NOTICE OF PROVIDER HANDBOOK CHANGES

Date: September 1, 2025

BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association.
bluecrossvt.org

The Provider Handbook has been updated with the following:

Summary:	Section 6.7 Claim Specific Guidelines
Explanation:	Under the Readmission to a Facility updated the title of Payment Policy CPP_21 to Inpatient Hospital Readmission to align with the August 1, 2025, updated policy. In addition, a reference was made to the document that provides the process for filing a reconsideration for inpatient hospital readmission denial. Changes below in red font. **Readmission to a Facility** Our Payment Policy CPP_21 "Inpatient Hospital Readmission" provides description, eligible and ineligible services and billing guidelines. The policy as well as the process for filing a reconsideration for inpatient hospital readmission denial are located on our provider website under Provider Policies, Provider Payment Policies.
Effective Date:	N/A maintenance
Link to Policy/ Manual:	https://www.bluecrossvt.org/documents/provider-handbook

Summary:	Section 1.4 Requirements of Contracted/Credentialed/Enrolled Providers/Groups
Explanation:	Under the Work with Patients to Reduce Chances of Unplanned Hospital Readmission, updated the title of Payment Policy CPP_21 to Inpatient Hospital Readmission to align with the August 1, 2025, updated policy. Changes below in red font. Please refer to our Inpatient Hospital Readmission Payment Policy CPP_21 for details of readmission services that are not eligible for additional reimbursement.
Effective Date:	N/A maintenance
Link to Policy/ Manual:	https://www.bluecrossvt.org/documents/provider-handbook

Summary:	Section 4 Integrated Health Functions
Explanation:	Under Retrospective Review of Prior Approvals - Act 111 – Blueprint Primary Care Provider (BP PCP) waiver of Prior Authorization, added the following note: Note: Retrospective prior authorization consideration will not be given to claims that did not report the ordering provider information correctly (or at all) on the claim form or electronic submission. See Section 12 of our on-line Provider Handbook for submission details. In these cases, a correct claim must be submitted with the ordering provider's information.
Effective Date:	N/A clarification to existing requirement

Link to Policy/ Manual:	https://www.bluecrossvt.org/documents/provider-handbook

Summary:	Section 10 Provider Voucher and 835 Transactions
Explanation:	Under Provider Voucher Reporting Variances added the following note: Professional claims – BlueCard issue only – when a member has met their benefits limit, the reporting on the provider voucher does not reflect the member liable for the difference between the total charges and the allowed amount. The 835P does report correctly. You can bill the member for the full charged amount.
Effective Date:	N/A clarification to existing requirement
Link to Policy/ Manual:	https://www.bluecrossvt.org/documents/provider-handbook

Summary:	Section 6.7 Claim Specific Guidelines
Explanation:	Added Drug Wastage see below in red font **Drug Wastage (effective 11/01/25)** The current Corporate Medical Policy for Drug Wastage is becoming a Payment Policy on 11/01/25. See Payment Policy CPP_47 Drug Wastage for details.
Effective Date:	November 1, 2025
Link to Policy/ Manual:	https://www.bluecrossvt.org/documents/provider-handbook

Summary:	Section 6.7 Claim Specific Guidelines
Explanation:	Added Spravato (esketamine) **Spravato (esketamine)** See Payment Policy CPP_40 Spravato (esketamine) for details
Effective Date:	N/A policy has been in effect since December 12, 2024, missed from adding to provider handbook
Link to Policy/ Manual:	https://www.bluecrossvt.org/documents/provider-handbook

Summary:	Section 6.7 Claim Specific Guidelines
Explanation:	Added Supervised Practice of Mental Health and Substance Use Trainees **Supervised Practice of Mental Health and Substance Use Trainees** See Payment Policy CPP_37 for details
Effective Date:	N/A policy has been in effect since 2018, missed from adding to provider handbook
Link to Policy/ Manual:	https://www.bluecrossvt.org/documents/provider-handbook

Summary:	Section 6.4 ClaimsXten-Select™, Cotiviti, Inc., and Clear Claim Connect (C3)

Explanation:	Removed Process to Submit Questions Relating to Coding Denial(s) detail as it is posted to the Provider Policies page, under Provider Payment Policies.
Effective Date:	N/A relocation of information
Link to Policy/ Manual:	https://www.bluecrossvt.org/documents/provider-handbook

Summary:	Section 6 Member Liabilities – How to Locate Information and When to Bill Members
Explanation:	Under Complaint and Grievances Process added the following details regarding what information an appeal should contain: When submitting an appeal request, you must include the member's name, date of birth, member policy identification number (ID number), date(s) of service, charge amount of the claim, and any clinical prior to the procedure that supports the medical necessity of the procedure (not just the results of the procedure).
Effective Date:	N/A clarifying information added
Link to Policy/ Manual:	https://www.bluecrossvt.org/documents/provider-handbook

Summary:	Section 6 Member Liabilities – How to Locate Information and When to Bill Members
Explanation:	Added the following language: **Surcharges and Convenience Fee** - Providers must have a fee-free way to collect member liabilities, regardless of whether a member is using a check, credit card, or debit card. Further, Providers may not impose credit card surcharges or other fees on members using either a personal debit card or an HSA/HRA issued debit card. A member should never be responsible for any additional fees beyond their reported liability.
Effective Date:	N/A clarifying information added
Link to Policy/ Manual:	https://www.bluecrossvt.org/documents/provider-handbook