Department of Vermont Health Access

# November/December 2025 Advisory

VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

## Inside This Issue





## New to Medicaid Screening

Help us engage new members! We need your help sharing the value of the New to Medicaid Survey!

Did you know, NEW MEDICAID members are eligible for a FREE SCREENING by the Agency of Human Services Vermont Chronic Care Initiative (VCCI) on behalf of the Department of Vermont Health Access? The free screening includes questions regarding:

- Access to care concerns (including primary and dental),
- The presence and status of health conditions, and
- Other needs that would assist them in maintaining and/or improving their health such as housing, food and safety.

Once the screening is completed, VCCI staff helps the member with direct connections to primary care and mental health services as well as dental care, and community resources. VCCI staff also help answer questions and orient members to some of their insurance plan benefits. When appropriate, they educate and offer VCCI case management services with a field-based nurse case manager in their community.

Members can complete the screening in two different ways:
1) Directly by responding to telephone outreach or calling a VCCI team member at 866-900-5004 or 2) Returning the completed screening which they will have received by mail, along with a postage paid return envelope. Coming later this year 2025, members will be able to complete the screening through an online member portal!

## Supervised Billing Update

The Department of Vermont Health Access (DVHA) has updated the Medicaid Supervised Billing Rule (HCAR 9.103). The new HCAR rule will become effective on 1/1/2026. Under the new version of HCAR 9.103, all supervisees will be required to enroll with Vermont Medicaid to bill on 1/1/2026.

Updated Supervised Billing Rule (effective 01/01/2026)

Updated Supervised Billing Manual (effective 01/01/2026)

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# Critical Care Audit Results

**Topic: Critical Care (CPT codes 99291 & 99292)**

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

**Review Criteria:**

Ten critical care providers were reviewed; 10 medical records were requested of each provider. Review of medical records documentation for billing of Current Procedural Terminology (CPT) codes 99291 *(critical care, evaluation and management of the critically ill or critically injured patient, first 30-74 minutes)* & 99292 *(critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes)* was conducted.

**Results: Date of Service**

A total of 10 providers (representing 100 dates of service) were reviewed for the time-period of calendar years 2022-2024. Out of the 100 dates of service, 29 (29%) were determined to have billing or medical record deficiencies identified as a result of our review.

- Critical care was billed when there was no documentation of critical care services (21/100) (21%)
- Critical care was billed when there was no documentation of the total time of critical care services (2/100) (2%)
- Critical care was billed when the total time of service did not meet the minimum code criteria (2/100) (2%)
- The date of service on the claims did not match the date of service in the documentation (1/100) (1%)
- The critical condition of the patient was not documented (1/100) (1%)

**Providers are encouraged to review the Educational Resources Listed Below:**

- **Vermont Medicaid General Billing and Forms Manual**
- **American Medical Association (AMA) Current Procedural Terminology (CPT)**

# Reconsideration and Timely Filing Reconsideration Processes

Gainwell Technologies would like to remind providers of our Reconsideration and Timely Filing Reconsideration processes.

Timely Filing Reconsiderations and Reconsiderations must be submitted within 90 days from your original denial. Claims cannot be resubmitted for a new denial date to extend the Reconsideration window.

All Reconsiderations mut be submitted with the required forms and documentation.

**Timely Filing Reconsideration Requests**

**Required:**

Timely Filing Reconsideration Request Form

- This form must be complete and accurate
- The most current form is always found directly on the VT Medicaid website

- A new red and white claim form
- Appeal request letter
  - Please note that this letter should contain an explanation of the extenuating circumstance or clearly documented follow-up activity.

**Optional:**

- Claim history and denials
- Remittance Advices (RAs)
- Account notes (do not include medical records)
- Other Insurance attachments

A Timely Filing denial is required to already be on file prior to submitting a Timely Filing Reconsideration.

Timely filing is only overridden when an extenuating circumstance beyond the provider's control prevented the claim from being filed timely or the provider can prove they were actively trying to resolve their claim denials.

**Additional Timely Filing Resources:**

- Timely Filing FAQ
- Timely Filing in the General Billing and Forms Manual (sections 3.3 – 3.3.1, 3.3.4 – 3.3.5)

**Reconsideration Requests**

**Required:**

Reconsideration Request Form

- This form must be complete and accurate
- The most current form is always found directly on the VT Medicaid website
- Remittance Advice (RAs)
- A new red and white claim form
- Appeal request letter
  - Please note that this letter must address the reason why your claim was denied, along with an explanation of why you feel this denial needs review
- Clinical documentation (not required when regarding psychiatric services)

**Optional:**

- Claim history and denials
- Coding-related supporting documentation

Reconsideration Requests are an option for coding-related denials and when an improper payment is received. Coding Reconsiderations include place of service codes, modifiers, diagnosis codes, and provider type/specialty. Improper Payments include non-payments or claims that paid differently than expected.

**Additional Reconsideration Request resources:**

- Provider Reconsideration Process in the General Provider Manual (section 1.2.10).

# Open Enrollment for 2026 Health Plans is Underway!

Open Enrollment for 2026 health insurance plans **kicked off on November 1 and runs until January 15, 2026.** This is the time for Vermonters to enroll OR make changes to their health care coverage.

Many Vermonters who already have coverage through Vermont Health Connect will be automatically renewed into the same plan. During Open Enrollment, these members also get the opportunity to shop for and change plans if they find one that better fits their health needs and household budget.

Any eligible Vermonter without coverage can also enroll in a Qualified Health Plan during Open Enrollment.

- The **first deadline the enroll is December 15** for coverage starting January 1.
- The **final deadline to enroll is January 15** for coverage starting February 1.

These deadlines also apply to existing customers wishing to enroll in a different plan.

**Heath Marketplace Changes in 2026**

There are many changes at the Federal level that will impact health insurance marketplaces, including Vermont Health Connect, and this year's open enrollment

The changes include:

- At this point in time, Congress has not extended the enhanced premium tax credits. That means that unless Congress acts, in 2026, many customers will get LESS premium tax credits, and some will get NO premium tax credits. **Many people will still be eligible for tax credits, but the amount of those credits will be smaller.**
- Members whose household income is more than 400% of the Federal Poverty Level (FPL) won't be able to get financial help through the marketplace anymore. For example, in 2026, the 400% FPL limit is $62,600 for a single person, and $128,600 for a family of four.
- Certain lawfully present immigrants will no longer be able to get financial help to pay for a Qualified Health Plan. Customers with a household income under 100% of the FPL who cannot get Medicaid because of the immigration status will no longer be eligible for tax credits.
- **No more Advanced Premium Tax Credit (APTC) repayment caps**. Beginning with the 2026 tax year, members who take APTC will owe back (Advance Premium Tax Credit (APTC) Repayment) ALL excess monies they received when filing taxes.

Learn more at Health Insurance Changes in 2026.

**It's Important To Update Household Information**

Vermont Health Connect is asking its enrolled members to check their online account and update their information as soon as possible. Information such as changes in income or household size is used to determine the amount of financial help for health care costs. If this information is not up to date, it could mean Vermonters may be getting fewer tax credits or paying higher monthly payments.

**How To Find A Plan That Meets Medical Needs And Fits A Budget**

The Plan Comparison Tool is a great way to get a quick estimate of eligibility for financial help. It can also compare individual plans and costs side-by-side, helping Vermonters find the health plan that will have the lowest cost for their age, income, and health needs.

## Reinstatement of Prior Authorization Requirements for DME, Prosthetics, Orthotics, and Supplies

Effective 12/1/2025, prior authorization requirements will be reinstated for items of durable medical equipment (DME), prosthetics, orthotics, and supplies for items in excess of quantities found on the Department of Vermont Health Access DME Limitation List. For additional information see DME Limitations and Guidelines.

It will be necessary for providers to submit prior authorization requests for medically necessary determinations for DMEPOS beyond published limits.

This change does not impact reimbursement as providers will continue to be paid for medically necessary items over the services limits with an approved prior authorization.

## VT Medicaid Provider Enrollment Information Reminder

Thank you for your continued participation in the Vermont Medicaid network, supporting VT members!

To ensure our members have the most up to date information about your practice, we ask that you please review your enrollment information on a regular basis.

All your enrollment information can be found on our Provider Management Module Provider Portal.

By logging in to your secure profile, you can view and update the following information:

- Legal Name
- Service Location Address (limited risk providers only)
- Mail-To Address
- Pay-To Address
- Legal Address
- Remittance Advice Address
- Contact Information (phone number, fax number, email, etc.)
- Accepting New Patients status
- Specialties and Taxonomies
- License and Certifications
- CLIA and DEA
- Group Affiliations and Authorized Administrator

If you do not have a Provider Portal account, or require assistance logging in, please contact a Gainwell enrollment representative.

Regular reviews of your information ensures Vermont Medicaid is providing the most current information to our members.

Thank you for your continued support!