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CHAPTER SIX

PHYSICIANS PROGRAM

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Chapter 6. Physicians.

Rule No. 560-X-6-.01.- Physician Program - General.

(1) The term "physician" shall mean (a) a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the state in which the doctor performs such functions; (b) a doctor of dentistry or of dental or oral surgery who is licensed to practice in the state in which the service is rendered, and legally authorized to perform such function but only with respect to: surgery related to the jaw, the reduction of any fracture related to the jaw or facial bones, or surgery within the oral cavity for removal of lesions or the correction of congenital defects.

(2) Participation. Providers who meet enrollment requirements are eligible to participate in the Alabama Medicaid Program. An enrollment application may be requested from HP Enterprise Services (HPES) Provider Enrollment, 301 Technacenter Drive, Montgomery, AL 36117, or downloaded from the Medicaid website at www.medicaid.alabama.gov. Completed enrollment applications should be returned to HPES Provider Enrollment.

Physicians having limited licenses will not be enrolled by the Medicaid fiscal agent unless complete information as to the limitations and reasons is submitted in writing to the Provider Enrollment Unit for review and consideration for enrollment.

(3) Non-physician Practitioner Services--Medicaid payment may be made for the professional services of the following physician-employed practitioners:

physician assistants (PAs)
certified registered nurse practitioners (CRNPs)

PAs and CRNPs: The Alabama Medicaid Agency will make payment for services of certified physician assistants (PAs) and certified registered nurse practitioners (CRNPs) who are legally authorized to furnish services and who render the services under the supervision of an employing physician with payment made to the employing physician. Medicaid will not make payment to the PA or CRNP.

a. The employing-physician must be an Alabama Medicaid provider in active status.

b.. The PA or CRNP must enroll with the Alabama Medicaid Agency and receive an Alabama Medicaid provider number with the employing-physician as the payee.

c. Covered services furnished by the PA or CRNP must be billed under the PAs or CRNPs name and National Provider Identifier (NPI) number.

d. PA or CRNP approved services include all injectable drugs, all laboratory services in which the laboratory is CLIA certified to perform, and select CPT

codes authorized for independent CRNPs and are listed in Appendixes H and O of the Alabama Medicaid Billing Manual.

e. The office visits performed by the PA or CRNP will count against the recipient's yearly benefit limitation.

f. The PA or CRNP must send a copy of the prescriptive authority granted by the licensing board for prescriptions to be filled. This information must be sent to:

HPES Provider Enrollment
301 Technacenter Drive
Montgomery, AL 36117

g. The PA or CRNP cannot make physician-required visits to hospitals or other institutional settings to qualify for payment to the physician or to satisfy current regulations as physician visits.

h. The employing-physician need not be physically present with the PA or CRNP when the services are being furnished to the recipient; however, he/she must be immediately available to the PA or CRNP for direct communication by radio, telephone, or telecommunication.

i. The PA's or CRNP's employing physician is responsible for the PA's or CRNP's professional activities and for assuring that the services provided are medically necessary and appropriate for the patient.

j. There shall be no independent, unsupervised practice by PAs or CRNPs.

(4) Physicians are expected to render medically necessary services to Medicaid patients in the same manner and under the same standards as for their private patients, and bill the Alabama Medicaid Agency their usual and customary fee.

(5) Payments from Medicaid funds can be made only to physicians who provide the services; therefore, no reimbursement can be made to patients who may personally pay for the service rendered.

(6) Refer to Chapter 20 concerning third-party insurance carriers.

(7) The physician agrees when billing Medicaid for a service that the physician will accept as payment in full, the amount paid by Medicaid for that service, plus any cost-sharing amount to be paid by the recipient, and that no additional charge will be made. The physician shall not charge or bill the recipient for cancelled or missed appointments. Conditional collections from patients, made before Medicaid pays, which

are to be refunded after Medicaid pays, are not permissible. The physician may bill the patient, in addition to the cost-sharing fee, for services rendered in the following circumstances:

(a) When benefits are exhausted for the year,

(b) When the service is a Medicaid non-covered benefit.

(8) A hospital-based physician who is a physician employed by and paid by a hospital may not bill Medicaid for services performed therein and for which the hospital is reimbursed. A hospital-based physician shall bill the Medicaid Program on a CMS-1500, Health Insurance Claim Form or assign their billing rights to the hospital, which shall bill the Medicaid Program on a CMS-1500 form. A hospital-based physician who is not a physician employed by and paid by a hospital shall bill Medicaid using a CMS-1500 Health Insurance Claim Form.

(9) A physician enrolled in and providing services through a residency training program shall not bill Medicaid for services performed. Medicaid will no longer require physicians enrolled in and providing services through a **residency** training program be assigned a pseudo Medicaid license number to be used on prescriptions written for Medicaid recipients. Effective for claims submitted on or after January 1, 2012, interns and non-licensed residents must use the NPI or license number of the teaching, admitting, or supervising physician.

(10) Supervising physicians may bill for services rendered to Medicaid recipients by residents enrolled in and providing services through a residency training program. The following rules shall apply to physicians supervising residents:

(a) The supervising physician shall sign and date the admission history and physical and progress notes written by the resident.

(b) The supervising physician shall review all treatment plans and medication orders written by the resident.

(c) The supervising physician shall be available by phone or pager.

(d) The supervising physician shall designate another physician to supervise the resident in his/her absence.

(e) The supervising physician shall not delegate a task to the resident when regulations specify that the physician perform it personally or when such delegation is prohibited by state law or the facility's policy.

(11) Off Site Mobile Physician's Services shall comply with all Medicaid rules and regulations as set forth in the State Plan, Alabama Medicaid Administrative Code, and Code of Federal Regulations including but not limited to the following requirements:

(a) Shall provide ongoing, follow-up, and treatment and/or care for identified conditions,

(b) Shall provide ongoing access to care and services through the maintenance of a geographically accessible office with regular operating business hours within the practicing county or within 15 miles of the county in which the service was rendered,

(c) Shall provide continuity and coordination of care for Medicaid recipients through reporting and communication with the Primary Medical Provider,

(d) Shall maintain a collaborative effort between the off-site mobile physician and local physicians and community resources. A matrix of responsibility shall be developed between the parties and available upon enrollment as an off-site mobile physician,

(e) Shall provide for attainable provider and recipient medical record retrieval,

(f) Shall maintain written agreements for referrals, coordinate needed services, obtain prior authorizations and necessary written referrals for services prescribed. All medical conditions identified shall be referred and coordinated, for example:

1. Eyeglasses,
2. Comprehensive Audiological services,
3. Comprehensive Ophthalmological services,
4. Patient 1st and EPSDT Referrals,

(g) Shall not bill Medicaid for services which are free to anyone. Provider shall utilize a Medicaid approved sliding fee scale based on Federal Poverty Guidelines,

(h) Shall ensure that medical record documentation supports the billing of Medicaid services, and

(i) Shall obtain signed and informed consent prior to treatment.

(12) (a) Effective April 1, 2008, all prescriptions for outpatient drugs for Medicaid recipients which are executed in written (and non-electronic) form must be executed on tamper-resistant prescription pads. The term "written prescription" does not include e-prescriptions transmitted to the pharmacy, prescriptions faxed to the pharmacy, or prescriptions communicated to the pharmacy by telephone by a prescriber. This requirement does not apply to refills of written prescriptions which were executed before April 1, 2008. It also does not apply to drugs provided in nursing facilities, intermediate care facilities for the mentally retarded, and other institutional and clinical settings to the extent the drugs are reimbursed as part of a per diem amount, or where the order for a drug is written into the medical record and the order is given directly to the pharmacy by the facility medical staff.

(b) To be considered tamper-resistant on or after April 1, 2008, a prescription pad must contain at least one of the following three characteristics:

1. one or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form; or

2. one or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber; or

3. one or more industry-recognized features designed to prevent the use of counterfeit prescription forms.

(c) To be considered tamper-resistant on or after October 1, 2008, a prescription pad must contain all of the foregoing three characteristics.

Author: Desiree Nelson; Program Manager; Medical Support
Statutory Authority: Title XIX, Social Security Act; 42 CFR, §§ 447.15, 405.522, .523, 401, et seq.; Code of Alabama §§ 34-24-75(d)(1975); State Plan.
History: Rule effective October 1, 1982. **Amended:** effective April 15, 1983, March 12, 1984, May 9, 1984, June 9, 1985, March 12, 1987; March 15, 1994; January 12, 1995; March 13, 1998; June 12, 2000; March 12, 2001; June 14, 2002; May 16, 2003; March 17, 2005; September 14, 2006; July 16, 2008. **Amended:** Filed May 11, 2012; effective June 15, 2012.

Rule No. 560-X-6-.02. Submission of Claims - General

(1) Effective March 1, 2010, all claims that do not require attachments (TPL denial), manual review (unclassified J codes), and an Administrative Review override by Medicaid or additional information to be printed on the claim (Work Incentive Program) must be submitted electronically to HPES. All paper claims received by HPES which do not meet the above requirements will be returned to the provider without being processed. Paper claims meeting the requirements should be submitted on CMS-1500 (Health Insurance Claim) forms. Each claim filed by a physician constitutes a contract with Medicaid.

(2) For claim filing limitations, refer to Chapter 1, Rule 560-X-1-.17.

(3) Physicians who want to participate in the Alabama Medicaid Program must be enrolled and receive a provider number.

(4) Claims must include the name and NPI number of the physician who takes responsibility for the services. The NPI number must identify the responsible individual, not a group or institution. Reimbursement may be made to a physician submitting a claim for services furnished by another physician in the event there is a reciprocal arrangement. The regular physician shall identify the services as substitute physician services by entering HCPCS modifier **Q5** (Service Furnished by a Substitute Physician under a Reciprocal Arrangement) or HCPCS modifier **Q6** (Service Furnished by a Locum Tenens Physician) after the procedure code. The substitute physician must be enrolled with Medicaid as an active provider. The reciprocal arrangement may not exceed 14 continuous days in the case of an informal arrangement or 60 continuous days in the case of an arrangement involving per diem or other fee-for-time compensation. The regular physician should keep a record on file of each service provided by the substitute physician and make this record available to Medicaid upon request. Payment may not be made for services provided by providers who have been suspended or terminated from participation in the Medicaid program. See Rule No. 560-X-4-.04 for details. Claims will be subject to post-payment review. Refer to the Alabama Medicaid Provider Manual, Chapter 28 for information regarding modifiers Q5 and Q6.

(5) Incomplete or inaccurate claim forms submitted for processing will be returned to the provider by the Medicaid fiscal agent for the necessary information.

(6) Before submitting a claim, a careful check should be made to see that the Medicaid identification number agrees with the number and exact spelling of the name on the patient's plastic Medicaid eligibility card.

(7) In filling out claim forms, providers must use diagnosis codes from the ICD-9-CM Code Book and procedure codes from the CPT Code Book, or approved procedures codes designated by Medicaid.

(8) Factoring arrangements in connection with the payment of claims under Medicaid are prohibited.

(9) Medicaid's fiscal agent will furnish to new providers a manual containing billing instructions.

(10) Pharmacists must have the physician's license number prior to billing for prescriptions. Refer to Chapter 16.

(11) Fragmentation of procedures, including laboratory procedures, under the Medicaid program is prohibited.

Author: Desiree Nelson; Program Manager; Medical Support
Statutory Authority: Title XIX, Social Security Act; 42 C.F.R., §§ 401, et seq.; State Plan; Omnibus Budget Reconciliation Act of 1990 (Public Law 105-508).
History: Rule effective October 1, 1982. **Amended**: effective March 12, 1984; November 11, 1985; March 12, 1987. **Emergency rule** effective April 1, 1991. **Amended**: effective July 13, 1991; October 13, 1992; March 15, 1994; January 12, 1995; June 14, 2002. **Amended:** Filed May 11, 2012; effective June 15, 2012.

Rule No. 560-X-6-.03. Submission of Claims by Hospital-Based Physicians.

Hospital-based physicians will be reimbursed under the same general system as is used in Medicare. Bills for services rendered will be submitted as follows:

(1) All hospital-based physicians, including emergency room physicians, radiologists, and pathologists, shall bill the Medicaid program on a CMS-1500, Health Insurance Claim form or assign their billing rights to the hospital, which shall bill the Medicaid program on a CMS-1500 (Health Insurance Claim) form.

(a) Physician services personally rendered for individual patients will be paid only on a reasonable charge basis (i.e., claims submitted under an individual provider number on a physician claim form). This includes services provided by a radiologist and/or pathologist.

(b) Reasonable charge services are: 1) personally furnished for a patient by a physician; 2) ordinarily require performance by a physician and; 3) contribute to the diagnosis or treatment of an individual patient.

(2) Services of hospital-based physicians that do not meet the criteria of reasonable charge as define above, but benefit a hospital or its patient are reimbursable only on a reasonable cost basis through the hospital cost report. Please refer to Laboratory, Radiology, and Hospital Chapters of this code for further details.

Author: Desiree Nelson; Program Manager; Medical Support
Statutory Authority: Title XIX, Social Security Act; 42 C.F.R., §§ 405.401, et seq.; State Plan.
History: Rule effective October 1, 1982. **Emergency rule** effective October 1, 1984; January 8, 1985. **Amended**: effective March 12, 1987; January 12, 1995. **Amended:** Filed May 11, 2012; effective June 15, 2012.

Rule No. 560-X-6-.04. Submission of Claims: Routing of Claims.

(1) MEDICAID ELIGIBLES.

(a) Claims should be submitted to the fiscal agent in accordance with instructions for these patients who are enrolled for MEDICAID ONLY.

(b) Reimbursement for physicians' services will NOT be made to the patient, sponsor, or nursing facility. The Medicaid program does not provide for reimbursement of this expense to these individuals or facilities.

(2) MEDICARE ELIGIBLES.

(a) For Medicaid patients who are also enrolled for benefits under Part B refer to Chapter 1, this Code and the Alabama Medicaid Provider Manual.

Authority: Title XIX, Social Security Act; 42 CFR, Section 401, Et seq.; and State Plan. Rule effective October 1, 1982. Amended May 9, 1984, and March 12, 1987. Emergency rule effective February 1, 1989. Amended May 12, 1989. Effective date of this amendment March 15, 1994.

Rule No. 560-X-6-.05. Submission of Claims: Out-of-State Claims DO NOT Need Prior Approval.

Except for those services which require prior approval as stated in Chapters 1 and 6 of this Administrative Code (i.e. transplants and select surgeries), medical care outside the State of Alabama does not require prior authorization by the Alabama Medicaid Agency.

Authority: Title XIX, Social Security Act; 42 C.F.R. Section 401, Et seq.; State Plan. Rule effective October 1, 1982. Amended October 9, 1984; March 12, 1987 and October 13, 1992. Effective date of this amendment March 15, 1994.

Rule No. 560-X-6-.06. Medicaid Provider Payments.

Payment from Medicaid funds can be made to the actual provider of service only. The only exceptions to this rule are payments made within the same group, or for substitute physicians.

Authority: Title XIX, Social Security Act; 42 C.F.R. Section 401, Et seq.; State Plan. Rule effective March 15, 1994.

Rule No. 560-X-6-.07. Enrollment of Out-of-State Providers.

An out-of-state physician who wishes to participate in the Alabama Medicaid Program must enroll with the Alabama Medicaid Program and be assigned a provider identification number. To do so, the physician should send a written request to Medicaid's fiscal agent, Provider Enrollment Division. The following information must be included in the enrollment application:

1. Name;
2. Address of Place of Business;
3. Provider Type and specialty;
4. Social Security Number;
5. Federal Employer Identification Number;
6. Medicaid License Number;
7. Personal Historical Data; and
8. Original Provider Signature.

Authority: Title XIX, Social Security Act; 42 C.F.R. Section 401, Et seq.; State Plan. Rule effective October 1, 1982. Amended May 9, 1984, March 12, 1987 and March 15, 1994. Effective date of this amendment January 12, 1995.

Rule No. 560-X-6-.08. Consent Statements Required Before Services Are Provided.

Refer to the rules regarding consent and authorization contained in paragraphs within this chapter regarding sterilization, and abortions, Chapter 14 of this Code, and to Title 22, Chapter 8, Code of Alabama, 1975. NOTE: Non-therapeutic sterilization performed for the sole purpose of rendering a person permanently incapable of reproducing is not available to persons under twenty-one (21) years of age under the Medicaid Program.

Arthur: Mary Timmerman, Associate Director, Medical Services Program
Statutory Authority: Title XIX, Social Security Act; 42 C.F.R. Section 441.257; Section 401, Et seq.; State Plan.
History: Rule effective October 1, 1982 and March 12, 1987. Amended March 15, 1994. Amended: Filed March 20, 2002; effective June 14, 2002.

Rule No. 560-X-6-.09. Consent Forms Required Before Payments Can Be Made.

(1) Abortions: A claim seeking payment for an abortion must be accompanied by one or more (depending on the circumstance) of the forms required by federal law and a copy of the medical records. Payment is available for abortions as provided under federal law.

In the event the abortion does not meet the requirements of federal law, and the recipient elects to have the abortion, the provider may bill the recipient for the abortion.

(2) Sterilization: A claim seeking payment for sterilization must be accompanied by a sterilization form (Form 193) or Medicaid approved substitute.

Sterilization by Hysterectomy

(a) Payment is not available for a hysterectomy if:

1. It was performed solely for the purpose of rendering an individual permanently incapable of reproducing, or

2. If there was more than one purpose to the procedure, it would not have been performed but for the purpose of rendering the individual permanently incapable of reproducing.

Hysterectomy procedures performed for the sole purpose of rendering an individual incapable of reproducing are no longer covered under Medicaid. Hysterectomies done as a medical necessity as treatment of disease can be paid for by the Medicaid funds under the physician's program.

(b) A claim seeking payment for a hysterectomy performed for reasons of medical necessity, and not for purpose of sterilization, must be accompanied by a Hysterectomy Consent Form PHY-81243 (rev. 02-10-2010) or Medicaid approved substitute. The doctor's explanation to the patient that the operation will make her sterile, and the doctor's and recipient's signature must precede the operation except in the case of unusual circumstances.

The physician who performed the hysterectomy must complete Part IV. Unusual Circumstances of the revised hysterectomy consent form certifying that, (1) the patient was already sterile when the hysterectomy was performed; the cause of sterility must be stated and supporting medical records (history and physical, operative notes, and discharged summary) must be attached, or (2) the hysterectomy was performed under a life-threatening emergency situation in which prior acknowledgement was not possible. Medical records supporting life-threatening emergency situation must be attached, or (3) the hysterectomy was performed during a period of retroactive Medicaid eligibility, and before the operation was performed, the physician informed the recipient that she would be permanently incapable of reproducing as a result of the operation.

Surgeons are responsible for submitting hard copy hysterectomy consent forms to HPES. The form must be signed by both the patient, or a representative, and the physician.

Author: Desiree Nelson; Program Manager; Medical Support.
Statutory Authority: Title XIX, Social Security Act; 42 C.F.R. §§ 401, et seq.; State Plan.
History: Rule effective October 1, 1982. **Amended:** effective March 12, 1987. **Emergency rule** effective March 1, 1989. **Amended:** June 16, 1989; March 15, 1994; June 14, 2002; May 16, 2003. **Amended**: Filed May 11, 2012; effective June 15, 2012.

Rule No. 560-X-6-.10. Physician's Role in Certification and Recertification.

(1) For information about hospital certification and recertification see Rule No. 560-X-7-.16.

(2) In a skilled or intermediate nursing care facility, in the hospital and for the Home Health Care Program, Medicaid patients must be recertified by a physician at least every sixty (60) days. The certification form will be made a permanent part of the patient's record.

Authority: Title XIX, Social Security Act, 42 C.F.R. Section 401, Et seq.; State Plan. Rule effective October 1, 1982. Amended July 8, 1983 and March 12, 1987. Effective date of this amendment March 15, 1994.

Rule No. 560-X-6-.11. Physician's Role in Extension of Hospital Days.

(1) With the exception of Medicaid recipients eligible for treatment under the EPSDT (MediKids) program, additional hospital days are not covered. Refer to Chapter 7, Hospital Program and Chapter 11, EPSDT, for specifics.

Authority: Title XIX, Social Security Act, 42 C.F.R. Section 401, Et seq.; State Plan. Rule effective October 1, 1982. Amended July 8, 1983 and March 12, 1987. Effective date of this amendment March 15, 1994.

Rule No. 560-X-6-.12. Covered Services: General

(1) In general, physician services are covered by Medicaid if the services are:

(a) Considered medically necessary by the attending physician. However, when the persons designated responsible for utilization review have issued a denial for inpatient days, no ancillary charge or professional charges will be reimbursed during the denied period.

(b) Designated by procedure codes in Physicians' Current Procedural Terminology (CPT), or designated by special procedure codes created by Medicaid for its own use.

(2) Physicians will not be paid for and should not submit claims for laboratory work done for them by independent laboratories or by hospital laboratories. Physicians may submit claims for laboratory work done by them in their own offices or own laboratory facilities. For specific information concerning the "professional component" and drawing and extraction reimbursement, see the laboratory chapter.

(3) If a physician is not sure whether a service is covered, that physician can contact the HPES Provider Assistance Center.

Author: Desiree Nelson, Program Manager; Medical Support
Statutory Authority: Title XIX, Social Security Act; 42 C.F.R, §§401, et seq.; State Plan.
History: Rule effective October 1, 1982. **Amended**: effective June 5, 1983; May 9, 1984; May 8, 1985; March 12, 1987; March 15, 1994; January 12, 1995; June 14, 2002. **Amended:** Filed May 11, 2012; effective June 15, 2012.

Rule No. 560-X-6-.13. Covered Services: Details on Selected Services.

(1) Acupuncture: Not covered.

(2) Administration of anesthesia is a covered service when administered by or directed by a duly licensed physician for a medical procedure which is a covered service under the Alabama Medicaid Program. Medical direction by an anesthesiologist of more than four Certified Registered Nurse Anesthetists (CRNAs) or Anesthesiology Assistants (AAs) concurrently will not be covered. For billing purposes, anesthesia services rendered with medical direction for one CRNA or AA is considered a service performed by the anesthesiologist. In order to bill for medical supervision, the anesthesiologist must be physically present and available within the operating suite. "Physically present and available" means the anesthesiologist would not be available to render direct anesthesia services to other patients. However, addressing an emergency of short duration or rendering the requisite CRNA or AA supervision activities (listed below in a. through g.) within the immediate operating suite is acceptable as long as it does not substantially diminish the scope of the supervising anesthesiologist's control. If a situation occurs which necessitates the anesthesiologist's personal continuing involvement in a particular case, medical supervision ceases to be available in all other cases. In order for the anesthesiologist to be reimbursed for medical supervision activities of the CRNA or AA , the anesthesiologist must document the performance of the following activities:

(a) performs a pre-anesthesia examination and evaluation;

(b) prescribes the anesthesia plan;

(c) personally participates in the most demanding procedures in the anesthesia plan, including induction as needed, and emergencies;

(d) ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified individual;

(e) monitors the course of anesthesia administration at frequent intervals;

(f) remains physically present and available for immediate diagnosis and treatment of emergencies; and

(g) provides indicated post-anesthesia care.

Administration of anesthesia by a self-employed Certified Registered Nurse Anesthetist (CRNA) is a covered service when the CRNA has met the qualifications and standards set forth in Rule No. 610-X-9-.01 through 610-X-9-.04 of the Alabama Board of Nursing Administrative Code. The CRNA must enroll and receive a provider number to bill under the Alabama Medicaid Program. When billing for anesthesia services, providers shall follow the guidelines set forth in the current Relative Value Guide published by the American Society of Anesthesiologists for basic value and time units. No Physical Status Modifiers can be billed.

Administration of anesthesia by a qualified Anesthesiology Assistant (AA) is a covered service when the AA has met the qualifications and standards set forth in the Alabama Board of Medical Examiners Administrative Code. Reimbursement shall be made only when the AA performs the administration of anesthesia under the direct medical supervision of the anesthesiologist.

Anesthesia services may include, but are not limited to, general anesthesia, regional anesthesia, supplementation of local anesthesia, or other supportive treatment administered to maintain optimal anesthesia care deemed necessary by the anesthesiologist during the procedure. Anesthesia services include all customary preoperative and postoperative visits, the anesthesia care during the procedure, the administration of any fluids deemed necessary by the attending physician, and any usual monitoring procedures. Therefore, additional claims for such services should not be submitted.

(h) Local anesthesia is usually administered by the attending surgeon and is considered to be part of the surgical procedure being performed. Thus, additional claims for local anesthesia by the surgeon should not be filed. Any local anesthesia administered by an attending obstetrician during delivery (i.e. pudendal block or paracervical block) is considered part of the obstetrical coverage. Thus, additional claims for local anesthesia administered by an attending obstetrician during delivery should not be filed.

(i) When regional anesthesia (i.e., nerve block) is administered by the attending physician during a procedure, the physician's fee for administration of the anesthesia will be billed at one-half the established rate for a comparable service when performed by an anesthesiologist. When regional anesthesia is administered by the attending obstetrician during delivery (i.e., saddle block or continuous caudal), the obstetrician's fee for administration of the anesthesia will be billed at one-half the established rate for a comparable service performed by an anesthesiologist. When regional anesthesia is administered by an anesthesiologist during delivery or other procedure, the anesthesiologist's fee will be covered and should be billed separately.

(j) When a medical procedure is a noncovered service under the Alabama Medicaid Program, the anesthesia for that procedure is also considered to be a noncovered service.

(3) Artificial Eyes: Must be prescribed by a physician.

(4) Autopsies: Not covered.

(5) Biofeedback: Not covered.

(6) Blood Tests: Not covered for marriage licenses.

(7) CAT Scans, CTA's, MRI's, MRA's and PET scans: See Chapter 34 of this code for specific details.

(8) Chiropractors: Not covered, except for QMB recipients and for services referred directly as a result of an EPSDT screening.

(9) Chromosomal Studies: Chromosomal studies (amniocentesis) on unborn children being considered for adoption are not covered. Medicaid can pay for these studies in the case of prospective mothers in an effort to identify conditions that could result in the birth of an abnormal child.

(10) Circumcision: Circumcision of newborns is a covered service. If medically necessary, non-newborn circumcision is covered.

(11) Diet Instruction: Diet instruction performed by a physician is considered part of a routine visit.

(12) Drugs:

(a) Non-injectable drugs: See Chapter 16 of this Code.

(b) Injectable drugs: Physicians who administer injectable drugs to their patients may bill Medicaid for the cost of the drug by using the procedure code designated by Medicaid for this purpose. The injectable administration code may be used only when an office visit or nursing home visit is not billed.

(13) Examinations: Office visits for examinations are counted as part of each recipient's annual office visit limit. See Rule No. 560-X-6-.14 for details about this limit.

(a) Annual routine physical examinations are not covered.

(b) Medical examinations for such reasons as insurance policy qualifications are not covered.

(c) Physical examinations for establishment of total and permanent disability status if considered medically necessary are covered.

(d) Medicaid requires a physician's visit once each 60 days for patients in a nursing home. Patients in intermediate care facilities for the mentally retarded will receive a complete physical examination at least annually.

(e) Physical examination, including x-ray and laboratory work, will be payable for recipients eligible through the EPSDT Program if the physician has signed an agreement with Medicaid to participate in the screening program.

(14) Experimental Treatment and/or Surgery: Not covered.

(15) Eyecare:

(a) Eye examinations by physicians are a Medicaid covered service.

(b) Office visits for eyecare disease are counted as part of each recipient's annual office visit limit. See Rule No. 560-X-6-.14 for details about this quota.

(16) Filing Fees: Not covered.

(17) Foot Devices: See Chapter 13 (Supplies, Appliances, and Durable Equipment) for specific details.

(18) Hearing Aids: See Hearing Aids Chapter in this Code.

(19) Hypnosis: Not covered.

(20) Immunizations: Payment for immunizations against communicable diseases will be made if the physician normally charges his patients for this service.

(a) The Department of Public Health provides vaccines at no charge to Medicaid physicians enrolled in the Vaccines For Children (VFC) Program and as recommended by the Advisory Committee on Immunization.

(b) Effective October 1, 1994, the Alabama Medicaid Agency will begin reimbursement of administration fees for vaccines provided free of charge through the Vaccines For Children (VFC) Program.

(c) Medicaid tracks usage of the vaccine through billing of the administration fee using the appropriate CPT codes.

(d) The Omnibus Budget Reconciliation Act of 1993 mandated that Medicaid can no longer cover a single antigen vaccine if a combined antigen vaccine is medically appropriate. This change will become effective January 1, 1994. The single antigen vaccines may still be billed only if prior approved before given and a medical justification is given. These vaccines are diphtheria, measles, mumps, and rubella. In order to request the prior approval for these vaccines, providers should contact the HPES, Prior Authorization Unit at P.O. Box 244036, Montgomery, AL 36124-4036.

(21) Infant Resuscitation: Newborn resuscitation (procedure code 99465) is a covered service when the baby's condition is life threatening and immediate resuscitation is necessary to restore and maintain life functions. Intubation, endotracheal, emergency procedure (procedure code 31500) cannot be billed in conjunction with newborn resuscitation.

(22) Intestinal Bypass: Not covered for obesity.

(23) Laetrile Therapy: Not covered.

(24) Newborn Claims: The five kinds of newborn care performed by physicians in the days after the child's birth when the mother is still in the hospital that may be filed under the mother's name and number or the baby's name and number are routine newborn care and discharge codes, circumcision, newborn resuscitation, standby services following a caesarean section or a high-risk vaginal delivery, and attendance at delivery (when requested by delivering physician) and initial stabilization of newborn. Standby services (procedure code 99360) are covered only when the pediatrician, family practitioner, neonatologist, general practitioner, or OB/GYN is on standby in the operating or delivery room during a cesarean section or a high-risk vaginal delivery. Attendance of the standby physician in the hospital operating or delivery room must be documented in the operating or delivery report. When filing claims for these five kinds of care, CPT codes shall be utilized. All other newborn care (any care other than routine newborn care for a well-baby), before and after the mother leaves the hospital, must be billed under the child's name and number.

(25) Obstetrical Services and Related Services: Office visits for obstetrical care are counted as part of each recipient's annual office visit limit under certain conditions. See Rule No. 560-X-6-.14 for details about this quota.

(a) Family Planning: See the Family Planning Chapter in this Code.

(b) Abortions: See Rule No. 560-X-6-.09 (1).

(c) Hysterectomy: See Rule No. 560-X-6-.09.

(d) Maternity Care and Delivery: The services normally provided in maternity cases include antepartum care, delivery, and postpartum care. When a physician provides total obstetrical care, the procedure code which shall be filed on the claim form is the code for all-inclusive "global" care. The indicated date of service on "global" claims should be the date of delivery. If a woman is pregnant at the time she becomes eligible for Medicaid benefits, only those services provided during the time she is eligible will be covered. When a physician provides eight (8) or more prenatal visits, performs the delivery, and provides the postpartum care, the physician shall use a "global" obstetrical code in billing. If a physician submits a "global" fee for maternity care and delivery, the visits covered by these codes are not counted against the recipient's limit of annual office visits. For purposes of "global" obstetrical billing, services rendered by members of a group practice are to be considered as services rendered by a single provider.

1. Antepartum care includes all usual prenatal services such as initial office visit at which time pregnancy is diagnosed, initial and subsequent histories, physical examinations, blood pressure recordings, fetal heart tones, maternity counseling, etc.; therefore, additional claims for routine services should not be filed. Antepartum care also includes routine lab work (e.g., hemoglobin, hematocrit, chemical urinalysis, etc.); therefore, additional claims for routine lab work should not be filed.

(i) To justify billing for global antepartum care services, physicians must utilize the CPT antepartum care global codes (either 4-6 visits, or 7 or

more visits), as appropriate. Claims for antepartum care filed in this manner do not count against the recipient's annual office visit limit. Physicians who provide less than four (4) visits for antepartum care must utilize CPT codes under office medical services when billing for these services. These office visit codes will be counted against the recipient's annual office visit limit.

(ii) Billing for antepartum care services in addition to "global" care is not permissible; however, in cases of pregnancy complicated by toxemia, cardiac problems, diabetes, neurological problems or other conditions requiring additional or unusual services or hospitalization, claims for additional services may be filed. If the physician bills fragmented services in any case other than high-risk or complicated pregnancy and then bills a "global" code, the fragmented codes shall be recouped. Claims for such services involved in complicated or high risk pregnancies may be filed utilizing CPT codes for Office Medical Services. Claims for services involving complicated or high risk pregnancies must indicate a diagnosis other than normal pregnancy and must be for services provided outside of scheduled antepartum visits. These claims for services shall be applied against the recipient's annual office visit limit.

2. Delivery and postpartum care: Delivery shall include vaginal delivery (with or without episiotomy) or cesarean section delivery and all in-hospital postpartum care. More than one delivery fee may not be billed for a multiple birth (twins, triplets, etc.) delivery, regardless of delivery method(s). Delivery fees include all professional services related to the hospitalization and delivery which are provided by the physician; therefore, additional claims for physician's services in the hospital such as hospital admission, may not be filed in addition to a claim for delivery or a claim for "global" care.

EXCEPTION: When a physician's first and only encounter with the recipient is for delivery ("walk-in" patient) he may bill for a hospital admission (history and physical) in addition to delivery charges.

3. Postpartum care includes office visits following vaginal or cesarean section delivery for routine postpartum care within sixty-two (62) days post delivery. Additional claims for routine visits during this time should not be filed.

4. Delivery only: If the physician performs the delivery only, he must utilize the appropriate CPT delivery only code (vaginal delivery only or C-section delivery only). More than one delivery fee may not be billed for a multiple birth (twins, triplets, etc.) delivery, regardless of the delivery method(s). Delivery fees include all professional services related to the hospitalization and delivery which are provided by the physician; therefore, additional claims for physician's services in the hospital such as hospital admission, may not be filed in addition to a claim for delivery only.

EXCEPTION: When a physician's first and only encounter with the recipient is for delivery ("walk-in" patient) he may bill for a hospital admission (history and physical) in addition to delivery charges.

5. Obstetrical ultrasounds are limited to two per pregnancy. Generally, first ultrasounds are conducted to detect gestational age, multiple pregnancies, and major malformations. Second ultrasounds may be conducted to detect fetal growth disorders (intrauterine growth retardation, macrosomia) and anomalies that would appear later or may have been unrecognizable in the earlier scan.

Additional ultrasounds may be prior approved by the Alabama Medicaid Agency if a patient's documented medical condition meets any of the following criteria:

(i) Gestational diabetes with complications (Type 1 diabetes, vascular disease, hypertension, elevated alpha-fetoprotein values, poor patent compliance);

(ii) Failure to gain weight, evaluation of fetal growth;

(iii) Pregnancy-induced hypertension;

(iv) Vaginal bleeding of undetermined etiology;

(v) Coexisting adnexal mass;

(vi) Abnormal amniotic fluid volume (polyhydramnios, oligohydramnios);

(vii) Pregnant trauma patient;

(viii) Congenital diaphragmatic hernia (CDH);

(ix) Monitoring for special tests such as fetoscopy, amniocentesis, or cervical cerclage placement;

(x) Assist in operations performed on the fetus in the uterus;

(xi) Detection of fetal abnormalities with other indicators or risk factors (Low human chorionic gonadotrophin (HCG) and high unconjugated oestriol (uE3) are predictive of an increased risk for Trisomy 18. Echogenic bowel grades 2 and 3 are indicative of an increased risk of cystic fibrosis and Trisomy 21);

(xii) Determination of fetal presentation;

(xiii) Suspected multiple gestation, serial evaluation of fetal growth in multiple gestation;

(xiv) Suspected hydatidiform mole;

(xv) Suspected fetal death;

(xvi) Suspected uterine abnormality;

(xvii) Suspected abruptio placenta;

(xviii) Follow-up evaluation of placental location for identified placenta previa.

Fee-for-service providers should submit requests for additional obstetrical ultrasounds to:

Prior Authorization Program
Alabama Medicaid Agency
P. O. Box 5624
Montgomery, AL 36103-5624

Maternity Waiver subcontractors should contact their Primary Provider for information regarding obstetrical ultrasounds.

(e) Sterilization: See the Family Planning Chapter in this Code.

(26) Medical Materials and Supplies: Costs for medical materials and supplies normally utilized during office visits or surgical procedures are to be considered part of the total fee for procedures performed by the physician and therefore are not generally a separately billable service.

(27) Oxygen and Compressed Gas: A physician's fee for administering oxygen or other compressed gas is a covered service under the Medicaid program. Oxygen therapy is a covered service based on medical necessity and requires prior authorization. Please refer to the Alabama Medicaid Administrative Code, Rule No. 560-X-13-.15 and the Alabama Medicaid Billing Manual Chapter 14, DME, for more information.

(28) Podiatrist Service: Covered for QMB or EPSDT referred services only.

(29) Post Surgical Visits:

(a) Hospital Visits: Post-surgical hospital visits for conditions directly related to the surgical procedures are covered by the surgical fee and cannot be billed separately the day of, or up to 90 days post surgery.

(b) Office Visits: Post-surgical office visits for procedures directly related to the surgical procedure are covered by the surgical fee and are not separately covered the day of, or up to 90 days post surgery, and cannot be billed separately, e.g. suture removal.

(c) Visits by Assistant Surgeon or Surgeons: Not covered.

(30) Preventive Medicine: The Medicaid program does not cover preventive medicine other than EPSDT screening.

(31) Prosthetic Devices: External prosthetic devices are not a covered benefit under the Physician's Program. Internal prosthetic devices (i.e., Smith Peterson Nail, pacemaker, vagus nerve stimulator, etc.) are a covered benefit only when implanted during an inpatient hospitalization. The cost of the device is reimbursed through the payment of the inpatient hospital per diem rate and is not separately reimbursable.

(32) Psychiatric Services: Office visits for psychiatric services are counted as part of each recipient's annual office visit limit. See Rule No. 560-X-6-.14 for details about this quota.

(a) Psychiatric Evaluation or Testing: Are covered services under the Physicians' Program if services are rendered by a physician in person and are medically necessary. Psychiatric evaluations shall be limited to one per calendar year, per provider, per recipient.

(b) Psychotherapy Visits: Shall be included in the annual office visit limit. Office visits shall not be covered when billed in conjunction with psychotherapy codes.

(c) Psychiatric Services: Under the Physicians' Program shall be confined to use with psychiatric diagnosis (290-319) and must be performed by a physician.

(d) Hospital Visits: Are not covered when billed in conjunction with psychiatric therapy on the same day.

(e) Services Rendered by Psychologist: See Chapter 11 (EPSDT) for specific information.

(f) Psychiatric Day Care: Not a covered benefit under the Physicians' Program.

(33) Second Opinions: Office visits for second opinions are counted as part of each recipient's annual office visit limit. See Rule No. 560-X-6-.14 for details about this quota.

(a) Optional Surgery: Second opinions (regarding non-emergency surgery) are highly recommended in the Medicaid program when the recipients request them. Payment is made in accordance with the provider's reasonable charge profile allowance for an initial office visit for the appropriate level of service.

(b) Diagnostic Services: Payment may be made for covered diagnostic services deemed necessary by the second physician.

(34) Self-Inflicted Injury: Covered.

(35) Surgery

(a) Cosmetic: Covered only when prior approved for medical necessity. Examples of medical necessity include prompt repair of accidental injuries or improvement of the functioning of a malformed body member.

(b) Elective: Covered when medically necessary.

(c) Multiple:

1. When multiple and/or bilateral surgical procedures, which add significant time or complexity are performed at the same operative session, payment may be made for the procedure with the highest allowed amount and half of the allowed amount for each subsequent procedure code that is not considered to be an integral part of the covered service. This also applies to laser surgical procedures. See Medicaid National Correct Coding Initiatives at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Medicaid-Nation-Correct-Coding-Initiative.html. Exceptions are noted in Rule No. 560-X-6-.14, Limitations on Services.

2. Certain procedures are commonly carried out as integral parts of a total service and as such do not warrant a separate charge. When incidental procedures (e.g. excision of previous scar or puncture of ovarian cyst) are performed during the same operative session, the reimbursement will be included in that of the major procedure only.

3. Laparotomy is covered when it is the only surgical procedure performed during the operative session or when performed with an unrelated surgical procedure.

4. CPT defined Add On codes are considered for coverage only when billed with the appropriate primary procedure code.

5. Appropriate use of CPT and HCPCs modifiers is required to differentiate between sites and procedures. For Medicaid approved modifiers, refer to the Alabama Medicaid Provider Manual.

(36) Telephone Consultations: Not covered.

(37) Therapy: Office visits for therapy are counted as part of each recipient's annual office visit limit. See Rule No. 560-X-6-.14 for details about this quota.

(a) Occupational and Recreational Therapies: Not covered.

(b) Physical Therapy: Is not covered when provided in a physician's office. Physical therapy is covered only when prescribed by a physician and provided in a hospital setting. See Rule No. 560-X-7-.12 for further requirements of coverage.

(c) Group Therapy: Shall be a covered service when a psychiatric diagnosis is present and the therapy is prescribed, performed, and billed by the physician personally.

(1) Group Therapy is included in the annual office visit limit.

(2) Group Therapy is not covered when performed by a case worker, social services worker, mental health worker, or any counseling professional other than a physician.

(d) Speech Therapy: The patient must have a speech related diagnosis, such as stroke (CVA) or partial laryngectomy. To be a covered benefit speech therapy must be prescribed by and performed by a physician in his office. Speech therapy performed in an inpatient or outpatient hospital setting, or in a nursing home is a covered benefit, but is considered covered as part of the reimbursement made to the facility and should not be billed by the physician.

(e) Family Therapy: Shall be a covered service when a psychiatric diagnosis is present and the physician providing the service supplies documentation which justifies the medical necessity of the therapy for each family member. Family therapy is not covered unless the patient is present. Family Therapy is included in the annual office visit limit. Family Therapy is not covered when performed by a case worker, social service worker, mental health worker, or any counseling professional other than a physician.

(38) Transplants: See Rule No. 560-X-1-.27 for transplant coverage.

(39) Ventilation Study: Covered if done in physician's office by the physician or under the physician's direct supervision. Documentation in the medical record should contain all of the following:

(a) Graphic record;

(b) Total and timed vital capacity;

(c) Maximum breathing capacity;

(d) Always indicate if the studies were performed with or without a bronchodilator.

(40) Well-Baby Coverage: Covered only on the initial visit, which must be provided within eight (8) weeks of the birth.

(41) Work Incentive: A claim stating physical examination for a child to be put into a day-care center for mother to work is a covered procedure. (Must state "Work Incentive Program.")

Author: Desiree Nelson, Program Manager; Medical Support
Statutory Authority: Title XIX, Social Security Act; 42 CFR, §§ 405.310(k), 440.50, et seq.; State Plan.
History: Rule effective October 1, 1982. **Amended:** effective April 15, 1983; June 5, 1983; July 8, 1983; November 10, 1983; April 12, 1984; June 8, 1984; October 9, 1984; January 8, 1985; May 8, 1985; June 8, 1985; July 9, 1985; September 9, 1985; **Emergency rule** effective January 22, 1986. **Amended:** effective April 11, 1986. **Emergency rule** effective December 1, 1986. **Amended:** effective March 12, 1987. **Emergency rule** effective March 4, 1987. **Amended:** effective June 10, 1987; June 10, 1988; October 12, 1988; July 13, 1989; May 15, 1990; June 14, 1990; October 13, 1990; April 17, 1991. **Emergency rule** effective July 1, 1991. **Amended:** effective October 12, 1991. Emergency rule effective January 1, 1992. **Amended:** effective April 14, 1992; March 15, 1994; January 12, 1995; January 14, 1997, and October 11, 2000; June 14, 2002; May 16, 2003; April 16, 2004; November 16, 2004; March 17, 2005. **Amended:** Filed May 11, 2012; effective June 15, 2012.

Rule No. 560-X-6-.14. Limitations on Services.

(1) Within each calendar year each recipient is limited to no more than a total of 14 physician office visits in offices, hospital outpatient settings, nursing homes, or Federally Qualified Health Centers. Visits counted under this quota will include, but not be limited to, visits for: prenatal care, postnatal care, family planning, second opinions, consultations, referrals, psychotherapy (individual, family, or group), for ESRD services not covered by the monthly capitation payment, and care by ophthalmologists for eye disease. Physician visits provided in a hospital outpatient setting that have been certified as an emergency do not count against the annual office visit limit.

(a) If a patient receives ancillary services in a doctor's office, by the physician or under his/her direct supervision, and the doctor submits a claim only for the ancillary services but not for the office visit, then the services provided will not be counted as a visit.

(b) For further information regarding outpatient maintenance dialysis and ESRD, refer to 560-X-6-.19 and Chapter 24.

(c) New patient office visit codes shall not be paid to the same physician or the same physician group practice for a recipient more than once in a three-year period.

(2) Physician services to hospital inpatients. In addition to the office visits referred to in paragraph (1) above, Medicaid covers up to 16 inpatient dates of service per physician, per recipient, per calendar year. For purposes of this limitation, each specialty within a group or partnership is considered a single provider.

(a) Physician hospital visits are limited to one visit per day, per recipient, per provider.

(b) Physician(s) may bill for inpatient professional interpretation(s) when that interpretation serves as the official and final report documented in the patient's medical record. Professional interpretation may be billed in addition to a hospital visit if the rounding physician also is responsible for the documentation of the final report for the

procedure in the patient's medical record. Professional interpretation may not be billed in addition to hospital visits if the provider reviews results in the medical record or unofficially interprets medical, laboratory, or radiology tests. Review and interpretation of such tests and results are included in the evaluation and management of the inpatient. Medicaid will cover either one hospital visit or professional interpretation(s) up to the allowed benefit limit for most services. Refer to the Alabama Medicaid Provider Manual for additional guidelines.

(c) Professional interpretations for lab and x-ray (CPT code 70000 through 80000 services) in the inpatient setting should be billed only by the specialist responsible for the official medical record report of interpretation. Professional interpretations performed by physicians of other specialties for services in this procedure code range are included in the hospital visit reimbursement.

(d) Professional interpretations for lab and x-ray services performed in an outpatient setting are considered part of the evaluation and management service and may not be billed in addition to the visit. Professional interpretations may be billed separately only by the specialist responsible for the official medical record report of interpretation. Only one professional interpretation per x-ray will be paid. Claims paid in error will be recouped.

(e) Professional interpretations for lab and x-ray services performed in an office setting are included in the global fee and should not be billed separately.

(f) A physician hospital visit and hospital discharge shall not be paid to the same physician on the same day. If both are billed, only the discharge shall be paid.

(3) Eyecare: Refer to Chapter Seventeen of this Code.

(4) Orthoptics: Orthoptics may be prior authorized by the Alabama Medicaid Agency when medically necessary.

(5) Telemedicine: Telemedicine services are covered. Physicians allowed to participate in telemedicine services include those with an Alabama license, regardless of location. Refer to the Alabama Medicaid Provider Manual, Chapter 28 for details on coverage.

(6) Telephone consultations: Telephone consultations are not authorized.

(7) Prior authorized services: These are subject to all limitations of the Alabama Medicaid Agency Program.

(8) Post surgical benefits: See Rule No. 560-X-6-.13.

(9) Surgery: When multiple and/or bilateral procedures are billed in conjunction with one another and meet the CPT's definition of "Format of Terminology" (bundled or subset), and/or comprehensive/component (bundled) codes, then the procedure with the highest allowed amount will be paid while the procedure with the

lesser allowed amount will not be considered for payment as the procedure is considered an integral part of the covered service.

(a) Operating microscope procedure coverage is limited. For details on coverage, refer to the Physician Chapter of the Alabama Medicaid Provider Manual.

(b) Mutually exclusive procedures are defined as those codes that cannot reasonably be performed in the same session and are considered not separately allowable or reimbursable. An example of this would be an abdominal and vaginal hysterectomy billed for the same recipient on the same date of service.

(c) Incidental procedures are defined as those codes which are commonly carried out as integral parts of a total service and as such do not warrant a separate charge. An example of this would be lysis of adhesions during the same session as an abdominal surgery.

(d) Casting and strapping codes as defined in the CPT and billed in conjunction with related surgical procedure codes are considered not separately allowable or reimbursable as the fracture repair or surgical code is inclusive of these services.

(e) Laparotomy Codes are covered when the laparotomy is the only surgical procedure during an operative session or when performed with an unrelated surgical procedure.

Author: Teresa Thomas, Program Manager, EPSDT/Related Svcs.
Statutory Authority: Title XIX, Social Security Act; 42 CFR Section 441.57, 441.56, Part 401, et seq.; State Plan, 42CFR Section 410.78.
History: Rule effective October 1, 1982. Amended July 8, 1983; February 8, 1984; October 9, 1984; January 8, 1985; March 11, 1985; June 8, 1985; September 9, 1985; December 1, 1986; March 12, 1987; July 10, 1987; January 12, 1990; December 12, 1990; January 1, 1992; April 14, 1992; March 15, 1994; January 12, 1995, and December 11, 2000; Amended: Filed March 20, 2002; effective June 14, 2002. **Amended:** Filed February 18, 2003; effective May 16, 2003. **Amended**: Filed May 20, 2003; effective August 18, 2003. **Amended**: Emergency Rule filed and effective April 9, 2004. **Amended**: Filed April 21, 2004; effective July 16, 2004. **Amended**: Filed August 20, 2004; effective November 16, 2004. **Amended**: Filed December 17, 2004, effective March 17, 2005. **Amended**: Filed November 18, 2009; effective February 15, 2010. **Amended:** Filed October 20, 2011, effective January 16, 2012.

Rule No. 560-X-6-.15. Reserved

Rule No. 560-X-6-.16. Billing of Medicaid Recipients by Providers.

(1) A provider may bill Medicaid recipients for the copay amount, for Medicaid noncovered services and for services provided to a recipient who has exhausted his/her yearly limitations. Conditional collections to be refunded post payment by Medicaid and partial charges for balance of Medicaid allowed reimbursement are not permissible. Billing recipient for services not paid by Medicaid due to provider correctable errors on claims submission or untimely filing is not permissible.

Authority: Title XIX, Social Security Act, 42 C.F.R. Section 447.15, Et seq.; State Plan. Amended July 9, 1984, June 8, 1985, and March 12, 1987. Effective date of this amendment March 15, 1994.

Rule No. 560-X-6-.17. Copayment (Cost-Sharing).

(1) Medicaid recipients are required to pay, and physician providers are required to collect, the designated copayment amount on each physician visit.

(2) Exceptions to the copayment requirement are listed in Rule No. 560-X-1-.25.

(3) A provider may not deny services to any eligible individual due to the individual's inability to pay the cost-sharing amount imposed.

Author: Desiree Nelson; Program Manager; Medical Support
Statutory Authority: Title XIX, Social Security Act; 42 C.F.R. §§ 447.50, 447.53, 447.55, et seq.; and State Plan Attachment 4.18-A.
History: Rule effective June 8, 1985. **Amended**: effective July 9, 1985; March 12, 1987; January 12, 1995. **Amended:** Filed May 11, 2012; effective June 15, 2012.

Rule No. 560-X-6-.18. Critical Care

(1) When caring for a critically ill patient in which the constant attention of the physician is required, the appropriate critical care procedure code must be billed. Refer to the CPT and the Alabama Medicaid Provider Manual for additional guidance and clarification.

(2) The actual time period, per day, spent in attendance at the patient's bedside, or performing duties specifically related to that patient, irrespective of breaks in attendance, must be documented in the patient's medical record.

(3) Only the following individual procedures related to critical care may be billed:

(a) Procedure code 99360 (stand by) and either procedure code 99221, 99222, or 99223 (initial hospital care) may be billed once with each hospital stay.

(b) An EPSDT screening may be billed in lieu of the initial hospital care (Procedure code 99221, 99222, or 99223).

(c) Procedure code 99082 (transportation/escort of patient) may be billed only by the attending physician. Residents or nurses who escort a patient may not bill either service.

(4) Pediatric and Neonatal Critical Care

The purpose of the following policy statements is to provide assistance to providers seeking to bill procedures for critical care. Refer to the CPT and the Alabama Medicaid Provider Manual for additional guidance and clarification.

(a) Pediatric and neonatal critical care codes begin with the day of admission and may be billed once per patient, per day, in the same facility.

(b) The pediatric and neonatal critical care codes include management, monitoring and treatment of the patient, including respiratory, pharmacological control of the circulatory system, enteral and parenteral nutrition, metabolic and hematologic maintenance, parent/family counseling, case management services and personal direct supervision of the health care team in the performance of their daily activities.

(c) Once the patient is no longer considered by the attending physician to be critical, the Subsequent Hospital Care codes should be billed.

(d) Refer to the Alabama Medicaid Provider Manual for guidelines on what additional procedures may be billed in conjunction with critical care. General guidelines are:

1. Initial history and physical or EPSDT screen may be billed in conjunction with 99293 or 99295. Both may not be billed. One EPSDT screen for the hospitalization will encompass all diagnoses identified during the hospital stay for referral purposes.

2. Standby (99360) or resuscitation (99465) at delivery or attendance at delivery (99464) may be billed in addition to critical care. Only one of the codes may be billed in addition to critical care.

3. Subsequent Hospital Care codes (99231-99233) may not be billed.

4. Critical care is considered to be an evaluation and management service. Although usually furnished in a critical or intensive care unit, critical care may be provided in any inpatient health care setting. Services provided which do not meet critical care criteria should be billed under the appropriate hospital care codes. If a recipient is readmitted to the NICU/ICU, the provider must be the primary physician in order for NICU/ICU critical care codes to be billed again.

5. Transfers to the pediatric unit from the NICU cannot be billed using neonatal critical care codes.

6. Global payments encompass all care and procedures which are included in the rate. Physicians may not perform an EPSDT screen and refer to partner or other physician to do procedures. All procedures which are included in the daily critical care rate, regardless of who performed them, are included in the global critical care code.

7. Consultant care rendered to children for which the provider is not the primary attending physician must be billed using consultation codes. Appropriate procedures may be billed in addition to consultations. If, after the consultation the provider assumes total responsibility for care, critical care may be billed using the appropriate critical care codes as defined in the Alabama Medicaid Provider Manual. The medical record must clearly indicate that the provider is assuming total responsibility for care of the patient and is the primary attending physician for the patient. Consultation and critical care cannot be billed on the same patient on the same day.

(5) Intensive (Non-Critical) Low Birthweight Services

The purpose of the following policy statement is to provide assistance to neonatology providers seeking to bill for intensive (non-critical) low birthweight services. Refer to the CPT and the Alabama Medicaid Provider Manual for additional guidelines and clarification. Intensive (non-critical) low birthweight services codes are used to report care subsequent to the day of admission provided by a neonatologist directing the continuing intensive care of the very low birthweight infant who no longer meets the definition of being critically ill. Low birthweight services are reported for neonates less than 2500 grams who do not meet the definition of critical care but continue to require intensive observation and frequent services and intervention only available in an intensive care setting.

Author: Desiree Nelson; Program Manager; Medical Support.
Statutory Authority: Title XIX, Social Security Act; 42 C.F.R. § 440.50; CPT.
History: Rule effective May 9, 1986. **Amended:** March 12, 1987, October 12, 1988, and June 12, 1991. **Emergency rule** effective January 1, 1992. **Amended**: effective April 14, 1992. **Emergency rule** effective May 7, 1992. **Amended**: effective August 12, 1992; March 13, 1993; March 15, 1994; June 14, 2002; August 18, 2003; March 17, 2005. **Amended:** Filed May 11, 2012; effective June 15, 2012.

Rule No. 560-X-6-.19. Physician Services for End-Stage Renal Disease (ESRD).

(1) All physician services rendered to each outpatient maintenance dialysis patient provided during a full month on an ongoing basis without interruption of the treatment regime (uninterruptedly) shall be billed on a monthly capitation basis. The monthly capitation payment is limited to once per month, per recipient, per provider.

(2) Physician services rendered to each outpatient maintenance dialysis patient not performed consecutively (interruptedly) during a full month, i.e., preceding and/or following the period of hospitalization, are allowed. Please refer to the physician's chapter of the Provider Manual for further details.

(3) Services not covered by the monthly capitation payment (MCP) and which are reimbursed in accordance with usual and customary charge rules are limited to:

(a) Declotting of shunts.

(b) Covered physician services furnished to hospital inpatients by a physician who elects not to receive the MCP for these services.

(c) Nonrenal related physician services. These services may be furnished either by the physician providing renal care or by another physician. They may not be incidental to services furnished during a dialysis session or office visit necessitated by the renal condition.

(4) Refer to the Renal Dialysis chapter for further details.

Author: Brenda Vaughn, Program Manager, Medical Services Program.

Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 405.542, and Federal Register dated July 2, 1986.
History: Emergency Rule effective January 1, 1987. Amended January 14, 1987, March 12, 1987, and March 15, 1994. Amended: Filed February 18, 2003; effective May 16, 2003.