

ALABAMA MEDICAID

July 2010 Provider Manual

Provider Insiders



Click on Bookmarks to the left to view Provider Insiders

RETURN TO MAIN MENU

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.



In This Issue...

New Version of Provider Electronic Solutions Software Is Now Available	1
Prior Authorization Needed for Orendia and Kineret	2
Notice for Vaccine for Children Providers	2
Lead Poison Screening is Essential	2
Change in Definition of Global Surgical Packages	2
SSI Certified Women and Unborn Babies	2
Clarification: TPL Policy on EPSDT / Preventive Services	3
Changes for Interactive Transactions Will Affect Users and Venders	3

PA Request for Ambulance	3
Sleep Studies Must be Billed With Correct Provider Number	4
An Oral Health Reminder	4
New Procedure for Billing Bilateral Procedures	4
Alabama Medicaid: In The Know	5
Attention DME Providers	6
Revised Billing Instructions for ESDST Referred Services	6
Important Mailing Addresses	6
Patient 1 st Recipient Dismissals	7
Patient 1 st InfoSolutions	7
State Fiscal Year 2006-2007 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 _____

Prior Authorization Needed For Orenzia and Kineret

Effective September 1, 2006, injectable drugs Orenzia 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 correctable 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.

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

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

**Alabama
Medicaid
Bulletin**



PRRST STD
U.S. POSTAGE
PAID
PERMIT # 77
MONTGOMERY AL

Provider Insider

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

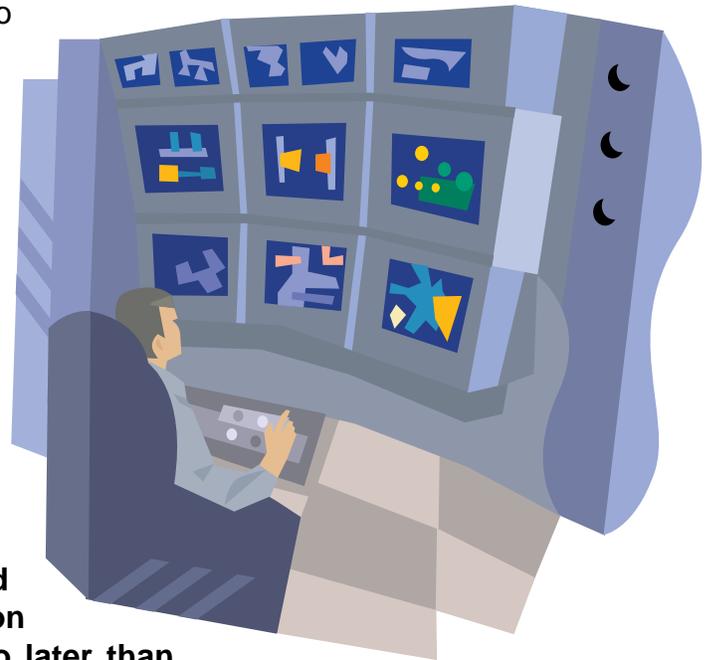
As always, the release of direct deposits and checks depends on the availability of funds.

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.

In This Issue...

Send Your NPI Information to EDS!	1	Medical Cost Overview	4
Global Surgical Package 10-Day Post Op Period Codes	2	Temporary Addition of Two Drugs	4
Eyeglasses Benefit Limit	2	Alabama Medicaid: In The Know	5
PA Requests for Air and Ground Ambulance	2	Prior Authorization Criteria for Synagis	6
Procedure for Billing Bilateral Procedures	2	Screening for Lead Poisoning is Essential	6
Transition Issues with CMS Coordination of Benefit Agreement (COBA)	3	Change in Max Units for Allergy Immunotherapy	6
Clarification of School-based Services	3	Are Your Educational Needs Met?	6
Important Mailing Addresses	3	New Online Catalog Offers More Materials and Streamlined Ordering Process	7
Changes for Interactive Transactions will Affect Users and Venders	3	Attention Anyone Who Uses a Software Vendor to Submit Electronic Claims	7
Hospice Program Changes	4	Attention Patient 1 st and EPSDT Providers	7
		Preparing for Emergencies at Home Handouts are Now Available	7
		State Fiscal Year 2006-2007 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 _____

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 recipients 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.

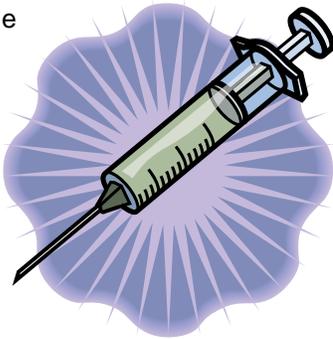
Transition Issues with CMS Coordination of Benefit Agreement (COBA)

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 Newline 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



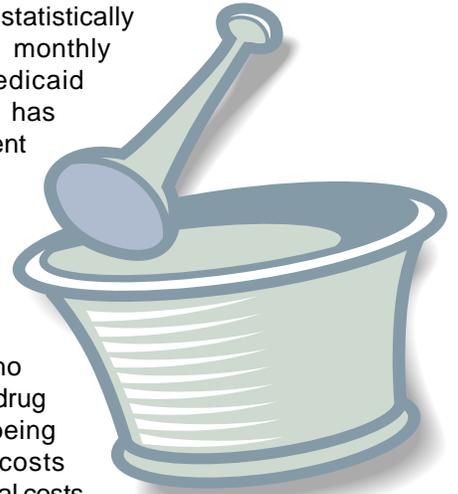
Providers can :

- ◆ 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[®] and Relenza[®], 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

Actos
Actoplus Met
Advair HFA
Avandaryl
Humalog
Rozerem

October 2, 2006 PDL Deletions*

Combipatch
Flonase
Nasarel
Wellbutrin XL

* 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/ac/ppp>. For any question, please call (334) 206-2966 or (800) 545-1098.

www.medicaid.alabama.gov

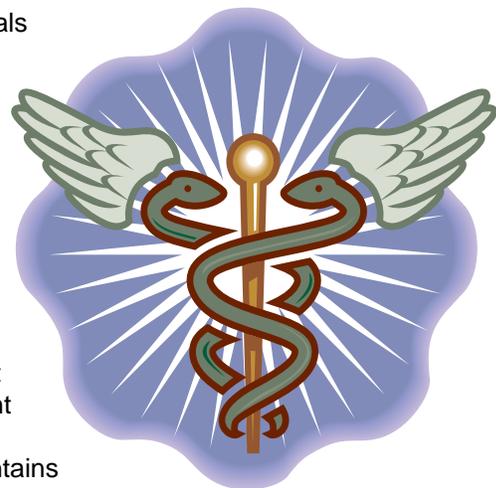
Change in Max Units For Allergy Immunotherapy

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

Post Office Box 244032
Montgomery, AL 36124-4032

**Alabama
Medicaid
Bulletin**



PRRST STD
U.S. POSTAGE
PAID
PERMIT # 77
MONTGOMERY AL

Provider Insider

Alabama Medicaid Bulletin

January 2007

The checkwrite schedule is as follows:

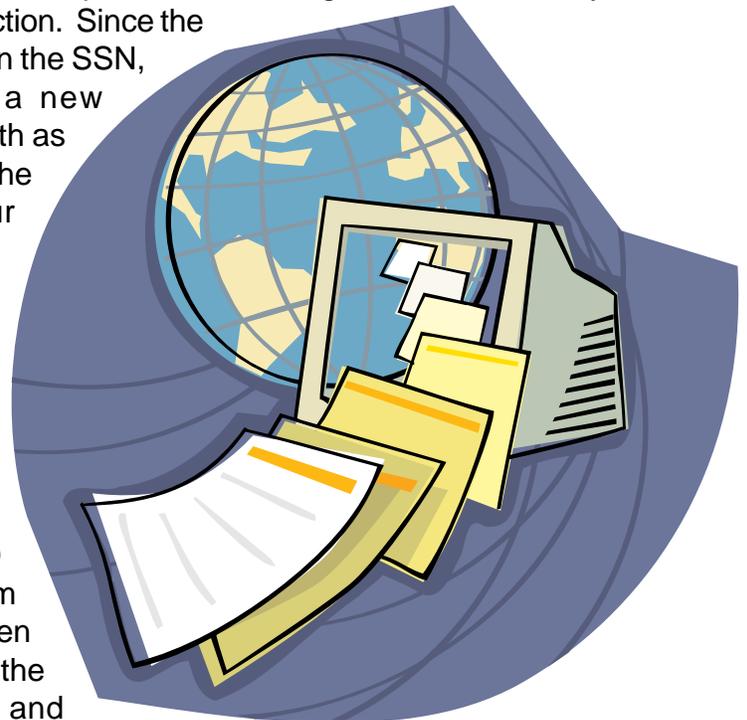
01/05/07 01/19/07 02/09/07 02/23/07 03/09/07 03/23/07

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

In This Issue...

All Alabama Medicaid Recipient ID Numbers are Changing	1
Eyecare Providers: Routine Checkups and Medicare	2
EPSDT Interperiodic Screening Codes Have Changed	2
Long Term Care Waivers Amended	2
PMP Open Caseloads	2
Third Party Billing for EPSDT Services and Vaccines for Children (VFC)	3
Attention DME Providers	3
Patient 1 st Referral Report	4

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**:

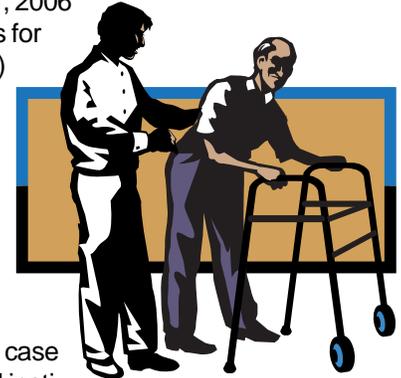
- 99211EP-99215EP – Office and/or Outpatient setting
- 99233EP – Inpatient Hospital setting

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.

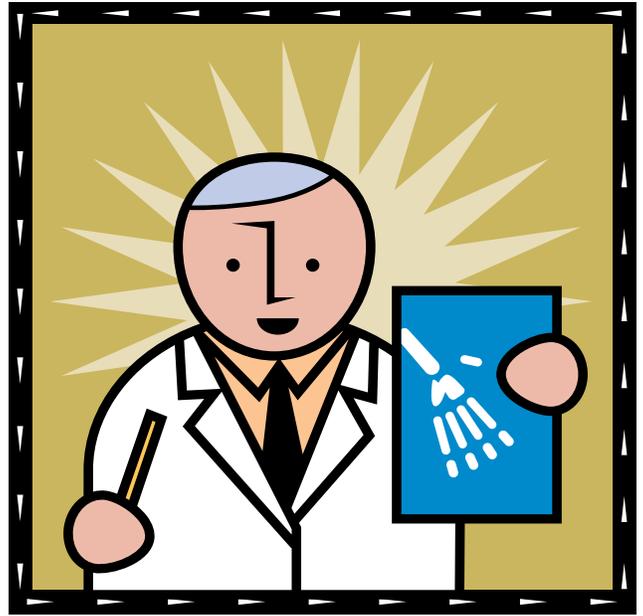
Providers who call with questions should be directed to the EDS provider help center at 1-800-688-7989. Information may also be found on the Medicaid website at: http://www.medicaid.alabama.gov/news/medicaid_id_numbers.aspx?tab=2



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.



Post Office Box 244032
Montgomery, AL 36124-4032

Alabama
Medicaid
Bulletin



PRRST STD
U.S. POSTAGE
PAID
PERMIT # 77
MONTGOMERY AL

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.

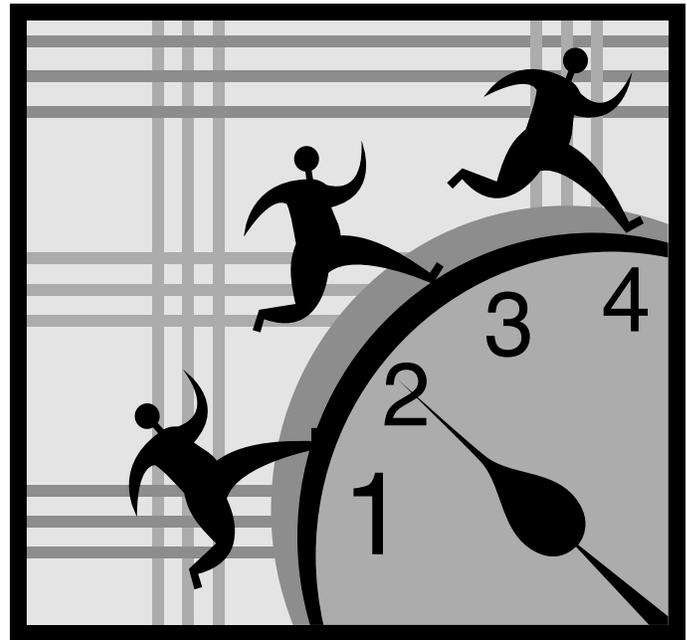
You should submit an NPI Notification form, which can be located on the Medicaid website at, www.medicaid.alabama.gov/billing/NPI.aspx, along with a copy of the notification letter received from the enumerator, to EDS. The NPI Notification form for Individual Providers should be completed to link your 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.

In This Issue...

NPI Notification Deadline Date Has Passed	1	Attention VFC Providers	3
Procedures Requiring Prior Authorization	2	Hyaluronan (Sodium Hyaluronate) or Derivative for Intra-Articular Injection	3
Pulse Oximetry Information	2	Attention Hospice Providers	3
Medicaid Adopts the CPT Modifier 51 Exempt Policy	2	DME Provider Information	3
EDS Is Not Accepting the Updated CMS-1500 or the UB-04 Forms	2	Dental Policy Clarifications	3
PMP Disenrollment From Patient 1 st	2	Procedures to Follow When Recipients Request to Change Rendering Providers for a Prior Authorized DME Procedure	3
Clarification on Billing Interperiodic EPSDT Screening	2	PMP Request Dismissal of Recipient	4
		EPSDT Interperiodic Screening Codes Have Changed	4

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.

PRRST STD
U.S. POSTAGE
PAID
PERMIT # 77
MONTGOMERY AL

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



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.

In This Issue...

The New Medicaid Claims Processing System Date Has Been Postponed	1
Billing Refractors for Dual Eligibles	2
Modifier "76"	2
Place of Service Restrictions for Physicians Billing Injectable Drugs	2
Distinct Procedural Service (Modifier 59)	2
Important Mailing Addresses	2
EDS Provider Representatives	3
Releasing the Prior Authorization Number	4
Reminder of Timely Submission of Prior Authorization Requests	4

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.

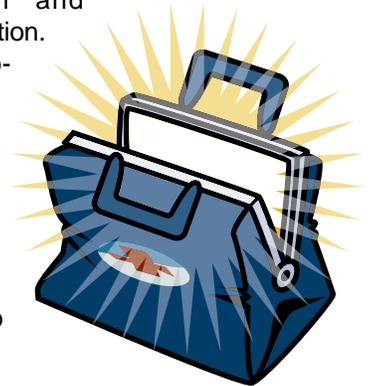


www.medicaid.alabama.gov

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

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



karen.hutto

@eds.com
334-215-4158

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

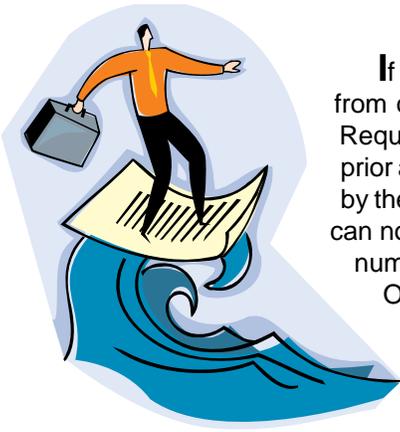
@eds.com
334-215-4156



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.

Montgomery, AL 36124-4032
Post Office Box 244032

**Alabama
Medicaid
Bulletin**



PRRST STD
U.S. POSTAGE
PAID
PERMIT # 77
MONTGOMERY AL

Provider Insider

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 deposits 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 www.infosolutions.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.

In This Issue...

The InfoSolutions Web Site Is Changing!	1
Medicaid is Now Partnered With APS Healthcare	2
Hospice Form Change	2
Organ Transplant Guidelines	2
Patient 1 st Care Coordination Services Available for Dental Providers	2
DME Provider Enrollment Update	2
Patient 1 st and EPSDT Services	3
Procedure Code Changes for Sodium Hyaluronate (Hyaluronan)	4
Procedure Code Changes for Immune Globulin	4

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 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 in-state.

- After the determination that the transplant cannot be performed in-state 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.

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.

Patient 1st

Health Care Close To Home

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.

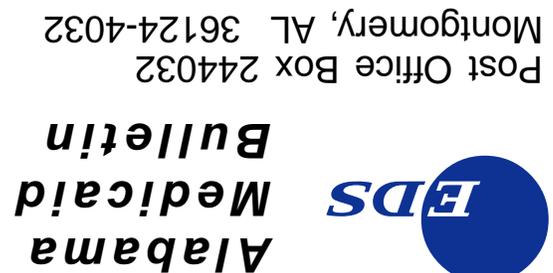
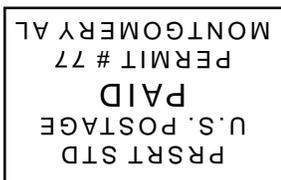
Please refer to the Physicians' Drug Fee Schedule on Medicaid's website at www.medicaid.alabama.gov or call the EDS Provider Assistance Center (800) 688-7989 for reimbursement and guidelines.

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, (Octagam), 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.



Provider Insider

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

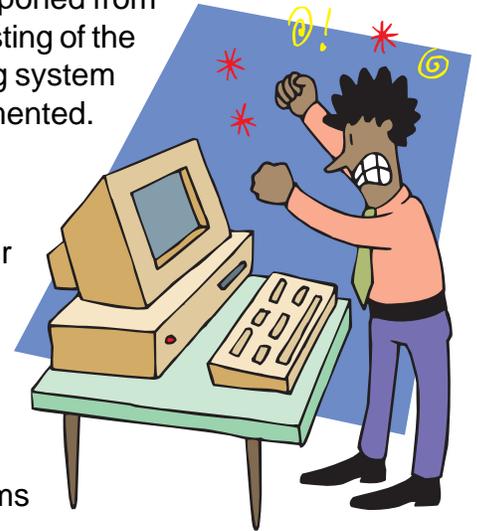
As always, the release of direct deposits and checks depends on the availability of funds.

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 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 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.

In This Issue...

The New Medicaid Claims Processing System Date Has Been Postponed	1
Prior Authorization Criteria For Synagis	2
In-state Inpatient Hospital Claims Must Follow PHP Payment Guidelines	2
Hospice Palliative Drug List	2
PMP Disenrollment From Patient 1 st	3
Tamper Resistant Prescription Pads	3
State Fiscal Year 2007-2008 Checkwrite Schedule	4

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 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.

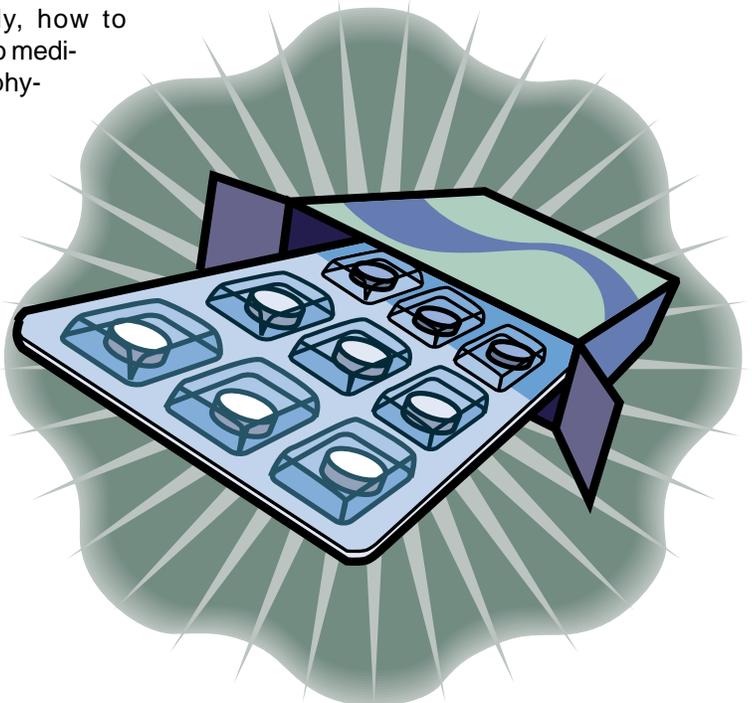
Tamper Resistant Prescription Pads

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

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



**Alabama
Medicaid
Bulletin**

PRRST STD
U.S. POSTAGE
PAID
PERMIT # 77
MONTGOMERY AL

Provider Insider

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



In This Issue...

interChange Beta Testing Available for Medicaid Providers and Vendors	1
Inpatient Hospital Claims Must Follow PHP Payment Guidelines	2
Resources Utilized to Determine if a Procedure Code Requires a PA	2
Modifier "76"	2
Dental Procedure Codes	2
Requirement for Nursing Facilities	2
Preferred Drug List Updates	3
Alabama Medicaid Increases Prescription Brand Limits	3
DME Updates	4

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 _____

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 I Receptor 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 Therapy 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.

PRRST STD
U.S. POSTAGE
PAID
PERMIT # 77
MONTGOMERY AL

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

Provider Insider

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



New Medicaid Claims Payment System to go Live	1	CMS-1500 Claim Form Filing Instructions	6	Important Information Regarding Compound Drug Billing	14
Determining Service Location On a Claim	2	UB-04 Claim Form Filing Instructions	8	Inpatient Hospitals Should Follow PHP Guidelines	14
Changes to Provider Electronic Solutions	2	Revised State Fiscal Year 2008-2009 Checkwrite Schedule	11	Instructions for the Final Checkwrite in the Current System	15
Changes to the LTC Software	2	Schedule for Upcoming Provider Workshops for the New System	12	Trading Partner ID Request Form	16
Providers Must Have the New NPI Number ...	2	UB-04 Field Changes	13		
Toll Free Number for Interactive Transactions Will Be Discontinued	2	Important Mailing Addresses	13		
Remittance Changes Due to interChange	3	EDS Contact Information	13		
Providers: Look for the New Web Portal PIN	3	New System Changes Quick List	13		
Trading Partner PIN Setup Instructions	3	New Alabama Interactive Website Will Replace Current Medicaid Website	14		

In This Issue...

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 Medical (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 activate the web portal PIN?

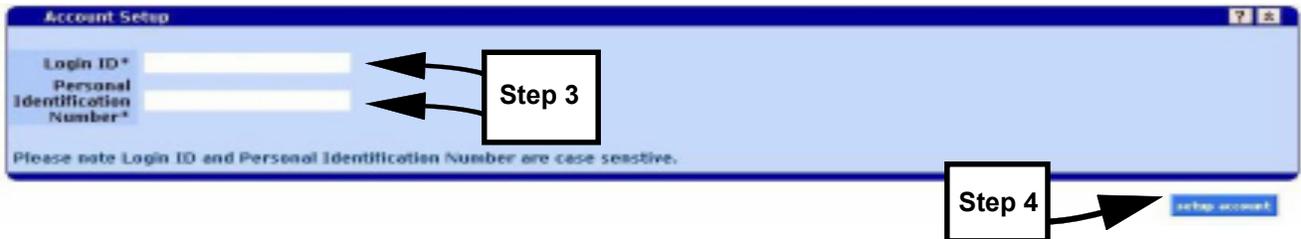
Step 1: Go to the new Medicaid web portal at: <https://www.medicaid.alabamaservices.org/ALPortal>

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 fields with an *Asterisk on the screen. Passwords must be at least 8 characters in length, with 6 alpha characters and two numeric characters.

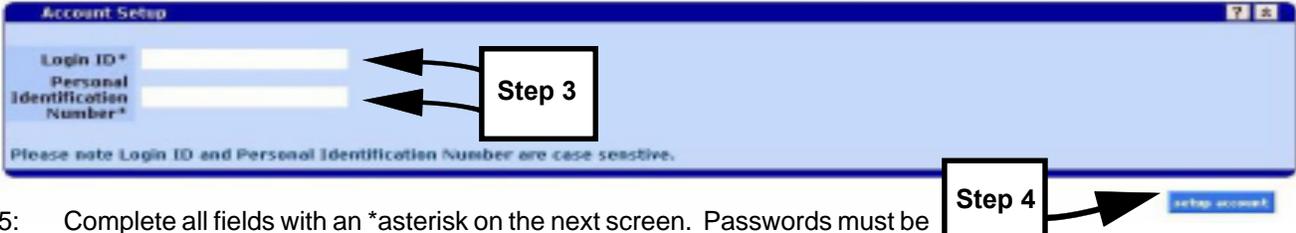
The screenshot shows the 'Account Setup' form with all fields filled. The 'Login ID' field contains '1004737B' and the 'Personal Identification Number' field contains 'ET5D6UmfW'. Below these fields is a note: 'Please note Login ID and Personal Identification Number are case sensitive. Required fields are indicated with an asterisk (*).'. The form includes the following fields: 'User Name*', 'Contact Last Name*', 'Contact First Name*', 'Phone Number*', '1st Secret Question*', '1st Answer*', '2nd Secret Question', '2nd Answer', 'Password*', 'Confirm Password*', 'EMail*', and 'Confirm EMail*'. At the bottom right, there are 'submit' and 'cancel' buttons.

Trading Partner PIN Setup Instructions

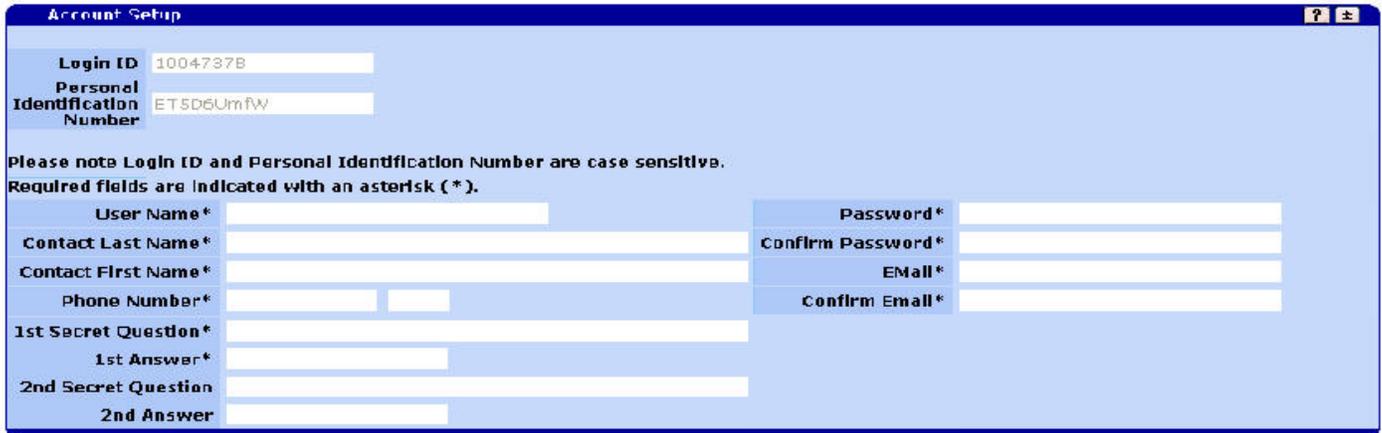
Trading partner PIN's will be issued to providers upon request. Providers must obtain a new trading partner PIN if they submit claims through Provider Electronic Solutions or a vendor that connects directly to EDS for claims submission. If you use a switch or a clearinghouse to submit your claims, you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

How do I register my Trading Partner PIN?

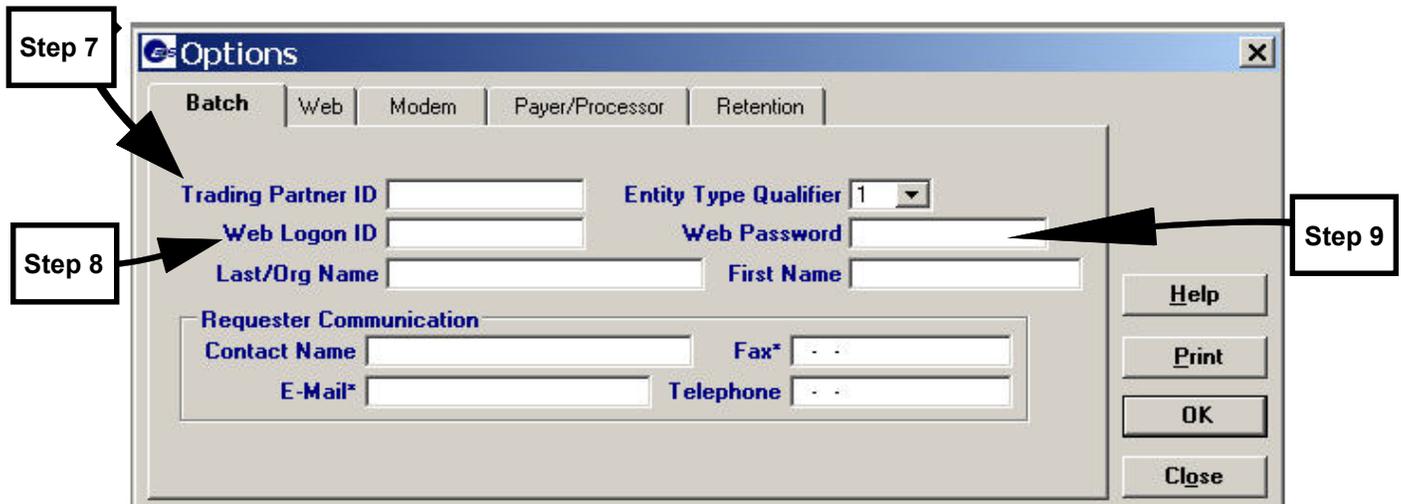
- Step 1: Access the new Medicaid web portal at: <https://www.medicaid.alabamaservices.org/ALPortal>
- Step 2: Go to Account then click on account setup
- Step 3: Enter the log in ID exactly as it appears on the letter in the logon ID field. Enter PIN from the letter in the Personal Identification Number 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: <ul style="list-style-type: none"> • 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 1 st , 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: <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • "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: <ul style="list-style-type: none"> ▪ 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	<p>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.</p> <p>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.</p> <p>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.</p>
12	Admission Date/Start Date of Care	<p>Enter the total days represented on this claim that are not covered. This is not required for outpatient claims.</p> <p>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.</p>
13	Admission hour (required field)	<p>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).</p>
14	Type of admission	<p>Enter the appropriate type of admission code for inpatient claims:</p> <ul style="list-style-type: none"> 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	<p>Enter the appropriate source of admission code for inpatient claims.</p> <p>For type of admission 1, 2, or 3</p> <ul style="list-style-type: none"> 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 <p>For type of admission 4 (newborn)</p> <ul style="list-style-type: none"> 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	<p>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.</p>
17	Patient discharge status	<p>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.</p> <p>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).</p>
18-28	Condition Codes	<p>The following UB-04 condition codes are valid for EPSDT referrals:</p> <ul style="list-style-type: none"> 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. <p>If A1 is entered here, a referring provider number must be indicated in block 78.</p>

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: <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • 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 implementation 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

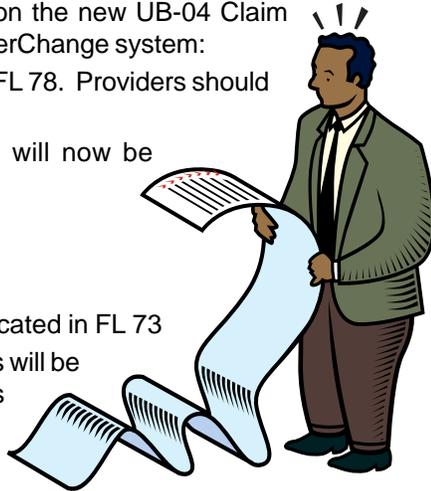
February 19

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 new Alabama 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 software 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 via an 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 9999999999. 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 guidelines. 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 activated. 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 Partner ID Request Form

Trading Partner 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 through 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.

PRRST STD
U.S. POSTAGE
PAID
PERMIT # 77
MONTGOMERY AL

Alabama
Medicaid
Bulletin



Post Office Box 244032
Montgomery, AL 36124-4032

ALABAMA MEDICAID

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.

ICN	2207223	Rendering Provider ID	{ Search }
Recipient ID		Claim Type	
TCN		Status	
FDOS		Date Paid	
TDOS			

Step 3

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



In This Issue...

Medicaid Requires a Dispense as Written Override	1
Eyeglasses "New Lenses Only"	2
CPT "Unlisted Services and Procedures"	2
Requirements for Hospital Cost Reports	2
Attention Nursing Home Providers	2
VTC With Third Party and Medicaid Coverage	2
IV/GA Permit for Dental Providers	2
2006 ADA Claim Form Required for Paper Dental Claims	3
Pulse Oximetry Information	3
EDS Provider Representative Contact Information	3
State Fiscal Year 2008-2009 Checkwrite Schedule	4

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 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:

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

Post Office Box 244032
Montgomery, AL 36124-4032

**Alabama
Medicaid
Bulletin**



PRSR1 STD
U.S. POSTAGE
PAID
PERMIT # 77
MONTGOMERY AL

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 deposits 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.



In This Issue...

Medicaid to Begin Accepting NDC's on Certain Administered Drugs	1
Instructions for Adding NDC Codes to Required Medicaid Forms - CMS-1500	2
Instructions for Adding NDC Codes to Required Medicaid Forms - UB-04	3
Medicaid Top 20 Physician-Administered Multiple Source Drugs	4
Questions Concerning NDC on Medicaid Claim Forms	11
Instructions for Adding NDC Codes to Required Medicaid Forms	12
Submitting NDC for Electronic Claims	13
New Version 2.09 Provider Electronic Solutions Available	13
Issues Identified and Resolved	13
Important Mailing Addresses	13
Patient 1 st Referral Report	14
Medicaid Implements New Process to Recoup Part D Drugs	14
EDS Provider Representatives	15
State Fiscal Year 2008-2009 Checkwrite Schedule	16

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 (NUCC)

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA/BLK/NG OTHER 1a. INSURER'S I.D. NUMBER

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 1b. PATIENT'S BIRTH DATE 1c. INSURER'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S ADDRESS (No. CITY ZIP CODE

4. OTHER INSURED'S NAME 5. OTHER INSURED'S POLICY 6. OTHER INSURED'S DATE OF BIRTH (MM DD YY) 7. EMPLOYER'S NAME OR SERVICE 8. INSURANCE PLAN NAME OR SERVICE 9. PATIENT'S OR AUTHORIZED REPRESENTATIVE'S SIGNATURE (to process this claim, I agree to the terms and conditions on the back of this form.) 10. DATE OF CURRENT SERVICE (MM DD YY) 11. NAME OF REFERRING PHYSICIAN 12. RESERVED FOR LOCAL USE

13. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Please Refer to I, C, E or F in Item 24E by Date)

14. MEDICARE RESUBMISSION CODE ORIGINAL REF NO. 15. AUTHORIZATION NUMBER

1	24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)			E. DIAGNOSIS (ICD-9-CM)	F. CHARGES	G. DRO (OR) LACS	H. UNIT (Per Day)	I. (N/A)	J. RENDERING PROVIDER ID #	
	From	To	MM	DD	YY	MM			DD	YY	CPT/HCPCS							MODIFIER
1	07	01	08	07	01	08	11	0	N4	55390031420	J9265							
2																		
3																		
4																		
5																		
6																		

16. FEDERAL TAX I.D. NUMBER SSN EIN 25. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT (YES/NO) 28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and am ready to pay thereof.) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH # ()

SIGNED DATE a. NPI b. NPI a. NPI b. NPI

NUCC Instruction Manual available at: www.nucc.org APPROVED OMB-0938-0999 FORM CMS-1500 (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.

1	24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)			E. DIAGNOSIS (ICD-9-CM)	F. CHARGES	G. DRO (OR) LACS	H. UNIT (Per Day)	I. (N/A)	J. RENDERING PROVIDER ID #
	From	To	MM	DD	YY	MM			DD	YY	CPT/HCPCS						
1	07	01	08	07	01	08	11	0	N4	55390031420	J9265						
2																	

ID Code Qualifier: N4
11-Digit NDC: 55390031420

Instructions for Adding NDC Codes to Required Medicaid Forms

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50			
8 PATIENT NAME	a	b	c	d	e	f	g	h	i	j	k	l	m	n	o	p	q	r	s	t	u	v	w	x	y	z	aa	ab	ac	ad	ae	af	ag	ah	ai	aj	ak	al	am	an	ao	ap	aq	ar	as	at	au	av	aw	ax	ay	az
10 BIRTHDATE	11 SEX	12 DATE	13 HR	14 TYPE	15 SRC	16 D-R	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50												
31 OCCURRENCE DATE	32 OCCURRENCE DATE	33 OCCURRENCE DATE	34 OCCURRENCE DATE	35 OCCURRENCE DATE	36 OCCURRENCE DATE	37 OCCURRENCE DATE	38 OCCURRENCE DATE	39 OCCURRENCE DATE	40 OCCURRENCE DATE	41 OCCURRENCE DATE	42 OCCURRENCE DATE	43 OCCURRENCE DATE	44 OCCURRENCE DATE	45 OCCURRENCE DATE	46 OCCURRENCE DATE	47 OCCURRENCE DATE	48 OCCURRENCE DATE	49 OCCURRENCE DATE	50 OCCURRENCE DATE																																	
39 CODE	40 CODE	41 CODE	42 CODE	43 CODE	44 CODE	45 CODE	46 CODE	47 CODE	48 CODE	49 CODE	50 CODE																																									
42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45	46 SERVIC UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49																																													
67	A	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK	AL	AM	AN	AO	AP	AQ	AR	AS	AT	AU	AV	AW	AX	AY	AZ								
68 ADMIT DATE	69 TREATMENT REASON/DR	70 OTHER PROCEDURE DATE	71 OTHER PROCEDURE DATE	72 OTHER PROCEDURE DATE	73 OTHER PROCEDURE DATE	74 OTHER PROCEDURE DATE	75 OTHER PROCEDURE DATE	76 OTHER PROCEDURE DATE	77 OTHER PROCEDURE DATE	78 OTHER PROCEDURE DATE	79 OTHER PROCEDURE DATE	80 OTHER PROCEDURE DATE	81 OTHER PROCEDURE DATE	82 OTHER PROCEDURE DATE	83 OTHER PROCEDURE DATE	84 OTHER PROCEDURE DATE	85 OTHER PROCEDURE DATE	86 OTHER PROCEDURE DATE	87 OTHER PROCEDURE DATE	88 OTHER PROCEDURE DATE	89 OTHER PROCEDURE DATE	90 OTHER PROCEDURE DATE	91 OTHER PROCEDURE DATE	92 OTHER PROCEDURE DATE	93 OTHER PROCEDURE DATE	94 OTHER PROCEDURE DATE	95 OTHER PROCEDURE DATE	96 OTHER PROCEDURE DATE	97 OTHER PROCEDURE DATE	98 OTHER PROCEDURE DATE	99 OTHER PROCEDURE DATE	100 OTHER PROCEDURE DATE																				
68 REMARKS	a	b	c	d	e	f	g	h	i	j	k	l	m	n	o	p	q	r	s	t	u	v	w	x	y	z	aa	ab	ac	ad	ae	af	ag	ah	ai	aj	ak	al	am	an	ao	ap	aq	ar	as	at	au	av	aw	ax	ay	az

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	45
1	636	N4 55390031420	J9265
2			

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
				Monoclote-P	00053-7656-01	CSL Behring
				Monoclote-P	00053-7656-02	CSL Behring
				Monoclote-P	00053-7656-04	CSL Behring
				Monoclote-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				
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				
				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								
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								

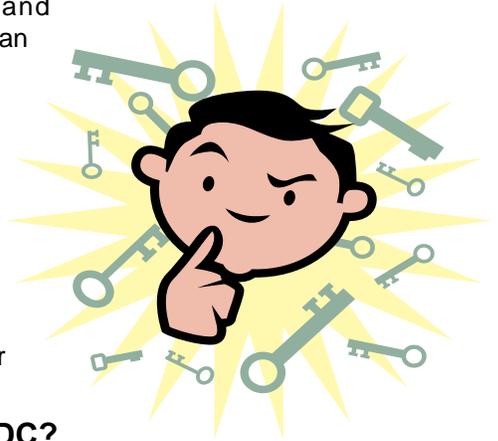
Questions Concerning NDC Additions to Medicaid Claim Forms

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-0XXXX-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.

Submitting NDC For Electronic Claims

For electronic claims, the information concerning submitting NDCs can be found in the addenda to version 4010 of the HIPAA 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 the Ambulatory 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

Patient 1st

Health Care Close To Home

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.

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

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



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

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

Post Office Box 244032
Montgomery, AL 36124-4032

**Alabama
Medicaid
Bulletin**



PRRST STD
U.S. POSTAGE
PAID
PERMIT # 77
MONTGOMERY AL

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

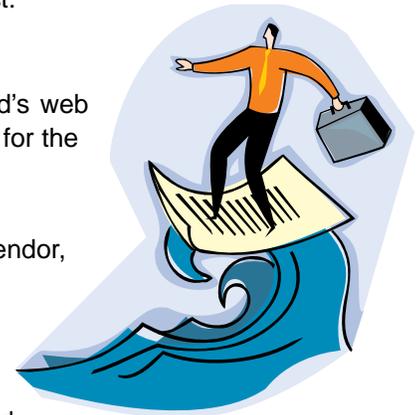
As always, the release of direct deposits and checks depends on the availability of funds.

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 portal letter, please e-mail at the ECM helpdesk at alabamasytemsemc@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 alabamasytemsemc@eds.com

(Continued on page 2)

In This Issue...

Important Information for Providers Submitting Crossover Claims	1
Fees for Form Completion Must Follow Medicaid Guidelines	2
DME Medical Criteria Update	2
Alabama Medicaid Policy for Modifier "JW"	2
Guidelines for Organ Transplants	2
Expanded Requirements of Tamper-Resistant Prescription Pads	3
Important Mailing Addresses	3
In-State Inpatient Hospital Claims Must Follow PHP Payment Guidelines	4
Inpatient Admission After Outpatient Hospital Services	4
NDC Now Mandatory on UB-04 and CMS-1500 Claims	4
Reminder to Hospitals and ER Physicians	5
Synagis Criteria for 2008-2009 Season	6
Medicaid is Not Recognizing Retroactive Awards for Long Term Care	6
What To Do If Your Claim Is In a Suspended Status	6
EDS Provider Representatives	7
State Fiscal Year 2009-2010 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 _____

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 documentation 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 recipients 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 in-state.
- 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

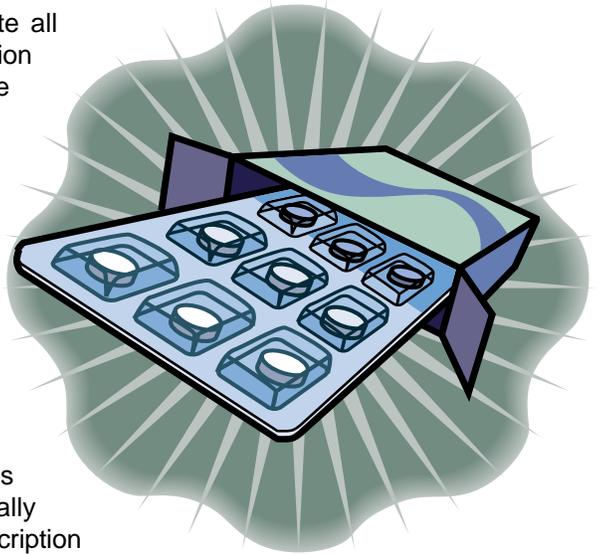
Expanded Requirements of Tamper-Resistant Prescription Pads Mandated by October 1, 2008

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 after, inpatient hospital claims will be paid 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.

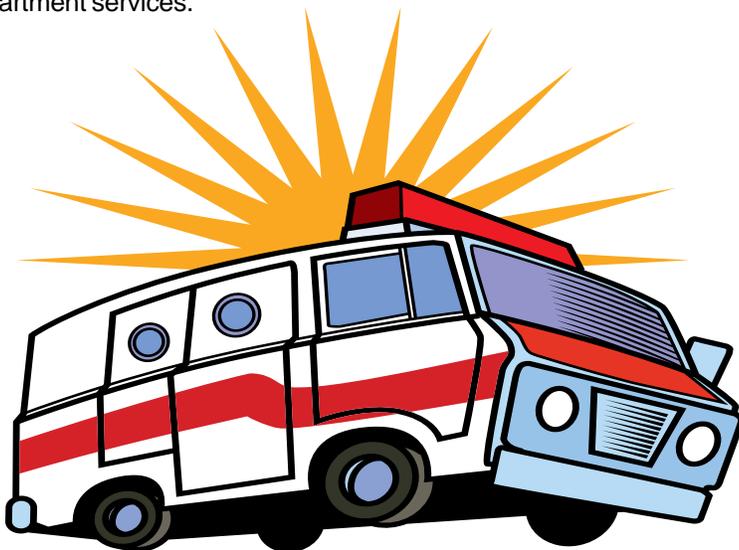
UB-04 claims for emergency department services must be coded according to the criteria established by Medicaid to be considered for payment. Refer to Section 19.5.3, Procedure Codes, and Modifiers, for level of care codes for emergency department services.

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

Post Office Box 244032
Montgomery, AL 36124-4032

**Alabama
Medicaid
Bulletin**



PRRST STD
U.S. POSTAGE
PAID
PERMIT # 77
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 deposits 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)

New Paper Medicaid/Medicare Related Claim Form Available in January	1	Claims Status Response File (CSR)	6	Implementation of Additional VFC Codes	10
Sample of New Medicaid/Medicare Related Claim Form	2	Urinalysis No Longer a Requirement of an EPSDT Screening	6	In-State Inpatient Hospital Claims Must Follow PHP Payment Guidelines	10
Medicaid/Medicare Related Claim Form Filing Instructions	3	EDS Provider Representatives	7	High Frequency Chest Wall Oscillation Air Pulse Generator	11
NDC Now Mandatory for Top 20 Drugs for UB-04 and CMS-1500 Claims	4	New Transformation Initiatives Office Established	7	Important Information for Providers Who Submit Crossover Claims	11
Attention Eye Care Providers	4	Eustachian Tube Inflation	7	New Federal Law Requires Providers to Comply with Medical Records Request	11
Medicaid Eliminating Paper UB-04 Medicaid/Medicare Related Claim Form	5	Home Moisture Exchange System	7	Form 340 Professional Medicare/Medicaid Related Claim Order Form	12
ICN Number Changes	5	Measles and Rubella Vaccination Coverage Discontinued	7		
Plan First Family Planning Program Extended Through September 2011	5	Home Infusion Therapy Policy	8		
Trading Partner IDs	6	Changes to the Patient 1 st Program	9		
		Controlled Dose Drug Delivery System	10		

In This Issue...

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.
1 st DX, 2 nd DX, 3 rd DX, 4 th 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 LT (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

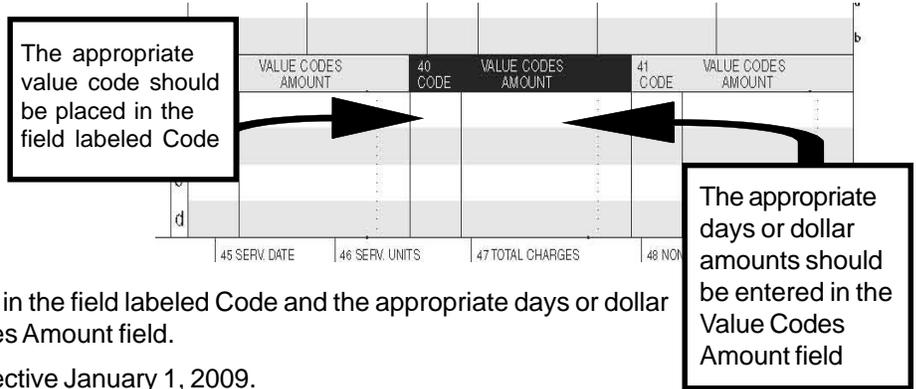
Medicaid Eliminating Paper UB-04 Medicaid/Medicare Related Claim Form

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 **1008017228613**
 NEW **4108017228613**

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

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



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

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.

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.

Patient 1st
Health Care Close To Home

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	Diphtheria, 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	Diphtheria, 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 11, 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

PRRST STD
U.S. POSTAGE
PAID
PERMIT # 77
MONTGOMERY AL

**Alabama
Medicaid
Bulletin**



Post Office Box 244032
Montgomery, AL 36124-4032

Provider Insider

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 deposits and checks depends on the availability of funds.

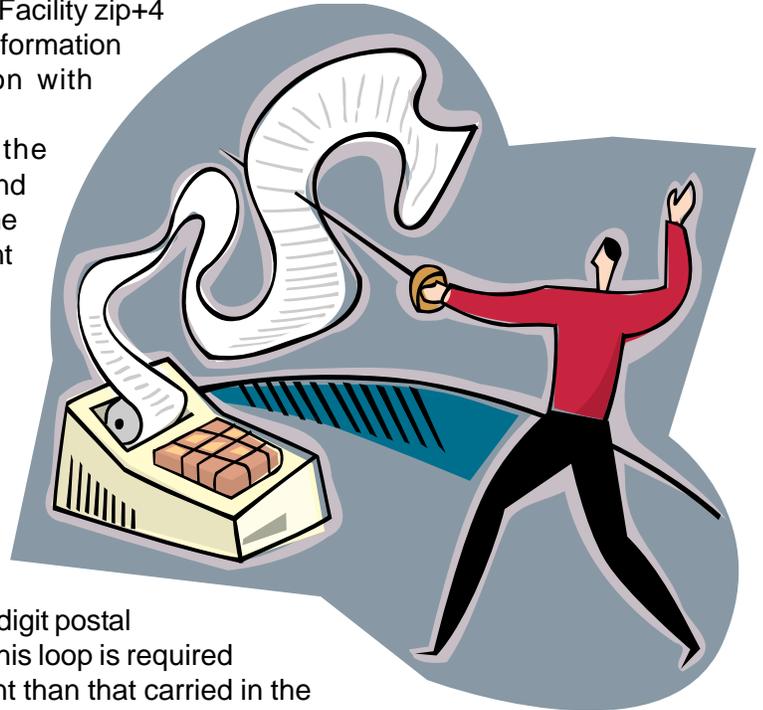
Important Change for Providers Who Submit Using Crossover Claims

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)

In This Issue...

Important Changes for Providers Who Submit Using Crossover Claims	1
Quality Assurance Program Contract Awarded	2
Pulse Oximetry Code Information	2
Attention Mental Retardation and Living at Home Waiver Providers	2
UB-04 Crossover Form Information	2
MedSolutions to Process Radiology Prior Authorizations	3
Medicaid Introduces the 1 st Look Program	3

Trofile Assay is Now a Covered Service	4
NDC is Required on CMS-1500	4
Processing Changes for Provider 1099	4
Changes to the Patient 1 st Program	5
State Seeks Input to Improve Medicaid Maternity Care Program	5
Attention DME Providers	6
Providers Recognized for Outstanding Vaccination Coverage Rates	6
Update to Preferred Drug List	6
EDS Provider Representatives	7
State Fiscal Year 2009-2010 Checkwrite Schedule	8

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 manufacturer, 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 manufacturer, 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.

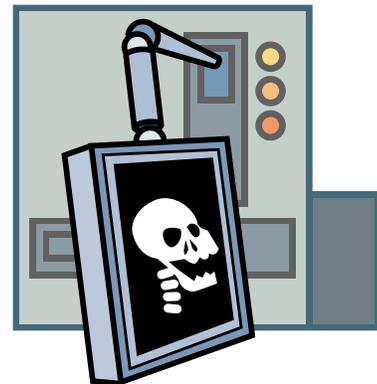
For all MRI's, MRA's, CT scans, CTA's, and PET scans performed on or after February 2, 2009, ordering providers will be required to request prior authorization from MedSolutions. MedSolutions will begin accepting prior authorization requests on February 2, 2009 for dates of service beginning February 2, 2009. Medicaid will provide a grace period to allow providers sufficient time to acclimate to the change. Providers will be required to submit Prior Authorizations 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.

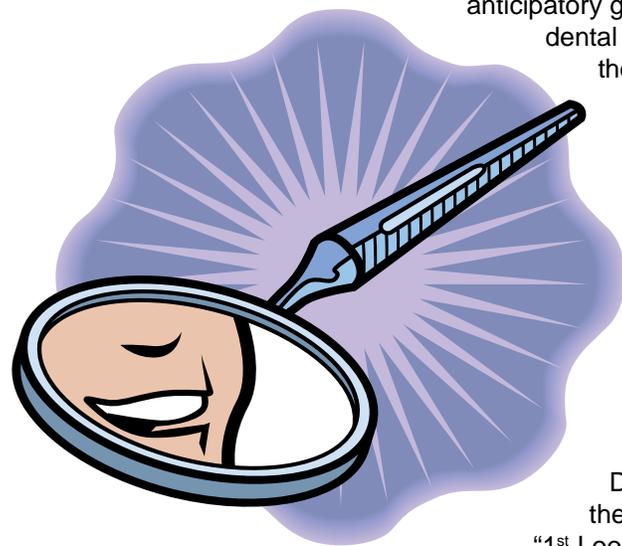
Developed by the Agency in partnership with the state's pediatric dentists and pediatricians, the 1st Look Program is designed to reduce early childhood caries by encouraging primary care physicians to perform dental risk assessments, provide anticipatory guidance, apply fluoride varnish when indicated, 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 Assay 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

837I Format:

(Continued from page 1)

- 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

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



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

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

Post Office Box 244032
Montgomery, AL 36124-4032

**Alabama
Medicaid
Bulletin**



PRSR1 STD
U.S. POSTAGE
PAID
PERMIT # 77
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.

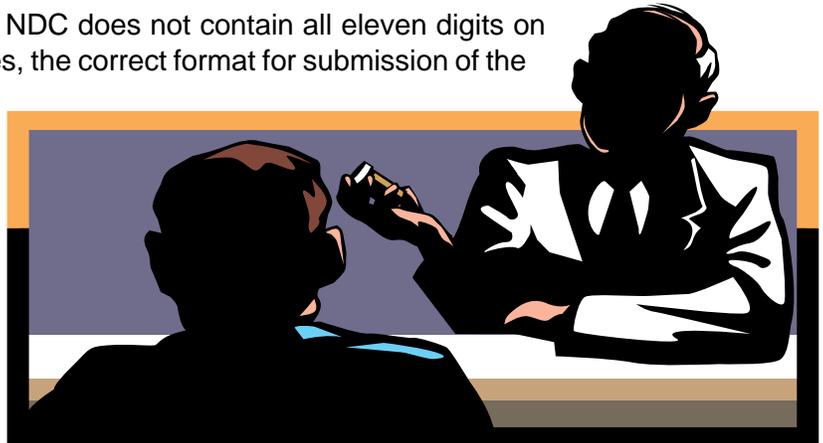
Result: 0xxxxxxxxx.

- 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: xxxxxxxx0x.



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.

In This Issue...

Guidance Regarding NDC's on CMS-1500and UB-04 Claim Forms	1
Instructions for Adding NDC Codes to Required Medicaid Forms - CMS-1500	2
Instructions for Adding NDC Codes to Required Medicaid Forms - UB-04	3
Medicaid Physician-Administered Multiple Source Drugs	4
Appropriate Utilization of Dispense As Written (DAW) Codes	16
Sterilization Claim and Primary Surgeon's Responsibility	17
Essure Method of Sterilization Guidelines	17
Providers Must Screen for Excluded Individuals	18
Indicating Correct NPI on Referral Forms	18
Where Providers Can Look for Excluded Parties	19
State Fiscal Year 2009-2010 Checkwrite Schedule	20
Clarification Concerning Billing NDCs for HCPCS Drug Code	20

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 0895

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FEED BACKLUNG OTHER												1a. INSURED'S I.D. NUMBER																																					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)												3. INSURED'S NAME (Last Name, First Name, Middle Initial)																																					
8. PATIENT'S ADDRESS (No. _____)																																																	
CITY _____																																																	
ZIP CODE _____																																																	
9. OTHER INSURED'S NAME _____																																																	
10. OTHER INSURED'S POLICY _____																																																	
11. OTHER INSURED'S DATE OF BIRTH (MM DD YY)																																																	
12. PATIENT'S OR AUTHORIZED REPRESENTATIVE'S SIGNATURE																																																	
14. DATE OF CURRENT SERVICE (MM DD YY)																																																	
17. NAME OF REFERRING PHYSICIAN																																																	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24C by Line)												22. MEDICARE RESUBMISSION CODE																																					
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS												25. MEDICARE REVISION NUMBER																																					
<table border="1"> <tr> <td>MM</td><td>DD</td><td>YY</td><td>MM</td><td>DD</td><td>YY</td><td>SERVICE</td><td>EMG</td><td>CPT/HCPOS</td><td>MODIFIER</td><td>DIAG</td><td>PC</td> </tr> <tr> <td>07</td><td>01</td><td>08</td><td>07</td><td>01</td><td>08</td><td>11</td><td>0</td><td>J9265</td><td></td><td></td><td></td> </tr> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>												MM	DD	YY	MM	DD	YY	SERVICE	EMG	CPT/HCPOS	MODIFIER	DIAG	PC	07	01	08	07	01	08	11	0	J9265																<p>N4 55390031420</p> <p>J9265</p> <p>ID Code Qualifier 11-Digit NDC</p>	
MM	DD	YY	MM	DD	YY	SERVICE	EMG	CPT/HCPOS	MODIFIER	DIAG	PC																																						
07	01	08	07	01	08	11	0	J9265																																									
26. FEDERAL TAX I.D. NUMBER												27. ACCEPT ASSIGNMENT (For use with Medicare)																																					
28. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS												29. BILLING PROVIDER I.D. & PH #																																					
29. SERVICE FACILITY LOCATION INFORMATION																																																	
SIGNED _____ DATE _____																																																	

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.

Instructions for Adding NDC Codes to Required Medicaid Forms

1	3	5	6	7
8	9	10	11	12
13	14	15	16	17
18	19	20	21	22
23	24	25	26	27
28	29	30	31	32
33	34	35	36	37
38	39	40	41	42
43	44	45	46	47
48	49	50	51	52
53	54	55	56	57
58	59	60	61	62
63	64	65	66	67
68	69	70	71	72
73	74	75	76	77
78	79	80	81	82
83	84	85	86	87
88	89	90	91	92
93	94	95	96	97
98	99	100	101	102
103	104	105	106	107
108	109	110	111	112
113	114	115	116	117
118	119	120	121	122
123	124	125	126	127
128	129	130	131	132
133	134	135	136	137
138	139	140	141	142
143	144	145	146	147
148	149	150	151	152
153	154	155	156	157
158	159	160	161	162
163	164	165	166	167
168	169	170	171	172
173	174	175	176	177
178	179	180	181	182
183	184	185	186	187
188	189	190	191	192
193	194	195	196	197
198	199	200	201	202
203	204	205	206	207
208	209	210	211	212
213	214	215	216	217
218	219	220	221	222
223	224	225	226	227
228	229	230	231	232
233	234	235	236	237
238	239	240	241	242
243	244	245	246	247
248	249	250	251	252
253	254	255	256	257
258	259	260	261	262
263	264	265	266	267
268	269	270	271	272
273	274	275	276	277
278	279	280	281	282
283	284	285	286	287
288	289	290	291	292
293	294	295	296	297
298	299	300	301	302
303	304	305	306	307
308	309	310	311	312
313	314	315	316	317
318	319	320	321	322
323	324	325	326	327
328	329	330	331	332
333	334	335	336	337
338	339	340	341	342
343	344	345	346	347
348	349	350	351	352
353	354	355	356	357
358	359	360	361	362
363	364	365	366	367
368	369	370	371	372
373	374	375	376	377
378	379	380	381	382
383	384	385	386	387
388	389	390	391	392
393	394	395	396	397
398	399	400	401	402
403	404	405	406	407
408	409	410	411	412
413	414	415	416	417
418	419	420	421	422
423	424	425	426	427
428	429	430	431	432
433	434	435	436	437
438	439	440	441	442
443	444	445	446	447
448	449	450	451	452
453	454	455	456	457
458	459	460	461	462
463	464	465	466	467
468	469	470	471	472
473	474	475	476	477
478	479	480	481	482
483	484	485	486	487
488	489	490	491	492
493	494	495	496	497
498	499	500	501	502
503	504	505	506	507
508	509	510	511	512
513	514	515	516	517
518	519	520	521	522
523	524	525	526	527
528	529	530	531	532
533	534	535	536	537
538	539	540	541	542
543	544	545	546	547
548	549	550	551	552
553	554	555	556	557
558	559	560	561	562
563	564	565	566	567
568	569	570	571	572
573	574	575	576	577
578	579	580	581	582
583	584	585	586	587
588	589	590	591	592
593	594	595	596	597
598	599	600	601	602
603	604	605	606	607
608	609	610	611	612
613	614	615	616	617
618	619	620	621	622
623	624	625	626	627
628	629	630	631	632
633	634	635	636	637
638	639	640	641	642
643	644	645	646	647
648	649	650	651	652
653	654	655	656	657
658	659	660	661	662
663	664	665	666	667
668	669	670	671	672
673	674	675	676	677
678	679	680	681	682
683	684	685	686	687
688	689	690	691	692
693	694	695	696	697
698	699	700	701	702
703	704	705	706	707
708	709	710	711	712
713	714	715	716	717
718	719	720	721	722
723	724	725	726	727
728	729	730	731	732
733	734	735	736	737
738	739	740	741	742
743	744	745	746	747
748	749	750	751	752
753	754	755	756	757
758	759	760	761	762
763	764	765	766	767
768	769	770	771	772
773	774	775	776	777
778	779	780	781	782
783	784	785	786	787
788	789	790	791	792
793	794	795	796	797
798	799	800	801	802
803	804	805	806	807
808	809	810	811	812
813	814	815	816	817
818	819	820	821	822
823	824	825	826	827
828	829	830	831	832
833	834	835	836	837
838	839	840	841	842
843	844	845	846	847
848	849	850	851	852
853	854	855	856	857
858	859	860	861	862
863	864	865	866	867
868	869	870	871	872
873	874	875	876	877
878	879	880	881	882
883	884	885	886	887
888	889	890	891	892
893	894	895	896	897
898	899	900	901	902
903	904	905	906	907
908	909	910	911	912
913	914	915	916	917
918	919	920	921	922
923	924	925	926	927

Medicaid Physician-Administered Multiple Source Drugs

In compliance with the Deficit Reduction Act, 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	63323-0345-10	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	00074-2333-11	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	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
			Monoclote-P	00053-7656-01	CSL Behring
			Monoclote-P	00053-7656-02	CSL Behring
			Monoclote-P	00053-7656-04	CSL Behring
			Monoclote-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	63323-0103-64	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			
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
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			

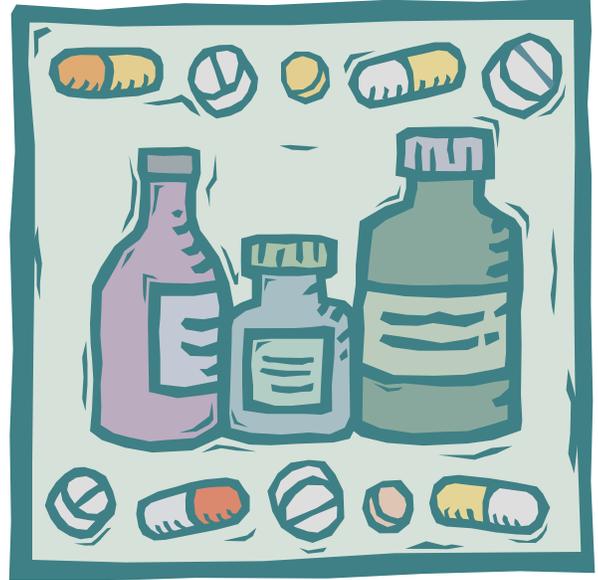
Medicaid Physician-Administered Multiple Source Drugs *(Continued)*

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 HCl 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 will **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 "Title of the person obtaining consent" designation which is 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 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)

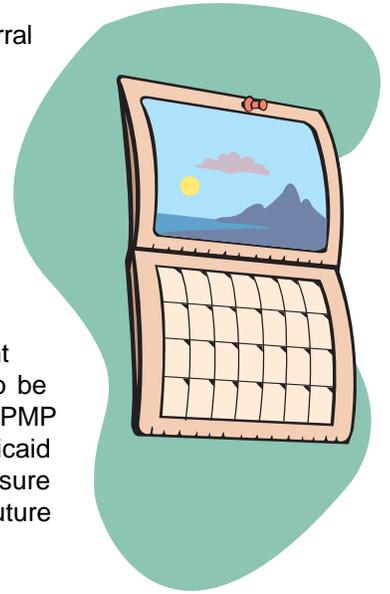


Indicating Correct NPI on Referral Forms

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 a 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.

PRSR1 STD
U.S. POSTAGE
PAID
PERMIT # 77
MONTGOMERY AL

**Alabama
Medicaid
Bulletin**



Post Office Box 244032
Montgomery, AL 36124-4032

Provider Insider

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.



In This Issue...

Recoupment of Medicare-Related Claims on July 10, 2009 Remittance Advice	1
Obtaining Medicaid Recipient Identification Numbers	2
Attention Eyecare Providers	2
New Version of Provider Electronic Solutions Now Available	2
Congratulations to Providers with Exceptional Vaccination Coverage Rates	2
Endovenous Laser Ablation of Varicose Veins and Endoluminal Radiofrequency Ablation of Saphenous Varicose Veins	3
Changing Procedure Codes on Radiology Prior Authorizations for CT Scans, MR Scans and PET Scans	3
Financial Help for Spaying and Neutering Your Pets Available Statewide	3
State Fiscal Year 2009-2010 Checkwrite Schedule	4

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

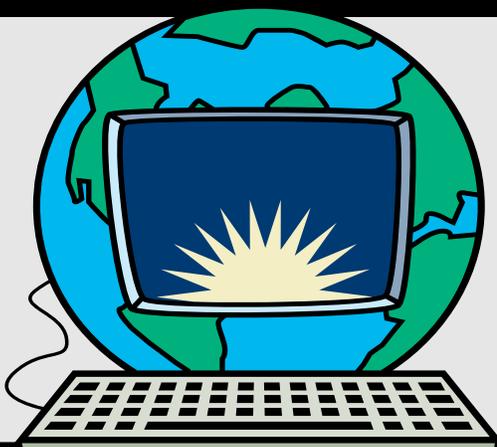
Providers can obtain a recipient's Medicaid Identification Number (RID) in one of two ways. All Medicaid providers have access to the Medicaid Provider Assistance Center at 1-800-688-7989 (out of state providers (334) 215-0111. The provider or the provider's representative can call the Medicaid Provider 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.

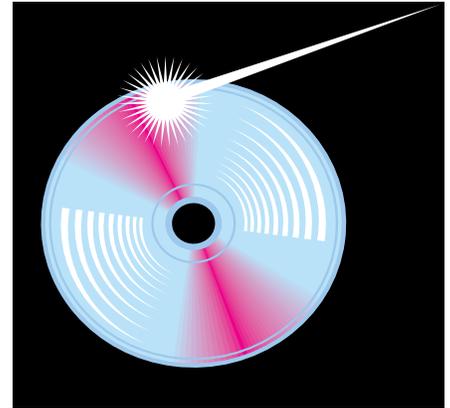
Visit Alabama Medicaid
ONLINE



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: alabamasytemsemc@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

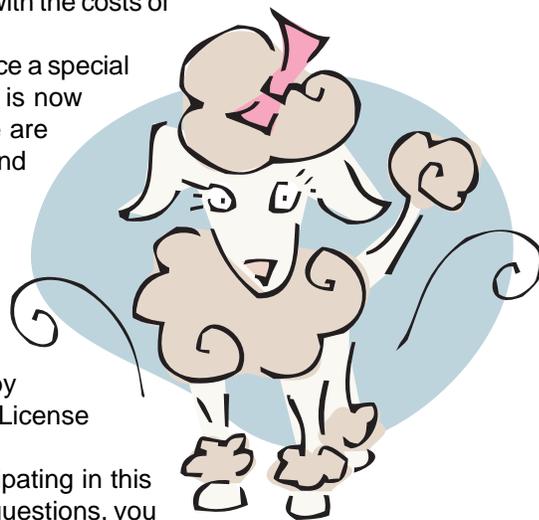
The Alabama Veterinary Medical Association (ALVMA) and The Alabama Veterinary Medical Foundation (ALVMF) are pleased to announce a new program available for Medicaid recipients to help with the costs of spaying and neutering their pets.

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

Post Office Box 244032
Montgomery, AL 36124-4032

**Alabama
Medicaid
Bulletin**



PRRST 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 deposits and checks depends on the availability of funds.

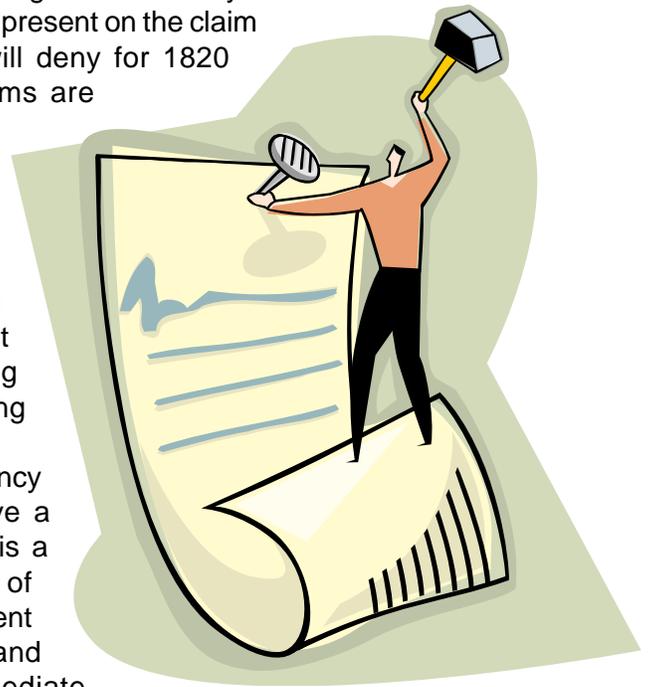
EDS Identifies Top Five Denials for Physician Claims

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 obtained 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.



(Continued on page 2)

In This Issue...

EDS Identifies Top Five Denials for Physician Claims	1
Review of Neonatal Critical Care Codes	2
Friendly Reminder Regarding Procedure D4355	2
Attention DME Providers	2
New Adolescent Protection: Part Three	3
Flu Season is Here!	3
Alabama Medicaid: In the Know - What is a BPA Error	4
New Dismissal Form for Patient 1 st Providers on Website	5
Essure Follow-up Procedures and the Plan First Recipient	5
COBA Denial Explanation	6
Synagis Criteria for 2009-2010 Season	6
Attention DME Providers Billing Procedure Code E1399 / E1399-EP	7
Claims Suspending for Edit 3306	7
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 _____

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 (PA) request is placed in an approved status in the Alabama Medicaid Interchange PA 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 indicator 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 institutional outpatient claims (837I), 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 interfere 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 becoming 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.

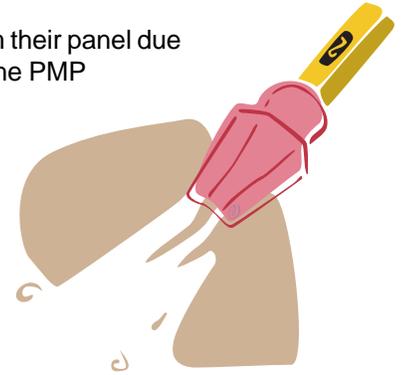
(Continued on page 5)

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.

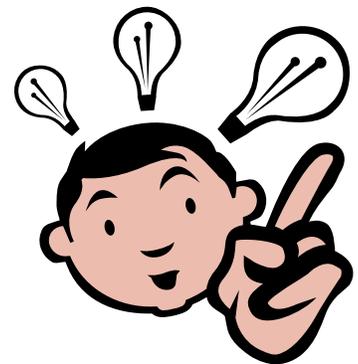
What is a BPA Error?

(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 Explanation

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®.

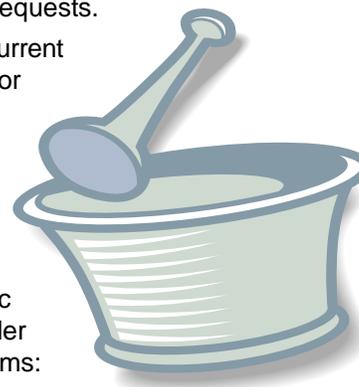
Highlights of the updated criteria include:

- 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 services 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

Post Office Box 244032
Montgomery, AL 36124-4032

**Alabama
Medicaid
Bulletin**



PRRST STD
U.S. POSTAGE
PAID
PERMIT # 77
MONTGOMERY AL

Provider Insider

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.



In This Issue...

HealthSpring Ends Medicare Advantage Contract with Alabama Medicaid	1
DME Medical Criteria Update	2
Monovalent H1N1 Vaccines Available	3
Reimbursement for Administration of Seasonal Influenza and H1N1 Vaccines	3
What To Do If Your Claim Is In a Suspended Status	3
Proper Claim Filing for Unclassified Drugs	4
Modifier "76"	4
Process for Billing Bilateral Procedures	4
Distinct Procedural Service (Modifier 59)	4
Top Five Denials for Nursing Home Claims	5
Plan First Recipients Prescription Information	5
What is a BPA Error?	6
QTool now Available to InfoSolutions Providers	7
EDS Is Now HP Enterprise Services	7
State Fiscal Year 2010-2011 Checkwrite Schedule	8

Pass It On!

Everyone needs to know the latest about Medicaid.

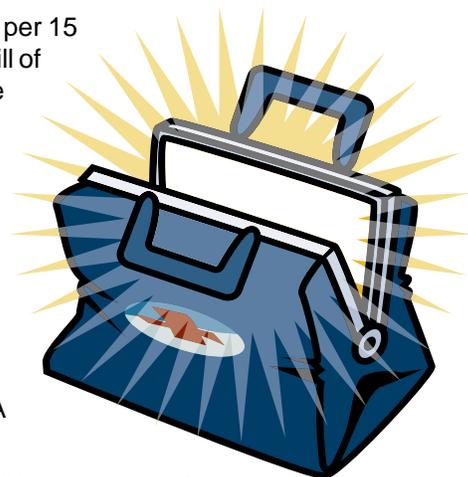
Be sure to route this to:

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

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		Tracheostomy Supply Requires PA, medical documentation and provider's invoice must be submitted for review and approval. Medicaid will reimburse at provider's invoice plus 20%
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 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), 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 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 injectable contraceptives and diaphragms.

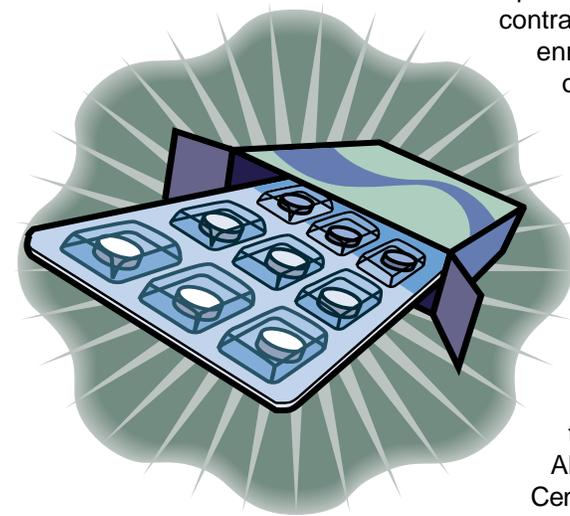
Medicaid Pharmacy Services Director Kelli Littlejohn, RPh. PharmD., emphasized that Plan First recipients who wish to fill their prescriptions at a community or outpatient pharmacy must have received the prescription from a private provider enrolled in the Plan First program. Oral contraceptives, the 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

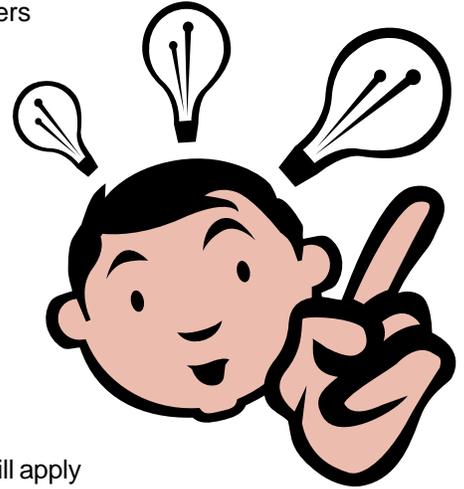
No Coverage

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
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

Post Office Box 244032
Montgomery, AL 36124-4032

**Alabama
Medicaid
Bulletin**



PRSR1 STD
U.S. POSTAGE
PAID
PERMIT # 77
MONTGOMERY AL

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.



In This Issue...

Ingenix to Conduct Medicaid Provider Post Payment Reviews	1
Medicaid Physician-Administered Multiple Source Drugs	2-14
Mirena IUD	2
Attention: Nursing Home Providers	2
Providers Must Use the Web Portal for Reports	2
Dental Provider List	2
Update to Dental Policy	2
Claims Billed by ADPH Nurse Practitioners	2
Physical Therapy Supervision	2
Essure	2
New HCPCS L Codes	14
VFC Utilization	14
Providing and Obtaining Appropriate Referrals Based on EPSDT Screenings	14
Telemedicine Services	15
Remittance Advise Availability	15
Medicaid Application Assisters / Hearing Services	15
Attention DME Providers	16

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, prophylaxis; 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, prophylaxis; 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	Ethylol	55390030803	Bedford Laboratories
			Ethylol	58178001701	Medimmune Oncology, Inc.
			Ethylol	58178001703	Medimmune Oncology, Inc.
			Ethylol	62756058140	Sun Pharmaceutical Industries, Ltd
			Ethylol	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	00703614001	Sicor Pharmaceuticals, Inc.
			Leucovorin Calcium	00703514501	Sicor Pharmaceuticals, Inc.
			J0695	Ceftriaxone sodium injection	250 MG
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	10019068627	Baxter Healthcare Corporation			
Ceftriaxone IN D5W	00338500341	Baxter Healthcare Corporation			
Ceftriaxone Sodium	10019068501	Baxter Healthcare Corporation			
Ceftriaxone Sodium	10019068602	Baxter Healthcare Corporation			
Ceftriaxone	10019008601	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	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	68330000801	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	00781321048	Sandoz
			Ceftriaxone	00781933048	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	000090347501	Pfizer, Inc
			Depo-Medrol	00009030602	Pfizer, Inc
			Depo-Medrol	000090347503	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	00008347523	Pfizer, Inc
			Depo-Medrol	00008347522	Pfizer, Inc
			Depo-Medrol	00008307323	Pfizer, Inc
			Depo-Medrol	00008307322	Pfizer, Inc
			Depo-Medrol	00008307303	Pfizer, Inc
			Depo-Medrol	00008307301	PharmaciaUPJHN
			Depo-Medrol	00008028052	PharmaciaUPJHN
			Depo-Medrol	00008028051	PharmaciaUPJHN
			Depo-Medrol	00008028003	PharmaciaUPJHN
			Depo-Medrol	00008028002	PharmaciaUPJHN
			Depo-Medrol	00008027401	PharmaciaUPJHN
			Methylprednisolone Acetate	00781313775	Sandoz
			Methylprednisolone Acetate	00781313670	Sandoz
			Methylprednisolone Acetate	00781313195	Sandoz
			Methylprednisolone Acetate	00781313171	Sandoz
			Methylprednisolone Acetate	00703004501	Scor Pharmaceuticals, Inc.
			Methylprednisolone Acetate	00703004301	Scor Pharmaceuticals, Inc.
			Methylprednisolone Acetate	00703003104	Scor Pharmaceuticals, Inc.
			Methylprednisolone Acetate	00703003101	Scor Pharmaceuticals, Inc.
			Methylprednisolone Acetate	00703005101	Scor Pharmaceuticals, Inc.
			Methylprednisolone Acetate	00703006301	Scor Pharmaceuticals, Inc.
			Methylprednisolone Acetate	00703005104	Scor 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	63323050801	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	Scor Pharmaceuticals, Inc.
			Dexamethasone Sodium Phosphate	00703352403	Scor Pharmaceuticals, Inc.
J1170	Hydromorphone injection	4 MG	Hydromorphone Hcl	00555111705	Barr Laboratories Inc
			Hydromorphone Hcl	00555111708	Barr Laboratories Inc
			Hydromorphone Hcl	00555111707	Barr Laboratories Inc
			Hydromorphone Hcl	00641234130	Baxter Healthcare Corporation
			Hydromorphone Hcl	00641012121	Baxter Healthcare Corporation
			Hydromorphone Hcl	00641234141	Baxter Healthcare Corporation
			Hydromorphone Hcl	00641012125	Baxter Healthcare Corporation
			Hydromorphone Hcl	00409126331	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	00088120926	Aventis Pharmaceuticals
			Anzemet	00088120808	Aventis Pharmaceuticals
			Anzemet	00088120632	Aventis Pharmaceuticals
			Anzemet	00088120876	Aventis Pharmaceuticals
J1586	Immune globulin, powder	500 MG	Gammagard S/D	00944262001	Baxter Healthcare
			Gammagard S/D	00944262002	Baxter Healthcare
			Gammagard S/D	00944262003	Baxter Healthcare
			Gammagard S/D	00944265503	Baxter Healthcare
			Gammagard S/D	00944262004	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	66758003901	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	64679086201	Wockhardt Americas, Inc.
			Granisetron HCl	64679086103	Wockhardt Americas, Inc.
			Granisetron HCl	64679086102	Wockhardt Americas, Inc.
J1631	Haloperidol Decanoate, Injectio 50 MG		Halopereidol Decanoate	63323047105	American Pharmaceutical Partners
			Halopereidol Decanoate	63323047101	American Pharmaceutical Partners
			Halopereidol Decanoate	63323048905	American Pharmaceutical Partners
			Halopereidol Decanoate	63323048901	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	00517080125	American Regent Laboratories, Inc.
			Ketorolac Tromethamine	10019003012	Baxter Healthcare Corporation
			Ketorolac Tromethamine	10019003004	Baxter Healthcare Corporation
			Ketorolac Tromethamine	10019003003	Baxter Healthcare Corporation
			Ketorolac Tromethamine	10019002902	Baxter Healthcare Corporation
			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	00408228761	Hospira
			Ketorolac Tromethamine	00408228831	Hospira
			Ketorolac Tromethamine	64679075808	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 Hd	63323037420	American Pharmaceutical Partners, Inc.
			Ondansetron Hd	63323037302	American Pharmaceutical Partners, Inc.
			Ondansetron Hd	60505074401	Apotex Corp.
			Ondansetron Hd	60505074406	Apotex Corp.
			Ondansetron Hd	00338176241	Baxter Healthcare Corporation
			Ondansetron Hd	10019090603	Baxter Healthcare Corporation
			Ondansetron Hd	10019090501	Baxter Healthcare Corporation
			Ondansetron Hd	10019090663	Baxter Healthcare Corporation
			Ondansetron Hd	10019090605	Baxter Healthcare Corporation
			Ondansetron Hd	10019090604	Baxter Healthcare Corporation
			Ondansetron Hd	10019090517	Baxter Healthcare Corporation
			Ondansetron Hd	10019090503	Baxter Healthcare Corporation
			Ondansetron Hd	10019090502	Baxter Healthcare Corporation
			Ondansetron Hd	55390030710	Bedford Laboratories
			Ondansetron Hd	55390012101	Bedford Laboratories
			Ondansetron Hd	55390030701	Bedford Laboratories
			Ondansetron Hd	55390012110	Bedford Laboratories
			Zofran	00173044202	Glaxosmithkline
			Zofran	00173044200	Glaxosmithkline
			Ondansetron Hd	00408475501	Hospira, Inc.
			Ondansetron Hd	00408475561	Hospira, Inc.
			Ondansetron Hd	00408112062	Hospira, Inc.
			Ondansetron Hd	00408475502	Hospira, Inc.
			Ondansetron Hd	00408475901	Hospira, Inc.
			Ondansetron Hd	00408475503	Hospira, Inc.
			Ondansetron Hd	00408475563	Hospira, Inc.
			Ondansetron Hd	00408476013	Hospira, Inc.
			Ondansetron Hd	00408475562	Hospira, Inc.
			Ondansetron Hd	61703024407	Mayne Pharma (Usa) Inc.
			Ondansetron Hd	61703024522	Mayne Pharma (Usa) Inc.
			Ondansetron Hd	00069070012	Pfizer
			Ondansetron Hd	00054008447	Roxane
			Ondansetron Hd	25021077850	Sagent Pharmaceuticals, Inc.
			Ondansetron Hd	00781305714	Sandoz
			Ondansetron Hd	00781301095	Sandoz
			Ondansetron Hd	00781305780	Sandoz
			Ondansetron Hd	00781301072	Sandoz
			Ondansetron Hd	00703722102	Sicor Pharmaceuticals, Inc.
			Ondansetron Hd	00703723939	Sicor Pharmaceuticals, Inc.
			Ondansetron Hd	00703722601	Sicor Pharmaceuticals, Inc.
			Ondansetron Hd	00703722104	Sicor Pharmaceuticals, Inc.
			Ondansetron Hd	00703722603	Sicor Pharmaceuticals, Inc.
			Ondansetron Hd	00703722101	Sicor Pharmaceuticals, Inc.
			Ondansetron Hd	62756018201	Sun Pharmaceutical Industries, Ltd
			Ondansetron Hd	62756018101	Sun Pharmaceutical Industries, Ltd
			Ondansetron Hd	00143989105	West-Ward, Inc
			Ondansetron Hd	00143989001	West-Ward, Inc
			Ondansetron Hd	64679072601	Wockhardt Americas, Inc.
			Ondansetron Hd	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	00078048461	Novartis
			Aredia	00078048391	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	00841149835	Baxter Healthcare Corporation
			Promethazine	00841149831	Baxter Healthcare Corporation
			Promethazine	00841149835	Baxter Healthcare Corporation
			Promethazine	00841149831	Baxter Healthcare Corporation
			Promethazine	00841095525	Baxter Healthcare Corporation
			Promethazine	00841095521	Baxter Healthcare Corporation
			Promethazine	00841095525	Baxter Healthcare Corporation
			Promethazine	00841095521	Baxter Healthcare Corporation
			Promethazine	00841094935	Baxter Healthcare Corporation
			Promethazine	00841094931	Baxter Healthcare Corporation
			Promethazine	00841094835	Baxter Healthcare Corporation
			Promethazine	00841094831	Baxter Healthcare Corporation
			Promethazine	00841092925	Baxter Healthcare Corporation
			Promethazine	00841092921	Baxter Healthcare Corporation
			Promethazine	00841092825	Baxter Healthcare Corporation
			Promethazine	00841092821	Baxter Healthcare Corporation
			Phenergan	60977000101	Baxter Healthcare Corporation
			Phenergan	60977000103	Baxter Healthcare Corporation
			Phenergan	60977000202	Baxter Healthcare Corporation
			Phenergan	60977000204	Baxter Healthcare Corporation
			Promethazine	00408231231	Hospira
			Promethazine	00408231202	Hospira
			Promethazine	00703220104	Sicor Pharmaceuticals, Inc.
			Promethazine	00703220101	Sicor Pharmaceuticals, Inc.
			Promethazine	00703219104	Sicor Pharmaceuticals, Inc.
			Promethazine	00703219101	Sicor Pharmaceuticals, Inc.
			Promethazine	00143988922	West-Ward, Inc
			Promethazine	00143988822	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	00409127832	Hospira, Inc.
			Fentanyl Citrate	00409909332	Hospira, Inc.
			Fentanyl Citrate	00409909422	Hospira, Inc.
			Fentanyl Citrate	00409909335	Hospira, Inc.
			Fentanyl Citrate	00409909338	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 Avon Willebrand Factor Com	68516460402	Grifols Biologicals INC
			Alphanate Avon Willebrand Factor Com	68516460302	Grifols Biologicals INC
			Alphanate Avon Willebrand Factor Com	68516460201	Grifols Biologicals INC
			Alphanate Avon Willebrand Factor Com	68516460101	Grifols Biologicals INC
			Alphanate	68516460002	Grifols Biologicals INC
			Alphanate	68516460001	Grifols Biologicals INC
			Koate-Dvi	13533088550	Talecris Biologicals Inc
			Koate-Dvi	13533088530	Talecris Biologicals Inc
			Koate-Dvi	13533088520	Talecris Biologicals Inc

Medicaid Physician-Administered Multiple Source Drugs *continued*

HCPCS CODE	SHORT DESCRIPTOR	HCPCS DOSAGE	LABELER DRUG NAME	NDC	LABELER
J7182	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	00026378660	Bayer Corporation Pharmaceutical
			Kogenate FS	00026379660	Bayer Corporation Pharmaceutical
			Kogenate FS Bio-set	00026379560	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	00026037990	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
J9000	Doxorubicin hcl 10 MG vial chemo 10 MG		Doxorubicin Hcl	63323088306	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	55390000501	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	61703038018	Mayne Pharma (Usa) Inc.
			Carboplatin	61703033922	Mayne Pharma (Usa) Inc.
			Carboplatin	61703038022	Mayne Pharma (Usa) Inc.
			Carboplatin	61703033950	Mayne Pharma (Usa) Inc.
			Carboplatin	61703038050	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	50111096576	Pfiva, Inc.
			Carboplatin	50111096576	Pfiva, Inc.
			Carboplatin	50111096776	Pfiva, Inc.
			Carboplatin	00703424401	Sicor Pharmaceuticals, Inc.
			Carboplatin	00703424901	Sicor Pharmaceuticals, Inc.
			Carboplatin	00703424801	Sicor Pharmaceuticals, Inc.
			Carboplatin	00703324911	Sicor Pharmaceuticals, Inc.
			Carboplatin	00591222011	Watson Labs
			Carboplatin	00591221911	Watson Labs
J9050	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	Cisplatin Injection	50 mg	Cisplatin	63323010351	American Pharmaceutical Partners, Inc.
			Cisplatin	63323010364	American Pharmaceutical Partners, Inc.
			Cisplatin	63323010365	American Pharmaceutical Partners, Inc.
			Cisplatin	55390009901	Bedford Laboratories
			Cisplatin	55390011250	Bedford Laboratories
			Cisplatin	55390011299	Bedford Laboratories
			Cisplatin	55390018701	Bedford Laboratories
			Cisplatin	55390041450	Bedford Laboratories
			Cisplatin	55390041499	Bedford Laboratories
			Cisplatin	00703574711	Sicor
			Cisplatin	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	83323015105	American Pharmaceutical Partners, Inc.
			Epirubicin	83323015125	American Pharmaceutical Partners, Inc.
			Epirubicin	83323015175	American Pharmaceutical Partners, Inc.
			Epirubicin	83323015100	American Pharmaceutical Partners, Inc.
			Epirubicin	55390020701	Bedford Laboratories
			Epirubicin	55390020801	Bedford Laboratories
			Epirubicin	10518010410	Dabur Oncology Ptc
			Epirubicin	10518010411	Dabur Oncology Ptc
			Epirubicin	81703035992	Mayne Pharma (Usa) Inc.
			Epirubicin	81703034735	Mayne Pharma (Usa) Inc.
			Epirubicin	81703035901	Mayne Pharma (Usa) Inc.
			Epirubicin	81703035993	Mayne Pharma (Usa) Inc.
			Epirubicin	81703035991	Mayne Pharma (Usa) Inc.
			Epirubicin	81703035902	Mayne Pharma (Usa) Inc.
			Epirubicin	81703035959	Mayne Pharma (Usa) Inc.
			Epirubicin	81703034859	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	00703308711	Sicor Pharmaceuticals, Inc.
			Epirubicin	00703308911	Sicor Pharmaceuticals, Inc.
			J9190	Fluorouracil injection	500 MG
Fluorouracil	83323011710	American Pharmaceutical Partners, Inc.			
Fluorouracil	83323011761	American Pharmaceutical Partners, Inc.			
Fluorouracil	83323011720	American Pharmaceutical Partners, Inc.			
Fluorouracil	10139006301	Generamedx, Inc.			
Fluorouracil	10139006310	Generamedx, Inc.			
Fluorouracil	10139006320	Generamedx, Inc.			
Fluorouracil	66758004401	Parenta Pharmaceuticals, Inc.			
Fluorouracil	66758004403	Parenta Pharmaceuticals, Inc.			
Adrucil	00703301513	Sicor Pharmaceuticals, Inc.			
Adrucil	00703301812	Sicor Pharmaceuticals, Inc.			
J9208	Irinotecan injection	20 MG	Irinotecan HCL	83323019302	American Pharmaceutical Partners, Inc.
			Irinotecan HCL	83323019305	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	55390029801	Bedford Laboratories
			Irinotecan HCL	55390029501	Bedford Laboratories
			Irinotecan HCL	10518010310	Dabur Oncology Ptc
			Irinotecan HCL	10518010311	Dabur Oncology Ptc
			Irinotecan HCL	81703034916	Mayne Pharma (Usa) Inc.
			Irinotecan HCL	81703034961	Mayne Pharma (Usa) Inc.
			Irinotecan HCL	81703034909	Mayne Pharma (Usa) Inc.
			Irinotecan HCL	81703034962	Mayne Pharma (Usa) Inc.
			Irinotecan HCL	81703034938	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	00781308672	Sandoz
			Irinotecan HCL	00781308675	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	00074368303	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
			Elgard	00024079375	Sanofi-Aventis, Us Llc
			Elgard	00024022205	Sanofi-Aventis, Us Llc
			Elgard	00024061030	Sanofi-Aventis, Us Llc
			Elgard	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
J9285	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 Ptc
			Paclitaxel	10518010209	Dabur Oncology Ptc
			Onxol	00172375895	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	Scior Pharmaceuticals, Inc.
			Paclitaxel	00703476401	Scior Pharmaceuticals, Inc.
			Paclitaxel	00703476801	Scior Pharmaceuticals, Inc.
			Paclitaxel	00703476701	Scior 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	Scior
			Mitoxantrone Hydrochloride	00703468001	Scior
			Mitoxantrone Hydrochloride	00703468601	Scior
J9390	Vinorelbine tartrate/10 mg	10 MG	Vinorelbine Tartrate	63323014801	American Pharmaceutical Partners, Inc.
			Vinorelbine Tartrate	63323014805	American Pharmaceutical Partners, Inc.
			Vinorelbine Tartrate	55390008901	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	56390028801	Bedford Laboratories
			Vinorelbine Tartrate	81703034108	Mayne Pharma (Usa) Inc.
			Vinorelbine Tartrate	81703034109	Mayne Pharma (Usa) Inc.
			Vinorelbine Tartrate	86758004501	Parenta Pharmaceuticals, Inc.
			Vinorelbine Tartrate	86758004502	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).
- Hibrix (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.

Psychiatrists 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 Rescreening 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

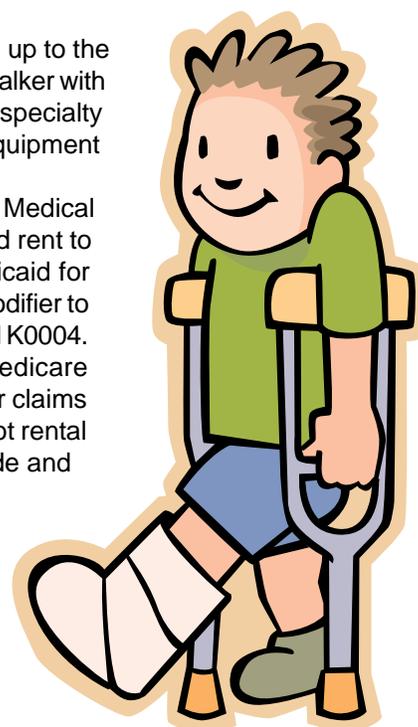
Effective April 1, 2010, combination vaccines and their single components will not be allowed to pay on the same date of service or within 30 days.

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 for Appliances 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.



Post Office Box 244032
Montgomery, AL 36124-4032

**Alabama
Medicaid
Bulletin**



PRSR STD
U.S. POSTAGE
PAID
PERMIT # 77
MONTGOMERY AL