

Provider Insider

Alabama Medicaid Bulletin

January 2007

The checkwrite schedule is as follows:

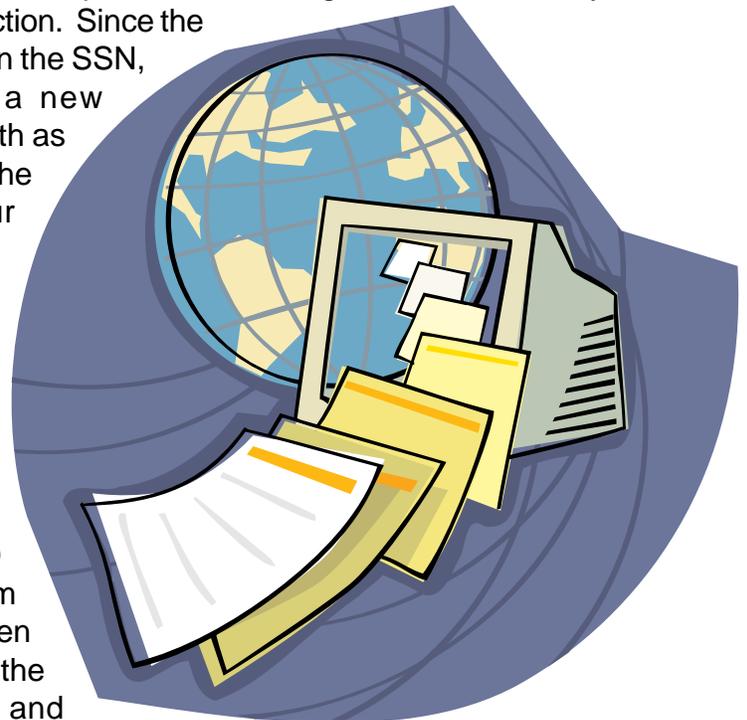
01/05/07 01/19/07 02/09/07 02/23/07 03/09/07 03/23/07

As always, the release of direct deposits and checks depends on the availability of funds.

All Alabama Medicaid Recipient ID Numbers are Changing

Governor Riley signed Act 2006-611 into law which prohibits revealing the Social Security number (SSN) of a person on any document for public inspection. Since the Alabama Medicaid Recipient ID number is based on the SSN, all of the current IDs will be converted to a new number. The new ID number will be the same length as the old number (13 digits including a check digit). The system conversion of these numbers will occur January 13th through 15th, 2007. New identification cards will be issued to all eligible recipients. The new ID cards will be mailed to recipients over a two to four week period after the system conversion is complete.

Since the old ID number will eventually be phased out, it is important that providers begin updating their records as recipients present their new ID cards. After obtaining the new ID number, providers should begin using it for claim submission and eligibility/claim status inquiries. Even though all recipients will receive a new ID number, the old ID number may still be used for all claims and transactions submitted to Alabama Medicaid. This will be allowed until the old ID number is phased out. Providers will be given significant advance notice before the old number is eliminated. Remember to always check eligibility before rendering services.



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Pass It On!

Everyone needs to know the latest about Medicaid.

Be sure to route this to:

- Office Manager
- Billing Dept.
- Medical/Clinical Professionals
- Other _____

Eyecare Providers: Routine Checkups And Medicare

Medicare routinely covers eye care services for medical eye conditions (i.e. glaucoma, cataracts, diabetes, etc.). For dual eligibles (recipients with Medicare and Medicaid), Medicaid is the payer of last resort. For medical eye conditions, Medicare should be billed first for consideration of payment. Upon Medicare payment, the crossover form and information should be forwarded to EDS for consideration of Medicaid payment. Should Medicare deny payment for a medical eye condition, seek all corrective Medicare remedies to ensure payment.

Medicare does not cover routine "Examination of Eyes and Vision" for a non-medical reason. When non-medical and routine "Examination of Eyes and Vision" services are denied by Medicare, paper claims (CMS 1500) should be sent to the Medical Support unit at the Alabama Medicaid Agency within 120 days of the Medicare EOMB date. The CMS 1500 claim must have the Medicare denial attached. These claims require manual review for appropriateness and will be overridden when indicated.

If the recipient is covered as QMB-only (aid category 95) and Medicare denies a vision service for any reason, Medicaid will deny payment also.

EPSDT Interperiodic Screening Codes Have Changed

Effective for dates of service January 1, 2007, and thereafter, the EPSDT Interperiodic screening codes changed. In order to bill an EPSDT Interperiodic screening, the following procedure codes **must** be utilized with an **EP modifier**:

- 99211EP-99215EP – Office and/or Outpatient setting
- 99233EP – Inpatient Hospital setting

The Evaluation and Management code level of care chosen must be supported by medical record documentation. It is **very important** to append the EP modifier when filing for an Interperiodic screening, as these screenings will not count against benefit limits. Refer to Chapter 28 for policy concerning filing office visits, inpatient visits and EPSDT screenings on the same date of service by the same provider or provider group.

Long Term Care Waivers Amended

The Alabama Medicaid Agency has received federal approval to amend two waiver programs, making it possible for more Medicaid recipients to receive the support they need to transition to a community-based setting. Both changes are retroactive to October 1, 2006

Approval was granted by the Centers for Medicare and Medicaid Services (CMS) to amend the State of Alabama Independent Living (SAIL) Waiver and the HIV/AIDS Waiver programs to fund case management activities to facilitate an individual's transition from a nursing facility, hospital or intermediate care facility for the mentally retarded into a community setting. Individuals served under the two waiver programs may receive case management services while they are still institutionalized for up to 180 consecutive days prior to being transitioned from the institution.

Additionally, CMS approved an amendment to the SAIL Waiver to permit environmental accessibility adaptations to assist an individual in transitioning from an institutional level of care to the SAIL Waiver. This change will help fund the necessary modifications, such as a wheelchair ramp or doorway revisions, to enable a waiver service recipient to receive services in the community.

The State of Alabama Independent Living (SAIL) Waiver provides services to disabled adults 18 years of age or older who have specific medical diagnoses and who would otherwise qualify for care in a nursing care facility. The SAIL Waiver is operated by the Alabama Department of Rehabilitation Services.

The HIV/AIDS Waiver provides services to qualifying adults diagnosed with HIV, AIDS and/or related illnesses who would otherwise require care in a nursing facility or institution. The HIV/AIDS Waiver is operated by the Alabama Department of Public Health.

For more information on Alabama Medicaid's Waiver programs, visit the website at www.medicaid.alabama.gov.



PMP Open Caseloads

The Agency has identified instances where providers are informing recipients they are not accepting new patients but have space available on their panel for assignments. Providers should be aware recipients will continue to be assigned to their Patient 1st panels based on the assignment process if caseload is available and criteria can be met (i.e. county, age, etc.). It is confusing and troublesome to recipients that are assigned to PMPs who refuse to provide care for them and who are then not able to seek care elsewhere due to referral requirements.

It is the responsibility of the PMP to notify EDS' Provider enrollment of any changes they wish to make to their caseload status, especially if they wish to decrease their available caseload. Otherwise, providers should accept enrollees for the purpose of providing and managing their health care needs.

Additionally, the PMP must accept individuals in the order in which they apply without restriction up to the limits set by the PMP and the Agency. Any changes made to the PMP's panel should be with the understanding that no individuals eligible to enroll in Patient 1st will be discriminated against on the basis of health status or the need for health care services.

Third Party Billing for EPSDT Services and Vaccines For Children (VFC)

Physicians and health departments are not required to file a recipient's primary insurance prior to filing Medicaid for preventive EPSDT services, including administration fees for VFC. **Exceptions** to this rule are as follows:

- (1) If the recipient has other insurance on file with Medicaid and their plan code is an "H", all services must be filed with the primary insurance first. The "H" does not always designate an HMO. Plan code "H" may indicate a prepaid health plan, or any policy that requires the use of an assigned provider. You may verify if Medicaid has assigned a plan code "H" through Provider Electronics Solutions (PES). The eligibility request response will inform you of the primary insurance carrier name, address, and plan coverage description. These items will be listed under "Other or Additional Payer (Buy-In & TPL)". You may also verify a plan code assignment "H" through AVRS at 1-800-727-7848. Please refer to the Alabama Medicaid Provider Manual – Appendix L for detailed instructions. If the plan coverage description/limitation is type "H", all services must be filed first to the primary insurance carrier. This includes all EPSDT services and Vaccines for Children administration fees. Although VFC administration fees must be filed to primary insurance first, for those with a plan code "H", vaccines may be given from your VFC stock.
- (2) If the provider is a Federally Qualified Health Clinic (FQHC), Independent Rural Health Clinic (IRHC) or Provider Based Rural Health Clinic (PBRHC), all services, including EPSDT and VFC, must be billed to the recipient's primary insurance first.

You may also access the Provider Electronic Solutions Manual and the following chapter / appendixes of the Provider Manual at www.medicaid.alabama.gov or you may contact the Provider Assistance Center at 1-800-688-7989, if additional information is needed:

Chapter 3 – Verifying Recipient Eligibility

Appendix K – Top 200 Third Party Carrier Codes

Appendix L – AVRS Quick Reference Guide

Attention DME Providers

Effective November 15, 2006, HCPC codes K0800-K0802, K0806-K0808, K0812-K0816, K0820-K0831, K0835-K0843, K0848-K0864, K0868-K0871, K0877-K0880, K0884-K0886, K0890, K0891 and K0898 will be used as appropriate for related motorized wheelchairs. Effective November 15, 2006, procedure codes K0010, K0011, K0012 and K0014 will no longer be used to cover motorized power wheelchairs.

Alabama Medicaid has added medical criteria for the Ventilator, BIPAP and CPAP machines. Please refer to the DME List Serv and the upcoming ALERT for this information. This new medical criteria will also be published in Chapter 14 of the January 2007 DME Provider Manual.

If you have any additional questions or need further clarification, please contact Ida Gray, at (334) 353-4753.



All Alabama Medicaid Recipient ID Numbers are Changing

Continued from Page 1

Most Alabama Medicaid recipients will learn their new ID number when they receive a new plastic ID card. The card, used to verify eligibility for Medicaid covered services, will be identical to the previous card except that the 13-digit number will start with a "5" instead of a "0" and will not contain the Social Security number. Cards will be issued over several weeks starting in mid-January of 2007.

Unborn babies, people who are on Medicaid in the nursing home or people who only get Medicare premiums paid by Medicaid will get a letter with the new Medicaid number instead of a card. In the case of unborn babies or those in nursing homes, the letter may be mailed to the baby's mother or nursing home patient's sponsor. Recipients, payees or sponsors who receive a letter are strongly encouraged to keep the letter for reference.

Since the old ID number will eventually be phased out, Alabama Medicaid providers are encouraged to update patient records as recipients present their new ID cards. Providers will be able to use the new number immediately although the old ID number may still be used for all claims and transactions submitted to Alabama Medicaid.

A letter explaining the change was sent to all recipients in early December. Recipients should call 1-800-362-1504 if they have questions or need to change their address.

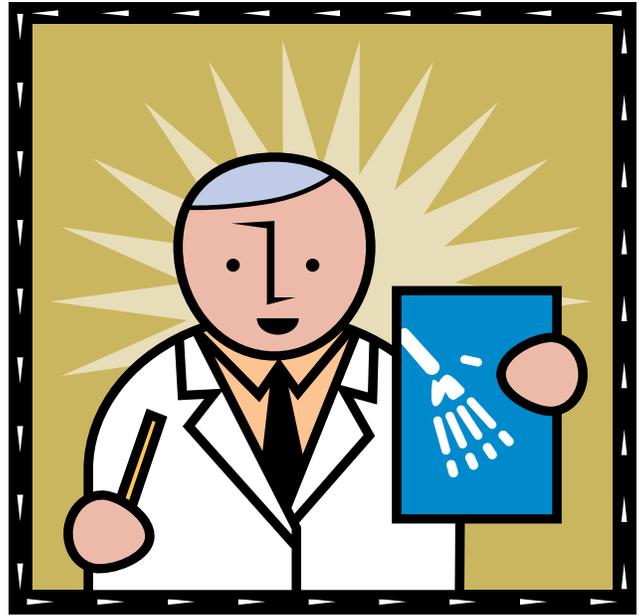
Providers who call with questions should be directed to the EDS provider help center at 1-800-688-7989. Information may also be found on the Medicaid website at: http://www.medicaid.alabama.gov/news/medicaid_id_numbers.aspx?tab=2



www.medicaid.alabama.gov

Patient 1st Referral Report

Coordination of care through the referral process is an important component of the Patient 1st Program. The appropriateness, duration and comprehensiveness of referrals are to be determined by the Primary Medical Provider (PMP). On occasion however, referrals are issued without the authorization of the PMP. In order to assist in identifying unauthorized use of referral numbers, the Agency provides a monthly Referral report. This report documents recipients who have had visits based on a referral using the PMP's referral number. The Patient 1st program is requesting each PMP carefully review this report and notify us of any identified discrepancies. Keep in mind, if a "cascading" referral is authorized by the PMP, the consulting physician may send the recipient on for visits to an entirely different provider. A "cascading" referral is one in which the PMP authorizes the consulting physician to refer the recipient to other providers for identified conditions or for additional conditions identified by the consulting physician. When reviewing the Referral report this might appear as an unauthorized referral. Please be aware of this when notifying the Agency of any suspected misuse of referral numbers. If you are not currently receiving the Referral Report or if you have questions regarding this report please contact Paige Clark at (334) 242-5148 or Gloria Wright at (334) 353-5907. Thank you for your interest and participation in the Patient 1st Program.



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Alabama
Medicaid
Bulletin



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