



Advisory

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THE OVHA WELCOMES THEIR NEW DIRECTOR

On December 9, 2008, the Office of Vermont Health Access welcomed Susan W. Besio, Ph.D., as their new Director. She replaces Joshua Slen, who served as Director at the OVHA since August 2003.

Agency of Human Services Secretary, Robert D. Hofmann, stated, "We thank Joshua for his dedicated service and commitment to the health care of our most vulnerable Vermonters, and his role in bringing our Medicaid program to the national stage. I am also delighted that Susan will be returning to the Agency of Human Services in this very critical role. She is a very hard worker and a quick study; her extensive knowledge of the healthcare system, strong relationship with the legislature, and operational experience in state government, make her the ideal candidate to take on this important challenge at this time".

Dr. Besio previously served as Director of Health Care Reform Implementation under the Agency of Administration, and will continue to serve as the single point of accountability for all state healthcare operations in her new role.

Governor Douglas stated, "Susan has proven herself time and again to be a versatile and highly capable healthcare leader in my administration, and I am very pleased that she has accepted this latest challenge at such a critical juncture. Her portfolio of work on healthcare reform will move with her to her new position at the OVHA, and will complement the essential work on Medicaid reform that needs to be fostered and supported here in Vermont and on a national level".

Prior to joining the Agency of Administration, Dr. Besio served as Commissioner of the former Department of Developmental and Mental Health Services, and then Director of Operations and Planning for the Agency of Human Services. She was responsible for the development of Vermont's first comprehensive five-year mental health plan in the early 1980's, the Vermont Agency of Human Services 2005 and 2006 Strategic Plans, and was a primary architect of the Douglas administration's Global Commitment to Health Medicaid 1115a demonstration waiver.

PROVIDER SERVICES PORTAL

EDS would like to announce that the Vermont Medicaid website (www.vtmedicaid.com) will soon open a new Provider Services Portal. This portal will allow providers to verify eligibility, check claim status, download recent Remittance Advices, and modify/maintain provider information.

In order to access this portal, EDS will need a *valid* email address on file. Initial communication for creating an account through the portal will be done using this email address. Please contact the Provider Services Help Desk at (800) 925-1706 (in-state) or (802) 878-7871 (out-of-state) to verify and/or change your email address.

Providers that currently use the Vermont Medicaid website for performing Transaction Services would only need to create an account if they wish to modify their provider information online or do not want their clearinghouse or other billing service to have access to their online Remittance Advice.

Website Updates:

-Fee Schedules

-PAC 8 & 9 Listing

-Active Provider List

-FAHC & DHMC House
Staff Lists

-Medicare Attachment
Summary Form

-“9 Block” Therapy
Extension Form

MEDICARE ATTACHMENT SUMMARY FORM

In an effort to standardize and simplify the processing of *Medicare* paid crossover claims, Vermont Medicaid introduced the “Medicare Attachment Summary Form”.

Beginning January 1, 2009, this form is the *only* acceptable attachment for billing Medicare crossover claims *on paper*. The Explanation of Medicare Benefits (EOMB) form for *paper crossover* submissions is no longer required. However, the EOMB is still required for claims *denied* by Medicare. Please make sure you split the claims that have details that were paid and details that were denied by Medicare. It is imperative that the details on the Medicare Attachment Summary Form match the *exact* details on your claims. If they do not match, the claims will be returned to you. Please do not include any details that were not billed to Medicare.

In addition, please make sure that you attach the correct form—one is only for CMS 1500 and one is for UB 04. The attachment summary forms do not have the same information, therefore it is essential that you attach the correct form to your claim.

At this time we also want to remind you to write the Other Insurance (NOT Medicare) amounts paid (the amount paid includes the sum of both paid amounts and contractual adjustment amounts) on your claim. The amount paid by Medicare should NEVER be on the front of your claim. Non-compliance with these two steps may cause your claim to pay incorrectly.

Please note: Claims will be returned to the provider after January 1, 2009 if the Medicare Attachment Summary Form is not attached to *paper* claims.

The forms are available at: www.vtmedicaid.com under *Downloads/Forms* (CMS 1500 Medicare Attachment Summary and UB 04 Medicare Attachment Summary). These forms may be completed electronically and printed. We would like to encourage you to do this in order to ensure correct processing of your claims. If you do not have access to the internet, you may contact the EDS Provider Services Help Desk at (800) 925-1706 (in-state) or (802) 878-7871 (out-of-state) to request a copy.

Medicare claims should automatically crossover to Vermont Medicaid electronically. If you do not receive the Vermont Medicaid balance, it is mandatory to wait six full weeks from the *Medicare paid date* to submit your paper claims to EDS.

*EDS offers FREE electronic billing software! Provider Electronic Solutions (PES) is available and easy to download. All providers are highly encouraged to use PES for electronic claim submissions. EDS will be offering PES training workshops in the future. For providers who are interested in attending a PES workshop, may contact our in-house Provider Relations Representative, Jean Gadue, at (802) 857-2948. Other questions regarding PES may be directed to the Provider Relations Representative assigned for your area.

MEDICARE CROSSOVER NPI INFORMATION

As a reminder, with NPI-only billing, all providers who were required by Medicare to obtain more than one NPI number (due to multiple service locations, for example), must supply EDS with *all* NPI numbers used when billing Medicare. When billing crossover claims for instances where Medicare required more than one NPI number, it is *imperative* that EDS has all current NPI information on file. Otherwise, the NPI number on your crossover claims may not correspond with the information in the EDS system resulting in possible delays in reimbursement.

In addition, if you are not seeing your Medicare crossover claims being automatically submitted to Vermont Medicaid, there may be a discrepancy with the NPI numbers used when billing Medicare. To ensure that your crossover claims are processed correctly and in a timely manner, please submit the appropriate taxonomy codes to Medicare. Although Medicare does not require or process taxonomy codes, Medicare claims should contain taxonomy codes for correct processing as crossovers to Vermont Medicaid.

Please note: The most critical taxonomy code is the *group* taxonomy and EDS recommends that providers enter their *group* taxonomy code wherever there is an option to enter a taxonomy.

Contact the EDS Provider Enrollment Help Desk at: (802) 879-4450, option #4, to submit all of your Medicare NPI numbers and/or if you have any further questions.

CHIROPRACTIC SERVICES UPDATE

Effective February 1, 2009 there is an Emergency Rule change for chiropractor coverage as follows:

Chiropractic: Adult

As of February 1, 2009, chiropractic coverage for adults in Medicaid and VHAP will be *discontinued*; adults may no longer go to a chiropractor for any service.

Chiropractic: Children

- ◆ Children under 21 years of age may still go to a chiropractor for manipulation of the spine to correct subluxation *only*.
- ◆ In order for children to get more than ten visits per calendar year, the chiropractor will be required to seek prior authorization.
- ◆ Children less than 12 years of age require prior authorization before any services are rendered.

This returns the rules to the status prior to July 1, 2008. As required by the Administrative Procedures Act, the OVHA will be filing a proposed rule change to be effective when the emergency rule expires on June 1. That rule is posted on the OVHA's website:

<http://ovha.vermont.gov/budget-legislative>.

DRG PAYMENT REDUCED TO PARTIAL ELIGIBILITY

In order to clarify the amount due from the patient that EDS attributed to non-eligible days, EDS will reduce the *billed number of days* to the *number of days eligible* on the [QTY BLD] field on the remittance advice. Providers can then calculate the amount due from the patient by dividing the amount paid by the days eligible, then multiplying this figure by the number of non-eligible days.

This change is relatively easy to accommodate, as the claims are currently manually priced and the change to the billed days to the eligible days can be done at the same time.

Due to the nature of the manual pricing, it will not be possible to calculate a modified contractual allowance amount to reflect the difference between the "original allowed" and the "manually calculated" allowed amount fields.

WHOM SHOULD I CONTACT?

To expedite resolution of claim status, eligibility inquiries and remittance advices, please use our website: www.vtmedicaid.com.

All questions regarding claim specific denials should be directed to the EDS Provider Services Help Desk at: (800) 925-1706 (in-state) or (802) 878-7871 (out-of-state).

For additional Customer Service needs or concerns, please contact the Provider Services Unit manager at: (802) 857-2964.

As a reminder, when calling the EDS Provider Services Help Desk, please have the following information available:

Provider Number or NPI/Taxonomy Combination
Recipient ID# or First Name, Last Name, and Date of Birth
Date(s) of Service or ICN#
Procedure Code(s)

Providing this information at the beginning of your call with help facilitate a resolution.

Electronic Data Systems, an HP Company

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, #1

Fax:
(802) 878-3440

Email:
VTProvServ@eds.com

EDI Assistance

Phone:
(802) 879-4450, #3

Email:
VTEDICoordinator@eds.com

The Office of Vermont Health Access

312 Hurricane Lane,
Suite 201
Williston, VT 05495

Phone:
(802) 879-5900

Fax:
(802) 879-5919

<http://ovha.vermont.gov>

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

SELF-INJECTABLE MEDICATIONS

SELF-INJECTABLE MEDICATIONS USED TO TREAT RHEUMATOID ARTHRITIS, JUVENILE ARTHRITIS, PSORIATIC ARTHRITIS, PSORIASIS, CROHN'S DISEASE AND ANKYLOSING SPONDYLITIS MUST BE OBTAINED FROM ICORE® SPECIALTY PHARMACY EFFECTIVE FEBRUARY 16, 2009.

ICORE Healthcare (ICORE®) is the exclusive specialty pharmacy provider for some specialty medications for OVHA beneficiaries. Beginning February 16, 2009, all beneficiaries with primary prescription drug benefit coverage through Vermont's publicly funded programs, must obtain the following injectable medications from ICORE®. We are notifying affected beneficiaries regarding this change.

Preferred Agents (self-injectable) After Clinical Criteria Are Met: Enbrel®, Humira®, Raptiva®

Non-Preferred Agent (self-injectable) After Clinical Criteria Are Met: Kineret®

If you have any beneficiaries being treated with ***Remicade®***, ***Amevive®***, ***Orencia®***, ***Cimzia®***, or ***Tysabri®***, please continue to obtain the medication in the matter you have been using. ICORE® will not be supplying these drugs at this time.

If you have any questions regarding these changes, please contact our on-site MedMetrics' Clinical Account Manager, Diane Neal, R.Ph, at (802) 879-5605 or ICORE® Healthcare directly at (800) 327-1392.

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