

## Banner Pages for July 24, 2009

### Adjustments

This RA may contain administrative adjustments that were initiated by EDS. The claims are recouped and repaid at the same amount with no net effect on payment. The adjustments were necessary in order to accurately identify the funding stream associated with the claim payment. The original claims contained incorrect funding assignments due to a change in the logic. We apologize for any inconvenience this may cause.

### July 17, 2009

#### VPharm Pilot Program: Statins and Proton Pump Inhibitors

Providers were notified that effective July 15, 2009, for beneficiaries enrolled in the VPharm programs, OVHA will only cover the cost-sharing (deductible, donut hole and coinsurance) for select generic and/or OTC statins (HMG COA reductase inhibitors) and proton pump inhibitors (PPIs). The effective date of this change has been moved to August 1, 2009, to provide prescribers and pharmacies additional time to implement this change.

As a reminder, most of the drugs covered under this program do not require prior authorization (PA) from the Part D Plans. However, if a beneficiary has obtained a PA from his/her Part D Plan prior to August 1, 2009, the drug continues to be covered by VPharm through its PA process. Our research suggests that the only affected drug is Lipitor for those enrolled in First Health Part D Premier Plan and First Health Part D Secure Plan.

#### 90-Day Prescriptions for Maintenance Drugs

Providers were notified that effective July 15, 2009, when OVHA is the primary payer, pharmacies will be required to dispense designated classes of maintenance drugs in 90-day supplies after the first fill. The effective date of this change has been moved to August 1, 2009, to provide prescribers and pharmacies additional time to implement the change.

As a reminder, when OVHA is the primary payer: after the first fill, prescriptions written for maintenance drugs must be rewritten for 90 days for the drug to be covered. The maximum quantity limit of 102 days still applies. This rule does not apply to beneficiaries who have other primary insurance, including Part D. The full list of classes of drugs affected by this change is posted on OVHA's website at <http://ovha.vermont.gov/for-providers>. See OVHA's Clinical Criteria document for drugs with other quantity limits: <http://ovha.vermont.gov/for-providers/preferred-drug-list-clinical-criteria>.

### July 10, 2009

#### Thank You

EDS would like to thank everyone for their sympathies during our difficult time. We sincerely appreciate all the support and patience we have received. Mark Towle was a wonderful manager as well as a good friend. The Provider Services Unit will truly miss his support and guidance.

### Denials Available Online

Please be advised, we are now providing the Vermont Medicaid specific EOB code(s) as part of the claim status function under Transaction Services and Provider Web Services. You will now see the Vermont Medicaid EOB on all claims in our history regardless of when they were processed.

Please also note: printouts of the ICN as it appears in claim status may be used as proof of timely filing, provided it is not an ICN of a claim that denied for timely filing.

July 3, 2009

### Prior Authorization Requests

Please be advised, when submitting prior authorization requests to the OVHA Clinical Unit, providers need to include their Vermont Medicaid provider number OR their NPI and taxonomy combination.

June 26, 2009

### Changes to Dental/Orthodontic PA Review Process

As of June 5, 2009, dental and orthodontic PA reviews for the Medicaid program will be transitioned from the Vermont Department of Health to the Office of Vermont Health Access. Effective June 5, 2009, please send all dental and orthodontic PA requests to: The Office of Vermont Health Access, 312 Hurricane Lane, Suite 201, Williston, Vermont 05495.

The Office of Oral Health at the Vermont Department of Health will continue to provide dental consultation for the following State Programs:

- The Children with Special Health Needs Program (CSHN)
- The Dental Care Assistance Program (DCAP)
- The Reach-Up Denture Program

Please continue to address correspondence related to these three programs to the Vermont Department of Health.

### Factor IX Billing

Please be advised, effective 30 days after notification, the current HCPCS code for Factor IX, J7195, will be restricted to include provider types 001 (general hospital), 005 (physician), T06 (nurse practitioner), and T37 (physician assistant), and places of service 11 (office), 50 (FQHC), 72 (RHC), 21 (inpatient hospital), 22 (outpatient hospital) and 23 (emergency room).

When the number of international units (IU) administered exceeds 5 digits, enter the total number in box 19 (or the narrative record) on the CMS 1500 claim form.

### Updated Dental Procedures/Fee Schedule

Please be advised of the following updates to the Dental Fee Schedule, effective for services provided on or after 06/05/2009:

- Based on the dentists determination of Medical Necessity both Intraoral and Panoramic Radiographs may be conducted once per beneficiary every 180 days without requiring prior authorization;
- Occlusal orthotic appliances only require prior authorization if more than one (1) appliance is requested

per beneficiary per year. Providers may access the 2009 Dental Fee Schedule online at: <http://ovha.vermont.gov/for-providers>.

### EDS Dental Provider Liaison

A dedicated EDS Dental Provider Liaison, Jean Gadue, will be the primary contact person for any issues or questions communicated by our dental providers. We assigned this single point of contact in order to ensure that dental providers receive consistent and accurate information with a focus on customer service.

To verify eligibility, claim status, adult limitation amounts, enrollment, remittance advice or questions on denied claims, please contact the Provider Services help desk at 802-878-7871 or 800-925-1706. For all other questions, please contact Jean Gadue at 802-857-2948.

### DME Recycling

This banner page refers to all vendors of Durable Medical Equipment who provide the following equipment to Medicaid beneficiaries (with the exception of dual eligible beneficiaries whose primary insurance will cover the cost of the device):

Manual Wheelchairs K0003-K0007  
Power Operated Vehicles  
Power Wheelchairs  
Standers  
Lifts  
Hospital Beds  
Rehab Shower Commode Chairs  
Augmentative Communication Devices/Speech Generating Devices

Beginning July 15, 2009, all vendors who provide this equipment will be required to affix a sticker on the item at the time of service delivery. This sticker will identify Medicaid as the owner of the device and will provide contact information regarding return of the device when it is no longer required by the beneficiary. Medicaid will provide these stickers. Stickers must be applied to an area of the device that is protected from daily wear and tear but is visible without excessive effort.

There will also be an accompanying signature sheet to be signed by the vendor and the beneficiary or their legal guardian. This form shall be kept on file at the vendor's office and be available for inspection and a copy provided to the beneficiary for their records. This form will be available on the OVHA and EDS website and is listed as the Durable Medical Equipment Ownership, Operation, and Maintenance Agreement.

Please contact the Office of VT Health Access at 802 879 6396 to obtain stickers and forms if you have not received them by July 1, 2009 or if you have run out.

### Updated Therapy Extension Request Form

The Rehab Therapy Extension Request Form was updated to capture certain new requirements for prior authorization documentation and will be effective 08/01/09.

This updated form is available online at: <http://ovha.vermont.gov/for-providers/> under HEALTH SERVICES/Forms/Treatment-Related/Therapy Extension.

For those providers who choose to not use this form, always include the following information in your documentation:

- 1) Documentation of beneficiary/caregiver adherence to home programming
- 2) Procedure codes you will be billing (not required for home health)
- 3) Billable therapy time per visit
- 4) MD/PA-C/NP endorsement of your plan of care
- 5) Medicaid ID number for each involved provider

This information is essential to avoid delays in the processing of your extension requests.

June 19, 2009

#### V5269 & V5274 Restrictions

Please be advised, effective 30 days from notification, HCPCS procedure codes V5269 and V5274 will no longer allow provider types 009 (pharmacy), 014 (DME supplier), and 015 (prosthetics/orthotics).

Allowed provider types for Assistive Listening Devices are 035 (audiologists), and (for billing purposes) 005 (physician) and 001 (general hospital).

#### Provider Reimbursement Rate Reductions

Effective for July 2009 dates of service, Medicaid rates paid to some provider groups will decrease by 2%. For pharmacies this will result in the reimbursement based on Average Wholesale Price (AWP) being reduced by 14.2% (from 11.9%) as of July 15, 2009. For certain other providers, rates will be reduced as July 1, 2009, though some provider types or billing codes are exempt from this decrease due to federal or state mandated reimbursement rates. For affected non-pharmacy providers, the reduction will be captured as the last step in claims processing. The Remittance Advice (RA) will include the following statement: "This payment has the reduced amount from the OVHA posted fee schedule of 2%." The on-line fee schedule will include the same disclaimer.

#### Limited Adult Chiropractic Services Reinstated

Effective as of a July 15, 2009 date of service, reimbursement for adult chiropractic services is reinstated for procedure codes 98940, 98941 and 98942. These chiropractic manipulative treatment codes include a pre-manipulation patient assessment.

#### Co-Pays in VHAP, VPharm and VermontRX

Effective July 15, 2009, the VScript, VHAP and VPharm plans will be modified to include a prescription drug copayment. VPharm, VScript, VScript Expanded VHAP-Pharmacy as well as VHAP beneficiaries at or above 100% of the federal poverty guideline will be affected. The co-pay will be \$1.00 for prescriptions costing \$29.99 or less and \$2.00 for prescriptions costing \$30.00 or more. However, the beneficiary will still owe the pharmacy any co-pay that is not paid. The pharmacy may tell the beneficiary that any later prescriptions may not be filled if the beneficiary does not pay what is owed.

### 90-Day Prescriptions for Maintenance Drugs

Effective July 15, 2009, when OVHA is the primary payer, pharmacies will be required to dispense designated classes of maintenance drugs in 90-day supplies after the first fill. This limit would not apply to the first fill. It will not apply to changes in dosage, as those are considered new scripts. After the first fill, prescriptions written for maintenance drugs must be rewritten for 90 days for the drug to be covered. The maximum quantity limit of 102 days still applies. This rule does not apply to beneficiaries who have other primary insurance, including Medicare Part D. The full list of classes of drugs affected by this change will be posted on the OVHA's website at <http://ovha.vermont.gov/for-providers>. See OVHA's Clinical Criteria document for drugs with other maximum quantity limits: <http://ovha.vermont.gov/for-providers/preferred-drug-list-clinical-criteria>.

### VPharm Pilot Program: Statins and Proton Pump Inhibitors

Effective July 15, 2009, OVHA will only cover the cost-sharing (deductible, donut hole and coinsurance) for select generic and/or OTC statins (HMG COA reductase inhibitors) and proton pump inhibitors (PPIs).

Most of the drugs covered under this program do not require prior authorization (PA) from the Part D Plans. However, if a beneficiary has obtained a PA from his/her Part D Plan, the drug continues to be covered by VPharm. Research suggests that the only affected drug is Lipitor for those enrolled in First Health Part D Premier Plan and First Health Part D Secure Plan. Prescribers and pharmacists identifying other branded statins or PPIs covered by Medicare Part D plans with prior authorization should notify Stacy Baker: (802) 879-5912.

### Dispensing Fees (Out of State)

Out-of-State Pharmacies: Effective July 15, 2009, dispensing fees paid to out-of-state pharmacies shall be reduced to \$2.50 per script.

### Bulk Powders Used in Compounding

Effective July 15, 2009, bulk powders/chemicals/products used in prescription compounding will no longer be covered by the pharmacy programs administered by OVHA. CMS has clarified that bulk products are not considered covered outpatient drugs because they are not prescription drug products approved under section 505, 505(j), or 507 of the Federal Food Drug and Cosmetic Act. Please be aware that when prescribing compound drug products to your patients, pharmacies will be required to utilize other non-bulk, FDA-approved products for the claim to be covered (for example, tablets or capsules). Bulk powders used to compound products for the prevention of pre-term labor will continue to be covered after Prior Authorization when no commercial alternative exists.

[June 12, 2009](#)

### 2009 Vermont Health Care Satisfaction Survey

Your views are very important. Over the past year, physicians, insurers and the Vermont Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) have worked together to create a statewide survey to gauge practitioner satisfaction levels with health insurers in Vermont.

The online BISHCA survey is available until August 15<sup>th</sup> and can be completed at: [http://www.surveymonkey.com/s.aspx?sm=W9BBX8UKTFZYCxR19ANDJg\\_3d\\_3d](http://www.surveymonkey.com/s.aspx?sm=W9BBX8UKTFZYCxR19ANDJg_3d_3d).

The survey results will be used to guide efforts to support high quality health care throughout Vermont. This is the first year that all state programs are included under the Green Mountain Care umbrella.

June 5, 2009

### Apnea Monitors

As a reminder, Vermont Medicaid covers the rental of an Apnea Monitor for use in the home when medically necessary, as per the OVHA Clinical Criteria, however purchase is not covered. The OVHA Clinical Guidelines for Apnea Monitors is available online at: <http://ovha.vermont.gov/for-providers/apnea-monitor-04-01-09.pdf>.

For beneficiaries under the age of one year (infants), prior authorization is not required. When the condition(s) which caused a need for the monitor have been resolved or stable for two to four months, please be sure to discontinue the monitor rental.

### T1013 Interpreter Services

When a Vermont Medicaid provider pays interpreter services for a beneficiary (who does not speak the same language as the provider), in person (at the office), or over the phone – or for the use of sign language (with a hearing impaired beneficiary), the provider may bill procedure code T1013 for every 15 minutes of service provided.

FQHC/RHC providers must bill T1013 for interpreter services using their non-FQHC/RHC provider numbers. Home Health Agencies must use revenue code 940 along with the HCPCS code T1013.

This information can also be found at: <http://ovha.vermont.gov/for-providers/provider-manuals> then click on CMS 1500 08/05 Supplement.

May 15, 2009

### Quarterly Training/Closed for the Holiday

Please be advised, the Provider Services Help Desk will be closed for quarterly training on Friday, May 22, 2009. If you have an urgent question, please leave a detailed message, as we will monitor and return calls throughout the day.

In addition, the Office of Vermont Health Access and EDS will be closed on Monday, May 25, 2009 for the Memorial Day holiday.

### Codes Deleted as of January 1, 2009

Please be advised, claims have been paid by Vermont Medicaid that include CPT and HCPCS codes which were deleted as of January 1, 2009. Claims billed with the following CPT and HCPCS codes will be recouped:

90772, 99431, 99433, 99436, 90760, 93731, 93741, 93743, 99299, J7602, J9182, J2860, & L3890

Once these claims have been recouped, providers should resubmit their claims with the appropriate replacement codes, as applicable. For questions or concerns, please contact the EDS Provider Services Unit at (800) 925-1706 or (802) 878-7871.

### Electronic Funds Transfer Form

The Electronic Funds Transfer Form (EFT) has been updated on the Vermont Medicaid website ([www.vtmedicaid.com](http://www.vtmedicaid.com) under Downloads/Forms). Additions to the forms include the printed name of the person signing the form and the phone number. A new form for providers who currently have EFT and are changing their bank information has been added, this form will also require the old transaction number and account number. A copy of a voided check continues to be required.

### PCP Recipient Listing

Please be advised, you will be receiving the Primary Care Plus Recipient Listing from EDS for your review within the next two weeks. Enclosed in this mailing, you will find a light green insert that provides instructions on how to complete your review.

This is a time-sensitive process, so upon completion of your review, please forward the results to the OVHAs Program Integrity Unit no later than June 20, 2009.

### Clarification for Vision

Please be advised, Vermont Medicaid coverage is for one comprehensive and one interim exam within a two year period. The interim exam is generally a refraction, which may be performed by an ophthalmologist or an optometrist.

### Lumbar Injections

Please be advised, effective 30 days from notification, CPT procedure codes 62270, 62282, 62290, 62311, & 72295 (Lumbar Injections) are being updated to allow place of service codes 11 (office), 21 (inpatient hospital), and 23 (emergency room), as well as provider types 001 (general hospital), 005 (physician), T06 (nurse practitioner), and T37 (physician's assistant).

### HCPCS A4534

Please be advised, effective 30 days from notification, as of 01/01/2005, procedure code A4534 (Youth-sized Incontinence) is no longer a valid code. Please use appropriate coding from the HCPCS manual for this product.

### Ventricular Assist Devices

Vermont Medicaid's coverage of Ventricular Assist Devices is based on the CMS National Coverage Determination 20.9, entitled "NCD for Artificial Hearts and Related Devices". Hospital and Physician providers are referred to the current CPT and HCPCS manuals for proper coding.

### Casting Supplies

Casting Supplies are used by physician and rehab therapy providers. Casting Supplies procedure codes (currently HCPCS codes Q4001-Q4051 and A4580-A4590) are billed by the provider who incurs the cost. Effective 30 days from notification, allowed places of service include 11 (office), 12 (home), 22 (outpatient hospital), and 23 (emergency room).

In addition, effective 30 days from notification, procedure code Q4049 will no longer be a reimbursable service.

### CPT Category III Procedure Codes

Category III codes are placed on file as non-covered because they represent "emerging technology, services and procedures". These services are universally considered experimental or investigational and therefore, not covered by Vermont Medicaid.

Should a service/procedure represented by a Category III code become accepted medical practice, providers may send written documentation to the OVHA Clinical Operations Unit (fax: 802-879-5963) requesting a coverage review.

### Adaptive Weighted Eating Utensils

Please be advised, effective immediately, the OVHA will allow for the reimbursement of "Adaptive Weighted Eating Utensils" when medically necessary for individuals who have significant tremors that interfere with daily activities (i.e., ability to feed self).

These utensils must be ordered by a physician, must be medically necessary, supplied by a DME/Pharmacy or DME vendor, and billed using non-specific HCPCS code A9999. Only one of each type of utensil is allowed. The billing/supplying provider must submit an invoice with the claim in order to be reimbursed.

May 8, 2008

### CPT 97533 Update

Please be advised, effective 30 days from notification, CPT procedure code 97533 is non-covered. Current evidence-based research determines that the effectiveness of this therapy remains unproven.

May 1, 2009

### Alveoloplasty Procedures

Please be advised, effective 30 days from notification, Alveoloplasty procedures (D7310, D7311, & D7320) are limited to four (4) quadrants per beneficiary per 365 days.

April 24, 2009

### Clarification for Vision

Please be advised, Vermont Medicaid coverage is for one comprehensive visual analysis and one interim exam within a two year period.

The interim exam is generally a refraction, which may be performed by either an ophthalmologist or an optometrist.

### DME Restrictions

Please be advised, the DME Restrictions list on the Vermont Medicaid website ([www.vtmedicaid.com](http://www.vtmedicaid.com) under Downloads/Manuals) has been updated to reflect restrictions that will be effective on 06/01/2009. This list includes current DME procedure codes and their restrictions, unit limitations, modifier indicators, and other pertinent information.

### CPT 16036 Update

Please be advised, effective 30 days from notification, procedure codes 16035 & 16036 will allow place of service codes 21 (inpatient) and 22 (outpatient) and will be restricted to diagnosis codes 709.2, 906.7, 940.1 and 941.22-948.97.

### Provider Recertification

As of November 2008, the preprinted Provider Recertification forms are mailed approximately one month prior to when your current state license expires. Please be advised, we should not receive your recertification forms until you are able to attach your new license. Otherwise, the forms will be returned to you. Please verify the information you provided is valid and make any corrections as needed in **red ink**.

Reminder: The Office of Vermont Health Access does not extend providers, nor do they retro-enroll providers. Please contact Provider Enrollment at 800-925-1706 if you have any questions.

#### CLIA:

If you provide any laboratory services, you must include a current copy of the CLIA certification with your recertification form.

#### HCPCS A8000-A8004

Please be advised, effective 30 days from notification, helmets (currently HCPCS procedure codes A8000-A8004) will require prior authorization from the OVHA Clinical Operations Unit. A completed medical necessity form (including physician's order) with justification of the medical need, must be submitted (fax: 802-879-5963) and approval obtained prior to dispensing a helmet to a Vermont Medicaid beneficiary.

April 17, 2009

#### Nurse Practitioner Recertification

Attention Nurse Practitioners: if you have not completed and returned your Vermont Medicaid Enrollment Recertification forms, it is imperative to do so immediately.

Nurse Practitioners who have not sent in their Recertification forms were only active as Vermont Medicaid providers through 03/31/2009. For questions or concerns, please contact Provider Enrollment at EDS at: 802-857-2967.

April 10, 2009

#### Manual Updates Online

Please be advised, the Provider Manual and the CMS 1500 Supplement have been updated and are currently available on the Vermont Medicaid website ([www.vtmedicaid.com](http://www.vtmedicaid.com) under Downloads/Manuals). Please note, all updates are indicated in red font for your convenience!

#### Provider Survey

EDS would like to announce Shawn Accavallo at Pediatric Associates in Rutland as the winner of the 2008 Provider Survey Pizza Party! She and up to 10 of her co-workers will receive a complimentary lunch courtesy of EDS!

Congratulations to Shawn and a big thank you to everyone who took the time to participate in the completion of this year's survey!

#### Provider Workshop

EDS will be holding a Medicaid 101, Website, and Claim Forms Workshop for new billers or as a refresher course for anyone that would like to attend. The workshop will be held on Wednesday, April 29<sup>th</sup> from 9:00am to 11:00am at the Rutland Regional Medical Center (160 Allen Street, Rutland, VT 05701), in conference room number 4.

Directions:

Drive into Rutland on Route 7. From Route 7, turn onto Allen Street. Where the road forks, the hospital will be visible on the right.

For more detailed information on directions, please contact the Rutland Regional Medical Center's information desk at: 802-747-1672.

Please contact Chris Lyon at 802-857-2963 to reserve your seat, as space is limited.

March 27, 2009

### CPT 49492

Please be advised, effective 30 days from notification, CPT procedure code 49492 is limited to provider types 001 (general hospital) and 005 (physician) and limited to place of service code 21 (inpatient).

### Vision Coverage

The Office of Vermont Health Access has removed the edit limiting refraction exams. All refraction exams are covered when provided by a participating Ophthalmologist or Optometrist, no prior authorization is required.

### HCPCS S8429, S8430 & S8431

Please be advised, effective 30 days from notification, Vermont Medicaid will not accept the use of procedure codes S8429, S8430 and S8431.

March 20, 2009

### T1013 Interpreter Services

When a Vermont Medicaid provider pays interpreter services for a beneficiary (who does not speak the same language as the provider), in person (at the office) or over the phone – or for the use of sign language (with a hearing impaired beneficiary), the provider may bill procedure code T1013 for every 15 minutes of service provided.

FQHC/RHC providers must bill T1013 for interpreter services using their non-FQHC/RHC provider numbers. This information can also be found at: <http://ovha.vermont.gov/for-providers/provider-manuals> then click on CMS 1500 08/05 Supplement.

### New Release of PES Available

A new release of PES (version 2.21) is now available on the Vermont Medicaid website ([www.vtmedicaid.com](http://www.vtmedicaid.com) under Downloads/Software). PES version 2.21 contains the following changes:

- The PES "Other Provider" list now allows the addition of different providers with the same EIN *and* Taxonomy. This will support the addition of hospital providers who have the same EIN and taxonomy.
- The default code qualifier value in the PES "Provider" and "Other Provider" lists has been set to XX in order to support the typical (NPI) value. For atypical providers without an NPI, the qualifier can still be changed to 1D in order to support the Vermont Medicaid ID.

-Place of service 35 is no longer valid for Professional claims. It is valid for Dental claims only and is reflected on the claim forms, drop downs and error codes.

If you are upgrading your existing software, please remember to upgrade incrementally. You cannot skip versions without risking database corruption.

March 13, 2009

### Timely Filing Appeals

As a reminder, when appealing a timely filing denial, providers must fully research and document in the request the extenuating circumstances surrounding the claim (e.g. submission dates, adjusted dates, and denial dates). If there is no documentation or the documentation is insufficient to validate extenuating

circumstances for the late submission, your appeal will be denied. Please send your appeal requests to: EDS, P.O. Box 888, Williston, VT 05495 Attn: OVHA Appeals.

March 6, 2009

### Mental Health Admission Requests-Clarification

Requests for all out-of-state mental health inpatient admissions (including elective border hospital admissions) are coordinated by the Office of Vermont Health Access. Calls should be directed to the Clinical Unit administrative staff at 802-879-5903.

There are no changes for requests for in-state mental health inpatient admissions.

### Patient Share & Nursing Homes

When a patient share is deducted and the beneficiary is discharged or deceased during the month, the nursing home must recoup all claims paid for the beneficiary for that month. A new claim with the eligible days for that month with the patient discharge status will need to be submitted to ensure reimbursement of the patient share back to the provider. This directly affects those providers that bill weekly or bi-weekly.

Example: The nursing home bills from the 1<sup>st</sup> through the 15<sup>th</sup> and the patient share was deducted. The next billing period is the 16<sup>th</sup> through the 30<sup>th</sup>. The patient expires or left the nursing home on the 19<sup>th</sup>. The nursing home must recoup the claim from the 1<sup>st</sup> through the 15<sup>th</sup> and rebill for the 1<sup>st</sup> through the 19<sup>th</sup>.

For questions or concerns, please contact your Provider Representative.

### Completing the Medicare Attachment Form Workshop

EDS will be conducting workshops for the new Medicare Attachment Summary Form(s) on Friday, March 20, 2009. We will be providing instructions on how to properly prepare the new Medicare Attachment Summary Form(s) when claims do not cross over electronically from Medicare. The workshop for CMS 1500 billing providers will be from 10:00 to 10:30 and the UB04 billing providers from 10:45 to 11:15. Both workshops will take place at EDS, 312 Hurricane Lane, Williston. To reserve a seat, please contact Betty Parent at 802-857-2959.

### Medicare Attachment Summary Form

In order to further improve collection of Medicare payment information, we have edited the CMS 1500 Medicare Attachment Summary Form.

A column titled "Medicare Paid Amount" has been added to capture the detail of paid amounts from Medicare. Please begin using the new version (REV-02/20/09) as soon as practically possible. The old version will not be accepted after 04/01/2009.

### Patient Share Adjustments

Adjustments requests for nursing home claims that involve a DCF change to the patient share amount, currently require manual handling for reprocessing. Please send an adjustment request form to: EDS, P.O. Box 888, Williston, VT 05495 Attn: Alissa Schirmer.

EDS is working on rectifying this system processing issue. We apologize for any inconvenience this may cause.

February 27, 2009

### Chiropractic Services Reminder

In reference to the January 14, 2009 memorandum from the OVHA outlining Medicaid and VHAP Chiropractic Services Rule Changes, please review the following:

#### **Chiropractic: Adult**

As of February 1, 2009, chiropractic coverage for adults in Medicaid and VHAP has been discontinued; the OVHA will no longer reimburse for any adult chiropractic services.

#### **Chiropractic: Children**

Children under age 21 in Medicaid may continue to see a chiropractor for manipulation of the spine to correct a subluxation only. Children under 12 require prior authorization before any services are rendered. Chiropractors must request a prior authorization for children to receive more than 10 visits in a calendar year.

**This returns the rules to their status prior to July 1, 2008.**

### Medicare Payments Reminder

As a reminder, if a beneficiary is covered by Medicare part C or MCR HMO, providers need to indicate this information on the claim form (box 9d on CMS 1500 and box 50 on UB04) when submitting paper claims to EDS.

**Also, if services are provided to a beneficiary who has Medicare part A, B, or C, it is very important that providers do NOT include any payments made by Medicare on the claim form when submitting claims on paper. The prior payment field (box 29 on CMS 1500 and box 54 on UB04) is strictly designated for other insurance payments (i.e. Cigna, BC/BS, etc.) EXCLUDING Medicare. If present on the claim, the Medicare payment could be considered another primary insurance and the claim could pay incorrectly or pay at \$0.00.**

Providers need to submit a paper claim to Vermont Medicaid with the Medicare EOMB attached if Medicare denied services in order for claims to process correctly.

February 20, 2009

### Billing & Appeals to Other Insurance

Providers billing for procedure codes:

S9445 HA	T1022 HA TF
S9445 HA U7	T1022 HA U6
S9445 HA U6	T1022 HA U7
S9445 HA U7 TF	T1022 HD U6
S9445 HA U6 TF	T1022 HD U7
G9009 HU	G9010 HU

Are exempt from the requirement to bill other insurance companies prior to Medicaid when billing for these specific list of services. When billing for any other services, providers must bill primary insurance first, but are exempt from appealing the denials from other insurance.

### Casting Materials

HCPCS casting supply procedure codes Q4001-Q4051 are for use by physician providers. Codes Q4003-Q4051 can also be used by physical and occupational therapists billing independently and by the outpatient hospital on behalf of their physical and occupational therapist employees. Non-specific casting supplies (currently represented by HCPCS codes A4580, A4590, Q4050, and Q4051) require prior authorization from the OVHA before the supplies are used for the Medicaid beneficiary. Documentation must clearly show why one of the specific cast supply codes is not appropriate and the anticipated cost (include example invoices).

### HCPCS A9999

Vermont Medicaid covers "Special Needs Feeder Bottles" (such as "Haberman Feeder" or "Haberman bottle") when medically necessary for an infant or child with a diagnosis involving dysphagia. These bottles must be ordered by a physician and supplied by a DME vendor. Quantity is limited to 10 bottles/nipples per 6 months.

There is no specific HCPCS code available at this time so the OVHA will accept the use of non-specific HCPCS code A9999. Since code A9999 requires prior authorization, the OVHA has instructed EDS to override the need for PA in this circumstance. The medical need for these special bottles must be clearly documented in the patient's medical records. An invoice is required with each claim submission.

February 13, 2009

### Closed for the Holiday

Please note, both EDS and the OVHA offices will be closed on Monday, February 16, 2009 for the President's Day holiday. Both offices will reopen on Tuesday, February 17, 2009.

### SFY 2010 Budget Document

Please note, you can view the OVHA proposed Budget Document at: <http://ovha.vermont.gov/budget-legislative> under Budget & Financial.

February 6, 2009

### 2008 Provider Survey

EDS would like to invite providers to participate in the 2008 Provider Survey! All feedback would be greatly appreciated, as your responses will help to enhance services and to better serve the provider community!

Join us at [www.vtmedicaid.com](http://www.vtmedicaid.com) under Information and participate in our new online version of the Provider Survey! Providers who do not have access to the internet, may request a paper copy by contacting the Help Desk at 802-878-7871 (out-of-state) or 800-925-1706 (in-state), and one will be provided.

Please note: If you wish to participate in our survey, it must be completed before February 20, 2009. Upon completion of the Provider Surveys, we will hold a random drawing for the 2008 Provider Survey pizza party! (You must complete the survey to enter the drawing). The winner will receive a complimentary pizza party for up to 10 their co-workers! Please take a moment to complete the survey for a chance to have lunch, courtesy of EDS! Thank you!

## Provider Services Portal

EDS would like to announce that the Vermont Medicaid website ([www.vtmedicaid.com](http://www.vtmedicaid.com)) will soon open a new Provider Service 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 RA.

## Mental Health Admission Requests

Please be advised, requests for Mental Health admissions are coordinated by the Office of Vermont Health Access and the reviews are done in collaboration with the Department of Mental Health. This includes out-of-state and in-state requests that require prior authorization or emergent notification of admission.

Calls should be directed to the Clinical Unit administrative staff at 802-879-5903.

## Eligibility Verification Downtime

Please note: All eligibility verification applications (Web, Malcolm, POS, etc.) will be unavailable for approximately two hours on Sunday, February 15<sup>th</sup> during the hours of 6:00 pm to 8:00 pm.

This downtime is necessary to perform required system upgrades to the current hardware and software. We apologize for any inconvenience this may cause however, in order to continue to provide reliable services, we must perform this routine maintenance.

January 30, 2009

## Electric Pneumatic Percussor

Please be advised, effective 03/02/2009, Vermont Medicaid covers only one month's rental of an electric or pneumatic percussor for in-home use. Rental may be necessary because of short-term need (e.g., acute exacerbation) or a trial period.

If the rental becomes a purchase, the rental reimbursement must be applied to the purchase payment.

When the percussor is known to be needed long-term, no rental is necessary. The current HCPCS procedure code which represents this item is E0480.

## Whom Should I Contact?

To expedite resolution of claim status, eligibility inquiries and remittance advices, please use our website: [www.vtmedicaid.com](http://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 will help facilitate a resolution.

### Rehabilitation Therapy Services

Physical and occupational therapists who are working in private practices, Comprehensive Outpatient Rehabilitation Facilities (CORFs) and outpatient hospital settings, and speech therapists who are working in CORFs and outpatient hospital settings, please note: New procedure codes have become available for use when billing Vermont Medicaid.

The 2008 CPT procedure codes representing speech therapy services are 92506, 92507, 92508, & 92605-92611. Physical and occupational therapy services are represented by 2008 CPT procedure codes 64550, 90901, 92526, 92597, 92605-92611, 95831-95852, 96105, 96110, 96111, 96125, & 97001-97750.

Not all of these codes are covered/allowed by Vermont Medicaid. To determine if a code is available, please refer to the fee schedule on the web at: <http://ovha.vermont.gov/for-providers>. To request coverage of a code not currently available, document the code and definition, your rationale for use of the code and documentation that the code reflects treatment permissible to your profession under the State Practice Act. Provide this documentation to the OVHA Reimbursement Department, 312 Hurricane Lane, Williston, VT 05495.

Notice of Decision responses to requests for prior authorization will display a range of CPT procedure codes (i.e., 92526-97750). Not all codes in the range are being authorized. The authorization applies only to those codes that are currently available to the specific discipline listed in the "Explanation of Decision" on the Notice of Decision.

### HCPCS Codes L0112-L0710

Currently, the system limits lumbar-sacral orthoses to 2 per year. Effective 03/02/2009, this audit will limit all spinal orthoses to one per beneficiary per year (365 days) for beneficiaries 19 years and older. Children aged 18 and younger are allowed a second spinal orthotic within 365 days when needed due to growth changes.

Standard medically-necessary rules apply. Current HCPCS procedure codes involved in this audit are L0112-L0710 and these limitations apply to any and all codes which meet the definition of a spinal orthotic. Only one orthotic is allowed at a time. Prior authorization from the OVHA Clinical Operations Unit is required prior to dispensing more than the number allowed.

### Medicaid Transportation: Out-of-State/Area Referrals

All in-state, out-of-area and out-of-state Medicaid transportation referrals must now be faxed to the OVHA for review and approval or denial; the fax# is 802-879-5919. All referrals must be submitted on the updated Out-of-State/Out-of-Area Medicaid Transportation Physician Referral Form at least 48 hours prior to when the scheduled trip shall occur to provide sufficient time for review.

This form can be found at: <http://ovha.vermont.gov/for-providers>; the updated submission and contact information is also located on the form. Please contact Peter McNichol at [Peter.McNichol@ahs.state.vt.us](mailto:Peter.McNichol@ahs.state.vt.us) or 802-879-5935 with any questions.

### LT/RT Modifier Combinations

Many CPT/HCPCS procedure codes allow modifiers RT (right) or LT (left) to identify the specific side of the body. In these cases, the base code (with no modifiers) is not valid and cannot be accepted by Vermont

Medicaid. The only exception is when the code's description states "unilateral or bilateral". Providers may also refer to the related banner page published on 09/05/2008 entitled "LT & RT Modifier Combinations".

### Developmental Screening

The AAP recommends that all infants and young children should be screened with valid, reliable screening instruments for developmental delays at regular intervals. To increase the use of a standardized screening instruments and to improve detection rates, as of 01/01/2009, the OVHA will allow billing for the well-child visit and the developmental screening (CPT 96110) on the same day when a standardized screening instrument is used. Changes in the billing are to allow a developmental screening to be billed by Primary Care Providers with the following preventive medicine services CPT codes on the same day: 99381, 99391, 99382, 99392, 99383, 99393, 99384, 99394, 99385, & 99395 for children less than 21 years of age in Medicaid, Dr. Dynasaur, or SCHIP.

Physicians or Primary Care Providers must use a standardized screening instrument to bill for developmental screening that occurs in conjunction with a well-child visit. Any standardized screening instrument listed in the Academy of Pediatrics policy statement will be accepted. Providers are required to maintain documentation of the screening and the screening instrument used in the patient record. Developmental screening is recommended when surveillance indicates the child may be at risk for developmental delay. In addition, all children should have periodic developmental screening at the 9, 18, 24, or 30 month visits. Providers cannot bill for developmental screening when the screening instrument is being used for surveillance.

January 23, 2009

### HCPCS Codes Requiring NDC

Please be advised, effective 02/23/2009, the following HCPCS codes will be added to the list of codes which require an NDC:

J3490, Q0169, & Q2009.

For a complete list of HCPCS codes requiring an NDC, visit [www.vtmedicaid.com](http://www.vtmedicaid.com) under *Information*.

### Procedure Code J3490

Please be advised, effective 02/23/2009, Vermont Medicaid will allow the use of non-specific procedure code J3490 for Arginine when supplied by and administered in the office or outpatient hospital setting as part of a growth hormone stimulation test to determine if a patient has a growth hormone deficiency. Although the non-specific procedure code J3490 requires prior authorization, the Arginine does not, therefore EDS is instructed to override the need for PA in these cases. The provider's claim must include the NDC, the invoice, the quantity supplied, and the route of administration.

### CPT 11980 Update

Please be advised, effective 02/23/2009, the OVHA has updated procedure code 11980 to the following:

- Allow provider types 001 (general hospital), 005 (physician), T03 (ambulatory surgical center), T06 (nurse practitioner), T37 (physician assistant);
- Allow place of service codes 22 (outpatient hospital), 24 (ambulatory surgical center), & 11 (office);
- Allows a maximum of one unit per billing;
- Restricted to only allow diagnosis codes 253.4 and 257.2;
- Restricted to 'males' only.

### Procedure Codes 99218-99220

Please be advised, effective 02/23/2009, procedure codes 99218, 99219, & 99220 will be restricted to place of service codes 22 (outpatient hospital) and 23 (ER) only.

### New 2008 DME Restrictions

Please be advised, unit limitations on the following 2008 DME HCPCS codes will in effect on 02/23/2009:

- A9283: Limited to one/foot/2 years, requires modifier RT or LT, and PA is required if billing for more than one unit;
- A7027 & A7028: Limited to 1 unit per billing, 2 units/365 days;
- B4087 & B4088: Limited to 2 units per billing, 2 units/6 months;
- E0328: Limited to 1 unit per billing, 1 unit/8 years; mattress included w/code;
- E0329: Limited to 1 unit per billing, 1 unit/5 years; mattress included w/code;
- E0856: Limited to 1 unit per billing, 1 unit/8 years;
- E2227, E2312, & E2313: Limited to 1 unit per billing, as medically necessary;
- E2228: Limited to 2 units per billing, as medically necessary;
- E2397: Limited to 1 unit per billing, 2 units/365 days;
- L7611-L7614, L7621 & L7622: Limited to 1 unit per billing, one/hand/5 years, requires modifier RT or LT, and PA is required if billing for more than one unit.

### CPT 99070 Updates

Please be advised, effective immediately, Albuterol inhalers do not require prior authorization. For those rare instances when an Albuterol inhaler must be dispensed in the physician's office, Vermont Medicaid allows billing with CPT code 99070 since there is no specific J-code available. The NDC and an invoice for the dispensed inhaler must be submitted with the claim for pricing purposes.

### January 16, 2009

#### PES Workshop – Billing Medicare Cross Over Claims

There will be a workshop on February 12, 2009 from 1:00 to 3:00 for billing Medicare deductible and co-insurance claims using Provider Electronic Solutions (PES) when your claim did not automatically cross over. This will take place at EDS and the address is 312 Hurricane Lane in Williston. Call Betty Parent at 802-857-2959 to reserve a seat.

#### Closed for the Holiday

Please be advised, EDS and the OVHA will be closed on Monday, January 19<sup>th</sup> 2009 to honor Martin Luther King Day. Both offices will reopen on Tuesday, January 20<sup>th</sup> 2009.

### January 9, 2009

#### New Drug Reversal Processing

As of the Remittance Advice (RA) dated 01/09/2009, Drug Reversals will appear in the "Adjusted Claims" section of your RA. This implementation will eliminate the need for the supplemental reversal RAs.