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GreenMountainCare
A HEALTHIER STATE OF LIVING

Vermont Medicaid
General Billing and Forms Manual

VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

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Section 1 Coordination of Benefits/Vermont Medicaid Payment Liability/Third Party Liability

1.1 Contractual Allowance

Vermont Medicaid is payer of last resort, and as such, will not consider and pay amounts that exceed the Vermont Medicaid rate, even when payment is combined with payments from primary insurance. 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. When the entire allowed amount is applied to the primary insurance deductible, the claim may be submitted to Vermont Medicaid but must be accompanied by an Explanation of Benefit (EOB). Vermont Medicaid will consider payment based on the Vermont Medicaid allowed amount after deducting any payment made by a primary insurer.

The provider is prohibited from collecting an amount that exceeds the contractual amount that is agreed upon in the contract with primary payer.

1.2 Reimbursement of Overpayments

Fraud Enforcement

Providers are reminded of the 2009 Fraud Enforcement and Recovery Act (FERA) which amended the False Claims Act, 31 U.S.C §§3729-3733, by increasing the scope of the false claims liability to include persons who knowingly conceal the retention of any overpayment of government money and the 2010 Patient Protections and Affordable Care Act (PPACA) which directly linked the retention of overpayments to false claims liability. PPACA requires the report and return of all overpayments within 60 days after the date on which the overpayment was identified or the date the corresponding cost report was due, whichever is later. Additionally, providers must submit notification in writing as to the reason of the overpayment. Gainwell will forward to the SIU cases for review when it’s discovered that overpayment was not refunded during the timeline mandated by PPACA. In addition to the above information Gainwell contracts with AIM HealthCare to audit hospitals for credit balances on accounts. This arrangement does not negate the provider's responsibility to report and return overpayments timely. Gainwell will forward cases for review to the DVHA Special Investigations Unit, when or if the discovered overpayment was not refunded during the timeline mandated by PPACA.

Extrapolated Overpayments

The Special Investigations Unit (SIU) is responsible for all Medicaid fraud, waste & abuse monitoring and referral activities. This may include an extrapolation from a random sampling of claims submitted by a provider and paid by DVHA.

1.3 Special Investigations Unit

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

- Billing for services not rendered or more services than actually performed.
- Providing and billing for unnecessary services.
- Billing for a higher level of services than actually performed.

- Charging higher rates for services to Vermont Medicaid than other providers.
- Coding billing records to get more reimbursement.
- Misrepresenting an unallowable service on bill as another allowable service.
- Falsely diagnosing so Vermont Medicaid will pay more for services.

The Special Investigations Unit (SIU) is responsible for all Medicaid fraud, waste & abuse monitoring and referral activities. This may include an extrapolation from a random sampling of claims submitted by a provider and paid by DVHA.

For more information on overpayments and potential interest charges, visit the General Provider Manual, section 6.

Suspected fraud, waste or abuse should be reported to the DVHA Special Investigations Unit, telephone 802.241.9210, or the Vermont Medicaid Fraud Control Unit of the Vermont's Attorney General's Office, telephone 802.828.5511.

1.4 Who is Responsible for Payment?

The provider must:

1. Verify that the Member is still eligible for Medicaid on the date the service is provided.

   and

2. Meet the following conditions when billing for a Medicaid covered service:
   a. Bill any other liable third parties prior to billing Medicaid.

      and

   b. Accept the Medicaid payment rate as payment in full and bill the Member only for any applicable co-payments once Medicaid has been accepted as a source of payment.

      and

   c. File a claim with the department or its agent, including all necessary information about the service and the identifying information from the Member's identification document.

   and

3. Meet the following conditions prior to billing a Member for a service that is not covered by Medicaid:
   a. The provider must advise the Member that Medicaid will not pay for the service before delivering the service.

      and

   b. The provider and patient must have a signed written agreement in place before delivering the services that specifically describes the services to be delivered and the amount that the Member must pay.

1.5 Verifying Eligibility Before Service

Providers are expected to verify eligibility for every member prior to providing the service or item to be clear about who has financial responsibility for the service. Eligibility can be verified up to

nine days in advance however, this is not a guarantee of payment. Eligibility can be verified through the automated Voice Response System (VRS), 800.925.1706, option 1 and then option 1 again or by utilizing online Transaction Services. If you need assistance with either of these options, please call the Provider Services Unit help desk for support. When an eligible aid category code is given, the provider should determine that the service to be provided is covered within that aid category. This will also show what other insurance is on file. To ensure timely processing of your claim, validate other insurance with member or refer them to the Department for Children and Families.

1.6 Billing the Member

All covered services provided to a Member shall be billed to DVHA. Provider shall not bill a Member or attempt in any way to collect any payment from a Member for any covered service, except for
co-payments allowed by DVHA. This provision is in force even if Provider fails to bill DVHA for a covered service. Violation of this provision may result in suspension of payments, recoupment of DVHA reimbursements and/or contract action up to and including termination of the General Provider Agreement.

If the provider bills Vermont Medicaid for a service or item, the provider may not bill the patient for any reason except the following:

- The amount due is for unpaid Vermont Medicaid co-payments and deductibles
- The claim was denied for lack of eligibility and the date of service was greater than 60 days beyond the loss of eligibility date
- The claim was denied because another insurer's rules were not followed
- The claim is submitted to Vermont Medicaid by Medicare for a patient enrolled in a Vermont Medicaid pharmacy only plan or
- If the Gainwell system reports that a member has other insurance, the provider must bill the service or item to the other medical insurance prior to billing Vermont Medicaid. If the member is no longer enrolled with the other insurer and the member does not report the insurance change to Vermont Medicaid within 30 days and after the 30 days have lapsed, the Gainwell system still reports that the patient has other insurance, the provider may bill the member.
- Under the Provider Enrollment Agreement (Conditions of Participation #9), failure to give advance notice that a Vermont Medicaid payment will not be accepted prevents the provider from billing the member. If the member is eligible for Vermont Medicaid and the provider has made the decision not to bill Vermont Medicaid for the service or item requested, the member must be informed in advance of providing the service.
- Federal Medicaid policy does not permit providers to bill Vermont Medicaid or the member any fee for missing a scheduled appointment.

Supplementation

Once Vermont Medicaid has been billed for a service or item, the provider may not attempt to collect any additional reimbursement for that service or item from the member, the member's family or anyone acting on behalf of the member, except for:

- The applicable conditions described below in Section 1.5, Who is Primary.

- Permitted deductible and co-payment amounts.
- Specific allowed supplementations authorized in Medicaid Rule 7602.

1.7 Who Is Primary?

When the DVHA is the primary payer (i.e., the Gainwell 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 Gainwell 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 member if they notify the member in writing, prior to rendering the service, that they will not bill Vermont Medicaid for the co-payment. The member must sign and date this notification; please retain documentation in the member's file.

If the third-party payment was made directly to the member, the provider may bill the member for the amount paid by such third parties. In addition, the provider may collect patient liability or spend-down amounts.

1.8 Notice That Vermont Medicaid Will Not Be Accepted

If a provider does not intend to bill Vermont Medicaid for specific services, the patient must be fully informed of the decision and its consequences prior to rendering the service. Patients must understand that they will be financially responsible for the service(s). To document that proper notice was given; providers are required to document the agreement/understanding between member and provider on their letterhead. Comprehensive documentation showing evidence that proper notice was given to the member should include the following information:

1. Provider's name and Vermont Medicaid provider ID number.
2. Member's name and signature or signature of a parent or guardian if the member is a minor.
3. Description of service(s) sought.
4. A clear statement that the provider is unwilling to accept Vermont Medicaid payment for the specific service(s) sought and if the member wants to get this service from this provider, the member or responsible adult must accept full financial responsibility.
5. Date of signing.

The provider is to give a copy to the member or responsible adult and retain a copy in the member's file. Failure to give advance notice prevents the provider from billing the member. When the member or responsible adult accepts financial responsibility, the claim cannot be submitted to Gainwell for processing.

1.9 Vermont Medicaid & Medicare Crossover Billing

A **Green Mountain Care** member 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 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.

Gainwell 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.

The Department of Vermont Health Access reviews all Medicare crossover claims where the Vermont 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 Vermont 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.

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 6 months from Medicare's processing date.

The Medicare Attachment Summary Form is only to be used for Members who are enrolled in both Medicare and Vermont Medicaid. It is not to be used for reporting actions by any other insurers.

1.10 Vermont and New Hampshire Providers

To crossover, Vermont Medicaid eligibility information must be clearly indicated on the Medicare claim. These claims, as well as any future adjustments to these claims, will crossover automatically to Gainwell for payment. If you do not receive the DVHA payment within 30 days of the Medicare paid date, submit the claim to Gainwell with the **Medicare Attachment Summary Form**, found on the Vermont Medicaid Forms page.

If a service or item is denied by Medicare as non-reimbursable and is reimbursable by the DVHA, submit a CMS-1500 claim, completed to the DVHA specifications, along with the Medicare denial to Gainwell within twelve months of the 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.

1.11 Other Out-of-State Providers (Except New Hampshire)

All out-of-state providers should first bill their regional Medicare carrier for services to dual eligible Vermont residents. After Medicare payment is received, send a claim to Gainwell for payment of any coinsurance or deductible as follows:

- Send a claim completed to the DVHA specifications with a copy of the Medicare Attachment Summary Form. The Medicare payment date must appear on the Medicare Attachment Summary Form.
- If a service or item is denied by Medicare as non-reimbursable and is reimbursable by the DVHA, submit a CMS-1500 claim with the EOMB, completed to the DVHA specifications to Gainwell within twelve months of the date of service; see Section 3.3 Timely Filing.

1.12 Third Party Liability (TPL)/Other Insurance (OI)

Vermont Medicaid is the payer of last resort. Providers are required to pursue and apply all third-party payment resources prior to billing Vermont Medicaid. Third party resources include, but are not limited to, Medicare, private/group health insurance plans, military and veteran's benefits, Worker's Compensation and accident (automobile, homeowners, etc.) insurance. See Section 1.8 for information specific to Workers Compensation and Accident Liability Billing.

TPL-Verification

The member's other insurance information, including the name of the other insurance company, address, carrier code and type of coverage, is available on the Vermont Medicaid website, (Provider Web Services, Transactions > Login) and the Voice Response System (VRS) when the provider checks the member's eligibility. Providers will review the members' eligibility information for the date of service and must bill other insurance carrier(s) before billing Vermont Medicaid. Providers may use the available information to guide billing.

Timely Filing of OI Claims

Providers will respect the member's right to receive all medically necessary services and equipment in a timely manner and must submit claims to primary insurers promptly to mitigate issues with member primary insurance benefits exhausting.

Other Insurance Denial/DVHA Authorization Request

The following procedures are required for DVHA authorization requests when the primary insurer has reviewed and denied a claim request for an item or service.

OI Denial for Non-Covered or Benefits Exhausted

The provider is required to submit to the DVHA the appropriate DVHA prior authorization request form, with documentation from the medical record to support the requested services, the notice of denial from the primary insurer that indicates the item, or service is not a covered benefit or that the benefit limit was determined to be exhausted, and all necessary documentation to support medical necessity. The DVHA will then review.

- The provider does not need to appeal to the primary insurer before billing Vermont Medicaid when the item/service is not covered, or benefits are exhausted.
- If the code/service does not require authorization from Vermont Medicaid, then the provider can bill Vermont Medicaid directly with a copy of the primary insurer's denial attached.

OI Authorizations and Policies

When a member has a primary insurance other than Medicare and/or Medicaid, and the requested item requires Medicaid prior authorization, the DME vendor must submit the request first to the primary insurer.

If the primary insurer denies via their prior authorization process or has a relevant corporate policy stating that the item is not a covered benefit, this denial must be submitted with the request for a Medicaid determination prior authorization.

After confirming that the primary insurer has no prior authorization requirement and no corporate policy, the DME vendor may submit a request for prior authorization to VT Medicaid and specify that there is no corporate policy and no primary insurer prior authorization requirement for the requested item.

OI Denial for Not Medically Necessary

The provider and/or member is required to pursue all levels of reconsideration and appeals with the primary insurer. If the request remains denied by the primary insurer, the provider and/or member is required to seek review by the Vermont Department of Financial Regulation if the cost of the item or service exceeds $100. If the denial stands, then the provider may submit the request to the DVHA with copies of all of the original documentation, the denials from the primary insurer and the Department of Financial Regulation's support of the denial. The provider should not submit any additional documentation other than what was reviewed by the primary insurer.

- If the code/service does not require authorization from Vermont Medicaid, then the provider may bill Vermont Medicaid directly, with copies of the primary insurer's denials (original and appeals) and the Department of Financial Regulation's support of the denial attached.
- Certain services that are not covered by Medicare may be covered by VT Medicaid for dually eligible members. Services identified on the VT Fee schedule, as allowed by Medicaid only, non-covered by Medicare, may be billed directly to VT Medicaid who will determine whether or not the service is covered and can be reimbursed.

OI Blanket Denials

Providers are required to submit blanket denials from a primary insurer to Gainwell every calendar year, for example: a blanket denial issued on July 7, 2018, will only be valid until December 31, 2018, and a new denial will be required as of January 1, 2019. 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
- Member name
- Date(s) of service
- Rev/Procedure code or description of service

Providers may obtain a "blanket statement" from an insurance company that states that the company never covers a particular service for the member's policy and attach it to the claim when

billing for that service. Blanket statement must be less than one year old and must be attached to each claim submitted. Providers must indicate the member's name and identification number and the applicable dates of service, and the provider must sign and date the blanket statement.

1.13 Medicare Qualified Independent Contractor

For members covered by Medicare it is required that the Medicare Qualified Independent Contractor appeal level be applied, except for wheelchairs that Medicare denies or downgrades. Upon documentation of the Medicare action, Vermont Medicaid will review for medical necessity and payment determination.

The DVHA will reject a request if there is reason to believe that the OI received incorrect or incomplete information from the provider and based its decision on that incorrect or incomplete information. Providers must determine OI and Medicare benefits before rendering the service to minimize the risk of non-coverage by both OI or Medicare and the DVHA.

1.14 Other Insurance Attachments

Providers may submit electronically to Gainwell claims that have been denied by another insurance company (third party payer/primary payer) when that payer has denied the claim using certain adjustment reason codes. Providers are required to include the adjustment reason code used by the primary payer when submitting the claim but will not need to send a copy of the primary insurance attachment. The list of adjustment reason codes that will be accepted electronically is available at Provider Resources, select 837 Adjustment Reason Codes. Gainwell may select your claim for post payment review and request a copy of the explanation of benefits; if so, providers are required to supply all supporting documentation in a timely manner. Failure to do so will result in the recoupment of your paid claim.

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 member's name, insurer's name, dates of service, service code or exact description of service, the amount reimbursed and the payment or denial date. If the carrier does not include this information in the documentation (i.e., the carrier issues a blanket statement that the service is not covered), the provider must write the necessary information on the attachment, then sign and date the attachment. It must be clear that the attachment relates to the specific services billed on the Vermont Medicaid claim.

If there was a payment made by the third party, providers must indicate the amount paid in the "prior payments" field. Documentation from the carrier is not required with the claim form if there is a payment amount, thus allowing the claims to be submitted electronically. In cases where a member has more than one other insurance, providers must indicate on paper, that payment was received (or denied) from each insurance company.

If the other insurance amount is less than $3.00, the provider must include the "other insurance" attachment verifying that exact payment amount.

Exceptions: Members are excluded from the third-party liability requirements specified above for the following services:

- Prenatal Care Services: This includes routine supervision of normal pregnancy, prenatal screening of mother or fetus, and care provided in the prenatal period to the mother for complications of pregnancy.

- Preventive Care Services: This includes immunizations, screening tests for congenital disorders, well-child visits, preventive medicine visits, preventative dental care, and screening and preventive treatment for infectious and communicable diseases.

Claims exempt from TPL may be submitted directly to Gainwell. Indicate “not billed” in the “other insurance” field when submitting paper claims. When submitting electronically, simply indicate “no” in the “other insurance” field. The provider should only indicate that other insurance has not been billed if that is, in fact, true.

If the provider chooses to first bill the third party in these cases, he or she must wait 30 days from the date of furnishing the service before billing Vermont Medicaid. Vermont Medicaid must be credited with any payments received from the other third-party payer.

1.15 Accidents

The Vermont Medicaid program must recover payment from liable third parties in accident cases. The information contained on a claim form is vital in researching these accident cases.

When filing a Vermont Medicaid claim when an accident may be involved, check the appropriate box in the accident fields and enter the date of the accident according to the appropriate billing instructions, if applicable. The claim will deny if all accident fields are not completed.

Claims billed with a “yes” in the accident field and those with a trauma diagnosis will be tracked in the claims processing system and monitored for post payment recovery from liable parties. To determine liability information, Gainwell will send questionnaires to members regarding some trauma cases.

1.16 Discrepancy in Third Party Liability Information

When a provider believes that the other insurance listed in the eligibility file is incorrect, contact the DCF district worker for clarification/correction or have the member contact Member Services.

1.17 HMOs

Are treated as other health insurance. When a Vermont Medicaid member does not comply with the rules of their HMO, such as securing prior authorization, the HMO may choose not to cover the service. In such cases, Vermont Medicaid will not pay for the service either and the member will be responsible for payment.

1.18 Third Party Liability Cost Avoidance

Gainwell maintains eligibility files, which contain member health insurance information. This data is integrated in the claims processing system to coordinate benefits.

1.19 Third Party Liability Coverage Codes

The VRS and the Vermont Medicaid website use the following codes to describe the type of services covered by a patient’s other insurance. The Coverage Codes (below) and the insurance matrix (see Appendix) will help in understanding how to interpret the information provided about third party liability. For example, if the VRS reports “07” for a member, the matrix shows that a dental claim for dental services will fail for reason 408 if the third-party information is not provided. Contact Gainwell if you do not know whether the coverage code refers to the service you have provided.

Code	Type of Coverage
01	Hospital Inpatient Services

Code	Type of Coverage
02	Hospital Outpatient Services
03	Hospital Inpatient/Outpatient Services
04	Physician Services
05	Physician Inpatient/Outpatient Services
06	Physician Inpatient/Outpatient Services/Major Medical
07	Dental Coverage
08	Vision Coverage
09	Drug Coverage
10	Physician Inpatient/Outpatient Services/Major Medical/Dental
11	Physician Inpatient/Outpatient Services/Major Medical/Vision
12	Physician Inpatient/Outpatient Services/Major Medical/Drug
13	Medicare Supplement A & B
14	Indemnity Coverage Payment to Client
15	Major Medical
16	Major Medical/Physician
17	Major Medical/Physician/Dental
18	Major Medical/Physician/Vision
19	Major Medical/Physician/Drug
20	Major Medical/Physician/Dental/Vision/Drug
21	Inpatient/Outpatient/Physician/Dental/Major Medical/Drug/Vision
22	Medicare Supplement Part A
23	Medicare Supplement Part B
24	Specialty Coverage (e.g., cancer)
25	HMO
26	Nursing Home
27	Veterans Home
28	Worker's Compensation
50	Absent Parent (4D)
99	Unknown
A1	Medicare A
B1	Medicare B

1.20 Workers Compensation/Accident Liability Billing

Providers have two choices regarding billing when a member is also covered by worker's compensation or accident insurance, such as auto insurance, homeowners, etc.

1. Bill Vermont Medicaid.
2. Bill workers compensation/auto insurance.

If the provider chooses to bill the workers compensation or the accident Insurance (i.e., auto insurance, homeowners, etc.), the provider cannot bill Vermont Medicaid simultaneously. (Refer to your provider enrollment/recertification agreement.)

If a provider decides at any point to bill Vermont Medicaid, the provider must withdraw the claim to the workers compensation/auto insurer. The withdrawn claim is still subject to the 180 days timely filing limit. Vermont Medicaid will pay the claim and bill the responsible insurance provider. Payments made by the insurance provider will come directly to Vermont Medicaid. No reimbursement will be made to the provider.

When a provider bills worker's compensation or accident insurance, and the claim is denied by workers compensation or accident insurance, the provider then has 1 year from the date of service to submit their claim to Vermont Medicaid for payment.

If a payment is received from a worker's compensation/accident insurer after the provider has received payment from Vermont Medicaid, the provider must return or refund the payment to Vermont Medicaid.

In regard to billing the member, 42 USC § 1396a (a)(25)(C) states: "In the case of an individual who is entitled to medical assistance under the State plan with respect to a service for which a third party is liable for payment, the person furnishing the service may not seek to collect from the individual (or any financially responsible relative or representative of that individual) payment of an amount for that service…"

1.21 Incarcerated Medicaid Members (Z9 Aid Category)

Incarcerated Medicaid members with full benefit Medicaid coverage will have their benefits suspended in the Medicaid Management Information System (MMIS) until they are released. This benefit suspension is represented by the "Z9" aid category code in the Provider Portal Eligibility Verification System.

When a Medicaid member has Z9 coverage, their benefits are suspended. Any claims for services billed with a date of service during the benefit suspension and prior to the member's date of release will deny. The only exception is for inpatient hospital services, which remain billable during the suspension of coverage.

Inpatient Billing for Incarcerated Medicaid Members

Effective 1/1/2026, Vermont Medicaid no longer requires the submission of Z9 forms for incarcerated inpatient hospital claims, and hospitals should not expect to receive Z9 forms from the Department of Corrections (DOC) or Wellpath.

Hospitals may bill Vermont Medicaid directly for inpatient services provided to DOC inmates when:

- The member has active Z9 coverage, or
- The member has other active Medicaid coverage that includes inpatient hospital services (even if the aid category is not Z9).

If a DOC inpatient is not enrolled in Medicaid at the time of hospitalization, the individual may be assisted in applying using the standard Medicaid application. If eligibility is approved, coverage for inpatient hospital services will be available consistent with Medicaid policy.

Release from Incarceration

Upon a member's release from incarceration, the benefit suspension is lifted and the Z9 aid category is removed. It may take 24-48 hours after release for the Z9 code to stop appearing in MMIS, but full benefits will be restored effective the day of release. Members with a Z9 code have full Medicaid coverage based on their underlying suspended aid category code (e.g. X3). This unsuspended coverage will be effective the date of their release. Providers should not delay or deny services solely based on the presence of the Z9 aid category code. Providers who need to verify coverage for an incarcerated Medicaid member who is approaching release may contact Provider Services to confirm the member's suspended aid category and coverage status. Providers are encouraged to re-verify eligibility on or before the appointment date to ensure accurate billing.

Section 2 Prior Authorization for 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 as per Medicaid Rule 7102.2.

A request for prior authorization of a covered health service will be approved if the health service:

- Is medically necessary (see rule HCAR 4.101).
- Is appropriate and effective to the medical needs of the Member.
- Is timely, considering the nature and present state of the Member's medical condition.
- Is the least expensive, appropriate health service available.
- Is FDA approved, if it is FDA regulated.
- Is subject to a manufacturer's rebate agreement, if a drug.
- Is not a preliminary procedure or treatment leading to a service that is not covered.
- Is not the repair of a VT Medicaid non-covered item or service.
- Is not experimental or investigational.
- Is furnished by a provider with appropriate credentials.

Prior Authorization involves a request for clinical review of each health service that is designated as requiring prior approval before the service is rendered. Please review the fee schedule for services that require a PA. Authorization will not be granted after the service is rendered.

The DVHA PA 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 Budget, Reports, Rules and Regulatory Information.

DVHA criteria can be found at Clinical Criteria.

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.

The start date of a PA commences with the receipt of all the administrative information required to process the PA request (an “actionable request”). To prevent a delay in the start date, the request **must** have all the information on the latest version of the appropriate form completed, including the PA request form signed by the Vermont Medicaid enrolled Provider. Forms can be found at Clinical Forms and Prior Authorization Forms.

Prior Authorization Requests must contain the exact codes and modifiers as will be billed on the claim.

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.

- **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.

2.1 Clinical Coverage Criteria

The Department of Vermont Health Access has adopted various Clinical Coverage Criteria 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 Clinical Criteria. The DVHA additionally utilizes InterQual®.

To access this tool, log into your vtmedicaid.com account. Once logged in, go to '**Secure Options**' and click on '**InterQual® solution**' from the drop-down menu.

2.2 Coverage Review

The Department of Vermont Health Access (DVHA) conducts code reviews on a quarterly or annual basis depending on the type of services that are being requested for consideration. This means that a newly released procedure code may not be available until the next quarterly or annual code review as applicable to the type of specific procedure code. Coverage reviews for non-covered procedure codes are initiated when a Non-Covered Code Request Form is received by Gainwell Provider Relations Representatives from a Vermont Medicaid-enrolled provider who is eligible to order the service for which the code review is being requested.

DVHA does not review requests for coverage by a manufacturer, a manufacturer's representative, a Durable Medical Equipment vendor, or other third parties (e.g., Associations). Refer to the Fee Schedule for information about the code coverage and to learn if the specific code in question requires a prior authorization. Code coverage determinations by the Department of Vermont Health Access are final and no further review will be completed.

2.3 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.

If it is determined during a surgical procedure that an unlisted procedure is appropriate and medically necessary, 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.

The prior authorization must be requested as early as possible and no less than 3 business days prior to the planned service, this timeframe includes DVHA's receipt of any additional information requested by DVHA to complete the review.

Prescription Drugs are reviewed by the Pharmacy Benefit Manager, Change Healthcare:

Change Healthcare Billing Information

Change Healthcare Prescriber Help Desk - 844.679.5363, 7:30am - 6:30pm, M-F 844.679.5366 After hours - on call 24/7 365 day/year

Change Healthcare Pharmacy Help Desk - 844.679.5362, 24/7 365 day/year

All drugs and supplies requiring prior authorization can be identified on the Preferred Drug List (PDL) which can be found at Preferred Drug List (PDL) & Clinical Criteria.

Some 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 Provider Resources.

2.4 Required Documentation

If the code/service requires prior authorization (see Fee Schedule), the appropriate DVHA prior authorization form (when applicable), medical record documentation to support medical necessity for the service, and a copy of the provider's order for the service/DMEPOS (when applicable) will be required to complete review. The DME supplier will submit this information to the DVHA for the PA request. Both the ordering provider and the DME vendor are required to keep legible copies of all information in the member's record per medical documentation rules.

The provider's order must be within 12 months of the dispensing date (billed DOS) for all items.

DVHA prior authorization forms are available at Clinical Forms and Prior Authorization Forms. Providers are expected to utilize the most current version of all forms.

2.5 Ensuring Efficiencies and Accuracy when Submitting Prior Authorization Requests

The Department of Vermont Health Access (DVHA) is providing the following guidance to all Vermont Medicaid providers to clarify the process and ensure efficient and timely submission of prior authorization requests for Vermont Medicaid members. Prior authorization requests DVHA receives that are incomplete, inaccurate, and/or lack the required clinical documentation to support a review of a prior authorization may be given an extension, per Medicaid Rule 4.103, if more information is needed and the extension is in the best interest of the member. Extensions for prior authorization requests should be the rare exception, not the rule. Submission of incomplete information and the lack of response to DVHA's request for additional information in the required timeframes may result in an administrative denial. Extensions allow the requesting provider an opportunity to submit the requested additional information and may result in an increased elapsed time for completion of a prior authorization request A standard prior authorization request must be decided within 7 calendar days of receipt of the request, but that time frame may be extended up to another 14 calendar days if the member or provider request the extension, or if the extension is needed to obtain additional information and an extension is in the member's interest. These requests will remain in "extension status" until:

- All the requested information is received by DVHA to complete the required clinical review and resulting medical necessity determination; or
- Provider does not comply within the 14-day allowance to submit the requested additional information, resulting in an administrative denial on day 14.

An administrative denial does not infer that a review for medical necessity has been completed, and the services(s) were deemed not medically necessary. An administrative denial is a determination made by DVHA when information required to conduct a medical necessity review is absent. Failure to supply necessary information leads to members' delay in receiving the requested service. The information that is most often missing or incorrect includes:

- Incorrect coding
- Lack of current, pertinent, and required clinical documentation. Clinical Criteria

- Failure to use current DVHA forms or to fully complete. Clinical Forms and Prior Authorization Forms

2.6 Immediate Need Exception

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.

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 Operations Unit by the next business day. The provider must 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

Emergency Medical Condition means an illness or medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the Member's physical or mental health, serious impairment of bodily functions, or serious dysfunction of any bodily organ or part. HCAR rule 4.102.

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. In the event that a member receives post emergency stabilization services from a provider outside of DVHA's network, DVHA will limit charges to the member to an amount no greater than what DVHA would charge if he or she had obtained the services through an in-network provider.

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.

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 Medicaid rule and HCAR.

2.7 Determination Time

Determination timeframes now correspond to 42 CFR §438.210. DVHA must issue a determination within 7 calendar days of receipt of the request, but that time frame may be extended up to additional 14 calendar days, with final determination by 21 days if the member or provider requests the extension, or if the extension is needed to obtain additional information and an extension is in the member's interest. Also, when a provider indicates, or DVHA determines, that following this timeframe could seriously jeopardize the member'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 member's health condition requires and no later than 72 hours after receipt of the request. This may be extended up to 14 calendar days if the member so requests, or if the extension is needed to obtain additional information and an extension is in the member's interest. Under federal law, the department is obligated to provide a response within 24 hours of a request for PA of a drug. Per 42 CFR, for both standard and expedited authorizations, when DVHA or one of it's IGA partners does not reach a decision and provide notice within the required time frames, this constitutes a denial and is thus an adverse action. DVHA/it's Intergovernmental Agreement (IGA) partner must mail a notice of adverse action to the enrollee on the date the time frame expires.

2.8 Peer-to-Peer Requests

The Department of Vermont Health Access (DVHA) will conduct a review of a denied prior authorization (prior to submission of claims) at the request of a provider. When a PA is denied, the provider can request a Peer-to-Peer or file for an appeal. A Peer-to-Peer which occurs after a denial notice is issued is an opportunity to discuss the denial. It cannot act as an appeal to overturn the denial. If in the course of the discussion, it is determined that the prior authorization could have been approved with additional new clinical information or clarification of submitted information, the provider can either appeal the denial or resubmit a new PA request.

A Peer-to-Peer meeting cannot be guaranteed before a scheduled elective service which was denied. A Peer-to-Peer request should be filed by the provider within five days of the denial. DVHA should hold a meeting with the filing provider within twenty calendar days (20) of the denial date. This is to allow the provider or member to file an appeal, which must be done within sixty (60) days of the denial.

The DVHA makes every effort to accommodate the timeliness of these requests, but scheduling is dependent on the availability of physician reviewers. This form is to be completed by the requesting physician and faxed or emailed to the DVHA. Further communications will follow via fax or email for ease of scheduling.

Please contact your Gainwell provider representative for a copy of the form that needs to be completed with your request.

2.9 Medical Necessity

Vermont Medicaid only pays for items that are medically necessary. Per HCAR 4.101, 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.

- Prevent deterioration or palliate the member's condition.
- 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.

Medical Necessity Form (MNF)

Effective March 1, 2025, DVHA will no longer require use of the medical necessity form with prior authorization requests.

2.10 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 medically necessary and align with generally accepted practice standards (HCAR 4.101.1). The reviews are generally an examination of clinical records, known as a desk audit, although they may also include an on-site visit from the DVHA staff.

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
- Symplr New Technology Assessments
- Other Nationally Recognized Evidence Based Criteria

Change Healthcare InterQual® Guidelines are available to providers on the Vermont Medicaid secure provider web portal. Once logged in, go to 'Secure Options' and click on 'InterQual® solution' from the drop-down menu. Guidelines are updated annually.

DVHA Clinical Guidelines are available at the DVHA website at Clinical Criteria. Vermont Medicaid State Rules are available at Budget, Reports, Rules and Regulatory Information.

2.11 Prior Authorization Notice of Decision

The Notice of Decision (NOD) is a system-generated form that is sent to the requesting and supplying provider, and the Member, in response to a Prior Authorization (PA) request.

The NOD contains the following information:

- Member Information: "The Department of Vermont Health Access has taken the following action on your request for medical services: 'Approved', 'Denied', or 'Information' (awaiting further information). Your request for service is: 'Approved', 'Denied', or 'Information'. The dates of service are as follows: Start *to be filled in as appropriate*; Stop *to be filled in as appropriate."*
- 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 revenue code, procedure code, NDC, or diagnosis

- Box 5: The number of units and/or occurrences
- A comments section with information specific to the authorization

2.12 Services Requiring Prior Authorization

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). This requirement only applies when Vermont 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.

Please note: Continue to use the File Transfer Protocol (FTP) for submitting information as required by other DVHA programs.

Out of-Network Elective Inpatient Hospital Admissions (Excluding Designated Border Hospitals)

All elective inpatient admissions to out-of-network (see VT Medicaid network information) 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 authorization-forms, clinical documentation, and an explanation as to why this care cannot be performed within the State of Vermont or at an in-network facility to fax number 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, Clinical Forms and Prior Authorization Forms. Clinical documentation, and an explanation as to why this care cannot be performed within the State of Vermont or at an in-network facility to fax number 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.

Out-of-Network Elective Outpatient Referrals

Prior authorization is required for referrals to out-of-network (OON) medical visits that are elective/non-emergency, 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 VT Medicaid network information.

Referring providers must submit requests using the OON Medical Office Request Form located at Clinical Forms and Prior Authorization Forms.

Fax all requests to the DVHA COU: 802.879.5963.

Note: For OON medical office visit PA requests, if the request is approved, 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. Please refer to the VT Medicaid fee schedules to determine if a service requires prior authorization.

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

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 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 855.275.1212. Forms are available at: Clinical Forms and Prior Authorization Forms.

Facility to Facility Transfer

During a medical or psychiatric inpatient stay, the treating provider may determine that the member requires a higher level or alternate level of care, including the transfer back to the in-network facility. As an example, a member may be in an inpatient medical or psychiatric facility, and it is determined there is a need for an inpatient procedure or treatment that is not available at the current facility. In these situations, there may be a need for a facility-to-facility transfer. Below are the required steps for a facility-to-facility transfer:

- The treating facility determines that a higher or alternate level of care is required and medically necessary.
- The treating facility makes a referral to an appropriate admitting facility.
- The admitting facility reviews the referral and supporting clinical documentation and determines medical necessity and accepts the referral for admission.
- A Prior Authorization (PA) is **not** required prior to admission to the admitting facility. Admitting facilities are expected to utilize clinical level of care criteria in determining whether a referred member's clinical presentation meets medical necessity for inpatient admission.
- Only psychiatric out-of-network inpatient emergent and urgent admissions will require notification to the DVHA within 24 hours or the next business day of admission. The admitting facility will fax to the DVHA either the medical or the psychiatric form to the number listed on the specific form.
    - Psychiatric: Vermont Medicaid Admission Notification Form for Inpatient & Detoxification Services form
        - Please note, for psychiatric admissions notification to the DVHA begins the concurrent review process (Please refer to the Vermont Medicaid Mental Health Services Supplement section 1.4 Concurrent Review for more information).

If there are questions regarding ambulance transportation, please refer to the following page for more information: Ambulance Services.

Out-of-Network Urgent/Emergent Inpatient Hospital Admissions: Psychiatric Admissions

Adults whose primary insurance is Vermont Medicaid admitted to a facility for psychiatric inpatient services will be assessed prior to admission by the admitting facility (provider) to determine medical necessity for inpatient level of care. All emergent and urgent admissions will require notification to the DVHA within 24 business hours of the admission. The admitting facility will fax to the DVHA the Vermont Medicaid Admission Notification Form for Inpatient & Detoxification Services form. All elective (planned) admissions require prior authorization. The provider will fax the Vermont Medicaid Admission Notification Form for Inpatient & Detoxification Services form with the supporting clinical information.

2.13 Rehabilitative and Habilitative Therapy

Please review the Physical Therapy (PT)/Occupational Therapy (OT)/Speech Language Pathology (SLP) Supplement for detailed information regarding Re/hab therapy services.

PT/OT/SLP Coding Diagnosis Codes: 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. Diagnosis codes on the claims and on prior authorization requests must match.

Diagnosis codes that are Non-Reimbursable as Primary Diagnoses for PT/OT/SLP Services

Codes that are considered not reimbursable when used as a primary diagnosis are those which:

- Are no longer valid codes in the American Medical Association (AMA) list of diagnostic codes.
- Are not clearly medical in nature.
- Are not specific and therefore prevent meaningful clinical review.
- Are for a sign or symptom of an underlying medical diagnosis.
- Are for a symptom of a medical diagnosis, where treatment of the symptom alone may be harmful to the member.
- Demonstrate that PT, OT or SLP services are not the most appropriate service for the condition.

Revenue and Procedure Codes for PT/OT/SLP services for Hospital Outpatient Services, Outpatient Clinics, and Home Health Agencies

Procedure Codes: 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.

Home health agencies bill using the revenue codes:

- 420-4 for PT
- 430-4 for OT
- 440-4 for SLP

1 unit = 1 visit for home health agency billing.

Outpatient clinics including hospital outpatient clinics bill using procedure codes. Providers should consult the DVHA Fee Schedule, to confirm code coverage and prior authorization requirements. Providers should also reach out to their Gainwell Provider Services representative for additional questions about claims and billing.

Specific procedure code information:

- 97755: covered only for technology which is currently covered by Vermont Medicaid.
- 97750: covered except for work or disability related functional capacity evaluations.
- 97124: 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).

- 97550, 97551, 97552: covered for the **rare** occasion when it is necessary to train caregivers without the member present. The standard for caregiver training is to do so with the member present. The therapist must clearly document the reason for the deviation in the standard of care.

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 re-evaluation and must not be billed using a re-evaluation code.

Medical equipment and supply codes: Therapists may submit claims for certain durable medical equipment and supplies. For information about specific codes, contact Gainwell Provider Services regarding the allowed provider types for the specific code.

Outpatient Therapy Modifiers: Vermont Medicaid follows Medicare's requirement that SLPs, OTs, and PTs 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 an annually updated list of therapy procedure codes for which these modifiers are required. Vermont Medicaid therapists need only reference the code list itself; do not use the column information.

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.

Billing Information

Other Insurance: Refer to Section 1 of **this manual for** information about Other Insurance including copays and deductibles. Note that when the entire allowed amount is applied to the primary insurance deductible, VT Medicaid rules regarding prior authorization apply.

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 was applied to the deductible, prior authorization is required for adults who have had a combined 60

outpatient physical, occupational, and speech language pathology visits.. If the primary insurance denies for lack of medical necessity, all levels of appeal are required before requesting prior authorization from Vermont Medicaid.

To ensure fairness for all members, the 60-visit limit before prior authorization is required applies whether or not the member also has a primary insurance.

For example, a member has a primary insurance that covers 21 visits.

Vermont Medicaid will cover up to the additional combined OT, PT, and ST 39 outpatient visits before prior authorization is required for adults, provided they are medically necessary.

All providers must determine whether the member has other insurance/Medicare benefits before rendering the service to minimize the risk of non-coverage by both the other insurance/Medicare and the DVHA. It is recommended that insurance status be reviewed before or during each visit.

Children' integrated Services-Early Intervention (CIS-EI): If a child has a condition that qualifies for Vermont Medicaid coverage of therapy services and has no other insurance, Vermont Medicaid is the pay source. If the child does not have a condition that qualifies for Vermont Medicaid coverage, then the bill will go directly to CIS EI for coverage, with no need for a Vermont Medicaid denial.

Billing and Visit Length: Certain therapy procedure codes have 15- or 30-minute time increments. For providers who bill with procedure codes, note that the number of units of timed codes used must not exceed the amount of time spent in actual treatment during the visit. A maximum of 4 units of the 15-minute timed codes are allowed per treatment session. It is considered unlikely that there is a medical necessity for outpatient treatment sessions longer than one hour in duration. Vermont Medicaid will only cover one hour of outpatient therapy services, per discipline, per day.

Evaluation, re-evaluation, and other non-timed codes may be billed in addition to the timed codes during a single session. The code for wheelchair management including assessment is the exception to the 4-unit maximum.

All timed codes refer to the face-to-face time with the patient. A unit of time is attained when the mid-point is passed. For example: for a 15-minute code, an additional 8 minutes of the procedure must be performed before 2 units of the code can be billed.

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

Example

A member is seen for an hour-long session of physical therapy services. The member receives an evaluation followed by 15 minutes of gait training, 15 minutes of therapeutic exercise, and 15 minutes of therapeutic activities. 3 timed units may be billed AND the evaluation may be billed. Note, however, that therapists who routinely bill for more than an hour of services by using untimed codes in addition to timed codes may be subject to review.

Example

A member is seen for a session of physical therapy services. Although the member receives 45 minutes of therapeutic exercise and 30 minutes of therapeutic activities, only 4 timed units may be billed. Vermont Medicaid will only cover one hour of therapeutic services.

Section 3 Reimbursement, Billing Procedures & Claim Processing

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 member.

DVHA does not incentivize or provide rewards to employees, providers, or contractors for denial of services or prior authorizations.

3.1 Denied Claims

The explanation of benefits (EOB) codes printed on the Remittance Advice (RA), explains the reason(s) why Vermont Medicaid claims are paid or denied. Full descriptions for each code are printed at the end of the RA.

EOB codes for denials, which pertain to the entire claim, are printed directly under the patient's name and the Internal Control Number (ICN) on the RA. Detail denials are printed under each billing detail on the RA. The RA contains up to ten header denials per claim and ten detail denials per billing line. Please review all areas of the claim before resubmitting directly to claims processing. If the reason for your denial is unclear, please contact the Provider Services Unit at 800.925.1706.

3.2 Adjustments Requests

Adjustment requests may be submitted to Gainwell when a claim is paid incorrectly. These requests can be initiated by the provider, Gainwell or the DVHA. If the error originates with the provider, then the provider must submit the adjustment. When requesting an adjustment, submit an adjustment form. Give a brief description of the reason for the adjustment and the action required.

A new claim form with the correct information is required when changing the pay to, provider number, member number or funding source. Any request, which does not have the proper attachments, will be returned. If timely filing also applies, then attach a copy of the RA.

Denied claims cannot be submitted as adjustment requests. A claim that has been denied should be corrected and resubmitted with all attachments as a new claim.

Adjustments are the preferred method of correction because they eliminate the use of providers' personal checks for repayment of incorrectly processed claims. Adjustments also provide an accurate record of how the claim was processed.

Once a claim has been processed and placed in a PAID status, providers have one year from the original paid date to adjust claims that would result in a positive financial outcome for the provider.

Providers can request adjustments and recoupments to claims billed incorrectly that result in a negative financial outcome for the provider within three years of the original date of service; the entire claim will be recouped. Partial recoupment requests are to be submitted as refunds. If the claim is more than three years old, the provider must refund the overpayment by completing the refund form and attaching the refund check. The Vermont Medicaid Refund form is available on our website at Forms.

Late Charges (Applies to UB-04 Hospital charges)

Late charges to the original paid claims must be submitted as adjustments. These adjustments must be submitted either using the Gainwell paper adjustment form or electronically through the Gainwell Provider Electronic Solutions (PES) Application. Paper claims with type of bill 117 (adjustment inpatient) or 137 (adjustment outpatient) will not be accepted.

For instructions on completing adjustments using Gainwell's PES software, visit PES software.

Forms for completing single and multiple adjustments can be downloaded from the Forms page.

3.3 Timely Filing

Vermont Medicaid claims must be filed in a timely manner. A claim is 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.

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 **retroactive enrollment** (backdate) claims must be received within 365 days from the date of service. Retroactive enrollment is determined by claims received within the retroactive period. The retroactive period is defined as the enrollment start date through the date that the retroactive update was implemented in the Gainwell database.
- When a recipient has been granted **retroactive eligibility** claims must be received within 365 days from the date of service. Retroactive eligibility is determined by claims received within the retroactive period. The retroactive period is defined as the eligibility start date through the date that the retroactive update was implemented in the Gainwell database.

3.4 Adjusted or Recouped Claims

Providers must comply with time limits for adjusted claims as indicated in Section 3.2 Adjustment Requests. Previously adjusted or recouped claims must be received within 180 days from the adjustment/recouped date.

- If you submitted an adjustment/recoupment request with a new claim attached for reprocessing that denied for something other than timely filing, you should submit a paper claim if it is within 180 days from the adjustment date with a copy of your adjusted RA. A note must be present in Field 19 on the CMS 1500, Field 35 on the ADA, or Field 80 of the UB-04 stating “adjusted claim”.
- If you submitted an adjustment/recoupment request without a new claim attached for reprocessing, a paper claim will be required once the claim is resubmitted. The claim must be received within 180 days from the adjustment date with a copy of your adjusted RA. A note must be present in Field 19 on the CMS 1500, Field 35 on the ADA, or Field 80 of the UB-04 stating “adjusted claim”.

3.5 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 present in Field 19 on the CMS 1500, Field 35 on the ADA, or Field 80 of the
  UB-04 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.

3.6 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.

For additional information please see the Timely Filing Frequently Asked Questions document located on our website at Provider Resources.

3.7 Timely Filing Reconsideration Requests

If the Department denies a claim for being untimely, providers may 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 circumstances resulting in failure to meet timely filing requirements and appropriate documentation. The Department shall grant requests for reconsideration only when the provider submits documents that show that appropriate action to meet filing requirements was taken and that the provider was prevented from filing as the result of exceptional circumstances that the provider could not foresee or control. If a provider fails to submit these documents with a timely filing reconsideration request, the Department will deny the reconsideration request. Providers shall not have a second opportunity to submit these documents.

It is the provider's responsibility to adequately staff and train employees to ensure that they properly file claims. Accordingly, employee negligence, employer failure to provide sufficient well-trained employees, or employer failure to properly monitor the activities of employees and agents (e.g., a provider's billing service) 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 alone are not proof of timely filing. Providers must submit claims before the timely filing deadline if they can possibly do so, even if they believe that the Department will ultimately deny the claim.

It is the provider's responsibility to ensure that their systems for gathering claims data and submitting claims are functional. Accordingly, providers must address any technical issues that result in failure to transmit accurate and acceptable claims or failure to identify transmission errors in a timely manner. Technical issues between the provider and a software vendor, billing agent, or clearinghouse do not constitute an acceptable reason to file a claim outside the timely filing period. Clearinghouse reports are not sufficient 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 evidence of timely follow-up includes billing account notes, call reference numbers, other insurance correspondence, or emails with the Department or the Department's fiscal agent. A provider's summary of the relevant events is not sufficient.

The Department will consider requests for review of timely filing denials on a case-by-case basis. If the Department accepts that the provider took appropriate action to meet filing requirements and was prevented from timely filing a claim by exceptional circumstances the provider could not foresee or control, the Department will process the claim on a future Remittance Advice. Please be aware that an approval for the timely filing reconsideration request does not remove the provider's responsibility to comply with correct coding, prior authorization, supporting documentation, and all other claims processing requirements. If a claim is denied for any reason other than timely filing, the provider is responsible for resubmitting the corrected claim within the allotted time specified in the timely filing approval letter. Failure to complete forms correctly or attach the approval letter to the resubmitted claim **will** cause the claim to be denied.

Providers submitting a timely filing reconsideration request must use the **Timely Filing Reconsideration Form** located at Forms. Completion instructions are included with the form. For

additional information please see the Timely Filing Frequently Asked Questions document located on our website at Provider Resources.

For all other reconsideration requests not related to timely filing requirements, please refer to Section 1.2.11, Provider Reconsideration Requests, in the Vermont Medicaid General Provider Manual.

All Timely Filing Reconsideration Requests for review must be submitted electronically to VT-reconsiderations@gainwelltechnologies.com.

3.8 Usual & Customary Rate (UCR)

Various claim forms (CMS-1500, UB-04 and 837) require the submission of "Charge" or "Total Charges" or "Charge Amount" to be reported for each service billed. The provider's "usual and customary charge" or "uniform charge" is a dollar amount in effect at the time of the specific date of service. This is the amount to be reported on the claim. This usual and customary charge is the amount that the provider bills to insured and self-pay persons for the same service. If the provider has more than one charge for a service, the lowest charge will be reported to Vermont Medicaid, except, if the charge has been reduced on an individual basis.

3.9 Incident-To Billing for Licensed Physicians

Incident-to billing is a way of billing for 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. NPPs that are eligible to enroll in Vermont Medicaid must enroll and bill using their own provider number and cannot bill incident-to.

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. Services billed in this manner may be subject to post payment review.

The billing/clinically supervising provider must:

- Be actively enrolled with Vermont Medicaid.
- 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 aid and direction throughout the time the service is performed.

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 present in the office suite and immediately available within 15 minutes.

3.10 Locum Tenens

A Locum Tenens is a physician to “step in” for another provider that is on leave or has permanently left a practice. The Locum Tenens physician must be licensed in Vermont and be actively enrolled in Vermont Medicaid. If a Locum Tenens physician is covering for a physician on leave, they are then allowed to use that physician’s NPI number for up to 60 days. Modifier Q6 (Service rendered by a Locum Tenens physician) should be used to show that the service was provided by a Locum Tenens physician. The Billing provider is 100% liable for all locum tenens billing.

3.11 Time-based Procedure Codes – Billing Guidelines

Critical Care Procedure Codes that are Time-based

- 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.
- 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. 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.
- 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.
- A unit of time is attained when the mid-point is passed. For example: for a 15-minute code, an additional 8 minutes of the procedure must be performed before 2 units of the code can be billed.

3.12 Electronic Claim Submission

The State of Vermont and Gainwell encourage Electronic Claim Submission (ESC). ECS allows for efficient, reliable, and economic transfer of claims between the provider's facility and Gainwell. The same standards and conditions applicable to paper claims, regarding accuracy and completeness also apply to claims submitted electronically.

ECS is fast, easy to use, and eliminates time-extensive paperwork. ECS prevents most errors, allowing providers to submit "clean" claims the first time. Turn-around time for electronic claims is considerably faster than for paper claims. If using a Clearinghouse, please reach out to the Clearinghouse directly for the appropriate set up forms. If intending to use Gainwell's Provider Electronic Solutions Software (PES) follow this link for the Trading Partner Agreement and EDI Registration forms. For more information on available methods of electronic billing, please contact the EDI Coordinator at 800.925.1706, option 3 or send an email to VT EDI Coordinator.

3.13 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.

EFT allows payment for "clean" claims within five business days. Funds are electronically deposited into a specified bank account, avoiding stop payments and reissues due to damaged or misplaced checks. EFT has no effect on billing procedures but does apply to all claim types submitted. Providers are not required to submit claims electronically to receive direct deposits.

At time of enrollment enter banking information into the EFT tab of the application. During this step of the process, you will fill out all section with a blue asterisk, Bank name, routing number, & account number. The one exception being the physical address of the bank, is not required.

Updates of EFT information can be managed on the Provider Management Module within the portal. This will be found under the EFT tab within each service location; system will request attachment for verification.

One of the following documents must be attached to both new EFT enrollment and change enrollment requests for verification of account owner and account number:

- Voided check. (Stater checks cannot be accepted, pre-printed name & address required.)

- Signed letter from your bank that lists the account holder's name, and the appropriate financial institution's account and routing numbers.

Questions regarding updating EFT information can be directed to VT Provider Enrollment.

3.14 Claim Disposition Information Introduction

This section will assist providers in reviewing the status of each of their claims on the Remittance Advice (RA). It will also explain steps providers must follow to make adjustments or refunds on paid claims. A strong knowledge of these available resources and procedures will assist providers in maintaining accurate payment records.

3.15 Remittance Advice (RA)

The Remittance Advice (RA) is a computer-generated report provided by the fiscal agent. It indicates the status of all claims that have been submitted for processing. The RA is posted on the Medicaid Provider Portal on a weekly basis, with your four most current RAs available. The banner page of the RA provides important information about policy and billing. See Section 7, Sample Remittance Advice.

The Explanation of Benefits (EOB) codes printed on the RA explain the reason(s) why Vermont Medicaid claims are paid or denied. Full descriptions for each code are printed at the end of the RA.

EOB codes for denials that pertain to the entire claim are printed directly under the patient's name and the ICN on the RA. Detail denials are printed under each billing detail on the RA. Please review all areas of the claim before resubmitting directly to claims processing. If the reason for your denial is unclear, please contact the Gainwell Provider Services Unit.

Providers that bill electronically will only receive electronic RAs. Please contact the EDI Department at Gainwell if you are interested in submitting and receiving this information electronically.

RA Sections

The RA is divided into the following sections:

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

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

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

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

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

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

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

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

RA Headings & Descriptions

Recipient Name - Member name is listed in alphabetical order. The name appears in last name, first name format.

MID - The member’s Vermont Medicaid Identification Number also known as the UID.

ICN - Each claim and any attachments received by Gainwell are assigned a unique identifying number called the Internal Control Number (ICN). This number is displayed in the third column on the RA. The fifteen-digit number aids in identifying, locating or researching the claim, either during or after processing. The following summary describes what each number represents:

Digit	Description
1-2	Valid region code values for paper claims are: • 10 - Paper Claim without attachments • 11 - Paper claim with attachments Valid region code values for ECS claims are: 40 - ECS The valid region code values for financial items are listed in the description of the financial items section.
3-6	The year the claim was received at Gainwell.
7-9	Three digits indicating the Julian Date on which Gainwell received the claim. These numbers correspond with the calendar dates; see the Appendix document. For example, 001 corresponds with January 1 and 365 correspond with December 31.
10-15	The last six digits following the date are designed for Gainwell control purposes. These numbers uniquely identify the claim and allow personnel to access the claim both manually and through the computer.

HVER - The version number of the claim. The original claim paid for the services rendered is version 00. The first adjustment to any payment is version 01, etc.

PT ACCT/RX# - The patient account or medical record number is reported as it appeared on the claim.

BILLED AMT - The amount charged for the service.

ALLOWED AMT -The Vermont Medicaid allowed reimbursement.

OI AMT - The amount paid by another insurance for this claim or detail.

LIAB AMT - The amount for which the patient is responsible, excluding co-pay.

COPAY AMT - The co-payment amount related to the claim.

PAID AMT - The amount included in the payment for this claim.

HEADER MESSAGES - These numbers relate to the EOB codes printed under the header information. These numbers, which are referred to as EOB codes, indicate the reasons for payment or denial for the claim on the header level (top portion of the claim).

DNUM - The detail number.

DVER - The version of the detail. The original detail paid is version 00. The first adjustment to any payment is version 01, etc.

FDOS - The beginning date of service as it appears on the claim.

TDOS - The ending date of service as it appears on the claim.

PROC+MODS - The procedure code and corresponding modifiers as they appear on the claim.

QTY BLD - The number of units of service as it appears on the claim.

DETAIL MESSAGES - The numbers relate to the EOB codes printed under the detail information. These numbers indicate the reasons for payment or denial on the detail level of the claim.

ADJUSTED CLAIMS - This section of the RA includes detailed information on both the original and the adjusted claim. The original claim data is displayed first, followed by the adjusted claim data and an explanation of the effect the adjustment had on the original claim.

RECIPIENT NAME - Member name on the adjusted claim is listed in alphabetical order. The name appears in last name, first name format.

MID - The member's Vermont Medicaid identification number on the adjusted claim.

ICN - The internal control number of the adjusted claim.

HVER - The version number of the adjusted claim. The original claim paid for the services rendered is version 00. The first adjustment to any payment is version 01 etc.

PT ACCT/RX # -The patient account or medical record number is reported as it appeared on the adjusted claim.

BILLED AMT - The amount charged for the service on the adjusted claim.

ALLOWED AMT - The Vermont Medicaid allowed reimbursement on the adjusted claim.

OI AMT - The amount paid by another insurance for this claim or detail on the adjusted claim.

LIAB AMT - The amount for which the patient is responsible, excluding co-pay on the adjusted claim.

COPAY AMT - The co-payment amount related to the adjusted claim.

PAID AMT - The amount included in the payment for this adjusted claim.

HEADER MESSAGES - These numbers relate to the message codes printed under the header information. These numbers, which are referred to as EOBs, indicate the reasons for payment or denial for the claim on the header level (top portion of the claim).

DNUM - The detail number on the adjusted claim.

DVER - The version of the detail on the adjusted claim. The original detail paid is version 00. The first adjustment to any payment is version 01, etc.

FDOS - The beginning date-of-service as it appears on the adjusted claim.

TDOS - The ending date-of-service as it appears on the adjusted claim.

PROC+MODS - The procedure code and corresponding modifiers as they appear on the adjusted claim.

QTY BLD - The number of units of service as it appears on the adjusted claim.

DETAIL MESSAGES - These numbers relate to the message codes printed under the detail information. These numbers indicate the reasons for payment or denial on the detail level of the adjusted claim.

ADJUSTMENT REASON - A text field that explains why the adjustment took place.

NET ADJUSTMENT AMOUNT - This field indicates the net effect the adjustment had on the claim. The value is equal to the difference between the Original Claim Paid Amount and the Adjusted Paid Amount.

Financial Items

The “Financial Items” section of the RA is printed only when a financial activity other than claims adjudication takes place. Please refer to the sample “Financial Items” section of the RA in Section 7, Sample Remittance Advice. The following summary describes the information in the “Financial Items” section:

CCN - The Cash Control Number of the financial transaction. The first two digits of the number indicate the type of financial transaction (i.e., system payout, recoupment, refund).

A/L NUMBER - The number assigned to the provider's ledger to account for the transaction.

MID - The member's ID number is shown if the financial transaction is related to a specific claim. When the transaction does not relate to a specific claim, this space is blank.

ICN - The Internal Control Number of the claim is shown if the financial transaction is related to a specific claim. When the transaction does not relate to a specific claim, this space is blank.

HVER - The version number of the related claim, if applicable.

DNUM - The detail number on the related claim, if applicable.

DVER - The detail version number of the claim, if applicable.

TXN DATE - This field indicates the date the transaction was entered and logged in the provider's account ledger.

ORIG AMT - The original amount to be exhausted by financial transactions.

TXN AMT - The dollar amount corresponding to the transaction. This is the actual amount of money included or withheld from the payment and applied to the original amount.

BAL AMT - The remaining balance to be exhausted by future financial cash transactions (amount still owed against the receivable or payable). This value is equal to the Original Amount less the Transaction Amount.

RSN CD - This field describes why the transaction was performed.

FINANCIAL ITEMS REASON CODE – The financial reason codes and their descriptions listed with any financial transactions on the RA.

TPL & MEDICARE INFORMATION - The TPL AND MEDICARE INFORMATION REPORT displays the members for whose claims denied for other insurance during the week. It is generated only when such transactions occur. The report lists only the insurance carrier that caused the claim to fail.

RECIPIENT NAME - The name of the member who had other insurance coverage for the denied claim.

ICN - The Internal Control Number assigned to each denied claim.

HVER - The header version number corresponds to the ICN and indicates the version of the claim. The original header has a version number of '00'. Subsequent version numbers (01, 02, etc.) are the result of adjustments made to the header.

DVER - The detail version number corresponds to the detail and indicates the version of the detail. The original detail has a version number of '00'. Subsequent version numbers (01, 02, etc.) are the result of adjustments made to the detail.

DNUM - The detail number corresponds to the ICN and indicates the detail of the claim.

OTHER INSURANCE - The name and address of the insurance carrier with whom the member has other insurance coverage.

CARRIER CODE - The carrier code of the insurance carrier listed above.

POLICY NAME - The name of the person who holds the insurance policy.

RELATIONSHIP DESCRIPTION - The relationship between the member and the policy holder.

POLICY - The policy number of the insurance policy that the member holds with the insurance carrier.

GROUP - The group number that the insurance policy falls under. This field is only populated if the member's insurance policy is a group policy.

MEDICARE - This field indicates the Medicare type. Possible values are 'PART A' and 'PART B'.

Earnings Data & Message Codes

EARNINGS DATA AND MESSAGES CODES - displays the financial data for the current RA and year-to-date as well as the message codes that were listed with any claims (EOB codes) on the RA.

NUMBER OF CLAIMS PROCESSED (CURRENT) - The total number of claims processed during the past week. This figure includes all paid, denied, suspended, and adjusted claims appearing on the RA.

NUMBER OF CLAIMS PROCESSED (YTD) - The total number of claims processed this calendar year. This figure includes all paid, denied, suspended, and adjusted claims appearing on the RA; it is equal to the sum of the “Number of Claims Processed” fields on each RA year-to-date.

DOLLAR AMOUNT PROCESSED (CURRENT) - The dollar amount paid for claims processed during the past week.

DOLLAR AMOUNT PROCESSED (YTD) - The dollar amount paid for claims processed this calendar year. This figure is equal to the sum of the “Dollar Amount Processed” fields on each RA year-to-date.

SYSTEM PAYOUT AMOUNT (CURRENT) - The dollar amount paid out as a result of system generated financial transactions during the past week.

SYSTEM PAYOUT AMOUNT (YTD) - The dollar amount paid out as a result of system generated financial transactions for this calendar year. This figure is equal to the sum of the “System Payout Amount” fields on each RA year-to-date.

MANUAL PAYMENT AMOUNT (CURRENT) - The dollar amount paid out through manual checks during the past week.

MANUAL PAYMENT AMOUNT (YTD) - The total dollar amount paid out through manual checks for this calendar year. This figure is equal to the sum of the “Manual Payout Amount” fields on each RA year-to-date.

RECOUP AMOUNT WITHHELD (CURRENT) - The dollar amount withheld as a result of recoupment financial transactions during the past week.

RECOUP AMOUNT WITHHELD (YTD) - The dollar amount withheld as a result of recoupment financial transactions for this calendar year. This figure is equal to the sum of the “Recoup Amount Withheld” fields on each RA year-to-date.

PAYMENT AMOUNT (CURRENT) - The total dollar amount paid for paid claims, system or manual payouts, minus recoup amounts.

PAYMENT AMOUNT (YTD) - The total dollar amount paid for claims submitted and financial transactions incurred for the calendar year. This figure is equal to the sum of the “Payment Amount” fields on each RA year-to-date.

CREDIT ITEMS (CURRENT) - The dollar amount relating to any credit items for the past week. Credit items are all Vermont Medicaid void transactions, State void transactions, and refund transactions.

CREDIT ITEMS (YTD) - The total dollar amount relating to any credit items for the calendar year. Credit items are all Vermont Medicaid void transactions, State void transactions, and refund transactions.

NET ADJUSTMENT AMOUNT (CURRENT) - The total net adjustment amount from adjusted claims processing during the past week. This figure is equal to the sum of the “Net Adjustment Amount” fields located in the “Adjustments” section of the RA for each adjusted claim.

NET ADJUSTMENT AMOUNT (YTD) - The total net adjustment from adjusted claims processing for the calendar year. This figure is equal to the sum of the “Net Adjustment” fields for each RA year-to-date.

NET 1099 ADJUSTMENT (CURRENT) - The net 1099 adjustment incurred from financial transactions during the past week. This figure is equal to the net sum of all positive and negative 1099 transactions during the past week.

NET 1099 ADJUSTMENT (YTD) - The total net 1099 adjustment incurred from financial transactions for the calendar year. This figure is equal to the net sum of the “NET 1099 Adjustment” fields on each RA year-to-date.

COVERED DAYS INCLUDING NURSERY (CURRENT) - This field only applies to hospital claims. It indicates the total number of covered days (including nursery care) billed during the past week.

COVERED DAYS INCLUDING NURSERY (YTD) - This field only applies to hospital claims. It indicates the total number of covered days (including nursery care) billed during the calendar year.

NET EARNINGS (CURRENT) - The net earnings for the past week. This figure is calculated as follows:

Claims Paid Amount

+ System Payout Amount

+ Manual Payout Amount

- Recoup Amount Withheld

- Credit Items

+/- Net 1099 Adjustment (may be positive or negative)

= Net Earnings

NET EARNINGS (YTD) - The total net earnings for the calendar year. This figure is equal to the sum of all the Net Earnings fields on each RA year-to-date.

ELECTRONIC FUNDS TRANSFER STATEMENT – The dollar amount deposited electronically. This statement includes the account number into which the money was deposited as well as the date the deposit was sent to the provider's bank.

MESSAGE CODES - The (EOB) codes displayed in other sections of the RA and a written explanation for each.

3.16 Refunds

In the event of a Vermont Medicaid overpayment, a refund check may be attached to a Vermont Medicaid "Refund Form" and sent to Gainwell. The Refund Form requires providers to state the reason for the refund and to designate the claim or account against which it should be applied. Refunds will be reflected on the Financial Items page of the RA. The refund amounts will be deducted automatically from the YEAR-TO-DATE total.

When other health insurance payments are received after Vermont Medicaid payment has been made, the provider should refund to Gainwell the lesser of the amount paid by the insurer or the Vermont Medicaid payment. Failure to do so may be criminally punishable as Medicaid fraud.

Check mailing address:

Gainwell Technologies
P.O. Box 1645, Williston, VT 05495

Section 4 Billing Procedures CMS-1500 & UB-04 Claim Types

4.1 Abortions

Abortions are subject to the requirements of administrative rule. Information contained in rule will not be repeated in the provider manuals. See Health Care Administrative Rule 4.223 Abortion.

Forms can be found by clicking on the applicable Abortion Certification link at Forms and Clinical Criteria. The two funding source forms are described below.

1. **Vermont Medicaid**
   Completion of form DVHA 219A is required for abortions performed if the pregnancy is a result of rape or incest, or when the mother's life is endangered by carrying the fetus to term. This consent form and the medical documentation of the situation must be sent to Gainwell with each claim.
2. **State Funds**
   Abortions considered medically necessary require the completion of Physician Certification form DVHA 219B and are paid by the Department for Children and Families (DCF) funding. The form must be completed, signed and attached to the claim when submitted for processing.

Spontaneous and missed abortions completed surgically are billable under Vermont Medicaid with use of the appropriate procedure and diagnosis codes. A certification form is not required.

Vermont Medicaid does reimburse for abortions performed by Certified Nurse Midwives.

Abortion Diagnosis Codes
Unspecified abortion diagnosis codes will not be accepted by Vermont Medicaid. When billing, use a more specific abortion diagnosis code. Providers should refer to a current ICD-10-CM manual for the correct code.

4.2 Aids/HIV

Vermonters living with HIV infection who meet certain income guidelines may be eligible for help with Vermont Medicaid co-payments for treatment drugs through the Vermont Medication Assistance Program (VMAP). Vermont residents not covered by Vermont Medicaid 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

4.3 Clinical Trials

Vermont Medicaid covers routine patient costs for services provided to VT Medicaid members who are participating in a qualified clinical trial. This benefit is mandatory but does not apply to drugs or procedures that are investigative. VT Medicaid has always provided coverage for Covered Services related to clinical trials.

The Department of Vermont Health Access is expanding coverage of non-emergency medical transportation for members who are participating in a clinical trial, including trials that are conducted out of state. This benefit is mandated in the Consolidated Appropriations Act of 2021 and 1905(a)(30) of the Social Security Act.

For services to be covered, a Clinical Trial Attestation form and Physician Referral Form need to be submitted. Additional information can be found at Clinical Trials.

4.4 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 Member 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 Vermont Medicaid benefit and should be billed under the recipient's Vermont Medicaid ID as both the patient and the insured and include the date of birth.

4.5 Organ Transplant Donor Complication

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 Vermont Medicaid Member'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 Vermont Medicaid Member (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 Vermont 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 Vermont 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

4.6 CPT Category III Procedure Codes

Category III codes are 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.

4.7 Factor HCPCS Codes

Factor HCPCS Codes are typically submitted through the pharmacy benefit (except in cases of emergency). Claims for services billed through the medical benefit require notes be included. All claims submitted for emergency room services are exempt from this requirement.

4.8 Fee Schedule

The Fee Schedule is 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.

4.9 Health Examination of Defined Subpopulation

DVHA will only accept diagnosis code 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 Z02.89 will be denied. Diagnosis code 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 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.

4.10 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, Hard-of-Hearing, and DeafBlind.

- 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)

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, who are Deaf, Hard-of-Hearing, and DeafBlind receive appropriate information about the proposed treatment to enable them to give informed consent to treatment.

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.

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 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 UB-04 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	01/01/2023	T1013		$120.00	6
Member 2	8:30 am to 9:55 am	01/01/2023	T1013	UP	$0.00	1
Member 3	8:30 am to 9:55 am	01/01/2023	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. However, the hiring entity is still responsible to pay for the interpreter's time.

Limited English Proficiency (LEP) Resources

- Voiance - Phone: 866.743.9010
- Language Line Services - Phone: 877.866.3885
- Vermont Refugee Resettlement Program - Phone: 802.655.1963
- Language Services Associates - (IN-PERSON) Phone: 800.305.9573

Deaf, Hard-of-Hearing, and DeafBlind Resources

- Vancro Integrated Interpreting Services - (Virtual/IN-PERSON) Phone: 802.271.0103
- Registry of Interpreters for the Deaf - Phone: 703.838.0030
- Vermont Department of Buildings and General Services (BGS) - Contract and Information - Phone: 802.828.3519
- Vermont Medical Society - Interpreter Issues and Resources
- Vermont 211 - For overnight/weekend emergency, call 211 to obtain contact information for an ASL interpreter.

4.11 Inpatient Newborn Services

Members may apply for a newborn ID for their child at the time of delivery using forms available at the facility or by application, at the Department for Children and Families (DCF) office. It is recommended providers wait for the child's ID number to be issued before billing Vermont Medicaid.

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, or claim will deny. This information (of payment) can be verified through the Provider Services help desk at 800.925.1706.

Example: Mother leaves hospital after three days and baby stays. The mother's ID can be used for the baby only those first three days; further claims for the baby must use the baby's ID.

Example: Both are hospitalized for more than seven days. Services for the baby on the eighth day and after must be billed using the baby's ID.

Since birthing room births are also billed as impatient, the place of service would always be 21.

The following information is required on the **CMS-1500 Claim Form**:

Field Locator - Information

- 1a - Mother’s Vermont Medicaid ID number
- 2 - Baby’s name
- Use the following name format to indicate twin and multiple-birth babies.
    - ABaby
    - BBaby
    - CBaby
- 3 - Baby’s date of birth
- 4 - Mother’s name
- 6 - Check “child”
- 19 - Write “billing for baby under Mother’s ID number”.

The following information is required on the **UB-04 Claim Form:**

Field Locator - Information

- 8b. - Baby's name
- Use the following name format to indicate twin and multiple-birth babies.
    - ABaby
    - BBaby
    - CBaby
- 10 - Baby's date of birth
- 58 - Mother's name
- 60 - Mother's ID number
- 80 - Write "Billing for baby under Mother’s ID number."
- Option 2: The provider can wait for the child’s permanent ID number to be issued.

4.12 Interrupted Psychiatric Stays and Rapid Re-Admission

Psychiatric inpatient admissions are considered “interrupted” when a patient is admitted to a psychiatric floor in a general hospital, transferred to a medical floor within the same facility and transferred back to the psychiatric floor. These stays are considered continuous for the purpose of applying the variable per diem adjustment and is considered one continuous stay for payment.

Rapid re-admissions are authorized and billed in different ways to account for the days a member may be on a medical floor during a stay, days spent out of the hospital, or if a member discharges and then re-admits on the same day. When a member re-admits to a psychiatric floor of a different hospital within 3 midnights, DVHA Utilization Review (UR) clinicians review documentation to determine if the second admission should start at day 1 (new episode) or should

continue as an extension of the first admission. This affects the rate of reimbursement for the second admission.

See the Vermont Medicaid Mental Health Inpatient and Detoxification Services Supplement, Section 8, Interrupted Psychiatric Stays and Rapid Re-admission for additional information.

4.13 Modifier 'LT' & 'RT'

Vermont Medicaid does not utilize the modifier combinations 'RTLT' or 'LTRT' (right and left; bilateral). When Correct Coding allows one of these combinations on the base procedure code and the item is supplied bilaterally, the Vermont Medicaid provider must bill two separate line items: one with modifier RT on the base code and another line with modifier LT on the base code. The RT and LT modifier must appear first when used in combination with another modifier.

4.14 Modifier KX

Vermont Medicaid requires use of the KX modifier to allow for claims processing for certain services administered to patients whose gender identification may not match their gender assigned at birth, such as transgender, non-binary, or intersex patients. Failing to use the KX modifier may result in a claim being denied because the procedure or diagnosis code does not typically agree with the patient's gender.

The KX Modifier should be used in the following circumstances to allow for claims processing:

- The procedure is not representative of the patient's gender.
- The diagnosis is not representative of the patient's gender; use of all relevant diagnosis codes is still required.

Please Note: Per federal rule CMS-2451-F, federal Medicaid funding for certain gender-affirming hormone treatments and surgical procedures for individuals under age 18 is prohibited. DVHA will continue to provide medically necessary coverage for Medicaid members under the age of 18 with state funds. Billing is not impacted.

4.15 Place of Service (POS) 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.

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 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 service.

Further information is included in these CMS publications: MLN Matters® Articles, Place of Service Code Set.

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

- Inpatient hospital (POS 21)
- Outpatient hospital (POS 22)

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

Professional services are paid at non-facility rates for procedures in the following settings:

- School (POS 03)
- Office (POS 11)
- Home or private residence (POS 12)
- Assisted living facility (POS 13)
- Mobile Unit (POS 15)
- Well Child Clinic (POS 17) (CMS Walk-in Retail Clinic)
- Birthing Center (POS 25)
- Nursing facility (POS 32)
- Custodial Care Facility (POS 33)
- Federally Qualified Health Center (POS 50)
- Intermediate Health Care Facility Developmentally disabled (POS 54)
- Residential Substance Abuse Treatment Facility (POS 55)
- Comprehensive Outpatient Rehabilitation Facility (POS 62)
- End-Stage Renal Disease Treatment Facility (POS 65)
- State or local Health Clinic (POS 71)
- Rural Health Clinic (POS 72)
- Independent Lab (POS 81)
- Other Place of Service (POS 99)

4.16 Spend-Down

In some cases, eligibility is contingent upon the applicant having extraordinary expenses. In these cases, the applicant must first become responsible for a specific dollar amount for medical expenses during a six-month period. The actual amount is known as the “spend-down” amount as calculated by DCF. A spend-down member becomes eligible for Vermont Medicaid on the day of the month in which the incurred medical expense amount equals or exceeds the specified “spend-down” amount. When the member becomes eligible, all providers performing a service on that first day of eligibility will receive a Notice of Decision letter (ESD 220MP) from the district office. The letter explains that the spend-down amount has been met by the member, or that a portion of the provider’s bill remains the responsibility of the member. The provider must deduct the spend-down amount, if any, shown in the ESD 220MP prior to claim submission. The following aid category codes indicate Notice of Decision (Spend Down) applies to services provided on the first day of a member’s eligibility: PA, PB, PC, PD, PP PR, P3, P4, P5, P6, P7 and P8.

When completing the UB-04 Claim Form involving spend-down, the provider must do the following:

1. Enter the spend-down amount shown on the Notice of Decision in field locator 54b. If there was a payment by a third-party insurance, add the other insurance payment and spend-down amount in field locator 54b.
2. Enter the spend down amount on the UB-04 Medicare Attachment Summary Form (MASF) for Medicare crossover claim types: X and W.
    a. If no Other Insurance payment, check box for NO (6b) on MASF; the provider is to enter the spend down amount in the other insurance field on the MASF.
    b. If there is an Other Insurance payment, check box for YES (6a) on MASF; the provider is to enter the total combined amount of the other insurance payment and the spend down in the other insurance field (6c) on the MASF.
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 member.
4. Attach a copy of the Notice of Decision to the claim and submit to Gainwell for processing. The Notice of Decision must be specific to the provider that is submitting the claim.

When submitting a CMS-1500 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 member.
2. Put your usual and customary charge in field locator 24f.
3. Total all the charges appearing on the claim form and write the total amount in field locator 28.
4. Put the amount of the spend-down in field locator 29.
5. Enter the spend-down amount on the Medicare Attachment Summary Form (MASF) for Medicare crossover claim type: Y.

a. If no Other Insurance payment, check box for NO (1b) on MASF; the provider is to enter the spend-down amount in the other insurance field on the MASF.

b. If there is an Other Insurance payment, check box for YES (1a) on MASF; the provider is to enter the total combined amount of the other insurance payment and the spend down in the other insurance field (1c) on the MASF.

6. Attach a copy of the Notice of Decision to the claim and submit to Gainwell for processing.

4.17 Long-Acting Reversible Contraceptives in an Inpatient Hospital Post-Partum Setting

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. 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	

4.18 Billing High-Investment Inpatient Drugs

Hospitals are required to bill separately for a list of specified inpatient drugs, which is known as the High-Investment Carve-Out Drug List. Prior authorization is required, and these drugs cannot be acquired through the 340B program. These inpatient drugs will be paid at the actual acquisition cost, and providers must submit an invoice documenting costs. The High-Investment Carve-Out Drug List is available on the Drug Coverage Lists page of the Department of Vermont Health Access (DVHA) website.

In addition to billing the High-Investment Carve-Out Drug on a HCFA-1500 with the invoice, the inpatient claim should be billed separately, excluding the high-cost drug. The inpatient claim will pay using the standard Diagnosis-Related Group (DRG) methodology. DVHA will conduct a post-payment review to ensure the high-cost drug was only billed on the HCFA-1500. In the event of duplicate billing, the inpatient payment will be recouped, and the billing entity will be instructed to re-bill appropriately. Reimbursement for High-Investment Carve-Out Drugs

Section 5 CMS-1500 Claim Submissions

This section contains billing information and instruction specific to the CMS-1500 Claim Form used to bill physician and other specified practitioner services; providers include audiologists, chiropractors, dentists, naturopathic physicians, nurse practitioners, podiatrists, psychologists, and transportation (emergency and non-emergency) providers.

An alphabetical list of billable services is located in the following section. The billable services under the Vermont Medicaid programs are too numerous to list in their entirety; therefore, only a selection of services is noted in detail.

5.1 Payment DVHA Primary

The DVHA uses the CMS Common Procedure Coding System to describe reimbursable items. Certain reimbursable services require prior authorization. For complete details and a list of codes that require prior authorization, see the Fee Schedule. Vermont Medicaid reimbursement policy for the various CMS-1500 billers is as follows:

Ambulance Services - Reimbursement basis is the lower of the provider's charge or Vermont Medicaid rate on file. The unit of service is the loaded mile, see Section 5.3.2, Ambulance Services.

Anesthesia Assistants - Reimbursement basis is 100% of the Vermont Medicaid rate on file.

Audiologist - Reimbursement basis is the lower of the provider's charge or Vermont Medicaid rate on file. The unit of service is the procedure.

Chiropractor - Reimbursement basis is the lower of the provider's charge or Vermont Medicaid rate on file. For additional Chiropractic information, see Section 5.3.10, Chiropractic Services.

Certified Nurse-Midwife - Reimbursement basis is 100% of the Vermont Medicaid rate on file.

CRNA - Reimbursement basis is 100% of the Vermont Medicaid rate on file.

Dental Hygienist - Reimbursement basis for CPT procedures is the lower of the provider's charge or the Vermont Medicaid rate on file when billing on a CMS-1500 Claim Form. All other billings are on the ADA Dental Claim Form.

See the Vermont Medicaid Dental Supplement.

Dentist - Reimbursement basis for CPT procedures is the lower of the provider's charge or the Vermont Medicaid rate on file when billing on a CMS-1500 Claim Form. All other billings are on the ADA Dental Claim Form.

See the Vermont Medicaid Dental Supplement.

Federally Qualified Health Center

- **Primary Care** - Reimbursement is on interim, cost-based encounter rates determined using Medicare principles and receiving the higher of encounter cost of PPS payment at the final cost settlement at year's end. There is an upper limit to the encounter rate when applicable.
- **Dental Services** - Reimbursement is fee-for-service with a cost settlement at year's end.

Independent Lab - Reimbursement basis is the lower of the provider's actual charge or the Vermont Medicaid rate on file not to exceed the Medicare maximum allowable amount. There is no cost settlement.

Independent Radiology - Reimbursement basis is the lower of the provider's actual charge for the Vermont Medicaid rate on file not to exceed the Medicare maximum allowable amount. There is no cost settlement.

International Board-Certified Lactation Consultants (IBCLCs) - Effective June 1, 2018, in-home lactation consulting services provided by International Board-Certified Lactation Consultants (IBCLCs) will be covered by Vermont Medicaid. IBCLCs must be licensed and enrolled as Vermont Medicaid providers and hold an IBCLC certificate. Provider enrollment in Vermont Medicaid may take up to 60 days. Eligible IBCLCs may begin enrolling prior to the June 1st effective date but will not be able to bill for services prior to that date.

Licensed Lay Midwife - 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. Reimbursement is limited to certain procedure codes.

Naturopathic Physicians - Reimbursement basis is the lower of the provider's charge or Vermont Medicaid rate on file.

Nurse Practitioner - 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.

Optician - Reimbursement basis is the lower of the provider's charge or Vermont Medicaid rate on file. The unit of service is the procedure.

Optometrist - Reimbursement basis is the lower of the provider's charge or Vermont Medicaid rate on file. The unit of service is the procedure.

Physician

- **Attending Physician** - Reimbursement basis is the lower of the provider's charge or Vermont Medicaid rate on file. The unit of service is the CPT procedure.
- **Anesthesiologist** - Reimbursement basis is the lower of the provider's charge or Vermont Medicaid rate on file for the procedure. The unit of service is 1-unit equals 1 minute.
- **Assistant Surgeon** - Reimbursement is 25% of allowed amount paid to surgeons. Reimbursement is limited to certain surgical procedures needing assistance.
- **Pathologists** - Reimbursement will be made in accordance with Medicare's *Medigram 83-11* and subsequent *Medigrams*. The unit of service is the CPT procedure.
- **Psychiatry** - Reimbursement basis is the lower of the provider's charge or Vermont Medicaid rate on file. The unit of service is per visit or for time elapsed.
- **Surgeons** - Reimbursement basis is the lower of the provider's charges or the Vermont Medicaid rate on file. The unit of service is the surgical procedure.
- **Physician Assistant** - 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.

Podiatrist - Reimbursement basis is the lower of the provider's charge or Vermont Medicaid rate on file. The unit of service is the procedure.

Psychological Services - see Section 5.3.47, Psychiatry/Psychology

Rural Health Clinic

- **Primary Care** - Reimbursement is on interim, cost-based encounter rates determined using Medicare principles and a final cost settlement at year's end. There is an upper limit to the encounter rate when applicable.
- **Dental Services** - Reimbursement is fee-for-service with a cost settlement at year's end.
- **Other Ambulatory Services** - Reimbursement is Vermont Medicaid fee-for-service rate on file.

5.2 Non-Reimbursable Services

For Medicaid members aged 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 Members under the age of 21 see EPSDT services.

See Coverage Exceptions for more information.

5.3 EPSDT Services for Medicaid Members Under Age 21

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a federally mandated benefit for Vermont Medicaid Members 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.[1] 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. Please refer to HCAR 4.106.

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, Fee Schedule, does not apply to Members 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 Member 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, Clinical Forms and Prior Authorization Forms.

[1] 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)

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
- Any that are not medically necessary

If the requested item is a non-covered drug, prior authorization forms can be found here: Preferred Drug List (PDL) & Clinical Criteria.

5.4 Custom Items Not Delivered

Vermont Medicaid will not provide reimbursement for inactive items, or equipment ordered and not delivered or picked up. In rare circumstances, a case-by-case review may be considered when a member dies or their medical condition changes significantly prior to delivery. The item must be one that is highly customized to meet the unique medical needs of a member and not able to be reused or repurposed for another individual. Cases will not be reviewed if a provider has delayed delivery beyond a reasonable timeframe. Request for consideration may be submitted to the DVHA Clinical Operations Unit with supporting clinical documentation for review.

Section 6 CMS-1500 Claim Type – Billing Information

6.1 Alcohol/Drug Detoxification Treatment

Physicians and Alcohol & Drug Abuse Programs (ADAP) provide services for inpatient alcohol/drug detoxification and are payable when provided within the geographical limits of the state. Treatment facilities outside the state that wish to bill the DVHA, including designated border facilities, must receive prior authorization. A request for prior authorization must be made by or on behalf of the referring or admitting physician. No telephone authorizations will be granted.

ADAP providers must bill services using their ADAP NPI (with taxonomy code when applicable) as the attending number, as well as continue to put the ADAP NPI number in field locator 33a.

6.2 Ambulance Services

All the following conditions must be met before reimbursement will be made:

1. The ambulance service must be certified for participation in Medicare.
2. An advanced practice provider, physician, or nurse must order ambulance transport and certify it as medically necessary (any other mode of transport would have endangered the health of the member).
3. The member is transported to the nearest appropriate facility.

6.3 Ambulance Billing

Vermont Medicaid is the payer of last resort. All other insurances, Medicare and town or city government must be billed prior to submitting a claim to Vermont Medicaid.

The completed claim must show the total loaded miles, i.e., the full number of miles the member was on board/transported.

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. When the actual milage is under 1 full mile, it should always be rounded up to 1. Examples: 0.7 miles becomes 1 mile. 0.3 miles also becomes 1 mile.

Other services incidental to the member’s condition such as disposable supplies, oxygen, tolls, and ferry expense are reimbursed when detailed on the claim. The invoice or receipt must be attached.

Ambulance providers must enter their own NPI in field locator 24j for each procedure code. The ambulance provider NPI must also be entered in field locator 33a with the provider’s name and address.

Basic/base rates include all procedures (e.g., administration of medications, application of splints). The DVHA does not accept the modifiers utilized by Medicare. Air mileage is no longer included within the ambulance service code and may be billed out separately.

When billing for round trip services on the same date of service, providers are required to bill each trip separately. Each claim must indicate the FROM and TO address in box 32 of the CMS-1500 form or in the notes section of the electronic claim. The claim must also indicate in box 19 of the CMS-1500 form or in the notes section of the electronic claim, whether it is the first or second transport.

Vermont Medicaid does not reimburse for miles accumulated when the member is not on board, or for waiting time.

Some service may be covered under Non–Emergency Transportation (NEMT), Section 5.3.40.

Service From	Service To	Allowed
Member's Home or Nursing Home	Hospital, inpatient admission	Yes
Hospital or Nursing Home or Discharged as Inpatient	Home, inpatient admission to another hospital, nursing home	Yes
Home or Nursing Home	Hospital and return for specialized diagnostic or therapeutic services (not simple follow-up visits)	Yes
Inpatient Hospital Status	Another hospital and return for specialized diagnostic or therapeutic services not available at first hospital	No*
Scene of Accident	Hospital for emergency room or inpatient admission	Yes
Home or Nursing Home	Hospital based renal dialysis facility & return	Yes
Home or Nursing Home	Physician's office**	Yes
Physician's Office	Home or nursing home**	Yes
Home or Hospital	VT Respite House	Yes

**This service is paid for by the hospital where trip originates.*
***Must be medically necessary, requires a Physician Certification Statement (PCS).*

6.4 Physician Certification

Ambulance providers are required to keep a completed Physician's Certification Statement (PCS) in every Vermont Medicaid member file substantiating each claim submitted for payment. A physician,
a registered nurse or a licensed practical nurse must sign this PCS. If the Medicare PCS form is used, the origin and destination must be written on the form.

Physicians are reminded that they are certifying "other methods of transportation are medically contraindicated" or "means of transportation other than ambulance would endanger the member's health." Since Vermont Medicaid pays for other forms of transportation (e.g., taxi, bus) to and from medically necessary services, members are able to access health care with no personal expense. Both the Vermont Medicaid program and Vermont ambulance service providers ask physicians to order and certify only those trips that are medically necessary, and to expedite their handling and return of the forms to the ambulance service.

A copy of the ambulance PCS form is required to be sent in with claims for non-emergency transport services for chemotherapy, dialysis and radiation treatment/services. The certification must state why other means of transportation were not acceptable. A PCS is not required with claims for emergency transport.

See Section 5.3.40, Non-Emergency Medical Transportation (NEMT) for information regarding transportation for eligible members to and from medically necessary medical services that are Vermont Medicaid billable.

6.5 Anesthesia

Payment is provided for anesthesia administered by an anesthesiologist, certified registered nurse anesthetist (CRNA) or anesthesia assistant that remains in constant attendance during the surgical procedure, for the sole purpose of providing the anesthesia service. Payment is not reimbursable for the operating physician when billing for the administration of anesthesia. The administration of anesthesia by the operating M.D. is included in the reimbursement for the surgery.

Medical Direction of Anesthesia: When services are performed by non-physician anesthetists and medically directed by the physician anesthesiologist, reimbursement may be made to the physician for medical direction of the anesthetist. In order to be reimbursed for medical direction, the physician must:

- Direct no more than four concurrent anesthesia procedures.
- Be physically present in the operating suite and available for immediate diagnosis and treatment of emergencies.
- Perform a pre-anesthetic examination and evaluation.
- Prescribe the anesthesia plan.
- Personally participate in the most demanding procedures in the anesthesia plan, including induction and emergent.
- Monitor the course of anesthesia administered at frequent intervals.
- Ensure that a qualified individual performs any procedures in the anesthesia plan that is not done by the physician.
- Provide indicated post-anesthesia care.

Oral surgery billed on a CMS-1500 using CPT coding is subject to the same rules as a physician. The fee for anesthesia provided during oral surgery by the operating physician or dentist is included within the payment for the surgical procedure. This is different from payments for dentistry. See: Oral Surgery

Allowable Modifiers

Billable by the Anesthesiologist

- **AA** - Services performed by an Anesthesiologist not medically directing
- **QY** - Medical direction of one case
- **QK** - Medical direction of 2, 3 or 4 cases
- **AD** - More than 4 cases (This change in current Vermont Medicaid policy follows Medicare’s reduction in base units from 4 to 3 for this modifier)

Billable by the CRNA or Anesthesia Assistant

- **QX** - Service with medical direction by Anesthesiologist

Billable by the CRNA only

- **QZ** - Service without medical direction by Anesthesiologist

Billable by the CRNA or Physician

- **QS** - Monitored anesthesiology care services (The QS modifier is for informational purposes. Providers must report actual anesthesia time on the claim.)

All anesthesia codes must be billed with the appropriate modifier. Reimbursement may be extended to the services of more than one anesthesiologist when written justification is attached to the claim with a copy of the operative report and the anesthesia record.

6.6 Epidural Catheter-Pain Management

In keeping with Medicare policy, the DVHA cannot pay either spinal cord catheter introduction or pain management on the same date as surgery and/or general anesthesia. Spinal catheter introduction and pain management is included within the surgical and anesthetic reimbursements. Daily management of epidural or subarachnoid drug administration is payable only after the day on which the catheter was introduced.

6.7 Units of Service

Anesthesia services (procedure codes which begin with zero in the CPT) are required to bill units in actual time spent in minutes. For example, one unit equals one minute of actual time spent in attendance. A limit of 600 units (10 hours) has been imposed on all anesthesia codes, with the exception for CPT codes 00211 and 00567 the unit limit is 480, and CPT code 01967 the unit limit is 360. When submitting a claim for anesthesia services with units greater than the maximum allowed amount for the same date of service; submit a paper CMS-1500 claim form and include the appropriate supporting documentation (e.g., an anesthesia report), except for code 01967 for which the unit cap is set.

The DVHA payment methodology for anesthesia services is the lower of the actual charge or the Vermont Medicaid rate on file. Under Level III PAC A pricing is the Medicare payment formula of (units of service + base unit) multiplied by a conversion factor. The units of service billed are based on Medicare billing requirements. The base unit values used by DVHA are those put in place by Medicare effective January 1, 2012. For ongoing updates, the DVHA will follow Medicare's update schedule each January 1.

Time begins when the anesthesiologist/CRNA prepares the member for the introduction of anesthesia and ends when the anesthesiologist/CRNA is no longer in constant attendance. Included within the scope of this payment are pre- and post-operative visits, the administration of anesthetic, and the administration of any fluid or blood incident to the anesthesia or surgery.

6.8 Local Anesthesia

Reimbursement for local anesthetic is included in the reimbursement for the procedure. Local anesthesia is never reimbursed as a separate service. This includes Novocain or topical anesthesia used by dentists.

6.9 Monitoring Services

The services of an anesthesiologist required to monitor the member during surgery performed under local anesthesia are reimbursable. A narrative justification for the service must accompany the claim.

6.10 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 is performed as an independent procedure for diagnostic or therapeutic reasons (not concurrent with surgery), and the code is covered by Vermont 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.

6.11 Pre-Surgical Examination

Pre-surgical examination is reimbursable as part of the surgical procedure code payment. Only when the surgery is cancelled will the pre-surgical examination be reimbursed as a separate service.

6.12 Antineoplastic Drugs

Antineoplastic drugs or agents necessary in the treatment of malignant diseases are reimbursed by Vermont Medicaid and are to be billed by the physician/physician group only when the physician/physician group has purchased the drug. Only drugs administered by parenteral infusion, perfusion and intracavity means will be paid. Reimbursement follows Medicare or by invoice. Use the appropriate HCPCS J code and NDC. For the administration of antineoplastic agents in the office or physician-based clinic, see procedure codes in the 964-- section of the CPT manual. The appropriate-level evaluation and management procedure code for the visit may also be billed.

6.13 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. 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.

6.14 Audiological Services/Hearing Aids

Health Care Administrative Rule 4.213 Audiology Services can be found on the Agency of Human Services website. Audiology services are subject to the requirements of administrative rule. Information contained in rule will not be repeated in the provider manuals.

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.

Batteries

12 batteries per month/per side for Clear in Canal (CIC) and Contralateral Routing of Signals (CROS) and BiCROS. Information to support medical necessity for the hearing aid(s) must be kept on file for auditing purposes. For all other hearing aid types, it remains 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).

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).

6.15 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 is not to be used on claims submitted for bilateral radiology services.

6.16 Capsule Endoscopy (Esophagus through Ileum)

Capsule Endoscopy is a reimbursable service by Vermont Medicaid and requires prior authorization from the DVHA. The cost of the capsule and the physician fee are included in the payment. This procedure code should be billed as one unit and includes a global follow-up care period of 90 days post-procedure. Providers should obtain prior authorization before scheduling the procedure.

Capsule endoscopy of only the esophagus is not covered.

6.17 Chiropractic Services

Health Care Administrative Rule 4.220 Chiropractic Services can be found on the Agency of Human Services website. Chiropractic Services are subject to the requirements of administrative rule. Information contained in rule will not be repeated in the provider manuals. Effective January 1, 2023, the number of chiropractic visits Medicaid members can receive before prior authorization is required will increase from 10 to 12. Prior authorization requirements for chiropractic visits will be reinstated for ACO-attributed members beginning January 1, 2023. See banner announcement from 12/23/2022.

6.18 Consultation

A consultation includes those services provided by a physician whose opinion or advice is requested by the attending physician in the evaluation or treatment of a member's illness or condition. A consultation may occur in any location or setting. A consultation must include a written report to the referring physician and must be available to Vermont Medicaid upon request. A consultation code is valid for a pre-op exam only when the surgeon is not the member's primary physician and is assessing the need for surgery. In such a case, the billed diagnosis must indicate the medical condition, not the pre-op Z-code.

When the surgery is already scheduled, the physician who performs the pre-op (history and physical) is to bill the appropriate E & M code, not a consultation code. Consultation codes will be denied when the diagnosis or other information indicates the service was a pre-op exam.

To bill for a consultation service, use the CMS-1500 claim form, and refer to the CPT manual for procedure codes and definitions. All initial consults are limited to one per member per diagnosis. The NPI number of the referring physician is mandatory in field locator 17b when billing a consultation code.

6.19 Detail Processing

Each line on the CMS-1500 claim form is called a "detail" and is processed individually. All of the details on a claim form have the same Internal Control Number (ICN). However, each detail has its own sequence number that is listed on the remittance advice right after the claim's ICN. Individual processing means that one detail from a claim may appear on the remittance advice in the Paid Claims section while another detail from the same claim may appear in the Suspended and/or Denied Claims section. This type of processing allows each detail to be processed individually. No detail is delayed by the processing of another detail.

6.20 Developmental & Autism Screening of Young Children

See the developmental and Behavioral Screening Guidelines and Preferred Tool List for additional information.

The American Academy of Pediatrics recommends that all infants and young children be screened with valid, reliable screening instruments for developmental delays at regular intervals. To improve detection rates through the use of standardized screening instruments by primary care providers, the DVHA will reimburse for a developmental screening (CPT 96110) with a standardized screening tool to be billed on the same day as a well-child visit or other E & M codes.

All infants or young children should have a general periodic developmental screening at the 9th, 18th, 24th or 30th month well child visits. Developmental screening is recommended when surveillance indicates an infant or young child may be at risk for developmental delay.

When billing for a general developmental screening of an infant or young child at the 9th, 18th, 24th or 30th month visits providers should use CPT Code 96110 and the appropriate "Z" diagnosis code. Providers are required to maintain documentation in the patient medical record of the screening, the screening tool used, and evidence of screening result or screening score.

To ensure children are screened with the most appropriate tools, the Vermont Child Health Improvement Program reviewed information on developmental screening tools identified in the AAP policy statement and coordinated a committee of developmental and primary care pediatricians to review and comment on this information resulting in a "preferred list" of developmental screening tools.

For most primary care physicians, tools that fall under the general screening category are going to be most useful and appropriate for young children. There will be instances where secondary screening tools, or domain specific tools, may be appropriate, and the decision to use such tools should be based on individual practice needs, physician experience, population needs, etc.

General Screening Tools

- Ages & Stages Questionnaire (ASQ) Third Edition (2009)
- Battelle Developmental Inventory: 2nd Edition (BDI-II) - Screening Test (2006)
- Bayley Scales of Infant and Toddler Development: 3rd Edition (Bayley-III) Screener (2005)
- Brigance Early Childhood Screens (2005)
- PEDS: Developmental Milestones

Secondary Screening Tools

- Ages & Stages Questionnaires: Social-Emotional (ASQ:SE)
- Child Behavior Checklist (CBCL) Achenbach System
- Communication and Symbolic Behavior Scale-Developmental Profile (CSBS-DP): Infant Toddler Checklist
- Early Language Milestone Scale (ELM Scale-2)
- Language Development Survey
- Alberta Infant Motor Scale (AIMS) (1994)

6.21 Autism Screening

The AAP recommends that young children should be screened with valid, reliable screening tool for autism at regular intervals. All children should have an autism specific screening at the 18th and 24th month well child visits. To improve detection rates through the use of standardized screening tool by primary care providers, the DVHA will allow for an autism screening (CPT 96110) with a standardized screening tool to be billed on the same day as a well-child visit or other E & M codes.

Primary care providers must use a standardized screening tool to bill for autism screening that occurs in conjunction with a well-child visit or other visit. Any standardized screening tool listed in the Academy of Pediatrics policy statement Identifying Infants and Young Children with Developmental Disorders in the Medical Home (Pediatrics, Vol. 18, #1, July 2006) can be used through December 31, 2011. As of January 1, 2012, reimbursement for child autism specific screening at the 18th and 24th month visits should only be requested when the standardized screening tool listed at the bottom of this guidance is used.

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.

6.22 Diabetic Teaching

Routine diabetic teaching is included within payment for the medical visit. When it is medically necessary for the member to be referred to a Certified Diabetic Educator for more in-depth counseling, billing instructions are provided to the appropriate providers upon enrollment.

6.23 Drugs Requiring Prior Authorization

The following medications (listed in alphabetical order) will require a 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)
- Tysabri (natalizumab)

For a list of ongoing changes, please see the DVHA website at Pharmacy.

All claims submitted for Zoledronic Acid must be billed using HCPCS code Q2051.

- Prior authorization is required from Change Healthcare 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 Myelona 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, J1740, J1745, and J2323.

For members with a primary insurance, a prior authorization is not required in the medical benefit if the primary insurer pays a portion of the claim. However, if the primary insurer denies the claim, the DVHA will require a prior authorization.

The following medications (listed in alphabetical order) may not be billed through the medical benefit: Soliris (eculizumab), Somatuline Depot (lanreotide), Synagis (palivizumab) and Xolair (omalizumab). For a list of ongoing changes, please see the DVHA website at Pharmacy.

Therefore, the following J codes, C codes or other codes (listed in numerical order) will not be accepted: 90378, C9003, C9237, J1300, J1743 and J2357.

These medications must be billed through the pharmacy benefit using NDCs. Please note that these medications do require prior authorization for payment through the pharmacy benefit.

Prescribers are instructed to call or fax the Change Healthcare Call Center to request prior authorization for the above-mentioned medications regardless of whether the medication will be billed through the medical or pharmacy benefit. Phone: 844.679.5363; fax: 844.679.5366. For clinical criteria and either the general or specific prior authorization forms at Pharmacy.

6.24 Dual Eligibility

See Section 1.6, Medicare & Vermont Medicaid Crossover Billing.

6.25 Emergency Indicator

Providers must indicate on the CMS-1500 form if the service provided is the result of an emergency situation. These situations must be indicated in the “EMG” field locator (24c) on the claim form.

6.26 Emergency Room Services

Emergency room services include, but are not limited to:

- Consultations
- ER physicians’ charges
- Radiology
- Laboratory services

Payment will not be made for professional services for medical follow-up services in the emergency room.

DVHA does not require the emergency room provider, hospital or fiscal agent to notify the enrollee’s provider, or DVHA of the enrollee’s screening and treatment within 10 calendar days of the enrollee’s presentation for emergency services.

6.27 EPSDT Program Well – Child Health Care

Vermont provides Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services to all Vermont Medicaid members up to age 21. EPSDT is a federal mandate that requires the state to provide all medically necessary services, regardless of whether the service is covered for adults. The goal of EPSDT is to prevent illness, complications and the need for long-term treatment by screening and detecting health problems early. Services are tracked for appropriate follow-up and reported to CMS by collection of data from Vermont Medicaid claims. The Vermont Department of Health (VDH) assists in EPSDT outreach and education.

Required EPSDT Screening Components

1. Comprehensive health and developmental history
2. Comprehensive unclothed physical exam
3. Appropriate immunizations
4. Laboratory tests (includes blood lead level and TB screening)
5. Health education/anticipatory guidance
6. Vision screens
7. Dental screens
8. Hearing screens

Screening Service Delivery and Content

- Screening is provided according to the American Academy of Pediatrics Bright Futures preventive screening guidelines and the Vermont Dental Periodicity Schedule as medically indicated.

- Eligible individuals have free choice of qualified providers

Screenings include developmental and nutritional assessment.

Diagnosis and Treatment Services

1. Diagnostic procedures are reimbursable when medically indicated by a screening examination.
2. Treatment services to correct or improve defects and physical and mental illnesses and conditions discovered by the screening services, are reimbursable, including:
    a. Vision services
    b. Dental services
    c. Hearing services
    d. Physical, Occupational, and Speech therapy (PT, OT and ST)
    e. Supportive nursing service (Medicaid High Tech Program)
    f. Case Management
3. Treatment services may require prior authorization and are limited to:
    a. Medically necessary, as defined by the Medicaid Division
    b. The most economical treatment approach
    c. Authorized providers

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 modifiers, “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”.

6.28 ESRD Related Services

Vermont Medicaid reimburses for End Stage Renal Disease (ESRD) related services provided by the physician to members in the home, office, outpatient department, skilled nursing facility, or nursing home.

Do not bill “daily” and “per full month” codes for the same calendar month. Documentation (usually the physician notes) must be available in the member’s record which shows that the service was given by the physician and the dates involved. Providers should refer ESRD members to Medicare for possible eligibility.

6.29 Evaluation & Management Services (Post-Operative Care)

Evaluation and Management: (99--- codes)

The following limits apply:

- Services included within payment for E&M service.
- Office visits limited to 5 per calendar month per attending.
- New patient visits limited to one per member/attending/3 years.
- One office visit/day for same member and same attending provider.

6.30 Post-Operative Care

When reporting a surgical procedure with a 90-day, 30-day, or a 10-day global period any E&M service billed during the global period by the same provider will be included within the surgical procedure payment and not reimbursed separately. Payments for surgical procedures with a 0-day global period will include established patient E&M services.

6.31 Family Planning Services

Family Planning is defined as any medically approved diagnostic test, treatment, counseling, drug, supply, or device which is prescribed or furnished by a provider to individuals of child-bearing age for purposes of enabling such individuals to freely determine the number and spacing of their children. Abortion is not considered Family Planning.

It is important that physicians and other providers identify such services as family planning in the appropriate field locator on the claim form. Reimbursement for implantation and/or removal of contraceptive devices includes all related services including the surgical tray, anesthetic, and physician visits within 30 days after the procedure. Implantation is reimbursable once every five years.

6.32 FQHC/RHC

Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) have at least two provider numbers: one for services paid at cost, and one for services paid per fee schedule. Services paid at cost are billed as encounters.

See the Vermont Medicaid FQHC/RCH Supplement for more information.

6.33 Health Maintenance Organization (HMO)

HMOs are insurance plans and are treated as such by the DVHA. Vermont Medicaid members covered by a commercial HMO must follow the HMO rules. Vermont Medicaid will make no payment for which an HMO is responsible or when the member has not followed the HMO rules. Providers may notify the members that he or she is responsible for payment when the HMO rules are not followed.

Vermont Medicaid will reimburse for HMO co-pay charges for physician office visits when the physician is capitated by the primary HMO. To bill the HMO co-pay only, use the procedure code T1015.

T1015 can be used only to bill Vermont Medicaid for the co-payment required by another primary insurer when that visit was included in a capitation agreement with the primary insurer.

Rural Health Centers and Federally Qualified Health Centers are not allowed to bill Gainwell for HMO co-payments. These will be included in the yearly cost settlement.

6.34 Hospital Based Physicians

Vermont Medicaid follows the billing procedures of the regional Medicare carrier. Reimbursement is made in accordance with the Medicaid fee schedule for services and must be billed on the CMS-1500 Claim Form.

The CPT codes for hospital inpatient services are used to report evaluation and management services provided to hospital inpatients. When the member is admitted as an outpatient, physician visits are billed with either the outpatient CPT codes or observation service CPT codes.

6.35 Hysterectomy

See Health Care Administrative Rule 4.224 Sterilizations and Related Procedures for the conditions for coverage for sterilizations and related procedures. The rule can be found on the Agency of Human Services website.

Prior authorization is required for hysterectomy for members under the age of 18. All hysterectomy claims on members under the age of 55 also require either:

- A valid Federal Consent for Sterilization Form and DVHA Hysterectomy Consent Form.
- A valid 'Notice of Decision" to provide retroactive eligibility.
- Operative notes or a statement that the member was already sterile prior to the hysterectomy.

The hysterectomy consent form is available on the Department of Vermont Health Access site and should be submitted with the claim.

6.36 Immunization

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.

6.37 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.

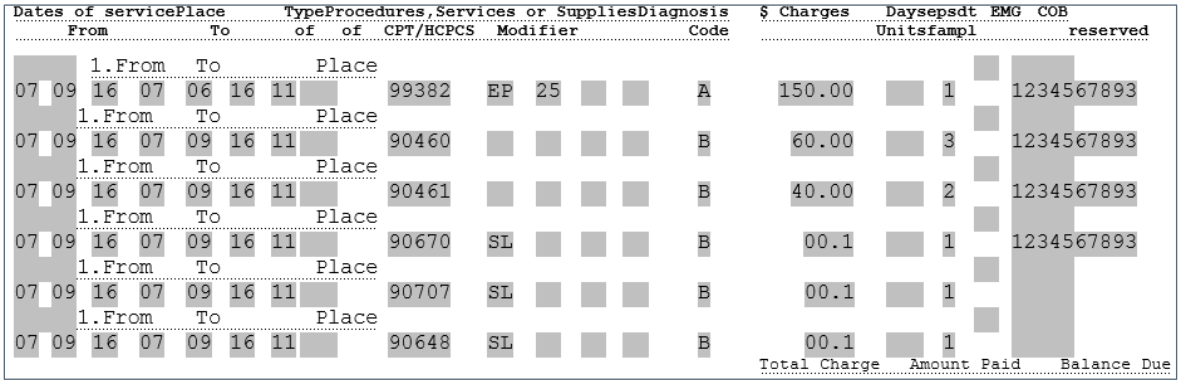
Immunization Administration Coding Example

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 Haemophilus 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 - Haemophilus influenza vaccine
- 90460 - Administration first component (1 unit)

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



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

6.38 Independent Laboratory

The referring physician is the physician or practitioner who actually ordered the tests for the member; he or she must be enrolled as a participating Vermont Medicaid provider. Enter the NPI/taxonomy code combination of the referring physician in field locators 17a and 17b. The billing provider's name and address, to which payment will be made, must appear in field locator 33 and the NPI number must appear in field locators 33a and 24j.

The DVHA follows the Medicare billing procedures for physician's billing for laboratory testing. It permits a physician to bill Vermont Medicaid for laboratory testing only when the physician or an employee of the physician performs the test. Physicians who expect to be reimbursed for lab services performed on site must indicate on the claim that the test was performed on site, by completing field locator 20 on the CMS-1500 claim form and indicate the CLIA certification is on file with DVHA.

The professional component (modifier 26) is valid only when the test requires interpretation by the billing physician. The result from the actual testing of a specimen usually requires no interpretation and, in some cases, is done by the lab specialist. The billing of the lab code with modifier 26 is not valid for these services.

The Clinical Laboratory Improvement Amendments of 1988 (CLIA) require all providers of lab services to meet quality standards and be certified by the U.S. Department of Health and Human Services. CLIA applies to virtually all laboratory testing of human specimens.

The DVHA must have documentation of CLIA Certification with each provider enrollment period. Lapsed certificates will result in claim denials. Immediately forward renewed/current CLIA certificates to Gainwell upon receipt.

Providers who perform laboratory services that have not obtained the appropriate CLIA certification are instructed to contact the Vermont Department of Health, 280 State Drive, Waterbury, VT 05671-8300, by phone 802-863-7200 or fax 802-865-7754.

In order to be reimbursed for laboratory services furnished in an office setting, providers submitting claims for laboratory services are required to have a CLIA certificate on file with Gainwell. The services being submitted must be covered by the certificate and within the effective dates.

Additionally, Vermont Medicaid will utilize the QW modifier to indicate CLIA waived tests following CMS guidelines for billing waived tests. To determine if your lab service requires at QW modifier please refer to the published list.

6.39 Lab Handling

Payment for the service of obtaining specimens is included in the reimbursement of the medical visit. For exceptions to this rule and the corresponding procedure codes, please refer to Specimen Collection Fee.

6.40 Injections

Flu Shots

Immunization for flu and pneumonia are available at little or no cost in Vermont via a program of the Vermont Agency of Human Services Department of Health. See the Vermont Immunization Manual. Members are encouraged to use this service. Local home health agencies and Area Agencies on Aging will administer flu vaccines in many locations around the state.

All in-state providers MUST obtain vaccines through the Vermont Department of Health (VDH) Vaccine for Children Program, for children through age 18. Influenza and H1N1 vaccines may be obtained through VDH; however, it is not a requirement. The SL modifier must be used with an appropriate procedure code when billing the CPT or HCPCS code to assure correct payment. Report the charge as $0.00 to represent the free vaccine.

Vaccines provided to adults over 18 or vaccines provided by out of state providers to patients of any age, do not have to be obtained by the VDH Vaccine Program. The SL modifier will not be required in either of those circumstances and payment will be based on the current fee schedule.

All vaccine administration fees must be supported with a vaccine code, even when there is no amount to be reimbursed.

Prescribers are instructed to call 844.679.5363 or fax 844.679.5366 the Change Healthcare Clinical Call Center to find out which drugs require prior authorization regardless of whether the medication will be billed through the medical or pharmacy benefit. For clinical criteria and either the general or specific prior authorization forms, visit Pharmacy.

Pharmacist-Administered

Flu Shots for Adults Effective September 30, 2011, DVHA-enrolled pharmacies may be reimbursed for injectable influenza vaccinations administered by pharmacists to adults 19 years and older enrolled in Vermont’s publicly funded programs. Pharmacists must be certified to administer vaccines in the state of Vermont and must be in compliance with all Vermont laws governing vaccine administration. Failure to comply with all Vermont immunization regulations will subject these claims to recoupment. Reimbursement will be based on either a written prescription or a non-patient specific written protocol based on a collaborative practice agreement per state law. These orders must be kept on file at the pharmacy. The billing pharmacy and the ordering prescriber's NPI is required on the claim for the claim to be paid.

Reimbursement and billing: Under this program, pharmacies are reimbursed for the cost of the vaccine and an administration fee. No dispensing fee is paid for these claims. Pharmacists should

bill DVHA using either the paper CMS-1500 claim form or the 837 electronic CMS-1500 Claim Form. A claim for the vaccine must accompany a claim for administration; therefore, these vaccinations cannot be billed at POS through the pharmacy benefit. The appropriate billing codes to be used are as follows: Influenza vaccine codes: 90656, 90658 and administration code 90471.

For instructions on billing with a CMS-1500 claim form, see the Provider Manual.

For information on reimbursement please refer to the Fee Schedule.

If you have additional billing questions, please contact Gainwell provider services at 800.925.1706. For other questions regarding this benefit, please contact a member of the DVHA pharmacy unit at 802.241.9210.

6.41 Inpatient Services

Certain elective procedures also require prior authorization (e.g., hysterectomies, bariatric surgery, etc.). These are usually requested by the physician, but the hospital is always/also responsible for making sure the DVHA approval is in place prior to the procedure being performed. This pertains to all in-state and out-of-network providers.

See Section 2, Prior Authorization of Medical Services for a complete listing of in-state and out-of-network hospital admissions prior authorization and notification requirements. Additional information is also available at Provider Resources and Clinical Programs..

6.42 Lead Screening

CMS has mandated that children ages one through five be screened for lead unless the physician determines it to be medically inappropriate. The act of obtaining the sample during a well-child or routine office visit is included within payment for that medical visit. The processing laboratory will bill the proper CPT code for the actual testing.

6.43 Maintenance Drug Prescriptions

When the DVHA is the primary payer; pharmacies are required to dispense designated classes of maintenance drugs in 90-day supplies after the first fill. When the DVHA is the primary payer, prescriptions written for maintenance drugs must be rewritten for 90 days for the drug to be covered. The maximum quantity limit of 102 days still applies. This rule does not apply to members who have other primary insurance, including Part D.

Maintenance drugs must be prescribed and dispensed for not less than 30 days and not more than 90 days, to which one dispensing fee will be applied. Excluded from this requirement are medications which the member takes or uses on an “as needed” basis or generally used to treat acute conditions. If there are extenuating circumstances in an individual case that, in the judgment of the prescriber, dictate a shorter prescribing period for these drugs, the supply may be for less than 30 days as long as the prescriber prepares in sufficient written detail a justification for the shorter period. The extenuating circumstance must be related to the health and/or safety of the member and not for convenience reasons. It is the responsibility of the pharmacy to maintain in the member’s record the prescriber’s justification of extenuating circumstances. In these circumstances, regardless of whether extenuating circumstances permit more frequent dispensing, only one dispensing fee may be billed.

For a complete listing of pharmacy related information and the Pharmacy Provider Manual, go to Pharmacy. See DVHA’s Clinical Criteria document for drugs with other quantity limits at Preferred Drug List (PDL) & Clinical Criteria.

6.44 Mastectomy

Mastectomy procedures will be restricted to a diagnosis involving benign and malignant neoplasm of the breast. When the primary diagnosis is any other, documentation is required to be submitted with the claim to substantiate medical necessity."

Prior Authorization is not required for reconstructive breast surgery if the primary diagnosis indicates malignant neoplasm of the breast/breast cancer.

6.45 Medical Nutrition Therapy

This service is paid through the enrolled primary care physician, inpatient hospital, outpatient hospital, registered dietitians (RD) and school health services. Registered Dietitian billing is restricted to three codes specific to RD services. These services are not reimbursable when billed by a physician.

6.46 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 as stated 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”.

6.47 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.

6.48 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.

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, triplets, or more at 150%.

- The provider should submit the appropriate delivery code on the claim and append with modifier 22 and the appropriate ICD-10 diagnosis code.
- The modifier shows that the physician performed a significantly more difficult delivery due to the presence of multiple babies.

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.

6.49 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 Midwifes 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 Section 5.3.35, 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

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.

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.

6.50 Multiple Surgery Pricing

Vermont Medicaid will price multiple surgery payments in order of the procedure code's Relative Value Unit and will price all surgical procedures in decreasing percentages of 100%, 50%, 40%, 30%, 30%...This includes surgical procedures billed with multiple units. Any codes that are add-on codes, or Modifier 51 exempt, as defined by the CPT, will be priced at 100% of the allowed amount.

Providers are required to bill multiple surgeries on a single claim. Any subsequent claims that are billed for multiple surgeries on the same day will be denied. If any billing changes need to be made, the original claim will need to be adjusted by the provider. Claims should be sent with surgery procedure codes in the RVU order from highest to lowest.

6.51 Naturopathic Physicians

Medically necessary health care services within the Vermont Medicaid benefit package provided by a Naturopathic Physician (N.D.) are a covered service. N.D.s must be licensed in Vermont and provide treatment within the scope of their practice as described in Chapter 81 of Title 26 of the Vermont Statutes. N.D.s having local admitting hospital privileges or a formal agreement with a physician who has local hospital admitting privileges and arranges 24 hour-a-day/seven days-a-week coverage for their members may enroll as primary care providers (PCPs) with Vermont Medicaid.

Naturopathic physicians wishing to participate in the PCP in the Primary Care Plus Program, must provide additional information. Please complete the Agreement for Participation for Naturopathic Physicians form (inpatient hospital admission information is required).

Please access forms at Provider Enrollment and Data Maintenance Forms. Mail, General Provider Agreement and the Agreement for Participation for Naturopathic Physicians, along with any additional documentation to:

Gainwell Technologies
Attn: Enrollment Unit
P.O. Box 888, Williston, VT 05495-0888

6.52 NDC (National Drug Code)

Vermont Medicaid requires the collection and submission of rebates for all drugs dispensed or administered by providers other than a pharmacy. This allows for the collection of Vermont

Medicaid drug rebates from manufacturers on all drugs dispensed in any office setting. The NDC billed to Vermont Medicaid must be the NDC that was dispensed to the member.

Drugs supplied by manufacturers currently participating in the rebate program will be the only drugs reimbursed by Vermont Medicaid. A list of these manufacturers, by code and name, can be found at Provider Resources.

To collect rebates from the correct manufacturers, Vermont Medicaid will require data elements at the detail level in addition to the HCPCS codes. These elements are the 11-digit National Drug Code (NDC) number, the Unit of Measurement Qualifier code, and the unit quantity. These must be reported on paper and electronic submissions of all professional claims.

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.

- **FL 24D:** HCPCS code
- **FL 24D Shaded area:** 11-digit NDC number, Unit of Measurement Qualifier, and Unit Quantity
- **FL 24G:** HCPCS unit

24D CPT/HCPCS Modifier	**E** DX Pointer	**F** Charges	**G** Days or Units
[60126598741] [UN] [1111.234]			
J1234 XX	1,2,3	$637.00	**5**
↑ **11 Digit NDC** ↑ **Unit of Measurement Qualifier *** ↑ **Unit**			

* Unit of Measurement Qualifier

- **F2** - International Unit
- **GR** – Gram
- **ML** – Milliliter
- **UN** - Unit

Some NDCs are displayed on drug packaging in a 10-digit format. Proper billing of an NDC requires an 11-digit number in a 5-4-2 format. Converting NDCs from a 10 to 11-digit format requires a strategically placed zero, dependent upon the 10-digit format. The following table shows common 10-digit NDC formats on packaging and the associated conversion to an 11-digit format with the proper placement of a zero:

10-Digit Format	**10-Digit Format Example**
4-4-2	9999-9999-99
5-3-2	99999-999-99

10-Digit Format	10-Digit Format Example
5-4-1	99999-9999-9
11-Digit Format	**11-Digit Format Example**
5-4-2	09999-9999-99
5-4-2	99999-0999-99
5-4-2	99999-9999-09
Actual 10-Digit NDC Example	**11-Digit Conversion Example**
0002-7597-01 Zyprexa IM 10mg vial	00002-7597-01
50242-040-62 Xolair	50242-0040-62
60574-4112-1 Synagis 50mg vial	60574-4112-01

6.53 Non-Emergency Medical Transportation (NEMT)

Non-Emergency Medical Transportation (NEMT) is a covered service for members enrolled in traditional, Primary Care Plus (PC Plus) Vermont Medicaid and the Dr. Dynasaur programs. NEMT is a statewide service, providing transports for eligible members to and from medically necessary medical services that are Vermont Medicaid billable. It is provided through personal services contracts between the State of Vermont, Agency of Human Services (AHS), Department of Vermont Health Access (DVHA) and local public transit brokers.

All providers are required to confirm a member's appointment when verification is requested from a Vermont Medicaid transportation provider. CMS requires transportation providers to verify that transportation is to and from eligible medical appointments. At this time, the DVHA requires transportation providers to verify 5% of all ride requests made by members.

For further NEMT information and requirements go to Non-Emergency Medical Transportation.

6.54 Oral Surgery

If oral surgery is billed with a CPT code, follow the physician’s rules for billing and bill on a CMS-1500 claim form. If oral surgery is billed using ADA codes, follow the dentist’s rules for billing, and bill on an approved dental claim form.

6.55 Over the Counter (OTC) Medications

Coverage of Over the Counter (OTC) medications is primarily 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 Vermont Medicaid, Dr. Dynasaur and VPharm. DVHA pays for OTCs only when there is a specific medical necessity and requires a 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, members 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 Pharmacy. The PDL can be found at Preferred Drug List (PDL) & Clinical Criteria.

6.56 Oximetry Services

When billing any medical visit, the following procedures are considered included within the reimbursement for the visit:

- Ear or pulse oximetry saturation-single determination
- Non-invasive ear or pulse oximetry for oxygen saturation; by multiple determinations
- Non-invasive ear or pulse oximetry for oxygen saturation; by continuous overnight monitoring

These services will be denied with EOB 091—Service denied; not reimbursed by Vermont Health Access Program.

6.57 Pharmacologic Management (Psychiatric)

Pharmacologic management is payable only for mental health and developmentally disabled members when providers must bill using appropriate procedure code with one unit of service per visit, regardless of time spent.

6.58 Physician Visit Limits

Pursuant to Medicaid Rule 7301.1.1, the following physician visit limits apply:

1. Payment for office or home visits is limited to five visits per member, per month.
2. Nursing facility visits are limited to one per provider per member per week.
3. Hospital visits are limited to one per day for the same or similar diagnosis for acute care, or after denial of acute care by utilization review, up to one visit per month for subacute care.

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 Forms and Clinical Criteria.

Non-emergency (elective) out-of-network medical visits will require prior authorization from DVHA (In network, but out-of-state (OOS) hospitals are excluded from this requirement). In network referring providers are to submit requests using the OOS Medical Office Request Form located at Clinical Forms and Prior Authorization Forms.

Mileage allowances for house calls apply only to the first member. If more than one member is seen during the visit, no mileage will apply to those members.

6.59 Post-Operative Follow-up Visits

For all CPT surgical procedure codes, Medicare has assigned a follow-up/global period of either 000, 010 or 090 days. This means that office visits that are related to the procedure are included within the payment for the procedure and may not be billed during the restricted follow-up period.

6.60 Partial Hospitalization Programs (PHP) and Intensive Outpatient Programs (IOP) Billing Guidance

Providers are allowed to bill for PHP and IOP services in outpatient settings (through the Outpatient Prospective Payment System, on a UB-04 claim form) or in office-based settings (on a CMS-1500 claim form), based on their provider type and how they have been approved to bill. Providers billing for PHP/IOP services in an outpatient setting may bill for professional services separately. Providers billing for PHP/IOP services in an office-based setting may not separately bill for professional services. This applies to PHP/IOP services provided in-person or via

telehealth. If providers bill for PHP/IOP services, they should not separately bill for these services for the same member on the same date of service. If providers bill for PHP/IOP services in an office-based setting, they should not separately bill for these codes for the same member on the same date of service. For more detailed information (including a table of services included in the PHP/IOP bundled payment and office-based codes that are included in PHP/IOP services when billed in an office-based setting) please refer to the Partial Hospitalization Programs (PHP) and Intensive Outpatient Programs (IOP) in outpatient and professional settings billing guidance, located on the Provider Resources page.

6.61 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.

6.62 Radiology

Radiologic Components

The professional component of radiologic services must be billed by the physician when those services are done in a hospital radiology department. The professional component includes any examination of and discussion with the member, supervision of technologist, interpretation of the results of diagnostic or therapeutic procedures and consultation with the attending physician. Only a radiologist will be paid for the radiology professional component. The appropriate CPT procedure code should be used with the modifier 26 when billing for the professional component.

Technical component

Includes the services of non-radiologist or non-physician personnel, materials, facilities, equipment, and space used for diagnostic or therapeutic services. The appropriate CPT procedure code should be used with the modifier TC when billing for the technical component.

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.

When the same radiology procedure code is done more than once on the same date of service **and is not done for reasons of comparison**, the provider should bill the appropriate radiology code **once only with multiple units.** Documentation must be maintained in the member records substantiating the purpose and number of multiple x-rays. Radiology services performed for comparison are not reimbursable.

Diagnostic Imaging Program Guidelines and other provider resources are available at Provider Resources.

The DVHA implemented a multiple procedure payment structure for CT, CTA, MRI and MRA imaging procedures. This structure will apply whenever multiple outpatient imaging services using the same or similar modality (MRI and MRA, CT and CTA) are performed on the same

day, by the same provider, on contiguous body areas.

In these cases, the procedure with the highest intensity will be paid at 100% of the fee schedule rate and subsequent procedures will be reimbursed at a lower rate. If two procedures are performed, the second procedure will be reimbursed at 50% of the fee schedule rate. The third and all subsequent procedures will be paid at 25% of the fee schedule rate. This rate structure applies only to the imaging procedure component of the claim. The professional (physician) component is not affected by this change.

Providers who choose to bill worker's compensation or accident insurance first, instead of Vermont Medicaid, will not be eligible for reimbursement if prior authorization is not obtained prior to the service being rendered.

6.63 Smoking Cessation Counseling

Face-to-face smoking cessation counseling is covered for eligible Vermont Medicaid members 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.

6.64 Pharmacological Coverage

See the most recent Clinical Criteria document at Preferred Drug List (PDL) & Clinical Criteria for Smoking Cessation Therapy information, preferred drug list and PA requirements.

6.65 Specimen Collection Fee

Payment for obtaining specimens is included in the reimbursement of the office visit. Physicians may bill Vermont Medicaid for a specimen collection fee in two situations only; for the collection of blood via venipuncture or for collection of a urine sample by catheterization. Federal Qualified Health Clinics and Rural Health Clinics have different guidelines for this process:

- Venipuncture (or blood draw fee) and the specimen handling fee are included as part of FQHC services. They are not considered part of the diagnostic laboratory services.
- Blood draws/venipuncture and specimen handling provided by nurses or technicians for services, such as lab tests and blood draws, do not bill an encounter. These charges are included within the encounter payment when the service was originally ordered. Clinical Diagnostic Laboratory tests performed on site should be billed separately as a fee for service.

6.66 Sterilizations

See Health Care Administrative Rule 4.224 Sterilizations and Related Procedures for the conditions for coverage for sterilizations and related procedures. The rule can be found on the Agency of Human Services website.

The Sterilization Consent Form can be found on the web here Sterilization Consent Form.

6.67 Team Care Program

The Team Care Program restricts a member to one physician and one pharmacy. If a member 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 member. The “lock-in” reflects the member’s choice of primary care physician. This information is also available through the VRS and the Vermont Medicaid web site.

6.68 Telemedicine Services

Health Care Administrative Rule 3.101 Telehealth can be found on the Agency of Human Services website. Providers’ use of telehealth practices are subject to the requirements of administrative rule. Information contained in rule will not be repeated in the provider manuals.

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).
5. Facility fees will not be reimbursed if the provider is employed by the same entity as the originating site.
6. GT modifier should not be used on Q301.
7. DVHA will not reimburse for teleophthalmology or teledermatology by store and forward means.

6.69 Topical Fluoride Varnish

Physicians, naturopaths, nurse practitioners, and physicians’ assistants with one of the following specialty types: general practice, family practice, internal medicine, pediatric medicine, nurse practitioner, family practitioner, naturopathic physician with childbirth endorsement & without childbirth endorsement, and pediatric practitioner are allowed to administer and bill for Topical Fluoride Varnish treatments for children ages 0-5.

6.70 Vision Care & Eyeglasses

HCAR 4.214, Eyewear and Vision Care Services can be found on the Agency of Human Services website. All eyewear and vision services are subject to the requirements of administrative rule. Information contained in the rule will not be repeated in the provider manuals.

See the Vermont Medicaid Vision Supplement for additional coverage information.

Section 7 UB-04 Claim Submissions

7.1 Hospital Inpatient

Reimbursable services include medically necessary care in a semi-private room; private room and intensive care when medically necessary; nursing and related services; use of hospital facilities, supplies, appliances and equipment; blood transfusions; therapeutic services; drugs furnished by the hospital; rehabilitation services; diagnostic services.

See Section 7, Prior Authorization for Medical Services.

7.2 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 Vermont Medicaid Outpatient MUE of Zero procedures (Inpatient only list) is available at Medicaid NCCI Edit Files.

7.3 Home Health

Reimbursable services include nursing care services when the services are related to the care of patients who are experiencing acute or chronic periods of illness if ordered by and included in the treatment plan established by the physician.

Reimbursable services include physical, occupational and speech therapy services. Therapy services must be directly related to an active treatment plan, of a level that a qualified therapist is required, and reasonable and necessary to the treatment of the patient's condition.

Reimbursable services also include Services of a home health aide.

7.4 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.

7.5 Assistive Community Care Services

Reimbursable services include case management, personal care services, nursing assessment & routine tasks, medication assistance, on-site assistive therapy and restorative nursing.

Choices for Care

1. **Enhanced Residential Care Services** include personal care, meal preparation, medication management, nursing overview, activities, 24-hour supervision, and laundry/housekeeping.

2. **Long Term Care Services** include personal care, meals/nutritional services, 24-hour skilled nursing, rehab & therapy, activities, 24-hour supervision, social services, laundry/housekeeping.
3. **Home Based Waiver Services** include case management, personal care, respite or companion care, adult day services, personal emergency response systems.

7.6 Reimbursement Policy

The Fee Schedule contains a complete list 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 member is actively eligible for Vermont Medicaid.

Inpatient services will be paid according to DRG payment methodology. Vermont-based Relative Weight Information is available on the Vermont Medicaid website.

Outpatient services will be paid according to OPPS methodology. Go to Provider Resources for a listing of revenue codes that are required to be billed with a HCPCS/CPT code. The full fee schedule for hospitals is also listed. The number of units billed on a detail line with the revenue code will represent the number of units for the HCPCS code.

DRG Hospital Reimbursement-Vermont Medicaid Ineligibility: With the DRG reimbursement methodology in effect, any claims for members who become eligible or ineligible for Vermont Medicaid during the duration of an inpatient stay must be billed to any third-party liability provider prior to billing Vermont Medicaid/Gainwell in its entirety. Gainwell will prorate these claims based on member eligibility and partially reimburse for the days the member was eligible for Vermont Medicaid. Please see Section 6.8.6 for billing instructions for Medicare primary and loss of Vermont Medicaid coverage.

Providers are instructed to bill the inpatient stay, including the Vermont Medicaid ineligible days for reimbursement, then balance bill the member for the remainder. Vermont Medicaid will not reimburse for days which the member was ineligible, thus it becomes the member's financial responsibility.

7.7 Patient Share (Applied Income) Reporting

The Gainwell claims processing system captures 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. Gainwell will generate a monthly report detailing these changes; we will adjust these claims. However, to receive your corrected payment quicker, we recommend you submit electronic adjustments.

The DCF District office will send the facility a copy of the notification sent to the members. This notification includes the amount of the patient's share, if any, that the member must apply toward the cost of his or her care. Patient Share obligations will be automatically deducted from Vermont Medicaid claims starting with the first claims of the month.

Section 8 General Hospital Billing Information

8.1 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.

8.2 In-Network & Extended Network Hospitals

In-Network Hospitals are subject to the same Vermont Medicaid policy as are those located within the geographical confines of the state of Vermont. Their physicians must be enrolled in Vermont Medicaid. A complete list of Green Mountain Care In-Network & Extended Network Hospitals is available online.

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.

Inpatient/Outpatient Overlap Examples

The general rule is when the patient does not leave the hospital campus going from the outpatient to inpatient setting, then all of the outpatient charges should be rolled into the inpatient claim and there should be no separate outpatient claim. The following scenarios are to assist you in billing for out/inpatient overlap claims.

- A patient comes into the ER Friday at 10:00 pm; patient is seen and stays in the ER for 8 hours while tests and consults are performed. On Saturday morning, the physician feels it is necessary to admit that patient as inpatient.
    - When a patient receives continuous outpatient care and then is admitted as an inpatient, all of the outpatient charges should be rolled into the inpatient claim.
- A patient comes into the ER Thursday at 8:00 pm and is admitted as an outpatient in the observation room. By Friday pm, the physician determines it is best to admit that patient as an inpatient.
    - 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 inpatient room. All of the charges associated with the observation room should be rolled into the inpatient claim.
- A patient comes in as an outpatient on Thursday am for services and leaves, then later in the day, is admitted as an inpatient.
    - Some hospitals may treat the outpatient and inpatient stay as one event and bill all charges on the inpatient claim. Other hospitals may treat these as two separate events since the patient left after the outpatient and bill one outpatient and one inpatient claim. Either method is acceptable.
- A patient comes in at 10:00 pm on Tuesday for ER services and leaves. Wednesday morning the patient is admitted as inpatient.
    - These services are billed as two separate claims, one outpatient and one inpatient, as they are different service events.
- A patient is discharged on Tuesday am, but is readmitted Tuesday pm.

- The services from the second admission are added to the first admission; the claim will be inclusive of all inpatient days.

- A patient is discharged on Tuesday am but comes in for outpatient services Tuesday pm.
  - These are billed separately, one inpatient claim and one outpatient claim, as they are different service events.

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. Submit your claim and all attachments to your Vermont Medicaid Provider Representative. (See Provider Resources and click the Provider Representative Map link).

DVHA does not recognize Provider Liable charges, and therefore the charges are not to be deducted from the billed amount. Do not indicate Provider liable charges in field locator 54 of the UB-04 Claim Form.

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. Submit your claim and all attachments to your Vermont Medicaid Provider Representative. (See Provider Resources and click the Provider Representative Map link).

If an inpatient claim 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 Vermont 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 Vermont Medicaid covered days as a separated DRG payment for the patient's Vermont Medicaid covered services and DVHA will pay a crossover claim for the coinsurance and deductible for the Medicare covered days.

Inpatient Claims: Medicare Primary but Medicaid Eligibility Termed During Stay

When a Vermont Medicaid member has Medicare A but their Vermont Medicaid has termed during the stay, providers are instructed to bill as follows:

1. Bill part A charges to Medicare
2. The inpatient claim for the entire stay should be billed to Vermont Medicaid.
3. If the patient is eligible for the first day of service, the Medicare A deductible will be paid. Complete the Medicare Attachment Summary. This claim can just be submitted directly to Gainwell.
4. If the patient is eligible with Vermont Medicaid for co-insurance days, you must attach the Medicare A EOB. On the Part A EOB write Medicare co-insurance start date is mm/dd/yy, write the co-insurance due and sign and date the part A EOMB.
5. Submit your claim and all attachments to your Vermont Medicaid Provider Representative. (See Provider Resources and click the Provider Representative Map link).

8.3 High Dollar Inpatient Stays

Effective 10/1/2021 the DVHA will no longer require review for high dollar inpatient stays with billed amounts of $300k or greater. This means that facilities will no longer be required to submit the DVHA Service Authorization form along with clinical documentation for review to DVHA. Instead, facilities should submit the claim including the appropriate level of care room and board revenue codes directly to Gainwell for processing. Please note that discontinuation of review for high dollar inpatient stays $300k or greater does not impact other existing prior authorization requirements currently in place. Notwithstanding any other review, the State reserves the right to review medical records at any time and without advance notice. For additional questions, contact your Provider Relations Representative.

8.4 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.

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

For Vermont Psychiatric Care Hospital and Brattleboro Retreat only, the rules are as follows regarding members with TPL63 Medicaid Benefits / SMI Designation:

Definition: *Members are eligible for SMI Designation when they are between the ages of 22 and 64 and are receiving inpatient services at an Institute of Mental Disease (IMD). Currently, the only IMD providers enrolled in VT Medicaid are the Vermont Psychiatric Care Hospital (VPCH) and Brattleboro Retreat (BBR). The population is covered under the Serious Mental Illness (SMI) designation and consists of two groups: Adult Psychiatry and Forensic Psychiatry. Forensic psychiatry cases are defined as those for individuals in the custody of penal authorities, such as the Department of Corrections.*

VPCH and BBR that have a long-term SMI Designated patient may bill interim claims in at least 120-day intervals. Interim bills for these providers do not require value code 75, however, they do require valid PAs for processing. Providers will be required to submit the **Interim Billing Request Form:** https://dvha.vermont.gov/forms-manuals/forms/clinical-prior-authorization-forms for each interval to ensure appropriate authorization.

The providers will be required to bill each segment separately and will be required to recoup the previous segment before billing the next one. Once the member is discharged, the final segment should be recouped. Then the entire stay should be rebilled as one claim. Each claim must include all applicable diagnoses and procedures.

Example: Full stay is 09/01/2025 – 05/10/2026

1. Provider submits Interim Billing Request Form for initial 120 days.
2. Once authorization is approved, provider submits claim for the first segment (09/01/2025 – 12/29/2025).
3. Before submitting Interim Billing Request Form for the next 120 days, provider is to recoup the initial segment. Once the prior claim recoups, provider submits for authorization of the next 120 days authorization.
4. Once authorization is approved, provider submits claim for the second segment (12/30/2025 – 04/28/2026).
5. Before submitting Interim Billing Request Form for the next 120 days, provider is to recoup the second segment. Once the prior claim recoups, provider submits for authorization of the remaining days.
6. Once authorization is approved, provider submits claim for the third segment (04/29/2026 – 05/10/2026).

7. Once the member discharges, provider is to recoup the third segment. Once the prior claim recoups, provider submits for authorization of the full stay. Provider is to use the Interim Billing Request Form and indicate the full date range and note that the member has discharged.
8. Once authorization is approved, provider submits claim for the full stay (09/01/2025 – 05/10/2026).

8.5 Present on Admission (POA) - Inpatient Admissions

The present on admission indicator (POA) will be required for all inpatient admissions. Vermont Medicaid will follow Medicare's guidelines. The indicator options are Y (Yes), N (No), U (Unknown), W (Not Applicable). If exempt from POA reporting leave the field blank. The POA indicator is the eighth digit and is required on all diagnosis codes listed on the UB-04 (principal field 67 and secondary field 67 A through Q). This is not required for the admit diagnosis (69). For electronic claims using the 837 Institutional, submit the POA indicator in HI01-9 of each appropriate HI segment. POA is always required first, followed by the principal diagnosis. The last secondary diagnosis indicator is followed by the letter Z to indicate the end of the data element. e.g., POAYNUW1YZ

A list of diagnosis codes exempt from requiring the POA indicator can be located at Provider Resources.

8.6 Short 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 1/4/18 and released 11:30 pm on 1/4/18. This is a same day stay.
- Example: Patient is admitted at 10:00 pm on 1/4/18 and released at 7:00 am on 1/5/18. This is not a same day stay.

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.

8.7 Same/Next Day Readmission Policy

DVHA will not reimburse separate DRG payments for two separate inpatient claims when the patient's subsequent claims 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 Member 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 Global Commitment to Health.

8.8 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. 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.

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.

8.9 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.

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.

8.10 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 Vermont Medicaid for the inpatient stay and will be paid under the normal DRG logic.

Section 9 Outpatient/Inpatient Hospital Services

9.1 Cardiac Rehabilitation

Cardiac rehabilitation is billable under revenue code 943. One unit is equal to one day regardless of the number of encounters. Cardiac rehabilitation is limited to 36 sessions within a 36-week timeframe. An additional 36 sessions may be approved by the DVHA Clinical Operations Unit when the claim includes the appropriate notes and meets the required criteria.

9.2 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, 841,851, and 881 Hemodialysis - requires HCPCS code 90999 be billed. This service is reimbursed at a per diem rate of $157.76.
- Revenue code 304, Lab services, non-routine dialysis - requires an appropriate HCPCS code be billed. Reimbursement is 100% 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.
- 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.

9.3 Inhalation Therapy

Vermont Medicaid will cover oxygen needed intermittently after a member has been discharged from acute care. Payment will be made to the hospital for this outpatient service.

9.4 Hospital Clinical Laboratory Tests

Packaged Clinical Laboratory Procedures

Lab related charges must include the corresponding CPT or HCPCS code with the laboratory revenue code on the UB-04 claim form.

Vermont Medicaid packages some Clinical Laboratory procedure codes when they are billed with a primary service on a hospital outpatient claim.

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 member on that date of service.
- The patient is neither an inpatient or outpatient of a hospital (the member is not physically present at the hospital) but has a specimen that is submitted for analysis.

- 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.

Clinical Laboratory Tests Reimbursed Separately

Modifier L1 is 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.
- 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: The Medicare Learning Network®.

9.5 Observation Rooms

Vermont Medicaid is packaging observation services with OPPS primary procedures. There are no exceptions for certain conditions as there are in Medicare. Charges for observation however will be included in the determination of whether or not the claim is eligible for an outlier payment.

Alternatively, Vermont Medicaid will pay for observation separately when there is NO primary procedure. Vermont Medicaid will pay the observation line on a claim provided that the G0378 HCPCS appears on the labor room or observation room revenue code detail line and the number of hours in observation is indicated in the units field. The DVHA will pay up to 24 hours of observation per stay at $35.00 per hour with a maximum reimbursement benefit of $840.00 per claim. Lab details as well as other CPT/HCPCS for which there is a separate OPPS fee assigned but are not designated as primary procedures in the OPPS will be paid separately.

9.6 Private Room

Private rooms are allowed only if certified medically necessary by a physician to avoid jeopardizing the health of the patient or to protect the health and safety of other patients.

9.7 Provider Based Billing

DVHA will not 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.

9.8 Hospital Inpatient Billing Instructions/Field Locators

Admission Indicator

- The billing field locator 14 requires one of four codes. It is the decision of the Admitting Physician **when** there is a question as to which admission indicator code to use.

Attending Physician

- 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. When billing Vermont Medicaid on the UB-04 Claim Form, the attending physician's NPI (with Taxonomy code when applicable) must appear in field locator 76.

Billing/Supplying Provider

- The billing/supplying provider name and address listed on your enrollment application must appear in the field locator 1 and the actual billing NPI (with taxonomy code when applicable) to which payment will be made must appear in field locator 56. If an atypical provider, use the Vermont Medicaid number in locator 57C.

Nurse-Midwife Services

- The nurse-midwife provider number should be entered in field locator 76 on the UB-04 claim form. The provider number of an associated physician should NOT be used as the attending.

Field Locators

- All information on the UB-04 Claim Form should be typed or legibly printed. The fields listed below are used by Gainwell when processing Vermont Medicaid claims. The fields designated by an asterisk (*) are mandatory; other fields are required when applicable. Only the fields listed below are used in the Vermont Medicaid Program; other fields do not need to be completed.

Field Locators	Required Information
1. UNLABELED FIELD*	Enter the Hospital name and address as it appears on the Vermont Medicaid Provider Enrollment form.
2. UNLABELED FIELD	Enter "Vermont Medicaid Hospital Inpatient".
3a. PATIENT CONTROL #	For accounting purposes, enter the patient control # in the field locator. The number may consist of up to 24 characters, alpha/numeric. This information will appear on the Remittance Advice (RA).
3b. MEDICAL RECORD #	Enter patient's medical record #.

Field Locators	Required Information
4. TYPE OF BILL*	Enter the code indicating the specific type of bill for Inpatient. The sequence is as follows: 1. Type of facility 1 - Hospital 2. Bill Classification 1 - Inpatient 3. Frequency 1 - Admit through discharge claim 2 - Interim-first claim 3 - Interim-continuity claim 4 - Interim-last claim
6. STATEMENT COVERS PERIOD	Enter the from and through service dates.
8b. PATIENT'S NAME*	Enter the patient's last name, first name and middle initial.
10. BIRTHDATE	Enter the date of birth.
12. ADMISSION DATE	Enter date of inpatient admission.
13. ADMISSION HOUR*	Enter the hour in which patient was admitted.
14. ADMISSION TYPE*	Enter the code indicating the priority of the admission: 1 - Emergency 2 - Urgent 3 - Elective 4 - Nursery
16. DISCHARGE HOUR	Enter the hour in which the patient was discharged.
17. STAT*	Enter the two-digit code indicating the patient's status as of the 'through date' of the statement period.
18-28. CONDITION CODES*	Enter code to identify if condition is related to the following: 02 - Condition is Employment Related A1 - EPSDT Related Services A4 - Family Planning Related Services C1 - PSRO Approved as Billed C5 - PSRO Post-Payment Review

Field Locators	Required Information
31-34. OCCURRENCE CODE & DATE*	Enter one of the following two-digit accident codes, and the corresponding occurrence date, if applicable or 52 if no other applies: 01 - Auto Accident 02 - Auto Accident/No Fault Insurance Involved 03 - Accident/Tort Liability 04 - Accident/Employment Related 05 - Other Accident 06 - Crime Victim 11 - No Accident/Onset of Symptoms or Illness 42 - Date of Discharge 50 - Medical Emergency-Non-accidental 51 - Outpatient Surgery Related 52 - Not an Accident
39. VALUE CODES AMOUNT*	Enter the number of covered days in the amount/dollar column. Do not count the day of discharge or the date of death. (The sum of all the days should be equal to the number of days being billed.)
42. REVENUE CODES*	Enter the appropriate revenue code for the service provided.
45. SERVICE DATE	Enter the 'FROM' date of the span of consecutive service dates being billed.
46. SERVICE UNITS*	Enter the quantitative measure of service rendered per revenue code.
47. TOTAL CHARGES*	Enter the total charges pertaining to each revenue code billed for the current billing period. Add the total charges for all revenue codes being billed and enter at the bottom of column 47 in the total field. (detail line 23)
50. PAYER*	On 50a, enter the primary payer's name or "Spend Down" if spend down amount applies to the claim. On 50b, enter the other insurance name if applicable. Enter "Vermont Medicaid" on 50c.
54. PRIOR PAYMENTS*	Enter the payment amount associated with the payer listed in field locator 50. Attach spend down Notice of Decision. Documentation must be attached if there was no payment, if the services are not covered by the primary, or if the payment by the primary is $3.00 or less.
55. ESTIMATED AMOUNT DUE	Enter the amount due after deducting any amount entered in field locator 54 from the total entered at the bottom of column 47.
56. NPI*	Enter the BILLING provider's NPI number.

Field Locators	Required Information
57a. TAXONOMY CODE(S)	Enter the BILLING provider's Taxonomy Code when applicable.
57c. VERMONT MEDICAID ID #	Atypical providers, enter your Vermont Medicaid billing provider number.
60. INSURED'S MEMBER ID*	Enter the member's Vermont Medicaid ID #.
67. PRINCIPAL DIAGNOSES CODE* (see Present On Admission - POA)	Enter the primary diagnosis code. Use the appropriate ICD-10 codes.
67 a-q. OTHER DIAGNOSES CODES (Present On Admission-POA)	Enter the appropriate ICD-10 codes; see any condition other than primary, which requires supplementary treatment.
69. ADMITTING DIAGNOSES CODE*	Enter the admitting diagnosis code.
74. PRINCIPAL PROCEDURE CODE & DATE	Enter the appropriate ICD-10-CM procedure code and corresponding date.
74 a-e. OTHER PROCEDURE CODE & DATE	Enter the appropriate ICD-10-CM procedure codes and dates other than the principal procedure performed.
76. ATTENDING PHYSICIAN*	Enter the individual Attending Physician's NPI number. 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.
78-79. OTHER PHYSICIAN NPI	Enter the Vermont Medicaid ID # of the physician who the patient was referred to for further treatment, if applicable.
80. REMARKS	Enter any notations relating specific information necessary to adjudicate the claim.
81CCa	Enter the taxonomy code for the attending provider. Must correspond with the NPI number in field locator 76.

9.9 Hospital Outpatient Billing Instructions/Field Locators

All information on the UB-04 claim form should be typed or legibly printed. The fields listed below are used by Gainwell when processing Vermont Medicaid claims. The fields designated by an asterisk (*) are mandatory; other fields are required when applicable. Only the fields listed below are used in the Vermont Medicaid Program; other fields do not need to be completed.

Field Locators	Required Information
1. UNLABELED FIELD*	Enter the Hospital name and address as it appears on the Vermont Medicaid Provider Enrollment form.
2. UNLABELED FIELD	Enter "Vermont Medicaid Hospital Outpatient".
3a. PATIENT CONTROL #	For accounting purposes, enter the patient control # in the field locator. The number may consist of up to 24 characters, alpha/numeric. This information will appear on the Remittance Advice (RA).

Field Locators	Required Information
3b. MEDICAL RECORD #	Enter patient's medical record #.
4. TYPE OF BILL*	Enter the code indicating the specific type of bill for Outpatient. The sequence is as follows: 1. Type of facility 1 - Hospital 2. Bill Classification 3 - Outpatient 4 - Patient not present 3. Frequency 1 - Admit through discharge claim
6. STATEMENT COVERS PERIOD*	Enter the from and through service dates.
8b. PATIENT'S NAME*	Enter the patient's last name, first name and middle initial.
10. BIRTHDATE	Enter the date of birth.
12. ADMISSION DATE	Enter date of admission.
13. ADMISSION HOUR	If billing for emergency services that are the result of an accident, enter the admission hour.
14. ADMISSION TYPE*	Enter the code indicating the priority of the admission: 1 - Emergency 2 - Urgent 3 - Elective 4 - Nursery
16. DISCHARGE HOUR	Enter the hour in which the patent was discharged.
17. DISCHARGE STATUS*	Enter the appropriate discharge code.
18-28. CONDITONS CODES	Enter code to identify if condition is related to the following: 02 - Condition is Employment Related A1 - EPSDT Related Services A4 - Family Planning Related Services

Field Locators	Required Information
31-34. OCCURRENCE CODE & DATE*	Enter one of the following two digit accident codes and the corresponding occurrence date, if applicable or 52 if no other applies: 01 - Auto Accident 02 - Auto Accident/No Fault Insurance Involved 03 - Accident/Tort Liability 04 - Accident/Employment Related 05 - Other Accident 06 - Crime Victim 11 - No Accident/Onset of Symptoms or Illness 35 - Physical Therapy 44 - Occupational Therapy 45 - Speech Therapy 50 - Medical Emergency- Non-accidental 51 - Outpatient Surgery Related 52 - Not an Accident
42. REVENUE CODES*	Enter the appropriate revenue code for the service provided.
43. NDC CODE*	Enter the NDC code of the drug that was dispensed. Use a “N4” indicator preceding the NDC to identify the information in FL 43 as an NDC.
44. HCPCS/CPT	Enter the appropriate HCPCS/CPT code, immediately followed by an applicable/appropriate modifier
45. SERVICE DATE*	Enter the actual date the service was rendered. If the service was rendered on more than one day, you must bill a separate charge for each day.
46. SERVICE UNITS*	Enter the quantitative measure of service.
47. TOTAL CHARGES*	Enter the total charges pertaining to each code billed for the current billing period. Add the total charges for all revenue codes being billed and enter at the bottom of column 47 in the total field. (detail line 23)
50. PAYER*	On 50a, enter the primary payer’s name or “Spend Down” if spend down amount applies to the claim. On 50b, enter the other insurance name if applicable. Enter “Vermont Medicaid” on 50c.
54. PRIOR PAYMENTS*	Enter the payment amount associated with the payer listed in field locator 50. Attach spend down Notice of Decision. Documentation must be attached if there was no payment, if the services are not covered by the primary, or if the payment by the primary is $3.00 or less.
55. ESTIMATED AMOUNT DUE	Enter the amount due after deducting any amount entered in field locator 54 from the total entered at the bottom of column 47.

Field Locators	Required Information
56. NPI*	Enter the BILLING provider’s NPI number.
57a. TAXONOMY CODE(S)	Enter the BILLING provider’s Taxonomy Code when applicable.
57c. VERMONT MEDICAID ID #	Atypical providers, enter your Vermont Medicaid billing provider number.
60. INSURED'S MEMBER ID*	Enter the member's Vermont Medicaid ID #.
67. PRINCIPAL DIAGNOSES CODE*	Enter the primary diagnosis code. Use the appropriate ICD-10-CM code.
67 a-q. OTHER DIAGNOSES CODES	Enter the appropriate ICD-10-CM codes for any condition other than primary, which requires supplementary treatment.
76. ATTENDING PHYSICIAN NPI*	Enter the individual Attending Physician’s NPI number. 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.
77. OPERATING PHYSICIAN NPI	Enter the Vermont Medicaid ID # of the Operating Physician.
78-79. OTHER PHYSICIAN NPI	Enter the Vermont Medicaid ID # of the physician who the patient was referred to for further treatment if applicable.
80. REMARKS	Enter any notations relating specific information necessary to adjudicate the claim.
81CCa	Enter the taxonomy code for the attending provider. Must correspond with the NPI number in field locator 76.

Section 10 Sample Remittance Advice

The following pages illustrate a sample RA.

PROV 0000000 NPI: 0000000000 VERMONT MEDICAID REMITTANCE ADVICE RA NUM 000000000000
LTC AND PROFESSIONAL PAGE NUM: 1
R/A DATE: 04/01/2018

Providers are required to notify Gainwell of changes specific to demographics, group affiliation, and address information (billing, mailing, service, prior authorization and legal addresses) in a timely manner. Failure to notify Vermont Medicaid of these changes can result in denied claims, undeliverable correspondence or delayed claims' payment. The current Provider Information Change Form is available on the Vermont Medicaid Web Portal at:
https://vtmedicaid.com/assets/provEnroll/VTMedProviderInfoChangeForm.pdf

Whenever changes occur, please complete the form and return it to the Gainwell Enrollment Unit. See the form for directions.

Vermont Medicaid regularly updates its forms and applications to reflect current state and federal requirements. All provider paperwork, including enrollment applications and forms, adjustment forms and refund forms, submitted on outdated versions, will be returned. Providers are encouraged to always check for the most current forms on the Vermont Medicaid website.
https://www.vtmedicaid.com/#/home

GETWELL PHYSICIANS
123 YOUR STREET
BURLINGTON, VT 05401

PROV 0000000 NPI: 0000000000 VERMONT MEDICAID REMITTANCE ADVICE RA NUM 000000000000
LTC AND PROFESSIONAL PAGE NUM: 2
R/A DATE: 04/01/2018

RECIPIENT NAME MID ICN HVER PT ACCT/RX# FRQ DRG Code DRGWeight

BILLED AMT ALLOWED AMT OI AMT LIAB AMT COPAY AMT PAID AMT

HEADER MESSAGES (EOB/ADJ RSN/AMT)

DNUM DVER FDOS TDOS PROC+MODS/REV+RPL QTY BLD

DETAIL MESSAGES (EOB/ADJ RSN/AMT)

PAID CLAIMS

CLAIM TYPE: HCFA1500

SMITH BOB XXXXXXXXX 402004999888977 00 199 0.0000

001 00 03/01/18 03/01/18 99213 1.0 176.00 73.63 0.00 0.00 0.00 73.63
0093/45 73.63

CLAIM TOTALS: 176.00 73.63 0.00 0.00 0.00 73.63

JONES BILL XXXXXXXXX 402004555008876 00 167 0.0000

001 00 03/15/18 03/15/18 99393 EP 1.0 243.00 95.43 0.00 0.00 0.00 95.43
0093/45

002 00 03/15/18 03/15/18 92551 1.0 25.00 8.81 0.00 0.00 0.00 8.81
0093/45

CLAIM TOTALS 268.00 104.24 0.00 0.00 0.00 104.24

TOTALS FOR CLAIM TYPE: HCFA1500 3 CLAIM(S) 444.00 177.87 0.00 0.00 0.00 0.00

PAID CLAIM TOTALS:3 CLAIM(S) 444.00 177.87 0.00 0.00 0.00 177.87

PROV 0000000 NPI: 0000000000 VERMONT MEDICAID REMITTANCE ADVICE RA NUM 000000000000
LTC AND PROFESSIONAL PAGE NUM: 3
R/A DATE: 04/01/2018

RECIPIENT NAME MID ICN HVER PT ACCT/RX# FRQ DRG Code DRGWeight

BILLED AMT ALLOWED AMT OI AMT LIAB AMT COPAY AMT PAID AMT

HEADER MESSAGES (EOB/ADJ RSN/AMT)

DNUM DVER FDOS TDOS PROC+MODS/REV+RPL QTY BLD

DETAIL MESSAGES (EOB/ADJ RSN/AMT)

DENIED CLAIMS

CLAIM TYPE: HCFA1500

SMITH BOB XXXXXXXXX 402004999888977 00 199 0.0000

001 00 03/08/18 03/08/18 99213 1.0 176.00 0.00 0.00 0.00 0.00 0.00
1098/211 0.00

CLAIM TOTALS: 176.00 0.00 0.00 0.00 0.00 0.00

JONES BILL XXXXXXXXX 402004555008876 00 167 0.0000

001 00 03/27/18 03/27/18 90750 1.0 243.00 0.00 0.00 0.00 0.00 0.00
1098/211

002 00 03/27/18 03/27/18 90471 1.0 61.00 0.00 0.00 0.00 0.00 0.00
1098/211

CLAIM TOTALS 304.00 0.00 0.00 0.00 0.00 0.00

TOTALS FOR CLAIM TYPE: HCFA1500 3 CLAIM(S) 304.00 0.00 0.00 0.00 0.00 0.00

DENIED CLAIM TOTALS:3 CLAIM(S) 304.00 0.00 0.00 0.00 0.00 0.00

PROV 0000000 NPI: 0000000000 VERMONT MEDICAID REMITTANCE ADVICE RA NUM 000000000000
LTC AND PROFESSIONAL PAGE NUM: 4
R/A DATE: 04/01/2018

RECIPIENT NAME MID ICN HVER PT ACCT/RX# FRQ DRG Code DRGWeight

BILLED AMT ALLOWED AMT OI AMT LIAB AMT COPAY AMT PAID AMT

HEADER MESSAGES (EOB/ADJ RSN/AMT)

DNUM DVER FDOS TDOS PROC+MODS/REV+RPL QTY BLD

DETAIL MESSAGES (EOB/ADJ RSN/AMT)

SUSPENDED CLAIMS

CLAIM TYPE: HCFA1500

SMITH BOB XXXXXXXXX 402004999888977 00 199 0.0000

001 00 03/31/18 03/31/18 90461 3.0 111.00 38.76 0.00 0.00 0.00 0.00
1098/211 0.00

CLAIM TOTALS: 111.00 38.76 0.00 0.00 0.00 0.00

JONES BILL XXXXXXXXX 402004555008876 00 167 0.0000

001 00 03/27/18 03/27/18 20610 RT 1.0 189.00 48.34 0.00 0.00 0.00 0.00
1098/211

002 00 03/27/18 03/27/18 20610 LT 1.0 189.00 48.34 0.00 0.00 0.00 0.00
1098/211

CLAIM TOTALS 378.00 96.68 0.00 0.00 0.00 0.00

TOTALS FOR CLAIM TYPE: HCFA1500 3 CLAIM(S) 489.00 135.44 0.00 0.00 0.00 0.00

SUSPENDED CLAIM TOTALS:3 CLAIM(S) 489.00 135.44 0.00 0.00 0.00 0.00

PROV 0000000 NPI: 0000000000 VERMONT MEDICAID REMITTANCE ADVICE RA NUM 000000000000
LTC AND PROFESSIONAL PAGE NUM: 5
R/A DATE: 04/01/2018

RECIPIENT NAME MID ICN HVER PT ACCT/RX# FRQ DRG Code DRGWeight

BILLED AMT ALLOWED AMT OI AMT LIAB AMT COPAY AMT PAID AMT

HEADER MESSAGES (EOB/ADJ RSN/AMT)

DNUM DVER FDOS TDOS PROC+MODS/REV+RPL QTY BLD

DETAIL MESSAGES (EOB/ADJ RSN/AMT)

ADJUSTED CLAIMS

CLAIM TYPE: HCFA1500

SMITH BOB XXXXXXXXX 402004999885467 00 199 0.0000

001 00 03/31/18 03/31/18 99887 1.0 35.00 30.00 0.00 0.00 0.00 30.00
039/000 0.00

ORIGINAL CLAIM TOTALS: 35.00 30.00 0.00 0.00 0.00 30.00
RECOUPMENT TO ORIGINAL CLAIM-PAID DATE: 06/16/04 RECOUPMENT AMOUNT: 30.00-

SMITH BOB XXXXXXXXX 402004999885467 00 199 0.0000

001 00 03/31/18 03/31/18 99887 2.0 70.00 60.00 0.00 0.00 0.00 60.00
039/000 0.00

ORIGINAL CLAIM TOTALS: 70.00 60.00 0.00 0.00 0.00 60.00

ADJUSTMENT CLAIM TOTAL: 65.00 60.00 0.00 0.00 0.00 60.00

ADJUSTMENT REASON: PROVIDER-REQUESTED REPROCESSING NET ADJUSTMENT AMOUNT: 30.00

ADJUSTED CLAIM TOTALS: 1 CLAIM(S) 65.00 60.00
0.00 0.00 0.00 0.00 60.00

PROV 0000000 NPI: 0000000000 VERMONT MEDICAID REMITTANCE ADVICE RA NUM 000000000000
LTC AND PROFESSIONAL PAGE NUM: 6
R/A DATE: 04/01/2018

FINANCIAL ITEMS

CCN A/L NUM MID ICN HVER DNUM DVER TXN DATE ORIG AMT TXN AMT BAL AMT RSN
532004096000987 55200476890321 XXXXXXXXX 402004999885467 00 01 00 06/16/04 35.00
35.00 35.00 149

502004096000992 55200476890321 06/14/04 35.00 35.00- 0.00 103

FINANCIAL ITEMS REASON CODES

103 WEEKLY PAYMENT APPLIED TO ACCOUNTS RECEIVABLE

149 AUTO RECOUPMENT- ORIGINAL CLAIM

PROV 0000000 NPI: 0000000000 VERMONT MEDICAID REMITTANCE ADVICE RA NUM 000000000000
LTC AND PROFESSIONAL PAGE NUM: 7
R/A DATE: 04/01/2018

TPL INFORMATION

RECIPIENT NAME ICN HVER DVR DNUM

SMITH BOB 402004356922001 00 01 00

BLUE CROSS/BLUE SHIELD OF VERMONT CARRIER CODE:
EE 100 STATE STREET

MONTPELIER, VT 05606

POLICY NAME: BOB SMITH RELATIONSHIP SELF POLICY 109885478773399 GROUP 6789085550

PROV 0000000 NPI: 0000000000 VERMONT MEDICAID REMITTANCE ADVICE RA NUM 000000000000
LTC AND PROFESSIONAL PAGE NUM: 8
R/A DATE: 04/01/2018

EARNINGS DATA

	CURRENT	YEAR-TO-DATE
NUM OF CLAIMS PROCESSED	4	1004
CLAIMS PAID AMOUNT	91.00	25,867
SYSTEM PAYOUT AMOUNT	0.00	0.00
MANUAL PAYOUT AMOUNT	0.00	0.00
RECOUP AMOUNT WITHHELD	35.00	35.00
PAYMENT AMOUNT	56.00	25,832
CREDIT ITEMS	0.00	0.00
NET ADJUSTMENT AMOUNT	35.00-	35.00
NET 1099 ADJUSTMENTS	0.00	0.00
NET EARNINGS	56.00	25,832

**$56.00 WAS DEPOSITED INTO ACCOUNT NUMBER 0123456789 ON 06/162004

EOB MESSAGE CODES

093 PAYMENT REDUCED TO MAXIMUM ALLOWABLE AMOUNT

096 CLAIM DENIED. EXACT DUPLICATE OF SERVICE PREVIOUSLY PAID

095 CLAIM CUTBACK DUE TO OTHER INSURANCE PAYMENT

408 PLEASE BILL OTHER INSURANCE CARRIER FIRST AND ATTACH COPY OF PAYMENT OR DENIAL