

VERMONT HEALTH ACCESS ADVISORY



Linking OVHA and EDS to your Office



October 2004, Volume XXX; Number 4

OVHA- <http://www.ahs.state.vt.us/districts/ovha/vha5.htm>
EDS-<http://www.vtmedicaid.com>

ALL PROVIDERS Swipe Box Upgrades

As previously announced by Vermont Medicaid, the Point of Service Omni terminal devices (POS swipe boxes) used by some providers to verify Vermont Medicaid eligibility are not HIPAA-compliant. Federal mandates require that these devices be capable of housing the new software application required for HIPAA-compliant transactions. In May, 2004 EDS began taking orders from providers who wanted to purchase new HIPAA-compliant swipe boxes. These boxes are manufactured by Verifone and must be ordered by Vermont Medicaid in lots of 100. Enough orders have been received for an initial order to be submitted to Verifone.

If you have ordered a box, you should receive it in January. If you have not already requested a replacement box and would like to do so, please fill out and mail the Omni 3740 Terminal Device Order Form available at www.vtmedicaid.com or call Provider Services at 802-878-7871 or (instate) at 800-925-1706. Please be aware that the next order cannot be placed with Verifone until orders for 100 new devices have been received from providers.

Swipe boxes currently in use will function until the new boxes are available. Existing swipe boxes will not function after January, 2005. Providers will be notified of the specific end date for existing devices in a future communication.

Swipe boxes are only one method for verifying eligibility. The Voice Response System (VRS or Malcolm) can also be used by calling 1-800-925-1706 or (802) 878-7871. Many providers are now verifying eligibility via the web. Details of web verification are given in the following article.

Checking Eligibility and Claims Status On-Line

The quickest way to check eligibility or claims status, interactive or in batch submission, is on-line using Provider Electronic Software (PES) version 4.0 or higher provided by EDS. If you have an active trading partner ID, you can access this information through www.vtmedicaid.com. First, go to Transaction Services and log into Production. This will bring you to the Interactive Services home page where you will see options to "Check Claim Status" or "Check Eligibility Status".

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When checking eligibility on-line, the system requires a 'from and to' effective date. This can be the same date or a span of dates. Providers may verify eligibility for the current date, and rely upon accuracy of the system nine days from the day of query. Providers may also verify eligibility up to one year in the past. If you need help, you can click on the question-mark icon.

When checking the status of a claim, you must enter the billing provider ID and the complete range of dates as submitted on the claim.

Web Page Updates

Our website, www.vtmedicaid.com, continues to grow as a useful resource for the Vermont provider community. Recent additions include the updated EOB Codes list, updated guide to PES software, updated dental procedure/fee schedule, and an introduction to the Global Clinical Record system for on-line prior authorization submission. New forms available for download include: Explanation of Rehabilitation Therapy, Hysterectomy Consent, Medical Necessity DME, Provider Inquiry, Multiple Provider Inquiry, Provider Notification to Recipients, Omni 3740 Order Form, and directions for submitting electronic adjustments.

Headers, Details, & the 777 Denial Code

Some may have noticed the '777' denial code on their Remittance Advice (RA) that states "Denied Service, please see header EOB information." As shown in the sample RA below, the 777 denial code directs you to the header denial code (i.e. 0009); the FIRST number that appears below the patient's LAST name.

| | | | | | | |
|---------------|----------------------|-----------------------|----------------------|-------|----------|--------|
| | Public, John Q. | XXXXXXXXXX | 40200400000000000000 | 00 | 12952270 | |
| | 0009 | 140 | 0.00 | | | |
| Header Denial | 001 | 00 09/08/04 | 09/08/04 | 99242 | | 1.000 |
| | | 0093/42 | 0.00 | | 0777/17 | 153.00 |
| | 002 | 00 09/08/04 | 09/08/04 | 95904 | | 3.000 |
| | | 0093/42 | 0.00 | | 0777/17 | 444.00 |
| | 003 | 00 09/08/04 | 09/08/04 | 95860 | | 1.000 |
| | | 0093/42 | 0.00 | | 0777/17 | 279.00 |
| | CLAIM TOTALS: | | | | | |

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Detail Denial Codes

Typically, header denials address problems with basic information, such as beneficiary names or provider numbers. EOB codes commonly found in the header are 008 (Beneficiary number not on file), 009 (Recipient name and number do not match), or 011 (Provider name and number must match that which is on the enrollment form). All EOB codes are explained on the last page of the RA.

NURSING HOMES

Enforcing Existing Policy

Recent system modifications required by HIPAA have enabled the automated enforcement of existing policy. Federal and State policy requires all providers billing nursing home services to seek payment from private insurance carriers, including Medicare, *before* submitting claims for potential reimbursement from the Office of Vermont Health Access. This is not new policy; Vermont Medicaid has always been the payor of last resort.

PHYSICIANS

Preferred Drug List and Drugs Requiring Prior Authorization

Some formerly preferred drugs are now non-preferred and will require Prior Authorization (PA) effective December 1, 2004. Others will be grandfathered.

Some formerly non-preferred drugs have now become preferred and will no longer require Prior Authorization. This is a two part process. Some drugs became newly preferred as of September 1, 2004. Others became newly preferred as of October 1, 2004. Please refer to the following website for up-to-date information: <http://www.path.state.vt.us/districts/ovha/ovha5.htm>

Referrals

The Primary Care Physician (PCP) is responsible for coordinating care between the PC Plus beneficiary and any specialty care that the beneficiary may need through the referral system. A referral takes place when a participating PCP refers a PC Plus beneficiary for medically necessary Medicaid-covered services not normally provided by the PCP.

Referrals may be made verbally or in writing. Both the PCP and the referral provider are required to keep documentation of the referral in the patient's medical record. The referral must include the following information: patient identification information, reason for referral, and requested service. Providers who make referrals in writing may use their form or the OVHA referral form available from EDS.

The following services do not require a referral from the PCP: dental services; emergency services; family planning services; gynecological services; personal care for children; prenatal and maternity care; routine eye exams, eyeglasses for children; mental health services; school-based health services; services rendered by the PCP or those providing back-up coverage for the PCP; substance abuse services; and transportation services.

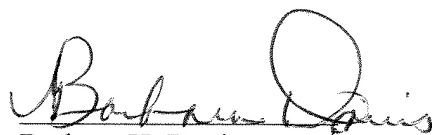
The Non-Participating Enrollment Agreement must be used by physicians who wish to be assigned a Medicaid provider number to be a referring or prescribing physician, even if they do not wish to submit claims for services.

Referrals and the Non-Participating Enrollment Agreement

Enrolling as a non-participating physician assures that other participating providers and facilities may be reimbursed for such prescribed services or items. A non-participating physician may not submit claims to Medicaid for payment for services.

Reminder

Please do not staple your claims together.



Barbara H. Davis
Program Director-EDS



Joshua Slen
Director-Office of Vermont Health Access

MEDICAID BULLETIN
ATTENTION: BUSINESS OFFICE

Prsrt Std
US Postage Pd
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Permit #55

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