



# Summary of Provider Manual Updates

## Summary of Updates

Detailed Summary of Updates .....	16
Updates for 8/1/2020 .....	16
General Billing and Forms Manual.....	16
6.4.7 High Dollar Inpatient Stays .....	16
6.4.8 Interim Inpatient Claims .....	16
Updates for 7/1/2020 .....	17
ABA Supplement .....	17
2.3 Fee-For-Service Requirements – Members who have other insurance .....	17
Durable Medical Equipment (DME) Supplement.....	17
3.3 Payment DVHA Primary/Manual Pricing .....	17
General Billing and Forms Manual.....	18
3.3.1 Timely Filing Limits .....	18
Updates for 5/1/2020 .....	18
Durable Medical Equipment (DME) Supplement.....	18
4.12 Medical Supplies .....	18
Updates for 4/1/2020 .....	18
General Billing and Forms Manual.....	18
5.3.52 Telemedicine Services.....	18
Updates for 3/1/2020 .....	19
General Provider Manual.....	19
1.2.11 Provider Reconsideration Process .....	19
DME Supplement .....	19
3.6.1 Use of a Detailed Standard Written Order (DSWO) for Durable Medical Equipment (DME) and Supplies .....	19
4.13 Oxygen .....	19
Updates for 2/1/2020 .....	20
PT/OT/ST Supplement .....	20
Section 2 Re/habilitative Therapy .....	20
2.1 Adult Coverage.....	21
2.2 Members Under Age 21.....	21
Section 3 Outpatient Therapy Modifiers.....	22
4.4 Obtaining SAME DAY coverage .....	22

4.5 Prior Authorization .....	23
4.5.1 Errors in Documentation .....	24
4.5.2 Electronic signatures .....	24
5.3 Outpatient Therapy Modifiers.....	24
5.3 Revenue and Procedure Codes for Hospitals, Outpatient clinics, and Home Health Agencies (previously Section 7).....	24
5.4 Correct Coding .....	25
8.1 Documentation .....	26
8.1.1 Errors in Documentation .....	26
8.1.2 Electronic signatures .....	26
8.1.3 Determining the date of initial therapy for the condition.....	27
DME Supplement .....	27
3.6.1 Use of a Detailed Written Order (DWO) for Durable Medical Equipment (DME) and Supplies .....	27
Updates for 1/1/2020 .....	27
Dental Supplement.....	27
2.1 Adult Program (AP) .....	27
2.19 Member Cost Sharing/Co-Pays .....	27
2.19.1 Exceptions to Co-Payments .....	27
2.24 Prior Authorization .....	28
4.13.3 Other Surgical Procedures/Splints .....	28
5.4.1 Space Maintainers .....	28
5.4.3 Custom Crowns .....	28
5.9.1 Fixed Partial Denture Pontics .....	28
5.9.2 Fixed Partial Denture Retainers – Crowns .....	28
5.11.5 Other Orthodontic Services .....	28
PT/OT/ST Supplement .....	29
2.2 Members Under Age 21.....	29
5.7.1 Under 21.....	29
DME Supplement .....	29
2.1 Capped Rentals (CR) .....	29
3.3 Payment DVHA Primary/Manual Pricing .....	30
3.4 Enhanced Pricing Criteria .....	32
3.5 Medical Necessity Form .....	32
Update for 12/16/2019.....	33

General Billing and Forms Manual.....	33
<del>5.3.9 Children with Special Health Needs Infant Toddler Programs.....</del>	<del>33</del>
Update for 12/11/2019.....	33
General Billing and Forms Manual.....	33
3.3 Timely Filing .....	33
3.3.1 Timely Filing Limits .....	34
3.3.2 Timely Filing Reconsideration Requests .....	35
Update for 11/25/2019.....	37
General Billing and Forms Manual.....	37
5.2 Non-Reimbursable Services .....	37
5.2.1 EPSDT Services for Medicaid Beneficiaries Under Age 21 .....	37
Update for 9/30/2019.....	38
Dental Supplement.....	38
Section 7 Fee Schedule .....	38
Updates for 9/16/2019 .....	38
General Billing and Forms Manual.....	38
1.6 Vermont Medicaid & Medicare Crossover Billing .....	38
Updates for 8/26/2019 .....	38
General Billing and Forms Manual.....	38
6.4.4 Inpatient Claims: No Medicare Part A; Has Medicare B Coverage.....	38
General Billing and Forms Manual.....	38
6.4.5 Inpatient Claims: Medicare Part A Exhausts or Begins During the Inpatient Stay .....	38
Vermont Medicaid Applied Behavior Analysis and Mental Health Services Supplement.....	39
Section 7 Applied Behavior Analysis Benefit Provider Guidance .....	39
Section 8 Policy References .....	43
Updates for 7/30/2019 .....	43
General Billing and Forms Manual.....	43
3.6 Supervised Billing for Behavioral Health Services.....	43
Updates for 5/21/2019 .....	43
General Billing and Forms Manual.....	43
3.8.1 Critical care procedure codes that are time-based .....	43
Dental Supplement.....	44
5.8.6 Interim Prosthesis .....	44
Updates for 4/5/2019 .....	44
General Billing and Forms Manual.....	44

3.6.1.2 Procedures for Billing.....	44
Updates for 2/4/2019 .....	44
8.2.1 Timely Filing Reconsideration Requests .....	44
Updates for 2/1/2019 .....	45
8.2 Timely Filing .....	45
8.2.1 Timely Filing Reconsideration Requests .....	46
Updates for 12/20/2018 .....	48
15.2.10 Choices for Care Short-Term Respite Stays .....	48
Updates for 12/4/2018 .....	48
10.3.54 Telemedicine Services.....	48
Updates for 11/6/2018 .....	48
9.8.3 Vermont Medicaid Billing .....	48
Updates for 10/29/2018 .....	49
<del>Section 18 Electronic Health Record Incentive Program.....</del>	<del>49</del>
Section 18 Promoting Interoperability Program (Formerly Electronic Health Record Incentive Program) .....	49
<del>18.1 Electronic Health Record Program Reconsideration Process .....</del>	<del>50</del>
18.1 PROMOTING INTEROPERABILITY PROGRAM/ELECTRONIC HEALTH RECORD INCENTIVE PROGRAM RECONSIDERATION PROCESS .....	50
<del>18.2 Appeal of EHR Incentive Program Reconsideration.....</del>	<del>51</del>
18.2 APPEAL OF PROMOTING INTEROPERABILITY PROGRAM/EHR INCENTIVE PROGRAM RECONSIDERATION .....	51
Updates for 10/25/2018 .....	52
10.3.49 Radiology .....	52
Updates for 8/21/2018 .....	52
10.3.54 Telemedicine Services.....	52
Updates for 7/11/2018 .....	52
7.3 Determination Time .....	52
Updates for 7/10/2018 .....	53
10.3.24 Scope-of-Service Related Encounter Rate Adjustments.....	53
Updates for 5/30/2018 .....	55
10.3.6 Audiological Services/Hearing Aids .....	55
<del>11.15.3 BICROS/CROS (Contralateral Routing of Sound).....</del>	<del>56</del>
Updates for 5/23/2018 .....	56
11.3 Rental/loaned .....	56

11.1 Rental Reimbursement Policies .....	57
11 Durable Medical Equipment (DME), Prosthetics, Orthotics & Medical Supplies .....	57
Updates for 5/3/2018 .....	57
11.5 PAYMENT DVHA PRIMARY/MANUAL PRICING .....	57
11.9 PROCEDURE CODES & PRICING.....	58
Updates for 4/16/2018 .....	58
<del>8.2.1 Timely Filing Reconsideration Requests</del> .....	58
8.2.1 Timely Filing Reconsideration Requests .....	59
11.3 Face-to-face Requirements.....	59
13.2 Face-to-face requirements .....	60
UPDATES FOR 3/22/2018 .....	61
<del>6.7 INDIVIDUAL CONSIDERATION/MANUAL PRICING.....</del>	61
<del>11.2 PAYMENT DVHA PRIMARY .....</del>	61
11.2 PAYMENT DVHA PRIMARY .....	62
UPDATES FOR 12/29/2017 .....	63
1.2.5 Claim Copy Requests .....	63
7.7.1 Concurrent Review for Admissions at Vermont & In-Network Border Hospitals.....	63
Updates for 12/08/2017 .....	64
8.12 Refunds .....	64
10.3.6 Audiological Services/Hearing Aids.....	64
updates for 11/09/2017.....	64
12.4.11 Subacute Care .....	64
Updates for 10/26/17 .....	65
10.3.53 Telemedicine.....	65
UPDATES FOR 09/28/17 .....	65
10.3.53 Telemedicine Outside a Facility Services .....	65
UPDATES FOR 08/24/17 .....	66
10.1 Payment DVHA Primary.....	66
11.3 Payment Dual Eligible/ Medicare Primary .....	66
Updates for 06/22/2017 .....	67
10.3.3 Anesthesia .....	67
Updates for 06/12/2017 .....	68
10.3.467 Psychiatry/Psychology .....	68
11.11.19 TENS/MNES NMES .....	70
10.3.27 Immunizations .....	70

1.2.7 Provider <del>Administrative Review</del> Reconsideration Process.....	71
8.2.1 Timely Filing Reconsideration Requests .....	72
Section 7 Prior Authorization of Medical Services .....	73
9.7 Health Examination of Defined Subpopulation .....	93
3.7 National Correct Coding Initiative (NCCI) Guidelines .....	93
12.4.1 Bilateral Billing Procedures .....	93
Updates for 02/10/2017 .....	93
10.3.52 Telemedicine Outside a Facility.....	93
8.4 Supervised Billing .....	94
7.8.1 Concurrent Review for Admissions at Vermont and In-Network Border Hospitals .....	94
Updates for 12/23/2016 .....	95
12.1 Reimbursable Services - Home Health Hospice .....	95
13.3 Home Health Agency & Hospice Services Billing Instructions/Field Locators .....	96
12.5.4 Hospital Clinical Laboratory Tests .....	97
9.11 Place of Service (POS) Codes .....	98
Updates for 12/01/2016 .....	98
10.3.5 Assistant Surgeon .....	98
Updates for 10/13/2016 .....	99
7.8.6 Rehabilitative Therapy .....	99
11.11.22 Wheelchairs & Seating Systems.....	100
Updates for 08/17/2016 .....	100
1.2.3 Claims System & Provider Services .....	100
7.2.3 Prior Authorization Requirements.....	100
Updates For 07/01/2016 .....	101
12.5.7 Provider Based Billing .....	101
Updates for 06/02/2016 .....	101
Section 15 Choices for Care: Enhanced Residential Care (ERC)/Nursing Facilities Home Based Waiver (HBW), Moderate Needs .....	101
12.5.9 Hospital Outpatient Billing Instructions/Field Locators .....	102
Updates for 04/18/2016 .....	102
9.14 Long Acting Reversible Contraceptives Provided in an Inpatient Hospital Post-Partum Setting .....	102
Updates for 04/01/2016 .....	102
8.4 Supervised Billing for Behavioral Health Services .....	102
10.3.46 Psychiatry/Psychology .....	103

Updates for 03/01/2016 .....	104
12.5.7 Provider Based Billing .....	104
9.11 Place of Service (POS) Codes .....	104
1.2.6 Provider Claim Modification Process .....	105
1.2.7 Provider Administrative Review Process .....	105
11.11.6 Continuous Passive Motion (CPM) Devices .....	105
18.1 Electronic Health Record Program Reconsideration Process .....	106
18.2 Appeal of EHR Incentive Program Reconsideration .....	106
Updates for 02/10/2016 .....	106
Section 9.9 Inpatient Newborn Services .....	106
Section 3.3.1 Correct Coding Practices .....	106
Section 3.3.2 New, Revised and Deleted Codes .....	107
Section 9.6 Fee Schedule .....	107
Updates for 01/19/2016 .....	107
Section 8.4 Supervised Billing for Behavioral Health Services .....	107
Updates for 12/18/2015 .....	113
Section 10.1 .....	113
Section 8.3 Incident to Billing for Licensed Physicians .....	113
Section 8.4 Supervised Billing for Behavioral Health Services .....	114
Updates for 12/01/2015 .....	117
Section 5 Provider Enrollment, Licensing & Certification .....	117
<del>Enrollment Agreement Signatures</del> .....	118
Section 5.1 Enrollment & Certification .....	118
<del>3.7 National Correction Coding Initiative (NCCI)</del> .....	120
3.7 National Correction Coding Initiative NCCI Guidelines .....	120
Updates for 11/01/2015 .....	121
Inpatient Newborn Services ( <del>Physician</del> ) .....	121
9.3 Organ Transplant .....	121
9.3.1 Organ Transplant Donor Complication .....	121
1.1 Important Telephone Numbers, Addresses and Websites .....	121
7.8.4 In-State & Out of State Psychiatric & Detoxification Inpatient Services .....	121
Updates For 10/15/2015 .....	122
10.3.39 Obstetrical Care New Instructions for OB Code Billing Instructions for ICD-10 ....	122
Updates for 10/01/2015 .....	123
9.1 Abortions .....	123



11.12 CMS 1500 Paper Claim Billing Instructions/Field Locators .....	123
ICD-9 and ICD-10 References Throughout Entire Manual .....	123
Updates for 09/01/2015 .....	123
10.3.46 Psychiatry/Psychology .....	123
ICD-9 and ICD-10 References Throughout Entire Manual .....	123
Updates For 08/01/2015 .....	123
9.4 Organ Transplant Donor Complication .....	123
Section 18 Electronic Health Record Incentive Program .....	124
18.1 Electronic Health Record Program Reconsideration Process .....	124
18.2 Appeal of EHR Incentive Program Reconsideration .....	125
7.5 Medical Necessity .....	126
<del>10.3.34 Midwife Services</del> .....	126
10.3.34 Midwife Services .....	128
<del>10.3.39 Obstetrical Care</del> .....	129
10.3.39 Obstetrical Care .....	130
7.8.1 Concurrent Review for Admissions at Vermont & In-Network Border Hospitals .....	132
8.1 Timely Filing .....	133
10.3.46 Psychiatry/Psychology .....	133
Updates For 07/13/2015 .....	133
<del>Section 1.2.6 Provider Administrative Appeal Process</del> .....	133
Section 1.2.6 Provider Administrative Review Process .....	136
Section 16.4 Program Integrity Reconsideration & Appeal Process .....	137
Updates for 07/01/2015 .....	138
Section 1.1.3 Claims System & Provider Services .....	138
Section 6.8 Third Party Liability (TPL)/Other Insurance (OI) .....	139
Section 11.12 CMS 1500 Paper Claim Billing .....	139
Updates for 06/01/2015 .....	139
Section 13.4.1 .....	139
Updates for 04/22/2015 .....	139
4.9 Member Grievance Process .....	139
6.6 Medicaid & Medicare Crossover Billing .....	139
7.8.6 Rehabilitative Therapy .....	140
10.3.7 Bilateral Procedures Physician/Professional Billing .....	140
11.11.8 Enteral Nutrition .....	140
12.4.3 Inpatient/Outpatient Overlap Examples .....	140

12.5.8	Hospital Inpatient Billing Instructions/Field Locators.....	140
12.5.9	Hospital Outpatient Billing Instructions/Field Locators.....	140
Updates for 2/1/2015.....		140
6.7	Individual Consideration/Manual Pricing.....	140
7.8.6	Rehabilitative Therapy .....	141
10.3.10	Chiropractic Services .....	141
10.3.34	Midwife Services .....	141
12.4.1	Bilateral Billing Procedures .....	141
Updates for 1/1/2015.....		142
7.1	Prior Authorization Reviewers .....	142
10.3.52	Telemedicine.....	142
12.5.8	Hospital Inpatient Billing Instructions/Field Locators.....	142
12.5.9	Hospital Outpatient Billing Instructions/Field Locators.....	143
13.5	Home Health Agency & Hospice Services Billing Instructions/Field Locators .....	143
15.2.12	Short Term Stays .....	143
15.3	Home Based Waiver (HBW) Billing Instructions/Field Locators .....	144
Updates for 12/1/2014.....		144
10.3.34	Midwife Services .....	144
11.12	CMS 1500 Paper Claim Billing Instructions/Field Locators.....	144
13.5	Home Health Agency & Hospice Services Billing Instructions/Field Locators .....	144
15.3	Home Based Waiver (HBW) Billing Instructions/Field Locators .....	145
Updates for 11/3/2014.....		145
6.1	Contractual Allowance.....	145
7.8.6	Rehabilitative Therapy .....	145
10.3.2	Ambulance Services .....	145
10.3.19	EPSDT Program Well – Child Health Care .....	146
11.12	CMS 1500 Paper Claim Billing Instructions/Field Locators.....	146
12.4.5	Inpatient Claims: Medicare Part A Exhausts or Begins During the Inpatient Stay 147	
12.5.7	Provider-Based Billing .....	148
Updates for 10/1/2014.....		148
1.2.4	Claim Submission & Correspondence Mailing Addresses.....	148
4.3	Member Bill of Rights .....	148
6.1	Contractual Allowance.....	148
7.8.3	Out-of-Network Elective Outpatient Referrals.....	149

10.3.46	Psychiatry/Psychology .....	149
12.4.9	Short <del>Same Day</del> Stays .....	149
12.4.10	Same/Next Day Readmission Policy .....	150
12.4.12	Transfer Cases.....	150
12.5.2	Dialysis .....	150
Updates for 8/23/2014 .....		150
12.5.1	Cardiac Rehabilitation.....	150
Updates for 8/1/2014 .....		151
6.7	Individual Consideration/Manual Pricing.....	151
7.3.1	General Exceptions.....	151
7.7	Prior Authorization Notice of Decision .....	151
8.1	Timely Filing .....	152
10.3.7	Bilateral Procedures Physician/Professional Billing.....	152
12.4.12	Outpatient Services Rendered During an Inpatient Stay.....	152
13.4.1	Telemonitoring .....	152
Updates for 7/1/2014 .....		153
6.6	Medicaid & Medicare Crossover Billing .....	153
12.5.4	Hospital Clinical Laboratory Tests.....	153
13.4	Adult Day Services Billing Instructions/Field Locators.....	154
Updates for 6/11/2014 .....		154
2.5.8	Referrals.....	154
3.6	Medicaid Rule & State Plan Resources .....	154
6.3	Who is Responsible for Payment?.....	154
9.10	Place of Service (POS) Codes .....	154
15	Choices for Care: Enhanced Residential Care (ERC)/Nursing Facilities Home Based Waiver (HBW), Moderate Needs .....	155
15.2	Choices for Care: Nursing Facilities - General Billing Information .....	155
15.2.10	Choices for Care Short-Term Respite Stays.....	155
14.5.10	Respite Care Billing in the Nursing Home.....	155
16.1	Fraud.....	156
Updates for 6/1/2014 .....		156
1.2.4	Claim Submission & Correspondence Mailing Addresses .....	156
7.8.6	Rehabilitative Therapy .....	157
11.11.21	Wheelchair Repairs .....	157
11.12	CMS 1500 Paper Claim Billing Instructions/Field Locators.....	157

12.2	Reimbursement Policy.....	157
Updates for 5/1/2014 .....		157
2.3	Primary Care Plus (PC PLUS).....	157
4.4	Beneficiary Cost Sharing/Co-pays and Premiums .....	158
11.12	CMS 1500 Paper Claim Billing Instructions/Field Locators.....	158
Updates for 4/1/2014 .....		158
1.1	Green Mountain Care Overview .....	158
2.1	Health Insurance Program Participation <del>Vermont Health Access Plan (VHAP)</del> .....	159
2.2	Prescription Assistance Pharmacy-Only Programs.....	159
2.3	Primary Care Plus (PC PLUS).....	159
3.2	Banner Page .....	160
3.6	Medicaid Rule & State Plan Resources .....	160
4.4	Beneficiary Cost Sharing/Co-pays and Premiums .....	160
7.8.6	Rehabilitative Therapy .....	162
9.2	Aids .....	162
10.2	Non-Reimbursable Services .....	162
10.3.6	Audiological Services/Hearing Aids.....	162
10.3.41	Over-The-Counter (OTC) Medications.....	162
10.3.54	Vision Care & Eyeglasses .....	163
Section 11 Durable Medical Equipment, Prosthetics, Orthotics & Medical Supplies.....		163
11.11.20	Wheelchairs & Seating Systems.....	163
11.12	CMS 1500 Paper Claim Billing Instructions/Field Locators.....	163
14.5.2	Beneficiary Placement Levels (RPL).....	164
Updates for 3/1/2014 .....		164
4.4	Beneficiary Cost Sharing/Co-pays and Premiums .....	164
5.1.1	Enrollment Agreement Signatures .....	164
12.5.4	Hospital Clinical Laboratory Tests.....	165
13.4	Home Health Agency & Hospice Services Billing Instructions/Field Locators .....	165
13.5	Adult Day Services Billing Instructions/Field Locators.....	165
14.2	Assistive Community Care Services (ACCS) Billing Instructions/Field Locators ...	165
14.4	ERC Paper Claim Submission Billing Instructions/Field Locators .....	166
14.6	Home Based Waiver (HBW) Billing Instructions/Field Locators .....	166
Updates for 1/24/2014 .....		166
3.8.1	The 835 Transaction (Electronic Remittance Advice).....	166
8.3	Incident-To Billing .....	166

8.3.1 Licensed Physician Incident-To Billing .....	167
8.3.2 Licensed Doctorate-Level Psychologist Incident-To Billing .....	168
3.5 Manuals for Providers.....	168
8.3 Incident-To Billing .....	169
Updates for 1/1/2014 .....	171
2.1 Health Insurance Program Participation .....	171
4.4.1 Private Insurer Co-Pays - Medicaid Secondary .....	171
6.4 Who Is Primary .....	172
8.3 Incident-To Billing .....	172
10.3.48 Smoking Cessation Counseling .....	176
Updates for 12/1/2013 .....	176
8.8 Electronic Funds Transfer (EFT) .....	176
Updates for 11/1/2013 .....	177
1.2.6 Provider Administrative Appeal Process.....	177
2.3.9 Case Management Responsibilities .....	177
7.2.3 Prior Authorization Requirements .....	177
9.12 Spend-Down .....	178
9.7.3 Vermont Medicaid Billing .....	178
10.3.23 FQHC/RHC .....	178
11.11.11 Medical Supplies .....	178
14.5.10 Respite Care Billing in the Nursing Home.....	178
Updates for 10/7/2013 .....	179
10.3.13 Developmental & Autism Screening of Young Children .....	179
Updates for 10/1/2013 .....	179
2.3.10 Case Management Fee and Treatment Plan.....	179
Treatment plan forms are available by contacting HPES' Provider Services Unit .....	179
3.4 Correct Form Versions .....	179
6.6 Medicaid & Medicare Crossover Billing .....	180
9.6 Health Examination of Defined Subpopulation.....	180
9.7 Interpreter Services/Limited English Proficiency (LEP).....	180
10.3.15 Drugs Requiring Prior Authorization .....	182
12.1 Reimbursable Services.....	182
Updates for 9/1/2013 .....	182
4.4.1 Private Insurer Co-Pays - Medicaid Secondary .....	182
6.8 Third Party Liability (TPL)/Other Insurance (OI).....	183

9.10	Spend-Down .....	183
12.1	Reimbursable Services.....	183
12.4.10	Subacute Care .....	184
Updates for 8/1/2013 .....		184
1.2.6	Provider Administrative Appeal Process .....	184
2.3.8	Referrals .....	184
11.11.3	BICROS/CROS (Contralateral Routing of Sound) .....	184
14.5.7	Nursing Home Claims & Patient Hospitalization .....	184
Updates for 7/1/2013 .....		185
4.4	Beneficiary Cost Sharing/Co-pays and Premiums .....	185
9.3	CPT Category III Procedure Codes .....	185
12.4.1	Bilateral Billing Procedures .....	186
Updates for 6/1/2013 .....		186
1.1	Green Mountain Care Overview .....	186
2.3.9	Case Management Responsibilities .....	186
4.4	Beneficiary Cost Sharing/Co-pays and Premiums .....	186
5.1	Enrollment & Certification .....	186
7.3.1	General Exceptions.....	186
7.3.2	Immediate Need Exception .....	187
8.6	Time-based Procedure Codes – Billing Guidelines .....	187
9.9	Place of Service Codes .....	187
10.3.2	Ambulance Services .....	189
11.11.4	Blood Pressure Monitors .....	189
Updates for 5/1/2013 .....		190
1.2.6	Provider Administrative Appeal Process .....	190
5.1	Enrollment & Certification .....	190
6.7	Individual Consideration/Manual Pricing .....	190
9.2	Aids .....	191
9.7	Inpatient Newborn Services (Physicians).....	191
10.3.23	FQHC/RHC .....	191
Updates for 4/1/2013 .....		191
1.2.6	Provider Administrative Appeal Process .....	191
4.5	Qualified Medicaid Beneficiary (QMBY) .....	194
7.8.1	Concurrent Review for Admissions at Vermont & In-Network Border Hospitals..	194
7.8.6	Rehabilitative Therapy .....	194

9.6	Interpreter Services/Limited English Proficiency (LEP)	195
10.3.23	FQHC/RHC	195
12.1	Reimbursable Services	195
Updates for 3/1/2013		196
5.4	Documentation of Services	196
10.3.36	Naturopathic Physicians	196
Updates for 2/20/2013		196
10.3.46	Psychiatry/Psychology	196
Updates for 2/20/2013		199
7.8.4	In-State & Out of State Psychiatric & Detoxification <i>Inpatient</i> Services	199
10.3.37	NDC (National Drug Code)	200
10.3.46	Psychiatry/Psychology	200
Updates for 1/01/2013		200
6.7	Individual Consideration/Manual Pricing	200
7.8.2	Inpatient Medically Managed Detoxification	201
7.8.4	Out-of-Network Elective Outpatient Referrals	201
7.8.7	Rehabilitative Therapy	201
11.3.46	Psychiatry/Psychology	202
10.3.46	Psychiatry/Psychology	205
10.3.51	Coverage for Services Delivered Via Telemedicine	207
10.3.53	Vision Care & Eyeglasses	208
11.12.5	CPAP & BIPAP	208
12.3	Patient Share (Applied Income) Reporting	208
12.4.8	Hospital Inpatient Billing Instructions/Field Locators	209
Updates for 11/03/2012		210
3.7	Remittance Advice	210
11.3.6	Audiological Services/Hearing Aids	210
11.3.53	Vision Care & Eyeglasses	211
Updates for 10/03/2012		211
3.6	National Correct Coding Initiative (NCCI)	211
7.8.7	Rehabilitative Therapy	211
11.3.44	Physician Visit Limits	211
12.5	Prescribing Provider	212
11.3.51	Coverage for Services Delivered Via Telemedicine	212
13.3.1	<del>Border Hospitals</del> In-Network and Extended Network Hospitals	212

13.4.2   Dialysis .....213

13.4.8   Hospital Outpatient Billing Instructions/Field Locators.....213

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## Detailed Summary of Updates

*Please note:*

- Sections below containing text in **red font** are *additions* to current policy or new policy. Previous verbiage will be noted, when applicable
- Deleted: ~~Strike through text~~

UPDATES FOR 8/1/2020

### GENERAL BILLING AND FORMS MANUAL

#### 6.4.7 HIGH DOLLAR INPATIENT STAYS

High dollar claims are defined as Medical and Behavioral Health Inpatient (IP) stays with billed amounts of \$300k or greater. It is required that DVHA clinical staff complete a review of high dollar claims to ensure the appropriate use of health care services and medical necessity.

A service authorization form must be submitted to DVHA by the facility along with clinical documentation that supports the billed level of care (LOC). This is required for ACO and non-ACO members.

Documentation requirements for high dollar IP claims include initial assessment, history and physicals, discharge summary, progress notes, diagnostic testing reports, procedures notes, and abnormal labs. Documentation requirements are outlined in detail on the service authorization form found at: <https://dvha.vermont.gov/forms-manuals/forms>.

Submission of the service authorization form and clinical documentation will be required and should be sent to DVHA prior to claim submission to fiscal agent. High dollar IP claims submitted to DVHA's fiscal agent prior to this process will be denied. Once the service authorization form and clinical documentation is reviewed, an authorization decision will be made, and the facility will be notified. A facility may then submit a claim to the fiscal agent if services are authorized.

#### 6.4.8 INTERIM INPATIENT CLAIMS

**For voluntary, involuntary or CRT inpatient mental health or detoxification admissions for adults and children using revenue code 124, 199, or 190 (does not pertain to DMH Level**

**1):** Inpatient acute care hospitals that have a long-term patient may bill interim claims in at least 60 day intervals. After billing for the first segment of an interim billing admission, each subsequent claim must show the cumulative number of previously billed days represented by # of units of value code 75. Any subsequent interim billing claims without value code 75 for previously billed days will be denied. Each claim must include all applicable diagnoses and procedures.

**Example:** All three claims should have the same admit date; only the from and to dates will change.

- 1<sup>st</sup> segment of interim billing admission:
  - 60 days authorized: bill for 60 days, no value code 75
- 2<sup>nd</sup> segment of interim billing admission:
  - 60 additional days authorized; bill for 60 days & enter 60 units of value code 75
- 3<sup>rd</sup> segment of interim billing admission:
  - 40 additional days authorized; bill for 40 days & enter 120 units of value code 75

~~Inpatient acute care hospitals that have a long-term patient may bill interim claims in at least 60-day intervals. Subsequent bills must be in the electronic adjustment bill format. Each bill must include all applicable diagnoses and procedures. Indicate in the note field: long-term inpatient stay greater than 60 days.~~

1. ~~Type of bill 112 – interim bill first claim use patient status – still a patient.~~
2. ~~Type of bill for subsequent claims will be 117 – electronic replacement claim.~~

~~Use Patient status – still a patient or a valid patient status – discharge code. Type of bill for subsequent claims will be 117 – electronic replacement claim. Patient status will be either patient status 30, or a discharged patient status code.~~

## UPDATES FOR 7/1/2020

### ABA SUPPLEMENT

#### 2.3 FEE-FOR-SERVICE REQUIREMENTS – MEMBERS WHO HAVE OTHER INSURANCE

**4. ABA Procedures for Billing:** Providers should use appropriate modifiers based on who delivers treatment services. Using the HO/HN modifier determines the correct reimbursement rate percentage on fee-for-service (FFS) claims. Modifiers should be utilized for both case rate shadow claims and FFS claims. Accurate claim submission ensures correct reimbursement rates. If additional support is needed, providers should reach out to their assigned DXC representative.

Provider Rendering Services	Modifier	Reimbursement for FFS Claims
<b>“Board Certified Behavior Analyst (BCBA)”</b> means a treatment provider who holds a master’s degree and is certified through the National Behavior Analyst Certification Board (BACB).	HO indicates master’s level degree	76% of Vermont Medicaid rate on file.
<b>“Board Certified assistant Behavior Analyst (BCaBA)”</b> means a treatment provider who holds a minimum of a bachelor’s degree, is certified through the BACB, and is directly supervised by a BCBA.	HN indicates bachelor’s level degree	66% of Vermont Medicaid Rate on File.

## DURABLE MEDICAL EQUIPMENT (DME) SUPPLEMENT

### 3.3 PAYMENT DVHA PRIMARY/MANUAL PRICING

The reimbursement methodology for manually priced codes is as follows:

- For dates of service prior to 1/1/2020 – the DVHA pays purchase **invoice cost plus 67% or MSRP minus 15%, up to the billed charge, whichever is lower.**
- For dates of service 1/1/2020 – ~~6/30/2020~~ **12/31/2020** – The DVHA pays purchase **invoice cost plus 49% or MSRP minus 15%, up to the billed charge, whichever is lower.**
- For dates of service ~~7/1/2020~~ **1/1/2021** and after – The DVHA pays purchase **invoice cost plus 30% or MSRP minus 15%, up to the billed charge, whichever is lower.**

## GENERAL BILLING AND FORMS MANUAL

### 3.3.1 TIMELY FILING LIMITS

When a provider has been granted retro-enrollment (backdate) claims must be received within 365 days from the date of service, ~~or an additional 45 days from the date of enrollment, whichever is later.~~ The Medicaid Enrollment Backdate form is available on our website at <http://vtmedicaid.com/#!/provEnrollDataMaint>.

## UPDATES FOR 5/1/2020

## DURABLE MEDICAL EQUIPMENT (DME) SUPPLEMENT

### 4.12 MEDICAL SUPPLIES

Medical supplies will be covered when:

- Prescribed by an enrolled physician or other authorized practitioner
- Used in a member's home due to a post-surgical or chronic condition
- Billed first to Medicare when the member is dual eligible
- Billed first to any other insurer or applicable organization
- Prior authorization is obtained for excess quantities

Medical supplies may be dispensed in three-month time periods. The "from" and "to" dates of service on the CMS-1500 Claim Form must accurately reflect the three-month date span. Providers are not allowed to dispense more than a three-month supply at a time.

~~Medical supplies will be covered when:~~

- ~~• Prescribed by an enrolled physician or other authorized practitioner~~
- ~~• Used in a member's home due to a post surgical or chronic condition~~
- ~~• Billed first to Medicare when the member is dual eligible~~
- ~~• Billed first to any other insurer or applicable organization~~
- ~~• Prior authorization is obtained for excess quantities~~

~~Medical supplies may be dispensed in two month time periods. The "from" and "to" dates of service on the CMS-1500 Claim Form must accurately reflect the two month date span." Providers are not allowed to dispense more than a two month supply at a time.~~

~~Vermont Medicaid allows a 10 day overlap in dates of service for enteral nutrition and some supply codes. This overlap will allow for delivery or shipping of refills. The supplier must deliver the enteral nutrition no sooner than 10 days prior to the end of the usage for the current product.~~

## UPDATES FOR 4/1/2020

## GENERAL BILLING AND FORMS MANUAL

### 5.3.52 TELEMEDICINE SERVICES

Billing Rules for Telemedicine:

1. All providers are required to follow correct coding rules, including application of modifiers, and only bill for services within their scope of practice that can be done via telemedicine.

2. All professional claims (CMS-1500 form) with services billed for telemedicine must have POS 02. Modifier GT should not be used on professional services.
3. All facility claims (UB-04 form) must include modifier GT on any telemedicine services delivered via interactive audio and/or video.
4. Originating facility site providers (patient site) may be reimbursed a facility fee (Q3014).
  - a. Facility fees will not be reimbursed if the provider is employed by the same entity as the originating site.
  - b. GT modifier should not be used on Q301

## UPDATES FOR 3/1/2020

### GENERAL PROVIDER MANUAL

#### 1.2.11 PROVIDER RECONSIDERATION PROCESS

A request for review must be made no later than ~~30~~ 90 calendar days after the DVHA gives notice to the provider of its original decision. Requests after ~~30~~ 90 days will be returned with no action taken.

### DME SUPPLEMENT

#### 3.6.1 USE OF A ~~DETAILED~~ STANDARD WRITTEN ORDER (DSWO) FOR DURABLE MEDICAL EQUIPMENT (DME) AND SUPPLIES

The Department of VT Health Access (DVHA) will also allow the use of the ~~Detailed~~ Standard Written Order for DME and supplies. This will allow the DVHA to more closely align with Medicare. Details about the DSWO can be found at:

<https://med.noridianmedicare.com/web/jddme/topics/documentation/detailed-written-orders>

<https://med.noridianmedicare.com/web/jddme/topics/documentation/standard-written-order>

For items that do NOT require prior authorizations, DVHA will allow providers to use a Medicare compliant ~~D~~SWO or an MNF. This documentation must be kept in the provider's files.

For items that require prior authorization, DVHA will allow providers to use the following documentation:

- A completed medical necessity form and supporting clinical documentation that clearly documents the medical necessity of the item, OR
- A Medicare compliant ~~Detailed~~ Standard Written Order and supporting clinical documentation that clearly documents the medical necessity of the item, OR
- A completed Wheelchair Evaluation and Prescription form, or a completed Speech Generating Device Evaluation and Prescription form.

#### 4.13 OXYGEN

~~The rental of respiratory equipment is on a monthly basis and includes all supplies necessary to use the piece of equipment. Supplies in excess of the monthly amounts are covered only when prior authorization from the DVHA has been granted. (This includes changes of supplies that pertain to infection control protocols and guidelines).~~

### Oxygen

VT Medicaid criteria will follow the current Medicare Guidelines as outlined under LCD33797 effective 1/1/2020.

<https://med.noridianmedicare.com/documents/2230703/7218263/Oxygen+and+Oxygen+Equipment+LCD+and+PA>

**Exceptions** - Per Medicare- if the beneficiary elects not to receive new equipment after the end of the 5-year reasonable useful lifetime and if the supplier transfers title of the equipment to the beneficiary, accessories, maintenance, and repairs are statutorily non-covered by Medicare. Contents are separately payable for beneficiary-owned gaseous or liquid systems. Medicaid elects to not allow member or itself to own oxygen equipment and supports the beginning of a new 36-month rental period.

### **Oximeter**

Medicaid will cover E0445 oximeter as a capped rental item and allow A4606 disposable probe replacement of 6 per month, effective 1/1/2020.

UPDATES FOR 2/1/2020

PT/OT/ST SUPPLEMENT

## SECTION 2 RE/HABILITATIVE THERAPY

Vermont Medicaid does not cover any treatments or any portions of a treatment, when the efficacy and/or safety of that treatment is not sufficiently supported in a preponderance of current peer reviewed medical literature.

All treatment must demonstrate medical necessity. See section 5.7 below for specific examples.

~~Examples of treatment that do not have sufficient support in current medical literature at this time include, but are not limited to:~~

- ~~• sensory integration therapy~~
- ~~• craniosacral therapy~~
- ~~• myofascial release therapy~~
- ~~• visceral manipulation therapy~~
- ~~• auditory integration training~~
- ~~• facilitated communication~~

~~Treatment with goals related to leisure, sports, recreation, and avocation are not covered benefits because they do not meet the bar of medical necessity. Treatment with goals related to vocation and education are not covered benefits because there are other resources for coverage, including the Department of Vocational Rehabilitation, Worker's Compensation, and the Agency of Education.~~

~~Procedure Codes: Per National Correct Coding regulations, treatment must be billed under the most specific code. Billing a non-covered service under a less specific code in order to obtain coverage could constitute fraud and could expose the provider to recoupment and fraud investigation.~~

~~Diagnosis Codes: Per National Correct Coding regulations, treatment must be billed under the most specific code. "Unspecified" diagnosis codes must be avoided whenever possible. The primary diagnosis code submitted must be the code for the underlying condition driving the care plan. Other pertinent diagnoses, including "therapy diagnoses" can be included but cannot be listed as the~~

~~primary diagnosis code. A list of diagnosis codes that are not covered as primary diagnoses is included in the DVHA Therapy guidelines, available at: <http://dvha.vermont.gov/providers/clinical-coverage-guidelines>.~~

## 2.1 ADULT COVERAGE

Physical, Occupational, and Speech Language Pathology (PT, OT, ST) outpatient services for Vermont Medicaid eligible adults are limited to 30 combined visits per calendar year. **See section 5.1 for exceptions.**

~~Prior authorization for therapy visits beyond 30 combined visits in a calendar year may be requested for members with the following diagnoses: spinal cord injury, traumatic brain injury, stroke, amputation, or severe burn.~~

**For members with a primary insurance, a prior authorization is not required if the primary insurer pays a portion of the claim. However, if the primary insurer denies the claim for being a non-covered service, if the primary insurance benefit has exhausted, or if the primary insurance applied all to the deductible, prior authorization is required for over 30 outpatient visits or for home health services.**

## 2.2 MEMBERS UNDER AGE 21

Providers must request prior authorization in advance of the 8th visit if additional therapy services are necessary. ~~Providers are required to determine the first date of treatment at any outpatient facility, regardless of coverage source. It is the responsibility of the therapists to track therapy visit/service history.~~

**For members with a primary insurance, a prior authorization is not required if the primary insurer pays a portion of the claim. However, if the primary insurer denies the claim for being a non-covered service, if the primary insurance benefit has exhausted, or if the primary insurance applied all to the deductible, prior authorization is required for over 8 visits.**

~~Per the Physical, Occupational and Speech Therapy guidelines posted at <http://dvha.vermont.gov/providers/clinical-coverage-guidelines>, therapy providers can bill a maximum of 4 units of timed therapy procedures codes are allowed per treatment session. The 4-unit maximum is the combined totaled of timed units, not a per procedure code limit. Evaluation, re-evaluation and other non-timed codes are not subject to the limit and may be billed in addition to the 4 timed codes during a single session. The code for wheelchair management, direct one-on-one patient contact, each 15 minutes” is an exception and is excluded from the 4-unit limit.~~

~~Providers should refer to Medicaid Rule and Therapy Guidelines for additional information at <http://dvha.vermont.gov/providers/clinical-coverage-guidelines>.~~

~~Authorization Requests: Therapists should utilize the Vermont Medicaid Request for Extension of Rehabilitation Therapy Services form. Be sure to include the original start of care date by any facility or provider, for the condition listed. The form is available at <http://dvha.vermont.gov/providers/forms-1>.~~

~~Physical, Occupational and Speech Therapists who choose to submit extension requests on forms other than the DVHA Therapy Extension Request form are strongly encouraged to use the new DVHA Cover Sheet, available at <http://dvha.vermont.gov/providers/forms-1>.~~

~~Use of this form with your alternative request documentation will ensure that DVHA receives the information required to process your prior authorization (PA) request. DVHA expects that the use of this form will speed the PA process.~~

Early and Periodic Screening, Diagnostic and Treatment (EPSDT): Vermont Medicaid will provide comprehensive services and furnish all Medicaid coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions for Medicaid members under age 21.

### SECTION 3 OUTPATIENT THERAPY MODIFIERS

~~Vermont Medicaid follows Medicare's requirement that speech, occupational and physical therapists bill with modifier GN, GO or GP to identify the discipline of the plan of care under which the service is delivered.~~

- ~~• GN – Services delivered under an outpatient speech language pathology plan of care~~
- ~~• GO – Services delivered under an outpatient occupational therapy plan of care~~
- ~~• GP – Services delivered under an outpatient physical therapy plan of care~~

~~Medicare provides a link to the list of applicable therapy procedure codes, (this list is updated annually by CMS). Vermont Medicaid therapists need only reference the code list itself; do not use the column information.~~

~~<http://www.cms.gov/Medicare/Billing/TherapyServices/AnnualTherapyUpdate.html>.~~

~~All therapy services (including codes listed as “Sometimes Therapy”) that are performed by a therapist (and billed with the therapist as the attending) must be part of an outpatient therapy plan of care and the billing codes must use one of the above therapy modifiers to bill.~~

~~Some codes on this list are “Always Therapy” services regardless of who performs them. These services must be part of an outpatient therapy plan of care and the Billing codes must use one of the above therapy modifiers to bill.~~

~~Practitioners other than therapists must use these modifiers when performing listed services which are delivered under an outpatient therapy plan of care.~~

~~These modifiers are not to be used with codes that are not specified on the list of applicable therapy codes.~~

~~Modifiers may be reported in any order.~~

~~Prior Authorization Requests must give the exact codes and modifiers in the same order as they will be billed on the claim.~~

### 4.4 OBTAINING SAME DAY COVERAGE

If a child has received therapy treatment within the past year for 8 outpatient visits by any practitioner of the same discipline, or if 4 months of Home Health therapy services have already been performed in the past, the current provider shall:

- See the beneficiary for the initial evaluation
- Contact the DVHA on the SAME DAY
- Submit documentation to request coverage WITHIN **ONE BUSINESS DAY**

#### 4.5 PRIOR AUTHORIZATION

Documentation for Authorization Requests: Therapists should utilize the Vermont Medicaid Request for Extension of Rehabilitation Therapy Services form. The form is available at <http://dvha.vermont.gov/for-providers/forms-1>.

Physical, Occupational and Speech Therapists who choose to submit extension requests on forms other than the DVHA Therapy Extension Request form are strongly encouraged to use the new DVHA Cover Sheet, available at <http://dvha.vermont.gov/for-providers/forms-1>.

Use of this form with your alternative request documentation will ensure that DVHA receives the information required to process your prior authorization (PA) request. DVHA expects that the use of this form will speed the PA process.

*Required Documentation* - Each prior authorization request must include the following documentation:

- Beneficiary name
- Birth date
- Beneficiary Vermont Medicaid number/unique identifier
- Supplying provider name and provider number(s)
- Attending physician name and provider number(s)
- Diagnoses, diagnosis codes, and dates of onset, which must match the diagnoses on the claim forms submitted
- The date of initial therapy for the condition (see below)
- Treatment frequency
- Patient-oriented goals with objective and measurable parameters
- Research based treatment plan that includes beneficiary/caregiver education, collaboration as describe above, and a discharge plan
- Objective, measurable results of any previous treatment goals
- Professional signature of the therapist and the referring provider.
- Measurable progress to date.

The therapy office/department must have the initial referring provider referral on file as well as the referring provider approval of the treatment plan established upon evaluation.

Additional information that may be required includes:

- The patient's complete medical record
- A response to clinical questions posed by the DVHA
- The practitioner's detailed and reasoned opinion in support of medical necessity
- A statement of the practitioner's evaluation of alternatives suggested by the DVHA and the provider's reason for rejecting them. (Medicaid Rule 7102.2)

Therapists are advised to keep an accurate record of treatment times on file to appropriately reconcile claims with treatment times.



#### 4.5.1 ERRORS IN DOCUMENTATION

All corrections to the medico-legal record, including the Therapy Extension form, must be a dated single line strike-out initialed by the therapist; no erasures, scribbles, use of liquid paper (white-out) or computer deletions are acceptable.

#### 4.5.2 ELECTRONIC SIGNATURES

Electronic signatures are acceptable.

Providers should refer to Medicaid Rule and Therapy Guidelines for additional information at <http://dvha.vermont.gov/for-providers/clinical-coverage-guidelines>

#### 5.3 OUTPATIENT THERAPY MODIFIERS

Vermont Medicaid follows Medicare's requirement that speech, occupational and physical therapists bill with modifier GN, GO or GP to identify the discipline of the plan of care under which the service is delivered.

- GN = Services delivered under an outpatient speech-language pathology plan of care
- GO = Services delivered under an outpatient occupational therapy plan of care
- GP = Services delivered under an outpatient physical therapy plan of care

Medicare provides a link to the list of applicable therapy procedure codes, (this list is updated annually by CMS). Vermont Medicaid therapists need only reference the code list itself; do not use the column information.

<http://www.cms.gov/Medicare/Billing/TherapyServices/AnnualTherapyUpdate.html>.

All therapy services (including codes listed as "Sometimes Therapy") that are performed by a therapist (and billed with the therapist as the attending) must be part of an outpatient therapy plan of care and the billing codes must use one of the above therapy modifiers to bill.

Some codes on this list are "Always Therapy" services regardless of who performs them. These services must be part of an outpatient therapy plan of care and the Billing codes must use one of the above therapy modifiers to bill.

Practitioners other than therapists must use these modifiers when performing listed services which are delivered under an outpatient therapy plan of care.

These modifiers are not to be used with codes that are not specified on the list of applicable therapy codes.

Modifiers may be reported in any order.

Prior Authorization Requests must give the exact codes and modifiers in the same order as they will be billed on the claim.

#### 5.3 REVENUE AND PROCEDURE CODES FOR HOSPITALS, OUTPATIENT CLINICS, AND HOME HEALTH AGENCIES (PREVIOUSLY SECTION 7)

Home health agencies bill using the revenue codes:

- 420-4 **for PT**
- 430-4 **for OT**
- 440-4 **for ST**

1 unit = 1 visit for home health agency billing.

Outpatient clinics including hospital outpatient clinics bill using the procedure codes:

29065	29075	29085	29086	29105	29125	29126	29130
29131	29200	29240	29260	29280	29358	29365	29405
29425	29435	29440	29445	29450	29505	29515	29520
29530	29540	29550	29580	29581	29582	29583	29584
29700	29705	29730	29740	29750	64550	92506	92507
92508	92526	92597	92605	92607	92608	92609	92610
92611	92618	95831	95832	95833	95834	95851	95852
95992	96105	96110	96111	96125	97010	97012	97014
97016	97018	97022	97026	97028	97032	97033	97034
97035	97036	97039	97110	97112	97113	97116	97124***
97139	97140	97150	97161	97162	97163	97164	97165
97166	97167	97168	97530	97532	97535*	97542	97597
97598	97602	97605	97606	97750**	97755*	97760	97761
97762	97799						

\*This code is covered only for technology which is currently covered by Vermont Medicaid.

\*\*This code is covered except for work or disability related functional capacity evaluations.

\*\*\*This code can only be used with other procedure codes, where there is a comprehensive plan of treatment. Massage therapy alone is not a covered benefit (Medicaid Rule 7307).

Note: Re-evaluation codes should only be used when there are new clinical findings, when there is a significant change in the patient's condition, or when there has been a failure to respond to the treatment provided. Periodic ongoing assessment does not constitute a reevaluation and must not be billed using a re-evaluation code.

*Therapists may petition the DVHA for consideration of additional procedure codes.*

#### 5.4 CORRECT CODING

Procedure Codes: Per National Correct Coding regulations, treatment must be billed under the most specific code. Billing a non-covered service under a less specific code in order to obtain coverage could constitute fraud and could expose the provider to recoupment and fraud investigation.

Diagnosis Codes: Per National Correct Coding regulations, treatment must be billed under the most specific code. "Unspecified" diagnosis codes must be avoided whenever possible. The primary diagnosis code submitted must be the code for the underlying condition driving the care plan. Other pertinent diagnoses, including "therapy diagnoses" can be included but cannot be listed as the primary diagnosis code. A list of diagnosis codes that are not covered as primary diagnoses is included in the DVHA Therapy guidelines, available at: <http://dvha.vermont.gov/providers/clinical-coverage-guidelines>.

## 8.1 DOCUMENTATION

~~Treatment techniques that do not have adequate research support at this time include, but are not limited to: sensory integration, craniosacral therapy, myofascial and visceral release, hippotherapy for conditions other than cerebral palsy, auditory integration therapy, hyperbaric oxygen treatment for brain injury, reflex integration therapy, and facilitated communication.~~

~~*Required Documentation:* Each prior authorization request must include the following documentation:~~

- ~~• Beneficiary name~~
- ~~• Birth date~~
- ~~• Beneficiary Vermont Medicaid number/unique identifier~~
- ~~• Supplying provider name and provider number(s)~~
- ~~• Attending physician name and provider number(s)~~
- ~~• Diagnoses, diagnosis codes, and dates of onset, which must match the diagnoses on the claim forms submitted~~
- ~~• The date of initial therapy for the condition (see below)~~
- ~~• Treatment frequency~~
- ~~• Patient-oriented goals with objective and measurable parameters~~
- ~~• Research-based treatment plan that includes beneficiary/caregiver education, collaboration as describe above, and a discharge plan~~
- ~~• Objective, measurable results of any previous treatment goals~~
- ~~• Professional signature of the therapist and the referring provider.~~

~~Measurable progress to date.~~

~~The therapy office/department must have the initial referring provider referral on file as well as the referring provider approval of the treatment plan established upon evaluation.~~

~~Additional information that may be required includes:~~

- ~~• The patient's complete medical record~~
- ~~• A response to clinical questions posed by the DVHA~~
- ~~• The practitioner's detailed and reasoned opinion in support of medical necessity~~
- ~~• A statement of the practitioner's evaluation of alternatives suggested by the DVHA and the provider's reason for rejecting them. (Medicaid Rule 7102.2)~~

~~Therapists are advised to keep an accurate record of treatment times on file to appropriately reconcile claims with treatment times.~~

### 8.1.1 ERRORS IN DOCUMENTATION

~~All corrections to the medico-legal record, including the Therapy Extension form, must be a dated single line strike-out initialed by the therapist; no erasures, scribbles, use of liquid paper (white-out) or computer deletions are acceptable.~~

### 8.1.2 ELECTRONIC SIGNATURES

~~Electronic signatures are acceptable.~~

### ~~8.1.3 DETERMINING THE DATE OF INITIAL THERAPY FOR THE CONDITION~~

~~For beneficiaries under 21 and adults treated by home health: All certification periods are based on the date of initial PT, OT or ST evaluation of the condition which is being treated, regardless of which agency provided the service and regardless of coverage by other resources. Therefore, it is imperative to determine this date. This date can be obtained upon Intake from the beneficiary, the physician record, or the previous therapy provider. When in doubt, see the SAME DAY technique described above for obtaining coverage.~~

## DME SUPPLEMENT

### 3.6.1 USE OF A DETAILED WRITTEN ORDER (DWO) FOR DURABLE MEDICAL EQUIPMENT (DME) AND SUPPLIES

The Department of VT Health Access (DVHA) will also allow the use of the Detailed Written Order for DME and supplies. This will allow the DVHA to more closely align with Medicare. Details about the DWO can be found at:

<https://med.noridianmedicare.com/web/jddme/topics/documentation/detailed-written-orders>

For items that do NOT require prior authorizations, DVHA will allow providers to use a Medicare compliant DWO or an MNF. This documentation must be kept in the provider's files.

For items that require prior authorization, DVHA will allow providers to use the following documentation:

- A completed medical necessity form and supporting clinical documentation that clearly documents the medical necessity of the item, OR
- A Medicare compliant Detailed Written Order and supporting clinical documentation that clearly documents the medical necessity of the item, OR

A completed Wheelchair Evaluation and Prescription form, or a completed Speech Generating Device Evaluation and Prescription form.

## UPDATES FOR 1/1/2020

## DENTAL SUPPLEMENT

### 2.1 ADULT PROGRAM (AP)

The Adult Program is limited to ~~\$540~~ **\$1,000** per individual per calendar year (annual cap).

If an individual reaches their 21st birthday and has received dental care during the course of the year, the dental benefit already paid will be applied to the annual ~~\$540~~ **\$1,000** adult maximum benefit. The benefit is considered exhausted if the total reimbursement is greater than or equal to ~~\$540~~ **\$1,000** and will not begin again until the start of the new calendar year.

### 2.19 MEMBER COST SHARING/CO-PAYS

Copayments are not required for **dental visits for certain preventative services only (see 2.19.2), Copayment are also not required** for family planning services and supplies, emergency services (includes: dental services covered by a GA Voucher), and durable medical equipment (DME) and medical supplies.

#### 2.19.1 EXCEPTIONS TO CO-PAYMENTS

1. Dental visits for one or more of the following preventive services only (D1110, D1206, D1208, D1320 & D0120).

## 2.24 PRIOR AUTHORIZATION

Vermont Department of Health will continue to provide dental ~~consultation~~ **assistance** for the following ~~State Programs~~,

~~The Dental Care Assistance Program (DCAP): 800.882.2437 or 802.863.7245~~

~~The Reach Up Denture Program: 800.479.6151~~

~~-or-~~

<http://dcf.vermont.gov/benefits/reachup>

## 4.13.3 OTHER SURGICAL PROCEDURES/SPLINTS

**D7922** – Lacement of Intra-Socket Biological Dressing to Aid in Hemostasis or Clot Stabilization, Per Site

## 5.4.1 SPACE MAINTAINERS

**D1510** - Space Maintainer – Fixed – Unilateral – **Per Quadrant**

~~**D1550** – Re-cementation of Space Maintainer~~

**D1551**- Re-Cement or Re-Bond Bilateral Space Maintainer – maxillary

**D1552** - Re-Cement or Re-Bond Bilateral Space Maintainer – mandibular

**D1553** - Re-Cement or Re-Bond Bilateral Space Maintainer – Per Quadrant

**D1575** - Distal Shoe Space Maintainer – Fixed – Unilateral – **Per Quadrant**

## 5.4.3 CUSTOM CROWNS

**D2753** - Crown – Porcelain Fused to Titanium and Titanium Alloys

## 5.9.1 FIXED PARTIAL DENTURE PONTICS

~~**D6243** - Pontic - Porcelain Fused to Titanium and Titanium Alloys~~

## 5.9.2 FIXED PARTIAL DENTURE RETAINERS – CROWNS

~~**D6753** - Retainer Crown – Porcelain Fused to Titanium and Titanium Alloys~~

## 5.11.5 OTHER ORTHODONTIC SERVICES

~~**D8692** – Replacement of Lost or Broken Retainer~~

~~**D8694** – Repair of Fixed Retainers, includes Reattachment~~

**D8698** - Re-Cement or Re-Bond Fixed Retainer – Maxillary

**D8699** - Re-Cement or Re-Bond Fixed Retainer – Mandibular

**D8701** – Repair of Fixed Retainer, Includes Reattachment – Maxillary

**D8702** - Repair of Fixed Retainer, Includes Reattachment – Mandibular

**D8703** – Replacement of Lost or Broken Retainer – Maxillary

**D8704** - Replacement of Lost or Broken Retainer – Mandibular

## PT/OT/ST SUPPLEMENT

### 2.2 MEMBERS UNDER AGE 21

For treatment other than through a home health agency, Department of Vermont Health Access is changing the Prior Authorization requirements effective 1/1/2020 for beneficiaries under the age of 21 from 'beyond eight therapy visits per discipline' to 'beyond eight therapy visits per discipline per calendar year'.

Providers must request prior authorization in advance of the 8th visit if additional therapy visits are medically necessary. Subsequent authorizations will be based on that start of care date.

~~For treatment other than through a home health agency the initial eight visits from the start of the beneficiary's condition are allowed, per therapy discipline, before prior authorization is required. Providers must request prior authorization in advance of the 8th visit if additional therapy visits are medically necessary. Providers must determine the first date of discipline-specific therapy by any discipline-specific provider for the condition, regardless of coverage source. Subsequent authorizations will be based on that start of care date.~~

### 5.7.1 UNDER 21

Medically necessary treatment is covered until the 21<sup>st</sup> birthday. ~~The certification periods are based on the date of discipline-specific initial evaluation for the condition~~ As of 1/1/20, certification periods are based on the date of discipline-specific initial evaluation and continue regardless of discharge/readmission from a particular service provider or a change in coverage sources. Additional coverage can be obtained through the prior authorization process as described above.

## DME SUPPLEMENT

### 2.1 CAPPED RENTALS (CR)

In an effort to be consistent with Medicare's requirements, the DVHA will use the Medicare capped rental code list and, like Medicare, when renting, will only allow a RR rental modifier. The exception to this rule is the small sub-set of codes included within the capped rental category with a rent OR purchase option. This change has been in effect since 1/1/2018.

For a full list of codes, please see Medicaid's Capped Rental List here:  
<http://www.vtmedicaid.com/#/resources>.

DVHA will not institute variable rental pricing depending on the month of rental and instead, will use Medicare guidance to set the rental rates to equal 1/10 of the purchase price of the capped rental.

Specifically, CRs will be paid in the following manner:

- Like Medicare, only the RR modifier can be billed with these codes.
- For CR items not classified as "Power Wheelchairs", the purchase price reflected on the fee schedule will be equal to the RR \* 10. The DVHA RR rate in months 1 – 10 will be equal to the Medicare Rate (Medicare RR Rate \* 3 + Medicare RR Rate \* .75 \* 10)/10 but not adjusted differentially in months 1 -3 and 4-13 as Medicare does.
- For CR items classified as "Power Wheelchairs", the purchase price will be equal to the Medicare RR / 0.15 to reflect that Medicare RR rates for these items represents 15% of the purchase price. The DVHA RR rate, therefore, will be equal to the purchase price/10. DVHA will not adjust the RR rate in months 1 -3 and 4 -13 as Medicare does. At this

time, DVHA will follow Medicare's classification of what is considered "Power Wheelchairs". A list of these codes will be provided upon request.

- At month 10, payments are capped and DVHA assumes ownership.

~~In an effort to be consistent with Medicare's requirements, the DVHA will use the Medicare capped rental code list and, like Medicare, when renting, will only allow a RR rental modifier. The exception to this rule is the small sub-set of codes included within the capped rental category with a rent OR purchase option. This change has been in effect since 1/1/2018. For a full list of codes, please see Medicare's DMEPOS fee schedule here: <https://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html> DVHA will not institute variable rental pricing depending on the month of rental and instead, will use Medicare guidance to set the rental rates to equal 1/10 of the purchase price of the capped rental. Specifically, CRs will be paid in the following manner: • Like Medicare, only the RR modifier can be billed with these codes • For CR items not classified as "Power Wheel Chairs", the purchase price reflected on the fee schedule will be equal to the RR \* 10. The DVHA RR rate in months 1 – 10 will be equal to the Medicare Rate (Medicare RR Rate \* 10)/10 but not adjusted differentially in months 1 – 3 and 4 – 13 as Medicare does. • For CR items classified as "Power Wheel Chairs", the purchase price will be equal to the Medicare RR / 0.15 to reflect that Medicare RR rates for these items represents 15% of the purchase price. The DVHA RR rate therefore, will be equal to the purchase price/10. DVHA will not adjust the RR rate in months 1 – 3 and 4 – 13 as Medicare does. At this time, DVHA 2019-02-22 DME Supplement 6 will follow Medicare's classification of what is considered "Power Wheel Chairs". A list of these codes will be provided upon request. • At month 10, payments are capped and DVHA assumes ownership.~~

### 3.3 PAYMENT DVHA PRIMARY/MANUAL PRICING

When the DVHA is the primary payer, payment amounts for DME (including augmentative communication devices and closed-circuit TV purchased from the Vermont Association for the Blind and Visually Impaired- VABVI), orthotics, prosthetics and medical supplies will be calculated in the following manner:

When the rate on file is a specific dollar amount, the DVHA pays the lesser of the actual charge or the rate on file;

When the rate on file is \$0.00 and the PAC is 6 (manually priced) the purchase invoice must be submitted with the claim. If the MSRP is present on the purchase invoice reimbursement will be whichever is lower, up to the billed charge.

The reimbursement methodology for manually priced codes is as follows:

- For dates of service prior to 1/1/2020 – the DVHA pays purchase invoice cost plus 67% or MSRP minus 15%, up to the billed charge, whichever is lower.
- For dates of service 1/1/2020 – 6/30/2020 – The DVHA pays purchase invoice cost plus 49% or MSRP minus 15%, up to the billed charge, whichever is lower.
- For dates of service 7/1/2020 and after – The DVHA pays purchase invoice cost plus 30% or MSRP minus 15%, up to the billed charge, whichever is lower.

Purchase invoice pricing documentation requirements:

- The purchase invoice must be submitted in its entirety. If any information (including pages) are missing or lines are marked out or whited out the claim will be denied.
  - Online sales aggregator (such as Amazon) receipts are accepted only if the item is purchased by the DME supplier and not available from any other



vendor. All below pricing documentation requirements still apply to online sales aggregator receipts.

- All discounts and totals must be clearly documented and disclosed.
- The purchase invoice or online sales aggregator receipt must be dated within one year from the date of service indicated on the claim. If the purchase invoice or online sales aggregator receipt date exceeds one year, the claim will be denied.
- The item(s) on the purchase invoice or online sales aggregator receipt must match the item(s) that are being billed on the claim. The applicable correct code must be written next to the item(s) on the purchase invoice, or online sales aggregator receipt. If the code for the item(s) are not documented on the purchase invoice or online sales aggregator receipt the claim will be denied. Item(s) that are specifically for the right or left side must be clearly documented with the correct modifiers for right or left next to the applicable code.

Documentation that states "Quote", "Remittance Advice", "Estimate", "Superbill", etc., and handwritten scripts or prescription papers, will result in claim denial. Exceptions are made for custom made items only, at the discretion of the DVHA.

Vermont Medicaid is payer of last resort. The DVHA does not reimburse when a primary insurance has been billed incorrectly and/or has insufficient information/coding.

When the DVHA is the primary payer, payment amounts for DME (including augmentative communication devices and closed circuit TV purchased from the Vermont Association for the Blind and Visually Impaired - VABVI), orthotics, prosthetics and medical supplies will be calculated in the following manner:

1. When the rate on file is a specific dollar amount, the DVHA pays the lesser of the actual charge or the rate on file;
2. If the rate on file is \$0.00 and the PAC is 5 or 6 (manually Priced) and if there is a Manufacturer's Suggested Retail Price (MSRP) for the item, the DVHA pays the lesser of the actual charge or 85% of the MSRP for all items;
3. If the rate on file is \$0.00 and the PAC is 5 or 6 (manually priced) and if there is no MSRP, the DVHA pays the lesser of the actual charge or 1.67 times the invoice or online sales aggregator cost.

The following pricing documentation requirements apply to MSRP (Manufacturer's Suggested Retail Price) or Invoice and must be billed on paper with the MSRP or invoice attachment:

- The option to submit either the MSRP or Invoice is allowed. The MSRP or invoice must be submitted in its entirety. If any information (including pages) are missing or lines are marked out or whited out the claim will be denied.
  - Online sales aggregator (such as Amazon) receipts are accepted only if the item is purchased by the DME supplier and not available from any other vendor. All below pricing documentation requirements still apply to online sales aggregator receipts.
- All discounts and totals must be clearly documented and disclosed.
- The MSRP sheet, invoice, or online sales aggregator receipt must be dated within 1 year from the date of service indicated on the claim. If the MSRP, invoice, or online sales aggregator receipt date exceeds one year, the claim will be denied.
- The item(s) on the MSRP sheet, invoice, or online sales aggregator receipt must match the item(s) that are being billed on the claim. The applicable correct code must be written next to the item(s) on the MSRP, invoice, or online sales aggregator receipt. If the code for the item(s) are not documented on the MSRP, invoice, or online sales



~~aggregator receipt the claim will be denied. Item(s) that are specifically for the right or left side must be clearly documented with the correct modifiers for right or left next to applicable code. This applies to both MSRP, invoice, and online sales aggregator receipts.~~

~~Documentation that states "Quote", "Remittance Advice", "Estimate", "Superbill", etc., and handwritten scripts or prescription papers, will result in claim denial. Exceptions are made for custom made items only, at the discretion of the DVHA.~~

~~Vermont Medicaid is payer of last resort. The DVHA does not reimburse when a primary insurance has been billed incorrectly and/or has insufficient information/coding.~~

### 3.4 ENHANCED PRICING CRITERIA

Enhanced pricing is available to DMEPOS providers when the purchase price of an item exceeds the Medicaid rate on file. The same pricing methodology applies to enhanced pricing as manually priced items. Requests for enhanced pricing must be received within 3 months from the date of service.

Items excluded from enhanced pricing include diapers and continuous long-term rentals. Capped rental items are eligible for review.

Providers are required to complete the enhanced pricing request form found here, <http://www.vtmedicaid.com/#!/forms>, as well as submit relevant clinical documentation which would include one of the following:

1. If there is a PA on file, providers must send a copy of the Notice of Decision for the PA with a copy of the invoice for reimbursement review.
2. If no PA is needed, a clinical review is required, and providers must submit a copy of the Medical Necessity Form or other supporting clinical documentation. A quote is acceptable to initiate the clinical review.
  - a. If clinical approval is granted, providers must then submit a copy of the request form along with the invoice indicating the purchase price of the item (including all discounts) for review of the enhanced reimbursement rate.

Invoices must be within 1 year from the date of service. Shipping charges are not included as part of the item cost. MSRP is not acceptable for enhanced pricing.

Claims approved for enhanced pricing should be submitted on paper with a copy of the signed approval form to the following address.

DXC Technology  
Attn: Special Pricing  
PO Box 888  
Williston, VT 05495

### 3.5 MEDICAL NECESSITY FORM

A completed Medical Necessity Form is required for Respiratory Therapy programs, DME and certain prescribed medical supply items with a few exceptions. The ordering physician or nurse practitioner needs to complete the MNF and give a clean copy to the patient or to the DME supplier.

Submission of the form and any necessary information to clearly document medical need is all that is needed to make the request for prior authorization. The form needs to contain the prescribing provider's signature, billing code and description of the item requested.

If the code/service requires prior authorization, the DME supplier will send the MNF and all pertinent information to the DVHA as a PA request.

Both the ordering providers and the DME vendor are required to keep legible copies of all information in the patient record. The signature date on the MNF/order must be within 12 months of the dispensing date (billed DOS). (The order is good for one year). The MNF for Items on the capped rental program is good for 12 months. Medicaid will follow Medicare's Oxygen guidelines for Initial, Recertification, and Revised criteria for Certificate of Medical Necessity requirements. Medical Necessity and prior authorization forms are available at <http://dvha.vermont.gov/for-providers/forms-1>.

~~A completed DVHA Medical Necessity Form (DVHA 60) is required for Respiratory Therapy programs, DME and certain prescribed medical supply items with a few exceptions. The ordering physician or nurse practitioner needs to complete the MNF and give a clean copy to the patient or to the DME supplier.~~

~~Submission of the form and any necessary information to clearly document medical need is all that is needed to make the request for prior authorization. The form needs to contain the prescribing provider's signature, billing code and description of the item requested.~~

~~If the code/service requires prior authorization, the DME supplier will send the MNF and all pertinent information to the DVHA as a PA request.~~

~~Both the ordering providers and the DME vendor are required to keep legible copies of all information in the patient record. The signature date on the MNF/order must be within 6 months of the dispensing date (billed DOS) for all items except ostomy and urologic supplies. (The order on these supplies is good for one year). The MNF for Items on the capped rental program is good for 10 months. Medical Necessity and prior authorization forms are available at <http://dvha.vermont.gov/for-providers/forms-1>.~~

UPDATE FOR 12/16/2019

GENERAL BILLING AND FORMS MANUAL

### ~~5.3.9 CHILDREN WITH SPECIAL HEALTH NEEDS INFANT TODDLER PROGRAMS~~

~~Aid Category Code — SH (Children with Special Health Needs, CSHN) is used only when submitting medical claims for Physical, Occupational and Speech Therapy (PT, OT, ST), Nutritionist (NU) or Autism Specialist (AU) services only, through CSHN programs. Dental claims for Children with Special Health Needs will continue to be processed through the Vermont Department of Health, PO Box 70, Burlington, VT 05402.~~

UPDATE FOR 12/11/2019

GENERAL BILLING AND FORMS MANUAL

### 3.3 TIMELY FILING

Vermont Medicaid claims must be filed in a timely manner. A claim is considered to be filed when the fiscal agent documents **receipt** of the claim.

With few exceptions, electronic claims can be submitted 24 hours a day, seven days a week. Claim receipt is documented by the assignment of an Internal Control Number (ICN).

Paper claim receipt is documented by the fiscal agent's imprinted ICN.

Holidays, weekends, and dates of business closure do not extend the timely filing period.

Dated claim signatures, computerized or clerically prepared claim listings, and/or postmarks and certified mail receipts do not constitute proof of receipt for timely filing purposes.

The provider is responsible for assuring that each claim is received within the timely filing period. If claim information does not appear on the RA within 30 days of an electronic transmission or a paper claim mailing and the claim has not been returned in the mail, the provider can contact the fiscal agent to determine the status of the claim and resubmit the claim if necessary.

Agent or software failure to transmit accurate and acceptable claims or failure to identify transmission errors in a timely manner needs to be resolved between the provider and their software vendor, billing agent or clearinghouse. Failure to comply with filing requirements - including timely filing - because of software product failure or the action (or inaction) of a billing agent are not recognized as extenuating circumstances beyond the provider's control.

Waiting for prior authorization or correspondence from the Department or the fiscal agent is not an acceptable reason for late filing. (Additional information on prior authorization requests can be found in Section 2, Prior Authorization for Medical Services.) Phone calls and other correspondence are not proof of timely filing. The claim must be submitted, even if the expected result is a denial.

### 3.3.1 TIMELY FILING LIMITS

- Medicaid primary claims must be received within 180 days from the begin date of service
- Global maternity and orthodontia claims must be received within 180 days from the begin date of service
- Inpatient claims must be received within 180 days from the discharge date (through date of service)
- Medicare primary claims must be received within 180 days from Medicare's processing date
  - For paper claims submitted within 180 days from Medicare's processing date the Medicare Attachment Summary Form (MASF) and/or a copy of the Medicare EOB, displaying the paid date, must be attached to prevent a timely filing denial
  - For paper crossover claims when the date of service is over 2 years old both the MASF and Medicare EOB are required
- When Other Insurance (excluding Medicare) is the primary claims must be received within 365 days from the date of service
- When a provider has been granted retro-enrollment (backdate) claims must be received within 365 days from the date of service, or an additional 45 days from the date of notice of enrollment, whichever is later. The Medicaid Enrollment Backdate form is available on our website at <http://vtmedicaid.com/#/provEnrollDataMaint>.
- When a recipient has been granted retro-eligibility claims must be received within 365 days from the date of service

- **Adjusted Claims:** Providers must comply with time limits for adjusted claims as indicated in Section 3.2 Adjustment Requests.
  - If a claim has been adjusted or recouped and denied for a reason other than timely filing, a paper claim must be submitted with a note in Field 19 on the CMS 1500 form or Field 80 on the UB-04 form stating, “adjusted claim”. Claims must be received within 180 days from the adjusted/recouped date
- **Corrected Claims:** Corrected claims must be received within 180 days from the initial Medicaid denial
  - The original RA must be attached to a paper claim if one of the following was changed:
    - Member UID
    - Billing Provider ID
    - Procedure Code
    - From or To Date of Service
  - A note must be added to Field 19 on the CMS 1500 form or Field 80 on the UB-04 form stating, “corrected claim”. A written explanation on the Medicaid RA explaining the change is also required
  - The claim can be submitted electronically if none of the above information has changed. No attachments are necessary
- **Timely Filing Reconsiderations:** Requests for timely filing reconsiderations must be received within 90 days from the initial Medicaid timely filing denial. The Medicaid Timely Filing Reconsideration Request form is available on our website at <http://www.vtmedicaid.com/#!/forms>.

For additional information please see the Timely Filing Frequently Asked Questions document located on our website at <http://www.vtmedicaid.com/#!/forms>.

### 3.3.2 TIMELY FILING RECONSIDERATION REQUESTS

Providers can submit a timely filing reconsideration request within 90 days from the initial timely filing denial. Requests for timely filing overrides must contain a detailed description of the extenuating circumstances **beyond the provider's control** resulting in failure to meet timely filing requirements. Exceptions are granted only where the provider is able to document that appropriate action to meet filing requirements was taken and that the provider was prevented from filing as the result of exceptional circumstances that could not have been foreseen or controlled.

Employee negligence, employer failure to provide sufficient, well-trained employees, or failure to properly monitor the activities of employees and agents (e.g., billing services) are not extenuating circumstances beyond the provider's control. Waiting for prior authorization or correspondence from the Department or the fiscal agent is not an acceptable reason for late filing. Phone calls and other correspondence are not proof of timely filing. The claim must be submitted, even if the expected result is a denial.

Issues resulting in failure to transmit accurate and acceptable claims or failure to identify transmission errors in a timely manner must be addressed. If the issue is between the provider and the software vendor, billing agent or clearinghouse, this does not constitute an acceptable reason to be outside the timely filing period. Clearinghouse reports are not accepted as proof of timely filing.

Providers can submit a timely filing reconsideration request for corrected claims beyond 180 days from the initial denial, if they can prove they were actively working to resolve claim issues. Failure to provide proof of timely follow-up will result in a denial.

Acceptable forms of supporting documentation include system account notes, call reference numbers and/or emails with the Department or fiscal agent. A summarization of events is helpful; however, it is not accepted as proof of timely follow-up.

Providers that have been granted retro-enrollment must attach the enrollment approval letter to their claim.

If the Agency of Human Services (AHS) feels that an extenuating circumstance justifies the override of the timely filing denial the AHS will approve the request. Understaffing, misplaced claims (including claims lost in the mail or not received electronically) or claims that have not been consistently followed-up on are not examples of extenuating circumstances and the original denial will be upheld. Continually resubmitting a claim without correcting the reason for denial does not constitute proof of timely follow-up.

Requests for review of timely filing denials will be considered on a case-by-case basis. If the reconsideration is denied requesting additional information, the provider must resubmit a new timely filing reconsideration request with the additional supporting documentation no later than 60 days from the date of the denial letter. Providers must also include a copy of the reconsideration denial letter to prevent unnecessary denials. Failure to respond within the time allotted will result in a final denial decision and no further review will be granted.

If the denial is reversed, the claim will be processed on a future Remittance Advice. Please be aware that an approval for the timely filing request does not preclude the mandates for correct coding, prior authorization, supporting documentation or any claims processing requirements. If the claim denies for any reason other than timely filing, the provider is responsible to resubmit the corrected claim within the allotted time specified in the approval letter. Failure to complete forms correctly or attach the approval letter to the resubmitted claim **will** cause the claim to deny.

Providers submitting a timely filing reconsideration request must use the “**Timely Filing Reconsideration Form**” located at <http://www.vtmedicaid.com/#!/forms>. Completion instructions are included with the form.

All Timely Filing Reconsideration Requests should be mailed to:

DXC Technology  
Attn: Timely Filing  
PO Box 888  
Williston, VT 05495-0888

For non-timely filing reconsideration requests, please refer to Section 1.2.11, Provider Reconsideration Requests, in the Vermont Medicaid General Provider Manual.  
<http://www.vtmedicaid.com/#!/manuals>

For additional information please see the Timely Filing Frequently Asked Questions document located on our website at <http://www.vtmedicaid.com/#!/forms>.

UPDATE FOR 11/25/2019

## GENERAL BILLING AND FORMS MANUAL

### 5.2 NON-REIMBURSABLE SERVICES

For Medicaid members age 21 and over, no payment will be made for a service or item that is not listed as eligible for reimbursement, unless authorized by DVHA through the exception request process. See Medicaid Covered Services Rule 7104. These authorizations may be made only when serious detrimental health consequences would arise. Any member interested in applying, may contact the **Green Mountain Care** Member Services Unit for the required forms. For beneficiaries under the age of 21 see EPSDT services.

~~No payment will be made for a service or item that is not eligible for reimbursement, unless authorized by the DVHA for reimbursement via section 7104 of Medicaid rules. These authorizations may be made only when serious detrimental health consequences would arise. Any member interested in applying, may contact the Green Mountain Care Member Services Unit for the required forms.~~

#### 5.2.1 EPSDT SERVICES FOR MEDICAID BENEFICIARIES UNDER AGE 21

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a federally mandated benefit for Vermont Medicaid beneficiaries under age 21. Under EPSDT, Vermont Medicaid will cover medically necessary health care services, including all mandatory and optional services that can be covered under the Medicaid Act, even if the service is not covered or coverage is limited for adults.<sup>1</sup> The EPSDT benefit is designed to assure that children receive early detection and care, so that health problems are averted or diagnosed and treated as early as possible.

For Medicaid members under the age of 21, payment will be made for any service or item when it (1) is within the scope of the categories of optional and mandatory services in the Medicaid Act, and (2) is medically necessary. For Medicaid members under the age of 21, medical necessity includes a case by case determination that a service is necessary to correct or ameliorate a diagnosis or health condition. It also includes a determination of whether a service is needed to achieve proper growth and development or prevent the worsening of a health condition.

Any code listed as “do not pay” on the PAC 9 (non-covered) list found here:

<http://www.vtmedicaid.com/#/feeSchedule/nonCoveredServices>, does not apply to beneficiaries under the age of 21. To request coverage for any of the services that are listed as non-covered (i.e., PAC 9) for a Medicaid beneficiary under the age of 21, a Medicaid enrolled provider must submit a prior authorization request with documentation of medical necessity for the member. Prior authorization forms can be found here: <https://dvha.vermont.gov/providers/clinical-prior-authorization-forms>.

The Department of Vermont Health Access will conduct a prior authorization review for each PAC 9 code request for medical necessity on a case by case basis.

Services that will not be approved for coverage include:

- Any that are not within the scope of category of services listed in the Medicaid Act;
- Those listed as not covered according to Health Care Administrative Services Rule 4.104, Medicaid Non-Covered Services, and;
- Any that are not medically necessary.

If the requested item is a non-covered drug, prior authorization forms can be found here:  
<https://dvha.vermont.gov/for-providers/preferred-drug-list-clinical-criteria/view>

<sup>1</sup> Vermont Medicaid's EPSDT benefit includes any medically necessary service that is within the scope of the categories of services listed as medical assistance in the Medicaid Act at 42 USC 1396d(a). (1905(a) of the Social Security Act)

UPDATE FOR 9/30/2019

DENTAL SUPPLEMENT

SECTION 7 FEE SCHEDULE

D1354	Interim caries arresting medicament application – per tooth	15	Y	Y	2 per tooth per lifetime	N	N	0
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UPDATES FOR 9/16/2019

GENERAL BILLING AND FORMS MANUAL

1.6 VERMONT MEDICAID & MEDICARE CROSSOVER BILLING

A Medicare Attachment Summary Form should not be attached if an item or service is non-reimbursable by Medicare. If the service or item is denied by Medicare, a completed claim along with the Medicare EOB should be submitted within ~~twelve months of the date of service~~ **6 months from Medicare's processing date.**

UPDATES FOR 8/26/2019

GENERAL BILLING AND FORMS MANUAL

6.4.4 INPATIENT CLAIMS: NO MEDICARE PART A; HAS MEDICARE B COVERAGE

When a Vermont Medicaid member has Medicare part B and no Medicare part A coverage, providers are instructed to bill as follows:

1. Days not covered under Medicare part A must be billed to Medicare B for payment of covered ancillary charges. Claims will crossover to Vermont Medicaid for payment of coinsurance and deductible.
2. Add together Medicare's part B payment, Medicare contractual adjustment amount on part B EOMB and Vermont Medicaid's crossover payment (part B) in field locator 54 (Prior Payments) of the UB-04 claim form.
3. **If ancillary charges occurred prior to the Medicare exhaust, a service date is required in field locator 45.**
4. **If ancillary charges occurred after the Medicare exhaust, follow the instructions in section 6.4.5 of this manual.**
5. Submit your claim and all attachments to your Vermont Medicaid Provider Representative. (See <http://www.vtmedicaid.com/#/manuals> and click the Provider Representative Map link).

GENERAL BILLING AND FORMS MANUAL

6.4.5 INPATIENT CLAIMS: MEDICARE PART A EXHAUSTS OR BEGINS DURING THE INPATIENT STAY

When a Vermont Medicaid member has Medicare part B coverage and Medicare part A has exhausted, providers are instructed to bill as follows:

1. Bill part A charges to Medicare. Claim will crossover to Vermont Medicaid for payment of deductible and/or coinsurance.



2. A claim for Inpatient dates of service not covered under Medicare part A must be billed to Medicare B for payment of covered ancillary charges. Claim will crossover to Vermont Medicaid for payment of coinsurance and deductible.
3. The inpatient claim for the entire stay should be billed to Vermont Medicaid with “Medicare benefits exhausted or began on mm/dd/yy” indicated in field locator 80 on the UB-04.
4. Add together the Medicare B payment, the Medicare B contractual adjustment, and the Vermont Medicaid crossover payment. Indicate this total amount in field locator 54a on the UB-04. Do not indicate any payment by Medicare A.
5. Attach both the part A and B EOBs. On part A EOMB, write “Medicare benefits exhausted or began on mm/dd/yy”. The charges will not match on part B EOMB. Sign and date part A EOMB.
6. If ancillary charges occurred prior to the Medicare exhaust, a service date is required in field locator 45.
7. If ancillary charges occurred after the Medicare exhaust, follow the instructions in section 6.4.5 of this manual.
8. Submit your claim and all attachments to your Vermont Medicaid Provider Representative. See <http://www.vtmedicaid.com/#/manuals> and click the Provider Representative Map link.

## VERMONT MEDICAID APPLIED BEHAVIOR ANALYSIS AND MENTAL HEALTH SERVICES SUPPLEMENT

### SECTION 7 APPLIED BEHAVIOR ANALYSIS BENEFIT PROVIDER GUIDANCE

#### 7.1 Introduction

Vermont Medicaid covers medically necessary, evidence-based diagnosis and treatment of autism spectrum disorders, including applied behavioral analysis supervised by nationally board-certified behavior analysts, for children birth until the age of 21 years. Vermont Medicaid pays for ABA using two separate funding methodologies depending on insurance status; Case Rate for individuals with only Medicaid as their sole insurance, and fee-for-service for individuals who have other insurance coverage in addition to Medicaid.

All ABA services (regardless of payment methodology) must be medically necessary. The same documentation standards apply, and clinical best practice is expected. The Case Rate requires consultation with the DVHA Autism Specialist or designee to identify tiers; Fee-for-service requires prior authorization. The ABA policy and clinical information and guidance documentation are available at: <http://dvha.vermont.gov/for-providers/applied-behavior-analysis-aba/>.

Information outlined in the ABA policy and ABA Clinical Guidelines will not be repeated in this provider manual. Providers can access the ABA policy and Clinical Guidelines at <http://dvha.vermont.gov/for-providers/applied-behavior-analysis-aba/>

#### 7.2 Documentation Requirements

DVHA requires that ABA providers must maintain documentation in a member’s file. Please review the ABA policy for specific documentation requirements at: <http://dvha.vermont.gov/for-providers/aba-policy-5.1.19.pdf>

#### 7.3 Case Rate specific requirements – Medicaid only members

Case Rate will be utilized for all members with an ASD diagnosis or an early childhood developmental disability disorder who have Medicaid only coverage.

1. **Consultation:** Consultations ensure tier assignments are effective for the first of the following month. Providers must contact the DVHA Autism Specialist or designee by the last business day prior to the 15<sup>th</sup> of the month to determine tier assignment based on clinically recommended treatment hours.



The following information must be provided to the Autism Specialist during consultations:

- Member's name
  - UID
  - DOB
  - Provider name
  - Projected hours
  - Tier request
  - Time frame (i.e. months requested)
  - Tier changes can be made as frequently as monthly based on changes in anticipated service delivery. Providers must contact the DVHA Autism Specialist or designee via e-mail [AHS.DVHAABABenefit@vermont.gov](mailto:AHS.DVHAABABenefit@vermont.gov) to make changes.
  - Providers must wait to receive notification from the DVHA Autism Specialist or designee prior to submitting initial claims for new members.
2. Services for members with an early childhood developmental disability diagnosis (non ASD diagnosis) require prior authorization, which may be determined during consultations with the DVHA Autism Specialist or designee. Determination letters will be sent by the Autism Specialist or designee following consultation.

### 7.3.1 Case Rate Tiers

The case rate is comprised of 14 tiers and is based on the number of anticipated service hours:

Tier	Hours
0	0
1	2-5
2	6-14
3	15-24
4	25 – 34
5	35 – 49
6	50 – 64
7	65 – 79
8	80 – 94
9	95 – 109
10	110 – 124
11	125 – 139
12	140 – 154
13	155 – 169
14	170 +

**Included codes** - The following CPT codes are included in monthly totals:

- **Assessment codes\*:**

- 97151
- 97152
- 0362T

- **Treatment codes:**

- 97153
- 97154

- 97158
- 0373T
- **Program Supervision\*:**
  - 97155
- **Parent Training:**
  - 97156
  - 97157
- **Team Conference\*:**
  - 99366
  - 99368

*\* Adherence to code restrictions is expected. Any exceptions must have supporting clinical documentation demonstrating medical necessity and should be discussed with DVHA Autism Specialist.*

3. **Assessments and Reassessments:** Assessment and reassessment hours will be included in the monthly total hours for tier assignments in the month they are administered. Providers should notify the DVHA Autism Specialist or designee if any assessments were completed that were not included in a tier assignment. Assessment code limitations are as follows:
  - 97151 – Limited to 4 BCBA hours every 6 months
  - 97152 – Limited to 4 BT hours every 6 months
  - 0362T – Limited to 4 BT hours every 6 months
4. **Shadow Claims:** While payment for services provided is no longer dependent on submitted claims, providers are expected to continue to submit “shadow” claims for purposes of data collection and reconciliation. Shadow claims are submitted in the same way as regular claims. See the ABA Policy: <http://dvha.vermont.gov/for-providers/applied-behavior-analysis-aba/> regarding claims submittal guidelines.
5. **Monitoring:** DVHA will conduct quarterly reviews to compare shadow claims with tier placement. The expectation is the hours provided match the projected tier. The Autism Specialist will contact the provider if tiers and hours don’t match. An action plan will be established (e.g. discuss tier selection, correct shadow claims, etc.)
6. **Site Visits:** DVHA will conduct bi-annual site visits, typically scheduled in advance but may be unannounced. Providers may also request a site visit by DVHA staff. During site visits the DVHA Autism Specialist or designee will meet with the providers on location and review all or a representative sample of members’ files. There are no specific requirements for the organization of charts (paper, electronic etc.). However, documentation should demonstrate adherence to clinical best practices. See the ABA Policy and Clinical Guidelines for documentation that should be included within member’s files: <http://dvha.vermont.gov/for-providers/applied-behavior-analysis-aba/>
7. **Reimbursement:** Once consultations with the DVHA Autism Specialist or designee have occurred and tiers have been set for each member, providers will receive their prospective payment. Providers will receive one payment that includes the tier rates for all Medicaid members they are providing services to. Payments will be issued the last Friday of every month.

8. **Reconciliation:** Reconciliation will occur annually for each calendar year (January 1<sup>st</sup> to December 31<sup>st</sup>)<sup>1</sup>. Reconciliation for the previous year will begin in April, using the Medicaid Management Information System (MMIS) as the data source for all claims used for the reconciliation, and will be based on the complete data set as of March 31<sup>st</sup>. Reconciliation will happen at the provider level, and all billed hours will be subject to review during the reconciliation process. All ABA services (allowable under the case rate) will be totaled for each month to determine the *Final Monthly Tier*. DVHA will review the *Final Monthly Tier* against the *Provider-Selected Monthly Tier* for each client for each month of service. Months will be aggregated to reconcile the total year-end difference for each client. Client differences will be aggregated to determine the total net loss or gain for the provider. Reconciliation will be to 100% of the difference.

Calculations will be based on the following:

CPT Code	Tier Calculation	Claims Hours
97151	Total Billable Monthly Hours	Hours
97152	Total Billable Monthly Hours	Hours
97153	Total Billable Monthly Hours	Hours
97154	Total Billable Monthly Hours	Hours
97155	Total Billable Monthly Hours	Hours
97156	Total Billable Monthly Hours	Hours
97157	Total Billable Monthly Hours	Hours
97158	Total Billable Monthly Hours	Hours
99366	Total Billable Monthly Hours	Hours
99368	Total Billable Monthly Hours	Hours
0362T	Total Billable Monthly Hours	Hours * 2
0373T	Total Billable Monthly Hours	Hours * 2

9. **Communication with DVHA:** All ABA providers have been given access to GlobalScape, a HIPAA compliant platform in which providers will share clinical documentation with DVHA. If a provider would like to make changes to tier(s) they should request this through email [AHS.DVHAABABenefit@vermont.gov](mailto:AHS.DVHAABABenefit@vermont.gov). Change confirmations will be sent from the DVHA QICIU ABA team.

If you have any questions or concerns regarding the Vermont Medicaid ABA benefit, please email [AHS.DVHAABABenefit@vermont.gov](mailto:AHS.DVHAABABenefit@vermont.gov).

#### 7.4 Fee-For-Service Requirements – Members who have other insurance

Providers will follow fee-for-service requirements for members with other insurance in addition to Medicaid.

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<sup>1</sup> For CY2019, the period for reconciliation will be July 1, 2019 – December 31, 2019.

If the primary insurance does not cover any or all ABA service claims, Medicaid may cover the service if determined clinically appropriate (requires prior authorization by DVHA). Provider must submit primary insurance denial letter with request.

1. **Prior Authorization:** Prior Authorization is required for fee for service. Required documentation found in the link in the *Documentation Requirements* section <http://dvha.vermont.gov/for-providers/applied-behavior-analysis-aba/> must be faxed to DVHA (855) 275-1212 and authorized prior to service delivery. DVHA uses evidence-based criteria to make authorization decisions and notifies providers within three business days of receiving **all** necessary information.
2. **Continued Authorization:** Continued Authorizations must be submitted every six months (unless greater frequency is clinically indicated) to the DVHA. Please refer to the ABA policy regarding required documentation: <http://dvha.vermont.gov/for-providers/aba-policy-5.1.19.pdf>.  
**Required documentation must be faxed to DVHA 855.275.1212 and authorized prior to service delivery.**
3. **Reimbursement:** Providers will be reimbursed for claims submitted for services rendered, as authorized by DVHA.

## SECTION 8 POLICY REFERENCES

### 7103 Medical Necessity

### 7102.2 Prior Authorization Determination

### Telehealth

### 9.103 Supervised Billing

Medicaid Rules: <http://humanservices.vermont.gov/on-line-rules>

UPDATES FOR 7/30/2019

## GENERAL BILLING AND FORMS MANUAL

### 3.6 SUPERVISED BILLING FOR BEHAVIORAL HEALTH SERVICES

**Individuals who have been on the roster that is maintained by the Office of Professional Regulation in the Office of the Secretary of State for more than five years after January 1, 2016 will no longer be eligible under Vermont Medicaid to provide clinical services.**

~~Extensions may be granted on a case-by-case basis. Designated Agency and Specialized Service Agency Providers only: For individuals seeking a waiver to the "Five-Year Rule", please fill out the Supervised Billing Five Year Rule Waiver form found at: <http://www.vtmedicaid.com/#!/provEnrollDataMaint>.~~

UPDATES FOR 5/21/2019

## GENERAL BILLING AND FORMS MANUAL

### 3.8.1 CRITICAL CARE PROCEDURE CODES THAT ARE TIME-BASED

In a facility setting, duration of time reflects time spent at the patient's bedside or elsewhere on the floor or unit. You must be immediately available to the patient. More than one physician may bill for critical care services rendered to a patient during any billable period of time. Code 99292 may be reported alone when critical care is reported by another physician of the same group and specialty on the same date as another provider reporting 99291. Time counted toward critical care may be continuous clock time or intermittent aggregated time.

~~In a facility setting, duration of time reflects time spent at the patient's bedside or elsewhere on the floor or unit. You must be immediately available to the patient. Only one physician may bill for critical care services rendered to a patient during any billable period of time. Time counted toward critical care may be continuous clock time or intermittent aggregated time.~~

## DENTAL SUPPLEMENT

### 5.8.6 INTERIM PROSTHESIS

**D5820** - Interim partial denture (maxillary) - Includes any necessary clasps and rests

**D5821** - Interim partial denture (mandibular) - Includes any necessary clasps and rests

## UPDATES FOR 4/5/2019

## GENERAL BILLING AND FORMS MANUAL

### 3.6.1.2 PROCEDURES FOR BILLING

b. Effective 1/1/2019, for Designated Agencies and Specialized Service Agencies: For claims submitted to DMH fund sources, the modifiers in the above table are required unless billing to Eldercare, Reach Up, or Success Beyond Six.

~~b. For Designated Agencies, Specialized Service Agencies, and ADAP Preferred Providers Only: For claims submitted to DMH or ADAP fund sources, the modifiers in the above table are not required.~~

## UPDATES FOR 2/4/2019

### 8.2.1 TIMELY FILING RECONSIDERATION REQUESTS

Providers can submit a timely filing reconsideration request within 3 months from the initial timely filing denial. Documentation to support the extenuating circumstance to override the timely filing denial must be submitted (e.g. account notes, emails, denials or other insurance correspondence). Please do not attach medical records with your timely filing reconsideration requests. Instead attach any account notes showing the follow-up actions that were taken resulting in the late submission. If the Agency of Human Services (AHS) feels that an extenuating circumstance justifies the override of the timely filing denial the AHS will approve the request. Understaffing, misplaced claims (including claims lost in the mail or not received electronically) or claims that have not been consistently followed up on are not examples of extenuating circumstances and the original denial will be upheld.

~~A Provider may request a review of denials based on untimely filing by submitting a Timely Filing Reconsideration Request Form within 3 months of the Remittance Advice denial. For timely filing reconsideration requests, providers must fully research and provide documentation to support the extenuating circumstances surrounding the claim (e.g. submission dates, adjusted dates, and denial dates). Providers should submit all supporting documentation (e.g. account notes, emails, denials or other insurance correspondence). Please do not attach medical records with your timely filing reconsideration requests. Instead attach any account notes showing the follow-up actions that were taken resulting in the late submission. If there is no documentation or the documentation is insufficient to validate extenuating circumstances for the late submission, your request will be denied.~~

## UPDATES FOR 2/1/2019

### 8.2 TIMELY FILING

**Below are the timely filing limitations.**

**Please note that one month equals 30 days on average, therefore 6 months equals 180 days.**

- When Medicaid is the primary insurer providers have 6 months from the date of service to submit a claim
- When Medicare is the primary insurer providers have 6 months from Medicare's paid date to submit a claim or 6 months from Medicare's denied date to submit a claim
- When Other Insurance (excluding Medicare) is the primary insurer providers have 12 months from the date of service to submit a claim
- For an inpatient claim, providers have 6 months from the discharge date to submit a claim
- For global maternity and orthodontia claims, providers have 6 months from the date of service to submit a claim
- When a provider has been granted retro-enrollment (backdate) they have up to 12 months from the date of service, or an additional 45 days from the date of notice of enrollment, whichever is later, to submit a claim. The Medicaid Enrollment Backdate form is available on our website at <http://vtmedicaid.com/#!/provEnrollDataMaint>
- When a recipient has been granted retro-eligibility providers have 12 months from the date of service to submit a claim
- Providers must request an adjustment to a PAID claim within 12 months from the original paid date when the adjustment would result in a positive financial outcome for the provider
- Providers may request an adjustment to a PAID claim within 3 years from the original date of service when the adjustment would result in a negative financial outcome for the provider. If the claim is more than 3 years old, the provider must refund the overpayment by completing the refund form and attaching the refund check. The Medicaid Refund form is available on our website at <http://www.vtmedicaid.com/#!/forms>
- Providers have 6 months from the initial Medicaid denial to submit a corrected claim

Providers have 3 months from the initial Medicaid timely filing denial to submit a timely filing reconsideration request. The Medicaid Timely Filing Reconsideration Request form is available on our website at <http://www.vtmedicaid.com/#!/forms>

~~When the system indicates that Vermont Medicaid is the primary payer, the timely filing limit for such claims is 180 days from the date of service. In no case will a claim be considered if the date of service is greater than two years prior to the DVHA's receipt of the claim. If a claim has a date or dates of service past the timely filing limit, it may be submitted for payment reconsideration directly to DXC if one or more of the following conditions are met:~~

- ~~• DXC denied the claim within the timely filing limit for a reason other than exceeding the time limit. A copy of the remittance advice showing the denial must be attached to each claim~~

- ~~A member's eligibility was made retroactive and the date of service is within the retroactive period. The claim must be submitted within the first twelve months of the date on the Notice of Decision.~~

- ~~Inpatient claim, the timely filing limit is 180 days from the date of discharge~~

~~When a claim is billed to Medicare with Vermont Medicaid noted as the secondary payer (using the crossover function), the crossover claim will be considered timely if it is received within two years of the date of service.~~

~~Global bills for maternity and orthodontia, which must be filed within 12 months of the first date of service.~~

~~When the system indicates that Vermont Medicaid is not the primary payer, providers can either file all claims (except Medicare crossover claims) within 180 days, or providers may separate these claims into two groups each with a different timely filing requirement.~~

~~For claims that are not "pay and chase" (see below), the timely filing limit is 12 months from the date of service the timely filing limit is 180 days from the date of service for "pay and chase" claims (i.e. where the system indicates that the member is covered by court ordered insurance D1, D2, D3, D5, D8 and D9) or the claim is for any of the following procedure and diagnosis codes:~~

- ~~Procedure codes: 99381-99385, 99391-99394 and 99173~~

- ~~Diagnosis codes: Please see [Appendix 1](#) for ICD-10 codes~~

~~Members covered by court ordered insurance can be identified by using the Voice Response System that says "The recipient has other insurance with (name) with coverage type (coverage code D1 or D2, etc.)."~~

## 8.2.1 TIMELY FILING RECONSIDERATION REQUESTS

A Provider may request a review of denials based on untimely filing by submitting a Timely Filing Reconsideration Request Form within 3 months of the Remittance Advice denial. For timely filing reconsideration requests, providers must fully research and provide documentation to support the extenuating circumstances surrounding the claim (e.g. submission dates, adjusted dates, and denial dates). Providers should submit all supporting documentation (e.g. account notes, emails, denials or other insurance correspondence). Please do not attach medical records with your timely filing reconsideration requests. Instead attach any account notes showing the follow-up actions that were taken resulting in the late submission. If there is no documentation or the documentation is insufficient to validate extenuating circumstances for the late submission, your request will be denied.

Providers that have been granted retro-enrollment must attach the enrollment approval letter to their claim(s).

Requests for review of untimely filing denials will be reviewed on a case-by-case basis. If the request is denied requesting additional information, the provider must resubmit a new timely filing reconsideration with the additional supporting documentation no later than 60 days from the date of the denial letter. Providers must also include a copy of the reconsideration denial letter to prevent unnecessary denials. Failure to respond within the time allotted will result in a final denial decision and no further review will be granted. If the denial is reversed, the claim will be processed for consideration on a future Remittance Advice. Please be aware that an approval for the timely filing request does not preclude the mandates for correct coding, prior authorization, supporting

documentation or any claims processing requirements. Failure to complete forms correctly or attach the approval letter to the resubmitted claim **will** cause the claim to deny.

Providers submitting a timely filing reconsideration request for a single claim should use the “Timely Filing Reconsideration Form – Single Claim”. For reconsideration requests that contain more than one claim for a single member, providers should use the “Timely Filing Reconsideration Form – Single Patient Multiple Claims”. No more than 25 claims per member can be submitted per multiple claims request. Requests containing multiple members will be returned to the provider. Both forms are located at <http://www.vtmedicaid.com/#!/forms>. Completion instructions are included with the form.

All Timely Filing Reconsideration Requests should be mailed to:

DXC Technology  
Attn: Timely Filing  
PO Box 888  
Williston, VT 05495-0888

For non-timely filing reconsideration requests, please refer to Section 1.2.11, Provider Reconsideration Requests, in the Vermont Medicaid General Provider Manual.  
<http://www.vtmedicaid.com/#!/manuals>

~~The Department of Vermont Health Access will review a decision of an untimely claim in unusual circumstances, if the claim has previously denied for timely filing.~~

~~For timely filing reconsideration requests, providers must fully research and document in the request the extenuating circumstances surrounding the claim (e.g. submission dates, adjusted dates, and denial dates). Providers should submit all supporting documentation (e.g. account notes, emails, denials or other insurance correspondence. Do not send Medical records with a timely filing reconsideration request).~~

~~Providers submitting a timely filing reconsideration request for a single claim should use the “Timely Filing Reconsideration Form – Single Claim”. For reconsideration requests that contain more than one claim for the same recipient, providers should use the “Timely Filing Reconsideration Form – Single Patient Multiple Claims”. Both forms are located at <http://www.vtmedicaid.com/#!/forms>. Completion instructions are included in the form.~~

~~If there is no documentation or the documentation is insufficient to validate extenuating circumstances for the late submission, your request will be denied.~~

~~All Timely Filing Reconsideration Requests should be mailed to:~~

~~DXC Technology  
Attn: Timely Filing  
PO Box 888~~

~~Williston, VT 05495~~

~~**For non-timely filing reconsideration requests, please see Section 1.2.7 Provider Reconsideration Requests.**~~



## UPDATES FOR 12/20/2018

### 15.2.10 CHOICES FOR CARE SHORT-TERM RESPITE STAYS

Individuals enrolled in Choices for Care in the home or ERC settings may receive short-term respite in a Vermont Medicaid licensed nursing facility by changing their Choices for Care setting. This is done by notifying DCF and DAIL using the ~~CFC 804 Change Form~~ **804B Choices for Care Form** found at <http://www.vtmedicaid.com/#/forms>. Once the DCF ACCESS long panel is updated with the nursing facility information, the facility may bill Medicaid using the appropriate revenue code. (Respite stays exceeding 30-days may trigger a change in patient share.

## UPDATES FOR 12/4/2018

### 10.3.54 TELEMEDICINE SERVICES

Visit <http://dvha.vermont.gov/telehealth> for additional information.

## UPDATES FOR 11/6/2018

### 9.8.3 VERMONT MEDICAID BILLING

A provider who pays for interpreter services for Vermont Medicaid members may bill procedure code T1013 for each 15 minutes of paid interpreter services provided, on-site or via telephone. This may include interpreter service outside of the actual healthcare provider encounter in order to fill out forms or review information/instructions.

The provider may not bill Vermont Medicaid or the member for a missed appointment per federal policy.

Claims are submitted using the CMS 1500 claim form with HCPCS code T1013, with the exception that Home Health Agencies use the UB04 claim form with revenue code 940 with the HCPCS code T1013.

Claims for services provided to multiple recipients during the same group therapy session should be reported using T1013 on multiple claims with the appropriate modifier to indicate how many patients were served.

- The first claim should be reported with procedure code T1013 without a modifier and include the total number of units for all patients served within the group session as well as the charge amount for the total session
- Additional claims should be reported with procedure code T1013 with one of the appropriate modifiers listed below with 1 unit and no charge amount.

Please see the example for further clarification.

Appropriate Modifiers on claims 2-6:

UN – 2 patients served  
UP – 3 patients served  
UQ – 4 patients served  
UR – 5 patients served  
US – 6 or more patients served

Same Group Session for Multiple Recipients Example:

Member	Appt Time	Date of Service	HCPCS Code	Modifier	Charge	# of Units
--------	-----------	-----------------	------------	----------	--------	------------

Member 1	8:30 am to 9:55 am	1/1/2015	T1013		\$75.00	6
Member 2	8:30 am to 9:55 am	1/1/2015	T1013	UP	\$0.00	1
Member 3	8:30 am to 9:55 am	1/1/2015	T1013	UP	\$0.00	1

FQHC/RHC providers must bill T1013 for interpreter services using their non-FQHC/RHC provider numbers.

When a member receives services that are not eligible for reimbursement, the interpreter services are ineligible for reimbursement.

## UPDATES FOR 10/29/2018

### ~~SECTION 18 ELECTRONIC HEALTH RECORD INCENTIVE PROGRAM~~

~~The EHRIP team is responsible for the implementation of the Vermont Medicaid Electronic Health Record Incentive Program (EHRIP). Established by the 2009 Health Information Technology for Economic and Clinical Health (HITECH) Act of the American Recovery & Reinvestment Act (ARRA), the program is designed to support providers during the transition to electronic systems and to improve the quality, safety, and efficiency of patient healthcare through the use of electronic health records (EHRs).~~

~~The EHR Incentive Program provides incentive payments to eligible professionals, eligible hospitals, and critical access hospitals as they adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology.~~

~~To receive an EHR incentive payment, providers must demonstrate they are “meaningfully using” their certified EHR technology by meeting certain measurement thresholds, which range from recording patient information as structured data to exchanging summary of care records. CMS has established these thresholds for eligible professionals and eligible hospitals. Meaningful Use objectives and measures evolve in distinct stages.~~

~~More information about the Vermont Medicaid EHR Incentive Program's policies and activities can be found at the website: <http://healthdata.vermont.gov/ehrip>~~

### SECTION 18 PROMOTING INTEROPERABILITY PROGRAM (FORMERLY ELECTRONIC HEALTH RECORD INCENTIVE PROGRAM)

The Medicaid Electronic Health Record Incentive Program (EHRIP) is now called the Promoting Interoperability Program (PIP). CMS is aligning and streamlining the EHRIP to move the program beyond the existing requirements of Meaningful Use (MU) to a new phase of Electronic Health Record measurement focused on interoperability and improving patient access to health information.

The PIP/EHRIP team is responsible for the implementation of the Vermont Medicaid Promoting Interoperability Program (formerly the Electronic Health Record Incentive Program). Established by the 2009 Health Information Technology for Economic and Clinical Health (HITECH) Act of the American Recovery & Reinvestment Act (ARRA), the program is designed to support providers during the transition to electronic systems and to improve the quality, safety, and efficiency of patient healthcare through the use of electronic health records (EHRs).

The Medicaid PIP/EHRIP provides incentive payments to eligible professionals, eligible hospitals, and critical access hospitals as they adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology.

Eligible Professionals may receive up to six yearly payments, and may skip one or more years through the duration of the program through 2021. Participation as of Program Year 2017 requires that the provider have received at least one Medicaid EHRIP payment in a previous year.

To receive an EHR incentive payment, providers must attest that they are “meaningfully using” their certified EHR technology by meeting certain measurement thresholds, which range from recording patient information as structured data to exchanging summary of care records. CMS has established these thresholds for eligible professionals and eligible hospitals.

More information about the Vermont Medicaid PIP/EHRIP’s policies and participation requirements can be found at the website: <https://healthdata.vermont.gov/ehrip>

## ~~18.1 ELECTRONIC HEALTH RECORD PROGRAM RECONSIDERATION PROCESS~~

### 18.1 PROMOTING INTEROPERABILITY PROGRAM/ELECTRONIC HEALTH RECORD INCENTIVE PROGRAM RECONSIDERATION PROCESS

The Department of Vermont Health Access (DVHA), **Promoting Interoperability Program/Electronic Health Record Incentive Program (PIP/EHRIP)** offers a Reconsideration and Appeal process.

#### **Reconsideration of PIP/EHRIP Decisions**

- A. A provider who receives notification regarding eligibility for: payment amount, overpayment amount, or recoupment, has the option to request reconsideration by the PIP/EHRIP.
- B. The request must be made within thirty (30) calendar days of the receipt of the overpayment notice OR of the denial notice OR within thirty (30) calendar days of the date of the PIP/EHRIP payment in dispute. The request must be filed on the *Request for PIP/EHRIP Reconsideration* form located at <https://healthdata.vermont.gov/ehrip/Audits/Appeals>
- C. All issues regarding the provider’s objection to the findings must be documented and no monetary threshold is applied. Failure to do so will result in the reconsideration request being waived.
- D. The reconsideration review will be conducted by a qualified person within the PIP/EHRIP of DVHA.
- E. DVHA has 30 calendar days to respond following the later of:
  1. Receipt of reconsideration form
  2. The date of a meeting with the provider, if one is scheduled
  3. The date additional information is received from the provider (if requested by DVHA)
- F. During the reconsideration process, the provider may request in writing an additional 14 days to respond to a request by DVHA.
- G. In some circumstances, DVHA may notify the provider that an additional 14-day extension is invoked.
- H. After review and reconsideration, DVHA will send the provider a final letter regarding its determination. DVHA may send a decision in the event the provider does not reply to a document request in a timely manner, or in the case a request for reconsideration is not filed in a timely manner.

A provider who is dissatisfied with the result of the reconsideration decision may follow the process to submit an **PIP/EHRIP** Appeal.

Submit Reconsideration Request and Forms to:

Office of the General Counsel  
**PIP/EHRIP** Appeals  
Department of Vermont Health Access  
NOB 1 South  
280 State Drive  
Waterbury, VT 05671-1010

## ~~18.2 APPEAL OF EHR INCENTIVE PROGRAM RECONSIDERATION~~

### 18.2 APPEAL OF PROMOTING INTEROPERABILITY PROGRAM/EHR INCENTIVE PROGRAM RECONSIDERATION

In order to initiate a **Promoting Interoperability Program/EHR Incentive Program (PIP/EHRIP)** Appeal the following process needs to occur:

- A. A **PIP/EHRIP** appeal must be filed within 30 days of the receipt of the reconsideration decision notice from DVHA or mail date. To file an **PIP/EHRIP** appeal a provider must complete the Request for Appeal of **PIP/EHRIP** Reconsideration form located at <http://healthdata.vermont.gov/ehrip/Audits/Appeals>
- B. The provider is required to list all objections to the reconsideration decision notice at the time of the **PIP/EHRIP** Appeal, otherwise claims are waived.
- C. **PIP/EHRIP** appeals will be divided into two categories:
  1. Cases in which a reconsideration decision was issued regarding an overpayment of \$15,000 or less will be reviewed by the Chief Medical Officer (CMO) or designee. At the discretion of the CMO or designee, written instructions will be issued to the provider explaining the process or providing for a meeting with the provider.
  2. Cases in which a reconsideration decision was issued regarding an overpayment of \$15,000 or more will be reviewed by the DVHA Commissioner or designee, who may convene a hearing to be scheduled within 90 days from the date of the receipt of the appeal. Appeal hearings shall be conducted under the same rules of conduct as in current use for hearings for the Human Services Board.
- D. Within 14 days of either a meeting by the Chief Medical Officer or designee, or an appeal hearing by the Commissioner or their designee, the following will be mailed to the provider:
  1. A written request for additional information or an additional meeting to discuss,

**-or-**

  2. A decision letter. The decision letter will indicate the next level of appeal, as indicated below, should the provider be dissatisfied with the decision.
- E. No money is collected from the provider or offset against claims until a final decision has been rendered on the **PIP/EHRIP** appeal.
- F. Upon receipt of an **PIP/EHRIP** Appeal decision letter, DVHA may demand payment from the provider or offset the overpayment determination from pending claims. The provider may request a payment plan from DVHA in order to reconcile the overpayment.

PIP/EHRIP appeal decisions are final. Disagreement with the decision has the option to file a civil action in Superior Court.

Submit Appeal Request and Forms to:

Office of the General Counsel  
PIP/EHRIP Appeals  
Department of Vermont Health Access  
NOB 1 South  
280 State Drive  
Waterbury, VT 05671-1010

## UPDATES FOR 10/25/2018

### 10.3.49 RADIOLOGY

Total component consists of the professional component and the technical component. The total component is reimbursable only for diagnostic or therapeutic radiology procedures done in the physician's office. The appropriate CPT procedure code without the modifier should be used when a claim for total component services is submitted to Vermont Medicaid.

The use of modifier 50 (bilateral) on CPT radiology codes (7\*\*\*\* series) is not valid because modifier 50 causes payment to be only 1.5 times the price on file. **The only exception is CPT codes 76641 and 76642, which will allow modifier 50 to be appended.**

## UPDATES FOR 8/21/2018

### 10.3.54 TELEMEDICINE SERVICES

Billing Rules for Telemedicine:

- 1) All providers are required to follow correct coding rules, including application of modifiers, and only bill for services within their scope of practice that can be done via telemedicine
- 2) All claims with services billed for telemedicine must have POS 02
- 3) ~~Providers~~ **Facilities** delivering "live" telemedicine services via interactive audio and video must apply the GT modifier - CMS and/or Encoder Pro telemedicine codes excluding non-covered services
- 4) Originating facility site providers (patient site) may be reimbursed a facility fee (Q3014)
  - a) Facility fees will not be reimbursed if the provider is employed by the same entity as the originating site.

## UPDATES FOR 7/11/2018

### 7.3 DETERMINATION TIME

The timeframes now correspond to 42 CFR §438.210. DVHA will continue to issue a notice of decision within 3 **business** days of receipt of all the necessary information. However, the longest time to wait for a decision is now 28 days, not 30. A request must be decided within 14 **calendar** days of receipt of the request, but that time frame may be extended up to another 14 **calendar** days if the beneficiary or provider request the extension, or if the extension is needed to obtain additional information and an extension is in the beneficiary's interest.

Also, when a provider indicates, or DVHA determines, that following this timeframe could seriously jeopardize the beneficiary's life, health, or ability to attain, maintain, or regain maximum function, DVHA must make an expedited decision and provide notice as expeditiously as the beneficiary's

health condition requires and no later than 3 **business** days after receipt of the request. This may be extended up to 14 **calendar** days if the beneficiary so requests, or if the extension is needed to obtain additional information and an extension is in the beneficiary's interest. Under federal law, the department is obligated to provide a response within 24 hours of a request for PA of a drug.

## UPDATES FOR 7/10/2018

### 10.3.24 Scope-of-Service Related Encounter Rate Adjustments

An FQHC or RHC may apply to the Department of Vermont Health Access (DVHA) for adjustment of its prospective payment system (PPS) encounter rate in accordance with the following requirements.

**I. General.** An adjustment in PPS encounter rate will be considered when there has been a HRSA-approved change in scope of project ("scope-of-project change") that gives rise to a change in type, intensity, duration and/or the amount of services delivered by the FQHC or RHC (a "scope-of-service change"). Proof of HRSA approval of the scope-of-project change must be supplied by the FQHC or RHC as supporting documentation for the encounter rate adjustment request.

**II. Additional Qualifying Criteria.** A change in costs, in and of itself, will not be considered a scope-of-service change unless all of the following apply:

- The increase or decrease in cost is attributable to an increase or decrease in scope of FQHC or RHC services.
- The cost is allowable under the Medicare reasonable cost principles set forth in 42 CFR Part 413.
- The change in scope of service is a change in type, intensity, duration or amount of service.
- The cost attributable to the scope-of-service change must account for an increase or decrease to the current cost per encounter greater than or equal to three percent (3.0%) net of any applicable cost offsets.

**III. Vermont Medicaid Scope-of-Service Change Types.** Potential encounter rate changes based on a scope-of-service change will be evaluated in accordance with Medicare cost principles set forth in 42 CFR Part 413. Subject to the conditions set forth in the preceding paragraph, a scope-of-service change means any the following:

- The addition of a new FQHC or RHC service that is not incorporated into the existing baseline PPS encounter rate, or the deletion of an FQHC or RHC service that is included in the existing baseline PPS encounter rate.
- The addition of professional staff licensed and hired to perform services that no other currently employed professional staff member performs.
- The departure of a licensed professional staff member that leaves no other licensed professional staff member performing those services currently provided by the departing staff member.
- A change in service due to amended federal or state regulatory requirements and/or a State of Vermont initiative that would impact FQHC or RHC costs.
- A change related to health information technology.

- An increase or decrease in service intensity attributable to changes in the types of patients served, including but not limited to populations with chronic diseases, or homeless, elderly, migrant or other special populations.
- Changes in any of the services described in Sections 1396d(a)(2)(B) & (C) of Title 42 of the United States Code, or in the provider mix of an FQHC or RHC or one of its sites.

**IIII. Request for Review.** FQHCs and RHCs must notify the DVHA Reimbursement Unit of any scope-of-project change, any scope-of-service change, or any requested PPS encounter rate adjustment based thereon. FQHCs and RHCs can request a PPS encounter rate adjustment based on a qualifying scope-of-service change once per calendar year. Notwithstanding anything to the contrary in this section 10.3.23, DVHA reserves the right to initiate a change-in-scope review for any reason, and for avoidance of doubt, shall not be limited to circumstances in which there has been a HRSA approved scope-of-project change.

The FQHC or RHC shall submit to the DVHA Reimbursement Unit the following required documentation with any request for a PPS encounter rate adjustment:

- Cost report.
- Written request for review (including as applicable the description of and reason for the change including a description of why the service is needed, the population(s) impacted, impact on operating cost specifically related to each change in scope of service, anticipated date services will begin, and all documentation submitted to HRSA).
- The estimated number of Medicaid members that will be impacted, number of total encounters anticipated on an annual basis for all Medicaid members, explanation/justification for the cost of providing care.
- Documentation that HRSA has approved the change in scope of project giving rise to the request.
- Audited financial statements.
- A detailed listing of all new cost(s) and cost offsets, if any, directly related to each qualifying change in scope.

The DVHA Reimbursement Unit will review all scope-of-service change related requests for rate adjustment along with supporting documentation and will issue its decision within 90 days of receipt. If a change in rate is granted, the new rate will be implemented on a prospective basis. All rate adjustments will be implemented on the 1<sup>st</sup> of the month. Rate adjustments resulting from requests received prior to the 15<sup>th</sup> of the month will be effective on the 1<sup>st</sup> of the month immediately following the decision (4<sup>th</sup> month). Rate adjustments resulting from requests received after the 15<sup>th</sup> of the month will not take effect until the 5<sup>th</sup> month due to MMIS implementation timeframes. DVHA Reimbursement reserves the right to extend review times for extenuating circumstances.

Adjusted encounter rates will be based on the reasonable costs associated with the scope-of-service change forming the basis of the request, as determined by the DVHA Reimbursement Unit. DVHA reserves the right to adjust encounter rates in connection with any DVHA-initiated reviews of scope-of-service changes.



## UPDATES FOR 5/30/2018

### 10.3.6 AUDIOLOGICAL SERVICES/HEARING AIDS

Audiology services are provided to members of any age. Coverage of hearing aids is limited to one hearing aid per ear every three years for specified degree of hearing loss. Prior authorization is required for requests prior to the three year limit.

Audiology services pre-approved for coverage are limited to:

- ☐ Audiologic examinations;
- ☐ Hearing screening;
- ☐ Hearing assessments;
- ☐ Diagnostic tests for hearing loss;
- ☐ Analog hearing aids, plus their repair or replacement for members of any age
- ☐ Digital hearing aids, plus their repair or replacement for members of any age (see below for further instruction).
- ☐ Prescriptions for hearing aid batteries — ~~twelve batteries per month~~ (see below for further instruction);
- ☐ Fitting/orientation/checking of hearing aids; and
- ☐ Ear molds.

Payment will be made for hearing aids for members who have at least one of the following conditions or if otherwise necessary under EPSDT found at rule 4100:

- ☐ Hearing loss in the better ear is greater than 30dB based on an average taken at 500, 1000, and 2000Hz.
- ☐ Unilateral hearing loss is greater than 30dB, based on an average taken at 500, 1000, and 2000Hz.
- ☐ Hearing loss in the better ear is greater than 40dB based on an average taken at 2000, 3000, and 4000Hz, or word recognition is poorer than 72 percent.

#### Batteries

~~Two packages of 6 batteries is reimbursable per month when there is a written prescription from the physician. Prior authorization is not required.~~ 12 batteries per month/per side for Clear in Canal (CIC) and Contralateral Routing of Signals (CROS) and BiCROS. A completed *Medical Necessity Form* (MNF): Substantiating the medical need for the hearing aid must be kept on file for auditing purposes. For all other hearing aid types it remains two packages of 6 batteries per month.

#### Hearing Aid Repairs

Prior authorization is required if a second repair/modification is needed within 365 days of a previous repair or any repair in excess of \$100. The cost of repairs/modifications should be less than 50% of the cost of replacing the aid. Repairs must never be billed on hearing aids that are still under warranty (new or repair/replacement).

~~Only Digital Hearing Aids in code range V5255-V5261 allow modifier "TJ" (child and/or adolescent).~~ Digital Hearing Aids using codes V5170, V5180, V5210, V5220, V5254, V5255, V5256, V5257, V5258, V5259, V5260 and V5261 allow modifier "TJ" (child and/or adolescent). The "TJ" modifier triggers a higher allowed amount to cover more sophisticated programming capability when medically necessary. For monaural codes, "TJ" will be the second modifier because modifier RT and LT must be given first (e.g. V5255RT/TJ).

#### Non-Covered Services



The following are non-covered services unless authorized for coverage via rule 7104: nonmedical items, such as: ~~air canal aids and maintenance items other than batteries, and fees associated with selection and trial periods or loaners. DVHA does not pay for “CIC” (completely in the canal) hearing aids.~~

### ~~11.15.3 BICROS/CROS (CONTRALATERAL ROUTING OF SOUND)~~

~~Vermont Medicaid does not cover CROS (Contralateral Routing of Sound) and BICROS hearing aids and related services.~~

~~Per review of current medical literature, the effectiveness of these aids is unproven. Related current HCPCS procedure codes are in the range of V5170–V5240.~~

## UPDATES FOR 5/23/2018

### 11.3 RENTAL/LOANED

The DVHA will rent equipment when it is expected to be cost-effective, medically necessary and short-term. The Department of Vermont Health Access has transitioned most, but not all rental reimbursements to rental (RR) logic. This logic calculates the rental modifier (RR) to allow 10% of the purchase price (rate on file) for the procedure code. ~~Most (but not all) rental periods are 30 days.~~ Providers are required to pro rate rentals when the rental period is less than 30 days.

Certain DME requires prior authorization to begin monthly rental. Rental equipment that does not initially require prior authorization will require prior authorization when the rental time is to exceed three months.

If an item's code does not specify Rental, use modifier RR. The rental will be priced at a monthly amount and is to be billed at a monthly amount unless stated otherwise.

The DVHA provides forms and tools to facilitate the prior authorization process. These forms and tools are available for the following DME items: wheelchairs, speech generating devices, TENS units, and custom orthotics, and can found at: <http://dvha.vermont.gov/for-providers/clinical-coverage-guidelines>. Use of these designated forms/tools is recommended to ensure that all required information is available for review by the DVHA Clinical Unit.

Effective for dates of service on or after May 1, 2018 providers may bill for supplies up to the DVHA quantity limit during the rental period for: E0445, E0465, E0466, E0470, E0471, E0565, E0600, and E0601. As part of the DVHA's annual Fee Schedule maintenance, the DVHA will solicit public comment on revisions to the code list. ~~Medical supplies which are necessary to the functioning of the equipment (e.g., leads and electrodes for TENS Unit) are included in the rental and not to be billed in addition to the rental of the equipment.~~ When billing for supplies on member owned equipment, the supplier must state on the claim or medical necessity form that the related piece of equipment is not being rented (e.g., “~~TENS Units~~ CPAP is not being rented” or “...is owned by the member”).

When DME is loaned (provided without charge) or rented, as part of an equipment trial and the equipment is then approved for purchase: The claim for the equipment is required to include the UE modifier when the equipment is to be retained by the member and was not new at the time of the loan or initial rental. Only if the equipment was new, or if the used equipment is being replaced by new equipment, should this modifier be omitted. The provider is to document the DME serial number in the member's record.

### 11.1 RENTAL REIMBURSEMENT POLICIES

Effective January 1st, 2018 the DVHA has implemented new rental reimbursement policies which will deduct payments issued for equipment rentals from the payment to purchase that same equipment. In addition, all rentals will be subject to a 10-month cap on rentals at which time the item will be considered purchased and paid in full. If the 10 month limit is reached for a capped rental (CR), ownership transfers to the DVHA. All rentals will continue to be subject, like new and used equipment purchases, to the lesser of billed charges and rate on file. The implementation of these rental policies is intended to reduce the overpayment of items so that the full purchase price of an item is paid, either in monthly rentals or a purchase, but not more than the purchase price.

The DVHA rental reimbursement policies are specific to DME claims are specific to professional claims (type 'M'), provider type 009, 014 or 015. Any rental (and must for capped rentals, see details below) are required to be submitted with an 'RR' modifier. Any new or used equipment must be submitted with the appropriate modifier (NU or UE). If a claim **for a non-capped rental code** is processed without the 'RR' modifier or with the modifier 'NU' or 'UE' the indication is that the equipment is purchased. A 14 month historical look back period will be used to assess the need to reconcile previous rental payments and/or apply the 10 month cap. The historical look back period will be prospective such that claims with dates of service between 1/1/2018-1/30/2018 will comprise the first month of historic data on which to the new rental policies will be based.

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

This section of this Manual is unique to Durable Medical Equipment (DME), Prosthetics, Orthotics and Medical Supplies. It contains information concerning billing, payment and specific instructions for completion of the CMS 1500 Claim Form.

**\*Please note: when a service or an item is limited to, for example, one per year, a year is defined as 365 days, unless otherwise specified.**

The Vermont Medicaid website, <http://www.vtmedicaid.com/#/>, will have information regarding DME codes, the modifiers allowed, unit limitations (i.e. one unit per 365 days) and pertinent prior authorization requirements. This information will be located under <http://www.vtmedicaid.com/#/resources>.

DME guidelines are available on the DVHA website at: <http://dvha.vermont.gov/providers/clinicalcoverage-guidelines>. It is imperative that you review the diagnosis restrictions in these guidelines.

### UPDATES FOR 5/3/2018

#### 11.5 PAYMENT DVHA PRIMARY/MANUAL PRICING

When the DVHA is the primary payer, payment amounts for DME (including augmentative communication devices and closed-circuit TV purchased from the Vermont Association for the Blind and Visually Impaired- VABVI), orthotics, prosthetics and medical supplies will be calculated in the following manner:

The following pricing documentation requirements apply to MSRP (Manufacturer's Suggested Retail Price) or Invoice and must be billed on paper with the MSRP or invoice attachment:

- The option to submit either the MSRP or Invoice is allowed. The MSRP or invoice must be submitted in its entirety. If any information (including pages) are missing or lines are marked out or whited out the claim will be denied.

- Online sales aggregator (such as Amazon) receipts are accepted only if the item is purchased by the DME supplier and not available from any other vendor. All below pricing documentation requirements still apply to online sales aggregator receipts.
- All discounts and totals must be clearly documented and disclosed.
- The MSRP sheet, or invoice, or online sales aggregator receipt must be dated within 1 year from the date of service indicated on the claim. If the MSRP, or invoice, or online sales aggregator receipt date exceeds one year, the claim will be denied.
- The item(s) on the MSRP sheet, or invoice, or online sales aggregator receipt must match the item(s) that are being billed on the claim. The applicable correct code must be written next to the item(s) on the MSRP, or invoice, or online sales aggregator receipt. If the code for the item(s) are not documented on the MSRP, or invoice, or online sales aggregator receipt the claim will be denied. Item(s) applicable to laterally must be clearly documented with the correct modifiers for right or left next to applicable code. This applies to both MSRP, and invoice, and online sales aggregator receipts.

Documentation that states “Quote”, “Remittance Advice”, “Estimate”, “Superbill”, etc., and handwritten scripts or prescription papers, will result in claim denial. Exceptions are made for custom made items only, at the discretion of the DVHA.

Vermont Medicaid is payer of last resort. The DVHA does not reimburse when a primary insurance has been billed incorrectly and/or has insufficient information/coding.

#### 11.9 PROCEDURE CODES & PRICING

A list of procedure codes for DME equipment, orthotics, prosthetics and supplies is available in electronic form which includes the code, rate on file, whether the code requires prior authorization, and other pertinent information. Fee Schedules are at <http://dvha.vermont.gov/for-providers/claims-processing-1>. Items on the fee schedule with a rate PAC on file of 5 or 6 “IC” (individual consideration) are manually priced. DME Restrictions, located at <http://www.vtmedicaid.com/#/resources>, inform DME providers of current restrictions on certain DME items/supplies.

Changes in the price on file will be reflected on the Fee Schedule. The DVHA reserves the right to change the price on file for any item or service without prior notice. For these reasons providers should be careful to retain the changes noted in the RAs and updated versions of the fee schedule. This file is for the convenience of the provider. Although the DVHA will attempt to keep the file 100% accurate, the actual price recorded in the computer system for payment is the only accurate price for the applicable date of service.

For items not prior priced or, when a vendor is requesting special pricing consideration, or manual pricing, an invoice including the manufacturer’s price to the vendor and any discounts, must be submitted with the claim. Individual Consideration/Manual Pricing. The rate on file for certain procedure codes does not have a specific dollar amount because no one amount is appropriate (e.g. code A4570, ex. miscellaneous splints codes). In these cases, the rate on file is set at “IC” (individual consideration) and the allowed amount will be calculated in accordance with the section titled “Payment, DVHA Primary/Manual Pricing”. This process is often called “manual pricing”.

#### UPDATES FOR 4/16/2018

##### 8.2.1 Timely Filing Reconsideration Requests

~~The Department of Vermont Health Access will consider paying an untimely claim in unusual circumstances if request is made within 30 days from DVHA's written notice.~~

~~For timely filing reconsideration requests, providers must fully research and document in the request the extenuating circumstances surrounding the claim (e.g. submission dates, adjusted dates, and denial dates). Providers submitting a timely filing reconsideration request for a single claim should use the "Timely Filing Reconsideration Form—Single Claim". For reconsideration requests that contain more than one claim, providers should use the "Timely Filing Reconsideration Form—Multiple Claims". Both forms are located at <http://www.vtmedicaid.com/#!/forms>. Completion instructions are included in the form. If there is no documentation or the documentation is insufficient to validate extenuating circumstances for the late submission, your appeal will be denied.~~

~~All Timely Filing Reconsideration Requests should be mailed to:  
DXC Technology  
Attn: Timely Filing  
PO Box 888  
Williston, VT 05495~~

### 8.2.1 Timely Filing Reconsideration Requests

The Department of Vermont Health Access will review a decision of an untimely claim in unusual circumstances, if the claim has previously denied for timely filing.

For timely filing reconsideration requests, providers must fully research and document in the request the extenuating circumstances surrounding the claim (e.g. submission dates, adjusted dates, and denial dates). Providers should submit all supporting documentation (e.g. account notes, emails, denials or other insurance correspondence. Do not send Medical records with a timely filing reconsideration request).

Providers submitting a timely filing reconsideration request for a single claim should use the "Timely Filing Reconsideration Form – Single Claim". For reconsideration requests that contain more than one claim for the same recipient, providers should use the "Timely Filing Reconsideration Form – Multiple Claims". Both forms are located at <http://www.vtmedicaid.com/#!/forms>. Completion instructions are included in the form. If there is no documentation or the documentation is insufficient to validate extenuating circumstances for the late submission, your request will be denied.

All Timely Filing Reconsideration Requests should be mailed to:  
DXC Technology  
Attn: Timely Filing  
PO Box 888  
Williston, VT 05495

### 11.3 Face-to-face Requirements

As of 4/1/2018, the Agency of Human Services (AHS) will require physicians enrolled in Vermont Medicaid to document that a face-to-face encounter occurred for the initial ordering of specified durable medical equipment and supplies. This change assures compliance with federal requirements at 42 CFR §440.70(f). This requirement only applies to durable medical equipment, supplies, and services that are also covered by Medicare as found at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS->

[Compliance-Programs/Medical-Review/Downloads/DME List of Specified Covered Items updated March 26 2015.pdf.](#)

Face-to-face Requirement also includes power wheelchairs.

The face-to-face encounter **must** be no more than 6 months prior to the start of service. Documentation of the face-to-face visit is a required component of the physician's order for services.

The following elements must be present in the documentation:

- The face-to-face encounter must be related to the primary reason the patient requires services.
- The face-to-face encounter may be conducted in person or through telemedicine.

The ordering physician must document:

- That the face-to-face encounter is related to the primary reason the patient requires services,
- That the face-to-face encounter occurred within the required timeframes,
- The practitioner who conducted the encounter, and
- The date of the encounter.

The non-physician practitioner performing the face-to-face encounter must communicate the clinical findings of that face-to-face encounter to the ordering physician. Those clinical findings must be incorporated into a written or electronic document included in the beneficiary's medical record. Qualified Providers

The following non-physician practitioners may perform the face-to-face encounter:

- A nurse practitioner, clinical nurse specialist, or certified nurse midwife working in collaboration with the ordering physician,  
**-or-**
- A physician assistant under the supervision of the ordering physician.

### 13.2 Face-to-face requirements

As of 4/1/2018, the Agency of Human Services (AHS) requires physicians enrolled in Vermont Medicaid to document that a face-to-face encounter occurred for the initial ordering of home health services. The ordering physician or non-physician practitioner **must** conduct a face-to-face encounter with the beneficiary no more than 90 days prior to, or 30 days after the start of service. Documentation of the face-to-face visit is a required component of the physician's order for services.

The face-to-face visit requirement applies to home health services as defined by federal regulations at 42 CFR §440.70. Medicaid Covered Services Rule 7401, Home Health Agency Services reflects that homebound status is not required.

Documentation indicating that the face-to-face visit occurred shall be included in the physician's initial order for services. The face-to-face encounter may be conducted in person or through telemedicine.

The ordering physician is required to document who conducted the face-to-face encounter and incorporate findings into the beneficiary's medical record. A specific form to document the face-

to-face visit is not required. How to incorporate the clinical findings into the medical record is at the discretion of the ordering physician.

The following elements must be present in the documentation:

- That the face-to-face encounter is related to the primary reason the patient requires services,
- That the face-to-face encounter occurred within the required timeframes,
- The practitioner who conducted the encounter, and
- The date of the encounter

The following non-physician practitioners may perform the face-to-face encounter:

A nurse practitioner, clinical nurse specialist, or certified nurse midwife working in collaboration with the ordering physician, or a physician assistant under the supervision of the ordering physician. Beneficiaries admitted to home health immediately after an acute or post-acute stay, the attending acute or post-acute physician may perform the face-to-face encounter. A certified nurse midwife may perform the face-to-face encounter for home health services.

## UPDATES FOR 3/22/2018

### 6.7 INDIVIDUAL CONSIDERATION/MANUAL PRICING

~~The rates on file for certain procedure codes do not have specific dollar amounts because no one amount is appropriate. In these cases, the rate on file is set at "IC" (individual consideration). The fiscal intermediary and the DVHA will calculate the allowed amount. This process is often called "manual pricing". For DME, see section [11.2 Payment DVHA Primary](#).~~

~~The following pricing documentation requirements apply to MSRP (Manufacturer's Suggested Retail Price) or Invoice:~~

- ~~• The MSRP sheet/invoice must be dated within 1 year from the date of service indicated on the claim.  
If the MSRP/invoice date exceeds one year  
the claim will be denied~~
- ~~• The item on the MSRP sheet/invoice must match the item that is being billed on the claim, and have the applicable procedure code written next to the item. If the procedure code is not listed the claim will be denied~~
- ~~• Please circle, star or underline the item on the MSRP sheet/invoice. If the item is highlighted, whited or blacked out the claim will be denied~~
- ~~• All discounts and totals must be clearly documented. If discounts/totals are whited or blacked out the claim will be denied~~
- ~~Documentation that states "Quote", "Remittance Advice", "Estimate", "Superbill", etc., and handwritten scripts or prescription papers, will result in claim denial. Exceptions are made for custom made items only, at the discretion of DVHA~~

### 11.2 PAYMENT DVHA PRIMARY

~~When the DVHA is the primary payer, payment amounts for DME (except augmentative communication devices and closed circuit TV purchased from the Vermont Association for the Blind and Visually Impaired - VABVI), orthotics, prosthetics and medical supplies will be calculated in the following manner:~~

- ~~1. When the rate on file is a specific dollar amount, the DVHA pays the lesser of the actual charge or the rate on file~~

- ~~2. If the rate on file is "IC" (Individual Consideration), and if there is a Manufacturer's Suggested Retail Price (MSRP) for the item, the DVHA pays the lesser of the actual charge or 85% of the MSRP for all items~~
- ~~3. If the rate on file is "IC", and if there is no MSRP, the DVHA pays the lesser of the actual charge or 1.67 times the invoice cost.~~

~~The commissioner may approve an exception to the methods, if the commissioner finds that payment for a particular item under the method in #2 or #3 is shown to cause a significant loss to the vendor. In such cases, the commissioner may approve payment at the lesser of the actual charge or the actual cost.~~

~~When the DVHA is the primary payer, payment amounts for augmentative communication devices will be calculated in the following manner:~~

- ~~• When the rate on file is a specific dollar amount, the DVHA pays the lesser of the actual charge or the rate on file~~
- ~~• If the rate on file is "IC" and if the seller is the manufacturer of the item, the DVHA pays the lesser of the actual charge or 85% of MSRP~~
- ~~• If the rate on file is "IC" for the item and if the seller is a distributor or retailer of the item, the DVHA pays the lesser of the actual charge or MSRP.~~
- ~~• When the DVHA is the primary payer, payment amounts for closed circuit TV devices purchased from the VABVI will be calculated in the following manner:~~
  - ~~• When the rate on file is a specific dollar amount, the DVHA pays the lesser of the actual charge or rate on file~~
  - ~~• If the rate on file is "IC", the DVHA pays the lesser of the actual charge or 1.67 times the invoice cost.~~

~~Vermont Medicaid is payer of last resort. The DVHA does not reimburse when a primary insurance has been billed incorrectly and/or has insufficient information/coding.~~

## 11.2 PAYMENT DVHA PRIMARY

When the DVHA is the primary payer, payment amounts for DME (including augmentative communication devices and closed-circuit TV purchased from the Vermont Association for the Blind and Visually Impaired- VABVI), orthotics, prosthetics and medical supplies will be calculated in the following manner:

The following pricing documentation requirements apply to MSRP (Manufacturer's Suggested Retail Price) or Invoice and must be billed on paper with the MSRP or invoice attachment:

- The option to submit either the MSRP or Invoice is allowed. The MSRP or invoice must be submitted in its entirety. If any information (including pages) are missing or lines are marked out or whited out the claim will be denied.
- All discounts and totals must be clearly documented and disclosed.
- The MSRP sheet or invoice must be dated within 1 year from the date of service indicated on the claim. If the MSRP or invoice date exceeds one year, the claim will be denied.



- The item(s) on the MSRP sheet or invoice must match the item(s) that are being billed on the claim. The applicable correct code must be written next to the item(s) on the MSRP or invoice. If the code for the item(s) are not documented on the MSRP or invoice the claim will be denied. Item(s) applicable to laterally must be clearly documented with the correct modifiers for right or left next to applicable code. This applies to both MSRP and invoice.
- Documentation that states "Quote", "Remittance Advice", "Estimate", "Superbill", etc., and handwritten scripts or prescription papers, will result in claim denial. Exceptions are made for custom made items only, at the discretion of the DVHA.

Vermont Medicaid is payer of last resort. The DVHA does not reimburse when a primary insurance has been billed incorrectly and/or has insufficient information/coding.

## UPDATES FOR 12/29/2017

### 1.2.5 Claim Copy Requests

When a member or an attorney for a member requests a copy of a claim which has been paid, please inform them that copies should be requested in writing from: DVHA - COB Unit, 342 Hurricane Lane, Suite 201 Williston, VT 05495. ~~280 State Drive, Waterbury, VT 05671.~~

### 7.7.1 Concurrent Review for Admissions at Vermont & In-Network Border Hospitals

The Inpatient Concurrent Review Procedures are available at <http://dvha.vermont.gov/providers/clinical-coverage-guidelines>.

~~All Vermont in-state hospitals and in-network border hospitals will be required to notify the Department of Vermont Health Access Clinical Unit of all inpatient stays at time of admission or by the next business day.~~ All Vermont hospitals, including in-network border hospitals, are not required to submit faxed daily census sheets to the Department of Vermont Health Access (DVHA) Clinical Operations Unit (COU). Please note: Continue to use the File Transfer Protocol (FTP) for submitting information as required by other DVHA programs. This requirement only applies when Medicaid is the primary payer. This requirement does not apply to Inpatient Rehabilitation stays, psychiatric unit and psychiatric hospital admissions. In addition, notification of patient discharge is required.

~~The admitting/discharging facility may fax admission notification in the form of a daily census sheet or a utilization face sheet. The following information must be supplied: date of admission, patient name, DOB, member Medicaid ID #, admitting diagnosis, admitting status and admitting provider.~~

Prior Authorization is required if the patient stay is to exceed 13 days. ~~The Admission Notification Form must be completed and submitted to the Clinical Unit to request authorization by day 13 of the inpatient stay.~~ The admitting facility must fax a completed Inpatient Concurrent Review Notification Form to the DVHA COU at (802) 879-5963 for all inpatient admissions that have an expected length of stay exceeding 13 days, including time in the emergency department and/or observation by day 13, but no earlier than day 10 of the admission. Failure to get a PA for an admission that exceeds 13 days will result in a denial of the claim. Forms are available at <http://dvha.vermont.gov/providers/forms-1>

~~Admission/discharge notifications, prior authorization requests and all required clinical information can be faxed to the Clinical Unit at (802) 879-5963.~~

Retrospective reviews will not be performed when DVHA is not notified of an admission by day 13, but no earlier than day 10 of the admission.



## UPDATES FOR 12/08/2017

### 8.12 Refunds

Check mailing address: DXC Technology, P.O. Box 1645 Williston, VT 05495

### 10.3.6 Audiological Services/Hearing Aids

- Prescriptions for hearing aid batteries – ~~twelve~~ six batteries per month (see below for further instruction);

#### Batteries

~~Two~~ One packages of 6 batteries is reimbursable per month when there is a written prescription from the physician. Prior authorization is not required. A completed *Medical Necessity Form* (MNF): Substantiating the medical need for the hearing aid must be kept on file for auditing purposes.

## UPDATES FOR 11/09/2017

### 12.4.11 Subacute Care

Swing bed hospitals should bill revenue code 16X on a separate claim from the acute care episodes (use appropriate discharge code) waiting for placement hospitals should bill revenue code 19X on the same claim as the acute care episodes.

Payment to hospitals for subacute care is made either for swing bed care or while a patient is waiting placement in a nursing facility. Vermont approved swing bed facilities are eligible for swing bed payments but not waiting placement payments.

The Vermont Medicaid benefit package includes short-term Nursing Facility services based on a physician's order with documentation of medical necessity limited to not more than 30 days per episode and 60 days per calendar year. As of November 1, 2014, individuals are not required to submit a Choices for Care application for short-term swing bed placements. For a stay greater than 30 days per episode or a cumulative stay greater than 60 days per calendar year, a Choices for Care Long-Term Care application is required.

~~Swing bed payments will be made only if the following conditions are met:~~

- ~~• The person must be found eligible for long term care Medicaid during the period for which payment is requested; and~~
- ~~• The person's income must be applied toward the cost of care, as determined by the district office.~~

Medicare part B must be billed for those services usually billable. On the Medicare B EOMB, write: "Member is not eligible for Medicare A, ancillary charges billed to Medicare B & Vermont Medicaid. Charges do not match. Medicare B and Vermont Medicaid payment combined in field locator 54." Sign and date the Medicare B EOMB.

The following hospitals have been approved to offer swing bed services:

Vermont: Northeastern VT Regional, North Country, Porter, Grace Cottage, Gifford, Mt Ascutney, Copley, Springfield.

New Hampshire: Upper CT Valley, Littleton, Valley Regional, Weeks

Hospitals not authorized to bill swing beds may bill for waiting placement for those days after it is determined that a patient no longer requires acute care. If the patient continues to be hospitalized

while awaiting placement in a nursing facility and no bed within the area is available, the hospital must be actively seeking placement. Payment is the same as a swing bed day.

## UPDATES FOR 10/26/17

### 10.3.53 Telemedicine

Telemedicine is defined in Act 64 as "...the delivery of health care services... through the use of live interactive audio and video over a secure connection that complies with the requirements the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191. Telemedicine does not include the use of audio-only telephone, e-mail, or facsimile." Act 64 is available at <http://legislature.vermont.gov/assets/Documents/2018/Docs/ACTS/ACT064/ACT064%20As%20Enacted.pdf>.

To bill Vermont Medicaid for clinically appropriate services delivered through telemedicine outside a health care facility or from facility to facility, the following requirements must be met:

#### Provider Eligibility Requirements:

- Must be a Medicaid-enrolled provider

~~Must be a Vermont licensed physician, naturopathic physician, an advanced practice registered nurse, or a physician assistant (Sec. 45. 33 V.S.A. § 1901(i))~~

~~Physicians must be Board Certified~~

~~Physician Assistants must have a supervising physician who is Board Certified~~

~~Advanced Practice Registered Nurse's (APRN's) must have their advanced degree in a primary care specialty~~

#### Billing Rules for Telemedicine:

- 1) All providers are required to follow correct coding rules, including application of modifiers, and only bill for services within their scope of practice that can be done via telemedicine
- 2) All claims with services billed for telemedicine must have POS 02
- 3) Providers delivering "live" telemedicine services via interactive audio and video must apply the GT modifier - CMS and/or Encoder Pro telemedicine codes excluding non-covered services
- 4) Originating facility site providers (patient site) ~~are required to document the reason the service is being provided by telemedicine rather than in person and~~ may be reimbursed a facility fee (Q3014)
  - a. Facility fees will not be reimbursed if the provider is employed by the same entity as the originating site.

\*DVHA will not reimburse for teleophthalmology or teledermatology by store and forward means.

## UPDATES FOR 09/28/17

### 10.3.53 Telemedicine ~~Outside a Facility~~ Services

Telemedicine is defined in Act 107 ~~64~~ as "...the delivery of health care services... through the use of live interactive audio and video over a secure connection that complies with the requirements the

Health Insurance Portability and Accountability Act of 1996, Public Law 104-191. Telemedicine does not include the use of audio-only telephone, e-mail, or facsimile.” Act 407 64 is available at <http://legislature.vermont.gov/assets/Documents/2018/Docs/ACTS/ACT064/ACT064%20As%20Enacted.pdf>. ~~<http://www.leg.state.vt.us/DOCS/2012/ACTS/ACT107.PDF>~~

~~In order to~~ To bill Vermont Medicaid for ~~primary care~~ clinically appropriate services delivered through telemedicine outside a health care facility and or from facility to facility, all of the following requirements must be met:

#### Provider Eligibility Requirements:

- Must be a Medicaid-enrolled provider
- Must be a Vermont licensed physician, naturopathic physician, an advanced practice registered nurse, or a physician assistant (Sec. 45. 33 V.S.A. § 1901(i))
- Physicians must be Board Certified
- Physician Assistants must have a supervising physician who is Board Certified
- Advanced Practice Registered Nurse’s (APRN’s) must have their advanced degree in a primary care specialty
- ~~Must complete the Telemedicine application at~~  
<http://www.vtmedicaid.com/assets/provEnroll/Telemedicine.pdf>

#### Billing Rules for Telemedicine:

- 1) ~~Distance site~~ All providers are required to follow correct coding rules, including application of modifiers, and only bill for services within their scope of practice that can be done via telemedicine
- 2) All claims with services billed for telemedicine must have POS 02
- 3) ~~Distance Site Providers are required to follow correct coding in the application of the GT modifier.~~ Providers delivering “live” telemedicine services via interactive audio and video must apply the GT modifier - CMS and/or Encoder Pro telemedicine codes excluding non-covered services
- 4) Originating facility site providers (patient site) are required to document the reason the service is being provided by telemedicine rather than in person and may be reimbursed a facility fee (Q3014)
  - a. Facility fees will not be reimbursed if the provider is employed by the same entity as the originating site.

\*DVHA will not reimburse for teleophthalmology or teledermatology by store and forward means.

#### UPDATES FOR 08/24/17

##### 10.1 Payment DVHA Primary

~~Nurse Practitioner - Reimbursement basis is the lower of the provider’s charge or the Vermont Medicaid rate on file for a physician providing the same service.~~ Reimbursement basis is the lower of the provider’s charge or ninety percent (90%) of the Vermont Medicaid rate on file for a physician providing the same service. The unit of service is the procedure.

##### 11.3 Payment Dual Eligible/ Medicare Primary

When Medicare is the primary payer, the provider must accept assignment of the claim (~~except as noted below~~) in order to receive any DVHA payment. This applies to all claims for services and items. See **Section 6.6 Medicaid & Medicare Crossover**.

If the claim is submitted to Medicare on an assigned basis, when the DVHA receives the crossover claim, it will pay the coinsurance and deductible amounts due.

In order to assure access, the DVHA has created five exceptions to the above procedure. ~~its requirement that claims for dual eligible individuals are to be submitted to Medicare on an assigned basis~~ The exceptions are limited to claims for:

- ☐ Wheelchairs
- ☐ Seating systems
- ☐ Cushions that are part of a seating system
- ☐ Seat lifts, and
- ☐ Repairs to wheelchairs for which Medicare did not participate.

For these items, a provider may submit a prior authorization request to the DVHA asking for a medical necessity determination and **provisional [or conditional] authorization for Medicaid coverage**. ~~waiver of the requirement to bill on an assigned basis.~~ When a provider submits a request for prior authorization of a wheelchair, seating system, cushions that are part of a seating system or seat lift for a dually eligible member, the DVHA will review the request for medical necessity and **for** sufficient information to support pricing. If the DVHA determines that the request is medically necessary, it will **provisionally [conditionally]** approve the request. **The claim must then be submitted to Medicare.** ~~enter a Medicaid allowed amount into the system and over-ride the Medicare assignment requirement. If the provider bills Medicare for the requested item on an unassigned basis, when the provider submits to the DVHA evidence of the Medicare payment or denial.~~

**If Medicare approves**, the DVHA will pay the difference between the Medicare paid amount and the Vermont Medicaid allowed amount.

**If Medicare denies**, the DME provider must submit proof of denial including the explanation of benefits (EOB) information. **Then, Medicaid will review the request and, if approved, will pay the Vermont Medicaid allowed amount.**

In addition, when the primary wheelchair is found by the DVHA to need repair, modification, and/or battery replacement; and Medicare denied or downgraded the purchase of the primary chair; or the DVHA determines that Medicare is unlikely to accept new documentation of medical necessity for the primary chair; the DVHA may approve ~~an over-ride of the assignment requirement~~ **the request with a prior authorization with specific wording that these items** ~~Approved repairs and modifications under this exception~~ may be billed directly to Vermont Medicaid.

To assure access, the DVHA will consider creating additional exceptions for items of DME which cost over \$100.00. Any request to add a service or item to the list (of exceptions for access reasons) must demonstrate to the satisfaction of the commissioner of the DVHA that the item is inaccessible statewide due to the Medicare payment level.

## UPDATES FOR 06/22/2017

### 10.3.3 Anesthesia

#### Spinal Injection/Nerve Block

Nerve blocks performed concurrent with surgery or on the same date of service as surgery are reimbursed as part of the surgical code payment and are not to be billed separately.

When a spinal injection or nerve block (~~e.g. procedure codes in the 622 and 644 series~~) is performed as an independent procedure for diagnostic or therapeutic reasons (not concurrent with

surgery), and the code is covered by Medicaid, it is billed as the surgical procedure. The physician, regardless of specialty (e.g. anesthesiologist, surgeon, etc.) must bill on a CMS 1500 claim form using the specific procedure code for the type of nerve block performed. A unit of service is not time expended: one nerve block equals one unit of service. Please refer to the Fee Schedule for covered codes.

## UPDATES FOR 06/12/2017

### 10.3.467 Psychiatry/Psychology

- If no E/M services are provided, use the appropriate psychotherapy code (90832, 90834, 90837)
- Psychotherapy with E/M is now reported by selecting the appropriate E/M service code and the appropriate psychotherapy add-on code.
- The E/M code is selected on the basis of the site of service and the key elements performed.
- The psychotherapy add-on code is selected on the basis of the time spent providing psychotherapy and does not include any of the time spent providing E/M services

Prescribing health care professionals, conducting pharmacologic management, will now use the appropriate E/M code. When psychotherapy is done during the same session as the pharmacologic management, one of the new psychotherapy codes should be used along with the E/M code. The psychiatrist or other qualified health care professional will specify the level of E/M work done and add the psychotherapy component based on the time spent delivering psychotherapy.

- Vermont licensure for CPs (Clinical Psychologists) is limited to the provider's scope of practice which does not include prescription and medication management
- Providers that are approved to bill E/M series codes are to report this service using the appropriate E/M series code

Enrolled provider types for Psychiatry and Psychology are:

- Licensed Clinical Social Worker (LCSW)
- Licensed Mental Health Counselor (LMHC)
- Licensed Marriage & Family Therapist (LMFT)
- Nurse Practitioner – Psychiatric
- Physician – Psychiatric
- Psychologist – Doctorate Level
- Psychologist – Masters Level

- a. For claims submitted to Medicaid, the following pricing modifiers must be used:

AH	Licensed Clinical Psychologist
AJ	Licensed Clinical Social Worker
HQ	Master's Degree Level Providers.

- b. **For Designated Agencies, Specialized Service Agencies, and ADAP Preferred Providers Only:** For claims submitted to DMH or ADAP fund sources, the modifiers in the above table are not required.

~~Vermont Medicaid is continuing to require the use of modifier AJ and AH. As of 01/01/2013, modifier AJ is reimbursed at 76% of allowed amount and effective 07/01/2015 modifier AH at 93% of allowed amount.~~

#### 10.3.47 Psychiatry/Psychology

- If no E/M services are provided, use the appropriate psychotherapy code (90832, 90834, 90837)
- Psychotherapy with E/M is now reported by selecting the appropriate E/M service code and the appropriate psychotherapy add-on code.
- The E/M code is selected on the basis of the site of service and the key elements performed.
- The psychotherapy add-on code is selected on the basis of the time spent providing psychotherapy and does not include any of the time spent providing E/M services

Prescribing health care professionals, conducting pharmacologic management, will now use the appropriate E/M code. When psychotherapy is done during the same session as the pharmacologic management, one of the new psychotherapy codes should be used along with the E/M code. The psychiatrist or other qualified health care professional will specify the level of E/M work done and add the psychotherapy component based on the time spent delivering psychotherapy.

- Vermont licensure for CPs (Clinical Psychologists) is limited to the provider's scope of practice which does not include prescription and medication management
- Providers that are approved to bill E/M series codes are to report this service using the appropriate E/M series code
- Vermont Medicaid enrolls the following provider types for Mental Health service. Proper use of the below modifiers is required to assure accurate reimbursement. Failure to use the correct modifier for license type may result in post payment review of your claims
- Vermont Medicaid is continuing to require the use of modifier AJ and AH. Modifier AJ is reimbursed at 76% of allowed amount modifier AH at 93% of allowed amount
- *Designated Agencies, Specialized Service Agencies and ADAP Preferred provider are not required to use the modifiers from the below table.*

Provider Type	License	Modifier Required
Psychologist -Doctorate Level	Psychologist Doctorate	AH - Clinical Psychologist
Psychologist -Masters Level	Psychologist – Master	AJ - Clinical Social Worker
Licensed Mental Health Counselor	LMHC	AJ - Clinical Social Worker
Licensed Clinical Social Worker	LCSW	AJ - Clinical Social Worker
Licensed Marriage & Family Therapist	LMFT	AJ - Clinical Social Worker
Licensed Drug and Alcohol Counselor	LADC	AJ - Clinical Social Worker
Physician –Psychiatric	Physician	No Mental Health Modifier Required
Nurse Practitioner -Psychiatric	Advanced Practice Registered Nurse	No Mental Health Modifier Required

#### 11.11.19 TENS/~~MNES~~ NMES

TENS and ~~MNES~~ NMES units must have a trial period of up to three months to determine effectiveness for the member. Purchase is to be considered only when the continuing medical need is documented and benefit is proven. Documentation by the physical therapist and/or physician must indicate the length of the trial period and the reasoning to support the effectiveness for each individual member.

The DVHA provides forms and tools to facilitate the prior authorization process. These forms and tools are found at: <http://dvha.vermont.gov/for-providers/clinical-coverage-guidelines>. Use of these designated forms/tools will ensure that all required information is available for review by the DVHA Clinical Unit.

#### 10.3.27 Immunizations

State supplied vaccines must be billed with modifier SL. When a vaccine is State supplied and billed with SL modifier, billed amount can be either \$0.00 or \$0.01. Reimbursement amount will be \$0.00

All vaccines and administrations for service provided on the same day, must be billed on one claim. Codes for vaccine administrations must be rolled up and billed on one line with the appropriate number of units. Number of units will depend on number of vaccines and components given.

If a claim where a billed immunization service is partially paid and partially denied, and either the vaccine or the administration services must be re-billed, the paid part of the claim must be recouped, and the whole claim must be rebilled at once. Otherwise, the partial new claim will be denied.

#### Immunization Administration Codes

There are several immunization administration codes, depending on age of the patient, whether counseling has been provided or not, and depending on route of administration. There are also codes for the first vaccine component and for each additional vaccine component. When more than one vaccine is administered at the same visit, it is imperative that number of immunization administration units matches the number of vaccine components given.

#### Administration Coding Example:

A 1-year old boy presents for a preventive visit (99382). In addition, the child's father is counseled by the physician on risks and benefits of the Pneumococcal (90670), MMR (90707) and Hemophilus influenza (90648) vaccines. The father signs consent to administration of these vaccines. A nurse prepares and administers each vaccine, completes chart documentation and vaccine registry entries, and verifies there is no immediate adverse reaction.

- 99382 - Preventative visit, age 1 through 4
- 90670 - Pneumococcal vaccine
- 90460 - Administration first component (1 unit)
- 90707 - Measles, mumps, and rubella (MMR) vaccine
- 90460 - Administration first component (1 unit)
- 90461 - Each additional component (1 unit)



- 90461 - Each additional component (1 unit)
- 90648 - Heamophilus influenza vaccine
- 90460 - Administration first component (1 unit)

Dates of service		Place		Type	Procedures, Services or Supplies	Diagnosis	\$ Charges	Daysepsdt	EMG	COB		
From	To	of	of	CPT/HCPCS	Modifier	Code		Units	fampl	reserved		
07 09	16 07 06 16 11	1.From	To	Place								
					99382	EP 25			A	150.00	1	1234567893
07 09	16 07 09 16 11	1.From	To	Place								
					90460				B	60.00	3	1234567893
07 09	16 07 09 16 11	1.From	To	Place								
					90461				B	40.00	2	1234567893
07 09	16 07 09 16 11	1.From	To	Place								
					90670	SL			B	00.1	1	1234567893
07 09	16 07 09 16 11	1.From	To	Place								
					90707	SL			B	00.1	1	
07 09	16 07 09 16 11	1.From	To	Place								
					90648	SL			B	00.1	1	
							Total Charge	Amount Paid	Balance Due			

When billing Vermont Medicaid program claims, you MUST use the billing method as explained here.

### 1.2.7 Provider Administrative Review Reconsideration Process

The Department of Vermont Health Access (DVHA) allows an enrolled provider a process for requesting a review of certain claims payments. DVHA's position is that providing a "second look" for certain decisions may help improve accuracy. DVHA will review a decision for the following:

- Timely filing denial
  - Prior Authorization (PA) denial: (1) PA disapproval by the DVHA or its agents (other than medical necessity determinations); (2) PA decisions about the "immediate need" for durable medical equipment; (3) PA disapproval because documentation was inadequate
  - Error in manual pricing (i.e. claim did not process according to fee schedule)
  - Purchase versus rental decisions for durable medical equipment
  - Improper payments or non payments—objections regarding fee schedules
- A request for review must be made no later than 30 calendar days after the DVHA gives written notice to the provider of its decision. Requests after 30 days will be returned with no action taken. The request for review must be filed on The Provider Administration Review Request Form at: <http://dvha.vermont.gov/for-providers/forms-1>.
  - For timely filing, providers must fully research and document in the request the extenuating circumstances surrounding the claim (e.g. submission dates, adjusted dates, and denial dates). Providers submitting a timely filing review request that contains 10 or more claims, all with the same late submission reason, are required to complete and submit the Timely Filing Review Claims List for 10 or more claims form located at: <http://www.vtmedicaid.com/#/forms>
  - All issues regarding providers' objection to the findings must be documented and no monetary threshold is applied. The review request should provide a brief background of the case, and the reasons why the provider believes the DVHA should have ruled differently.
  - Review requests will be reviewed by a qualified member of the DVHA. Upon receipt of the request and supporting information, the DVHA will review all information received. The DVHA



~~may consider additional information, either verbal or written, from the provider or others, in order to further clarify the case.~~

~~E. The qualified DVHA reviewer will issue a written decision to the provider of its review decision or notify the provider that an extension is needed within 30 calendar days of receipt of the request for review.~~

~~F. There is no additional review or reconsideration after the written decision on the review.~~

~~All requests for review must be addressed to:~~

~~DXC Technology  
Administrative Review  
PO Box 888  
Williston VT 05495~~

The Department of Vermont Health Access (DVHA) allows an enrolled provider a process for requesting a review of certain claims payments. DVHA's position is that providing a "second look" for certain decisions may help improve accuracy. DVHA will review a decision for the following:

- **Timely filing denial (refer to section 8.2.1 on Timely Filing Reconsideration Requests requirements)**
  - Improper payments or non-payments
  - Coding errors
- A. A request for review must be made no later than 30 calendar days after the DVHA gives notice to the provider of its decision. Requests after 30 days will be returned with no action taken.  
The request for review must be filed on the Reconsideration Request form (located at <http://www.vtmedicaid.com/#/forms>)
- B. All issues regarding providers' objection to the findings must be documented. The request should provide a brief background of the case, and the reasons why the provider believes the DVHA should have ruled differently.
- C. Requests will be reviewed by a qualified member of the DVHA when all information related to the claim is submitted. Upon receipt of the request and all supporting information, the DVHA will review all information received. The DVHA may consider additional information, either verbal or written, from the provider or others, to further clarify the case.
- D. The qualified DVHA reviewer will issue a written decision to the provider of its review decision or notify the provider that an extension is needed within 30 calendar days of receipt of the request for review.
- E. There is no additional review or reconsideration after the written decision on the review. This decision is final.

All requests for review must be addressed to:

DXC Technology  
Administrative Review  
PO Box 888  
Williston VT 05495

### 8.2.1 Timely Filing Reconsideration Requests

The Department of Vermont Health Access will consider paying an untimely claim in unusual circumstances if request is made within 30 days from DVHA's written notice.

For timely filing reconsideration requests, providers must fully research and document in the request the extenuating circumstances surrounding the claim (e.g. submission dates, adjusted dates, and denial dates). Providers submitting a timely filing reconsideration request for a single claim should use the “Timely Filing Reconsideration Form – Single Claim”. For reconsideration requests that contain more than one claim, providers should use the “Timely Filing Reconsideration Form – Multiple Claims”. Both forms are located at <http://www.vtmedicaid.com/#/forms>. Completion instructions are included in the form. If there is no documentation or the documentation is insufficient to validate extenuating circumstances for the late submission, your appeal will be denied.

All Timely Filing Reconsideration Requests should be mailed to:

DXC Technology  
Attn: Timely Filing  
PO Box 888  
Williston, VT 05495

## Section 7 Prior Authorization of Medical Services

~~Prior authorization (PA) is a process used to assure the appropriate use of health care services. The goal of PA is to assure that the proposed health service, item or procedure meets the medical necessity criteria; that all appropriate, less expensive alternatives have been given consideration; and the proposed service conforms to generally accepted practice parameters recognized by health care providers in the same or similar general specialty who typically treat or manage the diagnosis or condition. It involves a request for approval of each health service that is designated as requiring prior approval before the service is rendered. Authorization will not be granted after the service is rendered unless an exception applies, see section 7.3 Exceptions.~~

### 7.1 — PRIOR AUTHORIZATION REVIEWERS

~~All drugs and supplies requiring prior authorization can be identified on the Preferred Drug List (PDL) which can be found at <http://ovha.vermont.gov/for-providers/preferred-drug-list-clinical-criteria>.~~

~~Prescription drugs are reviewed by the pharmacy benefit manager Goold Health Systems. Pharmacy information is located at <http://dvha.vermont.gov/for-providers/pharmacy>.~~

~~Some DME items are subject to quantity limits that can be extended with Prior Authorization (PA). A listing of the codes that have quantity limits and what these limits are, is located in the DME Fee Schedule at <http://dvha.vermont.gov/for-providers/claims-processing-1>.~~

~~Select outpatient elective diagnostic imaging procedures require prior authorization; please see the Diagnostic Imaging Program Guidelines & list of radiology CPT codes requiring prior authorization located at~~

~~<http://www.vtmedicaid.com///resources>.~~

Contact numbers for the reviewers:

DVHA Clinical Unit (802) 879-5903  
Fax (802) 879-5963  
Dental (802) 879-5903  
VDH MH (802) 241-2604  
Pharmacy, Point of Sale  
Goold Health Systems Clinical Call Center (844) 679-5363, 7:30am–6:30pm, M-F  
8:00am–2:00pm, Sat.  
Goold Health Systems Fax (844) 679-5366, after hours on call 24/7  
365 day/year  
Elective Diagnostic Outpatient High Tech Imaging  
MedSolutions Customer Service (888) 693-3211, 8am to 9 pm, M-F  
MedSolutions Fax (888)693-3210  
Internet PA Requests <http://www.medsolutionsonline.com>

Fax forms can be obtained at <http://www.medsolutionsonline.com> or by calling MedSolutions Customer Service (888) 693-3211, 8a.m. to 9 p.m., M-F. Diagnostic Imaging Program Guidelines and a complete list of CPT codes requiring prior authorization can be accessed at <http://www.vtmedicaid.com/#!/resources>

## 7.2 PROCEDURES & REQUIREMENTS

### 7.2.1 Clinical Practice Guidelines

The Department of Vermont Health Access has adopted various Clinical Practice Guidelines that are based upon evidence based medicine. These guidelines outline the preferred approach for most patients and are used to support the decision making processes. The guidelines can be found <http://dvha.vermont.gov/for-providers/clinical-coverage-guidelines>

### 7.2.2 Date of Service

Unless otherwise indicated in a manual, the date of service is the actual date that the service was provided, or the item was delivered to the member. If the date of service is a range of dates, e.g. an inpatient stay, PA must be secured before the first day of service.

### 7.2.3 Prior Authorization Requirements

The DVHA PA criteria and regulations can be found in Medicaid Rule 7102. These rules and procedures govern PAs performed by the DVHA and its agents. DVHA rules are available online at <http://dvha.vermont.gov/budget-legislative>.

Prior Authorization (PA) is necessary if our eligibility system indicates that there is no other insurance coverage for the service or item. The DVHA PA requirements apply when the DVHA is known to be the primary payer for the service or item.

If a beneficiary's primary insurance (insurance that is not Medicaid) approves, no Prior Authorization is necessary and Vermont Medicaid will pay the difference up to our allowable amount for accepted codes.

The DVHA Clinical Operations Unit enters prior authorizations with the exact procedure code(s) given by the requesting provider on the request form. In those instances when the procedure code to be billed does not exactly match the code requested/authorized, the provider must notify the Clinical Unit in writing prior to claim submission. Include the DVHA prior authorization number, the rationale for the code change and signature. Fax information to (802) 879-5963.

All unlisted procedure codes (including urgent or emergent) require authorization from the DVHA Clinical Unit prior to the service being rendered.

If it is determined during a surgical procedure that an unlisted procedure is appropriate and medically necessary, prior authorization must be requested prior to claim submission.

Notes must be attached with the claim indicating the usual and customary charge for the service. Fax information to (802) 879-5963.

#### 7.2.4 Required Documentation

At a minimum, the documentation required to support a PA request includes a completed and legible copy of a medical necessity form, or other appropriate documentation, with the prescribing provider's signature, and all documents necessary for identification and pricing of the service requested. Providers need to keep the original or a legible copy of the medical necessity form on file in the patient's record. It is not necessary to submit a completed claim form with a PA request. The outside envelope or fax cover sheet should be clearly marked as a PA Request. If a request for PA is denied and a provider has questions or needs additional information, contact the DVHA Clinical Unit.

#### 7.2.5 Review of Records

Not with standing any other review, the State reserves the right to review medical records at any time and without advance notice.

### 7.3 EXCEPTIONS

Medicaid Rule 7102 allows two general exceptions to securing authorization prior to the date of service. Other specific exceptions for PA have been added as needed, see the two sections below for further details.

Under federal law, PA is not required to dispense a 72-hour supply of a covered drug in an emergency situation.

#### 7.3.1 General Exceptions

**Emergency Services:** Services normally requiring PA do not require PA when treating an emergency condition.

This exception applies to both the emergency care and the post-emergency stabilization. Post-emergency stabilization care will be provided until the attending emergency physician determines that the patient is sufficiently stabilized for transfer or discharge.

~~Retroactive Eligibility: Covered services that normally require PA, which are provided to an individual in the retroactive period (defined as eligibility start date to eligibility segment update date), do not require PA.~~

### ~~7.3.2 Immediate Need Exception~~

~~1. Authorization in advance does not have to occur if the service or item is rendered for urgently needed care as defined below and if the urgent care is required outside of normal DVHA business hours. If a request for authorization is shown to be for urgently needed care, and if the request for authorization is made on the next business day, the request will be considered timely. Payment for such services or items will further depend on a determination that they are medically necessary. If any such item is not considered medically necessary, the DVHA will provide normal reimbursement for a reasonable quantity of consumable items actually provided and/or the DVHA will provide normal reimbursement for the rental of such items in the minimum allowable period for the service.~~

~~2. Authorization in advance does not have to occur if the service or item is rendered for immediately needed care as defined below. However, the request for PA must be faxed to the DVHA Clinical Unit by the next business day. Following the notification, the provider should submit documentation of medical necessity and evidence that the care or item was immediately needed. This may take the form of an order or a discharge plan. Payment for such services or items will further depend on a determination that the service(s) are medically necessary. If any such item is not considered medically necessary, the DVHA will provide normal reimbursement for a reasonable quantity of consumable items actually provided and/or the DVHA will provide normal reimbursement for the rental of such items in thirty-day increments.~~

#### ~~Definitions:~~

~~1. "Emergency medical condition" means the sudden and, at the time, unexpected onset of an illness or medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by the prudent layperson who possess an average knowledge of health and medicine, to result in:~~

- ~~• Placing the member's physical or mental health in serious jeopardy; or~~
- ~~• serious impairment to bodily functions; or~~
- ~~• serious dysfunction of any bodily organ or part.~~

~~2. "Post Emergency Stabilization" is the care required after an emergency to stabilize the patient for transfer or discharge. The attending emergency physician determines when a patient has been sufficiently stabilized for transfer or discharge. Post-emergency stabilization care is covered 24 hours per day, 7 days per week as necessary to stabilize a patient after an emergency.~~

~~3. "Urgently needed care" or "urgent care" means those health care services that are necessary to treat a condition or illness of an individual that if not treated within twenty-four (24) hours presents a serious risk of harm.~~

~~4. "Immediately needed" means that action is needed on the same day to avoid delay in discharge or to allow the member to remain in a community setting.~~

~~These definitions are consistent with both Medicaid rules and those of the Vermont Department of Banking, Insurance, Securities and Health Care Administration.~~

## 7.4 — DETERMINATION TIME

Under Medicaid Rule 7102.4, the DVHA is obligated to make its review determinations within three working days of obtaining all necessary information. However, the longest wait time for a decision is 28 days. A request must be decided within 14 days of receipt. That time frame may be extended up to another 14 days if the member or provider requests an extension or if the extension is needed to obtain additional information and is in the member's best interest. A notice of decision will be issued within 28 days of receiving the initial PA request even if all necessary information has not been received. Written confirmation will be sent within 24 hours. Under federal law, the department is obligated to provide a response within 24 hours of a request for PA of a drug.

### 7.4.1 Payment Decision Review Process

The DVHA will conduct an internal review of the following types of DVHA decisions directly affecting providers in response to requests by providers:

1. — PA disapproval by the DVHA or its agents (other than medical necessity determinations);
2. — PA decisions about the "immediate need" for durable medical equipment;
3. — PA disapproval because documentation was inadequate;
4. — Error in manual pricing;
5. — Purchase versus rental decisions for durable medical equipment.

The DVHA will not review any decision other than those listed above.

Although this process is not an appeals process, the DVHA's position that providing a "second look" for certain decisions may help improve accuracy. Any affected provider may ask that the DVHA reconsider its decision. Such a request for reconsideration must be made no later than 21 calendar days after the DVHA gives written notice to the provider of its decision. The reconsideration request should provide a brief background of the case, and the reasons why the provider believes the DVHA should have found differently. The DVHA will base its reconsideration on the materials submitted by the provider in support of its reconsideration request and any additional information provided by the DVHA. It is expected that the request will contain all supporting documents. Supplemental information submitted after the reconsideration request is made, even if before decision, will not be considered by the DVHA except when the DVHA determines that extraordinary circumstances exist.

Upon receipt of the request and supporting information, the DVHA will review all information received. The DVHA may consider additional information, either verbal or written, from the provider or others, in order to further clarify the case. The Director of the DVHA, or a designee, will issue a written decision. The DVHA will notify the provider of its reconsideration decision within 30 calendar days of receipt of notice of the request for reconsideration by the provider or notify the provider that an extension is needed. There is no additional review or reconsideration after the DVHA Director or the designee has made a decision on reconsideration.

All requests for reconsideration must be addressed to:

Director, Department of Vermont Health Access

312 Hurricane Lane, Suite 201

## 7.5 — MEDICAL NECESSITY

~~Vermont Medicaid only pays for items that are medically necessary. Per the Medicaid Rule, 7103, medically necessary is defined as health care services that are appropriate, in terms of type, amount, frequency, level, setting and duration to the member's diagnosis or condition. Medically necessary care must be consistent with generally accepted practice parameters as recognized by health care providers in the same or similar general specialty as typically treat or manage the diagnosis or condition and~~

- ~~• Help restore or maintain the member's health OR~~
- ~~• Prevent deterioration or palliate the member's condition OR~~
- ~~• Prevent the reasonably likely onset of a health problem or detect an incipient problem~~

~~Additionally, for EPSDT-eligible members, medically necessary includes a determination that a service is needed to achieve proper growth and development or prevent the onset or worsening of a health condition.~~

### 7.5.1 Medical Necessity Form (MNF)

~~A completed DVHA Medical Necessity Form (DVHA 60) is the preferred documentation for Home Respiratory Therapy programs, DME and certain prescribed medical supply items with a few exceptions. The ordering physician or nurse practitioner needs to complete the MNF and give a clean copy to the patient or to the DME supplier.~~

~~Submission of the form and any necessary information to clearly document medical need is all that is needed to make the request for prior authorization.~~

~~If the code/service requires prior authorization, the DME supplier will send the MNF and all pertinent information to the DVHA as a PA request.~~

~~Both the ordering physician/nurse practitioner and the DME vendor are required to keep legible copies of all information in the patient record.~~

~~The signature date on the MNF/order must be within 6 months (before or after) of the dispensing date (billed DOS) for all items except ostomy and urologic supplies. (The order on these supplies is good for one year).~~

~~The DVHA MNFs are Form DVHA 286 and DVHA 60. Other medical necessity forms are acceptable as long as the following information is provided:~~

- ~~• Member name~~
- ~~• Member date of birth~~
- ~~• Member Vermont Medicaid ID number (MID)~~
- ~~• Diagnosis code(s) or description or full description of medical condition~~
- ~~• Where equipment/item will be used (home or other; if other, name of facility)~~
- ~~• Length of time it will be used~~

- ~~\_\_\_\_\_ Legible name of ordering provider (physician, nurse practitioner, or other allowable practitioner)~~
- ~~\_\_\_\_\_ Signature and provider number of ordering provider (physician, nurse practitioner or other allowable practitioner) excluding chiropractors and physicians assistants~~
- ~~\_\_\_\_\_ Date that ordering provider reviewed and signed the MNF. The signature date must be within 6 months (before or after) of the dispensing date (billed DOS) for all items except ostomy and urologic supplies. (The order on these supplies is good for one year).~~

~~Medical Necessity and prior authorization forms are available at <http://dvha.vermont.gov/for-providers/forms-1>.~~

## ~~7.6 — UTILIZATION REVIEW~~

~~The DVHA conducts numerous utilization management and review activities. Reviews are intended to assure that quality services are provided to members and that providers are using the program properly. The reviews are generally an examination of records, known as a desk audit, although they may also include an on-site visit from the utilization review unit.~~

~~DVHA staff utilizes clinical criteria for making Utilization Review (UR) decisions that are objective and based on sound medical evidence. Approved criteria include the following:~~

- ~~\_\_\_\_\_ McKesson Health Solutions InterQual® Guidelines~~
- ~~\_\_\_\_\_ DVHA Clinical Guidelines~~
- ~~\_\_\_\_\_ Vermont State Medicaid Rules~~
- ~~\_\_\_\_\_ Hayes and Cochrane New Technology Assessments~~
- ~~\_\_\_\_\_ Other Nationally Recognized Evidence Based Criteria~~

~~McKesson Health Solutions InterQual® Guidelines are now available to providers behind the Vermont Medicaid secure provider web portal at <http://www.vtmedicaid.com/#!/>, navigate to the Transactions menu and choose the appropriate login (Trading Partners use “Login”, Web Services use “Login – UAT”).~~

~~DVHA Clinical Guidelines and Vermont Medicaid State Rules will continue to be available at the DVHA website at <http://dvha.vermont.gov/for-providers/clinical-coverage-guidelines>.~~

## ~~7.7 — PRIOR AUTHORIZATION NOTICE OF DECISION~~

~~The Notice of Decision is a system-generated form that the requesting provider receives from the DVHA or DXC in response to a Prior Authorization (PA) request. Copies of this form are sent to the member; see Spend Down.~~

~~The Notice of Decision contains the following information:~~



- ~~Box 2: The value will be either “A” (approved) or “D” (denied) or “I” (awaiting further information)~~
- ~~Box 3: The dates of service~~
- ~~Box 4: The procedure code~~
- ~~Box 5: The number of units and/or occurrences~~

~~Per Medicaid Rule 7102.3, there are two exceptions to prior authorization requirements:~~

- ~~1. Emergency Services~~
- ~~2. Services that occurred during the Retroactive Eligibility segment~~

~~Therefore, a Notice of Decision (NOD) is not required for Prior Authorization if the service is provided in the ‘retroactive period’ defined as eligibility start date to eligibility segment update date.~~

## ~~7.8 SERVICES REQUIRING PRIOR AUTHORIZATION~~

### ~~7.8.1 Concurrent Review for Admissions at Vermont & In-Network Border Hospitals~~

~~The Inpatient Concurrent Review Procedures are available at <http://dvha.vermont.gov/for-providers/clinical-coverage-guidelines>~~

~~All Vermont hospitals, including in-network border hospitals, are not required to submit faxed daily census sheets to the Department of Vermont Health Access (DVHA) Clinical Operations Unit (COU). Please note: Continue to use the File Transfer Protocol (FTP) for submitting information as required by other DVHA programs. This requirement only applies when Medicaid is the primary payer. This requirement does not apply to Inpatient Rehabilitation stays, psychiatric unit and psychiatric hospital admissions. In addition, notification of patient discharge is required.~~

~~Prior Authorization is required if the patient stay is to exceed 13 days. The admitting facility must fax a completed Inpatient Concurrent Review Notification Form to the DVHA COU at (802) 879-5963 for all inpatient admissions that have an expected length of stay exceeding 13 days, including time in the emergency department and/or observation by day 13, but no earlier than day 10 of the admission. Failure to get a PA for an admission that exceeds 13 days will result in a denial of the claim. Forms are available at <http://dvha.vermont.gov/for-providers/forms-1>~~

~~Retrospective reviews will not be performed when DVHA is not notified of an admission by day 13, but no earlier than day 10 of the admission.~~

### ~~7.8.2 Out of State Elective Inpatient Hospital Admissions~~

~~(Excluding Designated Border Hospitals)~~

~~All elective inpatient admissions to out-of-state hospitals require prior authorization from the DVHA Clinical Unit prior to admission. The admitting facility must fax a completed Vermont Medicaid Out of State Preadmission Form located at <http://dvha.vermont.gov/for-providers/clinical-coverage-guidelines>, clinical documentation and an explanation as to why this care cannot be performed within the State of Vermont to (802) 879-5963. The prior authorization must be requested as early as possible and no less than 3 business days prior to the planned admission.~~

### ~~7.8.3 Out of Network Elective Outpatient Referrals~~

~~Prior authorization is required for referrals to out-of-state/out-of-network medical visits that are elective/non-emergency, for codes 99201-99215; 99241-99245; 99341-99360 and 99381-99456; however, PA is not required for referrals for office visits to:~~

- ~~• Providers affiliated with Extended network hospitals~~
- ~~• Providers affiliated with Out of state In network hospitals~~

~~All other PA requirements will apply. A list of Green Mountain Care in-network and extended network hospitals is available at <http://dvha.vermont.gov/for-providers/green-mountain-care-network>.~~

~~Referring providers must submit requests using the OOS Medical Office Request Form located at <http://dvha.vermont.gov/for-providers/clinical-coverage-guidelines>. Fax all requests to the DVHA Clinical Unit, 802-879-5963.~~

~~Note: Only office visit(s) are being approved. Do not proceed with any non-emergent outpatient procedure until you have first determined and documented that the service cannot be performed by an in-network provider.~~

### ~~7.8.4 In-State & Out of State Psychiatric & Detoxification Inpatient Services~~

~~The Department of Vermont Health Access (DVHA) in collaboration with the Department of Mental Health (DMH) requires concurrent review for psychiatric and detoxification inpatient admissions. This includes all children and adults, including those enrolled in CRT. Admitting facilities must complete the Vermont Medicaid Admission Notification form for Inpatient Psychiatric and Detoxification Services and fax it to the DVHA at 1-855-275-1212 within 24 hours of an urgent or emergent admission. Elective or planned admissions will require prior authorization by the DVHA. The admitting facility must fax a completed Vermont Medicaid Prior Authorization form to 1-855-275-1212. Forms are available at: <http://dvha.vermont.gov/for-providers/clinical-prior-authorization-forms>. For additional information please see the Vermont Medicaid Inpatient Psychiatric & Detoxification Manual available at: <http://dvha.vermont.gov/for-providers/mental-health-inpatient-detox>.~~

### ~~7.8.5 Out of State Urgent/Emergent Inpatient Hospital Admissions~~

~~(Excluding Designated Out of State Network Hospitals)~~

~~All urgent and emergent inpatient admissions to out-of-state (OOS) hospitals require notification to the DVHA Clinical Unit of the admission within 24 hours or the next business day. Concurrent review will begin at the time of notification and throughout the course of the inpatient hospital stay. The admitting hospital must fax a completed Out Of State Urgent and Emergent Hospital Admissions form located at <http://dvha.vermont.gov/for-providers/clinical-coverage-guidelines> and clinical documentation to the DVHA at (802) 879-5963.~~

~~The hospital is required to notify the DVHA upon patient discharge.~~

### ~~7.8.6 Rehabilitative Therapy~~

Speech-Language Pathology (SLP) providers may enroll as private practitioners with Vermont Medicaid. Coverage of private practice SLP services are limited to those services provided outside of the school or hospital systems for Medicaid members of any age.

The following statements apply to all therapy services:

- Medicaid does not cover any treatments or any portions of a treatment, when the efficacy and/or safety of that treatment is not sufficiently supported in current, peer reviewed medical literature.
- All treatment must demonstrate medical necessity.
- Per National Correct Coding regulations, treatment must be billed under the most specific code. Billing a non-covered service under a less specific code in order to obtain coverage could constitute fraud and could expose the provider to recoupment and fraud investigation.
- Examples of treatment that do not have sufficient support in current medical literature at this time include, but are not limited to: sensory integration therapy, craniosacral therapy, myofascial release therapy, visceral manipulation therapy, auditory integration training, and facilitated communication.

Note also, that treatment with goals related to leisure, sports, recreation, and avocation are not covered benefits because they do not meet the bar of medical necessity. Treatment with goals related to vocation and education are not covered benefits because there are other resources for coverage, including the Department of Vocational Rehabilitation and the Department of Education.

#### Adult Coverage

Physical, Occupational, and Speech Therapy outpatient services for Medicaid eligible adults are limited to 30 combined visits per calendar year.

Prior authorization for therapy visits beyond 30 combined visits in a calendar year may be requested for members with the following diagnoses: spinal cord injury, traumatic brain injury, stroke, amputation, or severe burn.

Changing programs or eligibility status within the calendar year does not reset the number of available visits. See Frequently Asked Questions (FAQ), under Therapy Guidelines at <http://dvha.vermont.gov/for-providers/clinical-coverage-guidelines>. Limitations and prior authorization requirements do not apply when Medicare is the primary payer.

The limit does not apply to services provided in inpatient facilities or by home health agencies; inpatient facilities and home health agencies should follow the rules and processes currently in place.

#### Members under age 21

Prior authorization for outpatient therapies (PT, OT, ST) changed for Medicaid members under age 21. The initial eight visits from the start of the member's acute care episode/condition are allowed, per therapy discipline, before prior authorization is required. Providers must request prior authorization in advance of the 8th visit if additional therapy services are necessary. Providers are required to determine the first date of treatment at any outpatient facility, regardless of coverage source. It is the responsibility of the therapists to track therapy visit/service history.

For members with a primary insurance, a prior authorization is not required if the primary insurer pays a portion of the claim. However if the primary insurer denies the claim for being a non-covered service, if the primary insurance benefit has exhausted, or if the primary insurance applied all to the deductible, prior authorization is required for over 8 visits.

Subsequent authorizations will be required at 4 month intervals, based on the start of care date.

This requirement does not apply to home health agencies.

Per the Physical, Occupational and Speech Therapy guidelines posted at <http://dvha.vermont.gov/for-providers/clinical-coverage-guidelines>, therapy providers can bill a maximum of 4 units of timed therapy procedure codes that state “15 minutes” are allowed per treatment session. The 4 unit maximum is the combined totaled of timed units, not a per procedure code limit. Evaluation, re-evaluation and other non-timed codes are not subject to the limit and may be billed in addition to the 4 timed codes during a single session. The code for wheelchair management, direct one-on-one patient contact, each 15 minutes” is an exception and is excluded from the 4 unit limit.

Providers should refer to Medicaid Rule and Therapy Guidelines for additional information at <http://dvha.vermont.gov/for-providers/clinical-coverage-guidelines>

Therapists should use the Medicaid Request for Extension of Rehabilitation Therapy Services form. Be sure to include the original start of care date by any facility or provider, for the condition listed.

Physical, Occupational and Speech Therapists who choose to submit rehabilitation therapy extension requests on forms other than the DVHA Therapy Extension Request form are strongly encouraged to use the new DVHA Cover Sheet, available at <http://dvha.vermont.gov/for-providers/forms-1>.

Use of this form with your alternative request documentation will ensure that DVHA receives the information required to process your prior authorization (PA) request. DVHA expects that the use of this form will speed the PA process.

#### Outpatient Therapy Modifiers

VT Medicaid follows Medicare's requirement that speech, occupational and physical therapists bill with modifier GN, GO or GP to identify the discipline of the plan of care under which the service is delivered.

GN – Services delivered under an outpatient speech language pathology plan of care

GO – Services delivered under an outpatient occupational therapy plan of care

GP – Services delivered under an outpatient physical therapy plan of care

Medicare provides a link to the list of applicable therapy procedure codes, (this list is updated annually by CMS). VT Medicaid therapists need only reference the code list itself; do not use the column information.

<http://www.cms.gov/Medicare/Billing/TherapyServices/AnnualTherapyUpdate.html>.

All therapy services (including codes listed as “Sometimes Therapy”) that are performed by a therapist (and billed with the therapist as the attending) must be part of an outpatient therapy plan of care and the billing codes must use one of the above therapy modifiers to bill.

~~Some codes on this list are “Always Therapy” services regardless of who performs them. These services must be part of an outpatient therapy plan of care and the Billing codes must use one of the above therapy modifiers to bill.~~

~~Practitioners other than therapists must use these modifiers when performing listed services which are delivered under an outpatient therapy plan of care.~~

~~These modifiers are not to be used with codes that are not specified on the list of applicable therapy codes.~~

~~Modifiers may be reported in any order.~~

~~Prior Authorization Requests must give the exact codes and modifiers in the same order as they will be billed on the claim.~~

## **Section 7 Prior Authorization of Medical Services**

Prior authorization (PA) is a process used to assure the appropriate use of health care services. The goal of PA is to assure that the proposed health service, item or procedure meets the medical necessity criteria; that all appropriate, less-expensive alternatives have been given consideration; and the proposed service conforms to generally accepted practice parameters recognized by health care providers in the same or similar general specialty who typically treat or manage the diagnosis or condition. It involves a request for approval of each health service that is designated as requiring prior approval before the service is rendered. Please review the fee scheduled at:

<http://dvha.vermont.gov/for-providers/claims-processing-1> for services that require a PA.

Authorization will not be granted after the service is rendered.

The DVHA PA criteria and regulations can be found in Medicaid Rule 7102. These rules and procedures govern PAs performed by the DVHA and its agents. DVHA rules are available online at <http://dvha.vermont.gov/budget-legislative>

No retroactive prior authorization will be granted. The DVHA PA requirements apply when the DVHA is known to be the primary payer for the service or item or the service or item is not a covered benefit by the member's primary insurer.

Waiver of Prior Authorization (Exceptions):

Medicaid Rule 7102.3 allows two general exceptions to securing authorization prior to the date of service.

- **Emergency Services:** Services normally requiring PA do not require PA when treating an emergency condition.

This exception applies to both the emergency care and the post-emergency stabilization. Post-emergency stabilization care will be provided until the attending emergency physician determines that the patient is sufficiently stabilized for transfer or discharge.

- **Retroactive Eligibility:** Covered services that normally require PA, which are provided to an individual in the retroactive period (defined as eligibility start date to eligibility segment update date), do not require PA.

### **7.1 Clinical Practice Guidelines**

The Department of Vermont Health Access has adopted various Clinical Practice Guidelines that are based upon evidence based medicine. These guidelines outline the preferred approach for most patients and are used to support the decision making processes. The guidelines can be found <http://dvha.vermont.gov/forproviders/clinical-coverage-guidelines>

## 7.2 Prior Authorization Requirements

The DVHA Clinical Operations Unit (COU) enters prior authorizations with the exact procedure code(s) given by the requesting provider on the request form. In those instances when the procedure code to be billed does not exactly match the code requested/authorized, the provider must notify the COU in writing prior to claim submission. Include the DVHA prior authorization number, the rationale for the code change and signature. Fax information to (802) 879-5963.

All unlisted procedure codes require authorization from the DVHA COU prior to the service being rendered.

If it is determined during a surgical procedure that an unlisted procedure is appropriate and medically necessary, prior authorization must be requested prior to claim submission. Fax information to (802) 879-5963. Surgical procedure notes must be attached with the claim indicating the usual and customary charge for the service.

### 7.2.1 Required Documentation

At a minimum, the documentation required to support a PA request must include a completed and legible copy of a medical necessity form, or other appropriate documentation, with the prescribing provider's signature, and all documents necessary for identification and pricing of the service requested, when applicable. Providers are required to keep the original legible copy of the medical necessity form in the patient's record. It is not necessary to submit a completed claim form with a PA request. If a request for PA is denied and a provider has questions or needs additional information, contact the DVHA Clinical Unit at (802) 879-5903.

Notwithstanding any other review, the State reserves the right to review medical records at any time and without advance notice.

### 7.2.2 Immediate Need Exception

1. **URGENT:** Authorization in advance does not have to occur if the service or item is rendered for urgently needed care as defined below and if the urgent care is required outside of normal DVHA business hours. If a request for authorization is shown to be for urgently needed care, and if the request for authorization is made on the next business day, the request will be considered timely. Payment for such services or items will further depend on a determination that they are medically necessary. If any such item is not considered medically necessary, the DVHA will provide normal reimbursement for a reasonable quantity of consumable items actually provided and/or the DVHA will provide normal reimbursement for the rental of such items in the minimum allowable period for the service.

2. **IMMEDIATE:** Authorization in advance does not have to occur if the service or item is rendered for immediately needed care as defined below. However, the request for PA must be faxed to the DVHA Clinical Unit by the next business day. The provider should submit documentation of medical necessity and evidence that the care or item was immediately needed. This may take the form of an order or a discharge plan. Payment for such services or items will further depend on a determination that the service(s) are medically necessary. If any such item is

not considered medically necessary, the DVHA will provide normal reimbursement for a reasonable quantity of consumable items actually provided and/or the DVHA will provide normal reimbursement for the rental of such items in thirty-day increments.

Definitions:

1. “Emergency Medical Condition” means the sudden and, at the time, unexpected onset of an illness or medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by the prudent layperson who possess an average knowledge of health and medicine, to result in:
  - Placing the member’s physical or mental health in serious jeopardy; -or-
  - serious impairment to bodily functions; -or-
  - serious dysfunction of any bodily organ or part.
2. “Post Emergency Stabilization” is the care required after an emergency to stabilize the patient for transfer or discharge. The attending emergency physician determines when a patient has been sufficiently stabilized for transfer or discharge. Post-emergency stabilization care is covered 24 hours per day, 7 days per week as necessary to stabilize a patient after an emergency.
3. “Urgently-Needed Care” or “Urgent Care” means those health care services that are necessary to treat a condition or illness of an individual that if not treated within twenty-four (24) hours presents a serious risk of harm.
4. “Immediately Needed” means that action is needed on the same day to avoid delay in discharge or to allow the member to remain in a community setting.

These definitions are consistent with both Medicaid rules and Department of Financial Regulation

### 7.3 DETERMINATION TIME

The timeframes now correspond to 42 CFR §438.210. DVHA will continue to issue a notice of decision within three days of receipt of all the necessary information. However, the longest time to wait for a decision is now 28 days, not 30. A request must be decided within 14 days of receipt of the request, but that time frame may be extended up to another 14 days if the beneficiary or provider request the extension, or if the extension is needed to obtain additional information and an extension is in the beneficiary’s interest.

Also, when a provider indicates, or DVHA determines, that following this timeframe could seriously jeopardize the beneficiary’s life, health, or ability to attain, maintain, or regain maximum function, DVHA must make an expedited decision and provide notice as expeditiously as the beneficiary’s health condition requires and no later than three working days after receipt of the request. This may be extended up to 14 days if the beneficiary so requests, or if the extension is needed to obtain additional information and an extension is in the beneficiary’s interest. Under federal law, the department is obligated to provide a response within 24 hours of a request for PA of a drug.

#### 7.3.1 PA Decision Reconsiderations

The DVHA will conduct a review of a denied prior authorization (**prior to submission of claims**) at the request of a provider. The DVHA will conduct the following review if requested by the provider (prior to submission of claim):

1. PA denial by the DVHA at the request of a provider
2. Peer to Peer review with DVHA Physician
3. PA denial about the “immediate need” for durable medical equipment;
4. PA denial because documentation was inadequate;
5. Purchase versus rental decisions for durable medical equipment.

The DVHA will not review any decision other than those listed above. All request for the above reconsiderations must be faxed to (802) 879-5963.

**Prior Authorization Contact information:**

DVHA Clinical Unit	(802) 879-5903
Fax	(802) 879-5963
Dental	(802) 879-5903

Prescription Drugs are reviewed by the Pharmacy Benefit Manager Change Healthcare

Change Healthcare Call Center	(844) 679-5363 (844) 679-5366	7:30am - 6:30pm, M-F after hours on call 24/7 365 day/year
Change Healthcare Pharmacy Help Desk Phone:	1-844-679-5362	

All drugs and supplies requiring prior authorization can be identified on the Preferred Drug List (PDL) which can be found at <http://dvha.vermont.gov/for-providers/pharmacy>

Select outpatient elective diagnostic imaging procedures require prior authorization; please see the Diagnostic Imaging Program Guidelines & list of radiology CPT codes requiring prior authorization located at <http://www.vtmedicaid.com/#!/resources>.

Elective Diagnostic Outpatient High Tech Imaging:

eviCore Customer Service	(888) 693-3211
eviCore Fax	(888) 693-3210
Web based PA Requests	<a href="http://www.medsolutionsonline.com">http://www.medsolutionsonline.com</a>

Fax forms can be obtained at <http://www.medsolutionsonline.com> or by calling MedSolutions Customer

Service (888) 693-3211, 8a.m. to 9 p.m., Monday through Friday. Diagnostic Imaging Program Guidelines and a complete list of CPT codes requiring prior authorization can be accessed at <http://dvha.vermont.gov/for-providers/claims-processing-1>

## 7.4 MEDICAL NECESSITY

Vermont Medicaid only pays for items that are medically necessary. Per the Medicaid Rule, 7103, medically necessary is defined as health care services that are appropriate, in terms of type, amount, frequency, level, setting and duration to the member’s diagnosis or condition. Medically necessary care must be consistent with generally accepted practice parameters as recognized by health care providers in the same or similar general specialty as typically treat or manage the diagnosis or condition and



- Help restore or maintain the member's health -OR-
- Prevent deterioration or palliate the member's condition -OR-
- Prevent the reasonably likely onset of a health problem or detect an incipient problem

Additionally, for EPSDT-eligible members, medically necessary includes a determination that a service is needed to achieve proper growth and development or prevent the onset or worsening of a health condition.

#### 7.4.1 Medical Necessity Form (MNF)

A completed DVHA Medical Necessity Form (DVHA 60) is the preferred documentation for Home Respiratory Therapy programs, DME and certain prescribed medical supply items with a few exceptions. The ordering physician or nurse practitioner needs to complete the MNF and give a clean copy to the patient or to the DME supplier.

Submission of the form and any necessary information to clearly document medical need is all that is needed to make the request for prior authorization.

If the code/service requires prior authorization, the DME supplier will send the MNF and all pertinent information to the DVHA as a PA request.

Both the ordering providers and the DME vendor are required to keep legible copies of all information in the patient record.

The signature date on the MNF/order must be within 6 months (before or after) of the dispensing date (billed DOS) for all items except ostomy and urologic supplies. (The order on these supplies is good for one year).

Medical Necessity and prior authorization forms are available at <http://dvha.vermont.gov/providers/forms1>.

### 7.5 UTILIZATION REVIEW

The DVHA conducts numerous utilization management and review activities. Reviews are intended to assure that quality services are provided to members and that providers are using the program properly. The reviews are generally an examination of records, known as a desk audit, although they may also include an on-site visit from the utilization review unit.

DVHA staff utilizes clinical criteria for making Utilization Review (UR) decisions that are objective and based on sound medical evidence. Approved criteria include the following:

- Change Healthcare InterQual® Guidelines
- DVHA Clinical Guidelines
- Vermont State Medicaid Rules
- Hayes and Cochrane New Technology Assessments
- Other Nationally Recognized Evidence Based Criteria

Change Healthcare InterQual® Guidelines are now available to providers behind the Vermont Medicaid secure provider web portal at <http://www.vtmedicaid.com/#/>, navigate to the Transactions menu and choose the appropriate login (Trading Partners use "Login", Web Services use "Login - UAT").

DVHA Clinical Guidelines and Vermont Medicaid State Rules will continue to be available at the DVHA website at <http://dvha.vermont.gov/for-providers/clinical-coverage-guidelines>.

## 7.6 PRIOR AUTHORIZATION NOTICE OF DECISION

The Notice of Decision is a system-generated form that the requesting and supplying provider receives as well as the member from the DVHA in response to a Prior Authorization (PA) request.

The Notice of Decision contains the following information:

- Box 2: The value will be either “A” (approved) or “D” (denied) or “I” (awaiting further information)
- Box 3: The dates of service
- Box 4: The procedure code
- Box 5: The number of units and/or occurrences

## 7.7 SERVICES REQUIRING PRIOR AUTHORIZATION

### 7.7.1 Concurrent Review for Admissions at Vermont & In-Network Border Hospitals

All Vermont in-state hospitals and in-network border hospitals will be required to notify the Department of Vermont Health Access Clinical Unit of all inpatient stays at time of admission or by the next business day.

This requirement only applies when Medicaid is the primary payer. This requirement does not apply to Inpatient Rehabilitation stays, psychiatric unit and psychiatric hospital admissions. In addition, notification of patient discharge is required.

The admitting/discharging facility may fax admission notification in the form of a daily census sheet or a utilization face sheet. The following information must be supplied: date of admission, patient name, DOB, member Medicaid ID #, admitting diagnosis, admitting status and admitting provider. The Inpatient Concurrent Review Procedures are available at <http://dvha.vermont.gov/for-providers/clinical-coverageguidelines>

Prior Authorization is required if the patient stay is to exceed 13 days. The Admission Notification Form must be completed and submitted to the Clinical Unit to request authorization by day 13 of the inpatient stay. Failure to get a PA for an admission that exceeds 13 days will result in a denial of the claim. Forms are available at <http://dvha.vermont.gov/for-providers/forms-1>.

Admission/discharge notifications, prior authorization requests and all required clinical information can be faxed to the Clinical Unit at (802) 879-5963.

Retrospective reviews will not be performed when DVHA is not notified of an admission.

### 7.7.2 Out of-State Elective Inpatient Hospital Admissions

(Excluding Designated Border Hospitals)

All elective inpatient admissions to out-of-state/out-of-network hospitals require prior authorization from the DVHA COU prior to admission. The admitting facility must fax a completed Vermont Medicaid Out of State Preadmission Form located at <http://dvha.vermont.gov/for-providers/clinical-coverage-guidelines>, clinical documentation and an explanation as to why this care cannot be performed within the State of Vermont to (802) 879-5963. The prior authorization must be requested as early as possible and no less than 3 business days prior to the planned admission.

### 7.7.3 Out-of-Network Elective Outpatient Referrals

Prior authorization is required for referrals to out-of-state/out-of-network medical visits that are elective/nonemergency, for codes 99201-99215, 99381-99456, and 99341-99360; however, PA is not required for referrals for office visits to:

- Providers affiliated with Extended-network hospitals
- Providers affiliated with Out-of-state In-network hospitals

All other PA requirements will apply. A list of Green Mountain Care in-network and extended network hospitals is available at <http://dvha.vermont.gov/for-providers/green-mountain-care-network>.

Referring providers must submit requests using the OOS Medical Office Request Form located at <http://dvha.vermont.gov/for-providers/clinical-coverage-guidelines>. Fax all requests to the DVHA COU: (802) 879-5963.

Note: Only office visit(s) are being approved. Do not proceed with any non-emergent outpatient procedure until you have first determined and documented that the service cannot be performed by an in-network provider.

### 7.7.4 In-State & Out of State Psychiatric & Detoxification Inpatient Services

The Department of Vermont Health Access (DVHA) in collaboration with the Department of Mental Health (DMH) requires concurrent review for psychiatric and detoxification inpatient admissions. This includes all children and adults, including those enrolled in CRT. Admitting facilities must complete the Vermont Medicaid Admission Notification form for Inpatient Psychiatric and Detoxification Services and fax it to the DVHA at 1-855-275-1212 within 24 hours of an urgent or emergent admission. Elective or planned admissions will require prior authorization by the DVHA. The admitting facility must fax a completed Vermont Medicaid Prior Authorization form to 1-855-275-1212. Forms are available at:

<http://dvha.vermont.gov/for-providers/clinical-prior-authorization-forms>. For additional information please see the Vermont Medicaid Inpatient Psychiatric & Detoxification Manual available at: <http://dvha.vermont.gov/for-providers/mental-health-inpatient-detox>.

### 7.7.5 Out-of-State Urgent/Emergent Inpatient Hospital Admissions

(Excluding Designated Out-of-State Network Hospitals)

All urgent and emergent inpatient admissions to out-of-state (OOS) hospitals require notification to the DVHA Clinical Unit of the admission within 24 hours or the next business day. Concurrent review will begin at the time of notification and throughout the course of the inpatient hospital stay. The admitting hospital must fax a completed Out-Of-State Urgent and Emergent Hospital Admissions form located at <http://dvha.vermont.gov/for-providers/clinical-coverage-guidelines> and clinical documentation to the DVHA at (802) 879-5963.

The hospital is required to notify the DVHA upon patient discharge.

### 7.7.6 Rehabilitative Therapy

Speech-Language Pathology (SLP) providers may enroll as private practitioners with Vermont Medicaid. Coverage of private practice SLP services are limited to those services provided outside of the school or hospital systems for Medicaid members of any age. The following statements apply to all therapy services:

- Medicaid does not cover any treatments or any portions of a treatment, when the efficacy and/or safety of that treatment is not sufficiently supported in current, peer reviewed medical literature.
- All treatment must demonstrate medical necessity.
- Per National Correct Coding regulations, treatment must be billed under the most specific code. Billing a non-covered service under a less specific code in order to obtain coverage could constitute fraud and could expose the provider to recoupment and fraud investigation.
- Examples of treatment that do not have sufficient support in current medical literature at this time include, but are not limited to: sensory integration therapy, craniosacral therapy, myofascial release therapy, visceral manipulation therapy, auditory integration training, and facilitated communication.

Note also, that treatment with goals related to leisure, sports, recreation, and avocation are not covered benefits because they do not meet the bar of medical necessity. Treatment with goals related to vocation and education are not covered benefits because there are other resources for coverage, including the Department of Vocational Rehabilitation and the Department of Education.

### **Adult Coverage**

Physical, Occupational, and Speech Therapy outpatient services for Medicaid eligible adults are limited to 30 combined visits per calendar year.

Prior authorization for therapy visits beyond 30 combined visits in a calendar year may be requested for members with the following diagnoses: spinal cord injury, traumatic brain injury, stroke, amputation, or severe burn.

Changing programs or eligibility status within the calendar year does not reset the number of available visits. See Frequently Asked Questions (FAQ), under Therapy Guidelines at <http://dvha.vermont.gov/forproviders/clinical-coverage-guidelines>. Limitations and prior authorization requirements do not apply when Medicare is the primary payer.

The limit does not apply to services provided in inpatient facilities or by home health agencies; inpatient facilities and home health agencies should follow the rules and processes currently in place.

### **Members under age 21**

Prior authorization for outpatient therapies (PT, OT, ST) changed for Medicaid members under age 21. The initial eight visits from the start of the member's acute care episode/condition are allowed, per therapy discipline, before prior authorization is required. Providers must request prior authorization in advance of the 8th visit if additional therapy services are necessary. Providers are required to determine the first date of treatment at any outpatient facility, regardless of coverage source. It is the responsibility of the therapists to track therapy visit/service history.

For members with a primary insurance, a prior authorization is not required if the primary insurer pays a portion of the claim. However if the primary insurer denies the claim for being a non-covered service, if the primary insurance benefit has exhausted, or if the primary insurance applied all to the deductible, prior authorization is required for over 8 visits.

Subsequent authorizations will be required at 4 month intervals, based on the start of care date.

This requirement does not apply to home health agencies.

Per the Physical, Occupational and Speech Therapy guidelines posted at <http://dvha.vermont.gov/forproviders/clinical-coverage-guidelines>, therapy providers can bill a maximum of 4 units of timed therapy procedures codes that state “15 minutes” are allowed per treatment session. The 4-unit maximum is the combined totaled of timed units, not a per-procedure code limit. Evaluation, re-evaluation and other non-timed codes are not subject to the limit and may be billed in addition to the 4 timed codes during a single session. The code for wheelchair management, direct one-on-one patient contact, each 15 minutes” is an exception and is excluded from the 4-unit limit.

Providers should refer to Medicaid Rule and Therapy Guidelines for additional information at <http://dvha.vermont.gov/for-providers/clinical-coverage-guidelines>

Therapists should use the Medicaid Request for Extension of Rehabilitation Therapy Services form. Be sure to include the original start of care date by any facility or provider, for the condition listed.

Physical, Occupational and Speech Therapists who choose to submit rehabilitation therapy extension requests on forms other than the DVHA Therapy Extension Request form are strongly encouraged to use the new DVHA Cover Sheet, available at <http://dvha.vermont.gov/for-providers/forms-1>.

Use of this form with your alternative request documentation will ensure that DVHA receives the information required to process your prior authorization (PA) request. DVHA expects that the use of this form will speed the PA process.

### **Outpatient Therapy Modifiers**

VT Medicaid follows Medicare’s requirement that speech, occupational and physical therapists bill with modifier GN, GO or GP to identify the discipline of the plan of care under which the service is delivered.

GN = Services delivered under an outpatient speech-language pathology plan of care

GO = Services delivered under an outpatient occupational therapy plan of care

GP = Services delivered under an outpatient physical therapy plan of care

Medicare provides a link to the list of applicable therapy procedure codes, (this list is updated annually by CMS). VT Medicaid therapists need only reference the code list itself; do not use the column information.

<http://www.cms.gov/Medicare/Billing/TherapyServices/AnnualTherapyUpdate.html>.

All therapy services (including codes listed as “Sometimes Therapy”) that are performed by a therapist (and billed with the therapist as the attending) must be part of an outpatient therapy plan of care and the billing codes must use one of the above therapy modifiers to bill.

Some codes on this list are “Always Therapy” services regardless of who performs them. These services must be part of an outpatient therapy plan of care and the Billing codes must use one of the above therapy modifiers to bill.

Practitioners other than therapists must use these modifiers when performing listed services which are delivered under an outpatient therapy plan of care.

These modifiers are not to be used with codes that are not specified on the list of applicable therapy codes.

Modifiers may be reported in any order.

Prior Authorization Requests must give the exact codes and modifiers in the same order as they will be billed on the claim.

### 9.7 Health Examination of Defined Subpopulation

DVHA will only accept diagnosis code V70.5 (ICD-9) or Z02.89 (ICD-10) (Health examination of defined subpopulations) when it is billed as the primary diagnosis for the subpopulation “Refugees”. All other claims containing diagnosis code V70.5 or Z02.89 will be denied. Diagnosis code V70.5 or Z02.89 is acceptable billing for new refugees, but only when used for their first domestic health examination and related diagnostic tests; and when medically necessary for a follow-up visit. Each claim must indicate V70.5 or Z02.89 as the primary diagnosis and must contain the notation “Refugee – Initial Exam” or “Refugee – Second Visit”. All subsequent care must be billed with an appropriate medical diagnosis per standard billing practice.

### 3.7 National Correct Coding Initiative (NCCI) Guidelines

#### NCCI Reconsiderations

Claims or procedure codes that have been denied based on NCCI guidelines may be reconsidered with an appropriate modifier or documentation of medical necessity. If the submitted procedure code is denied because NCCI guidelines indicate the code is included in another procedure, the claim may be reconsidered with a modifier if applicable. If a modifier does not apply but medical necessity can be proven, the provider must submit documentation of medical necessity that indicates both services were necessary on the same date of service.

For reconsideration instructions refer to: 1.2.67 ~~Provider Administrative Review~~ Reconsideration Process for additional information about requesting reconsideration claims.

### 12.4.1 Bilateral Billing Procedures

CPT codes that are not defined as bilateral but are performed bilaterally must be billed on one detail, using modifier 50 with 1 unit. Billing on one detail will result in the 150% reimbursement. Modifier 50 is not to be used on claims submitted for bilateral radiology services.

### UPDATES FOR 02/10/2017

### 10.3.52 Telemedicine Outside a Facility

Telemedicine is defined in Act 107 as “...the delivery of health care services...through the use of live interactive audio and video over a secure connection that complies with the requirements the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191. Telemedicine does not include the use of audio-only telephone, e-mail, or facsimile.” Act 107 is available at <http://www.leg.state.vt.us/DOCS/2012/ACTS/ACT107.PDF>.

In order to bill Vermont Medicaid for primary care services delivered through telemedicine outside a health care facility, all of the following requirements must be met:

- **Provider Eligibility Requirements:**
  - Must be a Medicaid-enrolled provider.
  - Must be a Vermont licensed physician, naturopathic physician, an advanced practice registered nurse, or a physician assistant (Sec. 45. 33 V.S.A. § 1901(i)).
  - Physicians must be Board Certified.

- Physician Assistants must have a supervising physician who is Board Certified.
  - Advanced practice registered nurses must have their advanced degree in a primary care specialty.
  - Must complete the Telemedicine application at <http://www.vtmedicaid.com/assets/provEnroll/TelemedicineEditable.pdf>
- 1) Distance site providers are required to follow correct coding in the application of the GT modifier - CMS and/or Encoder Pro telemedicine codes excluding non-covered services,
  - 2) Originating site providers (patient site) are required to document the reason the service is being provided by telemedicine rather than in person and may be reimbursed a facility fee (Q3014).
- DVHA will not reimburse for teleophthalmology or teledermatology by store and forward means.

#### 8.4 Supervised Billing

1. Supervising provider must use their unique provider number for services provided by unlicensed providers.
  - a. For claims submitted to Medicaid, the following pricing modifiers must be used:

Modifier	Definition	Information
AH	Licensed Clinical Psychologist	<i>This modifier should <u>not</u> be used when the claim is for supervised billing.</i>
AJ	Licensed Clinical Social Worker	<i>This modifier should <u>not</u> be used when the claim is for supervised billing.</i>
HO	Master's Degree Level	<i>This modifier <u>is required</u> when the claim is for supervised billing when the non-enrolled provider that is rendering the service is "Master's Degree Level."</i>
HN	Bachelor's Degree Level	<i>This modifier <u>is required</u> when the claim is for supervised billing when the non-enrolled provider that is rendering the service is "Bachelor's Degree Level."</i>

#### 7.8.1 Concurrent Review for Admissions at Vermont and In-Network Border Hospitals

~~All Vermont in-state hospitals and in-network border hospitals will be required to notify the Department of Vermont Health Access Clinical Unit of all inpatient stays at time of admission or by the next business day. This requirement only applies when Medicaid is the primary payer. This requirement does not apply to Inpatient Rehabilitation stays, psychiatric unit and psychiatric hospital admissions. In addition, notification of patient discharge is required.~~

~~The admitting/discharging facility may fax admission notification in the form of a daily census sheet or a utilization face sheet. The following information must be supplied: date of admission, patient name, DOB, member Medicaid ID #, admitting diagnosis, admitting status and admitting provider. The Inpatient Concurrent Review Procedures are available at <http://dvha.vermont.gov/for-providers/clinical-coverage-guidelines>.~~



~~Prior Authorization is required if the patient stay is to exceed 13 days. The Admission Notification Form must be completed and submitted to the Clinical Unit to request authorization by day 13 of the inpatient stay. Failure to get a PA for an admission that exceeds 13 days will result in a denial of the claim. Forms are available at <http://dvha.vermont.gov/for-providers/forms-1>.~~

~~Admission/discharge notifications, prior authorization requests and all required clinical information can be faxed to the Clinical Unit at (802) 879-5963.~~

~~Failure to notify the DVHA Clinical Unit will result in a retrospective review of the inpatient hospital admission to validate the quality of care, medical necessity, clinical coding, appropriateness of place of service and evaluation of length of stay associated with care. Results of the retrospective review will be utilized to assess refund requests for services that were determined to be inappropriate or not medically necessary.~~

All Vermont in-state hospitals and in-network border hospitals will be required to notify the Department of Vermont Health Access Clinical Unit of all inpatient stays at time of admission or by the next business day. This requirement only applies when Medicaid is the primary payer. This requirement does not apply to Inpatient Rehabilitation stays, psychiatric unit and psychiatric hospital admissions. In addition, notification of patient discharge is required.

The admitting/discharging facility may fax admission notification in the form of a daily census sheet or a utilization face sheet. The following information must be supplied: date of admission, patient name, DOB, member Medicaid ID #, admitting diagnosis, admitting status and admitting provider. The Inpatient Concurrent Review Procedures are available at <http://dvha.vermont.gov/for-providers/clinical-coverage-guidelines>.

~~Prior Authorization is required if the patient stay is to exceed 13 days. The Admission Notification Form must be completed and submitted to the Clinical Unit to request authorization by day 13 of the inpatient stay. Failure to get a PA for an admission that exceeds 13 days will result in a denial of the claim. Forms are available at <http://dvha.vermont.gov/for-providers/forms-1>.~~

~~Admission/discharge notifications, prior authorization requests and all required clinical information can be faxed to the Clinical Unit at (802) 879-5963.~~

~~Retrospective reviews will not be performed when DVHA is not notified of an admission.~~

## UPDATES FOR 12/23/2016

### 12.1 Reimbursable Services - Home Health Hospice

#### Home Health Hospice

Reimbursable services include: nursing, Home Health Aide, homemaker, rehabilitative therapy, social service, nutrition services, bereavement assessment and counseling, drugs, equipment, medical supplies, inpatient care and respite services in the home.

Vermont Medicaid pays a Per Diem rate.

Beginning January 1, 2016, a service intensity add-on (SIA) payment was authorized under the 'FY 2016 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements' published on August 5, 2015. CMS implemented payments to reflect changes in resource intensity in the provisions of care services during hospice care.



### 13.3 Home Health Agency & Hospice Services Billing Instructions/Field Locators

Beginning January 1, 2016, for Hospice Care only, a Service Intensity Add-On Payment may be billed in addition to the per diem rate for routine home care (RHC) level and is equal to the continuous home care (CHC) hourly rate if the following requirements are met:

- The day is an RHC level of care day
- The care occurs during the last seven days of an individual's life who is receiving hospice services and the individual has died.
- The skilled service is provided by a registered nurse (RN) or medical social worker (SW) for at least 15 minute but no more than four hours per day.
  - RN and SW hours are combined and cannot exceed four hours total;
  - RN and SW hours provided concurrently count separately;
  - RN and SW hours can occur over multiple visits per day;
  - the service is provided in per; and
  - the skilled service provided is clearly documented.

The SIA payment will be determined by the number of hours, in 15-minute increments of service provided multiplied by the hospice current CHC hourly rate.

Additional service code and two new billings codes, one for RN hours and one for SW hours have been created for the submission of claims for the SIA payment. The final claim should include routine home care level, the additional service codes for the SIA payment and a status code to indicate the death of the beneficiary.

**Current hospice revenue codes are listed below:**

<u>Rev Code</u>	<u>Description</u>	<u>Required HSPCS G Codes</u>
0651	Routine Home Care	No
0652	Continuous Home Care	Yes
0655	Inpatient Respite Care	No
0656	General Inpatient Care	No

**Listed below are the revenue codes that must used in order to receive the SIA payment:**

<u>Rev Code</u>	<u>Description</u>	<u>Required HSPCS G Codes</u>
0551	Routine Home Care	Yes
0561	Continuous Home Care	Yes

**Listed below are the current changes that will be effective 1/1/2016 for G codes for the valid discipline values:**

<u>HSPCS Code</u>	<u>Description</u>
G0154	Services of a skilled nurse in home health or hospice settings, each 15 minutes Discontinue 12/31/2015 replaced with G0299 & G0300
G0155	Services of a clinical social worker in home health or hospice settings, each 15 minutes
G0299	Direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting, each 15 minutes Effective 1/1/2016

G0300	Direct skilled nursing services of a license practical nurse (LPN) in the home health or hospice settings, each 15 minutes Effective 1/1/2016
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#### 17. STAT\*

Enter the two digit code indicating the patient's status as of the statement period. **For SIA Payment, please indicate date of death.**

#### 12.5.4 Hospital Clinical Laboratory Tests

~~Effective for claims submitted on or after 7/1/2014, CMS has created a new modifier, L1, to be used on the 13x bill type when non-referred clinical laboratory tests are eligible for separate payment under the following two exceptions:~~

- ~~• A hospital collects specimen and furnishes only the outpatient labs on a given date of service; or~~
- ~~• A hospital conducts outpatient lab tests that are clinically unrelated to other hospital outpatient services furnished the same day. "Unrelated" means the laboratory test is ordered by a different practitioner than the practitioner who ordered the other hospital outpatient services, for a different diagnosis.~~

~~A third exception is allowed for non-patient (referred) clinical laboratory specimens. Providers are to continue billing these outpatient lab tests separately on a type of bill 14x; do not use the L1 modifier.~~

~~For additional information, please refer to CMS publication: <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1412.pdf>.~~

**Effective for claims with dates of service 7/1/2014 to 12/31/2016**, CMS created a new modifier, L1, to be used on the 13x bill type when non-referred clinical laboratory tests are eligible for separate payment under the following two exceptions:

- A hospital collects specimen and furnishes only the outpatient labs on a given date of service; or
- A hospital conducts outpatient lab tests that are clinically unrelated to other hospital outpatient services furnished the same day. "Unrelated" means the laboratory test is ordered by a different practitioner than the practitioner who ordered the other hospital outpatient services, for a different diagnosis.

A third exception is allowed for non-patient (referred) clinical laboratory specimens. Providers are to continue billing these outpatient lab tests separately on a type of bill 14x; do not use the L1 modifier.

For additional information, please refer to CMS publication: <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1412.pdf>.

**Effective for claims with dates of service 1/1/17 and after**, L1 modifier will no longer need to be attached to laboratory codes on outpatient claims. CMS is discontinuing the use of the L1 modifier and will be packaging most lab tests, with a few exceptions, if they appear on a claim with other hospital outpatient services. DVHA will be aligning with CMS by also discontinuing the use of the L1 modifier as of January 1, 2017.

### 9.11 Place of Service (POS) Codes

<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1226.pdf>

<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/>

The list of settings where Professional services are paid at the **facility** rate:

Inpatient hospital (POS 21)	Skilled nursing facility (POS 31)	Psychiatry facility – partial hospitalization (POS 52)
Outpatient hospital (POS 22)	Hospice for inpatient care (POS 34)	Community mental health facility (POS 53)
Emergency room-hospital (POS 23)	Ambulance – Land (POS 41)	Psychiatric Residential Treatment Center (POS 56)
ASC for HCPCS on list of approved procedures (POS 24)	Ambulance – Air or water (POS 42)	Comprehensive Inpatient Rehabilitation Facility (POS 61)
Military treatment facility (POS 26)	Inpatient Psychiatry facility (POS 51)	Telehealth (POS 02)

### UPDATES FOR 12/01/2016

#### 10.3.5 Assistant Surgeon

~~Reimbursement of services is limited to the Medicare list of procedures requiring an assistant. It is further limited to one assistant surgeon during an operative session. An assistant surgeon is reimbursed at 25% of the allowed amount paid to the primary surgeon for the procedure. Use the appropriate modifier with the surgical code when billing for assistant surgeons:~~

- ~~• 80 Assistant Surgeon (must be an MD)~~
- ~~• AS Physician's Assistant~~

~~Many procedure codes do not require an assistant surgeon and therefore, Vermont Medicaid will not reimburse for the service. Assistant surgeon services are not to be billed in cases of co-surgery. In the case of co-surgery, each provider should bill on paper with the appropriate procedure code without a modifier and attach all related operative notes.~~

Reimbursement of services is limited to the Medicare list of procedures requiring an assistant. It is further limited to one assistant surgeon during an operative session. An assistant surgeon is reimbursed

at 25% of the allowed amount paid to the primary surgeon for the procedure. Only one of the assistant surgeon modifiers is allowed to be billed with a procedure code since each modifier indicates a different provider type and/or situation.

Use the appropriate modifier with the surgical code when billing for assistant surgeons:

- 80 - Assistant Surgeon (*For physicians; not intended for Physician Assistants, Nurse Practitioners, etc.*)
- 81 - Minimum Assistant Surgeon (Used when assistance required is minimal or for only a portion of the surgery) (*For physicians; not intended for Physician Assistants, Nurse Practitioners, etc.*)
- 82 - Assistant Surgeon (when qualified resident surgeon not available) (*For physicians; not intended for Physician Assistants, Nurse Practitioners, etc.*)
- AS - Physician Assistant (PA), Nurse Practitioner (NP), or Clinical Nurse Specialist (CNS) for assistant at surgery

Many procedure codes do not require an assistant surgeon and therefore, Vermont Medicaid will not reimburse for the service. Assistant surgeon services are not to be billed in cases of co-surgery. In the case of co-surgery, each provider should bill on paper with the appropriate procedure code with the appropriate modifier (not 80, 81, 82, AS) and attach all related operative notes.

## UPDATES FOR 10/13/2016

### 7.8.6 Rehabilitative Therapy

Per the Physical, Occupational and Speech Therapy guidelines posted at <http://dvha.vermont.gov/for-providers/clinical-coverage-guidelines>, therapy providers can bill a maximum of 4 units of timed therapy procedures codes that state “15 minutes” are allowed per treatment session. The 4-unit maximum is the combined totaled of timed units, not a per-procedure code limit. Evaluation, re-evaluation and other non-timed codes are not subject to the limit and may be billed in addition to the 4 timed codes during a single session. The code for wheelchair management, direct one-on-one patient contact, each 15 minutes” is an exception and is excluded from the 4-unit limit.

Providers should refer to Medicaid Rule and Therapy Guidelines for additional information at <http://dvha.vermont.gov/for-providers/clinical-coverage-guidelines>

Therapists should use the Medicaid Request for Extension of Rehabilitation Therapy Services form. Be sure to include the original start of care date by any facility or provider, for the condition listed.

Physical, Occupational and Speech Therapists who choose to submit rehabilitation therapy extension requests on forms other than the DVHA Therapy Extension Request form are strongly encouraged to use the new DVHA Cover Sheet, available at <http://dvha.vermont.gov/for-providers/forms-1>.

Use of this form with your alternative request documentation will ensure that DVHA receives the information required to process your prior authorization (PA) request. DVHA expects that the use of this form will speed the PA process.

### Outpatient Therapy Modifiers

Effective for dates of service on and after 04/01/13, VT Medicaid follows Medicare's requirement that speech, occupational and physical therapists bill with modifier GN, GO or GP to identify the discipline of the plan of care under which the service is delivered.

GN = Services delivered under an outpatient speech-language pathology plan of care

GO = Services delivered under an outpatient occupational therapy plan of care

GP = Services delivered under an outpatient physical therapy plan of care

#### 11.11.22 Wheelchairs & Seating Systems

The purchase and rental of wheelchairs requires prior authorization. Wheelchairs and seating systems are covered under various procedure codes (see current HCPCS manual). Refer to the Fee Schedule at <http://dvha.vermont.gov/for-providers> to determine the procedure codes that require prior authorization. To obtain prior authorization and individual consideration pricing, providers are required to submit a completed medical necessity form and pricing information to the clinical staff at the DVHA. When a member is also covered by Medicare, see [Section 12.4](#).

The DVHA provides forms and tools to facilitate the prior authorization process. These forms and tools are found at: <http://dvha.vermont.gov/for-providers/clinical-coverage-guidelines>. Use of these designated forms/tools will ensure that all required information is available for review by the DVHA Clinical Unit.

Vermont Medicaid follows Medicare's lead in requiring that certain wheelchairs must come from a supplier employing a RESNA-certified Assistive Technology Professional (ATP) who is directly involved in the wheelchair selection for the member. An ATP cannot review and sign off of the work of an individual who is not an ATP. The ATP must submit documentation that clearly demonstrates their in-person presence at the clinical evaluation. The wheelchairs that require ATP assessment are Group 2 single- or multiple-power option power wheelchairs, All Group 3, Group 4 and Group 5 power wheelchairs, power assist devices, ultra-lightweight manual wheelchairs, and tilt-in-space wheelchairs.

All suppliers who have obtained their ATP certification should sign all documentation regarding the above wheelchairs with their ATP designation. All ATP certified suppliers must send a copy of their certification to Vermont Medicaid Enrollment department on an annual basis to demonstrate that they have kept their certification current.

#### UPDATES FOR 08/17/2016

##### 1.2.3 Claims System & Provider Services

~~Providers are limited to 5 minutes per Help Desk call. This is to ensure we are serving all members of the provider community equally. Callers with inquiries lasting longer than 5 minutes can choose to call again or submit their inquiries in writing.~~

##### 7.2.3 Prior Authorization Requirements

Prior Authorization (PA) is necessary if our eligibility system indicates that there is no other insurance coverage for the service or item. The DVHA PA requirements apply when the DVHA is known to be the primary payer for the service or item.

If a beneficiary's primary insurance (insurance that is not Medicaid) approves, no Prior Authorization is necessary and Vermont Medicaid will pay the difference up to our allowable amount for accepted codes.

## UPDATES FOR 07/01/2016

### 12.5.7 Provider Based Billing

~~Provider based billing is the practice of charging for physician services separately from building/facility overhead. In provider based billing, also commonly referred to as hospital outpatient billing, one charge represents the facility or hospital charge and one charge represents the professional or physician fee.~~

~~The DVHA will reimburse for services provided in an outpatient clinic that has hospital provider-based status under 42 C.F.R. § 413.65, including clinics that meet the Medicare definition of a hospital-based provider (e.g., an outpatient clinic not on the hospital campus). Providers are to align their place of service billing between Medicare and Vermont Medicaid for outpatient clinics with provider-based status.~~

~~Providers are to bill Medicaid in two parts: one bill for the physician service on a CMS1500, and another bill for the hospital/facility resources and services on a UB04. There should be a matching UB04 for every CMS1500, with the physician claim billed with either a place of service (22) for "On-Campus Outpatient Hospital" or a (19) for "Off-Campus Outpatient Hospital". This will result in a facility payment to the physician (instead of a non-facility payment), thus minimizing what would otherwise be double payment for office expenses.~~

Effective for claims with dates of service 7/1/2016 and after, DVHA will no longer reimburse for the 51x clinic revenue code series. These revenue codes (510-519) indicate clinic charges for providing diagnostic, preventative, curative, rehabilitative, and education services to ambulatory patients.

The following codes will also no longer be reimbursed as of 7/1/2016 when submitted on an outpatient claim as these codes represent professional services provided in an office or clinic setting: G0463, 99201-99205, 99211-99215 and 99381-99397.

Hospital-owned practices may continue to bill on both a UB-04 (facility) claim along with a CMS-1500 (professional) claim, as appropriate. The professional claim must be billed with the appropriate outpatient place of service code if there is a corresponding facility claim being billed.

When hospital outpatient services are split billed on both a CMS-1500 and UB-04, the office place of service should not be used on the corresponding professional claim. The office place of service should only be used when the professional and facility charges are submitted together on the professional claim, with no corresponding facility claim being billed.

## UPDATES FOR 06/02/2016

Section 15 Choices for Care: Enhanced Residential Care (ERC)/Nursing Facilities Home Based Waiver (HBW), Moderate Needs

Due to the implementation of the long-term care 1115 waiver, patient share obligations will be automatically deducted from Vermont Medicaid claims starting with the first claim of the month for nursing homes, ERC and home-based providers. All nursing home claims will cost avoid for Medicare unless the provider has indicated why the service was not covered by Medicare. See Section 43.3 **12.3 Patient Share (Applied Income) Reporting.**

Eligibility for Choices for Care high/highest in all settings is based on specific clinical and financial eligibility criteria and is determined through the Choices for Care application process. Applications may be found at <http://dcf.vermont.gov/esd/lte-medicaid> <http://dcf.vermont.gov/benefits/LTC-Medicaid>

#### 12.5.9 Hospital Outpatient Billing Instructions/Field Locators

##### 44. HCPCS/CPT

Enter the appropriate HCPCS/CPT code, immediately followed by an applicable/appropriate modifier

### UPDATES FOR 04/18/2016

9.14 Long Acting Reversible Contraceptives Provided in an Inpatient Hospital Post-Partum Setting  
Vermont unintended pregnancy rate is 47%. Through the Vermont Department of Health, Long Acting-Reversible Contraceptives (LARC) utilization is being promoted as an efficient means to eliminate unplanned pregnancy. Women facing an unplanned pregnancy are at greater risk for a number of social, economic and health problems.

Effective dates of service with a discharge date of January 1, 2016 or after ,when a LARC is provided in an inpatient hospital setting, post-partum, providers must submit claims utilizing the appropriate code from each category listed in the below table. The claim will adjudicate and a LARC add-on payment of \$200.00 will be made in addition to the diagnosis-related group (DRG) portion.

ICD-10-PCS Inpatient Procedure Codes	ICD- 10-CM Diagnosis Codes
0UH97HZ	Z30.014
0UH98HZ	Z30.430
0UHC7HZ	
0UHC8HZ	
0UL74CZ	
0UL74DZ	
0UL74ZZ	
0UL78DZ	
0UL78ZZ	

### UPDATES FOR 04/01/2016

#### 8.4 Supervised Billing for Behavioral Health Services

- ~~2. Supervising provider must use their unique provider number for services provided by unlicensed providers.~~
  - ~~a. Modifier "HO" must be used to indicate the service was performed by a master's level non-licensed provider.~~
  - ~~b. Modifier "HN" must be used to indicate the service was performed by a bachelor's level non-licensed intern engaged in a graduate level mental health master's program.~~
2. Supervising provider must use their unique provider number for services provided by unlicensed providers.
  - a. For claims submitted to Medicaid, the following pricing modifiers must be used:

AH	Licensed Clinical Psychologist
AJ	Licensed Clinical Social Worker
HO	Master's Degree Level
HN	Bachelor's Degree Level

For Designated Agencies, Specialized Service Agencies, and ADAP Preferred Providers Only: For claims submitted to DMH or ADAP fund sources, the modifiers in the above table are not required.

#### 10.3.46 Psychiatry/Psychology

- ~~If no E/M services are provided, use the appropriate psychotherapy code (90832, 90834, 90837)~~
- ~~Psychotherapy with E/M is now reported by selecting the appropriate E/M service code and the appropriate psychotherapy add-on code.~~
- ~~The E/M code is selected on the basis of the site of service and the key elements performed.~~
- ~~The psychotherapy add-on code is selected on the basis of the time spent providing psychotherapy and does not include any of the time spent providing E/M services~~

Prescribing health care professionals, conducting pharmacologic management, will now use the appropriate E/M code. When psychotherapy is done during the same session as the pharmacologic management, one of the new psychotherapy codes should be used along with the E/M code. The psychiatrist or other qualified health care professional will specify the level of E/M work done and add the psychotherapy component based on the time spent delivering psychotherapy.

- ~~Vermont licensure for CPs (Clinical Psychologists) is limited to the provider's scope of practice which does not include prescription and medication management~~
- ~~Providers that are approved to bill E/M series codes are to report this service using the appropriate E/M series code~~

Enrolled provider types for Psychiatry and Psychology are:

- ~~Licensed Clinical Social Worker (LCSW)~~
- ~~Licensed Mental Health Counselor (LMHC)~~
- ~~Licensed Marriage & Family Therapist (LMFT)~~
- ~~Nurse Practitioner – Psychiatric~~
- ~~Physician – Psychiatric~~
- ~~Psychologist – Doctorate Level~~
- ~~Psychologist – Masters Level~~

Modifiers

- ~~AJ – applicable to MA counselors, LCMHC, LSW, LMFT~~
- ~~AH – applicable to Doctorate level Psychologist.~~

- If no E/M services are provided, use the appropriate psychotherapy code (90832, 90834, 90837)
- Psychotherapy with E/M is now reported by selecting the appropriate E/M service code and the appropriate psychotherapy add-on code.
- The E/M code is selected on the basis of the site of service and the key elements performed.



- The psychotherapy add-on code is selected on the basis of the time spent providing psychotherapy and does not include any of the time spent providing E/M services

Prescribing health care professionals, conducting pharmacologic management, will now use the appropriate E/M code. When psychotherapy is done during the same session as the pharmacologic management, one of the new psychotherapy codes should be used along with the E/M code. The psychiatrist or other qualified health care professional will specify the level of E/M work done and add the psychotherapy component based on the time spent delivering psychotherapy.

- Vermont licensure for CPs (Clinical Psychologists) is limited to the provider's scope of practice which does not include prescription and medication management
- Providers that are approved to bill E/M series codes are to report this service using the appropriate E/M series code

Enrolled provider types for Psychiatry and Psychology are:

- Licensed Clinical Social Worker (LCSW)
- Licensed Mental Health Counselor (LMHC)
- Licensed Marriage & Family Therapist (LMFT)
- Nurse Practitioner - Psychiatric
- Physician – Psychiatric
- Psychologist - Doctorate Level
- Psychologist - Masters Level

- c. For claims submitted to Medicaid, the following pricing modifiers must be used:

AH	Licensed Clinical Psychologist
AJ	Licensed Clinical Social Worker
HO	Master's Degree Level Providers.

- d. For Designated Agencies, Specialized Service Agencies, and ADAP Preferred Providers Only: For claims submitted to DMH or ADAP fund sources, the modifiers in the above table are not required.

## UPDATES FOR 03/01/2016

### 12.5.7 Provider Based Billing

Providers are to bill Medicaid in two parts: one bill for the physician service on a CMS1500, and another bill for the hospital/facility resources and services on a UB04. There should be a matching UB04 for every CMS1500, ~~both billed with a place of service (22) for outpatient hospital~~ **with the physician claim billed with either a place of service (22) for "On-Campus - Outpatient Hospital" or a (19) for "Off-Campus - Outpatient Hospital"**. This will result in a facility payment to the physician (instead of a non-facility payment), thus minimizing what would otherwise be double payment for office expenses.

### 9.11 Place of Service (POS) Codes

A POS Code reflects the actual place where the member receives the face-to-face service and determines whether the facility or non-facility rate is paid. The correct POS code ensures that reimbursement for the overhead portion of the payment is not paid incorrectly to the physician when

the service is performed in a facility setting. POS assigned by the physician/practitioner is the setting in which the member received the technical component (TC) service.

#### 1.2.6 Provider Claim Modification Process

The Department of Vermont Health Access (DVHA) allows claim reviews by Hewlett Packard Enterprise for the below modifications to claims:

- Modifiers: Changes (additions and/or removals) to modifiers. Requested modifications must be submitted on appropriate claim form with supporting documentation to Hewlett Packard Enterprise, PO Box 888, Williston, VT 05495
- Units: Changes to previously listed units may be reviewed when sent on appropriate claim form with any applicable supporting documentation to Hewlett Packard Enterprise, PO Box 888, Williston, VT 05495
- Place of Service or Diagnosis Codes: Changes to previously listed Place of Service codes or Diagnosis codes may be sent for review with appropriate claim form and any applicable supporting documentation to Hewlett Packard Enterprise, Attn: Utilization Review, PO Box 888, Williston, VT 05495
- Provider Type and Specialty: If a provider would like a review of the services covered under their specialty scope of practice, please send request and supporting documentation to Hewlett Packard Enterprise, Attn: Utilization Review, PO Box 888, Williston, VT 05495

#### 1.2.7 Provider Administrative Review Process

The Department of Vermont Health Access (DVHA) allows an enrolled provider a process for requesting a review of certain claims payments. DVHA's position is that providing a "second look" for certain decisions may help improve accuracy. DVHA will review a decision for the following:

- Timely filing denial
- Prior Authorization (PA) denial: (1) PA disapproval by the DVHA or its agents (other than medical necessity determinations); (2) PA decisions about the "immediate need" for durable medical equipment; (3) PA disapproval because documentation was inadequate
- Error in manual pricing (i.e. claim did not process according to fee schedule)
- Purchase versus rental decisions for durable medical equipment
- Improper payments or non-payments - objections regarding fee schedules

#### 11.11.6 Continuous Passive Motion (CPM) Devices

Per section 30.2.1 of CMS claims processing manual, CPM devices are to be billed as one billed unit = one day of rental and are limited to a maximum of 21 days of rental. The DVHA follows these CMS guidelines, "Continuous passive motion devices are covered for patients who have received a total knee replacement. To qualify for coverage, use of the device must commence within 2 days following surgery. In addition, coverage is limited to that portion of the 3 week period following surgery during which the device is used in the patient's home. Contractors make payment for each day that the device is used in the patient's home. No payment can be made for the device when the device is not used in the patient's home or once the 21 day period has elapsed. Since it is possible for a patient to receive CPM services in their home on the date that they are discharged from the hospital, this date counts as the first day of the three week limited coverage period."

The current HCPCS code for the knee joint is E0935RR. Modifier RR is required since CPM devices are only rented (never purchased). Each billed unit is reimbursed at a daily rate.

For consecutive, multiple days of rental, the claim must be billed with a date range and the corresponding multiple units (total number of days).

Please note that HCPCS code E0936RR, a CPM device for joints other than the knee, is covered only with prior authorization from the DVHA.

### 18.1 Electronic Health Record Program Reconsideration Process

Submit Appeal Request and Forms to:

~~Office of the General Counsel~~

~~EHRIP Appeals~~

~~Department of Vermont Health Access~~

~~312 Hurricane Lane, Suite 201~~

~~Williston VT 05495~~

Office of the General Counsel

EHRIP Appeals

Department of Vermont Health Access

NOB 1 South

280 State Drive

Waterbury, VT 05671-1010

### 18.2 Appeal of EHR Incentive Program Reconsideration

Submit Appeal Request and Forms to:

~~Office of the General Counsel~~

~~EHRIP Appeals~~

~~Department of Vermont Health Access~~

~~312 Hurricane Lane, Suite 201~~

~~Williston VT 05495~~

Office of the General Counsel

EHRIP Appeals

Department of Vermont Health Access

NOB 1 South

280 State Drive

Waterbury, VT 05671-1010

### UPDATES FOR 02/10/2016

#### Section 9.9 Inpatient Newborn Services

If the baby's MID is not yet available when the provider needs to bill, the mother's ID can be used only if the baby and mother are inpatient together for the duration of the stay, up to 7 consecutive days. The mother's inpatient delivery charge must be ~~paid~~ **received** or the claim will deny.

#### Section 3.3.1 Correct Coding Practices

Providers are responsible for correct and accurate billing including proper use as defined in the current manuals: AMA Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), Current Dental Terminology (CDT), the most recent International Classification of

Diseases clinical Modification (ICD-10-CM) and International Classification of Diseases Procedure coding system (ICD-10-PCS).

Please refer to the most current coding manuals for full details on proper coding and complete documentation. If your practice utilizes a billing agent, it is still the practice's responsibility to make sure correct coding of claims is occurring.

### Section 3.3.2 New, Revised and Deleted Codes

DVHA's Fee Schedule is updated on a monthly basis to reflect any code changes. It is the responsibility of the billing provider to refer to this schedule at: <http://dvha.vermont.gov/for-providers/claims-processing-1> (See section 9.6 Fee Schedule.) Codes are a National Standard and may be updated on a quarterly basis. Correct coding is the sole responsibility of the billing provider. DVHA is not authorized to give code selection guidance.

### Section 9.6 Fee Schedule

~~The Fee Schedule is published at <http://dvha.vermont.gov/for-providers/claims-processing-1> for providers to access current reimbursement rates on file for all procedure codes accepted by Vermont Medicaid. Other pertinent information includes pricing effective dates, whether the code requires a prior authorization and allowable provider types and specialties.~~

~~Services that are non-reimbursed by Vermont Medicaid are also identified. The PAC 8 (invalid codes) & 9 (non-covered) lists include all codes which are on file as "Do not pay". It is imperative that providers reference this list prior to rendering services to ensure validity of specific procedure codes. When a procedure code is updated to a PAC 8 or 9 status, providers are notified 30 days prior via banner pages. However, the Fee Schedule and PAC 8 & 9 lists are updated on a monthly basis, therefore, it is important to refer to these lists often.~~

~~The Fee Schedule is published at <http://dvha.vermont.gov/for-providers/claims-processing-1> for providers to access current reimbursement rates on file for all procedure codes accepted by Vermont Medicaid. Other pertinent information includes pricing effective dates, whether the code requires a prior authorization and allowable provider types and specialties.~~

~~Services that are non-reimbursed by Vermont Medicaid are also identified. The PAC 8 (invalid codes) & 9 (non-covered) lists include all codes which are on file as "Do not pay". It is imperative that providers reference this list prior to rendering services to ensure validity of specific procedure codes. When a procedure code is updated to a PAC 9 status, providers are notified 30 days prior to the change via banner page.~~

## UPDATES FOR 01/19/2016

### Section 8.4 Supervised Billing for Behavioral Health Services

~~These requirements apply to all providers being reimbursed for "supervised billing" under Medicaid.~~

~~"Supervised billing" is a way for a supervising provider who is enrolled in Vermont Medicaid to bill for clinical behavioral health services provided by non-licensed personnel under their direct supervision. Providers who are eligible to enroll in Vermont Medicaid must enroll and bill using their own provider number; they cannot bill under another provider's number.~~

~~Supervision of unlicensed providers is critical for patient care, and the service must clearly link to the clinical supervisor. Supervision requirements for professional licensure are described in the~~

~~administrative rules under the Secretary of State. The supervising provider must sign off on the treatment plan and demonstrate continuing involvement in supervising patient care. Services billed in this manner may be subject to post payment review.~~

#### 1. ~~Supervising Providers~~

~~The following Medicaid contracted providers may bill for supervised services:~~

- ~~• Licensed physician certified in psychiatry by the American Board of Medical Specialties;~~
- ~~• Licensed psychiatric nurse practitioner;~~
- ~~• Licensed psychologist;~~
- ~~• Licensed marriage and family therapist;~~
- ~~• Licensed clinical mental health counselor; and~~
- ~~• Licensed clinical social worker~~
- ~~• Licensed alcohol and drug abuse counselors~~

~~The following conditions apply to the Medicaid contracted provider in order to bill for unlicensed clinical services:~~

- ~~1. Supervisors must be licensed and actively enrolled in Vermont Medicaid.~~
- ~~2. All supervising providers must only supervise for services within their scope of practice.~~
- ~~3. For purposes of billing clinical services, any behavioral health provider licensed and enrolled in Medicaid and supervising within their scope of practice may provide supervision under this policy.~~
  - ~~○ Note: Unlicensed providers who are seeking licensure from the Office of Professional Regulation (OPR) will need to obtain supervised hours from a supervisor meeting the requirements outlined by OPR in order to apply for licensure. For Licensed Alcohol and Drug Abuse Counselors, supervisors must meet requirements outlined by the Vermont Alcohol and Drug Addiction Certification Board.~~
- ~~4. Supervisors do not need to provide direct services in order to bill for supervised services~~
- ~~5. Supervisors must provide regular, face-to-face ongoing supervision to the unlicensed provider, as outlined in the Secretary of State's or Vermont Department of Health's Administrative Rules for the specific provider type.~~
- ~~6. Supervisors must sustain an active part in the ongoing care of the patient.~~
- ~~7. A licensed provider qualified for scope of services must be immediately available in person or by phone within 15 minutes.~~

#### 2. ~~Non-Licensed Providers~~

~~Supervisors may bill Medicaid for clinical services provided by the following non-licensed providers:~~

- ~~• Master level mental health practitioners, including clinical social workers, clinical mental health counselors, and marriage and family therapists, actively fulfilling 3,000 hours of supervised practice.~~
- ~~• Psychiatric Nurse Practitioners actively fulfilling 24 months and 2,400 hours of supervised practice.~~
- ~~• Psychologists actively fulfilling 2,000 hours of supervised practice after receiving a doctoral or master's degree in psychology.~~
- ~~• Addiction counselors actively fulfilling the required number of hours of supervised work experience providing alcohol/drug counseling services, commensurate with their degree as outlined by the Vermont Alcohol and Drug Addiction Certification Board.~~

The following conditions must apply to non-licensed providers in order for the supervisor to bill for non-licensed services:

- ~~Mental health practitioners shall be entered on the roster of non-licensed and noncertified psychotherapists, and must be actively working towards professional licensure.~~
- ~~Psychologists shall be entered on the roster of non-licensed and noncertified psychotherapists, and must be actively working towards professional licensure.~~
- ~~Psychiatric Nurse Practitioners shall be a Registered Nurse with a Collaborative Provider Agreement, and must be actively working towards professional licensure.~~
- ~~Addiction counselors must be actively working towards professional licensure.~~

**~~Individuals who have been on the roster that is maintained by the Office of Professional Regulation in the Office of the Secretary of State for more than five years after January 1, 2016 will no longer be eligible under Medicaid to provide clinical services.~~** Extensions may be granted on a case-by-case basis.

**~~For Designated and Specialized Service Agency Providers Only:~~** For individuals seeking a waiver to the “Five Year Rule”, please fill out the Supervised Billing Five Year Rule Waiver form found at:

<http://www.vtmedicaid.com/Enrollment/forms/SupervisedBillingFiveYearWaiverEditable.pdf>. Return all completed forms to: Provider Member Relations Unit, Department of Vermont Health Access, 312 Hurricane Lane, Suite 201, Williston, VT 05495.

### ~~3. Billable services provided by supervised non-licensed providers~~

~~Clinical services within the provider’s scope of practice, including:~~

- ~~Diagnosis & Evaluation (with the exception of psychological testing and neuropsychological testing)~~
- ~~Individual Therapy~~
- ~~Group Therapy~~
- ~~Family Therapy~~
- ~~Medical Evaluation/ Management~~
- ~~Medication/ Psychotherapy~~

The following services are not eligible for reimbursement:

- ~~Services rendered by any provider who is eligible to be enrolled as a Vermont Medicaid provider but has not applied to be a Vermont Medicaid Provider.~~
- ~~Services performed by a non-licensed provider who cannot practice independently and is not actively working towards licensure.~~
- ~~Psychological testing and neuropsychological testing.~~

### ~~4. Procedures for Billing~~

~~3. Practices/Agencies must maintain documentation on unlicensed master’s level individuals providing clinical services that includes the following:~~

- a. ~~Name of rostered, unlicensed provider~~
- b. ~~Degree and discipline~~
- c. ~~Name of supervising provider~~

- ~~d. Status of license eligibility:
  - ~~i. License eligible~~
  - ~~ii. Rostered non-licensed and noncertified psychotherapists~~
  - ~~iii. Psychiatric Nurse Practitioners fulfilling 24 months and 2,400 hours of supervised practice.~~
  - ~~iv. Addiction counselors fulfilling required hours of supervised work experience.~~~~
- ~~e. Date when individual was entered on the roster that is maintained by the Office of Professional Regulation in the Office of the Secretary of State, if applicable.~~
- ~~4. Supervising provider must use their unique provider number for services provided by unlicensed providers.
  - ~~a. Modifier “HO” must be used to indicate the service was performed by a master’s level non-licensed provider.~~
  - ~~b. Modifier “HN” must be used to indicate the service was performed by a bachelor’s level non-licensed intern engaged in a graduate level mental health master’s program.~~~~
- ~~5. In the event of a supervisor’s short term absence (e.g. vacation) where another licensed provider is providing supervision, the documented licensed supervisor should continue to be included on the claim as the provider using the appropriate modifier indicated above. Length of absence appropriate for this approach should be defined in provider’s internal policy.~~

#### **NONCOMPLIANCE WITH POLICY**

~~MEDICAID CONTRACTED PROVIDERS MAY BE AUDITED REGARDING THESE REQUIREMENTS AND MAY BE REQUESTED TO REIMBURSE DVHA THE MONIES BILLED FOR THE NON-LICENSED PROFESSIONAL.~~

These requirements apply to all providers being reimbursed for “supervised billing” under Medicaid.

“Supervised billing” is a way for a supervising provider who is enrolled in Vermont Medicaid to bill for clinical behavioral health services provided by non-licensed personnel under their direct supervision. Providers who are eligible to enroll in Vermont Medicaid must enroll and bill using their own provider number; they cannot bill under another provider’s number.

Supervision of unlicensed providers is critical for patient care, and the service must clearly link to the clinical supervisor. Supervision requirements for professional licensure are described in the administrative rules under the Secretary of State, and must be adhered to for the purpose of “supervised billing”. The supervising provider must sign off on the treatment plan and demonstrate continuing involvement in supervising patient care. Services billed in this manner may be subject to post payment review.

#### **5. Supervising Providers**

The following Medicaid contracted providers may bill for supervised services:

- Licensed physician certified in psychiatry by the American Board of Medical Specialties;
- Licensed psychiatric nurse practitioner;
- Licensed psychologist;
- Licensed marriage and family therapist;
- Licensed clinical mental health counselor; and
- Licensed clinical social worker
- Licensed alcohol and drug abuse counselors

The following conditions apply to the Medicaid-contracted provider in order to bill for unlicensed clinical services:

8. Supervisors must be licensed and actively enrolled in Vermont Medicaid.
9. All supervising providers must only supervise for services within their scope of practice.
10. Supervisors must adhere to the supervision requirements outlined in the Secretary of State's Administrative Rules for their specific provider type. For Licensed Alcohol and Drug Abuse Counselors, supervisors must meet requirements outlined by the Vermont Alcohol and Drug Addiction Certification Board.
  - Note: For purposes of billing clinical services, any behavioral health provider licensed and enrolled Medicaid behavioral health providers and supervising within their scope of practice may provide supervision under this policy. Unlicensed providers who are seeking licensure from the Office of Professional Regulation (OPR) will need to obtain supervised hours from a supervisor meeting the requirements outlined by OPR in order to apply for licensure.
11. Supervisors do not need to provide direct services in order to bill for supervised services
12. Supervisors must provide regular, face-to-face ongoing supervision to the unlicensed provider, as outlined in the Secretary of State's or Vermont Department of Health's Administrative Rules for the specific provider type.
13. Supervisors must sustain an active part in the ongoing care of the patient.
14. A licensed provider qualified for scope of services must be immediately available in person or by phone within 15 minutes.

#### 6. Non-Licensed Providers

Supervisors may bill Medicaid for clinical services provided by the following non-licensed providers:

- Master-level mental health practitioners, including clinical social workers, clinical mental health counselors, and marriage and family therapists, actively fulfilling 3,000 hours of supervised practice.
- Psychiatric Nurse Practitioners actively fulfilling 24 months and 2,400 hours of supervised practice.
- Psychologists actively fulfilling 2,000 hours of supervised practice after receiving a doctoral or master's degree in psychology.
- Addiction counselors who are:
  - Actively fulfilling the required number of hours of supervised work experience providing alcohol/drug counseling services, commensurate with their degree as outlined by the Vermont licensing entity, or
  - Possessing (or will possess within 180 days of hire) a Vermont Addiction Apprentice Professional certificate, or
  - Possessing an Alcohol and Drug Counselor Certification.



The following conditions must apply to non-licensed providers in order for the supervisor to bill for non-licensed services:

- Mental health practitioners shall be entered on the roster of nonlicensed and noncertified psychotherapists, and must be actively working towards professional licensure.
- Psychologists shall be entered on the roster of nonlicensed and noncertified psychotherapists, and must be actively working towards professional licensure.
- Psychiatric Nurse Practitioners shall be a Registered Nurse with a Collaborative Provider Agreement, and must be actively working towards professional licensure.
- Non-certified addiction counselors must be actively working towards professional licensure.

**Individuals who have been on the roster that is maintained by the Office of Professional Regulation in the Office of the Secretary of State for more than five years after January 1, 2016 will no longer be eligible under Medicaid to provide clinical services.** Extensions may be granted on a case-by-case basis.

**7. Billable services provided by supervised non-licensed providers**

Clinical services within the provider's scope of practice, including:

- Diagnosis & Evaluation
- Individual Therapy
- Group Therapy
- Family Therapy
- Medical Evaluation/ Management
- Medication/ Psychotherapy

The following services are not eligible for reimbursement:

- Services rendered by any provider who is eligible to be enrolled as a Vermont Medicaid provider but has not applied to be a Vermont Medicaid Provider.
- Services performed by a non-licensed provider who cannot practice independently and is not actively working towards licensure.

**8. Procedures for Billing**

6. Practices/Agencies must maintain documentation on unlicensed master's level individuals providing clinical services that includes the following:
  - a. Name of rostered, unlicensed provider
  - b. Degree and discipline
  - c. Name of supervising provider
  - d. Status of license-eligibility:
    - i. License-eligible
    - ii. Rostered nonlicensed and noncertified psychotherapists
    - iii. Psychiatric Nurse Practitioners fulfilling 24 months and 2,400 hours of supervised practice.
    - iv. Addiction counselors fulfilling required hours of supervised work experience.
  - e. Date when individual was entered on the roster that is maintained by the Office of Professional Regulation in the Office of the Secretary of State, if applicable.

7. Supervising provider must use their unique provider number for services provided by unlicensed providers.
  - a. Modifier "HO" must be used to indicate the service was performed by a master's level non-licensed provider.
  - b. Modifier "HN" must be used to indicate the service was performed by a bachelor's level non-licensed intern engaged in a graduate-level mental health master's program.
8. In the event of a supervisor's short-term absence (e.g. vacation) where another licensed provider is providing supervision, the documented licensed supervisor should continue to be included on the claim as the provider using the appropriate modifier indicated above. Length of absence appropriate for this approach should be defined in provider's internal policy.
9. For neuropsychological testing, the supervising provider must conduct an initial face-to-face neurobehavioral status exam to determine the medical necessity for neuropsychological testing and the extent of such testing. Evaluations, including initial neurobehavioral status exam, administration of all tests, final report, and feedback session, if held, should be billed to Medicaid at the conclusion of the process on a single claim. The patient's record should include documentation of dates and times of face-to-face ongoing supervision to the unlicensed clinician. For other documentation requirements and best practice guidelines please see Local Coverage Determination (LCD) *Psychological and Neuropsychological Testing (L31990)*.

## **NONCOMPLIANCE WITH POLICY**

MEDICAID CONTRACTED PROVIDERS MAY BE AUDITED REGARDING THESE REQUIREMENTS AND MAY BE REQUESTED TO REIMBURSE DVHA THE MONIES BILLED FOR THE NON-LICENSED PROFESSIONAL.

## **UPDATES FOR 12/18/2015**

### Section 10.1

Anesthesia Assistants-Reimbursement basis is ~~80%~~ 100% of the Vermont Medicaid rate on file.

### Section 8.3 Incident to Billing for Licensed Physicians

#### ~~8.3.2 Licensed Doctorate Level Psychologist Incident To Billing~~

~~The billing/clinically supervising provider must:~~

- ~~• Be actively enrolled with Vermont Medicaid~~
- ~~• Be a licensed doctorate level psychologist~~
- ~~• Provide formal case oversight (documented one-on-one meetings to review the case)~~
- ~~• Be present in the office suite on site or immediately available within 15 minutes commute to provide assistance and direction throughout the time the service is performed~~

~~The person providing the service:~~

- ~~• Must be a masters level provider in the mental health field~~
- ~~• Is non-licensed and not enrolled in Vermont Medicaid and is in the mental health field~~
- ~~• Is licensed and not enrolled in Vermont Medicaid~~

Please note:

- ~~DVHA defers to the ruling of the Vermont Board of Psychological Examiners for special situations or questions~~
- ~~Community Mental Health Centers (Designated Agencies) follow rules set by the Department of Mental Health regarding Incident To billing~~

#### Section 8.4 Supervised Billing for Behavioral Health Services

***Supervised billing requirements as described below apply only to clinical services, and are not applicable to case management, specialized rehabilitation or Emergency Care and Assessment Services.***

These requirements apply to all providers being reimbursed for “supervised billing” under Medicaid.

“Supervised billing” is a way for a supervising provider who is enrolled in Vermont Medicaid to bill for clinical behavioral health services provided by non-licensed personnel under their direct supervision. Providers who are eligible to enroll in Vermont Medicaid must enroll and bill using their own provider number; they cannot bill under another provider’s number.

Supervision of unlicensed providers is critical for patient care, and the service must clearly link to the clinical supervisor. Supervision requirements for professional licensure are described in the administrative rules under the Secretary of State. The supervising provider must sign off on the treatment plan and demonstrate continuing involvement in supervising patient care. Services billed in this manner may be subject to post payment review.

#### 9. Supervising Providers

The following Medicaid contracted providers may bill for supervised services:

- Licensed physician certified in psychiatry by the American Board of Medical Specialties;
- Licensed psychiatric nurse practitioner;
- Licensed psychologist;
- Licensed marriage and family therapist;
- Licensed clinical mental health counselor; and
- Licensed clinical social worker
- Licensed alcohol and drug abuse counselors

The following conditions apply to the Medicaid-contracted provider in order to bill for unlicensed clinical services:

15. Supervisors must be licensed and actively enrolled in Vermont Medicaid.

16. All supervising providers must only supervise for services within their scope of practice.

17. For purposes of billing clinical services, any behavioral health provider licensed and enrolled in Medicaid and supervising within their scope of practice may provide supervision under this policy.

- Note: Unlicensed providers who are seeking licensure from the Office of Professional Regulation (OPR) will need to obtain supervised hours from a supervisor meeting the requirements outlined by OPR in order to apply for licensure. For Licensed Alcohol and Drug Abuse Counselors, supervisors must meet requirements outlined by the Vermont Alcohol and Drug Addiction Certification Board.

18. Supervisors do not need to provide direct services in order to bill for supervised services

19. Supervisors must provide regular, face-to-face ongoing supervision to the unlicensed provider, as outlined in the Secretary of State's or Vermont Department of Health's Administrative Rules for the specific provider type.

20. Supervisors must sustain an active part in the ongoing care of the patient.

21. A licensed provider qualified for scope of services must be immediately available in person or by phone within 15 minutes.

#### 10. Non-Licensed Providers

Supervisors may bill Medicaid for clinical services provided by the following non-licensed providers:

- Master-level mental health practitioners, including clinical social workers, clinical mental health counselors, and marriage and family therapists, actively fulfilling 3,000 hours of supervised practice.
- Psychiatric Nurse Practitioners actively fulfilling 24 months and 2,400 hours of supervised practice.
- Psychologists actively fulfilling 2,000 hours of supervised practice after receiving a doctoral or master's degree in psychology.
- Addiction counselors actively fulfilling the required number of hours of supervised work experience providing alcohol/drug counseling services, commensurate with their degree as outlined by the Vermont Alcohol and Drug Addiction Certification Board.

The following conditions must apply to non-licensed providers in order for the supervisor to bill for non-licensed services:

- Mental health practitioners shall be entered on the roster of non-licensed and noncertified psychotherapists, and must be actively working towards professional licensure.
- Psychologists shall be entered on the roster of non-licensed and noncertified psychotherapists, and must be actively working towards professional licensure.
- Psychiatric Nurse Practitioners shall be a Registered Nurse with a Collaborative Provider Agreement, and must be actively working towards professional licensure.
- Addiction counselors must be actively working towards professional licensure.

**Individuals who have been on the roster that is maintained by the Office of Professional Regulation in the Office of the Secretary of State for more than five years after January 1, 2016 will no longer be eligible under Medicaid to provide clinical services.** Extensions may be granted on a case-by-case basis.

#### 11. Billable services provided by supervised non-licensed providers

Clinical services within the provider's scope of practice, including:

- Diagnosis & Evaluation (with the exception of psychological testing and neuropsychological testing)
- Individual Therapy
- Group Therapy

- Family Therapy
- Medical Evaluation/ Management
- Medication/ Psychotherapy

The following services are not eligible for reimbursement:

- Services rendered by any provider who is eligible to be enrolled as a Vermont Medicaid provider but has not applied to be a Vermont Medicaid Provider.
- Services performed by a non-licensed provider who cannot practice independently and is not actively working towards licensure.
- Psychological testing and neuropsychological testing.

## 12. Procedures for Billing

10. Practices/Agencies must maintain documentation on unlicensed master's level individuals providing clinical services that includes the following:

- a. Name of rostered, unlicensed provider
- b. Degree and discipline
- c. Name of supervising provider
- d. Status of license-eligibility:
  - i. License-eligible
  - ii. Rostered non-licensed and noncertified psychotherapists
  - iii. Psychiatric Nurse Practitioners fulfilling 24 months and 2,400 hours of supervised practice.
  - iv. Addiction counselors fulfilling required hours of supervised work experience.
- e. Date when individual was entered on the roster that is maintained by the Office of Professional Regulation in the Office of the Secretary of State, if applicable.

11. Supervising provider must use their unique provider number for services provided by unlicensed providers.

- a. Modifier "HO" must be used to indicate the service was performed by a master's level non-licensed provider.
- b. Modifier "HN" must be used to indicate the service was performed by a bachelor's level non-licensed intern engaged in a graduate-level mental health master's program.

12. In the event of a supervisor's short-term absence (e.g. vacation) where another licensed provider is providing supervision, the documented licensed supervisor should continue to be included on the claim as the provider using the appropriate modifier indicated above. Length of absence appropriate for this approach should be defined in provider's internal policy.

## **NONCOMPLIANCE WITH POLICY**

MEDICAID CONTRACTED PROVIDERS MAY BE AUDITED REGARDING THESE REQUIREMENTS AND MAY BE REQUESTED TO REIMBURSE DVHA THE MONIES BILLED FOR THE NON-LICENSED PROFESSIONAL.

**For Designated and Specialized Service Agency Providers Only:** For individuals seeking a waiver to the "Five-Year Rule", please fill out the Supervised Billing Five Year Rule Waiver form found at: <http://www.vtmedicaid.com/Enrollment/forms/SupervisedBillingFiveYearWaiver.pdf>.

Return all completed forms to: Provider Member Relations Unit, Department of Vermont Health Access, 312 Hurricane Lane, Suite 201, Williston, VT 05495.

## UPDATES FOR 12/01/2015

### Section 5 Provider Enrollment, Licensing & Certification

In order to participate in and receive reimbursement from Vermont Medicaid Programs, providers must be enrolled. Licensed or certified health care providers may be enrolled as Vermont Medicaid providers if at least one service they provide is recognized in the Vermont Medicaid State Plan. Any health care provider who is interested in becoming enrolled in the Vermont Medicaid program should contact the HPE Provider Enrollment Unit. Enrollment requires that the provider submit a signed provider agreement and a copy of the applicable license/certification document and meet all federal and state requirements. When the DVHA accepts an application, a Vermont Medicaid provider ID number will be issued. Payments will not be made until a provider number has been assigned.

Enrollment may include the following:

- Regular enrollment is for participating providers who are in-state and out-of-state in network as well providers that are determined by DVHA to contribute to the Green Mountain Care network, and see Vermont Medicaid members on a regular basis.
- The attending physician, whether the physician or practitioner who actually performs the services for the patient or the referring or prescribing provider, must be enrolled as a participating Vermont Medicaid provider.
- Court ordered enrollment is for providers whose services have been ordered by a court, a fair hearing decision or by a Coverage Exception.
- Request (M108/7104) decision of the commissioner. Court ordered providers would only be enrolled for dates consistent with the order/decision.
- Special status is granted for out-of-state and out-of-network providers who have seen a Vermont Medicaid member in an emergency or urgent situation, or who have been prior approved for out-of-state services. The DVHA does not deem a provider enrolled in Medicare as enrolled in Vermont Medicaid. DVHA will pay for emergency and post-emergency stabilizations services delivered by providers who were not enrolled at the time of the emergency.
- Note: Non-participating enrollment is no longer accepted.

A provider cannot be paid for a date of service when the provider is not enrolled. If a provider has not been enrolled in Vermont Medicaid, the effective date for Vermont Medicaid enrollment is the date on which HPE received the completed enrollment application. If a provider has been enrolled in Vermont Medicaid and re-enrollment is completed within 30 days of the last certification date, there will be no lapse in enrollment. If a provider has been enrolled in Vermont Medicaid and re-enrollment is completed in more than 30 days of the last certification date, the new enrollment date is the date on which HPE received the completed re-certification application, unless an extension has been granted to a Primary Care Plus Primary Care Physician (PCP) for good cause. Special status providers will be enrolled for a date, or dates, agreed upon by the DVHA and the provider. Retroactive enrollment will be allowed to cover urgent or emergent care delivered by a provider outside of Vermont that is not considered a border provider.

A provider must be re-certified in order to continue participation in the program. Approximately 60 days prior to the re-certification date, a recertification request letter will be sent to the provider's

address on file. The recertification letter will include the information and directions necessary to complete the recertification process. Providers are required to forward a copy of their current provider license, recertification request letter and in some cases the Provider Enrollment/Recertification Form, at time of notification. A complete list of Provider Enrollment Forms can be accessed at <http://www.vtmedicaid.com/Downloads/forms.html>.

To assure that provider enrollment is uninterrupted; all requested applicable documentation is required to be returned to HPE by the date indicated on the recertification request letter.

Enrollment will be rejected if:

- Mandatory information is not received
- The provider is disbarred or sanctioned from participation in federal programs
- The provider is disbarred or sanctioned by the State of Vermont

Clinical Laboratory Improvement Amendments (CLIA)

Providers that provide laboratory services are required to include a current copy of their CLIA certification at time of enrollment or recertification.

### Enrollment Agreement Signatures

All signatures must be original and signed in ink. Applications with signatures deemed not original will not be processed. Stamped, faxed or copied signatures will not be accepted.

#### *Exception:*

Faxed signatures are allowed for certain cases including but not limited to out-of-state special enrollment for a single member and other special enrollment cases as identified by DVHA. Upon receipt of the faxed provider enrollment agreement, HPE is directed to telephone the provider to confirm that the provider did in fact send the fax. HPE may then begin the screening and enrollment process. Enrollment, including the assignment of a Vermont Medicaid provider number, may be completed with the use of the faxed agreement only.

### Section 5.1 Enrollment & Certification

In order to participate in and receive reimbursement from Vermont Medicaid Programs, providers must be enrolled. Licensed or certified health care providers may be enrolled as Vermont Medicaid providers if at least one service they provide is recognized in the Vermont Medicaid State Plan. Any health care provider who is interested in becoming enrolled in the Vermont Medicaid program should contact the HPE Provider Enrollment Unit. Enrollment requires that the provider submit applicable enrollment forms, a signed General Provider Agreement and a copy of the applicable license/certification document and meet all federal and state requirements. When the DVHA accepts an applicant, a Vermont Medicaid provider ID number will be issued and a confirmation of enrollment letter will be sent. Payments will not be made until a provider number has been assigned.

Enrollment may include the following:

- Full enrollment is for participating providers who are in-state and out-of-state in network as well providers that are determined by DVHA to contribute to the Green Mountain Care network and see Vermont Medicaid members on a regular basis
- Ordering, Prescribing, Referring and Attending providers and Residents, whether the physician or practitioner who actually performs the services for the patient or the referring or prescribing provider, must be enrolled as a participating Vermont Medicaid provider.



- Court ordered enrollment is for providers whose services have been ordered by a court, a fair hearing decision or by a Coverage Exception.
- Request (M108/7104) decision of the commissioner. Court ordered providers would only be enrolled for dates consistent with the order/decision.

Special status is granted for out-of-state and out-of-network providers who have seen a Vermont Medicaid member in an emergency or urgent situation, or who have been prior approved for out-of-state services. The DVHA does not deem a provider enrolled in Medicare as enrolled in Vermont Medicaid. DVHA will pay for emergency and post-emergency stabilizations services delivered by providers who were not enrolled at the time of the emergency.

*Note:* Non-participating enrollment is no longer accepted.

The difference between Enrollment, Re-Enrollment and Revalidation:

- **Enrollment** is for providers that have never previously registered with Green Mountain Care
- **Re-Enrollment** is for providers that have previously enrolled and their eligibility has lapsed
- **Revalidation** is for providers that have previously enrolled and who revalidate within the 90-day notification period

All providers interested in applying for enrollment, or need to Re-Enroll or Revalidate their eligibility, please visit <http://www.vtmedicaid.com/Enrollment/enrollmentIndex.html#/> for all application packets.

Enrollment will be rejected if:

- Mandatory information is not received
- The provider is disbarred or sanctioned from participation in federal programs
- The provider is disbarred or sanctioned by the State of Vermont

#### Clinical Laboratory Improvement Amendments (CLIA)

Providers that provide laboratory services are required to include a current copy of their CLIA certification at time of enrollment, re-enrollment or revalidation.

#### Enrollment Agreement Signatures

All signatures must be original and signed in ink. Applications with signatures deemed not original will not be processed. Stamped, faxed or copied signatures will not be accepted.

##### *Exception:*

Faxed signatures are allowed for certain cases including but not limited to out-of-state special enrollment for a single member and other special enrollment cases as identified by DVHA. Upon receipt of the faxed provider enrollment agreement, HPE is directed to telephone the provider to confirm that the provider did in fact send the fax. HPE may then begin the screening and enrollment process. Enrollment, including the assignment of a Vermont Medicaid provider number, may be completed with the use of the faxed agreement only. Original hardcopy signature must be submitted to Hewlett Packard Enterprise for file. Signatures should be in blue ink to denote authenticity.



### 3.7 National Correction Coding Initiative (NCCI)

In accordance with the National Correct Coding Initiative (NCCI), Vermont Medicaid has implemented pre-payment edits and applies NCCI guidelines for claims with a date of service on or after 10/01/2010.

MUE (Medically Unlikely Edits) have been implemented and apply to all Professional, ASC, Hospital and DME claims.

Vermont Medicaid is currently following the CMS MUE list (not Medicare's). This list is available for review at

[http://www.cms.gov/apps/ama/license.asp?file=/NationalCorrectCodInitEd/downloads/MGR\\_MUE-PractitionerServices.zip](http://www.cms.gov/apps/ama/license.asp?file=/NationalCorrectCodInitEd/downloads/MGR_MUE-PractitionerServices.zip)

DVHA implemented the Procedure to Procedure NCCI edit effective 01/01/12. Edit guidelines are available at: <http://www.cms.gov/NationalCorrectCodInitEd/NCCI/EP/list.asp#TopOfPage>

### 3.7 National Correction Coding Initiative NCCI Guidelines

The *Patient Protection and Affordable Care Act* (PPACA) mandates that all claims submitted on or after October 1st, 2010, must be filed in accordance with the National Correct Coding initiative (NCCI) guidelines. The NCCI was developed by CMS to promote the correct coding of health-care services by providers and to prevent improper payment when incorrect coding occurs.

For the *Medicaid NCCI Policy Manual* that contains the NCCI rules, relationships, and general information, *Medicaid NCCI FAQs*, and the complete edit files, please refer to:

<http://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/national-correct-coding-initiative.html> Code combinations are refreshed quarterly.

In accordance with the National Correct Coding Initiative (NCCI), Vermont Medicaid has implemented pre-payment edits and applies NCCI guidelines for claims with a date of service on or after 10/01/2010.

The National Correct Coding Initiative (NCCI) contains two types of edits:

- NCCI procedure-to-procedure (PTP) edits that define pairs of Healthcare Common Procedure Coding System (HCPCS) / Current Procedural Terminology (CPT) codes that should not be reported together for a variety of reasons. The purpose of the PTP edits is to prevent improper payments when incorrect code combinations are reported.

Medically Unlikely Edits (MUEs) define for each HCPCS / CPT code the maximum units of service (UOS) that a provider would report under most circumstances for a single beneficiary on a single date of service.

PTP Edits have been implemented apply to all:

- Practitioner
- Ambulatory surgical center (ASC) services
- Outpatient services in hospitals (including emergency department, observation, and hospital laboratory services)
- Provider claims for durable medical equipment (DME)

MUE Edits have been implemented and apply to all:

- Practitioner
- Ambulatory surgical center (ASC) services
- Outpatient services in hospitals (including emergency department, observation, and hospital laboratory services)
- Provider claims for durable medical equipment (DME)

Each NCCI code pair edit is associated with a CMS policy as defined in the *National Correct Coding Initiative Policy Manual*. Effective dates apply to code pairs in NCCI and represent the date when CMS added the code pair combination to the NCCI edits. Code combinations are processed based on the effective date. Termination dates also apply to code pairs in NCCI. The date represents when CMS removed the code pair combination from the NCCI edits.

*NOTICE: The MUE files have been updated with the addition of a new field on the rationale for each MUE, effective the third quarter of 2014. Please refer to Appendix B of the Medicaid National Correct Coding Initiative Edit Design Manual for explanations of the MUE rationales.*

### **NCCI Appeals**

Claims or procedure codes that have been denied based on NCCI guidelines may be appealed with an appropriate modifier or documentation of medical necessity. If the submitted procedure code is denied because NCCI guidelines indicate the code is included in another procedure, the claim may be appealed with a modifier if applicable. If a modifier does not apply but medical necessity can be proven, the provider must submit documentation of medical necessity that indicates both services were necessary on the same date of service.

For appeal instructions refer to: [1.2.6 Provider Administrative Review Process](#) for additional information about appealing claims.

## **UPDATES FOR 11/01/2015**

### **Inpatient Newborn Services (Physician)**

#### **9.3 Organ Transplant**

Vermont Medicaid covers organ transplantation services once the procedure is no longer considered experimental or investigational. Reimbursement will be made for medically necessary health care services provided to an eligible beneficiary or a live donor and for the harvesting, preservation, and transportation of cadaver organs. Post-transplant services for live organ donors are covered under the recipients Medicaid benefit and should be billed under the recipient's Medicaid ID **as both the patient and the insured and include the date of birth.**

##### **9.3.1 Organ Transplant Donor Complication**

#### **1.1 Important Telephone Numbers, Addresses and Websites**

##### **Hewlett Packard Enterprise Checks, Claim Submission and Correspondence Mail**

For all Checks: Hewlett Packard Enterprise, PO Box 1645, Williston, VT 05495

For all Claims and other mail: Hewlett Packard Enterprise, PO Box 888, Williston, VT 05495

#### **7.8.4 In-State & Out of State Psychiatric & Detoxification Inpatient Services**

~~The Department of Vermont Health Access (DVHA) in collaboration with the Department of Mental Health (DMH) requires prior authorization for psychiatric and detoxification inpatient admissions for~~

~~the following in-state facilities: Brattleboro Retreat, Central Vermont Hospital—Psychiatric Unit, Fletcher Allen Hospital, Rutland Regional Medical Center and Springfield Hospital Windham Psychiatric Center. All out-of-state psychiatric and detoxification inpatient admissions/services require prior authorization. This includes all children and adults, including those enrolled in CRT. Admitting facilities must complete the Vermont Medicaid Admission Notification Form for Psychiatric Inpatient Services and fax it to the DVHA at 802-879-5963 within 24 hours or the next business day of an urgent or emergent admission, please see the Inpatient Psychiatric & Detoxification Authorization Manual. All individuals enrolled in CRT, children and adolescents will continue to require screening by a Community Mental Health Center prior to admission. Notification forms are posted on the DVHA website at <http://dvha.vermont.gov/for-providers/forms-4>~~

The Department of Vermont Health Access (DVHA) in collaboration with the Department of Mental Health (DMH) requires concurrent review for psychiatric and detoxification inpatient admissions. This includes all children and adults, including those enrolled in CRT. Admitting facilities must complete the Vermont Medicaid Admission Notification form for Inpatient Psychiatric and Detoxification Services and fax it to the DVHA at 1-855-275-1212 within 24 hours of an urgent or emergent admission. Elective or planned admissions will require prior authorization by the DVHA. The admitting facility must fax a completed Vermont Medicaid Prior Authorization form to 1-855-275-1212. Forms are available at: <http://dvha.vermont.gov/for-providers/clinical-prior-authorization-forms>. For additional information please see the Vermont Medicaid Inpatient Psychiatric & Detoxification Manual available at: <http://dvha.vermont.gov/for-providers/mental-health-inpatient-detox>

## UPDATES FOR 10/15/2015

### 10.3.39 Obstetrical Care

New Instructions for OB Code Billing Instructions for ICD-10

#### **Global billing:**

The date of service for total OB care is the day of delivery even though it includes antepartum care received prior to this date and the postpartum check-up performed after the day of delivery.

#### **Non-global billing:**

##### *Billing instructions for antepartum care:*

- Antepartum Care, billing 1-3 visits; use appropriate E/M codes for each visit.
- Antepartum Care, billing 4-6 visits; use CPT code 59425 with the DOS of the sixth visit billed as 1 unit.
- Antepartum Care, billing 7 or more visits; use CPT code 59426 with the DOS of the last visit billed as 1 unit.

##### *Billing instructions for delivery:*

- Only one delivery code can be billed for a member in a 9-month date span (with the exception of twin deliveries. Please see special instructions below). The delivery date is the DOS.

##### *Billing instructions for postpartum care:*

- Only one postpartum code can be billed for a member in a 9-month date span. This code includes office or other outpatient visits following a vaginal or cesarean section delivery. Please use the 6 week check-up as the DOS.
- This code includes all after-delivery E/M visits related to the pregnancy

## UPDATES FOR 10/01/2015

### 9.1 Abortions

Vermont Medicaid does not reimburse for abortions performed by Certified Nurse Midwives.

### 10.3.34 Midwife Services

A "Licensed Midwife" means anyone who has met the requirements set down by the **American College of Nurse-Midwives and by the** North American Registry of Midwives and who meets the eligibility criteria set forth in rule. These are the two types of Licensed Midwives that Vermont Medicaid recognizes and reimburses...

### 11.12 CMS 1500 Paper Claim Billing Instructions/Field Locators

Exception: Professional/Professional Crossover Claims require the Ordering qualifier "DK" to be used 1st when the provider in Field 17 is an Independent Lab, Independent Radiology, DME Supplier, Prosthetics/Orthotics or Sole source Eye Glass provider.

### ICD-9 and ICD-10 References Throughout Entire Manual

All references to ICD-9 in the manual have been updated to reflect that as of Date of Service October 1, 2015, ICD-10 codes must be used.

## UPDATES FOR 09/01/2015

### 10.3.46 Psychiatry/Psychology

Vermont Medicaid is continuing to require the use of modifier AJ and AH. As of 1-1-2013, modifier AJ is reimbursed at 76% of allowed amount and **effective 07/01/2015** modifier AH at ~~90%~~ **93%** of allowed amount.

### ICD-9 and ICD-10 References Throughout Entire Manual

All references to ICD-9 in the manual have been updated to reflect that as of Date of Service October 1, 2015, ICD-10 codes must be used.

## UPDATES FOR 08/01/2015

### 9.4 Organ Transplant Donor Complication

Vermont Medicaid covers organ transplantation services once the procedure is no longer considered experimental or investigational. Reimbursement will be made for medically necessary health care services provided to an eligible beneficiary or a live donor and for the harvesting, preservation, and transportation of cadaver organs. Post-transplant services for live organ donors are covered under the recipients Medicaid benefit and should be billed under the recipient's Medicaid ID.

**The instructions below are only for billing donor complications related to the transplant surgery.**

*Institutional Electronic Claims for organ donor complications:*

- Enter patient relationship code 18 in Form Locator 59 (Patient's Relation to Insured)
- Enter the Medicaid beneficiary's (organ recipient) information in Form Locators: 08 (Patient Name/Identifier), 09 (Patient Address), 10 (Patient Birth Date), and 11 (Patient Sex)
- Add a value of 39 along with the Donor's name to the 837I Loop 2300 , Billing Note Segment NTE02 (NTE01 = ADD)
- Include Occurrence Code 36 (Date of Inpatient Hospital Discharge for covered transplant patients)

*Paper UB-04 claims:*

- Enter patient relationship code 39 in Form Locator 59 (Patient's Relation to Insured)
- Enter the Medicaid beneficiary (organ recipient) information in Form Locators: 08 (Patient Name/Identifier), 09 (Patient Address), 10 (Patient Birth Date), and 11 (Patient Sex)
- Enter the Donor's name Form Locator 80 (remarks)
- Include Occurrence Code 36 (Date of Inpatient Hospital Discharge for covered transplant patients);

*Electronic Professional Claims:*

- Enter the recipient's Medicaid number 2010BA Loop. Subscriber Name, NMI1 Segment, Element 9
- Enter the recipient's name 2010BA Loop- Subscriber Name, NM1 Segment, Element 3-5
- Enter 39 and the Donor's Name and address 2300 Loop- Claim Note, NTE segment or 2400 Loop-Line Note, NTE segment

*For Paper CMS 1500 claims:*

- Enter the recipient's Medicaid number on Item 1A- Insured's I.D. Number
- Enter the recipient's name on Item 2- Patient's Name
- Enter 39 and the Donor's Name and Address on Item 19- Reserved for Local Use

## Section 18 Electronic Health Record Incentive Program

The EHRIP team is responsible for the implementation of the Vermont Medicaid Electronic Health Record Incentive Program (EHRIP). Established by the 2009 Health Information Technology for Economic and Clinical Health (HITECH) Act of the American Recovery & Reinvestment Act (ARRA), the program is designed to support providers during the transition to electronic systems and to improve the quality, safety, and efficiency of patient healthcare through the use of electronic health records (EHRs).

The EHR Incentive Program provides incentive payments to eligible professionals, eligible hospitals, and critical access hospitals as they adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology.

To receive an EHR incentive payment, providers must demonstrate they are "meaningfully using" their certified EHR technology by meeting certain measurement thresholds, which range from recording patient information as structured data to exchanging summary of care records. CMS has established these thresholds for eligible professionals and eligible hospitals. Meaningful Use objectives and measures evolve in distinct stages.

More information about the Vermont Medicaid EHR Incentive Program's policies and activities can be found at the website: <http://hcr.vermont.gov/hit/ehrip>

### 18.1 Electronic Health Record Program Reconsideration Process

The Department of Vermont Health Access (DVHA), Electronic Health Record Incentive Program (EHRIP) offers a Reconsideration and Appeal process.

#### **Reconsideration of EHRIP Decisions**

A provider who receives notification regarding eligibility for: payment amount, overpayment amount, or recoupment, has the option to request reconsideration by the EHRIP.

- A. The request must be made within thirty (30) calendar days of the receipt of the overpayment notice OR of the denial notice OR within thirty (30) calendar days of the date of the EHRIP payment in dispute. The request must be filed on the *Request for EHRIP Reconsideration* form located at <http://hcr.vermont.gov/hit/ehrip/appeals>.
- B. All issues regarding the provider's objection to the findings must be documented and no monetary threshold is applied. Failure to do so will result in the reconsideration request being waived.
- C. The reconsideration review will be conducted by a qualified person within the EHRIP of DVHA.
- D. DVHA has 30 calendar days to respond following the later of:
  - (1) Receipt of reconsideration form
  - (2) The date of a meeting with the provider, if one is scheduled,
  - (3) The date additional information is received from the provider (if requested by DVHA).
- E. During the reconsideration process, the provider may request in writing an additional 14 days to respond to a request by DVHA.
- F. In some circumstances, DVHA may notify the provider that an additional 14 day extension is invoked.

After review and reconsideration, DVHA will send the provider a final letter regarding its determination. DVHA may send a decision in the event the provider does not reply

## 18.2 Appeal of EHR Incentive Program Reconsideration

In order to initiate an EHR Incentive Program (EHRIP) Appeal the following process needs to occur:

- A. An EHRIP appeal must be filed within 30 days of the receipt of the reconsideration decision notice from DVHA or mail date. To file an EHRIP appeal a provider must complete the Request for Appeal of EHRIP Reconsideration form located at <http://hcr.vermont.gov/hit/ehrip/appeals>.
- B. The provider is required to list all objections to the reconsideration decision notice at the time of the EHRIP Appeal, otherwise claims are waived.
- C. EHRIP appeals will be divided into two categories:
  - Cases in which a reconsideration decision was issued regarding an overpayment of \$15,000 or less will be reviewed by the Chief Medical Officer (CMO) or designee. At the discretion of the CMO or designee, written instructions will be issued to the provider explaining the process or providing for a meeting with the provider.
  - Cases in which a reconsideration decision was issued regarding an overpayment of \$15,000 or more will be reviewed by the DVHA Commissioner or designee, who may convene a hearing to be scheduled within 90 days from the date of the receipt of the appeal. Appeal hearings shall be conducted under the same rules of conduct as in current use for hearings for the Human Services Board.
- D. Within 14 days of either a meeting by the Chief Medical Officer or designee, or an appeal hearing by the Commissioner or their designee, the following will be mailed to the provider :
  - (1) A written request for additional information or an additional meeting to discuss, or
  - (2) a decision letter. The decision letter will indicate the next level of appeal, as indicated below, should the provider be dissatisfied with the decision.
- E. No money is collected from the provider or offset against claims until a final decision has been rendered on the EHRIP appeal.

- F. Upon receipt of an EHRIP Appeal decision letter, DVHA may demand payment from the provider or offset the overpayment determination from pending claims. The provider may request a payment plan from DVHA in order to reconcile the overpayment EHRIP appeal decisions are final. Disagreement with the decision has the option to file a civil action in Superior Court.

Submit Appeal Request and Forms to:

EHRIP Appeals  
Office of the General Counsel  
Department of Vermont Health Access  
312 Hurricane Lane, Suite 201  
Williston VT 05495

### 7.5 Medical Necessity

Vermont Medicaid only pays for items that are medically necessary. Per the Medicaid Rule, 7103, medically necessary is defined as health care services that are appropriate, in terms of type, amount, frequency, level, setting and duration to the member's diagnosis or condition. Medically necessary care must be consistent with generally accepted practice parameters as recognized by health care providers in the same or similar general specialty as typically treat or manage the diagnosis or condition and

- Help restore or maintain the member's health **-OR-**
- Prevent deterioration or palliate the member's condition **-OR-**

- Prevent the reasonably likely onset of a health problem or detect an incipient problem

Additionally, for EPSDT-eligible members, medically necessary includes a determination that a service is needed to achieve proper growth and development or prevent the onset or worsening of a health condition.

### ~~10.3.34 Midwife Services~~

~~Vermont Medicaid reimburses for the services of Certified Nurse Midwives (CNMs) and Licensed Midwives.~~

~~Certified Nurse Midwife/Licensed (non-nurse) Midwife: CNMs/LMs may be enrolled as independent practitioners or physicians may employ them. The appropriate CPT codes for Licensed Midwives are limited to:~~

~~59400, 59409, 59410, 59610, 59612, 59614, 59425, 59426, 59430, 99341, 99347, 99354, 99355, 99461, and 99381 (99381 requires EPSDT modifiers).~~

~~Important Billing Reminder for Licensed Midwives:~~

- ~~• Delivery codes are valid only for pregnancies with an estimated gestational age of 30 or more weeks (viability)~~
- ~~• See **OBSTETRICAL CARE** for antepartum care visit billing instructions~~
- ~~• Total OB and Partial OB codes cannot be billed for the same pregnancy~~
- ~~• Only one delivery code can be billed for a member in a 9-month date span~~
- ~~• Licensed Midwives will not be reimbursed for surgery or assistant-at-surgery charges~~
- ~~• Episiotomy included in delivery reimbursement~~



- ~~The date of service for total OB care is the day delivery even though it includes antepartum care received prior to this date~~

~~When the MD, nurse midwife or nurse practitioner monitors the labor in the member's home (for a planned home birth) but then has to admit the mother to the hospital for delivery, and the delivering MD is not a member of the same provider group, the initial provider can bill code(s) 99354 and/or 99355.~~

~~The DVHA will pay codes 99354 and 99355 only when a planned home delivery results in hospital admission and the delivery is done by a different MD/MD group. (These services are included in regular OB billing when the providers are of the same billing group).~~

~~The billed units must reflect the actual time spent in face to face contact with the member in the home and/or on the way to the hospital. Each claim will be suspended for review, so clear copies of the provider's actual records must be submitted with each bill and they must document the number of units being billed.~~

### Examples

- ~~1. The midwife and MD were present in the member's home to monitor the labor. Due to a lack of progression and meconium staining in the amniotic fluid, the member was transported to the hospital and her care transferred to the hospital physician, who delivered the baby. The initial MD was with the member "for the entire labor, monitoring the baby, the mother and the progress of the labor."  
The documented time shows 5 hours. For these services (which include the midwife's attendance), the DVHA can be billed one unit of procedure code 99354 and 8 units of 99355.~~
- ~~2. The nurse midwife monitored the labor in the home for 15 hours, transported the member by car (1/2 hour) and stayed 4 more hours at the hospital after the transfer. Upon admission to the hospital, the care was assigned to the hospital physician who delivered the baby by C-section. The midwife had started an IV of ringers lactate while still at the home. The nurse midwife's services may be billed with one unit of 99354 and 29 units of 99355. All care given during the face to face contact, including the IV insertion and supplies, is included within the reimbursement of these two procedure codes. There can be no charge for the initial MD/nurse's services as of the admission to the hospital since all care at this point becomes part of the delivery payment.~~

### Summary

~~The DVHA will pay codes 99354 and 99355 only when a planned home delivery results in hospital admission and the delivery is done by a different MD/MD group. (These services are included in regular OB billing when the providers are of the same billing group.) The billed units must reflect the actual time spent in face to face contact with the member in the home and/or on the way to the hospital. Each claim will be suspended for review, so clear copies of the provider's actual records must be submitted with each bill and they must document the number of units being billed. The place of service (POS) must be a 12 (home).~~

~~Licensed midwives may receive reimbursement for Rhogam injections using code J2790 with the appropriate NDC code and a maximum of one unit. See **NDC (National Drug Code)**.~~

~~Use the appropriate office visit code with diagnosis 626.0 when a member is seen at the office for a pregnancy test. If you bill a pregnancy diagnosis for the purpose of testing for a pregnancy that has not yet been established, your claim will cause subsequent prenatal claims to be~~



~~denied as it is considered to be one prenatal visit if a pregnancy diagnosis is recorded on the claim.~~

### 10.3.34 Midwife Services

A "Licensed Midwife" means anyone who has met the requirements set down by the North American Registry of Midwives and who meets the eligibility criteria set forth in rule. These are the two types of Licensed Midwives that Vermont Medicaid recognizes and reimburses:

1. "Certified (Nurse) Midwives" are advanced practice nurses and are licensed independent providers who possess a degree from a Vermont graduate program and are certified by the American College of Nurse-Midwives. Nurse Midwives are subject to the nursing and midwifery rules
2. "Licensed (Professional) Midwives" are laypersons certified by North American Registry of Midwives who possesses a high school degree or its equivalent; subject only to the midwifery rules.

Licensed Certified Nurse Midwives may be enrolled as independent practitioners or physicians may employ them.

#### Important Billing Reminder for Licensed Midwives (Nurse and Professional):

- Delivery codes are valid only for pregnancies with an estimated gestational age of 30 or more weeks (viability)
- Licensed Midwives (Nurse and Professional) will not be reimbursed for surgery of assistant-at-surgery charges
- See **OBSTETRICAL CARE** for Total OB and Partial OB billing instructions. Total OB codes and Partial OB codes cannot be billed for the same pregnancy.

When the MD, Licensed midwife (Nurse and Professional), or nurse practitioner monitors labor in the member's home (for a planned home birth) but then has to admit the mother to the hospital for delivery, and the delivering MD is not a member of the same provider group, the initial provider can bill for the prolonged services in the office or other outpatient setting.

The DVHA will reimburse prolonged services only when a planned home delivery results in a hospital admission and the delivery is done by a different Medical Doctor/Medical Doctor group (these services are included in regular OB billing when the providers are of the same billing group).

The billed units must reflect the time spent in face-to-face contact with the member in the home and/or on the way to the hospital. Each claim will suspend for review. Please submit copies of the provider's record(s) with each bill documenting the number of units billed.

#### Examples

3. The Licensed midwife (Nurse and Professional) and MD were present in the member's home to monitor the labor. Due to a lack of progression and meconium staining in the amniotic fluid, the member was transported to the hospital and her care transferred to the hospital physician, who delivered the baby. The initial MD was with the member "for the entire labor, monitoring the baby, the mother and the progress of the labor."

The documented time shows 5 hours. For these services (which include the midwife's attendance), the DVHA can be billed one unit of procedure code 99354 and 8 units of 99355.

4. The Licensed midwife (Nurse and Professional) monitored the labor in the home for 15 hours, transported the member by car (1/2 hour) and stayed 4 more hours at the hospital after the transfer. Upon admission to the hospital, the care was assigned to the hospital physician who delivered the baby by C-section. The midwife had started an IV of ringers lactate while still at the home. The nurse midwife's services may be billed with one unit of 99354 and 29 units of 99355. All care given during the face to face contact, including the IV insertion and supplies, is included within the reimbursement of these two procedure codes. There can be no charge for the initial MD/midwives services as of the admission to the hospital since all care at this point becomes part of the delivery payment.

#### Summary

The DVHA will reimburse prolonged services codes only when a planned home delivery results in hospital admission and the delivery is done by a different MD/MD group (these services are included in regular OB billing when the providers are of the same billing group.) The billed units must reflect the actual time spent in face-to-face contact with the member in the home and/or on the way to the hospital. Each claim will suspend for review, so clear copies of the provider's records must be submitted with each bill documenting the number of units billed. The place of service (POS) must be a 12 (home).

Licensed midwives (Nurse and Professional) may receive reimbursement for RhoGAM injections using the appropriate HCPCS & NDC code with a maximum of one unit. See **NDC (National Drug Code)**.

Use the appropriate office visit and diagnosis codes when a member is seen at the office for a pregnancy test. If you bill a pregnancy diagnosis for the purpose of testing for a pregnancy that has not yet been established, your claim will cause subsequent prenatal claims to be denied as it is considered to be one prenatal visit if a pregnancy diagnosis is recorded on the claim.

#### **10.3.39 Obstetrical Care**

~~Vermont Medicaid covers obstetrical (OB) care. Total OB care includes prenatal care, delivery, episiotomy, and postpartum care including complications. A CPT total OB procedure code is used when all OB related care is provided by the same physician/practitioner or practitioners in the same group practice.~~

~~When different physician groups provide OB care for the same pregnancy, total OB codes cannot be used. Please follow the Instructions below for all pregnancies that span dates from in 2010 into 2011.~~

#### Instructions

- ~~• Antepartum Care, billing 1-3 visits; use appropriate E/M codes for each visit.~~
- ~~• Antepartum Care, billing 4-6 visits; use CPT code 59425 with the range of dates billed as 1 unit.~~
- ~~• Antepartum Care, billing 7 or more visits; use CPT code 59426 with the range of dates billed as 1 unit.~~

#### Example A

~~Member goes to Dr. A for 3 visits; Dr. A would bill the appropriate E/M code for each visit with each applicable date of service.~~

~~Member switches to Dr. B for the remainder of her pregnancy. Dr. B sees the member for 6 visits; Dr. B bills out ONLY code 59425 with range of days and 1 unit. If Dr. B delivers, he would also bill the appropriate delivery code.~~

#### Example B

~~Member goes to Dr. A for 5 visits; Dr. A bills 59425. Member then goes to Dr. B for one visit; Dr. B will ONLY bill the E/M code for the visit he provided. Member goes to Dr. C for 8 visits; Dr. C would bill 59426 with range of days and 1 unit. Dr. C delivers and would bill the appropriate delivery code.~~

~~A Member may see more than one attending provider when billing multiple antepartum visits (CPT 59425 or CPT 59426) within the same billing group/practice. It is up to the practice to determine which attending provider number to use when submitting the claim.~~

~~OB deliveries pertain only to infants who have an Estimated Gestational Age (EGA) of 30 or more weeks (viability). When the fetus is less than 7 months EGA and a non-induced fetal demise occurs, see procedure codes for surgical intervention and/or medical visit codes for medical assistance. Do not use “delivery” codes. The combination of all partial OB charges for a given pregnancy cannot exceed the reimbursement rate for total OB care.~~

#### The Fetal Non-Stress Test

~~1 unit will cover the non-stress test for both twin A and twin B when billed with modifier 22. Notes are not required when a twin diagnosis is indicated on the claim.~~

#### Twin Deliveries

~~The DVHA will reimburse for the delivery of twins at 100% and 50% of the prices on file. The provider should bill both deliveries on the same claim and use diagnosis code V272 for both. One code has to be a “delivery only” code.~~

#### Assist at Cesarean Delivery

~~A surgical assistant at a cesarean delivery cannot bill the “Total OB” procedure code because the assistant did not give the prenatal care. To bill for service as the assistant, use the “delivery only” procedure code with one of the following modifiers:~~

~~80-Assistant surgeon (MD or nurse practitioner)~~

~~AS-Physician’s assistant assisting at surgery (Only one assistant is covered per surgery).~~

~~External cephalic version (ECV) is only eligible for reimbursement for pregnancies at or beyond 36 weeks gestational age. Notes are required to confirm the service was performed. Only one ECV (successful or not) is reimbursable per pregnancy.~~

### 10.3.39 Obstetrical Care

Vermont Medicaid covers obstetrical (OB) care (traditional and midwife services) by one of two methods outlined in the CPT book under the Surgery/Maternity Care & Delivery section and reiterated here in the Provider Manual. Services can be billed as total OB care (global billing) or partial (non-global billing). Charges for both Total OB codes and Partial OB codes cannot be billed

for the same pregnancy. The combination of all partial OB charges for a given pregnancy cannot exceed the reimbursement rate for total OB care.

A total OB procedure code is used when all OB-related care is provided by the same physician/practitioner or practitioners in the same group practice. A total OB procedure code encompasses the services normally provided in uncomplicated maternity cases, which include antepartum care, delivery, and postpartum care. *The date of service for total OB care is the day of delivery.*

When different physician groups provide OB care for the same pregnancy, total OB codes cannot be used.

*Please note:* Confirmation of pregnancy during a preventative or a problem oriented visit is not considered part of antepartum care and should be reported using the appropriate E/M service code.

*Antepartum care includes:* “initial and subsequent prenatal history and physical examinations; recording of weight, blood pressures, fetal heart tones, routine chemical urinalysis, and monthly visits up to 28 weeks gestation; biweekly visits to 36 weeks gestation; and weekly visits until delivery”

*Delivery includes:* “admission to the hospital, the admission history and physical examination, management of uncomplicated labor, vaginal delivery (with or without episiotomy, with or without forceps), or cesarean delivery”

*Postpartum includes:* “office or other outpatient visits following vaginal or cesarean section delivery”

#### Partial OB code billing Instructions:

The combination of all partial OB charges for a given pregnancy cannot exceed the reimbursement rate for total OB care.

##### Antepartum Care -

- Antepartum Care, billing 1-3 visits; use appropriate E/M codes for each visit.
- Antepartum Care, billing 4-6 visits; use CPT code 59425 with the range of dates billed as 1 unit.
- Antepartum Care, billing 7 or more visits; use CPT code 59426 with the range of dates billed as 1 unit.

##### Delivery Care –

- Only one delivery code can be billed for a member in a 9-month date span (with the exception of multiples. Please see special instructions below)

##### Postpartum Care –

- Only one unit of the postpartum care only code can be billed for a member, per pregnancy, using a single date of service (use the date of the final encounter completing postpartum care). This code includes all after-delivery E/M visits related to the pregnancy (office or other outpatient visits) following a vaginal or cesarean section delivery.

#### Special Instructions:

#### The Fetal Non-Stress Test

1 unit will cover the non-stress test for both twin A and twin B when billed with modifier 22. Notes are not required when a twin diagnosis is indicated on the claim.

#### Twin Deliveries

The DVHA will reimburse for the delivery of twins at 100% (twin A) and 50% (twin B) of the prices on file. The provider should bill both deliveries on the same claim and use a twin diagnosis code for both. One code has to be a “delivery only” code.

#### Assist at Cesarean Delivery

A surgical assistant at a cesarean delivery cannot bill the “Total OB” procedure code because the assistant did not give the prenatal care. To bill for service as the assistant, use the “delivery only” procedure code with one of the following modifiers:

80-Assistant surgeon (MD or nurse practitioner)

AS-Physician’s assistant assisting at surgery (Only one assistant is covered per surgery).

External cephalic version (ECV) is only eligible for reimbursement for pregnancies at or beyond 36 weeks gestational age. Notes are required to confirm the service was performed. Only one ECV (successful or not) is reimbursable per pregnancy.

#### Abortion

Abortion includes miscarriages (“spontaneous abortion”), missed abortion, and induced abortion.

OB deliveries pertain only to infants who have an Estimated Gestational Age (EGA) of 30 or more weeks (viability). When the fetus is less than 7 months EGA and a non-induced fetal demise occurs, see procedure codes for surgical intervention and/or medical visit codes for medical assistance. Do not use “delivery” codes.

#### Example A

Member goes to Dr. A for 3 visits; Dr. A would bill the appropriate E/M code for each visit with each applicable date of service.

Member switches to Dr. B for the remainder of her pregnancy. Dr. B sees the member for 6 visits; Dr. B bills out ONLY code 59425 with range of days and 1 unit. If Dr. B delivers, he would also bill the appropriate delivery code.

#### Example B

Member goes to Dr. A for 5 visits; Dr. A bills 59425. Member then goes to Dr. B for one visit; Dr. B will ONLY bill the E/M code for the visit he provided. Member goes to Dr. C for 8 visits; Dr. C would bill 59426 with range of days and 1 unit. Dr. C delivers and would bill the appropriate delivery code. A Member may see more than one attending provider when billing multiple antepartum visits (CPT 59425 or CPT 59426) within the same billing group/practice. It is up to the practice to determine which attending provider number to use when submitting the claim.

### **7.8.1 Concurrent Review for Admissions at Vermont & In-Network Border Hospitals**

~~Effective for dates of service July 1, 2012 and after,~~ All Vermont in-state hospitals and in-network border hospitals will be required to notify the Department of Vermont Health Access Clinical Unit of all inpatient stays at time of admission or by the next business day. This requirement only applies when Medicaid is the primary payer. This requirement does not apply to **Inpatient Rehabilitation stays**, psychiatric unit and psychiatric hospital admissions.

## 8.1 Timely Filing

If a claim has a date or dates of service past the timely filing limit, it may be submitted for payment **reconsideration** directly to HPES if one or more of the following conditions are met:

The DVHA will consider paying an untimely claim in unusual circumstances **if request is made within 30 days from DVHA's written notice.**

~~Providers submitting a timely filing appeal request that contains 10 or more claims, all with the same late submission reason, are required to complete and submit the Timely Filing Appeal Claims List for 10 or more claims form located at <http://www.vtmedicaid.com/Downloads/forms.html>.~~

~~A request for an exception can be made by sending the claim with a detailed explanation of why an exception should be granted, along with any other required attachments to: HP Enterprise Services, P.O. Box 888, Williston, Vermont 05495-0888 Attn: Timely Filing Appeals.~~

## 10.3.46 Psychiatry/Psychology

- **Group therapy (90853) is limited to no more than 3 sessions per week. Reimbursement is limited to one session per day, per group and no more than 10 in a group.**

## UPDATES FOR 07/13/2015

### Section 1.2.6 Provider Administrative Appeal Process

~~The Department of Vermont Health Access (DVHA) offers a program policy allowing an enrolled provider a process for reconsideration/appeal for certain claims payments. Information regarding the Provider Administrative Appeal Process applicable to each of the following is outlined below.~~

- ~~1. Improper payments and the recovery of overpayments~~
  - ~~2. Underpayments that cannot otherwise be timely resubmitted.~~
- ~~The program policy allows for three levels of reconsideration/appeal~~

#### **Level 1 – Reconsideration by DVHA**

~~Submit **Level 1** requests to:~~

~~HP Enterprise Services  
Attn: Level 1 Request  
PO Box 888  
Williston VT 05495~~

#### **Level 2 – Appeal to the DVHA commissioner**

~~Submit **Level 2** requests to:~~

~~Commissioner, Department of Vermont Health Access  
312 Hurricane, Suite 201  
Williston, VT 05495~~

#### **Level 3 – Pursue via the Vermont Superior Court.**

### *Improper Payments and the Recovery of Overpayments*

#### **Level 1 – Reconsideration by DVHA**

- ~~A qualified person will conduct the reconsideration~~
- ~~No monetary threshold is applied.~~
- ~~Provider must provide a written explanation of the reason for the disagreement, stating the amount of the payment~~
- ~~Provider has 30 days to file for a reconsideration from either the~~
  - ~~Date of the claim payment, or,~~
  - ~~Date on the remittance advice (RA), or,~~
  - ~~Date of receipt of notice of recovery.~~
- ~~DVHA has 30 days to respond following the~~
  - ~~Date of receipt of the request for reconsideration,~~
  - ~~Date of a meeting with the provider, if one is scheduled.~~
  - ~~If DVHA requests additional information from the provider, DVHA has 30 days to respond following the receipt of that information.~~
  - ~~In some circumstances, DVHA may notify the provider that an additional 14 day extension is invoked.~~
- ~~DVHA will consider a stay of recovery within the timeframe of the Level 1 reconsideration only if an adjustment has not been completed by the DVHA fiscal agent.~~
  - ~~Provider must document good cause~~
  - ~~Stay timeframe is, the earlier of, completion of administrative appeals process or six months.~~
  - ~~Stay does not apply to adjustment for third party liability (TPL) reason including Medicare or to recoupment of general claims processing errors.~~

## **~~Level 2 – Appeal to the DVHA Commissioner~~**

~~A provider who is dissatisfied with the result of the DVHA Reconsideration may appeal that decision to the DVHA Commissioner~~

- ~~Within 30 days from the date on the Level 1 Reconsideration decision notice~~
- ~~DVHA Commissioner or a hearing officer appointed by the Commissioner will schedule an appeal hearing within 30 days from the date of receipt of the request for an appeal to the Commissioner~~
- ~~Appeal hearing shall be conducted under the same rules of conduct as in current use for hearings before the Human Services Board.~~
- ~~A hearing officer does not render a decision about the legality of federal or state laws, including, but not limited to DVHA regulations. If the legality of such law or regulation is raised by the provider, the hearing officer renders a decision based on the applicable law as interpreted by DVHA~~
- ~~DVHA Commissioner has 14 days from the date of the appeal hearing to generate a decision, or notify provider that an additional 14 day extension has been invoked. The decision notice will indicate the next level of appeal should the provider be dissatisfied with the decision.~~

### **~~Level 3—Vermont Superior Court~~**

#### *~~Underpayments that Otherwise cannot be Timely Resubmitted~~*

### **~~Level 1—Reconsideration by DVHA~~**

- ~~A qualified person will conduct the reconsideration~~
- ~~No monetary threshold is applied~~
- ~~Provider owns the responsibility of presenting a preponderance of evidence that the claim was underpaid due to DVHA error~~
- ~~Provider must have submitted claim in a timely manner~~
- ~~Provider must have exhausted all other possible corrective actions per the Provider Manual~~
- ~~Date of service for claim for reconsideration must exceed the timely filing limit of 12 months, or when third party insurance is involved the filing limit is 18 months (final billing deadline)~~
- ~~A claim with date of service older than 24 months is not eligible for reconsideration/appeal~~
- ~~Provider must file for reconsideration within 30 days after date of remittance advice that first denied the claim for exceeding the final billing deadline~~
- ~~Provider must provide a written explanation of the reason for the disagreement, stating the amount of the payment, that the claim was underpaid as a result of DVHA error, and provide the following to substantiate that the claim was underpaid~~
  - ~~Statement outlining nature of appeal~~
  - ~~Evidence of claim's original timely submission and resubmission, if applicable~~
  - ~~Copies of applicable page from each remittance advice on which the claim was previously processed~~
  - ~~Copy of remittance advice that indicates final billing deadline has passed~~
  - ~~Statement describing nature of DVHA error that resulted in the underpayment of claim~~
  - ~~Legible and accurately completed paper claim and~~
  - ~~Any other documentation supporting the appeal, including any correspondence from DVHA~~
- ~~DVHA has 30 days to respond following the~~
  - ~~Date of receipt of the request for reconsideration,~~
  - ~~Date of a meeting with the provider, if one is scheduled.~~
  - ~~If DVHA requests additional information from the provider, DVHA has 30 days to respond following the receipt of that information.~~
  - ~~In some circumstances, DVHA may notify the provider that an additional 14 day extension is invoked.~~

~~The decision notice will indicate the next level of appeal should the provider be dissatisfied with the decision.~~



## **Level 2—Appeal to the DVHA Commissioner**

A provider who is dissatisfied with the result of the DVHA Reconsideration may appeal that decision to the DVHA Commissioner

- Within 30 days from the date on the Level 1 Reconsideration decision notice
- DVHA Commissioner or a hearing officer appointed by the Commissioner will schedule an appeal hearing within 30 days from the date of receipt of the request for an appeal to the Commissioner
- Appeal hearing shall be conducted under the same rules of conduct as in current use for hearings before the Human Services Board.
- A hearing officer does not render a decision about the legality of federal or state laws, including, but not limited to DVHA regulations. If the legality of such law or regulation is raised by the provider, the hearing officer renders a decision based on the applicable law as interpreted by DVHA
- DVHA Commissioner has 14 days from the date of the appeal hearing to generate a decision, or notify provider that an additional 14 day extension has been invoked.
- The decision notice will indicate the next level of appeal should the provider be dissatisfied with the decision.

## **Level 3—Vermont Superior Court**

### **Section 1.2.6 Provider Administrative Review Process**

The Department of Vermont Health Access (DVHA) allows an enrolled provider a process for requesting a review of certain claims payments. DVHA's position is that providing a "second look" for certain decisions may help improve accuracy. DVHA will review a decision for the following:

- Timely filing denial
  - Prior Authorization (PA) denial: (1) PA disapproval by the DVHA or its agents (other than medical necessity determinations); (2) PA decisions about the "immediate need" for durable medical equipment; (3) PA disapproval because documentation was inadequate
  - Error in manual pricing
  - Purchase versus rental decisions for durable medical equipment
  - Improper payments.
- G. A request for review must be made no later than 30 calendar days after the DVHA gives written notice to the provider of its decision. Requests after 30 days will be returned with no action taken. The request for review must be filed on The Provider Administration Review Request Form at <http://dvha.vermont.gov/for-providers/forms-1>.
- H. For timely filing, providers must fully research and document in the request the extenuating circumstances surrounding the claim (e.g. submission dates, adjusted dates, and denial dates). Providers submitting a timely filing review request that contains 10 or more claims, all with the same late submission reason, are required to complete and submit the Timely Filing Review Claims List for 10 or more claims form located at <http://www.vtmedicaid.com/Downloads/forms.html>
- I. All issues regarding providers' objection to the findings must be documented and no monetary threshold is applied. The review request should provide a brief background of the case, and the reasons why the provider believes the DVHA should have ruled

differently.

- J. Review requests will be reviewed by a qualified member of the DVHA. Upon receipt of the request and supporting information, the DVHA will review all information received. The DVHA may consider additional information, either verbal or written, from the provider or others, in order to further clarify the case.
- K. The qualified DVHA reviewer will issue a written decision to the provider of its review decision or notify the provider that an extension is needed within 30 calendar days of receipt of the request for review.
- L. There is no additional review or reconsideration after the written decision on the review.

All requests for review must be addressed to:

~~HP Enterprise Services  
Administrative Review  
PO Box 888  
Williston VT 05495~~

## Section 16.4 Program Integrity Reconsideration & Appeal Process

The Department of Vermont Health Access (DVHA), Program Integrity Unit offers a Reconsideration and Appeal process for improper payments and the recovery of overpayments.

### 16.4.1 Reconsideration of Improper Payment and the Recovery of Overpayments

A provider who receives a letter notifying of an overpayment determination has the option to request reconsideration by the Program Integrity Unit.

- A. The request must be made within thirty (30) calendar days of the date of the letter from Program Integrity and must file the request on the Request for Reconsideration of the Recovery of Overpayments by Program Integrity form located at <http://dvha.vermont.gov/for-providers/forms-1>.
- B. All issues regarding the provider's objection to the findings must be documented and no monetary threshold is applied. Failure to do so will result in the reconsideration request being waived.
- C. The reconsideration review will be conducted by a qualified person within the Program Integrity Unit of DVHA.
- D. DVHA has 30 calendar days to respond following the later of:
  - (1) Receipt of reconsideration form
  - (2) the date of a meeting with the provider, if one is scheduled,
  - (3) the date additional information is received from the provider (if requested by DVHA).
- E. During the reconsideration process, the provider may request in writing an additional 14 days to respond to a request by DVHA.
- F. In some circumstances, DVHA may notify the provider that an additional 14 day extension is invoked.
- G. After review and reconsideration, DVHA will send the provider a final letter regarding its determination. DVHA may send a decision in the event the provider does not reply to a document request in a timely manner, or in the case a request for reconsideration is not filed in a timely manner.

A provider who is dissatisfied with the result of the reconsideration decision may follow the process to submit a Program Integrity Appeal. Submit Reconsideration Request and Forms to:

Program Integrity Appeals  
Department of Vermont Health Access

312 Hurricane Lane, Suite 201  
Williston, VT 05495

#### 16.4.2 Program Integrity Appeal of Improper Payment and Overpayment Deficient Practice

In order to initiate a Program Integrity Appeal the following process needs to occur:

- A. A Program Integrity appeal must be filed within 30 days of the receipt of the reconsideration decision notice from DVHA or mail date. To file a Program Integrity appeal a provider must complete the Request for Appeal of a reconsideration decision by Program Integrity located at <http://dvha.vermont.gov/for-providers/forms-1>.
- B. The provider is required to list all objections to the reconsideration decision notice at the time of the Program Integrity Appeal, otherwise claims are waived.
- C. Program Integrity appeals will be divided into two categories:
  - Cases in which a reconsideration decision was issued regarding an overpayment of \$15,000 or less will be reviewed the Chief Medical Officer (CMO) or designee. At the discretion of the CMO or designee, written instructions will be issued to the provider explaining the process or providing for a meeting with the provider.
  - Cases in which a reconsideration decision was issued regarding an overpayment of \$15,000 or more will be reviewed by the DVHA Commissioner or designee, who may convene a hearing to be scheduled within 90 days from the date of the receipt of the appeal. Appeal hearings shall be conducted under the same rules of conduct as in current use for hearings for the Human Services Board.
- D. Within 14 days of either a meeting by the Chief Medical Officer or designee, or an appeal hearing by the Commissioner or their designee, the following will be mailed to the provider :
  - (1) A written request for additional information or an additional meeting to discuss, or
  - (2) A decision letter. The decision letter will indicate the next level of appeal, as indicated below, should the provider be dissatisfied with the decision.
- E. No money is collected from the provider or offset against claims until a final decision has been rendered on the Program Integrity appeal.
- F. Upon receipt of a Program Integrity Appeal decision letter, DVHA may demand payment from the provider or offset the overpayment determination from pending claims. The provider may request a payment plan from DVHA in order to reconcile the overpayment.

Program Integrity appeal decisions are final. Disagreement with the decision has the option to file a civil action in Superior Court. Submit Appeal Request and Forms to:

Program Integrity Appeals  
312 Hurricane Lane  
Williston VT 05495

## UPDATES FOR 07/01/2015

### Section 1.1.3 Claims System & Provider Services

Providers are limited to ~~5 inquiries/questions~~ 5 minutes per Help Desk call. This is to ensure we are serving all members of the provider community equally. Callers with inquiries lasting longer than 5

~~minutes~~ Callers with more than five inquiries can choose to call again or submit their inquiries in writing. The Help Desk is not authorized to verify eligibility for dates 9 or more days beyond the date of inquiry.

### Section 6.8 Third Party Liability (TPL)/Other Insurance (OI)

If there was a payment made by the third party, providers must indicate the amount paid, ~~plus any contractual allowance/discount~~, in the "prior payments" field.

### Section 11.12 CMS 1500 Paper Claim Billing

24a. DATE(S) OF SERVICE\* Enter the date of each service provided. If the From and To dates are the same, the To date is not required. ~~You can add up to 4 pointers per detail.~~

29. AMOUNT PAID\* Enter the amount paid by other health insurance coverage, ~~including contractual allowance if applicable~~ (exclude Medicare payments). If this field is completed, field locators 11a, 11b and 11c must also be completed.

Enter spend down if applicable. Documentation must be attached if the services are not covered by the primary, or if the payment by the primary is \$3.00 or less.

## UPDATES FOR 06/01/2015

### Section 13.4.1

When Telemonitoring services are provided to clinical eligible Medicaid patients, qualified providers may bill CPT S9110 for once every 30 days for telemonitoring of patient in their home, including all necessary equipment; computer system, connections, and software; maintenance; patient education and support; per month. CPT 98969 may be billed once every 7 days for ongoing assessment and management of telemonitoring data. ~~Providers should use revenue code 780 for both S9110 and 98969.~~

## UPDATES FOR 04/22/2015

### 4.9 Member Grievance Process

~~A member grievance is a complaint about issues other than actions, such as the location or convenience of their health care provider or the quality of the health care provided. A member may file a Grievance by calling the Green Mountain Care Member Customer Support Center when the member and provider are unable to resolve the issue, and it is within 60 days of the problem. DVHA will respond to the grievance within 90 days with a letter to the member. A member who filed a Grievance and is not satisfied with the results may ask for a Grievance Review by a neutral person to ensure that the grievance process was handled fairly. Neither member nor provider shall be subject to retribution or retaliation regarding the grievance. The member may also call the Office of Health Care Advocate at 1-800-917-7787 for assistance.~~

### 6.6 Medicaid & Medicare Crossover Billing

~~A Medicare Attachment Summary Form should not be attached if an item or service is non-reimbursable by Medicare. If the service or item is denied by Medicare, a completed claim along with the Medicare EOB should be submitted within twelve months of the date of service.~~

~~The Medicare Attachment Summary Form is only to be used for beneficiaries who are enrolled in both Medicare and Vermont Medicaid. It is not to be used for reporting actions by any other insurers.~~

### 7.8.6 Rehabilitative Therapy

### Members under age 21

For members with a primary insurance, a prior authorization is not required if the primary insurer pays a portion of the claim. However if the primary insurer denies the claim for being a non-covered service, if the primary insurance benefit has exhausted, or if the primary insurance applied all to the deductible, prior authorization is required for over 8 visits.

### 10.3.7 Bilateral Procedures Physician/Professional Billing

~~Modifier 50 is not to be used on claims submitted for bilateral radiology services. In addition, Modifier 50 is not to be used on institutional claims; it is not recognized under the VT OPPS Pricing Methodology.~~

### 11.11.8 Enteral Nutrition

Vermont Medicaid allows a 10 day overlap in dates of service for enteral nutrition codes. This overlap will allow for delivery or shipping of refills. The supplier must deliver the enteral nutrition no sooner than 10 days prior to the end of the usage for the current product. The DVHA Clinical Guidelines for enteral nutrition is available online at <http://dvha.vermont.gov/providers/clinical-coverage-guidelines>.

### 12.4.3 Inpatient/Outpatient Overlap Examples

When a patient is in the observation room, then transferred to an inpatient status, the admission date is the date of service the patient was admitted into the outpatient **inpatient** room. All of the charges associated with the observation room should be rolled into the inpatient claim.

## 12.5.8 Hospital Inpatient Billing Instructions/Field Locators

12. **ADMISSION DATE** Enter date of outpatient **inpatient** admission

### 12.5.9 Hospital Outpatient Billing Instructions/Field Locators

2. UNLABELED FIELD Enter "Vermont Medicaid Hospital Inpatient  
Outpatient"

4. TYPE OF BILL\* Enter the code indicating the specific type of bill for Inpatient  
Outpatient.

## UPDATES FOR 2/1/2015

## 6.7 Individual Consideration/Manual Pricing

The rates on file for certain procedure codes do not have specific dollar amounts because no one amount is appropriate. In these cases, the rate on file is set at “IC” (individual consideration). The fiscal intermediary and the DVHA will calculate the allowed amount. This process is often called “manual pricing”. For DME, see section **11.1 Payment DVHA Primary**.

The following pricing documentation requirements apply to MSRP (Manufacturer's Suggested Retail Price) or Invoice:

1. The MSRP sheet/invoice must be dated within 1 year from the date of service indicated on the claim. If the MSRP/invoice date exceeds one year the claim will be denied
2. The item on the MSRP sheet/invoice must match the item that is being billed on the claim, and have the applicable procedure code written next to the item. If the procedure code is not listed the claim will be denied
3. Please circle, star or underline the item on the MSRP sheet/invoice. If the item is highlighted, whited or blacked out the claim will be denied

4. All discounts and totals must be clearly documented. If discounts/totals are whited or blacked out the claim will be denied
5. Documentation that states "Quote", "Remittance Advice", "Estimate", "Superbill", etc., and handwritten scripts or prescription papers, will result in claim denial. Exceptions are made for custom made items only, at the discretion of DVHA

**Added: above red text**

### 7.8.6 Rehabilitative Therapy

Physical, Occupational and Speech Therapists who choose to submit rehabilitation therapy extension requests on forms other than the DVHA Therapy Extension Request form are strongly encouraged to use the new DVHA Cover Sheet, available at <http://dvha.vermont.gov/providers/forms-1>.

Use of this form with your alternative request documentation will ensure that DVHA receives the information required to process your prior authorization (PA) request. DVHA expects that the use of this form will speed the PA process.

**Added: above red text**

### 10.3.10 Chiropractic Services

DVHA will not pay for any x-rays necessary to substantiate the subluxation. Physicians, hospitals and other providers should be aware that Vermont Medicaid does not pay for any service ordered by a chiropractor. **Reimbursement for adult chiropractic is limited to manipulation of the spine.**

Members under age 21 may only receive chiropractic services for the manipulation of the spine to correct a subluxation. Chiropractic services for members under age 12 require prior authorization from the DVHA. Visits for adults and children are limited to 10 visits per calendar year. Prior Authorization, from the DVHA, is required for all members requiring additional visits over the 10 visit limit per calendar year. The PA request, accompanied by all pertinent clinical data documenting the need for treatment must be submitted to the DVHA in writing.

**Added: above red text**

### 10.3.34 Midwife Services

Vermont Medicaid reimburses for the services of Certified Nurse-Midwives (CNMs) and Licensed-Midwives.

Certified Nurse-Midwife/Licensed (non-nurse) Midwife: CNMs/LMs may be enrolled as independent practitioners or physicians may employ them. The appropriate CPT codes for Licensed Midwives are limited to:

59400, 59409, 59410, 59610, 59612, 59614, 59425, 59426, 59430, 99341, **99347**, 99354, 99355, 99461, and 99381—(99381 requires EPSDT modifiers).

**Added: above red text**

### 12.4.1 Bilateral Billing Procedures

CPT codes that are not defined as bilateral but are performed bilaterally must be billed ~~as two separate on one detail line items, using modifier 50 with 1 unit. Billing on one detail will result in the 150% reimbursement.~~ Each detail must contain the same revenue code, CPT code and 1 unit of service. ~~Modifier 50 is not to be used on institutional claims; it is not recognized under the VT OPPS Pricing Methodology. Billing one line item will result in a unilateral rate of reimbursement, regardless of the modifier submitted.~~

**Added: above red text**

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## UPDATES FOR 1/1/2015

### 7.1 Prior Authorization Reviewers

Replaced all references to Catamaran to Goold Health Systems; includes contact and fax numbers.

~~The services and items requiring prior authorization are listed in the Fee Schedule which can be accessed on the DVHA website at <http://dvha.vermont.gov/for-provider/claims-processing-1>.~~

All drugs and supplies requiring prior authorization can be identified on the Preferred Drug List (PDL) which can be found at <http://ovha.vermont.gov/for-providers/preferred-drug-list-clinical-criteria>.

**Replaced: all references to Catamaran to Goold Health Systems throughout manual. This includes contact and fax numbers.**

**Added: above red text**

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### 10.3.52 Telemedicine

Telemedicine is defined in Act 107 as "...the delivery of health care services...through the use of live interactive audio and video over a secure connection that complies with the requirements the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191.

Telemedicine does not include the use of audio-only telephone, e-mail, or facsimile." Act 107 is available at

<http://www.leg.state.vt.us/DOCS/2012/ACTS/ACT107.PDF>.

- 3) Distance site providers are required to follow correct coding in the application of the GT modifier - CMS and/or Encoder Pro telemedicine codes excluding non-covered services,
- 4) Originating site providers (patient site) are required to document the reason the service is being provided by telemedicine rather than in person and may be reimbursed a facility fee (Q3014).

DVHA will not reimburse for teleophthalmology or teledermatology by store and forward means.

~~Originating site provider locations are limited to:~~

- ~~• Physician or practitioner's office~~
- ~~• Hospital~~
- ~~• Critical access hospital~~
- ~~• Rural health clinic~~
- ~~• Federally qualified health center~~
- ~~• Community mental health center~~
- ~~• Skilled nursing facility~~
- ~~• Hospital-based or CAH-based renal dialysis center~~

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### 12.5.8 Hospital Inpatient Billing Instructions/Field Locators

#### FIELD LOCATORS

#### REQUIRED INFORMATION



18-28. CONDITION CODES\*

Enter code to identify if condition is related to the following (\*PSRO code is mandatory):

**Deleted: strikethrough text**

### 12.5.9 Hospital Outpatient Billing Instructions/Field Locators

#### **FIELD LOCATOR**

#### **REQUIRED INFORMATION**

12. ADMISSION DATE\*

Enter date of admission

**Deleted: asterisk**

### 13.5 Home Health Agency & Hospice Services Billing Instructions/Field Locators

4. TYPE OF BILL\*

Enter the code indicating the specific type of bill for Home Health. The sequence is as follows:

#### 2. Bill Classification

- 1-Hospice (Non-hospital based)
- 2-Hospice (Hospital based)
- 3 **2**-Home Health
- 4-Ambulatory Surgical Center
- 6-Respite

**Replaced: the number 3 with the number 2.**

#### 15.2.12 Short Term Stays

~~In an effort to better track accurate Medicaid expenditures associated with short and long term stays, Vermont Medicaid admissions with anticipated stay of less than 100 days should be coded as short term stays using revenue code 128.~~

The Medicaid benefit package includes a short-term Skilled Nursing Facility (SNF) stay that is limited to not more than 30 days per episode and 60 days per calendar year.

Admission of a Medicaid member to a Skilled Nursing Facility (SNF) per the benefit outlined above will be based on a physician's order for SNF services with documentation of medical necessity for the treatment of illness or injury. The admitting diagnosis must support all treatment and therapies ordered and maintain that the service cannot be provided at a lower level of care.

As of November 1, 2014, individuals are not required to submit a Choices for Care application for short-term SNF stays. Instead, the SNF will submit a notice of admission and discharge (long panel) to DCF using form CFC 804C. The facility will submit Medicaid claims for coverage using revenue code 128 and will be paid out of the Choices for Care budget under the Highest Need category.

For a stay greater than 30 days per episode or a cumulative stay greater than 60 days per calendar year, a Choices for Care Long-Term Care application is required.

The Department of Disabilities, Aging and Independent Living website provides access to the following information regarding this change:

- 1) Choices for Care 1115 Highest and High Needs Manual:  
Section II: Eligibility: <http://www.ddas.vermont.gov/ddas-policies/policies-cfc/policies-cfc-highest/policies-cfc-highest-documents/cfc-high-manual-section-2>  
Section V.1: Application and Eligibility Determination Procedures:  
<http://www.ddas.vermont.gov/ddas-policies/policies-cfc/policies-cfc-highest/policies-cfc-highest-documents/cfc-high-manual-section-5-1>



- 2) CFC 804C form: <http://www.ddas.vermont.gov/ddas-programs/programs-cfc/programs-cfc-default-page#highest>

**Added: above red text**

**Deleted: strikethrough text**

### 15.3 Home Based Waiver (HBW) Billing Instructions/Field Locators

#### 4. TYPE OF BILL \*

Enter the code indicating the specific type of bill for Enhanced Residential Care. The sequence is as follows:

##### 2. Bill Classification

- 1-Hospice (Non-hospital based)
- 2-Hospice (Hospital based)
- ~~3~~ 2-Home Health
- 4-Ambulatory Surgical Center
- 6-Respite

**Replaced: the number 3 with the number 2.**

### UPDATES FOR 12/1/2014

#### 10.3.34 Midwife Services

Vermont Medicaid reimburses for the services of Certified Nurse-Midwives (CNMs) and Licensed-Midwives.

Certified Nurse-Midwife/Licensed (non-nurse) Midwife: CNMs/LMs may be enrolled as independent practitioners or physicians may employ them. The appropriate CPT codes for Licensed Midwives are limited to:

59400, 59409, 59410, 59610, 59612, 59614, 59425, 59426, 59430, 99341, 99354, 99355, 99461, and 99381—(99381 requires EPSDT modifiers).

**Added: above red text**

### 11.12 CMS 1500 Paper Claim Billing Instructions/Field Locators

#### 14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY

Enter the first date of present illness injury, or pregnancy. For pregnancy, use the date of last menstrual period. Use qualifier “431” - Onset of Current Symptoms or “484” - Last Menstrual Period (LMP)

**Added: above red text**

### 13.5 Home Health Agency & Hospice Services Billing Instructions/Field Locators

#### 4. TYPE OF BILL \*

Enter the code indicating the specific type of bill for Home Health. The sequence is as follows:

##### 2. Bill Classification

- 1-Hospice (Non-hospital based)
- 2-Hospice (Hospital based)
- ~~2~~ 3-Home Health
- 4-Ambulatory Surgical Center
- 6-Respite

**Replaced: the number 2 with the number 3.**

## 15.3 Home Based Waiver (HBW) Billing Instructions/Field Locators

### 4. TYPE OF BILL\*

Enter the code indicating the specific type of bill for Enhanced Residential Care. The sequence is as follows:

#### 2. Bill Classification

- 1-Hospice (Non-hospital based)
- 2-Hospice (Hospital based)
- ~~2~~ 3-Home Health
- 4-Ambulatory Surgical Center
- 6-Respite

**Replaced: the number 2 with the number 3.**

## UPDATES FOR 11/3/2014

### 6.1 Contractual Allowance

~~Providers must reduce the expected payment from Vermont Medicaid.~~ When another insurance carrier has made a payment, document the total payments received by other insurance carriers in the appropriate field on your claim form.

The provider ~~must not bill Vermont Medicaid~~ **is prohibited from collecting** an amount that exceeds the contractual amount ~~allowance or discount that is they have agreed to upon in the contract with primary payer with other insurers.~~

**Added: above red text**

**Deleted: strikethrough text**

### 7.8.6 Rehabilitative Therapy

Speech-Language Pathology (SLP) providers may enroll as private practitioners with Vermont Medicaid. Coverage of private practice SLP services are limited to those services provided outside of the school or hospital systems for Medicaid members of any age.

The following statements apply to all therapy services:

- Medicaid does not cover any treatments or any portions of a treatment, when the efficacy and/or safety of that treatment is not sufficiently supported in current, peer reviewed medical literature.
- All treatment must demonstrate medical necessity.
- Per National Correct Coding regulations, treatment must be billed under the most specific code. Billing a non-covered service under a less specific code in order to obtain coverage could constitute fraud and could expose the provider to recoupment and fraud investigation.
- Examples of treatment that do not have sufficient support in current medical literature at this time include, but are not limited to: sensory integration therapy, craniosacral therapy, myofascial release therapy, visceral manipulation therapy, auditory integration training, and facilitated communication.

**Added: above red text**

### 10.3.2 Ambulance Services

All the following conditions must be met before reimbursement will be made:

1. The ~~vehicle and personnel~~ **ambulance service** must be certified for participation in Medicare.

<u>SERVICE FROM</u>	<u>SERVICE TO</u>	<u>ALLOWED</u>
7. Home or nursing home	Physician's office** ( <del>see NEMT</del> )	<del>No</del> Yes
8. Physician's office	Home or nursing home** ( <del>see NEMT</del> )	<del>No</del> Yes

\*This service is paid for by the hospital where trip originates.

\*\*Must be medically necessary, requires a physician certification statement (PCS).

**Added: above red text**

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### 10.3.19 EPSDT Program Well – Child Health Care

EPSDT services are billed to Vermont Medicaid on the CMS 1500 claim form using CPT procedure codes 99381-99385 and 99391-99395 and the appropriate modifier, "EP".

Provider-Based Billing requires EPSDT services to be billed on the UB 04 claim form using CPT procedure codes 99381-99385 and 99391-99395 and the appropriate modifier, "EP".

**Added: above red text**

### 11.12 CMS 1500 Paper Claim Billing Instructions/Field Locators

#### 11b. OTHER CLAIM ID (DESIGNATED BY NUCCU)

Property casualty payers (e.g. automobile, homeowner's, or worker's compensation insurers and related entities are to use qualifier Y4 and the Agency (property casualty) claim number as the identifier. Enter qualifier to the left of the vertical, dotted line and the identifier to the right. For workers compensation and property casualty enter the claim number assigned by the payer (if known).

#### 14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY

period.

Enter the first date of present illness injury, or pregnancy. For pregnancy, use the date of last menstrual

Use qualifier "431" - Onset of Current Illness or "484" - Last Menstrual Period (LMP))

#### 17. NAME OF REFERRING PROVIDER OR OR OTHER SOURCE

the  
referred/ordered the

Enter the name (First, Middle Initial, Last) followed by the credentials of professional who

service or supply. If multiple providers apply, enter one provider/qualifier in the following order:

- 1) DN – Referring Provider
  - 2) DK – Ordering Provider
  - 3) DQ – Supervising provider
- Exception: Professional/Professional Crossover Claims require the Ordering qualifier to be used 1<sup>st</sup> when the provider in Field 19 is an Independent Lab, Independent Radiology, DME Supplier,

Prosthetics/Orthotics or Sole source  
Eye Glass provider.

17a. TAXONOMY/REFERRING PROVIDER

Enter the referring provider's the  
**other ID number** of the referring, ordering, or  
supervising provider. Use the appropriate  
qualifier to indicate what the ID number  
represents; enter in field immediately to the  
right of 17b. Refer to <http://nucc.org/> for list  
of valid qualifiers. **Entry must support  
information entered in field 17. If applicable,  
field is required.**

17b. NPI\*

Enter the referring, ordering or supervising  
provider's NPI. **Entry must support  
information entered in field 17. If applicable,  
field is required.**

**Added: above red text**

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### 12.4.5 Inpatient Claims: Medicare Part A Exhausts or Begins During the Inpatient Stay

When a Vermont Medicaid member has Medicare part B coverage and Medicare part A has exhausted, providers are instructed to bill as follows:

1. Bill part A charges to Medicare. **Claim will crossover to Vermont Medicaid for payment of deductible and/or coinsurance.**
2. A claim for Inpatient dates of service not covered under Medicare part A must be billed to Medicare B for payment of covered **ancillary** charges. Claim will crossover to Vermont Medicaid for payment of coinsurance and deductible.
3. The inpatient claim for the **entire stay** should be billed to Vermont Medicaid with "Medicare benefits exhausted or began on mm/dd/yy" indicated in field locator 80 on the UB.
4. Add together the Medicare B payment, the Medicare B contractual adjustment, and the Vermont Medicaid crossover payment. Indicate this total amount in field locator 54a on the UB. **Do not indicate any payment by Medicare A.**
5. Attach both the part A and B EOBs. On part A EOMB, write "Medicare benefits exhausted or began on mm/dd/yy". The charges will not match on part B EOMB. Sign and date part A EOMB.
6. Submit your claim and all attachments to your Vermont Medicaid Provider Representative. (See <http://www.vtmedicaid.com under Information/Provider Representative Map>)

If an inpatient claim is submitted to Medicare as primary payer is denied by Medicare because the patient's Medicare covered benefits are exhausted, DVHA will pay the **exhausted day(s)** claim based on DRG Payment methodologies for the patient's Medicaid covered services.

If a patient becomes Medicare eligible during an inpatient stay, Medicare will pay Medicare covered days as the primary payer. **The claim will crossover to Vermont Medicaid for payment of deductible and/or coinsurance.** DVHA will pay **an inpatient claim** for the Medicaid covered days as a separated DRG payment for the patient's Medicaid covered services and DVHA will pay **a crossover claim** for the coinsurance and deductible for the Medicare covered days.

**Added: above red text**

### 12.5.7 Provider-Based Billing

Provider-based billing is the practice of charging for physician services separately from building/facility overhead. In provider-based billing, also commonly referred to as hospital outpatient billing, one charge represents the facility or hospital charge and one charge represents the professional or physician fee.

The DVHA will reimburse for services provided in an outpatient clinic that has hospital provider-based status under 42 C.F.R. § 413.65, including clinics that meet the Medicare definition of a hospital-based provider (e.g., an outpatient clinic not on the hospital campus). Providers are to align their place of service billing between Medicare and Vermont Medicaid for outpatient clinics with provider-based status.

Providers are to bill Medicaid in two parts: one bill for the physician service on a CMS1500, and another bill for the hospital/facility resources and services on a UB04. There should be a matching UB04 for every CMS1500, both billed with a place of service (22) for outpatient hospital. This will result in a facility payment to the physician (instead of a non-facility payment), thus minimizing what would otherwise be double payment for office expenses.

**Added: above red text**

## UPDATES FOR 10/1/2014

### 1.2.4 Claim Submission & Correspondence Mailing Addresses

To ensure your request is processed in a timely manner, use the correct PO Box specific to each correspondence type mailed to HP Enterprise Services.

- PO Box 999 – UB04 Claim Forms
- PO Box 777 – CMS 1500 Forms
- PO Box 1710 – Dental Forms
- PO Box 1645 – All Checks
- PO Box 888 – All Other Mail & Inquiries

Williston, VT 05495-0888

Health care providers and administrators wishing to send paperwork using a registered or certified carrier service are to use our physical office address:

HP Enterprise Services 312 Hurricane Lane, Suite 101 Williston, VT 05495

**Added: above red text**

### 4.3 Member Bill of Rights

Members have the right to look at their medical records, and to obtain copies of the records. A reasonable fee may be charged to cover making copies and postage. An office may not charge for copies of records needed to support a claim or an appeal or Copying of medical records for the purpose of supplying them to another health care provider.

**Added: above red text**

### 6.1 Contractual Allowance

Vermont Medicaid is payer of last resort, and as such, will not consider and pay amounts that ~~exceed the Medicaid rate, even when payment is combined with payments from primary insurance are considered to be the contractual allowable amount of a primary insurer.~~

Providers must reduce the expected payment from Vermont Medicaid ~~and note the contractual allowable adjustment of a primary insurer.~~ When another insurance carrier has made a payment,

~~you must add the contractual allowable adjustment/discount amount to the payment and document the total~~ **payments received by other insurance carriers** in the appropriate field on your claim form.

When the entire allowed amount is applied to the primary insurance deductible, ~~do not enter the contractual allowance~~ **the claim may be submitted to Vermont Medicaid but must be accompanied by an EOB.** Vermont Medicaid will consider payment based on the Vermont Medicaid allowed amount after deducting ~~any payment made by a primary insurer~~ any payment made by a primary insurer.

**The provider must not bill Vermont Medicaid an amount that exceeds any contractual allowance or discount that they have agreed to with other insurers.**

**Added: above red text**

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### 7.8.3 Out-of-Network Elective Outpatient Referrals

Prior authorization is required for referrals to out-of-state/out-of-network medical visits that are elective/non-emergency, for codes 99201-99215; 99241-99245; 99341-99360 and 99381-99456; however, PA is not required for referrals for office visits to:

- Providers affiliated with Extended-network hospitals
- Providers affiliated with Out-of-state In-network hospitals

All other PA requirements will apply. A list of Green Mountain Care in-network and extended network hospitals is available at <http://dvha.vermont.gov/for-providers/green-mountain-care-network>.

Referring providers must submit requests using the OOS Medical Office Request Form located at <http://dvha.vermont.gov/for-providers/clinical-coverage-guidelines>. Fax all requests to the DVHA Clinical Unit, 802-879-5963.

**Note: Only office visit(s) are being approved. Do not proceed with any non-emergent outpatient procedure until you have first determined and documented that the service cannot be performed by an in-network provider.**

**Added: above red text**

### 10.3.46 Psychiatry/Psychology

- Psychotherapy time includes face-to-face time spent with the patient and/or family member **and/or legal guardian.**

**Added: above red text**

### 12.4.9 Short ~~Same-Day~~ Stays

**Short stays** (defined as one calendar day) apply when a patient is admitted and discharged from the same acute care facility on the same calendar day, see below examples.

- Example: Patient is admitted 5:00 am on 12/4/13 and released 11:30 pm on 12/4/13. This is a same-day stay.
- Example: Patient is admitted at 10:00 pm on 12/4/13 and released at 7:00 am on 12/5/13. This is not a same day stay.

**Effective for inpatient claims with a date of service on or after 10-1-2014, if a claim has a discharge status code (07) and the length of stay is less than the assigned DRG geometric mean length of stay as identified by Medicare, the claim will also be considered a short stay.**

**Short Stay** claims will be paid the lesser of the cost of the case or the DRG payment.

**Added: above red text**

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#### 12.4.10 Same/Next Day Readmission Policy

Effective for inpatient claims for dates of service on or after 10-1-2014, DVHA will not reimburse separate DRG payments for two separate inpatient claims when the patient's subsequent claim's admit date is on the same or next day after their original claim's discharge date, both claims are for the same facility, and both claims are for the same or a related condition.

Condition code B4 applies to inpatient admissions with a date of service on and after October 1, 2014, when a beneficiary is readmitted to the same hospital on the same or next day after a previous discharge for symptoms unrelated to, or not for evaluation and management of, the prior stay's medical condition. Condition code B4 will allow the separate episode of care by indicating it is unrelated to the first admission. The code B4 is to be used only when appropriate and in addition to any other applicable condition codes.

For additional information and specific details pertaining to the proposed Inpatient Same/Next Day Readmission Policy, please refer to: <http://dvha.vermont.gov/administration/draft-versions-of-state-plan-changes>.

**Added: above red text**

#### 12.4.12 Transfer Cases

Transfer cases are defined as patients who initiate an inpatient stay in one hospital and are discharged/admitted from one acute care facility to another.

- The receiving hospital will be paid under normal DRG payment logic.
- The transferring hospital will be paid the lesser of the cost of the case or the DRG payment (including any eligible outlier payment).

Claims will be considered under the transfer methodology when an inpatient claim has a discharge status code of either 02, 05, 06, 62, or 65. When the transfer status code is 02, the claim will automatically fall under the transfer payment methodology.

Effective for inpatient claims with a date of service on or after 10-1-2014, when the transfer status code is either 05, 06, 62, or 65, and the assigned DRG falls within the list of DRGs that Medicare considers to be post-acute, the claim will fall under the transfer payment methodology.

**Added: above red text**

#### 12.5.2 Dialysis

- Revenue code 780, Telemedicine - is reimbursable when billed with the appropriate HCPCS code. Pricing is the current Level II price on for the HCPCS code billed on the claim.

**Added: above red text**

### UPDATES FOR 8/23/2014

#### 12.5.1 Cardiac Rehabilitation

Cardiac rehabilitation is billable under revenue code 943. One unit is equal to one day regardless of the number of encounters.

Effective for date of service May 16, 2012 and thereafter, cardiac rehabilitation is limited to 36 sessions within a 36 week timeframe. An additional 36 sessions may be approved by the DVHA



Clinical Unit when the claim includes the appropriate notes and meets the required criteria. ~~The maximum allowed number of additional sessions eligible for consideration is 72.~~

**Added: above red text**

**Deleted: strikethrough text**

## UPDATES FOR 8/1/2014

### 6.7 Individual Consideration/Manual Pricing

The rates on file for certain procedure codes do not have specific dollar amounts because no one amount is appropriate. In these cases, the rate on file is set at "IC" (individual consideration). The fiscal intermediary and the DVHA will calculate the allowed amount. This process is often called "manual pricing". For DME, see section 11.1 **Payment DVHA Primary**.

All requests for changes to place of service (POS), provider type (PT), provider specialty (PS), Modifier, number of units and diagnosis code (DX) restrictions/allowance are to be submitted on the POS, PT, PS, Modifier, Unit & DX Change Request Form located at <http://www.vtmedicaid.com/Downloads/forms.html>.

~~The form contains a tab designated for each of the above change requests. Please fill out the required information on the correct tab specific to your need. Providers only need to complete the columns highlighted in yellow.~~

~~Requests will be reviewed on the 1st and 15th day of each month (or the first business day thereafter). To guarantee timely processing, it is recommended providers submit their requests two business days prior to the review date.~~

~~Submit your request form to [vermonthipacontact@hp.com](mailto:vermonthipacontact@hp.com). Indicate your provider name in the subject line of your e-mail. Requests submitted without the form will not be reviewed. Providers will be notified of the approval/denial decision within 10 business days of the review date. In the event your request is denied, an appeal may be submitted via fax to the DVHA Clinical Unit Administrator at 802-879-5963. Your Appeal should include a cover letter of explanation.~~

**Deleted: strikethrough text**

### 7.3.1 General Exceptions

**Retroactive Eligibility:** Covered services that normally require PA, which are provided to an individual **in the retroactive period (defined as eligibility start date to eligibility segment update date)** on a date of service prior to when they were determined eligible for Vermont Medicaid, do not require PA. ~~A copy of the Notice of Decision (220MP), showing retroactive eligibility, which may be obtained from the member's District Office, must be attached to the claim.~~

**Added: above red text**

**Deleted: strikethrough text**

### 7.7 Prior Authorization Notice of Decision

**Per Medicaid Rule 7102.3, there are two exceptions to prior authorization requirements:**

- 1. Emergency Services**
- 2. Services that occurred during the Retroactive Eligibility segment**

**Therefore, a Notice of Decision (NOD) is not required for Prior Authorization if the service is provided in the 'retroactive period' defined as eligibility start date to eligibility segment update date.**

**Added: above red text**



## 8.1 Timely Filing

- A member's eligibility was made retroactive and the date of service is within the retroactive period. The claim must be submitted within the first twelve months of the date on the Notice of Decision. ~~Include a note with the claim stating the retroactive date of eligibility~~

**Deleted: strikethrough text**

### 10.3.7 Bilateral Procedures Physician/Professional Billing

When bilateral surgical procedures are performed during the same operative session, and the CPT code's description does not already state "bilateral", bill the CPT code only once using modifier 50 and bill one unit only. The system will allow one 150% payment.

Modifier 50 on is not to be used on claims submitted for bilateral radiology services. **In addition, Modifier 50 is not to be used on institutional claims; it is not recognized under the VT OPPS Pricing Methodology.**

**Added: above red text**

### 12.4.12 Outpatient Services Rendered During an Inpatient Stay

**Member is admitted to Hospital A for inpatient care. Member is transferred to Hospital B for outpatient services not able to be provided by Hospital A, and then Member is transferred back to Hospital A to complete their inpatient care. Hospital B is to bill Hospital A for the outpatient services provided. Hospital A is to bill Medicaid for the inpatient stay and will be paid under the normal DRG logic.**

**Added: above red text**

### 13.4.1 Telemonitoring

**Home Telemonitoring is a health service that allows and requires scheduled remote monitoring of data related to an individual's health, and transmission of the data from the individual's home to a licensed home health agency. Scheduled periodic reporting of the individual's data to a licensed physician is required, even when there have been no readings outside the parameters established in the physician's orders.**

#### **Eligibility Criteria:**

**Individuals receiving Medicaid telemonitoring services must:**

- **Have Medicaid as primary insurance or be dually-eligible with "non-home bound" status; and**
- **Have Congestive Heart Failure (any diagnosis; 428.xx); and**
- **Be clinically eligible for home health services; and**
- **Have a physician's plan of care with an order for telemonitoring services.**

#### **Qualified Providers:**

**A qualified telemonitoring provider must be a designated home health agency and enrolled in Vermont Medicaid.**

**Providers must use the following licensed health care professionals to review data:**

- **Registered nurse (RN)**
- **Nurse practitioner (NP)**
- **Clinical nurse specialist (CNS)**

- Licensed practical nurse (LPN), under the supervision of an RN
- Physician assistant (PA)

Providers must follow data parameters established by a licensed physician's plan of care.

In the event of a measurement outside of the established individual's parameters, the provider shall use the health care professionals noted above to be responsible for reporting the data to a physician.

The data transmission must comply with standards set by the Health Insurance Portability and Accountability Act (HIPAA).

### Reimbursement

When Telemonitoring services are provided to clinical eligible Medicaid patients, qualified providers may bill CPT S9110 for once every 30 days for telemonitoring of patient in their home, including all necessary equipment; computer system, connections, and software; maintenance; patient education and support; per month. CPT 98969 may be billed once every 7 days for ongoing assessment and management of telemonitoring data.

**Added: above red text**

## UPDATES FOR 7/1/2014

### 6.6 Medicaid & Medicare Crossover Billing

The Department of Vermont Health Access reviews all Medicare crossover claims where the Medicaid allowed amount (coinsurance / deductible) is over \$10,000.00. These claims require DVHA's review and approval prior to payments being made. To facilitate the processing of these claims, please attach the following information to your claim if the expected coinsurance /deductible payment from Medicaid is over \$10,000.00: the Medicare Attachment Summary Form, the Medicare EOMB and the discharge summary at the time of submission. Any claims submitted without the required supporting documentation will be denied.

**Added: above red text**

### 12.5.4 Hospital Clinical Laboratory Tests

#### Clinical Laboratory Tests Reimbursed Separately

Effective for claims submitted on or after 7/1/2014, CMS has created a new modifier, L1, to be used on the 13x bill type when non-referred clinical laboratory tests are eligible for separate payment under the following two exceptions:

- A hospital collects specimen and furnishes only the outpatient labs on a given date of service; or
- A hospital conducts outpatient lab tests that are clinically unrelated to other hospital outpatient services furnished the same day. "Unrelated" means the laboratory test is ordered by a different practitioner than the practitioner who ordered the other hospital outpatient services, for a different diagnosis.

A third exception is allowed for non-patient (referred) clinical laboratory specimens. Providers are to continue billing these outpatient lab tests separately on a type of bill 14x; do not use the L1 modifier.

For additional information, please refer to CMS publication: <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1412.pdf>.

**Added: above red text**

## 13.4 Adult Day Services Billing Instructions/Field Locators

### 76. ATTENDING PHYSICIAN NPI\*

If billing with a Vermont Medicaid ID #, leave the NPI field blank and enter the Vermont Medicaid ID # to the right of the qualifier box.

**Added: above red text**

## UPDATES FOR 6/11/2014

### 2.5.8 Referrals

Effective July 1, 2012, non-emergency (elective) out-of-state medical visits will require prior authorization from the DVHA Clinical Unit. Border Hospitals **Out-of-State Network Hospitals and Extended Network Hospitals** are excluded from this requirement.

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## 3.6 Medicaid Rule & State Plan Resources

Medicaid Rule, along with other DVHA rules is located online at

<http://humanservices.vermont.gov/on-line-rules/dvha>.

Note: Per State statute, Vermont's Secretary of State is charged with publication of a bulletin of rules. As such, the Secretary of State is the official source for the most current and comprehensive rules for DVHA. DVHA is not responsible for reliance on regulations posted should rules be different than those posted on the Secretary of State website. An electronic copy of the rules maintained by the Secretary of State is available via <http://www.lexisnexis.com/hottopics/codeofvrules/>.

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## 6.3 Who is Responsible for Payment?

Eligibility can be verified up to nine days in advance **however, this is not a guarantee of payment.**

**Added: above red text**

## 9.10 Place of Service (POS) Codes

~~For the professional component (PC) of diagnostic tests, the facility and non-facility payment rates are the same.~~

~~For Services to a patient who is a registered inpatient of a hospital (POS 21) or an outpatient hospital (POS 22), the facility rate is paid, regardless of where the face to face encounter occurred.~~

The list of settings where Professional services are paid at the **facility** rate:

~~ASC for HCPCS not on approved list after Jan 1, 2008 (POS 24)~~

Professional services are paid at **non-facility** rates for procedures in the following:

~~Pharmacy (POS 01)~~

~~Homeless Shelter (POS 04)~~

~~Prison /Correctional (POS 09)~~

~~Group Home (POS 14)~~

~~Temporary Lodging (POS 16)~~

~~Urgent Care Facility (POS 20)~~

Independent Clinic (POS 49)

Non-residential Substance Abuse Treatment Facility (POS 57)

Mass Immunization Center (POS 60)

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## 15 Choices for Care: Enhanced Residential Care (ERC)/Nursing Facilities Home Based Waiver (HBW), Moderate Needs

Eligibility for Choices for Care high/highest in all settings is based on specific clinical and financial eligibility criteria and is determined through the Choices for Care application process. Applications may be found at [http://dcf.vermont.gov/esd/ltc\\_medicaid](http://dcf.vermont.gov/esd/ltc_medicaid)

Moderate Needs Program eligibility is based on clinical and financial criteria and is limited to available provider funding. Applications can be found at <http://www.ddas.vermont.gov/ddas-programs/programs-cfc/programs-cfc-default-page#forms>.

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### 15.2 Choices for Care: Nursing Facilities - General Billing Information

#### 15.2.1 Authorization for Care & Non-Covered Services

The provider must complete the DVHA 280 or 281 form and submit the form to the local DCF office in order for the long-term care eligibility to be determined. The DCF district office will send the facility a copy of the notification that is also sent to the member.

#### 15.2.2 Member Placement Levels (RPL)

The following placement levels are used for specific classifications of long-term care members in the DCF ACCESS system long panel:

026	Cash & Counseling
-----	-------------------

~~This is based on the request of the long-term care facility. When the Long Term Care facility is requesting placement, they must utilize the above list when applying for an authorized placement level. Placement level is not equal to the level of care of the Long Term Care facility and is not reported on the UB-04 claim form.~~

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#### 15.2.10 Choices for Care Short-Term Respite Stays

Individuals enrolled in Choices for Care in the home or ERC settings may receive short-term respite in a Vermont Medicaid licensed nursing facility by changing their Choices for Care setting. This is done by notifying DCF and DAIL using the CFC 804 Change Form. Once the DCF ACCESS long panel is updated with the nursing facility information, the facility may bill Medicaid using the appropriate revenue code. (Respite stays exceeding 30-days may trigger a change in patient share.)

#### 14.5.10 Respite Care Billing in the Nursing Home

~~Nursing homes are required to obtain a Choices for Care, Aged/Disabled Waiver provider number when authorized by DAIL (Department of Aging and Independent Living) to provide respite services in your facility. The CFC waiver provider type and specialty will allow reimbursement for the respite care. The appropriate revenue code for choices for care respite care in the nursing home is 074. Providers billing for respite must select a type of bill from the following:~~

##### 1. Type of Facility

~~—8 Hospice or Special Facility~~

## 2. Bill Classification

~~—6 Respite~~

## 3. Frequency

~~—1 Admit through discharge claim~~

~~—2 Interim first claim~~

~~—3 Interim continuity claim~~

~~—4 Interim last claim~~

For additional information, please refer to: <http://ddas.vermont.gov/ddas-policies>.

**Replaced: section 14.5.10 with 15.2.10**

### 16.1 Fraud

- 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 Medicaid than other providers
- Coding billing records to get more reimbursement
- Misrepresenting an unallowable service on bill as another allowable service
- Falsely diagnosing so Medicaid will pay more for services
- ~~• File a claim for services which were not rendered~~
- ~~• File a false claim~~
- ~~• File a claim for unauthorized items or services~~
- ~~• Bill the beneficiary or the beneficiary's family for an amount in excess of that allowed by law or regulation~~
- ~~• Fail to credit the state or its agent for payments received from social security, insurance or other sources~~
- ~~• Receive unauthorized payment~~

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### UPDATES FOR 6/1/2014

#### 1.2.4 Claim Submission & Correspondence Mailing Addresses

- PO Box 1710 – Dental Forms and Vision Claim Forms

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### 7.8.6 Rehabilitative Therapy

Speech-Language Pathology (SLP) providers may enroll as private practitioners with Vermont Medicaid. Coverage of private practice SLP services are limited to those services provided outside of the school or hospital systems for Medicaid members ~~less than 22 years of age~~ of any age.

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#### 11.11.21 Wheelchair Repairs

Durable Medical Equipment (DME) providers who service wheelchairs may make repairs to wheelchairs provided to a Medicaid member by another DME provider, if the initial provider has gone out of business or the device records are unobtainable (for example, the records of the Scooter Store). In these instances, DME providers are allowed to make repairs to the device in order to assure the safety and independence of the Medicaid member. If there is any concern that the device is not medically appropriate to the medical needs of the member, an assessment by a physical or occupational therapist is advisable. The Department of Vermont Health Access website provides access to the following information regarding repairs:

Medicaid guidelines:

<http://dvha.vermont.gov/for-providers/dme-repairs-guidelines050313.pdf>.

Medicaid Rule (section 7506.4): <http://humanservices.vermont.gov/on-line-rules/dvha>.

**Added: above red text**

### 11.12 CMS 1500 Paper Claim Billing Instructions/Field Locators

21. ICD Ind.\*

Enter "9" for ICD-9 diagnosis codes. NOTE:  
ICD-10 codes are not valid until 40-44 10-  
1-15; enter "0" for ICD-10.

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### 12.2 Reimbursement Policy

Refer to the Fee Schedule for a complete listing of services that are reimbursable by Vermont Medicaid. Implementation of OPPS pricing has not changed the Vermont Medicaid policy regarding non-covered services.

Providers are allowed to compliantly bill the correct monthly code that meets the definition of the actual services provided for members subject to partial eligibility in any given month. However, providers may only bill the dates of service in which the beneficiary is actively eligible for Medicaid.

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### UPDATES FOR 5/1/2014

#### 2.3 Primary Care Plus (PC PLUS)

PCPs receive a monthly case management fee for each member enrolled with the PCP. This fee is for coordinating members' health care services. ~~regardless of whether the member is seen. When services are provided, the Medicaid fee for service reimbursement applies. When services are provided, the Medicaid fee for service reimbursement applies.~~ The case management payment structure is based on the number of patients that are attributed to the practice. Vermont Medicaid

will attribute beneficiaries to the PCP who has billed for appropriate services and has seen the beneficiary within the last 24 months.

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#### 4.4 Beneficiary Cost Sharing/Co-pays and Premiums

Certain beneficiaries must participate in the cost of care for services. Co-payments are never required of Medicaid beneficiaries under age 21 (effective 8/1/2012); pregnant or in a 60-day post-pregnancy period; living in a long-term care facility, nursing home or hospice; or for family planning services and supplies, emergency services (includes: dental services covered under a GA Voucher), and durable medical equipment (DME) and medical supplies (effective DOS 7/1/2013).

**Added: above red text**

### 11.12 CMS 1500 Paper Claim Billing Instructions/Field Locators

10. CONDITION RELATED TO\*

Check appropriate box to indicate:

- a. If condition is related to employment
- b. If condition is related to an auto accident
- c. If condition is related to any other type of accident.

If yes is checked in any of these boxes, enter the accident date in field locator 44-15.

17b. NPI\*

Enter the referring, ordering or supervising provider's NPI. If applicable; completion of field locator 17 is required.

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### UPDATES FOR 4/1/2014

#### 1.1 Green Mountain Care Overview

**Green Mountain Care** is the brand name for the publicly funded health coverage programs offered by the State of Vermont. Programs include Medicaid, Vermont Health Access Plan (VHAP), Dr. Dynasaur and prescription assistance pharmacy-only programs. a number of premium assistance pharmacy-only programs (VHAP Pharmacy, VScript, VPharm, Vscript Expanded) and Catamount Health. The **Green Mountain Care** website is <http://www.greenmountaincare.org>.

Catamount Health, offered in cooperation with the State of Vermont by Blue Cross Blue Shield of Vermont and MVP Health Care, is not part of this manual.

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## 2.1 Health Insurance Program Participation

### Vermont Health Access Plan (VHAP)

~~VHAP provides low cost, comprehensive health care benefits to low income adult Vermonters who are otherwise uninsured, have been uninsured for 12 months or more, with exceptions for Vermonters who recently lost their insurance because of a life change such as a divorce or loss of a job. The VHAP Medicaid expansion, authorized in 1995 by the Vermont General Assembly and supported by a Section 1115 Research and Demonstration Waiver approved by the federal government, and subsequently the Global Commitment 1115 Waiver, is designed to improve the accessibility and quality of health services for Vermont's most vulnerable populations through improved management of care.~~

~~All VHAP beneficiaries are expected to enroll in PC Plus managed care. Prior to enrollment in PC Plus, VHAP beneficiaries are enrolled into the VHAP Limited program. Co-payments are required; see Section 4.4 Beneficiary Cost Sharing/Co-pays and Premiums.~~

### VHAP Limited

~~This is a transition program, implemented on January 1, 1996, for use between initial enrollment and enrollment in VHAP managed care. VHAP Limited provides a benefit to low income uninsured adults and mirrors VHAP Managed Care; a beneficiary may need to select a Primary Care Physician (PCP) prior to receiving a service. If a beneficiary pays their initial premium, coverage is retroactive to the day eligibility was approved. The beneficiary will be responsible for the cost of services, however, if the initial premium is not paid.~~

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## 2.2 Prescription Assistance Pharmacy-Only Programs

~~VHAP Pharmacy The VHAP Pharmacy program expands pharmaceutical and vision benefits to assist low income, Vermonters age 65 or older and people with disabilities. The program covers prescription drugs and certain over the counter drugs. Co-payments are required,~~

~~VScript VScript assists with pharmaceutical benefits for maintenance drugs for long term medical problems for Vermonters age 65 and older and people of all ages with disabilities and who are not enrolled in Medicare.~~

~~Vscript Expanded Vscript Expanded helps Vermonters 65 and older and people of all ages with disabilities who are not enrolled in Medicare pay for prescription and over the counter maintenance drugs.~~

~~VPharm VPharm assists Vermonters enrolled in Medicare Part D with payment for prescription medications. The Medicare Part D prescription drug benefit began on January 1, 2006. In general, VPharm covers drug classes that are excluded from the Part D benefit, and may assist with premiums and cost sharing.~~

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## 2.3 Primary Care Plus (PC PLUS)

~~Primary Care Plus (PC Plus) is a primary care case management program developed by the DVHA as part of the State's Section 1115 waiver. This program was implemented on October 1, 1999. Vermont requires that all Medicaid and Dr. Dynasaur and VHAP beneficiaries enroll in PC Plus.~~

~~Membership in PC Plus is mandatory for all VHAP beneficiaries and all Medicaid and Dr. Dynasaur beneficiaries who are not otherwise exempt from managed care enrollment under the provisions of the 1115 waiver.~~

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### 3.2 Banner Page

The first page of the RA, the weekly report listing the status of each claim and any pertinent financial information, is referred to as the banner page. Messages on the banner page keep providers informed of important changes in policy or billing procedures. The banner page may be the only or first notification of a change in billing procedure. It is the provider's responsibility to obtain this information from their RA regarding DVHA policy or procedure. Banner pages are posted online weekly [at www.vtmedicaid.com/Information/whatsnew.html](http://www.vtmedicaid.com/Information/whatsnew.html) and are archived at the same online location.

The Banner Page can be emailed directly to you when you join our communications email distribution list. Send your email address to [vtadvisorycommunications@hp.com](mailto:vtadvisorycommunications@hp.com) to receive this resource and other communications relevant to Vermont Medicaid.

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### 3.6 Medicaid Rule & State Plan Resources

Medicaid Rule, along with other DVHA rules for other programs such as VHAP, pharmacy programs and premium assistance programs, is located online at <http://humanservices.vermont.gov/on-line-rules/dvha>.

The State Plan is a guiding document for changes applicable to Vermont's Medicaid population and includes the populations for the State's Children's Health Insurance Program (CHIP) and the Choices for Care program which are not covered by the Global Commitment (GC) to Health Waiver. State Plan information, is at <http://dvha.vermont.gov/administration> in the Service Administration section. Global Commitment to Health 1115 Demonstration Waiver information is at <http://dvha.vermont.gov/administration> in the Global Commitment section.

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### 4.4 Beneficiary Cost Sharing/Co-pays and Premiums

Certain beneficiaries must participate in the cost of care for services. Co-payments are never required of Medicaid beneficiaries under age 21 (effective 8/1/2012); pregnant or in a 60-day post-pregnancy period; living in a long-term care facility, nursing home or hospice; or for family planning services and supplies, emergency services and durable medical equipment (DME) and medical supplies (effective DOS 7/1/2013).

Although beneficiaries are required to make co-payments under Medicaid, if the member is unable to make the payment, Medicaid providers may not deny services. Per section 1916(c) of the Social Security Act, "no provider participating under the State [Medicaid] plan may deny care of services to an individual eligible for [Medicaid] on account of such individual's inability to pay (the copayment)."

#### **VHAP Co-Pays**

~~\$1.00 — for prescription drugs (at or above 100% FPL) costing less than \$30.00 (effective 8/1/2012);~~

~~\$2.00 — for prescription drugs (at or above 100% FPL) costing \$30.00 or more but less than \$50.00 (effective 8/1/2012);~~

~~\$3.00 — for prescription drugs (at or above 100% FPL) costing \$50.00 or more (effective 8/1/2012).~~

~~\$3.00 — outpatient hospital visits (effective 8/1/2012);~~

~~\$25.00—Emergency room visits (no additional co-pay will be required for post-emergency stabilization care)~~

~~VHAP co-pays apply regardless of beneficiary age.~~

~~AID CATEGORIES: J3-J8, U1-U6, UX, UA, UB, UC, UD, UE & UF~~

~~VHAP Pharmacy Beneficiaries Aid Categories V1, V2, V3, V5 & V6:~~

~~Effective 07/15/2009: Co-pays for prescriptions \$29.99 or less = \$1.00~~

~~Prescriptions \$30.00 or more = \$2.00~~

~~*Vision Coverage:* For beneficiaries with category codes V1, V2, V3, V5 & V6, Vermont Medicaid will cover an eye exam (92XXX) and refraction, but will NOT cover a medical eye exam (99XXX) and refraction.~~

~~*Crossover Coverage:* V5 & V6 only Beneficiaries are responsible for the Medicare coinsurance and/or deductible.~~

~~VScript Beneficiaries Aid Categories VA, VS, V7 & V8:~~

~~Effective 07/15/2009: Co-pays for prescriptions \$29.99 or less = \$1.00~~

~~Prescriptions \$30.00 or more = \$2.00~~

~~This Plan Covers:~~

~~Maintenance drugs ONLY and only when the manufacturer has a rebate agreement with the State of Vermont. When a drug is not covered under the program because it is not a maintenance drug or because there is no rebate agreement, beneficiaries may have coverage through the Healthy Vermonter's Program.~~

~~VScript Expanded Beneficiaries Aid Categories VB, VC, VT & VU:~~

~~Effective 07/15/2009: Co-pays for prescriptions \$29.99 or less = \$1.00~~

~~Prescriptions \$30.00 or more = \$2.00~~

~~This plan covers:~~

~~Maintenance drugs ONLY and only when the manufacturer has a rebate agreement with the State of Vermont.~~

~~When the drug is not covered under the program because it is not a maintenance drug or because there is no rebate agreement, beneficiaries may have coverage through the Healthy Vermonter's Program.~~

~~VHAP Pharmacy with Medicare Aid Category V4:~~

~~Effective 07/15/2009: Co-pays for prescriptions \$29.99 or less = \$1.00~~

~~Prescriptions \$30.00 or more = \$2.00~~

~~*Crossover Coverage:* Benefits include payment of Medicare coinsurance and deductible only.~~

~~*Vision Coverage:* For beneficiaries with category code V4, Vermont Medicaid will cover an eye exam (92XXX) and refraction but will NOT cover a medical eye exam (99XXX) and refraction.~~

~~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.~~

VPharm Pharmacy-Aid Categories VD, VE, VF, VG, VH, VI, **VJ**, VK, VL, VM, VN & VO:

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### 7.8.6 Rehabilitative Therapy

#### Adult Coverage

Physical, Occupational, and Speech Therapy outpatient services for Medicaid eligible adults ~~and VHAP~~ are limited to 30 combined visits per calendar year.

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### 9.2 Aids

Vermonters living with HIV infection who meet certain income guidelines may be eligible for help with Medicaid ~~and VHAP~~ co-payments for treatment drugs through the Vermont Medication Assistance Program (VMAP). [http://healthvermont.gov/prevent/aids/aids\\_index.aspx#Anchor-Th-57625](http://healthvermont.gov/prevent/aids/aids_index.aspx#Anchor-Th-57625)

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### 10.2 Non-Reimbursable Services

No payment will be made for a service or item that is not eligible for reimbursement, unless authorized by the DVHA for reimbursement via section 7104 of Medicaid rules. These authorizations may be made only when serious detrimental health consequences would arise. Any beneficiary interested in applying, may contact the **Green Mountain Care** Member Services Unit for the required forms. ~~This process is available to all Vermont Medicaid beneficiaries (i.e. not VHAP).~~

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#### 10.3.6 Audiological Services/Hearing Aids

Audiology services are provided to beneficiaries of any age. Coverage of hearing aids is limited to one hearing aid per ear every three years for specified degree of hearing loss. Prior authorization is required for requests prior to the three year limit. ~~VHAP and VHAP Limited exclude coverage for hearing aids or examinations for the prescription or fitting of hearing aids.~~

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#### 10.3.41 Over-The-Counter (OTC) Medications

~~Effective July 1, 2011,~~ Coverage of Over the Counter (OTC) medications is limited to generics only in categories determined to be medically necessary. All other OTC products will be excluded from coverage without the option for a prior authorization request through the Clinical Call Center. The coverage guidelines apply to ~~all state pharmacy benefit plans, e.g., Medicaid, Dr. Dynasaur, VHAP, and includes VPharm. OTC coverage in our "limited OTC" plan, s such as VScript Expanded and VPharm 3 will not change.~~ DVHA pays for OTCs only when there is a specific medical necessity, and requires a written prescription for the OTC product. Some OTC medications are already managed on our Preferred Drug list (PDL) and other restrictions may apply. Though the DVHA has restricted OTC medications to primarily generics, beneficiaries will continue to have at least one choice in all medically necessary drug categories. Please refer to the DVHA website for a list of covered OTC medication categories at <http://dvha.vermont.gov/for-providers> The PDL can be found at <http://dvha.vermont.gov/for-providers/preferred-drug-list-clinical-criteria>.

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### 10.3.54 Vision Care & Eyeglasses

#### Eyeglasses

Eyeglass benefits (frames, lenses, dispensing and repairs) are reimbursed only for Medicaid beneficiaries under age 21. ~~Eyeglasses are not a VHAP (including age 18 and older) or VHAP Pharmacy benefit.~~

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### Section 11 Durable Medical Equipment, Prosthetics, Orthotics & Medical Supplies

The DVHA provides forms and tools to facilitate the prior authorization process. These forms and tools are available for the following DME items: Wheelchairs, speech generating devices, TENS units, and custom orthotics, and can found at: <http://dvha.vermont.gov/for-providers/clinical-coverage-guidelines>. Use of these designated forms/tools is recommended to ensure that all required information is available for review by the DVHA Clinical Unit Clinical.

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### 11.11.20 Wheelchairs & Seating Systems

The purchase and rental of wheelchairs requires prior authorization. Wheelchairs and seating systems are covered under various procedure codes (see current HCPCS manual). Refer to the Fee Schedule at <http://dvha.vermont.gov/for-providers> to determine the procedure codes that require prior authorization. To obtain prior authorization and individual consideration pricing, providers are required to submit a completed medical necessity form and pricing information to the clinical staff at the DVHA. When a beneficiary is also covered by Medicare, see **section 12.4 Payment-Dual Eligibles/Medicare Primary**.

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### 11.12 CMS 1500 Paper Claim Billing Instructions/Field Locators

All information on the CMS 1500 Claim Form should be typed or legibly printed. Only the **02-12 08/05** version of this form is accepted for processing.

~~15. SAME OR SIMILAR ILLNESS~~

~~Enter the therapy start date in MMDDYY format if billing physical, occupational or speech therapy.~~

~~14. DATE OF CURRENT~~

~~If your response indicates a 'yes' in field locators 10a, 10b or 10c, enter the date of the occurrence.~~

**15. OTHER DATE (ACCIDENT DATE)**

**If your response indicates a 'yes' in field locators 10b or 10c, enter the date of the occurrence and qualifier "439".**

**17. NAME OF REFERRING PROVIDER OR OR OTHER SOURCE**

**Use qualifier "DN", until further notice**

**17a. TAXONOMY/REFERRING PROVIDER**

**Enter the referring provider's taxonomy code when applicable.**

**17b. NPI/REFERRING PROVIDER\***

**Enter the referring, ordering or supervising provider's NPI. Enter the prescribing NPI for independent lab and DME suppliers.**

**21. ICD Ind.**

**Enter "9" for ICD-9 diagnosis codes. NOTE: ICD-10 codes are not valid until 10-1-14; enter "0" for ICD-10.**

21. DIAGNOSIS CODE(S)\*

Enter the appropriate IDC-9-CM **or** ICD-10-CM diagnosis code that relates to the service rendered. You may use up to **twelve** ~~four~~ diagnosis codes.

24a. DATE(S) OF SERVICE\*

Enter the date of each service provided. If the From and To dates are the same, the To date is not required. **You can add up to 4 pointers per detail.**

24e. DIAGNOSIS POINTER\*

Enter the appropriate diagnosis 'pointer' that relates to the service rendered from field locator 21. **NOTE: The pointer character has changed from numbers to letters.**

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### 14.5.2 Beneficiary Placement Levels (RPL)

~~The VHAP benefit package includes a Skilled Nursing Facility (SNF) stay which is limited to 30 days per episode and 60 days per calendar year. This is an acute care benefit not a Long Term Care (LTC) benefit. This means the Choices for Care (CFC) LTC Medicaid application is no longer required for VHAP recipients accessing their SNF benefit. Admission of a VHAP recipient to a SNF is based on a physician's order for SNF services with documentation of medical necessity for the treatment of illness or injury; the admitting diagnosis must support all treatment and therapies ordered and indicate that the service cannot be provided at a lower level of care. The SNF should communicate with the recipient and have them apply to DCF/ESD for CFC LTC Medicaid coverage for a stay greater than 30 days per episode or if the recipient is near their 60 day calendar year limit.~~

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## UPDATES FOR 3/1/2014

### 4.4 Beneficiary Cost Sharing/Co-pays and Premiums

#### 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.~~

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### 5.1.1 Enrollment Agreement Signatures

**All signatures must be original and signed in ink. Applications with signatures deemed not original will not be processed. Stamped, faxed or copied signatures will not be accepted.**

#### ***Exception:***

**Faxed signatures are allowed for certain cases including but not limited to out-of-state special enrollment for a single beneficiary and other special enrollment cases as identified by DVHA. Upon receipt of the faxed provider enrollment agreement, HPES is directed to telephone the provider to**

confirm that the provider did in fact send the fax. HPES may then begin the screening and enrollment process. Enrollment, including the assignment of the VT Medicaid provider number, may be completed with the use of the faxed agreement only.

**Added above red text**

#### 12.5.4 Hospital Clinical Laboratory Tests

Lab related charges must include the corresponding CPT or HCPCS code with the laboratory revenue code on the UB-04 claim form.

Beginning in CY 2014, Medicare began packaging some Clinical Laboratory procedure codes when they are billed with a primary service on a hospital outpatient claim. In keeping with Medicare, Vermont Medicaid has also begun packaging these services, as reflected on the 2014 OPPS Fee Schedule.

The general rule for OPPS payment methodology is that laboratory tests should be reported on a 13X bill type. There are limited circumstances described below in which hospitals can bill separately for laboratory tests on a 14x bill type.

Laboratory tests may be separately payable under the following limited exceptions;

- the laboratory test is the only service provided to that beneficiary on that date of service; or
- the patient is neither an inpatient or outpatient of a hospital (the beneficiary is not physically present at the hospital), but has a specimen that is submitted for analysis; or
- the laboratory test is on the same date of service as the primary service, but is ordered for a different purpose than the primary service by a practitioner different than the practitioner who ordered the primary service.

It is the hospital's responsibility to determine when laboratory tests may be separately billed on the 14X bill type under these limited exceptions.

**Added above red text**

#### 13.4 Home Health Agency & Hospice Services Billing Instructions/Field Locators

##### 4. TYPE OF BILL \*

###### 2. Bill Classification

- ~~3~~-Home Health
- 2 Home Health

**Replaced 3 with 2**

#### 13.5 Adult Day Services Billing Instructions/Field Locators

##### 4. TYPE OF BILL \*

###### 2. Bill Classification

- ~~3~~-Home Health
- 2 Home Health

**Replaced 3 with 2**

#### 14.2 Assistive Community Care Services (ACCS) Billing Instructions/Field Locators

##### 4. TYPE OF BILL \*

###### 2. Bill Classification

~~3-Outpatient or~~ 2-Home Health or ACCS

**Deleted strikethrough text**

**Added above red text**

## 14.4 ERC Paper Claim Submission Billing Instructions/Field Locators

### 4. TYPE OF BILL \*

#### 2. Bill Classification

~~3-Home Health or H.B.W~~

2 Home Health or H.B.W

## 14.6 Home Based Waiver (HBW) Billing Instructions/Field Locators

### 4. TYPE OF BILL \*

#### 2. Bill Classification

~~3-Home Health or E.R.C~~

2 Home Health or E.R.C

**Replaced 3 with 2**

## UPDATES FOR 1/24/2014

### 3.8.1 The 835 Transaction (Electronic Remittance Advice)

VT Medicaid posts the 835 weekly, to the web portal [www.vtmedicaid.com](http://www.vtmedicaid.com), for Trading Partners who have elected the 835 transaction. The 835 is a pull from the website (i.e. must be downloaded). There is no restriction on the number of times the 835 can be downloaded and it is available until it rolls off the system; at a minimum, it is available for at least one month from the posting date.

Normal processing has financial cycle running on a Friday with the 835 posting late the following Monday or Tuesday. The requirement for the 835 posting is +/- (plus or minus) 3 days from the EFT effective date (always the Thursday following a financial cycle). In the event the 835 will be delayed past the required Sunday posting date, a banner will be placed on the web site referencing the delay, and if known, the cause and the expected posting time and date.

If your 835 is missing after COB Sunday (EFT+3), and no banner has been posted stating its release is delayed, please contact the EDI Coordinator at 802 879-4450 Option 3, or email [vtedicoordinator@hp.com](mailto:vtedicoordinator@hp.com). Include your Trading Partner ID and the week you are referencing.

**Added above red text**

### 8.3 Incident-To Billing

Incident-to billing is a way of billing for ~~outpatient~~ services in an office setting only, provided by a non-physician practitioner (NPP) whose provider type does not allow them to enroll with Vermont Medicaid. There is no incident-to billing in a facility. ~~including, but not limited to, a nurse practitioner (NP), physician assistant (PA), clinical nurse specialist, certified nurse midwife, clinical psychologist, clinical social worker or licensed drug abuse counselor (LADC).~~ NPPs that are required eligible to enroll in Vermont Medicaid must enroll and bill using their own provider number and cannot bill incident-to. ~~Many have their own provider number with Vermont Medicaid and may provide services without direct supervision. They can bill either directly for services or incident-to if those services meet the rules in this section.~~

When NPPs who are not eligible for enrollment in Vermont Medicaid provide services that are incident-to a physician or other practitioner's service, they may bill under the physician/practitioner's



Vermont Medicaid provider ID (NPI/Taxonomy) **if they are employed by the billing provider (part-time, full-time, leased, contracted) and** when the service is

- an integral, although incidental, part of the professional services
- commonly rendered without charge or included in the physician's bill
- of the type that is commonly furnished in physician offices or clinics
- furnished by the physician or auxiliary personnel under the physician's direct supervision.

Documentation is critical for patient care and must clearly link the service to the clinically-supervising provider, including for example, co-signature and credentials of both practicing and clinically supervising provider and notation within the medical record of the clinically supervising provider's involvement. There must be a plan of care in the record established by the supervising/billing provider. Services billed in this manner may be subject to post payment review.

### 8.3.1 Licensed Physician Incident-To Billing

The billing/clinically supervising provider must

- be actively enrolled with Vermont Medicaid
- have seen the patient first, made a diagnosis and create a plan of care
- provide formal case oversight (documented one-on-one meetings to review the case)
- be present in the office suite on site or immediately available within 15 minutes commute to provide assistance and direction throughout the time the service is performed.

~~Exception: if the provider who created the plan of care is not on site to supervise, another qualified/actively enrolled provider in the group may be the clinically supervising provider under whom the service is billed "incident-to".~~

~~The person providing the service~~

- ~~• may be a mid-level provider (MLP) such as physician's assistant (PA), nurse practitioner (NP), clinical nurse specialist (CNS), certified nurse-midwife (CNM)~~
- ~~• may or may not be enrolled with Vermont Medicaid~~
- ~~• actively enrolled MLP may bill using their own provider number when incident-to rules are NOT met (e.g., physician not immediately available, new patient, new diagnosis).~~
- ~~• actively enrolled MLP may treat new patients and established patients with a new medical condition (within scope of practice) but they must bill under their own Vermont Medicaid provider number (may not bill incident-to).~~
- ~~• must be employed by the billing/clinically supervising provider or the billing/clinically supervising provider's group.~~

The service must

- be within the scope of practice of person providing the service
- follow the plan of care created by the billing/clinically supervising provider; **and**
- be only for the diagnosis in the original plan of care
  - If the patient requires a service for another diagnosis, the visit does not qualify for "incident-to" billing.



- The billing/clinically supervising provider must see the patient to make a new diagnosis and create a plan of care before s/he can bill incident-to for a different diagnosis.

Incident-to billing is NOT Allowed if

- it is a new patient visit
- it is an established patient with a new problem/diagnosis
- there is no clinically supervising provider present in the office suite and immediately available within 15 minutes.

### 8.3.2 Licensed Doctorate-Level Psychologist Incident-To Billing

The billing/clinically supervising provider must

- be actively enrolled with Vermont Medicaid
- be a licensed doctorate-level psychologist
- provide formal case oversight (documented one-on-one meetings to review the case)
- be present in the office suite on site or immediately available within 15 minutes commute to provide assistance and direction throughout the time the service is performed.

The person providing the service

- must be a masters-level provider in the mental health field
  - is non-licensed and not enrolled in Vermont Medicaid and is in the mental health field
  - **is licensed and not enrolled in Vermont Medicaid**

Please note:

- DVHA defers to the ruling of the Vermont Board of Psychological Examiners for special situations or questions
- Community Mental Health Centers (Designated Agencies) follow rules set by the Department of Mental Health regarding Incident-To billing.

**Added above red text**

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## 3.5 Manuals for Providers

The Provider Manual, Dental Supplement and Inpatient Psychiatric & Detoxification Authorization Manual Supplement are available at <http://www.vtmedicaid.com/Downloads/manuals.html>. The 340B Medicaid Carve in Manual is located at <http://www.vtmedicaid.com/Downloads/forms.html>.

The Pharmacy Benefit Management Program Provider Manual is located at <http://dvha.vermont.gov/for-providers> under the Pharmacy section. The Pharmacy Benefit Management Program is for prescription drugs dispensed by retail pharmacies.

**DVHA clinical coverage guidelines for Durable Medical Equipment (DME), Laboratory and Radiology, Therapy, J Codes, Intensive Social Support Services, and other services are located at <http://dvha.vermont.gov/for-providers/clinical-coverage-guidelines>.**

Check monthly for manual revisions.

**Added above red text**

### 8.3 Incident-To Billing

Incident-to billing is a way of billing for outpatient services (~~rendered in the provider's office, which may be located in a separate office or in an institution~~) provided by a non-physician practitioner (NPP) including, but not limited to, a nurse practitioner (NP), physician assistant (PA), clinical nurse specialist, certified nurse midwife, clinical psychologist, clinical social worker or licensed drug abuse counselor (LADC). Many NPPs are required to have their own provider number with Vermont Medicaid and may provide services without direct supervision. They can bill either directly for services or incident-to if those services meet the rules in this section.

When NPPs provide services that are incident-to a physician or other practitioner's service, they may bill under the physician/practitioner's VT Medicaid provider ID (NPI/Taxonomy) when the service is

- an integral, although incidental, part of the professional services
- commonly rendered without charge or included in the physician's bill
- of the type that is commonly furnished in physician offices or clinics
- furnished by the physician or auxiliary personnel under the physician's direct supervision.

Documentation is critical for patient care and must clearly link the service to the clinically-supervising provider, including for example, co-signature and credentials of both practicing and clinically supervising provider and notation within the medical record of the clinically supervising provider's involvement. There must be a plan of care in the record established by the supervising/billing provider. Services billed in this manner may be subject to post payment review.

#### 8.3.1 Licensed Physician Incident-To Billing

The billing/clinically supervising provider must

- be actively enrolled with Vermont Medicaid
- have seen the patient first, made a diagnosis and create a plan of care
- provide formal case oversight (documented one-on-one meetings to review the case)
- be present in the office suite on site or immediately available within 15 minutes commute to provide assistance and direction throughout the time the service is performed.

Exception: if the provider who created the plan of care is not on site to supervise, another qualified/actively enrolled provider in the group may be the clinically supervising provider under whom the service is billed "incident-to".

The person providing the service

- may be a mid-level provider (MLP) such as physician's assistant (PA), nurse practitioner (NP), clinical nurse specialist (CNS), certified nurse-midwife (CNM)
- may or may not be enrolled with Vermont Medicaid
- actively enrolled MLP may bill using their own provider number when incident-to rules are NOT met (e.g., physician not immediately available, new patient, new diagnosis).

- actively enrolled MLP may treat new patients and established patients with a new medical condition (within scope of practice) but they must bill under their own Vermont Medicaid provider number (may not bill incident-to).
- must be employed by the billing/clinically supervising provider or the billing/clinically supervising provider's group.

The service must

- be within the scope of practice of person providing the service
- follow the plan of care created by the billing/clinically supervising provider
- be only for the diagnosis in the original plan of care
  - If the patient requires a service for another diagnosis, the visit does not qualify for "incident-to" billing.
  - The billing/clinically supervising provider must see the patient to make a new diagnosis and create a plan of care before s/he can bill incident-to for a different diagnosis.

Incident-to billing is NOT Allowed if

- it is a new patient visit
- it is an established patient with a new problem/diagnosis
- there is no clinically supervising provider immediately available within 15 minutes commute.

### 8.3.2 Licensed Doctorate-Level Psychologist Incident-To Billing

The billing/clinically supervising provider must

- be actively enrolled with Vermont Medicaid
- be a licensed doctorate-level psychologist
- ~~have seen the patient first, made a diagnosis and created a plan of care~~
- provide formal case oversight (documented one-on-one meetings to review the case)
- be present in the office suite on site or immediately available within 15 minutes commute to provide assistance and direction throughout the time the service is performed.

~~Exception: if the provider who created the plan of care is not on site to supervise, another qualified/actively enrolled provider in the group may be the clinically supervising provider under whom the service is billed "incident to".~~

The person providing the service

- must be a masters-level provider in the mental health field
  - ~~trainee (working toward licensure)~~
  - is non-licensed and not enrolled in Vermont Medicaid and is in the mental health field
  - is licensed and not enrolled in Vermont Medicaid
- ~~may or may not be enrolled with Vermont Medicaid~~

- ~~actively enrolled providers can bill using their own provider number when incident-to rules are NOT met (e.g., licensed doctorate-level psychologist not immediately available, new patient, new diagnosis)~~
- ~~actively enrolled providers can treat new patients and established patients with a new condition (within scope of practice) but they must bill under their own Vermont Medicaid provider number (may not bill incident-to)~~

The service must

- ~~be within the scope of practice of person providing the service~~
- ~~follow the plan of care created by the billing/clinically supervising provider~~
- ~~be only for the diagnosis in the plan of care~~
  - ~~If the patient requires a service for another diagnosis, the visit does not qualify for "incident-to" billing.~~
  - ~~The billing/clinically supervising provider must see the patient to make a new diagnosis and create a plan of care before s/he can bill incident-to for a different diagnosis.~~

Incident-to billing is NOT allowed if

- ~~it is a new patient visit~~
- ~~it is an established patient with a new problem/diagnosis~~
- ~~there is no clinically supervising provider immediately available within 15 minutes.~~

Please note

- DVHA defers to the ruling of the Vermont Board of Psychological Examiners for special situations or questions
- Community Mental Health Centers (Designated Agencies) follow rules set by the Department of Mental Health regarding Incident-To billing.

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## UPDATES FOR 1/1/2014

### 2.1 Health Insurance Program Participation

#### Dr. Dynasaur (Children)

Dr. Dynasaur encompasses all health care programs available for children up to age 48 **19** (State Children's Health Insurance Program (CHIP) and Underinsured Children) or to age 21 (Blind or Disabled and/or Medically Needy Children and General Medicaid).

**Added above red text**

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#### 4.4.1 Private Insurer Co-Pays - Medicaid Secondary

When Vermont Medicaid is secondary to a private insurer and a co-payment is requested by the primary insurer at time of service, the provider is to bill the claim to Vermont Medicaid and indicate the amount paid by the primary insurance. Vermont Medicaid reimburses their allowed amount, minus the amount the other insurer has paid.

~~Providers that do not wish to bill Vermont Medicaid for the co-payment are only allowed to bill the beneficiary if they notify the beneficiary in writing that they will not bill Vermont Medicaid for the co-payment prior to rendering the service. The beneficiary must sign and date this notification; please retain documentation in the beneficiaries file.~~

**Deleted: entire section**

## 6.4 Who Is Primary

When the DVHA is the primary payer (i.e. the HPES system indicates no other insurer) and Vermont Medicaid payment is accepted, the provider should submit all bills to the DVHA's fiscal intermediary and never to the patient. Under the provider agreement, the provider has agreed to accept the DVHA's payment or denial (except as enumerated above) as payment in full.

When the HPES system shows a source other than the DVHA as the primary payer (such as Medicare or any other insurance carrier) the DVHA is the payer of last resort. Under the provider agreement, certain restrictions apply.

When Vermont Medicaid is secondary to a **private insurer** and a co-payment is required by the primary insurer at time of service, the provider is to bill the claim to Vermont Medicaid and indicate the amount paid by the primary insurance. Vermont Medicaid reimburses their allowed amount, minus the amount the other insurer has paid.

Providers that do not wish to bill Vermont Medicaid for the co-payment are only allowed to bill the beneficiary if they notify the beneficiary in writing, prior to rendering the service, that they will not bill Vermont Medicaid for the co-payment. The beneficiary must sign and date this notification; please retain documentation in the beneficiaries file.

- ~~• If the third party payment to the provider is greater than the amount payable by the DVHA, the provider cannot bill the beneficiary for any balance~~
- ~~• If the third party payment to the provider is less than the amount payable by the DVHA and the balance is not greater than any applicable co-payment, the provider may bill the beneficiary for the lesser of any applicable co-payments or the difference between the third party payment and the DVHA rate~~
- ~~• If the third party payment to the provider is less than the amount payable by the DVHA but greater than any applicable co-payment amount, the provider may bill the beneficiary for the co-payment and the DVHA for the balance. The amount paid by the DVHA shall not be greater than the DVHA's allowed amount, less any applicable co-payment~~

If the third party payment was made directly to the beneficiary, the provider may bill the beneficiary for the amount paid by such third parties. In addition, the provider may bill the beneficiary for applicable co-payments and collect patient liability or spend-down amounts.

~~If the third party payment to the beneficiary is less than the amount payable by the DVHA, then the requirements of #2 or #3 apply, depending upon the payment amount.~~

**Added above red text**

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## 8.3 Incident-To Billing

Incident-to billing is a way of billing for outpatient services (rendered in the provider's office, which may be located in a separate office or in an institution) provided by a non-physician practitioner (NPP) including, but not limited to, a nurse practitioner (NP), physician assistant (PA), clinical nurse specialist, certified nurse midwife, clinical psychologist, clinical social worker or licensed drug abuse counselor (LADC). Many NPPs are required to have their own

provider number with Vermont Medicaid and may provide services without direct supervision. They can bill either directly for services or incident-to if those services meet the rules in this section.

When NPPs provide services that are incident-to a physician or other practitioner's service, they may bill under the physician/practitioner's VT Medicaid provider ID (NPI/Taxonomy) when the service is

- an integral, although incidental, part of the professional services
- commonly rendered without charge or included in the physician's bill
- of the type that is commonly furnished in physician offices or clinics
- furnished by the physician or auxiliary personnel under the physician's direct supervision.

Documentation is critical for patient care and must clearly link the service to the clinically-supervising provider, including for example, co-signature and credentials of both practicing and clinically supervising provider and notation within the medical record of the clinically supervising provider's involvement. There must be a plan of care in the record established by the supervising/billing provider. Services billed in this manner may be subject to post payment review.

### **8.3.1 Licensed Physician Incident-To Billing**

The billing/clinically supervising provider must

- be actively enrolled with Vermont Medicaid
- have seen the patient first, made a diagnosis and create a plan of care
- provide formal case oversight (documented one-on-one meetings to review the case)
- be present in the office suite on site or immediately available within 15 minutes commute to provide assistance and direction throughout the time the service is performed.

Exception: if the provider who created the plan of care is not on site to supervise, another qualified/actively enrolled provider in the group may be the clinically supervising provider under whom the service is billed "incident-to".

The person providing the service

- may be a mid-level provider (MLP) such as physician's assistant (PA), nurse practitioner (NP), clinical nurse specialist (CNS), certified nurse-midwife (CNM)
- may or may not be enrolled with Vermont Medicaid
- actively enrolled MLP may bill using their own provider number when incident-to rules are NOT met (e.g., physician not immediately available, new patient, new diagnosis).
- actively enrolled MLP may treat new patients and established patients with a new medical condition (within scope of practice) but they must bill under their own Vermont Medicaid provider number (may not bill incident-to).
- must be employed by the billing/clinically supervising provider or the billing/clinically supervising provider's group.

The service must

- be within the scope of practice of person providing the service
- follow the plan of care created by the billing/clinically supervising provider

- be only for the diagnosis in the original plan of care
  - If the patient requires a service for another diagnosis, the visit does not qualify for “incident-to” billing.
  - The billing/clinically supervising provider must see the patient to make a new diagnosis and create a plan of care before s/he can bill incident-to for a different diagnosis.

Incident-to billing is NOT Allowed if

- it is a new patient visit
- it is an established patient with a new problem/diagnosis
- there is no clinically supervising provider immediately available within 15 minutes commute.

### 8.3.2 Licensed Doctorate-Level Psychologist Incident-To Billing

The billing/clinically supervising provider must

- be actively enrolled with Vermont Medicaid
- be a licensed doctorate-level psychologist
- have seen the patient first, made a diagnosis and created a plan of care
- provide formal case oversight (documented one-on-one meetings to review the case)
- be present in the office suite on site or immediately available within 15 minutes commute to provide assistance and direction throughout the time the service is performed.

Exception: if the provider who created the plan of care is not on site to supervise, another qualified/actively enrolled provider in the group may be the clinically supervising provider under whom the service is billed “incident-to”.

The person providing the service

- must be a masters-level provider in the mental health field
  - trainee (working toward licensure)
  - employees who are a provider type that is not enrolled in Vermont Medicaid and is in the mental health field
- may or may not be enrolled with Vermont Medicaid
  - actively enrolled providers can bill using their own provider number when incident-to rules are NOT met (e.g., licensed doctorate-level psychologist not immediately available, new patient, new diagnosis)
  - actively enrolled providers can treat new patients and established patients with a new condition (within scope of practice) but they must bill under their own Vermont Medicaid provider number (may not bill incident-to)

The service must

- be within the scope of practice of person providing the service
- follow the plan of care created by the billing/clinically supervising provider

- be only for the diagnosis in the plan of care
  - If the patient requires a service for another diagnosis, the visit does not qualify for “incident-to” billing.
  - The billing/clinically supervising provider must see the patient to make a new diagnosis and create a plan of care before s/he can bill incident-to for a different diagnosis.

Incident-to billing is NOT allowed if

- it is a new patient visit
- it is an established patient with a new problem/diagnosis
- there is no clinically supervising provider immediately available within 15 minutes.

Please note

- DVHA defers to the ruling of the Vermont Board of Psychological Examiners for special situations or questions
- Community Mental Health Centers (Designated Agencies) follow rules set by the Department of Mental Health regarding Incident-To billing.

~~Note: These guidelines do not apply when the provider has a separate agreement with the DVHA on billing practices.~~

~~Also, with the exception of our “on-site” requirements, it is our intention to follow Medicare guidelines.~~

#### Doctoral Level Psychologists Can Bill “Incident To” When:

- ~~Staff/workers who are non-licensed and not enrolled with Vermont Medicaid/VHAP such as certain alcohol counselors, provide the service. OR~~
- ~~Licensed professionals who are not enrolled with Vermont Medicaid/VHAP provide a covered service.~~

~~In addition, the doctoral level psychologist must:~~

- ~~Provide and document formal case oversight (1-on-1 meetings to review case); and~~
- ~~Be either on site or immediately available (i.e. 15 minutes or less away)~~
- ~~Meet all other requirements per the Board of Practice Rules for Psychologists.~~

#### Physicians/Nurse Practitioners and Dentists Can Bill “Incident To” When:

- ~~Any practitioner whose provider type does not allow them to enroll with Vermont Medicaid may bill incident to the physician/dentist who assumes total responsibility and accountability.~~

~~In addition, the physician/NP/dentist must:~~

- ~~Provide and document formal case oversight (1-on-1 meetings to review case); and~~
- ~~Be either on site or immediately available (i.e. 15 minutes or less away), except clinics must have a physician or NP on site at all times.~~

#### Incident To Billing by Physicians and Dentists:



~~Please note, the CMS 1500 claim form says among other items “I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.” The dental claim form does not have such a certification but the expectation remains the same for dentists. Physicians and dentists are expected to follow our “incident to...” guidance set forth by the DVHA.~~

~~At this time, the DVHA has agreements with Fletcher Allen Health Care, University of Vermont and Dartmouth Hitchcock Medical Center regarding billing for residents and students enrolled in their training programs. Those agreements govern “incident to...” billing.~~

~~Community Mental Health Centers are required to follow the guidance of the Department of Mental Health regarding “incident to...” billing, not the DVHA guidance for Vermont Medicaid services.~~

~~For all physicians and dentists not governed by a separate agreement:~~

- ~~• If you employ a licensed provider that can be enrolled in the Vermont Medicaid program, you must enroll that person and bill that person’s services as the attending rather than bill it as “incident to...”~~
- ~~• If you employ staff (licensed or not) that cannot be enrolled and that staff provides a billable service, you may use the supervising, licensed provider’s NPI number as the attending and bill the service as “incident to...”~~
- ~~• If, however, two licensed providers in the practice deliver a single service, the practice may bill for that service using the NPI number as the attending based on the main purpose of the service.~~

**Added above red text**

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### 10.3.48 Smoking Cessation Counseling

Face-to-face smoking cessation counseling is covered for pregnant **eligible** Vermont Medicaid beneficiaries **of any age who use tobacco**. The maximum number of visits allowed per calendar year is 16. This coverage applies when furnished by (or under the direction of) a physician or by any other health care professional who is legally authorized to furnish such services under state law and licensure. “Qualified” Tobacco Cessation Counselors are also allowed, (requires at least eight hours of training in tobacco cessation services from an accredited institute of higher education).

Providers must code each claim with the correct diagnosis for tobacco use ~~complicating pregnancy~~.

**Added above red text**

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## UPDATES FOR 12/1/2013

### 8.8 Electronic Funds Transfer (EFT)

Vermont Medicaid requires health care provider payments to be made through Electronic Funds Transmission (EFT), **as stated in the Conditions of Participation of the Provider Enrollment Agreement/Recertification Agreement**. Failure to do so may result in the suspension of payments.

**Added above red text**

## UPDATES FOR 11/1/2013

### 1.2.6 Provider Administrative Appeal Process

#### 1.2.6.1 Improper Payments and the Recovery of Overpayments

DVHA has 30 days to respond following the

- Date of receipt of the request for reconsideration,
- Date of a meeting with the provider, if one is scheduled.
- If DVHA requests additional information from the provider, DVHA has 30 days to respond following the receipt of that information.

#### 1.2.6.2 Underpayments that otherwise cannot be Timely Resubmitted

DVHA has 30 days to respond following the

- Date of receipt of the request for reconsideration,
- Date of a meeting with the provider, if one is scheduled.
- If DVHA requests additional information from the provider, DVHA has 30 days to respond following the receipt of that information.

**Added above red text**

### 2.3.9 Case Management Responsibilities

- The PCP must agree to adhere to the appointment waiting times standards set out in the Medicaid Rule 7101.3 O (1)(b). These appointment standards state that any member should have immediate access to emergency care and for non-emergent care be seen within: 24 hours for urgent care, 2 weeks for non-urgent care with prompt follow-up and 90 days for preventive and routine physical examinations and 30 days for routine, laboratory, x-ray, general optometry, and all other routine services.

**Added above red text**

### 7.2.3 Prior Authorization Requirements

The DVHA PA criteria and regulations can be found in Medicaid Rule 7102. These rules and procedures govern PAs performed by the DVHA and its agents. DVHA rules are available online at <http://dvha.vermont.gov/budget-legislative>.

PA is necessary if our eligibility system indicates that there is no other insurance coverage for the service or item. The DVHA PA requirements apply when the DVHA is known to be the primary payer for the service or item.

The DVHA Clinical Operations Unit enters prior authorizations with the exact procedure code(s) given by the requesting provider on the request form. In those instances when the procedure code to be billed does not exactly match the code requested/authorized, the provider must notify the Clinical Unit in writing prior to claim submission. Include the DVHA prior authorization number, the rationale for the code change and signature. Fax information to (802) 879-5963.

All unlisted procedure codes (including urgent or emergent) require prior authorization from the DVHA Clinical Unit prior to the service being rendered.

If it is determined during a surgical procedure that an unlisted procedure is appropriate and medically necessary, prior authorization must be requested prior to claim submission.

Notes must be attached with the claim indicating the usual and customary charge for the service. Fax information to (802) 879-5963.

**Added above red text**

## 9.12 Spend-Down

Providers may obtain a copy of the spend-down notification by contacting the DCF Call Center at 800-479-6151 or Member Services for **Green Mountain Care**. The case worker will be notified of the request and will provide the information.

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## 9.7.3 Vermont Medicaid Billing

A provider who pays for interpreter services for VT Medicaid beneficiaries may bill procedure code T1013 for each 15 minutes of paid interpreter services provided, on-site or via telephone. This may include interpreter service outside of the actual healthcare provider encounter in order to fill out forms or review information/instructions.

The provider may not bill Vermont Medicaid or the beneficiary for a missed appointment per federal policy.

Claims are submitted using the CMS 1500 claim form with HCPCS code T1013, with the exception that Home Health Agencies use the UB04 claim form with revenue code 940 with the HCPCS code T1013. FQHC/RHC providers must bill T1013 for interpreter services using their non-FQHC/RHC provider numbers.

When a beneficiary receives services that are not eligible for reimbursement, the interpreter services are ineligible for reimbursement.

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## 10.3.23 FQHC/RHC

~~Minor equipment and supplies may be billed as part of the encounter. As a general rule, billings for DME items require a DME provider number to allow billing and would be paid per fee schedule.~~

- Minor equipment and supplies (such as band aids and ace bandages) are assumed to be part of the encounter and are not eligible for reimbursement on an individual basis.
- DME items are to be billed using the appropriate HCPCS codes and would be reimbursed per the fee schedule. A DME Provider Number is required to bill DME items. Your facilities NPI and taxonomy number must indicate that you are a licensed DME provider. A copy of your NPI letter will be required at time of enrollment.

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## 11.11.11 Medical Supplies

Medical supplies may be dispensed in two month time periods. The “from” and “to” dates of service on the CMS 1500 Claim Form must reflect the two month date span.” Providers are not allowed to dispense more than a two month supply.

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## 14.5.10 Respite Care Billing in the Nursing Home

Nursing homes are required to obtain a Choices for Care, Aged/Disabled Waiver provider number when authorized by DAIL (Department of Aging and Independent Living) to provide respite services in your facility. The CFC –waiver provider type and specialty will allow reimbursement

for the respite care. The appropriate revenue code for choices for care respite care in the nursing home is 074. Providers billing for respite must select a type of bill from the following:

1. Type of Facility

8-Hospice or Special Facility

2. Bill Classification

6-Respite

3. Frequency

1-Admit through discharge claim

2-Interim-first claim

3-Interim-continuity claim

4-Interim-last claim

For additional information, please refer to: <http://ddas.vermont.gov/ddas-policies>.

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## UPDATES FOR 10/7/2013

### 10.3.13 Developmental & Autism Screening of Young Children

~~When billing for autism specific screening at a visit, providers should use CPT Code 96110 with the modifier 59 and the appropriate "V" diagnosis code.~~

When an autism screening is completed in addition to a developmental screening, using two separate standardized screening instruments, bill both on the same claim form using the developmental screening 2013 CPT 96110 with two (2) units. Submit the claim with the required diagnosis for the routine child health check (well child visit) plus an additional diagnosis to indicate that a second screen for special screening for developmental delays in early childhood has been performed. This is necessary to differentiate for reporting purposes.

Required documentation must be maintained in the child's health record and at a minimum, includes the name of the screening instrument(s) used, the score(s) and the anticipated guidance related to the results.

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## UPDATES FOR 10/1/2013

### 2.3.10 Case Management Fee and Treatment Plan

Treatment plan forms are available by contacting HPES' Provider Services Unit.

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### 3.4 Correct Form Versions

The Department of Vermont Health Access and HP Enterprise Services requires the use of current form versions, this includes but is not limited to: prior authorization requests and patient consent forms. All requests and patient consent forms received on outdated form versions will be denied.

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## 6.6 Medicaid & Medicare Crossover Billing

A DVHA beneficiary may be eligible for both Vermont Medicaid and Medicare. When dual eligibility exists, Medicare must be billed first on an assigned basis. After Medicare payment, the DVHA pays deductibles and coinsurance for crossover claims.

Providers must include their NPI and taxonomy code on any claims sent to Medicare in order to assure proper automatic crossover and subsequent Vermont Medicaid processing of your claims. Vermont Medicaid is aware that Medicare does not have this same requirement but will include the taxonomy code, as submitted on the claim, on the crossover file.

HP Enterprise Services does not accept a CMS-1500 crossover claim submitted with multiple Medicare Attachment Summary Forms. When submitting a CMS-1500 crossover claim that contains more than 6 details, each 6 details must be submitted as an individual claim with its Medicare Summary Attachment Form; indicate the number of details and the total. The total must equal only the sum of the detail lines listed on that claim form.

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## 9.6 Health Examination of Defined Subpopulation

DVHA will only accept diagnosis code V70.5 (Health examination of defined subpopulations) when it is billed as the primary diagnosis for the subpopulation "Refugees". All other claims containing diagnosis code V70.5 will be denied.

Diagnosis code V70.5 is acceptable billing for new refugees, but only when used for their first domestic health examination and related diagnostic tests; and when medically necessary, a second follow-up visit.

Each claim must indicate V70.5 as the primary diagnosis and must contain the notation "Refugee – Initial Exam" or "Refugee – Second Visit".

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## 9.7 Interpreter Services/Limited English Proficiency (LEP)

Providers are required under federal and state laws to provide interpreters for patients with limited English proficiency (LEP) and for those who are deaf or hard of hearing.

- Title VI of the Civil Rights Act of 1964
- Title VI regulations, prohibiting discrimination based on national origin
- Executive Order 13166 issued in 2000
- Vermont's Patients' Bill of Rights (18 VSA 1852)
- Vermont Public Accommodations (9 VSA 4502)

### 9.7.1 Informed Consent

The Vermont Patients' Bill of Rights provides that "the patient has the right to receive from the patients' physician information necessary to give informed consent prior to the start of any procedure or treatment." Additionally, failing to obtain informed consent may be a factor in medical malpractice litigation, although there are some exceptions. For the purposes of medical malpractice actions, "lack of informed consent" is defined as a failure to disclose to the patient reasonably foreseeable risks, benefits, and alternatives to the proposed treatment, in a manner permitting the patient to make a knowledgeable evaluation. In addition, patients are entitled to reasonable answers to specific questions about foreseeable risks and benefits. [12 V.S.A. § 1909] Using interpreters, translations services or other communication aids and services may

be necessary to ensure that patients with LEP, deaf, or hard-of-hearing receive appropriate information about the proposed treatment to enable them to give informed consent to treatment.

#### 9.7.2 HIPAA

An interpreter or bilingual employee is covered under the health care operations exception for purposes of HIPAA, and the patient's written authorization to disclose protected health information is not required. Providers who utilize a private company for interpretation on an ongoing contractual basis should ensure that their contract conforms to the HIPAA Privacy Rule business associate agreement requirements. In other situations, with disclosures to family members, friends, or other persons identified by an individual as involved in his or her care, when the individual is present, the health care professional or facility may obtain the individual's agreement or reasonably infer, based on the exercise of professional judgment, that the individual does not object to the disclosure of protected health information to the interpreter.

#### 9.7.3 Vermont Medicaid Billing

A provider who pays for interpreter services for VT Medicaid beneficiaries may bill procedure code T1013 for each 15 minutes of paid interpreter services provided, on-site or via telephone. This may include interpreter service outside of the actual healthcare provider encounter in order to fill out forms or review information/instructions.

The provider may not bill Vermont Medicaid or the beneficiary for a missed appointment per federal policy.

Claims are submitted using the CMS 1500 claim form with HCPCS code T1013, with the exception that Home Health Agencies use the UB04 claim form with revenue code 940 with the HCPCS code T1013. FQHC/RHC providers must bill T1013 for interpreter services using their non-FQHC/RHC provider numbers.

#### 9.7.4 Limited English Proficiency (LEP) Resources

Organization:	AT&T On Demand Interpreter (PHONE)	
Web:	<a href="http://www.wireless.att.com/businesscenter/plans/plan-features/on-demand-interpreter.jsp">www.wireless.att.com/businesscenter/plans/plan-features/on-demand-interpreter.jsp</a>	
Organization:	Voiance (PHONE)	
Phone/Web:	1-866-743-9010	<a href="http://www.voiance.com">www.voiance.com</a>
Organization:	Language Line Services	(PHONE)
Phone/Web:	1-877-866-3885	<a href="http://www.language-line.com">www.language-line.com</a>
Organization:	Vermont Refugee Resettlement Program (IN-PERSON)	
Phone/Email:	1-802-655-1963	<a href="mailto:vrrp@uscrtv.org">vrrp@uscrtv.org</a>

#### 9.7.5 Deaf and Hard of Hearing Resources

Organization:	Language Services Associates (IN-PERSON)	
Phone/Web:	1-800-305-9573	<a href="http://www.lsaweb.com">www.lsaweb.com</a>
Organization:	Vermont Interpreter Referral Service (IN-PERSON)	
Phone/Web:	1-802-254-3920	<a href="http://www.virs.org">www.virs.org</a>
Organization:	Registry of Interpreters for the Deaf	
Phone/Web:	1-703-838-0030	<a href="http://www.rid.org">www.rid.org</a>

Vermont Agency of Human Services: In-house contract for interpretation services.

#### 9.7.6 Additional Online Information

<http://www.vtmd.org/interpreter-issues-and-resources>  
[http://www.ama-assn.org/ama1/pub/upload/mm/433/lep\\_booklet.pdf](http://www.ama-assn.org/ama1/pub/upload/mm/433/lep_booklet.pdf)

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### 10.3.15 Drugs Requiring Prior Authorization

The following medications (listed in alphabetical order) will require prior authorization when paid through the medical benefit as physician or hospital outpatient billing. This allows the consistency of prior authorization requirements between the medical and pharmacy benefits:

Amevive (alefacept), Boniva (ibandronate), Botox (botulinum Type A), Myobloc (botulinum Type B), Orencia (abatacept), Reclast (zoledronic acid injection), Remicade (infliximab), and Tysabri (natalizumab). For a list of ongoing changes, please see the DVHA website at <http://dvha.vermont.gov/for-providers>.

Effective for dates of service on and after 10/01/13, all claims submitted for Zoledronic Acid are to be billed using HCPCS code Q2051.

- Prior authorization is required from Catamaran when this medication is to be used for Osteoporosis or Paget's disease, and
- Prior authorization is not required when this medication is used to treat Hypercalcemia of Malignancy and Multiple Myeloma with bone metastasis from solid tumors.

This does not apply to Medicare crossover claims. The following J codes (listed in numerical order) are affected:

J0129, J0215, J0585, ~~J0587~~, J1740, J1745, and J2323 ~~and J3488~~

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### 12.1 Reimbursable Services

#### Hospital Outpatient

Reimbursable services include the use of facilities in connection with accidental injury or minor surgery, diagnostic tests, rehabilitative therapies and emergency room care.

Pre-certification review of hospital admissions for dental procedures is not required. When submitting claims use the appropriate dental HCPCS coding (D...).

Medicare restricts certain medical services that should be only performed in an inpatient hospital setting. These services are not eligible for reimbursement when provided by a physician in an outpatient setting. A list of Medicaid Outpatient MUE of Zero procedures (Inpatient only list) is available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html>; see the links under Medicaid NCCI edit files.

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### UPDATES FOR 9/1/2013

#### 4.4.1 Private Insurer Co-Pays - Medicaid Secondary

When Vermont Medicaid is secondary to a private insurer and a co-payment is requested by the primary insurer at time of service, the provider is to bill the claim to Vermont Medicaid and indicate the amount paid by the primary insurance. Vermont Medicaid reimburses their allowed amount, minus the amount the other insurer has paid.



Providers that do not wish to bill Vermont Medicaid for the co-payment are only allowed to bill the beneficiary if they notify the beneficiary in writing that they will not bill Vermont Medicaid for the co-payment prior to rendering the service. The beneficiary must sign and date this notification; please retain documentation in the beneficiaries file.

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## 6.8 Third Party Liability (TPL)/Other Insurance (OI)

### OI Blanket Denials

Providers are required to submit blanket denials from a primary insurer to HPES every calendar year, for example: a blanket denial issued on July 7, 2013, will only be valid until December 31, 2013 and a new denial will be required as of January 1, 2014. Blanket Denials are required each calendar year as health insurance benefits are reviewed and health care policies are generally, renewed yearly.

Vermont Medicaid will accept a blanket denial for the same calendar year as the date(s) of service of the claim(s) being submitted for payment.

All Blanket Denials are to include the following:

- Name of the insurance company
- Beneficiary name
- Date(s) of service
- Rev/Procedure code or description of service

When submitting a paper claim, an attachment is needed only when a third party insurance carrier has not made a payment. Providers must attach documentation from the carrier that verifies the beneficiary's name, insurer's name, dates of service, service code or exact description of service, the amount reimbursed and the payment or denial date.

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## 9.10 Spend-Down

When completing the UB04 Claim Form involving spend-down, the provider must do the following:

3. Write "Spend-down deducted \$(amount)" in field locator 80, labeled Remarks. If any or the entire spend-down amount has been satisfied, write the applicable Internal Control Number (ICN) and the total spend-down amount met by the beneficiary.

When submitting a CMS1500 Claim Form involving spend-down, the provider must do the following:

1. Indicate "spend down" and the amount in field locator 19. If any or the entire spend-down amount has been satisfied, write the applicable Internal Control Number (ICN) and the total spend-down amount met by the beneficiary.

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## 12.1 Reimbursable Services

### Hospital Outpatient

Reimbursable services include the use of facilities in connection with accidental injury or minor surgery, diagnostic tests, rehabilitative therapies and emergency room care.



Pre-certification review of hospital admissions for dental procedures is not required. When submitting claims use the appropriate dental HCPCS coding (D...).

Medicare restricts certain medical services that should be only performed in an inpatient hospital setting. These services are not eligible for reimbursement when provided by a physician in an outpatient setting. A list of Medicaid Outpatient MUE of Zero procedures (Inpatient only list) is available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html>; see the links under Medicaid NCCI edit files.

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#### 12.4.10 Subacute Care

The following hospitals have been approved to offer swing bed services:

Vermont: Northeastern VT Regional, North Country, Porter, Grace Cottage, Gifford, Mt Ascutney, Copley, Springfield.

New Hampshire: Upper CT Valley, Littleton, Valley Regional, Weeks

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### UPDATES FOR 8/1/2013

#### 1.2.6 Provider Administrative Appeal Process

##### Level 3 - Vermont Superior Court

**Applicable to addressing provider underpayments that otherwise cannot be timely resubmitted**

##### Level 1 – Reconsideration by DVHA

- A claim with date of service older than 36 24 months is not eligible for reconsideration/appeal

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#### 2.3.8 Referrals

The following services do not require a referral from the PCP:

- Naturopathic services

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#### 11.11.3 BICROS/CROS (Contralateral Routing of Sound)

Vermont Medicaid does not cover CROS (Contralateral Routing of Sound) and BICROS hearing aids and related services.

Per review of current medical literature, the effectiveness of these aids is unproven. Related current HCPCS procedure codes are in the range of V5170 - V2540 V5240.

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#### 14.5.7 Nursing Home Claims & Patient Hospitalization

When a nursing home bills an entire month but the patient was hospitalized for a portion of the billed month, the claim must be recouped and a corrected claim(s) resubmitted.

If the criteria is met to bill a hold bed, follow the directions stated in the Hold Bed, Section of this manual.

If the hold bed criteria is not met, 2 separate claims must be billed when a patient is discharged from a nursing home and later readmitted into the same nursing home in any one given month.

Do not send a partial refund for the days the patient is hospitalized; this will not correct the actual days that the patient was at the nursing home and does not constitute correct coding.

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## UPDATES FOR 7/1/2013

### 4.4 Beneficiary Cost Sharing/Co-pays and Premiums

Certain beneficiaries must participate in the cost of care for services. Co-payments are never required of Medicaid beneficiaries under age 21 (effective 8/1/2012); pregnant or in a 60-day post-pregnancy period; living in a long-term care facility, nursing home or hospice; or for family planning services and supplies, emergency services and **durable medical equipment (DME) and medical supplies (effective DOS 7/1/2013).**

#### Medicaid Co-Pays

- \$1.00 - for prescription drugs ~~and DME/medical supplies~~ costing less than \$30.00 (effective 8/1/2012);
- \$2.00 - for prescription drugs ~~and DME/medical supplies~~ costing \$30.00 or more but less than \$50.00 (effective 8/1/2012);
- \$3.00 - for prescription drugs ~~and DME/medical supplies~~ costing \$50.00 or more (effective 8/1/2012).
- \$3.00 per dental visit for adult's age 21 or older
- \$3.00 per day for hospital outpatient services

#### VHAP Co-Pays

- \$1.00 - for prescription drugs (at or above 100% FPL) ~~and DME/medical supplies~~ costing less than \$30.00 (effective 8/1/2012);
- \$2.00 - for prescription drugs (at or above 100% FPL) ~~and DME/medical supplies~~ costing \$30.00 or more but less than \$50.00 (effective 8/1/2012);
- \$3.00 - for prescription drugs (at or above 100% FPL) ~~and DME/medical supplies~~ costing \$50.00 or more (effective 8/1/2012).

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### 9.3 CPT Category III Procedure Codes

Many CPT Category III procedure codes are not covered by Vermont Medicaid because they represent emerging technologies, services and procedures. Providers are reminded to verify coverage before performing the service/procedure. If the Category III code is not on the PAC 8 or 9 (non-covered) listing on the fee schedule and the code has a status of "Review" in the system, it has not yet received review by the DVHA for coverage determination. Providers may request a coverage determination review per the usual process.

**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 DVHA Clinical Operations Unit (fax: 802-879-5963) requesting a coverage review.

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## 12.4.1 Bilateral Billing Procedures

CPT codes that are not defined as bilateral but are performed bilaterally must be billed as two separate detail line items. Each detail must contain the same revenue code, CPT code and 1 unit of service. Modifier 50 is not to be used on institutional claims; it is not recognized under the VT OPPS Pricing Methodology. Billing one line item will result in a unilateral rate of reimbursement, regardless of the modifier submitted

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## UPDATES FOR 6/1/2013

### 1.1 Green Mountain Care Overview

DVHA does not arbitrarily deny or reduce the amount, duration or scope of a required covered service solely because of diagnosis, type of illness or condition of the beneficiary.

DVHA does not incentivize or provide rewards to employees, providers or contractors for denial of services or prior authorizations.

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### 2.3.9 Case Management Responsibilities

DVHA may request a corrective action plan from the PCP if timely access responsibilities are not met.

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### 4.4 Beneficiary Cost Sharing/Co-pays and Premiums

\$25.00 – Emergency room visits (no additional co-pay will be required for post-emergency stabilization care)

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### 5.1 Enrollment & Certification

- Special status is granted for out-of-state and out-of-network providers who have seen a Vermont Medicaid beneficiary in an emergency or urgent situation, or who have been prior approved for out-of-state services. Special status providers will be enrolled for a date or dates, agreed upon by the DVHA and the provider. The DVHA does not deem a provider enrolled in Medicare as enrolled in Vermont Medicaid. DVHA will pay for emergency and post-emergency stabilizations services delivered by providers who were not enrolled at the time of the emergency.

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### 7.3.1 General Exceptions

Emergency Services: Services normally requiring PA do not require PA when treating an emergency condition.

This exception applies to both the emergency care and the post-emergency stabilization. Post-emergency stabilization care will be provided until the attending emergency physician determines that the patient is sufficiently stabilized for transfer or discharge.

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### 7.3.2 Immediate Need Exception

2. "Post Emergency Stabilization" is the care required after an emergency to stabilize the patient for transfer or discharge. The attending emergency physician determines when a patient has been sufficiently stabilized for transfer or discharge. Post-emergency stabilization care is covered 24 hours per day, 7 days per week as necessary to stabilize a patient after an emergency.

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## 8.6 Time-based Procedure Codes – Billing Guidelines

Please follow the below guidelines when billing time based procedure codes.

### Critical care procedure codes that are time-based

- The billed units must reflect the actual time spent in face-to-face contact with the beneficiary in the home and/or on the way to the hospital.
- The duration of time to be reported by a physician is the actual time spent evaluating, managing and providing the critically ill or injured patient's care. Services are not to be provided to any other patient. Your full attention is limited to the critically ill or injured patient's care.
- In a facility setting, duration of time reflects time spent at the patient's bedside or elsewhere on the floor or unit. You must be immediately available to the patient. Only one physician may bill for critical care services rendered to a patient during any billable period of time. Time counted toward critical care may be continuous clock time or intermittent aggregated time.
- Paper claims will be required if the number of units billed exceeds the allowed number of units. It is required that clear copies of the provider's actual records be submitted with each claim. The number of units billed must be documented.
- The total number of minutes and date of service must be clearly written in the documentation and circled.
- Failure to clearly mark the number of minutes will result in claim denial.

### All other time-based procedure codes

- The billed units must reflect the actual time spent.
- Paper claims will be required if the number of units billed exceeds the allowed number of units. It is required that clear copies of the provider's actual records be submitted with each claim. The number of units billed must be documented.
- The total number of minutes and date of service must be clearly written in the documentation and circled.

Failure to clearly mark the number of minutes will result in denial of the claim.

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## 9.9 Place of Service Codes

POS codes are 2-digit codes placed on health care professional claims to indicate the setting in which a service was provided. CMS maintains the nationwide use of POS codes.

The Department of Vermont Health Access (DVHA) follows CMS POS instruction when determining the correct facility/non-facility reimbursement. As an entity covered under HIPAA, DVHA must comply with standards and implementation guides adopted by regulations for ASC X12N 837 electronic claim transactions. All electronic and paper CMS 1500 claim forms are required to include a POS code.

A Place of Service (POS) Code reflects the actual place where the beneficiary receives the face-to-face service and determines whether the facility or non-facility rate is paid. The correct place-of-service code ensures that reimbursement for the overhead portion of the payment is not paid incorrectly to the physician when the service is performed in a facility setting. POS assigned by the physician/practitioner is the setting in which the beneficiary received the technical component (TC) service.

For Services to a patient who is a registered inpatient of a hospital (POS 21) or an outpatient hospital (POS 22), the facility rate is paid, regardless of where the face-to-face encounter occurred.

For the professional component (PC) of diagnostic tests, the facility and non-facility payment rates are the same.

Further information is included in these CMS publications:

- <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1226.pdf>
- [https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place\\_of\\_Service\\_Code\\_Set.html](https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html)

The list of settings where a physician's services are paid at the **facility** rate:

Inpatient hospital (POS 21)	Military treatment facility (POS 26)	Inpatient Psychiatry facility (POS 51)
Outpatient hospital (POS 22)	Skilled nursing facility (POS 31)	Psychiatry facility – partial hospitalization (POS 52)
Emergency room-hospital (POS 23)	Hospice for inpatient care (POS 34)	Community mental health facility (POS 53)
ASC for HCPCS on list of approved procedures (POS 24)	Ambulance – Land (POS 41)	Psychiatric Residential Treatment Center (POS 56)
ASC for HCPCS not on approved list after Jan 1, 2008 (POS 24)	Ambulance – Air or water (POS 42)	Comprehensive Inpatient Rehabilitation Facility (POS 61)

Physician services are paid at **non-facility** rates for procedures in the following settings:

Pharmacy (POS 01)	Temporary Lodging (POS 16)	Residential Substance Abuse Treatment Facility (POS 55)
School (POS 03)	Well Child Clinic (POS 17) (CMS Walk-in Retail Clinic)	Non-residential Substance Abuse Treatment Facility (POS 57)
Homeless Shelter (POS 04)	Urgent Care Facility (POS 20)	Mass Immunization Center (POS 60)
Prison /Correctional (POS 09)	Birth Center (POS 25)	Comprehensive Outpatient Rehabilitation Facility (POS 62)
Office (POS 11)	Nursing facility (POS 32)	End-Stage Renal Disease Treatment Facility (POS 65)
Home or private residence (POS 12)	Custodial Care Facility (POS 33)	State or local Health Clinic (POS 71)
Assisted living facility (POS 13)	Independent Clinic (POS 49)	Rural Health Clinic (POS 72)
Group Home (POS 14)	Federally Qualified Health Center (POS 50)	Independent Lab (POS 81)
Mobile Unit (POS 15)	Intermediate Health Care Facility/Mentally Retarded (54)	Other Place of Service (POS 99)

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### 10.3.2 Ambulance Services

Mileage must be rounded to the nearest whole number. When the digit following the decimal point is 0, 1, 2, 3, or 4, round down [keep the digit(s) before the decimal point and drop the digits following the decimal point]. When the digit is 5, 6, 7, 8, or 9, round up by one number. Examples: 36.3 miles becomes 36 miles; 36.5 miles becomes 37 miles.

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### 11.11.4 Blood Pressure Monitors

Vermont Medicaid covers two types of blood pressure monitors for home use when medically necessary per the online DVHA guidelines at <http://dvha.vermont.gov/for-providers/clinical-coverage-guidelines>.

Providers are required to follow national correct coding requirements.

1. Non-Continuous Automatic Blood Pressure Monitors consist of a digital gauge and a stethoscope in one unit and are powered by batteries. The cuff may be inflated manually or automatically depending on the model.  
Vermont Medicaid covers only the purchase of these monitors; coverage is not available for rental. The Medical need must be clearly documented in the patient's medical records.  
HCPCS has a specific billing code for these common BP monitors.
2. Continuous Automatic Blood Pressure Monitors Measures blood pressure continuously in real time and comes with a recording device. They are non-invasive and can be used with a cuff or finger sensor.

VT Medicaid covers only the rental of these monitors; coverage is not available for purchase. Prior authorization is required. VT Medicaid will accept the miscellaneous durable medical equipment HCPCS code, since a specific code is not yet in place for these special monitors.

Vermont Medicaid does not cover new or refurbished Dinamap Monitors.

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## UPDATES FOR 5/1/2013

### 1.2.6 Provider Administrative Appeal Process

Submit **Level 1** requests to:

HP Enterprise Services  
PO Box 888, Williston VT 05495  
Attn: Level 1 Request

.....  
Submit **Level 2** requests to:

Commissioner, Department of Vermont Health Access  
312 Hurricane, Suite 201  
Williston, VT 05495

- A claim with date of service older than 36 months is **not** eligible for reconsideration/appeal

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### 5.1 Enrollment & Certification

- The attending physician, whether the physician or practitioner who actually performs the services for the patient or the referring or prescribing provider, must be enrolled as a participating Vermont Medicaid provider.

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### 6.7 Individual Consideration/Manual Pricing

All requests for changes to place of service (POS), provider type (PT), provider specialty (PS), **Modifier**, number of units and diagnosis code (DX) restrictions/allowance are to be submitted on the POS, PT, PS, **Modifier**, Unit & DX Change Request Form located at <http://www.vtmedicaid.com/Downloads/forms.html>.

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## 9.2 Aids

Vermont residents not covered by the DVHA may be eligible for coverage of AZT and DDI, and/or for benefits through the HIV/AIDS Health Insurance Assistance Program. Application for this benefit may be obtained by writing to: AMAP Coordinator, Department of Health-Aids Medication Assistance Program (AMAP), P.O. Box 70, Burlington, VT 05402.

Vermonters living with HIV infection who meet certain income guidelines may be eligible for help with Medicaid and VHAP co-payments for treatment drugs through the Vermont Medication Assistance Program (VMAP). Vermont residents not covered by the DVHA may be eligible for coverage of HIV medications, and/or for benefits. Application for this benefit may be obtained by writing to: VMAP Coordinator, Department of Health-Vermont Medication Assistance Program (VMAP), P.O. Box 70, Burlington, VT 05402.

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## 9.7 Inpatient Newborn Services (Physicians)

Use the following name format to indicate twin and multiple-birth babies.

- ABaby
- BBaby
- CBaby

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### 10.3.23 FQHC/RHC

The T1015 encounter code ~~should~~ **is to** be billed with a zero charge amount or a negligible charge amount (i.e., \$.01 or \$1.00) if software prohibits using a zero charge amount.

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## UPDATES FOR 4/1/2013

### 1.2.6 Provider Administrative Appeal Process

The Department of Vermont Health Access (DVHA) offers a program policy allowing an enrolled provider a process for reconsideration/appeal for certain claims payments. Information regarding the Provider Administrative Appeal Process applicable to each of the following is outlined below.

- Improper payments and the recovery of overpayments
  - Underpayments that cannot otherwise be timely resubmitted.
- The program policy allows for three levels of reconsideration/appeal

**Level 1** - reconsideration by DVHA

**Level 2** - appeal to the DVHA commissioner

**Level 3** – pursue via the Vermont Superior Court.

### **Applicable to Improper Payments and the Recovery of Overpayments**

#### **Level 1 – Reconsideration by DVHA**

- A qualified person will conduct the reconsideration
- No monetary threshold is applied.



- Provider must provide a written explanation of the reason for the disagreement, stating the amount of the payment
- Provider has 30 days to file for a reconsideration from either the
  - Date of the claim payment, or,
  - Date on the remittance advice (RA), or,
  - Date of receipt of notice of recovery.
- DVHA has 30 days to respond following the
  - Date of receipt of the request for reconsideration,
  - Date of a meeting with the provider, if one is scheduled.
  - In some circumstances, DVHA may notify the provider that an additional 14 day extension is invoked.
- DVHA will consider a stay of recovery within the timeframe of the Level 1 reconsideration only if an adjustment has not been completed by the DVHA fiscal agent.
  - Provider must document good cause
  - Stay timeframe is, the earlier of, completion of administrative appeals process or six months.
  - Stay does not apply to adjustment for third party liability (TPL) reason including Medicare or to recoupment of general claims processing errors.

## **Level 2 - Appeal to the DVHA Commissioner**

A provider who is dissatisfied with the result of the DVHA Reconsideration may appeal that decision to the DVHA Commissioner

- Within 30 days from the date on the Level 1 Reconsideration decision notice
- DVHA Commissioner or a hearing officer appointed by the Commissioner will schedule an appeal hearing within 30 days from the date of receipt of the request for an appeal to the Commissioner
- Appeal hearing shall be conducted under the same rules of conduct as in current use for hearings before the Human Services Board.
- A hearing officer does not render a decision about the legality of federal or state laws, including, but not limited to DVHA regulations. If the legality of such law or regulation is raised by the provider, the hearing officer renders a decision based on the applicable law as interpreted by DVHA
- DVHA Commissioner has 14 days from the date of the appeal hearing to generate a decision, or notify provider that an additional 14 day extension has been invoked. The decision notice will indicate the next level of appeal should the provider be dissatisfied with the decision.

## **Level 3 - Vermont Superior Court**

### **Applicable to addressing provider underpayments that otherwise cannot be timely resubmitted**

#### **Level 1 – Reconsideration by DVHA**

- A qualified person will conduct the reconsideration
- No monetary threshold is applied
- Provider owns the responsibility of presenting a preponderance of evidence that the claim was underpaid due to DVHA error
- Provider must have submitted claim in a timely manner
- Provider must have exhausted all other possible corrective actions per the Provider Manual
- Date of service for claim for reconsideration must exceed the timely filing limit of 12 months, or when third party insurance is involved the filing limit is 18 months (final billing deadline)
- A claim with date of service older than 36 months is eligible for reconsideration/appeal
- Provider must file for reconsideration within 30 days after date of remittance advice that first denied the claim for exceeding the final billing deadline
- Provider must provide a written explanation of the reason for the disagreement, stating the amount of the payment, that the claim was underpaid as a result of DVHA error, and provide the following to substantiate that the claim was underpaid
  - Statement outlining nature of appeal
  - Evidence of claim's original timely submission and resubmission, if applicable
  - Copies of applicable page from each remittance advice on which the claim was previously processed
  - Copy of remittance advice that indicates final billing deadline has passed
  - Statement describing nature of DVHA error that resulted in the underpayment of claim
  - Legible and accurately completed paper claim and
  - Any other documentation supporting the appeal, including any correspondence from DVHA.
- DVHA has 30 days to respond following the
  - Date of receipt of the request for reconsideration,
  - Date of a meeting with the provider, if one is scheduled.
  - In some circumstances, DVHA may notify the provider that an additional 14 day extension is invoked.

The decision notice will indicate the next level of appeal should the provider be dissatisfied with the decision.

#### Level 2 - Appeal to the DVHA Commissioner

A provider who is dissatisfied with the result of the DVHA Reconsideration may appeal that decision to the DVHA Commissioner

- Within 30 days from the date on the Level 1 Reconsideration decision notice
- DVHA Commissioner or a hearing officer appointed by the Commissioner will schedule an appeal hearing within 30 days from the date of receipt of the request for an appeal to the Commissioner
- Appeal hearing shall be conducted under the same rules of conduct as in current use for hearings before the Human Services Board.

- A hearing officer does not render a decision about the legality of federal or state laws, including, but not limited to DVHA regulations. If the legality of such law or regulation is raised by the provider, the hearing officer renders a decision based on the applicable law as interpreted by DVHA
- DVHA Commissioner has 14 days from the date of the appeal hearing to generate a decision, or notify provider that an additional 14 day extension has been invoked. The decision notice will indicate the next level of appeal should the provider be dissatisfied with the decision.

### Level 3 - Vermont Superior Court

#### **Added: above section**

#### 4.5 Qualified Medicaid Beneficiary (QMBY)

A QMBY's only benefit is Medicare cost sharing coverage. They are not considered dual eligible.

- PQ – Pure QMBY
- VG – %150 VPharm and QMBY
- VH – %175 VPharm and QMBY
- VI – %225 VPharm and QMBY

#### **Added: above section**

#### 7.8.1 Concurrent Review for Admissions at Vermont & In-Network Border Hospitals

Effective for dates of service July 1, 2012 and after, all Vermont in-state hospitals and in-network border hospitals will be required to notify the Department of Vermont Health Access Clinical Unit of all inpatient stays at time of admission or by the next business day. **This requirement only applies when Medicaid is the primary payer.** This requirement does not apply to psychiatric unit and psychiatric hospital admissions. In addition, notification of patient discharge is required.

#### **Added: above red text**

#### 7.8.6 Rehabilitative Therapy

##### Outpatient Therapy Modifiers

Effective for dates of service on and after 04/01/13, VT Medicaid follows Medicare's requirement that speech, occupational and physical therapists bill with modifier GN, GO or GP to identify the discipline of the plan of care under which the service is delivered.

GN = Services delivered under an outpatient speech-language pathology plan of care

GO = Services delivered under an outpatient occupational therapy plan of care

GP = Services delivered under an outpatient physical therapy plan of care

Medicare provides a link to the list of applicable therapy procedure codes, (this list is updated annually by CMS). VT Medicaid therapists need only reference the code list itself; do not use the column information.

<http://www.cms.gov/Medicare/Billing/TherapyServices/AnnualTherapyUpdate.html>.

All therapy services (including codes listed as "Sometimes Therapy") that are performed by a therapist (and billed with the therapist as the attending) must be part of an outpatient therapy plan of care and the billing codes must use one of the above therapy modifiers to bill.

Some codes on this list are “Always Therapy” services regardless of who performs them. These services must be part of an outpatient therapy plan of care and the Billing codes must use one of the above therapy modifiers to bill.

Practitioners other than therapists must use these modifiers when performing listed services which are delivered under an outpatient therapy plan of care.

These modifiers are not to be used with codes that are not specified on the list of applicable therapy codes.

Modifiers may be reported in any order.

Prior Authorization Requests must give the exact codes and modifiers in the same order as they will be billed on the claim.

**Added: above red text**

**9.6 Interpreter Services/Limited English Proficiency (LEP)**

Limited English Proficiency (LEP) and interpreter services guidance for providers is available in the Interpreter Services and Resources FAQ document at

<http://www.vtmedicaid.com/Information/whatsnew.html>. Providers are required under federal and state laws to provide interpreters for patients with limited English proficiency (LEP) and for those who are deaf or hard of hearing.

**Added: above red text**

**10.3.23 FQHC/RHC**

(2) The patient has a medical visit with a physician, physician assistant, nurse practitioner, nurse midwife, or a visiting nurse, and a visit with a clinical psychologist, clinical social worker, or other health professional for mental health services. *Vermont Medicaid follows the same list of health professionals as Medicare.*

**Encounter Examples**

- The beneficiary is treated for a headache in the morning at the office and returns home. The beneficiary returns **to the same office** a few hours later because the headache is worse, sees the same or a different practitioner, and returns home. The beneficiary returns for the third time **to the same office** for the same problem, is treated by a third physician and returns home.
- The beneficiary is treated by a physician and a mental health provider on the same day. *This is billed and reimbursed as two separate encounters, even if the diagnoses are substantially the same, because one encounter is with a medical provider and the other is with a mental health provider.*
- ~~The beneficiary is treated by a physician and a mental health provider any time during the same day. This is billed and reimbursed as two separate encounters unless the diagnoses are substantially the same, then only one encounter can be billed.~~

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**12.1 Reimbursable Services**

**Hospital Outpatient**

Reimbursable services include the use of facilities in connection with accidental injury or minor surgery, diagnostic tests, rehabilitative therapies and emergency room care.

Pre-certification review of hospital admissions for dental procedures is not required. When submitting claims use the appropriate dental HCPCS coding (D...).

**Added: above red text**

## UPDATES FOR 3/1/2013

### 5.4 Documentation of Services

Each provider must keep written documentation for all medical services, actual case record notes for any services performed, or business records that pertain to beneficiaries for services provided and payments claimed or received. All documentation must be legible, contain complete and adequate information and applicable dates. Providers must submit information upon request of the State Agency of Human Services, Office of the Vermont Attorney General or U.S. Secretary of Health and Human Services and at no charge to the requester. The documentation for any service that was billed must be kept for seven years. This information must also be available at any time for on-site audits. Records of any business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5 year period ending on the date of the request, must be submitted within 35 days of the request.

### 5.4 Documentation of Services

~~Each provider must keep written documentation for all services that have been performed for beneficiaries. All documentation must be legible, contain all required information and applicable dates. Providers must be prepared to submit information on transactions upon request of the State Agency or HHS secretary for records of any business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5 year period ending on the date of the request, within 35 days; this includes the actual case record notes for any services performed. The documentation for any service that was billed must be kept for seven years. This information must also be available at any time for on-site audits.~~

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### 10.3.36 Naturopathic Physicians

N.D.s who do not meet the above conditions to become a PCP for Vermont Medicaid are considered specialists. Services from an N.D. as a specialist require a PCP referral.

Please note that you may choose to enroll as a specialist or a primary care provider.

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## UPDATES FOR 2/20/2013

### 10.3.46 Psychiatry/Psychology

#### Pharmacological Management

Effective January 1, 2013, psychologists providing pharmacologic management, including prescription and review of medication, when provided with psychotherapy services will use add-on code 90863. This code is to be used **only as an add-on** to a primary psychotherapy code (90832, 90834, 90837).

~~Prescribing health care professionals, who provide evaluation and management (E/M) services, CPT codes beginning with 99, will now use the appropriate E/M code when they do pharmacologic management for a patient. When psychotherapy is done during the same session as the pharmacologic management, one of the new psychotherapy codes should be~~

used along with the E/M code. The psychiatrist will specify the level of E/M work done and add the psychotherapy component based on the time spent delivering psychotherapy. Documentation of the visit must show the time spent on psychotherapy. The new pharmacologic management add-on code is **not** to be used by professionals that provide E/M services (psychiatrists). Pharmacologic management done by the professional during an E/M visit is considered part of the assessment and management of the patient. Please see the Inpatient Psychiatric & Detoxification Authorization Manual located at <http://www.vtmedicaid.com/Downloads/manuals.html>.

- If no E/M services are provided, use the appropriate psychotherapy code (90832, 90834, 90837)
- Psychotherapy with E/M is now reported by selecting the appropriate E/M service code and the appropriate psychotherapy add-on code.
- The E/M code is selected on the basis of the site of service and the key elements performed.
- The psychotherapy add-on code is selected on the basis of the time spent providing psychotherapy and does not include any of the time spent providing E/M services

Prescribing health care professionals, conducting pharmacologic management, will now use the appropriate E/M code. When psychotherapy is done during the same session as the pharmacologic management, one of the new psychotherapy codes should be used along with the E/M code. The psychiatrist or other qualified health care professional will specify the level of E/M work done and add the psychotherapy component based on the time spent delivering psychotherapy.

- Vermont licensure for CPs (Clinical Psychologists) is limited to the provider's scope of practice which does not include prescription and medication management
- Providers that are approved to bill E/M series codes are to report this service using the appropriate E/M series code

### Modifiers

- AJ = applicable to MA counselors, LCMHC, LSW, LMFT
- AH = applicable to Doctorate level Psychologist.

Vermont Medicaid is continuing to require the use of modifier AJ and AH. As of 1-1-2013, modifier AJ is reimbursed at 76% of allowed amount and modifier AH at 90% of allowed amount.

### Psychiatric Diagnostic Evaluation

- A distinction has been made between diagnostic evaluations without medical services and evaluations with medical services
- Interactive services are captured using an add-on code
- These codes can be used in any setting
- These codes can be used more than once in those instances where the patient and other informants are included in the evaluation
- These codes can be used for reassessments

- Psychiatrists and other medical providers have the option of using the appropriate E&M code in lieu of the 90792

Code Descriptions specifying “With medical services” refers to medical “thinking” as well as medical activities, such as: physical examination, prescription of medication, and review & ordering of medical diagnostic tests. Medical thinking must be documented, e.g. consideration of a differential diagnosis, medication change, change in dose of medication, drug-drug interactions, etc.

### Psychotherapy

The new series of psychotherapy codes (90832 – 90838) was established to replace individual psychotherapy codes (90804 – 90829). Site of service is no longer a criterion for code selection and time specifications were changed to be consistent with CPT convention.

- Psychotherapy codes are no longer site specific
- Psychotherapy time includes face-to-face time spent with the patient and/or family member
- Time is chosen according to the CPT time rule
- Interactive psychotherapy is reported using the appropriate psychotherapy code along with the interactive complexity add-on code

### Crisis Psychotherapy

Crisis is defined as:

“an urgent assessment and history of a crisis state, a mental status exam, and a disposition. The treatment includes psychotherapy, mobilization of resources to defuse the crisis and restore safety, and implementation of psychotherapeutic interventions to minimize the potential for psychological trauma. The presenting problem is typically life threatening or complex and requires immediate attention to a patient in high distress.”

A new subsection, Psychotherapy for Crisis, with guidelines was established to report these services. These are timed codes and additional instruction on the appropriate use of the new codes is included in the 2013 AMA CPT4 codebook.

- 90839, Psychotherapy for crisis, first 60 minutes  
(CPT Rule applies: 30-74 minutes)
- +90840 (add-on), Psychotherapy for crisis each additional 30 minutes

### Important Billing Concepts to Consider

#### *CPT Time Rule*

“A unit of time is attained when the mid-point is passed”

“When codes are ranked in sequential typical times and the actual time is between two typical times, the code with the typical time closest to the actual time is used.”

Example:      90832, 90833 is 16-37 minutes  
                     90834, 90836 is 38-52 minutes |  
                     90837, 90838 is 53 minutes and more

### *Interactive Complexity*

A new subsection has been added to the Psychiatry section for reporting interactive complexity. Interactive complexity is specific and recognized communication difficulties for various types of patients and situations that represent significant complicating factors that may increase the intensity of the primary psychiatric procedure.

Add-on Code 90785 is used to report interactive complexity services when provided in conjunction with psychotherapy codes. See the 2013 AMA CPT4 codebook for further explanation of when and how this code should be used. The guidelines include a list of requirements or factors to consider when determining appropriate use of the interactive complexity code.

- “Interactive” in previous codes was limited in use to times when physical aids, translators, interpreters, and play therapy was used
- “Interactive Complexity” extends the use to include other factors that complicate the delivery of a service to a patient and may be reported when at least one of the following is present:
  - Arguing or emotional family members in a session that interfere with providing the service
  - Third party involvement with the patient, including parents, guardians, courts, and schools
  - Need for mandatory reporting of a sentinel event
  - Impaired patients
  - Young and verbally undeveloped
- When performed with psychotherapy, the interactive complexity component (+90785) relates only to the increased work intensity of the psychotherapy service, but *does not* change the time for the psychotherapy service

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## UPDATES FOR 2/20/2013

### 7.8.4 In-State & Out of State Psychiatric & Detoxification *Inpatient Services*

~~Effective August 13, 2012~~ The ~~Department of~~ Vermont Health Access (DVHA) in collaboration with the Department of Mental Health (DMH) requires **prior** authorization for psychiatric and detoxification inpatient **admissions services** for **both the following** in-state facilities: **Brattleboro Retreat, Central Vermont Hospital - Psychiatric Unit, Fletcher Allen Hospital, Rutland Regional Medical Center and Springfield Hospital Windham Psychiatric Center. All out-of-state psychiatric and detoxification inpatient admissions/services require prior-authorization.** This includes all children and adults, including those enrolled in CRT. Admitting facilities must complete the Vermont Medicaid Admission Notification Form for Psychiatric Inpatient Services and fax it to the DVHA at 802-879-5963 within 24 hours or the next business day of an urgent or emergent admission, please see the Inpatient Psychiatric & Detoxification Authorization Manual. All individuals enrolled in CRT, children and adolescents will continue to require screening by a Community Mental Health Center prior to admission. Notification forms are posted on the DVHA website at <http://dvha.vermont.gov/for-providers/forms-1>.



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### 10.3.37 NDC (National Drug Code)

#### NDC Requirements on CMS 1500 Form

When entering an NDC on your claim form, please enter the following data elements in the following order: NDC, measurement qualifier code and unit quantity. Do not insert brackets, spaces or dashes. Claims formatted incorrectly will be denied.

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### 10.3.46 Psychiatry/Psychology

- Psychologist - Doctorate Level
- Psychologist - Masters Level

A new subsection has been added to the Psychiatry section for reporting interactive complexity. Interactive complexity is specific and recognized communication difficulties for various types of patients and situations that represent significant complicating factors that may increase the intensity of the primary psychiatric procedure. Code 90785 is an add-on code to report interactive complexity services when provided in conjunction with psychotherapy codes. See the 2013 AMA CPT4 codebook for further explanation of when and how this code should be used. The guidelines include a list of requirements or factors to consider when determining appropriate use of the interactive complexity code.

The new series of psychotherapy codes (90832 – 90838) were established to replace individual psychotherapy codes (90804 – 90829). Site of service is no longer a criterion for code selection and time specifications were changed to be consistent with CPT convention.

There are also new codes for psychotherapy for crisis when a patient presents in high distress with complex or life threatening circumstances that require urgent and immediate attention. A new subsection, Psychotherapy for Crisis, with guidelines for the two new codes (90839 and 90840) was established to report these services. These are timed codes and additional instruction on the appropriate use of the new codes is included in the 2013 AMA CPT4 codebook.

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## UPDATES FOR 1/01/2013

### 6.7 Individual Consideration/Manual Pricing

The rates on file for certain procedure codes do not have specific dollar amounts because no one amount is appropriate (e.g. code 99070). In these cases, the rate on file is set at “IC” (individual consideration). The fiscal intermediary and the DVHA will calculate the allowed amount. This process is often called “manual pricing”. For DME, see section 11.1 **Payment DVHA Primary**.

All requests for changes to place of service (POS), provider type (PT), provider specialty (PS), number of units and diagnosis code (DX) restrictions/allowance are to be submitted on the POS, PT, PS, Unit & DX Change Request Form located at <http://www.vtmedicaid.com/Downloads/forms.html>

The form contains a tab designated for each of the above change requests. Please fill out the required information on the correct tab specific to your need. Providers only need to complete the columns highlighted in yellow.

Requests will be reviewed on the 1st and 15th day of each month (or the first business day thereafter). To guarantee timely processing, it is recommended providers submit their requests two business days prior to the review date.

Submit your request form to [vermonthipacontact@hp.com](mailto:vermonthipacontact@hp.com). Indicate your provider name in the subject line of your e-mail. Requests submitted without the form will not be reviewed. Providers will be notified of the approval/denial decision within 10 business days of the review date. In the event your request is denied, an appeal may be submitted via fax to the DVHA Clinical Unit Administrator at 802-879-5963. Your Appeal should include a cover letter of explanation.

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### 7.8.2 Inpatient Medically Managed Detoxification

Effective March 1, 2011 the Department of Vermont Health Access implemented concurrent review and authorization of all inpatient medically managed detoxification services provided on a psychiatric floor or in a psychiatric facility. All emergent and urgent admissions will require notification to the DVHA within 24 hours or the next business day of admission and all elective admissions will require notification prior to admission. To notify DVHA of an admission and to begin the concurrent review process, please call, (802)879-8232.

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### 7.8.4 Out-of-Network Elective Outpatient Referrals

Effective July 1, 2012, non-emergency (elective) out-of-state medical visits will require prior authorization from the DVHA Clinical Unit. Enrolled border hospitals are excluded from this requirement. In network referring providers must submit requests using the Out-of-state Elective Office Visit Request Form located at <http://dvha.vermont.gov/for-providers/forms-1>. Fax requests to 802-879-5963.

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As of July 01, 2012, prior authorization is required for referrals to out-of-state/out-of-network medical visits that are elective/non-emergency, for codes 99201-99215; 99241-99245; 99341-99360 and 99381-99456; however, PA is not required for referrals to office visits to:

Providers affiliated with Extended-network hospitals

Providers affiliated with Out-of-state In-network hospitals

All other PA requirements will apply. A list of Green Mountain Care in-network and extended network hospitals is available at <http://dvha.vermont.gov/for-providers/green-mountain-care-network>.

Referring providers must submit requests using the OOS Medical Office Request Form located at <http://dvha.vermont.gov/for-providers/clinical-coverageguidelines>. Fax all requests to the DVHA Clinical Unit, 802-879-5963.

### 7.8.7 Rehabilitative Therapy

Speech-Language Pathology (SLP) providers may enroll as private practitioners with Vermont Medicaid. Coverage of private practice SLP services are limited to those services provided outside of the school or hospital systems for Medicaid beneficiaries less than 22 years of age.

**Added:** red text

### 11.3.46 Psychiatry/Psychology

#### Drug Management

In keeping with the federal guidelines for Medicare and Vermont Medicaid, services of drug management and psychotherapy cannot be paid for the same beneficiary for the same date of service. Drug management is considered included within the psychotherapy service and is not to be billed separately as an additional charge. Vermont Medicaid is required to follow this policy and deny CPT codes 90862 when it is billed in addition to individual psychotherapy.

#### Psychiatrists and Psychologists (Enrolled Providers)

- LCSW
- LMHC
- LMFT
- Physician/psychiatric

#### Mental Health and Substance Abuse Health Record Documentation Standards

At minimum, the documentation in a mental health/substance abuse health record will include the following core components

1. Identifying Data
  - Name/unique ID, date of birth, other demographic information, as needed
2. Dates of Service
  - Documentation by the primary treatment provider of all dates and times clinical services were provided
3. Comprehensive Clinical Assessment (e.g., biopsychosocial, medical history, etc.)
  - Evidence that a Comprehensive Clinical Assessment has been completed, with documentation of a presenting problem and client level of care to support clinical necessity for placement, such as
    - Outpatient
    - Intensive outpatient
    - Partial hospitalization
    - Inpatient/residential
  - Evidence of ongoing reassessment, as needed
4. Treatment and Continued Care Planning
  - Documentation of treatment plan, including the following
    - Prioritization of problems and needs
    - Evidence that goals and objectives are related to the assessment
    - Evidence that goals and objectives are individualized, specific, and measurable, with realistic timeframes for achievement
    - Specific follow-up planning, including but not limited to anticipated response to treatment, additional or alternative treatment interventions, and coordination with other treatment providers (e.g., PCP)
5. Progress Notes

- Documentation supporting continued need for services based on clinical necessity, including the following
  - Dated progress notes that link to initial treatment plan
  - Updates or modifications to treatment plan
  - Interventions provided and client's response
  - Printed staff name and signature or electronic equivalent.

For additional information concerning DVHA's *Mental Health and Substance Abuse Health Record Documentation Standards* and resources, see <http://dvha.vermont.gov/for-providers>.

### Community Mental Health Center Services

Covered services include rehabilitation services provided by qualified professional staff in a community mental health center designated by the Department of Mental Health. These services may be provided by physicians, psychologists, MSWs, psychiatric nurses, and qualified mental health professionals carrying out a plan of care approved by a licensed physician or licensed psychologist.

Beneficiaries receiving Community Rehabilitation and Treatment (CRT) services under the 1115 waiver are ineligible for this State Plan service.

### Accepted Procedure Codes

Psychologists/LCSW/LMHC/LMFT-Only the following procedure codes are allowed:  
Codes require a modifier of either:

- AJ = for MA, counselors, LCMHC, LSW, LMFT
- AH = for Doctorate level Psychologist.

(AJ is reimbursed at 71% of allowed amount and AH is reimbursed at 86% of allowed amount).

<u>Code</u>	<u>Description</u>	<u>Units</u>
90801	Diagnosis &Evaluation	1 unit = 1 visit (limit – 40 units per calendar year

CPT Code 90801 can be used beyond the initial evaluation under limited conditions such as

- Transitioning to a new therapist or mental health provider
- Returning for therapy after an extended period of absence
- New symptoms presenting unrelated to the original condition or a new focus in therapy related to a crisis situation such as a major life change or worsening of conditions

For additional information, go to <http://dvha.vermont.gov/for-providers> Mental Health & Substance Abuse.

90804	Psychotherapy-Less Than One Hour	1 unit = 20-30 min.
90806	Psychotherapy min.	1 unit = 45-50
90808	Psychotherapy-More Than One Hour min.	1 unit = 75-80

CPT Code 90808 can be used under limited conditions such as

- Temporary need for extended sessions as the patient transitions to less frequent therapy sessions
- Geographic or transportation issues that limit access to services
- Immediate aftermath of an acute trauma or life event and need for emotional stabilization and exploration of the incident
- An unexpected crisis situation during or arising from a regularly scheduled session (such as threats of violence or suicide) requiring time to stabilize the patient, involving family members or arranging for emergency care
- Therapeutic procedures requiring sessions of greater duration such as Prolonged Exposure Therapy (used by the Veteran's Administration) for treating trauma related conditions.

DVHA follows the Medicare Local Coverage Determination guidelines which state "the use of psychotherapy services in excess of 60 minutes is not the standard of care in most jurisdictions. To support Medical necessity, the provider must document the patient's need for these extended time codes". Use of CPT 90808 must be substantiated by clinical documentation.

For additional information, go to <http://dvha.vermont.gov/for-providers>  
Mental Health & Substance Abuse.

90846	Family Psychotherapy w/out Patient Present Limited to 12 units per calendar year	1 unit = 1 day
90847	Family Psychotherapy	1 unit = 1 day
90853	Group Therapy Limited to a maximum of eight units per day, 1 session per day and 3 sessions per week, for each beneficiary	1 unit = 15 min.
96102	Psychological Testing w/Qualified Health Care Professional, Interpretation & Report, administered by technician	1 unit = 60 min.
96103	Psychological Testing w/Qualified Health Care Professional, Interpretation & Report, administered by computer	1 unit = 60 min.
96119	Neuropsychological Testing w/Qualified Health Care Professional, Interpretation & Report, administered by technician	1 unit = 60 min.
96120	Neuropsychological Testing w/Qualified Health Care Professional, Interpretation & Report, administered by computer	1 unit = 60 min.

The following codes *are required to be billed with modifier AH* when provided by a Doctorate level PhD:

96101	Psychological Testing, both face-to-face time w/patient & time interpreting test results and report preparation	1 unit=60 min.
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96116	Neurobehavioral status exam, both face-to-face time w/patient & time interpreting test results and preparing the report test results	1 unit=60 min.
96118	Neuropsychological testing, both face-to-face time w/the patient & time interpreting test results and preparing the report	1 unit=60 min.
96150	Health and behavior assessment, clinical review observation	1 unit=15 min.
96151	Health and behavior re-assessment	1 unit=15 min.
96152	Health and behavior intervention face-to-face individual	1 unit=15 min.
96153	Health and behavior assessment face-to-face group w/2 or more patients	1 unit=15 min.
99251	Inpatient consultation for a new or established patient	1 unit

### Team Care Program

The Team Care Program restricts a beneficiary to one physician and one pharmacy. If a beneficiary is "locked-in" to a provider, that provider's name is available on the VRS and the Vermont Medicaid website. Claims for services by any provider other than the "lock-in" provider(s) are not reimbursable by Vermont Medicaid, except in the case of an emergency or when a provider performs a service by referral of the named provider.

The "lock-in" procedure also applies to a PC Plus beneficiary. The "lock-in" reflects the beneficiary's choice of primary care physician. This information is also available through the VRS and the Vermont Medicaid web site.

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### 10.3.46 **Psychiatry/Psychology**

#### Pharmacological Management

Effective January 1, 2013, psychologists providing pharmacologic management, including prescription and review of medication, when provided with psychotherapy services will use add-on code 90863. This code is to be used **only as an add-on** to a primary psychotherapy code (90832, 90834, 90837).

Prescribing health care professionals, who provide evaluation and management (E/M) services, CPT codes beginning with 99, will now use the appropriate E/M code when they do pharmacologic management for a patient. When psychotherapy is done during the same session as the pharmacologic management, one of the new psychotherapy codes should be used along with the E/M code. The psychiatrist will specify the level of E/M work done and add the psychotherapy component based on the time spent delivering psychotherapy. Documentation of the visit must show the time spent on psychotherapy. The new pharmacologic management add-on code is **not** to be used by professionals that provide E/M services

(psychiatrists). Pharmacologic management done by the professional during an E/M visit is considered part of the assessment and management of the patient. Please see the Inpatient Psychiatric & Detoxification Authorization Manual located at <http://www.vtmedicaid.com/Downloads/manuals.html>.

Enrolled provider types for Psychiatry and Psychology are

- Licensed Clinical Social Worker (LCSW)
- Licensed Mental Health Counselor (LMHC)
- Licensed Marriage & Family Therapist (LMFT)
- Physician - Psychiatric
- Nurse Practitioner - Psychiatric

#### Documentation Standards for Mental Health and Substance Abuse Health Records

At a minimum, the documentation in a mental health/substance abuse health record will include the following core components:

1. Identifying data

- Name/unique ID, date of birth, and other demographic information as needed,

2. Dates of service

- Documentation by the primary treatment provider of all dates and the amount of time clinical services were provided

3. Comprehensive clinical assessment (e.g., biopsychosocial, medical history, etc.)

- Evidence that a comprehensive clinical assessment has been completed, with documentation of a presenting problem and patient placement to support clinical level of care, such as:
  - a. Outpatient
  - b. Intensive outpatient
  - c. Partial hospitalization
  - d. Residential
  - e. Inpatient,
- Evidence of ongoing reassessment as needed

4. Treatment and continued care planning

- Documentation of treatment plan, including the following:
  - a. Prioritization of problems and needs,
  - b. Evidence that goals and objectives are related to the assessment,

- c. Evidence that goals and objectives are individualized, specific, and measurable, with realistic timeframes for achievement,
- d. Specific follow-up planning, including but not limited to anticipated response to treatment, additional or alternative treatment interventions, and coordination with other treatment providers (e.g., PCP)

## 5. Progress Notes

- Documentation supporting continued need for services based on clinical necessity, including the following:
  - a. Dated progress notes that link to initial treatment plan,
  - b. Updates or modifications to treatment plan,
  - c. Interventions provided and client's response,
  - d. Printed staff name and signature or electronic equivalent.

For additional information concerning DVHA's *Mental Health and Substance Abuse Health Record Documentation Standards* and resources see <http://dvha.vermont.gov/for-providers>.

### Community Mental Health Center Services

Covered services include rehabilitation services provided by qualified professional staff in a community mental health center designated by the Department of Mental Health. These services may be provided by qualified mental health providers as identified by the Vermont Department of Mental Health (DMH). For further information, see the DMH manual at <http://mentalhealth.vermont.gov/publications>.

### Team Care Program

The Team Care Program restricts a beneficiary to one physician and one pharmacy. If a beneficiary is "locked-in" to a provider, that provider's name is available on the Voice Response System and the Vermont Medicaid website. Claims for services by any provider other than the "lock-in" provider(s) are not reimbursable by Vermont Medicaid, except in the case of an emergency or when a provider performs a service by referral of the named provider.

The "lock-in" procedure also applies to a Primary Care (PC) Plus beneficiary. The "lock-in" reflects the beneficiary's choice of primary care physician. This information is also available through the VRS and the Vermont Medicaid web site.

### 10.3.51 Coverage for Services Delivered Via Telemedicine

The Department of Vermont Health Access (DVHA) implemented telemedicine pursuant to Act 107 from the 2011-2012 Legislative Session:

- 1) Distance site providers are required to follow correct coding in the application of the GT modifier - CMS and/or Encoder Pro telemedicine codes excluding non-covered services,
- 2) Originating site providers (patient site) are required to document the reason the service is being provided by telemedicine rather than in person and may be reimbursed a facility fee (Q3014).



Telemedicine is defined in Act 107 as "...the delivery of health care services...through the use of live interactive audio and video over a secure connection that complies with the requirements the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191. Telemedicine does not include the use of audio-only telephone, e-mail, or facsimile." Act 107 is available at <http://www.leg.state.vt.us/DOCS/2012/ACTS/ACT107.PDF>

The DVHA will not reimburse for teleophthalmology or teledermatology by store and forward means.

Originating site provider locations are limited to:

Physician or practitioner's office

Hospital

Critical access hospital

Rural health clinic

Federally qualified health center

Community mental health center

Skilled nursing facility

Hospital-based or CAH-based renal dialysis center

**Added:** red text- new section

### 10.3.53 Vision Care & Eyeglasses

#### Eyeglasses

Eyeglass benefits (frames, lenses, dispensing and repairs) are reimbursed only for Medicaid beneficiaries under age 21 ~~and for VHAP beneficiaries less than 18 years of age~~. **Eyeglasses are not a VHAP (including age 18 and older) or VHAP Pharmacy benefit.**

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### 11.12.5 CPAP & BIPAP

**Prior authorization is not required for the rental of CPAP & BIPAP devices. The purchase of CPAP and BiPAP devices does require prior authorization. Prior authorization requests must include appropriate documentation of medical need to support current best practice guidelines. (See McKesson Smart Sheets on our Website VTMedicaid.com/Transaction services)**

**Added:** red text – new section

### 12.3 Patient Share (Applied Income) Reporting

**The MMIS system tracks changes made to patient share amounts, the highest paid providers and when the patient has moved to a new facility. Providers can submit electronic replacement claim adjustments, for any claim that had deducted a different patient share amount, or if you are now the highest paid provider or if you are no longer the highest paid provider. Providers can also submit electronic adjustments when the patient was discharged to a new facility and no longer owes their patient share to the previously admitted facility. HPES will generate a monthly report detailing these changes and will adjust claims accordingly. However, to receive your corrected payment**

quicker, we recommend you submit electronic adjustments.

**Added:** red text

#### 12.4.8 Hospital Inpatient Billing Instructions/Field Locators

- 13.4 Home Health Agency & Hospice Services Billing Instructions/Field Locators
- 13.5 Adult Day Services Billing Instructions/Field Locators
- 14.2 Assistive Community Care Services (ACCS) Billing Instructions/Field Locators
- 14.4 ERC Paper Claim Submission Billing Instructions/Field Locators
- 14.5.9 Short Term Stays
- 14.6 Home Based Waiver (HBW) Billing Instructions/Field Locators

17. STAT\*

Enter the two digit code indicating the patient's status as of the 'through date' of the statement period.

- ~~01-Discharged to Home or Self Care~~
- ~~02-Discharged/Transferred to Another~~
  - ~~—Short Term General Hospital~~
- ~~03-Discharge/Transferred to Skilled~~
  - ~~—Nursing Facility (SNF)~~
- ~~04-Discharged/Transferred to an~~
  - ~~—Intermediate Care Facility (ICF)~~
- ~~05-Discharged/Transferred to Designated~~
  - ~~—Cancer Center or Children's Hospital~~
- ~~06-Discharged/Transferred to Home Under~~
  - ~~—Care of Organized Home Health Service~~
  - ~~—Organization~~
- ~~07-Left Against Medical Advice~~
- ~~20-Expired~~
- ~~21-Discharged/Transferred to Court/Law~~
  - ~~—Enforcement~~
- ~~30-Still A Patient (for awaiting placement~~
  - ~~—claims or long term inpatient care~~
  - ~~—(electronic adjustment claims greater than~~
  - ~~—60 days).~~
- ~~40-Expired at Home (Hospice Only)~~
- ~~41-Expired in Hospital, SNF, ICF, or Free~~
  - ~~—Standing Hospice (Hospice Only)~~
- ~~62-Transfer to Rehab Facility, including~~
  - ~~—Distinct part rehab facility~~
- ~~65-Transfer to a Psychiatric Hospital,~~
  - ~~—including distinct part psych unit.~~

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## UPDATES FOR 11/03/2012

### 3.7 Remittance Advice

When a provider submits VT Medicaid claims via electronic claim submission (ECS) directly or through a clearinghouse or billing service, the Remittance Advice (RA) will be posted to the VT Medicaid Portal at [www.vtmedicaid.com](http://www.vtmedicaid.com).

When a provider is not set up for ECS and is only submitting paper claims to Vermont Medicaid, the RA will be mailed weekly; however, if the provider switches to ECS, the RA will be posted to the web and the RA mailing will stop.

When a provider is set up for ECS, all RA information will be posted to the Web Portal regardless of whether the claims were submitted on paper, electronically or any combination thereof.

The Web RA is posted weekly to the Web Portal for providers to access. It reflects provider claim and payment information. Provider payments are made at the end of the week on Friday. The system maintains the four most recent Web RAs. When a fifth RA is posted to the Web Portal, the oldest dated RA will drop off the system. Once an RA drops off the system, it cannot be reposted; therefore, it is highly recommended that RA copies are saved/printed for future reference.

The Web RA can be accessed via two different account types a Trading Partner account, and a Provider Web Services (PWS) account.

Start by going to [www.vtmedicaid.com](http://www.vtmedicaid.com)

If you have a Trading Partner Account (User id starts with 701...) click on Transaction Services, then Production Logon.

If you have a PWS account, click on Provider Web Services. Then do the following:

- Use the Account ID and password to Logon

- For either method of access after logging on, click on View RA Files

- Pick the Provider Number from the drop down (if you have more than one)

- Click Go

- Click on the appropriate .pdf

- Click Open (this should display the RA on the screen)

For questions about an existing account, creating an account, or accessing the Web RA, please contact the EDI Coordinator at 802-879-4450, select option 3.

Providers with questions about their RA's content are to contact the HPES Help Desk at 800-925-1706 in-state or 802-878-7871 out-of-state.

**Added:** red text

### 11.3.6 Audiological Services/Hearing Aids

#### Cochlear Implant (re)Programming

CPT codes 92601- 92604 are accepted for diagnostic analysis of cochlear implants with (re)programming. This service (cochlear rehab, cochlear reprogramming, speech processor remapping) is billed as: 1 units=1 hour and is limited to a maximum of 8 hours per session and 18 hours per year (365 days) per beneficiary. Do not bill when (re)programming is not done.

**Deleted:** above text from section

### 11.3.53 Vision Care & Eyeglasses

When sending a Medicaid beneficiary's eyewear prescription to Classic Optical (the DVHA's sole-source eyewear provider), please provide the NPI of the ordering/prescribing practitioner. A business, group or company NPI Number will not be accepted. Classic Optical cannot fill the order without the NPI of the person giving the order.

**Added:** above red text

## UPDATES FOR 10/03/2012

### 3.6 National Correct Coding Initiative (NCCI)

In accordance with the National Correct Coding Initiative (NCCI), VT Medicaid has implemented pre-payment edits and applies NCCI guidelines for claims with a date of service on or after 10/01/2010.

MUE (Medically Unlikely Edits) have been implemented and apply to all Professional, ASC, Hospital and DME claims.

Vermont Medicaid is currently following the CMS MUE list (not Medicare's). This list is available for review at <http://www.cms.gov/apps/ama/license.asp?file=/MedicaidNCCICoding/Downloads/MCD-MUE-PractitionerServices.zip>

DVHA implemented the Procedure to Procedure NCCI edit effective 01/01/12. Edit guidelines are available at: [www.cms.gov/NationalCorrectCodInitEd/NCCIEP/list.asp#TopOfPage](http://www.cms.gov/NationalCorrectCodInitEd/NCCIEP/list.asp#TopOfPage)

**Added:** new section

### 7.8.7 Rehabilitative Therapy

#### Beneficiaries under age 21

Providers must request prior authorization in advance of the 8<sup>th</sup> 9<sup>th</sup> visit if additional therapy services are necessary.

#### Pediatric Beneficiaries

~~All medical reviews for therapies, including pediatric beneficiaries will be conducted by the DVHA. Request for therapy services for pediatric beneficiaries beyond the first four months of care, must be faxed to 802-879-5963 or may be mailed to: DVHA, Clinical Unit, 312 Hurricane Lane, Suite 201, Williston, VT 05495.~~

**Added:** red text

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### 11.3.44 Physician Visit Limits

Visits in excess of those listed above may be reimbursed if the services are medically necessary. A medical exception request documenting the medical necessity must be sent to the DVHA. Forms for prior authorization are located at <http://dvha.vermont.gov/for-providers/forms-1>.

Effective July 1, 2012, non-emergency (elective) out-of-state medical visits will require prior authorization from DVHA (border hospitals are excluded from this requirement). In network referring providers are to submit requests using the OOS Medical Office Request Form located at <http://dvha.vermont.gov/for-providers/clinical-coverage-guidelines>.

Mileage allowances for house calls apply only to the first beneficiary. If more than one beneficiary is seen during the visit, no mileage will apply to those beneficiaries.

**Added:** red text

## 12.5 Prescribing Provider

When billing for services to Vermont Medicaid, the prescribing/referring physician NPI number should appear in field locator 17a or b when billing on a CMS 1500 Claim Form. **The billing provider name and address must appear in field locator 33 and the NPI number must appear in field locators 33a and 24j.**

**Added:** red text

### 11.3.51 Coverage for Services Delivered Via Telemedicine

Effective for dates of service October 1, 2012 and after, the Department of Vermont Health Access (DVHA) has implemented telemedicine pursuant to Act 107 from the 2011-2012 Legislative Session:

- 1) Distance site providers are required to follow correct coding in the application of the GT modifier - CMS and/or Encoder Pro telemedicine codes excluding non-covered services.
- 2) Originating site providers (patient site) are required to document the reason the service is being provided by telemedicine rather than in person and may be reimbursed a facility fee (Q3014).

The DVHA will monitor the impact on service utilization and costs, and perform retrospective reviews.

Telemedicine is defined in Act 107 as “the delivery of health care services through the use of live interactive audio and video over a secure connection that complies with the requirements of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191. Telemedicine does not include the use of audio-only telephone, e-mail, or facsimile.” Act 107 is available at: <http://www.leg.state.vt.us/DOCS/2012/ACTS/ACT107.PDF>

The DVHA will not reimburse for teleophthalmology or teledermatology by store and forward means.

**Added:** new section

### 13.3.1 ~~Border Hospitals~~ In-Network and Extended Network Hospitals

~~Border hospitals~~ In-Network Hospitals are included in the Green Mountain Care Network due to their close proximity to Vermont and are subject to the same Vermont Medicaid policy as those located within the geographical confines of the state of Vermont. Their physicians are required to be enrolled in Vermont Medicaid. A complete list of Green Mountain Care In-Network & Extended Network Hospitals is available at <http://dvha.vermont.gov/for-providers/green-mountain-care-network>.

Out-of-state hospitals not designated as an In-Network Hospital must bill using the attending provider's NPI number in field locator 76, when the attending provider is not enrolled with Vermont Medicaid. ~~Please refer to the billing instructions at the end of this manual. For purposes of Vermont Medicaid reimbursement, the following hospitals are designated as “border hospitals”:~~

Alice Peck Day Hospital \_\_\_\_\_ Lebanon, NH  
Cottage Hospital \_\_\_\_\_ Woodsville, NH

Glens Falls Hospital	Glens Falls, NY
Littleton Hospital	Littleton, NH
Dartmouth Hitchcock Medical Center	Lebanon, NH
North Adams Hospital	North Adams, MA
Upper Connecticut Valley Hospital	Colebrook, NH
Valley Regional Hospital	Claremont, NH
Weeks Memorial Hospital	Lancaster, NH

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### 13.4.2 Dialysis

The DVHA has established a reimbursement policy for billing End Stage Renal Disease outpatient treatment services. This reimbursement method is excluded from OPPS pricing; providers identified as free standing dialysis centers are reimbursed under this method. Only the revenue codes listed below are reimbursable. All other billed revenue codes will be denied as incidental.

- Revenue codes 821, 831, 841 or 851 – Hemodialysis requires HCPCS code 90999 be billed. This service is reimbursed at a per diem rate of \$151.32
- Revenue code 304 – Lab services, non routine dialysis, requires an appropriate HCPCS code be billed. Reimbursement is 62% of the Level III price on file for the HCPCS code.
- Revenue code 636, separately-payable drugs except EPO - is reimbursed with the appropriate HCPCS and NDC coding (when applicable). Pricing is the current Level III price on file for the HCPCS or NDC code billed on the claim.
- Revenue codes 634 and 635 EPO – are reimbursed when billed with the appropriate HCPCS and NDC coding. Pricing is the current Level III price on file for the HCPCS or NDC code billed on the claim.

**Added:** new section

### 13.4.8 Hospital Outpatient Billing Instructions/Field Locators

#### 4. TYPE OF BILL

~~5-Late charges; this code is to be used only when submitting charges that were not included on a previously filed claim.~~

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