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Vermont Medicaid
Home Health Agency Services, Assistive Community Care Services and Enhanced Residential Care Supplement

VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

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Section 1 Home Health Agency Services

Health Care Administrative Rule 4.231 Home Health Services and related rules can be found on the Agency of Human Services website at: https://humanservices.vermont.gov/rules-policies/health-care-rules. All Home Health Agency Services are subject to the requirements of administrative rule. Information contained in rule will not be repeated in the provider manuals.

1.1 Conditions for Payment

If all conditions for Medicare are met and the patient is Medicare eligible, Medicare must be billed before Vermont Medicaid reimbursement is requested.

1.2 Face-to-face requirements

The Agency of Human Services (AHS) requires providers enrolled in Vermont Medicaid to document that a face-to-face encounter occurred for the initial ordering of home health services.

Additional face-to-face visit requirements can be found in Health Care Administrative Rule 4.231 Home Health Services at https://humanservices.vermont.gov/rules-policies/health-care-rules.

1.3 Reimbursable Services

General Information: Home health services are provided by certified home health agencies under a plan of treatment authorized and approved by a physician. The objective of the home health services is to restore, rehabilitate, or maintain patients in their own homes or in a domiciliary facility by providing professional care and/or supervision. Approved home health services include nursing care services, services of home health aides, speech therapy, physical therapy, occupational therapy, and medical supplies.

Covered services under the Vermont Medicaid Home Health Service Program are those which are necessary to restore, rehabilitate or maintain health, including care for the terminally ill, when provided under professional supervision in the home. Following are descriptions of home health visits covered under the Vermont Medicaid Program.

1.3.1 Visit at Patient's Place of Residence

A visit is a personal contact in the patient's place of residence for providing a covered home health service by a health worker on the staff of the home health agency or by others under contract or arrangement with the home health agency.

Initial Evaluation Visit: A visit to evaluate the patient, the patient's status, the physical environment and facilities available, attitudes of family members, availability of family members to assist in the care and to assess the appropriateness of home health care for the patient.

Services provided by the home health agency, except for the initial evaluation visit, must be furnished under a physician's plan of care. The physician establishes a written plan of care for the patient and supervises the plan in conjunction with the home health agency.

The plan of care must cover all pertinent diagnoses and include the following information:

- Mental status
- Types of professional services needed
- Frequency of visits
- Prognosis as a result of the services
- Rehabilitation potential
- Functional limitations

- Activities permitted
- Nutritional requirements
- Medication and treatments
- Any safety measures to protect against injury
- Instruction for timely discharge or referral

Specific therapy services - This should include the specific procedures and modalities to be used, and the amount, frequency and duration of the therapies.

The plan of care is reviewed periodically by the physician and home health agency personnel. The agency professional staff is responsible for promptly reporting to the physician any changes in the patient's condition which would warrant altering the plan of care.

1.3.2 Nursing Care Services

Nursing care services provided on a part-time or intermittent basis by a home health agency or, in the case where no agency exists in the area, by a registered nurse employed or contracted by the home health agency, are covered. Nursing services must be provided in accordance with the physician's plan of care.

1.3.3 Registered Nurse Services

Skilled nursing care consists of those services reasonable and necessary to the treatment of an illness or injury and for evaluation and assessment of the patient's condition. These services must be performed by or under the direct supervision of a licensed nurse in accordance with the current Nurse Practice Act (State Law) and the individual home health agency policy. Skilled services are covered for patients who have reached a maintenance level but are able to remain in the home if supervised periodically by an RN or therapist.

1.3.4 Licensed Practical Nurse Services

Intermittent or part-time nursing services may be provided to a patient by a licensed practical nurse when these services are ordered by the patient's physician and the licensed practical nurse is working under the direction of the registered nurse. LPN services are assigned and provided in accordance with the current Nurse Practice Act (State Law) and individual home health agency policy. Duties of a licensed practical nurse may include preparing clinical and progress notes, assisting the physician and/or registered nurse in performing specialized procedures, preparing equipment and materials for treatment, observing aseptic techniques as required, and assisting the patient in learning appropriate self-care techniques.

1.3.5 Home Health Aide Services

Home health aide services can be provided even if a skilled service is not needed; however, it is best practice for a registered nurse or appropriate therapist to make a supervisory visit every 2 weeks. The primary function of a home health aide is the personal care of a patient. The home health aide is assigned to a particular patient by the nurse or therapist. Written instructions for the patient's care are prepared by a registered nurse or therapist as appropriate. Routine small cost items such as cotton balls and tongue depressors are included in the home visit charges and will not be paid for separately.

1.3.6 Personal Duties

Personal duties provided in accordance with the written plan of care by the home health aide include medical assistance, assistance in the activities of daily living, such as helping the patient to bathe, to get in and out of bed, to care for hair and teeth, to exercise, assisting the patient in taking medicines specifically ordered by the physician which are ordinarily self-administered, retraining the patient in necessary self-help skills, and assisting with provision and maintenance of a desirable physical environment for the patient in his home.

1.3.7 Medical Duties

Medical duties include taking temperature, pulse, respirations and blood pressure, weighing the patient, reporting changes in the patient's conditions and needs, and completing appropriate records for the home health agency.

1.3.8 Household Services

Household services that are essential to the patient's health care and incidental to the medical care of the patient, such as light housekeeping, meal preparation, laundering essential to the comfort of the patient, etc. are considered covered services of a home health aide when these activities can be documented as a necessary adjunct to the patient's prescribed therapeutic plan of care. Light housekeeping may include, changing the bed, light cleaning, and rearrangement of room furnishings to accommodate patient's needs. Meal preparation, meeting patient's nutritional needs, may include purchase of food, meal preparation, and washing of utensils. Laundering may include being sure the patient has clean articles such as stump socks for amputees, elastic stockings, sleepwear, or undergarments for the incapacitated patient.

1.3.9 Hospice

See Health Care Administrative Rule 4.227 Hospice Services.
https://humanservices.vermont.gov/rules-policies/health-care-rules

Vermont Medicaid reimburses for hospice services provided to patients in nursing homes. Under federal regulations, hospice providers who contract with nursing homes to provide services become responsible for management of the patient's care and billing for all services, including the room and board normally paid to the nursing home. The revenue code 659 should be used for these hospice services and the name of the nursing home should be entered in field locator 80. Vermont Medicaid pays the hospice a rate which is equal to 95% of the nursing homes established per diem rate, and the hospice in turn, pays the nursing home.

The date of death is not eligible for reimbursement from Vermont Medicaid.

1.3.10 Respite Billing

Only provider types of Aged/Disabled Waiver, with Waiver indicated as provider specialty, may bill for respite care. Providers billing for respite must select a type of bill from the following:

1. **Type of Facility**
   8 - Hospice or Special Facility
2. **Bill Classification**
   6 - Respite
3. **Frequency**
   1 - Admit through discharge claim
   2 - Interim-first claim

3 - Interim-continuity claim
4 - Interim-last claim

For additional information, please refer to: https://asd.vermont.gov/content/choices-care-highhighest-manual

1.3.11 Telemonitoring

See Health Care Administrative Rule 3.101 Telehealth, https://humanservices.vermont.gov/rules-policies/health-care-rules/health-care-administrative-rules-hcar.

Home Telemonitoring is a health service that allows and requires scheduled remote monitoring of data related to an individual's health, and transmission of the data from the individual's home to a licensed home health agency. Scheduled periodic reporting of the individual's data to a licensed physician is required, even when there have been no readings outside the parameters established in the physician's orders. In the event of a measurement outside of the established individual's parameters, the provider shall use the health care professionals noted above to be responsible for reporting the data to a physician.

1.3.12 Reimbursement

When Telemonitoring services are provided to clinically eligible Vermont Medicaid patients, qualified providers may bill CPT S9110 for once every 30 days for telemonitoring of patient in their home, including all necessary equipment; computer system, connections, and software; maintenance; patient education and support; per month. CPT 98969 may be billed once every 7 days for ongoing assessment and management of telemonitoring data. Providers should use revenue code 780 for both S9110 and 98969.

1.4 Home Health Agency & Hospice Services Billing Instructions/Field Locators

For Hospice Care only, a Service Intensity Add-On Payment may be billed in addition to the per diem rate for routine home care (RHC) level and is equal to the continuous home care (CHC) hourly rate if the following requirements are met:

- The day is an RHC level of care day
- The care occurs during the last seven days of an individual's life who is receiving hospice services and the individual has died.
- The skilled service is provided by a registered nurse (RN) or medical social worker (SW) for at least 15 minutes but no more than four hours per day.
    - RN and SW hours are combined and cannot exceed four hours total;
    - RN and SW hours provided concurrently count separately;
    - RN and SW hours can occur over multiple visits per day;
    - the service is provided in per; **and**
    - the skilled service provided is clearly documented.

The SIA payment will be determined by the number of hours, in 15-minute increments of service provided multiplied by the hospice current CHC hourly rate.

Additional service code and two new billings codes, one for RN hours and one for SW hours have been created for the submission of claims for the SIA payment. The final claim should include routine home care level, the additional service codes for the SIA payment and a status code to indicate the death of the Member.

Current hospice revenue codes are listed below:

Rev Code	Description	Required HCPCS G Codes
0651	Routine Home Care	No
0652	Continuous Home Care	Yes
0655	Inpatient Respite Care	No
0656	General Inpatient Care	No

Listed below are the revenue codes that must be used to receive the SIA payment:

Rev Code	Description	Required HCPCS G Codes
0551	Routine Home Care	Yes
0561	Continuous Home Care	Yes

Listed below are the current changes that will be effective 1/1/2016 for G codes for the valid discipline values:

HCPCS Code	Description
G0154	Services of a skilled nurse in home health or hospice settings, each 15 minutes Discontinue 12/31/2015 replaced with G0299 & G0300
G0155	Services of a clinical social worker in home health or hospice settings, each 15 minutes
G0299	Direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting, each 15 minutes
G0300	Direct skilled nursing services of a license practical nurse (LPN) in the home health or hospice settings, each 15 minutes

All information on the UB-04 Claim Form should be typed or legibly printed. The fields listed below are used by Gainwell Technologies 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. See the Vermont Medicaid General Billing and Forms Manual, Section 6.3 Patient Share (Applied Income) Reporting. https://vtmedicaid.com/#/manuals

FIELD LOCATORS	REQUIRED INFORMATION
1. UNLABELED FIELD*	Enter the Home Health Agency name and address as it appears on the Vermont Medicaid Provider Enrollment form.
2. UNLABELED FIELD	Enter pay to name and pay to address
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 #.

FIELD LOCATORS	REQUIRED INFORMATION
4. TYPE OF BILL*	Enter the code indicating the specific type of bill for Home Health. The sequence is as follows: 1. Type of facility 3 - Home Health 8 - Hospice or Special Facility 2. Bill Classification 1 - Hospice (Non-hospital based) 2 - Hospice (Hospital based) 2 - Home Health 4 - Ambulatory Surgical Center 6 - Respite 3. Frequency 1 - Admit through discharge claim 2 - Interim-first claim 3 - Interim-continuity claim 4 - Interim-last claim 5 - Late charge(s) only
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	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
17. STAT*	Enter the two-digit code indicating the patient's status as of the statement period. For SIA Payment, please indicate date of death.
18-28. CONDITONS CODES	Enter code to identify if condition is related to the following (*PSRO code is mandatory): 02 - Condition is Employment Related A1 - EPSDT Related Services A4 - Family Planning Related Services *If the patient is found to have Medicare benefits that would not cover the home health visit for one of the following reason, enter the condition code: M3 - Not home bound M4 - Non-chronic M5 - Non-acute

FIELD LOCATORS	REQUIRED INFORMATION
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 42 - Date of Discharge 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. Each date of service must be entered separately at the detail.
45. SERVICE DATE*	Enter the actual date the service was rendered. Enter the from date of the span of consecutive service dates being billed.
46. SERVICE UNITS*	Enter the number of visits or units of time for which reimbursement is being requested. Nursing care and therapy services are reimbursed on a per visit basis. One visit = 1 unit. Home Health Aide services are reimbursed in 15-minute units; therefore, enter total number of units the aide was in the home (i.e., 45 minutes = 3 units.)
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*	Enter “Medicare” or “Spend Down” (if spend down amount applies to the claim.) on 50a if Medicare is the primary payer. 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 third party.
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.

FIELD LOCATORS	REQUIRED INFORMATION
57a. TAXONOMY CODE(S)	Enter the BILLING provider's Taxonomy Code.
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.
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 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.
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.

1.5 Adult Day Services 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 Gainwell Technologies 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 LOCATORS	REQUIRED INFORMATION
1. UNLABELED FIELD*	Enter the Home Health Agency name and address as it appears on the Vermont Medicaid Provider Enrollment form.
2. UNLABELED FIELD	Enter pay to name and pay to address
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 #.

FIELD LOCATORS	REQUIRED INFORMATION
4. TYPE OF BILL*	Enter the code indicating the specific type of bill for Enhanced Residential Care. The sequence is as follows: 1. Type of facility 3 - Home Health 2. Bill Classification 1 - Hospice (Non-hospital based) 2 - Hospice (Hospital based) 2 - Home Health 4 - Ambulatory Surgical Center 3. Frequency 1 - Admit through discharge claim 2 - Interim-first claim 3 - Interim-continuity claim 4 - Interim-last claim 5 - Late charge(s) only
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	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
17. STAT*	Enter the two-digit code indicating the patient’s status as of the statement period.
18-28. CONDITONS CODES	Enter code to identify if condition is related to the following (*PSRO code is mandatory): 02 - Condition is Employment Related A1 - EPSDT Related Services A4 - Family Planning Related Services *If the patient is found to have Medicare benefits that would not cover the home health visit for one of the following reason, enter the condition code: M3 - Not home bound M4 - Non-chronic M5 - Non-acute

FIELD LOCATORS	REQUIRED INFORMATION
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 mandatory for Residential Care Facility only in the amount/dollar column.
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 number of units which reimbursement is being requested.
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 NAME*	Enter "Medicare" or "Spend Down" (if spend down amount applies to the claim.) on 50a if Medicare is the primary payer. 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 third party.
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 #.

FIELD LOCATORS	REQUIRED INFORMATION
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.
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 NPI*	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 2 Assistive Community Care Services (ACCS)

The below General Billing Instruction applies to all Assistive Community Care Services - Choices for Care Programs (ACCS) for licensed Level III and Assisted Living Residences.

2.1 Revenue Code & Date Span Billing

ACCS providers must bill revenue code 0098 assigned by the Department of Disabilities, Aging and Independent Living (DAIL) in field locator 42. Only consecutive days may be billed in field locator 6. If there is a gap in service during a billing period, you must submit separate claims for each span of days. The day of admission is paid but the day of discharge is not paid. Please find the examples below.

2.1.1 Example 1: Continuous Stay

Patient in the facility July 1, 2018 through July 31, 2018.

You would submit as follows:

Single claim
Field locator 6 = 07/01/18 to 07/31/18
042 = 0098
Field locator 46 = 31 units

2.1.2 Example 2: Leave Days

Patient in the facility July 1, 2018 but leaves on July 15th to visit with family members. Patient returns on July 20th through July 31, 2018.

Submit two claims as follows:

First claim
Field locator 6 = 07/01/18 to 07/15/18
Field locator 42 = 0098
Field locator 46 = 15 units

Second claim
Field locator 6 = 07/20/18 to 07/31/18
Field locator 42 = 0098
Field locator 46 = 5 units

2.1.3 Example 3: Hospital Visit

Patient in the facility July 1, 2018 but is discharged to the hospital on July 10th. Patient returns on July 27th through July 31, 2018.

Submit two claims as follows:

First claim
Field locator 6 = 07/01/18 to 07/10/18
Field locator 42 = 0098
Field locator 46 = 9 units

Second claim
Field locator 6 = 07/27/18 to 07/31/18
Field locator 42 = 0098
Field locator 46 = 12 units

2.1.4 Example 4: Multiple Breaks

Patient in the facility July 1, 2018 but is discharged to the hospital on July 10th. Patient returns on July 13th but leaves with family on July 16th. Patient returns on July 18th through July 31, 2018.

Submit three claims as follows:

First claim	Field locator 6 = 07/01/18 to 07/10/18 Field locator 42 = 0098 Field locator 46 = 9 units
Second claim	Field locator 6 = 07/13/18 to 07/16/18 Field locator 42 = 0098 Field locator 46 = 4 units
Third claim	Field locator 6 = 07/18/18 to 07/31/18 Field locator 42 = 0098 Field locator 46 = 14 units

2.2 Assistive Community Care Services (ACCS) Billing Instructions/Field Locators

All information on the UB-04 claim form is to be typed or legibly printed. The fields listed below are used by Gainwell Technologies 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 LOCATORS	REQUIRED INFORMATION
1. UNLABELED FIELD*	Enter your Provider name and address as it appears on the Vermont Medicaid Provider Enrollment form.
2. UNLABELED FIELD	Enter "Assistive Community Care Services".
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 Enhanced Residential Care. The sequence is as follows: 1. Type of facility 3 - Home Health or Residential Care Facility 2. Bill Classification 2 - Home Health or ACCS 3. Frequency 1 - Admit through discharge claim 2 - Interim-first claim 3 - Interim-continuity claim 4 - Interim-last claim 5 - Late charge(s) only
6. STATEMENT COVERS PERIOD*	Enter the beginning and ending service dates included on the bill.
8b. PATIENT'S NAME*	Enter the patient's last name, first name, middle initial.
10. BIRTHDATE	Enter the date of birth
12. ADMISSION DATE*	Enter date of admission
13. ADMISSION HOUR*	Enter the hour in which patient was admitted

FIELD LOCATORS	REQUIRED INFORMATION
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 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. CONDITONS CODES	Enter code to identify if condition is related to the following (*PSRO code is mandatory): 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 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 mandatory for Residential Care Facility only in the amount/dollar column. Do not count the day of discharge or the date of death. (The sum of all days should be equal to the number 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 number of units which reimbursement is being requested. One visit= 1 units. Home Health Aide services are reimbursed in 15-minute units, therefore, enter total number of units that aide was in the home (i.e., 45 minutes= 3 units).
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)

FIELD LOCATORS	REQUIRED INFORMATION
50. PAYER NAME*	Enter “Medicare” or “Spend Down” (if spend down amount applies to the claim.) on 50a if Medicare is the primary payer. 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 third party.
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.
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 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 3 Choices for Care: Electronic Visit Verification (EVV), Enhanced Residential Care (ERC)/Nursing Facilities Home Based Waiver (HBW), Moderate Needs

Due to the implementation of the long-term care 1115 waiver, patient share obligations will be automatically deducted from Vermont Medicaid claims starting with the first claim of the month for nursing homes, ERC and home-based providers. All nursing home claims will cost avoid for Medicare unless the provider has indicated why the service was not covered by Medicare. See the Vermont Medicaid General Billing and Forms Manual, Section 6.3 Patient Share (Applied Income) Reporting. https://vtmedicaid.com/#/manuals

Eligibility for Choices for Care high/highest in all settings is based on specific clinical and financial eligibility criteria and is determined through the Choices for Care application process. Applications may be found at https://asd.vermont.gov/resources/forms.

Moderate Needs Program eligibility is based on clinical and financial criteria and is limited to available provider funding. Applications can be found at https://asd.vermont.gov/resources/forms.

3.1 Electronic Visit Verification (EVV) - Revenue and HCPCS Codes

(Submit "both" Revenue Code and HCPCS Code for service provided)

HCPCS Code	Revenue Code	EVV Service Description
S5130	0095	Homemaker
T1005	0073	Respite Care
T1019	0072	Personal Care
S5135	0073	Companion Care
T2025	0071	Moderate Needs

3.2 ERC Paper Claim Submission 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 Gainwell Technologies 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 LOCATORS	REQUIRED INFORMATION
1. UNLABELED FIELD*	Enter your Provider name and address as it appears on the Vermont Medicaid Provider Enrollment form.
2. UNLABELED FIELD	Enter "Enhanced Residential Care".
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 #.

FIELD LOCATORS	REQUIRED INFORMATION
4. TYPE OF BILL*	Enter the code indicating the specific type of bill for Enhanced Residential Care. The sequence is as follows: 1. Type of facility 3 - Home Health or E.R.C 2. Bill Classification 2 - Home Health or E.R.C 3. Frequency 1 - Admit through discharge claim 2 - Interim-first claim 3 - Interim-continuity claim 4 - Interim-last claim 5 - Late charge(s) only
6. STATEMENT COVERS PERIOD*	Enter the beginning and ending service dates included on the bill.
8b. PATIENT'S NAME*	Enter the patient's last name, first name, middle initial.
10. BIRTHDATE	Enter the date of birth
12. ADMISSION DATE*	Enter date of 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 patient was admitted.
17. STAT*	Enter the two-digit code indicating the patient's status as of the 'through date' of the statement period.
18-28. CONDITONS CODES	Enter code to identify if condition is related to the following (*PSRO code is mandatory): 02 - Condition is Employment Related A1 - EPSDT Related Services A4 - Family Planning Related Services
29. ACCIDENT STATE	

FIELD LOCATORS	REQUIRED INFORMATION
31-34. OCCURRENCE CODE & DATE*	Enter one of the following two digit accident codes and the corresponding date when 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 days should be equal to the number 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 number of units which reimbursement is being requested.
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 NAME*	Enter "Medicare" or "Spend Down" (if spend down amount applies to the claim.) on 50a if Medicare is the primary payer. 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 third party.
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 #.

FIELD LOCATORS	REQUIRED INFORMATION
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.
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 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.
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.

3.3 Choices for Care: Nursing Facilities - General Billing Information

3.3.1 Authorization for Care & Non-Covered Services

Eligibility for long-term care is based on income available for care, admission/discharge status and the medical need for the long-term care.

Personal comfort items, such as the following, are not covered under the Vermont Medicaid program:

- Radio
- Television
- Telephone
- Air conditioner
- Beauty and barber services
- Deodorant
- Denture cream
- Hairbrush

If the member requests any personal comfort items, the member must be advised that he or she will be charged. The facility may charge the member for store items secured for the member such as magazines, newspapers, candy, tobacco and dry cleaning.

3.4 Coverage Review

The Department of Vermont Health Access (DVHA) conducts code reviews on a quarterly or annual basis depending on the type of services that are being requested for consideration. Coverage reviews are initiated when a written prior authorization (PA) request is received by DVHA from a Vermont Medicaid enrolled provider for any Vermont Medicaid Member.

DVHA does not review requests for coverage by a manufacturer, a manufacturer's representative, a Durable Medical Equipment vendor, or other third parties.

Refer to the Fee Schedule at https://dvha.vermont.gov/providers/codesfee-schedules for information about the code coverage and if the specific code in question, requires a prior authorization. Questions about this policy can be directed to the DVHA Clinical Operations Unit at 802-879-5903.

3.4.1 Member Placement Levels (RPL)

The following placement levels are used for specific classifications of long-term care members in the DCF ACCESS system long panel:

010	NH Highest Coverage
011	ERC Highest Coverage
012	HCBS Highest Coverage
014	NH Highest Special
015	ERC Highest Special
016	Cash& Counseling High
020	NH High Coverage
021	ERC High Coverage
022	HCBS High Coverage
030	HCBS Mod Coverage
040	NH Highest Rehab

The RPL is determined by DAIL and entered into the Access system by DCF (high/highest needs) or DAIL (Moderate Needs Program). Placement is not reported on the UB-04 claim form.

3.4.2 DME in Health Care Institutions

Payment will not be made for DME, and supplies ordered by a physician when the member is an inpatient in a health care institution, specifically a general or psychiatric hospital, nursing facility, or intermediate care facility for the mentally retarded (ICF-MR). In these cases, the all-inclusive payment made to these facilities includes the equipment and supplies used by the members.

The one exception is that payment will be made for a seating system, including required accessories, for an individual residing in a long-term care facility when the seating system is prescribed by a masters or doctoral level physical or occupational therapist trained in rehabilitative equipment and is so unique to the individual that it would not be useful to other nursing home residents. Cushions not integral to the seating system are not covered by this exception.

Payment for orthotics and prosthetics, including ostomy supplies and elastic stockings, may be made to the DME vendor when furnished to members in residential facilities, including nursing homes. The doctor and vendor must keep a medical necessity form and/or order, completed by the physician, and/or other documentation of medical need in the member's record.

3.4.3 Duration of Coverage

A continuous period of long-term care residence begins in any long-term care facility with the most recent:

- Day of admission to the facility

- Initial date of Vermont Medicaid eligibility
- First day medical need for long-term care is established by the Utilization Review
- Committee decision

Payment ends on the last day of eligibility, or the day before the day of discharge or death.

3.4.4 Hold Bed

Payment for hold bed days, when a patient is hospitalized, is limited to six consecutive days. A facility may bill for hold bed days when the following criteria are met:

1. While the patient is Vermont Medicaid eligible
2. When the patient has been a resident of the nursing home and has been admitted directly to a hospital
3. When the patient's attending physician attests that the patient is expected to be readmitted to the nursing home in ten days or less or when the hospital's discharge planning unit provides notice that the discharge will occur on a day within the 10-day time limit **AND**
4. When the facility has no other licensed bed available that is also suitable to the gender of the patient for whom the bed will be held. (*Example: If the hospitalized patient is male and there are no other male beds available, a hold bed day can be billed even if one female bed is empty.)*

Under hold bed restrictions, the Vermont Medicaid Program will not reimburse for the following:

- Leave of absences during a hold bed stay
- Hold bed days for members with MR or MH admissions
- Hold bed days for swing bed facilities.

A Discharge Notice must be completed if the member is unlikely to be able to return to the nursing home or, if during the ten days, the member's condition changes such that he/she will not be able to return within the ten days. The date of discharge when a hospital admission is needed is the date of admission to the hospital. If the member's condition changes the date of discharge is the day on which the determination was made or the tenth day.
To bill for a hold bed situation, enter the appropriate revenue code (0185) in field locator 42 (Revenue Code). The hold bed start date is entered in field locator 45 (Service Date) and the total number of days to be billed should be entered in field locator 46 (Service Units). Enter total at the bottom of column 47 in the totals field.

Note: If separate nonconsecutive services occur, the provider must enter a separate detail line with the appropriate revenue code for the service.

For example:

Rev. Code & Description	Start Date	Days/Units	Billed Amount
120 - Room/Board	02/01/18	15	$1500.00
185 - Hold Bed	02/16/18	3	$300.00
120 - Room/Board	02/19/18	10	$1000.00

When billing a Hold Bed claim electronically, the information below is required in the claim note section.

Claim Note Section:
The information in the notes segment must state: CERT FORM and to and from dates the facility was

at maximum licensed occupancy. Electronic claims submitted without this information will be denied.

Providers submitting a Hold Bed claim on paper are required to include an Occupancy Certification Form stating that the nursing home would otherwise be at its maximum licensed occupancy. Paper claims submitted without the Occupancy Certification Form will be denied.

3.4.5 Leave of Absence

Leave days are counted by nights away from the facility for the purpose of a home visit. The maximum number of leave days is 24 per calendar year. If a patient is gone the night of the 4th, both the start date and the end date would be the 4th. If the patient leaves the 4th and returns on the 6th, the start date would be the 4th and the end date would be the 5th. The patient is considered back at the facility to sleep the night of the 6th.

To bill for a leave of absence situation, enter the appropriate revenue code (0182) in field locator 42 (Revenue Code). The leave of absence start date is entered in field locator 45 (Service Date) and the total number of days to be billed should be entered in field locator 46 (Service Units). Enter total at the bottom of column 47 in the totals field.

If separate non-consecutive services occur, the provider must enter a separate detail line with the appropriate revenue code for the service. For example:

Rev. Code & Description	Start Date	Days/Units	Billed Amount
120 - Room/Board	02/01/18	15	$1500.00
182 - Leave of Absence	02/16/18	3	$300.00
120 - Room/Board	02/19/18	10	$1000.00

3.4.6 Nursing Home Claims & Patient Hospitalization

When a nursing home bills an entire month, but the patient was hospitalized for a portion of the billed month, the claim must be recouped, and a corrected claim(s) resubmitted.

If the criteria are met to bill a hold bed, follow the directions stated in the Hold Bed, Section of this manual.

If the hold bed criteria is not met, 2 separate claims must be billed when a patient is discharged from a nursing home and later readmitted into the same nursing home in any one given month.

Do not send a partial refund for the days the patient is hospitalized; this will not correct the actual days that the patient was at the nursing home and does not constitute correct coding.

3.4.7 Patient Share in a Nursing Facility

Patient share amounts are deducted from nursing facilities the first claim of the month when a member is still a patient. When the patient is discharged from a nursing facility prior to month's end, providers are required to adjust & recoup all claims paid for the month of discharge and resubmit one claim for the entire month's service, using the appropriate patient status code. The claim will then be processed and reimbursed without the patient share deduction. See the Vermont Medicaid General Billing and Forms Manual, Section 6.3 Patient Share (Applied Income) Reporting. https://vtmedicaid.com/#/manuals

3.4.8 Prior Payments

Providers are required to report all prior payments made on a claim. This includes Patient Share, Medicare and all Third-Party payments are to be totaled and recorded in field locator 54b of the UB-04 Claim Form.

3.4.9 Choices for Care Short-Term Respite Stays

Individuals enrolled in Choices for Care in the home or ERC settings may receive short-term respite in a Vermont Medicaid licensed nursing facility by changing their Choices for Care setting. This is done by notifying DCF and DAIL using the CFC 804 Change Form. Once the DCF ACCESS long panel is updated with the nursing facility information, the facility may bill Vermont Medicaid using the appropriate revenue code. (Respite stays exceeding 30 days may trigger a change in patient share.

3.4.10 Services Included in Per Diem Rate

The services included in the per diem rate for the nursing facility are described in the Division of Rate Setting's reimbursement regulations. Please contact that division if you are in need of a copy of the regulations. A complete list of covered services included in a nursing facility's per diem rate for long term care can be found in DVHA's Medicaid Covered Service Rule 7603 at https://humanservices.vermont.gov/rules-policies/health-care-rules.

3.4.11 Short Term Stays

The Vermont Medicaid benefit package includes a short-term Skilled Nursing Facility (SNF) stay that is limited to not more than 30 days per episode and 60 days per calendar year.

Admission of a Vermont Medicaid member to a Skilled Nursing Facility (SNF) per the benefit outlined above will be based on a physician's order for SNF services with documentation of medical necessity for the treatment of illness or injury. The admitting diagnosis must support all treatment and therapies ordered and maintain that the service cannot be provided at a lower level of care.

As of November 1, 2014, individuals are not required to submit a Choices for Care application for short-term SNF stays. Instead, the SNF will submit a notice of admission and discharge (long panel) to DCF using form CFC 804C. The facility will submit Vermont Medicaid claims for coverage using revenue code 128 and will be paid out of the Choices for Care budget under the Highest Need category.

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.

The Department of Disabilities, Aging and Independent Living website provides access to the following information regarding this change:

1. Choices for Care 1115 Highest and High Needs Manual:
   Section II: Eligibility: https://asd.vermont.gov/resources/program-manuals
2. Section V.1: Application and Eligibility Determination Procedures:
   https://asd.vermont.gov/resources/program-manuals
3. CFC 804C form: https://asd.vermont.gov/resources/forms

3.4.12 Nursing Facilities 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 Gainwell Technologies 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 LOCATORS	REQUIRED INFORMATION
1. UNLABELED FIELD*	Enter your Nursing Home name and address as it appears on the Vermont Medicaid Provider Enrollment form.
2. UNLABELED FIELD	Enter "Vermont Medicaid Nursing Home".
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 Advise (RA).
3b. MEDICAL RECORD #	Enter patient's medical record #.
4. TYPE OF BILL*	Enter the code indicating the specific type of bill for Enhanced Residential Care. The sequence is as follows: 1. Type of facility 2 - Skilled Nursing 6 - Intermediate Care 8 - Respite Special Facility 2. Bill Classification 1 - Inpatient (Part A) 2 - Hospital Based or Inpatient (Part B) (Included HHA visits under a Part B plan of treatment) 5 - Intermediate Care-Level I 6 - Intermediate Care-Level II 7 - Sub-Acute Inpatient (Revenue code 19X required) 8 - Swing Bed (used to indicate billing for SNF level of care in a hospital with an approved swing bed agreement). 3. Frequency 1 - Admit through discharge claim 2 - Interim-first claim 3 - Interim-continuity claim 4 - Interim-last claim 5 - Late charge(s) only
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*	Enter the hour in which patient was admitted

FIELD LOCATORS	REQUIRED INFORMATION
14. SOURCE OF ADMISSION	Enter the appropriate source of admission 1 - Physician referral 2 - Clinic referral 3 - HMO referral 4 - Transfer from a Hospital 5 - Transfer from a Skilled Nursing Facility 6 - Transfer from another Health Care Facility 7 - Emergency Room 8 - Direction of the Court or Law Enforcement 9 - Information is not available. A - Transfer from a Critical Access Hospital B - Transfer from a Home Health Agency
16. DISCHARGE HOUR*	Enter the hour in which 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. CONDITONS CODES*	Enter code to identify if condition is related to the following (*PSRO code is mandatory): M1 - Benefits Exhausted M2 - Non-Qualifying Stay
31-34. OCCURRENCE CODE & DATE*	Enter one of the following two-digit accident codes and 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 days should be equal to the number of days being billed.)

FIELD LOCATORS	REQUIRED INFORMATION
42. REVENUE CODES*	Enter the appropriate revenue code for the service provided. Acceptable room revenue codes are as follows: 0120 = Room/Board/Semi-private, 2 beds 0128 = Short-term stay/Rehab 0130 = Room/Board/Semi-private, 3-4 beds 0182 = Leave of Absence 0185 = Hold Bed Days
45. SERVICE DATE*	Enter the appropriate start date of the revenue code being billed for this detail charge.
46. SERVICE UNITS*	Enter the number of days being billed for this detail charge for the room charge and units of service for any ancillary charges.
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*	Enter "Patient Share" in 50a, "Medicare" on 50b (if Medicare is the primary payer after patient share.) If other third party, enter name of insurer in 50b. Enter "Vermont Medicaid" on 50c. As of DOS 10/01/05, claims do not need to list patient share. This field will be auto populated.
54. PRIOR PAYMENTS*	Enter the payment amount associated with the payer listed in field locator 50.
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 DIAGNOSIS CODE*	Enter the primary diagnosis code. Use the appropriate ICD-10-CM code.
67a-q. OTHER DIAGNOSES CODES	Enter the appropriate ICD-10-CM codes for any condition other than primary, which requires supplementary treatment.
69. ADMITTING DIAGNOSIS 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.

FIELD LOCATORS	REQUIRED INFORMATION
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.
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.

3.5 Home Based Waiver (HBW) Billing Instructions/Field Locators

This section applies to members receiving Choices for Care home based high/highest and Moderate Needs services.

All information on the UB-04 claim form is to be typed or legibly printed. The fields listed below are used by Gainwell Technologies 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 LOCATORS	REQUIRED INFORMATION
1. UNLABELED FIELD*	Enter your Provider name and address as it appears on the Vermont Medicaid Provider Enrollment form.
2. UNLABELED FIELD	Enter "Home Based Waiver".
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 Enhanced Residential Care. The sequence is as follows: 1. Type of facility 3 - Home Health or H.B.W 2. Bill Classification 1 - Hospice (Non-hospital based) 2 - Hospice (Hospital based) 2 - Home Health or H.B.W 4 - Ambulatory Surgical Center 3. Frequency 1 - Admit through discharge claim 2 - Interim-first claim 3 - Interim-continuity claim 4 - Interim-last claim 5 - Late charge(s) only

FIELD LOCATORS	REQUIRED INFORMATION
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 the date patient care started for Home Based Waiver.
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
17. STAT*	Enter the two-digit code indicating the patient's status as of the 'through date' of the statement period.
18-28. CONDITONS CODES*	Enter code to identify if condition is related to the following (*PSRO code is mandatory): 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 42 - Date of Discharge 50 - Medical Emergency-Non-accidental 51 - Outpatient Surgery Related 52 - Not an Accident
39. VALUE CODES*	Enter the number of covered days. Do not count the day of discharge or the date of death. (The sum of all days should be equal to the number 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.

FIELD LOCATORS	REQUIRED INFORMATION
46. SERVICE. UNITS*	Enter the number of units which reimbursement is being requested.
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 NAME*	Enter "Patient Liability" in 50a, "Medicare" on 50b (if Medicare is the primary payer after Patient Share). If other third party, enter name of insurer in 50b. Enter "Vermont Medicaid" on 50c. Claims do not need to list patient share. This field will be auto populated.
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 third party.
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.
67a-q. OTHER DIAGNOSES CODES	Enter the appropriate ICD-10-CM codes for any condition other than primary, which requires supplementary treatment.
69. ADMITTING DIAGNOSES CODE*	Enter the Admitting Diagnoses Code
74. PRINCIPAL PROCEDURE	Enter the appropriate ICD-10-CM procedure code and corresponding date.
74a-e. OTHER PROCEDURE	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.
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 4 Special Investigations Unit

Vermont Medicaid pays only for services that are actually provided and that are medically necessary. In filing a claim for reimbursement, the code(s) should be chosen that most accurately describes the service that was provided. It is a felony under Vermont law 33VSA Sec. 141(d) knowingly to do, attempt, or aid and abet in any of the following when seeking for receiving reimbursement from Vermont Medicaid:

- Billing for services not rendered or more services than actually performed
- Providing and billing for unnecessary services
- Billing for a higher level of services than actually performed
- Charging higher rates for services to Vermont Medicaid than other providers
- Coding billing records to get more reimbursement
- Misrepresenting an unallowable service on bill as another allowable service
- Falsely diagnosing so Vermont Medicaid will pay more for services

For more information on overpayments and potential interest charges, visit the General Provider Manual, section 6. https://vtmedicaid.com/#/manuals

Suspected fraud, waste or abuse should be reported to the DVHA Special Investigations Unit at https://dvha.vermont.gov/providers/special-investigations-unit, telephone 802.241.9210, or the Vermont Medicaid Fraud Control Unit of the Vermont's Attorney General's Office, telephone 802.828.5511.