ALABAMA MEDICAID

January 2015 Provider Manual

Provider Insiders

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Provider *Insider*

Alabama Medicaid Bulletin **September 2006**

The checkwrite schedule is as follows:

07/07/06 07/21/06 08/04/06 08/18/06 09/08/06 09/15/06

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

New Version of Provider Electronic Solutions Software Is Now Available

EDS has released a new version of the Provider Electronic Solutions software. The new version (2.06) is now available, and contains the following enhancements:

- Nursing Home Providers: The **EDIT ALL** feature now updates the 'date of service' (service Tab) on all associated claim-details using the 'from' date of service on the header tab.
- Users can now archive Household Inquiry forms.
- Account Number requirement was removed from Eligibility Verifications (270 Transactions).
- Account Number requirement was removed from NCPDP Claim reversals.
- Communication Log message was repositioned to display all parts of messages returned to users.
- The untimely 'archive your claims' message was removed.

Provider Electronic Solutions version 2.06 (full install and upgrade) can be downloaded from the Alabama Medicaid website. To download the software, go to the Alabama Medicaid website at: *https://almedicalprogram.alabama-medicaid.com/secure/logon.do*. Click on WEB Help, scroll down to the software download section, and download the software. If you currently have any software version prior to 2.05 installed, you must upgrade to 2.05 **BEFORE** attempting to upgrade to 2.06. For further assistance, or to request the software on CD, please contact the ECS helpdesk at 1-800-456-1242.

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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 _____*

Prior Authorization Needed For Orencia and Kineret

Effective September 1, 2006, injectable drugs Orencia and Kineret will require prior authorization as Biologicals through Health Information Designs (HID) prior to treatment. Although these drugs have not been assigned HCPCS codes, you must request the Prior Authorization using procedure code J3490. After receiving authorization from HID, a CMS-1500 paper claim must be submitted to EDS including the dosage and NDC number. The letter of approval from HID must be attached to the claim, and "attachment" in block 19. These drugs must be approved through HID prior to administering and billing. HID may be contacted at 1-800-748-0130. The Prior Authorization forms are located on our website at *www.medicaid.alabama.gov*.

Notice for Vaccine for Children Providers

Please remember to update your provider number with the Health Department when your Alabama Medicaid provider number changes. The phone number for VFC is 1-800-469-4599 or you may email Sherri Poole, Medicaid Liaison, at spoole@adph.state.al.us.

Lead Poison Screening is Essential

Remember, it is essential to screen all children at ages 12 and 24 months for lead poisoning. Report ALL levels > 10ug/dL to the Health Department using the ADPH-FHS-135 form. Forms and educational materials are available at the Health Department's website *www.adph.org/aclppp*. For any questions, please call 1-334-206-2966 or 1-800-545-1098. Keep Alabama's kids lead free!

www.medicaid.alabama.gov

Change In Definition Of Global Surgical Packages

Effective for dates of adjudication October 1, 2006 and thereafter, Medicaid will adopt Medicare's RVU file designation for global surgical days. In the past and through September 30, 2006 adjudication, Medicaid has used a **62 day** post op period after major surgeries.

Effective for dates of adjudication October 1, 2006 and thereafter, Medicaid will use a zero, 10 day, and 90 day post op period for routine surgical care. Please refer to the Alabama Medicaid Agency Provider Manual, Chapter 28, for a revised listing of the 10 day post op codes. The codes listed for the 10 day post op period should **not** be billed with an office visit within 10 days of surgery, for routine care. Claims for these services will be subject to post payment review.

The 90 day post op period codes will not be published in the Provider Manual. Post operative office, hospital, or outpatient visits for routine surgical care should **not** be billed as, they are considered inclusive of the global surgical package.

SSI Certified Women and Unborn Numbers

Since the SSA certifies women for SSI, Medicaid is unable to assign unborn numbers for them. There were 937 births in Alabama for SSI women for FY 2005.

The Medicaid Agency has a form that is currently being used, Newborn Certification Form 284. Care coordinators, SOBRA eligibility workers and all hospitals have access to this form. They have been instructed to assist SSI women in completing this form.

Newborn charges in the day after the child's birth when the mother is still in the hospital may be billed using the mother's Medicaid number include:

1. Routine newborn care (99431, 99433, and discharge codes 99238 and 99239)
2. Circumcision (54150 or 54160)
3. Newborn resuscitation (99440)
4. Stand-by services following a caesarian section or a high-risk vaginal delivery (99360)
5. Attendance at delivery (when requested by delivering physician) and initial stabilization of newborn (99436)

Standby services (procedure code 99360) are covered only when the pediatrician, family practitioner, neonatologist, general practitioner, or non-delivering OB-GYN is on stand-by in the operating or delivery room during a caesarian section or a high-risk vaginal delivery. Attendance of the stand-by physician in the hospital operating or delivery room must be documented in the operating or delivery report.

Use CPT codes when filing claims for these five kinds of care.

If the services are billed under the mother's name and number and the infants are twins, indicate Twin A or Twin B in Block 19 of the claim form.

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.

Clarification: TPL Policy On EPSDT / Preventive Services

Alabama Medicaid is a secondary payer to all available third party resources. If the patient is enrolled in a HMO or Medicaid pays the provider on an encounter or capitation basis, the patient's other insurance must be filed first when billing for any type of EPSDT screening.

If the patient is not enrolled in a HMO or Medicaid does not pay the provider on an encounter or capitation basis, EPSDT screenings (99381EP-99385EP and 99391EP-99395EP) and immunizations may be billed to Medicaid first.

Interperiodic screenings (procedure codes 99391-99395-without an EP modifier) must always be filed with the patient's other insurance first. If the primary insurance is a HMO, the age appropriate interperiodic screening code must be submitted. Once the claim has been paid/denied, Medicaid may then be billed utilizing the interperiodic screening code that was submitted to the HMO.

If the primary insurance is not a HMO, bill the appropriate "office visit" code. Once the claim has been paid/denied from the patient's other insurance, a claim may be filed with Medicaid utilizing the same "office visit" code. When billing an office visit code for an interperiodic code, the following referral information must be on the claim form filed to Medicaid, in order to bypass benefit limitations:

Block 17 – Patient 1st or EPSDT provider name
Block 17a – Patient 1st or EPSDT provider number
Block 24h – If the child is assigned a PMP, then enter a "4"
If the child is not assigned a PMP, then enter a "1"

PLEASE NOTE: VERY IMPORTANT
If any other treatments are provided the same day (injections, lab, etc.), a "1" or "4" must also be reflected in Block 24h, **on each line item**, or the claim will deny.

PA Requests for Ambulance

Please note the following billing instructions for submitting a PA request:

A Prior Authorization is not required for services provided to QMB only recipients (Aid Category 95) since Medicaid is only responsible for the co-insurance and/or deductible. You must file the service to Medicare then if the service does not automatically crossover from Medicare to Medicaid, then you submit the Medicaid/ Medicare related claim to Medicaid. (For additional information regarding the different Aid Categories for Medicaid eligibles, please refer to Medicaid Provider Manual, Chapter 3, Verifying Recipient Eligibility.

All PA requests must be submitted within 30 business days from the date of service with the exception of those involving Retro eligibility. If not submitted within this time frame, it is considered by the Alabama Medicaid Agency to be a provider correctible error, and the recipient must not be billed.

If additional information is required, please contact Carol Akin @ 334-242-5580 or Janice O'Neal at 334-353-4771. For billing instructions please call Karen Hutto at 334-215-4158 or Laquita Thrasher at 334-215-4199.

Changes for Interactive Transactions will Affect Users and Vendors

Currently the Provider Electronic Solutions software permits users to submit an interactive transaction to Alabama Medicaid by pressing a 'submit' button on the related screen. Beginning May 23, 2007 interactive transactions will no longer be available through Provider Electronic Solutions or through a vendor software which currently utilizes the interactive toll-free dial-up service. The following interactive transaction types are currently permitted:

Eligibility inquiry Claim status inquiry Household inquiry

NCPDP drug claim submission, reversal and eligibility inquiry

Impact to PES users

Beginning May 23, 2007, Provider Electronic Solutions will only be utilized for batch transactions. Dial-up interactive transactions will be accommodated in the following three ways:

· Users without an Internet Service Provider may connect to the Remote Access Server (RAS) with an Internet browser such as Microsoft Internet Explorer or Netscape as outlined by chapter 17 within the current Provider Electronic Solutions User Manual. Once connected to the RAS server, the user may access the new Web Portal and perform the same interactive transactions listed above by means of an interactive form to enter and submit such requests. The RAS dial-up connection will also become a toll-free line.

- Users with an internet service provider may connect directly to the new Web Portal to perform these transactions.
- Users may contract with a clearinghouse to perform these interactive transactions.

User Training will be made available in 2007. This training will include changes made to Provider Electronic Solutions as well as instructional guidance to complete an interactive transaction using the forms available on the new Web Portal.

If you use a software vendor

Software vendors are also being notified of this change. If you have a question about whether this change will impact your vendor supplied software, please contact your vendor.

Sleep Studies Must Be Billed With Correct Provider Number

Sleep studies are an Alabama Medicaid covered service but must be billed through the enrolled physician's number or Outpatient Hospital provider number. Medicaid does not enroll sleep study clinics. Unattended sleep studies (95806) are not covered by Alabama Medicaid Please refer to Alabama Medicaid's LMRP (Local Medical Review Policies) on the website at *www.medicaid.alabama.gov* for additional limitations.

Visit Alabama Medicaid

ONLINE

Providers can :

- **Print Forms and Enrollment Applications**
- **Download Helpful Software**
- **Obtain Current Medicaid Press Releases and Bulletins**
- **Obtain Billing and Provider Manuals and Other General Information about Medicaid**

www.medicaid.alabama.gov

An Oral Health Reminder

By Ric Simpson, DMD, Chapter oral health representative/liaison to Alabama Academy of Pediatric Dentistry

Dental caries, the most prevalent disease in our nation's children, is an infectious and preventable disease. This progressive disease is caused by specific cariogenic bacteria that are usually vertically transmitted from the mother or other primary caregiver to the child during the months after the first tooth erupts. Numerous factors are involved in determining a child's risk for developing dental decay. The AAP Policy Statement entitled Oral Health Risk Assessment Timing and Establishment of the Dental Home (PEDIATRICS VOL.111 No. 5 May 2003, pp. 1113-1116) states that:

"To prevent caries in children, high-risk individuals must be identified at an early age (preferably high-risk mothers during prenatal care), and aggressive strategies should be adopted, including anticipatory guidance, behavior modifications (oral hygiene and feeding practices), and establishment of a dental home by one year of age for children deemed at risk."

The American Dental Association, the Academy of General Dentistry, the American Academy of Pediatric Dentistry, the American Academy of Pediatrics, supporting organizations of Bright Futures, and numerous other children's health organizations have endorsed the concepts of early caries risk assessment by primary care providers, referral of higher-risk children and mothers, and the ideal of establishment of the dental home by one year of age.

In Alabama, the Alabama Chapter-AAP is actively involved with the Alabama Medicaid Agency's Oral Health Coalition, which not only embraces these concepts, but strongly urges a statewide push of the "age one" dental home to reduce the incidence of early caries.

The AAP policy statement and numerous other resources for oral health and caries prevention can be found by going to the Section on Pediatric Dentistry at *www.aap.org*.

New Procedure for Billing Bilateral Procedures

Effective for dates of adjudication October 1, 2006 and thereafter, the procedure for billing bilateral procedures will change. Currently and through date of adjudication September 30, 2006, providers are instructed to bill for bilateral procedures on one line with modifier 50. The reimbursement is adjusted to 150% of Medicaid's fee schedule.

Effective October 1, 2006 and thereafter, the new procedure will be as follows:

- Bill the appropriate procedure code on two separate lines, one line with RT and one line with LT modifier, or other appropriate anatomical modifier.
- Modifier 50 will be used for informational purposes only.
- The payment will be 100% of Medicaid fee schedule for first line and 50% for second line.
- Claims will be subject to multiple surgery payment adjustments for multiple procedures.

Example: Line 1: 27558 RT
27558 LT

Alabama Medicaid utilizes Medicare's RVU file to determine whether a 50 modifier should be allowed with the procedure code billed. When an inappropriate procedure code is billed with modifier 50, the claim will deny.

ALABAMA MEDICAID

In The Know

General Information Providers Need to Know When Billing to the Alabama Medicaid Agency

Guidelines Regarding the Alabama Medicaid Agency Referral Form

The following are guidelines regarding the Agency Referral Form (form 362) including cascading referrals. There are up to six different types of referrals.

1. A **Patient 1st referral** is for a recipient who is assigned to a Patient 1st provider (PMP). This type of referral is for Patient 1st recipients only.
2. A **Lock-in referral** is for a recipient that is locked into one physician/pharmacy and must have a referral to see anyone other than their lock-in physician.
3. An **EPSDT referral** is for a referral resulting from an EPSDT screening (for the diagnoses suspected/made during the exam) of a recipient who is not enrolled in the Patient 1st program
4. A **Patient 1st /EPSDT referral** is for a recipient who is assigned to a PMP and has received an EPSDT screening. In this case, a recipient is being referred by the PMP or on behalf of the PMP to another provider for diagnoses suspected/made during the EPSDT exam.
5. A **Case Management referral** – is for a recipient being referred to a case manager for "at risk" recipients. A list of care coordinators is available on the Agency's website at *www.medicaid.alabama.gov*.
6. **Other referral** – is used when a Medicaid provider is referring any recipient to another provider. The blank space under "Type of Referral" may be used for this purpose.

Important things to keep in mind about referrals are:

- A written referral is required and indicates approval for a consultant/specialist to see a patient for further diagnosis and/or treatment. A written referral must be completed and furnished to the consultant/specialist within 72 hours if oral authorization is given. Failure to provide a written referral form may prevent the consultant/specialist from being paid.
- It is possible for more than one referral to be checked in the "Type of Referral" field – e.g., Patient 1st and Case Management/Care Coordinators.
- Date of screening (which is the **date the actual screening was performed**) needs to be indicated if an EPSDT or Patient 1st /EPSDT referral is being authorized. This is a **mandatory field**.
- The referral date may be different from the date of the screening.
- A copy of a referral form must be kept in a recipient's medical record for each provider who renders service(s).
- A cascading referral is used in situations where a physician thinks more than one consultant may be needed to provide treatment for identified condition(s). When this situation arises, the original referral form is generated from the PMP. If the first consultant determines a recipient should be referred to another consultant/specialist, it is his responsibility to provide a copy of the referral form to the second consultant. This process is continued until the condition(s) have been rectified or in remission.
  - The appropriate block to mark on the referral form for a cascading referral for a **single** condition is labeled "Referral to other provider for identified condition". The appropriate block to mark on the referral form for a cascading referral for **multiple** conditions is labeled "Referral to other provider for identified conditions".
- All consultants should furnish written results of findings to the referring provider or PMP (if different) promptly. Patient 1st and EPSDT providers are responsible for appropriate referrals and follow-up.

Lastly, the Agency is in the process of updating the current referral form for clarification purposes. Please continue to monitor the Provider Insider for future updates and notifications. If you have any questions, please visit our website address listed above or you may contact the Outreach & Education Unit at 334-242-5203.

Attention DME Providers

Effective August 1, 2006, reimbursement for home blood glucose monitors are limited to one per recipient every five years. The home blood glucose monitor no longer requires prior authorization.

For recipients with insulin dependent diabetes, blood glucose test strips or reagent strips are limited to 3 boxes (50 per box) each month. Lancets are limited to 2 boxes (100 per box) each month. For recipients with non insulin dependent diabetes, blood glucose test or reagent strips are limited to 2 boxes (50 per box) each month. Lancets are limited to 1 box (100 per box) each month.

When providing diabetic supplies for Medicaid patients who also have Blue Cross Blue Shield (BC/BS) of Alabama coverage it is important to verify the specific plan coverage. Some plans cover diabetic supplies through the Pharmacy only. If the recipient is covered by a BC/BS plan which requires diabetic supplies to be billed through the pharmacy program using a NDC the recipient and your business is not enrolled as a pharmacy you should refer the patient to a local pharmacy. Any questions regarding plan coverage should be referred to the plan, not Medicaid.

Procedure code A4256 (Normal, low high calibrator solution/chips) is now limited to 4 units per year per recipient.

Currently procedure code E0480 (percussor) is covered as a rental to purchase item.

Effective September 1, 2006, procedure code E0480 will be reimbursed as a purchase item.

Effective September 1, 2006, procedure code A9900 (miscellaneous DME supply, accessory, and/or service component of another HCPC code) will be deleted as a covered by Alabama Medicaid.

Effective October 1, 2006, DME provider will no longer be reimburse for CPT code 99503 (respiratory therapist visit).

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

www.medicaid.alabama.gov

Revised Billing Instructions for EPSDT Referred Services

If you file hard copy claims on the UB-92, you must complete the following fields:

- Block 2 – Enter the screening provider's nine-digit provider number
- Block 24 – Enter "**A1**" to indicate EPSDT

If you file electronically on the UB-92 (837 Institutional) using EDS Provider Electronic Solutions software, please refer to the latest edition of the Provider Electronic Solutions User Manual.

If you file claims on the **CMS-1500**, you must complete:

- Block 17 – Enter the name of screening provider
- Block 17a – Enter the screening provider's nine-digit Medicaid provider number
- Block 24h – Enter "1" to indicate EPSDT

If you file electronically on the CMS-1500 (837 Professional) using EDS Provider Electronic Solutions software, please refer to the latest edition of the Provider Electronic Solutions User Manual.

For Patient 1st and EPSDT Referred Services

If you file claims on the **UB-92**, you must complete:

- Block 2 – Enter the referring PMP's nine-digit provider number
- Block 24 – Enter "**A1**" to indicate EPSDT and managed care

If you file electronically on the UB-92 (837 Institutional) using EDS Provider Electronic Solutions software, please refer to the latest edition of the Provider Electronic Solutions User Manual.

If you file claims on the **CMS-1500**, you must complete:

- Block 17 – Enter the name of referring PMP
- Block 17a – Enter the referring PMP's nine-digit Medicaid provider number
- Block 24h – Enter "**4**" to indicate EPSDT and managed care

If you file electronically on the CMS-1500 (837 Professional) using EDS Provider Electronic Solutions software, please refer to the latest edition of the Provider Electronic Solutions User Manual.

Please note: Each line item on the claim form must have an indicator in block 24 or 24h if billing for a referred service.

For example: If the first line is an office visit and the indicator in block 24 or 24h is a "4" , all additional services for that date of service must also have an indicator of "4" in block 24 or 24h or the claim will deny.

Important Mailing Addresses	
All Claim forms, Consent forms, and other mail	EDS Post Office Box 244032 Montgomery, AL 36124-4032
Inquiries, Provider Enrollment Information, and Provider Relations	EDS Post Office Box 241685 Montgomery, AL 36124-1685
Adjustments	EDS Post Office Box 241684 Montgomery, AL 36124-1684

Patient 1st Recipient Dismissals

At times, the need may arise for Primary Medical Providers (PMPs) to dismiss recipients from their panel. Please be aware a PMP may request removal of a recipient from their panel for good cause. According to the guidelines listed in the 1915(b)(i) waiver of the Social Security Act which allows operation of the Patient 1st program, good cause is defined as:

- Behavior on the part of the recipient which is disruptive, unruly, abusive or uncooperative to the extent that the ability of the provider to provide services to the recipient or other affected recipients is seriously impaired,
- Persistent refusal of a recipient to follow a reasonable, prescribed course of treatment; or
- Fraudulent use of the Medicaid card.

Additionally, a Patient 1st recipient may be dismissed for nonpayment of co-payments or an outstanding balance if this is a standard operating procedure for the practice, is applicable to all patients regardless of payer source, and prior written notice has been provided to the recipient.

Any dismissals made to the PMP's panel should be with the understanding 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. Further, 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.

It is the responsibility of the PMP to inform both the recipient and Medicaid of the intended dismissal. The PMP should send a letter of dismissal to the recipient indicating the reason for the dismissal and include a copy of the letter as an attachment to documentation sent to Medicaid. The copy sent to the Agency should include the Provider's name and provider number (as enrolled in the Patient 1st program) the recipient's Name (if not the addressee) and Medicaid number. The dismissal letter should be addressed to the recipient or responsible party and signed by the PMP or their approved designee.

Another PMP, not one in the same group as the original PMP, will be selected for the recipient. The recipient will be given the opportunity to change the selected PMP before the active assignment date to the new PMP. **The original PMP must continue to provide services and/or make referrals for services on behalf of the recipient until such time the reassignment to another PMP becomes effective.**

Dismissal requests should be faxed to Medicaid at (334) 353-3856.

Patient 1st InfoSolutions

The Agency has partnered with Blue Cross/Blue Shield to offer InfoSolutions to Patient 1st and other Medicaid providers. InfoSolutions is a product that can provide physicians with pharmacy information about assigned recipients on their Patient 1st panel. This information can be accessed through a desktop system or be synchronized with a PDA. Additionally, information is available on Epocrates which includes Medicaid information on drug coverage, prior approval and overrides.

InfoSolutions is made available to assist in achieving the Agency goal of reducing pharmacy expenditures through appropriate utilization and knowledge of Medicaid's Preferred Drug List (PDL). Use of this product is voluntary, however; an additional fifty cents is included in the monthly case management fee for each recipient on a provider's panel when this service is utilized.

Medicaid monitors the use of this product by participating Patient 1st providers on a quarterly basis. If program monitoring shows the product has not been utilized in three (3) or more months the case management fee associated with this product will be suspended. If continuing monitoring of the program shows future usage by the provider, the case management fee will be reinstated for this component. Below is the quarterly schedule for suspension/reinstatement of the InfoSolutions case management fee:

January/February/March	Review usage in April	Suspend/Reinstate in May
April/May/June	Review usage in July	Suspend/Reinstate in August
July/August/September	Review usage in October	Suspend/Reinstate in November
October/November/December	Review usage in January	Suspend/Reinstate in February

If you are a Medicaid provider who is not currently using this product and you want more information about InfoSolutions or a participating Patient 1st provider who is having problems accessing InfoSolutions, please visit the InfoSolutions website at *www.infosolutions.net* or contact Paige Clark at (334) 242-5148.

State Fiscal Year 2006-2007 Checkwrite Schedule

10/06/06	01/05/07	04/06/07	07/06/07
10/20/06	01/19/07	04/20/07	07/20/07
11/03/06	02/09/07	05/11/07	08/10/07
11/17/06	02/23/07	05/25/07	08/24/07
12/08/06	03/09/07	06/08/07	09/07/07
12/15/06	03/23/07	06/22/07	09/14/07

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Alabama Medicaid Bulletin **November 2006**

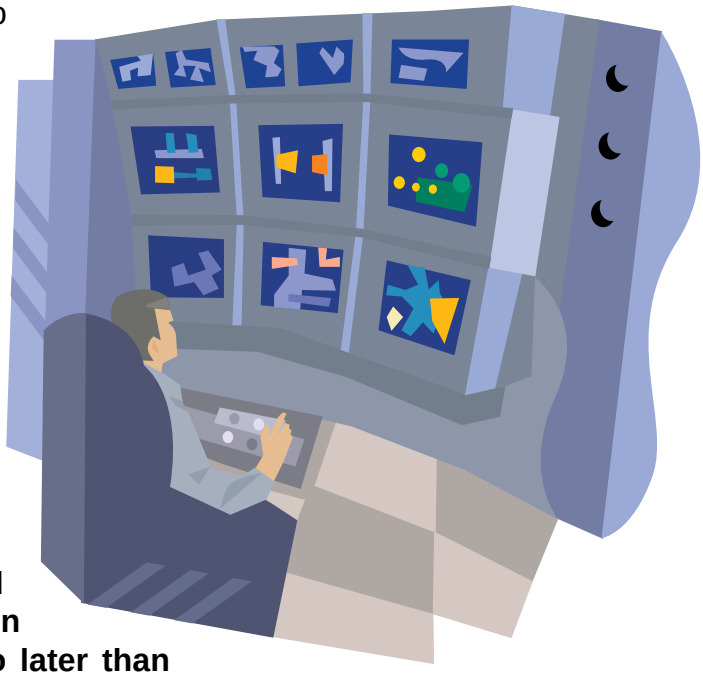
The checkwrite schedule is as follows:

11/03/06 11/17/06 12/08/06 12/15/06 01/05/07 01/19/07

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

Send Your NPI Information to EDS!

The compliance date for NPI, May 23, 2007, is less than 6 months away. Use of the NPI (National Provider Identifier) is mandated by the Health Insurance Portability and Accountability Act (HIPAA) and will also be needed to process claims on interChange, Alabama Medicaid's new claims processing system, after the NPI compliance date.



When you have received your NPI you should submit a NPI Notification form, which can be located on the Medicaid website, *www.medicaid.alabama.gov/billing/NPI.aspx*, along with a copy of the notification letter received from the enumerator, to EDS. The form and letter may be faxed to 334-215-4118 or mailed to:

EDS Provider Enrollment
P. O. Box 241685
Montgomery, AL 36124

To ensure claims are processed correctly and to avoid possible payment delays the Notification form and letter should be received by EDS no later than April 1, 2007. If you have questions regarding how to fill out the NPI Notification Form, contact your Provider Representative at 1-800-688-7989 (within Alabama) or (334) 215-0111 (outside of Alabama).

You will need to continue to submit claims with your current Alabama Medicaid provider number until the new system to accommodate NPI numbers is implemented on May 23, 2007.

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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* _____

Global Surgical Package 10-Day Post Op Period Codes

Please refer to the October 2006 Alabama Medicaid Agency Provider Manual, Chapter 28, for a listing of the 10 day post Op codes. Please delete code range 21325-21348 from this listing. Also, replace procedure code 36575 with 36576. As a reminder, the codes listed for the 10 day post Op period should not be billed with an office visit within 10 days of surgery, for routine care. The January 2007 provider manual will reflect the above corrections.

Eyeglasses Benefit Limit

The Alabama Medicaid benefit limits for eyeglasses are as follows:

- Recipients under 21 years of age are authorized one (1) pair of eyeglasses each calendar year,
- Recipients 21 years of age or older are authorized one (1) pair of eyeglasses every 2 calendar years.

Any exception to these benefits must be based on medical necessity and the reasons documented in the medical record. These limitations also apply to fittings and adjustments. An example of medical necessity could be treatment for eye injury, disease, or significant prescription change.

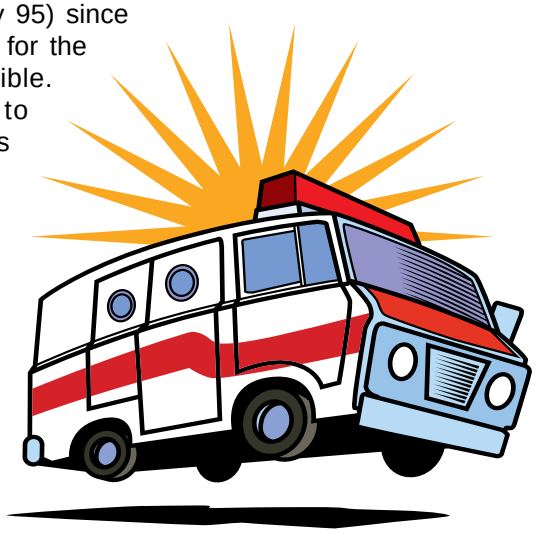
- Additional eyeglasses, fittings, and adjustments may require prior authorization by Medicaid for recipents 21 years of age and older. Please refer to the Alabama Medicaid Provider Manual, Chapter 15 for details.
- Additional eyeglasses can not be authorized for convenience but only for clearly documented medically necessary reasons.

Additional eyeglasses over and above eyeglass limits are subject to post payment review and recoupment when deemed not medically necessary.

www.medicaid.alabama.gov

PA Requests for Air and Ground Ambulance

Please note the following billing instructions for submitting a PA request: A Prior Authorization is not required for services provided to QMB only recipients (Aid Category 95) since Medicaid is only responsible for the co-insurance and/or deductible. You must file the service to Medicare then if the service does not automatically crossover from Medicare to Medicaid, then you submit the Medicaid/ Medicare related claim to Medicaid. (For additional information regarding the different Aid Categories for Medicaid eligibles, please refer to Medicaid Provider Manual, Chapter 3, Verifying Recipient Eligibility). All PA requests must be submitted within 30 business days from the date of service with the exception of those involving Retro eligibility. If not submitted within this time frame, it is considered by the Alabama Medicaid Agency to be a provider correctible error, and the recipient must not be billed. If additional information is required, please contact Sheryl Yelder (Air Transportation) at (334) 242-5960 or Janice O'Neal (Ground Ambulance) at (334) 353-4771. For billing instructions, please call Karen Hutto at (334) 215-4158 or Laquita Thrasher at (334) 215-4199.



Procedure for Billing Bilateral Procedures

Effective October 1, 2006 and thereafter, the process for billing bilateral procedures changed. In the past, (through September 30, 2006), providers were instructed to bill for bilateral procedures on one line with modifier 50 and the reimbursement was adjusted to 150% of Medicaid's fee schedule.

Effective October 1, 2006 and thereafter, for dates of payment, the new procedure is as follows:

- Bill the appropriate procedure code on two separate lines with RT and LT modifier, or other appropriate anatomical modifier.
- Modifier 50 will be used for informational purposes only and is no longer a pricing modifier.
- The payment will be 100% of Medicaid fee schedule for first line and 50% for second line.
- Claims will be subject to multiple surgery payment adjustments for multiple procedures.

Please refer to the Alabama Medicaid Provider Manual, Chapter 28, for details and examples.

Alabama Medicaid utilizes Medicare's RVU file to determine whether a modifier 50 should be allowed with the procedure code billed.

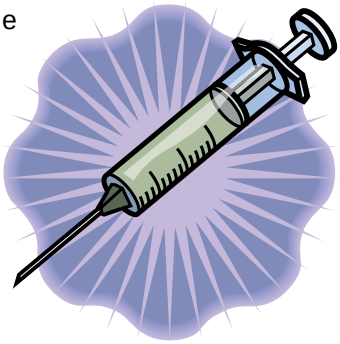
NOTE: When Medicaid payment occurs for an inappropriate procedure code billed with modifier 50, RT (right), and/or LT (left), the claim will be subject to a system adjustment in payment, post payment review, and recoupment.

Transition Issues with CMS Coordination of Benefit Agreement (COBA)

EDS recently implemented a new federally mandated process to handle Medicare crossover claims. In the past, EDS received claim tapes from the Medicare carriers. In the new COBA process, CMS is utilizing a contractor to collect all Medicare claims data and forward claims for Medicaid eligibles to the Medicaid claims processing agents. We are experiencing a low volume of crossover claims at this time. EDS is working with the CMS contractor to resolve the issue. Once resolved, claims sent to EDS by the CMS contractor will be processed. Until this issue has been corrected, providers will see a low volume of Medicare crossover claims on their Explanation of Payment reports.

For additional information, refer to your August Issue of the Medicare A Newsline newsletter, page 20.

New Vaccine for Children (VFC) Code



Effective October 01, 2006, the VFC Program added procedure code 90660 – Live, Attenuated Influenza Vaccine (LAIV) – for intranasal use. Please share this information with your billing staff. For more information concerning the new code, please contact the VFC Program at (800) 469-4599.

Important Mailing Addresses	
All Claim forms, Consent forms, and other mail	EDS Post Office Box 244032 Montgomery, AL 36124-4032
Inquiries, Provider Enrollment Information, and Provider Relations	EDS Post Office Box 241685 Montgomery, AL 36124-1685
Adjustments	EDS Post Office Box 241684 Montgomery, AL 36124-1684

Changes for Interactive Transactions will Affect Users and Vendors

Currently the Provider Electronic Solutions software permits users to submit an interactive transaction to Alabama Medicaid by pressing a 'submit' button on the related screen. Beginning May 23, 2007, interactive transactions will no longer be available through Provider Electronic Solutions or through a vendor software which currently utilizes the interactive toll-free dial-up service. The following interactive transaction types are currently permitted:

Eligibility inquiry Claim status inquiry Household inquiry

NCPDP drug claim submission, reversal and eligibility inquiry

Impact to Provider Electronic Solutions users

Beginning May 23, 2007, Provider Electronic Solutions will only be utilized for batch transactions. Dial-up interactive transactions will be accommodated in the following three ways:

· Users without an Internet Service Provider may connect to the Remote Access Server (RAS) with an Internet browser such as Microsoft Internet Explorer or Netscape as outlined by chapter 17 within the current Provider Electronic Solutions User Manual. Once connected to the RAS server, the user may access the new Web Portal and perform the same interactive transactions listed above by means of an interactive form to enter and submit such requests. The RAS dial-up connection will also become a toll-free line.

- Users with an internet service provider may connect directly to the new Web Portal to perform these transactions.
- Users may contract with a clearinghouse to perform these interactive transactions.

User Training will be made available in 2007. This training will include changes made to Provider Electronic Solutions as well as instructional guidance to complete an interactive transaction using the forms available on the new Web Portal.

If you use a software vendor

Software vendors are also being notified of this change. If you have a question about whether this change will impact your vendor supplied software, please contact your vendor.

Hospice Program Changes

Chapter 51 of the Alabama Medicaid Agency Administrative Code Manual has been amended. Hospice providers should review changes to Rule No. 560-X-51-.04. entitled Recipient Eligibility. It is very important that providers use current criteria when reviewing the appropriateness of hospice placement for a Medicaid recipient. Amendments for Rule No. 560-X-51-.04 have an effective date of October 17, 2006.

The Alabama Medicaid Agency Administrative Code manual is available on the agency website at *www.medicaid.alabama.gov.*

Visit Alabama Medicaid

ONLINE

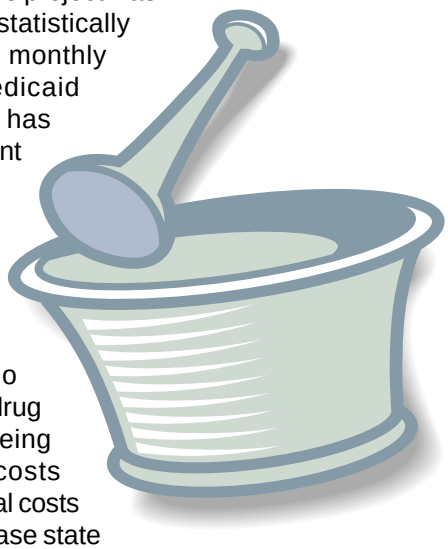
Providers can :

- **Print Forms and Enrollment Applications**
- **Download Helpful Software**
- **Obtain Current Medicaid Press Releases and Bulletins**
- **Obtain Billing and Provider Manuals and Other General Information about Medicaid**

www.medicaid.alabama.gov

Medical Cost Overview

Early in 2006, the Alabama Medicaid Agency and Health Information Designs (HID) launched a program to analyze the effects of the Preferred Drug List (PDL). The purpose of the project was to determine if there were any statistically significant changes in the total monthly medical costs for Alabama Medicaid beneficiaries after a drug class has been added to the PDL. Recipient medical and pharmacy costs were analyzed for the time period May 2003 through June 2005. The recipient population was selected by identifying all recipients (excluding dual eligible patients) in the designated timeframe who received a prescription for a PDL drug within the specific drug class being analyzed. The total medical costs analyzed were not limited to medical costs associated with the particular disease state represented by the drug class being analyzed but encompassed the patients' total medical costs. A p-value < 0.05 indicated a *statistically significant* change and a p-value > 0.05 indicated that there were *no significant changes* when comparing pre-PDL and post-PDL medical costs. Eighteen therapeutic PDL classes were reviewed. One class (Anti-Infectives) that did not have enough data post-PDL to allow for a valid pre- to post-PDL trend comparison. From May 2003 through June 2005, there was a significant reduction in medical cost trends for seven classes: Intranasal Corticosteroids, Antihypertensives, Anxiolytics/Sedatives/Hypnotics, CNS Stimulants/ADHD Agents, Skeletal Muscle Relaxers, Narcotic Analgesics, and Antidepressants. There were no significant changes in medical cost trends in ten classes: Alzheimer's Agents, Antidiabetic Agents, Proton Pump Inhibitors, Skin/Mucous Membrane Agents, Respiratory Agents, Cardiac Agents, Estrogens, Triptans, Antihyperlipidemic Agents, and Platelet Aggregation Inhibitors. There were no classes with significantly increased medical cost.



Temporary Addition of Two Drugs

Effective October 2, 2006, the Alabama Medicaid Agency temporarily added two anti-influenza drugs, Tamiflu[R] and Relenza[R], to our Preferred Drug List (PDL). No prior authorization (PA) will be needed to dispense these products until further notified.

This change in preferred status is in response to the recent announcement by the Center for Disease Control and Prevention (CDC) regarding recommendations for using antiviral agents for the 2006-07 influenza season.

For more information regarding the CDC announcement for this year's influenza season, please visit *www.cdc.gov/flu*. For any additional questions regarding this announcement, please contact Alabama Medicaid's Pharmacy Services at (334) 242-5050.

ALABAMA MEDICAID

In The Know

General Information Providers Need to Know When Billing to the Alabama Medicaid Agency

Preferred Drug List Update

Effective October 2, 2006, the Alabama Medicaid Agency updated the Preferred Drug List (PDL) to reflect recent Pharmacy and Therapeutics (P&T) recommendations as well as quarterly updates:

October 2, 2006 PDL Additions	**October 2, 2006 PDL Deletions***
Actos	Combipatch
Actoplus Met	Flonase
Advair HFA	Nasarel
Avandaryl	Wellbutrin XL
Humalog	
Rozerem	

* Denotes that these products are no longer preferred but are still covered by Alabama Medicaid and will require Prior Authorization (PA).

In addition to drug changes, the Agency updated its criteria for the following class (es): Estrogens.

- Prior therapies must include **prescribed and PDL preferred** agents.

For any drug classes where **stable therapy** applies, supporting documentation is required of the source of the medication meeting stable therapy requirements. Examples of acceptable documentation include pharmacy profile printouts, prescription copies, copies of the medical record medication list or progress notes documenting strength and quantity consistent with consecutive therapy timeframes. Stable therapy does not include medication samples or manufacturer vouchers.

The PA request form and criteria booklet, as well as a link for a new PA request form that can be completed and submitted electronically online, can be found on the Agency website at *www.medicaid.alabama.gov* and should be utilized by the prescribing physician or the dispensing pharmacy when requesting a PA. Please note that the Electronic PA system reviews drug claims in most PDL classes as the pharmacist bills a point of sale claim, and a PA may be automatically assigned (no hard copy PA needed) if the patient meets the appropriate criteria. Hard copy PA requests may be faxed or mailed to:

Health Information Designs (HID)
Medicaid Pharmacy Administrative Services
P. O. Box 3210
Auburn, AL 36832-3210
Fax: 1-800-748-0116
Phone: 1-800-748-0130

Incomplete PA requests or those failing to meet Medicaid criteria will be denied. If the prescribing physician believes medical justification should be considered, the physician must document this on the form or submit a written letter of medical justification along with the prior authorization form. Additional information may be requested. Staff physicians will review this information.

Policy questions concerning this provider notice should be directed to the Pharmacy Program at (334) 242-5050. Questions regarding prior authorization procedures should be directed to the HID help desk at 1-800-748-0130. Please note the Agency's new web address: *www.medicaid.alabama.gov* .

Prior Authorization Criteria for Synagis

Alabama Medicaid has updated its prior authorization criteria for Synagis. The approval time frame for Synagis was effective on October 1, 2006 and will be effective through March 31, 2007. A total of up to five (5) doses will be allowed per recipient in this timeframe. There are no circumstances that will allow for approval of a sixth dose. If a dose was administered in an inpatient setting, the date the dose was administered must be included on the request form. In addition, Medicaid accepts the following as risk factors for infants less than six (6) months old with gestational age of 33-35 weeks:

- Childcare attendance
- School-age siblings
- Congenital abnormalities of the airways
- Severe neuromuscular disease
- Exposure to environmental air pollutants

(Environmental air pollutants will not include second-hand smoke. Environmental air pollutants would include instances where a child is constantly exposed to particulate air matter.)

This year, requests for Synagis will be submitted on a separate prior authorization form. The new form and complete updated criteria specific to Synagis is available on our website at www.medicaid.alabama.gov under Programs: Pharmacy: Prior Authorizations/Override Criteria and Forms: Instruction Booklet for Form 369 and Form 351. Additional questions regarding Synagis criteria can be directed to Health Information Designs at 1-800-748-0130.

Screening for Lead Poisoning is Essential

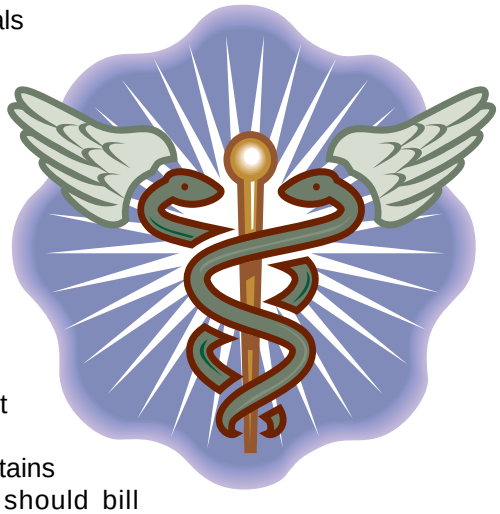
Remember, it is essential to screen all children at ages 12 and 24 months for lead poisoning. Report ALL levels >10ug/dL to the Health Department using the ADPH-FHS - 135 form. Forms and educational materials are available at the Health Department's website *http://www.adph.org/aclppp*. For any question, please call (334) 206-2966 or (800) 545-1098.

www.medicaid.alabama.gov

Change in Max Units For Allergy Immunotherapy

Procedure Code 95165 represents the preparation of vials of non-venom antigens. The reimbursement for procedure code 95165 is based on preparing a 10cc vial containing one mixture of all the appropriate antigens and removing aliquots with a volume of one (1) cc. Using this calculation, a 10cc vial would yield 10 doses.

Therefore, one (1) cc equals one (1) billing unit. This does not mean that the dosage must be in one (1) cc aliquots from a multidose vial. If a physician removes 1/2cc aliquots from a 10cc multidose vial for a total of 20 doses from one vial, he/she may only bill Medicaid for 10 doses. Billing for more than 10 doses per vial would represent an overpayment and be subject to post payment review and adjustment.



When a multidose vial contains less than 10cc, physicians should bill Medicaid for the number of one (1) cc aliquots that may be removed from the vial. If a physician prepares two 10cc vials, he/she may bill Medicaid for 20 doses. A physician may remove 1/2cc aliquots from the vial, but may not bill more than a total of 20 doses.

The maximum number of billable units (2-10cc vials) for procedure code 95165 will become "20" effective November 1, 2006. Please refer to the January 2007 update of Appendix H in the Alabama Medicaid Provider Manual. If you have any questions, please call Mary Timmerman (Medical Support) at (334) 242-5014.

Are Your Educational Needs Met?

The Alabama Medicaid Agency has an Outreach & Education Unit available to meet physician's offices educational needs. Following is a description of the educational activities in place.

Medicaid Outreach Representatives

Medicaid employs Outreach representatives who are trained in-depth regarding program policies. These representatives will educate providers about:

- Patient 1st
- EPSDT
- Family Planning and Plan First
- PT + 3 and,
- New programs or problem areas.

Providers are encouraged to call (334) 353-5203 anytime an educational in-service is needed or email *brenda.vaughn @medicaid.alabama.gov*. A telephone conference can also be arranged. We look forward to hearing from you soon!

New Online Catalog Offers More Materials and Streamlined Ordering Process

More educational materials and a streamlined ordering process are now available to Medicaid providers, thanks to recent updates to the Agency's online catalog. The catalog is available on the Agency website at www.medicaid.alabama.gov. To access the catalog directly, click on "Fast Find" at the upper right corner of any page on the site and select "Online Catalog."

The new catalog is designed to streamline orders by automating the fulfillment process. Because of these changes, providers need to be aware that effective December 1, 2006, all orders for educational materials will need to be placed online.

In addition to the expanded number of available items, the catalog features downloadable PDF versions of most documents and forms that can be printed directly by the provider or saved to the provider's computer for future use. To access these files, providers will need to click on the image of the document in the catalog to open the PDF document.

Providers needing assistance with an order should call (334) 353-5203, click on the catalog's "help" link or send an email to *CatalogOrders@medicaid.alabama.gov*.

Attention Anyone Who Uses a Software Vendor to Submit Electronic Claims

EDS is implementing a new claims processing system on May 23, 2007 to accommodate the changes that NPI requires. Some of the required fields in the HIPAA companion guides will be rewritten to facilitate the changes as well. A draft of the companion guide can be found on our website at the following address: *http://www.medicaid.alabama.gov/billing/NPI.aspx.*

Providers that use a vendor should make sure that their vendor is aware of the changes and is updating their software to accommodate them. If your software vendor has questions about the companion guide, they can contact our Electronic Claims Submission Department at (800) 456-1242. Providers who have questions about NPI can contact their provider representative at (800) 688-7989.

Attention Patient 1st and EPSDT Providers

Effective January 1, 2007, EPSDT Interperiodic screening codes will change. In order to bill an EPSDT Interperiodic screening, the following procedure codes (in service locations other than inpatient hospital), must be utilized with an **EP modifier**:

99211EP 99212EP 99213EP 99214EP 99215EP

If an Interperiodic screening is performed in an **inpatient hospital setting**, procedure code **99233EP** must be utilized.

Documentation requirements and reimbursement for EPSDT Interperiodic screenings will not change. Please refer to Appendix A for documentation requirements. 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.

NOTE: Interperiodic screenings must always be filed with the patient's other insurance first. Claims may be filed with the appropriate office visit or subsequent inpatient visit to the other insurance. Once the claim has been paid/denied from the other insurance, Medicaid may then be billed for the Interperiodic screening (with an EP modifier). Please refer to Chapter 5, Filing Claims, for information concerning third party billing instructions.

Please take the necessary actions for any computer system modifications to accommodate the above changes. If you have any questions, please contact Debbie Flournoy at (334) 242-5582.

Preparing for Emergencies at Home Handouts are Now Available

Two easy-to-read handouts for patients on when to go to the emergency room and how to prepare for health problems at home are now available on the Alabama Medicaid website and through the Agency's online catalog. The publications were designed in response to requests from physicians, hospitals and others for assistance in educating patients about appropriate ER use, according to Kim Davis-Allen, Director of Medicaid's Medical Services Division which includes the Agency's Patient 1st program.

"Many patients go to the emergency room for non-emergencies," Ms. Davis-Allen said. "Our goal is to help patients better understand when it is appropriate to use the emergency room and what to do when health problems arise at home."

The new publications are available on the agency's website at *www.medicaid.alabama.gov*

State Fiscal Year 2006-2007 Checkwrite Schedule

~~10/06/06~~	01/05/07	04/06/07	07/06/07
~~10/20/06~~	01/19/07	04/20/07	07/20/07
11/03/06	02/09/07	05/11/07	08/10/07
11/17/06	02/23/07	05/25/07	08/24/07
12/08/06	03/09/07	06/08/07	09/07/07
12/15/06	03/23/07	06/22/07	09/14/07

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Montgomery, AL 36124-4032

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MONTGOMERY AL

Provider *Insider*

Alabama Medicaid Bulletin **January 2007**

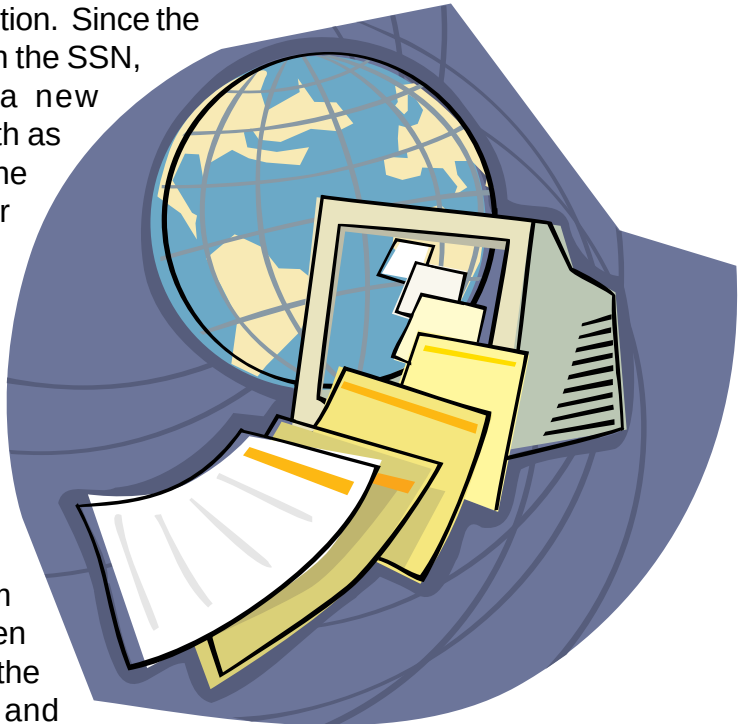
The checkwrite schedule is as follows:

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.

Continued on Page 3

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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.

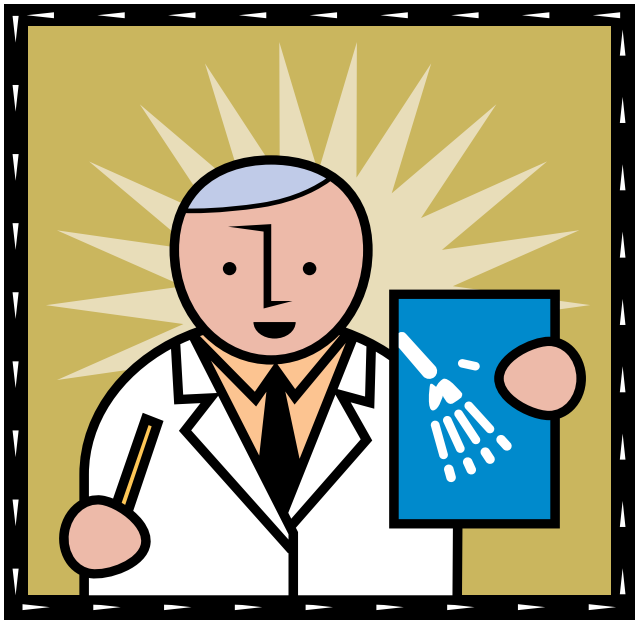
Since the old ID number will eventually be phased out, Alabama Medicaid providers are encouraged to update patient records as recipients present their new ID cards. Providers will be able to use the new number immediately although the old ID number may still be used for all claims and transactions submitted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

EDS

Alabama Medicaid Bulletin

Post Office Box 244032
Montgomery, AL 36124-4032

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Provider *Insider*

Alabama Medicaid Bulletin **March 2007**

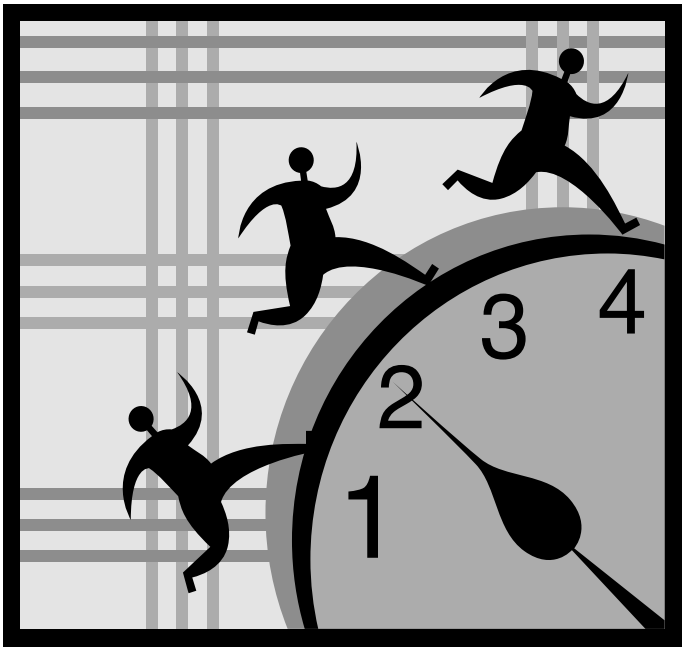
The checkwrite schedule is as follows:

03/09/07 03/23/07 04/06/07 04/20/07 05/11/07 05/25/07

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

NPI Notification Deadline Date Has Passed

The March 1, 2007 deadline for submitting your NPI numbers to EDS has expired. There remains a large number of providers who have not yet submitted their numbers. All eligible Alabama Medicaid Providers should immediately submit their NPI information, including taxonomy codes, to EDS.



You should submit an NPI Notification form, which can be located on the Medicaid website at, *www.medicaid.alabama.gov/billing/NPI.aspx*, along with a copy of the notification letter received from the enumerator, to EDS. The NPI Notification form for Individual Providers should be completed to link your individual performing numbers to your individual NPI. The NPI Notification form for Organizational Providers should be completed to link your group/payee or facility provider number(s) to your group's or facility's Organizational NPI. With the exception of providers, who are sole proprietors, group practices should submit a NPI notification form to report their organizational NPI.

If you are a large group practice and will be submitting more than 25 NPI numbers, you may use the NPI Large Group Provider Spreadsheet which can be located at the site indicated above.

If you currently have a group/payee number you will need to report the organizational NPI for your group/payee number.

The form and letter or spreadsheet may be faxed to 334-215-4118 or mailed to:

EDS Provider Enrollment
P.O. Box 241685
Montgomery, AL 36124

If you have questions regarding how to fill out the NPI Notification form, contact your Provider Representative at 1-800-688-7989 (within Alabama) or (334)215-0111 (outside of Alabama).

You will continue to submit claims with your current Alabama Medicaid Provider number until the new system to accommodate NPI numbers is implemented.

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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* _____

Procedures Requiring Prior Authorization

In order to determine if a procedure requires prior authorization, reference may be made to the Physician Fee Schedule posted on Medicaid's website at *www.medicaid.alabama.gov*, the Physician Drug Fee Schedule, and/or by calling the Provider Assistance Center at 1-800-688-7989. If further assistance is needed, you may contact your EDS Provider Representative at 1-800-688-7989.

Pulse Oximetry Information

Non-invasive ear or pulse oximetry services (procedure codes 94760-94762) are considered bundled services and, therefore, are not separately reimbursable. The only time these services are separately payable are when they are medically necessary and there are no other services payable under the physician fee schedule billed on the same date by the same provider. Non-invasive ear or pulse oximetry services are subject to post-payment review and adjustment.

Medicaid Adopts the CPT Modifier 51 Exempt Policy

Effective April 1, 2007, Medicaid will adopt the CPT Modifier 51 Exempt Policy. Therefore, all CPT designated Modifier 51 Exempt procedures will not be subject to the rule of the 50 percent reduction for multiple surgeries. The other exception to the 50 percent reduction is "Add-on" codes.

EDS Not Accepting Updated CMS-1500 or UB-04 Forms

EDS is not accepting the updated CMS-1500 or UB-04 forms at this time. If claim forms are received, they will be returned to the provider without being processed. Providers will be notified when the updated forms will be accepted.

www.medicaid.alabama.gov

PMP Disenrollment from Patient 1st

The Agency has identified instances of Primary Medical Providers (PMPs) leaving their practice without notifying the Agency. This creates a hardship for recipients who are assigned to that provider and hinders their access to care. It is imperative for the Agency to be notified, through EDS, of any changes to the provider's enrollment status. Please note the following when terminating or changing the status of your Patient 1st enrollment:

The PMPs agreement to participate in the Patient 1st program may be terminated by either the PMP or Agency, with cause or by mutual consent; **upon at least 30 days' written notice** and will be effective on the first day of the month, pursuant to processing deadlines. Failure to provide a 30-day notice may preclude future participation opportunities and/or recoupment of case management fees. The PMP should also notify the Agency of any and all changes to information provided on the initial application for participation. If such changes are not reported within 30 days of change, then future participation may be limited.

A written request must be submitted by the PMP to Provider Enrollment at EDS with the effective date given. Patients will automatically be reassigned based on the following:

If a PMP is leaving a group practice, then patients will be reassigned to a practitioner within the group; or

If the remaining group practitioner does not want to assume the caseload, then patients will be assigned through the automated assignment process. For a short period of time, these patients will not be enrolled in the **Patient 1st** Program; or

If the PMP has made arrangements with another practitioner to assume his/her caseload, then these specifics will be taken into consideration. The disenrollment notification must specify such arrangements.

Additionally, the PMP must give written notice of termination of the contract, within 15 days after receipt of the termination notice by Medicaid, to each enrollee who received his or her primary care from, or was seen on a regular basis.

If you have questions about the above requirements contact Paige Clark, R.N. at (334) 242-5148. To contact EDS Provider Enrollment call 1-800-362-1504.

Clarification on Billing Interperiodic EPSDT Screening

Reimbursement for EPSDT Interperiodic screenings has not changed. 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 the Alabama Medicaid Provider Manual 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. If further information is needed, concerning Interperiodic screenings, please refer to Appendix A.

NOTE: Interperiodic screenings must always be filed with the patient's other insurance first. Claims may be filed with the appropriate office visit or subsequent inpatient visit to the other insurance. Once the claim has been paid/denied from the other insurance, Medicaid may then be billed for the Interperiodic screening **(with an EP modifier)**. Please refer to Chapter 5, Filing Claims, for information concerning third party billing instructions.

Attention VFC Providers

Effective 11/1/06, the Human Papilloma Virus (HPV) vaccine was covered through the VFC Program. The HPV vaccine is covered for children 9 years of age through 18 years of age. Procedure code 90649 must be used when billing Medicaid for the administration of this vaccine.

NOTE: The Alabama Department of Public Health, VFC Program, has corrected their order forms to reflect the above age group. Please share this information with your billing staff. For more information concerning the HPV vaccine, please contact the VFC Program at 1-800-469-4599.

Hyaluronan (Sodium Hyaluronate) or Derivative for Intra-Articular Injection

The 2007 HCPCS code for Hyaluronan (sodium hyaluronate) has been changed to J7319. The previous HCPCS codes, J7317 and J7320 have been deleted. There is a misprint in the HCPCS Appendix 1 reference to the drug Orthovisc for J7318. Procedure Code J7318 is not a valid code as verified by Ingenix (HCPCS).

Attention Hospice Providers

All Medicaid hospice providers must use the revised Form 165B, the Hospice Recipient Status Change Form, beginning February 1, 2007. The revised form contains a confidentiality warning at the bottom of the document and is available on the Alabama Medicaid Agency website at *www.medicaid.alabama.gov*.

DME Provider Information

Effective January 1, 2007, procedure codes E0164 (commode chair, mobile with fixed arms) and E0166 (commode chair, mobile with detachable arms) were deleted. Procedure codes E0164 and E0166 were replaced with procedure code E0165 (commode chair, mobile or stationary, with detachable arms).

Effective January 1, 2007, procedure code E0180 (pressure pad alternating with pump) was deleted. Procedure code E0180 was replaced with procedure code E0181. The description for procedure code E0181 has been updated to reflect powered pressure reducing mattress overlay/pad, alternating with pump, includes heavy duty.

Effective January 1, 2007, procedure code E2320 (power wheelchair accessory, hand or chin control interface, remote joystick or touchpad, proportional, including all related electronics, and fixed mounting hardware) was deleted. It was replaced with procedure codes E2373 (power wheelchair accessory, hand or chin control interface, mini-proportional, compact, or short throw remote joystick or touchpad, proportional, including all related electronics and fixed mounting hardware) and E2374 (power wheelchair accessory, hand or chin control interface, standard remote joystick (not including controller), proportional, including all related electronics and fixed mounting hardware, replacement only).

Dental Policy Clarifications

Alabama Medicaid would like to clarify the policy limitations on the new CDT2007 codes implemented effective January 1, 2007.

D0145 Oral Evaluation for a Patient Under Three Years of Age and Counseling with Primary Caregiver

This code is intended to be for the first visit to a dental office for a patient under three (3) years of age, for evaluation of caries susceptibility, development of an appropriate preventive oral health regimen and communication with and counseling with the child's parent or guardian. The code will only be allowed once per recipient lifetime and cannot be billed on the same date of service as procedure codes D0120 (periodic exam); D0140 (limited oral evaluation) or D0150 (comprehensive oral evaluation).

D1206 Topical Fluoride Varnish, Therapeutic Evaluation for Moderate to High Risk Caries

In order to bill this code the patient must have documented evidence of moderate to high risk caries. This procedure can only be billed once annually and is not allowed on the same date of service as D1203 (topical application of fluoride – child); D1204 (topical application of fluoride – adult); D1110 (prophylaxis – adult) or D1120 (prophylaxis – child).

If you have additional questions, please call the Dental Program at (334) 353-5533.

Procedures To Follow When Recipients Request To Change Rendering Providers for a Prior Authorized DME Procedure

1. The initial rendering provider must submit a written request to the Alabama Medicaid Agency indicating that they are aware and agree with the decision of the recipient to change providers and that the approved PA may be cancelled with the effective end date for services.
2. The new provider must submit a written request to the Alabama Medicaid Agency stating that they will now be submitting a PA on the recipient's behalf and have the patient sign that they agree and understand the change.
3. Medicaid's PA Unit will cancel the approved PA request in the system.
4. Medicaid's PA Unit will review the new provider's PA request for approval or denial.

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

PMP Request Dismissal of Recipient

A PMP may request removal of a recipient from his panel due to good cause.* All requests for patients to be removed from a PMP's panel should be submitted in writing and provide the enrollee 30 days' notice from the first date of the month in which you are dismissing the enrollee.

*According to the guidelines listed in the 1915(b) (i) waiver of the Social Security Act which allows the operation of the Patient 1st Program, good cause is defined as:

- Behavior on the part of the recipient which is disruptive, unruly, abusive or uncooperative to the extent that the ability of the provider to provide services to the recipient or other affected recipients is seriously impaired,
- Persistent refusal of a recipient to follow a reasonable, prescribed course of treatment; or
- Fraudulent use of the Medicaid card.

The PMP is responsible for sending a letter of dismissal to the enrollee and including a copy as an attachment to documentation provided to Medicaid. The dismissal letter should be addressed to the patient and signed by the PMP.

The dismissal request to Medicaid should contain recipient name, Medicaid number, address, telephone number, and the reason why the PMP does not wish to serve as the recipient's PMP.

The recipient will be given the opportunity to change the selected PMP before the active assignment date. **The original PMP must continue to provide services or make referrals for services to the recipient until such time the reassignment is complete**. All reassignments will be made effective the 1st of a month.

Dismissal requests should be mailed or faxed to the Medicaid Agency. The fax number is (334) 353-3856. If you have questions about the above requirements, contact Gloria Wright at (334) 353-5907.

EPSDT Interperiodic Screening Codes Have Changed

Effective for dates of service, January 1, 2007, and thereafter, EPSDT Interperiodic screening codes were changed. In place of procedure codes 99391-99395 (with no modifier), the following Interperiodic procedure codes must be utilized with an EP modifier:

99211EP through 99215EP – Office and/or outpatient setting

99233EP – Inpatient Setting

NOTE: The Comprehensive EPSDT screening codes 99381EP –99385EP and 99381EP–99395EP did not change.

EDS

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Provider *Insider*

Alabama Medicaid Bulletin **May 2007**

The checkwrite schedule is as follows:

05/11/07 05/25/07 06/08/07 06/22/07 07/06/07 07/20/07

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

The New Medicaid Claims Processing System Date Has Been Postponed

The implementation of the new Medicaid claims processing system has been postponed. Look for the new implementation date in upcoming issues of the Provider Insider.

What you MUST do:

1. Continue to use the current claim submission methods with your current provider number until the new implementation date. Claims or other transactions submitted using the National Provider Identifier (NPI) numbers shall not be accepted until the implementation of the new claims processing system.

2. Continue to use the current UB-92 and the current CMS-1500 claim form. Paper claims submitted on the new claim forms shall be returned to the provider without being processed.

Rescheduling of this date will allow additional testing of the new system.

Provider training for the new Medicaid claims processing system will be held throughout the state in August. Invitations will be sent prior to the training.

The new Medicaid claims processing system, called interChange, will feature a fully functional web portal and will be fully NPI compliant. If you have not already sent in your NPI information to EDS, please do so immediately. The information can be found on the Medicaid website at:

http://www.medicaid.alabama.gov/billing/NPI.aspx?tab=6

Future notifications regarding cutoff dates and changes associated with new Medicaid claims processing system may be found at *www.medicaid.alabama.gov*. If you have questions regarding this delay, please contact your provider representative at 1-800-688-7989.

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Important Mailing Addresses 2
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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* _____

Billing Refractions for Dual Eligibles

Procedure Code 92015 (Refraction) should be billed by itself, for dually eligible (Medicare and Medicaid) recipients. The claim for refraction may be billed electronically or on a paper CMS 1500 claim form. This code is identified as Medicare Exempt and as such should not be filed on a Medicare Crossover claim form, and should not be filed on the same claim form with other procedure codes that are covered by Medicare.

Modifier "76"

Modifier "76" is used for repeat procedures only and should not be billed unless the procedure is actually a repeat procedure. This modifier should never be billed to obtain additional billing units for procedures that have restricted billing units (example; injectable drugs). Providers that have used this modifier inappropriately in the past should adjust those claims, and note that this issue is subject to post payment review and recovery.

Place of Service Restrictions for Physicians Billing Injectable Drugs

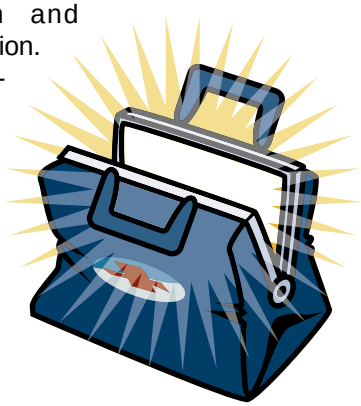
When physicians order drugs in an outpatient (POS 22), inpatient (POS 21), and emergency room (POS 23) setting, the physician should not bill for the injectable drug(s) as the facility will bill for the medication. This practice represents a duplication of service and is subject to post payment recovery.

www.medicaid.alabama.gov

Distinct Procedural Service (Modifier 59)

Modifier 59 may be used to indicate a service was performed on the same date of service but was distinct from the primary service provided the same day. Examples of when Modifier 59 would be appropriate to use include (but not limited to), different procedure or surgery, different site or organ system, separate incision/excision, which would not ordinarily be performed on the same day by the same physician.

Medical record documentation and diagnoses must support Modifier 59 utilization. When diagnoses alone do not support appropriate Modifier 59 utilization, the claim will be denied. When receiving a Modifier 59 or Multiple Surgery denial, a paper claim with an attached Operative Report (record "Op Report Attached" in block 19) must be submitted to EDS for reconsideration. The reconsideration should occur before a written appeal is made to the Alabama Medicaid Agency.



EXAMPLES

- Surgical debridement/shaving is normally considered an integral part of the primary surgical procedure (bundled). However, there are times when the debridement/shaving occurs at a different site or location during the same surgical session and it may be necessary to append a Modifier 59 to indicate a "separate and distinct service."

- When filing for a secondary procedure code 29877 for bilateral debridement/shaving of articular cartilage electronically, append Modifier RT (right) and Modifier 59 on the first line and on the second line append Modifier LT (left) and Modifier 59. Diagnoses must support the procedures billed.

- If the electronic claim rejects, then a paper claim (indicating RT/LT with mod. 59) should be forwarded to EDS, with the appropriate OP Report attached. The paper claim form should have block 19 marked indicating that the Op Report is attached.

Important Mailing Addresses	
All Claim forms, Consent forms, and other mail	EDS Post Office Box 244032 Montgomery, AL 36124-4032
Inquiries, Provider Enrollment Information, and Provider Relations	EDS Post Office Box 241685 Montgomery, AL 36124-1685
Adjustments	EDS Post Office Box 241684 Montgomery, AL 36124-1684

EDS Provider Representatives

G R O U P 1

sharmira.parker
@eds.com
334-215-4142

Nurse Practitioners
Podiatrists
Chiropractors
Independent Labs
Free Standing Radiology
CRNA
EPSDT (Physicians)
Dental
Physicians
Optometric
(Optometrists and Opticians)

misti.nichols
@eds.com
334-215-4113

G R O U P 2

Rehabilitation Services
Home Bound Waiver
Therapy Services (OT, PT, ST)
Children's Specialty Clinics
Prenatal Clinics
Maternity Care
Hearing Services
Mental Health/Mental Retardation
MR/DD Waiver
Ambulance
FQHC

laquita.thrasher
@eds.com
334-215-4199

karen.hutto
@eds.com
334-215-4158

Public Health
- Elderly and Disabled Waiver
- Home and Community Based Services
- EPSDT
- Family Planning
- Prenatal
- Preventive Education

Rural Health Clinic
Commission on Aging
DME
Nurse Midwives

G R O U P 3

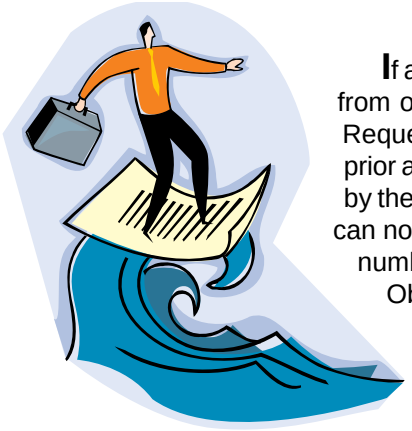
Ambulatory Surgical Centers
ESWL
Home Health
Hospice
Hospital
Nursing Home

holly.howe
@eds.com
334-215-4130

ann.miller
@eds.com
334-215-4156

shermeria.hardy
@eds.com
334-215-4160

Personal Care Services
PEC
Private Duty Nursing
Renal Dialysis Facilities
Swing Bed



Releasing the Prior Authorization Number

If a recipient in a target group requiring prior authorization requests to change case managers from one agency to another, the Target Case Management (TCM) provider must complete a Request for Interagency Transfer form. It is imperative that the transferring agency release the prior authorization number along with completing the Interagency Transfer form when requested by the receiving agency. Without a completed Interagency Transfer form, the receiving provider can not bill for TCM services in a timely manner. This form authorizes EDS to reassign the PA number to the receiving agency providing the continuation of case management services. Obtain the Request for Interagency Transfer forms from the Alabama Medicaid Agency, 501 Dexter Avenue, P.O. Box 5624, Montgomery, AL 36103-5624.

Reminder of Timely Submission of Prior Authorization Requests

Prior authorization request for purchase, rental, or recertification of DME must be received by Medicaid's Fiscal Agent within thirty calendar days of the signature date the equipment was dispensed.

If a prior authorization request is denied with code D-24 (inadequate information justifying medical necessity), this information must be received within thirty days from the date the information was requested. If additional information is not received within thirty days the prior authorization request will remain denied.

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

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Alabama Medicaid Bulletin **July 2007**

The checkwrite schedule is as follows:

08/10/07 08/24/07 09/07/07 09/14/07

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

The InfoSolutions Web Site Is Changing!

InfoSolutions will still offer the same valuable patient clinical information, but now a Blue Cross and Blue Shield of Alabama Individual User ID will be required to log in.

- If you already have an Individual User ID, simply go to wwwinfosolutions.net, enter your User ID and password in the spaces provided, and click "Sign In."

OR

- PRIOR to 7/26/2007 - If you do NOT have an Individual User ID, please go to www.infosolutions.net, click the link for InfoSolutions e-Prescribing, then select "Register Now For Your Individual User ID."

AFTER 7/26/2007 - If you do NOT have an Individual User ID, please go to *www.infosolutions.net*, click "Register for InfoSolutions," then follow the steps to register for an Individual User ID.

Questions? Call (205) 220-5900 to be directed to an InfoSolutions Representative.

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Pass It On!

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Be sure to route this to:

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- ❒ *Billing Dept.*
- ❒ *Medical/Clinical Professionals*
- ❒ *Other _____*

Medicaid is Now Partnered With APS Healthcare

Effective June 1, 2007, APS* Healthcare assumed responsibility for reviewing applications for admissions for the following programs: Hospice, PEC, Swing Beds, and the retrospective review process for appropriateness of admissions to Nursing Homes, ICF/MR facilities and IMD facilities. Applications for admission to Hospice which contain more than 30 pages, PEC and Swing bed programs should be mailed to APS at the address below.

APS Healthcare will request monthly retrospective reviews for Nursing Homes, ICF/MR facilities, and IMD facilities. Medical record documentation, in response to such requests which contains more than 30 pages shall be mailed to address below

APS Healthcare
1640 Phoenix Boulevard, Suite 200
Atlanta, Georgia 30349
Phone: (800) 809-5426

Medical record documentation which contains less than 30 pages may be faxed to APS Healthcare at (800) 218-6333.

Hospice Recipient Status Change Form (Form 165B) and Long Term Care Request for Action Forms shall continue to be faxed to the Medicaid Agency at (334) 353-5901.

For additional information as it relates to this program, please contact Nancy Headley at (334) 242-5684.

*Innovative Resource Group doing business as APS Healthcare Midwest

Hospice Form Change

The Form 165A Hospice Cover Sheet and Form 165B Hospice Recipient Status Change have been updated to require additional provider and recipient information. The forms now require the provider NPI number and the social security number of the hospice recipient. Both forms are available on the Medicaid Agency website at www.medicaid.alabama.gov.

www.medicaid.alabama.gov

Organ Transplant Guidelines

Please note the following guidelines for all Medicaid covered organ transplants (with the exception of cornea) that are being referred to an out-of-state facility or provider for possible transplantation:

- The patients referring physician must contact the appropriate transplant specialist at UAB to ensure that the transplant cannot be performed instate.
- After the determination that the transplant cannot be performed instate is made by UAB's Transplant Specialists, the recipient is referred by their physician to an out-of-state facility with the understanding that the out-of-state facility must coordinate the approval and reimbursement of the transplant with UAB's Transplant Services Coordinator

If you have additional questions regarding this information, please call Brenda Fincher at (334) 242-5455.

Patient 1st Care Coordination Services Available for Dental Providers

Public Health licensed Social Workers and Nurses provide care coordination services to Medicaid recipients statewide through the Patient 1st program. Historically, the dental community has under utilized these services. Care Coordinators understand the connection between proper dental hygiene and a child's overall health. They are equipped with the knowledge and materials to educate Medicaid recipients regarding dental matters.

Dentist can refer recipients for a variety of reasons. Some dental procedures require extensive coordination of services. Care coordinators can assure that the family has a clear understanding of the appointment and needed transportation. They can also educate families on the importance of keeping appointments, maintaining proper dental hygiene and exhibiting proper behavior while in the dental office. Availability of care coordination services in some counties is limited, so it is important that referrals for missed appointments be prioritized according to urgency

Referrals can be made by calling the Patient 1st Care Coordinator at your local county health department or accessing our on-line referral system at *www.adph.org/ccrs*. For additional information, contact Stacey Neumann at (800) 654-1385.

DME Provider Enrollment Update

Home Medical Equipment (HME) Service Providers shall be licensed annually by the Alabama Board of Home Medical Equipment Services Providers before the provider may engage in the provision of home medical equipment. This requirement is a condition of enrollment for Medicaid providers who must comply with this requirement on or before May 31, 2007. For information regarding how to become a licensed HME provider visit the HME website at www.homemed.state.al.us and click on the Forms link. This link contains the application for HME licensure. You will also find contact information for the HME representative who can answer questions or concerns you may have about the enrollment process. If you have any additional questions or need further clarification, please contact Ida Gray, at (334)-353-4753.

Patient 1st and EPSDT Services

For recipients of Medicaid, birth to age 21, the EPSDT screening is a comprehensive preventive service at an age appropriate, recommended schedule. It is the only reimbursable preventive medical service for this age group. There are numerous components of the EPSDT , all of which are required in the Federal Early Periodic Screening Diagnosis Treatment (EPSDT) program. All age appropriate components must be performed at the time of a screening exam. These components are listed and described in Appendix A of the Alabama Medicaid Provider Manual.

Patient 1st

Health Care Close To Home

PMP's are required to either perform or make arrangements for the performance of EPSDT screenings on those children on their panel below the age of 21. If a PMP cannot or chooses not to perform the comprehensive EPSDT screenings, the PMP may authorize another provider serving the PMP's county to perform the screenings for enrollees. This can be done by contracting with another provider to perform screenings for the PMP's enrollees or by referring them to another screener on a case-by-case basis. Any provider the PMP contracts with or refers recipients to must be an EPSDT certified screener. Regardless, the PMP is responsible for ensuring that age appropriate EPSDT screenings are provided.

If the PMP enters into an agreement with a screener in order to meet this Patient 1st requirement for participation, the agreement containing the original signatures of the PMP or the authorized representative and the screener or an authorized representative must be submitted within the enrollment application. The PMP must keep a copy of this agreement on file. If this agreement is executed after enrollment a copy must be submitted within ten (10) days of execution.

The agreement can be entered into or terminated at any time by the PMP or the screener. The Agency and EDS must be notified immediately of any change in the status of the agreement.

If there is an agreement between the PMP and a Screener to provide EPSDT services, the PMP agrees to:

- Refer Patient 1st patients for EPSDT screenings. If the patient is in the office, the physician/office staff will assist the patient in making a screening appointment with the Screener within ten (10) days.
- Maintain, in office, a copy of the physical examination and immunization records as part of the patient's permanent record.

- Monitor the information provided by the Screener to assure that children in the Patient 1st program are receiving immunizations as scheduled and counsel patients appropriately if found in non-compliance with well child visits or immunizations.
- Review information provided by the Screener to coordinate any necessary treatment and/or follow-up care with patients as determined by the screening.
- Notify the Agency and EDS immediately of any changes to this agreement.

The Screener must agree to:

- Provide age appropriate EPSDT examinations and immunizations within sixty (60) days of the request for patients who are referred by the PMP or are self-referred.
- Send EPSDT physical examination and immunization records within 30 days to the PMP.
- Notify the PMP of significant findings on the EPSDT examination or the need for immediate follow-up care within 24 hours.
- Allow the PMP to direct further referrals for specialized testing or treatment.
- Notify the Agency and EDS immediately of any changes to agreement..

www.medicaid.alabama.gov

Procedure Code Changes For Sodium Hyaluronate (Hyaluronan)

The Agency received CMS notification that procedure code J7319 (Hyaluronate [sodium hyaluronate]) was deleted effective March 31, 2007. The procedure code J7319 was replaced with the four temporary Q codes listed below and effective for dates of service beginning January 1, 2007.

Q4083 Hyaluronan or Derivative, Hyalgan or Supartz, for intra-articular injection, per dose,
Q4084 Hyaluronan or Derivative, Synvisc, for intra-articular injection, per dose,
Q4085 Hyaluronan or Derivative, Euflexxa, for intra-articular injection, per dose, and/or
Q4086 Hyaluronan or Derivative, Orthovisc, for intra-articular injection, per dose.

Please refer to the Physicians' Drug Fee Schedule on Medicaid's website at *www.medicaid.alabama.gov* or call the EDS Provider Assistance Center (800) 688-7989 for reimbursement and guidelines.

Procedure Code Changes for Immune Globulin

The Agency received CMS notification that procedure code J1567 (Immune globulin, intravenous, non-lyophilized (e.g. , liquid), 500 mg.) is being deleted effective June 30, 2007. The procedure code J1567 was replaced with the six temporary Q codes listed below and effective for dates of service beginning July 1, 2007.

Q4087 Injection, Immune Globulin, (Octogam), Intravenous, non-lyophilized, (e.g., liquid), 500 mg.
Q4088 Injection, Immune Globulin, (Gammagard), intravenous, non-lyophilized, (e.g. liquid), 500 mg.
Q4089 Injection, RHO (D) Immune Globulin (Human), Rhophylac), intravenous, 100 I.U.
Q4090 Injection, Hepatitis B Immune Globulin (Hepagam B), intramuscular, 0.5 ML
Q4091 Injection, Immune Globulin, (Flebogamma), intravenous, non-lyophilized, (e.g. liquid) 500 mg.
Q4092 Injection, Immune Globulin, (Gamunex), intravenous, non-lyophilized, (e.g. liquid), 500 mg.

Please refer to the Physicians' Drug Fee Schedule on Medicaid's website at *www.medicaid.alabama.gov* or call the EDS Provider Assistance Center (800) 688-7989 for reimbursement and guidelines.

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Alabama Medicaid Bulletin **September 2007**

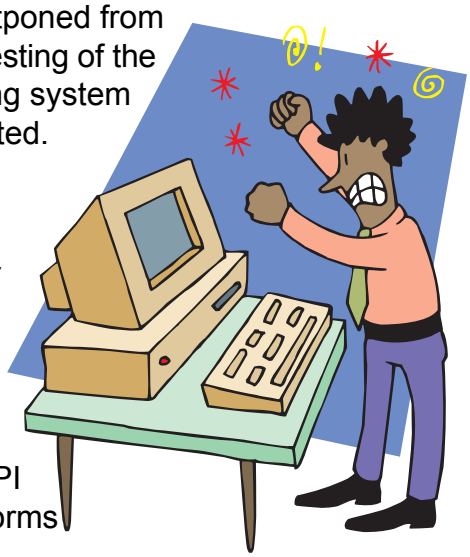
The checkwrite schedule is as follows:

09/07/07 09/14/07 10/05/07 10/19/07 11/02/07

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

The New Medicaid Claims Processing System Date Has Been Postponed

The new Medicaid claims processing system date has been postponed from September 17, 2007. Rescheduling of this date will allow continued testing of the new system. Provider training for the new Medicaid claims processing system will be held throughout the state before the new system is implemented. Invitations will be sent prior to the training.



What You MUST do:

1. Continue to use the current claim submission methods with your current provider number until the new implementation date. Claims or other transactions submitted using the National Provider Identifier (NPI) numbers shall not be accepted until the implementation of the new claims processing system.
2. Continue to use the UB-92 and CMS-1500 claim form without NPI information present. Paper claims submitted on the new claim forms shall be returned to the provider without being processed.

Reminder: The new Medicaid system, called interChange, will feature a fully functional web portal and will be fully NPI complaint. If you have not already sent in your NPI information to EDS, please do so immediately. The information can be found on the Medicaid website at *http://www.medicaid.alabama.gov/billing/NPI.aspx?tab=6*

Future notifications regarding cutoff dates and changes associated with the new Medicaid claims processing system may be found at *www.medicaid.alabama.gov*. If you have questions regarding this delay, please contact the Provider Assistance Center at 1-800-688-7989.

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Everyone needs to know the latest about Medicaid. Be sure to route this to:

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

Prior Authorization Criteria for Synagis®

Alabama Medicaid has updated its prior authorization criteria for Synagis ®. The approval time frame for Synagis® will begin October 1, 2007 and will be effective through March 31, 2008. A total of up to five (5) doses will be allowed per recipient in this timeframe. There are no circumstances that will allow for approval of a sixth dose. If a dose was administered in an inpatient setting, the date the dose was administered must be included on the request form. In addition, Medicaid accepts the following as risk factors for infants less than six (6) months old with gestational age of 33-35 weeks:

- Childcare attendance
- School-age siblings
- Congenital abnormalities of the airways
- Severe neuromuscular disease
- Exposure to environmental air pollutants (Environmental air pollutants will not include second-hand smoke. Environmental air pollutants must include instances where a child is constantly exposed to particulate air matter)

For approval of requests, the recipient must meet gestational and chronological age requirements. In order to meet chronological age requirements, the recipient must be the required age at the start of the RSV season.

Requests for Synagis ® will be submitted on a separate prior authorization form and may be accepted beginning September 1, 2007. The form and complete updated criteria specific to Synagis ® are available on our website at *www.medicaid.alabama.gov* under Programs: Pharmacy: Prior Authorizations/Override Criteria and Forms: Instruction Booklet for Form 369 and Form 351. Additional questions regarding Synagis® criteria can be directed to Health Information Designs at (800) 748-0130.

www.medicaid.alabama.gov

In-State Inpatient Hospital Claims Must Follow PHP Payment Guidelines

All in-state inpatient hospital claims follow Partnership Hospital Program (PHP) payment guidelines. PHP requires all claims to be filed by the last day of February of the following year

The fiscal year begins October 1 and ends September 30. Listed below are examples of filing deadlines:

- Any inpatient claims with dates of service from October 1, 2006 through September 30, 2007 that are filed after February 29, 2008 will be denied by EDS as exceeding the PHP filing limit. Recipients may not be billed if a claim is denied for this reason.
- Any inpatient claims for **retroactive coverage** with dates of service from October 1, 2006, through September 30, 2007 that are filed after February 29, 2008 will be denied by EDS. Hospital must seek payment, if any, from PHPs. Recipients may not be billed if a claim is denied for this reason. However, a hospital that accepts a patient as private pay before rendering service is not obligated to bill Medicaid if the patient receives retroactive eligibility. In this case, the recipient may be billed.
- Any inpatient claims with dates of service from October 1, 2006 through September 30, 2007 that are filed after February 29, 2008 with **third party liability** action (either paid or denied) will be denied by EDS. The usual third party filing limits will not apply. Recipient may not be billed if a claim is denied for this reason.
- Any inpatient claims with dates of service prior to October 1, of the previous fiscal year are considered outdated. Recipients may not be billed.

Claims that span September 30, 2007 and October 1, 2007 must be split billed due to the PHP year-end.

Claims should be filed as soon as possible after the September 30, 2007, year-end.

Hospice Palliative Drug List

In an effort to support the coordination of care between a recipient's hospice provider and pharmacy provider, the Alabama Medicaid Agency has developed a Hospice Palliative Drug List (HPDL). The HPDL shall be used as a guide for drugs that may be associated with the patient's terminal illness.

1. Reimbursement for disease specific drugs related to the recipient's terminal illness is included in the per diem for hospice covered services. These drugs will not be reimbursed through the Medicaid Pharmacy Program.

2. Reimbursement for drugs not related to the recipient's terminal illness may be made to the dispensing pharmacy through the Medicaid Pharmacy Program. These drugs will not be reimbursed through the per diem for hospice covered services.

3. Retrospective audits of the hospice and pharmacy providers will be conducted to ensure appropriate billing has occurred.

Policy questions related to HPDL should be directed to Hospice Services at (334) 242-5018.

For information related to HPDL go to: *http://www.medicaid.alabama.gov/documents/Program-LTC/3D-2c_14_Hospice-Palliative_Care_Drug_List-6-18-07.pdf*

PMP Disenrollment From Patient 1st

The Agency has identified instances of Primary Medical Providers (PMPs) leaving their practice without notifying the Agency. This creates a hardship for recipients who are assigned to that provider and hinders their access to care. It is imperative for the Agency to be notified, through EDS, of any changes to the provider's enrollment status.

Please note the following when terminating or changing the status of your Patient 1st enrollment:

- The PMP's agreement to participate in the Patient 1st program may be terminated by either the PMP or Agency, with cause or by mutual consent; **upon at least 30 days written notice** and will be effective on the first day of the month, pursuant to processing deadlines. Failure to provide a 30 day notice may preclude future participation opportunities and/or recoupment of case management fees. The PMP should also notify the Agency of any and all changes to information provided on the initial application for participation. If such changes are not reported within 30 days of change, then future participation may be limited.

Patient 1st
Health Care Close To Home

A written request must be submitted by the PMP to Provider Enrollment at EDS with the effective date given. Patients will automatically be reassigned based on the following:

- If a PMP is leaving a group practice, then patients will be reassigned to a practitioner within the group; or
- If the remaining group practitioner does not want to assume the caseload, then patients will be assigned through the automated assignment process. For a short period of time, these patients will not be enrolled in the Patient 1st Program; or
- If the PMP has made arrangements with another practitioner to assume his/her caseload, then these specifics will be taken into consideration. The dis-enrollment notification must specify such arrangements.
- Additionally, the PMP must give written notice of termination of the contract, within 15 days after receipt of the termination notice by Medicaid, to each enrollee who received his or her primary care from, or was seen on a regular basis.

If you have questions about the above requirements contact Paige Clark, R.N. at (334) 242-5148. To contact EDS Provider Enrollment call (800) 362-1504.

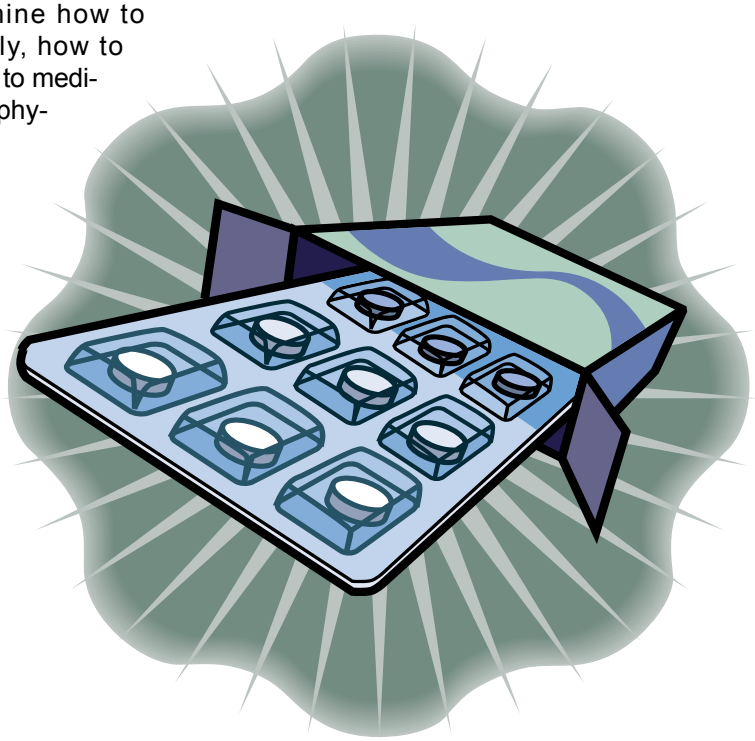
Tamper Resistant Prescription Pads

A provision of Public Law 110-28 (Iraq War Supplemental Appropriations bill) mandates that all non-electronic prescriptions provided to Medicaid recipients written on or after October 1, 2007 be written on tamper-resistant pads.

Alabama is taking immediate steps to determine how to comply with this federal law and most importantly, how to ensure that Medicaid recipients continue to have access to medically-necessary medications prescribed legally by their physicians.

Medicaid is coordinating with physician and pharmacy associations and conducting additional research to determine the necessary Administrative Code and Medicaid policy changes that need to be made to comply with the new federal law.

Updates regarding this new federal mandate and the Agency's response will be made available on the Agency's website at *www.medicaid.alabama.gov* and through the Pharmacy Program listserv. To subscribe to the Pharmacy listserv, visit the Agency website at *www.medicaid.alabama.gov*, click on Programs/Pharmacy Services/Click here to subscribe (on the right side of the screen) and follow the prompts to send a subscription email.



State Fiscal Year 2007-2008 Checkwrite Schedule

10/05/07	01/04/08	04/04/08	07/11/08
10/19/07	01/18/08	04/18/08	07/25/08
11/02/07	02/01/08	05/02/08	08/08/08
11/16/07	02/15/08	05/16/08	08/22/08
12/07/07	03/07/08	06/06/08	09/05/08
12/14/07	03/21/08	06/20/08	09/12/08

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Alabama Medicaid Bulletin **November 2007**

The checkwrite schedule is as follows:

11/16/07 12/07/07 12/14/07 01/04/08 01/18/08

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

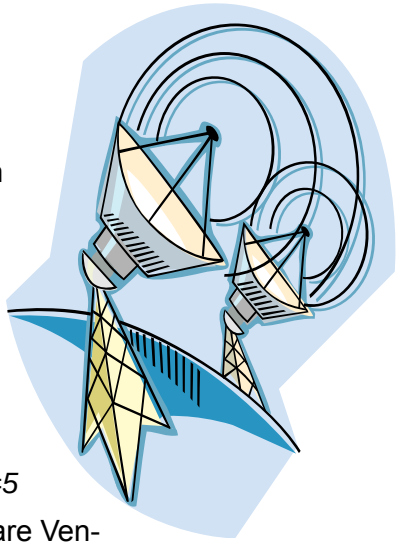
interChange Beta Testing Available for Medicaid Providers and Vendors

Beginning November 5, 2007 all Providers and Vendors interested in trading electronic transactions with Alabama Medicaid will have the opportunity to test with the new interChange system. This testing includes NPI.

Recipient and provider test data is not provided for this testing. A conversion of the current production system has been completed and testers may use production information to test.

Expectations:

- Submit a 270 eligibility request and receive a 271 eligibility response.
- Submit a 276 claim status request and receive a 277 claim status response.
- Claim submission, retrieval of the 997 and feedback via email on adjudication results if requested.
- 278, 835 and NCPDP testing will be available at a future date.



Before testing, please review the following documents available on the Medicaid Website.

The Interchange Test File Processing Publication for Vendors and Providers contains useful information on obtaining a testing ID, whom to contact for testing questions, testing expectations and an example of how to setup an account. *http://www.medicaid.alabama.gov/old_site/hipaa/vendornews.htm?tab=5*

The Alabama Interchange Vendor Specifications document is intended for Software Vendors to use when developing applications to interact with the interchange version of the Alabama Medicaid Interactive Web site. *http://www.medicaid.alabama.gov/old_site/hipaa/AL_interChange_Vendor_Specs_v1.0.pdf*

The Alabama HIPAA Companion Guides contains specific requirements, such as NPI requirements, to be used for processing data in the Alabama Medicaid Management Information System. *http://www.medicaid.alabama.gov/billing/npi_companion_guides.aspx*

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Resources Utilized to Determine if a Procedure Code Requires a PA

There are several ways by which a provider may determine whether or not a code requires prior authorization. The Agency's website *www.medicaid.alabama.gov* is a resource for the Alabama Medicaid Provider Manual and various listings and fee schedules. The following is a guide to identify helpful tools to determine a prior authorization requirement.

Chapter 4, and Appendix L, in the Medicaid Provider Manual located on the Medicaid website, outlines the steps needed to submit requests for prior approvals. The Physician's Fee Schedule identifies procedures requiring a PA and the Physician Drug Fee Schedule identifies administration or injectables requiring a PA.

Additionally, providers may call the Automated Voice Response System (AVRS) at (800) 727-7848, or their EDS Representative for information on prior authorization requirements for specific procedure codes.

Modifier "76"

Modifier "76" is used for repeat procedure only and should not be billed unless the procedure is actually a repeat procedure. This modifier should never be billed to obtain additional billing units for procedures that have restricted billing units (Example; injectable drugs). Providers that have used this modifier inappropriately in the past should adjust those claims, and note that this issue is subject to post payment review and recovery.

Dental Procedure Codes

Dental providers should be advised of the difference between D2952 and D2954. D2952 is an indirectly fabricated post and is commonly called a cast post. D2954 is a pre-fabricated post. Random provider audits will be conducted quarterly during the next year to ensure billing of the correct code. Providers will have to provide documentation which includes progress notes, lab bills and/or x-rays to support the billing of D2952. Lack of proper documentation will result in recoupment of claims filed for D2952. If you have any questions, you may contact the Dental Program at (334) 353-5263.

Requirement for Nursing Facilities

Payments to nursing facilities may be made for therapeutic leave visits to home, relatives, and friends for up to six days per calendar quarter . A therapeutic leave visit may not exceed three days per visit. A resident may have a therapeutic visit that is one, two, or three days in duration as long as the visit does not exceed three days per visit or six days per quarter . Visits may not be combined to exceed the three-day limit. The facility must obtain physician orders for therapeutic leave.

A nursing facility provider that fails to provide the required documentation or additional information for audit reviews as requested by the Alabama Medicaid Agency Long Term Care Medical and Quality Review Unit within ten working days from receipt of the certified letter shall be charged a penalty of one hundred dollars per recipient record per day for each calendar day after the established due date unless an extension request has been received and granted. The penalty will not be a reimbursable Medicaid cost. The Associate Director of the Long Term Care Medical & Quality Review Unit may approve an extension for good cause. Requests for an extension should be submitted in writing by the nursing facility Administrator to the Associate Director of the Long Term Care Medical and Quality Review Unit with supporting documentation. The request should be sent to the following address:

Alabama Medicaid Agency
P. O. Box 5624 501 Dexter Avenue
Montgomery, Alabama 36103-5624

Inpatient Hospital Claims PHP Filing Limits

All in-state inpatient hospital claims follow Partnership Hospital Program (PHP) payment guidelines. PHP requires all claims to be filed by the last day of February of the following year

The fiscal year begins October 1 and ends September 30. Listed below are examples of filing deadlines:

- Any inpatient claims with dates of service from October 1, 2006 through September 30, 2007 that are filed after February 29, 2008 will be denied by EDS as exceeding the PHP filing limit. Recipients may not be billed if a claim is denied for this reason.
- Any inpatient claims for **retroactive coverage** with dates of service from October 1, 2006, through September 30, 2007 that are filed after February 29, 2008 will be denied by EDS. Hospital must seek payment, if any, from PHPs. Recipients may not be billed if a claim is denied for this reason. However, a hospital that accepts a patient as private pay before rendering service is not obligated to bill Medicaid if the patient receives retroactive eligibility. In this case, the recipient may be billed.
- Any inpatient claims with dates of service from October 1, 2006 through September 30, 2007 that are filed after February 29, 2008 with **third party liability** action (either paid, denied, or recouped by Medicaid) will be denied by EDS. The usual third party filing limits will not apply. Recipient may not be billed if a claim is denied for this reason.
- Any inpatient claims with dates of service prior to October 1, of the previous fiscal year are considered outdated. Recipients may not be billed.

Claims that span September 30, 2007 and October 1, 2007 must be split billed due to the PHP year-end.

Claims should be filed as soon as possible after the September 30, 2007, year-end.

Preferred Drug List Updates

Effective October 1, 2007, the Alabama Medicaid Agency will update our Preferred Drug List (PDL) to reflect the recent Pharmacy and Therapeutics (P&T) recommendations as well as quarterly updates. The updates are listed below:

PDL Additions

Infergen-Anti-infective Agents /Interferons
†Relenza-Anti-infective Agents/Neuraminidase Inhibitors
†Tamiflu-Anti-infective Agents/Neuraminidase Inhibitors

** denotes that these products will no longer be preferred but are still covered by Alabama Medicaid and will require Prior Authorization (PA).*

† denotes that product will be preferred during the defined flu season (October 1 – March 31 unless otherwise specified)

PDL Deletions*

Altace-Cardiovascular Health-ACE Inhibitors
Foscavir-Anti-infective Agents/Miscellaneous Antivirals
Roferon A-Anti-infective Agents/Interferons
Teveten-Cardiovascular Health/Angiotensin II Receptor Antagonists
Teveten HCT-Cardiovascular Health/Angiotensin IReceptor Antagonists Combos
Zovirax-Anti-infective Agents/Nucleosides and Nucleotides (oral and injectable formulations only)

Below are the requirements for approval of PA requests for the anti-infective agents:

- The patient must have an appropriate diagnosis supported by documentation in the patient record.
- The patient must also have failed two treatment trials of no less than three-days each, with at least two prescribed and preferred anti-infectives, either generic, OTC or brand, for the above diagnosis within the past 30 days or have a documented allergy or contraindication to all preferred agents for the diagnosis submitted.
- Patients on anti-infective therapy while institutionalized once discharged or transferred to another setting or patients having 60 day consecutive stable therapy may continue on that therapy with supportive medical justification or documentation.
- Medical justification may include peer-reviewed literature, medical record documentation, or other information specifically requested. Approval may also be given, with medical justification, if the medication requested is indicated for first line therapy when there are no other indicated preferred agents available or if indicated by susceptibility testing or evidence of resistance to all preferred agents.
- PA requests that meet prior usage requirements for approval may be accepted verbally by calling HID at the number below.

The PA request form and criteria booklet, as well as a link for a PA request form that can be completed and submitted electronically online, can be found on the Agency website at *www.medicaid.alabama.gov* and should be utilized by the prescribing physician or the dispensing pharmacy when requesting a PA. Hard copy PA requests may be faxed or mailed to:

Health Information Designs (HID) / Medicaid Pharmacy Administrative Services
P. O. Box 3210 Auburn, AL 36832-3210
Fax: 1-800-748-0116 Phone: 1-800-748-0130

Incomplete PA requests or those failing to meet Medicaid criteria will be denied. If the prescribing physician believes medical justification should be considered, the physician must document this on the form or submit a written letter of medical justification along with the prior authorization form. Additional information may be requested. Staff physicians will review this information.

Policy questions concerning this provider notice should be directed to the Pharmacy Program at (334) 242-5050. Questions regarding prior authorization procedures should be directed to the HID help desk at (800) 748-0130.

Alabama Medicaid Increases Prescription Brand Limits

Effective January 1, 2008 Alabama Medicaid will increase the current four (4) brand limit policy to five (5) brand name prescriptions per month per recipient. There will not be a limit on the number of covered generic or over-the-counter prescriptions a recipient may receive. This limitation does not apply to children under the age of 21 and recipients living in nursing facilities.

In certain drug classes, allowances are allowed in the event of an adverse or allergic reaction, or failure to respond. Medicaid will also continue to allow for prescriptions to exceed the five (5) brand limit for anti-psychotic and anti-retroviral medications; however, there will be no instance where the limit may exceed ten (10) brand name drugs per month per recipient.

Providers with questions concerning the prescription limitation should contact:

Alabama Medicaid Agency
Pharmacy Services Division
P.O. Box 5624
Montgomery, Alabama 36103-5624
(334) 242-5050

DME Update

Wheelchairs Repair Codes

Effective October 1, 2007, procedure codes E0981, E0985, E0995, E2360, E2361, E2362, E2363, E2364, E2365,E2366, E2367,E2368, E2369, E2370, K0019, K0040, K0041, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0051, K0052,E2381, E2382, E2383, E2384, E2385, E2386, E2387, E2388, E2389, E2390, E2391, E2392, E2393, E2394, E2395, E2396,K0099 will be **EXEMPT** from the prior authorization requirement. DME providers dispensing these wheelchair repair codes **DO NOT** need **NRRTS** or **RESNA** certification.

CPAP and BIPAP Policy Revisions

Effective November 1, 2007, revisions have been made to the CPAP and BIPAP policies. The revisions to the CPAP policy are as follows:

- Sleep study is still required, but specific numbers of apneas and hypoapneas have been removed.
- Patient compliance as defined by smart card downloads has been further defined.

The revisions to the BIPAP policy are as follows:

- Certain neuromuscular diseases (muscular dystrophies, myopathies, spinal cord injuries or respiratory insufficiency, restrictive lung disease from thoracic wall deformities) do not require a sleep study and CPAP before going to BIPAP.

Compliance for continued coverage is further defined. The updated CPAP and BIPAP policies will be published in the next update to chapter 14, of the Alabama Medicaid Provider Manual. Copies of the updated CPAP and BIPAP policies will also be available on the Medicaid DME List Server and ADMEA Website.

Home IV Theraphy Services

Home IV Therapy Services must only be administered in the recipient's Home. Home IV Therapy Services not administered in the home setting will not be reimbursed by Alabama Medicaid.

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

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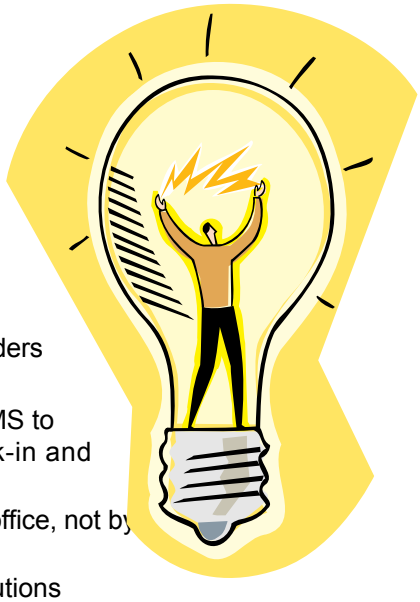
Alabama Medicaid Special Bulletin **February 2008**

New Medicaid Claims Payment System To Go Live

The Alabama Medicaid Agency and EDS have worked to develop a new system (interChange) that will provide better service to the provider community and enhance technology for the Medicaid Agency. The new system goes live on February 25, 2008, and features a fully functional web portal, and an NPI compliant system. The following are some of the enhancements and changes that are being implemented with the new system:

Enhancements

- Added features to the Web Portal
- Better electronic Remittance Advice (RA) Retention
- Easier electronic void/adjust claim process
- All claims submitted will be accepted into the system for processing
- Ability to check PA status on-line (Requesting provider only) and check PA status for non-pharmacy claims
- Compound Drug Billing Allowed for Pharmacy Providers



Changes

- Updated CMS-1500 form will be the only accepted claim form for professional providers
- New UB-04 form will be the only accepted claim form for institutional providers
- Only NPI numbers will be used on claim forms *(Unless you are not required by CMS to obtain an NPI). This includes referral numbers for Patient 1st, EPSDT Lock-in and anesthesia referrals
- Recipients will now be assigned by distance from a patient's home to a physician's office, not by county. (New assignments only)
- All providers will receive new log-on IDs for the web portal, Provider Electronic Solutions Software and some vendor software products. (See page 2 for more information)
- Interactive Transactions are no longer allowed through the current interactive toll free number which is (866) 627-0017 (See page 2 for more information)
- Prior Authorization Numbers will no longer be required on claims. As long as the units and services are approved, the claim will go through the system and process
- Interactive Claim Status Requests will no longer be available through Provider Electronic Solutions or your software vendor. To check claim status, providers will need to access the web portal or submit a batch 276 transaction
- Recipients and providers will be able to search for Patient 1st providers serving a recipient's area via the web portal
- NPI number must be used for all referrals. This includes Patient 1st, EPSDT, Lock-in and referrals for anesthesia providers
- Alabama specific RA codes will now print on Remittance Advice

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Determining Service Location on a Claim

With the implementation of the new interChange and the usage of NPI, providers will only have a single provider number. Medicaid will use the zip+4 code on the claim to determine a provider's service location. Should the zip+4 be the same for two locations, a taxonomy code will be required on the claim.

Changes to Provider Electronic Solutions

Along with the exciting upgrades that involve interChange, the Provider Electronic Solutions software has been upgraded. A complete software user guide is available on the new web portal, under AL Links. The new 2.07 version includes the following changes:

- It will require the 10-digit NPI number
- No interactive transactions will be accepted (includes eligibility verification, household inquiry, pharmacy claims and claim status)
- No Claim Submission Responses (CSR's) for batch transactions
- When entering provider lists, zip+4 is now required
- When adding a provider to the list that operates at multiple service locations, a separate entry using the taxonomy code will be required

Changes to the LTC Software

Along with the exciting upgrades that involve interChange, the Provider Electronic Solutions LTC software will also be upgraded. A complete software user guide is available on the new web portal, under AL Links. The new 2.02 version will include the following changes:

- The Provider ID fields (performing and provider ID) updated to accept the 10-digit NPI number
- Trading Partner ID is now different from the web login ID
- Response files are now in 'landscape' mode. To print correctly, change default settings on printer to landscape
- Each recipient on the report now has an individual heading section, making it easier to separate for inserting patient records

Providers Must Have the New NPI Number

Effective February 25, all claims must be submitted using the NPI number, regardless of the date of services.

We have received the majority of NPI numbers from providers, but we are not at 100% complete. To confirm we have your NPI information on file, you can call the Provider Assistance Center at (800) 688-7989 to verify the information.

EDS has mailed several alerts to providers requesting NPI information. The last few mailouts were just to providers which had not sent in NPI information. If you received a letter from EDS and it had a specific provider number on the letter, you need to send the NPI information in for the provider number on the letter. Failure to follow-up on this will result in denied claims on February 25, 2008.

If you are a provider which currently has both a payee and a performing provider number in the current system, you must do one of two things for interChange:

- Enumerate yourself through the NPI with both an individual and organizational NPI. Send the information to EDS to add to your file.
- If you choose not to enumerate yourself as you currently are, you must complete an updated provider enrollment form. In some cases (change of tax ID information) you will have to re-enroll.

Toll Free Number for Interactive Transactions Will Be Discontinued

Beginning on February 22, 2008 the following interactive transactions will no longer be available through the current toll-free number (866) 627-0017:

- 270/271 transaction – Eligibility inquiry
- 276/277 transaction – Claim status inquiry
- Household Inquiry
- NCPDP drug claim submission, reversal or eligibility inquiry

Vendors that currently utilize this toll-free number to connect to the EDS data center via Business Exchange Server (BES) will no longer have this capability. These vendors MUST contact a clearinghouse that has an established connection with the EDS data center if they wish to continue a similar service on or after February 22, 2008. This alert was originally sent out to all providers and vendors on August 21, 2006, and we requested vendors begin to plan for this change at that time.

The following clearinghouses currently connect with the EDS data center:

- Emdeon — www.emdeon.com
- Per-Se — www.per-se.com
- Healthcare Data Exchange — www.hdx.com
- Nebo — www.nebo.com
- TeraHealth — www.terahealth.com
- eRx — www.erxnetwork.com
- Passport Health — www.passporthealth.com

Impact to Providers

Providers will be able to complete an interactive request, such as an eligibility or claim status inquiry, by using the Medicaid Website.

Remote Access Server (RAS) Changes

EDS currently has a Remote Access Server in place for providers without an Internet Service Provider to utilize when submitting batch transactions. To obtain access to the RAS, call (800) 456-1242 or (334) 215-0111. If you use the RAS server, the new phone number will be (866) 421-1763.

Remittance Changes Due to interChange

With the implementation of the new interChange system, there are a number of changes for the EOP to be noted to avoid any issues.

- Explanation of Payment (EOP) is now called Remittance Advice (RA)
- Alabama specific Explanation of Benefit (EOB) codes will appear on paper RAs instead of the generic HIPAA standard codes.
- Crossover claim details will not be displayed upon implementation. They will be added back after implementation.

Claim Data Pages

Claim page sort order is different. First sort is by claim type: Inpatient Crossover, Medical Crossover, Outpatient Crossover, Dental, Inpatient, Inpatient Encounter, Inpatient Nursing Home, Medical, Outpatient, Drug, Compound Drug. Second sort is by claim status: Adjustment, Denied, Paid, Suspended.

- Example: A doctor's RA sorts as: Crossovers, then Mediical (each with the Adjusted, Denied, Paid, Suspended sort).
- Example: A hospital's RA sorts as: Inpatient Crossover, Outpatient Crossover, Inpatient, Inpatient Encounter, and Outpatient (each with the Adjusted, Denied, Paid, Suspended sort).

Adjustment Pages

The sort is only by recipient last name. There is no page change for type of adjustment. Each adjustment will have a single 'mother' line with the ICN (Internal Control Number) of the claim that is adjusted, followed by the 'daughter' claim with the adjustment ICN. With the exception of crossovers, details will appear on the daughter

- Additional Payment: If the adjustment generates an additional payment, the additional amount is displayed below that adjustment.
- Net Overpayment (AR): If the adjustment generates an accounts receivable, the amount due is displayed below that adjustment.
- Refund: If a cash receipt is posted for a claim, the amount applied is displayed below that adjustment.

Financial Transaction Page

There are three sections.

- Payouts: Lists non-claim expenditures made to the provider
- Refunds: Lists cash receipts received from the provider
- Accounts Receivable: Lists both non-claim and claim account receivables. interChange has the added ability to set up a non-claim AR so that it reduces over several financial cycles. This section displays the amount applied and remaining balances.

Summary page

There are two sections. Claims activity reports first, followed by payment reporting. Payment reporting has the most significant changes.

- The 'top' of the payment section is where to look for your check (or EFT) amount. It will appear visually in the middle of the page as NET PAYMENT. Warning: You will NOT see a negative amount here if you have a credit balance due to Medicaid. It will appear as 0.00 The amount due will only appear on the CREDIT BALANCE DUE 'letter' that would be the last page of your RA.
- If you are to receive a Capitation Payment, it will appear as a single line and amount in this 'top' section.
- The 'bottom' of the payment section displays any other financial data that may affect your NET EARNINGS.
- If any of your payment is being sent to the IRS, the deduction amount is noted in the 'bottom' section, and detailed in a message at the very bottom of the page.

Providers: Look for the New Web Portal PIN

Web Portal Provider PIN's will be issued to all active providers on our file. If you have group and individual provider numbers you will only receive one Web Portal Provider PIN for the group.

When will I use my Web Portal Provider PIN?

The web portal provider PIN will be used to access the secure website to perform transactions. It will also be accessed to register your trading partner ID's (If required to obtain one).

How do I activiate the web portal PIN?

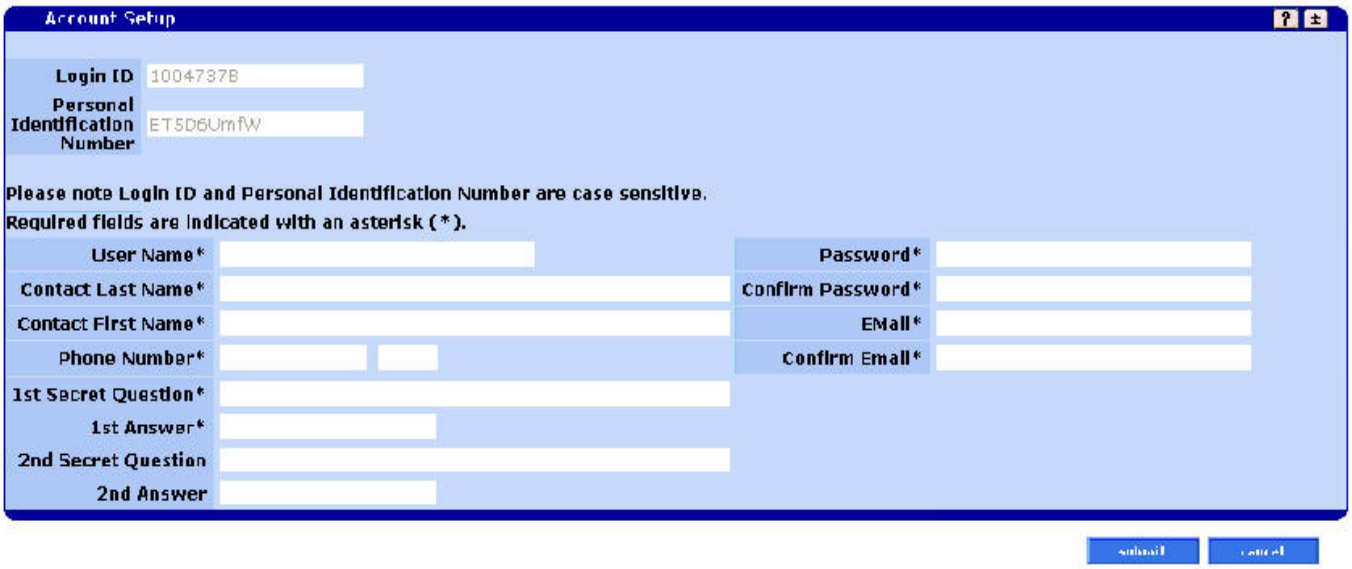
Step 1: Go to the new Medicaid web portal at: *https://www.medicaid.alabamaservices.org/ALPortal*

Step 2: Click on account, then click on account setup.

Step 3: Enter the information from the Web Portal PIN letter exactly as it appears. It will contain both upper and lower case values, the information is case sensitive.

Step 4: Click Setup Account.

Step 5: Complete all fieldswith an *Asterisk on the screen. Passwords must be at least 8 characters in length, with 6 alpha characters and two numeric characters.



Trading Partner PIN Setup Instructions

Trading partner PIN's will be issued to providers upon request. Providers must obtain a new trading partner PIN if they submit claims through Provider Electronic Solutions or a vendor that connects directly to EDS for claims submission. If you use a switch or a clearinghouse to submit your claims, you will not need to obtain a new trading partner PIN.

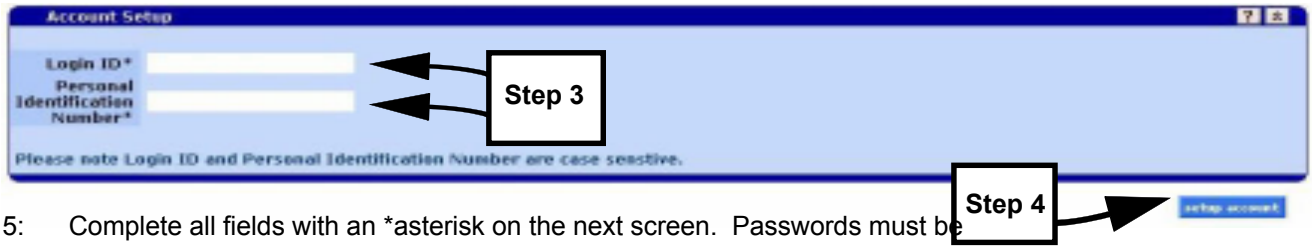
How do I register my Trading Partner PIN?

Step 1: Access the new Medicaid web portal at: https://www.medicaid.alabamaservices.org/ALPortal

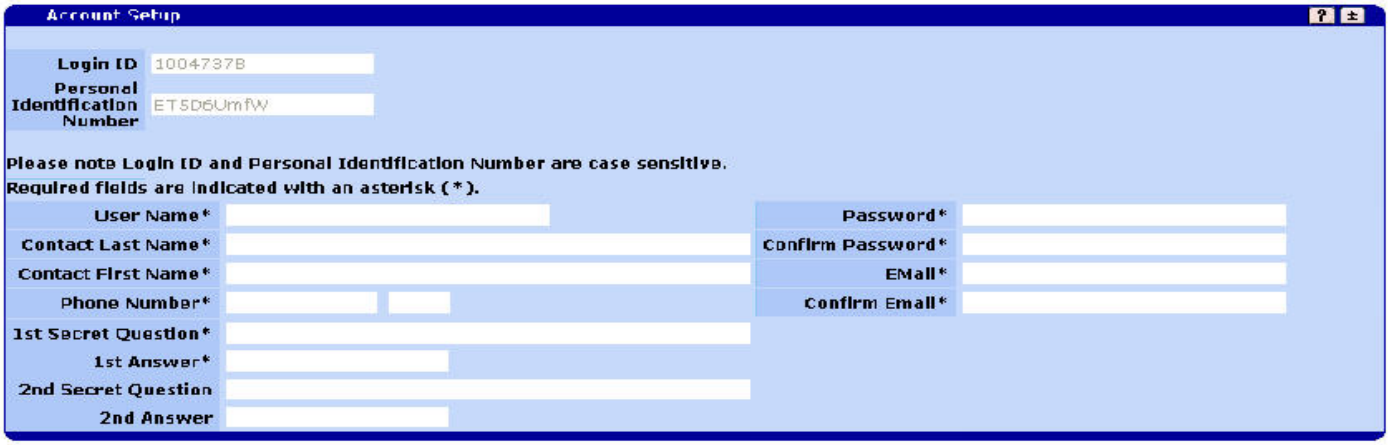
Step 2: Go to Account then click on account setup

Step 3: Enter the log in ID exactly as it appears on the letter in the logon ID field. Enter PIN from the letter in the Personal Identification Number field.

Step 4: Click Setup Account.



Step 5: Complete all fields with an *asterisk on the next screen. Passwords must be at least 8 characters in length, with 6 alpha characters and 2 numeric characters.

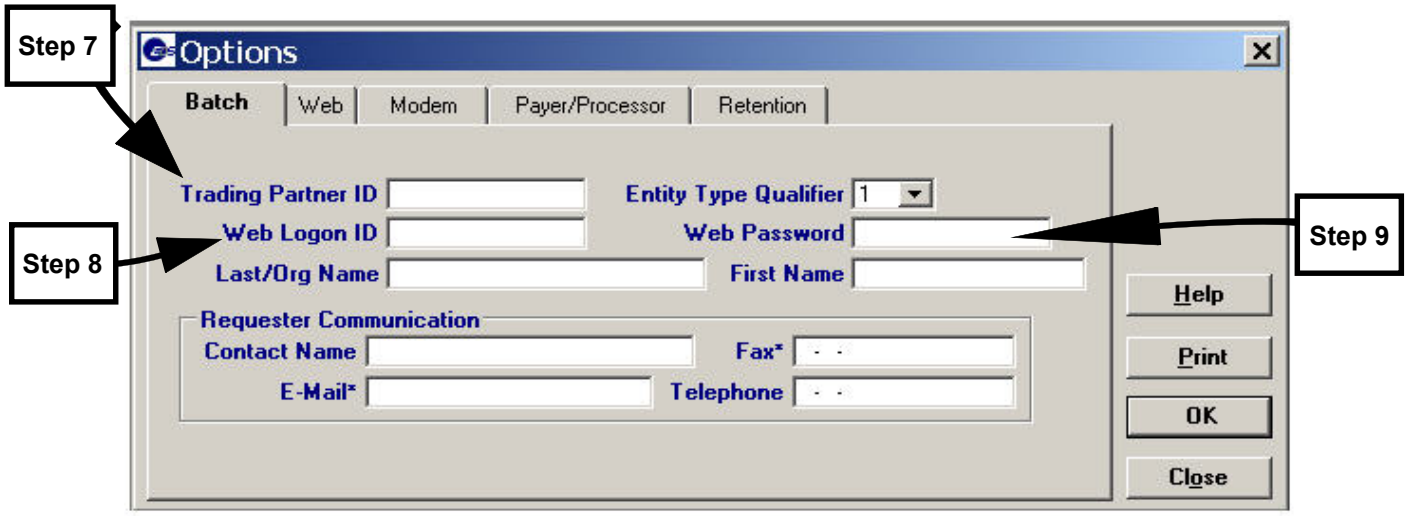


Step 6: Go to Provider Electronic Solutions or your vendor product and enter the information. In Provider Electronic Solutions, go to tools, options. See example below

Step 7: Enter your Login ID from the PIN letter in the Trading Partner ID field.

Step 8: Enter your Web Logon ID. This is your user name you created on the Setup Account page. information you entered. (For sake of simplicity, you may want to consider making your web logon ID the same as your trading partner ID.

Step 9: This is the web password you entered for your web logon user name on the Setup Account page.



CMS-1500 Claim Form Filing Instructions

The instructions describe information that must be entered in each of the block numbers on the CMS-1500 Claim Form. **Block numbers not referenced in the table may be left blank. They are not required for claims processing by EDS.**

Block No.	*Description*	*Guidelines*
1a	Insured's ID no.	Enter the patient's 13-digit recipient number (12 digits plus the check digit) from the Medicaid identification card and/or eligibility verification response.
2	Patient's name	Enter the recipient's name **exactly** as it is given to you as a result of the eligibility verification transaction. **Please note that the recipient name on the claim form must match the name on file for the RID number you entered in Block 1.** If a recipient has two initials instead of a first name, enter the first initial along with a long space, then the second initial and no periods. If a recipient's first name contains an apostrophe, enter the first name including the apostrophe. **Examples:** For recipient A. B. Doe, enter "Doe A B" with no punctuation. For recipient D'Andre Doe, enter "Doe D'Andre" with an apostrophe and no spaces.
3	Patient's date of birth Patient's sex	Enter the month, day, and year (MM/DD/YY) the recipient was born. Indicate the recipient's sex by checking the appropriate box.
5	Patient's address	Enter the patient's complete address as described (city, state, and ZIP code).
9-9d	Other insured's name	If the recipient has other health insurance coverage, enter all pertinent information. **Providers must submit the claim to other insurers prior to submitting the claim to Medicaid.**
10	Was condition related to: A) Patient's employment B) Auto accident C) Other accident	Indicate by checking the appropriate box. If applicable, enter all available information in Block 11, "Other Health Insurance Coverage."
17	Name of referring physician or other source	Enter one of the following, if applicable: • The name of the referring PMP provider • The EPSDT referring provider if the services are the result of an EPSDT screening • The referring lock-in physician if the eligibility verification response indicates the recipient has Lock-In status
17B	Referring NPI number	A referring provider number should only be included for lock-in, Patient 1st, EPSDT or anesthesia referrals. (Referral form updated in January 2007 with field for provider's NPI number)
19	Reserved for Local use	Use this block to provide remarks, as appropriate. Examples include, but are not limited to the following: • Home accident • Treatment due to disease • TPL paid (MM/DD/YY) • TPL denied (MM/DD/YY) • Retroactive eligibility award date The substitute provider's name may also be indicated here.
21	Diagnosis or nature of illness or injury	Enter the ICD-9 diagnosis code to the highest number of digits possible (3, 4, or 5). Do not include diagnosis descriptions. Do not use decimal points in the diagnosis code field.
24a	Date of service (DOS)	Enter the date of service for each procedure provided in a MM/DD/YY format. If identical services (and charges) are performed on the same day, enter the same date of service in both "from" and "to" spaces, and enter the units perform in Block 24g. **Exception:** Provider visits to residents in nursing facilities must be billed showing one visit per line.
24b	Place of service (POS)	Enter a valid place of service (POS) code for each procedure. For program-specific POS values, refer to the chapter in Part II that corresponds to your provider or program type.
24c	EMG	This field was located in field 24I. It is now in 24C. This field is used to indicate certain co-Payment exemptions, exemption for a certified emergency. Enter an 'E' for emergency, or 'P' for pregnancy, if applicable. Do not enter Y or N.

CMS-1500 Claim Form Filing Instructions

(Continued From Page 6)

Block No.	*Description*	*Guidelines*
24d	Procedures, Services, or Supplies CPT/HCPCS and MODIFIER	Enter the appropriate five-digit procedure code (and two-digit modifier, as applicable) for each procedure or service billed. Use the current CPT-4 book as a reference. Note: Up to 4 modifiers can be entered per procedure code.
24e	Diagnosis code	Enter the line item reference (1, 2, 3, or 4) for each service or procedure as it relates to the primary ICD-9 code identified in Block 21. If a procedure is related to more than one diagnosis, the primary diagnosis to which the procedure is related must be the one identified. Enter only one digit in this block.
24f	Charges	Indicate your usual and customary charges for each service listed. Charges must not be higher than fees charged to private-pay patients.
24g	Units	Enter the appropriate number of units. Be sure that span-billed daily hospital visits equal the units in this block. Use whole numbers only.
24h	EPSDT Family Planning	Enter one of the following values, if applicable: • "1" if the procedure billed is a result of an EPSDT referral • "2" if the procedure is related to Family Planning • "3" if the procedure is a Patient 1st (PMP) referral –Effective April 1, 2005 the referral requirement for Patient 1st recipients was reinstated. • "4" if the procedure is EPSDT and PMP referral
24I	ID Qual	Enter in the shaded area of 24I the qualifier identifying if the number is a non-NPI. This will only be used for providers that are not required to obtain an NPI. These providers should use the following identifier in 24I: 1D which identifies the number being used as a Medicaid provider number. Should a provider need to use a taxonomy code on a claim, use the following: ▪ ZZ which identifies the number being used is a provider taxonomy code.
24J	Rendering provider ID	The individual provider performing the service is reported in 24J. If not entering an NPI, the number should appear in the shaded area of the field. The NPI number should be entered in the non-shaded area.
26	Patient account number	This field is optional. Up to 20 alphanumeric characters may be entered in this field. If entered, the number appears on the provider's Explanation of Payment (EOP) to assist in patient identification.
28	Total charge	Enter the sum of all charges entered in Block 24f lines 1-6.
29	Amount paid	Enter any amount paid by an insurance company or other sources known at the time of submission. **Do not enter Medicaid copayment amount. Do not enter Medicare payments.**
30	Balance due	Subtract Block 29 from Block 28 and enter the balance.
31	Signature of physician or supplier	After reading the provider certification on the back of the claim form, sign the claim. In lieu of signing the claim form, you may sign a Medicaid Claims Submission Agreement, to be kept on file by EDS. The statement "Agreement on File" must be entered in this block. The provider or authorized representative must initial the provider's stamped, computer generated, or typed name.
33	Billing Provider Info and Phone Number	1st Line: Name of the Payee provider as it appears in the EDS system 2nd Line: Address 3rd Line: City, State and Zip Code (include zip+4) 33A: Enter the payee (group) NPI 33B: Enter the two-digit qualifier identifying the non-NPI number followed by the ID number. Do not enter a space, hyphen or other separator between the qualifier and the number. (Only for providers who do not qualify to receive an NPI).

UB-04 Claim Form Filing Instructions

The instructions describe information that must be entered in each of the block numbers on the UB-04 Claim Form. **Block numbers not referenced in the table may be left blank. They are not required for claims processing by EDS.**

Block No.	*Description*	*Guidelines*
1	Provider name, address, and telephone number	Enter the provider name, street address, city, state, ZIP code, and telephone number of the service location.
2	Pay to name/address	Required when the pay-to name and address information is different from the billing information in block 1. If used, providers must include, name, address, city, state and zip.
3A 3B	Patient control number	**Optional**: Enter patient's unique number assigned by the provider to facilitate retrieval of individual's account of services containing the financial billing records. **3B**: Enter the patient's medical record number assigned to the hospital. This number will be referenced on the provider's EOP for patient identification. Up to twenty-four numeric characters may be entered in this field. .
4	Type of bill (TOB) Most commonly used: 111 Inpatient hospital 131 Outpatient hospital 141 Non-patient (laboratory or radiology charges) 211 Long Term Care 331 Home health agency 811 Hospice 831 Ambulatory Surgical Center	Enter the four-digit type of bill (TOB) code: **1st Digit – Type of Facility** 1 Hospital 2 Long Term Care 3 Home Health Agency 7 Clinic (RHC, FQHC) *** see note** 8 Special Facility **** see note** **2nd Digit – Bill Classification** 1 Inpatient (including Medicare Part A) 2 Inpatient (Medicare Part B only) 3 Outpatient 4 Other (for hospital-reference diagnostic services; for example, laboratories and x-rays) **3rd Digit – Frequency** 0 Nonpayment/zero claim 1 Admit through discharge 2 Interim – first claim 3 Interim – continuing claim 4 Interim – last claim 5 Late charge(s) only claim ***Clinic requires one of the following as the 2nd Digit – Bill Classification:** 1 Rural Health 2 Hospital-Based or Independent Renal Dialysis Center 3 Free-Standing 4 Outpatient Rehabilitation Facility (ORF) 5 Comprehensive Outpatient Rehabilitation Facility (CORF) 6-8 Reserved for National Assignment 9 Other ****Special Facility requires one of the following as the 2nd Digit – Bill Classification:** 1 Hospice (non-hospital-based) 2 Hospice (hospital-based) 3 Ambulatory Surgical Center 4 Free-Standing Birthing Center 5 Critical Access Hospital 6 Residential Facility 7-8 Reserved for national assignment 9 Other
6	Statement covers period	Enter the beginning and ending dates of service billed. For inpatient hospital claims, these are usually the date of admission and discharge.

UB-04 Claim Form Filing Instructions

(Continued From Page 8)

Block No.	*Description*	*Guidelines*
8	Patient's Name	Enter the recipient's name **exactly** as it is given to you as a result of the eligibility verification transaction. **Please note that the recipient name on the claim form must match the name on file for the RID you entered in Block 60.** If a recipient has two initials instead of a first name, enter the first initial along with a space, then the second initial and no periods. If a recipient's first name contains an apostrophe, enter the first name including the apostrophe. **Examples:** For recipient A. B. Doe, enter "Doe A B" with no punctuation. For recipient D'Andre Doe, enter "Doe D'Andre" with an apostrophe and no spaces.
12	Admission Date/Start Date of Care	Enter the total days represented on this claim that are not covered. This is not required for outpatient claims. Enter numerically the date (MM/DD/YY) of admission for inpatient claims; date of service for outpatient claims; or start of care (SOC) for home health claims.
13	Admission hour (required field)	Military time (00 to 23) must be used for the time of admission for inpatient claims or time of treatment for outpatient claims. Code 99 is not acceptable. This block is not required for outpatients (TOB 141) or home health claims (TOB 331).
14	Type of admission	Enter the appropriate type of admission code for inpatient claims: 1 Emergency 2 Urgent 3 Elective 4 Newborn (This code requires the use of special source of admission code in Block 20) 5 Trauma Center
15	Source of admission	Enter the appropriate source of admission code for inpatient claims. For type of admission 1, 2, or 3 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 Court/Law enforcement 9 Information not available For type of admission 4 (newborn) 1 Normal delivery 2 Premature delivery 3 Sick baby 4 Extramural birth 5 Information not available 6 Transfer from another health care facility
16	Discharge hour	For inpatient claims, enter the hour of discharge or death. Use military time (00 to 23) to express the hour of discharge. If this is an interim bill (patient status of "30"), leave the block blank. Code 99 is not acceptable.
17	Patient discharge status	For inpatient claims, enter the appropriate two-digit code to indicate the patient's status as of the statement "through" date. Refer to the UB-04 Billing Manual for the valid patient status codes. If status code 30, the total days in blocks 7 and 8 should include all days listed in the statement covers period. If any other status code is used, do not count the last date of service (discharge date).
18-28	Condition Codes	The following UB-04 condition codes are valid for EPSDT referrals: A1 Denotes services rendered as the result of an EPSDT screening. Block 78 must also contain the screening 10-digit NPI number. A4 Denotes family planning and will exempt the claim from the $3 copay. If A1 is entered here, a referring provider number must be indicated in block 78.

UB-04 Claim Form Filing Instructions

(Continued From Page 9)

Block No.	*Description*	*Guidelines*
29	Accident State	REQUIRED ONLY IF AUTO ACCIDENT: Indicate two-digit state abbreviation where the accident occurred.
31-34	Occurrence Codes	Accident related occurrence codes are required for diagnoses between 80000-99499.
39-41	Value Codes and Amounts	Enter the appropriate value code and amount according to the following: 80 Covered Days 81 Non-Covered Days (These codes took the place of form locators 7-8 of the old UB-92). Medicaid continues to require the use of the crossover form for any Medicare related claims.
42, 43	Revenue codes, revenue description	Enter the revenue code(s) for the services billed.
44	HCPCS/Rates	Inpatient — Enter the accommodation rate per day. Home Health — Home Health agencies must have the appropriate HCPCS procedure code. Outpatient — Outpatient claims must have the appropriate HCPCS, procedure code.
45	Service date	Outpatient: Enter the date of service that the outpatient procedure was performed. Nursing Homes: Enter the beginning date of service for the revenue code being billed. Span Billing: When filing for services such as therapies, home health visits, dialysis, hospice, and private duty nursing within a month, the time period being billed should be entered in form locator (FL) 6 (statement covers period). In FL 45, the service date should be the first date in the statement covers period. The number of units should match the number of services reflected in the medical record.
46	Units of service	Enter total number of units of service for outpatient and inpatient services. For inpatient claims, this will be same as covered plus non-covered days.
47	Total charges	Enter the total charges for each service provided.
48	Non-covered charges	Enter the portion of the total that is non-covered for each line item.
50	Payer	Enter the name identifying each payer organization from which the provider might accept some payment for the charges.
54	Prior payments	Enter any amounts paid by third party commercial insurance carrier(s). **Do not enter Medicaid co-payment amount. Do not enter Medicare payment amount.**
56	NPI Number	Enter the 10- digit NPI Number
58	Insured's name	Enter the insured's name.
60	Insurance identification number	Enter the patient's 13-digit RID from the Medicaid eligibility verification response and the policy numbers for any other insurance on file.
61	Insured group's name	Enter the name of the group or plan through which the insurance is provided to the insured.
62	Insurance group number	Enter the group number of the other health insurance.
66	ICD Version Indicator	The qualifier denotes the version of the ICD reported. 9=Ninth Revision 0=Tenth Revision.
67	Principal diagnosis code	Enter the ICD-9 diagnosis code for the principal diagnosis to the highest number of digits possible (3, 4, or 5). Do not use decimal points in the diagnosis code field.
67A-67Q	Other diagnosis codes	Enter the ICD-9 diagnosis code to the highest number of digits possible (3, 4, or 5) for each additional diagnosis. Do not use decimal points in the diagnosis code field. Enter one diagnosis per block.
69	Admitting diagnosis	**For Inpatient Claims**: Enter the admitting ICD-9 diagnosis code to the highest number of digits possible (3, 4, or 5). Do not use decimal points in the diagnosis code field.
70	**Patient Reason DX**	**For Outpatient claims only-** Enter the diagnosis for reason the recipient came in for treatment. **NOTE:**, This diagnosis is not always the same as the primary diagnosis.

UB-04 Claim Form Filing Instructions

(Continued From Page 10

Block No.	*Description*	*Guidelines*
73	**Medicaid emergency/accident indicator**	**Enter an "H" to indicate that the service was rendered as a result of a home accident or_treatment due to disease. Enter "E" to indicate a certified emergency. Both values may be entered, as applicable. A certified emergency ER claim must be certified by the attending physician.**
74a-74e	Principal and other procedure codes and dates	For inpatient hospital claims only, enter the ICD-9 procedure code for each surgical procedure and the date performed. Up to 5 surgical procedure codes and dates may be entered into this field.
76	Attending Physician ID	Enter the attending physician's NPI number and the appropriate qualifier "0B" followed by the physician's license number. Refer to the Alabama Medicaid Agency Provider License Book for a complete listing of valid license numbers.
77	Operating physician ID	For inpatient hospital claims only, if surgical procedure codes are entered in Block 74, enter the surgeon's NPI number and the appropriate qualifier "0B" followed by the surgeon's license number.
78	Other physician ID	**Enter the referring physician's NPI number followed by the appropriate qualifier "DN" for the following types of referrals:** **• EPSDT referrals** **• Patient 1st referrals** **• Lock-in Physician referrals** **If not applicable, leave blank**
80	Remarks	Use this block to provide remarks, as appropriate. Examples include, but are not limited to the following: • TPL paid (MM/DD/YY) • TPL denied (MM/DD/YY) • Retroactive eligibility award date

Revised State Fiscal Year 2008-2009 Checkwrite Schedule

Due to the implematation of the new interChange system, the Checkwrite schedule for February has changed from February 1 and February 15 to February 8 and February 22. The change is bolded in the dates below:

~~10/05/07~~	~~01/04/08~~	04/04/08	07/11/08
~~10/19/07~~	~~01/18/08~~	04/18/08	07/25/08
~~11/02/07~~	**02/08/08**	05/02/08	08/08/08
~~11/16/07~~	**02/22/08**	05/16/08	08/22/08
~~12/07/07~~	03/07/08	06/06/08	09/05/08
~~12/14/07~~	03/21/08	06/20/08	09/12/08

Schedule for Upcoming Provider Workshops for the New System

February 4, 5 - Huntsville, AL

Trinity United Methodist Church
607 Airport Road Huntsville, AL

February 4
8:30-10:30 CMS-1500
11:30-1:30 UB-04
2:30-4:30 Dental
5:15-7:15 Pharmacy

February 5
8:30-10:30 UB-04
11:30-1:30 CMS-1500
2:30-4:30 CMS-1500

February 6, 7 - Gadsden, AL

Gadsden Regional Medical Center 300 Building
1007 Goodyear Avenue Building 300

February 6
8:30-10:30 UB-04
11:30-1:30 UB-04
2:30-4:30 CMS-1500
5:15-7:15 Pharmacy

February 7
8:30-10:30 Dental
11:30-1:30 CMS-1500
2:30-4:30 CMS-1500

February 12, 13 - Dothan, AL

Troy University Dothan Harrison Room
500 University Drive

February 12
8:30-10:30 Dental
11:30-1:30 CMS-1500
2:30-4:30 UB-04
5:15-7:15 Pharmacy

February 13
8:30-10:30 CMS-1500
11:30-1:30 UB-04
2:30-4:30 CMS-1500

February 18, 19 - Birmingham, AL

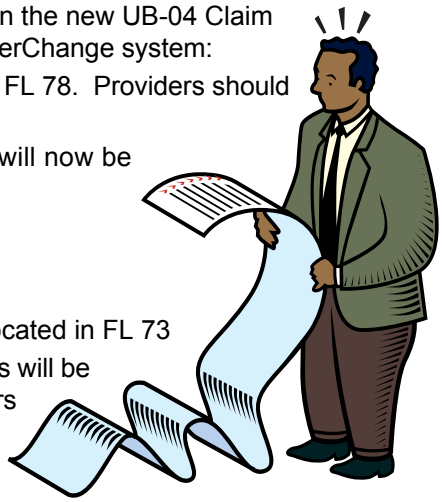
Embassy Suites
2300 Woodcrest Place

February 18
8:30-10:30 CMS-1500
11:30-1:30 UB-04
2:30-4:30 CMS-1500
5:15-7:15 Pharmacy

February 19
8:30-10:30 UB-04
11:30-1:30 Dental
2:30-4:30 CMS-1500

UB-04 Field Changes

The following are field changes on the new UB-04 Claim form for the newAlabama Medicaid interChange system:



- Referring Provider's NPI is now in FL 78. Providers should use qualifier DN.
- Covered and Non-covered days will now be located in FL 39-41
  - Appropriate values codes:
    80 - Covered Days
    81 - Non-covered days
- Emergency indicator "E" is now located in FL 73
- Attending and operating physicians will be located in FL 76 and 77. Providers should use NPI number , and the license number with qualifier code 0B
- Outpatient claims only: Patient reason diagnosis code will be required in FL 70. The patient reason diagnosis indicates the reason the recipient came in for treatment and may not always the same as principle dianosis.

Important Mailing Addresses	
All Claim forms, Consent forms, and other mail	EDS Post Office Box 244032 Montgomery, AL 36124-4032
Inquiries, Provider Enrollment Information, and Provider Relations	EDS Post Office Box 241685 Montgomery, AL 36124-1685
Adjustments	EDS Post Office Box 241684 Montgomery, AL 36124-1684

EDS Contact Information

Provider Assistance Center
(800) 688-7989

Provider Representatives
Group 1: Debbie Smith, Denise Baez, Kiki Hinton
Group 2: Laquita Thrasher
Group 3: Shermeria Harvest,Ann Miller

The Provider Representatives may be contacted via e-mail firstname.lastname@eds.com or by calling the Provider Assistance Center and asking for your Provider Representative.

New System Changes Quick List

The following is a quick list of the changes providers will see with the new interChange system:

- Providers must use NPI number for claims submission in interChange.
- Providers may need upgrade from soft ware vendor to make system NPI ready
- Make sure your vendor has tested in with EDS prior to going live.
- Web portal PIN letters will be mailed to all providers.
- Trading partner PINS available upon request. Interactive submission will continue through the web portal or clearinghouses with direct connections.
- Interactive transmissions will stop through the following interactive toll-free number: (866) 627-0017.
  Providers and software vendors were notified of this viaan Alert sent on August 21, 2006. Please check with your software vendor if you are affected.
- Prior Authorization Number no longer required on claims.
- CSR's no longer available through Provider Electronic Services or vendor
- All claims will be accepted in the new system (no 'upfront' rejections).
- Only UB-04 form or new CMS-1500 form accepted. Medicaid/Medicare related claim form is still required for crossovers.
- Alabama specific RA codes will now print on RA and will be available in the web portal.
- Check Prior Authorization status through web portal.

Alabama Medicaid ONLINE

www.medicaid.alabama.gov

New Alabama Interactive Website will Replace Current Medicaid Website

The new web portal will be available for you to begin registering your trading partner personal identification number (PINS) and web portal PINS beginning February 1, 2008 and will be available for processing transactions beginning on February 25, 2008.

PIN's will be mailed to all providers beginning in early February. When you receive the letter, you may go to the new web portal and begin setting up your account. **DO NOT DISCARD THIS PIN LETTER**. The provider web portal PIN will be mailed to all providers. If a provider has a payee and performing provider number, one letter will be sent to the group number. The recipient of the letter is considered the administrator of the account. You will use this ID to go to the new Medicaid web portal to perform the following tasks: check claim status, verify eligibility, submit interactive claims, adjustments and check or submit PA requests.

You may also set up clerks and assign roles for users on the web portal. With interChange, office staff members may only perform the transactions you authorize. For example, if you only select the role of eligibility verification for your front desk receptionist, that is the only function he/she can perform.

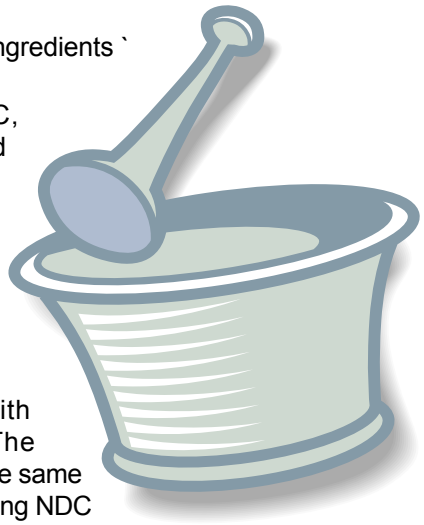
If you have a billing service that does billing for you, you will have to select the roles they can perform for your provider.

If you are a billing service, you must ask the administrator (the person who receives the PIN letter) to set up the roles you may perform for that provider. If you bill for several providers, each person that will do the billing must have roles set up and transactions they may perform. A complete web portal user guide is available on the new web portal under AL Links.

www.medicaid.alabama.gov

Important Information Regarding Compound Drug Billing

Effective February 25, 2008, EDS will begin to accept compound drugs on one claim for processing. The following is a list of helpful information to assist you in filing your claims.



- Compound drug billing with up to 25 ingredients ` will be allowed on a single claim.
- Claim will be priced based on NDC, multiply the quantity on the compound segment. Subtract co-pay and TPL amount.
- One dispensing fee will be paid based on the claim total.
- Pharmacy providers will continue to be paid 25 cents per minute for mixing the compound drug. This will require PA, and should be billed with an NDC code of 99999999999. The compounding time must be billed on the same claim as the compound drug. The mixing NDC must be billed on the same claim as the compound drugs
- If some drugs in the compound drug are non-covered they may still be billed. In order for the covered drugs to pay, an '8' must be indicated as the Submission Clarification Code (NCPDP field #420-DK). This will allow the covered ingredients to pay. If other ingredients are non-covered or fail another edit, they will zero pay, the other lines without an error will pay according to the outlined methodology If the "8" is not indicated, the entire claim will deny.

Inpatient Hospitals Should Follow PHP Guidelines

All in-state inpatient claims follow Partnership Hospital Program (PHP) payment guideliens. PHP requires all claims to be filed by the last day of February of the following year. We strongly encourage you to file all claims which will reach the PHP filing limit electronically before the implementation of the new claims processing system. If you are required to file a paper claim, we strongly urge you to make sure those claims are received by EDS on February 8, 2008 to allow processing in the current system.

SPECIAL NOTICE

Patient 1st Providers

For Patient 1st providers who electronically receive the initial Patient 1st report and the enrollment roster, and you want to continue to receive the reports together you must:

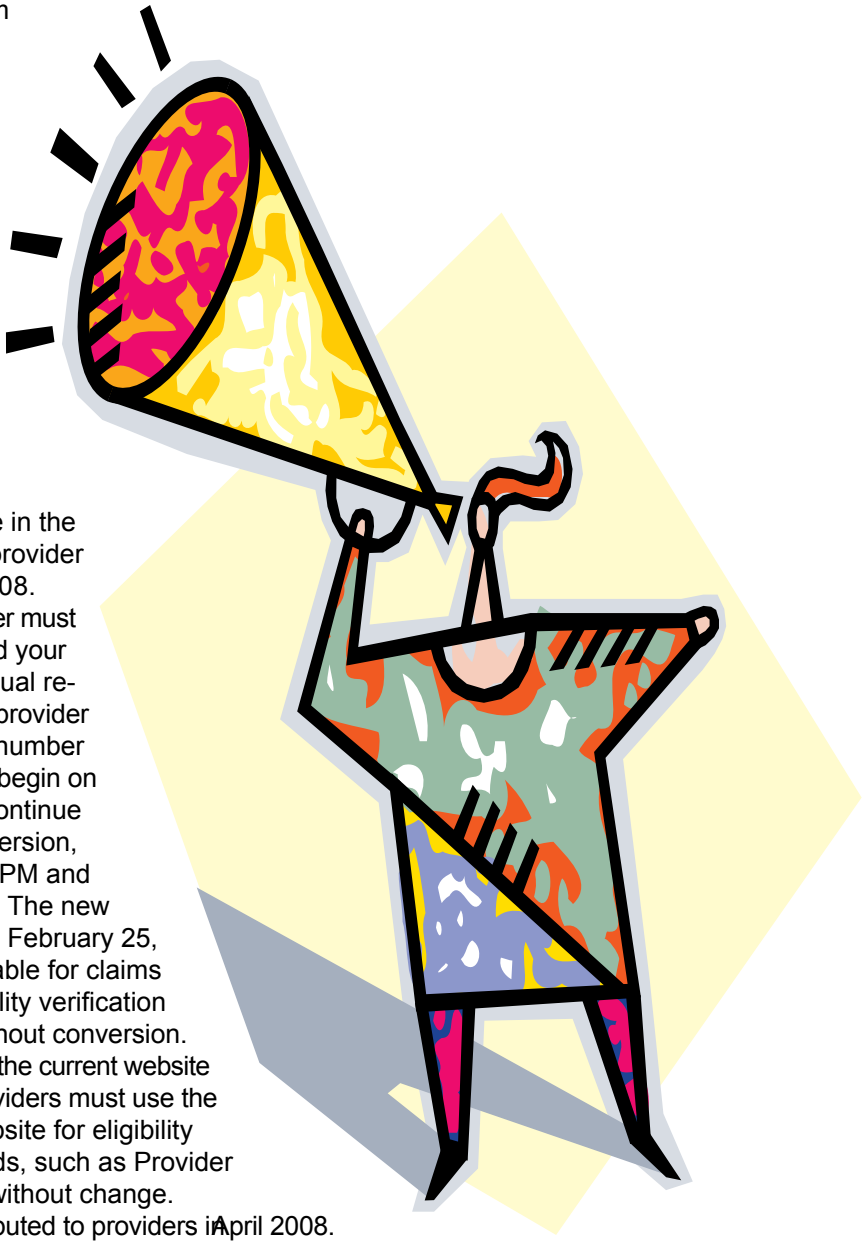
- Use your trading partner ID issued through ECS or your software vendor, or obtain a managed care trading partner ID

Instructions for the Final Checkwrite in the Current System

The final checkwrite in the current system will be February 22, 2008. The cutoff date to receive UB-92 and CMS paper claims for processing in the current system are as follows:

All PAPER claims on the current UB-92 and CMS-1500 claim form must be received by February 8, 2008 using the Medicaid provider number.

The implementation date to receive new UB-04 and updated CMS-1500 paper claims is **February 9, 2008** and all paper claims **MUST** be on the new UB-04 claim form and the revised CMS-1500 claim form.



Beginning on February 9, 2008, all paper claims received (including dental, pharmacy, UB-04, CMS-1500, or Medicare/Medicaid related claim form) **MUST** use the NPI number. All paper claims received on the old claim forms or with the Medicaid provider number instead of the NPI number, will be returned to the provider without being processed.

Paper claims received between February 9 and February 22 will be held until the new interChange system is officially activiated. On February 25, 2008, claims processing will resume.

Electronic claims submission will continue in the current electronic format using the Medicaid provider numbers until 5 PM CST on February 22, 2008. Beginning on February 25, 2008, the NPI number must be used instead of the provider number. Should your electronically received claim suspend for manual review on February 22, it will be denied and the provider must resubmit using the new format and NPI number.

Conversion of data to the new system will begin on February 22, 2008 at 5:01 PM CST and will continue through February 24, 2008. Because of conversion, non-pharmacy claims will be accepted until 5 PM and pharmacy claims will be accepted until 6 PM. The new system will begin accepting claims at 8:00 am February 25, 2008. Non-pharmacy claims will not be available for claims status checks until February 27, 2008. Eligibility verification will be up through the current methods throughout conversion.

Eligibility verification will be available using the current website through February 24, 2008. After this date, providers must use the current web portal, as the existing secure website for eligibility verification will cease. Other eligibility methods, such as Provider Electronic Solutions and AVRS, will continue without change.

The updated Provider Manual will be distributed to providers in April 2008. This release of the billing manual will contain the updated information needed for NPI. Providers will want to pay close attention to Chapter 5, claims filing instructions, to note the information that changed for NPI. Information regarding the updated CMS-1500 claim form and the new UB-04 claim form is included in the Provider Insider.

A Provider Electronic Solutions Upgrade will be made available to providers on February 23, 2008. **Providers should NOT install this upgrade until you have completed all your claims for the current system.** Once Provider Electronic Solutions has been upgraded to version 2.07 providers will only be able to submit claims using NPI information. Additionally, providers must be on the current version on Provider Electronic Solutions (version 2.06) before upgrading to the new NPI Compliant Version of Provider Electronic Solutions. To determine which version of Provider Electronic Solutions you are operating, open the software, go to help, click on about, the version of Provider Electronic Solutions will display. You may refer to the Medicaid website for upgrade instructions, and to download the upgrade. The link is: *http://www.medicaid.alabama.gov/billing/pes.aspx?tab=6*

Trading Parter ID Request Form

Trading Parter ID Request Form

PROVIDER NAME: _____

NPI NUMBER: _____

ADDRESS: _____

_____

CITY: _____ STATE: _____ ZIP: _____

PHONE NUMBER: ( ) _____

CONTACT NAME: _____

E-MAIL: _____

Please check which software solution is used for the submission and retrieval of Medicaid information.

☐ Provider Electronic Solutions ☐ Vendor Software Solutions

☐ Clearinghouse ☐ Other*

*Other: Please Explain _____

Please fill out the form in its entirety and return to the EMC Help Desk via mail: EMC Help Desk, 301 Technacenter Drive Montgomery, AL 36117;
Email: AlabamaSystemsEMC@eds.com
Fax: (334) 215-4272 Phone: (800) 456-1242 (334) 215-0111

Any provider that submits claims directly to EDS through Provider Electronic Solutions or a vendor with a direct connection, will need to obtain a new trading partner PIN. If you submit claims though a clearinghouse or a switch, you will not need to obtain a new ID. If you are unsure of how you connect to submit claims, contact your software vendor. When you receive your trading partner ID, you must access the web portal using the information in this letter to register the trading partner ID. You will then enter the user name and password in Provider Electronic Solutions or vendor product.

Once you set up the user name and passwords to access the web portal or to submit claims with your trading partner ID, you must remember the user name and password.

Users will be allowed to setup one or two security questions during the account setup process. If two security questions are created, then both answers are required in order to reset a web password in the event your password is lost. If you are unable to recall your password or are unable to answer your security questions, please contact the EMC Helpdesk for assistance where your account will be disabled and a new PIN letter will be issued in an overnight job. Therefore, please keep track of your account information and note that security answers and passwords are case sensitive.

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In The Know

How to Search for Batches of Claims in the New System

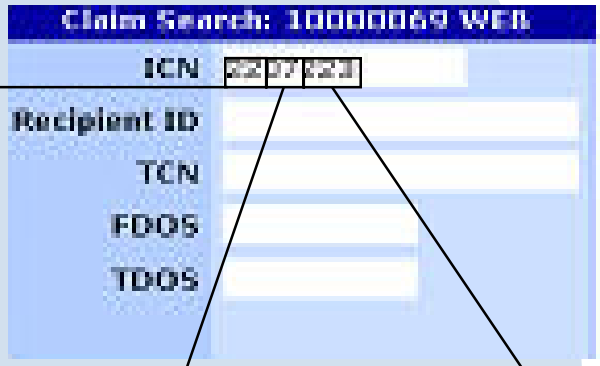
With interChange, providers will no longer be allowed to download Claim Status Report's (CSR's) from Provider Electronic Solutions or vendor products.

To check claim status on multiple claims submitted on the same day, follow these steps.

Step 1: Open the Medicaid web portal at the following link:

https://www.medicaid.alabamaservices.org/ALPortal

Step 2: Go to claims/search



You will then do a partial search on the Internal Control Number. An Internal Control Number is a number EDS assigns to every claim when the processing of the claim begins. Every number in the ICN identifies the claim. The first two numeric values are the region code, for example: 22 region code represents a claim submitted through the web portal, a 20 region code represents a claim submitted electronically through Provider Electronic Solutions or a vendor product. 10 Region code represents a paper claim and an 11 region code represents a paper claim with an attachment.

The next two numeric values represent the year the claim was received. For example, 07 means the claim was submitted in 2007.

The next three fields identify the julian date the claim was received. A julian date represents a numeric value assigned to each day of the year. January 1 is 001 on the julian date calendar, and December 31 is 365 on the julian date calendar. A complete julian date calendar can be found in Appendix F of the Provider Billing Manual.

The example below represents a partial search on an ICN with region code 22 (claim submitted through the web portal) year 07 and julian date 223 (August 11).

Step 3: Then click search

The search results window will display all ICNs which match the search criteria. The complete ICN, along with a paid or denied status will display. If the claim denies, the user may click on the claim, the information will populate in the claims entry screen within the web portal, and the user can make immediate corrections and resubmit the claim.

Users may also send a 276 transaction (Claim Status Request) through your vendor product or Provider Electronic Solutions and we will send a 277 transactions (Claim Status Response). Users may also continue to check claim status one at a time through the web portal by completing the criteria search.

Provider *Insider*

Alabama Medicaid Bulletin **May 2008**

Medicaid Requires a Dispense as Written Override

Effective May 1, 2008, the Alabama Medicaid Agency will require an override for a brand name drug with an exact generic equivalent submitted with a Dispense as Written (DAW) code of 1.

Currently, a pharmacist submitting a DAW code of 1 requires brand medically necessary (BMN) certification written on the face of the prescription in the physician's own handwriting. Beginning May 1, 2008, for a brand name drug that has an exact generic equivalent to be approved, the provider must request an override that documents medical necessity for the need of the brand rather than the available generic equivalent. This override applies to those instances where the prescriber has written a prescription for a brand name drug when a pharmaceutically and therapeutically equivalent drug product is available generically.

For approval, a Pharmacy Override Request Form 409 along with a Food and Drug Administration (FDA) MedWatch Form 3500 must be submitted including the clinical basis for the reason the generic equivalent is not clinically appropriate. Completed MedWatch forms will be forwarded to the FDA to report issues relating to the quality, authenticity, performance, or safety of the medication. A provider's unwillingness to complete a form or a patient's unwillingness to take generic drugs do not constitute appropriate clinical basis. Overrides may be approved for up to 12 months; renewals will not require an additional FDA MedWatch form to be submitted. Excluded from this process are carbamazepine, levothyroxine, phenytoin, and warfarin products. Override forms and more information on criteria can be found on the Medicaid website at *www.medicaid.alabama.gov*; click on Programs / Pharmacy Services / Override Criteria and Forms.

Override request forms can be faxed or mailed to:

Health Information Designs (HID)
Medicaid Pharmacy Administrative Services
P.O. Box 3210
Auburn, AL 36832-3210
Fax: 1-800-748-0116
Phone: 1-800-748-0130

Providers with policy questions concerning the DAW override may contact:

Alabama Medicaid Agency
Pharmacy Services Division
P.O. Box 5624
Montgomery, Alabama 36103-5624
(334) 242-5050

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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* _____

Eyeglasses "New Lenses Only"

Recipients who have old frames that meet Food and Drug Administration (FDA) impact-resistant regulations and conform to ANSI requirements may have new lenses installed instead of receiving new eyeglasses. Medicaid will pay for the lenses only.

Physicians should include the following statement in the recipient's record: "I hereby certify that I used this patient's old frames and that I did not accept any remuneration therefore."

CPT "Unlisted Services and Procedures"

Unlisted CPT codes require prior authorization before services are rendered. Whenever unusual procedures are performed and there is no exact descriptive CPT code, AMA requires the most appropriate CPT code be utilized with a modifier 22.

Requirements for Hospital Cost Reports

Alabama Medicaid will be amending its State Plan to require that hospitals must submit electronic versions of the Medicare cost report with Medicare as well as Medicaid sections completed beginning with the fiscal years ending in 2008 and thereafter. These must be submitted electronically to *Terry.Bryant @medicaid.alabama.gov*. If there are any questions, please contact Terry Bryant at 334-242-2301.

Attention Nursing Home Providers

Providers are submitting two sided page layouts of the Minimum Data Set (MDS) as part of the documentation requirements for the monthly audit to APS. Once the document is faxed in to APS it is being scanned and converted to an electronic document. Only one side of the document is being captured. Effective immediately, please fax only single pages to APS. If you have any questions please contact Nancy Headley at (334) 242-5684.

VFC with Third Party and Medicaid Coverage

The following information summarizes the use of Vaccinations for Children (VFC) vaccines and billing procedures:

1. Children, who have vaccination coverage through a third party carrier (with or without deductibles), and do not have Medicaid, must file on their primary insurance and would not be considered "VFC eligible".
2. Children who do not have vaccination coverage through a third party carrier, and do not have Medicaid, are considered under insured and would qualify for vaccinations through the VFC Program. This service would be provided at FQHCs, RHCs, etc… for these individuals.
3. Children who have traditional insurance such as Blue Cross/Blue Shield (with or without deductibles), and have Medicaid coverage, are eligible to receive vaccinations through the VFC Program. Providers may bill Medicaid for the appropriate administration fee without having to bill the third party carrier first.
4. Children who are covered with an HMO and Medicaid qualify for vaccination with a VFC vaccine. However the provider must file with the primary insurance first before billing Medicaid.

IV/GA Permit for Dental Providers

According to Chapter 13 in the Alabama Medicaid Provider Manual Dental providers are required to have a current state board IV/GA permit to bill for procedures D9220 and D9241. Also the Alabama Medicaid Provider Enrollment Application Check List indicates that Dental providers must submit a copy of their IV Sedation/GA permit with the provider application. Effective June 1, 2008, the IV/GA permit will be required for reimbursement of procedures D9220 and D9241. You may mail a copy of your permit to EDS Provider Enrollment, P.O. Box 241685, Montgomery, AL 36124.

SPECIAL NOTICE

Patient 1st Providers

For Patient 1st providers who electronically receive the initial Patient 1st report and the enrollment roster, and you want to continue to receive the reports together you must:

- Use your trading partner ID issued through ECS or your software vendor, or obtain a managed care trading partner ID

2006 ADA Claim Form Required for Paper Dental Claims

Effective June 1, 2008, all Medicaid dental providers must use the 2006 version of the American Dental Association (ADA) Dental Claim Form for claims which are filed on paper. Any paper claim received which is not on this form will be returned to the provider without being processed. Forms can be ordered from any vendor which supplies the 2006 version of the ADA Dental Claim Form.

Dental providers are encouraged to file all claims electronically. Exceptions for electronic filing include but are not limited to:

- Claims with Third Party Liability denials must come on paper with the remittance advice from the other insurance attached
- Claims that need an override for the root canal when root canal is not in the Medicaid system must come on paper with the x-ray attached.

Providers have several options to file claims electronically. Provider Electronic Solutions or Medicaid's Interactive Web Portal is available at no charge for electronic claims submission. Providers may also choose a software vendor for claims submission.

Any questions about using Provider Electronic Solutions or the Interactive Web Portal should be directed to your Provider Representative at 1-800-688-7989.

The attached instructions outline the fields required by Medicaid for the ADA Dental Claim Form for all claims received on or after June 1, 2008. Please note that these guidelines are now the same as the ADA guidelines for completing the paper dental claim form. In the future, Medicaid will follow any changes set forth by ADA guidelines.

Pulse Oximetry Information

Non-invasive ear or pulse oximetry services (procedure codes 94760-94762) are considered bundled services and, therefore, are not separately reimbursable. The only time these services are separately payable are when they are medically necessary and there are no other services payable under the physician fee schedule billed on the same date by the same provider. Non-invasive ear or pulse oximetry services are subject to post-payment review and adjustment.

EDS Provider Representitive Contact Information

To speak to a provider representitive, providers can call the toll-free number and request the appropriate group catagory for the provider. The toll-free number is 1-800-688-7989 and the group catagories are listed below:

Group 1

Nurse Practitioners
Podiatrists
Chiropractors
Independent Labs
Free Standing Radiology
CRNA
EPSDT (Physicians)
Dental
Physicians
Optometric
(Optometrists and Opticians)

Group 2

Public Health
Elderly and Disabled Waiver
Home and Community Based Services
EPSDT
Family Planning
Prenatal
Preventive Education
Rural Health Clinic
Commission on Aging
DME
Nurse Midwives
Rehabilitation Services
Home Bound Waiver
Therapy Services (OT, PT, ST)
Children's Specialty Clinics
Prenatal Clinics
Maternity Care
Hearing Services
Mental Health/Mental Retardation
MR/DD Waiver
Ambulance
FQHC

Group 3

Ambulatory Surgical Centers
ESWL
Home Health
Hospice
Hospital
Nursing Home
Personal Care Services
PEC
Private Duty Nursing
Renal Dialysis Facilities
Swing Bed

Revised State Fiscal Year 2008-2009 Checkwrite Schedule

~~10/05/07~~	~~01/04/08~~	~~04/04/08~~	07/11/08
~~10/19/07~~	~~01/18/08~~	~~04/18/08~~	07/25/08
~~11/02/07~~	~~02/08/08~~	05/02/08	08/08/08
~~11/16/07~~	~~02/22/08~~	05/16/08	08/22/08
~~12/07/07~~	~~03/07/08~~	06/06/08	09/05/08
~~12/14/07~~	~~03/21/08~~	06/20/08	09/12/08

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Provider *Insider*

Alabama Medicaid Bulletin **July 2008**

The checkwrite schedule is as follows:

07/25/08 08/8/08 08/22/08 09/05/08 09/12/08

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

Medicaid to Begin Accepting NDCs on Certain Administered Drugs

In compliance with the Deficit Reduction Act, effective July 1, 2008, Medicaid will begin accepting NDCs (National Drug Codes) on CMS-1500 and UB-04 claims for the top 20 physician-administered multiple source drugs for dates of service July 1, 2008, and thereafter. The top 20 physician-administered multiple source drugs that REQUIRE a NDC code are listed beginning on page 4. The list contains the HCPCS Code, description, HCPCS dosage, drug name, NDC, and labeler name. This requirement is for both straight Medicaid claims and Medicare/Medicaid crossover claims.

Providers classified by CMS as a 340B provider are not required to submit the NDC. Only a few providers are impacted by this classification.

Medicaid will provide a grace period to allow providers sufficient time to acclimate to the change. All providers may begin sending NDC information with the HCPCS procedure code on July 1, 2008. Medicaid will validate the data and will set an informational denial code, but will NOT deny the claim during this grace period.

Effective for dates of service August 1, 2008, the NDC numbers will be mandatory for claims processing and payment for CMS-1500 claims.

Effective for dates of service September 1, 2008, the NDC numbers will be mandatory for claims processing and payment for UB-04 claims. Inpatient hospital claims are exempt from this requirement; however, outpatient claims will require the use of the NDC number on the claim.

If you receive an informational denial code during the grace period, you must take action to prevent your claim from denying once the NDC is mandated.

See page 11 for a listing of the denial codes associated with the NDC requirement.

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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 _____*

Instructions for Adding NDC Codes to Required Medicaid Forms

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

CMS-1500 Instructions

Using the supplemental information in Item Number 24D, enter the identifier "N4" and the 11-digit NDC code. The identifier N4 tells the computer the following supplemental information is a NDC.

Do not enter a space between the identifier and the NDC.

Do not enter hyphens or spaces within the NDC.

This example demonstrates how the data are to be entered into the fields and is not meant to provide direction on how to code for certain services.

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	DIA PC
1 07	01	08	07	01	08	11	0	J9265	N4 55390031420	
2										

ID Code Qualifier

11-Digit NDC

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

Instructions for Adding NDC Codes to Required Medicaid Forms

UB-04 Instructions

In Form Locator 43 (Description), enter the "N4" qualifier in the first two (2) positions, left justified; followed immediately by the 11 character NDC number (no hyphens). The identifier "N4" tells the computer the following supplemental information is a NDC.

Do not enter a space between the identifier and the NDC.

Do not enter hyphens or spaces within the NDC.

This example demonstrates how the data are to be entered into the fields and is not meant to provide direction on how to code for certain services.

Revenue Code	ID Code Qualifier	11-Digit NDC	44 HCPCS / RATE / HIPPS CODE
636	N4	55390031420	J9265

Medicaid Top 20 Physician-Administered Multiple Source Drugs

Rank	HCPCS Code	Description	HCPCS Dosage	Labeler Drug Name	NDC	Labeler Name
1	**J9265**	Paclitaxel Injection	30 mg	Paclitaxel	55390-0314-20	Amerinet Choice
				Paclitaxel	55390-0314-50	Amerinet Choice
				Paclitaxel	55390-0304-05	Bedford Laboratories
				Paclitaxel	55390-0304-20	Bedford Laboratories
				Paclitaxel	55390-0304-50	Bedford Laboratories
				Paclitaxel	55390-0114-05	Bedford Laboratories
				Paclitaxel	55390-0114-20	Bedford Laboratories
				Paclitaxel	55390-0114-50	Bedford Laboratories
				Paclitaxel	55390-0314-05	Bedford Laboratories
				Paclitaxel	55390-0514-05	Bedford Laboratories
				Paclitaxel	55390-0514-20	Bedford Laboratories
				Paclitaxel	55390-0514-50	Bedford Laboratories
				Onxol	00172-3753-77	Ivax Pharmaceuticals
				Onxol	00172-3753-96	Ivax Pharmaceuticals
				Onxol	00172-3754-73	Ivax Pharmaceuticals
				Onxol	00172-3754-94	Ivax Pharmaceuticals
				Onxol	00172-3756-75	Ivax Pharmaceuticals
				Onxol	00172-3756-95	Ivax Pharmaceuticals
				Paclitaxel	00074-4335-04	Mayne Pharma
				Paclitaxel	61703-0342-09	Mayne Pharma
				Paclitaxel	61703-0342-22	Mayne Pharma
				Paclitaxel	61703-0342-50	Mayne Pharma
				Taxol	00015-3475-30	Mead Johnson and Co
				Taxol	00015-3476-30	Mead Johnson and Co
				Taxol	00015-3479-11	Mead Johnson and Co
2	**J9045**	Carboplatin Injection	50mg	Carboplatin	63323-0172-45	Abraxis Pharmaceutical
				Carboplatin	63323-0172-60	Abraxis Pharmaceutical
				Carboplatin	63323-0166-10	American Pharmaceutical Partners
				Carboplatin	63323-0167-21	American Pharmaceutical Partners
				Carboplatin	63323-0168-00	American Pharmaceutical Partners
				Carboplatin	55390-0150-01	Bedford Laboratories
				Carboplatin	55390-0151-01	Bedford Laboratories
				Carboplatin	55390-0152-01	Bedford Laboratories
				Carboplatin	55390-0153-01	Bedford Laboratories
				Carboplatin	55390-0154-01	Bedford Laboratories
				Carboplatin	55390-0155-01	Bedford Laboratories
				Carboplatin	55390-0156-01	Bedford Laboratories
				Carboplatin	55390-0220-01	Bedford Laboratories
				Carboplatin	55390-0221-01	Bedford Laboratories
				Carboplatin	55390-0222-01	Bedford Laboratories
				Carboplatin	00409-1129-10	Hospira
				Carboplatin	00409-1129-11	Hospira
				Carboplatin	00409-1129-12	Hospira
				Carboplatin	61703-0339-18	Mayne Pharma
				Carboplatin	61703-0339-22	Mayne Pharma
				Carboplatin	61703-0339-50	Mayne Pharma
				Carboplatin	61703-0339-56	Mayne Pharma
				Carboplatin	61703-0360-18	Mayne Pharma
				Carboplatin	61703-0360-22	Mayne Pharma
				Carboplatin	61703-0360-50	Mayne Pharma
				Carboplatin	15210-0061-12	OTN Generics
				Carboplatin	15210-0063-12	OTN Generics
				Carboplatin	15210-0066-12	OTN Generics
				Carboplatin	15210-0067-12	OTN Generics
				Carboplatin	50111-0965-76	PLIVA
				Carboplatin	50111-0966-76	PLIVA
				Carboplatin	50111-0967-76	PLIVA
				Carboplatin	00703-3249-11	SICOR
				Carboplatin	00703-3264-01	SICOR
				Carboplatin	00703-3266-01	SICOR
				Carboplatin	00703-3274-01	SICOR
				Carboplatin	00703-3276-01	SICOR

Medicaid Top 20 Physician-Administered Multiple Source Drugs *(Continued)*

Rank	HCPCS Code	Description	HCPCS Dosage	Labeler Drug Name	NDC	Labeler Name
2 Continued	**J9045**	Carboplatin Injection	50mg	Carboplatin	00703-3278-01	SICOR
				Carboplatin	00703-4244-01	SICOR
				Carboplatin	00703-4246-01	SICOR
				Carboplatin	00703-3248-01	SICOR
3	**J0696**	Ceftriaxone Sodium Injection	250 mg	Ceftriaxone Sodium	63323-0344-10	American Pharmaceutical Partners
				Ceftriaxone Sodium	63323-0345-10	American Pharmaceutical Partners
				Ceftriaxone Sodium	63323-0346-10	American Pharmaceutical Partners
				Ceftriaxone Sodium	63323-0347-20	American Pharmaceutical Partners
				Ceftriaxone Sodium	63323-0348-61	American Pharmaceutical Partners
				Ceftriaxone IN DSW	00264-3153-11	B. Braun Medical
				Ceftriaxone IN DSW	00264-3155-11	B. Braun Medical
				Ceftriaxone IN DSW	00338-5002-41	Baxter
				Ceftriaxone IN DSW	00338-5003-41	Baxter
				Ceftriaxone	10019-0098-01	Baxter
				Ceftriaxone Sodium	10019-0685-01	Baxter
				Ceftriaxone Sodium	10019-0686-02	Baxter
				Ceftriaxone Sodium	10019-0687-03	Baxter
				Ceftriaxone Sodium	10019-0688-04	Baxter
				Ceftriaxone	10019-0688-27	Baxter
				Ceftriaxone	10019-0689-05	Baxter
				Ceftriaxone	68330-000-201	Cephazone Pharma
				Ceftriaxone	68330-000-210	Cephazone Pharma
				Ceftriaxone	68330-000-310	Cephazone Pharma
				Ceftriaxone	68330-000-401	Cephazone Pharma
				Ceftriaxone	68330-000-410	Cephazone Pharma
				Ceftriaxone	68330-000-501	Cephazone Pharma
				Ceftriaxone	68330-000-601	Cephazone Pharma
				Rocephin	00004-1962-01	Hoffman-La Roche
				Rocephin	00004-1962-02	Hoffman-La Roche
				Rocephin	00004-1963-01	Hoffman-La Roche
				Rocephin	00004-1963-02	Hoffman-La Roche
				Rocephin	00004-1964-01	Hoffman-La Roche
				Rocephin	00004-1964-04	Hoffman-La Roche
				Rocephin	00004-1964-05	Hoffman-La Roche
				Rocephin	00004-1965-01	Hoffman-La Roche
				Rocephin	00004-1971-01	Hoffman-La Roche
				Ceftriaxone	00409-7332-01	Hospira
				Ceftriaxone	00409-7333-04	Hospira
				Ceftriaxone	00409-7333-49	Hospira
				Ceftriaxone	00409-7334-10	Hospira
				Ceftriaxone	00409-7335-03	Hospira
				Ceftriaxone	00409-7336-04	Hospira
				Ceftriaxone	00409-7336-49	Hospira
				Ceftriaxone	00409-7337-01	Hospira
				Ceftriaxone	00409-7338-01	Hospira
				Ceftriaxone	68180-0611-01	Lupin Pharmaceuticals
				Ceftriaxone	68180-0611-10	Lupin Pharmaceuticals
				Ceftriaxone	68180-0622-01	Lupin Pharmaceuticals
				Ceftriaxone	68180-0622-10	Lupin Pharmaceuticals
				Ceftriaxone	68180-0633-01	Lupin Pharmaceuticals
				Ceftriaxone	68180-0633-10	Lupin Pharmaceuticals
				Ceftriaxone	68180-0644-01	Lupin Pharmaceuticals
				Ceftriaxone	68180-0644-10	Lupin Pharmaceuticals
				Ceftriaxone	00781-3206-95	SANDOZ
				Ceftriaxone	00781-3207-95	SANDOZ
				Ceftriaxone	00781-3208-95	SANDOZ
				Ceftriaxone	00781-3209-95	SANDOZ
				Ceftriaxone	00781-3210-46	SANDOZ
				Ceftriaxone	00781-9326-95	SANDOZ
				Ceftriaxone	00781-9327-95	SANDOZ
				Ceftriaxone	00781-9328-95	SANDOZ
				Ceftriaxone	00781-9329-95	SANDOZ
				Ceftriaxone	00781-9330-46	SANDOZ
				Ceftriaxone	00703-0315-03	SICOR

Medicaid Top 20 Physician-Administered Multiple Source Drugs *(Continued)*

Rank	HCPCS Code	Description	HCPCS Dosage	Labeler Drug Name	NDC	Labeler Name
3 Continued	**J0696**	Ceftriaxone Sodium Injection	250 mg	Ceftriaxone	64679-0983-01	Wockhardt America
				Ceftriaxone	64679-0983-02	Wockhardt America
				Ceftriaxone	64679-0701-01	Wockhardt America
				Ceftriaxone	64679-0701-02	Wockhardt America
				Ceftriaxone	64679-0701-03	Wockhardt America
				Ceftriaxone	64679-0702-01	Wockhardt America
				Ceftriaxone	64679-0702-02	Wockhardt America
				Ceftriaxone	64679-0703-01	Wockhardt America
				Ceftriaxone	64679-0703-02	Wockhardt America
4	**J9217**	Leuprolide Acetate Suspension	7.5 mg	Eligard	00024-0222-05	Sanofi Pharmaceuticals
				Eligard	00024-0605-45	Sanofi Pharmaceuticals
				Eligard	00024-0610-30	Sanofi Pharmaceuticals
				Eligard	00024-0793-75	Sanofi Pharmaceuticals
				Lupron Depot-Ped	00300-2108-01	Tap Pharmaceuticals
				Lupron Depot-Ped	00300-2440-01	Tap Pharmaceuticals
				Lupron Depot	00300-3346-01	Tap Pharmaceuticals
				Lupron Depot	00300-3342-01	Tap Pharmaceuticals
				Lupron Depot	00300-3683-01	Tap Pharmaceuticals
5	**J1260**	Dotasetron Mesylate	10 mg	Anzemet	00088-1208-06	Abbott
				Anzemet	00088-1208-76	Abbott
				Anzemet	00088-1206-32	Aventis Pharmaceuticals
				Anzemet	00088-1209-26	Aventis Pharmaceuticals
6	**J7192**	Factor VIII Recombinant	1 iu	Helixate Fs	00053-8130-01	Aventis Behring
				Helixate Fs	00053-8130-02	Aventis Behring
				Helixate Fs	00053-8130-04	Aventis Behring
				Kogenate Fs	00026-0372-20	Baxter
				Kogenate Fs	00026-0372-30	Baxter
				Kogenate Fs	00026-0372-50	Baxter
				Recombinate	00944-2831-10	Baxter
				Recombinate	00944-2832-10	Baxter
				Recombinate	00944-2833-10	Baxter
				Advate L	00944-2941-10	Baxter
				Advate M	00944-2942-10	Baxter
				Kogenate Fs Bio-Set	00026-0379-20	Bayer
				Kogenate Fs Bio-Set	00026-0379-30	Bayer
				Kogenate Fs Bio-Set	00026-0379-50	Bayer
				Kogenate Fs	00026-3786-60	Bayer
				Kogenate Fs	00026-3796-60	Bayer
				Helixate	00053-8130-05	CSL Behring
				Refacto	58394-0005-02	Genetics Institute
				Refacto	58394-0006-02	Genetics Institute
				Refacto	58394-0007-02	Genetics Institute
				Refacto	58394-0011-02	Genetics Institute
7	**J2430**	Pamidronate Disodium	30 mg	Pamidronate Disodium	63323-0734-10	American Pharmaceutical Partners
				Pamidronate Disodium	63323-0735-10	American Pharmaceutical Partners
				Pamidronate Disodium	55390-0127-01	Bedford Laboratories
				Pamidronate Disodium	55390-0129-01	Bedford Laboratories
				Pamidronate Disodium	55390-0157-01	Bedford Laboratories
				Pamidronate Disodium	55390-0159-01	Bedford Laboratories
				Pamidronate Disodium	55390-0204-01	Bedford Laboratories
				Pamidronate Disodium	55390-0604-01	Bedford Laboratories
				Pamidronate Disodium	61703-0324-18	Mayne Pharma
				Pamidronate Disodium	61703-0326-18	Mayne Pharma
				Pamidronate Disodium	61703-0324-39	Mayne Pharma
				Pamidronate Disodium	61703-0325-18	Mayne Pharma
				Pamidronate Disodium	61703-0326-18	Mayne Pharma
				Aredia	00078-0463-91	Novartis
				Aredia	00078-0464-61	Novartis
				Pamidronate Disodium	15210-0401-11	OTN Generics
				Pamidronate Disodium	15210-0402-11	OTN Generics

Medicaid Top 20 Physician-Administered Multiple Source Drugs (Continued)

Rank	HCPCS Code	Description	HCPCS Dosage	Labeler Drug Name	NDC	Labeler Name
7 Continued	**J2430**	Pamidronate Disodium	30 mg	Pamidronate Disodium	00781-3147-84	SANDOZ
				Pamidronate Disodium	00781-3148-70	SANCOZ
				Pamidronate Disodium	00703-4075-59	SICOR
				Pamidronate Disodium	00703-4085-51	SICOR
8	**J7190**	Factor VIII	1 iu	Hemofil M	00944-2935-03	Baxter
				Hemofil M	00944-2935-04	Baxter
				Monarc-M	00944-1301-10	Baxter
				Monarc-M	00944-1302-10	Baxter
				Monarc-M	00944-1303-10	Baxter
				Monarc-M	00944-1304-10	Baxter
				Hemofil M	00944-2935-01	Baxter
				Hemofil M	00944-2935-02	Baxter
				Monoclate-P	00053-7656-01	CSL Behring
				Monoclate-P	00053-7656-02	CSL Behring
				Monoclate-P	00053-7656-04	CSL Behring
				Monoclate-P	00053-7656-05	CSL Behring
				Alphanate	68516-4600-01	Grifols
				Alphanate	68516-4600-02	Grifols
				Alphanate	68516-4601-01	Grifols
				Alphanate	68516-4602-01	Grifols
				Alphanate	68516-4603-02	Grifols
				Alphanate	68516-4604-02	Grifols
				Koate-Dvi	13533-0665-20	Talecris
				Koate-Dvi	13533-0665-30	Talecris
				Koate-Dvi	13533-0665-50	Talecris
9	**J9000**	Doxorubic Hcl	10 mg	Doxorubicin Hcl	63323-0101-61	American Pharmaceutical Partner
				Doxorubicin Hcl	63323-0883-05	American Pharmaceutical Partner
				Doxorubicin Hcl	63323-0883-10	American Pharmaceutical Partner
				Doxorubicin Hcl	63323-0883-30	American Pharmaceutical Partner
				Doxorubicin Hcl	10019-0920-01	Baxter
				Adriamycin	55390-0231-10	Bedford Laboratories
				Adriamycin	55390-0233-01	Bedford Laboratories
				Adriamycin	55390-0235-10	Bedford Laboratories
				Adriamycin	55390-0236-10	Bedford Laboratories
				Adriamycin	55390-0237-01	Bedford Laboratories
				Adriamycin	55390-0238-01	Bedford Laboratories
				Doxorubicin Hcl	55390-0241-10	Bedford Laboratories
				Doxorubicin Hcl	55390-0243-01	Bedford Laboratories
				Doxorubicin Hcl	55390-0245-10	Bedford Laboratories
				Doxorubicin Hcl	55390-0246-10	Bedford Laboratories
				Doxorubicin Hcl	55390-0247-01	Bedford Laboratories
				Doxorubicin Hcl	55390-0248-01	Bedford Laboratories
				Doxorubicin Hcl	00703-5040-01	SICOR
				Doxorubicin Hcl	00703-5043-03	SICOR
				Doxorubicin Hcl	00703-5046-01	SICOR
10	**J1885**	Ketorolac Tromethamine Injection	15 mg	Ketorolac Tromethamine	63323-0161-01	American Pharmaceutical Partners
				Ketorolac Tromethamine	63323-0162-01	American Pharmaceutical Partners
				Ketorolac Tromethamine	63323-0162-02	American Pharmaceutical Partners
				Ketorolac Tromethamine	00074-3796-61	Amerinet Choice
				Ketorolac Tromethamine	60505-0705-00	Apotex
				Ketorolac Tromethamine	60505-0706-00	Apotex
				Ketorolac Tromethamine	60505-0706-01	Apotex
				Ketorolac Tromethamine	60505-0710-01	Apotex
				Ketorolac Tromethamine	10019-0021-09	Baxter
				Ketorolac Tromethamine	10019-0022-09	Baxter
				Ketorolac Tromethamine	10019-0022-32	Baxter
				Ketorolac Tromethamine	10019-0029-02	Baxter
				Ketorolac Tromethamine	10019-0030-03	Baxter
				Ketorolac Tromethamine	10019-0030-04	Baxter
				Ketorolac Tromethamine	55390-0480-01	Bedford Laboratories
				Ketorolac Tromethamine	55390-0481-01	Bedford Laboratories
				Ketorolac Tromethamine	55390-0481-02	Bedford Laboratories
				Ketorolac Tromethamine	55390-0481-10	Bedford Laboratories

Medicaid Top 20 Physician-Administered Multiple Source Drugs *(Continued)*

Rank	HCPCS Code	Description	HCPCS Dosage	Labeler Drug Name	NDC	Labeler Name
10 Continued	**J1885**	Ketorolac Tromethamine Injection	15 mg	Ketorolac Tromethamine	00409-2287-21	Hospira
				Ketorolac Tromethamine	00409-2287-22	Hospira
				Ketorolac Tromethamine	00409-2287-31	Hospira
				Ketorolac Tromethamine	00409-2288-21	Hospira
				Ketorolac Tromethamine	00409-2288-61	Hospira
				Ketorolac Tromethamine	00409-2288-31	Hospira
				Ketorolac Tromethamine	00409-3793-01	Hospira
				Ketorolac Tromethamine	00409-3795-49	Hospira
				Ketorolac Tromethamine	00409-3795-01	Hospira
				Ketorolac Tromethamine	00409-3795-49	Hospira
				Ketorolac Tromethamine	00409-3795-61	Hospira
				Ketorolac Tromethamine	00409-3796-01	Hospira
				Ketorolac Tromethamine	00409-3796-49	Hospira
				Ketorolac Tromethamine	00409-3796-61	Hospira
				Ketorolac Tromethamine	64679-0757-01	Woodhardt Americas
				Ketorolac Tromethamine	64679-0757-02	Woodhardt Americas
				Ketorolac Tromethamine	64679-0758-01	Woodhardt Americas
				Ketorolac Tromethamine	64679-0758-02	Woodhardt Americas
				Ketorolac Tromethamine	64679-0758-04	Woodhardt Americas
				Ketorolac Tromethamine	64679-0758-06	Woodhardt Americas
11	**J9390**	Vinorelbine Tartrate	10 mg	Vinorelbine Tartrate	55390-0267-01	Amerinet
				Vinorelbine Tartrate	63323-0148-01	APP
				Vinorelbine Tartrate	63323-0148-05	APP
				Vinorelbine Tartrate	55390-0069-01	Bedford Laboratories
				Vinorelbine Tartrate	55390-0070-01	Bedford Laboratories
				Vinorelbine Tartrate	55390-0268-01	Bedford Laboratories
				Vinorelbine Tartrate	61703-0341-06	Mayne Pharma
				Vinorelbine Tartrate	61703-0341-09	Mayne Pharma (USA)
				Vinorelbine Tartrate	00703-4182-01	SICOR
				Vinorelbine Tartrate	00703-4182-81	SICOR
				Vinorelbine Tartrate	00703-4182-91	SICOR
				Vinorelbine Tartrate	00703-4183-01	SICOR
				Vinorelbine Tartrate	00703-4183-81	SICOR
				Vinorelbine Tartrate	00703-4183-91	SICOR
12	**J1100**	Dexamethasone Sodium Phosphate	1 mg	Dexamethasone Sodium Phos	63323-0165-01	American Pharmaceutical Partners
				Dexamethasone Sodium Phos	63323-0165-05	American Pharmaceutical Partners
				Dexamethasone Sodium Phos	63323-0165-30	American Pharmaceutical Partners
				Dexamethasone Sodium Phos	63323-0506-01	American Pharmaceutical Partners
				Dexamethasone Sodium Phos	63323-0506-01	American Pharmaceutical Partners
				Dexamethasone Sodium Phos	00517-4901-25	American Regent
				Dexamethasone Sodium Phos	00517-4905-25	American Regent
				Dexamethasone Sodium Phos	00517-4930-25	American Regent
				Dexamethasone Sodium Phos	00641-0367-25	Baxter
				Dexamethasone Sodium	00703-3524-03	SICOR
13	**J0640**	Leucovorin Calcium Injection	50 mg	Leucovorin Calcium	63323-0711-00	American Pharmaceutical Partners
				Leucovorin Calcium	55390-0009-01	Bedford Laboratories
				Leucovorin Calcium	55390-0051-10	Bedford Laboratories
				Leucovorin Calcium	55390-0052-10	Bedford Laboratories
				Leucovorin Calcium	55390-0053-01	Bedford Laboratories
				Leucovorin Calcium	55390-0054-01	Bedford Laboratories
				Leucovorin Calcium	55390-0818-10	Bedford Laboratories
				Leucovorin Calcium	55390-0824-01	Bedford Laboratories
				Leucovorin Calcium	55390-0825-01	Bedford Laboratories
				Leucovorin Calcium	55390-0826-01	Bedford Laboratories
				Leucovorin Calcium	00054-8497-06	Roxane
				Leucovorin Calcium	00054-8498-06	Roxane
				Leucovorin Calcium	00703-5140-01	SICOR
				Leucovorin Calcium	00703-5145-01	SICOR
				Leucovorin Calcium	62701-0900-30	Supergen
				Leucovorin Calcium	62701-0900-99	Supergen
				Leucovorin Calcium	62701-0901-25	Supergen
				Leucovorin Calcium	51079-0581-01	UDL
				Leucovorin Calcium	51079-0581-06	UDL
				Leucovorin Calcium	51079-0582-05	UDL

Medicaid Top 20 Physician-Administered Multiple Source Drugs *(Continued)*

Rank	HCPCS Code	Description	HCPCS Dosage	Labeler Drug Name	NDC	Labeler Name
14	**J3010**	Fentanyl Citrate Injection	0.1 mg	Fentanyl Citrate	10019-0033-72	Baxter
				Fentanyl Citrate	10019-0034-73	Baxter
				Fentanyl Citrate	10019-0035-74	Baxter
				Fentanyl Citrate	10019-0036-82	Baxter
				Fentanyl Citrate	10019-0037-83	Baxter
				Fentanyl Citrate	10019-0038-67	Baxter
				Fentanyl Citrate	00409-1276-32	Hospira
				Fentanyl Citrate	00409-9093-32	Hospira
				Fentanyl Citrate	00409-9093-35	Hospira
				Fentanyl Citrate	00409-9093-36	Hospira
				Fentanyl Citrate	00409-9093-38	Hospira
				Fentanyl Citrate	00409-9094-22	Hospira
				Fentanyl Citrate	00409-9094-25	Hospira
				Fentanyl Citrate	00409-9094-28	Hospira
				Fentanyl Citrate	00409-9094-31	Hospira
				Fentanyl Citrate	00409-9094-61	Hospira
				Sublimaze	11098-0030-02	Taylor
				Sublimaze	11098-0030-05	Taylor
				Sublimaze	11098-0030-20	Taylor
15	**J7050**	Normal Saline Solution Infus	250 cc	Sodium Chloride	00264-1400-00	B. Braun Medical
				Sodium Chloride	00264-1400-10	B. Braun Medical
				Sodium Chloride	00264-4000-55	B. Braun Medical
				Sodium Chloride	00264-4001-55	B. Braun Medical
				Sodium Chloride	00264-4002-55	B. Braun Medical
				Sodium Chloride	00264-7800-00	B. Braun Medical
				Sodium Chloride	00264-7800-10	B. Braun Medical
				Sodium Chloride	00264-7800-20	B. Braun Medical
				Sodium Chloride	00338-0044-03	Baxter
				Sodium Chloride	00338-0049-02	Baxter
				Sodium Chloride	00338-0049-03	Baxter
				Sodium Chloride	00338-0049-04	Baxter
				Sodium Chloride	00338-6304-02	Baxter
				Sodium Chloride	00338-6304-02	Baxter
				Sodium Chloride	00338-7800-20	Baxter
				Sodium Chloride	00409-1583-02	Hospira
				Sodium Chloride	00409-7101-02	Hospira
				Sodium Chloride	00409-7983-02	Hospira
				Sodium Chloride	00409-7983-03	Hospira
				Sodium Chloride	00409-7983-09	Hospira
				Sodium Chloride	00409-7983-30	Hospira
				Sodium Chloride	00409-7983-48	Hospira
				Sodium Chloride	00409-7983-53	Hospira
				Sodium Chloride	00409-7983-55	Hospira
16	**J2550**	Promethazine Hcl Injection	50 mg	Promethazine Hcl	00641-0928-25	Baxter
				Promethazine Hcl	00641-0929-25	Baxter
				Promethazine Hcl	00641-0948-35	Baxter
				Promethazine Hcl	00641-0949-35	Baxter
				Promethazine Hcl	00641-0955-25	Baxter
				Promethazine Hcl	00641-0956-25	Baxter
				Promethazine Hcl	00641-1495-35	Baxter
				Promethazine Hcl	00641-1496-35	Baxter
				Promethazine Hcl	10019-0097-01	Baxter
				Phenergan	60977-0001-01	Baxter
				Promethazine Hcl	60977-0001-03	Baxter
				Phenergan	60977-0002-02	Baxter
				Promethazine Hcl	60977-0002-04	Baxter
				Promethazine Hcl	00409-2312-31	Hospira
				Promethazine Hcl	00703-2191-04	SICOR
				Promethazine Hcl	00703-2201-04	SICOR

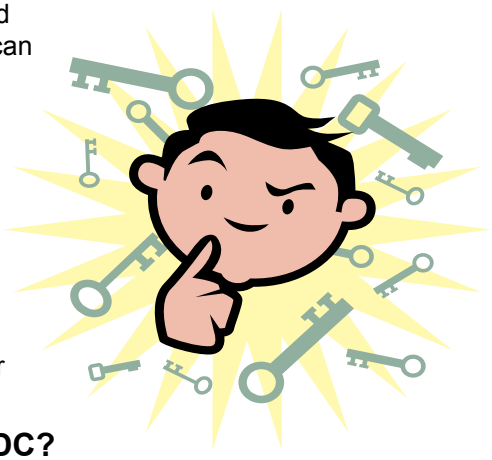
Medicaid Top 20 Physician-Administered Multiple Source Drugs *(Continued)*

Rank	HCPCS Code	Description	HCPCS Dosage	Labeler Drug Name	NDC	Labeler Name
17	J1631	Haloperidol Decanoate Injection	50 mg	Haloperidol Decanoate	63323-0469-01	American Pharmaceutical Partners
				Haloperidol Decanoate	63323-0469-05	American Pharmaceutical Partners
				Haloperidol Decanoate	63323-0471-01	American Pharmaceutical Partners
				Haloperidol Decanoate	63323-0471-05	American Pharmaceutical Partners
				Haloperidol Decanoate	60505-0702-01	Apotex
				Haloperidol Decanoate	60505-0703-01	Apotex
				Haloperidol Decanoate	55390-0412-01	Bedford Laboratories
				Haloperidol Decanoate	55390-0412-05	Bedford Laboratories
				Haloperidol Decanoate	55390-0413-01	Bedford Laboratories
				Haloperidol Decanoate	55390-0413-05	Bedford Laboratories
				Haloperidol Decanoate	55390-0423-01	Bedford Laboratories
				Haloperidol Decanoate	55390-0423-05	Bedford Laboratories
				Haloperidol Decanoate	00045-0253-01	McNeil Pharmaceutical
				Haloperidol Decanoate	00045-0253-03	McNeil Pharmaceutical
				Haloperidol Decanoate	00045-0254-14	McNeil Pharmaceutical
				Haloperidol Decanoate	00703-7011-03	SICOR
				Haloperidol Decanoate	00703-7013-01	SICOR
				Haloperidol Decanoate	00703-7021-03	SICOR
				Haloperidol Decanoate	00703-7023-01	SICOR
18	J7644	Ipratropium Bromide Inh Sol u d	1 mg	Ipratropium Bromide	00472-0753-23	Alpharma
				Ipratropium Bromide	00472-0753-30	Alpharma
				Ipratropium Bromide	00472-0753-60	Alpharma
				Ipratropium Bromide	60505-0806-01	Apotex
				Ipratropium Bromide	16252-0098-22	Cobalt Laboratories
				Ipratropium Bromide	16252-0098-33	Cobalt Laboratories
				Ipratropium Bromide	16252-0098-66	Cobalt Laboratories
				Ipratropium Bromide	49502-0685-26	Dey, L.P.
				Ipratropium Bromide	49502-0685-30	Dey, L.P.
				Ipratropium Bromide	49502-0685-31	Dey, L.P.
				Ipratropium Bromide	49502-0685-61	Dey, L.P.
				Ipratropium Bromide	51552-0393-01	Gallipot
				Ipratropium Bromide	51552-0393-02	Gallipot
				Ipratropium Bromide	51552-0393-04	Gallipot
				Ipratropium Bromide	51552-0393-05	Gallipot
				Ipratropium Bromide	00172-6407-44	Ivax Pharmaceuticals
				Ipratropium Bromide	00172-6407-49	Ivax Pharmaceuticals
				Ipratropium Bromide	00487-9801-01	Nephron Pharmaceuticals
				Ipratropium Bromide	00487-9801-25	Nephron Pharmaceuticals
				Ipratropium Bromide	00487-9801-30	Nephron Pharmaceuticals
				Ipratropium Bromide	00487-9801-60	Nephron Pharmaceuticals
				Ipratropium Bromide	66794-0002-25	RX Elite
				Ipratropium Bromide	66794-0002-30	RX Elite
				Ipratropium Bromide	66794-0002-60	RX Elite
19	J9060	Cisplatin Injection	10 mg	Cisplatin	63323-0103-51	American Pharmaceutical Partners
				Cisplatin	63323-0103-64	American Pharmaceutical Partners
				Cisplatin	63323-0103-65	American Pharmaceutical Partners
				Cisplatin	55390-0099-01	Bedford Laboratories
				Cisplatin	55390-0112-50	Bedford Laboratories
				Cisplatin	55390-0112-99	Bedford Laboratories
				Cisplatin	55390-0187-01	Bedford Laboratories
				Cisplatin	55390-0414-50	Bedford Laboratories
				Cisplatin	55390-0414-99	Bedford Laboratories
				Cisplatin	00703-5747-11	SICOR
				Cisplatin	00703-5748-11	SICOR
20	J9040	Bleomycin Sulfate Injection	15 units	Bleomycin Sulfate	55390-0005-01	Bedford Laboratories
				Bleomycin Sulfate	55390-0006-01	Bedford Laboratories
				Bleomycin Sulfate	61703-0323-22	Mayne Pharma
				Bleomycin Sulfate	61703-0332-18	Mayne Pharma
				Blenoxane	00015-3010-20	Mead Johnson and Company
				Bleomycin Sulfate	00703-3154-01	SICOR
				Bleomycin Sulfate	00703-3154-91	SICOR
				Bleomycin Sulfate	00703-3155-01	SICOR
				Bleomycin Sulfate	00703-3155-91	SICOR

Questions Concerning NDC Additions to Medicaid Claim Forms

What is a NDC?

The NDC is a universal number that identifies a drug. The NDC number consists of 11 digits in a 5-4-2 format. The first 5 digits identify the manufacturer of the drug and are assigned by the Food and Drug Administration. The remaining digits are assigned by the manufacturer and identify the specific product and package size. Some packages will display less than 11 digits, but leading zeroes can be assumed and need to be used when billing. For example:



XXXX-XXXX-XX = 0XXXX-XXXX-XX
XXXXX-XXX-XX = XXXXX-0XXX-XX
XXXXX-XXXX-X = XXXXX-XXXX-0X

The NDC is found on the drug container (that is vial, bottle, tube). **The NDC submitted to Medicaid must be the actual NDC number on the package or container from which the medication was administered**. Do not bill for one manufacturer's product and dispense another. The benefits of accurate billing include reductions in audits, telephone calls, and manufacturers' disputes of their rebate invoices.

Do I need to include units for both the HCPCS code and the NDC?

No. Provider reimbursement is based on the HCPCS description and units of service. Providers do not need to include the units for the NDC.

If a procedure code is being billed that requires a NDC, and the NDC is not present, what will happen to my claim?

During the grace period, your claim will pay but an informational denial code will be posted on your Remittance Advice. After the grace period, your claim will be denied.

The following is a list of applicable denial codes providers may see when billing a procedure code which requires a NDC.

Denial Code	Description
4260	NDC REQUIRED FOR PROCEDURE
4261	INVALID UNIT OF MEASURE VALUE
4262	NDC QUANTITY UNITS IS NOT NUMERIC
4263	NDC QUANTITY UNITS IS ZERO
4264	NDC NOT ON THE DRUG FILE
4265	INVALID HCPCS/NDC COMBINATION FOR PRIMARY NDC
4266	PRIMARY NDC NO LONGER ACTIVE ON DATE OF SVC
4267	SECONDARY NDC NO LONGER ACTIVE ON DATE OF SVC
4268	PRIMARY NDC NOT REBATABLE ON THE DATE OF SERVICE
4269	SECONDARY NDC NOT REBATABLE ON THE DATE OF SERVICE
4270	NDC RATED LESS THAN EFFECTIVE
4271	DUPLICATE NDC FOR CLAIM DETAIL
4272	NDC OBSOLETE/INVALID ON THE DATE OF SERVICE
4273	INVALID NDC QUALIFIER CODE, MUST EQUAL N4
4274	INVALID PRESCRIPTION QUALIFIER CODE, MUST EQUAL XZ
4275	DRUG UNIT PRICE IS NOT NUMERIC
4276	DRUG UNIT PRICE IS ZERO

What happens if I bill a NDC for a J code not in the required listing?

Medicaid will accept NDCs not in the top 20. If a NDC is present, the NDC will be validated but will not be denied for denial code 4178 (NDC required for procedure), but will be subjected to the other NDC validation edits listed above.

How do I bill for a drug when only a partial vial was administered?

Bill using the HCPCS code with the corresponding units administered.

Instructions for Adding NDC Codes to Required Medicaid Forms

This form is a required attachment for any Alabama Medicaid paper crossover claim using a drug HCPCS code on a Medical Crossover or an Institutional Crossover

Provider Name:_____

Provider NPI:_____

Recipient Name:_____

Recipient Medicaid Number:_____

Line No.	Procedure	NDC										
3	J9265	5	5	3	9	0	0	3	1	4	2	0

Enter the corresponding line number from the detail on the claim.

Enter the corresponding HCPCS procedure code from the detail on the claim.

Enter the 11-digit NDC for the HCPCS procedure code.

Submitting NDC For Electronic Claims

For electronic claims, the information concerning submitting NDCs can be found in the addenda to version 4010 of the HIPA Implementation Guides for the 837 Professional and 837 Institutional claim types. The information in the chart below should clear up any technical concerns.

1 **Loop:** 2410 **Name:** Drug Identification **Segment:** LIN
Expected Data: LIN02 = N4
LIN03 = NDC
Notes: Required; Loop may repeat 25 times

2 **Loop:** 2410 **Name:** Pricing Information **Segment:** CTP
Expected Data: CTP03 - Drug Unit Price
CTP04 - Quantity (National Drug Unit Count)
CTP05-1 - Unit of Measure
Notes: Optional; used only if price for the NDC in LIN03 is different than the price entered in SV102

3 **Loop:** 2410 **Name:** Reference Identification **Segment:** REF
Expected Data: REF01 = XZ
REF02 = Prescription Number
Notes: Optional

Important Mailing Addresses	
All Claim forms, Consent forms, and other mail	EDS Post Office Box 244032 Montgomery, AL 36124-4032
Inquiries, Provider Enrollment Information, and Provider Relations	EDS Post Office Box 241685 Montgomery, AL 36124-1685
Adjustments	EDS Post Office Box 241684 Montgomery, AL 36124-1684

REMINDER

Provider Enrollment Forms

Please ensure that the most current version of the provider enrollment form is submitted to EDS. Enrollment application form may be downloaded from the Medicaid web page at:

www.medicaid.alabama.gov

New Verison 2.09 Provider Electronic Solutions Available

Version 2.09 will be available June 30, 2008, and the information should be placed in the following fields on the 837 professional and the 837 institutional outpatient:

- NDC
- Unit of Measure
- Prescription Number
- Unit Price
- Unit Quantity

A new tab will be created in Provider Electronic Solutions and will be added to document the information. Provider Electronic Solutions will not be updated to accept NDC information for the 837I (inpatient claims).

Issues Identified and Resolved

The following is a list of system issues that were causing claims to deny inappropriately:

Denial Code 0813: Medicare COBA claims were denying for future Medicare payment date. These COBA claims were identified and reprocessed during the May and June check writes.

Denial Code 6010: Outpatient hospital surgical claims were counting against and denying for theAmbulatory Surgical Center benefit limit. The claims were identified and reprocessed during the June 6, 2008 check write.

Denial Code 4244: Inpatient hospital claims for emergency services deliveries were denying for no coverage. The issue has been corrected. The provider may now resubmit any claims that denied for 4244.

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 Janice O'Neal at (334) 353-4771.

Patient 1st

Health Care Close To Home

Medicaid Implements New Process to Recoup Part D Drugs

Alabama Medicaid denies prescription Part D covered drug claims for recipients who have Part A and/or Part B Medicare coverage at the time a prescription is dispensed. This denial is based upon Medicare information sent to the Medicaid Agency. Occasionally, Alabama Medicaid may pay for prescription drug claims that should have been billed to the recipient's Medicare Part D plan due to delays in receiving Medicare entitlement dates.

Effective June 1, 2008, the Alabama Medicaid Agency will implement a monthly process to recoup Part D covered drugs that were paid by Medicaid for recipients who were enrolled in a Medicare Part D plan at the time the prescriptions were dispensed.

Recoupments on erroneous claims to Medicaid will be listed on the financial transactions page of the provider's Remittance Advice (RA). Questions regarding this recoupment process should be directed to the Medicaid Third Party division at (334) 242-5248.

Medicare has a process in which a provider may verify Part D enrollment through their E1 query system. Pharmacies dispensing Part D covered drugs are strongly encouraged to utilize the E1 query process prior to dispensing so that correct billing is applied. For more information on the Medicare E1 query, the Part D Reference Guide for Pharmacists, and other valuable Part D information, please visit *http://www.cms.hhs.gov/pharmacy/* on the Medicare website for pharmacies.

EDS Provider Representatives

G R O U P 1

kiki.hinton
@eds.com
334-215-4155

debbie.smith
@eds.com
334-215-4142

gayle.simpson-jones
@eds.com
334-215-4113

Nurse Practitioners
Podiatrists
Chiropractors
Independent Labs
Free Standing Radiology
CRNA
EPSDT (Physicians)
Dental
Physicians
Optometric
(Optometrists and Opticians)

G R O U P 2

Rehabilitation Services
Home Bound Waiver
Therapy Services (OT, PT, ST)
Children's Specialty Clinics
Prenatal Clinics
Maternity Care
Hearing Services
Mental Health/Mental Retardation
MR/DD Waiver
Ambulance
FQHC

tim.dowdy
@eds.com
334-215-4158

jennifer.hatmaker
@eds.com
334-215-4199

Public Health
Elderly and Disabled Waiver
Home and Community Based Services
EPSDT
Family Planning
Prenatal
Preventive Education
Rural Health Clinic
Commission on Aging
DME
Nurse Midwives

G R O U P 3

Ambulatory Surgical Centers
ESWL
Home Health
Hospice
Hospital
Nursing Home

linda.hanks
@eds.com
334-215-4130

ann.miller
@eds.com
334-215-4156

shermeria.harvest
@eds.com
334-215-4160

Personal Care Services
PEC
Private Duty Nursing
Renal Dialysis Facilities
Swing Bed

Revised State Fiscal Year 2008-2009 Checkwrite Schedule

~~10/05/07~~	~~01/04/08~~	~~04/04/08~~	07/11/08
~~10/19/07~~	~~01/18/08~~	~~04/18/08~~	07/25/08
~~11/02/07~~	~~02/08/08~~	~~05/02/08~~	08/08/08
~~11/16/07~~	~~02/22/08~~	~~05/16/08~~	08/22/08
~~12/07/07~~	~~03/07/08~~	~~06/06/08~~	09/05/08
~~12/14/07~~	~~03/21/08~~	~~06/20/08~~	09/12/08

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Alabama Medicaid Bulletin
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Montgomery, AL 36124-4032

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Provider *Insider*

Alabama Medicaid Bulletin **September 2008**

The checkwrite schedule is as follows:

09/05/08 09/12/08 10/03/08 10/17/08 11/07/08 11/21/08

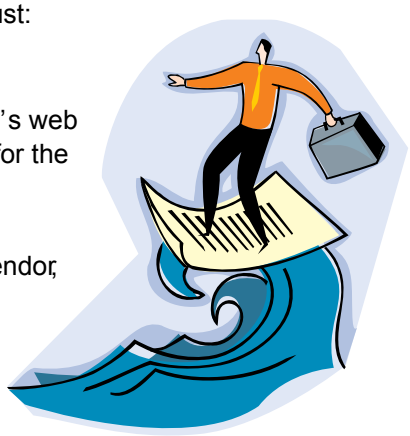
As always, the release of direct deposit s and checks depends on the availability of funds.

Important Information for Providers Submitting Crossover Claims

Medicaid/Medicare Paper Crossover Claim Forms

The only time you **must** submit a paper crossover claim form is when Medicare denies the claim. All other crossover claims may be filed electronically. EDS is in the process of updating the crossover claim forms to allow the NDC and secondary identifier information on the paper crossover claims. Until the forms are updated you must:

- **NDC**: Use the NDC attachment form found on the Medicaid website at:
  http://www.medicaid.alabama.gov/billing/forms.aspx
- **Secondary Identifier**: File your claims electronically through a vendor, Medicaid's web portal or Provider Electronic Solutions. Paper crossover claim forms are not an option for the secondary identifier information.



Electronic Claims Submission

The most efficient way for providers to submit claims is electronically either through a vendor, Interactive Medicaid Web Portal, or Provider Electronic Solutions.

- **Vendor**: EDS recognizes not all vendors allow for secondary claims processing electronically.
- **Interactive Medicaid Web Portal**: Allows claims submission one at a time for real time claims processing. The one page screen allows for simple navigation and immediate claim response. You can access the web portal by using the green web portal PIN letter mailed to your office in late January 2008 at the following link:
  https://www.medicaid.alabamaservices.org/ALPortal/Home/tabId/36/Default.aspx
- **Provider Electronic Solutions Software**: Allows batch claims processing, which allows for multiple claims submission at once. If you need to request a duplicate copy of your web port al letter, please e-mail at the ECM helpdesk at *alabamasystemsemc@eds.com.* You can access Provider Electronic Solutions at the following link:
  http://www.medicaid.alabama.gov/billing/pes.aspx?tab=6

For more information on the following, contact your Provider Representative at 1-800-688-7989 to:

- Request a trading partner ID to use Provider Electronic Solutions,
- Obtain instructions on how to enter crossover forms using the web portal,
- Obtain instructions on using Provider Electronic Solutions to submit your crossover claims.

For assistance with installing Provider Electronic Solutions, please contact the EMC Helpdesk at 1-800-456-1242 or e-mail at: *alabamasystemsemc@eds.com*

(Continued on page 2)

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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 _____*

Important Information for Providers Submitting Crossover Claims

On the crossover claim form, the provider address is required. The address information should be placed in the block below the heading: **Provider Mailing Address Required in Block Below**.

Failure to include your address may result in your claim not being processed. Without the address information, if you have more than one service location, EDS cannot determine what address to return the claim.

If you have any questions relating to completing form 340, please contact your Provider Representative at (800) 688-7989.

Fees for Form Completion Must Follow Medicaid Guidelines

While the Alabama Medicaid Agency does not reimburse providers for completing forms for school, family medical leave or other purposes not requested at the time of service, providers may charge patients for this service under certain conditions.

As is the case with other non-covered services, providers are asked to confer with and inform recipients prior to the provision of services about their responsibilities for payment of services not covered by the Medicaid program. Additionally, the charge must be one that is applied across the board to all patients, not just those on Medicaid. Additional information on billing for non-covered services is available in Chapter 7.1.7 of the Medicaid Provider Manual.

www.medicaid.alabama.gov

DME Medical Criteria Update

The medical criteria listed below for procedure codes E0148 (Heavy Duty Walkers without wheels, rigid or folding, any type, each) and E0149 (Heavy Duty walkers wheeled, rigid or folding, any type, each) and E0168 (Extra Wide Heavy Duty Stationary Commode Chair) will be effective September 1, 2008 and thereafter.

Medicaid will approve heavy duty walkers to accommodate weight capacities greater than 250 pounds and extra wide and/or heavy duty commode chairs with or without arms for weight capacities greater than 300 pounds.

The extra wide and/or heavy duty commode chairs and the stationary or mobile extra wide commode chairs with or without arms and/or heavy duty walkers with wheel or without wheels will require prior authorization. Providers must submit recipient's weight, depth and width for the extra wide and/or heavy duty commode chairs (E0168) and weight, width and length for the extra wide heavy duty walkers. A physician's prescription and medical document ation must be submitted justifying the need for the equipment.

Extra wide/and or heavy duty commode chairs, stationary or mobile with or without arms and heavy duty walkers with wheels and without wheels are limited to one per recipient every two years.

Effective August 1, 2008 procedure code B4087 (gastrostomy/jejunostomy tube, standard, any material, each) will be reduced from 15 units per month per recipient to 4 units per month per recipient.

Effective August 1, 2008 procedure code E1161 (manual adult wheelchair, includes tilt n space) will be covered for all Medicaid recipients.

Effective August 1, 2008 Alabama Medicaid procedure code A6531 (gradient compression stockings, below the knee, 30-40 mm Hg, ea) will be covered by Alabama Medicaid.

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

Alabama Medicaid Policy for Modifier "JW"

Modifier "JW" is used to identify unused drugs or biologicals from single use packages or vials that are discarded. Medicaid reimburses providers for discarded drugs within the parameters of the Alabama Medicaid Provider Manual, Appendix H but does not require the use of the JW modifier on claims submitted for services rendered to recipient s which are covered by Medicaid only . However, Medicare contractors are required to use this modifier in order to receive reimbursement for unused drugs or biologicals that are discarded. This modifier is identified as an informational only modifier in the Medicaid system.

Guidelines for Organ Transplants

Please note the following guidelines for all Medicaid covered organ transplants (with the exception of cornea) that is being referred to an out-of-state facility or provider for possible transplantation:

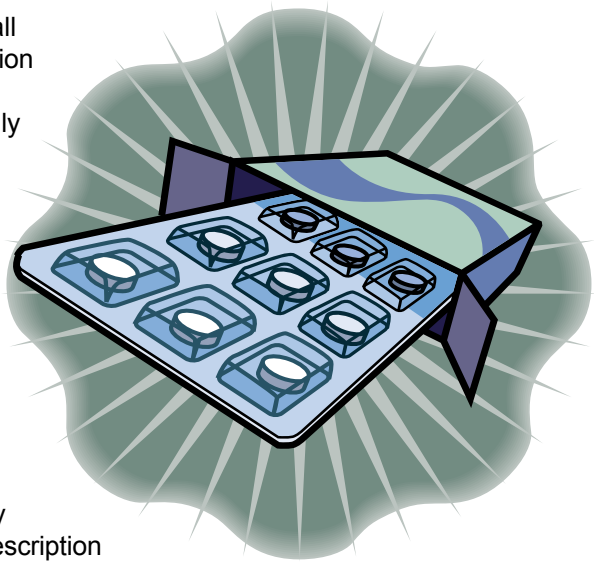
- The patients referring physician must contact the appropriate transplant specialist at UAB to ensure that the transplant cannot be performed instate.
- After the determination is made by UAB's transplant specialist that the transplant cannot be performed in-state, the recipient is referred by their physician to an out-of-state facility with the understanding that the out-of-state facility must coordinate the approval and reimbursement of the transplant with UAB's Transplant Services Coordinator

If you have additional questions regarding this information, please call Brenda Fincher at 334-242-5455

Expanded Requirements of Tamper-Resistant Prescription Pads Mandated by October 1, 2008

Effective October 1, physicians must use prescription pads with three federally required characteristics for written prescriptions to Medicaid recipients. The new requirements are the second phase of a new federal law to prevent unauthorized or fraudulent use of prescription pads. The first phase, implemented April 1, 2008, only required use of one of the three characteristics.

Enacted in 2007, the new federal law required physicians to write all paper, non-electronic Medicaid prescriptions on tamper-resistant prescription pads, which contain features preventing unauthorized or fraudulent use in order to be reimbursed by the federal government. The law applies only to written prescriptions for covered outpatient drugs. Prescriptions transmitted from the prescriber to the pharmacy verbally, by fax, or through an e-prescription are not impacted by the statute. The law applies whenever Medicaid pays any portion of the cost of a prescription.



The three required characteristics are industry-recognized features designed to prevent:

1) Unauthorized copying of a completed or blank prescription form
2) The erasure or modification of information written on the prescription pad by the prescriber
3) The use of counterfeit prescription forms. Some of these features include special ink that highlights erasures or changes, sequentially numbered forms, and special patterns or words that appear if the prescription is copied.

Prior guidance from CMS for printed prescriptions generated from Electronic Medical Records (EMR) or ePrescribing applications stated that special copy resistant paper would likely be required for printed prescriptions to be in compliance as of October 1, 2008. However, CMS has clarified this statement, and has now determined that while special paper may be used to achieve copy resistance, it is not necessary. EMR or ePrescribing generated prescriptions may be printed on plain paper and be fully compliant with all three categories of the tamper-resistant regulations presuming they contain at least one feature from each of the three categories.

CMS has determined that at least two such features utilized to prevent passing a copied prescription as an original can also be incorporated into plain paper computer generated prescriptions. The first of these is microprinting, which is the use of very small font that is readable when viewed at 5x magnification or greater, and illegible when copied. The second feature is a "void" pantograph accompanied by a reverse "Rx", which causes a word such as "Void," "Illegal," or "Copy" to appear when the prescription is photocopied. (Except where state law mandates the word "Void" or "Illegal", it is recommended that the pantograph show the word "Copy" if the prescription is copied.)

For more information on tamper-resistant prescription pads, visit: *http://www.medicaid.alabama.gov/programs/pharmacy_svcs/tamper-resistant_Rx_pads.aspx?tab=4*.

REMINDER

Integumentary System Surgical Graft

Effective 4/1/2007, Integumentary System Surgical Graft procedure codes (15040 thru 15431) no longer reflect age restrictions.

Important Mailing Addresses	
All Claim forms, Consent forms, and other mail	EDS Post Office Box 244032 Montgomery, AL 36124-4032
Inquiries, Provider Enrollment Information, and Provider Relations	EDS Post Office Box 241685 Montgomery, AL 36124-1685
Adjustments	EDS Post Office Box 241684 Montgomery, AL 36124-1684

In-State Inpatient Hospital Claims Must Follow PHP Payment Guidelines

All in-state inpatient hospital claims follow Partnership Hospital Program (PHP) payment guidelines. PHP requires all claims to be filed by the last day of February of the following year

The fiscal year begins October 1 and ends September 30. Listed below are examples of filing deadlines:

- Any inpatient claims with dates of service from October 1, 2007 through September 30, 2008 that are filed after February 28, 2009 will be denied by EDS as exceeding the PHP filing limit. Recipients may not be billed if a claim is denied for this reason.
- Any inpatient claims for **retroactive coverage** with dates of service from October 1, 2007, through September 30, 2008 that are filed after February 28, 2009 will be denied by EDS. Hospital must seek payment, if any, from PHPs. Recipients may not be billed if a claim is denied for this reason. However, a hospital that accepts a patient as private pay before rendering service is not obligated to bill Medicaid if the patient receives retroactive eligibility. In this case, the recipient may be billed.
- Any inpatient claims with dates of service from October 1, 2007 through September 30, 2008 that are filed after February 28, 2009 with **third party liability** action (either paid or denied) will be denied by EDS. The usual third party filing limits will not apply. Recipient may not be billed if a claim is denied for this reason.
- Any inpatient claims with dates of service prior to October 1, of the previous fiscal year are considered outdated. Recipients may not be billed.

Claims that span September 30, 2008 and October 1, 2008 must be split billed due to the PHP year-end. Claims should be filed as soon as possible after the September 30, 2008, year-end.

Effective for dates of service October 1, 2008 and there af ter, inpatient hospital claims will be p aid fee-for-service by Medicaid.

Inpatient Admission After Outpatient Hospital Services

If the patient is admitted as an inpatient before midnight of the day the outpatient services were rendered at the same hospital, all services are considered inpatient services for billing purposes. The day of formal admission as an inpatient is considered to be the first day of inpatient hospital services. If the patient was transferred to another hospital or facility, then the outpatient visit could be billed.

If an outpatient claim is paid in history, and the inpatient claim comes into the system, the inpatient claim will be denied with EOB code 5018. The provider will need to recoup the outpatient claim and resubmit all charges on the inpatient claim.

NDC Now Mandatory on UB-04 and CMS-1500 Claims

Effective for dates of service August 1, 2008, the NDC numbers will be mandatory for claims processing and payment for CMS-1500 claims.

Effective for dates of service September 1, 2008, the NDC numbers will be mandatory for claims processing and payment for UB-04 claims. Inpatient hospital claims are exempt from this requirement; however, outpatient claims will require the use of the NDC number on the claim.

If you receive an informational denial code during the grace period, you must take action to prevent your claim from denying now that the NDC is mandated.

For more information concerning the NDC number, see the July 2008 edition of the Provider Insider

Reminder to Hospitals and ER Physicians

Emergency room services are subject to post payment review by Medicaid and will be recouped if medical records do not support the service as a certified emergency. If fraud is suspected, a referral will be made to the Attorney General's Medicaid Fraud Control Unit. A hospital or physician may perform their own self audit to ensure that services billed were appropriately "certified" by the physician. The following is a reminder of the policy regarding 'Emergency Hospital Services' which can be found in the Alabama Medicaid Provider Manual, Hospital, Chapter 19:

Emergency Hospital Services

Emergency medical services provided in the hospital emergency room must be certified and signed by the attending physician at the time the service is rendered and documented in the medical record if the claim is filed as a "certified emergency."

When filing claims for recipients enrolled in the Patient 1st Program, refer to Chapter 39, Patient 1st, to determine whether your services require a referral from the Primary Medical Provider (PMP).

A certified emergency is an emergency medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual in serious jeopardy, serious impairment to body functions, or serious dysfunction of any bodily organ or part.

The attending physician is the only one who can certify an emergency visit. In determining whether a claim should be submitted and documented as a certified emergency, consider the following guidelines:

- The case should be handled on a situational basis. Take into consideration the recipient, their background, extenuating circumstances, symptoms, time of day, and availability of primary care (if a weekend, night or holiday).
- Determine whether the presenting symptoms as reported would be expected to cause the patient to believe that a lack of medical care would result in an unfavorable outcome.
- Document why this case is a certified emergency. Documentation does not need to be extensive but should justify the certification.
- If it is not an emergency, do not certify the visit as one. Follow-up care (such as physical therapy, suture removal, or rechecks) should not be certified as an emergency.
- Children or adults brought to the emergency department for exam because of suspected abuse or neglect may be certified as an emergency by virtue of the extenuating circumstances.

Certified emergency visits are unlimited if the medical necessity is properly documented and certified in the medical record by the attending physician at the time services are rendered. The claim form for a certified emergency must have an "E" in field 73 on the UB-04 claim form.

UB-04 claims for emergency department services must be coded according to the criteria established by Medicaid to be considered for payment. Refer to Section 19.5.3, Procedure Codes, and Modifiers, for level of care codes for emergency department services.

These procedure codes (99281-99285) may be billed only for services rendered in a hospital emergency department and must be listed on the UB-04 claim form with revenue code 450.

Non-certified visits to the emergency room are considered outpatient visits and count against the three outpatient hospital visits allowed per calendar year.

Only one emergency room visit per day per provider will be reimbursed by Medicaid.

Again, physician certification without supporting medical documentation may result in recoupment and/or referral to the Attorney General's Office in the case of suspected fraud and abuse.

Synagis® Criteria for 2008-2009 Season

Alabama Medicaid has updated its prior authorization criteria for Synagis®. The approval time frame for Synagis® will begin October 1, 2008 and will be effective through March 31, 2009. A total of up to five doses will be allowed per recipient in this timeframe. There are no circumstances that will allow for approval of a sixth dose. If a dose was administered in an inpatient setting, the date the dose was administered must be included on the request form.

For approval of requests, the recipient must meet gestational and chronological age requirements. In order to meet chronological age requirements, the recipient must not exceed the specified age at the start of the RSV season. Providers are to submit requests for Synagis® on a separate prior authorization form (Form 351) to Health Information Designs and may be accepted beginning September 1, 2008. The form and complete updated criteria specific to Synagis® are available on the Agency's website at *www.medicaid.alabama.gov* under Programs: Pharmacy Services: Prior Authorization/Overrides Criteria and Forms: Criteria/Instruction Booklet for Prior Authorization Forms.

Medicaid accepts the following as American Academy of Pediatrics risk factors for infants less than six months old with gestational age of 33-35 weeks:

- Childcare attendance
- School-age siblings
- Congenital abnormalities of the airways
- Severe neuromuscular disease
- Exposure to environmental air pollutants (Environmental air pollutants will not include second-hand smoke. Environmental air pollutants must include instances where a child is constantly exposed to particulate air matter.)

Additional questions regarding Synagis® criteria can be directed to the Agency's Prior Authorization contractor, Health Information Designs at 1-800-748-0130.

Medicaid is Not Recognizing Retroactive Awards for Long Term Care

The Alabama Medicaid Claims Payment System is currently not recognizing nursing home financial eligibility segments for recipients who receive a retroactive award from the Medicaid District offices. If you are submitting your long term care admission dates through the Long Term Care Admission Notification software and are receiving a rejection of "no financial eligibility" and you have an award notice that covers the submission date, please contact the Long Term Care Medical and Quality Review Services Unit at (334) 242-5149 for assistance.

You may fax an explanation of the problem, a copy of the award notice, and a copy of the rejection notice to the Long Term Care Medical and Quality Review Services Unit at (334) 353-4909.

What To Do If Your Claim Is In a Suspended Status

If you have claims in "Suspended" status, you do not need to do anything at this point. A suspended claim means EDS has received this claim and the claim is under review, but has not been finalized yet. Once the claim is finalized, it will appear as either paid or denied. **DO NOT RESUBMIT CLAIMS THAT ARE IN SUSPENDED STATUS.**

Suspended claims have been one of our main concerns with the implementation of the new Medicaid Claims Processing System on February 25, 2008. We have a large volume of suspended claims. Medicaid's two highest suspense audits are the "suspect duplicate" and the "multiple surgery."

Please be patient with us as we are working very diligently in resolving the suspended claims volume.

EDS Provider Representatives

G R O U P 1

kiki.hinton
@eds.com
334-215-4155

debbie.smith
@eds.com
334-215-4142

gayle.simpson-jones
@eds.com
334-215-4113

misty.curlee
@eds.com
334-215-4159

Nurse Practitioners
Podiatrists
Chiropractors
Independent Labs
Free Standing Radiology
CRNA
EPSDT (Physicians)
Dental
Physicians
Optometric
(Optometrists and Opticians)

mark.bonner
@eds.com
334-215-4132

G R O U P 2

Rehabilitation Services
Home Bound Waiver
Therapy Services (OT, PT, ST)
Children's Specialty Clinics
Prenatal Clinics
Maternity Care
Hearing Services
Mental Health/Mental Retardation
MR/DD Waiver
Ambulance
FQHC

jennifer.hatmaker
@eds.com
334-215-4199

Public Health
Elderly and Disabled Waiver
Home and Community Based Services
EPSDT
Family Planning
Prenatal
Preventive Education
Rural Health Clinic
Commission on Aging
DME
Nurse Midwives

G R O U P 3

Ambulatory Surgical Centers
ESWL
Home Health
Hospice
Hospital
Nursing Home

linda.hanks
@eds.com
334-215-4130

ann.miller
@eds.com
334-215-4156

shermeria.harvest
@eds.com
334-215-4160

Personal Care Services
PEC
Private Duty Nursing
Renal Dialysis Facilities
Swing Bed

State Fiscal Year 2009-2010 Checkwrite Schedule

10/03/08	01/02/09	04/03/09	07/10/09
10/17/08	01/16/09	04/17/09	07/24/09
11/07/08	02/06/09	05/01/09	08/07/09
11/21/08	02/20/09	05/15/09	08/21/09
12/05/08	03/06/09	06/05/09	09/04/09
12/12/08	03/20/09	06/19/09	09/11/09

EDS
Alabama Medicaid Bulletin
Post Office Box 244032
Montgomery, AL 36124-4032

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MONTGOMERY AL

Provider *Insider*

Alabama Medicaid Bulletin **November 2008**

The checkwrite schedule is as follows:

11/07/08 11/21/08 12/05/08 12/12/08 01/02/09 01/16/09

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

New Paper Medicaid/Medicare Related Claim Form Available in January

Medicaid is revising the paper Professional Medicaid/Medicare related claim form (form 340) effective January 1, 2009 to accommodate the NDC for the top twenty multi-source drugs and to allow for billing provider information on the paper claim form.

Cutoff date to order current form 340:

The last date providers may order the current form 340 is November 14, 2008. The new form 340 will be available December 1, 2008.

Cutoff date for EDS to receive paper claims on the current form 340 for processing:

All claims on the current form 340 must be received by December 5, 2008. Any claims on the current form 340 received after December 5 will be returned to the provider without being processed.

Implementation date of the revised form 340:

Beginning on December 8, 2008, all paper professional Medicare crossover claims must be on the revised form 340. Paper claims received between December 8 and December 31 will be held until 8 am January 1, 2009, when processing will begin on the revised form 340.

EDS will be converting to cut sheets forms for the revised form 340.

If you require the pin fed forms, please contact the Provider Assistance Center and advise you need pin fed forms. EDS will then determine if a need exists to order pin fed forms.

(Continued on page 4)

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Sample of New Medicaid/Medicare Related Claim Form (Form 340)

For your review, a copy of the revised 340 form is below You must order the claim forms beginning on December 1, 2008. The form 340 must be on original red drop-out ink, copies are not accepted.

Do not write in this space. Do not use red ink to complete this form.

MEDICAL
MEDICAID/MEDICARE
RELATED CLAIM

RECIPIENT INFORMATION

Medicaid ID	
First Name	
Last Name	
Med. Rec. #	
Patient Acct. # (Optional)	

OTHER INSURANCE INFORMATION

Covered by other insurance? Enter Y if yes (Except Medicare)	
Name of other insurance company (Except Medicare)	
Insurance Company. Carrier Code	
If payment was received from other insurance, post that amount here. (Do NOT put Medicare payment here.)	$

If other insurance rejected, attach rejection to completed claim and mail to EDS. * See remarks.

Diagnosis Codes

1st DX		2nd DX		3rd DX		4th DX	

	Dates of Service		POS	NDC M	Mod Un	it	Charges	edicare			
	From T	hru		Procedure Code				Allowed C	oins.	Deductible	Paid
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											
					TOTALS						

SAMPLE

Remarks

**Enter TPL Denied (MM/DD/YY)*

Billing Provider Name				
Billing Provider ID	NPI	Taxonomy Q	u	Secondary ID
Performing Provider Name				
Performing Provider ID	NPI	Taxonomy Q	u	Secondary ID

It is not necessary to attach Medicare EOMB to this claim unless claim dates of service are over one year old AND Medicare payment date is less than 120 days old.

Submit completed claim to:

EDS
Post Office Box 244032
Montgomery, AL 36124-4032

Form 340 Revised 12/08

Provider mailing address required in block below:

Medical Medicaid/Medicare-related Claim Filing Instructions

This form is required for all medical Medicare-related claims in lieu of the CMS-1500 claim form and the Medicare EOMB. The only required attachments are for third party denials. The Medicare EOMB is not required.

Field Description	*Guidelines*
Medicaid ID #	Enter the recipient's 13-digit RID number.
First Name	Enter the recipient's first name.
Last Name	Enter the recipient's last name.
HIC#	Enter the recipient's Medicare HIC number.
Patient Account #	Enter recipient's patient account number (to be referenced on the Remittance Advice (RA) for patient identification). Up to 20 characters may be entered into this field.
Covered by other insurance?	Enter a "Y" here if recipient has a commercial insurance other than Medicare. Otherwise leave blank.
Name of other insurance company	Enter name of other commercial insurance company (except Medicare).
Insurance company carrier code	Not used at this time.
If payment was received from other insurance, place that amount here.	Enter the amount the other insurance company paid in this block. Do not include Medicaid copayment amounts.
1st DX, 2nd DX, 3rd DX, 4th DX	Enter the diagnosis codes in these blocks to the highest number of digits possible (3, 4, or 5). Do not enter decimal points in the DX fields.
Dates of service	Enter the from and through dates in MMDDYY format.
POS	Enter the two-digit place of service as filed to Medicare.
NDC	**Enter the National Drug Code (NDC) for the procedure, if required.**
Procedure Code	Enter the five-digit procedure code.
Modifiers	Enter the modifiers for the procedure code. Enter up to 4 modifiers.
Units	Enter the number of units of service.
Charges	Enter the charge for each line item.
Allowed diem encounter rate	Enter the Medicare allowed amount for each line item. *FQHC, PBRHC, and IRHC should enter the per established by Medicaid for the facility for each line item.
Coinsurance	Enter the Medicare coinsurance amount for each line item. **Do not enter Medicaid copayment amount. Do not enter Medicare payments.**
Deductible	Enter the amount applied to the Medicare deductible for each line item.
Paid	Enter the Medicare paid amount for each line item. *FQHC, PBRHC, and IRHC should enter the Medicare per diem paid amount for each line item.
Totals	Total each column.
Billing Provider Name	**Enter the billing/payee provider name.**
Billing Provider ID	**NPI: Enter the NPI of the billing/payee provider** **Taxonomy: Enter the taxonomy code of the billing provider (optional)** **Qual: Enter the appropriate qualifier code for the secondary identifier. If using the legacy Medicaid provider number, indicator ID should be used.** **Secondary ID: Enter the secondary identifier for the billing provider ID. The secondary identifier should be the legacy Medicaid provider number. This is an optional field, but is required for providers with multiple service locations.**
Performing Provider Name	**Enter the name of the provider which performed the service.**
Performing Provider ID	**Enter the NPI of the provider which performed the service.** **Taxonomy: Enter the taxonomy code for the provider which performed the service. (Optional)** **Qual: Enter the appropriate qualifier code for the secondary identifier. If using the legacy Medicaid provider number, indicator ID should be used** **Secondary ID: Enter the secondary identifier for the billing provider. The secondary identifier should be the legacy Medicaid provider number of provider which rendered the service. This is an optional field, but is required for providers with multiple service locations.**
Provider Mailing Address	**Enter the billing address, city, state, and zipcode for the rendering (performing) provider.**
Remarks	Enter Medicare Paid/Denial Date (MMDDYY).

New Paper Medicaid/Medicare Related Claim Form Available in January

(Continued from page 1)

Obtaining the revised form 340:
Providers may begin placing orders for the new claim form on December 1, 2008.

Claim forms can be ordered through one of the following options:

- Complete and fax the attached form to: (334) 215-4140 (See page 12 for order form).
- Request the forms on-line using the following link: *http://www.medicaid.alabama.gov/billing/forms.aspx*
- Contact the Provider Assistance Center at 1-800-688-7989*.

*EDS encourages you to fax your request forms to ensure prompt service.
There is no cost associated with ordering form 340.

Electronic Claims:
There are no changes to electronic claims submission, which will continue through normal processes. As always, the fastest way to receive reimbursement on your claims is to file electronically.

If you have any questions, please contact the Provider Assistance Center at 1-800-688-7989.

NDC Now Mandatory for Top 20 Drugs for UB-04 and CMS-1500 Claims

Effective for dates of service August 1, 2008, the top 20 physician-administered multiple source drugs identified by CMS must be reported with the appropriate NDC for CMS-1500 claims.

Effective for dates of service September 1, 2008, the top 20 physician-administered multiple source drugs identified by CMS must be reported with the appropriate NDC for UB-04 claims. Inpatient hospital claims are exempt from this requirement; however, outpatient claims will require the use of the NDC number on the claim.

If you receive an informational denial code during the grace period, you must take action to prevent your claim from denying now that the NDC is mandated.

For more information concerning the NDC number, see the July 2008 edition of the Provider Insider. Be aware that the list posted in this July issue is out of date. The NDC's are updated quarterly and the following link will take you to CMS's website to find the most up to date NDC changes:

http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice

Attention Eye Care Providers

When submitting a prior authorization for lens, it is not necessary to use an TL (left) or RT (modifier). The claims processing system is designed to read two lens when submitted on the same date of service. Additionally, it is not required to use a modifier on the lens when submitting your claims.

Attention

Clarification on Change In Medicaid Release of Funds

Alabama Medicaid has changed the payroll date for the release of provider payrolls effective with the October 17, 2008 checkwrite. This is a permanent change for the release of funds.

This means that the funds previously released on Wednesdays after the checkwrite date will not be released until the Friday following the checkwrite date at midnight. This means funds will not be available until 12:01 AM on Saturday.

Important Mailing Addresses	
All Claim forms, Consent forms, and other mail	EDS Post Office Box 244032 Montgomery, AL 36124-4032
Inquiries, Provider Enrollment Information, and Provider Relations	EDS Post Office Box 241685 Montgomery, AL 36124-1685
Adjustments	EDS Post Office Box 241684 Montgomery, AL 36124-1684

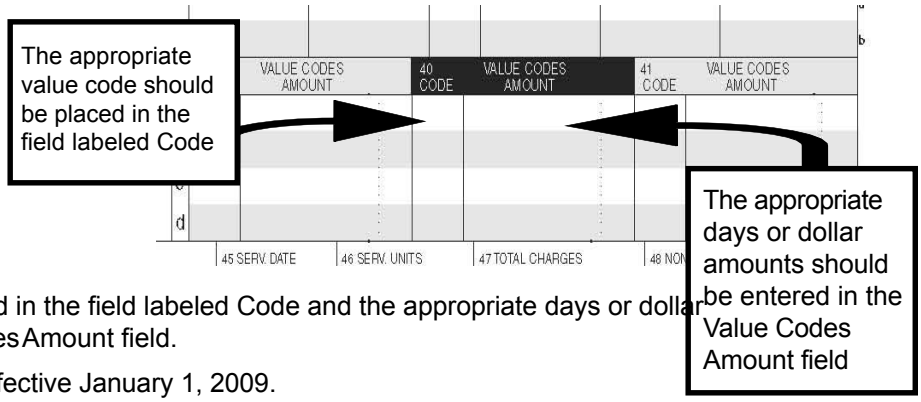
Medicaid Eliminating Paper UB-04 Medicaid/Medicare Related Claim Form

Medicaid will be **eliminating** the paper UB-04 Medicaid / Medicare related claim form for institutional billers effective January 1, 2009.

How will I file my paper crossover claims?

Value codes will be reported in form locaters 39-41 of the UB-04 claim form.

80 = Covered Days
81 = Non-Covered Days
82 = Co-insurance Days
83 = Lifetime Reserve Days
73 = Medicare Paid Amount
74 = Medicare Allowed Amount
A1 = Medicare Deductible Amount
A2 = Medicare Co-insurance Amount



The appropriate value code should be placed in the field labeled Code and the appropriate days or dollar amounts should be entered in the Value Codes Amount field.

This change applies to all claims received effective January 1, 2009.

To prepare for this change, all claims on the current Institutional UB-04 Medicaid/Medicare related claim form must be received for processing at EDS by December 5, 2008. After December 5, 2008, claims received on the UB-04 Medicaid/Medicare related claim form will be returned without being processed. The last date to order the current claim forms will be November 14, 2008.

If you have any questions, please contact your Provider Representative at 1-800-688-7989.

ICN Number Changes

When trying to adjust/void a claim with an internal control number (ICN) from the legacy system (prior to Feb 25, 2008) the first two digits of the old ICN should be replaced with the region codes of the new Alabama Medicaid Management Information System (AMMIS), based on the chart provided below:

Example:

OLD **10**08017228613

NEW **41**08017228613

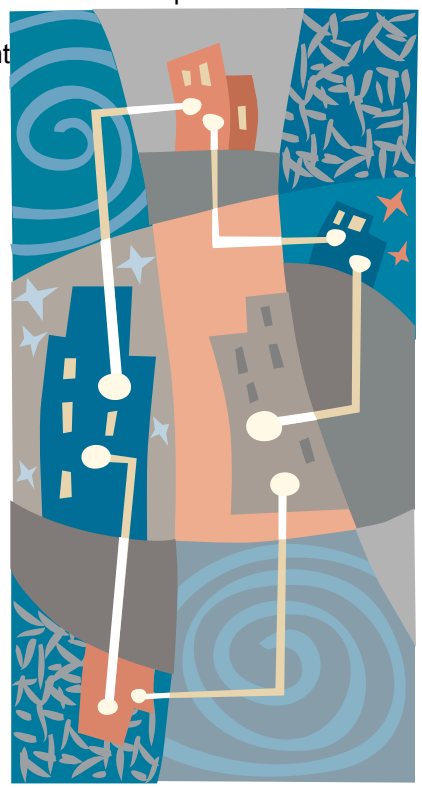
Old	New
05	40 (converted region 05 electronic claims)
10	41 (converted region 10 tape claims)
22	42 (converted region 22 cap claims –system generated)
33	43 (converted region 33 special batch)
50	44 (converted region 50 online adjustments)
51	45 (converted region 51 reversals and mass adjustments)
52	46 (converted region 52 provider adjustments)
98	47 (converted region 98 paper claims)

Plan First Family Planning Program Extended Through September 2011

Plan First, Alabama Medicaid's nationally-recognized family planning program has been approved for extension by the Center for Medicare and Medicaid Services (CMS) through September 30, 2011. The program began in October 2000 to provide family planning services to uninsured women ages 19 to 44 who would not qualify for Medicaid unless pregnant. This three year extension expands coverage through age 55. To qualify for the program, an applicant's family income must be at or below 133 percent of the Federal Poverty Level. Approximately 67,000 women are currently enrolled in the program which is jointly operated by Medicaid and the Alabama Department of Public Health.

Trading Partner IDs

All providers and vendors were issued new trading partner IDs (submitter ID in the legacy system) for the new AMMIS. These new IDs are 9-digit numbers that allow providers and vendors to upload batch files to the AMMIS for processing. Since implementation, many batches have been submitted with incorrect trading partner IDs, which fail and are not processed. A TA1 acknowledgement is sent to the submitter for files that fail for this reason. All submitters requesting a trading partner ID for the new AMMIS are provided a trading partner ID and personal identification number (PIN) to setup an account on the new web portal. When entering account information, the web portal has a web user ID field, which can be setup to the submitter's specifications. However, this web ID **should not be** substituted for the trading partner ID. The web user ID is for logging onto the web portal and the trading partner ID is sent within batches to identify who is trading files with the AMMIS.



Examples of incorrect trading partner IDs received:

ISA*00* *00* *ZZ***ABC123** *ZZ*752548221
*080919*0845*U*00401*423458738*1*P*:
GS*HC***ABC123***752548221*20080919*0845*423458737*X*004010X098A1

ISA*00* *00* *ZZ***WEBUSERNAME** *ZZ*752548221
*080919*0845*U*00401*423458738*1*P*:
GS*HC***WEBUSERNAME***752548221*20080919*0845*423458737*X*004010X098A1

Example of correct trading partner IDs:

ISA*00* *00* *ZZ***300000001** *ZZ*752548221
*080919*0845*U*00401*423458738*1*P*:
GS*HC***300000001***752548221*20080919*0845*423458737*X*004010X098A1

If there are any questions concerning the use of these IDs, please contact the EMC Help Desk at:
EMC Help Desk
Fax: (334) 215 – 4272
Phone: (800) 456 – 1242
(334) 215 – 0111
Email: *AlabamaSystemsEMC@eds.com*

Claim Status Response File (CSR)

Prior to implementation of the new AMMIS providers and vendors received a Claim Status Response File (CSR) for every batch of claims uploaded to the AMMIS, but this response was discontinued as of February 25, 2008. A new claim status response file is currently under construction and will be available by the end of the year . A more accurate implementation date will be provided once construction and testing have been completed. This new document will mimic the old CSR, but has been revised to meet the standards of the new AMMIS. The new Batch Response File (BRF) will communicate the pre final adjudication results, which will return error codes and error messages for claims that are suspended or denied. There will be one standard proprietary batch response file for the 837 Dental, Professional and Institutional transactions. This batch response will only be returned to the trading partner that uploads a batch of claims. The Batch Response File Companion Document is now available for review on the Medicaid website. This is a living document and is subject to change prior to implementation so be aware of the version numbers and updates made.

http://www.medicaid.alabama.gov/billing/npi_companion_guides.aspx?tab=6

Questions concerning this new transaction should be directed to Sarah Hataway at *sarah.hataway@eds.com*

Urinalysis No Longer a Requirement of an EPSDT Screening

The American Academy of Pediatrics (AAP) has recommended that a urinalysis (UA) no longer be performed as a routine part of any examination. Effective October 1, 2008, Medicaid is dropping the urinalysis requirement component of an Early Periodic Screening Developmental Testing (EPSDT) visit at five years of age and at each visit between 11 and 20 years of age. Urine screenings no longer need to be performed at the time of an EPSDT screening unless it is clinically indicated.

EDS Provider Representatives

G R O U P 1

kiki.hinton
@eds.com
334-215-4155

debbie.smith
@eds.com
334-215-4142

gayle.simpson-jones
@eds.com
334-215-4113

misty.curlee
@eds.com
334-215-4159

Nurse Practitioners
Podiatrists
Chiropractors
Independent Labs
Free Standing Radiology
CRNA
EPSDT (Physicians)
Dental
Physicians
Optometric
(Optometrists and Opticians)

mark.bonner
@eds.com
334-215-4132

G R O U P 2

Rehabilitation Services
Home Bound Waiver
Therapy Services (OT, PT, ST)
Children's Specialty Clinics
Prenatal Clinics
Maternity Care
Hearing Services
Mental Health/Mental Retardation
MR/DD Waiver
Ambulance
FQHC

jennifer.hatmaker
@eds.com
334-215-4199

savannah.brimhall
@eds.com
334-215-4158

Public Health
Elderly and Disabled Waiver
Home and Community Based Services
EPSDT
Family Planning
Prenatal
Preventive Education
Rural Health Clinic
Commission on Aging
DME
Nurse Midwives

G R O U P 3

Ambulatory Surgical Centers
ESWL
Home Health
Hospice
Hospital
Nursing Home

linda.hanks
@eds.com
334-215-4130

ann.miller
@eds.com
334-215-4156

shermeria.harvest
@eds.com
334-215-4160

Personal Care Services
PEC
Private Duty Nursing
Renal Dialysis Facilities
Swing Bed

New Transformation Initiatives Office Established

Medicaid has recently made some organizational changes to support its continued efforts to improve the Medicaid program. Effective October 1, 2008 Kim Davis-Allen became Director of the new Transformation Initiatives Office. She will continue to administer the Together for Quality project and the Patient 1st Program. Nancy Headley was appointed Director of the Medical Services Division. The Medical Services Division also welcomes Kaye Melnick to the EPSDT Program to replace Debbie Flournoy and Theresa Thomas to the Institutional Services Program to work with the radiology and laboratory programs.

Eustachian Tube Inflation

Effective August 25, 2008 procedure codes 69400-69401 are restricted to physicians with specialties of EENT and Otorhinolaryngology.

Home Moisture Exchange System

Effective October 1, 2008, the Home Moisture Exchange (HME) System will be covered using procedure code A7509. Effective October 1, 2008, the HME will no longer be covered using procedure code E1399. This code will require prior authorization (PA). All preexisting PAs approved under procedure code E1399 for the HME System will be honored.

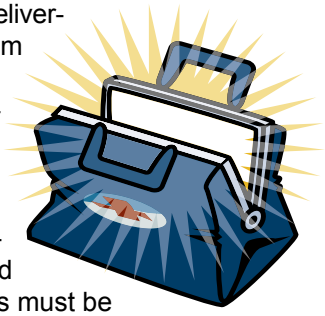
Measles And Rubella Vaccination Coverage Discontinued

Procedure Code 90708 for MR (Measles and Rubella) vaccination will no longer be designated as a Vaccines For Children (VFC) immunization effective September 17, 2008. The change in designation will be made in the January 2009 Alabama Provider Billing Manual, Appendix A. Please refer to Appendix A for a listing of immunization codes designated as VFC immunizations.

Home Infusion Therapy Policy

The Alabama Medicaid Agency has developed a Home Infusion Therapy (HIT) policy. The HIT policy is effective for dates of service October 1, 2008, and thereafter. This policy will replace currently used procedure code A9999 (supplies used in the IV Administration kit).

HIT includes administered infusion therapy and supplies provided to Medicaid recipients residing in a private residence. Infusion therapy is a procedure that involves the insertion of a catheter into a blood vessel that provides a painless way of drawing blood and delivering drugs and nutrients into a patient's bloodstream over a period of weeks, months, or even years. Common uses for intravenous therapy are intravenous antibiotic treatment, chemotherapy, and hydration.



HIT components can be provided and billed by enrolled DME Pharmacies and Durable Medical Equipment (DME) providers only as described in the HIT policy. Home Infusion DME providers must be accredited by nationally recognized accrediting body to be reimbursed for home infusion therapy services. This accreditation must occur before October 1, 2009. If providers are audited and it is found that they are not accredited, Alabama Medicaid will recoup all monies paid for home infusion services for all dates of service beginning October 1, 2009, and thereafter. Effective October 1, 2009, all prior authorization requests submitted for procedure code S9379 must also contain a copy of the provider's accreditation.

HIT must be prescribed by the attending physician as a medically necessary health care service to correct or ameliorate a defect, physical or mental illness, or a condition (health problem). Medical documentation must justify the need for the service. The physician's orders must clearly document the starting date for care, expected duration of therapy, the amount and types of services required. If the recipient requires multiple drug therapies, the therapies must be provided by the same agency. The medication administration record and or the nursing documentation should coincide with the billing based on the time of completion and discontinued use of the drug that required the need for durable medical supplies.

HIT services billed using the "S" codes include, antibiotic, antiviral or antifungal therapy (S9500; S9501; S9502; S9503; S9504), hydration therapy (S9373), chemotherapy (S9330), pain management therapy (S9326), specialty infusion therapies such as anti-coagulant (S9336), antiemetic (S9351), epoprostenol (S9347) and catheter care (S5498; S5501; S5520; S5521). These "S" codes include administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment. Drugs and nursing visits are billed separately. The "S" codes listed in this paragraph do not require prior authorization.

Procedure code S9379 (Home infusion therapy not otherwise classified) does require prior authorization. The LTC Medical Quality and Review Unit will consider authorization of home infusion therapies not otherwise classified on an individual basis. These special requests will require supportive documentation from peer reviewed medical literature and medical reviews.

Changes to the Patient 1st Program

The Patient 1st Program continues to be a success in meeting its goal of creating a medical home for our recipients. We have just completed the requisite waiver documents and want to thank the participation of our Patient 1st Advisory Council and various PMP's as the Agency has searched for ways to improve and to more clearly support the Medical Home model.

One action taken to accomplish this goal has been to revise the case management fee components and performance measures for the time period, January 1, 2009 – December 31, 2010. These changes were a reflection of providers indicating they would like to have measures of greater practice significance and more quality oriented. The central theme throughout the planning process was for the measures to be realistic, important to the overall enhancement of patient care and considered valuable across all physician peer groups.

The changes in the case management fee will require a reenrollment of all Patient 1st PMPs. New contracts, along with the revised Provider Manual, will be mailed in the first week of November. In addition, a detailed description of the Performance Measures including the algorithm for determining the measure will be part of the enrollment packet.

Patient 1st

Health Care Close To Home

Case Management Fee components

- 24/7 Voice-to-Voice Phone Coverage - $1.00
  This is a requirement of program participation and not optional. PMPs must have a voice-to-voice telephone coverage for their recipients.
- Radiology Management - $.50
  The Agency is implementing a prior approval process for Radiology services (CT Scans, MRI, MRA, PETS and CTA) for 2009. All Medicaid providers, regardless of program participation, will be required to request radiology services through prior approval.
- Administrative fee - $.10
  To offset the extra time the PMP and staff spend on completion of referrals, consultations, prior approvals, In-Home monitoring enrollment forms, Review of Care Coordination reports, etc.
- InfoSolutions/QTool (Electronic Health Record) - $1.00
  Use of InfoSolutions until such time as the QTool becomes available in the counties. QTool is Medicaid's web based electronic health record that is currently being piloted in 9 counties. Once QTool becomes available in a county; then requires use of the QTool for 25% of patient visits the first 3 months and 50% of visits from then on to earn the fee for this component. This is an optional component.

Performance Measures

Shared savings are based on the ability for the program to demonstrate measureable program savings as a result of the Patient 1st Program. For the waiver period the measures are: Generic Drug Use, Certified Emergency Room Use and Unique Office Visits. In addition, there will also be the efficiency score based on costs. The Agency will begin working to determine the program savings for the waiver period ending December 31, 2008. It is anticipated that any shared savings will be distributed April 2009.

For the upcoming waiver period (1/1/09 -1/31/10), the performance measures will be as follows:

- Emergency Room visits (certified and non-certified)
- Number of Hospital days per 1000 patients
- Percent of Generics Utilized
- Percent of Asthma patients who have had one or more ER visits with the primary diagnosis of Asthma
- Percent of Diabetic patients who have had at least one HbA1c test during review period
- EPSDT Visits for 0-5 population
- Office Visits per Unique Enrollee

The Agency looks forward to your continued participation and support of the Patient 1st program. Please watch your mail for enrollment information. If you have any questions or if you have not received an enrollment packet by November 30, 2008, please contact Amber Gladson at (334) 353-4301 or email to *amber.gladson@medicaid.alabama.gov*.

Controlled Dose Drug Delivery System

Alabama Medicaid Pharmacy Program currently covers the drug, Ventavis (20mcg/2ml) with NDC codes 10148010200 and 10148010100. This drug may only be delivered by the controlled dose inhalation drug delivery system (K0730). This drug delivery system will only be covered for eligible Medicaid recipients currently receiving the drug Ventavis and Alabama Medicaid must currently be reimbursing for this drug for these recipients.

Effective November 1, 2007, Alabama Medicaid began covering procedure code K0730 (Controlled dose inhalation drug delivery system). Procedure code K0730 will require prior authorization. This procedure code will be a ten-month capped rent to purchase item and at the end of the ten-month rental period the device will be a purchased item for the recipient. The drug delivery system will be limited to one per recipient every two years. Repairs for procedure code K0730 will be covered using procedure code E1399. All repair cost must be submitted with itemized providers invoice cost. Repairs will be reimbursed at the provider's invoice cost plus 20%. Providers will be required to bill with diagnosis code 416.8 when submitting claims for the controlled dose drug delivery system.

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

Implementation of Additional VFC Codes

The Advisory Committee on Immunization Practices (ACIP) has approved three vaccinations that are available through the VFC program. All three vaccines have achieved Food and Drug Administration (FDA) status.

The CPT code revisions will be reflected in the 2009 CPT codebook. Also, Appendix A of the Provider Billing Manual has been updated to reflect the addition of these codes. In the table below is a description of the CPT-4 codes, the immunizations and the dates of implementation for the three new VFC immunizations.

CPT-4 PROCEDURE CODE	IMMUNIZATION	EFFECTIVE DATE
90681	Rotavirus vaccine (RV1), human attenuated, 2 dose schedule for 2 and 4 months of age, live, for oral use.	06/25/2008
90696	Diptheria, tetanus toxoids, acellular pertusis vaccine and poliovirus vaccine, inactivated (DTaP-IPV), is indicated as a booster for children of 4 through 6 years of age (prior to 7 years of age).	06/26/2008
90698	Diptheria, tetanus toxoids, acellular pertussis vaccine, haemophilus influenza Type B, and poliovirus vaccine, inactivated (DTaP-Hib-IPV) for intramuscular use. It is indicated as a primary series and first booster dose (doses 1-4) at 2, 4 , 6 and 15-18 months of age.	06/26/2008

In-State Inpatient Hospital Claims Must Follow PHP Payment Guidelines

All in-state inpatient hospital claims follow Partnership Hospital Program (PHP) payment guidelines. PHP requires all claims to be filed by the last day of February of the following year

- The fiscal year begins October 1 and ends September 30. Listed below are examples of filing deadlines:
- Any inpatient claims with dates of service from October 1, 2007 through September 30, 2008 that are filed after February 28, 2009 will be denied by EDS as exceeding the PHP filing limit. Recipients may not be billed if a claim is denied for this reason.
- Any inpatient claims for retroactive coverage with dates of service from October 1, 2007, through September 30, 2008 that are filed after February 28, 2009 will be denied by EDS. Hospital must seek payment, if any, from PHPs. Recipients may not be billed if a claim is denied for this reason. However, a hospital that accepts a patient as private pay before rendering service is not obligated to bill Medicaid if the patient receives retroactive eligibility. In this case, the recipient may be billed.
- Any inpatient claims with dates of service from October 1, 2007 through September 30, 2008 that are filed after February 28, 2009 with third party liability action (either paid or denied) will be denied by EDS. The usual third party filing limits will not apply. Recipient may not be billed if a claim is denied for this reason.
- Any inpatient claims with dates of service prior to October 1, of the previous fiscal year are considered outdated. Recipients may not be billed.

High Frequency Chest Wall Oscillation Air Pulse Generator

Effective September 1, 2008, if a patient receives an air vest prior to becoming Medicaid eligible and requires a replacement, documentation in the medical record should indicate why a replacement is needed. A replacement is covered only if the patient meets the required four-month renewal Air Vest criteria. For these recipients Medicaid will make a onetime lump sum payment to providers for the replacement vest.

Four-month renewal Criteria – (the following conditions must be met)

1. The recipient continues to be eligible.
2. Medical documentation indicates:
   a. Therapy continues to be medically necessary; and
   b. Patient is compliant with prescribed use of air vest as documented through report from last 90 days documenting use at least 67% of time prescribed; and
3. Patient's respiratory status is documented as stable or improving.

Important Information for Providers Who Submit Crossover Claims

EDS recently implemented changes which should allow your crossover claims to crossover from Medicare to Medicaid. The changes were implemented on September 1, 2008. If your claims continue to deny for error code 1946 (multiple services locations for performing provider). Please take the following steps:

- Make sure your software vendor is submitting your zip+4 address information for the billing provider on your claims when they are sent to Medicare for processing. The billing zip+4 information can be found in the following loop:
- 2010AA – N403 It has to be 9 digits if there is no dash and 10 bytes if there is a dash. If you are unsure if the information is being sent on your claims, contact your software vendor.

  While this solution will help the majority of our providers, providers which have many service locations may continue to see some denials for error code 1946 (multiple service locations for performing provider). EDS is working to implement additional system changes to allow your claims to crossover . When these changes are implemented, your zip+4 information will need to be located in the service facility location on your claims when submitted to Medicare. The service location zip+4 information can be found in the following loop:

  - 2310D - Service Facility Location City/State/Zip Code - The entire 9-digit postal zip code should be submitted, without the dash.
- EDS does not have a date on the additional changes. More information will be provided in a future Insider
- Providers may use Medicaid's Interactive Web Portal or Provider Electronic Solutions Software for submitting crossover claims until crossover issues are resolved. If you have questions on how to use the web portal or Provider Electronic Solutions, call the Provider Assistance Center at 1-800-688-7989.

New Federal Law Requires Providers to Comply with Medical Records Requests

A new federal law to combat Medicaid provider fraud and abuse will soon require Alabama Medicaid providers to comply with federal auditors' requests for medical records.

The Medicaid Integrity Program (MIP), created by the Centers for Medicare and Medicaid Services (CMS) as a result of the Deficit Reduction Act of 2005, is a national program to support, not supplant, state program integrity efforts, according to Alabama Medicaid Program Integrity Director Jacqueline Thomas. The program, now underway in a handful of states, is expected to be implemented in Alabama within the next few months.

CMS has contracted with several organizations to review Medicaid claims to assess whether fraud or waste has occurred or is likely to occur, to identify overpayments for repayment to the federal government and to educate providers concerning program integrity and quality of care. A combination of field and desk audits will be performed based on Medicaid claims data for the 2004-2008 fiscal years.

Providers are required to comply with the law by submitting any requested documentation. Failure to respond or to provide all requested documentation on a timely basis will be recorded by CMS as an overpayment, requiring the Medicaid Agency to pay back federal dollars.

Form 340 Professional Medicaid/Medicare Related Claim Order Form

NPI or Provider Number: _____

Provider Name: _____

Attention: _____

Street Address: _____

City: _____ State: ____ Zip: _____

Form Preference (Circle one): Laser printer style Pin fed style No Preference

EDS

Alabama Medicaid Bulletin

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Alabama Medicaid Bulletin **January 2009**

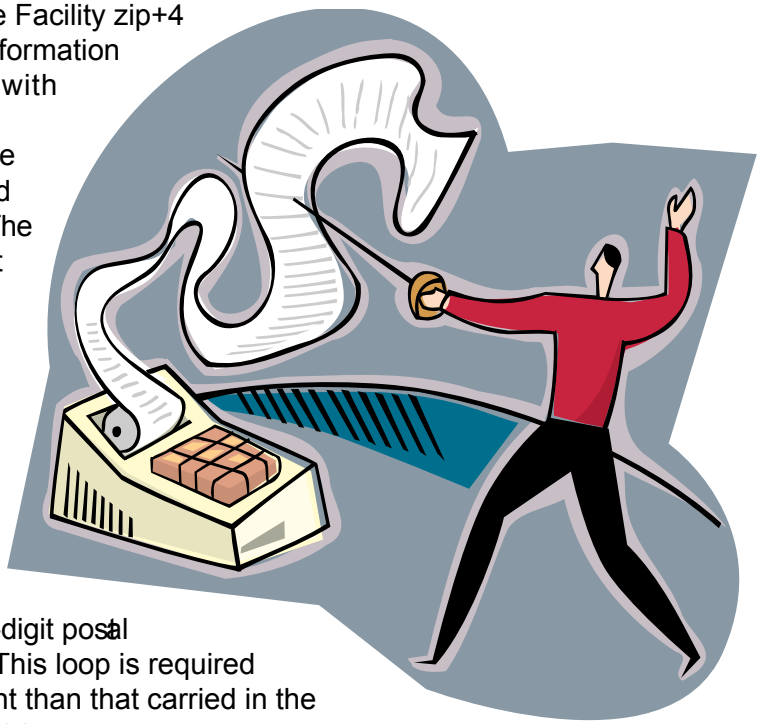
The checkwrite schedule is as follows:

01/02/09 01/16/09 02/06/09 02/20/09 03/06/09 03/20/09

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

Important Change for Providers Who Submit Using Crossover Claims

EDS will begin utilizing the Service Facility zip+4 as part of its provider crosswalk. Service Facility information should be submitted when the billing or rendering provider uses one NPI to bill for services performed in multiple locations. In order to resolve 1946 errors, the Service Facility zip+4 submitted must correspond to the location address information the provider used to enroll each service location with Medicaid.



Check with your software vendor to verify the information for service facility , rendering provider and billing provider information is being sent to Medicare. The information for the different addresses should be sent in the following loops:

837P Format:

- Billing Provider Address: 2010AA-N403 The entire 9-digit postal zip code should be submitted, without the dash.
- Rendering Provider Address: N/A, submit the appropriate taxonomy code.
- Service Facility Address: 2310D-Service Facility Location City/State/Zip Code -The entire 9-digit postal zip code should be submitted, without the dash. This loop is required when the location of health care service is different than that carried in the 2010AA (billing provider) or 2010AB (pay provider) loops.
- Service Facility Address (Detail): 2420C- Service Facility Location City/State/Zip Code- The entire 9 digit postal zip code should be submitted, without the dash. Required when the location of health care service for this service line is different than that carried in the 2010AA (Billing Provider), 2010AB (Pay-to Provider), or 2310D Service Facility Location loops.

(Continued on page 4)

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The Provider Insider publication will now be published once per quarter and will be distributed January April, July, and October of each year

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 _____*

Quality Assurance Program Contract Awarded

The inpatient hospital quality assurance program contract was awarded to the Arkansas Foundation for Medical Care (AFMC). Representatives from AFMC will be contacting your facility in order to establish contacts for inpatient quality activities. Hospitals are required to submit a utilization review plan and a medical care evaluation study annually. AFMC will be requesting this information from your facility. Hospitals may also expect a letter from AFMC requesting medical records for a quarterly retrospective medical review of inpatient admissions. The transition from the PHP to AFMC may result in other quality initiatives, which will require your participation. Notification will be sent to providers as progress is made regarding implementation of InterQual. Please feel free to contact me by e-mail at *jerri.jackson@medicaid.alabama.gov* or *fannie.oliver@medicaid.alabama.gov* or by phone at (334) 242-5630.

Pulse Oximetry Code Information

Pulse Oximetry codes (94760, 94761, and/or 94762) are considered bundled services which are included in Evaluation and Management codes for both physician and outpatient services. Since July 2006, these codes by policy are not separately billable/payable when other services are billed on the same day by a physician or outpatient provider.

Effective January 1, 2009, pulse oximetry codes (94760, 94761, and/or 94762) will no longer be considered separately billable/payable by Medicaid for physician and outpatient services. The changes to policy will appear in the April update to the Alabama Medicaid Provider Manual. The recipient cannot be billed for these services.

www.medicaid.alabama.gov

Attention Mental Retardation and Living at Home Waiver Providers

Effective February 23, 2008, the Home and Community-Based Waiver for Persons with Mental Retardation and the Living at Home Waiver providers will provide and bill Medical Supplies and Specialized Medical Equipment services as described in the language below:

Specialized Medical Equipment (T2029/Modifier UC- MR)
Specialized Medical Equipment (T2029/Modifier UD- LHW)

Specialized medical equipment includes devices, controls, or appliances specified in the plan of care, which enable recipients to increase their ability to perform activities of daily living or to perceive, control or communicate with the environment in which they live. Included items are those necessary for life support, and equipment necessary to the proper functioning of such items and durable and non-durable medical equipment not available under the Medicaid State Plan. Items reimbursed with waiver funds shall be in addition to any medical equipment furnished under the State Plan and shall exclude those items that are not of direct medical or remedial benefits to the recipient. Invoices for medical equipment must be maintained in the case record. All items shall meet applicable standards of manufacture, design and installation. Costs are limited to $5,000 per year, per individual.

Providers of this service must meet the same standards required for the providers under the Alabama State Plan.

Medical Supplies (T2028/Modifier UC – MR)
Medical Supplies (T2028/Modifier UD – LHW)

Medical supplies are necessary to maintain the recipient's health, safety, and welfare and to prevent further deterioration of a condition such as decubitus ulcers. These supplies do not include common over-the-counter personal care items such as toothpaste, mouthwash, soap, shampoo, Q-tips, deodorant, etc.

These medical supplies will only be provided when authorized by the recipient's physician and shall meet applicable standards of manufacture, design and installation. Providers of this service will be those who have a signed provider agreement with Medicaid and the Department of Mental Health and Mental Retardation. Medical supplies are limited to $1800.00 per recipient, per year. The Operating Agency must maintain invoices and documentation of items purchased for the recipient.
A unit is defined as a per diem rate.

If you have any additional questions or need further clarification, please contact Samantha McLeod at (334) 242-5584.

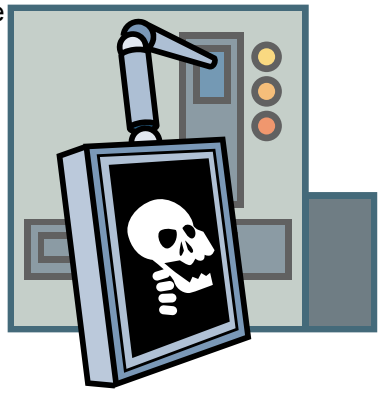
UB-04 Crossover Form Information

When submitting number of days on the UB04 Crossover forms (Covered, Non-Covered, Lifetime Reserve, and Coinsurance), be sure to submit the values **without** decimals. Acceptable values would be in a 00 or 0 format. Values **with** decimals in boxes 39-40 are recognized as dollar amounts. Applicable value codes for the various days are 80, 81, 82, and 83.

MedSolutions to Process Radiology Prior Authorizations

The Alabama Medicaid Agency has contracted with MedSolutions to implement a radiology prior authorization program effective February 2, 2009. MedSolutions is a radiology services organization that specializes in managing diagnostic services.

For all MRI's, MRA's, CT scans, CTA's, and PET scans performed on or after February 2, 2009, ordering providers will be required to request prior authorization from MedSolutions. MedSolutions will begin accepting prior authorization requests on February 2, 2009 for dates of service beginning February 2, 2009. Medicaid will provide a grace period to allow providers sufficient time to acclimate to the change. Providers will be required to submit PriorAuthorizations during this grace period. Medicaid will not deny any claims for these services performed from February 2nd through February 28th due to no prior authorization. However, beginning on March 1, 2009, any claims that are submitted for these radiological services for dates of service March 1, 2009 and thereafter without prior approval will be denied.



Exclusions from the PA requirement will be:

- Scans performed as an inpatient hospital service,
- Scans performed in an emergency room service as a certified emergency, and
- Scans for Medicaid recipients who are also covered by Medicare.

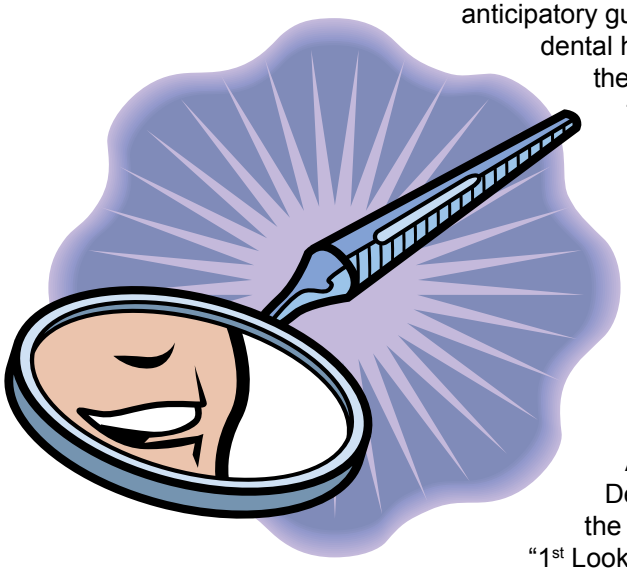
MedSolutions will soon be sending you more information to facilitate a smooth and successful transition to our radiology management program.

Providers with additional questions may contact Teresa Thomas, Program Manager, Lab/X-ray services at *teresa.thomas@medicaid.alabama.gov* or by phone at (334) 242-5048.

Medicaid Introduces the 1st Look Program

Infants and toddlers at high risk for serious dental problems will soon benefit from a collaborative effort aimed at preventing early childhood caries (ECC) in children covered by the Alabama Medicaid Agency.

Developed by the Agency in partnership with the state's pediatric dentists and pediatricians, the 1st Look Program is designed to reduce early childhood caries by encouraging primary care physicians to perform dental risk assessments, provide anticipatory guidance, apply fluoride varnish when indicated, and refer children to a dental home by age one. Children already seen by a dentist do not qualify for the 1st Look Program. Participating primary medical providers (PMPs) must first obtain certification by completing a Medicaid-approved training course. The 1st Look Program is scheduled to begin in January 2009.



"Early prevention of dental caries will ultimately result in improved oral health for high-risk Alabama children," said Medicaid Commissioner Carol Steckel. "This partnership between Patient 1st medical providers and the dental community is a win-win effort that will significantly impact the overall health and well-being of the children we serve."

Pediatric dentist Richard A. Simpson, DMD, of Tuscaloosa, has been instrumental in the collaborative effort, which has included representatives of the Alabama Academy of Pediatric Dentistry, the Alabama Chapter of the American Academy of Pediatrics, the Alabama Dental Association, and the Alabama Medicaid Agency. Alabama will be the 23rd state to offer this type of program.

"1st Look Program goals are to improve awareness of early childhood caries, increase early prevention education, enlarge the dental provider referral base, and reduce the incidence of dental caries in Alabama children", Dr. Simpson said. The key components of the 1st Look Program involve doctors assessing the risk for dental disease during check-ups of their young patients, utilizing a modified AAPD Caries Risk Assessment Tool (CAT). The parent or other caregiver then receives preventive education and is instructed on the importance of establishing a dental home, ideally by age one. Infants deemed to be at "high risk" for ECC receive a fluoride varnish application and are referred to a Patient 1st care coordinator to assist in the dental referral process.

Dr. Simpson stated that "recent studies are beginning to show that the combination of primary care physicians well trained in oral health assessment, repeated fluoride varnish applications, and appropriate early referral to a dentist can effectively reduce the incidence of ECC and, ultimately, the number of costly restorative procedures performed on very young patients." He also noted that North Carolina, the first state to implement such a program some 10 years ago, has reported a 39 percent reduction in caries in the anterior teeth of young children.

Trofile Assey Now is a Covered Service

The Trofile Assay is now a covered service by Medicaid with prior authorization effective December 1, 2008. The procedure code to be billed is 87999 (unlisted microbiology procedure). In order to be reimbursed by Medicaid for the Trofile Assay, the ordering provider must submit a Prior Authorization electronically or by paper on form 342. The form is available on the Agency's website at:

http://www.medicaid.alabama.gov/documents/Billing/5-F_Forms.Billing/
5F-2_Prior.Auth.Forms/5F2a_PA_Form342_fillable-2-26-08.pdf

Providers requesting a PA should include:

- Any past history of antiretroviral medications prescribed to include date prescribed and the date the drug was discontinued;
- The name and contact information of the HIV clinic that the provider is affiliated with if the requesting provider is not enrolled in Medicaid with specialty of infectious disease, and;
- The result of the most current HIV-1 RNA.

If you need further information, please see chapter 4 of the Provider Billing Manual for detailed instructions on the submission of prior authorizations. Providers with questions may contact Teresa Thomas, Program Manager, Lab/X-ray services at teresa.thomas@medicaid.alabama.gov or by phone at (334) 242-5048.

NDC is Required on CMS-1500

Effective for dates of service August 1, 2008 and thereafter, providers are required to submit NDC's (National Drug Codes) on CMS-1500 for the top 20 physician administered drugs. Effective for dates of service September 1, 2008 and thereafter, facilities are required to submit NDC's (National Drug Codes) for the top 20 physician administered drugs.

Since implementation of this requirement, EDS has noticed many paper claims being submitted with the NDC information in the wrong fields. Because claims are scanned for processing, it is imperative providers submit NDC information in the appropriate fields on the claim forms. NDC information not submitted correctly results in claim denials.

Please review the information on the next pages to ensure you are properly completing your paper claim forms with NDC information. For more information, see the July 2008 Provider Insider

Important Change for Providers Who Submit Using Crossover Claims

(Continued from page 1)

837I Format:

- Billing Provider Address: 2010AA-N403 The entire 9-digit postal zip code should be submitted, without the dash.
- Service Facility Address: 2310E,N403-Service Facility Location City/State/Zip Code- The entire 9-digit postal zip code should be submitted, without the dash. This loop is required when the location of health care service is different than that carried in the 2010AA (billing provider) or 2010AB (pay to provider) loops.
- Service Facility Address (Detail): 2420C- Service Facility Location City/State/Zip Code- The entire 9-digit postal zip code should be submitted, without the dash. Required when the location of health care service for this service line is different than that carried in the 2010AA (Billing Provider), 2010AB(Pay-to Provider), or 2310D Service Facility Location loops.

If you have further questions, please contact the Provider Assistance Center at 1-800-688-7989.

Processing Changes for Provider 1099

With the implementation of the new Medicaid claims processing system, there are changes for the way Provider 1099's will be processed. In the past, Providers received a separate 1099 form for each Medicaid Provider number on file. Beginning with the 2008 tax year, 1099's will be produced based on the Provider tax identification number (tax ID). Providers will receive one 1099 form for each tax ID. This means that if a tax ID has multiple NPI's associated to it, one 1099 will be produced with rolled up earnings totals for all associated providers. In the event of a tax ID change, providers will receive a separate 1099 for each tax ID that was used during the year.

Changes to the Patient 1st Program

The Patient 1st Program continues to be a success in meeting its goal of creating a medical home for our recipients. One action taken to accomplish this goal has been to revise the case management fee components and performance measures for the time period, January 1, 2009 – December 31, 2010. These changes were a reflection of providers indicating they would like to have measures of greater practice significance and more quality oriented. The central theme throughout the planning process was for the measures to be realistic, important to the overall enhancement of patient care and considered valuable across all physician peer groups.

The changes in the case management fee will require a reenrollment of all Patient 1st PMPs. New contracts, along with the revised Provider Manual, will be mailed in the first week of November. In addition, a detailed description of the Performance Measures including the algorithm for determining the measure will be part of the enrollment packet.

Patient 1st
Health Care Close To Home

Case Management Fee components

- 24/7 Voice-to-Voice Phone Coverage - $1.00
  This is a requirement of program participation and not optional. PMPs must have a voice-to-voice telephone coverage for their recipients.
- Radiology Management - $.50
  The Agency is implementing a prior approval process for Radiology services (CT Scans, MRI, MRA, PETS and CTA) for 2009. All Medicaid providers, regardless of program participation, will be required to request radiology services through prior approval.
- Administrative fee - $.10
  To offset the extra time the PMP and staff spend on completion of referrals, consultations, prior approvals, In-Home monitoring enrollment forms, Review of Care Coordination reports, etc.
- InfoSolutions/QTool (Electronic Health Record) - $1.00
  Use of InfoSolutions until such time as the QTool becomes available in the counties. QTool is Medicaid's web based electronic health record that is currently being piloted in 9 counties. Once QTool becomes available in a county; then requires use of the QTool for 25% of patient visits the first 3 months and 50% of visits from then on to earn the fee for this component. This is an optional component.

State Seeks Input to Improve Medicaid Maternity Care Program

Alabama Medicaid providers are invited to participate in an upcoming series of "Town Hall" sessions to provide input on how the Alabama Medicaid Maternity Care Program be revamped to more effectively increase the number of healthy babies born in the state. The forums to solicit input from maternity care providers, patient advocates and the general public are a cooperative effort of the Alabama Department of Public Health's State Perinatal Council, the Alabama Chapter of the March of Dimes, and the Alabama Medicaid Agency.

One session was held December 8 in Tuscaloosa. The other sessions in Birmingham (Jan. 13), Spanish Fort (Jan. 15), Montgomery (Jan. 22), and Huntsville (Jan. 29) are free to the public and pre-registration is not required. All sessions will begin at 5:30 p.m. A free web conference will be available in conjunction with the Montgomery session for those unable to attend one of the sessions in person. Further details are available on the Medicaid Agency Web site at:

http://www.medicaid.alabama.gov/programs/maternity_care/maternity_town_hall_meetings.aspx?tab=4

"We welcome any opinions and ideas on how to improve Alabama Medicaid's Maternity Care program and the state's infant mortality rate. We have a serious problem with a significant increase in our infant mortality rate, however, I am confident that, like we have done before, together, we can solve this problem," said Medicaid Commissioner Carol Steckel.

Information provided during the sessions will be considered by a Medicaid Maternity Care Review Committee that will be convened next year to explore program options available to the state. Current Alabama Medicaid maternity care providers have agreed to continue the present maternity program through December 2009 to allow time to facilitate a redesign of the program.

According to the Alabama Department of Public Health, the state's 2007 infant mortality rate increased to 10.0 deaths per 1,000 births, compared to 9.0 deaths per 1,000 births in 2006. Approximately 48 percent of all births in Alabama are funded by Medicaid.

Attention DME Providers

Effective February 1, 2009 Alabama Medicaid will reduce the payment for procedure code B9998 (NOC for enteral supplies) from $40.00 per month to $20.00 per month. This code is used to cover the extension tubing for the MIC-KEY Button. This cost reduction for procedure code B9998 is being implemented as a Medicaid cost savings measure.

Effective February 1, 2009 DME / Supply items selected for competitive bidding in 2008 will receive a 9.5% decrease in price. This price reduction coincides with Medicare's price reduction guidelines effective January 1, 2009.

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

Providers Recognized for Outstanding Vaccination Coverage Rates

The Alabama Department of Public Health, Immunization Division, honors Vaccine for Children (VFC) providers who reached 80% or greater vaccination coverage rates in 2007. A plaque was awarded to 76 VFC providers who contributed significantly towards reducing the spread of diseases in Alabama.

The Alabama Vaccines for Children Program is a statewide pediatric and adolescent immunization program designed to remove barriers to vaccination and enhance preventive health care.

www.medicaid.alabama.gov

Update to Preferred Drug List

Effective January 2, 2009 the Alabama Medicaid Agency will update the Preferred Drug List (PDL) to reflect the recent Pharmacy and Therapeutics (P&T) recommendations as well as quarterly updates. The updates are listed below:

PDL Additions

Simcor- Cardiovascular Health/HMG CoA Reductase Inhibitors

PDL Deletions*

Cedax - Anti-infective Agents/Cephalosporins

Lipitor - Cardiovascular Health/HMG CoA Reductase Inhibitors

* denotes that these brands will no longer be preferred but are still covered by Alabama Medicaid and will require Prior Authorization (PA). Available covered generic equivalents (unless otherwise specified) will remain preferred.

The PA request form and criteria booklet, as well as a link for a PA request form that can be completed and submitted electronically online, can be found on the Agency website at www.medicaid.alabama.gov and should be utilized by the prescribing physician or the dispensing pharmacy when requesting a PA. Providers are to mail or fax hard copy PA requests to:

Health Information Designs (HID)
Medicaid Pharmacy Administrative Services
P. O. Box 3210 Auburn, AL 36832-3210
Fax: 1-800-748-0116
Phone: 1-800-748-0130

Incomplete PA requests or those failing to meet Medicaid criteria will be denied. If the prescribing physician believes medical justification should be considered, the physician must document this on the form or submit a written letter of medical justification along with the prior authorization form to HID. Additional information may be requested. Staff physicians will review this information.

Policy questions concerning this provider notice should be directed to the Pharmacy Program at (334) 242-5050. Questions regarding prior authorization procedures should be directed to the HID help desk at 1-800-748-0130.

Important Mailing Addresses	
All Claim forms, Consent forms, and other mail	EDS Post Office Box 244032 Montgomery, AL 36124-4032
Inquiries, Provider Enrollment Information, and Provider Relations	EDS Post Office Box 241685 Montgomery, AL 36124-1685
Adjustments	EDS Post Office Box 241684 Montgomery, AL 36124-1684

EDS Provider Representatives

G R O U P 1

kiki.hinton
@eds.com
334-215-4155

debbie.smith
@eds.com
334-215-4142

gayle.simpson-jones
@eds.com
334-215-4113

misty.curlee
@eds.com
334-215-4159

Nurse Practitioners
Podiatrists
Chiropractors
Independent Labs
Free Standing Radiology
CRNA
EPSDT (Physicians)
Dental
Physicians
Optometric
(Optometrists and Opticians)

mark.bonner
@eds.com
334-215-4132

G R O U P 2

Rehabilitation Services
Home Bound Waiver
Therapy Services (OT, PT, ST)
Children's Specialty Clinics
Prenatal Clinics
Maternity Care
Hearing Services
Mental Health/Mental Retardation
MR/DD Waiver
Ambulance
FQHC

jennifer.hatmaker
@eds.com
334-215-4199

savannah.brimhall
@eds.com
334-215-4158

Public Health
Elderly and Disabled Waiver
Home and Community Based Services
EPSDT
Family Planning
Prenatal
Preventive Education
Rural Health Clinic
Commission on Aging
DME
Nurse Midwives

G R O U P 3

Ambulatory Surgical Centers
ESWL
Home Health
Hospice
Hospital
Nursing Home

linda.hanks
@eds.com
334-215-4130

ann.miller
@eds.com
334-215-4156

shermeria.harvest
@eds.com
334-215-4160

Personal Care Services
PEC
Private Duty Nursing
Renal Dialysis Facilities
Swing Bed

State Fiscal Year 2009-2010 Checkwrite Schedule

~~10/03/08~~	01/02/09	04/03/09	07/10/09
~~10/17/08~~	01/16/09	04/17/09	07/24/09
~~11/07/08~~	02/06/09	05/01/09	08/07/09
~~11/21/08~~	02/20/09	05/15/09	08/21/09
~~12/05/08~~	03/06/09	06/05/09	09/04/09
~~12/12/08~~	03/20/09	06/19/09	09/11/09

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MONTGOMERY AL

Provider *Insider*

Alabama Medicaid Bulletin **April 2009**

The checkwrite schedule is as follows:

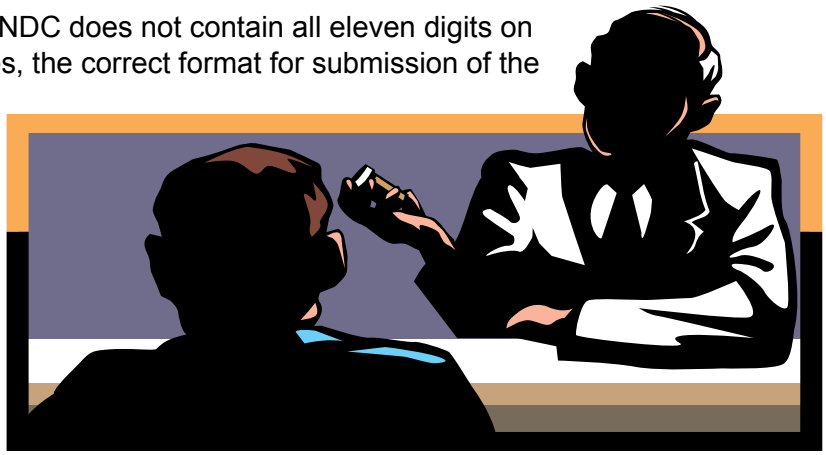
04/03/08 04/17/09 05/01/09 05/15/09 06/05/09 06/19/09

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

Guidance Regarding NDC's on CMS-1500 and UB-04 Claim Forms

Effective August 2008, Alabama Medicaid mandated that the National Drug Code (NDC) number be included on the CMS-1500 and UB-04 claim form for the Top 20 physician administered drugs as defined by CMS. Alabama Medicaid would like to clarify the required format for the NDC number that is submitted on these claim forms. Medicaid requires that each submitted NDC contain 11-digits (no dashes or spaces). The first 5-digits identify the labeler code of the manufacturer of the drug. The next 4 digits identify the specific strength, dosage form, and formulation of that drug. The last 2 digits identify the package size of the drug. An example of the correct submission of an NDC on the CMS-1500 and UB04 claim form is indicated on pages 2 and 3.

There may be some instances when an NDC does not contain all eleven digits on the product's container. In the following instances, the correct format for submission of the NDC is given:



- xxxx-xxxx-xx: in this case a zero (0) would need to be added in front of the first set of numbers.

  Result: 0xxxxxxxxxx.

- xxxxx-xxx-xx: in this case a zero (0) would need to be added in front of the second set of numbers.

  Result: xxxxx0xxxxx.

- xxxxx-xxxx-x: in this case a zero (0) would need to be added in front of the third set of numbers.

  Result: xxxxxxxxx0x.

Please refer to the Food and Drug Administration (FDA) website below for more information regarding the National Drug Code, *http://www.fda.gov/cder/ndc/index.htm*. For additional questions regarding the CMS list of Top 20 physician administered drugs, please contact Pharmacy Services at (334) 242-5050.

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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* _____

Instructions for Adding NDC Codes to Required Medicaid Forms

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (08/05)

CMS-1500 Instructions

Using the supplemental information in Item Number 24D, enter the identifier "N4" and the 11-digit NDC code. The identifier N4 tells the computer the following supplemental information is a NDC.

Do not enter a space between the identifier and the NDC.

Do not enter hyphens or spaces within the NDC.

This example demonstrates how the data are to be entered into the fields and is not meant to provide direction on how to code for certain services.

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	DIA PC
1	07	01	08	07	01	08	11	0	J9265	N4 55390031420	
2											

ID Code Qualifier

11-Digit NDC

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

Instructions for Adding NDC Codes to Required Medicaid Forms

UB-04 Instructions

In Form Locator 43 (Description), enter the "N4" qualifier in the first two (2) positions, left justified; followed immediately by the 11 character NDC number (no hyphens). The identifier "N4" tells the computer the following supplemental information is a NDC.

Do not enter a space between the identifier and the NDC.

Do not enter hyphens or spaces within the NDC.

This example demonstrates how the data are to be entered into the fields and is not meant to provide direction on how to code for certain services.

Revenue Code	ID Code Qualifier	11-Digit NDC	
42 REV. CD.	43 DESCRIPTION		44 HCPCS / RATE / HIPPS CODE
636	N4	55390031420	J9265

Medicaid Physician-Administered Multiple Source Drugs

In compliance with the Deficit ReductionAct, the Medicaid Physician-Administered Multiple Source Drugs listing is being updated effective May 1, 2009. The drugs identified in this listing require a NDC code.

HCPCS Code	Description	HCPCS Dosage	Labeler Drug Name	NDC	Labeler Name
J0640	Leucovorin Calcium Injection	50 mg	Leucovorin Calcium	63323-0711-00	American Pharmaceutical Partners
			Leucovorin Calcium	55390-0009-01	Bedford Laboratories
			Leucovorin Calcium	55390-0051-10	Bedford Laboratories
			Leucovorin Calcium	55390-0052-10	Bedford Laboratories
			Leucovorin Calcium	55390-0053-01	Bedford Laboratories
			Leucovorin Calcium	55390-0054-01	Bedford Laboratories
			Leucovorin Calcium	55390-0818-10	Bedford Laboratories
			Leucovorin Calcium	55390-0824-01	Bedford Laboratories
			Leucovorin Calcium	55390-0825-01	Bedford Laboratories
			Leucovorin Calcium	55390-0826-01	Bedford Laboratories
			Leucovorin Calcium	00703-5140-01	SICOR
			Leucovorin Calcium	00703-5145-01	SICOR
J0696	Ceftriaxone Sodium Injection	250 mg	Ceftriaxone Sodium	63323-0344-10	American Pharmaceutical Partners
			Ceftriaxone Sodium	63323-0345-10	American Pharmaceutical Partners
			Ceftriaxone Sodium	63323-0346-10	American Pharmaceutical Partners
			Ceftriaxone Sodium	63323-0347-20	American Pharmaceutical Partners
			Ceftriaxone Sodium	63323-0348-61	American Pharmaceutical Partners
			Ceftriaxone Sodium	00517-8711-10	American Regent Laboratories
			Ceftriaxone Sodium	00517-8722-10	American Regent Laboratories
			Ceftriaxone Sodium	00517-8725-10	American Regent Laboratories
			Ceftriaxone Sodium	00517-8750-10	American Regent Laboratories
			Ceftriaxone Sodium	60505-0679-05	Apotex
			Ceftriaxone Sodium	60505-0679-08	Apotex
			Ceftriaxone Sodium	60505-0679-09	Apotex
			Ceftriaxone Sodium	60505-0750-00	Apotex
			Ceftriaxone Sodium	60505-0750-04	Apotex
			Ceftriaxone Sodium	60505-0751-00	Apotex
			Ceftriaxone Sodium	60505-0751-04	Apotex
			Ceftriaxone Sodium	60505-0753-04	Apotex
			Ceftriaxone Sodium	60505-0753-00	Apotex
			Ceftriaxone Sodium	60505-0752-04	Apotex
			Ceftriaxone Sodium	60505-0752-00	Apotex
			Ceftriaxone IN DSW	00264-3153-11	B. Braun Medical
			Ceftriaxone IN DSW	00264-3155-11	B. Braun Medical
			Ceftriaxone IN DSW	00338-5002-41	Baxter
			Ceftriaxone IN DSW	00338-5003-41	Baxter
			Ceftriaxone	10019-0098-01	Baxter
			Ceftriaxone Sodium	10019-0098-71	Baxter
			Ceftriaxone Sodium	10019-0685-01	Baxter
			Ceftriaxone Sodium	10019-0685-71	Baxter
			Ceftriaxone Sodium	10019-0686-02	Baxter
			Ceftriaxone Sodium	10019-0686-71	Baxter
			Ceftriaxone Sodium	10019-0687-03	Baxter
			Ceftriaxone Sodium	10019-0687-05	Baxter
			Ceftriaxone Sodium	10019-0687-71	Baxter
			Ceftriaxone Sodium	10019-0688-04	Baxter
			Ceftriaxone Sodium	10019-0688-27	Baxter
			Ceftriaxone Sodium	10019-0689-05	Baxter
			Ceftriaxone Sodium	10019-0689-11	Baxter
			Ceftriaxone Sodium	68330-000-101	Cephazone Pharma
			Ceftriaxone Sodium	68330-000-110	Cephazone Pharma
			Ceftriaxone Sodium	68330-000-201	Cephazone Pharma
			Ceftriaxone Sodium	68330-000-210	Cephazone Pharma
			Ceftriaxone Sodium	68330-000-301	Cephazone Pharma
			Ceftriaxone Sodium	68330-000-310	Cephazone Pharma

Medicaid Physician-Administered Multiple Source Drugs *(Continued)*

HCPCS Code	Description	HCPCS Dosage	Labeler Drug Name	NDC	Labeler Name
J0696 Continued	Ceftriaxone Sodium Injection	250 mg	Ceftriaxone Sodium	68330-000-401	Cephazone Pharma
			Ceftriaxone Sodium	68330-000-410	Cephazone Pharma
			Ceftriaxone Sodium	68330-000-501	Cephazone Pharma
			Ceftriaxone Sodium	68330-000-601	Cephazone Pharma
			Rocephin	00004-1963-01	Hoffman-La Roche
			Rocephin	00004-1963-02	Hoffman-La Roche
			Rocephin	00004-1964-01	Hoffman-La Roche
			Rocephin	00004-1964-04	Hoffman-La Roche
			Ceftriaxone	00409-7332-01	Hospira
			Ceftriaxone	00409-7332-61	Hospira
			Ceftriaxone	00409-7333-04	Hospira
			Ceftriaxone	00409-7333-49	Hospira
			Ceftriaxone	00409-7334-10	Hospira
			Ceftriaxone	00409-7335-03	Hospira
			Ceftriaxone	00409-7336-04	Hospira
			Ceftriaxone	00409-7336-49	Hospira
			Ceftriaxone	00409-7337-01	Hospira
			Ceftriaxone	00409-7338-01	Hospira
			Ceftriaxone	68180-0611-01	Lupin Pharmaceuticals
			Ceftriaxone	68180-0611-10	Lupin Pharmaceuticals
			Ceftriaxone	68180-0622-01	Lupin Pharmaceuticals
			Ceftriaxone	68180-0622-10	Lupin Pharmaceuticals
			Ceftriaxone	68180-0633-01	Lupin Pharmaceuticals
			Ceftriaxone	68180-0633-10	Lupin Pharmaceuticals
			Ceftriaxone	68180-0644-01	Lupin Pharmaceuticals
			Ceftriaxone	68180-0644-10	Lupin Pharmaceuticals
			Ceftriaxone	00781-3206-95	SANDOZ
			Ceftriaxone	00781-3207-85	SANDOZ
			Ceftriaxone	00781-3207-95	SANDOZ
			Ceftriaxone	00781-3208-85	SANDOZ
			Ceftriaxone	00781-3208-95	SANDOZ
			Ceftriaxone	00781-3209-90	SANDOZ
			Ceftriaxone	00781-3209-95	SANDOZ
			Ceftriaxone	00781-3210-46	SANDOZ
			Ceftriaxone	00781-9326-95	SANDOZ
			Ceftriaxone	00781-9327-95	SANDOZ
			Ceftriaxone	00781-9328-85	SANDOZ *
			Ceftriaxone	00781-9328-95	SANDOZ
			Ceftriaxone	00781-9329-95	SANDOZ
			Ceftriaxone	00781-9330-46	SANDOZ
			Ceftriaxone	25021-0104-10	Sagent Pharmaceutical
			Ceftriaxone	25021-0105-10	Sagent Pharmaceutical
			Ceftriaxone	25021-0106-10	Sagent Pharmaceutical
			Ceftriaxone	25021-0107-20	Sagent Pharmaceutical
			Ceftriaxone Sodium	00703-0315-03	SICOR
			Ceftriaxone	00703-0325-03	SICOR
			Ceftriaxone	00703-0335-04	SICOR
			Ceftriaxone	00703-0346-03	SICOR
			Ceftriaxone	00703-0359-01	SICOR
			Ceftriaxone	00143-9856-25	West-Ward Pharmaceutical
			Ceftriaxone	00143-9857-25	West-Ward Pharmaceutical
			Ceftriaxone	00143-9858-25	West-Ward Pharmaceutical
			Ceftriaxone	00143-9859-25	West-Ward Pharmaceutical
			Ceftriaxone	64679-0701-01	Wockhardt America
			Ceftriaxone	64679-0701-02	Wockhardt America
			Ceftriaxone	64679-0701-03	Wockhardt America
			Ceftriaxone	64679-0702-01	Wockhardt America
			Ceftriaxone	64679-0702-02	Wockhardt America

Medicaid Physician-Administered Multiple Source Drugs *(Continued)*

HCPCS Code	Description	HCPCS Dosage	Labeler Drug Name	NDC	Labeler Name
J0696 Continued	Ceftriaxone Sodium Injection	250 mg	Ceftriaxone	64679-0703-01	Wockhardt America
			Ceftriaxone	64679-0703-02	Wockhardt America
			Ceftriaxone	64679-0983-01	Wockhardt America
			Ceftriaxone	64679-0983-02	Wockhardt America
J1100	Dexamethasone Sodium Injection	1 mg	Dexamethasone Sodium	63323-0165-01	American Pharmaceutical Partners
			Dexamethasone Sodium	63323-0165-05	American Pharmaceutical Partners
			Dexamethasone Sodium	63323-0165-30	American Pharmaceutical Partners
			Dexamethasone Sodium	63323-0506-01	American Pharmaceutical Partners
			Dexamethasone Sodium	63323-0516-10	American Pharmaceutical Partners
			Dexamethasone Sodium	00517-4901-25	American Regent
			Dexamethasone Sodium	00517-4905-25	American Regent
			Dexamethasone Sodium	00517-4930-25	American Regent
			Dexamethasone Sodium	00641-0367-21	Baxter
			Dexamethasone Sodium	00641-0367-25	Baxter
			Dexamethasone Sodium	00703-3524-01	SICOR
			Dexamethasone Sodium	00703-3524-03	SICOR
J1170	Hydromorphone Injection	4 mg	Dilaudid	00074-2332-11	Abbott Laboratories
			Dilaudid	00074-2333-11	Abbott Laboratories
			Dilaudid	00074-2333-26	Abbott Laboratories
			Dilaudid	00074-2334-11	Abbott Laboratories
			Dilaudid	00074-2414-21	Abbott Laboratories
			Dilaudid	00074-2453-11	Abbott Laboratories
			Dilaudid	00074-2453-27	Abbott Laboratories
			Dilaudid	00074-2453-51	Abbott Laboratories
			Dilaudid	00074-2455-31	Abbott Laboratories
			Hydromorphone HCl	17478-0540-01	Akorn Inc
			Hydromorphone HCl	17478-0540-05	Akorn Inc
			Hydromorphone HCl	17478-0540-50	Akorn Inc
			Hydromorphone HCl	00555-1117-05	Barr Laboratories Inc
			Hydromorphone HCl	00555-1117-06	Barr Laboratories Inc
			Hydromorphone HCl	00555-1117-07	Barr Laboratories Inc
			Hydromorphone HCl	00641-0121-21	Baxter Healthcare Corporation
			Hydromorphone HCl	00641-0121-25	Baxter Healthcare Corporation
			Hydromorphone HCl	00641-2341-39	Baxter Healthcare Corporation
			Hydromorphone HCl	00641-2341-41	Baxter Healthcare Corporation
			Hydromorphone HCl	00409-1283-31	Hospira Inc
			Hydromorphone HCl	00409-1304-31	Hospira Inc
			Hydromorphone HCl	00409-1312-30	Hospira Inc
			Hydromorphone HCl	00409-2172-01	Hospira Inc
			Hydromorphone HCl	00409-2172-05	Hospira Inc
			Hydromorphone HCl	00409-2540-01	Hospira Inc
			Hydromorphone HCl	00409-2552-01	Hospira Inc
			Hydromorphone HCl	00409-2634-01	Hospira Inc
			Hydromorphone HCl	00409-2634-05	Hospira Inc
			Hydromorphone HCl	00409-2634-50	Hospira Inc
			Hydromorphone HCl	00409-3356-01	Hospira Inc
			Hydromorphone HCl	00409-3365-01	Hospira Inc
			Hydromorphone HCl	59011-0441-10	Purdue Pharma
			Hydromorphone HCl	59011-0442-10	Purdue Pharma
			Hydromorphone HCl	59011-0442-25	Purdue Pharma
			Hydromorphone HCl	59011-0444-10	Purdue Pharma
			Hydromorphone HCl	59011-0445-01	Purdue Pharma
			Hydromorphone HCl	59011-0445-05	Purdue Pharma
			Hydromorphone HCl	59011-0445-50	Purdue Pharma
			Hydromorphone HCl	59011-0446-25	Purdue Pharma
J1260	Dotasetron Mesylate	10 mg	Anzemet	00088-1208-06	Abbott
			Anzemet	00088-1208-76	Abbott
			Anzemet	00088-1206-32	Aventis Pharmaceuticals
			Anzemet	00088-1209-26	Aventis Pharmaceuticals

Medicaid Physician-Administered Multiple Source Drugs *(Continued)*

HCPCS Code	Description	HCPCS Dosage	Labeler Drug Name	NDC	Labeler Name
J1626	Granisetron HCl Injection	100 mcg	Granisetron HCl	63323-0318-01	American Pharmaceutical Partners
			Granisetron HCl	63323-0317-01	American Pharmaceutical Partners
			Granisetron HCl	63323-0319-04	American Pharmaceutical Partners
			Granisetron HCl	60505-0692-00	Apotex Corp
			Granisetron HCl	60505-0693-00	Apotex Corp
			Granisetron HCl	60505-0764-02	Apotex Corp
			Granisetron HCl	10019-0053-03	Baxter Healthcare Corporation
			Granisetron HCl	10019-0053-14	Baxter Healthcare Corporation
			Granisetron HCl	55390-0250-10	Bedford Laboratories
			Kytril	00004-0239-09	Hoffmann-La Roche
			Kytril	00004-0240-09	Hoffmann-La Roche
			Kytril	00004-0242-08	Hoffmann-La Roche
			Granisetron HCl	66758-0035-01	Parenta Pharmaceutical
			Granisetron HCl	66758-0036-01	Parenta Pharmaceutical
			Granisetron HCl	66758-0037-02	Parenta Pharmaceutical
			Granisetron HCl	00703-7871-03	SICOR
			Granisetron HCl	00703-7891-02	SICOR
			Granisetron HCl	00703-7971-01	SICOR
			Granisetron HCl	00703-7971-03	SICOR
			Granisetron HCl	00703-7973-01	SICOR
			Granisetron HCl	64679-0661-02	Wockhardt Americas
			Granisetron HCl	64679-0661-03	Wockhardt Americas
			Granisetron HCl	64679-0662-01	Wockhardt Americas
J1631	Haloperidol Decanoate Injection	50 mg	Haloperidol Decanoate	63323-0469-01	American Pharmaceutical Partners
			Haloperidol Decanoate	63323-0469-05	American Pharmaceutical Partners
			Haloperidol Decanoate	63323-0471-01	American Pharmaceutical Partners
			Haloperidol Decanoate	63323-0471-05	American Pharmaceutical Partners
			Haloperidol Decanoate	60505-0702-01	Apotex
			Haloperidol Decanoate	60505-0703-01	Apotex
			Haloperidol Decanoate	55390-0412-01	Bedford Laboratories
			Haloperidol Decanoate	55390-0412-05	Bedford Laboratories
			Haloperidol Decanoate	55390-0413-01	Bedford Laboratories
			Haloperidol Decanoate	55390-0413-05	Bedford Laboratories
			Haloperidol Decanoate	55390-0423-01	Bedford Laboratories
			Haloperidol Decanoate	55390-0423-05	Bedford Laboratories
			Haloperidol Decanoate	00045-0253-01	McNeil Pharmaceutical
			Haloperidol Decanoate	00045-0253-03	McNeil Pharmaceutical
			Haloperidol Decanoate	00045-0254-14	McNeil Pharmaceutical
			Haloperidol Decanoate	00703-7011-03	SICOR
			Haloperidol Decanoate	00703-7013-01	SICOR
			Haloperidol Decanoate	00703-7021-03	SICOR
			Haloperidol Decanoate	00703-7023-01	SICOR
J1885	Ketorolac Tromethamine Injection	15 mg	Ketorolac Tromethamine	63323-0161-01	American Pharmaceutical Partners
			Ketorolac Tromethamine	63323-0162-01	American Pharmaceutical Partners
			Ketorolac Tromethamine	63323-0162-02	American Pharmaceutical Partners
			Ketorolac Tromethamine	00074-3796-61	Amerinet Choice
			Ketorolac Tromethamine	60505-0705-00	Apotex
			Ketorolac Tromethamine	60505-0706-00	Apotex
			Ketorolac Tromethamine	60505-0706-01	Apotex
			Ketorolac Tromethamine	60505-0710-01	Apotex
			Ketorolac Tromethamine	10019-0021-09	Baxter
			Ketorolac Tromethamine	10019-0022-09	Baxter
			Ketorolac Tromethamine	10019-0022-32	Baxter
			Ketorolac Tromethamine	10019-0029-02	Baxter
			Ketorolac Tromethamine	10019-0030-03	Baxter
			Ketorolac Tromethamine	10019-0030-04	Baxter
			Ketorolac Tromethamine	55390-0480-01	Bedford Laboratories
			Ketorolac Tromethamine	55390-0481-01	Bedford Laboratories
			Ketorolac Tromethamine	55390-0481-02	Bedford Laboratories
			Ketorolac Tromethamine	55390-0481-10	Bedford Laboratories

Medicaid Physician-Administered Multiple Source Drugs *(Continued)*

HCPCS Code	Description	HCPCS Dosage	Labeler Drug Name	NDC	Labeler Name
J1885 Continued	Ketorolac Tromethamine Injection	15 mg	Ketorolac Tromethamine	00409-2287-21	Hospira
			Ketorolac Tromethamine	00409-2287-22	Hospira
			Ketorolac Tromethamine	00409-2287-31	Hospira
			Ketorolac Tromethamine	00409-2288-21	Hospira
			Ketorolac Tromethamine	00409-2288-61	Hospira
			Ketorolac Tromethamine	00409-2288-31	Hospira
			Ketorolac Tromethamine	00409-3793-01	Hospira
			Ketorolac Tromethamine	00409-3795-49	Hospira
			Ketorolac Tromethamine	00409-3795-01	Hospira
			Ketorolac Tromethamine	00409-3795-49	Hospira
			Ketorolac Tromethamine	00409-3795-61	Hospira
			Ketorolac Tromethamine	00409-3796-01	Hospira
			Ketorolac Tromethamine	00409-3796-49	Hospira
			Ketorolac Tromethamine	00409-3796-61	Hospira
			Ketorolac Tromethamine	64679-0757-01	Woodhardt Americas
			Ketorolac Tromethamine	64679-0757-02	Woodhardt Americas
			Ketorolac Tromethamine	64679-0758-01	Woodhardt Americas
			Ketorolac Tromethamine	64679-0758-02	Woodhardt Americas
			Ketorolac Tromethamine	64679-0758-04	Woodhardt Americas
			Ketorolac Tromethamine	64679-0758-06	Woodhardt Americas
J2405	Ondansetron HCl Injection	1 mg	Ondansetron HCl	63323-0373-02	American Pharmaceutical Partners
			Ondansetron HCl	63323-0374-20	American Pharmaceutical Partners
			Ondansetron HCl	60505-0744-01	Apotex Corp
			Ondansetron HCl	60505-0744-06	Apotex Corp
			Ondansetron HCl	00338-1762-41	Baxter Healthcare
			Ondansetron HCl	10019-0905-01	Baxter Healthcare
			Ondansetron HCl	10019-0906-03	Baxter Healthcare
			Ondansetron HCl	10019-0905-17	Baxter Healthcare
			Ondansetron HCl	10019-0906-63	Baxter Healthcare
			Ondansetron HCl	55390-0121-01	Bedford Laboratories
			Ondansetron HCl	55390-0121-10	Bedford Laboratories
			Ondansetron HCl	55390-0307-01	Bedford Laboratories
			Ondansetron HCl	55390-0307-10	Bedford Laboratories
			Zofran	00173-0442-00	Glaxosmithkline
			Zofran	00173-0442-02	Glaxosmithkline
			Zofran	00173-0461-00	Glaxosmithkline
			Ondansetron HCl	00409-1120-62	Hospira Inc
			Ondansetron HCl	00409-4755-01	Hospira Inc
			Ondansetron HCl	00409-4755-02	Hospira Inc
			Ondansetron HCl	00409-4755-03	Hospira Inc
			Ondansetron HCl	00409-4755-61	Hospira Inc
			Ondansetron HCl	00409-4755-62	Hospira Inc
			Ondansetron HCl	00409-4755-63	Hospira Inc
			Ondansetron HCl	00409-4759-01	Hospira Inc
			Ondansetron HCl	00409-4760-13	Hospira Inc
			Ondansetron HCl	61703-0244-07	Mayne Pharma
			Ondansetron HCl	61703-0245-22	Mayne Pharma
			Ondansetron HCl	00781-3010-72	Sandoz
			Ondansetron HCl	00781-3010-95	Sandoz
			Ondansetron HCl	00781-3057-14	Sandoz
			Ondansetron HCl	00781-3057-80	Sandoz
			Ondansetron HCl	00703-7221-01	Sicor
			Ondansetron HCl	00703-7221-02	Sicor
			Ondansetron HCl	00703-7221-04	Sicor
			Ondansetron HCl	00703-7226-01	Sicor
			Ondansetron HCl	00703-7226-03	Sicor
			Ondansetron HCl	00703-7239-39	Sicor
			Ondansetron HCl	62756-0181-01	Sun Pharmaceuticals
			Ondansetron HCl	62756-0182-01	Sun Pharmaceuticals
			Ondansetron HCl	00143-9771-06	West-Ward Pharmaceuticals
			Ondansetron HCl	00143-9890-01	West-Ward Pharmaceuticals
			Ondansetron HCl	00143-9891-05	West-Ward Pharmaceuticals
			Ondansetron HCl	64679-0726-01	Wockhardt Americas
			Ondansetron HCl	64679-0727-01	Wockhardt Americas

Medicaid Physician-Administered Multiple Source Drugs *(Continued)*

HCPCS Code	Description	HCPCS Dosage	Labeler Drug Name	NDC	Labeler Name
J2430	Pamidronate Disodium	30 mg	Pamidronate Disodium	63323-0734-10	American Pharmaceutical Partners
			Pamidronate Disodium	63323-0735-10	American Pharmaceutical Partners
			Pamidronate Disodium	55390-0127-01	Bedford Laboratories
			Pamidronate Disodium	55390-0129-01	Bedford Laboratories
			Pamidronate Disodium	55390-0157-01	Bedford Laboratories
			Pamidronate Disodium	55390-0159-01	Bedford Laboratories
			Pamidronate Disodium	55390-0204-01	Bedford Laboratories
			Pamidronate Disodium	55390-0604-01	Bedford Laboratories
			Pamidronate Disodium	61703-0324-18	Mayne Pharma
			Pamidronate Disodium	61703-0326-18	Mayne Pharma
			Pamidronate Disodium	61703-0324-39	Mayne Pharma
			Pamidronate Disodium	61703-0325-18	Mayne Pharma
			Pamidronate Disodium	61703-0326-18	Mayne Pharma
			Aredia	00078-0463-91	Novartis
			Aredia	00078-0464-61	Novartis
			Pamidronate Disodium	15210-0401-11	OTN Generics
			Pamidronate Disodium	15210-0402-11	OTN Generics
			Pamidronate Disodium	00781-1314-70	SANDOZ
			Pamidronate Disodium	00781-1314-70	SANDOZ
			Pamidronate Disodium	00781-3147-70	SANDOZ
			Pamidronate Disodium	00781-3148-70	SANDOZ
			Pamidronate Disodium	00703-4075-59	SICOR
			Pamidronate Disodium	00703-4085-51	SICOR
J2550	Promethazine HCl Injection	50 mg	Promethazine Hcl	00641-0928-25	Baxter
			Promethazine Hcl	00641-0929-25	Baxter
			Promethazine Hcl	00641-0948-35	Baxter
			Promethazine Hcl	00641-0949-35	Baxter
			Promethazine Hcl	00641-0955-25	Baxter
			Promethazine Hcl	00641-0956-25	Baxter
			Promethazine Hcl	00641-1495-35	Baxter
			Promethazine Hcl	00641-1496-35	Baxter
			Promethazine Hcl	10019-0097-01	Baxter
			Phenergan	60977-0001-01	Baxter
			Promethazine Hcl	60977-0001-03	Baxter
			Phenergan	60977-0002-02	Baxter
			Promethazine Hcl	60977-0002-04	Baxter
			Promethazine Hcl	00409-2312-31	Hospira
			Promethazine Hcl	00703-2191-04	SICOR
			Promethazine Hcl	00703-2201-04	SICOR
J3010	Fentanyl Citrate Injection	0.1 mg	Fentanyl Citrate	10019-0033-39	Baxter
			Fentanyl Citrate	10019-0033-72	Baxter
			Fentanyl Citrate	10019-0034-18	Baxter
			Fentanyl Citrate	10019-0034-73	Baxter
			Fentanyl Citrate	10019-0035-39	Baxter
			Fentanyl Citrate	10019-0035-74	Baxter
			Fentanyl Citrate	10019-0036-82	Baxter
			Fentanyl Citrate	10019-0037-39	Baxter
			Fentanyl Citrate	10019-0037-83	Baxter
			Fentanyl Citrate	10019-0038-39	Baxter
			Fentanyl Citrate	10019-0038-67	Baxter
			Fentanyl Citrate	00409-1276-32	Hospira
			Fentanyl Citrate	00409-9093-32	Hospira
			Fentanyl Citrate	00409-9093-35	Hospira
			Fentanyl Citrate	00409-9093-36	Hospira
			Fentanyl Citrate	00409-9093-38	Hospira
			Fentanyl Citrate	00409-9094-22	Hospira
			Fentanyl Citrate	00409-9094-25	Hospira
			Fentanyl Citrate	00409-9094-28	Hospira
			Fentanyl Citrate	00409-9094-31	Hospira
			Fentanyl Citrate	00409-9094-61	Hospira
			Sublimaze	11098-0030-02	Taylor
			Sublimaze	11098-0030-05	Taylor
			Sublimaze	11098-0030-20	Taylor

Medicaid Physician-Administered Multiple Source Drugs *(Continued)*

HCPCS Code	Description	HCPCS Dosage	Labeler Drug Name	NDC	Labeler Name
J3370	Vancomycin HCL Injection	500 mg	Vancomycin HCl	63323-0221-10	American Pharmaceutical Partners
			Vancomycin HCl	63323-0284-20	American Pharmaceutical Partners
			Vancomycin HCl	63323-0295-61	American Pharmaceutical Partners
			Vancomycin HCl	63323-0314-61	American Pharmaceutical Partners
			Vancomycin HCl	00338-3551-48	Baxter Healthcare
			Vancomycin HCl	00338-3552-48	Baxter Healthcare
			Vancomycin HCl	10139-0501-12	Generamedix
			Vancomycin HCl	10139-0501-20	Generamedix
			Vancomycin HCl	00409-4332-01	Hospira Inc
			Vancomycin HCl	00409-4332-49	Hospira Inc
			Vancomycin HCl	00409-6509-01	Hospira Inc
			Vancomycin HCl	00409-6509-49	Hospira Inc
			Vancomycin HCl	00409-6533-01	Hospira Inc
			Vancomycin HCl	00409-6533-49	Hospira Inc
			Vancomycin HCl	00409-6533-61	Hospira Inc
			Vancomycin HCl	00409-6534-01	Hospira Inc
			Vancomycin HCl	00409-6534-49	Hospira Inc
			Vancomycin HCl	00409-6535-01	Hospira Inc
			Vancomycin HCl	00409-6535-49	Hospira Inc
J7050	Normal Saline Solution Infusion	250 cc	Sodium Chloride	00074-7984-27	Abbott Laboratories
			Sodium Chloride	00264-1800-31	B. Braun Medical
			Sodium Chloride	00264-1800-32	B. Braun Medical
			Sodium Chloride	00264-1800-36	B. Braun Medical
			Sodium Chloride	00264-4000-55	B. Braun Medical
			Sodium Chloride	00264-4001-55	B. Braun Medical
			Sodium Chloride	00264-4002-55	B. Braun Medical
			Sodium Chloride	00264-7800-00	B. Braun Medical
			Sodium Chloride	00264-7800-10	B. Braun Medical
			Sodium Chloride	00264-7800-20	B. Braun Medical
			Sodium Chloride	00338-0044-02	Baxter
			Sodium Chloride	00338-0044-03	Baxter
			Sodium Chloride	00338-0045-11	Baxter
			Sodium Chloride	00338-0049-02	Baxter
			Sodium Chloride	00338-0049-03	Baxter
			Sodium Chloride	00338-0049-04	Baxter
			Sodium Chloride	00338-0049-11	Baxter
			Sodium Chloride	00338-0049-18	Baxter
			Sodium Chloride	00338-0049-31	Baxter
			Sodium Chloride	00338-0049-38	Baxter
			Sodium Chloride	00338-0049-41	Baxter
			Sodium Chloride	00338-0553-11	Baxter
			Sodium Chloride	00338-0553-18	Baxter
			Sodium Chloride	00338-6045-12	Baxter
			Sodium Chloride	00338-6304-02	Baxter
			Sodium Chloride	00338-6304-03	Baxter
			Sodium Chloride	00338-6304-02	Baxter
			Sodium Chloride	00409-1583-01	Hospira
			Sodium Chloride	00409-1583-02	Hospira
			Sodium Chloride	00409-1584-11	Hospira
			Sodium Chloride	00409-7101-02	Hospira
			Sodium Chloride	00409-7101-66	Hospira
			Sodium Chloride	00409-7101-67	Hospira
			Sodium Chloride	00409-7983-02	Hospira
			Sodium Chloride	00409-7983-03	Hospira
			Sodium Chloride	00409-7983-09	Hospira
			Sodium Chloride	00409-7983-30	Hospira
			Sodium Chloride	00409-7983-48	Hospira
			Sodium Chloride	00409-7983-53	Hospira
			Sodium Chloride	00409-7983-55	Hospira
			Sodium Chloride	00409-7983-61	Hospira
			Sodium Chloride	00409-7984-13	Hospira
			Sodium Chloride	00409-7984-20	Hospira
			Sodium Chloride	00409-7984-23	Hospira
			Sodium Chloride	00409-7984-36	Hospira
			Sodium Chloride	00409-7984-37	Hospira

Medicaid Physician-Administered Multiple Source Drugs *(Continued)*

HCPCS Code	Description	HCPCS Dosage	Labeler Drug Name	NDC	Labeler Name
J7190	Factor VIII	1 iu	Hemofil M	00944-2935-03	Baxter
			Hemofil M	00944-2935-04	Baxter
			Monarc-M	00944-1301-10	Baxter
			Monarc-M	00944-1302-10	Baxter
			Monarc-M	00944-1303-10	Baxter
			Monarc-M	00944-1304-10	Baxter
			Hemofil M	00944-2935-01	Baxter
			Hemofil M	00944-2935-02	Baxter
			Monoclate-P	00053-7656-01	CSL Behring
			Monoclate-P	00053-7656-02	CSL Behring
			Monoclate-P	00053-7656-04	CSL Behring
			Monoclate-P	00053-7656-05	CSL Behring
			Alphanate	68516-4600-01	Grifols
			Alphanate	68516-4600-02	Grifols
			Alphanate	68516-4601-01	Grifols
			Alphanate	68516-4602-01	Grifols
			Alphanate	68516-4603-02	Grifols
			Alphanate	68516-4604-02	Grifols
			Koate-Dvi	13533-0665-20	Talecris
			Koate-Dvi	13533-0665-30	Talecris
			Koate-Dvi	13533-0665-50	Talecris
J7192	Factor VIII Recombinant	1 iu	Helixate Fs	00053-8130-01	Aventis Behring
			Helixate Fs	00053-8130-02	Aventis Behring
			Helixate Fs	00053-8130-04	Aventis Behring
			Kogenate Fs	00026-0372-20	Baxter
			Kogenate Fs	00026-0372-30	Baxter
			Kogenate Fs	00026-0372-50	Baxter
			Recombinate	00944-2831-10	Baxter
			Recombinate	00944-2832-10	Baxter
			Recombinate	00944-2833-10	Baxter
			Advate L	00944-2941-10	Baxter
			Advate M	00944-2942-10	Baxter
			Kogenate Fs Bio-Set	00026-0379-20	Bayer
			Kogenate Fs Bio-Set	00026-0379-30	Bayer
			Kogenate Fs Bio-Set	00026-0379-50	Bayer
			Kogenate Fs	00026-3786-60	Bayer
			Kogenate Fs	00026-3796-60	Bayer
			Helixate	00053-8130-05	CSL Behring
			Refacto	58394-0005-02	Genetics Institute
			Refacto	58394-0006-02	Genetics Institute
			Refacto	58394-0007-02	Genetics Institute
			Refacto	58394-0011-02	Genetics Institute
J7644	Ipratropium Bromide Inh Sol u d	1 mg	Ipratropium Bromide	00472-0753-23	Alpharma
			Ipratropium Bromide	00472-0753-30	Alpharma
			Ipratropium Bromide	00472-0753-60	Alpharma
			Ipratropium Bromide	60505-0806-01	Apotex
			Ipratropium Bromide	16252-0098-22	Cobalt Laboratories
			Ipratropium Bromide	16252-0098-33	Cobalt Laboratories
			Ipratropium Bromide	16252-0098-66	Cobalt Laboratories
			Ipratropium Bromide	49502-0685-26	Dey, L.P.
			Ipratropium Bromide	49502-0685-30	Dey, L.P.
			Ipratropium Bromide	49502-0685-31	Dey, L.P.
			Ipratropium Bromide	49502-0685-61	Dey, L.P.
			Ipratropium Bromide	51552-0393-01	Gallipot
			Ipratropium Bromide	51552-0393-02	Gallipot
			Ipratropium Bromide	51552-0393-04	Gallipot
			Ipratropium Bromide	51552-0393-05	Gallipot
			Ipratropium Bromide	00172-6407-44	Ivax Pharmaceuticals
			Ipratropium Bromide	00172-6407-49	Ivax Pharmaceuticals
			Ipratropium Bromide	00487-9801-01	Nephron Pharmaceuticals
			Ipratropium Bromide	00487-9801-25	Nephron Pharmaceuticals
			Ipratropium Bromide	00487-9801-30	Nephron Pharmaceuticals
			Ipratropium Bromide	00487-9801-60	Nephron Pharmaceuticals
			Ipratropium Bromide	66794-0002-25	RX Elite
			Ipratropium Bromide	66794-0002-30	RX Elite
			Ipratropium Bromide	66794-0002-60	RX Elite

Medicaid Physician-Administered Multiple Source Drugs *(Continued)*

HCPCS Code	Description	HCPCS Dosage	Labeler Drug Name	NDC	Labeler Name
J9000	Doxorubic HCl Injection	10 mg	Doxorubicin Hcl	63323-0101-61	American Pharmaceutical Partner
			Doxorubicin Hcl	63323-0883-05	American Pharmaceutical Partner
			Doxorubicin Hcl	63323-0883-10	American Pharmaceutical Partner
			Doxorubicin Hcl	63323-0883-30	American Pharmaceutical Partner
			Adriamycin	55390-0231-10	Bedford Laboratories
			Adriamycin	55390-0232-10	Bedford Laboratories
			Adriamycin	55390-0233-01	Bedford Laboratories
			Adriamycin	55390-0235-10	Bedford Laboratories
			Adriamycin	55390-0236-10	Bedford Laboratories
			Adriamycin	55390-0237-01	Bedford Laboratories
			Adriamycin	55390-0238-01	Bedford Laboratories
			Doxorubicin Hcl	55390-0241-10	Bedford Laboratories
			Doxorubicin Hcl	55390-0243-01	Bedford Laboratories
			Doxorubicin Hcl	55390-0245-10	Bedford Laboratories
			Doxorubicin Hcl	55390-0246-10	Bedford Laboratories
			Doxorubicin Hcl	55390-0247-01	Bedford Laboratories
			Doxorubicin Hcl	55390-0248-01	Bedford Laboratories
			Doxorubicin Hcl	00703-5040-01	SICOR
			Doxorubicin Hcl	00703-5043-03	SICOR
			Doxorubicin Hcl	00703-5046-01	SICOR
J9040	Bleomycin Sulfate Injection	15 units	Bleomycin Sulfate	55390-0005-01	Bedford Laboratories
			Bleomycin Sulfate	55390-0006-01	Bedford Laboratories
			Bleomycin Sulfate	61703-0323-22	Mayne Pharma
			Bleomycin Sulfate	61703-0332-18	Mayne Pharma
			Blenoxane	00015-3010-20	Mead Johnson and Company
			Bleomycin Sulfate	00703-3154-01	SICOR
			Bleomycin Sulfate	00703-3154-91	SICOR
			Bleomycin Sulfate	00703-3155-01	SICOR
			Bleomycin Sulfate	00703-3155-91	SICOR
J9045	Carboplatin Injection	50mg	Carboplatin	63323-0172-45	Abraxis Pharmaceutical
			Carboplatin	63323-0172-60	Abraxis Pharmaceuticals
			Carboplatin	63323-0166-10	American Pharmaceutical Partners
			Carboplatin	63323-0167-21	American Pharmaceutical Partners
			Carboplatin	63323-0168-00	American Pharmaceutical Partners
			Carboplatin	55390-0150-01	Bedford Laboratories
			Carboplatin	55390-0151-01	Bedford Laboratories
			Carboplatin	55390-0152-01	Bedford Laboratories
			Carboplatin	55390-0153-01	Bedford Laboratories
			Carboplatin	55390-0154-01	Bedford Laboratories
			Carboplatin	55390-0155-01	Bedford Laboratories
			Carboplatin	55390-0156-01	Bedford Laboratories
			Carboplatin	55390-0220-01	Bedford Laboratories
			Carboplatin	55390-0221-01	Bedford Laboratories
			Carboplatin	55390-0222-01	Bedford Laboratories
			Carboplatin	00409-1129-10	Hospira
			Carboplatin	00409-1129-11	Hospira
			Carboplatin	00409-1129-12	Hospira
			Carboplatin	61703-0339-18	Mayne Pharma
			Carboplatin	61703-0339-22	Mayne Pharma
			Carboplatin	61703-0339-50	Mayne Pharma
			Carboplatin	61703-0339-56	Mayne Pharma
			Carboplatin	61703-0339-61	Mayne Pharma
			Carboplatin	61703-0339-62	Mayne Pharma
			Carboplatin	61703-0339-63	Mayne Pharma
			Carboplatin	61703-0360-18	Mayne Pharma
			Carboplatin	61703-0360-22	Mayne Pharma
			Carboplatin	61703-0360-50	Mayne Pharma
			Carboplatin	15210-0061-12	OTN Generics
			Carboplatin	15210-0063-12	OTN Generics
			Carboplatin	15210-0066-12	OTN Generics
			Carboplatin	15210-0067-12	OTN Generics
			Carboplatin	66758-0047-01	Parenta Pharmaceutical
			Carboplatin	66758-0047-02	Parenta Pharmaceutical
			Carboplatin	66758-0047-03	Parenta Pharmaceutical

Medicaid Physician-Administered Multiple Source Drugs (Continued)

HCPCS Code	Description	HCPCS Dosage	Labeler Drug Name	NDC	Labeler Name
J9045 Continued	Carboplatin Injection	50mg	Carboplatin	50111-0965-76	PLIVA
			Carboplatin	50111-0966-76	PLIVA
			Carboplatin	50111-0967-76	PLIVA
			Carboplatin	00703-3249-11	SICOR
			Carboplatin	00703-3264-01	SICOR
			Carboplatin	00703-3266-01	SICOR
			Carboplatin	00703-3274-01	SICOR
			Carboplatin	00703-3276-01	SICOR
			Carboplatin	00703-3278-01	SICOR
			Carboplatin	00703-4244-01	SICOR
			Carboplatin	00703-4246-01	SICOR
			Carboplatin	00703-4248-01	SICOR
			Carboplatin	00591-2219-11	Watson Pharmaceuticals
			Carboplatin	00591-2220-11	Watson Pharmaceuticals
			Carboplatin	00591-3687-11	Watson Pharmaceuticals
J9060	Cisplatin Injection	10 mg	Cisplatin	63323-0103-51	American Pharmaceutical Partners
			Cisplatin	63323-0103-64	American Pharmaceutical Partners
			Cisplatin	63323-0103-65	American Pharmaceutical Partners
			Cisplatin	55390-0099-01	Bedford Laboratories
			Cisplatin	55390-0112-50	Bedford Laboratories
			Cisplatin	55390-0112-99	Bedford Laboratories
			Cisplatin	55390-0187-01	Bedford Laboratories
			Cisplatin	55390-0414-50	Bedford Laboratories
			Cisplatin	55390-0414-99	Bedford Laboratories
			Cisplatin	00703-5747-11	SICOR
			Cisplatin	00703-5748-11	SICOR
J9062	Cisplatin Injection	50 mg	Cisplatin	63323-0103-51	American Pharmaceutical Partners
			Cisplatin	63323-0103-64	American Pharmaceutical Partners
			Cisplatin	63323-0103-65	American Pharmaceutical Partners
			Cisplatin	55390-0099-01	Bedford Laboratories
			Cisplatin	55390-0112-50	Bedford Laboratories
			Cisplatin	55390-0112-99	Bedford Laboratories
			Cisplatin	55390-0187-01	Bedford Laboratories
			Cisplatin	55390-0414-50	Bedford Laboratories
			Cisplatin	55390-0414-99	Bedford Laboratories
			Cisplatin	00703-5747-11	SICOR
			Cisplatin	00703-5748-11	SICOR
J9178	Epirubicin HCl Injection	2 mg	Epirubicin	63323-0151-00	American Pharmaceutical Partners
			Epirubicin	63323-0151-05	American Pharmaceutical Partners
			Epirubicin	63323-0151-25	American Pharmaceutical Partners
			Epirubicin	63323-0151-75	American Pharmaceutical Partners
			Epirubicin	55390-0207-01	Bedford Laboratories
			Epirubicin	55390-0208-01	Bedford Laboratories
			Epirubicin	10518-0104-10	Dabur Oncology
			Epirubicin	10518-0104-11	Dabur Oncology
			Epirubicin	61703-0347-35	Mayne Pharma
			Epirubicin	61703-0348-59	Mayne Pharma
			Epirubicin	61703-0359-59	Mayne Pharma
			Epirubicin	61703-0359-01	Mayne Pharma
			Epirubicin	61703-0359-02	Mayne Pharma
			Epirubicin	61703-0359-91	Mayne Pharma
			Epirubicin	61703-0359-92	Mayne Pharma
			Epirubicin	61703-0359-93	Mayne Pharma
			Epirubicin	00009-5091-01	Pfizer
			Epirubicin	00009-5093-01	Pfizer
			Epirubicin	59762-5091-01	Pfizer
			Epirubicin	59762-5093-01	Pfizer
			Epirubicin	00703-3067-11	Sicor
			Epirubicin	00703-3069-11	Sicor

Medicaid Physician-Administered Multiple Source Drugs *(Continued)*

HCPCS Code	Description	HCPCS Dosage	Labeler Drug Name	NDC	Labeler Name
J9190	Fluorouracil Injection	500 mg	Fluorouracil	63323-0117-10	American Pharmaceutical Partners
			Fluorouracil	63323-0117-20	American Pharmaceutical Partners
			Fluorouracil	63323-0117-51	American Pharmaceutical Partners
			Fluorouracil	63323-0117-61	American Pharmaceutical Partners
			Fluorouracil	66758-0044-01	Parenta Pharm
			Adrucil	00703-3015-13	SICOR
			Adrucil	00703-3018-12	SICOR
			Adrucil	00703-3019-12	SICOR
			Fluorouracil	00187-3953-64	Valeant Pharmaceutical
J9206	Irinotecan Injection	20 mg	Irinotecan	63323-0193-02	American Pharmaceutical Partners
			Irinotecan	63323-0193-05	American Pharmaceutical Partners
			Irinotecan	10019-0934-01	Baxter Healthcare
			Irinotecan	10019-0934-02	Baxter Healthcare
			Irinotecan	10019-0934-17	Baxter Healthcare
			Irinotecan	10019-0934-79	Baxter Healthcare
			Irinotecan	55390-0295-01	Bedford Laboratories
			Irinotecan	55390-0296-01	Bedford Laboratories
			Irinotecan	10518-0103-10	Dabur Oncology
			Irinotecan	10518-0103-11	Dabur Oncology
			Irinotecan	61703-0349-09	Mayne Pharma
			Irinotecan	61703-0349-16	Mayne Pharma
			Irinotecan	61703-0349-36	Mayne Pharma
			Irinotecan	61703-0349-61	Mayne Pharma
			Irinotecan	61703-0349-62	Mayne Pharma
			Camptosar	00009-7529-01	Pfizer
			Camptosar	00009-7529-02	Pfizer
			Irinotecan	59762-7529-01	Pfizer
			Irinotecan	59762-7529-02	Pfizer
			Irinotecan	00781-3066-72	Sandoz
			Irinotecan	00781-3066-75	Sandoz
			Irinotecan	00703-4432-11	SICOR
			Irinotecan	00703-4434-11	SICOR
			Irinotecan	00703-4434-91	SICOR
			Irinotecan	00703-4437-11	SICOR
J9217	Leuprolide Acetate Suspension	7.5 mg	Eligard	00024-0222-05	Sanofi Pharmaceuticals
			Eligard	00024-0605-45	Sanofi Pharmaceuticals
			Eligard	00024-0610-30	Sanofi Pharmaceuticals
			Eligard	00024-0793-75	Sanofi Pharmaceuticals
			Lupron Depot-Ped	00300-2108-01	Tap Pharmaceuticals
			Lupron Depot-Ped	00300-2440-01	Tap Pharmaceuticals
			Lupron Depot	00300-3346-01	Tap Pharmaceuticals
			Lupron Depot	00300-3642-01	Tap Pharmaceuticals
			Lupron Depot	00300-3683-01	Tap Pharmaceuticals
J9265	Paclitaxel Injection	30 mg	Paclitaxel	55390-0314-20	Amerinet Choice
			Paclitaxel	55390-0314-50	Amerinet Choice
			Paclitaxel	00555-1984-14	Barr
			Paclitaxel	00555-1985-14	Barr
			Paclitaxel	55390-0304-05	Bedford Laboratories
			Paclitaxel	55390-0304-20	Bedford Laboratories
			Paclitaxel	55390-0304-50	Bedford Laboratories
			Paclitaxel	55390-0114-05	Bedford Laboratories
			Paclitaxel	55390-0114-20	Bedford Laboratories
			Paclitaxel	55390-0114-50	Bedford Laboratories
			Paclitaxel	55390-0314-05	Bedford Laboratories
			Paclitaxel	55390-0514-05	Bedford Laboratories
			Paclitaxel	55390-0514-20	Bedford Laboratories
			Paclitaxel	55390-0514-50	Bedford Laboratories
			Onxol	00172-3753-77	Ivax Pharmaceuticals
			Onxol	00172-3753-96	Ivax Pharmaceuticals
			Onxol	00172-3754-73	Ivax Pharmaceuticals
			Onxol	00172-3754-94	Ivax Pharmaceuticals
			Onxol	00172-3756-75	Ivax Pharmaceuticals
			Onxol	00172-3756-95	Ivax Pharmaceuticals
			Paclitaxel	61703-0342-09	Mayne Pharma
			Paclitaxel	61703-0342-22	Mayne Pharma
			Paclitaxel	61703-0342-50	Mayne Pharma

Medicaid Physician-Administered Multiple Source Drugs *(Continued)*

HCPCS Code	Description	HCPCS Dosage	Labeler Drug Name	NDC	Labeler Name
J9265	Paclitaxel Injection	30 mg	Taxol	00015-3475-30	Mead Johnson and Co
			Taxol	00015-3476-30	Mead Johnson and Co
			Taxol	00015-3479-11	Mead Johnson and Co
			Paclitaxel	00703-4767-01	SICOR
			Paclitaxel	00703-4766-01	SICOR
J9293	Mitoxantrone HCI Injection	5 mg	Mitoxantrone Hydrochloride	63323-0132-10	American Pharmaceutical Partners
			Mitoxantrone Hydrochloride	63323-0132-12	American Pharmaceutical Partners
			Mitoxantrone Hydrochloride	63323-0132-15	American Pharmaceutical Partners
			Mitoxantrone Hydrochloride	55390-0083-01	Bedford Laboratories
			Mitoxantrone Hydrochloride	55390-0084-01	Bedford Laboratories
			Mitoxantrone Hydrochloride	55390-0085-01	Bedford Laboratories
			Mitoxantrone Hydrochloride	10518-0105-10	Dabur Laboratories
			Mitoxantrone Hydrochloride	10518-0105-11	Dabur Laboratories
			Mitoxantrone Hydrochloride	10518-0105-12	Dabur Laboratories
			Mitoxantrone Hydrochloride	61703-0343-18	Mayne Pharma
			Mitoxantrone Hydrochloride	61703-0343-65	Mayne Pharma
			Mitoxantrone Hydrochloride	61703-0343-66	Mayne Pharma
			Mitoxantrone Hydrochloride	15210-0403-35	OTN Pharmaceuticals
			Mitoxantrone Hydrochloride	15210-0403-36	OTN Pharmaceuticals
			Mitoxantrone Hydrochloride	15210-0403-37	OTN Pharmaceuticals
			Novantvone	44087-1520-01	Serono Inc
			Mitoxantrone Hydrochloride	00703-4680-01	Sicor
			Mitoxantrone Hydrochloride	00703-4680-91	Sicor
			Mitoxantrone Hydrochloride	00703-4685-01	Sicor
			Mitoxantrone Hydrochloride	00703-4685-91	Sicor
			Mitoxantrone Hydrochloride	00703-4686-01	Sicor
			Mitoxantrone Hydrochloride	00703-4686-91	Sicor
			Mitoxantrone Hydrochloride	00703-4680-01	Sicor
J9390	Vinorelbine Tartrate Injection	10 mg	Vinorelbine Tartrate	63323-0148-01	American Pharmaceutical Partners
			Vinorelbine Tartrate	63323-0148-05	American Pharmaceutical Partners
			Vinorelbine Tartrate	55390-0069-01	Bedford Laboratories
			Vinorelbine Tartrate	55390-0070-01	Bedford Laboratories
			Vinorelbine Tartrate	55390-0267-01	Bedford Laboratories
			Vinorelbine Tartrate	55390-0268-01	Bedford Laboratories
			Vinorelbine Tartrate	61703-0341-06	Mayne Pharma
			Vinorelbine Tartrate	61703-0341-09	Mayne Pharma (USA)
			Vinorelbine Tartrate	66758-0045-01	Parenta Pharmaceuticals
			Vinorelbine Tartrate	66758-0045-02	Parenta Pharmaceuticals
			Vinorelbine Tartrate	64370-0210-01	Pierre Fabre
			Vinorelbine Tartrate	64370-0250-01	Pierre Fabre
			Vinorelbine Tartrate	00703-4182-01	SICOR
			Vinorelbine Tartrate	00703-4182-81	SICOR
			Vinorelbine Tartrate	00703-4182-91	SICOR
			Vinorelbine Tartrate	00703-4183-01	SICOR
			Vinorelbine Tartrate	00703-4183-81	SICOR
			Vinorelbine Tartrate	00703-4183-91	SICOR

Appropriate Utilization of Dispense As Written (DAW) Codes

Dispense As Written (DAW) product selection codes are an integral part of accurate billing to the Alabama Medicaid Agency and provide the agency with the reason why a specific brand or generic is dispensed based on the prescriber's instructions. Failure to accurately use DAW codes results in misinformation to the Pharmacy program and its decision making process. Misinformation on claims may also result in retrospective pharmacy review and/or recoupment. Inaccurate usage of DAW codes is among one of the discrepancies found during an audit and is one of the Primary Pharmacy Audit Components listed in the Provider Billing Manual Section 27.2.5. The following codes are the various DAW codes available to the Alabama Medicaid Pharmacy program with explanations that have been taken from the National Council on Prescription Drug Programs (NCPDP) version 5.1 data dictionary for field 408-D8 Product Selection Codes. Providers should utilize the correct codes based upon the information submitted on the prescription and the prescriber's signature.

Ø=No Product Selection Indicated - This is the field default value that is appropriately used for prescriptions where product selection is not an issue. Examples include prescriptions written for single source brand products and prescriptions written using the generic name and a generic product is dispensed.

1=Substitution Not Allowed by Prescriber - This value is used when the prescriber indicates, in a manner specified by prevailing law, that the product is to be Dispensed As Written.

2=Substitution Allowed-Patient Requested Product Dispensed - This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the patient requests the brand product. This situation can occur when the prescriber writes the prescription using either the brand or generic name and the product is available from multiple sources. (Not permitted by Alabama Medicaid)

3=Substitution Allowed-Pharmacist Selected Product Dispensed - This value is used when the prescriber has indicated, in a manner specified by prevailing law , that generic substitution is permitted and the pharmacist determines that the brand product should be dispensed. This can occur when the prescriber writes the prescription using either the brand or generic name and the product is available from multiple sources.

4=Substitution Allowed-Generic Drug Not in Stock - This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the brand product is dispensed since a currently marketed generic is not stocked in the pharmacy. This situation exists due to the buying habits of the pharmacist, not because of the unavailability of the generic product in the marketplace.

5=Substitution Allowed-Brand Drug Dispensed as a Generic - This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the pharmacist is utilizing the brand product as the generic entity.

6=Override (Not permitted by Alabama Medicaid)

7=Substitution Not Allowed-Brand Drug Mandated by Law - This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted but prevailing law or regulation prohibits the substitution of a brand product even though generic versions of the product may be available in the marketplace.

8=Substitution Allowed-Generic Drug Not Available in Marketplace - This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the brand product is dispensed since the generic is not currently manufactured, distributed, or is temporarily unavailable.

9=Other (Not permitted by Alabama Medicaid)

To indicate instructions to the dispensing pharmacy, a physician simply signs the prescription in a manner specified by prevailing law to indicate to a providing pharmacy whether or not generic substitution is allowed. Effective May 1, 2008 an override form and Medwatch 3500 form is required in order to medically justify a provider's reason for requesting a branded product when an exact generic equivalent is available. DAW overrides and the Medwatch 3500 form should be submitted to Health Information Designs. For more information or administrative questions regarding the DAW requirements, providers may call the Pharmacy Services unit at (334) 242-5050.

Sterilization Claim & Primary Surgeon's Responsibility

It is the responsibility of the performing surgeon to submit a copy of the sterilization consent form to EDS. Providers other than performing surgeon should not submit a copy of consent form to EDS. Receipt of multiple consent forms slows down the consent from review process and payment of claims. Therefore, please do not forward copies of completed consent forms to other providers for submission to EDS.

When the claim for the sterilization procedure is submitted to EDS, the claim will suspend in the system for 21 days waiting for the approved consent form to be entered. The Saturday after the claim is keyed into the system, it will check to see if the consent form has been entered. It will check the system each Saturday , up to 21 days, for the approved consent form. After the 21st day , the claim will deny for no consent form on file. If the approved consent form is found in the system during the 21 days, it will process the claim on the Saturday it finds the form.

Sterilization Consent Form

The provider must submit a copy of the recipient's signed sterilization consent form to EDS. EDS wil**NOT** pay any claims to ANY provider until a correctly completed appropriate form is on file at EDS. **All blanks on the consent form must be appropriately completed before Medicaid pays the provider for the sterilization procedure.** The only exception is the "Race and Ethnicity ," and the "T itle of the person obtaining consent" designation which is optional. Clarification of the completion of the sterilization consent form reflecting CMS regulations andAlabama Medicaid policy (refer to the current Appendix C of the Alabama Medicaid Provider Manual and 42CFR50 Revised October 1, 2001) located on *www.medicaid.alabama.gov*.

Essure Method of Sterilization Guidelines

The Essure method of sterilization is restricted to Prior Approval and **also requires a sterilization consent form**. As a reminder the criteria for prior approval are as follows:

This procedure must be performed in an outpatient setting and the patient must meet one of the following criteria:

- Morbid obesity (BMI of 45 or greater)
- Abdominal mesh that mechanically interfaces with laparoscopic tubal ligation sterilization procedures
- Permanent colostomy with documented adhesions
- Multiple abdominal/pelvic surgeries with documented severe adhesions
- Artificial heart valve requiring continuous anticoagulation
- Other severe medical problems that would be a contraindication to laparoscopic tubal ligation procedures based on medical documentation submitted.

Sterilization Consent Form

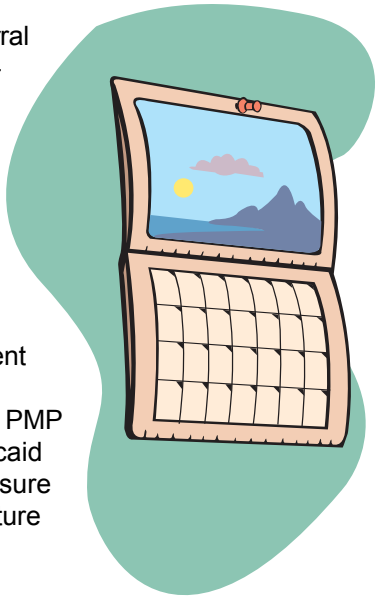
Most frequent causes of claims having to be returned for correction:

1. Patient's date of birth not the same on the claim and consent form.
2. Expected date of delivery not provided when the sterilization procedure is performed less than the required 30-day waiting period.
3. Expected date of delivery is recorded but indicator for premature delivery or emergency surgery is not checked.
4. All blanks not appropriately completed.
5. Physician's stamp signature not initialed by physician.
6. Date of sterilization not the same on the claim and on the consent form
7. Legibility of dates and signatures.
8. Facility name not on the consent form.

Reasons consent forms and associated claims will be denied:

1. Missing recipient signature
2. Missing or invalid date of recipient signature, including less than 30 days prior to procedure
3. Recipient under age 21 on date consent form was signed
4. Missing signature of person obtaining consent
5. Missing or invalid date of person obtaining consent, including date of procedure, or any later date
6. Missing interpreter signature (if one was used)
7. Legibility of dates and signatures.
8. Missing or invalid date of interpreter, including any date other than the date the recipient signed (if one was used)

Indicating Correct NPI on Referral Forms



When a recipient is assigned to a PMP and must be referred to another provider, the referral should indicate the NPI number of the ASSIGNED PMP. The referral should follow the recipient to the consulting provider and if cascading, should follow the recipient to any other providers the recipient receives services from based on the original referral.

There are occasions which allow recipients assigned to clinics that operate under one organization to obtain services at other "sister" clinics within that organization. If this is the case, it is essential for the "sister" clinic providing the service to indicate the NPI number of the clinic where the recipient is assigned and not their own NPI number. While seeing one another's recipients is acceptable it is recommended steps be taken to assign recipients to the clinic where the majority of their services will be obtained.

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). Additionally, it is the responsibility of the PMP to complete and submit the referral form correctly and in a timely manner. Verifying Medicaid eligibility and current PMP assignments will assist providers in completing referrals and ensure those referrals received are from the assigned PMP. This should lessen the chances of future claims denying due to incorrect referrals.

Providers Must Screen for Excluded Individuals

The HHS Office of Inspector General (HHS-OIG) excludes individuals and entities from participation in Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), and all Federal health care programs (as defined in section 1128B(f) of the Social Security Act (the Act)) based on the authority contained in various sections of the Act, including sections 1128, 1128A, and 1156.

When the HHS-OIG has excluded a provider, Federal health care programs (including Medicaid and SCHIP programs) are generally prohibited from paying for any items or services furnished, ordered, or prescribed by excluded individuals or entities (Section 1903(i)(2) of the Act; and 42 CFR section 1001.1901(b)). This payment ban applies to any items or services reimbursable under a Medicaid program that are furnished by an excluded individual or entity, and extends to:

- All methods of reimbursement, whether payment results from itemized claims, cost reports, fee schedules, or a prospective payment system
- Payment for administrative and management services not directly related to patient care, but that are a necessary component of providing items and services to Medicaid recipients, when those payments are reported on a cost report or are otherwise payable by the Medicaid program
- Payment to cover an excluded individual's salary, expenses or fringe benefits, regardless of whether they provide direct patient care, when those payments are reported on a cost report or are otherwise payable by the Medicaid program.

In addition, no Medicaid payments can be made for any items or services directed or prescribed by an excluded physician or other authorized person when the individual or entity furnishing the services either knew or should have known of the exclusion. This prohibition applies even when the Medicaid payment itself is made to another provider, practitioner or supplier that is not excluded. (42 CFR section 1001.1901(b))

The listing below sets forth some examples of types of items or services that are reimbursed by Medicaid which, when provided by excluded parties, are not reimbursable:

- Services performed by excluded nurses, technicians, or other excluded individuals who work for a hospital, nursing home, home health agency or physician practice, where such services are related to administrative duties, preparation of surgical trays or review of treatment plans if such services are reimbursed directly or indirectly (such as through a pay per service or bundled payment) by a Medicaid program, even if the individuals do not furnish direct care to Medicaid recipients;
- Services performed by excluded pharmacists or other excluded individuals who input prescription information for pharmacy billing or who are involved in any way in filling prescriptions for drugs reimbursed, directly or indirectly, by a Medicaid program;
- Services performed by excluded ambulance drivers, dispatchers and other employees involved in providing transportation reimbursed by a Medicaid program, to hospital patients or nursing home residents;

(Continued on page 7)

Providers Must Screen for Excluded Individuals (Continued from page 6)

- Services performed for program recipients by excluded individuals who sell, deliver or refill orders for medical devices or equipment being reimbursed by a Medicaid program;
- Services performed by excluded social workers who are employed by health care entities to provide services to Medicaid recipients, and whose services are reimbursed, directly or indirectly, by a Medicaid program;
- Services performed by an excluded administrator, billing agent, accountant, claims processor or utilization reviewer that are related to and reimbursed, directly or indirectly by a Medicaid program;
- Items or services provided to a Medicaid recipient by an excluded individual who works for an entity that has a contractual agreement with, and is paid by, a Medicaid program; and
- Items or equipment sold by an excluded manufacturer or supplier, used in the care or treatment of recipients and reimbursed, directly or indirectly, by a Medicaid program.

To further protect against payments for items and services furnished or ordered by excluded parties, all current providers and providers applying to participate in the Medicaid program **must** take the following steps to determine whether their employees and contractors are excluded individuals or entities:

- Screen all employees and contractors to determine whether any of them have been excluded. Providers can accomplish this by searching the exclusion list located on the Alabama Medicaid Agency's website. Providers must check the list prior to hiring staff and again monthly to ensure that existing staff have not been excluded from participation in the program since the last search.
- Search the HHS-OIG website by the names of any individual or entity. Providers must search the HHS-OIG website monthly to capture exclusions and reinstatements that have occurred since the last search.
- Providers must immediately report to Medicaid's Program Integrity Division any exclusion information discovered.

Civil monetary penalties may be imposed against Medicaid providers and managed care entities (MCEs) who employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid recipients (Section 1128A(a)(6) of the Act; and 42 CFR section 1003.102(a)(2)).

Where Providers Can Look for Excluded Parties

The HHS-OIG maintains the List of Excluded Individuals/Entities (LEIE), a database accessible to the general public that provides information about parties excluded from participation in Medicare, Medicaid, and all other Federal health care programs. The LEIE website is located at *http://www.oig.hhs.gov/fraud/exclusions.asp* and is available in two formats. The on-line search engine identifies currently excluded individuals or entities. When a match is identified, it is possible for the searcher to verify the accuracy of the match using a Social Security Number (SSN) or Employer Identification Number (EIN). The downloadable version of the database may be compared against an existing database maintained by a provider. However, unlike the on-line format, the downloadable database does not contain SSNs or EINs.

Additionally, Medicaid maintains an exclusion list, pursuant to 42 CFR section 1002.210, which include individuals and entities whom the State has barred from participating in State government programs. The exclusion list is located on the Medicaid website under the Fraud/Abuse Prevention tab. A link to the LEIE website is also available under the Fraud/Abuse Prevention tab. Providers are obligated to routinely search these lists.

State Fiscal Year 2009-2010 Checkwrite Schedule

04/03/09	07/10/09
04/17/09	07/24/09
05/01/09	08/07/09
05/15/09	08/21/09
06/05/09	09/04/09
06/19/09	09/11/09

Clarification Concerning Billing NDCs for HCPCS Drug Code

When a patient receives two injections of the same drug from different vials (different sizes), there are two different NDCs. The provider will need to include the unit of measure, the unit quantity , and the unit price for each NDC.

Claims for multiple NDCs to one HCPCS drug code, must be filed electronically and cannot be filed on paper.

When billing for a single NDC to HCPCS drug code, then the provider does not have to include the unit of measure, the unit quantity , and the unit price for the NDC.

The information contained within is subject to change. Please review your Provider Manual and all Provider Alerts for the most up to date information.

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Alabama Medicaid Bulletin **July 2009**

The checkwrite schedule is as follows:

07/10/09 07/24/09 08/07/09 08/21/09 09/04/09 09/11/09

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

Recoupment of Medicare-Related Claims on July 10, 2009 Remittance Advice

Claims paid between March 2008 and April 2009 with zero in the Medicare paid amount field will be recouped and denied for error message 8134 on the July 10, 2009 remittance advice. If Medicare limits have been exhausted and there is no Medicare payment, then Medicaid has no liability on the claim either

If your claim contains denial code 8134, and the claim is **WITHIN** the time filing limitation, you will need to resubmit these claims to EDS for payment with the correct MEDICARE information.

However, if your claim is **PAST** the time filing limitation you will need to:

- Complete a paper claim*
- Indicate "Medicaid recouped 07/10/09" in the "Remarks" box,
- Attach a copy of the July 10, 2009, RA showing the denial,
- Send claim and attachment to:

  Alabama Medicaid Agency
  Attention: System Support/Administrative Review
  P.O. Box 5624
  Montgomery, AL 36103

Administrative Review material must be received on or before October 31, 2009.

***Note**:

Professional claims should be submitted on the CMS-1500 Medicare/ Medicaid Related claim form. Inpatient claims should be submitted on a UB-04 claim form with the appropriate value codes in form locators 39-41.

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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 _____*

Obtaining Medicaid Recipient Identification Numbers

Providers can obtain a recipient's Medicaid Identification Number (RID) in one of two ways. All Medicaid providers have access to the Medicaid Provider Assistance Center at 1-800-688-7989 (out of state providers (334) 215-0111. The provider or the provider's representative can call the Medicaid Provider Assistance Center and with proper provider identification, the Provider Assistance Center can research the recipient's identification number and give it to the provider . The provider can also use the web portal to obtain the recipient's identification number.

Providers should not request that recipients contact the Recipient Call Center to obtain their RID. The Recipient Call Center personnel can not give out this information over the telephone.

Attention Eyecare Providers

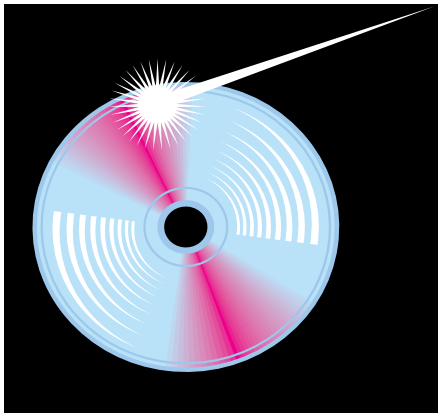
When requesting prior authorization for frames, lens exam and fit, the prior authorization type of AL (Vision Optometry) is required for both electronic and paper prior authorizations.

Visit Alabama Medicaid

ONLINE

www.medicaid.alabama.gov

New Version of Provider Electronic Solutions Now Available



Version 2.12 of the Provider Electronic Solutions software, upgrade and full install along with the billing manual, can be downloaded from the Medicaid website. The address for the website is *www.medicaid.alabama.gov*. Click 'billing,' scroll down to the software download section, and download the software. When applying the upgrade, you must upgrade to 2.11 before attempting to upgrade to 2.12. For further assistance, or to request the software on CD, contact the EMC helpdesk at 1-800-456-1242 or e-mail address: *alabamasystemsemc@eds.com*.

The new version of the software contains the following changes:

- All Crossover Claim Forms - Added a self-edit to the software to prevent saving Medicare Cross-over claims with zero in the Medicare Paid Amount field AND Medicare Deductible Amount field (one or both fields has to have a value greater than zero)
- OP Institutional Form - Added the fields to allow users to submit OP surgery claims using ICD-9 procedure codes
- Eligibility Verification Response - Corrected the display of used dental benefits on Eligibility Verification responses
- Provider List Builder - Removed the Medicaid ID from the COPY feature on the Provider List Builder
- Remember, users MUST be at version 2.11 before attempting to upgrade to 2.12.

Congratulations to Providers with Exceptional Vaccination Coverage Rates

During 2008, Alabama Department of Public Health (ADPH) staff performed VFC-AFIX quality improvement visits to VFC provider clinics. These visits allowed ADPH staff to determine if VFC providers are following VFC guidelines, to offer education and CEU credits for clinic staff, and to determine vaccine coverage levels of the clinic. As acknowledged for the first time in 2007, the results indicated 2008 VFC site visits for those clinics that achieved vaccine coverage levels of 100 percent, over 90 percent, and over 80 percent. The ADPH, Immunization Division, congratulates these VFC providers for an excellent accomplishment in 2008.

The Alabama VFC Program appreciates the knowledge and experience the providers exhibit in their daily preventive healthcare practice. Thank you for your outstanding performances!

Endovenous Laser Ablation of Varicose Veins and Endoluminal Radiofrequency Ablation of Saphenous Varicose Veins

Effective July 1, 2009, the following procedure codes will require prior authorization in order to determine medical necessity and reimbursement consideration before services are rendered to the recipient:

1. Procedure codes 36478 (Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated, and add on code 36479 (second and subsequent veins treated in a single extremity, each through separate access sites) should only be billed along with the primary code (36478).

2. Procedure codes 36475 (Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated, and Add on code 36476 (second and subsequent veins treated in a single extremity, each through separate access sites) should only be billed along with the primary code (36475).

These procedures are not covered by Medicaid for cosmetic purposes.

Changing Procedure Codes on Radiology Prior Authorizations for CT Scans, MR Scans and PET Scans

Effective June 22, 2009, providers will be allowed 30 days from the date of service to:

- change a code from "without contrast," to a code in the same family "with contrast" or "with and without contrast" or
- change a code from "with contrast" or "with and without contrast," to a code in the same family "without contrast" or
- add a study to radiology procedures when the Prior Authorization has already been obtained.

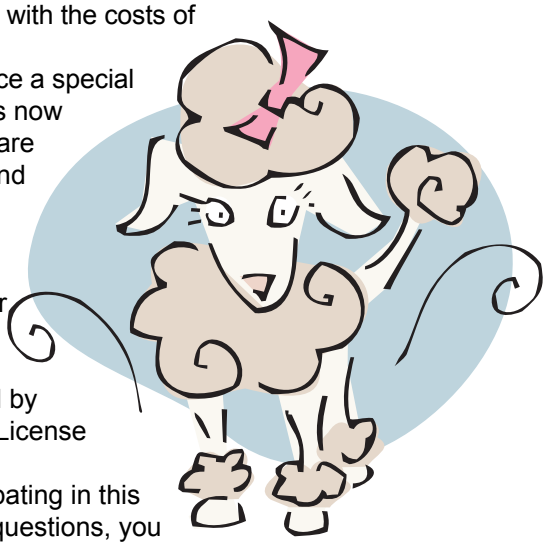
The ordering provider (physician's office) or the performing provider (facility) must call Medsolutions at 1-888-693-3211 to request that a code be changed. For changing a code to a higher code (from without contrast, to with contrast , or to with and without contrast), or adding a study Medsolutions will continue to review criteria for medical necessity before approval.

Providers with questions may contact Teresa Thomas, Program Manager, Lab/X-ray services by phone at (334) 242-5048 or by email at *teresa.thomas@medicaid.alabama.gov.*

Financial Help for Spaying and Neutering Your Pets Available Statewide

The Alabama Veterinary Medical Association (ALVMA) and The Alabama Veterinary Medical Foundation (ALVMF) are pleased to announce a new program available for Medicaid recipients to help with the costs of spaying and neutering their pets.

In November of 2007, the ALVMA and ALVMF began a campaign to produce a special car license plate encouraging the spaying and neutering of pets. The plate is now available to Alabama residents. Proceeds from the sale of the special plate are being used to help Medicaid pet owners underwrite the cost of these spay and neuter procedures for their cat or dog.



A co-pay of $10 per cat or $20 per dog must be paid by the Medicaid recipient but the remaining balance is paid through a grant from the Foundation. There is a limit of two (2) animals per household and proof of your Medicaid status and identification must be presented before any procedure is performed.

There is a map locator for participating veterinarians and it can be found by going to *www.alvma.com* and following the instructions under "Spay/Neuter License Plate Surgery Program."

Currently there are nearly 100 veterinary clinics around the state participating in this program. Additional programs are available at *www.spayalabama.org* or for questions, you may call toll free 866-9SPAYAL (866-977-2925).

State Fiscal Year 2009-2010 Checkwrite Schedule

~~10/03/08~~	~~01/02/09~~	~~04/03/09~~	07/10/09
~~10/17/08~~	~~01/16/09~~	~~04/17/09~~	07/24/09
~~11/07/08~~	~~02/06/09~~	~~05/01/09~~	08/07/09
~~11/21/08~~	~~02/20/09~~	~~05/15/09~~	08/21/09
~~12/05/08~~	~~03/06/09~~	~~06/05/09~~	09/04/09
~~12/12/08~~	~~03/20/09~~	~~06/19/09~~	09/11/09

EDS

Alabama Medicaid Bulletin

Post Office Box 244032
Montgomery, AL 36124-4032

PRSRT STD
U.S. POSTAGE
PAID
PERMIT # 77
MONTGOMERY AL

Provider *Insider*

Alabama Medicaid Bulletin **October 2009**

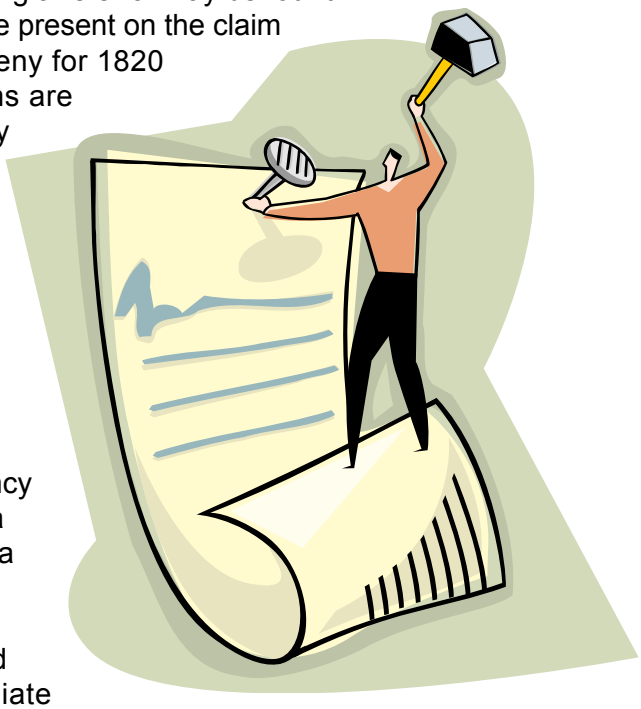
The checkwrite schedule is as follows:

10/02/09 10/23/09 11/06/09 11/20/09 12/04/09 12/18/09

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

EDS Identifies Top Five Denials for Physician Claims

EDS has conducted a recent review of the Top 5 denials for physician claims. Denial Code 1820 (Patient 1st claim requires a referral) remains a top denial. Please remember , a referral must be obt ained for services when a referral is required. A list of services requiring a referral may be found in chapter 39 of the provider billing manual. The referral must be present on the claim when it is billed. If a referral is not present, the claim will deny for 1820 (Patient 1st claim requires a referral). A top reason claims are denying for a Patient 1st referral is when the claim is originally being filed, the referral is being omitted from the claim. Claims are then corrected and re-filed using the appropriate Patient 1st referral. This rejection could be prevented by including the referral on the claim upon first submission.



If a physician or hospital uses an outside billing company to perform billing services, it is imperative that a communication system exist to provide the billing company with appropriate referral information prior to billing claims.

Hospitals and physicians which provide certified emergency services in the emergency room are not required to have a referral from the PMP . Please note a certified emergency is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual in serious jeopardy, serious impairment to body functions, or serious dysfunction of any bodily organ or part.

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Pass It On!

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Review Of Neonatal Critical Care Codes

A neonatologist is allowed to bill for one visit per day for a patient. However, provisions are made to allow an initial hospital care (procedure codes 99221, 99222 or 99223) to be billed on the initial date of service with a critical care code OR in lieu of the initial hospital code, an EPSDT Screening (99233-EP) may be billed in addition to the appropriate critical care code. HOWEVER, BOTH AN INITIAL HOSPITAL CARE AND EPSDT SCREENING CANNOT BE BILLED. One EPSDT screen for the hospitalization will encompass all diagnoses identified during the hospital stay for referral purposes. There is no provision for an EPSDT screen and a subsequent pediatric critical care visit (99469) to be paid on the same date of service. These guidelines are outlined in Chapter 28 of the Provider Manual.

Resuscitation / Standby / Attendance At Delivery

Standby (99360), or resuscitation (99465), or attendance at delivery (99464) may be billed in addition to critical care. Only one of these codes may be billed in addition to neonatal intensive care critical care codes on the initial date of service. Chapter 28 of the Provider Manual details these codes and the visit codes.

Friendly Reminder Regarding Procedure D4355

Procedure code D4355 is covered only when subgingival and/or supragingival plaque and calculus obstruct the ability to perform a comprehensive oral evaluation.

REMINDER

This is a reminder that the annual ICD-9-CM update will be effective for dates of service on or after October 1, 2009.

Attention DME Providers

Effective October 1, 2009, all Medicare DME providers are required to have Medicare accreditation and meet the Medicare Surety Bond requirement as of October 2, 2009. Alabama Medicaid Agency's DME providers must comply with Medicare rules and regulations in order to become a Medicaid provider or continue enrollment in the Durable Medical Equipment (DME) Program. Medicare DME providers are required to have a $50,000 Surety Bond. Failure of Medicare DME providers to comply with these requirements will result in their termination from the Alabama Medicaid Program.

All Medicaid DME providers must submit copies of their Medicare Accreditation and their Medicare Surety Bonds by October 31, 2009, to the Alabama Medicaid Agency at the following address:

Alabama Medicaid Agency
Long Term Care Policy Advisory Unit
Attention: Dodie Teel
501 Dexter Avenue
Montgomery, Alabama 36104-3744

Effective October 1, 2010, all Alabama DME providers will be required to acquire a $50,000 Medicaid Surety Bond for each of their DME store locations.

Prior authorization requests for wheelchairs and other DME items received with Julian date July 1, 2009, and thereafter, will no longer require providers to submit signed delivery tickets for wheelchairs and other DME items to Alabama Medicaid before the prior authorization (P A) request is placed in an approved status in the Alabama Medicaid Interchange P A System. However, a signed delivery ticket must be in the recipient's record for auditing purposes. If a recipient's record is audited and there is no signed delivery ticket showing proof of delivery of the wheelchair and other DME items, Alabama Medicaid will recoup all monies paid for the wheelchair and other DME items.

If you have additional questions or need further clarification, please contact Ida Gray at (334) 353-4753 or Robin Arrington at (334) 353-4754.

EDS Identifies Top 5 Denials for Physician Claims

(Continued from page 1)

When sending certified emergency information electronically through a vendor the information must be in the following loop for 837 claims:

Service Authorization Exception Code - Loop 2300 - Segment REF

When using Provider Electronic Solutions for professional claims (837P), a service authorization indicator of a 3 must be selected from the Header 2 tab. Selecting the emergency indictor of a Y on the Detail one header will not certify your claim as an emergency. When using Provider Electronic Solutions for institutional outpatient claims (837I), a service authorization indicator of a 3 must be selected from the Header 3 tab.

When using the Medicaid Interactive Web Portal for professional claims (837P), a service authorization code of a 3 must be selected from the header portion of the claim form. Selecting the emergency indicator of a Y on the detail line will not certify your claim as an emergency. When using the Medicaid Interactive Web Portal for instutional outpatient claims (837), a service authorization indicator of a 3 must be selected from the header portion of the claim form.

If you have any questions, please contact your Provider Representative at 1-800-688-7989.

New Adolescent Protection: Part Three

Vaccination against tetanus, diphtheria, and pertussis has greatly reduced the number of cases and deaths among all U.S. age groups. Approximately 10-20% of tetanus cases and 5-10% of diphtheria cases resulted in death. In 2005, 72 cases of pertussis were reported in Alabama. Tetanus differs from other vaccine preventable disease (VPDs) in that it is not contagious. Tetanus is an acute disease of the nervous system caused by an exotoxin produced by the bacterium Clostridium tetani. C. tetani usually enters the body through a wound or break in the skin. C. tetani spores are widely distributed in soil and the intestines and feces of dogs, cats, rats, guinea pigs, chickens, horses, cattle, and sheep. The incubation period depends upon the site of injury in proximity to the central nervous system (CNS). In general, the farther the injury site is from the CNS, the longer the incubation period. Three forms of tetanus involving the cranial nerves have been described: local, cephalic and generalized. Cephalic tetanus is rare. Local tetanus is uncommon affecting persistent contraction of muscles in the same anatomic area as the injury. Generalized tetanus is the most common type (80%) in which the disease usually presents with a descending pattern (moving from jaw to neck to rigidity of abdominal muscles). There is no laboratory findings characteristic of tetanus and the diagnosis is entirely clinical.

In addition to tetanus, adolescents must be properly vaccinated against diphtheria. Diphtheria is an acute toxin-mediated disease caused by the bacterium Corynebacterium diphtheriae. Transmission is through direct intimate respiratory contact. Diphtheria clinical features may involve any mucous membrane and is based on site of infection since it is imperative to begin presumptive therapy quickly. Classical sites of infection are anterior nasal (mucopurulent nasal discharge), pharyngeal/tonsillar (insidious onset of exudative pharyngitis with exudate spreading within 2-3 days), laryngeal (fever, hoarseness, barking cough), cutaneous (scaling rash or ulcers with demarcated edges), ocular (conjunctiva), and genital (vulvovaginal). Laboratory diagnosis confirmation is done through culture of the lesion although diagnosis is made on clinical presentation. Another common VPD is pertussis. Pertussis, or whooping cough, is an acute disease caused by the bacterium Bordetella pertussis and is highly contagious. The bacteria attach to cilia of the respiratory epithelial cells and ultimately interfer with the clearing of pulmonary secretions. Transmission occurs through direct contact with discharges from infected respiratory mucous membranes.

The three stages of the clinical course of the illness are catarrhal (insidious onset of coryza, sneezing), paroxysmal (cough stage in which diagnosis is usually suspected, posttussive vomiting), and convalescence (recovery is gradual usually 2-3 weeks). The diagnosis is based on a clinical history (cough for more than 2 weeks with whoop, paroxysms, or posttussive vomiting) and a variety of laboratory tests (culture, polymerase chain reaction [PCR], direct fluorescent antibody [DFA] and serology). Although a culture is considered the gold standard laboratory test, growth requirements for B. pertussis are difficult to culture. Specimens must be collected correctly (posterior nasopharynx). Cultures are variably positive (30-50%) and take as long as 2 weeks. In comparison to a culture, the PCR test has an increased sensitivity and faster reporting of results. PCR should be used in addition to a culture. No PCR product has been FDA approved. Like a culture, PCR is also affected by specimen collection.

Tetanus-diphtheria-acellular pertussis vaccine (Tdap) is an improvement to the conventional Td booster, because it adds protection from whooping cough while still maintaining protection from tetanus and diphtheria. Tdap is administered intramuscularly. All adolescents 11-18 years of age should get one booster dose of Tdap. Adolescents who have already gotten a booster dose of Td are encouraged to get a dose of Tdap for protection against pertussis. Waiting at least 5 years between Td and Tdap is encouraged, but not required. A dose of Tdap is recommended for all adolescents at their 11 or 12 year old check-up if 5 years have elapsed since last dose DTaP/DTP. Adolescents who did not get all their scheduled doses of DTaP or DTP as children should complete the series using a combination of Td and Tdap. Please call 1-866-674-4807 with the Vaccines for Children program for additional information or visit the Alabama Department of Public Health, Immunization Division at *www.adph.org*.

Flu Season is Here!

Annual influenza vaccination is the most effective method for preventing influenza virus infection and its complications. Flu vaccination is a covered service for eligible recipients. According to the CDC, the following changes or updates are recommended for 2009:

- Annual vaccination of all children aged 6 months—18 years should begin as soon as the 2009-2010 influenza vaccine is available. Annual vaccination of all children aged 6 months – 4 years and older children with conditions that place them at increased risk for complications from influenza should continue to be a primary focus of vaccination efforts as providers and programs transition to routinely vaccinating all children.
- The 2009-2010 trivalent vaccine virus strains are A/Brisbane/59/2007 (H1N1)-like, A/Brisbane/10/2007 (H3N2)-like, and B/Brisbane 60/2008-like antigens.
- Most seasonal influenza A (H1N1) virus strains tested from the United States and other countries are now resistant to oseltamivir. Recommendations for influenza diagnosis and antiviral use will be published later in 2009. CDC issued interim recommendations for antiviral treatment and chemoprophylaxis of influenza in December 2008, and these should be consulted for guidance pending recommendations from CDC's Advisory Committee on Immunization Practices (ACIP). The interim recommendations are available at *http://www2a.cdc.gov/HAN/ArchivesSys/ViewMsgV.asp?AlertNum=00279*.

ALABAMA MEDICAID

In The Know

General Information Providers Need to Know When Billing to the Alabama Medicaid Agency

What is a BPA Error?

When billing a claim, some of the terminology may be confusing to providers. The following is a list of terms and their definitions to help providers understand why claims are denying:

BPA – Benefit Plan Administration – Identifies a specific group of audits used in claims processing.

RP – Recipient Plan – The type of Medicaid coverage a recipient is eligible to receive. Based on eligibility criteria, recipients may be eligible for full Medicaid benefits, or for certain services only. A recipient's age, health care requirements, and place of residence may further define his or her eligibility for Medicaid programs or services. Additionally, a recipient's history of Medicaid benefits may render him or her eligible or ineligible for specific programs or services. For these reasons, it is very important that the providers verify recipient eligibility and ensure they understand all aspects of the eligibility response. Chapter 3 of the provider billing manual provides additional information on recipient eligibility

PC – Program Code or Provider Contract – Providers are assigned contracts and specialties which allow procedures to be reimbursed by provider type. Assignments are made based on certifications and licensure information. Chapter 2 of the provider billing manual provides additional information on be coming a Medicaid provider

RR – Reimbursement Rules – Rules established regarding reimbursement for a procedure. This includes restrictions by provider type, provider specialty or claim type.

DIAG – Diagnosis codes – The diagnosis code billed is not covered for the service rendered. This could be based on the recipient plan or procedure code. This could also include restrictions on the recipient benefit plan or procedure code

ICD9 – The ICD-9 surgical procedure codes – the audit is addressing the requirements for billing these codes

MOD – Modifiers – The modifier being billed is not allowable or not valid for the service performed

NDC – The National Drug Code assignment – The NDC being billed is not valid or non-covered

PROC – The HCPC or CPT-4 Procedure codes – The audit is addressing the requirements for the procedure code being billed

Listed below are some examples of BPA errors that may occur on a remittance advice:

Example 1: BPA – RP – PROC – No coverage

This error is stating no coverage for the procedure code billed based upon the recipient's benefit plan. This could be an error received by a hospital when trying to bill an emergency room visit for a Medicaid recipient with Plan First coverage.

Example 2: BPA – PC – PROC – No coverage

This error is stating no coverage for the procedure billed based upon the provider's contract with Alabama Medicaid. An example would be a doctor billing for an EPSDT screening without a contract on file to perform screenings.

Example 3: BPA – RR – No Reimb Rule

This error is stating the reimbursement rule is not associated with the procedure or HCPC being billed. The procedure code or HCPC could be non-covered or not updated in the Medicaid claims processing system.

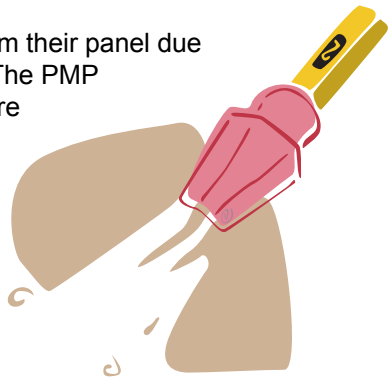
Example 4: BPA – PC – REV – Assignment Plan Restriction

This error is stating an incorrect revenue code is being billed for the recipient's Level of Care Assignment Plan. An example may include a nursing home billing for services when a recipient has not been added to the Level of Care file, or possibly billing incorrect revenue codes for services.

A BPA error may occur for different reasons on an RA. The denial description provides information on how to correct the error

(Continued on page 5)

New Dismissal Form for Patient 1st Providers on Website



A Primary Medical Provider (PMP) may request dismissal (removal) of a recipient from their panel due to good cause. The PMP is responsible for sending a letter of dismissal to the enrollee. The PMP should provide the enrollee 30 days notice from the first date of the month in which you are dismissing the enrollee.

In addition, the PMP should fill out the Dismissal Form (Form 450) and mail or fax the form to the Alabama Medicaid Agency, Attention: Patient 1st Program, 501 Dexter Avenue, Montgomery, AL 36103.

The fax number is (334) 353-3856. If you have questions about the above requirements contact Gloria Wright, at (334) 353-5907.

Essure Follow-up Procedures and the Plan First (Family Planning Only) Recipient

Once a sterilization claim is processed for a Plan First recipient, her financial eligibility is systematically ended. Currently a claim for a Plan First recipient for Essure related follow-up procedures (58340 and 74740) would deny due to no financial eligibility.

The providers rendering services should submit claims for procedures 58340 and 74740 to:

Plan First Program Manager
501 Dexter Avenue
Montgomery, Alabama 36103

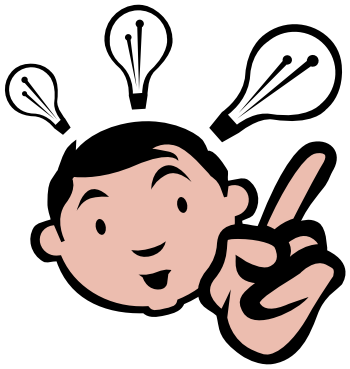
The claims will be researched and considered for a manual lump sum payment. If there is a paid claim in history for the Essure procedure then the claim for the follow up procedures will be processed.

What is a BPA Error?

(Continued from page 4)

The following is a guide on how to decipher BPA denials and explains what each portion of the denial code represents

Example: BPA – RP – PROC – Age Restriction (if applicable)



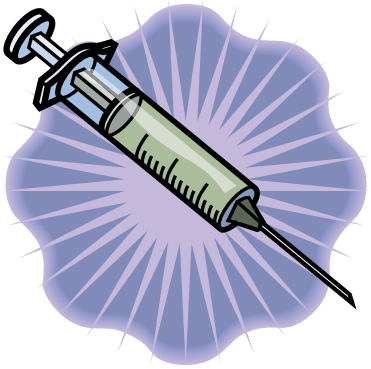
- BPA: identifies the denial as a benefit plan administration audit
- The second portion provides details on the denial
  - PC=Provider Contract
  - RP=Recipient Plan
  - RR=Reimbursement Rule
- The third portion provides additional information on the denial, when applicable
  - DIAG=Diagnosis Code
  - ICD-9 ICD-9 surgical procedure code
  - MOD=Modifier
  - NDC=NDC code
  - PROC = CPT-4 or HCPC procedure code
- The fourth portion provides additional information for assistance in correcting the denial
  - Age Restriction
  - Gender Restriction
  - No Reimb Rule (No reimbursement Rule)
  - Place of Service Restriction
  - Diagnosis Restriction
  - Assignment Plan Restriction (note this error usually only occurs with Long-Term Care recipients)
  - No Coverage

COBA Denial Explaination

Attention providers receiving 1825 denial (COBA denial-do not crossover). This denial means EDS does not have information on file for your claims to automatically crossover from Medicare to Medicaid. To eliminate this denial, send in a copy of the Medicare notification letter received when you became a Medicare provider to EDS Provider Enrollment. The letter should contain your NPI number as well as secondary identifiers for all service locations. Once this letter is received, information will be updated and claims should begin to crossover; eliminating this denial.

The following provider types should not submit Medicare notification letters because claims should never automatically crossover from Medicare to Medicaid.

- FQHC
- Rural Health Clinics
- Dialysis



The contact information for Provider Enrollment is the following:

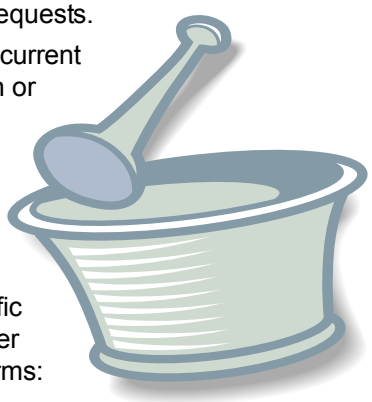
FAX: (334) 215-4298
EDS Provider Enrollment
PO Box 241685
Montgomery, AL 36124-1685

Synagis® Criteria for 2009-2010 Season

The Alabama Medicaid Agency has updated its prior authorization criteria for Synagis®.

Highlights of the updated criteria include:

- The approval time frame for Synagis® will begin October 1, 2009 and will be effective through March 31, 2010.
- Up to five doses will be allowed per recipient in this timeframe. Some recipients may only receive up to a max of 3 doses, depending on the gestational and chronological age.
- There are no circumstances that will result in approval of a sixth dose.
- If a dose was administered in an inpatient setting, the date the dose was administered must be included on the request form.
- For approval of requests, the recipient must meet gestational and chronological age requirements. In order to meet chronological age requirements, the recipient must not exceed the specified age at the start of the RSV season.
- Prescribers, not the pharmacy, manufacturer or any other third party entity, are to submit requests for Synagis® on a separate prior authorization form (Form 351) **directly** to Health Information Designs and completed forms may be accepted beginning September 1, 2009 (for an October 1 effective date).
- A copy of the hospital discharge summary from birth is required on all Synagis® PA requests.
- If approved, each subsequent monthly dose will require submission of the recipient's current weight and last injection date and may be faxed to HID by the prescribing physician or dispensing pharmacy utilizing the original PA approval letter.
- Letters will be faxed to both the prescriber and the dispensing pharmacy notating approval or denial.



Criteria

Alabama Medicaid follows the 2009 updated American Academy of Pediatrics (AAP) guidelines regarding Synagis® utilization. The form and complete updated criteria specific to Synagis® are available on the Agency's website at *www.medicaid.alabama.gov* under Programs: Pharmacy Services: Prior Authorization/Overrides Criteria and Pharmacy Forms: Synagis®.

Additional questions regarding Synagis® criteria can be directed to the Agency's Prior Authorization contractor, Health Information Designs at 1-800-748-0130.

Claims Suspending for Edit 3306

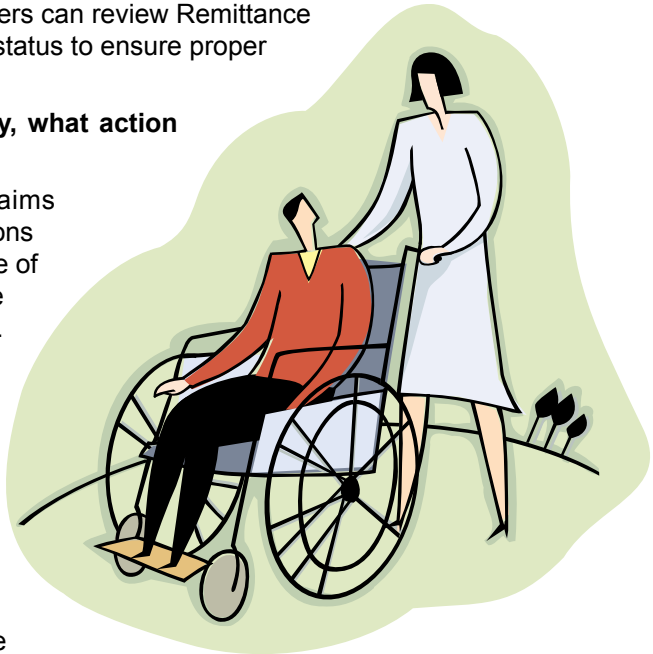
Claims may suspend for edit 3306 if total charges are over a specified threshold amount. The claims will remain in suspense until the provider is contacted by EDS to verify the claim amount. Providers who are billing monthly for their service and are receiving this edit may want to bill weekly. This will lower the claim total and may prevent the claim from suspending for this edit. If EDS is unable to reach the provider and verify charges, the claim will deny.

Attention DME Providers Billing Procedure Code E1399 / E1399-EP

A recent internal audit has revealed when prior authorization requests were approved for E1399/E1399-EP; the prior authorizations were not entered into the prior authorization system correctly. The time period when the prior authorizations were entered incorrectly was June 2008 through December 2008. The issue has been corrected, but some prior authorizations may be outstanding and require action on the behalf of the provider.

What steps should your office take to determine if prior authorizations for E1399/E1399-EP have processed incorrectly?

Conduct a self audit of Prior Authorizations with this procedure code/modifier combination. Review your accounts to see if payments for services has been received. Payment will range from $1 to $5, which is much less than the reimbursement amount for the services provided. Providers can review Remittance Advise information or may log onto the web portal to check claim status to ensure proper payment.



If our office determines claims have not processed correctly, what action should be taken to correct the problem?

Write down all your prior authorization numbers which have claims incorrectly processed against them. Contact your Provider Relations Representative. Your Provider Relations Representatives are aware of the issue, and can evaluate your specific circumstance and advise what corrective action will need to occur to ensure proper payment. You may contact your Provider Representative at 1-800-688-7989, ask for a Durable Medical Equipment Provider Representative.

In the future, how should prior authorization requests be completed for E1399/E1399-EP?

Providers may refer to Chapter 4 of the provider manual for specific instructions on completing the prior authorization requests. When submitting line item information for E1399 / E1399-EP, one line item should be requested, with one unit, adding the items into one lump sum dollar amount. This should be done even if multiple items are to be dispensed. The text portion of the prior authorization form should be used to describe the items requested. If additional dollars or items are required to be dispensed, and a prior authorization is already approved for that time period, a request to add additional items or dollars should be sent to the prior authorization department at EDS. Use the Prior Authorization approval letter and write the information in the remarks sections explaining what additions are necessary and fax the form to EDS. **An additional prior authorization request should not be sent in for approval.**

How should claims be filed for E1399/E1399-EP one prior authorization is granted?

Information on completing a claim form can be found in the Provider Billing Manual Appendix P, page P-28 states:

1. The procedure code must be entered on the claim as one line item.

2. The units billed must be entered as “1” unit.

3. The dollar amount billed must be the “total” dollar amount for all items approved on the prior authorization for the date of service on the claim. In other words, the money amounts for multiple items approved on a prior authorization request for E1399 or E1399 (EP) must be combined and the total money amount must be billed as one lump sum. The total units for all items must be billed as “one” unit. If each approved item for E1399 or E1399 (EP) is billed on separate lines or if more than one unit is billed, for the same dates of service, the claim will be denied.

State Fiscal Year 2010-2011 Checkwrite Schedule

10/02/09	01/08/10	04/02/10	07/09/10
10/23/09	01/22/10	04/16/10	07/23/10
11/06/09	02/05/10	05/07/10	08/06/10
11/20/09	02/19/10	05/21/10	08/20/10
12/04/09	03/05/10	06/04/10	09/10/10
12/18/09	03/19/10	06/18/10	09/17/10

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Alabama Medicaid Bulletin **January 2010**

The checkwrite schedule is as follows:

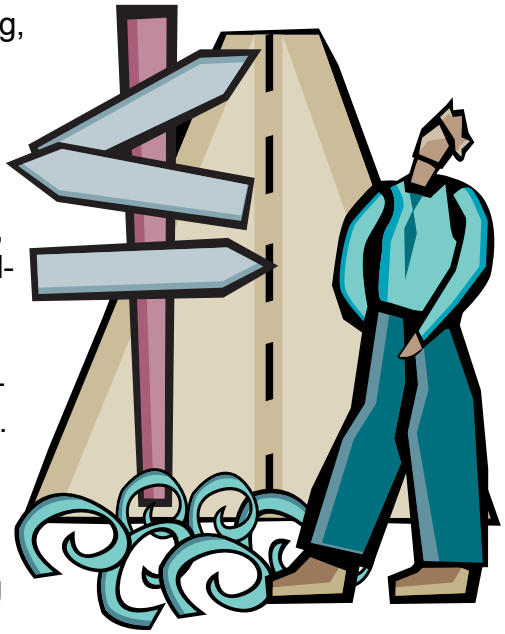
01/08/2010 01/22/2010 02/05/2010 02/19/2010 03/05/2010 03/19/2010

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

HealthSpring Ends Medicare Advantage Contract with Alabama Medicaid

Medicaid providers who currently accept HealthSpring enrollees should be aware that HealthSpring has ended its contract with the state effective January 1, 2010.

Current HealthSpring enrollees can choose to stay with HealthSpring, switch to another Medicare Advantage plan, or disenroll from HealthSpring and roll back to regular Medicare coverage. If they choose to stay with HealthSpring, they may be required to pay a monthly premium and other out-of-pocket costs.



If the patient has full Medicaid coverage or QMB-only coverage, they must be treated by a Medicaid-enrolled provider in order for Medicaid to cover the plan's co-pays or deductibles. If the doctor they currently use within HealthSpring's network does not accept Medicaid, the patient will need to switch to a Medicaid-enrolled provider in order for Medicaid to be billed for the co-pays or deductibles. If the patient chooses to remain with a non-Medicaid provider, the individual will be responsible for any plan co-pays or deductibles.

Providers with questions about HealthSpring's requirements should call HealthSpring directly. Recipients with questions about switching to another Medicare Advantage plan should call the Alabama State Health Insurance Assistance Program (SHIP) toll free at 1-800-243-5463 for assistance.

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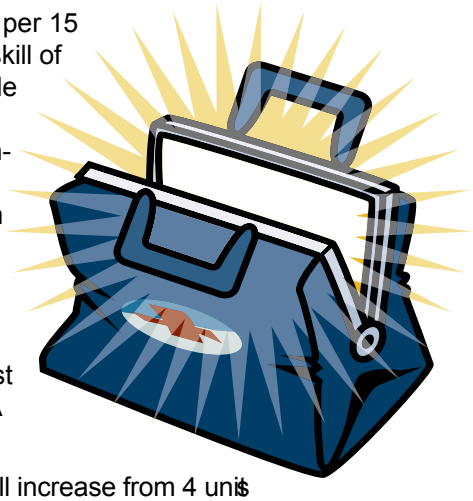
Pass It On!

Everyone needs to know the latest about Medicaid. Be sure to route this to:

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

DME Medical Criteria Update



Effective April 4, 2009, CMS deleted procedure code E1340 (Repair for DME, per 15 minutes, repair or non routine service for durable medical equipment requiring the skill of a technician, labor component, per 15 minutes) and replaced it with procedure code K0739 (Repair/SVC DME non oxygen equipment, repair or nonroutine service for durable medical equipment other than oxygen equipment requiring the skill of a technician, labor component, per 15 minutes).

Alabama Medicaid is deleting procedure code E1340 in the Interchange System on December 31, 2010. This will allow all existing PA's approved for date of service April, 2009 through December 31, 2010 to process and pay. Effective January 1, 2010, all PA requests for Repair/SVC DME non oxygen equipment, repair or nonroutine service for durable medical equipment other than oxygen equipment requiring the skill of a technician, labor component, per 15 minutes must be submitted using procedure code K0739. Alabama Medicaid will not accept any PA requests submitted for procedure code E1340 after December 31, 2009.

Effective September 1, 2009, the quantity restriction for procedure code A7526 will increase from 4 units per month to 31 units per month (1 per day). This update will be included in Chapter 14 and Appendix P of the DME Provider Manual. This information will also be placed on the Medicaid DME List Serv and the ADMEA List Serv.

Effective December 1, 2009, most of the tracheostomy (trach) supplies currently billed using procedure code E1399 will now be billed with a procedure code corresponding to the tracheostomy supply item. Procedure codes A4605, A7012, A7010, A7008, S8999 and A9990 will not require prior authorization but there are quantity restrictions. Procedure code S8189 will require prior authorization. Any other trach supply items requested must be submitted using procedure code E1399. The procedure codes listed below will be used to bill tracheostomy supply items:

TRACH SUPPLY	HCPC CODE	PRICE	HCPC DESCRIPTION
Delee	A4605 (4 per mo.)	$13.12 ea.	Tracheal suction catheter closed system
Drain Bag	A7012 (4 per mo.)	$3.18 ea.	Water collection device, used with large volume nebulizer
Aerosol	A7010 (per 100 ft.)	$16.04	Corrugated tubing disposable used with large volume nebulizer
Neb Adapters	A7008 (4 per mo.)	$7.48 ea.	Large volume nebulizer, disposable prefilled used with aerosol compressor
Resuscitation Bags	S8999 (2 per yr.)	$36.00 ea.	Disposable ambu bag
Suction Machine Bacteria Filters	A9900 (2 per yr.)	$6.00 ea.	Miscellaneous DME Supply
Customized/ Specialty Trachs (ex. Bivona)	S8189	**Requires** PA, medical documentation and provider's invoice must be submitted for review and approval. Medicaid will reimburse at provider's invoice plus 20%	Tracheostomy Supply
Peep Valves	E1399	**Requires** PA, medical documentation and provider's invoice must be submitted for review and approval. Medicaid will reimburse at provider's invoice plus 20%	
Respiguard Filters	E1399	**Requires** PA, medical documentation and provider's invoice must be submitted for review and approval. Medicaid will reimburse at provider's invoice plus 20%	
Twill Tape	E1399	Medicaid no longer covers twill tape. Medicaid increased trach collars from 4 per month to 31 per month. Trach collars replaced twill tape years ago	

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

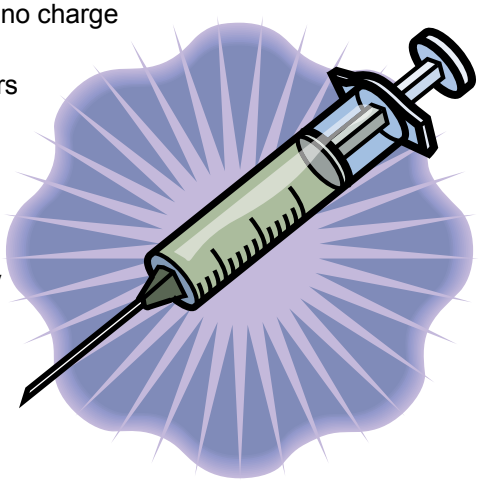
Monovalent H1N1 Vaccines Available

The Office for Disease Control and Prevention at ADPH has issued the following information regarding the monovalent 2009 H1N1 vaccine:

Alabama physicians may still order 2009 monovalent H1N1 vaccine by going to the adph.org web site, clicking on "Log In" and then choosing "ORDER." The department fills requests as vaccine becomes available, and so not every provider who has requested vaccine has received it yet. Providers must report each week the number of administered doses. Based on the amount of 2009 H1N1 vaccine distributed in Alabama, the Department of Public Health now recommends providers offer vaccine to all individuals in the ACIP target groups. Monovalent 2009 H1N1 vaccine is thus recommended for (1) persons aged 25 through 64 years who have medical conditions that put them at higher risk for influenza-related complications, (2) all persons aged 6 months through 24 years, (3) pregnant women, (4) persons who live with or provide care for infants less than 6 months of age, and (5) healthcare workers and emergency medical services personnel. The Department will continue to distribute 2009 H1N1 vaccine to providers as additional vaccine is made available.

Reimbursement for Administration of Seasonal Influenza and H1N1 Vaccines

Effective November 2, 2009, Alabama Medicaid began reimbursing Medicaid-enrolled pharmacy providers for the administration of the influenza and H1N1 vaccines for eligible recipients at age 19 and older. Alabama Medicaid will also continue to reimburse pharmacies for the seasonal influenza vaccine but will not reimburse pharmacies for the H1N1 vaccine because the H1N1 vaccine is being supplied by the Alabama Department of Public Health at no charge to the provider.



- Beginning November 2, pharmacy providers may bill the following NDC numbers on a pharmacy claim for reimbursement of vaccine administration:
  - NDC 99999-9999-10 for seasonal influenza vaccine administration
  - NDC 99999-9991-11 for H1N1 vaccine administration
- Reimbursement will be $5 per administration with no dispensing fee or co-pay applied.
- Claims should be submitted with a dispense quantity of 1 for vaccine administration. There will be a maximum quantity of 1 injection allowed per recipient per year for each vaccine.
- To facilitate coordination of care, Pharmacy providers are instructed to inform (via phone, fax, e-mail, mail) each recipient's Primary Medical Provider (PMP) upon administration of the vaccine(s). Documentation must be kept on file at the pharmacy of the notification to the PMP. If the PMP is unknown, the pharmacy may call the Alabama Medicaid Automated Voice Response System (AVRS) system at 1-800-727-7848 to obtain the PMP information. A suggested Immunization Provider Notification Letter, which can be used to notify the PMP, can be found on the Agency website at *http: www.medicaid.alabama.gov/programspharmacy_svcspharmacy_services.aspx*.
- Alabama State Board of Pharmacy law and regulation should be followed regarding dispensing and administration of legend drugs/vaccines.

What To Do If Your Claim Is In a Suspended Status

If you have claims in "Suspended" status, you do not need to do anything at this point. A suspended claim means HP has received the claim and the claim is under review, but has not been finalized yet. Once the claim is finalized, it will appear as either paid or denied. **DO NOT RESUBMIT CLAIMS THAT ARE IN SUSPENDED STATUS.**

Suspended claims should process within two checkwrites. Resubmitting the claim could possibly cause the claim to suspend longer, because the subsequent submissions will also require manual review.

Proper Claim Filing for Unclassified Drugs

When a provider administers a physician drug not listed, the following J Codes should be utilized:

J3490 - Unclassified drugs

J9999 - Not otherwise classified, antineoplastic drugs

The claim must be sent on paper with a description of the drug attached. Providers should submit a claim with the complete name of the drug, dosage and a National Drug Code (NDC) number Please be sure to search the Physician Drug List to see if the drug is possibly under a generic name. The claims containing the unclassified procedure code must be sent to: HP, Attn: Medical Policy , PO Box 244032, Montgomery, AL 36124-4032. HP will determine the price of the drug.

Modifier "76"

Modifier "76" is used for repeat procedures only and should not be billed unless the procedure is actually a repeat procedure. This modifier should never be billed to obtain additional billing units for procedures that have restricted billing units (example; injectable drugs). Providers that have used this modifier inappropriately in the past should adjust those claims, and note that this issue is subject to post payment review and recovery.

www.medicaid.alabama.gov

Procedure for Billing Bilateral Procedures

The following is the correct process for billing bilateral procedures. Please refer to the Alabama Medicaid Provider Manual, Chapter 28 for details and examples.

- Bill the appropriate procedure code on 2 separate lines with RT and LT modifier, or other appropriate anatomical modifier
- Modifier 50 will be used for informational purposes only and is no longer a pricing modifier
- The payment will be 100% of Medicaid fee schedule for first line and 50% for second line
- Claims will be subject to multiple surgery payment adjustments for multiple procedures

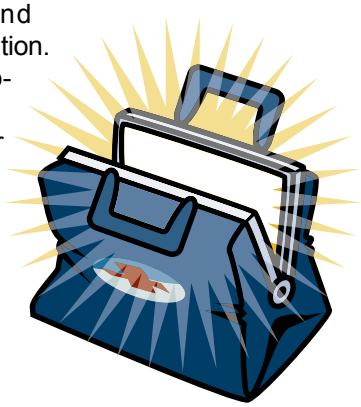
Example: Line 1: 27558 RT
27558 LT

Alabama Medicaid utilizes Medicare's RVU file to determine whether a 50 modifier should be allowed with the procedure code billed. When an inappropriate procedure code is billed with modifier 50, the claim will deny

Distinct Procedural Service (Modifier 59)

Modifier 59 may be used to indicate a service was performed on the same date of service but was distinct from the primary service provided the same day. Examples of when Modifier 59 would be appropriate to use include (but not limited to), diferent procedure or surgery, different site or organ system, separate incision/excision, which would not ordinarily be performed on the same day by the same physician.

Medical record documentation and diagnoses must support Modifier 59 utilization. When diagnoses alone do not support appropriate Modifier 59 utilization, the claim will be denied. When receiving a Modifier 59 or Multiple Surgery denial, a paper claim with an attached Operative Report (record "Op ReportAttached" in block 19) must be submitted to HP for reconsideration. The reconsideration should occur before a written appeal is made to the Alabama Medicaid Agency.



EXAMPLES

- Surgical debridement/shaving is normally considered an integral part of the primary surgical procedure (bundled). However, there are times when the debridement/shaving occurs at a different site or location during the same surgical session and it may be necessary to append a Modifier 59 to indicate a "separate and distinct service."

- When filing for a secondary procedure code 29877 for bilateral debridement/shaving of articular cartilage electronically, append Modifier RT (right) and Modifier 59 on the first line and on the second line append Modifier LT (left) and Modifier 59. Diagnoses must support the procedures billed.

- If the electronic claim rejects, then a paper claim (indicating RT/LT with mod. 59) should be forwarded to HP , with the appropriate OP Report attached. The paper claim form should have block 19 marked indicating that the Op Report is attached.

Top Five Denials for Nursing Home Claims

HP has conducted a review of denials received by nursing homes in the past year. The top 5 denials are as follows:

EOB Code 5013, Our records show this service for the date(s) of service billed is a duplicate. This denial is received if the submitted claim is an exact duplicate of a claim previously paid.

EOB Code 573, Total days on claim conflict with dates shown. This denial is received if the calculated number of days do not equal the days billed. The days are calculated as the number of days in the from and to dates of service fields. The date of discharge is not counted except when the patient status is between 30 and 39. If the patient status is between 30 and 39 the last day is counted.

EOB 570, Total days less than covered days. This denial is received if the total of detail units billed for accommodation revenue codes is not equal to the number of days calculated at the header from and to dates of service. The date of discharge is not counted except when the patient status is between 30 and 39. If the patient status is between 30 and 39 the last day is counted.

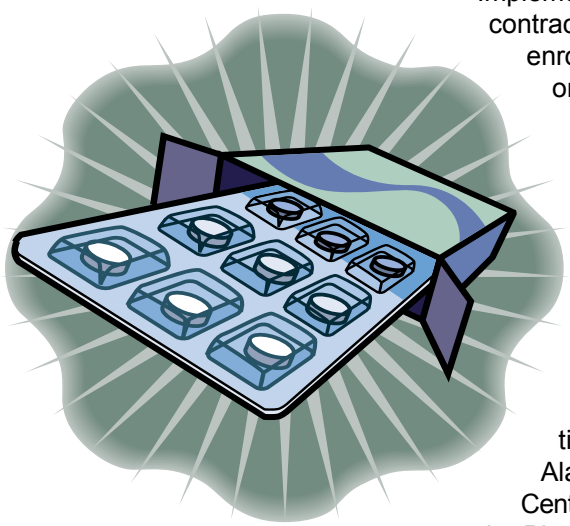
EOB 2504, File shows other insurance. Submit to other carrier This denial is received if the recipient is covered by a private insurance. The claim should be submitted hardcopy with a copy of the denial from the other insurance or the claim can be submitted electronically using a delay reason code of 9. If the delay reason code of 9 is submitted the provider must have documentation on file that the other insurance does not cover nursing home services.

EOB 1065, Provider name mismatch. This denial is received if the provider name submitted on the claim does not match the name on the provider file. When processing claims the first 2 letters of the provider name is compared to the provider file.

If you have any questions, please contact your Provider Representative at 1-800-688-7989.

Plan First Recipients Prescription Information

In an effort to improve recipients' access to covered contraceptive products, the Alabama Medicaid Agency has expanded the number of locations Plan First recipients can fill prescriptions.



Implemented November 1, the change allows women on Plan First to obtain oral contraceptives, the contraceptive ring, or the contraceptive patch at a Medicaid-enrolled community/outpatient pharmacy at a Federally-qualified Health Center or at the public health department. This is in addition to the contraceptive products already available at pharmacies, such as injectible contraceptives and diaphragms.

Medicaid Pharmacy Services Director Kelli Littlejohn, RPh. PharmD., emphasized that Plan First recipients who wish to fill their prescriptions at a community or outpatient pharmacy must have received the prescription from a private provider enrolled in the Plan First program. Oral contraceptives, the contraceptive ring, or the contraceptive patch are limited to one month's supply per fill.

"Women who prefer the convenience of getting a 12-month supply of oral contraceptives, the contraceptive ring, or the contraceptive patch at one time will still have the option of receiving family planning services from the Alabama Department of Public Health or from a Federally-qualified Health Center (FQHC). However, to receive contraceptive products from ADPH or a FQHC, the Plan First-eligible patient must have been seen first by the health department or the FQHC", Dr. Littlejohn said.

Community and outpatient pharmacies should be aware that there is no change for SOBRA-eligible women who receive a prescription for a contraceptive product when they are discharged from the hospital after giving birth. These women must continue to fill their contraceptive prescriptions at a Medicaid-enrolled pharmacy. After the 60-day postpartum period, these women will automatically become Plan First recipients. At that time, they may elect to obtain family planning services from an enrolled Plan First private provider, or directly from the Alabama Department of Public Health.

Questions regarding this change should contact Leigh Ann Hixon, Plan First Program Manager at *leighann.hixon@medicaid.alabama.gov* or call (334) 353-5263.

What is a BPA Error?

When billing a claim, some of the terminology may be confusing to providers. The following is a list of terms and their definitions to help providers understand why claims are denying:

BPA – Benefit Plan Administration – Identifies a specific group of audits used in claims processing.

RP – Recipient Plan – The type of Medicaid coverage a recipient is eligible to receive. Based on eligibility criteria, recipients may be eligible for full Medicaid benefits, or for certain services only. A recipient's age, health care requirements, and place of residence may further define his or her eligibility for Medicaid programs or services. Additionally, a recipient's history of Medicaid benefits may render him or her eligible or ineligible for specific programs or services. For these reasons, it is very important that the providers verify recipient eligibility and ensure they understand all aspects of the eligibility response.

PC – Program Code or Provider Contract – Providers are assigned contracts and specialties which allow procedures to be reimbursed by provider type. Assignments are made based on certifications and licensure information.

RR – Reimbursement Rules – Rules established regarding reimbursement for a procedure. This includes restrictions by provider type, provider specialty or claim type.

DIAG – Diagnosis codes – The diagnosis code billed is not covered for the service rendered. This could be based on the recipient plan or procedure code. This could also include restrictions on the recipient benefit plan or procedure code

ICD9 – The ICD-9 surgical procedure codes – the audit is addressing the requirements for billing these codes

MOD – Modifiers – The modifier being billed is not allowable or not valid for the service performed

NDC – The National Drug Code assignment – The NDC being billed is not valid or non-covered

PROC – The HCPC or CPT-4 Procedure codes – The audit is addressing the requirements for the procedure code being billed

Listed below are some examples of BPA errors that may occur on a remittance advice:

Example 1: BPA – RP – PROC – No coverage

This error is stating no coverage for the procedure code billed based upon the recipient's benefit plan. This could be an error received by a hospital when trying to bill an emergency room visit for a Medicaid recipient with Plan First coverage.

Example 2: BPA – PC – PROC – No coverage

This error is stating no coverage for the procedure billed based upon the provider's contract with Alabama Medicaid. An example would be a doctor billing for an EPSDT screening without a contract on file to perform screenings.

Example 3: BPA – RR – No Reimb Rule

This error is stating the reimbursement rule is not associated with the procedure or HCPC being billed. The procedure code or HCPC could be non-covered or not updated in the Medicaid claims processing system.

Example 4: BPA – PC – REV – Assignment Plan Restriction

This error is stating an incorrect revenue code is being billed for the recipient's Level of Care Assignment Plan. An example may include a nursing home billing for services when a recipient has not been added to the Level of Care file, or possibly billing incorrect revenue codes for services.

A BPA error may occur for different reasons on an RA. The denial description provides information on how to correct the error

The following is a guide on how to decipher BPA denials and explains what each portion of the denial code represents

Example: BPA – RP – PROC – Age Restriction (if applicable)

- BPA: identifies the denial as a benefit plan administration audit
- The second portion provides details on the denial

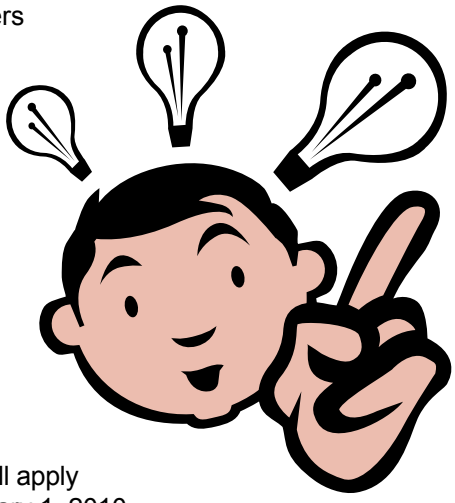
  PC=Provider Contract RP=Recipient Plan RR=Reimbursement Rule
- The third portion provides additional information on the denial, when applicable

  DIAG=Diagnosis Code ICD-9 ICD-9 surgical procedure code MOD=Modifier
  NDC=NDC code PROC = CPT-4 or HCPC procedure code
- The fourth portion provides additional information for assistance in correcting the denial

  Age Restriction Gender Restriction No Reimb Rule (No reimbursement Rule)
  Place of Service Restriction Diagnosis Restriction No Coverage
  Assignment Plan Restriction (note this error usually only occurs with Long Term Care recipients)

QTool Now Available to Info Solutions Providers

Medicaid has been working to transition current Patient 1st PMPs utilizing InfoSolutions to Medicaid's Electronic Health Record, QTool. InfoSolutions, currently hosted through Blue Cross/Blue Shield will be discontinued December 31, 2009. Providers currently using InfoSolutions will now have access to QTool. QTool allows you to see not only medication and procedure history but also offers information on past diagnoses, providers of care, allergies, lab results, vital signs, and even personal history. In addition, QTool offers an e-prescribing component to participating providers all at no cost. PMPs will be required to use QTool in order to receive the $1 in the monthly case management fee.



QTool was developed for use by Medicaid providers through a Medicaid Transformation Grant. A component of the grant is an evaluation of the effectiveness of the information available. In order to protect the integrity of the evaluation, QTool will not be available to PMPs in the following counties until April 1, 2010. (Counties postponed until April 1, 2010: Baldwin, Butler, Choctaw, Covington, Etowah, Lee, Madison, Marion, Morgan, Randolph and Walker). Medicaid will be working with these providers during the coming months to meet the April 1, 2010 start date. PMPs in these counties will continue to receive their additional case management fee until April 1, 2010 if they have historically used InfoSolutions.

1. For those providers required to use QTool, the following usage requirements will apply to receive the additional case management fee: During the time period January 1, 2010 – March 31, 2010, no minimum usage will be required.
2. During the time period of April 1, 2010 – June 30, 2010, your office will be required to use QTool for 25% of the unduplicated Medicaid patients seen in your office.
3. If the 25% usage requirements have been met at the end of this quarter (measured in July), then you will continue to qualify for your dollar reimbursement fee for the next two months (August-Sept).
4. During this next period (July- Sept), the required usage of the QTool increases to 50% of the unduplicated Medicaid patients seen in the office.
5. If the 50% usage requirements have been met at the end of this quarter, then you will continue to qualify for your dollar reimbursement for the subsequent quarters.
6. If the requirements are not met during a specific quarter/time period, the additional case management fee will be suspended for the next quarter/time period.
7. Usage during the suspended quarter will be measured and if minimum requirements are met, then the case management fee will be reinstated for the upcoming quarter.
8. As a reminder, each patient only counts once during each quarter. Multiple look-ups on the same patient will only count as one unduplicated patient for the monitored quarter.

If you have questions or would like to receive training on QTool, please contact: *Janice.oneal@medicaid.alabama.gov* or by phone (334) 353-4771 OR *kim.davis-allen@medicaid.alabama.gov* by phone (334) 242-5011. Policy questions can be directed to Paige Clark at *paige.clark@medicaid.alabama.gov*.

EDS Is Now HP Enterprise Services

In August 2008, Hewlett Packard (HP) acquired EDS, claims processor for the Alabama Medicaid program. On Wednesday, September 23, 2009 the EDS business unit of HP changed its name to HP Enterprise Services in most locations across the country and around the world.

How will that affect health care providers in Alabama? You probably won't notice much of any change. You'll begin to see the HP logo or the HP Enterprise Services name on correspondence. You'll begin to receive e-mails from an @hp.com e-mail address rather than an @eds.com address and you'll hear the hp name when calling the Montgomery office. Think of it as a sports team changing jerseys. The same players are on the field working hard to deliver the outstanding medicaid services you've come to expect from a trusted business ally.

While the EDS name and logo are being phased out, the technology services equity we've built over the past five decades will remain. This includes the attitude, expertise and commitment to delivering excellence that defined EDS. The new name reflects HP's commitment to the longtime success of its clients. It also reminds our clients of the enhanced value they now get from the combination of EDS' proven operational excellence plus the best in class technology of HP.

State Fiscal Year 2010-2011 Checkwrite Schedule

~~10/02/09~~	01/08/10	04/02/10	07/09/10
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~~11/20/09~~	02/19/10	05/21/10	08/20/10
~~12/04/09~~	03/05/10	06/04/10	09/10/10
~~12/18/09~~	03/19/10	06/18/10	09/17/10

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Provider *Insider*

Alabama Medicaid Bulletin **April 2010**

The checkwrite schedule is as follows:

04/02/2010 04/16/2010 05/07/2010 05/21/2010 06/04/2010 06/18/2010

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

Ingenix to Conduct Medicaid Provider Post Payment Reviews

The Alabama Medicaid Agency recently awarded a two-year contract to Ingenix Public Sector Solutions, Inc. to conduct federally mandated provider post payment reviews and recover any identified inappropriate payments made to providers. Post payment reviews will be conducted for all provider groups such as physicians, pharmacies, durable medical equipment, home health, dental, hospitals, etc. Ingenix will be reviewing claims filed for the past two years.

Ingenix provides advanced Program Integrity solutions to many state health and human services agencies across the country and brings a broad combination of technological, consulting, Medicaid, and provider expertise to Alabama. Our partnership with Ingenix will help us expand the post-payment review process and enhance our current fraud, misuse, and waste investigations. Through its enhanced technologies, we believe Ingenix will provide critical insights to the Agency's Program Integrity program.

The reviews will begin in the next few months. For more information, contact Schandra James, Project Manager at (334) 353-5121.

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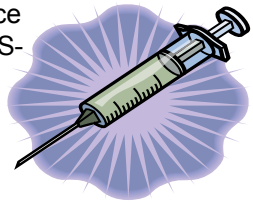
Pass It On!

Everyone needs to know the latest about Medicaid. Be sure to route this to:

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

Medicaid Physician-Administered Multiple Source Drugs



In compliance with the Deficit Reduction Act, the Medicaid Physician-Administered Multiple Source Drug listing is being updated. The drugs identified starting on page three, require an NDC code on CMS-1500 and UB-04 claims. This will be the last published update; on claims with dates of service July 1, 2010 forward, the NDC will be required on **ALL** Physician-Administered drugs in the ranges J0000-J9999, S0000-S9999 and Q0000-Q9999. Refer to the January 12, 2010, Provider Alert "Mandatory National Drug Codes (NDC) for **ALL** Physician-Administered Drugs" for more information.

Mirena IUD

Effective January 1, 2010, the Mirena IUD was restricted to one every five years. Exceptions are stated below.

Medicaid recipients must meet the following criteria to receive the Mirena IUD within the 5 year limit:

- Recipient develops high blood pressure or any other medical condition that would allow for a progestin only method.
- Any nulliparous woman who has a spontaneous expulsion within 6 months of placement.
- Mirena IUD is removed to allow a pregnancy. Once delivered, recipient is eligible for another Mirena IUD.

In order to receive reimbursement, providers will need to submit a clean claim and medical records documenting the above mentioned criteria to:

Plan First Program Manager
Alabama Medicaid Agency
Medical Services Division
P. O. Box 5624
Montgomery, AL 36103-5624

Attention: Nursing Home Providers

Nursing home providers must notify the Medicaid District Office to terminate nursing home eligibility by the 15th of the month when residents are discharged from the nursing home. Being that eligibility for Medicaid is on a month to month basis, timely notification to the District Office ensures the nursing home eligibility will be terminated by the end of the month. This will allow recipients to receive other Medicaid services they are eligible to receive. If notification is not reported timely, other service providers will be unable to submit claims for services provided to the recipient, or delay the delivery of services to the recipients.

If you have any question, please contact Samantha McLeod at (334) 242-5584.

Providers Must Use the Web Portal

Effective March 1, 2010, providers must use the web portal to download, print or save the following reports:

- Remittance Advices
- EPSDT Periodic Rescreening report
- Patient 1st referral report
- Monthly PMP Enrollment Roster for Patient 1st

Accessing the reports on the web portal is fast and easy.

Once successful log-on is complete, go to Trade Files, download, click the drop down menu, and select the the appropriate report. The reports display in a PDF format using Acrobat Reader.

Dental Provider List

Effective January 12, 2010, the Dental provider list is now a direct link to the *www.insurekidsnow.gov* website. The direct link is to Alabama's Oral Health Coverage Plans for Medicaid Fee for Service providers. This change is due to The Children's Health Insurance Program Reauthorization Act of 2009 legislation that passed to help ensure the health and well being of our nation's children. This listing will be updated on a quarterly basis.

Update to Dental Policy

Multiple visits needed to accomplish an exam, prophy; fluoride and sealants must have documented medical necessity in order for Medicaid payment to be allowable. Payment will be subject to recoupment if documentation does not support the medical necessity for multiple visits to accomplish an exam, prophy; fluoride and sealants.

It is considered fraudulent practice for a provider to intentionally schedule multiple appointments for no medical reason in order to maximize their reimbursement.

Claims Billed by ADPH Nurse Practitioners

All nurse practitioners affiliated with county health departments must enroll with HP Provider Enrollment. Nurse practitioners must use their assigned NPI number as the rendering provider in order to bill claims.

Physical Therapy Supervision

The Physical Therapist must render the hands-on treatment, write and sign the treatment note at a minimum of every sixth visit.

Essure

Effective January 1, 2010, medical providers will now use two procedure codes to bill for the Essure. A4264 will be used for reimbursement of the device and 58565 for reimbursement of the procedure. The outpatient facility will only bill 58565 for the surgical procedure.

Medicaid Physician-Administered Multiple Source

HCPCS CODE	SHORT DESCRIPTOR	HCPCS DOSAGE	LABELER DRUG NAME	NDC	LABELER
J0207	Amifostine	500 MG	Ethyol	55390030803	Bedford Laboratories
			Ethyol	58178001701	Medimmune Oncology, Inc.
			Ethyol	58178001703	Medimmune Oncology, Inc.
			Ethyol	62756058140	Sun Pharmaceutical Industries, Ltd
			Ethyol	62756058142	Sun Pharmaceutical Industries, Ltd
J0640	Leucovorin calcium injection	50 MG	Leucovorin Calcium	63323071100	American Pharmaceutical Partners, Inc.
			Leucovorin Calcium	55390005301	Bedford Laboratories
			Leucovorin Calcium	55390082401	Bedford Laboratories
			Leucovorin Calcium	55390005401	Bedford Laboratories
			Leucovorin Calcium	55390082501	Bedford Laboratories
			Leucovorin Calcium	55390005110	Bedford Laboratories
			Leucovorin Calcium	55390082601	Bedford Laboratories
			Leucovorin Calcium	55390000901	Bedford Laboratories
			Leucovorin Calcium	55390005210	Bedford Laboratories
			Leucovorin Calcium	55390081810	Bedford Laboratories
			Leucovorin Calcium	00703514001	Sicor Pharmaceuticals, Inc.
			Leucovorin Calcium	00703514501	Sicor Pharmaceuticals, Inc.
J0696	Ceftriaxone sodium injection	250 MG	Ceftriaxone Sodium	63323034410	American Pharmaceutical Partners, Inc.
			Ceftriaxone Sodium	63323034861	American Pharmaceutical Partners, Inc.
			Ceftriaxone Sodium	63323034510	American Pharmaceutical Partners, Inc.
			Ceftriaxone Sodium	63323034720	American Pharmaceutical Partners, Inc.
			Ceftriaxone Sodium	63323034610	American Pharmaceutical Partners, Inc.
			Ceftriaxone	00517872510	American Regent Laboratories, Inc.
			Ceftriaxone	00517875010	American Regent Laboratories, Inc.
			Ceftriaxone	00517871110	American Regent Laboratories, Inc.
			Ceftriaxone	00517872210	American Regent Laboratories, Inc.
			Ceftriaxone	60505075304	Apotex Corp.
			Ceftriaxone	60505075300	Apotex Corp.
			Ceftriaxone	60505075204	Apotex Corp.
			Ceftriaxone	60505075200	Apotex Corp.
			Ceftriaxone	60505075104	Apotex Corp.
			Ceftriaxone	60505075100	Apotex Corp.
			Ceftriaxone	60505075004	Apotex Corp.
			Ceftriaxone	60505075000	Apotex Corp.
			Ceftriaxone	60505067909	Apotex Corp.
			Ceftriaxone	60505067908	Apotex Corp.
			Ceftriaxone	60505067905	Apotex Corp.
			Ceftriaxone IN D5W	00264315311	B. Braun Medical Inc.
			Ceftriaxone IN D5W	00264315511	B. Braun Medical Inc.
			Ceftriaxone IN D5W	00338500241	Baxter Healthcare Corporation
			Ceftriaxone Sodium	10019068827	Baxter Healthcare Corporation
			Ceftriaxone IN D5W	00338500341	Baxter Healthcare Corporation
			Ceftriaxone Sodium	10019068501	Baxter Healthcare Corporation
			Ceftriaxone Sodium	10019068602	Baxter Healthcare Corporation
			Ceftriaxone	10019009801	Baxter Healthcare Corporation
			Ceftriaxone Sodium	10019068703	Baxter Healthcare Corporation
			Ceftriaxone Sodium	10019068905	Baxter Healthcare Corporation
			Ceftriaxone Sodium	10019068804	Baxter Healthcare Corporation
			Ceftriaxone	10019068911	Baxter Healthcare Corporation
			Ceftriaxone	10019068771	Baxter Healthcare Corporation
			Ceftriaxone	10019068671	Baxter Healthcare Corporation
			Ceftriaxone	10019009871	Baxter Healthcare Corporation
			Ceftriaxone	10019068571	Baxter Healthcare Corporation
			Ceftriaxone	55390031601	Bedford Laboratories
			Ceftriaxone	55390031210	Bedford Laboratories
			Ceftriaxone	55390031110	Bedford Laboratories
			Ceftriaxone	55390031010	Bedford Laboratories
			Ceftriaxone	55390030910	Bedford Laboratories
			Ceftriaxone Sodium	68330000201	Cephazone Pharma Llc
			Ceftriaxone Sodium	68330000301	Cephazone Pharma Llc
			Ceftriaxone Sodium	68330000501	Cephazone Pharma Llc
			Ceftriaxone Sodium	68330000401	Cephazone Pharma Llc
			Ceftriaxone Sodium	68330000601	Cephazone Pharma Llc
			Ceftriaxone Sodium	68330000210	Cephazone Pharma Llc
			Ceftriaxone Sodium	68330000310	Cephazone Pharma Llc
			Ceftriaxone Sodium	68330000410	Cephazone Pharma Llc
			Ceftriaxone	68330000110	Cephazone Pharma Llc
			Ceftriaxone	68330000101	Cephazone Pharma Llc
			Rocephin	00004196302	Hoffmann-La Roche
			Rocephin	00004196404	Hoffmann-La Roche
			Rocephin	00004196301	Hoffmann-La Roche
			Rocephin	00004196401	Hoffmann-La Roche

Medicaid Physician-Administered Multiple Source Drugs *continued*

HCPCS CODE	SHORT DESCRIPTOR	HCPCS DOSAGE	LABELER DRUG NAME	NDC	LABELER
			Ceftriaxone	00409733701	Hospira, Inc.
			Ceftriaxone	00409733801	Hospira, Inc.
			Ceftriaxone	00409733201	Hospira, Inc.
			Ceftriaxone	00409733304	Hospira, Inc.
			Ceftriaxone	00409733349	Hospira, Inc.
			Ceftriaxone	00409733410	Hospira, Inc.
			Ceftriaxone	00409733503	Hospira, Inc.
			Ceftriaxone	00409733604	Hospira, Inc.
			Ceftriaxone	00409733649	Hospira, Inc.
			Ceftriaxone	00409733561	Hospira, Inc.
			Ceftriaxone	00409733261	Hospira, Inc.
			Ceftriaxone	68180061101	Lupin Pharmaceuticals, Inc.
			Ceftriaxone	68180062201	Lupin Pharmaceuticals, Inc.
			Ceftriaxone	68180063301	Lupin Pharmaceuticals, Inc.
			Ceftriaxone	68180064401	Lupin Pharmaceuticals, Inc.
			Ceftriaxone	68180061110	Lupin Pharmaceuticals, Inc.
			Ceftriaxone	68180062210	Lupin Pharmaceuticals, Inc.
			Ceftriaxone	68180063310	Lupin Pharmaceuticals, Inc.
			Ceftriaxone	68180064410	Lupin Pharmaceuticals, Inc.
			Ceftriaxone	00069448310	Pfizer
			Ceftriaxone	00069448303	Pfizer
			Ceftriaxone	00069448210	Pfizer
			Ceftriaxone	00069448203	Pfizer
			Ceftriaxone	00069448110	Pfizer
			Ceftriaxone	00069448103	Pfizer
			Ceftriaxone	00069448010	Pfizer
			Ceftriaxone	00069448003	Pfizer
			Ceftriaxone Sodium	25021010410	Sagent Pharmaceuticals, Inc.
			Ceftriaxone Sodium	25021010510	Sagent Pharmaceuticals, Inc.
			Ceftriaxone Sodium	25021010610	Sagent Pharmaceuticals, Inc.
			Ceftriaxone Sodium	25021010720	Sagent Pharmaceuticals, Inc.
			Ceftriaxone	25021010899	Sagent Pharmaceuticals, Inc.
			Ceftriaxone	00781320695	Sandoz
			Ceftriaxone	00781932695	Sandoz
			Ceftriaxone	00781320795	Sandoz
			Ceftriaxone	00781932795	Sandoz
			Ceftriaxone	00781320895	Sandoz
			Ceftriaxone	00781932895	Sandoz
			Ceftriaxone	00781321046	Sandoz
			Ceftriaxone	00781933046	Sandoz
			Ceftriaxone	00781320995	Sandoz
			Ceftriaxone	00781932995	Sandoz
			Ceftriaxone	00781932990	Sandoz
			Ceftriaxone	00781932885	Sandoz
			Ceftriaxone	00781320990	Sandoz
			Ceftriaxone	00781320885	Sandoz
			Ceftriaxone	00781320785	Sandoz
			Ceftriaxone	00781320685	Sandoz
			Ceftriaxone Sodium	00703031503	Sicor Pharmaceuticals, Inc.
			Ceftriaxone	00703032503	Sicor Pharmaceuticals, Inc.
			Ceftriaxone	00703033504	Sicor Pharmaceuticals, Inc.
			Ceftriaxone	00703034603	Sicor Pharmaceuticals, Inc.
			Ceftriaxone	00703035901	Sicor Pharmaceuticals, Inc.
			Ceftriaxone	00703034601	Sicor Pharmaceuticals, Inc.
			Ceftriaxone	00703033501	Sicor Pharmaceuticals, Inc.
			Ceftriaxone	00143985925	West-Ward, Inc
			Ceftriaxone	00143985825	West-Ward, Inc
			Ceftriaxone	00143985725	West-Ward, Inc
			Ceftriaxone	00143985625	West-Ward, Inc
			Ceftriaxone	00143976801	West-Ward, Inc
			Ceftriaxone	64679070101	Wockhardt Americas, Inc.
			Ceftriaxone	64679070201	Wockhardt Americas, Inc.
			Ceftriaxone	64679098301	Wockhardt Americas, Inc.
			Ceftriaxone	64679070302	Wockhardt Americas, Inc.
			Ceftriaxone	64679070102	Wockhardt Americas, Inc.
			Ceftriaxone	64679070202	Wockhardt Americas, Inc.
			Ceftriaxone	64679070103	Wockhardt Americas, Inc.
			Ceftriaxone	64679098302	Wockhardt Americas, Inc.
			Ceftriaxone	64679070301	Wockhardt Americas, Inc.
J1040	Methylprednisolone inj	80 MG	Depo-Medrol	00009347501	Pfizer, Inc
			Depo-Medrol	00009030602	Pfizer, Inc
			Depo-Medrol	00009347503	Pfizer, Inc
			Depo-Medrol	00009030612	Pfizer, Inc

Medicaid Physician-Administered Multiple Source Drugs *continued*

HCPCS CODE	SHORT DESCRIPTOR	HCPCS DOSAGE	LABELER DRUG NAME	NDC	LABELER
			Depo-Medrol	00009347523	Pfizer, Inc
			Depo-Medrol	00009347522	Pfizer, Inc
			Depo-Medrol	00009307323	Pfizer, Inc
			Depo-Medrol	00009307322	Pfizer, Inc
			Depo-Medrol	00009307303	Pfizer, Inc
			Depo-Medrol	00009307301	Pharmacia/UPJHN
			Depo-Medrol	00009028052	Pharmacia/UPJHN
			Depo-Medrol	00009028051	Pharmacia/UPJHN
			Depo-Medrol	00009028003	Pharmacia/UPJHN
			Depo-Medrol	00009028002	Pharmacia/UPJHN
			Depo-Medrol	00009027401	Pharmacia/UPJHN
			Methylprednisolone Acetate	00781313775	Sandoz
			Methylprednisolone Acetate	00781313670	Sandoz
			Methylprednisolone Acetate	00781313195	Sandoz
			Methylprednisolone Acetate	00781313171	Sandoz
			Methylprednisolone Acetate	00703004501	Sicor Pharmaceuticals, Inc.
			Methylprednisolone Acetate	00703004301	Sicor Pharmaceuticals, Inc.
			Methylprednisolone Acetate	00703003104	Sicor Pharmaceuticals, Inc.
			Methylprednisolone Acetate	00703003101	Sicor Pharmaceuticals, Inc.
			Methylprednisolone Acetate	00703005101	Sicor Pharmaceuticals, Inc.
			Methylprednisolone Acetate	00703006301	Sicor Pharmaceuticals, Inc.
			Methylprednisolone Acetate	00703005104	Sicor Pharmaceuticals, Inc.
J1100	Dexamethasone sodium phos	1 MG	Dexamethasone Sodium Phosphate	63323016501	American Pharmaceutical Partners, Inc.
			Dexamethasone Sodium Phosphate	63323051610	American Pharmaceutical Partners, Inc.
			Dexamethasone Sodium Phosphate	63323016530	American Pharmaceutical Partners, Inc.
			Dexamethasone Sodium Phosphate	63323050601	American Pharmaceutical Partners, Inc.
			Dexamethasone Sodium Phosphate	63323016505	American Pharmaceutical Partners, Inc.
			Dexamethasone Sodium Phosphate	00517490125	American Regent Laboratories, Inc.
			Dexamethasone Sodium Phosphate	00517490525	American Regent Laboratories, Inc.
			Dexamethasone Sodium Phosphate	00517493025	American Regent Laboratories, Inc.
			Dexamethasone Sodium Phosphate	00641036721	Baxter Healthcare Corporation
			Dexamethasone Sodium Phosphate	00641036725	Baxter Healthcare Corporation
			Dexamethasone Sodium Phosphate	00703352401	Sicor Pharmaceuticals, Inc.
			Dexamethasone Sodium Phosphate	00703352403	Sicor Pharmaceuticals, Inc.
J1170	Hydromorphone injection	4 MG	Hydromorphone Hcl	00555111705	Barr Laboratories Inc
			Hydromorphone Hcl	00555111706	Barr Laboratories Inc
			Hydromorphone Hcl	00555111707	Barr Laboratories Inc
			Hydromorphone Hcl	00641234139	Baxter Healthcare Corporation
			Hydromorphone Hcl	00641012121	Baxter Healthcare Corporation
			Hydromorphone Hcl	00641234141	Baxter Healthcare Corporation
			Hydromorphone Hcl	00641012125	Baxter Healthcare Corporation
			Hydromorphone Hcl	00409128331	Hospira, Inc.
			Hydromorphone Hcl	00409255201	Hospira, Inc.
			Hydromorphone Hcl	00409131230	Hospira, Inc.
			Hydromorphone Hcl	00409335601	Hospira, Inc.
			Hydromorphone Hcl	00409130431	Hospira, Inc.
			Hydromorphone Hcl	00409254001	Hospira, Inc.
			Hydromorphone Hcl	00409336501	Hospira, Inc.
			Hydromorphone Hcl	00409263450	Hospira, Inc.
			Hydromorphone Hcl	00409217201	Hospira, Inc.
			Hydromorphone Hcl	00409263401	Hospira, Inc.
			Hydromorphone Hcl	00409217205	Hospira, Inc.
			Hydromorphone Hcl	00409263405	Hospira, Inc.
			Hydromorphone Hcl	59011044110	Purdue Pharma, L.P.
			Hydromorphone Hcl	59011044210	Purdue Pharma, L.P.
			Hydromorphone Hcl	59011044410	Purdue Pharma, L.P.
			Hydromorphone Hcl	59011044225	Purdue Pharma, L.P.
			Hydromorphone Hcl	59011044501	Purdue Pharma, L.P.
			Hydromorphone Hcl	59011044625	Purdue Pharma, L.P.
			Hydromorphone Hcl	59011044505	Purdue Pharma, L.P.
			Hydromorphone Hcl	59011044550	Purdue Pharma, L.P.
J1280	Dotasetron Mesylate	100 MG	Anzemet	00088120928	Aventis Pharmaceuticals
			Anzemet	00088120808	Aventis Pharmaceuticals
			Anzemet	00088120832	Aventis Pharmaceuticals
			Anzemet	00088120876	Aventis Pharmaceuticals
J1566	Immune globulin, powder	500 MG	Gammagard S/D	00944282001	Baxter Healthcare
			Gammagard S/D	00944282002	Baxter Healthcare
			Gammagard S/D	00944282003	Baxter Healthcare
			Gammagard S/D	00944285503	Baxter Healthcare
			Gammagard S/D	00944282004	Baxter Healthcare

Medicaid Physician-Administered Multiple Source Drugs *continued*

HCPCS CODE	SHORT DESCRIPTOR	HCPCS DOSAGE	LABELER DRUG NAME	NDC	LABELER
			Gammagard S/D	00944265504	Baxter Healthcare
			Carimune Nf	44206041603	Csl Behring, Llc.
			Carimune Nf	44206041706	Csl Behring, Llc.
			Carimune Nf	44206041812	Csl Behring, Llc.
J1626	Granisetron HCl injection	100 MCG	Granisetron HCl	63323031701	American Pharmaceutical Partners, Inc.
			Granisetron HCl	63323031801	American Pharmaceutical Partners, Inc.
			Granisetron HCl	63323031904	American Pharmaceutical Partners, Inc.
			Granisetron HCl	60505076402	Apotex Corp.
			Granisetron HCl	60505069300	Apotex Corp.
			Granisetron HCl	60505069200	Apotex Corp.
			Granisetron HCl	10019005303	Baxter Healthcare Corporation
			Granisetron HCl	10019005314	Baxter Healthcare Corporation
			Granisetron HCl	55390025010	Bedford Laboratories
			Kytril	00004023909	Hoffmann-La Roche
			Kytril	00004024009	Hoffmann-La Roche
			Granisetron HCl	66758003702	Parenta Pharmaceuticals, Inc.
			Granisetron HCl	66758003501	Parenta Pharmaceuticals, Inc.
			Granisetron HCl	66758003601	Parenta Pharmaceuticals, Inc.
			Granisetron HCl	00703797101	Sicor Pharmaceuticals, Inc.
			Granisetron HCl	00703789102	Sicor Pharmaceuticals, Inc.
			Granisetron HCl	00703797301	Sicor Pharmaceuticals, Inc.
			Granisetron HCl	00703787103	Sicor Pharmaceuticals, Inc.
			Granisetron HCl	00703797103	Sicor Pharmaceuticals, Inc.
			Granisetron HCl	64679066201	Wockhardt Americas, Inc.
			Granisetron HCl	64679066103	Wockhardt Americas, Inc.
			Granisetron HCl	64679066102	Wockhardt Americas, Inc.
J1631	Haloperidol Decanoate, Injectio	50 MG	Halopereidol Decanoate	63323047105	American Pharmaceutical Partners
			Halopereidol Decanoate	63323047101	American Pharmaceutical Partners
			Halopereidol Decanoate	63323046905	American Pharmaceutical Partners
			Halopereidol Decanoate	63323046901	American Pharmaceutical Partners
			Halopereidol Decanoate	60505602102	Apotex Corp.
			Halopereidol Decanoate	60505602002	Apotex Corp.
			Halopereidol Decanoate	60505070301	Apotex Corp.
			Halopereidol Decanoate	60505070201	Apotex Corp.
			Halopereidol Decanoate	55390041305	Bedford Laboratories
			Halopereidol Decanoate	55390041301	Bedford Laboratories
			Halopereidol Decanoate	55390041205	Bedford Laboratories
			Halopereidol Decanoate	55390041201	Bedford Laboratories
			Halopereidol Decanoate	00703702301	Sicor Pharmaceuticals, INC.
			Halopereidol Decanoate	00703702103	Sicor Pharmaceuticals, INC.
			Halopereidol Decanoate	00703701301	Sicor Pharmaceuticals, INC.
			Halopereidol Decanoate	00703701103	Sicor Pharmaceuticals, INC.
			Haldol	00045025301	Johnson & Johnson Health Care Systems,
			Haldol	00045025303	Johnson & Johnson Health Care Systems,
			Haldol	00045025414	Johnson & Johnson Health Care Systems,
J1885	Ketorolac Tromethamine, Inject	15 MG	Ketorolac Tromethamine	63323016202	American Pharmaceutical Partners
			Ketorolac Tromethamine	63323016201	American Pharmaceutical Partners
			Ketorolac Tromethamine	63323016101	American Pharmaceutical Partners
			Ketorolac Tromethamine	00517090225	American Regent Laboratories, Inc.
			Ketorolac Tromethamine	00517080125	American Regent Laboratories, Inc.
			Ketorolac Tromethamine	00517060125	American Regent Laboratories, Inc.
			Ketorolac Tromethamine	10019003012	Baxter Healthcare Corpoation
			Ketorolac Tromethamine	10019003004	Baxter Healthcare Corpoation
			Ketorolac Tromethamine	10019003003	Baxter Healthcare Corpoation
			Ketorolac Tromethamine	10019002902	Baxter Healthcare Corpoation
			Ketorolac Tromethamine	55390048110	Bedford Laboratories
			Ketorolac Tromethamine	55390048102	Bedford Laboratories
			Ketorolac Tromethamine	55390048101	Bedford Laboratories
			Ketorolac Tromethamine	55390048001	Bedford Laboratories
			Ketorolac Tromethamine	00409379661	Hospira
			Ketorolac Tromethamine	00409379649	Hospira
			Ketorolac Tromethamine	00409379601	Hospira
			Ketorolac Tromethamine	00409379561	Hospira
			Ketorolac Tromethamine	00409379549	Hospira
			Ketorolac Tromethamine	00409379501	Hospira
			Ketorolac Tromethamine	00409379349	Hospira
			Ketorolac Tromethamine	00409379301	Hospira
			Ketorolac Tromethamine	00409228721	Hospira
			Ketorolac Tromethamine	00409228722	Hospira
			Ketorolac Tromethamine	00409228731	Hospira
			Ketorolac Tromethamine	00409228821	Hospira

Medicaid Physician-Administered Multiple Source Drugs *continued*

HCPCS CODE	SHORT DESCRIPTOR	HCPCS DOSAGE	LABELER DRUG NAME	NDC	LABELER
			Ketorolac Tromethamine	00409228761	Hospira
			Ketorolac Tromethamine	00409228831	Hospira
			Ketorolac Tromethamine	64679075806	Wockhardt Americas, Inc.
			Ketorolac Tromethamine	64679075805	Wockhardt Americas, Inc.
			Ketorolac Tromethamine	64679075804	Wockhardt Americas, Inc.
			Ketorolac Tromethamine	64679075802	Wockhardt Americas, Inc.
			Ketorolac Tromethamine	64679075801	Wockhardt Americas, Inc.
			Ketorolac Tromethamine	64679075703	Wockhardt Americas, Inc.
			Ketorolac Tromethamine	64679075702	Wockhardt Americas, Inc.
			Ketorolac Tromethamine	64679075701	Wockhardt Americas, Inc.
J2405	Ondansetron HCL injection	1 MG	Ondansetron Hcl	63323037420	American Pharmaceutical Partners, Inc.
			Ondansetron Hcl	63323037302	American Pharmaceutical Partners, Inc.
			Ondansetron Hcl	60505074401	Apotex Corp.
			Ondansetron Hcl	60505074406	Apotex Corp.
			Ondansetron Hcl	00338176241	Baxter Healthcare Corporation
			Ondansetron Hcl	10019090603	Baxter Healthcare Corporation
			Ondansetron Hcl	10019090501	Baxter Healthcare Corporation
			Ondansetron Hcl	10019090663	Baxter Healthcare Corporation
			Ondansetron Hcl	10019090605	Baxter Healthcare Corporation
			Ondansetron Hcl	10019090604	Baxter Healthcare Corporation
			Ondansetron Hcl	10019090517	Baxter Healthcare Corporation
			Ondansetron Hcl	10019090503	Baxter Healthcare Corporation
			Ondansetron Hcl	10019090502	Baxter Healthcare Corporation
			Ondansetron Hcl	55390030710	Bedford Laboratories
			Ondansetron Hcl	55390012101	Bedford Laboratories
			Ondansetron Hcl	55390030701	Bedford Laboratories
			Ondansetron Hcl	55390012110	Bedford Laboratories
			Zofran	00173044202	Glaxosmithkline
			Zofran	00173044200	Glaxosmithkline
			Ondansetron Hcl	00409475501	Hospira, Inc.
			Ondansetron Hcl	00409475561	Hospira, Inc.
			Ondansetron Hcl	00409112062	Hospira, Inc.
			Ondansetron Hcl	00409475502	Hospira, Inc.
			Ondansetron Hcl	00409475901	Hospira, Inc.
			Ondansetron Hcl	00409475503	Hospira, Inc.
			Ondansetron Hcl	00409475563	Hospira, Inc.
			Ondansetron Hcl	00409478013	Hospira, Inc.
			Ondansetron Hcl	00409475562	Hospira, Inc.
			Ondansetron Hcl	61703024407	Mayne Pharma (Usa) Inc.
			Ondansetron Hcl	61703024522	Mayne Pharma (Usa) Inc.
			Ondansetron Hcl	00069070012	Pfizer
			Ondansetron Hcl	00054006447	Roxane
			Ondansetron Hcl	25021077650	Sagent Pharmaceuticals, Inc.
			Ondansetron Hcl	00781305714	Sandoz
			Ondansetron Hcl	00781301095	Sandoz
			Ondansetron Hcl	00781305780	Sandoz
			Ondansetron Hcl	00781301072	Sandoz
			Ondansetron Hcl	00703722102	Sicor Pharmaceuticals, Inc.
			Ondansetron Hcl	00703723939	Sicor Pharmaceuticals, Inc.
			Ondansetron Hcl	00703722601	Sicor Pharmaceuticals, Inc.
			Ondansetron Hcl	00703722104	Sicor Pharmaceuticals, Inc.
			Ondansetron Hcl	00703722603	Sicor Pharmaceuticals, Inc.
			Ondansetron Hcl	00703722101	Sicor Pharmaceuticals, Inc.
			Ondansetron Hcl	62756018201	Sun Pharmaceutical Industries, Ltd
			Ondansetron Hcl	62756018101	Sun Pharmaceutical Industries, Ltd
			Ondansetron Hcl	00143989105	West-Ward, Inc
			Ondansetron Hcl	00143989001	West-Ward, Inc
			Ondansetron Hcl	64679072601	Wockhardt Americas, Inc.
			Ondansetron Hcl	64679072701	Wockhardt Americas, Inc.
J2430	Pamidronate disodium	30 MG	Pamidronate Disodium	63323073410	American Pharmaceutical Partners, Inc.
			Pamidronate Disodium	63323073510	American Pharmaceutical Partners, Inc.
			Pamidronate Disodium	55390012701	Bedford Laboratories
			Pamidronate Disodium	55390015701	Bedford Laboratories
			Pamidronate Disodium	55390020401	Bedford Laboratories
			Pamidronate Disodium	55390060401	Bedford Laboratories
			Pamidronate Disodium	55390012901	Bedford Laboratories
			Pamidronate Disodium	55390015901	Bedford Laboratories
			Pamidronate Disodium	61703032418	Mayne Pharma (Usa) Inc.
			Pamidronate Disodium	61703032518	Mayne Pharma (Usa) Inc.
			Pamidronate Disodium	61703032618	Mayne Pharma (Usa) Inc.
			Pamidronate Disodium	61703035618	Mayne Pharma (Usa) Inc.
			Pamidronate Disodium	61703032439	Mayne Pharma (Usa) Inc.

Medicaid Physician-Administered Multiple Source Drugs *continued*

HCPCS CODE	SHORT DESCRIPTOR	HCPCS DOSAGE	LABELER DRUG NAME	NDC	LABELER
			Aredia	00078046461	Novartis
			Aredia	00078046391	Novartis
			Pamidronate Disodium	40042001710	Pharmaforce, Inc
			Pamidronate Disodium	40042001910	Pharmaforce, Inc
			Pamidronate Disodium	00781314870	Sandoz
			Pamidronate Disodium	00781314784	Sandoz
			Pamidronate Disodium	00781314770	Sandoz
			Pamidronate Disodium	00703408551	Sicor Pharmaceuticals, Inc.
			Pamidronate Disodium	00703407559	Sicor Pharmaceuticals, Inc.
J2550	Promethazine HCL, Injection	50 MG	Promethazine	10019009744	Baxter Healthcare Corporation
			Promethazine	10019009701	Baxter Healthcare Corporation
			Promethazine	00641149635	Baxter Healthcare Corporation
			Promethazine	00641149631	Baxter Healthcare Corporation
			Promethazine	00641149535	Baxter Healthcare Corporation
			Promethazine	00641149531	Baxter Healthcare Corporation
			Promethazine	00641095625	Baxter Healthcare Corporation
			Promethazine	00641095621	Baxter Healthcare Corporation
			Promethazine	00641095525	Baxter Healthcare Corporation
			Promethazine	00641095521	Baxter Healthcare Corporation
			Promethazine	00641094935	Baxter Healthcare Corporation
			Promethazine	00641094931	Baxter Healthcare Corporation
			Promethazine	00641094835	Baxter Healthcare Corporation
			Promethazine	00641094831	Baxter Healthcare Corporation
			Promethazine	00641092925	Baxter Healthcare Corporation
			Promethazine	00641092921	Baxter Healthcare Corporation
			Promethazine	00641092825	Baxter Healthcare Corporation
			Promethazine	00641092821	Baxter Healthcare Corporation
			Phenergan	60977000101	Baxter Healthcare Corporation
			Phenergan	60977000103	Baxter Healthcare Corporation
			Phenergan	60977000202	Baxter Healthcare Corporation
			Phenergan	60977000204	Baxter Healthcare Corporation
			Promethazine	00409231231	Hospira
			Promethazine	00409231202	Hospira
			Promethazine	00703220104	Sicor Pharmaceuticals, Inc.
			Promethazine	00703220101	Sicor Pharmaceuticals, Inc.
			Promethazine	00703219104	Sicor Pharmaceuticals, Inc.
			Promethazine	00703219101	Sicor Pharmaceuticals, Inc.
			Promethazine	00143986922	West-Ward, Inc
			Promethazine	00143986822	West-Ward, Inc
J3010	Fentanyl citrate injection	0.1 MG	Fentanyl Citrate	10019003867	Baxter Healthcare Corporation
			Fentanyl Citrate	10019003372	Baxter Healthcare Corporation
			Fentanyl Citrate	10019003473	Baxter Healthcare Corporation
			Fentanyl Citrate	10019003783	Baxter Healthcare Corporation
			Fentanyl Citrate	10019003574	Baxter Healthcare Corporation
			Fentanyl Citrate	00409127632	Hospira, Inc.
			Fentanyl Citrate	00409909332	Hospira, Inc.
			Fentanyl Citrate	00409909422	Hospira, Inc.
			Fentanyl Citrate	00409909335	Hospira, Inc.
			Fentanyl Citrate	00409909336	Hospira, Inc.
			Fentanyl Citrate	00409909338	Hospira, Inc.
			Fentanyl Citrate	00409909425	Hospira, Inc.
			Fentanyl Citrate	00409909428	Hospira, Inc.
			Fentanyl Citrate	00409909431	Hospira, Inc.
			Fentanyl Citrate	00409909461	Hospira, Inc.
			Sublimaze	11098003002	Taylor Pharmaceuticals
			Sublimaze	11098003005	Taylor Pharmaceuticals
			Sublimaze	11098003020	Taylor Pharmaceuticals
J3370	Vancomycin HCL, injection	500 mg	Vancomycin HCL	63323022110	American Pharmaceutical Partners, Inc.
			Vancomycin HCL	63323028420	American Pharmaceutical Partners, Inc.
			Vancomycin HCL	63323029561	American Pharmaceutical Partners, Inc.
			Vancomycin HCL	63323031461	American Pharmaceutical Partners, Inc.
			Vancomycin HCL	00338355148	Baxter Healthcare Corporation
			Vancomycin HCL	00338355248	Baxter Healthcare Corporation
			Vancomycin HCL	10139050120	Generamedix, Inc.
			Vancomycin HCL	10139050112	Generamedix, Inc.
			Vancomycin HCL	00409433201	Hospira, Inc.
			Vancomycin HCL	00409650901	Hospira, Inc.
			Vancomycin HCL	00409650949	Hospira, Inc.
			Vancomycin HCL	00409653301	Hospira, Inc.
			Vancomycin HCL	00409653349	Hospira, Inc.
			Vancomycin HCL	00409653361	Hospira, Inc.

Medicaid Physician-Administered Multiple Source Drugs *continued*

HCPCS CODE	SHORT DESCRIPTOR	HCPCS DOSAGE	LABELER DRUG NAME	NDC	LABELER
			Vancomycin HCL	00409653401	Hospira, Inc.
			Vancomycin HCL	00409653449	Hospira, Inc.
			Vancomycin HCL	00409653501	Hospira, Inc.
			Vancomycin HCL	00409653549	Hospira, Inc.
			Vancomycin HCL	00409651001	Hospira, Inc.
			Vancomycin HCL	00409653102	Hospira, Inc.
			Vancomycin HCL	00409433249	Novaplus Hospira
J7050	Normal Saline Solution Infusion 250 cc		Sodium Chloride	00074798427	Abbott Laboratories
			Sodium Chloride	00264780020	B. Braun Medical Inc.
			Sodium Chloride	00264780010	B. Braun Medical Inc.
			Sodium Chloride	00264780000	B. Braun Medical Inc.
			Sodium Chloride	00264400255	B. Braun Medical Inc.
			Sodium Chloride	00264400155	B. Braun Medical Inc.
			Sodium Chloride	00264400055	B. Braun Medical Inc.
			Sodium Chloride	00264180031	B. Braun Medical Inc.
			Sodium Chloride	00264180032	B. Braun Medical Inc.
			Sodium Chloride	00264180036	B. Braun Medical Inc.
			Sodium Chloride	00338630403	Baxter
			Sodium Chloride	00338630402	Baxter
			Sodium Chloride	00338004904	Baxter
			Sodium Chloride	00338004903	Baxter
			Sodium Chloride	00338004902	Baxter
			Sodium Chloride	00338004403	Baxter
			Sodium Chloride	00338004511	Baxter
			Sodium Chloride	00338004911	Baxter
			Sodium Chloride	00338004918	Baxter
			Sodium Chloride	00338004931	Baxter
			Sodium Chloride	00338004938	Baxter
			Sodium Chloride	00338004941	Baxter
			Sodium Chloride	00338055311	Baxter
			Sodium Chloride	00338055318	Baxter
			Sodium Chloride	00409158301	Hospira
			Sodium Chloride	00409158302	Hospira
			Sodium Chloride	00409158411	Hospira
			Sodium Chloride	00409710102	Hospira
			Sodium Chloride	00409710166	Hospira
			Sodium Chloride	00409710167	Hospira
			Sodium Chloride	00409798302	Hospira
			Sodium Chloride	00409798303	Hospira
			Sodium Chloride	00409798309	Hospira
			Sodium Chloride	00409798330	Hospira
			Sodium Chloride	00409798348	Hospira
			Sodium Chloride	00409798353	Hospira
			Sodium Chloride	00409798355	Hospira
			Sodium Chloride	00409798361	Hospira
			Sodium Chloride	00409798413	Hospira
			Sodium Chloride	00409798420	Hospira
			Sodium Chloride	00409798423	Hospira
			Sodium Chloride	00409798436	Hospira
			Sodium Chloride	00409798437	Hospira
J7190	Factor VIII	1 IU	Hemofil M	00944293504	Baxter Healthcare
			Hemofil M	00944293503	Baxter Healthcare
			Hemofil M	00944293502	Baxter Healthcare
			Hemofil M	00944293501	Baxter Healthcare
			Hemofil M	00944293301	Baxter Healthcare
			Hemofil M	00944293201	Baxter Healthcare
			Hemofil M	00944293101	Baxter Healthcare
			Hemofil M	00944293001	Baxter Healthcare
			Monoclate-P	00053765605	CSL Behring
			Monoclate-P	00053765604	CSL Behring
			Monoclate-P	00053765602	CSL Behring
			Monoclate-P	00053765601	CSL Behring
			Alphanate /von Willebrand Factor Com	68516460402	Grifols Biologicals INC
			Alphanate /von Willebrand Factor Com	68516460302	Grifols Biologicals INC
			Alphanate /von Willebrand Factor Com	68516460201	Grifols Biologicals INC
			Alphanate /von Willebrand Factor Com	68516460101	Grifols Biologicals INC
			Alphanate	68516460002	Grifols Biologicals INC
			Alphanate	68516460001	Grifols Biologicals INC
			Koate-Dvi	13533066550	Talecris Biologicals Inc
			Koate-Dvi	13533066530	Talecris Biologicals Inc
			Koate-Dvi	13533066520	Talecris Biologicals Inc

Medicaid Physician-Administered Multiple Source Drugs *continued*

HCPCS CODE	SHORT DESCRIPTOR	HCPCS DOSAGE	LABELER DRUG NAME	NDC	LABELER
J7192	Factor VIII Recombinant	1 IU	Advate	00944294610	Baxter Healthcare
			Advate	00944294510	Baxter Healthcare
			Advate	00944294410	Baxter Healthcare
			Advate	00944294310	Baxter Healthcare
			Advate	00944294210	Baxter Healthcare
			Advate	00944294110	Baxter Healthcare
			Recombinate	00944283310	Baxter Healthcare
			Recombinate	00944283210	Baxter Healthcare
			Recombinate	00944283110	Baxter Healthcare
			Kogenate FS 3000 Bio-set	00026379770	Bayer Corporation Pharmaceutical
			Kogenate FS 3000	00026378770	Bayer Corporation Pharmaceutical
			Kogenate FS	00026378550	Bayer Corporation Pharmaceutical
			Kogenate FS	00026379660	Bayer Corporation Pharmaceutical
			Kogentate FS Bio-set	00026379550	Bayer Corporation Pharmaceutical
			Kogenate FS Fixed Poly Bio-set	00026379330	Bayer Corporation Pharmaceutical
			Kogenate FS Fixed Poly Bio-set	00026379220	Bayer Corporation Pharmaceutical
			Kogenate Fs	00026378660	Bayer Corporation Pharmaceutical
			Kogenate Fs	00026378330	Bayer Corporation Pharmaceutical
			Kogenate FS Fixed Poly Classic	00026378220	Bayer Corporation Pharmaceutical
			Kogenate FS Bio-set	00026037960	Bayer Corporation Pharmaceutical
			Kogenate FS Bio-set	00026037930	Bayer Corporation Pharmaceutical
			Kogenate FS Bio-set	00026037920	Bayer Corporation Pharmaceutical
			Kogenate Fs	00026037250	Bayer Corporation Pharmaceutical
			Kogenate Fs	00026037230	Bayer Corporation Pharmaceutical
			Kogenate Fs	00026037220	Bayer Corporation Pharmaceutical
			Helixate FS 3000	00053813502	CSL Behring
			Helixate Fs	00053813005	CSL Behring
			Helixate Fs	00053813004	CSL Behring
			Helixate Fs	00053813002	CSL Behring
			Helixate Fs	00053813001	CSL Behring
			Refacto	58394001104	Genetics Institute Inc
			Refacto	58394001102	Genetics Institute Inc
			Refacto	58394000702	Genetics Institute Inc
			Refacto	58394000704	Genetics Institute Inc
			Refacto	58394000604	Genetics Institute Inc
			Refacto	58394000602	Genetics Institute Inc
			Refacto	58394000504	Genetics Institute Inc
			Refacto	58394000502	Genetics Institute Inc
J7644	Ipratropium Bromide Inh Solud	1 mg	Ipratropium Bromide	16252009822	Cobalt Laboratories
			Ipratropium Bromide	16252009833	Cobalt Laboratories
			Ipratropium Bromide	16252009866	Cobalt Laboratories
			Ipratropium Bromide	49502068526	Dey, L.P.
			Ipratropium Bromide	49502068530	Dey, L.P.
			Ipratropium Bromide	49502068531	Dey, L.P.
			Ipratropium Bromide	49502068562	Dey, L.P.
			Ipratropium Bromide	00487980160	Nephron Pharmaceuticals
			Ipratropium Bromide	00487980130	Nephron Pharmaceuticals
			Ipratropium Bromide	00487980125	Nephron Pharmaceuticals
			Ipratropium Bromide	00487980101	Nephron Pharmaceuticals
			Ipratropium Bromide	00487980102	Nephron Pharmaceuticals
J9000	Doxorubic hcl 10 MG vl chemo	10 MG	Doxorubicin Hcl	63323088305	American Pharmaceutical Partners, Inc.
			Doxorubicin Hcl	63323088310	American Pharmaceutical Partners, Inc.
			Doxorubicin Hcl	63323088330	American Pharmaceutical Partners, Inc.
			Doxorubicin Hcl	63323010161	American Pharmaceutical Partners, Inc.
			Adriamycin	55390023301	Bedford Laboratories
			Doxorubicin Hcl	55390024301	Bedford Laboratories
			Adriamycin	55390023701	Bedford Laboratories
			Doxorubicin Hcl	55390024701	Bedford Laboratories
			Adriamycin	55390023110	Bedford Laboratories
			Doxorubicin Hcl	55390024110	Bedford Laboratories
			Adriamycin	55390023510	Bedford Laboratories
			Doxorubicin Hcl	55390024510	Bedford Laboratories
			Adriamycin	55390023210	Bedford Laboratories
			Adriamycin	55390023610	Bedford Laboratories
			Doxorubicin Hcl	55390024610	Bedford Laboratories
			Adriamycin	55390023801	Bedford Laboratories
			Doxorubicin Hcl	55390024801	Bedford Laboratories
			Doxorubicin Hcl	00703504601	Sicor Pharmaceuticals, Inc.
			Doxorubicin Hcl	00703504303	Sicor Pharmaceuticals, Inc.
			Doxorubicin Hcl	00703504001	Sicor Pharmaceuticals, Inc.
J9040	Bleomycin Sulfate Injection	15 units	Bleomycin Sulfate	63323013720	APP Pharmaceuticals, LLC

Medicaid Physician-Administered Multiple Source Drugs *continued*

HCPCS CODE	SHORT DESCRIPTOR	HCPCS DOSAGE	LABELER DRUG NAME	NDC	LABELER
			Bleomycin Sulfate	55390000501	Bedford Laboratories
			Bleomycin Sulfate	55390000601	Bedford Laboratories
			Bleomycin Sulfate	61703032322	Mayne Pharma (Usa) Inc.
			Bleomycin Sulfate	61703033218	Mayne Pharma (Usa) Inc.
			Bleomycin Sulfate	00703315401	Sicor
			Bleomycin Sulfate	00703315501	Sicor
J9045	Carboplatin injection	50 MG	Carboplatin	63323016610	American Pharmaceutical Partners, Inc.
			Carboplatin	63323016721	American Pharmaceutical Partners, Inc.
			Carboplatin	63323016800	American Pharmaceutical Partners, Inc.
			Carboplatin	63323017245	American Pharmaceutical Partners, Inc.
			Carboplatin	63323017260	American Pharmaceutical Partners, Inc.
			Carboplatin	63323017215	American Pharmaceutical Partners, Inc.
			Carboplatin	63323017205	American Pharmaceutical Partners, Inc.
			Carboplatin	55390015001	Bedford Laboratories
			Carboplatin	55390015301	Bedford Laboratories
			Carboplatin	55390015101	Bedford Laboratories
			Carboplatin	55390015401	Bedford Laboratories
			Carboplatin	55390015201	Bedford Laboratories
			Carboplatin	55390015501	Bedford Laboratories
			Carboplatin	55390015601	Bedford Laboratories
			Carboplatin	55390022201	Bedford Laboratories
			Carboplatin	55390022101	Bedford Laboratories
			Carboplatin	55390022001	Bedford Laboratories
			Carboplatin	00409112912	Hospira, Inc.
			Carboplatin	00409112911	Hospira, Inc.
			Carboplatin	00409112910	Hospira, Inc.
			Carboplatin	61703033918	Mayne Pharma (Usa) Inc.
			Carboplatin	61703036018	Mayne Pharma (Usa) Inc.
			Carboplatin	61703033922	Mayne Pharma (Usa) Inc.
			Carboplatin	61703036022	Mayne Pharma (Usa) Inc.
			Carboplatin	61703033950	Mayne Pharma (Usa) Inc.
			Carboplatin	61703036050	Mayne Pharma (Usa) Inc.
			Carboplatin	61703033956	Mayne Pharma (Usa) Inc.
			Carboplatin	61703033963	Mayne Pharma (Usa) Inc.
			Carboplatin	61703033962	Mayne Pharma (Usa) Inc.
			Carboplatin	61703033961	Mayne Pharma (Usa) Inc.
			Carboplatin	66758004701	Parenta Pharmaceuticals, Inc.
			Carboplatin	66758004702	Parenta Pharmaceuticals, Inc.
			Carboplatin	66758004703	Parenta Pharmaceuticals, Inc.
			Carboplatin	50111098576	Pliva, Inc.
			Carboplatin	50111098676	Pliva, Inc.
			Carboplatin	50111098776	Pliva, Inc.
			Carboplatin	00703424401	Sicor Pharmaceuticals, Inc.
			Carboplatin	00703424601	Sicor Pharmaceuticals, Inc.
			Carboplatin	00703424501	Sicor Pharmaceuticals, Inc.
			Carboplatin	00703324911	Sicor Pharmaceuticals, Inc.
			Carboplatin	00591222011	Watson Labs
			Carboplatin	00591221911	Watson Labs
J9060	Cisplatin 10 MG injection	10 MG	Cisplatin	63323010351	American Pharmaceutical Partners, Inc.
			Cisplatin	63323010365	American Pharmaceutical Partners, Inc.
			Cisplatin	63323010364	American Pharmaceutical Partners, Inc.
			Cisplatin	55390011250	Bedford Laboratories
			Cisplatin	55390041450	Bedford Laboratories
			Cisplatin	55390011299	Bedford Laboratories
			Cisplatin	55390041499	Bedford Laboratories
			Cisplatin	55390009901	Bedford Laboratories
			Cisplatin Injection	55390018701	Bedford Laboratories
			Cisplatin	00703574711	Sicor Pharmaceuticals, Inc.
			Cisplatin	00703574811	Sicor Pharmaceuticals, Inc.
J9062	Cisplastin Injection	50 mg	Cisplastin	63323010351	American Pharmaceutical Partners, Inc.
			Cisplastin	63323010364	American Pharmaceutical Partners, Inc.
			Cisplastin	63323010365	American Pharmaceutical Partners, Inc.
			Cisplastin	55390009901	Bedford Laboratories
			Cisplastin	55390011250	Bedford Laboratories
			Cisplastin	55390011299	Bedford Laboratories
			Cisplastin	55390018701	Bedford Laboratories
			Cisplastin	55390041450	Bedford Laboratories
			Cisplastin	55390041499	Bedford Laboratories
			Cisplastin	00703574711	Sicor
			Cisplastin	00703574811	Sicor

Medicaid Physician-Administered Multiple Source Drugs *continued*

HCPCS CODE	SHORT DESCRIPTOR	HCPCS DOSAGE	LABELER DRUG NAME	NDC	LABELER
J9178	Inj, epirubicin hcl	2 MG	Epirubicin	63323015105	American Pharmaceutical Partners, Inc.
			Epirubicin	63323015125	American Pharmaceutical Partners, Inc.
			Epirubicin	63323015175	American Pharmaceutical Partners, Inc.
			Epirubicin	63323015100	American Pharmaceutical Partners, Inc.
			Epirubicin	55390020701	Bedford Laboratories
			Epirubicin	55390020801	Bedford Laboratories
			Epirubicin	10518010410	Dabur Oncology Plc
			Epirubicin	10518010411	Dabur Oncology Plc
			Epirubicin	61703035992	Mayne Pharma (Usa) Inc.
			Epirubicin	61703034735	Mayne Pharma (Usa) Inc.
			Epirubicin	61703035901	Mayne Pharma (Usa) Inc.
			Epirubicin	61703035993	Mayne Pharma (Usa) Inc.
			Epirubicin	61703035991	Mayne Pharma (Usa) Inc.
			Epirubicin	61703035902	Mayne Pharma (Usa) Inc.
			Epirubicin	61703035959	Mayne Pharma (Usa) Inc.
			Epirubicin	61703034859	Mayne Pharma (Usa) Inc.
			Ellence	00009509101	Pfizer, Inc
			Ellence	00009509301	Pfizer, Inc
			Epirubicin	59762509101	Pfizer, Inc.
			Epirubicin	59762509301	Pfizer, Inc.
			Epirubicin	25021020325	Sagent Pharmaceuticals, Inc.
			Epirubicin	25021020351	Sagent Pharmaceuticals, Inc.
			Epirubicin	00703306711	Sicor Pharmaceuticals, Inc.
			Epirubicin	00703306911	Sicor Pharmaceuticals, Inc.
J9190	Fluorouracil injection	500 MG	Fluorouracil	63323011751	American Pharmaceutical Partners, Inc.
			Fluorouracil	63323011710	American Pharmaceutical Partners, Inc.
			Fluorouracil	63323011761	American Pharmaceutical Partners, Inc.
			Fluorouracil	63323011720	American Pharmaceutical Partners, Inc.
			Fluorouracil	10139006301	Generamedix, Inc.
			Fluorouracil	10139006310	Generamedix, Inc.
			Fluorouracil	10139006320	Generamedix, Inc.
			Fluorouracil	66758004401	Parenta Pharmaceuticals, Inc.
			Fluorouracil	66758004403	Parenta Pharmaceuticals, Inc.
			Adrucil	00703301513	Sicor Pharmaceuticals, Inc.
			Adrucil	00703301812	Sicor Pharmaceuticals, Inc.
			Adrucil	00703301912	Sicor Pharmaceuticals, Inc.
J9206	Irinotecan injection	20 MG	Irinotecan HCL	63323019302	American Pharmaceutical Partners, Inc.
			Irinotecan HCL	63323019305	American Pharmaceutical Partners, Inc.
			Irinotecan HCL	10019093401	Baxter Healthcare Corporation
			Irinotecan HCL	10019093417	Baxter Healthcare Corporation
			Irinotecan HCL	10019093402	Baxter Healthcare Corporation
			Irinotecan HCL	10019093479	Baxter Healthcare Corporation
			Irinotecan HCL	55390029601	Bedford Laboratories
			Irinotecan HCL	55390029501	Bedford Laboratories
			Irinotecan HCL	10518010310	Dabur Oncology Plc
			Irinotecan HCL	10518010311	Dabur Oncology Plc
			Irinotecan HCL	61703034916	Mayne Pharma (Usa) Inc.
			Irinotecan HCL	61703034961	Mayne Pharma (Usa) Inc.
			Irinotecan HCL	61703034909	Mayne Pharma (Usa) Inc.
			Irinotecan HCL	61703034962	Mayne Pharma (Usa) Inc.
			Irinotecan HCL	61703034936	Mayne Pharma (Usa) Inc.
			Irinotecan HCL	66758004802	Parenta Pharmaceuticals, Inc.
			Irinotecan HCL	66758004801	Parenta Pharmaceuticals, Inc.
			Camptosar	00009752902	Pfizer, Inc
			Camptosar	00009752901	Pfizer, Inc
			Irinotecan HCL	59762752901	Pfizer, Inc.
			Irinotecan HCL	59762752902	Pfizer, Inc.
			Irinotecan HCL	25021020005	Sagent Pharmaceuticals, Inc.
			Irinotecan HCL	25021020002	Sagent Pharmaceuticals, Inc.
			Irinotecan HCL	00781306672	Sandoz
			Irinotecan HCL	00781306675	Sandoz
			Irinotecan HCL	00703443211	Sicor Pharmaceuticals, Inc.
			Irinotecan HCL	00703443411	Sicor Pharmaceuticals, Inc.
			Irinotecan HCL	00703443491	Sicor Pharmaceuticals, Inc.
			Irinotecan HCL	00703443711	Teva
J9217	Leuprolide acetate suspension	7.5 MG	Lupron Depot	00074368303	Abbott Laboratories
			Lupron Depot	00074366303	Abbott Laboratories
			Lupron Depot	00074364203	Abbott Laboratories
			Lupron Depot	00074364103	Abbott Laboratories
			Lupron Depot	00074334603	Abbott Laboratories
			Lupron Depot-Ped	00074244003	Abbott Laboratories

Medicaid Physician-Administered Multiple Source Drugs *continued*

HCPCS CODE	SHORT DESCRIPTOR	HCPCS DOSAGE	LABELER DRUG NAME	NDC	LABELER
			Lupron Depot-Ped	00074228203	Abbott Laboratories
			Lupron Depot-Ped	00074210803	Abbott Laboratories
			Eligard	00024079375	Sanofi-Aventis, Us Llc
			Eligard	00024022205	Sanofi-Aventis, Us Llc
			Eligard	00024061030	Sanofi-Aventis, Us Llc
			Eligard	00024060545	Sanofi-Aventis, Us Llc
			Lupron Depot	00300364201	Tap Pharmaceuticals Inc
			Lupron Depot-Ped	00300210801	Tap Pharmaceuticals Inc
			Lupron Depot-Ped	00300244001	Tap Pharmaceuticals Inc
			Lupron Depot	00300334601	Tap Pharmaceuticals Inc
			Lupron Depot	00300366301	Tap Pharmaceuticals Inc
			Lupron Depot	00300364101	Tap Pharmaceuticals Inc
			Lupron Depot	00300361228	Tap Pharmaceuticals Inc
			Lupron Depot-Ped	00300228201	Tap Pharmaceuticals Inc
			Lupron Depot	00300368301	Tap Pharmaceuticals Inc
J9265	Paclitaxel injection	30 MG	Paclitaxel	63323076350	American Pharmaceutical Partners, Inc.
			Paclitaxel	63323076316	American Pharmaceutical Partners, Inc.
			Paclitaxel	63323076305	American Pharmaceutical Partners, Inc.
			Paclitaxel	00555198414	Barr Laboratories Inc
			Paclitaxel	00555198514	Barr Laboratories Inc
			Paclitaxel	55390011405	Bedford Laboratories
			Paclitaxel	55390030405	Bedford Laboratories
			Paclitaxel	55390031405	Bedford Laboratories
			Paclitaxel	55390011420	Bedford Laboratories
			Paclitaxel	55390030420	Bedford Laboratories
			Paclitaxel	55390031420	Bedford Laboratories
			Paclitaxel	55390031450	Bedford Laboratories
			Paclitaxel	55390011450	Bedford Laboratories
			Paclitaxel	55390030450	Bedford Laboratories
			Paclitaxel	55390031450	Bedford Laboratories
			Paclitaxel	10518010207	Dabur Oncology Plc
			Paclitaxel	10518010209	Dabur Oncology Plc
			Onxol	00172375695	Ivax Pharmaceuticals, Inc.
			Onxol	00172375494	Ivax Pharmaceuticals, Inc.
			Onxol	00172375473	Ivax Pharmaceuticals, Inc.
			Onxol	00172375377	Ivax Pharmaceuticals, Inc.
			Paclitaxel	61703034209	Mayne Pharma (Usa) Inc.
			Paclitaxel	61703034222	Mayne Pharma (Usa) Inc.
			Paclitaxel	61703034250	Mayne Pharma (Usa) Inc.
			Taxol	00015347630	Mead Johnson And Company
			Taxol	00015347911	Mead Johnson And Company
			Paclitaxel	66758004301	Parenta Pharmaceuticals, Inc.
			Paclitaxel	66758004302	Parenta Pharmaceuticals, Inc.
			Paclitaxel	66758004303	Parenta Pharmaceuticals, Inc.
			Paclitaxel	00703476801	Sicor Pharmaceuticals, Inc.
			Paclitaxel	00703476401	Sicor Pharmaceuticals, Inc.
			Paclitaxel	00703476601	Sicor Pharmaceuticals, Inc.
			Paclitaxel	00703476701	Sicor Pharmaceuticals, Inc.
J9293	Mitoxantrone HCL Injection	5 mg	Mitoxantrone Hydrochloride	63323013215	American Pharmaceutical Partners, Inc.
			Mitoxantrone Hydrochloride	63323013212	American Pharmaceutical Partners, Inc.
			Mitoxantrone Hydrochloride	63323013210	American Pharmaceutical Partners, Inc.
			Mitoxantrone Hydrochloride	55390008501	Bedford Laboratories
			Mitoxantrone Hydrochloride	55390008401	Bedford Laboratories
			Mitoxantrone Hydrochloride	55390008301	Bedford Laboratories
			Mitoxantrone Hydrochloride	10518010512	Dabur Pharma US, Inc
			Mitoxantrone Hydrochloride	10518010511	Dabur Pharma US, Inc
			Mitoxantrone Hydrochloride	10518010510	Dabur Pharma US, Inc
			Mitoxantrone Hydrochloride	61703034366	Mayne Pharma (Usa) Inc.
			Mitoxantrone Hydrochloride	61703034365	Mayne Pharma (Usa) Inc.
			Mitoxantrone Hydrochloride	61703034318	Mayne Pharma (Usa) Inc.
			Mitoxantrone Hydrochloride	15210040336	OTN Generics, Inc
			Mitoxantrone Hydrochloride	15210040335	OTN Generics, Inc
			Mitoxantrone Hydrochloride	44087152001	Serono
			Mitoxantrone Hydrochloride	00703468501	Sicor
			Mitoxantrone Hydrochloride	00703468001	Sicor
			Mitoxantrone Hydrochloride	00703468601	Sicor
J9390	Vinorelbine tartrate/10 mg	10 MG	Vinorelbine Tartrate	63323014801	American Pharmaceutical Partners, Inc.
			Vinorelbine Tartrate	63323014805	American Pharmaceutical Partners, Inc.
			Vinorelbine Tartrate	55390006901	Bedford Laboratories
			Vinorelbine Tartrate	55390026701	Bedford Laboratories
			Vinorelbine Tartrate	55390007001	Bedford Laboratories

Medicaid Physician-Administered Multiple Source Drugs *continued*

HCPCS CODE	SHORT DESCRIPTOR	HCPCS DOSAGE	LABELER DRUG NAME	NDC	LABELER
			Vinorelbine Tartrate Amerinet Choice	55390026801	Bedford Laboratories
			Vinorelbine Tartrate	61703034108	Mayne Pharma (Usa) Inc.
			Vinorelbine Tartrate	61703034109	Mayne Pharma (Usa) Inc.
			Vinorelbine Tartrate	66758004501	Parenta Pharmaceuticals, Inc.
			Vinorelbine Tartrate	66758004502	Parenta Pharmaceuticals, Inc.
			Vinorelbine Tartrate	64370021001	Pierre Fabre Medicament
			Vinorelbine Tartrate	64370025001	Pierre Fabre Medicament
			Vinorelbine Tartrate	25021020401	Sagent Pharmaceuticals, Inc.
			Vinorelbine Tartrate	25021020405	Sagent Pharmaceuticals, Inc.
			Vinorelbine Tartrate	00703418201	Sicor Pharmaceuticals, Inc.
			Vinorelbine Tartrate	00703418281	Sicor Pharmaceuticals, Inc.
			Vinorelbine Tartrate	00703418291	Sicor Pharmaceuticals, Inc.
			Vinorelbine Tartrate	00703418381	Sicor Pharmaceuticals, Inc.
			Vinorelbine Tartrate	00703418301	Sicor Pharmaceuticals, Inc.
			Vinorelbine Tartrate	00703418391	Sicor Pharmaceuticals, Inc.

New HCPCS L Codes

Effective January 1, 2010 four HCPCS codes were added for cochlear implant system/component replacement supplies. L8627 and L8628 require a prior authorization and is age restricted to 0-20 years of age. These codes are similar to code L8619 which has been used previously for cochlear implant, external speech processor and controller , integrated system, replacement. Code L8627 covers only the external speech processor, component replacement and code L8628 covers only the controller component replacement. Two additional L codes were added that are covered for cross over claims only. Code L8629, transmitting coil and cable, integrated, for use with cochlear implant device, replacement and code L8692, auditory osseointegrated device, external sound processor, used without osseointegration, body worn, includes headband or other means of external attachment. Codes L8617 and L8690 continue to be effective codes which are similar new codes L8629 and L8692 respectively

VFC Utilization

Providers are encouraged to utilize licensed available combination vaccines when indicated, rather than the individual components of the vaccine.

- Gardasil (HPV) (procedure code 90649) vaccine was approved as a VFC for the male population ages 9-18 (Effective October 1, 2009).
- Hibirix (procedure code 90648), the HIB booster dose was approved August 19, 2009 for ages 15 months to 4 years. The ACIP recommends booster dose between 12 months and 4 years of age.

Providing and Obtaining Appropriate Referrals Based on Periodic and Interperiodic EPSDT Screenings

Medically necessary services provided above the normal benefit limitations require a referral from an EPSDT screening provider. The referral form (Form 362) must be completed appropriately by the **screening physician** including the screening date that the problem was identified and the reason for the referral. The instruction for completion of the Referral Form is located on the website at *www.medicaid.alabama.gov/billing/billingforms*. Medically necessary services are to be determined by an EPSDT screening provider and Patient 1st PMP, if applicable. Medically necessary services are rendered based on a current EPSDT screening (EPSDT referrals are valid for one year from the date of the EPSDT screening) that identified the problem that warranted services. The maximum time an EPSDT referral is valid is 12 months from the date of the EPSDT screening.

Telemedicine Services

Effective February 1, 2010, enrolled Telemedicine Providers with specialties of **dermatology** or **psychiatry** (includes psychiatrists only), will be allowed to bill the Agency for telemedicine services for covered procedure codes.

The intent of telemedicine services is to improve access to essential health care services that may not otherwise be available for Medicaid eligible recipients residing in medically underserved areas of Alabama. Please note, services provided via telecommunications technologies are not covered if the recipient has access to a comparable service within **50** miles of his/her place of residence

The following codes associated with specialties of dermatology or psychiatry will be considered for reimbursement:

- Consultations (99241-99245, 99251-99255),
- Office or Other Outpatient visits (99201-99205, 99211-99215),
- Individual Psychotherapy (90804-90809)
- Psychiatric Diagnostic (90801)
- Neurobehavioral Status Exam (96116)
- Physician Medical Assessment and Treatment (Rehabilitative option Program **only**) (90862-HE and 90862-HF).

Please note, all procedure codes billed by **dermatologists** will require either the **GT** modifier (via interactive audio and video telecommunications system), or the **GQ** modifier (via asynchronous (store & forward) telecommunications system). Additionally, Telemedicine procedures billed by **psychiatrists** will require the **GT** modifier only. These modifiers must be billed with all procedure codes identified as telemedicine services.

Psyciatrists and Dermatologists will need to contact the Alabama Medicaid Provider Enrollment Center for information on the enrollment process for telemedicine.

Remittance Advice Availability

When are RAs and other reports available on the web portal for download?

- RA's are available the Monday after each checkwrite.
- EPSDT Periodic Resreening Report is available the Monday after the second checkwrite of the month.

Patient 1st reports:

- MGD-A500-M (Patient 1st referral report) The report is available the first Monday of each month.
- MGD-0055-M (Monthly PMP Enrollment Roster) The reports is available around the 23rd of each month.
- MGD-A120-M (Capitation Summary by Payee Provider) The report is available the Monday after the first checkwrite of each month.

Medicaid Application Assisters

If you are certified as a Medicaid Application Assister and your certificate is more than two (2) years old, you will need to be recertified. Please contact Marcia Teel at (334) 242-4924 or *marcia.teel@medicaid.alabama.gov* for recertification.

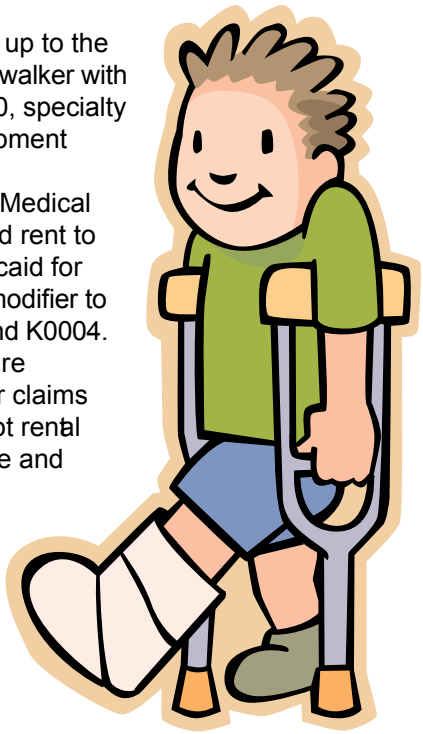
Hearing Services

When billing for hearing services, replacement items and supplies, providers should bill the actual acquisition cost.

Combination and Single Vaccine Billing

Effective April 1, 2010, combination vaccines and their single components will not be allowed to pay on the same date of service or within 30 days.

Attention DME Providers



Effective March 1, 2010, Alabama Medicaid covers specialty walkers for children up to the age of 21 through the EPSDT Program using procedure code E0140 with UE modifier (walker with trunk support, adjustable or fixed height, any height, any type). Prior to March 1, 2010, specialty walkers were previously covered using procedure code E1399 (durable medical equipment miscellaneous).

Provider's claims are routinely submitted to Medicare forAppliances and Durable Medical Equipment with the appropriate procedure code and RR modifier as a monthly capped rent to purchase item. When submitting these Medicare crossover claims to Alabama Medicaid for appliances and durable medical equipment items, please bill with the appropriate RR modifier to ensure proper processing of your claims for procedure codes such as K0001, K0003, and K0004. The RR modifier indicates that this claim is billed as a monthly rental item. Medicare reimburses for supplies as purchase items only When submitting Medicare crossover claims to Alabama Medicaid for supply items, do not bill with the RR modifier Supplies are not rental items. Submit claims for Medicare supply items using the appropriate procedure code and modifier as specified on the Medicare Fee Schedule (A7030 NU).

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

Alabama Medicaid Bulletin

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Alabama Medicaid Bulletin **July 2010**

The checkwrite schedule is as follows:

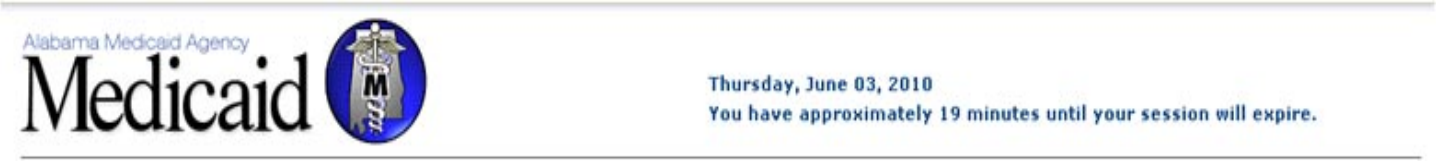
07/09/2010 07/23/2010 08/06/2010 08/20/2010 09/10/2010 09/17/2010

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

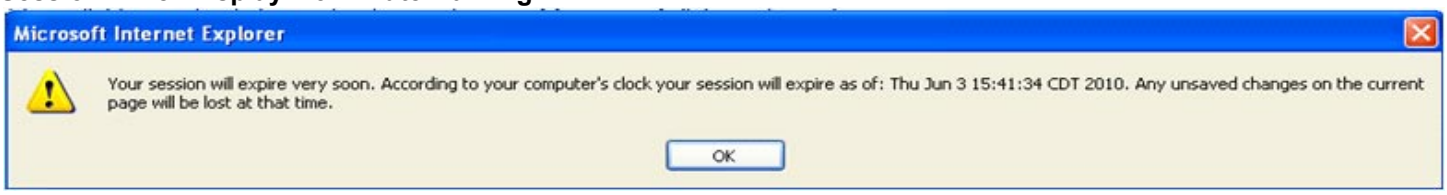
Web Portal Session Timer

A new feature has been added to the Web Portal that will notify users how long they have until a session will expire logging them off. A message displaying the amount of time a user has until the session expires is displayed in the upper right corner of the website on all pages. A session expires after 20 minutes of inactivity which is defined by a user sending a request to the web server. A request is sent to the web server when the user causes the screen to refresh, such as by clicking a button, selecting a search link or navigating between menu items. Simply entering data into a field does not send a request to the web server and therefore does not cause the 20 minute timer to reset. A warning message is displayed when 3 minutes remain and another message is displayed when the session has expired.

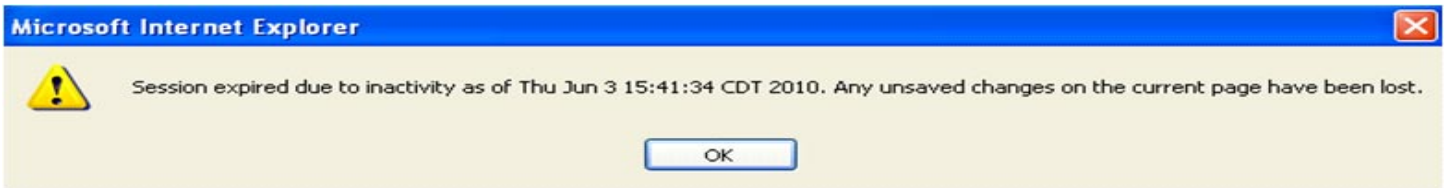
Session Timer Display



Session Timer Display – 3 minute warning



Session Timer Display – Session has expired



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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 _____*

Important Changes for DME Providers

Effective March 1, 2010, specialty walkers for children up to the age of 21 covered through the EPSDT Program should be billed using procedure code E0140 (walker with trunk support, adjustable or fixed height, any height, any type). **Modifier U8** is no longer required when billing this code.

Effective May 1, 2010, Alabama Medicaid began reimbursing Durable Medical Equipment (DME) providers the amounts listed for the following procedure codes:

E0149 - $161.00 (Walker, heavy duty without wheels, rigid or folding any type, each) Recipient's weight, width and height must be submitted with prior authorization requests.

E0168 - **$191.50** (Commode chair, extra wide and/or heavy duty stationary or mobile, with or without arms, any type, each) Recipient's weight, width and depth must be submitted with prior authorization requests.

E0303 - $2,037.00 (Hospital bed, heavy duty extra wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any typeside rails, with mattresses)

E0304 - (Hospital bed, extra heavy duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, with mattresses) Medicaid will reimburse for this code based on provider's invoice price plus 20%.

Recipient's weight must be submitted with prior authorization requests for procedure codes E0303 and E0304.

E0911 - $523.40 (Trapeze bar, heavy duty, for patient weight capacity greater than 250 pounds, attached to bed, with grab bar)

E0912 - (Trapeze bar, heavy duty, for patient weight capacity greater than 250 pounds, free standing, complete with grab bar) will be covered and Medicaid will reimburse for this based on provider's invoice price plus 20%.

Recipient's weight and width must be submitted with prior authorization requests for procedure codes E0911 and E0912.

Effective June 1, 2010, The National Registry of Rehabilitation Technology Supplier (NRRTS) or the Rehabilitation Engineering Assistive Technology Society of North America (RESNA) certified professional must have direct, in person involvement in the wheelchair selection for the recipient. RESNA certifications must be updated every two years. NRRTS certification must be updated annually Prior authorization requests will be denied if the NRRTS or RESNA professional's certification is not current; the contractor will deny the PA request.

Effective June 1, 2010, Alabama Medicaid began coverage of procedure code K0005 (ultralightweight wheelchair).

Effective June 1, 2010, the procedure codes used for the billing of Prosthetic, Orthotic and Pedorthic devices for Adults age 21 - 64 will no longer require prior authorization. DME providers of Prosthetics, Orthotics and Pedorthics devices for adults must be licensed by the Alabama Board of Prosthetics, Orthotics and Pedorthics. A copy of the provider's license must be maintained in the recipient's file for auditing purposes. The provider must be practicing as a Prosthetic, Orthotic or Pedorthic Practitioner in the state of Alabama at an accredited facility. The Occupational Therapist (OT) or the Physical Therapist (PT) performing the wheelchair assessment may not be employed by the DME company or contracted with the DME company requesting the physical therapy evaluation.

Effective July 1, 2010, the current blood glucose test strips and lancets policy for non-insulin dependent recipients will change as follows:

The number of blood glucose test strips will be changed from two boxes each month to one box each month and lancets from one box per month to one box every two months for non-insulin dependent diabetics. If more than one box of blood glucose test strips or lancets is needed, the provider should submit the request for the additional strips or lancets with medical documentation from the primary physician to the TPC Medical Quality and Review Unit for review and approval.

Effective August 1, 2010, Alabama Medicaid will require DME providers to complete Invacare's Seating/Mobility Evaluation Form as an attachment to the Alabama Medicaid Prior Review and Authorization form (Form 342). Invacare's Seating/Mobility Evaluation Form will replace Alabama Medicaid's Motorized/Power Wheelchair Assessment Form (Form 384). The Invacare Seating/Mobility Assessment Form will be accessible on the Alabama Medicaid website at www.medicaid.alabama.gov/billing/forms/prior authorization forms.

(continued on page 4)

Consent Forms

It is the responsibility of the performing surgeon to submit a **legible completed** copy of the sterilization/ hysterectomy consent form **after** the surgery to:

HP
P.O. Box 244032
Montgomery, AL 36124-4032
Attn: Desiree' Nelson (Do Not Fax consent forms)

Consent forms should not be submitted to HP prior to the surgery date. Providers other than performing surgeon **should not** submit a copy of consent form to HP. Receipt of multiple consent forms slows down the consent form review process and payment of claims.

Top Reasons for Sterilization/Hysterectomy Consent Forms Returned to Provider:

1. Consent form not legible.
2. Consent form is incomplete.
3. Incorrect consent form submitted.
4. Consent form sent prior to surgery
5. Wrong or missing surgery date.
6. Missing, invalid or incomplete recipient ID.
7. Expected date of delivery is missing in cases of premature delivery on sterilization consent form.
8. Physician signature and/or date are missing.
9. Interpreter's Statement does not contain N/A if an interpreter was not used on the sterilization consent form.
10. Missing ICD.9 code and stated diagnosis on hysterectomy consent form.

Top Reasons for Consent Form Denial:

1. Missing, incomplete or obscured signature/date.
2. Stamped signature missing initials.
3. Recipient not 21 years old when sterilization consent was obtained.
4. Person obtaining sterilization consent signed before recipient or the same date of surgery or after.
5. Less than 30 days elapsed from recipient signature date to surgery date and/or premature delivery date is less than 30 days from signature date.

COBA Denial-Do Not Crossover Denial 1825

What does denial 1825 "COBA Denial – Do Not Crossover" Mean?

This denial means HP does not automatically accept for payment your crossover claims from Medicare.

Changes to COBA Indicators on Provider File

Effective August 1, 2010, HP will turn all Coordination of Benefits Agreement (COBA) indicators on our provider file from "No" to "Yes". The "Yes" status means all claims will automatically crossover from Medicare to Medicaid and will process according to established Medicaid guidelines, without being denied for error 1825. Claims automatically crossing over from Medicare are identified with ICN beginning with "30".

What to do if you do not want your COBA indicator turned to "Yes"

If you do **not** want your COBA indicator turned to a "Yes" status, please send a letter on official office letterhead to HP Provider Enrollment.

The letter should state: *"I do **not** want my COBA indicator turned on to allow claims to automatically crossover."* Please include your NPI and all associated secondary identifiers.

The letter may be faxed to (334) 215-4298.

EXCEPTION: Providers whose COBA Indicators will remain "No"

The following providers' COBA indicators will **not** be turned on since their claims should never crossover from Medicare to Medicaid because of the difference in billing and reimbursement for services:

- Federally Qualified Health Centers
- Rural Health Clinics
- Renal Dialysis Facilities

Crossover claims from Medicare for these providers will continue to receive error 1825.

Important Changes for DME Providers

(continued from page 2)

Alabama Medicaid DME and medical supply providers will be required to have a $50,000.00 Surety Bond for each NPI by **October 1, 2010**. A DME provider who has been a Medicaid provider for five years or longer with no record of impropriety and whose refund requests have been repaid as requested will be exempt from the Alabama Medicaid $50,000.00 Surety bond requirement.

A DME and Medical Supply business is exempt from surety bond requirements if the DME and Medical supply business:

(a) Is a DME supplier who has been a Medicaid provider for five years or longer with no record of impropriety and whose refund requests have been repaid as requested; or

(b) Is a government-operated Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS); or

(c) Is a state-licensed orthotic and prosthetic personnel in private practice making custom-made orthotics and prosthetics; or

(d) Are physicians and non-physician practitioners, as defined in Section 1842(b)(18) of the Social Security Act; or

(e) Are physical and occupational therapists in private practice; or

(f) Are providers who received $100,000 or less Medicaid payment in the past two calendar years; or

(g) Are pharmacy providers; or

(h) Are phototherapy providers who only provide phototherapy services for infants; or

(i) Are Federally Qualified Health Centers.

DME suppliers who have been a Medicaid provider for five years or longer who are initially exempted from the Medicaid Surety Bond requirement as referenced in Rule (12)(a) of Administrative Code, Chapter 13, will be subject to the Surety Bond requirement if the Medicaid Agency identifies a consistent problem with improper billing or fraudulent activity.

DME providers requesting initial enrollment as an Alabama Medicaid provider will be required to have a $50,000.00 Surety Bond for three years before qualifying for the $100,000.00 two year exemption.

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

DME Consignment

DME will not be reimbursed if it is consigned. DME should be provided in accordance with Medicaid policy governing participation in the Alabama Medicaid DME Program (see page 14-2 of the Medicaid DME Provider Manual). You will note that "DME providers must have a physical location in the state of Alabama or within a 30-mile radius of the Alabama state line. Additionally, there must be one person to conduct business at the physical location. Answering machine and/or answering services are not acceptable as personal coverage during normal business hours. Satellite businesses affiliated with a provider are not covered under the provider contract; therefore, no reimbursement will be made to a provider doing business at a satellite location, however the satellite could enroll with a separate NPI." It is the position of the Alabama Medicaid Agency that equipment consigned to a clinic or physician office does not meet this requirement.

Clarification for Non-Oxygen DME Repairs/Parts (K0739, E1399)

Alabama does not require a PA for K0739 (repair or non-routine service for durable medical equipment other than oxygen equipment requiring the skill of a technician, labor component, per 15 minutes), however, a maximum of four units (1 unit = 15 minutes) for non-oxygen related repairs requiring the skill of a technician is allowed. Any repair request that requires labor exceeding the four units must be submitted to the ITC Medical Quality and Review Unit for review and approval.

Replacement parts are reimbursed based on the procedure code and fee schedule pricing. In situations where there are no procedure codes or fee schedule reimbursement for the repair item(s), the provider must submit procedure code E1399 (durable medical equipment, miscellaneous) with an itemized list of the needed repair items with invoice pricing for each item. Alabama Medicaid will reimburse for these repair items based on provider's invoice price plus 20%.

AAC Drug Pricing, Dispense Fee Increase Pending Before CMS

Thanks to ongoing stakeholder involvement and support, Alabama Medicaid is now on schedule to implement a new pharmacy reimbursement system this summer that not only provides a transparent, timely and accurate pricing method for the state but meets federally-mandated requirements to pay providers based on true estimated acquisition costs.

The Agency filed a State Plan Amendment (SPA) with the Centers for Medicare and Medicaid Services (CMS) in May that would remove Average Wholesale Price (AWP) from the "lower of" reimbursement methodology now in use, and add the invoice-based Average Acquisition Cost (AAC) method for brand and generic drug ingredient cost.

The proposed State Plan change pending before CMS also includes a companion request to increase the Agency's dispensing fee from $5.40 per prescription to $10.64 per prescription based on an independent Cost of Dispensing (COD) survey. The cost of dispensing modification and the drug pricing changes are also being submitted through state's Administrative Code process which includes a public comment period. Pending state and federal approvals, the changes are projected to be effective in August 2010.

According to Alabama Medicaid Commissioner Carol Steckel, the decision to move away from AWP pricing is directly related to a recent Alabama Supreme Court decision that reversed three verdicts that said Alabama Medicaid had been overcharged by drug manufacturers. In reversing the lower court verdicts, the Alabama Supreme Court criticized the state for not changing its pricing methodology since taking issue with the pharmaceutical manufacturers' price reporting methods.

"As AWP has been found to be inflated in both state and national litigation, our Agency must move away from fraudulent AWP pricing and toward reimbursement logic based on true estimated acquisition costs as mandated in federal guidelines," she said.

The Agency has contracted with Myers & Stauffer, a nationally recognized accounting firm, to conduct the semi-annual invoice surveys needed to calculate AAC for each drug. Each individual pharmacy will be randomly selected once during a two-year period and required to submit one month's worth of invoices. Pharmacies may submit invoices by mail, fax, or electronically, or may choose to have their wholesalers coordinate directly with Myers & Stauffer. Continuing with the Agency's current policy, drug prices will be updated on a weekly basis, and providers may submit specific pricing issues for research 24 hours a day through a web-based submission process.

"Our Agency has been studying ways to improve this system long before the lawsuits were filed in 2005. We have been fortunate to have the active involvement of pharmacy provider associations throughout this process to help us move to more accurate and fair reimbursement process based on the actual cost of dispensing and the actual drug ingredient cost," said Kelli Littlejohn, Pharm.D., Director of Pharmacy Services for Alabama Medicaid.

In a recent meeting to update all pharmacy provider associations and representatives on the status update of the AAC and COD progress, Dr. Littlejohn reported positive feedback from informal discussions with CMS regarding the proposed changes.

She also announced the Agency is looking forward to beginning work on the third phase of the reimbursement modification, which includes expanding the "Medical Home" concept by incorporating pharmacy providers into "medical neighborhoods." The "Medical Neighborhood" would allow pharmacies to be reimbursed for professional services while providing patient-centered coordinated care, and to participate in a "shared savings" effort similar to one offered within the Agency's Patient 1st Program.

"We very much appreciate the continuing support offered by pharmacy providers throughout this process. While this third phase is very preliminary in concept, the Agency will be coordinating with all pharmacy associations during the development process. We will continue to keep all associations apprised of our progress," she said, noting that a June meeting is scheduled for initial discussions.

Claims for Emergency Ground Transport

Claims for emergency ground transport must include one of the diagnosis codes listed in Chapter 8 of the Provider Manual. If not, your claim will be denied for edit 4580 – BAR-RP-PROC-DIAGNOSIS RESTRICTION-GROUP. System changes have been made that will ensure that this policy is enforced.

Effective May 14, 2010, Medicaid will no longer reimburse the full coinsurance and deductibles for Medicare/Medicaid crossover claims.Claims for dates of service thru 05/13/10 will continue to pay the full coinsurance and deductibles.

Effective May 14, 2010, mileage reimbursement (A0425) increased to $3.85 per mile. Providers with questions can contact one of their Provider Representatives at 1-800-688-7989.

Changes to Chapter 34 of the Alabama Medicaid Provider Manual

Please note the following changes to Chapter 34 of the Provider Manual:

Effective for dates of service July 1, 2010, and thereafter, the units of measure for Diagnostic Testing Codes 96101 – 96103 and 96118 – 96120 can be billed in 30-minute fractional units. When billing claims, .5 units will equal 30 minutes; 1 unit will equal 1 hour; 1.5 units will equal 1 ½ hours, etc. Providers cannot bill less than a 30-minute increment.

The time started and time ended of service delivery will not include time spent for interpretation of tests at this time.

Service documentation requirements have been further clarified and expounded.

Modifiers will be appended to procedure codes when services are performed by eligible allied mental health professional staff. The reimbursement rate for services performed and billed with a modifier will be 75% of the allowable rate. Services performed by an allied mental health professional but not billed with the modifier will be subject to recoupment on post payment review.

If you have further questions, you may contact Karen Smith via e-mail at Karen.watkins-smith@medicaid.alabama.gov or telephone at 334-353-4945.

Certified Registered Nurse Practioner (CRNP)

The CRNP cannot make physician required inpatient visits to hospitals or other institutional settings to qualify for payment to the physician, or to satisfy current regulations as physician visits. This requirement includes procedure code 99462 (Subsequent Hospital Care, per day, for evaluation and management of normal newborn).

Visit Alabama Medicaid

ONLINE

www.medicaid.alabama.gov

HP Provider Representative Contact Information

To speak to a provider representative, providers can call the toll-free number and request the appropriate group category for the provider. The toll-free number is 1-800-688-7989 and the group categories are listed below:

G R O U P 1

Misty Curlee
misty.curlee@hp.com
334-215-4159

Mark Bonner
bonner@hp.com
334-215-4132

gayle simpson-jones
gayle.simpson-jones@hp.com
334-215-4113

Michelle Patterson
katherine.patterson@hp.com
334-215-4155

Nurse Practitioners
Podiatrists
Chiropractors
Independent Labs
Free Standing Radiology
CRNA
EPSDT (Physicians)
Dental
Physicians
Optometric
(Optometrists and Opticians)

Debbie Smith
debbie.smith2@hp.com
334-215-4142

G R O U P 2

Rehabilitation Services
Home Bound Waiver
Therapy Services (OT, PT, ST)
Children's Specialty Clinics
Prenatal Clinics
Maternity Care
Hearing Services
Mental Health/Mental Retardation
MR/DD Waiver
Ambulance
FQHC

Aleetra Adair
aleetra.adair@hp.com
334-215-4158

Ashley Webb
ashley.r.webb@hp.com
334-215-4158

Nawanya Stroud
nawanya.l.stroud@hp.com
334-215-4161

Public Health
Elderly and Disabled Waiver
Home and Community Based Services
EPSDT
Family Planning
Prenatal
Preventive Education
Rural Health Clinic
Commission on Aging
DME
Nurse Midwives

G R O U P 3

Ambulatory Surgical Centers
ESWL
Home Health
Hospice
Hospital
Nursing Home

Linda Hanks
linda.hanks@hp.com
334-215-4156

Ann Miller
ann.miller2@hp.com
334-215-4156

Shermeria Hardy-Harvest
shemeria.harvest@hp.com
334-215-4160

Personal Care Services
PEC
Private Duty Nursing
Renal Dialysis Facilities
Swing Bed

State Fiscal Year 2010-2011 Checkwrite Schedule

1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
10/08/10	01/07/11	04/01/11	07/08/11
10/22/10	01/21/11	04/15/11	07/22/11
11/05/10	02/04/11	05/06/11	08/05/11
11/19/10	02/18/11	05/20/11	08/19/11
12/03/10	03/04/11	06/03/11	09/09/11
12/17/10	03/18/11	06/17/11	09/16/11

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Provider *Insider*

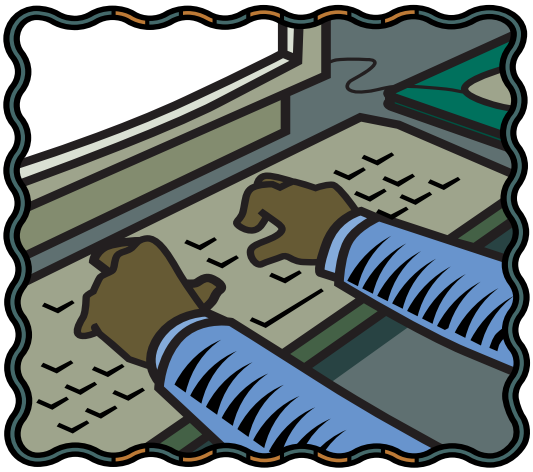
Alabama Medicaid Bulletin **October 2010**

The checkwrite schedule is as follows:

10/08/10 10/22/10 1 1/05/10 11/19/10 12/03/10 12/17/10

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

National Correct Coding Initiative (NCCI) Edits



The Patient Protection and Affordable Care Act (Public Law 111-148), Section 6507 requires that State Medicaid agencies implement National Correct Coding Initiatives (NCCI) edits into their claims processing systems. While the law specifies the effective date as October 1, 2010, Alabama Medicaid is anticip ating actual implementation in November due to the programming and system testing required. CMS has not provided guidance yet on whether states will be required to reprocess claims which were paid between October 1, 2010 and the actual implementation date. These edits are intended to reduce coding errors because of clerical mistakes and incorrect use of codes or their units of service. Therefore, in the coming months, the Alabama Medicaid Agency will implement the following edits:

(1) NCCI procedure to procedure edits for practitioner* and Ambulatory Surgical Center (ASC) claims
(2) NCCI procedure to procedure edits for outpatient hospital (including emergency department and observation) claims
(3) Medically Unlikely Edits (MUE) units of services for practitioner* and ASC claims
(4) MUE units of service for outpatient hospital (including emergency department and observation) claims
(5) MUE units of service for DME claims

*Practitioners are defined as: all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act of 1965, and the Code of Federal Regulations

NCCI procedure to procedure edits are coding edits, and are based on coding principles. The coding principles are explained in the National Correct Coding Initiative Policy Manual for Medicare Services available on the CMS NCCI website at *http://www.cms.gov.*

Educational tools are available on the CMS NCCI website at *http://www.cms.gov/nationalcorrectcodinited*. The Alabama Medicaid Agency will notify the providers of the actual date the NCCI edits are to be implemented and if any reprocessing will be required.

In This Issue…

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Clarification for Clinical Psychologist Billing 2
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NDC Number is now Mandatory on ALL Physician Administered Drug Claims 3
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State Fiscal Year 2010-2011 Checkwrite Schedule 8

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 _____*

New CDC Recommendations for Chlamydia Screening

The Center for Disease Control recommends yearly Chlamydia testing of all sexually active women under 25 years of age, older women with risk factors for chlamydial infections (those who have a new sex partner or multiple sex partners), and all pregnant women. An appropriate sexual risk assessment by a health care provider should always be conducted and may indicate more frequent screening for some women. See *http://www.cdc.gov/std/chlamydia/stdfact-chlamydia.htm* for further information.

Clarification for Clinical Psychologist Billing

The Alabama Medicaid Agency has received numerous questions on policy changes that were published in the July 2010 updates for Chapter 34 of the billing Provider Manual. A document with frequently asked questions has been posted on the Agency's website under Programs/ Mental Health Services/ Clinical Psychologists. Questions regarding this notice should be directed to Karen Smith at (334) 353-4945. The following changes are effective October 1, 2010 to the following E & M codes:

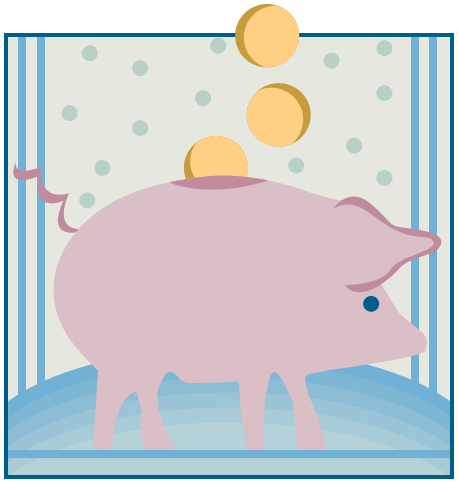
- 90805, 90807, 90809, 90811, 09813, 90815, 90817, 09819, 90822, 90824, 90827, 90829 will no longer be able to be billed to Medicaid by the psychologist or allied mental health professionals.
- Code 90887 will no longer be able to be billed to Medicaid by the psychologist or allied mental health professionals.

REMINDER

This is a reminder that the annual ICD-9-CM up date will be effective for dates of service on or af ter October 1, 2010.

Alabama Medicaid Surety Bond Requirement Update

The Alabama Medicaid DME and Medical Supply Providers will be required to have a $50,000.00 Surety Bond for each NPI by October 1, 2010. All Alabama Medicaid DME Surety Bonds must be received by the Alabama Medicaid Agency on or before October 31, 2010. DME providers that are not exempt from the Alabama Medicaid Surety Bond requirement who have not submitted their Medicaid Surety Bonds by October 31, 2010, will be terminated from the Medicaid Program. A legible copy of the Surety Bond may be faxed to (334) 215-4298, Attention Mr. Jeff Kochik. Surety Bonds may be sent certified mail to the address listed below:



HP Provider Enrollment
301 Technacenter Drive
Montgomery, Alabama, 36117

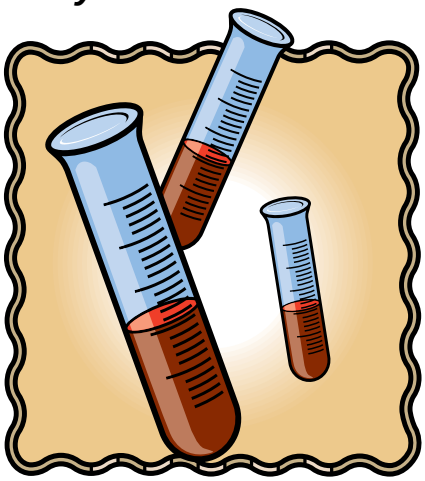
A DME and Medical Supply business is exempt from surety bond requirements if the DME and Medical supply business:

(a) Is a DME supplier who has been a Medicaid provider for five years or longer with no record of impropriety and whose refund requests have been repaid as requested; or
(b) Is a government-operated Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS); or
(c) Is a state-licensed orthotic and prosthetic personnel in private practice making custom-made orthotics and prosthetics; or
(d) Are physicians and non-physician practitioners, as defined in section 1842(b)(18) of the Social Security Act; or
(e) Are physical and occupational therapists in private practice; or
(f) Are providers who received $100,000 or less Medicaid payment in the past two calendar years; or
(g) Are pharmacy providers; or
(h) Are phototherapy providers who only provide phototherapy services for infants; or
(i) Are Federally Qualified Health Centers.

DME suppliers who have been a Medicaid provider for five years or longer who are initially exempted from the Medicaid Surety Bond requirement as referenced in Rule (12)(a) of Administrative Code, Chapter 13, will be subject to the Surety Bond requirement if the Medicaid Agency identifies a consistent problem with improper billing or fraudulent activity

DME providers requesting initial enrollment as an Alabama Medicaid provider will be required to have a $50,000.00 Surety Bond for three years before qualifying for the $100,000.00 two-year exemption. If you have additional questions or need further clarification, please contact Ida Gray at (334) 353-4753.

Update to Diabetic Supply Coverage Policy



Effective for dates of service October 1, 2010, and thereafter, Alabama Medicaid will change the current diabetic supply policy as follows:

Non-Insulin Dependent:
Claims for non-insulin dependent recipients **must** be filed **WITHOUT** using a modifier.

- A4253 - Blood glucose test or reagent strips for home blood glucose monitor, per box of 50, is limited to **two** boxes every three months.
- A4259 - Lancets, per box of 100, is limited to **one** box every three months.

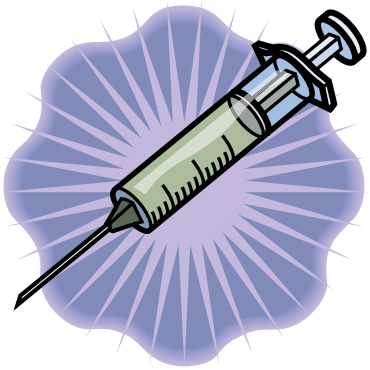
Insulin Dependent:

Claims for insulin dependent recipients **must** be filed **WITH modifier U6**.

- A4253-U6 - Blood glucose test or reagent strips for home blood glucose monitor, per box of 50, is limited to **three** boxes per month for insulin dependent recipients **age 21 and above.**
- A4253-U6 - Blood glucose test or reagent strips for home blood glucose monitor, per box of 50, is limited to **four** boxes per month for insulin dependent recipients **age 0-20**.
- A4259-U6 - Lancets, per box of 100, will be limited to two boxes every month regardless of age.

If recipients require additional strips or lancets above Medicaid established limits, providers must submit peer reviewed literature justifying the need. If you have additional questions or need further clarification, please contact Ida Gray at (334) 353-4753.

NDC Number is Now Mandatory on ALL Physician Administered Drug Claims



Effective October 1, 2010, the NDC number will be mandatory on ALL physician-administered drugs in the following ranges: J0000 – J9999, S0000 – S9999, and Q0000 – Q9999. Physician-administered drugs include any covered outpatient drug billed either electronically or on paper CMS-1500 or UB-04 claim forms. NDC's will be required on Medicare crossover claims for all applicable HCPCS codes on the list. The 11-digit NDC submitted must be the actual NDC number on the package or container from which the medicine was administered. This requirement applies to:

- All fee-for-service providers who bill physician-administered drug codes
- HCPCS codes in the ranges J0000 – J9999, S0000 – S9999, and Q0000 – Q9999
- Both electronic and paper submissions

On page 4 of the Provider Insider, a FAQ is available for more information.

Attention All Nursing Home Providers

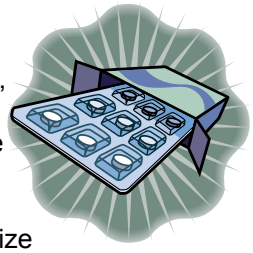
Effective with the September 2010 nursing home retrospective review (i.e., audit), approval letters will no longer be sent by the Agency or its designee (i.e., contractor). Providers will receive an acknowledgment letter that the requested documents for the review were received. Denial letters will continue to be sent, as appropriate.

In addition, per Chapter 26, Nursing Facilities, of the Billing Manual, "Review of Medicaid Residents: Medicaid or its designated agent will perform a review of Medicaid nursing facility/ICF/MR facility residents' records to determine appropriateness of admission."

It has come to the attention of the Agency that many of the records submitted by nursing facilities are incomplete and/or inaccurate. The Agency's contractor, the Alabama Quality Assurance Foundation (AQAF) has indicated that additional information must be requested several times from facilities.

Please be aware that if the nursing facility does not provide the requested information by the requested time frame, a letter of denial may be sent to the facility and may result in recoupment. The Agency and its contractor would like timely review of these records and appreciate the cooperation of all nursing facilities to achieve this.

NDC Number is Now Mandatory on ALL Physician Administered Drug Claims



The Deficit Reduction Act of 2005 (DRA) requires that all state Medicaid programs require the submission of National Drug Codes (NDC's) on claims submitted with HCPCS codes for physician-administered drugs in an outpatient setting. In 2008, the Alabama Medicaid Agency began requiring the NDC number for the top 20+ physician-administered multiple source drugs. Effective October 1, 2010, the NDC number will be mandatory on physician-administered drugs in the following ranges: J0000-J9999, S0000-S9999 and Q0000-Q9999. Providers are required to submit their claims with the exact NDC that appears on the product administered on HCPCS-1500 or UB-04 claims. The NDC is found on the medication's packaging and must be submitted in the 5digit-4digit-2digit format. As this process is to facilitate Medicaid drug rebates from manufactures, providers are required to utilize drugs manufactured by companies who hold a federal rebate agreement. These NDCs will be the only ones Medicaid will cover for payment.

Please see the following section for answers to the most common questions. If you have further questions or concerns about this information, please contact Provider Assistance Center at 1-800-688-7989.

NDC and HCPCS Frequently Asked Questions

1 Why do I have to bill with National Drug Codes (NDCs) in addition to Healthcare Common Procedure Coding System (HCPCS) codes?

The Deficit Reduction Act of 2005 (DRA) includes provisions about the state collection of data for the purpose of collecting Medicaid drug rebates from drug manufacturers for physician-administered drugs. Since there are often several NDCs linked to a single HCPCS code, the Centers for Medicare & Medicaid Services (CMS) deems that the use of NDC numbers is critical to correctly identify the drug and manufacturer in order to invoice and collect the rebates.

2 Which providers are affected by this requirement?

All fee-for-service providers who bill physician-administered HCPCS drug codes are affected. Physician-administered drugs include any covered outpatient drug billed either electronically or on paper CMS-1500 or UB-04 claim forms.

3 What is the Drug Rebate Program?

The Medicaid Drug Rebate Program was created by the Omnibus Budget Reconciliation Act of 1990 (OBRA'90) and became effective 1/1/1991. The law requires that drug manufacturers enter into an agreement with CMS to provide rebates for their drug products that are covered by Medicaid. Manufacturers that do not sign an agreement with CMS are not eligible for federal Medicaid coverage of their products. Outpatient Medicaid pharmacy providers bill with NDCs and Alabama Medicaid has received rebates for these claims since 1991. The DRA has now expanded the rebate requirement to physician-administered drugs.

4 What is an NDC?

The National Drug Code (NDC) is a universal number that identifies a drug. The NDC number consists of 11 digits in a 5-4-2 format. The first five digits identify the manufacturer of the drug and are assigned by the Food and Drug Administration. The remaining digits are assigned by the manufacturer and identify the specific product and package size. Some packages will display less than 11 digits, but leading zeroes can be assumed and need to be used when billing.

For example:

XXXX-XXXX-XX = 0XXXX-XXXX-XX
XXXXX-XXX-XX = XXXXX-0XXX-XX
XXXXX-XXXX-X = XXXXX-XXXX-0X

The NDC is found on the drug container (i.e., vial, bottle, tube). The NDC submitted must be the actual NDC number on the package or container from which the medication was administered. Do not bill for one manufacturers product and dispense another. It is considered a fraudulent billing practice to bill using an NDC other than the one administered. Please note: NDCs listed above have hyphens between the segments for easier visualization. When submitting NDCs on claims, submit the 11-digit NDC number with no hyphens or spaces between segments.

NDC and HCPCS Frequently Asked Questions

5 Does the drug administered and billed to Medicaid with an NDC have to be a "rebatable" drug?

Yes. For products to be eligible for coverage by Medicaid, manufacturers must first sign a rebate agreement with CMS.

6 How do I know if a drug is rebatable?

You may refer to the CMS website *http://www.cms.gov/MedicaidDrugRebateProgram/10_DrugComContactInfo.asp* to determine if an NDC is manufactured by a company that participates in the Federal Drug Rebate Program.

7 Will my claim be denied or rejected if the drug is non-rebatable?

Yes.

8 Will my claim be denied or rejected if I don't include the NDC?

Claims without the proper NDC qualifier and NDC that are not currently included in the Medicaid Physician-Administered multi-source Top 20+ HCPCS drug listing will deny beginning October 1, 2010. Claims with a date of service prior to this will pay, but an informational denial code will be posted on your Remittance Advice. Claims containing HCPCS from the Top 20+ HCPCS drug list will continue to deny if the NDC is not included.

9 If I am not sure which NDC was used, can I pick another NDC under the J Code and bill with it?

No. The NDC submitted must be the actual NDC number on the package or container from which the medication was administered.

10 Do drugs that are billed through a hospital outpatient department require an NDC?

Yes. Effective September 2008, Alabama Medicaid began requiring outpatient hospital departments to submit NDC numbers to accompany claims for the top 20 multi-source drugs that are billed separately on institutional claim forms that are identified on the claim with a Level II HCPCS code. Effective October 1, 2010, this will expand to all physician-administered drugs.

11 My clinic/hospital participates in the 340B program. Do I need to submit NDC codes for drug claims?

CMS has stated that this provision of the DRA does not apply to 340B drugs billed to Medicaid programs at the acquisition cost of the drug.

12 Do all J-code claims (or other drug codes) require an NDC?

No. For example, HCPCS codes considered a device do not have an NDC number. Examples are J7321, J7323, J7324 and J7325. To identify if a product is a drug, look for these three items: NDC- the package or container that held the drug would have an NDC on it; Lot and Expiration Date- All drugs have both a lot number and expiration date on the vial or container; Legend- This refers to statements such as, "Caution; Federal law prohibits dispensing without prescription, "Rx only" or similar words. All prescription drugs have these types of statements.

13 Do radiopharmaceuticals or contrast media require an NDC?

Not at this time.

14 Do vaccines/immunizations require an NDC?

No. Vaccines are not included in the rebate requirements.

15 Are Medicare claims included in the NDC requirement?

Yes. Because the state may pay Medicare coinsurance and deductibles, claims for recipients that are dually eligible for Medicare require NDCs with the HCPCS codes.

NDC and HCPCS Frequently Asked Questions

16 Should I bill the HCPCS code and NDC of a drug if I did not provide the drug, but just administered it?

No. For example, if the patient has a prescription filled and brings the drug into the office to have the physician administer it, the drug may not be billed by the physician. The physician should only bill for the administration of the drug. The retail pharmacy would have already billed for the drug.

17 How do I bill for a drug when only a partial vial was administered?

If the drug is packaged in a multi-dose vial (can be used for more than one patient), then only the units administered should be billed to Medicaid.
If the drug is packaged in a single-dose vial that cannot be used for multiple injections, then the whole vial may be billed to Medicaid.

18 Will Alabama Medicaid post a procedure code/NDC code crosswalk?

No. Alabama Medicaid will not be doing this because rebates are dependent upon correct NDCs being used. The actual NDC on the container that is administered is the one to be billed.

19 I have heard that only single-source drugs and 20 multiple source drugs will require NDCs. Can I just submit NDCs for just those drugs?

No. At this time, states are mandated to submit rebates on 20 drugs, but they are encouraged to expand their rebate program beyond that and Alabama Medicaid intends to do so. All physician-administered medications will require submission of NDCs. Please Note: Some products not traditionally considered drugs are included in those mandated for rebate (for example, J7050 Infusion, normal saline, 250 cc), so do not overlook these products when submitting NDCs.

Resources

For details on the Deficit Reduction Act (DRA):
http://www.cms.gov/Reimbursement10_MedicaidPrescriptionDrugsundertheDRA.asp

CMS ASP pricing and HCPCS/NDC crosswalk:
http://www.cms.gov/McrPartBDrugAvgSalesPrice/01a19_2010aspfiles.asp#TopOfPage

Medicaid Drug rebate program:
http://www.cms.gov/MedicaidDrugRebateProgram/

Alabama Provider Insider Newsletters, July 2008, April 2009, April 2010:
http://www.medicaid.alabama.gov/news/newsletters.aspx

Provider Alerts dated January 12, 2010 and August 3, 2010:
http://www.medicaid.alabama.gov/news/provider_alerts.aspx?tab=2

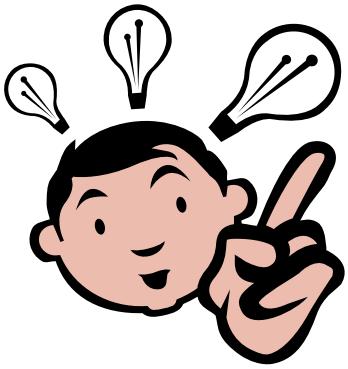
Drug Manufacturers with federal rebate agreement:
http://www.medicaid.alabama.gov/programs/pharmacy_svcs/resources_providers.aspx?tab=4

Provider Billing Manual:
http://www.medicaid.alabama.gov/billing/provider_manual.6-10.aspx

Other resource for HCPCS codes and billing:
https://www.dmepdac.com/crosswalk/index.html

Automated Voice Response System (AVRS), to check the status of an NDC:
1-800-727-7848

HP Provider Assistance Center:
1-800-688-7989



HP Provider Representatives

G R O U P 1

michelle patterson
michelle.patterson@hp.com
334-215-4155

debbie smith
debbie.smith2@hp.com
334-215-4142

gayle simpson-jones
gayle.simpson-jones@hp.com
334-215-4113

misty curlee
misty.curlee@hp.com
334-215-4159

Nurse Practitioners
Podiatrists
Chiropractors
Independent Labs
Free Standing Radiology
CRNA
EPSDT (Physicians)
Dental
Physicians
Optometric
(Optometrists and Opticians)

mark bonner
bonner@hp.com
334-215-4132

G R O U P 2

Rehabilitation Services
Home Bound Waiver
Therapy Services (OT, PT, ST)
Children's Specialty Clinics
Prenatal Clinics
Maternity Care
Hearing Services
Mental Health/Mental Retardation
MR/DD Waiver
Ambulance
FQHC

nawanya stroud
nawanya.l.stroud@hp.com
334-215-4161

ashley webb
ashley.r.webb@hp.com
334-215-4199

aleetra adair
aleetra.adair@hp.com
334-215-4158

Public Health
Elderly and Disabled Waiver
Home and Community Based Services
EPSDT
Family Planning
Prenatal
Preventive Education
Rural Health Clinic
Commission on Aging
DME
Nurse Midwives

G R O U P 3

Ambulatory Surgical Centers
ESWL
Home Health
Hospice
Hospital
Nursing Home

linda hanks
linda.hanks@hp.com
334-215-4130

ann miller
ann.miller@hp.com
334-215-4156

shermeria harvest
shermeria.harvest@hp.com
334-215-4160

Personal Care Services
PEC
Private Duty Nursing
Renal Dialysis Facilities
Swing Bed

State Fiscal Year 2010-2011 Checkwrite Schedule

10/08/10	01/07/11	04/01/11	07/08/11
10/22/10	01/21/11	04/15/11	07/22/11
11/05/10	02/04/11	05/06/11	08/05/11
11/19/10	02/18/11	05/20/11	08/19/11
12/03/10	03/04/11	06/03/11	09/09/11
12/17/10	03/18/11	06/17/11	09/16/11

Alabama Medicaid Bulletin

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Alabama Medicaid Bulletin **January 2011**

The Remittance Advice (RA) schedule is as follows:

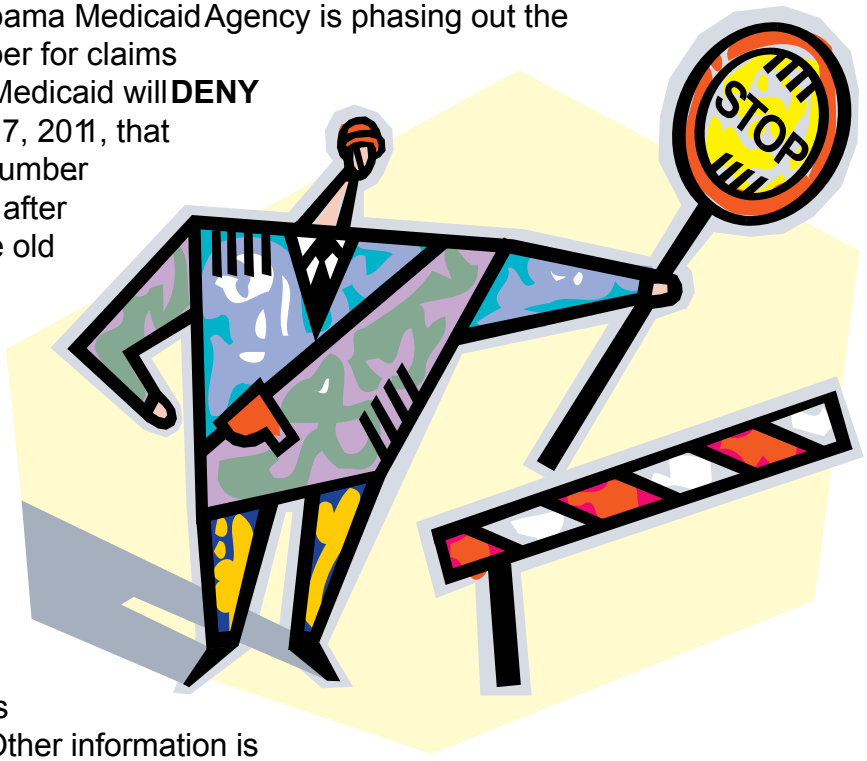
01/07/11 01/21/11 02/04/11 02/18/11 03/04/11 03/18/11

The release of funds is normally the second Monday after the RA date. Please verify direct deposit status with your bank. Go to *www.medicaid.alabama.gov* to view the payment delay update details. Payment alerts will be posted only if there will be a payment delay. As always, the release of direct deposits and checks depends on the availability of funds.

Medicaid Will No Longer Accept Old Recipient ID Numbers

After four years of transition, the Alabama Medicaid Agency is phasing out the acceptance of the old Medicaid ID number for claims processing, effective January 17, 2011. Medicaid will **DENY** any claims received on or after January 17, 2011, that are submitted with the old Medicaid ID number.

All new Medicaid ID numbers issued after the conversion also begin with a "5". The old Medicaid ID number begins with "000". Please verify the Medicaid ID number for Medicaid recipients at the time of service. If the Medicaid ID number begins with "000", obtain the correct Medicaid ID number before submitting the claim to Medicaid for processing.



Providers with questions about the new recipient ID numbers should contact the Provider Help Desk at 1-800-688-7989. Medicaid recipients with questions about the new ID numbers should call toll-free at 1-800-362-1504. Other information is available at: *http://www.medicaid.alabama.gov/news/medicaid_id_numbers.aspx?tab=2*

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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 _____*

Attention Eyecare Providers

Effective December 1, 2010, procedure code V2020 (Vision Services Frames Purchase) will have a maximum reimbursement rate of $13.95 per 1 unit.

Telemedicine Services

Effective October 1, 2010, the requirement for the 50 mile radius for telecommunication services was removed.

Periodic EPSDT Screening Will Not Be Billable in Hospital Setting

Effective January 1, 2011, Periodic EPSDT screening codes 99382-EP-99385-EP and 99392-EP-99395-EP will not be billable in the hospital setting (inpatient, outpatient, ER). You may continue to bill the interperiodic screening code using procedure code 99233-EP in the inpatient setting. This change is being made to support the use of the medical home concept for Medicaid recipients.

5010 Transactions Testing Will Begin Soon

The Alabama Medicaid Agency is currently working on the 5010 transactions. The testing for the provider and vendor community is expected to start by the summer of 2011.

Once a firm start date for testing has been established, the Alabama Medicaid Agency will notify providers and vendors through the use of mail, email, website notices, and the "Provider Insider" publications.

Web-Based Provider Enrollment and Update Application Coming in April

The Alabama Medicaid Agency will implement a Web-Based Provider Enrollment and Update Application in April 2011. All providers will be required to utilize the on-line application.

Once a provider or his/her representative completes the minimal required information, a Tracking Number will be generated. The tracking number must be retained to retrieve and complete a saved application or to check the status of a submitted application.

Providers will be required to submit supporting hard-copy documentation to HP. Instructions will be given to the provider for mailing the supporting documentation. Until the supporting documentation (with original signatures) is received, the application is not considered complete.

The on-line application will feature

- drop down lists which simplify entering information by reducing keystrokes
- online edits to reduce errors
- online help will be supplemented by Provider Enrollment Specialists

Training will be provided by HP to educate providers on the new Web-Based Enrollment and Update Application by providing onsite training for large provider groups and workshops will be held as necessary. More details will be forthcoming regarding the new Web-Based Enrollment and Update Application.

Changes Concerning CT Heart Codes

Beginning dates of service January 1, 2011 and thereafter CT heart codes 75571, 75572, 75573, 75574 will be covered through MedSolutions with prior authorization for ages 0-18. Providers with questions may contact Carolyn Thompson, Program Manager , Lab/X-ray services at *carolyn.thompson@medicaid.alabama.gov* or by phone at 334-242-5048.

Important Information About Fee Schedules

The fee schedules located on the Alabama Medicaid website are prepared as tools to assist Medicaid providers and are not intended to grant rights or impose obligations. Every effort is made to assure the accuracy of the information within the fee schedules as of the date they are posted. Medicaid makes no guarantee that this compilation of fee schedule information is error-free and will bear no responsibility or liability for the results or consequences of the use of these schedules.

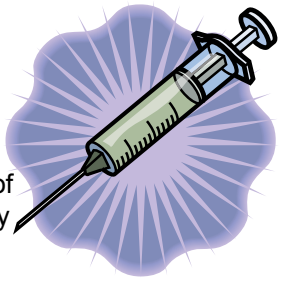
The fee schedules are not an all inclusive list of procedure codes covered by the Agency. These fee schedules do not reflect all information required for reimbursement of procedures such as prior authorization requirements, provider type and specialty restrictions, other coverage restrictions.

As the ultimate responsibility lies with the provider of service, it is recommended that providers contact the Provider Assistance Center at 1-800-688-7989 for confirmation of coverage and/or prior authorization requirements for the recipient and date of service in question.

Medicaid Introduces a Drug/NDC Lookup System

Effective October 5, 2010, the Alabama Medicaid Agency implemented a drug/NDC lookup system. The system allows providers to search for a drug by name or by NDC, and will provide the following information for outpatient pharmacy claims:

- If a drug is covered or non-covered
- If a drug is preferred or non-preferred
- If a prior authorization (PA) is required (PA outside of PDL)
- The maximum quantity allowed per month
- Reimbursement rate per unit



Prescribers/providers can also access the system to verify coverage of an NDC for the billing of a HCPCS code. Please note that pricing, prior authorization requirements, and maximum quantity limits listed do not apply for HCPCS claims, but the drug coverage field does apply

To access the NDC Drug Lookup system, please visit the Alabama Medicaid website and click on the "Drug Look Up" link under the Pharmacy Services page.

Helpful Hints for using the drug/NDC lookup system:

- When looking up a drug by NDC, do not include dashes or spaces in the NDC number.
- Please include a date if looking for information specific to a certain timeframe.
- When looking at a brand drug when a generic equivalent is available (DAW code of 1), please check the 'Dispense As Written' box to view the appropriate reimbursement rate for the brand version.

For more information or questions regarding the NDC Drug Lookup System, please call Health Information Designs at 1-800-748-0130.

Clarification for Billing J2001

Procedure code J2001 (Injection, lidocaine HCL for intravenous infusion, 10 mg) should not be billed when lidocaine/xylocaine is utilized for local anesthesia associated with a procedure (e.g. mixed with another drug for injection, bursa injection, Trigger point injections). The dosage indicated by the code description is specific to the treatment of cardiac arrhythmias and emergent care only. NCCI edits bundle procedure code J2001 therefore it should not be billed separately unless the patient is treated intravenously for cardiac arrhythmia. The CPT surgical package includes "local infiltration, metacarpal/metatarsal, digital block or topical anesthesia". If you use lidocaine as an anesthetic, consider the injection a component of the medical procedure. Claims are subject to post-payment review and adjustment.

Upcoming Changes to Psychological Billing

During the past year, a workgroup consisting of Alabama Medicaid Agency staff and representatives from the Alabama Psychological Association has collaborated to identify changes that enable the agency to maintain a basic package of services while preserving the health care safety net for our most vulnerable citizens. As a result of this effort, the following changes will be implemented on January 1, 2011:

Effective for dates of service January 1, 2011, and thereafter, the following codes annual max limit has been changed as follows:

- The following codes will have a combined annual max limitation of 12 units:
  - 90849 and 90853
- The following codes will have a combined annual max limitation of 26 units:
  - 90806, 90812, 90818, 90826 and 90847
- The following codes will have a combined annual max limitation of 52 units:
  - 90804, 90810, 90816, and 90823

The Alabama Medicaid Agency will not cover the following therapies:

- Equine assisted psychotherapy
- Biofeedback therapy
- Neurobiofeedback therapy
- Sleep therapy
- Dance therapy
- Music therapy
- Art therapy

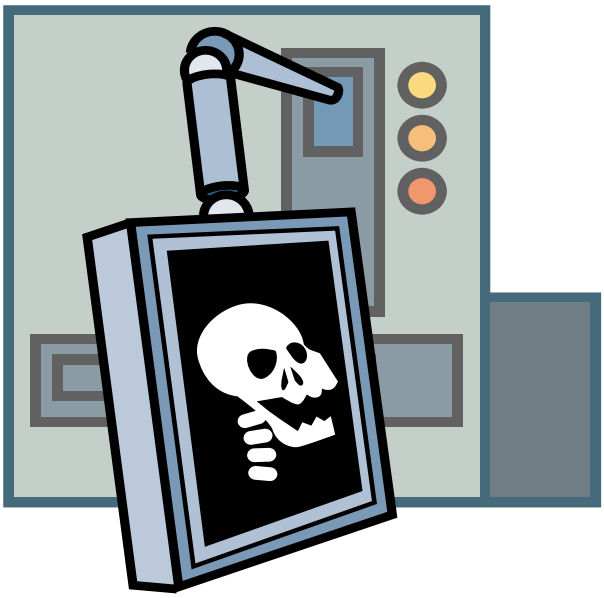
If you have further questions contact Karen Smith via phone at 334-353-4945 or e-mail at: *karen.watkins-smith@medicaid.alabama.gov*

Radiology Management Program "Gold Card" Changes

Effective January 1, 201 1, changes will be made to the "Gold Card" status based on Agency evaluation of prior authorization requests made between October 1, 2009 and September 30, 2010. The following changes will be made:

- Providers with "Gold Card" who maintained a 5% or less denial rate during the above timeframe will continue to have "Gold Card" status.
- Providers who currently have "Gold Card" status with low request volume will continue to have "Gold Card" status.
- Providers with high volume and high denial rate (>5%) will be removed from gold carding.
- Providers with high volume and low denial rates who will be added to the "Gold Card" program.

The status of all providers will be re-evaluated af ter one year. Redetermination will be based on the preceding 12 months' worth of data. Providers with questions may contact Carolyn Thompson, Program Manager, Lab/X-ray services by phone at (334) 242-5048 or email *carolyn.thompson@medicaid.alabama.gov.*



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Alabama Medicaid Bulletin **April 2011**

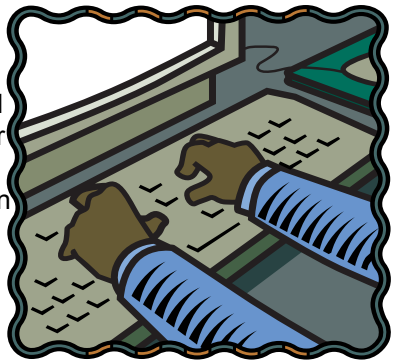
The Remittance Advice (RA) schedule is as follows:

04/01/11 04/15/11 05/06/11 05/20/11 06/03/11 06/17/11

The release of funds is normally the second Monday after the RA date. Please verify direct deposit status with your bank. Go to *www.medicaid.alabama.gov* to view the payment delay update details. Payment alerts will be posted only if there will be a payment delay. As always, the release of direct deposits and checks depends on the availability of funds.

National Correct Coding Initiatives (NCCI) Edits Appeal Process

Effective November 9, 2010, Medicaid introduced the NCCI edits into the Medicaid claims processing system. These edits were set as "informational" edits. On March 23, 2011, these edits were set to deny for any services that do not meet the NCCI edit criteria and were furnished on or after October 1, 2010.



The use of applicable modifiers will be critical in successful implementation of the NCCI procedure to procedure edits. Once a claim or line item on the claim has been denied for an NCCI procedure to procedure edit, then the claim cannot be adjusted by the provider. If a claim is denied for an NCCI Medically Unlikely Edit (MUE), the provider can resubmit the claim with the correct units as long as the units are equal to or lesser than the NCCI MUE edit allows. If the units are more than the NCCI MUE edit allows, then an appeal must be requested.

NCCI procedure to procedure edits are coding edits, and are based on coding principles. The Medicaid NCCI Coding is available on the CMS NCCI website at *http://www.cms.gov/MedicaidNCCICoding/01_Overview.asp#TopOfPage*

If the NCCI edit responsible for an NCCI denial has a modifier indicator of "0", an appeal can **NEVER** overturn the denial. These claims are final and no appeal is applicable except for an administrative law judge who can determine that the denied column two code should be paid. These instances will be rare.

If the NCCI edit responsible for an NCCI denial has a modifier indicator of "1" or is for an MUE, an appeal can be submitted.

All NCCI denials begin with an error code "59nn". To validate a claim denied for an NCCI error code, download the remittance advice from the web-portal which contains the Medicaid specific error codes.

Individual claim denials may be appealed at three levels. The levels, listed in order, are:

1. Redetermination Request
2. Administrative Review
3. Fair Hearing

If all appeals have been exhausted and the claim denies, the provider cannot collect from either the recipient or his/her sponsor or family. This denial is a provider liability.

(Continued on page 3)

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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 _____*

Rehabilitation Option Fee Schedule Posted

A revised 2009 Rehabilitation Option fee schedule has been posted to Medicaid's website under Providers/Fee Schedules or a copy may be obtained from the following link:

http://medicaid.alabama.gov/documents/6.0_Providers/6.6_Fee_Schedules/6.6_Rehab_Option_Fee_09_Schedule_2-3-11.pdf

The fee schedule will be updated as changes occur.

Attention All Providers

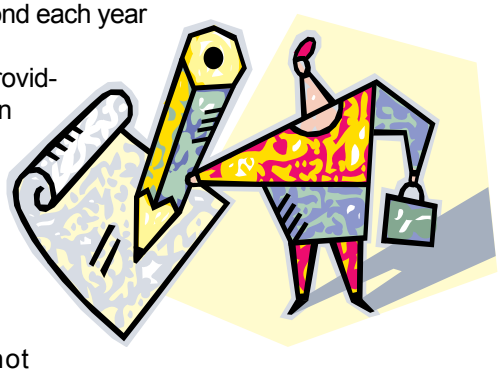
The telephone number (205) 834-3330 is no longer a valid telephone number to reach HP Enterprise Services. This number now belongs to a private individual. The telephone number for HP Enterprise Services is 1-800-688-7989 (AL,FL,MS,GA,TN) or (334) 215-0111 (all other areas). Additional contact information can be found on the Medicaid website (*www.medicaid.alabama.gov*) under contacts. Please update your telephone directory accordingly.

Clarification for Physicians

Chapter 28 of the Provider Manual states "Office visits are limited to one per day, per recipient, per provider . For purposes of this limitation, physicians within the same group are considered a single provider." Medicaid will allow claim submissions for recipient visits to any physician and a psychologist on the same date even if they are in the same group. For questions regarding this policy, please contact Karen Smith at (334) 353-4945 or *karen.watkins-smith@medicaid.alabama.gov*.

Durable Medical Equipment Renew Surety Bonds Each Year

Effective January 1, 2011, Medicaid will accept a copy of the renewal receipt for Medicare and Medicaid Surety Bonds. DME providers must renew their bond each year with the Surety Bond Company.



Durable Medical Equipment providers have the following language in their Medicare and Medicaid Surety Bonds.

"The term of the bond shall be from the ___ day of _____, _____ and shall be continuous until cancelled by the Surety."

If the Surety Bonds does not include the language above, the Surety Bond renewal receipt will not be allowed.

Providers with questions may contact Linda Stephens at (334) 242-5144. Medicare and Medicaid Surety Bonds renewal receipts may be mailed to the following address:

HP Provider Enrollment
301 Technacenter Drive
Montgomery, Alabama 36117
Or
Post Office Box 241685
Montgomery, Al 36124

Attention – All Providers Who Send in Refund Checks

There is a quicker and better way to refund this money to Medicaid:

- Use Medicaid's Interactive Web Portal. The portal lets you submit recoupments/adjustments in an online, real-time environment. This service is available to providers at no charge!
- Use Provider Electronic Solutions (PES) software – PES allows providers to submit adjustments on-line in batch mode.

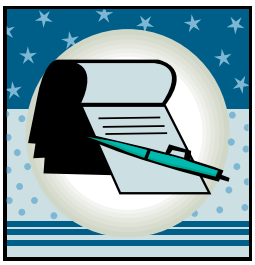
Contact HP today to learn more and eliminate your paperwork associated with generating and sending in refund checks!

National Correct Coding Initiatives (NCCI) Edits Appeal Process *(Continue from page 1)*

First Level of Appeal: Redetermination Request

The Alabama Medicaid Agency contracts with a fiscal agent (HP Enterprise Services {HPES}) to process and pay all claims submitted by providers of medical care, services, and equipment authorized under the Alabama Title XIX State Plan. HPES will also be responsible for the redeterminations, which is the first level of appeals and adjudication functions.

A *redetermination* is an examination of a claim and operative notes/medical justification by HPES personnel. The provider has 60 days from the date of receipt of the initial claim determination to request a redetermination. The provider must complete the attached HP Enterprise Services Request for NCCI Redetermination Review form. The request for a redetermination must include:



- Completed NCCI Redetermination Review form
- Corrected Paper Claim for the procedure codes that denied
- Operative Notes/Medical Justification

Send the request for redetermination review along with all supporting documentation to:

HP Enterprise Services / Request for NCCI Redetermination
PO Box 244032
Montgomery, AL 36124-4034

HPES will normally issue a decision via the remittance advice within 90 days of receipt of the Redetermination Request. The ICN region for the redetermination request will begin with '91'. For example 9111082123456.

Second Level of Appeal: Administrative Review

When the Redetermination Request results in a denial by HPES, the provider may request an *Administrative Review* of the claim. A written request for Administrative Review **must be received by the Alabama Medicaid Agency within 60 days of the date of the redetermination denial from HPES.**

To request an Administrative Review, the provider must complete the attached Alabama Medicaid Form 403 - Request for National Correct Coding Initiative (NCCI) Administrative Review. The request should clearly explain why you disagree with the redetermination denial.

The request for an Administrative Review must include:

- Completed Form 403 - Request for National Correct Coding Initiative (NCCI) Administrative Review
- Correct Paper Claim for the procedure codes that denied
- Copy of previous request for redetermination correspondence sent to HPES
- Copies of all relevant remittance advices or HPES' redetermination denial notification
- Copy of any other useful documentation

Send the request for Administrative Review along with all supporting documentation to:

NCCI Administrative Review / Alabama Medicaid Agency
Attn: System Support Unit
501 Dexter Avenue
P. O. Box 5624
Montgomery, AL 36103-5624

Documentation that is submitted after the Administrative Review request has been filed may result in an extension of the time required to complete the review . Further, any documentation noted in the redetermination as missing and any other evidence relevant to the appeal must be submitted prior to the issuance of the Administrative Review decision. Documentation not submitted at the Administrative Review level may be excluded from consideration at subsequent levels of appeal unless you show good cause for submitting the documentation late.

This information will be reviewed and a written reply will be sent to the provider within 60 days.

Third Level of Appeal: Fair Hearing

When the Administrative Review does not resolve the issue, the provider has the option to request a *Fair Hearing*. A written request must be received within 60 days of the date of the Administrative Review decision. The request must identify any new or supplemental documentation. Send the written request for a Fair Hearing to:

Alabama Medicaid Agency / Attn: Office of General Counsel
501 Dexter Avenue
P. O. Box 5624
Montgomery, AL 36103-5624

If you have further questions, contact the Provider Assistant Center at 1-800-688-7989 or (334) 215-0111.

National Correct Coding Initiatives (NCCI) Edits Appeal Process

(Continue from page 3)

Request for NCCI Redetermination Review
HP Enterprise Services
PO Box 244032
Montgomery AL 36124-4032

Complete ALL Fields Below - Print or Type

ICN #	Date of Service
Recipient Name	Recipient Medicaid Number
Provider Name	Provider NPI Number
NCCI Denial Code(s) 1. ☐ 2. ☐ 3. ☐	
Date of Denial	

Required Attachments (check box to indicate which attachment is being submitted with request):
Corrected paper claim submitted with procedure code(s) that denied along with specific reports (see below):

- ☐ Anesthesia report for denied procedure codes in the range: 00100 – 01999
- ☐ Operative report for denied procedure codes in the range: 10000 – 69999
- ☐ Radiology report for denied procedure codes in the range: 70000 – 79999
- ☐ Pathology or Laboratory report for denied procedure codes in the range: 80000 – 89999
- ☐ Medical report for denied procedure codes in the range: 90000 – 99605

Comments:

_____

_____

_____

Signature of either the provider or his/her representative

Date
Address
City, State and Zip code
Telephone Number, including area code
Signature

(Continue from page 4)

Alabama Medicaid Agency

Request For National Correct Coding Initiative (NCCI) Administrative Review

This form is to be completed only when the Redetermination Request results in a denial by the Fiscal Agent.

Section A

Print or Type

Provider's Name	Provider Number
Recipient 's Name	Recipient's Medicaid Number
Date of Service	ICN

I do not agree with the Redetermination denial by the Fiscal Agent Dated: _____

Section B

My reasons are:

Section C

Signature of either the provider or his/her representative

Provider Signature	Representative Signature
Address	Address
City, State and ZIP Code	City, State and ZIP Code
Telephone Number	Telephone Number
Date	Date

This form may be downloaded from the Alabama Medicaid Agency website: www.medicaid.alabama.gov

Form 483
Created 3-23-2011

Alabama Medicaid Agency

Upcoming Changes to Psychologist Chapter of the Provider Manual

During the past year, a workgroup consisting of Alabama Medicaid Agency staff and representatives from the Alabama Psychological Association has collaborated to identify changes that enable the agency to maintain a basic package of services while preserving the health care safety net for our most vulnerable citizens.
As a result of this ongoing effort, the following changes will be implemented effective April 1, 2011:

- A 52 unit annual maximum limit (including any claims with a date of service beginning January 1, 2011) will be imposed for any combination of the following codes:
  - Individual therapy codes 90804, 90806, 90810, 90812, 90816, 90818, 90823 and 90826.
  - Group therapy codes 90846, 90847, 90849 and 90853.
- Individual and group codes listed above are subject to a limit of one (1) unit per week (effective for date of service April 1, 2011 and thereafter). However, providers may bill one individual and one group code within the same week or on the same date of service. Both units will count towards the 52 unit annual maximum limit.
- To request an override to the maximum weekly limit, submit documentation of medical necessity and the exceptional circumstance (e.g. how the recipient is an imminent danger to self or others and/or is at risk for hospitalization or decompensation) along with the original CMS-1500 claim form (with the red drop out ink), related progress note(s) and cover letter to the following address:

Mental Health Program Director
Institutional Services
Alabama Medicaid Agency
P.O. Box 5624
Montgomery, AL 36103-5624

A sample cover letter titled "Psychologist Override Request Form" can be found at:

http://medicaid.alabama.gov/documents/4.0_Programs/4.4_Medical_Services/4.4.9_Mental_Health_Services/4.4.9.2_Clinical_Psychologists 4.4.9.2_Psychology_Override_Request_Template.pdf

- When billing for testing, please note the following:
  - The date of service billed must be the date the test was given.
  - Providers may bill for testing, scoring, interpretation and report writing in 30-minute increments. However, it is only necessary to document the time spent in face-to-face service delivery
  - Billing should reflect the total time for face-to-face administration, scoring, interpretation and report writing.
  - The test(s) given on the date of service billed must be documented in the treatment note for post payment review purposes.

Providers with questions should contact Karen Smith via phone at (334) 353-4945 or by e-mail at: *karen.watkins-smith@medicaid.alabama.gov*

Preferred Drug List Update

Effective April 1, 2011, the Alabama Medicaid Agency will update the Preferred Drug List (PDL) to reflect the recent Pharmacy and Therapeutics (P&T) Committee's recommendations as well as quarterly updates. The updates are listed below:

PDL Additions

Dulera-Respiratory/Inhaled Corticosteroids

Ritalin SR-Behavioral Health/Cerebral Stimulants/ Agents for ADD/ADHD-Short and Intermediate Acting

PDL Deletions*

Daytrana-Behavioral Health/Cerebral Stimulants for ADD/ ADHD-Long Acting

Dexedrine-Behavioral Health/Cerebral Stimulants for ADD/ ADHD-Short and Intermediate Acting

Pataday-EENT Preparations/Antiallergic Agents

Patanase- EENT Preparations/Antiallergic Agents

Patanol- EENT Preparations/Antiallergic Agents

* Denotes that these brands will no longer be preferred but are still covered by Alabama Medicaid and will require Prior Authorization (PA). Available covered generic equivalents (unless otherwise specified) will remain preferred.

For additional PDL and coverage information, visit our drug look-up site at *http://aldrug.rxexplorer.com/*.

The PA request form and criteria booklet, as well as a link for a PA request form that can be completed and submitted electronically online, can be found on the Agency's website at *www.medicaid.alabama.gov* and should be utilized by the prescribing physician or the dispensing pharmacy when requesting a PA. Providers requesting PAs by mail or fax should send requests to:

Health Information Designs (HID)
Medicaid Pharmacy Administrative Services
P. O. Box 3210 Auburn, AL 36832-3210
Fax: 1-800-748-0116
Phone: 1-800-748-0130

Incomplete PA requests or those failing to meet Medicaid criteria will be denied. If the prescribing physician believes medical justification should be considered, the physician must document this on the form or submit a written letter of medical justification along with the prior authorization form to HID. Additional information may be requested. Staff physicians will review this information.

Policy questions concerning this provider notice should be directed to the Pharmacy Program at (334) 242-5050. Questions regarding prior authorization procedures should be directed to the HID help desk at 1-800-748-0130.

Prior Authorization Change for DME Providers

DME Providers currently submit requests for custom wheelchairs and custom wheelchair accessories for children age 0-20 using procedure code E1220. The use of procedure code E1220 makes it difficult for the Agency to determine for what items payment is being made, without manually reviewing the prior authorization (PA) request.

Effective for PAs received May 1, 2011, and thereafter, DME providers will no longer submit requests for custom wheelchairs and custom wheelchair accessories for children age 0-20 using procedure code E1220. DME providers will be required to use valid procedure codes, from the DME Fee Schedule, for custom wheelchairs and custom wheelchair accessories for children age 0-20, whenever possible. DME providers must use valid procedure codes listed on the DME Fee Schedule when submitting PA requests for custom wheelchairs and custom wheelchair accessories for children age 0-20. DME providers may use procedure code K0108 (wheelchair component or accessory, not otherwise specified), for wheelchair accessories that have no valid procedure code listed on the DME Fee Schedule.

If you have any questions or need further clarification, please call Ida Gray at (334) 353-4753, or Vivian Bristow at (334) 353-4756.

Medicare Crossover and Medicaid Changes for Renal Dialysis Facilities

Medicare Crossover

Effective February 1, 2011, renal dialysis crossover claims will be received from Medicare and will be processed by Medicaid for all renal dialysis providers.
*Note: Crossover claims with Dates of Service prior to January 1, 2011 that crossover from Medicare will not pay correctly. These crossover claims must be electronically submitted through the previous claim submission process to Medicaid.

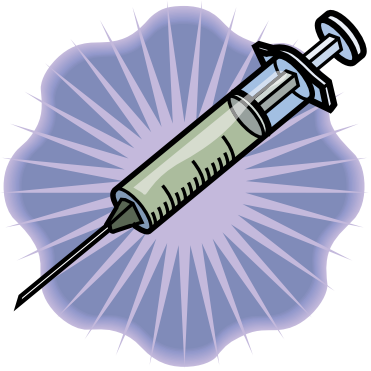
Medicare claims billed by renal dialysis providers will cross over directly from Medicare and will be processed by Medicaid. Providers are limited to the following codes on Medicare crossover claims. Future Medicare revisions may require code updates to this table:

Revenue Codes	Condition Codes	Procedure Code	Description
821, 881	71, 72,73, 74, 76	90999	Hemodialysis, home hemodialysis, self care training, home hemo training and ultrafiltration.
831, 841, 851	74	90945	Dialysis procedure other than hemodialysis
831, 841, 851	73	90993	Dialysis training, patient, including helper.
634,<10,000		Q4081	Injection epogen
635, >or = 10,000			
636		J0882	Darbopoetin alfa, injection
636		Appropriate Injectable Codes	Injectable Drugs
250		Appropriate NDC (No HCPCS) Codes	PO Drugs
31X, 921		Appropriate Lab Codes	Labs
270		A4697, A4913(IV)	Supply/Admin
771		Appropriate vaccine HCPCS	Vaccine

Medicaid

All Medicaid services beginning with dates of service January 1, 2011, and thereafter, must be billed according to the following policy. Medicaid's new requirements mirror Medicare's as closely as possible.

Revenue Codes	Condition Codes	Procedure Code	Description
821	71	90999	Hemodialysis, limited to 156 units per year.
831, 841, 851		90945	Dialysis procedure other than hemodialysis.
831, 841, 851	73, 74	90993	Dialysis training, patient, including helper. Limited to 12 per lifetime.
634,<10,000 635, >or = 10,000		Q4081	Injection epogen
636		J0882	Darbopoetin alfa, injection
636		Injectable Codes	See Alabama Medicaid Injectable Drug Listing in appendix H for covered injectable drugs.



Providers may contact Jerri Jackson, RN, BSN, at (334) 242-5630 or e-mail at *jerri.jackson@medicaid.alabama.gov* if you have any questions.

EPO and Aranasp Monitoring Policy

Medicaid is requiring providers include the GS modifier, the ED modifier, or the EE modifiers in mirroring Medicare's policy, refer to Chapter 8 of the Medicare Claims Processing Manual for further definition. These modifiers will be considered 'informational only' when billed to Medicaid and no reductions in payment will be made for straight Medicaid claims. Medicaid expects the provider to adhere to the strict definitions defined below:

GS Dosage of EPO or Darbopoetin Alfa has been reduced and maintained in response to hematocrit or hemoglobin level.

ED The hematocrit level has exceeded 39.0% (or hemoglobin level has exceeded 13.0g/dL) 3 or more consecutive billing cycles immediately prior to and including the current billing cycle

EE The hematocrit level has exceeded 39.0% (or hemoglobin level has exceeded 13.0g/dL) less than 3 consecutive billing cycles immediately prior to and including the current billing cycle.

Providers may contact Jerri Jackson, RN, BSN, at (334) 242-5630 or e-mail at *jerri.jackson@medicaid.alabama.gov* if you have any questions.

Clarification of Routine Post-Surgical Care

Routine post-surgical care in the hospital or office visits for conditions directly related to major surgical procedures are covered by the surgical fee. Post-surgical visits cannot be billed separately the day of, or up to 90 days after surgery. In 2006, Medicaid adopted Medicare's zero (0) day, or ten (10) day or ninety (90) day global surgical package designation to define post surgical periods.

For conditions unrelated to the surgical procedure, bill the appropriate (E&M) procedure code with a 24 modifier appended. The diagnosis and medical record must support use of the modifier 24. The claims are subject to post payment review.

Multiple NDCs for a Single HCPCS Drug Code

At times it may be necessary for providers to report multiple NDCs for a single procedure code. If two or more NDCs are to be submitted for a procedure code, the procedure code must be repeated on separate lines for each unique NDC. On the first line, the procedure code, NDC and procedure quantity are reported with a KP modifier (first drug of a multi drug). On the second line, the procedure code, NDC and procedure quantity are reported with a KQ modifier (second/subsequent drug of a multi drug). When reporting more than two NDCs per procedure code, the KQ modifier is also used on the subsequent lines.

Hospice Drug Policy for Reimbursement

Reimbursement for disease specific drugs related to the recipient's terminal illness as well as drugs found on the Hospice Palliative Drug List (HPDL) are included in the per diem rates for hospice covered services and will not be reimbursed through the Medicaid Pharmacy Program. The HPDL is on the agency website at *www.medicaid.alabama.gov.*

Please refer to the NOTE box in Chapter 18 – Hospice, Section 18.2.9 Reimbursement for Levels of Care, of the Alabama Medicaid Provider Manual and Chapter 51 – Hospice Care, Rule No. 560-X-51-.10 in the Alabama Medicaid Agency Administrative Code. Hospice Providers with questions may contact Felicha Fisher, Program Manager, LTC Provider/Recipient Services at (334) 353-5153 or email *felicha.fisher@medicaid.alabama.gov*.

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Medicaid Policy Change for Native American Indians

Effective immediately, Native American Indians that present an "active user letter" issued by Indian Health Services (IHS) will be exempt from the Medicaid required copayment.

System changes are in place for immediate filing of the medical, institutional, and pharmacy claims when submitted via the 837P, 837I, and NCPDP transactions. To exempt the claim from the required copayment, the provider must:

- 837P – in loop 2400, SV115 field, enter a value of "0" indicating co-pay exemption for a native American Indian with an active user letter
- 837I – in loop 2300, segment, condition information, enter condition code "AJ" indicating co-pay exemption for a Native American Indian with an active user letter
- NCPDP – in the claim segment field 461-EU, prior authorization type code, enter a value of "4", indicating co-pay exemption for a native American Indian with an active user letter

Also, system changes are in place for immediate filing of the institutional UB-04 paper, PES, and web claims submissions. To exempt the claim from the required copayment, the provider must:

- UB-04 – in form locators 18- 28, enter a condition code "AJ" indicating co-pay exemption for a Native American Indian with an active user letter
- PES – in condition code field, enter a value of "AJ"
- Web – in condition code field, enter a value of "AJ"

System changes are not in place for medical and pharmacy claims submitted via paper, PES, or web at this time. System changes are in work and are expected to be completed no later than May 1, 2011.

NET Program Ready to Serve Recipients

The Non-Emergency Transportation (NET) Program provides necessary non-ambulance transportation services to Medicaid recipients. Medicaid pays for rides to a doctor, dentist office (recipients are eligible for dental services up to their 21st birthday) or clinic for medical care or treatment that is covered by Medicaid. Additional information regarding the NET Program can be found in Appendix G of Medicaid's Provider Manual. If you have additional questions regarding this information, please call the NET Program at 1-800-362-1504.

All Providers Billing Laboratory Procedures

There are several new 2011 HCPCS codes that have been approved for coverage, but are not loaded to the system at this time since Medicare has not posted any CLIA information to the CLIA website regarding these new lab codes. If providers bill these codes their claims will suspend for 60 days. If after 60 days a price and CLIA information has not been loaded to the system, Medicaid will deny the claim. As soon as this information is made available, Medicaid will post this information to the system and the providers can resubmit previously denied claims. These codes are listed as follows: 80104, 85598, 87501, 87502, 87503, 88120, 88121, and 88177.

www.medicaid.alabama.gov

HP Provider Representatives

G R O U P 1

Debbie Smith
debbie.smith2@hp.com
334-215-4142

Michelle Patterson
katherine.patterson@hp.com
334-215-4155

Gayle Simpson-Jones
gayle.simpson-jones@hp.com
334-215-4113

Misty Nelson
misty.nelson@hp.com
334-215-4159

Nurse Practitioners
Podiatrists
Chiropractors
Independent Labs
Free Standing Radiology
CRNA
EPSDT (Physicians)
Dental
Physicians
Optometric
(Optometrists and Opticians)

Roxana Alexander
roxana.alexander@hp.com
334-215-4132

G R O U P 2

Nawanya Stroud
nawanya.stroud@hp.com
334-215-4161

Rehabilitation Services
Home Bound Waiver
Therapy Services (OT, PT, ST)
Children's Specialty Clinics
Prenatal Clinics
Maternity Care
Rural Health Clinic
Nurse Midwives

Ashley Webb
ashley.webb@hp.com
334-215-4199

Hearing Services
MR/DD Waiver
Ambulance
FQHC
Mental Health/Mental Retardation
Commission on Aging
DME

Hayley Lavender
hayley.lavender@hp.com
334-215-4158

Public Health
Including:
Elderly and Disabled Waiver
Home and Community Based Services
EPSDT
Family Planning
Prenatal
Preventive Education

G R O U P 3

Aleetra Adair
aleetra.adair@hp.com
334-215-4130

Personal Care Services
Private Duty Nursing
Renal Dialysis Facilities
Swing Bed

Ann Miller
ann.miller2@hp.com
334-215-4156

PEC
ESWL
Nursing Home

Shermeria Hardy-Harvest
shermeria.harvest@hp.com
334-215-4160

Ambulatory Surgical Centers
Home Health
Hospice
Hospital

State Fiscal Year 2010-2011 Checkwrite Schedule

~~10/08/10~~	~~01/07/11~~	04/01/11	07/08/11
~~10/22/10~~	~~01/21/11~~	04/15/11	07/22/11
~~11/05/10~~	~~02/04/11~~	05/06/11	08/05/11
~~11/19/10~~	~~02/18/11~~	05/20/11	08/19/11
~~12/03/10~~	~~03/04/11~~	06/03/11	09/09/11
~~12/17/10~~	~~03/18/11~~	06/17/11	09/16/11

Alabama Medicaid Bulletin

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Alabama Medicaid Bulletin **July 2011**

The Remittance Advice (RA) schedule is as follows:

07/08/11 07/22/11 08/05/11 08/19/11 09/09/11 09/16/11

The release of funds is normally the second Monday after the RA date. Please verify direct deposit status with your bank. Go to *www.medicaid.alabama.gov* to view the payment delay update details. Payment alerts will be posted only if there will be a payment delay. As always, the release of direct deposits and checks depends on the availability of funds.

Clarification for Medicaid's Outpatient Observation Policy

Effective for dates of service October 1, 2010, and thereafter, outpatient observation CPT codes 99218 through 99220 have been replaced with HCPCS Level II procedure code G0378. The policy is revised as written below:

Outpatient Observation

Outpatient observation is a covered service billable only by a hospital provider enrolled in the Medicaid program.

Outpatient observation is the medically necessary extended outpatient care provided to a patient whose condition warrants additional observation before a decision is made about admission to the hospital or prolonged patient care. Outpatient observation is limited to 23 hours or less.

Outpatient observation is considered an outpatient visit and will be counted in the yearly outpatient visit benefit unless documented as a certified emergency by the attending physician at the time of service. An observation unit is an area designated by the hospital in which patient beds are set aside to provide any medically necessary extended outpatient care to a patient whose condition requires additional observation. These beds may be located in various parts of the hospital depending on the type of extended care needed for the patient. The following guidelines apply:

- Patient must be admitted through the emergency room.
- A physician's order is required for admission and discharge from the observation unit.
- A physician must have personal contact with the patient at least once during the observation stay.
- A registered nurse or an employee under his/her direct supervision must monitor patients in the observation unit.
- Medical records must contain appropriate documentation of the actual time a patient is in the observation unit as well as the services provided.
- A recipient must be in the observation unit at least three hours but less than 24 hours.

(Continued on Page 4)

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The information contained within is subject to change. Please review your Provider Manual and all Provider Alerts for the most up to date information.

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 _____*

Coverage Information for Enuresis Alarms

Effective May 1, 2011, Alabama Medicaid will cover enuresis alarms through the Durable Medical Equipment (DME) program for recipients age 5 years up to age 21. Providers may submit procedure code S8270 for coverage of the alarm and should bill Medicaid their usual and customary charge for reimbursement.

In 2008, the American Academy of Family Physicians (AAFP) published recommendations for the treatment of enuresis stating there are 2 first line therapies, enuresis alarms and desmopressin. Alarms have been shown to have a two-thirds success rate for recipients with monosymptomatic nocturnal enuresis. Providers are encouraged to prescribe the enuresis alarm as a first line and cost effective therapy.

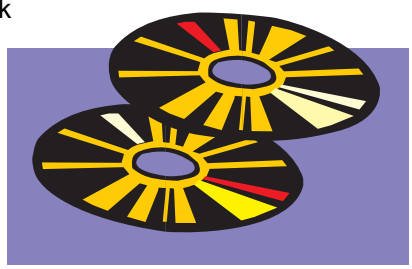
Guidelines for Billing Prolonged Services

Effective July 1, 2011, Procedure Codes 99354 and 99355:

- Maybe billed only in conjunction with procedure codes 99201-99215, 99241-99245, 99324-99337, 99341-99350. May not be billed with these codes when the EP modifier is billed.
- May not be billed alone. Also, time must be documented clearly in the medical record to indicate the beginning of service time and the end of service time to justify these codes being billed in addition to the office visit. These services are subject to post payment review and recoupment.

Provider Electronic Solutions Has Been Upgraded to 2.16

Version 2.16 of the Provider Electronic Solutions software, upgrade and full install along with the billing manual, can be downloaded from the Medicaid website at www.medicaid.alabama.gov. Click 'providers,' then click 'provider electronic solutions software,' and scroll down to the bottom of the page to the software download section. When applying the upgrade, you must upgrade to 2.15 before attempting to upgrade to 2.16. For further assistance, or to request the software on CD, contact the EMC helpdesk at 1-800-456-1242 or e-mail address: *alabamasystemsemc@hp.com*.



The new version of the software contains the following changes:

Inpatient Claim Form – Added condition code AJ for co-pay exemptions and updated the help text.

NCPDP Claim Form – Add Co-Pay/PA indicator 4 for co-pay exemptions and updated the help text.

Archive – Allows the user to archive older transactions without setting an error message.

Resubmit – Allows the user to use the 'copy' feature to resubmit batch transactions without setting an error message.

Remember, users MUST be at version 2.15 before attempting to upgrade to 2.16.

Alabama Medicaid is Now On Facebook

The Alabama Medicaid Agency has established a Facebook page to better inform the general public about many of the current topics and issues the Agency is addressing. The page also offers insight on how the Agency impacts health care in the state, as well as highlight Agency personnel and activities.

To ensure you receive timely updates, please go to the Agency's page and click on "Like." The page can be found at *www.facebook.com/pages/Alabama-Medicaid-Agency/141645862533621*

New Medicaid Cards To Contain a Security Hologram

Beginning in June 2011, Medicaid cards will contain a hologram which will be located in the upper right corner. This hologram is designed to make card replication more difficult. New cards will only be issued upon recipient request. Medicaid IS NOT issuing new cards to all recipients.

As always, providers should check eligibility prior to rendering services to Medicaid recipients. Providers may refer to Chapter 3 of the provider manual for information on eligibility verification.

HP Provider Representatives

G R O U P 1

Debbie Smith
debbie.smith2@hp.com
334-215-4142

Michelle Patterson
katherine.patterson@hp.com
334-215-4155

Gayle Simpson-Jones
gayle.simpson-jones@hp.com
334-215-4113

Misty Nelson
misty.nelson@hp.com
334-215-4159

Nurse Practitioners
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Physicians
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(Optometrists and Opticians)

Roxana Alexander
roxana.alexander@hp.com
334-215-4132

G R O U P 2

Rehabilitation Services
- Home Bound Waiver
- Therapy Services (OT, PT, ST)
- Children's Specialty Clinics

Prenatal Clinics
Maternity Care
Rural Health Clinic
Nurse Midwives
Hearing Services
- MR/DD Waiver

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Mental Health/Mental Retardation
Commission on Aging
DME
Public Health Including:
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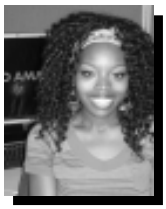
- Home and Community Based Services
- EPSDT
- Family Planning
- Prenatal
- Preventive Education

Nawanya Stroud
nawanya.stroud@hp.com
334-215-4161

Hayley Lavender
hayley.lavender@hp.com
334-215-4158



Shamekia Pena
shamekia.pena@hp.com
334-215-4199

G R O U P 3

Aleetra Adair
aleetra.adair@hp.com
334-215-4130

Ann Miller
ann.miller2@hp.com
334-215-4156

Shermeria Hardy-Harvest
shermeria.harvest@hp.com
334-215-4160

Personal Care Services
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Renal Dialysis Facilities
Swing Bed
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Nursing Home
Ambulatory Surgical Centers
Home Health
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Hospital

Clarification for Medicaid's Outpatient Observation Policy

(Continued from Page 1)

Outpatient observation charges must be billed in conjunction with the appropriate facility fee (99281 – 99285).Observation coverage is billable in hourly increments only. A recipient must receive observation services a minimum of 30 minutes before the observation charge can be billed. Observation charges are billed as follows:

- For the first three hours of observation the provider should bill a facility fee (99281 - 99285) with units of one.
- Procedure code G0378 should be used to bill the 4th through 23rd hour for the evaluation and management of a patient in outpatient observation.

Procedure Code G0378 must be billed with a facility fee (99281-99285). The facility fee is billed with units of one and covers the first three hours.

Ancillary charges (lab work, x-ray etc.) may be billed with the facility fee and observation charge. If the observation spans midnight and the recipient is discharged from the observation unit the following day, the provider should bill all observation charges using the date of admission to the observation unit on the claim form.

If a recipient is admitted to the hospital from outpatient observation before midnight of the day the services were rendered at the same hospital, all observation charges must be combined and billed with the inpatient charges. The provider should indicate the date of admission to the inpatient hospital as the admission date on the claim form for inpatient services.
Outpatient observation charges cannot be billed in conjunction with outpatient surgery.

Medical records will be reviewed retrospectively by Medicaid to ensure compliance with the above-stated guidelines and criteria. If there are any questions contact Jerri Jackson by telephone at (334) 242-5630 or by e-mail at *jerri.jackson@medicaid.alabama.gov*

Alabama Medicaid Bulletin

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Alabama Medicaid Bulletin **October 2011**

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10/07/11 10/21/11 11/04/11 11/18/11 12/02/11 12/16/11

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5010 and NCPDP Transactions

The following 5010 X12 and NCPDP D.0 transactions are being added or updated in preparation for the CMS mandated implementation on January 1, 2012:

- 270/271 - Health Care Eligibility Benefit Inquiry and Response
- 276/277 - Health Care Claim Status Request and Response
- 278 - Health Care Services Review – Request for Review and Response
- 835 - Health Care Claim Payment/Advice
- 837 - Health Care Claim (dental, institutional, and professional)
- NCPDP Batch 1.2
- NCPDP D.0
  - Claim Billing – B1
  - Claim Reversal – B2
  - Eligibility Verification – E1
  - Prior Authorization Request Only – P4
- 999 - Implementation Acknowledgement for Health Care Insurance.

5010

will be here
January 1, 2012

Are you ready?

If you do not comply, you will not be paid!

Medicaid will also continue to send the current version of the 277U Health Care Payer Unsolicited Claim Status transaction, TA1 Interchange Acknowledgement, and BRF Batch Response File. Current 4010 and NCPDP 5.1 transactions will continue to be accepted through some means until December 31, 2011. As mandated by CMS, on January 1, 2012 Alabama Medicaid will only accept and send 5010, NCPDP Batch 1.2, NCPDP D.0.

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- ❒ *Medical/Clinical Professionals*
- ❒ *Other _____*

The information contained within is subject to change. Please review your Provider Manual and all Provider Alerts for the most up to date information.

HIPAA 5010 Testing

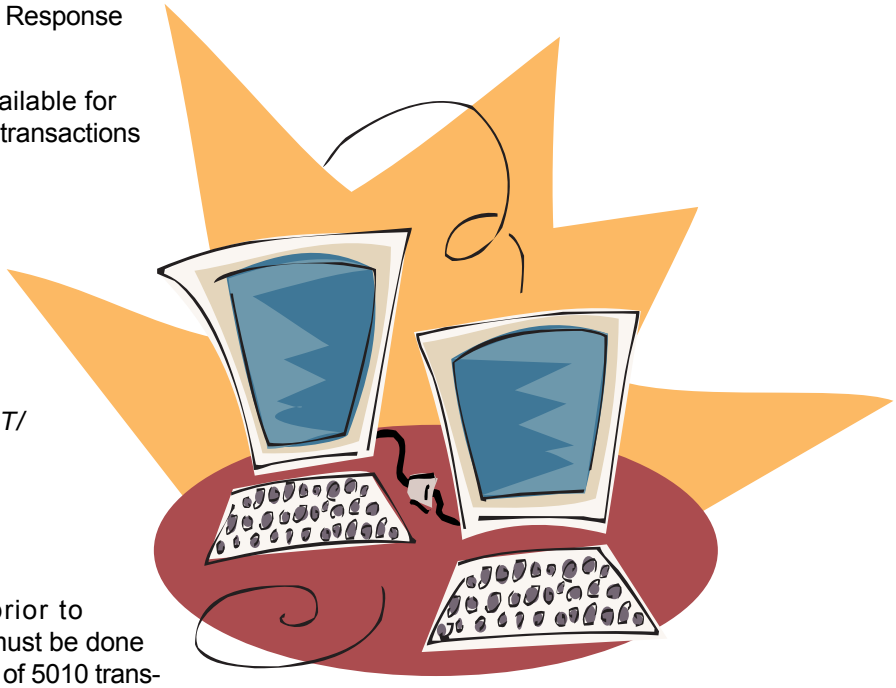
Testing is now available for providers and vendors. Testing 5010 transactions is required and highly encouraged prior to the submission of 5010 transactions into production. If you submit claims through a vendor, your vendor must make the necessary changes for your transactions to be sent to HPES for processing. Please check with your software vendor to make sure they have made the necessary changes. For details regarding 5010 testing please review the website:

http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.5_HIPAA_5010.aspx

The following transaction types are currently available for testing through the Trade Files option via the testing website:

- 270 Eligibility Request/271 Eligibility Response
- 276 Claim Status Request/277 Claim Status Response
- 999 HIPAA Compliance Response

It is anticipated all transactions will be available for testing on or before December 1, 2011. As new transactions become available notification will be sent.



Companion Guide

The Alabama Medicaid 5010 Companion Document and the NCPDP D.0 Companion Guide are available for review:

http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.3_Companion_Guides.aspx

Test Setup

Please contact the EMC Help Desk prior to starting testing as a minimal amount of setup must be done for each Trading Partner prior to the submission of 5010 transactions. This setup only needs to be done initially to start testing and each Trading Partner will be set up for the submission of all 5010 transactions, however only the available transactions should be submitted for testing.

When contacting the EMC Help Desk, request that Trading Partner ID be updated for testing 5010 transactions and provide the Trading Partner ID to the representative on the phone. The help desk will provide a time when testing will become available once setup is complete.

- (800) 456-1242 - AL, FL, GA, MS and TN
- (334) 215-0111 - All other locations
- Fax: (334) 215-4272
- Email: *AlabamaSystemsEMC@hp.com*

NCPDP D.0 Version Changes

The NCPDP D.0 version offers new functionality related to the reporting of other payer patient responsibility data. With the implementation of D.0, Alabama Medicaid will begin capturing values sent in fields:

- 353-NR (other payer patient responsibility count)
- 351-NP (other payer patient responsibility qualifier)
- 352-NQ (other payer patient responsibility amount)

When a payment has been received from another payer, the amount reported in the patient pay amount (505-F5) must be entered in the 352-NQ field, along with an "06" qualifier code in field 351-NP. Alabama Medicaid will consider this amount submitted in determining the final amount that Medicaid will pay.

In addition, if the value in the other coverage code field (308-C8) indicates other coverage exists (values 02, 03, 04, or 08), then the 352-NQ field must be greater than zero or the claim will reject.

Summary of 5010 Claim Changes

Provider Electronic Solutions (PES) Software Users:

Providers will need to **upgrade** to the most current version (2.16) before upgrading to the 5010 version (3.0). Version 3.0 will be available for download once Alabama Medicaid is ready to accept 5010 X12 and NCPDP D.0 transactions. Once you download and install version 3.0, you will only be able to send 5010 and NCPDP D.0 transactions. Upgrade instructions are currently on the RA Banners and the Web Portal. If you need assistance with the upgrade or have additional questions, please contact the EMC Helpdesk at 1-800-456-1242 or *AlabamaSystemsEMC@eds.com.*

How will Provider Electronic Solutions Change With Version 3.0?

Generally visible changes are minimal with the most dramatic changes occurring on Health Care Services Review (Prior Authorization) screens. Overall, some fields have been removed and others have been added, valid values lists have been updated, and some field lengths have changed. The greatest impact will be that users will not be allowed to copy claims submitted in the pre-3.0 format. By upgrading to version 3.0 the PES provider and recipient information will be preserved. However, the claims information will not. You can still use the web portal to retrieve your claims. Once claims have been recreated, they may then be copied and edited for future submissions. Additional details will be forthcoming. For specific information, refer to the Provider Electronic Solutions Manual.

Adjustments of Claims

During the concurrent processing timeframe, adjustments can be submitted in either 4010 or 5010 formats (with the exception of PES and Web Portal which will not have a concurrent processing period). Beginning on January 1, 2012, when only 5010 and NCPDP D.0 transactions will be accepted, all provider submitted adjustments will be in the new format. Standard 5010 PES and Web Portal edits will notify the user of any missing data when adjusting a claim submitted in the previous format.

Paper Claims

There are no changes to the paper claim form. Any code values that have changed will be systematically converted. A larger prescription number (up to 12 characters) will be accepted on Pharmacy claims.

Secondary Identifier Qualifier Code Changing

When using a secondary provider identifier (i.e. Medicaid Provider number) in claims submission, the current qualifier code is 1C or 1D. These codes are being replaced with G2. Paper claims submitted with these values will be automatically converted to G2.

Submitting Medicare Crossover Claims

For 5010 transactions, the Medicare allowed amounts can no longer be submitted by the provider. The Medicaid claims processing system will systematically calculate the allowed amount based on the Medicare paid amount and adjustment amounts submitted on the claim. WEB and paper claims will continue to require the Medicare allowed amount to be submitted.

Patient Reason for Visit Required on Outpatient Hospital Claim

A new edit will be implemented for providers submitting institutional claims. Edit 255 will require a patient reason code for the visit to be present on claims with type of bill 013X (outpatient hospital claim) with type of admission 1, 2 or 5 (emergency, urgent care, trauma center) when revenue code 045X (emergency room), 0526 (urgent care clinic) or 0762 (observation room) is present on the claim.

Additional Diagnosis Codes Allowed for Providers Submitting 837P Transactions

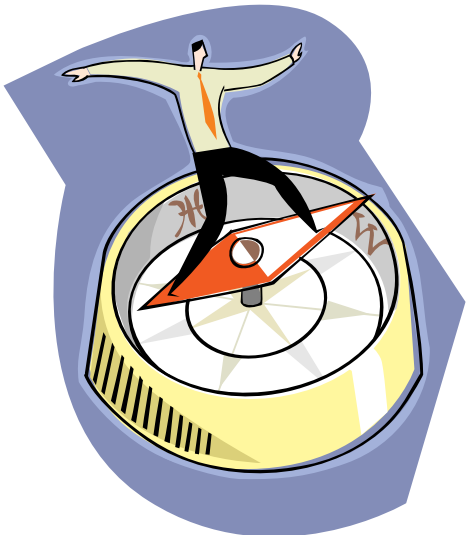
Providers submitting 837P transactions will be allowed to submit up to twelve diagnosis codes instead of the current limit of eight. In order to prepare for the implementation of ICD-10 diagnosis and surgical procedure codes, the claim file formats have been modified to accept the larger values. However, any ICD-10 diagnosis or surgical procedure values submitted prior to October 1, 2013 will be denied.

Claim Payment/Advice (835 Transaction)

During the concurrent processing period where both versions 837 X12 and NCPDP transactions are being received and processed, both 4010 and 5010 835 transactions will be produced for each and will be made available as separate files through the normal process. This will provide vendors the ability to retrieve whichever version is needed. As of January 1, 2012, only 5010 transactions will be created.

5010 Prior Authorization Changes

The Prior Authorization (PA) transaction format has changed significantly with the implementation of HIPAA 5010 (278) and the following information is what Alabama Medicaid is expecting to receive when submitting a PA request for services.



- Alabama Medicaid is expecting a single servicing provider per PA.
- Alabama Medicaid is expecting a single diagnosis code per PA.
- Alabama Medicaid is expecting a single PA service type code per request. For example a request for Medical Services would not be combined with a request for Dental services on a single PA, but submitted separately.
- Although ICD-10 values can be entered only ICD-9 values will be accepted until ICD-10 is implemented.

Prior Authorization Assignment Code Crosswalk

Alabama Medicaid has provided this crosswalk as a reference for understanding how the Prior Authorization Assignment Codes in 4010 will be related to the new 5010 assignment codes, specifically 4010 codes that are retired (48, 50) and no longer available with 5010. Once 5010 has been implemented all 4010 assignment codes will be converted to a 5010 assignment code as listed in the table below with the exception of codes 48 and 50. All new Prior Authorization records created through the HIPAA 4010 278 process will be returned on the 278 response with a 4010 code as submitted, but will be converted and saved to the Medicaid Management System as a 5010 code. To search for a Prior Authorization after 5010 implementation has occurred, search for the new 5010 Assignment Code descriptions.

4010 Assignment Codes - 48 - Hospital Inpatient

5010 Assignment Codes - 69 - Maternity, 40 - Oral Surgery

The 4010 PA assignment code '48' is being closed. The existing PAs are not being converted to the new assignment codes; for existing PA numbers search using 'Hospital – Inpatient'. When creating new PAs use the following 5010 code that best fits the service type: **Hospitals will use 69 - Maternity. All others will use 40 - Oral Surgery**

4010 Assignment Codes - 50 - Hospital Outpatient

5010 Assignment Codes - 88 - Pharmacy, 40 - Oral Surgery

The 4010 PA assignment code '50' is being closed. The existing PAs are not being converted to the new assignment codes; for existing PA numbers search using 'Hospital – Outpatient'. When creating new PAs use the following 5010 code that best fits the service type: **88 - Pharmacy** **40 - Oral Surgery**

4010 Assignment Codes - 56 - Ground Transportation

5010 Assignment Codes - 56 - Medically Related Transportation

The description of code '56' is changing from 'Ground Transportation' to 'Medically Related Transportation'. When searching for PAs use 'Medically Related Transportation'. **(Continued on page 5)**

www.medicaid.alabama.gov

Prior Authorization Assignment Code Crosswalk

(Continued from page 4)

4010 Assignment Codes - 57 - Air Transportation

5010 Assignment Codes - 56 - Medically Related Transportation

The 4010 PA assignment code '57' is being closed.The existing PAs are being converted to the new assignment code. When creating new PAs or searching for existing PAs use the following 5010 code: **56 - Medically Related Transportation**

4010 Assignment Codes - 98 - Professional Visit - Office

5010 Assignment Codes - 88 - Pharmacy

The existing PA assignment code '98' is being closed. The existing PAs are being converted to the new assignment code. When creating new PAs or searching for existing PAs use the following 5010 code: **88 - Pharmacy**

4010 Assignment Codes - 99 - Professional Visit - Inpatient

5010 Assignment Codes - 88 - Pharmacy

The existing PA assignment code '99' is being closed. The existing PAs are being converted to the new assignment code. When creating new PAs or searching for existing PAs use the following 5010 code: **88 - Pharmacy**

4010 Assignment Codes - A0 - Professional Visit - Outpatient

5010 Assignment Codes - 88 - Pharmacy

The existing PA assignment code 'A0' is being closed. The existing PAs are being converted to the new assignment code. When creating new PAs or searching for existing PAs use the following 5010 code: **88 - Pharmacy**

4010 Assignment Codes - A3 - Professional Visit - Home

5010 Assignment Codes - 88 - Pharmacy

The existing PA assignment code 'A3' is being closed. The existing PAs are being converted to the new assignment code. When creating new PAs or searching for existing PAs use the following 5010 code: **88 - Pharmacy**

4010 Assignment Codes - A7 - Psychiatric - Inpatient

5010 Assignment Codes - A4 - Psychiatric

The existing PA assignment code 'A7' is being closed. The existing PAs are being converted to the new assignment code. When creating new PAs or searching for existing PAs use the following 5010 code: **A4 - Psychiatric**

4010 Assignment Codes - A8 - Psychiatric - Outpatient

5010 Assignment Codes - CQ - Case Management

The existing PA assignment code 'A8' is being closed. The existing PAs are being converted to the new assignment code. When creating new PAs or searching for existing PAs use the following 5010 code: **CQ - Case Management**

4010 Assignment Codes - AC - Rehabilitation - Outpatient

5010 Assignment Codes - CQ - Case Management

The existing PA assignment code 'AC' is being closed. The existing PAs are being converted to the new assignment code. When creating new PAs or searching for existing PAs use the following 5010 code: **CQ - Case Management**

4010 Assignment Codes - PH - Pharmacy

5010 Assignment Codes - 88 - Pharmacy

The existing internal PA assignment code 'PH' is being closed. The existing PAs are being converted to the new assignment code. When creating new PAs or searching for existing PAs use the following 5010 code: **88 - Pharmacy**

Pharmacy Changes Effective October 2011

Antipsychotics:

Effective October 3, 2011, the Alabama Medicaid Agency will require prior authorization (PA) of all antipsychotic medications utilizing the electronic PA process. The PA process will affect all recipients (children and adults) as well as all antipsychotics (brand and generic, first and second generation). The PA criteria for this drug class can be found on the Agency's website at www.medicaid.alabama.gov.

Claims not approved through the electronic PA process at the pharmacy point of sale will require a manual PA form to be submitted; prescribers will receive automatic fax notification if additional medical justification is required.

Four Brand Limit:

Effective October 1, 2011, the Alabama Medicaid Agency will limit the number of brand name prescriptions to four per month per recipient. There will not be a limit on the number of covered generic or over-the-counter prescriptions a recipient may receive. This limitation does not apply to children under the age of 21 or to recipients living in nursing facilities. In certain drug classes, allowances are allowed in the event of an adverse or allergic reaction, or failure to respond. Medicaid will also continue to allow for prescriptions to exceed the four brand limit for anti-psychotic and anti-retroviral medications; however, there will be no instance where the limit may exceed ten brand name drugs per month per recipient. Providers with questions concerning the prescription limitation should contact:

Alabama Medicaid Agency
Pharmacy Services Division
P.O. Box 5624
Montgomery, Alabama 36103-5624
(334) 242-5050

PA for Protonix:

Effective October 1, 2011, the Alabama Medicaid Agency will no longer require prior authorization (PA) for payment of generic pantoprazole (Protonix). Brand name Protonix will continue to require prior authorization.

For additional PDL and coverage information, visit our drug look-up site which can be accessed using the following link: *http://medicaid.alabama.gov/CONTENT/4.0_Programs/4.5_Pharmacy_Services.aspx*

PA Request Information:

The PA request form and criteria booklet, as well as a link for a PA request form that can be completed and submitted electronically online, can be found on the Agency's website at *www.medicaid.alabama.gov* and should be utilized by the prescribing physician or the dispensing pharmacy when requesting a PA. Providers requesting PAs by mail or fax should send requests to:

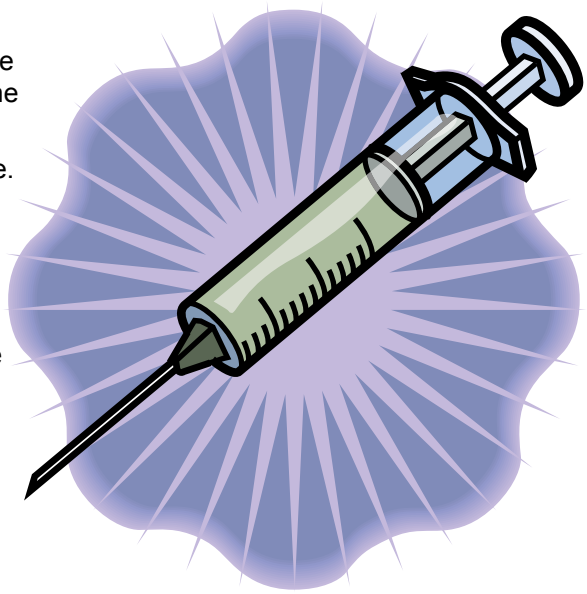
Health Information Designs (HID)
Medicaid Pharmacy Administrative Services
P. O. Box 3210 Auburn, AL 36832-3210
Fax: 1-800-748-0116
Phone: 1-800-748-0130

Incomplete PA requests or those failing to meet Medicaid criteria will be denied. If the prescribing physician believes medical justification should be considered, the physician must document this on the form or submit a written letter of medical justification along with the prior authorization form to HID. Additional information may be requested. Staff physicians will review this information.

Synagis® Criteria for 2011 – 2012 RSV Season

The Alabama Medicaid Agency has updated the prior authorization criteria for Synagis® during the 2011-2012 RSV season. Below are some highlights for the season. Complete criteria can be found on the website at the following link:

http://medicaid.alabama.gov/CONTENT/4.0_Programs/4.5.0_Pharmacy/4.5.14_Synagis.aspx



- The approval time frame for Synagis® will begin October 1, 2011 and will be effective through March 31, 2012.
- Up to five doses will be allowed per recipient in this timeframe. Some recipients may only receive up to a max of 3 doses, depending on the gestational and chronological age.
- There are no circumstances that will result in approval of a sixth dose.
- If a dose was administered in an inpatient setting, the date the dose was administered must be included on the request form.
- For approval of requests, the recipient must meet gestational and chronological age requirements. In order to meet chronological age requirements, the recipient must not exceed the specified age at the start of the RSV season.
- Prescribers, not the pharmacy, manufacturer or any other third party entity, are to submit requests for Synagis® on a separate prior authorization form (Form 351) directly to Health Information Designs and completed forms may be accepted beginning September 1, 2011 (for an October 1 effective date).
- Stamped or copied physician signatures will not be accepted and will be returned to the provider.
- A copy of the hospital discharge summary from birth or documentation of the first office visit with pertinent information (gestational age, diagnosis, etc.) is required on all Synagis® PA requests.
- If approved, each subsequent monthly dose will require submission of the recipient's current weight and last injection date and may be faxed to HID by the prescribing physician or dispensing pharmacy, utilizing the original PA approval letter.
- Letters will be faxed to both the prescriber and the dispensing pharmacy notating approval or denial.

Criteria

Alabama Medicaid follows the 2009 updated American Academy of Pediatrics (AAP) guidelines regarding Synagis® utilization. Additional questions regarding Synagis® criteria can be directed to the Agency's Prior Authorization contractor, Health Information Designs at 1-800-748-0130.

Imported Levoleucovorin Use Due to Fusilev Shortage J0641

To manage ongoing shortages of Leucovorin and Levoleucovorin, the FDA has authorized Spectrum Pharmaceuticals to import Levoleucovorin 100 mg powder for injection manufactured by Pfizer into the US market from Italy. No other entity except for Spectrum is authorized by the FDA to import or distribute Pfizer Levoleucovorin 100 mg powder for injection in the US.

Effective with dates of service February 1, 2011 forward, providers should use the created NDC number 99999-9991-00 when billing for the 100 mg vial.

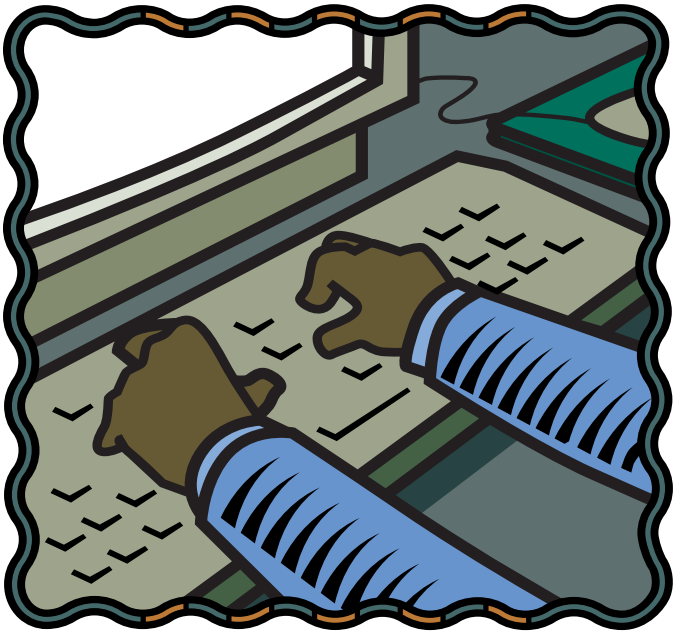
If billing for the 50 mg vial, use NDC 68152-0101-00.

When billing Levoleucovorin, continue to use HCPCS code J0641.

The Medicaid claim processing system has been modified to accept both NDCs as valid for J0641. For questions, contact HP Provider Assistance at 1-800-688-7989.

ePrescribe System is Coming to Alabama Medicaid

The HPES Healthcare ePrescribe System gives providers the ability to electronically transmit most prescriptions directly to the pharmacy.



Enrolled prescribers utilizing the ePrescribe system will be able to transmit prescriptions electronically to a Surescripts participating pharmacy designated by the patient. The transmission occurs through the network connections between the prescriber's office, Surescripts, and the pharmacy. As part of this process, prescribers will have access to formulary and benefit information that applies to patients determined to be eligible for pharmacy benefits.

The Healthcare ePrescribe System will be available through the existing web portal. To use the Healthcare ePrescribe System, providers must be a Medicaid registered provider and request a log-on which is separate from the web portal log-on. A form is available on page 9 of the Insider to complete and send in to obtain an ePrescribe ID. If the provider is permitted to prescribe electronically, the ePrescribe link will appear on the provider page of the provider portal.

A provider is required to register with the Healthcare ePrescribe System. The onetime ePrescribe prescriber registration process requires entry of several key pieces of information. This includes name and contact information, DEA number (for prescribing controlled substances on paper), provider specialty and a self created Personal Identification Number (PIN) which is used by the prescriber to finalize prescriptions written using this system. In addition, the prescriber must indicate if he/she grants access to portal delegates to perform clerical functions such as updating the patient profile or performing an eligibility transaction. If the Grant Delegate Access is set to 'Yes', provider portal delegates for that prescriber can have the ability to access the clerical functions of ePrescribe. Please note that delegates do not have the capability to finalize a prescription because the prescriber PIN is needed to complete this process. Upon completion of the prescriber profile, the only time the prescriber needs to access the profile is to update any profile information.

New NDC Look-up Site

Effective October 1, 2011, the current NDC Look-up Site will be retired. It will be replaced with an NDC Look-up Site available through Medicaid's Interactive Website. Users will access the current Medicaid Interactive Web Portal using the following address:

https://www.medicaid.alabamaservices.org/ALPortal/Account/Secure%20Site/tabId/65/Default.aspx.

Users will then click the tab labeled 'NDC Look-up.' A user ID and password is NOT required to access this portion of the web portal. Once the NDC look-up panel is accessed, searches can still be done by NDC, NDC and date, drug name or drug name and date.

As always, information contained on this website is not a guarantee of payment. Medicaid will continue to pay for medication pursuant to current Medicaid policies.

Flu Season is Here!

Annual influenza vaccination is the most effective method for preventing influenza virus infection and its complications. Flu vaccination is a covered service for eligible recipients.

 (Continued from Page 8)

ePrescribe ID Request Form

Please fill out the form in its entirety and return to the EMC Help Desk via mail, email or by fax.

EMC Help Desk
HP Enterprise Service
301 Technacenter Drive
Montgomery, AL36117
Email: AlabamasystemsEMC@hp.com
Fax: (334) 215 – 4272
Phone: (800) 456 – 1242 / (334) 215 – 0111

Provider Name _____

NPI Number _____

Medicaid Number _____

DEA # _____

Address _____

City, State, Zip _____

Telephone Number _____

Email _____

Contact Name _____

Please check which software solution is used for the submission and retrieval of Medicaid information.

☐ Provider Electronic Solutions ☐ Vendor software solution

☐ Clearinghouse ☐ ePrescribe

Other, please explain:

Federal Rules Governing the Hospice Program

The federal rules governing the Hospice Program provides that an additional amount is paid to the hospice on behalf of an individual residing in a nursing facility. This amount must equal at least 95% of the per diem rate that the Medicaid Agency would have paid to that nursing facility for the individual in that facility. For example, if you have three (3) individuals receiving hospice services through your Agency, each residing in a different nursing facility, you should bill the room and board for each individual based upon 95% of that facility's per diem rate. If the per diem rate for the facility is $135.00, you should bill the room and board at $128.25.

If you are not aware of what the nursing facility per diem rate is, you should first request this information directly from the nursing facility. If you are unable to obtain this information from the nursing facility you may request this information in writing from the Alabama Medicaid Agency, LTC, Provider/Recipient Services Unit, 501 Dexter Avenue, Montgomery, AL 36103-5624, or fax to (334) 353-5696. Below is a sample letter for you to recreate in requesting this information.

LTC, Provider/Recipient Services Unit
501 Dexter Avenue
Montgomery, Alabama 36103-5624
FAX #: (334) 353-5696

Requesting Hospice Provider: _____

Hospice Provider #: _____

Hospice Provider Telephone #: _____

Hospice Provider Fax #: _____

Contact Person's Name: _____

Nursing Facility: _____

Address: _____

Do you now provide Hospice services to individuals in this facility? Yes or No

Received AMA: _____

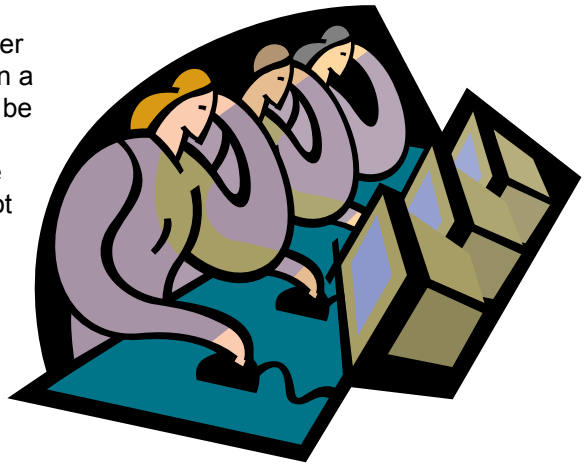
Returned by Fax on: _____

Signature: _____

Coming Soon!

Electronic Provider Enrollment Web Portal

The Alabama Medicaid Agency will be implementing an electronic provider enrollment web portal application. The Alabama Medicaid Provider Enrollment Web Portal will allow new providers to enroll with Alabama Medicaid. This site will be available 24-hours a day, seven days a week, excluding time for scheduled maintenance. The address to access the portal is *www.medicaid.alabama.gov.*



A user ID or password is not required to access and submit a Provider Enrollment application, however, when selecting the "finish later" function a tracking number, tax ID and password will be required. The password must be 8 to 20 characters in length, not the same as the user ID and contain a minimum of 1 numeric digit, 1 uppercase letter and 1 lowercase letter. Be aware that HP staff cannot retrieve the passwords and passwords cannot be reset. To check the status of a submitted enrollment application, a tracking number and tax ID will be required.

Once the application is submitted and confirmed, a tracking number will be assigned and a bar-coded cover sheet must be printed for submission with all materials to HPES Provider Enrollment. The applicant will be required to use the bar coded cover sheet with both faxed and mailed information. Please consult the website to learn what forms are required.

A training guide will be available with step by step instructions on navigating through the web portal. The address to access the training guide is *www.medicaid.alabama.gov.*

Training will be available to providers requesting assistance with completing the electronic enrollment application. Providers requiring training should contact their Provider Representative at 1-800-688-7989 (in-state) or (334) 215-0111 (out-of-state).

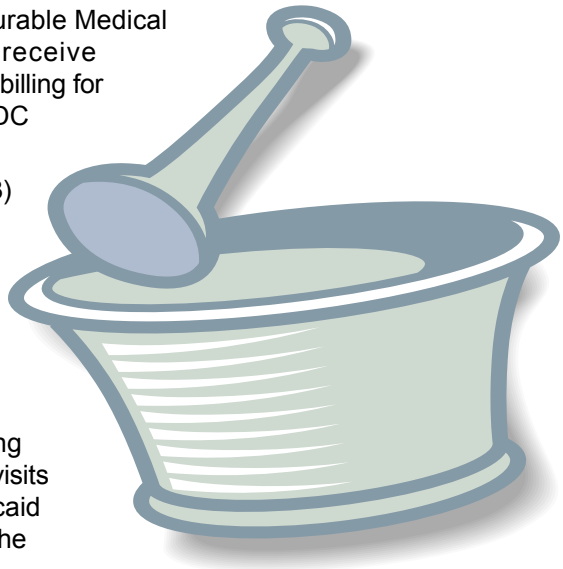
On-line Provider Contact Information Update Capability

For providers who are already enrolled in Medicaid, you will be able to update your contact information, telephone numbers, and address using the existing provider portal. However, for changes to the "service location address," please follow the current procedures and contact HPES' Provider Enrollment.

Federal Regulations Requiring Medicaid Re-enrollment Every Five Years

New federal regulations require that all providers re-enroll with Medicaid every five (5) years. To comply with this regulation, HP Enterprise Services will begin re-enrolling providers on October 1, 2011. The first providers which will require re-enrollment are providers with an enrollment date prior to October 1, 1999. HPES will move forward with re-enrollment using enrollment dates over the next several years. Providers will be notified via mail when re-enrollment is required and provided instructions on how the re-enrollment process will proceed.

Pharmacy Providers Enrolled for DME



Pharmacy providers that are enrolled with Alabama Medicaid as Durable Medical Equipment (DME) providers must follow DME billing procedures to receive reimbursement for services provided to Alabama Medicaid recipients. When billing for DME items and supplies, you must bill with the correct HCPC code, not NDC codes.

If you are having difficulty submitting your claims for diabetic strips (A4253) and lancets (A4259) or any other DME items or supplies, please contact your HPES provider representative for assistance.

Your HPES provider representatives are:

- Hayley Lavender (334) 215-4158 Email: *hayley.lavender@hp.com*
- Shamekia Pena (334) 215-4199 Email: *shamekia.pena@hp.com*

Your HPES provider representatives can assist you with any DME billing problems you may have. HPES provider representatives also make onsite visits for purposes of training to any DME company enrolled as an Alabama Medicaid provider located in the state of Alabama, or within a thirty-mile radius of the Alabama state line.

If you have any questions regarding DME policies or DME coverage issues, please contact the Pharmacy DME Unit at 334-353-4753 or 334-353-4756.

Newly Covered Code for the Prosthetic, Orthotic and Pedorthic Program

Effective immediately, Medicaid has approved Procedure Code L5972 (Flexible Keel Foot) as a newly covered code for the Prosthetic, Orthotic, and Pedorthic Program.

Procedure Code L5972 must be provided by a licensed prosthetic, orthotic and/or pedorthic practitioner in the State of Alabama practicing at an accredited facility. The provider must obtain a written prescription, must keep the prescription on file, and must have supporting documentation that the device is medically necessary.

Medicaid pays for basic level prosthetic, orthotic, and pedorthic devices for ages 21 to 65. For questions or concerns regarding the POP Program, please contact Felicha Fisher at (334) 353-5153.

DME Wheelchair Changes

Effective October 1, 2011, the Alabama Medicaid Agency's Motorized/Power Wheelchair Assessment Form 384 must be completed and signed by a licensed Occupational Therapist or Physical Therapist with prior authorization requests for custom manual wheelchairs provided for children through the EPSDT program and for manual wheelchairs with additional accessories for adults.

Completion of Form 384 is already required for all power wheelchairs for children and adults.

Providers are no longer required to obtain the physician's signature on the Motorized/Power Wheelchair Assessment Form 384.

If you have questions or need further clarification, please contact Ida Gray at (334) 353-4753 or Linda Stephens at (334) 242-5144.

Reminder

This is a reminder that the ICD-9-CM updates will be effective for dates of service on or after October 1, 2011.

Prescribing Physician's NPI or License Number on Pharmacy Claims

Pharmacies participating in the Alabama Medicaid program are required to use the prescribing physician's NPI or license number when filing a claim with the Agency. A recent review of pharmacy billing practices found that numerous pharmacies are using an incorrect prescribing physician number on claims submitted to the Agency.

Effective October 17, 2011, the Alabama Medicaid Agency will no longer recognize physician license number 19776 on any claims. Pharmacy providers should coordinate with their software vendors to validate physician license number 19776 or any other 'pseudo number' is not hard coded in their system for Alabama Medicaid claims processing.

Providers are reminded that any pharmacy claim with an incorrect prescribing physician number is subject to recoupment. Pharmacies with repeated violations will be subject to revocation of their Medicaid provider agreement, and referral to federal or state law enforcement personnel for criminal prosecution.

New Medicaid Enrollment Requirements for Prescribing, Ordering or Referring Providers

Federal law now requires all physicians and other practitioners who prescribe or order services for Medicaid recipients, or who refer Medicaid recipients to other providers must be enrolled as a participating Medicaid Provider no later than December 31, 2011.

As a result, services rendered based on a referral, order, or prescription will be reimbursable only if the referring, ordering, or prescribing physician or practitioner is enrolled in the Alabama Medicaid Program, effective January 1, 2012.

Residency Information: On January 1, 2012, interns and non-licensed residents must use the NPI or license number of the teaching, admitting, or supervising physician on the claim for reimbursement. If the resident has a medical license, then the resident must be enrolled with Medicaid to qualify for reimbursement. If the licensed resident is not enrolled, he/she may not be identified on a Medicaid claim as the Prescribing, Ordering or Referring provider

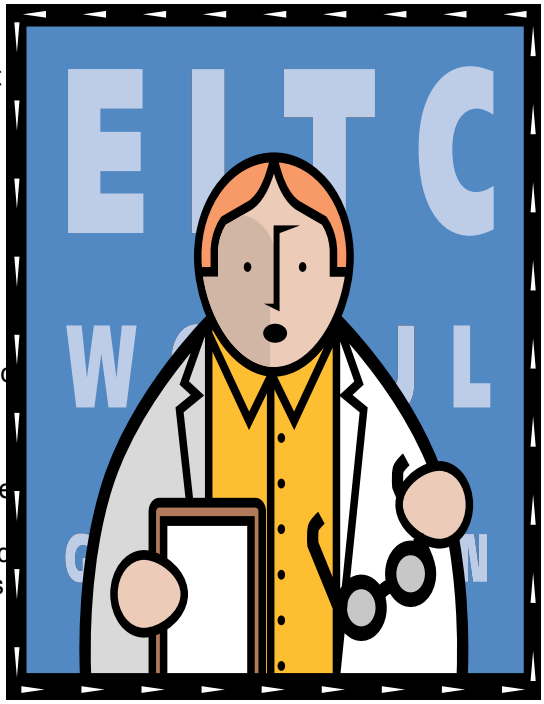
To accommodate the new federal law, the Alabama Medicaid Agency is changing its policy for a physician enrolled in and providing services through a **residency** training program. Medicaid will no longer require these physicians be assigned a pseudo Medicaid license number to be used on prescriptions written for Medicaid recipients.

A new application is being developed for those providers who do not routinely treat Alabama Medicaid recipients for payment. These physicians and practitioners will be able to enroll as a Prescribing, Ordering or Referring Alabama Medicaid non-provider. Providers will be notified when the enrollment application is available.

Please contact HPES Provider Enrollment at 1-888-223-3630 (in-state) or 1-334-215-0111 (out-of-state) with any questions or go to: *http://www.medicaid.alabama.gov/CONTENT/8.0_Contact/8.2.5_Provider_Enrollment.aspx.*

www.medicaid.alabama.gov

New Award for Central Source Contractor for Eyeglasses



The Alabama Medicaid Agency awarded a new contract through an Invitation To Bid process to Steven Baker, Inc., D/B/A Korrect Optical as the Central Source Contractor for Eyeglasses. The effective date of the contract was July 1, 2011. Korrect Optical began accepting eyeglass orders on Tuesday, September 6, 2011. Korrect Optical's Customer Service number is 1-800-624-4225.

The Alabama Medicaid Provider Manual, Chapter 15 was updated in the October 2011 edition to include prices and approved frames. The manual will include changes made in the Eye Care Program regarding eyeglasses, such as previous stand-alone codes will now become add-on codes. Previously, stand-alone lens codes could not be billed with other lens. With add-on codes, the lens code and the applicable add-on code may both be billed on the same date of service. The changes will provide Alabama Medicaid with improved utilization data.

Eye Care providers may continue to order or fabricate eyeglasses as in the past and at the new contracted allowed amounts. Please refer to the Alabama Medicaid Provider Manual, Chapter 15, for the Eye Care Program policies and for the new allowed amounts for lens, add-on codes, prior authorization codes and frame codes. The new contracted allowed amounts for eyeglasses became effective August 1, 2011.

The Alabama Medicaid Agency is appreciative of your contributions and efforts as a Medicaid Eye Care Provider.

Korrect Optical is Ready to Accept Orders

The Alabama Medicaid Agency's new central source contractor, Korrect Optical, is now accepting orders on their website at *www.korrect.com*. On their home page, a link is provided to assist Alabama Medicaid Providers with the placement, processing, and tracking of optical orders with Korrect Optical. Also, instructions for the web ordering system and a printable PDF Optical Order Form for submission via fax or mail can be found on the website. Customer service representatives are available from 6:30 a.m. to 11 p.m. CST at 1-800-624-4225 for assistance.

Under this new contract, replacement frames will be replaced by Korrect Optical at no cost to the provider or Alabama Medicaid.

Please refer to Chapter 15 of the October 2011 Alabama Medicaid Provider Manual for additional information about the changes to the Eye Care program.

If you have any questions, you may contact Leigh Ann Hixon, RN, by telephone at (334) 353-3031 or by email at *leighann.hixon@medicaid.alabama.gov.*

www.medicaid.alabama.gov

Korrect Optical

www.korrect.com
(800) 624-4225

Hours:
6:30 a.m to 11 p.m
Central Standard Time

Top 5 Reasons for Claim Denials for NCCI Edit or Multiple Surgery Audit 5656

1. **Missing anatomical modifiers:** E1 – E4, FA, F1 – F9, TA, T1 – T9, LC, LD, and RC.
2. **Missing RT or LT modifiers for bilateral procedures on separate detail line items (Modifier 50 is informational only).**

   Example:

   Line 1: 49495 RT

   Line 2: 49495 LT

3. **Missing modifier 59 for distinct procedural services.**

   From an NCCI perspective, the definition of different anatomic sites includes different organs or different lesions in the same organ. However, it does not include treatment of contiguous structures of the same organ. For example, treatment of the nail, nail bed, and adjacent soft tissue constitutes treatment of a single anatomic site. Treatment of posterior segment structures in the ipsilateral eye constitutes treatment of a single anatomic site. Arthroscopic treatment of a shoulder injury in adjoining areas of the ipsilateral shoulder constitutes treatment of a single anatomic site.
4. **Missing modifier 25 for significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service.** Modifier 25 may be appended to an evaluation and management (E&M) CPT code to indicate that the E&M service is significant and separately identifiable from other services reported on the same date of service.
5. **Improper billing of "scout" procedures.** For example, if an arthroscopy is performed as a "scout" procedure to assess the surgical field or extent of disease, it is not separately reportable. If the findings of a diagnostic arthroscopy lead to the decision to perform an open procedure, the diagnostic arthroscopy may be separately reportable. Modifier 58 may be reported to indicate that the diagnostic arthroscopy and non-arthroscopic therapeutic procedures were staged or planned procedures. The medical record must indicate the medical necessity for the diagnostic arthroscopy.

Refer to Chapter 28 of the Alabama Medicaid Provider Manual and the following web address for more information:

http://www.cms.gov/MedicaidNCCICoding/01_Overview.asp#TopOfPage

Changes in Payment for Hospitals

Effective for dates of service on or after October 1, 2011, all outpatient services will be reimbursed based on a fee-for-service payment methodology. Claims that are processed on or after October 1, 2011, for dates of service prior to October 1, 2011, will continue to be processed based on the encounter payment methodology. The fee schedule for outpatient services for dates of service on or after October 1, 2011 is posted on the Medicaid website.

Inpatient rates will remain unchanged. Hospitals will not receive rate letters in October of this year. The rates that are currently in effect will remain so until further notice.

If you have any questions concerning this new payment methodology, you may contact Jerri Jackson via e-mail at *jerri.jackson@medicaid.alabama.gov* or via phone at (334) 242-5630.

ATTENTION!

In the near future, HPES Provider Representatives will be reached by dialing a toll free number, then entering a telephone extension. The new toll free number and extensions will be available soon.

The following address on the Medicaid website will provide updates for the change:

http://www.medicaid.alabama.gov/CONTENT/8.0_Contact/8.2.6_Provider_Representatives.aspx.

State Fiscal Year 2011-2012 Checkwrite Schedule

10/07/11	01/06/12	04/06/12	07/06/12
10/21/11	01/20/12	04/20/12	07/20/12
11/04/11	02/03/12	05/04/12	08/03/12
11/18/11	02/17/12	05/18/12	08/17/12
12/02/11	03/02/12	06/06/12	09/07/12
12/16/11	03/16/12	06/17/12	09/14/12

The release of funds is normally the second Monday after the RA date. Please verify direct deposit status with your bank. Go to *www.medicaid.alabama.gov* to view the payment delay update details. Payment alerts will be posted only if there will be a payment delay. As always, the release of direct deposits and checks depends on the availability of funds.

Alabama Medicaid Bulletin

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Montgomery, AL 36124-4032

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MONTGOMERY AL

Provider *Insider*

Alabama Medicaid Bulletin **January 2012**

The Remittance Advice (RA) schedule is as follows:

01/06/12 01/20/12 02/03/12 02/17/12 03/02/12 03/16/12

The release of funds is normally the second Monday after the RA date. Please verify direct deposit status with your bank. Go to *www.medicaid.alabama.gov* to view the payment delay update details. Payment alerts will be posted only if there will be a payment delay. As always, the release of direct deposits and checks depends on the availability of funds.

Electronic Provider Enrollment Web Portal

Go Live Date:

January 9, 2012

The Alabama Medicaid Agency will be implementing an electronic provider enrollment web portal application effective January 1, 2012.

Medicaid will continue to process any paper applications received through January 23, 2012, Any paper application received on January 24, 2012 and thereafter will be returned to the provider instructing them to use the Alabama Medicaid Provider Enrollment Web Portal.

The Alabama Medicaid Provider Enrollment Web Portal will allow new providers to enroll with Alabama Medicaid. This site will be available 24-hours a day, seven days a week, excluding time for scheduled maintenance. The address to access the portal is www.medicaid.alabama.gov.

A user ID or password is not required to access and submit a Provider Enrollment application, however, when selecting the "finish later" function a tracking number, tax ID and password will be required. The password must be 8 to 20 characters in length, not the same as the user ID and contain a minimum of 1 numeric digit, 1 uppercase letter and 1 lowercase letter. Be aware that HP staff cannot retrieve the passwords and passwords cannot be reset.

To check the status of a submitted enrollment application, a tracking number and tax ID will be required. Once the application is submitted and confirmed, a tracking number will be assigned and a bar-coded cover sheet must be printed for submission with all materials to HPES Provider Enrollment. The applicant will be required to use the bar coded cover sheet with both faxed and mailed information. Please consult the website to learn what forms are required.

A training guide is available with step by step instructions on navigating through the web portal. The address to access the training guide is www.medicaid.alabama.gov.

Training will be available to providers requesting assistance with completing the electronic enrollment application. Providers requiring training on the web portal should contact their provider representative at 855-523-9170 (see page 7 of the Insider for representative extensions).

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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 _____*

The information contained within is subject to change. Please review your Provider Manual and all Provider Alerts for the most up to date information.

ALABAMA MEDICAID

In The Know

General Information Providers Need to Know When Billing to the Alabama Medicaid Agency

Locum Tenens and Substitute Physician Under Reciprocal Billing Arrangements

It is common practice for physicians to retain substitute physicians to take over their professional practices when the regular physicians are absent for reasons such as illness, pregnancy vacation, or continuing medical education, and for the regular physician to bill and receive payment for the substitute physician's services as though he/she performed them. The substitute physician generally has no practice of his/her own and moves from area to area as needed. The regular physician generally pays the substitute physician a fixed amount per diem, with the substitute physician having the status of an independent contractor rather than of an employee. The substitute physicians are generally called "locum tenens" physicians.

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 reciprocal arrangement may not exceed 14 days in the case of an informal arrangement or 90 continuous days in the case of an arrangement involving per diem or other fee-for-time compensation. Providers participating in a reciprocal arrangement should be enrolled with the Alabama Medicaid Agency. 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. Claims will be subject to post-payment review. Please refer to Chapter 28, Physician, section 28.5.3, Procedure Codes and Modifiers for information regarding modifiers Q5 and Q6.

Preferred Drug List (PDL) Update

Effective January 3, 2012, the Alabama Medicaid Agency will update the Preferred Drug List (PDL) to reflect the recent Pharmacy and Therapeutics (P&T) Committee's recommendations as well as quarterly updates. The updates are listed below:

PDL Additions	PDL Deletions*	
None	Azasite	EENT Preparations/Antibacterials
	Nasacort AQ	EENT Preparations/Intranasal Corticosteroids
	Neosporin	EENT Preparations/Antibacterials
	Poly-pred	EENT Preparations/Antibacterials

* Denotes that these brands will no longer be preferred but are still covered by Alabama Medicaid and will require Prior Authorization (PA). Available covered generic equivalents (unless otherwise specified) will remain preferred.

For additional PDL and coverage information, visit our drug look-up site at *https://www.medicaid.alabamaservices.org/ALPortal/NDC%20Look%20Up/tabId/39/Default.aspx.*

The PA request form and criteria booklet, as well as a link for a PA request form that can be completed and submitted electronically online, can be found on the Agency's website at *www.medicaid.alabama.gov* and should be utilized by the prescribing physician or the dispensing pharmacy when requesting a PA. Providers requesting PAs by mail or fax should send requests to:

Health Information Designs (HID)
Medicaid Pharmacy Administrative Services
P. O. Box 3210 Auburn, AL 36832-3210
Fax: 1-800-748-0116
Phone: 1-800-748-0130

Incomplete PA requests or those failing to meet Medicaid criteria will be denied. If the prescribing physician believes medical justification should be considered, the physician must document this on the form or submit a written letter of medical justification along with the prior authorization form to HID. Additional information may be requested. Staff physicians will review this information.

Policy questions concerning this provider notice should be directed to the Pharmacy Program at (334) 242-5050. Questions regarding prior authorization procedures should be directed to the HID help desk at 1-800-748-0130.

Prolonged Services Direct Contact in Office or Other Outpatient Setting
(Procedure Codes 99354 & 99355)

Procedure code 99354 prolonged physician services in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service; first hour and Procedure code 99355 prolonged physician services in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service; each additional 30 minutes will be limited to one per recipient per provider per year. For purposes of this limitation, a physician or physicians of the same specialty from the same group practice are considered a single provider. Time must be documented clearly in the medical record to indicate the beginning of service time and the end of service time to justify these codes being billed in addition to the office visit. These services will be subject to post-payment review.

REMINDER

Office Visits

Office visits are limited to one per day, per recipient, per provider. For purposes of this limitation, a physician or physician of the same specialty from the same group practice are considered a single provider. Annual office visit benefit limits are 14 office visits per calendar year.

Appropriate Use of Modifiers

Modifiers use has changed because of NCCI edits. Refer to this CMS link for more information regarding NCCI edits: *http://www.cms.gov/MedicaidNCCICoding 01_Overview.asp#TopOfPage*

Evaluation and Management Billed with Drug Administration Codes

When an Evaluation and Management service is provided and a Drug Administration code (96372, 96373, 96374, 96375, and 96376), is provided at the same time, the E&M code, Drug Administration Code, and the HCPCs Code for the drug may be billed. A **Significant Separately Identifiable Service** must be performed in conjunction with the Drug Administration code for consideration of payment for the E&M Code. A **Modifier 25** must be appended to the E&M service for recognition as a **"Significant Separately Identifiable Service."** Medical Record documentation must support the medical necessity of the visit as well as the level of care provided.

When an Evaluation and Management service is provided and a Hydration, Therapeutic, Prophylactic, Diagnostic and Chemotherapy Administration code is provided at the same time, the E&M code, Drug Administration Code, and the HCPCs Code for the drug may be billed. A **Significant Separately Identifiable Service** must be performed in conjunction with these administration codes for consideration of payment for the E&M Code. A **Modifier 25** must be appended to the E&M service for recognition as a **"Significant Separately Identifiable Service."** Procedure Code 99211 will not be allowed with a modifier 25 or when billed in conjunction with the above administration codes. Medical record documentation must support the medical necessity and level of care of the visit.

However, when no **Significant Separately Identifiable** E&M service is actually provided at the time of a Drug Administration, an E&M code should not be billed. In this instance, the Drug Administration Code and the HCPCs Code for the drug may be billed. An example of this is routine monthly injections like B-12, iron, or Depo-Provera given on a regular basis without a **Significant Separately Identifiable** E&M service being provided. These services will be subject to post payment review.

Policy Changes for Residency Training Program

Alabama Medicaid Agency is changing its policy for a physician enrolled in and providing services through a residency training program. Medicaid will no longer require these physicians be assigned a pseudo Medicaid license number to be used on prescriptions written for Medicaid recipients.

On January 1, 2012, interns and non-licensed residents must use the NPI or license number of the teaching, admitting, or supervising physician on the claim for reimbursement. If the resident has a medical license, then the resident must be enrolled with Medicaid to qualify for reimbursement.

Pharmacy Providers Enrolled for DME

Pharmacy providers that are enrolled with Alabama Medicaid as Durable Medical Equipment (DME) providers must follow DME billing procedures to receive reimbursement for services provided to Alabama Medicaid recipients. When billing for DME items and supplies, you must bill with the correct HCPC code, not NDC codes.

If you are having difficulty submitting your claims for diabetic strips (A4253) and lancets (A4259) or any other DME items or supplies, please contact your HPES provider representative for assistance.

Your HPES provider representatives are:

- Hayley Lavender (334) 215-4158 Email: *hayley.lavender@hp.com*
- Shamekia Pena (334) 215-4199 Email: *shamekia.pena@hp.com*

Your HPES provider representatives can assist you with any DME billing problems you may have. HPES provider representatives also make onsite visits for purposes of training to any DME company enrolled as an Alabama Medicaid provider located in the state of Alabama, or within a thirty-mile radius of the Alabama state line.

If you have any questions regarding DME policies or DME coverage issues, please contact the Pharmacy DME Unit at 334-353-4753 or 334-353-4756.

5010 and NCPDP Transactions

The following 5010 X12 and NCPDP D.0 transactions have been added for the CMS mandated implementation on January 1, 2012:

- 270/271 - Health Care Eligibility Benefit Inquiry and Response
- 276/277 - Health Care Claim Status Request and Response
- 278 - Health Care Services Review – Request for Review and Response
- 835 - Health Care Claim Payment/Advice
- 837 - Health Care Claim (dental, institutional, and professional)
- NCPDP Batch 1.2
- NCPDP D.0
    - Claim Billing – B1
    - Claim Reversal – B2
    - Eligibility Verification – E1
    - Prior Authorization Request Only – P4
- 999 - Implementation Acknowledgement for Health Care Insurance.

5010

Is Here!

January 1, 2012

Are you ready?

Prior Authorization Change Request Form Clarification

Per Chapter 4, Obtaining Prior Authorization, of the Billing Manual, the prior authorization (PA) change request form (Form 471) is **NOT** to be used for reconsiderations of denied PAs or for procedure code changes. Providers must submit reconsideration for a denied PA following the usual process of faxing or mailing the PA denial letter to HP, along with the supporting documentation for reconsideration. Providers may submit a new PA for procedure code changes.

Form 471 is for revisions to a prior authorization in evaluation status, or for simple changes to an approved PA, such as revising dates of service. Please ensure that the PA documents support any requested change.

Complete the appropriate sections on the form and fax to the Alabama Medicaid Agency at (334) 353-9352 or (334) 353-4909. The form may now be completed on-line and then faxed to one of the aforementioned numbers. Please allow three business days for processing. The form may be accessed at:

http://medicaid.alabama.gov/documents/5.0_Resources/5.4_Forms_Library/5.4.1_Billing 5.4.1_Form%20471_PA_Change_Request_fillable_12-8-11.pdf

IUDs and Implants: Changes to Contraceptive Coverage

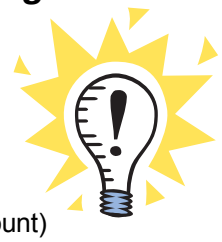
The Alabama Medicaid Agency is making important changes regarding the coverage of intrauterine devices (IUDs) and implantable contraceptive devices. Effective January 1, 2012, these devices will be reimbursed only when billed on a medical claim. Pharmacies will no longer be able to bill for these devices for a specific patient and ship to the provider for insertion/implantation. Example devices include Mirena®, Paragard®, Implanon®, etc.

Questions regarding this change can be sent to *Nancy.Headley@medicaid.alabama.gov* or by calling (334) 242-5684.

Attention!

The compliance date for 5010 transactions is January 1, 2012. The Centers for Medicare and Medicaid Services (CMS) announced that Covered Entities that are not compliant with 5010 will be subject to penalties on March 31, 2012.

NCPDP D.0 Version Changes



The NCPDP D.0 version offers new functionality related to the reporting of other payer patient responsibility data. With the implementation of D.0, Alabama Medicaid will begin capturing values sent in fields:

- 353-NR (other payer patient responsibility count)
- 351-NP (other payer patient responsibility qualifier)
- 352-NQ (other payer patient responsibility amount)

When a payment has been received from another payer, the amount reported in the patient pay amount (505-F5) must be entered in the 352-NQ field, along with an "06" qualifier code in field 351-NP. Alabama Medicaid will consider this amount submitted in determining the final amount that Medicaid will pay.

In addition, if the value in the other coverage code field (308-C8) indicates other coverage exists (values 02, 03, 04, or 08), then the 352-NQ field must be greater than zero or the claim will reject.

Claim Submission Changes Regarding Third Party Insurance Payments

Pursuant to 5010 changes, the Alabama Medicaid Agency is modifying the requirement for claims with Third Party payments. The Alabama Medicaid will require that Third Party payment information be submitted at the detail line item level for Dental, Professional and Outpatient claims. Inpatient and LongTerm Care claims will continue to have the third party payment information submitted at the header level.

The Alabama Medicaid Agency will also require that a Patient Responsibility Amount be submitted as part of Third Party payment information. The Patient Responsibility Amount is the amount processed by the other insurance payer as the patient's responsibility and represents the amount remaining for Medicaid payment consideration.

Attention!

Procedure Codes 80100, 80101, and 80104

Effective January 1, 2012, procedure codes 80100, 80101, and 80104 will be limited to one per day, per recipient, per provider for each procedure code. Providers within the same group practice are considered a single provider.

New Medicaid Enrollment Requirements for Prescribing, Ordering or Referring Providers

The implementation date for the enrollment of prescribing, ordering, or referring providers referenced in the October 2011 Provider Insider has been delayed. Providers will be notified when the enrollment process begins.

Perinatal Care Town Hall Meetings

The Alabama Medicaid Maternity Care Program invites delivering OB physicians and midwives to participate in Physician-Led Town Hall Meetings to discuss quality in perinatal care. These open forum meetings are designed to further our efforts to lower Alabama's infant mortality rate and improve maternal and infant health. The sessions are free and pre-registration is not required.

Montgomery

6:00pm, January 12 or March 8
AUM School of Nursing
Moore Hall, Room 106
7461 East Drive,AUM Campus

Huntsville

6:00pm, January 17
Corporate University Center at
109 Governor's Drive

6:00pm, March 13
Children's Rehab Services at
3000 Johnson Road

Birmingham

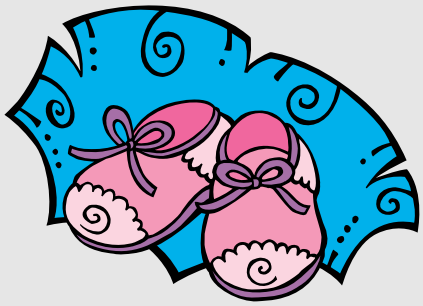
6:00pm, Jan 26 or March 6
Vestavia Hills Library
1112 Montgomery Highway

Mobile

6:00pm, January 24 or March 27
Saad Healthcare
1515 University Boulevard South

Webinar

The March 8, 2012 meeting will also be available by webinar. Visit the Maternity Care Program page under Medical Services at *www.medicaid.alabama.gov* for more information.



HP Provider Representatives

Debbie Smith
debbie.smith2@hp.com
855-523-9170
Ext. 2334581

Michelle Patterson
katherine.patterson@hp.com
855-523-9170
Ext. 2334583

Gayle Simpson-Jones
gayle.simpson-jones@hp.com
855-523-9170
Ext. 2334582

Misty Nelson
misty.nelson@hp.com
855-523-9170
Ext. 2334578

Hayley Lavender
hayley.lavender@hp.com
855-523-9170
Ext. 2334584

Shamekia Pena
shamekia.pena@hp.com
855-523-9170
Ext. 2334588

Provide Assistance for:

CRNA
Chiropractors
EPSDT (Physicians)
Dental
Free Standing Radiology
Independent Labs
Nurse Practitioners
Opticians
Optometrists
Physicians
Podiatrists

Rehabilitation Services
- Home Bound Waiver
- Therapy Services (OT, PT, ST)
- Children's Specialty Clinics

Prenatal Clinics
Maternity Care
Rural Health Clinic
Nurse Midwives
Hearing Services
- MR/DD Waiver

Ambulance

FQHC
Mental Health/Mental Retardation
Commission on Aging
DME
Public Health Including:
- Elderly and Disabled Waiver
- Home and Community Based Services
- EPSDT
- Family Planning
- Prenatal
- Preventive Education

Provide Assistance for:

Personal Care Services
Private Duty Nursing
Renal Dialysis Facilities
Swing Bed
PEC
ESWL
Nursing Home
Ambulatory Surgical Centers
Home Health
Hospice
Hospital

Aleetra Adair
aleetra.adair@hp.com
855-523-9170
Ext. 2334587

Ann Miller
ann.miller2@hp.com
855-523-9170
Ext. 2334589

Shermeria Hardy-Harvest
shermeria.harvest@hp.com
855-523-9170
Ext. 2334586

State Fiscal Year 2011-2012 Checkwrite Schedule

~~10/07/11~~	01/06/12	04/06/12	07/06/12
~~10/21/11~~	01/20/12	04/20/12	07/20/12
~~11/04/11~~	02/03/12	05/04/12	08/03/12
~~11/18/11~~	02/17/12	05/18/12	08/17/12
~~12/02/11~~	03/02/12	06/06/12	09/07/12
~~12/16/11~~	03/16/12	06/17/12	09/14/12

The release of funds is normally the second Monday after the RA date. Please verify direct deposit status with your bank. Go to *www.medicaid.alabama.gov* to view the payment delay update details. Payment alerts will be posted only if there will be a payment delay. As always, the release of direct deposits and checks depends on the availability of funds.

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Provider *Insider*

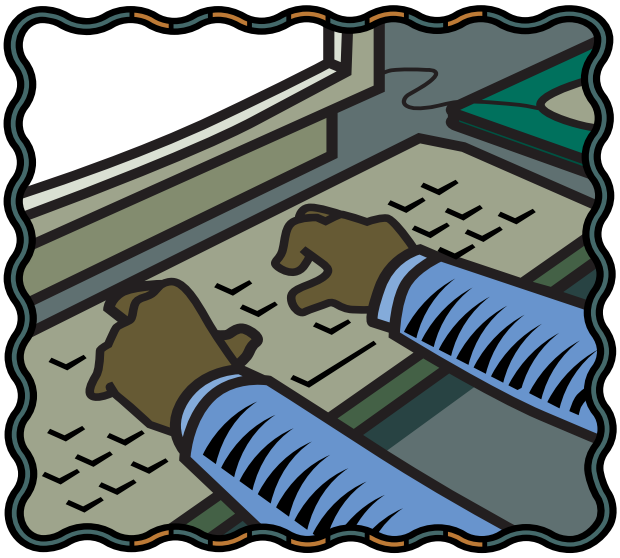
Alabama Medicaid Bulletin **April 2012**

The Remittance Advice (RA) schedule is as follows:

04/06/12 04/20/12 05/04/12 05/18/12 06/08/12 06/22/12

The release of funds is normally the second Monday after the RA date. Please verify direct deposit status with your bank. Go to *www.medicaid.alabama.gov* to view the payment delay update details. Payment alerts will be posted only if there will be a payment delay. As always, the release of direct deposits and checks depends on the availability of funds.

Alabama Medicaid's ePrescribe System is Now Available



Medicaid formulary and prescribing history are now available to any provider utilizing an eprescribing tool. Additionally, any prescriber can now enroll to transmit prescriptions electronically through the existing Medicaid web portal.

To use the HPES Healthcare ePrescribe System, available through the Medicaid web portal, providers must be a Medicaid registered provider and request a log-on which is separate from the web portal log-on. A form is available on page 2 of this Insider to complete and send in to obtain an ePrescribe ID. If the provider is permitted to prescribe electronically, the ePrescribe link will appear on the provider page of the provider portal.

A provider is required to register with the Healthcare ePrescribe System. The one-time ePrescribe prescriber registration process requires entry of several key pieces of information. This includes name and contact information, DEA number (for prescribing controlled substances on paper), provider specialty and a self-created Personal Identification Number (PIN) which is used by the prescriber to finalize prescriptions written using this system. In addition, the prescriber must indicate if he/she grants access to portal delegates to perform clerical functions such as updating the patient profile or performing an eligibility transaction. If the Grant Delegate Access is set to 'Yes', provider portal delegates for that prescriber can have the ability to access the clerical functions of ePrescribe. Please note that delegates do not have the capability to finalize a prescription because the prescriber PIN is needed to complete this process. Upon completion of the prescriber profile, the only time the prescriber needs to access the profile is to update any profile information.

For questions please contact the EMC helpdesk at 1-800-456-1242.

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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 _____*

The information contained within is subject to change. Please review your Provider Manual and all Provider Alerts for the most up to date information.

Alabama Medicaid's ePrescribe System is Now Available

(Continued from Page 1)

ePrescribe ID Request Form

Please fill out the form in its entirety and return to the EMC Help Desk via mail, email or by fax.

EMC Help Desk
HP Enterprise Services
301 Technacenter Drive
Montgomery, AL36117
Email: AlabamasystemsEMC@hp.com
Fax: (334) 215 – 4272
Phone: (800) 456 – 1242 / (334) 215 – 0111

Provider Name _____

NPI Number _____

Medicaid Number _____

DEA # _____

Address _____

City, State, Zip _____

Telephone Number _____

Email _____

Contact Name _____

Please check which software solution is used for the submission and retrieval of Medicaid information.

☐ Provider Electronic Solutions ☐ Vendor software solution

☐ Clearinghouse ☐ ePrescribe

Other, please explain:

New "My Medicaid" Web Site to Benefit Recipients and Applicants

With the February 6 launch of a new user-friendly web site for Alabama Medicaid applicants and recipients, state Medicaid officials hope to better meet the needs of its customers while saving money for the Agency.

Known as "My Medicaid," the Web site is now available to expedite the process of requesting a replacement ID card, checking benefit limits, changing Patient 1st primary care doctors and updating address or other personal information, according to Lee Rawlinson, Deputy Commissioner, Beneficiary Services. The site, which also allows applicants to track the status of a pending application, is available on the Agency's Web site at www.medicaid.alabama.gov under "Recipients" and may be accessed from any computer.

The launch of "My Medicaid" website for applicants and recipients is an important milestone in the Agency's strategic plan to reduce costs and increase efficiency through innovation and technology, she said. Previously, applicants and recipients were limited to calling a toll-free telephone line for help, sending information in via regular mail or by making a personal visit to a worker's office.

"Before the "My Medicaid" Web site, recipients had to make multiple calls or remain on hold before getting the help they needed because of the volume of requests. With "My Medicaid," recipients now have 24/7 direct access," Ms. Rawlinson said. "As more people learn about this Web site, we hope it will result in a more positive experience for our recipients and their families."

Address Update Capability on Secure Provider Web Portal

The Medicaid Agency has implemented the capability within the secure Provider Web Portal, *www.medicaid.alabamaservices.org/ALPortal/*, to allow providers to update Service Location contact information, Payee and Mailing addresses and phone numbers. To access this functionality after signing into the secure web portal, click "Providers" on the top menu bar. The current Payee and Mailing address and service location contact information will be displayed. Providers can make changes to the displayed information. The changes will be made to the provider's file immediately.

Prior to March 12, 2012, providers were able to submit written requests to update the above information. Now, any written requests received by Provider Enrollment after March 12, 2012 will be returned to the provider directing them to the secure Provider Web Portal to make requested updates. Providers are not presently allowed to update the service location address and must continue to contact Provider Enrollment to make those changes.

Face-to-Face Communication Requirement for the Hospice Program

With passage of the Affordable Care Act in March 2010, Congress required hospice physicians or hospice nurse practitioners to have a face-to-face encounter with Medicare hospice patients prior to the 180th day recertification and every recertification thereafter, and to attest that the encounter occurred. This new face-to-face encounter requirement became effective for Medicare on January 1, 2011.

The Alabama Medicaid Agency will not require the Face-to-Face Communication for Medicaid hospice recipients. However, if a face-to-face visit has been performed for a Medicaid-only hospice recipient, Alabama Medicaid highly recommends that any documentation pertaining to the face-to-face visit be submitted to the Agency or its designee with the complete medical record. Submission of this information may provide important supporting documentation to validate the terminal status of the Medicaid hospice recipient and may also expedite review of the hospice record. Therefore, although not a requirement, hospice providers are strongly encouraged to submit face-to-face documentation, if available.

For questions or concerns regarding the Face-to-Face Communication for the Hospice Program, please contact Felicha Fisher at (334) 353-5153.

Attention!

Effective February 22, 2012, patients less than 21 years of age are authorized two pair of glasses each year if indicated by an examination. A prior authorization will be required for subsequent pairs requested in the calendar year.

REMINDER

When a physical therapist and an occupational therapist perform the same procedure for the same recipient for the same day of service, the maximum units reimbursed by Medicaid will be the daily limit allowed for procedure, not the maximum units allowed for both providers.

Lead Screening Requirements for Children

While lead screening is required for all Medicaid children at 12 and 24 months of age, 20% do not receive this vital test even though children on Medicaid or WIC benefits face a higher risk for lead poisoning than the general population. When not detected early, even low levels of lead exposure may cause damage to the brain and central nervous system, learning/behavioral problems and even mental disabilities.

Because children's blood lead levels increase most rapidly at 9-12 months and peak at 18-24 months, Alabama Medicaid requires that all children have a blood lead toxicity screening at 12 and 24 months. Providers have the option of obtaining the initial lead screening at 9 or 12 months. A lead toxicity screening is also required for any child 36 to 72 months of age who has not previously received a blood lead toxicity screening or who presents with symptoms of possible lead poisoning. Additionally, providers should assess a child's risk of blood lead poisoning beginning at 9 months; those determined to be at high risk of lead poisoning should receive parental education and nutritional counseling.

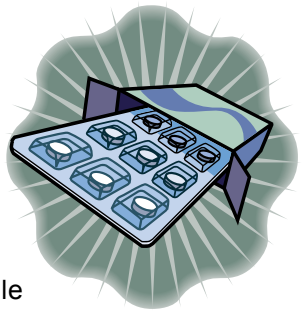
The screening test of choice is the blood lead measurement and replaces the erythrocyte protoporphyrin (EP) test. EPSDT care coordination is initiated for children with a confirmed blood lead level of more than 10 µg/dL. EPSDT care coordinators will assess the family's social and environmental needs; develop a case plan with a goal of reducing blood lead levels; educate family members regarding lead risk behaviors; schedule blood lead level retest; and refer providers to appropriate resources regarding lead screening guidelines. An environmental investigation is initiated for children with a confirmed venous blood lead level of more than 15 ug/dL. The child's residence will be investigated to identify lead hazards and recommend interim control or abatement measures, if necessary.

The State Laboratory will supply microvettes, mailing containers and forms for obtaining blood lead levels at no cost to providers upon request. Please call (334) 260-3400 for additional information. For clinical consultation, contact Case Management Coordinator, Alabama Childhood Lead Poisoning Prevention Project at (334) 206-2966 and/or Pediatric Lead Poisoning Consultant, University of Alabama at Birmingham at (800) 222-1222.

Implantable Contraceptive Capsules

Effective December 31, 2011, two CPT® codes (11975 and 11977) for reporting removal and insertion of implantable contraceptive capsules (e.g., Implanon, Nexplanon) were deleted.

As a result, Medicaid providers should use the following codes:



1. To bill insertion of a non-biodegradable drug delivery implant for contraception, use:
   - 11981 – Insertion, non-biodegradable drug delivery implant
   - This replaces deleted code 11975: Insertion, implantable contraceptive capsules
2. To bill removal of implantable contraceptive capsules with subsequent insertion of non-biodegradable drug delivery implant, use:
   - 11976 – Removal, implantable contraceptive capsules
   - 11981 – Insertion, non-biodegradable drug delivery implant
   - These codes replace deleted code 11977: Removal with reinsertion, implantable contraceptive capsules

If a provider is enrolled with the Alabama Medicaid Plan First program, the – FP modifier must be appended to family planning service claims.

Refer to Medicaid Provider Manual Appendix C: Family Planning for additional details; the CPT code changes will be reflected in the April quarterly update.

For questions, contact Laura Hamilton, Associate Director, Maternity Care and Plan First at (334) 353-5539 or *laura.hamilton@medicaid.alabama.gov*

DME Manual Administrative Review of Paper Claims Changes

In an effort to expedite provider payment and decrease the manual administrative review process for Agency staff, the following procedures are being implemented. Effective February 1, 2012, K0739 (Repair) procedure code's allowable units have been increased to 12. However, providers must continue to submit justification when billing more than four units. Please include all units over four on the PA request with justification for repairs. The request will be reviewed by Qualis Health. The PA letter will state the total units approved in the analyst's remarks section.

Effective March 1, 2012, DME diabetic testing supplies claims billed for recipients with Gestational Diabetes must contain a diagnosis code in the range of 64880-64884. Units will be increased for procedure codes A4259 to two (2) per calendar month and for A4253 to four (4) per calendar month. These claims should be submitted electronically to HP for processing. All documentation must be kept in the recipient's file and will be monitored by Alabama Medicaid on a quarterly basis.

Effective April 1, 2012, Disaster claims (fire and theft) should be submitted electronically to HP for processing. Provider must file these claims with the appropriate procedure code and Modifier CR. The provider must keep all documentation (fire report, theft report, etc) in the recipient's file. These claims will be monitored by Alabama Medicaid on a quarterly basis.

Submission of Hospice Records

All recipients who have only Medicaid eligibility and those with a third party insurance, other than Medicare, must submit medical documentation for approval of hospice services. Please refer to the Administrative Code, Chapter 51 for criteria: *http://medicaid.alabama.gov documents 5.0_Resources 5.2_Administrative_Code Chapters_51_615.2_Adm_Code_Chap_51_Hospice_12-19-11.pdf.*

Pediatric cases and other diagnoses not found in the Administrative Code are reviewed on a case-by-case basis. Each record must have a complete and accurate HP Hospice Cover Sheet, along with the required medical documentation and Hospice Election Form 165. Note that the "Recipient Medicaid ID" requires all 13 digits on the coversheet. Coversheet and/or mailing packet from provider must contain correct mailing address in the event the record must be returned to the provider.

Mail the packet to: Hospice Records / HP Enterprise Services
PO Box 244032, Montgomery AL 36124-4032

Agency's contractor, Qualis Health, will be able to review hospice records more efficiently if the below guidelines are followed:

- Submit medical records pertinent to the terminal illness
- Do NOT send the entire medical record, only information that supports the request for hospice services
- Do NOT send with pages that are double-sided; these records are scanned electronically, and the scanner is unable to scan double-sided pages. This results in blank pages in the electronic record.
- Initial and recertification documentation MUST include:
  - Form 165A coversheet
  - Form 165-Medicaid Hospice Election and Physician's Certification Form
  - Physicians' orders, including medication(s) taken by the recipient
  - Assessment and a plan of care
  - Specific terminal illness must be documented and substantiated by labs, x-rays and other medical documentation specific to the terminal disease as set forth by the Alabama Medicaid criteria
  - For six-month recertification records, please submit documentation that supports progression, rapid decline at or prior to, the time of recertification

Please refer to the ALERT dated February 6, 2012 for information regarding face-to-face communication, *http://medicaid.alabama.gov/news_detail.aspx?ID=6127.*

Recovery Audit Contractor (RAC) Audits

Mandatory provisions of the Affordable Care Act require the Alabama Medicaid Agency to select and provide oversight for a Medicaid Recovery Audit Contractor (RAC) to perform provider audits. These audits will begin immediately for this contract year. OptumInsight, a Minnesota-based firm which has previously performed program integrity audits on behalf of the Agency, has been selected to conduct audits using at least three approaches: computer-based analysis of billing errors across all providers, in-depth desk audit reviews of targeted areas, and broad-based audits based on statistical methods used to select providers and extrapolate findings from random sample audits to the universe of a provider's claims. These approaches are designed to ensure a comprehensive review of claims while minimizing the administrative burden on the provider of supplying medical records when requested. In addition to the three approaches mentioned above, OptumInsight will also conduct second pass credit balance audits.

Health Management Systems (HMS), a Texas-based firm has been selected to conduct long-term care audits. The purpose of the Long Term Care audit is to identify and recover payments made incorrectly according to the Alabama Medicaid Agency's long term care claim reimbursement policy. These efforts to identify and obtain reimbursement from long term care audits will supplement not duplicate, other Agency long term care audits and other activities.

Providers are reminded that the Alabama Administrative Code and their Provider Agreements require compliance with requests for medical records for Medicaid program audits.

Questions regarding the audits should be directed to Vanesia Boyd, RAC Program Manager, at (334) 242-5339 or *vanesia.boyd@medicaid.alabama.gov* or Jacqueline Thomas, Program Integrity Division Director, at (334) 242-5318 or *jacqueline.thomas@medicaid.alabama.gov.*

Post-Operative Eye Care

Medicaid will not pay post-operative management claims until the referring ophthalmologist has received payment for surgery. The surgeon must first submit a modifier 54 with the appropriate surgical code. The optometrist should then submit a modifier 55 with the appropriate surgical code after the ophthalmologist has been paid in order to be paid for post-operative care. Medicaid will deny post-operative claims when the surgeon (ophthalmologist) receives payment for the global amount. It is the responsibility of the optometrist to confer with the surgeon for appropriate claim corrections and/or submissions.

The date of service for post operative care cannot be greater than 7 days after the global surgical procedure. For example, if the surgery was performed on December 1, then the follow up must be performed on or before December 8.

Payment Error Rate Measurement (PERM)
Results For FY 2010 And Announcement Of FY 2013 PERM Review

The PERM program measures improper payments in Medicaid and the State Children's Health Insurance Program (SCHIP) and produces state and national-level error rates for each program. The Centers for Medicare and Medicaid Services (CMS) developed PERM to comply with the Improper Payments Information ACT (IPIA) of 2002.

Results are in for the FY2010 PERM review. The top three reasons for Medicaid FFS Medical Review errors in terms of projected dollars in error are: policy violation, insufficient documentation, and no documentation. These errors account for over 83% of Alabama's Medical Review errors. Other errors include number of units, policy violation, pricing errors, and non-covered service. Alabama's overall error rate is 1.5% for the fee-for-service component.

The measurement for the FY 2013 cycle will begin October 1, 2012. Once the medical record review process begins, it is very important for providers to comply with the requests and submit documentation in a timely manner. Providers should ensure records are complete (i.e. physician signatures, correct dates, treatments plans, progress notes, etc.).

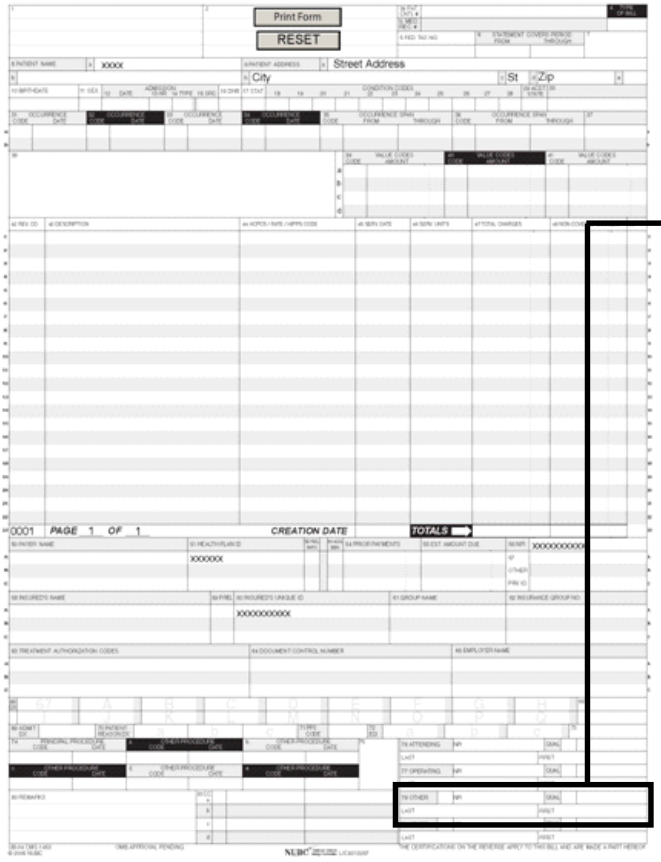
CMS uses contractors to conduct both the data processing (DP) reviews and the medical records (MR) reviews. For FY 2010, CMS used Livanta, LLC as the statistical contractor and APlus Government Solutions for the DP and MR reviews. If there is a change in contractors for the FY2013 cycle, the Agency will provide updated information. The contacts are Patricia Jones at (334) 242-5609 and Jacqueline Thomas at (334) 242-5318.

Estate Recovery Reviews

Health Management Systems (HMS) has been contracted by Alabama Medicaid to perform estate recovery services. These services are for the recovery of medical assistance payments from the estates of certain deceased Medicaid recipients and/or their spouses who previously received nursing home care paid for by Medicaid. Nursing home providers may soon be receiving letters or a questionnaire from HMS requesting information in order to recover the costs of Medicaid services, when it is appropriate. HMS is working as an authorized agent for the Alabama Medicaid Agency and security agreements are in place for a provider to be able to release recipient and sponsor information to HMS.

Providers are asked to complete requests from HMS within two weeks of receipt of the notice. Questionnaires must be completely filled out with all requested documentation and faxed to (855) 809-3983 or mailed to HMS, the Alabama Medicaid Estate Recovery Contractor, P. O. Box 166709, Irving, TX 75016-6709. Any questions about any letter or questionnaire should be referred to HMS at (855) 543-8395. Any questions that need to be directed to the Agency regarding the estate recovery services being performed by HMS can be directed to Keith Thompson at (334) 242-5248.

UB-04 Paper Claims: Form Locator 78



Form locator 78 is used to identify other provider name and identifiers. Medicaid uses this form locator to identify the referring provider or other operating physician, as applicable.

78 OTHER		NPI		QUAL		
LAST				FIRST		

Enter the referring physician's NPI number preceded by the appropriate qualifier "DN" (referring provider) for the following types of referrals: EPSDT referrals, Patient 1st referrals, Lock-in Physician referrals.

Enter "G2" (provider commercial number) followed by the Medicaid provider number.

78 OTHER	DN	NPI	1234567890	QUAL	G2	111222
LAST	Doe			FIRST	John	

Enter the other operating physician's NPI number preceded by "ZZ" (other operating physician) and enter "0B" (license number) followed by the surgeon's license number.

78 OTHER	ZZ	NPI	1234567890	QUAL	0B	123
LAST	Doe			FIRST	John	

If not applicable, leave blank.

Provide Assistance for:

- Ambulance
- Ambulatory Surgical Centers
- CRNA
- Chiropractors
- Dental
- DME
- EPSDT (Physicians)
- ESWL
- Free Standing Radiology
- FQHC
- Hearing Services
- Waiver Services
- Home Health
- Hospice
- Hospital
- Independent Labs
- Maternity Care
- Mental Health
- Nursing Home
- Nurse Midwives
- Nurse Practitioners
- Opticians
- Optometrists
- PEC
- Personal Care Services
- Physicians
- Podiatrists
- Prenatal Clinics
- Private Duty Nursing
- Public Health Including:
  - Elderly and Disabled Waiver
  - Home and Community Based Services
  - EPSDT
  - Family Planning
  - Prenatal
  - Preventive Education
- Rehabilitation Services
  - Home Bound Waiver
  - Therapy Services (OT, PT, ST)
  - Children's Specialty Clinics
- Renal Dialysis Facilities
- Rural Health Clinic
- Swing Bed

HP Provider Representatives

Michelle Patterson
katherine.patterson@hp.com
855-523-9170
Ext. 2334583

Gayle Simpson-Jones
gayle.simpson-jones@hp.com
855-523-9170
Ext. 2334582

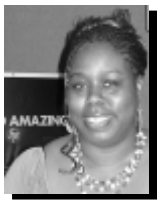
Misty Nelson
misty.nelson@hp.com
855-523-9170
Ext. 2334578

Hayley Lavender
hayley.lavender@hp.com
855-523-9170
Ext. 2334584

Debbie Smith
debbie.smith2@hp.com
855-523-9170
Ext. 2334581

Aleetra Adair
aleetra.adair@hp.com
855-523-9170
Ext. 2334587

Araceli Wright
araceli.f.wright@hp.com
855-523-9170
Ext. 2334560



Shermeria Hardy-Harvest
shermeria.harvest@hp.com
855-523-9170
Ext. 2334586

Shamekia Pena
shamekia.pena@hp.com
855-523-9170
Ext. 2334588

Ramona Riley
remona.riley@hp.com
855-523-9170
Ext. 2334532

State Fiscal Year 2011-2012 Checkwrite Schedule

~~10/07/11~~	~~01/06/12~~	04/06/12	07/06/12
~~10/21/11~~	~~01/20/12~~	04/20/12	07/20/12
~~11/04/11~~	~~02/03/12~~	05/04/12	08/03/12
~~11/18/11~~	~~02/17/12~~	05/18/12	08/17/12
~~12/02/11~~	~~03/02/12~~	06/08/12	09/07/12
~~12/16/11~~	~~03/16/12~~	06/22/12	09/14/12

The release of funds is normally the second Monday after the RA date. Please verify direct deposit status with your bank. Go to *www.medicaid.alabama.gov* to view the payment delay update details. Payment alerts will be posted only if there will be a payment delay. As always, the release of direct deposits and checks depends on the availability of funds.

Alabama Medicaid Bulletin

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Montgomery, AL 36124-4032

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Provider Insider

Alabama Medicaid Bulletin **July 2012**

The checkwrite schedule is as follows:

07/20/12 • 08/03/12 • 08/17/12 • 09/07/12 • 09/14/12 • 10/05/12 • 10/19/12 • 11/02/12 • 11/16/12 • 12/07/12 • 12/14/12

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

New Medicaid Enrollment Requirements for Ordering, Prescribing, and Referring (OPR) Providers

Federal law now requires all physicians and other practitioners who prescribe or order services for Medicaid recipients, or who refer Medicaid recipients to other providers must be enrolled as a Medicaid provider.

As a result of this law, services rendered based on a referral, order, or prescription will be reimbursable **only** if the ordering, prescribing, or referring physician/practitioner is enrolled in the Alabama Medicaid Program.

A new enrollment application was developed for those providers who do not treat Alabama Medicaid recipients for payment, but who do order, prescribe, or refer. These providers will be enrolled as an OPR provider. Medicaid will not make payment to an OPR provider but will recognize their NPI for services rendered by participating Medicaid providers. An abbreviated enrollment application is located on the Alabama Medicaid Agency website at the following link in the Administrative Forms section:

http://medicaid.alabama.gov/CONTENT/5.0 Resources/5.4 Forms Library/5.4.6 Provider Enrollment Forms.aspx.

The application must contain the provider's original signature. The application, along with a copy of the provider's DEA certificate, if applicable, should be mailed to:

HPES Provider Enrollment, P.O. Box 241685, Montgomery, AL 36124

Faxed or emailed copies will not be accepted.

If an OPR provider submits a claim for payment, the claim will deny for error code 1032 (provider type claim input conflict). Medicaid will allow a grace period until September 30, 2012 for OPR providers to become enrolled. On October 1, 2012, claims for services that contain an NPI of an ordering, prescribing, or referring provider not enrolled in Medicaid (either as a participating provider or as an OPR provider) will be denied.

Medicaid encourages all participating providers to be proactive and ensure the ordering, prescribing, referring physician/practitioner is enrolled in Medicaid prior to the October 1, 2012 deadline.

Providers should contact one of the following HPES Provider Representatives with any questions:

- Araceli Wright 1-855-523-9170 extension 2334560
- Remona Riley 1-855-523-9170 extension 2334532
- Shamekia Pena 1-855-523-9170 extension 2334588
- Aleetra Adair 1-855-523-9170 extension 2334587

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Pass It On!

Everyone needs to know the latest about Medicaid. Be sure to route this to:

- ❒ *Office Manager*
- ❒ *Billing Department*
- ❒ *Medical/Clinical Professionals*
- ❒ *Other* _____

General Fund Proration

As a result of General Fund proration declared on March 16, 2012, the Alabama Medicaid Agency has been directed to identify and implement cuts to its overall budget. After program impact analysis and multiple provider meetings and communications, the Agency will implement these cuts in three ways:

1) Reduction of payments to certain provider groups by 10 percent

- Physicians
- Dentists
- Physician Lab & X-ray
- Durable Medical Equipment
- Independent Lab & X-ray
- Other licensed practitioners
- Maternity primary contractors (Effective for dates of service on or after May 14, 2012)

2) Reduction in services to adults (benefits to children remain unchanged)

- Change coverage of routine eye exams and work-up for refractive error to once every three years
- End coverage of eyeglasses as a benefit
- Limit drugs to one brand-name drug per month; generics and covered OTCs remain unlimited. Allowances will remain for up to 10 brands per month for antipsychotics, antiretrovirals, and switchovers. (In addition to children, LTC recipients are excluded from this reduction.)

3) Reduction in cough/cold covered drugs for all recipients

- Legend generic cough/cold drugs will no longer be covered (legend brand drugs are currently non-covered). Certain OTC drugs will remain covered.

Except as specified otherwise above, these reductions will be effective for dates of service on or after June 1, 2012.

Agency to Begin Re-Enrollment of Providers Starting in July

Federal requirements mandate providers re-enroll periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-enroll. Failure to re-enroll and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-enroll, providers will have to submit a new application for enrollment.

Alabama Medicaid is Preparing for ICD-10 Implementation

ICD-10 planning and preparation is well underway for Alabama Medicaid!

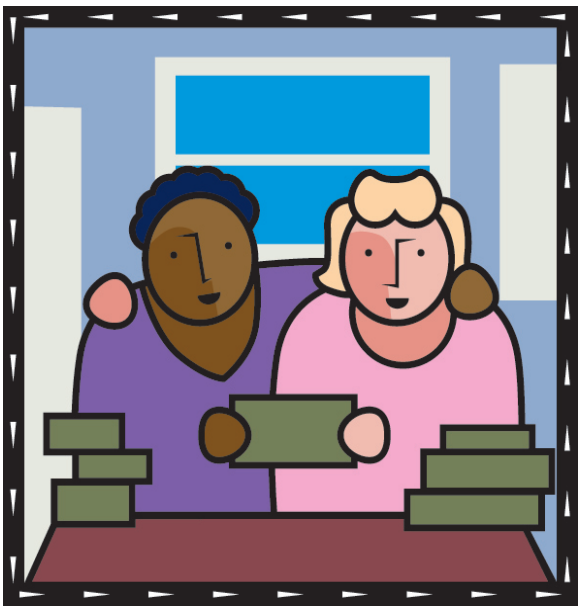
Although, the Centers for Medicare and Medicaid Services (CMS) has proposed a delay in implementation for ICD-10 from October 1, 2013, to October 1, 2014, the Alabama Medicaid is preparing for ICD-10 implementation. We are working with our fiscal agent, HP Enterprise Services, to make the necessary system changes to accommodate ICD-10. We will be using system parameters for the ICD-9 end date and the ICD-10 begin date. Once the proposed rule is finalized, our system parameters will be set accordingly. We are planning for an implementation as early as October 1, 2013, but no later than October 1, 2014.

Our planned system testing is set for early 2013. In order to meet this date, we request that our Alabama Providers and Vendors be prepared to test with us beginning Spring 2013.

Providers and vendors will be selected quarterly to receive and complete surveys related to ICD-10 readiness. If you receive a survey, please take a few moments to complete and return it as this will provide us with information needed to assess readiness and determine the best means of communicating changes and status with you going forward.

More information on our ICD-10 project will be provided in the coming months. Please pay attention to Provider Insiders, RA Banner messages and Alerts related to ICD-10, and be on the lookout for a survey on ICD-10 readiness.

Attention Nursing Home Providers



The Centers for Medicare and Medicaid Services (CMS) has mandated states to develop a process for MDS 3.0 Section Q that requires any nursing facility resident indicating an interest in returning to the community to be given an opportunity for a face-to-face visit with a Local Contact Agency (LCA). CMS has also instructed State Medicaid Agencies to identify a contact for nursing facilities to communicate with when making resident referrals.

The Alabama Medicaid Agency has identified the Alabama Department of Rehabilitation Services as the Local Contact Agency (LCA). Nursing facilities are required to submit Form 431 with the name of the referral to the Local Contact.

Form 431 may be retrieved from the Alabama Medicaid Agency website at *www.medicaid.alabama.gov* under Programs/Long Term Care Services/Resources & Forms/Long Term Care Forms.

If you have any questions, please contact the LCA (ADRS) at 334-293-7011 or *steve.autrey@rehab.alabama.gov.*

Patient 1st Referral Requirements Have Changed

Effective June 1, 2012 the Alabama Medicaid Agency will change Patient 1st Referral requirements to allow PMPs to see patients who are in the process of transferring to their panel without a referral. Once the PMP change becomes official, claims for the previous 60 days from the new PMP will be paid. When a recipient wishes to change their PMP, the change can be made directly by the recipient or made by the new PMP. In the past, the new PMP would have to obtain a referral from the old PMP in order to see the recipient prior to the official change date. PMP changes typically take 15 to 45 days. For example, if a PMP change is requested on June 18 it would become official on August 1. The new PMP will be able to treat the recipient, and claims for dates of service 60 days prior to August 1 will be paid on or after the effective date. These claims will deny prior to the change becoming official.

The new policy will allow the new PMP to both provide services and make referrals. Claims for referrals will also not pay until the PMP change is official. If the change does not become official the claims will not pay without a referral. This could happen if a subsequent change in PMP request is made before the original change is made active. This change does not alter the process or rules for the old PMP. Claims from the old PMP will be paid as normal. The old PMP should no longer be requested to provide referrals for a recipient transferring to other PMPs. Medicaid will monitor PMP changes to ensure that this policy change is not misapplied.

Effective February 22, 2012, patients less than 21 years of age are authorized two (2) pair of glasses, which includes fitting and lenses each year if indicated by an examination.

A prior authorization will be required for subsequent pairs requested in the calendar year. Four new benefits audits will also be implemented with the policy - 6185 lenses, 6186 frames, 6187 exams, and 6188 fittings.

REMINDER ***to all Acute Care Hospitals, Residential Treatment Facilities and Inpatient Psychiatric Hospitals.***

Reporting POAs correctly to Medicaid on the UB-04 claim form:

Reporting Hospital-Acquired Conditions (HAC) and Present on Admission (POA) on the UB-04 Claim Form

Hospital-Acquired Conditions are conditions that are reasonably preventable and were not present or identified at the time of admission; but are either present at discharge or documented after admission. The Present on Admission (POA) Indicator is defined as a set of specified conditions that are present at the time the order for inpatient hospital occurs. Conditions that develop during an outpatient encounter, including the emergency room, observation, or outpatient surgery, are considered POA.

The hospital may use documentation from the physician's qualifying diagnoses to identify POA which must be documented within 72 hours of the occurrence. Medicaid also recommends that the event be reported to Medicaid on the claim or via e-mail within 45 days of occurrence.

It is the responsibility of the hospital to identify these events, report them, and not seek any additional payment for additional days. Medicaid will accept all POA indicators as listed below:

- **Y**-Yes. Diagnosis **was present** at time of inpatient admission.
- **N**-No. Diagnosis **was not present** at time of inpatient admission.
- **U**-No information in the record. **Documentation insufficient** to determine if the condition was present at the time of inpatient admission.
- **W**-Clinically undetermined. Provider **unable to clinically determine** whether the condition was present at the time of inpatient admission.
- **1**-Unreported/Not used. **Exempt** from POA reporting.

If the value code '81' is indicated; then non-covered days must be present and the amount field must be greater than '0'.

It is the hospital's responsibility to include all supporting documentation with the chart for a review to be conducted by Medicaid's contracted Quality Improvement Organization (QIO). Submission of a root cause analysis is not required but may be submitted as part of the documentation to support billing.

Need to Update Third Party Information on a Recipient?

During the eligibility verification process, if it is determined that Medicaid has a Third Party Insurance that is no longer on file, providers can contact the Third Party Division at the Medicaid Agency with a policy cancellation date and request the file be updated.

The most efficient way to contact the Third Party Division is to go to Medicaid's website at:
http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.1_Benefit_Coordination.aspx
Select: Update Health Insurance Information, and complete the on-line form to report the change.

Providers may also call the Third Party Division by calling the direct line of the appropriate staff person to update health insurance. Please call the number listed below based on the recipient's last name:

- Recipient's Last Name A through F 334-242-5249
- Recipient's Last Name G through K 334-242-5280
- Recipient's Last Name L through Q 334-242-5254
- Recipient's Last Name R through Z 334-242-5253

REMINDER *Billing Claims for Long Term Care Providers (Completing the UB-04 Claim Form)*

- **Home Health Program**
- **Hospice Program**
- **Intermediate Care Facility for the Mentally Retarded Program**
- **Nursing Home Program**
- **Private Duty Nursing Program**

When completing the UB-04 Claim Form, please be mindful that Long Term Care Providers must enter the beginning and ending dates of service billed for the Statement Covers Period.

Additional description and guidelines regarding claim filing are as follows:

- **OUTPATIENT:** Enter the date of service that the outpatient procedure was performed.
- **NURSING HOMES:** Enter the beginning date of service for the revenue code being billed.
- **SPAN BILLING:** When filing for services such as therapies, home health visits, hospice, and private duty nursing within a month, the time period being billed should be entered in form locator FL 6 (Statement Covers Period). In FL 45, the service date should be the first date in the Statement Covers Period. The number of units should match the number of services reflected in the medical record.

Additionally, when billing through the Web Portal, be sure that the header and detail dates contain the same data - both dates must match. Be sure that the detail dates are within the header date span. **Example:** If you are billing one code for the specific date span, the header and detail dates of service must match. In addition, the header dates should not span beyond the period the services were rendered; i.e. do not bill the header date span for the entire month when home health services were only rendered on the 12th of the month.

For Nursing Home claims regarding patient days, Medicaid covers the day of admission, but not the day of discharge.

For questions regarding billing procedures, please contact HP Provider Assistance at (800) 688-7989.

Cascading Referrals

A cascading referral is used in situations where more than one consultant may be needed to provide treatment for an identified condition(s). When this situation arises, the original referral form is generated by the assigned primary medical provider.

If the first consultant determines a recipient should be referred to another consultant/specialist, it is the first consultant's responsibility to provide a copy of the referral form to the second consultant. This process is continued until the condition(s) have been rectified or in remission, or referral expires, at which time a new screening and referral must be obtained. A new approval/EPSDT screening must be provided anytime the diagnosis, plan of care, or treatment changes. The consultant must contact the PMP for a new referral/screening at that time.

The appropriate block to mark on the referral form for a cascading referral is labeled: "Referral to other provider for identified condition (cascading referral)."

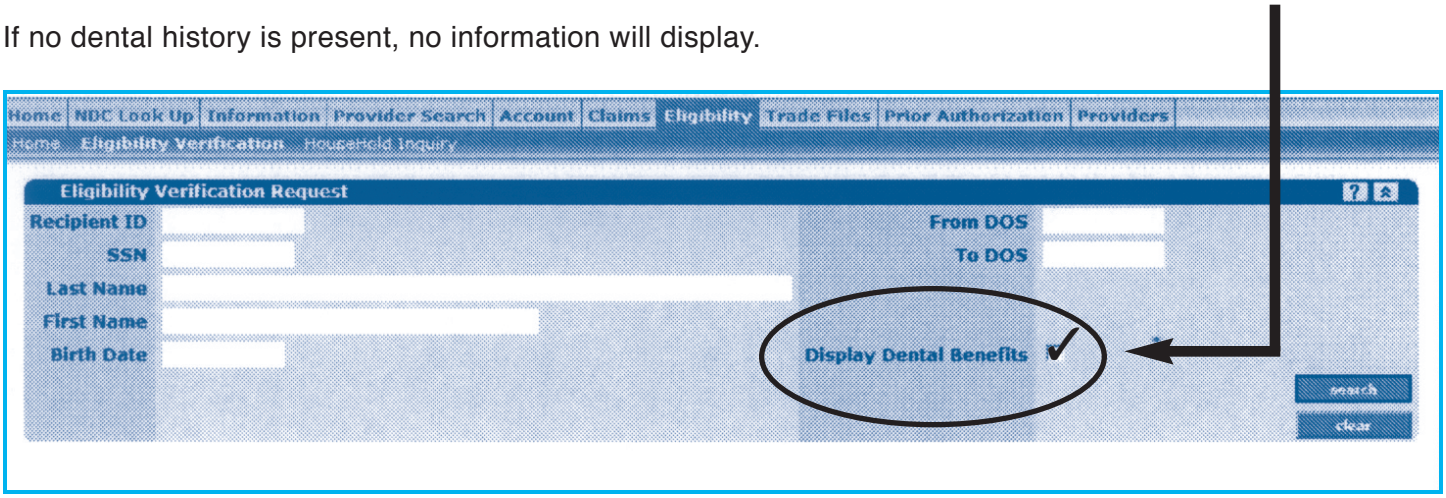
All consultants should furnish written results of findings to the referring provider or PMP promptly. Patient 1st and EPSDT providers are responsible for appropriate referrals and follow-up.

If you have any questions regarding cascading referrals, you may contact Toni Hopgood at 334-353-4724 or Gloria Wright at 334-353-5907.

Attention Dental Providers

In order to obtain dental history during the eligibility verification process on the web portal, the "Display Dental History" box must be checked. If this box is not checked, the system will not return any data.

If no dental history is present, no information will display.



If no dental history is present, no information will display.

To verify eligibility, select the eligibility tab and choose eligibility verification. Providers may search for eligibility using any of the following combinations:

1. Enter the Medicaid number and the From DOS & To DOS.
2. Enter the First & Last Name, date of birth, and the From DOS & To DOS.
3. Enter the social security number, date of birth, and the From DOS & To DOS.

Once the eligibility screen displays, the dental history will show at the very bottom of the screen.

Provider Electronic Solutions Upgrade Now Available

Version 3.01 of the Provider Electronic Solutions software, upgrade and full install along with the billing manual, can be downloaded from the Medicaid website at *www.medicaid.alabama.gov*. Click 'providers,' then click 'provider electronic solutions software,' and scroll down to the bottom of the page to the software download section. When applying the 3.01upgrade, your current version must be 3.00. For further assistance, or to request the software on CD, contact the EMC helpdesk at 1-800-456-1242 or e-mail address: *alabamasystemsemc@eds.com*.

The 3.01 version of the software contains the following changes:

Professional Claim Form -
Users can select a 'blank' or a 'P' for the Patient Signature Indicator field.

List Builder Forms -
Users can enter up to 10 digits in the Carrier ID code field on the Carrier or Policyholder List builder forms.

Inpatient Claim Form -
On Header 1, users can enter a 'from date of service' that is up to 3 days prior to the 'admit date' on Header 5.

NCPDP Batch Responses -
When a pharmacy claim is denied for other insurance, detailed information related to the other insurance is displayed.

Remember, users **MUST** be at version 3.00 before attempting to upgrade to 3.01.

HP Provider Representatives

Michelle Patterson
katherine.patterson@hp.com
855-523-9170
Ext. 2334583

Gayle Simpson-Jones
gayle.simpson-jones@hp.com
855-523-9170
Ext. 2334582

Misty Nelson
misty.nelson@hp.com
855-523-9170
Ext. 2334578

Hayley Lavender
hayley.lavender@hp.com
855-523-9170
Ext. 2334584

Debbie Smith
debbie.smith2@hp.com
855-523-9170
Ext. 2334581

Aleetra Adair
aleetra.adair@hp.com
855-523-9170
Ext. 2334587

Araceli Wright
araceli.f.wright@hp.com
855-523-9170
Ext. 2334560

Shermeria Hardy-Harvest
shermeria.harvest@hp.com
855-523-9170
Ext. 2334586

Shamekia Pena
shamekia.pena@hp.com
855-523-9170
Ext. 2334588

Ramona Riley
remona.riley@hp.com
855-523-9170
Ext. 2334532

Provide Assistance for:

- Ambulance
- Ambulatory Surgical Centers
- CRNA
- Chiropractors
- Dental
- DME
- EPSDT (Physicians)
- ESWL
- Free Standing Radiology
- FQHC
- Hearing Services
- Waiver Services
- Home Health
- Hospice
- Hospital
- Independent Labs
- Maternity Care
- Mental Health
- Nursing Home
- Nurse Midwives
- Nurse Practitioners
- Opticians
- Optometrists
- PEC
- Personal Care Services
- Physicians
- Podiatrists
- Prenatal Clinics
- Private Duty Nursing
- Public Health including:
  - Elderly and Disabled Waiver
  - Home and Community Based Services
  - EPSDT
  - Family Planning
  - Prenatal
  - Preventive Education
- Rehabilitation Services
  - Home Bound Waiver
  - Therapy Services (OT, PT, ST)
  - Children's Specialty Clinics
- Renal Dialysis Facilities
- Rural Health Clinic
- Swing Bed

2012 State Checkwrite Schedule

~~01/06/12~~	~~04/06/12~~	07/06/12	10/05/12
~~01/20/12~~	~~04/20/12~~	07/20/12	10/19/12
~~02/03/12~~	~~05/04/12~~	08/03/12	11/02/12
~~02/17/12~~	~~05/18/12~~	08/17/12	11/16/12
~~03/02/12~~	~~06/08/12~~	09/07/12	12/07/12
~~03/16/12~~	~~06/22/12~~	09/14/12	12/14/12

The release of funds is normally the second Monday after the RA date. Please verify direct deposit status with your bank. Go to *www.medicaid.alabama.gov* to view the payment delay update details. Payment alerts will be posted only if there will be a payment delay. As aways, the release of direct deposits and checks depends on the availability of funds.

Alabama Medicaid Bulletin

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Provider Insider

Alabama Medicaid Bulletin **October 2012**

10/05/12 • 10/19/12 • 11/02/12 • 11/16/12 • 12/07/12 • 12/14/12 • 01/04/13 • 01/18/13 • 02/08/13 • 02/22/13 • 03/08/13 • 03/22/13
As always, the release of direct deposits and checks depends on the availability of funds.

Provider Re-enrollment In Progress for All Providers

New for Re-enrollment

Starting in October, on the 5th working day of each month a list of the providers scheduled for re-enrollment will be available on the Medicaid Agency website. The list will include the provider's name, NPI and Medicaid identification number. Providers can access this list to determine if they are scheduled for re-enrollment.

Federal requirements mandate providers re-enroll periodically with the Alabama Medicaid program. Alabama Medicaid's fiscal agent, HP Enterprise Services, began the provider re-enrollment process in July 2012. Providers are selected for re-enrollment monthly based on the longest date of enrollment. A letter will be sent to the payee address on file for the provider when it is time for the provider to re-enroll. Only providers who are sent a letter will be allowed to download a facsimile from the interactive website. Please **do not** notify other providers or everyone in your network of the need to complete re-enrollment, as this has caused mass panic to those who had not yet been selected (not because they were omitted but because they were not due yet), and problems with HP receiving an influx of calls and unnecessary information.

The letter instructs the provider to log onto the Interactive Medicaid Secure website and download a facsimile of the information on file. Instructions for downloading the facsimile can also be found on the Medicaid Agency website. Once the information has been printed and reviewed, the provider should sign page three of the facsimile, complete the appropriate forms and mail to HP Enterprise Services using the address provided on the letter and the facsimile. If changes are necessary, providers should make the appropriate changes on the facsimile. Please read the information on the facsimile carefully, as some providers have to send in additional information (For example EPSDT screening providers have to complete another EPSDT screening agreement form and return for processing). Documentation requirements can be found on the Medicaid Agency Website.

FACILITY OR GROUP: If the provider enrolling is a facility or a group (not an individual practitioner), the signed facsimile, a provider agreement for the group, any additional forms as outlined below and a provider disclosure form for each individual that is an owner, Agent, Managing employee, Officer, Directors, and Shareholders with 5% or more controlling interest must be completed and returned.

STATE AGENCIES: A list will be sent from the Medicaid program area to the DMH/DHR/DYS state agencies as providers are selected for re-enrollment. This list will be distributed by the state agencies to all of their contractors. Please check the list to see if your facility has been selected. If your facility has been selected, please complete the re-enrollment process.

NOTE: The individuals *practitioners* enrolled under the group do not complete an agreement until the provider has received notification to re-enroll. It is important to know that not all providers within the group will re-enroll at the same time.

In This Issue

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Pass It On!

Everyone needs to know the latest about Medicaid. Be sure to route this to:

- ❒ *Office Manager*
- ❒ *Billing Department*
- ❒ *Medical/Clinical Professionals*
- ❒ *Other* _____

Alabama Medicaid's ePrescribe System is Now Available

Medicaid formulary and prescribing history are now available to any provider utilizing an eprescribing tool. Additionally, any prescriber can now enroll to transmit prescriptions electronically through the existing Medicaid web portal.

To use the HPES Healthcare ePrescribe System, available through the Medicaid web portal, providers must be a Medicaid registered provider and request a log-on which is separate from the web portal log-on.

If the provider is permitted to prescribe electronically, the ePrescribe link will appear on the provider page of the provider portal. A provider is required to register with the Healthcare ePrescribe System. The one-time ePrescribe prescriber registration process requires entry of several key pieces of information. This includes name and contact information, DEA number (for prescribing controlled substances on paper), provider specialty and a self-created Personal Identification Number (PIN) which is used by the prescriber to finalize prescriptions written using this system. In addition, the prescriber must indicate if he/she grants access to portal delegates to perform clerical functions such as updating the patient profile or performing an eligibility transaction. If the Grant Delegate Access is set to 'Yes', provider portal delegates for that prescriber can have the ability to access the clerical functions of ePrescribe. Please note that delegates do not have the capability to finalize a prescription because the prescriber PIN is needed to complete this process. Upon completion of the prescriber profile, the only time the prescriber needs to access the profile is to update any profile information.

For questions please contact the EMC help desk at 1-800-456-1242.

Provider Re-enrollment In Progress for All Providers (continued)

INDIVIDUAL PRACTITIONER: If the re-enrollment is for an individual practitioner (not a facility or group), the provider must return the signed facsimile, the completed additional forms outlined below, the provider agreement, and the individual disclosure form.

The following forms may be required based on the provider's current enrollment:

- **EPSDT Agreement** - The agreement is required if the EPSDT specialty is indicated on the facsimile or if the Provider is adding the EPSDT specialty
- **Plan First Agreement -** The agreement is required if the Plan 1st specialty is indicated on the facsimile or if the Provider adding the Plan First specialty.
- **Corporate Board of Directors Resolution** - The form is required if the provider is a Physician group that operates as a corporation.
- **Electronic Funds Transfer Form** - The form is required if the facsimile has "Y" after the EFT indicator on page 2 of the facsimile.

The following documents may be required based on changes indicated on the submitted facsimile:

- **W-9 Tax Form** - The form is required if changing the service location address or the tax name.
- **CLIA Certificate** - A copy of the certificate is required if changing the CLIA certificate number.
- **DEA Certificate -** A copy of the DEA certificate is required if changing or adding a DEA number.

ON-SITE VISITS: The Affordable Care Act requires some providers have an on-site visit prior to a new enrollment and prior to re-enrollment. The on-site visits are being conducted by Medicaid's fiscal agent, HP Enterprise Services. When a Provider Relations Representative makes an on-site visit to your facility, they are done by walk-in without notification or appointment. The HP representatives will wear an employee badge with the HP logo and their photograph present; they will also provide you with a business card.

When an HP representative arrives at your office, please take a few moments to answer their brief questions, and allow them access to your facility. This will help to complete your enrollment/re-enrollment smoothly. Failure to answer their questions or assist could affect your current enrollment or re-enrollment with Alabama Medicaid.

FAILURE TO RE-ENROLL: Failure to re-enroll *and* provide appropriate documentation (including the Provider Agreement and Disclosure forms) to complete re-enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-enroll, providers will have to submit a new application for enrollment and enroll. Providers will be REQUIRED to use the web portal application to (re)enroll with Medicaid.

If you have questions related to Provider Reenrollment, you may contact 1-888-223-3630.

Medicaid Enrollment Requirements for Ordering, Prescribing, and Referring (OPR) Providers – Grace Period Extended Until December 31, 2012

Federal law now requires all physicians and other practitioners who prescribe or order services for Medicaid recipients, or who refer Medicaid recipients to other providers must be enrolled as a Medicaid provider.

As a result of this law, services rendered based on a referral, order, or prescription will be reimbursable only if the ordering, prescribing, or referring physician/practitioner is enrolled in the Alabama Medicaid Program.

A new enrollment application was developed for those providers who do not treat Alabama Medicaid recipients for payment, but who do order, prescribe, or refer. These providers will be enrolled as an OPR provider. Medicaid will not make payment to an OPR provider but will recognize their NPI for services rendered by participating Medicaid providers. An abbreviated enrollment application is located on the Alabama Medicaid Agency website at the following link in the Administrative Forms section: *http://medicaid.alabama.gov/CONTENT/5.0_Resources/5.4_Forms_Library/5.4.6_Provider_Enrollment_Forms.aspx.*

The application must contain the provider's original signature. The application, along with a copy of the provider's DEA certificate, if applicable, should be mailed to:

HPES Provider Enrollment
P.O. Box 241685
Montgomery, AL 36124

Faxed or emailed copies will not be accepted.

If an OPR provider submits a claim for payment, the claim will deny for error code 1032 (provider type claim input conflict).

Medicaid will allow a grace period until December 31, 2012 for OPR providers to become enrolled. On January 1, 2013 claims for services that contain an NPI of an ordering, prescribing, or referring provider not enrolled in Medicaid (either as a participating provider or as an OPR provider) will be denied.

Medicaid encourages all participating providers to be proactive and ensure the ordering, prescribing, referring physician/practitioner is enrolled in Medicaid prior to the January 1, 2013 deadline.

DME Complex Rehabilitation Technology (CRT) Category

Effective October 1, 2012, Alabama Medicaid provides recognition for individually configured complex rehabilitation technology (CRT) products and services for complex needs patients under the age of 21. These HCPCS codes include complex rehabilitation power wheelchairs, highly configurable manual wheelchairs, adaptive seating and positioning systems, and other specialized equipment such as standing frames and gait trainers. Refer to Appendix P, Durable Medical Equipment (DME) Procedure Codes and Modifiers, for applicable CRT procedure codes.

Continuous Positive Airway Pressure Device (CPCP) Capped Rental

Effective January 1, 2013, the CPAP will be a capped rental to purchase item. The equipment can be rented for up to 3 months. After 3 months, if the recipient continues to meet criteria and must continue on the CPAP, the CPAP machine will transition to a purchase, with the total rental payments during the first 3 months and a subsequent one month payment equaling the purchase rate. No additional payment will be made by Alabama Medicaid on the CPAP machine and the machine will be considered to be owned by the recipient. The monthly payment will include delivery, in-service for the care giver, maintenance, repair and supplies. Recertification is required after the initial three months until the recipient no longer meets the criteria, the device is removed from the home, or the device becomes a purchased item for the recipient. If the CPAP is determined not be medically necessary (i.e., the criteria is no longer met) and if the total rental amount paid is less than the established purchased price the device will be returned to the supplier.

ICD-10 IMPLEMENTATION

Providers and Vendors Should Be Preparing Now For ICD-10 Implementation

The International Classification of Diseases, 10th Revision (ICD-10) medical coding system is mandated for use by the U.S. Department of Health and Human Services (DHHS); replacing ICD-9 CM codes (volumes 1-3). Due to the enhanced specificity and level of detail of the ICD-10 code set, the transition is anticipated to have a significant impact on the Alabama Medicaid program, health care providers and trading partners. ICD-10 Clinical Modification (CM) and the ICD-10 Procedure Code System (PCS) codes will improve the ability to monitor the incidence and prevalence of diseases, track treatment and health care delivery, prepare for Electronic Health Record (EHR) use, and manage reimbursement.

The current implementation date for this code set is October 1, 2013. DHHS proposed a rule that would delay the compliance date for ICD-10 from October 1, 2013 to October 1, 2014. Public comments gathered during the comment period are being analyzed and the Department will issue a final rule as expeditiously as possible.

Alabama Medicaid is currently in the process of making system modifications for ICD-10. To keep providers informed, we have created a link on the Medicaid website for ICD-10 information and updates. The link will be updated regularly as new information becomes available for providers and vendors. The link is located on the Medicaid website on the provider tab.

HP will also be asking providers and vendors to complete a readiness survey beginning in January. The links will be available on the Medicaid website, and information will be used to ensure a smooth transition for ICD-10.

ICD-10 COMMUNICATION

To receive email or fax updates concerning ICD-10 changes please take a moment to update contact information.

- **Providers**
  Providers interested in receiving updates concerning ICD-10 should ensure email and fax numbers are updated by logging onto the Provider Web Portal and updating contact information.

  Website: *https://www.medicaid.alabamaservices.org/ALPortal/default.aspx*

  Navigation: Providers > Provider Maintenance > Provider Location Contact Information

- **Trading Partners**
  Trading Partners interested in receiving updates concerning ICD-10 should ensure email addresses are updated by logging onto the Provider Web Portal and updating account information.

  Website: *https://www.medicaid.alabamaservices.org/ALPortal/default.aspx*

  Navigation: Account > Account Maintenance

Medicaid now has a section on our website dedicated to ICD-10. The information can be found at the following link: *http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.12_ICD-10/6.12_ICD-10.aspx*

The website will be updated regularly as new information is made available for providers.

ICD-10 TESTING

Medicaid now has a section on our website dedicated to ICD-10. The information can be found at the following link: *http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.12_ICD-10/6.12_ICD-10.aspx*

Testing will be available summer of 2013. Once a firm start date and further testing definition is established the website will be updated so continue to check back regularly.

ICD-10 TESTING PARTICIPATION

Alabama Medicaid would like to engage Providers and Trading Partners interested in testing ICD-10 in summer 2013. Please submit the following to *alabamaictesting@hp.com.*

- Provider/Trading Partner Name
- Testing Contact Name
- Testing Contact Number, Email
- List transactions interested in testing

If interested in testing and continuing to receive updates on testing please ensure your communication contact information is up to date. Please go back and review the ICD-10 Communication section on this page for directions on updating this information.

ICD-10 TYPES OF TESTING

Testing is highly encouraged and will focus on transactions that provide for the submission of ICD-10 codes.

The following is a list of transactions anticipated for testing:

- Claims - 837 Professional, 837 Institutional
- Prior Authorization
- 835 Remittance Advice

ICD-10 END-TO-END TESTING

Full End-to-End Testing will be available. The following information provides direction for setup and what to expect.

- To ensure claims submitted will be available on the 835 a link between the Trading Partner ID and the Provider ID submitted in the claims transactions must be established. The following form 835 Testing TP Link Form must be copied into an email and submitted to alabamaictesting@hp.com prior to the start of end-to-end testing. An email notification will be returned once the link has been completed and end-to-end testing may begin.
- Please submit claims transactions with an ISA15 Interchange Usage Indicator value of a "P" if an 835 is desired.
- 835 files will be available for download through the trade files option on the web portal each Friday after 3:00 pm.

ICD-10 SECURE TESTING WEBSITE ***https://www.alabama-uat.com/ALPortal/***

ICD-10 TEST MONITORING AND STATUS REPORTING

Alabama Medicaid would like to hear from Providers and Trading Partners who are actively testing and will be asking for feedback on testing efforts in general. A testing progress form will be made available once testing begins and all parties testing will be asked to complete this testing progress form.

ICD-10 GENERAL TESTING INQUIRIES

For general questions about ICD-10 testing please send an email to ***alabamaictesting@hp.com***.

ICD-10 PROVIDER ELECTRONIC SOLUTIONS (PES) SOFTWARE

The Provider Electronic Solutions Software is currently undergoing modifications for ICD-10 and a test version will be made available for testing summer 2013.

Diagnosis Restricted Procedure Codes

In the near future, a link will be available on the Alabama Medicaid Agency's website under the Provider tab for providers to use as a reference to identify procedure codes that are diagnosis restricted. The link will list J, Q, & S procedure codes and the covered diagnosis codes. This list is not all inclusive and does not imply Medicaid coverage, reimbursement, or lack thereof. Other restrictions such as age, prior authorization, and max units may apply and can be found on the physician administered drug fee schedule. The pricing file through the Automated Voice Response System (AVRS) can also be used to determine coverage and reimbursement amounts. Providers may access AVRS by calling 1-800-727-7848. For additional information, please contact the Provider Assistance Center at 1-800-688-7989.

Payment Error Rate Measurement (PERM)
Results for FY 2010 and Announcement of FY 2013 PERM Review

The PERM program measures improper payments in Medicaid and the State Children's Health Insurance Program (SCHIP) and produces state and national-level error rates for each program. The Centers for Medicare and Medicaid Services (CMS) developed PERM to comply with the Improper Payments Information ACT (IPIA) of 2002.

Results are in for the FY 2010 PERM review. The top three reasons for Medicaid FFS Medical Review errors in terms of projected dollars in error are: policy violation, insufficient documentation, and no documentation. These errors account for over 83% of Alabama's Medical Review errors. Other errors include number of units, policy violation, pricing errors, and non-covered service. Alabama's overall error rate is 1.5% for the fee-for-service component.

The measurement for the FY 2013 cycle will begin October 1, 2012. Once the medical record review process begins, it is very important for providers to comply with the requests and submit documentation in a timely manner. Providers should ensure records are complete (i.e. physician signatures, correct dates, treatments plans, progress notes, etc.).

CMS uses contractors to conduct the PERM reviews. For FY 2010, CMS used Livanta, LLC as the statistical contractor and APlus Government Solutions as the review contractor. For the FY 2013 cycle, CMS has contracted with The Lewin Group as the statistical contractor. However, the review contractor has not been named at this time. For questions, please contact Patricia Jones (334) 242-5609, PERM Program Manager, or Jacqueline Thomas (334) 242-5318, Program Integrity Division Director.

National Correct Coding Initiative

The Centers for Medicare and Medicaid Services (CMS) initially developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment of Medicare Part B claims. The coding policies were based on coding conventions defined in the American Medical Association's *Current Procedural Terminology (CPT) Manual,* national Medicare policies, coding guidelines developed by national societies, standard medical and surgical practice, and current coding practice.

Medicaid introduced the NCCI edits into the Medicaid claims processing system on November 9, 2010. These edits were initially set as "informational" edits. On March 23, 2011, these edits were set to deny for services that do not meet the NCCI edit criteria and were furnished on or after October 1, 2010.

CMS publishes the NCCI Coding Policy Manual for Medicare and Medicaid Services and this may be used as a reference for claims-processing edits. The manual is updated annually, and the NCCI edits are updated quarterly (*http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html*).

NCCI includes two types of edits: NCCI Procedure-to-Procedure (PTP) edits and Medically Unlikely Edits (MUE).

NCCI PTP edits prevent inappropriate payment of services that should not be reported together. Services that are integral to another service are component parts of the more comprehensive service. *For example*, vaccine administration code and an evaluation and management visit code when the patient only presented for immunizations. Each edit has a column one and column two HCPCS/CPT code. If a provider reports the two codes of an edit pair for the same beneficiary on the same date of service, the column one code is eligible for payment but the column two code is denied. The edits do not include all possible combinations of correct coding edits or types of unbundling that exist. Providers are obligated to code correctly even if edits do not exist to prevent use of an inappropriate code combination.

If the NCCI edit responsible for an NCCI denial has a modifier indicator of "0", an appeal can NEVER overturn the denial. These claims are final and no appeal is applicable except for an administrative law judge who can determine that the denied column two code should be paid. These instances will be rare.

If the NCCI edit responsible for an NCCI denial has a modifier indicator of "1", an appeal can be submitted for review. See the example chart showing the modifier indicators 0, 1, 9

Column 1	Column 2	Effective Date	Deletion Date	Modifier Indicator 0=not allowed 1= allowed 9= not applicable
00100	0228T	20110101		1
00100	0230T	20110101		1
00100	0251T	20110101		1
00100	0253T	20110101	20110101	9
00100	31505	20101001		1
00100	31515	20101001		1
00100	31527	20101001		1
00100	31622	20101001		1
00100	31634	20110101		1
00100	31645	20101001		1
00100	36000	20101001		1
00100	36010	20101001		0
00100	36011	20101001		1

NCCI MUEs prevent payment for an inappropriate number/quantity of the same service on a single day. An MUE for a HCPCS/CPT code is the maximum number of units of service (UOS) under most circumstances reportable by the same provider for the same beneficiary on the same date of service.

If a claim is denied for an NCCI MUE, the provider can resubmit the claim with the correct units as long as the units are equal to or lesser than the NCCI MUE allowed units. If the units are more than the NCCI MUE allowed units, then an appeal must be requested. See the example chart below:

HCPCS/CPT Code	Practitioner Services MUE Values
17000	1
17003	13
17004	1
17106	1
17107	1
17108	1
17110	1
17111	1
17264	3

Reminder

- Providers must report services correctly
- Providers should not report multiple HCPCS/CPT codes when a single comprehensive HCPCS/CPT

code describes these services. For example, vaginal hysterectomy on a uterus weighing less than 250 grams with bilateral salpingo-oophorectomy should be reported with one single code 58262.

- Providers should not fragment a procedure into component parts. For example, Upper GI Endoscopy with biopsy of stomach should be reported with 43239. It is improper to unbundle this procedure and bill 43235 (Upper GI Endoscopy Diagnostic) and 43242 (with transendoscopic ultrasound…fine needle aspiration/ biopsy).
- Providers should not unbundle services that are integral to a more comprehensive procedure (surgical access, insertion of urinary catheter, wound irrigation…).
- Providers must avoid down coding.
- Providers must avoid up coding (code only if all services described by that code are performed).
- Providers must report units of service correctly using HCPCS/CPT criteria for that code. Some codes are reported in fifteen minute increments and other codes may be reported per session. Providers should not report a "per session" code using fifteen minute increments.
- Providers should use applicable NCCI modifiers if the clinical circumstances justify the use of the modifier. A modifier should not be appended to a HCPCS/CPT code solely to bypass an NCCI edit if the clinical circumstances do not justify its use. In general these circumstances may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician.

NCCI Administrative Review and Fair Hearing

Individual claim denials may be appealed at three levels. The levels listed in order, are:

1. Redetermination Request
2. Administrative Review
3. Fair Hearing

Redetermination

HP is responsible for the redeterminations, which is the first level of appeals and adjudication functions.

A *redetermination* is an examination of a claim and operative notes/medical justification by HP personnel. The provider has **60 days from the date of receipt of the initial claim determination to request a redetermination**. The provider must complete the HP Enterprise Services Request for NCCI Redetermination Review form. The request for a redetermination must include:

- Completed NCCI Redetermination Review form: *http://medicaid.alabama.gov/CONTENT/5.0_Resources/5.4_Forms_Library/5.4.1_Billing_Forms.aspx*
- Corrected Paper Claim for the procedure codes that denied
- Operative Notes/Medical Justification

Send the request for a Redetermination Review along with all supporting documentation to:

HP Enterprise Services
Request for NCCI Redetermination
PO Box 244032
Montgomery, AL 36124-4034

HP will normally issue a decision via the remittance advice within 90 days of receipt of the redetermination request. The ICN region for the redetermination request will begin with '91'. For example: 9111082123456.

Administrative Review

When the redetermination request results in a denial by HP, the provider may request an *administrative review* of the claim. A written request for an administrative review **must be received by the Alabama Medicaid Agency within 60 days of the date of the redetermination denial from HP**. The request should clearly explain why the provider disagrees with the redetermination denial. The request for an administrative review must include:

- Completed Form 403 - Request for National Correct Coding Initiative (NCCI) *http://medicaid.alabama.gov/CONTENT/5.0_Resources/5.4_Forms_Library/5.4.1_Billing_Forms.aspx*
- Correct Paper Claim for the procedure codes that denied
- Copy of previous request for redetermination correspondence sent to HP
- Copies of all relevant remittances advices or HP's redetermination denial notification
- Copy of any other useful documentation

Send the request for an Administrative Review along with all supporting documentation to:

NCCI Administrative Review
Alabama Medicaid Agency
Attn: System Support Unit
501 Dexter Avenue
P. O. Box 5624
Montgomery, AL 36103-5624

Fair Hearing

When the administrative review does not resolve the issue, the provider has the option to request a fair hearing. A written request must be received within 60 days of the date of the administrative review decision. The request must identify any new or supplemental documentation. Send the written request for a fair hearing to:

Alabama Medicaid Agency
Attn: Office of General Counsel
501 Dexter Avenue
P. O. Box 5624
Montgomery, AL 36103-5624

2013 State Checkwrite Schedule

10/05/12	01/04/13	04/05/13	07/05/13
10/19/12	01/18/13	04/19/13	07/19/13
11/02/12	02/08/13	05/03/13	08/02/13
11/16/12	02/22/13	05/17/13	08/16/13
12/07/12	03/08/13	06/07/13	09/06/13
12/14/12	03/22/13	06/21/13	09/13/13

The release of funds is normally the second Monday after the RA date. Please verify direct deposit status with your bank. Go to *www.medicaid.alabama.gov* to view the payment delay update details. Payment alerts will be posted only if there will be a payment delay. As aways, the release of direct deposits and checks depends on the availability of funds.

Alabama Medicaid Bulletin

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Alabama Medicaid Bulletin **January 2013**

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05/03/13 • 05/17/13 • 06/07/13 • 06/21/13 • 07/05/13 • 07/19/13 • 08/02/13 • 08/16/13 • 09/06/13 • 09/13/13
As always, the release of direct deposits and checks depends on the availability of funds.

Attention Physicians

Effective for dates of service on or after 10/24/2012: Audit 5664, Initial office visit/ prior visit contra, has been established to deny the reimbursement of an initial office visit procedure (99201 - 99205) when billed for the same recipient, by the same billing provider, same rendering provider specialty, within 3 (three) years after any subsequent office, hospital, or nursing home evaluation and management service (99211 - 99499).

Effective for dates of service on or after 10/24/2012: Audit 5665, Prior visit/initial office visit contra, has been established to deny the reimbursement of subsequent office, hospital, or nursing home evaluation and management service (99211 - 99499) when billed for the same recipient, by the same billing provider, same rendering provider, provider specialty, anytime within 3 (years) prior to an initial office visit procedure (99201 - 99205).

If you have questions, contact the Provider Assistance Center at 1–800–688–7989.

Vendor Survey on ICD-10 Readiness

Providers: Please pass this information along to your software vendors.

Alabama Medicaid and HP would like software vendors to log on to the Medicaid website between January 2 and January 21, 2013 to complete a brief survey on ICD-10 readiness. The surveys should take less than five minutes to complete and will provide Medicaid with information on provider and vendor readiness to implement ICD-10. The survey is located at the following link: http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.12_ICD-10/6.12.1.1_ICD-10_Surveys.aspx.

A similar survey for providers will be available between February 14 and March 5, 2013.

Our goal is to implement changes related to ICD-10 on or before October 1, 2013, but not accept ICD-10 codes until October 1, 2014. Please stay abreast of updates by visiting the ICD-10 page on the Medicaid website located at the following link: *http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.12_ICD-10/6.12_ICD-10.aspx*. If you have any questions about ICD-10 please send an email to alabamaictesting@hp.com.

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Pass It On!

Everyone needs to know the latest about Medicaid. Be sure to route this to:

- ❒ *Office Manager*
- ❒ *Billing Department*
- ❒ *Medical/Clinical Professionals*
- ❒ *Other* _____

ICD-10 Email Notifications

To receive email notifications concerning ICD-10 changes, please log on to the Alabama Medicaid Provider Web Portal and update your Account Maintenance email address.

If more than a single person is to receive these notifications, **create a single email distribution address within your own email server. Enter this single email address on the Account Maintenance page.**

Providers and Trading Partners may update their email by logging onto the Provider Web Portal. Website: ***https://www.medicaid.alabamaservices.org/ALPortal/default.aspx*** Navigation: Account > Account Maintenance.

Changes to Initial Office Visit, Subsequent Office, Hospital Evaluation, Nursing Home Evaluation and Management Service Billing

Effective October 24, 2012, Medicaid made changes to comply with the Current Procedural Terminology Manual (CPT). Providers may no longer bill for any subsequent office, hospital, or nursing home evaluation and management service (99211 - 99499) and an initial office visit procedure (99201 - 99205) for the same recipient, by the same billing provider, same rendering provider specialty, within a three-year time frame. Please refer to current CPT guidelines for clarification.

Attention Eye Care Providers

The Medicaid Secure website is currently not displaying eye care benefit limitations (frames, lens, exam and fit) correctly at this time for children under the age of 21. To verify eligibility for eye care limitations (frames, lens, exam and fit) for recipients under the age of 21, providers should call the Provider Assistance Center at 1-800-688-7989. Providers will be notified when they may resume using the Medicaid Secure Website to verify eligibility.

Clarification on Recent Changes Related to Claims With Another Insurance Primary

A new TPL attachment form has been created for submitting paper claims and reporting the following other payer information: paid amount, deductible amount, coinsurance amount and co-pay amount. This form will be required with the CMS 1500 form when third party applies to a claim. The forms are available free of charge and may be ordered by calling the Provider Assistance Center at 1-800-688-7989.

When Should This Attachment Be Used?
This attachment should only be used when a provider must submit a claim on paper and the provider needs to submit information regarding the amounts processed by the other payer: paid amount, deductible amount, coinsurance amount, co-pay amount (For example, third party PAID or applied all the allowed charges to patient responsibility but an administrate review is needed on the claim). **Please remember, Medicaid requires claims be submitted electronically unless an administrative or manual review is required. The majority of these claims will continue to be submitted electronically.**

Claims with third party denials should continue to be submitted in this fashion:

- Indicate TPL denial on the claim in the appropriate block/form locator (for example, Block 19 of CMS-1500 claim form)
- Attach TPL denial to the error free claim for processing

Providers should now be able to submit more claims electronically when the other payer paid **or when the other payer applied the charges to patient responsibility.** A provider can now submit a claim for TPL electronically when the other payer pays zero, but the patient responsibility is greater than zero.
This can include:

- If any amount greater than zero is entered in the other payer co-pay field, and/or
- If any amount greater than zero is entered in the other payer deductible field, and/or
- If any amount greater than zero is entered in the other payer coinsurance field

In order for claims with TPL to be considered for payment, the patient responsibility must be greater than zero. Patient responsibility is calculated by adding together any co-payments, co-insurance and deductible.

Claims that do not contain a patient responsibility will deny with error status code 631 (TPL Patient Responsibility is Zero for Payer). When calculating payment methodology for claims with TPL primary, Medicaid will pay the lesser of patient responsibility or Medicaid allowed amount minus TPL paid amount for professional claims only. All other claim types will continue to price as usual at this time.

If you have any questions, please contact the Provider Assistance Center at 1-800-688-7989.

PSYCHIATRIC SERVICES 2012 TO 2013 CROSSWALK

To: All Psychologists and Rehabilitation Option Providers

Due to recent CPT code changes by the American Psychiatric Association (APA), the Alabama Medicaid Agency will implement the following CPT coding changes effective for dates of service January 1, 2013, and thereafter. Incorrectly coded claims will deny on or after this date.

For Psychology Providers

Code 90792 will not be a covered service for psychologists.

2012			2013		
Service	CPT Code	2013 Status	Service	CPT Code	Report with interactive complexity (+90785)
Diagnostic					
Diagnostic interview examination	90801	DELETED	Diagnostic evaluation (no medical)	90791	When appropriate
			Diagnostic evaluation with medical	90792	
Interactive diagnostic interview examination	90802	DELETED	Diagnostic evaluation (no medical)	90791	Yes
			Diagnostic evaluation with medical	90792	
Psychotherapy					
Individual psychotherapy 20-30 min	90804, 90816	DELETED	Psychotherapy 30 (16-37*) min	90832	When appropriate
45-50 min	90806, 90818		45 (38-52*) min	90834	
75-80 min	90808, 90821		60 (53+*) min	90837	
Interactive individual psychotherapy 20-30 min	90810, 90823	DELETED	30 (16-37*) min	90832	Yes
45-50 min	90812, 90826		45 (38-52*) min	90834	
75-80 min	90814, 90828		60 (53+*) min	90837	

For Rehabilitation Option Providers

Code 90792 will be a covered service for the physician (psychiatrist) only.

The Family and Group Therapy codes 90846, 90847, 90849, and 90853 remain unchanged.

2012			2013		
Service	CPT Code	2013 Status	Service	CPT Code	Report with interactive complexity (+90785)
Diagnostic					
Diagnostic Interview Examination	90801	DELETED	Diagnostic evaluation (no medical)	90791	When appropriate
			Diagnostic evaluation with medical	90792	
Individual psychotherapy 20-30 min	90804	DELETED	Psychotherapy 30 (16-37*) min	90832	When appropriate
			45 (38-52*) min	90834	
			60 (53+*) min	90837	

For additional information in reference to the current behavioral health CPT code changes, click on the following link: *http://www.psychiatry.org/practice/managing-a-practice/cpt-changes-2013* and go to the documents listed in the Additional Coding Resources section.

If you have further questions, you may contact the HP Provider Assistance Center at (800) 688-7989.

SPECIAL ATTENTION

Hospitals Designated as 340-B Entities

Effective for claims submitted on October 1, 2012, and thereafter, hospitals designated as 340-B entities may bill 'total charges' on the UB-04 claim form when billing for outpatient pharmacy charges. For any questions, contact Jerri Jackson via e-mail at *jerri.jackson@medicaid.alabama.gov* or via phone at 334-242-5630.

Hospital - Based Physician Clinics

Effective for dates of service on or after October 1, 2012, Medicaid will allow revenue code 51X, clinic, to be billed with evaluation and management procedure codes 99201-99215. For any questions, contact Jerri Jackson via e-mail at *jerri.jackson@medicaid.alabama.gov* or via phone at 334-242-5630.

Chlamydia and Gonorrhea

Effective for dates of service on or after September 1, 2012, chlamydia (87491) or gonorrhea (87591), when billed on the same date of service for any one patient will deny. If both procedures are performed on the same date of service, procedure code 87801 (infectious agent antigen detection by nucleic acid (DNA or RNA), multiple organisms; amplified probe(s) technique) should be billed instead. For any questions, contact Toni Hopgood via e-mail at *toni.hopgood@medicaid.alabama.gov* or via phone at 334-353-4724.

Hospital Billers and Quality Assurance Case Managers

Medicaid will no longer require in state and border hospital providers to report dates of service that do not meet InterQual® Adult and Pediatric Medical Criteria and Alabama Medicaid Local Policy on the UB-04 claim form. Medicaid will continue to utilize the Alabama Medicaid Adult and Pediatric Inpatient Care Criteria (SI/IS) for utilization review, billing and reimbursement purposes. This criteria can be found on the following link: *http://medicaid.alabama.gov/documents/4.0_Programs/4.4_Medical_Services/4.4.6_Hospital_Services/4.4.6_Inpatient_Care_Criteria.pdf.* For any questions, contact Jerri Jackson via e-mail at *jerri.jackson@medicaid.alabama.gov* or via phone at 334-242-5630.

EPSDT Periodicity Schedule

Periodic screenings must be performed annually (per calendar year) through 20 years of age beginning with the third birthday. For any questions, contact Toni Hopgood via e-mail at *toni.hopgood@medicaid.alabama.gov* or via phone at 334-353-4724.

Medicaid's Quantitative Drug Screening Policy

Medicaid's Quantitative Drug Screening Policy was implemented January 1, 2012. This policy is referenced in Medicaid's Independent Laboratory Provider Manual Chapter 20 and is applicable to any provider that bills Medicaid for drug screens. For any questions, contact Toni Hopgood via e-mail at *toni.hopgood@medicaid.alabama.gov* or via phone at 334-353-4724.

Newborn Screening Policy

Medicaid's Newborn Screening Policy has been updated in Appendix A -'Well Child Check-Up'. This was an outdated policy and revisions were made to include revised Newborn Screening tests. These revisions were coordinated with the Alabama Department of Public Health. For any questions, contact Toni Hopgood via e-mail at *toni.hopgood@medicaid.alabama.gov* or via phone at 334-353-4724.

Renal Dialysis Facilities and Independent Laboratories

This is a reminder that per treatment, weekly and monthly lab values are considered part of the composite rate billed by renal dialysis facilities for hemodialysis and peritoneal dialysis. These lab values should not be billed separately from the composite rate by an independent laboratory or the renal dialysis facility. These lab tests are listed in Chapter 35, Renal Dialysis Facility, of the Provider Manual. For any questions, contact Jerri Jackson via e-mail at *jerri.jackson@medicaid.alabama.gov* or via phone at 334-242-5630.

"Policy change to J9035, Avastin"

Effective for dates of service January 1, 2013, Alabama Medicaid will no longer reimburse providers for the breast cancer diagnosis for J9035, Avastin. This decision has been made as a result of the FDA withdrawing approval for use of Avastin for breast cancer and after consulting with Clinical Oncologists at both UAB and USA.

Alabama Medicaid will continue to reimburse providers for recipients who have received Avastin for breast cancer within the past twelve calendar months. Claims for recipients who have never received Avastin for breast cancer will be denied. Claims for recipients who have not received Avastin for breast cancer within the past twelve calendar months will also be denied.

All other approved diagnosis will continue to be covered.

SPECIAL ATTENTION

Policy Reminder for Physicians Writing Prescriptions

If a prescription to be paid by Medicaid exceeds the drug's maximum unit limit allowed per month, the prescriber or pharmacist must request an override for the prescribed quantity. If the override is denied, then the excess quantity above the maximum unit limit is non-covered and the recipient can be charged as a cash recipient for that amount in excess of the maximum unit limit. In other words, for a prescription to be "split billed" (the maximum unit allowed paid by Medicaid and the remainder paid by the patient), a maximum unit override must be requested by the provider and denied. A prescriber should not write separate prescriptions, one to be paid by Medicaid and one to be paid as cash, to circumvent the override process. Note: A provider's failure or unwillingness to go through the process of obtaining an override does not constitute a non-covered service. For more information, this policy can be found in the Alabama Medicaid Provider Billing Manual, Chapter 27.

Physician-Employed Practitioner Reminder

Physician Assistants (PAs) or Certified Registered Nurse Practitioners (CRNP) who are legally authorized to furnish services and who render services under the supervision of an employing physician must enroll with the Alabama Medicaid Agency and receive a NPI number with the employing physician as the payee. The employing physician must be a Medicaid provider in active status. Covered services furnished by the PA or CRNP must be billed under the PA's or CRNP's name and NPI. The PA's or CRNP's employing physician is responsible for the professional activities of the PA or CRNP and for assuring that the services provided are medically necessary and appropriate for the patient. Services billed outside a PA or CRNP scope of practice and/or collaborative agreement is subject to post-payment review.

Medicaid Enrollment Requirements for Ordering, Prescribing, and Referring (OPR) Providers

Claims for services that contain an NPI of an ordering, prescribing, or referring provider not enrolled in Medicaid (either as a participating provider or as an OPR provider) will be denied effective for claims received January 1, 2013, and thereafter.

Federal law requires all physicians and other practitioners who prescribe or order services for Medicaid recipients, or who refer Medicaid recipients to other providers must be enrolled as a Medicaid provider.

As a result of this law, services rendered based on a referral, order, or prescription will be reimbursable only if the ordering, prescribing, or referring physician/practitioner is enrolled in the Alabama Medicaid Program.

If an OPR provider submits a claim for payment, the claim will deny for error code 1032 (provider type claim input conflict).

An enrollment application was developed for those providers who do not treat Alabama Medicaid recipients for payment, but do order, prescribe, or refer. These providers will be enrolled as an OPR provider. Medicaid will not make payment to an OPR provider but will recognize their NPI for services rendered by participating Medicaid providers. An abbreviated enrollment application is located on the Alabama Medicaid Agency website at the following link in the Administrative Forms section: *http://medicaid.alabama.gov/CONTENT/5.0_Resources/5.4_Forms_Library/5.4.6_Provider_Enrollment_Forms.aspx.*

The application must contain the provider's original signature. The application, along with a copy of the provider's DEA certificate, if applicable, should be mailed to:

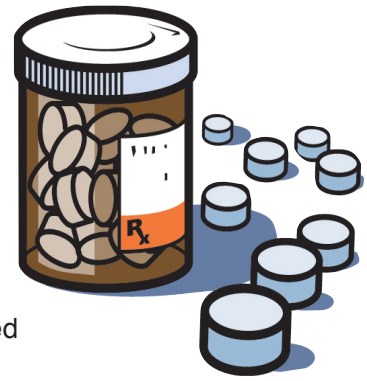
HPES Provider Enrollment
P.O. Box 241685
Montgomery, AL 36124

Faxed or emailed copies will not be accepted.

NO-SHOW FEE

A Medicaid recipient may not be charged or billed for a cancelled or missed appointment.

Attention Pharmacy Providers Billing for Compound Drugs



The following changes will be effective January 1, 2013:

- When compound drugs are being billed to Medicaid, an additional NDC must be billed with the compound drug.
- A compound drug with a reimbursable amount over $200 requires a prior authorization prior to being billed.
- A compound drug which exceeds $200 that is submitted without a prior authorization on file will be denied.
- Pharmacy claims filed for bulk chemicals should only be billed when the claim is billed as a compound drug, and must meet the criteria outlined above.

"Payer of Last Resort" Rule Maximizes Taxpayer Dollars for Medicaid

Alabama Medicaid recipients often have private health insurance as well as Medicaid. To maximize state taxpayer dollars, the Alabama Medicaid Agency's Third Party Division is responsible for ensuring that Medicaid is the "payer of last resort." Generally, this means that providers are responsible for filing for reimbursement from the primary insurance prior to billing Medicaid. However, there are some federally required exceptions to this rule:

1. When the service is a preventive pediatric service
2. When the service is for prenatal care provided outside of managed care

Under these federal exceptions, Medicaid is required to pay the claim if Medicaid is billed first as the primary insurance. Medicaid then bills the other insurance plan for reimbursement—a process known as "pay and chase." Please NOTE: The federal rule is a Centers for Medicare and Medicaid (CMS) requirement for Medicaid to pay if they are billed first. This is not a federal requirement for the health care provider. Providers may choose to bill preventive pediatric services (such as EPSDT screenings and preventive dental services) to the other insurance plan first before billing Medicaid. Billing the other insurance plan first is acceptable and eliminates the need for Medicaid to "pay and chase" the claim.

Procedure codes with modifier EP **are** used for billing EPSDT screenings and are included in the preventive pediatric services "federal exception" group. These codes include:

Well Office Visit Preventive Procedure Codes-Modifier

99381-EP – New Patient (under 1 year of age)
99382-EP – New Patient (1 through 4 years of age)
99383-EP – New Patient (5 through 11 years of age)
99384-EP – New Patient (12 through17 years of age)
99385-EP – New Patient (18 through 20 years of age)
99391-EP – Established Patient (under 1 year of age)
99392-EP – Established Patient (1 through 4 years of age)
99393-EP – Established Patient (5 through 11 years of age)
99394-EP – Established Patient (12 through17 years of age)
99395-EP – Established Patient (18 through 20 years of age)

Dental Procedure Codes included in "pay and chase" as a preventive pediatric service include:

D0110	D1351
D0120	D1510
D1110	D1515
D1120	D1520
D1203	D1525
D1204	D1550
D1330	

Providers with questions regarding benefit coordination, filing procedures, or other billing issues should contact HP Provider Assistance Center at 1-800-688-7989.

Important Changes for Providers Performing Reconstructive/Cosmetic Procedures

Effective January 1, 2013, the Alabama Medicaid Agency will:
Require prior authorization to determine medical necessity before services are rendered to the recipient for the following CPT codes:

21740 (Reconstructive repair of pectus excavatum or carinatum; open), **21742** (Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach, without thoracoscopy), **21743** (Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach, with thoracoscopy), **56620** (Vulvectomy simple; partial), **56625** (Vulvectomy simple; complete), **64821** (Sympathectomy; radial artery), **64822** (Sympathectomy; ulnar artery), **64823** (Sympathectomy; superficial palmar arch), and **97033** (Application of a modality to 1 or more areas; iontophoresis, each 15 min).

Require prior authorization to determine medical necessity before services are rendered to the recipient for ages **5 and olde**r for the following Strabismus Surgery CPT codes:

67311 (Strabismus surgery, recession or resection procedure; 1 horizontal muscle), **67312** (2 horizontal muscles), **67314** (1 vertical muscle), **67316** (2 or more vertical muscles), **67318** (Strabismus surgery, any procedure, superior oblique muscle), **67320** (Transposition procedure, any extraocular muscle), **67331** (Strabismus surgery on patient with previous eye surgery or injury that did not involve the extraocular muscles), **67332** (Strabismus surgery on patient with scarring of extraocular muscles), **67334** (Strabismus surgery by posterior fixation suture technique, with or without muscle recession), **67335** (Placement of adjustable suture(s) during strabismus surgery), and **67340** (Strabismus surgery involving exploration and/or repair of detached extraocular muscles).

Continue coverage of the following CPT codes for Crossover and QMB claims only:

11200 (Removal of skin tags), **11201** (Removal of skin tags; each additional 10 lesions), **15819** (Cervicoplasty), **15820** (Blepharoplasty, lower lid), **15821** (Blepharoplasty, lower lid; with extensive herniated fat pad), **15832** (Excise excessive skin tissue; thigh), **15833** (Excise excessive skin tissue; leg), **15834** (Excise excessive skin tissue; hip), **15835** (Excise excessive skin tissue; buttock), **15836** (Excise excessive skin tissue; arm), **15837** (Excise excessive skin tissue; forearm or hand), **15838** (Excise excessive skin tissue; submental fat pad), **15839** (Excise excessive skin tissue; other area), **17360** (Chemical exfoliation for acne), **30120** (Excision or surgical planning of skin of nose for rhinophyma), **64650** (Chemodenervation of eccrine glands; both axillae), **64653** (other area(s) per day), and 96912 (Photochemotherapy; psoralens and ultraviolet A).

End coverage of the following CPT codes:

11950 (Subcutaneous injection of filling material; 1 cc or less), **11951** (Subcutaneous injection of filling material; 1.1 to 5.0 cc), **11952** (Subcutaneous injection of filling material; 5.1 to 10.0 cc), **11954** (Subcutaneous injection of filling material; over 10 cc), **15788** (Chemical peel, facial; epidermal), **15789** (Chemical peel, facial; epidermal; dermal), **15792** (Chemical peel, nonfacial; epidermal), **15793** (Chemical peel, nonfacial; dermal), **15824** (Rhytidectomy; forehead), **15876** (Suction assisted lipectomy; head and neck), **15877** (Suction assisted lipectomy; trunk), **15878** (Suction assisted lipectomy; upper extremity), **15879** (Suction assisted lipectomy; lower extremity), **17380** (Electrolysis epilation, each 30 minutes), and **96904** (Whole body integumentary photography).

Continue coverage of the following CPT codes for **female recipients ages 0 – 20 years for medical necessity:**

56805 (Clitoroplasty for intersex state), **57291** (Construction of artificial vagina; without graft), **57292** (Construction of artificial vagina; with graft), **57295** (Revision of prosthetic vaginal graft; vaginal approach), and **57296** (Revision of prosthetic vaginal graft; open abdominal approach).

CPT Codes 12011 – 12015 (Simple repair of superficial wounds) will be denied when billed for **ear piercing complications**. Earlobe repair, or repair of a body site piercing, to close a stretched pierced hole in the absence of traumatic injury is considered cosmetic and therefore not medically necessary.

Provider Electronic Solutions (PES) Software Version 3.02 is Now Available

Please refer to Appendix C Change Log in the PES User Manual for a full list of the changes included in the new PES version. Please note the following:

- PES version 3.02 includes changes for ICD-10.
- The upgrade process will set all previous Claim and Prior Authorization ICD versions to ICD-9 ('9').
- The ICD version field on new Claims and Prior Authorizations will default to ICD-9 ('9').
- The Procedure/HCPCS list has been split into multiple lists:
  - Procedure HCPCS (non-surgical procedure codes)
  - Procedure ICD-9 (surgical procedure codes)
  - Procedure ICD-10 (surgical procedure codes)
- Procedure codes currently entered on the 'Procedure/HCPCS' list will be moved to both 'Procedure HCPCS' AND "Procedure ICD-9' when an upgrade to version 3.02 is performed. Users will need to remove invalid codes from each respective list.
- The Diagnosis list has been split into multiple lists:
  - Diagnosis ICD-9
  - Diagnosis ICD-10
- Diagnosis codes currently entered on the diagnosis list will be moved to the new 'Diagnosis ICD-9' list when an upgrade to version 3.02 is performed.
- Users may begin building ICD-10 lists now. ICD-10 codes should not be submitted until the CMS mandated date of October 1, 2014.

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01/04/13 • 01/18/13 • 02/08/13 • 02/22/13 • 03/08/13 • 03/22/13 • 04/05/13 • 04/19/13
05/03/13 • 05/17/13 • 06/07/13 • 06/21/13 • 07/05/13 • 07/19/13 • 08/02/13 • 08/16/13 • 09/06/13 • 09/13/13
As always, the release of direct deposits and checks depends on the availability of funds.

PCP Rate Increase

As the result of the Affordable Care Act (ACA), eligible primary care physicians will soon receive increased payments for certain primary care services provided to Medicaid recipients between January 1, 2013 and December 31, 2014.

The primary care services subject to the increased payment are Current Procedural Terminology (CPT) Evaluation and Management procedure codes 99201 to 99499, and VFC Vaccine Administration codes. The Alabama Medicaid Agency requires the VFC administration fees to be billed using the specific product code (vaccine codes). These VFC codes are: 90633, 90636, 90645, 90647, 90648, 90649, 90650, 90655, 90656, 90657, 90658, 90660, 90669, 90670, 90680, 90681, 90696, 90698, 90700, 90702, 90707, 90710, 90713, 90714, 90715, 90716, 90718*, 90721, 90723, 90732, 90733, 90734, 90744, and 90748. *CPT deleted 90718 effective 12/31/2012; however, this code would still be used in calculating the 60% threshold for CY 2012.

Eligible physicians include those with a specialist designation of family medicine, general internal medicine and pediatric medicine or subspecialists related to one of these primary care specialists. They must be board certified in the specialty or subspecialty; or can verify that 60 percent or more of the Medicaid codes paid in the previous year were primary care codes and the above listed codes for vaccine administration codes.

Increased payment will also be made for primary care services rendered by physician assistants or certified nurse practitioners working under the personal supervision of a qualifying physician. In this case, the physician must assume professional/financial responsibility and is legally liable for the quality of services provided under his or her supervision.

Eligible providers must self-attest to being board certified by the American Board of Physician Specialties, American Osteopathic Association, or the American Board of Medical Specialties in one of the eligible physician categories or verify that 60 percent or more of the Medicaid codes they billed in 2012 were E&M codes and Vaccine Administration codes. Letters were mailed in late February to all physicians who are currently enrolled with a primary care specialty or subspecialty designation.

Before payments can be made, the Agency must obtain final approval from the Centers for Medicare and Medicaid Services (CMS) for the planned payment changes, determine the rate that will be paid to providers, and make the necessary system changes to issue the payments. Medicaid will make retroactive payments for the increase for services that qualify under the federal regulations by reprocessing the affected claims in order for the physician to receive the increased payment.

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Pass It On!

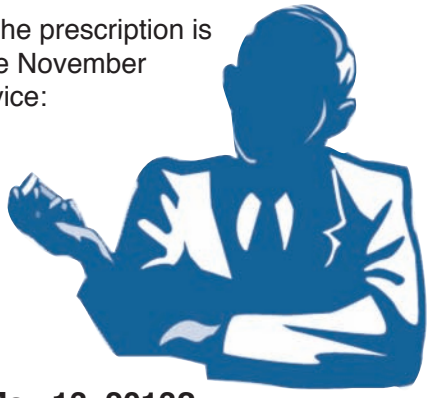
Everyone needs to know the latest about Medicaid. Be sure to route this to:

- ❒ *Office Manager*
- ❒ *Billing Department*
- ❒ *Medical/Clinical Professionals*
- ❒ *Other* _____

New Edits to be Activated Soon - Drug Enforcement Administration (DEA) Validation for Controlled Substances

Effective May 13, 2013, Alabama Medicaid will DENY any claim for a controlled drug written by a prescriber who does not have their DEA number registered with the Department of Justice (DOJ) **and** on file at Medicaid.

These edits are designed to prevent controlled substances from being filled when the prescription is written by an unauthorized prescriber. The following edits have been in place since November 2012 and are currently displaying as informational on the provider's remittance advice:



Edit	Description
1038	DEA NOT ON FILE FOR PRESCRIBER
1039	PRESCRIBER DEA NOT EFFECTIVE FOR DATE PRESCRIBED
1040	PRESCRIBER DEA DOES NOT PERMIT DRUG SCHEDULE

NOTE: *The claims which are currently paying and posting one of the informational edits above, will deny effective May 13, 2013.*

What action needs to be taken to prevent claims from denying on May 13, 2013?

PHYSICIANS – Make sure your DEA number is registered with DOJ and is on your enrollment file at Medicaid. **Medicaid deadline for submission: May 1, 2013.**

To confirm if your DEA number is appropriately registered with the DOJ, and to ensure your correct address/contact information is registered with the DOJ, **you may call the Department of Justice Registration Number Toll Free: (888) 514-7302 or (888) 514-8051**. Prescribers of controlled substances are mandated to re-register their DEA license every three years.

To ensure your DEA is on file at Medicaid, fax a copy of the provider's DEA Registration Certificate to Provider Enrollment (fax 334-215-4298) and include the provider's Name, NPI number, and license number on the certificate. Medicaid will apply the DEA to all service locations based on the provider's NPI and license number. **The DEA information should be received by Provider Enrollment prior to May 1, 2013**. This deadline will allow Provider Enrollment time to enter the information in the provider's file before the May 13, 2013, implementation date.

PHARMACIES – If you are receiving the informational edits, contact the provider who ordered the prescription and advise them to fax a copy of the provider's DEA Registration Certificate to Provider Enrollment (fax 334-215-4298) and include the provider's Name, NPI number, and license number on the certificate.

Why is Medicaid implementing these changes?

In September 2009, the Government Accountability Office (GAO) issued the report "Medicaid Fraud and Abuse Related to Controlled Substance Identified in Selected States" which highlighted fraudulent, improper, or abusive actions in prescribing and dispensing of controlled substances. One of the report's primary recommendations was that states should use the Drug Enforcement Administration (DEA) Controlled Substance Registration file as part of their Medicaid claims processing efforts to prevent paying for controlled substances ordered by unauthorized prescribers.

PRESCRIBERS: Please take a moment to validate your DEA number information. Medicaid encourages all providers to be proactive and ensure the DEA number of the prescribing provider is registered with the Department of Justice (DOJ) and on file at Medicaid prior to May 1, 2013.

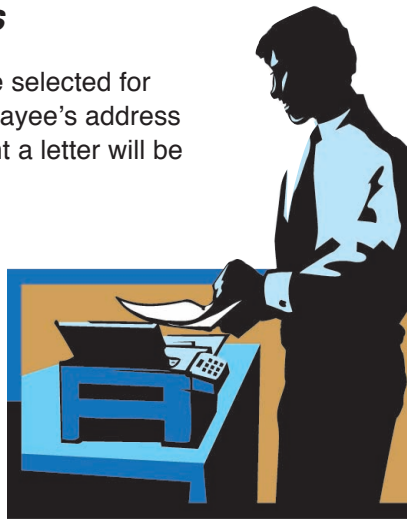
Revision to January 2013 Article "Important Changes for Providers Performing Reconstructive/Cosmetic Procedures"

CPT Codes **11200** and **11201** Removal of skin tags, coverage will continue for all eligible benefit types. These CPT codes will be diagnosis restricted to prevent payment when billed with diagnosis codes for hypertrophic and atrophic skin conditions.

Strabismus surgery CPT codes **67311** – **67340** coverage will continue for all eligible benefit types without prior authorization.

Effective March 1, 2013, CPT Code **54163 Repair Incomplete Circumcision**, will require a **Prior Authorization** before services are rendered to the recipient to determine medical necessity.

Important Provider Re-enrollment Reminders



Re-enrollment for providers is on-going for Alabama Medicaid providers. Providers are selected for re-enrollment monthly based on the longest date of enrollment. A letter is sent to the payee's address on file for the provider when it is time for them to re-enroll. Only providers who are sent a letter will be able to download a facsimile from the Medicaid Interactive website.

When a provider receives a letter it is time to re-enroll, they should log onto the Interactive Website and download a facsimile for review. Instructions for downloading the facsimile can be found on the Medicaid Agency website. Once the information has been printed and reviewed, the provider should sign page three of the facsimile, complete the appropriate forms and mail to HP using the address on the letter and facsimile. If changes are necessary, providers should make the appropriate changes on the facsimile. Please read all information on the facsimile carefully, because additional information is required (For example, provider agreement and provider disclosure forms). Documentation requirements can be found on the Medicaid Agency Website.

It is important to point out the facsimile is not the only information needed for re-enrollment. The facsimile indicates which additional forms are required.

If unsure of required forms, please contact Provider Re-enrollment at 888-223-3630 Option 2 for assistance. **Failure to send in additional documentation delays your re-enrollment.** Approximately 50% of the re-enrollments received lack the required paperwork to complete re-enrollment upon receipt and require outreach.

Individual practitioners enrolled under the group do not complete an agreement until the provider has received notification to re-enroll. Not all providers within a group will re-enroll at the same time.

How will providers know when it is time for re-enrollment? In addition to the letter sent to the payee address on file, providers are sent two final notice letters. Providers may also log onto the Medicaid website after the 5th working day of each month to view a list of providers scheduled for re-enrollment. The list includes the provider's name, NPI and Medicaid identification number.

The Affordable Care Act requires some providers have an onsite visit prior to a new enrollment or prior to re-enrollment. The onsite visits are conducted by Medicaid's fiscal agent, HP Enterprise Services. The visits are unscheduled and not announced prior to the time of visit. When a Provider Relations Representative arrives at your facility, please make time to answer questions, and allow them access to your facility. The HP representatives will wear an identification badge with the HP logo and their photograph; they will also provide you with a business card. Failure to answer their questions or assist could affect your current enrollment or re-enrollment with Alabama Medicaid.

What happens if re-enrollment is not completed timely? Failure to re-enroll and provide appropriate documentation (including required additional forms) to complete re-enrollment will result in an end-date being placed on the provider file. Once a provider has been closed to failure to timely re-enroll, providers will have to submit a new application for enrollment. Please do not hesitate to contact Provider Re-enrollment with any questions at 1-888-223-3630 Option 2.

Correction to the January 2013 Insider Article "Attention Providers"

Audits 5664, Initial office visit/ prior visit contra, and 5665, Prior visit/initial office visit contra, are effective for claims received on or after 10/24/2012.

Effective for claims received on or after 10/24/2012: Audit 5664, Initial office visit/ prior visit contra, has been established to deny the reimbursement of an initial office visit procedure (99201 - 99205) when billed for the same recipient, by the same billing provider, same rendering provider specialty, within 3 (three) years after any subsequent office, hospital, or nursing home evaluation and management service (99211 - 99499).

Effective for claims received on or after 10/24/2012: Audit 5665, Prior visit/initial office visit contra, has been established to deny the reimbursement of subsequent office, hospital, or nursing home evaluation and management service (99211 - 99499) when billed for the same recipient, by the same billing provider, same rendering provider, provider specialty, anytime within 3 (years) prior to an initial office visit procedure (99201 - 99205).

If you have questions, contact the Provider Assistance Center at 1–800–688–7989.

REMINDER: Claims Processing for the Hospice Program

Below are a few tips in an effort to assist Hospice Providers with the processing of Hospice claims:

- For a dually eligible recipient in the community, the recipient is not on the Level of Care panel and the hospice provider does not bill Medicaid for services.
- For a dually eligible recipient in a nursing home, if financially eligible, the recipient is on the Level of Care panel. Medicaid reimburses the hospice provider 95% of the nursing home rate applicable for that year for the room and board that would have been paid to the nursing home (Revenue Code 659/Procedure Code T2046-SE). Hospice bills Medicare for routine care services.
- For a straight Medicaid recipient (meaning Non-Medicare) in the community, if financially and medically eligible, the recipient is on the Level of Care panel. Medicaid reimburses the hospice provider for every day service is rendered at the appropriate care level (Revenue Code 651/Procedure Code T2042 for Routine Home Care or Revenue Code 652/Procedure Code T2042-SC for Continuous Home Care).
- For a straight Medicaid recipient in a nursing facility, if financially and medically eligible, the recipient is on the Level of Care panel. Medicaid reimburses the hospice provider for the appropriate care level for every day service is rendered + 95% of the nursing home rate applicable for that year for the room & board that would have been paid to the nursing home (Revenue Code 659/Procedure Code T2046 for Nursing Home Room and Board, Routine Care or Revenue Code 659/Procedure Code T2046-SC for Nursing Home Room and Board, Continuous Care).

NOTE: For a straight Medicaid recipient, Medicaid will reimburse Hospice for every day services are rendered. This includes reimbursement for Date of Death or Discharge when the recipient is in a nursing facility for a straight Medicaid recipient (meaning Non-Medicare). If the recipient revokes hospice or is discharged from hospice, but does not physically leave the nursing facility, the hospice provider can submit a claim to the Agency for reimbursement regarding room and board and other hospice services that were administered to the recipient.

Reimbursement for disease specific drugs related to the recipient's terminal illness as well as drugs found on the Hospice Palliative Drug List (HPDL) are included in the per diem rates for hospice covered services and will not be reimbursed through the Medicaid Pharmacy Program. The HPDL is on the agency website at www.medicaid.alabama.gov (Refer to Hospice Provider Manual Chapter 18 NOTE under 18.2.9 Reimbursement for Levels of Care).

For questions or concerns regarding claims processing for Hospice Program, please contact Felicha Fisher at (334) 353-5153.

Provider Payment Accuracy is Focus of State-based RAC Program

Mandatory provisions of the Affordable Care Act require the Alabama Medicaid Agency to select and provide oversight for a Medicaid Recovery Audit Contractor (RAC) to perform provider audits. Goold Health Systems (GHS), a Maine-based firm, has been selected to be Alabama Medicaid's Recovery Audit Contractor (RAC) for a two-year period beginning January 1, 2013.

The RAC program is designed to improve payment accuracy by identifying under and overpayments in Medicaid. The Medicaid RAC program is a separate program from the Medicare RAC which is overseen by the Centers for Medicare and Medicaid Services.

Reviews will be conducted by GHS staff to include full time medical directors, pharmacists, certified professional coders, and experienced clinicians. Audits will be conducted by GHS using a "top down" approach where data analysis, through data mining, is applied against the universe of paid claims to identify patterns of utilization or billing which look atypical based on Alabama Medicaid and/or national standards. Following the high-level claims analysis, GHS may expand its review by requesting clinical records and/or other documents in accordance with state and federal regulations.

GHS has been informed of the critical role that all providers play in a successful Medicaid program and requires that auditors be professional, objective, and consistent in performing all required audits/reviews.

Providers with questions about the RAC requirements may contact Vanesia Boyd, Contract Manager, the Alabama Medicaid Agency at (334) 242-5339, or by email at vanesia.boyd@medicaid.alabama.gov .

ICD-10 Updates

CMS has delayed implementation for ICD-10 from October 1, 2013 to October 1, 2014. The Alabama Medicaid Agency is preparing for ICD-10 implementation as early as October 1, 2013, but no later than October 1, 2014. This means Medicaid will have its claims processing system ready for ICD-10, but will not accept nor require the provider to use ICD-10 codes on their claims until the CMS mandate of October 1, 2014. Providers are encouraged to review updates related to ICD-10 implementation on the Alabama Medicaid website.
http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.12_ICD-10/6.12_ICD-10.aspx

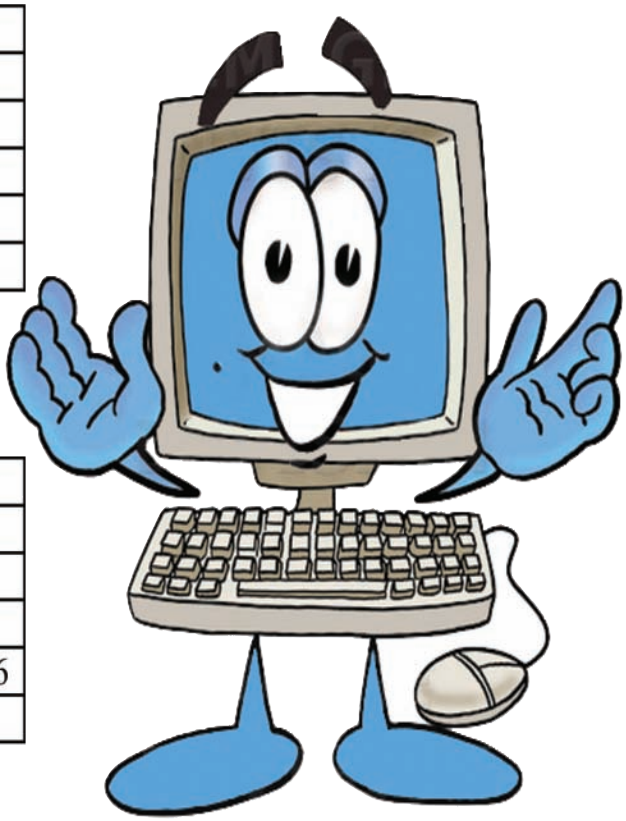
If you would like to receive e-mail notifications concerning ICD-10 changes, please log on to the Alabama Medicaid Provider Web Portal and update your Account Maintenance e-mail address. Providers and trading partners may update their e-mail by logging onto the Provider Web Portal.
https://www.medicaid.alabamaservices.org/ALPortal/Account/Secure%20Site/tabId/66/Default.aspx
Navigation: Account>Account Maintenance

Provider Electronic Solutions Software version 3.02 includes modification for ICD-10.
Please download version 3.02 to ensure you are submitting claims with the latest version of the software.
You should not start to use ICD-10 diagnosis codes until you are advised to submit them by Medicaid.

Vendor and provider surveys related to ICD-10 readiness will continue until implementation.
The next survey for **vendors** will be open April 2-19, 2013.
The next survey for providers will be May 16 - June 4, 2013.
The survey will be available on the Medicaid website in the ICD-10 section under Provider information.
We encourage providers and vendors to complete our surveys (which should take less than 5 minutes).
The surveys will help us track the progress, uncover issues, and identify training that may be helpful to providers.

QUARTERLY VENDOR SCHEDULE:

Quarter	Scheduled
1st Quarter 2013	January 2 – January 21
2nd Quarter 2013	April 2 – April 19
3rd Quarter 2013	July 1 – July 18
4th Quarter 2013	October 1 – October 18
1st Quarter 2014	January 10 – January 29



PROVIDER QUARTERLY SURVEY SCHEDULE:

Quarter	Scheduled
1st Quarter 2013	February 14-March 5
2nd Quarter 2013	May 16-June 4
3rd Quarter 2013	August 14-September 2
4th Quarter 2013	November 7-November 26
1st Quarter 2014	February 18-March 7

ATTENTION:

All Long Term Care, Hospice and Inpatient Psychiatric Facilities

Please be reminded that records requested for retrospective review, or which require a medical review must be mailed to HP with a correctly completed HP coversheet. All 13 digits of the recipient's Medicaid ID are required. Records received at HP without a correctly completed HP coversheet, or no coversheet, will be returned to the provider. This may result in penalties for nursing home providers which fail to submit records timely and/or a delay in the review of the record. **Providers submitting more than one record should clearly separate each record and ensure that a HP coversheet is included for each recipient.** Providers are also encouraged to review each submission and to send only what is requested for an audit, and/or to meet criteria. For example, it is not necessary to send social work, chaplain or aide visit notes for a hospice record.

HP coversheets are found on the Medicaid website at this link,
http://medicaid.alabama.gov/CONTENT/5.0_Resources/5.4_Forms_Library/5.4.3_LTC_Forms.aspx

ATTENTION:

All DME Providers

Please be reminded that durable medical equipment is a covered service under the hospice benefit and therefore should not be billed separately. Per Chapter 18, Hospice, of the Billing Manual on page 17, *"Appliances include durable medical equipment as well as other self-help and personal comfort items provided by the hospice for use in the patient's home for the palliation or management of the patient's terminal illness and/or related condition. These appliances and supplies must be included in the written plan of care."* Therefore, if the requested DME is related to the terminal diagnosis and the recipient's eligibility response indicates hospice, neither a prior authorization request nor a claim should be submitted to Medicaid.

Referring NPI Numbers Now Validated on All Claims Received for Processing

All claims submitted with a referring provider number will be validated during claims processing. If a referring NPI is placed on the claim but is NOT required, the claim will deny if the number is not valid in the HP claims processing system.

Providers should not place referring NPI numbers on claims unless it is required for processing.

A written order or a signed prescription from the attending physician must be dated prior to or on the delivery date, unless a different effective date is clearly documented on the prescription. Otherwise, the effective date is the date of the physician signature. (Verbal orders must be signed within 48 hours of the order being issued.) An effective date that is handwritten on a prescription and differs from the date of the physician's signature, must be initialed and dated by the physician to verify the effective date.

ESRD Laboratory Services

Laboratory tests listed in Chapter 35 (Renal Dialysis Facility) are considered routine and are included as part of the composite rate of reimbursement. When any of these tests are performed at a frequency greater than specified,the additional tests are separately billable and are covered only if they are medically necessary and billed directly by the actual provider of the service. A diagnosis of ESRD alone is not sufficient medical evidence to warrant coverage of additional tests. The nature of the illness or injury (diagnosis, complaint, or symptom) requiring the performance of the test(s) must be present on the claim.

PERM Provider Education Sessions

The Centers for Medicare and Medicaid Services (CMS) is hosting four PERM Provider Education Webinar/Conference calls during Cycle 2.The purpose of Payment Error Rate Measurement (PERM) Provider Education Webinars/Conference Calls is to provide opportunities for the providers of the Medicaid and CHIP communities to enhance their understanding of specific provider responsibilities during PERM. The webinars/conference calls will cover the PERM process and provider responsibilities during a PERM review, frequent mistakes and best practices for documentation submission, and an overview of the Electronic Submission of Medical Documentation (ESMD) program. Dates, times and other information for the four sessions that will be hosted by CMS are listed below.

1. **Tuesday, May 21, 2013**, 2:00 p.m. - 3:00 p.m. **Central Time**

   To Join Meeting:
   Audio: 1-877-267-1577; Meeting ID# 4964
   Webinar: https://webinar.cms.hhs.gov/permcycle2web1/

2. **Wednesday, June 5, 2013**, 2:00 p.m. - 3:00 p.m. **Central Time**

   To Join Meeting:
   Audio: 1-877-267-1577; Meeting ID# 4964
   Webinar: https://webinar.cms.hhs.gov/permcycle2web2/

3. **Tuesday, June 18, 2013**, 2:00 p.m. - 3:00 p.m. **Central Time**

   To Join Meeting:
   Audio: 1-877-267-1577; Meeting ID# 4964
   Webinar: https://webinar.cms.hhs.gov/permcycle2web3/

4. **Tuesday, July 2, 2013**, 2:00 p.m. - 3:00 p.m. **Central Time**

   To Join Meeting:
   Audio: 1-877-267-1577; Meeting ID# 4964
   Webinar: https://webinar.cms.hhs.gov/permcycle2web4/

There will be time available for Q&As at the end of the presentations. However, CMS encourages all participants to submit questions in advance to the designated PERM Provider email address at PERMProviders@cms.hhs.gov.

Presentation materials and participant call-in information will be posted on the Provider Education Calls link at: http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/PERM/Provider_Education_Calls.html.

The webinars are being presented on a Connect Pro platform. To test your connection in advance, launch: https://webinar.cms.hhs.gov/common/help/en/support/meeting_test.htm.

Alabama Medicaid Bulletin

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2013 State Checkwrite Schedule

~~01/04/13~~	04/05/13	07/05/13
~~01/18/13~~	04/19/13	07/19/13
~~02/08/13~~	05/03/13	08/02/13
~~02/22/13~~	05/17/13	08/16/13
~~03/08/13~~	06/07/13	09/06/13
~~03/22/13~~	06/21/13	09/13/13

The release of funds is normally the second Monday after the RA date. Please verify direct deposit status with your bank. Go to *www.medicaid.alabama.gov* to view the payment delay update details. Payment alerts will be posted only if there will be a payment delay. As aways, the release of direct deposits and checks depends on the availability of funds.

Provider Insider

Alabama Medicaid Bulletin **July 2013**

07/05/13 • 07/19/13 • 08/02/13 • 08/16/13 • 09/06/13 • 09/13/13 • 10/04/13 • 10/18/13 • 11/01/13 • 11/15/13
12/06/13 • 12/13/13 • 01/03/14 • 01/17/14 • 02/07/14 • 02/21/14 • 03/07/14 • 03/21/14 • 04/04/14 • 04/18/14
As always, the release of direct deposits and checks depends on the availability of funds.

Copayment Changes Effective July 1, 2013

Effective for dates of service July 1, 2013, and thereafter, copayments for Medicaid covered services will be based on the federally approved maximum amounts shown below (including Medicare crossovers):

- **Office Visit** *(including visits to physicians, optometrists, nurse practitioners):*
  The copayment amount is:
  $3.90 for procedure codes reimbursed $50.01 and greater
  $2.60 for procedure codes reimbursed between $25.01 and $50.00
  $1.30 for procedure codes reimbursed between $10.01 and $25.00

The following CPT codes are considered office visits and the copayment is based on Medicaid's allowed amount (fee schedule) for each procedure:
90847, 90849, 90853, 90865, 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99281, 99282, 99283, 99284, 99285, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

- **Federally Qualified Health Center (FQHC)**
  The copayment amount is $3.90 per visit (encounter)
- **Rural Health Clinic (RHC)**
  The copayment amount is $3.90 per visit (encounter)
- **Ambulatory Surgical Center**
  The copayment amount is $3.90 per visit.
- **Outpatient Hospital**
  The copayment amount is $3.90 per visit.
- **Inpatient Hospital**
  The copayment amount is $50.00 per admission.

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Pass It On!

Everyone needs to know the latest about Medicaid. Be sure to route this to:

- ❒ *Office Manager*
- ❒ *Billing Department*
- ❒ *Medical/Clinical Professionals*
- ❒ *Other* _____

Drug Enforcement Administration (DEA) Validation for Controlled Substances

Medicaid extended the May 13, 2013, implementation date of the DEA validation of controlled substance prescription claims to July 8, 2013. Effective July 8, 2013, Medicaid will **DENY** any claim for a controlled drug written by a prescriber who does not have their DEA number registered with the Department of Justice (DOJ) and on file at Medicaid.

What action needs to be taken to prevent claims from denying on July 8, 2013?

Physicians – Make sure your DEA number is registered with DOJ and is on your enrollment file at Medicaid.

See ALERT on Medicaid's website dated May 16, 2013, for more details.

Eligibility Verification Enhancement- Providers Can Now Check to See the Status of a Recipient's Application

Providers can now check the application status for recipients to see if an application for Medicaid has been received. Using the Medicaid Secure Website, providers should go to eligibility, enter the recipient's Name and Date of Birth, or Name, Date of Birth and Social Security Number, and select Recipient Eligibility Status. The system checks application status for families, family planning, pregnancy (TXIX SOBRA), assistance with paying premiums and elderly and disabled. It will let the provider know if the application is pending, approved, **or** denied. This will help prevent duplicate applications and let a provider know the patient has applied for Alabama Medicaid.

Copayment Changes Effective July 1, 2013

(article continued from page 1)

- **Durable Medical Equipment (DME)**
  *(**examples of DME**: canes, crutches, walkers, wheelchairs, hospital beds, and oxygen equipment)*

  The copayment amount is:
  $3.90 for item reimbursed $50.01 and greater
  $2.60 for item reimbursed between $25.01 and $50.00
  $1.30 for item reimbursed between $10.01 and $25.00

- **Medical Supplies and Appliances**
  ***(example of supplies:** syringe with needle, alcohol wipes, ostomy pouch, tape, gauze)*
  ***(example of appliances:** hearing aids, orthoses (braces, supports, and other devices) and prostheses (replacement limbs and facial parts)*

  The copayment amount is:
  $3.90 for item reimbursed $50.01 and greater
  $2.60 for item reimbursed between $25.01 and $50.00
  $1.30 for item reimbursed between $10.01 and $25.00
  $0.65 for item reimbursed less than $10.00

- **Prescription Drugs**

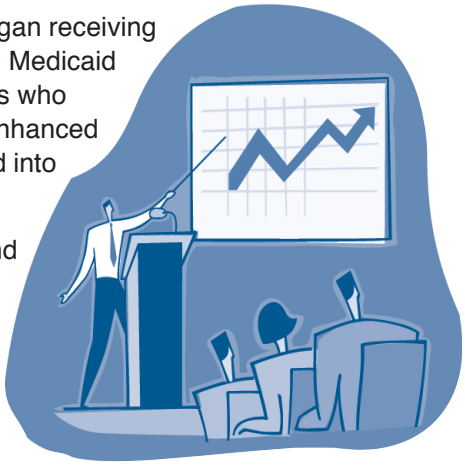
  The copayment amount is:
  $3.90 for prescription reimbursed $50.01 and greater
  $2.60 for prescription reimbursed between $25.01 and $50.00
  $1.30 for prescription reimbursed between $10.01 and $25.00
  $0.65 for prescription reimbursed less than $10.00

Copayment does <u>not</u> apply to services provided:

- to pregnant women
- to nursing facility residents
- to recipients less than 18 years of age
- to Native American Indians with an active user letter from Indian Health Services (IHS)
- for Emergencies
- for Family Planning

The provider may not deny services to any eligible Medicaid recipient because of the recipient's inability to pay the cost-sharing (co-payment) amount imposed.

Primary Care Physician Rate Increase (BUMP) to comply with ACA



As the result of the Affordable Care Act (ACA), eligible primary care physicians began receiving increased payments on June 8, 2013, for certain primary care services provided to Medicaid recipients between January 1, 2013 and December 31, 2014. Qualifying physicians who submitted their self-attestation to HPES on or after June 8, 2013, will be paid the enhanced reimbursement for dates of service beginning with the date the attestation is entered into the system by HPES.

In July 2013, Medicaid will begin reprocessing claims paid under the old rate and should have all reprocessing completed by the end of September 2013.

The primary care services subject to the increased payment are Current Procedural Terminology (CPT) Evaluation and Management procedure codes 99201 to 99499, and Vaccine Administration codes. The Alabama Medicaid Agency requires the VFC administration fees to be billed using the specific product code (vaccine codes).

These VFC codes are: 90633, 90636, 90645, 90647, 90648, 90649, 90650, 90655, 90656, 90657, 90658, 90660, 90669, 90670, 90680, 90681, 90696, 90698, 90700, 90702, 90707, 90710, 90713, 90714, 90715, 90716, 90721, 90723, 90732, 90733, 90734, 90744, and 90748.

Increased payment is also being made for primary care services rendered by physician assistants or certified nurse practitioners working under the personal supervision of a qualifying physician. In this case, the physician must assume professional/financial responsibility and is legally liable for the quality of services provided under his or her supervision.

Hospital UR Plans and MCE Study Reviews

Federal regulations require that hospitals submit Utilization Review (UR) Plans and Medical Care Evaluation Studies (MCE) annually as part of an ongoing quality improvement process. To that end, Alabama Medicaid has contracted with AFMC to perform annual reviews of hospital Utilization Review (UR) Plans and Medical Care Evaluation (MCE) Studies.

As the state's Quality Improvement Organization, AFMC is required to collect and maintain a copy of these documents on an annual basis. A review of 50 percent of the hospitals is to be done each year so that every hospital has a completed UR Plan and MCE Study every two years.

All in-state and border hospitals must submit MCE Studies (i.e. Performance Improvement Studies) and Utilization Review (UR) Plans to AFMC by the date requested. The Alabama Medicaid Agency monitors provider compliance in meeting this requirement, as part of the oversight process.

For more information refer to the Provider Manual Hospital Chapter 19, page 19-13 and the Administrative Code Chapter 7 Hospitals, Rule No. 560-X-7.16 (6).

Corrections and Addendum to January and April 2013 Article "Important Changes for Providers Performing Reconstructive/Cosmetic Procedures"

Coverage for the following CPT codes will continue without any age restriction: **57295** (Revision of prosthetic vaginal graft; vaginal approach) and **57296** (Revision of prosthetic graft; open abdominal approach).

CPT code **97033** (Application of a modality to 1 or more areas; iontophoresis, each 15 minutes) will be covered for crossover only claims effective August 1, 2013.

Photographs are not required for review when requesting prior authorization for CPT codes **54163** (Repair incomplete circumcision), **56620** (Vulvectomy simple; partial) and **56625** (Vulvectomy simple; complete). In lieu of photographs, a detailed written description documenting the condition/area to be corrected must be submitted along with other supporting documentation (progress notes, operative notes, etc.).

Modifiers Matter When Coding Multiple Procedures/Services on the Same Day

MODIFIER 25 SIGNIFICANT, SEPARATELY IDENTIFIABLE EVALUATION AND MANAGEMENT (E/M) SERVICE BY THE SAME PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL ON THE SAME DAY OF THE PROCEDURE OR OTHER SERVICE

The physician may need to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a **significant, separately identifiable E/M service above and beyond** the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. While there is not a requirement that you have two different diagnoses or reasons for performing two services (an E/M and a procedure) both services **must be documented and distinct.**

Example of correct use of Modifier 25

30-year-old female patient presents to the physician's office for a scheduled monthly injection of vitamin B-12. During the encounter, the patient complained of pain in bilateral ankles. The physician found during the examination that both ankles were swollen. The patient was given a prescription for a non-steroidal anti-inflammatory drug and was asked to return in 2 weeks. Due to the extra physician work that was required to examine the patient's ankles, obtain the history of the ankle problem, and the medical decision to treat, it would be appropriate to append modifier 25 to the E/M service.

MODIFIER 59 DISTINCT PROCEDURAL SERVICE

Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other non E&M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E&M services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician. However, **when another already established modifier is appropriate, it should be used rather than modifier 59**. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.

Example of correct use of Modifier 59

An oncologist performs a bone marrow aspiration, CPT code 38220, of the right iliac crest and a bone marrow needle biopsy of the sternum, CPT code 38221. Appending modifier 59 to 38220 is appropriate to represent a different site.

MODIFIER 76 REPEAT PROCEDURE OR SERVICE BY SAME PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL

The physician may need to indicate that a procedure or service was repeated subsequent to the original procedure or service. From a coding perspective, modifier 76 is intended to describe the same procedure or service repeated, rather than the same procedure being performed at multiple sites.

Example of correct use of Modifier 76

A cardiovascular surgeon performed a percutaneous thrombectomy, of the right upper arm arteriovenous fistula in the morning. Later that day, the fistula clotted and the same surgeon repeated the entire procedure again that evening.

ANATOMIC MODIFIERS

Anatomic-specific modifiers, designate the area or part of the body on which the procedure is performed.

When **eyelid** procedures are coded, instead of modifiers RT or LT, the procedure codes should be appended with modifiers:

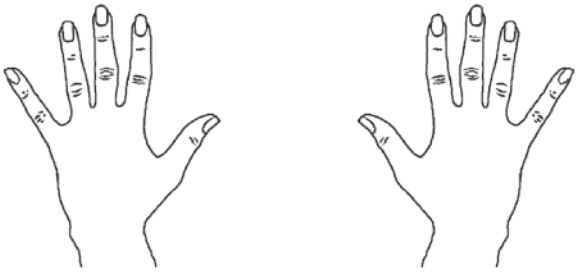
- **E1** Upper left, eyelid
- **E2** Lower left, eyelid
- **E3** Upper right, eyelid
- **E4** Lower right, eyelid

Example of correct use of eyelid modifiers

1. 67930 E1
2. 67935 E3

When **digits** of the **hands or feet** are coded, instead of modifier RT or LT, the procedure codes should be appended with:

FA Left hand, thumb
F1 Left hand, second digit
F2 Left hand, third digit
F3 Left hand, fourth digit
F4 Left hand, fifth digit
F5 Right hand, thumb
F6 Right hand, second digit
F7 Right hand, third digit
F8 Right hand, fourth digit
F9 Right hand, fifth digit

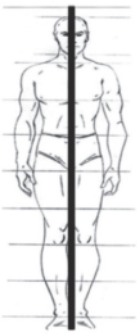


When coding procedures perform on either the right or left side of the body, the procedure codes should be appended with modifiers:

RT Right side
LT Left side

Example of correct use of Modifiers RT and LT

1. 69436 **RT**
2. 69436 **LT**



Sterilization Consent Form

It is the responsibility of the **performing surgeon** to submit a legible hard copy of the recipient's signed sterilization consent form to HP. Therefore, providers other than performing surgeon **should not** submit a copy of the consent form to HP. Receipt of multiple consent forms slows down the consent form review process and payment of claims. All blanks on the consent form must be completed with the only exceptions being the "Race and Ethnicity" and the "Title of the person obtaining consent" designation which is optional. Consent forms submitted to HP with missing and/or invalid information in non-correctable fields (signature and date of recipient and person obtaining consent) of the consent form will be denied by HP and not returned to the provider. Before sending the consent form to HP, it is imperative that the **date of surgery** be clarified by reviewing the operative note to remedy claim denials due to incorrect date of surgery. Consent forms should be mailed to:

HPES
PO Box 244032,
Montgomery, AL 36124-4032.
Attn: Medical Policy Unit/Consent Forms

Modifier 26 and CG for Physician Inpatient Professional Interpretation(s)

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. The procedure code must be billed with modifier **26** (Professional Component) and modifier **CG** (Policy criteria applied) appended. Please refer to the Alabama Medicaid Provider Manual, Chapter 28, for a list of inpatient professional interpretation services that are allowed in addition to a hospital visit.

Physician(s) **may not** bill for inpatient professional interpretation(s) 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.

Oncotype DX™

Effective for dates of service, July 1 and thereafter, Medicaid will cover the Oncotype DX™ genetic profiling lab test if the patient meets Medicaid's prior authorization criteria. Oncotype DX™ is a genetic profiling test developed to classify the risk of recurrence among women treated for early stage breast cancer.

The use of the 21-gene RT-PCR Assay (i.e., Oncotype DX™) to determine recurrence risk for deciding whether or not to undergo adjuvant chemotherapy meets Alabama Medicaid's medical criteria for coverage in women with early stage breast cancer with **ALL** of the following characteristics:

- Newly diagnosed, primary, early stage breast cancer (stage I or stage II) in a female without significant co-morbidities;
- Unilateral, non-fixed tumor;
- Hormone receptor positive (ER-positive or PR-positive);
- HER2-negative;
- Tumor size 0.6-1cm with moderate/poor differentiation or unfavorable features OR tumor size > 1cm;
- Node negative;
- Will be treated with adjuvant endocrine therapy, e.g., tamoxifen or aromatase inhibitors; AND
- When the test result will aid the patient in making the decision regarding chemotherapy (i.e., when chemotherapy is considered a therapeutic option); AND
- When ordered within 6 months following breast cancer diagnosis.

Limitations:

- The 21-gene RT-PCR Assay Oncotype DXTM should only be ordered on a tissue specimen obtained during surgical removal of the tumor and after subsequent pathology examination of the tumor has been completed and determined to meet the above criteria (i.e., the test should not be ordered on a preliminary core biopsy).
- The test should be ordered in the context of a physician-patient discussion regarding risk preferences when the test result will aid in making decisions regarding chemotherapy. This discussion must be documented in the patient's clinical record and a copy of the progress note (signed by the ordering physician) must accompany the PA request (Form 342).
- The Oncotype DXTM test will be limited to one per lifetime, per recipient.
- Repeat tests will not be covered.
- The test will be limited to the following diagnoses: malignant neoplasm of the female breast, carcinoma in situ of breast, and personal history of malignant neoplasm, breast.

Providers must bill procedure code S3854 (gene expression profiling panel for use in the management of breast cancer).

The Oncotype DX™ will be exempt from Patient 1st and EPSDT requirements. The Form 342 **must be** completely filled out, signed by the ordering physician and indicate the name and phone number of the ordering physician. The Form 342 will suffice as the prescription for the test. The test must be performed by an enrolled independent laboratory and ordered by a physician. Please contact Toni Hopgood at toni.hopgood@medicaid.alabama.gov for any questions.

Nerve Conduction Studies and Electromyography

Effective July 1, 2013 and thereafter, the following policy will apply to providers performing Nerve Conduction Studies and Electromyography: Nerve Conduction Studies (NCS) measure action potentials recorded over the nerve or from an innervated muscle. Nerve Conduction Velocity (NCV), one aspect of NCS, is measured between two sites of stimulation or between a stimulus and a recording site. It is axiomatic that neurodiagnostic studies are an extension of the history and physical examination of the patient and must be performed as part of a face-to-face encounter. Obtaining and interpreting nerve conduction velocities requires extensive interaction between the performing physician and patient and is most effective when both obtaining raw data and interpretation are performed together on a real-time basis.

Results of NCV reflect on the integrity and function of: 1) the myelin sheath {Schwann cell-derived insulation covering an axon}; and, 2) the axon {an extension of the neuronal cell body} of a nerve. Axonal damage or dysfunction generally results in loss of nerve or muscle potential amplitude, whereas demyelination leads to prolongation of conduction time.

The following are examples of appropriate clinical settings where nerve conduction studies are helpful in diagnosing:

- Focal neuropathies or compressive lesions such as carpal tunnel syndrome, ulnar neuropathies or root lesions for localization.
- Traumatic nerve lesions for diagnosis and prognosis.
- Diagnosis or confirmation of suspected generalized neuropathies, such as diabetic, uremic, metabolic, inflammatory or immune.
- Repetitive nerve stimulation in diagnosis of neuromuscular junction disorders such as myasthenia gravis and myasthenic syndromes.

F-wave studies are often performed in conjunction with motor NCS; H-reflex studies involve both sensory and motor nerves and their connections with the spinal cord. The device used must be capable of recording amplitude, duration, response configuration (motor NCV) and latency and sensory nerve action potential amplitudes (sensory NCV).

Electromyography (EMG) is the study of intrinsic electrical properties of skeletal muscle utilizing insertion of a (frequently disposable) needle electrode into muscles of interest. EMG testing relies on both auditory and visual feedback from the electromyographer. EMG results reflect not only the integrity of the functioning connection between a nerve and its innervated muscle, but on the integrity of the muscle itself. The device used must be capable of recording motor unit recruitment, amplitude, configuration, spontaneous and insertional activity. Use for intraoperative monitoring of central nervous system tissue during the resection of benign and malignant neoplasia and during corrective surgery for scoliosis may also be needed.

The axon innervating a muscle is primarily responsible for the muscles' volitional contraction, survival and trophic functions. Prime examples of diseases characterized by abnormal EMG are disc disease with abnormal nerve compression, amyotrophic lateral sclerosis and neuropathies. Axonal and muscle involvement are most sensitively detected by EMGs, and myelin and axonal involvement are best detected by NCV.

Use of EMG with Botulinum Toxin Injection

EMG may be used to optimize the anatomic location of botulinum toxin injection. It is expected there will be one study performed per anatomic location of injection, if needed. It is expected that the accompanying study to the injection be billed as a limited study (95874) unless supportive documentation is noted to show why more extensive studies are indicated.

Limitations

- Sensory nerve function testing performed with various sensory discrimination and pressure-sensitive devices, including but not limited to current perception testing (e.g., Neurometer®), is not covered. Do not report such testing as nerve conduction testing using any CPT code included in this Policy.
- Nerve conduction studies and EMG will not be covered if provided in the beneficiary's home.

Providers shall consider a service to be reasonable and necessary if the provider determines that the service is:

- Safe and effective.
- Not experimental or investigational (exception: routine costs of qualifying clinical trial services with dates of service on or after September 19, 2000, which meet the requirements of the clinical trials NCD are considered reasonable and necessary).
- Appropriate, including the duration and frequency that is considered appropriate for the service, in terms of whether it is:
  - o Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member.
  - o Furnished in a setting appropriate to the patient's medical needs and condition.
  - o Ordered and furnished by qualified personnel.
  - o The EMG must always be ordered, performed and interpreted by a physician trained in electrodiagnostic medicine.
  - o The NCS may be performed by a physician or a trained allied health professional working under the direct supervision of a physician trained in electrodiagnostic medicine. The American Association of Neuromuscular and Electrodiagnostic Medicine (AANEM) states, "NCSs should be either (a) performed directly by physician or (b) performed by a trained individual under the direct supervision of a physician. Direct supervision means that the physician is in close physical proximity to the EDX laboratory while testing is underway, is immediately available to provide the trained individual with assistance and direction, and is responsible for selecting the appropriate NCSs to be performed". One that meets, but does not exceed, the patient's medical need.
  - o At least as beneficial as an existing and available medically appropriate alternative.

Documentation Requirements

Documentation supporting the medical necessity should be legible, maintained in the patient's medical record and made available to Medicaid upon request.

It is expected that the (Nerve Conduction Velocity) NCV and EMG reports will contain data from the study as well as the interpretation and diagnosis.

- In the event of a review for medical necessity, the patient's medical record must support the need for the studies performed. The number of limbs or areas tested should be the minimum needed to evaluate the patient's condition. Repeat testing should be infrequent; limitation of testing services will be determined on the basis of individual medical necessity.
- Documentation addressing the need to evaluate the patient for peripheral neuropathy must be maintained by the practitioner and available upon request.
- Documentation addressing the indications and circumstances requiring individual nerve conduction studies (without accompanying EMG) must be maintained by the practitioner, and made available upon request.
- Credentials of providers billing for needle electromyography must be made available on request. According to the AANEM American Association of Neuromuscular & Electrodiagnostic Medicine, the EMG must be performed and interpreted by a physician who received training during residency and/or in special EDX fellowships after residency. Knowledge of EDX medicine is necessary to pass the board exams given by the American Board of Physical Medicine and Rehabilitation and the American Board of Psychiatry and Neurology.
- The NCS may be performed by a physician or by a trained allied health professional under direct supervision of a physician trained in electrodiagnostic medicine; although always interpreted by a credentialed physician..
- The record must reflect the need for EMG to localize the optimal injection site for the botulinum toxin.

Medicaid would not expect to see multiple uses of EMG in the same patient at the same location for the purpose of optimizing botulinum toxin injections.

Medicaid does not expect to see nerve conduction testing accomplished with discriminatory devices that use fixed anatomic templates and computer-generated reports used as an adjunct to physical examination routinely on all patients.

Note: Medicaid requires the medical necessity for each service reported to be clearly demonstrated in the patient's medical record.

For any questions, contact Toni Hopgood via e-mail at toni.hopgood@medicaid.alabama.gov.

Prevnar 13

Medicaid currently covers Prevnar 13 through the Vaccines for Children program for children 0-5 years of age with no restrictions. Effective beginning date of service June 1, 2013, and thereafter Medicaid will cover Prevnar 13 vaccine for ages 6 years and above who are at high risk for invasive pneumococcal disease because of:

- Anatomic or functional asplenia (sickle cell disease, other hemoglobinopathies, congenital or acquired asplenia, or splenic dysfunction)
- Immunocompromising conditions (HIV infection, chronic renal failure/nephrotic syndrome, congenital immunodeficiency, diseases associated with treatment with immunosuppressive drugs/radiation therapy, including malignant neoplasms, leukemias, lymphomas, and Hodgkin disease; or solid organ transplant)
- Cochlear implant
- Cerebrospinal fluid (CSF) leaks.

Please note: Prevnar 13 should be ordered through the vaccines for children program for children 0-18 years of age.

If you have any further questions, contact Toni Hopgood at toni.hopgood@medicaid.alabama.gov or Jerri Jackson at jerri.jackson@medicaid.alabama.gov.

Lead Screening Guidelines

Lead Screening guidelines have been revised in Appendix A (EPSDT) of the Provider Manual. Please review these guidelines in this version of the Provider Insider. If you have further questions, please contact Toni Hopgood at toni.hopgood@medicaid.alabama.gov.

Attention: Nursing Home Providers Tips for an Efficient Medical Review

- Please accurately complete the Admission and Evaluation Data (Form 161) in its entirety. This includes documenting the **Name, Medicaid Number and Date on pages 2 and 3 of the form.** If the recipient is a spend down, please check spend down on the form and give the dates of the spend down status.

- Please ensure that the Medicaid date is documented correctly on the Form 161. When the physician signs the form he/she is stating that "I certify this resident requires nursing facility care effective on the admission date appearing on this form".

- The facility is not required to send the entire medical record, only information that supports the request for LTC.

- Initial audit requests and requests for additional information **must** be submitted timely to avoid any penalties as referenced in the Administrative Code **Rule Number Rule No. 560-X-10-. 07. Review of Medicaid Residents.**

- If unstable medical condition is the qualifying criterion (criterion G), the medical record must contain information to support the condition and the active treatment rendered within 60 days prior to admission.

- PRN Oxygen is not covered; must submit MAR showing regular usage.

- Multiple criteria under K will count as one criterion.

- When criteria K is checked on Form 161, please submit at least 1 week of nurse's notes or ADLS flow sheets, approximately 1 week prior to the Medicaid admission date if transferring from Medicare to Medicaid. This information can also be documented on Form 161 under the section of Diagnosis and Pertinent Medical Information.

- Submit the full MDS prior to and closest to the Medicaid admission date.

- Cannot mark A and K7,
  MUST BE ONE OR THE OTHER.

- Cannot mark G and K9,
  MUST BE ONE OR THE OTHER.

- If the recipient is out in the community greater than 30 days, then the recipient will be a new admission and must meet at least two criteria.

- Transfer from out of state will require two criteria – Cannot use preadmission screening information from another state.

Look Up Feature for Operating Performing or Referring (OPR) Providers

Providers may now check to see if another provider is on file with Medicaid.

Providers should access the Medicaid Secure Website. Provider should click on the 'Providers' tab at the far right corner. The provider's NPI or license number is required to perform the search. The system will display the name, location and indicate if the provider is active/inactive. If a provider has multiple locations with both active and inactive locations, the system will list the first active location match in the HP claims processing system.

Effective April 1, 2013, replacement for lost, stolen or broken glasses for adults will not be covered due to budget constraints. Any claims submitted prior to April 1, 2013 can be processed (excluding the period June 1, 2012 - October 31, 2012 when there was no coverage for adults).

Important Password Requirements for Medicaid Secure Website

Effective July 23, 2013, new password requirements will be implemented for providers using the Medicaid Secure Website.

The password requirements will be as follows:

Password must be at least 8 characters in length and must contain 3 of the 4 requirements below:

- One lower case value (b)
- One upper case value (B)
- One numeric value (6)
- One Special Character (~!@#$%^&*_+-=`I\(){}[]:;”<>,.?/)

If your password does not currently meet the requirement, you will be required to use the new password requirements when your current password expires. Passwords must be updated every sixty days. If you have any questions, please contact the Electronic Media Helpdesk at 1-800-456-1242.

Proper Claim Filing for Unclassified Drugs

A provider who administers a physician drug not listed should use the following J Codes:

J3490 – Unclassified drugs

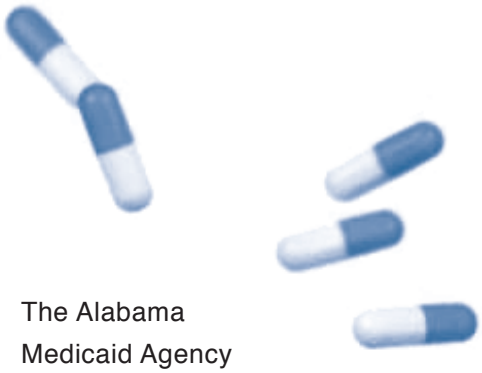
J3590 – Unclassified biologics

J9999 – Not otherwise classified, antineoplastic drug

Providers should submit an original red drop-out CMS-1500 claim with the complete name of the drug, total dosage that was administered and a National Drug Code (NDC) number. Please be sure to search the Physician Drug List to see if the drug is possibly under a generic name. The claims containing the unclassified procedure code must be sent to:

HPES, Attn: Medical Policy
PO Box 244032
Montgomery, AL 36124-4032

HPES will determine the price of the drug.



The Alabama Medicaid Agency supports the avoidance of wasted (discarded) medicine whenever possible. Medicaid accepts the use of modifier JW on a second line item to indicate the wasted (discarded) amount of medication.

Provider Assistance for:

- Ambulance
- Ambulatory Surgical Centers
- CRNA
- Chiropractors
- Dental
- DME
- EPSDT (Physicians)
- ESWL
- Free Standing Radiology
- FQHC
- Hearing Services
- Waiver Services
- Home Health
- Hospice
- Hospital
- Independent Labs
- Maternity Care
- Mental Health
- Nursing Home
- Nurse Midwives
- Nurse Practitioners
- Opticians
- Optometrists
- PEC
- Personal Care Services
- Physicians
- Podiatrists
- Prenatal Clinics
- Private Duty Nursing
- Public Health Including:
  - Elderly and Disabled Waiver
  - Home and Community Based Services
  - EPSDT
  - Family Planning
  - Prenatal
  - Preventive Education Rehab Services
  - Home Bound Waiver
  - Therapy Services (OT, PT, ST)
  - Children's Specialty Clinics
- Renal Dialysis Facilities
- Rural Health Clinic
- Swing Bed

HP PROVIDER REPRESENTATIVES

ALEETRA ADAIR
aleetra.adair@hp.com
855-523-9170 Ext. 2334587

ARACELI WRIGHT
araceli.f.wright@hp.com
855-523-9170 Ext. 2334560

SHERMERIA HARDY-HARVEST
shermeria.harvest@hp.com
855-523-9170 Ext. 2334586

Debbie Smith
debbie.smith2@hp.com
855-523-9170 Ext. 2334581

MISTY NELSON
misty.nelson@hp.com
855-523-9170 Ext. 2334578

SHAMEKIA PENA
shamekia.pena@hp.com
855-523-9170 Ext. 2334588

GAYLE SIMPSON-JONES
gayle.simpson-jones@hp.com
855-523-9170 Ext. 2334582

MELISSA GILL
Melissa.gill@hp.com
855-523-9170 Ext. 2334589

TORI TILLERY-DENNIS
tori-tillery-dennis@hp.com
855-523-9170 Ext. 2334583

Alabama Medicaid Bulletin

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Montgomery, AL 36124-4032

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MONTGOMERY AL

2013 State Checkwrite Schedule

07/05/13	10/18/13	02/07/14
07/19/13	11/01/13	02/21/14
08/02/13	11/15/13	03/07/14
08/16/13	12/06/13	08/16/13
09/06/13	12/13/13	03/21/14
09/13/13	01/03/14	04/04/14
10/04/13	01/17/14	04/18/14

The release of funds is normally the second Monday after the RA date. Please verify direct deposit status with your bank. Go to *www.medicaid.alabama.gov* to view the payment delay update details. Payment alerts will be posted only if there will be a payment delay. As aways, the release of direct deposits and checks depends on the availability of funds.

Provider Insider

Alabama Medicaid Bulletin October 2013

10/04/13 • 10/18/13 • 11/01/13 • 11/15/13 • 12/06/13 • 12/13/13
01/03/14 • 01/17/14 • 02/07/14 • 02/21/14 • 03/07/14 • 03/21/14 • 04/04/14 • 04/18/14
As always, the release of direct deposits and checks depends on the availability of funds.

Agency Employs Multiple Strategies to Save Money, Preserve Access

By employing a combination of financial, clinical and administrative strategies, Alabama Medicaid officials hope to cut approximately $11 million in state dollars from its pharmacy program in FY 2014 while still providing access to most critical medications for more than 600,000 Medicaid recipients who qualify for drug coverage each year.

The first cost-cutting measures were implemented July 1 and included reimbursement changes for compounded drugs, increased co-payments on drugs and a change to prevent stockpiling of medications via early refills. The three measures are estimated to save about $1 million in state funds during the 2014 fiscal year.

The next round of changes will start October 1 and include an end to coverage of most over-the-counter drugs. Other measures set to begin on October 1 are a change to the Agency's "lower of" payment methodology and expanded efforts of the Agency's Drug Utilization Review board. Prescription drug limits and a mandatory three-month supply for certain drugs used to treat selected chronic diseases will be phased in to begin January 1, 2014. Together they are projected to save $11.1 million during FY 2014.

One of the most visible changes will be the limit on prescription drugs for adults and a mandatory dispensing of a three month supply of certain drugs. Adult recipients will be limited to a total of five drugs per month, four of which may be brand-name drugs. However, recipients who require anti-psychotic, anti-epileptic (seizure) and/or anti-retroviral (HIV/AIDS) drugs will be allowed to have up to 5 additional (10 total) brand-name or generic versions of these drugs per month.

Additionally, the Agency is phasing in the drug limits to allow prescribers, pharmacists and recipients to find the best schedule for the recipient, according to Director of Clinical Services and Support, Kelli Littlejohn, Pharm.D.

"While the prescription limit for adults may be challenging, the Agency is also implementing a mandatory three-month supply of certain medications for chronic disease states such as hypertension, diabetes, depression, asthma, thyroid disease, and high cholesterol as well as contraceptives," she said. "The three month supply will only be applied to the recipient's prescription limit during the month in which the drug is dispensed, however. Not only will this provide flexibility for the recipient, we also hope that this will benefit recipients who may have transportation or other barriers to timely refills."

Article continued on page 2

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Pass It On!

Everyone needs to know the latest about Medicaid. Be sure to route this to:

- ❒ *Office Manager*
- ❒ *Billing Department*
- ❒ *Medical/Clinical Professionals*
- ❒ *Other* _____

EPSDT Referral on Inpatient (UB-04) Claim Form

An EPSDT-referring provider number is not required on an inpatient claim form (UB-04). The A1 condition code **is** required on all inpatient claims that are EPSDT referred.

Vaccines for Children Update

The following vaccines have been added to the VFC list in Appendix A:

90672 Influenza Virus Vaccine, quadrivalent, live, for intranasal use effective 08/01/13 (0-18 years).

90685 Influenza Virus Vaccine, quadrivalent, Split Virus, Preservative Free, when administered to children 6-35 months of age, for intramuscular use effective 7/01/2013 (age 6-35 months).

90686 Influenza Virus Vaccine, quadrivalent, Split Virus, Preservative Free, when administered to individuals 3 years of age and older, for intramuscular use effective 7/01/2013 (age 3-18 years).

Summary of Changes - Medicaid Pharmacy Program

- **July 2013**
  - Compounding Changes
    - Compounding time no longer reimbursed
    - Most bulk products not covered for adults
    - Change in how claims for bulk powders are submitted
    - Maximum $200 payment for compounded products without prior approval
  - Increased co-payments for drugs based on drug cost
    - From 50 cents - $3, to 65 cents - $3.90)
  - Edits to prevent stockpiling of drugs via early refills
- **October 2013**
  - Phase-in period for Prescription Drug Limit for adults begins
  - Phase-in period for Three Month supply for certain drugs begins
  - End coverage of OTC drugs for adults and children (Insulin and Nutritionals excluded)
  - Expansion of Agency's Drug Utilization Review Board activities
  - Change to Agency's "lower of" reimbursement method so that Wholesale Acquisition Cost (WAC) is changed from WAC+9.2% to WAC+0%
- **January 2014**
  - Prescription Drug Limit for adults goes into effect
    - Five total drugs per month, four of which may be brand-name drugs
    - Up to five additional (10 total) for brand-name and generic anti-psychotic, anti-epileptic (seizure) and/or anti-retroviral (HIV/AIDS) drugs

Attention Patient 1st Providers

If you are enrolled as a group provider to receive your Patient 1st assignments or if you are a physician not part of a group and enrolled with Medicaid individually, you may now log on to the Medicaid Secure Website and change a recipient's Patient 1st doctor. The secure website is available at the following location: **https://www.medicaid.alabamaservices.org/ALPortal/Account/Secure%20Site/tabId/66/Default.aspx.** This site may be linked from the Medicaid website using the drop-down menu under Providers.

Providers should then access the following path: **providers/PMP assignment**
A recipient's Medicaid number, or name and date of birth or date of birth and SSN must then be entered to request the change. The same criteria for patient's assignments must still be met. Providers will have the capability to override panel holds, age restrictions, and gender restrictions set by the PMP. The provider's PMP panel must be open, and the caseload not be met at the time the assignment is being made. Providers will not be allowed to override the following restrictions in addition to some other restrictions:

Recipient is locked into another physician (Not a Patient 1st assignment)
Recipient has been previously dismissed from PMP attempting to make the assignment
Requesting provider is not a Patient 1st participating provider
PMP panel at contractual maximum limit
Recipient is not currently eligible for the Patient 1st program

If the change is made by the 15th of the month, the effective date of the Patient 1st change will be the 1st day of the next month. If made after the 15th, it will be effective the following month. This eliminates the need to fax or e-mail Patient 1st change requests to HP Enterprise Services, and assures you the change has been made. In the future, the system will be modified so that all Patient 1st providers will be able to access the Medicaid Secure Website to make Patient 1st changes. Providers will be notified when modifications are completed. If you have any questions, please contact Provider Assistance Center at 1-800-688-7989.

Revised Form 340B (Medicaid/Medicare Related Claim Form)

When submitting Medicare/Medicaid related claims that MUST be sent on paper, effective October 28, 2013, providers must use a revised copy of Form 340B. The forms are available through HP Enterprise Services at no charge by calling 1-800-688-7989.

The following fields are changing:
Section 2 Other Insurance Information-added fields for TPL information
Section 3 Diagnosis Codes Expanded to 12 fields (A-L)
Section 4 Version Indicate version of diagnosis code, ICD-9 /ICD-10
Section 5 F Mod Providers may now enter up to 4 modifiers
Section 5 G DIAG PTR Providers may now enter up to 4 diagnosis pointers on a line item

Do not write in this space. Do not use red ink to complete this form.

MEDICAL
MEDICAID/MEDICARE
RELATED CLAIM

1. RECIPIENT INFORMATION

a. Medicaid ID	
b. First Name	
c. Last Name	
d. Med. Rec. #	
e. Patient Acct. # (Optional)	

2. OTHER INSURANCE INFORMATION

a. Covered by other insurance (Except Medicare)? Enter Y if yes or N if no	
b. If other insurance rejected, attach rejection to completed claim and mail to HP and enter date TPL was denied here (MM/DD/YY).	
c. If other insurance paid, attach the completed Medicaid Other Insurance Attachment form (ALTPL01) and mail to HP.	

3. DIAGNOSIS CODES

A._____ B._____ C._____ D._____ E._____ F._____
G._____ H._____ I._____ J._____ K._____ L._____

4. VERSION: 9=ICD-9, 0=ICD-10 ☐

5. DETAIL OF SERVICES PROVIDED

	a. DATES OF SERVICE		b. POS	c. NDC	e. UNIT	f. MOD	g. DIAG PTR	h. CHARGES	MEDICARE			
	FROM	THRU		d. PROCEDURE CODE					i. ALLOWED	j. COINS.	k. DEDUCTIBLE	l. PAID
1												
2												
3												
4												
5												
6												
7												
8												
9												
							6. TOTALS	a.	b.	c.	d.	e.

It is not necessary to attach Medicare EOMB to this claim unless claim dates of service are over one year old AND Medicare payment is less than 120 days old.

7. Billing Provider Name	a.			
7. Billing Provider ID	b. NPI	c. Taxonomy	d. Qu	e. Secondary ID
8. Performing Provider Name	a.			
8. Performing Provider ID	b. NPI	c. Taxonomy	d. Qu	e. Secondary ID

Submit completed claim to:

HP
Post Office Box 244032
Montgomery, AL 36124-4032

9. Billing Provider mailing address required in block below:

Form 340 Revised 10/12

Form ALTPL-01 10/12 Medicaid Other Insurance Attachment

When providers submit a claim on paper for a recipient with other insurance and a payment has been made, effective October 28, 2013 providers must use the Medicaid Other Insurance Attachment form (ALTPL-01). The TPL attachment form has been created for submitting paper claims and reporting the following other payer information: paid amount, deductible amount, coinsurance amount and co-pay amount. This form will be required with the CMS 1500 form when third party applies to a claim. The forms are available free of charge and may be ordered by calling the Provider Assistance Center at 1-800-688-7989.

When Should This Attachment Be Used?
This attachment should only be used when a provider must submit a claim on paper and the provider needs to submit information regarding the amounts processed by the other payer: paid amount, deductible amount, coinsurance amount, co-pay amount (For example, third party PAID or applied all the allowed charges to patient responsibility but an administrative review is needed on the claim). **Please remember, Medicaid requires claims be submitted electronically unless an administrative or manual review is required. The majority of these claims will continue to be submitted electronically.**

Claims with third party denials should continue to be submitted in this fashion:
• Indicate TPL denial on the claim in the appropriate block/form locator (for example, Block 19 of CMS-1500 claim form)
• Attach TPL denial to the error free claim for processing

Providers are now able to submit more claims electronically when the other payer paid **or when the other payer applied the charges to patient responsibility.** A provider can now submit a claim for TPL electronically when the other payer pays zero, but the patient responsibility is greater than zero. This can include:

- If any amount greater than zero is entered in the other payer co-pay field, and/or
- If any amount greater than zero is entered in the other payer deductible field, and/or
- If any amount greater than zero is entered in the other payer coinsurance field

In order for claims with TPL to be considered for payment, the patient responsibility must be greater than zero. Patient responsibility is calculated by adding together any co-payments, co-insurance and deductible. Claims that do not contain a patient responsibility will deny with error status code 631 (TPL Patient Responsibility is Zero for Payer). When calculating payment methodology for claims with TPL primary, Medicaid will pay the lesser of patient responsibility or Medicaid allowed amount minus TPL paid amount for professional claims only. All other claim types will continue to price as usual at this time. If you have any questions, please contact the Provider Assistance Center at 1-800-688-7989.

Do not write in this space. Do not use red ink to complete this form.

MEDICAID
OTHER INSURANCE ATTACHMENT

1. Billing Provider ID	a. NPI	Name	b.
2. Medicaid ID	a.	Name	b.

3. List other payors in order of responsibility. Sequence 1=Primary, 2=Secondary, 3=Tertiary

SEQ	a. HEALTH PLAN ID	b. PAYOR NAME AND ADDRESS	c. POLICY NUMBER	d. DATE PAID
1.				
2.				
3.				

4. Indicate TPL payment amounts per claim detail. (Note: For header amount on Institutional claims use detail number 0.)

a. DTL	b. PAYOR SEQ	c. COPAY	d. COINSURANCE	e. DEDUCTIBLE	f. TPL PAID

Submit completed claim to:

HP
Post Office Box 244032
Montgomery, AL 36124-4032

Form ALTPL-01 10/12

PERM Reviews Are Underway

The Payment Error Rate Measurement (PERM) program measures improper payments in Medicaid and the State Children's Health Insurance Program (SCHIP) and produces state and national-level error rates for each program. PERM audits authorized by the Centers for Medicare & Medicaid Services (CMS) are underway for FY13. APlus Government Solutions, CMS PERM contractor, has begun requesting medical records from providers. If contacted by APlus, it is very important for providers to comply with the requests and submit documentation in a timely manner. Providers should ensure records are legible and complete (i.e. physician signatures, correct dates, treatments plans, progress notes, etc.). For questions, please contact Patricia Jones (334) 242-5609, PERM Program Manager.

Synagis® Criteria for 2013-2014 Season

ATTENTION ALL PROVIDERS:

- The Alabama Medicaid Agency has updated its prior authorization criteria for the Synagis® 2013-2014 season. Below are some highlights for the season. Complete criteria can be found on the website at the following link:

  http://medicaid.alabama.gov/CONTENT/4.0_Programs/4.5.0_Pharmacy/4.5.14_Synagis.aspx

- The approval time frame for Synagis® will begin October 1, 2013 and will be effective through March 31, 2014.
- Up to five doses will be allowed per recipient in this time-frame. Some recipients may only receive up to a max of 3 doses, depending on the gestational and chronological age.
- There are no circumstances that will result in approval of a sixth dose.
- If a dose was administered in an inpatient setting, the date the dose was administered must be included on the request form.
- For approval of requests, the recipient must meet gestational and chronological age requirements. In order to meet chronological age requirements, the recipient must not exceed the specified age at the start of the RSV season.
- Prescribers, not the pharmacy, manufacturer or any other third party entity, are to submit requests for Synagis® on a separate prior authorization form (Form 351) directly to Health Information Designs and completed forms may be accepted beginning September 3, 2013 (for an October 1 effective date).
- Stamped or copied physician signatures will not be accepted and will be returned to the provider.
- A copy of the hospital discharge summary from birth or documentation of the first office visit with pertinent information (gestational age, diagnosis, etc.) is required on all Synagis® PA requests.
- If approved, each subsequent monthly dose will require submission of the recipient's current weight and last injection date and may be faxed to HID by the prescribing physician or dispensing pharmacy utilizing the original PA approval letter.
- Letters will be faxed to both the prescriber and the dispensing pharmacy notating approval or denial.

CRITERIA

Alabama Medicaid follows the 2012 American Academy of Pediatrics (AAP) Redbook guidelines regarding Synagis® utilization. Additional questions regarding Synagis® criteria can be directed to the Agency's Prior Authorization contractor, Health Information Designs at 1-800-748-0130.

ICD-10 Information for Providers Using Medicaid Interactive Web Portal to Submit Claims

Alabama Medicaid is planning to implement ICD-10 coding changes as early as October 28, 2013, but will not require nor accept ICD-10 codes until the federal mandate date of October 1, 2014. When Alabama Medicaid implements changes related to ICD-10, providers will be able to view ICD-10 diagnosis codes when performing diagnosis and surgical procedure code searches in the Medicaid Interactive Web Portal. ICD-10 codes should not be submitted on claims until you are instructed to begin using them. Submitting a claim with an ICD-10 code before the federal mandate date will cause your claims to deny.

Upcoming NCCI Edits for Evaluation-and-Management Services Billed with Surgical Procedures

On October 1, 2013 the Medicaid National Correct Coding Initiative (NCCI) will add over 300,000 Procedure-to-Procedure (PTP) edits that pair some evaluation-and-management (E&M) CPT codes in the code ranges 99201 - 99499 and 92002 - 92014 as column two codes with all surgical procedure codes (over 5,000 codes). These edits were implemented in the Medicare NCCI program on July 1, 2013.

Ordering/Referring Provider's NPI Must Be Present on Claims

Effective October 1, 2013

Code of Federal Regulations (42 CFR 455.440) requires all claims for the payment of items and services that are ordered, referred, or prescribed to contain the National Provider Identifier (NPI) of the physician or other professional who ordered, referred, or prescribed such items or services.

Effective for claims received on or after October 1, 2013, all Medicaid claims from laboratories, imaging centers, X-ray clinics, home health agencies, and durable medical equipment providers MUST have the NPI of the ordering/referring provider. If the ordering/referring provider operates at more than one location, the legacy Medicaid number should also be provided and will be a required entry for proper claims processing.

There are three basic requirements:

1. The physician or non-physician practitioner must be en rolled in Medicaid as either a regular Medicaid provider or as an OPR provider.
2. The NPI used must be for an individual physician or non-physician practitioner and cannot be an organizational NPI.
3. Interns and non-licensed residents must use the NPI of the teaching, admitting, or supervising physician on the claim for reimbursement. If the resident has a medical license, then the resident must be enrolled with Medicaid and the NPI of the resident must be used on the claim for reimbursement.

Attention Physicians and Non-physician Practitioners:

You must furnish your NPI on all orders/referrals for laboratory, imaging services, home health services, and durable medical equipment.
The laboratory facility, the radiology/imaging center, the pharmacy, the home health agency, and the medical supply company will always need the NPI of an ordering/prescribing/referring physician or non-physician practitioner in order to submit their claims for payment to the Medicaid program.

An enrollment application is available for those providers who do not treat Alabama Medicaid recipients for payment, but who do order, prescribe, or refer. These providers will be enrolled as an OPR provider. Medicaid will not make payment to an OPR provider but will recognize their NPI for services rendered by participating Medicaid providers. An abbreviated enrollment application is located on the Alabama Medicaid Agency website at the following link in the Administrative Forms section:

http://medicaid.alabama.gov/CONTENT/5.0_Resources/5.4_Forms_Library/5.4.6_Provider_Enrollment_Forms.aspx

Providers can check to see if an ordering or referring provider is enrolled with Medicaid through the Medicaid Secure Website. Providers may search using an NPI or license number of a provider. This is available on the Providers/Provider Search tab using the following link. **https://www.medicaid.alabamaservices.org/ALPortal/Account/Secure%20Site/tabld/66/Default.aspx**

ATTENTION: HOSPICE PROVIDERS

REMINDER: Claims Processing for the Hospice Program

For a dually eligible recipient in a nursing home, if financially eligible, the hospice provider is on the Level of Care panel. Medicaid reimburses the hospice provider, for every day service is rendered, 95% of the nursing home rate applicable for that year for the room and board that would have been paid to the nursing home (Revenue Code 659/Procedure Code T2046-SE). Hospice bills Medicare for routine care services.

New Information on Eligibility Requests To Display

Affordable Care Act (ACA) Section 1104 requires standards be applied in the eligibility verification response (271) in order to enable the determination of an individual's eligibility benefits and financial responsibility for specific services prior to or at the date of service.

Effective October 28, 2013, providers will now have the option of viewing all recipient eligibility information (information currently displayed) or specifying certain types of coverage information. Additionally, copayment information will also display for providers. ***As always, providers should check eligibility PRIOR to rendering any services.*** Currently, the eligibility response returns the benefit plan information and limitation information. This information will continue to be returned, but will be modified to accept and process multiple service type codes.

Providers need to refer to the specific chapter in their billing manuals for coverage restrictions, as not all services are covered for all recipients. Providers should refer to the billing manual for:

- Copayment exemptions
- Copayment exceptions
  - o The maximum copayment amount will display for the benefit type selected
- The information displayed is general coverage information and general copayment requirements.

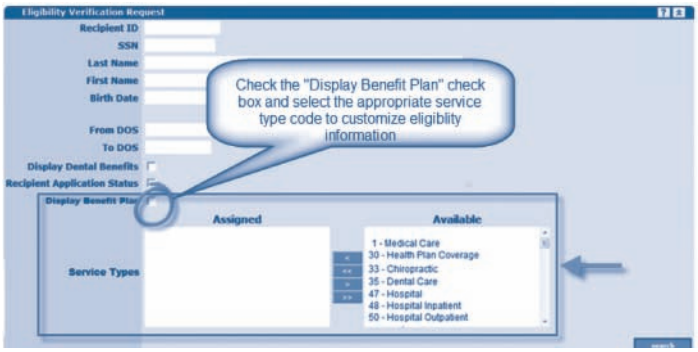
For providers that have varying copayments amounts, refer to the provider manual for specific information.

If you use a vendor to check recipient eligibility, please contact your software vendor regarding the changes and how they affect your office.

Medicaid Interactive Web Portal Changes for Eligibility Requests

If you use Medicaid's Interactive Web Portal, the following information is changing:

Providers will now see additional information displayed on the eligibility verification request panel. (See below). If a provider wants to view all information as they currently do, DO NOT check the box next to 'Display Benefit Plan'. If a provider wants to customize the eligibility information, then check the box and select the most appropriate service type code.

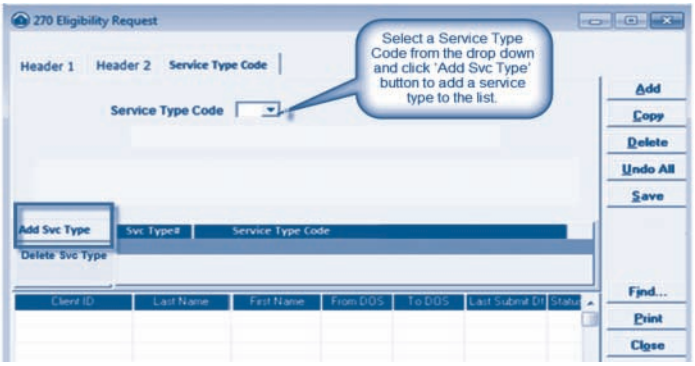


Copayment information will be returned regardless of the service type code selected

Provider Electronic Solutions Changes for Eligibility Requests

If you use Provider Electronic Solutions to verify eligibility, the following information is changing:

A new "Service Type Code" tab is available on the Eligibility Verification Request form. If a provider does not access this tab during the eligibility process, then ALL information for eligibility will display. If a provider accesses this tab, they may customize the type of service codes they wish to view.



Automated Voice Response System Changes for Eligibility Requests

Providers will be able to select the service type codes they wish to retrieve, or select 30 for information currently displayed.

Generic Service Type Codes for Eligibility Requests

A **generic** inquiry request is defined as a request for eligibility information for the service type – 30 (Health Benefit Plan Coverage). Medicaid is adopting the ACA standard codes only, which include:

Codes continued on page 8

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

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Explicit Service Type Codes for Eligibility Requests

An **explicit** inquiry request is defined as a request for eligibility information for any service type other than 30. The service type codes associated with an explicit request are listed here:

Svc Type Code	Description
1	Medical Care
2	Surgical
4	Diagnostic X-Ray
5	Diagnostic Lab
6	Radiation Therapy
7	Anesthesia
8	Surgical Assistance
12	Durable Medical Equipment Purchase
13	Facility
18	Durable Medical Equipment Rental
20	Second Surgical Opinion
33	Chiropractic
35	Dental Care
40	Oral Surgery
42	Home Health Care
45	Hospice
47	Hospital
48	Hospital - Inpatient
50	Hospital - Outpatient
51	Hospital - Emergency Accident
52	Hospital - Emergency Medical
53	Hospital - Ambulatory Surgical
62	MRI/CAT Scan
65	Newborn Care
68	Well Baby Care
73	Diagnostic Medical

Svc Type Code	Description
76	Dialysis
78	Chemotherapy
80	Immunizations
81	Routine Physical
82	Family Planning
86	Emergency Services
88	Pharmacy
93	Podiatry
98	Professional (Physician) Visit - Office
99	Professional (Physician) Visit - Inpatient
A0	Professional (Physician) Visit - Outpatient
A3	Professional (Physician) Visit - Home
A6	Psychotherapy
A7	Psychiatric Inpatient
A8	Psychiatric Outpatient
AD	Occupational Therapy
AE	Physical Medicine
AF	Speech Therapy
AG	Skilled Nursing Care
AI	Substance Abuse
AL	Vision (Optometry)
BG	Cardiac Rehabilitation
BH	Pediatric
MH	Mental Health
UC	Urgent Care

If you have questions, please contact the Provider Assistance Center at 1-800-688-7989.

Provider Insider

Alabama Medicaid Bulletin January 2014

01/03/14 • 01/17/14 • 02/07/14 • 02/21/14 • 03/07/14 • 03/21/14 • 04/04/14 • 04/18/14
As always, the release of direct deposits and checks depends on the availability of funds.

Alabama Medicaid PDL Available Through Epocrates®

Providers can access Alabama Medicaid's Preferred Drug List (PDL) using the Epocrates® drug reference software on their mobile device (iPhone, iPod Touch, iPad, Android, and BlackBerry) or an internet-connected computer. By downloading the Epocrates® application to a mobile device or through the internet, providers can check preferred drug status, prior authorization requirements, drug alternatives, generic substitutes and quantity limits.

Additionally, the software features a drug reference that includes information such as indication, dosing, contraindications, drug interactions and adverse reactions. The PDL and drug reference is available at www.epocrates.com.

EPOCRATES® - How to Add the Alabama Medicaid PDL

1. Go to www.epocrates.com
2. Click on "My Account' in the top right.
3. Sign in using a username and password, if needed. You will have to create a username and password if you do not currently have one.
4. Click on "Edit Formularies".
5. For "State" choose Alabama and for "Category" choose Health Plans. Select and add the Alabama Medicaid formulary. Click the "Done" button when you are finished.
6. Update your Epocrates® mobile app, and the formularies on your mobile device will be changed accordingly.

For more detailed instructions or assistance with a forgotten username and password, contact customer support at goldsupport@epocrates.com or call 1-800-230-2150.

An error appeared in the October 2013 article titled "Form ALTPL-01 10/12 Medicaid Other Insurance Attachment"

The first paragraph states: This form will be required with the CMS 1500 form when third party applies to a claim. It should have stated this form is required anytime a paper claim is required and third party has made a payment.

Pass It On!

Everyone needs to know the latest about Medicaid. Be sure to route this to:

- ❒ *Office Manager*
- ❒ *Billing Department*
- ❒ *Medical/Clinical Professionals*
- ❒ *Other* _____

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Alabama Medicaid Transitions to New CMS-1500 Paper Claim Form

Based on recommendations of the National Uniform Claim Committee (NUCC), the Centers for Medicare & Medicaid Services (CMS) is mandating use of the revised CMS-1500 claim form.

Effective April 1, 2014, Alabama Medicaid will accept only the revised version of the CMS-1500 (02/12) paper claim form. Paper claims submitted on the current version of the CMS-1500 (08/05) after March 31, 2014, will not be processed and will be returned to the provider. Both current and revised forms will be accepted during a transition period from January 6, 2014, through March 31, 2014. **The effective dates for transition to the new form are based on date of claim submission rather than date of service.**

Time line for transitioning to the revised CMS-1500 paper claim form

Current Form	*Revised Form*	Transition Period (Current and Revised forms Accepted) *Start Date*	*End Date*	*Only Revised Forms Accepted (Cutover Date)*
CMS-1500 (08/05)	CMS-1500 (02/12)	01/06/2014	03/31/2014	04/01/2014

HP Enterprise Services does not supply this form. Providers should obtain this form from a vendor supplying current CMS-1500 forms.

REMINDER: Alabama Medicaid requires all claims be submitted electronically. The only time a provider should submit a paper claim is for administrative review or other exceptions previously outlined. If you have any questions, please contact the Provider Assistance Center at 1-800-688-7989.

SUMMARY OF CHANGES

The revised CMS-1500 (02/12) claim form includes the following changes:

- **Box 10d:** Changed title from 'Reserved for Local Use' to **'Claim Codes'**:
  Description: Identifies additional information about the patient's condition or the claim.
  Guidelines: Enter the appropriate condition code allowed by NUCC. Valid values include:
  - AA – Abortion performed due to rape
  - AB – Abortion performed due to incest
  - AC – Abortion performed due to serious fetal genetic defect, deformity, or abnormality
  - AD – Abortion performed due to life endangering physical condition caused by, rising from or exacerbated by the pregnancy Itself
  - AE – Abortion performed due to physical health of mother that is not life endangering
  - AF – Abortion performed due to emotional/psychological health of mother
  - AG – Abortion performed due to social or economic Reasons
  - AH – Elective Abortion
  - AI - Sterilization

- **Box 19:** Changed title from 'Reserved for Local Use' to **'Additional Claim Information'**.
  Description: Identifies additional information about the patient's condition or the claim.
  Guidelines: Use this block to provide remarks, as appropriate. Examples include, but are not limited to the following:
  - TPL paid (MM/DD/YY)
  - TPL denied (MM/DD/YY)
  - Recouped claim (MM/DD/YY)

  The substitute provider's name may also be indicated here.

- **Box 21: ICD indicator** was added to reflect the ICD-9 or ICD-10 code set.
  Description: Identifies the version of the ICD code set being reported
  Guidelines: Enter ICD indicator for diagnosis codes entered in fields 21A – 21L.
  - Enter "9" for ICD-9
  - Enter "0" for ICD-10
    Provider may not submit both ICD versions together on the same claim.
    Providers should not submit ICD-10 codes until CMS mandate date.

- **Boxes 21:** Changed title from 'Diagnosis or Nature of Illness or Injury;' to **'Diagnosis or Nature of Illness'**
  Description: Additional fields for up to 12 diagnosis codes were added.
  Guidelines: A. - L. Enter the diagnosis codes in these blocks to the highest number of digits possible (3, 4, or 5). Do not enter decimal points in the DX fields.

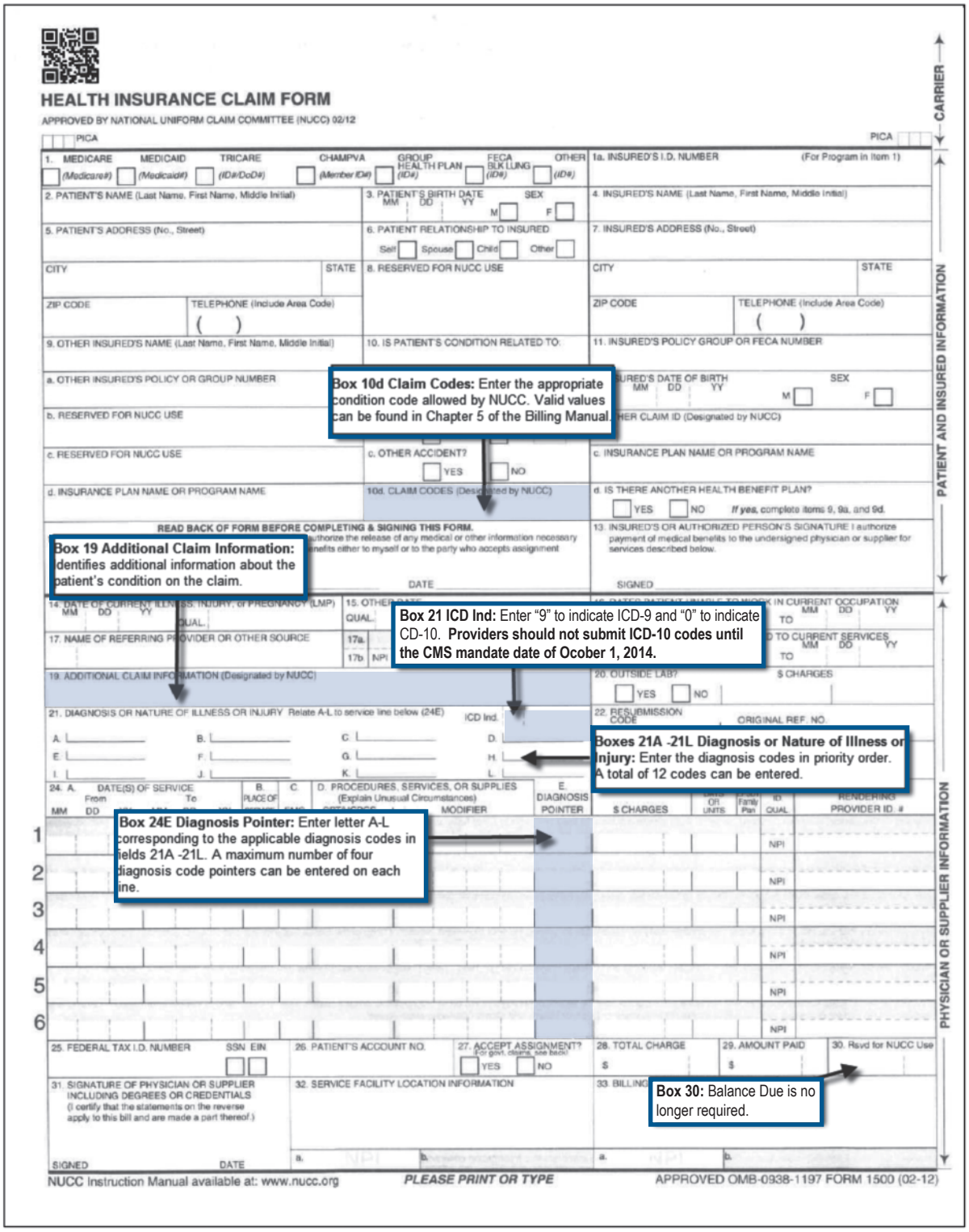
- **Box 24E:** Changed title from 'Diagnosis Code' to **'Diagnosis Pointer'**

  Description: Accommodations for up to four related diagnosis code pointers, with letters A-L corresponding to the applicable diagnosis codes in fields 21 A-L

  Guidelines: Enter the line item reference (A - L) for each service or procedure as it relates to the primary ICD-9 code identified in Block 21. If a procedure is related to more than one diagnosis, the primary diagnosis to which the procedure is related must be the one identified. Up to 4 characters can be entered in this block per procedure code

- **Box 30 Balance Due:** Field is no longer required.

Revised CMS-1500 health Insurance Claim Form



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Look Up Feature For Consent Forms Now Available on Medicaid Secure Website

Providers can now check to see if a consent form is on file with Medicaid.

Providers can access the tool by selecting the Provider tab (far right corner) and click on Consent Form Search. The recipient's 12-digit Alabama Medicaid number and the date of surgery are required to perform the search. The system will display the Date Form was Received, Date Last Status Change, Form Type (Abortion, Hysterectomy, Sterilization), and the Status (Approved, Denied)

ICD-10 Teleconferences for Vendors Coming Soon

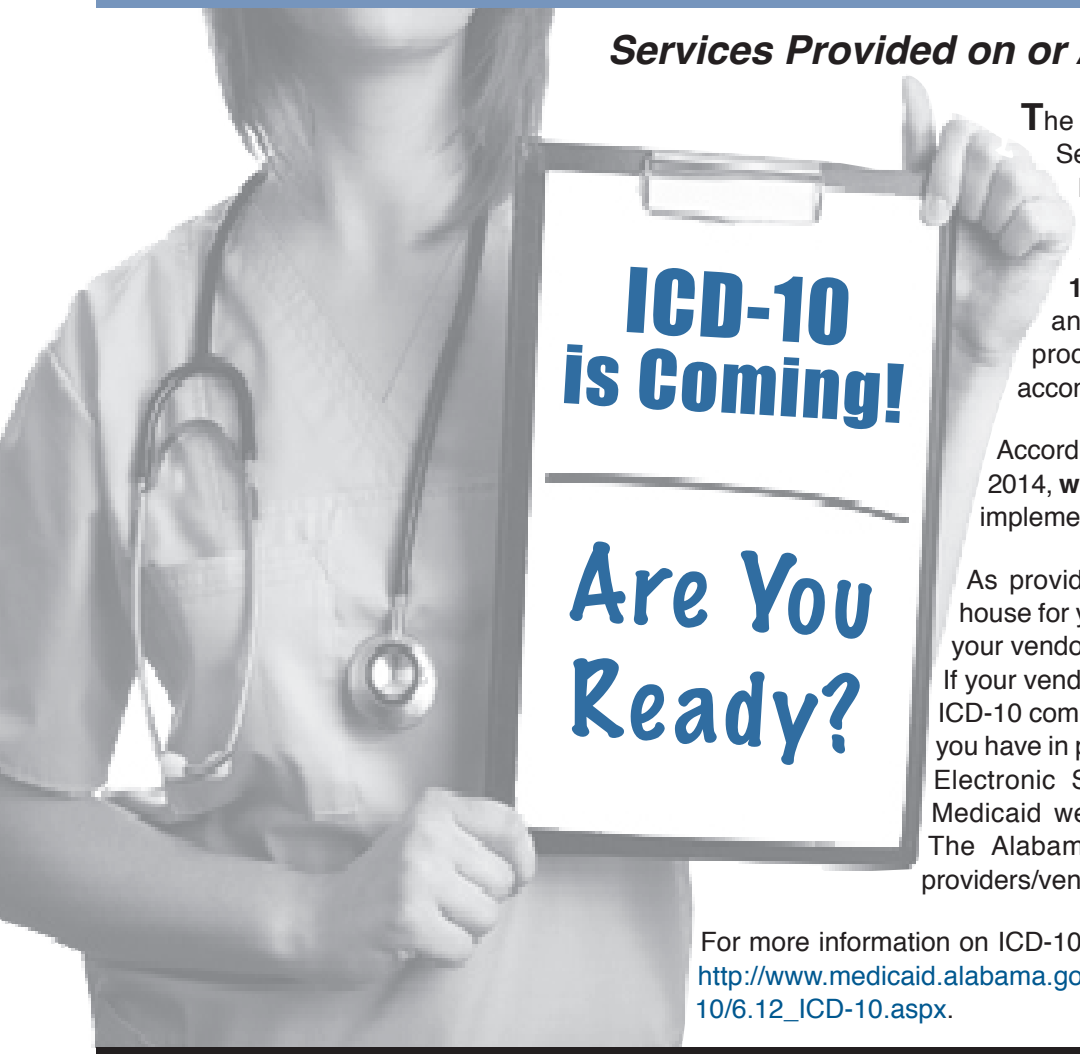
Beginning Spring 2014, the HP ICD-10 team will offer "ICD-10 Testing" teleconferences for vendors. The teleconferences are being provided as a means of providing support for existing testing partners as well as encouraging new vendors to join the testing effort. Each session will include a segment where the ICD-10 team will be available to answer questions. A schedule of session dates will be made available on the Alabama Medicaid website early 2014. The schedule will indicate dates and times for each session being offered.

If you have a suggestion on a topic to be covered during the teleconferences or need assistance with ICD-10 testing, contact the HP ICD-10 team via e-mail at alabamaictesting@hp.com

Provider *Insider*

Alabama Medicaid Bulletin **April 2014**

04/04/14 • 04/18/14 • 05/02/14 • 05/16/14 • 06/06/14 • 06/20/14 • 07/11/14 • 07/25/14 • 08/08/14 • 08/22/14 • 09/05/14 • 09/12/14
As always, the release of direct deposits and checks depends on the availability of funds.



Services Provided on or After - October 1, 2014

The Centers for Medicare and Medicaid Services (CMS) implementation date for ICD-10 compliance is **October 1, 2014. The compliance date is based on services provided on or after October 1, 2014.** The Alabama Medicaid Agency and HPES have completed the claims processing system changes necessary to accommodate ICD-10.

According to sources at CMS, the October 1, 2014, **will not** be postponed again. The original implementation date was October 1, 2013.

As providers, if you use a vendor or clearinghouse for your claims submission, please be sure your vendor or clearinghouse is ready for ICD-10. If your vendor or clearinghouse is not ready for the ICD-10 compliance date, what contingency plan do you have in place? The Alabama Medicaid Provider Electronic Solution Software and the Alabama Medicaid web portal are compatible for ICD-10. The Alabama Medicaid Agency strongly urges providers/vendors/clearinghouses to test with us.

For more information on ICD-10, please refer to Medicaid's website at http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.12_ICD-10/6.12_ICD-10.aspx.

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Pass It On!

Everyone needs to know the latest about Medicaid. Be sure to route this to:

- ❒ *Office Manager*
- ❒ *Billing Department*
- ❒ *Medical/Clinical Professionals*
- ❒ *Other* _____

Alabama Medicaid Cutover to the Revised CMS-1500 (02/12) Paper Claim Form

Effective April 1, 2014, Alabama Medicaid will ONLY accept the revised version of the CMS-1500 (02/12) paper claim form. Paper claims submitted on the CMS-1500 (08/05) form after March 31, 2014, will not be processed and will be returned to the provider.

Note: HP Enterprise Services does not supply this form. Providers should obtain this form from a vendor supplying CMS-1500 forms.

REMINDER: Alabama Medicaid requires all claims be submitted electronically. The only time a provider should submit a paper claim is for administrative review or when attachments are required. If you have any questions, please contact the Provider Assistance Center at 1-800-688-7989.

REMINDER:

Pharmacy "Auto-Refills" Not Allowed

The use of automatic refills by pharmacies is not allowed by the Medicaid Agency. Prescriptions that have been filled but not picked up by the patient or patient's authorized representative should be credited back to pharmacy stock and Medicaid through claims reversal within sixty days.

Violations of these policies may result in unauthorized charges. The pharmacy may be held liable or Medicaid may cancel the pharmacy vendor agreement.

ICD- Teleconference Training Information

In order to prepare providers and vendors for the upcoming changes that will be implemented as a result of ICD-10, Alabama Medicaid will be conducting virtual teleconferences beginning April 2014. Virtual training lets you take advantage of training from the convenience of your own office - all you need is a computer and telephone. There will be two ICD-10 classes offered as described below:

- **ICD-10 General Overview** - Discuss the changes being made by Alabama Medicaid for ICD-10. Topics to be covered during the session include: Alabama Medicaid website overview, affected /unaffected transactions, provider web portal and PES software changes, claim form changes, and new and modified EOBs. Time will be available for questions and answers.
- **ICD-10 Testing** - Provide information on how the changes being made by Alabama Medicaid will affect you and the transactions you submit, as well as the types of testing that should be completed prior to the CMS ICD-10 implementation date. Specific topics to be covered include: test data set-up, tips for testing, testing contact information, ICD-10 testing dates, and testing strategies. Time will be available for questions and answers.

To register for a class, follow the instructions provided below. If you have a suggestion on a topic to be covered during the teleconference or need additional information, contact the HP ICD-10 team via email at alabamaictesting@hp.com.

Register to Attend ICD-10 Teleconference Training

Registration is required in order to attend an ICD-10 teleconference session. You may register for one or multiple sessions. To register, access the ICD-10 Teleconference Training Information page of the Alabama Medicaid website at:

http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.12_ICD-10/6.12.6_ICD-10_Teleconference_Training.aspx.

Select the registration link associated with the session, date, and time you wish to attend. We encourage you to register today. Once your registration has been received, a confirmation e-mail will be sent along with both conference line and Virtual Room link instructions. We encourage testing your connectivity prior to the start of the session to confirm that you are able to successfully connect.

The following table outlines the teleconference sessions currently available.

Class	Date	Time
ICD-10 General Overview	April 22, 2014	10:00 - 11:00 AM
ICD-10 General Overview	May 14, 2014	2:00 - 3:00 PM
ICD-10 General Overview	June 11, 2014	10:00 - 11:00 AM
ICD-10 Testing	April 22, 2014	2:00 - 3:00 PM
ICD-10 Testing	May 14, 2014	10:00 - 11:00 AM
ICD-10 Testing	June 11, 2014	2:00 - 3:00 PM

Vendor and Provider Surveys on ICD-10 Readiness

Providers: Please read and pass this information along to your software vendors.
Alabama Medicaid and HP would like software vendors to log on to the Medicaid website between April 1 and April 30, 2014 to complete a brief survey on ICD-10 readiness.

The surveys should take less than five minutes to complete and will provide Medicaid with information on provider and vendor readiness to implement ICD-10. The survey is located at the following link: http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.12_ICD-10/6.12.1_ICD-10_Surveys.aspx.

A similar survey for providers will be available between May 9 and May 28, 2014. HP has implemented the changes related to ICD-10, but will not accept nor require ICD-10 codes until October 1, 2014. Please stay abreast of updates by visiting the ICD-10 page on the Medicaid website located at the following link: http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.12_ICD-10/6.12_ICD-10.aspx. If you have any questions about ICD-10 please send an email to alabamaictesting@hp.com.

ALABAMA
Perinatal Excellence
COLLABORATIVE

APEC Provides Evidence-based Protocols, OB Care Resources

A little more than two years after a group of physicians and state health leaders launched a statewide initiative to improve perinatal outcomes and ultimately the health and welfare of women and infants throughout Alabama, the Alabama Perinatal Excellence Collaborative (APEC) has emerged as an exemplary resource for obstetric care and other providers throughout the state of Alabama.

The cornerstone of this effort in Alabama is the group's goal to develop and implement evidence-based obstetric care protocols, according to Alabama Medicaid Medical Director Robert Moon, M.D. He noted that APEC's ultimate goal is to improve pregnancy outcomes by providing OB care practitioners with evidence-based practice protocols and decision trees, identifying meaningful quality benchmarks, developing data collection measures, reviewing quality data and providing feedback to individual providers and institutions and developing mechanisms to help providers in achieving benchmarks.

APEC was developed in mid-2012 as a joint effort between Alabama Medicaid's Maternity Care Program, the Alabama Department of Public Health, the University of Alabama at Birmingham, the University of South Alabama, and community care providers to lower infant mortality and improve maternal and infant health.

To view APEC protocols go to the Alabama Medicaid website listed below or go to the APEC website at peace-p.org (Pregnancy Education Activation Communication Enhancement for Providers). Peace-p.org provides an avenue for easy access to the protocols and direct contact with APEC leaders via your personal computer, tablet, or smart phone.

Medicaid website for the APEC Protocols is:
http://medicaid.alabama.gov/CONTENT/4.0_Programs/4.4.0_Medical_Services/4.4.7.5_APEC.aspx.

Tobacco Cessation Counseling Services for Pregnant Women

Beginning January 1, 2014, the Alabama Medicaid Agency covers a new smoking cessation benefit for Medicaid-eligible pregnant women. Medicaid will reimburse for up to four face- to-face counseling sessions in a 12-month period. The reimbursement period will begin in the prenatal period and continue through the postpartum period (60 days after delivery or pregnancy end). Documentation must support each counseling session.

Additional information regarding this mandate can be accessed at
http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD11-007.pdf.

Face-to-face counseling services must be provided by or under the supervision of a physician; or by any health care professional who is legally authorized to furnish such services under State law within their scope of practice and who is authorized to provide Medicaid covered services other than tobacco cessation services.

Outpatient hospitals, physicians, nurse practitioners, nurse midwives, health departments, federally qualified health care centers (FQHCs), rural health clinics, opticians, optometrists, and pharmacies may provide this service if enrolled as a Medicaid provider.

The following CPT Codes are applicable:

- **99406** Smoking and tobacco use cessation counseling visit; intermediate, greater than three minutes up to 10 minutes
- **99407** Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes

The following diagnosis codes are applicable and must be billed on the claim (UB-04 or CMS-1500 claim form) in order to be reimbursed by Medicaid:

V220-V222 - Normal pregnancy	**V230-V233** - Supervision of high-risk pregnancy
V2341-V237 - Pregnancy with other poor obstetric history	**V242** - Routine postpartum follow-up
AND	
3051 - Tobacco use disorder	

Pharmacies must bill for these specific services through their DME NPI.

NOTE: Although this policy was effective as of January 1, 2014, system changes have not been made to allow claim payment. As soon as system changes are implemented, an ALERT will be sent out to providers.

Attention Plan First Providers

To assure compliance with standards and appropriateness of care as outlined in the Plan First 1115 Research and Demonstration Waiver, effective April 1, 2014, the Alabama Medicaid Agency will conduct reviews of Plan First Providers' medical records.

Random sampling methodology will be used to determine the audit sample. Some reviews may be conducted on-site while others may be completed as desk-reviews by requesting records to be mailed to the Alabama Medicaid Agency, Managed Care Division. The request for records will be generated through official written notice from Medicaid and will include all details for record submission. If an on-site review is indicated, arrangements will be made via telephone communication with official written confirmation.

If you have additional questions, please contact:

Yulonda Morris, Quality Review Coordinator at 334-353-3227 or via e-mail at Yulonda.morris@medicaid.alabama.gov
or
Ruth Harris, Program Manager for Plan First at 334-353-3562 or via e-mail at Ruth.harris@medicaid.alabama.gov.

Long Acting Reversible Contraception (LARC)

Effective for dates of service April 1, 2014, and thereafter, Alabama Medicaid will cover long acting birth control in the inpatient hospital setting **immediately** after a delivery or up to the time of the inpatient discharge for postpartum women, or in an outpatient setting **immediately** after discharge from the inpatient hospital. The cost of the device or drug implant will be captured in the hospital's cost. The *insertion* of the device/drug implant will be billable to Medicaid by both the physician and hospital for reimbursement.

Inpatient Hospital Setting:

The hospital will continue to bill Medicaid for inpatient delivery services. The hospital must use an ICD-9 delivery diagnosis code within the range 630 – 67914 ***and*** must use the ICD-9 surgical code 69.7 (insertion contraceptive device) to document LARC services provided after the delivery.

> **NOTE:** No additional payment will be made to the hospital for LARC inpatient services. The hospital must capture the cost of the device or drug implant in the hospital's cost.

Outpatient Hospital Setting:

When a postpartum woman is discharged from the hospital, she may receive a LARC in the outpatient hospital setting immediately after discharge from the inpatient hospital. The hospital should bill on a UB-04 claim form using one code from each of the following: *Modifier "FP" is required on 11981 and 11983.

Procedure codes:

- 58300 Insertion of IUD
- 11981-FP* Insertion, non-biodegradable drug delivery implant
- 11983-FP* Removal with reinsertion, non-biodegradable drug delivery implant

ICD-9 diagnosis codes:

- V255 Encounter for contraceptive management, insertion of implantable subdermal contraceptive
- V2511 Insertion of intrauterine contraceptive device
- V2502 Initiate contraceptive NEC
- V251 Insertion of IUD

> **NOTE:** The inpatient claim **must** be in Medicaid's system in order for outpatient services to be paid. The inpatient and outpatient hospital must capture the cost of the device through the cost report.

Physician Billing for LARC Services Provided in the Inpatient/Outpatient Hospital Settings:

The physician should bill Medicaid utilizing a CMS 1500 claim form and one code from each of the following:

Procedure codes:

- 58300 Insertion of IUD
- 11981-FP* Insertion, non-biodegradable drug delivery implant
- 11983-FP* Removal with reinsertion, non-biodegradable drug delivery implant

*Modifier "FP" is required on 11981 and 11983.

ICD-9 diagnosis codes:

- V255 Encounter for contraceptive management, insertion of implantable subdermal contraceptive
- V2511 Insertion of intrauterine contraceptive device
- V2502 Initiate contraceptive NEC
- V251 Insertion of IUD

Place of Service:

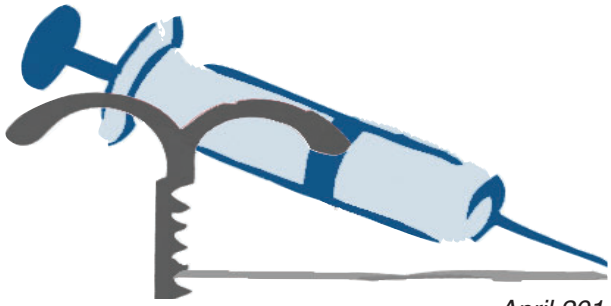
- 21 Inpatient hospital setting
- 22 Outpatient hospital setting

There are no changes to contraceptive management services currently furnished in the physician's office setting. These services will continue to be billed as you do today.

> **NOTE:** The Alabama Medicaid Agency covers permanent sterilization only if the recipient has signed a consent form at least 30 days before the procedure is performed.

For questions regarding hospital billing contact Solomon Williams, Associate Director, Institutional Services at 334-353-3206 or via e-mail at solomon.williams@medicaid.alabama.gov.

For questions regarding physician billing contact Jessie Burris, Program Manager, Physicians Program, at 334-242-5014 or via e-mail at jessie.burris@medicaid.alabama.gov.



Sterilization Consent Forms

It is the responsibility of the performing surgeon to submit a legible completed copy of the sterilization consent form after the surgery. Consent forms should not be submitted to HP prior to the surgery date. Consent forms should be mailed to:

HPES
P.O. Box 244032
Montgomery, AL 36124-4032
Attn: Medical Policy Unit/Consent Forms

HP will **NOT** pay any claims to ANY provider until a correctly completed appropriate form is on file at HP. **All blanks on the consent form must be appropriately completed before Medicaid pays the provider for the sterilization procedure**. The only exception is the "Race and Ethnicity," and the "Title of the person obtaining consent" designations which are optional. Clarification of the completion of the sterilization consent form reflecting CMS regulations and Alabama Medicaid policy (refer to the current Appendix C of the Alabama Medicaid Provider Manual and 42CFR50 Revised January 1, 2014) is located on www.medicaid.alabama.gov.

Consent forms submitted to HP with missing and/or invalid information in non-correctable fields (signature and date of recipient and person obtaining consent) of the consent form will be denied by HP and not returned to the provider. Before sending the consent form to HP, it is imperative that the **date of surgery** be clarified by reviewing the operative note to remedy claim denials due to incorrect date of surgery.

Top Reasons for Sterilization Consent Forms Returned to Provider:

1. Consent form not legible.
2. Consent form is incomplete.
3. Consent form sent prior to surgery.
4. Missing, invalid or incomplete recipient ID.
5. Stamped physician signature without initials.
6. Patient's date of birth not the same on the claim and consent form.
7. Interpreter's Statement does not contain N/A if an interpreter was not used.
8. Expected date of delivery not provided when the sterilization procedure is performed less than the required 30-day waiting period.
9. Expected date of delivery is recorded but indicator for premature delivery or emergency surgery is not checked.
10. Date of sterilization not the same on the claim and on the consent form.
11. Facility name not on the consent form.

Top Reasons for Consent Form Denial:

1. Missing, incomplete or obscured recipient signature.
2. Missing or invalid date of recipient signature.
3. Recipient under age 21 on date consent form was signed.
4. Missing signature of person obtaining consent.
5. Missing or invalid date of signature of person obtaining consent, including date of procedure, or any later date.
6. Person obtaining sterilization consent signed before recipient or the same date of surgery or after.
7. Missing interpreter signature (if one was used).
8. Missing or invalid date of interpreter signature, including any date other than the date the recipient signed (if one was used).
9. Sterilization performed less than **72 hours** after the date of the individual's signature in cases of premature delivery or emergency abdominal surgery.
10. Less than **30 days** or more than **180 days** elapsed from recipient signature date to surgery date and/or premature delivery date is less than 30 days from signature date.

Outpatient Hospital-Based Clinic Visits

Effective January 1, 2014, CMS made changes to the CY 2014 Hospital Outpatient prospective payment system for hospital outpatient clinic visits, which the Alabama Medicaid Agency will follow effective for dates of service April 1, 2014, and thereafter.

CMS's policy calls for hospital to bill for all outpatient hospital clinic visits using a single HCPCS code, G0463 (Hospital outpatient clinic visit for assessment and management of a patient), which replaces CPT E&M codes 99201 - 99205 and 99211 - 99215.

Effective for dates of service April 1, 2014, and thereafter, HCPCS code G0463 (Hospital Outpatient Clinic Visit for Assessment and Management of a Patient) will replace CPT E&M codes 99201 - 99205 and 99211 - 99215 for outpatient hospital-based clinic visits.

For claims with dates of service through March 31, 2014, the hospital will continue to bill the CPT E&M codes 99201 - 99205 and 99211-99215 for outpatient hospital-based clinic visits.

For claims with dates of service April 1, 2014, and thereafter the hospital will bill G0463 for outpatient hospital-based clinic visits.

For questions, please contact: Solomon Williams, Associate Director, Institutional Services at 334-353-3206 or via email at Solomon.williams@medicaid.alabama.gov.

REMINDER:

All Nursing Facility Providers

A nursing facility provider that fails to provide the required documentation or additional information for audit reviews as requested by the Agency or its designee within ten working days from receipt of the faxed letters shall be charged a penalty of one hundred dollars per recipient record per day for each calendar day after the established due date unless an extension request has been received and granted. The penalty will not be a reimbursable Medicaid cost. **The Agency may approve an extension for good cause. Requests for an extension should be submitted in writing by the nursing facility Administrator to the Clinical Services & Support Division, Medical & Quality Review Unit with supporting documentation.**

Mail the request to:
Medical & Quality Review Unit
501 Dexter Avenue
P.O. Box 5624
Montgomery, Alabama 36103-5624

Providers should request an extension as soon as it is determined that the requested record(s) will be late.

Coming Soon! Digital Submission of Certain Medical Records

Providers will be soon be able to fax or upload Hospice, Long Term Care (LTC), Inpatient Psychiatric (IP), Post Hospital Extended Care (PEC) Bed and Swing Bed medical records for review via the Forms menu of the Alabama Medicaid Interactive Web Portal. Providers will be able to access a listing of digital LTC forms currently only available in paper within the Forms Library of the Alabama Medicaid Website. The recipient's 12-digit Alabama Medicaid number, providers' NPI number, and recipient first and last name will be required to submit medical records for review. Additionally, Source of Admission is required for Psychiatric records.

The required format for document upload is that of PDF. If a provider does not have the capability to create PDF versions of the medical records, a fax cover sheet will be provided on the Alabama Medicaid Interactive Web Portal for the submission of documentation via fax.

Please note an Alabama Medicaid Interactive Web Portal account is required to access this functionality.

More information on the availability date of this new functionality will be available this summer!

Alabama Medicaid Bulletin

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Perplexed with Filing Claims for Unclassified J Codes?

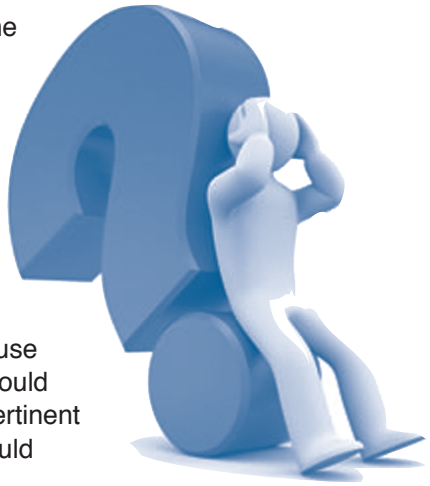
Appendix H of the Medicaid Provider Manual indicates the following J codes should be used for unlisted, unclassified drugs:

- J3490 - Unclassified Drugs
- J3590- Unclassified Biologics
- J9999 - Not otherwise classified, antineoplastic/chemotherapy drugs.

Providers should submit a red drop-out, paper claim with the complete name of the drug, total dosage that was administered and a National Drug Code (NDC) number on the claim.

An attachment with the description of the drug should be included with the name of the drug, total dosage given, the purpose the medication is being given, and any other pertinent information. Please be sure to search the Physician Drug List to see if the drug is possibly under a generic name. The claims containing the unclassified procedure code must be sent to:

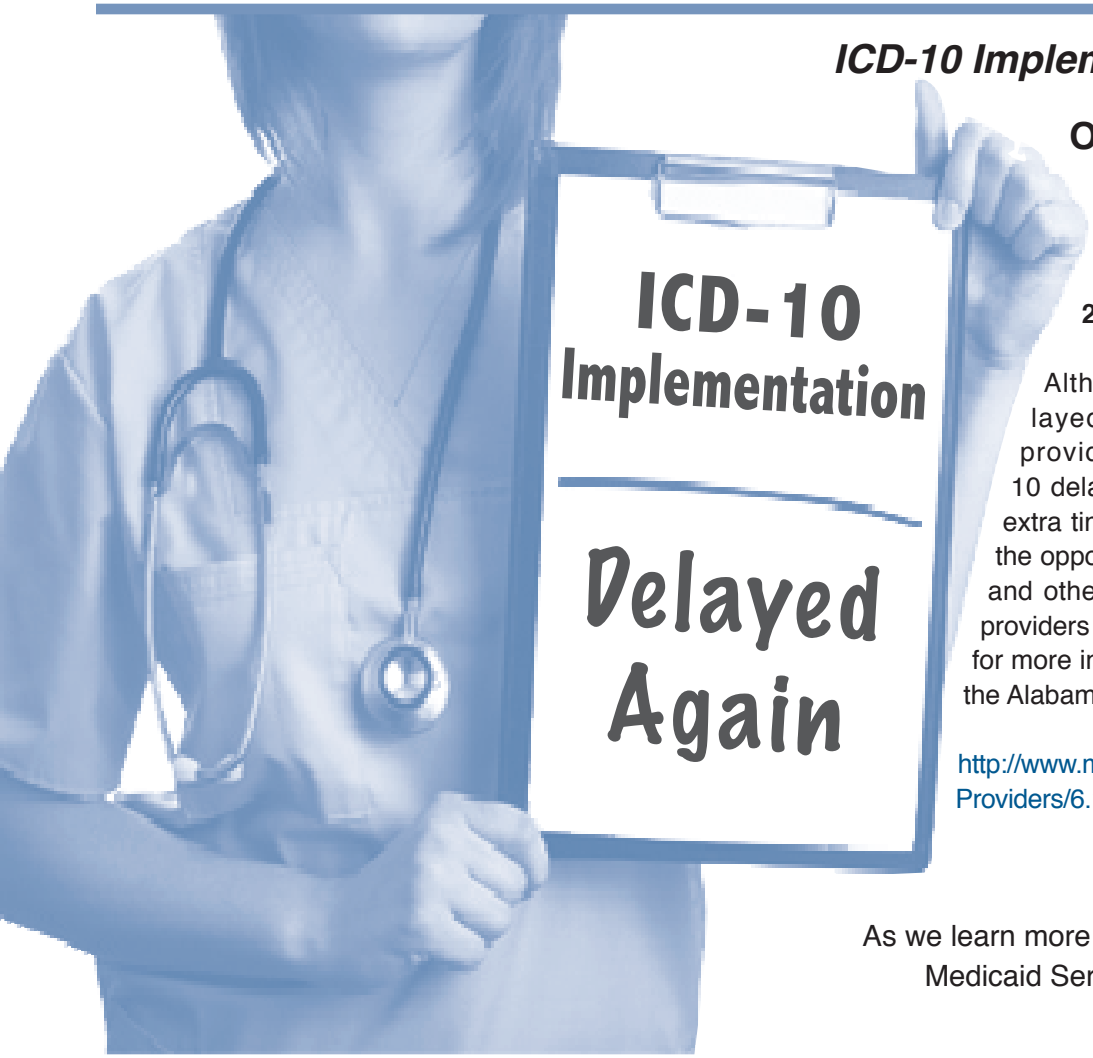
HP
Attn: Medical Policy
PO Box 244032
Montgomery, AL 36124-4032



Note: If the medication is being given for “off label use,” (a medication prescribed for use other than for the use approved by the FDA), additional supporting documentation should be submitted with the claim including a letter of medical necessity, medical records pertinent to the use of the drug, peer-reviewed literature, and any other documentation that would justify the need to cover.

Provider *Insider*

Alabama Medicaid Bulletin **July 2014**



ICD-10 Implementation

On April 1, 2014, the Protecting Access to Medicare Act of 2014 (PAMA) (Pub. L. No. 113-93) was enacted, which said that the Secretary **may not adopt ICD-10 prior to October 1, 2015.**

Although implementation has been delayed, Alabama Medicaid urges the providers and vendors to use the ICD-10 delay to maximize your readiness. The extra time created by the delay, will give you the opportunity to test with Alabama Medicaid and other payers. Our testing is open to all providers and vendors. Please visit our website for more information on ICD-10 and testing with the Alabama Medicaid Agency.

http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.12_ICD-10/6.12_ICD-10.aspx

As we learn more from the Centers of Medicare and Medicaid Services (CMS), we will let you know.

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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 _____

The information contained within is subject to change. Please review your Provider Manual and all Provider Alerts for the most up to date information.

Clarification on Provider Signatures on the 362 Form

In Rule No. 560-X-1-.18 (2) (d), Provider/Recipient Signature Requirements, Referral Forms, the Alabama Medicaid Administrative Code says the following: 'For hard copy referrals, the printed, typed, or stamped name of the primary care physician with an original signature of the physician or designee is required. Photocopied signatures will not be accepted. For electronic referrals, provider certification shall be in accordance with the electronic signature policy in subsection (1) (a) of this rule'.

This means that a signature signed by the physician's designee, **must be a complete signature, not initials.**

ICD-10 End To End Testing Continues With Alabama Medicaid

Alabama Medicaid encourages providers and vendors to test end to end to ensure ICD-10 readiness prior to the CMS federal mandate date, which is currently October 1, 2015. It is critical that providers and trading partners test with Alabama Medicaid prior to implementation. We continue to encourage early testing, please do not wait until the federal mandate date to test. Information on how to test can be found at the following link:
http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.12_ICD-10/6.12.3_ICD-10_Testing.aspx

Webinar materials related to testing are also located at this link: http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.12_ICD-10/6.12.6_ICD-10_Teleconference_Training.aspx Additional teleconferences on how to test will be scheduled in the future.

In order to facilitate testing both the end of ICD-9 code submission and the beginning of ICD-10 code submission, Alabama Medicaid has provided testing dates different than the CMS mandate date that will allow a provider to submit claims with ICD-9 codes and claims with ICD-10 codes to ensure processing will work as expected in anticipation of the CMS implementation.

CURRENT TEST DATES

> ICD-9 END DATE	**09/30/2013**
> ICD-10 START DATE	**10/01/2013**

Attention Provider Submitting Paper Claims for Processing

In support of the changes for ICD-10, all **paper** claim forms submitted must have the new ICD Version field populated with a '9' indicating ICD-9 until such time that ICD-10 is implemented. ICD-10 implementation has been delayed and cannot be implemented before October 1, 2015.

When ICD-10 is implemented the indicator must be either a '9' indicating ICD-9 or '0' indicating ICD-10. ICD-9 and ICD-10 diagnosis codes and/or surgical procedure codes may not be billed on the same claim. The ICD Version entered on the claim form applies to all diagnosis codes and/or surgical procedure codes entered.

ICD Version form fields:
CMS1500 = Block 21
Form 340B (Medical Medicaid/Medicare Related Claim (Crossover) = Block 4
UB04 = Block 66

Attention Physical Therapists: Medicaid is Expanding the Locum Tenens and Substitute Physician Policy to Include Physical Therapists. This change is effective April 1, 2014.

Locum Tenens and Substitute Physical Therapist Under Reciprocal Billing Arrangements

It is common practice for physical therapists to retain substitute physical therapists to take over their professional practices when the regular physical therapists are absent for reasons such as illness, pregnancy, vacation, or continuing medical education, and for the regular physical therapist to bill and receive payment for the substitute physical therapists services as though he/she performed them. The substitute physical therapist generally has no practice of his/her own and moves from area to area as needed. The regular physical therapist generally pays the substitute physical therapist a fixed amount per diem, with the substitute physical therapist having the status of an independent contractor rather than of an employee. The substitute physical therapists are generally called “locum tenens” physical therapists.

Reimbursement may be made to a physical therapist submitting a claim for services furnished by another physical therapist in the event there is a reciprocal arrangement. The reciprocal arrangement may not exceed 14 days in the case of an informal arrangement. Effective for claims submitted on or after June 15, 2012, the reciprocal arrangement may not exceed 60 continuous days in the case of an arrangement involving per diem or other fee-for-time compensation. Providers participating in a reciprocal arrangement must be enrolled with the Alabama Medicaid Agency. The regular physical therapist should keep a record on file of each service provided by the substitute physical therapist and make this record available to Medicaid upon request. Claims will be subject to post-payment review.

Coming in July! Digital Submission of Certain Medical Records

Providers will be able to fax or upload Hospice, Long Term Care (LTC), Inpatient Psychiatric (IP), Psychiatric Retrospective Review, Post Hospital Extended Care (PEC) Bed and Swing Bed medical records for review via the Forms menu of the Alabama Medicaid Interactive Web Portal starting in July. Providers will be able to access a listing of digital LTC forms currently only available in paper within the Forms Library of the Alabama Medicaid Website. The recipient’s 13-digit Alabama Medicaid number, providers’ Medicaid ID number, and recipient’s first and last name will be required to submit medical records for review. Additionally, Source of Admission is required for Psychiatric records.

The required format for document upload is that of PDF. If a provider does not have the capability to create PDF versions of the medical records, a fax cover sheet will be provided on the Alabama Medicaid Interactive Web Portal for the submission of documentation via fax.

Please note an Alabama Medicaid Interactive Web Portal account is required to access this functionality.

The start date and instructions for Digital Submission will be available on the Forms Library of the Alabama Medicaid Website. Instructions for Digital Submission will also be available via the Forms menu of the Alabama Medicaid Interactive Web Portal.

Oncotype DX™

Effective July 1, 2013, Medicaid began covering the Oncotype DX™ genetic profiling lab test for patients meeting Medicaid's prior authorization criteria. Oncotype DX™ is a genetic profiling test developed to classify the risk of recurrence among women treated for early stage breast cancer. **The PA request must be received by the Agency's fiscal agent, HP, within 30 days from the requested date of service.** Please read Chapter 4, Obtaining Prior Authorization, in the Provider Manual for information about submitting a PA request,

http://medicaid.alabama.gov/documents/6.0_Providers/6.7_Manuals/6.7.8_Provider_Manuals_2014/6.7.8.2_April_2014/Apr14_04.pdf

The use of the 21-gene RT-PCR Assay (i.e., Oncotype DX™) to determine recurrence risk for deciding whether or not to undergo adjuvant chemotherapy meets Alabama Medicaid's medical criteria for coverage in women with early stage breast cancer with **all** of the following characteristics:

- Newly diagnosed, primary, early stage breast cancer (stage I or stage II) in a female without significant co-morbidities;
- Unilateral, non-fixed tumor;
- Hormone receptor positive (ER-positive or PR-positive);
- HER2-negative;
- Tumor size 0.6 - 1cm with moderate/poor differentiation or unfavorable features OR tumor size > 1cm;
- Node negative;
- Will be treated with adjuvant endocrine therapy, e.g., tamoxifen or aromatase inhibitors; AND
- When the test result will aid the patient in making the decision regarding chemotherapy (i.e., When chemotherapy is considered a therapeutic option);
  AND
- When ordered within 6 months following breast cancer diagnosis.

Limitations:

- The 21-gene RT-PCR Assay Oncotype DX™ should only be ordered on a tissue specimen obtained during surgical removal of the tumor and after subsequent pathology examination of the tumor has been completed and determined to meet the above criteria (i.e., the test should not be ordered on a preliminary core biopsy).
- The test should be ordered in the context of a physician-patient discussion regarding risk preferences when the test result will aid in making decisions regarding chemotherapy. This discussion must be documented in the patient's clinical record and a copy of the progress note (signed by the ordering physician) must accompany the PA request (Form 342).
- The Oncotype DX™ test will be limited to one per lifetime, per recipient.
- Repeat tests will not be covered.
- The test will be limited to the following diagnoses: malignant neoplasm of the female breast, carcinoma in situ of breast, and personal history of malignant neoplasm, breast.

Providers must bill procedure code S3854 (gene expression profiling panel for use in the management of breast cancer). The Oncotype DX™ will be exempt from Patient 1st and EPSDT requirements. The Form 342 **must be** completely filled out, signed by the ordering physician and indicate the name and phone number of the ordering physician. The Form 342 will suffice as the prescription for the test. The form 342 is located at this link on the website, http://medicaid.alabama.gov/documents/5.0_Resources/5.4_Forms_Library/5.4.1_Billing/5.4.1_PA_Form_342_Revised_Fillable_12-7-11.pdf.

The test must be performed by an enrolled independent laboratory and ordered by a physician.

Please contact Russell Green at Russell.Green@medicaid.alabama.gov for any questions.

All Hospitals: Change of Ownership (CHOW) and Closures

Effective July 1, 2014, and thereafter, hospitals are to notify Medicaid of any Change of Ownership (CHOW) or closure as soon as it is known to ensure proper payment and prevent recoupments.

Procedures Following a Change in Ownership:

- When Medicaid or HP Enterprise Services (HPES) verifies an ownership change or closure of an acute care hospital (Public or Private), the hospital's contract will be end dated effective with the date of the sale or closure.
- The facility's new owner should submit an enrollment application to Medicaid as soon as the purchase has been finalized. When HPES approves the new enrollment application, the hospital will be assigned a Medicaid provider number and a temporary six-month contract based on the effective date of the CHOW.
- This temporary enrollment will allow the new owners to bill for services provided on or after the CHOW effective date. It will also allow Medicaid time to receive the Certification and Transmittal (C&T) form from the Alabama Department of Public Health (ADPH). Once the C&T is received from ADPH, then Medicaid will update the hospital's contract. If Medicaid is not notified of the CHOW within six months, the contract will automatically expire.

Claims Processing:

- Claims for dates of service on or after the ownership change must be filed using the NPI/Medicaid ID for the new owner.
- Claims for dates of service prior to the date of the ownership change will continue to be billed under the previous owner's NPI.

Procedure Following a Closure

In the event that a hospital is closed, HPES will end date the hospital's contract effective the date of the closure. Any claims paid for dates of service after the closure will be recouped.

For Additional Information

Providers with questions should contact Solomon Williams, Associate Director, Institutional Services, at 334-353-3206 or via e-mail at solomon.williams@medicaid.alabama.gov

ATTENTION

EPSDT SCREENING PROVIDERS

When submitting a claim for an EPSDT screening, you must enter the modifier 'EP' in the first modifier position. If other modifiers are necessary, please append in the other positions.

Eye Care Providers

HP has made the necessary system changes to allow benefit limits for recipients under 21 to display during the eligibility verification process (Medicaid Secure web portal, Provider Electronic Solutions and Automated Voice Response System). The Provider Assistance Center will no longer provide eligibility verification to eye care providers for recipients less than 21 years of age.

Provider Application Fees Required by the Federal Government

Federal regulations now require States to collect an application fee from all reenrolling or newly enrolling institutional providers. States must collect this fee from institutional providers prior to enrollment or reenrollment if these providers have not paid a fee to Medicare or another State or are not enrolled with Medicare, another State's Medicaid program, or CHIP. Physicians and non-physician practitioners are not subject to the fee. The application fee amount is established by CMS and is updated annually. Currently the FY2014 fee amount is $542.

Institutional providers who are required to submit a fee include, but are not limited to the following: ambulance service suppliers, ambulatory surgical centers, hospitals, community mental health centers, DME suppliers, rural health clinics, outpatient therapy groups, hospices, home health agencies, rehabilitation facilities, extended care facilities, laboratories, federally qualified health centers, end stage renal disease centers, etc. (A complete list can be viewed on the Agency website at www.medicaid.alabama.gov.)

Institutional providers must submit the application fee in the form of a certified or cashier's check at the time of their initial enrollment or reenrollment. The application fee should be mailed to HPES Provider Enrollment Department at P. O. Box 241685, Montgomery, Alabama 36124-1685. Those institutional providers who have paid the application fee to Medicare or another State or are enrolled with Medicare, another State's Medicaid program, or CHIP will be exempt from paying the fee to Alabama Medicaid. Proof of this payment or enrollment must be submitted by the provider at the time of initial enrollment or reenrollment. Providers may also request a hardship exception from CMS as needed. If a hardship exception is granted by CMS, proof of the exception should be submitted to Alabama Medicaid at the time of initial enrollment or reenrollment. Providers can obtain more information on the hardship exception by visiting www.cms.gov.

Changes to Medicaid's provider enrollment system and the enrollment web portal are being developed and will be implemented by July 1, 2014. Any initial applications or revalidations from institutional providers already submitted or to be submitted will be subject to the application fee.

If you have any questions, please contact Provider Enrollment at 1-888-223-3630, option 1.

Institutional providers who are required to submit a fee include but are not limited to the following:

- *Ambulance service suppliers*
- *Ambulatory surgical centers*
- *Hospitals*
- *Community mental health centers*
- *DME suppliers*
- *Rural health clinics*
- *Outpatient therapy groups*
- *Hospices*
- *Home health agencies*
- *Rehabilitation facilities*
- *Extended care facilities*
- *Laboratories*
- *Federally qualified health centers*
- *End stage renal disease centers, etc.*

A complete list can be viewed on the Agency website at www.medicaid.alabama.gov.)

CareCore National to Process Cardiology Prior Authorizations

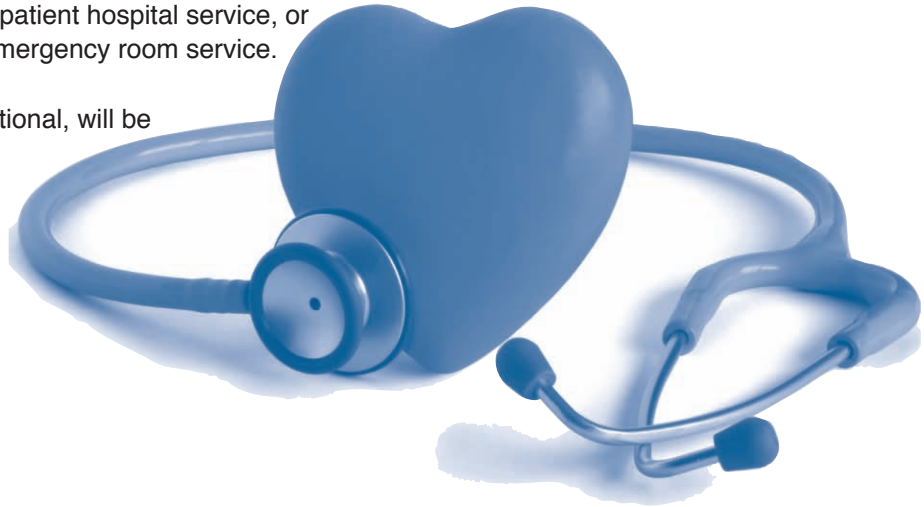
The Alabama Medicaid Agency contracted with CareCore National to implement a Cardiology prior authorization program. Additional information will be forth coming regarding the date when CareCore will begin accepting PA requests in the next few months. CareCore National is a healthcare solutions company with a specialty in cardiac imaging and cardiac implantable management.

For all cardiology services such as Nuclear Cardiology, Diagnostic Heart Catherization, Stress Test (ECHO), Transesophageal Echo, and Transthoracic Echo, ordering providers will be required to request and receive prior authorization (PA) from CareCore National. Additional information will be forth coming regarding the time schedule when CareCore National will begin accepting PA requests.

Exclusions from the PA requirement will be:

- Cardiology services performed as an inpatient hospital service, or
- Cardiology services performed as an emergency room service.

During the upcoming months, CareCore National, will be sending you more information to facilitate a smooth and successful transition regarding our cardiology management program. Providers with additional questions may contact Russell Green, Associate Director, Medical Services Division at Russell.Green@medicaid.alabama.gov, or by telephone at (334) 353-4783.



REMINDER: Recovery Audit Contractor (RAC) Audits

Mandatory provisions of the Affordable Care Act require the Alabama Medicaid Agency to select and provide oversight for a Medicaid Recovery Audit Contractor (RAC) to perform provider audits. Goold Health Systems (GHS), a Maine-based firm, was selected to be Alabama Medicaid's Recovery Audit Contractor (RAC) for a two-year period that began January 1, 2013.

The RAC program is designed to improve payment accuracy by identifying under and overpayments in Medicaid. The Medicaid RAC program is a separate program from the Medicare RAC which is overseen by the Centers for Medicare and Medicaid Services.

Reviews will be conducted by GHS staff to include full time medical directors, pharmacists, certified professional coders, and experienced clinicians. Audits will be conducted by GHS using a "top down" approach where data analysis, through data mining, is applied against the universe of paid claims to identify patterns of utilization or billing which look atypical based on Alabama Medicaid and/or national standards. Following the high-level claims analysis, GHS may expand its review by requesting clinical records and/or other documents in accordance with state and federal regulations.

GHS has been informed of the critical role that all providers play in a successful Medicaid program and requires that auditors be professional, objective, and consistent in performing all required audits/reviews.

Providers are reminded that the Alabama Administrative Code and their Provider Agreements require compliance with requests for medical records for Medicaid program audits.

Questions regarding the audits should be directed to Sandra Shaw, RAC Program Manager, at (334) 242-5372 or **sandra.shaw@medicaid.alabama.gov** or Jacqueline Thomas, Program Integrity Division Director, at (334) 242-5318 or jacqueline.thomas@medicaid.alabama.gov

Alabama Medicaid Bulletin

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State Checkwrite Schedule

07/11/14	09/05/14	10/31/14
07/25/15	09/12/14	11/14/14
08/08/14	10/03/14	12/05/14
08/22/14	10/17/14	12/12/14

The release of funds is normally the second Monday after the RA date. Please verify direct deposit status with your bank. Go to *www.medicaid.alabama.gov* to view the payment delay update details. Payment alerts will be posted only if there will be a payment delay. As aways, the release of direct deposits and checks depends on the availability of funds.

Provider Insider

Alabama Medicaid Bulletin October 2014

CARDIOLOGY PRIOR AUTHORIZATION MANAGEMENT SERVICES

On October 1, 2014, CareCore National, LLC (CareCore) began implementing the Alabama Medicaid Agency prior authorization (PA) program for Cardiology procedures listed below:

1. Nuclear Cardiology – 78451, 78452, 78453, 78454
2. Diagnostic Heart Catheterization – 93452, 93453, 93454, 93455, 93456, 93457, 93458, 93459, 93460, 93461
3. Stress Echocardiography – 93350, 93351
4. Transesophageal Echo – 93312, 93313, 93314
5. Transthoracic Echo – 93303, 93304, 93306, 93307, 93308

Any of the procedures specified above will require a PA from CareCore. Information is now being accepted (i.e., online submissions, or via telephone), for services rendered on or after October 1, 2014.
The PA requirements will apply to Medicaid recipients for the State of Alabama:

1. SOBRA Children
2. Parents and Other Caretaker Relatives (POCR) Program, formerly, Medicaid for Low Income Families Program
3. Refugees, or
4. Supplemental Security Income

Please note that no PA is required for the following:

1. Medicare patients
2. Cardiology services performed as an inpatient hospital service, or
3. Cardiology services performed as an emergency room service

This Program is applicable to services provided in the following settings:

1. Freestanding imaging facilities
2. Hospital outpatient facilities
3. Physician offices
4. Public Health Clinics
5. Rural Health Clinics
6. Federally Qualified Health Clinics

(Article continued on page 2)

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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 _____

The information contained within is subject to change. Please review your Provider Manual and all Provider Alerts for the most up to date information.

PCL

TO ALL HOSPITAL COST REPORT PREPARERS:

You must now request a Paid Claims Listing (PCL) to assist you in the preparation of your Medicare and Medicaid Cost Reports from Medicaid's Provider Audit Division. The PCL will be customized to your specifications.

All requests should be submitted by e-mail to **Gladys.Gray@medicaid.alabama.gov** or you may contact her at (334) 242-2327.

ATTENTION HOSPITALS

Claims that overlap September 30 and October 1 must be split billed. Services prior to 10/01 must be billed on one claim and services on or after 10/01 must be on a separate claim.

Physicians may request a PA by contacting CareCore using one of the following methods:

1. Telephone (Alabama Medicaid) 1-855-774-13188924, or Online: www.carecorenational.com

Training:
CareCore provided training webinars during the month of September 2014, to facilitate providers understanding about our program. The webinars addressed the scope of the cardiology PA process; provided guidance on obtaining a PA, and answered providers' questions. To learn more about the PA cardiology process, please visit the Tools and Criteria Page at: www.carecorenational.com. You may find additional information about CareCore, and their policies, and procedures that you and your staff will need to participate in the program on CareCore's website at: www.carecorenational.com. Providers may register on-line to set up an account to use CareCore's web site to submit PA requests.

Questions
Frequently Asked Question (FAQ) are available on CareCore's website, along with a complete list of Cardiology procedures. You may also telephone CareCore at 1-800-918-8924, and then choose option "2".

Providers with additional questions may contact Russell Green, Associate Director, Medical Services Division, at (334) 353-4783. Thank you for your services to Alabama Medicaid recipients.

Attention Patient 1st Providers

Patient 1st
Health Care Close To Home

Changes were recently implemented to allow providers to make Patient 1st assignment changes on the Medicaid Interactive Web Portal. If you are enrolled as a group provider to receive your Patient 1st assignments or if you are an individual physician not enrolled as a group, you may log on to the web portal as you do for all other transactions. If you are enrolled as an individual Patient 1st provider within a non-patient 1st group, you were mailed a letter in March 2014 with an additional web portal log on to access the web portal for each provider in the group to make Patient 1st assignment changes only. For any other features via the web portal please continue to use your current user id log on.

The secure website is available at the following location: https://www.medicaid.alabamaservices.org/ALPortal/Account/Secure%20Site/tabId/66/Default.aspx.

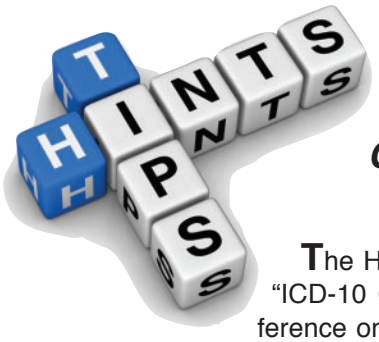
This site may be linked from the Medicaid website using the drop-down menu under Providers. Providers should then access the following path: **providers/PMP assignment**

A recipient's Medicaid number, or name and date of birth or date of birth and SSN must then be entered to request the change. The same criteria for patient's assignments must still be met. Providers will have the capability to override panel holds, age restrictions, and gender restrictions set by the PMP. The provider's PMP panel must be open, and the caseload not be met at the time the assignment is being made.

Providers will not be allowed to override the following restrictions in addition to some other restrictions:

- Recipient is locked into another physician (Not a Patient 1st assignment)
- Recipient has been previously dismissed from PMP attempting to make the assignment
- Requesting provider is not a Patient 1st participating provider
- PMP panel at contractual maximum limit
- Recipient is not currently eligible for the Patient 1st program

If the change is made by the 15th of the month, the effective date of the Patient 1st change will be the 1st day of the next month. If made after the 15th, it will be effective the following month. This eliminates the need to fax or e-mail Patient 1st change requests to HP Enterprise Services, and assures you the change has been made. If you have any questions, please contact Provider Assistance Center at 1-800-688-7989.



Coming Soon - General Overview ICD-10 Teleconference

The HP ICD-10 team will offer an "ICD-10 General Overview" teleconference on October 21, 2014 at 10:00 a.m. The teleconference will provide an overview of the changes being implemented by Alabama Medicaid for ICD-10. The session will include a segment where the ICD-10 team will be available to answer questions. Registration is now open and available on the Alabama Medicaid website at http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.12_ICD-10/6.12.6_ICD-10_Teleconference_Training.aspx.

If you have any questions or require assistance with ICD-10 testing, contact the HP ICD-10 team via e-mail at alabamaictesting@hp.com.

Cascading Referrals

A Specialist may refer to another Specialist on a Cascading referral as long as the Referring Patient 1st provider has received documentation that the referral has occurred. A non-Patient 1st provider should not be referring to a specialist, unless it is a Cascading referral.

All Specialists should be communicating with the referring Patient 1st PMP to ensure proper case management has occurred.

Written Referrals Given Within 72 Hours of Verbal Approval

Alabama Medicaid encourages providers to continue to authorize Referrals **prior** to the treatment of patients. It will be re-enforced to the PMP; **if** verbal referrals are given prior to the treatment of the patient, a written Referral Form must follow within **72-hours** of the verbal authorization. The form can be obtained by accessing Medicaid's Form's Library link:

http://medicaid.alabama.gov/documents/5.0_Resources/5.4_Forms_Library/5.4.7_Referral_Forms/5.4.7_Referral_Form362_fillable_7-10_Revised.pdf

Patient 1st Referrals

The Alabama Medicaid Agency made changes to the Patient 1st Referral process on June 1, 2014, that no longer allowed a specialist or Primary Medical Physician to bill/refer using a Group NPI number. The effective date of this change has been extended to allow more time to implement this change.

In the interim, the Group's NPI number on the referral /claim/prior authorization as the Referring Provider will be accepted. However, Medicaid requests that specialists and PMP's continue to write referrals and bill Medicaid utilizing the individual NPI number whenever possible.

The reasons Medicaid is requesting providers continue to bill/refer utilizing the individual NPI include:

- Reinforce Medical Home Concept
- Ensure referrals are managed by the PMP
- Ensure PMP is responsible for recipient's total care
- Properly track caseload assignment for PMP's
- Obtain accurate profiler reports for case management

Medicaid will notify providers through an ALERT, prior to implementing a new effective date, when the change will resume. Please contact Latonda Cunningham, Associate Director of the Patient 1st Program via e-mail at latonda.cunnigham@medicaid.alabama.gov or via phone at (334) 353-4122 for any questions.

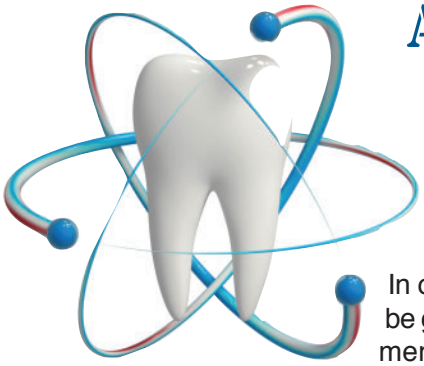
Synagis® Criteria for 2014-2015 Season

- The Alabama Medicaid Agency has updated its prior authorization criteria for the Synagis® 2014 - 2015 season. Below are some highlights for the season. Complete criteria can be found on the website at the following link: http://medicaid.alabama.gov/CONTENT/4.0_Programs/4.5.0_Pharmacy/4.5.14_Synagis.aspx
- The approval time frame for Synagis® will begin October 1, 2014 and will be effective through March 31, 2015. Up to five doses will be allowed per recipien in this timeframe. There are no circumstances that will result in the approval of a 6th dose.
- If a dose was administered in an inpatient setting, the date the dose was administered must be included on the request form. Subsequent doses will be denied if child experiences a breakthrough RSV hospitalization during the RSV season.
- **Prescribers**, not the pharmacy, manufacturer or any other third party entity, are to submit requests for Synagis® on a separate prior authorization form (Form 351) directly to Health Information Designs and completed forms may be accepted beginning September 2, 2014 (for an October 1 effective date).
- Stamped or copied physician signatures will not be accepted and will be returned to the provider.
- A copy of the hospital discharge summary from birth or documentation of the first office visit with pertinent information (gestational age, diagnosis, etc.) is required on all Synagis® PA requests.
- If approved, each subsequent monthly dose will require submission of the recipient's current weight and last injection date and may be faxed to HID by the prescribing physician or dispensing pharmacy utilizing the original PA approval letter.
- Medicaid is the payor of last resort. Claims must be billed to the primary payor if other third party coverage exists. Use of NCPDP Other Coverage Codes will be reviewed and inappropriately billed claims will be recouped.

Criteria

Alabama Medicaid follows the 2014 American Academy of Pediatrics (AAP) Redbook guidelines regarding Synagis® utilization. The AAP Guidelines were updated 7/28/14 and there are major changes that may affect your patients in the upcoming RSV season. For more details, please review a copy of the guidelines found at http://pediatrics.aappublications.org/content/early/2014/07/23/peds.2014-1665.

Additional questions regarding Synagis® criteria can be directed to the Agency's Prior Authorization contractor, Health Information Designs at 1-800-748-0130.



ATTENTION: DENTAL PROVIDERS

Reimbursement Changes for Dental Claims with TPL

Effective October 01, 2014, Alabama Medicaid will be changing its reimbursement for dental claims that have TPL. HP will begin capturing Third Party Liability patient responsibility amounts at both header and detail levels for Dental claims.

In order for claims with TPL to be considered for payment, the patient responsibility must be greater than zero. Patient responsibility is calculated by adding together any co-payments, co-insurance and deductible. Claims that do not contain a patient responsibility will deny with error status code 631 (TPL Patient Responsibility is Zero for Payer).

When calculating payment methodology for claims with TPL primary, Medicaid will pay the lesser of patient responsibility or Medicaid allowed amount minus TPL paid amount for dental claims.

Coming Soon - Important Affordable Care Act (ACA) Related Changes

Section 1104 of the Patient Protection and Affordable Care Act (ACA) establishes new requirements for administrative transactions that will improve the effectiveness of the existing Health Insurance Portability and Accountability Act (HIPAA) transactions and reduce administrative costs. Effective Summer 2015, Alabama Medicaid Agency and HP will implement updates to comply with Phase III - Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) Electronic Funds Transfer (EFT) & Electronic Remittance Advice (ERA) Operating Rules.

The rules should be reviewed by all providers and their trading partners to determine impacts to their systems. The rules can be accessed on the CAQH Web site at http://www.caqh.org/ORMandate_EFT.php.

Medicaid now has a section on our website dedicated to CAQH CORE Operating Rules. The information can be found at the following link: http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.5_CAQH_Core_Operating_Rules.aspx. The website will be updated regularly as new information is made available for providers.

Rule 350 Health Care Claim Payment/Advice (835) Infrastructure – Action Required by Providers

Rule 350 defines dual-delivery (paper/electronic) of remits. Alabama Medicaid currently offers electronic v5010 835 remittance advice (ERA) transactions to enrolled submitters as well as proprietary remittance advice reports via web access. All providers will be required to have access to the Electronic Remittance Advice (ERA).

Provider Next Steps – Enroll for ERA

If you **DO NOT** have a Trading Partner ID, visit the Alabama Medicaid Interactive Portal at: https://www.medicaid.alabamaservices.org/ALPortal/Tab/41/content/InformationLinks/InformationLinks.html.spage. Click on Information/Alabama Links and download the Trading Partner ID Request Form. Complete the appropriate sections and return to the EMC Help Desk via mail, email or by fax. EMC will process the form. A PIN letter will be generated and mailed to you.

If you **DO** have a Trading Partner ID visit the **Administrative Forms** section of the Alabama Medicaid website at http://medicaid.alabama.gov/CONTENT/5.0_Resources/5.4_Forms_Library/5.4.6_Provider_Enrollment_Forms.aspx. Download the Electronic Remittance Agreement. Complete the appropriate sections and return to the EMC Department via mail, or by fax.

Providers can contact the EMC Help Desk toll-free at: (800) 456-1242 or (334) 215-0111 for more information.

Rule 360 Uniform Use of CARC/RARC Codes in 835 – Information Only

Rule 360 identifies a set of four Core-defined Business Scenarios with a maximum set of Core-required code combinations that can be used to provide details on a Provider Remittance Advice about claims adjustments or denials to providers. Explanation of Benefit Codes (EOB) will now be assigned to a particular Business Scenario and only valid combinations of Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) defined by CAQH CORE for the assigned Business Scenario will be allowed for return on the 835. Alabama Medicaid currently provides a crosswalk between its proprietary error codes and the HIPAA (Core defined) CARC in Appendix J: Provider Remittance Advice (RA) Codes of the Alabama Medicaid Provider Manual.

Initial updates for Alabama Medicaid are planned for Summer 2015. Subsequent changes will be implemented three times per year to coincide with updates received from CAQH CORE. Beginning January 2015, the Explanation of Benefits Listing will be published to a dedicated page on the Medicaid website after each release. Appendix J: of the Provider Manual will be revised to contain a link to the listing on the Medicaid website. An RA Banner message will be produced to coincide with each update.

Rule 370 EFT & ERA Re-association (CCD+/835) – Action Required by Providers

To comply with the EFT & ERA Re-association (CCD+/835) Operating Rule, Alabama Medicaid will provide standardized data to match the EFT payment to the 835 Remittance Advice detail. This data is delivered to providers using the following:

- Version 5010 X12 835 Remittance Advice (ERA) transaction
- Automated Clearing House (ACH) Cash Concentration and Disbursement Plus One Addenda Record (CCD+) transaction format for EFT as specified in the National Automated Clearing House Association (NACHA) Operating Standards

Provider Next Steps – Request Re-association Information

Alabama Medicaid implemented CCD+ changes September 2013. Providers must contact their financial institutions to request that the necessary data for re-association is sent with each EFT payment.

CAQH CORE has developed a sample letter you may customize and email to your bank or use as talking points for a phone or in person meeting with bank contacts. The sample letter is available in the CORE section of the CAQH website at http://www.caqh.org/Host/CORE/EFT-ERA/Sample_Provider_EFT_Re-association_Data_Request_Letter.pdf.

ATTENTION:

Hospital Providers

Reimbursement Changes for Inpatient Claims with TPL

Effective October 1, 2014, Alabama Medicaid will be changing its reimbursement for inpatient claims that have TPL. Inpatient claims will continue to capture Third Party Liability patient responsibility amounts at the header.

In order for claims with TPL to be considered for payment, the patient responsibility must be greater than zero. Patient responsibility is calculated by adding together any co-payments, co-insurance and deductible. Claims that do not contain a patient responsibility will deny with error status code 631 (TPL Patient Responsibility is Zero for Payer).

When calculating payment methodology for claims with TPL primary, Medicaid will pay the lesser of patient responsibility or Medicaid allowed amount minus TPL paid amount for inpatient claims.

System changes will be implemented at a later date for the payment methodology for Outpatient claims.

Hospice Providers

Changes to Reimbursement for Levels of Care - Claims Processing for the Hospice Program

Effective October 1, 2014, the following billing changes will be implemented for Hospice levels of care:

1. Hospice Providers will be required to span bill claims (up to one month) – billing only one detail line per claim.

2. Hospice Providers should bill one procedure code for one unit/per day of service for all hospice procedure codes except T2045 General Inpatient Care/per day, which can be billed with T2042 Routine Home Care/per day. T2042 should be billed on a separate claim with overlapping dates of service.

NOTE: This does not include T2042-SC Continuous Care. The Continuous Care billed amount must be calculated based upon the number of hours of care provided. The units will continue to be based upon the number of days.

The Agency will conduct a retrospective review of Hospice claims going back one year. If a Hospice Provider has "double-billed" and received reimbursement from the Agency within the review period, the Agency will recoup monies that were reimbursed for the erroneous billing.

For questions regarding Claims Processing for the Hospice Program, please contact Felicha Fisher, Hospice Program Manager @ (334) 353-5153 or felicha.fisher@medicaid.alabama.gov.

REMINDER:

Recovery Audit Contractor (RAC) Audits

Mandatory provisions of the Affordable Care Act require the Alabama Medicaid Agency to select and provide oversight for a Medicaid Recovery Audit Contractor (RAC) to perform provider audits. Goold Health Systems (GHS), a Maine-based firm, was selected to be Alabama Medicaid's Recovery Audit Contractor (RAC) for a two-year period that began January 1, 2013.

The RAC program is designed to improve payment accuracy by identifying under and overpayments in Medicaid. The Medicaid RAC program is a separate program from the Medicare RAC which is overseen by the Centers for Medicare and Medicaid Services.

Reviews will be conducted by GHS staff to include full time medical directors, pharmacists, certified professional coders, and experienced clinicians. Audits will be conducted by GHS using a "top down" approach where data analysis, through data mining, is applied against the universe of paid claims to identify patterns of utilization or billing which look atypical based on Alabama Medicaid and/or national standards. Following the high-level claims analysis, GHS may expand its review by requesting clinical records and/or other documents in accordance with state and federal regulations.

GHS has been informed of the critical role that all providers play in a successful Medicaid program and requires that auditors be professional, objective, and consistent in performing all required audits/reviews.

Providers are reminded that the Alabama Administrative Code and their Provider Agreements require compliance with requests for medical records for Medicaid program audits.

Questions regarding the audits should be directed to Sandra Shaw, RAC Program Manager, at (334) 242-5372 or sandra.shaw@medicaid.alabama.gov or Jacqueline Thomas, Program Integrity Division Director, at (334) 242-5318 or jacqueline.thomas@medicaid.alabama.gov.

Alabama Medicaid Bulletin

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Check Write Schedule Reminder:

Note: **There will be 3 check writes in October.**
There will be 1 check write in November
There will be 2 back-to-back check writes in December.

10/03/14	12/12/14	03/06/15	05/15/15
10/17/14	01/02/15	03/20/15	06/05/15
10/31/14	01/16/15	04/03/15	06/19/15
11/14/14	02/06/15	04/17/15	07/10/15
12/05/14	02/20/15	05/01/15	07/24/15

The release of funds is normally the second Monday after the RA date. Please verify direct deposit status with your bank. Go to *www.medicaid.alabama.gov* to view the payment delay update details. Payment alerts will be posted only if there will be a payment delay. As aways, the release of direct deposits and checks depends on the availability of funds.

Provider *Insider*

Alabama Medicaid Bulletin **January 2015**

REMINDER:

RECOVERY AUDIT CONTRACTOR (RAC) AUDITS

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Providers are reminded that the Alabama Administrative Code and their Provider Agreements require compliance with requests for medical records for Medicaid program audits.

Questions regarding the audits should be directed to:

Ethel Talley, RAC Program Manager,
at (334) 242-5340 or
ethel.talley@medicaid.alabama.gov

or

Bakeba Thomas, Provider Review Associate Director,
at (334) 242-5634 or
bakeba.thomas@medicaid.alabama.gov

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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 _____

The information contained within is subject to change. Please review your Provider Manual and all Provider Alerts for the most up to date information.

PROVIDER NOTICE:

Physicians' Signature Designee

In the Alabama Medicaid Agency Provider Manual, there are many references to medical documentation (e.g., orders, referrals, plans of care, plans of treatment, treatment plans, etc.) requiring a physician's signature or the physician's designee signature. This is to clarify that a physician's designee, for the purpose of signing medical documentation, must be either a physician or a non-physician practitioner. Failure on the part of the provider to comply will result in non-compliance citations during Medicaid audits and may result in recoupment of funds paid by Medicaid.

DURABLE MEDICAL EQUIPMENT (DME) PROGRAM CHANGES

Attention:
DME Providers, Prosthetics & Orthotics (P&O) Providers, Pharmacies, Physicians, Physician Assistants, Nurse Practitioners

DME Repair with "RB" Modifier Process

Effective January 1, 2015, Alabama Medicaid will implement the RB Modifier for specific wheelchair (manual or power) repair/accessory procedure codes. For recipients ages 21 years and over, repairs exceeding $1000.00 dollars per day will require prior authorization (PA). For recipients ages 0-20, repairs will continue to require PA.

The "RB" modifier must be used with the HCPCS code(s) for all replacement parts furnished in conjunction with the repair of the beneficiary-owned base equipment. Miscellaneous parts that are not identified by a specific HCPCS code(s) are billed using procedure code K0108. Procedure code K0108 will not be included in this process and will continue to require PA.

This process will not override the current limitation audits for each of the procedure codes. For example, if the recipient has already received the yearly limit for a specific procedure code (e.g., 2 per calendar year), the repair will require PA, even if it is less than the threshold amount of $1000.00 dollars per day.

More information, including a list of codes requiring PA, can be found on the DME fee schedule published on the Agency's website at the following link: http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.6_Fee_Schedules.aspxthe.

NEED TO UPDATE THIRD PARTY INFORMATION ON A RECIPIENT?

During the eligibility verification process, if it is determined that Medicaid has a Third Party Insurance that is no longer on file; providers can contact the Third Party Division at the Medicaid Agency with a policy cancellation date and request the file be updated.

The most efficient way to contact the Third Party Division is to go to Medicaid's website at: http://www.medicaid.alabama.gov/CONTENT /6.0_Providers/6.1_Benefit_Coordination.aspx.

Select: Update Health Insurance Information, and complete the on-line form to report the change.

Providers may also call the Third Party Division by calling the direct line of the appropriate staff person to update health insurance. Please call the number listed below based on the recipient's last name:

Recipient's Last Name	**A – H**	334-242-5249
Recipient's Last Name	**I – P**	334-242-5280
Recipient's Last Name	**Q – Z**	334-242-5254

Fax Number: 334-353-2922

In the event that the assigned worker is unable to assist you, please contact either of the other workers. If an answering machine picks up please leave a message as all calls are returned the day they are received.

ADDRESS UPDATE CAPABILITY ON SECURE PROVIDER WEB PORTAL

The Medicaid Agency has the capability within the secure Provider Web Portal, https://www.medicaid.alabamaservices.org/ALPortal/Account/Secure%20Site/tabId/66/Default.aspx, to allow providers to update Service Location contact information, Payee and Mailing addresses and phone numbers. To access this functionality after signing into the secure web portal, click "Providers" on the top menu bar. The current Payee and Mailing address and service location contact information will be displayed. Providers can make changes to the displayed information. The changes will be made to the provider's file immediately.

Prior to March 12, 2012, providers were able to submit written requests to update the above information. Now, any written requests received by Provider Enrollment after March 12, 2012, will be returned to the provider directing them to the secure Provider Web Portal to make requested updates. Providers are not presently allowed to update the service location address and must continue to contact Provider Enrollment to make those changes.

EMERGENCY SERVICES ONLY

The following aid categories are covered for "emergency services" only:

EK
EY
EC
ED
EP

In order for these "emergency services" to be paid by Medicaid, the provider must submit the recipient's claim as an "emergency". Please refer to chapter 5 of the Provider Billing Manual or to the Companion Guide for instructions on filing a claim for an "emergency."

REMINDER:

ALL ACUTE CARE HOSPITALS, RESIDENTIAL TREATMENT FACILITIES AND INPATIENT PSYCHIATRIC HOSPITALS

Reporting Hospital-Acquired Conditions (HAC) and Present on Admission (POA) on the UB-04 Claim Form

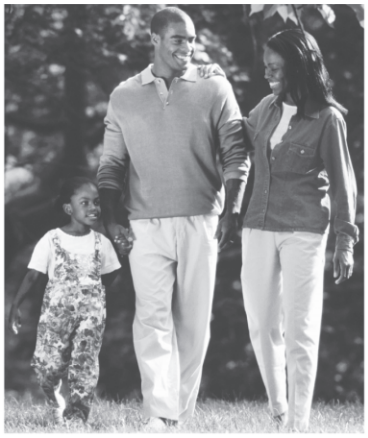
Hospital-Acquired Conditions are conditions that are reasonably preventable and were not present or identified at the time of admission; but are either present at discharge or documented after admission. The Present on Admission (POA) Indicator is defined as a set of specified conditions that are present at the time the order for inpatient hospital occurs. Present on admission is defined as present at the time the order for inpatient admission occurs-conditions that develop during an outpatient encounter, including the emergency room, observation, or outpatient surgery, are considered present on admission.

It is the responsibility of the hospital to identify these events, report them, and not seek any additional payment for additional days. Medicaid will accept all POA indicators as listed below:

- **Y –** Yes.
  Diagnosis **was present** at time of inpatient admission.
- **N –** No.
  Diagnosis **was not present** at time of inpatient admission.
- **U –** No information in the record.
  Documentation insufficient to determine if the condition was present at the time of inpatient admission.
- **W –** Clinically undetermined.
  Provider **unable to clinically determine** whether the condition was present at the time of inpatient admission.
- **1 –** Unreported/not used. **Exempt** from POA reporting.

If the value code '81' is indicated; then non-covered days must be present and the amount field must be greater than '0'.

When requested, it is the hospital's responsibility to include all supporting documentation with the chart for a review to be conducted by Medicaid's contracted Quality Improvement Organization (QIO). Submission of a root cause analysis is not required but may be submitted as part of the documentation to support billing.



Patient 1st

Health Care Close To Home

ATTENTION: PATIENT 1ST PROVIDERS

Effective March 1, 2015, providers will be required to use the Medicaid Interactive Web Portal to make Patient 1st assignments changes. If you are not already using the web portal to make Patient 1st assignment changes, please read the following information for instruction on how to begin using this user friendly tool.

If you are enrolled as a group provider to receive your Patient 1st assignments or if you are an individual physician not enrolled as a group, you may log on to the web portal as you do for all other transactions. If you are enrolled as an individual Patient 1st provider within a non-patient 1st group, you were mailed a letter in March 2014 with an additional web portal log on to access the web portal for each provider in the group to make Patient 1st assignment changes only. For any other features via the web portal, please continue to use your current User ID log on. The secure website is available at the following location: **https://www.medicaid.alabamaservices.org/ALPortal/Account/Secure%20Site/tabId/66/Default.aspx**.

This site may be accessed from the Medicaid website using the drop-down menu under Providers. Providers should then access the following path: **providers/PMP assignment.**

A recipient's Medicaid number, or name and date of birth, or date of birth and SSN must then be entered to request the change. The same criteria for patient's assignments must still be met. Providers will have the capability to override panel holds, age restrictions, and gender restrictions set by the PMP. The provider's PMP panel must be open, and the caseload not be met at the time the assignment is being made. Providers will not be allowed to override the following restrictions in addition to some other restrictions:

- Recipient is locked into another physician (Not a Patient 1st assignment)
- Recipient has been previously dismissed from PMP attempting to make the assignment
- Requesting provider is not a Patient 1st participating provider
- PMP panel at contractual maximum limit
- Recipient is not currently eligible for the Patient 1st program

If the change is made by the 15th of the month, the effective date of the Patient 1st change will be the 1st day of the next month. If made after the 15th, it will be effective the following month. This eliminates the need to fax or e-mail Patient 1st change requests to HP Enterprise Services, and assures you the change has been made. If you have any questions, please contact Provider Assistance Center at 1-800-688-7989 or contact one of your Provider Representatives, contact information is available at the following location: **http://medicaid.alabama.gov/CONTENT/8.0_Contact/8.2.6.1_Provider_Reps_G1.aspx.**

PATIENT 1ST / EPSDT REFERRALS

When conditions are identified during EPSDT Screenings and referrals are needed, the reason for the EPSDT referral must be included on the Alabama Medicaid Referral Form (Form 362) or other medical documentation. If using Form 362, the reason for the referral should be noted in the box labeled: "Reason for Referral". Completing the referral form correctly and including the reason for referral or other medical documentation will eliminate audit citations for this oversight. The referral form may be accessed in paragraph E.18, Appendix E, of the Medicaid Provider Manual on Alabama Medicaid Agency's website by clicking the following link:

http://www.medicaid.alabama.gov/documents/6.0_Providers/6.7_Manuals/6.7.8_Provider_Manuals_2014/6.7.8.4_October_2014/Oct14_E.pdf.

COMING SOON - ICD-10 GENERAL OVERVIEW TELECONFERENCE

The HP ICD-10 team will offer an additional "ICD-10 General Overview" teleconference on January 29, 2015 at 10:00 a.m. as the January 22, 2015 session has reached capacity. Both teleconferences will provide an overview of the changes being implemented by Alabama Medicaid for ICD-10. The session will include a segment where the ICD-10 team will be available to answer questions.

Registration is now open and available on the Alabama Medicaid website at http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.12_ICD-10/6.12.6_ICD-10_Teleconference_Training.aspx.

If you have any questions or require assistance with ICD-10 testing, contact the HP ICD-10 team via e-mail at alabamaictesting@hp.com.

ELECTRONIC UPLOAD AND SUBMISSION OF MEDICAL RECORDS NOW AVAILABLE

Changes have been made to allow Long Term Care, Hospice, PEC, Swing Bed and Inpatient Psychiatric Providers to attach and upload medical records via the Medicaid Interactive Web Portal, eliminating the cost of mailing documents in for processing. A secure logon or access to the Medicaid Interactive Web Portal must be established if one does not already exist to access this new attachment option. Documents may be uploaded two different ways:

- Medicaid Interactive Web portal (preferred) https://www.medicaid.alabamaservices.org/ALPortal/Account/Secure20Site/tabId/66/Default.aspx.
- Fax information in for processing (bar coded cover sheet required)

The August 28, 2014, ALERT outlines detailed instructions on how to upload medical records. The ALERT can be accessed via the following link: http://medicaid.alabama.gov/news_detail.aspx?ID=9092.

Paper submission of the medical records will not be allowed in the future, therefore, providers are encouraged to start using the electronic upload and submission.

Providers with questions concerning the upload of medical records should contact one of their Provider Representatives. A link to the Provider Representative's contact information may be found at the following link: http://www.medicaid.alabama.gov/CONTENT/8.0_Contact/8.2.6.1_Provider_Reps_G1.aspx.

ATTENTION:

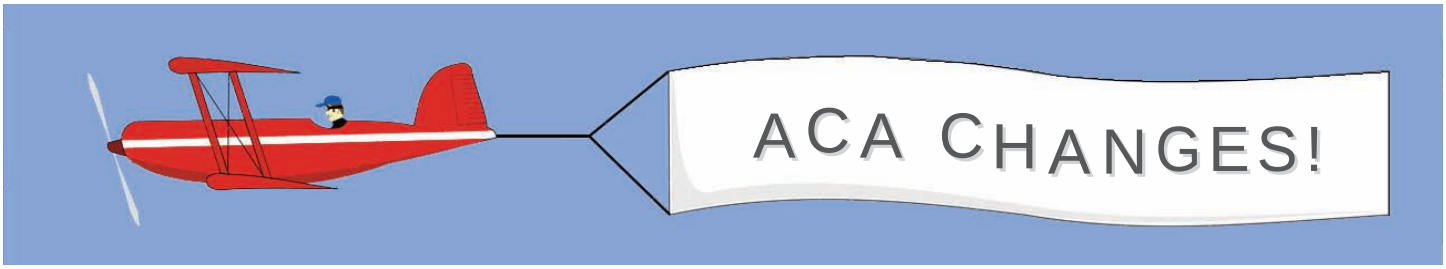
ALL HOSPITALS

REIMBURSEMENT OF HOSPITAL OUTPATIENT VISITS

Effective for dates of service January 1, 2015, and thereafter, outpatient visits will no longer be limited to 3 per calendar year. The Alabama Medicaid Agency will reimburse all in-state and out-of-state hospitals claims for medically necessary outpatient visits without regard to an annual limitation.

Note: At this time, physician office visits will continue to be limited to 14 per calendar year and physician hospital visits will continue to be limited to 16 per calendar year.

For questions, contact Solomon Williams, Associate Director, Institutional Services at 334-353-3206 or via e-mail at solomon.williams@medicaid.alabama.gov.



COMING SOON: *AFFORDABLE CARE ACT (ACA) CHANGES*

Effective Summer 2015, Alabama Medicaid Agency and HP will implement updates to comply with Phase III - Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) Electronic Funds Transfer (EFT) & Electronic Remittance Advice (835/ERA) Operating Rules. The Phase III rules are Rule 350, Rule 360, Rule 370, Rule 380 and Rule 382. Information provided within this communication is in relation to some of the aforementioned rules.

Providers and trading partners should review these rules to determine impacts to their systems. The rules can be accessed on the CAQH Web site at http://www.caqh.org/ORMandate_EFT.php.

Alabama Medicaid and HP encourage providers and trading partners to access the CAQH CORE Operating Rules page on the Alabama Medicaid Agency at the following link:
http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.5_CAQH_Core_Operating_Rules.aspx. The website will be updated regularly as new information is made available.

Rule 350 Enroll for Electronic Remittance Advice (ERA) – Action Required by Providers

Electronic Remittance Advice (ERA), or the 835, is the HIPAA-compliant detailed explanation of how a submitted health care claim was processed.

Why should a provider enroll for an 835/ERA? All providers will be required to obtain a trading partner ID or identify a trading partner to receive 835s/ERAs on their behalf, and complete the ERA enrollment.

If you are not yet enrolled in 835/ERA follow the below steps:

- If you **DO NOT** have a trading partner ID, visit the Alabama Medicaid Interactive Portal at:
  https://www.medicaid.alabamaservices.org/ALPortal/Tab/41/content/InformationLinks/InformationLinks.html.spage
  Click on Information/Alabama Links and download the trading partner ID Request Form.
  Complete the appropriate sections and submit to the Electronic Media Claims (EMC) Help Desk as directed on the form

- If you **DO** have a trading partner ID visit the **Administrative Forms** section of the Alabama Medicaid website at:
  http://medicaid.alabama.gov/CONTENT/5.0_Resources/5.4_Forms_Library/5.4.6_Provider_Enrollment_Forms.aspx.
  Download the Electronic Remittance Agreement.
  Complete the appropriate sections and submit to the EMC Help Desk as directed on the form.

Providers can contact the EMC Help Desk Toll-free
Monday – Friday, 7:00 a.m. – 8:00 p.m. CST, or Saturday, 9:00 a.m. – 5:00 p.m. CST at (800) 456-1242

Rule 360 Uniform Use of CARC/RARC Codes in 835 – Information Only

Rule 360 identifies a set of four Core-defined Business Scenarios with a maximum set of Core-required code combinations that can be used to provide details on a Provider's Remittance Advice (PDF or 835/ERA) about claims adjustments or denials.

Initial updates for Alabama Medicaid are planned for Summer 2015. Subsequent changes will be implemented three times per year to coincide with updates received from CAQH CORE. Beginning January 2015, the Explanation of Benefits (EOB) Listing will be published to a dedicated page on the Alabama Medicaid Agency website after each release. An RA Banner message will be produced to coincide with each update.

Rule 370 Re-association Request: Contact Your Bank – Action Required by Providers

Re-association is a process that supports matching of payments with claim data for posting to your patient accounts. Alabama Medicaid implemented Cash Concentration and Disbursement Plus One Addenda Record (CCD+) changes September 2013.

Providers should contact their financial institutions to request the necessary data to associate EFT payments to 835/ERAs.

A sample letter is available in the CORE section of the CAQH website at http://www.caqh.org/benefits.php. (Go to Mandated Operating Rules then select EFT and ERA. Scroll down to Implementation Resources section). The Sample Provider EFT Re-association Data Request Letter is available to use as a guide for creating a letter to submit to your financial institution or to use as a talking point guide when calling your financial institution to discuss re-association.

Why is it important for providers to complete the re-association request? This process allows providers to obtain data needed to associate the electronic remittance advice (835s/ERAs) to their electronic funds transfer (EFT). It does not affect claims processing. You do not need to send any information to Alabama Medicaid or HP Enterprise Services.

NOTE: An automated means of re-association cannot be supported if:

- A provider is not enrolled to receive both EFT and 835/ERA;
- A provider is not receiving the necessary 835/ERA re-association information from their trading partner, or;
- A provider has not yet made arrangements with their financial institution to receive the new CCD+ re-association information on their EFT.

Rule 370 EFT/ERA Elapsed Time Requirements - Process Change Notification

In order to meet the requirements of Affordable Care Act (ACA) Operating Rule 370 (EFT and ERA Re-association Rule (CCD+/835)) elapsed time requirements, Alabama Medicaid must release the v5010 X12 835 (ERA) and the corresponding EFT within three (3) business days of each other.

Effective Summer 2015, Alabama Medicaid will begin releasing ERA/835's within three (3) business days (plus or minus) of the EFT being released. This is a change to current day processes where the 835/ERA is made available to providers even when funds related to the 835/ERA have not yet been released.

Note: There is currently no change to the availability of the proprietary RA which will continue to be available on the web portal following each check write cycle.

Providers and trading partners are encouraged to monitor the CAQH CORE Operating Rules page on the Medicaid website at: http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.5_CAQH_Core_Operating_Rules.aspx as it will be updated regularly as new information is made available.

Rule 370 Late or Missing EFT and 835/ERA Transaction Resolution Procedures

Affordable Care Act Operating Rule 370, section 4.3, designates that a health plan must establish written Late or Missing EFT and 835/ERA Transaction Resolution procedures defining the process a healthcare provider must use when researching and resolving a late or missing Healthcare EFT Standards payment and/or corresponding late or missing v5010 X12 835 (ERA).

Late or Missing is defined as a maximum elapsed time greater than three (3) business days following the receipt of either the Healthcare EFT Standards or v5010 X12 835 (ERA).

Detailed information on resolving Late or Missing EFT and 835/ERA Transaction Resolution Procedures can be found on the Alabama Medicaid website at: http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.5.2.3_CAQH_CORE_370.aspx. If the information on the Medicaid website does not produce an answer to the late or missing EFT or 835/ERA, please contact the EMC Help Desk toll-free Monday – Friday, 7:00 a.m. – 8:00 p.m. CST, or Saturday, 9:00 a.m. – 5:00 p.m. CST at (800-456-1242).

Rule 350 Health Care Claim Payment/Advice Batch Acknowledgement – Action Required by Providers

Rule 350, Health Care Claim Payment/Advice Batch Acknowledgement Requirement requires trading partners to return a v5010 X12 999 Implementation Acknowledgement (Inbound 999) to a health plan (Alabama Medicaid) for each group of v5010 X12 835 (ERA) transactions received to indicate the transactions were either accepted, accepted with errors or rejected. HPES and the Alabama Medicaid Agency are required to accept the Inbound 999 from trading partners.

Instructions on how to submit the Inbound 999 using the Web Portal are provided on the Alabama Medicaid Agency website at: http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.5.2.1_CAQH_CORE_350.aspx.

Alabama Medicaid Bulletin

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01/02/15	03/20/15	05/15/15	07/24/15
01/16/15	04/03/15	06/05/15	08/07/15
02/06/15	04/17/15	06/19/15	08/21/15
02/20/15	05/01/15	07/10/15	09/04/15
03/06/15			09/11/15

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