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Website Updates

- [-Fee Schedules](#)
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- [-CMS 1500 08/05 Billing Supplement](#)

PROVIDER REPRESENTATIVES UPDATE

EDS would like to welcome Chris Lyon as our newest addition to the Provider Representatives team. Please be advised of the following updates to Provider Representative assignments:

- Betty Parent:** DMHC and FAHC (802-857-2959)
- Chris Lyon:** Bennington, Orange, Rutland, Windham and Windsor counties (802-857-2963)
- Deb Safford:** Addison, Chittenden, Franklin and Grand Isle counties (802-857-2957)
- Jean Gadue:** In-House Representative
- Spring Shower:** Caledonia, Essex, Lamoille, Orleans and Washington counties (802-857-2956)

For a full-color detailed map depicting each Provider Representative and their corresponding territories, visit: <http://www.vtmedicaid.com> under Information/Provider Representative Map.

DME BILLING REQUIREMENT - CMS 1500 08/05

As a reminder, effective for claims received on or after 08/01/2008, Vermont Medicaid will require DME service providers to supply the prescribing providers NPI in field locator 17b & the DME supplier's NPI in field locators 33a and 24j for claims processing.

90853 RETRACTION

On August 8th, 2008, provider notification was issued to providers regarding procedure code 90853 and the correct billing of units. This directive, effective 09/08/2008, instructed provider to bill one unit per visit and sessions would be limited to one session per day, 3 sessions per week. Effective immediately, the Office of Vermont Health Access has authorized EDS to retract and delay the implementation of billing requirements for procedure code 90853 until further notice.

CROSSOVER REQUIREMENTS

Please be advised of the following information regarding Medicare and Vermont Medicaid crossover billing:

- Vermont Medicaid no longer receives any Medicare or Medicaid ID numbers on crossover files,
- Providers must verify that all billing NPI numbers submitted to Medicare are on file with Vermont Medicaid to ensure that claims crossover properly (please verify with Provider Services (800-925-1706 or 802-878-7871) and follow-up with Provider Enrollment, if necessary),
- Even though Medicare does not require or process taxonomy codes, Medicare claims should contain taxonomy codes for correct processing as crossovers to Vermont Medicaid. The most critical taxonomy codes is the *group* taxonomy code and EDS recommends that providers enter their group taxonomy code wherever there is an option to enter a taxonomy.

Contacting EDS

Electronic Data Systems (EDS)

312 Hurricane Lane,
Suite 101
Williston, VT 05495

Phone:
802-879-4450

Provider Services:
Hours of Operation:
8:00am-5:00pm

Out-of-State:
802-878-7871

In-State:
800-925-1706

Fax:
802-878-3440

Email:
VTProvServ@eds.com

EDI Assistance:

Phone:
802-879-4450, #3

DRUGS REQUIRING PRIOR AUTHORIZATION

Effective 09/15/2008, the following medications (listed in alphabetical order) will require a prior authorization when paid through the medical benefit as physician or hospital outpatient billing:

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

This does not apply to Medicare crossover claims. This change is being made so that there is consistency in prior authorization requirements between the medical & pharmacy benefits. The following J codes (listed in numerical order) are affected:

J0129, J0215, J0585, J0587, J1740, J1745, J2323 & J3488.

For beneficiaries 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 denies the claim, the OVHA will require a prior authorization.

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

Elaprase (idursulfase), Soliris (eculizumab), Somatuline Depot (lanreotide), Synagis (palivizumab) & Xolair (omalizumab).

Therefore, the following codes will not be accepted:

90378, C9003, C9237, J1300, J1743 & J2357.

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

Prescribers are instructed to call or fax the Medmetrics Prescriber Call Center (formerly known as the Clinical 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: (800) 918-7549 fax: (866) 767-2649. For clinical criteria & prior authorization forms, visit <http://ovha.vermont.gov/for-providers>.

RA & WEEKLY CHECK AMOUNTS NOW AVAILABLE ON THE WEB!

All providers who submit electronic claims to Vermont Medicaid, will be required to obtain their remittance advice (RA) by downloading it from the web. EDS will continue to mail the paper RA until 09/05/2008. We request that you verify your ability to successfully obtain your web RA prior to the discontinuation of the paper version.

We recently mailed information to providers who submit electronically, outlining the necessary steps for web RA functionality. If you have already completed this, you should be able to access your RA beginning 07/28/2008. If you are unable to access your web RA, please contact the EDI Coordinator via email at: vtedicordinator@eds.com. Effective with RAs dated 09/05/2008, this will be a mandatory requirement for all providers who submit claims electronically.

Contacting OVHA

The Office of Vermont Health Access

312 Hurricane Lane,
Suite 201
Williston, VT 05495

Phone:
802-879-5900

Fax:
802-879-5919

Hours of Operation:
Monday-Friday 7:45-4:30, excluding holidays

NATUROPATHIC PHYSICIAN COVERAGE

On March 6, 2008, Vermont Legislature authorized the OVHA to provide coverage for medically necessary health care services within the Vermont Medicaid & VHAP Benefit Packages provided by a Naturopathic Physician (ND). NDs must be licensed in Vermont & provide treatment within the scope of their practice.

NDs must provide additional required information if they wish to enroll as a Primary Care Provider (PCP) in the Primary Care Plus Program with Vermont Medicaid. This includes having a formal arrangement with a physician who has local hospital admitting privileges. NDs seeking to enroll as PCP's, must complete the Agreement for Participation for Naturopathic Physicians available at: www.vtmedicaid.com under Downloads/Forms.

For additional information, please refer to the Provider Manual under Downloads/Manuals. NDs who do not meet the above conditions to become a PCP for Vermont Medicaid are considered Specialists & services will require a PCP referral.

MODIFIER "RTL" COMBINATIONS

Please be advised, Vermont Medicaid does not utilize the modifier combinations "RTL" or "LRTL". When Correct Coding allows one of these combinations on the base procedure code & the item is supplied bilaterally, providers must bill two separate details/lines: one with the modifier RT & another with the modifier LT.

Updates from the Office of Vermont Health Access

CPT CATEGORY III PROCEDURE CODES

Many CPT Category III Procedure Codes may not be covered by Vermont Medicaid since these codes represent emerging technologies, services & procedures. Providers are reminded to verify coverage before performing the service or procedures. If the Category III code is not on the PAC 8 or 9 (non-covered) listing on the website (<http://ovha.vermont.gov/for-providers>) & does not have an active status on the Fee Schedule, it has probably not yet been reviewed by the OVHA for coverage determination. Providers may request a coverage determination review per the usual process.

OTHER INSURANCE DENIALS AND APPEALS

1.) When the Vermont Medicaid beneficiary's primary insurer (including Medicare) denies a claim as "non-covered" or "benefits exhausted", the provider does not need to appeal to that primary insurer before billing Medicaid.

- a) If the code/service requires prior authorization (PA) from VT Medicaid, then the provider will need to request retrospective authorization from the OVHA in the regular manner (fax all standard documentation required for a clinical review) and include a copy of the other insurer's (or Medicare's) denial.
- b) If the code/service does NOT require prior authorization (PA) from VT Medicaid, then the provider can bill Medicaid directly with a copy of the primary insurer's denial attached.

2.) When the Vermont Medicaid beneficiary's primary insurer (including Medicare) denies a claim for other reasons (such as "not medically necessary", "pre-existing condition" or "waiting period not met"), the provider must first appeal to the primary insurer. Only after all OI/Medicare appeals (through the Qualified Independent Contractor level and BISHCA if eligible and available) are denied can the provider then request coverage by VT Medicaid. All documentation showing the original and appeals' denials must be attached.

- a) If the code/service requires prior authorization (PA) from VT Medicaid, then the provider will need to request retroactive authorization from the OVHA in the regular manner (fax all standard documentation required for a clinical review) and include copies of the other insurer's or Medicare's denials and appeals.
- b) If the code/service does NOT require prior authorization (PA) from VT Medicaid, then the provider can bill Medicaid directly with copies of the primary insurer's denials (original and appeals) attached.

3.) For beneficiaries covered by Medicare, the requirement to go through the Medicare Qualified Independent Contractor appeal level applies with the exception of wheelchairs that Medicare denies or downgrades. Upon documentation of the Medicare action, Medicaid will make its own medical necessity and payment determination.

4.) The OVHA will reject a request if there is reason to believe that the OI received incorrect or incomplete information on which to base its decision.

5.) It is highly recommended that providers determine OI/Medicare benefits before rendering the service to minimize the risk of non-coverage by both OI or Medicare and the OVHA.

OVHA CARE COORDINATOR PROGRAM

The OVHA Care Coordination Program (CCP) is a statewide initiative launched in 2006 to assist the highest risk and most complex Vermont Medicaid beneficiaries with management of their chronic conditions. The CCP implementation is achieved by placing dyads of registered nurse and medical social worker teams in eight districts around the state to work proactively with select beneficiaries and their primary care provider, in support of a joint plan of care to help manage their chronic conditions.

In recognition of the time and engagement of primary care providers and their critical role in developing a joint plan of care, the OVHA has developed a special reimbursement rate for providers who collaborate with the CCP teams, **and who have been notified that their patients are CCMP participants.** This includes three specific points in administration of the beneficiary plan of care:

Development of the Plan of Care: PCPs can bill to meet with the OVHA CCP team to develop and/or review and approve the joint plan of care. The reimbursement is \$55.00

Enhanced PMPM during implementation of the POC: PCPs can bill an enhanced monthly rate during the time they are engaged with the CCP team to jointly manage priority health conditions. The enhanced rate is \$15.00/month.

Transfer to the Chronic Care Management Program (CCMP): At the time of transfer from the CCP intensive services, a summary of outcomes and next steps will be sent by the OVHA team to the MD. At this time, the beneficiary will be transferred to the CCMP telephonic nurse case management services to assist beneficiaries in sustaining changes made during intensive case management. The PCP can bill a program discharge fee of \$55.00 upon receipt of the transfer/discharge summary.

Again, these enhanced reimbursements are available only to primary care providers who have received written notification from OVHA that they are managing specific patients enrolled in CCMP.

The OVHA CCP and CCMP teams have been instrumental in securing a medical home and/or improving the relationship between the beneficiary and the medical care provider and facilitating more proactive engagement in their own healthcare. Staff assist in decreasing the rate of missed appointments and support beneficiaries in understanding and following the recommendations of the medical provider between appointments. For more information on the OVHA chronic care initiatives, please visit our website at: <http://ovha.vermont.gov>.

Non-Covered Services by Vermont Medicaid

AUTOMATIC EXTERNAL DEFIBRILLATOR (AED)

Vermont Medicaid does not reimburse for AEDs. Current scientific evidence concludes there is not significant improvement in survival rate with the use of this equipment.

GASTRIC NEUROSTIMULATORS

Gastric neurostimulators are non-covered. Vermont Medicaid does not reimburse for services or items related to gastric neurostimulation due to Policy M106.39, the requested service is investigational.

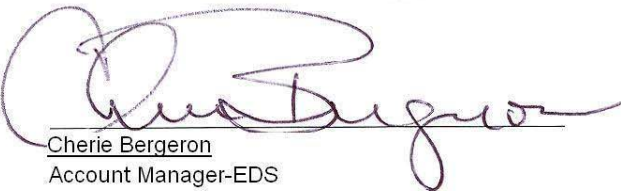
CONTINUOUS INTERSTITIAL GLUCOSE MONITORING

Vermont Medicaid does not reimburse for Continuous Glucose Monitoring (CGM) because its effectiveness has not yet been established. This is also known as "Ambulatory Continuous Glucose Monitoring of Interstitial Tissue Fluid" & "Interstitial Continuous Glucose Monitoring".


NIGHT TIME LYMPHEDEMA GARMENTS

Night time lymphedema garments (e.g., Solaris Tribute) are not covered. Their effectiveness in reducing fibrosis has not been proven & they are not the least expensive appropriate alternative (M106.3, 4) for the treatment of lymphedema.

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