Department of Vermont Health Access

March/April 2023 Advisory

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HEDIS Performance Measure Medical Record Review (MRR) Requests

HEDIS stands for Healthcare Effectiveness Data and Information Set and is one of the most widely used sets of health care performance measures in the United States. Medicaid (and commercial) plans across the country produce them to measure health plan processes and member health outcomes. To produce some of the HEDIS measures, DVHA must request members' medical records from providers and then trained clinicians review pieces of the member's record for information that doesn't show up through claims processing. This includes information like lab results, documentation of certain screening tools being used, even a member's height, weight or blood pressure.

DVHA has contracted with a company named Cotiviti to retrieve medical records from providers for five hybrid measures. Cotiviti will launch the record retrieval in March 2023. You may receive a letter requesting records for one or more of your patients that qualify for these measures. The top of the letter will have DVHA's logo on it and the bottom will be signed by DVHA's Chief Medical Officer Dr. Michael Rapaport.

Please pay close attention to the HEDIS Measure Requirements and Dates of Service on both the Measure Page and/or the Patient List and only submit the type of record requested within the stated timeframe. Providers are required to participate at no cost, as stated in your signed Medicaid Provider Enrollment Agreement: ARTICLE VI. AUDIT INSPECTION. DVHA may enforce a 10% withholding of all VT Medicaid payments for providers that do not submit the required medical records at no cost within ten (10) business days.

For more information, please click here: https://dvha.vermont.gov/providers/audits/hedis-hybrid-measure-medical-record-review-mrr

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2023 Prior Authorization Requirements

The Department of Vermont Health Access (DVHA) is providing clarifying information related to the new prior authorization requirements for Vermont Medicaid members that became effective January 1, 2023.

A previous banner page from December 23, 2022[1] announced DVHA's intent to align prior authorization requirements for specifically identified services for both ACO and non-ACO attributed members. Please see below for information specific to those 2023 prior authorization changes. Additional resources have been included as a reference. Prior authorization requests submitted without the required demographic and clinical information may result in an extended review time and or an administrative denial.

DVHA reserves the right to conduct audits, reviews, or investigations as necessary. Providers are required to maintain medical records for up to seven years as necessary to disclose fully the extent of services provided to members. For more information, providers should refer to their provider agreements with DVHA or DVHA's General Provider Agreement.[2]

OUT OF NETWORK SERVICES

- All Medicaid members (ACO-attributed and non-ACO-attributed) require prior authorization for out of network services, including office visits, inpatient admissions, and procedures. Urgent or emergent services do not require prior authorization.
- Please refer to the DVHA fee schedule[3] and PA Requirements Grid[4] to confirm prior authorization requirements for requested procedures and additional information related to facilities.
- Requests for out of network services are clinically reviewed for medical necessity and with the expectation that services for Medicaid members be transitioned to in-network when clinically appropriate.
- Clinical documentation that supports why the requested out of network services are medically necessary versus receiving in-network services is required *(for example, a referring provider could cite the in-network specialists that were consulted, and provide the resulting recommendation or consult note for specialty care at an out of network facility, or confirmation that the level of care required is unable to be provided in network)*.
- DVHA prior authorization review timeframe is three days from the submission of all required and requested clinical documentation, in order to complete the medically necessary determination.
- New out of network request forms have been developed to provide instruction, best support the review process, and ensure efficiencies. These forms are located on the DVHA website.[5]

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[1] DVHA Banner Archive: http://www.vtmedicaid.com/assets/banners/2022BannerArchive.pdf
[2] DVHA General Provider Agreement: http://www.vtmedicaid.com/assets/provEnroll/General_Provider_Agreement.pdf
[3] DVHA Fee Schedule: http://www.vtmedicaid.com/#/feeSchedule
[4] DVHA PA Requirements for Out Of State Providers: https://dvha.vermont.gov/sites/dvha/files/doc_library/2023%20PA%20requirements_0.pdf
[5] DVHA Clinical Forms and Prior Authorization Forms: https://dvha.vermont.gov/forms-manuals/forms/clinical-prior-authorization-forms

DURABLE MEDICAL EQUIPMENT (DME), PROSTHETICS, ORTHOTICS, & SUPPLIES

- Prior authorization and excess quantity authorizations for all Medicaid members (ACO-attributed and non-ACO-attributed) are not required for DME, prosthetics, orthotics and supplies, except for those items listed on the Imminent Harm Code List.
- Please refer to the DME and Supplies Limitation Guidance posted on the DVHA website; however, claims will not deny automatically for lack of authorization if the DME and supply limits from this guidance document are exceeded.
- Providers are expected to ensure medical necessity is documented for DME, prosthetics, orthotics, and supplies if deviating from the posted guidance.

PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY SERVICES

- All Medicaid members (ACO-attributed and non-ACO-attributed) regardless of age may receive a combined total of thirty (30) physical, speech, and occupational therapy services per calendar year before prior authorization is required for additional visits. Providers may check information on how many visits a member has used through the secure provider portal at https://www.vtmedicaid.com/secure/logon.do.

IMMINENT HARM CODES

- All Medicaid members (ACO-attributed and non-ACO-attributed) require prior authorization for the services, procedures, and/or DME listed on the Imminent Harm code list (see Footnote #6 below for hyperlink to Imminent Harm Code List).
- Prior authorization for hysterectomies is not required except for members under the age of 18.

CHIROPRACTIC SERVICES

- All Medicaid members (ACO-attributed and non-ACO-attributed) ages 12 and older may receive twelve (12) chiropractic visits before prior authorization is required for additional visits.
- Prior authorization is not required for any visits for Medicaid members aged 6-11 with pediatric chiropractic providers with the identified credentials DC, CACCP.

DENTAL

- Prior authorization is not required except for the following dental services: orthodontic services, cone beam imaging, and miscellaneous dental codes. Please refer to the DVHA Fee Schedule (hyperlink in footnote #3) for prior authorization requirements for dental services.

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[6] DVHA Imminent Harm Code List: https://dvha.vermont.gov/document/imminent-harm-list

[7] DVHA DME and Supplies Limitation Guidance: https://dvha.vermont.gov/sites/dvha/files/doc_library/DMELimitationsandGuidelines.pdf

Medicaid Renewals are Restarting

Starting in April 2023, Medicaid renewals will begin again. The rules about who can be on Medicaid have not changed. The only change is the return to the normal process of checking whether Vermonters on Medicaid are eligible. Federal policy requires all states, including Vermont, to begin checking Medicaid eligibility. The State of Vermont is committed to supporting Vermonters through this change.

Not all Vermonters enrolled in Medicaid will be reviewed for eligibility at the same time. The renewal effort will be spread out over 12-14 months. More Vermonters will be contacted ahead of their renewal month. Many Vermonters enrolled in Medicaid will need to take action to continue to have health insurance coverage when Medicaid renewals begin.

No one's Medicaid will simply end. Some Vermonters will have their Medicaid renewed automatically. Some Vermonters will no longer qualify for Medicaid, and they will have the opportunity to get different health coverage. There is money available to help Vermonters afford health plans on the health insurance marketplace, Vermont Health Connect. Over 90% of people who are enrolled through the health insurance marketplace qualify for financial help. 25% of enrollees pay less than $25 a month for their health plans, and 10% pay less than $10 a month.

It is very important for Vermonters enrolled in Medicaid to check their mail and be on the lookout for a white envelope with a red stripe. Not responding to the request will result in termination of coverage.

To help Vermonters, DVHA is asking you to help spread the word. Find more information at https://dvha.vermont.gov/unwinding. Provider Resources will be posted under Partners & Providers. Thank you for working to ensure Vermonters are aware of their Medicaid eligibility.

It's important you have all the information!

Scan this QR code.

You First Fee Schedule Available

The You First program Fee Schedule for 2023 has been updated and is available on the Vermont Medicaid Fee Schedule page. Please review the fee schedule and review You First membership eligibility.

The You First program (formerly Ladies First) is able to pay for heart health, breast and cervical cancer screenings for eligible Vermonters. We appreciate any referrals to our program and are available by phone and email for any questions from providers, billers, and potential members. Learn more about us by visiting our website, calling 1-800-508-2222, or emailing YouFirst@vermont.gov.

Psychotherapy Audit Results

The Special Investigations Unit (SIU) conducts routine desk provider audits. The audits only request a small sample of records from a provider to minimize administrative burden to produce large amounts of medical records. The SIU reviews the records to determine if they contain the necessary information to substantiate what was billed to VT Medicaid. The goal of these audits is to recoup the overpayments identified and educate providers about any identified deficiencies and improper billing practices to avoid recoupments of future claims. Below is a snapshot of a recent audit. If there are any questions, please contact the SIU at 802-241-9210.

Topic: Individual Psychotherapy

Review Criteria: Procedure code, 90837 - *Individual Psychotherapy, 60 minutes with patient*.

Results:
A total of 8 providers (representing 126 claims) were reviewed for the time period 2020 - 2021. Out of 126 claims reviewed, 75 were determined to be deficient. A breakdown of the discrepancies is identified below.

Overall error rate - 59% (75 out of 126)

- Missing face-to-face time with patient - 59%
- Missing co-signature from supervising clinicians - 37%
- Missing type of service provided - 37%
- Missing 2nd patient identifier - 27%
- Substandard documentation - 25%
- Missing provider signature - 19%
- Illegible documentation - 15%
- Place of service billed on claim did not match documentation - 5%
- Alteration of documentation - 5%
- Incorrect modifier - 4%
- Missing provider credentials - 4%
- Procedure code billed on claim did not match documentation - 1%

Providers are encouraged to review the Educational Resources listed below:

- Centers for Medicare & Medicaid Services (CMS), Billing and Coding: Psychiatric Diagnostic Evaluation and Psychotherapy Services
- Vermont Agency of Human Services Rule 9.103.3 – Conditions for Supervised Billing
- Vermont Medicaid General Billing and Forms Manual - Supervised Billing for Behavioral Health Services Rule 3.6.2 – Procedures for Billing
- Vermont Medicaid General Billing and Forms Manual Rule 3.8.2 All Other Time-based Procedure Codes
- Vermont Medicaid General Billing and Forms Manual Rule 4.12 – Place of Service (POS) codes
  Vermont Medicaid General Billing and Forms Manual Rule 5.3.46.6 - Documentation Standards for Mental Health and Substance Abuse Health Records
- Vermont Medicaid Provider Manual Rule 5.4 – Documentation of Services
- Vermont Medicaid Provider Manual Rule 8.5 – Supervised Billing for Behavioral Health Services

Provider Resources

Provider Manuals: http://www.vtmedicaid.com/#/manuals
Provider Resources: http://www.vtmedicaid.com/#/resources
VT Medicaid Banner: http://www.vtmedicaid.com/#/bannerMain
Provider Enrollment Resources: http://www.vtmedicaid.com/#/provEnrollDataMaint

Gainwell Technologies
28 Walnut Street, Suite 245 Building C,
Maple Tree Place Shopping Center, Williston, VT 05495
Monday - Friday: 8:00AM to 5:00PM
Phone: 800.925.1706
Fax: 802.433.4201
http://www.vtmedicaid.com/#/home

Department Of Vermont Health Access
280 State Drive, NOB 1 South, Waterbury, VT 05671
Monday - Friday: 7:45AM to 4:30PM
Phone: 802.879.5900
Fax: 802.241.0260
http://dvha.vermont.gov