) claim based on DRG Payment methodologies for the patient’s Vermont Medicaid covered services.

If a patient becomes Medicare eligible during an inpatient stay, Medicare will pay Medicare covered days as the primary payer. The claim will crossover to Vermont Medicaid for payment of deductible and/or coinsurance. DVHA will pay an inpatient claim for the Vermont Medicaid covered days as a separated DRG payment for the patient’s Vermont Medicaid covered services and DVHA will pay a crossover claim for the coinsurance and deductible for the Medicare covered days.

6.4.6 Inpatient Claims: Medicare Primary but Medicaid Eligibility Termed During Stay

When a Vermont Medicaid member has Medicare A but their Vermont Medicaid has termed during the stay, providers are instructed to bill as follows:

1. Bill part A charges to Medicare
2. The inpatient claim for the entire stay should be billed to Vermont Medicaid.
3. If the patient is eligible for the first day of service, the Medicare A deductible will be paid. Complete the Medicare Attachment Summary. This claim can just be submitted directly to DXC Technology.
4. If the patient is eligible with Vermont Medicaid for co-insurance days, you must attach the Medicare A EOB. On the Part A EOB write Medicare co-insurance start date is mm/dd/yy, write the co-insurance due and sign and date the part A EOMB.
5. Submit your claim and all attachments to your Vermont Medicaid Provider Representative. See <http://www.vtmedicaid.com/#/manuals> and click the Provider Representative Map link.

6.4.7 Interim Inpatient Claims

Inpatient acute care hospitals that have a long-term patient may bill interim claims in at least 60-day intervals. Subsequent bills must be in the electronic adjustment bill format. Each bill must include all applicable diagnoses and procedures. Indicate in the note field: long term inpatient stay greater than 60 days.

1. Type of bill 112 – interim bill-first claim use patient status – still a patient.
2. Type of bill for subsequent claims will be 117 - electronic replacement claim. Use Patient status - still a patient or a valid patient status – discharge code.

Type of bill for subsequent claims will be 117 - **electronic** replacement claim. Patient status will be either patient status 30, or a discharged patient status code.

6.4.8 Present on Admission (POA) - Inpatient Admissions

The present on admission indicator (POA) will be required for all inpatient admissions. Vermont Medicaid will follow Medicare's guidelines. The indicator options are: Y (Yes), N (No), U (Unknown), W (Not Applicable). If exempt from POA reporting leave the field blank. 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 HI01-9 of each appropriate HI segment. 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 exempt from requiring the POA indicator can be located at <http://www.vtmedicaid.com/#/resources>.

6.4.9 Short Stays

Short stays (defined as one calendar day) apply when a patient is admitted and discharged from the same acute care facility on the same calendar day, see below examples.

- Example: Patient is admitted 5:00 am on 1/4/18 and released 11:30 pm on 1/4/18. This is a same-day stay.
- Example: Patient is admitted at 10:00 pm on 1/4/18 and released at 7:00 am on 1/5/18. This is not a same day stay.

Effective for inpatient claims with a date of service on or after 10/1/2014, if a claim has a discharge status code (07) and the length of stay is less than the assigned DRG geometric mean length of stay as identified by Medicare, the claim will also be considered a short stay.

Short Stay claims will be paid the lesser of the cost of the case or the DRG payment.

6.4.10 Same/Next Day Readmission Policy

Effective for inpatient claims for dates of service on or after 10/1/2014, DVHA will not reimburse separate DRG payments for two separate inpatient claims when the patient's subsequent claims admit date is on the same or next day after their original claim's discharge date, both claims are for the same facility, and both claims are for the same or a related condition.

Condition code B4 applies to inpatient admissions with a date of service on and after October 1, 2014, when a beneficiary is readmitted to the same hospital on the same or next day after a previous discharge for symptoms unrelated to, or not for evaluation and management of, the prior stay's medical condition. Condition code B4 will allow the separate episode of care by indicating it is unrelated to the first admission. The code B4 is to be used only when appropriate and in addition to any other applicable condition codes.

For additional information and specific details pertaining to the proposed Inpatient Same/Next Day Readmission Policy, please refer to <http://dvha.vermont.gov/global-commitment-to-health/global-commitment-register>.

6.4.11 Subacute Care

Swing bed hospitals should bill revenue code 16X on a separate claim from the acute care episodes (use appropriate discharge code) waiting for placement hospitals should bill revenue code 19X on the same claim as the acute care episodes.

Payment to hospitals for subacute care is made either for swing bed care or while a patient is waiting placement in a nursing facility. Vermont approved swing bed facilities are eligible for swing bed payments but not waiting placement payments.

The Vermont Medicaid benefit package includes short-term Nursing Facility services based on a physician's order with documentation of medical necessity limited to not more than 30 days per episode and 60 days per calendar year. As of November 1, 2014, individuals are not required to submit a Choices for Care application for short-term swing bed placements. For a stay greater than 30 days per episode or a cumulative stay greater than 60 days per calendar year, a Choices for Care Long-Term Care application is required.

Medicare part B must be billed for those services usually billable. On the Medicare B EOMB, write: "Member is not eligible for Medicare A, ancillary charges billed to Medicare B & Vermont Medicaid. Charges do not match. Medicare B and Vermont Medicaid payment combined in field locator 54." Sign and date the Medicare B EOMB.

The following hospitals have been approved to offer swing bed services:

Vermont: Northeastern VT Regional, North Country, Porter, Grace Cottage, Gifford, Mt. Ascutney, Copley, Springfield.

New Hampshire: Upper CT Valley, Littleton, Valley Regional, Weeks

Hospitals not authorized to bill swing beds may bill for waiting placement for those days after it is determined that a patient no longer requires acute care. If the patient continues to be hospitalized while awaiting placement in a nursing facility and no bed within the area is available, the hospital must be actively seeking placement. Payment is the same as a swing bed day.

6.4.12 Transfer Cases

Transfer cases are defined as patients who initiate an inpatient stay in one hospital and are discharged/admitted from one acute care facility to another.

- The receiving hospital will be paid under normal DRG payment logic.
- The transferring hospital will be paid the lesser of the cost of the case or the DRG payment (including any eligible outlier payment).

Claims will be considered under the transfer methodology when an inpatient claim has a discharge status code of either 02, 05, 06, 62, or 65. When the transfer status code is 02, the claim will automatically fall under the transfer payment methodology.

Effective for inpatient claims with a date of service on or after 10-1-2014, when the transfer status code is either 05, 06, 62, or 65, and the assigned DRG falls within the list of DRGs that

Medicare considers to be post-acute, the claim will fall under the transfer payment methodology.

6.4.13 Outpatient Services Rendered During an Inpatient Stay

Member is admitted to Hospital A for inpatient care. Member is transferred to Hospital B for outpatient services not able to be provided by Hospital A, and then Member is transferred back to Hospital A to complete their inpatient care. Hospital B is to bill Hospital A for the outpatient services provided. Hospital A is to bill Vermont Medicaid for the inpatient stay and will be paid under the normal DRG logic.

6.5 Outpatient/Inpatient Hospital Services

6.5.1 Cardiac Rehabilitation

Cardiac rehabilitation is billable under revenue code 943. One unit is equal to one day regardless of the number of encounters.

Effective for date of service May 16, 2012 and thereafter, cardiac rehabilitation is limited to 36 sessions within a 36-week timeframe. An additional 36 sessions may be approved by the DVHA Clinical Unit when the claim includes the appropriate notes and meets the required criteria.

6.5.2 Dialysis

The DVHA has established a reimbursement policy for billing End Stage Renal Disease outpatient treatment services. This reimbursement method is excluded from OPPS pricing; providers identified as free-standing dialysis centers are reimbursed under this method. Only the revenue codes listed below are reimbursable. All other billed revenue codes will be denied as incidental.

- Revenue codes 821, 831, 841 or 851, Hemodialysis - requires HCPCS code 90999 be billed. This service is reimbursed at a per diem rate of \$151.32
- Revenue code 304, Lab services, non-routine dialysis - requires an appropriate HCPCS code be billed. Reimbursement is 62% of the Level III price on file for the HCPCS code.
- Revenue code 636, separately-payable drugs except EPO - is reimbursed with the appropriate HCPCS and NDC coding (when applicable). Pricing is the current Level III price on file for the HCPCS or NDC code billed on the claim.
- Revenue codes 634 and 635 EPO - are reimbursed when billed with the appropriate HCPCS and NDC coding. Pricing is the current Level III price on file for the HCPCS or NDC code billed on the claim.
- Revenue code 780, Telemedicine - is reimbursable when billed with the appropriate HCPCS code. Pricing is the current Level II price on for the HCPCS code billed on the claim.

6.5.3 Inhalation Therapy

Vermont Medicaid will cover oxygen needed intermittently after a member has been discharged from acute care. Payment will be made to the hospital for this outpatient service.

6.5.4 Hospital Clinical Laboratory Tests

6.5.4.1 Packaged Clinical Laboratory Procedures

Lab related charges must include the corresponding CPT or HCPCS code with the laboratory revenue code on the UB-04 claim form.

Vermont Medicaid packages some Clinical Laboratory procedure codes when they are billed with a primary service on a hospital outpatient claim.

The general rule for OPPS payment methodology is that laboratory tests should be reported on a 13X bill type. There are limited circumstances described below in which hospitals can bill separately for laboratory tests on a 14x bill type.

Laboratory tests may be separately payable under the following limited exceptions:

- the laboratory test is the only service provided to that member on that date of service **-or-**
- the patient is neither an inpatient or outpatient of a hospital (the member is not physically present at the hospital), but has a specimen that is submitted for analysis **-or-**
- the laboratory test is on the same date of service as the primary service but is ordered for a different purpose than the primary service by a practitioner different than the practitioner who ordered the primary service.

It is the hospital's responsibility to determine when laboratory tests may be separately billed on the 14X bill type under these limited exceptions.

6.5.4.2 Clinical Laboratory Tests Reimbursed Separately

Effective for claims submitted on or after 7/1/2014, CMS has created a new modifier, L1, to be used on the 13x bill type when non-referred clinical laboratory tests are eligible for separate payment under the following two exceptions:

- A hospital collects specimen and furnishes only the outpatient labs on a given date of service **-or-**
- A hospital conducts outpatient lab tests that are clinically unrelated to other hospital outpatient services furnished the same day. "Unrelated" means the laboratory test is ordered by a different practitioner than the practitioner who ordered the other hospital outpatient services, for a different diagnosis.

A third exception is allowed for non-patient (referred) clinical laboratory specimens. Providers are to continue billing these outpatient lab tests separately on a type of bill 14x; do not use the L1 modifier.

For additional information, please refer to CMS publication: <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1412.pdf>.

6.5.5 Observation Rooms

Vermont Medicaid is packaging observation services with OPPS primary procedures. There are no exceptions for certain conditions as there are in Medicare. Charges for observation however will be included in the determination of whether or not the claim is eligible for an outlier payment.

Alternatively, Vermont Medicaid will pay for observation separately when there is NO primary procedure. Vermont Medicaid will pay the observation line on a claim provided that the G0378 HCPCS appears on the labor room or observation room revenue code detail line and the number of hours in observation is indicated in the units field. The DVHA will pay up to 24 hours of

observation per stay at \$35.00 per hour with a maximum reimbursement benefit of \$840.00 per claim. Lab details as well as other CPT/HCPCS for which there is a separate OPSS fee assigned but are not designated as primary procedures in the OPSS will be paid separately.

6.5.6 Private Room

Private rooms are allowed only if certified medically necessary by a physician to avoid jeopardizing the health of the patient or to protect the health and safety of other patients.

6.5.7 Provider Based Billing

Effective for claims with dates of service 7/1/2016 and after, DVHA will no longer reimburse for the 51x clinic revenue code series. These revenue codes (510-519) indicate clinic charges for providing diagnostic, preventative, curative, rehabilitative, and education services to ambulatory patients.

The following codes will also no longer be reimbursed as of 7/1/2016 when submitted on an outpatient claim as these codes represent professional services provided in an office or clinic setting: G0463, 99201-99205, 99211-99215 and 99381-99397.

Hospital-owned practices may continue to bill on both a UB-04 (facility) claim along with a CMS-1500 (professional) claim, as appropriate. The professional claim must be billed with the appropriate outpatient place of service code if there is a corresponding facility claim being billed.

When hospital outpatient services are split billed on both a CMS-1500 and UB-04, the office place of service should not be used on the corresponding professional claim. The office place of service should only be used when the professional and facility charges are submitted together on the professional claim, with no corresponding facility claim being billed.

6.5.8 Hospital Inpatient Billing Instructions/Field Locators

Admission Indicator

The billing field locator 14 requires one of four codes. It is the decision of the Admitting Physician when there is a question as to which admission indicator code to use.

Attending Physician

The attending physician, whether the physician or practitioner who actually performs the services for the patient or the referring or prescribing provider, must be enrolled as a participating Vermont Medicaid provider. When billing Vermont Medicaid on the UB-04 Claim Form, the attending physician's NPI (with Taxonomy code when applicable) must appear in field locator 76.

Billing/Supplying Provider

The billing/supplying provider name and address listed on your enrollment application must appear in the field locator 1 and the actual billing NPI (with taxonomy code when applicable) to which payment will be made must appear in field locator 56. If an atypical provider, use the Vermont Medicaid number in locator 57C.

Nurse-Midwife Services

The nurse-midwife provider number should be entered in field locator 76 on the UB-04 claim form. The provider number of an associated physician should NOT be used as the attending.

Field Locators

All information on the UB-04 Claim Form should be typed or legibly printed. The fields listed below are used by DXC Technology when processing Vermont Medicaid claims. The fields designated by an asterisk (*) are mandatory; other fields are required when applicable. Only the fields listed below are used in the Vermont Medicaid Program; other fields do not need to be completed.

<u>FIELD LOCATORS</u>	<u>REQUIRED INFORMATION</u>
1. UNLABELED FIELD*	Enter the Hospital name and address as it appears on the Vermont Medicaid Provider Enrollment form.
2. UNLABELED FIELD	Enter "Vermont Medicaid Hospital Inpatient".
3a. PATIENT CONTROL #	For accounting purposes, enter the patient control # in the field locator. The number may consist of up to 24 characters, alpha/numeric. This information will appear on the Remittance Advice (RA).
3b. MEDICAL RECORD #	Enter patient's medical record #.
4. TYPE OF BILL*	Enter the code indicating the specific type of bill for Inpatient. The sequence is as follows: <u>1. Type of facility</u> 1-Hospital <u>2. Bill Classification</u> 1-Inpatient <u>3. Frequency</u> 1-Admit through discharge claim 2-Interim-first claim 3-Interim-continuity claim 4-Interim-last claim
6. STATEMENT COVERS PERIOD	Enter the from and through service dates.
8b. PATIENT'S NAME*	Enter the patient's last name, first name and middle initial.
10. BIRTHDATE	Enter the date of birth.
12. ADMISSION DATE	Enter date of inpatient admission.
13. ADMISSION HOUR*	Enter the hour in which patient was admitted.
14. ADMISSION TYPE*	Enter the code indicating the priority of the admission: 1-Emergency 2-Urgent 3-Elective 4-Nursery
16. DISCHARGE HOUR	Enter the hour in which the patient was discharged.

17. STAT*	Enter the two-digit code indicating the patient's status as of the 'through date' of the statement period.
18-28. CONDITION CODES*	<u>Enter code to identify if condition is related to the following</u> 02- Condition is Employment Related A1-EPSTD Related Services A4-Family Planning Related Services C1-PSRO Approved as Billed C5-PSRO Post-Payment Review
31-34. OCCURRENCE CODE & DATE*	Enter one of the following two-digit accident codes, and the corresponding occurrence date, if applicable or 52 if no other applies: 01-Auto Accident 02-Auto Accident/No Fault Insurance Involved 03-Accident/Tort Liability 04-Accident/Employment Related 05-Other Accident 06-Crime Victim 11-No Accident/Onset of Symptoms or Illness 42-Date of Discharge 50-Medical Emergency-Non-accidental 51-Outpatient Surgery Related 52-Not an Accident
39. VALUE CODES AMOUNT*	Enter the number of covered days in the amount/dollar column. Do not count the day of discharge or the date of death. (The sum of all the days should be equal to the amount of days being billed.)
42. REVENUE CODES*	Enter the appropriate revenue code for the service provided.
45. SERVICE DATE	Enter the 'FROM' date of the span of consecutive service dates being billed.
46. SERVICE UNITS*	Enter the quantitative measure of service rendered per revenue code.
47. TOTAL CHARGES*	Enter the total charges pertaining to each revenue code billed for the current billing period. Add the total charges for all revenue codes being billed and enter at the bottom of column 47 in the total field. (detail line 23)

50. PAYER*	On 50a, enter the primary payer name or “Spend Down” if spend down amount applies to the claim. On 50b, enter the other insurance name if applicable. Enter “Vermont Medicaid” on 50c.
54. PRIOR PAYMENTS*	Enter the payment amount associated with the payer listed in field locator 50. Attach spend down Notice of Decision. Documentation must be attached if there was no payment, if the services are not covered by the primary, or if the payment by the primary is \$3.00 or less.
55. ESTIMATED AMOUNT DUE	Enter the amount due after deducting any amount entered in field locator 54 from the total entered at the bottom of column 47.
56. NPI*	Enter the BILLING provider’s NPI number.
57a. TAXONOMY CODE(S)	Enter the BILLING provider’s Taxonomy Code when applicable.
57c. VERMONT MEDICAID ID #	Atypical providers, enter your Vermont Medicaid billing provider number.
60. INSURED'S MEMBER ID*	Enter the member's Vermont Medicaid ID #.
67. PRINCIPAL DIAGNOSES CODE* (see Present On Admission - POA)	Enter the primary diagnosis code. Use the appropriate ICD-10 codes.
67 a-q. OTHER DIAGNOSES CODES (Present On Admission-POA)	Enter the appropriate ICD-10 codes; see any condition other than primary, which requires supplementary treatment.
69. ADMITTING DIAGNOSES CODE*	Enter the admitting diagnosis code.
74. PRINCIPAL PROCEDURE CODE & DATE	Enter the appropriate ICD-10-CM procedure code and corresponding date.
74 a-e. OTHER PROCEDURE CODE & DATE	Enter the appropriate ICD-10-CM procedure codes and dates other than the principal procedure performed.
76. ATTENDING PHYSICIAN*	Enter the individual Attending Physician’s NPI number. If billing with a Vermont Medicaid ID #, leave the NPI field blank and enter the Vermont Medicaid ID # to the right of the qualifier box.
78-79. OTHER PHYSICIAN. NPI	Enter the Vermont Medicaid ID # of the physician who the patient was referred to for further treatment, if applicable.

80. REMARKS	Enter any notations relating specific information necessary to adjudicate the claim.
81CCa	Enter the taxonomy code for the attending provider. Must correspond with the NPI number in field locator 76.

6.5.9 Hospital Outpatient Billing Instructions/Field Locators

All information on the UB-04 claim form should be typed or legibly printed. The fields listed below are used by DXC Technology when processing Vermont Medicaid claims. The fields designated by an asterisk (*) are mandatory; other fields are required when applicable. Only the fields listed below are used in the Vermont Medicaid Program; other fields do not need to be completed.

FIELD LOCATOR	REQUIRED INFORMATION
1. UNLABELED FIELD*	Enter the Hospital name and address as it appears on the Vermont Medicaid Provider Enrollment form.
2. UNLABELED FIELD	Enter "Vermont Medicaid Hospital Outpatient".
3a. PATIENT CONTROL #	For accounting purposes, enter the patient control # in the field locator. The number may consist of up to 24 characters, alpha/numeric. This information will appear on the Remittance Advice (RA).
3b. MEDICAL RECORD #	Enter patient's medical record #.
4. TYPE OF BILL*	Enter the code indicating the specific type of bill for Outpatient. The sequence is as follows: <u>1. Type of facility</u> 1-Hospital <u>2. Bill Classification</u> 3-Outpatient 4-Patient not present <u>3. Frequency</u> 1-Admit through discharge claim
6. STATEMENT COVERS PERIOD*	Enter the from and through service dates.
8b. PATIENT'S NAME*	Enter the patient's last name, first name and middle initial.
10. BIRTHDATE	Enter the date of birth.
12. ADMISSION DATE	Enter date of admission.
13. ADMISSION HOUR	If billing for emergency services that are the result of an accident, enter the admission hour.

14. ADMISSION TYPE*	<u>Enter the code indicating the priority of the admission:</u> 1-Emergency 2-Urgent 3-Elective 4-Nursery
16. DISCHARGE HOUR	Enter the hour in which the patient was discharged.
17. DISCHARGE STATUS*	Enter the appropriate discharge code.
18-28. CONDITIONS CODES	Enter code to identify if condition is related to the following: 02-Condition is Employment Related A1-EPSDT Related Services A4-Family Planning Related Services
31-34. OCCURRENCE CODE & DATE*	Enter one of the following two digit accident codes and the corresponding occurrence date, if applicable or 52 if no other applies: 01-Auto Accident 02-Auto Accident/No Fault Insurance Involved 03-Accident/Tort Liability 04-Accident/Employment Related 05-Other Accident 06-Crime Victim 11-No Accident/Onset of Symptoms or Illness 35-Physical Therapy 44-Occupational Therapy 45-Speech Therapy 50-Medical Emergency- Non-accidental 51-Outpatient Surgery Related 52-Not an Accident
42. REVENUE CODES*	Enter the appropriate revenue code for the service provided.
43. NDC CODE*	Enter the NDC code of the drug that was dispensed. Use a "N4" indicator preceding the NDC to identify the information in FL 43 as an NDC.
44. HCPCS/CPT	Enter the appropriate HCPCS/CPT code, immediately followed by an applicable/appropriate modifier
45. SERVICE DATE*	Enter the actual date the service was rendered. If the service was rendered on more than one day, you must bill a separate charge for each day.
46. SERVICE UNITS*	Enter the quantitative measure of service.

47. TOTAL CHARGES*	Enter the total charges pertaining to each code billed for the current billing period. Add the total charges for all revenue codes being billed and enter at the bottom of column 47 in the total field. (detail line 23)
50. PAYER*	On 50a, enter the primary payer name or “Spend Down” if spend down amount applies to the claim. On 50b, enter the other insurance name if applicable. Enter “Vermont Medicaid” on 50c.
54. PRIOR PAYMENTS*	Enter the payment amount associated with the payer listed in field locator 50. Attach spend down Notice of Decision. Documentation must be attached if there was no payment, if the services are not covered by the primary, or if the payment by the primary is \$3.00 or less.
55. ESTIMATED AMOUNT DUE	Enter the amount due after deducting any amount entered in field locator 54 from the total entered at the bottom of column 47.
56. NPI*	Enter the BILLING provider’s NPI number.
57a. TAXONOMY CODE(S)	Enter the BILLING provider’s Taxonomy Code when applicable.
57c. VERMONT MEDICAID ID #	Atypical providers, enter your Vermont Medicaid billing provider number.
60. INSURED'S MEMBER ID*	Enter the member's Vermont Medicaid ID #.
67. PRINCIPAL DIAGNOSES CODE*	Enter the primary diagnosis code. Use the appropriate ICD-10-CM code.
67 a-q. OTHER DIAGNOSES CODES	Enter the appropriate ICD-10-CM codes for any condition other than primary, which requires supplementary treatment.
76. ATTENDING PHYSICIAN NPI*	Enter the individual Attending Physician’s NPI number. If billing with a Vermont Medicaid ID #, leave the NPI field blank and enter the Vermont Medicaid ID # to the right of the qualifier box.
77. OPERATING PHYSICIAN NPI	Enter the Vermont Medicaid ID # of the Operating Physician.
78-79. OTHER PHYSICIAN NPI	Enter the Vermont Medicaid ID # of the physician who the patient was referred to for further treatment if applicable.

80. REMARKS	Enter any notations relating specific information necessary to adjudicate the claim.
81CCa	Enter the taxonomy code for the attending provider. Must correspond with the NPI number in field locator 76.

Section 7 Sample Remittance Advice

The following pages illustrate a sample RA.

PROV 0000000 NPI: 0000000000 VERMONT MEDICAID REMITTANCE ADVICE RA NUM 000000000000
LTC AND PROFESSIONAL PAGE NUM: 1
R/A DATE: 04/01/2018

Providers are required to notify DXC Technology of changes specific to demographics, group affiliation, and address information (billing, mailing, service, prior authorization and legal addresses) in a timely manner. Failure to notify Vermont Medicaid of these changes can result in denied claims, undeliverable correspondence or delayed claims' payment. The current Provider Information Change Form is available on the Vermont Medicaid Web Portal at:
<http://www.vtmedicaid.com/assets/provEnroll/VTMedProviderInfoChangeForm.pdf>

Whenever changes occur, please complete the form and return it to the DXC Enrollment Unit. See the form for directions. Contact the DXC Enrollment Unit for further assistance at Out-of-State, (802) 878-7871, In-State, (800) 925-1706, option 4.

Vermont Medicaid regularly updates its forms and applications to reflect current state and federal requirements. All provider paperwork, including enrollment applications and forms, adjustment forms and refund forms, submitted on outdated versions, will be returned. Providers are encouraged to always check for the most current forms on the Vermont Medicaid website.
<http://www.vtmedicaid.com/#/home>

GETWELL PHYSICIANS
123 YOUR STREET
BURLINGTON, VT 05401

PROV 0000000 NPI: 0000000000

VERMONT MEDICAID REMITTANCE ADVICE

RA NUM 000000000000

LTC AND PROFESSIONAL

PAGE NUM: 2

R/A DATE: 04/01/2018

RECIPIENT NAME	MID	ICN	HVER	PT ACCT/RX#	FRQ	DRG Code	DRGWeight	BILLED AMT	ALLOWED AMT	OI AMT	LIAB AMT	COPAY AMT	PAID AMT
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HEADER MESSAGES (EOB/ADJ RSN/AMT)

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

PAID CLAIMS

CLAIM TYPE: HCFA1500

SMITH BOB	XXXXXXXXXX	402004999888977	00	199		0.0000							
001	00	03/01/18	03/01/18	99213	1.0	176.00	73.63	0.00	0.00	0.00	0.00	0.00	73.63
		0093/45				73.63							
CLAIM TOTALS:								176.00	73.63	0.00	0.00	0.00	73.63
JONES BILL	XXXXXXXXXX	402004555008876	00	167		0.0000							
001	00	03/15/18	03/15/18	99393 EP	1.0	243.00	95.43	0.00	0.00	0.00	0.00	0.00	95.43
		0093/45											
002	00	03/15/18	03/15/18	92551	1.0	25.00	8.81	0.00	0.00	0.00	0.00	0.00	8.81
		0093/45											
CLAIM TOTALS								268.00	104.24	0.00	0.00	0.00	104.24
TOTALS FOR CLAIM TYPE: HCFA1500 3 CLAIM(S)								444.00	177.87	0.00	0.00	0.00	0.00
PAID CLAIM TOTALS: 3 CLAIM(S)								444.00	177.87	0.00	0.00	0.00	177.87

PROV 0000000 NPI: 0000000000

VERMONT MEDICAID REMITTANCE ADVICE

RA NUM 000000000000

LTC AND PROFESSIONAL

PAGE NUM: 3

R/A DATE: 04/01/2018

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
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DETAIL MESSAGES (EOB/ADJ RSN/AMT)

DENIED CLAIMS

CLAIM TYPE: HCFA1500

CLAIM TYPE: HCFA1500												

SMITH BOB	XXXXXXXXXX	402004999888977	00	199		0.0000						
001	00	03/08/18	03/08/18	99213	1.0	176.00	0.00	0.00	0.00	0.00	0.00	0.00
		1098/211			0.00							
CLAIM TOTALS:						176.00	0.00	0.00	0.00	0.00	0.00	0.00
JONES BILL	XXXXXXXXXX	402004555008876	00	167		0.0000						
001	00	03/27/18	03/27/18	90750	1.0	243.00	0.00	0.00	0.00	0.00	0.00	0.00
		1098/211										
002	00	03/27/18	03/27/18	90471	1.0	61.00	0.00	0.00	0.00	0.00	0.00	0.00
		1098/211										
CLAIM TOTALS						304.00	0.00	0.00	0.00	0.00	0.00	0.00
TOTALS FOR CLAIM TYPE: HCFA1500 3 CLAIM(S)						304.00	0.00	0.00	0.00	0.00	0.00	0.00
DENIED CLAIM TOTALS:3 CLAIM(S)						304.00	0.00	0.00	0.00	0.00	0.00	0.00

PROV 0000000 NPI: 0000000000

VERMONT MEDICAID REMITTANCE ADVICE

RA NUM 000000000000

LTC AND PROFESSIONAL

PAGE NUM: 4

R/A DATE: 04/01/2018

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
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DETAIL MESSAGES (EOB/ADJ RSN/AMT)

SUSPENDED CLAIMS

CLAIM TYPE: HCFA1500

SMITH BOB	XXXXXXXXXX	402004999888977	00	199		0.0000						
001	00	03/31/18	03/31/18	90461	3.0	111.00	38.76	0.00	0.00	0.00	0.00	0.00
		1098/211			0.00							
CLAIM TOTALS:						111.00	38.76	0.00	0.00	0.00	0.00	0.00
JONES BILL	XXXXXXXXXX	402004555008876	00	167		0.0000						
001	00	03/27/18	03/27/18	20610 RT	1.0	189.00	48.34	0.00	0.00	0.00	0.00	0.00
		1098/211										
002	00	03/27/18	03/27/18	20610 LT	1.0	189.00	48.34	0.00	0.00	0.00	0.00	0.00
		1098/211										
CLAIM TOTALS						378.00	96.68	0.00	0.00	0.00	0.00	0.00
TOTALS FOR CLAIM TYPE: HCFA1500 3 CLAIM(S)						489.00	135.44	0.00	0.00	0.00	0.00	0.00
SUSPENDED CLAIM TOTALS: 3 CLAIM(S)						489.00	135.44	0.00	0.00	0.00	0.00	0.00

PROV 0000000 NPI: 0000000000

VERMONT MEDICAID REMITTANCE ADVICE

RA NUM 000000000000

LTC AND PROFESSIONAL

PAGE NUM: 5

R/A DATE: 04/01/2018

RECIPIENT NAME	MID	ICN	HVER	PT ACCT/RX#	FRQ	DRG Code	DRGWeight	BILLED AMT	ALLOWED AMT	OI AMT	LIAB AMT	COPAY AMT	PAID AMT
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HEADER MESSAGES (EOB/ADJ RSN/AMT)

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

ADJUSTED CLAIMS

CLAIM TYPE: HCFA1500

SMITH BOB	XXXXXXXXXX	402004999885467	00	199		0.0000
001	00	03/31/18	03/31/18	99887	1.0	35.00
		039/000				0.00

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	XXXXXXXXXX	402004999885467	00	199		0.0000
001	00	03/31/18	03/31/18	99887	2.0	70.00
		039/000				0.00

ORIGINAL CLAIM TOTALS:

70.00 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:

0.00

1 CLAIM(S) 65.00 60.00

0.00 0.00 60.00

PROV 0000000 NPI: 0000000000 VERMONT MEDICAID REMITTANCE ADVICE RA NUM 000000000000
LTC AND PROFESSIONAL PAGE NUM: 6
R/A DATE: 04/01/2018

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

PROV 0000000 NPI: 0000000000 VERMONT MEDICAID REMITTANCE ADVICE RA NUM 000000000000
LTC AND PROFESSIONAL PAGE NUM: 7
R/A DATE: 04/01/2018

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 0000000 NPI: 0000000000

VERMONT MEDICAID REMITTANCE ADVICE
LTC AND PROFESSIONAL
R/A DATE: 04/01/2018

RA NUM 000000000000
PAGE NUM: 8

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