GreenMountainCare
A HEALTHIER STATE OF LIVING

Provider Manual

VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS
dvha.vermont.gov/

DXC.technology
vtmedicaid.com/#/home

Summary of Updates

The Detailed Summary of Provider Manual Changes contains all detailed changes made to this Provider Manual is maintained and available for review at http://www.vtmedicaid.com/#/manuals

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02/01/2019	Timely Filing	8.2
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12/4/2018	Telemedicine Services	10.3.54
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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 Medicaid, Dr. Dynasaur and premium assistance pharmacy-only programs.

1.1 IMPORTANT TELEPHONE NUMBERS, ADDRESSES AND WEBSITES

Department of Vermont Health Access
280 State Drive
Waterbury, VT 05671
Telephone: 1.802.879.5900
Fax: 1.802.879.5619
Website: http://dvha.vermont.gov

DXC Technology
312 Hurricane Lane
Suite 101
Williston, VT 05495
Telephone: 1.802.878.7871 (Out-of-State) or 1.800.925.1706 (In-State)
Fax: 1.802.878.3440
Website: http://www.vtmedicaid.com/#/

DXC Technology Provider Call Center
Toll-Free In-State: 1.800.925.1706
Local and Out-Of-State: 1.802.878.7871

DXC Technology Enrollment Unit
1.802.879.4450, option 4
Email: vtproviderenrollment@DXC.com

DXC Technology Checks, Claim Submission and Correspondence Mail
For all Checks: DXC Technology, PO Box 1645, Williston, VT 05495
For all Claims and other correspondences: DXC Technology, PO Box 888, Williston, VT 05495

1.2 ADMINISTRATION & RESPONSIBILITIES

1.2.1 Member Eligibility Determination

Application for health benefit eligibility and other public benefit determinations may be made online at http://dcf.vermont.gov/mybenefits/apply_for_benefits or at a DCF Economic Services Division (ESD) District Office http://dcf.vermont.gov/esd/contact_us/district_offices. Eligible members are enrolled in the appropriate health care assistance program by the Department for Children and Families, Economic Services Division (ESD), Health Access Eligibility Unit (HAEU). Questions about applying and other information queries can be made at any DCF District Office http://dcf.vermont.gov/ or by calling the Benefits Service Center/District Office.

Benefits Service Center/District Offices:
Telephone (800) 479-6151

The Benefits Service Center's call center interactive voice response (IVR) system services providers and member statewide. Providers should stay on the line after the message for a separate queue, and will be serviced directly.

1.2.2 Administration of Insurance Programs

The Department of Vermont Health Access (DVHA) has the primary responsibility for establishing program policy direction and administration of Vermont's health insurance programs, determining service coverage, establishing provider reimbursement rates, and provides funding for provider payments.

Department of Vermont Health Access:
Telephone (802) 879-5900
http://dvha.vermont.gov/
312 Hurricane Lane, Suite 201
Williston, VT 05495

DVHA operates the **Green Mountain Care** Member Services Unit to provide information to health benefit applicants and respond to questions and problems from members.

Green Mountain Care Member Services:
Telephone (800) 250-8427
TTY: (888) 834-7898
101 Cherry Street, Suite 320
Burlington, VT 05401-9823

1.2.3 Claims System & Provider Services

The State of Vermont contracts with a fiscal agent DXC Technology (DXC) to process Medicaid claims and perform other duties as required by the contract. This includes maintenance of the eligibility sub-system, claims processing billing codes and rates, and electronic fund transfers for reimbursement of services.

The Provider Services Unit of DXC Technology 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 at http://www.vtmedicaid.com/#/resources

- Provider Services/DXC: Toll-free in Vermont (800) 925-1706
- Local and Out-of-State (802) 878-7871

*Note: DXC does not assist or take 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
Call Center Agents are available to assist providers with program eligibility questions, provide service limitation information, assist with claim inquiries and other information not available through the Voice Response System (VRS) or Vermont Medicaid website http://www.vtmedicaid.com/#/

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

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

- Date of Remittance Advice (RA)

The Help Desk is not authorized to verify eligibility for dates 9 or more days beyond the date of inquiry.

Provider Relations Representatives

Provider Relations Representatives are available to travel throughout the state for problem solving and provider education. These representatives work to increase provider participation by speaking at professional association meetings, scheduling provider visits, and presenting 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 at http://www.vtmedicaid.com/#/manuals

Written Inquiries

To ensure accuracy and consistency, submit written inquiries on the *Provider Inquiry Form*, available at http://www.vtmedicaid.com/#/forms. Send completed inquiries to:

DXC Technology
Provider Services Unit
P.O. 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 DXC with copies of all required attachments, when applicable. If there are no attachments, claims may be resubmitted electronically, see **Section 8.1 Adjustment Requests**.

1.2.4 Claim Submission & Correspondence Mailing Addresses

To ensure your request is processed in a timely manner, use the correct PO Box specific to each correspondence type mailed to DXC Technology.

- PO Box 1645 – All Checks
- PO Box 888 – All Claims, Other Mail & Inquiries

  Williston, VT 05495-0888

Health care providers and administrators wishing to send paperwork using a registered or certified carrier service are to use our physical office address:

- DXC Technology 312 Hurricane Lane, Suite 101 Williston, VT 05495

1.2.5 Claim Copy Requests

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

1.2.6 Provider Claim Modification Process

The Department of Vermont Health Access (DVHA) allows claim reviews by DXC Technology for the below modifications to claims:

- Modifiers: Changes (additions and/or removals) to modifiers. Requested modifications must be submitted on appropriate claim form with supporting documentation to DXC Technology, PO Box 888, Williston, VT 05495
- Units: Changes to previously listed units may be reviewed when sent on appropriate claim form with any applicable supporting documentation to DXC Technology, PO Box 888, Williston, VT 05495
- Place of Service or Diagnosis Codes: Changes to previously listed Place of Service codes or Diagnosis codes may be sent for review with appropriate claim form and any applicable supporting documentation to DXC Technology, Attn: Utilization Review, PO Box 888, Williston, VT 05495
- Provider Type and Specialty: If a provider would like a review of the services covered under their specialty scope of practice, please send request and supporting documentation to DXC Technology, Attn: Utilization Review, PO Box 888, Williston, VT 05495

1.2.7 Provider Reconsideration Process

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

- Timely filing denial (**refer to section 8.2.1 on Timely Filing Reconsideration Requests requirements**)
- Improper payments or non-payments
- Coding errors

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

   The request for review must be filed on the Reconsideration Request form (located at http://www.vtmedicaid.com/#/forms)

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

C. Requests will be reviewed by a qualified member of the DVHA when all information related to the claim is submitted. Upon receipt of the request and all supporting information, the DVHA will review all information received. The DVHA may consider additional information, either verbal or written, from the provider or others, to further clarify the case.

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

E. There is no additional review or reconsideration after the written decision on the review. This decision is final.

All requests for review must be addressed to:
DXC Technology
Administrative Review
PO Box 888
Williston VT 05495

Section 2 Green Mountain Care

Green Mountain Care is a family of state-sponsored low-cost and free health insurance programs for uninsured Vermonters.

2.1 MEDICAID FOR ADULTS

Medicaid programs for adults provide low-cost or free coverage for Vermonters who are eligible based on income and resources. Medicaid provides a broad benefit package that may include acute care, long-term care, dental, pharmacy and, if necessary, transportation to medical services.

Members are enrolled in PC Plus managed care and 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).

2.2 DR. DYNASAUR (CHILDREN)

Dr. Dynasaur encompasses all health care programs available for children up to age 19 Children's Health Insurance Program (CHIP) and Underinsured Children Members are enrolled in the PC Plus managed care program.

2.3 PRESCRIPTION ASSISTANCE PHARMACY-ONLY PROGRAMS

Prescription assistance programs help Vermonters pay for prescription medicines based on income, disability status and age. Pharmacy program requirements apply http://dvha.vermont.gov/for-providers.

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 enrolled in Medicare Part D with payment for prescription medications. In general, VPharm covers drug classes that are excluded from the Part D benefit, and may assist with premiums and cost-sharing.

Healthy Vermonters - Healthy Vermonter's provides a discount on both long-term and short-term prescriptions for Vermonters not eligible for other pharmacy assistance programs.

2.4 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 Medicare premiums, deductibles and co-insurance but not for any other payments

Specified Low-Income Beneficiaries - A Specified Low-Income Medicare Beneficiary (SLMB) is an aged, blind or disabled individual who is eligible for Medicaid payment of their Medicare Part B premium if the individual would be eligible for QMB except for income with income above 100% but at or below 120%FPL.

Qualified Individuals – A Qualified Individual (QI-1) is an aged, blind or disabled individual with income at or below 100% FPL who is eligible for Medicaid payment of Medicare Part B premium if the individual would be eligible for QMB except for income with income above 100% but at or below 135%FPL and does not receive any other federally-funded medical assistance except for coverage for excluded drug classes under part D when the individual is enrolled in part D.

2.5 PRIMARY CARE PLUS (PC PLUS)

Primary Care Plus (PC Plus) is a primary care case management program developed by the DVHA as part of Vermont's Global Commitment. Vermont requires that all Medicaid and Dr. Dynasaur member enroll in PC Plus. Many services covered under PC Plus need to be authorized by the Primary Care Provider (PCP). Services rendered to a member enrolled in a primary care case management (PCCM) must follow the guidelines for the PCCM program.

The key goals of PC Plus are to:

- Enhance the continuity of care through the creation of a “medical home”
- Establish a partnership between the Medicaid administration and community providers
- Maximize dollars spent for medical services

PCPs coordinate their members’ health care needs by providing the following services:

- Primary care medical services, covered by Vermont Medicaid
- Referral authorization for needed specialty and other covered medical services
- Arrange 24-hour-a-day/seven days-a-week coverage

PCPs receive a monthly case management fee for each member enrolled with the PCP. This fee is for coordinating members’ health care services. The case management payment structure is based on the number of patients that are attributed to the practice. Vermont Medicaid will attribute members to the PCP who has billed for appropriate services and who has seen the member within the last 24 months.

Membership in PC Plus is mandatory for all Medicaid and Dr. Dynasaur members who are not otherwise exempt from managed care enrollment under the provisions of the 1115 waiver. Under the waiver, individuals who have third party insurance, in addition to Medicaid/Dr. Dynasaur, and individuals who are on home and community-based waivers, are exempted from PC Plus enrollment. In addition, individuals enrolled in the Medicaid High Tech Program and individuals living in long-term care facilities are exempt from PC Plus enrollment.

Once they are found eligible, members who are not exempt are sent an enrollment package from the **Green Mountain Care** Member Services Unit and are asked to select a primary care provider. A primary care provider is assigned to those members who do not make a selection within 30 days.

Members may change their PCP by contacting the Member Services Unit. Members can be verified as members of PC Plus using the VRS and the Vermont Medicaid web site http://www.vtmedicaid.com/#/

A PCP enrolled in the PC Plus program must meet all of the following requirements listed in the below sections.

2.5.1 Allowed Practitioner Types

The PCP must be enrolled and in good standing in the Vermont Medicaid program and be routinely providing services as a:

- Family Practice Physician
- General Practice Physician
- Internal Medicine Physician (general internists)
- Pediatric Physician
- Adult, Pediatric or Family Nurse Practitioner
- Naturopaths

Physician specialists, with one or more sub-specialties, may enroll as PCPs for members with life-threatening, degenerative or disabling conditions or disease. They must agree to meet the obligations of a PCP and have experience in and are willing to provide primary care services.

2.5.2 Application

Providers who wish to be a PCP in the PC Plus program must be actively enrolled in the Vermont Medicaid program and are required to complete and return the PCP "Agreement For Participation".

Providers who are enrolling with PC Plus as a group, must complete a single "Application for Participation", signed by a representative of the practice group. The PCP Agreement for Participation and the Provider Enrollment Agreement can be accessed at: http://www.vtmedicaid.com/#/provEnrollDataMaint

2.5.3 Enrollment Minimum/Maximum

PC *Plus* PCPs can set a limit on the number of **PC *Plus*** members to be enrolled in their practice. Maximum enrollment for a PCP is 1500.

Should a PCP desire to increase or decrease the maximum number of members to be managed, the PCP must notify DXC in writing at least 60 days prior to the new change. A new Application for Participation will not be required.

2.5.4 Monthly Enrollment List

PCPs will receive a monthly roster of enrolled members. The roster does not assure continuing eligibility; therefore, eligibility should be verified for each date of service prior to rendering the service. It is required that incorrect member information is noted and a revised roster be returned to the DXC Enrollment Unit for updating. This information may be returned by fax to 802-878-3440, Attn: enrollment or mailed to: DXC Technology, Attn: Enrollment, PO Box 888, Williston, VT 05495.

2.5.5 Provider Enrollment Status Change

PCPs must notify DXC in writing should any of the changes listed below occur which will affect participation in the plan. Mail written notification to DXC Technology, PC Plus, and P.O. Box 888, Williston, Vermont 05495-0888 or faxed to (802) 878-3440.

Group Composition
If there is any change in the composition of individual providers in a group that originally agreed to participate in the Primary Care Plus Plan, the moving PCP is required to complete a new Agreement for Participation prior to the effective date of change.

In addition, any provider who has not previously participated in the PC Plus plan will need to complete the Agreement for Participation located at http://www.vtmedicaid.com/#/provEnrollDataMaint

Office Location
Any change in PCP office address, telephone numbers or name of practice, must be communicated in writing to DXC as soon as possible and prior to the effective date of the change.

2.5.6 Notice of Termination of Participation in PCP Plus

All individually participating or group identified PCPs must notify DXC of their intention to withdraw from participation, in writing, at least 90 days prior to the termination date. Providers are required to give their patients 30 day notice prior to termination.

2.5.7 Hospital Admitting Privileges

A **PC *Plus*** PCP must have either local hospital admitting privileges or a formal arrangement with a physician who has local hospital admitting privileges and who agrees to abide by **PC *Plus*** requirements.

2.5.8 Referrals

Referral of **PC *Plus*** members can be made to any provider currently enrolled in the Vermont Medicaid program.

The goals of the referral process are to:

- Ensure that the PCP is involved in medical decisions affecting members

- Reduce utilization of unnecessary medical services
- Reduce duplication of services
- Promote continuity of care

The PCP will be responsible for coordinating care between the member and any specialty care that the member may need through the referral system. A referral takes place when a participating PCP refers their PC Plus member for medically necessary covered services not normally provided by the PCP. Referrals by the member's PCP will be required for payment of claims submitted by specialty providers. Members seeking specialty care without a referral from their PCP will be responsible for the visit, if they are informed in advance and in writing that because they have no referral, they will have to accept financial responsibility for the visit. See Section 6.5 Notice That Medicaid Will Not Be Accepted.

Effective July 1, 2012, non-emergency (elective) out-of-state medical visits will require prior authorization from the DVHA Clinical Unit. Out-of-State Network Hospitals and Extended Network Hospitals are excluded from this requirement. In network referring providers must submit requests using the Out-of-State Elective Office Visit Request Form located at: http://dvha.vermont.gov/for-providers/forms-1. Fax requests to 802-879-5963.

Referrals may be made orally or in writing. Both the PCP and the referral to specialty provider are required to keep documentation of the referral in the patient's medical records. The referral must include the following information:

- Patient identification information
- Date
- Reason for referral
- Requested service (evaluate, evaluate and treat)

Providers who make referrals in writing may do so using their own referral form. Referral forms do not need to be attached when submitting claims. The referral provider will be reimbursed on a fee-for-service basis for Vermont Medicaid covered services.

The following services do not require a referral from the PCP:

- Chiropractic services
- Dental services (Medicaid/Dr. Dynasaur only)
- Emergency services
- Family planning services, defined as services that prevent or delay pregnancy
- Gynecological services
- Naturopathic services
- Personal care for children
- Prenatal and maternity care
- Routine eye exams for adults/children and eyeglasses for children
- Mental health services
- School-based health services
- Services rendered by the PCP or those providing back-up coverage for the PCP
- Substance abuse services

- Local Transportation services (Medicaid/Dr. Dynasaur only)

2.5.9 Case Management Responsibilities

In addition to providing primary care services, PCPs must provide a number of case management services. Responsibilities include:

- For referrals, the PCP must use Vermont Medicaid participating providers or providers enrolled to serve members enrolled in the PC Plus program, unless the required service is not otherwise available from a currently enrolled Vermont Medicaid provider. If the PCP wants to use a provider who is not enrolled, DXC should be notified to solicit the enrollment of the provider.
- The PCP must have provisions for access to 24-hour/seven days-per-week coverage that will assure practitioner availability in person or by phone.
- The PCP (or PCP's practice) must maintain office-visiting hours at least four days per week for at least twenty-five hours per week for member appointments, unless this provision is waived by the DVHA in order to assure access to services and providers. Participating PCPs who work in a practice on a part-time basis, must inform the DVHA of the times they are available to see patients.
- DVHA may request a corrective action plan from the PCP if timely access responsibilities are not met.
- The PCP must assure that all members have a current medical history and record, and must maintain medical records for each member.
- The PCP must agree to adhere to the appointment waiting times standards set out in the Medicaid Rule 7101.3 O (1) (b). These appointment standards state that any member should have immediate access to emergency care and for non-emergent care be seen within: 24 hours for urgent care, 2 weeks for non-urgent care with prompt follow-up and 90 days for preventive and routine physical examinations and 30 days for routine, laboratory, x-ray, general optometry, and all other routine services.
- PCPs must provide all covered primary care services consistent with their qualifications.
- The PCP must assure that every child or adolescent enrolled in the practice is screened according to the requirements of the Vermont Department of Health's EPSDT Periodicity Schedule.
- The PCP must follow the provisions of the Generic Drug Act where it permits substitution and will prescribe the lowest cost equivalent available.
- After consultation with specialists, the PCP will review and approve medically necessary specialty services as appropriate, except for services exempted or those approved by the DVHA or the DVHA's designated prior authorization agent.
- The PCP must participate in quality improvement projects agreed to by participants in the PC Plus network and the DVHA.
- The PCP must cooperate with the DVHA's accessibility surveyors. The DVHA will provide each PCP practice site with the results of any accessibility survey conducted.
- The PCP must notify the DVHA of any change in his/her office physical plant that might change physical accessibility to The Department.

2.5.10 Case Management Fee and Treatment Plan

In addition to fee-for-service reimbursement, PCPs will be paid a monthly case management fee for each member assigned to their practice. The PCP does not need to file a claim for the case management fee. Claims for the monthly fee will be generated by DXC based on the number of members enrolled in the

practice and payment will appear on the Remittance Advice (RA). Actual services provided to members will be reimbursed on a fee-for-service basis in accordance with Vermont Medicaid fee-for-service payment policies and procedures.

When a PCP develops a treatment plan for a member, the PCP may submit a claim to DXC for reimbursement for the development of this plan using procedure code G9001. A PCP may submit no more than one treatment plan claim, per member, per calendar year. A covering practitioner cannot bill for a treatment plan. Payment will be made in accordance with the Vermont Medicaid fee schedule for this service. The treatment plan does not have to be submitted with the claim; however, it must be kept in the member's medical records. Treatment plans must include, at a minimum, the following information:

- Presenting clinical problems
- Expected outcomes
- Services required, including level of intensity
- Provider(s) of services

Section 3 Policies & Other Informational Resources

3.1 ADVISORY

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

3.2 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 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 at www.vtmedicaid.com/#/bannerMain 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@DXC.com to receive this provider resource and other communications relevant to Vermont Medicaid.

3.3 CLAIM EDIT STANDARDS

Vermont Medicaid adheres to the following edit standards:

- AMA, CPT, HCPCS and NCCI;
- National Specialty Society Edit Standards; or
- Proprietary NCPDP-compliant pharmacy adjudication software provided through our Prescription Benefit Management(PBM) Goold Health Systems ®
- Other appropriate nationally-recognized edit standards, guidelines or conventions approved by the commissioner.

3.3.1 Correct Coding Practices

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

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

3.3.2 New, Revised and Deleted Codes

DVHA's Fee Schedule is updated on a monthly basis to reflect any code changes. It is the responsibility of the billing provider to refer to this schedule at: http://dvha.vermont.gov/for-providers/claims-processing-1 (See section 9.6 Fee Schedule.) Codes are a National Standard and may be updated on a quarterly basis. Correct coding is the sole responsibility of the billing provider. DVHA is not authorized to give code selection guidance.

3.4 CORRECT FORM VERSIONS

The Department of Vermont Health Access and DXC Technology requires the use of current form versions, this includes but is not limited to: prior authorization requests and patient consent forms. All requests and patient consent forms received on outdated form versions will be denied.

3.5 MANUALS FOR PROVIDERS

The Provider Manual, Dental Supplement and the Applied Behavior Analysis, Mental Health and Substance Abuse Services Supplement are available at http://www.vtmedicaid.com/#/manuals

The Inpatient Psychiatric & Detoxification Authorization Manual Supplement is available at http://dvha.vermont.gov/for-providers/mental-health-inpatient-detox

The 340B Medicaid Carve-In Manual and Amendments are located at http://www.vtmedicaid.com/#/forms

The Pharmacy Benefit Management Program Provider Manual is located at http://dvha.vermont.gov/for-providers under the Pharmacy section. The Pharmacy Benefit Management Program is for prescription drugs dispensed by retail pharmacies.

DVHA clinical coverage guidelines for Durable Medical Equipment (DME), Laboratory and Radiology, Therapy, J Codes, Intensive Social Support Services, and other services are located at http://dvha.vermont.gov/for-providers/clinical-coverage-guidelines.

Check monthly for manual revisions.

3.6 MEDICAID RULE & STATE PLAN RESOURCES

Medicaid Rule, along with other DVHA rules, are located online at http://humanservices.vermont.gov/on-line-rules/dvha.
Note: Per State statute, Vermont's Secretary of State is charged with publication of a bulletin of rules. As such, the Secretary of State is the official source for the most current and comprehensive rules for DVHA. DVHA is not responsible for reliance on regulations posted should rules be different than those posted on the Secretary of State website. An electronic copy of the rules maintained by the Secretary of State is available via http://www.lexisnexis.com/hottopics/codeofvtrules/.

3.7 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: https://www.medicaid.gov/medicaid/program-integrity/ncci/index.html. Code combinations are refreshed quarterly.

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

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

- NCCI procedure-to-procedure (PTP) edits that define pairs of Healthcare Common Procedure Coding System (HCPCS) / Current Procedural Terminology (CPT) codes that should not be reported together for a variety of reasons. The purpose of the PTP edits is to prevent improper payments when incorrect code combinations are reported.

Medically Unlikely Edits (MUEs) define for each HCPCS / CPT code the maximum units of service (UOS) that a provider would report under most circumstances for a single beneficiary on a single date of service.

PTP Edits have been implemented apply to all:

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

MUE Edits have been implemented and apply to all:

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

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

NOTICE: The MUE files have been updated with the addition of a new field on the rationale for each MUE, effective the third quarter of 2014. Please refer to Appendix B of the Medicaid National Correct Coding Initiative Edit Design Manual for explanations of the MUE rationales.

NCCI 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 refer to: 1.2.7 Provider Reconsideration Process for additional information about claims reconsideration

3.8 REMITTANCE ADVICE

The Remittance Advice (RA) is a computer-generated report provided by the fiscal agent. It indicates the status of all claims that have been submitted for processing and payment information. The RA is posted at http://www.vtmedicaid.com/#/ under Transactions→Login on a weekly basis. The banner page of the RA provides important information about policy and billing.

- When a provider submits VT Medicaid claims via electronic claim submission (ECS) directly or through a clearinghouse or billing service, the Remittance Advice (RA) will be posted to the VT Medicaid Portal at http://www.vtmedicaid.com/#/
- When a provider is not set up for ECS and is only submitting paper claims to Vermont Medicaid, the RA will be mailed weekly; however, if the provider switches to ECS, the RA will be posted to the web and the RA mailing will stop.
- When a provider is set up for ECS, all RA information will be posted to the Web Portal regardless of whether the claims were submitted on paper, electronically or any combination thereof.

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

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

- Go to http://www.vtmedicaid.com/#/

If you have a Trading Partner Account (User ID starts with 701), navigate to Transactions→Login or if you have a Provider Web Services (PWS), navigate to Transactions→Login-UAT.

If you have a Trading Partner Account (User id starts with 701…) click on Transaction Services, then Production Logon.

If you have a PWS account, click on Provider Web Services.

- Use the Account ID and password to Logon
- For either method of access after logging on, click on View RA Files
- Pick the Provider Number from the drop down (if you have more than one)
- Click Go
- Click on the appropriate pdf
- Click Open (this should display the RA on the screen)

For questions about an existing account, creating an account, or accessing the Web RA, please contact the EDI Coordinator at 802-879-4450, select option 3 or email at vtedicoordinator@DXC.com.

Providers with questions about their RA's content are to contact the DXC Technology Help Desk at 800-925-1706 in-state or 802-878-7871 out-of-state.

3.8.1 The 835 Transaction (Electronic Remittance Advice)

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

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

If your 835 is missing after Sunday (EFT+3), and no banner has been posted stating its release is delayed, please contact the EDI Coordinator at 802 879-4450 Option 3, or email vtedicoordinator@DXC.com. Include your Trading Partner ID and the week you are referencing.

Section 4 Member Information

4.1 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. Eligibility is determined at the Health Access Eligibility Unit or a district office of the Vermont Department for Children and Families, 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 Medicaid must apply for health care benefits through Vermont Health Connect at http://healthconnect.vermont.gov/ or by calling 1-855-899-9600.

Each member is assigned a unique identification (UID) number and 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 is to 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 eligibility and other insurance information using the patient's Medicaid UID number by accessing either of the automated eligibility verification systems.

4.1.1 Partial Eligibility

Providers are allowed to 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 Medicaid.

4.1.2 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 and Appendix.

- Voice Response System (VRS), 802-878-7871, option 1; or
- Go to www.vtmedicaid.com/#/, navigate to the Transactions menu and select the appropriate Login (Trading Partners use "Login", Web Services use "Login - UAT").

If for any reason you are unable to use either method, you may call the DXC Provider Services Help Desk at (800) 925-1706 or (802) 878-7871.

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 http://www.vtmedicaid.com/#/manuals to the aid category listing (see Appendix to the Provider Manual), in order to determine the program in which the member is enrolled in. This will assist you in determining covered services and co-payment requirements where applicable. Providers may verify eligibility for the current date, up to one year in the past and rely on the accuracy of the response 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 or if that amount is zero, the amount and date of the last payment given.

All provider calls to DXC are routed through the VRS. Spoken prompts will direct you on how to access the service/information you require-Contact the DXC Provider Services Unit for information that is not available through VRS or the http://www.vtmedicaid.com/#/ website.

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 are (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
- Date of birth
- Co-pay indication

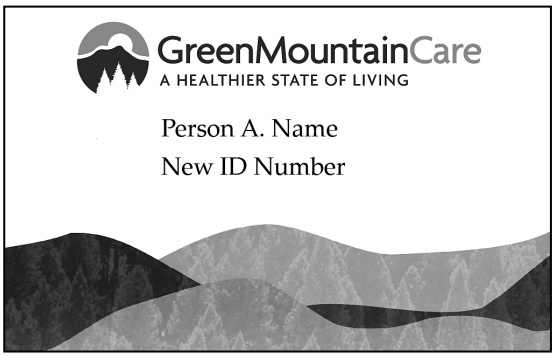
- Service Limitations when exhausted
- Office visits
- Visual refractions
- Visual glasses
- Adult dental benefits (dollars spent)
- Last dental oral exam
- Chiropractic visits
- Current RA check amount

Carrier Codes

Carrier Codes are two or three digit codes that identify other insurance carriers. The complete list can be accessed on the Vermont Medicaid Portal at http://www.vtmedicaid.com/#/resources

4.2 IDENTIFICATION

A **Green Mountain Care** identification card is issued to each person 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 that the member is eligible on the date that 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.



4.3 MEMBER BILL OF RIGHTS

DVHA is a Managed Care Organization (MCO) and must ensure that its enrolled health care providers are aware of our Member Bill of Rights and that health care providers take these rights into account when providing services to members.

The 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.

4.4 MEMBER COST SHARING/CO-PAYS AND PREMIUMS

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

Co-payments are never required of Medicaid members who are:

- Under age 21;
- Pregnant or in a 60-day post-pregnancy period;
- Living in a long-term care facility, nursing home or hospice;

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

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

Medicaid Co-Pays

- $1.00 - for prescription drugs costing less than $30.00
- $2.00 - for prescription drugs costing $30.00 or more but less than $50.00
- $3.00 - for prescription drugs costing $50.00 or more
  $3.00 - per dental visit
- $3.00 - per day for hospital outpatient services

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

Aid Category VP

Offers access to drugs at a discounted price, which is the Vermont Medicaid rate for prescription drugs.

4.5 QUALIFIED MEDICAID MEMBER (QMB)

A QMBY'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

4.6 NOTICE OF DECISION

The Department for Children and Families (DCF) notifies members in writing of its decisions made regarding eligibility, retroactive eligibility, spend-down requirements and other determinations of status or program changes. These letters are called "Notice of Decision" letters and are issued by the district office or HAEU. A copy of the Notice of Decision is a required attachment for certain claims involving spend-down.

4.7 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.

4.8 RETROACTIVE ELIGIBILITY

Vermont Medicaid eligibility is occasionally granted retroactively. The provider may bill for services rendered during the retroactive period. A note indicating the date of retroactive eligibility must accompany the claim to waive the timely filing limit; see section, 8.1 Timely Filing.

4.9 MEMBER GRIEVANCE PROCESS

A member grievance is a complaint about issues other than actions, such as the location or convenience of their health care provider or the quality of the health care provided. A member may file a Grievance by calling the Green Mountain Care Member Customer Support Center when the member and provider are unable to resolve the issue, and it is within 60 days of the problem. DVHA will respond to the grievance within 90 days with a letter to the member. A member who filed a Grievance and is not satisfied with the results may ask for a Grievance Review by a neutral person to ensure that the grievance process was handled fairly. Neither member nor provider shall be subject to retribution or retaliation regarding the grievance. The member may also call the Office of Health Care Advocate at 1-800-917-7787 for assistance.

4.10 MEMBER APPEAL PROCESS

Members may ask for review of certain actions if they disagree with the action. For decisions made by DVHA, a request for an appeal or fair hearing may be requested through **Green Mountain Care** Member Services by calling 1-800-250-8427 or by letter to: **Green Mountain Care** Member Services, Department of Vermont Health Access, 101 Cherry Street, Suite 320, Burlington, VT 05401. Requests must be made within 90 days from the decision date and appeals are heard by a qualified person not responsible for the original decision.

A provider may ask for an appeal on behalf of the member, if requested to do so by the member. In most instances, a decision will be made within 45 days of the appeal request. In some instances, the process can

be extended up to an additional 14 days. However, a decision will always be made within 59 days of the appeal request.

If the need for the denied benefit is an emergency, an expedited appeal may be requested. If after review it is determined that the appeal is an emergency, a decision will be made within three business days.

The following actions may be appealed:

- Denial or limit of a covered service or eligibility for service, including the type, scope or level of service;
- Reduction, suspension or termination of a previously approved covered service or a service plan;
- Denial, in whole or in part, of payment for a covered service;
- Failure to provide a clinically-indicated covered service, by any provider;
- Failure to act in a timely manner when required by State rule;
- Denial of a request to obtain covered services from a provider who is not enrolled in Medicaid (note that the provider who is not enrolled in Medicaid cannot be reimbursed by Medicaid).

Members with an employer –sponsored insurance plan may call the customer service number on the back of their ID card to obtain information on appealing a decision made by that plan.

When a member is told that the benefit has changed because of a change in a federal or state law, the member may not ask for an appeal but may request a fair hearing. For additional information, refer to the Health Care Programs Handbook located at http://www.greenmountaincare.org/member_information.html, Member Handbooks.

4.11 FAIR HEARING

A member that disagrees with the appeal decision may request a fair hearing by the department responsible for the decision. The request must be made within 90 days from the date of the original notice of decision or action, or 30 days from the date of an appeal decision.

4.12 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 matter consistent with the confidentiality requirements in 45 CFR parts 160 and 164 and as required by state law. http://www.cms.hhs.gov/securitystandard/downloads/securityfinalrule.pdf.
Providers can obtain Advance Directive (AD) forms and additional information on AD from the Vermont Ethics Network website: http://www.vtethicsnetwork.org/ or by mailing your request to:

Vermont Ethics Network
61 Elm Street
Montpelier, Vermont 05602

Section 5 Provider Enrollment, Licensing & Certification

5.1 ENROLLMENT & CERTIFICATION

In order to participate in and receive reimbursement from Vermont Medicaid Programs, providers must be enrolled. Licensed or certified health care providers may be enrolled as Vermont Medicaid providers if at least one service they provide is recognized in the Vermont Medicaid State Plan. Any health care provider who is

interested in becoming enrolled in the Vermont Medicaid program should contact the DXC Provider Enrollment Unit. Enrollment requires that the provider submit applicable enrollment forms, a signed General Provider Agreement and a copy of the applicable license/certification document and meet all federal and state requirements. When the DVHA accepts an applicant, a Vermont Medicaid provider ID number will be issued and a confirmation of enrollment letter will be sent. Payments will not be made until a provider number has been assigned.

Enrollment may include the following:

- Full enrollment is for participating providers who are in-state and out-of-state in network as well providers that are determined by DVHA to contribute to the Green Mountain Care network and see Vermont Medicaid members on a regular basis
- Ordering, Prescribing, Referring and Attending providers and Residents, whether the physician or practitioner who actually performs the services for the patient or the referring or prescribing provider, must be enrolled as a participating Vermont Medicaid provider.
- Court ordered enrollment is for providers whose services have been ordered by a court, a fair hearing decision or by a Coverage Exception.
- Request (M108/7104) decision of the commissioner. Court ordered providers would only be enrolled for dates consistent with the order/decision.

Special status is granted for out-of-state and out-of-network providers who have seen a Vermont Medicaid member in an emergency or urgent situation, or who have been prior approved for out-of-state services. The DVHA does not deem a provider enrolled in Medicare as enrolled in Vermont Medicaid. DVHA will pay for emergency and post-emergency stabilizations services delivered by providers who were not enrolled at the time of the emergency.

Note: Non-participating enrollment is no longer accepted.

The difference between Enrollment, Re-Enrollment and Revalidation:

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

All providers interested in applying for enrollment, or need to Re-Enroll or Revalidate their eligibility, please visit http://www.vtmedicaid.com/#/provEnrollAppPackets for all application packets.

Enrollment will be rejected if:

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

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

5.1.1 Enrollment Agreement Signatures

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

Exception:
Faxed signatures are allowed for certain cases including but not limited to out-of-state special enrollment for a single member and other special enrollment cases as identified by DVHA. Upon receipt of the faxed provider enrollment agreement, DXC is directed to telephone the provider to confirm that the provider did in fact send the fax. DXC may then begin the screening and enrollment process. Enrollment, including the assignment of a Vermont Medicaid provider number, may be completed with the use of the faxed agreement only. Original hardcopy signature must be submitted to DXC Technology for file. Signatures should be in blue ink to denote authenticity.

5.2 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

5.3 CONDITIONS OF PARTICIPATION

The Conditions of Participation are stated in the Provider Enrollment/Recertification Agreement and the General Provider Agreement and the applicable provision by provider type. Please consult your current agreement for details.

5.4 DOCUMENTATION OF SERVICES

Each provider must keep written documentation for all medical services, actual case record notes for any services performed, or business records that pertain to members for services provided and payments claimed or received. All documentation must be legible, contain complete and adequate information and applicable dates. Providers must submit information upon request of the State Agency of Human Services, Office of the Vermont Attorney General or U.S, Secretary of Health and Human Services and at no charge to the requester. The documentation for any service that was billed must be kept for seven years. This information must also be available at any time for on-site audits. Records of any business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5 year period ending on the date of the request, must be submitted within 35 days of the request.

5.5 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

5.6 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 DXC Technology or by indicating on 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.

Section 6 Coordination of Benefits/Medicaid Payment Liability/Third Party Liability

6.1 CONTRACTUAL ALLOWANCE

Vermont Medicaid is payer of last resort, and as such, will not consider and pay amounts that exceed the Medicaid rate, even when payment is combined with payments from primary insurance

When another insurance carrier has made a payment, document the total payments received by other insurance carriers in the appropriate field on your claim form.

When the entire allowed amount is applied to the primary insurance deductible, the claim may be submitted to Vermont Medicaid but must be accompanied by an EOB. Vermont Medicaid will consider payment based on the Vermont Medicaid allowed amount after deducting any payment made by a primary insurer.

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

6.2 REIMBURSEMENT OF OVERPAYMENTS

Providers are reminded of the 2009 Fraud Enforcement and Recovery Act (FERA) which amended the False Claims Act, 31 U.S.C §§3729-3733, by increasing the scope of the false claims liability to include persons who knowingly conceal the retention of any overpayment of government money and the 2010 Patient Protections and Affordable Care Act (PPACA) which directly linked the retention of overpayments to false claims liability. PPACA requires the report and return of all overpayments within 60 days after the date on which the overpayment was identified or the date the corresponding cost report was due, whichever is later. Additionally, providers must submit notification in writing as to the reason of the overpayment. DXC will forward any cases in which the discovered overpayment was not refunded during the timeline mandated by PPACA to the DVHA Program Integrity Unit for their review.

Hospitals (in addition to the above information) DXC contracts with AIM HealthCare to audit hospitals for credit balances on accounts. This arrangement does not negate the provider's responsibility to report and return overpayments timely. DXC will forward any cases in which the discovered overpayment was not refunded during the timeline mandated by PPACA to the DVHA Program Integrity Unit for their review.

6.3 WHO IS RESPONSIBLE FOR PAYMENT?

Verifying eligibility before service:
Providers are expected to verify eligibility for every member prior to providing the service or item to be clear about who has financial responsibility for the service. Eligibility can be verified up to nine days in advance however, this is not a guarantee of payment. Eligibility can be verified through the automated Voice Response System (VRS/Malcolm), online Transaction Services (http://www.vtmedicaid.com/#/) or by calling the Provider Services Unit help desk. When an eligible aid category code is given, the provider should determine that the service to be provided is covered within that aid category. This will also show what other insurance is on file. To ensure timely processing of your claim, validate other insurance with member or refer them to the Department for Children and Families.

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

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

Federal Medicaid policy does not permit providers to bill Vermont Medicaid or the member any fee for missing a scheduled appointment.

6.3.1 Supplementation

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

- The applicable conditions described below in section **6.4 Who is Primary**
- Permitted deductible and co-payment amounts
- Specific allowed supplementations authorized in Medicaid Rule 7602

6.4 WHO IS PRIMARY

When the DVHA is the primary payer (i.e. the DXC system indicates no other insurer) and Vermont Medicaid payment is accepted, the provider should submit all bills to the DVHA's fiscal intermediary and never to the patient. Under the provider agreement, the provider has agreed to accept the DVHA's payment or denial (except as enumerated above) as payment in full.

When the DXC system shows a source other than the DVHA as the primary payer (such as Medicare or any other insurance carrier) the DVHA is the payer of last resort. Under the provider agreement, certain restrictions apply.

When Vermont Medicaid is secondary to a **private insurer** and a co-payment is required by the primary insurer at time of service, the provider is to bill the claim to Vermont Medicaid and indicate the amount paid by the primary insurance. Vermont Medicaid reimburses their allowed amount, minus the amount the other insurer has paid.

Providers that do not wish to bill Vermont Medicaid for the co-payment are only allowed to bill the member if they notify the member in writing, prior to rendering the service, that they will not bill Vermont Medicaid for the co-payment. The member must sign and date this notification; please retain documentation in the member's file.

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

6.5 NOTICE THAT MEDICAID WILL NOT BE ACCEPTED

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

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

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

6.6 MEDICAID & MEDICARE CROSSOVER BILLING

A **Green Mountain Care** member may be eligible for both Vermont Medicaid and Medicare. When dual eligibility exists, Medicare must be billed first on an assigned basis.
After Medicare payment, the DVHA pays deductibles and coinsurance for crossover claims.

Providers must include their NPI and taxonomy code on any claims sent to Medicare in order to assure proper automatic crossover and subsequent Vermont Medicaid processing of your claims. Vermont Medicaid is aware that Medicare does not have this same requirement but will include the taxonomy code, as submitted on the claim, on the crossover file.

DXC Technology does not accept a CMS-1500 crossover claim submitted with multiple Medicare Attachment Summary Forms. When submitting a CMS-1500 crossover claim that contains more than 6 details, each 6 details must be submitted as an individual claim with its Medicare Summary Attachment Form; indicate the number of details and the total. The total must equal only the sum of the detail lines listed on that claim form.

The Department of Vermont Health Access reviews all Medicare crossover claims where the Medicaid allowed amount (coinsurance / deductible) is over $10,000.00. These claims require DVHA's review and

approval prior to payments being made. To facilitate the processing of these claims, please attach the following information to your claim if the expected coinsurance /deductible payment from Medicaid is over $10,000.00: the Medicare Attachment Summary Form, the Medicare EOMB and the discharge summary at the time of submission. Any claims submitted without the required supporting documentation will be denied.

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

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

Vermont and New Hampshire Providers:

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

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

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

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

- Send a claim completed to the DVHA specifications with a copy of the Medicare Attachment Summary Form. The Medicare payment date must appear on the Medicare Attachment Summary Form.
- If a service or item is denied by Medicare as non-reimbursable and is reimbursable by the DVHA, submit a CMS 1500 claim with the EOMB, completed to the DVHA specifications to DXC within twelve months of the date of service; see section **8.1 Timely Filing**

6.7 THIRD PARTY LIABILITY (TPL)/OTHER INSURANCE (OI)

Vermont Medicaid is the payer of last resort. Providers are required to pursue and apply all third party payment resources prior to billing Vermont Medicaid. Third party resources include, but are not limited to, Medicare, private/group health insurance plans, military and veteran's benefits, Worker's Compensation and accident (automobile, homeowners, etc.) insurance. (See Section 6.9 for information specific to Workers Compensation and Accident Liability Billing)

TPL-Verification
The member's other insurance information, including the name of the other insurance company, address, carrier code and type of coverage, is available on the Vermont Medicaid website, Provider Web Services (http://www.vtmedicaid.com/#/, Transactions→Login - UAT) and the Voice Response System (VRS) when the provider checks the member's eligibility. Providers will review the member's eligibility information for the date of service and must bill other insurance carrier(s) before billing Vermont Medicaid. Use of the available information will guide providers in billing.

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

Other Insurance Denial/DVHA Authorization Request

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

OI Denial for Non-Covered or Benefits Exhausted

The provider is required to submit to the DVHA the authorization request form (Medical Necessity Form or other) with all standard documentation, the notice of denial from the primary insurer that indicates the item or service is not a covered benefit or that the benefit limit was determined to be exhausted, and all necessary documentation to support medical necessity. The DVHA will then review.

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

OI Denial for Not Medically Necessary

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

- If the code/service does not require authorization from Vermont Medicaid, then the provider can bill Medicaid directly, with copies of the primary insurer's denials (original and appeals) and the Department of Financial Regulation's support of the denial attached.

OI Blanket Denials

Providers are required to submit blanket denials from a primary insurer to DXC every calendar year, for example: a blanket denial issued on July 7, 2013, will only be valid until December 31, 2013 and a new denial will be required as of January 1, 2014. Blanket Denials are required each calendar year as health insurance benefits are reviewed and health care policies are generally, renewed yearly.

Vermont Medicaid will accept a blanket denial for the same calendar year as the date(s) of service of the claim(s) being submitted for payment.

All Blanket Denials are to include the following:

- Name of the insurance company
- Member name
- Date(s) of service
- Rev/Procedure code or description of service

Providers may obtain a "blanket statement" from an insurance company that states that the company never covers a particular service for the member's policy and attach it to the claim when billing for that service. Blanket statement must be less than one year old and must be attached to each claim submitted. Providers must indicate the member's name and identification number and the applicable dates of service and the provider must sign and date the blanket statement.

Medicare Qualified Independent Contractor

For members covered by Medicare, the requirement to go through the Medicare Qualified Independent Contractor appeal level applies, with the exception of wheelchairs that Medicare denies or downgrades.

Upon documentation of the Medicare action, Medicaid will review for medical necessity and payment determination.

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

Other Insurance Attachments

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

When submitting a paper claim, an attachment is needed only when a third party insurance carrier has not made a payment. Providers must attach documentation from the carrier that verifies the member's name, insurer's name, dates of service, service code or exact description of service, the amount reimbursed and the payment or denial date. If the carrier does not include this information in the documentation (i.e. the carrier issues a blanket statement that the particular service is not covered), the provider must write the necessary information on the attachment, then sign and date the attachment. It must be clear that the attachment relates to the specific services billed on the Medicaid claim.

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

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

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

- Prenatal Care Services: This includes routine supervision of normal pregnancy, prenatal screening of mother or fetus, and care provided in the prenatal period to the mother for complications of pregnancy
- Preventive Care Services: This includes immunizations, screening tests for congenital disorders, well-child visits, preventive medicine visits, preventative dental care, and screening and preventive treatment for infectious and communicable diseases
- Court-enforced Medical Support Members: This is identified by an insurance coverage type D1 through D9 which indicates "Absent Parent"

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

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

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

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

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

TPL Cost Avoidance: DXC maintains eligibility files, which contain member health insurance information. This data is integrated in the claims processing system to coordinate benefits.

6.7.1 Third Party Liability Coverage Codes

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

Code	Type of Coverage
01	Hospital Inpatient Services
02	Hospital Outpatient Services
03	Hospital Inpatient/Outpatient Services
04	Physician Services
05	Physician Inpatient/Outpatient Services
06	Physician Inpatient/Outpatient Services/Major Medical
07	Dental Coverage
08	Vision Coverage
09	Drug Coverage
10	Physician Inpatient/Outpatient Services/Major Medical/Dental
11	Physician Inpatient/Outpatient Services/Major Medical/Vision
12	Physician Inpatient/Outpatient Services/Major Medical/Drug
13	Medicare Supplement A & B
14	Indemnity Coverage Payment to Client
15	Major Medical
16	Major Medical/Physician
17	Major Medical/Physician/Dental

18	Major Medical/Physician/Vision
19	Major Medical/Physician/Drug
20	Major Medical/Physician/Dental/Vision/Drug
21	Inpatient/Outpatient/Physician/Dental/Major Medical/Drug/Vision
22	Medicare Supplement Part A
23	Medicare Supplement Part B
24	Specialty Coverage (e.g., cancer)
25	HMO
26	Nursing Home
27	Veterans Home
28	Worker's Compensation
50	Absent Parent (4D)
99	Unknown
A1	Medicare A
B1	Medicare B

6.8 WORKERS COMPENSATION/ACCIDENT LIABILITY BILLING

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

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

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

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

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

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

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

Section 7 Prior Authorization for Medical Services

Prior authorization (PA) is a process used to assure the appropriate use of health care services. The goal of PA is to assure that the proposed health service, item or procedure meets the medical necessity criteria; that all appropriate, less-expensive alternatives have been given consideration; and the proposed service conforms to generally accepted practice parameters recognized by health care providers in the same or similar general specialty who typically treat or manage the diagnosis or condition. It involves a request for approval of each health service that is designated as requiring prior approval before the service is rendered. Please review the fee scheduled at: http://dvha.vermont.gov/for-providers/claims-processing-1 for services that require a PA. Authorization will not be granted after the service is rendered.

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

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

Waiver of Prior Authorization (Exceptions):

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

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

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

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

7.1 CLINICAL PRACTICE GUIDELINES

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

7.2 PRIOR AUTHORIZATION REQUIREMENTS

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

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

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

7.2.1 Required Documentation

At a minimum, the documentation required to support a PA request must include a completed and legible copy of a medical necessity form, or other appropriate documentation, with the prescribing provider's

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

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

7.2.2 Immediate Need Exception

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

Definitions:

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

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

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

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

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

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

7.3 DETERMINATION TIME

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

Also, when a provider indicates, or DVHA determines, that following this timeframe could seriously jeopardize the beneficiary's life, health, or ability to attain, maintain, or regain maximum function, DVHA must make an expedited decision and provide notice as expeditiously as the beneficiary's health condition requires and no later than 3 business days after receipt of the request. This may be extended up to 14 calendar days if the beneficiary so requests, or if the extension is needed to obtain additional information and an extension is in the beneficiary's interest. Under federal law, the department is obligated to provide a response within 24 hours of a request for PA of a drug.

7.3.1 PA Decision Reconsiderations

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

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

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

Prior Authorization Contact information:

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

Prescription Drugs are reviewed by the Pharmacy Benefit Manager Change Healthcare

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

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

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

Elective Diagnostic Outpatient High Tech Imaging:

eviCore Customer Service	(888) 693-3211
eviCore Fax	(888) 693-3210
Web based PA Requests	http://www.medsolutionsonline.com

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

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

7.4 MEDICAL NECESSITY

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

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

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

7.4.1 Medical Necessity Form (MNF)

A completed DVHA Medical Necessity Form (DVHA 60) is the preferred documentation for Home

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

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

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

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

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

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

7.5 UTILIZATION REVIEW

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

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

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

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

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

7.6 PRIOR AUTHORIZATION NOTICE OF DECISION

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

The Notice of Decision contains the following information:

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

7.7 SERVICES REQUIRING PRIOR AUTHORIZATION

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

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

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

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

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

7.7.2 Out of-State Elective Inpatient Hospital Admissions

(Excluding Designated Border Hospitals)

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

7.7.3 Out-of-Network Elective Outpatient Referrals

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

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

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

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

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

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

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

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

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

(Excluding Designated Out-of-State Network Hospitals)

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

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

7.7.6 Rehabilitative Therapy

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

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

All treatment must demonstrate medical necessity.

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

Examples of treatment that do not have sufficient support in current medical literature at this time include, but are not limited to: sensory integration therapy, craniosacral therapy, myofascial release therapy, visceral manipulation therapy, auditory integration training, and facilitated communication.

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

Adult Coverage

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

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

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

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

Members under age 21

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

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

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

This requirement does not apply to home health agencies.

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

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

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

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

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

Outpatient Therapy Modifiers

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

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

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

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

Medicare provides a link to the list of applicable therapy procedure codes, (this list is updated annually by CMS). VT Medicaid therapists need only reference the code list itself; do not use the column information. http://www.cms.gov/Medicare/Billing/TherapyServices/AnnualTherapyUpdate.html.

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

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

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

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

Modifiers may be reported in any order.

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

Section 8 Reimbursement, Billing Procedures and Claim Processing

DVHA does not arbitrarily deny or reduce the amount, duration or scope of a required covered service solely because of diagnosis, type of illness or condition of the member

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

8.1 ADJUSTMENTS REQUESTS

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

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

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

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

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

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

Late Charges (Applies to UB-04 Hospital charges)

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

For instructions on completing adjustments using DXC Technology's PES software, please visit http://www.vtmedicaid.com/#/pes

Forms for completing single and multiple adjustments can be downloaded from http://www.vtmedicaid.com/#/forms

8.2 TIMELY FILING

Below are the timely filing limitations.

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

- When Medicaid is the primary insurer providers have 6 months from the date of service to submit a claim
- When Medicare is the primary insurer providers have 6 months from Medicare's paid date to submit a claim or 6 months from Medicare's denied date to submit a claim
- When Other Insurance (excluding Medicare) is the primary insurer providers have 12 months from the date of service to submit a claim
- For an inpatient claim, providers have 6 months from the discharge date to submit a claim
- For global maternity and orthodontia claims, providers have 6 months from the date of service to submit a claim
- When a provider has been granted retro-enrollment (backdate) they have up to 12 months from the date of service, or an additional 45 days from the date of notice of enrollment, whichever is later, to submit a claim. The Medicaid Enrollment Backdate form is available on our website at http://vtmedicaid.com/#/provEnrollDataMaint
- When a recipient has been granted retro-eligibility providers have 12 months from the date of service to submit a claim

- Providers must request an adjustment to a PAID claim within 12 months from the original paid date when the adjustment would result in a positive financial outcome for the provider
- Providers may request an adjustment to a PAID claim within 3 years from the original date of service when the adjustment would result in a negative financial outcome for the provider. If the claim is more than 3 years old, the provider must refund the overpayment by completing the refund form and attaching the refund check. The Medicaid Refund form is available on our website at http://www.vtmedicaid.com/#/forms
- Providers have 6 months from the initial Medicaid denial to submit a corrected claim

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

8.2.1 Timely Filing Reconsideration Requests

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

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

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

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

All Timely Filing Reconsideration Requests should be mailed to:

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

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

8.3 USUAL & CUSTOMARY RATE (UCR)

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

8.4 INCIDENT-TO BILLING FOR LICENSED PHYSICIANS

Incident-to billing is a way of billing for services in an office setting only, provided by a non-physician practitioner (NPP) whose provider type does not allow them to enroll with Vermont Medicaid. There is no incident-to billing in a facility. NPPs that are eligible to enroll in Vermont Medicaid must enroll and bill using their own provider number and cannot bill incident-to.

When NPPs who are not eligible for enrollment in Vermont Medicaid provide services that are incident-to a physician or other practitioner’s service, they may bill under the physician/practitioner’s Vermont Medicaid provider ID (NPI/Taxonomy) if they are employed by the billing provider (part-time, full-time, leased, contracted) and when the service are:

- An integral, although incidental, part of the professional services
- Commonly rendered without charge or included in the physician’s bill
- Of the type that is commonly furnished in physician offices or clinics
- Furnished by the physician or auxiliary personnel under the physician’s direct supervision

Documentation is critical for patient care and must clearly link the service to the clinically-supervising provider, including for example, co-signature and credentials of both practicing and clinically supervising provider and notation within the medical record of the clinically supervising provider’s involvement. Services billed in this manner may be subject to post payment review.

The billing/clinically supervising provider must:

- Be actively enrolled with Vermont Medicaid
- Have seen the patient first, made a diagnosis and created a plan of care
- Provide formal case oversight (documented one-on-one meetings to review the case)
- Be present in the office suite on site or immediately available within 15 minutes commute to provide assistance and direction throughout the time the service is performed

The service must:

- Be within the scope of practice of person providing the service;
- Follow the plan of care created by the billing/clinically supervising provider
- Be only for the diagnosis in the original plan of care
    - If the patient requires a service for another diagnosis, the visit does not qualify for “incident-to” billing
    - The billing/clinically supervising provider must see the patient to make a new diagnosis and create a plan of care before s/he can bill incident-to for a different diagnosis.

Incident-to billing is NOT Allowed if:

- It is a new patient visit

- It is an established patient with a new problem/diagnosis
- There is no clinically supervising provider present in the office suite and immediately available within 15 minutes

8.5 SUPERVISED BILLING FOR BEHAVIORAL HEALTH SERVICES

Supervised billing (formerly known as "Incident-To" billing) requirements as described below apply only to clinical services, and are not applicable to case management, specialized rehabilitation or Emergency Care and Assessment Services.

These requirements apply to all providers being reimbursed for "supervised billing" under Medicaid.

"Supervised billing" is a way for a supervising provider who is enrolled in Vermont Medicaid to bill for clinical behavioral health services provided by non-licensed personnel under their direct supervision. Providers who are eligible to enroll in Vermont Medicaid must enroll and bill using their own provider number; they cannot bill under another provider's number.

Supervision of unlicensed providers is critical for patient care, and the service must clearly link to the clinical supervisor. Supervision requirements for professional licensure are described in the administrative rules under the Secretary of State, and must be adhered to for the purpose of "supervised billing". The supervising provider must sign off on the treatment plan and demonstrate continuing involvement in supervising patient care. Services billed in this manner may be subject to post payment review.

1. Supervising Providers

The following Medicaid contracted providers may bill for supervised services:

- Licensed physician certified in psychiatry by the American Board of Medical Specialties;
- Licensed psychiatric nurse practitioner;
- Licensed psychologist;
- Licensed marriage and family therapist;
- Licensed clinical mental health counselor; and
- Licensed clinical social worker
- Licensed alcohol and drug abuse counselors

The following conditions apply to the Medicaid-contracted provider in order to bill for unlicensed clinical services:

1. Supervisors must be licensed and actively enrolled in Vermont Medicaid.
2. All supervising providers must only supervise for services within their scope of practice.
3. Supervisors must adhere to the supervision requirements outlined in the Secretary of State's Administrative Rules for their specific provider type. For Licensed Alcohol and Drug Abuse Counselors, supervisors must meet requirements outlined by the Vermont Alcohol and Drug Addiction Certification Board.
    - Note: For purposes of billing clinical services, any behavioral health provider licensed and enrolled Medicaid behavioral health providers and supervising within their scope of practice may provide supervision under this policy. Unlicensed providers who are seeking licensure from the Office of Professional Regulation (OPR) will need to obtain supervised hours from a supervisor meeting the requirements outlined by OPR in order to apply for licensure.
4. Supervisors do not need to provide direct services in order to bill for supervised services
5. Supervisors must provide regular, face-to-face ongoing supervision to the unlicensed provider, as outlined in the Secretary of State's or Vermont Department of Health's Administrative Rules for the specific provider type.
6. Supervisors must sustain an active part in the ongoing care of the patient.

7. A licensed provider qualified for scope of services must be immediately available in person or by phone within 15 minutes.

2. Non-Licensed Providers

Supervisors may bill Medicaid for clinical services provided by the following non-licensed providers:

- Master-level mental health practitioners, including clinical social workers, clinical mental health counselors, and marriage and family therapists, actively fulfilling 3,000 hours of supervised practice.
- Psychiatric Nurse Practitioners actively fulfilling 24 months and 2,400 hours of supervised practice.
- Psychologists actively fulfilling 2,000 hours of supervised practice after receiving a doctoral or master's degree in psychology.
- Addiction counselors who are:
    - Actively fulfilling the required number of hours of supervised work experience providing alcohol/drug counseling services, commensurate with their degree as outlined by the Vermont licensing entity, -or-
    - Possessing (or will possess within 180 days of hire) a Vermont Addiction Apprentice Professional certificate, -or-
    - Possessing an Alcohol and Drug Counselor Certification.

The following conditions must apply to non-licensed providers in order for the supervisor to bill for non-licensed services:

- Mental health practitioners shall be entered on the roster of non-licensed and noncertified psychotherapists, and must be actively working towards professional licensure.
- Psychologists shall be entered on the roster of non-licensed and noncertified psychotherapists, and must be actively working towards professional licensure.
- Psychiatric Nurse Practitioners shall be a Registered Nurse with a Collaborative Provider Agreement, and must be actively working towards professional licensure.
- Non-certified addiction counselors must be actively working towards professional licensure.

Individuals who have been on the roster that is maintained by the Office of Professional Regulation in the Office of the Secretary of State for more than five years after January 1, 2016 will no longer be eligible under Medicaid to provide clinical services. Extensions may be granted on a case-by-case basis. **Designated Agency and Specialized Service Agency Providers only:** For individuals seeking a waiver to the "Five-Year Rule", please fill out the Supervised Billing Five Year Rule Waiver form found at: http://www.vtmedicaid.com/#/provEnrollDataMaint. Return all completed forms to: Provider Member Relations Unit, Department of Vermont Health Access, 312 Hurricane Lane, Suite 201, Williston, VT 05495.

3. Billable services provided by supervised non-licensed providers

Clinical services within the provider's scope of practice, including:

- Diagnosis & Evaluation
- Individual Therapy
- Group Therapy
- Family Therapy
- Medical Evaluation/ Management
- Medication/ Psychotherapy
-

The following services are not eligible for reimbursement:

- Services rendered by any provider who is eligible to be enrolled as a Vermont Medicaid provider but has not applied to be a Vermont Medicaid Provider.

- Services performed by a non-licensed provider who cannot practice independently and is not actively working towards licensure.

4. Procedures for Billing
    1. Practices/Agencies must maintain documentation on unlicensed master's level individuals providing clinical services that includes the following:
        a. Name of rostered, unlicensed provider
        b. Degree and discipline
        c. Name of supervising provider
        d. Status of license-eligibility:
            i. License-eligible
            ii. Rostered non-licensed and noncertified psychotherapists
            iii. Psychiatric Nurse Practitioners fulfilling 24 months and 2,400 hours of supervised practice.
            iv. Addiction counselors fulfilling required hours of supervised work experience.
        e. Date when individual was entered on the roster that is maintained by the Office of Professional Regulation in the Office of the Secretary of State, if applicable.
    2. Supervising provider must use their unique provider number for services provided by unlicensed providers.
        a. For claims submitted to Medicaid, the following pricing modifiers must be used:

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

        b. For Designated Agencies, Specialized Service Agencies, and ADAP Preferred Providers Only: For claims submitted to DMH or ADAP fund sources, the modifiers in the above table are not required.
    3. In the event of a supervisor's short-term absence (e.g. vacation) where another licensed provided is providing supervision, the documented licensed supervisor should continue to be included on the claim as the provider using the appropriate modifier indicated above. Length of absence appropriate for this approach should be defined in provider's internal policy.
    4. For neuropsychological testing, the supervising provider must conduct an initial face-to-face neurobehavioral status exam to determine the medical necessity for neuropsychological testing and the extent of such testing. Evaluations, including initial neurobehavioral status exam, administration of all tests, final report, and feedback session, if held, should be billed to Medicaid at the conclusion of the

process on a single claim. The patient's record should include documentation of dates and times of face-to-face ongoing supervision to the unlicensed clinician. For other documentation requirements and best practice guidelines please see Local Coverage Determination (LCD) *Psychological and Neuropsychological Testing (L31990)*.

NONCOMPLIANCE WITH POLICY

MEDICAID CONTRACTED PROVIDERS MAY BE AUDITED REGARDING THESE REQUIREMENTS AND MAY BE REQUESTED TO REIMBURSE DVHA THE MONIES BILLED FOR THE NON-LICENSED PROFESSIONAL.

8.6 LOCUM TENENS

A Locum Tenens is a physician to "step in" for another provider that is on leave or has permanently left a practice. The Locum Tenens physician must be licensed in Vermont and be actively enrolled in Vermont Medicaid.

If a Locum Tenens physician is covering for a physician on leave, they are then allowed to use that physician's NPI number for up to 60 days. Modifier Q6 (Service rendered by a Locum Tenens physician) should be used to show that the service was provided by a Locum Tenens physician. The Billing provider is 100% liable for all locum tenens billing.

8.7 TIME-BASED PROCEDURE CODES – BILLING GUIDELINES

Please follow the below guidelines when billing time based procedure codes.

Critical care procedure codes that are time-based

- The billed units must reflect the actual time spent in face-to-face contact with the member in the home and/or on the way to the hospital.
- The duration of time to be reported by a physician is the actual time spent evaluating, managing and providing the critically ill or injured patient's care. Services are not to be provided to any other patient. Your full attention is limited to the critically ill or injured patient's care.
- In a facility setting, duration of time reflects time spent at the patient's bedside or elsewhere on the floor or unit. You must be immediately available to the patient. Only one physician may bill for critical care services rendered to a patient during any billable period of time. Time counted toward critical care may be continuous clock time or intermittent aggregated time.
- Paper claims will be required if the number of units billed exceeds the allowed number of units. It is required that clear copies of the provider's actual records be submitted with each claim. The number of units billed must be documented.
- The total number of minutes and date of service must be clearly written in the documentation and circled.
- Failure to clearly mark the number of minutes will result in claim denial.

All other time-based procedure codes

- The billed units must reflect the actual time spent.
- Paper claims will be required if the number of units billed exceeds the allowed number of units. It is required that clear copies of the provider's actual records be submitted with each claim. The number of units billed must be documented.
- The total number of minutes and date of service must be clearly written in the documentation and circled.

- Failure to clearly mark the number of minutes will result in denial of the claim.

8.8 ELECTRONIC CLAIM SUBMISSION

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

ECS is fast, easy to use and eliminates time-extensive paperwork. ECS prevents most errors, allowing providers to submit "clean" claims the first time. Turn-around time for electronic claims is considerably faster than for paper claims. For information on available methods of electronic billing, please contact the Electronic Data Interchange (EDI) Coordinator at DXC.

8.9 ELECTRONIC FUNDS TRANSFER (EFT)

Vermont Medicaid requires health care provider payments to be made through Electronic Funds Transmission (EFT), as stated in the Conditions of Participation of the Provider Enrollment Agreement/Recertification Agreement. Failure to do so may result in the suspension of payments.

EFT allows payment for "clean" claims within five business days. Funds are electronically deposited into a specified bank account, avoiding stop payments and reissues due to damaged or misplaced checks.

EFT has no effect on billing procedures but does apply to all claim types submitted. Providers are not required to submit claims electronically to receive direct deposits.

At time of enrollment, complete the Electronic Funds Transfer Request Form located on the Vermont Medicaid Portal at http://www.vtmedicaid.com/#/provEnrollDataMaint. This form is also used to facilitate a change or cancelation of EFT enrollment.

Select the above link to open the forms page of the Vermont Medicaid Web Portal; scroll down to Enrollment, click the Electronic Funds Transfer Request Form. Once opened, select "save as" from the file drop down menu and rename the document to save a copy to your PC. Open the saved Electronic Funds Transfer Request Form from your PC. Light blue fields indicate where text can be entered. Please remember to save the form whenever changes are made, complete all required sections and obtain the authorized signature.

One of the following documents must be attached to both new EFT enrollment and change enrollment requests for verification of account owner and account number: (1) voided check or (2) a signed letter from your bank that lists the account holder's name, and the appropriate financial institution's account and routing numbers.

Return your completed Electronic Funds Transfer Request Form by mail to: DXC Technology, P.O. Box 888, Williston, VT 05495 or fax to 802-878-3440. Please direct all questions and EFT status requests to the DXC Enrollment Unit at 802-879-4450 (option 4).

8.10 CLAIM DISPOSITION INFORMATION INTRODUCTION

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

8.11 REMITTANCE ADVICE (RA)

The Remittance Advice (RA) is a computer-generated report provided by the fiscal agent. It indicates the status of all claims that have been submitted for processing. The RA is posted at http://www.vtmedicaid.com/#/ a weekly basis, with your four most current RAs available. The banner page of the RA provides important information about policy and billing. See Appendix for RA example.

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

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

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

8.11.1 RA Sections

The RA is divided into the following sections:

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

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

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

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

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

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

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

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

8.11.2 RA Headings & Descriptions

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

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

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

Digit	Description
1-2	Valid region code values for paper claims are: 10-Paper Claim without attachments. 11- Paper claim with attachments Valid region code values for ECS claims are: 40 - ECS The valid region code values for financial items are listed in the description of the financial items section
3-6	The year the claim was received at DXC

7-9	Three digits indicating the Julian Date on which DXC received the claim. These numbers correspond with the calendar dates; see the Appendix document. For example, 001 corresponds with January 1 and 365 correspond with December 31
10-15	The last six digits following the date are designed for DXC control purposes. These numbers uniquely identify the claim and allow personnel to access the claim both manually and through the computer

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

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

BILLED AMT - The amount charged for the service.

ALLOWED AMT -The Vermont Medicaid allowed reimbursement.

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

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

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

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

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

DNUM - The detail number.

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

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

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

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

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

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

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

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

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

ICN - The internal control number of the adjusted claim.

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

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

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

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

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

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

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

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

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

DNUM - The detail number on the adjusted claim.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MEDICARE ID - The Medicare ID of the member if applicable.

8.11.3 Earnings Data & Message Codes

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Claims Paid Amount

\+ System Payout Amount
\+ Manual Payout Amount
\- Recoup Amount Withheld
\- Credit Items
+/- Net 1099 Adjustment (may be positive or negative)

= Net Earnings

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

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

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

8.12 REFUNDS

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

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

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

Section 9 Billing Procedures CMS1500 & UB04 Claim Types

9.1 ABORTIONS

Induced abortions are billable only when the Abortion Certification Form has been submitted and approved by the appropriate funding source prior to the procedure being rendered. Forms can be found by clicking on the applicable Abortion Certification link at http://ovha.vermont.gov/for-providers/forms-1. The two funding source forms are described below.

1. Vermont Medicaid

   Completion of form DVHA 219A is required for abortions performed if the pregnancy is a result of rape or incest, or when the mother's life is endangered by carrying the fetus to term. This consent form and the medical documentation of the situation must be sent to DXC with each claim.

2. State Funds

   Abortions considered medically necessary require the completion of Physician Certification form DVHA 219B, and are paid by the Department for Children and Families (DCF) funding.

   The form must be completed, signed and attached to the claim when submitted for processing.

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

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

Abortion Diagnosis Codes

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

9.2 AIDS/HIV

Vermonters living with HIV infection who meet certain income guidelines may be eligible for help with Medicaid co-payments for treatment drugs through the Vermont Medication Assistance Program (VMAP) http://healthvermont.gov/prevent/aids/aids_index.aspx#Anchor-Th-57625.

Vermont residents not covered by the Medicaid may be eligible for coverage of HIV medications, and/or for benefits. Application for this benefit may be obtained by writing to: VMAP Coordinator, Department of Health-Vermont Medication Assistance Program (VMAP), P.O. Box 70, Burlington, VT 05402.

9.3 ORGAN TRANSPLANT

Vermont Medicaid covers organ transplantation services once the procedure is no longer considered experimental or investigational. Reimbursement will be made for medically necessary health care services provided to an eligible beneficiary or a live donor and for the harvesting, preservation, and transportation of cadaver organs. Post-transplant services for live organ donors are covered under the recipients Medicaid benefit and should be billed under the recipient's Medicaid ID as both the patient and the insured and include the date of birth.

9.3.1 Organ Transplant Donor Complication

The instructions below are only for billing donor complications related to the transplant surgery.

Institutional Electronic Claims for organ donor complications:

- Enter patient relationship code 18 in Form Locator 59 (Patient's Relation to Insured)
- Enter the Medicaid beneficiary's (organ recipient) information in Form Locators: 08 (Patient Name/Identifier), 09 (Patient Address), 10 (Patient Birth Date), and 11 (Patient Sex)
- Add a value of 39 along with the Donor's name to the 837I Loop 2300 , Billing Note Segment NTE02 (NTE01 = ADD)
- Include Occurrence Code 36 (Date of Inpatient Hospital Discharge for covered transplant patients)

Paper UB-04 claims:

- Enter patient relationship code 39 in Form Locator 59 (Patient's Relation to Insured)
- Enter the Medicaid beneficiary (organ recipient) information in Form Locators: 08 (Patient Name/Identifier), 09 (Patient Address), 10 (Patient Birth Date), and 11 (Patient Sex)
- Enter the Donor's name Form Locator 80 (remarks)
- Include Occurrence Code 36 (Date of Inpatient Hospital Discharge for covered transplant patients);

Electronic Professional Claims:

- Enter the recipient's Medicaid number 2010BA Loop. Subscriber Name, NMI1 Segment, Element 9
- Enter the recipient's name 2010BA Loop- Subscriber Name, NM1 Segment, Element 3-5
- Enter 39 and the Donor's Name and address 2300 Loop- Claim Note, NTE segment or 2400 Loop-Line Note, NTE segment

For Paper CMS 1500 claims:

- Enter the recipient's Medicaid number on Item 1A- Insured's I.D. Number
- Enter the recipient's name on Item 2- Patient's Name
- Enter 39 and the Donor's Name and Address on Item 19- Reserved for Local Use

9.4 CPT CATEGORY III PROCEDURE CODES

Category III codes are non-covered because they represent "emerging technology, services and procedures". These services are universally considered experimental or investigational and therefore not covered by Vermont Medicaid. Should a service/procedure represented by a Category III code become accepted medical practice, providers may send written documentation to the DVHA Clinical Operations Unit (fax: 802-879-5963) requesting a coverage review.

9.5 FACTOR HCPCS CODES

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

9.6 FEE SCHEDULE

The Fee Schedule is published at http://dvha.vermont.gov/for-providers/claims-processing-1 for providers to access current reimbursement rates on file for all procedure codes accepted by Vermont Medicaid. Other pertinent information includes pricing effective dates, whether the code requires a prior authorization and allowable provider types and specialties.

Services that are non-reimbursed by Vermont Medicaid are also identified. The PAC 8 (invalid codes) & 9 (non-covered) lists include all codes which are on file as "Do not pay". It is imperative that providers reference this list prior to rendering services to ensure validity of specific procedure codes. When a procedure code is updated to a PAC 9 status, providers are notified 30 days prior to the change via banner.

9.7 HEALTH EXAMINATION OF DEFINED SUBPOPULATION

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

9.8 INTERPRETER SERVICES/LIMITED ENGLISH PROFICIENCY (LEP)

Providers are required under federal and State laws to provide interpreters for patients with limited English proficiency (LEP) and for those who are deaf or hard of hearing.

- Title VI of the Civil Rights Act of 1964
- Title VI regulations, prohibiting discrimination based on national origin
- Executive Order 13166 issued in 2000
- Vermont's Patients' Bill of Rights (18 VSA 1852)
- Vermont Public Accommodations (9 VSA 4502)

9.8.1 Informed Consent

The Vermont Patients' Bill of Rights provides that "the patient has the right to receive from the patients' physician information necessary to give informed consent prior to the start of any procedure or treatment." Additionally, failing to obtain informed consent may be a factor in medical malpractice litigation, although there are some exceptions. For the purposes of medical malpractice actions, "lack of informed consent" is defined as a failure to disclose to the patient reasonably foreseeable risks, benefits, and alternatives to the proposed treatment, in a manner permitting the patient to make a knowledgeable evaluation. In addition, patients are entitled to reasonable answers to specific questions about foreseeable risks and benefits. [12 V.S.A. § 1909] Using interpreters, translations services or other communication aids and services may be necessary to ensure that patients with LEP, who are deaf or hard-of-hearing receive appropriate information about the proposed treatment to enable them to give informed consent to treatment.

9.8.2 HIPAA

An interpreter or bilingual employee is covered under the health care operations exception for purposes of HIPAA, and the patient's written authorization to disclose protected health information is not required. Providers who utilize a private company for interpretation on an ongoing contractual basis should ensure that their contract conforms to the HIPAA Privacy Rule business associate agreement requirements. In other

situations, with disclosures to family members, friends, or other persons identified by an individual as involved in his or her care, when the individual is present, the health care professional or facility may obtain the individual's agreement or reasonably infer, based on the exercise of professional judgment, that the individual does not object to the disclosure of protected health information to the interpreter.

9.8.3 Vermont Medicaid Billing

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

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

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

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

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

Please see the example for further clarification.

Appropriate Modifiers on claims 2-6:

UN – 2 patients served

UP – 3 patients served

UQ – 4 patients served

UR – 5 patients served

US – 6 or more patients served

Same Group Session for Multiple Recipients Example:

Member	Appt Time	Date of Service	HCPCS Code	Modifier	Charge	# of Units
Member 1	8:30 am to 9:55 am	1/1/2015	T1013		$75.00	6
Member 2	8:30 am to 9:55 am	1/1/2015	T1013	UP	$0.00	1
Member 3	8:30 am to 9:55 am	1/1/2015	T1013	UP	$0.00	1

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

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

9.8.4 Limited English Proficiency (LEP) Resources

Organization: AT&T On Demand Interpreter (PHONE)
Web: www.att.com/interpreter

Organization: Voiance (PHONE)
Phone/Web: 1-866-743-9010 www.voiance.com

Organization: Language Line Services (PHONE)
Phone/Web: 1-877-866-3885 www.languageline.com

Organization: Vermont Refugee Resettlement Program (IN-PERSON)
Phone/Email: 1-802-655-1963 vrrp@uscrivt.org

9.8.5 Deaf and Hard of Hearing Resources

Organization: Language Services Associates (IN-PERSON)
Phone/Web: 1-800-305-9573 www.lsaweb.com

Organization: Vermont Interpreter Referral Service (IN-PERSON)
Phone/Web: 1-802-254-3920 www.virs.org

Organization: Registry of Interpreters for the Deaf
Phone/Web: 1-703-838-0030 www.rid.org

Vermont Agency of Human Services: In-house contract for interpretation services.

9.8.6 Additional Online Information

http://www.vtmd.org/interpreter-issues-and-resources
http://www.aot.state.vt.us/civilrights/Documents/VermontTranslationServices-GeneralPublic.pdf

9.9 INPATIENT NEWBORN SERVICES

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

If the baby's MID is not yet available when the provider needs to bill, the mother's ID can be used only if the baby and mother are inpatient together for the duration of the stay, up to 7 consecutive days. The mother's inpatient delivery charge must be paid or claim will deny. This information (of payment) can be verified through the Provider Services help desk at 800-925-1706 or 802-878-7871.

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

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

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

The following information is required on the **CMS1500 Claim Form**:

Field Locator - Information

1a - Mother's VT Medicaid ID number

2 - Baby's name

Use the following name format to indicate twin and multiple-birth babies.

- ABaby
- BBaby
- CBaby

3 - Baby's date of birth

4 - Mother's name

6 - Check "child"

19 - Write “billing for baby under mother’s ID number”.

The following information is required on the **UB04 Claim Form**:

Field Locator - Information

8b. - Baby's name

Use the following name format to indicate twin and multiple-birth babies.

- ABaby
- BBaby
- CBaby

10 - Baby's date of birth

58 - Mother's name

60 - Mother's ID number

80 - Write "Billing for baby under mother's ID number"

Option 2: The provider can wait for the child’s permanent ID number to be issued.

9.10 MODIFIER ‘LT’ & ‘RT’

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

9.11 PLACE OF SERVICE (POS) CODES

POS codes are 2-digit codes placed on health care professional claims to indicate the setting in which a service was provided. CMS maintains the nationwide use of POS codes.

DVHA follows CMS POS instruction when determining the correct facility/non-facility reimbursement. As an entity covered under HIPAA, DVHA must comply with standards and implementation guides adopted by regulations for ASC X12N 837 electronic claim transactions. All electronic and paper CMS 1500 claim forms are required to include a POS code.

A POS Code reflects the actual place where the member receives the face-to-face service and determines whether the facility or non-facility rate is paid. The correct POS code ensures that reimbursement for the overhead portion of the payment is not paid incorrectly to the physician when the service is performed in a facility setting. POS assigned by the physician/practitioner is the setting in which the member received the technical component service.

Further information is included in these CMS publications:

- https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/
- https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html

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

Inpatient hospital (POS 21)	Skilled nursing facility (POS 31)	Psychiatry facility – partial

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

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

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

9.12 REHABILITATIVE THERAPY SEE SECTION 7.7.6

9.13 SPEND-DOWN

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

The following aid category codes indicate Notice of Decision (Spend Down) applies to services provided on the first day of a member's eligibility: PA, PB, PC, PD, PP PR, P3, P4, P5, P6, P7 and P8.

When completing the UB04 Claim Form involving spend-down, the provider must do the following:

1. Enter the spend-down amount shown on the Notice of Decision in field locator 54b. If there was a payment by a third party insurance, add the other insurance payment and spend-down amount in field locator 54b.
2. Enter the spend down amount on the UB04 Medicare Attachment Summary Form (MASF) for Medicare crossover claim types: X and W.
    a. If no Other Insurance payment, check box for NO (6b) on MASF; the provider is to enter the spend down amount in the other insurance field on the MASF.
    b. If there is an Other Insurance payment, check box for YES (6a) on MASF; the provider is to enter the total combined amount of the other insurance payment and the spend down in the other insurance field (6c) on the MASF.
3. Write "Spend-down deducted $(amount)" in field locator 80, labeled Remarks. If any or the entire spend-down amount has been satisfied, write the applicable Internal Control Number (ICN) and the total spend-down amount met by the member.
4. Attach a copy of the Notice of Decision to the claim and submit to DXC for processing. The Notice of Decision must be specific to the provider that is submitting the claim.

When submitting a CMS1500 Claim Form involving spend-down, the provider must do the following:

1. Indicate "spend down" and the amount in field locator 19. If any or the entire spend-down amount has been satisfied, write the applicable Internal Control Number (ICN) and the total spend-down amount met by the member.
2. Put your usual and customary charge in field locator 24f.
3. Total all of the charges appearing on the claim form and write the total amount in field locator 28.
4. Put the amount of the spend down in field locator 29.
5. Enter the spend down amount on the Medicare Attachment Summary Form (MASF) for Medicare crossover claim type: Y.
    a. If no Other Insurance payment, check box for NO (1b) on MASF; the provider is to enter the spend down amount in the other insurance field on the MASF.
    b. If there is an Other Insurance payment, check box for YES (1a) on MASF; the provider is to enter the total combined amount of the other insurance payment and the spend down in the other insurance field (1c) on the MASF.
6. Attach a copy of the Notice of Decision to the claim and submit to DXC for processing.

9.14 LONG ACTING REVERSIBLE CONTRACEPTIVES PROVIDED IN AN INPATIENT HOSPITAL POST-PARTUM SETTING

Vermont unintended pregnancy rate is 47%. Through the Vermont Department of Health, Long Acting-Reversible Contraceptives (LARC) utilization is being promoted as an efficient means to eliminate unplanned pregnancy. Women facing an unplanned pregnancy are at greater risk for a number of social, economic and health problems.

Effective dates of service with a discharge date of January 1, 2016 or after ,when a LARC is provided in an inpatient hospital setting, post-partum, providers must submit claims utilizing the appropriate code from each

category listed in the below table. The claim will adjudicate and a LARC add-on payment of $200.00 will be made in addition to the diagnosis-related group (DRG) portion.

ICD-10-PCS Inpatient Procedure Codes	ICD- 10-CM Diagnosis Codes
0UH97HZ	Z30.014
0UH98HZ	Z30.430
0UHC7HZ	
0UHC8HZ	
0UL74CZ	
0UL74DZ	
0UL74ZZ	
0UL78DZ	
0UL78ZZ	

Section 10 CMS 1500 Claim Submissions

This section contains billing information and instruction specific to the CMS 1500 Claim Form used to bill physician and other specified practitioner services, providers include: audiologists, chiropractors, dentists, naturopathic physicians, nurse practitioners, podiatrists, psychologists, and transportation (emergency and non-emergency) providers. See section 11.16 to obtain CMS 1500 form field locator information and requirements.

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

10.1 PAYMENT DVHA PRIMARY

The DVHA uses the CMS Common Procedure Coding System to describe reimbursable items. Certain reimbursable services require prior authorization. For complete details and a list of codes that require prior authorization, see the Fee Schedule available at http://www.vtmedicaid.com/#/manuals

Vermont Medicaid reimbursement policy for the various CMS 1500 billers is as follows:

Ambulance Services-Reimbursement basis is the lower of the provider's charge or Vermont Medicaid rate on file. The unit of service is the loaded mile, see **Section 10.3.2 Ambulance Services.**

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

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

Chiropractor-Reimbursement basis is the lower of the provider's charge or Vermont Medicaid rate on file. For additional Chiropractic information, see **Section 10.3.10 Chiropractic Services**.

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

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

Dentist-Reimbursement basis for CPT procedures is the lower of the provider's charge or the Vermont Medicaid rate on file when billing on a CMS1500 Claim Form. All other billings are on the ADA Dental Claim Form (see Dental Supplement located at http://www.vtmedicaid.com/#/manuals)

Federally Qualified Health Center**:**

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

Dental Services - Reimbursement is fee-for-service with a cost settlement at year's end.

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

Independent Radiology - Reimbursement basis is the lower of the provider's actual charge for the Vermont Medicaid rate on file not to exceed the Medicare maximum allowable amount. There is no cost settlement. For additional Radiology information, see the CMS 1500 Manual.

Licensed Lay Midwife - Reimbursement basis is the lower of the provider's charge or ninety percent (90%) of the Vermont Medicaid rate on file for a physician providing the same service. Reimbursement is limited to certain procedure codes.

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

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

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

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

Physician:

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

Anesthesiologist - Reimbursement basis is the lower of the provider's charge or Vermont Medicaid rate on file for the procedure. The unit of service is 1 unit equals 1 minute.

Assistant Surgeon - Reimbursement is 25% of allowed amount paid to surgeons. Reimbursement is limited to certain surgical procedures needing assistance.

Pathologists - Reimbursement will be made in accordance with Medicare's *Medigram 83-11* and subsequent Medigrams. The unit of service is the CPT procedure.

Psychiatry - Reimbursement basis is the lower of the provider's charge or Vermont Medicaid rate on file. The unit of service is per visit or for time elapsed.

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

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

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

Psychological Services - see **Section 10.3.47 Psychiatry/Psychology**

Rural Health Clinic:

Primary Care - Reimbursement is on interim, cost-based encounter rates determined using Medicare principles and a final cost settlement at year's end. There is an upper limit to the encounter rate when applicable.

Dental Services - Reimbursement is fee-for-service with a cost settlement at year's end.

Other Ambulatory Services - Reimbursement is Vermont Medicaid fee-for-service rate on file.

10.2 NON-REIMBURSABLE SERVICES

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

The following list identifies some of the most frequently billed non-reimbursable services (this list is not an all-inclusive list):

- Acupuncture
- Biofeedback Therapy
- Cellular Therapy
- Certain prescription drugs
- Cochleostomy with neurovascular transplant for Meniere's disease
- Colonic irrigation
- Cosmetic surgery-Providers are reminded that cosmetic surgery and expenses incurred in connection with such surgery are not covered by Vermont Medicaid. Coverage is available only when such surgery is required for the prompt repair of accidental injury or the improvement of the functioning of malformed body members (that coincidentally serves some cosmetic purpose). Examples of such required surgeries include the treatment of severe burns, facial repair following an auto accident, or severe congenital malformations.
- Electro sleep therapy
- Endothelial cell photography
- Experimental and/or investigational procedures
- Eyeglasses for adults
- Hair analysis
- Hemodialysis for the treatment of cancer
- Hospital and ancillary services related to a non-covered surgery
- In vitro fertilization
- Laetrile and related substances
- Low intensity direct current treatment of ischemic skin ulcers
- Non-medically necessary services
- Non-rebate National Drug Code (NDC)
- Oxygen treatment of inner ear/carbon therapy
- Plethysmography, category II

- Poison ivy desensitization
- Prolotherapy, joint sclerotherapy and ligamentous injections with sclerosing agents
- Repeat sterilizations
- Reversal of sterilizations
- Routine foot care
- Services performed for administrative reasons
- Services related to any non-reimbursable service, such as services ancillary to the reversal of a sterilization
- State-supplied vaccines
- Sterilization under age 21 at the time of signature on the consent form
- Thermal (capsular) heating/shrinkage procedures/surgery
- Thermogenic therapy
- Transvenous (catheter) pulmonary embolectomy

10.3 CMS 1500 CLAIM TYPE – BILLING INFORMATION

10.3.1 Alcohol/Drug Detoxification Treatment

Physicians and Alcohol & Drug Abuse Programs (ADAP) provide services for inpatient alcohol/drug detoxification and are payable when provided within the geographical limits of the state. Treatment facilities outside the state that wish to bill the DVHA, including designated border facilities, must receive prior authorization. A request for prior authorization must be made by or on behalf of the referring or admitting physician. No telephone authorizations will be granted, see the Inpatient Psychiatric & Detoxification Authorization Manual located at http://dvha.vermont.gov/for-providers/mental-health-inpatient-detox for further instruction.

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

10.3.2 Ambulance Services

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

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

Vermont Medicaid is the Payer of Last Resort

All other insurances, Medicare and town or city government must be billed prior to submitting a claim to Vermont Medicaid.

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

Mileage must be rounded to the nearest whole number. When the digit following the decimal point is 0, 1, 2, 3, or 4, round down [keep the digit(s) before the decimal point and drop the digits following the decimal point]. When the digit is 5, 6, 7, 8, or 9, round up by one number. Examples: 36.3 miles becomes 36 miles; 36.5 miles becomes 37 miles.

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

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

Basic/base rates include all procedures (e.g. administration of medications, application of splints). The DVHA does not accept the modifiers utilized by Medicare. Air mileage is no longer included within the ambulance service code and may be billed out separately.
Some service may be covered under **Non–Emergency Transportation (NEMT)** **Section 10.3.38**

SERVICE FROM	SERVICE TO	ALLOWED
1. Member's Home or Nursing Home	Hospital, inpatient admission	Yes
2. Hospital Or Nursing Home Or Discharged As Inpatient	Home, inpatient admission to another hospital, nursing home	Yes
3. Home or Nursing Home	Hospital and return for specialized diagnostic or therapeutic services (not simple follow-up visits)	Yes
4. Inpatient Hospital Status	Another hospital and return for specialized diagnostic or therapeutic services not available at first hospital	No*
5. Scene of Accident	Hospital for emergency room or inpatient admission	Yes
6. Home or Nursing Home	Hospital based renal dialysis facility & return	Yes
7. Home or Nursing Home	Physician's office**	Yes
8. Physician's Office	Home or nursing home**	Yes
9. Home or Hospital	VT Respite House	Yes

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

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

Physician Certification

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

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

trips that are medically necessary, and to expedite their handling and return of the forms to the ambulance service.

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

See **Section 10.3.39 Non-Emergency Medical Transportation (NEMT)** for information regarding transportation for eligible members to and from medically necessary medical services that are Medicaid billable.

10.3.3 Anesthesia

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

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

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

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

Allowable Modifiers

Billable by the Anesthesiologist

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

Billable by the CRNA or Anesthesia Assistant

- QX-Service with medical direction by Anesthesiologist

Billable by the CRNA only

- QZ-Service without medical direction by Anesthesiologist

Billable by the CRNA or Physician

- QS-Monitored anesthesiology care services

  The QS modifier is for informational purposes. Providers must report actual anesthesia time on the claim.

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

Epidural Catheter-Pain Management

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

Units of Service

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

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

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

Local Anesthesia

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

Monitoring Services

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

Spinal Injection/Nerve Block

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

When a spinal injection or nerve block is performed as an independent procedure for diagnostic or therapeutic reasons (not concurrent with surgery), and the code is covered by Medicaid, it is billed as the surgical procedure. The physician, regardless of specialty (e.g. anesthesiologist, surgeon, etc.) must bill on

a CMS 1500 claim form using the specific procedure code for the type of nerve block performed. A unit of service is not time expended: one nerve block equals one unit of service. Please refer to the Fee Schedule for covered codes.

Pre-Surgical Examination

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

10.3.4 Antineoplastic Drugs

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

10.3.5 Assistant Surgeon

Reimbursement of services is limited to the Medicare list of procedures requiring an assistant. It is further limited to one assistant surgeon during an operative session. An assistant surgeon is reimbursed at 25% of the allowed amount paid to the primary surgeon for the procedure. Only one of the assistant surgeon modifiers is allowed to be billed with a procedure code since each modifier indicates a different provider type and/or situation.

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

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

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

10.3.6 Audiological Services/Hearing Aids

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

Audiology services pre-approved for coverage are limited to:

- Audiologic examinations;
- Hearing screening;
- Hearing assessments;

- Diagnostic tests for hearing loss;
- Analog hearing aids, plus their repair or replacement for members of any age;
- Digital hearing aids, plus their repair or replacement for members of any age (see below for further instruction);
- Prescriptions for hearing aid batteries (see below for further instruction);
- Fitting/orientation/checking of hearing aids; and
- Ear molds.

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

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

Batteries

12 batteries per month/per side for Clear in Canal (CIC) and Contralateral Routing of Signals (CROS) and BiCROS. A completed *Medical Necessity Form* (MNF): Substantiating the medical need for the hearing aid must be kept on file for auditing purposes. For all other hearing aid types it remains two packages of 6 batteries per month.

Hearing Aid Repairs

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

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

Non-Covered Services

The following are non-covered services unless authorized for coverage via rule 7104: nonmedical items, such as: maintenance items other than batteries, and fees associated with selection and trial periods or loaners.

10.3.7 Bilateral Procedures Physician/Professional Billing

When bilateral surgical procedures are performed during the same operative session, and the CPT code’s description does not already state “bilateral”, bill the CPT code only once using modifier 50 and bill one unit only. The system will allow one 150% payment.

Modifier 50 is not to be used on claims submitted for bilateral radiology services.

10.3.8 Capsule Endoscopy (Esophagus through Ileum)

Capsule Endoscopy is a reimbursable service by Vermont Medicaid and requires prior authorization from the DVHA. The cost of the capsule and the physician fee are included in the payment. This procedure code

should be billed as one unit and includes a global follow-up care period of 90 days post-procedure. Providers should obtain prior authorization before scheduling the procedure.

Capsule endoscopy of only the esophagus is not covered.

10.3.9 Children with Special Health Needs Infant Toddler Programs

Aid Category Code – SH (Children with Special Health Needs) is used only when submitting medical claims for Physical, Occupational and Speech Therapy (PT,OT,ST), Nutritionist (NU) or Autism Specialist (AU) services only.

Dental claims for Children with Special Health Needs will continue to be processed through the Vermont Department of Health, PO Box 70, Burlington, VT 05402.

10.3.10 Chiropractic Services

DVHA will not pay for any x-rays necessary to substantiate the subluxation. Physicians, hospitals and other providers should be aware that Vermont Medicaid does not pay for any service ordered by a chiropractor. Reimbursement for adult chiropractic is limited to manipulation of the spine.

Members under age 21 may only receive chiropractic services for the manipulation of the spine to correct a subluxation. Chiropractic services for members under age 12 require prior authorization from the DVHA. Visits for adults and children are limited to 10 visits per calendar year. Prior Authorization, from the DVHA, is required for all members requiring additional visits over the 10 visit limit per calendar year. The PA request, accompanied by all pertinent clinical data documenting the need for treatment must be submitted to the DVHA in writing.

10.3.11 Consultation

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

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

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

10.3.12 Detail Processing

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

10.3.13 Developmental & Autism Screening of Young Children

The American Academy of Pediatrics recommends that all infants and young children be screened with valid, reliable screening instruments for developmental delays at regular intervals. To improve detection rates through the use of standardized screening instruments by primary care providers, the DVHA will

reimburse for a developmental screening (CPT 96110) with a standardized screening tool to be billed on the same day as a well-child visit or other E & M codes.

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

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

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

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

General Screening Tools

- Ages & Stages Questionnaire (ASQ) Third Edition (2009) www.agesandstages.com
- Battelle Developmental Inventory: 2nd Edition (BDI-II) - Screening Test (2006) www.riverpub.com
- Bayley Scales of Infant and Toddler Development: 3rd Edition (Bayley-III) Screener (2005) www.pearsonassessments.com
- Brigance Early Childhood Screens (2005) www.curriculumassociates.com
- Infant Development Inventory (IDI) (1998) www.childdevrev.com
- Parents’ Evaluation of Developmental Status (PEDS) (1997) www.pedstest.com
- PEDS: Developmental Milestones (2006) www.pedstest.com

Secondary Screening Tools

- Ages & Stages Questionnaires: Social-Emotional (ASQ:SE) www.agesandstages.com
- Child Behavior Checklist (CBCL) Achenbach System http://www.aseba.org/
- Communication and Symbolic Behavior Scale-Developmental Profile (CSBS-DP):Infant Toddler Checklist http://www.brookespublishing.com/store/books/wetherby-csbsdp/index.htm
- Early Language Milestone Scale (ELM Scale-2) http://www.proedinc.com/customer/ProductLists.aspx?SearchWord=ELM
- Language Development Survey http://www.aseba.org/
- Alberta Infant Motor Scale (AIMS) (1994) http://www.us.elsevierhealth.com/product.jsp?isbn=9780721647210

Autism Screening

The AAP recommends that young children should be screened with valid, reliable screening tool for autism at regular intervals. All children should have an autism specific screening at the 18th and 24th month well child visits. To improve detection rates through the use of standardized screening tool by primary care

providers, the DVHA will allow for an autism screening (CPT 96110) with a standardized screening tool to be billed on the same day as a well-child visit or other E & M codes.

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

When an autism screening is completed in addition to a developmental screening, using two separate standardized screening instruments, bill both on the same claim form using the developmental screening 2013 CPT 96110 with two (2) units. Submit the claim with the required diagnosis for the routine child health check (well child visit) plus an additional diagnosis to indicate that a second screen for special screening for developmental delays in early childhood has been performed. This is necessary to differentiate for reporting purposes.

Required documentation must be maintained in the child's health record and at a minimum, includes the name of the screening instrument(s) used, the score(s) and the anticipated guidance related to the results.

Preferred tool list for autism specific screening

Modified Checklist for Autism in Toddlers (MCHAT) (1999)
http://www.firstsigns.org/screening/tools/rec.htm#asd_screens

10.3.14 Diabetic Teaching

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

10.3.15 Drugs Requiring Prior Authorization

The following medications (listed in alphabetical order) will require a prior authorization when paid through the **medical benefit** as physician or hospital outpatient billing. This allows the consistency of prior authorization requirements between the medical and pharmacy benefits:

Amevive (alefacept), Boniva (ibandronate), Botox (botulinum Type A), Myobloc (botulinum Type B), Orencia (abatacept), Reclast (zoledronic acid injection), Remicade (infliximab), and Tysabri (natalizumab). For a list of ongoing changes, please see the DVHA website at http://dvha.vermont.gov/for-providers.

Effective for dates of service on and after 10/01/13, all claims submitted for Zoledronic Acid must be billed using HCPCS code Q2051.

- Prior authorization is required from Goold Health Systems when this medication is to be used for Osteoporosis or Paget's disease, and
- Prior authorization is not required when this medication is used to treat Hypercalcemia of Malignancy and Multiple Myelona with bone metastasis from solid tumors.

This does not apply to Medicare crossover claims. The following J codes (listed in numerical order) are affected:

J0129, J0215, J0585, J1740, J1745, and J2323

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

The following medications (listed in alphabetical order) may not be billed through the medical benefit:

Soliris (eculizumab), Somatuline Depot (lanreotide), Synagis (palivizumab) and Xolair (omalizumab). For a list of ongoing changes, please see the DVHA website at http://dvha.vermont.gov/for-providers/pharmacy.

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

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

Prescribers are instructed to call or fax the Goold Health Systems Clinical Call Center to request prior authorization for the above mentioned medications regardless of whether the medication will be billed through the medical or pharmacy benefit. Phone: 1-844-679-5363; fax: 1-844-679-5366. For clinical criteria and either the general or specific prior authorization forms at http://dvha.vermont.gov/for-providers/pharmacy.

10.3.16 Dual Eligibility

See Section 6.6 Medicare & Medicaid Crossover Billing

10.3.17 Emergency Indicator

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

10.3.18 Emergency Room Services

Emergency room services include, but are not limited to:

- Consultations
- ER physicians charges
- Radiology
- Laboratory services
- Payment will not be made for professional services for medical follow-up services in the emergency room.

10.3.19 EPSDT Program Well – Child Health Care

Vermont provides Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services to all Vermont Medicaid members under age 21. The goal of the program is to prevent illness, complications and the need for long-term treatment by screening and detecting health problems in the early stages. Services are tracked for appropriate follow-up and reported to CMS by collection of data from Vermont Medicaid claims. The Vermont Department of Health (VDH) assists in EPSDT outreach and education through its’ Partners in Health Program. Under an agreement to implement EPSDT services, the VDH has established protocols and standards for screening services and is available to all providers.

Required EPSDT Screening Components

A. Comprehensive health and developmental history
B. Comprehensive unclothed physical exam
C. Appropriate immunizations
D. Laboratory tests (includes blood lead level and TB screening)
E. Health education/anticipatory guidance
F. Vision screens
G. Dental screens

H. Hearing screens

Screening Service Delivery and Content

A. Screening is provided according to AAP recommended intervals, Vermont Division of Dental Health Services standards, DOH periodicity schedules and as medically indicated

B. Eligible individuals have free choice of qualified providers

Screens include developmental and nutritional assessment

Diagnosis and Treatment Services

A. Diagnostic procedures are reimbursable when medically indicated by a screening examination.

B. Treatment services to correct or improve defects and physical and mental illnesses and conditions discovered by the screening services, are reimbursable, including:

- Vision services
- Dental services
- Hearing services
- Physical, Occupational, and Speech therapy (PT, OT and ST)
- Supportive nursing service (Medicaid High Tech Program)
- Case Management

C. Treatment services may require prior authorization and are limited to:

- Medically necessary, as defined by the Medicaid Division
- The most economical treatment approach
- Authorized providers

EPSDT services are billed to Vermont Medicaid on the CMS 1500 claim form using CPT procedure codes 99381-99385 and 99391-99395 and the appropriate modifiers, “EP”.

Provider-Based Billing requires EPSDT services to be billed on the UB 04 claim form using CPT procedure codes 99381-99385 and 99391-99395 and the appropriate modifier, “EP”.

10.3.20 ESRD Related Services

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

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

10.3.21 Evaluation & Management Services (Post-Operative Care)

Evaluation and Management: (99--- codes)

The following limits apply:

- Services included within payment for E&M service
- Office visits limited to 5 per calendar month per attending
- New patient visits limited to one per member/attending/3 years

- One office visit/day for same member and same attending provider

Post-Operative Care

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

10.3.22 Family Planning Services

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

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

10.3.23 FQHC/RHC

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

Encounters

An Encounter at a FQHC/RHC is defined as a face-to-face visit between a member and a provider. Face-to-face visits with more than one provider and multiple visits with the same provider that take place on the same day and the same location constitute a single visit, except when one of the following conditions exists

(1) After the first encounter, the member suffers illness or injury requiring additional diagnosis or treatment
(2) The patient has a medical visit with a physician, physician assistant, nurse practitioner, nurse midwife, or a visiting nurse, and a visit with a clinical psychologist, clinical social worker, or other health professional for mental health services. *Vermont Medicaid follows the same list of health professionals as Medicare.*

A Vermont Medicaid encounter does not include total OB care.
Centers must bill procedure code T1015 for the encounter in addition to CPT/HCPCS codes for the services provided. The T1015 encounter code is to be billed with a zero charge amount or a negligible charge amount (i.e., $.01 or $1.00) if software prohibits using a zero charge amount. CPT/HCPCS codes for the services must be billed using your usual and customary charge.

Encounter Examples

1. The member is treated for a headache in the morning at the office and returns home. The member returns to the same office a few hours later because the headache is worse, sees the same or a different practitioner, and returns home. The member returns for the third time to the same office for the same problem, and is treated by a third physician and returns home.

   This must be billed and reimbursed as one encounter since the encounters were for the same diagnosis at the same location on the same day.

2. The member is treated during a single visit for both a headache and stomach ache.

   This must be billed and reimbursed as one encounter.

3. The member is treated in the *morning for a headache and returns home. The member* returns the same day for treatment of a laceration.

   This is billed and reimbursed as two separate encounters. When the member has left the office and returns for an unrelated reason, then the service can be billed and reimbursed as a second encounter.

4. The member is treated by a physician and a mental health provider on the same day.

   This is billed and reimbursed as two separate encounters, even if the diagnoses are substantially the same, because one encounter is with a medical provider and the other is with a mental health provider.

5. The member sees her OB for a standard pre-natal visit and returns home. The member returns the same day to see her OB for a separate, pre-natal concern.

   Neither of these antepartum (pre-natal) visits with an OB are considered an encounter by Vermont Medicaid. Antepartum care visits are typically billed globally after the birth.

Hospital or Nursing Home Services

FQHC/RHC provider services delivered at hospitals may be billed as either encounters or fee for service. The billing method used should be consistent throughout the fiscal year.

- Encounter billing: Use the facility number if the services are billed as encounters. The time spent by the provider should be attributed to the same account.
- Fee for Service billing: Use the non-FQHC/RHC provider number and service billed with the appropriate CPT code. These services would are subject to cost settlement and the provider's time spent at the hospital is not an FQHC/RHC allowable cost.
- FQHC/RHCs shall report the method used to the cost report auditor.

Other Insurance

If an FQHC/RHC provides one or more services on the same day to a Vermont Medicaid member with insurance other than Medicare, the visit should first be billed to the other insurer using the appropriate CPT code(s). The facility may bill Vermont Medicaid for the balance between the other insurance payment and the facility's encounter rate using T1015 as the encounter code. (See also instructions for completing field locator 29 on the CMS 1500 form.)

Insurance plans impose various rules for members covered by their plan including a commercial HMO. If a Vermont Medicaid member has other insurance, the member must follow the rules (such as network limitation) of that insurer. Vermont Medicaid will not make a payment for which another insurer is responsible or would be responsible if the member had followed that insurer's rules.

If the other insurer requires a co-payment for office visits that are paid under the capitated rate, Vermont Medicaid will reimburse the provider for this office visit co-pay charge only. To bill the co-pay amount, use procedure code T1015. If FQHC/RHCs want to bill for the co-pay for visits under capitation, they can claim a T1015 but must use the non-FQHC/RHC provider number.

Other Services

- Laboratory services provided by a FQHC or RHC should be billed using the non-FQHC/RHC provider number. These services are paid per fee schedule. See Specimen Collection.
- Radiology services, except dental films, should be billed using the non-FQHC/RHC provider number.
- Dental services provided by FQHC should be billed using the appropriate dental code and the FQHCs dental provider number. These services are paid on the Vermont Medicaid fee schedule, but will be cost settled at year end.

- When a FQHC or RHC bills for completing DVHA treatment plans or refugee forms, or providing Healthy Babies services or planning for an IEP, the service should be billed using the non-FQHC/RHC number.
- Minor equipment and supplies (such as band aids and ace bandages) are assumed to be part of the encounter and are not eligible for reimbursement on an individual basis.
- DME items are to be billed using the appropriate HCPCS codes and would be reimbursed per the fee schedule. A DME Provider Number is required to bill DME items. Your facilities NPI and taxonomy number must indicate that you are a licensed DME provider. A copy of your NPI letter will be required at time of enrollment.

Interim Settlements

After a FQHC or RHC files a cost report, it can request that an interim settlement be made by sending a letter either to DVHA or the DVHA auditor requesting such. DVHA will pay up to 90% of the balance due to the facility, based on the recommendations of the auditor.

10.3.24 Scope-of-Service Related Encounter Rate Adjustments

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

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

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

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

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

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

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

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

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

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

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

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

10.3.25 Health Maintenance Organization (HMO)

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

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

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

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

10.3.26 Hospital Based Physicians

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

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

10.3.27 Hysterectomy

All hysterectomy claims require prior approval from the DVHA Clinical Operation Unit. All hysterectomy claims on members under the age of 55 also require either:

- A valid hysterectomy consent form, or if a valid consent form is not available
- A valid 'Notice of Decision" to provide retroactive eligibility, -or-
- Operative notes or a statement that the member was already sterile prior to the hysterectomy.

The hysterectomy consent form is available on the Department of Vermont Health Access site at http://dvha.vermont.gov/for-providers/clinical-prior-authorization-forms

Note: No prior authorization is required, if the procedure billed is hysterectomy with the primary diagnosis indicating cancer of the genital system.

10.3.28 Immunization

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

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

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

Immunization Administration Codes

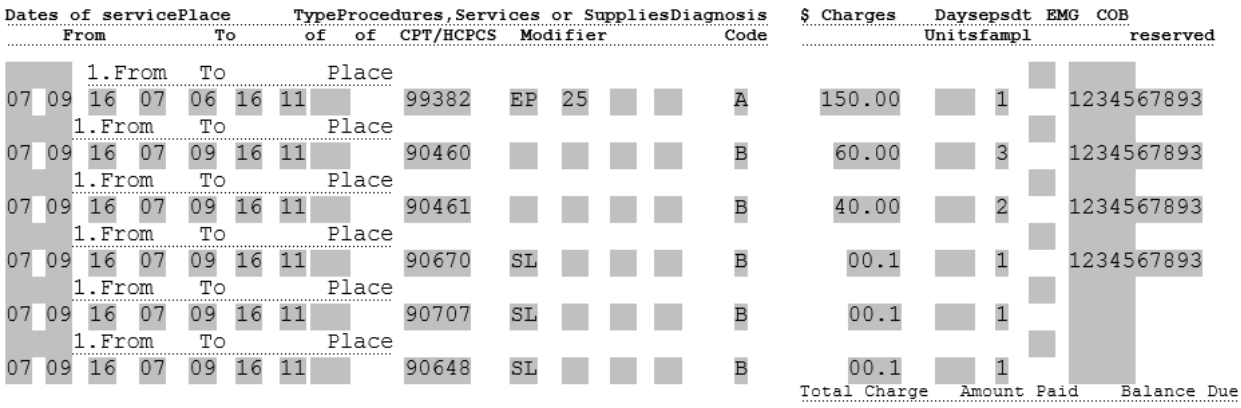
There are several immunization administration codes, depending on age of the patient, whether counseling has been provided or not, and depending on route of administration. There are also codes for the first vaccine component and for each additional vaccine component. When more than one vaccine is administered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

Administration Coding Example:

A 1-year old boy presents for a preventive visit (99382). In addition, the child's father is counseled by the physician on risks and benefits of the Pneumococcal (90670), MMR (90707) and Heamophilus influenza (90648) vaccines. The father signs consent to administration of these vaccines. A nurse prepares and

administers each vaccine, completes chart documentation and vaccine registry entries, and verifies there is no immediate adverse reaction.

- 99382 - Preventative visit, age 1 through 4
- 90670 - Pneumococcal vaccine
- 90460 - Administration first component (1 unit)
- 90707 - Measles, mumps, and rubella (MMR) vaccine
- 90460 - Administration first component (1 unit)
- 90461 - Each additional component (1 unit)
- 90461 - Each additional component (1 unit)
- 90648 - Heamophilus influenza vaccine
- 90460 - Administration first component (1 unit)



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

Total Charge Amount Paid Balance Due

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

10.3.29 Independent Laboratory

The referring physician is the physician or practitioner who actually ordered the tests for the member; he or she must be enrolled as a participating Vermont Medicaid provider. Enter the NPI/taxonomy code combination of the referring physician in field locators 17a and 17b. The billing provider name and address, to which payment will be made, must appear in field locator 33 and the NPI number must appear in field locators 33a and 24j.
The DVHA follows the Medicare billing procedures for physician's billing for laboratory testing. It permits a physician to bill Vermont Medicaid for laboratory testing only when the physician or an employee of the physician performs the test. Physicians who expect to be reimbursed for lab services performed on site must indicate on the claim that the test was performed on site, by completing field locator 20 on the CMS 1500 claim form, and indicate the CLIA certification is on file with DVHA.

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

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

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

Providers who perform laboratory services that have not obtained the appropriate CLIA certification are instructed to contact the Vermont Department of Health, 108 Cherry Street, Burlington, VT 05401 by phone (802) 652-4145 or fax at (802) 865-7701 for information.

In order to be reimbursed for laboratory services furnished in an office setting, providers submitting claims for laboratory services are required to have a CLIA certificate on file with DXC. The services being submitted must be covered by the certificate and within the effective dates. DXC requires a copy of the most current CLIA certificate used by each individual provider, group or facility be sent directly to DXC Technology, Provider Enrollment Unit, PO Box 888, Williston, VT 05495. Please be sure to include your NPI and Taxonomy Code(s) when mailing your copy to DXC.

Additionally, Vermont Medicaid will utilize the QW modifier to indicate a CLIA waived tests following CMS guidelines for billing waived tests. To determine if your lab service requires at QW modifier please refer to the list published at: http://www.cms.gov/CLIA/downloads/waivetbl.pdf.

Lab Handling

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

10.3.30 Injections

Flu Shots

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

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

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

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

Prescribers are instructed to call (1-844-679-5363) or fax (1-844-679-5366) the Goold Health Systems Clinical Call Center to find out which drugs require prior authorization regardless of whether the medication will be billed through the medical or pharmacy benefit. For clinical criteria and either the general or specific prior authorization forms, visit http://dvha.vermont.gov/for-providers/pharmacy.

Pharmacist-Administered

Flu Shots for Adults Effective September 30, 2011, DVHA-enrolled pharmacies may be reimbursed for injectable influenza vaccinations administered by pharmacists to adults 19 years and older enrolled in Vermont's publicly funded programs. Pharmacists must be certified to administer vaccines in the state of Vermont and must be in compliance with all Vermont laws governing vaccine administration. Failure to comply with all Vermont immunization regulations will subject these claims to recoupment. Reimbursement will be based on either a written prescription or a non-patient specific written protocol based on a

collaborative practice agreement per state law. These orders must be kept on file at the pharmacy. The billing pharmacy and the ordering prescriber's NPI is required on the claim for the claim to be paid.

Reimbursement and billing: Under this program, pharmacies are reimbursed for the cost of the vaccine and an administration fee. No dispensing fee is paid for these claims. Pharmacists should bill DVHA using either the paper CMS-1500 claim form or the 837 electronic CMS-1500 Claim Form. A claim for the vaccine must accompany a claim for administration; therefore these vaccinations cannot be billed at POS through the pharmacy benefit. The appropriate billing codes to be used are as follows: Influenza vaccine codes: 90656, 90658 and administration code 90471.

For instructions on billing with a CMS 1500 claim form, see the Provider Manual at: http://www.vtmedicaid.com/#/manuals

For information on reimbursement please refer to the Fee Schedule on the DVHA website: http://dvha.vermont.gov/for-providers/claims-processing-1.

If you have additional billing questions, please contact DXC Technology provider services at 800-925-1706. For other questions regarding this benefit, please contact a member of the DVHA pharmacy unit at 802-879-5900.

10.3.31 Inpatient Services

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

See Section 7 Prior Authorization of Medical Services for a complete listing of in-state and out-of-state hospital admissions prior authorization and notification requirements. Additional information is also available at http://dvha.vermont.gov/for-providers.

10.3.32 Lead Screening

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

10.3.33 Maintenance Drug Prescriptions

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

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

For a complete listing of pharmacy related information and the Pharmacy Provider Manual, go to http://dvha.vermont.gov/for-providers/pharmacy. See DVHA's Clinical Criteria document for drugs with other quantity limits at http://dvha.vermont.gov/for-providers/preferred-drug-list-clinical-criteria.

10.3.34 Mastectomy

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

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

10.3.35 Medical Nutrition Therapy

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

10.3.36 Multiple Surgery Pricing

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

10.3.37 Naturopathic Physicians

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

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

Please access forms at: http://www.vtmedicaid.com/#/provEnrollDataMaint and mail the completed Provider Enrollment Application, General Provider Agreement and the Agreement for Participation for Naturopathic Physicians, along with any additional documentation, to: DXC Technology, Attn: Enrollment Unit, P.O. Box 888, Williston, VT 05495-0888.

10.3.38 NDC (National Drug Code)

Vermont Medicaid requires the collection and submission of rebates for all drugs dispensed or administered by providers other than a pharmacy. This allows for the collection of Medicaid drug rebates from manufacturers on all drugs dispensed in any office setting. The NDC billed to Vermont Medicaid must be the NDC that was dispensed to the member.

Drugs supplied by manufacturers currently participating in the rebate program will be the only drugs reimbursed by Vermont Medicaid. A list of these manufacturers, by code and name, can be found at http://www.vtmedicaid.com/#/resources.

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

NDC Requirements on CMS 1500 Form

When entering an NDC on your claim form, please enter the following data elements in the following order: NDC, measurement qualifier code and unit quantity. Do not insert brackets, spaces or dashes. Claims formatted incorrectly will be denied.

FL 24D: HCPCS code

FL 24D Shaded area: 11 digit NDC number, Unit of Measurement Qualifier, and Unit Quantity

FL 24G: HCPCS unit

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

* Unit of Measurement Qualifier
F2-International Unit GR-gram ML-Milliliter UN-Unit

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

10-Digit Format on Package	10-Digit Format Example	11-Digit Format	11-Digit Format Example	Actual 10-Digit NDC Example	11-Digit Conversion Example
4-4-2	9999-9999-99	5-4-2	**0**9999-9999-99	0002-7597-01 Zyprexa IM□ 10mg vial	**0**0002-7597-01
5-3-2	99999-999-99	5-4-2	99999-**0**999-99	50242-040-62 Xolair□	50242-**0**040-62
5-4-1	99999-9999-9	5-4-2	99999-9999-**0**9	60574-4112-1 Synagis□ 50mg vial	60574-4112-**0**1

10.3.39 Non-Emergency Medical Transportation (NEMT)

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

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

For further NEMT information and requirements go to http://dvha.vermont.gov/for-providers/transportation.

10.3.40 Obstetrical Care

Vermont Medicaid covers obstetrical (OB) care (traditional and midwife services) by one of two methods outlined in the CPT book under the Surgery/Maternity Care & Delivery section and reiterated here in the Provider Manual. Services can be billed as total OB care (global billing) or partial (non-global billing). Charges for both Total OB codes and Partial OB codes cannot be billed for the same pregnancy. The combination of all partial OB charges for a given pregnancy cannot exceed the reimbursement rate for total OB care.

A total OB procedure code is used when all OB-related care is provided by the same physician/practitioner or practitioners in the same group practice. A total OB procedure code encompasses the services normally provided in uncomplicated maternity cases, which include antepartum care, delivery, and postpartum care. *The date of service for total OB care is the day of delivery.*

When different physician groups provide OB care for the same pregnancy, total OB codes cannot be used.

Please note: Confirmation of pregnancy during a preventative or a problem oriented visit is not considered part of antepartum care and should be reported using the appropriate E/M service code.

Antepartum care includes: “initial and subsequent prenatal history and physical examinations; recording of weight, blood pressures, fetal heart tones, routine chemical urinalysis, and monthly visits up to 28 weeks gestation; biweekly visits to 36 weeks gestation; and weekly visits until delivery”

Delivery includes: “admission to the hospital, the admission history and physical examination, management of uncomplicated labor, vaginal delivery (with or without episiotomy, with or without forceps), or cesarean delivery”

Postpartum includes: “office or other outpatient visits following vaginal or cesarean section delivery”

Partial OB code billing Instructions:

The combination of all partial OB charges for a given pregnancy cannot exceed the reimbursement rate for total OB care.

Antepartum Care

- Antepartum Care, billing 1-3 visits; use appropriate E/M codes for each visit.
- Antepartum Care, billing 4-6 visits; use CPT code 59425 with the range of dates billed as 1 unit.
- Antepartum Care, billing 7 or more visits; use CPT code 59426 with the range of dates billed as 1 unit.

Delivery Care

Only one delivery code can be billed for a member in a 9-month date span (with the exception of multiples. Please see special instructions below)

Postpartum Care

Only one unit of the postpartum care only code can be billed for a member, per pregnancy, using a single date of service (use the date of the final encounter completing postpartum care). This code includes all after-delivery E/M visits related to the pregnancy (office or other outpatient visits) following a vaginal or cesarean section delivery.

New Instructions for OB Code Billing Instructions for ICD-10

Global billing:

The date of service for total OB care is the day of delivery even though it includes antepartum care received prior to this date and the postpartum check-up performed after the day of delivery.

Non-global billing:

Billing instructions for antepartum care:

- Antepartum Care, billing 1-3 visits; use appropriate E/M codes for each visit.
- Antepartum Care, billing 4-6 visits; use CPT code 59425 with the DOS of the sixth visit billed as 1 unit.
- Antepartum Care, billing 7 or more visits; use CPT code 59426 with the DOS of the last visit billed as 1 unit.

Billing instructions for delivery:

- Only one delivery code can be billed for a member in a 9-month date span (with the exception of twin deliveries. Please see special instructions below). The delivery date is the DOS.

Billing instructions for postpartum care:

- Only one postpartum code can be billed for a member in a 9-month date span. This code includes office or other outpatient visits following a vaginal or cesarean section delivery. Please use the 6 week check-up as the DOS.
- This code includes all after-delivery E/M visits related to the pregnancy

Special Instructions:

The Fetal Non-Stress Test

1 unit will cover the non-stress test for both twin A and twin B when billed with modifier 22. Notes are not required when a twin diagnosis is indicated on the claim.

Twin Deliveries

The DVHA will reimburse for the delivery of twins at 100% (twin A) and 50% (twin B) of the prices on file. The provider should bill both deliveries on the same claim and use a twin diagnosis code for both. One code has to be a “delivery only” code.

Assist at Cesarean Delivery

A surgical assistant at a cesarean delivery cannot bill the “Total OB” procedure code because the assistant did not give the prenatal care. To bill for service as the assistant, use the “delivery only” procedure code with one of the following modifiers:

80-Assistant surgeon (MD or nurse practitioner)

AS-Physician’s assistant assisting at surgery (Only one assistant is covered per surgery).

External cephalic version (ECV) is only eligible for reimbursement for pregnancies at or beyond 36 weeks gestational age. Notes are required to confirm the service was performed. Only one ECV (successful or not) is reimbursable per pregnancy.

Abortion

Abortion includes miscarriages (“spontaneous abortion”), missed abortion, and induced abortion.

OB deliveries pertain only to infants who have an Estimated Gestational Age (EGA) of 30 or more weeks (viability). When the fetus is less than 7 months EGA and a non-induced fetal demise occurs, see procedure codes for surgical intervention and/or medical visit codes for medical assistance. Do not use “delivery” codes.

Example A

Member goes to Dr. A for 3 visits; Dr. A would bill the appropriate E/M code for each visit with each applicable date of service.

Member switches to Dr. B for the remainder of her pregnancy. Dr. B sees the member for 6 visits; Dr. B bills out ONLY code 59425 with range of days and 1 unit. If Dr. B delivers, he would also bill the appropriate delivery code.

Example B

Member goes to Dr. A for 5 visits; Dr. A bills 59425. Member then goes to Dr. B for one visit; Dr. B will ONLY bill the E/M code for the visit he provided. Member goes to Dr. C for 8 visits; Dr. C would bill 59426 with range of days and 1 unit. Dr. C delivers and would bill the appropriate delivery code.

A Member may see more than one attending provider when billing multiple antepartum visits (CPT 59425 or CPT 59426) within the same billing group/practice. It is up to the practice to determine which attending provider number to use when submitting the claim.

10.3.41 Midwife Services

A "Licensed Midwife" means anyone who has met the requirements set down by the American College of Nurse-Midwives and by the North American Registry of Midwives and who meets the eligibility criteria set forth in rule. These are the two types of Licensed Midwifes that Vermont Medicaid recognizes and reimburses:

1. “Certified (Nurse) Midwives” are advanced practice nurses and are licensed independent providers who possess a degree from a Vermont graduate program and are certified by the American College of Nurse-Midwives. Nurse Midwives are subject to the nursing and midwifery rules
2. “Licensed (Professional) Midwives” are laypersons certified by North American Registry of Midwives who possesses a high school degree or its equivalent; subject only to the midwifery rules.

Licensed Certified Nurse Midwives may be enrolled as independent practitioners or physicians may employ them.

Important Billing Reminder for Licensed Midwives (Nurse and Professional):

Delivery codes are valid only for pregnancies with an estimated gestational age of 30 or more weeks (viability)

Licensed Midwives (Nurse and Professional) will not be reimbursed for surgery of assistant-at-surgery charges

See **Section 10.3.40 Obstetrical Care** for Total OB and Partial OB billing instructions. Total OB codes and Partial OB codes cannot be billed for the same pregnancy.

When the MD, Licensed midwife (Nurse and Professional), or nurse practitioner monitors labor in the member’s home (for a planned home birth) but then has to admit the mother to the hospital for delivery, and the delivering MD is not a member of the same provider group, the initial provider can bill for the prolonged services in the office or other outpatient setting.

The DVHA will reimburse prolonged services only when a planned home delivery results in a hospital admission and the delivery is done by a different Medical Doctor/Medical Doctor group (these services are included in regular OB billing when the providers are of the same billing group).

The billed units must reflect the time spent in face-to-face contact with the member in the home and/or on the way to the hospital. Each claim will suspend for review. Please submit copies of the provider's record(s) with each bill documenting the number of units billed.

Examples

The Licensed midwife (Nurse and Professional) and MD were present in the member's home to monitor the labor. Due to a lack of progression and meconium staining in the amniotic fluid, the member was transported to the hospital and her care transferred to the hospital physician, who delivered the baby. The initial MD was with the member "for the entire labor, monitoring the baby, the mother and the progress of the labor."

The documented time shows 5 hours. For these services (which include the midwife's attendance), the DVHA can be billed one unit of procedure code 99354 and 8 units of 99355.

The Licensed midwife (Nurse and Professional) monitored the labor in the home for 15 hours, transported the member by car (1/2 hour) and stayed 4 more hours at the hospital after the transfer. Upon admission to the hospital, the care was assigned to the hospital physician who delivered the baby by C-section. The midwife had started an IV of ringers lactate while still at the home. The nurse midwife's services may be billed with one unit of 99354 and 29 units of 99355. All care given during the face to face contact, including the IV insertion and supplies, is included within the reimbursement of these two procedure codes. There can be no charge for the initial MD/midwives services as of the admission to the hospital since all care at this point becomes part of the delivery payment.

Summary

The DVHA will reimburse prolonged services codes only when a planned home delivery results in hospital admission and the delivery is done by a different MD/MD group (these services are included in regular OB billing when the providers are of the same billing group.) The billed units must reflect the actual time spent in face-to-face contact with the member in the home and/or on the way to the hospital. Each claim will suspend for review, so clear copies of the provider's records must be submitted with each bill documenting the number of units billed. The place of service (POS) must be a 12 (home).

Licensed midwives (Nurse and Professional) may receive reimbursement for RhoGAM injections using the appropriate HCPCS & NDC code with a maximum of one unit. See NDC (National Drug Code).

Use the appropriate office visit and diagnosis codes when a member is seen at the office for a pregnancy test. If you bill a pregnancy diagnosis for the purpose of testing for a pregnancy that has not yet been established, your claim will cause subsequent prenatal claims to be denied as it is considered to be one prenatal visit if a pregnancy diagnosis is recorded on the claim.

10.3.42 Oral Surgery

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

10.3.43 Over-The-Counter (OTC) Medications

Coverage of Over the Counter (OTC) medications is primarily limited to generics only in categories determined to be medically necessary. All other OTC products will be excluded from coverage without the option for a prior authorization request through the Clinical Call Center. The coverage guidelines apply to Medicaid, Dr. Dynasaur and VPharm. DVHA pays for OTCs only when there is a specific medical necessity, and requires a prescription for the OTC product. Some OTC medications are already managed on our Preferred Drug list (PDL) and other restrictions may apply. Though the DVHA has restricted OTC medications to primarily generics, members will continue to have at least one choice in all medically necessary drug categories. Please refer to the DVHA website for a list of covered OTC medication categories at http://dvha.vermont.gov/for-providers/pharmacy. The PDL can be found at http://dvha.vermont.gov/for-providers/preferred-drug-list-clinical-criteria.

10.3.44 Oximetry Services

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

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

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

10.3.45 Pharmacologic Management (Psychiatric)

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

10.3.46 Physician Visit Limits

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

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

Visits in excess of those listed above may be reimbursed if the services are medically necessary. A medical exception request documenting the medical necessity must be sent to the DVHA. Forms for prior authorization are located at http://dvha.vermont.gov/for-providers/forms-1.

Non-emergency (elective) out-of-state medical visits will require prior authorization from DVHA (In network OOS hospitals are excluded from this requirement). In network referring providers are to submit requests using the OOS Medical Office Request Form located at http://dvha.vermont.gov/for-providers/clinical-coverage-guidelines.

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

10.3.47 Post-Operative Follow-up Visits

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

10.3.48 Psychiatry/Psychology

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

Prescribing health care professionals, conducting pharmacologic management, will now use the appropriate E/M code. When psychotherapy is done during the same session as the pharmacologic management, one of the new psychotherapy codes should be used along with the E/M code. The

psychiatrist or other qualified health care professional will specify the level of E/M work done and add the psychotherapy component based on the time spent delivering psychotherapy.

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

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

Psychiatric Diagnostic Evaluation

- A distinction has been made between diagnostic evaluations without medical services and evaluations with medical services
- Interactive services are captured using an add-on code
- These codes can be used in any setting
- These codes can be used more than once in those instances where the patient and other informants are included in the evaluation
- These codes can be used for reassessments
- Psychiatrists and other medical providers have the option of using the appropriate E&M code in lieu of the 90792

Code Descriptions specifying "With medical services" refers to medical "thinking" as well as medical activities, such as: physical examination, prescription of medication, and review & ordering of medical diagnostic tests. Medical thinking must be documented, e.g. consideration of a differential diagnosis, medication change, change in dose of medication, drug-drug interactions, etc.

Psychotherapy

The new series of psychotherapy codes (90832 – 90838) was established to replace individual psychotherapy codes (90804 – 90829). Site of service is no longer a criterion for code selection and time specifications were changed to be consistent with CPT convention.

- Psychotherapy codes are no longer site specific
- Psychotherapy time includes face-to-face time spent with the patient and/or family member and/or legal guardian
- Time is chosen according to the CPT time rule
- Interactive psychotherapy is reported using the appropriate psychotherapy code along with the interactive complexity add-on code
- Group therapy (90853) is limited to no more than 3 sessions per week. Reimbursement is limited to one session per day, per group and no more than 10 in a group.

Crisis Psychotherapy

Crisis is defined as:

> "An urgent assessment and history of a crisis state, a mental status exam, and a disposition. The treatment includes psychotherapy, mobilization of resources to defuse the crisis and restore safety, and implementation of psychotherapeutic interventions to minimize the potential for psychological trauma. The presenting problem is typically life threatening or complex and requires immediate attention to a patient in high distress."

A new subsection, Psychotherapy for Crisis, with guidelines was established to report these services. These are timed codes and additional instruction on the appropriate use of the new codes is included in the 2013 AMA CPT4 codebook.

- 90839, Psychotherapy for crisis, first 60 minutes
  (CPT Rule applies: 30-74 minutes)
- +90840 (add-on), Psychotherapy for crisis each additional 30 minutes

Important Billing Concepts to Consider

CPT Time Rule

"A unit of time is attained when the mid-point is passed"

"When codes are ranked in sequential typical times and the actual time is between two typical times, the code with the typical time closest to the actual time is used."

Example: 90832, 90833 is 16-37 minutes
90834, 90836 is 38-52 minutes |
90837, 90838 is 53 minutes and more

Interactive Complexity

A new subsection has been added to the Psychiatry section for reporting interactive complexity. Interactive complexity is specific and recognized communication difficulties for various types of patients and situations that represent significant complicating factors that may increase the intensity of the primary psychiatric procedure.

Add-on Code 90785 is used to report interactive complexity services when provided in conjunction with psychotherapy codes. See the 2013 AMA CPT4 codebook for further explanation of when and how this code should be used. The guidelines include a list of requirements or factors to consider when determining appropriate use of the interactive complexity code.

- "Interactive" in previous codes was limited in use to times when physical aids, translators, interpreters, and play therapy was used

- "Interactive Complexity" extends the use to include other factors that complicate the delivery of a service to a patient and may be reported when at least one of the following is present:
    - Arguing or emotional family members in a session that interfere with providing the service
    - Third party involvement with the patient, including parents, guardians, courts, and schools
    - Need for mandatory reporting of a sentinel event
    - Impaired patients
    - Young and verbally undeveloped
- When performed with psychotherapy, the interactive complexity component (+90785) relates only to the increased work intensity of the psychotherapy service, but *does not* change the time for the psychotherapy service

<u>Documentation Standards for Mental Health and Substance Abuse Health Records</u>

At a minimum, the documentation in a mental health/substance abuse health record will include the following core components:

1. Identifying data
    - Name/unique ID, date of birth, and other demographic information as needed,
2. Dates of service
    - Documentation by the primary treatment provider of all dates and the amount of time clinical services were provided
3. Comprehensive clinical assessment (e.g., biopsychosocial, medical history, etc.)
    - Evidence that a comprehensive clinical assessment has been completed, with documentation of a presenting problem and patient placement to support clinical level of care, such as:
        a. Outpatient
        b. Intensive outpatient
        c. Partial hospitalization
        d. Residential
        e. Inpatient,
    - Evidence of ongoing reassessment as needed
4. Treatment and continued care planning
    - Documentation of treatment plan, including the following:
        a. Prioritization of problems and needs,
        b. Evidence that goals and objectives are related to the assessment,
        c. Evidence that goals and objectives are individualized, specific, and measurable, with realistic timeframes for achievement,
        d. Specific follow-up planning, including but not limited to anticipated response to treatment, additional or alternative treatment interventions, and coordination with other treatment providers
        (e.g., PCP)
5. Progress Notes

- Documentation supporting continued need for services based on clinical necessity, including the following:
    a. Dated progress notes that link to initial treatment plan,
    b. Updates or modifications to treatment plan,
    c. Interventions provided and client's response,
    d. Printed staff name and signature or electronic equivalent.

For additional information concerning DVHA's *Mental Health and Substance Abuse Health Record Documentation Standards* and resources see http://dvha.vermont.gov/for-providers and click on "Clinical Initiatives".

Community Mental Health Center Services

Covered services include rehabilitation services provided by qualified professional staff in a community mental health center designated by the Department of Mental Health. These services may be provided by qualified mental health providers as identified by the Vermont Department of Mental Health (DMH). For further information, see the DMH manual at http://mentalhealth.vermont.gov/publications.

10.3.49 Radiology

Radiologic Components

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

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

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

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

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

High-tech outpatient elective diagnostic imaging scans require prior authorization from MedSolutions. Diagnostic Imaging Program Guidelines and other provider resources are available at http://www.vtmedicaid.com/#/resources

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

In these cases, the procedure with the highest intensity will be paid at 100% of the fee schedule rate and

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

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

10.3.50 Smoking Cessation Counseling

Face-to-face smoking cessation counseling is covered for eligible Vermont Medicaid members of any age who use tobacco. The maximum number of visits allowed per calendar year is 16. This coverage applies when furnished by (or under the direction of) a physician or by any other health care professional who is legally authorized to furnish such services under state law and licensure. “Qualified” Tobacco Cessation Counselors are also allowed, (requires at least eight hours of training in tobacco cessation services from an accredited institute of higher education).

Providers must code each claim with the correct diagnosis for tobacco use.

Pharmacological Coverage

See the most recent Clinical Criteria document at http://dvha.vermont.gov/for-providers/preferred-drug-list-clinical-criteria for Smoking Cessation Therapy information, preferred drug list and PA requirements.

10.3.51 Specimen Collection Fee

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

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

10.3.52 Sterilizations

Sterilizations of either a male or female member are covered only when the following conditions are met:

1. The member has voluntarily given informed consent and has so certified by signing the Sterilization Consent Form located at http://www.vtmedicaid.com/#/forms
2. The member is mentally competent
3. The member is at least 21 years of age at the time consent is obtained
4. At least 31 days but not more than 180 days have passed between the date of informed consent and the date of sterilization except in the case of premature delivery or emergency abdominal surgery. In those cases, at least 72 hours must have passed between the informed consent and the operation.

Operations or procedures performed for the purpose of reversing or attempting to reverse the effects of any sterilization procedure are not covered. Federal law does not permit payment for sterilization of any members under the age of 21.

10.3.53 Team Care Program

The Team Care Program restricts a member to one physician and one pharmacy. If a member is "locked-in" to a provider, that provider's name is available on the Voice Response System and the Vermont Medicaid website. Claims for services by any provider other than the "lock-in" provider(s) are not reimbursable by Vermont Medicaid, except in the case of an emergency or when a provider performs a service by referral of the named provider.

The "lock-in" procedure also applies to a Primary Care (PC) Plus member. The "lock-in" reflects the member's choice of primary care physician. This information is also available through the VRS and the Vermont Medicaid web site.

10.3.54 Telemedicine Services

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

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

- Must be a Medicaid-enrolled provider

Billing Rules for Telemedicine:

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

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

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

10.3.55 Topical Fluoride Varnish

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

10.3.56 Vision Care & Eyeglasses

Eye Exams

Reimbursement for eye exams is limited to one comprehensive visual analysis and one interim eye exam within a two-year period. The quantity limitations for reimbursement of eyeglasses and associated fitting fees are below. In line with current DVHA policy related to dates of service, providers may bill eyeglass fitting fees on the day they order the glasses.

Eyeglasses

Eyeglass benefits (frames, lenses, dispensing and repairs) are reimbursed only for Medicaid members under age 21.

When sending a Medicaid member's eyewear prescription to Classic Optical (the DVHA's sole-source eyewear provider), please provide the NPI of the ordering/prescribing practitioner. A business, group or company NPI Number will not be accepted. Classic Optical cannot fill the order without the NPI of the person giving
the order.

Coverage for eyeglasses is limited to one pair of glasses every two years per member, see exception noted below. Earlier replacement for any reason restarts the benefit period. Reimbursement for earlier replacement is limited to the following:

- Eyeglasses have been lost or broken beyond repair, or scratched to the extent that visual acuity is compromised
- Change of at least one-half diopter in lens strength.

Exception: Members under the age of six are allowed one pair of eyeglasses every year without obtaining prior authorization. Clinical best-practice validates annual replacement for children under age 6 years due to physical growth.

- Eyeglasses are provided only under the terms of a contract between the state and the sole source vendor, Classic Optical Laboratories, Inc. All frames and lenses must be ordered from:

Classic Optical Laboratories, Inc.
P.O. Box 1341
Youngstown, Ohio 44501

Phone: 888-522-2020
www.classicoptical.com

Business Hours:
8:00 am-5:30 pm EST, Monday through Friday

- Providers submitting requests for lost or broken eyeglasses (lenses & frames) are required to include that information on the order form or add the KX modifier to indicate lost or broken.
- Eyeglass cases can be billed only by Classic Optical as part of the sole-source contract.

Procedure Codes - Fitting vs. Repair and Refitting

- Fitting of Spectacles CPT code descriptions should be viewed when fitting a new pair of eyeglasses to the member and if glasses are replaced if lost or broken beyond repair to select the most appropriate billing code. The claim must indicate the circumstance in form locator 19 on the CMS1500 or electronically in the Notes section regarding replacements. One fitting fee code applies, whether one or both eyes are involved.
- Repair and Refitting Spectacles codes are used for the in-office repair of eyeglasses. Codes for Repair and Refitting Spectacles are not applicable when ordering frames, lenses or eyeglasses or for replacement.

Eligibility

Eligibility verification is the responsibility of the provider and must be verified before an order is sent to Classic Optical. Providers may check eligibility through web access at http://www.vtmedicaid.com/#/ or call the Voice Response System (VRS) at (800) 925-1706 (in-state only) or (802) 878-7871.

Prior Authorization (PA)

Medical necessity for special frames or lenses outside of Vermont Medicaid's sole-source contract requires that the prescribing optometrist or ophthalmologist seek prior authorization from DVHA. This applies for new lenses when Classic Optical determines that the member's current lenses cannot be incorporated safely and reasonably into the special frames.

The following circumstances require prior authorization:

- Frame has been outgrown and needs to be replaced within the benefit period
- Replacement for a change in Rx (must be at least +/- 0.50 D in at least one eye) within the benefit period
- Replacement of frames or lenses other than those that are broken or lost within benefit period
- Scratched lenses to the extent that visual acuity is compromised.

The following benefits require prior authorization

- V2025 (deluxe frames)
- V2744 (photochromic lens)
- V2745 (any other tint added to the lens)
- V2762 (polarized lens)
- V2199, V2299, V2399, V2799 (miscellaneous vision service)

The Prior Authorization Form is available from

- Classicoptical.com or phone 1-888-522-2020
- http://dvha.vermont.gov/for-providers/forms-1

The requesting/dispensing provider's NPI and taxonomy combination must be listed on the Prior Authorization Form and must match the NPI # and corresponding provider name on the CMS-1500 claim form. Per federal regulation, do not use the Medicaid ID number.

Prior Authorization change requests must come from the original requesting provider. Any requests to change or update an original or an existing prior authorization must be in the form of a detailed letter referencing the PA number, stating the change(s) requested, and explaining why the change is needed. A copy of the existing PA is not necessary.

Contact Lenses

- Prior authorization is required.
- Reimbursement may be available from the DVHA for contact lenses for the optimum management of ocular conditions such as aphakia, keratoconus, or corneal transplant.
- A single lens, not a pair, is considered one unit. When a physician supplies two contact lenses to a member, one for each eye, the procedure code must be billed twice; once with modifier LT and once with modifier RT.

Cataract Removal

Cataract procedures are reimbursable and prior authorization is not required.

Non-Reimbursable Items:

- Oversized frames and lenses
- Tints-Unless for ultra violet cataract lens

Additional clinical information is located at http://dvha.vermont.gov/for-providers/clinical-coverage-guidelines (Vision Care).

See Section 10.3.21 **EVALUATION & MANAGEMENT SERVICES** for information on billing non-routine vision office visits.

Section 11 Durable Medical Equipment (DME), Prosthetics, Orthotics & Medical Supplies

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

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

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

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

11.1 RENTAL REIMBURSEMENT POLICIES

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

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

11.2 CAPPED RENTALS (CR)

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

For a full list of codes, please see Medicare's DMEPOS fee schedule here:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html.

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

Specifically, CRs will be paid in the following manner:

- Like Medicare, only the RR modifier can be billed for these codes
- For CR items not classified as "Power Wheel Chairs", the purchase price reflected on the fee schedule will be equal to the RR * 10. The DVHA RR rate in months 1 – 10 will be equal to the Medicare Rate (Medicare RR Rate * 10)/10 but not adjusted differentially in months 1 -3 and 4-13 as Medicare does.
- For CR items classified as "Power Wheel Chairs", the purchase price will be equal to the Medicare RR / 0.15 to reflect that Medicare RR rates for these items represents 15% of the purchase price. The DVHA RR rate therefore, will be equal to the purchase price/10. DVHA will not adjust the RR rate in months 1 -3 and 4 -13 as Medicare does. At this time, DVHA will follow Medicare's classification of what is considered "Power Wheel Chairs". A list of these codes will be provided upon request.
- At month 10, payments are capped and DVHA assumes ownership.

11.3RENTAL/LOANED

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

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

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

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

Effective for dates of service on or after May 1, 2018 providers may bill for supplies up to the DVHA quantity limit during the rental period for: E0445, E0465, E0466, E0470, E0471, E0565, E0600, and E0601. As part of the DVHA's annual Fee Schedule maintenance, the DVHA will solicit public comment on revisions to the code list. When billing for supplies on member owned equipment, the supplier must state on the claim or medical necessity form that the related piece of equipment is not being rented (e.g., "CPAP is not being rented" or "…is owned by the member").

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

11.4 FACE-TO-FACE REQUIREMENTS

As of 4/1/2018, the Agency of Human Services (AHS) will require physicians enrolled in Vermont Medicaid to document that a face-to-face encounter occurred for the initial ordering of specified durable medical equipment and supplies. This change assures compliance with federal requirements at 42 CFR §440.70(f). This requirement only applies to durable medical equipment, supplies, and services that are also covered by Medicare as found at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Downloads/DME_List_of_Specified_Covered_Items_updated_March_26_2015.pdf.

Face-to-face Requirement also includes power wheelchairs.

The face-to-face encounter **mus**t be no more than 6 months prior to the start of service. Documentation of the face-to-face visit is a required component of the physician's order for services.

The following elements must be present in the documentation:

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

The ordering physician must document:

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

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

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

- A nurse practitioner, clinical nurse specialist, or certified nurse midwife working in collaboration with the ordering physician,

  -or-

- A physician assistant under the supervision of the ordering physician.

11.5 REIMBURSABLE/NON-REIMBURSABLE SERVICES

Reimbursable/non-reimbursable information and prior authorization information is available on the Department of Vermont Health Access website at http://dvha.vermont.gov/for-providers/claims-processing-1 .

DME guidelines, including wheelchairs and other mobility devices, augmentative communication devices, prosthetics, orthotics and medical supplies are available at http://dvha.vermont.gov/for-providers/clinical-coverage-guidelines. See Medicaid Rules, 7504, 7505, 7506, 7507, and 7508; at http://humanservices.vermont.gov/on-line-rules.

11.6 PAYMENT DVHA PRIMARY/MANUAL PRICING

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

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

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

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

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

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

11.7 PAYMENT-DUAL ELIGIBLE/MEDICARE PRIMARY

When Medicare is the primary payer, the provider must accept assignment of the claim in order to receive any DVHA payment. This applies to all claims for services and items. See **Section 6.6 Medicaid & Medicare Crossover**.
If the claim is submitted to Medicare on an assigned basis, when the DVHA receives the crossover claim, it will pay the coinsurance and deductible amounts due.

In order to assure access, the DVHA has created five exceptions to the above procedure. The exceptions are limited to claims for:
☐Wheelchairs

☐Seating systems

☐Cushions that are part of a seating system

☐Seat lifts, and

☐Repairs to wheelchairs for which Medicare did not participate.

For these items, a provider may submit a prior authorization request to the DVHA asking for a medical necessity determination and provisional [or conditional] authorization for Medicaid coverage. When a provider submits a request for prior authorization of a wheelchair, seating system, cushions that are part of a seating system or seat lift for a dually eligible member, the DVHA will review the request for medical necessity and for sufficient information to support pricing. If the DVHA determines that the request is medically necessary, it will provisionally [conditionally] approve the request. The claim must then be submitted to Medicare.

If Medicare approves, the DVHA will pay the difference between the Medicare paid amount and the Vermont Medicaid allowed amount. If Medicare denies, the DME provider must submit proof of denial including the

explanation of benefits (EOB) information. Then, Medicaid will review the request and, if approved, will pay the Vermont Medicaid allowed amount.

In addition, when the primary wheelchair is found by the DVHA to need repair, modification, and/or battery replacement; and Medicare denied or downgraded the purchase of the primary chair; or the DVHA determines that Medicare is unlikely to accept new documentation of medical necessity for the primary chair; the DVHA may approve the request with a prior authorization with specific wording that these items may be billed directly to Vermont Medicaid.

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

11.8 PRESCRIBING PROVIDER

Doctors of Medicine (M.D.s), Doctors of Osteopathy (D.O.s), Nurse Practitioners (NPs), Physician Assistants (PAs) and certain other licensed practitioners may write prescriptions for DME and medical supplies. Audiologists may prescribe hearing aids. Physical and occupational therapists may prescribe wheelchairs and seating systems (MD endorsement of the prescription is required). Augmentative communication devices require a prescription by a speech/language pathologist with MD endorsement of the prescription. All written prescriptions must be legible, contain the required information and applicable dates.

The physician/nurse practitioner prescriber must be enrolled as a participating Vermont Medicaid provider and the prescribing/attending NPI number on the CMS 1500 claim must be valid. When billing for services to Vermont Medicaid, the prescribing/referring physician NPI number should appear in field locator 17a or b when billing on a CMS 1500 Claim Form. The billing provider name and address must appear in field locator 33 and the NPI number must appear in field locators 33a and 24j.

DME providers must keep prescriptions on file for five years for members in DVHA programs.

11.9 DATES OF SERVICE

The billed date of service on the claim must be the date that the item was dispensed /delivered to the member. The date of service may not be earlier than the date the item was dispensed/delivered. There are two exceptions:

- When the billings are for monthly DME rentals, the dates of service should span the rental month;
- When the member becomes ineligible after a customized item has been ordered but before it can be dispensed, the date may be the actual date of the order.

  Custom order items include: the evaluation, fitting, casting and taking of measurements in the allowance of the item. There will be no separate payment for these services. Providers may not seek additional reimbursement.

11.10 PROCEDURE CODES & PRICING

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

Changes in the price on file will be reflected on the Fee Schedule. The DVHA reserves the right to change the price on file for any item or service without prior notice. For these reasons providers should be careful to retain the changes noted in the RAs and updated versions of the fee schedule. This file is for the

convenience of the provider. Although the DVHA will attempt to keep the file 100% accurate, the actual price recorded in the computer system for payment is the only accurate price for the applicable date of service.

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

11.11 REPAIRS

Repairs to covered items are covered when the repairs are necessary to make the items useful, are not included in a warranty, have been ordered by a physician, and do not total more than 50% of replacement cost. Suppliers must check the procedure code listing in the Fee Schedule for the specific code representing the repair being considered to determine the need for prior authorization. Payment will not be made for repairs to equipment for use in skilled nursing homes, ICFs, ICF-MRs, mental or general hospitals or psychiatric facilities.

Mileage

Mileage incurred by providers associated with the repair of a DME item, is reimbursable by Vermont Medicaid and cannot be charged to the member. The mileage is billed with procedure code K0739. The mileage should be determined from their closest facility, if the vendor is providing multiple deliveries; the only portion that will be reimbursed is the portion of the mileage specific to the Vermont Medicaid member.

If the member is able to take the DME item that needs to be repaired to the vendor that is the expectation. Charges for delivery of a DVHA reimbursed DME item, cannot be made to Vermont Medicaid or to a member.

11.12 SUPPLY RETURNS

DME purchased by Vermont Medicaid for eligible members, remains the property of Vermont Medicaid. If a member no longer has a medical need for equipment purchased by Vermont Medicaid, the member should be instructed to contact the DVHA Clinical Review Unit at: 802-879-6396. DME suppliers should also contact this number if Vermont Medicaid owned DME is returned to them.

11.13 DURABLE MEDICAL EQUIPMENT (DME) RECYCLING

DME vendors who provide the following equipment to Medicaid members are required to affix a sticker on the item at the time of delivery that identifies Medicaid as the owner of the device

- Manual Wheelchairs
- Power Operated Vehicles
- Power Wheelchairs
- Standers
- Lifts
- Hospital Beds
- Rehab Shower Commode Chairs
- Augmentative Communication Devices/Speech Generating Devices.

Medicaid provides the stickers with contact information regarding return of the device when it is no longer required by the member. The sticker must be applied to an area of the device that is protected from daily

wear and tear but is visible without excessive effort. The accompanying Durable Medical Equipment Ownership, Operation, and Maintenance Agreement form must be signed by the vendor and the member or the member's legal guardian. The completed form must be kept on file at the vendor's office and be available for inspection by DVHA, and a copy provided to the member for their records. The DVHA may request a copy of the completed form as part of the clinical review process for items which require prior authorization. The Durable Medical Equipment Ownership, Operation, and Maintenance Agreement form is available on the DVHA website at http://dvha.vermont.gov/for-providers/forms-1. Contact DVHA at 802-879-6396 to obtain stickers and forms.

Exception: equipment for dual eligible members whose primary insurance covered the cost of the device does not require a sticker.

11.14 REHABILITATION EQUIPMENT REVIEW

The DVHA contracts with the Veteran's Administration to provide second opinion consults for select rehabilitation equipment that requires prior authorization. Members may be contacted by a VA representative to arrange this consultation. Consultations will take place at the member's home or at a VA clinic. Members and providers will be notified when the DVHA has required a consult.

11.15 DME BILLING INFORMATION - EQUIPMENT SPECIFIC (ALPHABETICAL)

11.15.1 Adaptive Weighted Eating Utensils

Vermont Medicaid allows for the reimbursement of "Adaptive Weighted Eating Utensils" when medically necessary for individuals who have significant tremors that interfere with daily activities (i.e., ability to feed self).

These utensils must be ordered by a physician, must be medically necessary, supplied by a DME/Pharmacy or DME vendor, and billed using non-specific HCPCS code A9999. Only one of each type of utensil is allowed. The billing/supplying provider must submit an invoice with the claim in order to be reimbursed.

11.15.2 Apnea Monitors

Vermont Medicaid covers the rental of an Apnea Monitor for use in the home when medically necessary, as per the DVHA Clinical Criteria, however purchase is not covered. The DVHA Clinical Guidelines for Apnea Monitors is available online at http://dvha.vermont.gov/for-providers/clinical-coverage-guidelines. For members under the age of one year (infants), prior authorization is not required. When the condition(s) which caused a need for the monitor have been resolved or are stable for two to four months, monitor rental must be discontinued.

11.15.3 Blood Pressure Monitors

Vermont Medicaid covers two types of blood pressure monitors for home use when medically necessary per the online DVHA guidelines at http://dvha.vermont.gov/for-providers/clinical-coverage-guidelines.

Providers are required to follow national correct coding requirements.

Non-Continuous Automatic Blood Pressure Monitors consist of a digital gauge and a stethoscope in one unit and are powered by batteries. The cuff may be inflated manually or automatically depending on the model.

Vermont Medicaid covers only the purchase of these monitors; coverage is not available for rental. The Medical need must be clearly documented in the patient's medical records. HCPCS has a specific billing code for these common BP monitors.

Continuous Automatic Blood Pressure Monitors Measures blood pressure continuously in real time and comes with a recording device. They are non-invasive and can be used with a cuff or finger sensor.

VT Medicaid covers only the rental of these monitors; coverage is not available for purchase. Prior authorization is required. VT Medicaid will accept the miscellaneous durable medical equipment HCPCS code, since a specific code is not yet in place for these special monitors.

Vermont Medicaid does not cover new or refurbished Dinamap Monitors.

11.15.4 Breast Pumps

Providers and suppliers are responsible for ensuring medical necessity and should refer to the Coverage Guidelines for Electric Breast Pumps on the DVHA website http://dvha.vermont.gov/for-providers/clinical-coverage-guidelines.

DME providers are allowed to bill using the mother's name and UID; a diagnosis must be specified for the baby.

11.15.5 Continuous Passive Motion (CPM) Devices

Per section 30.2.1 of CMS claims processing manual, CPM devices are to be billed as one billed unit = one day of rental and are limited to a maximum of 21 days of rental. The DVHA follows these CMS guidelines, "Continuous passive motion devices are covered for patients who have received a total knee replacement. To qualify for coverage, use of the device must commence within 2 days following surgery. In addition, coverage is limited to that portion of the 3 week period following surgery during which the device is used in the patient's home. Contractors make payment for each day that the device is used in the patient's home. No payment can be made for the device when the device is not used in the patient's home or once the 21 day period has elapsed. Since it is possible for a patient to receive CPM services in their home on the date that they are discharged from the hospital, this date counts as the first day of the three week limited coverage period."

The current HCPCS code for the knee joint is E0935RR. Modifier RR is required since CPM devices are only rented (never purchased). Each billed unit is reimbursed at a daily rate.

For consecutive, multiple days of rental, the claim must be billed with a date range and the corresponding multiple units (total number of days).

Please note that HCPCS code E0936RR, a CPM device for joints other than the knee, is covered only with prior authorization from the DVHA.

11.15.6 CPAP & BIPAP

Prior authorization is not required for the rental of CPAP & BIPAP devices. The purchase of CPAP and BIPAP devices does require prior authorization. Prior authorization requests must include appropriate documentation of medical need to support current best practice guidelines. (See McKesson Smart Sheets on our website, www.vtmedicaid.com/#/, navigate to the Transactions menu and choose the appropriate login [Trading Partners use "Login", Web Services use "Login - UAT])

11.15.7 Crutches

A physician's order for crutches usually refers to common, wooden, underarm crutches. If other types are dispensed by the DME supplier, the medical necessity form must be specific as to the type ordered and why the common wood crutches are not sufficient.

11.15.8 Enteral Nutrition

Vermont Medicaid allows a 10 day overlap in dates of service for enteral nutrition codes. This overlap will allow for delivery or shipping of refills. The supplier must deliver the enteral nutrition no sooner than 10 days prior to the end of the usage for the current product. The DVHA Clinical Guidelines for enteral nutrition is available online at http://dvha.vermont.gov/for-providers/clinical-coverage-guidelines.

11.15.9 Glucometers

The basic glucometer does not require prior authorization. The prescribing provider's medical necessity form must document that the member is a diagnosed diabetic.

Glucometers with special features (such as voice response) require prior authorization from the Department of Vermont Health Access. The prescribing provider's medical necessity form must document that the member is a diagnosed diabetic. Information on the special feature(s) of the unit, why the unit is medically necessary and pricing information is required.

The Department of Vermont Health Access limits the quantity of diabetic supplies for eligible Vermont Medicaid members (such as glucose meters and test strips). Extra equipment and supplies require prior authorization.

Vermont Medicaid will reimburse pharmacies only for the following meters and the test strips for those meters:

FreeStyle® Lite, FreeStyle Flash®, FreeStyle Freedom®, Precision Xtra™, One Touch® Ultra® 2, One Touch® UltraMini™ and One Touch® Ultra® Smart.

All other meters and test strips will require a prior authorization.

11.15.10 Hospital Beds

All semi-electric and electric/electronic hospital beds for use in the home require prior authorization from the DVHA. This includes rentals and all other modifier-code combinations. Regardless of the procedure code/modifier to be used, prior authorization must be obtained prior to placement of the bed in the home.

The only exception is the "Immediate Needs" exception as explained in Section 7 Prior Authorization. This prior authorization requirement is not new, as semi-electric and electric/electronic hospital beds have required prior authorization for many years.

11.15.11 Incontinence Supplies

Incontinence supplies are covered under HCPCS procedure codes. Dispensing providers are required to maintain a completed and current medical necessity form on file for each item, justifying the medical need and quantities used.

11.15.12 Medical Supplies

Medical supplies will be covered when:

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

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

11.15.13 Oxygen

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

11.15.14 Peak Flow Meters

Members with a diagnosis of asthma or reactive airway disease may obtain Peak Flow Meters (e.g., Access, MiniWright, Pulmograph) from any qualified provider (physician or DME).

11.15.15 Special Needs Feeder Bottles

HCPCS procedure code S8265 is accepted by Vermont Medicaid to bill for the Haberman Feeder (special needs bottle with nipple) when medically necessary for dysphasia due to cleft lip/palate. When the cause of the dysphasia is other than cleft lip/palate or the bottle is not Haberman, unlisted procedure code A9999 is allowed.

All special needs feeder bottles are reusable, must be ordered by a physician, and supplied by a DME/pharmacy vendor. Quantity is limited to 10 bottles with nipples per six months. Prior authorization is not required. The medical need must be clearly documented in the patients' medical records and an invoice is required with each claim submission.

11.15.16 Speech Augmentation Devices

Effective 6/01/2012, the Department of Vermont Health Access (DVHA) will begin covering iPad/iPod devices as dedicated speech generating/augmentative communication devices for VT Medicaid members whose severe communication impairment prevents writing, telephone use, and/or talking. DVHA does not cover this or any other device to be used solely for educational, vocational, or avocational purposes. Multiple devices are not covered.

Because the device supplier is not a standard Durable Medical Equipment (DME) provider, Speech Language Pathologist (SLP) performing the evaluation will be considered the provider of record. The prescribing SLP is required to be an enrolled Vermont provider. If the member has more than one SLP, for example a school and a medical model SLP or an expert consultant, and one SLP is an enrolled VT Medicaid provider, SLP collaboration will be allowed during the evaluation/ prescribing process; the enrolled SLP submits the request.

Note: There has been no change to Medicaid Rule and no change to the prior authorization process for all other types of augmentative communication devices. Prior authorization is required for all augmentative communication devices.

A packet that includes the DVHA evaluation and prescription form, the DVHA Ownership form, Rule related to speech generating devices and a procedure checklist is available at http://www.dvha.vermont.gov/for-providers/clinical-coverage-guidelines. See the link titled Augmentative Communication Device Packet.

11.15.17 Splints

When a miscellaneous splint code must be used because there is no included code available, providers must submit a request for prior authorization and a completed Medical Necessity Form. Claims must also be submitted with an invoice and an invoice for identification and cost.

11.15.18 TENS/NMES

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

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

11.15.19 Tracheostomy Care Kits

Tracheostomy care kits are not approved unless a compelling clinical case can be established and prior authorization is obtained. The necessary supplies for tracheostomy care come in bulk quantities and

providers are advised to furnish bulk supplies when appropriate. All these supplies have individual procedure codes.

11.15.20 Ventricular Assist Devices

Vermont Medicaid's coverage of Ventricular Assist Devices is based on the CMS National Coverage Determination 20.9, entitled "NCD for Artificial Hearts and Related Devices". Hospital and physician providers are referred to the current CPT and HCPCS manuals for proper coding.

11.15.21 Wheelchairs & Seating Systems

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

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

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

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

11.15.22 Wheelchair Repairs

All repairs on wheelchairs less than one year old require prior authorization from the DVHA. The DVHA expects that these chairs would still be under the manufacturer's warranty and therefore any repairs, regardless of the dollar amount, require prior authorization. For wheelchairs over one year old and not under warranty, prior authorization is required only for repairs greater than $300.00.

Requests for prior authorization for wheelchair repairs must include a completed Medical Necessity form in addition to the following:

- The date the wheelchair was purchased/delivered
- When the chair is less than 4 years old, the cost of repair vs. cost of replacement
- Equipment guarantees, warranty and denial of third party coverage
- The condition of the existing equipment

Durable Medical Equipment (DME) providers who service wheelchairs may make repairs to wheelchairs provided to a Medicaid member by another DME provider, if the initial provider has gone out of business or the device records are unobtainable (for example, the records of the Scooter Store). In these instances, DME providers are allowed to make repairs to the device in order to assure the safety and independence of the Medicaid member. If there is any concern that the device is not medically appropriate to the medical needs of the member, an assessment by a physical or occupational therapist is advisable. The Department of Vermont Health Access website provides access to the following information regarding repairs:

Medicaid guidelines:
http://dvha.vermont.gov/for-providers/dme-repairs-guidelines050313.pdf.

Medicaid Rule (section 7506.4): http://humanservices.vermont.gov/on-line-rules/dvha.

Assistive Technology Suppliers (ATS)

Vermont Medicaid follows Medicare's lead in requiring that certain wheelchairs must come from a supplier employing a RESNA-certified Assistive Technology Supplier (ATS) who is directly involved in the wheelchair selection for the member. This applies to the following wheelchairs: Group 2 single- or multiple-power option power wheelchairs, any Group 3 or Group 4 power wheelchair or a push-rim power assist device for a manual wheelchair. All suppliers who have obtained their ATS certification should sign all documentation regarding the above wheelchairs with their ATS designation. All ATS certified suppliers must send a copy of their certification to Vermont Medicaid Enrollment department on an annual basis to demonstrate that they have kept their certification current.

It is understood that RESNA will be changing the Supplier certification to a Practitioner certification in the near future. Providers should send a copy of all updated certificates to the DVHA.

11.16 CMS 1500 PAPER CLAIM BILLING INSTRUCTIONS/FIELD LOCATORS

Multiple Page Claims

When billing a multiple page claim, you must indicate "page x of y" in Box 19, "Local Use" of the CMS-1500 claim form. To indicate the conclusion of the entire claim, field 28 of the last page of the claim must also include the total billed amount.

Example: page 1 of 3 (1st page of claim), 2 of 3 (2nd page of claim) & 3 of 3 (3rd page of claim).

Field Locators

All information on the CMS 1500 Claim Form should be typed or legibly printed. Only the 02-12 version of this form is accepted for processing. The field locators listed below are used by DXC when processing Vermont Medicaid claims. The field locators designated by an asterisk (*) are mandatory; other field locators are required when applicable. The field locators not listed below are not used in the Vermont Medicaid program and do not need to be completed.

FIELD LOCATOR	REQUIRED INFORMATION
1. CARRIER IDENTIFICATION	Check the Medicaid box
1a. INSURED'S ID NUMBER*	Enter the Vermont Medicaid ID number as shown on the member's Member ID card.
2. PATIENT'S NAME*	Enter the member's last and first name.
10. CONDITION RELATED TO*	Check appropriate box to indicate: a. If condition is related to employment b. If condition is related to an auto accident c. If condition is related to any other type of accident. If yes is checked in any of these boxes, enter the accident date in field locator 15.
11. INSURED'S POLICY NUMBER	If the member has other health insurance (excluding Medicare), enter the applicable policy number.

	a. Enter the insured's date of birth in MMDDYY format; check the appropriate box to indicate insured's sex. b. Enter the insured's employer or school name. c. Enter the name of the other health insurance carrier
11b. OTHER CLAIM ID (DESIGNATED BY NUCCU)	Property casualty payers (e.g. automobile, homeowner's, or worker's compensation insurers and related entities are to use qualifier "Y4" and the Agency (property casualty) claim number as the identifier. Enter qualifier to the left of the vertical, dotted line and the identifier to the right. For workers compensation and property casualty enter the claim number assigned by the payer (if known).
11d. IS THERE ANOTHER HEALTH BENEFIT PLAN*	Check the appropriate box. If yes, complete fields 9 a-c. Health benefits provided under Green Mountain Care are not considered other insurance. Other insurance only pertains to a private health insurance carrier.
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY	Enter the first date of present illness injury, or pregnancy. For pregnancy, use the date of last menstrual period. Use qualifier "431" - Onset of Current Symptoms or Illness or "484" – Last Menstrual Period (LMP)
15. OTHER DATE (ACCIDENT DATE)	If your response indicates a 'yes' in field locators10b or 10c, enter the date of the occurrence and qualifier "439".
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	Enter the name (First, Middle Initial, Last) followed by the credentials of the professional who referred/ordered the service or supply. If multiple providers apply, enter one provider/qualifier in the following order: 1) DN – Referring Provider 2) DK – Ordering Provider 3) DQ – Supervising provider *Exception:* Professional/Professional Crossover Claims require the Ordering qualifier "DK" to be used 1st when the provider in Field 17 is an Independent Lab, Independent Radiology, DME Supplier, Prosthetics/Orthotics or Sole source Eye Glass provider.
17a.	Enter the other ID number of the referring, ordering, or supervising provider. Use the appropriate qualifier to indicate what the ID number represents; enter in field immediately

	to the right of 17b. Refer to http://nucc.org/ for list of valid qualifiers. Entry must support information entered in field 17. If applicable, field is required.
17b. NPI*	Enter the referring, ordering or supervising provider's NPI. Entry must support information entered in field 17. If applicable, field is required.
19. LOCAL USE	Use this field to explain unusual services or circumstances and to indicate "page x of y" of a multiple page claim.
21. ICD Ind.*	Enter "9" for ICD-9 diagnosis codes. ICD-10 codes are not valid until 10-1-15; enter "0" for ICD-10.
21. DIAGNOSIS CODE(S)*	Enter the appropriate IDC-9-CM or ICD-10 diagnosis code that relates to the service rendered. You may use up to twelve diagnosis codes.
24a. DATE(S) OF SERVICE*	Enter the date of each service provided. If the From and To dates are the same, the To date is not required.
24b. PLACE OF SERVICE*	Enter the appropriate two digit place of service code.
24c. EMG	Enter '1' to indicate if the service provided was the result of an emergency. *This field is mandatory only if emergency services were provided.
24d. PROCEDURE CODE*	Enter the appropriate procedure code to explain the service rendered.
24e. DIAGNOSIS POINTER*	Enter the appropriate diagnosis 'pointer' that relates to the service rendered from field locator 21. NOTE: The pointer character has changed from numbers to letters.
24f. CHARGES*	Enter the usual and customary charge for the service rendered.
24g. DAYS OR UNITS*	Enter the number of days or units of service which were rendered.
24h. EPSDT/FAMILY PLAN	Enter one of the following Vermont Medicaid EPSDT and Family Planning indicators: 1-Both EPSDT and Family Planning 2-Neither EPSDT nor Family Planning 3-EPSDT Only 4-Family Planning Only
24j. ATTENDING PROVIDER*	Enter attending physician's NPI. Enter the billing provider NPI for independent labs and DME suppliers.

	If Atypical, enter the 7-digit Vermont Medicaid ID number in the shaded area.
26. PATIENT'S ACCOUNT NUMBER	Enter the account number you have assigned to the member. DXC can accept up to 12 digits; alpha, numeric, or alpha/numeric in this field. This information will print on the Remittance Advice summary for your accounting purposes.
28. TOTAL CHARGE*	Add the charges from field locator 24f for each line and enter the total in this field.
29. AMOUNT PAID*	Enter the amount paid by other health insurance coverage (exclude Medicare payments). If this field is completed, field locators 11a, 11b and 11c must also be completed. Enter spend down if applicable. Documentation must be attached if the services are not covered by the primary, or if the payment by the primary is $3.00 or less.
31. SIGNATURE	Enter the provider's signature or facsimile, or signature of the provider's authorized representative. Enter the date of the signature.
33. BILLING PROVIDER*	Enter the payee provider name and address (Individual provider format: last name, first name)
33a. BILLING PROVIDER'S NPI*	Enter the billing provider's NPI.
33b. BILLING PROVIDER'S TAXONOMY	Enter the billing provider's taxonomy code when applicable. If Atypical, enter the 7-digit Vermont Medicaid ID number in the shaded area.

Section 12 UB04 Claim Submissions

12.1 REIMBURSABLE SERVICES

Hospital Inpatient

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

See **Section 7 Prior Authorization for Medical Services**

Hospital Outpatient

Reimbursable services include the use of facilities in connection with accidental injury or minor surgery, diagnostic tests, rehabilitative therapies and emergency room care.

Pre-certification review of hospital admissions for dental procedures is not required. When submitting claims use the appropriate dental HCPCS coding (D…).

Medicare restricts certain medical services that should be only performed in an inpatient hospital setting. These services are not eligible for reimbursement when provided by a physician in an outpatient setting. A list of Medicaid Outpatient MUE of Zero procedures (Inpatient only list) is available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html; see the links under Medicaid NCCI edit files.

Home Health

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

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

Reimbursable services also include Services of a home health aide.

Home Health Hospice

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

Vermont Medicaid pays a Per Diem rate.

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

Assistive Community Care Services

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

Choices for Care

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

12.2 REIMBURSEMENT POLICY

The Fee Schedule contains a complete list of services that are reimbursable by Vermont Medicaid. Implementation of OPPS pricing has not changed the Vermont Medicaid policy regarding non-covered services.

Providers are allowed to compliantly bill the correct monthly code that meets the definition of the actual services provided for members subject to partial eligibility in any given month. However, providers may only bill the dates of service in which the member is actively eligible for Medicaid.

Inpatient services will be paid according to DRG payment methodology.
Vermont-based Relative Weight Information is available at http://www.vtmedicaid.com/#/resources

Outpatient services will be paid according to OPPS methodology. Go to http://www.vtmedicaid.com/#/resources for a listing of revenue codes that are required to be billed with a

HCPCS/CPT code. The full fee schedule for hospitals is also listed. The number of units billed on a detail line with the revenue code will represent the number of units for the HCPCS code.

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

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

12.3 PATIENT SHARE (APPLIED INCOME) REPORTING

The DXC claims processing system captures changes made to patient share amounts, the highest paid providers and when the patient has moved to a new facility. Providers can submit electronic replacement claim adjustments, for any claim that had deducted a different patient share amount, or if you are now the highest paid provider or if you are no longer the highest paid provider. Providers can also submit electronic adjustments when the patient was discharged to a new facility and no longer owes their patient share to the previously admitted facility. DXC will generate a monthly report detailing these changes; we will adjust these claims. However, to receive your corrected payment quicker, we recommend you submit electronic adjustments.

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

12.4 GENERAL HOSPITAL BILLING INFORMATION

12.4.1 Bilateral Billing Procedures

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

12.4.2 In-Network & Extended Network Hospitals

In-Network Hospitals are subject to the same Vermont Medicaid policy as are those located within the geographical confines of the state of Vermont. Their physicians must be enrolled in Vermont Medicaid. A complete list of **Green Mountain Care** In-Network & Extended Network Hospitals is available at http://dvha.vermont.gov/for-providers/green-mountain-care-network.

Out-of-state hospitals not designated as an In-Network Hospital must bill using the attending provider's NPI number in field locator 76, when the attending provider is not enrolled with Vermont Medicaid.

12.4.3 Inpatient/Outpatient Overlap Examples

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

- A patient comes into the ER Friday at 10:00 pm; patient is seen and stays in the ER for 8 hours while tests and consults are performed. On Saturday morning, the physician feels it is necessary to admit that patient as inpatient.

  When a patient receives continuous outpatient care and then is admitted as an inpatient, all of the outpatient charges should be rolled into the inpatient claim.

- A patient comes into the ER Thursday at 8:00 pm and is admitted as an outpatient in the observation room. By Friday pm, the physician determines it is best to admit that patient as an inpatient.

  When a patient is in the observation room, then transferred to an inpatient status, the admission date is the date of service the patient was admitted into the inpatient room. All of the charges associated with the observation room should be rolled into the inpatient claim.

- A patient comes in as an outpatient on Thursday am for services and leaves, then later in the day, is admitted as an inpatient

  Some hospitals may treat the outpatient and inpatient stay as one event and bill all charges on the inpatient claim. Other hospitals may treat these as two separate events since the patient left after the outpatient and bill one outpatient and one inpatient claim. Either method is acceptable.

- A patient comes in at 10:00 pm on Tuesday for ER services and leaves. Wednesday morning the patient is admitted as inpatient.

  These services are billed as two separate claims, one outpatient and one inpatient, as they are different service events.

- A patient is discharged on Tuesday am, but is readmitted Tuesday pm.

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

- A patient is discharged on Tuesday am but comes in for outpatient services Tuesday pm.

  These are billed separately, one inpatient claim and one outpatient claim, as they are different service events.

12.4.4 Inpatient Claims: No Medicare Part A; Has Medicare B Coverage

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

1. Days not covered under Medicare part A must be billed to Medicare B for payment of covered ancillary charges. Claims will crossover to Vermont Medicaid for payment of coinsurance and deductible.
2. Add together Medicare's part B payment, Medicare contractual adjustment amount on part B EOMB and Vermont Medicaid's crossover payment (part B) in field locator 54 (Prior Payments) of the UB-04 claim form.
3. Submit your claim and all attachments to your Vermont Medicaid Provider Representative. (See http://www.vtmedicaid.com/#/manuals and click the Provider Representative Map link).

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

12.4.5 Inpatient Claims: Medicare Part A Exhausts or Begins During the Inpatient Stay

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

1. Bill part A charges to Medicare. Claim will crossover to Vermont Medicaid for payment of deductible and/or coinsurance.
2. A claim for Inpatient dates of service not covered under Medicare part A must be billed to Medicare B for payment of covered ancillary charges. Claim will crossover to Vermont Medicaid for payment of coinsurance and deductible.

3. The inpatient claim for the ***entire stay*** should be billed to Vermont Medicaid with "Medicare benefits exhausted or began on mm/dd/yy" indicated in field locator 80 on the UB.
4. Add together the Medicare B payment, the Medicare B contractual adjustment, and the Vermont Medicaid crossover payment. Indicate this total amount in field locator 54a on the UB. Do not indicate any payment by Medicare A.
5. Attach both the part A and B EOBs. On part A EOMB, write "Medicare benefits exhausted or began on mm/dd/yy". The charges will not match on part B EOMB. Sign and date part A EOMB.
6. Submit your claim and all attachments to your Vermont Medicaid Provider Representative. (See http://www.vtmedicaid.com/#/manuals and click the Provider Representative Map link)

If an inpatient claim is submitted to Medicare as primary payer is denied by Medicare because the patient's Medicare covered benefits are exhausted, DVHA will pay the exhausted day(s) claim based on DRG Payment methodologies for the patient's Medicaid covered services.

If a patient becomes Medicare eligible during an inpatient stay, Medicare will pay Medicare covered days as the primary payer. The claim will crossover to Vermont Medicaid for payment of deductible and/or coinsurance. DVHA will pay an inpatient claim for the Medicaid covered days as a separated DRG payment for the patient's Medicaid covered services and DVHA will pay a crossover claim for the coinsurance and deductible for the Medicare covered days.

12.4.6 Inpatient Claims: Medicare Primary but Medicaid Eligibility Termed During Stay

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

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

12.4.7 Interim Inpatient Claims

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

1. Type of bill 112 – interim bill-first claim use patient status – still a patient.
2. Type of bill for subsequent claims will be 117 - electronic replacement claim. Use Patient status - still a patient or a valid patient status – discharge code.

Type of bill for subsequent claims will be 117 - **electronic** replacement claim. Patient status will be either patient status 30, or a discharged patient status code.

12.4.8 Present on Admission (POA) - Inpatient Admissions

The present on admission indicator (POA) will be required for all inpatient admissions. Vermont Medicaid will follow Medicare's guidelines. The indicator options are: Y (Yes), N (No), U (Unknown), W (Not Applicable). If exempt from POA reporting leave the field blank. The POA indicator is the eighth digit and is

required on all diagnoses codes listed on the UB 04 (principal field 67 and secondary field 67 A through Q). This is not required for the admit diagnosis (69). For electronic claims using the 837 Institutional, submit the POA indicator in HI01-9 of each appropriate HI segment. POA is always required first, followed by the principal diagnosis. The last secondary diagnosis indicator is followed by the letter Z to indicate the end of the data element. e.g., POAYNUW1YZ

A list of diagnosis codes exempt from requiring the POA indicator can be located at http://www.vtmedicaid.com/#/resources

12.4.9 Short Stays

Short stays (defined as one calendar day) apply when a patient is admitted and discharged from the same acute care facility on the same calendar day, see below examples.

- Example: Patient is admitted 5:00 am on 12/4/07 and released 11:30 pm on 12/4/07. This is a same-day stay.
- Example: Patient is admitted at 10:00 pm on 12/4/07 and released at 7:00 am on 12/5/07. This is not a same day stay.

Effective for inpatient claims with a date of service on or after 10-1-2014, if a claim has a discharge status code (07) and the length of stay is less than the assigned DRG geometric mean length of stay as identified by Medicare, the claim will also be considered a short stay.

Short Stay claims will be paid the lesser of the cost of the case or the DRG payment.

12.4.10 Same/Next Day Readmission Policy

Effective for inpatient claims for dates of service on or after 10-1-2014, DVHA will not reimburse separate DRG payments for two separate inpatient claims when the patient's subsequent claim's admit date is on the same or next day after their original claim's discharge date, both claims are for the same facility, and both claims are for the same or a related condition.

Condition code B4 applies to inpatient admissions with a date of service on and after October 1, 2014, when a beneficiary is readmitted to the same hospital on the same or next day after a previous discharge for symptoms unrelated to, or not for evaluation and management of, the prior stay's medical condition. Condition code B4 will allow the separate episode of care by indicating it is unrelated to the first admission. The code B4 is to be used only when appropriate and in addition to any other applicable condition codes.

For additional information and specific details pertaining to the proposed Inpatient Same/Next Day Readmission Policy, please refer to: http://dvha.vermont.gov/administration/draft-versions-of-state-plan-changes.

12.4.11 Subacute Care

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

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

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

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

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

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

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

Hospitals not authorized to bill swing beds may bill for waiting placement for those days after it is determined that a patient no longer requires acute care. If the patient continues to be hospitalized while awaiting placement in a nursing facility and no bed within the area is available, the hospital must be actively seeking placement. Payment is the same as a swing bed day.

12.4.12 Transfer Cases

Transfer cases are defined as patients who initiate an inpatient stay in one hospital and are discharged/admitted from one acute care facility to another.

- The receiving hospital will be paid under normal DRG payment logic.
- The transferring hospital will be paid the lesser of the cost of the case or the DRG payment (including any eligible outlier payment).

Claims will be considered under the transfer methodology when an inpatient claim has a discharge status code of either 02, 05, 06, 62, or 65. When the transfer status code is 02, the claim will automatically fall under the transfer payment methodology.

Effective for inpatient claims with a date of service on or after 10-1-2014, when the transfer status code is either 05, 06, 62, or 65, and the assigned DRG falls within the list of DRGs that Medicare considers to be post-acute, the claim will fall under the transfer payment methodology.

12.4.13 Outpatient Services Rendered During an Inpatient Stay

Member is admitted to Hospital A for inpatient care. Member is transferred to Hospital B for outpatient services not able to be provided by Hospital A, and then Member is transferred back to Hospital A to complete their inpatient care. Hospital B is to bill Hospital A for the outpatient services provided. Hospital A is to bill Medicaid for the inpatient stay and will be paid under the normal DRG logic.

12.5 OUT-PATIENT/INPATIENT HOSPITAL SERVICES

12.5.1 Cardiac Rehabilitation

Cardiac rehabilitation is billable under revenue code 943. One unit is equal to one day regardless of the number of encounters.

Effective for date of service May 16, 2012 and thereafter, cardiac rehabilitation is limited to 36 sessions within a 36 week timeframe. An additional 36 sessions may be approved by the DVHA Clinical Unit when the claim includes the appropriate notes and meets the required criteria.

12.5.2 Dialysis

The DVHA has established a reimbursement policy for billing End Stage Renal Disease outpatient treatment services. This reimbursement method is excluded from OPPS pricing; providers identified as free standing dialysis centers are reimbursed under this method. Only the revenue codes listed below are reimbursable. All other billed revenue codes will be denied as incidental.

- Revenue codes 821, 831, 841 or 851, Hemodialysis - requires HCPCS code 90999 be billed. This service is reimbursed at a per diem rate of $151.32

- Revenue code 304, Lab services, non-routine dialysis - requires an appropriate HCPCS code be billed. Reimbursement is 62% of the Level III price on file for the HCPCS code.
- Revenue code 636, separately-payable drugs except EPO - is reimbursed with the appropriate HCPCS and NDC coding (when applicable). Pricing is the current Level III price on file for the HCPCS or NDC code billed on the claim.
- Revenue codes 634 and 635 EPO - are reimbursed when billed with the appropriate HCPCS and NDC coding. Pricing is the current Level III price on file for the HCPCS or NDC code billed on the claim.
- Revenue code 780, Telemedicine - is reimbursable when billed with the appropriate HCPCS code. Pricing is the current Level II price on for the HCPCS code billed on the claim.

12.5.3 Inhalation Therapy

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

12.5.4 Hospital Clinical Laboratory Tests

Packaged Clinical Laboratory Procedures

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

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

The general rule for OPPS payment methodology is that laboratory tests should be reported on a 13X bill type. There are limited circumstances described below in which hospitals can bill separately for laboratory tests on a 14x bill type.

Laboratory tests may be separately payable under the following limited exceptions;

- the laboratory test is the only service provided to that member on that date of service -or-
- the patient is neither an inpatient or outpatient of a hospital (the member is not physically present at the hospital), but has a specimen that is submitted for analysis -or-
- the laboratory test is on the same date of service as the primary service, but is ordered for a different purpose than the primary service by a practitioner different than the practitioner who ordered the primary service.

It is the hospital's responsibility to determine when laboratory tests may be separately billed on the 14X bill type under these limited exceptions.

Clinical Laboratory Tests Reimbursed Separately

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

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

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

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

12.5.5 Observation Rooms

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

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

12.5.6 Private Room

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

12.5.7 Provider Based Billing

Effective for claims with dates of service 7/1/2016 and after, DVHA will no longer reimburse for the 51x clinic revenue code series. These revenue codes (510-519) indicate clinic charges for providing diagnostic, preventative, curative, rehabilitative, and education services to ambulatory patients.

The following codes will also no longer be reimbursed as of 7/1/2016 when submitted on an outpatient claim as these codes represent professional services provided in an office or clinic setting: G0463, 99201-99205, 99211-99215 and 99381-99397.

Hospital-owned practices may continue to bill on both a UB-04 (facility) claim along with a CMS-1500 (professional) claim, as appropriate. The professional claim must be billed with the appropriate outpatient place of service code if there is a corresponding facility claim being billed.

When hospital outpatient services are split billed on both a CMS-1500 and UB-04, the office place of service should not be used on the corresponding professional claim. The office place of service should only be used when the professional and facility charges are submitted together on the professional claim, with no corresponding facility claim being billed.

12.5.8 Hospital Inpatient Billing Instructions/Field Locators

Admission Indicator

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

Attending Physician

The attending physician, whether the physician or practitioner who actually performs the services for the patient or the referring or prescribing provider, must be enrolled as a participating Vermont Medicaid provider. When billing Vermont Medicaid on the UB-04 Claim Form, the attending physician's NPI (with Taxonomy code when applicable) must appear in field locator 76.

Billing/Supplying Provider

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

Nurse-Midwife Services

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

Field Locators

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

FIELD LOCATORS	**REQUIRED INFORMATION**
1. UNLABELED FIELD*	Enter the Hospital name and address as it appears on the Vermont Medicaid Provider Enrollment form.
2. UNLABELED FIELD	Enter "Vermont Medicaid Hospital Inpatient"
3a. PATIENT CONTROL #	For accounting purposes, enter the patient control # in the field locator. The number may consist of up to 24 characters, alpha/numeric. This information will appear on the Remittance Advice (RA).
3b. MEDICAL RECORD #	Enter patient's medical record #.
4. TYPE OF BILL*	Enter the code indicating the specific type of bill for Inpatient. The sequence is as follows: 1. Type of facility 1-Hospital 2. Bill Classification 1-Inpatient 3. Frequency 1-Admit through discharge claim 2-Interim-first claim 3-Interim-continuity claim 4-Interim-last claim
6. STATEMENT COVERS PERIOD	Enter the from and through service dates
8b. PATIENT'S NAME*	Enter the patient's last name, first name and middle initial.
10. BIRTHDATE	Enter the date of birth
12. ADMISSION DATE	Enter date of inpatient admission
13. ADMISSION HOUR*	Enter the hour in which patient was admitted
14. ADMISSION TYPE*	Enter the code indicating the priority of the admission: 1-Emergency 2-Urgent 3-Elective 4-Nursery
16. DISCHARGE HOUR	Enter the hour in which the patient was discharged.
17. STAT*	Enter the two digit code indicating the patient's status as of the 'through date' of the statement period.

18-28. CONDITION CODES*	Enter code to identify if condition is related to the following 02- Condition is Employment Related A1-EPSDT Related Services A4-Family Planning Related Services C1-PSRO Approved as Billed C5-PSRO Post-Payment Review
31-34. OCCURRENCE CODE & DATE*	Enter one of the following two digit accident codes, and the corresponding occurrence date, if applicable or 52 if no other applies: 01-Auto Accident 02-Auto Accident/No Fault Insurance Involved 03-Accident/Tort Liability 04-Accident/Employment Related 05-Other Accident 06-Crime Victim 11-No Accident/Onset of Symptoms or Illness 42-Date of Discharge 50-Medical Emergency-Non-accidental 51-Outpatient Surgery Related 52-Not an Accident
39. VALUE CODES AMOUNT*	Enter the number of covered days in the amount/dollar column. Do not count the day of discharge or the date of death. (The sum of all the days should be equal to the amount of days being billed.)
42. REVENUE CODES*	Enter the appropriate revenue code for the service provided.
45. SERVICE DATE	Enter the 'FROM' date of the span of consecutive service dates being billed.
46. SERVICE UNITS*	Enter the quantitative measure of service rendered per revenue code.
47. TOTAL CHARGES*	Enter the total charges pertaining to each revenue code billed for the current billing period. Add the total charges for all revenue codes being billed and enter at the bottom of column 47 in the total field. (detail line 23)
50. PAYER*	On 50a, enter the primary payer name or "Spend Down" if spend down amount applies to the claim. On 50b, enter the other insurance name if applicable. Enter "Vermont Medicaid" on 50c.

54. PRIOR PAYMENTS*	Enter the payment amount associated with the payer listed in field locator 50. Attach spend down Notice of Decision. Documentation must be attached if there was no payment, if the services are not covered by the primary, or if the payment by the primary is $3.00 or less.
55. ESTIMATED AMOUNT DUE	Enter the amount due after deducting any amount entered in field locator 54 from the total entered at the bottom of column 47.
56. NPI*	Enter the BILLING provider's NPI number.
57a. TAXONOMY CODE(S)	Enter the BILLING provider's Taxonomy Code when applicable.
57c. VERMONT MEDICAID ID #	Atypical providers, enter your Vermont Medicaid billing provider number.
60. INSURED'S MEMBER ID*	Enter the member's Vermont Medicaid ID #.
67. PRINCIPAL DIAGNOSES CODE* (see Present On Admission -POA)	Enter the primary diagnosis code. Use the appropriate ICD-9-CM code (for dates of service on or after October 1, 2015, ICD-10 codes must be used).
67 a-q. OTHER DIAGNOSES CODES (Present On Admission-POA)	Enter the appropriate ICD-9-CM codes (for dates of service on or after October 1, 2015, ICD-10 codes must be used) see any condition other than primary, which requires supplementary treatment.
69. ADMITTING DIAGNOSES CODE*	Enter the admitting diagnosis code.
74. PRINCIPAL PROCEDURE CODE & DATE	Enter the appropriate ICD-9-CM procedure code and corresponding date (for dates of service on or after October 1, 2015, ICD-10 codes must be used).
74 a-e. OTHER PROCEDURE CODE & DATE	Enter the appropriate ICD-9-CM procedure codes and dates other than the principal procedure performed (for dates of service on or after October 1, 2015, ICD-10 codes must be used).
76. ATTENDING PHYSICIAN*	Enter the individual Attending Physician's NPI number. If billing with a Vermont Medicaid ID #, leave the NPI field blank and enter the Vermont Medicaid ID # to the right of the qualifier box.
78-79. OTHER PHYSICIAN. NPI	Enter the Vermont Medicaid ID # of the physician who the patient was referred to for further treatment, if applicable.
80. REMARKS	Enter any notations relating specific information necessary to adjudicate the claim.

81CCa	Enter the taxonomy code for the attending provider. Must correspond with the NPI number in field locator 76.

12.5.9 Hospital Outpatient Billing Instructions/Field Locators

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

FIELD LOCATOR	**REQUIRED INFORMATION**
1. UNLABELED FIELD*	Enter the Hospital name and address as it appears on the Vermont Medicaid Provider Enrollment form.
2. UNLABELED FIELD	Enter “Vermont Medicaid Hospital Outpatient”
3a. PATIENT CONTROL #	For accounting purposes, enter the patient control # in the field locator. The number may consist of up to 24 characters, alpha/numeric. This information will appear on the Remittance Advice (RA).
3b. MEDICAL RECORD #	Enter patient’s medical record #.
4. TYPE OF BILL*	Enter the code indicating the specific type of bill for Outpatient. The sequence is as follows: 1. Type of facility 1-Hospital 2. Bill Classification 3-Outpatient 4-Patient not present 3. Frequency 1-Admit through discharge claim
6. STATEMENT COVERS PERIOD*	Enter the from and through service dates.
8b. PATIENT’S NAME*	Enter the patient’s last name, first name and middle initial.
10. BIRTHDATE	Enter the date of birth
12. ADMISSION DATE	Enter date of admission
13. ADMISSION HOUR	If billing for emergency services that are the result of an accident, enter the admission hour.
14. ADMISSION TYPE*	Enter the code indicating the priority of the admission: 1-Emergency 2-Urgent 3-Elective 4-Nursery
16. DISCHARGE HOUR	Enter the hour in which the patent was discharged.

17. DISCHARGE STATUS*	Enter the appropriate discharge code.
18-28. CONDITONS CODES	Enter code to identify if condition is related to the following: 02-Conditon is Employment Related A1-EPSDT Related Services A4-Family Planning Related Services
31-34. OCCURRENCE CODE & DATE*	Enter one of the following two digit accident codes and the corresponding occurrence date, if applicable or 52 if no other applies: 01-Auto Accident 02-Auto Accident/No Fault Insurance Involved 03-Accident/Tort Liability 04-Accident/Employment Related 05-Other Accident 06-Crime Victim 11-No Accident/Onset of Symptoms or Illness 35-Physical Therapy 44-Occupational Therapy 45-Speech Therapy 50-Medical Emergency- Non-accidental 51-Outpatient Surgery Related 52-Not an Accident
42. REVENUE CODES*	Enter the appropriate revenue code for the service provided.
43. NDC CODE*	Enter the NDC code of the drug that was dispensed. Use a “N4” indicator preceding the NDC to identify the information in FL 43 as an NDC.
44. HCPCS/CPT	Enter the appropriate HCPCS/CPT code, immediately followed by an applicable/appropriate modifier
45. SERVICE DATE*	Enter the actual date the service was rendered. If the service was rendered on more than one day, you must bill a separate charge for each day.
46. SERVICE UNITS*	Enter the quantitative measure of service.
47. TOTAL CHARGES*	Enter the total charges pertaining to each code billed for the current billing period. Add the total charges for all revenue codes being billed and enter at the bottom of column 47 in the total field. (detail line 23)
50. PAYER*	On 50a, enter the primary payer name or “Spend Down” if spend down amount applies to the claim. On 50b, enter the other insurance name if applicable. Enter “Vermont Medicaid” on 50c.
54. PRIOR PAYMENTS*	Enter the payment amount associated with the payer listed in field locator 50. Attach spend down Notice of Decision. Documentation must be attached if there was no payment, if the services are not covered by

	the primary, or if the payment by the primary is $3.00 or less.
55. ESTIMATED AMOUNT DUE	Enter the amount due after deducting any amount entered in field locator 54 from the total entered at the bottom of column 47.
56. NPI*	Enter the BILLING provider's NPI number.
57a. TAXONOMY CODE(S)	Enter the BILLING provider's Taxonomy Code when applicable.
57c. VERMONT MEDICAID ID #	Atypical providers, enter your Vermont Medicaid billing provider number.
60. INSURED'S MEMBER ID*	Enter the member's Vermont Medicaid ID #.
67. PRINCIPAL DIAGNOSES CODE*	Enter the primary diagnosis code. Use the appropriate ICD-9-CM code (for dates of service on or after October 1, 2015, ICD-10 codes must be used).
67 a-q. OTHER DIAGNOSES CODES	Enter the appropriate ICD-9-CM codes (for dates of service on or after October 1, 2015, ICD-10 codes must be used) for any condition other than primary, which requires supplementary treatment.
76. ATTENDING PHYSICIAN NPI*	Enter the individual Attending Physician's NPI number. If billing with a Vermont Medicaid ID #, leave the NPI field blank and enter the Vermont Medicaid ID # to the right of the qualifier box.
77. OPERATING PHYSICIAN NPI	Enter the Vermont Medicaid ID # of the Operating Physician
78-79. OTHER PHYSICIAN NPI	Enter the Vermont Medicaid ID # of the physician who the patient was referred to for further treatment if applicable.
80. REMARKS	Enter any notations relating specific information necessary to adjudicate the claim.
81CCa	Enter the taxonomy code for the attending provider. Must correspond with the NPI number in field locator 76.

Section 13 Home Health Agency Services

13.1 CONDITIONS FOR PAYMENT

If all conditions for Medicare are met and the patient is Medicare eligible, Medicare must be billed before Vermont Medicaid reimbursement is requested. Payment for covered home health care services is authorized when the conditions for Medicare (Part A or Part B) payment are met or when all of the following conditions are met:

The service or item is furnished in the member's place of residence. A place of residence includes:

- Member's own dwelling, an apartment, congregate such as senior citizen or adult day center, a community care home, and a hospital, but the last only for the purpose of an initial observation, assessment and evaluation visit.); and
- Items and services are ordered and furnished under a written plan, signed by the attending physician and incorporated into the agency's permanent record for the patients, which relates the items and services to the patient's condition, as follows:
    1. Includes the diagnosis and description of the patient's functional limitation resulting from illness or injury; and
    2. Specifies the type and frequency of needed service, e.g., nursing services, drugs and medications, special diet, permitted activities, rehabilitation and therapy services, home health aide services, medical supplies and appliances; and
    3. Provides a long-range forecast of likely changes in the patient's condition; and
    4. Specifies changes in the plan in writing, signed by the attending physician or by a registered professional nurse on the agency staff pursuant to the physician's verbal orders; and
    5. Is reviewed by the attending physician, in consultation with professional agency personnel every 60 days, or more frequently as the severity of the patient's condition requires, and shows the day of each review and physician's signature; and
    6. The attending physician certifies that the services and items specified in the treatment plan can, as a practical matter, be provided through a Home Health Agency in the patient's place of residence.

For Vermont Medicaid reimbursement, there is no homebound restriction, nor a three day prior hospitalization required. Patient's condition may be either an episode of acute illness or injury, or a chronic condition requiring home health care under a physician's order.

13.2 FACE-TO-FACE REQUIREMENTS

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

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

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

The ordering physician is required to document who conducted the face-to-face encounter and incorporate findings into the beneficiary's medical record. A specific form to document the face-to-face visit is not required. How to incorporate the clinical findings into the medical record is at the discretion of the ordering physician.
The following elements must be present in the documentation:

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

The following non-physician practitioners may perform the face-to-face encounter:
A nurse practitioner, clinical nurse specialist, or certified nurse midwife working in collaboration with the

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

13.3 REIMBURSABLE SERVICES

General Information: Home health services are provided by certified home health agencies under a plan of treatment authorized and approved by a physician. The objective of the home health services is to restore, rehabilitate, or maintain patients in their own homes or in a domiciliary facility by providing professional care and/or supervision. Approved home health services include nursing care services, services of home health aides, speech therapy, physical therapy, occupational therapy, and medical supplies.

Covered services under the Vermont Medicaid Home Health Service Program are those which are necessary to restore, rehabilitate or maintain health, including care for the terminally ill, when provided under professional supervision in the home. Following are descriptions of home health visits covered under the Vermont Medicaid Program.

13.3.1 Visit at Patient's Place of Residence

A visit is a personal contact in the patient's place of residence for providing a covered home health service by a health worker on the staff of the home health agency or by others under contract or arrangement with the home health agency.

Initial Evaluation Visit: A visit to evaluate the patient, the patient's status, the physical environment and facilities available, attitudes of family members, availability of family members to assist in the care and to assess the appropriateness of home health care for the patient.

Services provided by the home health agency, except for the initial evaluation visit, must be furnished under a physician's plan of care. The physician establishes a written plan of care for the patient and supervises the plan in conjunction with the home health agency. The physician must sign the plan of care initially and review and sign it every 60 days. The plan of care becomes a permanent part of the patient's records. It must be kept on file at the home health agency. If any changes in the plan of treatment are ordered by the physician, these changes must also be signed. They may be given verbally by the physician, and then reduced to writing by the registered nurse or qualified therapist (who must date and sign the changes); however, the physician must countersign the order as soon as possible thereafter.

The plan of care must cover all pertinent diagnoses and include the following information:

- Mental status
- Types of professional services needed
- Frequency of visits
- Prognosis as a result of the services
- Rehabilitation potential
- Functional limitations
- Activities permitted
- Nutritional requirements
- Medication and treatments
- Any safety measures to protect against injury
- Instruction for timely discharge or referral

Specific therapy services - This should include the specific procedures and modalities to be used, and the amount, frequency and duration of the therapies.

The plan of care is reviewed periodically by the physician and home health agency personnel. The agency professional staff is responsible for promptly reporting to the physician any changes in the patient's condition which would warrant altering the plan of care.

13.3.2 Nursing Care Services

Nursing care services provided on a part-time or intermittent basis by a home health agency or, in the case where no agency exists in the area, by a registered nurse employed or contracted by the home health agency, are covered. Nursing services must be provided in accordance with the physician's plan of care.

13.3.3 Registered Nurse Services

Skilled nursing care consists of those services reasonable and necessary to the treatment of an illness or injury and for evaluation and assessment of the patient's condition. These services must be performed by or under the direct supervision of a licensed nurse in accordance with the current Nurse Practice Act (State Law) and the individual home health agency policy. Skilled services are covered for patients who have reached a maintenance level but are able to remain in the home if supervised periodically by an RN or therapist.

13.3.4 Licensed Practical Nurse Services

Intermittent or part-time nursing services may be provided to a patient by a licensed practical nurse when these services are ordered by the patient's physician and the licensed practical nurse is working under the direction of the registered nurse. LPN services are assigned and provided in accordance with the current Nurse Practice Act (State Law) and individual home health agency policy. Duties of a licensed practical nurse may include preparing clinical and progress notes, assisting the physician and/or registered nurse in performing specialized procedures, preparing equipment and materials for treatment, observing aseptic techniques as required, and assisting the patient in learning appropriate self-care techniques.

13.3.5 Home Health Aide Services

Home health aide services can be provided even if a skilled service is not needed; however, a registered nurse or appropriate therapist must make a supervisory visit every 2 weeks. The primary function of a home health aide is the personal care of a patient. The home health aide is assigned to a particular patient by the nurse or therapist. Written instructions for the patient's care are prepared by a registered nurse or therapist as appropriate. Routine small cost items such as cotton balls and tongue depressors are included in the home visit charges and will not be paid for separately.

13.3.6 Personal Duties

Personal duties provided in accordance with the written plan of care by the home health aide include medical assistance, assistance in the activities of daily living, such as helping the patient to bathe, to get in and out of bed, to care for hair and teeth, to exercise, assisting the patient in taking medicines specifically ordered by the physician which are ordinarily self-administered, retraining the patient in necessary self-help skills, and assisting with provision and maintenance of a desirable physical environment for the patient in his home.

13.3.7 Medical Duties

Medical duties include taking temperature, pulse, respirations and blood pressure, weighing the patient, reporting changes in the patient's conditions and needs, and completing appropriate records for the home health agency.

13.3.8 Household Services

Household services that are essential to the patient's health care and incidental to the medical care of the patient, such as light housekeeping, meal preparation, laundering essential to the comfort of the patient,

etc. are considered covered services of a home health aide when these activities can be documented as a necessary adjunct to the patient's prescribed therapeutic plan of care. Light housekeeping may include, changing the bed, light cleaning, and rearrangement of room furnishings to accommodate patient's needs. Meal preparation, meeting patient's nutritional needs, may include purchase of food, meal preparation, and washing of utensils. Laundering may include being sure the patient has clean articles such as stump socks for amputees, elastic stockings, sleepwear, or undergarments for the incapacitated patient.

13.3.9 Hospice

Vermont Medicaid reimburses for hospice services provided to patients in nursing homes. Under federal regulations, hospice providers who contract with nursing homes to provide services become responsible for management of the patient's care and billing for all services, including the room and board normally paid to the nursing home. The revenue code 659 should be used for these hospice services and the name of the nursing home should be entered in field locator 80. Vermont Medicaid pays the hospice a rate which is equal to 95% of the nursing home's established per diem rate, and the hospice in turn, pays the nursing home.

The date of death is not eligible for reimbursement from Vermont Medicaid.

13.3.10 Respite Billing

Only provider types of Aged/Disabled Waiver, with Waiver indicated as provider specialty, may bill for respite care. Providers billing for respite must select a type of bill from the following:

1. Type of Facility
   8-Hospice or Special Facility

2. Bill Classification
   6-Respite

3. Frequency
   1-Admit through discharge claim
   2-Interim-first claim
   3-Interim-continuity claim
   4-Interim-last claim

For additional information, please refer to: http://ddas.vermont.gov/ddas-policies/policies-cfc/policies-cfc-highest/policies-cfc-highest-manual.

13.3.11 Telemonitoring

Home Telemonitoring is a health service that allows and requires scheduled remote monitoring of data related to an individual's health, and transmission of the data from the individual's home to a licensed home health agency. Scheduled periodic reporting of the individual's data to a licensed physician is required, even when there have been no readings outside the parameters established in the physician's orders.

Eligibility Criteria:

Individuals receiving Medicaid telemonitoring services must:

- Have Medicaid as primary insurance or be dually-eligible with "non-home bound" status; and
- Have Congestive Heart Failure (any diagnosis; 428.xx); and
- Be clinically eligible for home health services; and
- Have a physician's plan of care with an order for telemonitoring services.

Qualified Providers:

A qualified telemonitoring provider must be a designated home health agency and enrolled in Vermont Medicaid.

Providers must use the following licensed health care professionals to review data:

- Registered nurse (RN)
- Nurse practitioner (NP)
- Clinical nurse specialist (CNS)
- Licensed practical nurse (LPN), under the supervision of an RN
- Physician assistant (PA)

Providers must follow data parameters established by a licensed physician's plan of care.

In the event of a measurement outside of the established individual's parameters, the provider shall use the health care professionals noted above to be responsible for reporting the data to a physician.

The data transmission must comply with standards set by the Health Insurance Portability and Accountability Act (HIPAA).

Reimbursement

When Telemonitoring services are provided to clinical eligible Medicaid patients, qualified providers may bill CPT S9110 for once every 30 days for telemonitoring of patient in their home, including all necessary equipment; computer system, connections, and software; maintenance; patient education and support; per month. CPT 98969 may be billed once every 7 days for ongoing assessment and management of telemonitoring data. Providers should use revenue code 780 for both S9110 and 98969.

13.4 HOME HEALTH AGENCY & HOSPICE SERVICES BILLING INSTRUCTIONS/FIELD LOCATORS

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

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

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

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

Current hospice revenue codes are listed below:

Rev Code	Description	Required HCPCS G Codes
0651	Routine Home Care	No
0652	Continuous Home Care	Yes
0655	Inpatient Respite Care	No
0656	General Inpatient Care	No

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

Rev Code	Description	Required HCPCS G Codes
0551	Routine Home Care	Yes
0561	Continuous Home Care	Yes

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

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

All information on the UB-04 Claim Form should be typed or legibly printed. The fields listed below are used by DXC Technology when processing Vermont Medicaid claims. The fields designated by an asterisk (*) are mandatory; other fields are required when applicable. Only the fields listed below are used in the Vermont Medicaid Program; other fields do not need to be completed. See Section 12.3 Patient Share (Applied Income) Reporting.

FIELD LOCATORS	**REQUIRED INFORMATION**
1. UNLABELED FIELD*	Enter the Home Health Agency name and address as it appears on the Vermont Medicaid Provider Enrollment form.
2. UNLABELED FIELD	Enter pay to name and pay to address
3a. PATIENT CONTROL #	For accounting purposes, enter the patient control # in the field locator. The number may consist of up to 24 characters, alpha/numeric. This information will appear on the Remittance Advice (RA).
3b. MEDICAL RECORD #	Enter patient's medical record #.
4. TYPE OF BILL*	Enter the code indicating the specific type of bill for Home Health. The sequence is as follows:

	1. Type of facility 3-Home Health 8-Hospice or Special Facility 2. Bill Classification 1-Hospice (Non-hospital based) 2-Hospice (Hospital based) 2-Home Health 4-Ambulatory Surgical Center 6-Respite 3. Frequency 1-Admit through discharge claim 2-Interim-first claim 3-Interim-continuity claim 4-Interim-last claim 5-Late charge(s) only
6. STATEMENT COVERS PERIOD*	Enter the from and through service dates.
8b. PATIENT'S NAME*	Enter the patient's last name, first name and middle initial.
10. BIRTHDATE	Enter the date of birth
12. ADMISSION DATE*	Enter date of admission
13. ADMISSION HOUR	Enter the hour in which patient was admitted.
14. ADMISSION TYPE	Enter the code indicating the priority of the admission: 1-Emergency 2-Urgent 3-Elective 4-Nursery
17. STAT*	Enter the two digit code indicating the patient's status as of the statement period. For SIA Payment, please indicate date of death.
18-28. CONDITONS CODES	Enter code to identify if condition is related to the following (*PSRO code is mandatory): 02-Conditon is Employment Related A1-EPSDT Related Services A4-Family Planning Related Services *If the patient is found to have Medicare benefits that would not cover the home health visit for one of the following reason, enter the condition code: M3-Not home bound M4-Non-chronic M5-Non-acute
31-34. OCCURRENCE CODE & DATE*	Enter one of the following two digit accident codes, and the corresponding occurrence date, if applicable or 52 if no other applies: 01-Auto Accident 02-Auto Accident/No Fault Insurance Involved

	03-Accident/Tort Liability 04-Accident/Employment Related 05-Other Accident 06-Crime Victim 11-No Accident/Onset of Symptoms or Illness 35-Physical Therapy 42-Date of Discharge 44-Occupational Therapy 45-Speech Therapy 50-Medical Emergency- Non-accidental 51-Outpatient Surgery Related 52-Not an Accident
42. REVENUE CODES*	Enter the appropriate revenue code for the service provided. Each date of service must be entered separately at the detail.
45. SERVICE DATE*	Enter the actual date the service was rendered. Enter the from date of the span of consecutive service dates being billed.
46. SERVICE UNITS*	Enter the number of visits or units of time for which reimbursement is being requested. Nursing care and therapy services are reimbursed on a per visit basis. One visit= 1 unit. Home Health Aide services are reimbursed in 15 minute units; therefore, enter total number of units the aide was in the home (i.e. 45 minutes= 3 units.)
47. TOTAL CHARGES*	Enter the total charges pertaining to each code billed for the current billing period. Add the total charges for all revenue codes being billed and enter at the bottom of column 47 in the total field. (detail line 23)
50. PAYER*	Enter “Medicare” or “Spend Down” (if spend down amount applies to the claim.) on 50a if Medicare is the primary payer. On 50b, enter the other insurance name if applicable. Enter “Vermont Medicaid” on 50c.
54. PRIOR PAYMENTS*	Enter the payment amount associated with the payer listed in field locator 50. Attach spend down Notice of Decision. Documentation must be attached if there was no payment, if the services are not covered by the third party.
55. ESTIMATED AMOUNT DUE	Enter the amount due after deducting any amount entered in field locator 54 from the total entered at the bottom of column 47.
56. NPI*	Enter the BILLING provider’s NPI number.
57a. TAXONOMY CODE(S)	Enter the BILLING provider’s Taxonomy Code.
57c. VERMONT MEDICAID ID #	Atypical providers, enter your Vermont Medicaid billing provider number.

60. INSURED'S MEMBER ID*	Enter the member's Vermont Medicaid ID #.
67. PRINCIPAL DIAGNOSES CODE*	Enter the primary diagnosis code. Use the appropriate ICD-9-CM code (for dates of service on or after October 1, 2015, ICD-10 codes must be used).
67 a-q. OTHER DIAGNOSES CODES	Enter the appropriate ICD-9-CM codes (for dates of service on or after October 1, 2015, ICD-10 codes must be used) for any condition other than primary, which requires supplementary treatment.
74. PRINCIPAL PROCEDURE CODE & DATE	Enter the appropriate ICD-9-CM (for dates of service on or after October 1, 2015, ICD-10 codes must be used) procedure code and corresponding date.
74 a-e. OTHER PROCEDURE CODE & DATE	Enter the appropriate ICD-9-CM (for dates of service on or after October 1, 2015, ICD-10 codes must be used) procedure codes and dates other than the principal procedure performed.
76. ATTENDING PHYSICIAN NPI*	Enter the individual Attending Physician's NPI number. If billing with a Vermont Medicaid ID #, leave the NPI field blank and enter the Vermont Medicaid ID # to the right of the qualifier box.
78-79. OTHER PHYSICIAN NPI	Enter the Vermont Medicaid ID # of the physician who the patient was referred to for further treatment if applicable.
80. REMARKS	Enter any notations relating specific information necessary to adjudicate the claim.
81CCa.	Enter the taxonomy code for the attending provider. Must correspond with the NPI number in field locator 76.

13.5 ADULT DAY SERVICES BILLING INSTRUCTIONS/FIELD LOCATORS

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

FIELD LOCATORS	**REQUIRED INFORMATION**
1. UNLABELED FIELD*	Enter the Home Health Agency name and address as it appears on the Vermont Medicaid Provider Enrollment form.
2. UNLABELED FIELD	Enter pay to name and pay to address
3a. PATIENT CONTROL #	For accounting purposes, enter the patient control # in the field locator. The number may consist of up to 24 characters, alpha/numeric.

	This information will appear on the Remittance Advice (RA).
3b. MEDICAL RECORD #	Enter patient's medical record #.
4. TYPE OF BILL*	Enter the code indicating the specific type of bill for Enhanced Residential Care. The sequence is as follows: 1. Type of facility 3-Home Health 2. Bill Classification 1-Hospice (Non-hospital based)} 2-Hospice (Hospital based) 2-Home Health 4-Ambulatory Surgical Center 3. Frequency 1-Admit through discharge claim 2-Interim-first claim 3-Interim-continuity claim 4-Interim-last claim 5-Late charge(s) only
6. STATEMENT COVERS PERIOD*	Enter the "from" and "through" service dates.
8b. PATIENT'S NAME*	Enter the patient's last name, first name and middle initial.
10. BIRTHDATE	Enter the date of birth
12. ADMISSION DATE*	Enter date of admission
13. ADMISSION HOUR	Enter the hour in which patient was admitted.
14. ADMISSION TYPE	Enter the code indicating the priority of the admission: 1-Emergency 2-Urgent 3-Elective 4-Nursery
17. STAT*	Enter the two digit code indicating the patient's status as of the statement period.
18-28. CONDITONS CODES	Enter code to identify if condition is related to the following (*PSRO code is mandatory): 02-Conditon is Employment Related A1-EPSDT Related Services A4-Family Planning Related Services *If the patient is found to have Medicare benefits that would not cover the home health visit for one of the following reason, enter the condition code: M3-Not home bound M4-Non-chronic M5-Non-acute
31-34. OCCURRENCE CODE & DATE*	Enter one of the following two digit accident codes, and the corresponding occurrence date,

	if applicable or 52 if no other applies: 01-Auto Accident 02-Auto Accident/No Fault Insurance Involved 03-Accident/Tort Liability 04-Accident/Employment Related 05-Other Accident 06-Crime Victim 11-No Accident/Onset of Symptoms or Illness 42-Date of Discharge 50-Medical Emergency-Non-accidental 51-Outpatient Surgery Related 52-Not an Accident
39. VALUE CODES AMOUNT*	Enter the number of covered days mandatory for Residential Care Facility only in the amount/dollar column.
42. REVENUE CODES*	Enter the appropriate revenue code for the service provided.
45. SERVICE DATE*	Enter the 'FROM' date of the span of consecutive service dates being billed.
46. SERVICE UNITS*	Enter the number of units which reimbursement is being requested.
47. TOTAL CHARGES*	Enter the total charges pertaining to each revenue code billed for the current billing period. Add the total charges for all revenue codes being billed and enter at the bottom of column 47 in the total field. (detail line 23)
50. PAYER NAME*	Enter "Medicare" or "Spend Down" (if spend down amount applies to the claim.) on 50a if Medicare is the primary payer. On 50b, enter the other insurance name if applicable. Enter "Vermont Medicaid" on 50c.
54. PRIOR PAYMENTS*	Enter the payment amount associated with the payer listed in field locator 50. Attach spend down Notice of Decision. Documentation must be attached if there was no payment, if the services are not covered by the third party.
55. ESTIMATED AMOUNT DUE	Enter the amount due after deducting any amount entered in field locator 54 from the total entered at the bottom of column 47.
56. NPI*	Enter the BILLING provider's NPI number.
57a. TAXONOMY CODE(S)	Enter the BILLING provider's Taxonomy Code when applicable.
57c. VERMONT MEDICAID ID #	Atypical providers, enter your Vermont Medicaid billing provider number.

60. INSURED'S MEMBER ID*	Enter the member's Vermont Medicaid ID #.
67. PRINCIPAL DIAGNOSES CODE*	Enter the primary diagnosis code. Use the appropriate ICD-9-CM code (for dates of service on or after October 1, 2015, ICD-10 codes must be used).
67 a-q. OTHER DIAGNOSES CODES	Enter the appropriate ICD-9-CM codes (for dates of service on or after October 1, 2015, ICD-10 codes must be used) for any condition other than primary, which requires supplementary treatment.
69. ADMITTING DIAGNOSES CODE*	Enter the admitting diagnosis code.
74. PRINCIPAL PROCEDURE CODE & DATE	Enter the appropriate ICD-9-CM procedure code (for dates of service on or after October 1, 2015, ICD-10 codes must be used) and corresponding date.
74 a-e. OTHER PROCEDURE CODE & DATE	Enter the appropriate ICD-9-CM procedure codes (for dates of service on or after October 1, 2015, ICD-10 codes must be used) and dates other than the principal procedure performed.
76. ATTENDING PHYSICIAN NPI*	If billing with a Vermont Medicaid ID #, leave the NPI field blank and enter the Vermont Medicaid ID # to the right of the qualifier box.
77. OPERATING PHYSICIAN NPI	Enter the Vermont Medicaid ID # of the Operating Physician
78-79. OTHER PHYSICIAN NPI	Enter the Vermont Medicaid ID # of the physician who the patient was referred to for further treatment if applicable.
80. REMARKS	Enter any notations relating specific information necessary to adjudicate the claim.
81CCa.	Enter the taxonomy code for the attending provider. Must correspond with the NPI number in field locator 76.

Section 14 Assistive Community Care Services (ACCS)

The below General Billing Instruction applies to all Assistive Community Care Services - Choices for Care Programs (ACCS) for licensed Level III and Assisted Living Residences.

14.1 REVENUE CODE & DATE SPAN BILLING

ACCS providers must bill revenue code 0098 assigned by the Department of Disabilities, Aging and Independent Living (DAIL) in field locator 42. Only consecutive days may be billed in field locator 6. If there is a gap in service during a billing period, you must submit separate claims for each span of days. The day of admission is paid but the day of discharge is not paid. Please find the examples below.

Example 1: (Continuous Stay)

Patient in the facility July 1, 2013 through July 31, 2013.

You would submit as follows:

Single claim	Field locator 6= 07/01/13 to 07/31/13 042=0098 Field locator 46= 31 units

Example 2: (Leave Days)

Patient in the facility July 1, 2013 but leaves on July 15th to visit with family members. Patient returns on July 20th through July 31, 2013.

Submit two claims as follows:

First claim	Field locator 6=07/01/13 to 07/15/13 Field locator 42= 0098 Field locator 46= 15 units
Second claim	Field locator 6= 07/20/13 to 07/31/13 Field locator 42= 0098 Field locator 46= 5 units

Example 3: (Hospital Visit)

Patient in the facility July 1, 2013 but is discharged to the hospital on July 10th. Patient returns on July 27th through July 31, 2013.

Submit two claims as follows:

First claim	Field locator 6= 07/01/13 to 07/10/13 Field locator 42= 0098 Field locator 46= 9 units
Second claim	Field locator 6= 07/27/13 to 07/31/13 Field locator 42= 0098 Field locator 46= 12 units

Example 4: (Multiple Breaks)

Patient in the facility July 1, 2013 but is discharged to the hospital on July 10th. Patient returns on July 13th but leaves with family on July 16th. Patient returns on July 18th through July 31, 2013.

Submit three claims as follows:

First claim	Field locator6= 07/01/13 to 07/10/13 Field locator 42= 0098 Field locator 46= 9 units
Second claim	Field locator 6= 07/13/13 to 07/16/13 Field locator 42= 0098 Field locator 46= 4 units
Third claim	Field locator 6= 07/18/13 to 07/31/13 Field locator 42= 0098 Field locator 46= 14 units

14.2 ASSISTIVE COMMUNITY CARE SERVICES (ACCS) BILLING INSTRUCTIONS/FIELD LOCATORS

All information on the UB-04 claim form is to be typed or legibly printed. The fields listed below are used by DXC when processing Vermont Medicaid claims. The fields designated by an asterisk (*) are mandatory; other fields are required when applicable. Only the fields listed below are used in the Vermont Medicaid

Program; other fields do not need to be completed.

FIELD LOCATORS	REQUIRED INFORMATION
1. UNLABELED FIELD*	Enter your Provider name and address as it appears on the Vermont Medicaid Provider Enrollment form.
2. UNLABELED FIELD	Enter “Assistive Community Care Services”.
3a. PATIENT CONTROL #	For accounting purposes, enter the patient control # in the field locator. The number may consist of up to 24 characters, alpha/numeric. This information will appear on the Remittance Advice (RA).
3b. MEDICAL RECORD #	Enter patient’s medical record #.
4. TYPE OF BILL*	Enter the code indicating the specific type of bill for Enhanced Residential Care. The sequence is as follows: 1. Type of facility 3-Home Health or Residential Care Facility 2. Bill Classification 2- Home Health or ACCS 3. Frequency 1-Admit through discharge claim 2-Interim-first claim 3-Interim-continuity claim 4-Interim-last claim 5-Late charge(s) only
6. STATEMENT COVERS PERIOD*	Enter the beginning and ending service dates included on the bill.
8b. PATIENT’S NAME*	Enter the patient’s last name, first name, middle initial.
10. BIRTHDATE	Enter the date of birth
12. ADMISSION DATE*	Enter date of admission
13. ADMISSION HOUR*	Enter the hour in which patient was admitted
14. ADMISSION TYPE*	Enter the code indicating the priority of the admission: 1-Emergency 2-Urgent 3-Elective 4-Nursery
16. DISCHARGE HOUR	Enter the hour in which patient was Discharged
17. STAT*	Enter the two digit code indicating the patient’s status as of the ‘through date’ of the statement period.

18-28. CONDITONS CODES	Enter code to identify if condition is related to the following (*PSRO code is mandatory): 02-Conditon is Employment Related A1-EPSDT Related Services A4-Family Planning Related Services
31-34. OCCURRENCE CODE & DATE*	Enter one of the following two digit accident codes, and the corresponding occurrence date, if applicable or 52 if no other applies: 01-Auto Accident 02-Auto Accident/No Fault Insurance Involved 03-Accident/Tort Liability 04-Accident/Employment Related 05-Other Accident 06-Crime Victim 11-No Accident/Onset of Symptoms or Illness 42-Date of Discharge 50-Medical Emergency-Non-accidental 51-Outpatient Surgery Related 52-Not an Accident
39. VALUE CODES AMOUNT*	Enter the number of covered days mandatory for Residential Care Facility only in the amount/dollar column. **Do not count the day of discharge or the date of death. (The sum of all days should be equal to the amount of days being billed.)**
42. REVENUE CODES*	Enter the appropriate revenue code for the service provided.
45. SERVICE DATE*	Enter the 'FROM' date of the span of consecutive service dates being billed.
46. SERVICE UNITS*	Enter the number of units which reimbursement is being requested. One visit= 1 units. Home Health Aide services are reimbursed in 15 minute units, therefore, enter total number of units that aide was in the home (i.e. 45 minutes= 3 units).
47. TOTAL CHARGES*	Enter the total charges pertaining to each revenue code billed for the current billing period. Add the total charges for all revenue codes being billed and enter at the bottom of column 47 in the total field. (detail line 23)
50. PAYER NAME*	Enter "Medicare" or "Spend Down" (if spend down amount applies to the claim.) on 50a if Medicare is the primary payer. On 50b, enter the other insurance name if applicable. Enter "Vermont Medicaid" on 50c.

54. PRIOR PAYMENTS*	Enter the payment amount associated with the payer listed in field locator 50. Attach spend down Notice of Decision. Documentation must be attached if there was no payment, if the services are not covered by the third party.
55. ESTIMATED AMOUNT DUE	Enter the amount due after deducting any amount entered in field locator 54 from the total entered at the bottom of column 47.
56. NPI*	Enter the BILLING provider's NPI number.
57a. TAXONOMY CODE(S)	Enter the BILLING provider's Taxonomy Code when applicable.
57c. VERMONT MEDICAID ID #	Atypical providers, enter your Vermont Medicaid billing provider number.
60. INSURED'S MEMBER ID*	Enter the member's Vermont Medicaid ID #.
67. PRINCIPAL DIAGNOSES CODE*	Enter the primary diagnosis code. Use the appropriate ICD-9-CM code (for dates of service on or after October 1, 2015, ICD-10 codes must be used).
67 a-q. OTHER DIAGNOSES CODES	Enter the appropriate ICD-9-CM codes (for dates of service on or after October 1, 2015, ICD-10 codes must be used) for any condition other than primary, which requires supplementary treatment.
69. ADMITTING DIAGNOSES CODE*	Enter the admitting diagnosis code.
74. PRINCIPAL PROCEDURE CODE & DATE	Enter the appropriate ICD-9-CM (for dates of service on or after October 1, 2015, ICD-10 codes must be used) procedure code and corresponding date.
74 a-e. OTHER PROCEDURE CODE & DATE	Enter the appropriate ICD-9-CM procedure codes (for dates of service on or after October 1, 2015, ICD-10 codes must be used) and dates other than the principal procedure performed.
76. ATTENDING PHYSICIAN NPI*	Enter the individual Attending Physician's NPI number. If billing with a Vermont Medicaid ID #, leave the NPI field blank and enter the Vermont Medicaid ID # to the right of the qualifier box.
77. OPERATING PHYSICIAN NPI	Enter the Vermont Medicaid ID # of the Operating Physician
78-79. OTHER PHYSICIAN NPI	Enter the Vermont Medicaid ID # of the physician who the patient was referred to for further treatment if applicable.
80. REMARKS	Enter any notations relating specific information necessary to adjudicate the claim.

81CCa	Enter the taxonomy code for the attending provider. Must correspond with the NPI number in field locator 76.

Section 15 Choices for Care: Enhanced Residential Care (ERC)/Nursing Facilities Home Based Waiver (HBW), Moderate Needs

Due to the implementation of the long-term care 1115 waiver, patient share obligations will be automatically deducted from Vermont Medicaid claims starting with the first claim of the month for nursing homes, ERC and home-based providers. All nursing home claims will cost avoid for Medicare unless the provider has indicated why the service was not covered by Medicare. See Section 12.3 Patient Share (Applied Income) Reporting.

Eligibility for Choices for Care high/highest in all settings is based on specific clinical and financial eligibility criteria and is determined through the Choices for Care application process. Applications may be found at http://dcf.vermont.gov/benefits/LTC-Medicaid

Moderate Needs Program eligibility is based on clinical and financial criteria and is limited to available provider funding. Applications can be found at http://www.ddas.vermont.gov/ddas-programs/programs-cfc/programs-cfc-default-page#forms.

15.1 ERC PAPER CLAIM SUBMISSION BILLING INSTRUCTIONS/FIELD LOCATORS

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

FIELD LOCATORS	**REQUIRED INFORMATION**
1. UNLABELED FIELD*	Enter your Provider name and address as it appears on the Vermont Medicaid Provider Enrollment form.
2. UNLABELED FIELD	Enter “Enhanced Residential Care”.
3a. PATIENT CONTROL #	For accounting purposes, enter the patient control # in the field locator. The number may consist of up to 24 characters, alpha/numeric. This information will appear on the Remittance Advice (RA).
3b. MEDICAL RECORD #	Enter patient’s medical record #.
4. TYPE OF BILL*	Enter the code indicating the specific type of bill for Enhanced Residential Care. The sequence is as follows: 1. Type of facility 3. Home Health or E.R.C 2. Bill Classification 2-Home Health or E.R.C 3. Frequency 1-Admit through discharge claim 2-Interim-first claim 3-Interim-continuity claim

	4-Interim-last claim 5-Late charge(s) only
6. STATEMENT COVERS PERIOD*	Enter the beginning and ending service dates included on the bill.
8b. PATIENT'S NAME*	Enter the patient's last name, first name, middle initial.
10. BIRTHDATE	Enter the date of birth
12. ADMISSION DATE*	Enter date of admission
13. ADMISSION HOUR*	Enter the hour in which patient was admitted
14. ADMISSION TYPE*	Enter the code indicating the priority of the admission: 1-Emergency 2-Urgent 3-Elective 4-Nursery
16. DISCHARGE HOUR	Enter the hour in which patient was admitted.
17. STAT*	Enter the two digit code indicating the patient's status as of the 'through date' of the statement period.
18-28. CONDITONS CODES	Enter code to identify if condition is related to the following (*PSRO code is mandatory): 02-Conditon is Employment Related A1-EPSDT Related Services A4-Family Planning Related Services
29. ACCIDENT STATE	
31-34. OCCURRENCE CODE & DATE*	Enter one of the following two digit accident codes and the corresponding date when applicable or 52 if no other applies: 01-Auto Accident 02-Auto Accident/No Fault Insurance Involved 03-Accident/Tort Liability 04-Accident/Employment Related 05-Other Accident 06-Crime Victim 11-No Accident/Onset of Symptoms or Illness 42-Date of Discharge 50-Medical Emergency-Non-accidental 51-Outpatient Surgery Related 52-Not an Accident
39. VALUE CODES AMOUNT	Enter the number of covered days in the amount/dollar column. **Do not count the day of discharge or the date of death. (The sum of all days should be equal to the amount of days being billed.)**
42. REVENUE CODES*	Enter the appropriate revenue code for the service provided.

45. SERVICE DATE*	Enter the 'FROM' date of the span of consecutive service dates being billed.
46. SERVICE UNITS*	Enter the number of units which reimbursement is being requested.
47. TOTAL CHARGES*	Enter the total charges pertaining to each revenue code billed for the current billing period. Add the total charges for all revenue codes being billed and enter at the bottom of column 47 in the total field. (detail line 23)
50. PAYER NAME*	Enter "Medicare" or "Spend Down" (if spend down amount applies to the claim.) on 50a if Medicare is the primary payer. On 50b, enter the other insurance name if applicable. Enter "Vermont Medicaid" on 50c.
54. PRIOR PAYMENTS*	Enter the payment amount associated with the payer listed in field locator 50. Attach spend down Notice of Decision. Documentation must be attached if there was no payment, if the services are not covered by the third party.
55. ESTIMATED AMOUNT DUE	Enter the amount due after deducting any amount entered in field locator 54 from the total entered at the bottom of column 47.
56. NPI*	Enter the BILLING provider's NPI number
57a. TAXONOMY CODE(S)	Enter the BILLING provider's Taxonomy Code when applicable.
57c. VERMONT MEDICAID ID #	Atypical providers, enter your Vermont Medicaid billing provider number.
60. INSURED'S MEMBER ID*	Enter the member's Vermont Medicaid ID #.
67. PRINCIPAL DIAGNOSES CODE*	Enter the primary diagnosis code. Use the appropriate ICD-9-CM code (for dates of service on or after October 1, 2015, ICD-10 codes must be used).
67 a-q. OTHER DIAGNOSES CODES	Enter the appropriate ICD-9-CM codes (for dates of service on or after October 1, 2015, ICD-10 codes must be used) for any condition other than primary, which requires supplementary treatment.
74. PRINCIPAL PROCEDURE CODE & DATE	Enter the appropriate ICD-9-CM procedure code (for dates of service on or after October 1, 2015, ICD-10 codes must be used) and corresponding date.
74 a-e. OTHER PROCEDURE CODE & DATE	Enter the appropriate ICD-9-CM procedure codes (for dates of service on or after October 1, 2015, ICD-10 codes must be used) and dates other than the principal procedure performed.
76. ATTENDING PHYSICIAN NPI*	Enter the individual Attending Physician's NPI number.

	If billing with a Vermont Medicaid ID #, leave the NPI field blank and enter the Vermont Medicaid ID # to the right of the qualifier box.
80. REMARKS	Enter any notations relating specific information necessary to adjudicate the claim.
81CCa.	Enter the taxonomy code for the attending provider. Must correspond with the NPI number in field locator 76.

15.2 CHOICES FOR CARE: NURSING FACILITIES - GENERAL BILLING INFORMATION

15.2.1 Authorization for Care & Non-Covered Services

Eligibility for long-term care is based on income available for care, admission/discharge status and the medical need for the long-term care.

Personal comfort items, such as the following, are not covered under the Vermont Medicaid program:

- Radio
- Television
- Telephone
- Air conditioner
- Beauty and barber services
- Deodorant
- Denture cream
- Hair brush

If the member requests any personal comfort items, the member must be advised that he or she will be charged. The facility may charge the member for store items secured for the member such as magazines, newspapers, candy, tobacco and dry cleaning.

15.2.2 Member Placement Levels (RPL)

The following placement levels are used for specific classifications of long-term care members in the DCF ACCESS system long panel:

010	NH Highest Coverage
011	ERC Highest Coverage
012	HCBS Highest Coverage
014	NH Highest Special
015	ERC Highest Special
016	Cash& Counseling High
020	NH High Coverage
021	ERC High Coverage
022	HCBS High Coverage

030	HCBS Mod Coverage
040	NH Highest Rehab

The RPL is determined by DAIL and entered into the Access system by DCF (high/highest needs) or DAIL (Moderate Needs Program). Placement is not reported on the UB-04 claim form.

15.2.3 DME in Health Care Institutions

Payment will not be made for DME and supplies ordered by a physician when the member is an inpatient in a health care institution, specifically a general or psychiatric hospital, nursing facility, or intermediate care facility for the mentally retarded (ICF-MR). In these cases, the all-inclusive payment made to these facilities includes the equipment and supplies used by the members.

The one exception is that payment will be made for a seating system, including required accessories, for an individual residing in a long-term care facility when the seating system is prescribed by a masters or doctoral level physical or occupational therapist trained in rehabilitative equipment and is so unique to the individual that it would not be useful to other nursing home residents. Cushions not integral to the seating system are not covered by this exception.

Payment for orthotics and prosthetics, including ostomy supplies and elastic stockings, may be made to the DME vendor when furnished to members in residential facilities, including nursing homes. The doctor and vendor must keep a medical necessity form and/or order, completed by the physician, and/or other documentation of medical need in the member's record.

15.2.4 Duration of Coverage

A continuous period of long-term care residence begins in any long-term care facility with the most recent:

- Day of admission to the facility
- Initial date of Vermont Medicaid eligibility
- First day medical need for long-term care is established by the Utilization Review
- Committee decision

Payment ends on the last day of eligibility, or the day before the day of discharge or death.

15.2.5 Hold Bed

Payment for hold bed days, when a patient is hospitalized, is limited to six consecutive days. A facility may bill for hold bed days when the following criteria are met:

1. While the patient is Medicaid eligible
2. When the patient has been a resident of the nursing home and has been admitted directly to a hospital
3. When the patient's attending physician attests that the patient is expected to be readmitted to the nursing home in ten days or less or when the hospital's discharge planning unit provides notice that the discharge will occur on a day within the 10-day time limit AND
4. When the facility has no other licensed bed available that is also suitable to the gender of the patient for whom the bed will be held. (*Example: If the hospitalized patient is male and there is no other male beds available, a hold bed day can be billed even if one female bed is empty.)*

Under hold bed restrictions, the Vermont Medicaid Program will not reimburse for the following:

- Leave of absences during a hold bed stay
- Hold bed days for members with MR or MH admissions

- Hold bed days for swing bed facilities.

A Discharge Notice must be completed if the member is unlikely to be able to return to the nursing home or, if during the ten days, the member's condition changes such that he/she will not be able to return within the ten days. The date of discharge when a hospital admission is needed is the date of admission to the hospital. If the member's condition changes the date of discharge is the day on which the determination was made or the tenth day.
To bill for a hold bed situation, enter the appropriate revenue code (0185) in field locator 42 (Revenue Code). The hold bed start date is entered in field locator 45 (Service Date) and the total number of days to be billed should be entered in field locator 46 (Service Units). Enter total at the bottom of column 47 in the totals field.

Note: If separate nonconsecutive services occur, the provider must enter a separate detail line with the appropriate revenue code for the service. For example:

Rev. Code & Description	Start Date	Days/Units	Billed Amount
120 - Room/Board	02/01/07	15	$1500.00
185 - Hold Bed	02/16/07	3	$300.00
120 - Room/Board	02/19/07	10	$1000.00

When billing a Hold Bed claim electronically, the information below is required in the claim note section.

Claim Note Section:
The information in the notes segment must state: CERT FORM and to and from dates the facility was at maximum licensed occupancy. Electronic claims submitted without this information will be denied.

Providers submitting a Hold Bed claim on paper are required to include an Occupancy Certification Form stating that the nursing home would otherwise be at its maximum licensed occupancy. Paper claims submitted without the Occupancy Certification Form will be denied.

15.2.6 Leave of Absence

Leave days are counted by nights away from the facility for the purpose of a home visit. The maximum number of leave days is 24 per calendar year. If a patient is gone the night of the 4th, both the start date and the end date would be the 4th. If the patient leaves the 4th and returns on the 6th, the start date would be the 4th and the end date would be the 5th. The patient is considered back at the facility to sleep the night of the 6th.

To bill for a leave of absence situation, enter the appropriate revenue code (0182) in field locator 42 (Revenue Code). The leave of absence start date is entered in field locator 45 (Service Date) and the total number of days to be billed should be entered in field locator 46 (Service Units). Enter total at the bottom of column 47 in the totals field.

If separate non-consecutive services occur, the provider must enter a separate detail line with the appropriate revenue code for the service. For example:

Rev. Code & Description	Start Date	Days/Units	Billed Amount
120 - Room/Board	02/01/07	15	$1500.00
182 - Leave of Absence	02/16/07	3	$300.00
120 - Room/Board	02/19/07	10	$1000.00

15.2.7 Nursing Home Claims & Patient Hospitalization

When a nursing home bills an entire month but the patient was hospitalized for a portion of the billed month, the claim must be recouped and a corrected claim(s) resubmitted.

If the criteria **is** met to bill a hold bed, follow the directions stated in the Hold Bed, Section of this manual.

If the hold bed criteria **is not** met, 2 separate claims must be billed when a patient is discharged from a nursing home and later readmitted into the same nursing home in any one given month.

Do not send a partial refund for the days the patient is hospitalized; this will not correct the actual days that the patient was at the nursing home and does not constitute correct coding.

15.2.8 Patient Share in a Nursing Facility

Patient share amounts are deducted from nursing facilities the first claim of the month when a member is still a patient. When the patient is discharged from a nursing facility prior to month's end, providers are required to adjust & recoup all claims paid for the month of discharge and resubmit one claim for the entire month's service, using the appropriate patient status code. The claim will then be processed and reimbursed without the patient share deduction. See Section 13.3 Patient Share (Applied Income) Reporting.

15.2.9 Prior Payments

Providers are required to report all prior payments made on a claim. This includes Patient Share, Medicare and all Third-Party payments are to be totaled and recorded in field locator 54b of the UB04 Claim Form.

15.2.10 Choices for Care Short-Term Respite Stays

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

15.2.11 Services Included in Per Diem Rate

The services included in the per diem rate for the nursing facility are described in the Division of Rate Setting's reimbursement regulations. Please contact that division if you are in need of a copy of the regulations. A complete list of covered services included in a nursing facility's per diem rate for long term care can be found in DVHA's Medicaid Covered Service Rule 7603 at http://humanservices.vermont.gov/on-line-rules/dvha/medicaid-covered-services-7100-7700/view.

15.2.12 Short Term Stays

The Medicaid benefit package includes a short-term Skilled Nursing Facility (SNF) stay that is limited to not more than 30 days per episode and 60 days per calendar year.

Admission of a Medicaid member to a Skilled Nursing Facility (SNF) per the benefit outlined above will be based on a physician's order for SNF services with documentation of medical necessity for the treatment of illness or injury. The admitting diagnosis must support all treatment and therapies ordered and maintain that the service cannot be provided at a lower level of care.

As of November 1, 2014, individuals are not required to submit a Choices for Care application for short-term SNF stays. Instead, the SNF will submit a notice of admission and discharge (long panel) to DCF using form CFC 804C. The facility will submit Medicaid claims for coverage using revenue code 128 and will be paid out of the Choices for Care budget under the Highest Need category.

For a stay greater than 30 days per episode or a cumulative stay greater than 60 days per calendar year, a Choices for Care Long-Term Care application is required.

The Department of Disabilities, Aging and Independent Living website provides access to the following information regarding this change:

1) Choices for Care 1115 Highest and High Needs Manual:
   Section II: Eligibility: http://www.ddas.vermont.gov/ddas-policies/policies-cfc/policies-cfc-highest/policies-cfc-highest-documents/cfc-high-manual-section-2

   Section V.1: Application and Eligibility Determination Procedures: http://www.ddas.vermont.gov/ddas-policies/policies-cfc/policies-cfc-highest/policies-cfc-highest-documents/cfc-high-manual-section-5-1

2) CFC 804C form: http://www.ddas.vermont.gov/ddas-programs/programs-cfc/programs-cfc-default-page#highest

15.2.13 Nursing Facilities Billing Instructions/Field Locators

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

FIELD LOCATORS	**REQUIRED INFORMATION**
1. UNLABELED FIELD*	Enter your Nursing Home name and address as it appears on the Vermont Medicaid Provider Enrollment form.
2. UNLABELED FIELD	Enter “Vermont Medicaid Nursing Home”.
3a. PATIENT CONTROL #	For accounting purposes, enter the patient control # in the field locator. The number may consist of up to 24 characters, alpha/numeric. This information will appear on the Remittance Advise (RA).
3b. MEDICAL RECORD #	Enter patient’s medical record #.
4. TYPE OF BILL*	Enter the code indicating the specific type of bill for Enhanced Residential Care. The sequence is as follows: 1. Type of facility 2-Skilled Nursing 6-Intermediate Care 8-Respite Special Facility 2. Bill Classification 1-Inpatient (Part A) 2-Hospital Based or Inpatient (Part B) (Included HHA visits under a Part B plan of treatment) 5-Intermediate Care-Level I 6-Intermediate Care-Level II 7-Sub-Acute Inpatient (Revenue code 19X required) 8-Swing Bed (used to indicate billing for

	SNF level of care in a hospital with an approved swing bed agreement). 3. Frequency 1-Admit through discharge claim 2-Interim-first claim 3-Interim-continuity claim 4-Interim-last claim 5-Late charge(s) only
6. STATEMENT COVERS PERIOD*	Enter the from and through service dates
8b. PATIENT'S NAME*	Enter the patient's last name, first name and middle initial.
10. BIRTHDATE	Enter the date of birth
12. ADMISSION DATE*	Enter date of admission
13. ADMISSION HOUR*	Enter the hour in which patient was admitted
14. SOURCE OF ADMISSION	Enter the appropriate source of admission 1. Physician referral 2. Clinic referral 3. HMO referral 4. Transfer from a Hospital 5. Transfer from a Skilled Nursing Facility 6. Transfer from another Health Care Facility 7. Emergency Room 8. Direction of the Court or Law Enforcement 9. Information is not available. A. Transfer from a Critical Access Hospital B. Transfer from a Home Health Agency
16. DISCHARGE HOUR*	Enter the hour in which patient was discharged
17. STAT*	Enter the two digit code indicating the patient's status as of the 'through date' of the statement period.
18-28. CONDITONS CODES*	Enter code to identify if condition is related to the following (*PSRO code is mandatory): M1- Benefits Exhausted M2- Non Qualifying Stay
31-34. OCCURRENCE CODE & DATE*	Enter one of the following two digit accident codes and corresponding occurrence date if, applicable or 52 if no other applies: 01-Auto Accident 02-Auto Accident/No Fault Insurance Involved 03-Accident/Tort Liability 04-Accident/Employment Related 05-Other Accident 06-Crime Victim 11-No Accident/Onset of Symptoms or Illness 42-Date of Discharge 50-Medical Emergency-Non-accidental 51-Outpatient Surgery Related

	52-Not an Accident
39. VALUE CODES AMOUNT*	Enter the number of covered days in the amount/dollar column. **Do not count the day of discharge or the date of death. (The sum of all days should be equal to the amount of days being billed.)**
42. REVENUE CODES*	Enter the appropriate revenue code for the service provided. Acceptable room revenue codes are as follows: 0120= Room/Board/Semi-private, 2 beds 0128= Short-term stay/Rehab 0130= Room/Board/Semi-private, 3-4 beds 0182= Leave of Absence 0185= Hold Bed Days
45. SERVICE DATE*	Enter the appropriate start date of the revenue code being billed for this detail charge.
46. SERVICE UNITS*	Enter the number of days being billed for this detail charge for the room charge and units of service for any ancillary charges.
47. TOTAL CHARGES*	Enter the total charges pertaining to each revenue code billed for the current billing period. Add the total charges for all revenue codes being billed and enter at the bottom of column 47 in the total field. (detail line 23)
50. PAYER*	Enter “Patient Share” in 50a, “Medicare” on 50b (if Medicare is the primary payer after patient share.) If other third party, enter name of insurer in 50b. Enter “Vermont Medicaid” on 50c. As of DOS 10/01/05, claims do not need to list patient share. This field will be auto-populated.
54. PRIOR PAYMENTS*	Enter the payment amount associated with the payer listed in field locator 50.
55. ESTIMATED AMOUNT DUE	Enter the amount due after deducting any amount entered in field locator 54 from the total entered at the bottom of column 47.
56. NPI*	Enter the BILLING provider’s NPI number.
57a. TAXONOMY CODE(S)	Enter the BILLING provider’s Taxonomy Code when applicable.
57c. VERMONT MEDICAID ID #	Atypical providers, enter your Vermont Medicaid billing provider number.
60. INSURED'S MEMBER ID*	Enter the member’s Vermont Medicaid ID #.
67. PRINCIPAL DIAGNOSIS CODE*	Enter the primary diagnosis code. Use the appropriate ICD-9-CM code (for dates of service on or after October 1, 2015, ICD-10 codes must be used).

67a-q. OTHER DIAGNOSES CODES	Enter the appropriate ICD-9-CM codes (for dates of service on or after October 1, 2015, ICD-10 codes must be used) for any condition other than primary, which requires supplementary treatment.
69. ADMITTING DIAGNOSIS CODE	Enter the admitting diagnosis code.
74. PRINCIPAL PROCEDURE CODE & DATE	Enter the appropriate ICD-9-CM procedure code (for dates of service on or after October 1, 2015, ICD-10 codes must be used) and corresponding date.
74 a-e. OTHER PROCEDURE CODE & DATE	Enter the appropriate ICD-9-CM procedure codes (for dates of service on or after October 1, 2015, ICD-10 codes must be used) and dates other than the principal procedure performed.
76. ATTENDING PHYSICIAN*	Enter the individual Attending Physician's NPI number. If billing with a Vermont Medicaid ID #, leave the NPI field blank and enter the Vermont Medicaid ID # to the right of the qualifier box.
80. REMARKS	Enter any notations relating specific information necessary to adjudicate the claim.
81CCa.	Enter the taxonomy code for the attending provider. Must correspond with the NPI number in field locator 76.

15.3 HOME BASED WAIVER (HBW) BILLING INSTRUCTIONS/FIELD LOCATORS

This section applies to members receiving Choices for Care home based high/highest and Moderate Needs services.

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

FIELD LOCATORS	**REQUIRED INFORMATION**
1. UNLABELED FIELD*	Enter your Provider name and address as it appears on the Vermont Medicaid Provider Enrollment form.
2. UNLABELED FIELD	Enter "Home Based Waiver".
3a. PATIENT CONTROL #	For accounting purposes, enter the patient control # in the field locator. The number may consist of up to 24 characters, alpha/numeric. This information will appear on the Remittance Advice (RA).
3b. MEDICAL RECORD #	Enter patient's medical record #.
4. TYPE OF BILL*	Enter the code indicating the specific type of bill for Enhanced Residential Care. The sequence is as follows: 1. Type of facility

	3-Home Health or H.B.W 2. Bill Classification 1-Hospice (Non-hospital based) 2-Hospice (Hospital based) 2-Home Health or H.B.W 4-Ambulatory Surgical Center 3. Frequency 1-Admit through discharge claim 2-Interim-first claim 3-Interim-continuity claim 4-Interim-last claim 5-Late charge(s) only
6. STATEMENT COVERS PERIOD*	Enter the from and through service dates
8b. PATIENT'S NAME*	Enter the patient's last name, first name and middle initial.
10. BIRTHDATE	Enter the date of birth
12. ADMISSION DATE*	Enter the date patient care started for Home Based Waiver.
13. ADMISSION HOUR*	Enter the hour in which patient was admitted
14. ADMISSION TYPE*	Enter the code indicating the priority of the admission: 1-Emergency 2-Urgent 3-Elective 4-Nursery
17. STAT*	Enter the two digit code indicating the patient's status as of the 'through date' of the statement period.
	18-28. CONDITONS CODES* Enter code to identify if condition is related to the following (*PSRO code is mandatory): 02-Conditon is Employment Related A1-EPSDT Related Services A4-Family Planning Related Services
31-34. OCCURRENCE CODE & DATE*	Enter one of the following two digit accident codes, and the corresponding occurrence date, if applicable or 52 if no other applies: 01-Auto Accident 02-Auto Accident/No Fault Insurance Involved 03-Accident/Tort Liability 04-Accident/Employment Related 05-Other Accident 06-Crime Victim 11-No Accident/Onset of Symptoms or Illness 42-Date of Discharge 50-Medical Emergency-Non-accidental 51-Outpatient Surgery Related 52-Not an Accident

39. VALUE CODES*	Enter the number of covered days. **Do not count the day of discharge or the date of death. (The sum of all days should be equal to the amount of days being billed.)**
42. REVENUE CODES*	Enter the appropriate revenue code for the service provided.
45. SERVICE. DATE*	Enter the 'FROM' date of the span of consecutive service dates being billed.
46. SERVICE. UNITS*	Enter the number of units which reimbursement is being requested.
47. TOTAL CHARGES*	Enter the total charges pertaining to each revenue code billed for the current billing period. Add the total charges for all revenue codes being billed and enter at the bottom of column 47 in the total field. (detail line 23)
50. PAYER NAME*	Enter "Patient Liability" in 50a, "Medicare" on 50b (if Medicare is the primary payer after Patient Share). If other third party, enter name of insurer in 50b. Enter "Vermont Medicaid" on 50c. As of DOS 10/01/05, Claims do not need to list patient share. This field will be auto-populated.
54. PRIOR PAYMENTS*	Enter the payment amount associated with the payer listed in field locator 50. Attach spend down Notice of Decision. Documentation must be attached if there was no payment, if the services are not covered by the third party.
55. ESTIMATED AMOUNT DUE	Enter the amount due after deducting any amount entered in field locator 54 from the total entered at the bottom of column 47.
56. NPI*	Enter the BILLING provider's NPI number.
57a. TAXONOMY CODE(S)	Enter the BILLING provider's Taxonomy Code when applicable.
57c. VERMONT MEDICAID ID #	Atypical providers, enter your Vermont Medicaid billing provider number.
60. INSURED'S MEMBER ID*	Enter the member's Vermont Medicaid ID #.
67. PRINCIPAL DIAGNOSES CODE*	Enter the primary diagnosis code. Use the appropriate ICD-9-CM code (for dates of service on or after October 1, 2015, ICD-10 codes must be used).
67a-q. OTHER DIAGNOSES CODES	Enter the appropriate ICD-9-CM codes (for dates of service on or after October 1, 2015, ICD-10 codes must be used) for any condition other than primary, which requires supplementary treatment.
69. ADMITTING DIAGNOSES CODE*	Enter the Admitting Diagnoses Code

74. PRINCIPAL PROCEDURE	Enter the appropriate ICD-9-CM procedure code (for dates of service on or after October 1, 2015, ICD-10 codes must be used) and corresponding date.
74a-e. OTHER PROCEDURE	Enter the appropriate ICD-9-CM procedure codes (for dates of service on or after October 1, 2015, ICD-10 codes must be used) and dates other than the principal procedure performed.
76. ATTENDING PHYSICIAN*	Enter the individual Attending Physician's NPI number. If billing with a Vermont Medicaid ID #, leave the NPI field blank and enter the Vermont Medicaid ID # to the right of the qualifier box.
80. REMARKS	Enter any notations relating specific information necessary to adjudicate the claim
81CCa	Enter the taxonomy code for the attending provider. Must correspond with the NPI number in field locator 76.

Section 16 Program Integrity

16.1 FRAUD

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

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

Suspected fraud, waste or abuse should be reported to the DVHA Program Integrity Unit at http://dvha.vermont.gov/for-providers/program-integrity, telephone (802) 879-5900 or the Medicaid Fraud Control Unit of the Vermont's Attorney General's Office, telephone (802) 828-5511.

16.2 PRIVATE LITIGATION

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.

16.3 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 http://humanservices.vermont.gov/on-line-rules/dvha and at each DCF District Office and at the state library in Montpelier.

16.4 PROGRAM INTEGRITY RECONSIDERATION & APPEAL PROCESS

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

16.4.1 Reconsideration of Improper Payment and the Recovery of Overpayments

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

A. The request must be made within thirty (30) calendar days of the date of the letter from Program Integrity and must file the request on the Request for Reconsideration of the Recovery of Overpayments by Program Integrity form located at http://dvha.vermont.gov/for-providers/forms-1.
B. All issues regarding the provider's objection to the findings must be documented and no monetary threshold is applied. Failure to do so will result in the reconsideration request being waived.
C. The reconsideration review will be conducted by a qualified person within the Program Integrity Unit of DVHA.
D. DVHA has 30 calendar days to respond following the later of:
   (1) Receipt of reconsideration form
   (2) the date of a meeting with the provider, if one is scheduled,
   (3) the date additional information is received from the provider (if requested by DVHA).
E. During the reconsideration process, the provider may request in writing an additional 14 days to respond to a request by DVHA.
F. In some circumstances, DVHA may notify the provider that an additional 14 day extension is invoked.
G. After review and reconsideration, DVHA will send the provider a final letter regarding its determination. DVHA may send a decision in the event the provider does not reply to a document request in a timely manner, or in the case a request for reconsideration is not filed in a timely manner.
   A provider who is dissatisfied with the result of the reconsideration decision may follow the process to submit a Program Integrity Appeal. Submit Reconsideration Request and Forms to:
   Program Integrity Appeals
   Department of Vermont Health Access
   312 Hurricane Lane, Suite 201
   Williston, VT 05495

16.4.2 Program Integrity Appeal of Improper Payment and Overpayment Deficient Practice

In order to initiate a Program Integrity Appeal the following process needs to occur:

A. A Program Integrity appeal must be filed within 30 days of the receipt of the reconsideration decision notice from DVHA or mail date. To file a Program Integrity appeal a provider must complete the Request for Appeal of a reconsideration decision by Program Integrity located at http://dvha.vermont.gov/for-providers/forms-1.
B. The provider is required to list all objections to the reconsideration decision notice at the time of the Program Integrity Appeal, otherwise claims are waived.
C. Program Integrity appeals will be divided into two categories:
   - Cases in which a reconsideration decision was issued regarding an overpayment of $15,000 or less will be reviewed the Chief Medical Officer (CMO) or designee. At the

discretion of the CMO or designee, written instructions will be issued to the provider explaining the process or providing for a meeting with the provider.

- Cases in which a reconsideration decision was issued regarding an overpayment of $15,000 or more will be reviewed by the DVHA Commissioner or designee, who may convene a hearing to be scheduled within 90 days from the date of the receipt of the appeal. Appeal hearings shall be conducted under the same rules of conduct as in current use for hearings for the Human Services Board.

D. Within 14 days of either a meeting by the Chief Medical Officer or designee, or an appeal hearing by the Commissioner or their designee, the following will be mailed to the provider :
   (1) A written request for additional information or an additional meeting to discuss, or
   (2) A decision letter. The decision letter will indicate the next level of appeal, as indicated below, should the provider be dissatisfied with the decision.
E. No money is collected from the provider or offset against claims until a final decision has been rendered on the Program Integrity appeal.
F. Upon receipt of a Program Integrity Appeal decision letter, DVHA may demand payment from the provider or offset the overpayment determination from pending claims. The provider may request a payment plan from DVHA in order to reconcile the overpayment.

Program Integrity appeal decisions are final. Disagreement with the decision has the option to file a civil action in Superior Court. Submit Appeal Request and Forms to: Program Integrity Appeals, 312 Hurricane Lane, Williston VT 05495

16.5 VIOLATIONS

Suspected violations of Vermont Medicaid policies should be reported to the Program Integrity Unit (802) 879-5900. All information will be treated confidentially.

Section 17 Other Provider Information

17.1 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

17.2 PHARMACY TAX

A monthly assessment is due to the State of Vermont for each prescription fill 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 fill or refill. The completed Pharmacy Assessment Monthly Documentation Form, available online at http://dvha.vermont.gov/for-providers/pharmacy-forms 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 18 Promoting Interoperability Program (Formerly Electronic Health Record Incentive Program)

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

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

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

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

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

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

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

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

Reconsideration of PIP/EHRIP Decisions

A. A provider who receives notification regarding eligibility for: payment amount, overpayment amount, or recoupment, has the option to request reconsideration by the PIP/EHRIP.

B. The request must be made within thirty (30) calendar days of the receipt of the overpayment notice OR of the denial notice OR within thirty (30) calendar days of the date of the PIP/EHRIP payment in dispute. The request must be filed on the *Request for PIP/EHRIP Reconsideration* form located at https://healthdata.vermont.gov/ehrip/Audits/Appeals

C. All issues regarding the provider’s objection to the findings must be documented and no monetary threshold is applied. Failure to do so will result in the reconsideration request being waived.

D. The reconsideration review will be conducted by a qualified person within the PIP/EHRIP of DVHA.

E. DVHA has 30 calendar days to respond following the later of:

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

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

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

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

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

Submit Reconsideration Request and Forms to:

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

18.2 APPEAL OF PROMOTING INTEROPERABILITY PROGRAM/EHR INCENTIVE PROGRAM RECONSIDERATION

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

A. A PIP/EHRIP appeal must be filed within 30 days of the receipt of the reconsideration decision notice from DVHA or mail date. To file a PIP/EHRIP appeal a provider must complete the Request for Appeal of PIP/EHRIP Reconsideration form located at https://healthdata.vermont.gov/ehrip/Audits/Appeals

B. The provider is required to list all objections to the reconsideration decision notice at the time of the PIP/EHRIP Appeal, otherwise claims are waived.

C. PIP/EHRIP appeals will be divided into two categories:

1. Cases in which a reconsideration decision was issued regarding an overpayment of $15,000 or less will be reviewed by the Chief Medical Officer (CMO) or designee. At the discretion of the CMO or designee, written instructions will be issued to the provider explaining the process or providing for a meeting with the provider.

2. Cases in which a reconsideration decision was issued regarding an overpayment of $15,000 or more will be reviewed by the DVHA Commissioner or designee, who may convene a hearing to be scheduled within 90 days from the date of the receipt of the appeal. Appeal hearings shall be conducted under the same rules of conduct as in current use for hearings for the Human Services Board.

D. Within 14 days of either a meeting by the Chief Medical Officer or designee, or an appeal hearing by the Commissioner or their designee, the following will be mailed to the provider:

1. A written request for additional information or an additional meeting to discuss,

-or-

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

E. No money is collected from the provider or offset against claims until a final decision has been rendered on the PIP/EHRIP appeal.

F. Upon receipt of a PIP/EHRIP Appeal decision letter, DVHA may demand payment from the provider or offset the overpayment determination from pending claims. The provider may request a payment plan from DVHA in order to reconcile the overpayment. PIP/EHRIP appeal decisions are final. Disagreement with the decision has the option to file a civil action in Superior Court.

Submit Appeal Request and Forms to:
Office of the General Counsel
PIP/EHRIP Appeals
Department of Vermont Health Access
NOB 1 South
280 State Drive
Waterbury, VT 05671-1010

Appendix 1

ICD-10 Code	ICD-10 Description
I50.1	Left ventricular failure
I50.20	Unspecified systolic (congestive) heart failure
I50.21	Acute systolic (congestive) heart failure
I50.22	Chronic systolic (congestive) heart failure
I50.23	Acute on chronic systolic (congestive) heart failure
I50.30	Unspecified diastolic (congestive) heart failure
I50.31	Acute diastolic (congestive) heart failure
I50.32	Chronic diastolic (congestive) heart failure
I50.33	Acute on chronic diastolic (congestive) heart failure
I50.40	Unspecified combined systolic (congestive) and diastolic (congestive) heart failure
I50.41	Acute combined systolic (congestive) and diastolic (congestive) heart failure
I50.42	Chronic combined systolic (congestive) and diastolic (congestive) heart failure
I50.43	Acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure
I50.9	Heart failure, unspecified
O09.00	Supervision of pregnancy with history of infertility, unspecified trimester
O09.01	Supervision of pregnancy with history of infertility, first trimester
O09.02	Supervision of pregnancy with history of infertility, second trimester
O09.03	Supervision of pregnancy with history of infertility, third trimester
O09.10	Supervision of pregnancy with history of ectopic or molar pregnancy, unspecified trimester
O09.11	Supervision of pregnancy with history of ectopic or molar pregnancy, first trimester
O09.12	Supervision of pregnancy with history of ectopic or molar pregnancy, second trimester
O09.13	Supervision of pregnancy with history of ectopic or molar pregnancy, third trimester
O09.211	Supervision of pregnancy with history of pre-term labor, first trimester
O09.212	Supervision of pregnancy with history of pre-term labor, second trimester
O09.213	Supervision of pregnancy with history of pre-term labor, third trimester
O09.219	Supervision of pregnancy with history of pre-term labor, unspecified trimester
O09.291	Supervision of pregnancy with other poor reproductive or obstetric history, first trimester
O09.292	Supervision of pregnancy with other poor reproductive or obstetric history, second trimester
O09.293	Supervision of pregnancy with other poor reproductive or obstetric history, third trimester
O09.299	Supervision of pregnancy with other poor reproductive or obstetric history, unspecified trimester
O09.30	Supervision of pregnancy with insufficient antenatal care, unspecified trimester
O09.31	Supervision of pregnancy with insufficient antenatal care, first trimester
O09.32	Supervision of pregnancy with insufficient antenatal care, second trimester
O09.33	Supervision of pregnancy with insufficient antenatal care, third trimester
O09.40	Supervision of pregnancy with grand multiparity, unspecified trimester
O09.41	Supervision of pregnancy with grand multiparity, first trimester
O09.42	Supervision of pregnancy with grand multiparity, second trimester
O09.43	Supervision of pregnancy with grand multiparity, third trimester
O09.511	Supervision of elderly primigravida, first trimester
O09.512	Supervision of elderly primigravida, second trimester
O09.513	Supervision of elderly primigravida, third trimester
O09.519	Supervision of elderly primigravida, unspecified trimester
O09.521	Supervision of elderly multigravida, first trimester
O09.522	Supervision of elderly multigravida, second trimester
O09.523	Supervision of elderly multigravida, third trimester
O09.529	Supervision of elderly multigravida, unspecified trimester
O09.611	Supervision of young primigravida, first trimester
O09.612	Supervision of young primigravida, second trimester
O09.613	Supervision of young primigravida, third trimester
O09.619	Supervision of young primigravida, unspecified trimester

O09.621	Supervision of young multigravida, first trimester
O09.622	Supervision of young multigravida, second trimester
O09.623	Supervision of young multigravida, third trimester
O09.629	Supervision of young multigravida, unspecified trimester
O09.70	Supervision of high risk pregnancy due to social problems, unspecified trimester
O09.71	Supervision of high risk pregnancy due to social problems, first trimester
O09.72	Supervision of high risk pregnancy due to social problems, second trimester
O09.73	Supervision of high risk pregnancy due to social problems, third trimester
O09.811	Supervision of pregnancy resulting from assisted reproductive technology, first trimester
O09.812	Supervision of pregnancy resulting from assisted reproductive technology, second trimester
O09.813	Supervision of pregnancy resulting from assisted reproductive technology, third trimester
O09.819	Supervision of pregnancy resulting from assisted reproductive technology, unspecified trimester
O09.821	Supervision of pregnancy with history of in utero procedure during previous pregnancy, first trimester
O09.822	Supervision of pregnancy with history of in utero procedure during previous pregnancy, second trimester
O09.823	Supervision of pregnancy with history of in utero procedure during previous pregnancy, third trimester
O09.829	Supervision of pregnancy with history of in utero procedure during previous pregnancy, unspecified trimester
O09.891	Supervision of other high risk pregnancies, first trimester
O09.892	Supervision of other high risk pregnancies, second trimester
O09.893	Supervision of other high risk pregnancies, third trimester
O09.899	Supervision of other high risk pregnancies, unspecified trimester
O09.90	Supervision of high risk pregnancy, unspecified, unspecified trimester
O09.91	Supervision of high risk pregnancy, unspecified, first trimester
O09.92	Supervision of high risk pregnancy, unspecified, second trimester
O09.93	Supervision of high risk pregnancy, unspecified, third trimester
O10.011	Pre-existing essential hypertension complicating pregnancy, first trimester
O10.012	Pre-existing essential hypertension complicating pregnancy, second trimester
O10.013	Pre-existing essential hypertension complicating pregnancy, third trimester
O10.019	Pre-existing essential hypertension complicating pregnancy, unspecified trimester
O10.02	Pre-existing essential hypertension complicating childbirth
O10.03	Pre-existing essential hypertension complicating the puerperium
O10.111	Pre-existing hypertensive heart disease complicating pregnancy, first trimester
O10.112	Pre-existing hypertensive heart disease complicating pregnancy, second trimester
O10.113	Pre-existing hypertensive heart disease complicating pregnancy, third trimester
O10.119	Pre-existing hypertensive heart disease complicating pregnancy, unspecified trimester
O10.12	Pre-existing hypertensive heart disease complicating childbirth
O10.13	Pre-existing hypertensive heart disease complicating the puerperium
O10.211	Pre-existing hypertensive chronic kidney disease complicating pregnancy, first trimester
O10.212	Pre-existing hypertensive chronic kidney disease complicating pregnancy, second trimester
O10.213	Pre-existing hypertensive chronic kidney disease complicating pregnancy, third trimester
O10.219	Pre-existing hypertensive chronic kidney disease complicating pregnancy, unspecified trimester
O10.22	Pre-existing hypertensive chronic kidney disease complicating childbirth
O10.23	Pre-existing hypertensive chronic kidney disease complicating the puerperium
O10.311	Pre-existing hypertensive heart and chronic kidney disease complicating pregnancy, first trimester
O10.312	Pre-existing hypertensive heart and chronic kidney disease complicating pregnancy, second trimester
O10.313	Pre-existing hypertensive heart and chronic kidney disease complicating pregnancy, third trimester
O10.319	Pre-existing hypertensive heart and chronic kidney disease complicating pregnancy, unspecified trimester
O10.32	Pre-existing hypertensive heart and chronic kidney disease complicating childbirth
O10.33	Pre-existing hypertensive heart and chronic kidney disease complicating the puerperium
O10.411	Pre-existing secondary hypertension complicating pregnancy, first trimester
O10.412	Pre-existing secondary hypertension complicating pregnancy, second trimester
O10.413	Pre-existing secondary hypertension complicating pregnancy, third trimester
O10.419	Pre-existing secondary hypertension complicating pregnancy, unspecified trimester
O10.42	Pre-existing secondary hypertension complicating childbirth
O10.43	Pre-existing secondary hypertension complicating the puerperium

O10.911	Unspecified pre-existing hypertension complicating pregnancy, first trimester
O10.912	Unspecified pre-existing hypertension complicating pregnancy, second trimester
O10.913	Unspecified pre-existing hypertension complicating pregnancy, third trimester
O10.919	Unspecified pre-existing hypertension complicating pregnancy, unspecified trimester
O10.92	Unspecified pre-existing hypertension complicating childbirth
O10.93	Unspecified pre-existing hypertension complicating the puerperium
O11.1	Pre-existing hypertension with pre-eclampsia, first trimester
O11.2	Pre-existing hypertension with pre-eclampsia, second trimester
O11.3	Pre-existing hypertension with pre-eclampsia, third trimester
O11.9	Pre-existing hypertension with pre-eclampsia, unspecified trimester
O12.00	Gestational edema, unspecified trimester
O12.01	Gestational edema, first trimester
O12.02	Gestational edema, second trimester
O12.03	Gestational edema, third trimester
O12.20	Gestational edema with proteinuria, unspecified trimester
O12.21	Gestational edema with proteinuria, first trimester
O12.22	Gestational edema with proteinuria, second trimester
O12.23	Gestational edema with proteinuria, third trimester
O13.1	Gestational [pregnancy-induced] hypertension without significant proteinuria, first trimester
O13.2	Gestational [pregnancy-induced] hypertension without significant proteinuria, second trimester
O13.3	Gestational [pregnancy-induced] hypertension without significant proteinuria, third trimester
O13.9	Gestational [pregnancy-induced] hypertension without significant proteinuria, unspecified trimester
O14.00	Mild to moderate pre-eclampsia, unspecified trimester
O14.02	Mild to moderate pre-eclampsia, second trimester
O14.03	Mild to moderate pre-eclampsia, third trimester
O14.10	Severe pre-eclampsia, unspecified trimester
O14.12	Severe pre-eclampsia, second trimester
O14.13	Severe pre-eclampsia, third trimester
O14.20	HELLP syndrome (HELLP), unspecified trimester
O14.22	HELLP syndrome (HELLP), second trimester
O14.23	HELLP syndrome (HELLP), third trimester
O14.90	Unspecified pre-eclampsia, unspecified trimester
O14.92	Unspecified pre-eclampsia, second trimester
O14.93	Unspecified pre-eclampsia, third trimester
O15.02	Eclampsia in pregnancy, second trimester
O15.03	Eclampsia in pregnancy, third trimester
O15.1	Eclampsia in labor
O15.2	Eclampsia in the puerperium
O16.1	Unspecified maternal hypertension, first trimester
O16.2	Unspecified maternal hypertension, second trimester
O16.3	Unspecified maternal hypertension, third trimester
O16.9	Unspecified maternal hypertension, unspecified trimester
O20.0	Threatened abortion
O20.8	Other hemorrhage in early pregnancy
O20.9	Hemorrhage in early pregnancy, unspecified
O21.0	Mild hyperemesis gravidarum
O21.1	Hyperemesis gravidarum with metabolic disturbance
O21.2	Late vomiting of pregnancy
O21.8	Other vomiting complicating pregnancy
O21.9	Vomiting of pregnancy, unspecified
O23.00	Infections of kidney in pregnancy, unspecified trimester
O23.10	Infections of bladder in pregnancy, unspecified trimester
O23.20	Infections of urethra in pregnancy, unspecified trimester
O23.30	Infections of other parts of urinary tract in pregnancy, unspecified trimester
O23.40	Unspecified infection of urinary tract in pregnancy, unspecified trimester

O23.41	Unspecified infection of urinary tract in pregnancy, first trimester
O23.42	Unspecified infection of urinary tract in pregnancy, second trimester
O23.43	Unspecified infection of urinary tract in pregnancy, third trimester
O23.519	Infections of cervix in pregnancy, unspecified trimester
O23.529	Salpingo-oophoritis in pregnancy, unspecified trimester
O23.599	Infection of other part of genital tract in pregnancy, unspecified trimester
O23.90	Unspecified genitourinary tract infection in pregnancy, unspecified trimester
O23.91	Unspecified genitourinary tract infection in pregnancy, first trimester
O23.92	Unspecified genitourinary tract infection in pregnancy, second trimester
O23.93	Unspecified genitourinary tract infection in pregnancy, third trimester
O24.319	Unspecified pre-existing diabetes mellitus in pregnancy, unspecified trimester
O24.32	Unspecified pre-existing diabetes mellitus in childbirth
O24.419	Gestational diabetes mellitus in pregnancy, unspecified control
O24.429	Gestational diabetes mellitus in childbirth, unspecified control
O24.439	Gestational diabetes mellitus in the puerperium, unspecified control
O24.911	Unspecified diabetes mellitus in pregnancy, first trimester
O24.912	Unspecified diabetes mellitus in pregnancy, second trimester
O24.913	Unspecified diabetes mellitus in pregnancy, third trimester
O24.92	Unspecified diabetes mellitus in childbirth
O24.93	Unspecified diabetes mellitus in the puerperium
O25.10	Malnutrition in pregnancy, unspecified trimester
O25.11	Malnutrition in pregnancy, first trimester
O25.12	Malnutrition in pregnancy, second trimester
O25.13	Malnutrition in pregnancy, third trimester
O25.2	Malnutrition in childbirth
O25.3	Malnutrition in the puerperium
O26.00	Excessive weight gain in pregnancy, unspecified trimester
O26.01	Excessive weight gain in pregnancy, first trimester
O26.02	Excessive weight gain in pregnancy, second trimester
O26.03	Excessive weight gain in pregnancy, third trimester
O26.11	Low weight gain in pregnancy, first trimester
O26.12	Low weight gain in pregnancy, second trimester
O26.13	Low weight gain in pregnancy, third trimester
O26.20	Pregnancy care for patient with recurrent pregnancy loss, unspecified trimester
O26.21	Pregnancy care for patient with recurrent pregnancy loss, first trimester
O26.22	Pregnancy care for patient with recurrent pregnancy loss, second trimester
O26.23	Pregnancy care for patient with recurrent pregnancy loss, third trimester
O26.41	Herpes gestationis, first trimester
O26.42	Herpes gestationis, second trimester
O26.43	Herpes gestationis, third trimester
O26.611	Liver and biliary tract disorders in pregnancy, first trimester
O26.612	Liver and biliary tract disorders in pregnancy, second trimester
O26.613	Liver and biliary tract disorders in pregnancy, third trimester
O26.619	Liver and biliary tract disorders in pregnancy, unspecified trimester
O26.62	Liver and biliary tract disorders in childbirth
O26.811	Pregnancy related exhaustion and fatigue, first trimester
O26.812	Pregnancy related exhaustion and fatigue, second trimester
O26.813	Pregnancy related exhaustion and fatigue, third trimester
O26.819	Pregnancy related exhaustion and fatigue, unspecified trimester
O26.821	Pregnancy related peripheral neuritis, first trimester
O26.822	Pregnancy related peripheral neuritis, second trimester
O26.823	Pregnancy related peripheral neuritis, third trimester
O26.829	Pregnancy related peripheral neuritis, unspecified trimester
O26.831	Pregnancy related renal disease, first trimester
O26.832	Pregnancy related renal disease, second trimester

O26.833	Pregnancy related renal disease, third trimester
O26.839	Pregnancy related renal disease, unspecified trimester
O26.891	Other specified pregnancy related conditions, first trimester
O26.892	Other specified pregnancy related conditions, second trimester
O26.893	Other specified pregnancy related conditions, third trimester
O26.90	Pregnancy related conditions, unspecified, unspecified trimester
O30.001	Twin pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, first trimester
O30.002	Twin pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, second trimester
O30.003	Twin pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, third trimester
O30.009	Twin pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, unspecified trimester
O30.011	Twin pregnancy, monochorionic/monoamniotic, first trimester
O30.012	Twin pregnancy, monochorionic/monoamniotic, second trimester
O30.013	Twin pregnancy, monochorionic/monoamniotic, third trimester
O30.019	Twin pregnancy, monochorionic/monoamniotic, unspecified trimester
O30.031	Twin pregnancy, monochorionic/diamniotic, first trimester
O30.032	Twin pregnancy, monochorionic/diamniotic, second trimester
O30.033	Twin pregnancy, monochorionic/diamniotic, third trimester
O30.039	Twin pregnancy, monochorionic/diamniotic, unspecified trimester
O30.041	Twin pregnancy, dichorionic/diamniotic, first trimester
O30.042	Twin pregnancy, dichorionic/diamniotic, second trimester
O30.043	Twin pregnancy, dichorionic/diamniotic, third trimester
O30.049	Twin pregnancy, dichorionic/diamniotic, unspecified trimester
O30.091	Twin pregnancy, unable to determine number of placenta and number of amniotic sacs, first trimester
O30.092	Twin pregnancy, unable to determine number of placenta and number of amniotic sacs, second trimester
O30.093	Twin pregnancy, unable to determine number of placenta and number of amniotic sacs, third trimester
O30.099	Twin pregnancy, unable to determine number of placenta and number of amniotic sacs, unspecified trimester
O30.101	Triplet pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, first trimester
O30.102	Triplet pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, second trimester
O30.103	Triplet pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, third trimester
O30.109	Triplet pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, unspecified trimester
O30.111	Triplet pregnancy with two or more monochorionic fetuses, first trimester
O30.112	Triplet pregnancy with two or more monochorionic fetuses, second trimester
O30.113	Triplet pregnancy with two or more monochorionic fetuses, third trimester
O30.119	Triplet pregnancy with two or more monochorionic fetuses, unspecified trimester
O30.121	Triplet pregnancy with two or more monoamniotic fetuses, first trimester
O30.122	Triplet pregnancy with two or more monoamniotic fetuses, second trimester
O30.123	Triplet pregnancy with two or more monoamniotic fetuses, third trimester
O30.129	Triplet pregnancy with two or more monoamniotic fetuses, unspecified trimester
O30.191	Triplet pregnancy, unable to determine number of placenta and number of amniotic sacs, first trimester
O30.192	Triplet pregnancy, unable to determine number of placenta and number of amniotic sacs, second trimester
O30.193	Triplet pregnancy, unable to determine number of placenta and number of amniotic sacs, third trimester
O30.199	Triplet pregnancy, unable to determine number of placenta and number of amniotic sacs, unspecified trimester
O30.201	Quadruplet pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, first trimester
O30.202	Quadruplet pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, second trimester
O30.203	Quadruplet pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, third trimester

O30.209	Quadruplet pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, unspecified trimester
O30.211	Quadruplet pregnancy with two or more monochorionic fetuses, first trimester
O30.212	Quadruplet pregnancy with two or more monochorionic fetuses, second trimester
O30.213	Quadruplet pregnancy with two or more monochorionic fetuses, third trimester
O30.219	Quadruplet pregnancy with two or more monochorionic fetuses, unspecified trimester
O30.221	Quadruplet pregnancy with two or more monoamniotic fetuses, first trimester
O30.222	Quadruplet pregnancy with two or more monoamniotic fetuses, second trimester
O30.223	Quadruplet pregnancy with two or more monoamniotic fetuses, third trimester
O30.229	Quadruplet pregnancy with two or more monoamniotic fetuses, unspecified trimester
O30.291	Quadruplet pregnancy, unable to determine number of placenta and number of amniotic sacs, first trimester
O30.292	Quadruplet pregnancy, unable to determine number of placenta and number of amniotic sacs, second trimester
O30.293	Quadruplet pregnancy, unable to determine number of placenta and number of amniotic sacs, third trimester
O30.299	Quadruplet pregnancy, unable to determine number of placenta and number of amniotic sacs, unspecified trimester
O30.801	Other specified multiple gestation, unspecified number of placenta and unspecified number of amniotic sacs, first trimester
O30.802	Other specified multiple gestation, unspecified number of placenta and unspecified number of amniotic sacs, second trimester
O30.803	Other specified multiple gestation, unspecified number of placenta and unspecified number of amniotic sacs, third trimester
O30.809	Other specified multiple gestation, unspecified number of placenta and unspecified number of amniotic sacs, unspecified trimester
O30.811	Other specified multiple gestation with two or more monochorionic fetuses, first trimester
O30.812	Other specified multiple gestation with two or more monochorionic fetuses, second trimester
O30.813	Other specified multiple gestation with two or more monochorionic fetuses, third trimester
O30.819	Other specified multiple gestation with two or more monochorionic fetuses, unspecified trimester
O30.821	Other specified multiple gestation with two or more monoamniotic fetuses, first trimester
O30.822	Other specified multiple gestation with two or more monoamniotic fetuses, second trimester
O30.823	Other specified multiple gestation with two or more monoamniotic fetuses, third trimester
O30.829	Other specified multiple gestation with two or more monoamniotic fetuses, unspecified trimester
O30.891	Other specified multiple gestation, unable to determine number of placenta and number of amniotic sacs, first trimester
O30.892	Other specified multiple gestation, unable to determine number of placenta and number of amniotic sacs, second trimester
O30.893	Other specified multiple gestation, unable to determine number of placenta and number of amniotic sacs, third trimester
O30.899	Other specified multiple gestation, unable to determine number of placenta and number of amniotic sacs, unspecified trimester
O30.90	Multiple gestation, unspecified, unspecified trimester
O30.91	Multiple gestation, unspecified, first trimester
O30.92	Multiple gestation, unspecified, second trimester
O30.93	Multiple gestation, unspecified, third trimester
O31.00X0	Papyraceous fetus, unspecified trimester, not applicable or unspecified
O31.01X0	Papyraceous fetus, first trimester, not applicable or unspecified
O31.02X0	Papyraceous fetus, second trimester, not applicable or unspecified
O31.03X0	Papyraceous fetus, third trimester, not applicable or unspecified
O31.10X0	Continuing pregnancy after spontaneous abortion of one fetus or more, unspecified trimester, not applicable or unspecified
O31.10X1	Continuing pregnancy after spontaneous abortion of one fetus or more, unspecified trimester, fetus 1
O31.10X2	Continuing pregnancy after spontaneous abortion of one fetus or more, unspecified trimester, fetus 2
O31.10X3	Continuing pregnancy after spontaneous abortion of one fetus or more, unspecified trimester, fetus 3
O31.10X4	Continuing pregnancy after spontaneous abortion of one fetus or more, unspecified trimester, fetus 4

O31.10X5	Continuing pregnancy after spontaneous abortion of one fetus or more, unspecified trimester, fetus 5
O31.10X9	Continuing pregnancy after spontaneous abortion of one fetus or more, unspecified trimester, other fetus
O31.11X0	Continuing pregnancy after spontaneous abortion of one fetus or more, first trimester, not applicable or unspecified
O31.11X1	Continuing pregnancy after spontaneous abortion of one fetus or more, first trimester, fetus 1
O31.11X2	Continuing pregnancy after spontaneous abortion of one fetus or more, first trimester, fetus 2
O31.11X3	Continuing pregnancy after spontaneous abortion of one fetus or more, first trimester, fetus 3
O31.11X4	Continuing pregnancy after spontaneous abortion of one fetus or more, first trimester, fetus 4
O31.11X5	Continuing pregnancy after spontaneous abortion of one fetus or more, first trimester, fetus 5
O31.11X9	Continuing pregnancy after spontaneous abortion of one fetus or more, first trimester, other fetus
O31.12X0	Continuing pregnancy after spontaneous abortion of one fetus or more, second trimester, not applicable or unspecified
O31.12X1	Continuing pregnancy after spontaneous abortion of one fetus or more, second trimester, fetus 1
O31.12X2	Continuing pregnancy after spontaneous abortion of one fetus or more, second trimester, fetus 2
O31.12X3	Continuing pregnancy after spontaneous abortion of one fetus or more, second trimester, fetus 3
O31.12X4	Continuing pregnancy after spontaneous abortion of one fetus or more, second trimester, fetus 4
O31.12X5	Continuing pregnancy after spontaneous abortion of one fetus or more, second trimester, fetus 5
O31.12X9	Continuing pregnancy after spontaneous abortion of one fetus or more, second trimester, other fetus
O31.13X0	Continuing pregnancy after spontaneous abortion of one fetus or more, third trimester, not applicable or unspecified
O31.13X1	Continuing pregnancy after spontaneous abortion of one fetus or more, third trimester, fetus 1
O31.13X2	Continuing pregnancy after spontaneous abortion of one fetus or more, third trimester, fetus 2
O31.13X3	Continuing pregnancy after spontaneous abortion of one fetus or more, third trimester, fetus 3
O31.13X4	Continuing pregnancy after spontaneous abortion of one fetus or more, third trimester, fetus 4
O31.13X5	Continuing pregnancy after spontaneous abortion of one fetus or more, third trimester, fetus 5
O31.13X9	Continuing pregnancy after spontaneous abortion of one fetus or more, third trimester, other fetus
O31.20X0	Continuing pregnancy after intrauterine death of one fetus or more, unspecified trimester, not applicable or unspecified
O31.20X1	Continuing pregnancy after intrauterine death of one fetus or more, unspecified trimester, fetus 1
O31.20X2	Continuing pregnancy after intrauterine death of one fetus or more, unspecified trimester, fetus 2
O31.20X3	Continuing pregnancy after intrauterine death of one fetus or more, unspecified trimester, fetus 3
O31.20X4	Continuing pregnancy after intrauterine death of one fetus or more, unspecified trimester, fetus 4
O31.20X5	Continuing pregnancy after intrauterine death of one fetus or more, unspecified trimester, fetus 5
O31.20X9	Continuing pregnancy after intrauterine death of one fetus or more, unspecified trimester, other fetus
O31.21X0	Continuing pregnancy after intrauterine death of one fetus or more, first trimester, not applicable or unspecified
O31.21X1	Continuing pregnancy after intrauterine death of one fetus or more, first trimester, fetus 1
O31.21X2	Continuing pregnancy after intrauterine death of one fetus or more, first trimester, fetus 2
O31.21X3	Continuing pregnancy after intrauterine death of one fetus or more, first trimester, fetus 3
O31.21X4	Continuing pregnancy after intrauterine death of one fetus or more, first trimester, fetus 4
O31.21X5	Continuing pregnancy after intrauterine death of one fetus or more, first trimester, fetus 5
O31.21X9	Continuing pregnancy after intrauterine death of one fetus or more, first trimester, other fetus
O31.22X0	Continuing pregnancy after intrauterine death of one fetus or more, second trimester, not applicable or unspecified
O31.22X1	Continuing pregnancy after intrauterine death of one fetus or more, second trimester, fetus 1
O31.22X2	Continuing pregnancy after intrauterine death of one fetus or more, second trimester, fetus 2
O31.22X3	Continuing pregnancy after intrauterine death of one fetus or more, second trimester, fetus 3
O31.22X4	Continuing pregnancy after intrauterine death of one fetus or more, second trimester, fetus 4
O31.22X5	Continuing pregnancy after intrauterine death of one fetus or more, second trimester, fetus 5
O31.22X9	Continuing pregnancy after intrauterine death of one fetus or more, second trimester, other fetus
O31.23X0	Continuing pregnancy after intrauterine death of one fetus or more, third trimester, not applicable or unspecified
O31.23X1	Continuing pregnancy after intrauterine death of one fetus or more, third trimester, fetus 1
O31.23X2	Continuing pregnancy after intrauterine death of one fetus or more, third trimester, fetus 2
O31.23X3	Continuing pregnancy after intrauterine death of one fetus or more, third trimester, fetus 3

O31.23X4	Continuing pregnancy after intrauterine death of one fetus or more, third trimester, fetus 4
O31.23X5	Continuing pregnancy after intrauterine death of one fetus or more, third trimester, fetus 5
O31.23X9	Continuing pregnancy after intrauterine death of one fetus or more, third trimester, other fetus
O31.30X0	Continuing pregnancy after elective fetal reduction of one fetus or more, unspecified trimester, not applicable or unspecified
O31.30X1	Continuing pregnancy after elective fetal reduction of one fetus or more, unspecified trimester, fetus 1
O31.30X2	Continuing pregnancy after elective fetal reduction of one fetus or more, unspecified trimester, fetus 2
O31.30X3	Continuing pregnancy after elective fetal reduction of one fetus or more, unspecified trimester, fetus 3
O31.30X4	Continuing pregnancy after elective fetal reduction of one fetus or more, unspecified trimester, fetus 4
O31.30X5	Continuing pregnancy after elective fetal reduction of one fetus or more, unspecified trimester, fetus 5
O31.30X9	Continuing pregnancy after elective fetal reduction of one fetus or more, unspecified trimester, other fetus
O31.31X0	Continuing pregnancy after elective fetal reduction of one fetus or more, first trimester, not applicable or unspecified
O31.31X1	Continuing pregnancy after elective fetal reduction of one fetus or more, first trimester, fetus 1
O31.31X2	Continuing pregnancy after elective fetal reduction of one fetus or more, first trimester, fetus 2
O31.31X3	Continuing pregnancy after elective fetal reduction of one fetus or more, first trimester, fetus 3
O31.31X4	Continuing pregnancy after elective fetal reduction of one fetus or more, first trimester, fetus 4
O31.31X5	Continuing pregnancy after elective fetal reduction of one fetus or more, first trimester, fetus 5
O31.31X9	Continuing pregnancy after elective fetal reduction of one fetus or more, first trimester, other fetus
O31.32X0	Continuing pregnancy after elective fetal reduction of one fetus or more, second trimester, not applicable or unspecified
O31.32X1	Continuing pregnancy after elective fetal reduction of one fetus or more, second trimester, fetus 1
O31.32X2	Continuing pregnancy after elective fetal reduction of one fetus or more, second trimester, fetus 2
O31.32X3	Continuing pregnancy after elective fetal reduction of one fetus or more, second trimester, fetus 3
O31.32X4	Continuing pregnancy after elective fetal reduction of one fetus or more, second trimester, fetus 4
O31.32X5	Continuing pregnancy after elective fetal reduction of one fetus or more, second trimester, fetus 5
O31.32X9	Continuing pregnancy after elective fetal reduction of one fetus or more, second trimester, other fetus
O31.33X0	Continuing pregnancy after elective fetal reduction of one fetus or more, third trimester, not applicable or unspecified
O31.33X1	Continuing pregnancy after elective fetal reduction of one fetus or more, third trimester, fetus 1
O31.33X2	Continuing pregnancy after elective fetal reduction of one fetus or more, third trimester, fetus 2
O31.33X3	Continuing pregnancy after elective fetal reduction of one fetus or more, third trimester, fetus 3
O31.33X4	Continuing pregnancy after elective fetal reduction of one fetus or more, third trimester, fetus 4
O31.33X5	Continuing pregnancy after elective fetal reduction of one fetus or more, third trimester, fetus 5
O31.33X9	Continuing pregnancy after elective fetal reduction of one fetus or more, third trimester, other fetus
O31.8X10	Other complications specific to multiple gestation, first trimester, not applicable or unspecified
O31.8X11	Other complications specific to multiple gestation, first trimester, fetus 1
O31.8X12	Other complications specific to multiple gestation, first trimester, fetus 2
O31.8X13	Other complications specific to multiple gestation, first trimester, fetus 3
O31.8X14	Other complications specific to multiple gestation, first trimester, fetus 4
O31.8X15	Other complications specific to multiple gestation, first trimester, fetus 5
O31.8X19	Other complications specific to multiple gestation, first trimester, other fetus
O31.8X20	Other complications specific to multiple gestation, second trimester, not applicable or unspecified
O31.8X21	Other complications specific to multiple gestation, second trimester, fetus 1
O31.8X22	Other complications specific to multiple gestation, second trimester, fetus 2
O31.8X23	Other complications specific to multiple gestation, second trimester, fetus 3
O31.8X24	Other complications specific to multiple gestation, second trimester, fetus 4
O31.8X25	Other complications specific to multiple gestation, second trimester, fetus 5
O31.8X29	Other complications specific to multiple gestation, second trimester, other fetus
O31.8X30	Other complications specific to multiple gestation, third trimester, not applicable or unspecified
O31.8X31	Other complications specific to multiple gestation, third trimester, fetus 1
O31.8X32	Other complications specific to multiple gestation, third trimester, fetus 2
O31.8X33	Other complications specific to multiple gestation, third trimester, fetus 3
O31.8X34	Other complications specific to multiple gestation, third trimester, fetus 4
O31.8X35	Other complications specific to multiple gestation, third trimester, fetus 5

O31.8X39	Other complications specific to multiple gestation, third trimester, other fetus
O31.8X90	Other complications specific to multiple gestation, unspecified trimester, not applicable or unspecified
O31.8X91	Other complications specific to multiple gestation, unspecified trimester, fetus 1
O31.8X92	Other complications specific to multiple gestation, unspecified trimester, fetus 2
O31.8X93	Other complications specific to multiple gestation, unspecified trimester, fetus 3
O31.8X94	Other complications specific to multiple gestation, unspecified trimester, fetus 4
O31.8X95	Other complications specific to multiple gestation, unspecified trimester, fetus 5
O31.8X99	Other complications specific to multiple gestation, unspecified trimester, other fetus
O32.0XX0	Maternal care for unstable lie, not applicable or unspecified
O32.0XX1	Maternal care for unstable lie, fetus 1
O32.0XX2	Maternal care for unstable lie, fetus 2
O32.0XX3	Maternal care for unstable lie, fetus 3
O32.0XX4	Maternal care for unstable lie, fetus 4
O32.0XX5	Maternal care for unstable lie, fetus 5
O32.0XX9	Maternal care for unstable lie, other fetus
O32.1XX0	Maternal care for breech presentation, not applicable or unspecified
O32.1XX1	Maternal care for breech presentation, fetus 1
O32.1XX2	Maternal care for breech presentation, fetus 2
O32.1XX3	Maternal care for breech presentation, fetus 3
O32.1XX4	Maternal care for breech presentation, fetus 4
O32.1XX5	Maternal care for breech presentation, fetus 5
O32.1XX9	Maternal care for breech presentation, other fetus
O32.2XX0	Maternal care for transverse and oblique lie, not applicable or unspecified
O32.2XX1	Maternal care for transverse and oblique lie, fetus 1
O32.2XX2	Maternal care for transverse and oblique lie, fetus 2
O32.2XX3	Maternal care for transverse and oblique lie, fetus 3
O32.2XX4	Maternal care for transverse and oblique lie, fetus 4
O32.2XX5	Maternal care for transverse and oblique lie, fetus 5
O32.2XX9	Maternal care for transverse and oblique lie, other fetus
O32.3XX0	Maternal care for face, brow and chin presentation, not applicable or unspecified
O32.3XX1	Maternal care for face, brow and chin presentation, fetus 1
O32.3XX2	Maternal care for face, brow and chin presentation, fetus 2
O32.3XX3	Maternal care for face, brow and chin presentation, fetus 3
O32.3XX4	Maternal care for face, brow and chin presentation, fetus 4
O32.3XX5	Maternal care for face, brow and chin presentation, fetus 5
O32.3XX9	Maternal care for face, brow and chin presentation, other fetus
O32.4XX0	Maternal care for high head at term, not applicable or unspecified
O32.4XX1	Maternal care for high head at term, fetus 1
O32.4XX2	Maternal care for high head at term, fetus 2
O32.4XX3	Maternal care for high head at term, fetus 3
O32.4XX4	Maternal care for high head at term, fetus 4
O32.4XX5	Maternal care for high head at term, fetus 5
O32.4XX9	Maternal care for high head at term, other fetus
O32.6XX0	Maternal care for compound presentation, not applicable or unspecified
O32.6XX1	Maternal care for compound presentation, fetus 1
O32.6XX2	Maternal care for compound presentation, fetus 2
O32.6XX3	Maternal care for compound presentation, fetus 3
O32.6XX4	Maternal care for compound presentation, fetus 4
O32.6XX5	Maternal care for compound presentation, fetus 5
O32.6XX9	Maternal care for compound presentation, other fetus
O32.8XX0	Maternal care for other malpresentation of fetus, not applicable or unspecified
O32.8XX1	Maternal care for other malpresentation of fetus, fetus 1
O32.8XX2	Maternal care for other malpresentation of fetus, fetus 2
O32.8XX3	Maternal care for other malpresentation of fetus, fetus 3
O32.8XX4	Maternal care for other malpresentation of fetus, fetus 4

O32.8XX5	Maternal care for other malpresentation of fetus, fetus 5
O32.8XX9	Maternal care for other malpresentation of fetus, other fetus
O32.9XX0	Maternal care for malpresentation of fetus, unspecified, not applicable or unspecified
O32.9XX1	Maternal care for malpresentation of fetus, unspecified, fetus 1
O32.9XX2	Maternal care for malpresentation of fetus, unspecified, fetus 2
O32.9XX3	Maternal care for malpresentation of fetus, unspecified, fetus 3
O32.9XX4	Maternal care for malpresentation of fetus, unspecified, fetus 4
O32.9XX5	Maternal care for malpresentation of fetus, unspecified, fetus 5
O32.9XX9	Maternal care for malpresentation of fetus, unspecified, other fetus
O33.0	Maternal care for disproportion due to deformity of maternal pelvic bones
O33.1	Maternal care for disproportion due to generally contracted pelvis
O33.2	Maternal care for disproportion due to inlet contraction of pelvis
O33.3XX0	Maternal care for disproportion due to outlet contraction of pelvis, not applicable or unspecified
O33.3XX1	Maternal care for disproportion due to outlet contraction of pelvis, fetus 1
O33.3XX2	Maternal care for disproportion due to outlet contraction of pelvis, fetus 2
O33.3XX3	Maternal care for disproportion due to outlet contraction of pelvis, fetus 3
O33.3XX4	Maternal care for disproportion due to outlet contraction of pelvis, fetus 4
O33.3XX5	Maternal care for disproportion due to outlet contraction of pelvis, fetus 5
O33.3XX9	Maternal care for disproportion due to outlet contraction of pelvis, other fetus
O33.4XX0	Maternal care for disproportion of mixed maternal and fetal origin, not applicable or unspecified
O33.4XX1	Maternal care for disproportion of mixed maternal and fetal origin, fetus 1
O33.4XX2	Maternal care for disproportion of mixed maternal and fetal origin, fetus 2
O33.4XX3	Maternal care for disproportion of mixed maternal and fetal origin, fetus 3
O33.4XX4	Maternal care for disproportion of mixed maternal and fetal origin, fetus 4
O33.4XX5	Maternal care for disproportion of mixed maternal and fetal origin, fetus 5
O33.4XX9	Maternal care for disproportion of mixed maternal and fetal origin, other fetus
O33.5XX0	Maternal care for disproportion due to unusually large fetus, not applicable or unspecified
O33.5XX1	Maternal care for disproportion due to unusually large fetus, fetus 1
O33.5XX2	Maternal care for disproportion due to unusually large fetus, fetus 2
O33.5XX3	Maternal care for disproportion due to unusually large fetus, fetus 3
O33.5XX4	Maternal care for disproportion due to unusually large fetus, fetus 4
O33.5XX5	Maternal care for disproportion due to unusually large fetus, fetus 5
O33.5XX9	Maternal care for disproportion due to unusually large fetus, other fetus
O33.6XX0	Maternal care for disproportion due to hydrocephalic fetus, not applicable or unspecified
O33.6XX1	Maternal care for disproportion due to hydrocephalic fetus, fetus 1
O33.6XX2	Maternal care for disproportion due to hydrocephalic fetus, fetus 2
O33.6XX3	Maternal care for disproportion due to hydrocephalic fetus, fetus 3
O33.6XX4	Maternal care for disproportion due to hydrocephalic fetus, fetus 4
O33.6XX5	Maternal care for disproportion due to hydrocephalic fetus, fetus 5
O33.6XX9	Maternal care for disproportion due to hydrocephalic fetus, other fetus
O33.7	Maternal care for disproportion due to other fetal deformities
O33.8	Maternal care for disproportion of other origin
O33.9	Maternal care for disproportion, unspecified
O34.00	Maternal care for unspecified congenital malformation of uterus, unspecified trimester
O34.01	Maternal care for unspecified congenital malformation of uterus, first trimester
O34.02	Maternal care for unspecified congenital malformation of uterus, second trimester
O34.03	Maternal care for unspecified congenital malformation of uterus, third trimester
O34.10	Maternal care for benign tumor of corpus uteri, unspecified trimester
O34.11	Maternal care for benign tumor of corpus uteri, first trimester
O34.12	Maternal care for benign tumor of corpus uteri, second trimester
O34.13	Maternal care for benign tumor of corpus uteri, third trimester
O34.21	Maternal care for scar from previous cesarean delivery
O34.29	Maternal care due to uterine scar from other previous surgery
O34.30	Maternal care for cervical incompetence, unspecified trimester
O34.31	Maternal care for cervical incompetence, first trimester

O34.32	Maternal care for cervical incompetence, second trimester
O34.33	Maternal care for cervical incompetence, third trimester
O34.40	Maternal care for other abnormalities of cervix, unspecified trimester
O34.41	Maternal care for other abnormalities of cervix, first trimester
O34.42	Maternal care for other abnormalities of cervix, second trimester
O34.43	Maternal care for other abnormalities of cervix, third trimester
O34.511	Maternal care for incarceration of gravid uterus, first trimester
O34.512	Maternal care for incarceration of gravid uterus, second trimester
O34.513	Maternal care for incarceration of gravid uterus, third trimester
O34.519	Maternal care for incarceration of gravid uterus, unspecified trimester
O34.521	Maternal care for prolapse of gravid uterus, first trimester
O34.522	Maternal care for prolapse of gravid uterus, second trimester
O34.523	Maternal care for prolapse of gravid uterus, third trimester
O34.529	Maternal care for prolapse of gravid uterus, unspecified trimester
O34.531	Maternal care for retroversion of gravid uterus, first trimester
O34.532	Maternal care for retroversion of gravid uterus, second trimester
O34.533	Maternal care for retroversion of gravid uterus, third trimester
O34.539	Maternal care for retroversion of gravid uterus, unspecified trimester
O34.591	Maternal care for other abnormalities of gravid uterus, first trimester
O34.592	Maternal care for other abnormalities of gravid uterus, second trimester
O34.593	Maternal care for other abnormalities of gravid uterus, third trimester
O34.599	Maternal care for other abnormalities of gravid uterus, unspecified trimester
O34.60	Maternal care for abnormality of vagina, unspecified trimester
O34.61	Maternal care for abnormality of vagina, first trimester
O34.62	Maternal care for abnormality of vagina, second trimester
O34.63	Maternal care for abnormality of vagina, third trimester
O34.70	Maternal care for abnormality of vulva and perineum, unspecified trimester
O34.71	Maternal care for abnormality of vulva and perineum, first trimester
O34.72	Maternal care for abnormality of vulva and perineum, second trimester
O34.73	Maternal care for abnormality of vulva and perineum, third trimester
O34.80	Maternal care for other abnormalities of pelvic organs, unspecified trimester
O34.81	Maternal care for other abnormalities of pelvic organs, first trimester
O34.82	Maternal care for other abnormalities of pelvic organs, second trimester
O34.83	Maternal care for other abnormalities of pelvic organs, third trimester
O34.90	Maternal care for abnormality of pelvic organ, unspecified, unspecified trimester
O34.91	Maternal care for abnormality of pelvic organ, unspecified, first trimester
O34.92	Maternal care for abnormality of pelvic organ, unspecified, second trimester
O34.93	Maternal care for abnormality of pelvic organ, unspecified, third trimester
O35.0XX0	Maternal care for (suspected) central nervous system malformation in fetus, not applicable or unspecified
O35.0XX1	Maternal care for (suspected) central nervous system malformation in fetus, fetus 1
O35.0XX2	Maternal care for (suspected) central nervous system malformation in fetus, fetus 2
O35.0XX3	Maternal care for (suspected) central nervous system malformation in fetus, fetus 3
O35.0XX4	Maternal care for (suspected) central nervous system malformation in fetus, fetus 4
O35.0XX5	Maternal care for (suspected) central nervous system malformation in fetus, fetus 5
O35.0XX9	Maternal care for (suspected) central nervous system malformation in fetus, other fetus
O35.1XX0	Maternal care for (suspected) chromosomal abnormality in fetus, not applicable or unspecified
O35.1XX1	Maternal care for (suspected) chromosomal abnormality in fetus, fetus 1
O35.1XX2	Maternal care for (suspected) chromosomal abnormality in fetus, fetus 2
O35.1XX3	Maternal care for (suspected) chromosomal abnormality in fetus, fetus 3
O35.1XX4	Maternal care for (suspected) chromosomal abnormality in fetus, fetus 4
O35.1XX5	Maternal care for (suspected) chromosomal abnormality in fetus, fetus 5
O35.1XX9	Maternal care for (suspected) chromosomal abnormality in fetus, other fetus
O35.2XX0	Maternal care for (suspected) hereditary disease in fetus, not applicable or unspecified
O35.2XX1	Maternal care for (suspected) hereditary disease in fetus, fetus 1
O35.2XX2	Maternal care for (suspected) hereditary disease in fetus, fetus 2

O35.2XX3	Maternal care for (suspected) hereditary disease in fetus, fetus 3
O35.2XX4	Maternal care for (suspected) hereditary disease in fetus, fetus 4
O35.2XX5	Maternal care for (suspected) hereditary disease in fetus, fetus 5
O35.2XX9	Maternal care for (suspected) hereditary disease in fetus, other fetus
O35.3XX0	Maternal care for (suspected) damage to fetus from viral disease in mother, not applicable or unspecified
O35.3XX1	Maternal care for (suspected) damage to fetus from viral disease in mother, fetus 1
O35.3XX2	Maternal care for (suspected) damage to fetus from viral disease in mother, fetus 2
O35.3XX3	Maternal care for (suspected) damage to fetus from viral disease in mother, fetus 3
O35.3XX4	Maternal care for (suspected) damage to fetus from viral disease in mother, fetus 4
O35.3XX5	Maternal care for (suspected) damage to fetus from viral disease in mother, fetus 5
O35.3XX9	Maternal care for (suspected) damage to fetus from viral disease in mother, other fetus
O35.4XX0	Maternal care for (suspected) damage to fetus from alcohol, not applicable or unspecified
O35.4XX1	Maternal care for (suspected) damage to fetus from alcohol, fetus 1
O35.4XX2	Maternal care for (suspected) damage to fetus from alcohol, fetus 2
O35.4XX3	Maternal care for (suspected) damage to fetus from alcohol, fetus 3
O35.4XX4	Maternal care for (suspected) damage to fetus from alcohol, fetus 4
O35.4XX5	Maternal care for (suspected) damage to fetus from alcohol, fetus 5
O35.4XX9	Maternal care for (suspected) damage to fetus from alcohol, other fetus
O35.5XX0	Maternal care for (suspected) damage to fetus by drugs, not applicable or unspecified
O35.5XX1	Maternal care for (suspected) damage to fetus by drugs, fetus 1
O35.5XX2	Maternal care for (suspected) damage to fetus by drugs, fetus 2
O35.5XX3	Maternal care for (suspected) damage to fetus by drugs, fetus 3
O35.5XX4	Maternal care for (suspected) damage to fetus by drugs, fetus 4
O35.5XX5	Maternal care for (suspected) damage to fetus by drugs, fetus 5
O35.5XX9	Maternal care for (suspected) damage to fetus by drugs, other fetus
O35.6XX0	Maternal care for (suspected) damage to fetus by radiation, not applicable or unspecified
O35.6XX1	Maternal care for (suspected) damage to fetus by radiation, fetus 1
O35.6XX2	Maternal care for (suspected) damage to fetus by radiation, fetus 2
O35.6XX3	Maternal care for (suspected) damage to fetus by radiation, fetus 3
O35.6XX4	Maternal care for (suspected) damage to fetus by radiation, fetus 4
O35.6XX5	Maternal care for (suspected) damage to fetus by radiation, fetus 5
O35.6XX9	Maternal care for (suspected) damage to fetus by radiation, other fetus
O35.8XX0	Maternal care for other (suspected) fetal abnormality and damage, not applicable or unspecified
O35.8XX1	Maternal care for other (suspected) fetal abnormality and damage, fetus 1
O35.8XX2	Maternal care for other (suspected) fetal abnormality and damage, fetus 2
O35.8XX3	Maternal care for other (suspected) fetal abnormality and damage, fetus 3
O35.8XX4	Maternal care for other (suspected) fetal abnormality and damage, fetus 4
O35.8XX5	Maternal care for other (suspected) fetal abnormality and damage, fetus 5
O35.8XX9	Maternal care for other (suspected) fetal abnormality and damage, other fetus
O35.9XX0	Maternal care for (suspected) fetal abnormality and damage, unspecified, not applicable or unspecified
O35.9XX1	Maternal care for (suspected) fetal abnormality and damage, unspecified, fetus 1
O35.9XX2	Maternal care for (suspected) fetal abnormality and damage, unspecified, fetus 2
O35.9XX3	Maternal care for (suspected) fetal abnormality and damage, unspecified, fetus 3
O35.9XX4	Maternal care for (suspected) fetal abnormality and damage, unspecified, fetus 4
O35.9XX5	Maternal care for (suspected) fetal abnormality and damage, unspecified, fetus 5
O35.9XX9	Maternal care for (suspected) fetal abnormality and damage, unspecified, other fetus
O36.0110	Maternal care for anti-D [Rh] antibodies, first trimester, not applicable or unspecified
O36.0111	Maternal care for anti-D [Rh] antibodies, first trimester, fetus 1
O36.0112	Maternal care for anti-D [Rh] antibodies, first trimester, fetus 2
O36.0113	Maternal care for anti-D [Rh] antibodies, first trimester, fetus 3
O36.0114	Maternal care for anti-D [Rh] antibodies, first trimester, fetus 4
O36.0115	Maternal care for anti-D [Rh] antibodies, first trimester, fetus 5
O36.0119	Maternal care for anti-D [Rh] antibodies, first trimester, other fetus
O36.0120	Maternal care for anti-D [Rh] antibodies, second trimester, not applicable or unspecified
O36.0121	Maternal care for anti-D [Rh] antibodies, second trimester, fetus 1

O36.0122	Maternal care for anti-D [Rh] antibodies, second trimester, fetus 2
O36.0123	Maternal care for anti-D [Rh] antibodies, second trimester, fetus 3
O36.0124	Maternal care for anti-D [Rh] antibodies, second trimester, fetus 4
O36.0125	Maternal care for anti-D [Rh] antibodies, second trimester, fetus 5
O36.0129	Maternal care for anti-D [Rh] antibodies, second trimester, other fetus
O36.0130	Maternal care for anti-D [Rh] antibodies, third trimester, not applicable or unspecified
O36.0131	Maternal care for anti-D [Rh] antibodies, third trimester, fetus 1
O36.0132	Maternal care for anti-D [Rh] antibodies, third trimester, fetus 2
O36.0133	Maternal care for anti-D [Rh] antibodies, third trimester, fetus 3
O36.0134	Maternal care for anti-D [Rh] antibodies, third trimester, fetus 4
O36.0135	Maternal care for anti-D [Rh] antibodies, third trimester, fetus 5
O36.0139	Maternal care for anti-D [Rh] antibodies, third trimester, other fetus
O36.0190	Maternal care for anti-D [Rh] antibodies, unspecified trimester, not applicable or unspecified
O36.0191	Maternal care for anti-D [Rh] antibodies, unspecified trimester, fetus 1
O36.0192	Maternal care for anti-D [Rh] antibodies, unspecified trimester, fetus 2
O36.0193	Maternal care for anti-D [Rh] antibodies, unspecified trimester, fetus 3
O36.0194	Maternal care for anti-D [Rh] antibodies, unspecified trimester, fetus 4
O36.0195	Maternal care for anti-D [Rh] antibodies, unspecified trimester, fetus 5
O36.0199	Maternal care for anti-D [Rh] antibodies, unspecified trimester, other fetus
O36.0910	Maternal care for other rhesus isoimmunization, first trimester, not applicable or unspecified
O36.0911	Maternal care for other rhesus isoimmunization, first trimester, fetus 1
O36.0912	Maternal care for other rhesus isoimmunization, first trimester, fetus 2
O36.0913	Maternal care for other rhesus isoimmunization, first trimester, fetus 3
O36.0914	Maternal care for other rhesus isoimmunization, first trimester, fetus 4
O36.0915	Maternal care for other rhesus isoimmunization, first trimester, fetus 5
O36.0919	Maternal care for other rhesus isoimmunization, first trimester, other fetus
O36.0920	Maternal care for other rhesus isoimmunization, second trimester, not applicable or unspecified
O36.0921	Maternal care for other rhesus isoimmunization, second trimester, fetus 1
O36.0922	Maternal care for other rhesus isoimmunization, second trimester, fetus 2
O36.0923	Maternal care for other rhesus isoimmunization, second trimester, fetus 3
O36.0924	Maternal care for other rhesus isoimmunization, second trimester, fetus 4
O36.0925	Maternal care for other rhesus isoimmunization, second trimester, fetus 5
O36.0929	Maternal care for other rhesus isoimmunization, second trimester, other fetus
O36.0930	Maternal care for other rhesus isoimmunization, third trimester, not applicable or unspecified
O36.0931	Maternal care for other rhesus isoimmunization, third trimester, fetus 1
O36.0932	Maternal care for other rhesus isoimmunization, third trimester, fetus 2
O36.0933	Maternal care for other rhesus isoimmunization, third trimester, fetus 3
O36.0934	Maternal care for other rhesus isoimmunization, third trimester, fetus 4
O36.0935	Maternal care for other rhesus isoimmunization, third trimester, fetus 5
O36.0939	Maternal care for other rhesus isoimmunization, third trimester, other fetus
O36.0990	Maternal care for other rhesus isoimmunization, unspecified trimester, not applicable or unspecified
O36.0991	Maternal care for other rhesus isoimmunization, unspecified trimester, fetus 1
O36.0992	Maternal care for other rhesus isoimmunization, unspecified trimester, fetus 2
O36.0993	Maternal care for other rhesus isoimmunization, unspecified trimester, fetus 3
O36.0994	Maternal care for other rhesus isoimmunization, unspecified trimester, fetus 4
O36.0995	Maternal care for other rhesus isoimmunization, unspecified trimester, fetus 5
O36.0999	Maternal care for other rhesus isoimmunization, unspecified trimester, other fetus
O36.1110	Maternal care for Anti-A sensitization, first trimester, not applicable or unspecified
O36.1111	Maternal care for Anti-A sensitization, first trimester, fetus 1
O36.1112	Maternal care for Anti-A sensitization, first trimester, fetus 2
O36.1113	Maternal care for Anti-A sensitization, first trimester, fetus 3
O36.1114	Maternal care for Anti-A sensitization, first trimester, fetus 4
O36.1115	Maternal care for Anti-A sensitization, first trimester, fetus 5
O36.1119	Maternal care for Anti-A sensitization, first trimester, other fetus
O36.1120	Maternal care for Anti-A sensitization, second trimester, not applicable or unspecified

O36.1121	Maternal care for Anti-A sensitization, second trimester, fetus 1
O36.1122	Maternal care for Anti-A sensitization, second trimester, fetus 2
O36.1123	Maternal care for Anti-A sensitization, second trimester, fetus 3
O36.1124	Maternal care for Anti-A sensitization, second trimester, fetus 4
O36.1125	Maternal care for Anti-A sensitization, second trimester, fetus 5
O36.1129	Maternal care for Anti-A sensitization, second trimester, other fetus
O36.1130	Maternal care for Anti-A sensitization, third trimester, not applicable or unspecified
O36.1131	Maternal care for Anti-A sensitization, third trimester, fetus 1
O36.1132	Maternal care for Anti-A sensitization, third trimester, fetus 2
O36.1133	Maternal care for Anti-A sensitization, third trimester, fetus 3
O36.1134	Maternal care for Anti-A sensitization, third trimester, fetus 4
O36.1135	Maternal care for Anti-A sensitization, third trimester, fetus 5
O36.1139	Maternal care for Anti-A sensitization, third trimester, other fetus
O36.1190	Maternal care for Anti-A sensitization, unspecified trimester, not applicable or unspecified
O36.1191	Maternal care for Anti-A sensitization, unspecified trimester, fetus 1
O36.1192	Maternal care for Anti-A sensitization, unspecified trimester, fetus 2
O36.1193	Maternal care for Anti-A sensitization, unspecified trimester, fetus 3
O36.1194	Maternal care for Anti-A sensitization, unspecified trimester, fetus 4
O36.1195	Maternal care for Anti-A sensitization, unspecified trimester, fetus 5
O36.1199	Maternal care for Anti-A sensitization, unspecified trimester, other fetus
O36.1910	Maternal care for other isoimmunization, first trimester, not applicable or unspecified
O36.1911	Maternal care for other isoimmunization, first trimester, fetus 1
O36.1912	Maternal care for other isoimmunization, first trimester, fetus 2
O36.1913	Maternal care for other isoimmunization, first trimester, fetus 3
O36.1914	Maternal care for other isoimmunization, first trimester, fetus 4
O36.1915	Maternal care for other isoimmunization, first trimester, fetus 5
O36.1919	Maternal care for other isoimmunization, first trimester, other fetus
O36.1920	Maternal care for other isoimmunization, second trimester, not applicable or unspecified
O36.1921	Maternal care for other isoimmunization, second trimester, fetus 1
O36.1922	Maternal care for other isoimmunization, second trimester, fetus 2
O36.1923	Maternal care for other isoimmunization, second trimester, fetus 3
O36.1924	Maternal care for other isoimmunization, second trimester, fetus 4
O36.1925	Maternal care for other isoimmunization, second trimester, fetus 5
O36.1929	Maternal care for other isoimmunization, second trimester, other fetus
O36.1930	Maternal care for other isoimmunization, third trimester, not applicable or unspecified
O36.1931	Maternal care for other isoimmunization, third trimester, fetus 1
O36.1932	Maternal care for other isoimmunization, third trimester, fetus 2
O36.1933	Maternal care for other isoimmunization, third trimester, fetus 3
O36.1934	Maternal care for other isoimmunization, third trimester, fetus 4
O36.1935	Maternal care for other isoimmunization, third trimester, fetus 5
O36.1939	Maternal care for other isoimmunization, third trimester, other fetus
O36.1990	Maternal care for other isoimmunization, unspecified trimester, not applicable or unspecified
O36.1991	Maternal care for other isoimmunization, unspecified trimester, fetus 1
O36.1992	Maternal care for other isoimmunization, unspecified trimester, fetus 2
O36.1993	Maternal care for other isoimmunization, unspecified trimester, fetus 3
O36.1994	Maternal care for other isoimmunization, unspecified trimester, fetus 4
O36.1995	Maternal care for other isoimmunization, unspecified trimester, fetus 5
O36.1999	Maternal care for other isoimmunization, unspecified trimester, other fetus
O36.20X0	Maternal care for hydrops fetalis, unspecified trimester, not applicable or unspecified
O36.20X1	Maternal care for hydrops fetalis, unspecified trimester, fetus 1
O36.20X2	Maternal care for hydrops fetalis, unspecified trimester, fetus 2
O36.20X3	Maternal care for hydrops fetalis, unspecified trimester, fetus 3
O36.20X4	Maternal care for hydrops fetalis, unspecified trimester, fetus 4
O36.20X5	Maternal care for hydrops fetalis, unspecified trimester, fetus 5
O36.20X9	Maternal care for hydrops fetalis, unspecified trimester, other fetus

O36.21X0	Maternal care for hydrops fetalis, first trimester, not applicable or unspecified
O36.21X1	Maternal care for hydrops fetalis, first trimester, fetus 1
O36.21X2	Maternal care for hydrops fetalis, first trimester, fetus 2
O36.21X3	Maternal care for hydrops fetalis, first trimester, fetus 3
O36.21X4	Maternal care for hydrops fetalis, first trimester, fetus 4
O36.21X5	Maternal care for hydrops fetalis, first trimester, fetus 5
O36.21X9	Maternal care for hydrops fetalis, first trimester, other fetus
O36.22X0	Maternal care for hydrops fetalis, second trimester, not applicable or unspecified
O36.22X1	Maternal care for hydrops fetalis, second trimester, fetus 1
O36.22X2	Maternal care for hydrops fetalis, second trimester, fetus 2
O36.22X3	Maternal care for hydrops fetalis, second trimester, fetus 3
O36.22X4	Maternal care for hydrops fetalis, second trimester, fetus 4
O36.22X5	Maternal care for hydrops fetalis, second trimester, fetus 5
O36.22X9	Maternal care for hydrops fetalis, second trimester, other fetus
O36.23X0	Maternal care for hydrops fetalis, third trimester, not applicable or unspecified
O36.23X1	Maternal care for hydrops fetalis, third trimester, fetus 1
O36.23X2	Maternal care for hydrops fetalis, third trimester, fetus 2
O36.23X3	Maternal care for hydrops fetalis, third trimester, fetus 3
O36.23X4	Maternal care for hydrops fetalis, third trimester, fetus 4
O36.23X5	Maternal care for hydrops fetalis, third trimester, fetus 5
O36.23X9	Maternal care for hydrops fetalis, third trimester, other fetus
O36.4XX0	Maternal care for intrauterine death, not applicable or unspecified
O36.4XX1	Maternal care for intrauterine death, fetus 1
O36.4XX2	Maternal care for intrauterine death, fetus 2
O36.4XX3	Maternal care for intrauterine death, fetus 3
O36.4XX4	Maternal care for intrauterine death, fetus 4
O36.4XX5	Maternal care for intrauterine death, fetus 5
O36.4XX9	Maternal care for intrauterine death, other fetus
O36.5110	Maternal care for known or suspected placental insufficiency, first trimester, not applicable or unspecified
O36.5111	Maternal care for known or suspected placental insufficiency, first trimester, fetus 1
O36.5112	Maternal care for known or suspected placental insufficiency, first trimester, fetus 2
O36.5113	Maternal care for known or suspected placental insufficiency, first trimester, fetus 3
O36.5114	Maternal care for known or suspected placental insufficiency, first trimester, fetus 4
O36.5115	Maternal care for known or suspected placental insufficiency, first trimester, fetus 5
O36.5119	Maternal care for known or suspected placental insufficiency, first trimester, other fetus
O36.5120	Maternal care for known or suspected placental insufficiency, second trimester, not applicable or unspecified
O36.5121	Maternal care for known or suspected placental insufficiency, second trimester, fetus 1
O36.5122	Maternal care for known or suspected placental insufficiency, second trimester, fetus 2
O36.5123	Maternal care for known or suspected placental insufficiency, second trimester, fetus 3
O36.5124	Maternal care for known or suspected placental insufficiency, second trimester, fetus 4
O36.5125	Maternal care for known or suspected placental insufficiency, second trimester, fetus 5
O36.5129	Maternal care for known or suspected placental insufficiency, second trimester, other fetus
O36.5130	Maternal care for known or suspected placental insufficiency, third trimester, not applicable or unspecified
O36.5131	Maternal care for known or suspected placental insufficiency, third trimester, fetus 1
O36.5132	Maternal care for known or suspected placental insufficiency, third trimester, fetus 2
O36.5133	Maternal care for known or suspected placental insufficiency, third trimester, fetus 3
O36.5134	Maternal care for known or suspected placental insufficiency, third trimester, fetus 4
O36.5135	Maternal care for known or suspected placental insufficiency, third trimester, fetus 5
O36.5139	Maternal care for known or suspected placental insufficiency, third trimester, other fetus
O36.5190	Maternal care for known or suspected placental insufficiency, unspecified trimester, not applicable or unspecified
O36.5191	Maternal care for known or suspected placental insufficiency, unspecified trimester, fetus 1
O36.5192	Maternal care for known or suspected placental insufficiency, unspecified trimester, fetus 2
O36.5193	Maternal care for known or suspected placental insufficiency, unspecified trimester, fetus 3

O36.5194	Maternal care for known or suspected placental insufficiency, unspecified trimester, fetus 4
O36.5195	Maternal care for known or suspected placental insufficiency, unspecified trimester, fetus 5
O36.5199	Maternal care for known or suspected placental insufficiency, unspecified trimester, other fetus
O36.5910	Maternal care for other known or suspected poor fetal growth, first trimester, not applicable or unspecified
O36.5911	Maternal care for other known or suspected poor fetal growth, first trimester, fetus 1
O36.5912	Maternal care for other known or suspected poor fetal growth, first trimester, fetus 2
O36.5913	Maternal care for other known or suspected poor fetal growth, first trimester, fetus 3
O36.5914	Maternal care for other known or suspected poor fetal growth, first trimester, fetus 4
O36.5915	Maternal care for other known or suspected poor fetal growth, first trimester, fetus 5
O36.5919	Maternal care for other known or suspected poor fetal growth, first trimester, other fetus
O36.5920	Maternal care for other known or suspected poor fetal growth, second trimester, not applicable or unspecified
O36.5921	Maternal care for other known or suspected poor fetal growth, second trimester, fetus 1
O36.5922	Maternal care for other known or suspected poor fetal growth, second trimester, fetus 2
O36.5923	Maternal care for other known or suspected poor fetal growth, second trimester, fetus 3
O36.5924	Maternal care for other known or suspected poor fetal growth, second trimester, fetus 4
O36.5925	Maternal care for other known or suspected poor fetal growth, second trimester, fetus 5
O36.5929	Maternal care for other known or suspected poor fetal growth, second trimester, other fetus
O36.5930	Maternal care for other known or suspected poor fetal growth, third trimester, not applicable or unspecified
O36.5931	Maternal care for other known or suspected poor fetal growth, third trimester, fetus 1
O36.5932	Maternal care for other known or suspected poor fetal growth, third trimester, fetus 2
O36.5933	Maternal care for other known or suspected poor fetal growth, third trimester, fetus 3
O36.5934	Maternal care for other known or suspected poor fetal growth, third trimester, fetus 4
O36.5935	Maternal care for other known or suspected poor fetal growth, third trimester, fetus 5
O36.5939	Maternal care for other known or suspected poor fetal growth, third trimester, other fetus
O36.5990	Maternal care for other known or suspected poor fetal growth, unspecified trimester, not applicable or unspecified
O36.5991	Maternal care for other known or suspected poor fetal growth, unspecified trimester, fetus 1
O36.5992	Maternal care for other known or suspected poor fetal growth, unspecified trimester, fetus 2
O36.5993	Maternal care for other known or suspected poor fetal growth, unspecified trimester, fetus 3
O36.5994	Maternal care for other known or suspected poor fetal growth, unspecified trimester, fetus 4
O36.5995	Maternal care for other known or suspected poor fetal growth, unspecified trimester, fetus 5
O36.5999	Maternal care for other known or suspected poor fetal growth, unspecified trimester, other fetus
O36.60X0	Maternal care for excessive fetal growth, unspecified trimester, not applicable or unspecified
O36.60X1	Maternal care for excessive fetal growth, unspecified trimester, fetus 1
O36.60X2	Maternal care for excessive fetal growth, unspecified trimester, fetus 2
O36.60X3	Maternal care for excessive fetal growth, unspecified trimester, fetus 3
O36.60X4	Maternal care for excessive fetal growth, unspecified trimester, fetus 4
O36.60X5	Maternal care for excessive fetal growth, unspecified trimester, fetus 5
O36.60X9	Maternal care for excessive fetal growth, unspecified trimester, other fetus
O36.61X0	Maternal care for excessive fetal growth, first trimester, not applicable or unspecified
O36.61X1	Maternal care for excessive fetal growth, first trimester, fetus 1
O36.61X2	Maternal care for excessive fetal growth, first trimester, fetus 2
O36.61X3	Maternal care for excessive fetal growth, first trimester, fetus 3
O36.61X4	Maternal care for excessive fetal growth, first trimester, fetus 4
O36.61X5	Maternal care for excessive fetal growth, first trimester, fetus 5
O36.61X9	Maternal care for excessive fetal growth, first trimester, other fetus
O36.62X0	Maternal care for excessive fetal growth, second trimester, not applicable or unspecified
O36.62X1	Maternal care for excessive fetal growth, second trimester, fetus 1
O36.62X2	Maternal care for excessive fetal growth, second trimester, fetus 2
O36.62X3	Maternal care for excessive fetal growth, second trimester, fetus 3
O36.62X4	Maternal care for excessive fetal growth, second trimester, fetus 4
O36.62X5	Maternal care for excessive fetal growth, second trimester, fetus 5
O36.62X9	Maternal care for excessive fetal growth, second trimester, other fetus
O36.63X0	Maternal care for excessive fetal growth, third trimester, not applicable or unspecified

O36.63X1	Maternal care for excessive fetal growth, third trimester, fetus 1
O36.63X2	Maternal care for excessive fetal growth, third trimester, fetus 2
O36.63X3	Maternal care for excessive fetal growth, third trimester, fetus 3
O36.63X4	Maternal care for excessive fetal growth, third trimester, fetus 4
O36.63X5	Maternal care for excessive fetal growth, third trimester, fetus 5
O36.63X9	Maternal care for excessive fetal growth, third trimester, other fetus
O36.70X0	Maternal care for viable fetus in abdominal pregnancy, unspecified trimester, not applicable or unspecified
O36.70X1	Maternal care for viable fetus in abdominal pregnancy, unspecified trimester, fetus 1
O36.70X2	Maternal care for viable fetus in abdominal pregnancy, unspecified trimester, fetus 2
O36.70X3	Maternal care for viable fetus in abdominal pregnancy, unspecified trimester, fetus 3
O36.70X4	Maternal care for viable fetus in abdominal pregnancy, unspecified trimester, fetus 4
O36.70X5	Maternal care for viable fetus in abdominal pregnancy, unspecified trimester, fetus 5
O36.70X9	Maternal care for viable fetus in abdominal pregnancy, unspecified trimester, other fetus
O36.71X0	Maternal care for viable fetus in abdominal pregnancy, first trimester, not applicable or unspecified
O36.71X1	Maternal care for viable fetus in abdominal pregnancy, first trimester, fetus 1
O36.71X2	Maternal care for viable fetus in abdominal pregnancy, first trimester, fetus 2
O36.71X3	Maternal care for viable fetus in abdominal pregnancy, first trimester, fetus 3
O36.71X4	Maternal care for viable fetus in abdominal pregnancy, first trimester, fetus 4
O36.71X5	Maternal care for viable fetus in abdominal pregnancy, first trimester, fetus 5
O36.71X9	Maternal care for viable fetus in abdominal pregnancy, first trimester, other fetus
O36.72X0	Maternal care for viable fetus in abdominal pregnancy, second trimester, not applicable or unspecified
O36.72X1	Maternal care for viable fetus in abdominal pregnancy, second trimester, fetus 1
O36.72X2	Maternal care for viable fetus in abdominal pregnancy, second trimester, fetus 2
O36.72X3	Maternal care for viable fetus in abdominal pregnancy, second trimester, fetus 3
O36.72X4	Maternal care for viable fetus in abdominal pregnancy, second trimester, fetus 4
O36.72X5	Maternal care for viable fetus in abdominal pregnancy, second trimester, fetus 5
O36.72X9	Maternal care for viable fetus in abdominal pregnancy, second trimester, other fetus
O36.73X0	Maternal care for viable fetus in abdominal pregnancy, third trimester, not applicable or unspecified
O36.73X1	Maternal care for viable fetus in abdominal pregnancy, third trimester, fetus 1
O36.73X2	Maternal care for viable fetus in abdominal pregnancy, third trimester, fetus 2
O36.73X3	Maternal care for viable fetus in abdominal pregnancy, third trimester, fetus 3
O36.73X4	Maternal care for viable fetus in abdominal pregnancy, third trimester, fetus 4
O36.73X5	Maternal care for viable fetus in abdominal pregnancy, third trimester, fetus 5
O36.73X9	Maternal care for viable fetus in abdominal pregnancy, third trimester, other fetus
O36.80X0	Pregnancy with inconclusive fetal viability, not applicable or unspecified
O36.80X1	Pregnancy with inconclusive fetal viability, fetus 1
O36.80X2	Pregnancy with inconclusive fetal viability, fetus 2
O36.80X3	Pregnancy with inconclusive fetal viability, fetus 3
O36.80X4	Pregnancy with inconclusive fetal viability, fetus 4
O36.80X5	Pregnancy with inconclusive fetal viability, fetus 5
O36.80X9	Pregnancy with inconclusive fetal viability, other fetus
O36.8120	Decreased fetal movements, second trimester, not applicable or unspecified
O36.8121	Decreased fetal movements, second trimester, fetus 1
O36.8122	Decreased fetal movements, second trimester, fetus 2
O36.8123	Decreased fetal movements, second trimester, fetus 3
O36.8124	Decreased fetal movements, second trimester, fetus 4
O36.8125	Decreased fetal movements, second trimester, fetus 5
O36.8129	Decreased fetal movements, second trimester, other fetus
O36.8130	Decreased fetal movements, third trimester, not applicable or unspecified
O36.8131	Decreased fetal movements, third trimester, fetus 1
O36.8132	Decreased fetal movements, third trimester, fetus 2
O36.8133	Decreased fetal movements, third trimester, fetus 3
O36.8134	Decreased fetal movements, third trimester, fetus 4
O36.8135	Decreased fetal movements, third trimester, fetus 5
O36.8139	Decreased fetal movements, third trimester, other fetus

O36.8190	Decreased fetal movements, unspecified trimester, not applicable or unspecified
O36.8191	Decreased fetal movements, unspecified trimester, fetus 1
O36.8192	Decreased fetal movements, unspecified trimester, fetus 2
O36.8193	Decreased fetal movements, unspecified trimester, fetus 3
O36.8194	Decreased fetal movements, unspecified trimester, fetus 4
O36.8195	Decreased fetal movements, unspecified trimester, fetus 5
O36.8199	Decreased fetal movements, unspecified trimester, other fetus
O36.8910	Maternal care for other specified fetal problems, first trimester, not applicable or unspecified
O36.8911	Maternal care for other specified fetal problems, first trimester, fetus 1
O36.8912	Maternal care for other specified fetal problems, first trimester, fetus 2
O36.8913	Maternal care for other specified fetal problems, first trimester, fetus 3
O36.8914	Maternal care for other specified fetal problems, first trimester, fetus 4
O36.8915	Maternal care for other specified fetal problems, first trimester, fetus 5
O36.8919	Maternal care for other specified fetal problems, first trimester, other fetus
O36.8920	Maternal care for other specified fetal problems, second trimester, not applicable or unspecified
O36.8921	Maternal care for other specified fetal problems, second trimester, fetus 1
O36.8922	Maternal care for other specified fetal problems, second trimester, fetus 2
O36.8923	Maternal care for other specified fetal problems, second trimester, fetus 3
O36.8924	Maternal care for other specified fetal problems, second trimester, fetus 4
O36.8925	Maternal care for other specified fetal problems, second trimester, fetus 5
O36.8929	Maternal care for other specified fetal problems, second trimester, other fetus
O36.8930	Maternal care for other specified fetal problems, third trimester, not applicable or unspecified
O36.8931	Maternal care for other specified fetal problems, third trimester, fetus 1
O36.8932	Maternal care for other specified fetal problems, third trimester, fetus 2
O36.8933	Maternal care for other specified fetal problems, third trimester, fetus 3
O36.8934	Maternal care for other specified fetal problems, third trimester, fetus 4
O36.8935	Maternal care for other specified fetal problems, third trimester, fetus 5
O36.8939	Maternal care for other specified fetal problems, third trimester, other fetus
O36.8990	Maternal care for other specified fetal problems, unspecified trimester, not applicable or unspecified
O36.8991	Maternal care for other specified fetal problems, unspecified trimester, fetus 1
O36.8992	Maternal care for other specified fetal problems, unspecified trimester, fetus 2
O36.8993	Maternal care for other specified fetal problems, unspecified trimester, fetus 3
O36.8994	Maternal care for other specified fetal problems, unspecified trimester, fetus 4
O36.8995	Maternal care for other specified fetal problems, unspecified trimester, fetus 5
O36.8999	Maternal care for other specified fetal problems, unspecified trimester, other fetus
O36.90X0	Maternal care for fetal problem, unspecified, unspecified trimester, not applicable or unspecified
O36.90X1	Maternal care for fetal problem, unspecified, unspecified trimester, fetus 1
O36.90X2	Maternal care for fetal problem, unspecified, unspecified trimester, fetus 2
O36.90X3	Maternal care for fetal problem, unspecified, unspecified trimester, fetus 3
O36.90X4	Maternal care for fetal problem, unspecified, unspecified trimester, fetus 4
O36.90X5	Maternal care for fetal problem, unspecified, unspecified trimester, fetus 5
O36.90X9	Maternal care for fetal problem, unspecified, unspecified trimester, other fetus
O36.91X0	Maternal care for fetal problem, unspecified, first trimester, not applicable or unspecified
O36.91X1	Maternal care for fetal problem, unspecified, first trimester, fetus 1
O36.91X2	Maternal care for fetal problem, unspecified, first trimester, fetus 2
O36.91X3	Maternal care for fetal problem, unspecified, first trimester, fetus 3
O36.91X4	Maternal care for fetal problem, unspecified, first trimester, fetus 4
O36.91X5	Maternal care for fetal problem, unspecified, first trimester, fetus 5
O36.91X9	Maternal care for fetal problem, unspecified, first trimester, other fetus
O36.92X0	Maternal care for fetal problem, unspecified, second trimester, not applicable or unspecified
O36.92X1	Maternal care for fetal problem, unspecified, second trimester, fetus 1
O36.92X2	Maternal care for fetal problem, unspecified, second trimester, fetus 2
O36.92X3	Maternal care for fetal problem, unspecified, second trimester, fetus 3
O36.92X4	Maternal care for fetal problem, unspecified, second trimester, fetus 4
O36.92X5	Maternal care for fetal problem, unspecified, second trimester, fetus 5

O36.92X9	Maternal care for fetal problem, unspecified, second trimester, other fetus
O36.93X0	Maternal care for fetal problem, unspecified, third trimester, not applicable or unspecified
O36.93X1	Maternal care for fetal problem, unspecified, third trimester, fetus 1
O36.93X2	Maternal care for fetal problem, unspecified, third trimester, fetus 2
O36.93X3	Maternal care for fetal problem, unspecified, third trimester, fetus 3
O36.93X4	Maternal care for fetal problem, unspecified, third trimester, fetus 4
O36.93X5	Maternal care for fetal problem, unspecified, third trimester, fetus 5
O36.93X9	Maternal care for fetal problem, unspecified, third trimester, other fetus
O40.1XX0	Polyhydramnios, first trimester, not applicable or unspecified
O40.1XX1	Polyhydramnios, first trimester, fetus 1
O40.1XX2	Polyhydramnios, first trimester, fetus 2
O40.1XX3	Polyhydramnios, first trimester, fetus 3
O40.1XX4	Polyhydramnios, first trimester, fetus 4
O40.1XX5	Polyhydramnios, first trimester, fetus 5
O40.1XX9	Polyhydramnios, first trimester, other fetus
O40.2XX0	Polyhydramnios, second trimester, not applicable or unspecified
O40.2XX1	Polyhydramnios, second trimester, fetus 1
O40.2XX2	Polyhydramnios, second trimester, fetus 2
O40.2XX3	Polyhydramnios, second trimester, fetus 3
O40.2XX4	Polyhydramnios, second trimester, fetus 4
O40.2XX5	Polyhydramnios, second trimester, fetus 5
O40.2XX9	Polyhydramnios, second trimester, other fetus
O40.3XX0	Polyhydramnios, third trimester, not applicable or unspecified
O40.3XX1	Polyhydramnios, third trimester, fetus 1
O40.3XX2	Polyhydramnios, third trimester, fetus 2
O40.3XX3	Polyhydramnios, third trimester, fetus 3
O40.3XX4	Polyhydramnios, third trimester, fetus 4
O40.3XX5	Polyhydramnios, third trimester, fetus 5
O40.3XX9	Polyhydramnios, third trimester, other fetus
O40.9XX0	Polyhydramnios, unspecified trimester, not applicable or unspecified
O40.9XX1	Polyhydramnios, unspecified trimester, fetus 1
O40.9XX2	Polyhydramnios, unspecified trimester, fetus 2
O40.9XX3	Polyhydramnios, unspecified trimester, fetus 3
O40.9XX4	Polyhydramnios, unspecified trimester, fetus 4
O40.9XX5	Polyhydramnios, unspecified trimester, fetus 5
O40.9XX9	Polyhydramnios, unspecified trimester, other fetus
O41.00X0	Oligohydramnios, unspecified trimester, not applicable or unspecified
O41.00X1	Oligohydramnios, unspecified trimester, fetus 1
O41.00X2	Oligohydramnios, unspecified trimester, fetus 2
O41.00X3	Oligohydramnios, unspecified trimester, fetus 3
O41.00X4	Oligohydramnios, unspecified trimester, fetus 4
O41.00X5	Oligohydramnios, unspecified trimester, fetus 5
O41.00X9	Oligohydramnios, unspecified trimester, other fetus
O41.01X0	Oligohydramnios, first trimester, not applicable or unspecified
O41.01X1	Oligohydramnios, first trimester, fetus 1
O41.01X2	Oligohydramnios, first trimester, fetus 2
O41.01X3	Oligohydramnios, first trimester, fetus 3
O41.01X4	Oligohydramnios, first trimester, fetus 4
O41.01X5	Oligohydramnios, first trimester, fetus 5
O41.01X9	Oligohydramnios, first trimester, other fetus
O41.02X0	Oligohydramnios, second trimester, not applicable or unspecified
O41.02X1	Oligohydramnios, second trimester, fetus 1
O41.02X2	Oligohydramnios, second trimester, fetus 2
O41.02X3	Oligohydramnios, second trimester, fetus 3
O41.02X4	Oligohydramnios, second trimester, fetus 4

O41.02X5	Oligohydramnios, second trimester, fetus 5
O41.02X9	Oligohydramnios, second trimester, other fetus
O41.03X0	Oligohydramnios, third trimester, not applicable or unspecified
O41.03X1	Oligohydramnios, third trimester, fetus 1
O41.03X2	Oligohydramnios, third trimester, fetus 2
O41.03X3	Oligohydramnios, third trimester, fetus 3
O41.03X4	Oligohydramnios, third trimester, fetus 4
O41.03X5	Oligohydramnios, third trimester, fetus 5
O41.03X9	Oligohydramnios, third trimester, other fetus
O41.1010	Infection of amniotic sac and membranes, unspecified, first trimester, not applicable or unspecified
O41.1011	Infection of amniotic sac and membranes, unspecified, first trimester, fetus 1
O41.1012	Infection of amniotic sac and membranes, unspecified, first trimester, fetus 2
O41.1013	Infection of amniotic sac and membranes, unspecified, first trimester, fetus 3
O41.1014	Infection of amniotic sac and membranes, unspecified, first trimester, fetus 4
O41.1015	Infection of amniotic sac and membranes, unspecified, first trimester, fetus 5
O41.1019	Infection of amniotic sac and membranes, unspecified, first trimester, other fetus
O41.1020	Infection of amniotic sac and membranes, unspecified, second trimester, not applicable or unspecified
O41.1021	Infection of amniotic sac and membranes, unspecified, second trimester, fetus 1
O41.1022	Infection of amniotic sac and membranes, unspecified, second trimester, fetus 2
O41.1023	Infection of amniotic sac and membranes, unspecified, second trimester, fetus 3
O41.1024	Infection of amniotic sac and membranes, unspecified, second trimester, fetus 4
O41.1025	Infection of amniotic sac and membranes, unspecified, second trimester, fetus 5
O41.1029	Infection of amniotic sac and membranes, unspecified, second trimester, other fetus
O41.1030	Infection of amniotic sac and membranes, unspecified, third trimester, not applicable or unspecified
O41.1031	Infection of amniotic sac and membranes, unspecified, third trimester, fetus 1
O41.1032	Infection of amniotic sac and membranes, unspecified, third trimester, fetus 2
O41.1033	Infection of amniotic sac and membranes, unspecified, third trimester, fetus 3
O41.1034	Infection of amniotic sac and membranes, unspecified, third trimester, fetus 4
O41.1035	Infection of amniotic sac and membranes, unspecified, third trimester, fetus 5
O41.1039	Infection of amniotic sac and membranes, unspecified, third trimester, other fetus
O41.1090	Infection of amniotic sac and membranes, unspecified, unspecified trimester, not applicable or unspecified
O41.1091	Infection of amniotic sac and membranes, unspecified, unspecified trimester, fetus 1
O41.1092	Infection of amniotic sac and membranes, unspecified, unspecified trimester, fetus 2
O41.1093	Infection of amniotic sac and membranes, unspecified, unspecified trimester, fetus 3
O41.1094	Infection of amniotic sac and membranes, unspecified, unspecified trimester, fetus 4
O41.1095	Infection of amniotic sac and membranes, unspecified, unspecified trimester, fetus 5
O41.1099	Infection of amniotic sac and membranes, unspecified, unspecified trimester, other fetus
O41.1210	Chorioamnionitis, first trimester, not applicable or unspecified
O41.1211	Chorioamnionitis, first trimester, fetus 1
O41.1212	Chorioamnionitis, first trimester, fetus 2
O41.1213	Chorioamnionitis, first trimester, fetus 3
O41.1214	Chorioamnionitis, first trimester, fetus 4
O41.1215	Chorioamnionitis, first trimester, fetus 5
O41.1219	Chorioamnionitis, first trimester, other fetus
O41.1220	Chorioamnionitis, second trimester, not applicable or unspecified
O41.1221	Chorioamnionitis, second trimester, fetus 1
O41.1222	Chorioamnionitis, second trimester, fetus 2
O41.1223	Chorioamnionitis, second trimester, fetus 3
O41.1224	Chorioamnionitis, second trimester, fetus 4
O41.1225	Chorioamnionitis, second trimester, fetus 5
O41.1229	Chorioamnionitis, second trimester, other fetus
O41.1230	Chorioamnionitis, third trimester, not applicable or unspecified
O41.1231	Chorioamnionitis, third trimester, fetus 1
O41.1232	Chorioamnionitis, third trimester, fetus 2
O41.1233	Chorioamnionitis, third trimester, fetus 3

O41.1234	Chorioamnionitis, third trimester, fetus 4
O41.1235	Chorioamnionitis, third trimester, fetus 5
O41.1239	Chorioamnionitis, third trimester, other fetus
O41.1290	Chorioamnionitis, unspecified trimester, not applicable or unspecified
O41.1291	Chorioamnionitis, unspecified trimester, fetus 1
O41.1292	Chorioamnionitis, unspecified trimester, fetus 2
O41.1293	Chorioamnionitis, unspecified trimester, fetus 3
O41.1294	Chorioamnionitis, unspecified trimester, fetus 4
O41.1295	Chorioamnionitis, unspecified trimester, fetus 5
O41.1299	Chorioamnionitis, unspecified trimester, other fetus
O41.1410	Placentitis, first trimester, not applicable or unspecified
O41.1411	Placentitis, first trimester, fetus 1
O41.1412	Placentitis, first trimester, fetus 2
O41.1413	Placentitis, first trimester, fetus 3
O41.1414	Placentitis, first trimester, fetus 4
O41.1415	Placentitis, first trimester, fetus 5
O41.1419	Placentitis, first trimester, other fetus
O41.1420	Placentitis, second trimester, not applicable or unspecified
O41.1421	Placentitis, second trimester, fetus 1
O41.1422	Placentitis, second trimester, fetus 2
O41.1423	Placentitis, second trimester, fetus 3
O41.1424	Placentitis, second trimester, fetus 4
O41.1425	Placentitis, second trimester, fetus 5
O41.1429	Placentitis, second trimester, other fetus
O41.1430	Placentitis, third trimester, not applicable or unspecified
O41.1431	Placentitis, third trimester, fetus 1
O41.1432	Placentitis, third trimester, fetus 2
O41.1433	Placentitis, third trimester, fetus 3
O41.1434	Placentitis, third trimester, fetus 4
O41.1435	Placentitis, third trimester, fetus 5
O41.1439	Placentitis, third trimester, other fetus
O41.1490	Placentitis, unspecified trimester, not applicable or unspecified
O41.1491	Placentitis, unspecified trimester, fetus 1
O41.1492	Placentitis, unspecified trimester, fetus 2
O41.1493	Placentitis, unspecified trimester, fetus 3
O41.1494	Placentitis, unspecified trimester, fetus 4
O41.1495	Placentitis, unspecified trimester, fetus 5
O41.1499	Placentitis, unspecified trimester, other fetus
O41.8X10	Other specified disorders of amniotic fluid and membranes, first trimester, not applicable or unspecified
O41.8X11	Other specified disorders of amniotic fluid and membranes, first trimester, fetus 1
O41.8X12	Other specified disorders of amniotic fluid and membranes, first trimester, fetus 2
O41.8X13	Other specified disorders of amniotic fluid and membranes, first trimester, fetus 3
O41.8X14	Other specified disorders of amniotic fluid and membranes, first trimester, fetus 4
O41.8X15	Other specified disorders of amniotic fluid and membranes, first trimester, fetus 5
O41.8X19	Other specified disorders of amniotic fluid and membranes, first trimester, other fetus
O41.8X20	Other specified disorders of amniotic fluid and membranes, second trimester, not applicable or unspecified
O41.8X21	Other specified disorders of amniotic fluid and membranes, second trimester, fetus 1
O41.8X22	Other specified disorders of amniotic fluid and membranes, second trimester, fetus 2
O41.8X23	Other specified disorders of amniotic fluid and membranes, second trimester, fetus 3
O41.8X24	Other specified disorders of amniotic fluid and membranes, second trimester, fetus 4
O41.8X25	Other specified disorders of amniotic fluid and membranes, second trimester, fetus 5
O41.8X29	Other specified disorders of amniotic fluid and membranes, second trimester, other fetus
O41.8X30	Other specified disorders of amniotic fluid and membranes, third trimester, not applicable or unspecified
O41.8X31	Other specified disorders of amniotic fluid and membranes, third trimester, fetus 1

O41.8X32	Other specified disorders of amniotic fluid and membranes, third trimester, fetus 2
O41.8X33	Other specified disorders of amniotic fluid and membranes, third trimester, fetus 3
O41.8X34	Other specified disorders of amniotic fluid and membranes, third trimester, fetus 4
O41.8X35	Other specified disorders of amniotic fluid and membranes, third trimester, fetus 5
O41.8X39	Other specified disorders of amniotic fluid and membranes, third trimester, other fetus
O41.8X90	Other specified disorders of amniotic fluid and membranes, unspecified trimester, not applicable or unspecified
O41.8X91	Other specified disorders of amniotic fluid and membranes, unspecified trimester, fetus 1
O41.8X92	Other specified disorders of amniotic fluid and membranes, unspecified trimester, fetus 2
O41.8X93	Other specified disorders of amniotic fluid and membranes, unspecified trimester, fetus 3
O41.8X94	Other specified disorders of amniotic fluid and membranes, unspecified trimester, fetus 4
O41.8X95	Other specified disorders of amniotic fluid and membranes, unspecified trimester, fetus 5
O41.8X99	Other specified disorders of amniotic fluid and membranes, unspecified trimester, other fetus
O41.90X0	Disorder of amniotic fluid and membranes, unspecified, unspecified trimester, not applicable or unspecified
O41.90X1	Disorder of amniotic fluid and membranes, unspecified, unspecified trimester, fetus 1
O41.90X2	Disorder of amniotic fluid and membranes, unspecified, unspecified trimester, fetus 2
O41.90X3	Disorder of amniotic fluid and membranes, unspecified, unspecified trimester, fetus 3
O41.90X4	Disorder of amniotic fluid and membranes, unspecified, unspecified trimester, fetus 4
O41.90X5	Disorder of amniotic fluid and membranes, unspecified, unspecified trimester, fetus 5
O41.90X9	Disorder of amniotic fluid and membranes, unspecified, unspecified trimester, other fetus
O41.91X0	Disorder of amniotic fluid and membranes, unspecified, first trimester, not applicable or unspecified
O41.91X1	Disorder of amniotic fluid and membranes, unspecified, first trimester, fetus 1
O41.91X2	Disorder of amniotic fluid and membranes, unspecified, first trimester, fetus 2
O41.91X3	Disorder of amniotic fluid and membranes, unspecified, first trimester, fetus 3
O41.91X4	Disorder of amniotic fluid and membranes, unspecified, first trimester, fetus 4
O41.91X5	Disorder of amniotic fluid and membranes, unspecified, first trimester, fetus 5
O41.91X9	Disorder of amniotic fluid and membranes, unspecified, first trimester, other fetus
O41.92X0	Disorder of amniotic fluid and membranes, unspecified, second trimester, not applicable or unspecified
O41.92X1	Disorder of amniotic fluid and membranes, unspecified, second trimester, fetus 1
O41.92X2	Disorder of amniotic fluid and membranes, unspecified, second trimester, fetus 2
O41.92X3	Disorder of amniotic fluid and membranes, unspecified, second trimester, fetus 3
O41.92X4	Disorder of amniotic fluid and membranes, unspecified, second trimester, fetus 4
O41.92X5	Disorder of amniotic fluid and membranes, unspecified, second trimester, fetus 5
O41.92X9	Disorder of amniotic fluid and membranes, unspecified, second trimester, other fetus
O41.93X0	Disorder of amniotic fluid and membranes, unspecified, third trimester, not applicable or unspecified
O41.93X1	Disorder of amniotic fluid and membranes, unspecified, third trimester, fetus 1
O41.93X2	Disorder of amniotic fluid and membranes, unspecified, third trimester, fetus 2
O41.93X3	Disorder of amniotic fluid and membranes, unspecified, third trimester, fetus 3
O41.93X4	Disorder of amniotic fluid and membranes, unspecified, third trimester, fetus 4
O41.93X5	Disorder of amniotic fluid and membranes, unspecified, third trimester, fetus 5
O41.93X9	Disorder of amniotic fluid and membranes, unspecified, third trimester, other fetus
O42.00	Premature rupture of membranes, onset of labor within 24 hours of rupture, unspecified weeks of gestation
O42.011	Preterm premature rupture of membranes, onset of labor within 24 hours of rupture, first trimester
O42.012	Preterm premature rupture of membranes, onset of labor within 24 hours of rupture, second trimester
O42.013	Preterm premature rupture of membranes, onset of labor within 24 hours of rupture, third trimester
O42.019	Preterm premature rupture of membranes, onset of labor within 24 hours of rupture, unspecified trimester
O42.02	Full-term premature rupture of membranes, onset of labor within 24 hours of rupture
O42.10	Premature rupture of membranes, onset of labor more than 24 hours following rupture, unspecified weeks of gestation
O42.111	Preterm premature rupture of membranes, onset of labor more than 24 hours following rupture, first trimester
O42.112	Preterm premature rupture of membranes, onset of labor more than 24 hours following rupture, second trimester

O42.113	Preterm premature rupture of membranes, onset of labor more than 24 hours following rupture, third trimester
O42.119	Preterm premature rupture of membranes, onset of labor more than 24 hours following rupture, unspecified trimester
O42.12	Full-term premature rupture of membranes, onset of labor more than 24 hours following rupture
O42.90	Premature rupture of membranes, unspecified as to length of time between rupture and onset of labor, unspecified weeks of gestation
O42.911	Preterm premature rupture of membranes, unspecified as to length of time between rupture and onset of labor, first trimester
O42.912	Preterm premature rupture of membranes, unspecified as to length of time between rupture and onset of labor, second trimester
O42.913	Preterm premature rupture of membranes, unspecified as to length of time between rupture and onset of labor, third trimester
O42.919	Preterm premature rupture of membranes, unspecified as to length of time between rupture and onset of labor, unspecified trimester
O42.92	Full-term premature rupture of membranes, unspecified as to length of time between rupture and onset of labor
O43.011	Fetomaternal placental transfusion syndrome, first trimester
O43.012	Fetomaternal placental transfusion syndrome, second trimester
O43.013	Fetomaternal placental transfusion syndrome, third trimester
O43.019	Fetomaternal placental transfusion syndrome, unspecified trimester
O43.021	Fetus-to-fetus placental transfusion syndrome, first trimester
O43.022	Fetus-to-fetus placental transfusion syndrome, second trimester
O43.023	Fetus-to-fetus placental transfusion syndrome, third trimester
O43.029	Fetus-to-fetus placental transfusion syndrome, unspecified trimester
O43.101	Malformation of placenta, unspecified, first trimester
O43.102	Malformation of placenta, unspecified, second trimester
O43.103	Malformation of placenta, unspecified, third trimester
O43.109	Malformation of placenta, unspecified, unspecified trimester
O43.111	Circumvallate placenta, first trimester
O43.112	Circumvallate placenta, second trimester
O43.113	Circumvallate placenta, third trimester
O43.119	Circumvallate placenta, unspecified trimester
O43.191	Other malformation of placenta, first trimester
O43.192	Other malformation of placenta, second trimester
O43.193	Other malformation of placenta, third trimester
O43.199	Other malformation of placenta, unspecified trimester
O43.811	Placental infarction, first trimester
O43.812	Placental infarction, second trimester
O43.813	Placental infarction, third trimester
O43.819	Placental infarction, unspecified trimester
O43.891	Other placental disorders, first trimester
O43.892	Other placental disorders, second trimester
O43.893	Other placental disorders, third trimester
O43.899	Other placental disorders, unspecified trimester
O43.90	Unspecified placental disorder, unspecified trimester
O43.91	Unspecified placental disorder, first trimester
O43.92	Unspecified placental disorder, second trimester
O43.93	Unspecified placental disorder, third trimester
O44.01	Placenta previa specified as without hemorrhage, first trimester
O44.02	Placenta previa specified as without hemorrhage, second trimester
O44.03	Placenta previa specified as without hemorrhage, third trimester
O44.10	Placenta previa with hemorrhage, unspecified trimester
O44.11	Placenta previa with hemorrhage, first trimester
O44.12	Placenta previa with hemorrhage, second trimester

O44.13	Placenta previa with hemorrhage, third trimester
O45.001	Premature separation of placenta with coagulation defect, unspecified, first trimester
O45.002	Premature separation of placenta with coagulation defect, unspecified, second trimester
O45.003	Premature separation of placenta with coagulation defect, unspecified, third trimester
O45.011	Premature separation of placenta with afibrinogenemia, first trimester
O45.012	Premature separation of placenta with afibrinogenemia, second trimester
O45.013	Premature separation of placenta with afibrinogenemia, third trimester
O45.021	Premature separation of placenta with disseminated intravascular coagulation, first trimester
O45.022	Premature separation of placenta with disseminated intravascular coagulation, second trimester
O45.023	Premature separation of placenta with disseminated intravascular coagulation, third trimester
O45.091	Premature separation of placenta with other coagulation defect, first trimester
O45.092	Premature separation of placenta with other coagulation defect, second trimester
O45.093	Premature separation of placenta with other coagulation defect, third trimester
O45.8X1	Other premature separation of placenta, first trimester
O45.8X2	Other premature separation of placenta, second trimester
O45.8X3	Other premature separation of placenta, third trimester
O45.8X9	Other premature separation of placenta, unspecified trimester
O45.91	Premature separation of placenta, unspecified, first trimester
O45.92	Premature separation of placenta, unspecified, second trimester
O45.93	Premature separation of placenta, unspecified, third trimester
O46.001	Antepartum hemorrhage with coagulation defect, unspecified, first trimester
O46.002	Antepartum hemorrhage with coagulation defect, unspecified, second trimester
O46.003	Antepartum hemorrhage with coagulation defect, unspecified, third trimester
O46.009	Antepartum hemorrhage with coagulation defect, unspecified, unspecified trimester
O46.011	Antepartum hemorrhage with afibrinogenemia, first trimester
O46.012	Antepartum hemorrhage with afibrinogenemia, second trimester
O46.013	Antepartum hemorrhage with afibrinogenemia, third trimester
O46.019	Antepartum hemorrhage with afibrinogenemia, unspecified trimester
O46.021	Antepartum hemorrhage with disseminated intravascular coagulation, first trimester
O46.022	Antepartum hemorrhage with disseminated intravascular coagulation, second trimester
O46.023	Antepartum hemorrhage with disseminated intravascular coagulation, third trimester
O46.029	Antepartum hemorrhage with disseminated intravascular coagulation, unspecified trimester
O46.091	Antepartum hemorrhage with other coagulation defect, first trimester
O46.092	Antepartum hemorrhage with other coagulation defect, second trimester
O46.093	Antepartum hemorrhage with other coagulation defect, third trimester
O46.099	Antepartum hemorrhage with other coagulation defect, unspecified trimester
O46.8X1	Other antepartum hemorrhage, first trimester
O46.8X2	Other antepartum hemorrhage, second trimester
O46.8X3	Other antepartum hemorrhage, third trimester
O46.8X9	Other antepartum hemorrhage, unspecified trimester
O46.90	Antepartum hemorrhage, unspecified, unspecified trimester
O46.91	Antepartum hemorrhage, unspecified, first trimester
O46.92	Antepartum hemorrhage, unspecified, second trimester
O46.93	Antepartum hemorrhage, unspecified, third trimester
O47.00	False labor before 37 completed weeks of gestation, unspecified trimester
O47.02	False labor before 37 completed weeks of gestation, second trimester
O47.03	False labor before 37 completed weeks of gestation, third trimester
O47.1	False labor at or after 37 completed weeks of gestation
O47.9	False labor, unspecified
O48.0	Post-term pregnancy
O48.1	Prolonged pregnancy
O60.00	Preterm labor without delivery, unspecified trimester
O60.02	Preterm labor without delivery, second trimester
O60.03	Preterm labor without delivery, third trimester
O60.10X0	Preterm labor with preterm delivery, unspecified trimester, not applicable or unspecified

O60.12X0	Preterm labor second trimester with preterm delivery second trimester, not applicable or unspecified
O60.13X0	Preterm labor second trimester with preterm delivery third trimester, not applicable or unspecified
O60.14X0	Preterm labor third trimester with preterm delivery third trimester, not applicable or unspecified
O64.1XX0	Obstructed labor due to breech presentation, not applicable or unspecified
O64.1XX1	Obstructed labor due to breech presentation, fetus 1
O64.1XX2	Obstructed labor due to breech presentation, fetus 2
O64.1XX3	Obstructed labor due to breech presentation, fetus 3
O64.1XX4	Obstructed labor due to breech presentation, fetus 4
O64.1XX5	Obstructed labor due to breech presentation, fetus 5
O64.1XX9	Obstructed labor due to breech presentation, other fetus
O64.2XX0	Obstructed labor due to face presentation, not applicable or unspecified
O64.2XX1	Obstructed labor due to face presentation, fetus 1
O64.2XX2	Obstructed labor due to face presentation, fetus 2
O64.2XX3	Obstructed labor due to face presentation, fetus 3
O64.2XX4	Obstructed labor due to face presentation, fetus 4
O64.2XX5	Obstructed labor due to face presentation, fetus 5
O64.2XX9	Obstructed labor due to face presentation, other fetus
O64.3XX0	Obstructed labor due to brow presentation, not applicable or unspecified
O64.3XX1	Obstructed labor due to brow presentation, fetus 1
O64.3XX2	Obstructed labor due to brow presentation, fetus 2
O64.3XX3	Obstructed labor due to brow presentation, fetus 3
O64.3XX4	Obstructed labor due to brow presentation, fetus 4
O64.3XX5	Obstructed labor due to brow presentation, fetus 5
O64.3XX9	Obstructed labor due to brow presentation, other fetus
O64.4XX0	Obstructed labor due to shoulder presentation, not applicable or unspecified
O64.4XX1	Obstructed labor due to shoulder presentation, fetus 1
O64.4XX2	Obstructed labor due to shoulder presentation, fetus 2
O64.4XX3	Obstructed labor due to shoulder presentation, fetus 3
O64.4XX4	Obstructed labor due to shoulder presentation, fetus 4
O64.4XX5	Obstructed labor due to shoulder presentation, fetus 5
O64.4XX9	Obstructed labor due to shoulder presentation, other fetus
O64.5XX0	Obstructed labor due to compound presentation, not applicable or unspecified
O64.5XX1	Obstructed labor due to compound presentation, fetus 1
O64.5XX2	Obstructed labor due to compound presentation, fetus 2
O64.5XX3	Obstructed labor due to compound presentation, fetus 3
O64.5XX4	Obstructed labor due to compound presentation, fetus 4
O64.5XX5	Obstructed labor due to compound presentation, fetus 5
O64.5XX9	Obstructed labor due to compound presentation, other fetus
O64.8XX0	Obstructed labor due to other malposition and malpresentation, not applicable or unspecified
O64.8XX1	Obstructed labor due to other malposition and malpresentation, fetus 1
O64.8XX2	Obstructed labor due to other malposition and malpresentation, fetus 2
O64.8XX3	Obstructed labor due to other malposition and malpresentation, fetus 3
O64.8XX4	Obstructed labor due to other malposition and malpresentation, fetus 4
O64.8XX5	Obstructed labor due to other malposition and malpresentation, fetus 5
O64.8XX9	Obstructed labor due to other malposition and malpresentation, other fetus
O64.9XX0	Obstructed labor due to malposition and malpresentation, unspecified, not applicable or unspecified
O64.9XX1	Obstructed labor due to malposition and malpresentation, unspecified, fetus 1
O64.9XX2	Obstructed labor due to malposition and malpresentation, unspecified, fetus 2
O64.9XX3	Obstructed labor due to malposition and malpresentation, unspecified, fetus 3
O64.9XX4	Obstructed labor due to malposition and malpresentation, unspecified, fetus 4
O64.9XX5	Obstructed labor due to malposition and malpresentation, unspecified, fetus 5
O64.9XX9	Obstructed labor due to malposition and malpresentation, unspecified, other fetus
O65.0	Obstructed labor due to deformed pelvis
O65.1	Obstructed labor due to generally contracted pelvis
O65.2	Obstructed labor due to pelvic inlet contraction

O65.3	Obstructed labor due to pelvic outlet and mid-cavity contraction
O65.4	Obstructed labor due to fetopelvic disproportion, unspecified
O65.8	Obstructed labor due to other maternal pelvic abnormalities
O65.9	Obstructed labor due to maternal pelvic abnormality, unspecified
O66.2	Obstructed labor due to unusually large fetus
O66.6	Obstructed labor due to other multiple fetuses
O67.0	Intrapartum hemorrhage with coagulation defect
O67.8	Other intrapartum hemorrhage
O67.9	Intrapartum hemorrhage, unspecified
O68	Labor and delivery complicated by abnormality of fetal acid-base balance
O75.5	Delayed delivery after artificial rupture of membranes
O77.0	Labor and delivery complicated by meconium in amniotic fluid
O77.1	Fetal stress in labor or delivery due to drug administration
O77.8	Labor and delivery complicated by other evidence of fetal stress
O77.9	Labor and delivery complicated by fetal stress, unspecified
O86.11	Cervicitis following delivery
O86.13	Vaginitis following delivery
O86.19	Other infection of genital tract following delivery
O86.20	Urinary tract infection following delivery, unspecified
O86.21	Infection of kidney following delivery
O86.22	Infection of bladder following delivery
O86.29	Other urinary tract infection following delivery
O88.011	Air embolism in pregnancy, first trimester
O88.012	Air embolism in pregnancy, second trimester
O88.013	Air embolism in pregnancy, third trimester
O88.019	Air embolism in pregnancy, unspecified trimester
O88.02	Air embolism in childbirth
O88.03	Air embolism in the puerperium
O88.111	Amniotic fluid embolism in pregnancy, first trimester
O88.112	Amniotic fluid embolism in pregnancy, second trimester
O88.113	Amniotic fluid embolism in pregnancy, third trimester
O88.119	Amniotic fluid embolism in pregnancy, unspecified trimester
O88.12	Amniotic fluid embolism in childbirth
O88.13	Amniotic fluid embolism in the puerperium
O88.211	Thromboembolism in pregnancy, first trimester
O88.212	Thromboembolism in pregnancy, second trimester
O88.213	Thromboembolism in pregnancy, third trimester
O88.219	Thromboembolism in pregnancy, unspecified trimester
O88.22	Thromboembolism in childbirth
O88.23	Thromboembolism in the puerperium
O88.311	Pyemic and septic embolism in pregnancy, first trimester
O88.312	Pyemic and septic embolism in pregnancy, second trimester
O88.313	Pyemic and septic embolism in pregnancy, third trimester
O88.319	Pyemic and septic embolism in pregnancy, unspecified trimester
O88.32	Pyemic and septic embolism in childbirth
O88.33	Pyemic and septic embolism in the puerperium
O88.811	Other embolism in pregnancy, first trimester
O88.812	Other embolism in pregnancy, second trimester
O88.813	Other embolism in pregnancy, third trimester
O88.819	Other embolism in pregnancy, unspecified trimester
O88.82	Other embolism in childbirth
O88.83	Other embolism in the puerperium
O90.5	Postpartum thyroiditis
O90.6	Postpartum mood disturbance
O90.81	Anemia of the puerperium

O90.89	Other complications of the puerperium, not elsewhere classified
O91.011	Infection of nipple associated with pregnancy, first trimester
O91.012	Infection of nipple associated with pregnancy, second trimester
O91.013	Infection of nipple associated with pregnancy, third trimester
O91.019	Infection of nipple associated with pregnancy, unspecified trimester
O91.02	Infection of nipple associated with the puerperium
O91.03	Infection of nipple associated with lactation
O91.111	Abscess of breast associated with pregnancy, first trimester
O91.112	Abscess of breast associated with pregnancy, second trimester
O91.113	Abscess of breast associated with pregnancy, third trimester
O91.119	Abscess of breast associated with pregnancy, unspecified trimester
O91.12	Abscess of breast associated with the puerperium
O91.13	Abscess of breast associated with lactation
O91.211	Nonpurulent mastitis associated with pregnancy, first trimester
O91.212	Nonpurulent mastitis associated with pregnancy, second trimester
O91.213	Nonpurulent mastitis associated with pregnancy, third trimester
O91.219	Nonpurulent mastitis associated with pregnancy, unspecified trimester
O91.22	Nonpurulent mastitis associated with the puerperium
O91.23	Nonpurulent mastitis associated with lactation
O92.011	Retracted nipple associated with pregnancy, first trimester
O92.012	Retracted nipple associated with pregnancy, second trimester
O92.013	Retracted nipple associated with pregnancy, third trimester
O92.019	Retracted nipple associated with pregnancy, unspecified trimester
O92.02	Retracted nipple associated with the puerperium
O92.03	Retracted nipple associated with lactation
O92.111	Cracked nipple associated with pregnancy, first trimester
O92.112	Cracked nipple associated with pregnancy, second trimester
O92.113	Cracked nipple associated with pregnancy, third trimester
O92.119	Cracked nipple associated with pregnancy, unspecified trimester
O92.12	Cracked nipple associated with the puerperium
O92.13	Cracked nipple associated with lactation
O92.20	Unspecified disorder of breast associated with pregnancy and the puerperium
O92.29	Other disorders of breast associated with pregnancy and the puerperium
O92.3	Agalactia
O92.5	Suppressed lactation
O92.6	Galactorrhea
O92.70	Unspecified disorders of lactation
O92.79	Other disorders of lactation
O98.011	Tuberculosis complicating pregnancy, first trimester
O98.012	Tuberculosis complicating pregnancy, second trimester
O98.013	Tuberculosis complicating pregnancy, third trimester
O98.019	Tuberculosis complicating pregnancy, unspecified trimester
O98.02	Tuberculosis complicating childbirth
O98.03	Tuberculosis complicating the puerperium
O98.111	Syphilis complicating pregnancy, first trimester
O98.112	Syphilis complicating pregnancy, second trimester
O98.113	Syphilis complicating pregnancy, third trimester
O98.119	Syphilis complicating pregnancy, unspecified trimester
O98.12	Syphilis complicating childbirth
O98.13	Syphilis complicating the puerperium
O98.211	Gonorrhea complicating pregnancy, first trimester
O98.212	Gonorrhea complicating pregnancy, second trimester
O98.213	Gonorrhea complicating pregnancy, third trimester
O98.219	Gonorrhea complicating pregnancy, unspecified trimester
O98.22	Gonorrhea complicating childbirth

O98.23	Gonorrhea complicating the puerperium
O98.311	Other infections with a predominantly sexual mode of transmission complicating pregnancy, first trimester
O98.312	Other infections with a predominantly sexual mode of transmission complicating pregnancy, second trimester
O98.313	Other infections with a predominantly sexual mode of transmission complicating pregnancy, third trimester
O98.319	Other infections with a predominantly sexual mode of transmission complicating pregnancy, unspecified trimester
O98.32	Other infections with a predominantly sexual mode of transmission complicating childbirth
O98.33	Other infections with a predominantly sexual mode of transmission complicating the puerperium
O98.42	Viral hepatitis complicating childbirth
O98.43	Viral hepatitis complicating the puerperium
O98.511	Other viral diseases complicating pregnancy, first trimester
O98.512	Other viral diseases complicating pregnancy, second trimester
O98.513	Other viral diseases complicating pregnancy, third trimester
O98.519	Other viral diseases complicating pregnancy, unspecified trimester
O98.52	Other viral diseases complicating childbirth
O98.53	Other viral diseases complicating the puerperium
O98.611	Protozoal diseases complicating pregnancy, first trimester
O98.612	Protozoal diseases complicating pregnancy, second trimester
O98.613	Protozoal diseases complicating pregnancy, third trimester
O98.619	Protozoal diseases complicating pregnancy, unspecified trimester
O98.62	Protozoal diseases complicating childbirth
O98.63	Protozoal diseases complicating the puerperium
O98.811	Other maternal infectious and parasitic diseases complicating pregnancy, first trimester
O98.812	Other maternal infectious and parasitic diseases complicating pregnancy, second trimester
O98.813	Other maternal infectious and parasitic diseases complicating pregnancy, third trimester
O98.819	Other maternal infectious and parasitic diseases complicating pregnancy, unspecified trimester
O98.82	Other maternal infectious and parasitic diseases complicating childbirth
O98.83	Other maternal infectious and parasitic diseases complicating the puerperium
O98.911	Unspecified maternal infectious and parasitic disease complicating pregnancy, first trimester
O98.912	Unspecified maternal infectious and parasitic disease complicating pregnancy, second trimester
O98.913	Unspecified maternal infectious and parasitic disease complicating pregnancy, third trimester
O98.919	Unspecified maternal infectious and parasitic disease complicating pregnancy, unspecified trimester
O98.92	Unspecified maternal infectious and parasitic disease complicating childbirth
O98.93	Unspecified maternal infectious and parasitic disease complicating the puerperium
O99.011	Anemia complicating pregnancy, first trimester
O99.012	Anemia complicating pregnancy, second trimester
O99.013	Anemia complicating pregnancy, third trimester
O99.019	Anemia complicating pregnancy, unspecified trimester
O99.02	Anemia complicating childbirth
O99.03	Anemia complicating the puerperium
O99.280	Endocrine, nutritional and metabolic diseases complicating pregnancy, unspecified trimester
O99.281	Endocrine, nutritional and metabolic diseases complicating pregnancy, first trimester
O99.282	Endocrine, nutritional and metabolic diseases complicating pregnancy, second trimester
O99.283	Endocrine, nutritional and metabolic diseases complicating pregnancy, third trimester
O99.284	Endocrine, nutritional and metabolic diseases complicating childbirth
O99.285	Endocrine, nutritional and metabolic diseases complicating the puerperium
O99.320	Drug use complicating pregnancy, unspecified trimester
O99.321	Drug use complicating pregnancy, first trimester
O99.322	Drug use complicating pregnancy, second trimester
O99.323	Drug use complicating pregnancy, third trimester
O99.324	Drug use complicating childbirth
O99.325	Drug use complicating the puerperium
O99.340	Other mental disorders complicating pregnancy, unspecified trimester
O99.341	Other mental disorders complicating pregnancy, first trimester

O99.342	Other mental disorders complicating pregnancy, second trimester
O99.343	Other mental disorders complicating pregnancy, third trimester
O99.344	Other mental disorders complicating childbirth
O99.345	Other mental disorders complicating the puerperium
O99.411	Diseases of the circulatory system complicating pregnancy, first trimester
O99.412	Diseases of the circulatory system complicating pregnancy, second trimester
O99.413	Diseases of the circulatory system complicating pregnancy, third trimester
O99.419	Diseases of the circulatory system complicating pregnancy, unspecified trimester
O99.42	Diseases of the circulatory system complicating childbirth
O99.43	Diseases of the circulatory system complicating the puerperium
O99.53	Diseases of the respiratory system complicating the puerperium
O99.63	Diseases of the digestive system complicating the puerperium
O99.810	Abnormal glucose complicating pregnancy
O99.814	Abnormal glucose complicating childbirth
O99.815	Abnormal glucose complicating the puerperium
O99.834	Other infection carrier state complicating childbirth
O99.835	Other infection carrier state complicating the puerperium
O99.89	Other specified diseases and conditions complicating pregnancy, childbirth and the puerperium
O9A.23	Injury, poisoning and certain other consequences of external causes complicating the puerperium
Z00.00	Encounter for general adult medical examination without abnormal findings
Z00.01	Encounter for general adult medical examination with abnormal findings
Z00.110	Health examination for newborn under 8 days old
Z00.111	Health examination for newborn 8 to 28 days old
Z00.121	Encounter for routine child health examination with abnormal findings
Z00.129	Encounter for routine child health examination without abnormal findings
Z00.5	Encounter for examination of potential donor of organ and tissue
Z00.6	Encounter for examination for normal comparison and control in clinical research program
Z00.70	Encounter for examination for period of delayed growth in childhood without abnormal findings
Z00.71	Encounter for examination for period of delayed growth in childhood with abnormal findings
Z00.8	Encounter for other general examination
Z02.0	Encounter for examination for admission to educational institution
Z02.1	Encounter for pre-employment examination
Z02.2	Encounter for examination for admission to residential institution
Z02.3	Encounter for examination for recruitment to armed forces
Z02.4	Encounter for examination for driving license
Z02.5	Encounter for examination for participation in sport
Z02.6	Encounter for examination for insurance purposes
Z02.81	Encounter for paternity testing
Z02.82	Encounter for adoption services
Z02.83	Encounter for blood-alcohol and blood-drug test
Z02.89	Encounter for other administrative examinations
Z04.6	Encounter for general psychiatric examination, requested by authority
Z11.0	Encounter for screening for intestinal infectious diseases
Z11.1	Encounter for screening for respiratory tuberculosis
Z11.2	Encounter for screening for other bacterial diseases
Z11.3	Encounter for screening for infections with a predominantly sexual mode of transmission
Z11.51	Encounter for screening for human papillomavirus (HPV)
Z11.59	Encounter for screening for other viral diseases
Z11.6	Encounter for screening for other protozoal diseases and helminthiases
Z11.8	Encounter for screening for other infectious and parasitic diseases
Z11.9	Encounter for screening for infectious and parasitic diseases, unspecified
Z13.0	Encounter for screening for diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism
Z13.1	Encounter for screening for diabetes mellitus
Z13.21	Encounter for screening for nutritional disorder

Z13.220	Encounter for screening for lipoid disorders
Z13.228	Encounter for screening for other metabolic disorders
Z13.29	Encounter for screening for other suspected endocrine disorder
Z13.4	Encounter for screening for certain developmental disorders in childhood
Z13.828	Encounter for screening for other musculoskeletal disorder
Z13.89	Encounter for screening for other disorder
Z20.01	Contact with and (suspected) exposure to intestinal infectious diseases due to Escherichia coli (E. coli)
Z20.09	Contact with and (suspected) exposure to other intestinal infectious diseases
Z20.1	Contact with and (suspected) exposure to tuberculosis
Z20.2	Contact with and (suspected) exposure to infections with a predominantly sexual mode of transmission
Z20.3	Contact with and (suspected) exposure to rabies
Z20.4	Contact with and (suspected) exposure to rubella
Z20.5	Contact with and (suspected) exposure to human immunodeficiency virus [HIV]
Z20.6	Contact with and (suspected) exposure to human immunodeficiency virus [HIV]
Z20.810	Contact with and (suspected) exposure to anthrax
Z20.811	Contact with and (suspected) exposure to meningococcus
Z20.820	Contact with and (suspected) exposure to varicella
Z20.828	Contact with and (suspected) exposure to other viral communicable diseases
Z20.89	Contact with and (suspected) exposure to other communicable diseases
Z20.9	Contact with and (suspected) exposure to unspecified communicable disease
Z22.0	Carrier of typhoid
Z22.1	Carrier of other intestinal infectious diseases
Z22.2	Carrier of diphtheria
Z22.31	Carrier of bacterial disease due to meningococci
Z22.321	Carrier or suspected carrier of Methicillin susceptible Staphylococcus aureus
Z22.322	Carrier or suspected carrier of Methicillin resistant Staphylococcus aureus
Z22.330	Carrier of Group B streptococcus
Z22.338	Carrier of other streptococcus
Z22.39	Carrier of other specified bacterial diseases
Z22.4	Carrier of infections with a predominantly sexual mode of transmission
Z22.50	Carrier of unspecified viral hepatitis
Z22.51	Carrier of viral hepatitis B
Z22.52	Carrier of viral hepatitis C
Z22.59	Carrier of other viral hepatitis
Z22.8	Carrier of other infectious diseases
Z23	Encounter for immunization
Z33.1	Pregnant state, incidental
Z34.00	Encounter for supervision of normal first pregnancy, unspecified trimester
Z34.01	Encounter for supervision of normal first pregnancy, first trimester
Z34.02	Encounter for supervision of normal first pregnancy, second trimester
Z34.03	Encounter for supervision of normal first pregnancy, third trimester
Z34.80	Encounter for supervision of other normal pregnancy, unspecified trimester
Z34.81	Encounter for supervision of other normal pregnancy, first trimester
Z34.82	Encounter for supervision of other normal pregnancy, second trimester
Z34.83	Encounter for supervision of other normal pregnancy, third trimester
Z34.90	Encounter for supervision of normal pregnancy, unspecified, unspecified trimester
Z34.91	Encounter for supervision of normal pregnancy, unspecified, first trimester
Z34.92	Encounter for supervision of normal pregnancy, unspecified, second trimester
Z34.93	Encounter for supervision of normal pregnancy, unspecified, third trimester
Z38.00	Single liveborn infant, delivered vaginally
Z38.01	Single liveborn infant, delivered by cesarean
Z38.1	Single liveborn infant, born outside hospital
Z38.2	Single liveborn infant, unspecified as to place of birth
Z38.30	Twin liveborn infant, delivered vaginally
Z38.31	Twin liveborn infant, delivered by cesarean

Z38.4	Twin liveborn infant, born outside hospital
Z38.5	Twin liveborn infant, unspecified as to place of birth
Z38.61	Triplet liveborn infant, delivered vaginally
Z38.62	Triplet liveborn infant, delivered by cesarean
Z38.63	Quadruplet liveborn infant, delivered vaginally
Z38.64	Quadruplet liveborn infant, delivered by cesarean
Z38.65	Quintuplet liveborn infant, delivered vaginally
Z38.66	Quintuplet liveborn infant, delivered by cesarean
Z38.68	Other multiple liveborn infant, delivered vaginally
Z38.69	Other multiple liveborn infant, delivered by cesarean
Z38.7	Other multiple liveborn infant, born outside hospital
Z38.8	Other multiple liveborn infant, unspecified as to place of birth
Z41.8	Encounter for other procedures for purposes other than remedying health state
Z51.89	Encounter for other specified aftercare
Z76.1	Encounter for health supervision and care of foundling
Z76.2	Encounter for health supervision and care of other healthy infant and child
Z79.810	Long term (current) use of selective estrogen receptor modulators (SERMs)
Z79.811	Long term (current) use of aromatase inhibitors
Z79.818	Long term (current) use of other agents affecting estrogen receptors and estrogen levels
Z79.890	Hormone replacement therapy (postmenopausal)