Children's Integrated Services Manual
Bundled Claims for Non-Medicaid Populations
& Zero-pay Encounter Claims

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This manual was developed in collaboration with:

Children's Integrated Services,

Gainwell Technologies, and

the Department for Vermont Health Access

Section 1   Overview

1.1   Populations Served by CIS

Children's Integrated Services (CIS) services pregnant people and people up to two-months post-partum, infants, children up to the age of 13, and consults to Early Childhood Education (aka Child Care) providers (refer to the CIS Contract for discreet definitions of these populations). These are the service definitions. When we discuss billing, we discuss these populations in terms of how CIS services (bundled claims) are reimbursed.

From a service reimbursement standpoint, CIS clients primarily fall within the following definitions:

- clients with **Medicaid**
- client's birth to three who are eligible for Part C, **Early Intervention services regardless of insurance status**
- clients **without Medicaid and who are not eligible Part C, Early Intervention services**
- Early Childhood Education programs receiving consultation – these services are not currently reimbursed at the per member rate. Rather, reimbursement for these services is built into the overall CIS Case Rate.

1.2   Populations Discussed in this Guidance Manual

There are four different populations referred to within the Children's Integrated Services (CIS) program based on their insurance and/or service eligibility type. Each of these populations has its own billing/processing rules.

The four populations are:

- Early Intervention Clients with Medicaid coverage. These members are currently known to the MMIS and have Medicaid Aid Category codes.
- Early Intervention Clients without Medicaid coverage. These members are currently known to the MMIS and have an FI Voucher with an Aid Category of 50.
- Non-Early Intervention Clients without Medicaid coverage. This population is currently not known to the MMIS. These clients will be manually entered by the State from data submitted by the regions (see below for guidance). These members will be uploaded into MMIS through a manual process and have an FI Voucher with an Aid Category of FS.
- Non-Early Intervention Clients who are already enrolled in Medicaid. This population are billed using the details contained in this manual. However, since they are already known to the MMIS and have Medicaid Aid Category codes, bundled billing and encounter claims are submitted using their existing Medicaid UID's. This population will not receive any additional guidance within this manual as they do not require any special conditions.

1.3   Why report claims and encounters through Gainwell?

The MMIS will be utilized as the single source of truth for paid and encounter claims processing and tracking of service utilization under the existing phase, as well as any future phases, of CIS payment reform.

Encounter data claims will only be submitted by the "fiscal agents" (with an existing defined set of Medicaid provider IDs) in each CIS region, not by the multiple subcontractors performing services under the bundled rates. Encounters are reported using a defined set of (CPT and HCPCS) procedure codes which enables MMIS to track utilization of services under the CIS bundled rate.

CIS encounter data claims to enable reporting activities to understand the full CIS service set without requiring additional reporting by the field.

1.4   Where Can I Go if I Have Questions?

General questions about entering claims (both paid and zero-pay including clients with the Aid Category FS):

If you would like a high-level orientation to the general data you need to have on hand in order to submit a claim, please see this orientation to the [CMS 1500 Form](.).

Note: you will not be submitting any bundle or zero-pay encounter claims using the paper CMS 1500 form. However, this does provide a good high-level overview as a foundational reference if you have never submitted a claim through the Gainwell PES system before.

- **Contact your Gainwell Provider Representative:** https://vtmedicaid.com/assets/resources/ProviderRepMap.pdf
- **Check a client's eligibility:** https://vtmedicaid.com/assets/manuals/GeneralProviderManual.pdf starts on page 17 and page 47
- **The Vermont Medicaid portal that contains this resource, manuals, etc. can be found at:** https://vtmedicaid.com/#/home or https://vtmedicaid.com/#/resources
- **If you are sure what aid category should cover a service:** Check the aid category listing https://vtmedicaid.com/assets/resources/AidCategoryListing.pdf
- **Questions about your rate or the codes available to report encounters:** Contact your CIS TA Liaison https://dcf.vermont.gov/cdd/cis

Section 2   Providers Participating

The following are the providers participating in this program.

Provider ID	Provider Type/Specialty	Provider Name
1004768	T21/060	Lamoille Family Center
1004793	T21/060	Springfield Area Parent Child Center
1005137	T21/060	Rutland Area VNA and Hospice
1005178	T21/060	Sunrise Family Resource Center
1005625	T21/060	The Family Place
1005993	T21/060	Winston Prouty
1008641	T21/060	Family Center of Washington County
6709039	T21/060	Northeast Kingdom Community Action
1031449	T21/060	Howard Center

2.1   Bundled Code Billing

All the populations above bill the T1024HU procedure code to receive the per member, per month Bundled Payment using the rate from the regional CIS Contracts. This procedure code/modifier combination is currently set up for Level I Pricing for each of the provider IDs listed above. Each provider will have two annual caps established. One for Medicaid funds and the other for State Only Funds (often referred to as State General Fund (GF)). Claims billed with the bundled code for providers who have already met their cap in either category will be paid zero with an EOB attached indicating that the claim paid zero because the cap had been met. Because these claims are in a paid status, they can be adjusted should additional funds be added to the provider's cap. Had they been denied they would need to be resubmitted by the provider.

The bundled code (T1024HU) can be submitted only one time per month per fiscal agent. If a fiscal agent submits a second claim in a month using T1024HU, this second claim will be denied. If a client moves during a calendar month and is served by two different regions within that same month, each region's fiscal agent is able to submit claims and eligible to be reimbursed for T1024HU. This is only allowable for one month per client. If those same two regions bill a second month to the same client, the earliest claim filed in the second month will be processed for payment, while the subsequent payment by the different region will be denied. This edit allows for each region to be eligible to receive a bundled payment one time if they both serve a client who is physically moving residences from one region to another.

See Section 5.11.2 Multiple CIS Services below for specific guidance on how to submit claims to document the full array of services provided to a CIS Client. Claims should clearly document each individual service, with the appropriate procedure code and units of service, that a client receives during each visit as a separate claim row within the claim.

2.2   Encounter Processing

Below is the list of procedure codes that will be used to bill the encounter claims. Any time one of the providers above bills one of these codes the claim will be reimbursed at a rate of zero and an EOB will be assigned to the claim indicating the claim was treated as a CIS Encounter claim. The expectation is that the provider IDs above will never bill the codes below expecting to be paid fee for service. The expectation is that **no procedure code modifiers will be used for zero pay encounter**

claims for this project (the HU modifier is only used when billing the T1024 bundled rate code). If a modifier is used, the code will deny and will need to be resubmitted without a modifier.

See Section 5.11.2 Multiple CIS Services below for specific guidance on how to submit claims to document the full array of services provided to a CIS Client. Claims should clearly document each individual service, with the appropriate procedure code and units of service, that a client receives during each visit as a separate claim row within the claim.

Code	Code Limitations	Service	Unit
S9445	maximum 2/day	Patient Education, not otherwise classified, non-physician provider, individual	Per session (regardless of duration)
T1022	maximum 1/day	Contracted home health agency services, all services provided under contract	per day
97129	maximum 1/day	Developmental Cognitive Therapy	initial 15 minutes
97130	maximum 999/day	Developmental Cognitive Therapy after Initial 15 min	Each 15-minute unit after initial 15 minutes (which should be reported as 97129)
T1016	maximum 999/day	Case Management [Case management services are services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services]	per 15 minutes
T1017	maximum 999/day	Targeted Case Management [Targeted case management services are provided only in instances where the case management serves to coordinate across service providers in very complex cases involving multiple providers and client needs.]	per 15 minutes
T1024	maximum 1/day	Evaluation and treatment by an integrated, specialty team contracted to provide coordinated care to multiple or severely handicapped children. Note: Initial Evaluations completed to determine eligibility for Early Intervention (Part C of IDEA) are billed outside of the CIS bundle using H2000 or via invoice as directed by the CIS State Team.	Per session
T1027	maximum 999/day	Family training and counseling for child development	per 15 minutes
90791	maximum 1/day	ECFMH Clinical Assessment	*per session (regardless of duration)*

Code	Code Limitations	Service	Unit
H0024	maximum 1/day	Behavioral health prevention information dissemination service (one-way direct or non-direct contact with service audiences to affect knowledge and attitude)	per session (regardless of duration)
H2014	All providers (000) = 999/day Mental Health Clinic (037) = 999/day	Skills Training and Development	per 15 minutes
H2017	maximum 999/day	Psychosocial rehabilitation services	per 15 minutes
H2019	maximum 999/day	Therapeutic behavioral services	per 15 minutes
H2032	maximum 999/day	Activity therapy	per 15 minutes
99366	maximum of 1/day	Medical team conference with interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30 minutes or more, participation by nonphysician qualified health care professional.	Per session (minimum of 30 min.)
99367	maximum of 1/day	Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physician.	Per session (minimum of 30 min.)
99368	maximum of 1/day	Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by nonphysician qualified health care professional.	Per session (minimum of 30 min.)
99199	Unlisted Special Service, Procedure or report	*Use this code to distinguish those services provided by qualified personnel for specialized childcare coordination that doesn't meet other code definitions.*	Per session (regardless of duration)
99082	Travel		Mileage

Section 3 Population Specific Processing

3.1 Early Intervention Clients with Medicaid Only

This population will have a Medicaid Aid Category and will have a FI voucher on file. FI Vouchers are created through a weekly file upload to MMIS from the State. In order for these clients to have a voucher created in MMIS, CIS providers must submit the minimum data set to the CIS State Team via GlobalScapes, using the spreadsheet available at https://dcf.vermont.gov/cdd/partners/cis/forms.

The minimum data needed to create the FI voucher includes:

- SSN
- Last Name (ensure spelling is correct)
- First Name (ensure spelling is correct; and provide the full name – no nicknames)
- DOB
- Gender (selected from the drop-down)
- Date of Referral

Claims will be processed as either an encounter claim, fee for service claim, or bundled rate claim. It is the expectation that the provider IDs listed above may bill for services not on the permutations list for these members that will be paid fee for service. The bundled rate claims will be paid under funding source I as dictated by the billing provider ID and in the case of provider 1031449, the HU modifier is driving the funding source.

The payments will only be made if there are funds left on the cap at the time the claim is processed. If the provider has met their Medicaid cap and if there are funds remaining on the GF Cap, monies will be moved to the Medicaid cap to cover the claim. If there are no funds left on either cap, the claim will be zero paid and an EOB will be applied that indicates why the claim paid zero.

Encounter claims will be identified by the provider being one of those listed above and the procedure code/modifier combination being billed being on the permutations list. These claims will be zero paid and an EOB applied indicating why the claim was paid zero.

3.2 Early Intervention Client with No Medicaid

This population will have an Aid Category of FI and will have a voucher on file. FI Vouchers are created through a weekly file upload to MMIS from the State. In order for these clients to have a voucher created in MMIS, CIS providers must submit the minimum data set to the CIS State Team via GlobalScapes, using the spreadsheet available at https://dcf.vermont.gov/cdd/partners/cis/forms.

The minimum data needed to create the FI voucher includes:

- SSN
- Last Name (ensure spelling is correct)
- First Name (ensure spelling is correct; and provide the full name – no nicknames)
- DOB
- Gender (selected from the drop-down)
- Date of Referral

Claims will be processed as either an encounter claim, fee for service claim, or bundled rate claim. It is the expectation that provider IDs listed above may bill for services not on the permutations list for these members and those will be paid fee for service.

The T1024HU bundled rate claims will be paid using fund source I and will be captured on a separate line in the weekly draw letter called "CIS State Only". These claims will count against the provider's State Only funding cap.   The payments will only be made if there are funds left on the cap at the time the claim is processed. If not, they will be paid zero as outlined above.

Encounter claims will be identified by the provider being one of those listed above and the procedure code/modifier combination being billed being on the permutations list. These claims will be zero paid and an EOB applied indicating why the claim was paid <u>zero.</u>

3.3   Non-Early Intervention Non-Medicaid Client

This population is not automatically represented in MMIS. Rather, the State will manually submit each unique CIS Client who does not have a current active Medicaid status or Active EI status through a weekly file upload to MMIS. We refer to these clients as "Non-Early Intervention Non-Medicaid".

In order for Non-Early Intervention Non-Medicaid clients to be manually entered into the MMIS system through the weekly file upload, and thereby have a voucher created, Regions must submit the minimum data set via GlobalScapes, using the spreadsheet available at: https://cispartners.vermont.gov/content/cis-data-reporting-guidance.

The minimum data needed includes:

- SSN
- Insured UID/Group#
- Insurance Type (selected from the drop-down)
- Last Name (ensure spelling is correct)
- First Name (ensure spelling is correct; and provide the full name – no nicknames)
- DOB
- Gender (selected from the drop-down)
- Ethnicity (selected from the drop-down)
- Date of Referral (this will be the date the client was referred to CIS or transitioned out of EI and continued with CIS under a different service)
- Date of Exit (date a client exited all CIS services or the date the client received an intra-CIS referral for CIS-EI services)
- Exit Reason (selected from the drop-down)

If you are able to submit all minimum data for a client at a future date for a prior month, they will be manually added into the State's database, so a voucher can be created during the weekend file upload. All data will be entered into the State's database within 5 business days of receipt of a spreadsheet.

Data is uploaded to the Gainwell system each weekend. Therefore, clients should be able to be found in the Gainwell system within 10 days of submission of their full data on a spreadsheet. The State will not be sending notices about missing data. Regions will be expected to monitor their data submissions internally and track for missing data in order to assure that client vouchers are able to be created in MMIS.

The bundled rate claims will be paid under fund source I and count against the provider's State Only cap. The payments will only be made if there are funds left on the cap at the time the claim is processed. If not, they will be paid zero as outlined above.

As with the other populations encounter claims will be determined by the billing provider and the procedure code/modifier combination billed being on the permutations list. All other claims received for this population will be denied as non-covered.

NOTE: It is important that Regions submit the 'Date of Exit' to the State CIS team for each client within this Non-Early Intervention Non-Medicaid population. These clients require a 'Date of Exit' when they are no longer receiving any CIS services, or when they become part of the Early Intervention population (i.e., they are determined to be eligible for and made active with CIS Early Intervention).

3.4   CIS Early Intervention Initial Evaluation Billing Process

Claims may be paid outside of the CIS Bundled Billing for the initial evaluation performed on a child to determine Eligibility for CIS Early Intervention services as discussed below. For auto-eligible children: evaluations are not currently reimbursed. Contact the CIS State Team if you have questions about what constitutes auto eligibility.

For CIS-EI children with Medicaid, billing will be submitted through Gainwell by the fiscal agent and the money remitted to the fiscal agent to disburse to the CIS-EI Host Agency. The fiscal agent will need to amend their sub-contract with the regional CIS-EI Host Agency (where applicable) to indicate how the funds for initial evaluations will be remitted to the CIS-EI Agency. Providers should use billing code H2000-HU.

For CIS-EI children who do not have Medicaid, billing for initial evaluation is done by invoicing the State directly using the current "Invoice from Early Intervention Program for the Initial Evaluation to Determine Eligibility for CIS Early Intervention" found on the CIS website https://dcf.vermont.gov/cdd/partners/cis/forms under Early Intervention Forms.

The State will only accept invoices using the current version of the form posted on the CIS website for children who are not enrolled in Medicaid (the State will check to ensure those invoiced are, in fact, non-Medicaid children). If the child has Medicaid, a claim must be submitted through Gainwell as indicated above.

The State will only accept invoices that are filled out completely, including all tracking data completed in the final two columns of the invoice form ("Was the child found eligible", "Was the child screened").

The State will only process invoices for children for whom the State has received the fully completed required Referral information on Child Count.

For children needing re-evaluations to determine eligibility due to the child not being found eligible previously, or having exited the program for at least 180 days and then being re-referred, these evaluations will be reimbursed following the guidance under "For CIS EI children who do not have Medicaid" above if any of the following conditions are met:

- The child exited the CIS program after having had a full evaluation, being found eligible for Part C, and had a signed One Plan – a region can bill for another "Initial Evaluation" if the child's date of exit is greater than 180 days from the date of re-referral.

- The child was evaluated, but not found eligible for Part C - a region can bill for another "Initial Evaluation" if the child's date of exit is greater than 180 days from the date of re-referral.

- The child was auto-eligible for Part C upon their first referral to CIS, and the child is still under the age of 2 – a region cannot bill for an "Initial Evaluation" even with a subsequent re-referral.

- The child was auto-eligible upon their first referral to CIS but was not made active with a signed One Plan due to lost to follow up/family choosing not to receive services, and the child is age 2 or older - a region can bill for another "Initial Evaluation" if the child's date of exit is greater than 120 days from the date of re-referral.

Regardless of previous eligibility/active status, if a child is re-referred for Part C services less than 90 days from their 3rd birthday, a region must follow the "Late Referral" guidance provided to regions in 2017. Following this guidance may result in the region not conducting an evaluation for the child.

Reimbursement for initial evaluations will remain at current rate on file with Vermont Medicaid (i.e., https://vtmedicaid.com/#/feeSchedule/hcpcs). The same rate will be reimbursed for every non-Medicaid child invoiced to the State.

The reimbursement rate is intended to cover 2 different disciplines conducting an all-domain assessment using a State-approved tool. The list of State-approved all-domain assessment tools can be found at: https://outside.vermont.gov/dept/DCF/Shared%20Documents/CDD/CIS/CIS-Developmental-Screening-Tools.pdf

All practitioners participating in the initial evaluation who are being acknowledged as a 'discipline' per Federal regulations must be qualified to assess a child (please see CIS job descriptions for qualified personnel on page 40 of the CIS Guidance Manual (https://outside.vermont.gov/dept/DCF/Shared%20Documents/CDD/CIS/CIS-Guidance-Manual.pdf); these may also include other non-CIS licensed/certified disciplines). The lead CIS-EI practitioner who is responsible for the initial evaluation must hold a CIS-EI Certificate.

Section 4   Submitting Electronic Claims to Gainwell Using PES

You should have set up Gainwell's free software, PES, per earlier guidance.

- To get step-by-step guidance on how to enter claims using PES, please refer to the "PES Guide for PNMI & PRTF Providers" that has been sent to you.

- See section 3 of Appendix 1 for more information on getting started with PES.

For Information on navigating the PES system or adding new users, see section 5 of Appendix 1.

Note: If you are a new trading partner, meaning you have never billed through Gainwell before, please see Appendix 1 for information on getting started as a trading partner before continuing with this manual.

Section 5   Provider Electronic Solutions (PES) Billing

5.1   List Function Overview

The list function has been added to the software for two reasons. First, it allows a provider to enter information that is frequently used and then access this information in a transaction using a Drop-Down Data Window (DDDW) and second, it reduces the size of the transaction screens by requiring certain information to be entered into a list.

There are many data elements included in the software that are required to generate a HIPAA compliant format. This is especially true of provider and client information. As a result, the Provider Electronic Solutions software requires that these lists be entered prior to completing a transaction. Additional lists include procedure code, diagnosis code, revenue center code and place of service.

There are two lists that have been populated with data. They are Carrier, which lists the codes and names of other insurance companies and the Place of Service list. Both of these lists may be updated to add, delete or change the information to better serve your office. Please be aware that the codes listed are standard codes and may not be changed without notice resulting from HIPAA or Gainwell updates.

The lists may be accessed from the Main Menu by selecting the List option or by double clicking in the appropriate field. This option allows a provider to add the information, as they need it, rather than requiring that all information be entered prior to keying a transaction.

Once the information has been keyed into the list, it is available from the DDDW to populate the fields. Although not all of the information from the list will appear on the transaction screen, it will be used when formatting the HIPAA transaction prior to submission.

Lists may be sorted by the row headers. The client list is sorted by selecting the Client ID, Last Name or First Name heading. Selecting the header one time will sort in ascending order. Selecting twice will sort in descending order. Upon opening, the Client and Provider lists are sorted by the ID number.

5.2   How to Bill Provider Lists
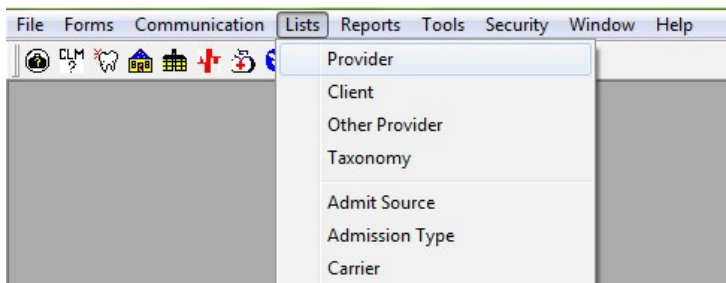
1. Click on **Lists** and select **Provider**.
2. Enter the fields listed below:

    Each of fields listed are required.

    a. **Provider ID/NPI** - Enter Group NPI
    b. **Provider ID/NPI Code Qualifier** - Select XX
    c. **Taxonomy Code** - Enter Group Provider Taxonomy
    d. **Entity Type Qualifier** - Select 2 (non-person)
    e. **Last/Org Name** - Enter Full group provider name

f. **SSN/Tax ID** - Enter Tax ID

g. **SSN/Tax IF Qualifier** - Select 24

h. **Line 1** - Provider address *This address cannot be a PO Box.

i. **City** - Town

j. **State** - State

k. **Zip** - Zip Code *You must enter entire zip code including last 4 digits, if you don't know the last 4 digits enter four zeros' (as shown below).

3. Click **Save** (right hand side)

4. Then click **Add** (right hand Side)

Note: If you don't have an individual rendering provider; If your Agent/Group information is also going to be your rendering provider on your claim you will need to enter in your Agent/Group information in twice. Once using the steps above, and then a second time following the instructions listed below.

5.3 How to Bill Client Lists
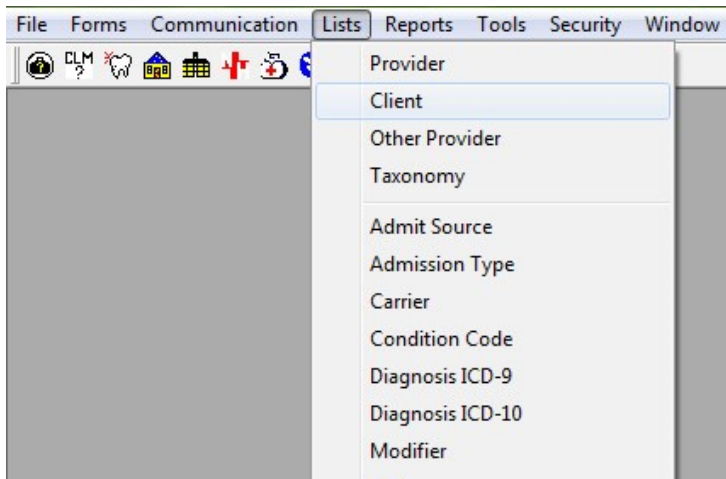
1. Click on **Lists** and select **Client**.

2. Enter the fields listed below:

a. **Client ID** - Enter VT Medicaid's UID number

b. **ID Qualifier** - Select MI

c. **Account #** - Your account number *It doesn't matter what is recorded in this field, however, there has to be something in this field.

d. **Client SSN** - Leave blank *Please do not enter the patient's SSN number, because it's not needed for the processing of the claim.

e. **Last Name** - Patients last name

f. **First Name** - Patients first name

g. **Clients DOB** - Patient's date of birth

h. **Gender** - select Female or Male

i. **Line 1** – Provider's address

j. **City** - Town

k. **State** - State

l. **Zip** - Zip Code *You must enter entire zip code including last 4 digits, if you don't know the last 4 digits enter four zeros' (as shown below).

3. Then click **Save** (right hand side)

If you have more clients to add then click add (right hand side). If no, then click close or the red X in the upper right-hand corner.

5.4   Adding a Diagnosis
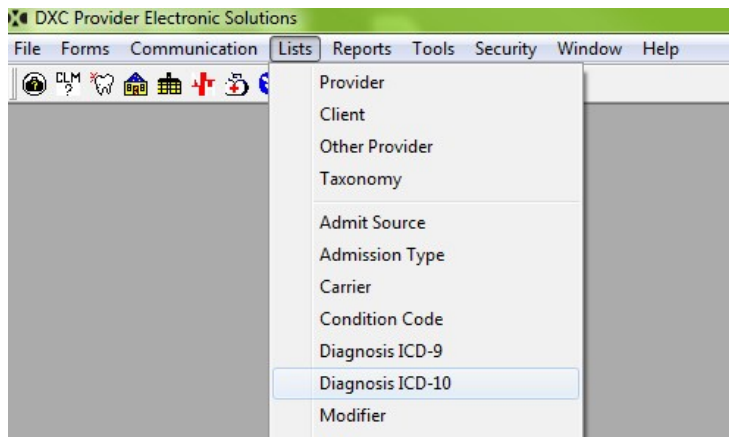
1. Click on **Lists** and select **Diagnosis ICD-10**.

2. Enter the fields listed below:

a. **Diagnosis Code** - Enter your ICD-10 Diagnosis Code without the decimal point.

b. **Description** - Enter your description for the Diagnosis.

3. Then click **Save** (right hand side)

If you have more diagnosis codes to add then click add (right hand side). If no, then click close or the red X in the upper right-hand corner.

5.5 Adding a Modifier

1. Click on **Lists** and select **Modifier**.

2. Enter the **Modifier Code** - HU (Modifier Code: HU should be used only when submitting claims for T1024 (bundled claims). No modifiers should be used when submitting zero-pay encounter claims. If a modifier is used, zero-pay encounter claims will be denied and must be resubmitted correctly without a modifier.)

3. Enter the **Description** for the Modifier Code.

4. Then click **Save** (right hand side)

If you have more diagnosis codes to add then click add (right hand side). If no, then click close or the red X in the upper right-hand corner.

5.6   Adding a Procedure/HCPCS Code
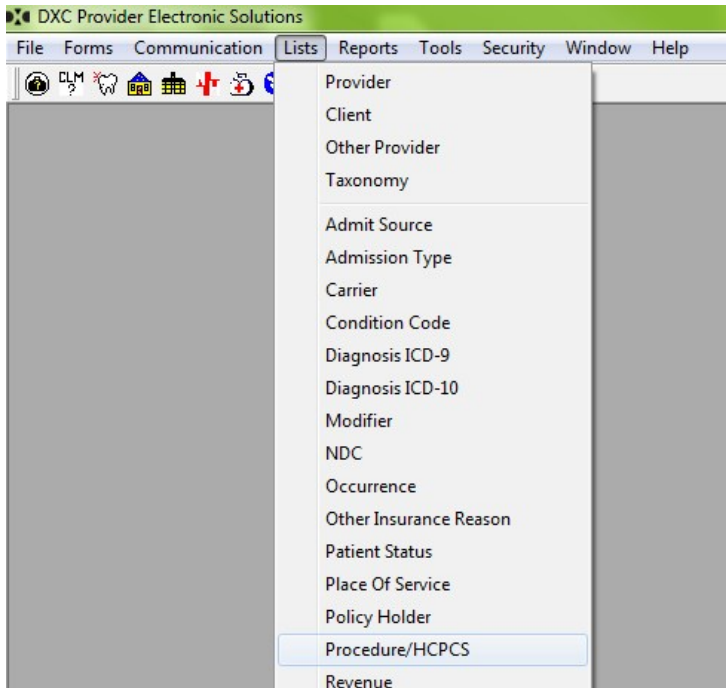
1. Click on **Lists** and select **Procedure/HCPCS**.
2. Enter the Procedure/HCPCS
3. Enter the description of your procedure/HCPCS.
4. Then click Save (right hand side)
5. If you have more procedure/HCPC codes to enter, click add (right hand side). If no, then click close or the red X in the upper right-hand corner.

Note: See above for allowed codes for CIS Encounter reporting.
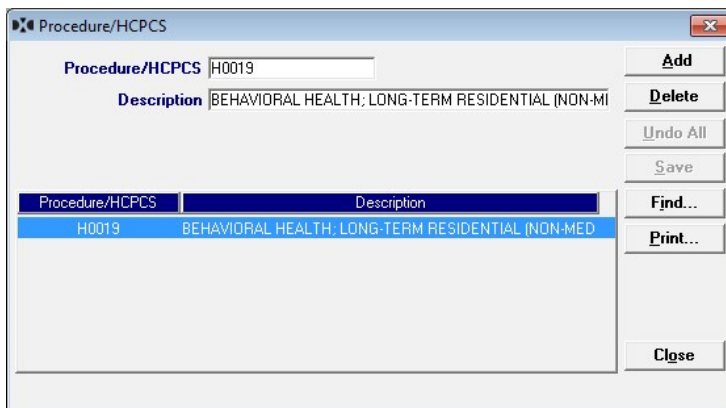
5.7   Building your Claim

Click on the Blue Medical symbol (837 Professional), on the main menu.
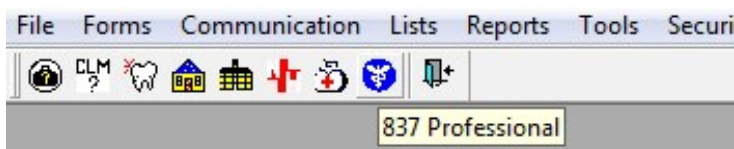
Now we can start building the claim.

5.7.1　HDR1 Tab

1. Click the drop down on the field labeled provider ID/NPI and select your provider information.
2. Hit the tab button on your keyboard. Hitting tab will fill in the rest of the group provider information.

3. Click the drop down on the field labeled Client ID and select the patient you are trying to bill for.
4. Hit the tab button on your keyboard. Hitting tab will fill in the rest of the patient information.
5. That is all the information you need to enter into HDR1 tab.

5.7.1.1   HDR1 Example

5.8   HDR2 Tab

1. Click the drop-down arrow next to the field labeled type and select 10 (ICD-10)

2. Now click the drop down next to field 1 and select the diagnosis code for the patient you are billing for.

5.8.1.1 HDR2 Example

5.9   HDR3 Tab

- Here is HDR3 you do not have to enter any information in this tab and can move right to HDR4.

5.10   HDR4 Tab

- Here is HDR4 you will also not have to enter any information in this tab, and you can now move to the SRV1 tab.

5.11   Srv1 Tab

Below is the list of fields that need to be completed, and what is required in each field:

- From DOS - Enter your date of service then hit tab.
- By hitting tab, it will fill in the To DOS field.
- To DOS - Enter your date of service
- Place of Service - Select your place of service
- Procedure -Select your CPT code

- Modifier - Select the appropriate modifier if applicable.
- HU: Funded By Child Welfare Agency.
- Diag PTR - enter the number 1
- Unit - Enter the total days/units you are billing
- Billed Amount - Enter your total charge

NOTE: Billed Amount:

For CIS Bundled Claims (T1024HU) this would be the current per member per month rate based on your CIS contract that was in effect on the date of service.

For CIS Encounter Data, these will be set to pay zero, but a system limitation requires that an amount be entered. Therefore, you should enter .01 or 1 cent

5.11.1   SRV1 Example

5.11.2   Multiple CIS Services Example

If a client receives a single visit in a month, document T1024HU on the claim to receive the bundled rate for that visit. Then add claim rows to detail the service(s) provided during that single visit (see example below for DOS 03/05/2023). T1024HU must always be accompanied by at least one other encounter claim row to detail the services provided.

If a client receives multiple visits in a month, document those visits as follows:

- first document T1024HU on the claim to receive the bundled rate for the first visit conducted in the month. Add claims rows to detail the service(s) provided during that initial visit (see example below for DOS 03/05/2023)
- next document the next date of service provided in the month and add claim rows to detail the service(s) provided during each subsequent visit (reference the full example below from DOS 03/05/2023 and DOS 03/22/2023).

The example above reflects a client who received responsive family support (30 minutes) and case management services (15 minutes) on March 5. Then, on March 22, the client received some services in their childcare. These services included 45 minutes of child development training for the family and some consultation for the childcare provider and family to support the child's successful development and/or placement in the childcare setting.

Additional claim rows would be added as needed to document each individual service (known as the 'procedure') that was provided during each visit (known as the 'date of service'). It is feasible that in a given month a client could receive many days of services (ex. 4 days of service), with multiple types of service provided during each visit (ex. a team meeting one day, parent training, an evaluation, and case management on another day, etc.). The aim is to submit claim rows for each CIS service provided on any given day to a client to accurately document the full array of CIS services each client receives.

5.12   Srv2 Tab

Under the Rendering Provider section please select:

- **Provider ID/NPI** - Select either your Individual Provider **or** select your Agent/Group provider number (the one listed under your VT Medicaid provider number).

- Then hit Tab on your keyboard. Hitting tab will fill in the rest of the provider information.

5.12.1 SRV2 Example

5.13 Srv3 Tab

- You do not need to enter any information on this tab.

- Now click Save on right hand side. If all the mandatory information has been entered the claim will save and bring you back to the HDR1 tab.

If information is missing an error message box will pop-up.

If this box appears, double click on the error and it will bring you to the field that needs to be corrected. Once the correction has been made, click save on the right-hand side.

Once the claim is saved you will see it listed on the HDR 1 tab in R status at the bottom. That means the claim is ready to be submitted.

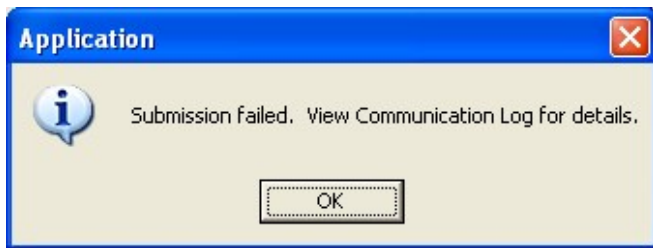## 5.14   Submitting Claim(s)/Receiving Transactions

Click on Communication on the main menu and select Submission.

Under "Files to send" select the bottom one that says 837 Professional. Then click submit on the right hands side.

This screen will appear if the submission was successful.


This screen will appear if the submission fails.

Once the claims have been submitted, they will be in F status meaning they have been submitted.

- If you wish to receive return files please wait 5 minutes from your successful submission, then unselect the 837 Professional under the "Files to Send"

Under "Files to Receive" select the bottom to reports name Claim Accept/Reject Report and Functional Acknowledgement Report. Once selected click submit.

- The Claim Accept/Reject Report and Functional Acknowledgement Report can be retrieved after each submission of 837 transactions. Reminder return reports will not be available for 5 minutes after a successful submission.
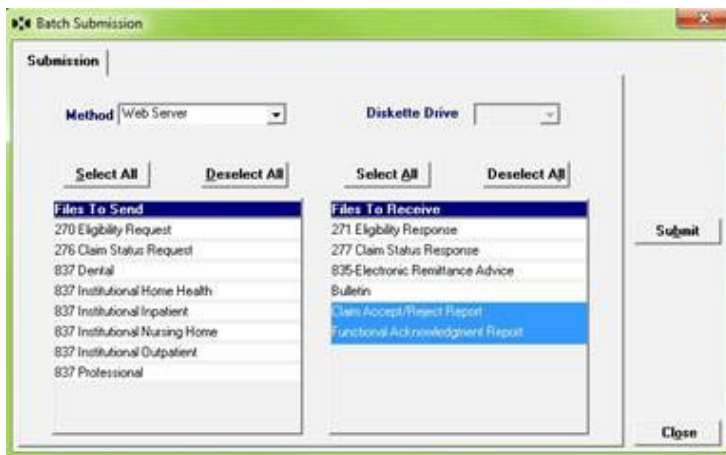
The **Functional Acknowledgement Report** will inform you of the HIPAA compliancy of the submission. This report pertains to the HIPAA compliancy of the entire file. In cases of rejection, it is the entire file that is rejected, and the error must be corrected prior to submitting the file. This file extension is .999. Please refer to page 12 of the HIPAA Standard Companion Guide here: https://vtmedicaid.com/assets/hipaaTools/HIPAACompGuidev5010.pdf.

The **Claim Accept/Reject Report** is claim specific for errors that prevents Gainwell from processing the claim. This file extension is .html. This report cannot be read inside of PES. If you receive a .html report, please outreach to the EDI Coordinator for assistance.

5.15   How to Copy Claim in F status

When you go to bill again, you can copy the claim you previously submitted to make the process quicker. Then all you would have to do is change the dates of service, units and billed amount. Below is the instruction on how to copy a previously submitted claim.

- On the HRD 1 tab select the patient name of the claim you would like to copy.

- Then click copy on the right-hand side. Once you click copy the "claim frequency" field will highlight blue.
- Now click on the SRV1 tab and change the Date of service, units, and billed amount, and any other changes you need to make.

- Once you have completed your changes/update click the save button on the right-hand side.
- The new claim will be listed at the bottom of the screen in R status. Which mean it's ready to be submitted.

Section 6   Remittance Advice

This is what your Encounter claims will look like, once processed and paid on your RA.

```
PROV:          NPI:                    VERMONT MEDICAID REMITTANCE ADVICE          RA NUM:  000
                                          LTC AND PROFESSIONAL
                                          RA DATE: 09/18/2020                      PAGE NUM:    17

RECIPIENT NAME  MID        ICN       HVER  PT ACCT/RX #      FRQ    DRG CODE  DRG WEIGHT

                                                     BILLED AMT  ALLOWED AMT     OI AMT  LIAB AMT  COPAY AMT   PAID AMT
HEADER MESSAGES (EOB/ADJ RSN/AMT)
DNUM DVER  FDOS     TDOS      PROC+MODS/REV+RPL    QTY BLD
      DETAIL MESSAGES (EOB/ADJ RSN/AMT)
P A I D   C L A I M S
---------------------------------------------------------------------------------------------------------------------
CLAIM TYPE: HCFA1500
-----------------------------
  Last  Firstname  111111    40202000000000   00 2264614520                    0.0000
  001 00 08/17/20  08/17/20  97153               23.000       0.01        0.01        0.00      0.00      0.00      0.00
      1960/132         0.00 | 1963/132        0.01 |

        CLAIM TOTALS:                                         0.01        0.01        0.00      0.00      0.00      0.00
```

What you can expect to see on your RA for:

- CIS Bundled Payments: if the cap has not yet been met, and the claim was filed correctly, you will see the amount remitted. If the cap was met, the amount remitted will be "0" and will indicate that the cap has been met.

- CIS Encounter Claims: each claim will be listed, with "0" amount remitted, and will indicate "*Processed as a CIS Zero-pay encounter claim.*"

6.1.1   RA Sections

The RA is divided into the following sections:

- Paid Claims - All claims paid in the current cycle. EOB codes under the claim header and details indicate the reason(s) for the payment amount. There may be as many as ten EOB codes per header and per denial.

- Denied Claims - All claims denied in the current cycle. EOB codes under the claim header and details indicate the reason(s) for the denial. There may be as many as ten EOBs per header and per detail.

- Suspended Claims - Claims requiring manual review by either Gainwell or the DVHA will be identified in this section prior to disposition. The purpose of this section is to inform the provider that Gainwell has received the claim, and payment or denial will be forthcoming.

- Adjusted Claims - Claims for which adjustments have been processed to correct information, overpayment, underpayment, or payment to the wrong provider.

- Financial Items - Financial transactions such as recoupments, manual payouts and TPL recoveries.

- TPL & Medicare Information - Other insurance and Medicare information for members with related denials on the RA.

- Earnings Data - This "Earnings Data" section of the RA is provided to show the current RA totals as well as cumulative year-to-date details.

- Message Codes - Definitions of the EOB codes listed on the RA.

Additional information can be found in the General Billing and Forms Manual on the VT Medicaid web portal. https://vtmedicaid.com/#/manuals

Section 7   Appendix 1 – For New Trading Partners

7.1   Upon Enrollment with Vermont Medicaid

Once you have been enrolled and have a provider # with Vermont Medicaid, you will need to look at the options for billing and the various requirements of each option.

7.2   Paper Claims

If you want to bill on paper, no trading partner account is needed. You may simply mail your paper claims to Gainwell. Please note that paper claims do require additional processing time; electronic claims are able to be processed and paid more quickly.

- To learn more about paper claims, go to the Vermont Medicaid website: https://vtmedicaid.com/assets/manuals/CMS1500UB04BillingGuide.pdf

 Proper coding must be adhered to use of CPT coding books and consultation with Provider office on diagnoses codes maybe helpful.

7.3   Electronic Claims – Submitted by Your Facility

If you want to bill electronically (PES or other software), you need a trading partner account.

- You may also get Gainwell's free software, PES, if you would like. Please refer to the "PES Guide for PNMI & PRTF Providers" that has been sent to you.

7.4   Electronic Claims – Submitted by Your Billing Service

If you are going to have a clearing house or billing service do your billing electronically (using Gainwell's PES software or another software), you do not need a trading partner account.

- You should contact the clearinghouse or billing service and get a prefilled EDI Registration, which you should sign and send into Gainwell.

7.5   Trading Partner Account

1. Verify that you don't already have your own logon starting with 701….

    a. If you don't have one, continue to step 2.

    b. If you do have a logon starting with 701…, call Gainwell's EDI Coordinator at 800.925.1706, option 3.

2. Go to https://vtmedicaid.com/#/hipaaTools.

3. Print, fill out and sign the Trading Partner Agreement and EDI Registration

4. Documents should be submitted via email to vtedicoordinator@gainwelltechnologies.com or via mail to PO BOX 888 Williston VT 05495. Once Gainwell receives your documents, Gainwell will:

    a. Create test and production accounts

    b. Send an email confirmation with your new account information and if you will be using PES, set up a time to assist with the download and installation of the PES software.

If you have questions about filling out the paperwork, please call Gainwell's EDI Coordinator at 800.925.1706, option 3.

Section 8   System Set-Up

8.1   Equipment Requirements

Provider Electronic Solutions is designed to operate on a personal computer system with the following equipment requirements.

Please Note: PES is not compatible with MAC's/Chromebook's/Tablets or Windows 10/11 S Mode.

Minimum	Recommended
Windows 10	Windows 10 or higher
4 Gigabytes RAM	8 Gigabytes RAM
800 X 600 Resolution	1024 X 768 Resolution
Internet Connection	Internet Connection
WinZip	WinZip

8.2   Provider Electronic Solutions Software Media

The Provider Electronic Solutions application programs and files are located on Vermont Medicaid's website at https://vtmedicaid.com/#/pes.

Section 9   Program Installation

The Provider Electronic Solutions application was designed for installation on the PC hard drive or to a network. To simplify installation, an automatic installation program is included in the download. Your computer must have WinZip in order to install the software. The instructions are as follows:

1. Access the web site, https://vtmedicaid.com/#/pes.

2. Use the filter option **Type** and select **Full Install** to view only the Full Install files.

3. Click on **2.xx Full Install**.

4. The file will be saved to a temporary file on your PC. When the following screen is displayed, double click on the file titled "VT_V02xx_setup.exe". This will begin the install and automatically proceed through the process.

5. Select Next at the Welcome screen.
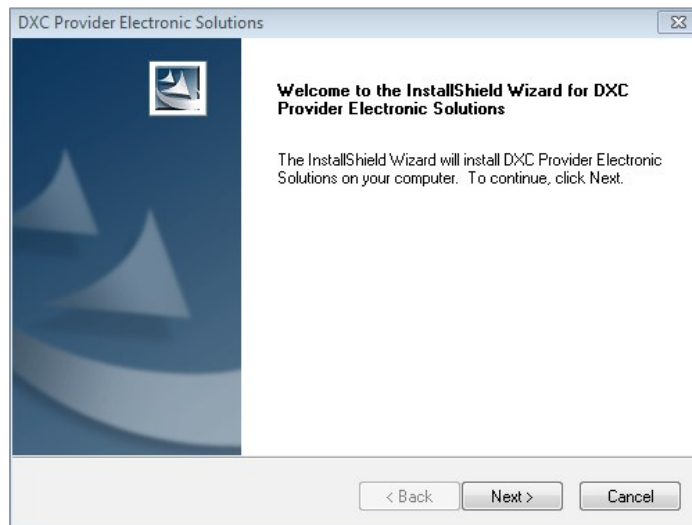
6. At the Setup Type screen, highlight TYPICAL or WORKSTATION and select the Next button. Most installations will be a typical installation.

    a. The Typical installation installs all the files, including the database. This installation is used to install to a stand-alone PC, or initially to a network server.

    b. The Workstation installation is used for all additional PCs that are connected to a network server where all users share the database. The initial installation of Typical to a PC has been completed as noted above. This installation type does not load the database files to the PC; however, it does allow for sharing the database files that were installed to the network.
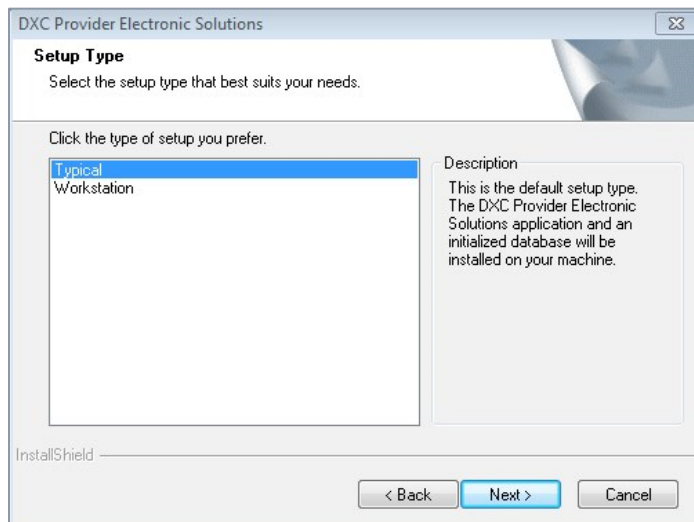
7. At the Choose Destination Location screen, select Next to install to the default directory, C:\vthipaa. If the software on the PC is to run from a network rather than the PC hard drive, select the appropriate destination drive.
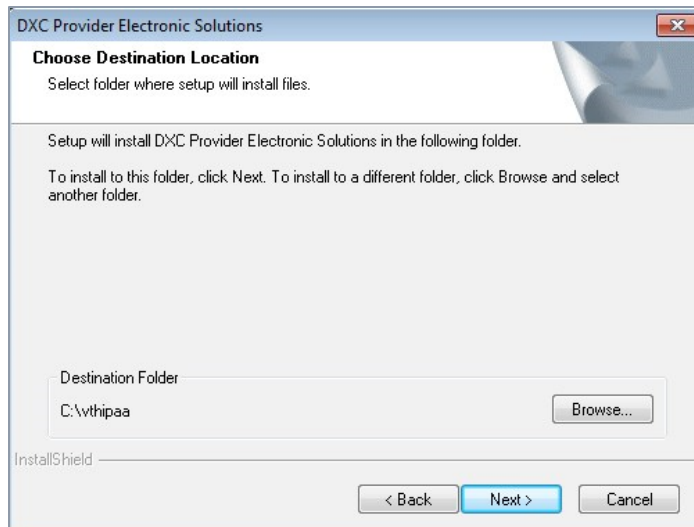

8. At the Choose Database Destination Location screen, select Next to load the database in the default directory, C:\vthipaa, or select the appropriate destination drive for installing to a network.
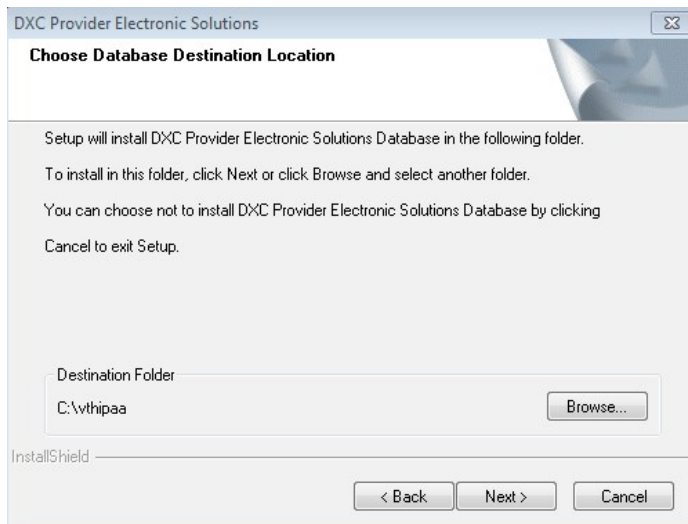
9. At the Information screen, select OK. As stated on this screen, note the drive and directory where the files were installed. The system will then install the program files.
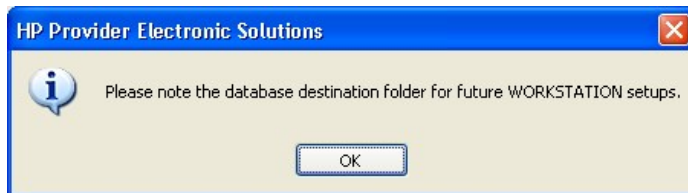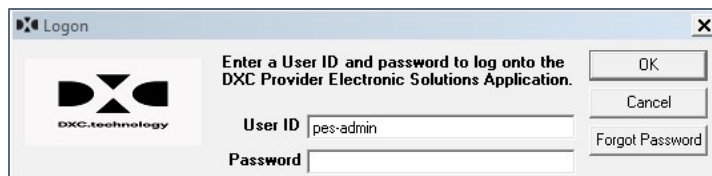
10. At the InstallShield Wizard Complete screen, select Finish to complete the setup.

11. There will be an application folder placed on your desktop titled VT Gainwell Technology Provider Electronic Solutions. At this time, you may close the WinZip window.
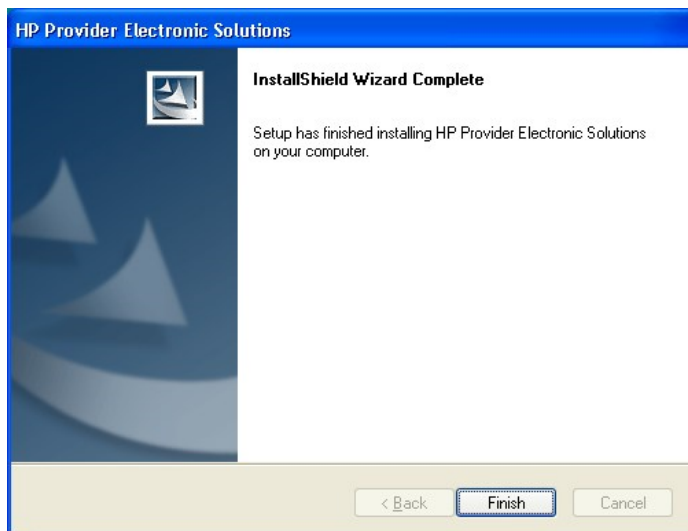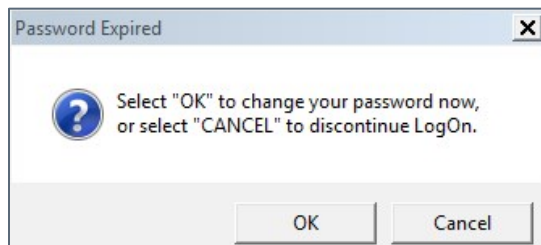
Section 10 Basic Skills

1. Double click the application folder from the desktop and then select Gainwell Technology Provider Electronic Solutions or select the **Start** button in the bottom left-hand corner of the PC, then select the Program option and then select "VT Gainwell Provider Electronic Solutions" and then "VT Gainwell Provider Electronic Solutions".

2. Once the option is selected, the Logon screen appears. The default User ID is "pes-admin" and the default password is "eds-pes". **Note:** The first time you log on you will be prompted to change the password. If this is your first log on, proceed to Step 4.
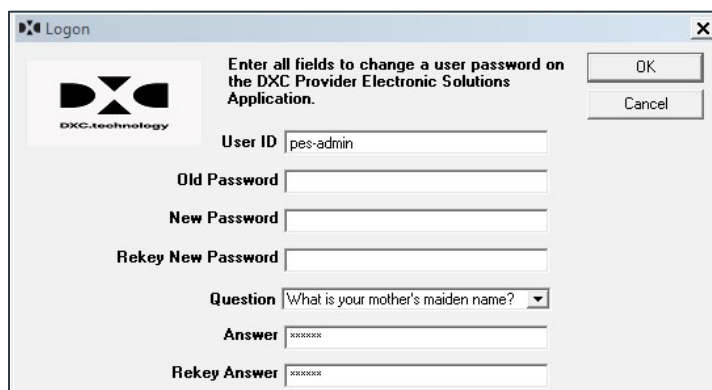
3. Select OK.

4. Enter the old password and then enter a new password twice. The software has a feature to allow for password reset beginning with version 2.14. Click on the drop-down arrow on the Question field and select one of the questions listed. Enter the appropriate answer in the Answer and Rekey Answer fields. Select OK. A dialog box displays a message stating whether the update was successful.
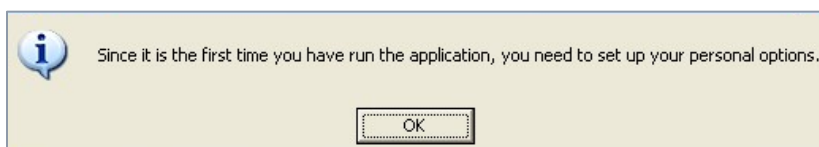
5. Select OK if the update was successful.
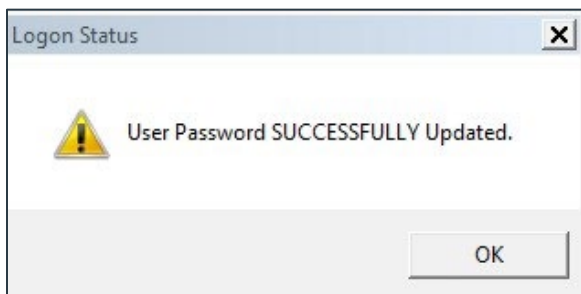
6. If this is your first logon, the system will display the message shown. Select OK to update personal options. The Options dialog box will display.

7. Select the Batch tab. This information is necessary for connecting with the web site for uploading and downloading files. All fields are required, however, only one Communication Number and Qualifier is needed. Please note that the Web User ID is the same as your Trading Partner number.

   Note: In addition, the password below must match the password you created on the web site.

8. Select the Web tab. This is pre-set to use the Internet Explorer Settings on your PC. You will need to change the Environment Ind to A for submitting an acceptance test. Once you receive confirmation from Gainwell that the test was successful, you will need to change the Environment Ind to P.

9. Select the Modem Tab. If your PC has a modem, select the **Detect** button on the Modem tab. If the modem is not automatically detected, find the modem information by selecting the Start button from the bottom left corner of the desktop screen. Then select Settings and Control Panel. Depending on the version of Windows the next option is either Modems or Phone and Modem Options.

10. The Modem Tab must be completed even if no modem is present on the PC. In this case, place the cursor in the Modem Type field to access the modem listing. Select Generic Configuration, for most modems.

11. Select the Interactive tab. Verify that the Modem In it String field is populated from the modem type selected on the Modem tab.

12. Select the Carrier tab. This information is necessary for the submission of the transactions.

    a. Choose the transaction type by selecting it at the bottom of the screen. It will highlight in blue. Using the drop-down arrow, select the carrier type with a phone number appropriate for your area. If there is not a local number available, select one of the toll-free numbers. Update the DTR (modem speed) to the appropriate speed to match your modem. You will need to set the X12 Production/Test Indicator to T for submitting a test. Once you receive confirmation from Gainwell that the test was successful, you will need to change the indicator to P.

    b. Transaction Type Interactive is used for Eligibility Verification and Claim Status Request when you want an immediate response. Transaction Type Batch Transmit is used for submitting claims.

13. Select the Retention tab. This tab lists options for file storage and archiving.

14. Only versions greater than 2.32 will have accurate Payer/Processor tab information populated. Please make sure your tab matches the snip below:

Section 11   Using the Software

Now that all the necessary information to submit your transactions has been entered, you may begin using the software. This application appearance has been designed based on Windows. Each of the options at the top of the screen has the standard Windows options. The software has been enhanced to allow users to review each option through the Help feature.

11.1   Main Menu

The icons under the menu titles represent each of the forms that may be submitted. Each of them is listed at the end of this section. You may also select Forms from the tool bar to select your form.

From the menu you may select any of the options. They include the following:

- File
- Forms
- Communication
- Lists
- Reports
- Tools
- Security Maintenance
- Window

11.1.1   File

The File menu item exits the application. You may also select the X box in the upper right-hand corner of the screen.
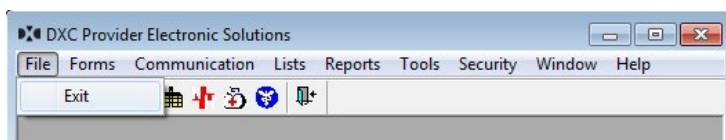
11.1.2   Forms

The Forms menu item allows you to open any of the transactions for entry. These are the same as the icons listed on the second line of the menu bar.

11.1.3   Communication

The **Communication** menu item allows for the following:

- **Submission:** transmits transactions via vtmedicaid.com to the Oxi Translator.
- **Resubmission:** resubmits a batch or copies the claims from a batch for editing and submitting.
- **View Batch Response:** allows viewing of downloaded responses to Eligibility Verification and Claim Status requests.
- **View 835 ERA:** This functionality is disabled. If you are set up for 835 ERA files you will download them directly from vtmedicaid.com
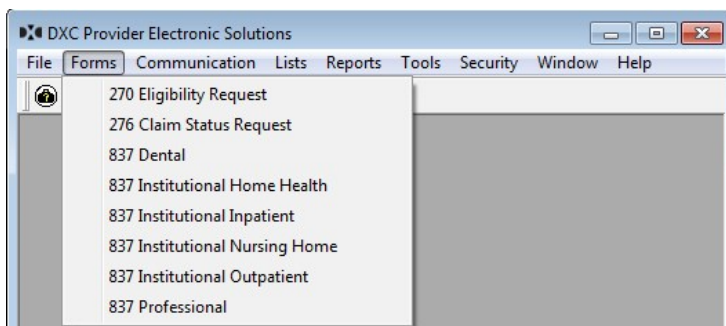- **View Accept/Reject Claim Report - Functional Acknowledgement:** allows viewing of the Gainwell created report listing claims or files that were unable to be loaded into the system.
- **View Communication Log:** indicates the claim batch number and submission details.
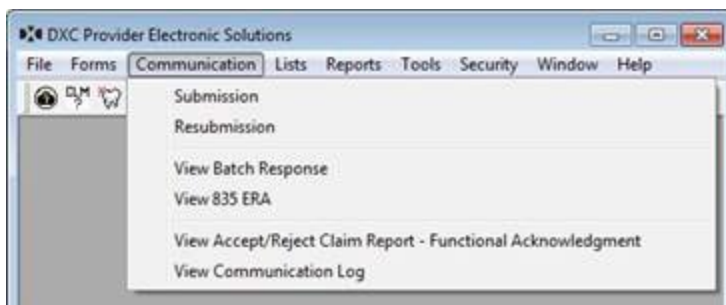
11.1.4   Lists

The Lists menu item allows you to select from the available lists to enter or edit the information. The lists are described further in Section 5.
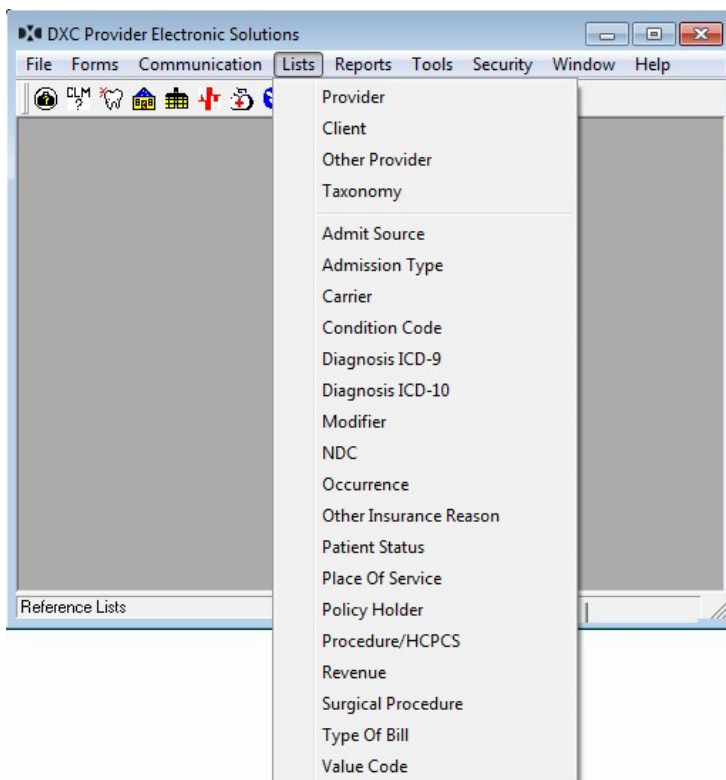
11.1.5   Reports

The Reports file menu item allows the printing of detail and summary reports for transactions and the contents of lists. Detail and summary reports may be printed for all the transactions. You may select one or more of the selection criteria to narrow the transactions to be printed.
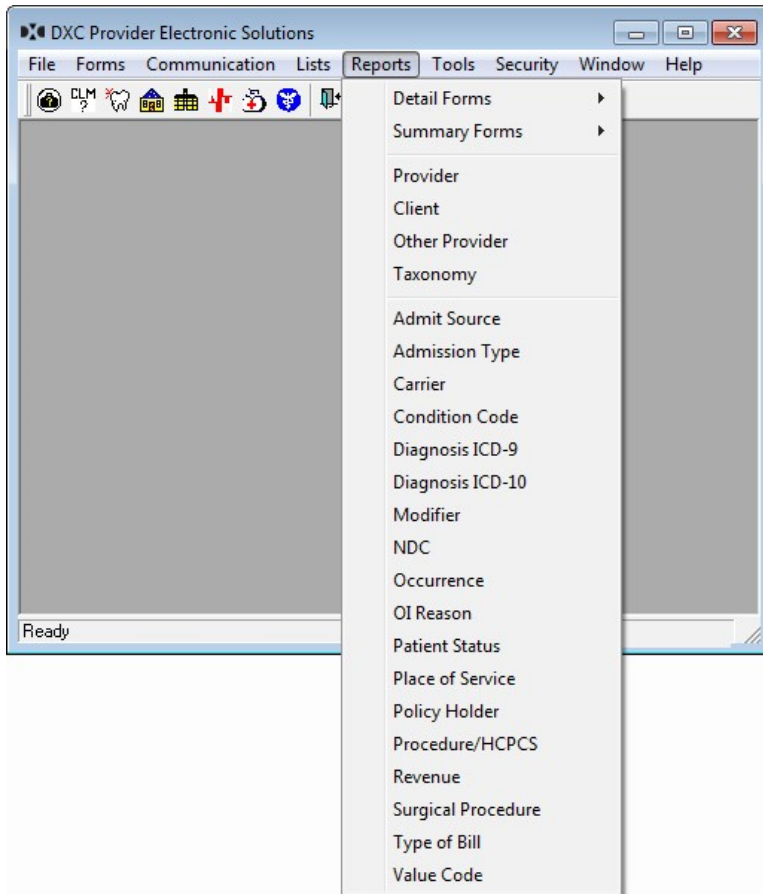
11.1.6   Tools

The Tools file menu item allows for the following:

- Archive allows you to archive old transactions or restore transactions that were previously archived.

- Database recovery allows the user to compact, repair and unlock the database.

- Get Upgrades allows you to dial into the web site to check for and download upgrades to the software. See Section 9 for instructions on downloading upgrades.

- Change password allows users to change their passwords. For Options, refer to Section 3 – Basic Skills Signing On.
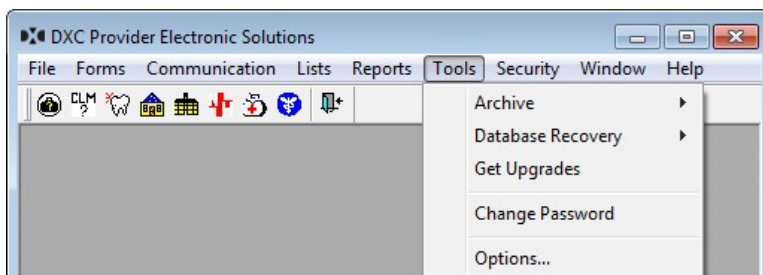
11.1.7　Security

The Security file menu item allows administrators to enter, update and remove users, their passwords and authorization levels.
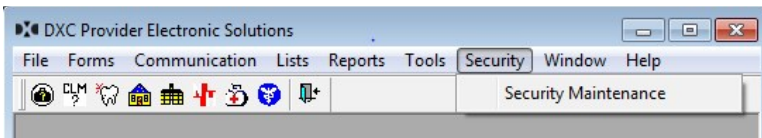
11.1.7.1　Adding a New User

Each user should be assigned their own User ID and password. To add a new user:

1. Select Security and then Security Maintenance from the Menu Bar.

2. Assign a User ID unique to the individual.

3. Enter an initial password. The user will be required to change their password when they log into the system for the first time.

4. Enter the Authorization Level. A user with an Authorization Level of 2 User (Non-Administrator) is allowed to enter, transmit, and download transactions and files. An Authorization Level of 3 Administrator is allowed the same security as a User, and is also allowed to enter, modify, or delete User IDs. The Security option will not appear on the menu of a person that is assigned the authorization level of 2.
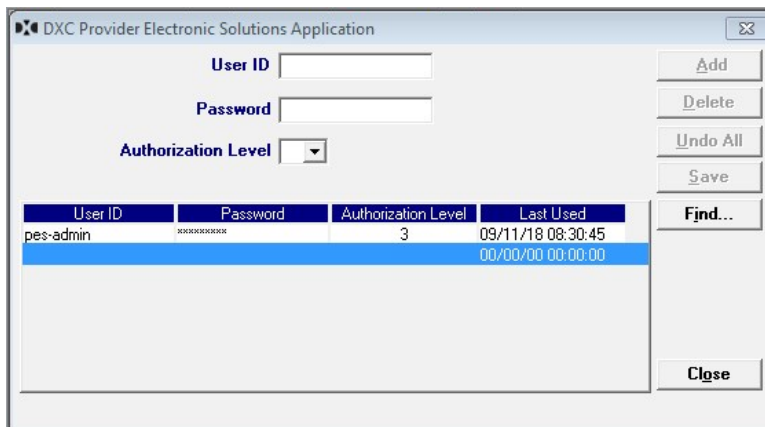
11.1.8　Window

The Window file menu item allows you to arrange the screens displayed.
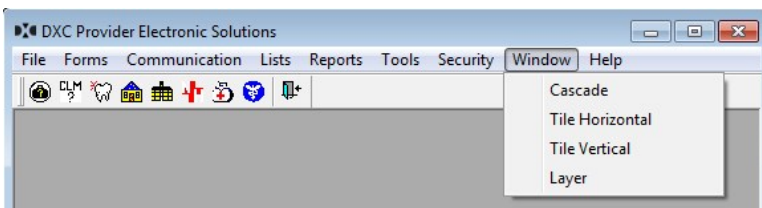
Note: The Help function is described in Section 4.

11.2   Menu Options

From the menu you may select any of the icons. The icons shown below represent each of the transaction types that are currently functional. To access the transaction, click on the appropriate icon or select Forms from the toolbar.

- 270 Eligibility Request

- 276 Claim Status Request

- 837 Dental

- 837 Institutional – Home Health

- 837 Institutional – Inpatient

- 837 Institutional – Nursing Home

- 837 Institutional – Outpatient

- 837 Professional

Placing the mouse pointer on the icon displays the name.

Before you may begin entering transactions, several lists must be completed. This may be done now, or as you key in your transactions. There are four lists that should be used and completed prior to finishing a transaction: Provider, Client, Other Provider, and Taxonomy Code.

- The **Provider List** maintains the provider's information by Medicaid Provider Number.

- The **Client List** maintains the client information by Vermont Medicaid Client Identification Number.

- The **Other Provider List** maintains the provider's information by Medicaid Provider Number.

- The **Taxonomy Code List** represents the provider type, classification, area of specialization and training and education indicator. A list of taxonomy codes is available from the Washington Publishing Company at https://wpc-edi.com/.

Because of certain requirements of the ANSI ASC X12 transactions, the software is designed to require the entry of the lists for Provider and Client. Entering the information on the individual transaction is no longer required and size of the transactions screens is kept to a minimum.

Section 12 How to Check Eligibility Via Web Portal

1. Navigate to Vermont Medicaid Portal (https://vtmedicaid.com/#/home).

2. Then click on Transactions drop down and select Login.
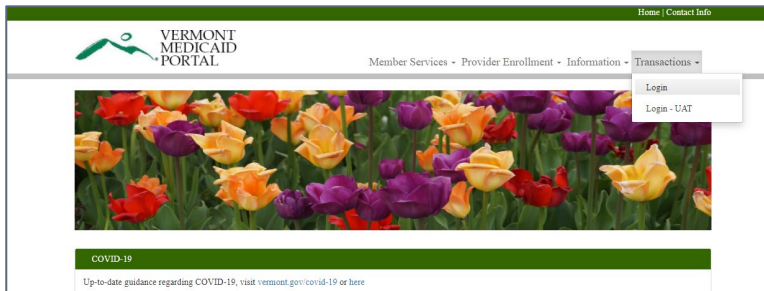
3. Log in using your Trading Partner ID and Password or Web User ID and password.

4. Once logged in you will click on Check Eligibility Status.
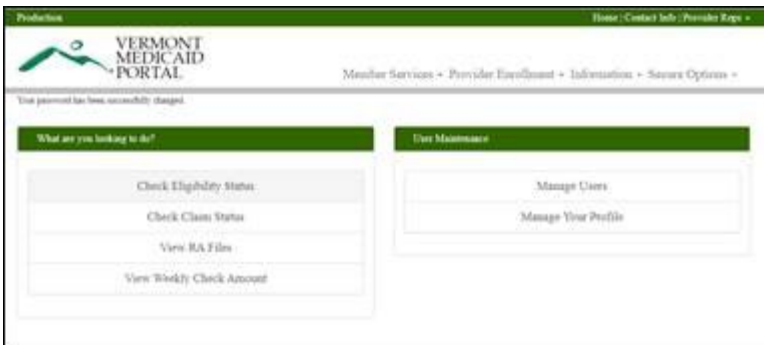
5. Select your provider number from the dropdown menu. If you are associated to a single provider this field will auto populate. Then enter the Member's ID, and date of service you are check eligibility on, click search.

6. Once you click search, it will yield the patient's eligibility for the date of service being checked.

Member Information

We are now returning member's unique id, not SSN. Use the unique id for all transactions for this individual

Member's ID Number:
Member's Name:
Date of Birth:
Gender:
Member's Address:

Date of Death:

Transaction Control Number: 0139760112

Eligibility

Start Date	End Date	Status	Benefit Plan	Service Type(s)	Max Co-Pay	ACO Attributed
03/16/2021	03/16/2021	Eligible	MEDICAID - KC	1 - Medical Care 33 - Chiropractic 47 - Hospital 48 - Hospital - Inpatient 86 - Emergency Services 98 - Professional (Physician) Visit - Office AL - Vision (Optometry) MH - Mental Health UC - Urgent Care	$0.00	Y - 2021
03/16/2021	03/16/2021	Eligible	MEDICAID - KC	35 - Dental Care 50 - Hospital - Outpatient 88 - Pharmacy	$0.00	Y - 2021

Third Party Liability

Start Date	End Date	Coverage Description
01/01/2019	12/31/2382	DRUG COVERAGE A79 - EXPRESS SCRIPTS
01/01/2019	12/31/2382	PHYSICIAN INPATIENT / OUTPATIENT SERVICES EE - BC/BS OF VT

Service Limits - as of 03/16/2021 (Only exhausted limits will be displayed)

Last Serviced	Limit Description

Lock-In

Start Date	End Date	Description

Dental Dollars - 2021

Dollars Paid to Date	Dollars currently pending in the system
$0.00	$0.00

7. If a patient has just aid category FS (Non-EI, Non-Medicaid) the patient's eligibility will yield the below results.

Member Information

We are now returning member's unique id, not SSN. Use the unique id for all transactions for this individual

Member's ID Number:
Member's Name:
Date of Birth:
Gender:
Member's Address:

Date of Death:

Transaction Control Number:

Eligibility

Start Date	End Date	Status	Benefit Plan	Service Type(s)	Max Co-Pay	ACO Attributed
05/26/2021	05/26/2021	Eligible	NON EI; NON MEDICAID - FS	A3 - Professional (Physician) Visit - Home	$0.00	N - 2021
LIMITED BENEFIT						
05/26/2021	05/26/2021	Eligible	FITP - FI	PT - Physical Therapy AD - Occupational Therapy AF - Speech Therapy	$0.00	N - 2021

Section 13 Special Investigations Unit

Vermont Medicaid pays only for services that are actually provided and that are medically necessary. In filing a claim for reimbursement, the code(s) should be chosen that most accurately describes the service that was provided. It is a felony under Vermont law 33VSA Sec. 141(d) knowingly to do, attempt, or aid and abet in any of the following when seeking for receiving reimbursement from Vermont Medicaid:

- Billing for services not rendered or more services than actually performed
- Providing and billing for unnecessary services
- Billing for a higher level of services than actually performed
- Charging higher rates for services to Vermont Medicaid than other providers
- Coding billing records to get more reimbursement
- Misrepresenting an unallowable service on bill as another allowable service
- Falsely diagnosing so Vermont Medicaid will pay more for services

For more information on overpayments and potential interest charges, visit the General Provider Manual, section 6. https://vtmedicaid.com/#/manuals

Suspected fraud, waste or abuse should be reported to the DVHA Special Investigations Unit at https://dvha.vermont.gov/providers/special-investigations-unit, telephone 802.241.9210, or the Vermont Medicaid Fraud Control Unit of the Vermont's Attorney General's Office, telephone 802.828.5511.