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GreenMountainCare
A HEALTHIER STATE OF LIVING

Vermont Medicaid
General Provider Manual

VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

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Section 1 General Information and Administration

The Department of Vermont Health Access (DVHA) is responsible for the administration of the State of Vermont's publicly funded health insurance programs.

Green Mountain Care is the brand name for the family of publicly funded health coverage programs offered by the State of Vermont. Programs include Vermont Medicaid, Dr. Dynasaur, premium assistance pharmacy-only programs and Pharmacy Discount Programs.

Important Telephone Numbers, Addresses and Websites

Department of Vermont Health Access

280 State Drive, NOB 1 South, Waterbury, VT 05671-1010
Telephone: 802.879.5900
Fax: 802.879.5619
Website: Department of Vermont Health Access

Gainwell Technologies

28 Walnut Street, Suite 245, Building C, Maple Tree Place Shopping Center, Williston, VT 05495-0888
Telephone: 800.925.1706
Fax: 802.433.4201

Website: Vermont Medicaid

Gainwell Checks, Claim Submission and Correspondence Mail

For all Checks:
Gainwell Technologies, PO Box 1645, Williston, VT 05495-0888

For all Claims and other correspondences:
Gainwell Technologies, PO Box 888, Williston, VT 05495-0888

Administration & Responsibilities

Member Eligibility Determination

Applications for health benefit eligibility and other public benefit determinations can be found online at MyBenefits Portal or at a DCF Economic Services Division (ESD) District Office. Eligible members are enrolled in the appropriate health care assistance program by the Department of Vermont Health Access (DVHA) and the Health Access Eligibility and Enrollment Unit (HAEEU). Questions about applying and other information queries can be made by calling 800.250.8427.

Benefits Service Center/District Offices: Telephone 800.479.6151

The Benefits Service Center's call center interactive voice response (IVR) system services members statewide.

Administration of Insurance Programs

The Department of Vermont Health Access (DVHA) has the primary responsibility for establishing health care program policy and administration of Vermont's health insurance programs,

determining service coverage, establishing provider reimbursement rates, and funding for provider payments.

Department of Vermont Health Access:
Telephone: 802.879.5900
Department of Vermont Health Access
280 State Drive, NOB 1 South, Waterbury, VT 05671-1010

DVHA/HAEEU is responsible for managing the **Green Mountain Care** Member Customer Support Center to provide information to health benefit applicants and respond to questions and concerns from members.

Green Mountain Care Member Customer Support Center
Telephone: 800.250.8427
TTY: 888.834.7898
426 Industrial Ave, Ste 151, Williston, VT 05495

Claims System & Provider Services

The State of Vermont contracts with a fiscal agent, Gainwell, to enroll/re-enroll Vermont Medicaid providers, manage and maintain a Provider Call Center, manage and maintain the MMIS (Medicaid Management Information System), process Vermont Medicaid claims, pay enrolled health care providers and perform other duties.

The Provider Services Unit of Gainwell consists of four components: Provider Relations Representatives, Provider Call Center Agents, Provider Enrollment and the Publications Coordinator. This unit is available to assist Vermont Medicaid providers and their billing personnel (at no cost), Monday through Friday from 8:00am to 5:00pm (except for State holidays; see the Holiday Closure Schedule.

Gainwell Provider Services: 800.925.1706

***Note:** Gainwell does not assist with or accept calls from members. Please direct all member questions to **Green Mountain Care** Member Services, 800.250.8427.

Provider Enrollment

Provider Enrollment facilitates the enrollment and revalidation of providers requesting to participate in the Vermont Medicaid Program. Representatives are available during regular business hours to answer written and verbal inquires; see Section 5, Provider Enrollment, Licensing & Certification.

Provider Call Center

Provider Call Center Agents are available to assist providers with program eligibility questions, provide service limitation information, claim inquiries and other information not available through the Voice Response System (VRS) or Vermont Medicaid website.

Gainwell provides claim and member information to enrolled Vermont Medicaid providers only; therefore, providers are required to state their provider number at the time of contact. The following information will be requested, when applicable:

- Member ID Number
- Internal Control Number (ICN)
- Date of Service
- Date of Remittance Advice (RA)

The Provider Call Center is authorized to verify eligibility only for up to 9 days from the date of inquiry.

Provider Relations Representatives

Provider Relations Representatives travel throughout the state to outreach and to assist with claims and/or billing issues and help with provider education. These representatives work to increase provider participation by speaking at professional association meetings, scheduling provider visits, and presenting at statewide workshops for Vermont Medicaid. Providers wishing to schedule a visit or identify the representative assigned to their area are directed to the Provider Representative Map.

Written Inquiries

To ensure accuracy and consistency, submit written inquiries on the Provider Inquiry Form. Send completed inquiries to:

Gainwell Technologies
Provider Services Unit, PO Box 888, Williston, Vermont 05495-0888

To expedite the handling of your request, complete boxes one through twelve of the Provider Inquiry Form and attach the appropriate documentation.

Note: Provider Inquiry Forms may not be used to:

- Resubmit corrected claims*
- Request an adjustment on a paid claim
- Check on the status of a claim

*Corrected claims should be sent directly to Gainwell with copies of all required attachments, when applicable. If there are no attachments, claims may be resubmitted electronically, see Section 3.1, Adjustment Requests, in the Vermont Medicaid General Billing and Forms Manual.

Claim Copy Requests

When a member or an attorney for a member requests a copy of a claim which has been paid, please inform them that copies should be requested in writing from:

DVHA - COB Unit
280 State Drive, NOB 1 South, Waterbury, VT 05671-1010

Provider Claim Modification Process

The DVHA allows Gainwell to conduct claim reviews based on any of the following:

Modifiers - Changes (additions and/or removals) to modifiers.

Units - Changes to previously listed units.

Place of Service or Diagnosis Codes - Changes to previously listed Place of Service codes or Diagnosis codes may be sent for review with appropriate claim form and any applicable supporting documentation.

Provider Type and Specialty - A provider would like a review of the services covered under their specialty scope of practice.

Requested modifications must be submitted on appropriate claim form with supporting documentation to Gainwell Technologies, PO Box 888, Williston, VT 05495-0888.

Provider Reconsideration Process

The DVHA allows an enrolled provider a process for requesting a review of certain claims payments. DVHA's position is that providing a "second look" for certain decisions may help improve accuracy. For a Timely Filing denial please refer to Section 3.3.4, Timely Filing Reconsideration, and 3.3.5 Timely Filing Reconsideration Requests, in the Vermont Medicaid General Billing and Forms Manual.

DVHA will review a decision for the following:

- Improper payments or non-payments - claims that paid differently than expected
- Coding errors - place of service, modifiers, diagnosis and provider type/specialty

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

The request for review must be filed on the Reconsideration Request form.

All issues regarding providers' objection to the findings must be documented. The request should provide a brief background of the case, and the reasons why the provider believes the DVHA should have ruled differently.

Requests will be reviewed by a qualified member of the DVHA when all information related to the claim is submitted. Upon receipt of the request and all supporting information, the DVHA will review all information received and make a determination. The qualified DVHA reviewer will issue a written decision to the provider of its review decision.

There is no additional review or reconsideration after the written decision on the review. This decision is final. All requests for review must be submitted electronically to VT-reconsiderations@gainwelltechnologies.com.

Section 2 Green Mountain Care

Green Mountain Care is the brand name for the family of publicly funded health coverage programs offered by the State of Vermont.

2.1 Vermont Medicaid for Children and Adults (MCA)

Vermont Medicaid programs for children and adults provide low-cost or free coverage for Vermonters who are eligible based on family size and household income - additional resources are not considered. Vermont Medicaid provides a broad benefit package that may include acute care, long-term care, dental, pharmacy and, if necessary, transportation to medical services.

Members enrolled in PC Plus managed care or the Accountable Care Organization (ACO) may be responsible for certain co-payments for services performed in an inpatient and outpatient hospital setting as well as for pharmacy and dental benefits (see Section 4.4, Member Cost Sharing/Co-pays and Premiums).

2.2 Vermont Medicaid for the Aged, Blind, and Disabled (MABD)

Vermont Medicaid programs for the aged, blind, and disabled provide low-cost or free coverage for Vermonters who are eligible based on family size and household income as well as additional resources that are considered.

2.3 Dr. Dynasaur (Children)

Dr. Dynasaur provides low-cost or free health coverage for children, teenagers under age 19 and pregnant women.

2.4 Children's Health Insurance Program (CHIP)

Serves uninsured children up to age 19 in families with incomes too high to qualify them for Vermont Medicaid.

2.5 Pharmacy Discount Programs

Prescription assistance programs help Vermonters pay for prescription medicines based on income, disability status and age. Pharmacy program requirements apply.

There is a monthly premium based on income, and co-pays based on the cost of the prescription; see Section 4.4, Member Cost Sharing/Co-pays and Premiums.

VPharm - VPharm assists Vermonters who are enrolled in Medicare Part D with paying for prescription medicines. This includes people age 65 and older as well as people of all ages with disabilities and includes an affordable monthly premium. After participants pay a $20 monthly premium, patient is responsible for $1 or $2, depending on the cost of the drug.

Healthy Vermonters - Allows Vermonters without other prescription insurance to purchase covered drugs at a discounted rate on both long-term and short-term prescriptions.

2.6 Medicare Savings Programs (MSP)

Qualified Medicare Beneficiary - A Qualified Medicare Beneficiary (QMB) is an aged, blind or disabled individual with income at or below 100% FPL who is eligible for Medicaid payment of their Medicare Part A and B premiums, deductibles and co-insurance.

Specified Low-Income Medicare Beneficiary - A Specified Low-Income Medicare Beneficiary (SLMB) is an aged, blind or disabled individual with income above 100% but below 120% FPL who is eligible for Medicaid payment of their Medicare Part B premiums.

Qualified Individual – A Qualified Individual (QI-1) is an aged, blind or disabled individual with income that is at least 120% but less than 135% FPL who is eligible for Medicaid payment of Medicare Part B premiums.

2.7 Primary Care Plus (PC PLUS)

The Vermont Medicaid program requires all members enrolled in Vermont Medicaid or Dr. Dynasaur as their primary health insurer, to enroll in the PC Plus program and to choose a primary care physician to provide and coordinate their health care.

See the Vermont Medicaid PCP Manual.

Section 3 Policies & Other Informational Resources

Advisory

The Department of Vermont Health Access Advisory is a bi-monthly publication of Gainwell and the DVHA. This newsletter provides important information which is necessary for accurate billing to Vermont Medicaid. Providers may retain copies of the Advisory and consult them whenever a question arises regarding DVHA policy or procedure or use the Advisory archive. To request electronic delivery, e-mail vtpubs-comm@gainwelltechnologies.com.

Vermont Medicaid Banner

The first page of the Remittance Advice (RA), the weekly report listing the status of each claim and any pertinent financial information, is referred to as the Vermont Medicaid Banner. Messages on the Vermont Medicaid Banner page keep providers informed of important changes in policy or billing procedures. The Vermont Medicaid Banner may be the only or first notification of a change in billing procedure. It is the provider's responsibility to obtain this information from their RA regarding DVHA policy or procedure. The Vermont Medicaid Banner is posted online weekly and is archived at the same online location.

The Vermont Medicaid Banner can be emailed directly to you when you join our communications email distribution list. Send your email address to vtpubs-comm@gainwelltechnologies.com to receive this provider resource and other communications relevant to Vermont Medicaid.

Claim Edit Standards

Vermont Medicaid adheres to the following edit standards:

- AMA, CPT, HCPCS and NCCI
- National Specialty Society Edit Standards
- Proprietary NCPDP-compliant pharmacy adjudication software provided through our Pharmacy Benefit Manager (PBM), Change Healthcare.
- Other appropriate nationally recognized edit standards, guidelines or conventions approved by the commissioner.

Correct Coding Practices

Providers are responsible for correct and accurate billing including proper use of coding as defined in the current manuals: AMA Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), Current Dental Terminology (CDT), the most recent International Classification of Diseases Clinical Modification (ICD-10-CM) and International Classification of Diseases Procedure Coding System (ICD-10-PCS).

Please refer to the most current coding manuals for full details on proper coding and complete documentation. If your practice utilizes a billing agent, it is still the practice's responsibility to make sure correct coding of claims is occurring.

National Correct Coding Initiative (NCCI) Guidelines

The Patient Protection and Affordable Care Act (PPACA) mandates that all claims submitted on or after October 1st, 2010, must be filed in accordance with the National Correct Coding initiative

(NCCI) guidelines. The NCCI was developed by CMS to promote the correct coding of health-care services by providers and to prevent improper payment when incorrect coding occurs.

For the Medicaid NCCI Policy Manual that contains the NCCI rules, relationships, and general information, Medicaid NCCI FAQs, and the complete edit files, please refer to The Medicaid National Correct Coding Initiative. Code combinations are refreshed quarterly.

In accordance with the National Correct Coding Initiative (NCCI), Vermont Medicaid has implemented pre-payment edits and applies NCCI guidelines for claims with a date of service on or after 10/01/2010.

The National Correct Coding Initiative (NCCI) contains two types of edits, they are:

- NCCI procedure-to-procedure (PTP) - edits that define pairs of Healthcare Common Procedure Coding System (HCPCS) / Current Procedural Terminology (CPT) codes that should not be reported together for a variety of reasons. The purpose of the PTP edits is to prevent improper payments when incorrect code combinations are reported.
- Medically Unlikely Edits (MUEs) - define for each HCPCS/CPT code the maximum units of service (UOS) that a provider would report under most circumstances for a single Member on a single date of service.

PTP Edits have been implemented and apply to all:

- Practitioners
- Ambulatory surgical center (ASC) services
- Outpatient services in hospitals (including emergency department, observation, and hospital laboratory services)
- Provider claims for durable medical equipment (DME)

MUE Edits have been implemented and apply to all:

- Practitioners
- Ambulatory surgical center (ASC) services
- Outpatient services in hospitals (including emergency department, observation, and hospital laboratory services)
- Provider claims for durable medical equipment (DME)

Each NCCI code pair edit is associated with a CMS policy as defined in the National Correct Coding Initiative Policy Manual. Effective dates apply to code pairs in NCCI and represent the date when CMS added the code pair combination to the NCCI edits. Code combinations are processed based on the effective date. Termination dates also apply to code pairs in NCCI. The date represents when CMS removed the code pair combination from the NCCI edits.

Please refer to Appendix B of the Medicaid National Correct Coding Initiative Edit Design Manual for explanations of the MUE rationales.

NCCI Reconsideration

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

For reconsideration instructions and for additional information about claims reconsideration refer to Section 1.2.10 Provider Reconsideration Process.

New, Revised and Deleted Codes

DVHA's Fee Schedule is updated on a monthly basis to reflect any code changes. It is the responsibility of the billing provider to refer to this schedule. (See Vermont Medicaid General Billing and Forms Manual, Section 4.6, Fee Schedule.) Codes are a National Standard and may be updated on a quarterly basis. Correct coding is the sole responsibility of the billing provider. DVHA is not authorized to give code selection guidance.

Correct Form Versions

The DVHA and Gainwell regularly updates its forms and applications to reflect current state and federal requirements. Providers are required to use the most current versions of all provider paperwork, including enrollment applications, adjustment forms and refund forms. Providers are encouraged to always use the most current forms on the Vermont Medicaid and DVHA websites.

Manuals for Providers

The Provider Manual, Dental Supplement, Durable Medical Equipment (DME) Supplement, Physical/Occupational/Speech Therapy (PT/OT/ST) Supplement and the Applied Behavior Analysis, Mental Health and Substance Abuse Services Supplement are available on the Vermont Medicaid website.

The 340B Medicaid Carve-In Manual and Amendments are located on the Vermont Medicaid website.

The Pharmacy Benefit Management Program Provider Manual is located under the Pharmacy section on the DVHA website. The Pharmacy Benefit Management Program is for prescription drugs dispensed by retail pharmacies.

DVHA clinical coverage guidelines for Durable Medical Equipment (DME), Laboratory and Radiology, Re/habilitative Therapies, J Codes, Intensive Social Support Services, and other services are located at Provider Resources and Clinical Programs.

Check monthly for manual revisions.

Medicaid Rule & State Plan Resources

Health Care Administrative Rules (HCAR), along with other DVHA rules, are located online at Rules and Statutes.

Providers must adhere to the requirements of administrative rules. Information contained in rule will not be repeated in the provider manuals.

Note: Per State statute, Vermont's Secretary of State is charged with publication of a bulletin of rules. As such, the Secretary of State is the official source for the most current and comprehensive rules for DVHA. DVHA is not responsible for reliance on regulations posted elsewhere should those rules be different than as posted on the Secretary of State website. An electronic copy of the rules maintained by the Secretary of State.

Remittance Advice

The Remittance Advice (RA) is a computer-generated report provided by the fiscal agent. The RA shows the status of all claims that have been submitted for processing along with claim(s) payment information. The RA is posted at Transactions→Login on a weekly basis. The banner page of the RA provides important information about policy and billing.

When a provider submits Vermont Medicaid claims via electronic claim submission (ECS) directly or through a clearinghouse or billing service, the Remittance Advice (RA) will be posted to the Vermont Medicaid Portal.

When a provider is not set up for ECS and is only submitting paper claims to Vermont Medicaid, the RA will be mailed weekly; however, if the provider switches to ECS, or requests the RA go to the web when establishing a Provider Web Services (PWS), the RA will be posted to the web and the RA mailing will stop.

When a provider has chosen to use the ECS, all RA information will be posted to the Web Portal regardless of whether the claims were submitted on paper, electronically or any combination thereof.

Provider payments are made at the end of the week on Friday. The system retains the eight most recent Web RAs. When a ninth RA is posted to the Web Portal, the oldest dated RA will drop off the system. Once an RA drops off the system, it cannot be reposted; therefore, it is highly recommended that RA copies are saved/printed for future reference.

The Web RA can be accessed via two different account types a Trading Partner account, and a Provider Web Services (PWS) account.

1. Go to Vermont Medicaid Portal
2. Click on Transactions→Login
3. Use the Account ID and password to Logon
4. Click on Secure Options
5. Select View RA Files
6. Pick the Provider Number from the drop down (if you have more than one)
7. Click Go
8. Click on the appropriate pdf
9. Click Open (this should display the RA on the screen)

For questions about an existing account, creating an account, or accessing the Web RA, please contact the EDI Coordinator at 800.925.1706, Option 3, or email at vtedicoordinator@gainwelltechnologies.com.

Providers with questions about their RA's content may contact the Gainwell Provider Call Center at 800.925.1706.

The 835 Transaction (Electronic Remittance Advice)

Vermont Medicaid posts the 835 weekly, to the web portal for Trading Partners who have elected the 835 transaction. The 835 is a pull from the website (i.e., must be downloaded). There is no restriction on the number of times the 835 can be downloaded and it is available until it rolls off the system; at a minimum, it is available for at least one month from the posting date.

Normal processing has financial cycle running on a Friday with the 835 posting late the following Monday or Tuesday. The requirement for the 835 posting is +/- (plus or minus) 3 days from the EFT effective date (always the Thursday following a financial cycle). In the event the 835 will be delayed past the required Sunday posting date, a banner will be placed on the web site referencing the delay, and if known, the cause and the expected posting time and date.

If your 835 is missing after Sunday (EFT+3), and no banner has been posted stating its release is delayed, please contact the EDI Coordinator at 800.925.1706, Option 3, or email vtedicoordinator@gainwelltechnologies.com. Include your Trading Partner ID and the week you are referencing.

Section 4 Member Information

Eligibility

"Member" is the term used to refer to a person who has been determined eligible for and enrolled in one of the Vermont health insurance programs. Healthcare eligibility is determined by DVHA's HAEEU, the DVHA Long Term Care (LTC) unit or DVHA Coordination of Benefits (COB) Unit, based on a review of the applicant's needs, income and resources. The various Vermont health insurance programs have differing eligibility requirements and benefits. Effective January 1, 2014, individuals who are 65 or older, blind or are disabled and not yet entitled to or don't have Vermont Medicaid must apply for health care benefits through Vermont Health Connect at or by calling 855.899.9600.

The eligibility system assigns each member a unique identification (UID) number. Each member receives a **Green Mountain Care** member card imprinted with their name and UID. The UID number will be 1 to 8 digits in length and must be entered on the claim exactly as it is shown on the member's card.

When submitting an electronic claim for member with a one-digit Unique ID Number insert a zero in front of the single digit UID (04, 05, 06 and etc.); to allow the claim to be accepted. This instruction does not apply to paper claims.

Providers must verify the patient's health care eligibility and other insurance information using the patient's Vermont Medicaid UID number by accessing either of the automated eligibility verification systems.

Partial Eligibility

Providers can compliantly bill the correct monthly code that meets the definition of the actual services provided in a month for members who have partial eligibly in that month. However, providers may only bill the dates-of-service during the time frame in which the member is actively eligible for Vermont Medicaid.

Eligibility Verification

The **Green Mountain Care** Eligibility Verification System (EVS) provides member information to participating health care providers. There are two components of the EVS that are described in this manual.

Voice Response System (VRS), 1.800.925.1706, option 1;
-or-
Go to Vermont Medicaid Portal

- Click on Transactions→Login.

If for any reason you are unable to use either method, you may call the Gainwell Provider Call Center at 800.925.1706.

The EVS delivers a response that is clear to the user and appropriate for the method of access used in making the inquiry. The DVHA encourages all providers to take full advantage of this

system to verify a patient's eligibility status before services are rendered. This system offers the following functionality:

- Available 24 hours a day, seven days a week (except for routine maintenance)
- Responds with rapid verification information
- Substantially minimizes the risk of non-payment for services rendered to ineligible patients
- Decreases the number of claim resubmissions due to inaccurate eligibility information

Providers should complete all VRS or website transactions to be sure that all the pertinent information is captured. Compare the aid category given on the VRS or web site to the aid category listing in this manual (Section 14), in order to determine the program in which the member is enrolled. This will assist you in determining covered services and co-payment requirements where applicable. Providers may verify member eligibility for dates, up to one year retroactively. The accuracy of the response is reliable for up to nine days beyond the "current" date.

Providers should retain the authorization number issued by the system to assure that the information received can be verified by the system. The number is not a guarantee of payment. The member must be eligible on the date of service and the services provided must be medically necessary and covered.

In addition to eligibility verification, providers can receive other insurance information and determine if service limits are approaching or have been reached. Providers can also confirm the amount to be paid in the next RA, if that amount is zero, or the amount and date of the last payment given.

All provider calls to Gainwell are routed through the VRS. Spoken prompts will direct you on how to access the service/information you require. Contact the Gainwell Provider Services Unit for information that is not available through VRS or the Vermont Medicaid Portal.

At the beginning of each call users are asked to enter their Vermont Medicaid provider number followed by their PIN number. The provider number and PIN number are a security measure to ensure the user is authorized to access the requested information. If the provider or PIN numbers entered are not valid or current, access will be blocked.

To expedite the process, please have the following information ready when placing a call to the VRS:

- Provider number
- Provider PIN number
- Member identification number
- Dates of service

Transactions are limited to ten (10) per call (example: five eligibility and five service limits)

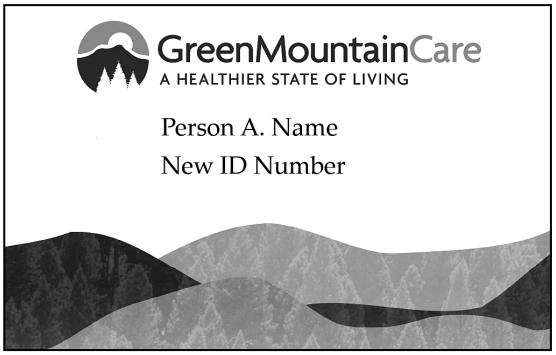
Providers using the VRS have access to the following data:

- Eligibility Verification
- Date-specific eligibility
- Third party liability information (up to five segments)
- Member lock-in data for providers and pharmacy
- Date of birth
- Co-pay indication
- Service Limitations when exhausted
- Office visit limitations
- Visual refractions
- Visual glasses
- Adult dental benefits (dollars spent)
- Last dental oral exam
- Chiropractic visits
- Current RA check amount
- Carrier Codes

Carrier codes are two or three-digit codes that identify other insurance carriers. They are required on all claims involving members who have other insurance policies. These codes, like all other insurance information, can be obtained by verifying eligibility via the Voice Response System (VRS) or Transaction Services on the Vermont Medicaid website. Also, the most frequently used codes are available on the Vermont Medicaid Portal.

Identification

A **Green Mountain Care** identification card is issued to each member enrolled in a Vermont Medicaid program. Members must present their card for any covered service. Because the card is not surrendered when eligibility stops, providers must verify eligibility each time a medical service is delivered to be certain the member is eligible on the date the service is provided. The system knows of each termination of benefits nine days prior to the effective date. Verification can be made up to nine days in advance of the appointment. Note: there are only room for 25 characters on the **Green Mountain Care** card for the member's name, so some names will not be completely printed.



Member Bill of Rights

As a member of a Vermont health care program, an individual member has the right to:

- Be treated with respect and courtesy
- Be treated with thoughtfulness for his or her dignity and privacy
- Choose and change providers
- Get facts about program services and providers
- Get complete, current information about his or her health in understandable terms
- Be involved in decisions about his or her health care, including having questions answered and having the right to refuse treatment
- Ask for and get a copy of his or her medical records and ask for changes to be made to them when he or she believes the information is wrong
- Get a second opinion from a qualified provider who is enrolled in Vermont Medicaid
- Complain about the program or his or her health care
- Be free from any form of restraint or isolation used as a means of bullying, discipline, convenience, or retaliation
- Ask for a reconsideration if services are denied that he or she thinks are needed
- Members have the right to look at their medical records, and to obtain copies of the records. A reasonable fee may be charged to cover making copies and postage. An office may not charge for copies of records needed to support a claim or a reconsideration or copying of medical records for the purpose of supplying them to another health care provider.

Member Cost Sharing/Co-pays and Premiums

See Health Care Administrative Rule 6.100 Medicaid Cost Sharing for additional copayment and exception details. Information contained in rule will not be repeated in the provider manual.

Certain members must participate in the cost of care for services.

Exceptions to Co-Payments

1. An individual residing in a participating long-term care facility (nursing home). Gainwell has this information on file and will not deduct the co-payment from the amount paid to the provider.
2. Pregnant women and through the end of the calendar month during which the 60th day following the end of pregnancy occurs. Gainwell does not have this information on file. When submitting claim forms for payment, you must indicate pregnancy and 60-day post pregnancy by adding the “HD” modifier to the end of each procedure code. The “HD” modifier must be used for all procedures. For example, when submitting for a periodic oral evaluation, use procedure code D0120HD.
3. An individual who is under 21 years of age and considered a child by the Department of Vermont Health Access.
4. Members who are eligible for Medicaid coverage under the Breast and Cervical Cancer Treatment Program.

Copayments are not required for family planning services and supplies, preventive services, emergency services (includes dental services covered by a GA Voucher), and durable medical equipment (DME) and medical supplies.

Although some members are required to make co-payments under Vermont Medicaid, if the member is unable to make the payment, Vermont Medicaid providers may not deny services. Per section 1916(c) of the Social Security Act, "no provider participating under the State [Medicaid] plan may deny care of services to an individual eligible for [Medicaid] on account of such individual's inability to pay [the copayment]."

Vermont Medicaid Co-Pays

Vermont Medicaid co-pay amounts can be found in Health Care Administrative Rule 6.100 Medicaid Cost Sharing.

VPharm Pharmacy

Aid Categories VD, VE, VF, VG, VH, VI, VJ, VK, VL, VM, VN & VO:

- $1.00 - Co-pays for prescriptions less than $30.00
- $2.00 - Prescriptions $30.00 or more

VPharm covers drug classes that are excluded from the Part D benefit.

Medicare Crossover Coverage: For members with category codes VG, VH, VI.

Vision Coverage: For members with category codes VG, VD, VJ & VM.

Healthy Vermonter’s Program: VP - Offers access to drugs at a discounted price, which is the Vermont Medicaid rate for prescription drugs.

Qualified Medicaid Beneficiary (QMB)

A QMB’s only benefit is Medicare cost sharing coverage. They are not considered dual-eligible.

- PQ – Pure QMB

- VG – %150 VPharm and QMB
- VH – %175 VPharm and QMB
- VI – %225 VPharm and QMB

Notice of Decision

The Department of Vermont Health Access (DVHA) notifies members in writing of its decisions made regarding health care eligibility, retroactive eligibility, spend-down requirements, prior authorization request determinations, and other determinations of status or program changes. These letters are called “Notice of Decision” on eligibility issues and “Notice of Adverse Benefit Determination” on services issues. The notices are issued by the DVHA Clinical Unit, HAEEU, LTC Unit or the COB Unit. A copy of the Notice of Decision is a required attachment for certain claims involving spend-down and retroactive eligibility.

Court Ordered Services

If a member is mandated by a court to seek a service, the service may be covered if it meets the medical necessity and Vermont Medicaid guidelines.

Retroactive Eligibility

Vermont Medicaid eligibility is occasionally granted retroactively. The provider may bill for services rendered during the retroactive period. A “Notice of Decision” indicating the date of retroactive eligibility must accompany the claim to waive the timely filing limit; see Section 3.2.1, Timely Filing Reconsideration Requests, in the Vermont Medicaid General Billing and Forms Manual.

Member Grievance Process

A member, or a member’s provider or authorized representative, may file a Grievance by calling Customer Support at 800.250.8427 at any time. A member who filed a Grievance and is not satisfied with the results may ask for a Grievance Review by a neutral person to ensure that the grievance process was handled fairly. The Medicaid Program will ensure that no punitive action is taken against a member or provider who files a grievance or an appeal. The member may also call the Office of Health Care Advocate at 800.917.7787 for free assistance. Full details on the grievance process can be found at Health Care Administrative Rule 8.100.8 – Member Grievances.

Member Internal Appeals & State Fair Hearings on Medicaid Services

Members, or a member’s provider or authorized representative with the member’s written permission, may appeal if they disagree with a Notice of Adverse Benefit Determination on Medicaid services. An appeal must be filed within 60 days of the mailing of the Notice of Adverse Benefit Determination. In most cases, a member must exhaust the internal appeal process before going to a State fair hearing. The provider or member may request an expedited appeal if waiting on a regular appeal (which can take 30 days) might seriously jeopardize the member’s health. A member who filed an internal appeal and is not satisfied with the results may request a State fair hearing. The member may call the Office of Health Care Advocate at 800.917.7787 for free assistance. Members may request for the reduced or terminated benefits to continue from the time an appeal is filed or a State fair hearing is requested. The member may, consistent with state

policy, be required to pay the cost of service provided while the appeal or state fair hearing is pending if the final decision is adverse to the member.

To request an internal appeal, call Customer Support at 800.250.8427 or write to:

Department of Vermont Health Access
Health Care Appeals Team
280 State Drive, NOB 1 South, Waterbury, Vermont 05671-1010

For detailed information about appeals, see Health Care Administrative Rule 8.100 – Internal Appeals, Grievances, Notices, and State Fair Hearings on Medicaid Services.

Members with a qualified health plan (QHP) or an employer sponsored insurance plan may call the Customer Service number listed on the back of their ID card to obtain information on appealing a decision made by that plan or may contact the Department of Financial Regulation.

Advanced Directives

Hospitals, nursing homes, home health agencies, hospices and prepaid health care organizations are required to provide certain patients with information about their right to formulate advance directives and maintain written policies and procedures with respect to advance directives. They are also required to document in patients' files whether or not an advance directive is in effect, provide education for staff and the community on issues concerning advance directives, and ensure compliance with State law on advanced directives at their facilities. Providers are responsible to guard the confidentiality of member information in a manner consistent with the confidentiality requirements in 45 CFR parts 160 and 164 and as required by state law.

Providers can obtain Advance Directive (AD) forms and additional information on AD from the Vermont Ethics Network website or by mailing your request to:

Vermont Ethics Network
61 Elm Street, Montpelier, Vermont 05602

Section 5 Provider Enrollment, Licensing & Certification

Online Provider Management Module

With our online Provider Management Module, enrolling in Vermont Medicaid is fast and efficient. You are no longer required to submit paper application forms and supporting documentation. This can all be done online, tailored to your provider type, streamlining the process. This online process decreases the time you spend on filling out forms as well as decreasing the overall processing time of your application. To learn more about Vermont Medicaid's online **Provider Management Module**, please visit Provider Management Module Training.

Enrollment & Certification

In order to participate in and receive reimbursement from Vermont Medicaid Programs, providers must be enrolled. Licensed or certified health care providers may be enrolled as Vermont Medicaid providers if at least one service they provide is recognized in the Vermont Medicaid State Plan. Any health care provider who is interested in becoming enrolled in the Vermont Medicaid program should contact the Gainwell Provider Enrollment Unit. Enrollment requires that the provider submit applicable enrollment forms, a signed General Provider Agreement and a copy of the applicable license/certification document and meet all federal and state requirements. When the DVHA accepts an applicant, a Vermont Medicaid provider ID number will be issued, and a confirmation of enrollment letter will be sent. Payments will not be made until a provider number has been assigned.

Enrollment may Include the Following

Full enrollment is for participating providers who are in-state and out-of-state in network as well providers that are determined by DVHA to contribute to the **Green Mountain Care** network and see Vermont Medicaid Members on a regular basis.

Ordering, Prescribing, Referring and Attending providers and Residents, whether the physician or practitioner who actually performs the services for the patient or the referring or prescribing provider, must be enrolled as a participating Vermont Medicaid provider.

Court ordered enrollment is for providers whose services have been ordered by a court, a fair hearing decision or by a Coverage Exception. Court ordered providers would only be enrolled for dates consistent with the order/decision.

Note: Non-participating enrollment is no longer accepted.

Difference between Enrollment, Re-Enrollment and Revalidation

- **Enrollment** is for providers that have never previously enrolled with **Green Mountain Care**
- **Re-Enrollment** is for providers that have previously enrolled and their eligibility has lapsed
- **Revalidation** is for providers that have previously enrolled and who revalidate within the 90-day notification period

All providers interested in applying for enrollment, or need to Re-Enroll or Revalidate their eligibility, please visit Provider Management Module.

Enrollment will be rejected if:

- Mandatory information is not received
- The provider is disbarred or sanctioned from participation in federal programs
- The provider is disbarred or sanctioned by the State of Vermont

Clinical Laboratory Improvement Amendments (CLIA)

Providers that provide laboratory services are required to include a current copy of their CLIA certification at time of enrollment, re-enrollment or revalidation.

Enrollment Agreement Signatures

All signatures must be original and signed in ink. Applications with signatures deemed not original will not be processed. Stamped, faxed or copied signatures will not be accepted.

Payment Conditions

Providers are entitled to payment for diagnostic, therapeutic, rehabilitative or palliative services when all of the following conditions are met:

- The provider is enrolled with Vermont Medicaid
- The services are covered by the applicable program
- The services are medically necessary
- The services are within the scope of the provider's license
- The services are documented in the patient's medical records
- Prior approval, if required, has been obtained
- The claim is submitted within the timely filing limits and contains all required information
- The provider complies with the Advance Directives Law
- The member is eligible on the date of service
- Billing may not be done in advance of any service to be performed or supplied

Documentation of Services

Each provider must keep written documentation for all medical services, actual case record notes for any services performed, or business records that pertain to members for services provided and payments claimed or received. **Providers must document all services provided on the same day of the encounter or within a reasonable time. In this section, "a reasonable time" means within one week of providing the service, unless extenuating circumstances prevent the provider from documenting a service within that time. If extenuating circumstances prevent a provider from documenting a service within one week of providing the service, the provider must also document those extenuating circumstances.** All documentation must be legible, contain complete and adequate information and applicable dates.

At minimum, documentation must include:

- Two patient identifiers

- Provider rendering services
- Provider signature, printed name & date

Providers should reference supplemental manuals as needed.

Rights & Responsibilities

Participation in Vermont Medicaid is voluntary. Participating health care providers:

- May not discriminate on the basis of race, color, sexual orientation, or national origin
- May not treat a Vermont Medicaid member any differently than a patient with other payer sources
- May not refuse service to a Vermont Medicaid member simply because the member is covered by other health insurance
- Must meet commonly accepted standards of professional practice.
- Must submit claims and required documentation in a form acceptable to the State of Vermont
- Must ensure that claims are received within the timely filing limits
- May not bill Vermont Medicaid or member any fee for missing a scheduled appointment per Federal Medicaid policy
- Adhere to other applicable federal and State of Vermont laws, rules and procedures

Termination

Providers who no longer wish to participate in the Vermont Medicaid Program are required to notify DVHA of their intent to terminate their enrollment. This may be done at any time by either writing a letter to Gainwell or by completing and submitting the Vermont Medicaid Termination form. If requested, the provider's enrollment will be closed on the date specified. Providers are required to give their patients 30-day notice prior to termination. Primary care providers in PC Plus are required to give 90-day notice before termination of the PC Plus agreement.

Overview & Federal Requirements

Affordable Care Act

In accordance with Section 6401 of the Affordable Care Act of 2010 (ACA), all enrolled and newly enrolling providers will be subject to federal screening requirements. State Medicaid Agency requirements are available for review here.

Provider Screening, Risk Categories & Change in Risk Level

In accordance with Title 42 Code of Federal Regulations (CFR) §§ 455.410 and 455.450, all participating providers must undergo screening upon initial enrollment and during revalidation. The Department of Vermont Health Access (DVHA) categorizes health care providers based on screening levels established by the Centers for Medicare & Medicaid Services (CMS). The screening levels of Limited, Moderate, and High, are determined by the assessed risk of fraud, waste, and abuse associated with each provider or supplier type. DVHA reserves the right to

reassign a provider's risk level at any time. If DVHA reassigns a provider's risk level, then the new risk level designation will apply to the provider in subsequent enrollment-related transactions.

Risk Level Screening Requirements

1. **Limited Risk Providers/Suppliers**
   Providers in the limited risk category are subject to verification that they meet all applicable federal and state requirements relevant to their provider or supplier type.
2. **Moderate Risk Providers/Suppliers**
   In addition to the screening requirements for limited risk, moderate risk providers are also subject to on-site visits conducted by DVHA.
3. **High Risk Providers/Suppliers**
   High risk providers must comply with both limited and moderate risk screening requirements. Additionally, they must undergo a fingerprint-based criminal background check.

Site Visit Requirements

For providers in the Moderate and High-risk categories, DVHA may conduct either an on-site or virtual site visit as required under 42 CFR § 455.432. Site visits may be coordinated with other activities provided that the screening and enrollment verification activities are documented separately and the decision to combine the visits is made before the site visit occurs. DVHA may rely on site visits conducted for enrollment and screening purposes by:

- Medicare,
- Another State Medicaid Authority, or
- Another department within the Vermont Agency of Human Services.

For further information regarding Vermont Medicaid's provider enrollment requirements, please visit Provider Enrollment and Data Maintenance Forms.

Retroactive Enrollment Effective Dates

Up to 90-Day Requested Retroactive Effective Dates – Submitted on the Enrollment Application

Effective June 1, 2026, Vermont Medicaid (DVHA) permits retroactive enrollment effective dates for billing purposes for up to 90 days prior to the date a complete new enrollment or re-enrollment application is received and accepted in the Provider Management Module (PMM) by Gainwell Technologies. A separate Retroactive Enrollment Request Form is not required for this 90-day period.

Providers must enter the requested retroactive effective date within the Requested Effective Date field of the PMM enrollment application. All required screenings, credentials, and supporting documentation must fully cover the entire retroactive period in order for the request to be considered.

Beyond 90 Days and Up to 180 Days – Submitted After Enrollment Approval

For retroactive effective date requests beyond 90 days—and up to 180 days prior to the new enrollment effective date—actively enrolled Vermont Medicaid providers may submit a Retroactive Enrollment Request Form to Gainwell Technologies. This form must be submitted within 90 days of the approval date of the initial enrollment application.

Gainwell will verify that the requested retroactive date falls within the allowable timeframe and was submitted on time as outlined in the request form. Requests meeting the criteria will be forwarded to DVHA for review. Requests submitted outside the applicable policy window may be denied.

DVHA will review the Retroactive Enrollment Request Form and issue a determination based on policy criteria outlined in the form. If the supporting rationale does not meet policy requirements and the 90- to 180-day request is denied, DVHA may consider a 90-day retroactive effective date as a final option, if such a request was not already submitted at the time of initial enrollment.

Approval of a retroactive enrollment effective date does not guarantee payment for services rendered during the retroactive period. All claims submitted for that period must meet Vermont Medicaid's timely filing standards and comply with all applicable billing and coverage requirements.

Section 6 Special Investigations Unit

Fraud

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

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.

Private Litigation

Private litigation refers to any legal proceeding which does not involve the United States government, or any department or agency of the U.S. government, as a party.

Providers are asked to notify Vermont Medicaid if they receive any information regarding private litigation in which the DVHA may have an interest. These private litigations might include malpractice suits involving Vermont Medicaid members, accident suits or personal injury suits.

Sanctions

The DVHA may take administrative action against providers found in violation of Vermont Medicaid policy. See section 7106 of the Medicaid Rules for regulatory details pertaining to sanctions and appeals. A copy of Medicaid Rules is posted at Rules and Statutes and at each DCF District Office and at the state library in Montpelier.

Special Investigations Unit Reconsideration & Appeal Process

The Department of Vermont Health Access (DVHA), Special Investigations Unit offers a Reconsideration and Appeal process for improper payments and the recovery of overpayments.

Reconsideration of Improper Payment & Recovery of Overpayments

A provider who receives a letter notifying of an overpayment determination has the option to request reconsideration by the Special Investigations Unit.

A. The request must be made within thirty (30) calendar days of the receipt of the letter from DVHA.

B. All issues regarding the providers' objection to the findings must be documented and no monetary threshold is applied. Failure to do so will result in reconsideration request being waived.

C. The reconsideration review will be conducted by a qualified person within the Special Investigations Unit of DVHA.

D. DVHA has 60 calendar days to respond following the later of:

   1. Receipt of reconsideration request.
   2. The date of a meeting with the provider, if one is scheduled.
   3. The date additional information is received from the provider (if requested by DVHA).

E. During the reconsideration process, the provider may request in writing an additional 14 days to respond to a request by DVHA.

F. In some circumstances, DVHA may notify the provider that an additional 14-day extension is invoked.

G. After review and reconsideration, DVHA will send the provider a final letter regarding its determination. DVHA may send a decision in the event the provider does not reply to a document request in a timely manner, or in the case a request for reconsideration is not filed in a timely manner.

A provider who is dissatisfied with the result of the reconsideration decision may follow the process to submit a Special Investigations Unit appeal.

Special Investigations Unit Appeal of Improper Payment & Overpayment Deficient Practice

In order to initiate a Special Investigations Unit appeal, the following process needs to occur:

1. A Special Investigations Unit appeal must be filed within 30 days of the reconsideration decision. To file a Special Investigations Unit appeal, a provider must complete the Request for Appeal of a reconsideration decision by Special Investigations Unit located at Notice of Appeal Form.
2. The provider is required to list all objections to the reconsideration decision notice at the time of the Special Investigations Unit appeal, otherwise claims are waived.
3. Special Investigations Unit appeals will be divided into two categories:
   - **Overpayments of $15,000 or Less:** Cases in which a reconsideration decision was issued regarding an overpayment of $15,000 or less will be reviewed the Chief Medical Officer (CMO) or designee. At the discretion of the CMO or designee, written instructions will be issued to the provider explaining the process or providing for a meeting with the provider. If a meeting is scheduled, it shall occur within 90 days from the date of the receipt of the appeal.
   - **Overpayment of more than $15,000:** Cases in which a reconsideration decision was issued regarding an overpayment of $15,000 or more will be reviewed by the DVHA Commissioner or designee, who may convene a hearing to be scheduled within 90 days

from the date of the receipt of the appeal. Appeal hearings shall be conducted under the same rules of conduct as in current use for hearings for the Human Services Board.

4. Within 14 days of either a meeting by the Chief Medical Officer or designee, or an appeal hearing by the Commissioner or their designee, the following will be mailed to the provider:
    - A written request for additional information to include a timeframe in which the information is to be provided by or an additional meeting to discuss, or
    - A decision letter. The decision letter will indicate the next level of appeal, as indicated below, should the provider be dissatisfied with the decision.
5. If the option for a meeting or an appeal hearing is not exercised, then the CMO, Commissioner or their designee will have 90 days from the date of the receipt of the appeal to request additional documentation. The CMO, Commissioner or designee shall include in their request for additional documentation a reasonable timeframe for the documentation to be submitted.
6. If the documentation is not submitted within the timeframe, the CMO or Commissioner may proceed with a decision without that information.
7. Within 14 days of the receipt of documentation a decision letter will be mailed to the provider unless, due to the volume of documentation, more time is needed. The decision letter will indicate the next level of appeal, as indicated below, should the provider be dissatisfied with the decision.
8. No money is collected from the provider or offset against claims until a final decision has been rendered on the Special Investigations Unit appeal.
9. Upon receipt of a Special Investigations Unit appeal decision letter, DVHA may demand payment from the provider or offset the overpayment determination from pending claims. The provider may request a payment plan from DVHA in order to reconcile the overpayment.

Interest

Providers who did not request reconsideration or appeal will have one year, from date of the overpayment determination becoming final, before interest will begin to accrue. Interest will begin to accrue, on any amount that remains unpaid, one year after the determination became final.

Providers who go through the Special Investigations Unit appeal process must return any overpayment within 90 days of the final appeal decision. Interest will begin to accrue 90 days after the final appeal decision, on any amount that remains unpaid.

The rate of interest on overpayments will be the lower of (i) the rate as fixed by the Federal Reserve Prime Rate or (ii) twelve percent.

Special Investigations Unit appeal decisions are final. Disagreement with the decision has the option to file a civil action in Superior Court.

Submit Appeal Request and Forms to:

Special Investigations Unit Appeals
NOB 1 South, 280 State Drive, Waterbury, VT 05671-1010

Extrapolated Overpayments

The Special Investigations Unit (SIU) is responsible for all Medicaid fraud, waste & abuse monitoring activities that may include an extrapolation from a random sampling of claims submitted by a provider and paid by DVHA. In any action to recover overpayments, the SIU may ascertain the amount of the overpayments based on a statistically valid random sample (SVRS) applied to a sample drawn from the total number of claims paid to a provider during a given period and extrapolating the results of the review over the entire period. SIU employs statistically valid techniques in establishing the size and distribution of the sample to ensure that it is a valid representative sample.

Special Investigations Appeal of Improper Payments via Extrapolation

To initiate a Special Investigations Extrapolation Appeal, the following process needs to occur:

1. A Special Investigations appeal must be filed within 30 days of the mailing date of the letter notifying the provider of the finding of improper payments. To file a Special Investigations appeal, a provider must complete the Request for Appeal.
2. As part of the appeal a provider may conduct a self-review of claims involved in the universe. The provider will have 60 days after submitting the appeal notification to complete review of the claims. The provider may engage a 3rd party to review the claims. If a provider engages a third party to review claims, notice must be provided to DVHA identifying the 3rd party. A provider will have 30 days from the filing of the appeal to establish a relationship with a 3rd party reviewer. Any extrapolation must follow statistical principals as defined in Section 8.4.3 of the Medicare Program Integrity Manual for sample selection and must mirror the same error threshold, confidence interval and sample size as the State's extrapolation process.
    a. Special Investigations Unit appeals will be reviewed by the DVHA Commissioner or designee. The DVHA Commissioner or designee may provide written instructions to the provider explaining the process or convene a hearing to be scheduled within 90 days from the date of the receipt of the appeal. Appeal hearings shall be conducted under the same rules of conduct as in current use for hearings for the Human Services Board.
    b. If the DVHA Commissioner or the designee determines a hearing is not necessary, a determination may be based on a review of the documents provided. In either instance the Commissioner or designee may request additional information to assist in making the determination.
    c. Within 14 days of the appeal hearing, or review of documents provided, the following will be mailed to the provider:
        i. A written request for additional information or an additional meeting to discuss, or;

ii. A decision letter. The decision letter will indicate the next level of appeal, as indicated below, should the provider be dissatisfied with the decision.

3. No money is collected from the provider or offset against claims until a final decision has been rendered on the Special Investigations Unit appeal.
4. Upon receipt of a Special Investigations Unit appeal decision letter, DVHA may demand payment from the provider or offset the overpayment determination from pending claims. The provider may request a payment plan from DVHA to reconcile the overpayment.

Special Investigations Unit appeal decisions are final. Providers in disagreement with the decision have the option to file a civil action in Superior Court.

Provider Under a Repayment Agreement

Interest

Providers who are under the repayment agreement must pay the full overpayment within 12 months (1 year) from the date the agreement is signed. Interest will begin to accrue on any amount that remains unpaid 1 year after the provider entered into the agreement. The rate of interest on overpayments will be the lower of the interest rate as fixed by the Federal Reserve Prime Rate or 12 percent.

Final Overpayments (Current Language on Final Overpayment Notices)

Providers who did not request reconsideration or appeal will have one year, from date of the overpayment determination becoming final, before interest will begin to accrue. Interest will begin to accrue on any amount that remains unpaid, one year after the determination became final.

Providers who go through the Special Investigations Unit appeal process must return any overpayment within 90 days of the final appeal decision. Interest will begin to accrue 90 days after the final appeal decision, on any amount that remains unpaid.

The rate of interest on overpayments will be the lower of (i) the rate as fixed by the Federal Reserve Prime Rate or (ii) twelve percent.

Section 7 Other Provider Information

Provider Tax

State law requires payments, according to a schedule established by The Department of Vermont Health Access (DVHA). If a health care provider fails to pay its assessments, the commissioner may, after notice and opportunity for hearing, deduct these assessments arrears and any late-payment penalties from Vermont Medicaid payments otherwise due the provider pursuant to 33 V.S.A 1952(f).

The DVHA Commissioner retains the authority to adopt an alternative payment schedule for your organization for good cause shown. If for some reason your financial position demands an alternative payment schedule, you must seek and gain approval from the Commissioner in advance of the due date.

Contact the Reimbursement Administrator if you have questions at 802.879.5937.

Your payments should be mailed to:
Lockbox
State of Vermont State Agency of Human Services Supplemental/Tax Assessment
PO Box 1335
Williston, VT 05495-0888

Pharmacy Tax

A monthly assessment is due to the State of Vermont for each prescription filled or refill sold by retail pharmacies. This applies to all scripts, and not only to Vermont Medicaid scripts. The amount of the assessment is $0.10 for each prescription filled or refill. The completed Pharmacy Assessment Monthly Documentation Form, along with additional information regarding the tax, needs to accompany each monthly payment. Chain pharmacies with more than one NPI number should complete a separate form for each facility every month.

Section 8 Face-to-Face Requirements

Home Health Face-to-Face Requirements

The Agency of Human Services (AHS) requires providers enrolled in Vermont Medicaid to document that a face-to-face encounter occurred for the initial ordering of home health services.

Additional face-to-face visit requirements can be found in Health Care Administrative Rule 4.231 Home Health Services.

Durable Medical Equipment Face-to-Face Requirements

The Agency of Human Services (AHS) requires providers to document that a face-to-face encounter occurred for the initial ordering of specified durable medical equipment and supplies. This requirement only applies to durable medical equipment, supplies, and services that are also covered by Medicare as found at DME List of Specified Covered Items.

Face-to-face Requirement also includes power wheelchairs.

Additional face-to-face visit requirements can be found in Health Care Administrative Rule 4.209 DME.

Section 9 Glossary of Terms & Phrases

Actual Charge
The dollar amount charged for each medical service or item to patients before discounts, contractual allowances or similar reductions.

Administrative Agent
The financial institution that acts as the agent that processes and pays provider claims on behalf of the department.

Advance Directives Law
An advance directive is a legal document that allows individuals to give instructions for a broad range of health care decisions and appoint an agent to make those decisions if they become unable or unwilling to do so. It may also be known as a Living Will or Durable Power of Attorney for Health Care. Federal law requires hospitals, nursing facilities, home health agencies, hospices and prepaid health care organizations to provide patients with information regarding advance directives. Vermont Advance Directive Registry (VADR) is a secure database service that stores a scanned copy of an advance directive electronically so that it can be found immediately by any hospital or doctor in an emergency. Information on advance directives is available from the Vermont Ethics Networks or the Health Department at 800.548.9455 or Advance Directives.

Agent
Any person who has been delegated the authority to obligate or act on behalf of the provider.

AIDS Medication Assistance Program
A specific program designed to assist HIV positive individuals with AIDS pharmaceutical costs.

Affiliate(s)
Person(s) having an overt or covert relationship such that any one of them directly or indirectly controls or has the power to control another.

Assignment
The term used where a member assigns right to compensation to a provider. Providers must accept as payment in full the program's payment and may not "balance bill" or charge the member any additional amount, other than nominal cost-sharing amounts the benefit program may impose for certain services.

Audit
A computer-based or manual comparison of each claim to the member's claims history.

Billing/Supplying Provider
The billing/supplying provider name, address and provider number that payment will be made to must appear in the appropriate field of the claim form. The billing/supplying provider information must appear identical to the format in which the billing/supplying provider enrolled with Vermont Medicaid. Individual billing provider names must read last name, first name.

When billing on the CMS-1500 claim form, the billing provider NPI# is entered in field 33.

The 2019 dental claim form requires the NPI # to be listed in field locator 49.

Center for Medicare and Medicaid Services (CMS)
The agency in the Department of Health and Human Services responsible for administering the Medicaid, State Children's Health Insurance, and Medicare programs at the federal level program. Formerly known as HCFA.

Children's Health Insurance Program (CHIP)
Enacted in the 1997 Balanced Budget Act of Title XXI of the Social Security Act, CHIP is a federal-state matching program of health care coverage for uninsured low-income children.

Closed-End Vermont Medicaid Provider Agreement
An agreement that is for a specified period of time not to exceed twelve months.

Co-Payment
A fixed dollar amount paid by a Vermont Medicaid member at the time of receiving a covered service from an enrolled provider. This nominal cost-sharing is for certain programs, groups of members and services.

Crossover Claim
Claim processed by Medicare and electronically sent to Vermont Medicaid for Medicaid payment of the cost sharing-deductible.

Current Procedural Terminology (CPT) Guide
The CPT Guide, developed by the American Medical Association, is a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians and other providers. The manual is designed to provide a uniform language that accurately describes surgical, medical, and diagnostic services to provide an effective means for reliable nationwide communication.

Deferment of Payments
The withholding of payments due a provider pending resolution of a specified problem. It may be taken or continued as a sanction or imposed as an administrative precaution upon discovery of a provider discrepancy.

Department for Children and Families (DCF)
The Department for Children and Families; formerly the Department of Prevention, Assistance, Transition and Health Access, and before that, the Department of Social Welfare.

Department of Vermont Health Access (DVHA)
The Department of Vermont Health Access is responsible for the administration of the Vermont public health insurance system.

Detail Number
Each line on a claim is numbered and is called the detail number. Most claims are processed and paid at the detail level, which means that a problem with one line will not stop processing or payment on the other lines.

Diagnosis Codes
Diagnosis codes come from The International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM). ICD-10-CM diagnosis codes consist of three to seven digits to indicate

the member's diagnosis. Enter the complete code. Any variation to the actual codes, such as leading or trailing zeroes, may delay payment.

Disclosing Entity
A Vermont Medicaid provider (other than an individual practitioner or group of practitioners) (i.e. the health plan) or a fiscal agent.

Disproportionate Share Hospital (DSH) Payments
Payments made by a state's Medicaid program to hospitals that the state designates as serving a "disproportionate share" of low-income or uninsured patients.

Dual Eligible Beneficiary
"Dual eligible beneficiaries" is the general term that describes individuals who are enrolled in both Medicare and Medicaid. The term includes individuals who are enrolled in Medicare Part A and/or Part B and receive full Medicaid benefits and/or assistance with Medicare premiums or cost sharing through one of these "Medicare Savings Program" (MSP) categories:

- Qualified Medicare Beneficiary (QMB) Program – Helps pay for Part A and/or Part B premiums, deductibles, coinsurance, and copayments
- Specified Low-Income Medicare Beneficiary (SLMB) Program – Helps pay for Part B premiums
- Qualifying Individual (QI) Program – Helps pay for Part B premiums
- Qualified Disabled Working Individual (QDWI) Program – Pays the Part A premium for certain people who have disabilities and are working
- Please see Section 2.4, Medicare Savings Program (MSP) of the General Provider Manual for additional information.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services
EPSDT is a federally mandated benefit for all Vermont Medicaid eligible children under age 21. EPSDT requires the state to provide any health care service that is medically necessary, even if the service is not covered for adults. EPSDT services include periodic screenings to identify physical and mental conditions, vision, hearing, dental problems and follow-up diagnostic and treatment services.

Edit
An edit is a computer system inspection of claim data for validity, accuracy and the relationship of information within the claim.

Electronic Claims Submission (ECS)
ECS is a paperless method of submitting claims for processing.

Electronic Funds Transfer (EFT)
EFT is a paperless method of paying providers where payments are deposited directly into their bank accounts. This payment method is mandatory for all providers.

Eligibility
Every member must first be found to be eligible for benefits. These determinations are made by eligibility specialists at the Health Access Eligibility and Enrollment Unit (HAEEU).

Eligibility Verification System (EVS)
The EVS refers to the automated systems that inform enrolled providers about member eligibility. Eligibility must be confirmed by the provider prior to providing services using either the Voice Response System (VRS) or the website under Transactions and choose the appropriate Login.

Exclusion from Participation
Termination of a provider's participation in the Vermont Medicaid Program, with the probability that it is permanent.

Explanation of Medicare Benefits (EoMB)
An EOMB is a notice issued by Medicare to the Member that explains in detail the payment or non-payment of a specific claim submitted on behalf of the Member to Medicare.

Family Planning Services
Any item or course of treatment furnished to a Member of childbearing age for purposes of enabling the individual to freely determine the number and spacing of children.

Federal Financial Participation (FFP)
The term for federal Medicaid matching funds paid to states for allowable expenditures for Medicaid services or administrative costs. States received FFP for expenditures for services at different rates, or Federal Medical Assistance Percentage (FMAP), depending on per capita incomes.

Fee-For-Service (FFS)
A traditional method of payment for medical services in which providers are paid for each service provided.

Fiscal Agent (FA)
A contractor that processes and reimburses for claims on behalf of the State of Vermont; A contractor that processes and pays vendor claims on behalf of the Medicaid Agency.

Federally Qualified Health Center (FQHC)
FQHCs are safety net providers that primarily provide services typically furnished in an outpatient clinic. FQHCs include community health centers, migrant health centers, health care for the homeless health centers, public housing primary care centers, and health center program “look-alikes.” They also include outpatient health programs or facilities operated by a tribe or tribal organization or by an urban Indian organization. FQHCs are paid based on the FQHC Prospective Payment System (PPS) for medically necessary primary health services and qualified preventive health services furnished by an FQHC practitioner.

Green Mountain Care
Green Mountain Care is the brand name for the family of publicly funded health coverage programs offered by the State of Vermont. Programs include Vermont Medicaid, Dr. Dynasaur, premium assistance pharmacy-only programs and Pharmacy Discount Programs.

Green Mountain Care Member Card
Each member receives a Green Mountain Care member identification card with their unique ID. Members generally receive the card two to three weeks after being determined eligible; however, the notice of eligibility will confirm initial eligibility status.

Header Processing
Information pertinent to an entire claim, including all details, is contained in the header of each claim. Examples are the member name and number. Errors in the header information may cause the entire claim to deny before the individual details are considered.

Health Access Eligibility and Enrollment Unit (HAEEU)
A unit within the Department of Vermont Health Access responsible for processing eligibility applications for health care insurance coverage.

Health Insurance Portability and Accountability Act (HIPAA)
Federal law requires each state's Medicaid management information system (MMIS) and medical providers to use transaction standards when electronically exchanging health information of health plan Members.

Healthcare Common Procedure Coding System (HCPCS)
A comprehensive coding system adopted by the Centers for Medicare and Medicaid Services to provide a common system for referencing health care procedures performed under the Medicare and Medicaid programs. It incorporates both Current Procedural Terminology (CPT) and Current Dental Terminology (CDT) codes.

Hospice
A program of care and support for people who are terminally ill (with a life expectancy of 6 months or less, if the illness runs its normal course) and their families.

Indirect Ownership Interest
An ownership interest in an entity that has an ownership interest in the disclosing entity or in an entity that has an indirect ownership interest in the disclosing entity.

Individual Consideration (IC)
The code used to indicate that the reimbursement amount will be calculated on a case-by-case basis.

Internal Control Number (ICN)
A unique fifteen-digit number assigned to each claim by the claims processing system for identification and tracking purposes.

International Classification of Diseases-Clinical Modification (ICD-10-CM)
The International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) is a system used by physicians and other healthcare providers to classify and code all diagnoses, symptoms and procedures recorded in conjunction with hospital care in the United States.

Julian Date
A chronological date of the year, 001 through 365 (or 366), beginning with a four-digit year designation, (e.g., 2018121 = May 1, 2018).

Lock-In
An action that restricts a member's choice of medical provider for a reasonable time because of over-utilization of certain services. Lock-in is also used to designate the member's primary care physician or pharmacy when one is required. The locked in provider can be identified by using the

automated eligibility verification systems: the Voice Response System (VRS), 800.925.1706, option 1; or the online at Transactions and choose the appropriate Login at VT Medicaid.

Managed Care Entity
The federal term for a managed care plan participating in Vermont Medicaid.

Managing Employee
A general manager, business manager, administrator, director or other individual who exercises operational or managerial control over or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency.

Medicare Hospice
Hospice care is usually given in your home, but it also may be covered in a hospice inpatient facility, depending on your terminal illness and related conditions.

Member
An individual who is eligible for and enrolled in the state health benefit program managed by the Department of Vermont Health Access, **Green Mountain Care**.

Member Services Unit
The DVHA has a dedicated unit that is prepared to respond to member inquiries regarding eligibility and coverage for all of the health care benefit programs. The **Green Mountain Care** Member Customer Support Center can be reached at 800.250.8427.

Medicaid Management Information System (MMIS)
A state's computer system for tracking Vermont Medicaid enrollment, claims processing and payment information.

Notice of Decision (NOD)
A written notification used to inform Members and providers of its decisions, such as eligibility or prior authorization requests.

National Provider Identifier (NPI)
The 10-digit National Provider Identifier.

Offsetting of Payments
A reduction or other adjustment of the amounts paid to a provider on deferred, pending, or future bills for purposes of recovering over-payments previously made to the provider.

Other Disclosing Entity
Any other Vermont Medicaid disclosing entity and any entity that does not participate in Vermont Medicaid but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII or XX of the Act. This includes: (a) any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic or health maintenance organization that participates in Medicare (title XVIII); (b) any Medicare intermediary or carrier; and (c) any entity (other than an individual practitioner or group of practitioners) that furnishes or arranges for furnishing of health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.

Ownership Interest
The possession of equity in the capital, the stock or the profits of the disclosing entity.

Palliative Care
Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial, and spiritual.

PC Plus
The name for Vermont's primary care case management program in which a member must select a primary care provider to assist in the management of medical care. This managed health care delivery system is administered by the DVHA.

Person
Any natural person, company, firm, association, corporation or other legal entity.

Person with Ownership or Control Interest
A person or corporation that:

- Has an ownership interest totaling 5% or more in a disclosing entity;
- Has an indirect ownership interest equal to 5% or more in a disclosing entity;
- Has a combination of direct and indirect ownership interests equal to 5% or more in a disclosing entity;
- Owns an interest of 5% or more in any mortgage, deed of trust, note or other obligation secured by the disclosing entity;
- Is an officer or director of the disclosing entity that is organized as a corporation;
- Or is a partner in the disclosing entity that is organized as a partnership.

Primary Care Case Management (PCCM)
A type of managed care entity, which in Vermont is called PC Plus. Members select their Primary Care Provider (PCP) and access health services through their PCP who works with the member to assure high quality medical care. The DVHA administers PC Plus.

Prior Authorization (PA)
A mechanism used to monitor and control use of covered items or services. When an item or services is subject to prior authorization, DVHA will not pay unless approval is given in advance by the DVHA Clinical Unit, using specific criteria for making utilization review decisions. Prior authorizations are determined on a case-by-case basis.

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. Coverage reviews are initiated when a written prior authorization (PA) request is received by DVHA from a Vermont Medicaid enrolled provider for any Vermont Medicaid Member.

DVHA does not review requests for coverage by a manufacturer, a manufacturer's representative, a Durable Medical Equipment vendor, or other third parties.

Refer to the Fee Schedule for information about the code coverage and if the specific code in question, requires a prior authorization. Questions about this policy can be directed to the DVHA Clinical Operations Unit at 802-879-5903.

Private Litigation
Providers are asked to notify the DVHA if they receive any information regarding private litigation in which the DVHA may have an interest. These private litigations might include malpractice suits involving DVHA Members, accident suits or personal injury suits.

Procedure Code
A five-character description of a medical service or other health care service. Vermont Medicaid requires providers to use a procedure code when billing Vermont Medicaid (see CPT, CDT and HCPCS).

Provider
Any individual, firm, corporation, association or institution that is currently approved to provide medical assistance to a member pursuant to the Vermont Medicaid Program.

Provider Enrollment Agreement
The form that sets out the terms and conditions agreed to as a part of the enrollment or annual re-certification process. It must be completed by each provider and the provider accepted for enrollment by DVHA in order to bill Gainwell for the service or item.

Provider Number
The unique seven-digit number assigned to each enrolled provider.

Qualified Medicare Beneficiary (QMB)
An aged, blind or disabled individual with income at or below 100% FPL who is eligible for Vermont Medicaid payment of their Medicare premiums, Medicare deductibles and Medicare co-insurance.

Remittance Advice (RA)
A computer generated report available to providers indicating the status of all claims that have been submitted and entered into the system for processing. Providers should review the RA weekly and contact the Provider Call Center with questions.

Retro-Eligibility
Retroactive Eligibility for Vermont Medicaid means that the coverage of Vermont Medicaid benefits for an applicant may date back for a full three full months prior to the month in which the application for Vermont Medicaid is filed.

Review Methods
The methods by which the department or its administrative agent determines whether payment errors have been made.

Rural Health Clinic (RHC)
A clinic located in a rural, medically under-served area in the United States that has a separate reimbursement structure from the standard medical office under the Medicare and Medicaid programs. The program was established to address an inadequate supply of physicians

serving Medicare and Medicaid Members in rural areas and to increase the utilization of non-physician practitioners.

Spend-Down
Spend-down, as determined by the DVHA, HAEEU or LTC, is a specific amount of medical expenses for which the member must be responsible before eligibility is granted. A spend-down member becomes eligible for Vermont Medicaid on the day of the month in which he or she reaches the incurred medical expense amount that equals or exceeds the specified “spend-down” amount.

Subcontractor
An individual, agency or organization to which a disclosing entity (i.e. the health plan) has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; -or- An individual, agency or organization with which a fiscal agent has entered into a contract, agreement purchase order or lease (or leases of real property) to obtain space, supplies, equipment or services provided under the Vermont Medicaid agreement (i.e. the agreement with the health plan).

Suspension from Participation
Temporary expulsion from participation in the Vermont Medicaid Program for a specified period of time or until specified conditions are met.

Third Party Liability (TPL)
This refers to the legal obligation of third parties (e.g., certain individuals, entities, insurers, or programs) to pay part or all of the expenditures for medical assistance furnished under a Medicaid state plan. By law, all other available third-party resources must meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual eligible for Vermont Medicaid.

Unique Identification Number
A unique number assigned to each Vermont Medicaid member that may be referred to as the UID or MID. The number appears on the Members **Green Mountain Care** Card.

Usual and Customary Rate (UCR)
Various claim forms (CMS 1500, UB04 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 insurer and private-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 because of a sliding-fee scale based on the patient’s documented inability to pay. Sale prices should be used during the sale period. If a service or item is offered free-of-charge by the provider, no charge will be made to Vermont Medicaid. Providers may not discriminate against Vermont Medicaid Members by charging a higher fee for the same service than that charged to a private-pay patient, except as noted above regarding sliding-fee scale.

Version Number
The processing version of a claim. The first claim paid for the services rendered is version 00. The first adjustment to any paid claim is version 01, etc.

Voice Response System (VRS)
A system which allows Vermont Medicaid providers to verify member eligibility, dental dollars spent, third party liability information, limitation status and remittance amount by using a touch tone telephone.

Section 10 Acronyms/Abbreviations

Acronym/Abbreviations	Meaning
AABD	Aid to the Aged, Blind and Disabled
ADA	American Dental Association
ADAP	Alcohol and Drug Abuse Program
AHS	Agency of Human Services
AMA	American Medical Association
AMAP	Aids Medication Assistance Program
ANFC	Aid to Needy Families with Children
AWP	Average Wholesale Price
BC/BS	Blue Cross/Blue Shield
CMS	Centers for Medicare and Medicaid Services-Formerly HCFA
CPT	Physician's Current Procedural Terminology
CSHN	Children with Special Health Needs
DCF	Department for Children and Families
DME	Durable Medical Equipment
DOB	Date of Birth
DOS	Date of Service
DSU	Division of Substance Use Programs
DVHA	Department of Vermont Health Access
DMH	Department of Mental Health
EAC	Estimated Acquisition Cost
ECS	Electronic Claims Submission
EDI	Electronic Data Interchange
EFT	Electronic Funds Transfer
EVS	Eligibility Verification System
EOB	Explanation of Benefits
EOMB	Explanation of Medicare Benefits
EPSDT	Early and Periodic Screening, Diagnostic and Treatment
FA	Fiscal Agent
FFP	Federal Financial Participation
FFS	Fee-for-Service
FDA	Food and Drug Administration
FQHC	Federally Qualified Health Centers

Acronym/Abbreviations	Meaning
HAEEU	Health Access Eligibility and Enrollment Unit
HCPCS	Healthcare Common Procedure Coding System
HHA	Home Health Agency
HHS	Department of Health and Human Services (federal)
HIPAA	Health Insurance Portability & Accountability Act
IC	Individual Consideration
ICD-10-CM	International Classification of Disease - 10th Edition
ICF/MR	Intermediate Care Facility for the Mentally Retarded
ICN	Internal Control Number
ID	Identification
MC	Medicare
MCO	Managed Care Organization
MFRAU	Medicaid Fraud & Residential Abuse Unit
MSU	Member Services Unit
NDC	National Drug Code
NEMT	Non-Emergency Medical Transportation
NF	Nursing Facility
NOD	Notice of Decision
NP	Nurse Practitioner or Naturopathic Physician
NPI	National Provider Identifier
OTC	Over the Counter
PA	Prior Authorization or Physician's Assistant
PCCM	Primary Care Case Management
PCP	Primary Care Provider
PC PLUS	Primary Care Plus
PI	Program Integrity Unit (of DVHA)
POC	Plan of Care
POS	Place of Service
QMB	Qualified Medicare Beneficiary
RA	Remittance Advice
RN	Registered Nurse
RPL	Recipient Placement Level
SCHIP	State Children's Health Insurance Program

Acronym/Abbreviations	Meaning
SLMB	Specified Low-Income Medicare Beneficiary
SNF	Skilled Nursing Facility
SSI	Supplemental Security Income
TPL	Third Party Liability
UCR	Usual and Customary Rate
UID	Unique Identification Number
VDH	Vermont Department of Health
VRS	Voice Response System
YTD	Year to Date

Section 11 Insurance Coverage Matrix

Coverage Codes	5	7	8	9	13	14	24	26	29	34	A1	B1	C1	C2	D1	D4	D5	D8	D9	P1
Services																				
Crossover A	Y				Y				Y											
Crossover B	Y				Y				Y											
Dental		Y															Y			
DME - Durable Medical Equipment	Y				Y				Y		Y	Y	Y	Y	Y	Y				
EPSDT- Early and Periodic Screening, Diagnostic, and Treatment	Y									Y					Y	Y				
Home Health	Y				Y				Y		Y	Y	Y	Y	Y	Y				
Hospice	Y				Y				Y		Y		Y	Y	Y	Y				
Independent Lab	Y				Y				Y			Y	Y	Y	Y	Y				
Inpatient	Y				Y				Y	Y	Y		Y	Y	Y	Y				
Nursing Home LVL 01					Y			Y	Y		Y		Y	Y						
Nursing Home LVL 02-04								Y												
Outpatient	Y				Y				Y	Y		Y	Y	Y	Y	Y				
Pharmacy				Y					Y				Y		Y				Y	Y
Physician/Ambulance	Y				Y				Y	Y		Y	Y	Y	Y	Y				
Vision			Y															Y		
Behavioral Health Services **coverage code 34 is primary to Medical coverage for MH services*	Y				Y				Y	Y	Y	Y	Y	Y	Y	Y				

Section 12 Web Eligibility Request & Response Screens

The web 270 (Eligibility Request) includes a Service Type drop down display. The new Service Type drop down display default is set at 30 (Health Benefit Plan Coverage). The default setting will provide the eligibility response for all service types listed in Table 1. When a specific service type is selected from Table 2, you will be provided with the eligibility response for only that selected service type.

Table #1

Service Type Code	Service Description
1	Medical Care
33	Chiropractic
35	Dental Care
47	Hospital
48	Hospital - Inpatient
50	Hospital - Outpatient
86	Emergency Services
88	Pharmacy
98	Professional (Physician) Visit - Office
AL	Vision (Optometry)
MH	Mental Health
UC	Urgent Care

Table #2

Service Type Code	Service Description
1	Medical Care
2	Surgical
4	Diagnostic X-Ray
5	Diagnostic Lab
6	Radiation Therapy
7	Anesthesia
8	Surgical Assistance
12	Durable Medical Equipment Purchase
13	Ambulatory Service Center Facility
18	Durable Medical Equipment Rental
20	Second Surgical Opinion
33	Chiropractic

Service Type Code	Service Description
35	Dental Care
40	Oral Surgery
42	Home Health Care
45	Hospice
47	Hospital
48	Hospital - Inpatient
50	Hospital - Outpatient
51	Hospital - Emergency Accident
52	Hospital - Emergency Medical
53	Hospital - Ambulatory Surgical
62	MRI/CAT Scan
65	Newborn Care
68	Well Baby Care
73	Diagnostic Medical
76	Dialysis
78	Chemotherapy
80	Immunizations
81	Routine Physical
82	Family Planning
86	Emergency Services
88	Pharmacy
93	Podiatry
98	Professional (Physician) Visit - Office
99	Professional (Physician) Visit - Inpatient
A0	Professional (Physician) Visit
A3	Professional (Physician) Visit - Home
A6	Psychotherapy
A7	Psychiatric - Inpatient
A8	Psychiatric - Outpatient
AD	Occupational Therapy
AE	Physical Medicine
AF	Speech Therapy
AG	Skilled Nursing Care

Service Type Code	Service Description
AI	Substance Abuse
AL	Vision (Optometry)
BG	Cardiac Rehabilitation
BH	Pediatric
MH	Mental Health
UC	Urgent Care

Section 13 Voice Response System (VRS)

Providers access member eligibility and other information using the VRS. Call one of the following VRS numbers using a touch-tone phone: 800.925.1706 (select option 1)

The VRS answers the phone with the following welcome message:

- “Good morning/good afternoon/good evening, thank you for calling the Vermont Medicaid voice information service. For eligibility verification, service limits or current remittance advice payment amount, press 1. For assistance from a Gainwell representative, press 0.”

The system must check the user’s Vermont Medicaid provider number to determine if the user is authorized to access information. The system prompts the user to enter a provider number as follows:

- “Good morning/good afternoon/good evening, thank you for calling the Vermont Medicaid voice information service. Please listen carefully because some of our prompts have changed.”

The system prompts the user to enter a provider number as follows:

- “If your Vermont Medicaid Voice Response User ID contains digits only, press 1.”
- “If your Vermont Medicaid Voice Response User ID contains digits and letters, press 2.”
- “For assistance from provider services press 0.”
- “To repeat these choices press *.”

Providers with a Voice Response User ID that contains both digits and letters will be instructed to do the following:

- “Using your touch tone keypad please enter your Vermont Medicaid Voice Response User ID followed by the pound sign, use 7 for the letter Q and 9 for the letter Z.”

You have two attempts to enter a valid provider number. If you enter an invalid number on your first attempt, you will hear:

- “Invalid provider number.”

If you enter an invalid provider number on your second attempt, you will hear one of the two following messages, depending on whether it is during business hours, after hours or on a holiday:

- “Invalid provider number. We are sorry, you have not entered the required data at this step. If you would like assistance from a Gainwell representative-press zero.”
- “We’re sorry, provider number (XXXXXXX) is not authorized. For assistance from a Gainwell representative, please call back between 8:00 a.m. and 5:00 p.m., except weekends and holidays, and we will be happy to assist you”.

If your provider number is valid, you will be asked to:

- “Enter your four-digit PIN followed by a pound sign”.

To create your PIN number-enter 9999-pound sign-you will hear:

- “Wait while your PIN number is verified. The PIN value you have entered -9999- has expired. You will need a new PIN number before proceeding. Please enter a new four-digit

PIN number that is different from your previous PIN number and it's not all the same (e.g. "1111") followed by the pound sign.
Please wait while your PIN number is updated. Your PIN number has been successfully changed. Your new PIN# is XXXX. Please write this number down for future use."

You will then return to the following options:

- "For eligibility verification, press 1, for service limits, press 2…"

It is important to remember that you have **three** attempts to enter a valid PIN number. After the third failed attempt, your number will be suspended and will need to be reset by a representative.

If the provider and PIN number combination that you have entered is invalid, and it is your first or second attempt of the three, you will hear:

- "We're sorry, provider number XXXXXXX with PIN XXXX is not authorized" "Please enter your seven-digit provider number followed by a pound sign. Enter your four-digit PIN number followed by a pound sign."

If on your third attempt, your provider number/PIN number combination is still invalid, you will hear the following message depending on whether it is during business hours, after hours or a holiday:

- "We're sorry, provider number XXXXXXX with PIN number XXXX has been suspended. Please hold for a Gainwell representative."

-or-

- "We're sorry; provider number XXXXXXX with PIN number XXXX is not authorized. For assistance from and Gainwell representative, please call back between 8:00 a.m. and 5:00 p.m. except on weekends and holidays and we will be happy to assist you."

Reset PIN Number

When you have had your PIN number reset by a representative, you will create a new PIN number by entering 9999- pound sign- you will hear:

- "Wait while your PIN number is verified. The PIN value you have entered- 9999- has expired. You will need a new PIN number before proceeding. Please enter a new four-digit PIN number that is different from your previous PIN number, followed by the pound sign."
- "Please wait while your PIN number is updated. Your PIN number has been successfully changed. Your new PIN number is XXXX. Please write this number down for future use."

You will then be returned to the following options:

- "For eligibility verification, press 1…"

Providers will be required to change their PIN numbers every 90 days. If you enter a PIN that has expired, you will be prompted to change your PIN with the following message:

- "The PIN value you have entered has expired. You will need to enter a new PIN before proceeding. Please enter a new four-digit PIN, different from your previous PIN, followed by a pound sign."

Remember - Valid PIN numbers must be four numbers (cannot be all same e.g. 2222). The new PIN number must be different from your expired number.

After entering your new PIN number, you will hear:

- “Please wait while your PIN number is being updated.”

If your new PIN number is accepted and successfully updated in the database, you will hear:

- “Your PIN number has been successfully changed. Your new PIN is XXXX. Please write this number down for future use.”

A provider may change their PIN number before the 90-day expiration by choosing option #4-change PIN#. Once you have entered a new PIN number that is not the same as the previous or is not all the same number, e.g. 888- you will hear:

- “Your PIN number has been successfully changed. Your new PIN is XXXX. Please write this number down for future use.”

Please note that some provider numbers will require an alpha to numeric conversion in order to enter their provider number.

When the user enters a provider number, the system performs an edit to ensure that it is **seven** digits. After the user enters a provider number in the correct format, the system verifies that the user’s provider number is on the Provider Master File. The system asks the user to wait:

- “Please wait while your authorization is verified.”

Once the system has verified the user’s authorization, the VRS presents the following menu of services:

- “For eligibility verification, press 1. For service limits, press 2. For current remittance advice payment amount, press 3. For assistance from a Gainwell representative, press 0.”

The system ensures that the user enters a valid number and performs the requested function.

Eligibility Inquiry

To obtain member eligibility information, you will need to enter a valid member ID number, from date-of- service and to date-of-service. The ID uses the same format as all Vermont Medicaid IDs. First, the system prompts the user for the member ID as follows:

- "Please enter the nine-digit Medicaid member number followed by the pound sign."

When the system receives a correctly formatted member identification number, it prompts the user for a from date-of-service:

- "Please enter the six digits from date-of-service in a month, day, year format followed by the pound sign or enter a pound sign only for today's date."

Enter the date-of-service in a MMDDYY format followed by the pound sign (#). The system edits the date to ensure it is in the correct format and if a future date, within nine days.

When the system receives a correctly formatted from date-of-service, it prompts the user for a to date-of-service:

- "Please enter the six digit to date-of-service in a month, day, year format followed by the pound sign or enter the pound sign only if the to date-of-service is the same as the from date-of-service."

Enter the to date-of-service in a MMDDYY format followed by the pound sign (#). The system edits the date to ensure it is in the correct format, greater than or equal to the from date-of-service and is valid.

If the member identification number does not exist on the Member Eligibility Master file, the system informs the user:

- "Member (member ID) is not on file. To inquire on another member's eligibility, press 1. To return to the main menu, press 9. For assistance from a Gainwell Representative, press 0. If this concludes your call, you may hang up."

If the member is not eligible on the specified date-of-service or a date of service within a date range, the system responds with the following message:

- "Member (member ID) is not eligible for benefits from (From Date-of-Service) through (To Date-of-Service). To inquire on another member's eligibility, press 1. To return to the main menu, press 9. For assistance from a Gainwell representative, press 0. If this concludes your call, you may hang up."

Since the member is not eligible for services, the system does not provide any more eligibility information.

If the member is eligible, the system responds with one of the following messages specific to program eligibility, depending on the aid category. An example of this is:

- "Member (member ID) is eligible for VScript benefits with aid category (aid category) from (From Date-of-Service) through (To Date-of-Service). The member date of birth is (DOB). The member's last name is (last name) and the first name is (first name). This benefit allows coverage for -------"

The VRS responds with up to three different eligibility segments per inquiry. If co-payment may be required, the system speaks the following message:

- "Possible Co-pay"

Please refer to the Co-payment requirements in Section 4.4, Member Cost Sharing/Co-Pays and Premiums.

If the member is locked into less than three providers, the system responds with one of the following messages, depending on the lock-in type:

HMO Lock-in

- "Member number (Member ID) is locked into MVP."
- "Member number (Member ID) is locked into The Vermont Health Plan."

-or-

Medical Services Lock-in

- "For medical care, member number (Member ID) is locked into provider last name (Provider Last Name) and first name (Provider First Name)."

Provider last name for ten characters and provider first name for five characters.

-or-

Case Managers Lock-in

- "Member number (Member ID) is locked into Case Manager. Services must be prior approved or referred by a Case Manager."

-or-

Pharmacy services Lock-in

- "For Pharmacy services, member number (Member ID) is locked into pharmacy name (Pharmacy Name), provider number (Provider Number)."

If the member is locked in to more than two providers, the system responds with one of the following messages, depending on whether it is during business hours, after hours or a holiday:

- "Member number (Member ID) is locked into more than two providers. For assistance from a Gainwell representative, press 0. To continue, press 2."

-or-

- "Member number (Member ID) is locked into more than two providers. Further information is not available because our office is closed. We are open from 8:00 a.m. to 5:00 p.m. except weekends and holidays. Please call back and we will be happy to assist you or to continue, press 2."

The VRS reports any third-party liability information available. It provides information for up to five third party liability insurance carriers per member.

If the member does not have an insurance policy with another insurance company, the system informs the user as follows:

- "The member is not insured by another carrier."

For Members with other insurance carriers, the system first informs the caller of how many insurance carriers the member has with the following message:

- "The member has insurance policies with (Number of Other Insurance Carriers) carriers."

If the carrier number is "4D", the system responds:

- "This individual has insurance through a child support order. Carrier number is (Member-Other Insurance Company Name-Company Code). If there are any problems in billing this insurance, you may bill Medicaid and Medicaid will pursue."

-otherwise-

The system tells the user the company name for another insurance carrier.

- "The member has an insurance policy with (Other Insurance Company Name)."

If the insurance company name is on the list of the 50 most frequently used carrier names, the system speaks the recorded company name. If the insurance company name is not on the list, the system speaks the company code:

- "(Member -Other Insurance-Company-Name) with coverage type (Coverage-Type)."

-or-

- "Carrier number (Member-Other Insurance Company Code)."

If the system has information for another insurance carrier, it pauses to give the user a chance to record the information from the last response. The system then provides the following options:

- "There is/are (Number-Other Insurance-Remaining) carrier/carriers remaining. To hear information for the next insurance carrier, press 1. To skip the remaining carrier information, press 2."

The system will speak five TPL segments and on the sixth segment the system will provide the user with the following options:

- "There is/are (Number-Other Insurance-Remaining) carrier/carriers remaining. For assistance from a Gainwell representative, press 0. To skip the remaining carrier information, press 2."

At this point, the system has completed the Member Eligibility information. The user may now get service limit information on the same member, do another eligibility inquiry or return to the main menu. The system prompts the user accordingly:

- "For service limits on the same member, press 2. To inquire on another member's eligibility, press 1. To return to the main menu, press 9. For assistance from a Gainwell representative, press 0. If this concludes your call, you may hang up."

End of Data Marker

The pound sign key (#) signals to the system that the user has finished entering the requested data. The user should always press the pound sign key to mark the end of the data to get the quickest response from the system.

Use Previous Data

The user may also use the pound sign key to tell the system to reuse data previously entered for a specific prompt. The user simply presses only the pound sign key at the prompt. For example, if the user wishes to perform another transaction on the previously entered member number, the provider can enter the pound sign key when the system prompts for the member number. This automatically causes the system to use the previously entered member number. If the system determines that the user has never entered a member number, it prompts the user again to enter one.

Repeat Response of Prompt

The VRS interacts with the user by using a series of prompts and responses. It uses prompts to ask the user to enter data or to indicate what action the system should take next. It gives the requested information in the form of a voice response. Sometimes it is necessary to hear a prompt or a response over again. The VRS provides this capability. To tell the system to repeat its last response, press the pound sign key at an options menu prompt. To tell the system to repeat its last prompt, press the asterisk key at an options menu or main menu prompt.

Void Data

Two successive asterisks (**) indicate that all data in the current field should be deleted and the data following the asterisks be used in its place. For example, if the user intended to enter 12345 and accidentally keyed 12567, the mistake could be corrected by entering “**” followed by the correct data. The sequence of keystrokes is illustrated below:

1256712345#**

When the VRS examines the input data, it discards all data in the field preceding the two asterisks and takes the data following the double asterisks as the user's intended input. Therefore, the final input to the system would be "12345".

Alphabetic Data

Since the telephone touch-tone keypad has only numeric digits 0-9, a special method must be used to allow users to enter alphabetic characters. To enter alphabetic data, press the asterisk key (*) followed by a two- digit numeric code. This numeric code represents a specific alphabetic character. The first digit corresponds to the key cap number on which the character appears. The second digit corresponds to one of the three alphabetic characters on the key cap. Therefore, the code "*21" is used to input the letter "A" since the "A" appears in position one on key cap, two on the touch-tone keypad.

The characters "Q" and "Z" do not appear on the touch-tone keypad. Therefore, these two characters are treated as though they are the first two characters on key cap one. To enter "Q", the user enters "*11". To enter "Z", the user enters "*12".

Service Limit Inquiry

To obtain member service limit information, you must enter a valid member ID number, from date-of-service and to date-of-service. The ID format is the same for all Vermont Medicaid IDs. First, the system prompts the user for the member ID as follows:

- "Please enter the nine-digit Medicaid member number followed by the pound sign."

You may press the pound sign to tell the system to use the last member number entered. If this option is used, the system ensures that the user has previously entered a member number before proceeding. In some cases, there may be a slight delay while the system waits for the information to return from the host, so the system informs the user with the message:

- "Please wait while the requested information is retrieved."

When the system receives a correctly formatted member identification number, it prompts the user for a from date-of-service:

- "Please enter the six digits from date-of-service in a month, day, year format followed by the pound sign, or enter a pound sign only for today's date."

Enter the date-of-service in a MMDDYY format followed by the pound sign (#). The system edits the date to ensure it is in the correct format and is valid.

When the system receives a correctly formatted from date-of-service, it prompts the user for a to date-of-service:

- "Please enter the six digit To date-of-service in a month, day, year format followed by the pound sign or enter the pound sign only if the to date-of-service is the same as the from date-of-service."

Enter the date-of-service in a MMDDYY format followed by the pound sign (#). The system edits the date to ensure it is in the correct format, greater than or equal to the from date-of-service and is valid.

If the member identification number does not exist on the Member Eligibility Master file, the system informs the user:

- "Member (member ID) is not on file. To inquire on another member’s eligibility, press 1. To return to the main menu, press 9. For assistance from a Gainwell Representative, press 0. If this concludes your call, you may hang up."

If the member is not eligible on the specified date-of-service or a date of service within a date range, the system responds with the following message:

- "Member (member ID) is not eligible for benefits from (From Date-of-Service) through (To-Date-of-Service). To inquire on another member's eligibility, press 1. To return to the main menu, press 9. For assistance from a Gainwell Representative, press 0. If this concludes your call, you may hang up."

Since the member is not eligible for services, the system does not provide any more eligibility information. If none of the member’s service limits are exhausted, the system responds:

- "Member (member ID) has not exhausted service limits based on paid claims as of the last processing cycle."

If the system has information for another service limit, the system pauses to give the user a chance to record the information from the last response. The system then provides the following options:

- "There is/are (Number Services Remaining) service limit/limits remaining. To hear the next service limit, press 1. To skip the remaining service limit information, press 2."

At this point, the system has completed the service limit information. The user may now get service limit information on another member or return to the main menu. The system prompts accordingly:

- "To inquire on another member’s service limits, press 2. To return to the main menu, press 9. For assistance from a Gainwell representative, press 0. If this concludes your call, you may hang up."

RA Payment Inquiry

When the system verifies the provider number, it also obtains remittance advice information. If remittance advice payment information is available for the provider, the system gives the following message:

- "For provider number (Provider Number), the most recent remittance was issued on (RA Date) in the amount of (Check Amount)."

If no remittance advice payment information is available for the provider, the system informs the user:

- "For provider number (Provider Number), no remittance is found."

After the transaction is complete, the system prompts with the following message:

- "To return to the main menu, press 9. For assistance from a Gainwell representative, press 0. If this concludes your call, you may hang up."